

ABSTRACT

Introduction:

National health policies related to early detection and control of Non-communicable diseases had received a gradual attention and priority since early 1990s in Sri Lanka. However, there was no systematic evidence-based policy development and implementation till early 2000. With the national level political commitment, development partner interest, global commitments and evidence generation through pilot projects on NCD screening programmes, a national programme was established as

‘Healthy Lifestyle Centres’ for screening and prevention of NCDs in 2011. The objective was to universally screen all who have no previous diagnosis of a chronic disease above the age of 40 and provide healthy lifestyle guidance. Since 2011, different implementation strategies had been deployed by the policy makers and implementors to improve screening but the uptake of screening at HLCs remained low at 10% of the target population by 2019. There was evidence on disparities in uptake levels across districts and among men and women.

Objective:

To describe the policy makers perspective on the NCD screening policy evolution to derive policy learnings and to estimate people’s preference for a NCD screening service delivery model in Kalutara District, Sri Lanka.

Methods:

The study consists of a policy analysis on the NCD screening policy evolution and a Discrete Choice Experiment to estimate people’s preference for a NCD screening service delivery model. Twenty-five policy actors who were involved in NCD policy making from year 2000 – 2019 were interviewed. They represented the national and regional level of Ministry of Health and key donor agencies involved with NCD screening project implementation. NCD policy development related documents were identified and analysed along with the interview transcripts using standard policy analysis frameworks and theories. For the Discrete Choice Experiment part of the study, the choice design and the general survey questionnaire was developed through focus

group discussions, literature reviews and stakeholder consultations to estimate people's preference for a NCD screening model. The 'choice design' consisted of six attributes, which are different options for the participants to state their preference; the place of screening (with 5 options), who conducts screening (3 options), the access time for screening (4 options), time spent at screening (3 options), behaviour and attitude of staff (2 options) and cost of screening (4 options). Each participant looked at 10 'choice task pairs' and made a selection each resulting in 10 choice selections that gave them the maximum benefit. The field survey was conducted in Kalutara District by stratified random sampling of urban, rural and estate sectors. Data was collected from 187 participants from the urban sector, 253 participants from the rural sector and 152 participants from the estate sector. Peoples' preference was assessed as utility estimates derived using conditional logistic regression. The beta-coefficients allowed to identify a priority ranking of attributes the people most valued in a health care delivery model for NCD screening.

Results:

Six key policy learnings were derived from the policy analysis. Political commitment towards NCD screening and service delivery had played an important role in driving the policy process forward. Strong policy actors with a good network of influence have effectively utilized the 'policy windows', thus, supported in prioritizing NCDs and establishing the HLC programme. Donor agencies and development partners such as JICA, World Bank and WHO have played a significant role in the policy process. JICA had supported in prioritizing NCD screening and generating evidence towards the screening model that contributed to the development of the national programme. The WHO set the global agenda and had provided guidelines and tools for implementation. The World Bank supported in expanding the screening and later HLCs. The early stages of the screening programme was supported by evidence, which eventually gave more prominence and visibility for NCDs. Later, the use of evidence to inform policy decisions had varied due to lack of quality evidence.

The DCE results from the three sectors (urban, rural and estate) identified different combination of characteristics for NCD screening as the most preferred option. The urban sector attributed a high utility for attitude and behaviour of staff ($\beta = 1.75$, $P < 0.001$), less than an hour spent at screening compared to two hours or more ($\beta = 1.41$, $P < 0.001$) and cost free screening compared

to having to spend Rs. 1,500 ($\beta = 1.35$, $P < 0.001$). The formally employed population ranked workplace screening as the highest preferred characteristic compared to Healthy Lifestyle Centres ($\beta = 1.75$, $P < 0.001$). The rural sector identified, behaviour of staff, time spent less than two hours with similar priorities ($\beta = 1.33$, $P < 0.001$). Cost-free screening was the next most prioritized attribute ($\beta = 1.05$, $P < 0.001$). The formally employed in this sector too ranked workplace screening as important ($\beta = 1.34$, $P < 0.001$). The estate sector attributed the highest priority for cost free screening compared to having to spend Rs. 1,500 ($\beta = 1.35$, $P < 0.001$) and even not having to spend Rs. 1,000. Different sectors preferred different access times. Saturday was preferred by the urban sector while early morning or evening access was preferred by rural and estate sectors. In the estate sector, men preferred access time of early morning but did not prefer Saturday morning access compared to women. Men were not concerned about the poor attitude of staff compared to women. People with a higher income or a higher educational level had lost more utility by experiencing rude and unfriendly behaviour of health staff in all sectors compared to the poorer and who are with a low educational level. In the urban and rural sectors, though preference variances were seen, these were not found to be significant at a p value < 0.05 . These factors were only found to affect the choice preferences significantly at a p < 0.05 in the estate sector.

Conclusions:

Political support and policy networks with influential policy actors can effectively be utilized to create visibility to the much-needed policy areas. Performance indicators that are carefully identified can drive policy development and implementation. It is recommended to assess the point of view of policy beneficiaries before any policy development or implementation. Preferences of the people on service delivery aspects as desired by them may not have been the government priority. This may hinder the success of outcomes from implementing of such policies. Across all the three sectors, cost free screening with less than two hours spent on screening, where staff is warm and friendly to clients found are to be significant attributes contributing to the peoples' choices in a model screening system.

However, 'One strategy fits all' service delivery options may not be effective as different sectors have identified different combination of service delivery aspects as what gives them the highest utility.

Keywords:Non-communicable disease screening, policy analysis, discrete choice experiment, peoples' preference