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## Case Report,

# Non Communicable Disease Programme of Colombo District, Sri Lanka: A Technical Report

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### Abstract:

Non Communicable Diseases (NCD) are the dominant chronic health problem in Sri Lanka. They are basically classified into 2 types namely; acute NCD & chronic NCD. Policies, strategies, activities and monitoring & evaluation plans regarding prevention and control of ncds are in place in the National NCD programme of Sri Lanka.

The objective of this report is to study the Non Communicable Disease Programme of the division of Regional Director of Health Services (RDHS) – Colombo. Key informant's interviews, review of secondary literature and observation in district review meetings were used to collect information.

It was found that RDHS division - Colombo is responsible for both preventive and curative health care, for a population of 2.2 million, through 56 health care institutions. With regard to ncds; injury surveillance, advocacy, capacity building, development of information, education & communication material, social media strategies and regular reviews are in good progress while deficiencies were seen in pre admission care, coverage of services, utilization pattern of people, standards of treatment of ncds, health promotion activities, inter sectorial collaboration and information management systems.

Nominal group technique was used for prioritization of the problems identified. The issue of "NCD curative care provision is not optimum" was selected as the highest priority problem. Fish born diagram was developed to find root causes. The arm of "Physician factors" was selected to give recommendations and action plan was prepared accordingly.

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**Key words:** Non Communicable Diseases prevention & control)

### Introduction:

#### National NCD Programme

Non Communicable Diseases (NCD) are the dominant health problem in Sri Lanka which is the leading cause of mortality, morbidity and disability which utilize increasing amounts of health resources. The key factors causing NCD are the aging population, urbanization and lifestyle changes. It has led to a decrease in quality of life, a decrease of economic growth and a rising demand on family & national budget.

Ncds are basically classified into 2 types namely; acute ncds & chronic ncds. Acute ncds are comprised of different type's injuries while chronic ncds are comprised of Cardio Vascular Diseases (CVD), cerebrovascular Diseases (cevd), Hypertension (HT), Diabetes Mellitus (DM),

Chronic Respiratory Tract Diseases (CRTD) & Chronic Renal Diseases (CRD). Major risk factors are identified as smoking, unhealthy diet, physical inactivity, alcohol, stress in life and air pollution. Ncds can be prevented, controlled and managed, if evidence based policies are formulated and relevant programmes are implemented successfully.

#### Policies, Activities and Monitoring & Evaluation of national NCD programme:

Acute NCD programme is administered based on the decisions taken by the Injury Prevention Policy; National Centre for Injury Prevention; National Committee for Prevention of Injuries (NCPI); Technical working groups such as Police, First aid groups, Red cross and Schools; Medical Officers (MO) - ncds in district level and the 5 year

- Action Plan.

Main activities described in the implementation plan include; injury surveillance; pre admission care; injury information management system; training of public health (PH) staff; developing training manuals for PH staff; developing educational material and conducting awareness programmes for the health care staff, non health sectors and the public. Monitoring and evaluation at national level are done by the national committee for prevention of injuries and technical working groups. Relevant activities conducted by Medical Officers - ncDs are monitored at the review meetings at the district and national level.

**Chronic NCD programme** is administered based on decisions taken by the Chronic NCD & control Policy; National health council; National Steering Committee for NCD; Technical working groups; NCD Bureau (NCD unit, Mental health Unit, Cancer control unit); Planning & coordination body of PDHS and NCD cell of RDHS. Chronic NCD policy has 09 key strategies namely; 1. Prevention by Reduction of risk factors; 2. NCD screening at community level; 3. Provision of optimum NCD care by strengthening the health system; 4. Promotion of healthy life styles through community empowerment; 5. Human resource development for NCD activities; 6. Establishing a national health information system; 7. Encouraging research; 8. Establishing financing mechanisms; and 9. Incorporating NCD in policies of other ministries.

Monitoring and evaluation of chronic NCD programme is carried out by measuring morbidity, mortality and risk factors of chronic ncDs by conducting periodic surveys. Further, Conducting review meetings at central level such as NCD steering committee meeting, National Advisory Board meeting on NCD and Quarterly MO (NCD) review meeting at district level facilitate regular monitoring of the progress of activities.

**Objective:**

To study the Non Communicable Disease Programme of the division of Regional Director of Health Services (RDHS) – Colombo, Sri Lanka.

**Methodology:**

Key informant's interviews, Review of secondary literature and observation in district review meetings were used to collect information.

**Findings:**

**NCD programme of Colombo district**

The Colombo RDHS division is responsible for

both preventive and curative health care for a population of 2.2 Million. There are 56 health care institutions in the district including Base Hospitals, Divisional Hospitals, Primary Medical Care Institutions and Medical Officer of Health divisions. There is a Medical Officer - NCD at RDHS office to coordinate and facilitate NCD activities to be carried out according to the annual action plan.

With respect to acute ncDs;

- “Injury surveillance activities” are carried out in Base Hospitals and necessary training, printed formats and supervision are provided by the RDHS level.
- “Advocacy” meetings have been conducted to improve the awareness.
- “Training of Trainers” programmes have been conducted for school teachers and training of school children on first aid has been carried out.
- “A first aid hand book” has been provided to schools as a health education and a social marketing strategy.
- “Quarterly review meetings” are conducted at both RDHS and PDHS levels to improve monitoring and a quarterly bulletin is developed incorporating the information on the progress of acute NCD activities.

However, there is questionable gap in accuracy; quality and timeliness of injury surveillance process which needs further strengthening. Even though pre admission care is emphasized, the coverage of capacity building to include categories such as public health staff, school children, bus drivers, three wheel drivers, drivers of school vans and general public with regard to preadmission care needs further attention and needs huge amount of resources. Injury information management system too was found to have deficiencies in integration with other management systems to facilitate better decision making.

With respect to chronic ncDs;

- Training has been given to health managers on establishing “healthy life style centres” as a part of advocacy.
- Training has been given on “pre admission services and on WHO core package on NCD care” to relevant health staff.
- In addition, “IEC material and necessary equipment” has been provided. Establishment of gymnasiums in recognized health centres are in progress.

- “Awareness programmes on hlcs” to school principals/ teachers/ children/ community organizations have been conducted.
- Under social media strategy “a booklet named “API Nirogi wemu” (Let’s be healthy)” and IEC material on healthy diet and salt reduction has been distributed among schools.
- “Food composition tables” developed at national level have been used to educate both health staff and the public.
- Training has been given to health personnel of new technology innovations such as “personal health records”.
- Capacity building programmes to PHC staff on “communication and life skills” has been conducted by the health education officer.
- A project has been established a “health promotion setting” in “Hanwella” division.
- Consultant Community Physician at the Provincial Director and the western province Governor have started health promotion activities under “poverty alleviation programme”.
- Some other awareness programmes have been conducted on risk factors, ncDs, home based activities, composting and house gardening in cooperation with agricultural department.
- There are “Mother support groups” established in every Medical Officer of Health (MOH) division for health promotion.
- “Work place surveys” are conducted under the supervision of Environment & Occupational Health unit of Ministry of Health.
- Mental health activities such as “Gender Based Violence and suicides” are attended by Public Health Midwives.

Even though risk factor reduction has been promoted with policies, regulations and services, activities implemented have gaps especially in coverage. There are thirty-two “Healthy Life Style Centres” (HLC) functioning in 15 MOH areas in Colombo RDHS area. Adhering to guidelines, two hlcs have been established in each MOH area, both in curative and preventive settings. However, there are issues with regard to achievement of the target of 80 individuals screened per week. Utilization of

this service by the healthy public is below the expected level. Suggested mobile clinics and work place screening are not to be seen as expected in majority of institutions. Support from private sector and community based organizations is not received in a recognizable way.

NCD care provision including prompt diagnosis, emergency care, proper referral system, supply of essential drugs, equipment and laboratory facilities too need further strengthening. Training of health staff needs further coverage to make all the relevant staff competent. “Health Promoting settings” have been established in some hospitals, schools and work places which need further distribution. “Risk factor surveillance” and “disease surveillance” is not satisfactorily carried out. Research findings for ncDs are not well coordinated, integrated and used at regional level for evidence based practice. Other sectors are too involved in NCD prevention of RDHS division such as schools and work places but inter sectoral corporation needs to be enhanced.

#### **Problem identification:**

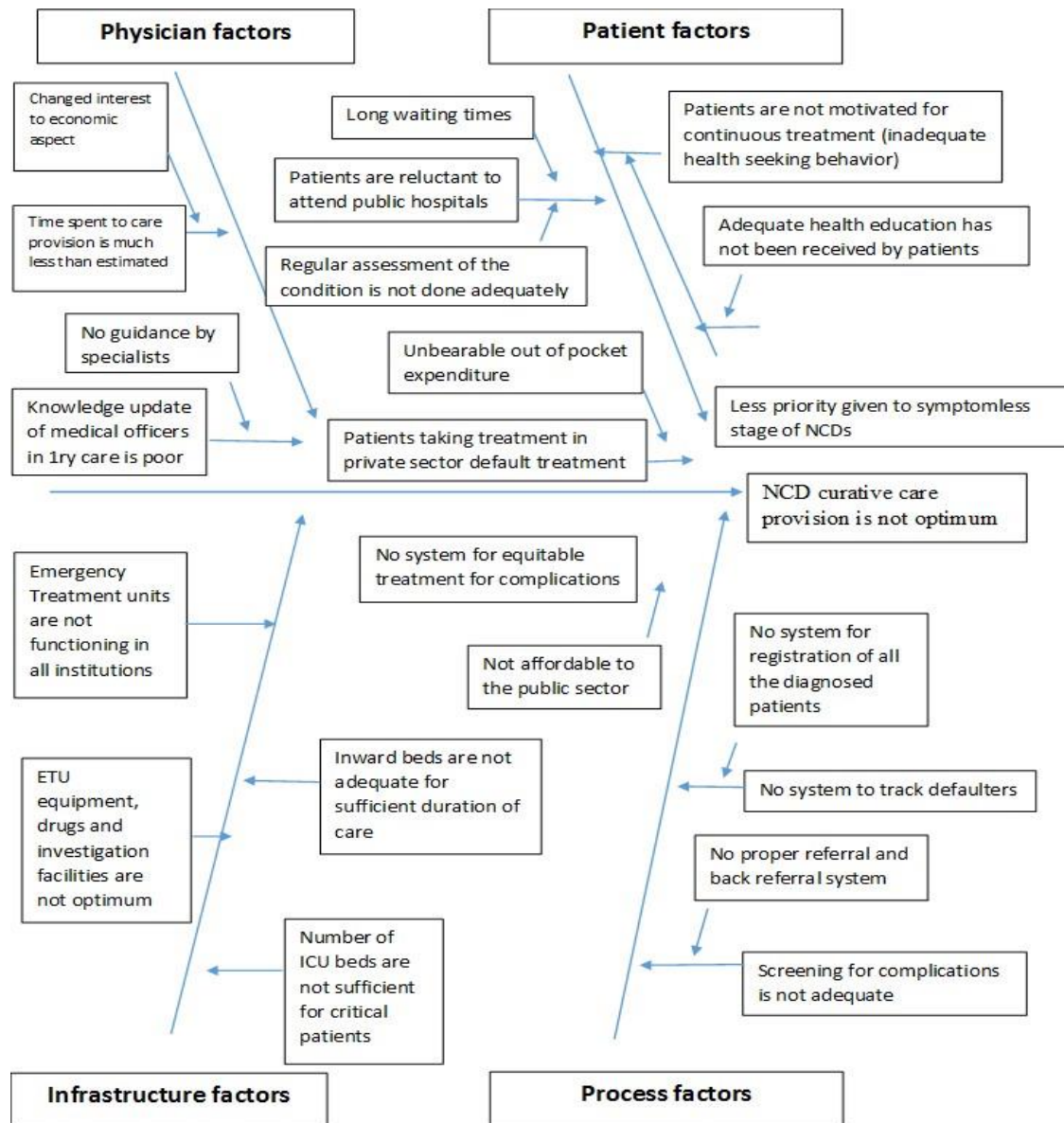
1. Training on pre admission care for acute ncDs is low.
2. Achievement of the targets by “healthy Lifestyle centres” is low.
3. NCD curative care provision is not optimum.
4. Concept of Health Promoting settings is not well institutionalized.
5. Inter - sectorial corporation needs to be enhanced.

#### **Problem prioritization:**

Nominal Group Technique was used to score and rank the different problem based on the following criteria; 1.Magnitude of the problem on the community (financially, years of life lost and years of life with disability, worsening of the problem); 2. Seriousness of complications and benefits of reducing complications; 3. Feasibility of correcting the problem with existing technology and knowledge and 4. Problem perception by the community. Accordingly problem of “NCD curative care provision is not optimum” was selected as the highest priority problem.

#### **Root cause analysis:**

Root cause analysis was performed to identify the root causes for less optimal provision of curative care services for chronic ncDs.



**Conclusions:**

1. Patients are not motivated for continuous treatment because they have not received adequate health education.
2. Patients are reluctant to attend public hospitals because of long waiting times and regular assessment of their condition is not done adequately.
3. Patients taking treatment in private sector default treatment due to unbearable out of pocket expenditure.
4. There is no system to track defaulters as there is no system for registration of all the diagnosed patients.
5. Screening for complications is not adequate as there is no proper referral and back referral system.
6. There is no system for equitable treatment for complications because it is not affordable to the public sector.
7. Knowledge update of Medical Officers in primary care hospitals is poor as there are no guidance of specialists.
8. Actual time spent for care provision by health care personnel is much less than estimated because of changed interests to economic aspect.
9. Emergency Treatment units are not functioning in all institutions
10. ETU equipment, drugs and investigation facilities are not optimum
11. Inward beds are not adequate for sufficient duration of care
12. Number of ICU beds are not sufficient for critical patients

### Recommendations:

The arm “physician factors’ was selected to give recommendations.

1. Knowledge of Medical Officers in primary care hospitals should be updated with the guidance of specialists.
2. Actual time spent for care provision by health care personnel should be improved by efforts to improve interests towards duties and responsibilities.

### Action plan:

1. All heads of primary care institutions must be invited for a training program by the RDHS with the resource inputs of consultant physicians to educate them about the existing gap of knowledge and practice in treating patients with chronic diseases.
2. They must be trained on leadership, planning, project management, supervision, conflict management, time management, teamwork and monitoring and evaluation.
3. Establish a system in primary care institutions for performance review meetings with the participation of the RDHS and MO - NCD.
4. Workshops should be organized at district level to update the knowledge and practical skills of medical officers.
5. Guidelines, procedures and video presentations should be displayed in

primary care hospitals to cover all levels of staff.

6. Monitoring should be strengthened to ensure adherence to duty rosters by Medical Officers using fly squad system.
7. Medical Officers should be persuaded for self - discipline, job satisfaction, and internal motivation towards better performance using the developed leadership qualities of heads of institutions.
8. A short training course on “Hospital Administration, Management and Preventive health services” should be given to all post intern doctors at RDHS level before placing at appointed places.

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