World Health Organization
Sri Lanka

WHO SRI LANKA ANNUAL REPORT 2017

Making a difference

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CONTENTS

ACRONYMS AND ABBREVIATIONS

AMR	antimicrobial resistance
ART	antiretroviral therapy
CCS	Country Cooperation Strategy
CKDu	chronic kidney disease of unknown etiology
DHS	Demographic and Health Survey
FCTC	WHO Framework Convention on Tobacco Control
FHB	Family Health Bureau
HIES	Household Income and Expenditure Survey
HPV	human papillomavirus
HRH	human resources for health
HTA	health technology assessment
IHR	International Health Regulations
LF	lymphatic filariasis
LKR	Sri Lankan rupee
MCH	maternal and child health
MDG	Millennium Development Goal
MDR	multidrug resistant
MoH	Ministry of Health, Nutrition and Indigenous Medicine
MTCT	mother-to-child transmission
NATA	National Authority on Tobacco and Alcohol
NCD	noncommunicable disease
NHA	National Health Accounts
NMRA	National Medicines Regulatory Authority
NSACP	National STD/AIDS Control Programme
OOPE	out-of-pocket expense
POCQI	point-of-care quality improvement
SDG	Sustainable Development Goal
SSB	sugar-sweetened beverage
STD	sexually transmitted disease
STI	sexually transmitted infection
T&CM	Traditional and Complementary Medicine
TB	tuberculosis
UNDP	United Nations Development Programme
WHO	World Health Organization

FOREWORD

Sri Lanka started 2017 with many public health achievements under its belt – elimination of malaria, lymphatic filariasis and maternal–neonatal tetanus as public health problems. While each is noteworthy, elimination of malaria deserves special mention; many countries in the Region and beyond would want to learn from this success story.

The country continues to maintain high immunization coverage rates and has successfully added human papillomavirus (HPV) vaccine to the Expanded Programme on Immunization in 2017.

Widespread coverage and access to maternal and child health services has helped maintain low maternal and neonatal mortality rates; however, these rates have been stagnating for almost a decade and further reduction will require “business unusual”.

With much to celebrate, there is also a sobering reality. The epidemiological and demographic transition of the country poses new and emerging challenges – an ageing population and increasing burden of noncommunicable diseases (NCDs). Both these conditions require reorientation and reorganization of the otherwise historically successful health system, and development of service delivery models focused more on disease prevention and health promotion, and on care more than treatment. This requires a paradigm shift in approach, design and service delivery.

Responding to the call, the Ministry of Health, Nutrition and Indigenous Medicine has already taken affirmative action. A multisectoral action plan on NCDs has been developed and implementation has started. Work is ongoing to address elderly care and disability, and policy and legislative measures have been taken on implementing and/or increasing taxation on unhealthy lifestyles and food choices (the country leads the region in implementation of the WHO Framework Convention on Tobacco Control, and taxation on alcohol and excise duty on sugar-sweetened beverages has been introduced). The primary health care system is being reorganized to address the increasing burden of NCDs and health needs of an ageing population.

The island nation is highly vulnerable to climate change – the increased frequency of natural disasters and extreme weather events in the recent year bear testimony to the fact. Lessons learnt in handling emergencies and disasters in the past – the 2004 tsunami or the post-war rehabilitation and reconciliation provide important lessons for preparedness, response and recovery. While the country has been able to mount the needed response to emergencies and disasters, there is a continuing need to build resilient and sustainable systems that will boost preparedness, response and recovery. Efforts are ongoing to develop a robust national framework for tackling emergencies and disasters.

This annual report provides a synopsis of the key activities and achievements of 2017 and highlights areas needing further attention. It also provides a preview of the key priorities and focus areas within the Country Cooperation Strategy 2018–2023.

Dr. Razia Pendse,
WHO Representative, Sri Lanka

CHAPTER 1. TACKLING THE UNFINISHED AGENDA OF THE MDGs

The Millennium Development Goals (MDGs) fundamentally changed how development priorities were identified and key decisions made at the highest levels. They created robust networks and served as the focus for successful partnerships between states and nongovernmental bodies.

They contributed to more than one billion people being lifted out of extreme poverty,[1] and **saved the lives of more than 300 000 mothers and 6.7 million children**[2] between 2000 and 2013. Prevention, diagnosis and treatment interventions for tuberculosis (TB) saved an estimated 37 million lives.[3] In the same period, new HIV infections fell by approximately 40%, from an estimated 3.5 million cases to 2.1 million.[1]

Sri Lanka's successes with the MDGs are a model for the World Health Organization (WHO) South-East Asia Region. This is especially true in the health sector, where progress in eliminating malaria, and declining child and maternal mortality rates are proof of a well-functioning public health-care system.

Despite many successes, challenges remain. While the global reduction in the maternal mortality rate was 44% and Sri Lanka achieved a 60% reduction in maternal mortality, it still fell short of the targeted 75% reduction.[4]

More needs to be done to promote equitable and quality health care and services across the country for all newborns, children, adolescents, girls and women, and ensure that no one is left behind.

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1 The Millennium Development Goals report 2015. New York: United Nations; 2015 (http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf, accessed 24 January 2018).

2 Strategies toward ending preventable maternal mortality (EPMM). Geneva: World Health Organization; 2015 (http://who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/, accessed 24 January 2018).

3 Global tuberculosis report 2014. Geneva: World Health Organization; 2014 (http://apps.who.int/medicinedocs/documents/s21634en/s21634en.pdf, accessed 24 January 2018).

4 Sri Lanka Millennium Development Goals country report 2014. Colombo: United Nations Development Programme; 2015 (http://www.lk.undp.org/content/srilanka/en/home/library/mdg/sri-lanka-millennium-development-goals-country-report-2014.html, accessed 24 January 2018).

A public health midwife examines a pregnant woman. Further improvements in quality of care will strengthen maternal and child health programmes.

MDGs 4 and 5 were related to reducing child mortality and improving maternal health, respectively

The baseline year for the MDGs was 1990, and during the MDG era, the country successfully reduced the under-five mortality rate from 22.2 deaths per 1000 live births in 1991 to 10 in 2013.[5] The maternal mortality ratio declined from 92 deaths per 100 000 live births in 1990 to 33.7 in 2015.[5] The institutional delivery rate and antenatal care coverage had almost reached universal coverage according to the Demographic and Health Survey (DHS), 2016.[5]

Sri Lanka's current infant mortality rate of 8.2 infant deaths per 1000 live births[6] is lower than that of many high-income countries. However, progress in maternal and child health (MCH) has stalled, and further gains in improving maternal mortality have remained elusive.

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5 Sri Lanka Demographic and Health Survey (DHS), 2016. Colombo: Department of Census and Statistics, Ministry of Health, Nutrition and Indigenous Medicine; 2017 (http://www.aidsdatahub.org/sri-lanka-demographic-and-health-survey-2016-department-census-and-statistics-dcs-and-ministry, accessed 24 January 2018).

6 Sri Lanka: Expanded Programme of Immunization (EPI) Factsheet 2016. New Delhi: WHO Regional Office for South-East Asia; 2016 (http://www.searo.who.int/immunization/data/srilanka.pdf, accessed 24 January 2018).

Sri Lanka is not the only country to find itself in this position. In an analysis that compared the progress of countries with similar statistics, WHO found that as many as 70 countries had reported the same challenge.[7]

Looking at subnational performance is key to analysing this issue, as is improving the quality of care across the board. Regional disparities in Sri Lanka reveal areas where mothers and children are left vulnerable by gaps in health-care service delivery.

In addition, analysis of the causes of maternal deaths have revealed a shift – direct obstetric causes relating to complications in pregnancy or childbirth used to be the main reason for maternal deaths. Now, it is heart disease, pneumonia and liver conditions that are most likely to lead to the death of a pregnant woman. In fact, 60% of maternal deaths are due to medical diseases that complicate pregnancy.[8]

Suicides are another factor, contributing to 4–5 deaths per year during pregnancy and the postpartum period, highlighting the need to pay particular attention to the mental health of mothers during pregnancy and after childbirth.

With regard to child mortality, the majority of child deaths occur during the neonatal period. According to the Family Health Bureau (FHB), more than 70% of infant deaths occur in the first 28 days of life. Congenital abnormalities and prematurity (48% and 28%, respectively) are the leading causes.[11]

An estimated 24 500 babies are born premature each year,[9] which can negatively impact the infant's growth and early childhood development. In addition, persistently high levels of nutritional problems among children (stunting and wasting rates are 17.3% and 15.1%,[8] respectively, in children under 5 years) will require targeted and effective interventions.

Further, the DHS 2016 confirmed that children born in the estate sector have a slightly higher probability (13 per 1000 live births) of dying before reaching year 1 of their lives compared to children in the urban and rural sectors (10 per 1000 live births).[8]

Targeted interventions to address infant deaths occurring during the neonatal period and improving management of medical diseases that complicate pregnancy are needed to drive further improvements.

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7 Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: WHO: 2015 (http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1, accessed 24 January 2018).

8 Family Health Bureau annual report 2015. Colombo: Ministry of Health, Nutrition and Indigenous Medicine

Promoting quality improvements for maternal and child health

The country has good coverage of evidence-based interventions for MCH. The activities implemented in the 2016–2017 biennium aimed to catalyse the national effort to end preventable maternal and child mortality and morbidity, with a focus on providing quality and equitable health care.

With the objective of achieving a single-digit maternal mortality ratio and neonatal mortality rate of less than 2.2 per 1000 live births by 2030, WHO assisted the FHB in developing the second Maternal and Newborn Strategic Plan 2016–2025. The new Strategic Plan is based on the Global strategy for women's, children's and adolescents' health (2016–2030), WHO strategies to end preventable maternal mortality and the Every NEWBORN ACTION PLAN.

WHO together with the FHB developed a quality assurance system to ensure a positive childbirth experience to reduce the morbidity and mortality related to childbirth. This includes maternal and newborn care standards, guidelines and norms for service delivery.

During this biennium, quality assessment tools for maternal and newborn health care were also designed. WHO supported progressive capacity-building on quality improvement for health staff, starting with 10 health institutions in 2017. This will continue in the next biennium with the introduction of point-of-care quality improvement (POCQI) techniques.

9 Family Health Bureau. Every newborn action plan 2017–2020 and bottleneck analysis on newborn care. Colombo: Ministry of Health, Nutrition and Indigenous Medicine (http://fhb.health.gov.lk/web/index.php?option=com_phocagallery&view=category&id=16:launching-srilanka-every-newborn-action-plan-2017-2020-bottle-neck-analysis-on-newborn-care&Itemid=137&lang=en&limitstart=20, accessed 24 January 2018).

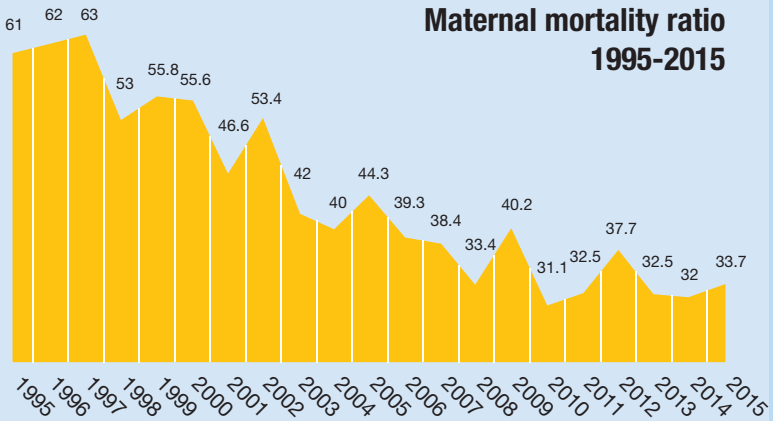
10 Ministry of Health, Sri Lanka Every Newborn Action Plan to End Preventable Morbidity and Mortality 2017 – 2020, Family Health Bureau, Goals, pp 22 – 24, 2016. Avalable @ fhb.health.gov.lk accessed on 01012018

11 Global strategy for women's, children's and adolescents' health (2016–2030). Survive, thrive, transform. Every Woman, Every Child; 2015 (http://who.int/life-course/partners/global-strategy/globalstrategyreport2016-2030-lowres.pdf, accessed 23 January 2018).

12 WHO, UNICEF. Reaching the every newborn national 2020 milestones: country progress, plans and moving forward. Geneva: WHO; 2017 (http://apps.who.int/iris/bitstream/10665/255719/1/9789241512619-eng.pdf?ua=1, accessed 23 January 2018).

Ending preventable maternal deaths

- Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy



Today

Antenatal care coverage almost **100%**

99.9%

Institutional delivery rate: **99.9%** (**95.5%** in the government sector and **4.4%** in private sector)

Within the government sector more than **95%** deliveries take place in comprehensive emergency obstetric and new born care (CEmONC) facilities

92% of women receive home based postnatal care

Changes in major causes of maternal mortality, 2001–2015

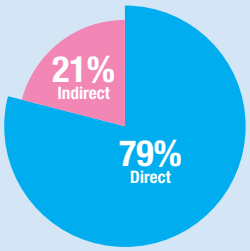
2001

Cause	Number of cases
Haemorrhage	41
PIH and eclampsia	27
Amniotic fluid/pulmonary embolism	21
Heart disease complicating pregnancy	16
Other causes	15
Septic abortion	14
Liver disease complicating pregnancy	8

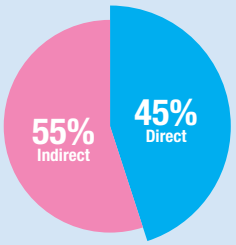
2015

Cause	Number of cases
Heart disease	28
Respiratory disease	20
Obstetric heamorrhage	12
Medical (other)	9
Hypertensive disorders	7
Sepsis	5
Malignancy	5
DVT - Thromboembolism	5
Amniotic fluid embolism	5

2001
Direct vs Indirect causes of maternal mortality



2015
Direct vs Indirect causes of maternal mortality



Improve the **quality of information** and use for decision-making

Ensure **multidisciplinary care** where relevant

Proposed areas of intervention

Ensure quality of care through **quality improvement initiatives**

Strengthen **supervision** and **monitoring**

Establish three **highly specialised centres** at Colombo, Kandy and Anuradhapura to manage **complicated pregnancies**

Source: Maternal Morbidity and Mortality Surveillance Unit, FHB

A mother breastfeeds her child. Sri Lanka is a world leader in breastfeeding according to the World Breastfeeding Trend Initiative.

Promoting breastfeeding

As breastfeeding improves both the mother's and child's health, promoting and protecting the practice has been an integral part of the MCH programme of Sri Lanka.

Sri Lanka is among the top 23 countries that have achieved exclusive breastfeeding rates, according to the World Breastfeeding Trends Initiative.[13] WHO is providing technical assistance to convert the Sri Lanka code for protection and promotion of breastfeeding[14] into an Act of Parliament.

Other initiatives include capacity-building of health staff, and advocating for promotion and protection of breastfeeding through breastfeeding weeks that are observed every year. As part of this effort, WHO has trained key health staff on the tenets of lactation management, and how it could promote good nutrition and development among young children.

13 World Breastfeeding Trends Initiative (WBTi) [website] (http://worldbreastfeedingtrends.org/about/, accessed 24 January 2018).

14 Sri Lanka code for the promotion, protection and support of breast feeding and marketing of designated products: (amended code – 2002). Colombo: Nutrition Coordination Division, Ministry of Healthcare, Nutrition and Uva Wellasa Development; 2004 (https://docs.google.com/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxoZWFsdGh5c3JpbGFua2F8Z3g6N2UxMTQ4YzlkNjAxOGYxNQ, accessed 24 January 2018).

Breast (milk) is best

Venusan's face lights up when he hears his mother's voice. Jayalakshmi dropped her youngest child off at the Madulkelle Tea Estate's crèche. She works on the high slopes over an hour away; to breastfeed her child, she has to trek back twice a day.

Venusan and the other children are left in the care of S. Anandajyothi, a community development officer (CDO). Anandajyothi's early training emphasized how important breastfeeding is, but she found that in practice, things were very different.

Anandajaytothi at the crèche

The mothers simply could not find the time: with cooking and cleaning to do at home, relatives to care for and the pressures of work, most simply chose top feeding for their children. And there was another factor – thanks to the advertising campaigns they saw on TV, they believed powdered milk is as good, in fact even better than breast milk.

The turning point came when Anandajyothi attended a workshop supported by WHO in September 2017. At the workshop, WHO brought together doctors and midwives who spoke about the importance of breastfeeding and offered practical solutions to some of the problems mothers faced.

Anandajyothi says one of her key takeaways was that babies below the age of 6 months did not need to be given water. Contaminated water places children at risk of diarrhoea. Giving babies water also reduced their appetite for milk, increasing the risk of malnourishment.

Anandajyothi returned to Madulkelle more determined than ever before to get the mothers to breastfeed. As the CDO, she even convinced the women's husbands and in-laws that they needed to help with the chores and free up the mothers to breastfeed.

A few months later, Anandajyothi has some success to report. On a shelf are a row of sterilized containers, all filled with breast milk that Jayalakshmi and the others left this morning. The women are encouraged because they have seen immediate results. Their children are healthier and fall sick less often.

Jayalakshmi and her children

Jayalakshmi says she did not exclusively breastfeed her other children, but that Anandajyothi's training has made her change her approach with her youngest daughter.

Although breastfeeding rates here are among the highest in the world, as Anandajyothi has found, every new mother needs to be reminded of its benefits.

Focusing on adolescent health

Studies have confirmed that investing in adolescent health provides the maximum benefit for countries.[15] Health issues among adolescents tend to be more psychological than physical, and are in most part due to rapid changes at this age and increased exposure to new social environments. Keeping this group's unique needs in mind, WHO assisted the MoH to strengthen adolescent- and youth-friendly health services through developing a toolkit to implement these in the country, which included standards for adolescent-friendly health services, quality assessment tools, a supervision checklist and implementation guide. Further, the orientation manual for adolescent- and youth-friendly health services has been revised and will be used to train health-care providers in future. WHO is working with the MoH to identify the best model for adolescent- and youth-friendly health services and to develop an adolescent health strategic plan for 2018–2025.

WHO worked with the United Nations Development Programme (UNDP) to enhance the knowledge of the youth on healthy eating and mental health through youth dialogues.

Addressing Communicable diseases

Proof of Sri Lanka's successes in addressing communicable diseases can be seen in the rapidly falling morbidity and mortality attributable to these diseases. **The island made public health history in 2016 by receiving WHO certification for the elimination of malaria, lymphatic filariasis (LF), and maternal and neonatal tetanus as public health problems.**

Sri Lanka will need to sustain elimination of malaria, LF, and maternal and neonatal tetanus. To maintain Sri Lanka's hard-won malaria elimination status, the country will need to prevent reintroduction in the context of movement across borders, a flourishing tourism industry, and trade and migrant worker mobility. Continuous disease surveillance is critical.

Diseases with outbreak potential such as dengue and leptospirosis continue to pose a challenge to the country. New cases are reported every year.

By strengthening its surveillance efforts, Sri Lanka has so far kept itself free of imported cases of emerging diseases such as Ebola virus disease, Middle East respiratory syndrome coronavirus (MERS-CoV) and influenza A (H7N9).

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15 Global Accelerated Action for Health of the Adolescents (AA-HA!): guidance to support country implementation. Geneva: World Health Organization; 2017 (http://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/, accessed 24 January 2018).

Moving towards the elimination of vaccine-preventable diseases

A midwife vaccinates an infant. Sri Lanka maintains an impressive immunization coverage – supporting and maintaining elimination of many vaccine-preventable diseases.

Today the island boasts of some of the most impressive immunization figures in the world. Sri Lanka has achieved **near 100% immunization coverage for all childhood vaccinations.**[9] The country's provision of free health-care services at the point of delivery and an extensive public health network focused on MCH are critical for the success of the country's immunization programme. Human papillomavirus (HPV) vaccine was rolled out this year as part of the immunization programme, and has already registered a very high acceptance rate.

WHO is a long-standing partner of the National Immunization Programme, providing strategic advice, particularly on the introduction of new vaccines. It also closely monitors the progress of immunization coverage to ensure that disease incidence is coming down and the country achieves its elimination targets.

Sri Lanka is moving towards measles elimination and rubella control by 2020. Disease surveillance has been strengthened with the confirmation of laboratory diagnosis of reported cases of measles and rubella. The country is also on track for eliminating rabies as a public health issue by 2020.

Bending the curve for tuberculosis

In Sri Lanka, the prevalence of TB has remained stagnant over the past decade, while the number of patients presenting with multidrug-resistant (MDR)-TB has gradually increased over the years. TB continues to be a public health problem with nearly 8000–10 000 new cases reported every year. The country now needs to "bend the curve" by reducing the number of TB cases. Priority interventions for achieving this goal will be to improve case-finding, ensure treatment completion among TB patients and contain drug resistance. In addition, disparities in the prevalence of TB across geographical sectors and socioeconomic classes need to be addressed.

WHO's support for the prevention and control of TB in 2017 included epidemiological analysis and programme reviews, and development of national strategic plans. WHO is also helping the country with capacity development of human resources as well as boosting diagnostic capacity.

A national TB manual[16] with protocols for early diagnosis, management and follow up of patients with TB was developed in 2017.

With funding support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), WHO provided technical assistance for a TB drug resistance survey.

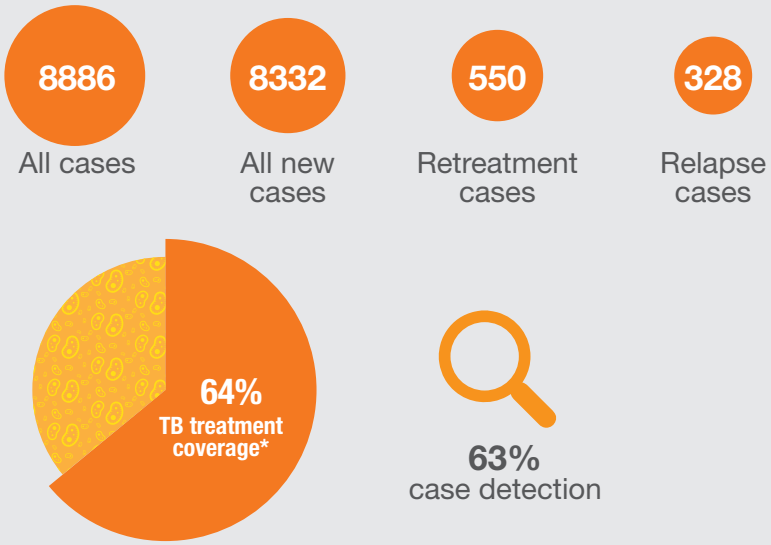
WHO also supported the mid-term review of Sri Lanka's National Programme for TB Control and Chest Diseases (NPTCCD) in July 2017 to evaluate the current status of TB control in the country. At the end of the review, specific interventions to improve case detection, strengthen monitoring and evaluation systems, and enhance coordination between stakeholders were proposed to the MoH. WHO will continue to support the national TB programme to strengthen the services required to "bend the curve" for TB.

16 National Tuberculosis Programme Manual, MoH Sri Lanka, 2016

Bending the curve for tuberculosis (TB)

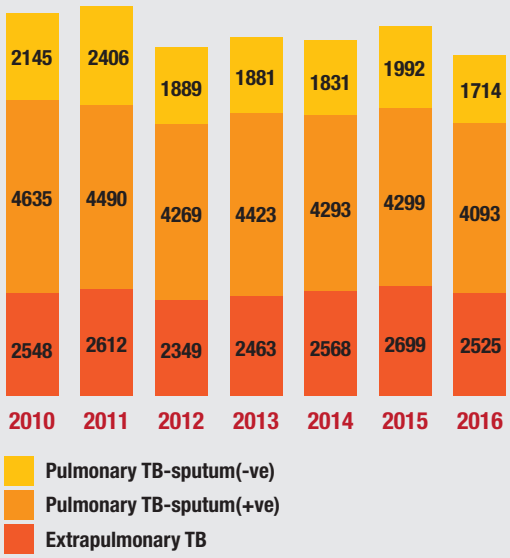
- Tuberculosis (TB) is caused by bacteria (*Mycobacterium tuberculosis*) that most often affect the lungs
- Tuberculosis is curable and preventable
- TB continues to be a public health problem in Sri Lanka

In 2016:



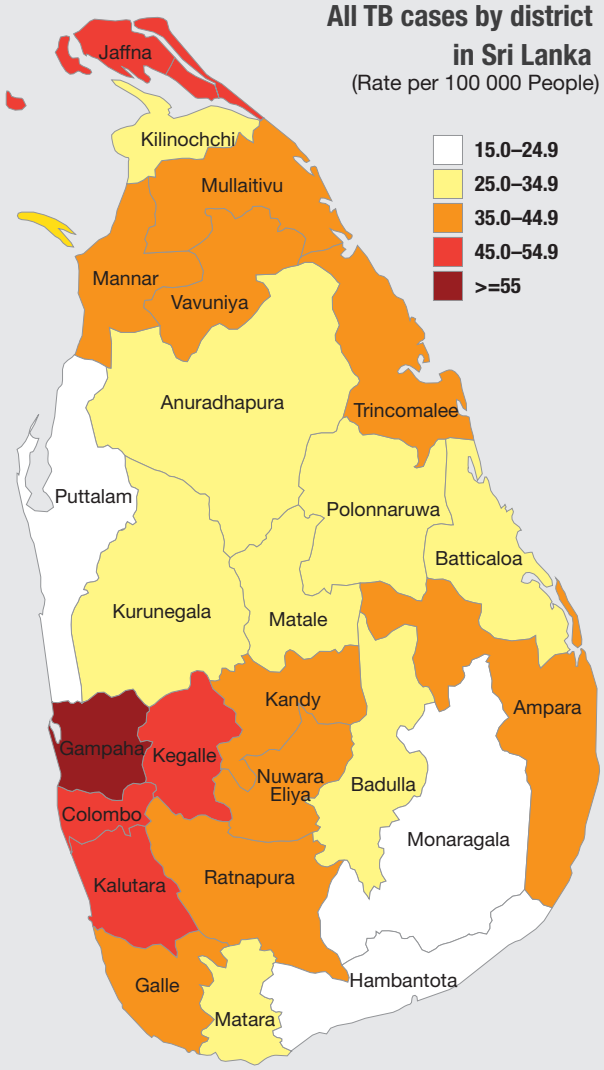
* Notified / estimated incidence, 2016 (49–87)

Number of new TB cases 2010–2016



All TB cases by district in Sri Lanka

(Rate per 100 000 People)



Source: National Programme for Tuberculosis Control and Chest Diseases (NPTCCD) Annual Report 2016

Addressing HIV/AIDS and other sexually transmitted infections

Sri Lanka continues to have a low prevalence of HIV in the general population at 0.1%; however, the prevalence is higher among key populations; and is reported at 1.5% among men who have sex with men.[17] HIV is also reported fairly regularly among female external migrant workers; however, this is unlikely to be a key driver of the epidemic. Since 2004, no HIV cases have been reported following blood transfusions.

In 2016, a total of 249 new HIV cases were identified, of whom 181 (72%) were started on antiretroviral therapy (ART). In 2017, an estimated 4000 people were living with HIV in Sri Lanka; 2139 (53%) knew their HIV status; 1068 PLHIV are on treatment (27%) and 825 (21%) are virally suppressed (NSACP, 2016).[18]

External review of the National HIV/AIDS Programme conducted in October 2017 recognized the importance of facilitating national policies to protect the rights of people living with HIV to combat stigma and discrimination, which continued to create challenges and barriers to accessing health services. The review also recommended scaling up and fast-tracking prevention, treatment and care services for key population groups, including prisoners. It was also noted that the sexually transmitted disease (STD) clinics have become friendlier and more accessible to key populations. The review recommendations have informed the five-year National Strategic Plan for HIV/AIDS (2018–2022).[19]

The prevalence of mother-to-child transmission (MTCT) of HIV is 0.6 per 100 000 live births and that of congenital syphilis is 2.5 per 100 000 live births.[22] Of the estimated 369 000 pregnant women in 2016, 349 259 received antenatal care and 323 518 were tested for HIV. Twenty-three HIV-positive pregnant women received ART in 2016, of whom 16 delivered in 2016. All 16 infants delivered during 2016 received prophylactic antiretrovirals (ARVs); they were tested for HIV and none confirmed HIV positive [22]

The scale up of HIV screening of pregnant mothers started in 2013 and universal coverage was achieved in late 2016. The country has universal coverage for screening of syphilis and treatment of HIV-positive pregnant women and HIV-exposed infants. By 2018, Sri Lanka is expected to achieve the targets for the elimination of MTCT of syphilis and HIV.

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17 National STD/AIDS Control Programme, Annual Report 2016. Ministry of Health, Sri Lanka

18 National STD/AIDS Control Programme Sri Lanka. Annual report 2016. Colombo: NSACP, Ministry of Health, Nutrition and Indigenous Medicine, 2017 (http://www.aidscontrol.gov.lk/images/pdfs/publications/Annual-report-2016-online-version_1.pdf, accessed 24 January 2018).

19 Towards ending AIDS: national HIV/STI strategic plan Sri Lanka, 2018–2022. Colombo: NSACP, Ministry of Health, Nutrition and Indigenous Medicine; 2017 (http://aidscontrol.gov.lk/images/pdfs/publications/stratergies/NSP-HIV-2018-22-Sri-Lanka.pdf, accessed 24 January 2018).

As of 2017, there were 33 full-time STD clinics and 23 branch STD clinics, providing etiological diagnosis and care services for sexually transmitted infections (STIs) to nearly 200 000 attendees annually. Over the years, bacterial STIs have shown a gradual decline while viral STIs such as genital herpes and genital warts have shown an increasing trend.

WHO is supporting the National STD/AIDS Control Programme (NSACP) in generating data through sentinel surveillance, implementing targeted interventions among key and vulnerable populations, and monitoring progress towards elimination of MTCT of syphilis and HIV.

Renewing efforts in the battle against leprosy

While leprosy was eliminated as a public health issue in the 1990s, a small but worrying increase in the number of cases has been noted in the recent past. The presence of paediatric leprosy cases indicates active transmission, while deformities and relapses highlight late case detection and poor compliance with leprosy treatment.

Around 2000 leprosy cases are reported in Sri Lanka each year, of which 10% are found in children.[20] The biggest problem is access to treatment. To address this problem, WHO supported the creation of outreach satellite clinics that would bring key diagnostic and treatment services closer to communities, especially in rural areas.

An increasing number of relapses from 2013 indicate the possibility of drug resistance. In response, WHO is supporting an assessment on drug resistance in leprosy to identify and prioritize key interventions for impact.

Donor contributions in cash and kind through the WHO Regional Office for South-East Asia has helped in accelerating leprosy control activities.

WHO will continue to support Sri Lanka in maintaining its leprosy elimination status.

20 Anti-Leprosy Campaign Annual Report, MoH Sri Lanka, 2015

Life after leprosy

Shanthi Perera lived with leprosy for six months. It began when she noticed a small patch, a circle of numbness, just above her knee. She recognized the symptoms from a leprosy campaign poster she had seen on a notice board. As a health worker at an OPD in a hospital, Shanthi knew enough to immediately seek out treatment at the clinic.*

Also known as Hansen disease, leprosy is a chronic, progressive infection caused by the bacterium Mycobacterium leprae. If left untreated, it can result in disability and disfigurement.

Shanthi was determined to keep her condition a secret. As she underwent treatment, weathering bouts of headaches and nausea in the early stages and then eventually making a full recovery, she did not tell any of her colleagues or anyone outside her immediate family of her condition. She knew the stigma was worse than the disease.

Like Shanthi, most of the clinic patients live near Kiribathgoda. However, many face constraints related to travel; some must rely on public transport; others, like labourers who live off day-to-day wages, can seldom afford to take regular leave to visit a large hospital where a consultant dermatologist could be found. The outreach clinic helps such individuals access services with ease.

The satellite clinic where Shanthi was diagnosed opened in 2015, and they already receive some 20 leprosy patients a day. Today, there are clinics like this in every district in Sri Lanka and they have helped to improve new case detection and offer patients easy access to treatment. WHO has supported the creation of such clinics across the island with access to diagnostic facilities, drugs and other logistics.

As a beneficiary of this network of satellite clinics, today Shanthi gratefully reports that she has been completely cured. She gently touches the circle where her leprosy manifested. Sensation has returned fully, and a barely recognizable scar is all that is left of the biopsy. Looking back, she says that even in her worst moments she was not scared. She believed the doctors when they told her she would be fine. Now, she is back to her old self. "I wish people knew that leprosy is completely curable," says Shanthi, "then they wouldn't be so frightened".

**name changed for confidentiality*

Doctors at the leprosy clinic

CHAPTER 2. ADDRESSING NONCOMMUNICABLE DISEASES AND THEIR RISK FACTORS

Seventy-five per cent of total deaths in Sri Lanka are attributable to NCDs. Cardiovascular diseases are now the leading cause of death, with cancer coming in second. **NCDs are estimated to account for nearly 20% of premature deaths in the country (i.e. deaths that occur between the ages of 30 and 70 years).**

Aside from being a public health issue, the NCD epidemic now poses a serious economic burden for Sri Lanka. NCDs are on the rise due to a combination of factors, such as an ageing population, increasingly sedentary and unhealthy lifestyles, and poor food choices.

In response, Sri Lanka has adopted innovative policies – from promoting healthy diets to strengthening tobacco control initiatives. WHO has provided technical support to the MoH to drive the NCD agenda forward.

Promoting a healthy diet

A mother feeds her child nutritious food. Appropriate nutrition can help prevent obesity

In Sri Lanka, children and adults alike are increasingly becoming overweight and obese. **Nearly 30% of adults and 5–6% of schoolchildren are overweight according to National Nutrition Data of 2016, FHB. Close to 8% of adults have diabetes.**[21] Unhealthy weight gain, fuelled by diets high in sugar, salt and fat, as well as physical inactivity, are significant contributors to the rising prevalence of NCDs. Obesity among children is an area of concern. Being overweight as a child can have serious long-term consequences in adulthood – from low self-esteem and depression to conditions such as diabetes and heart disease.

21 Non communicable disease risk factor survey, Sri Lanka, 2015. Colombo: Ministry of Health, Nutrition and Indigenous Medicine, WHO; 2015 (http://www.searo.who.int/srilanka/areas/noncommunicable_diseases/steps-report-2015-sri-lanka.pdf?ua=1, accessed 24 January 2018).

Addressing marketing strategies of unhealthy foods to children

In 2016, the WHO Country Office commissioned an assessment of the frequency and impact of advertising and marketing of foods and non-alcoholic beverages that are high in fat, sugar and salt (HFSS FNAB) to children. Among other factors, these marketing campaigns have contributed to an epidemic of poor diets high in fat, salt and sugar.

Using compelling research on marketing strategies, WHO organized a consultation with a wide spectrum of stakeholders to address the issue. The consultation was instrumental in achieving a national consensus on a policy approach to regulating the marketing of such foods and beverages, especially to children.

A young campaigner takes to the streets during World Diabetes Day

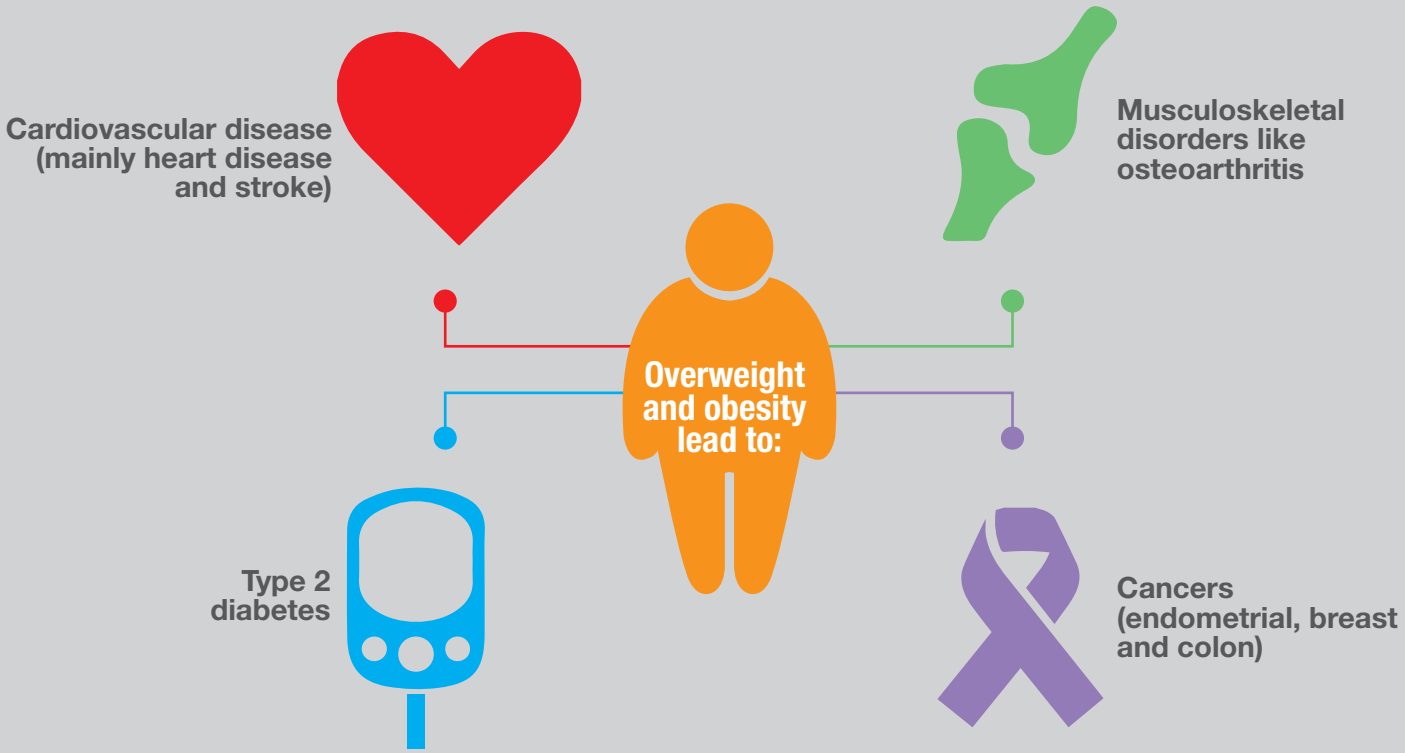
Developing a nutrient profiling model

WHO is supporting the country in developing a nutrient profiling method that uses a scientific methodology to categorize foods and non-alcoholic beverages based on sugar, fat and salt content.

The model will inform how authorities make policy decisions and apply fiscal measures such as taxation on sugar-sweetened beverages (SSBs). It will help regulate food marketing communications to children. The model will also outline a standardized front-of-pack nutrient labelling system, improving the traffic-light labelling on sugar levels in packaged food and drinks. The goal is to promote and provide healthy food choices for children and adults.

Rising challenge of overweight and obesity

- Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health
- Increased intake of energy-dense foods that are high in fat and an increase in physical inactivity lead to overweight and obesity



30% adults overweight

5–6% school children overweight

Nearly **1 in 4 males (24.6%)** overweight or obese

1 in 3 females overweight or obese

Source: STEPS Survey for Noncommunicable Diseases,Sri Lanka, 2016.
Nutrition Month Data, Family Health Bureau

ENDING OVERWEIGHT & OBESITY

Promote intake of healthy foods

Weight management

Reduce intake of foods and beverages high in fat and sugar

Health, nutrition and physical activity for school-age children

Promote physical activity

Early childhood diet and physical activity

Promote and protect breastfeeding

Taxing sugar-sweetened beverages

The “Rethink Your Drink: sugar content in sugar-sweetened beverages (SSBs)” box being presented to the Minister of Health, Nutrition and Indigenous Medicine, Dr Rajitha Senaratne. Photo credit: MoH

A major contributor to high sugar diets is the intake of SSBs. Per capita consumption of SSBs has increased by 68% in the past nine years in Sri Lanka. The 2016 Sri Lanka Global School-based Student Health Survey[22] found that more than 1 in 4 students (26.2%) reported drinking carbonated soft drinks one or more times a day. The economic impact of SSB consumption is also extensive; about LKR 28 billion is lost due to SSB consumption annually through adverse health consequences and resultant health-care costs.[23] Poor urban households spend more on SSBs than on fruits, milk and health care combined.

On the request of the Minister of Health, WHO commissioned an evaluation to assess the effects of drinking SSBs in Sri Lanka. The results of the study were used to advocate for incremental taxation on SSBs, based on sugar content.

These taxes would result in a price increase and are expected to reduce the demand and consumption of such beverages.[27] The tax would also incentivize SSB manufacturers to reformulate and reduce free sugars in their products.

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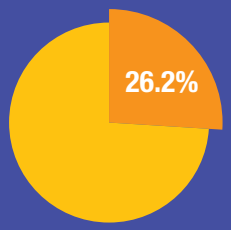
22 Global school-based student health survey: Sri Lanka, 2016 fact sheet (http://www.who.int/ncds/surveillance/gshs/SRH2016_fact_sheet.pdf?ua=1, accessed 24 January 2018).

23 Report on Fiscal Tools to reduce Sugar Sweetened Beverages Consumption, World Health Organization Country Office for Sri Lanka, 2017

Taxing sugar-sweetened beverages (SSBs) for better health outcomes

- Sugary drinks are a major contributor to obesity and overweight
- SSBs contain sugars such as sucrose and fructose in large amounts which lead to high energy density diets

Per capita consumption of SSBs has increased by **68%** in the last 9 years in Sri Lanka



More than **¼** of students drink carbonated soft drinks one or more times a day

Every year in Sri Lanka an estimated **52 000 years** of healthy life are lost due to consumption of SSBs

About **LKR 28 billion** is lost due to SSB consumption annually

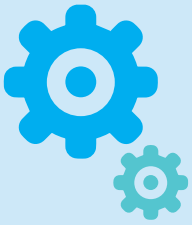
Poorer urban households spend **more on SSBs** than on fruits, milk and healthcare combined

WHO's proposed tax of LKR 1-for-1 gram of added sugar per 100 ml* will:

**Where the total sugar content exceeded more the 6 g per 100 mL*

Increase prices on average by **24%**

Reduce consumption of SSBs by **26%**



Generate revenues by an estimated **LKR 5.3 billion**

Incentivize SSB manufacturers to **reduce free sugars** in their products

Source: Fiscal Tools to Reduce Sugar Sweetened Beverages Consumption in Sri Lanka, WHO Country Office for Sri Lanka 2017.
2016 Sri Lanka Global School Health Survey

Key to this initiative has been political advocacy at the highest levels of government – WHO officials met with the Health Minister to present the justification for the tax on SSBs. The Minister of Health, Dr Rajitha Senaratne, submitted the tax proposal to the Cabinet and when the new budget was proposed in 2017, it included a "sugar tax" on sweetened beverages, with excise duty based on the quantum of sugar contained. The rate established was 50 cents per gram of sugar.[24]

At the same time, WHO is also working with the Government to develop comprehensive action plans – combining taxation, regulation of marketing of sugary products to children and integrated health education campaigns – to halt the rise of obesity and diabetes in the country.

Strengthening tobacco control

Tobacco use is one of the main risk factors for a number of NCDs, including cancer, lung diseases and cardiovascular diseases. **In Sri Lanka, 25% of adults consume tobacco in either smoked or smokeless form, resulting in 20 000 deaths each year. Approximately 1 in 2 men use tobacco (in any form); 29% of adult men smoke tobacco and 26% consume smokeless tobacco.**[25]

24 Sri Lanka Budget 2018. In: Parliament of Sri Lanka [website] (https://www.parliament.lk/budget-2018, accessed 24 January 2018).

Fighting tobacco

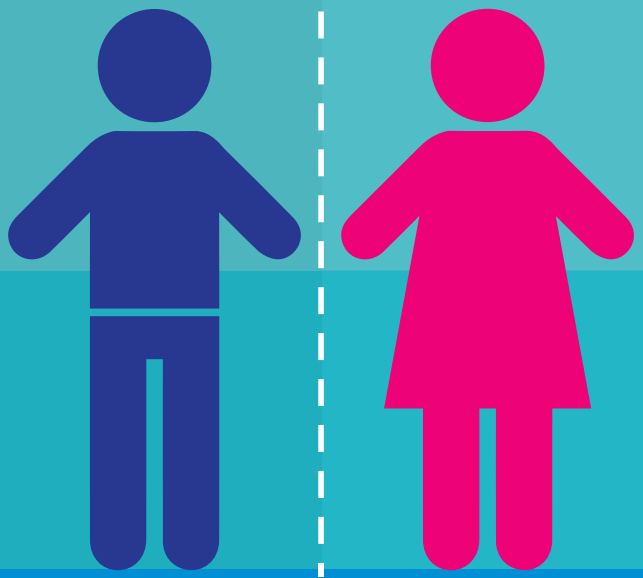
Adolescents (13-17 years)

Current tobacco users (smoked and / or smokeless)

7% | 4% | 1%

Current tobacco smokers

3% | <1%



Current smokeless tobacco users

4% | <1%

Secondhand smoke (exposure to tobacco smoke)

Outdoor public places — 1 in 3 — Enclosed Public Places

Home 1 in 10

Timeline of tobacco control milestones

2003	2006	2014	2016	2017
Signatory to WHO FCTC	NATA Act	Pictoral warnings	Tax increase on cigarettes	Tobacco quitline

Adults

Current tobacco users (smoked and / or smokeless)

46% 26% 5%

Current tobacco smokers

29% 0.1%

Current smokeless tobacco users

26% 5%

Secondhand smoke (exposureto tobacco smoke)

Home
1 in 4

Workplace
1 in 4

Future Milestones

2017–2030

- FCTC 2030 strategy
- *Alternative livelihoods for tobacco farmers*
- *Plain packaging*
- *Single stick sale ban*
- *Licensing tobacco sales*

Source: Global Youth Tobacco Survey 2015
Noncommunicable Disease Risk Factor Survey 2015

The most effective way to combat tobacco use is to reduce demand, e.g. by restricting marketing, banning smoking in public places and implementing health warnings on packages. A particularly effective strategy is to increase taxes on tobacco, as higher prices discourage consumers from purchasing these products.

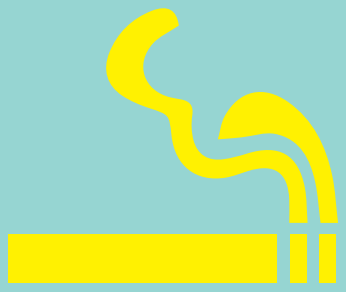
Initially, the country had no data on the actual cost of tobacco. Informed policy decisions could not be made without clear evidence of the negative impact of tobacco use on health and socioeconomic development. This was a major obstacle to developing programmatic interventions to tackle tobacco use such as tobacco taxation.

Working with the National Authority on Tobacco and Alcohol (NATA) and with the Sri Lanka Medical Association, WHO coordinated a study to assess the cost implications (both through costs for health care and loss of productivity) of alcohol and tobacco use in Sri Lanka.

The study was based on the WHO methodology of health technology assessment (HTA) and was conducted by a multidisciplinary team from the Health Intervention and Technology Assessment Programme (HITAP), Thailand and local research experts.

Cost implications of alcohol and tobacco use in Sri Lanka, 2015

29%
adult males smoke tobacco



35%
adult males consume alcohol

Tobacco cost
LKR 89.37 billion
(US$ 662.0 Million)

Alcohol cost
LKR 119.66 billion
(US$ 886.37 Million)

The total economic costs of alcohol and tobacco (from health expenditures and productivity losses combined) in Sri Lanka were estimated to be **LKR 209.03 billion (US$ 1.55 billion)** accounting for **1.95%** of GDP for 2015. The costs related to curative care for alcohol and tobacco related disorders as well as indirect costs from lost earnings due to mortality and morbidity.

Alcohol-related injuries imposed the highest burden **(LKR 33 922.3 million/ US$ 251.3 million)** to the economy among all disease conditions that were studied.

This analysis helped Sri Lanka in increasing taxes on tobacco products to a maximum of 80% of the selling price of the most popular brand of cigarettes in the country.[25]

In addition to discouraging tobacco use through taxes, it was clear that more support would be needed to help tobacco users give up the habit. In 2017, WHO helped to create Sri Lanka's first national tobacco quitline. The number of operators increased from five to over twenty. WHO also provided training for tobacco quitline counsellors.

International recognition and support for tobacco control

Sri Lanka was recognized for its outstanding achievements in tobacco control in 2017, when the country's NATA took home WHO's prestigious World No Tobacco Day Award. Among the achievements highlighted by the Award were NATA's role in providing the evidence to support the Government's decision to increase taxation on tobacco as well as working with WHO to address the illicit trade on tobacco products.

Sri Lanka's political commitment to address tobacco control has also been recognized with the WHO Framework Convention on Tobacco Control (FCTC) 2030 grant. The 5-year FCTC 2030 project will bring support to Sri Lanka from WHO, WHO FCTC Secretariat and UNDP to strengthen tobacco control.

WHO is also supporting formulation of policies on plain packaging, and addressing the effects and impact of smokeless tobacco, i.e. tobacco that is chewed, dipped or snuffed. Helping tobacco farmers explore alternative, sustainable livelihoods will be critical to eliminating tobacco use as a public health problem, the goal that Sri Lanka aspires to achieve.

25 Extraordinary Gazette of Democratic Socialist Republic of Sri Lanka, October 3, 2016

Understanding and addressing CKDu

Chronic kidney disease of unknown etiology (CKDu) is a serious public health problem in Sri Lanka. Twenty years after it was identified, a lack of understanding and data on the disease persists. In the meanwhile, thousands of Sri Lankans continue to be affected by CKDu, the majority of them poor farmers living in remote areas.

WHO, in collaboration with the MoH, convened an International Expert Consultation on CKDu in 2016, which helped national consensus on case definitions for CKDu to support disease surveillance and monitoring.

In 2017, the WHO Country Office for Sri Lanka in collaboration with the Epidemiology Unit of the MoH and the National Science Foundation initiated a large-scale community-based survey to estimate the burden and understand the etiology of CKDu. The survey was conducted in five selected study settings in the Anuradhapura district, with participation of 5300 study units in July–August 2017. Improving understanding of the causes of CKDu will help in developing policies and services for the affected population.

Addressing disability

Over 1 billion people – 15% of the world's population, or in other words, 1 in 7 people live with disability. It is indeed unfortunate that half of these people with disabilities cannot afford health care.

Sri Lanka is one of the fastest ageing countries in the world, and this demographic transition is expected to affect the disability rate. According to the Department of Census and Statistics, about 1.6 million people in Sri Lanka, i.e. almost 10% of the population, live with disabilities.[26]

To achieve the Sustainable Development Goals (SDGs), there should be equitable access to health and social services, and equal employment opportunities for all, including those with disabilities. The Sustainable Development Agenda explicitly mentions disabilities for the first time in a global development framework. It is included in Goal 4 – education; Goal 8 – employment and economic growth; Goal 10 – reduced inequalities – i.e. social, economic and political inclusion; Goal 11 – sustainable cities with access to transport, water and communities; Goal 17 – partnerships for the Goals with emphasis on disability-disaggregated data and monitoring.

The Government of Sri Lanka ratified the UN Convention on the Rights of Persons with Disabilities[27] in February 2016. This requires the country to "recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination of disability".

WHO, in collaboration with the MoH, launched the Priority Assistive Products List (APL)[28] developed by WHO to enable people to function better, and live healthy and productive lives. The APL includes 50 priority assistive products that can be adapted to the local context. The APL is highly relevant to Sri Lanka, and investing in assistive products will contribute to the country's economy. Promoting access to assistive products is vital for moving towards Sri Lanka's goal of universal health coverage and sustainable development.

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26 Department of Census and Statistics, Census 2012 Final Report, http://www.statistics.gov.lk/PopHouSat/CPH2011/Pages/Activities/Reports/FinalReport/FinalReport.pdf Accessed on 01/01/2018

27 Convention on the Rights of Persons with Disabilities. New York: United Nations; 2006 (http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf, accessed 24 January 2018).

28 Priority Assistive Products List. Geneva: WHO; 2016 (http://www.who.int/phi/implementation/assistive_technology/EMP_PHI_2016.01/en/, accessed 24 January 2018).

Occupational health and safety

The country is facing challenges due to climate change and environmental pollution. Diseases related to the respiratory system are the third leading cause of hospitalization and fourth leading cause of hospital deaths, highlighting the impact of air pollution. The health of workers is a new focus area of the MoH. WHO, together with the Chulabhorn Research Institute of Thailand, conducted a training workshop for divisional-level medical officers on chemical risk assessment. Her Royal Highness, Princess Chulabhorn Mahidol graced the occasion. The technical capacity of the National Water Supply and Drainage Board was enhanced in making water and sanitation safety plans through international experts. As an Executive Board member of the World Health Assembly, Sri Lanka together with Tanzania worked on the Executive Board agenda on workers' health.

CHAPTER 3. **ADVANCING HEALTH SECURITY AND RESILIENCE**

Disaster tests a country at every level. During a flood, for instance, information is hard to come by and access is often compromised. The response to an emergency demands a huge multisectoral effort, putting pressure on health-care networks, and necessitating swift and effective action from all stakeholders.

Disasters and conflicts push individuals into extremes of experiences that are stressful and need support for developing coping mechanisms. The 2004 tsunami and the 30-year-long conflict that ended in 2009 are two such examples that tested the physical, mental and psychosocial resilience of affected communities.

People also seek a sense of health security – a guarantee that they can obtain quality health services when needed without risking impoverishment.

Sustainable solutions require innovative approaches that empower communities and drive change for better preparedness and response.

Responding to emergencies

When devastating floods swept across parts of Sri Lanka in May 2017, WHO immediately mobilized US$ 175 000 from the South-East Asia Regional Health Emergency Fund (SEARHEF) within 24 hours to provide lifesaving medical assistance.

Rapid responses and resources were critical in the field: Emergency Medical Teams were supported with supplies and essential provisions to deliver lifesaving medical services to the affected areas. Special emphasis was placed on providing mental and psychosocial support for those affected. The twin disasters of floods and the dengue epidemic required strong surveillance to contain the spread of communicable diseases.

This swift response was enabled by the new WHO Health Emergencies Programme (WHE). As the crisis unfolded in Sri Lanka, WHO provided comprehensive guidance to facilitate a coordinated response and quick turnaround.

WHO led the health sector response within the Humanitarian Country Team throughout the emergency. In an effort to further strengthen the response of the Government, WHO mobilized assistance through the UN Central Emergency Response Fund (CERF) and the United States Agency for International Development (USAID).

WHO is working with the MoH to further improve the country's preparedness and response capacity by supporting development of district health emergency preparedness and response plans in the eight worst-affected districts.

In collaboration with the Government, WHO is also conducting district-level training programmes to strengthen disease surveillance, implement the International Health Regulations (2005) and improve risk communication.

In the wake of heavy floods, mobile teams provide medical assistance for displaced communities in Kalutara. Photo credit: MoH

Floods and landslides, May 2017

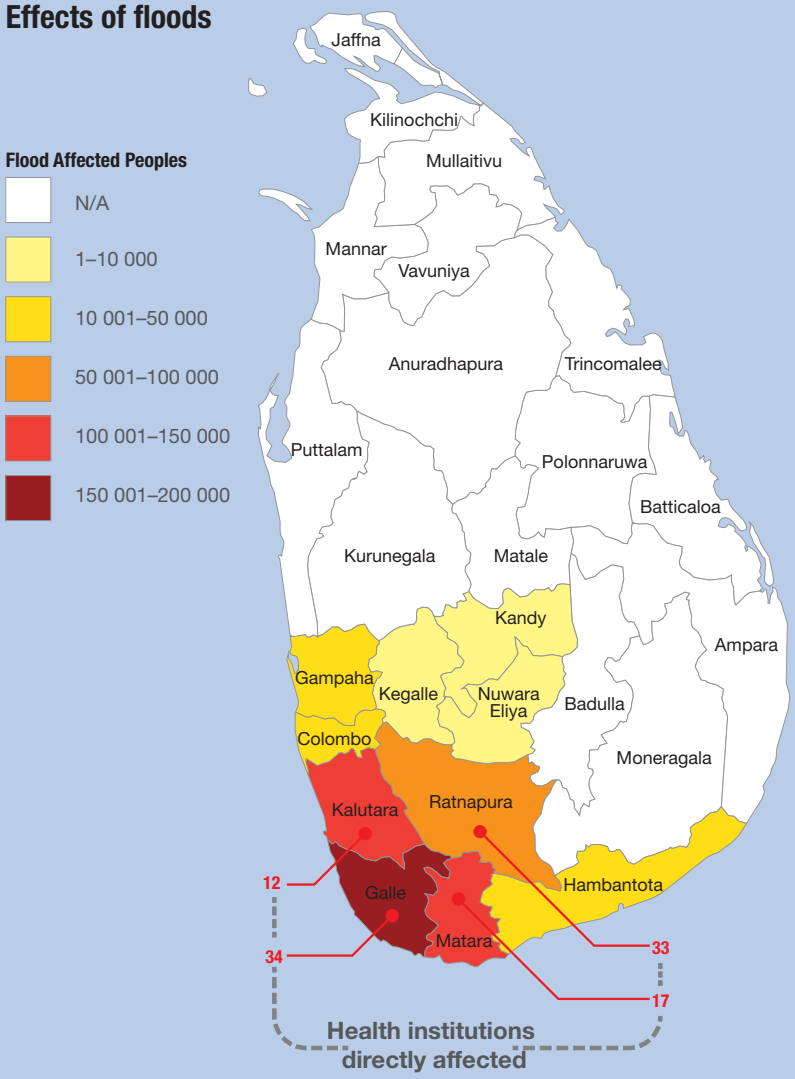
Total affected people
522 080

Total deaths
201

Missing people
130

Houses damaged
9192

Effects of floods



Total amount of health sector loses and damages
LKR 670.55 million

Total health institutes affected
96

Total MOH areas affected
32

Source: Situation report, Disaster Management Center, Floods & Landslides May 2017
Sri Lanka Post Disaster Needs Assessment, Health Sector, Ministry of Health

Emergency response to floods and landslides May–June 2017

LKR

Resources mobilized from SEARHEF, USAID and CERF

Immediate medical deployment

- Health promotion
- Medical care
- Mental health and psychosocial support

Medical supplies and equipment

- Interagency emergency health kits (IEHKs)
- Personal protective equipment (PPE)
- Medical camp kits (MCKs) and tents
- Deployment kits
- Equipment for provision of medical services for survivors
- Biomedical equipment
- Equipment for cold chain maintenance (e.g. Ice packs, cool boxes, refigerators)

Capacity-building for 8 districts worst-affected by floods and landslides

- Reviewed and revised health-sector disaster preparedness plans
- Disease surveillance
- Risk communication

Established a subnational health emergency operations centre (EOC)

Surviving floods

The flood arrived at Harshani Abeykoone's doorstep at 3:30 am on 26 May. Harshani remembers the sound it made as it rushed into their home. Clutching her 3-year-old son Idusha, she tried to reach the entrance and was met by a wall of water. The current tore her child from her arms. Harshani could not swim; she could barely think. The water was a maelstrom of furniture, branches and household goods. She remembers screaming for help.

Harshani and Idusha

Sameera, her husband, found them. He managed to take his son, Idusha to safety on a high slope. Elsewhere, the rest of the family was in crisis: Harshani's mother-in-law was trapped against a car, her body pressed to the metal by the force of the surge. All of them were fortunate to make it out alive.

After it was all over, Harshani would take her mother-in-law to the medical camp to remove a nail that had sunk deep into her foot. These camps, set up by the MoH with support from WHO and other humanitarian organizations, were in place to provide critical health-care services for survivors. M.A.I. Udayangani, a public health midwife, was among those working there. She remembers that they were treating a spectrum of cases – from rashes to broken bones and deep cuts.

Public health midwife Udayangani

Funds mobilized by WHO were deployed to support these emergency medical services. Udayangani estimates that as many as 450 people visited the Bulathsinhala camp alone. And survivors continued to need support in the days that followed.

After the floods had receded, Harshani recalls how the midwives and doctors made house visits and provided treatment and counselling. They also provided chlorine to clean the water, and medicines for her son.

Today, her house shows no trace of the floods, and Idusha is beginning to overcome his trauma. Having survived the disaster, Harshani is filled with gratitude.

Supporting dengue control

The tiny mosquitos Aedes aegypti and Aedes albopictus are formidable foes of the Sri Lankan health authorities. They are the vectors of dengue. **Between 1 January and 31 December 2017, the dengue virus was responsible for a reported 185 688 cases.**[29]

A young girl with dengue at Lady Ridgeway Hospital. In 2017, the dengue crisis highlighted the need to strengthen Sri Lanka's capacity to anticipate and respond to health emergencies.

WHO worked with the MoH to develop a multisectoral action plan to address the dengue situation, with the objective of bringing down the caseload and reducing the case fatality rate. Key to controlling this crisis was limiting the spread of the vector. Besides controlling breeding sites, WHO trained entomologists, public health inspectors and medical officers of health on identification and elimination of mosquito breeding sites.

29 Disease Surveillance Data 2017, Epidemiology Unit, Ministry of Health, Nutrition and Indigenous Medicine

WHO Regional staff on field visits inspecting potential breeding sites

The Country Office also supported capacity-building efforts for improving case management with the help of the WHO Collaborating Centre for Case Management of Dengue/Dengue Haemorrhagic Fever, Queen Sirikit National Institute of Child Health (QSNICH), Thailand. WHO also supported revision of the triage protocol in June 2017 to rationalize admissions to hospitals and strengthen hospital capacity by supplying essential equipment for diagnosis and clinical management.

To support the response, WHO mobilized assistance from the Australian Department of Foreign Affairs and Trade (DFAT) to strengthen clinical management, diagnostic facilities, vector control and epidemiological surveys. These activities would help in enhancing the preparedness and response to infectious disease outbreaks. The activities will continue until mid-2018.

Response to dengue epidemic 2017

Clinical management
Supported clinical training for doctors and nurses on dengue case management.

Reviewed triage protocol for streamlining and rationalizing hospital admissions to address overcrowding

Strengthened clinical management capacity
Supported diagnostic capacity with 3 5-part analysers and extended support to expand laboratory testing for full blood count and antigen tests.

Vector Control
Conducted capacity building on vector control - training on identification and source reduction of mosquito breeding sites.

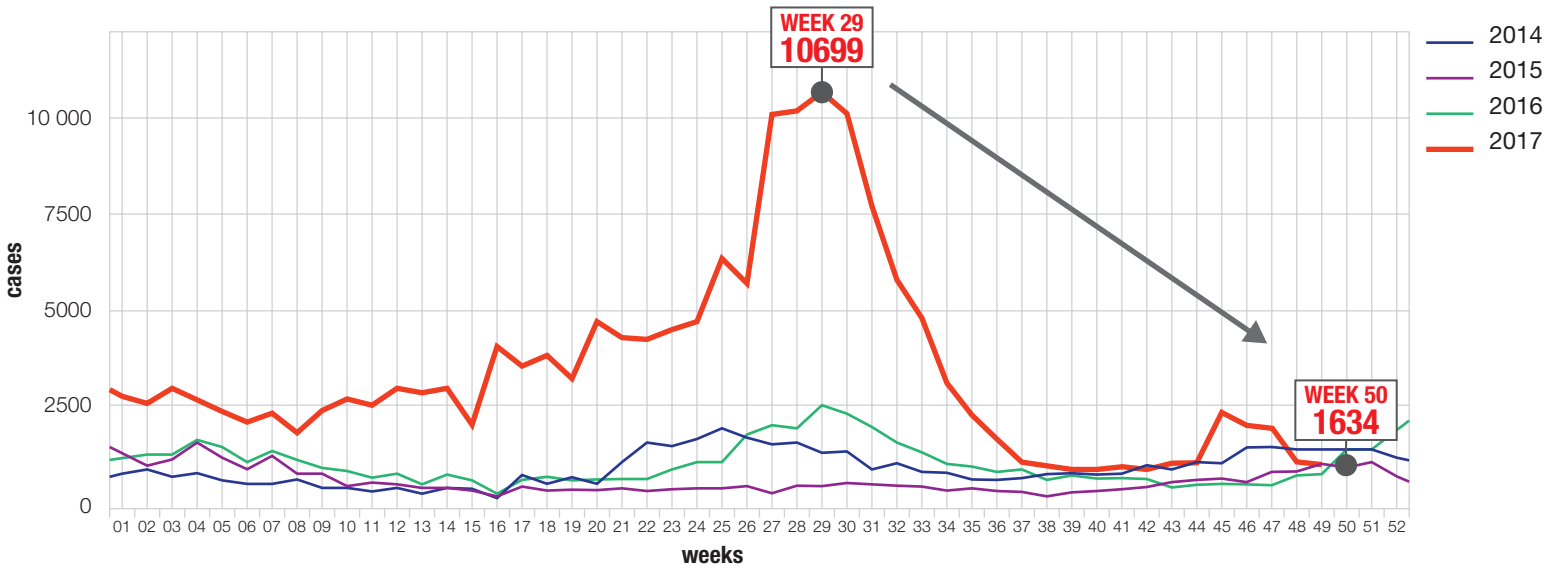
Developed information, education and communication (IEC) materials on dengue prevention and control

Provided 100 fogging machines to MoH

Technical assistance
Mobilised technical assistance from SEARO, WHO collaborating centre, Ministry of Public Health, Thailand and WHO Sri Lanka

Technical experts from WHO and MoH developed a strategic and operational plan to reduce dengue morbidity and mortality

Total dengue cases by week, 2014–2017



Source: Disease surveillance data, epidemiology unit, MoH

Strengthening International Health Regulations (IHR) core capacities

Sri Lanka, being a signatory to the International Health Regulations (2005) (IHR), volunteered to conduct the Joint External Evaluation on IHR in 2017. WHO supported the Government in conducting a comprehensive multi-stakeholder assessment of the core capacities required to prevent, detect and respond to public health threats.

Over a period of five days, the exercise involved more than 100 stakeholders from various government departments working together with international experts to assess the 19 areas of concern. The detailed discussion and consensus on the current level of capabilities informed the development of the action plan on public health threats.[30] Priorities include strengthening multisectoral engagement, enhancing surveillance, and ensuring sustainable and scalable health security through improved documentation of national plans and operating procedures.

Developing a national strategic plan to address antimicrobial resistance

Antimicrobial resistance (AMR) is a looming public health threat, not just in Sri Lanka but across the world. In the European Union alone, a subset of drug-resistant bacteria is responsible annually for some 25 000 deaths.[31] Studies have revealed that multidrug resistance is a significant problem in Sri Lankan hospitals, posing formidable challenges to treatment and exacting a huge toll in terms of patient deaths in the face of spiralling health-care costs.[32] Sri Lanka needs to change the way it prescribes and uses antibiotics.

To address this challenge, Sri Lanka has developed a National Strategic Plan for Combating Antimicrobial Resistance 2017–2022.[36] The WHO Country Office Sri Lanka supported the Government to convene a multisectoral coordination group on AMR for developing the National Strategic Plan.

Launched in May 2017, the Plan identifies clear priorities and sets targets. Drawing upon the WHO Global action plan on antimicrobial resistance and based on the One Health Approach, it encompasses all related dimensions of AMR, including human, animal and aquatic health, crop production and food safety.

WHO is supporting the development of a surveillance system to assess the extent of AMR in the country, and conducting research to assess public awareness of AMR and the pattern of antibiotic use in the country.

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30 Mission Report on Joint External Evaluation of IHR Core Capacities, Sri Lanka 2017 (unpublished)

31 Global action plan on antimicrobial resistance. Geneva: World Health Organization; 2017 (http://www.who.int/antimicrobial-resistance/global-action-plan/en/, accessed 24 January 2018).

32 National strategic plan for combating antimicrobial resistance 2017–2022. Colombo: Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka; 2017 (http://www.searo.who.int/srilanka/areas/antimicrobial_resistance/national_strategic_plan_combat_amr.pdf?ua=1, accessed 24 January 2018).

Providing psychosocial support to post-war communities

Following decades of civil war, psychosocial programmes are strengthening peace-building and reconciliation efforts.

Sri Lanka's National Mental Health Policy 2005–2015 was developed in the wake of the 2004 tsunami to support affected people. When the war came to an end in 2009, the need to strengthen mental health services and make them available to affected communities was once again recognized. Sri Lanka chose to adopt an innovative and sustainable approach that prioritized deploying mental health services at the community level. This decentralized model has its benefits.

By 2015, acute inpatient care units were available in 23 of the 26 (85%) health districts within general hospital settings, as compared to 10 health districts in 2004.[33] Presently, there are 24 adult inpatient units, three child inpatient units . There is one forensic psychiatry unit in the country which provides reports and information to courts, and conducts trainings for health professionals. There are also 215 outreach clinics covering almost all health divisions.[37]

Building on these early successes, comprehensive mental health-care services were introduced in specialized clinics. Child-focused clinics and gender-based violence desks have been set up to address childhood disorders and violence against women and children, respectively.

The country has also seen gains in health workforce development to support the growing demand for mental health services.

Despite the impressive progress, challenges remain. Social stigma prevents people from accessing mental health services; an ageing population is limited by its ability to reach services, and social issues such as the increased use of alcohol, growing numbers of suicide attempts, and deliberate self-harm and violence against women and children demand wider availability and accessibility of services at the community level.

To address this need for community interventions, WHO, together with the Directorate of Mental Health, MoH and experts from various fields, developed “Manohari”, a community-based violence prevention programme. Funding for this programme was through the United Nations Peacebuilding Fund’s Immediate Response Facility (PBF-IRF), and managed by UNDP Sri Lanka.

Piloted in Mullaitivu and Kilinochchi in 2017, Manohari targeted community leaders and community mental health professionals with the support of the district’s Regional Director of Health Services. The training exercise relied on a self-exploratory and reflective approach to help participants gain basic knowledge on how to identify, regulate and respond to negative emotions or stressful circumstances.

Experience and feedback from each training cycle are used to further revise and update the training modules.

The programme will be extended to more districts through the continued support of the Peacebuilding Fund. Independent evaluation of the completed pilot study shows an attitudinal change among the participants. The project will also look into implementing the programme in areas not directly affected by the war but subject to other economic or sociocultural inequalities.

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33 Best practices in mental health care in Sri Lanka. Colombo: World Health Organization; 2017 (unpublished).

Community mental health workers at the Savalanka Foundation in Vavuniya participate in a psychosocial mental health programme.

Defusing anger starts at home

Antonita at a meeting of Manohari participants

“The anger is everywhere,” says Nayaga Seelan Antonita, adding, “every person has it, but they don’t realize what results it has.” Slender and petite, Antonita is a mother of two, who lives with her husband and mother-in-law. The 44-year-old works at a Community Service Organization in Mullaitivu, and has an

air of calm competence about her. It is hard to imagine that there was a time when Antonita struggled with bursts of uncontrollable anger.

It wasn't until she attended Manohari, a community-based violence prevention programme, that she says she was able to identify her problem. "It has been very relevant and useful in my personal life," she says, "I learned that anger can destroy me as well as others."

Antonita is not alone in this. "The conflict begins with the words that come out of my mouth," says Hemadas Arundhani, a counsellor who also works in Mullaitivu. She says that post-war, many families are still dealing with lingering trauma and with new tensions that have come as a result of socioeconomic pressures.

Identifying the roots of violence has been key to helping her break the cycle in her own home. These are lessons she wants to teach her own children. Another participant, Jusuraja Shyamini, speaks up: "Before I used to blame my feelings on external circumstances or other people, but now I know that I have control over how I respond."

The three women are among the 55 trainees who attended two workshops in July 2017, and have all worked their way through all 10 modules of Manohari.

Participants were drawn from among community leaders, women's organizations and development groups, as well as community-based organizations. Breaking away from traditional models of mental health treatment and counselling, the programme relied instead on story-telling, drama, dialogue and role-play to help communicate practical knowledge on how to identify and cope with difficult emotions like rage and jealousy.

Created by a diverse multidisciplinary team of reputed experts supported by WHO, the programme sought to address some of the underlying problems contributing to psychosocial problems such as domestic abuse and alcoholism. Identifying the huge stigma that exists around seeking treatment for mental disorders, Manohari prioritizes an approach that is simple and tailored to the needs of the community. It is also self-sufficient, in that no external resources are required to train others in the community. Programmes such as Manohari that promote emotional regulation and help diffuse community tensions, are important first steps in the journey to bridge gaps and promote reconciliation.

CHAPTER 4. STRENGTHENING HEALTH SYSTEMS FOR UNIVERSAL HEALTH COVERAGE AND SUSTAINABLE DEVELOPMENT

Health is a State subject and all services are provided free to all citizens. Despite free health care at the point of delivery, there is inequitable access to these services. Gaps need to be addressed and standards improved, particularly for services for the elderly, disabled, and those needing rehabilitation and palliative care.

The out-of-pocket expense (OOPE) is around 40% and has led to catastrophic health spending for economically vulnerable families .[34]

WHO contributes to the country's health systems by addressing the six building blocks that are essential to a strong and resilient health-care system. These are: (1) service delivery; (2) health workforce; (3) health information systems; (4) access to essential medicines; (5) health financing; and (6) leadership/governance.

The goal is to support improved access to quality health care, ensure greater responsiveness from health-care providers and systems, provide social and financial risk protection for patients, and increase efficiency and equity in health.

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34 Sri Lanka National health accounts 2013. Colombo: Health Economics Cell, Ministry of Health, Nutrition and Indigenous Medicine; 2016 (http://www.health.gov.lk/enWeb/publication/NHA/Sri%20Lanka%20National%20Health%20Accounts%202013.pdf, accessed 24 January 2018).

Taking the lead on the ‘health’ SDG

SDG 3, the health goal, presents a comprehensive and ambitious aspiration “to ensure healthy lives and promote well-being for all at all ages”.

For a country like Sri Lanka, well-known in this Region for its health system, reaching the last mile is about attention to detail: regional disparities need to be addressed, access to health care improved and services made more comprehensive. Policy measures need to be put in place to protect vulnerable families from incurring catastrophic health-care costs.

In 2017, the WHO Country Office developed Sri Lanka’s health SDG profile – an essential first step in creating systems for measuring, implementing and monitoring the country’s progress towards SDG 3. Sri Lanka was the first country in the Region to complete the baseline survey for SDG 3.

Through a consultative process with the MoH, WHO and key stakeholders, the SDG Core Health Indicators were identified and aligned with national health priorities. The criteria for target-setting were discussed, baseline data sources identified, potential weaknesses highlighted and a monitoring framework was agreed upon with the relevant stakeholders. WHO helped the MoH in further analysing SDG 3 indicators, stratified by age, sex, ethnicity, geography, income, etc. A workshop on the use of the Health Equity Analysis Tool was conducted to increase the capacity of stakeholders in equity analysis.

Assessing SDG 3 stratified by different variables will help the Government make necessary changes to policy and practice so that inequalities are reduced and no one is left behind.

WHO is helping the MoH to develop a “strategic framework for achieving sustainable development”. WHO will also continue to provide technical support to the Parliamentary Subcommittee on Sustainable Development in Sri Lanka.

Providing evidence for policy

Publishing the National Health Accounts

Does Sri Lanka really offer free public health care at the point of delivery? If not, how much are Sri Lankans spending on health out of pocket?

In 2016, the country attempted to answer these questions with the first-ever in-house publication of National Health Accounts (NHA) 2013. WHO provided technical expertise and assistance to the MoH.[39]

Compiled by the Health Economics Cell of the MoH, the report analysed how funds were being distributed and prioritized. It gave useful insights into diseases with the biggest investments, distribution of funds across the prevention, promotion and treatment continuum, as well as allocation based on service delivery levels. This helped in identifying areas needing further attention.

The report highlighted that the Government of Sri Lanka was responsible for financing around 55% of the total expenditure, while around 40% was contributed by people out of pocket. WHO supported a retrospective analysis of health-care spending since 2000 and established that the OOPE had been around 40% throughout the past decade.[39]

The NHA 2014–2016 will be published by the early 2018. Based on the System of Health Accounts 2011,[35] the new report follows an internationally accepted methodology advocated by WHO. This allows comparison of NHAs across countries, and sharing of best practices.

Analysing the Household Income and Expenditure Survey

The MoH and WHO worked closely together to analyse the Household Income and Expenditure Survey (HIES) data for 2013 to further disaggregate the cost components under OOPE for health. HIES 2012/2013 identified outpatient visits (36%), medicines (24%) and laboratory tests (8%) as major cost contributors. The findings also showed that OOPE was there even among the poorest quintiles.[35]

The HIES analysis also showed that the poorest five deciles in the country spent more on alcohol and tobacco than on health care, highlighting the need to address tobacco and alcohol consumption among vulnerable populations.

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35 OECD, Eurostat, WHO. A system of health accounts, 2011. OECD, European Union, WHO; 2011 (http://www.who.int/health-accounts/methodology/sha2011.pdf, accessed 24 January 2018).

Making essential medicines affordable

In 2003, pharmaceutical price controls were abolished in Sri Lanka, resulting in a sharp increase in the prices of medicines. The increasing burden of NCDs such as heart disease, cancer and diabetes, coupled with the high prices of medicines prescribed as treatment for these diseases necessitated a review of pricing regulation. With 75% of the current disease burden due to NCDs, and a projected increase in the future, price regulation of essential medicines is critical.

In 2016, upon request from the National Medicines Regulatory Authority (NMRA), WHO conducted an analysis of Sri Lanka's approach to pharmaceutical price control. The evidence was presented to the NMRA, health policy-makers and administrators.

Subsequently, the Government issued a notice by Extraordinary Gazette capping the prices of 48 essential medicines, which were mostly used to treat NCDs. Pharmaceutical companies would no longer be allowed to arbitrarily increase the prices of medicines above the maximum retail price (MRP) stipulated in the Gazette.

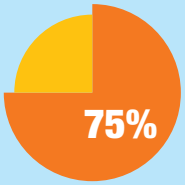
Sri Lanka's successful regulation of pharmaceutical prices shows how evidence-based policies can protect patients' rights, reduce OOPE, ensure affordable access to quality medicines and advance the principles of universal health coverage.

36 Household income and expenditure survey 2012/13: final report. Colombo: Department of Census and Statistics, Ministry of Policy Planning Economic Affairs, Child Youth and Cultural Affairs, Sri Lanka; 2015 (http://www.statistics.gov.lk/HIES/HIES2012_13FinalReport.pdf, accessed 24 January 2018).

Ensuring affordable essential medicines for all

Challenges

NCD epidemic



NCDs account for **75%** of total deaths

Ageing population
12.4% in **2012**
16.8% in **2021**

High cost of essential medicines for treating NCDs

Amount spent on health care:

Household without any NCDs

LKR 927.49

Household with an individual having an NCD

LKR 2279.13

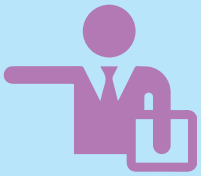
Household with an elderly person

LKR 2227.52

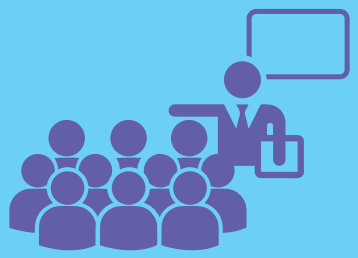
Greater need for **affordable essential medicines**

WHO's response

Supported the MoH to establish the essential drug list for the county



Facilitated technical expertise to review the drug pricing mechanism in Sri Lanka



Advocated the government on reducing the price of essential medicines

Result

Price of **48** essential medicines **reduced by** up to **85%**

Safeguarded patients' rights to access affordable medicines and further advance **universal health coverage**

“If they had not reduced the prices, I would have had to give up my medicines.”

Kusumalatha holds her monthly medicines

This is 55-year-old Kusumalatha’s medical regimen: first thing in the morning, it is one pill of metformin, a dose she repeats at lunch and dinner. Before breakfast, she takes half a tablet of hydrocortisone, saving the other half for later that day; after breakfast, she takes a tablet of levothyroxine. She finishes her regimen with two Gliclazide tablets – one in the morning, the second in the afternoon. These are essential medicines for Kusumalatha. On average, she spends Rs 2000 every month.

The grandmother of two has been a diabetic for twenty years. Last year, she was diagnosed with a heart disorder and a thyroid problem. Attending the clinic regularly was a burden for Kusumalatha as she had a busy working schedule, and on many occasions, she missed going to the clinic and was not on regular treatment.

The good news for Kusumalatha came in October 2016 when Sri Lankan authorities, based on research evidence supported by WHO, introduced regulations that capped the price of key essential medicines. The Government issued a notice by Extraordinary Gazette setting price ceilings for 48 essential medicines used to treat NCDs such as diabetes, heart disease, high blood pressure and high cholesterol, among others.

The revised drug price formula led to the cost of some essential medicines dropping by as much as 85%.

For Kusumalatha, it has made a significant difference. Her bill now is Rs 765 a month, less than half of what she paid earlier. With two grandchildren to look after, as well as her husband, Kusumalatha can no longer needs to do extra work. "If they had not reduced the prices, I would have had to give up my medicines," she says. "I am able to stay home with the children. It has had a great impact on me and the quality of life for my entire family."

Kusumalatha with her grandchildren

Integrating traditional and complementary medicine to promote health and well-being

President Maithripala Sirisena with Health Minister Dr. Rajitha Senarathne, Professor Sampath Amaratunge and WHO Regional Director for South-East Asia, Dr Poonam Khetrapal Singh at the ceremonial opening of TradMed International 2017 in Colombo

WHO was a co-organizer of the International Symposium on Traditional and Complementary Medicine (T&CM) hosted by the MoH in November 2017. The International Symposium provided an interdisciplinary platform for researchers and practitioners to discuss the most recent research evidence, innovations and practical challenges encountered in T&CM research. The Symposium provided a boost to research on T&CM; 16 countries, 36 foreign and 15 national researchers and scientists participated in the Symposium and a total of 248 research papers were presented. Another important outcome of the International Symposium was the drafting of the Colombo Declaration on Traditional Medicine, which recognized the commitment of countries in the South-East Asia Region to integrating evidence-based traditional medicine practices to advance universal health coverage.

Supporting developments in the health workforce and health information systems

People are at the heart of the health system

Human resources for health

The WHO Country Office supported the technical committee that was appointed on “human resource management and development” to review the human resources for health (HRH) set-up in Malaysia. As a follow up, an HRH unit was established in the MoH by a Parliamentary Act. This unit is responsible for coordination on recruitment, training, deployment and planning of HRH.

WHO supported the MoH in developing capacity for transformative education through study visits and revision of training programmes.

In addition, a Health Labour Market Analysis was done jointly by the MoH and World Health Organization (WHO Country Office, Regional Office and headquarters). The study evaluated the human resources situation in the country with regard to training, deployment, retention and migration of medical officers and nurses. It was conducted from April to December 2017. The analysis provides strategic recommendations on strengthening the health workforce policies and strategies; improving regulation and monitoring of the private sector; developing an integrated approach to managing health workforce migration, and improving the collection of coordinated and systematic HRH data to ensure equitable service delivery to the population. The results will be used for the development of a strategic roadmap and policies on the health workforce.

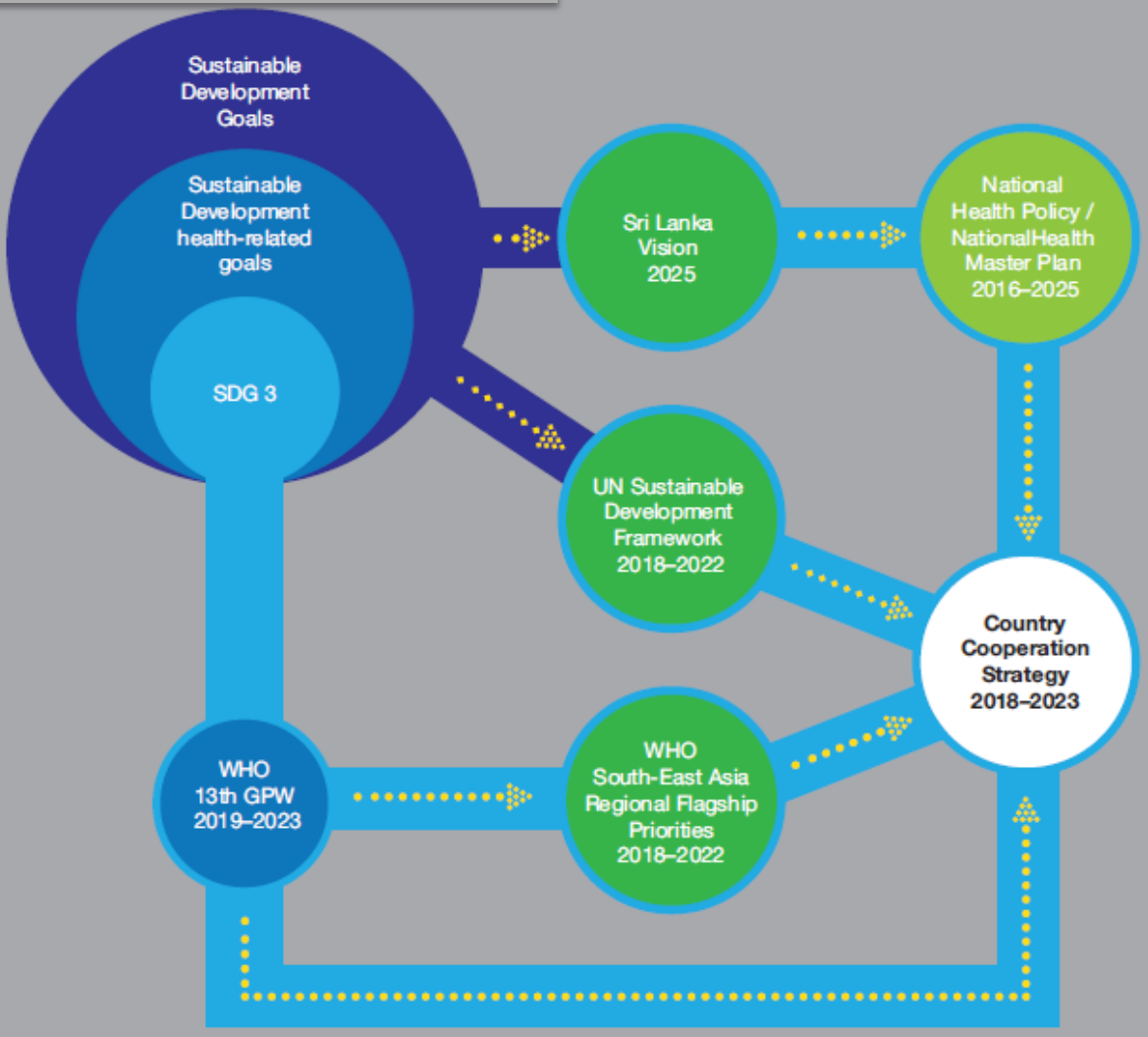
With WHO’s support, MoH’s Health Facility Survey Management System evolved from a paper-based system to a web-based system. The latter is expected to fast-track the assessment and gap analysis of health facilities, and ensure timely and effective delivery of services to the population.

WHO also supported evidence generation on selected NCDs, including the extent of coverage, access and financial protection of patients with diabetes mellitus, and the effectiveness of management and availability of post-stroke services in Sri Lanka.

This analysis is based on the multisectoral action plan for Sri Lanka and will help in identifying key priorities for the NCD multisectoral response. Sri Lanka will report back on its progress at the UN General Assembly in September 2018.

Country Cooperation Strategy (CCS) 2018–2023

Planning framework for CCS 2018–2023



Four strategic priorities and ten focus areas

- Sustainable and equitable health financing
- Human resources for health (HRH) to face health challenges
- Primary health care delivery addressing changing demographic profile
- Sustaining and strengthening achievements from MDGs

Policy support for service delivery

Addressing NCDs and determinants

- NCDs including cancer and mental health
- Road traffic injuries

Country Cooperation Strategy 2018–2023

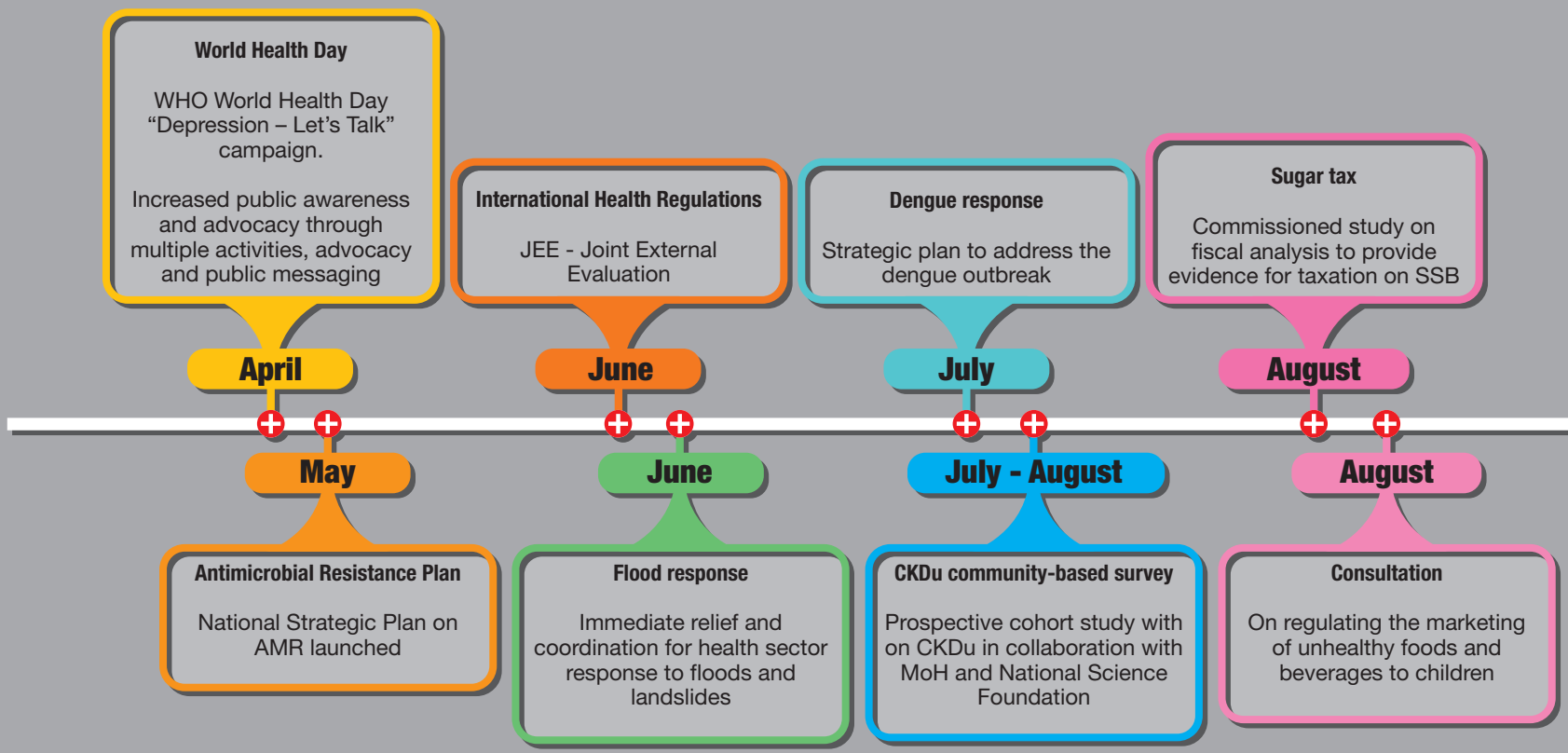
Resilience in the face of health threats

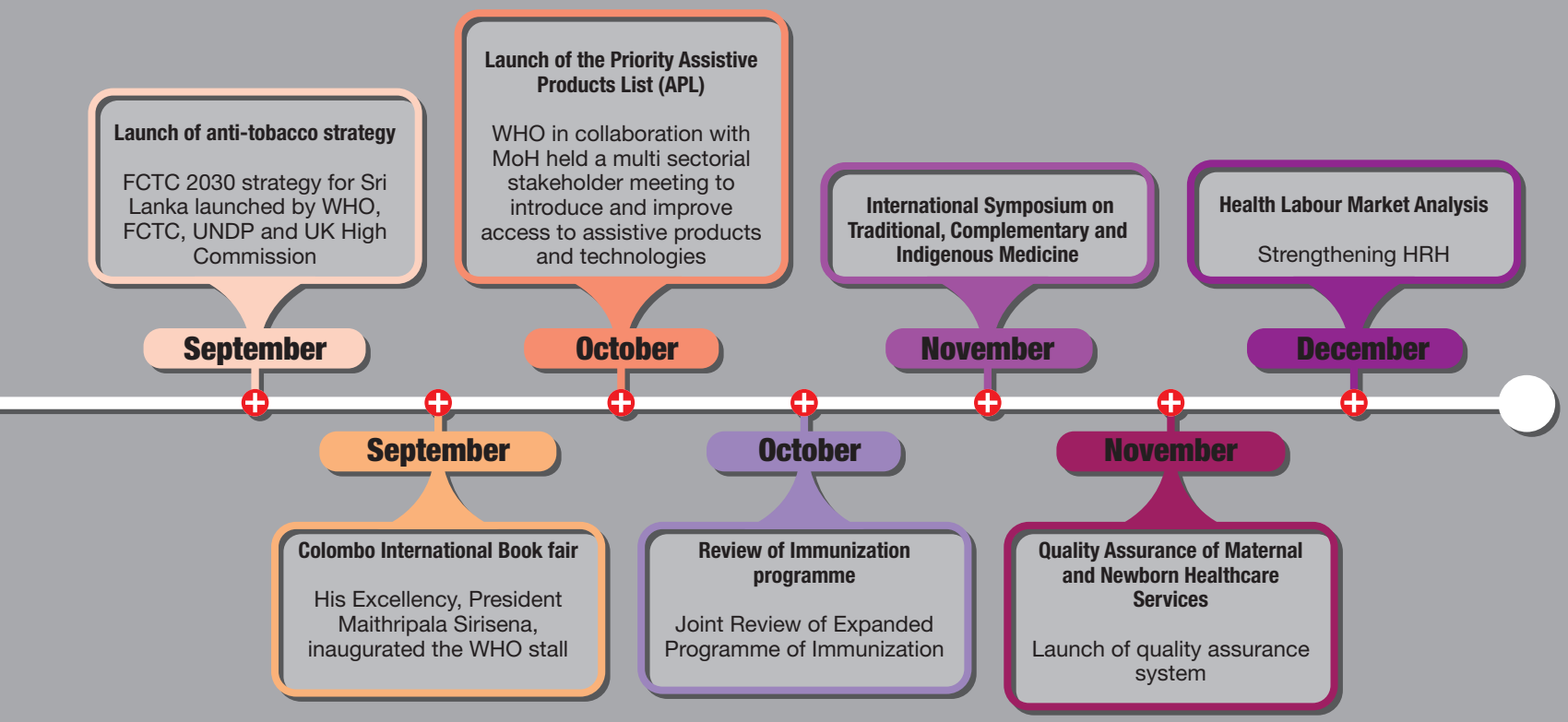
- Country preparedness for all threats, including AMR

Knowledge-based approach to health

- Global health diplomacy
- Information and evidence for action
- Community knowledge and empowerment

Timeline of key events for the WHO Country Office for Sri Lanka 2017




Launch of anti-tobacco strategy
FCTC 2030 strategy for Sri Lanka launched by WHO, FCTC, UNDP and UK High Commission
September
Launch of the Priority Assistive Products List (APL)
WHO in collaboration with MoH held a multi sectorial stakeholder meeting to introduce and improve access to assistive products and technologies
October
International Symposium on Traditional, Complementary and Indigenous Medicine
November
Health Labour Market Analysis
Strengthening HRH
December
September
Colombo International Book fair
His Excellency, President Maithripala Sirisena, inaugurated the WHO stall
October
Review of Immunization programme
Joint Review of Expanded Programme of Immunization
November
Quality Assurance of Maternal and Newborn Healthcare Services
Launch of quality assurance system

Collaboration between WHO and Sri Lanka on improving health outcomes

The WHO Country Cooperation Strategy (CCS) provides a strategic vision for WHO's work in and with the country. It helps in responding to country-specific priorities and finding the resources needed to advance the health agenda within national policies and plans. It is also aligned to regional and global goals.

The CCS 2018–2023 is designed to realize the health agenda of the SDGs within the United Nations Sustainable Development Framework (UNSDF) for Sri Lanka.

The CCS is aligned to the high-level strategic vision of the proposed Thirteenth General Programme of Work (GPW) as well as the WHO South-East Asia Region's Flagship Priorities.

The CCS, which is a result of a consultative process involving the Government of Sri Lanka, UN agencies and other key stakeholders, will provide a framework for collaboration on health between the Government of Sri Lanka and WHO.

As the country addresses the challenge of strengthening the national health-care system, WHO is committed to working closely with the Government and other stakeholders to support the delivery of equitable and quality health services to all Sri Lankans, and advance universal health coverage, leaving no one behind.

Ten priorities for 2018/19

1. Neglected Tropical Diseases
2. Anti Microbial Resistance
3. Non Communicable Diseases
4. Mental Health
5. Violence and Injuries
6. Reproductive, maternal, newborn, child and adolescent health
7. Health and the environment
8. National health policies, strategies and plans
9. Access to medical products and strengthening regulatory capacity
10. Emergency risk management and crisis management

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