Public Health Success in Sri Lanka
Sri Lanka has achieved remarkable success in public health. The country has developed a robust public health network, having prioritized free access to health services for the entire population for several decades. Strong foundations are in place, such as robust health systems, trained health professionals and widespread accessibility to primary and tertiary level health services. These cornerstones led to the achievement of major milestones in public health highlighted in the following briefs. WHO is proud to partner with the Ministry of Health for over 60 years of this journey.
Fighting Filariasis & Achieving Elimination
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Following a prolonged battle against lymphatic filariasis (LF), Sri Lanka achieved a major public health milestone in 2016 and received WHO Certification for the Elimination of Lymphatic Filariasis as a public health problem. This brief highlights the strategies that were instrumental towards achieving this milestone.

What’s at stake?

Sri Lanka has a long history with lymphatic filariasis, one of the oldest and most debilitating neglected tropical diseases. The earliest known cases can be traced back to the 4th century BC. Lymphatic filariasis causes profound disfiguration, permanent disability and psychological stress. The first national surveys conducted from 1937-1939 indicated a microfilaria (Mf) rate ranging from 20 –24 %, meaning almost one in every four people was affected by the disease. Eight districts in the country were endemic to this disease.

Key approaches

Political Commitment

- Strong political commitment to prevent and control lymphatic filariasis led to the establishment of the Anti-Filaria Campaign (AFC) in 1947.
Key Strategies

• The AFC implemented key strategies to stop the spread of the disease, including; intensification of mosquito control efforts and parasitological surveillance, increased access to health services, treatment and disability management for those affected, mass drug administration campaigns and health education programmes to reduce stigma associated with the disease.

• Systematic surveys and surveillance generated rich data for precise endemicity mapping and the design of evidence-based strategies and targeted interventions.

• Collaboration with WHO and other key partners ensured strong technical support for the AFC.

Mass Drug Administration Campaigns

• In 2002, a national elimination programme was launched, focusing attention on the eight LF endemic districts, where 11 million people resided. Mass drug administration (MDA) campaigns were conducted annually for 5 consecutive years.

Health Workforce

• A highly trained workforce including Public Health Inspectors, midwives and local volunteers ran social mobilization campaigns to ensure the success of the MDA campaigns in endemic areas.

Elements of success

The mass drug administration campaigns conducted between 2002 and 2006 achieved over 80% coverage, which subsequently reduced the MF rate to 0.05% and enabled the country to target lymphatic filariasis elimination.

Post-MDA surveillance and Transmission Assessment Surveys (TAS) conducted from 2011-2013 proved that the disease dynamics were in decline.

The MF rate is stable at 0.03% since 2015.

In July 2016, Sri Lanka officially received WHO Certification for Elimination of Lymphatic Filariasis as a public health problem.
Lessons learned

- Strong political leadership is a prerequisite for the elimination of neglected tropical diseases.
- Commitment to technical excellence, evidence-based strategies and a highly trained, dedicated workforce achieved major gains in the fight against lymphatic filariasis.
- Strategic collaboration and partnerships ensured critical long term technical and financial support for the AFC.
- Investment in the capacity building of healthcare staff especially on morbidity management and disability prevention is a cost-effective intervention.
- High coverage of MDA campaigns for five consecutive years was instrumental in bringing down the disease burden and gearing the country towards elimination of lymphatic filariasis.
After embarking upon an elimination drive, the Anti-Malaria Campaign brought indigenous cases down to zero in November 2012. After 3 years of maintaining this figure, Sri Lanka received certification from WHO in September 2016 for achieving malaria elimination.

Sri Lanka is now focused on maintaining elimination status and preventing the re-introduction of malaria. The country remains highly vulnerable to malaria transmission and importation of the disease is a major threat. The AMC is engaging in multi-stakeholder partnerships, working closely with the security forces, airport authorities, UNHCR and IOM to screen high risk populations entering the country and prevent re-introduction of the disease.

Lessons learned

• Increased access to health services enabled early diagnosis and prompt treatment by trained health workers, which led to reductions in morbidity and mortality.

• Shifting strategies from vector control to parasite control proved very effective.

• The focus on high-risk areas and high-risk populations was a cost effective measure which led to major progress against malaria.

• Intensive disease surveillance, integrated vector management, rigorous community engagement and research were key strategies.

• Partnerships with stakeholders enabled strong technical and financial support to bolster the Anti-Malaria Campaign's efforts.

• A strong public health system has been critical to the success of the AMC and the elimination of malaria in Sri Lanka.
Conquering Malaria: How to Reach Zero Cases

Malaria has caused death and devastation in Sri Lanka for centuries. At its height, over one million cases were recorded each year. After a prolonged battle, the country has now reduced the number of indigenous malaria cases to zero. This brief highlights the key strategies used in a low-resource setting to eliminate this public health threat.

What’s at stake?

Malaria has a long and turbulent history in Sri Lanka. During the most devastating outbreak in 1935, there were over 1.5 million cases of malaria, causing 80,000 deaths. This is an astonishing figure, given that the total population of Sri Lanka was around 6 million people at that time. Through intensive mosquito control efforts, the country almost achieved malaria elimination in 1963, when just 17 cases of the disease were recorded. However, malaria resurfaced and it took five decades to recover the ground lost against the disease and achieve elimination status.

Key approaches

- The Anti-Malaria Campaign (AMC) was established by 1911 to strengthen malaria control efforts.
- The catastrophic outbreaks of the 1930s were largely controlled by larvicides used to kill mosquito larvae.
- DDT insecticide was introduced to Sri Lanka for indoor residual spraying during the 1940s which proved highly effective in controlling the mosquito population.
- This led to the dramatic reduction in the number of malaria cases by the 1960s and a marked decline in morbidity and mortality levels.
- The number of health facilities increased throughout the island and health care workers were trained on early diagnosis and treatment of malaria.
- In 1957, Sri Lanka embarked on a malaria eradication strategy. In 1963, just 17 cases of malaria were detected for the entire year. The country almost reached elimination status.
- However, political and financial support wavered and within a few short years, malaria resurfaced on a virulent scale. By 1969, the number of malaria cases had soared to over 500,000.

Malaria incidence in Sri Lanka, 1911-2015

Source: Anti Malaria Campaign, Ministry of Health Sri Lanka
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Malaria control efforts were intensified by the AMC. Key strategies were implemented including; Indoor Residual Spraying (IRS); larvae control; regular surveys of adult and larvae mosquitoes in endemic districts to monitor and detect insecticide resistance; and strengthened case detection through blood film testing (parasitological surveillance) both actively and passively.

Elements of success

During the 1990s, the AMC changed from vector control to parasite control strategies which greatly enhanced the programme’s success. From 1999 onwards steady progress on malaria was made. By 2008, the country recorded less than 1,000 cases of malaria per year, enabling Sri Lanka to target elimination.

Shrinking the Malaria Map Sri Lanka 1999

Shrinking the Malaria Map Sri Lanka 2013
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**Lessons learned**

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Healthy Lifestyle Centres: Taking NCD Care to the Heart of the Community
Healthy Lifestyle Centres: Taking NCD Care to the Heart of the Community

In response to the growing threat of non-communicable diseases, Sri Lanka employs innovative approaches to prevent and treat NCDs. This brief outlines Sri Lanka’s low-cost, people-centred actions to combat this health challenge through the establishment of Healthy Lifestyle Centres.

What’s at stake?

Each year, 103,500 Sri Lankans die from non-communicable diseases, such as heart disease, lung disease, stroke, cancer and diabetes. NCDs account for three in every four deaths in Sri Lanka. The prevalence of NCDs is rising, due to the ageing population, urbanization, changes to a more sedentary and unhealthy lifestyle, and associated risk factors. One out of three people have raised blood pressure, one in three adults are either overweight or obese. The NCD epidemic is a serious economic issue. NCD treatment costs account for a huge proportion of the annual health budget. Although health care in Sri Lanka is free, NCD care is increasingly financed by out-of-pocket spending.

Key approaches

Policy and Strategic Framework

- The Government of Sri Lanka launched the National NCD Policy and Strategic Framework for Chronic NCDs in 2010 to reduce premature mortality due to chronic NCDs and expand evidence-based curative services.

- The Ministry of Health initiated the Healthy Lifestyle Centres (HLCs) in 2011 as part of this strategic framework to provide a high impact NCD screening service at primary care units.

- The central objective of HLCs is to reduce the risk of NCDs amongst 40-65 year olds through early detection of risk factors and detection and management of NCDs.
Key approaches

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• The central objective of HLCs is to reduce the risk of NCDs amongst 40-65 year olds through early detection of risk factors and detection and management of NCDs.

Health Workforce

• Trained health care workers screen clients at HLCs for fasting blood sugar, blood pressure, body mass index and additional behavioural risk factors such as smoking, alcohol, physical inactivity and unhealthy diet.
• Lifestyle counselling, nutrition and health advice is provided to those at risk of developing NCDs and follow-up screenings are scheduled. For those at high risk of cardiovascular disease, a referral system for specialized medical treatment is in place.

HLC Referral and Recruitment

• The current HLC model encourages the targeted population - almost 25% of the national population to use the HLC services largely by self-referral. The target population is also reached through Hospital Out Patient Departments and through promotional talks at health institutions.

Action Plan

• The recently launched ‘National Multi-sectoral Action Plan for the Prevention and Control of NCDs in Sri Lanka 2016-2020’ will enhance actions on NCDs through additional outreach programmes, mass media campaigns and the expansion of opening hours of HLCs to increase public awareness and encourage further male participation at HLCs.

Elements of success

HLCs empower communities to adopt healthy lifestyle practices. HLCs are a successful mechanism to prevent and control NCDs.

The number of HLCs in Sri Lanka has grown from 126 in 2011 to 826 in 2016.

HLCs function across all levels of facilities – primary, secondary and tertiary care hospitals.

The screening of the targeted population increased from 2.5 % in 2011 to 25 % in 2016.

Political commitment and support from the highest level of government have been instrumental in driving the success of this initiative.

Collaboration with multiple stakeholders is a vital ingredient in building the capacity of the HLCs through training and funding support.

Lessons learned

• Investing in NCD prevention and early detection of NCDs are cost effective strategies to reduce NCD morbidity and mortality.
• Incorporating HLCs at the primary health care level ensures improved accessibility to preventive services for the public.
• Empowering the community to adopt and advocate healthy lifestyles is an effective NCD preventative mechanism.
• Capacity building of primary health care staff through training programmes on HLC protocols and maintenance of up-to-date patient records is crucial to optimize the function of HLCs.
Ending Preventable Maternal Deaths
Ending Preventable Maternal Deaths

Sri Lanka has invested in a robust public health system, which ensures access to free health care for the population. This investment has resulted in the dramatic reduction of maternal mortality and other public health gains. This brief sets out the key strategies employed to protect women during pregnancy and childbirth to reduce preventable maternal deaths.

What’s at stake?

Severe life threatening complications arise in about 15% of all pregnancies, such as dangerously high blood pressure, excessive bleeding during childbirth or serious postpartum infection. Without appropriate treatment, women risk disability and death. Globally, over 300,000 women die each year from complications related to pregnancy or childbirth. Over 99% of these deaths take place in developing countries. Sri Lanka serves as a model for the significant gains it has made in maternal mortality reduction.

Key approaches

Accessibility and affordability

- In the 1930s and 1940s, the government focused on expanding free healthcare services throughout the country. Health units were established at the primary level to provide community based maternal and child care and other preventive care services. Health units were supported by rapidly expanding small hospitals and the referral network.

- Maternity care was provided free to the population, and the majority of services was provided by well-trained midwives.

- Transportation with ambulances was recognized as an essential component of the referral system. The national ambulance fleet was rapidly expanded from the 1960s.

![Maternal Mortality Ratio (MMR) 1930 - 1996](image)
Professionalization of Midwifery

- Public health midwives have been an essential part of the health unit network since its inception. Midwives visit pregnant women at home and register them for antenatal care, providing a critical link to the health system.

Quality improvements

- Maternal deaths were recorded in Sri Lanka’s civil registration system since 1900, providing valuable information for health system planning, monitoring and evaluation.
- Effective systems of information management are used to continuously improve maternal health. Maternal death inquiries are administered to identify problems and determine why a complicated delivery was not detected early enough to save a life. Solutions are identified to avoid similar occurrences in future.

Family planning

- Recognizing the need for birth control, the government initiated island wide family planning services in 1965, which were incorporated into existing Maternal and Child Health (MCH) services to further improve mother and child health.

Elements of success

Sri Lanka halved the maternal deaths (relative to the number of live births) every six to 12 years since 1935.

Sri Lanka has reduced maternal mortality ratio from almost 2000 deaths per 100 000 live births in the 1930s to 33 deaths per 100 000 live births in 2015.

There is comprehensive, island-wide access to MCH care. There are currently 343 health units, 77 hospitals with Comprehensive Emergency Obstetric and Neonatal Care services, 517 hospitals with Basic Emergency Obstetric and Neonatal Care services and 474 primary health care units in the country.

Sri Lanka has experienced a huge increase in the number of skilled practitioners attending to births. In 1940, 30% of births were attended by skilled practitioners, compared to 99.9% of births in 2015.
Lessons learned

• Sri Lanka spent far less on health than many other developing countries and achieved much gains. The reduction in maternal mortality is one of country’s greatest public health achievements.

• Rapid progress on maternal mortality prevention can be made when strong foundations are in place, such as robust health systems, trained health professionals and widespread accessibility to primary and tertiary level health services.

• Maternal health benefited from step-wise strategies to expand access to health services, promote utilization of those services, conduct systematic reviews and targeted interventions.

• Overall improvements in living standards and a strong education system which focused on gender equity contributed to the success of maternal and child health care in Sri Lanka and reductions in maternal mortality.

• Today, the causes of maternal mortality have shifted from direct obstetric causes of maternal mortality to an increasing proportion of indirect causes, such as non-communicable disease and ageing of the maternal population.

• Sri Lanka is targeting single digit maternal mortality ratio by 2030.
5 Taking on Big Tobacco & Winning
Taking on Big Tobacco & Winning

Sri Lanka has been an early adopter of strong tobacco control measures. This brief highlights the policies used to combat powerful tobacco lobbies and reduce tobacco consumption nationwide.

What’s at stake?

Tobacco is the only legal product which kills one in every two of its users. It causes 6 million deaths globally each year. 25% of adults in Sri Lanka consume tobacco in either smoke or smokeless form, resulting in 20,000 deaths each year. Exposure to second hand smoke causes serious health risks. It is particularly harmful for pregnant women and unborn children. In Sri Lanka, one in four adults is exposed to secondhand smoke in both the workplace and the home. Tobacco places a severe burden on the public health system, with large numbers of hospital admissions and treatment costs for chronic tobacco-related diseases.

Key approaches

Political leadership

- Strong political leadership has been a critical factor in driving forward the tobacco control agenda in Sri Lanka.

Taxation

- Excise tax was first introduced on tobacco in 1990. There have been regular increases in tobacco excise rates in recent years, which have led to a decreased demand for cigarettes.

WHO FCTC

- In November 2003, Sri Lanka became the first country in Asia and the fourth country in the world to ratify the WHO Framework Convention on Tobacco Control (FCTC). This public health treaty legislates against some of the root causes of the tobacco epidemic including trade liberalization, tobacco advertising, promotion and sponsorship and illicit trade in tobacco products.

- On 8 February 2016, Sri Lanka became the first country in the WHO South-East Asia Region, and the fourteenth country in the world to accede to the Protocol to Eliminate Illicit Trade in Tobacco Products, which is part of the WHO Framework Convention on Tobacco Control. This protocol provides tools for preventing illicit trade by securing the supply chain, establishing an international tracking and tracing system and law enforcement measures which enable international cooperation.

NATA

- In 2006, the National Authority on Tobacco and Alcohol Act No. 27 was adopted. The National Authority on Tobacco and Alcohol (NATA) was established under this Act as a government agency responsible for reducing harm from tobacco and alcohol in Sri Lanka through policy development and advocacy.
The NATA Act banned tobacco advertising, sponsorship and other types of promotions, prohibited smoking in public places and the sale of tobacco products to persons below the age of 21.

**Pictorial HealthWarnings**

- The NATA Act mandated pictorial health warnings to appear on tobacco packages covering 60% of the package. Pictorial health warnings are an important demand reduction measure that reduces the effectiveness of tobacco packaging as a form of advertising and promotion and discourages new users, particularly young people.
- In 2015, the Minister of Health mandated pictorial health warnings to cover 80% of both sides of tobacco packs. The tobacco industry mounted strong opposition through the courts. The former Minister of Health and current President of Sri Lanka, Hon. Maithripala Sirisena attended lengthy court hearings demonstrating the highest level commitment to enforce the tobacco control law.

**Civil Society**

- Civil society was mobilized, public demonstrations and peaceful protests were held to support the introduction of the new regulations. The media was lobbied to increase coverage, which greatly influenced public opinion in favour of the pictorial warnings.

**Elements of success**

The Supreme Court ruled in favour of the introduction of strong new anti-tobacco legislation, which mandated pictorial warnings to cover 80 per cent of cigarette packets.

Smoking is now banned in all public institutions in Sri Lanka including government departments, offices, schools, hospitals, hotels and restaurants.

The Global Youth Tobacco Survey found a significant drop in exposure of 13–15 year olds to second-hand smoke at home from over 50% in 2003 to 13% in 2015.

National legislation prohibits all forms of tobacco advertisements in national media and at point of sale.

Health care workers have been trained to provide tobacco cessation services in health-care institutions. A national quit-line has been established.

**Lessons learned**

- Strong political leadership is necessary for the introduction of strong tobacco control legislation.
- A multipronged approach on tobacco is needed to limit advertising and promotion of tobacco products, increase taxation on tobacco, launch public awareness campaigns on the harmful effects of tobacco and support cessation services for those seeking to break free from tobacco addiction.
- The introduction of pictorial health warnings is a proven tobacco demand reduction measure to discourage consumption at the point of sale.
- Increasing tobacco taxation is a proven intervention which reduces mortality and morbidity related to tobacco.
Building Resilience - Strengthening Emergency Preparedness & Response
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In the wake of the 2004 Indian Ocean Tsunami, Sri Lanka implemented key strategies to strengthen the emergency preparedness and response capacity of the health sector, achieving remarkable gains at policy, implementation and field level.

What’s at stake?

The devastating tsunami of 2004 left Sri Lanka and many other countries in South-East Asia reeling. Over 30,000 people died and around half a million people were internally displaced in the immediate aftermath of the disaster. 97 healthcare institutions were completely or partially destroyed which severely hampered the provision of health care services. Sri Lanka had never experienced a disaster on this scale before. The tsunami led to the prioritization of emergency preparedness and response by the Government. Sri Lanka has made remarkable progress on disaster management during the past decade. The legal framework for emergencies has been expanded and health systems have been strengthened with strategic planning, capacity building, training and collaboration with various stakeholders.

Key approaches

Legal Framework

- The Disaster Management Act No.13 was passed in 2005 which provided the legal basis for the Disaster Risk Management (DRM) system in the country. The Act encompasses directives and key plans in disaster management and mitigation including multi-agency and participatory approaches.

- Key institutions such as the Ministry of Disaster Management, the National Council for Disaster Management and the Disaster Management Centre were established under this Act.

- The Disaster Preparedness and Response Division was established in the Ministry of Health to coordinate the health response during a disaster.

- Sri Lanka now has an extensive, strategic system of DRM.

Strengthening Health Systems

- Health sector emergency units and a network of emergency focal points were established at national, provincial and district levels to ensure a coordinated, island wide health sector response during an emergency.

- Training programmes and emergency planning programmes were established in the health sector and academic institutions.

- An Emergency Operations Centre (EOC) was established at national level in the Ministry of Health, while the establishment of EOCs at sub-national level is underway in three locations in the Ratnapura, Badulla and Trincomalee districts.

- Ministry of Health collaborates with professional medical associations, academic institutions and non-health stakeholders to strengthen knowledge and develop multi-sector capacity on disaster risk management.
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Elements of success

Sri Lanka’s Strategic Plan for Health Sector Emergency/ Disaster Preparedness (guided by the Sendai Framework for Disaster Risk Reduction) aims to reduce mortality and morbidity by ensuring safe hospitals and enhanced community participation in health emergency management.

The Safe Hospitals Initiative was launched in 2014 to ensure that hospitals remain fully operational in the event of an emergency in order to provide critical health care services.

Drills have been conducted in 56 health institutions since 2014 to assess hospital preparedness plans.

The strong public health network in Sri Lanka ensured the prevention of disease outbreaks after the tsunami in 2004. The country has not experienced major disease outbreaks following disasters and emergencies during the past decade.

In May 2016, Sri Lanka experienced a flood and landslide disaster which resulted in over 100 deaths and the displacement of over 400,000 people. The Ministry of Health coordinated the rapid, effective, public health response.

Sri Lanka is strengthening disaster preparedness in relation to chemical, biological, radio and nuclear (CBRN) threats through the training of health care staff and the provision of medical supplies and specialist equipment.
Lessons learned

- Comprehensive strategic plans based on international DRM frameworks are critical to set out multi-sector guidelines, roles and responsibilities for the coordination of a rapid and effective response to an emergency.

- A disaster management mechanism with an appropriate administrative structure is an essential component for the coordination of the response by the health sector and other stakeholders in the event of an emergency.

- Robust public health infrastructure is the foundation for a strong and rapid response during any emergency. Health facilities must be built and modified to withstand disasters. Hospital emergency preparedness and response plans must be developed and tested.

- The capacity of health personnel for emergency response must be strengthened through regular trainings and simulation exercises.
Transforming Mental Health Services in Sri Lanka

Lessons learned

• Robust mental health policies and frameworks must be in place to guide targeted measures to reduce mental health treatment gaps and address the unfinished agenda in mental wellbeing. Sufficient funding should be made available to strengthen these services.

• Multi-stakeholder coordination through the planning, execution, monitoring and evaluation of mental health care is needed to ensure the sustainable expansion of quality, community based mental health services.

• The rights of people with mental health needs must be protected through strategies which promote best practices in reducing discrimination and stigma.

• Human resources should be expanded across a wide array of disciplines including; psychiatrists, clinical psychologists, Medical Officers of Mental Health, social workers, psychiatric nurses and counsellors. Resource personnel should be equitably distributed.
Transforming Mental Health Services in Sri Lanka

Sri Lanka serves as a model for mental health care due to its transformation of mental health care over the past decade. This brief outlines the key strategies employed to achieve significant gains in the expansion of mental health services and reforms in mental health care provision.

What’s at stake?

With a global estimate of 2-4% of the population affected by mental health disorders, the provision of mental health care services is an increasing priority. Sri Lanka provides free healthcare through the government system to its 21.3 million residents. However, issues around suicide; depression; substance abuse; gender-based violence; the breakdown of social structures and family units; and child mental health are prevalent needs. In the past, mental health care in Sri Lanka was plagued by a lack of funding, scarcity of trained mental health professionals, over-reliance on tertiary level hospitals and limited mental health resources outside of urbanized districts. Despite having a great need for psychological attention, most of the conflict-affected regions, had only a limited number of trained medical personnel to provide mental health-related services.

Key approaches

Political Commitment

- Following the tsunami, there was increased political commitment to prioritize mental health services in Sri Lanka.
- The “Mental Health Policy of Sri Lanka 2005-2015” was approved in 2005. A decentralized, community-based system of mental health care was proposed and the operational framework for the next decade was laid out.
- Major changes in the organization of mental health services took place, moving away from institutionalized mental health care towards care at the community level.

Mental Health Infrastructure

- Mental health infrastructure was developed. The National Institute for Mental Health (NIMH) was founded and acute care units were established in General Hospitals. Intermediate care facilities helped expand delivery of basic and specialized mental health services. Outreach clinics were set up to improve accessibility of mental health services and reduce treatment gaps.
- The Directorate of Mental Health was established in 1997 as the national focal point responsible for policy and strategic planning, capacity building, coordination, monitoring and evaluation of the National Mental Health Programme.
- The coordination of efforts by Ministry of Health, WHO and numerous bilateral donors and international funders contributed to the growth of mental health infrastructure and capacity building in Sri Lanka.

Mental Health Workforce

- Sri Lanka adopted innovative approaches to deal with shortages in the mental health workforce. The Community Support Officer (CSO) Programme was launched mainly in the tsunami affected districts. CSOs or community mental health workers were recruited directly from their resident communities, which ensured their interventions were appropriate and accepted.
- Training programmes on psychiatry and mental health were launched for medical professionals including a one-year diploma in psychiatry for doctors and a one-year diploma in basic psychiatric nursing. The government also created Medical Officer for Mental Health (MOMH) district focal points positions at Regional Director of Health Services Office.
- Psychiatric Social Workers, Psychiatric Nurses and Occupational Therapists were appointed to Mental Health units to support the establishment of multi-disciplinary care.
Elements of success

The number of districts with acute inpatient units in General Hospitals and intermediate care-stay rehabilitation units increased from 10 to 22 health districts and from 5 to 17 health districts respectively between 2004 and 2015. Outreach clinics are now present in almost all health divisions, with a total of 215 clinics nationwide.

Mental health outreach services have enabled people with mental illness to receive treatment and adequate follow-up within their community. This has reduced the need for re-admission to acute care units in hospitals.

New education programmes have been introduced from Diploma to Master’s degree to strengthen the mental health workforce.

500 Community Support Officers (CSO) were trained from 2005-2008. The CSO Programme increased client trust and confidentiality, reduced stigma and generated greater acceptance of treatment of mental illnesses.

Every district in Sri Lanka has at least one doctor with a diploma in psychiatry. There are currently 252 Medical Officers of Mental Health, 78 Consultant Psychiatrists and 187 nurses trained in psychiatry in different parts of the country.
Lessons learned

- Robust mental health policies and frameworks must be in place to guide targeted measures to reduce mental health treatment gaps and address the unfinished agenda in mental wellbeing. Sufficient funding should be made available to strengthen these services.

- Multi-stakeholder coordination through the planning, execution, monitoring and evaluation of mental health care is needed to ensure the sustainable expansion of quality, community based mental health services.

- The rights of people with mental health needs must be protected through strategies which promote best practices in reducing discrimination and stigma.

- Human resources should be expanded across a wide array of disciplines including; psychiatrists, clinical psychologists, Medical Officers of Mental Health, social workers, psychiatric nurses and counsellors. Resource personnel should be equitably distributed.