Sri Lanka’s Health Improvements as an Example of the Implementation of the Alma-Ata Declaration

Vinya Ariyaratne

Sri Lanka, an island nation located in the Indian Ocean at the southern tip of India, has demonstrated remarkable gains in population health despite a low per capita income. Sri Lanka’s success story has been studied extensively (Halstead 1985; Caldwell 1986). Past scholarship has emphasized uniquely Sri Lankan advantages underlying these gains, based on geography, religion, and culture. However, the health achievements of Sri Lanka were not inevitable blessings of its history—a series of deliberate choices were made that others can learn from. Unlike other former British colonies that struggled to build operational public health systems, Sri Lanka embraced a system of local public health departments that have proven themselves as well as invested in making primary clinical services accessible to all residents.

Sri Lanka gained independence in 1948 with few macroeconomic advantages. Following independence, its political system underwent regular turmoil. Nevertheless, it was able to transform its communities’ health by turning to a legacy of cultural traditions and a commitment to principles of multisectoral comprehensive community participation that are enshrined in the Alma-Ata Declaration. The institutions built in Sri Lanka were sorely tested by a long civil war, but they showed resilience despite this challenge. Being able to isolate design principles underlying that resilience will be of value for readers who are eager to build comprehensive primary health care (PHC) systems that can function and thrive under the challenges of political instability and economic resource scarcity.

The lessons of Sri Lanka are partly inseparable from its context but partly universal. In describing the Sri Lankan health success, I attempt to demarcate the uniquely Sri Lankan features, including the geographical, epidemiologi-
cal, and political backdrop of the country. In subsequent sections, I narrate the series of policy choices that built the functional governmental and non-governmental institutions that constitute the current systems contributing to the health of the Sri Lankan people. The chapter teases out those universal principles that readers can learn and apply in other contexts. This narrative cannot be confined to the health sector and health services. People’s health is inextricably connected to and determined by social, economic, and political factors more than ever in history. This analysis and commentary is based on a public health practitioner’s point of view and reflects a broad perspective on the major determinants of health.

Recent Trends in Health Status

Sri Lanka has a land area of 62,705 square kilometers and a population of 21.2 million. The country’s key health indicators have shown steady improvement since the early decades of the twentieth century, particularly during the decades following independence from the British colonial rule.

Maternal and child mortality have decreased dramatically. As of 2013, the maternal mortality ratio stands at 26.8 per 100,000 live births, and the infant mortality rate is 8.3 per 1,000 live births (Ministry of Health 2016). Life expectancy, too, has risen steadily, to 76 for females and 72 for males (Ministry of Health 2016). The total fertility rate had declined to a below replacement level of 1.9 by 2006, though it increased to 2.3 in 2016 (DHS 2016). Still, challenges remain in child nutrition and health disparities based on region and gender. According to data from the Sri Lanka Demographic and Health Survey of 2016, the proportion of children with low birth weight stands at 15.7%. The proportions of children with stunting (17.3%), wasting (15.1%), and underweight (20.5%) have not fallen much compared to prior decades. There are also wide regional disparities in health indicators. For example, while the national level of low-birth-weight babies is recorded at 11.4 per 100 live births, it is recorded at a higher level of 17.8 for Nuwara Eliya District (Ministry of Health 2015). Similar disparities are seen in the lagging progress of health and nutrition among women of Sri Lanka (DHS 2016). This is evident especially among estate sector women. Nuwara Eliya District, which accounts for a large number of estate sector women, has one of the highest maternal mortality ratios of the country: while the national level indicates 32 deaths per 100,000 live births, it is reported at 62.7 in the Nuwara Eliya District (Ministry of Health 2015) (table 11.1).
Table 11.1. Annexure 1: demographic and health indicators, 1917–2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>4,497,900</td>
<td>6,657,300</td>
<td>9,389,000</td>
<td>11,992,000</td>
<td>14,190,000</td>
<td>16,586,000</td>
<td>18,784,000</td>
<td>20,217,000</td>
<td>21,444,000</td>
</tr>
<tr>
<td>Population above 65 years</td>
<td>443,842</td>
<td>611,624</td>
<td>883,716</td>
<td>1,146,758</td>
<td>1,873,000</td>
<td>1,684,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>50.3</td>
<td>37.1</td>
<td>19.4</td>
<td>14.3</td>
<td>9.0</td>
<td>8.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>75.3</td>
<td>57.0</td>
<td>22.4</td>
<td>17.9</td>
<td>11.1</td>
<td>9.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Mortality ratio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27.0</td>
<td>33.4</td>
<td>33.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude death rate</td>
<td>31.2</td>
<td>13.0</td>
<td>9.7</td>
<td>7.9</td>
<td>6.6</td>
<td>5.8</td>
<td>6.0</td>
<td>5.9</td>
<td>6.5</td>
</tr>
<tr>
<td>Crude birth rate</td>
<td>38.9</td>
<td>35.8</td>
<td>32.0</td>
<td>28.5</td>
<td>20.7</td>
<td>17.2</td>
<td>18.5</td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>42.8</td>
<td>61.7</td>
<td>63.1</td>
<td>67.3</td>
<td>69.2</td>
<td>69.7</td>
<td>74.2</td>
<td>75.0</td>
<td></td>
</tr>
<tr>
<td>Literacy rate (male, %)</td>
<td>56.3</td>
<td>75.9</td>
<td>85.8</td>
<td>85.6</td>
<td>91.1</td>
<td>92.6</td>
<td>92.8</td>
<td>94.1</td>
<td></td>
</tr>
<tr>
<td>Literacy rate (female, %)</td>
<td>21.2</td>
<td>53.6</td>
<td>67.5</td>
<td>70.9</td>
<td>83.2</td>
<td>89.7</td>
<td>90.0</td>
<td>92.2</td>
<td></td>
</tr>
</tbody>
</table>

Note: Sri Lanka has a land area of 62,705 square kilometers and a population of 21.2 million (Department of Census and Statistics 2016).

1 Census of Population and Housing 1981.
9 Statistical Abstract 2014.
10 World Bank 2016.
Health Infrastructure

Today in Sri Lanka, a health care facility can be found on average not farther than 1.4 kilometers from most homes, and free government health care services are available within 4.8 kilometers of most homes. Other physical infrastructure has also improved significantly over the past two decades, leading to greater ease of accessing these widely distributed facilities (Marga Institute 2006).

Historical Context

Sri Lanka has twenty-five hundred years of recorded history. The country was ruled by monarchies up until the start of British rule in 1815. The country was first occupied by the Portuguese (1505), followed by the Dutch (1656), and then by the British (1796). However, the Portuguese and the Dutch could only occupy the coastal areas of Sri Lanka, and it was solely the British who could conquer the entire island.

Buddhism was introduced to Sri Lanka in the fifth century B.C. Buddhism, practiced by a majority of people in Sri Lanka, has had a strong influence over health and well-being for more than two millennia. People’s health was a primary concern of all kings who ruled the country, as Buddhism recognized care of the sick as a highly meritorious deed. Sri Lanka’s archeological ruins include what may have been the first hospital ever built in the world. Ancient Sri Lankans also constructed sanitation works, leaving behind the remains of privies, urinals, and baths (Uragoda 1987).

Traditional practices and systems of medicine existed in Sri Lanka as well. Western, Ayurvedic, Unani, Siddha, acupuncture, and homeopathy systems of medicine are all practiced in Sri Lanka. However, the dominant system of medicine in Sri Lanka today, the Western allopathic system, was introduced to the country by the colonial powers. The Portuguese first brought the country into contact with Western medicine, but their influence on local medical practice was marginal (Uragoda 1987). The Dutch, toward the latter part of their rule, built hospitals in different parts of the island and managed them with their physicians and surgeons, primarily to serve the colonial expatriate workforce and secondarily to care for the local population.

During British rule (from 1796 to 1948), Western medicine took deep roots and transformed medical practice in the country. It is observed that, unlike the Portuguese and the Dutch, the British, from the very inception of their rule, were very concerned about the health of the local population. The
British could be credited for the establishment and expansion of preventive and curative Western health care.

During the British rule in the late nineteenth century, coffee, tea, and rubber plantations were introduced to Sri Lanka. As the local population was not willing to work as wage laborers on these plantations, the British planters brought down south Indian Tamil laborers to work on their estates in Sri Lanka. The British colonial government made the plantation owners responsible for the health of their workers. As these workers came from extremely poor communities in South India, living in unhealthy and unhygienic conditions, they were subjected to many infectious diseases. The plantation workers later became citizens of Sri Lanka as a distinct ethnic community known as “Tamils of Indian origin” (to distinguish them from “Sri Lankan Tamils,” who inhabited the island long before the era of colonial rule in Sri Lanka). The health status of this estate population in Sri Lanka continued to lag behind compared to other ethnic communities living in the country.

Role of Education in Health Improvements

Traditionally, the people of Sri Lanka, irrespective of their ethnic and religious background, have always treated education as a virtue. They have seen its practical value as a means of upward social mobility. Long before the British introduced the formal, Western-modeled education system in the country, Sri Lanka had a temple-based (pirivena) education system. This societal demand for education for both sexes paved the way toward building a highly literate population, which in return provided a firm foundation on which public health could also be built. This does not mean that traditional beliefs and practices were not playing a role in the Sri Lankan population. Rather, Sri Lankan society has an interesting health-related belief system that is deeply, culturally rooted and coexists within a predominantly Western, modern medical care system. Especially when it comes to mental health issues, communities in rural areas of the country still resort to traditional rituals (Yaaga) for healing. In addition, communicable diseases such as chickenpox and measles are considered to be caused by supernatural forces.

Health Behavior

Given the importance assigned to people’s health by the ancient rulers of Sri Lanka and the health care systems introduced during colonial rule, it is observed that the people of Sri Lanka have been, by and large, a “health con-
At the center of Sri Lanka’s health improvements lies the concept of a “conscious” population. Positive health behaviors and values have been transmitted across generations for several centuries and played a decisive role in creating receptivity to the public health initiatives of the health units in Sri Lanka. To illustrate, Pieris (1999) wrote:

It might be assumed that the traditional health beliefs would be weaker among an educated population, however, the study found the situation in Sri Lanka more complex. The treatments for illness have changed drastically without a concomitant change in health beliefs. Indeed, although most Sri Lankans hold traditional beliefs concerning illness causation and appropriate treatment, this does not prevent them from using modern medicine in preference to traditional medicine.

Sri Lankans believe, and have long believed, that illness can be cured through treatment and do[es] not have to be left to fate. For instance, the illnesses that people suffer from today as a result of changes in lifestyle, such as heart attacks and cancer, are regarded as being a result of bad karma (fate). Nevertheless, Sri Lankans recognize that these diseases can be treated, and, on occasion, cured through modern treatment.

While Ayurvedic treatment is most used for a few specific diseases, in a less obvious way it is used for other diseases, too. Many people, for example, use Ayurvedic medicine as a follow-up treatment to restore the equilibrium of the bodily fluids after modern medicine has quickly cured the symptoms of the disease.

The mortality decline in Sri Lanka is not entirely explained by the implementation of modern health care. Though the modern health system was an essential prerequisite for mortality decline, it would not have been effective had the people not willingly accepted and experimented with [a] new type of treatment. Sri Lankans were willing to accept the new health system since they saw sickness primarily as a physical problem, rather than, as is often the case elsewhere in South Asia, as a divine punishment. This attitude may be largely due to the influence of religious teaching, particularly of Buddhism. Sri Lanka’s Buddhist heritage, encourages men and women to think of themselves and to make decisions independently.

(239–240)

Governance and Politics

A strong demand for participatory governance is part of Sri Lankan political culture despite a history of monarchic and colonial rule. Prior to the British
colonial rule, there existed a Gram Sabha (village council) system in Sri Lanka (Fernando 2010). It is widely accepted that this system was established during the Anuradhapura Kingdom and lasted until 1833, when the Gram Sabha system was formally abolished according to the recommendations of the Colebrook Commission. According to Professor Laksiri Fernando of the University of Colombo, inscriptions of the tenth century indicate that those Gram Sabhas were instrumental in making decisions related to law and order, water management, dispute resolution, and agricultural land allocation.

The citizens of Ceylon (as Sri Lanka was known at the time of the British colonial rule) had been agitating for their representation in administration since the early part of the twentieth century. As a result, the British Government introduced far-reaching political reforms, including limited representation of locals in the Legislative Council in 1910 and universal adult franchise of all men and women in 1931 (Election Commission of Sri Lanka, n.d.). Sri Lanka was the second country, after New Zealand, to enjoy universal franchise in the Asian and Australian region. The evolving competitive political system under the new constitution provided new capacity for elected representatives to articulate the urgent needs of their electorates on the Executive (the British Government) for larger allocation of resources for social services for their constituencies. At the same time, the citizens also found, through franchise, a powerful new tool to demand services to fulfill their basic needs by electing representatives who they believed could deliver those services. This especially emanates from the pre-1977 political system of the country, in which there was a single elected Member of Parliament responsible and accountable for an electoral constituency. Therefore, the constituents could hold their MP accountable for the effective delivery of public services in the area.

Hence, policies for essential social services such as health, education, and food subsidy started to evolve and develop well before the country gained independence (in 1948). Officials found that they could achieve electoral success through expansion of facilities for provision of state-supported health services and education in all parts of the country. Despite regular turnover of elected governments within the multiparty system, the state’s commitment toward universal free health care did not change. As R. Rannan-Eliya and L. Sikurajapathy (2009) observed: “Once democracy had served to establish a widely dispersed government health infrastructure, accessible by all, it then acted to ensure its survival under often difficult, fiscal conditions. Subsequently, successful market-oriented and reform-minded governments in Sri
Sri Lanka have generally understood that the cost of adequate public sector health services accessible to the poor was a small fiscal price to pay for the political support that they engender to enable other more important economic reforms.” The political logic supporting and maintaining provision of fully state-supported health services and wide health coverage was the result of broader historical and social factors (Gunatilleke 1985, 1).

Establishment of the Health Unit System

One of the most important elements of the health system introduced during the British period was the health unit system. A health unit is a well-defined geographic area that is under the purview of a medical officer of health (MOH). An MOH is assisted by a team consisting of public health inspectors (PHIs), who are responsible for environmental health and control of communicable diseases, and public health nurses and midwives, who are responsible for maternal and child health (MCH). The network of health units paralleled the domestic system of district health offices that the British Parliament legislated for themselves in the Public Health Acts of 1848 and 1875 (Szreter 1988). In Sri Lanka, the government norm is for each MOH unit to cover a population of eighty thousand to one hundred thousand. Today, there are about three hundred MOH units delivering public health services. The MCH staff typically includes one to two public health nursing sisters, one to three supervising public health midwives, and a team of public health midwives. The PHI team is much smaller, typically consisting of one supervising PHI and a small team of PHIs. The government norm is for PHIs to cover a population of about ten thousand, while public health midwives cover about three thousand. The MOH supervises the work of both the MCH staff and the PHIs.

Sri Lanka’s Health Unit Program has been cited as a model of “selective” PHC (Hewa 2011). However, I would argue that this view fails to recognize the longer history and much more extensive formal institutionalization of the health unit system in Sri Lanka. The MOH health unit system was not at all a model to deliver a few selective PHC interventions. Conversely, it was staffed with career public health professionals who were assessing and addressing a multitude of pertinent health issues. The staff in Sri Lankan health units were gauging community health issues and assuring local solutions just like their counterpart district health officers were back in England. For epidemiological reasons, Sri Lankan health units logically focused on
MCH, environmental health, and food hygiene. They certainly made use of selective interventions as appropriate, but their approach was far broader. Because Sri Lankan health units had built channels of surveillance, communication, and problem-solving they became natural platforms to contribute to the success of a host of “vertical” disease control programs, such as malaria, leprosy, and filariasis programs, all of which used the MOH health unit system in their preventive interventions (Ellepola and Dayaratne 2016). With a strong horizontal platform in place, each vertical program did not have to recreate the public health infrastructure it would need to succeed. Therefore, the health unit system should be seen as a model that provided a solid platform on which a range of public health services could be provided in a coordinated manner. This is the very definition of comprehensive PHC as opposed to selective PHC.

Alma-Ata Declaration

It is within this longer historical context of a progressive and equity-oriented public health system that the Alma-Ata Declaration became an important touchstone in the evolution of the health care sector in Sri Lanka. The Alma-Ata Declaration gave a tremendous boost and legitimacy to further build on core elements of Sri Lanka’s health unit system. As can be clearly seen from the forgoing analysis, the basic elements of the PHC approach endorsed by the Alma-Ata Declaration were already an integral part of the Sri Lankan health system in 1978. Sri Lanka became an active promoter and subsequently a signatory to the Alma-Ata Declaration. Decades of experience with the Sri Lankan model were promoted at a Bellagio conference on PHC in 1985 and held up for emulation (Halstead 1985; Hewa 2011).

Community Participation in Primary Health Care in Sri Lanka

Sri Lanka has a rich tradition of community participation in various aspects related to fulfilling people’s basic needs. Because of its agricultural economy, people’s direct participation in managing and maintaining community resources including irrigation systems, as well as jointly preparing land for cultivation, harvesting, and marketing, has been a routine practice since pre-colonial times.

Historically, mobilizing public participation for health was triggered by the threat of infectious diseases. During the malaria epidemic of 1934–1935, more than a million people were affected, and there were more than 125,000
ble deaths. Arising from this devastating event, the Suriya Mal Movement mobilized a large number of volunteers to combat the epidemic among the poor and to address root causes in nutrition and housing. Various voluntary development organizations have facilitated community participation in addressing health and nutritional issues in rural villages, focusing on linking remote and inaccessible rural communities with government health services (Halstead 1985).

In the late 1970s, the emphasis was on building awareness and raising public consciousness regarding available services. Health volunteers became the link between the community and government health services, particularly in promoting MCH services. The communities had been passive recipients of services delivered by nongovernmental organizations (NGOs) and transitioned to a more “empowerment”-oriented approach. The concepts of PHC emerging from Alma-Ata gave new inspiration and legitimacy to community participation promoted by the NGOs. There emerged active engagement of communities in preventive health work including nutrition, water supply and sanitation, and early child education—areas directly connected to community health but not part of mainstream government health services.

In the late 1980s, community participation focused on combatting specific communicable diseases, such as malaria. For example, community groups deployed trained volunteers to detect cases of malaria. Starting in the early 1990s, community participation began to include control of sexually transmitted diseases and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The nongovernment sector was also important in building community collective action for health, as is illustrated by the Sarvodaya Shramadana Movement (see box on page 268).

In 2018, an extensive consultative and review process was carried out by the Ministry of Health, Nutrition and Indigenous Medicine in the reorganization of PHC in Sri Lanka. The subcommittee appointed to study the current status of beneficiary engagement, gender, and citizens’ voice concluded that the current status of citizen engagement was unsatisfactory (Ministry of Health, Nutrition and Indigenous Medicine 2017). It was the unanimous opinion of the committee that “the health system must increase patient empowerment and engagement in their health,” and it offered a series of recommendations that included establishing a formal mechanism for citizen engagement and a grievance redressal mechanism (Ministry of Health, Nutrition and Indigenous Medicine Sri Lanka 2017, 33). Coming years should see a reemphasis of this traditional feature of public health in Sri Lanka.
The Sarvodaya Shramadana Movement of Sri Lanka

The Sarvodaya Shramadana Movement is by far the largest grassroots nongovernmental development organization in the country. Founded in 1958, members of the Sarvodaya Shramadana Movement have worked with underprivileged and poverty-stricken communities in Sri Lanka to uplift their living standards through a unique, holistic, integrated, and participatory approach.

Main strategies of the organization in development or awakening of a village community is divided into five stages, and they are concentrated on each dimension of empowerment (i.e., spiritual and ethical, cultural, social, economic, and political.

• Stage 1: Psychological infrastructure development
  *Spiritual and ethical empowerment*

• Stage 2: Social infrastructure development and training
  *Cultural empowerment*

• Stage 3: Satisfaction of basic human needs and institutional development
  *Social empowerment*

• Stage 4: Income and employment generation and self-financing
  *Economic empowerment*

• Stage 5: Sharing with neighboring villages and good governance
  *Political empowerment*

The lowest level of the Sarvodaya organization is at the village level. To initiate these activities at the village level, a group called the Sarvodaya Village Shramadana Samithiya is convened. Initial activities revolve around organizing Shramadana campaigns. These campaigns form a variety of groups such as women’s groups, youth groups, children groups, farmers’ groups, and so forth, and identify their own unique needs as the village-level organization is progressing.

Sarvodaya provide initial leadership and skills training, and subsequently they often develop a Children’s Services Center. They also try to solve the issues related to the provision of ten basic needs within the village, and the main Sarvodaya organization assists with these initial activities. The organization is expected to be progressing through the five strategic stages listed previously to ultimately reach the “Gram Swaraj” village status.

At each level, village communities are assisted by various units of the Sarvodaya Shramadana Movement. For example, the village organization is registered under the Societies Ordinance at Stage 3, and the legal unit of the main branch assists in the process. At Stage 4, the SEEDS (Sarvodaya Economic Enterprises Development Services) unit assists the village community to develop a micro-financial organization.

Sarvodaya has an outreach of fifteen thousand villages over a period of six decades, with fifty-four hundred villages having been formed as independent village organizations as described earlier. In the 1960s and 1970s, Sarvodaya’s work in community health, such as early childhood development and nutrition, was regarded as a novel experiment in promoting people’s health. Sri Lankan experiences helped inform the buildup to the Alma-Ata Conference in 1978 (United Nations Children’s Fund, 1977).

The Sarvodaya Shramadana Movement, which covered the entire country with its community development programs, played a critical role in the satisfaction of basic needs in a large number of rural villages in Sri
Sri Lanka’s Health Improvements

Lanka. The ten basic needs approach adopted by Sarvodaya addressed the determinants of ill-health through participatory and voluntary action. For over five decades, Sarvodaya has evolved innovative programs to address emerging health challenges while continuing to address key social and economic determinants of health. As disease control activities had to be carried out during the height of armed conflict in Sri Lanka, Sarvodaya, being a neutral party involved in both humanitarian and development activities in war-affected areas, was able to deliver the services to the “last mile.”

In addition to working at the community level and in close collaboration and coordination with the Ministry of Health and other key stakeholders working in the health sector, the Sarvodaya Shramadana Movement also works at the national level to influence policies related to health. Because of their organizational experience and credibility, Sarvodaya’s leaders serve in national-level policy-making bodies such as the Nutrition Steering Committee on Noncommunicable Diseases, the National Committee on Mental Health, the Technical Advisory Committee on Health of Young Persons, and others. Sarvodaya is a founding member of the People’s Health Movement, and since its inception in 2000, it has served as the national coordinator bringing together more than sixty organizations working in the health sector, including a few key trade unions. The People’s Health Movement in Sri Lanka has carried out extensive advocacy programs on national drug policy and the rights of sex workers and the LGBTQ community, and most importantly it has led in a nationwide campaign to include health as a fundamental right in the constitution of Sri Lanka.

The village level and the organization of communities create the foundations and the building blocks of Sarvodaya’s work, where ownership of sustainable development lies with the communities themselves. The Sarvodaya Shramadana Movement has three related objectives: (1) the consciousness objective of transforming human consciousness through spiritual, moral, and cultural awakening, and deepening the societal commitment for nonviolence; (2) the economic objective of transforming the society through the creation of a fully engaged economic system that creates sustainable village economies, which meets the basic needs of all Sri Lankans through social, economic, and technological empowerment; and (3) the power objective of transforming the present political system to establish community self-governance, participatory democracy, and good governance through political and legal reforms. Empowerment would need to go a long way to create the socioeconomic and political order that serves justice and awakening to all.

The Civil War and the Impact on Health

Sri Lanka was engulfed in a violent internal armed conflict from 1983 to 2009. A separatist campaign by the Liberation Tigers of Tamil Eelam against the government resulted in hundreds of thousands of lost lives, largely those of civilians. There was widespread damage to livelihoods and property. The northern and eastern parts of the country were directly affected by the war,
while the rest of the country also suffered due to attacks on civilians and as a result of the negative effects on the economy. Nearly a million people were internally displaced during the period of the war. The war came to an end in May 2009 with a comprehensive military victory by the government over the Liberation Tigers of Tamil Eelam. However, the war that had lasted for twenty-six years left a devastating impact on the population exposed to the war.

A country that had had a reputation of maintaining good vital statistics for more than a century found itself unable to collect, collate, and report the vital statistics for more than twenty years for the northern and eastern districts affected by the war. Hence, it was difficult to objectively evaluate trends of morbidity and mortality during the period of the war. It is still challenging to fully assess the health impact of the war on the population in Sri Lanka, and thus there is a paucity of epidemiological evidence (Siriwardhana and Wickramage 2014). However, based on findings of the few studies that are available, it could be concluded that there has been a significantly negative impact on the health status of people living in the conflict zones (Family Health Bureau 2010). A large number of people also suffer from psychological effects of the war, including post-traumatic stress disorder (de Jong et al. 2002). The war negatively affected overall public health and development across the nation. S. Johnson (2017) wrote: “Perhaps more insidious was the lost momentum, and the loss of what could have been achieved in terms of infant and maternal deaths prevented, in terms of increased longevity, and in terms of the wealth and happiness that could have come with better health, in the absence of war” (25).

However, despite lost years of progress, the war did not eliminate Sri Lanka’s culture of community-based, population-level, multisectoral public health practice. Nor did it alter a basic expectation that people should do their part to ensure the health of themselves and communities. The professional cadres to staff health units around the country remain and have been doing their jobs. The NGO community remains vibrant and is seeking to restore a sense of national solidarity around a shared health destiny.

Since the end of the war in 2009, the government has taken urgent measures to rebuild the destroyed health infrastructure, and today almost all hospitals and clinics have been rehabilitated and staffed, and are being made functional. The MOH units are also functioning, providing preventive health services.
Current Challenges and Responses

Several challenges remain for the future of public health in Sri Lanka. The country must face its epidemiological transition to noncommunicable diseases (NCDs), it needs to ensure quality of care, and it needs to grapple with rising costs of financing health care and protecting vulnerable groups from catastrophic costs. Sri Lanka’s past achievements in building comprehensive PHC platforms around the country is a cause for optimism. To explore each of these challenges in further detail:

*Changing epidemiological profile to NCDs.* Sri Lanka has brought down morbidity and mortality due to maternal and perinatal causes and has made great strides in controlling infectious diseases. Sri Lanka was declared malaria-free by the World Health Organization on September 5, 2016 (World Health Organization 2016). However, the burden of NCDs is rising and will continue to expand in the years to come.

*Quality of care.* Though “access to care” for the entire population seems to be satisfactory, the quality of care in terms of availability of medical personnel in remote areas, availability of medicines, long waiting times, and so forth are not optimal. Further attention to these matters will be needed moving forward.

*Health financing.* High out-of-pocket expenditures and high utilization of private sector services even by those in the lowest income quintile remain concerns. There is also an issue of an emerging “third tier,”* where some individuals accessing state health care that is free at the point of delivery actually bear some of the costs of drugs, investigations, and surgery (de Silva et al. 2016). This cost sharing with patients is resulting in catastrophic health expenditures for individuals as well as delays in and noncompliance with treatment.

The Role of Primary Health Care in Responding to Twenty-First-Century Health Challenges

First and foremost, Sri Lankans are served by a network of effective health units, and many if not most Sri Lankan communities have NGO-based health units.

*Third tier* is defined broadly as payment to a private party for obtaining goods or services, as part of accessing state-sector services.
organizations such as the local Sarvodaya Movement chapters. These are important resources to cope with each emerging and ongoing challenge. The control of NCDs requires a multisectoral response that can emerge when community groups and public health professionals gather to understand and counteract root causes. Responses to tobacco, alcohol, injuries, and climate change can require the coordination of representatives from education, industry, commerce, transport, and energy at all levels of society. Sri Lanka’s legacy of coordinated social action for health is well poised to spread the necessary political will to gather and deploy evidence-based solutions. For example, local chapters of the Sarvodaya Movement have played an important role in organizing measures to prepare for the natural disasters due to climate change.

Political will for health is essential because NCD control measures and progress to mitigate climate change typically generate vociferous opposition from industries that profit from the status quo. Restrictions on tobacco, alcohol, and unhealthy food are always difficult to launch and sustain.

Networks of concerned citizens have been an important component of social accountability approaches to health care quality. Having well-trained public health officers present in every part of the country gives Sri Lanka a platform from which to launch cycles of supportive supervision and provider education to improve medical care practices. Citizen-based social accountability systems are yet to be introduced in Sri Lanka. However, the recently introduced National Health Performance Framework (Ministry of Health 2018) and the citizen engagement mechanism proposed in the new strategy for reorganization of PHC in Sri Lanka provide promise (Ministry of Health 2017).

Finally, the efforts to engage the community in responding to their concerns about their growing NCD burden and health care quality naturally lead to a groundswell of interest in achieving better health care financing and coverage. An important part of the political solutions to create fiscal space for health care for all is a sense of social solidarity regarding health that enables pooling public finances.

Toward the end of 2017, the Ministry of Health, Nutrition and Indigenous Medicine initiated a major process to restructure PHC in Sri Lanka. (Ministry of Health 2017). There has been a keen interest to review the health system, particularly primary care systems (World Health Organization 2017).

The Ministry of Health, with technical assistance from the World Bank, initiated a process to develop a new strategy for the health sector based on a PHC approach. This is very timely as Sri Lanka is experiencing a demographic and epidemiological transition. There has been a resurging interest
in strengthening the PHC approach with comprehensive community-based and family-focused care to address the existing health issues in Sri Lanka (Senanayake 2017; World Health Organization 2017).

The proposed strategy adopts three general areas of action: (1) reorganizing PHC to meet Sri Lanka’s future needs; (2) using data and information to improve health care; and (3) strengthening the health sector. The table 11.2 gives the details of thematic areas identified under each action area.

This new initiative is aimed at enhancing citizen engagement in PHC institutions. As of now, the citizens’ engagement at the PHC level has been limited to the status of passive receivers (patients); PHC institutions have also lacked a proper system to address public grievances. In response, the new initiative aims to

- engage “the people” in people-centered PHC to ensure meaningful citizen participation in oversight of the PHC system;
- build health staff capacity to understand the importance of and to provide respectful and effective communication and care for patients;
- develop, adopt, and promote the use of a Patients’ Rights Charter at all PHC facilities;
- foster patients’ engagement in managing their own health through health cards, health awareness training, and health education;
- solicit input from the community and clients through suggestion boxes at all government health facilities, conducting regular patient

**Table 11.2. Action and thematic areas of Sri Lanka’s new primary health care approach**

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Thematic Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1: Restructuring primary health care</td>
<td>Reorientation of primary health care (including Ministry of Health and primary medical care unit integration, human resources, specific measures to tackle noncommunicable diseases, referral and transportation system, and health life centers)</td>
</tr>
<tr>
<td>#2: Using information and data</td>
<td>Reorientation of primary health care (especially: monitoring and evaluation)</td>
</tr>
<tr>
<td></td>
<td>Health information and IT systems</td>
</tr>
<tr>
<td>#3: Strengthening the health sector</td>
<td>Procurement systems</td>
</tr>
<tr>
<td></td>
<td>Health financing</td>
</tr>
<tr>
<td></td>
<td>The private sector</td>
</tr>
<tr>
<td></td>
<td>Beneficiary engagement and citizen voice</td>
</tr>
</tbody>
</table>

_Sri Lanka’s Health Improvements_
satisfaction surveys, strengthening community advisory and oversight committees for health services, and facilitating citizen participation in monitoring and evaluation assessments of health services;
• create mechanisms for submission and independent investigation of grievances against public and private sector health services; and
• enable representatives from health centers to participate in other community processes.

Open Government Partnership
The Open Government Partnership (OGP) was launched in 2011 to provide an international platform for domestic reformers committed to making their governments more open, accountable, and responsive to citizens. The Government of Sri Lanka committed to the OGP in 2015. More information can be found at: https://www.opengovpartnership.org/countries/sri-lanka. One of the twelve commitments of the OGP is on health. Under the OGP health component, the Government of Sri Lanka subscribed to three commitments:

1. improving public access to preventive and curative strategies to combat chronic kidney disease of unknown etiology,
2. transparent policy to provide safe and affordable medicines for all, and

There has been some progress on all three commitments since 2015. The Sarvodaya Movement and the People’s Health Movement in Sri Lanka are jointly driving the OGP civil society partnership to pressure the government to implement the commitments. The Right to Information legislation is also giving an opportunity for the citizens to address their grievances by demanding information related to service delivery.

Way Forward
Dr. Ruviaz Haniffa, the newly elected president of the Sri Lanka Medical Association, posed the question of Sri Lanka’s future as follows: “Has Sri Lanka got health system mechanisms in place to provide services to match the current and future health care consumption needs of our population?” (Haniffa 2018, 6). He observes that while the country’s health system has been successful in delivering satisfactory curative and preventive care in the state sector, the primary curative care services vary in terms of quality and
quantity between state and private sectors. He calls for “a shift from diseases to patients” (14).

In recent years, particularly since the change of the government in 2015, there have been several important initiatives to critically look at current health care delivery services and make necessary policy changes. In 2016, the Ministry of Health took the lead to prepare a new national health policy and called for public input (Ministry of Health, Nutrition and Indigenous Medicine 2016). It is unclear as to the extent of the response, but it is encouraging to note that the views from the public were sought by the government. Civil society organizations such as the Sri Lanka Chapter of the People’s Health Movement convened consultations to discuss the draft policy and submitted its recommendations to the ministry. The new Sri Lanka National Health Policy, 2016–2025, was finalized and cabinet approval obtained on July 18, 2017. The policy is claimed to be a “patient- and people-centered policy, considering the concept of Universal Health Coverage, assuring the patient’s rights and social justice” (Ministry of Health, Nutrition and Indigenous Medicine 2017).

Sri Lanka counts its ability to extensively pursue PHC as one of its greatest historical assets. Factors that enabled Sri Lanka to implement comprehensive PHC combine both gifts from history and deliberate choices. Sri Lanka inherited a sociocultural milieu based on Buddhist philosophy, which created a positive public consciousness reinforcing health-promoting behavior patterns. They also inherited a conducive environment for both indigenous medical systems and allopathic systems to take root. However, the Sri Lankan people also made choices to pursue progressive policies based on democratic governance. As a result, politicians were receptive to initiatives that provided universally free education and health services with equitable access, and provision of food subsidies to vulnerable communities.

Having realized the importance of strengthening PHC, Sri Lanka’s most recent efforts can be interpreted as serious steps by the government to restructure the PHC system, building on historical gains while adapting to face new challenges. However, as it has been proven in the past, the success and the sustainability of a reformed health care system in Sri Lanka continues to depend on the effective performance of the health workforce, particularly at the community level. It will also depend on the degree of people’s involvement through community-based organizations and NGOs. These organizations help perpetuate the maintenance of the culture of positive health behavior, and they facilitate the mechanisms by which the citizens hold service providers (mainly the state) accountable.

Sri Lanka’s Health Improvements
REFERENCES (SEE PAGE 341 FOR FULL CITATIONS FOR BOXED TEXT)


