Paradox of healthcare in Sri Lanka
A snapshot of the last decade from a partnership of sixty years
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September 2014
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I am pleased to send this message of appreciation for the publication, reminiscing the achievements of the World Health Organization in Sri Lanka over the last decade.

Since the establishment of the WHO Country Office in Sri Lanka 62 years ago, in 1952, the cooperation with the Ministry of Health has been very close and fruitful and has grown from strength to strength.

His Excellency the President and the Government of Sri Lanka are committed to maintaining free health services for every citizen of the country, as stated clearly in the national policy document “Mahinda Chintanaya—Vision for the Future”. Since “health is supreme wealth” according to Buddhism, our Government considers health as an investment.

Today, Sri Lanka is recognised globally for its success in mitigating diseases, promoting the health of its people and implementing global health initiatives. The improvements in health indicators, extending advantages of good health-care to poor and marginalised populations as well as the progress in achieving the MDGs, have been outstanding in Sri Lanka.

WHO was designated as health coordinator within the UN family by the Government of Sri Lanka and its role was clearly demonstrated when Sri Lanka faced major disasters such as the tsunami in 2004 and the humanitarian operations in 2009 and was able to maximise on long established knowledge gathered from decades of helping member states respond to large scale disasters, with support from the Regional Office and Headquarters of WHO.

Currently, priority areas of action have been identified as addressing the control of non-communicable diseases, nutrition, injuries, development and ageing. I am certain that we will be able to achieve satisfactory outcomes in these areas with the long standing partnership with WHO.

I am very thankful to WHO officials at all levels, especially the Regional Director and WHO Representative for Sri Lanka, for providing maximum support for the development of the health sector of Sri Lanka.

Maithripala Sirisena
Minister of Health
The World Health Organization (WHO) is privileged to support the national authorities in their endeavours in addressing the epidemiological, demographic and socio-economic challenges and rapid transitions that the country is undergoing.

Sri Lanka’s achievements in the sphere of the control of communicable diseases are commendable. The country is on the verge of eliminating leprosy and lymphatic filariasis. However the country experiences outbreaks of infectious diseases such as dengue and leptospirosis periodically. The Expanded Programme of Immunisation in Sri Lanka is among the most successful in the region as well as globally. Malaria is no longer a public health problem in Sri Lanka and the country is resolved to eliminate malaria by 2015.

WHO has supported the Government of Sri Lanka’s efforts in working together to improve the health of the people of Sri Lanka for the last six decades. This publication attempts to capture the achievements and the lessons learnt in the last decade as well as to identify the challenges and opportunities for the future.

WHO remains committed to continue supporting the efforts of the Government with support and guidance from the Regional Office and Headquarters to achieve the maximum health and developmental benefits for the people of Sri Lanka.

Dr Firdosi Rustom Mehta
WHO Representative for Sri Lanka
WHO’s presence in Sri Lanka dates back to 1952. Between then and now, WHO has partnered with the Sri Lankan Government for the betterment of health and well-being in this island nation.

Today, Sri Lanka is well on its way to achieving most of the Millennium Development Goals (MDGs) related to health. There is a strong push to achieve health-related MDGs on time. Progress on improving health indicators has already been exceptional. The nation has nearly eliminated, among others, vaccine preventable diseases; Japanese encephalitis; neonatal tetanus; and congenital syphilis. However, some other communicable diseases (CDs) such as dengue and leptospirosis continue to be a challenge.

Furthermore, the burden on Sri Lanka’s health system is shifting from CDs to non-communicable diseases (NCDs). There is a rise in cardiovascular, chronic respiratory, neoplastic and diabetic disease. These diseases are responsible for almost 70% of deaths. Accidental injuries are a major cause of hospitalisation. Among NCDs, the need to address mental health issues is also of high importance.

The nation’s maternal and child health indicators are excellent compared to her peers. Sri Lanka’s infant mortality rate (IMR) is just 8 per 1,000 live births. This figure is lower than that of countries much wealthier than Sri Lanka. Child mortality targets outlined in the MDGs are within close reach. There are however, regional disparities in IMRs across the country. Reducing regional disparity is a costly and difficult challenge that Sri Lanka’s health system faces.

Addressing demographic and epidemiological transitions require fast reorientation in the health infrastructure. There is now a focus to quickly deploy infrastructure through increased investment. Improving infrastructure will allow the country to meet changing health needs. Additionally, it will provide more equitable access to healthcare regardless of geographic location.

Aside from conventional challenges, Sri Lanka’s health system has experienced some very unique problems. The 2004 tsunami tested emergency response and preparedness. The end of the thirty year civil war in 2009 resulted in a need to rapidly rebuild and reintegrate affected areas.

Collaboration between WHO, Sri Lankan Government, Ministry of Health and other bodies has been exceptional to address healthcare challenges faced by an evolving nation. A healthy, productive population is crucial for Sri Lanka’s transition into an upper middle-income country. WHO remains committed to playing its role in taking the nation’s health to globally competitive levels. In doing so, this document focuses on six key areas. That is, communicable diseases; non-communicable diseases; injuries and mental health; maternal, child and adolescent health and nutrition; health systems; emergency preparedness and response; enhanced partnerships and resource mobilisation for health. The purpose of this publication is to document achievements and challenges in these areas over the past ten years.
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Sri Lanka has achieved tremendous success in addressing communicable diseases, mainly vaccine preventable diseases. However, maintaining this success, mainly for some of the emerging and re-emerging diseases amidst a growing epidemic of non-communicable diseases, demographic transition and changes in environment, remain a challenge.

Sri Lanka’s achievements in the sphere of controlling communicable diseases are commendable. There have been no cases of poliomyelitis in the country since 1993 and there were no reports of indigenous malaria since October 2012. Further, Sri Lanka is on the verge of eliminating some vaccine preventable diseases such as measles, neonatal tetanus and congenital rubella syndrome and other diseases such as lymphatic filariasis and leprosy. However, many infectious diseases are still prevalent in the country including, but not limited, to dengue.

The country reported the largest outbreak of dengue in 2012, when 44,456 cases were recorded. In the following year, a total of 32,063 cases were reported (Figure 1). The case fatality rate (CFR) was near 1% in 2009 which has been reduced in the subsequent years. The striking increase in the incidence of dengue and its severe manifestations necessitated the mobilisation of support from many sectors, along with the establishment of the Presidential Task-Force on Dengue (Figure 2).
Communicable Diseases

WHO has been supporting the Government in several ways in their fight against dengue. It facilitated training doctors and nurses at centres of excellence, mainly in Thailand, to strengthen the clinical management of dengue fever and dengue haemorrhagic fever. Close monitoring of dengue patients has been facilitated by provision of “haematocrit machines” to high dependency units in hospitals in endemic areas. Diagnostic facilities have been enhanced by providing ELISA equipment to three provincial laboratories. These measures have resulted in a marked reduction in the case-fatality rate. Efforts have been made to enhance control activities by providing in-service training to the staff in health and other sectors. Supplies and equipment necessary for vector control and surveillance have been provided. At the request of the Ministry of Health, a study to determine the feasibility of introducing aerial spraying of Bti for vector control was supported in 2012. A “communication for behavioural impact (COMBI)” plan has been developed for the prevention and control of dengue. The plan is currently being implemented. WHO has also provided technical and financial support to conduct a regional workshop on integrated vector management and clinical management of dengue. Annual reviews of dengue control activities are supported by WHO at central and district levels.

Figure 1: Dengue Cases and Deaths (2000 - 2013)

Source: Epidemiology Unit, Ministry of Health
Figure 2: Presidential Task-Force on Dengue

- **National Level**
  - HE President
  - Ministry of Health
  - Ministry of Education
  - Ministry of Environment
  - Ministry of Defence
  - Ministry of Public Administration
  - Ministry of Local Government & Provincial Councils
  - Ministry of Disaster Management
  - Ministry of Mass Media and Information
  - Inter-Ministerial Coordination

- **Provincial Level**
  - Provincial Committee
  - Hon. Governors
  - Hon. Chief Ministers
  - Chief Provincial Authority
  - Chief Secretaries
  - Provincial Directors of Health Services

- **District Level**
  - District Political Authority
  - Main District Committee
  - Government Agents
  - Deputy Directors of Health and other Government Servants

- **Divisional Secretary Level**
  - Divisional Committee
  - Director, Health and Services
  - Divisional Political Authority and Divisional Secretaries

- **Community Health Service Groups**
  - Chief (Family Health/Public Health) Councils/Grama Sevaka/Samurdhi/Govi Niyamaka/Religious and other grass root level members

A snapshot of the last decade from a partnership of sixty years
A zoonotic disease that has re-emerged is leptospirosis (Figure 3). Next to dengue, leptospirosis is the communicable disease mostly reported in Sri Lanka. As it is mainly seen in farmers, it can also be considered an occupational disease. In 2008, the country experienced the largest ever outbreak, with 7423 cases and 207 deaths (CFR 2.8%). In 2013, a total of 4276 cases and 80 deaths (CFR 1.9%) have been reported. WHO has been able to improve the efforts to prevent and control neglected tropical diseases, such as leptospirosis and leishmaniasis, mainly by supporting awareness programmes and review meetings.

Paddy cultivators are the most vulnerable to Leptospirosis

Source: Epidemiology Unit, Ministry of Health
Due to high levels of acceptability for vaccines and vaccination coverage, many vaccine preventable diseases (VPD) are rarely reported in Sri Lanka (Figure 4). The Expanded Programme on Immunisation (EPI) in Sri Lanka is among the most successful not only in the region but also in the world. However, there are certain issues that still require attention. These include a slight fall in vaccine coverage among school children - especially after reporting of some serious adverse events, laboratory confirmation of VPD cases reported, introduction of new vaccines and disparities between different districts in the quality of services. Increasing contribution in immunisation from the private sector, especially in urban areas, is the other topic hotly discussed. The reporting mechanism in the private sector is an area yet to be addressed. WHO continues to provide support for performance reviews and surveillance of VPD. A recent outbreak of measles in 2013 with a total number of 2153 cases, mainly attributed to change in the immunisation schedule, is a concern. However, it has been fully controlled with an islandwide measles supplementary immunisation campaign in late 2013.

Source: Epidemiology Unit
Communicable Diseases

**Rabies**
Sri Lanka has achieved significant success in rabies control through implementation of a comprehensive rabies control programme. The number of human rabies deaths has declined from 377 in 1973 to only 28 deaths in 2013. This has been achieved through dog vaccination campaigns and an exemplary post-exposure treatment and prophylaxis programme. However, irrational use of post-exposure prophylactic treatment and ineffective management of stray animals still remain issues that needs to be tackled. The most challenging aspect is that the dog subpopulation with the highest probability of encountering rabies virus is also the same subpopulation least vaccinated in traditional dog vaccination programmes. Further, high usage of post-exposure treatment (PET) following animal bites is resulting in significant spending of the health budget.

Rabies elimination is a realistic objective for Sri Lanka if appropriate control strategies are used to mainly reduce rabies virus transmission within the canine population. This also needs effective resources mobilisation for implementation of appropriate strategies. WHO has supported several training programmes on laboratory diagnosis of animal and human rabies, training on intradermal vaccination, awareness programmes and reviews of surveillance activities in the past.

**Tuberculosis**
Sri Lanka is classified as a country with a moderate burden of tuberculosis (TB) (Figure 6). TB burden estimates for Sri Lanka have been more or less static over the period 2000 to 2012 in comparison to a declining trend of the average burden estimates for the countries in WHO South East Asian Region (SEAR). In 2012, the
an increase (9.6%) in 2012 as compared to 2011. Exploring the age sex pattern of TB cases in 2012, the highest number of new TB cases were seen in the age category of 45-54 years and the male, female ratio among the new cases was 2.25:1. The number of laboratory-confirmed multidrug-resistant tuberculosis (MDR-TB) cases in 2012 was 5. The number of HIV positives among the TB cases in 2012 was 5, out of 3,379 TB cases tested for HIV status, indicating the country has a low burden of HIV.

burden estimates for Sri Lanka (prevalence 109 per 100,000 population, incidence 66 per 100,000 population and mortality 5.9 per 100,000 population) were found to be clearly higher than the average burden estimates for WHO SEAR.

In 2012, the ratio of the smear positive pulmonary TB and smear negative PTB in Sri Lanka was 2.25:1. This ratio has remained so over the past decade. Of the different types of TB cases, retreatment cases were the only type that had shown
Communicable Diseases

HIV/AIDS

Sri Lanka is considered a low-prevalence country for HIV infection. The main mode of transmission is through heterosexual contact. The estimated prevalence of HIV among the age group of 15-49 years remains less than 0.1%. The cumulative total of HIV cases diagnosed by the end of 2013 was 1845 with 1110 males (60%). Similar figures for AIDS were 491 and 332 (68%). Though there is a preponderance of males among those infected, the proportion of females infected is increasing over the years.

Malaria

Fifty years after narrowly missing the opportunity to eliminate malaria from Sri Lanka in the 1960s, the country has now interrupted malaria transmission. There were no indigenous cases of malaria since November 2012 (Figure 7). It is a great achievement amidst a civil conflict (ended in 2009) in areas that were endemic for malaria. The challenge now is sustaining the malaria-free status and preventing the reintroduction of malaria in the context of rapid post-war development, increased travel to and from the country, booming tourist industry and an influx of labour and refugees from neighbouring malarious countries combined with the continued presence of malaria vectors in formerly endemic areas.

The absence of indigenous malaria has led to a loss of awareness among the medical profession, resulting in delayed diagnosis of malaria (imported cases) despite the availability of an extensive malaria diagnosis service. Highly prevalent vector-borne diseases such as dengue are competing for health-service resources. Interventions that are necessary at this critical time include sustaining a state-of-the-art surveillance and response system for malaria and

Comprehensive HIV tests lead to early detection and control of the infection
advocacy to maintain awareness among the medical profession, sustained funding for the Anti-Malaria Campaign and for implementation research and technical guidance on elimination. In 2013, WHO supported an extensive review of the malaria control and elimination programme in the country.

**Figure 7: Confirmed cases of malaria (1985–2013)**

Leprosy

Sri Lanka showed significant progress in reducing the disease burden due to leprosy. However, in recent years a slight increase in the detection of new cases has been observed with a gradual increase in the percentage of multibacillary patients since 2000 (in 2000, 36.5% and in 2013, 47.6%). In 2013, the total number of registered cases was 2131, while the number of new cases detected was 1990. The number of children affected remains around 10% (in 2013, 9.2%) of new cases indicating disease transmission. Further, the rate of deformity...
Communicable Diseases

(G II) was 6.7% in 2013, emphasising the need for intervention for early case detection. Alarmingly, there was an abrupt increase in the number of relapses during 2013 (59 cases, 3%), and this warrants a detailed investigation. It is also timely to look at the pros and cons of the integration of leprosy services into the general health services in 2001/2002. Over the years, WHO continues to facilitate the in-kind donation of all anti Leprosy drugs to Sri Lanka.

Filaria

Five rounds of mass drug administration (MDA) have been conducted successfully in all the districts endemic for lymphatic filariasis (LF), resulting in the elimination of LF from Sri Lanka. The Lymphatic Filariasis Elimination Programme was bolstered by the support extended by WHO to the Mass Drug Administration Programme and the Disability Prevention Programme.

Pandemic Influenza

Up to now, Sri Lanka has remained free from avian influenza of type H5N1. However, the A/H1N1 pandemic of 2009 did not spare the country which experienced two waves of epidemic during 2009–2011 this placed a significant burden on the health services. WHO provided the Government with medicines and supplies worth over USD 2.9 million, which included 1.93 million doses of monovalent vaccine against influenza A (H1N1), anti-viral drugs and personal protective equipment. WHO also provided technical support to strengthen disease surveillance activities at points of entry to Sri Lanka.

WHO continues to provide technical and funding support to a number of communicable disease prevention and control programmes with special emphasis on disease surveillance, pandemic influenza preparedness and response, emerging and re-emerging diseases such as dengue, leptospirosis and rabies, neglected tropical diseases including leprosy and lymphatic filariasis, immunisation and vaccine preventable diseases. Technical assistance has been provided mainly for strengthening of capacity in surveillance, planning and implementation of control activities, monitoring and evaluation of disease control programmes, as well as for the development of guidelines, manuals and national strategic plans.

WHO has been the sole partner providing technical as well as funding assistance for many communicable disease control programmes, especially for emerging and re-emerging communicable diseases. Provision of critical medical supplies and equipment for the implementation of disease control programmes has also been bolstered. At a district level, WHO was able to take steps to support and build the capacity of rapid response teams. Further, WHO has been providing intensified technical assistance for the development of proposals for grants from GFATM.

As a member of the Oversight Committee and as a representative of international partners in the Country Coordinating Mechanism, WHO continues to provide its technical input for effective implementation of GFATM supported activities in Sri Lanka.
Achievements

- Moving towards certification of elimination of malaria from the whole island - last indigenous case reported in October 2012

- Acceptability and accessibility to childhood vaccines which resulted in high vaccination coverage has ensured near elimination of many vaccine preventable diseases

- Effective clinical management has brought down drastically the dengue case fatality rate despite high morbidity due to frequent outbreaks
Non-Communicable Diseases, Injuries and Mental Health
Sri Lanka has been quick to respond to the growing burden of NCDs and Mental Health issues and is trying various innovative approaches to deal with them effectively. These problems are complex in nature and need untiring efforts and resources to tackle and with the technical backing of WHO and other partners, Sri Lanka is ready to face challenges.

The epidemiological transition is clearly visible in Sri Lanka. The differences are the greatest in the case of cardiovascular diseases and asthma. This is because during the past three decades, mortality rates from NCDs, especially cardiovascular diseases, have fallen significantly in developed countries but not Sri Lanka.

Figure 8: Percentage of deaths due to NCD

Source: WHO Global Health Observatory 2011
Non-Communicable Diseases, Injuries and Mental Health

The risk factors for NCDs in Sri Lanka, when compared to those in the developed countries, range from some that are lower (e.g. hypertension, obesity and use of alcohol) to some that are higher (e.g. use of tobacco among men, dyslipidaemias and physical inactivity). The prevalence of most of these risk factors can be expected to rise in the coming years.

Addressing the social determinants of health (SDH) is an integral part of the prevention and control of NCDs. Mortality from cardiovascular disease and diabetes increases with the improvement in the socioeconomic status. However, the burden of asthma is much higher among the poor than the wealthy (IHP 2010).

National response to the NCD epidemic

Currently, the national NCD prevention and control efforts are within the jurisdiction of the directorates for NCD and Cancer. A major achievement has been the development of a NCD Policy and Strategic Framework, together with the Medium-Term Operational Plan. This is now being re-visited to comply with WHO’s Global Action Plan for the Prevention and Control of NCDs which was released recently.

There have been various pilot projects in place for the prevention and management of NCDs. These projects include the Package of Essential NCD interventions (PEN) supported by WHO, a project on health promotion and preventive measures for chronic NCDs supported by the Japan International Cooperation Agency (JICA), the Nirogi Lanka project funded by the World Diabetic Foundation (WDF) as well as pilots carried out through the Policy and Planning Unit of the Ministry of Health. These pilot projects are expected to add to the evidence-base that could play a valuable role in the development of future strategies and policies for prevention and control of NCDs and for adoption of global indicators and targets relating to NCDs where strong intersectoral coordination is imperative.
The National Cancer Programme works mainly towards targeting the risk factors and early detection and have initiated island-wide campaigns for this. A significant achievement has been the strengthening of the palliative care set up in Sri Lanka and initiating a postgraduate diploma course in palliative care.

**Key challenges in NCD prevention and control**

The quantum of public sector human resources for health has risen over the past few decades. At present, 89% of the staff works in curative care and 11% in preventive care. One of the challenges facing the country is the inequitable distribution of staff across different districts.

There are gaps in infrastructure, information systems, availability of essential medicines and clinical investigations which are being addressed by the Ministry of Health.

A formal referral system is also not in place and Government policy permits self-referral on demand to secondary and tertiary facilities. This results in underutilisation of primary care facilities with overcrowding at tertiary and secondary care facilities.

Improving intersectoral coordination has also been identified as a priority for the achievement of policy goals.
Sri Lanka has done work in the area of CKDu over many years. A coordinated research initiative over a period of 27 months funded by NSF and WHO has yielded evidence to initiate policy dialogue which has resulted in the highest political commitment translated into action by different stakeholders and ministries.

Population based CKDu prevalence survey in the field
Chronic Kidney Disease of uncertain aetiology (CKDu) is an apparently new form of chronic kidney disease which cannot be attributed to diabetes mellitus, hypertension, primary glomerular nephritis or other known aetiology and has emerged in selected areas of Sri Lanka. The total number of affected individuals with CKDu is approximately in excess of 8,000 people. To resolve this public health issue, the Minister of Health requested support from WHO HQ which resulted in a collaborative research effort between the Ministry of Health, WHO and the National Science Foundation. The detailed findings of the research effort has been compiled and submitted to the Government of Sri Lanka who have initiated action on the recommendations.

A brief account of the work done under the research effort is summarised in Figure 10. A comprehensive final report, a scientific publication in the International Journal of Nephrology as well as a literature repository on CKDu have been compiled.
"Good health adds life to years" is a WHO concept that focuses on how good health throughout life can help older men and women lead full and productive lives and be a resource for their families and communities.

The current proportion of the elderly population in Sri Lanka is above 9% and is predicted to increase to 30% by 2050 with a rapid increase in the share of the very old. This demographic transition in Sri Lanka is said to be dramatic (World Bank 2008).

**National response to the ageing population**

Recognising this trend, the Government has taken steps by putting in place policies, programmes and services that impact directly or indirectly on the well being of the elderly. Establishment of a National Secretariat for Elders in the Department of Social Services and enactment of the Parliament Act No. 9 of 2000 for the protection of the rights of elders are significant landmarks.
By this act, the National Council for Elders was established for the promotion and protection of the welfare and rights of elders under the Ministry of Social Services where many activities are being carried out. A major strength for Sri Lanka is the establishment of over 10,000 village level Elders’ Committees, which offer many services. The Ministry of Health has established a separate unit for the Elderly which works very closely with the Ministry of Social Services. A national policy for the elderly is in place and a National Action Plan was also formulated which is to be finalized. Sri Lanka’s first ever age-friendly city was also declared in the area of Wellawaya together with age-friendly primary healthcare. The setting up of the Sri Lanka Association of Geriatric Medicine has also been of paramount importance to further the field of geriatric medicine as a specialty in Sri Lanka and a post graduate diploma course in geriatric medicine has also been initiated.

**Key challenges in response to ageing population**

As there are two ministries involved in this area of work, it is imperative that there is strong collaboration which is now emerging. Strong commitment is there to address this issue from the Government and many other partners including NGOs supporting this effort.
There has been a paradigm shift in approaches to disability. In recent decades, the move has been from a medical understanding towards a social understanding. Disability arises from the interaction between people with a health conviction and their environment.

Although the true extent of disability in Sri Lanka is unknown, WHO estimates 15% of the population has some form of disability. The magnitude of the problem in Sri Lanka is likely to be higher due to various factors including a post conflict situation, rapidly ageing population, high incidence of Non Communicable Diseases as well as high incidence of Road Traffic Injuries.

National response to Disability
The two key Ministries working in the area of disability are the Ministry of Social Services and Ministry of Health. A separate secretariat has been set up in the Ministry of Social Services with a directorate providing services including provision of assistive devices, livelihood and monetary support. A significant achievement was the launch of the World Disability Report which highlights the different barriers that people with disabilities face – attitudinal, physical and financial, which was followed by a formulation of a National Action Plan on disability. Strengthening of Community Based Rehabilitation is an integral part of the whole effort with provision of technical and financial support from WHO.

Key challenges in response to disability
The role of WHO has been to provide Governments and civil society with a comprehensive description of the importance of disability and an analysis of the responses provided, based on the best available scientific information. Based on this analysis, recommendations are made for action at national and international levels. Improving the technical capacities of the two Ministries has been the main area of focus which needs further strengthening. Translation of the National Action Plan into practical action is also seen as another challenge as many stakeholders are involved in this effort.

Making all healthcare services accessible to people with disabilities is achievable and will reduce unacceptable health disparities

- remove physical barriers to health facilities, information and equipment
- make health care affordable
- invest in specific services such as rehabilitation
- train all health care workers in disability issues including rights
Injury Prevention

WHO works with partners - governmental and non-governmental, to raise the profile of the preventability of road traffic injuries and promote good practices related to helmet and seat-belt wearing, prevent drunk driving, ensure adherence to speed limits as road traffic injuries constitute the majority of injuries.

Traumatic injuries, poisoning and burns are the major types of injuries reported in the National Health Statistics. Traumatic injuries continue to be the leading cause of hospitalisation since 1995 caused by various modes, intentional and unintentional, poisoning and burns. Among the unintentional injuries, Road Traffic Injuries (RTI) represents the major fraction whilst home accidents are also an important area where due consideration is needed.

National response to Injury Prevention

With Road Traffic Injuries being the main cause for injuries, greater emphasis has been placed on addressing this through the Road Safety Council which is a multisectoral body set up through an act of Parliament. Sri Lanka has been proactive on this issue with a special Parliamentary Committee also set up to look into the alarming rise in road traffic injuries. Many activities including strengthening of legislation, advocacy, awareness, strengthening of data collection and capacity building have been done. The launch of the “Decade of Road Safety” was done by HE, the President of Sri Lanka and a draft National Action Plan has also been compiled.

Two other areas which are being addressed are poisoning and drowning. Support has been provided to the National Poisons Information Centre through capacity building efforts, advocacy and support through the provision of equipment and technologies. Drowning prevention also has gathered momentum and initiatives are underway to prepare a situational analysis report as well as strengthen available services.

Key challenges in response to Injury Prevention

While it is known that different injury types need different approaches, an analysis of the current injury prevention efforts in Sri Lanka reveals that collaborative action needs to be enhanced with enforcement of laws and regulations. This is seen as a priority area for the Government and continued efforts are underway to strengthen them.
Non-Communicable Diseases, Injuries and Mental Health

Figure 11: Partners Involved in Road Safety

**Ministry of Transport**
- National Council for Road Safety
- Department of Motor Traffic
- National Transport Commission
- National Transport Medical Institute

**Ministry of Highway and Road Development**
- Road Development Authority

**Ministry of Local Government and Provincial Councils**
- Municipal Councils

**Ministry of Education**
- Director/Health and Nutrition Branch - Education Quality Development Division
- National Institute of Education

**Ministry of Defence**
- Traffic Police

**Ministry of Health**
- NCD Unit
- National Committee on Prevention of Injuries
- Mental Health Unit
- National Centre for Medical Toxicology
- Trauma Secretariat
- Directorate for Youth, Elderly, Disabled, Displaced
- Environmental & Occupational Health Unit

Injuries
- Burns
- Drowning
- Poisoning
- Road Traffic
- Falls
Mental Health

As part of the epidemiological transition that Sri Lanka is undergoing, issues relating to mental health play a prominent part in the morbidity and mortality patterns. The magnitude of substance and alcohol abuse has increased over the past two decades and although suicide rates have been steadily declining, it still is an issue that needs to be dealt with, particularly the high number of suicide attempts, mainly by poisoning. Domestic violence is also another cause for concern.

Before the 2004 tsunami, mental health services in Sri Lanka were hospital-based and largely provided through tertiary-level hospitals located in major cities mainly in or near Colombo. Furthermore, there was a dearth of trained mental health workforce in the country. However the mental health reforms that took place after the tsunami clearly demonstrated that community-based mental health services can be successfully established even in areas with resource constraints.

The early response - National Plan of Action

The political commitment and priorities related to mental health changed dramatically since the 2004 tsunami. A Presidential Task-Force was set up immediately after the tsunami with the support of WHO to work on the modalities for mental health relief. Subsequently, after extensive deliberations with important stakeholders, a ‘National Plan of Action’ was developed in January 2005 for the management and delivery of mental health services to the affected people. At the request of the Ministry of Health (MoH), WHO Country Office for Sri Lanka initially facilitated planning and implementation of a mental health and psychosocial project in tsunami affected districts. The main components of this project included training of primary healthcare professionals and mental health workers and supporting human resource to work at grass-root level. Evidence-based guidelines on the appropriate psychological approaches while dealing with survivors, in a nutshell, a “mental well-being and psychosocial response” rather than a “psychiatric response” was recommended bringing the public health and multidisciplinary approaches together to the fore.

The MoH with the assistance of WHO Country Office for Sri Lanka, Sri Lanka College of Psychiatrists (SLCP) and National Institute of Mental Health (NIMH) initiated implementation of mental health activities. The international community also responded with great generosity. Donor agencies offered assistance to implement various short-term mental health and social support services to the affected population. Initially the activities were restricted to tsunami affected districts and then gradually expanded to other districts.

National Mental Health Policy

With the momentum of mental health initiatives created by the response to tsunami victims, the MoH initiated the mental health policy-development process with the technical support of WHO, SLCP and NIMH. After consultation with a broad range of stakeholders, in October 2005, the Cabinet of Ministers of Sri Lanka approved the “National Mental Health Policy of Sri Lanka: 2005-2015”. The new policy guides efforts to strengthen the governance, technical and organisation development, infrastructure development, human resource development, community participation, empowerment, research and ethics.
The comprehensive mental healthcare facilities were established in six of the 26 health districts in Sri Lanka with funding from Government of Finland and WorldVision Australia channeled through WHO. Currently, 21 out of 26 health districts (81%) have functioning acute inpatient units within general hospital settings, compared to 10 out of 26 (38%) before the tsunami 2004. In addition, there are 16 fully functional intermediate stay rehabilitation units, compared to five units in 2004. Establishment of acute care units and intermediate care facilities helped to expand the delivery of basic and specialised mental health services in the country.

The impetus of accelerating the process of comprehensive mental health care in the aftermath of the tsunami has been sustained and has been instrumental in achieving a lot within a short time span. However, the demand for mental health services remain and innovative approaches are being adopted to reduce the mental health treatment gap and improve mental well-being in the country.
Mental health outreach clinics have been established in most of the MoH divisions in the country, enabling people with mental illness to live and be treated in the community itself with adequate follow-up services. This has contributed to the reduction in the re-admission rate to acute care units in the major hospitals. Furthermore, psychosocial rehabilitation services were provided to those with longer care-needs with a strong focus on rehabilitation and integration into their respective communities.

The National Mental Health Advisory Council (NMHAC) was established in 2008 as a key institutional mechanism to ensure continuous development of mental health services and sustainability. NMHAC oversees implementation of the National Mental Health Policy and Action Plan. It is chaired by the Secretary, MoH and the members are officials from MoH and representatives from other relevant ministries such as Women Empowerment, Social Services, Education and Justice, representatives from professional bodies, WHO and NGOs and also included are service users and carers.

Implementation of the national mental health policy has also resulted in significant improvement in the quality of services provided at hospitals in the country. The Mental Hospital at Angoda in Colombo district, commissioned in 1925 as a ‘lunatic asylum’, played a rather undesirable and unfortunate role in propagating the social stigma with regard to mental illnesses and mental health care for years since its inception. This institution evolved rapidly in the recent years and was renamed as the “National Institute of Mental Health” according to the mental health policy of Sri Lanka. WHO supported to categorise clients according to their functional level to undergo rehabilitation programmes using CPQ (Community Placement Questionnaire) project. WHO also supported NIMH in human resource development, infrastructure development (independent living facility) and logistic support to upgrade facilities. The institute received the award for the Best Director and Hospital in 2008-2009 and received the bronze medal for quality of services among the large scale institutions in 2010-2011.

**Human resources for mental health**

The greatest challenge for mental health services in Sri Lanka was the lack of resources including a trained mental health workforce in 2005. Out of the fourteen tsunami affected districts, nine did not have trained medical officers to lead the mental health team. However following the tsunami, Sri Lanka adopted innovative approaches to deal with workforce shortfalls.

A community-level mental health workforce known as Community Support Officers (CSO) were deployed at affected districts after appropriate training. The CSO programme was a collaborative work of MoH, WHO, SLCP and NIMH which was implemented with the administrative assistance of Regional and Provincial Directorates of Health Services. WHO played a vital role by providing financial and technical support to this programme. More than 500 CSOs were deployed and the distribution was in accordance with the level of displacement of local population. They identified people with early signs of mental illness, psychosocial problems and provided regular and practical support and helped them get access to resources including compensation and living allowances. Meanwhile, they also ensured treatment compliance of people who had been already diagnosed with mental illnesses. The hallmark of the success of the CSO programme lies in the fact that the CSOs were recruited from the local
Non-Communicable Diseases, Injuries and Mental Health

A cadre for Medical Officers of Mental Health (MOMH) was initiated by Sahanaya, National Council for Mental Health with the collaboration of MoH as a World Bank project before 2004. There were nearly 35 MOMHs serving before the tsunami and currently there are 131 Medical Officers of Mental Health (MOMH) and 34 Medical Officers of Psychiatry (MO/Psychiatry) serving in different parts of the country. The Medical Officers of Mental Health had three months training in theory and placement at National Institute of Mental Health (NIMH) under the supervision of Consultant Psychiatrists.

Apart from the above cadre, at National level in 2007, the MoH and SLCP initiated a one year diploma course in psychiatry with the assistance of WHO. Since 2010, MoH and SLCP have been conducting this diploma course without any external assistance, demonstrating commitment in keeping the momentum and sustainability. Altogether there are nearly 60 diploma holders working in all 25 districts of the country. They are mainly based in secondary-level hospitals and conduct hospital as well as out-reach clinics and community level mental health activities in the district.

The Ministry of Health deployed 45 graduates as Developmental Assistants to provide mental health and psychosocial support in 2005. The MoH and NIMH with financial and technical support of WHO trained these graduates for a period of 6 months to work as psychiatric social workers in the districts. Currently there are 35 such experienced graduates working in the country and providing invaluable service in the clinics and community outreach facilities.

Awareness initiatives carried out on Mental Health communities they operated in. This ensured that their interventions were culturally appropriate and acceptable. All these resulted in increased client trust and confidentiality, reduction in family and community stigma regarding mental health issues and acceptance of treatment of mental illnesses.
Furthermore, the Mental Health Policy Action Plan recommends the appointment of at least two community psychiatric nurses (CPN) per district working in the field of mental health. Accordingly, MoH, NIMH and SLCP trained 46 nurses from different districts in community mental health with the collaboration of WHO. These nurses were trained at NIMH for a period of two months and they provide follow-up care in the community. They also closely work with the primary health care staff attached to MOH offices. Involvement of nurses at the community level mental health activities was considered a milestone in the history of development of mental health services in Sri Lanka.

WHO has also been continuously supporting the Sri Lanka College of Psychiatrists in capacity building of mental health professionals.

**Child and Adolescence Mental Health**

WHO provided support in the area of child mental health through the development of various manuals and publications such as Child Mental Health for Medical Officers, Parents’ guides on childhood autism, hyperactivity and learning disability. The field testing of mhGap modules for childhood development disorders has also been conducted through the support of the Universities of Colombo and Kelaniya.

**Community participation and empowerment**

The MoH established consumer and carer societies across the country with technical and funding support from WHO. Basic Needs, Voluntary Service Overseas (VSO) and NGO’s also contributed in establishing consumer and carer societies in some districts. Another initiative that was supported actively by the MoH and donor agencies was the establishment of community support centres to promote mental well-being with counselling services and educational programmes in community settings. Nearly thirty such centres were established in nine districts and these centres also paved the way for more community involvement.

Sensitising media on mental health issues and dissemination of health education materials also helped to reduce the stigma associated with mental health illnesses and facilitated community involvement and partnerships.
Non-Communicable Diseases, Injuries and Mental Health

Contribution from health partners and donor agencies

In addition to WHO, a number of health partners and donor agencies contributed greatly to the development of mental health services in Sri Lanka. WHO closely collaborated with MoH, SLCP and NIMH at national level and supported development of mental health services particularly in six districts (Kalutara, Kalmunai, Jaffna, Hambantota, Matara and Galle). WHO by its mandate and as the health cluster lead agency has continued to play a catalytic role in bringing the health partners and donor agencies together to support the health sector efforts of the Government of Sri Lanka.

The significant progress made by Sri Lanka in mental health care, in the aftermath of the tsunami, has placed Sri Lanka amongst the top 10 countries studied in relation to development of sustainable mental health care after emergency situations. In addition, the mental health action plan 2015 – 2020 and new National Mental Health Policy of Sri Lanka 2015 – 2025 is in the process of formulation for future implementation, to reduce the mental health treatment gap and improve mental well-being in the country.
Achievements

• Sri Lanka has been cited as a lighthouse country for NCD prevention and control with sound policies and programmes in place
• Sri Lanka has placed great emphasis in addressing the aged population with interaction between Ministries of Health and Social Services
• With the formulation of a National Action Plan on Disability, Sri Lanka is well placed in addressing this issue
• The collaborative research effort on CKDu yielded evidence on the causation and public health measures needed to combat it
Maternal, Child and Adolescent Health and Nutrition
Sri Lanka’s Maternal and Child Health (MCH) care is seen as exemplary. MCH indicators in Sri Lanka speak for themselves. The successes are reaped through very effective services extending right to the grass-root level by continuing care through the life cycle approach. However, regional disparities do exist and challenges relating to poor nutrition are complex and require a multisectoral approach in which health plays a pivotal role.

Sri Lanka has achieved remarkable progress in providing maternal, child health and nutritional care over the past few decades and this has been the foundation for its present health-related successes and achievements.

The Infant Mortality Rate (IMR) has declined steadily since the beginning of the last decade, from 12.6 in 2001 to 9.7 in 2009 (RG). In 2009, Neonatal Mortality Rate (NMR) was 5.9 per 1000 live births (Registrar General) and the neonatal (NN) deaths accounted for nearly 80% of infant deaths. The Child Mortality rate (number of deaths in children in the age group 1 – 4 year per 1000 children in that age group for the same year) shows a steady decline from 13.7 in 2002 (Ministry of Health, 2007) to 12.1 in 2009.
The Maternal Mortality Ratio (MMR) declined steadily until 2004, but the average value has been hovering around 38 per 100,000 live births for a while since then. It was 33.46 per 100,000 live births in 2008 and 37.7 in 2012. The common causes of maternal mortality are postpartum haemorrhage, pregnancy-induced hypertension (PIH), complications due to heart disease and complications due to abortion.

An upward trend in life expectancy is seen from 61.9 years for males and 61.4 years for females in 1963 to 70.3 for males and 77.9 for females in 2007. The rapid increase in the life span and the higher values for life expectancy seen among females compared to males indicate improved survival rates among the groups that were more at risk such as women in the child bearing age group, infants and pre-school children.
Successive Demographic and Health Surveys show a consistent decline in fertility rates from a total fertility rate of 2.8 during the period 1982–1987 to 1.9 during the period 1995–2000 with a marginal increase reported in 2006/07 of 2.3. (Department of Census and Statistics, 2008).

The provision of antenatal care extends to 100% of the population and 95% of mothers are registered for antenatal care before 12 weeks of pregnancy. About 85% of postnatal women receive at least one postnatal visit from the Public Health Midwife (PHM) during the first 10 days. Almost all women deliver in hospital and 99% receive skilled attendance during childbirth, while 92% deliver in hospitals with specialised facilities. However, the status of some indicators, such as the Caesarean section rate (30% in 2012), low birth-weight rate (16.6% in 2007), prevalence of anaemia among pregnant women (16.6%), and prevalence of protein energy malnutrition among pregnant women (BMI of less than 18.5 in 29% of pregnant mothers at the time of registration), is a cause of concern for those involved in the implementation of the maternal and child health (MCH) programme.

WHO has extended support to conduct the External Programme Review on Maternal and Newborn Health in which the following recommendations were put forward to: support the development of a national strategic plan on maternal and newborn health (MNH) for the period of 2011–2015, facilitate the establishment of a national steering committee on family health to address policy issues on family health and two advisory committees on MNH care and to redesign the package for maternal care services delivery to suit new and emerging demands.

Although MCH indicators show significant progress, all these indicators have also shown inter-district disparities. In 2007, WHO supported an external programme review on Maternal and Newborn Health by a team of local and international experts focusing on its current situation, past gains, gaps and to obtain recommendations to plan the way forward. WHO continues to strongly advocate the implementation of the recommendations of the MNH review and supports this effort both, technically and financially. Following are some important recommendations already implemented by the MoH.

1. A National Strategic Plan for Maternal and Newborn Health formulated for the period of 2012-2016.

2. National Committee on FH established under the chairmanship of the Secretary of Health and two advisory committees on Maternal Health and Child Health established.
WHO supported publications on maternal and child health

WHO Sri Lanka technically assisted the adaptation of generic planning modules on managing programmes to improve child health to cover maternal and child health; and family planning and this is used as a guide to develop district plans.

WHO also technically assisted the redesigning of the existing maternal care package, based on WHO’s ante natal care model and scaling it up nationally to all provinces. (Reorganised the service delivery packages, domiciliary care/clinic care frequency and time of visits/quality of visits/adding structured parent craft class/revised the ante natal records and integration of Congenital Syphilis Elimination and Prevention of Mother to Child Transmission, Postpartum Psychosis and Strengthening of Maternal Nutrition)

WHO Sri Lanka has also provided support in the development of the national quality standards of newborn care and maternal care based on WHO generic guides.

WHO has been impactful in providing technical support in developing the programme and guidelines for such initiatives including the management of labour rooms, post-partum care in the field and neonatal intensive care units/special care units for babies. These protocols and guidelines were printed and introduced into the system in conjunction with staff training as part of the implementation process. WHO’s technical support, adaptations have also been made to the Medical Eligibility Criteria (MEC) wheel for family planning and the Pregnancy Childbirth Post-partum Newborn Care (PCPNC) manual.
WHO also supported the introduction of new training packages in the following areas to scale up essential interventions and for more effective programme planning: Essential Newborn Care Course (ENCC), Baby-Friendly Hospital Initiative (BFHI), Infant and Young Child Feeding (IYCF) and a short programme review on Child Health was also carried out through WHO’s support.

WHO technically and financially assisted to develop and implement a preconception care to improve reproductive health outcomes by improving the health of newly married couples.

WHO has assisted the child health programme to include differently abled children and to prevent and manage birth defects.

Through WHO’s role in MCH in Sri Lanka, many initiatives were taken in order to promote gender equality and the empowerment of women. Through these initiatives, capacity-building of health staff in comprehensive management of primary prevention and handling of gender-based violence utilising a multi-sectoral approach based on the principles of ethics and human rights was facilitated through the country budget as a CCS priority and UNIFEM project. Furthermore, the introduction of a needs-based healthcare delivery service to deal with the violation of ethics and human rights of migrant women workers and their families was carried out. WHO’s contributions were able to strengthen the capacity to address the disparities in women’s health and advocate the significance of the Social Determinants of Health facilitated through a multi-sectoral approach which all contribute to improving MCH in a broader sense. Moreover, an assessment was made of the laws and policies on adolescent sexual and reproductive health using the human rights approach.
WHO technically assisted the country to develop master trainers on Adolescent Psychosocial Development & Mental Health as there was a need to improve the psychological well-being of adolescents. 

The monitoring of maternal, newborn and reproductive health programmes was facilitated by the development and introduction of performance appraisal tools and self-evaluation tools for MCH staff. Research and surveys were also conducted during the period of the last CCS. Some of the research and survey focuses included the multi-country survey on maternal and newborn care and severe maternal and newborn morbidity, determinants of low birth weight (LBW) and the formulation of the birth weight curve, national standards on symphysis fundal height to assess uterine growth in pregnancy, and district surveys to assess the MCH service delivery status. Through the input and processing of indicators, WHO alongside with other MCH collaborators have been able to monitor the progress in the implementation of the Millennium Development Goals 4 and 5 pertaining to MCH.

Nutrition
Sri Lanka has shown significant improvements in maternal and child health indicators during the past few decades. However, indicators related to nutritional status have not shown comparable improvements particularly in maternal and child under nutrition. Therefore it still remains as a significant public health problem.

According to Demographic and Health Surveys from 1987 to 2006/07, there is a reduction in the prevalence of chronic under-nutrition (stunting) among children under five years in all sectors and in both sexes, the overall prevalence being 27.2% in 1987 to 18.0% in 2000. DHS 2006/07 reported that 17.3% of the pre-school children were stunted with 4%, being severely stunted.

**Figure 15: Percentage of Low Birth Weight (1988-2006)**

Data on nutritional status among school children aged 5 – 18 years between 2003 and 2010 based on surveys carried out in schools show a reduction in the prevalence of stunting, wasting and obesity with an increase in the prevalence of overweight.
Having recognised the importance of addressing nutrition in the country, the Government launched a special programme titled “Vision 2016: Sri Lanka, a Nourished Nation” and commissioned the National Nutrition Council (NNC). The NNC is chaired by HE the President and consists of relevant Ministers, Chief Ministers of the nine Provinces and Members of Parliament from all parties who have experience in nutrition. It is supported by a National Steering Committee on Nutrition, a Technical Advisory Committee on Nutrition and the National Nutrition Secretariat of Sri Lanka. A Multi Sector Action Plan for Nutrition has been developed which complements the National Nutrition Policy (2009 – 2013).

**Landscape Analysis**

**To Accelerate Actions to Reduce Maternal and Child Undernutrition in Sri Lanka**

A landscape analysis was conducted by using a tool developed by WHO, to identify the readiness to accelerate actions on reduction of maternal and child undernutrition. It aimed at identifying critical health system constraints for scaling up nutrition-related activities, engaging with key policy makers and senior managers; analysing the capacity gaps hindering the optimal scaling up of nutrition-related activities; making strategic, relevant and specific recommendations to the national plans of actions in the scaling up of nutrition-related activities and building capacity of national, provincial and district personnel in the conduct of a detailed nutrition programmatic assessment.
As an output of this activity, 25 district plans were developed and for the first time dedicated funds to the tune of LKR 52 million was allocated to the health sector to improve nutrition by the Ministry of Finance.

One Health Costing Tool

The United Nations OneHealth Model is a new software tool designed to strengthen health system analysis, costing and financing scenarios at country level. Its primary purpose is to assess public health investment needs in low and middle income countries. For the first time, planners have a single framework for planning, costing, impact analysis, budgeting and financing of strategies for all major diseases and health system components.

As a follow up of the landscape analysis on nutrition, Sri Lanka decided to hold a capacity building programme for a group of national and district officers responsible for MCH and nutrition planning and officers from the National Council on Nutrition. The groups were trained on MCH and nutrition modules of the OneHealth tool. This training programme was facilitated by resource personnel from WHO HQ and Futures Institute USA. The entire process was facilitated by WCO Sri Lanka.

WHO in their normative role, assisted the Government to develop and implement a National Strategic Plan on Low Birth Weight prevention. However, WHO’s role in nutritional initiatives in the country of Sri Lanka has not been limited to just the Landscape Analysis. WHO has supported projects to strengthen the nutrition surveillance system, bring food-based dietary guidelines (FBDG) and hospital nutrition guidelines up to date and mainstream them, and enhance the capacity in food safety, which were some of WHO’s more formidable accomplishments.
Achievements

• Sri Lanka is on track in achieving MDGs 4 & 5 and the Maternal and Child Health Programme has been redesigned to go beyond MDGs

• District Nutrition Action Plans initiated based on WHO supported guidelines

• Improved capacity in planning and costing at all levels in MCH and Nutrition programmes and development of a National Strategic Plan on MNH

• Expanded service delivery of preconception care to address birth defects and differently abled children
Health Systems 4

World Health Organization
Overview

Sri Lanka has a very well established, robust health system extending to all its masses and is seen as a system able to achieve so much with so little. However, in the light of epidemiological, demographic and economic transitions, the system is now challenged with a new set of issues to deal with and calls for timely innovative reforms.

Sri Lanka holds a unique position in the WHO South-East Asia Region as one of the first of the less developed nations to provide universal health and free education to its people, while ensuring gender equality and providing better opportunities for social mobility.

The health system in Sri Lanka is enriched by the operational coexistence of allopathic, ayurvedic, sidha, unani and several other systems of medicine. Of these systems, it is the allopathic system which is dominant and caters to the majority of the health needs of the people.

As in many other countries, the health system in Sri Lanka consists of both state and private sectors. The responsibility of protecting and promoting the health of the people lies primarily with the Ministry of Health (MoH) which is headed by a Cabinet Minister. The Ministry’s key functions include the formulation of policy guidelines, supervision of medical, nursing and paramedical education and training, management of teaching, specialised medical institutions and procurement of medical supplies.
Health Systems

The enforcement of the Provincial Councils Act in 1989 led to the devolution of health services. Thus, while the MoH functioned at the national level, separate provincial ministries of health emerged in the nine provinces. There are 26 Regional Directors of Health Services (RDHS) who assist nine Provincial Directors of Health Services. The area under each RDHS is subdivided into several areas, each under a Medical Officer of Health. The MoH and the provincial health services provide a wide range of promotive, preventive, curative and rehabilitative healthcare. Sri Lanka has an extensive network of health-care institutions (Figure 16).

Figure 16: Government health institutions in Sri Lanka

Field Health staff being trained in computer applications
The challenges faced by the health system are many. A major challenge relates to the sustainability of the free health system. Though this system is supposed to ensure universal access to health, currently out-of-pocket expenditure of outpatient care is more than 50%. The health-care financing policy opinion are being discussed to address this problem.

The health information system has been reviewed and is being revised to further enhance its analytical capacity and utility. There are plans to revitalise primary healthcare to enhance quality at all levels. Also, efforts are on to create more regularised referral systems. The social determinants of health (SDH) are being given importance at all levels to ensure truly universal access to health.

WHO Sri Lanka has taken an active role within health system development through various projects across the country. Recently, two WHO collaborating centres have been established at the National Institute of Health Sciences, Kalutara (Public Health Workforce Development) and the Faculty of Medicine, University of Colombo (Occupational Health). WHO has provided support to initiate the commencement of the first MPH programme in the country by the University of Kelaniya which marks a landmark step towards improving and educating other young professionals about health systems within and outside the country. Technical support was provided by WHO, in conducting an external review of the Human Resources for Health. Other projects involving health systems which benefited from the support of WHO include the launching of an island-wide patient safety initiative and a periodic workplan review alongside MoH.

**Health Information Systems**

In terms of the advancement of health information systems in Sri Lanka, WHO has provided assistance and support for capacity building in GIS for health staff and supported the electronic indoor morbidity and mortality (eIMMR) initiative. In addition, external reviews of HIS were conducted and support was provided for the quality improvement of Causes of Death Statistics. WHO has also helped the health staff of Sri Lanka by providing readily accessible health information through access to online medical journals such as HINARI and HELLIS networks and improvements in library facilities.

**Health-care financing**

Although the healthcare system in Sri Lanka remains a tax-financed, publicly managed one, there is an increasing recognition of the role of the private sector, both in financing and the provision of health services.

While shaping the national health system, Sri Lanka was guided by the concept of the welfare state. Almost all of the country’s achievements in the health sector can be attributed to the welfare state approach introduced in the 1940s. This approach covered areas such as health, education, nutrition and social services. The major task that lies ahead is to develop a strategy for social health protection within the welfare state model. For this purpose, social health protection needs to be placed high on the national agenda and social health protection priorities for the next 4 - 5 years must be identified. Those priorities then need to be linked to the budget.
In the light of the new challenges presented by the economic, epidemiological, social and demographic transitions in Sri Lanka, improvement of the national health financing system has been identified as one of the strategic objectives to improve the peoples’ health status and reduce inequalities. Now that Sri Lanka is a middle-income country (MIC) and aspires to double the GDP per capita (from around USD 2000 to around USD 4000) by 2015, it faces the challenge of becoming a high performer among its new peers, and also needs to ensure that the poorest and most vulnerable population groups continue to play a part in the fulfillment of the nation’s aspirations. To meet these challenges, significant modernisation of the health system must be undertaken urgently. This task would require an increase in investments. Also, there is a need to revamp the health financing mechanism in a manner that enhances effectiveness, efficiency and equity simultaneously.

Of particular concern is the increasing share of household out-of-pocket spending, which has been consistently above 40% of the total health expenditure during the last decade and is currently estimated at 51%. On the other hand, the share of the government in the total health expenditure declined from 2.1% in 2006 to 1.5% in 2009.

It is important to develop and maintain a good evidence base on health expenditures by public and private sources. The Ministry of Health has recognised the importance of National Health Accounts (NHA) and is taking steps to institutionalise them in Sri Lanka with the support of WHO.

### Human resources in health

An adequate health workforce which is committed and motivated and which has the required public health and clinical competencies is a must for the effective functioning of the health system. While the number of different types and categories of health workers is important, their proper utilisation is a prerequisite for better functioning of the health system, as is the provision of an enabling working environment and proper supporting logistics. Figure 17 shows the human resources for health per 100,000 population in Sri Lanka.

**Figure 17: Human resources for health per 100,000 population (1990-2012)**

![Human resources for health per 100,000 population (1990-2012) graph]

Source: Annual Health Bulletin 2012, Ministry of Health
The curriculum of the paramedical and the allied health science courses is being revised to ensure that the health work force is equipped to address the present health needs more effectively.

**Development of pharmaceutical sector**

A major challenge facing both public and private health sectors is the provision of access to safe, efficacious and good-quality medical products and technologies. Several steps have been introduced to improve the situation such as practicing Good Manufacturing Practices (GMP), conducting inspections, requiring bio equivalence data for certain drug categories for registration, signing memorandum of understanding (MOU) with Bangladesh for drug imports. National concern has been drawn to encourage local manufacturing of drugs required by the country by motivating them by giving the buy back guarantee and giving priority to the local manufacturers at tenders. Startup of a Large Volume Parenteral (LVP) Plant with Government involvement after cabinet approval is also a milestone to improve the above situation. Irrational use of medicines that are available leads to wastage of Government funds. Initiations have been taken to establish Drugs and Therapeutic Committees at public sector hospitals to intervene and ensure better healthcare through rational use of medicine. This situation can be attributed mainly to the absence of a proper policy dealing with the selection, supply, surveillance and use of pharmaceutical products. The existing legal framework needs to be brought up to date to address these issues on the basis of the National Medicinal Drug Policy approved by the Cabinet in 2005.
Health Systems

Improving medical laboratory technology, part of Health Systems Development

Organised medical record keeping, an integral part of Health Information Systems
Achievements

- Two WHO Collaborating Centres have been established in Sri Lanka
- Health Economics Cell established at the Ministry of Health
- Human Resources for Health Strategic Plan available for Sri Lanka
- Primary Healthcare revitalization process has been initiated
- Health Information Systems being strengthened to meet growing demand for health information
Emergency Preparedness and Response
Lessons learnt from experiences in the past have made Sri Lanka more resilient and prepared to respond to emergencies of the future. Positive efforts are underway using the disaster risk management framework to strengthen the health sector for emergencies.

Disasters from natural hazards have been occurring in Sri Lanka intermittently over the past decade. The 2004 tsunami hit 13 of the 25 districts and settlements along two-thirds of the coastline affecting one million people. Regular floods have also inflicted their share of damage. At the height of the May 2010 floods, 606,702 people were displaced from their homes. The January 2011 floods, which were caused by overflowing dams and irrigation tanks, affected 1.2 million people in 18 districts. According to the UNDP’s 2004 report on Reducing Disaster Risk, Sri Lanka experienced an average of 1.29 flood events per year between 1980 and 2000. When considering physical exposure of its population to floods, Sri Lanka ranks 11th in the world in terms of annual average exposure in proportion to its population.1

1 A Global Report, Reducing Disaster Risk, A Challenge for Development, UNDP 2004
Emergency Preparedness and Response

Disasters from human-generated hazards, including conflict, fire and other hazards are also intermittent. A major emergency was the 30-year armed conflict between the separatist militant organisation and the Government of Sri Lanka, which ended in May 2009. In the final days of the conflict, about 300,000 people were displaced from their areas of origin in the Northern Province and they were accommodated in six welfare villages. When people returned to their homes after the conflict, they found themselves in areas with damaged social infrastructure and very limited health services. WHO was part of the humanitarian support efforts post-conflict in 2009.

Disasters from human-generated hazards have thus resulted not only in the loss of lives, but also in the destruction of and damage to health facilities in the affected districts. It is estimated that more than 60% of the health facilities were damaged in some of the districts affected by the conflict.

Figure 18: Map showing post conflict displacement in 2009

Source: UNOCHA/DMC
Despite the enormous degree of support extended to the MoH by the country’s health partners and international agencies, such as the World Bank and the Asian Development Bank, the process of revitalising the health system is complex and would take time. Years of continued hard work and support has gone in from all stakeholders to restore the damaged health system in the Northern and Eastern provinces.

In light of the growing concern for health emergency management, WHO has supported various efforts to educate the people of Sri Lanka on how to deal with the potential of more frequent emergency situations. Furthermore, WHO has supported the implementation of a postgraduate diploma on health sector disaster management at the postgraduate Institute of Medicine of the University of Colombo and the PHEMAP course at the Health Emergency Disaster Management Training Centre at the University of Peradeniya aiming to prepare and educate health professionals on health emergency management. WHO has aided the process of updating the National Influenza Pandemic Preparedness plan and has been instrumental in ensuring that 15 sectors have a BCP (Business Continuity Plan) in place. As Sri Lanka continues to face the possibility of both natural and human-generated disasters from occurring again, WHO has taken an instrumental role in supporting projects to help prepare the country should an emergency ever occur.

WHO assisted the MoH in the development of the Ministry of Health’s “Strategic Plan for Health Sector Disaster/Emergency Preparedness”. This strategic plan was finalised and published by the end of 2011. The final draft document for the Emergency Standard Operating Procedures (SOPs) was prepared in the last quarter of 2010. A stakeholders’ meeting to finalise this document was organised by the MoH on 9 December 2010. The final document was completed in the first quarter of 2011.

WHO continued to work closely with the Disaster Preparedness and Response Division of the MoH to strengthen programmes and activities related to emergency preparedness. This was vital since Sri Lanka had always been vulnerable to natural disasters and calamities on account of its location and recurrent disasters, triggered by global warming and climate change, could not be ruled out.
Emergency Preparedness and Response

WHO was instrumental in mobilising the necessary resources to assist the MoH in providing immediate humanitarian support to the flood-affected population. These funds were used to support the operational capacity of the MoH in deploying health workers from other parts of the country to the flood-affected areas. The MoH was thus able to provide essential health services, emergency medical supplies and chlorination of water sources needed to ensure the availability of safe drinking water to the affected population. WHO staff also conducted assessment visits to the flood-affected areas with officials of the MoH and the Regional Directorates of Health Services to identify important gaps and needs.

WHO mobilised internal and external voluntary funds to assist the MoH in the following areas.

Coordination: Through the Inter-Agency Steering Committee and Health Cluster mechanism, WHO supported the MoH in the coordination of the health response of the partners for emergencies.

Provision of essential health services: WHO supplemented the MoH's efforts to provide health services especially to the post-conflict displacement of communities. Support was provided through emergency health kits, mobilisation of health assistants and rehabilitation of damaged health facilities.

Sri Lanka has been prone to recurrent floods and in the recent years, the frequency and severity of these floods have increased. At the height of the floods in May 2010, 606,000 people were affected in 15 districts. The amount of rainfall caused by La Nina in December 2010 was unprecedented. From December 2010 to June 2011, 1.2 million people in 18 districts were affected due to the overflowing of dams and irrigation tanks and landslides (in the central hilly districts) triggered by the incessant downpour.
Strengthening of the disease surveillance and response system: In collaboration with the Epidemiology Unit (MoH), WHO strengthened the disease surveillance and response system in the Northern Province after the conflict. Public Health Inspectors (PHIs) were also mobilised to support epidemiological data collection and reporting.

Capacity-building of health workers: In collaboration with the MoH, WHO supported training programmes for health workers in the areas of communicable disease surveillance, emergency treatment and management including trauma care, laboratory diagnosis and water quality monitoring. Similar training programmes were also later conducted for health workers in the resettlement areas.
Emergency Preparedness and Response

**Achievements**

- **2005**: National Mental Health Policy developed with the support of WHO and initiated after the Asian Tsunami of 2004
- **2006**: WHO commenced providing support to IDPs affected by the Eastern crisis.
- **2007**:
  - Commencement of training on disaster management at the University of Peradeniya (National Training Course in Public Health Emergency and Disaster Management)
  - South-East Asia Regional Health Emergency Fund (SEARHEF) was formally established
  - Disaster Preparedness and Response Division (DPRD) of the MOH was established
- **2009**: Ending of a 30-year conflict
- **2011**: Strategic plan for health sector disaster/emergency preparedness
- **2012**: Emergency Standard Operation Procedures (SOPs) drafted
- **2013**: Comprehensive National Disaster Management Plan 2013-2017 drafted by the Ministry of Health
- **2013**: WHO South-East Asia Region assessment of Benchmarks for Emergency Preparedness and Response Framework conducted in Sri Lanka

- **2013**: Health sector responded to the needs of Northern IDPs and the challenge of restoring damaged health systems
Achievements

- No Major outbreaks after the tsunami of 2004 and the post conflict displacement in 2009
- Development of training courses to strengthen health emergency management; PHEMAP, Post-Graduate Diploma in Disaster Management
- Establishment of the Disaster Preparedness and Response Division (DPRO) at the MoH
- Drafting of the Comprehensive National Disaster Management Plan 2013 – 2017
- Funding support mechanism for acute emergency through the South East Asia Regional Health Emergency Fund (SEARHEF)
Enhanced Partnerships and Resource Mobilisation for Health
WHO has consistently played a catalytic and convening role, bringing partners together and building bridges for working towards a common goal of building a healthier Sri Lanka.

The devastating 2004 tsunami and the cessation of a 30 year old conflict in the North and East catalysed an increased interest in the health sector in Sri Lanka on the part of the country’s international partners.

External financial resources for the health sector amounted to LKR 6,302 million in 2010. Donor funds contributed 6% of the total public health expenditure. In 2009 alone, the international community contributed US$ 8,174,147 to support the efforts of the Ministry of Health (MoH) to address the health needs of more than 300,000 people displaced during the final stages of the armed conflict in the northern peninsula.

As shown in Figure 19, there are a multitude of stakeholders who support the work of WHO in the area of health in the country. Robust coordination among all partners is necessary so that the resources available can be used more efficiently, making the programmes in the health sector more effective.

WHO, through its role as a neutral broker in health, is seen as a well trusted partner to bring together different partners working in health. The role played by WHO in the 2004 tsunami aftermath and at the end of the civil conflict in 2009 bears witness to the ability for WHO to build bridges and convene partners.

WHO Country Office has also supported partnership coordination by publishing the second edition of a directory of health partners which includes all partners in health including the professional colleges, medical associations and societies, regulatory bodies and international development partners and the private sector in addition to the NGOs.

Integration of Health into the development agenda has strengthened and coordination demands have increased...
The WHO Country Representative to Sri Lanka takes an active part in the activities of the the Country Coordinating Mechanism Sri Lanka (CCMSL) which was established in March 2002 for the purpose of coordinating, developing and submitting proposals to the Global Fund, and monitoring projects in Sri Lanka that are funded by the GFATM. The CCMSL is a national-level multisectoral organisation, comprising the public sector, the private sector, members of academia, civil society and faith-based organisations, multilateral/bilateral partners and people living with or affected by diseases.

Non-Governmental Organisations
Since the response to the tsunami in 2004, when many national and international nongovernmental organisations (NGOs) supported the efforts of the MoH to address the health needs of the affected population, several NGOs have continued to play a role in the health sector. During the humanitarian crisis of 2009, WHO worked in tandem with these organisations through coordination work in the health cluster mechanism in order to assist the MoH’s overall efforts at providing health-care services to the nearly 300,000 affected people. In addition, WHO worked in partnership with some international nongovernmental organisations (INGOs) in complimenting health care in the IDP camps. The efforts of all health partners supplemented the commitment of the MoH to rebuild the health system in the Northern Province, which was the worst affected by the ethnic conflict.

The third generation Country Cooperation Strategy (CCS) which articulates WHO’s strategy for cooperation with Sri Lanka for the period 2012 – 2017 was launched in 2011 and is now operational. WHO Sri Lanka also marked its 60 years of presence in Sri Lanka in 2012 and a book was published giving a historical perspective of its six decade long presence and activities in the island. A commemorative stamp was issued to mark this important landmark.

Figure 19: Inter-relationship between different stakeholders working with WHO in the health sector.

Enhanced Partnerships and Resource Mobilisation for Health

First Day Cover to commemorate sixty years of WHO in Sri Lanka

WHO Country Cooperation Strategy 2012-2017
Achievements & Challenges

- WHO CCS Sri Lanka 2012-2017 in place and operational
- A directory of profile of partners, second edition published and distributed
- Health cluster structure was led by the MoH and co-chaired by WHO which resulted in coordination and complimentality of delivery of services during the humanitarian post-conflict stage
- Increased funding will be required to address Sri Lanka’s rapid epidemiological, demographic and socioeconomic transitions by a multi-sectoral and inter-ministerial basis and not by the Ministry of Health alone