Concept Note

CONSULTATIVE DISCUSSIONS TO SUPPORT ESTABLISHMENT AND IMPLEMENTATION OF SHARED CARE CLUSTER SERVICES IN THE 9 DISTRICTS BASED ON THE HEALTH SERVICE REORGANIZATION POLICY AND THE ESSENTIAL SERVICE PACKAGE

ADB Financed Health System Enhancement Project, Sri Lanka

Background

The ADB financed Health System Enhancement Project (HSEP) as described under Output 1.4 (section on project description in the Project Administration Manual of the HSEP), intends to support the policy reform related to the establishment of 9 shared care clusters on a phase one pilot basis. The phase one implementation is based on the recently drafted 'essential service package'[1] and the recently approved 'reorganizing health care delivery for universal health coverage policy'[2].

The hospital clusters (one base hospital (secondary care hospital) linked with feeder divisional hospitals and primary medical care units (primary curative care facilities) and their catchment areas (based on health seeking behavior identified by Grama Niladhari divisions)) are already identified by the respective Provincial and Regional Directors of Health Services and their teams in each of the 9 districts of Moneragala, Badulla, Nuwera Eliya, Matale, Kandy, Rathnapura, Kegalle, Anuradhapura and Polonnaruwa, where the HSEP is implemented (Annex 1).

The administrative reforms including the directive required to establish shared care clusters are expected to be issued by the Ministry of Health, Nutrition and Indigenous Medicine and the required documentation and processes that need to be followed for providing high quality services will also need to be documented prior to launching a cluster service to the defined catchment population. The services that will be shared across each of the clusters will also be agreed prior to the establishment of the shared care clusters. The services that would be provided as inpatients, clinic patients and as out patients via cluster care may include the following areas /activities:

- elderly care
- family planning services
- stroke care including cerebrovascular diseases
- rehabilitation and disability care
- palliative care
- care for selected NCDs: diabetes, cardiovascular diseases, chronic respiratory diseases and asthma, mental illnesses, and care for selected cancers
- laboratory services related to chemical pathology, haematology, histopathology, microbiology and biochemistry.

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[1] The essential service package (ESP) is currently in draft form and will be finalized towards October 2018 by the MOHNIM and WHO. The ESP has attempted to identify / list the services that is required to be delivered at one of 5 levels of care (home/community, field clinic and MOH office, PMCU, DH and the apex secondary level hospital).

[2] Policy on healthcare delivery for UHC, Sri Lanka
https://drive.google.com/file/d/1DoTqSlMP_dn1D5SJxdQE4LUaxkpL8bG8/view?usp=sharing

- imaging services – US scanning and radiology services
- disease surveillance activities
- infection prevention and control measures
- health care waste management services
- emergency care services

The necessary investments for providing shared care services in the above identified service areas in each of the clusters are expected to be supported via the HSEP.

This includes;

(i) health information technology system in place for sharing health information and continuity of care (an interconnected electronic patient management system, issuing a patient identification number, electronic system to share patient health information, laboratory and imaging services and results across the secondary and primary care facilities, drug availability information and for sharing disease surveillance information);
(ii) required medical equipment and furniture for providing the above services,
(iii) some essential civil works repairs at the PHCs.
(iv) PHC Innovation Fund for supporting cluster implementation (Annex 2).

The clusters will be established based on the reorganization policy and the circular 01/06 – 2019 dated 22 January 2019. Performance of the cluster will need to be evaluated with the draft framework in Annex 3 (adapted from the reorganization policy). A draft methodology for carrying out the evaluation is attached in Annex 4. The services will be monitored using the PHC (curative) monitoring guidelines issued via the MOHNIM Circular No: 2-166/2015 dated Nov 30, 2015 in Annex 5. The clusters are expected to be functional by October 2019.

Consultative Discussions

It is proposed to have a series of consultations at each of the provinces followed by a two day residential workshop to further discuss and finalize the process to establish and support implementation of the proposed shared care clusters in each of the selected 9 districts supported under the ADB financed HSEP.

The objective of the workshop/s is/are to:

- to support establishment and implementation of shared care cluster services in the 9 districts based on the health service reorganization policy, cluster implementation circular, and the essential service package with the development of all necessary implementation plans by each cluster to define the necessary guidelines and other standard operating procedures required for the implementation of a shared care cluster.

The following activities will be carried out during the workshop;

- Discuss and agree on the focal points and responsible teams for establishing clusters
- Review the cluster list of facilities and revise the list if necessary and identify the medical officer of health (MOH) areas that need to be linked to the cluster facilities for disease surveillance and other MOH led preventive services.

- Discuss the catchment populations of the defined clusters (using GIS technology and the mapping that has already been carried out)
- Discuss the authorizations and directives required to introduce shared care cluster services to strengthen primary health care
- Discuss and work out a communications strategy to carry out advocacy for the cluster reform within the cluster facilities, within and outside of the health sector in the respective districts
- Discuss and define the services (based on the ESP) that will be provided at the Cluster linked facilities
- Discuss the types of guidelines that need to be developed for providing referrals (referral pathways), sharing selected services (e.g., standard operating procedures for sharing laboratory services, rehabilitation services, imaging services, clinic services, family planning services, elderly care, palliative care and clinical pathways for some selected diseases etc.)
- Agree on the modalities for developing the required guidelines, standard operating procedures.
- Explore and suggest ways of sharing human resources within the cluster
- Explore and suggest ways of sharing financial resources within the cluster
- Discuss the inputs that are currently planned for the clusters and identify the gaps in terms of equipment, facilities, drugs, etc. that will be required at the PMCUs/ DHS/ and the Apex hospital to provide shared care services
- Discuss and define the functions that need to be included in the health information technology system that is required to be installed
- Discuss the proposed monitoring plan and the results monitoring framework for the shared care clusters
- Discuss the proposed evaluation methodology of the clusters
- Develop cluster wise implementation plans by each district
- Discuss the proposed PHC innovation fund (funded by the ADB HSEP) utilization guidelines

Timeline

It is expected that the shared care cluster pilots wil be established by October 2019 following the development and establishment of all the above addressed objectives in the 9 HSEP supported cluster sites.

Funding sources:

The GOSL and the ADB HSEP resources are made available via the planned activities and via the PHC Innovation fund of the HSEP.

Annex 1:

List of Cluster health facilities in each of the 9 districts to be supported under the ADB financed Health System Enhancement Project

			CLUSTER	
Sno.	**Province**	**District**	**Apex Name**	**Facilities**
1	North Central Province	Polonnaruwa	BH Medirigiriya	PMCU Ambaguswewa
2				PMCU Meeguswewa
3				PMCU Wijepura
4				PMCU Divulankadawala
5				MOH Medirigiriya
6		Anuradhapura	BH Thambuththegama	DHB Thalawa
7				DHB Eppawala
8				Galnewa DHC
9				Rajanganaya tract 5 DHC
10				Rajanganaya tract 11 DHC
11				Katiyawa DHC
12				Giribawa DH
13				Parakumpura PMCU
14				Mahananneriya DHC
15				Siyambalangamuwa PMCU
16	Uva	Moneragala	BH Bibile	PMCU Godigamuwa
17				PMCU Nannapurawa
18				DHB Medagama
19				DHC Pitakumbura
20				PMCU Rathmalagehaella
21		Badulla	BH Welimada -B Type	DHB Uva paranagama
22				DHC Wewegama
23				CD Pannalawela
24				DHC Bogahakumbura
25				DHC Boralanda
26				DHC Haggala
27				PMCU Keppetipola
28				DHC Downside
29				DHC Kirkeels
30				DHC Mirahawatta
31				DHC Nadungamuwa
32				DHC Udaweriya
33				PMCU-Hevanakumbura

34				PMCU-Silmiyapura
35	Sabaraga muwa	Kegalle	BH Karawanella	DHA Kitulgala
36				DHA Deraniyagala
37				DHC Amithirigala
38				DHC Higuralakanda
39				DHC Gonagaldeniya
40				DHC Maliboda (Estate)
41				DHC Panawatta (Estate)
42				DHC Nagastenna (Estate)
43				DHC Halgolla (Estate)
44				DHC Sapumalkanda (Estate)
45				DHC Amanawala
46				PMCU Pothdenikanda
47				PMCU Boralankada
48				PMCU Basnagala
49				PMCU Atala
50				PMCU Yatiyantota
51		Ratnapura	BH Kahawaththa	DHA Godakawela
52				PMCU Hiramadaga\ma
53				PMCU Atakalampanna
54				DHC Madampe
55				PMCU Babaragasthenna (Welkeniyaya)
56				DHA Rakwana
57				DHC Palmadulla
58				ERH Haupe
59				PMCU Kalallela
60				DHC Endana
61				PMCU Galpaya
62				DHC Ranwala
63				PMCU Udawela
64				DHC Hunuwala
65				PMCU Narissa
66	Central	Nuwara Eliya	BH Rikillagaskada	DHC Gonagantenna
67				DHC Gonapitiya
68				DHC Hanguranketha
69				DHC Madulla
70				DH Madaramnuwara
71				DH Mathurata
72				DHC Muloya
73				DHC Nildandahinna
74				DHC Theripa
75				DHA Walapane

76				PMCU Kurupanawela
77				PMCU Keerthibandarapura
78				PMCU Manakola
79				PMCU Rupaha
80		Matale	BH Dambulla	DHC Galewale
81				DHB Madipola
82				DHC Sigiriya
83				Aluthwewa PMCU
84				Dewahuwa PMCU
85				Wahakotte PMCU
86				Kalundawa PMCU
87				Wewalawewa PMCU
88		Kandy	BH Teldeniya	MOH Menikhinna
89				DHA Menikhinna
90				MOH Kundasale
91				PMCU Digana-Rajawella
92				DHC Dunhinna
93				DHC Narampanawa
94				PMCU Ragala-Makuldeniya
95				PMCU Sandasiridunuwila
96				DHB Medamahanuwara
97				MOH Medamahanuwara
98				PMCU Meemure
99				DH Ududumbara
100				MOH Ududumbara
101				Prison Hospital Pallekela
102				Digana Rehabilitation Hospital

Annex 2:

GUIDELINES FOR PRIMARY HEALTH CARE INNOVATION FUND

A. Planned PHC Development in Sri Lanka

1. Sri Lankan's demand for health services is evolving because of population aging, changing lifestyle and disease burden, and medical and socio-economic developments. To maintain past achievements and respond to new challenges for universal health coverage, the country's public health system must be adjusted and scaled up.

2. Sri Lanka has developed an extensive network of preventive and curative health services with substantial human resources providing quality of care at low cost. However, with free patient choice to use any public health services. PHC services are often being bypassed in favor of secondary and tertiary hospitals (and private services for diagnostics).[3] This has resulted in less

[3] MOHNIM. *Health Sector Plan 2016–2020.* Colombo.

use and inefficiency of PHC and overloading of secondary and tertiary hospital with routine cases. A mix of factors likely contribute to this trend including public perceptions of health needs and services, staff and supply shortages, lack of diagnostic services and specialized care, limited preventive services for noncommunicable diseases (NCDs), and lack of a sound referral system.

3. The Government remains firmly committed to the unique Sri Lankan model of free choice of health services at no cost, which is a major driver for the country's strong health sector performance is. The Ministry of Health, Nutrition and Indigenous Medicine (MOHNIM) notes that PHC is lagging behind in terms of its share of resources and investments compared to larger hospitals, and is planning to make PHC services more responsive to public demand by scaling up PHC providing a comprehensive package of health services and continuum of care with referral services. While this is expected to improve demand, MOHNIM also desires to explore innovative strategies to further improve PHC services, also for vulnerable groups.

4. In 2009, the MOHNIM Policy and Analysis Unit carried out an analysis of the existing health service structure and policies.[4] This led to the understanding that the health system was not geared to prevention and continuity of care for lifestyle related and chronic diseases. Proposed developments were shared at the National Policy Forum for Strengthening PHC in 2010. Protocols, tools and monitoring plans were developed to improve PHC. This included the development of a personal health record and clinic record for adults, emergency care guidelines, education material for health staff, an essential medicines list for NCDs, lifestyle guidance tools, checklists for institutional assessment for infrastructure and logistics and a social marketing tool.

5. In 2013, to increase demand for and quality of PHC, a "shared care cluster system" was proposed whereby a specialist hospital serves surrounding primary level hospitals.[5] This was based on the assumptions that (i) strengthening PHC will be overall cost-neutral for the sector, (ii) this will allow maintaining people's free choice of health services, and (iii) implementation of private sector price and quality control of services will reduce workload for public services.

6. According to the Master Plan 2016–2025, the aim is to improve the fully accessible PHC to provide personalized, family centered, continuity of care of good quality, where good health outcomes can be achieved with reduced out of pocket expenditure to the people. This is conceived as the basis for achieving universal health coverage.

7. The Policy on Healthcare Delivery for Universal Health Coverage, 2018[6] provides details for strengthening PHC to address the changing disease burden and challenges in service delivery. Its objectives are to (i) respond to evolving needs with quality years to life added, resulting amongst others in elders living with less disability; (ii) reduce catastrophic health spending for lower and middle-income groups, and (iii) improve overall satisfaction of people and health experience.

8. Priority areas of the policy are quality first contact, family-centered approach, continuity of care, equitable access to specialized services, health literacy and rational health seeking behavior, protection from financial risks, and monitoring and adaptation. This is to be implemented through the shared care cluster system including e-Health, improving HRH including 1 family doctor for every 5000 people and community workers, access to essential medicines, access to laboratory services, access to emergency services, and improving management and monitoring. Expanding PHC services, for diagnostics, should also reduce out of pocket spending.

[4] MOHNIM. *National Health Strategic Master Plan, 2016–2025.* Vol IV Health Administration and HRH. Colombo.

[5] Sharing both patient care and resources.

[6] MOHNIM. 2018. *Policy on Healthcare Delivery for Universal Health Coverage.* Colombo.

9. The Concept note on Management Support for Primary Care Strengthening[7] and related Results Framework propose improvements in (i) cluster management including monitoring, supervision and community participation; (ii) advocacy, education and outreach; (iii) infrastructure; (iv) HRH including training of family doctors and community workers; (v) and improving the essential package of health services (NCDs, diagnostics and emergency services).

10. The cluster approach needs to be further tested. A set of interventions is proposed to be implemented in selective clusters and compared to standard services outside these clusters, to find ways for strengthening PHC. The set of cluster interventions will not be standardized but will be based on local priorities to address gaps in the services based on the scope as provided in the policy and results framework.

11. As clusters and services are different, the main point of interest is to compare trends. An assessment mechanism is to be included. Drivers of change in demand for PHC services are likely to be multiple and mutually reenforcing, and will be difficult to pin down to individual interventions. The entire range of PHC functions will be assessed to identify improvements, including management and monitoring, outreach, referral, diagnostic services and NCD services.

B. Proposed PHC Innovation Fund

12. The Sri Lanka Health System Enhancement Project (HSEP) is a $60 million project financed by the Asian Development Bank (ADB) and the Government of Sri Lanka to (i) upgrade PHC in a total of 9 districts in Central, North Central, Sabragamuwa, and Uva provinces; (ii) strengthen medical information technology and disease surveillance systems; and (iii) improve PHC related policies and capacities.

13. Under output 1, HSEP includes a $2 million PHC Innovation Fund (PIF) to provide grants to explore PHC Development based on the shared-care cluster system for a subdistrict population. In each cluster, preventive and curative health services will be expanded and interlinked with one apex hospital for referral services using information technology. Under the HSEP, one cluster will be developed in each of the nine districts in these four provinces.

14. The PIF will support local health officials to use their own insights to improve PHC in terms of access, range, quality or efficiency of services. Preference is given to developing the cluster system in the targeted clusters/subdistricts, but other interventions will also be considered. The grant is provided to prepare, implement and monitor a grant-financed project within the approved scope and conditions as provided.

15. MOHNIM / PMU will request each Provincial Governments of the four provinces to establish a PIF chapter at provincial level that will be managed by the provincial project steering committee. Provincial health directors of the four provinces will invite eligible government health offices to submit grant proposals of up to $100,000 to explore innovative strategies for PHC improvement. The PIU will issue guidelines and application forms to potential grant applicants and assist these applicants with the preparation of proposals.

16. The focus of the proposal will be on PHC development, preferably in the clusters, to demonstrate how PHC could be improved. This may include activities for community engagement,

[7] MOHNIM Management, Development and Planning Unit. 2018. *Concept Note: Management Support for PHC Strengthening, and Results Framework*. Colombo.

other sectors, and referral hospitals. Based on the MOHNIM policy and concept paper, 5 groups of interventions have been identified, which may be packaged to enhance impact:

(i) **Improving PHC management**, including cluster management, a supervisory system, performance monitoring, gender promotion, and environmental and social safeguards;
(ii) **Human resources development** including training doctors in family medicine, training midwives in field health stations in preventive care, nutrition counselling.
(iii) **Information technology** 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.
(iv) **Scaling up services** including health and nutrition promotion, diagnostic services, emergency services, family medicine, NCD services, and infection prevention and control;
(v) **Rehabilitation of facilities** including roofs, electricity, sanitation, water supply, and waste management (no new constructions).

17. A strong before-and-after assessment and monitoring system will be put in place in all clusters to be able to assess progress using both quantitative and qualitative instruments. The instruments will track all functions of the PHC system at all levels, but probably limited to the apex hospital, 2-3 PHC services, and related MOH and outreach services.

18. The implementation arrangements for the PIF are in Attachment 1. The draft application form is in Attachment 2.

Attachment 1: Guidelines for Primary Health Care Innovation Fund

A. Purpose

1. The Sri Lanka Health System Enhancement Project (HSEP) is a US$60 million project financed by the Asian Development Bank (ADB) and the Government of Sri Lanka to (i) upgrade PHC in a total of 9 districts in 4 provinces; (ii) strengthen health information technology and disease surveillance systems; and (iii) improve PHC related policies and capacities.

2. Under output 1, HSEP includes a $2 million PHC Innovation Fund (PIF) to provide grants to explore PHC Development based on the shared-care cluster system for a subdistrict population. In each district, one cluster will be developed: preventive and curative PHC will be expanded and interlinked with one apex hospital for referral services using information technology.[8] MOHNIM is considering engaging a cluster manager for this purpose or nominate a person from the regional health office or divisional hospital to perform such a task.

3. The MOHNIM requests provincial health offices to invite eligible government health offices in the four provinces to submit grant proposals of up to a maximum of $100,000 per office to explore innovative strategies for PHC development in the nine districts targeted under the project, preferably in the clusters. The PIF will support local health officials to use their own insights to improve PHC in terms of access, range, quality or efficiency of services. Eligible government health offices are all provincial and regional health offices, divisional hospitals, primary medical care units and medical officers of health.

B. Scope

4. Targeted districts are Polonnaruwa and Anuradhapura districts (North-Central Province); Nuwara Eliya, Matale, and Kandy districts (Central Province), Badulla and Monaragala districts (Uva Province); and Ratnapura and Kegalle districts (Sabaragamua Province).

5. Within each of these nine districts, one subdistrict area has been selected as a cluster, with each an apex hospital and a range of PHC services. It is proposed that, rather than using PIF for interventions scattered across the district, most of PIF support will be used to target these clusters, in terms of providing **investments to upgrade PHC services in that particular cluster**, so as to be able to see the results of these efforts. This focus may not be 100%, as certain investments like for repair of facilities or training may have a wider coverage, but the idea is to demonstrate if the cluster approach can make a difference.

6. Secondly, to make implementation more practical, it is proposed to **use a package approach**, combining various interventions in one approach for PHC upgrading/development, which may be more efficient and easier to implement. For example, management improvement could be combined with improving the range of services, setting up a referral system, and improving information technology (IT).

7. The focus of the proposal will be on PHC, and may include support for community, other sectors, and referral hospitals. Based on the MOHNIM policy and concept paper, 5 groups of

[8] PHC in the contact of the Sri Lanka public health sector includes curative services provided by divisional hospitals and primary medical care units (PMCU), and preventive services provided by the Medical Officer of Health and staff in Field Health Stations.

interventions have been identified. It remains to be decided which interventions are mandatory for all clusters:

(i) **Improving PHC management**, including cluster management, a supervisory system, performance monitoring, gender promotion, and environmental and social safeguards;
(ii) **Human resources development** including training doctors in family medicine, training midwives in field health stations in preventive care, nutrition counseling.
(iii) **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.
(iv) **Scaling up services** including health and nutrition promotion, diagnostic services, emergency services, family medicine, NCD services, and infection prevention and control;
(v) **Rehabilitation of facilities** including roofs, electricity, sanitation, water supply, and waste management (no new constructions).

8. The grant is provided to **prepare, implement and monitor** a grant-financed project within the approved scope and conditions as provided. The grant applicant may want to be informed about, take advantage of, and build on **ongoing initiatives** and experiences in and outside the 4 provinces. For example, Sri Lanka has several ongoing initiatives to improve NCD services, nutrition interventions, health management information systems, and medical waste management.

C. PIF Application

9. A national Project Steering Committee (PSC) will provide project oversight including for PIF. A Project Management Unit (PMU) headed by a Project Director has been established in MOHNIM. The PMU will support 4 Provincial Implementation Units (PIU) established under the Provincial Council to implement the project in each province. Each PIU will report to the provincial project coordination committee (PCC) headed by the Chief Secretary. The PMU will manage the PIF on behalf of the PSC, and establish provincial PIF in each of the provinces. The provincial PIF will be managed by the PIU on behalf of the PCC.

10. **The PIF application process will be managed and supported by the PIUs**. Following internal circulation inviting eligible government offices to apply, each applicant downloads the guidelines and application form, and expresses interest to the PIU to confirm eligibility for the PIF. As only government offices are eligible for PIF support, the PIF invitation will be sent directly to all eligible government offices in the 4 provinces and will be advertised in the project website.

11. Any eligible office can submit one proposal for grant financing a time, up to $100,000. The lead officer applying for the grant and accountable for its proper use will be a senior civil servant working in the health sector in the province.

12. The applicant may seek information and assistance from the PMU/PIU for completing the application (email addresses to be provided). The applicant may also submit to the PIU a two-page proposal and budget to apply for preparation money up to $1,000 for consultations and field assessment, Additional funding may be requested for feasibility studies or baseline assessment. In case of proposed infrastructure development, the provincial engineer will be consulted.

13. The indicative application form is in Attachment 2. The proposal will basically state the problem(s) being addressed, the objective and purpose, for whom, how, by whom, when and where, how much it would cost, expected results and how these will be measured and shared, and risks.

14. Specifically, the proposal will include a description of the location and target population and targeted beneficiaries including vulnerable groups.

15. The projects should preferably take less than 3 months to prepare and be implemented within one year. Progress is reported on a quarterly basis. The final report should be submitted within 3 months of completion of the project.

16. In terms of measuring results, a before-and-after community survey will not be warranted for most PIF grants. A before-and-after assessment and monitoring system focused on providers and use of services including client satisfaction will be able to track relevant PHC functions at all levels including the apex hospital, 2-3 PHC services, and related MOH and outreach services.

17. A standard budget will be prepared as shown in Attachment 2. Following are eligible expenditures:

(i) Salaries of project staff[9]
(ii) Workshops/meetings
(iii) Travel costs and per diem
(iv) IT and other system design
(v) Facility repairs and waste disposal
(vi) Facility equipment and furniture
(vii) Community based program costs

18. The applicant will assess if there are any major feasibility issues or implementation risks and, if so, propose how these shall be mitigated. The following project risks may be considered:

(i) Requires regulation or other legal requirement
(ii) Completion depends on other funding
(iii) Requires skilled persons which may not be available
(iv) Requires behavioral change
(v) Requires physical facilities that may not be available
(vi) Project is technically complex
(vii) Project may face strong objections from certain stakeholders
(viii) Project may negatively affect certain populations

19. The PAM provides details on gender action plan and safeguards requirements[10] which are also applicable for the use of the PIF. The PIU will (i) inform potential grant applicants regarding ADB's gender action plan and social and environmental safeguards; (ii) assist in compliance with the gender action plan and environmental and social safeguards; (iii) ensure that ADB gender dimensions and safeguards are adequately addressed in the proposals; and (iv) monitor and report compliance. Rehabilitation works to be funded by the PIF will be subject to SPS 2009 even if they may be exempted from national environmental regulations.

[9] Project staff are persons not already paid for services by MOHNIM either as regular or contractual staff. MOHNIM pensioners are eligible as project staff.
[10] ADB. 2009. Safeguard Policy Statement. Manila.

20. All completed applications will be officially submitted to the PCC in the Provincial Council, via the concerned RDHS and PDHS, with copy to the PIU as the secretariat of the PCC. The PIU will forward a copy to the PMU for any comments prior to the PCC meeting.

D. Grant Evaluation

21. The Chief Secretary or deputy will chair the PCC including for PIF grant approval and monitoring. It includes as members the PDHS or deputy, the RDHS, the deputy project director heading the project implementation unit (PIU) (secretary), and 2 other persons to be nominated by the PCC. The PCC will meet quarterly to review and approve grants and record decisions.

22. The PCC may decide to assess the proposal in the field or request experts to review the proposal. The PCC may also invite the lead project officer to present the proposal in a briefing meeting. The PCC may share its observations and recommendations in writing, but this is not for negotiation.

23. All proposals will be considered for funding based on several criteria to be reviewed, revised and adopted by the PCC (the selection committee). Following selection criteria may be considered:

(i) Focus on PHC cluster approach
(ii) Support for system development
(iii) Targeting vulnerable populations
(iv) Potential results and sustainability
(v) Management and participation
(vi) Financial arrangements
(vii) Risks and Safeguard issues
(viii) Monitoring arrangements

24. The PCC may reject the proposal for funding, suggest necessary amendments for the proposal or approve the proposal. The decision of the PCC shall be minuted and signed and is considered as final. After PCC approval, the project is eligible to receive money from the fund.

25. An MOU will be signed between the Chief Secretary/PDHS and the lead applicant stipulating the scope, implementation arrangements, and terms and conditions for use of the grant. The PIU headed by the Deputy Project Director will monitor utilization of the grant funds.

26. The MOHNIM steering committee, in consultation with the Provincial Councils, can adjust the scope and implementation of the PIF subject to ADB concurrence.

E. Implementation Arrangements

27. Implementation arrangements for the PIF will use the overall project management structure, and in the case of civil works may also use the Ministry of Local Government and Provincial Council. The grant applicant and supervising office are responsible for project implementation. The PIU is responsible for supervision of the grant project to ensure proper use of grant funds. All procurement related activities will be managed by the PIU at the request of the lead project officer of the approved project and like the rest of the project, the ADB procurement and disbursement guidelines will be followed. For training, authorized advances for training will be provided to the lead project officer who would be required to submit the expenditure details to

the PIU. Additional training advances will be provided only following the submission of expenditures to the earlier advance by the lead project officer.

28. After grant approval, the successful applicant will submit an updated project schedule with proposed activities. The quarterly progress report submitted to the PIU shall describe the progress of work according to the time frame submitted before applying for the next instalment.

29. A project is considered as successful based on completion of project activities, substantive and demonstrable results, meeting administrative and safeguard requirements, and timely reconciliation of expenditures. The PCC can at any time decide to terminate the project on the basis of redundancy, poor performance, or with evidence of fraud or malpractices. Even if the project is terminated, the lead project officer must comply with the final technical, administrative and financial project completion reporting obligations.

30. For overall project implementation, MOHNIM will establish a project account at a state owned commercial bank managed by the PMU. The PMU will transfer funds including for PIF to the four provinces into the respective sub-project bank accounts for project related activities. These sub-project accounts established at a state-owned commercial bank will be managed by the PIUs including for PIF. ADB will provide project funds including for PIF based on an annual project plan approved by the PSC, which is based on plans for project activities at central and provincial levels.

31. The PMU will be responsible for reconciliation of the accounts. monitoring and auditing of sub-project accounts at the PIUs, and preparation and submission of withdrawal applications for replenishment of the advance accounts. Project funds will be disbursed in accordance with ADB's Loan Disbursement Handbook (2017, as amended from time to time), and detailed arrangements agreed upon between the Government and ADB. The PIUs will be responsible for all activities that are managed at the PIU level which will mainly include civil works, training and PIF activities.

32. The project accountant of the PIU in each of the provinces will provide oversight of all PIF related activities. The applicant/implementing office will be responsible for grant implementation, monitoring and reporting. The implementing office/ lead project officer will request all procurements in the approved proposal to be carried out by the PIU and will only seek cash advances for training programs. The PIU will manage the reconciliation and replenishment based on each approved activity in the proposal (on a quarterly basis so that cashflow for project implementation is ensured) based on approved ADB guidelines.

33. All expenditures under a single proposal will be less than $100,000. The PMU and PIUs will use statement of expenditures (SOE) for liquidation of expenditures of $100,000 equivalent per individual proposal. Supporting documents and records for the expenditures claimed under the SOE should be maintained at the PIU level and made readily available for ADB review, upon ADB's request for submission of supporting documents on a sampling basis, and for independent audit.

34. MOHNIM and the provinces (PMU and the 4 PIUs) will maintain, or cause to be maintained, separate books and records by funding source for all expenditures incurred on the project. Sri Lanka has a system of project wise budget in their computerized accounting system CIGAS and the same is proposed to be used in the ADB project. All funds under the Project shall be routed through the PMU and the province level PIUs which will ensure that ADB project accounts are separately recorded and maintained. MOHNIM will prepare consolidated project

financial statements which shall include at a minimum, a statement of receipts and payments with accompanying notes and schedules.

35. All procurement of works, goods and services under the PIF will follow ADB procurement guidelines (like the rest of the project). Procurement under PIF will be for minor civil works, equipment and furniture, and/or services including for training and IT system design. These items will be small in value and may follow nationally advertised bidding or shopping procedures. Any consulting services required for PIF will be engaged by PMU in accordance with ADB's Guidelines on the Use of Consultants (March 2013) and ADB's procurement regulations and policy.

Attachment 2: Grant Application Form for the PHC Innovation Fund under the ADB 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*)	PHC management and monitoring Information technology Scaling up health services Rehabilitating facilities HRH development and training
10	Targeted beneficiaries or services	
11	Proposed starting and ending dates	Starting date: year/month Completion 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	Polonnaruwa				
	Anuradhapura				
Sabaragamua	Ratnapura				
	Kegalle				
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	
1.7	Gender training	
1.8	Environmental examination and monitoring	
1.9	Engagement of vulnerable populations	
1.10	Patient satisfaction monitoring	
1.11	Other	
B. Information technology		
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	
5.1	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	When	By Whom	How

Table 7: Implementation schedule

nr		Year 20..				Year 20..			
	Activity								

Table 8: Detailed Cost estimates

		Cost items	Rate	Amount	3 monthly Cost Breakdown							
					20..				20..			
1.	Personnel											
	Salary											
	Travel allowance											
	Other											
2.	Civil Works											
	Repair facility											
	Water supply											
	Waste management											
	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*	

* 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

Annex 3: **Cluster Performance Assessment and Results Framework**

Cluster Performance Assessment and Results Framework			
Results chain	**Cluster Performance Indicators with Targets and Baselines**	**Data and Reporting**	**Risks**
Cluster Outcome Efficiency, effectiveness, equity, and responsiveness of the cluster linked PHC facilities are improved	At least 50% increase in outpatient utilization (for each of females and males) at cluster PHC facilities (PMCUs and DHs) (age, sex, place of residence, district, and province disaggregated) (2018 baseline: No data available to be collected from baseline survey) At least 50% increase in patients reporting knowledge of and satisfaction of using cluster linked PHC services (age, sex, district disaggregated) (baseline: No data available to be collected from baseline survey)	Baseline survey of the cluster pilot facilities an end line survey of the cluster care pilot. b. Baseline and endline surveys of the cluster care pilot.	Changing health seeking behavior can take longer than predicted periods.
	At least 90% of notified notifiable diseases investigated within the stipulated time in the medical officer of health areas linked to the cluster hospitals in the target provinces (2018 baseline: No data available to be collected from baseline survey)	c. Province level routine data from a 25% sample of medical officer of health areas	
Cluster Output PHC services enhanced in the cluster linked PHC facilities in Central, North Central, Sabaragamuwa, and Uva provinces	Policy and Governance Level activities and decisions		
	A circular / directive is issued by MOHNIM to implement the policy on reorganizing health care delivery for universal health coverage by establishing, on a pilot basis, cluster care services by linking selected PHCs to a selected secondary care facility	MOHNIM records	Delay in issuing of approvals related to implementation of national level policy is likely.
	Healthcare management level activities and decisions		
	A circular / directive issued by the MOHNIM / province to appoint a Deputy Regional Director Health Services / or a similar level officer as the cluster coordinator for each of the clusters	MOHNIM records	Delay in issuing of approvals related to implementation of management level reforms likely.
	A circular / directive is issued by MOHNIM / province authorizing sharing of human resources, materials and equipment and finances within each of the cluster care projects in the 9 districts	MOHNIM records	

Results chain	Cluster Performance Indicators with Targets and Baselines	Data and Reporting	Risks
	The administrative and quality services that would be provided based on the ESP via a shared care cluster defined. (e.g. HCWM practices, infection prevention and control activities, laboratory services, imaging services, outpatient, inpatient and emergency care services, disease surveillance activities, antimicrobial resistance surveillance etc.)		
	Advocacy workshops carried out to inform all categories of staff in the cluster linked facilities on cluster care and the services that would be shared	Province and District records	
	Communication material developed to inform public of all services that would be available via the shared care cluster approach at the cluster linked PHCs	Province and District records (with the BCC firm records)	
	Clinical activities and decisions		
	The clinical services that would be provided via a shared care approach to be defined for each cluster. (e.g. elderly care, family planning services, cerebrovascular care including stroke care, care for selected NCDs: diabetes, cardiovascular diseases, chronic respiratory diseases and asthma, care for selected cancers, and mental illnesses)		
	Clinical guidelines, circulars, standard operating procedures developed for providing selected shared care services within the clusters.		
	Gap analysis carried out to identify the material (equipment and supplies) that are required to be procured.		
	PHC products and services		
	% of cluster linked PHCs having adequate stocks (a months' buffer stock?) of all identified essential drugs and supplies		
	% of institutions offering the prescribed / defined laboratory tests at a given time		
	% of cluster linked PHCs having the required Emergency equipment		

Results chain	Cluster Performance Indicators with Targets and Baselines	Data and Reporting	Risks
	At least 90% of PHC facilities in the clusters in target provinces provide gender responsive and inclusive family planning services as outpatient and clinic services		
	At least 90% of PHCs linked to clusters in target provinces provide nutrition services (including counselling)		
	HRH and training		
	Human resource assessment carried out within the defined clusters to identify gaps in HR for providing the defined services based on the ESP.		
	Develop approaches to address HR gaps via task sharing, retraining, and task shifting of available staff and also by appointing new staff where essential		
	% of medical officers, nurses and support staff trained by Apex hospital on emergency care		
	No of orientation and review meetings held within the cluster		
	Number of Medical Officer of Health meetings attended by cluster hospital doctors		
	At least 75% of medical officers and other staff of PMCUs and DHs linked to clusters (of which 40% are women) are trained in PHC (family medicine)		
	Health information technology system		
	At least 90% of PMCUs and DHs and medical officer of health areas linked to a cluster use electronic patient information sharing system across the cluster facilities.		
	At least 90% of PMCUs and DHs in the clusters sending notifiable disease surveillance information via an electronic system to the medical officers of health areas.		
	Atleast 90% of patients who use the PMCUs and DHs that are linked to the clusters receive an unique patient identification number		
	Clinical Outputs		
	Atleast 90% of cluster linked PMCUs and DHs provide family planning services as defined in the ESP.		

Results chain	Cluster Performance Indicators with Targets and Baselines	Data and Reporting	Risks
	Atleast 90% of cluster linked PMCUs and DHs provide elderly care services (to be defined)		
	% increase of diabetic patients seeking regular follow up care at the cluster linked PMCUs and DHs		
	% increase of hypertensive patients seeking regular follow up care at the cluster linked PMCUs and DHs		
	% reduction of readmission (for the same illness within. 30 days) of patients to the cluster linked hospitals or to other hospitals	Survey	
	Percentage of surgical site infections in clean surgeries performed each year in the cluster linked hospitals	Survey	
	At least 75% of PMCUs and DHs linked to clusters provide nutrition services (including counselling) to adults, children and elderly		

Annex 4: ***Baseline and Endline Survey Methodology for Evaluation of HSEP***

The objectives of the Baseline and Endline survey will be to (i) assess the performance of the HSEP using the agreed Design and Monitoring Framework, Gender Action Plan and the BCC strategy results framework; and (b) assess the performance of the cluster care pilot on providing shared care at the primary health care level using the cluster results monitoring framework and other selected indicators.

The surveys will be conducted in early 2019 and mid 2023 respectively and will consist of three types of surveys:

- household survey that collects information on health service utilization, health seeking behavior, health awareness, OOP and other areas in line with GAP and DMF.
- PHC facility survey that collects data on indicators in DMF and GAP and cluster pilot indicators in terms of efficiency, effectiveness, responsiveness, quality of care, and patient satisfaction.
- Stakeholder and focus group discussions

The surveys will collect data from the proposed three comparison groups:

A. **Group 1 (Cluster Group):** All primary health care facilities (DHs, PMCUs, other identified hospitals, medical officer of health offices and the Apex Hospital) that are linked (structurally and /or functionally) to the defined ADB supported clusters and the Grama Niladhari (GN) areas served by these cluster linked facilities in the 9 districts.

B. **Group 2 (PHC/FHC Group):** All ADB HSEP supported PHC facilities (135 excluding the ADB financed PHCs that are also linked to the clusters (which would be included in Group 1) and the 127 FHCs) and the respective GN areas served by these facilities.

C. **Group 3 (Non ADB financed PHC/FHC group)**: All non ADB financed / supported PHCs and FHCs and all GN's that are not served by any ADB project facilities

(determined based on distance or time taken to reach facility. The exact parameters will be further identified through consultation).

A GIS expert will be engaged to identify catchment GN's that are served by health facilities in groups 1, 2, and 3. The firm will then appropriately identify survey samples and select households and facilities for data collection. The firm is responsible for all aspects related to the primary data collection and in periodically monitoring the DMF, GAP and BCC frameworks through support to the PIUs and PMU as needed. The household and facility surveys are expected to identify the changes that would be seen with the implementation of this 5 year HSEP.

Identification of GNs for Household Survey

GN divisions falling under group 1, 2, and 3 will be identified through provincial consultation and GIS mapping for the purpose of identifying the catchment population for the household survey. The methodology listed below will be used to identify each group.

Group 1: The GN divisions served by the nine cluster pilots have been identified through a mapping and consultative process with the provinces. All GNs were first mapped around the cluster health facilities and then validated through a consultative process with the provincial health departments. Provincial health departments identified where the patients for each cluster facility typically reside and validated the GIS mapping which was based on distance of GNs from the facilities.

Group 2: GNs will be identified through a similar process as group 1. All GNs around ADB project facilities should be mapped and those proximally located to the facilities should be listed. Provinces should review the GN list to validate that patient flow into project facilities is from identified GNs.

Group 3: Facilities outside the ADB investment in the nine districts will be mapped. Of these, discussion with provinces should identify any additional clusters that are planned for these facilities in the future. Any facilities that may be clustered over the next five years, should be excluded and mapping of GNs around remaining facilities should be completed and validated with provinces (similar validation process as group 1 and 2).

Annex 5:

General Circular letter No. 02 - 166 / 2015

My No:HPS/OD/09/2015
Management Development Planning Unit
Ministry of Health Nutrition & Indigenous Medicine
"Suwasiripaya'
Colombo10.
30/10/2015

Provincial/ Regional Directors of Health Services
Director/ NIHS
Heads of Institutions- PHC units
All Provincial/ District level CCPs

Re: Supervision of Primary Health Care Curative Institutions (Divisional Hospitals and Primary Medical Care Units)

Primary Health Care curative institutions of Sri Lanka consist of type A, B, C Divisional Hospitals and Primary Medical Care Units. All of these institutions are under the supervision of Regional Directors of Health Services with few exceptions.

It has noted that management and patient care services can be improved in response to the growing demand of new health challenges. As part of the improvement process, Ministry of Healthcare has developed a supervision tool to supervise Primary Healthcare Institutions. This supervision tool consists of 3 parts.

A) **General and Outpatient Department**
B) **In-ward Services**
C) **Supportive services**

It is advised to at least supervise two institutions (Divisional Hospitals / PMCU) per month by RDHS and his/her district level officials. The Supervision tool herewith annexed should be used. You are also advised to maintain copies of the Supervision report duly filed in office. A corresponding file should be maintained at institutional level which contains all previous supervision reports with recommendations.

You are also responsible to improve services and follow up the implementation of the recommendations given.

.....

Dr. P. G. Mahipala
Director General of Health Services
Ministry of Health, Nutrition & Indigenous Medicine
"Suwasiripaya"
385, Ven. Baddegama Wimalawansa Thero Mw
Colombo 10.

Dr. P.G. Mahipala

Director General of Health Services

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නව සෞඛ්‍ය අභියෝගයන් කෙරෙහි වර්ධනය වෙමින් පවතින ඉල්ලුමට ප්‍රතිචාර වශයෙන් කළමණාකරන සහ රෝගී සත්කාර සේවාවන් වැඩිදියුණු කළ හැකි බව හඳුනා ගෙන ඇත. මෙම සංවර්ධන ක්‍රියාවලියේ කොටසක් ලෙස සෞඛ්‍ය පෝෂණ හා දේශීය වෛද්‍ය අමාත්‍යාංශය විසින් ප්‍රාථමික සෞඛ්‍ය සත්කාර ආයතන අධීක්ෂණය සඳහා අධීක්ෂණ ක්‍රමවේදයක් නිර්මාණය කර ඇති අතර එය කොටස් තුනකින් සමන්විත වේ.
අ) සාමාන්‍ය සහ බාහිර රෝගී අංශය
ආ) වාට්ටු අභ්‍යන්තර සේවා
ඇ) උපකාරක සේවා

ප්‍රාදේශීය සෞඛ්‍ය සේවා අධ්‍යක්ෂ සහ ඔහුගේ/ඇයගේ දිස්ත්‍රික් මට්ටමේ නිලධාරීන් විසින් මසකට අවම වශයෙන් ආයතන දෙකක්වත් (ප්‍රාදේශීය රෝහල්/ ප්‍රාථමික වෛද්‍ය සත්කාර ඒකක) අධීක්ෂණය කළ යුතු බවට උපදෙස් ලබා දෙන අතර මේ සමඟ අමුණා ඇති අධීක්ෂණ ක්‍රමවේදය (Supervision tool) භාවිතයට ගත යුතුය. අධීක්ෂණ වාර්තාවේ පිටපත් නිසි ලෙස ගොනු කර කාර්යාලයේ පවත්වාගන යාමට ඔබට උපදෙස් ලබා දෙන අතර නිර්දේශ සහිත පෙර සිදුකරන ලද සියලු අධීක්ෂණ වාර්තා ඇතුළත් ගොනුවක් ආයතනික මට්ටමෙන් පවත්වාගෙන යා යුතුය. මෙම සේවාවන් වැඩිදියුණු කිරීම හා ලබා දී ඇති නිර්දේශ ක්‍රියාත්මක කිරීම සම්බන්ධයෙන් ද වගකීම් ඔබ සතුවේ.

වෛද්‍ය පී. පී. මහිපාල
සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජනරාල්
සෞඛ්‍ය, පෝෂණ හා දේශීය වෛද්‍ය අමාත්‍යාංශය
"සුවසිරිපාය"
385, පූජ්‍ය බිද්දේගම් විමලවංශ හිමි මාවත,
කොළඹ10.

වෛද්‍ය. පී.පී.මහිපාල
සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජනරාල්

பொது சுற்றறிக்கை கடித இல :- 02 - 166 / 2015
எனது இல :- HPS/OD/09/2015

முகாமைத்துவ அபிவிருத்தி திட்டமிடல் பிரிவு,
சுகாதார பராமரிப்பு போசனை மற்றும் உள்நாட்டு வைத்தியத்துறை அமைச்சு,
"சுவசிரிபய"
கொழும்பு- 10
2015/10/30

மாகாண/பிராந்திய சுகாதார சேவைகள் பணிப்பாளர்கள்,
பணிப்பாளர் /NISH
நிறுவனத் தலைவர்கள் /PHC பிரிவுகள்
மாகாண/ மாவட்ட மட்ட CCPS

ஆரம்ப சுகாதார பராமரிப்பு நோய் குணப்படுத்தல் நிறுவனங்களில் மேற்பார்வை (பிரதேச வைத்தியசாலைகள் மற்றும் ஆரம்ப மருத்துவ பராமரிப்பு பிரிவுகள்)

இலங்கை ஆரம்ப சுகாதார பராமரிப்பு நோய் குணப்படுத்தல் நிறுவனங்கள் A,B,C வகையிளன பிரதேச வைத்தியசாலைகள் மற்றும் ஆரம்ப மருத்துவ பராமரிப்பு நிறுவனங்கள் என்பவற்றை உள்ளடக்கியுள்ளன. இந்த அனைத்து நிறுவனங்களும் சில விதிவிலக்குகள் தவிர பிராந்திய சுகாதார சேவைகள் பணிப்பாளர்களின் மேற்பார்வையின் கீழ் உள்ளன.

முகாமைத்துவ மற்றும் நோயாளர் பராமரிப்பு சேவைகள் , வளர்ந்து வரும் புதிய சுகாதார சவால்களின் தேவைகளை ஈடு செய்யும் வகையில் மேம்படுத்தலாம் என குறிப்பிடப்பட்டுள்ளது. முனேற்ற செயற்பாட்டின் பகுதியாக சுகாதார பராமரிப்பு அமைச்சு ஆரம்ப சுகாதார பராமரிப்பு நிறுவனங்களை மேற்பார்வை செய்வதற்கு மேற்பார்வை சாதனம் ஒன்றை உருவாக்கியுள்ளது. மேற்பார்வை சாதனம் பின்வரும் மூன்று ( ) பகுதிகளை உள்ளடக்கியுள்ளது.

அ) பொது மற்றும் வெளி நோயாளர் பிரிவு
ஆ) உள்ளக சேவைகள்
இ) ஆதரவு சேவைகள்

மாதந்தோறும் ஆகக் குறைந்தது இரண்டு நிறுவனங்கள் (பிரதேச வைத்தியசாலைகள் / ஆரம்ப மருத்துவ பராமரிப்பு பிரிவுகள்) பிராந்திய சுகாதார சேவைகள் பணிப்பாளர்களினால் மற்றும் அவர் / அவருடைய மாவட்ட மட்ட அதிகாரிகளினால் மேற்பார்வை செய்வதற்கு அறிவுறுத்தப்பட்டுள்ளது. இங்கு இணைக்கப்பட்டுள்ள மேற்பார்வை சாதனம் பயன்படுத்தப்பட வேண்டும். மேலும் முறையாக பூர்த்தி செய்யப்பட்ட மேற்பார்வை செய்பவரும் அறிக்கைகளின் பிரதிகளை அலுவலகத்தில் பேணிப் பாதுகாக்குமாறு நீர் அறிவுறுத்தப்படுகின்றீர். தொடர்புடைய கோவை ஒன்று நிறுவன மட்டத்தில் பேணப்பட வேண்டும். அது பரிந்துரைகளுடன் உள்ளடக்கியிருக்கும்.

சேவைகள் மேம்படையச் செய்யவும், வழங்கப்படும் பரிந்துரைகள் நிறைவேற்றப்படுவதை தொடர்வதற்கும் நீர் பொறுப்பாக இருத்தல் வேண்டும்.

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சுவசிரிபாய
SUWASIRIPAYA

මගේ අංකය
எனது இல
My No:
HPS/OD/A/19/2018

ඔබේ අංකය
உமது இல
Your No:

දිනය
திகதி
Date
22.01.2019

සෞඛ්‍ය, පෝෂණ හා දේශීය වෛද්‍ය අමාත්‍යාංශය
சுகாதார, போசணை மற்றும் சுதேசவைத்திய அமைச்சு
Ministry of Health, Nutrition & Indigenous Medicine

General Circular No: 01 - 06 | 2019

All Provincial Chief Secretaries
All Provincial Health Secretaries
All Provincial Directors of Health Services
All Regional Directors of Health Services
Relevant Heads of Institutions

Implementation of Shared Care Clusters at District Level for Improvement of Service Delivery for Universal Health Coverage

The Ministry of Health, Nutrition & Indigenous Medicine approved the Policy on Healthcare Delivery for Universal Health Coverage in April 2018.
(http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/2018/phduhc-2018.pdf)

Based on the Policy, it is recommended to establish 'shared care clusters' linking a specialist care institution (Base Hospital or above) with a group of Divisional Hospitals and Primary Medical Care Units to serve as a 'cluster' of facilities to provide a people-centered healthcare with continuity of service to the health seekers in Sri Lanka.

Two Development Partners, The Asian Development Bank (ADB) and the World Bank will support the strengthening of primary care to support implementation of the policy.

The ADB financed Health System Enhancement Project (HSEP), which will be implemented from 2018 to 2023, will support to establish, implement, monitor and evaluate 9 newly established 'clusters' in the districts of Kandy, Matale, Nuwara Eliya, Anuradhapura, Polonnaruwa, Ratnapura, Kegalle, Badulla and Monaragala.

Based on the policy, a key function to operationalize the cluster would be its management. A suitable officer should be designated to carry out cluster management functions giving leadership,

385, පූජ්‍ය බද්දේගම විමලවංශ හිමි මාවත, කොළඹ 10, 385இ வணக்கத்துக்குரிய பத்தேகம விமலவங்ச தேரோ மாவத்தை, கொழும்பு 10.
385, Rev. Baddegama Wimalawansa Thero Mawatha, Colombo 10, Sri Lanka.

creating structural and functional linkages with the identified feeder primary care level hospitals and other providers to provide continuity of care to health users.

Available human resources need to be reorganized within the cluster which links primary and specialist care facilities to provide services across the cluster in line with the recently developed Essential Services Package. In addition, financial allocations for cluster implementation and functioning need to be provided and an inter linked health information system to enhance the quality of services need to be established to enhance and develop the services to meet the criteria that are identified in the policy (Annexes I to IV defined in the policy).

The cluster linked facilities should be supervised by using monitoring tools that are defined in the General Circular Letter No 2-166 / 2015 dated November 30, 2015 issued by the Ministry of Health, Nutrition & Indigenous Medicine and monitor the cluster performance using a results monitoring framework adapted from the results framework in the policy. A comprehensive comparative evaluation should be carried out by 2023 to assess the performance of the cluster based reform introduced to strengthen primary health care for ensuring universal health coverage in these selected areas.

All provincial directors, regional directors and heads of line ministry and provincial institutions are hereby advised to;

a. Identify the respective cluster and to develop the clusters in a phased manner (The ADB supported districts have identified the initial phase I clusters as per annex I).
b. To identify a suitable arrangement to coordinate, supervise and monitor cluster-based developments and activities.
c. To develop district health plans inclusive of cluster-based development, strengthening primary healthcare, identifying results to be achieved and responsible development partners/agencies for funding purposes.
d. The apex/specialist hospitals to be guided by annex VII of the policy, available in the docket of the policy document, which gives the expected development profile of each specialist institution.

Secretary

Wasantha Perera
Secretary
Ministry of Health, Nutrition & Indigenous Medicine
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Copies:

All Additional Secretaries
Director General of Health Services
All Deputy Director Generals
Head, Human Resources Coordination Unit
Relevant Directors

} For information

ANNEX I

List of Cluster health facilities in each of the 9 districts to be supported under the ADB financed Health System Enhancement Project

No.	Province	District	Apex Name	Facilities
1	North Central Province	Polonnaruwa	BH Medirigiriya	PMCU Ambaguswewa
2				PMCU Meeguswewa
3				PMCU Wijepura
4				PMCU Divulankadawala
5				MOH Medirigiriya
6		Anuradhapura	BH Thambuththegama	DHB Thalawa
7				DHB Eppawala
8				Galnewa DHC
9				Rajanganaya tract 5 DHC
10				Rajanganaya tract 11 DHC
11				Katiyawa DHC
12				Giribawa DH
13				Parakumpura PMCU
14				Mahananneriya DHC
15				Siyambalangamuwa PMCU
16	Uva	Moneragala	BH Bibile	PMCU Godigamuwa
17				PMCU Nannapurawa
18				DHB Medagama
19				DHC Pitakumbura
20				PMCU Rathmalagehaella
21		Badulla	BH Welimada -B Type	DHB Uvaparanagama
22				DHC Wewegama
23				CD Pannalawela
24				DHC Bogahakumbura
25				DHC Boralanda
26				DHC Haggala
27				PMCU Keppetipola
28				DHC Downside
29				DHC Kirkeels
30				DHC Mirahawatta
31				DHC Nadungamuwa
32				DHC Udaweriya
33				PMCU-Hevanakumbura
34				PMCU-Silmiyapura
35	Sabaragamuwa	Kegalle	BH Karawanella	DHA Kitulgala
36				DHA Deraniyagala
37				DHC Amithirigala
38				DHC Higuralakanda
39				DHC Gonagaldeniya
40				DHC Maliboda (Estate)
41				DHC Panawatta (Estate)
42				DHC Nagastenna (Estate)

90				MOH Kundasale
91				PMCU Digana-Rajawella
92				DHC Dunhinna
93				DHC Narampanawa
94				PMCU Ragala-Makuldeniya
95				PMCU Sandasiridunuwila
96				DHB Medamahanuwara
97				MOH Medamahanuwara
98				PMCU Meemure
99				DH Ududumbara
100				MOH Ududumbara
101				Prison Hospital Pallekela
102				Digana Rehabilitation Hospital