WHO
Country Cooperation Strategy
2012–2017
Democratic Socialist Republic of Sri Lanka

World Health Organization
Country Office for Sri Lanka
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Message from the Minister of Health

It is my privilege to issue this message for the WHO Country Cooperation Strategy (CCS) document, 2012–2017. The first WHO CCS for Sri Lanka was developed for the period of 2002–2005, and since then, new challenges have arisen to health development in the country.

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.

The Ministry of Health developed a 10-year master plan for health for the period 2007–2016. Even though the Government of Sri Lanka spends a sizable amount from the budgetary allocations towards achieving the objectives of this plan, as well as towards maintaining the continuum of free health care, the country still needs the support of its development partners to achieve the Ministry of Health’s vision of a healthier nation in which good health contributes to economic, social, mental and spiritual development.

WHO has always worked very closely with the Government of Sri Lanka, even prior to the development of a CCS, to help the country achieve its health objectives. The CCS has further cemented this collaborative partnership and made it possible to make an in-depth analysis of the key challenges and key strengths. It takes into account the strategic objectives of the Ministry of Health while detailing how WHO will support the implementation of national health development programmes.

During a series of consultations with WHO, the issues to be included in the CCS were refined through a process of prioritization. A series of multisectoral consultations were also held for the purpose with key stakeholders in the Ministry of Health and related ministries, as well as specialized UN agencies, development partners, members of academia, the private sector and civil society representatives.

I am very thankful to WHO officials at all levels, especially the Regional Director and WHO representative (WR), for providing the maximum support for the development of the health sector of Sri Lanka.
The Country Cooperation Strategy (CCS) is a key instrument of the World Health Organization (WHO) and a medium-term vision for its technical cooperation in support of Sri Lanka’s National Health Plan.

The World Health Organization has been working hand in hand for many years with the Member States of the South-East Asia Region to improve the health of its people. In fact, the Region was the first to promote CCSs, which guide WHO on how to support national health development according to the challenges, strengths, and strategic objectives and priorities of the country. In the case of Sri Lanka, WHO began working with the Government of Sri Lanka since 1952, the year when the first WHO office was opened at the Galle Face Hotel.

The previous CCS in Sri Lanka covered the period 2006–2011, a time when the country was recovering from the effects of the devastating tsunami of 2004. Since this disaster, the country has been experiencing economic, social, epidemiological and demographic transitions. As such, it is the right time to develop a new CCS, for the period 2012–2017, to address the changes which have occurred.

The process of the development of the current CCS took over a year. It did not involve just the Ministry of Health, but all stakeholders working in the health sector, including developmental partners, sister UN agencies, nongovernmental organizations and civil society, since all stakeholders have a part to play in complementing the efforts of the Ministry of Health to address the emerging health needs and priorities of the country. This comprehensive consultative process ensured that WHO’s inputs would effectively supplement and provide the maximum support to the health development efforts spearheaded by the Ministry of Health in Sri Lanka.

I would like to take this opportunity to thank all those who have been involved in the development of this CCS, which has the full support of the Regional Office. Over the next six years, we shall work together to achieve its objectives in order to provide the maximum health benefits to the people of Sri Lanka. I am confident that with our joint efforts, we shall be able to achieve the vision of the Ministry of Health—to build a healthier nation in which good health contributes to economic, social, mental and spiritual development.

Dr Samlee Plianbangchang
Regional Director
The World Health Organization (WHO) and the Government of Sri Lanka have been working together to improve the health of the people of Sri Lanka for many years. The Country Cooperation Strategy (CCS) provides a strong foundation for this collaboration. The CCS provides an in-depth analysis of the key challenges and key strengths, and takes into account the strategic objectives of the Ministry of Health while detailing how WHO will support the implementation of national health development strategies.

The current CCS for Sri Lanka is the third-generation version of the document. It articulates WHO’s strategy for cooperation with the Member State at the country level for the period 2012–2017. The strategic agenda reflects and envisages the health agenda of the Government of the Democratic Socialist Republic of Sri Lanka and is aligned and in tandem with the mandate for collaboration in health with WHO.

This CCS is the fruit of a series of concerted and intensive multisectoral consultations with key stakeholders in the Sri Lankan health sector. These include the Ministry of Health, other related ministries, specialized UN agencies, development partners, members of academia, the private sector and civil society representatives.

The purpose of this CCS is to reflect WHO’s medium-term vision for its cooperation with Sri Lanka and to elucidate the strategic framework for such cooperation. In order to maximize its contribution to national health development, the CCS attempts to strike a balance between evidence-based country priorities and WHO’s strategic priorities.

It gives me great pleasure to present the third WHO–Sri Lanka CCS, a very comprehensive strategic document. I hope that this CCS will be used extensively by the national and international partners in health to ensure better cooperation and collaboration in the planning and implementation of relevant activities so that the health and well-being of the people of Sri Lanka may be enhanced.

Dr Firdosi Rustom Mehta
WHO Representative to Sri Lanka
**Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>AEFI</td>
<td>adverse events following immunization</td>
</tr>
<tr>
<td>BFHI</td>
<td>baby friendly hospital initiative</td>
</tr>
<tr>
<td>BMI</td>
<td>body mass index</td>
</tr>
<tr>
<td>CCMSL</td>
<td>Country Coordinating Mechanism Sri Lanka</td>
</tr>
<tr>
<td>CCS</td>
<td>Country Cooperation Strategy</td>
</tr>
<tr>
<td>CERF</td>
<td>Central Emergency Relief Fund</td>
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<tr>
<td>CFR</td>
<td>case fatality rate</td>
</tr>
<tr>
<td>CHAP</td>
<td>common humanitarian action plan</td>
</tr>
<tr>
<td>COMBI</td>
<td>communication for behavioural impact</td>
</tr>
<tr>
<td>CSO</td>
<td>community support officers</td>
</tr>
<tr>
<td>DALYs</td>
<td>disability-adjusted life years</td>
</tr>
<tr>
<td>DHF</td>
<td>dengue haemorrhagic fever</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>DMC</td>
<td>Disaster Management Centre</td>
</tr>
<tr>
<td>ELISA</td>
<td>enzyme-linked immunosorbent assay</td>
</tr>
<tr>
<td>EmCC</td>
<td>emergency care course</td>
</tr>
<tr>
<td>ENCC</td>
<td>essential newborn care course</td>
</tr>
<tr>
<td>EPI</td>
<td>expanded programme on immunization</td>
</tr>
<tr>
<td>ETU</td>
<td>emergency treatment units</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organization of the United Nations</td>
</tr>
<tr>
<td>FBDG</td>
<td>food-based dietary guidelines</td>
</tr>
<tr>
<td>FHB</td>
<td>Family Health Bureau</td>
</tr>
<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunizations</td>
</tr>
<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GIS</td>
<td>geographic information system</td>
</tr>
<tr>
<td>GNI</td>
<td>gross national income</td>
</tr>
<tr>
<td>GoSL</td>
<td>Government of Sri Lanka</td>
</tr>
<tr>
<td>HeLLIS</td>
<td>Health Literature, Library and Information Services</td>
</tr>
<tr>
<td>HINARI</td>
<td>Health inter network access to research initiative</td>
</tr>
<tr>
<td>HSDP</td>
<td>Health system development project</td>
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<tr>
<td>HSMP</td>
<td>Health sector master plan</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>---------</td>
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</tr>
<tr>
<td>HWF</td>
<td>health workforce</td>
</tr>
<tr>
<td>IDD</td>
<td>iodine deficiency disorders</td>
</tr>
<tr>
<td>IEHK</td>
<td>interagency emergency health kits</td>
</tr>
<tr>
<td>IHD</td>
<td>ischaemic heart disease</td>
</tr>
<tr>
<td>IHP</td>
<td>Institute for Health Policy</td>
</tr>
<tr>
<td>IHR</td>
<td>International Health Regulations</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated management of childhood illnesses</td>
</tr>
<tr>
<td>IMMR</td>
<td>Indoor morbidity and mortality return</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant mortality rate</td>
</tr>
<tr>
<td>INGOs</td>
<td>International nongovernmental organizations</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
<tr>
<td>IYCF</td>
<td>infant and young child feeding</td>
</tr>
<tr>
<td>JICA</td>
<td>Japan International Cooperation Agency</td>
</tr>
<tr>
<td>JPA</td>
<td>joint plan of action/activities</td>
</tr>
<tr>
<td>KoFIH</td>
<td>Korean Fund for International Healthcare</td>
</tr>
<tr>
<td>KOICA</td>
<td>Korean International Cooperation Agency</td>
</tr>
<tr>
<td>LBW</td>
<td>low birth weight</td>
</tr>
<tr>
<td>LF</td>
<td>lymphatic filariasis</td>
</tr>
<tr>
<td>MCH</td>
<td>maternal and child health</td>
</tr>
<tr>
<td>MDA</td>
<td>mass drug administration</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MDR-TB</td>
<td>multidrug-resistant tuberculosis</td>
</tr>
<tr>
<td>MIC</td>
<td>middle-income country</td>
</tr>
<tr>
<td>MMR</td>
<td>maternal mortality ratio</td>
</tr>
<tr>
<td>MNH</td>
<td>maternal and newborn health</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOMH</td>
<td>Medical officers of Mental Health</td>
</tr>
<tr>
<td>MO–Psychiatry</td>
<td>Medical officer–Psychiatry</td>
</tr>
<tr>
<td>NCDs</td>
<td>Noncommunicable diseases</td>
</tr>
<tr>
<td>NECORD</td>
<td>North East Community Restoration and Development Project</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-governmental organizations</td>
</tr>
<tr>
<td>NHA</td>
<td>national health accounts</td>
</tr>
<tr>
<td>NHC</td>
<td>National Health Commission</td>
</tr>
<tr>
<td>NIHS</td>
<td>National Institute of health sciences</td>
</tr>
<tr>
<td>NMM</td>
<td>newborn and maternal mortality</td>
</tr>
</tbody>
</table>
Executive summary

The first Country Cooperation Strategy for Sri Lanka covered the period of work of WHO in the Member State from 2002 to 2005. The second CCS took it ahead to cover the period 2006 to 2011. This Country Cooperation Strategy for Sri Lanka is now the third generation version of the document, which articulates the World Health Organization’s strategy for cooperation with the Member State at the country level for the period 2012–2017. The Strategic Agenda complements the agenda for health of the Government of the Democratic Socialist Republic of Sri Lanka and is aligned and in tandem with the mandate for collaboration in health of WHO. It also factors in comparative advantages, existing and planned policies, guiding principles of the government for charting a roadmap to better health for the people, as well as planning cycles of WHO and the Ministry of Health.

The decadal period 2002 to 2011 witnessed significant developments in the health sector in Sri Lanka. It was apparent that the rapidly changing demographic and epidemiological transitions influenced the disease and epidemiological pattern in the country. Health needs and demands were further influenced by technological and social development, as well as the rising expectations of the people from the advancements made in the field of medicine and research.

The strong commitment of the national government to health and its untiring efforts directed at achieving the health-related targets envisaged in the UN Millennium Development Goals (MDGs) is reflected inter alia in “Mahinda Chinthanaya – Vision for the future” and the Health Sector Master Plan 2007–2016 based on the “Strategic Framework for Health Development”.

Sri Lanka’s main development challenges, as emphasized in the government’s 10-year Development Framework, are to accelerate growth through increased investment in infrastructure, achieve more equitable development through assistance to the lagging regions, and strengthen public services delivery to ensure quality and performance of services to meet modern development needs. There is also a significant need for developing the North and the East of the country which suffered in great measure from the recent civil conflicts and inadequate investment over a considerable period of time. At the same time, the government faces the challenge of stabilizing the economy by reducing inflation and the fiscal deficit while aiming at a higher growth over a sustained period of time.
Sri Lanka needs a healthy and productive population to sustain its transition to a middle-income country (MIC). Rapid ageing of the population and the relentlessly increasing burden of noncommunicable diseases (NCDs) are impediments in the way of the country’s successful emergence as a middle-income country. Effectively managing these two issues will, therefore, be a critical pre-requisite for the transition. NCDs have already become the largest contributor to the disease burden in Sri Lanka, accounting for 85% of disability-adjusted life years (DALYs) in the country.

This CCS is the fruit of a series of concerted and intensive multisectoral consultations with key stakeholders in the Sri Lankan health sector. These include the Ministry of Health, other ministries, UN specialized agencies, development partners, and members of academia and the private sector and civil society representatives.

The strategic agenda developed by WHO in close collaboration with the Ministry of Health and other partners is to concentrate on six areas of work for the next six years. These are:

- Health Systems
- Communicable diseases
- Noncommunicable diseases, injuries and mental health
- Maternal, child and adolescent health including nutrition and food safety
- Emergency preparedness and response
- Enhanced partnerships and resource mobilization for health

The Strategic Agenda for WHO cooperation outlined in Chapter 5, defines the Strategic Priorities, as well as the Main Focus Areas and Strategic Approaches for their implementation.

In implementing the Country Cooperation Strategy and in accordance with its mandate, WHO will work closely with the Ministry of Health and other bilateral and multilateral agencies as well as with health-related NGOs and stakeholders in the country.
The WHO Country Cooperation Strategy (CCS) is a medium-term vision statement relating to the Organization’s technical cooperation with a Member State of the South-East Asia Region. The CCS supports and promotes the country’s national health policy, strategy or plan.

The current CCS for Sri Lanka is the third-generation version of the document. It articulates WHO’s strategy for cooperation with the Member State at the country level for the period 2012–2017. While the first CCS for Sri Lanka covered the period 2002–2005, the second spanned from 2006 to 2011. The Strategic Agenda reflects and envisages the health agenda of the Government of the Democratic Socialist Republic of Sri Lanka and is in keeping with the mandate for collaboration in health with WHO. It has also factored in comparative advantages of the existing and planned policies, the guiding principles on the basis of which the Government has made a roadmap for improving the people’s health as well as the planning cycles of WHO and the Ministry of Health (MoH) (Figure 1.1).

Figure 1.1: Alignment in WHO’s planning cycles
The current CCS is the fruit of a series of intensive multisectoral consultations with key stakeholders in the Sri Lankan health sector. These include the MoH, other relevant ministries, specialized UN agencies, development partners, academia, private sector and civil society representatives.

The decadal period 2002–2011 witnessed significant developments in the health sector in Sri Lanka. It was apparent that the rapidly changing demographic and epidemiological scenario was influencing the disease pattern and trends in the country. Health needs and demands were further influenced by technological and social changes, as well as the rising expectations resulting from the advancements made in the field of medicine, communication and research. Being alert to these emerging challenges, the MoH moved swiftly to develop a comprehensive Health Sector Master Plan (HSMP) in 2003. A landmark development in the continuing process of bolstering health care and services in the country was the publication (2003) of the National Strategic Framework for Health Development in Sri Lanka (Figure 1.2), which outlined the strategic directions and priorities of the Ministry in its quest to address the changing health needs and demands. The HSMP, based on this strategic framework, defines and outlines the broad activities to be undertaken in the field of health during 2007–2016.

**Figure 1.2:** Strategic framework for health development in Sri Lanka

The Government’s strong commitment to health and its untiring efforts to achieve the health-related targets envisaged in the UN Millennium Development Goals (MDGs) are reflected, inter alia, in “Mahinda Chinthanaya - Vision for the Future”1 and the HSMP

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1 Government policy document
2007–2016. The increasing emphasis on the achievement of the MDGs, especially those related to health, has been another significant cornerstone of the national health development process and the corpus of health plans. The high stakes that the Government of Sri Lanka has placed in health and the untiring efforts and unrelenting desire of the MoH to achieve the health-related targets of the MDGs give WHO good reason to provide the necessary support.

Government initiatives in the area of public health have reduced the incidence of many communicable diseases. The policy of free health care, coupled with general socioeconomic development, has brought down Sri Lanka’s mortality statistics to a significant extent. Sri Lanka’s achievements with respect to the social indicators that are subject to the public sector health-care policies and practices are truly impressive vis-a-vis those of other developing countries that are comparable in size, population and other parameters, and also reflect a significant improvement over the conditions in Sri Lanka itself in relatively recent times (Table 1).

Table 1: Socio-economic indicators of several Member States of the WHO SEA Region

<table>
<thead>
<tr>
<th>Country</th>
<th>HDI rank 2006*</th>
<th>GDP per capita, PPP (Int $)</th>
<th>Gini index</th>
<th>Average GDP per capita growth (2000-2006)</th>
<th>Life expectancy at birth in years</th>
<th>Poverty headcount ratio at $1 a day PPP (% of population)</th>
<th>Unemployment, total (% of labour force)</th>
<th>Adult female literacy rate (% of female age 15 and above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>137</td>
<td>2 217</td>
<td>33</td>
<td>3.6</td>
<td>62</td>
<td>41</td>
<td>4</td>
<td>41</td>
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<tr>
<td>India</td>
<td>126</td>
<td>3 827</td>
<td>5.4</td>
<td>63</td>
<td>34</td>
<td>47</td>
<td>5</td>
<td>48</td>
</tr>
<tr>
<td>Indonesia</td>
<td>108</td>
<td>4 130</td>
<td>34</td>
<td>3.4</td>
<td>66</td>
<td>8</td>
<td>10</td>
<td>87</td>
</tr>
<tr>
<td>Maldives</td>
<td>98</td>
<td>1 681</td>
<td>4.6</td>
<td>68</td>
<td>2</td>
<td>1.2</td>
<td>2</td>
<td>96</td>
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<tr>
<td>Nepal</td>
<td>138</td>
<td>1 596</td>
<td>47</td>
<td>1.1</td>
<td>63</td>
<td>24</td>
<td>9</td>
<td>35</td>
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<tr>
<td>Sri Lanka</td>
<td>93</td>
<td>5 081</td>
<td>40</td>
<td>4.1</td>
<td>75</td>
<td>6</td>
<td>8</td>
<td>89</td>
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<tr>
<td>Thailand</td>
<td>74</td>
<td>9 331</td>
<td>42</td>
<td>4.0</td>
<td>71</td>
<td>2</td>
<td>2</td>
<td>91</td>
</tr>
</tbody>
</table>

Source: World Development Indicators 2000-2006, most recent data available, World Bank; blank cells represent unavailable data
*Source: Human Development Report 2006, UNDP

Sri Lanka’s main development strategies, as emphasized in the Government’s 10-year Development Framework, are to accelerate growth through increased investment in infrastructure, achieve more equitable development through assistance to regions that are lagging behind, and strengthen the delivery and quality of public services to meet modern development needs. There is also a significant need to develop the north and the east of the country, which suffered a great deal due to the recent civil conflict and inadequate investment over a considerable period of time. At the same time, the Government faces the challenge of stabilizing the economy by reducing inflation and the fiscal deficit while aiming at a higher growth rate over a sustained period of time.
The success stories that have accompanied resource mobilization for health projects during the past several years have not only created new opportunities, but also thrown up fresh challenges for the health sector. The development of capacity for the full utilization of the resources mobilized in order to reap the maximum benefit is a critical issue for a system that must maintain its focus on the poor and marginalized. The Macroeconomics and Health Initiative has highlighted the need to plan priority interventions and investments targeting the poor.

Sri Lanka, an island state in the Indian Ocean, lying between the Arabian Sea and the Bay of Bengal, is prone to natural disasters such as floods, cyclones, landslides, droughts and tsunamis. In the past few decades, such disasters have occurred with alarming regularity, and caused increasing loss of life and property. The devastation caused by the tsunami of December 2004, however, was unprecedented and demonstrated that the island nation is vulnerable to low-frequency but high-impact events with extensive damage. Prior to 2004, several initiatives were taken by successive governments to deal with the damages caused by natural disasters. However, the measures taken were mostly reactive, with an emphasis on relief and recovery, rather than proactive steps aimed at pre-empting or preventing damage or strategies for minimizing harm.

The 2004 tsunami made the different agencies/departments concerned to act collectively to evolve a comprehensive, long-term and holistic disaster risk management framework. The Sri Lanka Disaster Management Act No. 13 of 2005 was enacted in May 2005. It provided for the establishment of a powerful National Council for Disaster Management under the President, and the Disaster Management Centre (DMC) as the lead agency for disaster risk management in the country.

Having been designated a lower middle-income country (LMIC) by the International Monetary Fund, Sri Lanka now aspires to double its per capita income from US$ 2000 to US$ 4000 by 2015. The greatest challenge it faces in the context of retaining its current rating as a high performer on social and health indices among its new peers in the world is perhaps to ensure that the poorest and most vulnerable population groups continue to be included in the ambit of this new aspiration and success. There is thus an urgent need for modernization of the health system that will require enhanced investments, and to revamp the health financing mechanism in a manner that enhances effectiveness, efficiency and equity simultaneously.

The country needs a healthy and productive population to retain its MIC ranking. The rapid ageing of the population and the relentlessly increasing burden of noncommunicable diseases (NCDs) are some impediments in its way. The effective management of these two issues is, therefore, a critical pre-requisite for retaining the MIC ranking. NCDs have already become the largest contributor to the disease burden in Sri Lanka, accounting for 85% of disability-adjusted life years (DALYs) in the country.
The need for increased investments means overcoming the fiscal constraints by utilizing the Government’s resources and by leveraging development partners such as the World Bank and the private sector, while simultaneously seeking additional mechanisms for health-care financing. While the public sector health services (both preventive and curative) cover the whole country, there is a growing private sector with an increasing market share that fills the gaps in the public system especially in the curative sector. A little over 50% of the total health expenditure is financed by the private sector, which provides roughly 50% of all outpatient care and 10% of inpatient care. The high rate of out-of-pocket expenditure (mainly for outpatient visits, drugs and laboratory tests) also needs to be addressed. One option could be to consider revamping Agrahara², making it a progressive financing mechanism and extending its coverage to the organized labour force beyond the pool of public servants. A well-defined benefit package could be included in the scheme to cover items that currently attract out-of-pocket spending.

² National health insurance scheme for public servants
2 — Health and development challenges

2.1 Demographic situation in Sri Lanka

The population of Sri Lanka in 2010 was estimated at 20.4 million. In the early 1950s, there was a population boom in the country. However, with an effective maternal and child health programme in place, made possible by a high female literacy rate (89.2%), the annual population growth rate was reduced to 1.3%, the current level (Table 2.1). With an increase in life expectancy at birth (currently 73 years) and a female life expectancy that is nine years higher than that of males, along with steady declines in the total fertility rate till 2000 (1.9), which has increased lately to 2.3 (DHS 2006), and the crude death rate (5.9 per 1000 population in 2003), Sri Lanka is ageing rapidly. It is projected that by 2026, 18.9% of Sri Lanka’s population will be 60 years of age or above. These trends clearly indicate that Sri Lanka is entering the third stage of the demographic transition (Figure 2.1).

Table 2.1: Demographic situation in Sri Lanka

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (2010)</td>
<td>20,409,900</td>
</tr>
<tr>
<td>% aged under 15 (2005)</td>
<td>24</td>
</tr>
<tr>
<td>Population distribution % rural (2010)</td>
<td>86</td>
</tr>
<tr>
<td>Life expectancy at birth (2008)</td>
<td>69</td>
</tr>
<tr>
<td>Under-5 mortality rate per 1000 (2008)</td>
<td>17</td>
</tr>
<tr>
<td>Maternal mortality ratio per 100,000 live births (2008)</td>
<td>33.5</td>
</tr>
<tr>
<td>Total expenditure on health % GDP (2007)</td>
<td>4.2</td>
</tr>
<tr>
<td>General Government expenditure on health as % of general Government expenditure (2007)</td>
<td>8.5</td>
</tr>
<tr>
<td>Human Development Index, out of 169 countries (2010)</td>
<td>91</td>
</tr>
<tr>
<td>Gross national income (GNI) per capita US$ (2009)</td>
<td>1,990</td>
</tr>
<tr>
<td>Population living below poverty line % (2007)</td>
<td>15.2</td>
</tr>
<tr>
<td>Adult (15+) literacy rate (2006)</td>
<td>90.8</td>
</tr>
<tr>
<td>% population with sustainable access to an improved water source (2007)</td>
<td>90</td>
</tr>
<tr>
<td>% population with sustainable access to improved sanitation (2008)</td>
<td>91</td>
</tr>
</tbody>
</table>

Sources: 1 United Nations Population Division; 2 World Health Statistics 2010; 3 World Development Indicators 2011 (World Bank); 4 International Human Development Indicators (UNDP); 5 Family Health Bureau, Ministry of Health
The current population bulge in the reproductive age group underlines the increasing reproductive health needs of the population. There is also a need to carefully look into the impact of the marginal increase in the total fertility rate (TFR) on other maternal and newborn outcomes. Also, the impact of the expansion of the post-reproductive age population needs to be ascertained, especially the effect on women’s health and health care needs.

As much as the ageing of the population is a distressful reality for Sri Lanka, “the demographic bonus” - or the higher proportion of the working age population relative to the dependent population - is also a reality, one which augurs well for the development planning efforts in the country in the 21st century. It is a period that can be described as a golden window of opportunity and is expected to last for about 26 years from 1991 to 2017.

### 2.2 Current state of development

Sri Lanka’s graduation from the International Monetary Fund’s Poverty Reduction and Growth Facility is one tangible indicator of the country’s economic success. This success was achieved through a model of economic growth that prioritized investment in the people, on the basis of recognition of the fact that human development is essential for economic development. Sri Lanka’s social indicators, such as life expectancy, mortality rates and literacy rate, are leading among developing countries and some statistics
are comparable with those of developed countries. Importantly, the social welfare paradigm in Sri Lanka ensured that economic growth has come, to a large degree, without sacrificing equity.

2.3 Health situation in Sri Lanka

Fertility and mortality trends

The infant mortality rate (IMR) has declined steadily (10.1 per 1000 live births in 2006) since the beginning of the last century. In 2006, the neonatal mortality rate was 7.4 per 1000 live births (Registrar General) and neonatal deaths accounted for nearly 80% of infant deaths. 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 (Figures 2.2 and 2.3). The common causes of maternal mortality are postpartum haemorrhage, pregnancy-induced hypertension (PIH), complications due to heart disease and complications due to incomplete abortion. Figure 2.4 shows the significant inter-district variations in the infant and maternal mortality rates. The regional disparity was observed in TFR as well. According to 2006 DHS, TFR was 2.3% at the national level, while in the plantation sector and Batticaloa district it was 2.6%.

Figure 2.2: Maternal mortality ratio (per 1000 live births), 1930–1996
**Figure 2.3:** Maternal mortality ratio (per 100 000 live births), 1992–2008

![Graph showing maternal mortality ratio (MMR) from 1992 to 2008.](image)

**Figure 2.4:** Inter-district variation of MMR (per 100 000 live births), 2010

![Graph showing inter-district variation of MMR in 2010.](image)
**Figure 2.5:** Total fertility rate, 1953–2007

**Figure 2.6:** Trends in infant and neonatal mortality rates
Maternal, child, adolescent and reproductive health

Sri Lanka has achieved remarkable progress in providing maternal care over the years, and this has been the foundation for its present health-related successes and achievements. The provision of antenatal care extends to 100% of the population and 95% of mothers are registered for care before 12 weeks of pregnancy. About 85% of postnatal women receive at least one postnatal visit from the PHM during the first 10 days. Almost all women deliver in hospital and 99% receive skilled attendance during childbirth, while 84% deliver in hospitals with specialized facilities. However, the status of some indicators, such as the caesarean section rate (30% in 2008), low birth-weight rate (16.6% in 2007), prevalence of anaemia among pregnant women (16.6%), and prevalence of protein energy malnutrition (BMI of less than 18.5) among pregnant women (29% at the time of registration), are causes of concern for those involved in the implementation of the maternal and child health (MCH) programme.

The national Demographic and Health Survey (DHS) carried out in 2006 revealed that the malnutrition rates among children were high - 21.6% of the children surveyed were underweight, 15% were “wasted” and 18% were “stunted”. These rates have improved only marginally since the previous DHS survey in 2000.

Figure 2.7: Trends in under-nutrition among under-five children (DHS 1975 - 2006)
Figure 2.8: Prevalence of underweight among children aged less than five years, classified by district (DHS 2006–2007)

Figure 2.9: Prevalence of stunting among children aged less than five years, classified by district (DHS 2006)
Magnitude and extent of noncommunicable diseases and trends in major risk factors

The epidemiological transition is clearly visible in Sri Lanka. During the past half a century, the proportion of deaths due to circulatory diseases has increased eight fold from 3% to 24%, while that due to communicable diseases has decreased by half from 24% to 12%. Mortality rates from noncommunicable diseases (NCDs) are currently 20%–50% higher in Sri Lanka than the average in developed countries (Figures 2.11–2.14).

Figure 2.11: A comparison of mortality rates for NCDs in Sri Lanka and developed countries

Data are age-standardized mortality rates for 2000-2002
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 in Sri Lanka.

**Figure 2.12: NCD burden - mortality**

![NCD mortality: percentage of NCD deaths out of all deaths, Sri Lanka, 2008](source)

Source: WHO Global Health Observatory 2011 http://apps.who.int/ghodata/

**Figure 2.13: NCD burden - morbidity**

![NCD burden: percentage out of all disease burden, and a share of major NCDs out of NCD burden, Sri Lanka, 2004](source)

Source: WHO Global Health Observatory 2011 http://apps.who.int/ghodata/
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 (Figure 2.15).

Addressing the social determinants of health (SDH) is an integral part of the prevention and control of NCDs. The mortality pattern in Sri Lanka is one of a rise in overall mortality from NCDs in urban areas and among the richer segments of the population. 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 well to do (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 the NCD Policy and Strategic Framework, together with the medium-term operational plan. In addition, all districts have their own district plans in place. The development of policies, planning and assessments are coordinated at the central level.

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There is a need to set up a NCD surveillance system and discussions have been initiated for this purpose. The system would be useful for strategic planning and monitoring the progress made in prevention and control efforts. As a part of this surveillance system, it is necessary to improve the inpatient and outpatient data to allow for a more refined analysis.

The public sector provides 85%–90% of all inpatient care and 40%–50% of the outpatient care through a network of strategically placed hospitals of different levels. The private sector too plays a major role in service delivery and financing. Independent units, mostly in the urban areas, provide 50%–60% of outpatient care, with the remainder being inpatient care (Figures 2.16–2.17).
**Figure 2.16:** Expenditures on major NCDs by public and private sources (%), Sri Lanka, 2005

<table>
<thead>
<tr>
<th>Condition</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant Neoplasms</td>
<td>26.3</td>
<td>91.9</td>
</tr>
<tr>
<td>Other Ischaemic Heart Disease</td>
<td>56.9</td>
<td>43.1</td>
</tr>
<tr>
<td>Acute Myocardial Infarction</td>
<td>13.4</td>
<td>86.6</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>18.8</td>
<td>81.2</td>
</tr>
<tr>
<td>Asthma</td>
<td>13.4</td>
<td>86.6</td>
</tr>
</tbody>
</table>

Source: Prevention and control of selected NCDs in Sri Lanka: policy options and actions (World Bank, 2010)

**Figure 2.17:** Expenditure on major NCDs by major spending areas (%), Sri Lanka

Source: Prevention and control of selected NCDs in Sri Lanka: policy options and actions (World Bank, 2010)
Pilot projects are in progress for the prevention and treatment of NCDs. These projects include the Package of Essential NCD interventions (PEN) supported by WHO (Figure 2.18), a project on health promotion and preventive measures for chronic NCDs supported by the Japan International Cooperation Agency (JICA), and the Nirogi Lanka project funded by the WDF. The Diabetes Prevention Task Force of the Sri Lanka Medical Association is piloting a project for the enhancement of the primary–tertiary care partnership in the management of NCDs. Further, the task force is making efforts to promote a team approach to care through the training of a cohort of nurse educators. It is also working on a community empowerment project in the urban areas of Colombo. 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, and for adoption of global indicators and targets relating to NCDs. Strong intersectoral coordination is imperative for the prevention of NCDs and WHO is well placed to support this effort.

**Figure 2.18:** WHO Package for Essential NCD Interventions (PEN) for primary care in low-resource settings

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**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 the infrastructure and information system required for the prevention and control of NCDs. Essential provisions for clinical investigations and the medical equipment necessary to diagnose and manage NCDs are often not available at many institutions at the primary and secondary care level. Another cause for concern is the inadequate supply of essential medication for the treatment of NCDs. The health information systems are reasonably well developed, but suffer from some major limitations. The data on both inpatients and outpatients do not contain key information on the patient’s characteristics and diagnosis, which limits the usefulness of the data for purposes of assessment and planning.

A formal referral system is not in place and government policy allows self-referral on demand to secondary and tertiary facilities. Thus, patients often use higher-level facilities under the impression that primary facilities lack the capacity to manage NCDs, for example, to conduct all the required clinical investigations and to provide the entire gamut of medications. This is, however, currently being addressed through the PEN initiative.

Sri Lanka’s total health expenditure is lower than that of other countries with similar demographics. The expenditure for the treatment of cancers and acute heart attacks is predominantly publicly financed (92% and 57% respectively from public sources). On the other hand, the expenditure on management of diabetes, asthma and other heart diseases is predominantly privately financed with 19%, 13% and 26% respectively coming from public sources. For cardiovascular disease, diabetes and asthma, about half of the total out-of-pocket expenditure is for outpatient care and medications.
Financing is a key issue and the options with respect to financing policy include mobilizing greater resources for NCD prevention and control (both from public and private sources), establishing a mechanism to raise higher contributions to the healthcare expenditure from richer population groups, increasing the overall efficiency levels in the public sector and reducing costs in the private sector, as well as expanding public financing of NCD drugs targeted at the poorer segments of the population.

Improving intersectoral coordination has also been identified as a priority for the achievement of policy goals.

**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 hospitalization since 1995 (Figure 2.19).

**Figure 2.19:** Injuries (traumatic injuries, burns, poisoning & others) - admissions to government hospitals (IMMR data)

Among unintentional injuries, road traffic injuries (RTI) represent the major fraction. In 2008, there were a total of 31,872 RTIs, of which 2,176 were fatal accidents, resulting in 2,328 deaths. In Sri Lanka, around 150 crashes are reported daily and an average of five to six lives are lost every day. Every year, Sri Lanka loses around 500,000 man-days owing to occupational injuries. In 2008, 49 fatal and 1,525 non-fatal injuries were reported from occupational settings (Industrial Safety Division, 2008). Unintentional home injuries are another important area which needs attention. The exact magnitude of this problem is not known (Figure 2.20).
**Figure 2.20:** Registered deaths in Sri Lanka (Registrar General’s Department, 2005)

<table>
<thead>
<tr>
<th>Injuries (30 548)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport accidents (2211)</td>
<td>7.2</td>
</tr>
<tr>
<td>Falls (956)</td>
<td>3.1</td>
</tr>
<tr>
<td>Accidental drowning and submersion (844)</td>
<td>2.8</td>
</tr>
<tr>
<td>Exposure to smoke, fire and flames (313)</td>
<td>1.0</td>
</tr>
<tr>
<td>Accidental poisoning and exposure to noxious substances (181)</td>
<td>0.6</td>
</tr>
<tr>
<td>Intentional self-harm, Assault, Disappearance (5062)</td>
<td>16.6</td>
</tr>
<tr>
<td>All other external causes (20 981)</td>
<td>68.7</td>
</tr>
</tbody>
</table>

**Mental health situation**

Sri Lanka is experiencing an epidemiological transition: noncommunicable diseases and mental health are beginning to figure increasingly in the morbidity and mortality patterns. The magnitude of substance and alcohol abuse has also increased over the past two decades, and pesticide poisoning, which has been the cause of many suicides, has been a long-term problem. Sri Lanka has among the highest suicide rates in the world. Though there is a declining trend in suicides now, on an average 11 people commit suicide every day. The psychological well-being of the people in Sri Lanka is a matter of great concern, as not only is the suicide rate but the level of alcohol and substance abuse is high; there are numerous bids to inflict harm on the self; domestic violence is common; and child abuse is not rare.

Before the 2004 tsunami, mental health services in Sri Lanka were offered predominantly by large institutions in or near Colombo. The pool of trained staff in the country was extremely limited and there were a few facilities, mainly concentrated in the urban areas of the districts of Colombo, Kandy and Galle. There was increased political commitment in the area of mental health after the tsunami and the priorities changed dramatically.

WHO is supporting the Government of Sri Lanka in the development of effective and humane decentralized mental health services in line with the National Mental Health Policy of the country. This policy was developed with the support of WHO and was adopted by Parliament in 2005. By 2011, 20 of the 26 health districts (77%) had functional acute inpatient units within general hospital settings, compared with 10 out of 26 districts (38%) before the tsunami (Figure 2.21). There are 16 (62%) fully functional intermediate-stay rehabilitation units, compared to only five (19%) such units in 2004.
Outreach clinics for mental health have been established in almost all the major MoH divisions in the country. All the districts in Sri Lanka now have at least one or two doctors holding a diploma in psychiatry. Apart from this, there were 131 Medical Officers of Mental Health (MOMH) and 34 Medical Officers of Psychiatry (MO, Psychiatry) serving in different parts of the country in 2011 (Figure 2.22). The Mental Health Action Plan, in line with the Mental Health Policy, recommends that a minimum of two nurses should be working in the field of mental health in each district. Accordingly, 46 nurses have been trained in community mental health and appointed in different districts (Figure 2.23). This was a significant milestone in the history of the development of mental health services in Sri Lanka.

In general, it is now felt that mental health services, which were predominantly hospital-based in the past, have to be expanded to the community. There is also an awareness of the fact that many mental illnesses are not recognized because of the social stigma they invite and also, due to lack of awareness among people. Therefore, there is a need to pilot community mental health and psychosocial models in different settings. A community-based approach could minimize the disease burden in the community. Support has been extended by WHO and other partners to improve the country’s capability to develop evidence-based strategies, programmes and interventions for the prevention and management of mental illnesses and related issues, including suicidal behaviour.

**Figure 2.21:** Expansion of mental health care facilities 2004 – 2011
Figure 2.22: Human resource development – Medical Officers, Mental Health

Figure 2.23: Human resources development in mental health

2.23a: Diploma holders in psychiatry

2.23b: Community psychiatric nurses
Communicable diseases

If one takes an overview of the South-East Asia Region, Sri Lanka’s achievements in the sphere of the control of communicable diseases are commendable. Sri Lanka is on the verge of eliminating lymphatic filariasis, leprosy, malaria and poliomyelitis. However, the country experiences outbreaks of infectious diseases such as dengue and leptospirosis periodically. Sri Lanka reported the largest outbreak of dengue in 2009, when 35 008 cases were recorded. In the following year, a total of 34 105 cases were reported (Figure 2.24). The case fatality rate (CFR) was nearly 1% during this biannual period (2009–2010). The striking increase in the incidence of dengue and its severe manifestations necessitated the mobilization of support from many sectors, along with the establishment of the Presidential Taskforce on Dengue (Figure 2.25). A total of 28 473 cases and 185 deaths were reported in 2011 (CFR 0.7%).

Figure 2.24: Trend of morbidity and mortality for dengue (1992–2011)

![Dengue Cases and Deaths 1992-2011](image)

Source: Epidemiology Unit

A street drama to create dengue awareness

Public Health Inspectors mobilize community action for Dengue Control
Figure 2.25: Presidential Taskforce on Dengue
A disease that has re-emerged is leptospirosis (Figure 2.26). In 2008, the country experienced the largest-ever outbreak, with 7423 cases and 207 deaths (CFR 2.8%). In 2011, a total of 6689 cases and 96 deaths (CFR 1.4%) were reported.

Figure 2.26: Trend of morbidity for leptospirosis (1992–2011)

The Expanded Programme on Immunization (EPI) in Sri Lanka is among the most successful in the Region as well as globally. It has achieved high vaccine coverage and resulted in an extremely low incidence of vaccine-preventable diseases (VPD) (Figures 2.27 and 2.28). The last case of poliomyelitis was reported in 1993 and diphtheria in 1996. However, there are certain issues that still require attention. These include vaccine coverage among schoolchildren, laboratory confirmation of reported cases of VPD, investigation of adverse events following immunization (AEFI) and disparities between different districts in the quality of services.

From 2001 to 2009, 50–100 human rabies deaths were reported annually in the country. The total number of deaths fell to below 50 for the first time in 2010. In 2010 and 2011, only 49 and 41 deaths were reported respectively. The most likely reasons for the programme’s slow progress in the elimination of rabies were low vaccination coverage among the dog population and ineffective management of stray animals. Annually, a large component of the health budget is spent on post-exposure treatment (PET) following animal bites.
**Figure 2.27:** Measles immunization coverage and number of reported cases (1985–2010)

Source: Epidemiology Unit

**Figure 2.28:** Pertussis (whooping cough) immunization coverage and number of reported cases (1985–2009)

Source: Epidemiology Unit
Sri Lanka is among the countries in the Region that have a low prevalence of tuberculosis (TB) (Figure 2.29). Since 2000, the annual incidence rate of new TB cases has remained around 40 per 100 000 population. However, there are disparities between the districts. The annual mortality rate for TB remains between 1 and 2 per 100 000 cases. In 2011, out of 9508 new cases, 72.5% were detected to be pulmonary TB cases; among them 65.1% were smear-positive. The number of laboratory-confirmed multidrug-resistant tuberculosis (MDR-TB) cases in 2011 was 13.

Sri Lanka is considered a low-prevalence country in the context of 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%. Though there is a preponderance of males among those infected, the proportion of females infected is increasing over the years.

Sri Lanka has made tangible progress towards elimination of leprosy. More cases are being detected since the leprosy services were integrated into the general health services. A gradual increase in the proportion of multibacillary cases among new patients has been observed since 2002. The proportion of child cases and the deformity rate had come down compared to the figures reported in early 2000s indicating disruption of transmission and detection of cases in early stages. However, a marginal increase in the above figures has been noticed in recent years, which is a concern for the programme.

Five rounds of mass drug administration (MDA) have been conducted successfully in all endemic districts resulting in the elimination of lymphatic filariasis (LF) from Sri Lanka. Meanwhile, WHO continues to support disability prevention and rehabilitation programmes targeted at those who had the disease.
Malaria is no longer a major public health problem in Sri Lanka and the country is planning to eliminate malaria by 2015. The disease burden has come down significantly and currently, the country is witnessing only sporadic cases and occasional outbreaks (Figure 2.30). There has been a dramatic reduction in the case load in the past decade, the number of cases falling from 210,039 in 2000 to 124 in 2011. Apart from the total number of cases, the proportion of falciparum cases has also come down over the years. In 2000, the proportion of falciparum cases (including mixed infection) was 28.4% and by 2011, this figure had fallen to 3.2%.

Figure 2.30: Confirmed cases of malaria, 1985–2010

Source: Anti Malaria Campaign

National Reference Laboratory at the Medical Research institute, Colombo.
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 the epidemic during 2009–2011 that placed a significant burden on the health services (Figure 2.31).

**Figure 2.31:** Distribution of confirmed cases of H1N1 influenza by time during the first and second waves

**First Wave: Distribution of confirmed H1N1 cases by week (June 2009-Feb 2010)**

1st Wave
- No. of cases: 642
- No. of deaths: 48

**Second Wave: Distribution of confirmed H1N1 cases by week (Sep 2010-Jan 2011)**

2nd Wave
- No. of cases: 552
- No. of deaths: 28

Source: Epidemiology Unit
With regard to implementation of the International Health Regulations (2005), specific units have been designated for public health risk surveillance and coordination of communication during public health events. Further, a national public health emergency response plan for hazards and point of entry is also available.

2.4 Health systems

Sri Lanka holds a unique position in the WHO South-East Asia Region as one of the first of the developing nations to provide universal healthcare and free education to its people, along with 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 the state and private sectors. The health services of the government are headed by a cabinet minister. The responsibility of protecting and promoting the health of the people lies primarily with the Ministry of Health (MoH). The ministry’s key functions include the formulation of policy guidelines, supervision of medical, nursing and paramedical education and training, management of teaching and specialized medical institutions, and procurement of medical supplies (Annexure I: Organogram of MoH).
The enforcement of the Provincial Councils Act in 1989 led to the devolution of health services. As a result while the MoH continued to function at the national level, separate provincial ministries of health have emerged in the nine provinces. Currently, there are 25 Regional Directors of Health Services (RDHS) who assist nine Provincial Directors of Health Services. Further, there are several middle-level managers under the purview of RDHS dealing with different technical areas (Figure 2.32). The district under each RDHS is subdivided into several areas, each under a Medical Officer of Health (Annexure II: Organogram of District Health Services). The MoH and the provincial health services provide a wide range of promotive, preventive, curative and rehabilitative health care through an extensive network of health-care institutions (Figure 2.33).

**Figure 2.32:** Middle-level health managers at district level

The challenges faced by the health system are many. A major challenge relates to the sustainability of the free health services at the point of delivery. Though this system is supposed to ensure universal access to health, the fact is that currently, the out-of-pocket expenditure on outpatient care is more than 50%. The health-care financing policy is being revised to address this problem.
Figure 2.33: Government health institutions in Sri Lanka
The health information system has been reviewed and is being revised to further enhance its analytical capacity and utility. There are plans to revitalize primary health care to enhance quality at all levels. As a prerequisite, efforts are on to create more regularized referral systems. Further, the social determinants of health (SDH) are being given importance at all levels to ensure truly universal access to health.

**Health-care financing**

Although the health care 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 in the national agenda, and social health protection priorities for the next 4–5 years have to be identified and 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 people’s health status and reduce inequalities. Now that Sri Lanka is a middle-income country (MIC) and aspires to double the GDP (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 modernization of the health system has to 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 recognized the importance of National Health Accounts (NHA) and is taking steps to institutionalize them in Sri Lanka.
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 utilization is a prerequisite for better functioning of the health system, as is the provision of an enabling working environment and proper supporting logistics. Table 2.2 shows the human resources for health per 100,000 population in the SEAR countries.

**Table 2.2:** Human resources for health per 100,000 population in SEAR countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Doctors</th>
<th>Nurses</th>
<th>Midwives</th>
<th>Dentists</th>
<th>Pharmacists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>3</td>
<td>1.4</td>
<td>1.8</td>
<td>0.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Bhutan</td>
<td>2</td>
<td>8</td>
<td>0.8</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>32</td>
<td>37</td>
<td>2.7</td>
<td>3.7</td>
<td>6</td>
</tr>
<tr>
<td>India</td>
<td>7</td>
<td>8</td>
<td>4.7</td>
<td>0.6</td>
<td>5.6</td>
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<tr>
<td>Indonesia</td>
<td>2</td>
<td>13</td>
<td>2</td>
<td>0.3</td>
<td>0.3</td>
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<tr>
<td>Maldives</td>
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<td>33</td>
<td>N/A</td>
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<td>7.3</td>
</tr>
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<td>Myanmar</td>
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<td>4</td>
<td>6</td>
<td>0.3</td>
<td>N/A</td>
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<tr>
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<td>2</td>
<td>2</td>
<td>2.4</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Sri Lanka</td>
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<td>14</td>
<td>1.6</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Thailand</td>
<td>3</td>
<td>14</td>
<td>1.7</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>Timor-Leste</td>
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<td>4</td>
<td>0.5</td>
<td>0.2</td>
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</table>

Source: 11 Health Questions from 11 SEAR Countries
The government is also addressing the issue of the management of the human resources in health in the context of equity and the epidemiological and demographical transitions. The end of the prolonged civil conflict has paved the way for better deployment of human resources in the Northern and Eastern provinces.

The curriculum of the paramedical and the allied health science courses is being revised to ensure that the health workforce is equipped to address the present health needs more effectively.

**Development of pharmaceutical sector**

A major challenge facing both the public and private health sectors is the provision of access to safe, efficacious and good-quality medical products and technologies. Irrational use of the medicines that are available leads to wastage of government funds. 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.

There is a severe shortage of qualified pharmaceutical personnel, both in the state and private sectors. Although there are few options available with the Ministry of Health to train them, none of these is suitable for the present-day needs, especially in the field of drug evaluation, analysis and management. The pharmacists trained at a higher level under the Ministry of Higher Education are not absorbed into the state sector.

**Natural and man-made disasters**

Natural disasters 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. In terms of 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

Man-made disasters, including conflict, fire and other hazards, also occur regularly (Figure 2.34). An obvious example is the 30-year armed conflict between the separatist militant organization 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 (Figure 2.35). When people returned to their homes after the conflict, they found themselves in areas with damaged social infrastructure and very limited health services.

¹ A Global Report, Reducing Disaster Risk, A Challenge for Development, UNDP 2004
Figure 2.34: Incident Summary

Source: UNOCHA/DMC
Man-made disasters 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.

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, there are still several gaps in the health system and many health needs have yet to be met. The process of revitalizing the health system cannot be completed overnight. It may take a few more months, or even years, of continued hard work and support from all stakeholders for the MoH to completely repair the damaged health system in the North and East provinces.

Emergency preparedness and response

The end of the armed conflict between a separatist militant organization and the Government of Sri Lanka in May 2009 has given the country an opportunity to rebuild its health system, which, as mentioned earlier, was damaged during this long period of strife. The damaged health facilities are being either rehabilitated or reconstructed and medical equipment is being replaced. The health staff is being trained and equipped with the necessary technical skills. Though there has been considerable progress in the last two years, much work remains to be done, especially in terms of restoring the damaged health systems to a level that is comparable with the standards seen in the rest of the country.
Sri Lanka will continue to experience natural disasters such as cyclones, floods and landslides, particularly as a result of climate change. In addition, global threats from avian and pandemic influenza will continue to pose a risk to the health of the people in the country. Therefore, the government will continue to require support in the areas of disaster preparedness, mitigation and response activities.
The three decades of conflict between a separatist militant organization and the national government finally ended in May 2009, and with the resulting peace, there was a renewed 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 Sri Lankan Rupees 6302 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 province.

Although the international community would continue to support development activities in the health sector, it is projected in 2012 that it might not be at the same level of support as for the humanitarian response during the recent civil conflict.

As shown in Figure 3.1, there is 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.

Launching of a Directory on Partners for Health - April 2011
3.1 Traditional development partners

Bilateral donors

Japan has been a significant bilateral donor to Sri Lanka since 2003. The Japan International Cooperation Agency (JICA) has provided technical expertise to the MoH to strengthen the health systems through policy development and health infrastructure development. The Korean International Cooperation Agency (KOICA) has provided funds to the MoH to construct the Tissamaharama Base Hospital in the district of Hambantota and the Base Hospital at Avissawella in the district of Colombo.

The Italian government, through WHO, provided support for the rehabilitation of the Nelukulam District Hospital and the Cheddikulum Base Hospital in the district of Vavuniya, as well as the Padaviya District Hospital in the district of Anuradhapura to strengthen the MoH response to the displaced persons in the north.

China and India have also emerged as new donors to support the efforts of the MoH, contributing to the rehabilitation of health facilities and provision of medical equipment and ambulances.
**Development-oriented banks**

The World Bank has been supporting the health sector in Sri Lanka by helping it to adapt to the challenges resulting from the double burden of diseases. It attempts to do this by improving the degree of equity, quality and efficiency of the health system. The Health Sector Development Project (September 2004 to December 2010) was funded by the International Development Administration (IDA)/World Bank and implemented by the MoH and the provincial health authorities. The original grant was US$ 73 million, which consisted of an IDA grant of US$ 60.5 million and a contribution of US$ 12.5 million from the Government of Sri Lanka. Preparatory work is already in progress for the next Health Sector Development Project (HSDP). The World Bank will continue to strengthen the capacity of the district health management, as well as take steps to bolster health priorities, such as maternal and child health, noncommunicable diseases, nutrition and health system issues.

Through its NECORD project, the Asian Development Bank (ADB) has been assisting the MoH in improving health-care services through the reconstruction of health infrastructure facilities such as district hospitals.

**Specialized and funding agencies of the United Nations system**

The United Nations Development Assistance Framework (UNDAF) outlines the development objectives for the specialized and the funding agencies of the UN system. A new UNDAF document covering the period 2012–2017 is under preparation.

In the North-East, the United Nations Development Programme (UNDP) has been supporting the MoH in rebuilding the health infrastructure and in its efforts to create awareness of landmines. The United Nations High Commission for Refugees (UNHCR) has been facilitating the return of displaced people and their reintegration into their communities. The World Food Programme (WFP) provides emergency food assistance, assists in general food distribution, offers food for work and facilitates training for livelihood activities in the post-conflict areas. The Food and Agriculture Organization (FAO) assists with food production and the creation of home gardens etc. to generate more food. The International Labour Organization (ILO) is assisting in strengthening the development of human resources, eliminating child labour, and promoting occupational safety and health. The United Nations Population Fund (UNFPA) is supporting the government’s efforts to improve reproductive health through quality information, education and communication efforts. Mobile clinics on reproductive health have been deployed in areas that were earlier affected by conflict.

Two programmes of the International Organization for Migration (IOM) that are in operation are “Movement, Emergency and Post-Crisis Migration Management” and “Migration Health”. Under these programmes, the specialized agency supports emergency humanitarian action (in case of conflict and natural disasters) and post-conflict recovery of health systems. It also provides technical assistance to the Government of Sri Lanka in matters of migration, health and development.
**Global health initiatives**

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and Global Alliance for Vaccines and Immunizations (GAVI) are the two largest public–private partnerships in the health sector. The GFATM or the Global Fund was created to dramatically increase the resources to fight three of the world’s most devastating and pernicious diseases - AIDS, tuberculosis and malaria - and it disburses these additional resources to the appropriate activities.

The Country Coordinating Mechanism Sri Lanka (CCMSL) 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 organization, comprising the public sector, private sector, members of academia, civil society, faith-based organizations, multilateral/bilateral partners and people living with or affected by the target diseases. The WHO Country Representative to Sri Lanka takes an active part in the activities of the CCMSL, of which he is a member.

In the first nine rounds of funding by GATFM, Sri Lanka has received 14 grants - three for HIV, seven for malaria and four for TB - with approved funding of US$ 65 786 859. Of this, US$ 41 409 047 was disbursed by the mid-2012.

GAVI’s Health System Strengthening (HSS) Project was designed to address the need to develop a competent health workforce which can deliver primary care services efficiently and effectively. This project was implemented in the Northern and Eastern Provinces, districts of Badulla and Nuwara Eliya, and the seven regional training centres located in Galle, Ratnapura, Badulla, Kandy, Batticaloa, Jaffna and Vavuniya. The development of infrastructure facilities at the National Institute of Health Sciences at Kalutara was also later incorporated into the purview of the project since it is a national-level training centre. The duration of the project is five years, from 2008 to 2012, and its total cost is Sri Lanka Rupees 450 500 000.

**Nongovernmental organizations**

Since the response to the tsunami in 2004, when many national and international nongovernmental organizations (NGOs) supported the efforts of the MoH to address the health needs of the affected population, several NGOs have continued to play a crucial role in the health sector. During the humanitarian crisis of 2009, WHO worked in tandem with these organizations 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 organizations (INGOs) in providing essential health care.
3.2 Post-conflict relief and reconstruction

After the end of the conflict in May 2009, the process of rehabilitating all damaged health infrastructure and facilities in the northern part of the country began in earnest, starting with the affected areas in the Northern Province. The international community, including development banks such as the ADB and the World Bank, assisted the MoH in its efforts, which also covered the reconstruction of accommodation facilities for health staff. Attempts were made to step up the provision of medical equipment, furniture and supplies to these facilities, and to build the capacity of health workers. As with other UN agencies and INGO/NGO partners, support to the MoH was provided through the deployment of health workers from other parts of the country to the Northern Province, and through emergency ambulance services and mobile clinics to supplement the health services of the MoH.

Funding facilities such as the South-East Asia Relief and Emergency Fund (SEARHEF) have enabled the MoH to address the immediate health needs of the resettled population in the Northern Province. The UN’s Central Emergency Response Fund (CERF) and the Korean Fund for International Healthcare (KoFIH) have also provided immediate support to the MoH in this regard. Longer-term funding mechanisms, such as those of the Common Humanitarian Action Plan (CHAP) and the recently launched Joint Plan of Action (JPA) 2011, are resource mobilization initiatives to facilitate early development and recovery activities, and to rebuild the health systems that were affected in the conflict-hit areas.

Rebuilding the damaged health systems in the Northern Province will probably take many years. Meanwhile, the Government of Sri Lanka requires continued support for its efforts to ensure that the people returning to their homes in the Northern Province are provided with essential health services.
The World Health Organization, being a specialized technical agency of the United Nations, is mandated to provide Sri Lanka with technical and financial support in the sphere of health. The Organization’s main partner in the country is the Ministry of Health (MoH), with which it maintains close contact at the national, provincial and district levels. Apart from working with the government, WHO also collaborates with development partners, and key national and international stakeholders in the health sector. Its overall goal as stated in its Constitution is to support the people to attain the highest levels of health. This can be achieved by strengthening the health systems in Member States on the basis of the principles of equity, fairness and responsiveness.

Figure 4.1: AC and VC funding from WHO for Sri Lanka during last three bienniums

The figure above shows that the regular budget allocation for Sri Lanka from WHO has not changed much during the biennia 2006–07, 2008–09 and 2010–11.

4.1 Specific areas of WHO support

During the past six years (i.e. last three biennia), WHO’s inputs were mainly focused on the five key areas of Sri Lanka’s Strategic Framework for Health Development and the
Health Master Plan. Figure 4.2 shows the synergy and alignment between the Country Cooperation Strategy (CCS), the strategic objectives of the WHO work plan and the Health Master Plan of the MoH.

**Figure 4.2:** Synergy between CCS, strategic objectives and Sri Lanka’s Master Plan

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**Health system development**

**Primary health care:** The WHO Country Office (WCO) has been providing support for the revitalization of the primary health care system in Sri Lanka in view of addressing the social, economic, political and epidemiological transitions the country is going through. The new primary health care model aims at strengthening the referral system and enhancing the quality of health care. It is expected to be cost-effective, thereby contributing to a better health-care financing strategy.

**Health-care financing:** The health-care financing system has been revamped, with the support of the WCO, to retain the provision of free health care, while reducing the out-of-pocket expenses of the poor and enhancing social health protection.

**Health planning:** The WCO extended support to the MoH to build capacity for health planning, and monitoring and the evaluation of the health system.

**Health information system:** The health information system was reviewed with
WCO support and a strategic plan for health information is being developed. The WCO has helped to enhance the flow of health information by improving the quality of data and effective utilization of data. It has also supported the use of the Geographic Information System (GIS) at all levels of data collection in the country.

**Knowledge management and information:** Access to essential health information and knowledge assets has been made possible through the Health Literature, Library and Information Services (HeLLIS) and the Health Inter Network Access to Research Initiative (HINARI) Network. Access to HINARI was facilitated by the WCO, which also supported workshops for training on utilization of HeLLIS and HINARI.

**Human resources:** The Human Resource Strategic Plan has been developed with the support of WCO taking into consideration the country’s current and future health needs. The WCO has facilitated the formation of a human resource unit to help the MoH to streamline the management of human resources. It has supported training and capacity-building of the health workforce at various levels. A review of institutions and curricula, with special reference to the National Institute of Health Sciences, was carried out under the aegis of the WCO. The WCO has also helped in the repair and rehabilitation of the health infrastructure in the areas affected by the civil conflict, paying special attention to the development of human resources.

**Health research:** The WCO has helped to promote evidence-based public health research in the universities and the MoH. Capacity building of ethical review committees has also been supported by WHO.

**Social determinants of health:** The Lighthouse Project aimed at addressing the social determinants of health (SDH) was supported by the WCO in the following ways:

- Helping the MoH to coordinate SDH activities and to generate clear scientific evidence to inform and support the health policy-making process.
- Promoting a community approach, empowering the community and encouraging intersectoral participation to facilitate a holistic approach to health.
- Supporting a disease-based approach to tackle the SDH.

**Medical products and technologies:** WHO has provided significant support in this area by facilitating:

- Development of the National Medicinal Drug Policy and the National Blood Policy.
- Building capacity of the pharmaceutical and laboratory staff of the MoH through fellowships and in-service training programmes, both within the country and abroad.
WHO country cooperation strategy  Sri Lanka  2012-17

- Strengthening of health laboratories, and drug regulatory, quality assurance and supply divisions by providing reagents, standards and equipment.
- Support to universities and professional associations in advocacy programmes in the area of rational use of medicines.

Communicable disease control

WHO has provided technical and financial support to a number of communicable disease prevention and control programmes during the period 2006–2011, with special emphasis on pandemic influenza, emerging and re-emerging diseases such as dengue, leptospirosis, rabies, and surveillance of adverse events following immunization (AEFI) for vaccine-preventable diseases and diseases targeted for elimination, including leprosy, lymphatic filariasis and malaria. WHO has also been providing technical assistance for the development of the proposals for Global Fund for AIDS, Tuberculosis and Malaria (GFATM) support. Since 2003, GFATM has been financially supporting some strategic steps to prevent and control HIV, tuberculosis and malaria.

Technical assistance has been provided mainly for strengthening the capacity in planning, implementation, disease surveillance, monitoring and evaluation of disease control programmes, as well as for the development of guidelines and national strategic plans. The provision of critical medical supplies and equipment for the implementation of disease control programmes has also been bolstered. Further, WHO has been the sole partner providing technical as well as financial assistance for many communicable disease control programmes, especially for emerging and re-emerging diseases.

The WCO, through the biennial working plans as well as by mobilizing support from the WHO Headquarters and Regional Office, has provided specific technical and financial support in the following areas:

- Strengthening of clinical management of dengue fever/dengue haemorrhagic fever (DHF) resulting in the reduction of case fatality rate. Efforts have been made to enhance dengue control activities by promoting in-service training programmes for the staff in the health and other sectors. Supplies and equipment necessary for vector control and vector surveillance have been provided. Diagnostic facilities have been enhanced by providing ELISA facilities to three provincial laboratories. “Communication for behavioural impact (COMBI)” plan has been developed facilitating prevention and control of dengue and the plan is currently under implementation.
- Strengthening of AEFI surveillance for vaccine-preventable diseases.
- Development of evidence-based proposals for financial support from GFATM (Round 6 - TB control; Round 8 - malaria control; and Round 9 - HIV prevention; and Round 10 - TB control).
Bolstering of the lymphatic filariasis elimination programme by extending support to the Mass Drug Administration Programme and the Disability Prevention Programme.

Strengthening of rabies control activities by providing support for improving canine vaccination coverage, training dog vaccinators, conducting review meetings to monitor and evaluate control strategies, implementing animal birth control activities, and development of behaviour change communication material for prevention of dog bites.

Capacity building of rapid response teams at the district level.

Strengthening of disease surveillance activities at the points of entry, especially in the context of pandemic influenza outbreaks (avian influenza and A/H1N1 influenza 2009). Support was provided for mitigation of the effects of pandemic A/H1N1 influenza.

Capacity building of health staff working in the national malaria, TB and HIV programmes at the central as well as district levels.

Strengthening of communicable disease surveillance activities.

Prevention and control of neglected tropical diseases, such as cutaneous leishmaniasis, leprosy and leptospirosis.

Development of national strategic plans for prevention and control of TB, STD/HIV and malaria.

Development of national guidelines/ manuals for several disease control programmes.

**Maternal, newborn and child health**

WHO extended support to conduct an external programme review of Maternal and Newborn Health. The following recommendations were made after the review:

- Support the development of the national strategic plan for maternal and newborn health (MNH) for the period 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.
- Redesign the package for maternal care services delivery to suit new and emerging demands.
Technical support was provided for the development of protocols and guidelines on:

- Management of labour rooms, post-partum care in the field, and neonatal intensive care units/special care units for babies.
- Adaptation of Pregnancy Childbirth Post-partum Newborn Care (PCPNC) manual.
- Adaptation of the medical eligibility criteria (MEC) wheel for family planning.

Assistance was also provided for printing of the above protocols and guidelines and introduction into the system with staff training.

WHO also supported the introduction of new training packages in the following areas to scale up essential interventions and effective programme planning:

- Essential Newborn Care Course (ENCC)
- Baby-Friendly Hospital Initiative (BFHI)
- Infant and Young Child Feeding (IYCF)
- Operational Guidelines on Adolescent Health
- Short Programme Review on Child Health (adapted as programme review on maternal and child health)
- Programme Planning on Child Health (adapted as programme planning on MCH)
- Master training programme on MCH (training was extended to the districts in partnership with UNFPA and UNICEF).

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
- Input and process indicators to monitor the progress in the implementation of the Millennium Development Goals 4 and 5.

Research and surveys were also conducted on the following during the period of the last CCS:

- Multicountry 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 symphisio-fundal height to assess uterine growth in pregnancy
- District surveys to assess the MCH service delivery status.
In addition, an assessment was made of the laws and policies on adolescent sexual and reproductive health.

**Gender:** The following initiatives were taken in order to promote gender equality and to empower women:

- Capacity-building of health staff in primary prevention and comprehensive management of gender-based violence utilizing a multisectoral approach based on the principles of ethics and human rights.
- Introduction of a needs-based health-care delivery service to deal with the violation of ethics and human rights of migrant women workers and their families.
- Strengthening the capacity for addressing disparities in women’s health and advocating the significance of the SDH, facilitated through a multisectoral approach.

**Nutrition:** In the field of nutrition, WHO supported the following initiatives:

- Reviewing the nutrition policies and strategies (landscape analysis) and development and implementation of district plans on nutrition.
- Updating and mainstreaming food-based dietary guidelines (FBDG) and hospital nutrition guidelines.
- Strengthening the nutrition surveillance system.
- Enhancing capacity in the field of food safety.
- Establishment of the National Council on Nutrition.
Promoting healthy lifestyles and reducing environmental risks

The development of the NCD Policy and Strategic Framework and the medium-term operational plan, supported by WHO, has been a major achievement. Though the policy development, planning and assessments are coordinated at the central level, under the National NCD Policy and Strategic Framework, districts have developed their own district plans.

A national NCD surveillance system needs to be established and discussions have already been initiated in this regard. The proposed surveillance system will include: behavioural risk factors, morbidity and mortality associated with NCDs, utilization of health services, quality of care, and special registries (such as for cancer and injuries). This will assist in strategic planning and help to assess the progress of prevention and control efforts.

Pilot projects are under way for the prevention and treatment of NCDs. These 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 and the Nirogi Lanka Project funded by the WDF. These pilot projects are expected to add to the evidence-base that would serve as a valuable resource for the development of prevention and control policies.

WHO, in collaboration with the UN Regional Commissions, is the coordinator of road safety activities. It supported the initiatives of the Parliamentary Select Committee on Road Safety, including the development of the Framework of Action for the Decade of Road Safety.
Emergency preparedness and response

During the past biennium, WHO assisted the MoH in the finalization of the draft for the “Strategic Plan for Health Sector Disaster/Emergency Preparedness”. This strategic plan was finalized and published by the end of 2011.

In addition to this, the final draft document for the Emergency Standard Operating Procedures (SOPs) was prepared in the last quarter of 2010. A stakeholders’ meeting to finalize this document was organized 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.

WHO assistance for flood response

There has been a significant rise in the number of natural disasters in the past decade due to global warming. Sri Lanka has been prone to recurrent floods and in the past six years, the frequency and severity of these floods has 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.
WHO was instrumental in mobilizing 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 material needed to ensure the availability of drinking water to the affected population. The WHO staff also made 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.

**Rehabilitation and reconstruction in the Northern Province**

WHO mobilized 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 in the Northern Province. Regular health cluster meetings were organized in Colombo and Vavuniya district to provide a platform for information sharing with the MoH and other health partners at the central and field levels, and to identify the gaps and needs of the affected population. The cluster mechanism provided a forum for consultations with the health cluster partners which led to the formulation of the Common Humanitarian Action Plan (CHAP) and the Joint Plan of Action (JPA) 2011.

**Provision of essential health services:** WHO supplemented the MoH’s efforts to provide health services to more than 300,000 displaced people who were accommodated in the welfare centres in Vavuniya district by providing inter-agency emergency health kits (IEHK). In addition, it bolstered the operational capacity of the MoH through redeployment of health workers from other parts of the country to Menik Farm in Vavuniya. Emergency ambulances were provided to strengthen emergency referral services from different welfare centres. Doctors and nurses working in Menik Farm were provided with temporary accommodation to reduce their travel time to and from Menik Farm. Identified health facilities were revived to cater to the increasing number of consultations and admissions from the welfare centres and additional medical equipment was also provided.

In the resettlement areas, WHO supported the mobilization of health assistants to cater to the needs of the population returning to these areas. These health workers offered preventive and curative services, and were responsible for the referral of emergency cases to tertiary health facilities. In addition, WHO supported the rehabilitation of some of the health facilities that had been identified as priority facilities, such as the Vaddakachchi and Dharmapuram divisional hospitals. Medical equipment and supplies were also provided to other major hospitals in the Northern Province.
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 with much focus on Menik Farm. In Menik Farm, WHO helped to mobilize retired public health inspectors (PHIs) to collect daily morbidity data from different welfare centres, and to immediately follow up and refer suspected cases of communicable diseases with outbreak potential to close-by hospitals. They were also involved in ensuring the quality of the drinking water provided to the displaced population, and monitoring hygiene and sanitation standards. PHIs were also later mobilized to strengthen the disease surveillance and response system in the resettlement areas. WHO, along with the MoH, produced an epidemiological update/report every week and shared this with all the partners to inform them about the health situation in Menik Farm.

Capacity-building of health workers: In collaboration with the MoH, WHO supported training programmes for health workers deployed at Menik Farm. These training programmes were mainly on communicable disease surveillance, emergency treatment and management including trauma care, laboratory diagnosis and water quality monitoring. Similar training programmes were later conducted for health workers in the resettlement areas also. In one of the training programmes conducted by the College of Surgeons in Jaffna, refresher training courses were provided for doctors and nurses working in emergency treatment units (ETU).

Mental health and psychosocial support

WHO has been supporting the Government of Sri Lanka in the development of effective and humane decentralized mental health services, in line with the National Mental Health Policy, which was developed with assistance from WHO and adopted by Parliament in 2005.

WHO focused on the following priority areas with the aim of building a cost-effective and comprehensive mental health system:

- Provision of acute inpatient care through general hospitals and intermediate care facilities
- Establishment of outreach clinics at MoH divisions
- Bolstering basic human resources
- Development of a community-based workforce that identifies and follows up persons with severe mental disorders and provides basic care to persons with mild to moderate mental disorders.

Post-traumatic stress disorders (PTSD) and other mental illnesses are common among people who have experienced severe traumatic conditions in their lives. For the displaced people accommodated in Menik Farm, this issue was addressed and
managed appropriately. In collaboration with the MoH’s Mental Health Unit and the College of Psychiatrists, WHO has supported the mobilization of community support officers (CSO). These officers, recruited from local communities, served as the link between people with mental health and psychosocial problems, and the nearest health facility. The CSOs also assisted in the follow-up of clients at the household level, and identified new cases and referred them for proper management.

4.2 Overall performance in priority areas

In Table 4.1, an attempt has been made to evaluate the performance in the priority areas identified in the previous CCS vis-à-vis the six core functions of WHO. The scoring in this table is based on the scope of work conducted under the regular budget and the actual budget spent. It is not an attempt to evaluate the quality of the support provided – this has been done through a number of specific monitoring and review exercises.

Three of the 5 priority areas received the most assistance: emergency preparedness and response, child, adolescent and reproductive health, NCD and mental health, which is consistent with the country situation reflected in the post-tsunami period, major humanitarian operation in the north and the frequent natural disasters such as floods, and the epidemiological transition from communicable to noncommunicable diseases. The core functions mainly focused in this assistance were providing technical support, providing leadership and articulating ethical and evidence-based policy positions.

Scoring in this table indicates the priorities for the support that served to guide WHO activities.
Table 4: Prioritization of WHO’s Core Functions in Relation to the Priority Areas of the CCS, 2006 - 2011

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<tr>
<th>Priority Areas Identified in CCS 2006-2011</th>
<th>WHO’s Core Functions</th>
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<tr>
<td></td>
<td>Providing leadership on matters critical to health and engaging in partnerships where joint action is needed</td>
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<td>The Health System</td>
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<tr>
<td>Human Resources for Health</td>
<td>++ +</td>
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<tr>
<td>Communicable disease control</td>
<td>++</td>
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<tr>
<td>Noncommunicable Diseases and Mental Health</td>
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<tr>
<td>Child, Adolescent and Reproductive Health</td>
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<td>Emergency Preparedness &amp; response</td>
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5 Strategic agenda for WHO cooperation

5.1 Prioritization process to select the strategic priorities and focus areas

A country cooperation strategy (CCS) drafting team was set up in the WHO Country Office in early 2011. The team was led by the WHO Representative. The CCS team gathered and shared essential information and data, and also undertook a process of documentation. Then the team made a critical analysis of the situation with respect to health and development; the national health policy and strategic plans; the cooperation with WHO over the past CCS cycles; and the contributions of other UN agencies and the development partners.

Extensive consultations were held with the stakeholders to review the performance of the CCS 2006–2011 and to obtain the stakeholders’ views in the context of the formulation of the CCS 2012–2017. An electronic polling system was used to obtain the stakeholders’ feedback, perceptions about WHO’s roles and functions, and their views on which health needs should be given priority. They were also requested to rank the focus areas and strategic approaches identified for the CCS 2012–2017 in order of priority. The result of the electronic polling is provided in Annex III.

The exercise in prioritization provided the information necessary for developing the strategic agenda. The strategic agenda defines the strategic priorities, as well as the main focus areas and strategic approaches to be considered in their implementation.

5.2 Strategic agenda

<table>
<thead>
<tr>
<th>STRATEGIC PRIORITY 1: Health systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribute to the strengthening of the health system to further develop capacity for policy-development, planning and improved service delivery</td>
</tr>
</tbody>
</table>

1.1 Main focus area

To revitalize primary health care keeping in mind the socio-demographic and epidemiological transitions

1.1.1 Strategic approach

The process of the revitalization of primary health care is under way to address the socio-demographic and epidemiological transitions and ensure quality health care, with different models being piloted.

1.1.2 Strategic approach

Promote actions to reduce health inequities through inter-sectoral policies and plans in order to effectively address the key social determinants of health.
### 1.2 Main focus area

To further ensure universal access by retaining the free health system through an increase in the health budget and a decrease in out-of-pocket expenses, to be achieved by strengthening health care financing

#### 1.2.1 Strategic approach

Increasing health financing by diversifying funding sources: The need for increased investments means overcoming fiscal constraints by utilizing the Government’s own resources and by leveraging development partners and the private sector, and looking for additional mechanisms for health care financing

#### 1.2.2 Strategic approach

Promoting efficiency and eliminating waste

#### 1.2.3 Promoting public–private partnerships

Partnerships need to be built with the private sector to yield mutually beneficial investments in health, in particular to find ways of leveraging the private investments towards public policy goals

### 1.3 Main focus area

To strengthen the health information system and research capacity for effective decision-making at all levels

#### 1.3.1 Strategic approach

The health information system in the country will be reviewed, and it would be re-modeled to address the existing gaps and ensure that it is better utilized at all levels

#### 1.3.2 Strategic approach

Building capacity in geographic information system (GIS) methods at all levels for better utilization, interpretation and dissemination of information for decision-making

#### 1.3.3 Strategic approach

Supporting evidence-based research in public health to ensure that future planning is more fruitful

### 1.4 Main focus area

To ensure an equitable and efficient health workforce

To support need-based public health training and creating an efficient health workforce

To strengthen the quality of performance of the health staff in the private sector (public–private partnership)

#### 1.4.1 Strategic approach

Supporting the strengthening and upgrading of institutions involved in the production of public health workers (PHW)

Supporting the National Institute of Health Sciences (NIHS), Kalutara to become a regional training centre, as well as a centre of excellence in the development of PHW

#### 1.4.2 Strategic approach

Addressing the quality of the health workforce in the private sector by strengthening regulations and supporting the development and accreditation of private nursing schools
### STRATEGIC PRIORITY 1: Medical Products and Technologies

**1.5 Main focus area**
To ensure equitable access to good-quality medical products and technologies both in the public and private sectors

<table>
<thead>
<tr>
<th>1.5.1 Strategic approach</th>
<th>1.5.2 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting the Ministry of Health (MoH) in the implementation of the National Medicinal Drug Policy</td>
<td>Strengthening regulatory mechanisms to safeguard the rights of patients with regard to access to affordable and good-quality medical products and technologies</td>
</tr>
</tbody>
</table>

### STRATEGIC PRIORITY 2: Communicable diseases

**Enhance country capacity in prevention, control and elimination of communicable diseases, and prevention and control of pandemics and disease outbreaks**

<table>
<thead>
<tr>
<th>2.1 Main focus area</th>
<th>2.1.1 Strategic approach</th>
<th>2.1.2 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>To strengthen communicable disease surveillance for prevention and timely control of disease outbreaks</td>
<td>Supporting the MoH Epidemiology Unit in its surveillance efforts and dissemination of information through the Weekly and Quarterly Epidemiological Reports</td>
<td>Strengthening prevention and control of communicable disease outbreaks through the establishment of public health laboratories, especially for outbreak investigation and control, response and preparedness for disease outbreaks and pandemics, in accordance with the International Health Regulations (IHR) 2005</td>
</tr>
<tr>
<td></td>
<td>Supporting initiatives to coordinate and collaborate with the private health sector to obtain disease surveillance information on notifiable diseases</td>
<td></td>
</tr>
</tbody>
</table>

#### 2.1.3 Strategic approach
Supporting efforts to build the capacity of rapid response teams at the district level and strengthening disease surveillance activities at points of entry

#### 2.1.4 Strategic approach
Advocating and supporting inter-sectoral approaches for preparedness and response to pandemic influenza

### 2.2 Main focus area
To enhance the capacity of the health workforce to achieve a reduction in morbidity and mortality due to priority communicable diseases

<table>
<thead>
<tr>
<th>2.2.1 Strategic approach</th>
<th>2.2.2 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing technical inputs to build the capacity of the health staff at all levels in the clinical management of communicable diseases, with special emphasis on hemorrhagic diseases and pandemic/epidemic-prone diseases</td>
<td>Strengthening efforts for the elimination of malaria, leprosy, filariasis, rabies and vaccine-preventable diseases of childhood</td>
</tr>
</tbody>
</table>
### 2.2.3 Strategic approach
Enhancing the health care system’s capacity to control infections so that it can deal with diseases of epidemic potential and prevent hospital-acquired infections, and co-infections

### 2.2.4 Strategic approach
Supporting the development of policy, guidelines, strategy and other tools for prompt diagnosis, treatment and care of patients with HIV/AIDS, tuberculosis and malaria
Supporting the Country Coordinating Mechanism (CCM) and grant management of GFATM-approved projects

### STRATEGIC PRIORITY 3: Noncommunicable diseases, injuries and mental health

#### 3.1 Main focus area
To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases including injuries

<table>
<thead>
<tr>
<th>3.1.1 Strategic approach</th>
<th>3.1.2 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocating for higher priority to the prevention and control of NCDs including injuries, and integrating this into policies across all government ministries and private sector organizations</td>
<td>Supporting the prevention of chronic NCDs, injuries and disability by strengthening policy and regulatory and service delivery measures aimed at the reduction of the level of risk factors in the population</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.1.3 Strategic approach</th>
<th>3.1.4 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowering the community to adopt healthy lifestyles for the prevention and control of NCDs</td>
<td>Ensuring sustainable financing mechanisms that support cost-effective health interventions, both preventive and curative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.1.5 Strategic approach</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening the national health information system, including disease and risk factor surveillance</td>
<td></td>
</tr>
</tbody>
</table>

#### 3.2 Main focus area
To support the Government of Sri Lanka in the development of effective and holistic decentralized mental health services, in line with the National Mental Health Policy

<table>
<thead>
<tr>
<th>3.2.1 Strategic approach</th>
<th>3.2.2 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting the implementation of national policies and strategic plans for the prevention and control of mental health problems</td>
<td>Supporting government initiatives to establish cadres for mental health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.2.3 Strategic approach</th>
<th>3.2.4 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting the implementation of policies and programmes for the prevention of harm resulting from alcohol and substance use, and for the promotion of healthy lifestyles</td>
<td>Supporting initiatives for mitigating the stigma associated with mental disorders and to improve access to mental health services</td>
</tr>
</tbody>
</table>
### STRATEGIC PRIORITY 4: Maternal, child and adolescent health, including nutrition and food safety

#### 4.1 Main focus area
To sustain and expand the existing maternal, child and adolescent health services, including nutrition and reproductive health programmes by supporting the addition of new evidence-based interventions and approaches through effective policies, plans, strategies, and periodic monitoring and programme evaluation

<table>
<thead>
<tr>
<th>4.1.1 Strategic approach</th>
<th>4.1.2 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting the implementation of a national policy and a five-year strategic plan on maternal and newborn care, and a revised maternal care package and essential service package for newborn, and child and adolescent health.</td>
<td>Assisting in the development of the capacity of key programme managers at national and district levels in the areas of programme planning, monitoring and evaluation, and institutionalizing proper planning, monitoring and evaluation of programmes at all levels, including GIS mapping, with an emphasis on vulnerable groups.</td>
</tr>
<tr>
<td>Supporting phased implementation of service and intervention packages for children with special needs and integrated management of childhood illnesses (IMCI) in selected settings, and for youth-friendly health services.</td>
<td></td>
</tr>
<tr>
<td>Ensuring adequate horizontal programmatic linkages with other relevant programmes to address major women’s health issues, including NCDs, HIV and gender</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>4.1.3 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing technical assistance for the development and mainstreaming of evidence-based service delivery packages for pre-pregnant and post-reproductive women.</td>
</tr>
</tbody>
</table>

#### 4.2 Main focus area
To address issues of food safety and nutritional problems among pregnant women, children under five and other vulnerable groups

<table>
<thead>
<tr>
<th>4.2.1 Strategic approach</th>
<th>4.2.2 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting the MoH to address key nutritional problems, such as low birth-weight, malnutrition and micronutrient deficiencies among pregnant women, children under five and other vulnerable groups, as spelt out in the national policy and plan of action on nutrition by adopting evidence-based interventions and strengthening the monitoring of marketing codes on breast milk substitutes, and through capacity-building of health workers and partnerships with the other stakeholders.</td>
<td>Assisting the MoH in the implementation of Codex activities and in its efforts to eliminate iodine deficiency disorders through the adoption of guidelines, capacity-building of staff and the development of a strategic plan on food safety.</td>
</tr>
</tbody>
</table>

#### 4.3 Main focus area
To strengthen the health sector response to gender and gender-related issues

<table>
<thead>
<tr>
<th>4.3.1 Strategic approach</th>
<th>4.3.2 Strategic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening the health sector response to gender-based violence and equipping it to prevent such violence through capacity building; enabling it to detect and manage cases of gender-based violence using protocols and guidelines</td>
<td>Strengthening community-based response to gender-based violence by empowering the civil society and building partnerships with the civil society and other stakeholders</td>
</tr>
<tr>
<td>STRATEGIC PRIORITY 5: Emergency preparedness and response</td>
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<td>---------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>5.1 Main focus area</strong></td>
<td></td>
</tr>
<tr>
<td>To support and strengthen the capacity of the health sector for disaster risk management (DRM) and build an evidence-base to guide the strengthening of DRM in the health sector</td>
<td></td>
</tr>
<tr>
<td><strong>5.1.1 Strategic approach</strong></td>
<td></td>
</tr>
<tr>
<td>Supporting the implementation of the national plan “Road Map for Disaster Management - Towards a Safer Sri Lanka”</td>
<td></td>
</tr>
<tr>
<td><strong>5.1.2 Strategic approach</strong></td>
<td></td>
</tr>
<tr>
<td>Strengthening multisectoral collaboration during emergencies</td>
<td></td>
</tr>
<tr>
<td><strong>5.1.3 Strategic approach</strong></td>
<td></td>
</tr>
<tr>
<td>Address priorities in capacity gaps in disaster risk management</td>
<td></td>
</tr>
<tr>
<td><strong>5.2 Main focus area</strong></td>
<td></td>
</tr>
<tr>
<td>To continue addressing the health and rehabilitation needs of those in the areas that were affected by conflict and to integrate recovery efforts with the longer-term health system development</td>
<td></td>
</tr>
<tr>
<td><strong>5.2.1 Strategic approach</strong></td>
<td></td>
</tr>
<tr>
<td>Support island-wide disaster risk reduction initiatives by the health sector</td>
<td></td>
</tr>
<tr>
<td><strong>5.2.2 Strategic approach</strong></td>
<td></td>
</tr>
<tr>
<td>Support the government’s efforts to rebuild health systems in the areas that were affected by the conflict</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>STRATEGIC PRIORITY 6: Enhanced partnerships and resource mobilization for health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6.1 Main focus area</strong></td>
</tr>
<tr>
<td>To help the MoH to coordinate and collaborate with all health stakeholders</td>
</tr>
<tr>
<td><strong>6.1.1 Strategic approach</strong></td>
</tr>
<tr>
<td>Helping the MoH to coordinate and collaborate with UN agencies, INGOs/NGOs, academia and the civil society</td>
</tr>
<tr>
<td><strong>6.1.2 Strategic approach</strong></td>
</tr>
<tr>
<td>Developing public–private partnerships and partnerships with developmental partners such as the World Bank and ADB</td>
</tr>
<tr>
<td><strong>6.2 Main focus area</strong></td>
</tr>
<tr>
<td>To mobilize resources for addressing health priorities</td>
</tr>
<tr>
<td><strong>6.2.1 Strategic approach</strong></td>
</tr>
<tr>
<td>Continuing the efforts of mobilizing resources through funding mechanisms such as the Joint Plan of Action (JPA), Common Humanitarian Action Plan (CHAP), South-East Asia Relief and Humanitarian Emergency Fund (SEARHEF) and Central Emergency Response Fund (CERF).</td>
</tr>
</tbody>
</table>
6 — Implementing the strategic agenda: implications for WHO Secretariat

6.1 WHO Country Office: role and presence

The WHO Country Office is the platform for effective engagement with the Member States to support their national health policies, strategies and plans. Sri Lanka joined WHO in 1948 and the Organization has had the presence in the country since then. The WHO Country Office in Sri Lanka would continue to facilitate exchange of information with the Ministry of Health (MoH), Sri Lanka, on global, regional and country-specific health agendas, priorities and initiatives. WHO would also help in improving coordination and knowledge management, including the dissemination of information on public health.

To achieve the strategic objectives enshrined in the Country Cooperation Strategy (CCS), the WHO Country Office needs to be equipped with adequate staff and financial resources. At present, the staff includes three international members, namely the WHO Representative, the Administrative Officer and the Technical Officer (Emergency Humanitarian Action). There are five incumbent National Professional Officers (NPOs) for Communicable Disease Control, Making Pregnancy Safer, Health Systems Development, Noncommunicable Diseases and Health Information System. Three Temporary National Professional positions are also in place. There is an 18-member national support staff and 14 Special Services Agreement (SSA) holders working in Colombo and the two field offices in Jaffna and Vavuniya. Table 6.1 shows the financial resources and staff strength available for the biennium 2012–2013. These resources need to be bolstered.

Table 6.1: Resources available for 2012–2013

<table>
<thead>
<tr>
<th>Financial resources (US$)</th>
<th>Staff strength</th>
<th>Total staff strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available assessed contributions (regular budget)</td>
<td>5 215 000</td>
<td>11 (includes 5 NPOs and 3 TNPs)</td>
</tr>
<tr>
<td>Planned voluntary contributions</td>
<td>2 947 286</td>
<td></td>
</tr>
</tbody>
</table>
There is no major increase in the allocation of assessed contributions to the Member countries. Efforts will continue to be made for the mobilization of voluntary contributions. Sharing of resources among various cross-cutting technical areas needs to be enhanced more effectively. WHO staff will continue to explore new avenues for mobilizing funding resources during duty travel and while participating in international meetings. There would be increased interaction with development partners and other UN country teams to mobilize financial resources. The Multi-Donor Trust Fund, whereby donors agree to pool resources to support plans that have been jointly developed by UN agencies, has come to play an important role in humanitarian response, recovery and development operations. The WHO Country Office in Sri Lanka signed a memorandum of understanding (MoU) with five other UN specialized agencies in October 2010. According to the terms of this MoU, the WHO Country Office received approximately US$ 215 000 for a three-year project on the prevention of gender-based violence in Sri Lanka.

Efforts will also be made to persuade the private sector to play a more active role in addressing public health issues, including noncommunicable diseases and emergencies.

6.2 Collaboration with the WHO Regional Office

Collaborative activities with WHO will be implemented in coordination with the Regional Office for South-East Asia (SEARO) in New Delhi, India. The Regional Office will help in technical backstopping and providing policy direction. The participation of national counterparts in the inter-country meetings organized by SEARO or other Member States will be facilitated and financially supported. The Regional Office will arrange fellowship programmes within and outside the Region for national counterparts.

The Regional Office will also play a key role in mobilizing financial resources for priority areas which are underfunded through assessed contributions. Large parts of several Member countries of the South-East Asia Region are vulnerable to regular and severe natural disasters and emergencies, which have accounted for an alarming 58% of global mortalities in the past decade (1996–2005). In view of this, the 11 Member States of the Region have established the South-East Asia Regional Health Emergency Fund (SEARHEF) to provide support to countries in the Region in the immediate aftermath of an emergency to kick-start the relief work. During the period 2008–2010, the WHO Country Office in Sri Lanka received US$ 525 000 to support the MoH in providing emergency health services to the displaced people in Menik Farm and strengthening health services for those returning to their areas of origin in the Northern Province.

The Regional Office has also developed tools to assist SEAR Member States to assess their level and capacity of emergency preparedness and response. One such tool that Sri Lanka has applied is the SEARO Benchmark that indicates the level of country emergency preparedness through 12 standards and corresponding indicators.
In collaboration with the Health Emergency and Disaster Management and Training Centre (HEDMaTC) of the University of Peradinya, WHO has been able to conduct five courses of Public Health and Emergency Management in Asia and the Pacific (PHEMAP) to build up national capacity on emergency preparedness and response. Over 200 health and non-health sector professionals had been trained so far.

6.3 Collaboration with WHO Headquarters

Technical and funding back-up support from WHO Headquarters is essential. In view of the almost zero growth in the allocation of assessed contributions in recent times, the Country Office will solicit Headquarters through the Regional Office to provide funds from unspecified core voluntary contributions wherever possible. The UN Central Emergency Response Fund (CERF) has been an important source of funding for Sri Lanka to respond to the health needs of the displaced population during the civil conflict in the Northern Province. Since 2008, WHO has received US$ 2 364 330 from this Fund to respond to the emergency needs of the people during the humanitarian crisis in the Northern Province and in the aftermath of the floods in 2010.

The WHO Headquarters also provides technical support in conducting investigations, research and surveys for the Chronic Kidney Diseases of Uncertain Aetiology Project funded predominantly by the National Science Foundation of Sri Lanka. A Lighthouse Project on the Social Determinants of Health is being piloted in rural, urban and underserved plantation settings with assistance from the Headquarters.

6.4 WHO internal coordination

Coordination between various levels of the Organization is important to maximize support for the Country Cooperation Strategy especially through the following:

(i) Information sharing in specific technical areas with the SEA Regional Office and Headquarters including horizontal collaboration with other SEAR countries.

(ii) Coordination for resource mobilization as a follow-up with donors and interested funding agencies and organizations.

(iii) Joint planning with all health stakeholders for biennium work plans.

(iv) Technical support including joint efforts in capacity building and programme reviews.

(v) Sustainable partnerships development.

6.5 Coordination with the Ministry of Health and partners

In implementing the CCS, WHO will work closely with the MoH and other stakeholders in the country including bilateral and multilateral agencies, and NGOs. WHO will
also work with other ministries, councils and professional colleges for promoting and advocating work on prevention and control of NCDs including injuries and road traffic accidents, disabilities and nutrition.

Following the decentralization of health services, WHO maintains close links with the provincial health ministries with the concurrence of the central MoH. It also works closely with the universities, which come under the purview of the Ministry of Higher Education.

6.6 Monitoring and evaluation of CCS

An internal review will be conducted during the CCS cycle to analyse the extent of implementation of the strategic agenda. The review will consider whether the strategic priorities, work plans, and allocation of human and financial resources are consistent with each other. The aim of the review will be to identify the internal operational elements that have an impact on WHO’s capacity to influence health development in the country.

To ensure that WHO Country Office programmes contribute and supplement activities of other health sector partners, regular periodic consultations and review meetings with the MoH and other key stakeholders would be organized.
Bibliography


Annexes
Stakeholder perceptions on WHO’s roles and functions

Annex 3

Actively support national health policies strategies and plans (NHPSP)

- ★ ★ 0.0% 2.5%
- ★ ★★ 27.8%
- ★★★★★ 69.6%

Working with UN agencies and other developmental partners to shape the priority health needs within the country

- ★ ★ 0.0% 3.8%
- ★ ★★ 30.4%
- ★★★★★ 65.8%

Leading the international response in emergencies and building capacity to respond to crisis situations and national public health emergencies

- ★ ★ 2.6% 3.8%
- ★★ ★★ 17.9%
- ★★★★★ 75.6%

Monitoring the implementation of global health initiatives
Eg: MDG, IHR, FCTC

- ★ ★ 1.3% 7.5%
- ★★ ★★ 25.0%
- ★★★★★ 66.3%

Stars denote the range of agreement expressed by stakeholders, whereas minimum agreement is represented by ★; and maximum agreement is represented by ★★★★★
Technical advisor on policy, trusted broker and convenor that facilitates partners contribution to the NHPSP

Priority ranking of WHO core functions by stakeholders

In light of the devolved health system in the country (13th Amendment) should WHO collaborate more with provincial health authorities to improve efficiencies and impact?

- Yes 46.8%
- No 40.5%
- Maybe 12.7%

Providing Leadership and engaging in partnerships, where joint action is needed
Shaping the research agenda and dissemination of valuable knowledge
Setting norms and standards
Articulating ethical and evidence based policy options
Providing technical support, catalysing change and supporting sustainability
Monitoring health situations and assessing trends
This WHO country cooperation strategy, Sri Lanka 2012-2017 is a comprehensive strategic document in support of national health development and plans. It articulates the World Health Organization’s strategy for cooperation in, and with, the country for the medium term, covering the period 2012–2017. The strategy is based on in-depth analysis of health challenges facing Sri Lanka and contributes to the United Nations Development Assistance Framework in the country. It represents the fruit of multisectoral consultations with key stakeholders in the Sri Lankan health sector.

At the heart of the country cooperation strategy is its strategic agenda. This was developed by WHO in close collaboration with the Ministry of Health and other partners. Six areas of work have been identified as strategic priorities for the coming six years of cooperation:

- health systems
- communicable diseases
- noncommunicable diseases, injuries and mental health
- maternal, child and adolescent health, including nutrition and food safety
- emergency preparedness and response
- enhanced partnerships and resource mobilization for health.

The strategic agenda for WHO cooperation is outlined in Chapter 5 of this document. It defines not only the strategic priorities, but also the main focus areas and strategic approaches for their implementation.

Sri Lanka needs a healthy and productive population to sustain its transition to a middle-income country. In the above context, population ageing and the rise of noncommunicable diseases are but two key examples which need to be managed effectively if the country is to transition successfully.

In implementing this country cooperation strategy and in accordance with its mandate, WHO will work closely with the Ministry of Health and a range of partners and stakeholders in health and sustainable development.