Addressing noncommunicable diseases in a lower-middle-income country

Sri Lanka’s approach

1. Political commitment
2. Importance of public health in the national agenda
3. Addressing social determinants of health, multi-sectoral and multi-stakeholder coordination
4. Optimal use of existing infrastructure and human resources
5. Emphasis on early detection of the most common NCDs, prevention and health promotion
6. Strengthening the health system
7. Prioritizing research and evidence-based strategies
8. Learning from demonstration projects
9. Receptivity to global good practices
10. Accepting there are gaps

Lessons learnt by doing
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Message from Honourable Maithripala Sirisena, Health Minister of Sri Lanka

Although Sri Lanka achieved high health standards compared to some other countries in the region, it is now facing a new challenge in the form of rapidly emerging non-communicable diseases (NCDs) which has become the leading cause of deaths in the country. Even though we have successfully impacted upon vaccine preventable diseases, reduced maternal mortality rates, effectively curbed and controlled communicable diseases to a great extent we now face a rapid epidemiological and demographic transition.

Unless we can find innovative solutions to meet this challenge, the financial and social burden of healthcare will get larger with every passing decade.

National programmes have been launched on mobilizing commitments and actions to address Non Communicable Diseases (NCDs) not only from the health sector but from others sectors as well with much political support and advocacy. We are indeed happy to be part of the effort to disseminate and share experiences on our journey with other countries in the region as well as at global level. A major achievement has been the development of the NCD Policy and Strategic Framework, together with the medium-term operational plan.

I appreciate your endeavour to highlight this emerging challenge and take timely measures for its control and prevention with help and cooperation of WHO.

Honourable Maithripala Sirisena, Health Minister of Sri Lanka
Message from 
Dr Samlee Plianbangchang, 
Regional Director for South-East Asia

The public health landscape is changing due to ageing population, rapid urbanization and globalization. Non-communicable diseases, such as cardiovascular diseases, diabetes, cancers and chronic respiratory diseases, have seen a dramatic upsurge in recent times. Non-communicable diseases are now the leading cause of death and illness across the globe. In addition to the tremendous health burden, non-communicable diseases pose a huge financial burden on individuals and governments due to long-term costs of health care, premature death, disability, and loss of income.

We know that cost-effective interventions are available to tackle non-communicable diseases; however, there are many challenges to addressing these diseases including the need to deal with underlying determinants that lie beyond the health sector. Addressing non-communicable diseases requires “whole of government” and “whole of society” approaches. At the government level, many departments need to work together to create health-promoting environments. In addition to the government, businesses and organizations, academia, and various stakeholder communities need to collaborate to create an enabling environment to promote healthier lifestyles.

Sri Lanka has shown the world that even with limited resources, by investing in and creating a strong health-care system based on the principles of primary health care, it is possible to reduce the burden of communicable diseases and improve the health of people. Building on a robust primary health care system and existing community networks, Sri Lanka is now taking up the challenge of non-communicable diseases.

Countries across the globe face similar health challenges. By exchanging experiences and learning from each other, we are better placed to solve our common problems. It is our hope that policy-makers and public health agencies around the world will find Sri Lanka’s approach useful as they develop their own programmes for taking actions against non-communicable diseases to protect and promote the health of their people.

Dr Samlee Plianbangchang
Regional Director

Foreword
Dr F R Mehta, 
WHO Representative to Sri Lanka

Sri Lanka is at a cross road undergoing several transitions simultaneously; demographic, epidemiological, social and economic to name a few. These transitions occur in every country as they move towards middle and high income status. In Sri Lanka though, these transitions are happening at a very fast pace with a much smaller resource base than most developed nations. The response to these transitions from the government of Sri Lanka has been encouraging.

Sri Lanka has always stood out on its indicators for health. Sri Lanka is on track on most of the United Nations Millennium Development Goals. The country ranked 92 out of 187 on the United Nations Development Programme’s (UNDP) 2012 Human Development Index (HDI). This is mainly due to favourable social and economic indicators of health, education and income.

Sri Lanka’s past success in healthcare were not accidental – they were the end-result of a series of measures. It is therefore timely that a synopsis of the countries efforts are captured in this document which highlights key factors of success. The most important lesson of Sri Lanka’s story in health is that a country does not have to wait till it is rich to invest in the well-being of its citizens. If there is political will and good governance, it can achieve a lot even with meagre resources. Rapid rise in female literacy rate, social equity and justice by successive governments have facilitated accelerated the response to the rising burden of NCDs. This document looks at some of the good practices and mechanisms in Sri Lanka’s health services & civil administration which can serve as models for other countries facing similar transitions and challenges.

Dr F R Mehta, 
WHO Representative to Sri Lanka
Executive summary

Addressing noncommunicable diseases - can Sri Lanka be a case-study?

Despite limited resources and an internal conflict spanning nearly three decades, how has Sri Lanka outperformed its South Asian neighbours and many other developing countries in health outcomes? This question has, for years, been the subject of animated and scholarly discussion worldwide. The fact that Sri Lanka is on track to meet most of the Millennium Development Goals (MDGs) is not by accident or good luck. The country ranks 92 out of 187 in the Human Development Index which represents a broader definition of well-being and provides a composite measure of three basic dimensions of human development: health, education, and income. This has happened because Sri Lanka has had an enlightened political leadership for decades. The vision at the top combined with coherent public health policies, regulatory measures, multilateral and multistakeholder efforts have translated into commitment and results on the ground. The political leadership at the top has invested resources in key areas: free education that helped to empower women and medical care that is accessible and provided free of charge. One telling strategy: the creation and sustenance of a cadre of public health midwives to bring services closer to communities and households. This has enabled Sri Lanka to achieve high scores on maternal and child health relative to other countries in South Asia and the developing world as a whole.

After about 30 years of violence, the conflict in Sri Lanka ended in May 2009. The Government is now in the process of rebuilding the nation. Along with other essential services, the health sector is also undergoing reorientation. During the years of internal turmoil, Sri Lanka’s health system faced a set of challenges. Those who needed medical assistance could not reach hospitals in time. Roads and other infrastructure were damaged or in disarray in conflict- scarred parts of the country. Today, the situation has changed. Travelling from one region to another is much easier now.

However, Sri Lanka today faces new challenges. The country is in an advanced stage of a demographic transition with life expectancy of 71 years for males and 78 years for females. At the same time, the epidemiological transition is showing the disease burden from communicable diseases to what are popularly known as "lifestyle diseases". These are what health experts call noncommunicable diseases (NCDs) including cardiovascular diseases (such as heart attacks and strokes), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. There are several reasons for this emerging trend – urbanization, lifestyle transformations and related factors. Individually and cumulatively, the epidemiological, demographic and socioeconomic transitions are fuelling a surge in NCDs which now account for 65% of all deaths in the country. Among these NCD-related deaths, 25% are occurring prematurely before the age of 60 years.

This is not just a public health issue. It is a development issue with wide ramifications for Sri Lanka’s future. The NCD burden escalates the need for long-term care. This care is especially needed for the elderly, as they are more at risk from NCDs. NCDs also affect labour force participation. Both these effects have a significant impact at two levels – higher costs of health care and productivity losses.

At this critical juncture, Sri Lanka is fortunate to have political leadership that recognizes the severity of the risks that NCDs pose to the country’s future. NCDs are prioritized in the Presidential Manifesto, "Mahinda Chinthana" (Mahinda’s Vision), which refers to the NCD challenges as do a series of other policy documents such as the National Development Policy Framework for Development and Growth in Sri Lanka and the Five-Year National Health Sector Development Plan (NHSDP) 2013. Sri Lanka is not merely talking about preventing and controlling NCDs. Its political commitment is demonstrated by four sets of specific actions: addressing risk factors through multistakeholder partnerships; health system strengthening; efforts to make essential drugs and technologies available and monitoring and evaluation as part of bringing in accountability. These nationwide interventions are being implemented by the country’s robust public health structure and civil society including community networks such as youth clubs. In doing so, Sri Lanka is tapping into the best practices that have yielded positive outcomes in the past such as community-level involvement in the rollout of health initiatives. The focus is on prevention and early detection of NCDs. Schools have captive audiences for action and therefore, key concepts about healthy diet, the importance of physical activities and avoidance of tobacco, alcohol and other harmful substances are being incorporated into the curriculum. Alongside, Sri Lanka has healthy canteen guidelines for schools and workplaces which are translated into practice through routine monitoring by public health inspectors.

In the policy space, a major achievement is the National Policy and Strategic Framework for Prevention and Control of Chronic Noncommunicable Diseases (2009). Another is the establishment of healthy lifestyle centres (HLCs) and promotion of mass screenings for early diagnosis of NCDs. There are 668 such HLCs in the country today that offer free NCD screening services and follow-up guidance. Sri Lanka’s Health Ministry has also dedicated mid-management level staff in the form of medical officers for NCDs (MO-NCD) in all districts. The Health Ministry has drawn up a list of 16 essential NCD drugs and has issued circulars to ensure that they are available at all primary health care institutions. Sri Lanka has already committed substantial additional resources from the treasury – approximately US$ 7 million from 2011 to 2013 – for NCD prevention and control. Alongside, it is leveraging technical and financial support from multilateral and bilateral agencies such as Japan International Cooperation Agency (JICA), The World Bank and the World Health Organization (WHO). The policies, regulatory measures and initiatives on the ground show that Sri Lanka is determined to be willing to not only capitalize from its own good practices, but also from other countries and international agencies.
The context: How has Sri Lanka achieved such remarkable success in public health with limited resources?

“The growing incidence and mortality from noncommunicable diseases will be brought under control and reduced through preventive and curative actions. An intensified national NCD programme, focusing initially on high-burdened NCDs, will be implemented to reduce the growing NCD burden in Sri Lanka. Better coordination between preventive and curative programmes is vital for this purpose...”

Mahinda Chinthana – vision for the future
Among developing countries, Sri Lanka has always been the outlier. In the 1950s and 1960s, when the world at large focused on growth-centric theories of development, Sri Lanka embraced the basic needs approach. Since its independence in 1948, successive governments have implemented welfare-oriented policies and programmes which have allowed it to achieve relatively high standards of social and health development in comparison with countries of similar levels of economic development. The trend continued despite an ethnic conflict in the last three decades that ravaged parts of the country. This unwavering focus on human development has made Sri Lanka not only a pioneer in South Asia, but in the developing world. Only a handful of developing countries such as China, Costa Rica, Cuba and Viet Nam can list as many achievements on the social front as Sri Lanka.

Today, Sri Lanka is on track for most of the United Nations Millennium Development Goals. The country ranked 92 out of 187 on the United Nations Development Programme’s (UNDP) 2012 Human Development Index (HDI). Sri Lanka’s lead role in public health is particularly remarkable. According to the Sri Lankan Human Development Report (UNDP 2012), Sri Lanka’s life expectancy of 74.9 years in 2011 is high compared with most developing countries. Its infant mortality rate has declined steeply from 19.8 per 1000 live births in 1990 to 8.5 in 2007, while the maternal mortality ratio has declined from 92 per 100,000 live births in 1990 to 39.3 in 2006 and is the lowest in the South-East Asia Region.

How has this island republic in the Indian Ocean achieved such remarkable success in public health with limited resources? There lies a fascinating tale of political commitment, public action and community mobilisation. This report showcases Sri Lanka’s “good health at low cost” template as the country addresses the new scourge of NCDs. The report is not an exhaustive account of all that is happening on the ground, but it is hoped that a snapshot of some of the good practices in Sri Lanka’s NCD strategy and vignettes from the field will be of use to other developing countries confronting a similar epidemiological transition.

The Sri Lankan success story in health has its roots in focused and intelligent Government investment in public goods. The main provider of public health services is the State. The country has developed a robust public health network. Most Sri Lankans live in close proximity of a public health facility. Whether it is a system of primary, secondary and referral facilities, in practice, patients are free to go to the institution of their choice and the one that is the most accessible. This is remarkable even by the standards of developed countries that have widespread public health systems. The well-developed preventive health care system in the country has been tools to tackle maternal, reproductive, adolescent and child health care, immunization and health promotion.

Sri Lanka’s impressive health outcomes can also be tracked to Government interventions in other areas. A key contributor is public investment in education. Though private international schools in Sri Lanka have increased in recent years, the country has been providing free school education to its people since 1938. This has translated into high female literacy, women’s empowerment and willingness of the mother to access allopathic care for the family, putting Sri Lanka way ahead of other South Asian countries. Sri Lanka’s net primary enrolment rate for both males and females was more than 95% in 2009-2010. Sub-national disparities notwithstanding, overall, Sri Lanka has the highest level of human development among the countries of the South-East Asian Region.
Sri Lanka’s education attainment levels are high, if judged by basic indicators such as literacy, access to primary education and education completion rates. This lead in education has helped it in implementing health programmes effectively. Adult literacy reached 91% in 2008 and the country has almost achieved the MDG targets for universal primary education and gender equity in education. In 2006, it attained a primary enrolment rate of 97.5%, and practically reached gender parity in primary education, with the ratio of girls to boys at 99%. Sri Lanka is, therefore, often cited as a nation with high educational achievements despite being a lower-middle-income country. Significantly, Sri Lanka’s development philosophy is rooted in ancient tradition (See Box 1).

Sri Lanka’s legendary King Dutugamunu built hospitals for Buddhist monks and a maternity hospital as early as 173 B.C. The country has had a community-based health unit system from early twelfth century. The key strategy of the health unit system was to identify the most common and serious infectious diseases in each health unit area, and to tackle them through improvements in sanitation, health education, immunization and treatment with the help of local communities. For the first time in Asia, such a health unit was established in Kalutara in 1926 with support from the Rockefeller Foundation, which was the beginning of primary health care and community care with clinical settings. Today, this has evolved into the Medical Officer of Health (MOH) Unit, the lowest level in the public health care system.

First Public Health Unit in Sri Lanka - Katu 1st July 1926
(Presently, National Institute of Health Sciences)

（Box）
Sri Lanka’s ethnic conflict came to an end in 2009. The nation is now on the cusp of a new chapter in its history. Since 2010, Sri Lanka has maintained relatively high levels of growth, spurred by private sector demand, graduating to a lower-middle-income country. On the horizon are new opportunities and challenges.

Like other countries in South and South-East Asia, Sri Lanka is being buffeted by a plethora of changes: the country is in an advanced stage of demographic transition with life expectancy at 74.9 years. It is also going through an epidemiological transition that is shifting the disease burden from maternal and child health (MCH) and communicable diseases to NCDs. Urbanization, lifestyle transformations and related factors are causing a surge in cardiovascular diseases, diabetes, various cancers and non-communicable diseases. According to the Sri Lankan Health Ministry, NCDs now account for 65% of all deaths in the country. NCDs are part of a global trend and these transitions have happened in every country as it moved towards middle and high-income status. (See Box 2.)

The global scenario

NCDs are the leading cause of death in the world, responsible for 63% of the 57 million deaths that occurred in 2008. Most of these deaths—36 million—were attributed to cardiovascular diseases and diabetes, cancers and chronic respiratory diseases. In most middle- and high-income countries, NCDs were responsible for more deaths than all other causes of death combined, with almost all high-income countries reporting the proportion of NCD deaths to total deaths to be more than 70%. Low- and lower-middle-income countries have the highest proportion of deaths under 60 years from NCDs. Common, preventable risk factors underlie most NCDs. These risk factors are a leading cause of the death and disability burden in nearly all countries, regardless of economic development. The leading risk factor for mortality globally is raised blood pressure (responsible for 13% of deaths globally), followed by tobacco use (9%), raised blood glucose (6%), physical inactivity (6%), and overweight and obesity (5%). “Cumulative losses in global economic output due to NCDs will total US$ 47 trillion, or 5% of the GDP by 2030. Modest investments to prevent and treat NCDs could bring major economic returns and save tens of millions of lives,” according to a 2012 Chatham House Briefing Paper by Sudeep Chand of the Centre on Global Health Security.
In Sri Lanka, health care costs are escalating, partly due to the expanding NCD burden. Total health expenditures increased from 3.5% of the GDP in 1995 to 4% in 2008, while the public spending in this area dropped from 47% to 43%.

The emerging challenges which not only impact health but the future trajectory of the nation require multisectoral collaboration. Treatment costs for NCDs at the secondary level are prohibitive. A developing country where health care is free would find it very difficult to sustain this system if health care costs are allowed to spin out of control. Therefore, the focus has to be necessarily on prevention, health promotion and follow-up care at the primary level. Given its nationwide preventive health care network and proven expertise of its health workers, Sri Lanka is uniquely positioned to offer NCD interventions at low cost. The Sri Lankan Government has come up with multiple mechanisms to meet the challenge posed by NCDs. It has allocated US$ 7 million from 2011 to 2013 for NCD prevention and control. Simultaneously, it is leveraging technical and financial support from multilateral and bilateral agencies such as JICA, The World Bank and WHO. The discussion paper titled “Prevention and Control of Selected Chronic NCDs in Sri Lanka: Policy Options and Action” produced by The World Bank in 2010 also gives an insight into economic burden and possible actions.

Leadership and political commitment at the top are the key drivers ensuring action on the ground. A series of policy proclamations starting with the President’s manifesto called “Mahinda Chinthana” (Mahinda’s Vision), the National Development Policy Framework for Development and Growth in Sri Lanka, the Five-Year National Health Sector Development Plan (NHSDP) 2013-2017, other policy formulations, regulations and ground-level interventions demonstrate that the Government recognizes the gravity of the challenge posed by NCDs to Sri Lanka’s future. Prevention and control of NCDs also greatly depend on action taken by non-health sectors. In Sri Lanka, all arms of the Government and community-level networks are coming together to fight epidemics of cardiovascular diseases, cancers, chronic lung diseases and diabetes. Field visits to different parts of the country show promising signs: the existing public health infrastructure and the “good health at low cost” template for which Sri Lanka is justifiably renowned are being leveraged to prevent the spread of NCDs and promote health-seeking behaviour among all age groups.
Sri Lanka is one of the few countries in the world that provides free health care to its people. This has been a national priority, articulated in several policy documents. The public health system is financed and operated by the Ministry of Health in Colombo and the nine provincial health ministries. The decentralization of the health system took place in the late 1980s, following the 13th amendment to the Sri Lankan Constitution (1987) which led to the establishment of provincial councils. As a result, apart from the Health Ministry at the national level, there are nine provincial ministries of health. The private sector has traditionally had a smaller role in health care than the public sector. However, this is changing. The important point to note is that much of the private sector medical activity in the country is actually provided by Government medical doctors working during their off-duty hours. This is allowed in Sri Lanka. There are disadvantages to this system, but the advantage is that it allows Government servants to supplement their relatively modest wages and helps retain health professionals within the public sector. As of now, the public sector provides most of the inpatient care while the private sector typically has a 50% contribution in outpatient care.

Health system in Sri Lanka: the primary health care service delivery structure

Sri Lanka’s primary health delivery structure is divided into preventive and curative care. The Health Ministry provides overall direction and monitoring of public health services throughout the country, and supports service delivery down to the grass roots. At the provincial and regional (district) levels, line agency staff manage programme implementation under the administrative control of the provincial governments.

The lowest level is the MOH unit, headed by the Medical Officer of Health (MOH), who is tasked with preventive care. There are 331 such Medical Officer of Health (MOH) areas in the country. Each MOH area serves a population between 100,000 and 150,000. The MOH team includes nurses and public health midwives, who have traditionally provided maternal and child health services, and public health inspectors who provide environmental health and disease control services. The availability of curative care institutions are approximately in the ratio of 1:22,000, though the population is not defined for each institution.
Sri Lanka has a robust hospital infrastructure, but it is not equitably distributed. There are fewer Government hospitals in the Northern and Eastern provinces due to the years of conflict. The situation, however, is changing with large scale development of health infrastructure in the north and east. Inequitous distribution of health personnel across provinces is common and poses challenges to the implementation of the NCD programme. However, this is also being addressed with more recruitment of health personnel for northern and eastern regions.

The health services are provided by medical officer/s and several categories of field level health personnel, mainly public health nursing sister (PHNS), public health inspectors (PHI) and public health midwives (PHM), focusing mainly on the promotive and preventive aspects of health care. The Sri Lankan public health midwife has probably been the most effective intervention in the country’s health success story. PHMs are recruited from the communities they are meant to serve. This puts them in a vantage position by reducing geographical and cultural barriers. Every household in Sri Lanka comes under an identified PHM area. These midwives who have been critical to Sri Lanka’s much-admired maternal and child health care indicators are playing a key role in Sri Lanka’s NCD programme. A unique feature of Sri Lanka which has again emphasized the country’s commitment to NCD prevention and control is the presence of medical officers for NCD at the district level who act as the arms for implementation at that level.

In addition to the presence of the Health Ministry at the district level, Sri Lanka also has a very strong civil administration structure. The districts of Sri Lanka are divided into administrative sub-units known as divisional secretariats, further sub-divided into Grama Niladhari divisions. A Sri Lankan public official appointed by the central Government termed “Grama Niladhari” is present at this level to carry out administrative duties. There are also other centrally appointed officials termed “Samurdhi Officers” (poverty alleviation officers) and agricultural research officers present at this level. The involvement of these officials outside the health sector was deemed important in initiating a successful NCD prevention and control programme.

The presence and mobilization of voluntary committees such as youth committees, elders’ committees and women’s committees also assist in NCD prevention at the community level.
Sri Lanka’s disease burden

Globally, approximately 4000 people die per hour of NCDs; Regionally, approximately 900 people die per hour of NCDs; for Sri Lanka, the corresponding figure is approximately 9.

- WHO Country Office, Sri Lanka

Sri Lanka’s exceptional record in health achievements continues to hold good today. Nevertheless, the country now confronts various health challenges that will test its mettle in the future. The epidemiological transition is shifting the disease burden from maternal and child health and communicable diseases to NCDs which are now the leading causes of mortality, morbidity and disability. Estimates made in 2008 indicate that NCDs accounted for 65% of all deaths in Sri Lanka – with cardiovascular diseases accounting for 30%, cancers 9%, respiratory diseases 8% and diabetes 4%. Injuries accounted for 26% of the deaths, while 11% were due to communicable, maternal, perinatal and nutritional conditions.

Source: WHO Country Profiles, 2011

NCD mortality

<table>
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<th>Year</th>
<th>Total NCD deaths (000)</th>
<th>NCD death under age 60 (Percent of all NCD death)</th>
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<td></td>
<td>males</td>
<td>females</td>
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<td>2008</td>
<td>66.8</td>
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Age-standardized death rate per 100 000:
- All NCDs: 746.2
- Cancers: 90.0
- Chronic respiratory diseases: 101.5
- Cardiovascular diseases and diabetes: 384.9

NCDs are estimated to account for 65% of all deaths.
Cancer is also causing increasing number of morbidities in the country. According to Sri Lanka’s National Policy Strategic Framework on Prevention and Control of Cancers (currently in draft form), cancers of the breast, oral cavity, oesophagus, cervix, lungs, thyroid, colon and rectum, lymphoma, ovary and leukaemia are among the ten most common cancers in Sri Lanka in the years 2001–2006. Higher incidence of cancers was reported in females (79.0 per 100000 population) compared with male patients (62.7 per 100000 population). In 2006, the five most common cancers among males were found in the oral cavity, lungs, oesophagus, colon and rectum and lymphoma, while the five most common cancers among females occurred in the breast, cervix, ovary and thyroid and oesophagus. (Cancer incidence data: Sri Lanka, Year 2006).

The fight against cancer

Despite advances in medical science, cancer still evokes fear. The incidence of cancer is rising in Sri Lanka. Indeed, the country has one of the world’s highest rates of oral cancer. Sri Lanka provides free cancer treatment to those who are in need of it, but given its prohibitive cost, there are long-term implications for the national exchequer if the number of those living with cancer continues to rise.

“The emphasis is on cancer prevention rather than cancer treatment. Community awareness is vital. We have been conducting various campaigns. In July 2012, we did an oral cancer social marketing. One key target group was bus drivers. We have brought out many booklets such as the one on early detection of breast cancer. There are plans to have medical officers especially tasked for cancer prevention and control…”

Dr Neelamani Paranagama, Director, National Cancer Control Programme, Sri Lanka

The National Health Policy (1992), ‘Mahinda Chinthana’ (2005), ‘Mahinda Chinthana Way Forward’ (2010) and Health Master Plan 2007–2016 of Sri Lanka have recognized prevention and control of cancers as part of a broader concept of NCD prevention. Sri Lanka has a National Cancer Control Programme and a draft national policy and strategic framework on prevention and control of cancers. Recently, a major policy decision was taken by the Government of Sri Lanka to recognize palliative care as one of the main strategies of the national policy on cancer control. Palliative care units are scheduled to be established at cancer control units attached to provincial cancer treatment centres in the near future.

The well women clinic programme

Pap smear screening is used for early detection of cervical cancer. The target population consists of married women above 35. There are currently 750 well women clinics in MOH areas and primary care settings. This programme is coordinated nationally by the Family Health Bureau, Ministry of Health. Partners include the National Cancer Control Programme along with the Colleges of Pathologists and of Obstetricians and Gynaecologists.
At a time when the South-East Asia Region is battling NCDs, Sri Lanka’s policies and practices to control them are of great interest. Sri Lanka’s past successes in health care were not accidental — they were the result of a series of measures. So it is with NCDs. The building blocks for Sri Lanka’s cost-effective NCD control programme can be summarized as follows:

1. **Political commitment**

   Political vision and commitment are at the heart of Sri Lanka’s cost-effective NCD programme. This emanates from the highest level, H.E. President Mahinda Rajapaksa, who has personally intervened in the efforts to control communicable and NCDs in the country through Mahinda Chinthana, or “Mahinda’s Vision”. The vision is based on a holistic economic philosophy that holds that growth in GDP alone would not bring economic prosperity to society. The Mahinda Chinthana goal (MCG) is to increase the GDP to provide benefits to every segment of society in a justifiable manner. The political recognition of the urgency to reduce the country’s NCD burden at this defining moment in Sri Lanka’s history, when the end of a 27-year conflict has opened up infinite possibilities, is reflected in the prioritization of NCDs in the country’s development policy agenda. The National Development Policy Framework for Development and Growth in Sri Lanka (2010) of the Ministry of Finance and Planning notes that “the growing incidence and mortality from NCDs will be brought under control and reduced through preventive and curative actions” and that “an intensified national NCD programme, focusing initially on high-burden NCDs, will be implemented to reduce the growing NCD burden in Sri Lanka.”

   “I consider it my responsibility to preserve the free health service and safeguard the right of every citizen for benefits thereunder. In this regard immediate action will be taken to enhance these services both quantitatively and qualitatively.”

   Mahinda Chinthana 2005, p. 67

   “It is imperative that a healthy work-force is maintained, and that should be the prime responsibility of the health sector during this second decade of the 21st century, when the country is to move towards a modern state with a speedy economic development process. In this backdrop, I will further strengthen this service by enhancing the physical and technical infrastructure of the health service, upgrading its human resources, and bringing about positive attitudinal changes in order to provide a still better service to the general public.”

   Mahinda Chinthana 2010, pp. 77-78

   “Earlier, much attention was paid to communicable diseases and epidemics. However, as a result of busy lifestyles in a competitive world, attention has to be paid to prevent NCDs. Unlike the present day, in the past, NCDs were reported mainly from urban areas. But NCDs are reported from almost all parts of the country today.”

   H E. Mahinda Rajapaksa, President of Sri Lanka.

   “By declaring the year 2013 as the ‘year of preventing noncommunicable diseases’, we have made prevention everyone’s business! Sri Lanka’s NCD programme believes in ‘catching them young’ and this will accelerate the ongoing efforts that are already in place.”

   Honourable Maithripala Sirisena, Health Minister of Sri Lanka.
Political commitment at the highest level has had a knock-on effect on Sri Lanka, generating commitment at national, provincial and district levels. The commitment has been translated into policies and creation of an institutional architecture that is vital for effective implementation of programmes.

Some significant examples:
Appointment of a presidential task force in 2010 to mainly look into malnutrition has been a good platform to also address policy-related matters in relation to unhealthy diet and physical inactivity. This is an interministerial committee chaired by H.E. the President. Establishment of a National Nutrition Secretariat of Sri Lanka (NNSSL) that functions within the presidential secretariat again affirms the commitment of the Government in the area of nutrition and it is hoped that in the future, a broader agenda inclusive of the other three risk factors for NCD, namely physical inactivity, tobacco and alcohol use will be part of their mandate.

The National Policy and Strategic Framework for Prevention and Control of Chronic Non-communicable Diseases is another example – the main objective of this 2009 policy is to reduce premature mortality due to chronic NCDs by 2% annually over the next 10 years through expansion of evidence-based curative services and individual and community-wide health promotion measures for reduction of risk factors. It has identified the following nine strategies to address the NCD burden in Sri Lanka:

1. Support prevention of chronic NCDs by strengthening policy, regulatory and service delivery measures for reducing level of risk factors of NCDs in the population;
2. Implement a cost-effective NCD screening program at community level with special emphasis on cardiovascular diseases;
3. Facilitate provision of optimal NCD care by strengthening the health system to provide integrated and appropriate curative, preventive, rehabilitative and palliative services at each service level;
4. Empower the community for promotion of healthy lifestyle for NCD prevention and control;
5. Enhance human resource development to facilitate NCD prevention and care;
6. Strengthen national health information system including disease and risk factor surveillance;
7. Promote research and utilization of its finding for prevention and control of NCDs;
8. Ensure sustainable financing mechanisms that support cost effective health interventions at both preventive and curative sectors;
9. Raise priority and integrate prevention and control NCDs into policies across all government ministries and private sector organizations;

The National Health Council, National Authority on Tobacco and Alcohol, NCD Steering Committee, National Cancer Advisory Group and the National NCD Working Group within the Ministry of Health are again a few structural bodies that have been formed to assist in translating policies into action. The NCD Steering Committee chaired by Secretary Health is the platform created at ministry level to bring all sectors together.

The Sri Lankan Government’s political commitment to deal with NCDs is backed by financial resources which has strengthened the fight against NCD. It has allocated US$ 7 million for prevention and control of NCDs for the period 2011-2013. This is supplemented by financial and technical support from multilateral and bilateral agencies like JICA, The World Bank and WHO.

Sri Lanka’s policy choices also extend to international treaties. It was the first country in the South-East Asia Region to ratify the WHO FCTC (WHO Framework Convention on Tobacco Control) in 2006. As a follow-up to ratifying the WHO FCTC, Sri Lanka enacted legislations for tobacco and alcohol control. It has established a National Authority on Tobacco and Alcohol (NATA) to implement the Act through District Cells (DTCC). The array of health ministers that have been overseeing the Ministry have been strong anti-tobacco activists. The current Minister of Health, Honourable Maithripala Sirisena has been strongly supporting the implementation of pictorial warnings as well as the strengthening and revision of the current NATA legislation.
3. Policy to practice – action on the ground

Sri Lanka’s policy and institutional framework to deal with NCDs has triggered a series of actions on the ground in the following areas:

A. human resources and dedicated institutions
B. health systems / infrastructure
C. guidelines, quality and uniformity
D. essential drugs and medicinal devices
E. demonstration projects
F. monitoring, evaluation and surveillance
G. multisectoral action
H. involvement of professional colleges and other organizations

A. Human resources and dedicated institutions

Human resources are essential to effective outcomes in health care. The key actions in this area have been the creation of a specialized unit to deal with NCDs. Its mandate, as described in the portal of Sri Lanka’s Ministry of Health, is “prevention and control of inequitably distributed rapidly growing NCDs to lessen the human, social and economic impact to the people in the country.”

The second key action is the federal Government’s appointment of medical officers specifically for NCDs. Today, each of Sri Lanka’s 25 districts has a medical officer in charge of NCD prevention and control. The Government has also put in place a NCD surveillance system and evaluation of prevention and control activities at the district level every three months. District-level tobacco control cells (DTCC) have been set up in all districts with the involvement of all stakeholders. Medical officers tasked to deal with NCDs are designated secretaries to the DTCC.

B. Health systems / infrastructure

Sri Lanka’s NCD programme is not a vertical, stand-alone one. Its cost-effectiveness rests largely on the systems approach that the country has adopted. The country is investing in strengthening its time-tested, much-lauded primary health care system to address the burden of NCDs. In 2011, after several meetings with all stakeholders, the Ministry of Health decided to implement the Package of Essential NCD interventions through the setting up of HLCs in primary health care institutions throughout the country for people between the ages of 35 and 65, previously undiagnosed for NCDs. Guidelines for establishing HLCs were issued in September that year. Screening for early detection of NCDs is a key goal of the national NCD prevention programme. The HLCs are equipped to provide health guidance, screening, basic treatment, referral and follow-up for the target population. Presently, there are 668 HLCs in the country, up from 297 HLCs in 2011. In most HLCs, there are two screening sessions per month and 25 people can be accommodated for check-up and counselling in each session.
Mass screenings for NCDs are done in a variety of settings. In Kurunegala district, for example, one HLC is housed in the community support centre at Halayiwala inside a temple. This is what is known as a mobile clinic. A public health nursing sister who supervises midwives says advocacy for NCD screening starts with midwives doing home visits as part of routine ante-natal care for pregnant women. Family members are also urged to go and get themselves checked up at the HLC. Midwives and other health staff such as public health inspectors attend funerals and visit temples and schools. Health promotion talks are designed to be entertaining. Cinema and comedy shows were featured for the assembled crowd. A public health inspector says this is the “happiness mode”. Mutual support groups of mothers are also crucial to health promotion.

Dr Thalatha Liyanage, Director, NCD unit, Ministry of Health

C. Guidelines, quality and uniformity

Sri Lanka has issued national guidelines in several key areas related to NCD prevention to ensure quality and uniformity of services at all levels. For example, national guidelines are being used for screening at HLCs and primary health care institutions. These guidelines, which have adopted the “total risk assessment approach”, were prepared using the WHO PEN (Package of Essential NCD Interventions for Primary Health Care in Low-resource Settings) protocol after extensive consultations with various stakeholders.

D. Essential drugs and technologies

In order to implement programmes, it is important to know the missing links. Two things which are vital to providing quality care are appropriate and well-maintained equipment. They also form part of PEN. The 2010 World Bank study notes that there is substantial underprovision of essential medicines required for routine management of chronic NCDs in Government health facilities in Sri Lanka. This corroborates an earlier study by WHO assessing the availability of 32 essential medicines for chronic diseases in Sri Lanka and five other low and middle-income countries. In Sri Lanka, the median proportion of these 32 essential drugs available in public health facilities was a mere 28%. The corresponding figure for the availability of such drugs in the private sector was 79%. This explains the rising out-of-pocket expenditure for patients suffering from NCDs in Sri Lanka. As of now, gaps still remain, but corrective measures for being taken. The Ministry of Health has compiled a list of 16 essential NCD drugs and has issued circulars to ensure that they are available at all primary health care institutions. This list includes medication for management of cardiovascular diseases, diabetes and respiratory diseases and attempts are now underway for inclusion of medication related to palliative care.

E. Demonstration projects

There have been key pilot initiatives to roll out Sri Lanka’s NCD prevention and control strategy. These include the NCD Prevention Project (NPP), supported by JICA and piloted in two MoH areas in Kurunegala and Polonnaruwa; the National Initiative to Reinforce and Organise General Diabetes Care In Sri Lanka (NIROGI Lanka) supported by the World Diabetes Foundation (2009), the pilot of Package of Essential NCD (PEN) Interventions in the Uva province in the Badulla Regional Directorate of Health Services area, covering 18 health facilities within three MoH areas from 2009 to 2011 supported by the WHO Country Office and the Pilot by the policy planning unit of the Ministry of Health which selected health institutes in three districts.

NPP: This initiative, which kicked off in 2008, assisted the Ministry of Health in implementing interventions to prevent the development of risk factors for cardiovascular diseases by providing risk check-ups, health guidance and health promotion programmes at the primary and secondary health care institutions and in communities. As part of the project, guidelines for health check-ups, guidance and promotions have been drafted and various intervention tools are being pilot-tested in Badulla, Gampaha and Polonnaruwa for technical, institutional and financial feasibility in implementation and for countrywide expansion. People aged 40 to 75 years without a past history of NCD (total target population 64,000) are provided with health guidance support, a health check-up, and a risk analysis in the pilot programme. Health promotion for low-risk people is provided in two settings – village and workplace. For those already diagnosed or with newly diagnosed NCDs, referrals are made to primary care centres or higher-level facilities as appropriate.

NIROGI Lanka: The National Initiative to Reinforce and Organise General Diabetes Care in Sri Lanka (NIROGI Lanka) was supported by the World Diabetes Foundation (2009). This pilot project was a collaboration between the Diabetes Prevention Task Force, the Sri Lanka Medical Association, Ministry of Health, Collaborative Research Group on Diabetes and Metabolism, Diabetes Association of Sri Lanka, and the Healthy Life Diabetes Clinic.

The Package of Essential NCD (PEN) Interventions Pilot: The pilot supported by WHO in the Uva province in the Badulla Regional Directorate of Health Services area covered 18 health facilities within three MoH areas from 2009 to 2011. This package included six core activities as well as plans to introduce comprehensive NCD care within the primary care settings. It also covered assessment of availability of human resources and essential equipment needs for NCD care, updating the health staff with the latest knowledge about NCD care, ensuring that the essential list of drugs available in the facilities included the first line of NCD drugs, development and application of 10-year cardiovascular disease risk scores, target population and development and introduction of protocols for follow-up care and management of NCDs.

Kurunegala district in the North-Western Province was among the first to pilot a cost-effective NCD-screening programme at the community level, using the WHO Multiple Risk Assessment Approach. Financial and technical support for the pilot which kicked off in 2008 came from the NCD Unit of the Ministry of Health, the Province-Specific Development Grant of the North-Western Province and JICA. The pilot started with advocacy among provincial and district leaders as well as through billboards and banners. Health personnel were introduced to the screening methodology. Public health midwives, other health staff and community volunteers were sensitized about the target population and taught how to motivate people to come to the screening centre. After screening, there were follow-ups and continued interventions of high-risk groups. Those with a history of cardiovascular diseases and those with an increased cardiovascular risk were provided with information on health risks. Recruitment for screening was done mainly by self-referral and through the help of health staff such as community health midwives, volunteers and sometimes through referrals by doctors. Sri Lanka is using the WHO and International Society of Hypertension (ISH) risk prediction charts for assessment of cardiovascular risk for prevention and control of cardiovascular diseases in low- and middle-income countries. The main link between the health system and the community is the public health midwife.
Schools are important sites of action and key concepts about healthy diet, the importance of physical activities and avoidance of tobacco, alcohol and other harmful substances are being incorporated into the curriculum.

Dr Lakshmi Somatunge – Deputy Director General (Medical Services), Ministry of Health

F. Monitoring, evaluation and surveillance

The NCD unit at the Ministry of Health conducted its first STEPS risk factor survey in 2006 which covered five of the 25 districts. In addition, the results of studies and surveys by individual researchers and academics are available that contribute in elucidating the disease burden as well as the mortality in relation to NCDs as well as the related risk factors. In 2008, a nationwide survey—the Sri Lanka Diabetes, Cardiovascular Study (SLDCS)—was carried out among adults on diabetes and pre-diabetes in the country. For the first time, the study measured risk factors for diabetes for the 18 and above age groups. Another significant source of data about NCDs in Sri Lanka is the Ragama Health Study (RHS), a collaborative effort between the Faculty of Medicine, University of Kelaniya, Sri Lanka and the International Medical Centre of Japan (IMCJ). The study sought to diagnose metabolic syndrome (MetS) in a section of the urban Sri Lankan Population. Metabolic syndrome is a complex web of metabolic risk factors associated with a five-fold risk of type 2 diabetes (T2DM) and a two-fold risk of cardiovascular disease. The study has contributed to the mapping of prevalence of MetS among South Asians who are high-risk populations with respect to diabetes and cardiovascular diseases. However, the burgeoning private health sector in the country does not yet have a proper system of collecting or sending health sector data to the Government, barring notifications of communicable diseases and special research studies.

G. Multisectoral action

Sri Lanka recognizes that the battle against NCDs cannot be won by just health interventions and that multistakeholder partnerships and multisectoral initiatives are critical for success. This is evident through many activities for NCD prevention and control that have been initiated in the country. Some examples:

Community-led interventions

In Sri Lanka, empowering the community to adopt a healthy lifestyle, or a “bottom to top” approach, has been the key health promotion strategy in the context of prevention and control of NCDs. Health promotion activities are on in a variety of settings for maximum impact—schools, workplaces, villages, youth networks, ante-natal clinics and so on. The concept of “healthy home” and “healthy village” is being propagated as an adjunct to the strengthening of the health system.

Youth networks

A 2004 survey revealed disturbing trends—on average, most adolescents had experimented with smoking, use of alcohol and other substances of abuse around the age of 14 or 15. The Ministry of Health has signed a Memorandum of Understanding with the Ministry of Youth Affairs and Skills Development and the National Youth Services Council. Three districts have been selected to pilot an integrated effort to sensitize members of youth clubs about the risk factors behind NCDs. The network of youth clubs under the National Youth Services Council has a footprint in 12 000 out of 14 000 villages in the country.

Schools - the site of action

“Schools are important sites of action and key concepts about healthy diet, the importance of physical activities and avoidance of tobacco, alcohol and other harmful substances are being incorporated into the curriculum.”

Dr Lakshmi Somatunge – Deputy Director General (Medical Services), Ministry of Health

Three main concepts about healthy diet, the importance of physical activity and avoidance of tobacco and other harmful substances are being integrated into the school curriculum. In order to further the adoption of a “healthy diet”, the ministries of education and health have teamed up to formulate healthy diet guidelines. Circulators to schools spell out what should be made available, such as rice-based food and fruits and what should not be available, such as fizzy drinks and junk food. Public health inspectors do the rounds of schools checking if school canteens comply with the healthy food policy.
Workplaces – an entry point for NCD prevention and control
As we spend most of our waking time at the workplace, it is mandatory and deemed most effective to address the workplace for health promotion and NCD prevention. There is much interest from many actors within and outside the Health Ministry in various initiatives including initiation of physical activity within the workplace, healthy meeting menus as well as healthy canteen guidelines. Since the workplace is a truly multisectoral setting, many actors are engaged in this field from within the Health Ministry as well as other ministries.

H. Involvement of professional colleges and other organizations
In Sri Lanka, professional colleges have always played a key role in the NCD prevention and control programme, especially in formulating guidelines, capacity building and training efforts as well as initiation of a social media campaign. The Super 8 concept identified by the college of community physicians is a very useful marketing tool in identifying eight targets for healthy living. In addition, several nongovernmental organizations that are very active in the field of NCD prevention, work in unison with the Ministry of Health, creating a high impact. Attempts are underway to unite the nongovernmental organizations through formation of a national NCD alliance.

Vignettes from the field: How the battle against NCDs is being fought on the ground

Health talk to the villagers on NCD prevention by a Public Health Inspector (PHI).

Measuring height for BMI calculation.

A nurse with a healthy diet message to the participants of HLC clinic.

Kurunegala, North Western Province
At the Digampitiya Healthy Lifestyle Centre in Kurunegala district, North Western Province, one watches the NCD prevention strategy at work. Thirty-six-year-old Dilani Jayasinghe, a married woman with two children, is one among several women who have come for a NCD screening at the HLC. It is her first such check-up. Recurring body pains led her to visit the doctor at the primary care unit. The doctor urged her to visit the HLC, about 2 km from her home. There are many women like Dilani inside the room, but male faces are few. Dilani’s husband, 43-year-old Anura, has come to drop his wife at the HLC, but is reluctant to seek an appointment for a similar check-up for himself. The reasons are all too familiar – he will wait till Dilani has finished with her tests; he does not have enough time; he does not feel the need for a screening. Anura’s reluctance to get himself screened for possible NCDs tellingly illustrates a key challenge facing Sri Lanka’s mass screening programme. Men are more at risk of NCDs, but paradoxically, they are more reluctant to come to the HLCs. The most commonly cited reason is lack of time and too much work.

The NCD programme has so far managed more or less with existing staff despite challenges on the ground. Over the last two years, 124 HLCs have been established in Kurunegala district alone.
Batticaloa, Eastern Province

Mahiladithewu, a small island in Batticaloa district in Sri Lanka’s Eastern Province, illustrates the challenges of rolling out the NCD programme in remote, rural pockets as well as what is possible if there is commitment. Access to health care is a big problem in these parts, though the Mannarai bridge, being built with Japanese assistance, will certainly improve connectivity once it is completed. With the end of the civil war, things are looking up. Five years ago, there was only one ferry service a day to the island. That has gone up to two. But there is still a lot to be done in the days ahead. At the Divisional Hospital in Mahiladithewu, there are promising signs. The hospital uses an integrated management system with the help of a consultant physician and cardiologist who are based in urban hospitals. In Batticaloa, one also witnessed how the Medical Officer NCD used routine meetings with community leaders and members of networks like the Mothers’ Support Group to promote awareness about the social determinants of NCD. Such networks provide additional links to the community and are being used to spread the word about NCD screening. During many of these interactive sessions, visual images are used to help those with low or no education absorb key messages.

Lessons learnt

As Sri Lanka embarks on an intensified national NCD control programme, there are several useful takeaways from the work it has done so far. The lessons relate to the pivotal role of the following factors: (1) primacy of political will and vision; (2) importance of public health in the national agenda and development plans which ensures provision of adequate funds to the Ministry of Health; (3) addressing social determinants of health: multisectoral and stakeholder coordination; (4) optimal use of existing health infrastructure; (5) emphasis on prevention and early detection of the most common NCDs; (6) strengthening the health system; (7) prioritizing research and evidence-based strategies; (8) learning from pilot initiatives; (9) receptivity to global good practices; (10) accepting there are gaps.
Political commitment

Importance of public health in the national agenda

Optimal use of existing infrastructure and human resources

Emphasis on early detection of the most common NCDs, prevention and health promotion

Addressing social determinants of health: multi-sectoral and multi-stakeholder coordination

Optimizing research and evidence-based strategies

Learning from demonstration projects

Receptivity to global good practices

Accepting there are gaps

In Sri Lanka, the battle against NCDs is positioned not just as a health issue but also as a development issue which can make or mar national aspirations and the future of the country. As noted earlier, the political commitment stems from the highest authority – the President – and trickles down to every level of Government. There is political consensus in Sri Lanka about free health care.

The Development Policy Framework of Sri Lanka’s Ministry of Finance and Planning (2010) lauds Sri Lanka for having achieved commendable progress in providing universal health care and notes that the country “must maintain its global lead role in health care in the future.” It is this self-image of the country as a trailblazer in public health care, and the importance accorded to the Ministry of Health, that creates an environment conducive to the multistakeholder and multisectoral interventions embedded in Sri Lanka’s NCD strategy. This also sets it apart from other countries in the Region where public health is not on top of the national priority list. Sri Lanka has shown that it is willing to learn from others, but its success story in health care is not externally-driven. As an October 2010 study by The World Bank noted, “The Ministry of Health receives grants and loans from external development partners for NCDs including JICA, The World Bank and WHO. These external resources accounted for less than 5% of total health expenditures during the past decade.”

Sri Lanka recognizes that to effectively battle NCDs, it has to adopt strategies that are spearheaded by multiple stakeholders and multiple sectors and this is evident in most of the policies and plans initiated. A significant example is the School Health and Nutrition Programme – a joint initiative of the ministries of education and health.

The health promotion policy at schools includes the following elements – school canteen guidelines, allocation of 15 minutes in the morning for exercise, health and physical education as a compulsory subject for Grades 1–9 and as one of the options for Grades 10–11.

Sri Lanka’s story in providing “good health at low cost” has been often attributed to health system factors: universal adult franchise and universal free education. However, as a recent report by the Institute of Policy Studies of Sri Lanka pointed out, there are several other sectors at play, such as a wide transport network that enable access to health services, land reforms that reduced the concentration of wealth in an elite land-owning group and a strong culture that recognized the important role played by females (for example the celebration of menarche, and aims-giving for pregnant mothers). Unlike many other countries in the South-East Asian Region, women in Sri Lanka have relatively more mobility, a higher rate of literacy and therefore can access ANC services more easily. The crucial role of women in NCD prevention and control has to be acknowledged, as they are seen as “agents of change” within the home setting.

Sri Lanka’s NCD strategy convincingly demonstrates the optimal use of existing human resources. The public health midwife, central to Sri Lanka’s success in maternal and child health, also plays a key role in the NCD interventions; for example, her local knowledge and rapport with communities are leveraged to get people to healthy life centres for screening of NCDs. A study done by the Alcohol and Drug Information Centre (ADIC) on the outcome of a community intervention project introduced to reduce harm from alcohol use at three selected locations in two districts of Sri Lanka. (June to November 2009) noted that the P+H and the PHM were the people who identified health problems among alcohol-consuming families. Subsequently, alcohol prevention activities were incorporated into the programmes of community organizations. The project, supported by the WHO South-East Asia Regional Office (implemented in Uthukkada and Randobage villages in the District of Galle and Ensalawa estate in the District of Matara), demonstrated that frontline workers are key to community mobilization which in turn helps a community to realize the harm caused by alcohol use and can lead to community action with enthusiasm to solve problems on their own.
Secondary and tertiary-level health care costs a lot more than primary care and can hugely impact the national budget. By focusing on prevention, early detection of the most common NCDs, and health promotion, Sri Lanka has shown that its NCD strategy will follow the “good health at low cost” template for which the country is famous. One such example emanates from a structured review of data from cancer registries in Sri Lanka, conducted to extract evidence related to the burden and early detection of breast cancer. The data from the cancer registries clearly showed an increasing incidence of breast cancer among females during the last 20 years, giving an age-standardized incidence rate of 18.4 /100,000 in 2005. From 2000 to 2005, approximately 25% of newly detected female cancers each year were breast cancers. When the age-specific breast cancer incidence rates were compared during 2000–2005, the highest incidence rate was reported among women 50–69 years of age. This evidence made Sri Lanka’s health authorities realize that since breast cancer patients were still being diagnosed only in advanced stages and there was relatively low coverage of early detection of breast cancer, awareness activities for health professionals and the public, as well as regular monitoring and evaluation of the programme needed to be conducted.

Strengthening the health system is central to Sri Lanka’s goal of providing NCD services at different levels. This is happening by building capacity at the level of primary care with the supply of essential tools and technologies.

The research agenda for NCD, prioritized by WHO, has assisted countries in highlighting the priority areas in relation to NCD, so that limited funds are channelled in a productive manner. Sri Lanka has again achieved a milestone in this area with the establishment of the ASCEND research network (Asian Collaboration for Excellence in Noncommunicable Diseases). This is supported by Monash University and continuously strengthens the area of research. In addition, the Government itself is providing financial incentives for persons who undertake research as part of their in-service training. The National Science Foundation under the Ministry of Science and Technology provides financial support for research through awarding of grants in areas of health which has again assisted in enriching the culture of research within the country.

The pilot initiatives by various partners ranging from health promotion models to health system strengthening have played a key role in formulating the current NCD prevention and control programme. This brought Sri Lanka the comparative advantage of being able to identify best practices as well as the difficulties faced in implementation. These efforts are still being consolidated. On completion, this will again assist the current programme.

“Now Sri Lanka is at a crossroads where it is facing rapid epidemiological, social, demographic and socioeconomic transitions—the country’s response to this and prioritized action could serve to assist other countries facing similar challenges in the region and beyond.”

Dr F R Mahta, Country Representative, World Health Organization, Country Office Sri Lanka

It is sometimes difficult to introduce a new concept in a country. Despite being a highly respected technical organization with the mandate of being a specialized technical agency, the WHO Country Office in Sri Lanka too faced difficulties, especially in relation to the introduction of cardiovascular risk assessments. This was counteracted by continuous technical support from WHO headquarters as well as the WHO Regional Office for South-East Asia through national consultations and capacity building efforts at periodic intervals. Key people in Sri Lanka were then identified to continue this effort through the Ministry of Health and professional bodies.

In addition, it was found that rather than simply initiating a pilot with tools and technologies received from WHO, the acceptance and sustainability were higher when a national level consensus was obtained prior to its implementation. This was strongly evident in the implementation of PEN in Sri Lanka.

Though Sri Lanka has rolled out an impressive NCD programme, field visits indicate that there are gaps which need to be addressed. The good sign is that Sri Lanka’s health policy-makers recognize this and are taking steps to bridge them.

“We have achieved a lot. For instance, treatment for cancer is free in this country. But we still have concerns. One key concern is the equity of health services across the country. Some areas are very well-served. Others are not so well-served. In this battle against noncommunicable diseases, we have to ensure that available health personnel and services are equitably distributed. Even a very poor person should be able to access the range of NCD services. One of our main priorities is to identify areas where there are gaps.”

Dr Y D Nihal Jayathilaka, Secretary, Ministry of Health, Sri Lanka
Sri Lanka has taken impressive strides in tackling noncommunicable diseases. Just as health care costs began to escalate, it rolled out a series of timely and low-cost interventions in NCD prevention that will yield results in the years to come, and which other developing countries can replicate. However, it will have the following challenges like any other developing country.

(1) Keeping costs down
A substantial proportion of care for NCDs is currently delivered by the private sector where patients pay for almost all their treatment costs. Public sector facilities offer free consultation, but then refer patients to private clinics and pharmacies for diagnostics and medical care, which have to be paid for. Treatment of cancer and acute myocardial infarction is predominantly publicly financed while expenditures for chronic NCDs, such as diabetes, asthma and other types of ischemic heart disease (IHD), are not. This has financial implications for families and communities. In order to quantify the cost-effectiveness of various interventions that are being rolled out to prevent and control NCDs, it is critical to plug the data and evidence deficits.

(2) Capacity building
Sri Lanka has done a great job in health care, but its health systems are overstretched due to the growing NCD burden. In the future, it will be necessary to expand and strengthen the capacity of the health workforce, so that it can effectively implement the programmes that are being rolled out.

(3) Improving attendance at HLCs, especially that of men
At the micro-level, there is another key challenge. It is not enough to set up more HLCs and staff them. Increasing attendance is pivotal to the success of the programme. Existing data show men are more at risk of NCDs, but getting men to realize that they are vulnerable and to get them to come for NCD screenings so that such diseases, if any, are detected early, is a difficult task. Many steps have been taken to address this. Screenings are now being held across the country at worksites, in public places like banks and at railway stations. A variety of methods are being deployed to improve male attendance at the HLCs. For this, a major training of trainer (TOT) programme is under way for visiting physicians in NCD management protocol. In 2012–2013, 2,448 medical officers have also undergone similar training in all the districts.

(4) Access to medicines
The burden of chronic noncommunicable diseases cannot be reduced without equitable access to essential medicines. NCD medicines are critical to the treatment of cardiovascular diseases, diabetes, chronic respiratory diseases (i.e. chronic obstructive pulmonary disease, asthma), many cancers (including for palliative care), mental and neurological disorders. Demand for medicines is growing rapidly along with the rising number of NCD patients.

(5) Ageing
The double burden of an ageing population and the surge in noncommunicable diseases challenges many of Sri Lanka’s aspirations, especially since it is undergoing these transitions at a much lower level of national income than most developed countries. But Sri Lanka has demonstrated that it has the political commitment to battle NCDs. The policy options it has adopted also show that the country is on the right track. As it rolls out an intensified NCD programme, its experiences on the ground will be tracked by other countries in the Region and across the developing world battling a similar demographic and epidemiological transition.
This is no mean feat for a developing country that is still recovering from a long internal conflict. If one single factor has to be credited for Sri Lanka’s proactive stance towards NCDs, it is political commitment which percolates down from the top, and impacts the grass roots. Health experts, however, say that given the magnitude of the problem, more needs to be done on primary prevention, health promotion and in addressing inequities plaguing the health care system, if Sri Lanka is to sustain its growth trajectory.

Health ministry officials in Colombo agree. There are plans to streamline the healthy lifestyle centres, train all doctors on the Multiple Risk Factor Approach and Management Protocol, lay more emphasis on health promotion and develop a national NCD surveillance system. Provision of optimal NCD care by strengthening the health system will remain a top priority, as will a multisectoral approach. Initiatives are already under way to address some of the bottlenecks on the ground such as access to medicines for NCDs at the primary care level. The Health Ministry has given instructions to ensure that 16 essential NCD drugs are available at all primary health care institutions. Plans are being drawn up to ensure uninterrupted supply of NCD medicines.

Conclusion

Sri Lanka stands out as a country that has done “so much with so little”. It has boldly addressed the challenges of NCDs with political commitment translated into policy and action in a planned and coordinated manner soon after the end of the conflict in 2009. It therefore, stands out as a good practice country example for addressing NCDs in a practical and cost-effective manner which other countries in the Region may wish to draw upon through exchange visits, south–south collaboration, operational research and dissemination of experiences at various national, regional and global forums. The WHO Regional Office and the country office in Sri Lanka remain committed to assisting Member States in this endeavour.