The Right to Health and the "Crisis" at

General Hospital Anuradhapura

HUMAN RIGHTS COMMISSION OF SRI LANKA

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1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

   (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the health dvelopment of the child;

   The improvement of all aspects of environmental and industrial hygiene;

   (b) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

   (c) The creation of conditions which would assure to all medical service and medical attenton in the event of sickness.

Article 12,
International Covenant on Economic, Social and Cultural Rights

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GLOSSARY

Base Hospital	-	A Hospital of app. to 250 to 350 beds with on specialist toeach of the specialties.
Bed occupancy rate	-	This measures the percentage of the total avilable beds that are occupied by patients
D.D.H.S.	-	Divisional Director of Health Services
District Hospital	-	A Hospital in the charge of a District Medical office
GHA	-	General Hospital Annuradhapura
ICESCR	-	International Covenant on Economic, Social & Cultural Right
ICU	-	Intensive care unit
MOH	-	Medical officer of Health
MS	-	Medical Superintendent
NCP	-	North Central Province
OPD	-	Out Patient Department in a Hospital
OT	-	Operating Theatre
Path lab		Pathology Laboratory
PC	-	Provincial Council
PDHS	-	Provincial Director of Health Services
TH	-	Teaching Hospital
UDHR	-	UNiversal Declaration of Human Rights

(i)

Introduction

(i) Introduction

1. The Human Rights Commission of Sri Lanka- Its Functions and Powers

The Human Rights Commission of Sri Lanka (hereafter the Commission) was established by Parliament through Act No.21 of 1996. The Commission is an independent commission which comes within the purview of the Seventeenth Amendment to the Constitution of Sri Lanka. Its functions include the following [1]

- to inquire into and investigate complaints regardinginfringements or imminent infringements of fundamental rights, and
- to make recommendations to the government of Sri Lanka on measures which should be taken to ensure that national laws and administrative practices are in accordance with international norms and practices

Wide powers have been vested with the Commission to carry out its numerous statutory functions including an *omnibus* clause, which empowers the Commission to "...do all such other things as are necessary or conducive to the discharge of its functions" [2]. Pursuant to its powers, the Commission intends to also conduct fact-finding missions on various human rights issues, with a view to making necessary recommendations to the relevant authorities.

2. Emphasis on Economic, Social and Cultural Rights

The Commission, recognizing the principle of indivisibility of all human rights has taken a policy decision to emphasize in its work the realization of economic, social and cultural rights. In particular, it has prioritised the realization of the right to health and education. Sri Lanka has ratified, among others, the International Covenant on Economic, Social and Cultural Rights. The State has thereby undertaken

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[1] Section 10 of Act No.21 of 1996.

[2] Id. Section 11.

international legal obligations to realize, among others, the right to an adequate standard of mental and physical health of all persons within its jurisdiction[3]. In doing so, the State is obliged to respect the principles of non-discrimination and the right to equal protection of the law.[4]

3. Why a Fact-Finding Mission to the Anuradhapura General Hospital?

The Commission was deeply concerned by reports in the media that appeared towards the end of the year 2003 and early 2004 that a serious crisis was taking place at the Anuradhapura General Hospital (hereafter GHA), whereby large numbers of people were deprived of health care.[5] Media reports pointed to a near total breakdown of services provided by the GHA due to the corruption and mal-administration on the part of the Provincial Government of the North Central Province. The reports also contained interviews given by several medical specialists in the GHA in which they had demanded the immediate take over of the administration of the hospital by the central government. The GHA is the only general hospital in the country which comes under the authority of a Provincial Council, as opposed to the central government. According to the specialists, the only solution to the crisis at the GHA was such a take over.

The GHA serves hundreds of thousands of patients not only from the North Central Province where it is situated, but also from other adjacent provinces as it is the largest hospital in the region. The Commission was of the view that the situation had to be investigated urgently. If the allegations were true then the implications for the right to health were serious.

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[3] Article 12 of the International Covenant on Economic, Social and Cultural Rights.

[4] Id. Article 2.

[5] E.g. Daily News "A'pura Hospital Patients in a Fix" 11 November,2003; Lankadeepa "Signs of the Imminent Closure if the Anuradhapura Intensive Care Unit" 12 January, 2004. Several television news items, especially the "Helidarawwa" program on the "crisis" in the AGH aired on the Swarnavahini television channel which showed in graphic detail the decrcpit state of the hospital were observed by the Commissin. See the Newspaper reports attached to the report.

The terms of reference of the fact-finding mission were as follows-

- **Ascertain and assess the current position of the GHA with regard to available services and personnel in the light of actual requirements**
- **If there is evidence of a crisis, ascertain the contributing factors**
- **Analyse the human rights implications of the above situation**
- **Make recommendations to the relevant authorities**

It must be stated at the outset that the Commission, in recognition of the principle of devolution of power enshrined in the Thirteenth Amendment to the Constitution of Sri Lanka, was not concerned about whether the GHA came under the authority of the central government or the provincial government, as long as authority was assumed in compliance with constitutional provisions. The main concern of the Commission was to address its concerns and recommendations to the relevant legally constituted authorities with a view to correcting any deficiencies in the administration of the hospital.

The fact-finding team consisted of experts with specialized knowledge and experience in the fields of both human rights law and public health administration (see Annex I). The mission took place from 29-30 January 2004. Given the political charged nature of the subject, the publication of the report was deliberately delayed until the intervening parliamentary and Provincial Council elections were concluded.

4. Methodology

The fact-finding team, before embarking on the field visit to Anuradhapura, studied relevant media reports, literature pertaining to socio-economic indicators on the North Central Province and the Anuradhapura district, health statistics including government statistics relating to the allocation of resources for health care to the various provinces, UN and other literature pertaining to the right to health and,

reports submitted by the Commission's Anuradhapura regional office and the Regional Committee consisting of prominent citizens of the NCP.

On our field visit to Anuradhapura we interviewed the following regarding the situation at the GHA and health policy of the Provincial Council:

(i) Mr. Berty Premalal Dissanayake, Chief Minister of the NCP (28/01/04)
(ii) Group of retired civil servants (29/01/04)
(iii) Chief Secretary NCP, Mr. J. A. M. Karunaratne and the Provincial Secretary of Health NCP, Mr Sunil Thilakeratne, (29/01/04)
(iv) Provincial Director of Health Services NCP, Dr. W. M. T. B. Wijekoon (29/01/04)
(v) Medical Superintendent of GHA, Dr. Lakshman Gamlath (29/01/04)
(vi) Group of medical specialist attached to the GHA (29/01/04)
(vii) Representatives of the Anuradhapura Chamber of Commerce (30/01/04)
(viii) Governor NCP, Dr. Jagath Balasooriya (30/01/04)
(ix) Leader of the opposition NCP Provincial Council, Mr. R.B. Abeysinghe (30/01/04)
(x) Ven Pallegma Hemarathana of the Ruwanweli Mahaseya Temple and Ven Ethanavatuniwewa Ghnavimala of Mirisavati Mahaseya Temple (31/01/04)
(xi) Representatives of the NGO community in NCP (31/01/04)
(xii) Group of professionals from NCP (31/01/04)xiii)A private medical practitioner from NCP (31/01/04)

Although the team wished to interview the representatives of the Government Medical Officers Association (GMOA) we were informed that they were unable to keep the appointment due to another pressing engagement.

The fact-finding team visited the GHA on 29th January 2004. The MS and the medical specialists were interviewed on the premises of the hospital. The team inspected the hospital and its premises, in particular the surgical theatres, several wards including the Paediatric and the Maternity wards, the Intensive Care Unit, the Pathology Lab, the kitchen and the mortuary.

The controversial new building of the GHA was also visited by the team. It inspected the entire premises of the new building.

In order to study peripheral hospitals the team visited the Thambuththegama Base Hospital (BH) and Thalawa Peripheral Unit (PU).

5. Structure of the Report

Part II of the report contains a detailed analysis of international obligations of Sri Lanka on the right to health. It forms the backdrop to the report. The observations of the fact-finding team are discussed in part III. Part III also contains a discussion on the role of the media and civil society. A human rights analysis of the situation in the GHA is provided in Part IV. The recommendations are set out in Part V. While the terms of reference of the mission are specific to the situation in the GHA, the recommendations are made within the broader health policy framework both at the levels of provincial and central government. It is obvious that the issues pertaining to the GHA cannot be dealt in isolation. The report also contains annexures containing relevant statistics.

(ii)

The Right to Health and State Obligations

II. The Right to Health and State Obligations

1. Introduction

Human right to health enjoys a central place among all human rights as an indispensable right for the meaningful exercise of all other civil, political, social, economic and cultural rights. Right to health is recognised as an essential aspect of the right to life. In the absence of at least the minimum level of right to health, even the most celebrated rights such as equality, freedom of expression or assembly loses all meaning. An advanced and well functioning health care system is also an indicator of sustainable development and good governance.

Sri Lanka has ratified a number of international human rights treaties. In addition to the binding international obligations stemming from these treaties, it can be argued that under the Fundamental Rights Chapter of the 1978 Constitution too remedies could be sought when the right to health is adversely affected[6]. As such, it is the responsibility of the Sate to ensure that a proper health care system is established and maintained throughout the country.

2. Sources of the Right to Health under International Law

Sri Lanka is bound to uphold the human rights recognized in the International Bill of Human Rights. The human right to health was first recognized in Article 25 of the **Universal Declaration on Human Rights**[7]. The primary source of the right to health is found in Article 12 of the International Covenant on Social Economic and Cultural Rights (hereinafter ICESCR) which declares as follows:

1. State parties to the present Covenant recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of still birth rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions, which would assure to all, medical service and medical attention in the event of sickness.

Sri Lanka is a signatory to the Covenant and is bound to comply with the above obligations. In addition, there are other international treaties that Sri Lanka has ratified which recognize the right to health care. These too are binding obligations under international law.[8]

3. Substance of the Right to Health

The right to health has been defined as the right to be healthy. This includes freedoms and entitlements that ensure the 'highest attainable standard of health'. The General Comment on the Right to Health[9] issued by the UN Committee on Economic, Social and Cultural Rights contains the most authoritative interpretation of the right in international law. It recognizes the essential elements of the right to health.

(i) Availability

This refers to the availability of 'public health and health care facilities, goods and services as well as programmes' in a sufficient *quantity* within the state. This will require a State to take into account the population and as well as the percentage in

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[8] In addition to the above, Article 10, 12, and 14 of the Convention on the Elimination of All forms of Discrimination Against Women, Artical 24 of the Convention on the Rights of the Child and Artical 5 of the Convention on the Elimination of All Forms of Racial Discrimination too have recognized to health.

[9] Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C. 12/2000/4 (2000)

the population relying on public health care, in providing adequate facilities. This includes the availability of hospitals,health care centres, trained medical professionals and other staff, medical equipment, essential drugs etc.

(ii) Accessibility

Accessibility refers to the possibility of obtaining these services by all segments in the population. This has within itself four aspects of accessibility -

Non-discrimination: Health care must be accessible to all, especially the most vulnerable and marginalized groups in the population. Vulnerable and marginalized groups will include the internally displaced persons, indigenous communities, those living in rural underdeveloped parts of the country, as well as the poorest households in the society.

Physical Accessibility: The health care facilities must be within a safe physical distance accessible to all, specially the marginalized groups.

Economic Accessibility: Health care must be affordable to all. Accordingly, the health care services must be based on equity, and whether state sponsored or privately provided, health care must be affordable to all.

Information Accessibility: Right to seek, receive and impart information with regard to health issues, subject to confidentiality requirements of personal health data.

(iii) Acceptability

The health care facilities must be culturally appropriate to all groups within the society and must be respectful of medical ethics.

(iv) Quality

The health care provided must be 'scientifically and medically appropriate and of good quality'. The General Comments states that this includes skilled medical personal, scientifically approved and unexpired drugs and hospital equipment, safe and portable water and adequate sanitation.

4. State Obligations on the Right to Health

(i) General Obligations

Article 2 of the ICESCR states that "Each State Party undertakes to take steps...to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present covenant by all appropriate means..." Article 2 has taken into consideration the challenges faced by the resource constrained developing and least developed countries, by recognizing the concept of 'progressive realization'.

Progressive realization is not interpreted so as to permit States the right to defer indefinitely their efforts to ensure the full realization of the right to health.[10] On the contrary, all State Parties have the obligation to begin immediately to take steps to fulfill their obligations under the Covenant".[11] It must also be noted that the obligation of

progressive realization exists independently of the increase in resources, as it requires the effective use of available resources.[12]The

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[10] Artical 9 of the General Comment 3 on 'The Nature of States Parties' Obligations' states: 'Nevertheless, the fact that realization over time, or in other words progressively, is foreseen under the Covenant should not be misinterpreted as depriving the obligation of all meaningful content. (Fifth session, 1990), U.N. Doc. E/1991/23

[11] General Comment 3 on 'The Nature of States Parties' Obligations' and Section 8 of the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights

[12] Section 23

measures so that health standards are complied with by the private medical centres, ensuring that the privatisation of the health sector does not have an adverse impact on the right to health, maintaining proper standards in the medical equipment, drugs, as well as the training of medical professionals.

c. The obligation to **fulfill** requires more commitment on the part of the State as it aims at the full realisation of the right to health. This includes legislative measures, policy formulation and planning with a view to realise the right to the highest attainable level of health.

5. The Right to Health Under the Constitution

The Fundamental Rights Chapter of the Constitution of Sri Lanka (1978) does not expressly recognize the right to health. The Chapter is heavily tilted in favour of civil and political rights and provides little guidance as to the plight of social and economic rights. An examination of the judgments of the Supreme Court in the recent past, however, point to the fact that the court has moved beyond the literal meaning of the words in the Chapter. As such the right to health can be recognized in the following manner –

i. Equal protection of the law

Article 12 (1), which states that all persons are entitled to the equal protection of the law, has been expansively interpreted.[17] Today, Article 12 stands for rule of law and good governance which brings in the necessary checks and balances over the exercise of discretion by State functionaries. The Supreme Court has stated that '...discretions are conferred on public functionaries in trust for the public, to be used for the public good, and the propriety of the exercise of such discretion is to be judged by reference to the purpose for which they were so

[17] In the recent Intellectual Property Determination the Supreme Courts highlighted the health aspect of intellectual property rights, with a determination to the effect that patent rights in the absence of provision for parallel exports and compulsory licensing will amount to a violation of Article 12 (1), SC (SD) 08/2003

entrusted.'[18] As such, the conduct of State officials in the health sector cannot undermine the realization of the right to health of the people—which is the very purpose of the State health sector.

Moreover, in accordance with Article 12 of the Constitution discriminatory State action is a definite violation of the fundamental rights of the people. Therefore, any resource allocations that result in discrimination of a particular group of people or a particular locality or a province amounts to arbitrary action and is in violation of Article 12 of the Constitution.

ii. Right to life

In the recent case of *Sriyani Silva* v *Iddamalgoda and others*[19] the Supreme Court recognized that the right to life, although not expressly stated in the Constitution, is implied in Articles 11 and 13 (4). Justice Mark Fernando in this landmark judgment recognized the right to life but refrained from expounding it in greater detail. Adopting a cautionary approach His Lordship stated that "Thus Article 13 (4), by necessary implication, recognizes that a person has a right to life – at least in the sense of mere existence, as distinct from the quality of life – which he can be deprived of only under a court order."[20] The Supreme Court stated:

"I hold that Article 11 (read with Article 13(4) recognizes a right not to deprive of life – whether by way of punishment or otherwise – and, by necessary implication, a right to life. That right must be interpreted broadly, and the jurisdiction conferred by the Constitution on this Court for the sole purpose of protecting fundamental rights against executive action must be deemed to have conferred all that is reasonably necessary for this Court to protect those rights effectively"[21]

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[18] Premachandra v Jayawickrema and another (1994) 2 Sri.LR 90 at 105

[19] SC No 471 / 2000 FR

[20] Ibid at p 8

[21] Ibid at p 9

The above is a salutary development in the law which is particularly relevant to the right to health. Considering the developments that have taken place in the South African Constitutional Court, and in particular, the Indian Supreme Court, health is now recognised as a component of the right to life. [22] Article 21 of the Indian Constitution recognises the right to life, and has been interpreted to include right to medical treatment.[23] Such an interpretation of the law however is yet to take place in Sri Lanka. Considering the above mentioned recent developments, both in Sri Lanka and internationally, it can be argued that a right to a minimum level of health care is an important aspect of the right to life, and is indeed justiciable.

iii Freedom from torture, cruel, inhuman and degrading treatment or punishment

Article 11 of the Constitution guarantees freedom from torture, cruel, inhuman, and degrading treatment. Gross inadequacies within the health system that severely jeopardise the well being of citizens, and especially those that deny access to health care or subject the people to an unacceptable standard of treatment should surely result in a breach of Article 11.

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[22] The South African courts have adopted the approach that right to a human existence, even in the very basic sense commands the State to consider its minimus core obligations of right to health seriously. In Minister for Health v. Treatment Action Campaign Case No : 21182/2001) the Constitutional Court of South Africa, considered the State obligation to fulfil at least the minimum core obligations as a necessary prerequisite for a life with dignity. In this decision, the Constitutional Court found that South Africa's refusal to provide antiretroviral drugs to HIV positive pregnan women a violation of right of every person to have access to health.

[23] In the case of Paschim Banga Khet Mazdoor Samity v State of West Bengal (No.796 of 1992) the cour recognised the duty to provide medical treatment on the part of the State as well as the medical professionals as a component of the right to life.The supreme Court stated : "The government hospitals run by the State and the medical officers employed there in are duty bound of (sic) extend medical assistance for preserving human life. Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21"

The non provision of at least certain types of medical treatment is now being considered by many as resulting in inhuman treatment. A case in point is that of *D v. the United Kingdom*,[24] where the **European Court of Human Rights** noted that a the expulsion of the petitioner, who had contracted AIDS and was in the terminal stage of the illness amounted to inhuman and degrading treatment. The court compared the medical service provided by the applicant's own country and the nature of the health care which he was receiving in the UK. Considering the grave reduction in the provision of health care in the event of expulsion, and the exceptional circumstances faced by the applicant, the court concluded that an order of expulsion would amount to a breach of Article 3 of the European Convention, relating to the prohibition of torture, cruel, inhuman and degrading treatment. It can therefore be argued that, the non-provision or reduction of health care may amount to inhuman and degrading treatment, and thereby infringing Article 11 of the Constitution.

In the case of *Gerald Mervin Perera v OIC Wattala*[25] the Supreme Court recognised the right of a torture victim to seek medical treatment at a State hospital or a private hospital. In either event, the court noted, there is an obligation on the State to reimburse the medical expenditure. In awarding compensation the court noted that:

"Citizens have the right to choose between State and private medical care, and in the circumstances the Petitioner's wife's choice of the latter was not unreasonable – and was probably motivated by nothing other than the desire to save his life. Article 12 of the International Covenant on Economic Social and Cultural Rights recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[26]

6. Responsibility of the State Toward the Realisation of the Right to Health

The legal obligation to realise the human right to health vests on the State, and this includes all State agencies. Hence all State agencies

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[24] 2 May 1997, European Court Of Human Rights
[25] SC No 328 / 2002 (FR)
[26] Id page 10

that are entrusted with this duty, are bound to fulfil the same in a collective and a complementary manner. Any incompatibility, friction or inefficiency in the working of these State institutions will undermine the realisation of the right to health.

Under the Thirteenth Amendment to the Constitution the subject of 'health' appears both in the devolved and the concurrent lists. Under the devolved list powers vested with the Provincial Councils include the power to establish and maintain public hospitals, provision of facilities for the same, and many other areas such as the public health services, health education, nutrition, sanitation etc.[27] The subject of health is also found in the concurrent list where medical education, population control and family planning, and the constitution of the Provincial Medical Boards are included[28]. Therefore it can be noted that the main responsibility towards ensuring the right to health of the people is entrusted to the Provincial Councils. The reality is however somewhat different. The Provincial Councils are not financially independent and to a large extent depend on the central government to provide funds for all activities, including health. The central government is therefore bound to honour its international legal obligations by providing the necessary funds to ensure that Provincial Councils can adequately cater to the health needs of the people, and thereby realising the right to health.

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[27] The Thirteenth Amendment to the COnstitution, Ninth Schedule, List 1 (Provincial Council List) Section 11

[28] List II (Concurrent List) Section 9

(iii)

Observations / Analysis

III. Observations/Analysis

1. Brief profile of Health Service Facilities in the North Central Province (NCP) and G.H. Anuradhapura

The NCP has a land area of 9,741 sq. km with an estimated population of 1,134,867 (2003). The province comprises two districts, namely: Anuradhapura and Polonnaruwa, with annual population growth rates of 1.2 and 1.6 respectively[29]. The population of the NCP is predominantly engaged in agriculture and are low-income earners. They depend mainly on the government health services with the main referral hospital being GHA.

The other referral hospitals outside the NCP are in Jaffna, Kandy, Colombo and Kurunegala, all of which are over 120 km. from Anuradhapura. GHA provides tertiary care to the population of the NCP and also provides tertiary care to the population from Mannar, Kilinochchi, Mullaitivu and Trincomalee. More over in the NCP the transport services are poorly developed making travel to and from Anuradhapura extremely difficult. During the latter part of 1986 and up to the late 1990s, GHA played a major role in providing high quality tertiary care to those armed forces personnel who were admitted with injuries sustained during the civil conflict in the North East. It is regrettable that this hospital has during the past two years rapidly deteriorated. Ideally, it should function as a model provincial hospital in Sri Lanka considering its strategic location and the population served both with the NCP and beyond.

For administrative purposes the province is divided into 27 Divisional Secretary (former AGA) divisions, which corresponds to 26 Divisional Director Health Services (DDHS) areas or Medical Officer of Health (MOH) areas. The MOH areas in turn are subdivided into 105 Public Health Inspector (PHI) ranges and 417 Public Health Midwives (PHM) areas[30] This structure provides the preventive health services to the community with the PHM area being the smallest working unit in this system. In respect of the curative services, the province is served by

[29] Census of Population and Housing - 2001

[30] 2001 General Information in Anuradhapura District - Annual Health Bulletin 2002

84 hospitals or medical institutions that provide outpatient services and inpatient care. These hospitals categorized as primary, secondary and tertiary care institutions have a total of 4,177 beds. The hospitals range from a Provincial General Hospital (in Anuradhapura), a Base Hospital (in Polonnaruwa), to District Hospitals, Peripheral Units and Rural Hospitals. The Provincial and Base Hospitals equipped with specialized services also serve as Referral Hospitals in their respective Districts.

At present the hospital has 1,092 beds amounting to 26% of beds in the entire province (see Annex II). With the completion of a new four storied block the hospital bed strength would increase to 32%. At present there is over crowding in this hospital with a bed occupancy rate of around 120 percent. This overcrowding is critical in some units such as the obstetric unit that caters to 40% of deliveries for the entire district, but has only 8% of the total maternity beds in the district. Admissions (to all wards) comprise 28% of all inpatient admissions in the province, pointing to the heavy patient load.

The staffing pattern (medical and nursing) at the GHA at present is as follows:

Medical Officers Administration	-	01
Specialists (all)	-	23
Medical Officers	-	132
Intern Medical Officers	-	32
Dental Surgeons	-	09
Nursing Officers :		
Special Grade	-	02
Grade I	-	23
Staff Nurses	-	362
Midwives	-	38
Pharmacists	-	19
MLTT	-	18
Radiographers	-	12
Physiotherapists	-	09
ECG Technologists	-	06
Ophthalmic Technologists	-	01

(Source : MS/GHA)

Specialist services at present include general medicine, general surgery, obstetrics & gynaecology, paediatrics, ophthalmology, ENT, dental services/faciomaxillary surgery and recently cardiology. With the completion of the new four storied block with 256 beds and 3 operating theatres, expansion of the services into the finer specialities viz: neurology, neurosurgery, orthopaedics and oncology is envisaged. An intensive care unit (ICU) and recovery section is also proposed in the new building, but the provision made for the ICU does not conform to the standard requirements of an ICU and will need to be redesigned as early as possible, since the main components of the building are nearing completion. There appears to be adequate justification for constructing this building in order to improve the specialist services in this provincial general hospital given its central location and the population it serves. Allegations however surround the award of the contract for this building, built as a "turnkey" project, with an estimated basic construction cost of Rs. 79M and an estimated cost, when completed and functional, of Rs. 150M. We were informed that there is an inquiry before the Bribery Commission with regard to the awarding of this contract. Obtaining the required staff cadre approval for the various categories (other than the specialists) appears to have been delayed and will affect the ultimate commissioning of this building to make it functional.

Anuradhapura district has several satellite hospitals which if functioning optimally, should provide a very good level of patient care, and support GHA in reducing the patient load. There are five District Hospitals, two of which are currently undergoing infrastructure development with a view to upgrading them to the level of Base Hospitals. Once commissioned as fully functional Base Hospitals, these two institutions i.e. BH Thambuttegama and BH Kebithigollawa would be able to provide secondary care to the population in their respective areas and considerably ease the congestion at GHA. In due course the Provincial Council would do well to commission the Operating Theatre (OT) and provide for the necessary staff at DH Padaviya, which would cater to the needs of the people in the extreme North East of the NCP. In addition to the above institutions there are several Peripheral Units, Rural Hospitals and Central Dispensaries serving the population of the district.

2. The "Crisis" at the GHA: The Story Unearthed

The mission was undertaken by the HRC with grave concern as to the alleged situation at the GHA, which appeared to endanger the rights of the patients. The media portrayed the situation at the GHA to have reached a level of "crisis" with the operating theatre closed down, giving the impression that the hospital is completely unable to cater to the health needs of the people.

It transpired that the events leading to the "crisis" was precipitated by the sudden closure of a Operating Theatre 'B' (OT 'B') in October, 2003. Several medical specialists had refused to perform surgery on the basis that the it was not properly equipped and required renovation. Their main concerns appear to be a faulty surgery door, OT lamp and an air-conditioner. When the fulty equipment had been fixed, they had refused to perform surgery until the floor of the surgery was retiled as they had maintained that the existing tiles were cracked and posed a health hazard to the patients undergoing surgery. The Medical Superintendent (MS) of the hospital categorically stated that he had not authorized the closure of OT 'B'. The specialists appear to have taken it on themselves to unilaterally close down the surgery and not perform surgery. This situation had spiralled into what was termed a "crisis" in the GHA.

The Chief Minister of NCP readily pointed out his side of the story, which was not given much publicity by the media. He stated that the amount of funds provided by the Treasury was insufficient to run the hospital, and stated with confidence that if funds are forthcoming many of the issues at GHA can be resolved. He alleged that the media campaign was launched with ulterior motives, exaggerating the situation at GHA. He emphasized that the medical specialists at GHA are agitating to transfer the GHA from the purview of the NCP to the central government. The Chief Minister admitted that certain major repairs to operating theatre B were done within a short period, (which included a repairs to the door and certain lighting), but the prolonged closure of the operating theatre was due to a work stoppage by the medical staff until the theatre was "tiled" and some other renovations (such as removing a window) were completed. The medical specialists had not mentioned these secondary repairs in the beginning, but

4. The Issue of Governance

The debate over the 'crisis' at the GHA focused primarily on whether or not the provincial government should have control over its administration. While the provincial authorities clearly demanded that GHA should be retained within its purview, the medical specialists were emphatic that the administration should move immediately to the line ministry at the centre in order to get over the 'crisis'. The Commission's observation was that in the final analysis most of the people interviewed were not concerned whether control was by the centre or the province. What they expected, however, was good governance which was seen to be lacking. Some issues surfaced that highlight the need for good governance.

(a) Corruption

Many of those we interviewed made very strong allegations of corruption, intimidation and mismanagement that undermines the morale of public officers, who as a result, are reluctant to take on responsibility and stand up for what is correct. Allegations of corruptions were made especially with regard to the award of tenders in the construction of hospital buildings and the provision of goods and services. Investigation of corruption is not within the mandate of the Commission and will have to be undertaken by the appropriate authorities. The Commission's concerns are about the aspects of mismanagement that violates the right of the people to the best possible health care.

(b) Lack of planning

Does a master plan for new constructions, alterations and additions to buildings at G.H. Anuradhapura exist? This does not seem to be the case and responses provided have been vague. *Ad hoc* decisions appears to be the general rule, most of which emanate from the Provincial Council without any discussion with the MS/GHA and the hospital staff regarding what should be provided. A case in point has been small *ad hoc* alterations/additions that have come up which appeared to be unwarranted, resulting in unsightly structures and congestion, described by some as multiple "chicken coops" of little or

no use. The underlying problem appears to be that unilateral decisions are taken by the Provincial Council. Added to poor planning or the lack of planning, are and the issues pertaining to the allegedly irregular manner in which contracts for construction are awarded.

During the visit to the hospital the team observed numerous shortcomings and deficiencies. The state of cleanliness in the hospital left much to be desired in spite of a janitorial service being maintained at considerable cost. Small buildings scattered the landscape of the hospital, making the hospital unsightly. In the early nineties GHA was maintained as a model institution, with buildings constructed according to a plan and well preserved green areas, making the entire hospital complex pleasing to the eye.

A new building had been constructed to house some of the finer specialities. While it is accepted that the bed occupancy rate of the hospital is 120 percent and there is a need for additional accommodation, the ground floor of the new building earmarked for three operating theatres and the Intensive Care Unit have not been suitably planned. The ground floor was dark and gloomy and it lacked the ancillary facilities which are needed for operating theatres. These facilities would have to be constructed at an additional cost. The area set apart for the ICU is unsuitable. It was said to house ten ICU beds. However, at best, it can only accommodate six beds. Moreover facilities for medical officers, nursing personnel, stores and nurses bay were not available either. It was felt that the ground floor of the building was poorly planned to provide for the services for which it was intended. It is of grave concern that a large sum of money, allegedly in the region of Rs. 77 million, had been spent on the building in spite of such poor planning.

The over reliance placed on the services of GHA by a large population can be attributed to poor planning and administration of the overall health service delivery in the province through Base Hospitals and Peripheral Units. As most of those units are not functioning optimally, there appears to be a strong tendency for medical personnel in those hospitals to transfer a large number of patients to the GHA without adequate reasons.

GHA has a bed occupancy rate of 120%. This is particularly so in the surgical and maternity units. This is understandable considering the strategic location of GHA. The in-ward patients of a tertiary care

institution such as GHA is made up of daily admissions through the OPD, admissions from the specialist clinics and from transfers from peripheral institutions for specialist treatment. In any secondary and tertiary care institution, it is commonplace to see a reasonable number of transfers taking place from the periphery. A review of transfers to GHA reveals that a large number of "unnecessary" transfers seem to take place from peripheral institutions. This is unsatisfactory. Such transfers cause severe over crowding at GHA, which is already overcrowded, with untold hardships to patients and their relatives. The Department also incurs unnecessary expenditure. The Provincial Director of Health Services (PDHS) would do well to study this situation immediately and stop unnecessary transfers taking place to GHA from the periphery.

Regarding the satellite hospitals in the district a welcome decision has been taken to improve the service facilities in Base Hospital (BH) Thambuttegama and BH Kebitigollawa. Some construction work has already been initiated. We believe that it is a step in the right direction and must be commended. It is essential that the Provincial Ministry be provided with adequate funds to develop BH Thambuttegama and BH Kebithigollawa as fully fledged Base Hospitals, which would provide secondary care to a population living in a large area of the NCP, and also provide much needed relief to GHA by way of patient load.

The team visited BH Thambuttegama. It was observed that while the basic infrastructure work is nearing completion, much work is yet to be done. Completion of the work in the OT, supply of equipment to the OT, development of a Path Lab, X'ray, ICU, Recovery Unit etc. are yet to be undertaken. Furthermore when the work is nearing completion the Provincial Council would do well to request the various categories of staff needed, from the Ministry of Health, i.e. Surgeon, Obstetrician, Anaesthetist, Eye Surgeon, ENT Surgeon, House Officers, Nursing personnel, MLTT, Radiographers etc. A fully qualified Physician is already in position at this institution. Additional allocations would have to be requested from the Treasury/Finance Commission for upgrading this institution including the required recurrent expenditure. Another important consideration is the provision of suitable living quarters for the different categories of staff since housing is difficult in areas such as Thambuttegama.

(c) Abuse of Power

The politicisation of recruitment of personnel to the non-staff grades appear to have had an adverse effect on the maintenance of discipline in the hospital. Adherence to established Government procedures in awarding tenders to provide supportive/ancillary services appears to be lacking. This appears to be so with regard to awarding tenders regarding janitorial services, laundry service, security services etc. The abuse of power in this manner needs further investigation by the appropriate authority/authorities. It is clear that there is a strong perception of corrupt practices because of large scale abuse of authority by the provincial administration.

The above has resulted in undermining the credibility of the Provincial Health Authorities vis-à-vis the administration and staff of GHA. This needs to be urgently rectified since it is not in the best interest of the hospital and the patients. Procedures have been laid down as part of Government regulations and need to be followed. Officials must be allowed to attend to their work that comes under their purview, without undue interference.

5. Administration of G.H. Anuradhapura (Both theProvincial Health Administration and Hospital Administration)

(a) Lack of proper coordination between the Provincial health authorities and the MS/GHA

The hospital and the Provincial Ministry of Health appear to work in isolation of each other without any coordination between them. This factor has been a central issue contributing towards the deterioration of the administration of GHA.

It is noteworthy that in 1990, the GHA was considered a model institution, which provided invaluable service to the civilian population as well as the large number of casualties of the war from the North and the East. Ironically, at the present time with peace prevailing in the country, it has become an institution that is much criticized. Due recognition should have been paid to GHA by the Provincial Council in view of its strategic importance in serving the needs of the population.

given the facts described above is that there is indeed inadequate coordination and that this factor has had a very negative bearing on GHA.

Decisions with regard to matters such as repairs and the award of tenders pertaining to the running of the hospital appear to be taken solely by the provincial authorities. Many of the persons whom we interviewed stated that there are clear indications that the PDH does not act as an independent professional and that he is partial towards the political authorities in the provincial government. Lack of political independence on the part of professionals who are expected by the public to act as buffers between them and politicians destroy institutions and systems. Such was the case in GHA where the negative role played by the PDHS has had an extremely adverse impact in the running of the hospital.

(c) Role of the Medical Superintendent GHA (MS)

When the head of the institution who is expected to administer and give leadership is isolated by the Provincial Ministry of Health, it is natural that other forces and vested interests take advantage of such a situation. At the same time, the Commission's observation is that if the MS (now designated the "Director") had more actively and aggressively taken up the shortcomings of the hospital with the provincial authorities, and given strong leadership to the hospital staff, it would have averted in large measure the current unsatisfactory situation prevailing at the hospital.

In October 2003, the specialists have taken undue advantage of this situation. It resulted in the closure of OT 'B'. Total disruption of the work of the institution had taken place and this had led to breakdown of discipline among the staff. During the period of closure of OT 'B' for six weeks, it would be interesting to ascertain whether OT 'A' was utilized to its full capacity with the assistance from the staff and equipment of OT 'B' which remained closed. There are long waiting lists for surgery in most hospitals and GHA is no exception. However, the highhanded act of refusing to perform surgery by the specialists and

the closing down of the operating theatres without authority had completely disrupted the surgical services. The public in sheer desperation had sought services in the private sector at great difficulty inconvenience and cost. Since OT 'B' staff were available, additional surgical lists should have been undertaken in OT 'A' which would have alleviated the problem at least to some extent.

The Medical Superintendent of a Provincial tertiary care institution plays a pivotal role in the efficient management of the institution providing the best possible care to the patients who seek treatment. The above is ensured by his/her leadership and the cooperation s/he obtains from other categories of staff. The MS should delegate authority to Heads of various sections within the hospital. The MS should maintain a regular dialogue with the specialist medical officers and other medical officers, the matrons, and other senior nursing personnel as well as the administrative officer of the institution. MS must undertake regular ward rounds with the Matron and the AO and pay surprise visits to the different units in the hospital. The MS is also expected to regularly monitor the supply of drugs, surgical consumables, bio-medical equipment with the pharmacist in-charge. Had there been proper coordination and cooperation between the MS and the staff on the one hand, and on the other with the Provincial health authorities the sad story of the OT closure may not have taken place. In the absence of a cooperative environment, the medical specialists appear to have taken the upper hand.

The Commission observed the sorry state of the pathology lab (path lab) and the mortuary. The Path Lab is housed on the upper floor of the Chest Clinic Building. The lab stands as it did 20 years ago when the institution had 500 beds. No improvement has been effected to the Path Lab since its inception. There is a dearth of necessary facilities. During the "crisis" period, the Path Lab figured prominently in the media, and not without reason either. It does not have a proper water supply nor a proper waste disposal system. Some of the media publicized photographs of the Path Lab where blood collected from patients for investigation had been washed down from the Path Lab which flowed into a drain. Some members of the hospital staff informed the Commission that what was shown on media was an exaggeration as blood was not freely disposed into the drain system, and that this incident was staged in order to portray the situation in the hospital in

the worst possible light. Even though the situation at the Path Lab is not as appalling as it was made out to be in the media, the Commission is of the view that vast improvements will have to be made in providing suitable lab facilities. The Commission suggests that the provincial health authorities should take action to construct a suitable building for the Path Lab and upgrade it according to the modern concept of a Path Lab. Facilities at the X-ray Department needs to be upgraded as well.

Today more than ever, the accuracy of diagnosis and treatment is greatly dependent on accurate and reliable reports provided by the Path Lab and the X-ray Department. This emphasizes the need for updating the two facilities. Unfortunately, the quality of the Path Lab at the GHA has neither of these and the reports provided by such laboratories remain highly questionable and controversial.

At about the same time as the surgical misadventure, a breakdown of services at the hospital mortuary was also highlighted by the Judicial Medical Officer. This mortuary which had four freezers (Japanese model) and two coolers (Indian model) had also ceased to function. There had been inordinate delays in undertaking the necessary repairs or in obtaining replacements, resulting in what was described as a "health hazard". Immediate action is required to either repair the existing coolers or in the alternative to invest in a set of new mortuary coolers.

Again the lack of cooperation between the MS and the Provincial Health Authority surfaces, since this situation could well have been averted had timely action been taken without waiting for all available equipment to breakdown. In this context the problem was aggravated by bodies brought from "outside" by the Police. In 2003, of 722 deaths, 117 bodies were brought from outside by the Police. There is an urgent need for a separate Police mortuary to take in such bodies.

The Provincial Council claims that the problem of the hospital mortuary was not brought to its attention early enough, but instead information released to the press in order to discredit the Provincial Council. Overall while the culpability of the provincial authorities in regard to the improvements in the hospital is evident, the passivity with which the MS has so far dealt with the authorities is a key contributing element to the current state of affairs.

6. The Role of Health Professionals

In the present "unhealthy" environment that prevails at GHA, some of the doctors, particularly the specialists led by the surgeons, had taken it on themselves to agitate for the return of GHA to the central government. That this would be in contravention of the 13th Amendment of the Constitution unless agreed to by the Chief Minister of the Provincial Council, appeared to be of no concern to them.

In this context, the specialists involved had lobbied the Governor of the NCP, the Mahanayake of the Ruwanwelisaya and the opposition members of the Provincial Council, to the extent that a resolution was even proposed in the Provincial Council by the JVP which was in the opposition, to return GHA to the line ministry. On the day this resolution was proposed specialists were said to have been present in the public gallery of the Provincial Council to support the resolution. The media too appears to have been co-opted in an effort to condemn the management of the hospital by the PC, with articles and interviews by specialists appearing in the printed and the electronic media.. Further, the Commission was informed by several sources that the specialists were instrumental in bringing into the hospital premises a TV unit (Swarnawahini), which had then obtained video footage of specific defects in the hospital that had been pinpointed. The MS stated that he was not informed of a media unit been invited into the hospital premises. What is significant is that when the programme on the hospital was telecast on the "Helidarauwwa" programme by the Swarnawahini Television channel, prior notice had been given to the Anuradhapura public, by way of a leaflet, stating the date and time of the "show". The motive appears to have been to highlight the inefficiency of and the abuse of power by the provincial health administration, and thereby highlight the need to bring the hospital under the central government.

The above facts points to a well organized campaign on the part of the specialists to win their demands. In our discussions with the specialists they pointed out that the hospital had deteriorated to such an extent because of administration by the provincial government and that the situation had reached chronic proportions. Thereby they claim that the continued delivery of services to the patients was becoming extremely difficult, and endangered the lives of patients. The solution they said was to bring the hospital under the central government. They

were of the opinion that in such an event the needs of the hospital would be quickly met by the central government authorities. It clearly appears to be the case that the specialists entertained an overly optimistic view regarding the efficiency of administration by the line ministry.

The specialists also pointed out that prospects of career advancement and professional development were very limited in the provincial health service. Many more opportunities of obtaining scholarships and other professional benefits such as loans would be available to them if they came under the central health service.

The concerns expressed by the specialists are justifiable. The Commission notes however, that the refusal on the part of surgeons to perform surgery and the closure of OT 'B', coupled with the exaggerated portrayal through the media that the hospital services were at a complete breakdown, are acts clearly in breach of their professional and ethical obligations towards the patients.On 3rd October 2003 the surgeons decided unilaterally to stop work citing some defects

in one of the functioning OT 'B' namely; a malfunctioning air conditioner, a broken OT door and two bulbs that needed replacement in the OT lamp. The Provincial Council stated that they were unaware of these shortcomings and had not been informed about this prior to the stoppage of work. Following the OT closure, the provincial ministry took action to rectify the three defects referred to above. This work, it was stated, was completed in 11 days. However the surgeons now wanted the floor tiles replaced and a window to be removed and replaced by a brick wall. This precipitated a prolonged closure of the OT and resulted in major inconvenience to patients for a further six weeks. There has been no written authorization to carry out this additional work and here again the non-adherence to proper Government procedures comes into question. It was also noted that routine operations at GHA under "normal" working conditions did not take place after 1.00 p.m., except for casualties. This leaves the surgeons relatively free after 1.00 p.m. The reasons adduced was the shortage of nurses and the lack of some medical equipment (the anaesthetist is said to have stated that he requires 5 Boyles machines though currently three are available!). The surgeons stated that they need very good facilities ("state of the art").

This state of affairs, the Commission learnt, resulted in a large number of patients being transferred to National Hospital Colombo and other General Hospitals. It was also pointed out to the Commission that due to the media publicity which projected a near breakdown of services at the GHA many patients on their own thought fit to seek treatment in far away hospitals such as GH Kandy and TH Kurunagala.

The Commission is mindful that civil society representatives repeatedly pointed to the fact that the very same specialists who refused to perform their functions at the GHA for want of better facilities were oblivious to the poor facilities in the private hospitals in which they conduct private practice. In this context it must be mentioned that there are two private institutions with facilities for surgery, where standards are unlikely to conform to "state of the art" conditions, as stated by the doctors in the GHA. Needless to say the work performed there carries an attractive fee for service. It was stated that some nursing staff of the hospital are also taken to these private institutions to assist the surgeons.

It must be reiterated that the unilateral and highhanded action by the doctors/surgeons involved cannot be condoned and needs to be strongly condemned. Patients have been used as pawns to try and obtain the demands of the doctors, for the takeover of GHA by the line ministry. The Commission is surprised that the appropriate authority had not taken the initiative to institute disciplinary proceedings against those specialists who unilaterally and arbitrarily refused to perform their duties.

7. The Role of the Media

The "crisis" at the GHA was highlighted in the press and the electronic media. A special investigative TV programme on *Swarnawahini* channel was dedicated to the "crisis" and the shortcomings at GHA highlighted. It was this media blitz that alerted the HRC to decide to investigate this situation from a health rights perspective. The HRC took an unprecedented initiative to investigate this crisis as it has a mandate to monitor the protection of human rights of the people in accordance with international obligations of Sri Lanka.

In this sense, the media played its role by raising public awareness of taking up a matter of public interest. This aspect of the role of the media was laudable. Whether the publicity given by the media in the manner it was done had other hidden agendas or political motivations is a matter of conjecture, but needs to be discussed.

From the news items published in the print media and the exposé by *Swarnavahini* it is evident that there was a distinct slant in the media coverage. Most news items appear to have supported the cause espoused by the doctors of the GHA who had refused to use the operating theatres and gave details that seem to justify their stand. The blame was consistently placed on the NC Provincial Chief Minister and the provincial health administrators. This point of view was strongly in agreement with the position taken by the GHA doctors.

The media is a critical element in safeguarding the public interest. The public - i.e. patients who came for treatment to the GHA - had to face immense difficulties as a result of the GHA doctors 'downing tools' and not undertaking surgery. HRC team observed the seriousness of the work stoppage. The possible consequences on the immediate and long-term health of the patients affected by the doctors' action could be serious. The absence of any media attention on this aspect of the crisis, which is the critical aspect that the public would have expected the media to highlight, was conspicuous by its absence. The media highlighted only the deficiencies of the Chief Minister and the provincial health administration, thereby advocating support for the GHA doctors' position that the GHA should be taken over by the central government line ministry. The media should have analysed the problem more in-depth and in an objective manner. The public would have been served better if the media highlighted not only the deficiencies and culpability of the provincial administration, but also the questionable motives and actions of certain senior health professionals attached to the GHA.

8. Response of the Civil Society

The HRC team met with representatives of NGOs, the Chamber of Commerce of Anuradhapura, professionals and retired civil servants from NCP to ascertain their views on the "crisis". The representatives were of the view that though the conditions in the GHA were very

problematic, services in other hospitals in NCP were no better. Horowapathana, Kebettigolawa and Medawachchiya were cited as prime examples.

In one voice all groups expressed serious concerns about the negative role played by both the provincial administration and also the health professionals the in deterioration of services at GHA. In general there was consensus that it did not matter to them whether the administration of the hospital came under the authority of the provincial government or the central government. Several representatives of NGOs expressed the view that the hospital was an asset of the province. What was emphasized was the need for good governance at all levels of government. Many were critical of the provincial government alleging that there was corruption, inefficiency, poor planning and callous disregard towards the public. The general view was that the authorities were not acting in the best interests of the public.

Similarly, the representatives spoke of the lack of empathy and sympathy to the plight of patients on the part of the health professionals. They pointed to the fact that while the medical specialists had unilaterally stopped providing certain services at the GHA (for example closing down the operating theatre) for lack of adequate facilities, they continued to work in the private sector hospitals which were very poorly equipped. The profit motivation of the medical specialists was referred to with great cynicism. The view was expressed that the medical specialists, in their quest to bring the GHA under the central government had seriously undermined the rights of the patients.

It also must be mentioned though there is a large network of NGOs in the NCP, many seem not to have the human and financial resources to make an adequate impact on the life of the people of the region who are deprived of basic amenities and services. Even though the NGO representatives expressed strong opinions regarding the GHA and the provision of health services in NCP in general, by their own admission, for various reasons, they had failed to launch a public campaign to address the problematic situation at the GHA. The need for collective and cohesive action to exert civil society pressure on the authorities to redress urgent grievances of the people had not been high on their agenda of activities. The need to strengthen such civil society organisations for concerted action on issues that are crying for urgent attention by the provincial authorities cannot be over-emphasised.

It is undoubtedly the case that civil society organizations in the region should organize themselves better to address contemporary problems facing the community. In order to address politically sensitive issues, they could derive strength from networking with larger national NGOs and working closely with the Commission.

(iv)

A Human Rights Analysis of the "crisis" at the GHA

IV. A Human Rights Analysis of the "crisis" at the GHA

Many factors have contributed to the deterioration of the functioning of GHA in the recent past. Except for the closure of one operating theatre for dubious reasons, it is not possible to conclude that there was a substantial breakdown so as to portray the situation as a 'crisis'. The situation however is far from satisfactory and calls for urgent remedial steps.

The main protagonists in this episode appear to be the provincial government headed by the Chief Minister and several Medical Specialists attached to the GHA. The faulty provincial administration provided the backdrop for the agitation lunched by a few health professionals who appear to have acted with scant regard for the rights and welfare of the patients.

The Commission is of the opinion that the following factors have contributed to the current unsatisfactory situation –

a. Poor planning, abuse of authority and mal-administration on the part of the provincial government.

b. A strong possibility that there is rampant corruption on thepar of the provincial authorities especially in the award of tenders.

c. Inadequate financial allocations for the hospital.

d. The politicization of many aspects of the provincial health care system.

e. Lack of coordination between the provincial health authorities and the hospital administration.

f. The negative role played by the some of the specialists attached to the GHA.

g. Weak leadership on the part of the MS/GHA.

The above observations clearly highlight that the right to health of the people has not been the governing consideration in shaping the attitude or the conduct of all responsible parties. The central, provincial and the hospital administration as well the medical professionals appear

to be somewhat preoccupied with issues that affect one's own interests, and have not worked in a cooperative manner to ensure that the best possible service is provided to the patients.

The legal obligations to respect, protect and fulfill the right to health have been severely affected by the various factors discussed above. The right to respect entails, as discussed in Chapter II above, that the State should not violate the right to health through State action. Obligation to protect requires the State to regulate third party activity including the health professionals in order to provide protection to the public. The obligation to fulfill is discharged when a State actively takes measures to comply with the right to health.

(i) The obligation to **respect** was undermined by:

a. the denial of access to available health care facilities at theGHA brought about by the events and factors discussed above;

b. the central government drastically reducing the resources allocated for the GHA;

c. the provincial authorities not utilizing even the availableresources in an effective manner;

d. failing to address mismanagement and corrupt practices inthe implementation of health care policy by the provincialauthorities;

e. failing to check poor coordination between the provincial health authorities and the hospital administration.

(ii) The obligation to **protect** was undermined by:

a. the failure on the part of the provincial authorities to investigate and take appropriate actionagainst those healthcareprofessionals who disrupted the functioning of the GHA;

b. the failure of the provincial authorities and the hospital administration, in the face of media reports which pointed to a total breakdown of services at the GHA, to reassure the public that whilst some services were indeed disrupted during the material time, that certain services were available.

(iii) The obligation to fulfill was undermined by:

a. the failure to formulate and implement ahealthcarepolicy for the province that was sensitive to the right to health;

b. the failure on the part of the central government todraw up a health care resource allocation policy that tookinto consideration the right to health.

In addition to violating the right to health, it could well be argued that the authorities by their action and inaction, discussed above, have violated the patients' human right to equal protection of the law and the right to be free from inhuman treatment, which are also guaranteed by the Constitution of Sri Lanka (1978).

In view of the above, the Commission makes the following recommendations to the central government, the provincial authorities of the NCP and the administration of the GHA.

(v)

Recommendations

V. Recommendations

It is assumed that GHA will continue to remain under the administrative control of the Provincial Council, as the Provincial Council does not accept the position that it should be handed over to the line Ministry of Health. Hence until the situation stabilizes, the following recommendations are made here to ensure better coordination with the central government and smooth functioning of the GHA.

1. Provision of Adequate Resources by the Financ Commission

The Financial Commission/Treasury to provide adequate allocation for capital as well as recurrent expenditure to the hospital. More importantly, provide funds for equipping and opening of the new hospital building.

2. Improving Coordination Between the Central Government and Provincial Government:

(a) Since the Provincial Council does not wish to hand over the institution to the line Ministry and the Provincial Ministry had been shown to be inept in managing this institution it is strongly recommended that a Board of Management be appointed. This recommendation is made mindful of the fact that the GHA is the only GH under a Provincial Council. Until the situation stabilises in the GHA, through the provision of adequate resources and the establishment of proper administration and management systems, the Commission is of the opinion that the establishment of a Board of Management consisting of responsible officials from both the centre and the province will tremendously help in discharging their respective functions under the Thirteenth Amendment to the Constitution. The ultimate objective of the Board of Management should be the capacity building within the provincial authorities to run the GHA.

The members of the Board should be from the line Ministry as well as the Provincial Council. This is recommended as an interim measure to ensure smooth functioning of the institution for a limited period of time. It is suggested that the line Ministry be represented by the Deputy Director General (Medical Services) and the Director (Tertiary Care Services) while the Provincial Ministry to be represented by the Provincial Secretary/Health and the Provincial Director of Health Services. This Board shall be responsible for all activities and services of the institution. The Board shall meet at least once a month. The Board shall also look into the disbursement of finances, provision of equipment, supply of drugs, appointment of staff etc. They shall also examine the financial allocations needed for the institution in respect of capital/recurrent expenditure. The MS (who is now designated as the 'Director') must be assisted by a 'Deputy Director' (DD). The Director and the DD shall work under the Board of Management and provide the necessary cooperation to the Board.

(b) The issue of which authority has the power to take disciplinary action against medical doctors under the Thirteenth Amendment to the Constitution must be resolved in an authoritative manner. As the instant case shows, arbitrary action on the part of health professionals can have serious implications for the right to health of the people. Such high handed action necessarily calls for disciplinary action by the appropriate authority / ties in the interest of the public.

3. Improving Coordination Between GHA Administration and the Provincial Health Authorities

The Provincial Health Ministry, and in particular PDHS should pay very special attention to GHA by way of regular visits and monthly consultation with the MS, Administrative Officer, Accountant and Matrons. It is essential that the MS be consulted with regard to the formulation and implementation of all policy decision regarding the GHA.

4. Improving the Role of the Provincial Health Authorities

(a) The preparation of a holistic health policy for the province in consultation with the relevant stakeholders. The preparation of such a policy is absolutely essential if healthcare services are to be delivered effectively and efficiently, optimally utilising the available resources. Such a policy should include a 'master plan' for the development of GHA.

(b) The peripheral hospitals, and especially the two satellite hospitals, namely BH Thambuththegama and BH Kabithigollewa must be provided with adequate resources. The provincial authorities should complete the constructions work in these hospitals and provide human and other resources through the central ministry.

(c) Since a large number of unnecessary transfers are taking place from peripheral institutions in the NCP to GHA daily PDHS should carefully examine the reasons for these transfers and prevent unnecessary transfers taking place to GHA.

(d) Respect the principle of transparency in respect of all the tender procedures i.e. building work and other services in the hospital

(e) The Provincial Ministry should make a request from the line Ministry of Health to fill all the vacancies of Nursing Officers in Grade I & Grade II, as there appears to be an acute shortage of nursing personnel which is very vital for delivery of proper patient care.

(f) Immediate action to be taken by the Director/MS through the Provincial Ministry to either repair the existing mortuary coolers/ install new coolers as a matter of urgency.

(g) The Provincial Ministry to look into the shortage of equipment in the OT/ICU and Dental Units.

(h) Early action to be taken to the opening and the proper functioning of the new building.

5. Improving the Administration of GHA

(a) Appoint a Deputy Director to assist the Director in the day-to-day work. This is justified as the hospital will have 1300 beds when the new building is commissioned. Most of the Provincial Teaching Hospitals have DD to assist the Director in his/her work.

(b) Appoint an Administrative Officer (non medical) for general administration, who would be responsible to the Director and the DD in respect of the work of all the other categories of staff except medical, nursing and PSM grades. He shall also supervised the work of the Overseers and ensure cleanliness of the institution.

(c) It would be most desirable to appoint a Grade I Nursing Officer experienced in operation theatre work and designate her as Theatre Superintendent to overlook the working of the Operating theatres, Intensive Care Units and the recovery units etc. This would be enable the Director to take immediate action on the short comings brought to his notice by the Theatre Superintendent.

(d) It is recommended that an Accountant/senior financial officer be appointed for the purpose of maintaining proper accounts in the hospital as the annual budget for the hospital exceeds Rs. 800 million.

(e) The Director and the DD to have regular meetings with the Specialist staff, senior nursing officers and other grades of medical officers look into their grievances if any and take remedial measures without delay wherever possible

(f) Action to be taken to improve the Path Lab/construct a new Path lab and provide modern equipment to ensure reliability of the reports provided. Automation of the Path Lab in respect of certain investigations is strongly recommended. This would ensure reliability of the reports.

(g) Develop the Radiological services in keeping with requirements of a Provincial Hospital.

(h) The Director as well as the DD should instil discipline and a high morale among all categories of staff which is at a very low ebb at present.

(i) The Public Health Inspector of the area to which the hospital belongs should visit the hospital at least thrice a week and supervise the sanitation of the institution along with the overseers. The PHI should maintain the sanitation register, which would be submitted to the Director/DD for perusal.

(j) Director/DD should undertake daily ward rounds in the hospital accompanied by an Administrative Officer, Matron, Overseer etc.

(k) Organize in-service training for all minor categories of staff.

Annexes

Annex I

MEBER OF THE FACT - FINDING TEAM

1. Dr. Deepika Udagama, CommissionerHRC(teamLeader)
2. Ms. Cressida Senanayake, Commissioner / HRC
3. Dr. Joe Fernando, Former Director - General & Secretary, Ministry of Health
4. Dr. N.W. Vidyasagara, Former Director (Maternal and Child Health), Ministry of Health & Retired Regional Adviser (Maternal and Child Health), World Health Organization (SE Asia Regional Office, New Delhi)
5. Professor Susirith Mendis, Dean, Faculty of Medicie& Professor of Physiology, University of Ruhuna; Member, Sri LankaMedial Council

Support Staff

1. Mr. Senaka Dissanayaka, Project Coordinator, NPDS for IDPs Project, HRC
2. Ms. Avanthi Gunatillake, Attorney- at Law, Researcher / Law Review Project, HRC
3. Ms. B. K. Sarma, Acting Reioonal Coordinator/ HRCRegional Office Anuradhpa
4. Mr. Chamara Milinda Panagoda, Accounts / Adminisration Assistant, NPDS For IDPs Project, HRC Regional Office, Vavuniya

Annex II

5. 4 Bed Strength & Bed Occupancy rate

Table 5.4.1 Bed Strenth & Bed Occupancy Rate - 2002

District/ Province	DDHS AREA	Type of Institution	Name of Institution	NO OF BEDS	Bed Occupancy rate
Anuradhapura	N.P.E	GH	Anuradhapura	1092	120
		RH	Nelubewa	35	101
				1127	
	N.P.C	RH	Parasangaswewa	22	41
		RH	Mahawilachchiya	24	115
		RH	Thanthirimale	32	79
				78	
	MEDAWACHCHIYA	DH	Medirigiriya	129	43.2
				129	
	KAHATAGASDIGILIYA	DH	Kahatagasdigiliya	69	19
				69	
	PADAVIYA	DH	Padaviya	146	36
				146	
	KIKERAWA	DH	Kekirawa	102	31
		RH	Maradankadawala	27	78
		RH	Habarana	53	2
				182	
	HOROWPOTHANA	PU	Horowpothana	60	37
		RH	Kapugollewa	21	4
				81	
	NOCHIYAGAMA	DH	Nochchiyagama	88	59
		RH	Ranorawa	34	3
				122	
	MIHINTHALE	PU	Mihinthale	71	53
		RH	Thammennawa	26	54
				97	
	GALENBIDUNUWEWA	PU	Huruluwewa	54	31
		PU	Galenbidunuwewa	30	55
				84	
	TALAWA	PU	Talawa	65	33
		PU	Eppawela	43	82
		RH	Kattiyawa	15	20
				124	
	GALNEWA	PU	Galnewa	55	62
		RH	Negampaha	22	34
				77	
	THABUTHTHAGAMA	BH	Thambuttegama	101	74
				101	
	IPPALOGAMA	RH	Kalawewa	26	53
		RH	Senapura	36	55
				62	
	KEBITHIGOLLAWA	BH	Kebethigollewa	30	50
				30	
	RAMBEWA	RH	Rambewa	18	128
				18	
	TIRAPPANE	RH	Pairamaduwa	18	22
				18	
	PALAGALA	RH	Adiyagala	16	22
		RH	Galkiriyagama	28	45
				44	
	RAJANGANAYA	RH	Rajanganaya Tr 5	43	41
		RH	Rajanganaya Tr 11	28	45
				71	
Polonnaruwa	THAMANKADUWA	GH	Polonnaruwa	508	95.2
				508	
	HIGURAKGODA	RH	Jayanthipura	42	41.2
				42	
	MEDIRIGIRIYA	DH	Medirigiriya	129	43.2
				129	
	ELAHERA	DH	Bakamoona	76	39.2
				76	
	LANKAPURA	PU	Gal Amuna	47	24.2
		RH	Pulasthigama	56	35.4
				103	
	DIMBULAGALA	PU	Aralaganwila	71	47
		PU	Welikanda	63	45.7
				134	

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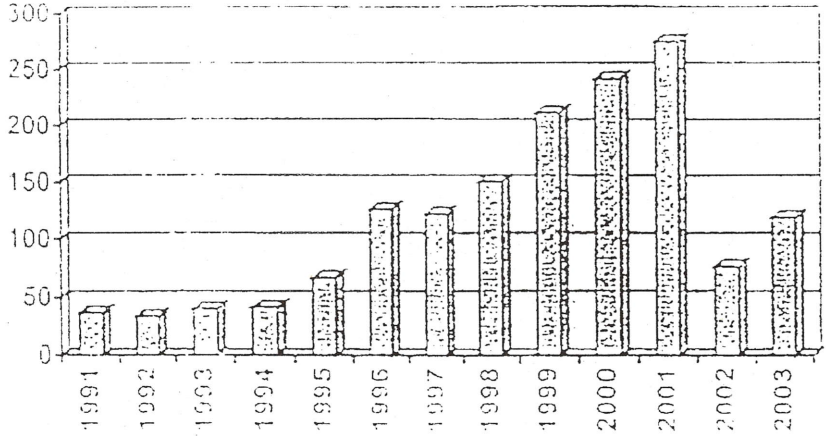
Annex III

මූල්‍යමය සම්පත්

උතුරු මැද පළාත් සෞඛ්‍ය දෙපාර්තමේන්තුව සඳහා වෙන්කල ප්‍රතිපනත

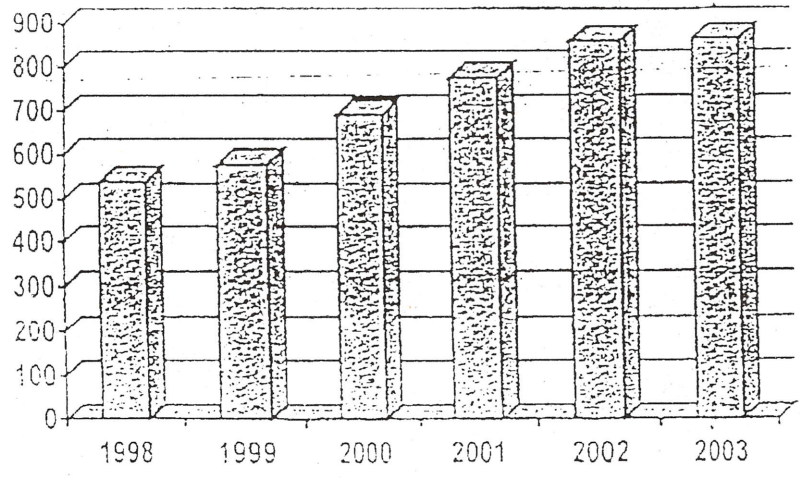
CAPITAL EXPENDITURE

මූල ධන සඳහා වෙන් කිරීම් (රු මිලියන)



RECURRENT EXPENDIYURE

පුනරාවර්ථන සඳහා වෙන් කිර්මි (රු මිලියන)



Annex IV

General Hospital - Anuradhapura

Vote	2003 Allocation	Expenditure
1001	89,000,000.00	110,126,612.48
1002	32,000,000.00	43,137,099.79
1003	47,000,000.00	58,692,708.27
Sub Total	**168,000,000.00**	**211,956,420.54**
1101	750,000.00	2,055,493.27
Sub Total	**750,000.00**	**2,055,493.27**
1201	2,000,000.00	3,513,093.17
1202	2,500,000.00	3,017,955.80
1203	1,200,000.00	1,180,483.75
1204	16,000,000.00	17,356,806.86
1205	5,500,000.00	5,219,939.57
1206	400,000.00	296,500.00
1207	100,000.00	53,140.90
Sub Total	**27,700,000.00**	**30,637,920.05**
1301	500,000.00	274,991.80
1302	75,000.00	226,147.50
1303	100,000.00	305,553.00
1304	50,000.00	49,901.00
Sub Total	**725,000.00**	**856,593.30**
1401	-	-
1402	1,000,000.00	1,772,375.94
1403	150,000.00	81,052.50
1404	27,000,000.00	37,760,756.57
1405	-	72,000.00
1406	-	-
1407	15,000,000.00	18,861,609.84
Sub Total	**43,150,000.00**	**58,547,794.85**
1903	100,000.00	-
1904	450,000.00	-
1905	-	-
Sub Total	**550,000.00**	-
Total	**240,875,000.00**	**304,054,222.01**

Annex V

TEACHING HOSPITAL - KURUNEGALA

Vote	2003 Allocation	Expend
1001	124,740,000	179,677,824
1002	27,342,000	57,651,031
1003	49,024,000	90,021,787
Sub Total	201,106,000	327,350,642
1101	1,000,000	963,756
Sub Total	1,000,000	963,756
1201	905,000	937,948
1202	1,761,000	2,221,700
1203	1,197,000	975,012
1204	11,975,000	11,076,114
1205	-	-
1206	700,000	710,965
1207	4,347,000	4,668,023
Sub Total	20,885,000	20,589,762
1301	683,000	688,902
1302	251,000	359,656
1303	490,000	584,641
1304	121,000	122,126
Sub Total	1,545,000	1,755,325
1401	35,000	46,607
1402	1,372,000	1,660,915
1403	105,000	114,087
1404	18,291,000	19,708,912
1405	1,318,000	1,158,931
1406	126,700	126,660
1407	12,589,000	13,755,228
Sub Total	33,836,700	36,571,340
1903	296,500	311,380
1905	23,000	32,755
Sub Total	319,500	344,135
TOTAL	258,692,200	387,574,960

<u>වැය විස්තරය</u>

<u>පුද්ගලික පඩිනඩි.</u>

1001 වැටුප් හා වේතන
1002 අතිකාල හා නිවාඩු දින වැටුප්
1003 වෙනත් දීමනා

<u>ගමන් වියදම්.</u>

1101 ගමන් වියදම් - දේශීය
1102 ගමන් වියදම් - විදේශීය

<u>සැපයීම්.</u>

1201 ලිපි ද්‍රව්‍ය හා කාර්යාලීය උපකර
1202 ඉන්ධන හා ලිහිසි තෙල්
1203 නිල ඇඳුම්
1204 ආහාර පාන
1205 වෛද්‍ය සැපයීම්
1206 යන්ත්‍රෝපකරණ හා විදුලි උපකරණ
1207 වෙනත් සැපයීම්

<u>නඩත්තු වියදම්</u>

1301 වාහන
1302 යන්ත්‍ර සූත්‍ර සහ සවිකිරීම් උපකරණ
1303 ගොඩනැගිලි සහ සවි කිරීම්
1304 වෙනත්

<u>ගිවිසුම්ගත සේවා.</u>

1401 ප්‍රවාහන වියදම්
1402 විදුලි සංදේශ සේවා
1403 තැපැල් ගාස්තු
1404 විදුලිය හා ජලය
1405 බදු කුලී හා කුලී ගාස්තු
1406 ප.පා.පා [illegible]

දිනමිණ 2003-11-10 පිටුව අංක 01

අනුරපුර රෝහල වසා දැමීමේ තත්ත්වයක!
උතුරු මැද අනෙක් රෝහල්ද පණ අදිනවා

ඔස්මන්ට් වින්සන්ට් සහ
හිඟුරක්ගොඩ විශේෂ

උතුරු මැද පළාත් සභාවේ සෞඛ්‍ය අංශයට ලැබිය යුතු මුදල් නොලැබීම නිසා අනුරාධපුර මහ රෝහලේ වැඩ කටයුතු කරගෙන යාමට නොහැකිව වසා දැමීමේ තත්ත්වයට පත්ව තිබේ.

උතුරු මැද පළාතේ අනෙකුත් සියලු රෝහල්ද දැඩි බෙහෙත් පවා හරිහැටි නැතිව පණ අදින තත්ත්වයට පත්ව තිබේ.

මේ සම්බන්ධයෙන් අනුරාධපුර මහ රෝහලේ වෛද්‍ය අධිකාරී ලක්ෂ්මන් වීරසිංහ මහතාගෙන් විමසූ විට කීවේ ශල්‍යාගාරය සම්පූර්ණයෙන්ම වසා දැමිය යුතු තත්ත්වයට පත්ව ඇති බවය. රෝහලේ උපකරණ මෙන්ම දැඩි බෙහෙත් හිඟයක් ද පවතින බව ඒ වෛද්‍ය අධිකාරීවරයා විශේෂඥ ශල්‍ය වෛද්‍යවරුන් එකොළොස් දෙනෙක්ම ඉවත්ව යාමට තීරණය කර ඇතැයි ද කීවේ ය.

උතුරු මැද පළාත් මහ ඇමති බර්ටි ප්‍රේමලාල් දිසානායක මහතා දිනමිණ කළ විමසුමකට පිළිතුරු දෙමින්, මධ්‍යම රජයෙන් උතුරු මැද පළාත් සභාවට ලැබිය යුතු මුදල් නිසි පරිදි නොලැබීම නිසා රෝහලේ වත්මන් තත්ත්වයට හේතුවී ඇතැයි සඳහන් කළේය.

10 වැනි පිටුවට

දිනමිණ 2003-11-10 පිටුව අංක 12

උතුරු මැද සෞඛ්‍ය...

මේ පිළිබඳව කොතෙක් පෙත්සම් දුන්නත් එය ...රි අලින්ට වීණා ගැයීමක් වැනි යැයිද ඒ මහතා ...ය. රජය අවශ්‍ය ප්‍රතිපාදන ලබා නොදුන්නොත් ...රෝහල මුළුමනින්ම වසා දැමිය යුතු තත්ත්වයට ...ත් වීම වැළැක්විය නොහැකි යයිද මහ ඇමති-...රයා කීය.

අනුරාධපුර මහ රෝහලේ අඩුපාඩු සම්පූර්ණ ...ර දෙන්නේ නම් මහ රෝහල මධ්‍යම රජයට ...වරා දීමට දැවන් සූදානම් යයිද උතුරු මැද පළාත් සභාවේ සෞඛ්‍ය ඇමැති ආර්. එම්. පී. බී. රත්නායක මහතා හිඟුරක්ගොඩ පැවැති අමාත්‍ය කාර්යාලයේ දී අපගේ වාර්තා කරුවකුට ඊයේ පැවසීය.

රෝහලේ පවතින අඩුපාඩු අපේ මට්ටමෙන් සම්පූර්ණ කිරීමට පියවර ගෙන තිබෙනවා. ශල්‍යාගාරයේ වායු සමීකරණ යන්ත්‍රය, විදුලි උපකරණ සහ ඇතුළත බිම සකසා අවසානයි රත්නායක මහතා කීවේය

අමාත්‍යාංශ පවරා...

දිවයින 2003-11-11 පිටුව අංක 12

අනුරාධපුර රෝහලේ අර්බුදය උග්‍රවෙයි

විශේෂඥ වෛද්‍යවරු 12 දෙනකු රෝහල හැරයෑමේ තීරණයක

[illegible] විශේෂඥ 12 [illegible] විමසීමකදී අනුරාධපුර මහ රෝහලේ රෝහල් අධ්‍යක්ෂ ලක්ෂ්මන් ගම්ලත් මහතා පැවසුයේ විශේෂඥ වෛද්‍යවරු 12 දෙනකු ලිඛිතව තමාට ඒ බව දැනුම් දී ඇති බවයි.

දිවයිනේ පිහිට ප්‍රධාන රෝහල් අතරින් තුන්වන තැන හිමිවන අනුරාධපුර මහ රෝහලට අවශ්‍ය භෞතික සම්පත් නොමැතිකමින්, රෝහල් කටයුතු රැසක්ම අවපණ වී ඇතැයි වෛද්‍ය ගම්ලත් මහතා පැවසීය.

උතුර, නැගෙනහිර, වයඹ, මධ්‍යම ඇතුළු සැත්කම් රැසක් රෝහලේ ශල්‍යාගාර අඛණ්ඩව තත්ත්වයේ පැවතීම හේතුවෙන් ඉකුත් 03 වැනිදා සිට නතර කර දමා තිබෙන අතර, මේ හේතුවෙන් රෝහලට පැමිණෙන අසාධ්‍ය රෝගීන් වෙනත් රෝහල්වලට මාරු කර යවන බවද හෙතෙම පැවසීය.

දැනට රෝහල යටතට විශේෂඥ වෛද්‍යවරු 21 දෙනකු සිටින බවත්, තවත් වෛද්‍යවරු 20 දෙනකුගේ සහ රෝහල් කාර්ය මණ්ඩලයේ 250 පමණ හිඟයක් තිබෙන බවද වෛද්‍යවරයා පැවසීය.

රෝහල් නවත්තු කටයුතු සඳහා රුපියල් කෝටි 125 අවශ්‍ය වූවත්, මෙතෙක් පළාත් සභාව විසින් ලබාදී ඇත්තේ රුපියල් කෝටි 60 ක් බවද ගම්ලත් මහතා පැවසීය.

දිවයින 2003-11-11 පිටුව අංක 04

අනුරාධපුර රෝහලේ වැඩ නතර කරන තත්ත්වයක්

ජයන්ති මාරපේ

අත්‍යවශ්‍ය වෛද්‍ය උපකරණ වර්ග 210 ක් හිඟව පැවතීම හේතුවෙන් අනුරාධපුර මහ රෝහලේ විශේෂඥ ප්‍රතිකාර ඇතුළු රෝගී ප්‍රතිකාර කටයුතු නතර කිරීමට සිදු වන තත්ත්වයක් උද්ගතව ඇතැයි රෝහලේ වෛද්‍යවරුන් සෞඛ්‍ය අමාත්‍යාංශය වෙත පසුගිය සතියේදී දැනුම් දී තිබේ.

සැත්කම් සඳහා භාවිත කරන කතුරුවල සිට සී.ටී. ස්කෑන් ඇතුළු රෝගී පරීක්ෂණ උපකරණ දක්වා වන සෑම වෛද්‍ය උපකරණයක්ම පාහේ අනුරාධපුර රෝහලේ හිඟව පවතින බව රෝහල් ප්‍රකාශකයෙක් 'දිවයින'ට පැවැසීය.

මෙම වෛද්‍ය උපකරණ රෝහලට කඩිනමින් සපයා නොදෙන්නේ නම් රෝගී ප්‍රතිකාර කටයුතු නතර කිරීම හැර ගත හැකි වෙනත් විකල්ප ක්‍රියාමාර්ගයක් නැතැයි එම ප්‍රකාශකයා කීවේය.

ශල්‍යාගාර අවලත් තත්ත්වයේ පැවැතීම හා වෛද්‍ය උපකරණ හිඟය හේතුවෙන් අනුරාධපුර මහ රෝහලේ සිදු කෙරෙන සියලු සැත්කම් ඉකුත් මස (ඔක්තෝබර්) 03 ද සිට නතර කර තිබේ. අසාධ්‍ය රෝගීන්ගේ සැත්කම් පමණක් උපකරණ හිඟය මත වුවද අසීරුවෙන් කරගෙන යන බව රෝහලේ විශේෂඥ ශල්‍ය වෛද්‍යවරු පවසති.

උපකරණ හිඟය නිසා රෝහලේ රෝගී ප්‍රතිකාර කටයුතු පවත්වාගෙන යනුයේද අසීරුතා මැද බව ඔවුහු කියා සිටිති. විශේෂිත ප්‍රතිකාර ඒකක හා දැඩි සත්කාර ඒකකවල කටයුතුද පවත්වාගෙන යා නොහැකි තත්ත්වයක් උද්ගතව ඇතැයි එම වෛද්‍යවරු පෙන්වා දෙති.

මෙම තත්ත්වය මත අනුරාධපුර මහ රෝහලේ පවතින අඩුපාඩු සොයා බලා ඒවාට යෙදිය යුතුත් පිළියම් විමසා බැලීම සඳහා සෞඛ්‍ය ඇමැති පී. දයාරත්න මහතා ඉකුත් සෙනසුරාද (07ද) රෝහලට යාමට නියමිතව තිබුනද, ඇමැතිවරයාගේ ගමනද අවලංගු කර ඇති අතර, සෞඛ්‍ය අමාත්‍යාංශයේ නිලධාරීන් පිරිසක් ඇමැතිවරයා වෙනුවෙන් රෝහලට ගොස් ඇති බව අනුරාධපුර රෝහල් ආරංචි මාර්ග පැවැසීය.

මේ සම්බන්ධව කළ විමසුමකදී වෛද්‍ය සැපයුම් අංශයේ අධ්‍යක්ෂ වෛද්‍ය හේමන්ත බෙනරගම මහතා කියා සිටියේ මෙම වසර සඳහා අනුරාධපුර මහ රෝහලට අවශ්‍ය වෛද්‍ය උපකරණ හා බෙහෙත් මිලදී ගැනීමට අදළ මුදල් ප්‍රතිපාදන උතුරු මැද පළාත් සභාවට ලබාදී ඇති නිසා, හිඟව පවතින සියලු වෛද්‍ය උපකරණ මෙම අවස්ථාවේ සැපැයීමට අසීරු බවයි.

දිවයින 2003-11-15 පිටුව අංක 02

දිවයින

2003 නොවැම්බර් මස 15 වැ

...න් පුවත්

වැඩි තණ්හාව අත්හැර ලද දෙයින්

අනුරාධපුර රෝහලේ අංශ 4 ක් හැර අනිත් කොටස් වසන ලෙස ඉල්ලීමට යයි

එච්.ජී. මාරඹේ

දැනට පවතින වෛද්‍ය උපකරණ ඇතුළු පහසුකම් හිඟය මත අනුරාධපුර මහ රෝහලේ විශේෂිත ප්‍රතිකාර අංශ 4 ක් හැර සෙසු සියලු අංශවලට අයත් වාට්ටු හා දැඩි සත්කාර ඒකක වසා දමන ලෙස සෞඛ්‍ය අමාත්‍යාංශයෙන් ඉල්ලා සිටීමට රෝහලේ වෛද්‍යවරුන් තීරණය කර ඇත.

මේ අනුව වෛද්‍ය, ළමා රෝග, ප්‍රසව හා නාරිවේද හා ශල්‍ය යන අංශ හැර රෝහලේ සෙසු සියලු අංශවලට අයත් වාට්ටු හා දැඩි සත්කාර ඒකක වසා දමා ඒවායේ සේවය කරන හෙදියන් ඇතුළු කාර්ය මණ්ඩලය ඉහත කී අංශ හතරේ සේවයට යොදවන ලෙස අමාත්‍යාංශයෙන් ඉල්ලා සිටින බවට අනුරාධපුර මහරෝහලේ ජ්‍යෙෂ්ඨ වෛද්‍යවරයෙක් 'දිවයින' ට පැවැසීය.

පසුගියදා පැවැති අනුරාධපුර රෝහලේ වෛද්‍යවරුන්ගේ රැස්වීමකදී මෙම තීරණය ගෙන ඇත.

අනුරාධපුර මහරෝහලේ සෑම අංශයකම වෛද්‍ය උපකරණ, සේවකයන් ඇතුළු පහසුකම් හිඟව පැවතීම නිසා ඒවායේ රෝගී ප්‍රතිකාර කටයුතු පවත්වාගෙන යෑම අසීරු වී ඇති හෙයින් මෙම පියවර ගන්නා බව හෙතෙම සඳහන් කළේය.

මේ අතර යාපනයේ සිට කුරුණෑගල දක්වා පවතින ප්‍රදේශවල ජනතාව ප්‍රතිකාර සඳහා අනුරාධපුර මහරෝහලට පැමිණීම හේතුවෙන් එම රෝගීන්ගේ පහසුව තකා පුත්තලම් හෝ වවුනියාවට යන මූලික රෝහල් දෙකෙන් එක රෝහලක් මධ්‍යම රජයට පවරාගෙන ශික්ෂණ රෝහලක් දියුණු කරන ලෙසත් අනුරාධපුර මහ රෝහල මූලික රෝහලක් පවත්වාගෙන යන ලෙසත් රෝහල් වෛද්‍යවරු සෞඛ්‍ය බලධාරීන් වෙත දැනුම් දී තිබේ.

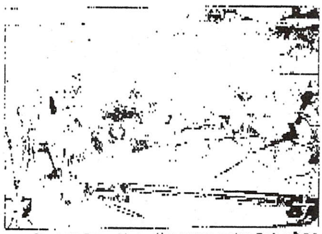
අනුරාධපුර මහරෝහලේ ශල්‍යාගාර සංකීර්ණය අබලන් තත්ත්වයක පැවතීම නිසා රෝහලේ සිදු කෙරෙන සියලු සැත්කම් ගිය ඔක්තෝබර් 3 වැනිදා සිට නතර කර තිබෙන අතර මෙම තත්ත්වය මත රෝහලේ සේවය කරන විශේෂඥ වෛද්‍යවරුන් 24 දෙනාගෙන් 11 දෙනකුම වෙනත් රෝහල්වලට ස්ථාන මාරු ලබා යෑමට තීරණය කර ඇත.

අනුරාධපුර රෝහලේ උද්ගතව ඇති තත්ත්වය පිළිබඳව විමසීමට රෝහලේ අධ්‍යක්ෂ වෛද්‍ය ලක්ෂ්මන් ගමලත් හා උතුරුමැද පළාත් සෞඛ්‍ය සේවා අධ්‍යක්ෂ වෛද්‍ය ඩබ්. විජේසෝම යන අය දුරකථනයට සම්බන්ධ කර ගැනීමට උත්සාහ දැරුවද ඔවුන් සේවා ස්ථානවලින් පිටව ගොස් සිටීම නිසා එය ව්‍යර්ථ විය.

ලංකාදීප 2003-10-31 පිටුව අංක 35

අත්‍යවශ්‍ය උපකරණ නෑ: හෙදි හිඟය උග්‍රයි:

අනුරපුර රෝහලේ නොමේරූ ළදරු ඒකකය දැඩි සත්කාර ඒකකය වැසීයාමේ අවදානමක



උතවල් කාලයේදී නිවසෙක් බිඳ මුදල් සොරාගත් සැකකරු ලොබෝ"ට කොටුවෙලා

ලංකාදීප 2003-10-30 පිටුව අංක 17

අනුරපුර රෝහලේ නඩත්තුව පළාත් සභාවට බෑ වහාම මධ්‍යම රජයට පවරා දෙන්න

උතුරු මැද පළාත් සභා විපක්ෂයෙන් යෝජනාවක්

[illegible]

දිවයින 2003-10-03

අනුරාධපුර රෝහලේ අක්ෂි සැත්කම් නවතී

ජයන්ති මාරංගි

අනුරාධපුර මහ රෝහලේ සිදු කෙරෙන සියලු අක්ෂි සැත්කම් ඊයේ (02 ද) සිට නතර කර තිබේ.

මේ හේතුවෙන් එම සැත්කම් අපේක්ෂාවෙන් අනුරාධපුර මහ රෝහලේ ලියාපදිංචි වී සිටින ඇසේ සුද (කැටරැක්ට්) ඇතුළු අක්ෂි රෝගවලින් පෙළෙන අනුරාධපුර හා ඊට අවට ප්‍රදේශවල පදිංචි රෝගීහු දහස් ගණනක් දැඩි අසීරුතාවයකට පත්ව සිටිති.

අක්ෂි සැත්කම් සිදු කිරීම සඳහා අනුරාධපුර මහ රෝහලට සපයා දී ඇති කතුරු ඇතුළු ශල්‍ය උපකරණ මිනිස් ඇසක සැත්කමක් කළ නොහැකි තරමට තත්ත්වයෙන් බාල ඒවා වීම නිසා එම සැත්කම් නතර කළ බව රෝහලේ ප්‍රකාශකයෙක් 'දිවයින'ට පැවැසීය.

අක්ෂි සැත්කම් නතර කිරීම හේතුවෙන් ඊයේ දිනයේ අනුරාධපුර මහ රෝහලේ සිදු කිරීමට නියමිතව තිබූ අක්ෂි සැත්කම් ලැයිස්තුව අවලංගු කර ඇත.

සාමාන්‍යයෙන් දිනකට රෝහලේ අක්ෂි සැත්කම් 15-20 ...

... අතර ඒවායින් බොහොමයක් වයස්ගත වූවන්ගේ ඇසේ සුද ඉවත් කිරීමේ සැත්කම්ය. රෝහලේ අක්ෂි සැත්කම් පෝලිම ලබන වසර (2004) මැද දක්වා දිස්ව ඇති බව පැවැසේ.

අනුරාධපුර රෝහලෙන් අක්ෂි සැත්කම් සිදු කර ගැනීම සඳහා කුරුණෑගල, වවුනියාව, මන්නාරම, පුත්තලම වැනි ප්‍රදේශවලින්ද රෝගීන් පැමිණෙන බව රෝහල් අංශ පවසයි.

මේ පිළිබඳව විමසූ විට අනුරාධපුර මහ රෝහලේ වැඩබලන අධ්‍යක්ෂ වෛද්‍ය වෛද්‍යරත්න මහතා කියා සිටියේ තත්ත්වයෙන් බාල උපකරණ සපයා දී තිබීම නිසා අක්ෂි සැත්කම් නතර කළ බවයි. භාවිතයට නුසුදුසු තත්ත්වයේ පැවැතීම නිසා එම උපකරණ විනාශ කළ බවද හෙතෙම සඳහන් කළේය.

අනුරාධපුර මහ රෝහලට තත්ත්වයෙන් බාල උපකරණ සැපයීම හා ඇතැම් උපකරණ අඩුවෙන් සැපයීම පිළිබඳව සෞඛ්‍ය අමාත්‍යාංශය වෙත කිහිප වරක්ම දැනුම් දී තිබුණද මෙතෙක් එයට කිසිදු ප්‍රතිචාරයක් ලැබී නැතැයි රෝහලේ ...

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අනුරාධපුර රෝහලේ අඩුපාඩුකම් රැසක්

උතුරුමැද පළාත් සභාව නිදි

අනුරාධපුර සමූහ

අනුරාධපුර මහ රෝහලෙහි පවතින අඩුපාඩුකම් සපුරාලීමට උතුරු මැද පළාත් සභාව මේ වනතෙක් අපොහොසත්වී ඇති නිසා එහි අංශ ගණනාවකම සේවා සම්පූර්ණයෙන්ම ඇනහිටි ඇතැයි විශේෂඥ වෛද්‍යවරු පවසති.

රෝහලට අවශ්‍ය ශල්‍ය උපකරණ විශාල ගණනාවකින් [illegible] තැත.

[illegible] උපකරණ බොහොමයක් [illegible] [illegible]. ඇතැම් උපකරණ පරීක්ෂණය කිරීමට පවා නොහැකි තත්ත්වයේ පවතින බව ශල්‍ය විශේෂඥ වෛද්‍ය මහානාම ගුණසේකර මහතා [illegible] පැවසීය.

උතුරු මැද පළාත, උතුරු නැගෙනහිර, වයඹ යන පළාත් ගණනාවකම රෝගීනට මේ රෝහල මගින් සේවාවන් සැපයේ. එසේ සේවා සැපයීමට උතුරු මැද පළාතේ රජයට [illegible] මුදලින් [illegible] රෝහල නඩත්තු කළේ [illegible].

ලංකාවේ විශාලතම රෝහල් අතරින් අනුරාධපුර [illegible] රෝහල තුන්වන ස්ථානයට පත්ව ඇත. එහි නේවාසික රෝගීන් සඳහා වෙන්වූ ඇඳන් සංඛ්‍යාව 1348 කි.

රෝහලේ පොදු දුරකථන [illegible] ගෙවීම නිසා විසන්ධි කර ඇත. විශේෂඥ වෛද්‍යවරුන් සියලුදෙනාගේම නිල නිවාසවල දුරකථනද විසන්ධි කර ඇතැයි විශේෂඥ වෛද්‍ය මහානාම ගුණසේකර මහතා පැවසීය.

කිසිදු [illegible] අඩුවක් පවතින බව [illegible] කියයි. විශේෂඥ වෛද්‍යවරුන් විධිමත් [illegible] මහරෝහලේ සිටියත් එම අංශ සඳහා උපකරණ [illegible] ඉතා අඩුවෙන් බව [illegible] විශේෂඥ වෛද්‍ය [illegible] ඩී. දිසානායක මහතා පැවසීය.

මහ රෝහලට අවශ්‍ය වෛද්‍ය උපකරණ සඳහා [illegible] රුපියල් කෝටි [illegible] මුදලක් අවශ්‍ය කරන බවත් එහි පවතින අඩුපාඩුකම් සපුරාලීමට පළාත් සභාව මේ වන විට අපොහොසත්වී ඇති නිසා මහ රෝහල මධ්‍යම රජය පවරා ගත යුතු බව විශේෂඥ වෛද්‍යවරු ඉල්ලා සිටිති.

කිසිදු [illegible] රෝහල [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] විශේෂඥ [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible].

[illegible] උපකරණ [illegible] [illegible] [illegible] [illegible] විශේෂඥ වෛද්‍ය [illegible] මහතා පැවසීය.

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible].

[illegible]

[illegible] [illegible] 111 [illegible] [illegible] [illegible].

ලංකාදීප 2003-10-14 පිටුව අංක 15

ලංකාදීප

පැලැස්තර විසඳුම් අපට එපා අඩුපාඩු මැද සැත්කම් කරනු බෑ

අනුරපුර රෝහල මධ්‍යම රජයට පවරා නොදුන්නොත් රෝගීන් අනතුරේ

විශේෂඥ වෛද්‍යවරු අනතුරු අඟවති

ශනිදා වාසනාව	ජයවිරු සම්පත	සුපිරි වාසනා සම්පත	සංවර්ධන වාසනාව	වාසනා සම්පත	මහජන සම්පත
1444 වාරය ප්‍රසාද අංකය 13 ඔක්තෝබර් 15 වැනිදා	171 වැනි වාරය ඔක්තෝබර් 15 වැනිදා	211 වැනි වාරය ඔක්තෝබර් 11 වැනිදා	517 වැනි වාරය 14 වැනිදා	479 වැනි වාරය ප්‍රසාද අංකය 65 ඔක්තෝබර් 9 වැනිදා	1515 වැනි වාරය 14 වැනිදා
02-25-28-38-47	H-26-50-51-52	14-17-51-66	20-23-47-49	05-30-31-42	K-0-8-8-1-6-9

රුපියල් දෙකෝටි විසි දෙලක්ෂයක ජල-විදුලි-හලෝ බිල්පත් ගෙවා නෑ

අනුරපුර මහ රෝහලේ සේවා නවතින ලකුණු

දිවයින 2003-10-11 පිටුව අංක 04

අනුරාධපුර රෝහලේ [illegible]

සියලු සැත්කම් නවතා සතියක් ගෙවුණත් විසඳුමක් නෑ

[illegible]

අනුරාධපුර මහ රෝහලේ සිදු කෙරෙන සියලු සැත්කම් නතර කර [illegible] (10) දිනක සතියක කාලයක් ගතවිය.

මෙම කාලය තුළදී සැලසුම් කර තිබූ සැත්කම් 800 ක් පමණ අවලංගු කර ඇතැයි රෝහල් ආරංචි මාර්ග පැවැසීය.

ශල්‍ය උපකරණ හිඟවීමත්, රෝහලේ ශල්‍යාගාර [illegible] සිදු කිරීම සඳහා සුදුසු [illegible] කරන ලද [illegible] අනුරාධපුර මහ රෝහලේ සිදු කෙරෙන සියලු සැත්කම් නතර කිරීමට ශල්‍ය වෛද්‍යවරු ඉකුත් 01 වැනිදා තීරණය කළහ.

මෙම තත්ත්වය මත රෝහලේ ඇස්, විකලාංග, උගුර, කණ, නාසය ඇතුළු සැත්කම් සඳහා [illegible] රෝගීන් [illegible] දින [illegible] අසරණ වී ඇතැයි රෝහලේ ශල්‍ය වෛද්‍යවරු පවසති.

[illegible] ඇතුළු [illegible] ශල්‍ය උපකරණ [illegible] සැත්කම් සිදු කිරීමෙන් [illegible] අනුරාධපුර රෝහලේ [illegible] අතර, රෝහලේ [illegible] ඇතුළු උපකරණ සැත්කම් සිදු කිරීමට [illegible] ඇතැයි රෝහලේ [illegible] වෛද්‍ය [illegible] දිවයින ට පැවැසීය.

[illegible] රෝහල්වල [illegible] සඳහා ලබා දී ඇති මුදල් ප්‍රතිපාදනවලින් අනුරාධපුර රෝහලට වෙන් කර ඇති ප්‍රතිපාදන ප්‍රමාණවත් නොවීම නිසා රෝහලට අවශ්‍ය ශල්‍ය උපකරණ මිලදී ගත නොහැකි වී ඇති [illegible]

රෝහලේ ශල්‍යාගාර [illegible] ලක්ෂ [illegible] මුදලක් [illegible] ඇති අතර එම [illegible] දිනවල සිදු කරගත [illegible] සඳහන් කළේය.

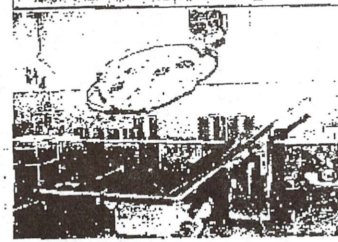
එහෙත් අනුරාධපුර රෝහලේ [illegible] ශල්‍යාගාර [illegible] [illegible] නිසා, එවා සැත්කම් සඳහා [illegible] ශල්‍ය වෛද්‍යවරුන් විසින් [illegible] කර තිබෙන බවයි. [illegible] එම ශල්‍යාගාරවල [illegible] සිදු [illegible] සැත්කමට [illegible] [illegible] වෛද්‍යවරු [illegible]

ලංකාදීප 2003-10-11 පිටුව අංක 03

අනුරපුර රෝහලේ සිසේරියන් ශල්‍යකර්මත් නැවැත්වීමට යයි

ඇඳ උස් පහත් කරන්න බෑ: නුල් ඉඳිකටුපවා පිටින් ගේන්න වෙලා

විශේෂඥ වෛද්‍ය දර්ශන ද සිල්වා කියයි



සිසේරියන් ශල්‍යකර්ම සිදුකිරීම සඳහා භාවිත කෙරෙන [illegible]

දිවයින 2003-11-01

දිවයින

2003 නොවැම්බර් මස 01 වැනිදා සෙනසුරාදා

ශල්‍යාගාර හොඳටම අබලන්වෙලා

ගිය මාසේ අනුරපුර රෝහලේ සැත්කම් 2900 ක් අවලංගුයි

රනිල් හා හකීම් අතර

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