Integrated Response of Health Care System to Rapid Population Ageing

Report of the Focus Group Discussion
Sri Lanka

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NATIONAL INTER DISCIPLINARY COMMITTEE FOR INTRA II

Stakeholders involved:

- **From the Ministry of Health:**
  - Deputy Director General (Public Health Services).
  - Deputy Director General (Planning). – Not attended
  - Director / Youth, Elderly, Disabled and Displaced Persons.
  - Director / Primary Health Care.
  - Director / Maternal and Child Health. – Representative attended
  - Director / Health Education Bureau.
  - Director / Population.
  - Director / Non Communicable Diseases.
  - Director / Mental Health Services.
  - Director / Tertiary Care Service.
  - Director / National Institute of Health Science.

- **From other Ministries:**
  - Director / National Secretariat for Elders. (Min. of Social Services)

- **Non-governmental Organizations:**
  - Executive Director / HelpAge Sri Lanka.
  - President / NGO Forum for Elderly. – Not attended
  - General Secretary / Sri Lanka Pensioners Association.

- **Academic Institutions:**
  - Prof. of Community Medicine - Faculty of Medicine, Colombo. – Not attended
  - Consultant Physician – Faculty of Medicine Galle.

- **UN agencies:**
  - WHO Representative.
  - UNFPA Representative.
Overall structure, organization and delivery of health care system

Health Services of the government of Sri Lanka, functions under a cabinet minister. With the implementation of the Provincial Council Act in 1999, the health services were devolved resulting in the Ministry of Health in the central (national) level and separate provincial health ministries in 08 provinces. The central Ministry is primarily responsible for the protection and promotion of people’s health. Its key functions are setting policy guidelines, medical and para medical education, management of Teaching and Specialized medical institutions (Tertiary Care Institutions) and bulk purchase of medical requisites.

The 08 Provincial Director of Health Services (PDHS) are totally responsible for management of Provincial and Base hospitals (secondary care institutions) and District Hospitals, Peripheral Units Rural Hospitals and Maternity Homes and out patient facilities such as Central Dispensaries and Visiting Stations (primary health care institutions). There are 25 Deputy Provincial Directors of Health Services (DPDHS) to assist the 08 PDHS. Each DPDHS area is further the sub divided in to several Medical Officer of Health (MOH) areas.

Preventive Care

MOH is responsible for preventive and promotional health care within a population of 60,000 to 80,000. There is Public Health staff such as Public Health Inspectors (PHI), Public Health Nursing Sisters (PHNS), and Public Health Midwives (PHM) working at field level under the MOH. There are number of health centres scattered through out the MOH division. Regular antenatal, child welfare including immunization, family planning and also well women clinics are conducted in these health sectors. Providing preventive health services for elders (especially men) such as screening for early identification of diseases is not a regular feature, or a responsibility of a MOH and public health staff. This is gradually changing, since introduction of the “Active Ageing Programme” to MOH and staff since year 2000.

Curative Care

There are number of curative care institutions within the primary health care level (MOH division), which provide treatment for elders as primary care institutions. They are district hospitals, peripheral units, rural hospitals and central dispensaries. However patients can seek curative care in any one of those medical institutions according to their choice.
Organization of preventive and curative care services at divisional level

Central level
- Central Ministry

Provincial level
- PDHS

District level
- DPDHS

Divisional level
- PREVENTIVE CARE
  - MOH
  - PHI
  - PHNS
  - PHM
  - Volunteers

CURATIVE CARE
- DMO (District Hospital)
- MO Peripheral unit
- MO Rural Hospital
- MO Central Dispensary
Collated information of structure and policy with national team

Figure 1
Organizational structure for coordination between professionals in Health / *Social Services* for elderly services

<table>
<thead>
<tr>
<th>Central level</th>
<th>Ministry of Health</th>
<th><em>Ministry of Social Services</em></th>
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<tbody>
<tr>
<td></td>
<td>Director / Elderly</td>
<td><em>Director / National Secretariat for Older Persons</em></td>
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</tbody>
</table>

| Provincial level | Provincial Director of Health Services | *Provincial Director Social Services* |

| District and Divisional level | Deputy Provincial Director of Health Services |

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Curative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS Provincial Hospital</td>
<td>DMO Base Hospital</td>
</tr>
</tbody>
</table>

| Divisional Director of Health Services / Medical Officer of Health (MOH) | DMO District Hospital | *Divisional Secretary* |

<table>
<thead>
<tr>
<th>Grass root level</th>
<th>Primary Health Care Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Nursing Sisters (PHNS)</td>
<td>MO / Peripheral Unit</td>
</tr>
<tr>
<td>Public Health Inspectors (PHI)</td>
<td>MO / Rural Hospital</td>
</tr>
<tr>
<td>Public Health Midwives (PHM)</td>
<td>MO / Central Dispensary</td>
</tr>
</tbody>
</table>
Ministry of Health works in close collaboration with other governmental / non-governmental organizations that are mainly involved in the field of ageing. They include the Ministry of Social Services, Min. of Education, National Institute of Education and NGOO such as HelpAge Sri Lanka. As they share a common vision, this concerted effort has been very useful especially in sharing of resources for human resource development, development of training manuals, curricular, leaflets, booklets and coordinating Elders Day Centre programmes, outreach cataract programme, programme for training of volunteers for home care, distribution of assistive devices for needy elders etc. This has helped to a great deal in containing cost and avoiding duplication of services.

The coordination existing between various organizations at present can be regarded as complementary.

The Ministry of Social Services has initiated the formulation of the National Policy for Health and welfare of Older Persons.

The preparation of the National Plan of Action for improving the well being of the older persons has been done with involvement of all relevant stakeholders (Government, NGO, professional bodies)

National Council on Elders chaired by the Secretary Social Services has representation from all main stakeholders. (established with a view to monitor the activities geared towards elderly that are implemented government and NGO sectors)

Most of the government services including health and welfare services are decentralised in the country for purposes of administration – at each level Central, provincial, district and divisional directors monitors and review the progress of service delivery (Figure 1) by meetings, periodic returns of data, information and close super vision.

Monthly meetings are held with the central health ministry with Provincial Secretaries and Provincial Directors (National Health Developmental Council meeting) also with Deputy Provincial Directors, Component Directors and Hospital Directors by Health Development Council meeting to monitor the progress.

The National Health Policy mentions the need to provide services for the emerging health needs for the elderly

There is a good organizational structure in the preventive care system, which reaches the community up to the grass root level, however at PHC level an organised health and welfare system serving elderly has not yet been established.

The post of Director / Elderly and Disabled has been established in the Ministry of Health at central level (1998 June) with the main intention of facilitating the planning, implementation, monitoring and co-ordination of health care delivery for elders with the support of the provincial ministry.

Appointment of Director / NCD and Director / PHC was also done in the Ministry of Health during the same period.

Within the Ministry of Health the collaboration and coordination existing at present can be regarded as complementary and also overlapping at times. Information regarding the
programs carried out by each director in the ministry is usually shared by annual progress reports published. However planning of programs and resource planning are usually done independently. This needs to be improved.

- Director / Elderly and Disabled work in close collaboration with the Director / National Secretariat for Elderly of Social Services Ministry and with other relevant Govt. and Non Govt. agencies.

- Within the PHC the health personnel in the curative and the preventive health care services work in close coordination for prevention and control of communicable diseases (Eg: EPI control diseases, mosquito transmitted diseases, control of diarrhoeal diseases by sending notification regarding such patients to MOH for community follow up). This coordination has not yet been developed for control of NCDs.

- At the PHC level the Divisional Secretary managing an area corresponding to the MOH area has Grama Niladaris and Samurdhi Niladaris etc. working at grass root level. Divisional Secretary conducts regular meetings to monitor the services provided for the public in this area for which MOH also attends. This forum at present does not usually monitor the services provided for elderly by any sector.

- With the leadership of MOOH various campaigns are organized within the PHC structure through social mobilization and with participation of GO, NGO and private / community such as National Immunization days, dengue control week. Such partnership building and socio mobilization at divisional level take place to a lesser extent for improvement of elderly care.

- As the elderly programme has not yet considered as very high priority by the Ministry of Health no specific budgetary allocations has been done for the necessary human resource development and improvement of other facilities for delivery of health care to the PHC level.

- Most of the international funding agencies are sceptical regarding the need for providing funds for improvement of elderly health. WHO is a notable exception, which had supported Min. of Health in introducing the elderly health programme to the preventive health care system at PHC level?

- Preventive health service is still largely geared to address the women on reproductive health group and the under 5 child population, although the births and the under 5 population is declining in proportion and in absolute numbers comparison to the rapidly rising population of elderly.

- Irrespective of age, government hospitals provide out patient care and in patient care free of charge to all patients. (55% and 80% utilization of government hospitals respectively for out patient care and in patient care)

- The referral system is not enforced in the country. Hence patients by pass small medical institutions and come for treatment to the health institution of their choice.

- This has led to the under utilization of small institutions in the PHC structure and overcrowding in bigger institutions, which have specialists and better facilities for investigation.

- Thus the Out-Patient Departments (OPD) of major government curative care institutions (base, provincial and general hospitals) and the clinics in these hospitals which offer
the monthly quota of drugs to the patient for continuation of treatment are crowded with elderly.

- Regarding regular care for chronic illnesses, sometimes the drugs and some of the investigation facilities are not available in the nearby hospital, so they may have to spend their own money to buy them. As such they prefer to go to district hospital bypassing smaller hospitals even with difficulty.
- Patients diagnosed with illness, sometimes do not continue with their treatment due to distance, lack of money for transport, lack of awareness regarding the need for continued treatment, waiting time, in-adequate health staff for proper follow up, absence of appointment system, absence of a back referral system to the local hospital

- Allocation of drug by the Medical Supplies Division to state curative care institutions is graded as first, second and third level drugs depending availability of the specialists. Eg: a patient with hypertension treated by a specialist in a major care institution with the third level drugs are not usually back referred to the smaller institution in his home town for regular continuation of treatment as the third level drugs are not available in the smaller institution.

- Even if they are back referred to smaller institutions for continuation of treatment the poor patients may have to purchase the drugs from private pharmacies.

- Bed occupancy rate and the duration of the stay in major curative care institutions have increased due to elders suffering from illnesses needing long term care.

- No preference given to elders except in few hospitals, which provides separate OPD facilities.

- No preference for elders in allocation of beds in hospitals.
- There is a high shortage of physiotherapists, occupational therapists and speech therapists in the country; even to work in base hospitals as such provision of an out reach service for therapists to visit the community will be very difficult at the moment.

- There are no geriatricians in the country hence elders do not get priority for provision of health services.

- There are hardly any multi disciplinary teams established to work in the health institutions or in community

- The attitudes of most health care personnel regarding provision of treatment to very old are not favourable. (Ageism prevails!)

- The elders were hardly aware regarding the health and social services that need to be provided for them by each stakeholder for continuity of care.

- There is no LTC policy formulated yet in the Ministry of Health. However there is a National Policy on Disability prepared by the Ministry of Social Services, which includes the roles and responsibilities of the Ministry of Health regarding care of disabled persons.

- There are no organised schemes / programmes through government and non-government, organizations for supporting older persons with functional limitations by modification of housing and improvement of the physical and social environment.

- The programme on “Promotion of Active Ageing” in an on going programme initiated by the Unit of Elderly in the Ministry of Health with the support of the WHO, has been
introduced to one half of the total MOH areas in the country (since 2000 June) with a view to provide integrated health and welfare service at PHC level. This introduction will be completed in the whole country within the next 2 years. In those areas, the Primary Health Care staff are trained on elderly care and the elders in the PHC area are identified, their baseline information collected through a house-to-house survey. In addition, the PHC staff is trained to work in collaboration with other governmental, non-governmental sectors, private organisations and community for the health and welfare of elderly. Placing the onus of the programme with the community has ensured the sustainability of this programme.

- in such areas field screening clinics are conducted for elders by MOOH,
- in addition day centres have been established in PHC areas with the support of community participation and with NGO support and
- Volunteers are also trained to provide home care for elderly.

- However roles and responsibilities on care of elderly have not yet been “officially” handed over to the PHC (preventive) health staff, the PHM (the grass root level worker) does home visits usually within a 3,000 populations mainly for maternal and child health care.

- Most elderly patients discharged from hospital and sent home after surgery of hip fracture etc. may still need continuation of physiotherapy etc. which is not available free of charge in the community and as a result the recovery may be slow or partial.

- There is a lack of long stay hospitals in the community where chronically ill and disabled elderly can be transferred after the acute stage.

- Regarding elderly people with ADL disorders due to physical and psychological problems who require the assistance of the carers, the absence of family carers has become a major obstacle for a proper rehabilitation process. Hired home care is not affordable by the majority.

- Trained carers are also scarce to meet the demand.

- As such almost all home care provided for elderly is informal (family, relatives, neighbours), with some home care provided by trained volunteers in areas in which the “Active Ageing Programme” has been introduced.

- Volunteers (unpaid) trained on home care drop out from service after a short period, due to lack of incentives / benefits.

- Respite programmes are not available for helping formal and informal caregivers.

- At present the professionals or team responsible for continuation of care are MOH, PHNS, PHI, PHM – coordinate, monitor, provide advise at PHC level and train volunteers who provide home care to elders in the community

- Director / Elderly - Ministry of Health, Provincial Director Health Services, Deputy Provincial Director Health Services, HelpAge Sri Lanka and other relevant NGOO, Director / National Secretariat of Elders are engaged in coordination of training of the volunteers who provide home care at PHC level.
FORMAT USED FOR GATHERING INFORMATION FROM COMMITTEE MEMBERS OF NIC ON INTEGRATED RESPONSE OF HEALTH CARE SYSTEMS TO RAPID POPULATION AGEING

Name of the committee member : ......................................................................................
Designation : .............................................................................................................

SOURCES SERVICES OF CARE

• What are the sources / services of different health related care services offered today for 50+, among and out side PHC centres?
........................................................................................................................................

• How are the roles and responsibilities distributed between the different sources of care? Who does what?
........................................................................................................................................

• Would it be possible to broaden the scope of services offered at PHC centres?
........................................................................................................................................

• What type of services should / could be integrated? Hospital, health centre, home / family care etc.
........................................................................................................................................

ON COLLABORATION / COORDINATION

1. Describe the current degree of collaboration and coordination existing between the various components of the PHC and their interface with other areas of care provisions - within PHC, outside the PHC including social care sector

   a. Identify the level of services involved E.g.: Primary care, secondary and tertiary care, LTC, social welfare, NGO sector
      ........................................................................................................................................

   b. Describe the nature of their relationship. E.g.: complimentary? Fragmented? Overlapping?
      ........................................................................................................................................

   c. Document what functions are shared with regard to information, decision-making, resource and planning
      ........................................................................................................................................

   d. Would coordination of activities be beneficial?
      – At what level of services? (E.g.: primary, secondary or tertiary care etc.);
      ........................................................................................................................................

      – For what function? (E.g.: information, decision-making, resource and planning)
      ........................................................................................................................................

      – with whom (E.g.: GP's, nurses, social workers, other health care workers)
      ........................................................................................................................................
– for what services? (E.g.: health promotion, prevention, screening, social support, home support)

– What are the factors which facilitate collaboration / coordination

– What are the factors which act as barriers for collaboration / coordination?

– Ascertain the potential for increased collaboration / coordination.

ON CONTINUITY OF SERVICES

– Who would be the most appropriate professionals providing continuity of care to older persons within/out side PHC? (Physicians, nurses, social and community workers etc.)

– What type of training would that require?

– What are the factors, which facilitate continuity of care?

– What are the factors, which act as barriers to continuity of care?

– What attempts if any could be made to improve continuity?
Sampling and recruitment of Health care service users and providers for FGDs.

Choosing areas (low SES, high SES) for carrying out INTRA project

- **The criteria for selection of areas (low SES and high SES) and members**

  The members for the focus groups were selected from two districts Kalutara and Rathnapura. Kalutara district comprise of 10 Medical Officer of Health areas; Rathnapura district has 14 MOH areas. Kalutara was considered as a district of high SES, compared to the other, in relation to availability of better facilities for obtaining treatment, the literacy level of people, transport and other facilities available for the public. In order to qualify further to the socio economic status, those members selected for the focus group in district with high SES were either having an income of their own (as a pension or provident fund or having a regular income by the occupation or from savings) and are not dependent on their children or others for their basic needs. In contrast the participants in district with low SES consisted of elders who were poor, mostly illiterate and who were either financially supported by their children or state for their day-to-day living.

- **Existing health institutions available in each area**

  Each district has rural hospitals, peripheral units and district or base hospitals providing curative care for the ailments they suffer from. In addition to these institutions providing allopathic treatment there are few ayurvedic treatment (indigenous medicine) centers catering to chronic problems of elderly. Some of the elders mostly from high SES area go for General Practitioners or to the Physicians or Medical Officers of the government sector who do private practice after the official hours.

  Orientation was done for district leaders regarding the tasks to be carried out and the methods of selection of members for FGDs - Orientation meeting were conducted at high SES and low SES areas separately by the principal investigator and the team by visiting the respective areas and conducting meetings with the key authorities of health and social services, in order to explain to them regarding the study and to get their cooperation.

  The FGD protocols provided from Geneva were adapted to suit the background and education level of each category and were translated in to local language by the focal point Ministry of Health. Series of questions were added to the existing protocol in order to make it user friendly and to support the theory of preparing FGD protocols – “from known to unknown”

  Consent forms, instruction guides were also translated to local language.

  Discussions with coordinators of Kalutara and Ratnapura districts were also carried out regarding sampling and recruitment of 50+ users for the 8 focus groups; guidelines were also provided for identification of the facilitators, reporters and supervisors of FGD

- **The method of selection of 50+ users for FGD**

  Most of the participants for the focus groups were selected from the clinic records of the above mentioned health institutions in the PHC structure, as those who attended at least 3 times within this year for regular treatment for their chronic conditions. Few of them from the high SES area were selected as those who visit Private Practitioners for regular treatment for their illnesses.
Inclusion criteria –

those who obtain treatment three or more times in the last 6 months for at least one or more chronic illnesses from a health institution at a Primary Health Care level.

Exclusion criteria –

those with dementia, who were very ill or who had hearing and speech difficulties

Sampling and recruitment of health professionals

Sampling and recruitment of health professionals such as nurses, para medical workers and doctors for a total of 4 focus group discussions, (one FGD per category from each low SES / high SES area) was done from those who provided services at the health institutions from which the 50+ users were attending.

Volunteers "and " social workers were chosen from the respective districts of 50+ users.

<table>
<thead>
<tr>
<th>Category</th>
<th>No.s</th>
</tr>
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<tbody>
<tr>
<td>Social Workers &quot;and &quot; Volunteers</td>
<td>– 2 FGDs</td>
</tr>
<tr>
<td>Nurses &quot;and &quot; para-medical workers</td>
<td>– 2 FGDs</td>
</tr>
<tr>
<td>Doctors</td>
<td>– 2 FGDs</td>
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Training of the facilitators, reporters and supervisors of FGD

There were different facilitators and reporters appointed for conducting each focus group. Training was provided for all the facilitators, reporters and supervisors on conducting the FGDs.

The adapted FGD protocols were reviewed and revised with the help of the facilitators and reporters.

Settings of FGDs -

The focus group discussions of the users were conducted at 8 different places close to their place of residence; the hospital was purposely avoided as a place to conduct the FGD.

FGDs of health providers were done in clinics or hospitals.

FGDs for Doctors were conducted in a hotel.

Provision of facilities for FGDs

The necessary stationary, audiocassettes were supplied to each group. Seating accommodation, refreshments and lunch were provided to all members of the group. The black board / white board were used to illustrate the important points of the discussion and tape recorders were used at all discussions. Written consent for participation in the FGDs were obtained from all those who were involved by the facilitators and reporters. Duration of each discussion varied from 4hrs. to 6hrs.

Four focus groups were conducted with older persons 50+ and one focus groups were conducted with health providers, another with volunteers and social workers from each SES area.
There were supervisors appointed to visit each place to ensure the quality of FGDs. The written reports and the audiocassettes of the focus group discussions were collected by the supervisors at the end of each session and were handed over to the principal investigator for analysis and compilation.

*02 FGDs for Doctors were conducted one per each SES area.*

In addition professionals of different sectors involved in providing health or Social services were picked up for providing information according to the questionnaire provided to them.

**Characteristics of groups:**

**Group 1 / Location - Siri Kheththaramaya, Seelagama**  
SES - Low / Gender - Female / Age group - 65+ / Date - 21.05.2004 / Time - 9.30a.m /  
Duration - 6hrs  
Moderator - Supervisory Public Health Inspector  
Reporter – Public Health Midwife  
No. of participants - 10

**Information of the participants**

05 were married 05 widowed. 03 have not attended school. Another 03 have had 1-5 years of schooling and the rest 6-10 years of the schooling. 02 were living with only the spouse and the rest with married or unmarried children / relatives. 07 were living in their own house and the rest, living in the home owned by their children or relatives. 03 of them were employed as labourers, 02 were engaged in business, 03 in farming, 01 in traditional medicine, the other a housewife. At present 06 are not employed / housewives, only 01 engaged as a labour, 01 in business, 01 in farming and the other continuing as a traditional medical practitioner. Regarding the source of income 07 people have no guarantied income, 03 people depend on government subsidy. Regarding their judgment of the health status for 05 it was poor, for 04 averages and 01 had said was good. Regarding the chronic illnesses they suffer from for half of them it was joint pains, for 02 asthma, there was a person having hypertension another with heart problem and diabetes. They were all of moderate severity.

![Image](image_url)

**Group 2 / Location - Sri Sudharshana Rankoth Viharaya, Rassagala**  
SES - Low / Gender - Female / Age group - 50-64 / Date - 21.05.2004 / Time - 9.30a.m /  
Duration – 4 1/2 hrs  
Moderator - Public Health Inspector  
Reporter – Public Health Nursing Sister  
No. of participants – 10

**Information of the participants**

07 were married, 02 were not married and 01 was separated. 02 have not attended school. Another 02 have had 1-5 years of schooling and 05 have 6-10 years of the schooling, 01 has studied up to GCE A/L. 03 were living with only the spouse and the rest with married or unmarried children / relatives. 07 were living in their own house and the rest living in the home owned by their children or relatives. 01 was employed as labourer and the others were housewives. At present all are housewives. Regarding the source of income all of them have no guarantied income. Regarding their judgment of the health status for 04 it was poor, for 04 average
and 02 have said was good. Some persons were suffering from more than 01 chronic illness. Regarding the chronic illnesses they suffer from for 06 of them it was joint pains, for 01 asthma, there was a person who had a fracture, another with heart problem and 02 with diabetes. They were all of moderate severity.

Group 3 / Location - Sri Jinendraramaya, Damohana
SES - Low / Gender - Male / Age group – 65+ / Date - 21.05.2004 / Time - 9.30a.m / Duration - 1 1/2 hrs No. of participants – 10
Moderator - Supervisory Public Health Inspector Reporter – Public Health Inspector

Information of the participants

All 10 were married. 03 have not attended school. 02 have had 1-5 years of schooling and the rest 6-10 years of the schooling. 03 were living with only the spouse and the rest with married or unmarried children/relatives. 09 were living in their own house and 01 was living in the home owned by their children or relatives. 09 of them were employed in farming, 01 as a labour. At present 06 are not employed, 04 in farming. Regarding the source of income all have no guarantied income. Regarding their judgment of the health status for 04 it was poor, for 03 average and 02 have said was good. Some persons were suffering from more than 01 chronic illness. Regarding the chronic illnesses they suffer from for half of them it was heart problems, 02 with diabetes, 01 with asthma and the rest with hypertension. They are of mild to moderate.

Group 4 / Location - Sri Maha Bodhi Viharaya, Kanathiriyanwala
SES - Low / Gender - Male / Age group – 50-64 / Date - 21.05.2004 / Time - 9.30a.m / Duration - 6hrs No. of participants – 10
Moderator - Public Health Inspector Reporter – Public Health Nursing Sister

Information of the participants

07 of them were married, 02 of them were not married. 06 have had 1-5 years of schooling and the rest 6-10 years of the schooling. 01 was living alone, 04 were living with only the spouse and the rest with married or unmarried children/relatives. 06 were living in their own house, 03 were living in the home owned by their children or relatives and 01 had no permanent place to live. 07 of them were employed in farming, 02 as labours and 01 was engaged as a craft-man. At present all are not employed. Regarding the source of income 08 have no guarantied income and 02 living with government subsidy. Regarding their judgment of the health status for
health status for 02 it was poor, for 07 average and 01 had said was good. Some persons were suffering from more than 01 chronic illness. Regarding the chronic illnesses they suffer from for half of them it was hypertension, 04 of them with asthma, 01 has heart problems, 03 with diabetes, 01 with joint pain and 02 have had fractures. They were all of moderate severity.

Group 5 / Location - Base Hospital, Horana
SES - High / Gender - Female / Age group - 65+ / Date - 18.05.2004 / Time - 9.00a.m /
Duration - 5hrs No. of participants – 10
Moderator - Public Health Nursing Sister Reporter – Public Health Inspector

Information of the participants

All 10 were married. Half of them have had 6-10 years of schooling and the rest technical or vocational trained. 01 was living alone, 04 were living with only the spouse and the rest with married or unmarried children / relatives. 09 were living in their own house, 01 was living in the home owned by their children or relatives. 04 of them were employed as teachers, 01 as executive / manager, 01 as a housewife, 01 in clerical, 01 a landed proprietor and 02 of them in technical staff. At present all are not employed. Regarding the source of income 08 were getting a pension / Wand OP and the other 02 property and bank savings. Regarding their judgment of the health status for all 10 averages. Some persons were suffering from more than 01 chronic illness. Regarding the chronic illnesses they suffer from for 03 of them it was hypertension, 01 of them with asthma, 03 having heart problems, 02 with cancer, 03 with diabetes, 04 with joint pains and 01 has had fractures. They were all of moderate severity.

Group 6 / Location - Health Centre, Henegama
SES - Low / Gender - Female / Age group - 50-64 / Date - 18.05.2004 / Time - 9.40a.m /
Duration - 5hrs No. of participants – 10
Moderator - Public Health Nursing Sister Reporter – Public Health Inspector

Information of the participants

All 10 were married. 04 of them have had 6-10 years of schooling and the 01 diploma holder, 01 university graduate, 02 with GCE A/L and 03 in 1-5 years of schooling. 01 was living alone, 04 were living with
only the spouse and the rest with unmarried children / relatives. All 10 were living in their own house. 01 of them were employed as teachers, 03 as housewives, 02 were engaged as hospital labourers and 03 of them in technical staff. At present all are housewives. Regarding the source of income 05 were getting a pension / Wand OP and the other 05 property and bank savings. Regarding their judgment of the health status for all 10 averages. Some persons were suffering from more than 01 chronic illness. Regarding the chronic illnesses they suffer from for 02 of them it was hypertension, 01 has heart problems, 03 with cancer, 04 with diabetes, 02 with joint pains. They were all of moderate severity.

**Group 7 / Location - Clinic Centre, Ingiriya**
SES - Low / Gender - Male / Age group - 50-64 / Date - 18.05.2004 / Time - 9.30a.m /
Duration - 5hrs
Moderator - Public Health Nursing Sister
No. of participants – 09
Reporter – Public Health Inspector

**Information of the participants**

All 09 of them were married. 02 of them were 6-10 years of the schooling, 03 with GCE A/L, 01 university graduate, 01 diploma holder, 02 technical / vocational trained. 04 were living only with the spouse and the rest with unmarried children. All 09 were living in their own house. 01 was a lawyer, 02 of them were employed as executive / manager, 4 were in clerical and 01 was engaged as a teacher. At present 02 were not employed, 01 remains to be an executive / manager, 02 in clerical, 01 in technical and 03 in minor sales and business. Regarding the source of income 03 pension and 06 living with bank savings / property / business. Regarding their judgment of the health status for 02 it was poor, 06 average and 01 had said was good. Some persons were suffering from more than 01 chronic illness. Regarding the chronic illnesses they suffer from for 02 of them it was hypertension, 01 of them with asthma, 04 having heart problems, 06 with diabetes, 02 with joint pains. They were all of moderate severity.

**Group 8 / Location - Sri Sunethrarama Temple, Kahatapitiya**
SES - Low / Gender - Male / Age group - 65+ / Date - 18.05.2004 / Time - 9.10a.m /
Duration - 3hrs
Moderator - Public Health Nursing Sister
No. of participants – 08
Reporter – Member of Hospital Committee, Base Hospital

**Information of the participants**

All 8 of them were married. 01 of them was 1-5 years of the schooling, 01 of them was 6-10 years of the schooling, 04 with GCE A/L, 01 university graduate, 01 diploma holder. 03 were living only with the17
spouse, 01 living alone and the rest with unmarried children. All 08 were living in their own house. 02 of them were technical, 02 were engaged in business, 02 were in clerical and 02 were engaged as teachers. At present 07 were not employed, 01 is a land ed proprietor. Regarding the source of income 6 pension and 02 living with bank savings / property / business. Regarding their judgment of the health status for 01 it was poor, for 06 average and 01 had said was good. Some persons were suffering from more than 01 chronic illness. Regarding the chronic illnesses they suffer from for 03 of them it was hypertension, 01 of them with asthma, 01 having heart problem, 04 with diabetes and 03 with joint pains. They were all of moderate severity.
Characteristics of the total users

The characteristics of the total 50+ users were analyzed as follows:

### TABLE 1  GROUPS 1-8 (TOTAL)

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Married</td>
<td>66</td>
<td>86.84</td>
</tr>
<tr>
<td>2. Not married</td>
<td>4</td>
<td>5.26</td>
</tr>
<tr>
<td>3. Divorced</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. Widowed</td>
<td>5</td>
<td>6.58</td>
</tr>
<tr>
<td>5. Separated</td>
<td>1</td>
<td>1.32</td>
</tr>
<tr>
<td>* Total</td>
<td>76</td>
<td>100.00</td>
</tr>
</tbody>
</table>

### TABLE 2  Level of education

<table>
<thead>
<tr>
<th>Level of education</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Not attended school</td>
<td>8</td>
<td>10.26</td>
</tr>
<tr>
<td>2. Grade 1 to 5</td>
<td>17</td>
<td>21.79</td>
</tr>
<tr>
<td>3. Grade 6 to 10</td>
<td>30</td>
<td>38.46</td>
</tr>
<tr>
<td>4. G.C.E. (A/L)</td>
<td>10</td>
<td>12.82</td>
</tr>
<tr>
<td>5. University graduate</td>
<td>3</td>
<td>3.85</td>
</tr>
<tr>
<td>6. Diploma holder</td>
<td>3</td>
<td>3.85</td>
</tr>
<tr>
<td>7. Technical / Vocational trained</td>
<td>7</td>
<td>8.97</td>
</tr>
<tr>
<td>* Total</td>
<td>78</td>
<td>100.00</td>
</tr>
</tbody>
</table>

### TABLE 3  Person living with

<table>
<thead>
<tr>
<th>Person living with</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Living alone</td>
<td>4</td>
<td>5.19</td>
</tr>
<tr>
<td>2. With spouse</td>
<td>27</td>
<td>35.07</td>
</tr>
<tr>
<td>3. With children</td>
<td>32</td>
<td>41.56</td>
</tr>
<tr>
<td>4. With married child / Relatives</td>
<td>14</td>
<td>18.18</td>
</tr>
<tr>
<td>5. With friends / Non relatives</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>* Total</td>
<td>77</td>
<td>100.00</td>
</tr>
</tbody>
</table>

### TABLE 4  Place of stay

<table>
<thead>
<tr>
<th>Place of stay</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Own house</td>
<td>65</td>
<td>84.42</td>
</tr>
<tr>
<td>2. Child / Relatives home</td>
<td>11</td>
<td>14.28</td>
</tr>
<tr>
<td>3. Friends home</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. Elders home</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5. No permanent place to live</td>
<td>1</td>
<td>1.30</td>
</tr>
<tr>
<td>* Total</td>
<td>77</td>
<td>100.00</td>
</tr>
</tbody>
</table>

### TABLE 5  Employment - last

<table>
<thead>
<tr>
<th>Employment - last</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Not employed / house wife</td>
<td>14</td>
<td>18.18</td>
</tr>
<tr>
<td>2. Professional (Doctor / Lawyer / Engineer)</td>
<td>1</td>
<td>1.30</td>
</tr>
<tr>
<td>3. Administrative (Executive / Manager)</td>
<td>3</td>
<td>3.90</td>
</tr>
<tr>
<td>4. Traditional medicine</td>
<td>1</td>
<td>1.30</td>
</tr>
<tr>
<td>5. Teaching</td>
<td>8</td>
<td>10.39</td>
</tr>
<tr>
<td>6. Clerical</td>
<td>7</td>
<td>9.09</td>
</tr>
<tr>
<td>7. Minor sales</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8. Fishing</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Employment - present</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----</td>
<td>---</td>
</tr>
<tr>
<td>1. Not employed / house wife</td>
<td>61</td>
<td>79.22</td>
</tr>
<tr>
<td>2. Professional (Doctor / Lawyer / Engineer)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3. Administrative (Executive / Manager)</td>
<td>1</td>
<td>1.30</td>
</tr>
<tr>
<td>4. Traditional medicine</td>
<td>1</td>
<td>1.30</td>
</tr>
<tr>
<td>5. Teaching</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Clerical</td>
<td>2</td>
<td>2.60</td>
</tr>
<tr>
<td>7. Minor sales</td>
<td>1</td>
<td>1.30</td>
</tr>
<tr>
<td>8. Fishing</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9. Farming</td>
<td>5</td>
<td>6.48</td>
</tr>
<tr>
<td>10. Land ed Proprietor</td>
<td>1</td>
<td>1.30</td>
</tr>
<tr>
<td>11. Craftsmanship</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>12. Technical</td>
<td>1</td>
<td>1.30</td>
</tr>
<tr>
<td>13. Business</td>
<td>3</td>
<td>3.90</td>
</tr>
<tr>
<td>14. Labour</td>
<td>1</td>
<td>1.30</td>
</tr>
<tr>
<td>* Total</td>
<td>77</td>
<td>100.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source of income</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No guaranteed income / Children / Relatives</td>
<td>35</td>
<td>45.45</td>
</tr>
<tr>
<td>2. From occupation / Property / Business / Bank savings</td>
<td>15</td>
<td>19.48</td>
</tr>
<tr>
<td>3. Pension / W and OP</td>
<td>22</td>
<td>28.58</td>
</tr>
<tr>
<td>4. Government Subsidy</td>
<td>5</td>
<td>6.49</td>
</tr>
<tr>
<td>* Total</td>
<td>77</td>
<td>100.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health status (Last month)</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Good</td>
<td>8</td>
<td>10.39</td>
</tr>
<tr>
<td>2. Average</td>
<td>50</td>
<td>64.94</td>
</tr>
<tr>
<td>3. Poor</td>
<td>18</td>
<td>23.37</td>
</tr>
<tr>
<td>4. Very poor</td>
<td>1</td>
<td>1.30</td>
</tr>
<tr>
<td>* Total</td>
<td>77</td>
<td>100.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distribution of Chronic illnesses at present</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diabetes</td>
<td>25</td>
<td>23.15</td>
</tr>
<tr>
<td>2. Heart problems</td>
<td>17</td>
<td>15.74</td>
</tr>
<tr>
<td>3. Hypertension</td>
<td>23</td>
<td>21.30</td>
</tr>
<tr>
<td>4. Asthma / Dyspnea</td>
<td>11</td>
<td>10.18</td>
</tr>
<tr>
<td>5. Joint pains</td>
<td>23</td>
<td>21.30</td>
</tr>
<tr>
<td>6. Fracture</td>
<td>4</td>
<td>3.70</td>
</tr>
<tr>
<td>8. Cancer</td>
<td>5</td>
<td>4.63</td>
</tr>
<tr>
<td>* Total</td>
<td>108</td>
<td>100.00</td>
</tr>
</tbody>
</table>
Characteristics of the groups in FGDs of Health Providers

**Group 9** / Location – MOH Office, Imbulpe – Ratnapura District
SES - Low / Gender - Male and Female / Date - 20.05.2004 / Time - 9.10a.m /
Duration - 3hrs Moderator – Medical Officer of Health, Balangoda
No. of participants – 12 Reporter – Medical Officer of Health, Imbulpe

Information of the participants

Public Health Nursing Sister, Nursing Officer, 04 Public Health Inspectors, Pharmacist, Hospital Overseer, 02 Planning and Programme Assistants and Ophthalmic Technologist

**Group 10** / Location – Base Hospital, Horana – Kalutara District
SES – High / Gender - Male and Female / Date - 17.05.2004 / Time - 9.00a.m /
Duration - 3hrs Moderator – Deputy District Medical Officer, BH Horana
No. of participants – 12 Reporter – Matron, BH Horana

Information of the participants

02 Public Health Nursing Sister, Public Health Inspector, Health Education Officer - Kalutara District, Health Education Nursing Officer - BH Horana, Pharmacist, Medical Laboratory Technologist, 02 Planning and Programme Assistants and Ophthalmic Technologist

**Group 11** / Location – MOH Office, Imbulpe – Ratnapura District
SES - Low / Gender - Male and Female / Date - 20.05.2004 / Time - 9.30a.m /
Duration - 3hrs Moderator – Public Health Inspectors, Imbulpe
No. of participants – 12 Reporter – Public Health Inspectors, Balangoda

Information of the participants

11 volunteers engaged in voluntary home care, 01 volunteer in charge of elderly day centre.
**Group 12** / Location – Base Hospital, Horana – Kalutara District  
SES – High / Gender - Male and Female / Date - 17.05.2004 / Time - 9.10a.m /  
Duration - 4hrs  
Moderator – Public Health Inspectors, MOH Office Horana  
No. of participants – 10  
Reporter – Public Health Nursing Sister, MOH Office Horana  

**Information of the participants**  
10 Social workers

---

**Group 13** / Location – Rest House – Ratnapura District  
SES - Low / Gender - Male and Female / Date - 26.05.2004 / Time - 10.30a.m /  
Duration - 3hrs  
Moderator – Director / YEDD  
No. of participants – 08  
Reporter – Project Officer, HelpAge

**Information of the participants**  
08 Medical Officers engaged in curative and preventive services in Kalutara District

---

**Group 14** / Location – Rest House – Ratnapura District  
SES – High / Gender - Male and Female / Date - 26.05.2004 / Time - 02.45p.m /  
Duration – 2 ½ hrs  
Moderator – Director / YEDD  
No. of participants – 09  
Reporter – Project Officer, HelpAge

**Information of the participants**  
09 Medical Officers engaged in curative and preventive services in Ratnapura District
Questionnaires / Guide and the format for recording used in

I. PHC users 50 years and older

To be filled by supervisor:

<table>
<thead>
<tr>
<th>SES</th>
<th>Location</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Duration: No. of participants in FGD -

Moderator - Reporter -

Instructions:
- To be used by facilitators and reporters of FGDs only.
- Please use this format to report your FGD.
- Use “A” – the view of the majority (3/4)
- Use “B” – the view of the half the participants (1/2)

Approach
- What are the types of institutions, organizations and committees in your area that provide health and social services for 50+ and to what extent? Prompt from list if they don’t answer.

<table>
<thead>
<tr>
<th>Institutions, organizations and committees</th>
<th>% provided</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Base hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. District hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Peripheral unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Medical Officer of Health clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Private Health clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Institute of Indigenous medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Private laboratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Divisional Secretary Office (DS, SSO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Municipal Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Pradeshiya Saba</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Voluntary Organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Death Donation Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Temple</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Lions club</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Rotary club</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. HelpAge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Elders Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Any other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Sources needs of care

- What are the types of services do you or older persons in your area usually receive? and What are the services that are not provided at present? (Please prompt from the following list, if they are unable to answer regarding the types of services, when reporting try to ascertain whether these services are obtained within PHC and out side of the PHC)
- According to your view, if available, how much are they being met? Provided by whom, where, when, on what (Out of this list)
- Are you satisfied with the care and services you and older persons receive?
- If not what thinks specifically are you unhappy about?
- How might we improve them?

<table>
<thead>
<tr>
<th>Health Needs – Promotive / Preventive / Curative / Rehabilitative</th>
<th>Available (√) / Not available (×)</th>
<th>If available, % met provided by whom, where, when, on what</th>
<th>Satisfied / Not satisfied ways of improving any other</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Care provided to elders by family members, relatives and neighbours.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Elders homes in the area for destitute and unmarried elderly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Health education for prevention of illnesses. (in hospital, health education talks in community, health education programmes in mass media, during home visits by volunteers and public health midwives)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Community day centres for elders.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Medical investigations and treatment from nearest hospitals for chronic illnesses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Regular follow up of chronic illnesses by institutional care system.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Voluntary home care for disabled and needy elders (e.g. bathing, dressing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. First aid and distribution of indigenous oils and ointments for elders at in community through volunteers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Screening clinics in the community for early detection of (diabetes, hypertension, mental illness, visual problems, dental problems etc.).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Community follow up of the health status of elderly having chronic illnesses and disabilities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Counseling service through volunteers / field health staff.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Activities conducted for promotion of mental and spiritual well being (Cultural programmes, sports festivals, felicitation ceremonies, get-togethers for elders, opportunities for display talents of elders - singing, drama, music, Pilgrimages and pleasure trips for elders, Meditation programmes and religious observances).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Provisions for physical adaptation of the house / latrine to meet the needs of disabled individuals.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social services / NGO

a. Special identity cards for elders to obtain various concessions
b. Public assistance for needy elders
c. Pension for retired public servant
d. Mediation boards for settlement of disputes in families.
e. Provision of aids and appliances for rehabilitation of the poor disabled elders in the community
f. Donations of drugs, other equipment and transport facilities for those who cannot afford
g. Nutrition supplementation
h. Training and financial assistance for income generating activities

2. Coordination

- What can you tell about the coordination between different types of service providers and the organizations providing services to elderly? eg.: coordination between Doctor in government hospital and the Physiotherapist or the GP. Coordination between service providers of health service with those in Social Service / NGO.

- Can you tell us how we could improve coordination within the organization / between organizations providing you the above services?

<table>
<thead>
<tr>
<th>Coordination</th>
<th>Available (√) / Not available (✗)</th>
<th>If available, % met</th>
<th>Satisfied / Not satisfied ways of improving any other</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Continuity of Care

- As a patient receiving treatment for a chronic illness, what can you tell about the follow up care? ie. the care you receive until recovery / for management of a disability until death.

- Who is the person most suitable to provide follow up? (Doctor, nurse, community health worker, social worker)

- What are the ways of improving the follow up care?
II Health Providers (of 50+ users)

(adapted to the local context and understanding)

To be filled by supervisor:

<table>
<thead>
<tr>
<th>SES</th>
<th>-</th>
<th>Location</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>-</td>
<td>Time</td>
<td>-</td>
</tr>
<tr>
<td>Duration</td>
<td>-</td>
<td>No. of participants in FGD</td>
<td>-</td>
</tr>
<tr>
<td>Moderator</td>
<td>-</td>
<td>Reporter</td>
<td>-</td>
</tr>
</tbody>
</table>

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- Use “A” – the view of the majority. (3/4)
- Use “B” – the view of the half the participants (1/2)

Approach

- What are the types of institutions, organizations and committees in your area that provide health and social services for 50+ and to what extent? Who is/are the main health/social welfare provider in each organization? Prompt from list if they don’t answer.

<table>
<thead>
<tr>
<th>Institutions, organizations and committees</th>
<th>% provided</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Base hospital / District hospital / Peripheral unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Medical Officer of Health clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Private Health clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Institute of Indigenous medicine</td>
<td></td>
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</tr>
<tr>
<td>e. Pharmacy</td>
<td></td>
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<tr>
<td>c. Pradeshiya Saba</td>
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<td>e. Death Donation Society</td>
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<tr>
<td>f. Temple</td>
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<td>g. Lions club</td>
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<td>h. Rotary club</td>
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<tr>
<td>i. HelpAge</td>
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<td>j. Elders Home</td>
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1. Sources needs of care
Are you happy with the care and services provided to older persons at present?
What are the types of services older persons in your area receive? (Please prompt from the following list, if they are unable to answer regarding the types of services. When reporting try to ascertain whether these services are obtained within PHC and outside of the PHC)
If not what thinks specifically are you unhappy about?
According to your view, how much are they being met? What are the services that are not provided at present?
What are your suggestions to improve these services?

<table>
<thead>
<tr>
<th>Health Needs – Promotive / Preventive / Curative / Rehabilitative</th>
<th>Available (√) / Not available (✗)</th>
<th>If available, % met Provided by whom, where, when, on what</th>
<th>Satisfied / Not satisfied ways of improving any other</th>
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<tbody>
<tr>
<td>a. Care provided to elders by family members, relatives and neighbours.</td>
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<tr>
<td>b. Elders homes in the area for destitute and unmarried elderly.</td>
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<tr>
<td>c. Health education for prevention of illnesses. (in hospital, health education talks in community, health education programmes in mass media, during home visits by volunteers and public health midwives)</td>
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<tr>
<td>d. Community day centres for elders.</td>
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<tr>
<td>e. Medical investigations and treatment from nearest hospitals for chronic illnesses.</td>
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<td>f. Regular follow up of chronic illnesses by institutional care system.</td>
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<td>g. Voluntary home care for disabled and needy elders (eg: bathing, dressing)</td>
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<td>h. First aid and distribution of indigenous oils and ointments for elders at in community through volunteers</td>
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<tr>
<td>i. Screening clinics in the community for early detection of (diabetes, hypertension, mental illness, visual problems, dental problems etc.).</td>
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<td>j. Community follow up of the health status of elderly having chronic illnesses and disabilities.</td>
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<td>k. Counseling service through volunteers / field health staff.</td>
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</table>
1. Activities conducted for promotion of mental and spiritual well being (Cultural programmes, sports festivals, felicitation ceremonies, get-togethers for elders, opportunities for display talents of elders - singing, drama, music, Pilgrimages and pleasure trips for elders, Meditation programmes and religious observances).

m. Provisions for physical adaptation of the house / latrine to meet the needs of disabled individuals.

Social services / NGO

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<tr>
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<tbody>
<tr>
<td>a.</td>
<td>Special identity cards for elders to obtain various concessions</td>
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<tr>
<td>b.</td>
<td>Public assistance for needy elders</td>
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<tr>
<td>c.</td>
<td>Pension for retired public servant</td>
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<td>d.</td>
<td>Mediation boards for settlement of disputes in families.</td>
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<tr>
<td>e.</td>
<td>Provision of aids and appliances for rehabilitation of the poor disabled elders in the community</td>
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<td>f.</td>
<td>Donation of drugs, other equipment and transport facilities for those who cannot afford</td>
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<td>g.</td>
<td>Nutrition supplementation</td>
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<tr>
<td>h.</td>
<td>Training and financial assistance for income generating activities</td>
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- Why do you think that the particular services are not being met at present? (eg: such service is not available / nor proper coordination / lack of finances / no referral system / distance / lack of trained personnel / lack of knowledge of the providers regarding the necessity of such services)

2. Coordination

- What type of services should be integrated? Hospital, health centre, elders day centre, community screening clinics, home care service and family care, other organizations, providing health and welfare to elderly.
- What can you tell about the coordination between different types of service providers and the organizations providing services to elderly? Exist / does not exist, satisfactory / not satisfactory eg.: coordination between Doctor in government hospital and the Physiotherapist or the GP. Coordination between service providers of health service with those in Social Service / NGO.

<table>
<thead>
<tr>
<th>Coordination</th>
<th>Available (✓) / Not available (✗)</th>
<th>If available, % met</th>
<th>Satisfied / Not satisfied ways of improving any other</th>
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<tr>
<td>a.</td>
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• Can you tell us how we could improve coordination within the organization and between organizations providing you the above services?
  – At what level of services? (Eg: primary, secondary or tertiary care etc.);
  – For what function? (Eg: information, decision-making, resource and planning)
  – with whom (Eg: GP’s, nurses, social workers, other health care workers)
  – for what services? (Eg: health promotion, prevention, screening, social support, home support)
  – What are the factors which facilitate coll. / coor.
  – What are the factors which act as barriers for coll. / coor.
  – Ascertain the potential for increased coll. / coor.

3. Continuity of Care

• What can you tell about the follow up care of a patient receiving treatment for a chronic illness? ie. the care you receive until recovery, for management of disability until death.
• Who is the person most suitable to provide follow up in each place? Hospital clinic, community clinic, at home (Doctor, nurse, community health worker, social worker)
• What are the ways of improving the follow up care?

II. 50+ PHC users

1. Needs and Sources of Care

Most of them said they are usually happy at present, as they received the necessary care, food and clothing by their family members, relatives and neighbours.

- Care provided to elders by family members, by relative or neighbour and elders homes for destitute elders (Health promotion, social and moral support)
  50+ users in general identified the care provided by the family as the most important service out of all those needs that are being met at present. At times when all other people at home go for work they also received the social support from relatives and neighbours. But this is also gradually diminishing now.

  They highlighted the importance of the care and protection that should be provided by the children as part of their responsibility, to their old parents and the Elders Homes should be the last resort, which should be only suitable for the destitute and unmarried elderly.

- Most of the elders seem to be unaware regarding the range of health needs (facilities) they should be provided by health and social services etc. But when prompted according to the questionnaire used, they commented regarding each service they received. They are follows.

- Community day centres for elders (Health promotion, social and moral support)
  They mentioned that the provision of the day centres for elders (which are coordinated by the PHC centre with community, MoSS, volunteers and NGO support) were helpful for psychological support, allaying their loneliness and as a source of providing recreation. They said that more and more such centres should be made available in the community within their reach.
Investigation and treatment of chronic illnesses by institutional care system – within PHC level

Regarding the provision of treatment at small government hospitals within the PHC area, most of them mentioned that the necessary drugs needed for long term treatment are sometimes not available and there are no specialists hence they by pass small institutions and go to bigger health institutions outside PHC even if the waiting time there is long and the traveling is difficult. Sometimes the bigger institutions are very crowded and for a less than 3 – 5 minute consultation they have to spend 1 – 3 hrs as waiting time to see the doctor and about another half an hour to one hour at the dispensary to collect the medicine. They said the facilities of the smaller hospitals should be uplifted with provision of the necessary drugs, laboratory facilities and specialist. The attitudes of the health personnel working in larger hospitals should be made more favourable towards elderly.

There are instances that they have gone to private laboratories although they have to spend their own money, as the waiting time to get it from government hospital will be very long. Sometimes it takes 2 to 3 days to provide the report from the government hospital.

Regular follow up of chronic illnesses by institutional care system – within PHC level

They also mentioned the need to empower the older people and create more awareness regarding the need for obtaining continued treatment for chronic illnesses, lifestyle changes and also regarding the common illnesses they face so that they will be able to seek treatment for their illnesses before complications setup. They also pointed out that the family members also should consider their complaints/early symptoms regarding their illnesses seriously and take them for medical treatment early.

Special ID cards for 65+ to get preference at hospital OPD, post office, banks and drugs at discount from state pharmacies (Health promotion, social and moral support) – within + outside PHC level

The special ID cards offered for 65+ are sometimes not helpful, not accepted by some hospitals due to lack of awareness among some of the health workers especially minor staff. Hence they requested that more awareness programs should be carried out among hospital workers and general public regarding this ID card.

Village committees which plan / monitor activities for elders (Health promotion, social and moral support)

They mentioned that there are lots of village committees that are actively involved in welfare programs of elder. For e.g.: The Farmers Associations, Pensioners Association and Death Donation Societies. They also plan, organize and monitor activities such as recreational activities, health awareness programs, provision of nutritional meals to poor elders etc. Now the Secretariat of Older Persons of Social Services Ministry registers all village committees that are actively involved in welfare programs of elderly. They also provide a small grant (once and for all). Which means government policy also promotes active participation of the community in health and welfare programs.

Cultural programs; sports festivals, felicitation ceremonies, get-togethers for elders, Opportunities for display talents of elders - singing, drama, music, Pilgrimages and pleasure trips for elders, Meditation programs and religious observances (health promotion, social and moral support) – within PHC level

They also identified the above mentioned health promotion activities coordinated by the primary health care staff in collaboration with MoSS, NGOO, volunteers and community support quite important for their psychological well being.

Public assistance for needy elders, Pension (Wand OP for retired public servants) - (Health promotion, social and moral support)
Those elders especially from low SES area mentioned the need to increase the amount of public financial assistance provided to needy elders and also the need to raise the pension allowance as they find difficult sometimes to bare the cost of drugs which they have to buy from pharmacy.

- **Home care for dressing, washing and help with mobility (social and moral support)**
The elders especially from the low SES area mentioned regarding the range of services they received from the volunteers living in the community such as home care and the support they get from the existing village committees in various ways such as first aid and distribution of indigenous oils and ointments. They mentioned the necessity to expand the home care programme for elderly.

- **Distribution and application of indigenous oils and ointments for joint pains (rehabilitation for chronic ailments)**

- **First aid for minor ailments, cleaning and dressing of wounds (treatment for acute and chronic ailments)**

The need of above mentioned programs were also identified by the 50+ users

- **Field medical clinics for assessment of diabetes, hypertension, visual and mobility problems etc. and referral for specialized care**

- **Donation of drugs for those who cannot afford**

- **Assistive devices for needy elders such as spectacles, IOCL, wheel chairs etc.**
  Usually they receive the above from Lions Club, Rotary Club or NGO such as Sarvodaya.

2. **Coordination**

The 50+ users said that it would be easier for them to get the above-mentioned services if there is a proper coordinating mechanism. Especially between health, social services, volunteers and NGO.

If there is more coordination within and among service providers / organizations especially for giving priority for elders for obtaining the services, then they would be able to save time and energy and will be less frustrated.

For e.g.: When an intra ocular lens is prescribed by the surgeon of a particular hospital, for a poor patient having cataract, if such a person is to get it free through the Social Service Department which is situated elsewhere or from an NGO in the community, he has to go through several procedures. First the particular elder will have to get a certificate from the Grama Niladhari of the area he is living which should also be endorsed by the particular Divisional Secretary for him to obtain this, intra ocular lens free of charge.

The patient will have to go through this hazard, as this service is not available within the health institutions (the budgetary allocation from the treasury for provision of aids and appliances free of charge to poor patients is made to the Social Services Department and not for the Ministry of Health). Neither there is a social worker attached to the health institutions.

The same procedures have to be adopted by the patient if they are to get a wheel chair, protheses, crutches or walking frames free of charge from Social Services Department or from an NGO.

They said that necessary steps should be taken to improve coordination.

3. **Continuity of care**
For patients receiving treatments for chronic illnesses the only formal continuity of care available is through regular follow up at the hospital clinic, which the patient was treated. Usually there is no referral of the patient to the peripheral care institution close to his or her home. (this may be due to lack of facilities such as unavailability of the drugs in the peripheral care institution, that are being used by the patient at discharge or the attitudes of the doctor who treated in taking an interest for back referral.

In the community there is no follow up of the patient at home by any health personnel, as public health midwives only follow up the pregnant mothers and under 5 children.

### III Findings of the focus group discussions of health providers and from answers to the questionnaires by the professionals and from Discussions carried out at national inter disciplinary meetings

#### 1. Needs and Sources of Care

**Suggestions for improving the services provided for 50+**

- **Treatment and follow up of their illnesses through hospital clinics**
  
  Some of the health providers said that the patients usually go to bigger hospitals where they were treated first, also for follow up, although such places are crowded. It is because they know that there are specialist and sophisticated facilities for laboratory investigations and also because they are not referred back.

  But there were few exceptional doctors in-charge of Peripheral Units who mentioned that they have managed to get the patient for follow up to their hospital by convincing them that they can be treated equally well in peripheral units too (as most of their illnesses which are of mild to moderate degree of severity). They have also developed certain strategies of attracting the patients to the small hospital by offering refreshments for all the elders coming for follow up care at monthly clinics.

  Some of the health providers were of the view that among those who come to hospital, there are some elders who tend to exaggerate the symptoms in order to attract more attention and acceptance of the health providers. There are some elders who come to hospital very often complaining of some serious complain such as chest pain in order to get admitted to the ward. This may be because they want to stay in the ward for a few days due to poverty or the lack of attention of their family members.

  The main reason for some elders to choose a private practitioner (instead of coming to a government institution) is because they usually spend more time listening to elders.

- **Health education regarding prevention and management of common health problems**

  Health providers also mentioned the advantages and the necessity of the elder being accompanied by a family member when they come to hospital (as usual). They felt that most of the elders cannot understand the instructions of the doctor and also the elders cannot clearly explain their health problems. *(Is it because doctors cannot spare much time listening to the elder?)*

  Some of the other health providers mentioned that providing instructions to the elder regarding the methods of changing the lifestyle in certain illnesses it is easy for them to practice them if those are explained also to the family member who accompanied them. *(Is it because elders have no voice?)*
They said it is important to educate the family members regarding the continuity of taking medicine for chronic illnesses the elders suffer, as they are the people who have to accompany the elder to the hospital clinic.

- **Screening clinics for early diagnosis and referral**
  Health providers mentioned that the preventive health services regularly available for 50+ at present are Well Women Clinics for screening women over 35+. There is a need to conduct regular field medical clinics for assessment of diabetes, hypertension, visual and mobility problems etc. and referral for specialized care monthly in the community for both men and women. As there are hardly any screening programs for males, the males are less aware regarding preventive measures. It is also important to get the support of employment agencies / factories in the area to refer males for screening programs.

  They mentioned that by conducting the screening clinic as a joint effort of the curative and preventive care institutions the referral and follow up of the patient would be made easy. The regular screening clinics can be conducted in the community and follow up of the patient could be facilitated by providing transport facilities and the necessary instruments for screening, such as gluco-meters to the preventive health care providers. This would be possible with community mobilization, where the support of the village committees could also be obtained for provision of refreshments and the purchase of medicine for the clients.

- **Rehabilitation for disabled.** “This service is mainly available at present in larger hospitals only as there are no therapists working in smaller hospitals. The community based rehabilitation program is not a continuous program as the volunteers trained for providing rehabilitation care trend to dropout. However a multi disciplinary team should be formed at PHC level to work in the hospital as well as for out reach service in future in orders to prevent unnecessary admissions and readmissions.”

- **Special ID cards for 65+ to get preference at hospital OPD, post office, banks and drugs at discount from state pharmacies (Health promotion, social and moral support)**
  “Some of the elders who come to hospital try to seek preferential treatment, not only at OPD but also at follow up clinics, by showing the special ID cards for 65+. Giving preference to the elder who bare the elders’ identity card at the medical clinic would be difficult when they come for follow up to the hospital, as most of them belong to the old age category. They said that the over crowding can be prevented to a large extent, if elderly patients who have illnesses such as hypertension and diabetes of mild degree are treated at peripheral hospitals and also those treated at large hospitals are referred back to smaller institutions for follow up.”

- **Out reach treatment service operating from hospital**
  “Arthritis and joint pains were identified as most common problems among elderly. They find it difficult to reach the hospitals hence the need for planning an out reach treatment service in community.”

**Education and training**

Education and training programs for preventive health care / institutional health staff on care of elderly

The Doctors, Nurses, Other paramedical workers, Social workers and the volunteers who participated in FGD and the doctors who answered the questionnaire given to them highlighted the importance of providing continuous training for all categories of health personnel on gerontology and need for introduction of geriatrics as a sub specialty for doctors.
They said that the following training programs could also be organized by Central and provincial offices of MoH in collaboration with MoSS / MoH / MoIM and other related agencies.

- Education and training of volunteers for provision of home care
- Awareness programs for elders regarding types of illnesses during old age, symptoms of early recognition, the need for seeking early treatment and follow up
- Education programs for Pre-retirees
- Awareness programs for family members of elders
- Education on healthy lifestyle for elders
- Exercise program for elderly

They pointed out the need to educate the family members regarding the illness of the elderly person. In organizing and improving services for elders the help of the neighbours and the voluntary organizations at village level will be necessary. They felt that the attitudes of the community (social stigma) should be changed regarding certain illnesses such as mental illness, leprosy and cancer in order to make the elder remain in the community without being institutionalized.

They mentioned that these awareness programs could be conducted by PHC centers / volunteers / mass media / MoSS / day centers and central MOH

- Establishment of a proper referral system from hospital to community clinics and vice versa
  “The Medical Officer of Health conducting the screening clinics at field level should be able to refer patients direct to hospital for lab test and treatment and they should be attended to without having waiting in the OPD queue.”

- Improving coordination
  “There is a need to strengthen the inter personnel coordination between health professionals of different categories especially between preventive and curative care. Coordination should be improved at all levels (village, divisional, district, provincial and central) within and among all sectors / organizations and among primary, secondary and tertiary health care institutions.”

- Establishment of a community fund for needy elders
  “There is a need to establish a community fund at elder's day centre or temple to support the elders who cannot afford to buy certain medications and for getting the necessary lab test done from private labs.”

- Assistive devices for needy elders such as spectacles, IOCL, wheel chairs etc.
  They also pointed out the necessity to improve coordination among different personnel such as health providers / divisional secretary / social services officer and NGOO personnel in order to facilitate getting the assistive devices for the elder without difficulty when prescribed by the health authorities.

- Improving infrastructure facilities at peripheral hospitals
  The health authorities mentioned the possibility of improving the physical infrastructure facilities in peripheral curative care institutions by getting the help of private sector organization in those areas.

- Health insurance schemes
  The social workers and volunteers mainly suggested the need of establishing health insurance schemes for elderly irrespective of age and the need to establish elders’ committees at village level.

- Practical support for dressing, washing and help with mobility through home care
They said provision of home care by the volunteers trained as a collaborative effort of HelpAge and Director / Elderly of Ministry of Health has benefited lot of elders. Visit of the volunteers to some homes has also helped to make the family members realize the need to look after their disabled mothers and fathers who have been neglected before, by keeping them at home. In addition, volunteers also help elders to accompany them to hospital or fetch the monthly quota of drugs from hospital for them.

The health providers emphasized the necessity of training more volunteers to support the elders in the community. They mentioned that the poor elders in the community would be largely benefited by expansion of the ongoing training programme on voluntary community health care for elders.

It is important to mobilize finances from government, NGOO, the community itself, international NGOO or private sector for continuation of the volunteer training programme.

- **The village level committees** (formal / informal) should be established throughout the divisions with community mobilization to plan and organize and implement programs for the benefit of elders. These committees should promote governmental and non-governmental organizations, business establishments, religious organizations, and philanthropists of the community to participate in improving the services for elderly through provision of logistics, under-utilized buildings, and human resource.”

- “Through these committees it would be possible to improve the health care delivery at grass root level. These community based associations have been and would be successful in mobilizing financial resources from major NGOs and from the National Secretariat for Older Persons for building up a community fund for carrying out health, nutrition, and income security programs for the needy elderly.”

- **Policy formulation**
They mentioned that all these suggestions are to be implemented they should be incorporated in the elderly health policy. It is important to include the need for providing health screening for elders in the community to the duty list of all Medical Officers.

“The responsibility of coordinating the health screening programs for elderly in the division could be handed over to an Officer attached to the Divisional Secretary Office.”

- **Counseling service**
“Training should be provided, for NGO personnel, health personnel and selected elders in the community to provide friendly and basic counseling service to elders especially to home bounds. Create awareness regarding this counseling facility in the community.”

- **Mass media awareness programs**
“There should be more mass media awareness programs on the repercussions of maltreatment towards elders by the children and the consequences such as suicide among elders.”

**Health and social service related needs mentioned by 50+ and health providers**

- Day centers
- Investigation, treatment through hospitals
- Regular follow up through hospitals
Home care
Field medical clinics
Special ID cards for 65+
First aid, Indigenous oils and ointments
Donation of drugs
Assistive devices
Rehabilitation for disabled
Cultural program, sports festivals
Opportunities for display talents
Pilgrimages and pleasure trips
Village committees
Meditation programs
Elders homes
Public assistance
Pension

2. Coordination

Barriers to coordination

- As pointed out by the health providers who participated in FGDs and those among the NIC and some of the members of the NIC, “the Unwillingness to engage in multi-disciplinary coordination (hospital, specialists, GP, Social Services Officer, volunteers, family members, neighbours etc.) could be due to "Cultural differences" between the different organizations. These may also be due to differences in their training and background, the lack of trust etc. between specialists and generalists and lack of trust etc.”
- Also “unwillingness to accept elderly care as a priority concern (creation of professional empires for existing services identified as priority areas in the past.”
- “Conflicts between professional groups, within professional groups, within primary health care services, with outside organizations (government, non-government, community based) regarding roles and responsibilities, boundaries and demarcations, allocation of resources and sharing of information knowledge and skills.”
- “Lack of budgetary allocation for Ministry of Health for elderly care.”

Suggestions by the health providers for improvement of coordination

- “Coordination between curative and preventive care sectors to be also established for community follow up of patients with NCDs and those with disability when discharged from the hospital.”
- “Ensure improved collaboration among all sectors (relevant GO, NGO, private sector) for planning, implementation and monitoring.”
- “Formulation of multi-sectoral coordinating committee to coordinate and monitor the progress of health and welfare of elderly at provincial, district, divisional and village levels (similar to the link established among relevant sectors at national level by establishing the National Council for Elderly).”
- Community leaders through village committees can get actively involved in planning,
implementation, monitoring and evaluation of Health and welfare services of elders in the community.

- **Coordination can be improved by** “involvement of all stakeholders dealing with elderly care at regular coordinating meetings at PHC level.” Eg: MOH with MO in-charge of local hospital / Social Services / NGO / community leader / volunteer.”

- **“By using a common record to be used by all stakeholders** for each elderly patient for referral and back referral.”

- **‘By establishing a management Information System (MIS) developed with data on elderly from PHC level with regular feedbacks to all stakeholders.”**

3. **Continuity of Care**

   **FGD findings of professionals and from answers of the questionnaires by the professionals**

   **Definition (s) given in the group of “Continuity of care”**

   Regular follow up of older person’s diagnosed of a physical / psychological illness or a social problem. Hence this will include mainly curative care and follow up, provision of supplies and assistive devices and drugs, rehabilitation, home care / social support, counseling and emotional support, strengthening family support, housing adaptation and respite care

   **Continuity of care**

   **Suggestions for improvement by health providers and NIC members**

   - “Continuity of care for elderly should become a priority concern of the Ministry of Health with more support from political and policy makers.”

   - “Ensure establishment of the referral system with clear-cut responsibilities, procedures, protocols and guidelines identified for each curative health care institutions and a flow chart on pathway.”

   - “Arrange with peripheral health units to issue a Personnel Health Record Book for each person (60+) as a means of maintaining health records, laboratory findings and for referrals to be used by all designated health and social welfare providers.”

   - “Provide adequate human resources, funds and other resources allocated for elderly care at central, provincial, district and divisional levels. (Government, NGO partnership)”

   - “Improve the curricular of pre-service and in-service training for medical and paramedical personnel, including promotion of healthy life style, active ageing and other information for prevention of health problems in old age and on health promotion (with the contents on attitude change and skills).”

   - “Include specifically the care of elderly in the job functions of all relevant categories of health personnel.”

   - “More training manuals and guides to be prepared on elderly care for training health personnel, volunteers and NGO personnel.”
- “IEC materials to be produced (leaflets, booklets, videos) for providing information on elderly care for health personnel, general public and elderly.”

- Train PHC personnel on information provision for school and out of school youth and volunteers on health of elders and active ageing

- Recruit and train health and social workers on gerontology and geriatrics and develop multi disciplinary teams (nurses therapist, social workers) to work with them (MoH, MoSS)

- Develop a system for housing modification of older persons with significant physical limitations. (Community support, MoSS)

- Increase the numbers of medical / paramedical personnel (preventive, curative) designated to work for improvement of elderly health, at grass root, divisional, district, provincial and central levels

- National Plan of Action should be prepared based on integrated health care with multi-sectoral involvement for improving preventive, curative rehabilitative services related to elderly health

- Management information system to be established for collection of data and for monitoring of elderly health at PHC level upwards.

- Systems to be established in the health sector at each level for continuous monitoring and evaluation of above activities

- Allocate to peripheral curative care institutions a quota of the types of drugs that are being used in major care institutions (Eg: third level drugs) to facilitate back referral of patients treated for NCDs.

- Ensure availability of essential drugs used for identified number of common NCDs such as drugs use for hypertension, diabetes, heart disease, arthritis, asthma and mental illness in governmental medical institutions at PHC level and also price reduction of essential drugs.

- For the patient discharged from hospital, community follow up to be done by the PHM or any other field officer designated for care of elderly.

- As a pilot study to set up mobile home care service with inter disciplinary teams, consisting of nurses, therapists and social workers to visit homes of disabled elders in the community also to provide advise and to train family members, a religious leader can also be included in the team as a counselor.

- Support older people who need assistance by training more and more volunteers. (PHC staff, MoH, MoSS, NGOO, village committees)

- Train volunteers, other caregivers and counselors to be supported with an incentive scheme to facilitate them to remain engaged in service for a long period (community funding schemes through village committees / NGO, private and public partnerships)

- Make available, incentive schemes for volunteers supported by private sector such as drug companies.
- Offer prices for best day centre for elderly, best counselor, best village committee, most popular counselor etc. selected from PHC area.

- Caregiver support programme (respite) need to be developed. (Community organizations, MOH staff, MoSS, NGO)

- Preferential facilities to be provided for elders at OPD and dispensary / adoption of an appointment system.

- Regular mobile field screening clinics for elders held in PHC areas for detection and referral of common health problems.

- Long stay hospitals to be established with NGO and community support for transfer of chronically ill destitute elders before sending them to community.

- For community follow up of patient by PHM, she should be given a less population to be hand led; or else by increasing the number of PHMs per PHC area.

- In addition, continuous follow up of patients taking treatment, regular monitoring of their BP and blood glucose level and health education can be done by recruiting and training new category of field level officer in the Health Ministry or attached to the MoSS or Ministry of Samurdhi. This will reduce the number of admissions and re-admissions to hospital.
  - This will largely address the problem of youth unemployment among educated youth where successive governments are pressurized with for finding solutions.

- Another alternative is to develop a new category of health personnel call the community health nurse to provide home visits to elders for nursing care, health education and training family members of the affected elder as carers.

The following can also be suggested towards improvement of health and well being of elders

- Train the school teachers on information provision, value education and skill building for school children and their parents on healthy life style and active ageing

- Each MOH area to prepare their own plan of action on care of elderly based on the needs of the community including the activities, inputs, targets, quantifiable outputs, time frame resource availability, taking into consideration the strategies laid down in the national plan of action. The indicators for monitoring the progress have also been identified. This should be done with the leadership of medical officer of the health and in collaboration with other sectors.

- Village committees to encourage the elders to form pressure groups in the community to voice their opinion with a view to improve the gaps and shortcomings regarding provision of health services for the elders in the area.

- More evidence based research need to be done in the community for identification of ways and means of strengthening the integrated health and welfare system.

- Train elders to educate their peers on early recognition of elderly health problems and care of elderly.

- Family members of elders and community leaders to be made aware on early recognition of elderly health problems and care of elderly.
• NGO personnel, health personnel and elders in community to be trained as befrienders / counselors.

• To make available of counseling centres in the community for benefit of elders.

• School children to be made aware regarding healthy life styles, active ageing, health problems of elderly and care of elderly.

• Elderly friendly services to be established in hospitals and specialized clinics.

• Youth and elderly volunteers to be trained as carers for the elders in the community.

• Peripheral units to be strengthened with improved lab facilities and drugs for treating common illnesses of elderly.

**Conclusion**

A total of 14 Focus Group Discussions (08 FGDs with users and 06 FGDs with providers) were conducted in order to explore the existing services provided to 50+ populations on health and welfare and to elicit information regarding the interactions and linkages among the existing health care system, health care providers and users.

The participants for the FGDs were recruited from two separate areas differing in socio economic status. The discussions provided insights regarding the need and the ways of formulating an integrated / comprehensive health care system within the framework of primary health care for the benefit of older persons. The existing services have many positive aspects for provision of integrated health service for elders – a common vision shared by almost all stakeholders involved, an infrastructure, which can be improved for provision of a better health service for older person and positive attitudes health providers, who have already identified the need for establishment of a comprehensive integrated health care system for the benefit of older persons. However a strong government commitment would be needed to achieve these.

**Acknowledgements**

I would like to express my sincere thanks to

• Dr. Alexandre Kalache, Coordinator, Ageing and Life Course, Health Promotion, Surveillance, Prevention and Management of NCDs of WHO Geneva and Mrs. Nejma Macklai, INTRA Project Coordinator, Ageing and Life Course for including Sri Lanka in this study, for providing funds and guidance,

• To the Dutch Ministry of Health, Welfare and Sports, especially Lucy Aarnink of Ageing and Life Course for her unstinted support extended to us during the conference in Hague, Netherlands,

• To all health personnel and my staff who joined hands with me throughout this study, with eagerness to see the out come and justice being done for older persons,

• To the staff of HelpAge Sri Lanka, for their generous support in helping me,
• The informants of the Focus Group Research, the members of the National Inter Disciplinary Team for providing valuable ideas and last but not least,

• Mr. N.W.E. Wijewantha, my counter part for the INTRA project for his cordial support.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

Annexure

INTRA II - CHRONOGRAM

Main activities conducted with the responsibility of Dr. Deepthi Perera, Focal Point for Ministry of Health for INTRA and budget

• Approval obtained from Ministry of Health to be the focal point for INTRA project. - 30th March 2004

• Nomination of chairman and members for National Inter Disciplinary meeting. (The list of members selected annexed) - at HelpAge 19th February 2004
  Mr. N.W.E. Wijewantha
  Dr. Deepthi Perera
  Mrs. Sujeewa
  Driver - E.W.P. Pathmalal

• Review of literature / references –on reference material sent from Geneva on INTRA I, INTRA II methodology also other references made on Integrated Health Care Services for preparation of power point presentations for NICs and for designing the Focus Group Discussions – 23rd February 2004 to 31st March 2004
  Dr. Deepthi Perera

• Meeting for briefing the stakeholders of the Ministry of Health regarding the INTRA project - 21st April 2004
  Dr. Deepthi Perera
  Sagarika Gunasekara
  Latha Ranasinghe
  Sujinth Wijesooriya
  Ruwini Abeysirinarayana

  The following Doctors from the Ministry of Health participated:
  Director / Primary Health Care.
  Director / Health Education Bureau.
  Director / Non Communicable Diseases.
  Director / Mental Health Services.
  Director / Tertiary Care Service.

• Obtaining approval from Director General of Health Services for the list of nominees of NIC.

• Informing the members selected for National Inter Disciplinary meeting regarding their appointment. - 28th April 2004
  Dr. Deepthi Perera
  Sagarika Gunasekara
  Latha Ranasinghe
Sujintha Wijesooriya
Ruwini Abeysirinarayana

- Preparation of budgets for holding National Inter Disciplinary meetings and sending to HelpAge for obtaining the advance - 29th April 2004
  Dr. Deepthi Perera
  Ruwini Abeysirinarayana

- Preparation of power point presentation for 1st NIC meeting on INTRA – 30th April 2004 and 03rd May 2004
  Dr. Deepthi Perera
  Ruwini Abeysirinarayana

- Holding first NIC meeting and discussion regarding the INTRA project and the need for integrated service for benefit of elders. Lunch and refreshments were provided to the participants – 06th May 2004 – 10.00 am to 01.45 pm

  o Ministry of Health

  Deputy Director General (Public Health Services). - Chairman
  Director / Primary Health Care.
  Director / Maternal and Child Health. – Representative
  Director / Health Education Bureau.
  MO / Health Education Bureau.
  Director / Population.
  Director / Mental Health Services.
  Director / Tertiary Care Service.

  o Non-governmental Organizations:

  Executive Director / HelpAge Sri Lanka.
  General Secretary / Sri Lanka Pensioners Association.

  o Academic Institutions:

  Consultant Physician – Faculty of Medicine Galle.

  o UN agencies:

  for WHO Representative. (Dr. Thushara Fernando)

  Coordinated by: Director YEDD

  Supporting staff:
  Sagarika Gunasekara
  Latha Ranasinghe
  Sujintha Wijesooriya
  Ruwini Abeysirinarayana

  Expenditure incurred so far
  Participants = Rs. 9,000.00
  Conference Facilities = Rs. 2,720.00
• Selecting members for the National Inter-disciplinary Committee to provide information according to the guide, preparation of questionnaire to be distributed and (by fax) among them - 01st June 2004

The following members were selected to answer the questionnaire
- Director / Non Communicable Diseases – Ministry of Health
- Consultant MO Representing Director / Family Health Bureau
- Director / Mental Health Services
- Director / Tertiary Care Services
- Director / Health Education Bureau
- Director / Population Division
- Director / Social Services
- A Consultant Physician attached to University Teaching Unit, Karapitiya

• Preparation of power point presentation for 2nd NIC meeting on INTRA – 03rd June 2004
Dr. Deepthi Perera
Ruwini Abeysirinarayana

• Holding second NIC meeting and discussion regarding the INTRA project and the need for integrated service for benefit of elders – 04th June 2004 – 10.00 am to 01.45 pm

  o Ministry of Health
  Deputy Director General (Public Health Services).- Chairman
  Director / Maternal and Child Health. – Representative
  Director / Health Education Bureau.
  Director / Population.
  Director / Non Communicable Diseases.
  Director / Mental Health Services.
  Director / National Institute of Health Science.

  o From other Ministries:
  Director / National Secretariat for Elders. (Min. of Social Services)

  o Non-governmental Organizations:
  Executive Director / HelpAge Sri Lanka.

  o UN agencies:
  for UNFPA Representative. (Miss. Tania Weerasooriya)

  Coordinated by: Director YEDD

Supporting staff:
Sagarika Gunasekara
Latha Ranasinghe
Sujintha Wijesooriya
Ruwini Abeysirinarayana

Expenditure incurred so far
  Participants = Rs. 8,000.00
  Conference Facilities = Rs. 1,314.00
Photographs = Rs. 1,467.00
Total = Rs.10,781.00

- **Adaptation of the FGD protocols to suite the country and district – 13th and 14th March 2004**
  
  Dr. Deepthi Perera

- Typing the adopted the FGD protocol and guide lines for conducting FGD and making copies to be given to Kalutara and Ratnapura regions - **15th March 2004**
  
  Ruwini Abeysirinarayana
  Sujintha Wijesooriya

- Choosing areas (low SES, high SES) for carrying out INTRA project – **19th April 2004**
  
  Dr. Deepthi Perera

- **Orientation of district leaders regarding the tasks to carried out and the methods of selection of members for FGDs - 22nd April 2004 at Horana** Dr. Deepthi Perera, Driver – E.W.P. Pathmalal and **23rd April 2004 at Ratnapura** Dr. Deepthi Perera, Mrs. S. Abeyratna and Mr. Wickrama Gunaratna of HelpAge

- Preparation of budgets for FGDs and training for FGDs – at HelpAge **24th April 2004**
  
  Dr. Deepthi Perera
  Mrs. S. Abeyratna and Mr. Wickrama Gunaratna of HelpAge
  Driver - E.W.P. Pathmalal

- Discussions with coordinators of Kalutara and Ratnapura districts regarding sampling and recruitment of 50+ users for the 8 focus groups, providing guide lines and identification of the facilitators, reporters and supervisors of FGD – **26th and 27th April 2004**
  
  Dr. Deepthi Perera
  Dr. T. Kalubowila – Horana Hospital
  Dr. Anoja Hapugaswatte – Imbulpe MOH
  Sagarika Gunasekara
  Latha Ranasinghe
  Sujintha Wijesooriya
  Ruwini Abeysirinarayana

- **Preparation of printed formats and guide lines of FGD** to be distributed among supervisor, facilitators and reporters – **06th May 2004**
  
  Sujintha Wijesooriya

- **Training of the facilitators, reporters and supervisors of FGD – 07th May 2004 at Samudi Hall Ratnapura**
  
  Dr. Deepthi Perera
  Mrs. S. Abeyratna and Mr. Wickrama Gunaratna of HelpAge
  Sagarika Gunasekara
  Latha Ranasinghe
  Driver - E.W.P. Pathmalal

**Expenditure incurred so far**

<table>
<thead>
<tr>
<th>Description</th>
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<tr>
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<tr>
<td>Conference Facilities</td>
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<td>Stationary</td>
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<td><strong>Total</strong></td>
<td><strong>Rs.33,454.50</strong></td>
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• The adapted FGD protocols were reviewed and revised with the help of the facilitators and reporters. Typing, making copies, preparation of files, purchasing of stationary and audiocassettes. – **10th to 14th May 2004**

**Sagarika Gunasekara**

**Latha Ranasinghe**

**Ruwini Abeysirinarayana**

**Sujintha Wijesooriya**

**Driver - E.W.P. Pathmalal**

• Two focus groups were conducted with health providers – **17th May 2004 in Kalutara District**

• Four focus groups were conducted with older persons 50+. – **18th May 2004 in Kalutara District**

• Two focus groups were conducted with health providers – **20th May 2004 in Ratnapura District**

• Four focus groups were conducted with older persons 50+. – **21st May 2004 in Ratnapura District**

• **Supervision of FGDs conducted – 17th and 18th May 2004 in Kalutara District**

  **Dr. T. Kalubowila – Horana Hospital**

  **Mrs. S. Abeyratna and Mr. Wickrama Gunaratna of HelpAge**

  **Sagarika Gunasekara**

  **Latha Ranasinghe**

  **Ruwini Abeysirinarayana**

  **Driver - E.W.P. Pathmalal**

**Expenditure incurred so far**

<table>
<thead>
<tr>
<th>Item</th>
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<tr>
<td>Expenses for 06 groups</td>
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<td><strong>Total</strong></td>
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• **Supervision of FGDs conducted – 20th and 21st May 2004 in Ratnapura District**

  **Dr. Anoja Hapugaswatte – Imbulpe MOH**

  **Mrs. S. Abeyratna and Mr. Wickrama Gunaratna of HelpAge**

  **Latha Ranasinghe**

  **Ruwini Abeysirinarayana**

  **Driver - E.W.P. Pathmalal**

**Expenditure incurred so far**

<table>
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<td><strong>Total</strong></td>
<td><strong>Rs. 61,232.00</strong></td>
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following payments were identified for conducting each FGDs

- for the participants of FGDs
- for the facilitators, reporters, supervisors and the helpers
- for refreshments and lunch
- for transporting patients who are unable to come on their own to the respective places
- for accommodation and lodging of the supervisors and drivers
- for secretarial assistance and supportive staff

• Preparation of formats for FGD of Doctors - 25th May 2004
  Dr. Deepthi Perera  
  Ruwini Abeysevirinarayana  
  Latha Ranasinghe  
  Sagarika Gunasekara  
  Sujintha Wijesooriya  

• FGDs for Doctors were conducted in Conference Hall, Ratnapura Rest House. – 26th May 2004
  Dr. Deepthi Perera  
  Mr. Wickrama Gunaratna of HelpAge  
  Sagarika Gunasekara  
  Driver - E.W.P. Pathmalal

Expenditure incurred so far

<table>
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<td>Fuel</td>
<td>500.00</td>
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<td><strong>30,903.10</strong></td>
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</table>

following payments were identified and for conducting each FGDs for doctors
- for the participants of FGDs
- for the facilitators, reporters
- for refreshments and lunch
- for transport of some of the Doctors

• Analysis and entering data on Socio economic characteristic of 50+ users - 07th to 11th June 2004
  Dr. Deepthi Perera  
  Ruwini Abeysevirinarayana  
  Latha Ranasinghe

• Cross checking the analysed data - 11th June 2004
  Sagarika Gunasekara

• Analysing FGD findings of users and providers – 05th and 06th June 2004 and 12th and 13th June 2004
  Dr. Deepthi Perera

• Preparation of report on analysing FGD findings of users and data on Socio economic characteristic providers and typing and preparing the transparencies of the FGD report - 14th and 15th June 2004 and 17th to 19th June 2004 – 10.00 am to 8.00 pm
  Dr. Deepthi Perera  
  Ruwini Abeysevirinarayana  

Expenditure incurred so far

<table>
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<tr>
<th>Item</th>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

• Analysis of findings of questionnaire answered by selected members of NIC and writing the FGD report - 15th, 16th, 19th and 21st July 2004
  Dr. Deepthi Perera
FGD Report data entry, type setting and preparation of report - 15th, 16th, 19th and 21st July 2004
Ruwini Abeysirinarayana

Annexure

DETAILED ACCOUNTS OF EXPENDITURE DONE SO FAR

Total money received from Geneva to HelpAge for Part I and Part II (US$ 5750 + US$ 4000) = Rs.570,475.00 + Rs.404,704.00
= Rs.975,179.00
(1 US$ = about 100 Sri Lankan Rupees)

----------------------------------------------------------------------------------------------------------------

Part I – To set up teams hold NIC meetings, host INTRA I representative

Expenditure done by HelpAge

Money paid for,
Mr. Wijewantha for writing the report on Country Profile = Rs. 150,000.00
Dr. Abeykoon for consultancy to write report on Country Profile = Rs. 50,000.00
Telephone, Fax, Stationary = Rs. 29,705.00
Secretarial Assistance (HelpAge) = Rs. 28,474.00
Money set aside for the meeting with Thailand counterpart (not used) = Rs. 65,000.00
Total = Rs.323,179.00

----------------------------------------------------------------------------------------------------------------

Total money handed over to Dr. Deepthi Perera from HelpAge for holding 02 NIC meetings from Part I = Rs.570,475.00 – Rs.323,179.00 = Rs.247,296.00

Total money handed over from HelpAge to be spent for Part II = Rs.404,704.00

----------------------------------------------------------------------------------------------------------------

Expenditure done by Ministry of Health

Payments for NIC Meetings done at Min. of Health (conducted at Min. of Health)

<table>
<thead>
<tr>
<th>Name</th>
<th>No. of days involved in preparation of presentations and questionnaire for NIC members</th>
</tr>
</thead>
</table>
### Part I – Conducting National Information Campaigns (NICs)

<table>
<thead>
<tr>
<th>Name</th>
<th>No. of days involved in conducting NIC</th>
<th>Pay (Rs.)</th>
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<tbody>
<tr>
<td>Dr. Deepthi Perera</td>
<td>03</td>
<td>14,145.30</td>
</tr>
<tr>
<td>Mr. N.W.E. Wijewantha (HelpAge)</td>
<td>03</td>
<td>14,145.30</td>
</tr>
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</table>

**Supportive Staff**

<table>
<thead>
<tr>
<th>Name</th>
<th>No. of days involved in preparation and assistance</th>
<th>Pay (Rs.)</th>
</tr>
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<tbody>
<tr>
<td>Ruwini Abeysirinarayana</td>
<td>08</td>
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<td>Sujintha Wijesooriya</td>
<td>04</td>
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<td>Sagarika Gunasekara</td>
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<tr>
<td>Latha Ranasinghe</td>
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<tr>
<td>E.W.P. Pathmalal</td>
<td>03</td>
<td>14,145.30</td>
</tr>
<tr>
<td>Mrs. Sujeewa (HelpAge)</td>
<td>02</td>
<td>9,430.20</td>
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</table>

**Sub Total**

Rs. 221,610.00

Expenditure incurred by the Ministry of Health for holding 02 NIC meetings:

- Rs. 25,686.00 (as payments for participants of 2 NIC meetings, conference facilities and stationary)
- Rs. 247,296.00

---

### Part II – To set up and conduct Focus Group Research

Total money handed over from HelpAge to be spent for Part II: Rs. 404,704.00

**Payments for FGDs organizing, conducting, synthesis and analysis**

<table>
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<tr>
<th>Name</th>
<th>No. of days involved</th>
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<tbody>
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<tr>
<td>Dr. T. Kalubowila</td>
<td>03</td>
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<tr>
<td>Dr. Anoja Hapugaswatte</td>
<td>03</td>
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<tr>
<td>Mrs. S. Abeyratna (HelpAge)</td>
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<tr>
<td>Mr. Wickrama Gunaratna (HelpAge)</td>
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<tr>
<td>Ruwini Abeysirinarayana</td>
<td>17</td>
<td>25,169.52</td>
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<tr>
<td>Sujintha Wijesooriya</td>
<td>10</td>
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<tr>
<td>Sagarika Gunasekara</td>
<td>13</td>
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<tr>
<td>Latha Ranasinghe</td>
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<tr>
<td>E.W.P. Pathmalal</td>
<td>10</td>
<td>14,805.60</td>
</tr>
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</table>

**FGD Report data entry and type setting of report**

<table>
<thead>
<tr>
<th>Name</th>
<th>No. of days involved</th>
<th>Pay (Rs.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ruwini Abeysirinarayana</td>
<td>10</td>
<td>14,805.60</td>
</tr>
</tbody>
</table>

**Sub Total**

Rs. 214,681.40

Expenditure incurred for holding 14 meetings for FGDs in regions:

- Rs. 190,022.60 (as payments for
  - Participants of the training programme of FGD facilitators and reporters in regions,
  - Facilitators and reporters in regions of 14 FGDs for data collection, etc.)
Conference facilities, Stationary for training and conducting FGDs in regions and per diem allowance for participants in regions of FGDs)

Total from Part I and Part II = Rs.570,475.00 + Rs.404,704.00
(US$ 5750 + US$ 4000) = Rs.975,179.00

Ministry of Health staff of Dr. Deepthi Perera, who helped

Ruwini Abeysirinarayana
Sujintha Wijesooriya
Sagarika Gunasekara
Latha Ranasinghe
E.W.P. Pathmalal

Dr. T. Kalubowila - Coordinator for FGD – Kalutara District
Dr. Anoja Hapugaswatte - Coordinator for FGD – Ratnapura District

Annexure

PA/YEDD/PE/INTRA/01/04

NATIONAL INTER-DISCIPLINARY COMMITTEE (NIC) MEETING ON INTEGRATED RESPONSE OF HEALTH CARE SYSTEMS TO RAPID POPULATION AGEING (INTRA PROJECT)

I take this opportunity thank every one of you for attending the first NIC and for the valuable contributions made during the meeting.

The second NIC meeting will be focused mainly on an in-depth discussion on how we should deliver the health and social services in order to better address the needs of ageing individuals of our country. Attached here is a questionnaire that has been formulated in order to elicit information from the members, which will be discussed at this meeting. I would be much grateful if you could kindly provide your views for each question in writing and bring it along for this meeting.

This meeting will be held

on : 04th June 2004
at : Conference Room, Planning Unit, Ministry of Health, Suwasiripaya, Colombo 10.
from : 11.00 a.m. to 01.00 p.m.

Your participation is greatly appreciated.

Thanking you,
Dr. Deepthi Perera
Director / (YEDD)
Convener and
INTRA project
Focal Point of the Ministry of Health for the INTRA project

Signed: Dr. Manil Fernando
DDG (PHS) and
Chairperson for NIC of
INTRA project