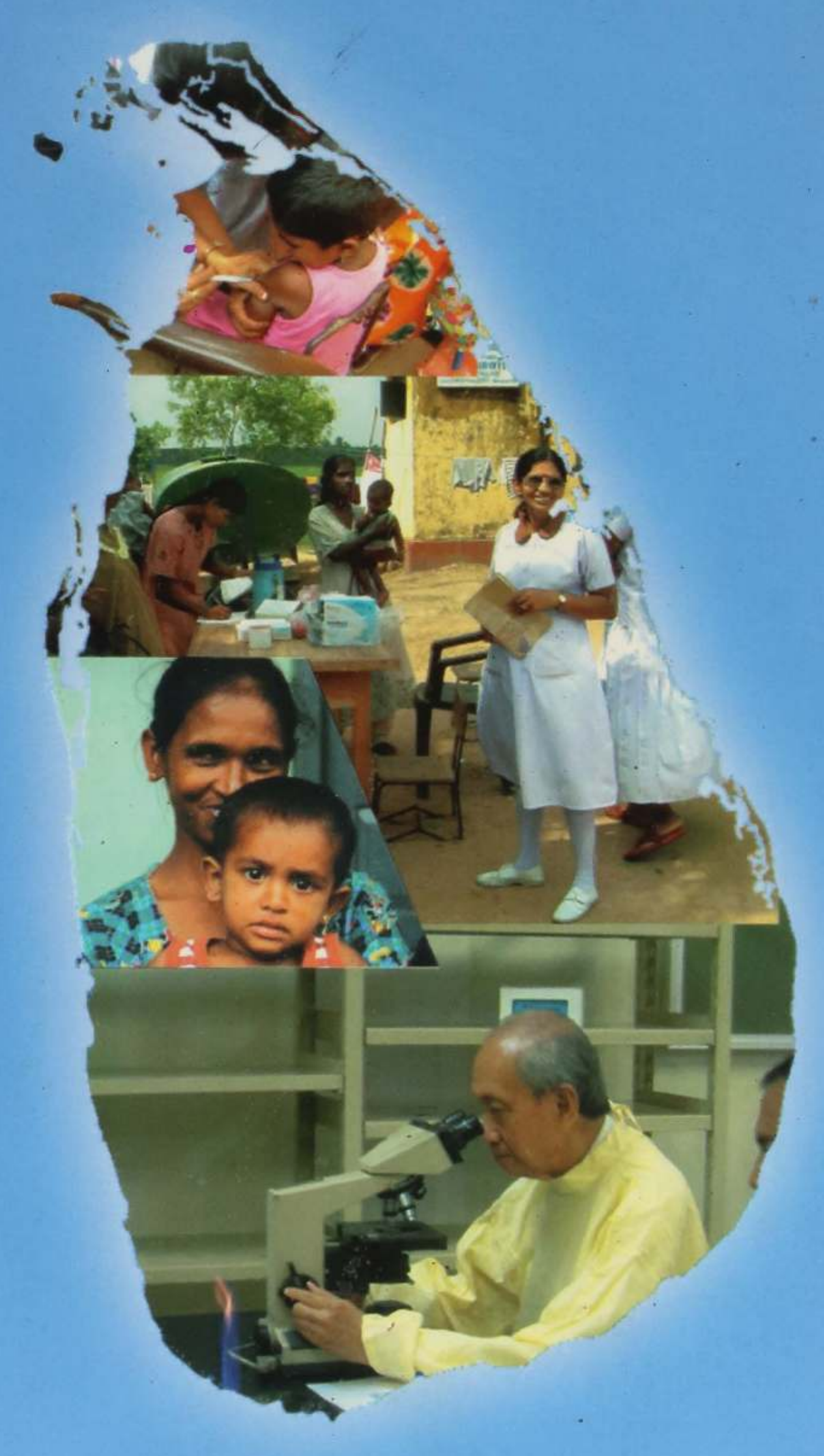
WHO Country Cooperation Strategy 2006–2011

Democratic Socialist Republic of Sri Lanka



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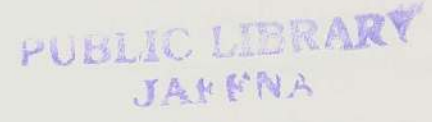

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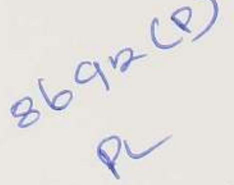

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Preface

The collaborative activities of the World Health Organization in the South-East Asia Region are geared to improve the health status of the population in the Member States. In achieving this objective, WHO recognizes that there are other health development partners working at the country level. Furthermore, WHO has limited resources in terms of funding and staff. In this context, there is a need for a thorough analysis and discussion of how WHO can maximize its contribution to health in each country in our Region.

The South-East Asia Region was the first Region to promote Country Cooperation Strategies (CCS) as a process to identify how best WHO could support health development in our Member States. Over the past six years, all 11 Member States in the Region have prepared their CCS. In the case of Sri Lanka, the previous CCS covered the period 2002–2005. Since it was prepared, many changes have taken place, in terms of the health situation, the government's own health development efforts and those of key partners. Therefore, it is appropriate that a new CCS has been developed for the country covering the period, 2006–2011.

The process of developing the new CCS has been underway for almost two years and was disrupted by the tsunami relief efforts. An analysis of the current health situation and the likely scenario over the next six years have formed the basis for the priorities outlined in this CCS. We appreciate the inputs and suggestions from the Ministry of Health, key health experts and our health development partners in the country. This consultative process will help to ensure that WHO's inputs provide the maximum support to health development efforts in Sri Lanka.

To help achieve the objectives of this CCS, we recognize the importance of a strong WHO Country Office to work closely with key counterparts keeping in mind local conditions. Nonetheless, the commitment to the work of the CCS is from the entire Organization. The staff of the Regional Office will use the CCS in determining regional priorities and in supporting collaborative activities in Sri Lanka. Furthermore, we will also seek assistance, as necessary, from WHO headquarters to assist these efforts.

I would like to thank all those who have contributed to developing this Country Cooperation Strategy, which has the full commitment of the Regional Office. We will provide our maximum support towards achieving its objectives over the next six years. Our joint efforts, I am confident, will help achieve the maximum health benefits for the people of Sri Lanka.

7 February 2006

Samlee Plianbangchang, M.D., Dr.P.H.
Regional Director

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Foreword

Over the last several decades, Sri Lanka has been known for its achievements in health: they are an established fact and have been well documented.

Most of the health-related Millennium Development Goals had already been reached on a nationwide basis several years ago. It would be quite easy to think that all we need now is some simple maintenance work to keep up these achievements.

The reality is that health developments in the country over the last five to ten years have generated new challenges; the demographic and epidemiological transitions that have accompanied increased life expectancy and literacy, are forming the basis of a new health profile for the country. Replacing the typical pattern of infectious/communicable diseases, noncommunicable diseases such as cancer, cardiovascular disease and diabetes are becoming the leading causes of hospital mortality.

The cost of providing health care is increasing so rapidly that it will soon be difficult for the Government to cover health expenditure fully as in the past. Provision of free health care will prove increasingly difficult, necessitating the need to explore innovative ways of health care financing, including the judicious use of public-private partnerships.

The main purpose of this document is to outline priority areas for the work of the World Health Organization in Sri Lanka. Following a comprehensive review of the epidemiological and health situation, and through a series of consultations with key stakeholders and partners in health, six major priority areas for work have been identified. This process also helped in reviewing the cooperation between WHO and its partners and to look ahead on how best to deal with the challenges of the coming six years.

It is my pleasure, as the newly-appointed WHO Representative to Sri Lanka, to present this document to the Ministry of Health and the other health-related Ministries and development partners. I fully endorse the priority areas identified and am confident that by focusing on these areas, WHO will continue to provide the best possible contribution to the health development efforts of Sri Lanka.

Agostino Borra

February 2006

Dr Agostino Borra
WHO Representative, Sri Lanka

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Executive summary

Significant changes in health and health care have occurred since the publication of the first Country Cooperation Strategy (CCS) for Sri Lanka in 2002. This was followed by the development of the National Strategic Framework for Health Development in Sri Lanka (2003) and the Health Sector Master Plan in 2003. This revision of the CCS, covering the period 2006–2011, follows a two-year consultation process between WHO and its partners in health development in the country.

In terms of development and health, Sri Lanka is better off than most countries in the Region, although pockets of poverty still remain. While enjoying a high level of health as shown by various epidemiological indicators, the aging population is becoming more susceptible to chronic, noncommunicable diseases (cardiovascular, metabolic, mental illness, cancer), adding to the classical burden of communicable diseases, diseases of the reproductive tract, trauma and child malnutrition. Public health measures such as vector control and immunization are well advanced although there is still a moderate incidence of infections such as malaria, especially in the East, and tuberculosis, especially in Colombo and surrounding districts. Dengue seems to be re-emerging. The Millennium Development Goals are being achieved nationally but there are regional disparities. Natural and man-made disasters have continued to extract a heavy toll.

The health system relies heavily on a network of excellent government hospitals providing largely free tertiary and secondary health care and complemented by a growing private sector. Unfortunately, smaller rural facilities are short-staffed and less well equipped and, as a result, treat much fewer patients. System improvements are now guided by a Master Plan which addresses all the major weaknesses in health care delivery. Financial barriers to good health care are also being looked into.

The major challenges in the period covered by this document come from the health system (financing, rural health system development, information technology, public-private partnership and community response), human resources, communicable diseases, mental illnesses, noncommunicable diseases, child/ adolescent/ reproductive health and the need for emergency preparedness and response.

After the tsunami, Sri Lanka has benefited from the generosity of many donors and partners in the health sector including bilateral donors, the development banks, UN agencies, global health initiatives and international NGOs. Support for tsunami relief has resulted in large volumes of aid, much of which is still continuing. Coordination and optimal use of this support are essential to fill all the gaps produced by the disaster, as well as in ensuring sustainability of the projects.

Funds available for WHO's regular activities have changed little in recent years, but the tsunami donations greatly increased extra-budgetary activities for 2005–2006. Five strategic areas were identified as priorities in 2002 as described in the previous CCS. The specific WHO activities in these areas over the past four years are outlined in Chapter 4. An objective appraisal of these

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activities shows that, of all the core functions of the Organization, *change brought about by technical and policy support* addressed these areas best, and that *development of technology tools and guidelines* by WHO contributed the least to the identified priorities.

In the past few years WHO has done much to rationalize its work globally and regionally, in order for its core functions to better meet the needs of Member States. Gaps and unmet needs in the health sector of the various Member States have been analysed and a global agenda developed that addresses most of them. WHO's core functions have also been refined and applied to these gaps systematically. The aim has been to maximize health outcomes, address health determinants, advance in policy development and, on the whole, to make WHO more effective and efficient.

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

- Health System,
- Human Resources for Health,
- Communicable Diseases,
- Noncommunicable Diseases and Mental Health
- Child, Adolescent and Reproductive Health,
- Emergency Preparedness and Response.

In Chapter 6, the strategic objectives and approaches proposed for each of these areas are outlined.

Meanwhile, WHO will strengthen its capacity at the country level with appropriate staffing and resources. Increased coordination with the Regional Office and headquarters will also be ensured to enable the entire Organization to fulfil the expectations of its partners in Sri Lanka.

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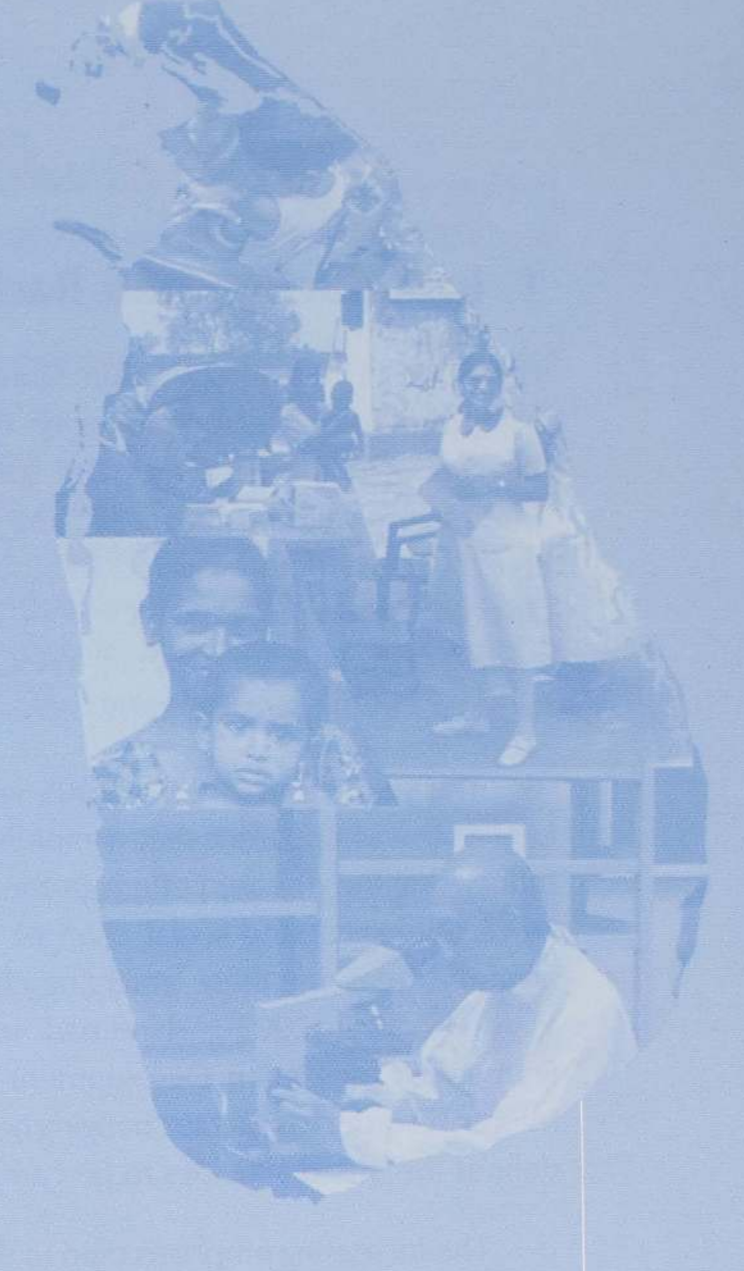

1

Introduction and Background

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1. Introduction and Background

The first Country Cooperation Strategy (CCS) for Sri Lanka, developed in 2002 provided the framework of cooperation between WHO and the Government. A medium-term strategy paper, it was based on the principles and core values to which WHO commits itself world-wide for the betterment of the health sector. The health issues, problems and challenges that prevailed in the country at the time provided the foundation on which the CCS was developed. The document covered the period of WHO work in Sri Lanka from 2002 to 2005 and served as the central guiding document for planning WHO technical programmes in the country. It provided direction for WHO to prepare the 2002–2003 and 2004–2005 biennial country workplans.

The years from 2002 to 2005 witnessed significant developments in the health sector in Sri Lanka. It was apparent that a rapidly changing demographic and epidemiological scenario was influencing the disease pattern in the country. Health needs and demands were further moulded by technological and social changes that increased the expectations of the people. The Health Ministry[1], realizing these emerging challenges, moved swiftly to develop a Health Sector Master Plan (HSMP) in 2003. A landmark in this process was the publication of the National Strategic Framework for Health Development in Sri Lanka outlining the strategic direction of the Health Ministry in order to react to changing health needs and demands. The HSMP, based on this document, defines the broad activities to be carried out in the coming decade.

The increasing emphasis paid to the Millennium Development Goals (MDGs), especially those related to health, was another significant milestone in the national health development process. The ownership taken by the Government in general and the desire of the Health Ministry to achieve the targets of the health-related MDGs in particular, are strong indicators for WHO to provide essential support to the essential processes for meeting the MDGs.

The success stories that have accompanied resource mobilization for health projects during the past four years have created new opportunities but also challenges for the health sector. Development of capacity for full utilization of the resources mobilized in order to reap their maximum benefit is a critical issue for a system that must maintain its focus on the poor and marginalized. The Macroeconomics and Health Initiative has highlighted the need to plan priority interventions and investments targeting the poor.

All these changes had indicated a need to re-visit the CCS and to re-adjust its focus. In April 2004, the first consultative meeting led by the Health Ministry, with the participation of regional and country WHO officials and other stakeholders, was held to review the CCS. The 2002–2005 CCS was looked at anew in the light of these challenges. Through technical presentations and group work by participants, six priority areas were identified at that meeting for the new CCS.

Further discussions were then organized with a wider stakeholder group in order to cover the full range of necessary strategic activities. These discussions enabled the review team to identify, over a broad base the areas, needing WHO inputs in terms of technical and financial assistance.

[1]The Health Ministry has recently changed its official title to "Ministry of Health care and Nutrition"

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The findings of these groups were fed into a further series of meetings with relevant stakeholders who reviewed the draft CCS paper as a whole and proposed additions to ensure its comprehensiveness.

Finalization of this process, scheduled initially for January 2005, was delayed by the unexpected events of 26 December 2004, when the Sri Lankan coastline was devastated by a tsunami. It was only possible to return to the finalization of the CCS in September 2005, when three more stakeholder meetings were organized with officials of the Health Ministry, university academics, development partners and NGOs in order to finalize the CCS document. These meetings were facilitated by the WHO Country Office with the assistance of staff from WHO Headquarters and the Regional Office for South-East Asia (SEARO). The interactions with these stakeholders helped to define a set of strategic objectives and approaches that would implement WHO core functions. They are listed in detail in Chapter 6 of this document.

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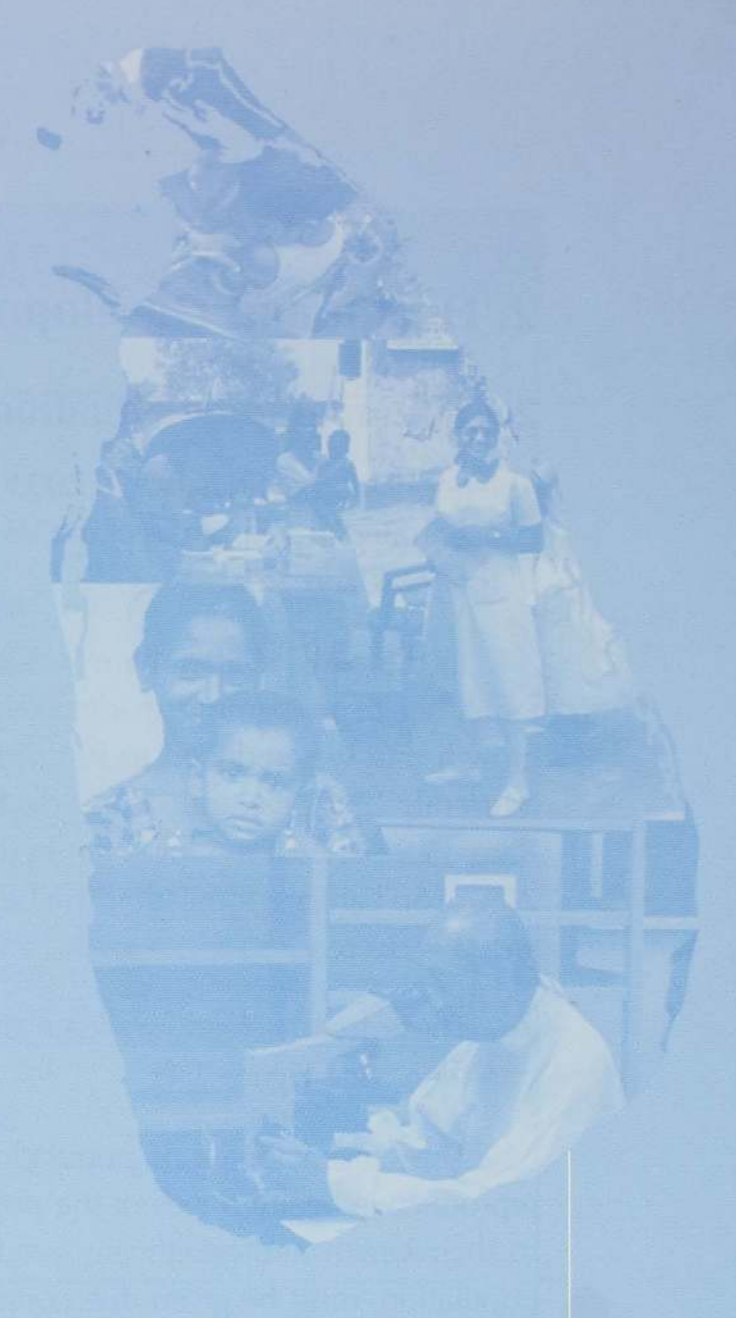

2

Health and Development Challenges

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2. Health and Development Challenges

2.1 Demographic Situation

The population of Sri Lanka in 2003 was estimated at 19.25 million. Over half of this population is concentrated in small areas of the Western, Central and Southern provinces, which make up 23.2% of the total land area.

In the early 1950's there was a population boom in Sri Lanka. However, with an effective family health programme, made possible by a high female literacy rate (89.2%), the annual population growth rate was reduced to its current 1.3% level. With an increase in Life Expectancy at birth (currently 73 years) and steady declines in Total Fertility Rate (1.9% in 2000) and Crude Death Rate, (5.9 per 1,000 population in 2003), Sri Lanka is aging rapidly.[2] It is projected that by 2020, 20% of Sri Lanka's population will be 60 years of age or over, while the proportion in the young age group is decreasing.

These trends clearly indicate that Sri Lanka is entering the third stage of the demographic transition[3] (see Figure 2.1).

The current bulge of population in the reproductive age group underlines the increasing reproductive health needs of the population. Also, the impact, especially on women, with regard to their health and healthcare needs as a result of the expansion of the post-reproductive age population, must be given due consideration.

2.2 Current Stage of Development

Sri Lanka has achieved relatively high standards of social and health development compared with countries of similar economic development. In 2002, the Human Development Index was 0.740[4] while Life Expectancy at birth was a creditable 73 years. The Literacy Rate (>90%) is comparable with more developed countries. Similarly, Sri Lanka's Gender Development Index of 0.738[5] is well above the average for developing countries. Gender empowerment in Sri Lanka for example, is much higher than in the rest of the countries in South Asia.

Growth of GDP in 2003 was around 5.9%.[6] However, the conflict in the North-East had adversely affected overall economic performance by an estimated 2.3% points per year. The 2000–2002 drought followed by floods in 2003 further contributed to serious erosion of the economy. In addition, Sri Lanka was among the countries severely affected by the tsunami of December 2004,

[2] Department of Census & Statistics (2001)

[3] Frank Notestein, a Princeton demographer, formulated in 1945 the idea of three observable stages in demographic transition that explain widely different population growth rates seen in the world today. In the first stage, represented by the pre-industrial societies of the past, both birth rates and death rates were high and balanced out close to zero growth rate in a relatively small population. In later societies, death rates fell because of new developments in the treatment of infectious disease, while birth rates remained high. This difference created a demographic imbalance and an explosive population growth resulting in an enormous increase in the size of the population. This is the second stage of the demographic transition. As modernization continued, birth rates fell and came into balance with the already low death rates. Once again balance was reached but at the level of a large population. This population stabilization at low birth rates and low death rates as seen in Sri Lanka represents the third stage of the demographic transition. The aging population results in the rise of chronic and degenerative disease – the "epidemiological transition".

[4] Human Development Report of UN (2004)

[5] Human Development Report of UN (2004)

[6] Central Bank of Sri Lanka, Annual Report (2003)

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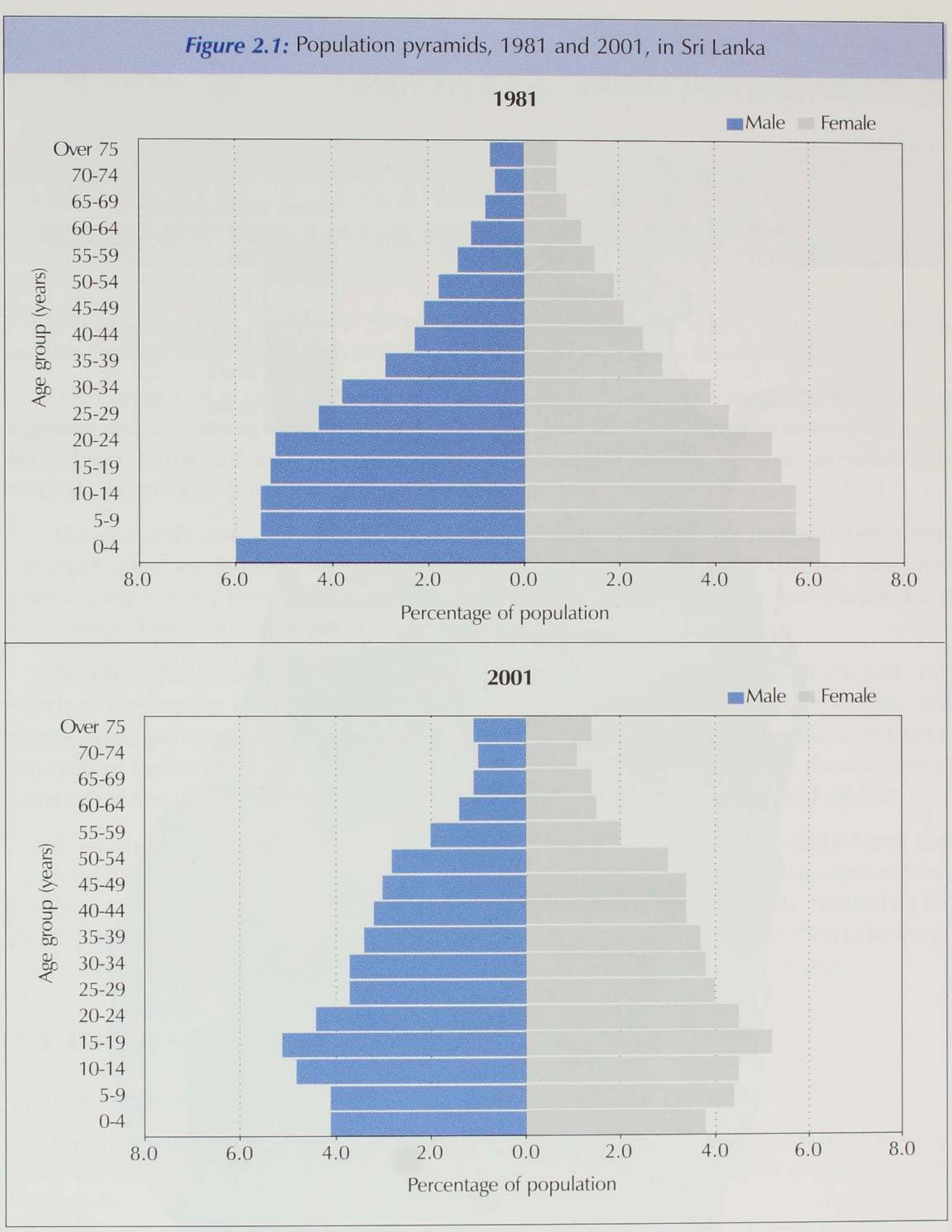

Source: Annual Health Bulletin 2002, Ministry of Health

causing widespread destruction, killing over 31,000 people, destroying over 99,000 homes and damaging natural ecosystems and coastal infrastructure including over 92 health facilities.

Poverty appears to be widespread in Sri Lanka. About 23% of the population lives below the World Bank standard poverty line of one USD a day in seven of the eight provinces in the country[7].

[7] World Bank Country Assistance Strategy, 2004

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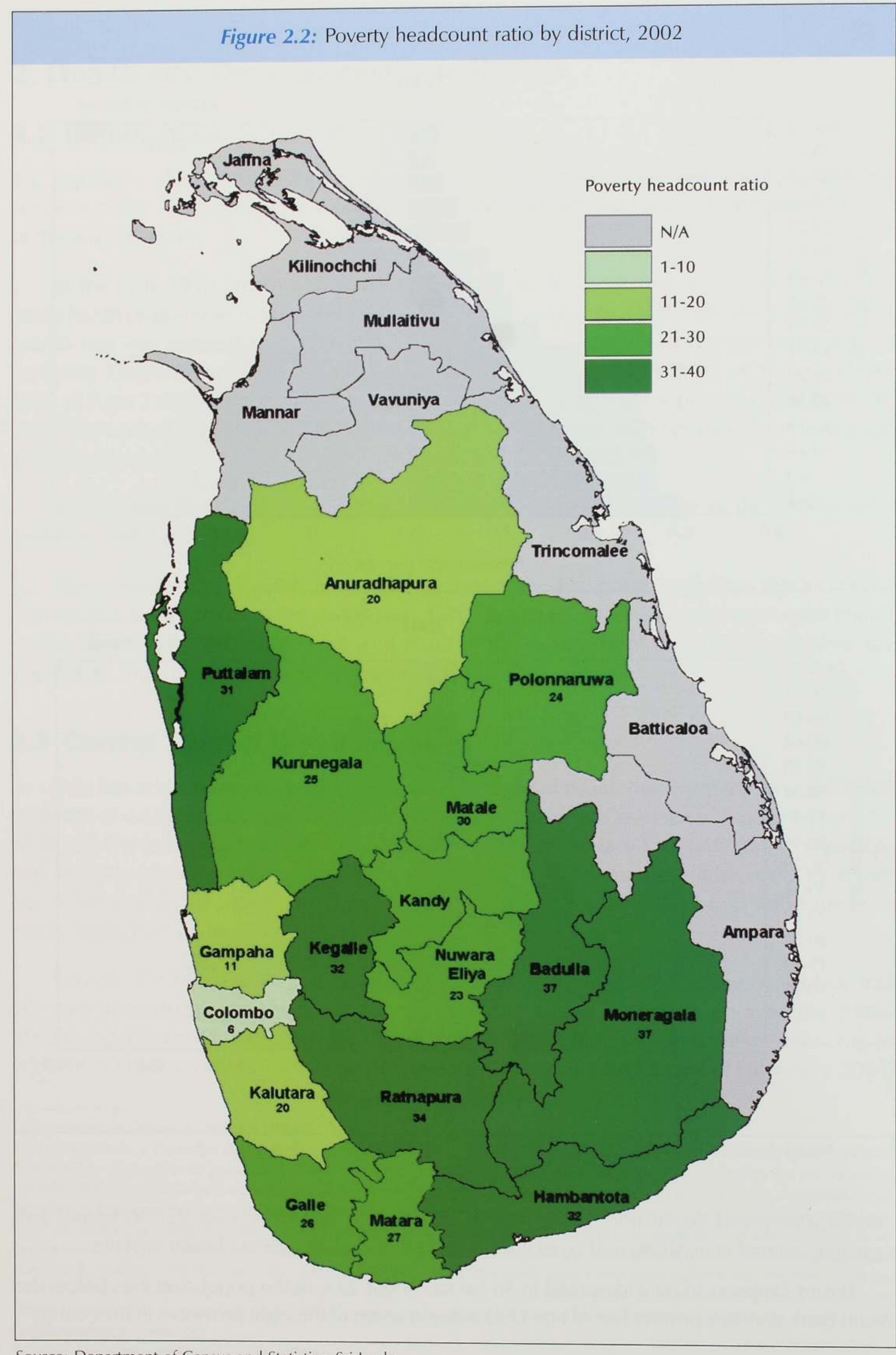
Figure 2.2: Poverty headcount ratio by district, 2002



Source: Department of Census and Statistics, Sri Lanka

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Table 2.1: *Percent of population below the poverty line by location, 1990–2002*

Location	1990/91	1995/96	2002
Urban	16%	14%	8%
Rural	29%	31%	25%
Estate	21%	38%	30%
Sri Lanka	26%	29%	23%

Source: Department of Census and Statistics, Sri Lanka

Household survey data suitable for poverty measurement does not exist for the districts in the conflict-affected North-East, which have by far the lowest per capita income in the country.

The highest level of poverty is in the estate sector, which comprises the plantations in the central highlands and surrounding areas. About 30% of the population living on estates fall below the poverty line followed by the rural areas, where about 25% of the population do. Urban areas, in contrast, are relatively prosperous – poverty is considerably less.[8]

On social indicators such as access to sanitation, safe drinking water, cooking fuel and electricity, the estate areas are also the least developed. The immunization coverage of children under five years is comparatively lower in this sector and the children are more likely to be malnourished and underweight than in the rural and urban areas.

Sri Lanka has recently emerged from two decades of civil conflict in the North-East. The effects of the conflict include psychological trauma, damage to infrastructure and homes, and displacement and restricted mobility, as well as disruption of the local economy, community networks, educational facilities and health services. Since the ceasefire in 2002 however, there has been some rebuilding of damaged infrastructure, homes, businesses, health facilities and schools.

Even while its population was still suffering from the effects of the long civil war, the North-East was hard-hit by the tsunami in December 2004, compounding previously existing vulnerabilities. For the country as a whole, it is not yet clear what will be the ultimate effect of the tsunami on the development process. In view of the large amount of rehabilitation and reconstruction to be done, post-tsunami work will almost certainly have to continue for at least three to five years.

2.3 Health Situation

Epidemiology and Health Data

Life Expectancies at birth for males and females at birth are 70.7 yrs and 75.4 yrs (2001) respectively, while the Literacy Rate for males and females is 92.2% and 89.2% (2001) respectively (see Figure 2.3).

Sri Lanka's progress in health and social development can be seen in the vital health outcomes. The Infant Mortality Rate (IMR) has declined steadily since the beginning of the last century (11.2 per 1,000 live births – 2003) while the Maternal Mortality Ratio (MMR) steadily declined until 1992 but remained stagnant thereafter (47 per 100,000 live births – 2001), as shown in Figure 2.4.

However, Figure 2.5 shows the significant district variation in infant and maternal mortality rates. The Total Fertility Rate (TFR) in 2000 reached a new low of 1.9%.[9]

[8] Household income and expenditure survey 1995/96, Department of Census and Statistics
[9] Demographic Health Survey (2000)

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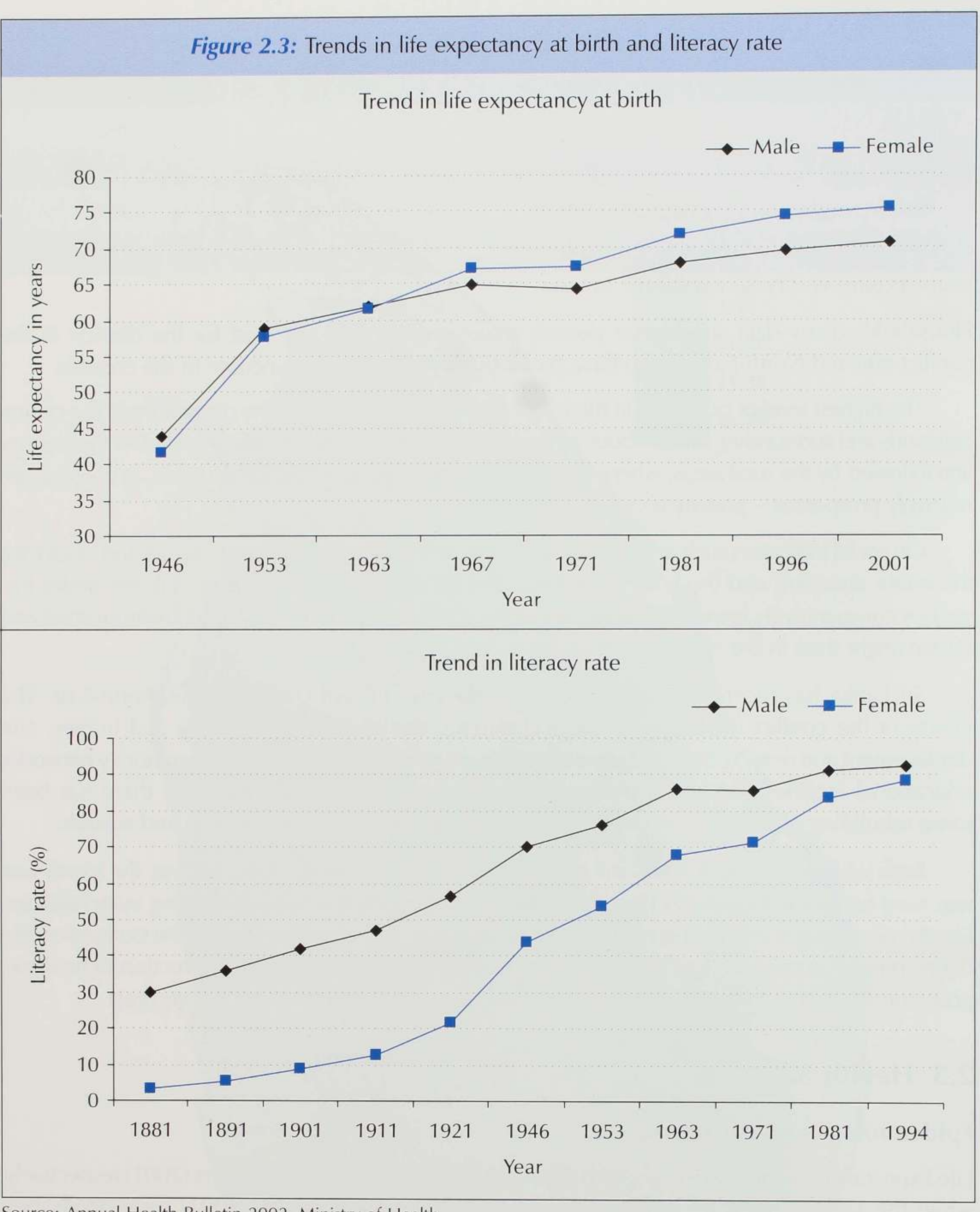

Source: Annual Health Bulletin 2002, Ministry of Health

Child, Adolescent and Reproductive Health

Sri Lanka has achieved the targets of Universal Child Immunization with immunization coverage of children under three years reaching above 98.5%. The OPV/DT coverage of 5-year-old children is 86.8%. Since 1996 polio has not been reported and Sri Lanka is now on the way to reach the landmark of polio eradication. With all these improvements however. the child, adolescent and reproductive health needs are still seen as priority areas for improvement. The national Demographic and Health Survey carried out in 2000 showed that childhood malnutrition rates were high with 29.4% of children surveyed being underweight, 14% wasted and 13.5% stunted, and that micronutrient deficiencies were common.

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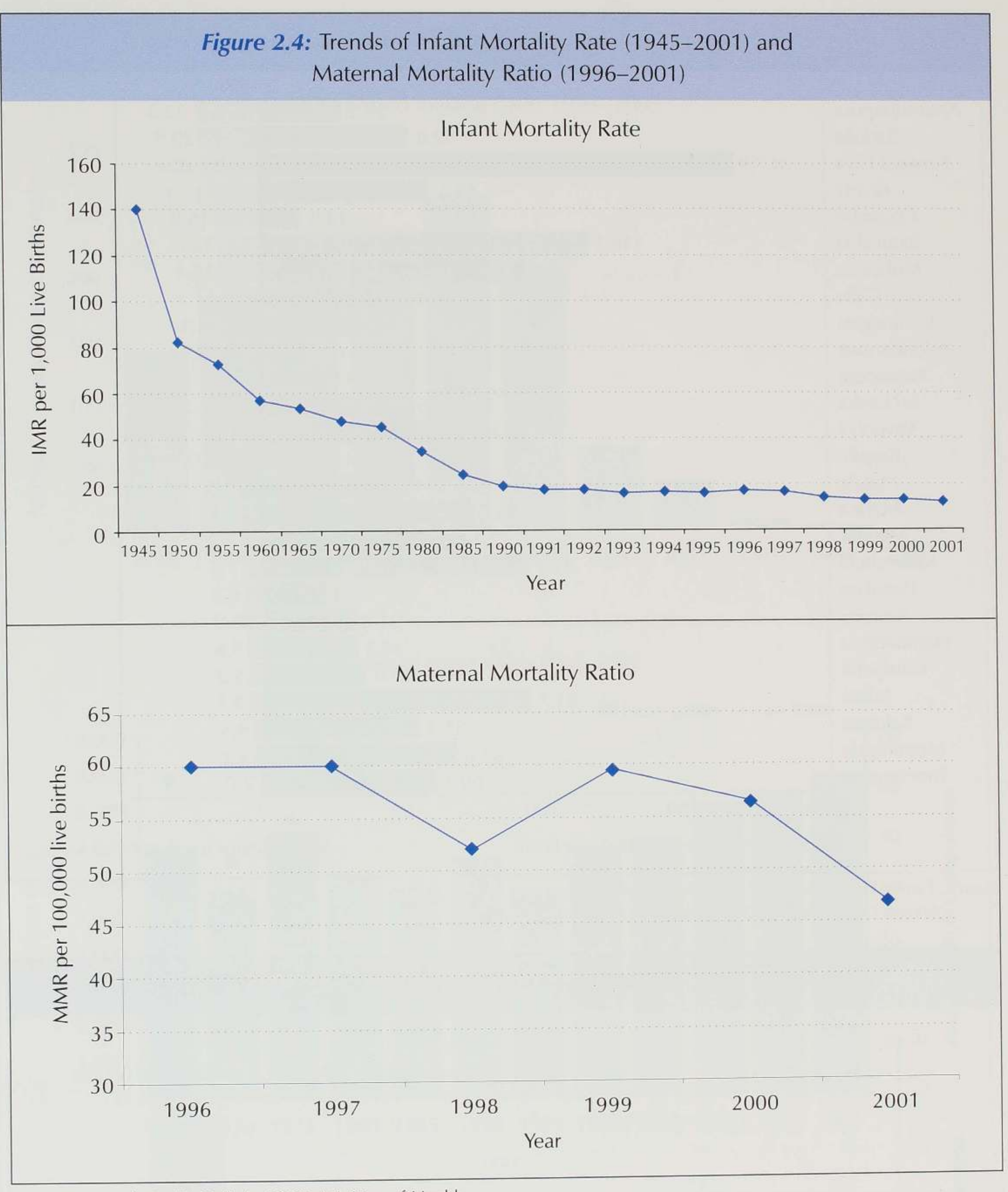

Source: Annual Health Bulletin 2002, Ministry of Health
Family Health Bureau, Ministry of Health

There has also been a gradual increase in the incidence of reproductive tract malignancies as shown below:

The Double Burden of Disease

Sri Lanka is experiencing an epidemiological transition. While still being affected by communicable diseases like malaria, tuberculosis, dengue, Japanese encephalitis, diarrhoea and acute respiratory infections, diseases such as cardiovascular and cerebro-vascular illnesses, diabetes and cancer are now emerging more strongly in the morbidity and mortality patterns. Tobacco, substance and alcohol abuse have increased in magnitude over the past two decades, and pesticide poisoning has been a long-term problem, leading to suicides. Sri Lanka has one of the world's

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Figure 2.5: District variation of Maternal and Infant Mortality Rates – 2001

District	Maternal deaths per 100,000 live births	Infant deaths per 1,000 live births
Anuradhapura	29.2	22.5
Badulla	52.8	20.9
Nuwara Eliya	167.9	20.7
Kandy	59.5	17.3
Colombo	14.9	15.9
Batticaloa	116.1	14.6
Mullaitivu	93.7	14.4
Galle	42.5	13.5
Kurunegala	34.1	13.1
Polonnaruwa	15.3	13.1
Ratnapura	27.9	12.4
Sri Lanka	46.9	12.2
Vavuniya	72.1	10.0
Kegalle	26.4	10.0
Matale	44.8	7.9
Matara	73.6	7.6
Mannar	72.1	7.5
Kilinochchi	93.7	7.3
Puttalam	22.3	6.8
Ampara	31.8	5.9
Hambantota	33.3	5.6
Gampaha	36.0	5.2
Jaffna	93.7	5.1
Kalutara	55.1	4.3
Moneragala	67.8	3.2
Trincomalee	60.3	2.0

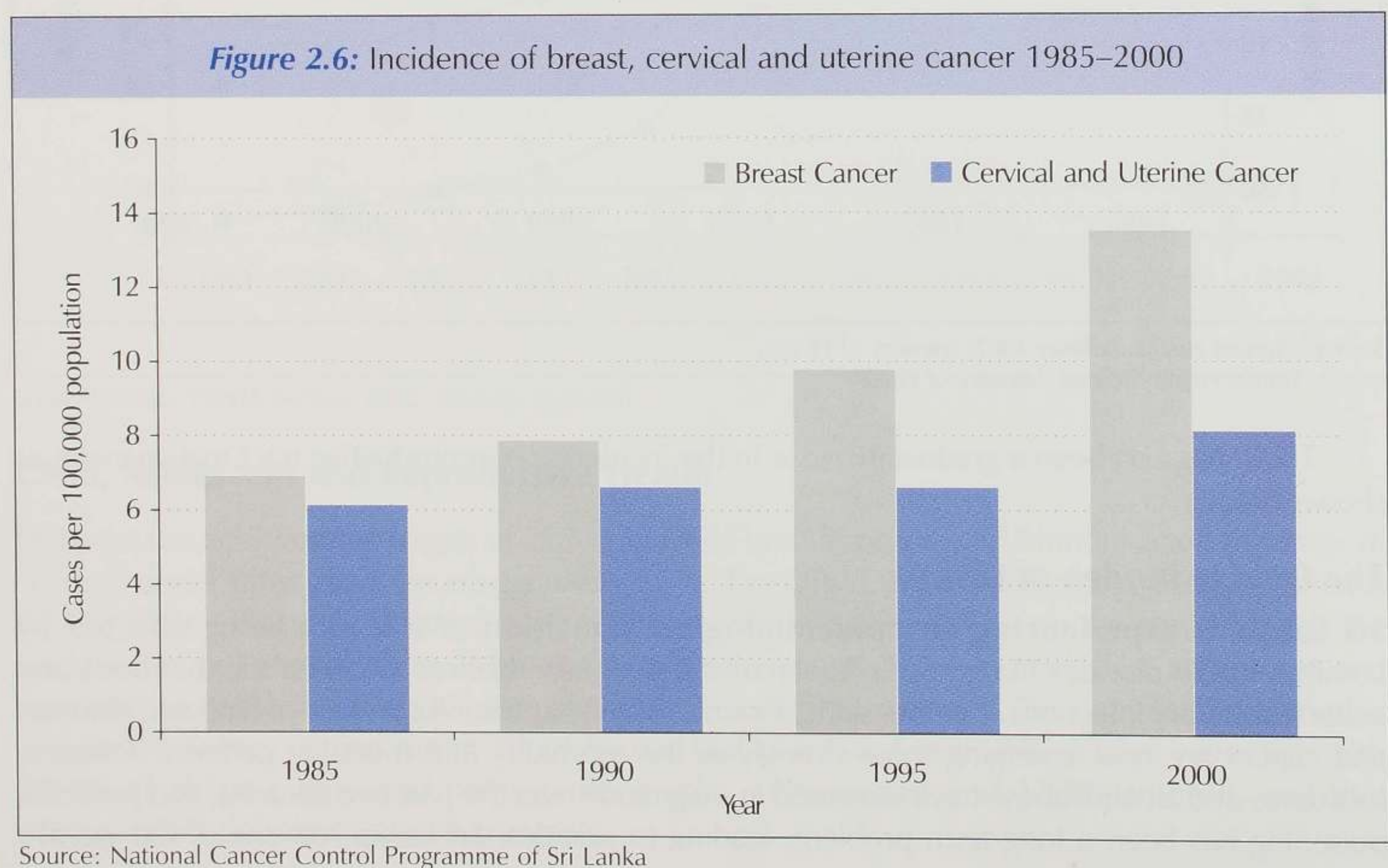
200 150 100 50 0 50

Maternal deaths per 100,000 live births

Infant deaths per 1,000 live births

Source: Family Health Bureau 2001, Ministry of Health
Annual Health Bulletin 2001, Ministry of Health

Figure 2.6: Incidence of breast, cervical and uterine cancer 1985–2000



Source: National Cancer Control Programme of Sri Lanka

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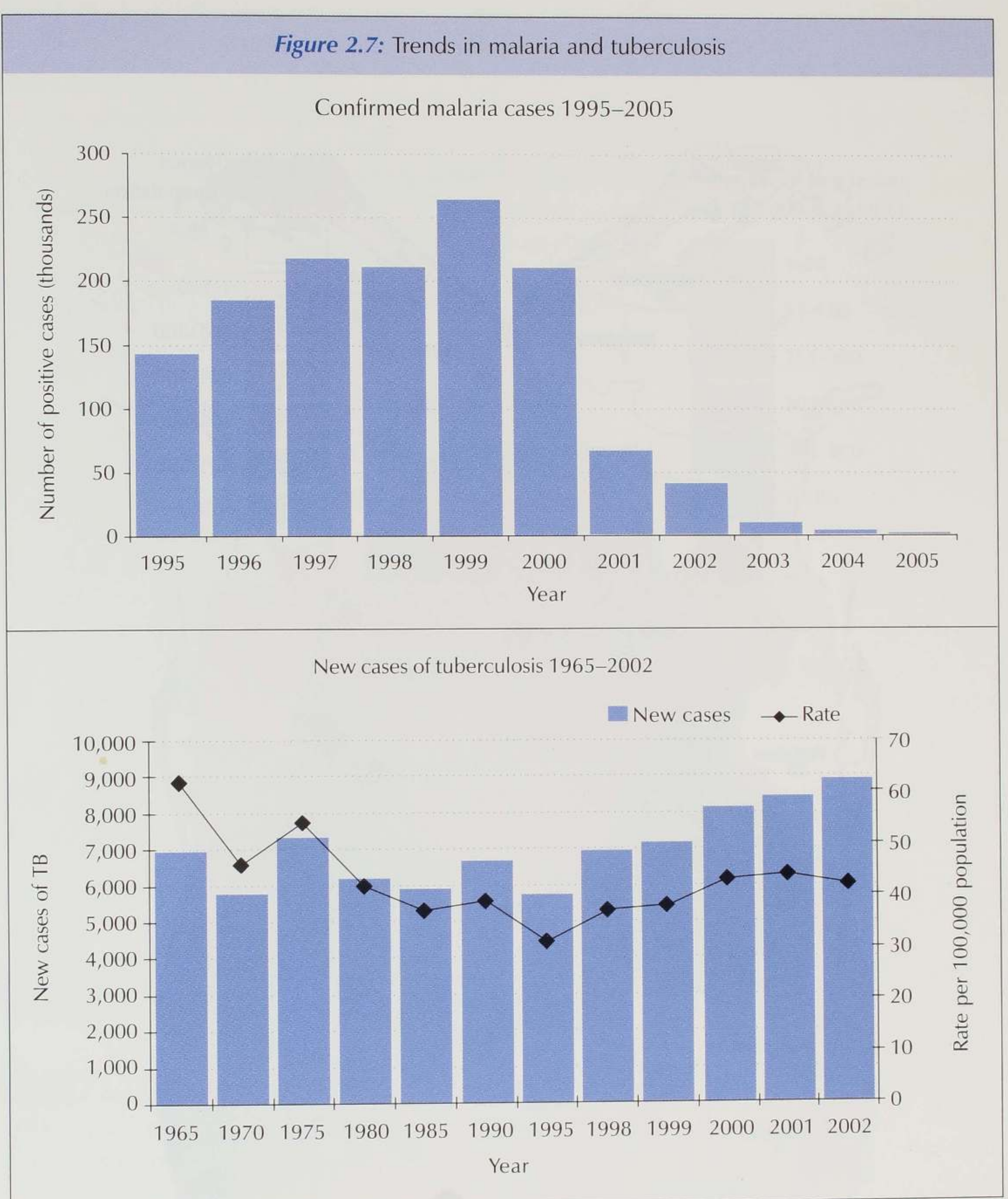
Figure 2.7: Trends in malaria and tuberculosis



Source: Anti Malaria Campaign, Sri Lanka
National Programme for Tuberculosis Control and Chest Diseases, Sri Lanka

highest suicide rates amongst adolescents and young adults and it is also very high among those over 70. Malnutrition exists amongst disadvantaged populations especially in parts of the North East, North-Central and Uva provinces.

Efforts to prevent and control communicable diseases over the past several years have resulted in a marked reduction in vaccine-preventable and vector-borne illnesses. However, despite overall national downturns in the incidence of diseases such as malaria and tuberculosis, Figure 2.8 shows that there are significant geographical variations demanding focused interventions in high disease prevalence districts.

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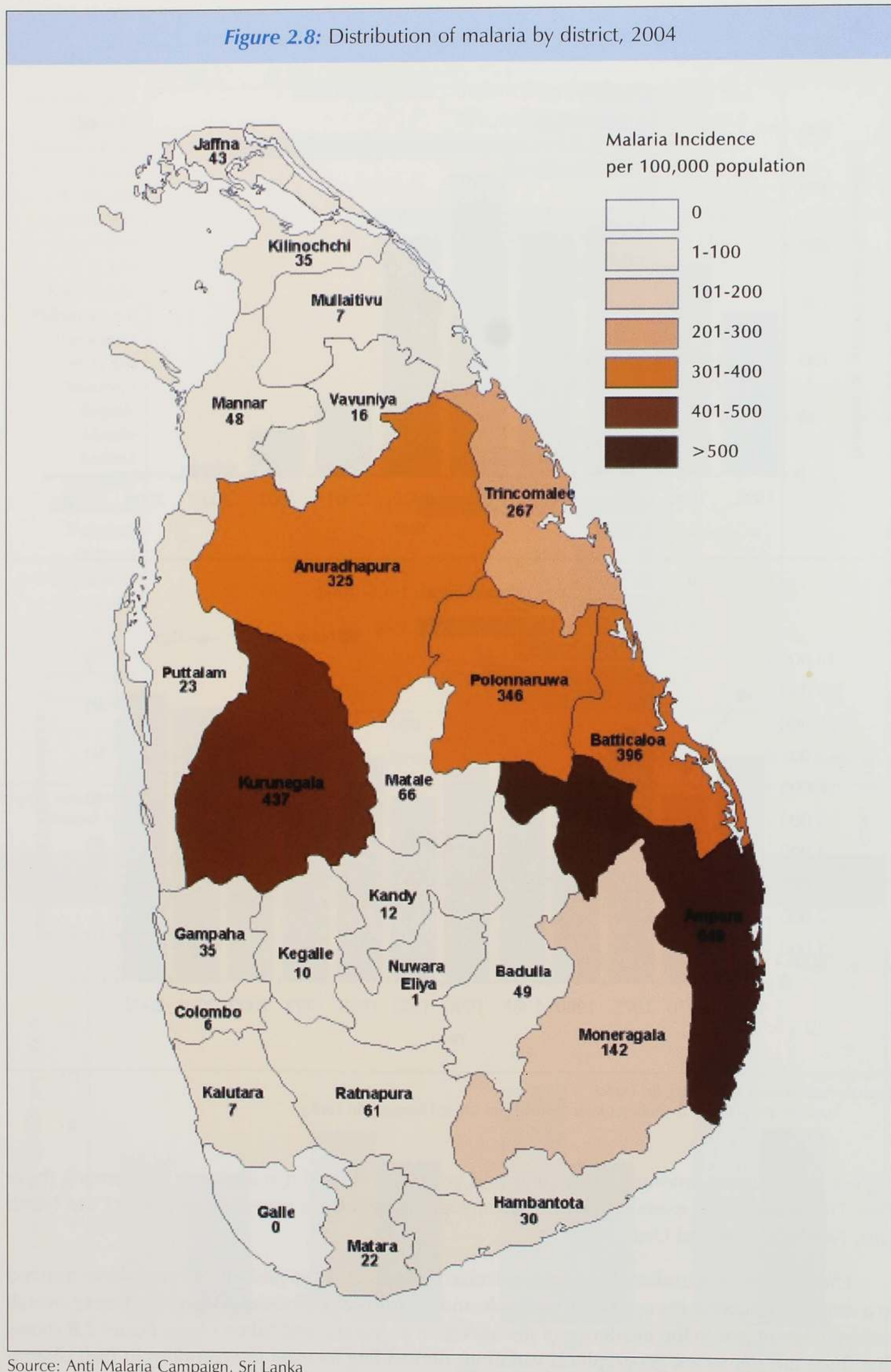
Figure 2.8: Distribution of malaria by district, 2004



Source: Anti Malaria Campaign, Sri Lanka

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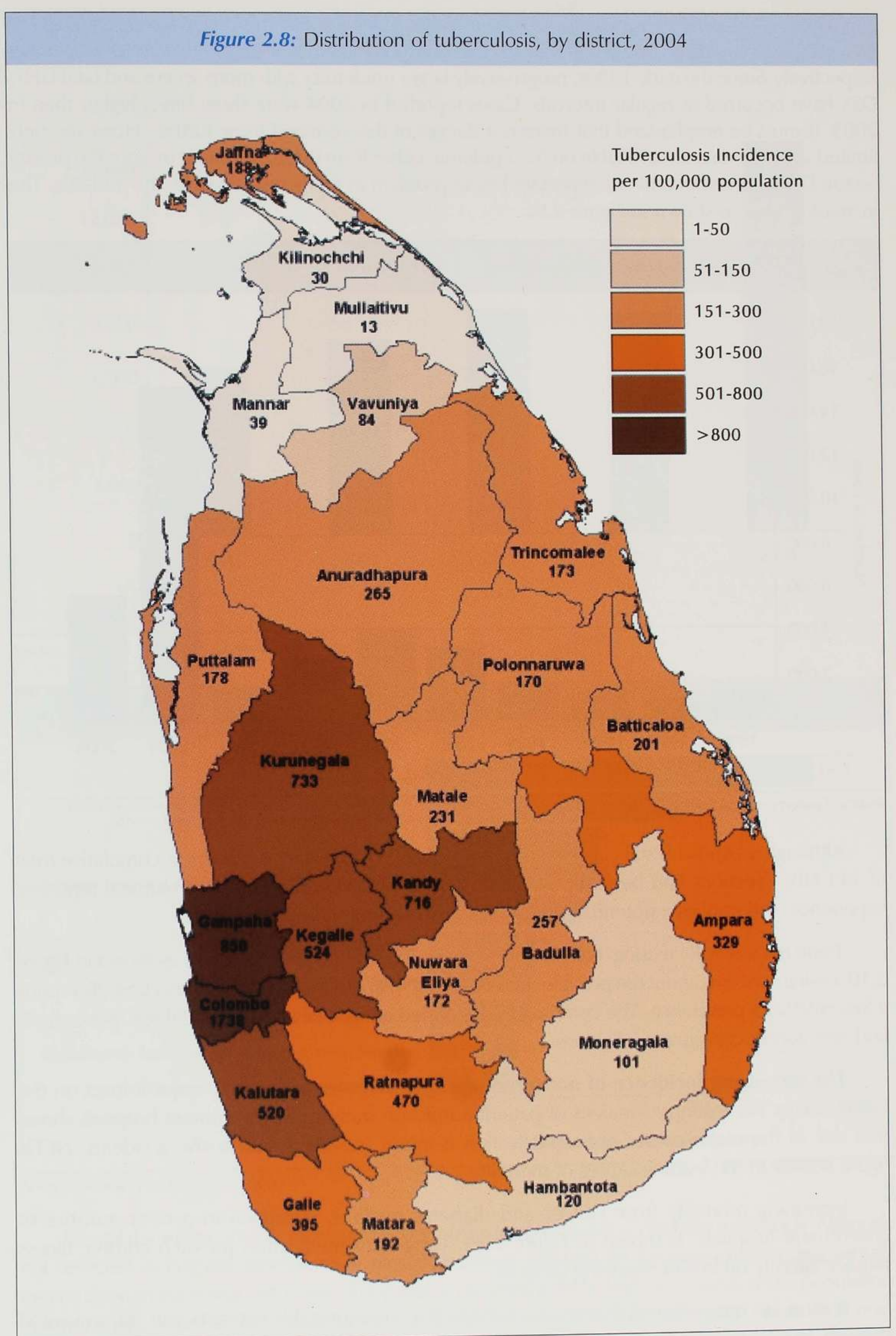
Figure 2.8: Distribution of tuberculosis, by district, 2004



Source: National Programme for Tuberculosis Control and Chest Diseases, Sri Lanka

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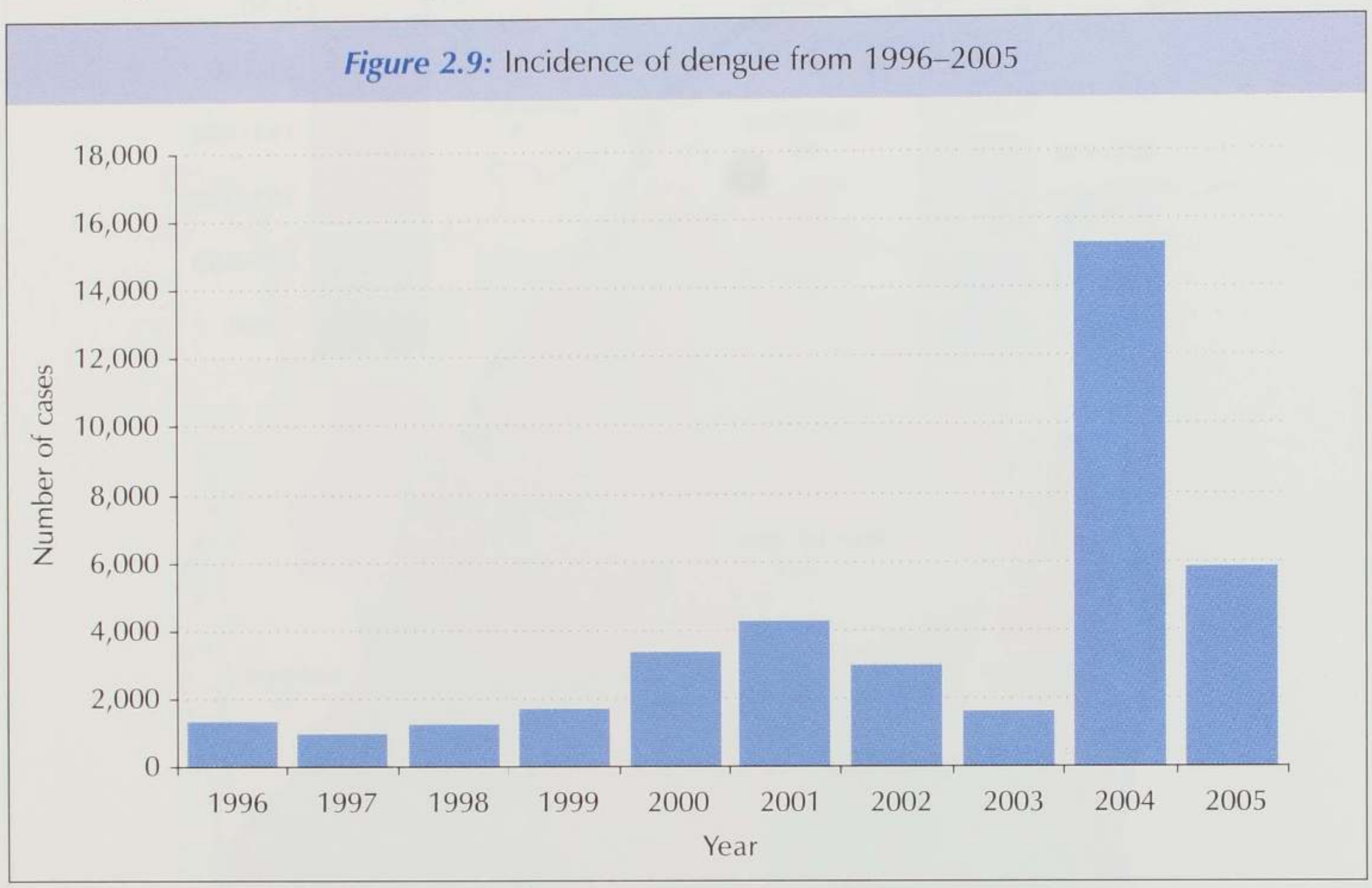
There is seasonal transmission of Dengue Fever / Dengue Haemorrhagic Fever (DF/DHF) in Sri Lanka, with two peaks occurring following the monsoon rains in June-July and October-December respectively. Since the early 1990s, progressively larger epidemics with more severe and fatal DHF/DSS have occurred at regular intervals. Cases reported in 2004 were three times higher than in 2003. It must be emphasized that there is a danger of this caseload rising further. However, only limited virologic data are available on this epidemic either from the government or from the private sector. Dengue has become an important health problem in many districts since the mid 90s. The increasing trend is shown in Figure 2.9.

Figure 2.9: Incidence of dengue from 1996–2005



Source: Epidemiological Unit, Ministry of Health

Although Sri Lanka is still classified as a low HIV/AIDS-prevalence country, a cumulative total of 743 HIV infections had been reported by the end of 2005. Based on international reporting experience, this implies a potential 5,000 cases in the country.

There is a slowly increasing incidence of Sexually Transmitted Infections (STI) as shown in Figure 2.10, raising concerns about the possible outbreak of HIV/AIDS although the country currently reports a low HIV/AIDS prevalence. The common STIs reported are genital herpes, candidiasis, gonorrhoea and non-gonococcal genital infections.

The increasing incidence of noncommunicable diseases is having a major impact on the health sector. For example, analysis of patient admission statistics in government hospitals shows that one of the major causes of hospitalization is injury, including road traffic accidents. NCDs figure heavily in the leading causes of mortality.

Increasing mortality from cancer and diabetes mellitus, based on in-patient statistics of government hospitals, is shown in Figure 2.13. Long-term medication for such chronic illness impacts heavily on health financing capacity.

It must be remembered that many of these noncommunicable diseases can be prevented through low-cost measures such as healthy diet, regular physical activity and avoiding cigarette and alcohol consumption. In addition, there is a need to assist families, especially women, to cope with the increased burden of care needed for family members with long-term, chronic illness.

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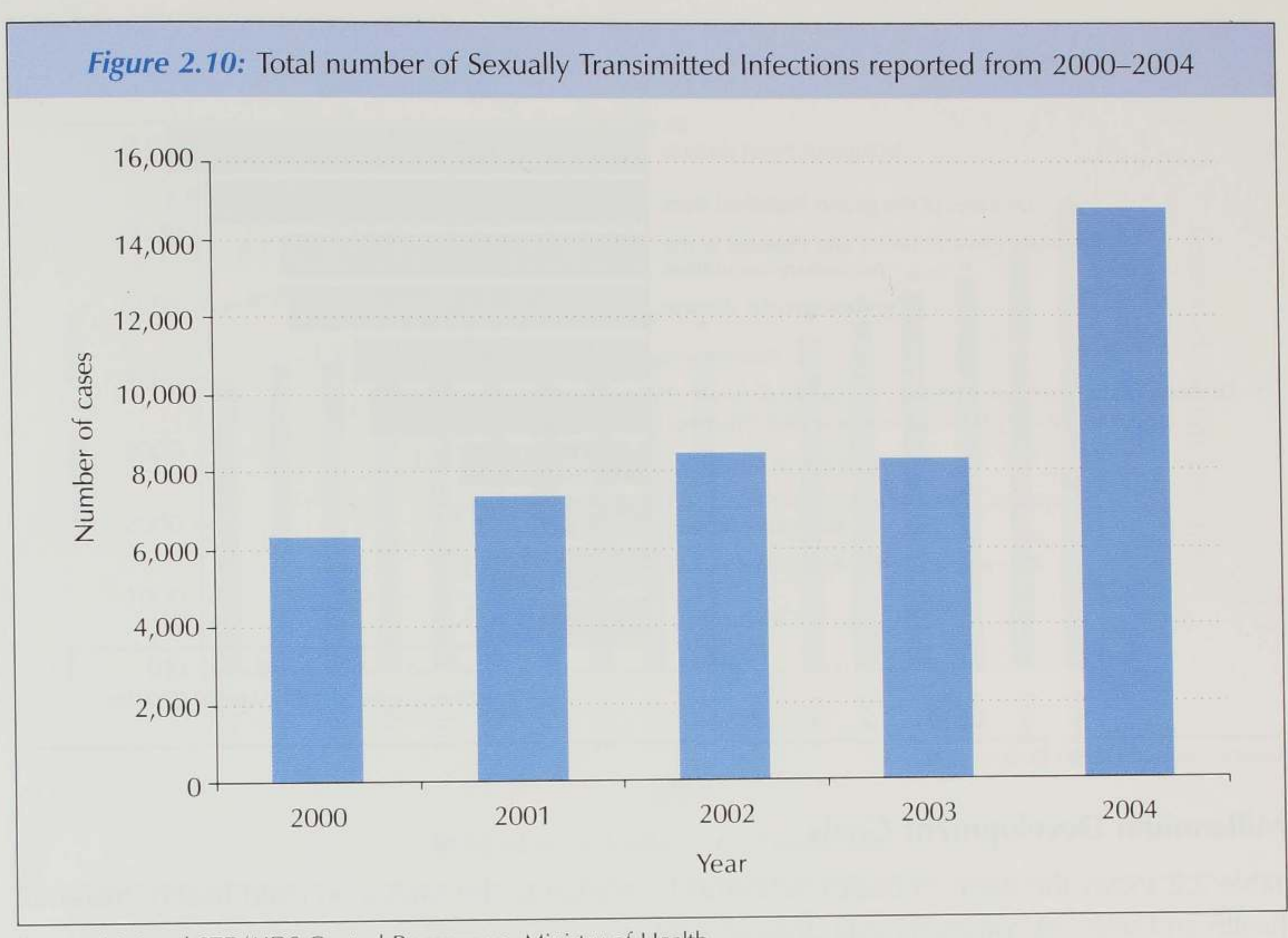
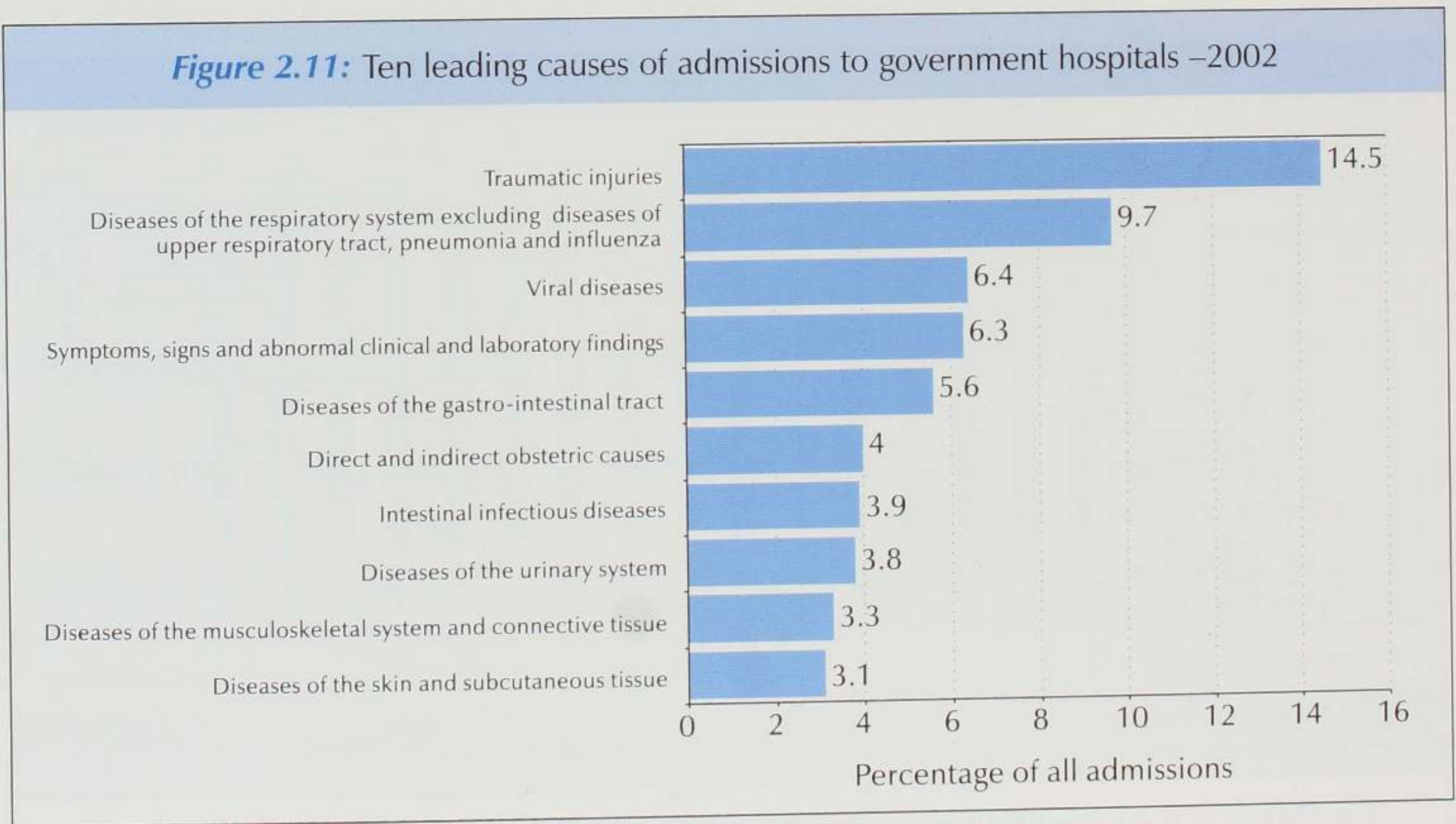
Figure 2.10: Total number of Sexually Transimitted Infections reported from 2000–2004



Source: National STD/AIDS Control Programme, Ministry of Health

Figure 2.11: Ten leading causes of admissions to government hospitals –2002



Source: Annual Health Bulletin 2002

Mental disorders currently represent four of the ten leading causes of disability worldwide. Although not reflected in hospital admissions or mortality, almost 400,000 Sri Lankans experience a serious mental disorder each year, with rates of depression reported to be as high as a quarter of the population in some areas. A further 10% of Sri Lankans experience some other form of mental illness each year. Suicide rates are among the highest in the world, accounting for an average of 6,000 deaths per year and are the leading cause of hospital mortality in some parts of the country. Based on research, it has been estimated that a further 100,000 people will attempt suicide each year.

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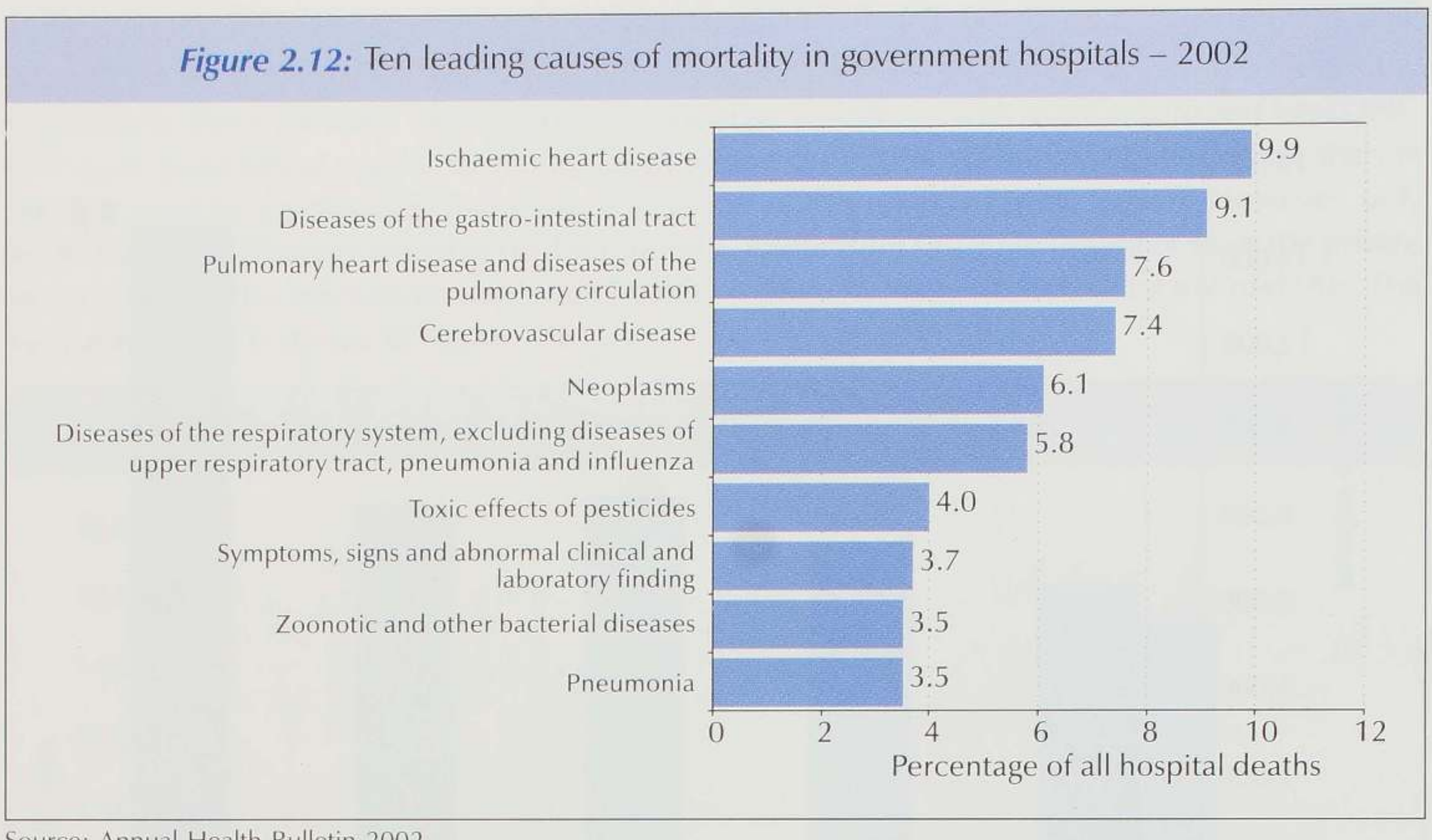
Figure 2.12: Ten leading causes of mortality in government hospitals – 2002



Source: Annual Health Bulletin 2002

Millennium Development Goals

Table 2.2 shows the status of health indicators in relation to the MDGs on child health, maternal health and selected communicable diseases.

Table 2.2: *MDG health indicators in 1990, 2001 and 2015*

MDG Indicator	Benchmark 1990	Value 2001	Target for 2015
Prevalence of underweight children < 5 years	–	29.4%	15.0%
% population with minimal level of dietary energy consumption	49.3% (1995 data)	51.3%	39.3%
Under-5 mortality rate	22.2/1000 LB	18.8/1000 LB	12/1000 LB
Infant mortality rate	19.3/1000LB	12.2/1000 LB	9/1000 LB
% of 1-year-old immunized against measles	–	90.1%	99%
Maternal mortality ratio	50/100,000 LB	47/100 000 LB	20/100 000 LB
% births attended by skilled health personnel	–	97%	99%
Condom use rate (as a percentage of modern contraceptive methods used)	–	3.7%	4.5%
Prevalence of TB	2.4/100,000 pop.	1.8/100,000 pop.	0.7/100,000 pop.
% of TB cases detected and cured under directly observed treatment short course (DOTS)	–	74.8%	85%

The figures in the table are averages covering the whole country. However, when these figures are broken down geographically (dis-aggregated), clear regional differences appear.

Natural and Man-Made Disasters

Over decades, Sri Lanka has been intermittently affected by droughts, floods and landslides. Man-made disasters, such as the North-East conflict which lasted about two decades had caused significant damage to the health system in the North-East and the bordering districts. Even though in early

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Figure 2.13: Death rates of cancer and diabetes, 1980–2000

Source: Health Sector Master Plan, 2005-2015

2002 the ceasefire paved the way to rehabilitate the war-torn areas to some extent, there were still about 350,000 displaced people residing in the North-East before the tsunami caused further destruction.

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In recent years, Sri Lanka has experienced a severe cyclone with landslides and flooding (2003), droughts (2002–04), and the tsunami (Dec. 2004). Each of these has had social, economic and health impacts, particularly on the most vulnerable groups. The worst disaster-prone areas are shown in Figure 2.14.

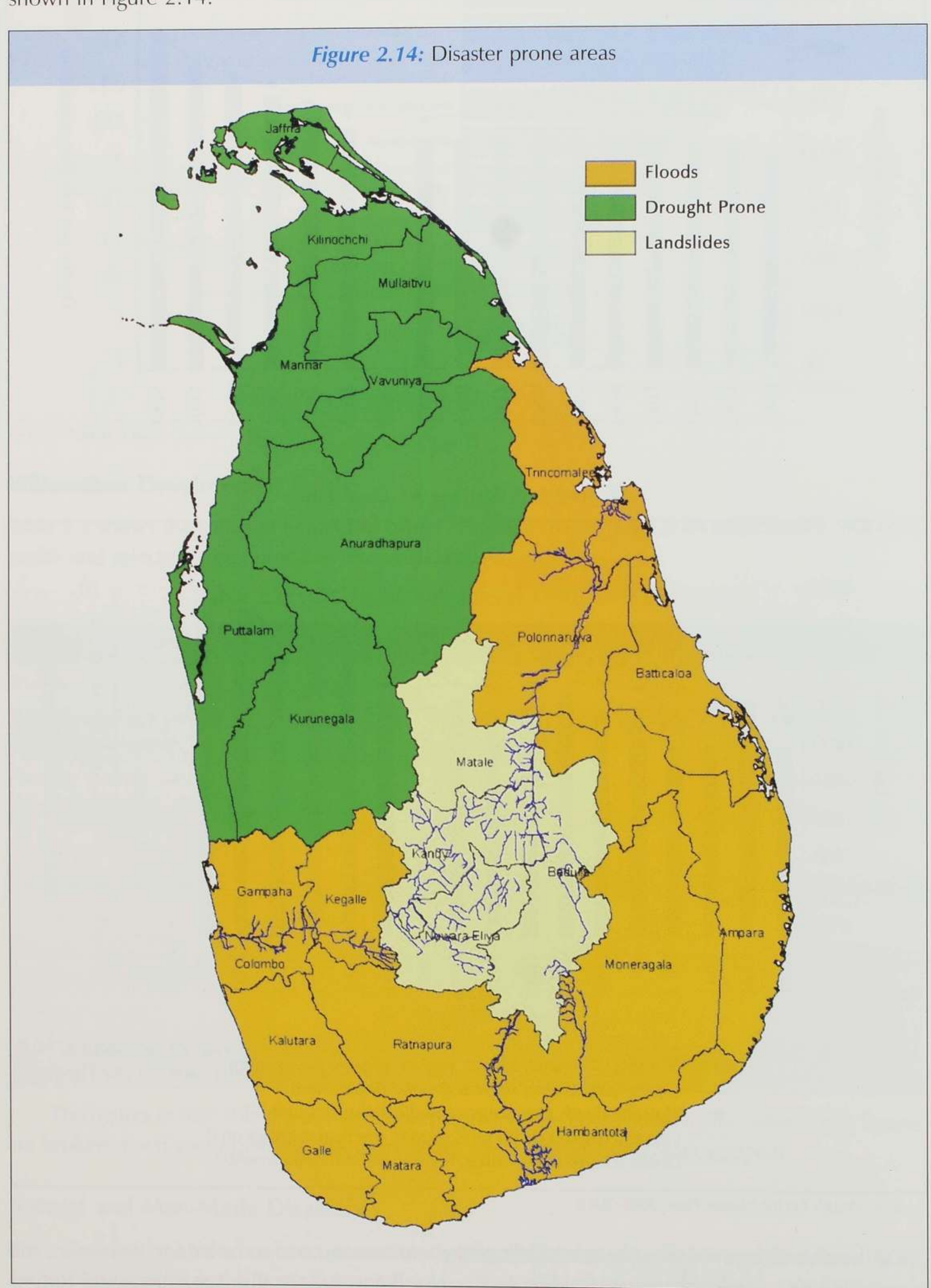

Figure 2.14: Disaster prone areas

Source: National Disaster Management Centre, Ministry of Health

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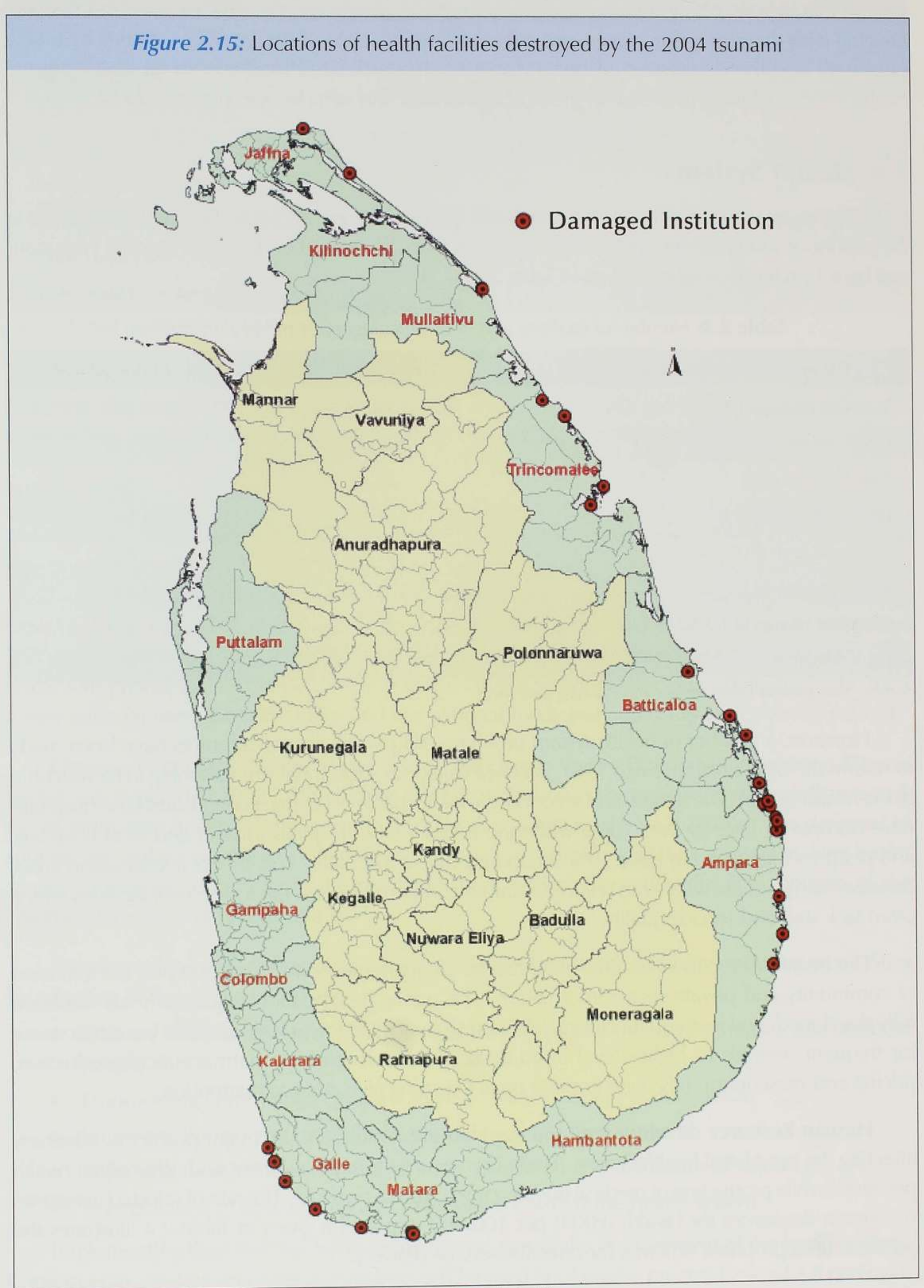
Figure 2.15 shows the location of destroyed health facilities following the tsunami disaster of December 2004.

Figure 2.15: Locations of health facilities destroyed by the 2004 tsunami



Source: Management Development and Planning Unit, Ministry of Health

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The tsunami caused over 23,000 injuries and displaced 850,000 people, of which, at the end of 2005, over 500,000 were living in temporary or semi-permanent shelters exposed to the risk of potential outbreaks of communicable diseases such as diarrhoea, measles, malaria and dengue. Dealing with the emergency was made more difficult because of the fatalities suffered by health personnel and the destruction of health facilities. The estimated total cost of rehabilitating the health sector including provision of medical equipment and vehicles was put at USD 84 million.[10]

2.4 Health System

Sri Lanka has an extensive network of public health clinics and hospitals across the country, with most of the population (except in the North-East) living within 5 km of a facility. Distribution of medical institutions and beds by referral category is given in Table 2.3.

Table 2.3: *Number of facilities and beds by category of medical institution*

Category of medical institution	Number	Total number of beds
Teaching Hospital (TH)	19	17,488
Provincial Hospital (PH)	7	5,629
Base Hospital (BH)	35	9,881
District Hospital (DH)	157	14,345
Peripheral Unit (PU)	102	5,031
Rural Hospital (RH)	172	4,337
Maternity Homes (MH) &CD	85	871
Other hospitals	27	2,053

Source: Management Development and Planning Unit MoH

However, a number of health system problems still persist. Several attempts have been made to reform the health system since 1987. All have called for substantial strengthening in stewardship of the health system. The tertiary and secondary level hospitals (teaching, general, and base hospitals) have occupancy rates of over 100% while the primary care hospitals (district and rural hospitals, and peripheral units) often have 30% occupancy rates. This highly cost-ineffective situation arises because many people with even relatively simple conditions bypass the lower level facilities which often lack staff and service quality.

The health information systems need further strengthening with IT support and the inclusion of community and private sector information. The public health laboratory system has not been fully developed, and inadequate clinical laboratory capacity in lower level facilities is a major cause for frequent referrals to higher level institutions. Quality control in pharmaceutical production, pricing and prescription has been a major issue yet to receive adequate attention.

Human Resource development and deployment continue to be major problems, adversely affecting the peripheral health system. There is an acute shortage of nurses and other allied health personnel while production of medical doctors continues at a high rate. The rate of selected categories of Human Resources for Health (HRH) per 100,000 population given in Table 2.4 illustrates the problem of appropriate skill mix for effective service delivery.

[10] Gaps Analysis – Joint production of Government of Sri Lanka and the UN Country Office / OCHA (July 2005)

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Table 2.4: *Human Resources in 2002*

Category of Health Worker	Number as at 2002	Rate per 100,000 Population
Medical Officers	9290	48.9
Dental Surgeons	867	4.6
Nurses	16,517	86.9
Pharmacists	911	4.8
Medical Laboratory Technologists	871	4.6
Radiographers	342	1.8
Public Health Midwives	4819	25.4
Public Health Inspectors	1470	7.7

Source: Annual Health Bulletin 2002

The workforce imbalance is further exacerbated by the unwillingness of some health professionals to accept the conditions in peripheral areas with consequent health worker concentrations in the larger urban centres. This is shown graphically in Figure 2.16.

Health Policy

The National Health Policy document, published by the Health Ministry in 1996 continues to be relevant in respect of the broad health aims. More recently, a collaborative consultation during 2002–2003 resulted in the Health Ministry publishing the *Strategic Framework for Health Development in Sri Lanka*. It explicitly outlines health strategies aimed at building upon the success and experience of the past in order to address the challenges of the present and the future. The document provides the strategic direction to the Health Sector Master Plan 2005–2015. In 2005 a new national mental health policy and the national medicinal and drugs policy were finalized.

Development of the Health Master Plan – the Health Master Plan (HMP) covering a 10-year period was initiated in 2002 by the Health Ministry. It addresses the policy and strategic framework for an innovative health system over the next decade, targeting the year 2015. It was designed to support Sri Lanka's overall economic and social goals. It aims to facilitate equity by making health services accessible, especially to the poor and marginalized, thus endorsing the concepts of the Macroeconomics and Health initiative.

It is planned to achieve the overarching aim of improving health status and reducing inequalities by adopting of five strategies. These are:

- Delivery of comprehensive health services, which reduce the disease burden and promote health;
- Empowering communities to participate actively in health maintenance;
- Improving human resources for health delivery and management;
- Improving health financing, mobilization, allocation and utilization of resources; and
- Strengthening of stewardship and management within the health system.

Implementing the HMP has become an integral part of the management of the health system. Consequently, existing structures and regimes will be used in taking the process forward. Of particular importance will be to make the best use of systems of financing and planning. Steps have been taken to strengthen the Health Ministry's contribution to budget negotiations with the Ministry of Finance. WHO assisted the Health Ministry in the development of the HMP.

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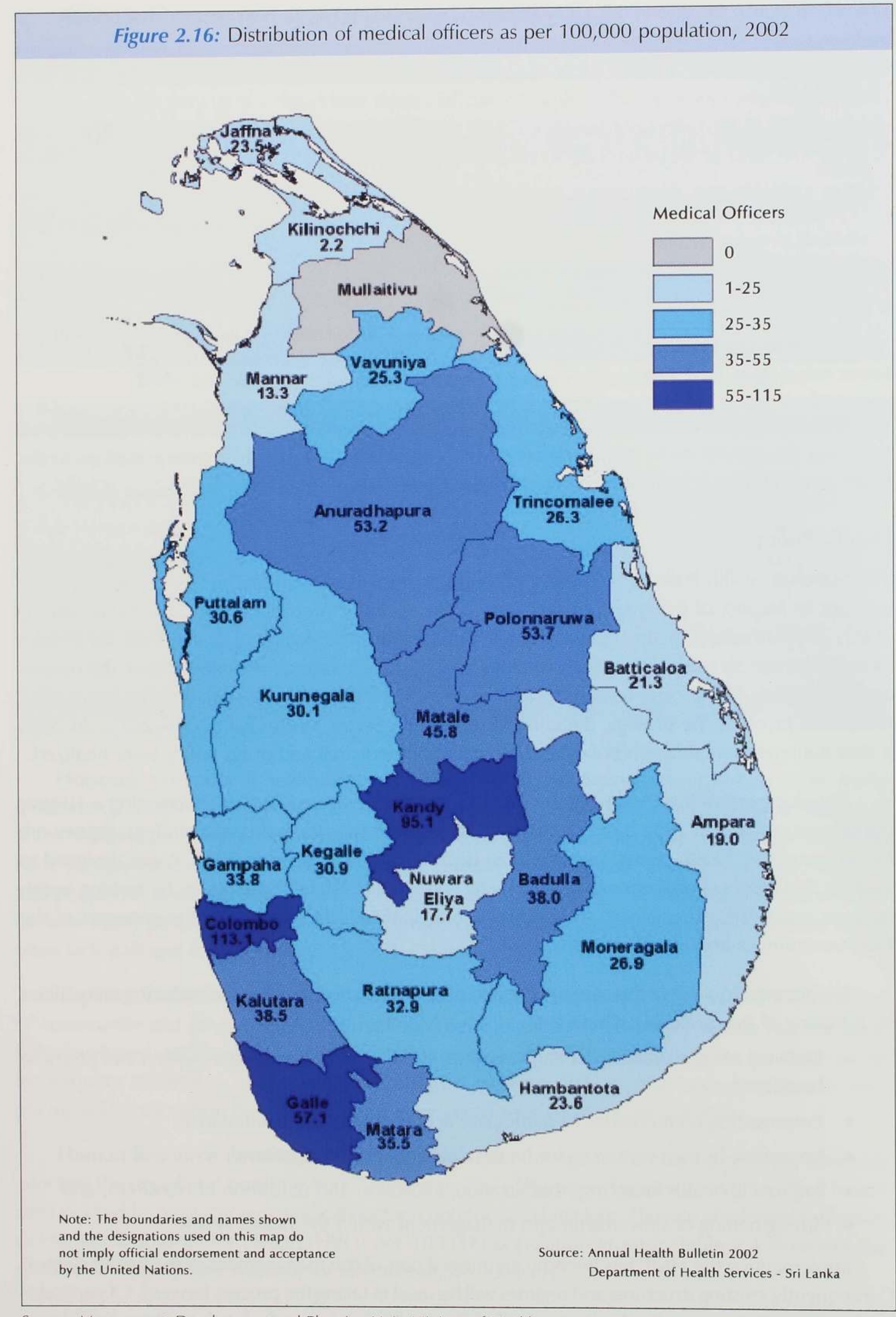

Source: Management Development and Planning Unit, Ministry of Health

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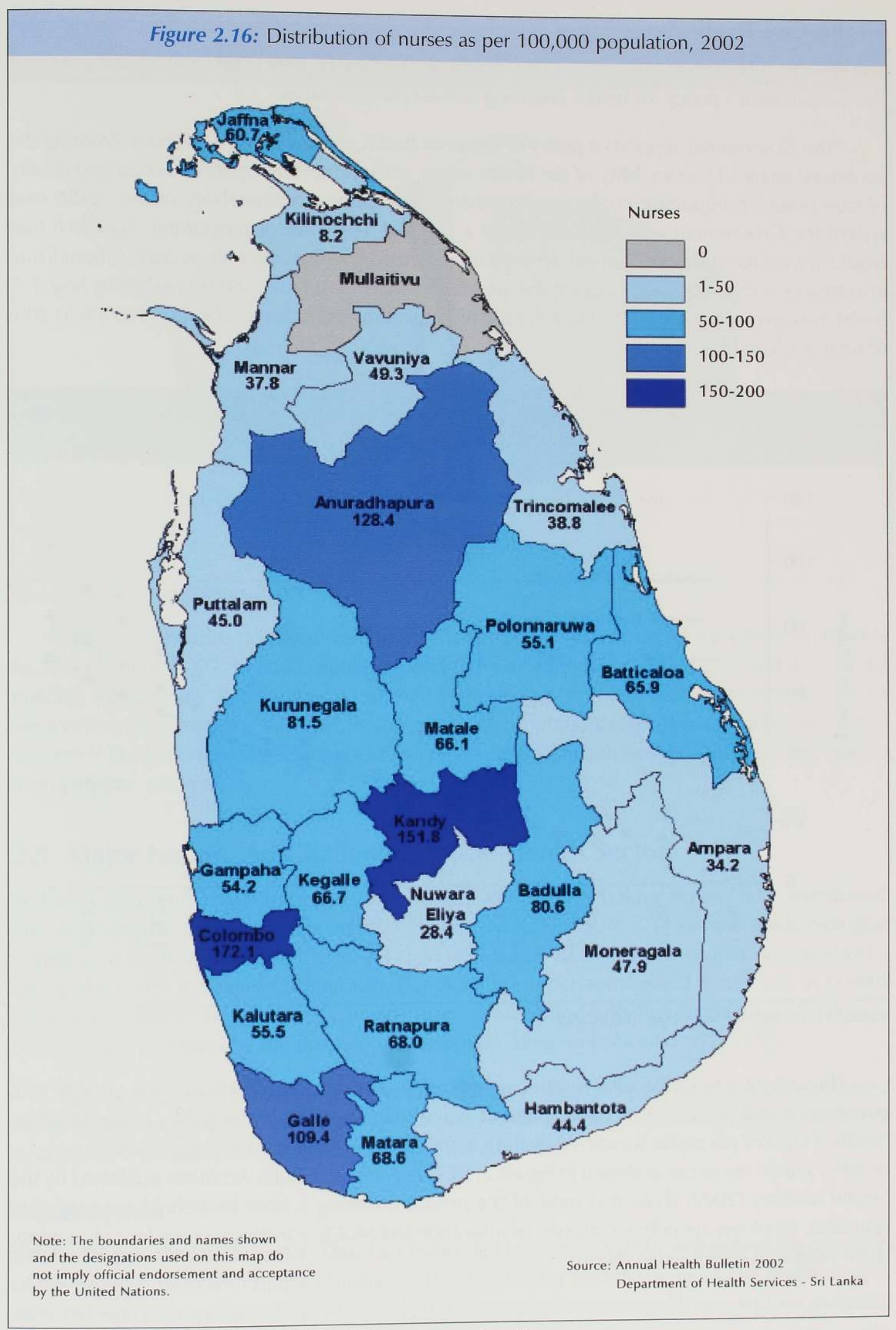

Figure 2.16: Distribution of nurses as per 100,000 population, 2002

Source: Management Development and Planning Unit, Ministry of Health

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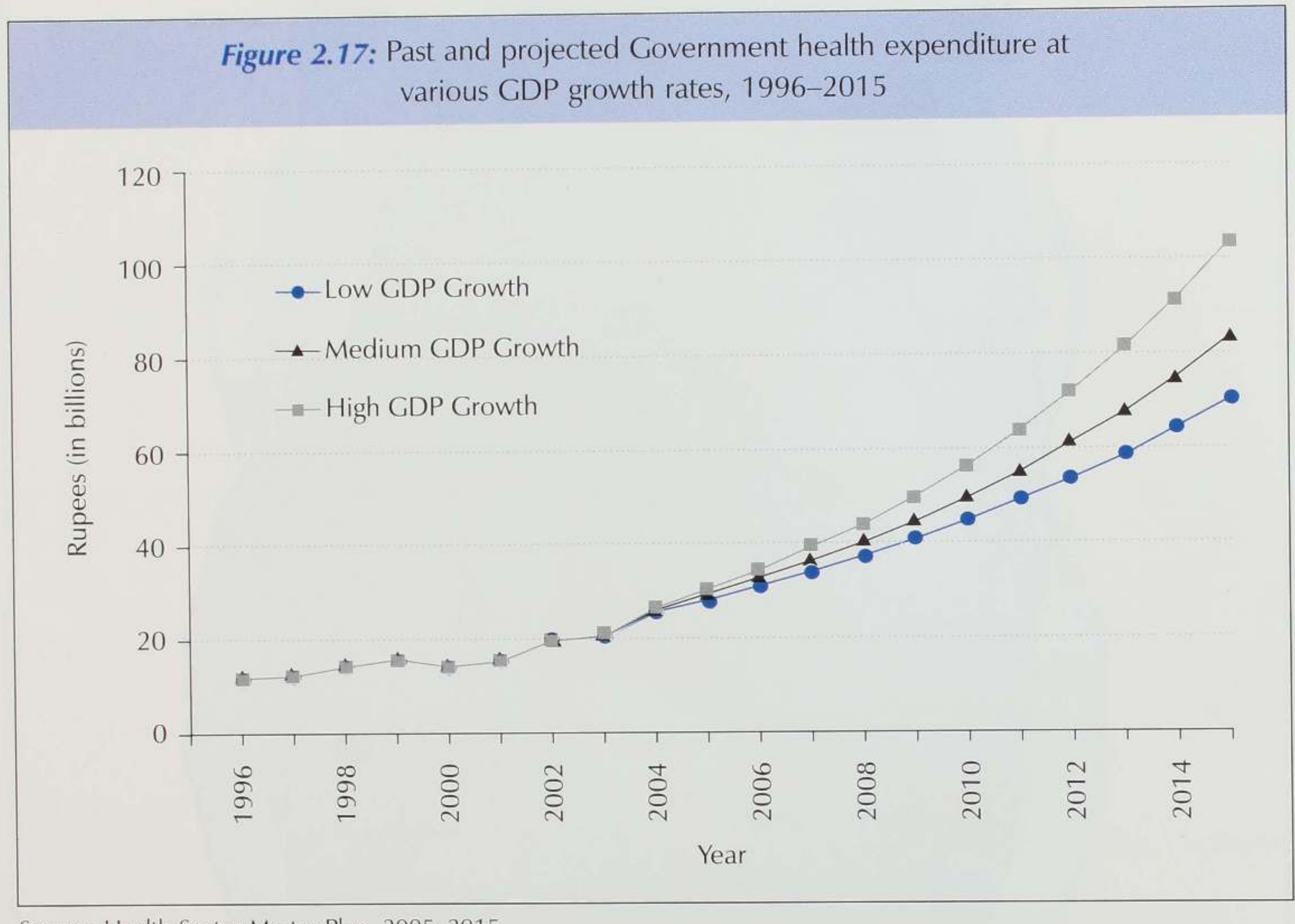
Health Care Financing

The Poverty Reduction Strategy Paper[11] developed by the Government of Sri Lanka in 2002 outlines the Government's policy for health financing and access to services:

"The Government supports a policy of universal health services for all its citizens. Ensuring the continued financial sustainability of the health sector while protecting equity of access and quality of care poses an important challenge. To enhance the financial sustainability of the health care system the Government will, by 2003, adopt a national health sector programme approach that would introduce measures aimed at overcoming regional disparities in access, rationalizing investments and services, encouraging the adoption of health insurance and strengthening hospital-based management systems. The Government will maintain health care expenditures at 8% to 10% of total public outlays."

Figure 2.17: Past and projected Government health expenditure at various GDP growth rates, 1996–2015



Source: Health Sector Master Plan, 2005–2015

Throughout the 1990s, total health expenditure in Sri Lanka was 3.1% to 3.5% of GDP with government and private sectors taking almost equal shares[12]. Most of the public expenditure on health of USD29 per capita is incurred by the Central Government with very little provincial revenue or other public resources as shown in Figure 2.18. The National Health Accounts published by the Health Ministry (2002) show that most of the private financing is from household out-of-pocket spending. Employer spending, commercial insurance and NGOs activities account for only a minor share of overall health expenditure.

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[11] Poverty Reduction in Sri Lanka (2003)

[12] National Health Accounts (2002)

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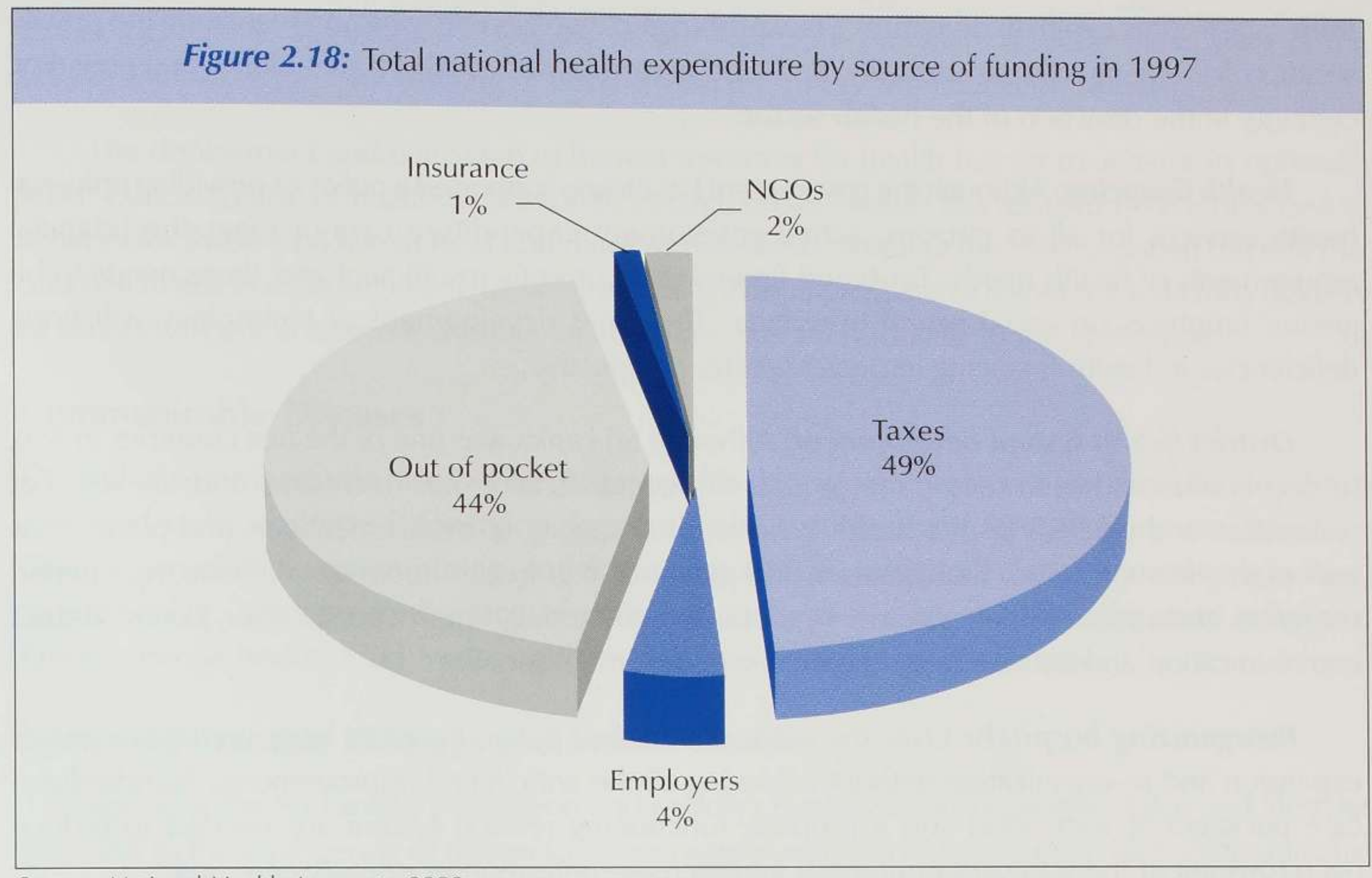
Figure 2.18: Total national health expenditure by source of funding in 1997



Source: National Health Accounts, 2002

Public expenditure on health at current market prices grew from Rs.5.6 billion in 1990 to Rs.25.4 billion in 2002. In 2002, public expenditure on health was 1.6% of GNP and 4.3% of the national expenditure. The proportion of the health budget in 2002 spent on community health services was approximately 8.6% of this total, with a disproportionately larger allocation for curative services.[13] The government pays for about half of the national health budget – the other half coming from patients' pockets.

2.5 Major Issues and Challenges in the Health Sector

Sri Lanka is currently experiencing several changes, some of which have already been mentioned. The demographic transition is apparent in the age pyramid (Figure 2.1) and the epidemiological transition in the disease profile (Figure 2.11). In the country as a whole, economic development is taking place with increased GDP growth, but there are important regional differences in poverty rates, social factors that influence health care consumption and the extent of technological development as shown by the proportion of hospitals using sophisticated technology.

Transition implies change and that brings uncertainty. The challenges listed below reflect some of the important changes taking place in the country where careful planning will be needed to avoid, or at least take into account, the related uncertainties.

Health System

Stewardship in the health sector: The changes needed in the health sector will present the managers of the health system with major challenges. There is a need to increase equity to ensure that all men and women, especially the poor, have better access to affordable health care and are protected

[13]Management Development and Planning Unit, Ministry of Healthcare and Nutrition

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from catastrophic health expenditure. Stewardship also involves engaging and regulating the private sector, collaborating with the education and other sectors as well as other stakeholders, and providing certainty in the direction of the health sector.

Health financing: Although the government has always supported a policy of providing universal health services for all its citizens, actual government expenditure cannot meet the financial requirements of health needs. Tax-based financing is currently insufficient and there needs to be greater emphasis on social health insurance. The rapid development of technology will bring deficiencies in health financing into ever greater perspective.

District health system development: Although Sri Lanka was one of the first countries in Asia to decentralize its health sector, the process of decentralization has been slow and uneven. For sustainable and efficient district health systems, the capacity of health managers and planners as well as the instruments for management and planning (e.g. health information, financing, human resources and procurement systems) need to be substantially improved. Further, centre-district communication and coordination need to be better institutionalized.

Reorganizing hospitals: Over the last two decades, public hospitals have undergone major expansion and re-organization without achieving all the anticipated improvements. Standardized care packages at each level and a properly functioning referral system are needed to reduce overcrowding of the specialist institutions and increase utilization of primary care units.

Information technology (IT): The existing health information systems of the Health Ministry, based largely on a traditional paper submission system and relying on manual reporting, urgently need technical and logistical improvement. Very few of the country's major hospitals and the provincial health services have a computer network to support their heavy burden of documentation and information processing. Solving this deficiency will involve a triad of activities – training in computer usage, use of simple but workable software, and installation and maintenance of reliable and well-maintained computer networks. The human resource gaps in health institutions must be reviewed keeping in mind these new challenges.

Strengthening public-private partnership: The private sector in Sri Lanka has been growing exponentially particularly in urban areas. Although this gives a choice to consumers, several issues merit consideration. Private facilities are concentrated in urban areas and have to be paid for out-of-pocket, raising access and equity issues. Most private sector health professionals are, at the same time, state-sector employees, exacerbating staff shortages and geographical maldistributions. Statistics on private sector patient workload and disease profiles are not collected, making a comprehensive overview of the entire health sector impossible.

Enhancing community response: Sri Lanka does not have a patients' Bill of Rights to protect health service consumers. Operationally, there are few formal mechanisms to ensure quality of the services provided. Moreover, health care consumers are not well informed about the health services and their rights. Empowerment of the community could help achieve a higher degree of responsiveness and better quality of health services.

Human Resources for Health

Sri Lanka produces over 2,000 health care providers every year. However, there are serious shortages of nurses, paramedical and auxiliary health personnel such as pharmacists, medical laboratory

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technologists and radiographers. Training of all health care providers is under the control of the Health Ministry except for training of doctors which is under the Education Ministry.

The deployment and utilization of human resources for health has yet to achieve its optimum level. Concentration of health professionals in large urban centres has resulted in lack of access to services for those who live in rural and more remote areas. Mismatches exist between the skill mix and skill needs in different health facilities resulting in inefficient use of resources and costly delivery of services. There is a severe shortage of adequate human resources in the North-East.

Communicable Diseases

Control of communicable diseases has progressed in the last four years, but geographical disparities still need to be addressed. Emerging diseases such as dengue and HIV/AIDS require attention. Disease surveillance, early warning, pandemic preparedness and rapid response mechanisms need strengthening, more so in the face of potential pandemics such as SARS and avian influenza. Environmental health, food, water safety and sanitation also pose challenges.

Noncommunicable Diseases and Mental Health

The ageing of the Sri Lankan population and rapidly changing socio-economic status and lifestyles have led to the emergence of diseases not previously common in the country. Noncommunicable diseases such as diabetes, cancer and cardiovascular disease now have a high incidence and are becoming major contributors to disease morbidity and mortality. Health promotion, lifestyle change, extending primary care and community services to prevent and manage noncommunicable diseases and control the escalation of health expenditure are now major challenges.

With the advance of the demographic and epidemiological transitions, increased services for the ageing population are required. Presently, there are limited facilities offering specific services for patients who suffer from chronic and degenerative diseases. Community and home-based support to assist these patients to remain active and independent is yet to be developed.

Mental Health – the Health Ministry with technical assistance from WHO has developed new mental health legislation and a new national mental health policy. These will provide for a comprehensive range of hospital and community services in all districts, with increased medical and nursing staffing and new cadres of psychologists, social workers and occupational therapists. A comprehensive survey of mentally ill patients in long-stay hospital care has revealed that the majority could be returned to the community if adequate local support services were available.

The main challenges in mental health care are: lack of trained staff; difficulties in posting staff to hard-to-recruit areas; development of infrastructure; managing the large psychiatric hospitals in transition and improving the quality of care, and developing a referral system for patients with mental illnesses.

Child, Adolescent and Reproductive Health

While Sri Lanka has been successful in improving overall population health, adolescent and reproductive health needs remain a priority. People of reproductive age are a growing section of the population whose needs should be specifically addressed. Even though the Maternal Mortality Rate has been declining steadily for half a century, the decline seems to have stagnated from the

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mid-nineties on, and there are significant geographical variations. Haemorrhage remains the most common cause of maternal deaths while in 2002 seven percent of reported maternal deaths were probably due to unsafe abortions[14]. There is a high incidence of reproductive tract infections and sexually transmitted infections, raising concerns also about HIV/AIDS. Malignancies of the cervix, uterus and breast are increasing. Emphasis needs to be given to the provision of adequate adolescent health services, promotion of reproductive health education, training staff and expansion of reproductive health services.

Malnutrition is a problem in Sri Lanka. The Demographic and Health Survey carried out in 2000 shows that the childhood malnutrition rates are high with 29.4% of children underweight, 14% wasted and 13.5% stunted.

Emergency Preparedness and Response

The political situation in the North-East is still unstable although many development activities including reconstruction are being carried out. Over the past few years, different parts of Sri Lanka have experienced natural disasters such as drought, floods, sea-erosion and then the tsunami. In addition, there are the potential dangers of pandemics such as SARS and avian influenza. Strengthening the health emergency preparedness and response system is an urgent need.

[14] Ministry of Health. Annual Health Bulletin 2002

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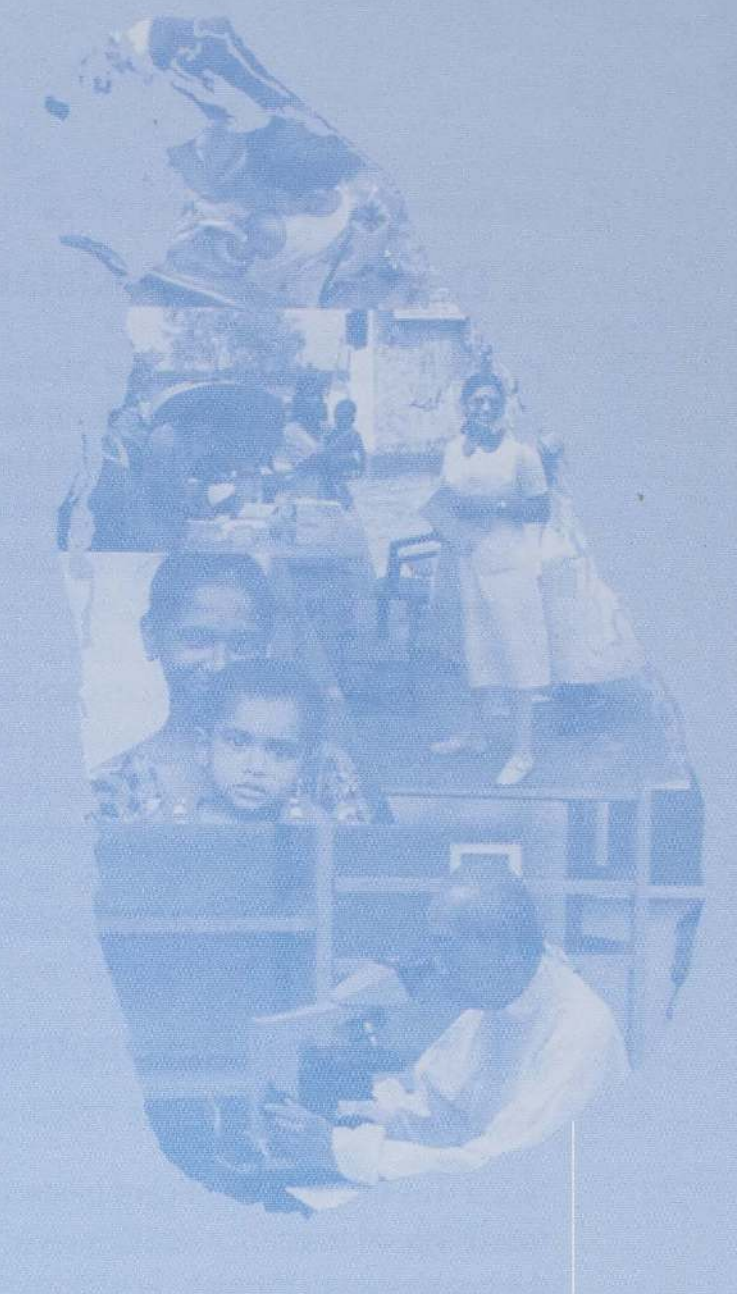

3

Development Assistance and Partnerships

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3. Development Assistance and Partnerships

The ceasefire followed by the Memorandum of Understanding signed between the Government and the Liberation Tigers of Tamil Eelam (LTTE) in February 2002, raised optimism for long-term peace. This has led to revived interest by the international development community to invest in the health sector of Sri Lanka. The post-tsunami assistance brought further assistance to the country, much of which was distributed in the health sector. By far the biggest actors in tsunami relief were the international NGOs (INGOs).

External financing sources contributed an estimated USD 14.3M to the health sector in 2003[15]. Donor funds for the health sector in that year represented 5.4% of total public health expenditure. However, this pattern of a very moderate contribution from external financing changed dramatically in 2005 by the inflow of large humanitarian aid. While it is expected that this aid will continue for several years, if not at the same level, the sustainability of the projects carried out with foreign contributions for health development is an important issue.

3.1 Traditional Development Partners

Bilateral Donors

Japan was the only significant bilateral donor to Sri Lanka in 2003, and provided two thirds of the total bilateral assistance (USD 3.7M). JICA focussed all its development assistance on strengthening the health system through providing technical expertise for policy development in the Health Ministry and making capital investments to strengthen health service delivery. In addition, the Japanese Ministry of Foreign Affairs (MOFA) provided capital funds for the improvement of the General Hospital, Ratnapura, and for upgrading medical equipment in the General Hospital, Matara.

AusAID contributed USD 926,000 through UNICEF for nutritional supplements for children. Austria and Finland provided some support for building and rehabilitation of hospitals.

Development Banks

Japan Bank for International Cooperation (JBIC) and the World Bank (WB) have been funding the health sector through concessional loans. Two WB IDA loans were activated in 2002–2004: (a) the National HIV/AIDS prevention project (USD 10.9m) 2003–2008; and (b) the Health Sector Development project (USD 63.6m) 2004–2009. Both loans comprise health sector strengthening components and components for priority health needs such as MCH services, prevention of communicable and noncommunicable diseases, improving quality of curative care at institutions, improving health of vulnerable groups, and enhancing district management capacity.

JBIC is assisting the Health Ministry in improving the blood safety programme by construction of infrastructure, procurement of equipment and supplies and, through WHO, providing technical assistance to the National Blood Transfusion Services. In addition to a number of smaller loans for various rural hospital projects, JBIC loaned approximately USD 13m to build a new National Blood Transfusion Centre in Colombo and to equip a number of rural blood centres.

[15]Sources: GAVI and GFATM expenditure report 2003; WHO data base, WB data Base, bilateral agencies, UNICEF and UNFPA; OECD International Development Statistics Online, Creditor Reporting System

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The ADB has been providing assistance for re-developing the health infrastructure of the North-East.

Agencies of the United Nations

The work of the United Nations (UN) organizations is coordinated under the UN Development Assistance Framework (UNDAF). In the North-East, the United Nations Development Programme (UNDP) has been helping the war-affected by assisting rehabilitation of traumatized women and children, creating mine awareness and providing prosthesis and physiotherapy services. The United Nations High Commission for Refugees (UNHCR) has been facilitating the return and reintegration of the displaced to their communities. The World Food Programme (WFP) provides emergency food assistance and food for work especially in the conflict-affected areas. The Food and Agriculture Organization (FAO) assists with food production and setting up home gardens, etc. The International Labour Organization (ILO) is assisting at strengthening human resource development, eliminating child labour and promoting occupational safety and health.

UN agencies, WHO, UNICEF and UNFPA jointly contributed USD 3.1m to the health sector in 2003. UNICEF's current five-year programme (2002–2007) includes support for early childhood development, the learning years and adolescence programmes, and for the protection of women and children. It has a separate programme for the North-East which deals with refugees, women and children, resettlement of Internally Displaced People (IDPs) and problems faced by the population in the conflict-affected areas.

UNFPA is supporting the government efforts to improve the reproductive health through quality information, education, communication and Well Women's Clinics that facilitate screening for cervical and breast cancer, diabetes and hypertension.

Global Health Initiatives

The Global Fund against AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI), the two largest global health initiatives in the health sector, jointly contributed USD 3.8m in 2003. Novartis has been assisting the Government in its efforts in leprosy elimination.

Application for and receipt of GFATM funding requires that an inter-sectoral Country Coordination Mechanism (CCM) be established to formulate proposals and to oversee the use of funds allocated. In Sri Lanka an inter-sectoral CCM was established with members from the Health Ministry, UN Agencies, the World Bank, universities, NGOs, service clubs and the private sector. The total grant amount mobilized under the GFATM for Sri Lanka since 2002 was approximately USD 15m for five years. In 2003, GFATM funds were allocated to malaria control in conflict-affected districts with a very high malaria burden (USD 2.4m) and to strengthen the TB control programme by enhancing the efficacy of the DOTS programme through increasing outreach activities in underserved areas and promoting the partnership with NGOs in the private sector (USD 0.7m).

A similar fund, FIDELIS, has provided a grant to extend and strengthen the DOTS programme for tuberculosis. The initial grant was USD 250,000 for 2005.

GAVI is providing USD 3.7m to support the introduction of Hepatitis B vaccines (USD 2.8m) and improve injection safety (0.8m) over five years (2002–2007).

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Nongovernmental Organizations

There are several international and national nongovernmental organizations that have been working in health and health-related areas for decades. Since the initiation of the tsunami response, the involvement of the NGOs has increased markedly. Although in the past WHO has not played a major role in working with NGOs, the tsunami relief activities provided the Organization with an opportunity to get involved in the coordination of international and national NGO activities.

3.2 Post-tsunami Relief and Reconstruction

One of the major factors in the post-tsunami rehabilitation of the health sector has been the enormous volume of support provided by the international community to restore the damage in the wake of the tsunami. The outpouring of financial and material aid, especially from the general public in western countries and channelled largely through their INGOs, is unparalleled in recent history.

For many of the bilateral donors, UN agencies and INGOs, the objective was not just to replace damaged structures, equipment and vehicles, but to take advantage of the large funds available to make long-term improvements to the existing systems – to "Build Back Better".

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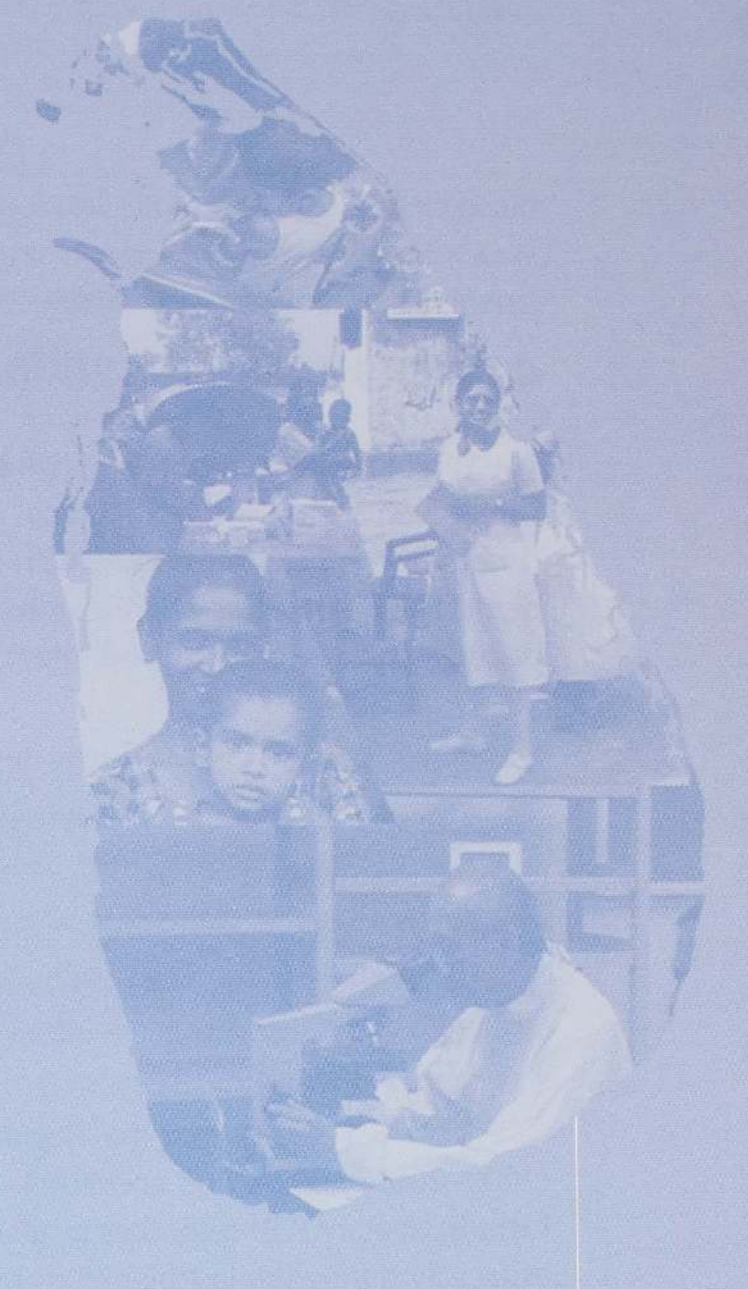

4

WHO's Work – 2000–2005

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4. WHO's Work – 2000–2005

The World Health Organization (WHO) as a technical agency of the UN is mandated to provide Sri Lanka with technical and financial support for health. The Organization's main partner in the country is the Health Ministry, with which it maintains close contacts at national, provincial and district levels. As well as working with the Government, WHO provides support to other development partners and key national and international stakeholders in the health sector.

The overall goal of WHO is stated in its Constitution – to support the people to attain the highest level of health. This can be achieved through strengthening of the health system on the principles of equity, fairness and responsiveness with emphasis on the poor and marginalized.

Table 4.1 shows that the Regular Budget (RB) changed little during the last three biennia (2000–2001, 2002–2003 and 2004–2005). However, there has been a significant increase in the Extra-Budgetary (EB) resources available and in the WHO Country Office (WCO) staffing pattern especially during the last biennium mainly due to post-tsunami rehabilitation activities.

Table 4.1: *Biennial budget and staffing pattern of WHO Country Office 2000–2005*

	2000–2001					2002–2003					2004–2005				
	USD (000)	%	Staffing			USD (000)	%	Staffing			USD (000)	%	Staffing		
			P	G	total			P	G	total			P	G	total
RB	4,600	93	4	16	20	4,620	79	3	19	22	4,556	30	4+2 *	19	25
EB	328	7	0	0	0	1,252	21	0	0	0	10,527	70	10#, 1**	14#	25
Total	**4,928**	**100**	**4**	**16**	**20**	**5,872**	**100**	**3**	**19**	**22**	**15,083**	**100**	**17**	**33**	**50**

P-professional G-general staff * NPO under RB ** NPO under EB # includes tsunami funds and tsunami staff

Current WCO staffing supported by the RB consists of the Country Representative, three other long-term staff covering Planning, Emergency Preparedness and Response, and Administration, and three National Professional Officers (NPOs) concentrating on separate areas: Planning, Health Systems Development and Reproductive Health; Communicable and Noncommunicable Diseases, Food Safety and Nutrition; HIV/STD, Tuberculosis and Malaria control. Professional staff employed under EB funds vary according to agreements with the donors and approval of the Health Ministry. Most are employed for a limited period to cover specific projects. Currently, most of these national and international EB staff are employed on tsunami-related projects.

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Apart from the tsunami programme, WHO's direct financial contribution to the national health sector has been relatively small compared to overall Government expenditure on health. However, through its technical inputs and collaborative efforts, WHO has been exerting considerable influence on the development of national health policy, strategies and plans.

4.1 Areas of WHO Support

In the last six years (three biennia), WHO inputs have concentrated on five key areas. These include:

- Health sector reform and health system development
- Communicable disease control
- Promoting healthy life styles and reducing environmental risk factors
- Integrating health services to enhance efficiency and effectiveness
- Emergency preparedness and response

These parallel the Organization's core functions internationally: evidence-based policy and advocacy, managing information, assessing health patterns and trends, catalyzing change, developing partnerships, setting, validating and monitoring implementation of norms and standards, and development of new technologies, tools and guidelines. The relationship between the two is described in Section 4.3.

4.2 Specific Areas of Support

Health Sector Reform and Health System Development

WHO has been providing technical assistance to the overall development of the health system mainly in the areas of health planning and management, health information system development, decentralization and health services delivery. WHO has also supported the Health Ministry in conducting a detailed assessment of the health sector and in the development of the HMP in collaboration with JICA and the World Bank.

WHO has supported the training of nationals on result-based management and planning, and on monitoring and evaluation with emphasis on provincial and district level capacity building. The Macroeconomics and Health Initiative introduced three years ago has increased awareness at the highest levels of Government for the need to mobilize and invest more in the health sector. WHO has also been instrumental in successfully mobilizing external resources for the health sector.

North-East health system re-development: The mutual observation of the Ceasefire Agreement signed by the Government and the LTTE in 2002 has provided an opportunity for the North-East to re-build its health system. WHO actively provided technical and other support to the North-East Provincial Council, with the objective of improving health service delivery and re-integrating the North-East health system into the national health sector.

Communicable Disease Control

WHO has been providing technical and financial support to a number of communicable disease prevention and control programmes with special emphasis on HIV/AIDS, TB, Malaria and Dengue.

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In the case of the latter two diseases considerable material and training support has been given to ensure more effective vector control throughout the country.

WHO supported the piloting of new strategies for rabies control, the monitoring of leprosy elimination activities and social mobilization for filariasis control including development of the one-day treatment strategy. WHO has also assisted in strengthening disease surveillance and laboratory diagnosis capabilities, particularly in the North-East.

Promoting Healthy Life Styles and Reducing Environmental Risks

WHO has supported the introduction of health promotion competencies in Sri Lanka related to the five strategies of health promotion enunciated in the Ottawa Charter. Further support has been given for mapping national capacity in health promotion. National programme managers were exposed to many international forums and programmes to update their knowledge on recent developments in this area such as health promotion settings. WHO activities also strengthened media advocacy and partnership for health promotion.

The Framework Convention on Tobacco Control (FCTC), has been one of the landmark initiatives in the recent history of public health. Sri Lanka was one of the first countries to sign the FCTC. A further indication of the Government's strong commitment to reduce tobacco use in the country has been the deliberate and concerted efforts in raising awareness of the public and the decision makers on the negative impact of tobacco on the household and the national economy as well as on the health of the individuals.

Major developments were witnessed in the area of mental health with the availability of extra-budgetary funds (World Bank and UN tsunami flash appeal). The main result of the support has been the preparation of a new mental health policy and the drafting of a new Mental Health Act. WHO continues to assist the Ministry of Health in the implementation of the mental health policy. A lot of work carried out by WHO was related to supporting the Government in implementing its provisions. These activities are continuing.

Support for the transition period is being provided as the emphasis of services shifts from the large psychiatric hospitals to more community-oriented facilities and activities. The ongoing initiatives include development of staff and curriculum, and the development of a new Code of Practice to support the implementation of the new Mental Health Act.

Integrating Health Services for Efficiency and Effectiveness

A major area of health care where efficiency and effectiveness have been improved with the assistance of WHO in recent years is blood safety. With technical support from WHO and financial support from Japan, Sri Lanka has greatly improved its blood transfusion system. Work has been initiated on a new National Blood Transfusion Centre in Narahenpitiya (near Colombo) and equipment has been provided to upgrade the testing and production facilities of six regional blood centres situated strategically across the country.

Technical assistance has been provided in project management and in development of transfusion medicine discipline. Human resource development in blood transfusion services was supported with the establishment of in-country training programmes and by providing opportunities for international training in specialized areas. Assistance was also provided in re-

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designing the legislation covering blood transfusion and in strengthening the role of the National Blood Transfusion Service.

Emergency Preparedness and Response

Flooding due to heavy monsoons or its failure with consequent droughts, are regular features in Sri Lanka. WHO has assisted the Health Ministry to cope with the associated health issues on a number of occasions. Further, when several Asian countries experienced outbreaks of SARS (2003), Avian influenza (2004) and potential threats of biological warfare (e.g. Anthrax), WHO supported the Health Ministry to train key health officials on emergency preparedness, and to strengthen the disease surveillance system, the Infectious Diseases Hospital and the capabilities of the clinical and public health laboratories.

During the past six years, the WHO Country Office has been able to respond rapidly to a number of potential disasters and to provide immediate humanitarian support to various affected populations. Many droughts and floods occurred, the most serious of which before the tsunami resulted from the extreme weather conditions that hit Ratnapura in May 2003. The resultant landslides and flooding of large areas presented acute public health risks which were mitigated by provision of material and technical support by WHO to local authorities. Immediately after the tsunami hit most of the country's coastal areas on 26 December 2004, WHO played a leading role in the health aspects of the disaster, providing emergency supplies, mobilizing considerable resources and managing a series of critical projects in most of the affected districts.

North-East Emergency Reconstruction Project

As part of the World Bank-funded North-East Emergency Reconstruction Programme, WHO provided considerable support during 2003–2004:

Provision of basic health services – WHO carried out a health needs assessment in the North-East and documented rebuilding and staffing needs, recommending reconstruction of about 65% of health institutions. It also supplied emergency material to the most seriously affected institutions. Major support was provided for laboratory services (basic laboratory training, introduction of rapid diagnostic techniques, supply of incinerators, consultancy services); environmental health (environmental survey of health institutions, Healthy District Initiative, investigation of outbreaks); and for mental health (training in case detection, setting up multi-disciplinary mental health teams, opening rehabilitation units, setting up outreach clinics).

Strengthening of human resources – through special emergency recruitment contracts, WHO recruited nine specialist doctors and six general medical officers for institutions where there were shortages of government medical staff. These doctors treated well over 20,000 patients and carried out several thousand surgical operations. The nursing schools in Jaffna and in Batticaloa were given emergency assistance and a detailed plan was developed for their rehabilitation. Volunteers in the health system were surveyed and their skills and activities analyzed. WHO carried out extensive training programmes in mental health, multi-disease surveillance, management information systems and laboratory procedures. Several thousand staff members were trained.

Strengthening of the health information system – WHO made a detailed analysis of the current health information system and existing procedures, designed a comprehensive health information system including a Geographic Information System, deployed computer networks in

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most districts with training of staff and senior health officials, and produced a plan for a computerized health information network in the NE. This plan was later adapted for the districts affected by the tsunami.

Strengthening of multi-disease surveillance (MDS) – WHO strengthened MDS through the improvement of laboratory services and infectious disease notification. Several training activities were conducted and detailed plans, standards and procedures for recording and reporting notifiable diseases developed.

Strengthening of planning & management – WHO assisted the North-East Provincial Council (NEPC) by providing a draft scheme for hospital design in the NE, and compiled a document to facilitate decision making in infrastructure development. Assistance was given in HIS assessment and redesign, and, together with its UN partners, a transitional strategy document was developed for improving health care in the country in general and in the NE in particular. Project activities were monitored and a number of plans were prepared to assist the NEPC in improving planning and management at the provincial and district levels.

Post-Tsunami Rehabilitation

Immediately following the tsunami disaster in December 2004, WHO supported the national and local health authorities with needs assessments, provision of essential medical supplies and drugs, strengthening the cold chain, and in ensuring mobility for medical teams and health personnel. In the following year, the main contributions of WHO to the post-tsunami response were:

Co-ordination and monitoring of health sector response – WHO provided technical and material assistance in three main areas:

- **Coordination –** WHO assisted the Health Ministry to establish a 24-hour tsunami operation cell in each district and organized special committees, teams and working groups to oversee the emergency service delivery and distribution of medical donations and supplies. Coordination at the central level was facilitated with regular meetings between all health partners.
- **Capacity building –** Training programmes were conducted for laboratory staff on diagnosis of diseases of public health importance. Several other categories of health care workers were trained in infection control and bio-safety, water and food microbiology and in outbreak investigations. A workshop on Quality Assurance and Accreditation was organized for microbiologists and pathologists from all over the country. Onsite training for nurses, Medical Laboratory Technologists (MLTs) and Medical Officers (MOs) in collection and transportation of samples and bio-safety was also carried out. A national "Post-Tsunami Lessons Learned and Best Practices" workshop was held in June 2005, attended by government, nongovernmental and international donor groups. Approximately 75 representatives from the national, provincial, district and community levels participated at this workshop.
- **Project Management and Logistics –** the necessary resources for medical relief assistance and rehabilitation were mobilized, augmented by international assistance and community organizations. Psycho-social and mental health interventions were carried out, along with relevant capacity building programmes. Periodic field visits were organized to monitor the implementation of different projects.

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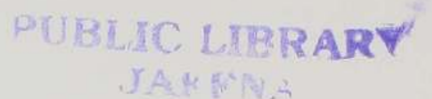

Surveillance and Early Warning – training programmes in laboratories coupled with the supply of essential equipment brought about significant improvements in laboratory technical services, ensuring swift and accurate diagnosis. A simplified computerized database for registration of in-patients and notifiable diseases treated in out-patient settings was established and is proceeding rapidly. A Local Area Network (LAN) with server and workstations has been installed in three districts (the main hospital and the district health department) and is helping to speed up and improve notifications.

Communicable disease control with specific focus on vector-borne disease control – WHO carried out many training exercises on vector control and solved logistic difficulties in fogging and spraying. Workshops were held for field staff on "Strengthening of surveillance infrastructure and disease prevention and control". Support was provided in procuring essential equipment and supplies i.e. laptops, computers and printers, to enable the experts to function effectively in the task of advising the health authorities in tackling the emergent situations. Over 90,000 mosquito nets were distributed to affected families and over 10,000 malaria rapid diagnostic kits and over 100,000 anti-malaria tablets were supplied.

Health Services and systems – in addition to material support to replace lost assets, infrastructure and supplies, technical expertise was provided to reactivate previously available health services and to facilitate early recovery and rehabilitation. In particular, equipment and supplies were procured for the hospital laboratories while emergency and first-aid kits were distributed throughout the country to meet the immediate health needs.

As a direct consequence of the tsunami, guidelines have been developed on various aspects of response to disasters with WHO support, and technical expertise made available in different fields to advise the authorities to respond to critical health situations. The highest level of this support was the preparation for the high level conference held in Phuket (Thailand) for senior health policy makers of the Region to review experiences during the disaster and identify lessons learnt for improving future responses to similar crises.

Water Quality and Environmental Sanitation – WHO's activities in this area included provision of training for public health staff on lab instruments, development of water surveillance policy, hygiene promotion activities for communities, health workers and hospitals and strengthening the water testing labs in affected districts. Supplies and equipment were provided in the area of water quality (water testing kits, guidance manuals, bleaching powder for wells and drinking water tanks and sanitation kits for camp latrines). Over 100,000 chlorine tablets, 500 chlorine testing kits, 30 bacteriological testing kits and 900 sanitation kits were distributed. Workshops were also carried out in the area of water quality (national, regional and to various community groups).

Mental Health – WHO assisted with the extensive coordination efforts, and supported the development of plans for training of all staff groups with special emphasis on social interventions and making staff available in all areas. Assistance was also provided to the Ministry of Health to initiate the implementation of plans to strengthen the mental health care system. In this context, 500 community-level mental health workers have been appointed and, in addition to basic training, they are being trained in problem solving skills and approaches to deal with alcohol abuse. WHO is regularly monitoring the work carried out in all 14 districts.

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4.3 Overall Performance in Priority Areas

In Table 4.2, an attempt is made to evaluate the performance of the priority areas identified in the previous CCS against WHO's six core functions. The scoring in this table is based on the scope of work conducted under the regular budget and the budget spent. It is not an attempt to evaluate the quality of the support provided – this has been done by a number of specific monitoring and review exercises and is reported separately.

Table 4.2: *Performance in priority areas (2002–2005) in relation to WHO's core functions*

Priority areas identified in CCS 2002	WHO's Core Functions					
	Articulating evidence-based policy and advocacy	Managing information, assessing trends, research & development	Catalyzing change by technical and policy support	Negotiating and sustaining partnerships	Setting, validating and monitoring norms and standards	Development of technology tools and guidelines
Health sector reform and health system development	++	+++	++	+	++	+
Communicable disease control	+++	++	++	++	+	+
Promoting healthy life styles, reducing environmental risks	+	+	++	+	+	++
Integrating health services for efficiency & effectiveness	+	++	++	+	++	++
Emergency preparedness and response	++	+	+++	+++	++	+

Three of the five priority areas received the most assistance: *Health sector reform and health system development*; *Communicable disease control*; and *Emergency preparedness and response*. The core functions mainly used in this assistance were *Catalyzing changes through technical and policy support*; *Managing information, assessing trends, research and development*; and *Articulating evidence-based policy and advocacy positions*.

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5

WHO Policy Framework: Global and Regional Directions

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5. WHO Policy Framework: Global and Regional Directions

5.1 Global Policy Framework

The General Programme of Work[16] (GPW) is the core policy document of WHO. The 11th GPW (2006–2015) sets out the direction for international public health during 2006 through 2015. The document notes that there have been substantial improvements in health over the last 50 years. However, significant challenges remain, as described in the following four gaps:

(1) Gaps in social justice – Clearly poverty is a key factor in access to quality health services, perpetuating the vicious cycle of poor health and poverty. Discrimination by ethnicity or gender also reduces access to services and the special issues of women's health are often not adequately addressed. In some countries the life expectancy of the poor is 20 years lower than the privileged members of society.

(2) Gaps in responsibility – Solving health problems is no longer merely a responsibility of those working in the health sector, but requires action by those outside the health sector. International conflicts and national crises often disrupt social services including health care. Globalization and decisions regarding international trade have a direct effect on health, especially in the area of pharmaceuticals and the movement of health professionals. Ministries of health often do not have the capacity to influence important causes of ill-health outside the health sector.

(3) Gaps in implementation – The technology exists to implement cost-effective interventions to improve health. However, these are not implemented because of shortage of funds, lack of human resources or an ineffective health system. The available resources may often be allocated to high-cost curative services and favour urban areas, while inexpensive and effective interventions in rural and remote areas are neglected.

(4) Gaps in knowledge – Advances in science and technology have improved the effectiveness and efficiency of medical services, prevention and treatment. However, information about these advances is not available in all countries. Furthermore, lack of information about health conditions, needs and programmes has made it difficult to formulate and manage effective health policies and interventions. Finally, operational research aimed at those most in need of health services is generally not conducted, further reducing the efficiency of key programmes.

In order to reduce these gaps over the coming 10 years, the 11th GPW outlines a global health agenda consisting of seven priority areas. These are:

(1) Investing in health to reduce poverty

(2) Building individual and global health security

(3) Promoting universal coverage, gender equality, and health-related human rights

(4) Tackling the determinants of health

(5) Strengthening health systems and equitable access

[16] "General Programme of Work" (SEARO 2005)

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(6) Harnessing knowledge, science and technology

(7) Strengthening governance, leadership and accountability

This global health agenda is meant for all those working in the area of health development. WHO will contribute to this agenda by concentrating on its core functions, as shown in the box below[17], based on the comparative advantages of the Organization.

WHO's core functions

(1) Providing leadership on matters critical to health and engaging in partnerships where joint action is needed

(2) Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge

(3) Setting norms and standards, and promoting and monitoring their implementation

(4) Articulating ethical and evidence-based policy options

(5) Providing technical support, catalysing change, and building sustainable institutional capacity

(6) Monitoring the health situation and assessing health trends

In accordance with the global health agenda and WHO's core functions, the Organization has set the following priorities:

(1) Providing support to countries in moving to universal coverage with effective public health interventions;

(2) Strengthening global health security;

(3) Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;

(4) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health; and

(5) Strengthening WHO's leadership at global and regional levels and by supporting the work of governments at country level.

WHO will implement these priorities through its Medium-term Strategic Plan[18] (2008–2013) and the biennium budget of the Organization. The Director-General of WHO has clearly put a major focus on the work of the Organization at the country level. The Regional Offices and Headquarters have been directed to emphasize support for country work and implement these priorities in its Member States, especially where the health needs are greatest.

5.2 Regional Policy Framework

The South-East Asia Region (SEAR) has the second highest population among the six WHO regions and carries the greatest burden of disease. While there has been significant economic development in recent years, the problems of poverty and poor health persist. Many countries have faced health emergencies in the last decade and the threat of disease outbreaks is ever-present. At the same

[17]this list of WHO's core functions is distilled from the list of 22 functions laid down in Article 2 of WHO's Constitution in the *Eleventh General Programme of Work*, 2006-2015 – WHO Executive Board

[18]"Medium Term Strategic Plan" (WHO HQ 2005)

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time, noncommunicable diseases have become an increasingly important cause of morbidity and mortality in countries of the Region. Therefore, the global policy framework of WHO is appropriate for the countries of the Region, with special attention on strengthening their capacity to support public health interventions.

The South-East Asia Region has always placed a strong emphasis on its work in Member States. Of the budget provided to the Region, 75% is allocated for countries, the highest in any WHO Region. The 11 Member countries of the Region have strong WHO Country Offices active in health development initiatives. The Regional Director has recently increased the delegation of authority to country offices so they can plan and implement programmes with a high degree of independence and are fully accountable for their work. At the same time, he has emphasized that the Regional Office staff should give the highest priority to support the work in countries. The Country Cooperation Strategies should focus WHO support for countries to maximize health benefits.

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6

Strategic Agenda

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6. Strategic Agenda

The significant health achievements made over the last few decades that gave the citizens of Sri Lanka the highest health status in South Asia, need to be consolidated and further advanced given the rapidly changing demographic and epidemiological scenario in the country. The demographic and epidemiological transitions resulting from declining fertility and mortality, and a shift from communicable to chronic and noncommunicable disease patterns, have made it necessary for the Government to assess the effectiveness of past strategies in dealing with its current and future health issues.

The CCS underlines a process of readjustment of priorities within WHO to meet the health needs of Sri Lanka. It elaborates how WHO's strategic directions, operational principles and core functions will be used to assist Sri Lanka in achieving its national health sector development goals and objectives. This new CCS is planned to cover the period 2006 to 2011.

Six strategic areas of work have been identified for WHO's collaborative action in the next six years. They are:

- **Health System.** Enhance fairness and financial risk protection in health care and optimal use of resources; enhance management and quality in delivery of services and interventions.
- **Human Resources for Health.** Rationalize the development and management of human resources; support pre-service and continuing education in clinical, public health and management competencies; strengthen the regulatory framework to ensure quality of performance of health staff.
- **Communicable Diseases.** Strengthen the surveillance system for existing, emerging and re-emerging diseases; address priority communicable disease programmes; coordinate action for pandemic preparedness.
- **Noncommunicable Diseases and Mental Health.** Support prevention and control of major NCDs, mental health disorders and related priorities; promote integrated and cost-effective approaches for prevention and management of major NCDs; support surveillance of NCD risk factors and their determinants.
- **Child, Adolescent and Reproductive Health.** Reorient the existing maternal and child health services by inclusion of a package of services and interventions for child, adolescent and reproductive health and nutrition using a lifecycle approach.
- **Emergency Preparedness and Response.** Strengthen and communicate information for emergency preparedness, response and dissemination; contribute to networks for coordinated preparedness and crisis management; continue to address health and rehabilitation in post-tsunami and post-conflict areas; institutionalize the Emergency Preparedness and Response programme within the health sector.

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The matrix in Table 6.1 indicates which WHO core functions will be applied to each area of work. The indications in this table are the result of collaborative discussions with the Health Ministry and consultations with various stakeholders including a workshop on "Catalyzing Change and Partnerships". They indicate the priorities for support that will serve to guide WHO activities.

Table 6.1: *Prioritization of WHO's Core Functions in relation to the Priority Areas of the CCS, 2006–2011*

Priority Areas Identified in CCS 2006-2011	WHO's Core Functions					
	Providing leadership on matters critical to health and engaging in partnerships where joint action is needed	Articulating ethical and evidence-based policy positions	Setting norms and standards, and promoting and monitoring their implementation	Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge	Providing technical support, catalyzing change and developing sustainable institutional capacity	Monitoring the health situation and assessing health trends
The Health System	++	++	++	+++	+++	+++
Human Resources for Health	+++	+++	+++	++	+++	++
Communicable Diseases	++	++	+	+++	+++	++
Noncommunicable Diseases and Mental Health	+++	+++	+	+++	+++	+
Child, Adolescent and Reproductive Health	+++	+++	+++	++	+++	+++
Emergency Preparedness and Response	+++	++	++	++	+++	++

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The following sections describe each of these priority areas, giving the strategic objectives the Organization hopes to achieve in each area, and the approaches that are planned to provide adequate support to all interested partners.

6.1 Strategic Objectives and Approaches for Each Priority Area of Work

The World Health Organization will work with the Health Ministry and other relevant partners towards achieving the objectives outlined below covering the six strategic areas:

The Health System

Strategic objectives

- Enhance fairness and financial risk protection in health care and optimal use of resources
- Enhance management and quality in delivery of services and interventions

Approaches – The issue of equity and burden in paying for health services will be analysed and assistance provided in the development of an investment plan for resource mobilization. The national and sub-national capacity to use National Health Accounts will be institutionalized. Public-private partnership will be strengthened through appropriate incentives, regulations, standards and sharing of information. The organization and use of different types of health institutions will be rationalized, including packages of care, standards and referral, taking into consideration the increasing need for community/home-based care. IT capability will be strengthened - the quality of data, information use and evidence-based decision-making at all levels of the health system will be facilitated by provision of adequate IT support. Management, quality of care and accountability of the health system will be improved by better stewardship and by clarifying roles and responsibilities at each level. WHO will support the implementation of the new National Medicinal Drug Policy (NMDP).

Human Resources for Health

Strategic objectives

- Rationalize the development, deployment, retention and management of HRH
- Support pre-service (basic) and continuing education in clinical, public health (including community/home-based care) and service management competencies
- Strengthen the regulatory framework to ensure quality of performance of health staff (public-private partnership)

Approaches – A 15-year Human Resource Development Plan will be developed. WHO will collaborate with stakeholders working in this area. It is planned to enhance quality in basic education for HRH, especially in the NE and other remote areas and to develop systematic and continuous education programmes using distance education and other approaches. There will be a review of legislation, regulations and licensing of human resources for health (public and private). In particular, it is planned to augment the health workforce availability and performance in the North East and in remote areas. As in other areas, WHO will work with professional organizations to strengthen their positive influence in HRH issues.

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Communicable Diseases

Strategic objectives

- Strengthen the surveillance system (including early warning and rapid response) for existing, emerging and re-emerging diseases
- Address priority communicable disease programmes, in particular malaria, HIV/AIDS, tuberculosis, leprosy, dengue, rabies, filariasis and vaccine-preventable diseases of childhood
- Coordinate action for potential pandemic disease preparedness.

Approaches – The development of a National Pandemic Preparedness Plan. Will be supported. WHO will ensure that each infectious disease control programme is reviewed regularly so that technically sound progress reviews become a pre-requisite for the development of updated strategies and workplans. Steps will be taken to establish/strengthen regional public health laboratories. Community-based approaches for diseases surveillance, prevention and control will also be strengthened. It is also planned to enhance hospital hygiene, safety and waste management and to strengthen environmental health initiatives in general with the emphasis on food safety, water and sanitation.

Noncommunicable Diseases and Mental Health

Strategic objectives

- Support prevention and control of major NCDs and related priorities (cardiovascular disease, cancer, diabetes, psychosocial and mental health, alcohol and substance abuse, violence and injuries particularly road traffic and occupational accidents)
- Promote integrated and cost-effective approaches for prevention and management of the major NCDs and mental illnesses
- Support surveillance of NCD risk factors and their determinants.

Approaches – It is proposed to develop an evidence-based position paper on prioritizing NCDs for action and to support the development and implementation of national policies and strategic plans for the prevention and control of NCDs. Evidence-based guidelines and protocols to promote integrated approaches to management will be produced, to improve health outcomes of priority NCDs at the community level. This will be part of a number of community and school-based approaches to promote healthy lifestyles including nutrition, through promotion of adequate dietary guidelines with the emphasis on infant and young child feeding and nutrition for adolescents. Links will also be established with existing networks to strengthen prevention of important NCDs. As a complement to these activities, WHO will support the development and implementation of an integrated surveillance system which will cover both communicable and noncommunicable diseases. As a means of seriously tackling NCDs, operational research will be promoted to identify the types of cancers amenable to public health preventive efforts. Support will be continued to implement the Framework Convention on Tobacco Control. Among the initiatives started as part of the tsunami programme, WHO puts special emphasis on community-based mental health initiatives taken during the post-tsunami period as a way to ensure implementation of the new mental health policy.

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Child, Adolescent and Reproductive Health

Strategic objective

- Reorient the existing maternal and child health services by ensuring inclusion of a package of services and interventions for child, adolescent and reproductive health and nutrition using the lifecycle approach.

Approaches – WHO will work in partnership with other stakeholders in this area in order to ensure good coordination and collaboration. It is planned to develop and implement a national policy and a five-year strategic plan on maternal, newborn and child health with the focus on adolescent and reproductive health. Support will be extenxded for a phased implementation of service and intervention packages [including Integrated Management of Childhood Illnesses (IMCI) and Integrated Management of Pregnancy and Childbirth (IMPAC)] as well as the development and implementation of strategies and programmes for neonatal care. An important area is the design and implementation of nutritional programmes for high risk groups, with the emphasis on infants, young children and adolescents. The latter could be through Health and Nutrition Promoting/ Friendly Schools. Of particular importance is the design and implementation of programmes to control cancers of the breast and the female reproductive tract.

Emergency Preparedness and Response

Strategic objectives

- Strengthen and share the information and intelligence base for emergency preparedness, response and dissemination
- Contribute to networks for coordinated preparedness planning and crisis management
- Continue addressing health and rehabilitation needs of the post-tsunami and post-conflict areas including nutritional surveillance and camp management
- Institutionalize the Emergency Preparedness and Response programme within the health sector

Approaches – An important approach to fulfil these objectives will be to map, monitor and communicate risks to life and health (threats/hazards, vulnerabilities, capacities) within the overall national plan "*Road Map for Disaster Management - Towards a Safer Sri Lanka*", prepared by the Ministry of Disaster Management functioning under the direct supervision of the Prime Minister. It is proposed to strengthen inter-linkages between public health programmes and other sectors for emergencies and to support delivery of health services and interventions in crises with special focus on disease control, mental health, water and sanitation, logistics and medical supply management.

Emphasis will be put on the disaster mitigation and preparedness role of the various health facilities and to implement programmes under the national health sector plan that are integrated with the plans for national disaster risk reduction. WHO will ensure that national and sub-national policy, plans, protocols and information are available and applied in emergency situations. In this context, systematic capacity building and training programmes will be supported. It is anticipated that these approaches will progressively mainstream EPR into the overall health system. This will be followed with quarterly reassessments.

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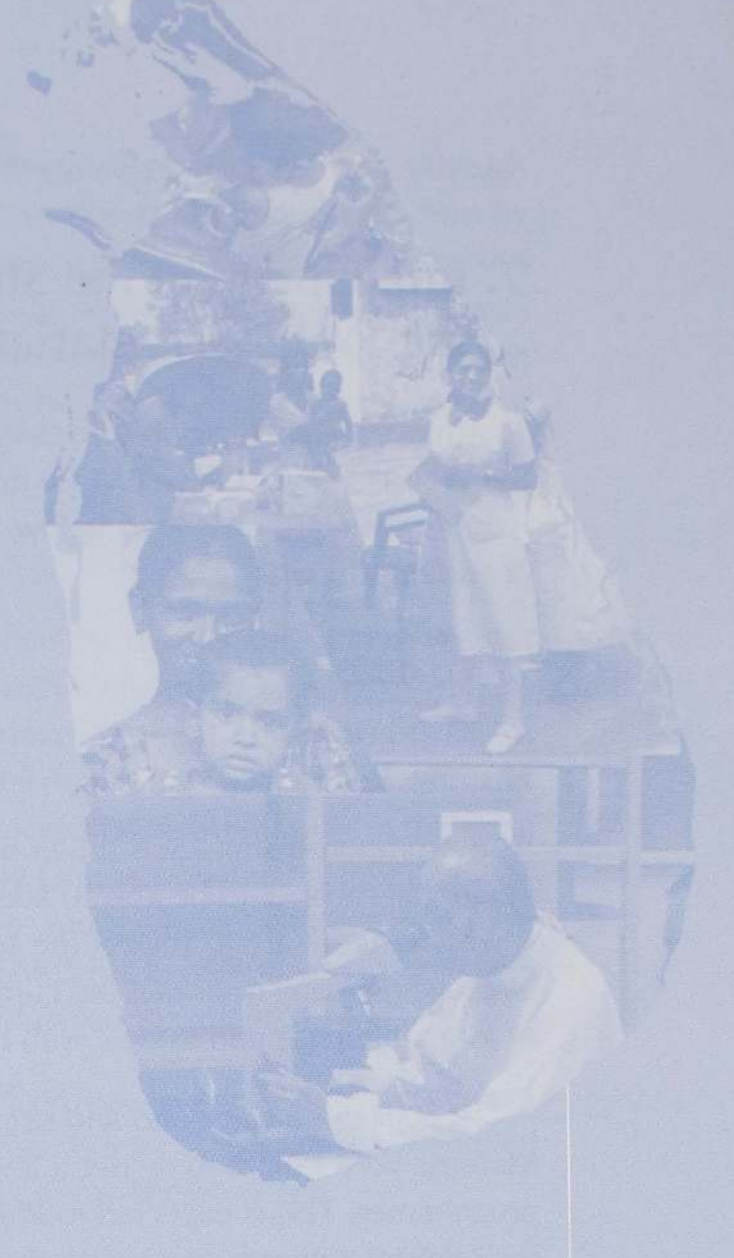

7

Implementing the Strategic Agenda: Implications for the WHO Secretariat

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7. Implementing the Strategic Agenda: Implications for the WHO Secretariat

To achieve the strategic objectives in each of the priority areas as outlined in Section 6 of this CCS, the WHO Country Office (WCO) in Sri Lanka must have adequate staff and resources. These new requirements are described below, indicating the various units of the Organization that will be providing support.

7.1 Country Office

Human Resources

As the proposed strategy is an ambitious one, it will be necessary to strengthen the WCO with additional capacity to be able to adequately cover all these strategic areas. As these areas expand, it will be necessary to review the technical expertise needed to support each programme. It is already becoming clear that the current capacity of the WCO to adequately respond to the threat of avian influenza and to deal with the increased emphasis now being given to NCDs is weak.

It is planned to extend and strengthen existing mechanisms of collaboration with the Health Ministry. WHO plans to recruit a few government staff for short periods to collaborate on certain programmes. This is expected to improve their capacity to handle similar work on their return to the ministry. Other necessary mechanisms will be explored.

The staff deployed in the WHO Country Office have been allotted responsibilities to cover the needs of the current programmes in health system development on a routine basis. However, the NPO specifically assigned to health systems development is also expected to cover reproductive health. Since health systems development needs an NPO full-time, an additional NPO/APO will need to be recruited in the areas of child, adolescent and reproductive health.

Because of the threat of pandemics such as avian influenza, there is a need for a full-time epidemiologist to cover the CCS period. It is anticipated that Voluntary Contributions can be found to cover this additional post. The current tsunami operations team will be scaled down as the operations are completed and their activities are mainstreamed into regular work. The staffing pattern to address post-tsunami and post-conflict periods as well as preparedness for the health sector may vary as the situation evolves.

If there are additional WHO projects funded by Voluntary Contributions to support any of the priority areas of the CCS, additional long-term staff may need to be recruited to implement the projects in addition to administrative and support staff.

Financial Resources

In addition to the Regular Budget, Extrabudgetary resources will be mobilized to allow a more selective and strategic approach while working with the Health Ministry and other development partners in the six priority areas. Emphasis will be given to WHO's role of providing technical assistance in the form of advice, guidance, demonstration and advocacy.

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The WCO currently has a small number of international and national professional staff. Although some of the WCO shortfalls in technical competence may be compensated in the short-term by using technical experts from SEARO and HQ, there are areas needing full-time attention and technical support at the country level. This applies especially to the area of communicable diseases including avian influenza, NCDs and child, adolescent and reproductive health. It is expected that part of extrabudgetary resources to be mobilized will need to be used to obtain the services of experts in these areas.

7.2 Regional Office

Multi-Country Activities (MCA) is a new mechanism established by the Regional Office for the 2006–2007 biennium to replace the previous ICP-II. SEAR countries often face common problems and, in many cases, have developed similar strategies to achieve common objectives or results. MCAs are designed to benefit two or more countries and include inter-country meetings, common assessments and training sessions or consultants to provide services to several countries at the same time. Implementation of MCA involves different WHO Country Offices working together and with the concerned technical unit in SEARO to implement activities more efficiently rather than each doing them separately. It also includes activities conducted in SEARO but benefiting several countries such as development of a protocol, operational guidelines or survey instruments.

In addition, it is expected that the WHO Regional Office will provide technical and management support for the initial implementation of the workplans in the country. The CCS has identified special areas of support that are requested from the Regional Office. These cover:

- Health Systems Research
- Computerization of health information systems
- Development of new degree programmes for the health workforce
- Health Care Waste Management
- Strengthening of Regional Laboratories
- Adolescent health, including the recruitment of a Short Term Professional (STP)
- Emergency preparedness and response areas in post-tsunami rehabilitation
- Post-conflict rehabilitation and Emergency Preparedness and Response in the Health Sector.

WHO Headquarters and the Regional Office will be working jointly to support the country office on management and re-organization of health services and human resources development in the North-East and in remote areas. Technical support (including assigning an STP during various periods) on NCDs will also be provided in coordination with Headquarters, specifically for building the evidence base for NCD.

7.3 Headquarters

WHO Headquarters (Hq) can assist especially in the areas of health systems development, health financing and in control of noncommunicable diseases. The area of NCDs requires coordination with initiatives concerning cancer registry establishment taken up by the International Agency for Research on Cancer (IARC), Lyon.

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While it is recognized that the country and regional offices are involved with efforts to obtain donor funds, WHO Hq plays a key role in the mobilization of resources in the strategic priority areas identified, at the same time responding to other country requests. This is particularly important in priority areas where country resources are limited, such as health systems development and control of noncommunicable diseases. The following global initiatives and partnerships will be implemented and supported in Sri Lanka:

- Framework Convention on Tobacco Control (FCTC)
- Global Alliance for Vaccines and Immunization (GAVI)
- Global Fund against AIDS, Tuberculosis and Malaria (GFATM)
- Global Programme for Leprosy Elimination
- Global Programme to Eliminate Lymphatic Filariasis (GPELF)
- Health Metrics Network (HMN)
- Iodine Deficiency Disorder Elimination (IDDE)
- Leptospirosis Elimination
- Making Pregnancy Safer (MPS)
- Roll Back Malaria
- Stop TB.

7.4 WHO Internal Coordination

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

(1) Information sharing in specific technical areas

(2) Coordination for resource mobilization as follow-up with donors and interested funding organizations

(3) Joint planning for biennium work plans

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

(5) Sustainable partnerships development.

7.5 Coordination with the Health Ministry and Partners

In implementing the CCS, WHO will maintain a close partnership with the Health Ministry and with other bilateral and multilateral agencies as well as with health-related NGOs and stakeholders in the country. WHO will conduct regular consultations and review meetings with the Health Ministry to ensure that the priorities identified in the CCS are implemented fully.

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Abbreviations

ADB	Asian Development Bank
APO	Assistant Professional Officer
AusAID	Australian Government Overseas Aid Program
CCM	Country Coordination Mechanism
CCS	Country Cooperation Strategy
DF/DHF	Dengue Fever / Dengue Haemorrhagic Fever
DOTS	Directly Observed Treatment Short-course (for tuberculosis)
EB	Extra Budget (WHO budget received from bilateral donors usually for specific projects)
EPI	Expanded Programme of Immunization
FAO	Food and Agriculture Organization
FCTC	Framework Convention on Tobacco Control
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund against AIDS, Tuberculosis and Malaria
GPELF	Global programme to eliminate lymphatic filariasis
GPW	General Programme of Work
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HMN	Health Metrics Network
HMP	Health Master Plan
HQ	WHO Headquarters (Geneva)
HRH	Human Resources for Health
IDDE	Iodine Deficiency Disorder Elimination
IDPs	Internally Displaced People
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illnesses
IMMR	In-patient Morbidity and Mortality Report
IMPAC	Integrated Management of Pregnancy and Childhood
INGO	International NGO
IT	Information Technology
JBIC	Japan Bank for International Cooperation
JICA	Japan International Cooperation Agency
LTTE	Liberation Tigers of Tamil Eelam
M	Million
MCA	Multi-Country Activities (SEARO initiative)
MDGs	Millennium Development Goals

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MoFA	Ministry of Foreign Affairs
MoH	Ministry of Health and Nutrition (referred to as "Health Ministry" in this paper)
MPS	Making Pregnancy Safer
MTSP	Medium-Term Strategic Plan
NCD	Non-Communicable Disease
NE	North East
NEPC	North East Provincial Council
NGO	Non Governmental Organization
NPO	National Professional Officer
OPV/DT	Oral Polio Vaccine / Diphtheria and Tetanus
RB	Regular Budget (WHO regular contributions from member states)
SARS	Severe Acute Respiratory Syndrome
SEAR	South-East Asia Region
SEARO	South East Asia Regional Office (of WHO)
STI	Sexually-transmitted Infection
STP	Short Term Professional (recruited to the WCO)
TFR	Total Fertility Rate (the average number of children that a woman gives birth to in her lifetime)
UN	United Nations
UNDAF	UN Development Assistance Framework
UNDP	UN Development Programme
UNFPA	UN Population Fund
UNHCR	UN High Commission for Refugees
UNICEF	UN International Children's Emergency Fund
USD	United States Dollars
WB	World Bank
WB/IDA	World Bank / International Development Association
WCO	World Health Organization Country Office (in Sri Lanka)
WFP	UN World Food Programme
WHO	World Health Organization

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Bibliographies

1. Sri Lanka, Ministry of Health, Department of Census and Statistics. *Demographic and health survey 2000*. Colombo, 2002.

2. Sri Lanka, Ministry of Health, Department of Health Services. *Annual health bulletin 2001*. Colombo, 2002.

3. Asian Development Bank, Japan Bank for International Cooperation, World Bank. *Sri Lanka 2005 post-tsunami recovery program: preliminary damage and needs assessment*. Colombo, 2005. (Accessed 25 July 2006: http://www.humanitarianinfo.org/srilanka/infocentre/assessments/others/doc/JNA_ADB_World_Bank/Fulldoc.pdf).

4. Sri Lanka, Ministry of Finance. Sri Lanka poverty reduction strategy, 2001. In: *Regaining Sri Lanka: vision and strategy for accelerated development*. (Acessed 25 July 2006: http://www.imf.org/external/np/prsp/2002/lka/01/120502.pdf='Sri%20Lanka%20poverty%20reduction%20strategy%202001').

5. Sri Lanka, Ministry of Health and Institute of Policy Studies. Sri Lanka national health accounts: Sri Lanka national health expenditures 1990–1991. In: Yazbeck, AS, Peters DH. Eds. *Health policy research in South Asia: building capcity for reform*. Washington: World Bank, 2003. pp. 163-194. (Accessed 25 July 2006: http://lnweb18.worldbank.org/sar/sa.nsf/Attachments/chapt7/$File/07_Yazbeckfinal.pdf).

6. Michaud CM. External resource flows to the health sector in Sri Lanka. In: *Flow of donor funds in Cambodia, Indonesia and Sri Lanka: synthesis of key findings*. Paper prepared for CMH unit. Geneva, WHO, 2005. (Accessed 25 July 2006: http://www.who.int/macrohealth/documents/michaud_annexc.pdf).

7. World Health Organization. *Eleventh general programme of work, 2006–2015*. Geneva, 2006.

8. World Health Organization. *Medium-term strategic plan*. Geneva, 2006.

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