



Sri Lanka–WHO

Country Cooperation Strategy | 2018–2023



**World Health
Organization**

Sri Lanka

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Contents

Message from the Minister of Health, Nutrition and Indigenous Medicine	iv
Message from the Regional Director	v
Preface	vii
Acknowledgement	viii
Abbreviations	ix
Executive summary	x
1. Introduction	I
2. Health and development situation	
2.1 Political, social and macroeconomic context	4
2.2 Health status and system challenges	5
2.3 Health system response	13
2.4 Cross-cutting issues	14
2.5 WHO's engagement with development partners in Sri Lanka	16
2.6 Sri Lanka's role in global health	17
3. The Sustainable Development Goals and their implications for Sri Lanka	18
4. Strategic priorities for the WHO–Sri Lanka Country Cooperation Strategy	21
Strategic priority 1. Policy support for service delivery	21
Strategic priority 2. Addressing NCDs and their determinants	23
Strategic priority 3. Resilience in the face of health threats	25
Strategic priority 4. Knowledge-based approach to health	26
5. Implementing the strategic agenda	34
5.1 Means of delivery	34
5.2 Implications for the WHO Secretariat	34
5.3 Performance management and evaluation	35

Message from the Minister of Health, Nutrition and Indigenous Medicine



In a culture that considers “good health to be the supreme wealth”, Sri Lanka is rich with many health-related successes. Dating back some 2500 years, our historical manuscripts have documented how the great leaders of the past had invested in health of their people, through developing not only curative care but also aspects of preventive and promotive health care. All governments that came into power since Independence have continued to support the provision of free health care to the population.

Since the first Country Cooperation Strategy (CCS) was launched in 2002, the country’s health system has achieved significant milestones and improved its resilience in the face of health threats and emergencies. However, as the system evolved, other challenges emerged. Communicable diseases have been replaced by noncommunicable diseases as the leading cause of disease burden in the country. Improved access to and quality of health care has increased longevity with a resultant increase in the proportion of the elderly. Increased urbanization, climate change and technological advances, while easing some of the hardships, have also brought in a new set of issues such as sedentary lifestyles and unhealthy food habits, threatening the health gains.

The CCS 2018–2023 provides a framework for the partnership between the World Health Organization (WHO) and the Ministry of Health and other partners, to effectively work towards the goal of universal health coverage. The CCS strategic priorities are aligned with the Sustainable Development Goals, global and regional health priorities and, more importantly, complement the national policies and strategies.

His Excellency, the President and the Government of Sri Lanka firmly believe that investment in health is key to a productive nation and economic prosperity. It will be the driver for our vision of becoming a high-income country by 2030 and achieving the Sustainable Development Goals.

I acknowledge that the fourth CCS was the product of a series of consultations with multiple stakeholders in health, from the Ministry of Health and other related ministries, as well as other UN agencies, development partners, academia, the private sector and civil society. I am thankful to WHO officials at all levels, especially the Regional Director and WHO Country Representative and her team of dedicated professionals, for their unwavering commitment to supporting the health sector. Together, we can work towards a healthier and wealthier Sri Lanka.

A handwritten signature in black ink, appearing to read 'Rajitha Senarathne'.

Dr Rajitha Senarathne

Minister of Health, Nutrition and Indigenous Medicine

Message from the Regional Director



The fourth Country Cooperation Strategy (2018-2023) between the Government of Sri Lanka and World Health Organization comes at a time of demographic and epidemiologic transition within the health sector in the country. Successive governments in the past decades have prioritized health and education paid for by the state. This has paid rich dividends exemplified by the health sector success in the country making it a regional leader in ensuring health and well-being for its citizens and at modest investment. The country has had universal health care much before the global discourse on UHC.

While the gains in controlling and eliminating communicable diseases and ensuring health and survival of mothers, newborn and children continue, the country now faces new and emerging challenges posed by non-communicable diseases that now account for almost three quarters of mortality and morbidity. The island nation is also equally, if not more vulnerable to the adverse health impacts of climate change and environmental degradation. As the economy grows, so does disparity. Despite 'free' healthcare, out of pocket spending is on the rise.

To address the emerging health challenges, the Primary Health Care is undergoing a review and reorganization to ensure universal health coverage and it is opportune to have the new CCS framework to guide WHO strategic support to ensure UHC.

The current CCS has been developed following extensive consultations with key stakeholders across sectors and has been informed by contextual analysis and evidence. It follows the evolution of the WHO-CCS and has prioritization and focus on deliverables and outcomes.

The four strategic priorities of the CCS underpin WHO comparative advantage and address national priorities. The strategic priorities compliment the national health sector plan. I am glad to note that the CCS is guided by the Sustainable Development Agenda, is aligned to the UN Sustainable Development Framework for Sri Lanka and builds on the priorities identified in the Thirteenth General Programme of Work. The strategic priorities and focus areas are linked to the WHO SEA Regional flagships. I am confident that the inclusive approach for the development will continue through implementation and facilitate multi-sectoral cooperation that is key to achieving the sustainable development goals on health.

WHO continues to have a mutually beneficial and fruitful partnership with the Government of Sri Lanka to ensure attainment of highest possible standards of health

and well-being for all people in the country. We are privileged to be part of the journey as the country endeavors to sustain its extraordinary achievements in public health and overcome the emerging challenges.

A handwritten signature in black ink, appearing to read 'P. Khetrpal'.

Dr Poonam Khetrpal Singh
Regional Director
WHO South-East Asia Region

Preface

Since 1952, the World Health Organization (WHO) and the Government of Sri Lanka have been working together to improve the health and well-being of all Sri Lankans.

The Fourth Country Cooperation Strategy (CCS) outlines the medium-term strategic vision and provides a framework for collaboration on health between Sri Lanka and WHO over the next six years, 2018–2023. This CCS is the result of a year-long consultative process to identify strategic priorities and focus areas to optimize WHO’s comparative advantage and expertise in advancing health and well-being for all in Sri Lanka. The underlying principles include equity, respect for human rights, a people-centred approach, value for money and a results-driven approach. The CCS also aims to foster and further Sri Lanka’s contribution to global health through sharing of lessons learned and best practices in international forums.

The CCS 2018–2023 builds on the ongoing reorganization of primary health care in the country to address the epidemiological and demographic transition, and is the key strategy towards achieving universal health coverage and the health-related targets of the Sustainable Development Goals (SDGs). The four strategic priorities of the CCS are strengthening the health system through a supportive policy environment, tackling noncommunicable diseases and their determinants, promoting resilience in the face of health threats and adopting a knowledge-based approach to health policy development. The strategic priorities respond to the priorities identified within the national health policy and plans. They are also aligned with WHO’s Thirteenth General Programme of Work and WHO South-East Asia Region’s Flagship Priority Areas. The CCS is nested in the Sustainable Development Agenda and builds on the United Nations Sustainable Development Framework for Sri Lanka.

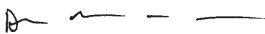
The CCS will serve as a tool for multisectoral engagement and integrated approaches to achieving the health-related SDGs.

On behalf of the Government of Sri Lanka and WHO, we express our gratitude to national counterparts within the Ministry of Health and other related ministries, academia, professional associations, civil society organizations, development partners and United Nations (UN) agencies for their contribution to the development of the CCS. We would also like to thank the WHO Regional Office for South-East Asia and WHO headquarters for providing valuable feedback. We also acknowledge the guidance and support provided by the technical advisory group.

We look forward to working together to implement the CCS, and improving health and well-being for all in Sri Lanka.



Mr Janaka Sugathadasa
Secretary, Ministry of Health,
Nutrition & Indigenous
Medicine



Dr Anil Jasinghe
Director-General of Health Services
Ministry of Health, Nutrition &
Indigenous Medicine



Dr Razia Pendse
WHO Country Representative
Sri Lanka

Acknowledgement

The Fourth Country Cooperation Strategy 2018–2023 (CCS) was developed in partnership and collaboration between the WHO and the Ministry of Health, Nutrition and Indigenous Medicine, Government of Sri Lanka with inputs from other related government ministries, professional organizations, academic institutions, civil society organizations, bilateral and multilateral partners and UN agencies. Thank you for your valuable contribution and support in developing this document.

We would like to acknowledge the facilitation and guidance of the Technical Advisory Group composed of Dr Palitha Abeykoon, Dr Susantha de Silva, Dr Amala de Silva and Dr Herbert Tennakoon. We are grateful to Dr Andrew Cassels who helped conceptualize the document and other technical experts and professionals who attended various consultations and provided inputs; all WCO Staff for their contributions; WHO SEARO and WHO HQ staff for their review and inputs towards finalization of the document.

The CCS 2018-2023 document was prepared under the overall guidance of WHO Representative to Sri Lanka, Secretary and Director General Health Services of the Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.

Abbreviations

ADB	Asian Development Bank
AMR	antimicrobial resistance
ANC	antenatal care
BMI	body mass index
CCM	country coordinating mechanism
CCS	Country Cooperation Strategy
CKDu	chronic kidney disease of unknown etiology
GBV	gender-based violence
GDP	gross domestic product
GPW	General Programme of Work
HIV	human immunodeficiency virus
HRH	human resources for health
ICT	information and communication technology
IHR	International Health Regulations
IMR	infant mortality rate
MDR-TB	multidrug-resistant tuberculosis
MDG	Millennium Development Goal
MMR	maternal mortality ratio
MoH	Ministry of Health, Nutrition and Indigenous Medicine
NCD	noncommunicable disease
PHC	primary health care
SDG	Sustainable Development Goal
STEPS	WHO STEPwise approach to surveillance
TB	tuberculosis
U5MR	under-5 mortality rate
UHC	universal health coverage
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WHO FCTC	WHO Framework Convention on Tobacco Control
OOPE	out-of-pocket expenditure
UNSDF	United Nations Sustainable Development Framework

Executive summary

Sri Lanka is a fast-growing economy and is now a lower-middle-income country. Health and education are the two strong pillars of the society, and free health and education have been prioritized and maintained by successive governments since Independence. The country achieved many of the Millennium Development Goals at the national level. All Sri Lankan citizens have access to free health care through a vast network of primary, secondary and tertiary health care facilities, and the country has thus implemented universal health coverage for a long time.

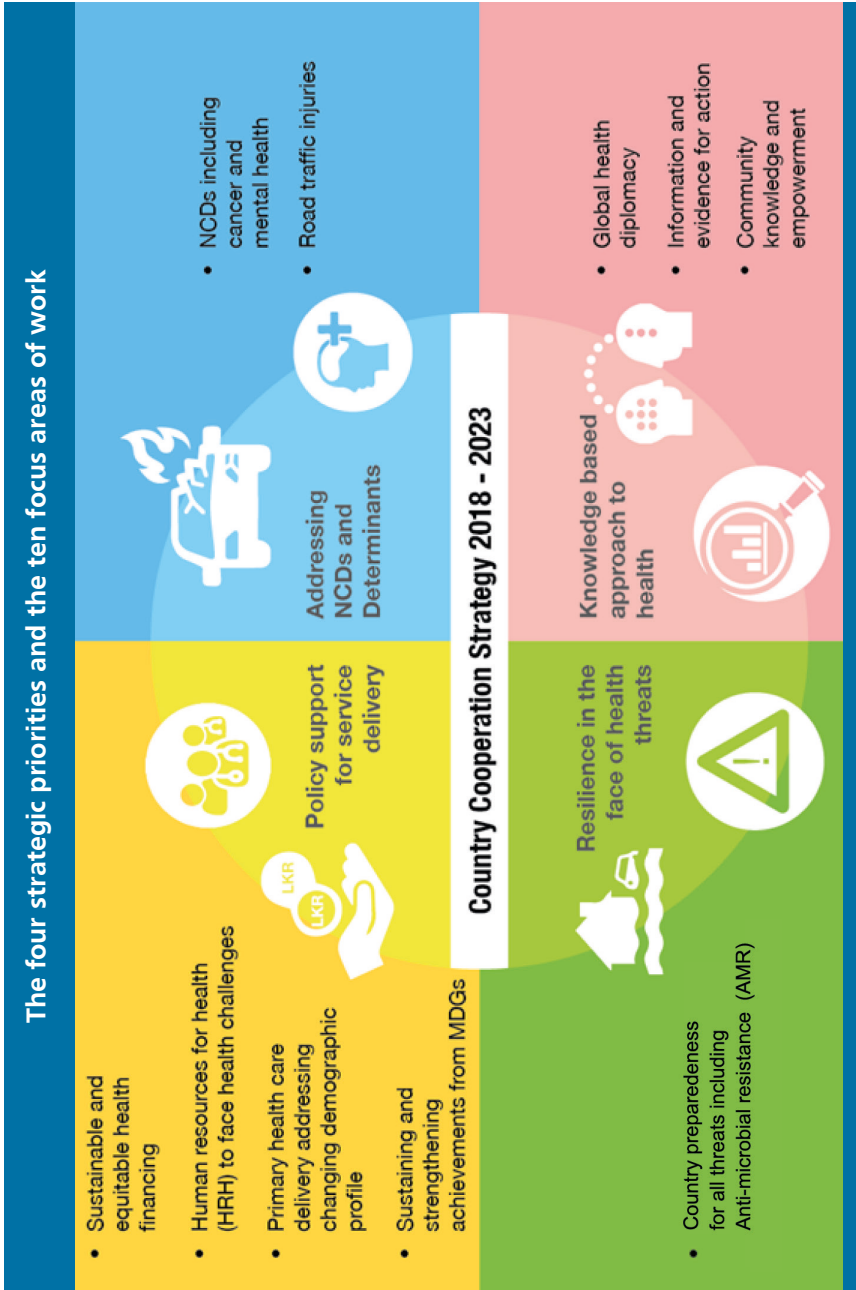
Systematic investments in health have resulted in the country's many health achievements, including very low maternal and neonatal mortality rates, elimination of many communicable diseases, most notable of them being malaria, and increased life expectancy. There are many best practices and lessons learnt that can help other countries. Sri Lanka has been a front runner in implementing global guidance and has been recognized globally for its efforts in advancing the health and well-being of its citizens.

Despite these achievements, challenges persist and newer ones are emerging. Noncommunicable disease rates are rising and the proportion of the elderly is increasing. Despite free health care, out-of-pocket spending is increasing. Mental health and road traffic accidents persist as significant health issues. Health systems that have delivered results until now need to be reviewed and reorganized to address the epidemiological and demographic challenges. The supply-driven systems need to be more people-centred with focus on prevention of diseases and health promotion, besides treatment. The island nation is equally, if not more, vulnerable to the adverse impacts of climate change. Disaster mitigation and response need to be further strengthened. To maximize the impact of evidence-based interventions and global best practices, local and contextual evidence supported by data is critical for delivering on the results and sustaining the gains.

The fourth Country Cooperation Strategy (CCS) 2018–2023 is WHO's mid-term strategic vision for the Organization's work with the Government of Sri Lanka and partners. The CCS 2018–2023 is informed by review and analysis of the evolving health and development context, and the epidemiological and demographic transition within the country. It builds upon the lessons learnt from implementation of the previous CCS. The four strategic priorities were arrived at following extensive stakeholder consultations over several months, and review of national, regional and global priorities. The strategic priorities respond to WHO's strategic advantage and value addition to further the health and development agenda in the country. The CCS is aligned to the Sustainable Development Goal (SDG) framework, United Nations Sustainable Development Framework for Sri Lanka, WHO's Thirteenth General Programme of Work, WHO South-East Asia Region's Flagship Priorities and National Health Master Plan for Sri Lanka.

The four strategic priorities for the CCS 2018–2023 are as follows:

- Policy support for service delivery
- Addressing noncommunicable diseases and their determinants
- Resilience in the face of health threats
- Knowledge-based approach to health.



Introduction

The Country Cooperation Strategy (CCS) is WHO's medium-term strategic vision for the Organization's work in, and with, a country. It responds to the country's specific priorities and institutional resources needed to achieve its national policies, strategies and plans, as well as the actions needed to achieve national targets of the Sustainable Development Goals (SDGs). WHO-supported initiatives to assist the Government of Sri Lanka chart the way forward on how to measure, implement and achieve SDG 3 and other health-related goals.

Through a consultative process, 42 out of 46 SDG core health indicators were identified and agreed upon in alignment with national health priorities. These priorities were considered in developing the strategic priorities for the CCS.

The development of the Country Cooperation Strategy (CCS) for 2018–2023 by the WHO country office for Sri Lanka and Ministry of Health, Nutrition and Indigenous Medicine (MoH), government of Sri Lanka was preceded by a review conducted on the previous CCS, which extended from 2012 to 2017. The present CCS built on the progress achieved and lessons learnt during implementation of the previous CCS. The Technical Advisory Group (TAG), which included MoH officials, external experts, WHO staff, international and national consultants, provided strategic guidance for the development of the new CCS.

The CCS 2018–2023 was conceptualized as a strategic framework to realize the health agenda of the SDGs by the year 2030, mainly SDG 3 “To ensure healthy lives and promote well-being for all at all ages” in Sri Lanka.

The strategic priorities were also guided by the United Nations Sustainable Development Framework (UNSDF) for Sri Lanka 2018–2022. The UNSDF is grounded in a human rights-based approach to programming, ensuring equal access to basic services, prevention of discrimination and increased citizen–State trust in development

cooperation, policy formulation and technical assistance. The identified strategic priorities for UNSDF 2018–2022 are the following:

- Driver 1: Towards improved data, knowledge management and evidence-based policy*
- Driver 2: Strengthened, innovative public institutions and engagement towards lasting peace*
- Driver 3: Human security and socioeconomic resilience*
- Driver 4: Enhancing resilience to climate change and disasters, and strengthening environmental management.*

Under the UNSDF, the UN system in Sri Lanka is committed to the “do as one” initiative: one programme, one common budgetary framework, one leadership – operating as one and communicating as one.¹

The CCS is also aligned with the high-level strategic vision of the Thirteenth General Programme of Work (13th GPW), as well as the WHO South-East Asia Region’s Flagship Priorities. The GPW 2018–2023 vision is rooted in Article 1 of WHO’s Constitution, “A world in which all people attain the highest possible level of health and well-being” and a mission to “Promote health, keep the world safe, serve the vulnerable”.

WHO’s contribution is based on its core functions, as shown in Fig. 1.

Figure 1: Core functions of WHO



¹ United Nations. United Nations Sustainable Development Framework 2018–2022. Colombo: United Nations System in Sri Lanka; 2017 (http://lk.one.un.org/wp-content/uploads/2017/08/Final_UNSDF_2018-2022.pdf, accessed 18 January 2018).

The series of consultations, meetings and focus group discussions with stakeholders across government and nongovernment agencies entailed a review of various national health policies, strategies and plans developed by the MoH, and other relevant documents such as, but not limited to, the following:

- *2016 Health SDG profile for Sri Lanka*
- *Population projection of Sri Lanka, 2001–2101: trends and implications*
- *National health policy, Sri Lanka, 2016–2025*
- *National health strategic master plans for Sri Lanka, 2016–2025*
- *Public investment programme for Sri Lanka, 2017–2020*
- *Sri Lanka national health accounts, 2013*

2

Health and development situation

2.1 Political, social and macroeconomic context

Sri Lanka is an island nation in the Indian Ocean with a population of 21.2 million² and a land mass of 65 610 km². Over the past century, the country has witnessed significant changes in its political, socioeconomic and health scenarios. Sri Lanka, then referred to as Ceylon, gained independence from the British in 1948 and has a parliamentary system of governance. The country successfully ended the three-decade long civil conflict in 2009.

It is a lower-middle-income country with a per capita gross domestic product (GDP) of US\$ 3835.³ Its economy grew markedly post-conflict at an average rate of 6.4% between 2010 and 2015. The GDP in 2016 was US\$ 81.32 billion. The improved economy limits overseas development assistance to the country.

Public expenditure on health from domestic sources as a percentage of total public expenditure was 7.9% in 2015. The current health expenditure is about 3% of the GDP,^{4,5} with a public:private proportionate contribution of 55:45. Per capita health expenditure was estimated to be US\$ 97.⁵

The government has a long-standing commitment to free health and free education. The Sri Lankan health system can be labelled as a high-impact, low-cost model, built on the foundation of free health care delivered through a network of public health-care facilities across the country. Literacy rates have risen from 56.4% in males and 21.2% in females (1921) to 94.1% for males and 91.4% for females (2012). Sri Lanka is placed 73rd globally on the Human Development Index (0.766).⁶

2 Sri Lanka Labour Force Survey 2015. Colombo: Department of Census and Statistics, Ministry of National Policies and Economic Affairs; 2016 (<http://www.statistics.gov.lk/page.asp?page=Labour%20Force>, accessed 19 January 2018).

3 Central Bank of Sri Lanka. Annual report 2016 (http://www.cbsl.gov.lk/pics_n_docs/10_pub/_docs/efr/annual_report/AR2016/English/content.htm, accessed 18 January 2018).

4 WHO Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2017 (<http://apps.who.int/nha/database>, accessed 18 January 2018).

5 Noncommunicable disease risk factor survey, 2015. Colombo: Ministry of Health; 2016 (http://www.searo.who.int/srilanka/areas/noncommunicable_diseases/steps-report-2015-sri-lanka.pdf?ua=1, accessed 18 January 2018).

6 Human development report 2015: work for human development. New York: United Nations Development Programme; 2015 (http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf, accessed 18 January 2018).

The country achieved the targets of the Millennium Development Goals (MDGs), especially those related to neonatal, infant, under-five and maternal mortality. The country statistics on housing, water supply and sanitation are also noteworthy. The government is committed to accelerating the achievement of the SDGs through the Sri Lanka Sustainable Development Act, No. 19 of 2017.⁷

The country is highly vulnerable to climate change, ranking 54th on the Climate Risk Index.⁸ The adverse effect of climate change has implications for the socioeconomic situation of the country, and impacts public health, nutrition and infrastructure development, among other areas.

The Government of Sri Lanka is committed to attaining peace through reconciliation, accountability, transitional justice and development.⁹

2.2 Health status and system challenges

Sri Lanka has impressive health indicators. However, more remains to be done for it to be at par with developed countries.

Many health-related challenges remain and newer ones are emerging. The ageing population, increasing burden of noncommunicable diseases (NCDs), emerging infectious diseases, high rates of mental health illness including suicide, increasing road traffic accidents, stagnating maternal, neonatal and child mortality rates, effects of climate change and the need for stronger regulation on food and pharmaceuticals are some of the critical health-care challenges that the country faces.

While health services are provided free at the point of care in all public facilities, the out-of-pocket expenditure (OOPE) is relatively high, at 40% of the total health expenditure. The national health indicators have masked the disparities and inequities among the urban, rural and estate sectors. Engagement of the private sector in health is limited, and there is scope for more effective and synergistic partnerships. There is also an active market for health professionals with both inward and outward migration, which has implications for the availability and quality of human resources for health.

7 Sri Lanka Sustainable Development Act, No. 19 of 2017. Colombo: Parliament of the Democratic Socialist Republic of Sri Lanka; 2017 (http://srilankalaw.lk/gazette/2017_pdf/19-2017_E.pdf, accessed 18 January 2018).

8 Kreft S, Eckstein D, Melchior I. Global climate risk index 2017. Germanwatch e.V, Bonn: Germanwatch e.V; 2016 (<https://germanwatch.org/en/download/16411.pdf>, accessed 18 January 2018).

9 Sri Lanka peace-building priority plan – concept note. Colombo: United Nations and Government of Sri Lanka; 2016 (<http://lk.one.un.org/wp-content/uploads/2017/01/SCRM-and-PBF-Sec-Concept-Note-16-Jan-2017.pdf>, accessed 18 January 2018).

Table 1: Selected health indicators for Sri Lanka compared to middle and high income countries

	Sri Lanka	Maldives	Thailand	Malaysia	Australia	Sweden	United Kingdom
Infant mortality rate (per 1000 live births) – 2015 *	8.4	7.4	11.0	6.0	3.0	2.4	3.5
Maternal mortality ratio (per 100 000 population) – 2015 *	30	68	20	40	6	4	9
Neonatal mortality rate (per 1000 live births) – 2015 *	5.4	4.9	6.7	3.9	2.2	1.6	2.4
Under-5 mortality rate – 2015 *	9.8	8.6	12.3	7.0	3.8	3.0	4.2
Life expectancy (at birth) – 2015 *	74.9	78.5	74.9	75.0	82.8	82.4	81.2
Per capita health expenditure (US\$) – 2014 **	127	1165	228	456	6031	6808	3 935
Total health expenditure as % of GDP – 2014 **	3.5	13.7	4.1	4.2	9.4	11.9	9.1
OOPE as % of total health expenditure – 2014 **	42.1	18.3	11.9	35.3	18.8	14.1	9.7

Sources: * WHO Global Health Observatory Data Repository 2015

** Global Health Expenditure Database 2014

Health status

Health of women, children and adolescents

Over the past 90 years, Sri Lanka has made significant gains in reducing infant, neonatal, under-five and maternal mortality, but these indicators are now stagnant. Access to health care has improved, but there is a need to focus on equity and quality to shift the needle on these indicators. Review and reorganization of programmes and service delivery are needed, based on lessons learned and global best practices.

Congenital malformations account for a third of infant deaths.¹⁰ Prematurity, sepsis and asphyxia are other important causes of perinatal deaths. Survival rates for very small and extremely small babies have increased; however, further reductions in perinatal and neonatal mortality can be achieved only through greater investments in improving prenatal diagnosis, counselling and treatment, as well as strengthening

10 Annual health bulletin 2015. Colombo: Medical Statistics Unit, Ministry of Health, Nutrition and Indigenous Medicine; 2015 (http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/AHB/2017/AHB%202015.pdf, accessed 18 January 2018).

neonatal intensive care. While the survival of infants with very low and extremely low birth weights has improved, there is little information on the long-term quality of life of these survivors.

The MMR declined from 92 deaths per 100 000 live births in 1990 to 33.7 in 2015.¹¹ The institutional delivery rate is high and antenatal care is almost universal.¹² However, progress in maternal mortality has stalled; a phenomenon reported from over 70 countries.¹³ In Sri Lanka, this may be attributed to regional disparities in access to care and the shifting causes of maternal deaths from obstetric complications to medical diseases that complicate pregnancy.¹⁴

Malnutrition remains a concern, particularly chronic undernutrition among children; 25% of children under 5 years of age are underweight.¹² Despite improvements in addressing nutritional problems such as anaemia and iodine deficiency, the persistence of undernutrition, wasting and stunting remains a public health issue that has shown slow improvement, especially among the most vulnerable. At the same time, obesity among children, adolescents and the youth is on the rise, warranting focus on healthy diet and physical activity.

A quarter of the Sri Lankan population is currently between 10 and 24 years of age. Risk behaviours in this group render them vulnerable to premature death due to accidents, suicide, violence, pregnancy-related complications and other illnesses that are either preventable or treatable. Nine per cent of adolescents are current tobacco users (4% are cigarette smokers) and 3% current marijuana users.¹⁵ Unhealthy habits such as tobacco and alcohol use, poor dietary practices and lack of exercise result in illness or premature death in adult life. However, adolescents and the youth have not been identified as a target group by the health sector; inclusion of these would yield dividends not only in health but in social and economic capital as well.

Gender-based violence (GBV) is recognized as a problem across cultural, geographical, religious, social and economic boundaries in Sri Lanka.¹⁶ Based on the increasing incidence of reported GBV and intimate partner violence in the past, many initiatives have been undertaken by the government, WHO and other UN agencies to strengthen health sector response to GBV.¹⁷

11 United Nations Development Programme. Sri Lanka Millennium Development Goals country report 2014. Colombo: United Nations Sri Lanka; 2015 (<http://www.lk.undp.org/content/srilanka/en/home/library/mdg/sri-lanka-millennium-development-goals-country-report-2014.html>, accessed 18 January 2018).

12 Sri Lanka Demographic and Health Survey 2016. Colombo: Department of Census and Statistics, Ministry of Health, Nutrition and Indigenous Medicine; 2017 (<http://www.statistics.gov.lk/page.asp?page=Health>, accessed 18 January 2018).

13 Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1, accessed 18 January 2018).

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

15 Global School-based Student Health Survey Sri Lanka: 2016 fact sheet. Colombo: Ministry of Health; 2017 (Global School Health Survey 2016. Colombo, accessed 19 January 2018).

16 Health sector response to gender-based violence: an assessment of the Asia Pacific Region. Bangkok, Thailand: United Nations Population Fund; 2010 (<http://asiapacific.unfpa.org/sites/default/files/pub-pdf/Assessment.pdf>, accessed 19 January 2018).

17 Guruge S, Jayasuriya-Illesinghe V, Gunawardena N, Perera J. Intimate partner violence in Sri Lanka: a scoping review. Ceylon Med J. 2015;60:133–8.

Unfinished MDG health agenda on TB/HIV/AIDS

In addition to addressing the MDG unfinished agenda on neonatal, child and maternal health, Sri Lanka needs to also focus on TB and HIV/AIDS. The HIV prevalence in Sri Lanka is low, at <0.1%, and is concentrated among key populations and in specific geographical regions.

The prevalence of TB has remained stagnant over the past decade and continues to be endemic in several areas. The estimated incidence is 65 per 100 000 population. The number of patients presenting with multidrug-resistant (MDR)-TB has increased over the years, which is a cause for concern.¹⁰

Burden from noncommunicable diseases

The disease burden has shifted from communicable to noncommunicable causes and NCDs are now the leading cause of death in the country. In 2015, MoH conducted the WHO Stepwise approach to surveillance (STEPS) survey with over 5000 adults aged 18–69 years. The study found that NCDs such as heart disease, lung disease, diabetes and cancer are a major public health concern in Sri Lanka, causing 75% of total deaths each year. Currently, Sri Lanka also has a rapidly ageing population. According to the Census of 2012, the percentage of the elderly was 12.2%² and is expected to rise to 18.6% by 2031, which will add 1.5 million people to the cohort above 60 years of age.¹⁸

Key findings of the STEPS survey 2015

- 7.4% of the population has elevated blood glucose.
- 21% of the population has high blood pressure.
- 34% of adult females and 25% of adult males were found to be overweight and obese.
- 29.4% of adult males smoked tobacco.
- 35% of adult males used alcohol.

Rapid urbanization and the shift from an agriculture-based to a service-sector economy lends itself to unhealthy food choices, increased stress and sedentary lifestyle. The population consumption of sugar, salt, fats and unhealthy foods has increased, commensurate with the increasing rates of obesity, high cholesterol levels and increase in body mass index (BMI).

¹⁸ De Silva WL. A population projection for Sri Lanka for the new millenium 2001–2101: trends and implications. Colombo: Institute of Health Policy; 2007 (<http://www.ihp.lk/publications/publication.html?id=706>, accessed 19 January 2018).

Chronic kidney disease of unknown etiology (CKDu) is a serious public health problem in Sri Lanka. CKDu appears to disproportionately affect poor, rural, male farmers in hot climates. Despite more than 20 years of study in Sri Lanka and globally, the problem of CKDu is not well understood.

Ageing and disability

Currently, around 80% of the elderly are cared for by their immediate family members. Decreasing family size and increasing migration, mainly for economic reasons, complicates care of the elderly, and is expected to increase in the future. The country's health-care system lacks the organization and the desired skill mix to cater to the ever-increasing needs of the elderly and those with special needs. Specialized services such as palliative care are needed for geriatric patients.

Mental health issues

Mental health is an issue of public health concern in Sri Lanka. Data on mental health are available only for adolescents. Nine per cent of adolescents have had suicidal ideation, of whom 7% ended up attempting suicide. Lack of reliable data on mental health hinders efforts towards programme design, systematic interventions for service delivery and resource allocation.. The current community-based mental health-care approach facilitates identification of mental health needs; however, social stigma continues to be a strong barrier to reaching everyone in need.

Injuries and road safety

Trauma was the leading cause of hospitalization through the years from 2006 to 2015, with 943 297 cases being admitted to State medical facilities in 2015. Decades of civil conflict, increasing urbanization, increasing motorization, poor road safety, and high incidence of alcohol use and related violence have contributed to increase in trauma cases. The MoH initiated trauma surveillance in selected hospitals in 2015 to plan preventive, promotive and control measures.¹⁰ Sri Lanka is one of the first countries to launch the “Framework of action for the decade of road safety” in line with the UN guidelines. A Parliamentary select committee has been established to look into the alarming increase in road traffic injuries/accidents. A national action plan on road safety has been developed.

Climate change and health sector resilience

The severity and frequency of floods, landslides and drought have increased with climate change. Over the past six years, many disasters have occurred – the 2014 Koslanda landslide; 2014/2015 floods; the 2016 as well as 2017 floods and landslides were some of the worst incidents affecting thousands of people.

The International Health Regulations (IHR) (2005) detail a set of critical core capacities that a country should strengthen in order to prevent, detect and respond to a range of public health threats that today's globalized world is facing. Following the Joint External Evaluation of IHR core capacities in 2017, two of the priority areas for action in the coming years are to further strengthen capacity to ensure global public health security and multisectoral engagement using the One Health Approach.¹⁹ It is important to develop national action plans for health security that can integrate all aspects of health service planning within the One Health Approach.

Health of the working population

Of the total labour workforce of 15.4 million, the economically active population is 8.3 million (53.8%). Seventy-five per cent of men and 36% of women are in the current labour force – agricultural sector 27.1%, industry 26.4% and the service sector 46.5%. The public health sector employs around 1.5 million people and has a formal system of medical examination for recruitment. It also has a contributory social health insurance scheme “Agrahara”. Social health insurance either does not exist or is limited to the private and informal agricultural sector where health-care seeking is largely from public health facilities. This limited employee health-care system restricts information on events and conditions leading to chronic diseases and disability, as well as premature deaths among productive sections of the population.

Migrant health

The Sri Lankan economy benefits greatly from remittances through labour migrants. Foreign employment revenues rank among the top three for the country. The majority of labour migrants are in the unskilled and semiskilled categories.²⁰ A range of health and social issues such as HIV, sexually transmitted infections (STIs), drug use, sexual violence, teenage pregnancy, disrupted families, alcohol-related problems, childhood malnutrition, violence, suicide, school absenteeism and poor educational performance have been documented among migrants and their families.

Health system challenges

Health-care financing

The country's health system is considered as a high-impact, low-cost model that provides all its citizens with moderate-quality health services free at the point of service delivery. However, there is an inherent inequity in coverage and financial protection for the

19 Joint external evaluation of IHR core capacities of the Democratic Socialist Republic of Sri Lanka: mission report. 19–23 June 2017. Geneva: WHO; 2017 (<http://apps.who.int/iris/handle/10665/259266>, accessed 20 January 2018).

20 Siriwardhana C, Wickramage K, Jayaweera K, Adikari A, Weerawarna S, Van Bortel T et al. Impact of economic labour migration: a qualitative exploration of left-behind family member perspectives in Sri Lanka. *J Immigr Minor Health*. 2015;17(3):885–94.

essential package of services. About 95% of inpatient care and 45% of outpatient care is delivered by public facilities; the remaining is delivered by the private sector.

Sri Lankan households spent around 40% out of pocket for health in the past 15 years despite the free health-care policy in public facilities. Based on a secondary analysis of Household Income and Expenditure Survey (HIES) 2012–2013, 6.2% of households had spent more than 10% of their total expenditure on health, while 1.1% had reported spending in excess of 25% of their total expenditure on health. The bulk of OOPe on health is for fees to private medical practitioners (36%), purchase of medical and pharmaceutical items (24%), and payments to private hospitals and nursing homes (22%).

Primary health care reform/reorganization

Nearly 95% of inpatient health care services are provided by public sector hospitals. Analysis of service utilization patterns show that tertiary-care facilities are overutilized while divisional-level hospitals remain underutilized. A national survey conducted by the MoH in 2013 revealed that approximately 94.5% of deliveries had taken place in hospitals with specialists (base hospitals and above) while only 5.5% of deliveries had taken place in divisional-level hospitals.²¹ Suboptimal utilization of these primary-care facilities adversely affects optimal resource use and results in higher OOPe by the patients.²² Reorganization of primary health care (PHC) is linked not only to improving the quality of care, but also to increasing access to health care and reducing catastrophic health-care expenses that result in impoverishment.

Food, medical products and pharmaceutical regulation

Death due to cancer is now the second leading cause of death, up from fourth place a decade ago.¹⁰ Food additives and preservatives are identified as risk factors for certain cancers. The Food Act of 1980 and its subsequent amendments govern the regulatory framework for food items in the country.²³ Measures to decrease the salt, sugar, trans-fat and energy content of foods are also needed to address food safety and NCD risks.

The State Pharmaceutical Manufacturing Cooperation produces only a limited amount of needed medicines and medical products. Quality assurance processes and systems for medicines and products, as well as Good Manufacturing Practices need to be strengthened. The National Medicines Regulatory Authority (NMRA) is responsible for ensuring that pharmaceuticals and medical devices available to the public meet

21 Emergency obstetric and neonatal care needs assessment: provincial report, 2012, Colombo: Ministry of Health, Nutrition and Indigenous Medicine; 2014.

22 Perera S. Chapter 10: Primary health care reforms in Sri Lanka: aiming at preserving universal access to health. In: Medcalf A, Bhattacharya S, Momen H, Saavedra M, Jones M, editors. Health for all: the journey of universal health coverage. Hyderabad: Orient Blackswan; 2015.

23 Food Act No. 26 of 1980 (Sri Lanka) ([http://203.94.76.60/FOODWEB/files/regulations/draft/food_\(import_inspection\)_regulations.pdf](http://203.94.76.60/FOODWEB/files/regulations/draft/food_(import_inspection)_regulations.pdf), accessed 19 January 2018).

the required standards of quality and are within the existing legislative framework on production, marketing and sale of these items.

Human resources for health

Almost all the human resources for health (HRH) in Sri Lanka are produced within the country. The nine medical faculties are responsible for the production of medical, dental and selected paramedical categories, while the MoH training facilities produce most of the other human resources (pharmacists, laboratory technicians, ECG technicians, midwives, public health inspectors, etc.). There is poor coordination in planning, production, placement and retention of HRH. Retaining human resources in rural areas continues to be a challenge in many parts of the country. A well-structured, quality assured, continuous medical education system is found wanting for all staff categories. Career development pathways are limited.

Some recommendations from Health Labour Market Analysis of Sri Lanka (MoH, 2017)

- Undertake a study to identify staffing needs based on the workloads of different institutions (WISN) to develop norms, facilitate planning for human resources for health and making rational projections for these.
- Develop a health workforce policy for Sri Lanka and a strategic health workforce action plan for the period 2019–2030.
- Improve the accreditation mechanism for private (and public) educational institutions to ensure high-quality training across private and State institutions.
- Undertake a survey for motivation and productivity of health workers.
- Improve the health workforce information system through the implementation of the National Health Workforce Accounts modules.

While the country may pride itself on the vast network of community-based family care workers, retooling and reskilling of frontline health functionaries is needed to address the NCD epidemic that the country is facing. Specific human resource skills such as care of the elderly, palliative care and rehabilitation care need to be expanded and strengthened.

Information management

Obtaining reliable and timely information from the hospitals remains a challenge. Information recorded in the indoor morbidity and mortality register is the main source of statistics for the country. This information is based on the diagnosis made and documented on the relevant bed-head tickets, and its validity and accuracy have been

challenged. This information does not include information from the private sector, which accounts for more than 50% of the total outpatient care in the country.¹⁰ There is a need to embed information mechanisms for performance within routine systems. This can support effective linkage between measurement and improvement.

Despite efforts by the MoH to increase the number of research studies by providing financial incentives to medical officers, few high-quality studies are conducted by the medical fraternity in Sri Lanka and very few are published in indexed journals. Generation of research evidence in the local context and translation of these into policy and practice needs to be further expanded.

2.3 Health system response

Sustained political commitment by successive governments to the provision of free education and health services to the population, and the trust placed by the people in the medical system has seen the country emerge as a regional leader in health. The health-care delivery system consists of a network of State and private medical institutions. An expanding private sector operates in select urban settings complementing the State sector hospitals. The private sector caters to 5% of inpatient care and 55% of outpatient care. Ayurveda, Siddha, Unani and acupuncture systems of medicine are also used by some people for specific ailments.

The public sector preventive health-care system provides a comprehensive care package that includes maternal and child health services, immunization, maintenance of food and water hygiene, and prevention and control of communicable diseases through an islandwide network of 344 health units. The policy of free health care coupled with socioeconomic development has reduced Sri Lanka's mortality rates significantly. The private sector plays a key role in service delivery, particularly in outpatient and laboratory services.

Reorganization and revitalization of PHC is proposed by the MoH. This PHC system, based on geographically located clusters, is expected to increase health-care coverage for the population and will address the increasing NCD burden of the country. Priority will be given to targeted screening and care to the population under each cluster. This would minimize catastrophic health expenditure, especially in low- and middle-income groups.

Country achievements in health include the following:

- WHO certified Sri Lanka free of malaria, lymphatic filariasis, and maternal and neonatal tetanus in 2016.
- The country was among the first few in the world to ratify the WHO Framework Convention on Tobacco Control (FCTC) and has taken affirmative

action on tobacco taxation. It is one of the three countries chosen for the FCTC 2030 project, in recognition of the gains in national tobacco control policies.

- The National Authority on Tobacco and Alcohol was conferred the prestigious WHO “World No Tobacco Day Award” on 31 May 2017.
- In August 2016, Sri Lanka became the first country in the WHO South-East Asia Region to successfully introduce a “traffic light” labelling system to raise awareness about the sugar content of packaged beverages.
- In 2017, an excise duty of 50 cents per gram of sugar contained in beverages has been proposed in the budget of 2018.
- Sri Lanka has one of the lowest rates of maternal, neonatal and infant mortality in the Region.

Moving forward, the government aims to strengthen the public health system, improve its health management and monitoring and evaluation systems, and develop a national strategic approach to quality. Continuous and systemic improvement in the health system can drive all actions toward the goal of universal health coverage (UHC), which underlies Sustainable Development Goal 3 (SDG3) and other health-related goals. Stakeholders in health recognize the need to adapt to major societal, epidemiological and demographic changes to sustain the gains and to achieve the SDGs. This requires the health sector to “think outside the box”, strengthen strategic partnerships between the government and the private sector, including civil society, to ensure equitable and universal access to health care, so that no one is left behind. The SDGs and UHC framework, with their emphasis on quality, provide a unique opportunity for the health system to follow a holistic and integrated approach that is equitable, people centred and focused on the vulnerable.

2.4 Cross-cutting issues

Poverty and inequality

In Sri Lanka, 6.7% of the population is currently living under the national poverty line,²⁴ of which 86.5% are from rural areas.²⁵ Inequities persist, especially between provinces. The Gini Index varies between 0.3 and 0.4 depending on the province.²⁵ The Uva, Central and Sabaragamuwa provinces, which include many of the plantations, still suffer from high levels of poverty, hunger and malnutrition.²⁵

24 Poverty in Sri Lanka 2017. In: Asian Development Bank [website] (<https://www.adb.org/countries/sri-lanka/poverty>, accessed 20 January 2018).

25 Household income and expenditure survey 2012/13: Poverty Indicators. Colombo: Department of Census and Statistics; 2015 (http://www.statistics.gov.lk/HIES/HIES2012_13FinalReport.pdf, accessed 3 October 2017).

Gender equality

The Gender Inequality Index, an international tool that evaluates the level of gender inequality in a country, ranked Sri Lanka 87th in 2015.²⁶ Programmes aimed at social and economic issues such as poverty, often lack gender differentiation in their design. The gender gap is particularly high in the labour market as the women's unemployment rate is twice as high as that of men. Several efforts and law reforms have been implemented by the government to promote gender equality. A chapter on Women's Rights has been included in the National Action Plan for the Protection and Promotion of Human Rights (2017–2021) to address law reforms, women affected by war and employment of women, among other issues.²⁷ There will also be an independent commission for women, established through the Constitutional Council, which would enable women to lodge complaints directly to the commission. Other reforms currently being discussed include medical termination of pregnancies, marital rape and strengthening the implementation of the Prevention of Domestic Violence Act. Currently, women's participation in politics at 6% is very low; however, a 25% quota has been allocated for women in local government bodies.

Violence against women and gender-based violence

Sri Lanka has a lower rate of GBV compared to other countries of the Region. The Ministry of Women and Child Affairs has developed a National Action Plan for 2016–2020 with a multisectoral approach aimed at eliminating GBV in the country.²⁸ Since 2015, a manual and training on these issues have been made available to the police.²⁹ However, Sri Lanka still needs strong legislation against GBV. Indeed, rape is very difficult to prove in court due to a ruling of the Supreme Court claiming that a victim of rape has to show evidence of struggle and resistance. Marital rape is also not considered a crime unless judicial separation has been ordered.³⁰

Human rights

Since 2015, the Sri Lankan government has committed itself to several human rights issues that have been acknowledged by the Human Rights Council (HRC). In 2017, when designing the human rights action plan, a ban on discrimination against sexual

26 Human development report 2016: human development for everyone. New York: United National Development Programme; 2016 (<http://hdr.undp.org/en/2016-report>, accessed 3 October 2017).

27 National action plan for the protection and promotion of human rights 2017–2021. Colombo: Ministry of Foreign Affairs; 2017 (<http://www.mfa.gov.lk/index.php/en/home/national-action-plan-2017-2021>, accessed 22 January 2018).

28 Policy framework and national plan of action to address sexual and gender-based violence in Sri Lanka 2016–2020. Colombo: Ministry of Women and Child Affairs, UNDP; 2016 (<http://www.lk.undp.org/content/srilanka/en/home/library/poverty/Policy-Framework-and-National-Plan-of-Action-to-address-SGBV-in-SriLanka.html>, accessed 20 January 2018).

29 Manual on Sexual and gender-based violence presented to Sri Lanka police. In: United Nations Sri Lanka [website] – Media Center. April 2015 (<https://lk.one.un.org/news/manual-on-sexual-and-gender-based-violence-presented-to-sri-lanka-police/>, accessed 1 October 2017).

30 Prevention of Domestic Violence Act (No. 34 of 2005). In: Sri Lanka Consolidated Acts [website] (http://www.commonlii.org/lk/legis/num_act/podva34o2005371/, accessed 200 January 2018).

orientation was added.³¹ Furthermore, Sri Lanka accepted investigations and began a reconciliation process to heal the wounds of tribal or ethnic divisions, civil war and violence that occurred in the past. In 2016, the HRC approved the National Action Plan for the Protection and Promotion of Human Rights for 2017–2021, in collaboration with the UN and the Inter-ministerial Committee on Human Rights. It also supported the establishment of a constitutional council, the creation of an office of missing persons and other reforms.

2.5 WHO's engagement with development partners in Sri Lanka

- Development partners such as the World Bank, Asian Development Bank (ADB) and Japan International Cooperation Agency (JICA) engage and coordinate with WHO for technical support on health policy and planning in the sector, for example, on the NCD Prevention Project (NPP) of JICA and the World Bank Health Sector Development Project (HSDP).
- As a member of the Oversight Committee and as a representative of international/bilateral partners in the Country Coordinating Mechanism (CCM), WHO continues to provide technical assistance for effective implementation of activities funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria in Sri Lanka.
- Sri Lanka has been designated by WHO as a fast-track country for NCDs to receive “One-WHO”-integrated technical support at the global, regional and national levels. This is a joint UN initiative.
- The Country Office received support for implementing activities in response to floods and landslides (May 2017 till date) and dengue control (July 2017 till date) from the South-East Asia Regional Health Emergency Fund (SEARHEF), United States Agency for International Development (USAID), United Nations Central Emergency Response Fund (CERF) and Department of Foreign Affairs and Trade, Australia (DFAT).
- There are 23 UN agencies, including WHO, that work closely with the Government of Sri Lanka, guided by the United Nations Sustainable Development Framework agreed upon jointly by the UN and the Government.

31 Report of the Office of the United Nations High Commissioner for Human Rights on Sri Lanka. Human Rights Council, 34th session, 27 February–24 March 2017. Agenda item 2 (<http://www.ohchr.org/EN/Countries/AsiaRegion/Pages/LKIndex.aspx>, accessed 20 January 2018).

2.6 Sri Lanka's role in global health

Sri Lanka has emerged as a leader in health. It has shared many lessons and experiences in international and regional conferences and meetings, as well as hosted many study visits for other countries. An example is the role that Sri Lanka played in the triangular cooperation on the 5S-Kaizen-TQM approach for quality between Japan and countries in the African Region. This could be further built upon for 2018–23.

The country is a member of the WHO Executive Board (EB) from 2017 until 2020. As an EB member, Sri Lanka has the opportunity to advocate for health issues of national and regional importance. Further strengthening the skills and capacity of officials on global health diplomacy will facilitate the proactive engagement of the country in international forums.

3

The Sustainable Development Goals and their implications for Sri Lanka

All Member States of the United Nations have agreed to the Sustainable Development Agenda of 2030. The SDGs are a set of 17 goals and 169 associated targets to be reached by the year 2030, and include a range of economic, social and environmental objectives that promise a more peaceful and inclusive society. The SDGs have set an ambitious vision to end poverty and improve health, education, food security and nutrition, among others. An integrated approach, with interconnectedness across the goals, has been put forward to achieve these targets.

Figure 2: Health in the SDG era³²



32 Infographics on Sustainable Development Goals (SDGs). In: World Health Organization [website] (<http://www.who.int/sdgs/infographics/en/>, accessed 20 February 2018).

Of the 17 SDGs, one specific goal focuses on health. Health is a cross-cutting and interrelated aspect of all the other goals, as highlighted in Fig. 2. Achieving SDG3 will depend on the progress in other SDGs – poverty reduction, education, nutrition, gender equality, clean water and sanitation, sustainable energy and safer cities. Thus, ensuring the well-being and health of the population, especially the vulnerable, requires a holistic approach with intersectoral coordination and collaboration.

The Government of Sri Lanka intends to design, develop and implement a strategic framework on sustainable development that will facilitate interagency cooperation to deliver and monitor the progress towards national SDG targets. A responsible council will also be established to guide and monitor implementation of the strategy. The Sri Lanka Sustainable Development Act No. 19 of 2017 was passed to ensure the development and implementation of a national strategy and policy for sustainable development in the country.³³

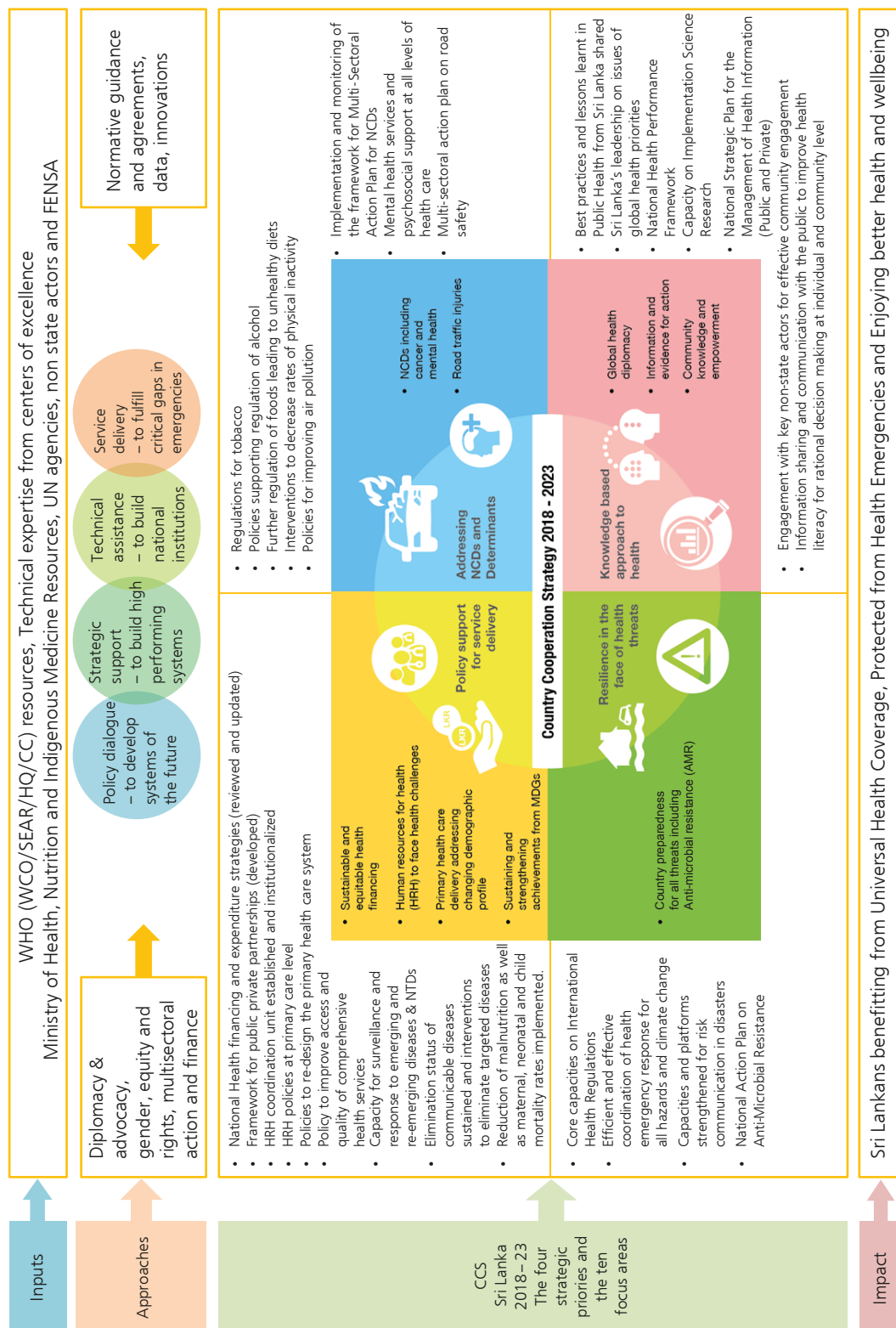
With the need for an integrated approach across the SDG goals, the health sector needs to review and rethink its health service delivery model for an integrated people-centred continuum of care. Sri Lanka is well positioned to redesign its service delivery model to ensure a resilient and strengthened health system anchored in the PHC approach. Policy reforms will be analysed using the systems approach, as all essential components of the health system are interconnected. Health services need to adapt and reorganize to manage and support acute problems and, at the same time, ensure continuity of quality care for chronic conditions and preparedness for health emergencies.

The SDGs emphasize the impact that other sectors can have on health and thus allow a platform to engage with non-health sectors. While many multisectoral action plans have been developed, effective implementation is a challenge. There is a need to build coalitions and effective partnerships that promote responsibility and accountability for health outcomes. The “health-in-all-policies” approach paves the way for addressing the social determinants of health and other cross-cutting issues.

At the heart of UHC is equity, with a focus on the vulnerable, ensuring that no one is left behind. Sociocultural and geographical differences exist in health-care service delivery, access, utilization as well as health outcomes. Addressing the equity determinants will require information processes that allow demographic data to be disaggregated. Sri Lanka has reviewed and finalized the health-related SDG indicators for the country, assessed the baseline and identified data sources. A monitoring matrix with SDG targets and indicators, including equity stratifiers, has been developed. Monitoring will be supported by a pool of officials trained in the use of the Health Equity Analysis Tool.

³³ Sri Lanka Sustainable Development Act of 2017 (<http://srilankalaw.lk/Alphabetical-List-of-Statutes/sri-lanka-sustainable-development-act.html>, accessed 19 February 2018).

Figure 3: Theory of change



Strategic priorities for the WHO–Sri Lanka Country Cooperation Strategy

The development of strategic priorities for Sri Lanka–WHO cooperation 2018–2023 was a year-long consultative process with health and non-health partners. It is nested in the SDGs and aligned with the Thirteenth General Programme of Work (GPW), 2019–2023.

The following strategic priorities were identified based on national priorities, WHO’s comparative advantage and available resources.

Strategic priority 1. Policy support for service delivery

Strategic priority 2. Addressing NCDs and determinants

Strategic priority 3. Resilience in the face of health threats

Strategic priority 4. Knowledge-based approach to health

Strategic priority 1. Policy support for service delivery

This strategic priority aims to maximize WHO’s technical expertise in a wide range of health domains reflected in the SDGs, and its capacity to provide evidence-based guidance to the government on health system issues. WHO is also committed to supporting the national strategy for quality improvement, which seeks to secure national commitment to quality and support the drive towards institutionalizing it for overall improved health outcomes and demand for quality services. This Strategic priority will focus on the following areas:

(1) Sustainable and equitable health financing

The primary focus of policy support is to develop a financing system that ensures financial risk protection in health and equitable allocation of resources for the population. Financial barriers should not prevent people from using the services they need, and health-care costs should not drive

people into poverty or have them suffer catastrophic spending. WHO will provide the technical expertise to review the health-care financing situation of the country, and assist the country in developing options for a sustainable and equitable financing system. It will also identify ways to increase domestic investment in health and attain efficiency gains in resource use. The expected outcome is financial protection for the population; especially the poor and vulnerable.

(2) Human resources for health to successfully face the health challenges

Strengthening health workforce policies and strategies to meet the needs of the population is a key step in providing effective access to health services. Retooling and reskilling of frontline health functionaries is needed to address current and emerging health-care needs such as the unfinished MDG agenda, rising burden of NCDs and age-related health issues. The expected outcomes would be to develop a team of frontline health workers with specialized skills such as elderly care, palliative care and rehabilitation. Community health workers with the right skill mix are also needed to deliver the proposed changes in the PHC delivery system to address NCDs.

(3) PHC delivery to effectively address changing demographic and epidemiological transition

The Government of Sri Lanka commits to achieving UHC by reorganizing the PHC delivery system of the country. There is a need for a responsive, people-centred PHC model that effectively addresses the current and emerging health sector needs with referral linkages to higher levels of care. Currently, the MoH is exploring various models to reorganize the service delivery mechanism and strengthen the various building blocks of the health system, particularly at the local level. It is anticipated that the proposed model will increase the health-care coverage of the population, and ensure an integrated and comprehensive continuum-of-care package delivered close to where people live with referral linkages for higher-level care.

(4) Sustaining and strengthening achievements from the MDGs

Among the MDG-related issues that need strengthened policy support in Sri Lanka are stagnating maternal, newborn and infant mortality rates; improved health and social care services for elders; adolescent health issues; services to address gender-based and intimate partner violence; interventions to reduce the incidence of TB and the emergence of MDR-TB, among others. Addressing policy and programme needs will ensure equitable coverage and access to quality services for all in need.

Deliverables for Strategic priority 1

- National health financing and expenditure strategies reviewed and updated
- Framework for public–private partnerships developed
- HRH coordination unit established and institutionalized within the MoH, and HRH policies to support PHC reorganization developed
- Policies to organize the PHC system for integrated, people-centred health-care delivery developed and implemented
- Policy to improve access to and quality of comprehensive health services implemented, including standards and regulations of pharmaceuticals and medical devices
- Capacity strengthened for surveillance and response to emerging and re-emerging diseases and neglected tropical diseases
- Status of eliminated communicable diseases (malaria, filariasis and neonatal tetanus) sustained and interventions to eliminate targeted diseases accelerated
- Interventions implemented for further reduction of malnutrition and improvement of maternal, newborn, child and adolescent health.

Strategic priority 2. Addressing NCDs and their determinants

The disease burden in Sri Lanka has shifted from a communicable to a predominantly noncommunicable disease pattern, with NCDs as the leading cause of morbidity and mortality. This Strategic priority will focus on the following areas:

(1) NCDs, including cancer and mental health

The management of NCDs starts with modifying the risk factors for disease. These risk factors are dependent on individual and societal behaviours, which in turn are dependent on the wider social determinants of health. Thus, to effectively tackle these behaviours, intersectoral interventions need to be implemented. This was demonstrated by WHO's recent work with national partners to address these risk factors: health promotion was integrated into the national School Health Programme to address unhealthy habits in children; a comprehensive tax was proposed on sugar-sweetened beverages as well as health promotion regulations, such as restricting marketing to children and nutrition labelling; and taxes on tobacco increased by up to 80% (the largest increase in recent years). These collaborations and partnerships with other sectors generated information and data that

were used for advocacy among academics, civil society and policy-makers. This work highlighted the importance of political advocacy in driving policy change.

Building on these successes, future work in the field of NCDs will involve further policy development and refinement in managing these risk factors, as well as accelerated implementation and monitoring of progress. As Sri Lanka is one of the WHO fast-track countries for NCDs, it is eligible to receive “One WHO” integrated technical support for implementation of the NCD Multisectoral Action Plan at the global, regional and national levels. WHO has a comparative advantage in policy development as it is able to provide evidence-based, best practice guidance for policy decisions and feasible options for implementation. This is achieved through WHO’s multisectoral approach and consultative reach to partners and stakeholders responsible for the causes and effects of NCDs. The expected outcome is a collective awareness of the risk factors associated with NCDs among Sri Lanka’s population, which will then drive community-led approaches to minimize exposure to risk factors.

Reorganization of PHC is key to the prevention and treatment of NCDs. Healthy lifestyle clinics were established in 2011 for screening of NCDs and the WHO package of essential NCD interventions (PEN) contributed to the design. Since 2016, services have been expanded to provide screening for breast, oral and cervical cancers. As described in Strategic priority 1, increasing efforts will be made to expand the workforce in these PHC clinics to further strengthen NCD service delivery and continuously improve the quality of care.

The health sector in Sri Lanka is increasingly reporting a growing number of cases and referrals for mental health care. Work in this area will be cross-cutting in order to address the social stigma and the stressors that lead to exacerbation of mental health problems, such as job insecurity, poverty and gender inequalities. The capacity to manage mental health conditions at all levels of care will be critical in effectively and equitably reaching the target population.

(2) Road traffic injuries

Tackling road safety requires multipronged action. WHO will provide technical advice and support to national stakeholders for ensuring road safety through advocacy and increased awareness of the risk factors related to road traffic injuries. Lowering of the threshold for driving under the influence of alcohol is a priority. The outcomes expected are to lower

road traffic morbidity and mortality rates by strengthening road safety regulations.

Urgent action is needed to achieve the ambitious target adopted in the 2030 Agenda for Sustainable Development: *halving the global number of deaths and injuries from road traffic crashes by 2020*. To prevent accidents and save lives, all road users must act with civic responsibility. WHO will coordinate the efforts of all stakeholders and continue to provide technical support to national road safety initiatives in implementing the National Action Plan along with the MoH and other ministries.

Deliverables of Strategic priority 2

- Regulations for tobacco implemented
- Policies supporting regulation of alcohol introduced
- Regulations on salt, sugar and trans-fats implemented
- Interventions to increase physical activity supported
- Policies for addressing air pollution developed and implemented
- Framework for Multisectoral Action Plan for NCDs implemented and monitored
- Mental health services strengthened and psychosocial support at all levels of health care improved
- Multisectoral action plan developed to strengthen road safety.

Strategic priority 3. Resilience in the face of health threats

Climate change, increasing global travel and trade, rapid and unplanned urbanization, irrational use of antibiotics and many other factors are increasing the vulnerability of people to health threats across the world. Emergencies and disasters are becoming more frequent, repeated, intense and multiple, and Sri Lanka is no exception. In 2017 alone, Sri Lanka experienced drought, floods, and landslides, coupled with a serious dengue epidemic with the highest-ever reported number of cases in the country. The human and health costs following these incidents are huge and the health sector is expected to play a critical role in the response to minimize damage to human lives and safeguard the health and well-being of survivors. Preparedness is critical, and the core capacities as outlined in the IHR (2005) need further strengthening to ensure that Sri Lanka is fully equipped to prevent, detect and respond to public health threats of any kind. Evidence-based disaster risk reduction measures are the foundation for building resilience in the face of health threats.

Antimicrobial resistance (AMR) is an emerging global public health problem and a WHO regional and Country Office priority. Sri Lanka launched the multistakeholder National Strategic Plan (NSP) for combating AMR in 2017, in line with the Global Action Plan. Its implementation and monitoring are critical for achieving the expected results in the coming years.

Emergency preparedness and response is an Organizationwide priority for WHO, with the establishment of the WHO Health Emergencies Programme (WHE). With its global network, technical expertise and capability of mobilizing resources rapidly, the Programme, along with the Country Office, Sri Lanka, will fully support the government in building capacity to prevent, detect and respond to any public health threat.

Deliverables of Strategic priority 3

- Core capacities strengthened in IHR to prevent, detect and rapidly respond to public health emergencies of international concern, including outbreaks
- Efficient and effective coordination of the health emergency response to all hazards and climate change facilitated
- Capacities and platforms for risk communication in disasters strengthened
- National Action Plan on Antimicrobial Resistance implemented and monitored.

Strategic priority 4. Knowledge-based approach to health

A knowledge-based approach to health requires generation of knowledge and evidence that is contextual. It is important for sustainable scaling up of interventions and development of supportive policies for UHC.

Implementation science/operational research needs to be embedded within programme implementation plans for monitoring progress, making course corrections, and sharing successes and lessons learnt for wider dissemination within and beyond countries. Opportunities provided through innovative solutions and information technology will help the health sector in expanding the use of and maximizing the digital dividend for the betterment of health and development of populations.

There is an opportunity for development of information and communication technology (ICT)-enabled low-cost novel health delivery models for preventive and promotive community care, including self-care in a health- and technology-literate society such as Sri Lanka. ICT-based approaches will be key in reaching populations in resource-scarce and remote areas with needed health-care services. Furthermore, it will be important to make linkages between local experience/knowledge/evidence generation on quality of care from frontline workers and central level policy units. With its global presence, pool of internal and external technical expertise in all aspects of health, and

a direct agenda of evidence-based health-care delivery, WHO has the comparative advantage of supporting the government in the following areas:

(1) Global health diplomacy

“Health diplomacy is the chosen method of interaction between stakeholders engaged in public health and politics for the purpose of representation, cooperation, resolving disputes, improving health systems, and securing the right to health for vulnerable populations.”³⁴ It is a relatively new field that addresses the growing concern for multilateral cooperation on critical global health problems. Strong global health diplomacy enables developing nations such as Sri Lanka to influence major policy decisions affecting global public health.

Many of the lessons learnt from the Sri Lankan success story have already been documented. An evidence-based synthesis and dissemination of lessons learnt will benefit other countries in the Region and beyond. Sri Lanka has taken steps to implement best practices in controlling risk factors for NCDs such as increased taxation on tobacco and alcohol; fiscal analyses for taxation and demand reduction of sugar-sweetened beverages; and regulated health-care costs through capping prices of essential medicines. WHO’s comparative advantage in gathering and assessing evidence and knowledge management globally will help Sri Lanka in its endeavours to contribute to global knowledge and public health, as well as learn from other country experiences.

(2) Information and evidence for action

Knowledge and information generation for decision-making is another aspect that needs to be strengthened in the country. Lack of timely and reliable data on prevalence hinders efforts at systematic interventions for service provision and resource allocation. Sri Lanka has developed a national health sector performance framework for improving accountability within the health sector. A national policy and strategic plan are needed for health information management, which facilitates and encourages collection, analyses, use and dissemination of information in real time for effective policy and programme decisions as well as for obtaining feedback from relevant stakeholders.

While the CCS is informed by health equity and human rights principles, certain areas of policy analysis are more sensitive to gender and other stratifiers, such as emergency response, mental health, road traffic accidents, elderly care, and maternal and child health. There is also a

34 Lee K, Smith R. What is ‘global health diplomacy’? A conceptual review. *Global Health Governance*. 2011;5 (1).

need to develop a gender-sensitive monitoring and evaluation framework for UHC and the SDGs. A key aspect in this work will be advocacy and capacity-building on the systematic use of data disaggregated by age, sex, geographical location, ethnicity, income quintile, etc.

A multisectoral coordination and collaboration platform for generating evidence for policy and programming in the health sector is an imperative. Learning while doing through implementation /operational research for monitoring the utilization and impact of evidence-based interventions will help generate locally relevant evidence not only for national consumption but also for adding to global knowledge and learning. The country needs evidence on access to quality health services, financial risk protection, human resources for health, people's utilization and satisfaction with services.

(3) Community knowledge and empowerment

The Sri Lankan health-care system remains a “hospital- and illness”-based care model, where people with illness seek care from hospitals that deliver the care. Only 5% of the health budget is directed towards the preventive health services while 91% of the budget is channelled towards the curative sector and that too, mainly for specialized care facilities.³⁵ Despite high levels of health literacy among the population, there is a significant burden of hidden morbidities and health-care needs. Services for screening and early diagnosis of chronic conditions remain poorly utilized. This leads to late diagnosis and complications, with heavy human and financial costs to individuals and systems. Changing this mindset among people as well as policy-makers is important for achieving UHC.

An identified need is a system to deliver relevant and appropriate health information to create awareness not only of illness and wellness but also of service availability and access. Creating community knowledge is expected to shift this care model from the current provider-based “hospital and illness” model to people-oriented “community-empowered wellness” model, where individuals will be in charge of their own health and well-being. Empowered communities will be better engaged with the implementation and monitoring of health sector programmes, making them more focused, efficient and effective. Therefore, individuals, families, communities, civil society organizations and nongovernmental organizations will have a role to play in addressing the burden of communicable diseases such as dengue, TB and HIV, as well as for the prevention and management of NCDs and care of the elderly.

35 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 21 January 2018).

ICT tools will be used for transfer of knowledge to the masses. WHO will bring relevant and appropriate technical expertise, experience and technology from within and outside the Organization to ensure an effective interface between the health sector and communities.

Deliverables of Strategic priority 4

- Best practices and lessons learnt from Sri Lanka in public health documented, published and shared in regional and global forums
- Sri Lanka's leadership on issues of global health priority facilitated, e.g. migration and health, access to affordable medicines and products, tobacco and alcohol control, among others,
- National Health Performance Framework implemented
- Capacity strengthened on implementation/operational research for generating local evidence to inform policy, plans and practices
- The National Strategic Plan for the Management of Health Information (public and private), developed and guided by the need to strengthen gender, equity and human rights
- Key non-State actors engaged for effective community involvement, including patients' right to information on health-care services and costs
- Information-sharing and communication supported and strengthened with the public to improve health literacy for rational decision-making at individual and community levels.

A summary of the CCS strategic priorities and main focus areas are summarized below. These are aligned to the WHO GPW outcomes, SDG national targets, WHO Regional Office for South-East Asia Flagship Priority Programmes and Health Master Plan 2016–2025.

Table 2: Alignment of the Country Cooperation Strategy of Sri Lanka 2018–2023 with UN, WHO and Sri Lankan health priorities

CCS Strategic priority	CCS Focus area	Health Master Plan 2016–2025	WHO GPW Outcomes 2019–2023	Regional Flagship Priorities 2015–2020	SDGs 2030 / UNSDF drivers 2018–2022
1. Policy support for service delivery	Sustainable and equitable health financing	Thematic areas 5.1, 5.2, 5.3 and 5.4 on financing Health-care insurance (5.1) Financing issues in preventive sector (5.2)/curative sector (5.3) and rehabilitative sector (5.4)	<ul style="list-style-type: none"> Outcome 1: Strengthened health systems in support of universal health coverage without financial hardship, including equity of access based on gender, age, income and disability Outcome 10: Improved management of financial, human and administrative resources towards transparency, efficient use and effective delivery of results 	UHC with focus on HRH and essential medicines	SDG1, SDG 3, SDG 5, SDG 6, SDG 8, SDG 10, SDG 17 Driver 1: Towards improved data, knowledge management and evidence-based policy Driver 3: Human security and socioeconomic resilience
	Human resources for health to face health challenges	Thematic areas 4.2, 4.3, 4.4 and 4.5 Strengthening of middle-level management (4.2) HR in preventive sector (4.3)/curative sector (4.4)/rehabilitative sector (4.5)	<ul style="list-style-type: none"> Across all these areas 		

CCS Strategic priority	CCS Focus area	Health Master Plan 2016–2025	WHO GPW Outcomes 2019–2023	Regional Flagship Priorities 2015–2020	SDGs 2030 / UNSDF drivers 2018–2022
	Primary health care delivery that addresses changing demographic profile	Thematic areas 1.1 and 2.1 Changing burden of disease (1.2) Patient-centered care (2.1)	<ul style="list-style-type: none"> Outcome 1: Strengthened health systems in support of universal health coverage without financial hardship, including equity of access based on gender, age, income and disability Outcome 9: Strengthened leadership, governance, management and advocacy for health 		
	Sustaining and strengthening achievements from the MDGs	Thematic area of 1.1 Changing burden of disease	<ul style="list-style-type: none"> Outcome 5: Accelerated elimination and eradication of high-impact communicable diseases Outcome 6: Antimicrobial resistance decreased Outcome 3: Improved human capital across the life course 	Measles elimination and rubella control by 2020, accelerate efforts to end TB by 2030 Ending preventable maternal, newborn and child deaths with a focus on neonatal deaths	

CCS Strategic priority	CCS Focus area	Health Master Plan 2016–2025	WHO GPW Outcomes 2019–2023	Regional Flagship Priorities 2015–2020	SDGs 2030 / UNSDF drivers 2018–2022
2. Addressing NCDs and their determinants	NCDs, including cancer and mental health	Thematic area of 1.1 Changing burden of disease	<ul style="list-style-type: none"> Outcome 4: Noncommunicable diseases prevented, treated, managed, and their risk factors controlled, and mental health prioritized and improved 	Prevention of noncommunicable diseases through multisectoral policies and plans with a focus on “best buys”	SDG 1, SDG 3, SDG 5, SDG 8, SDG 10, SDG 11, SDG 12, SDG 13, SDG 17 Driver 2: Strengthened, innovative public institutions and engagement towards lasting peace Driver 3: Human security and socioeconomic resilience
3. Resilience in the face of health threats	Country preparedness to face all threats	Thematic area 1.1.7, 1.1.19 Increasing trend for natural disasters due to climate changes Increase of man-made disasters Quarantine (ensure the maximum security against the international spread of diseases, with the minimum interference with world	<ul style="list-style-type: none"> Outcome 2: Strengthened national, regional and global capacities for better protecting people from epidemics and other health emergencies and ensuring that populations affected by emergencies have rapid access to essential lifesaving health services, including health promotion and disease prevention 	Scaling up capacity development in emergency risk management in countries	SDG 1, SDG 2, SDG 3, SDG 5, SDG 6, SDG 8, SDG 10, SDG 11, SDG 12, SDG 13, SDG 17 Driver 4: Enhancing resilience to climate change and disasters, and strengthening environmental management.

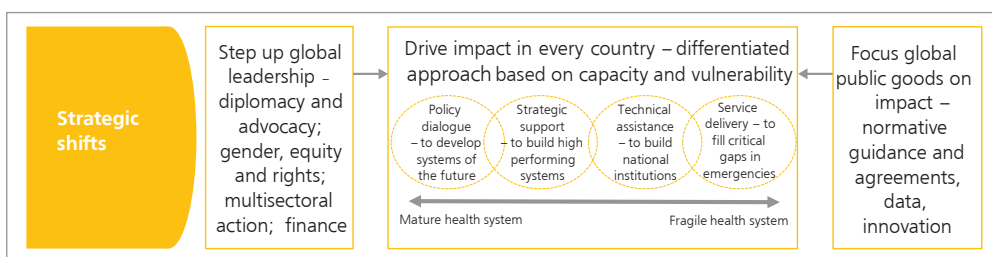
CCS Strategic priority	CCS Focus area	Health Master Plan 2016–2025	WHO GPW Outcomes 2019–2023	Regional Flagship Priorities 2015–2020	SDGs 2030 / UNSDF drivers 2018–2022
		To strengthen POE to prevent a possible entry of diseases concern with international spread in complying with IHR	<ul style="list-style-type: none"> Outcome 7: Health impacts of climate change, environmental risks and other determinants of health addressed, including in small island developing States and other vulnerable settings 	Building national capacity for preventing and combating antimicrobial resistance	Driver 3: Human security and socioeconomic resilience
4. Knowledge-based approach to health	Global health diplomacy		<ul style="list-style-type: none"> Outcome 8: Strengthened country capacity for data and innovation 	Ending preventable maternal, newborn and child deaths with a focus on neonatal deaths	SDG 3, SDG 5, SDG 8, SDG 10, SDG 17 Driver 1: Towards improved data, knowledge management and evidence-based policy
	Information and evidence for action	Cross-cutting across all thematic areas		Cross-cutting through all Priority Areas	
	Community knowledge and empowerment			Cross-cutting through all Priority Areas	

Implementing the strategic agenda

5.1 Means of delivery

The new WHO 13th GPW provides guidance on how WHO will deliver on the identified strategic priorities. The strategic shifts shown in Fig. 4 reflect WHO's core functions:

Figure 4: How WHO will contribute



Source: Draft Thirteenth General Programme of Work, WHO, 26 January 2018

5.2 Implications for the WHO Secretariat

The WHO Country Office will function as the link between the Member State and the WHO Regional Office and headquarters, and the wider global health community. The core staffing of the WHO Country Office is expected to consist of a critical number of experienced senior international staff with a broad skill mix, including technical, managerial, analytical and communication skills, working closely with the senior national professional officers. The responsibilities of the Country Office staff will be closely linked to the strategic priorities identified in the CCS. The WHO Representative will call upon the WHO Regional Office for South-East Asia, WHO headquarters and beyond for specific expertise as and when needed.

5.3 Performance management and evaluation

Monitoring and evaluation

The CCS is grounded in the SDGs, and evaluation of the CCS will include evaluation of SDG 3 and related SDGs. WHO will continuously monitor workplan implementation at the Country Office level jointly with the MoH and partners.

Timing

Progress will be monitored quarterly with mid-term evaluation for adjustment and course correction, and evaluation at the end of the biennium for both technical and financial implementation. Formal evaluation will be carried out at the end of the CCS cycle.

Evaluation methodology

- Regular monitoring

The CCS will be implemented through biennial workplans, which will include objectives, activities and deliverables in line with the CCS framework. The status of implementation will be jointly monitored by the WHO Country Office and the MoH. Regular monitoring meetings will assess how each strategic priority was implemented and what possible actions could be taken to optimize outputs and outcomes. Evaluation of the CCS will be done in conjunction with a careful examination of the Country Office's risk register; and the timing will coincide with a risk identification exercise.

- End of CCS evaluation

The end of the CCS cycle coincides with the mid-point of the SDG timeline. A final evaluation will be done to assess relevance, effectiveness, efficiency and impact, using standard methods. Health, mostly dealt with under SDG 3, will have its own set of indicators and a monitoring framework agreed upon by the Government of Sri Lanka. The monitoring framework defines the indicators as well as the level of stratification (age, sex, geographical subnational levels, sectors of residence and for selected indicators, disability status). Sources of information will include national surveys and specific surveys conducted by the Department of Census and Statistics, research studies undertaken by the MoH and partners, as well as routine data collected by the MoH.

Risk management

Contextual risks

There is a small risk of change in national priorities if a shift in the political leadership is witnessed in the forthcoming elections in 2020. The CCS was developed with inputs

from all possible stakeholders, and the final agreed upon strategic priorities and their focus areas were aligned with the Health Master Plan 2016–2025, SDGs, WHO Regional Flagship Priorities and WHO GPW priorities. Further, WHO will continue to work with the MoH on evidence-based global best practices that can be replicated and implemented in Sri Lanka. In planning for the CCS, WHO incorporated projections for foreseeable demographic and epidemiological changes, and will monitor contextual risks such as natural disasters, and changing political and socioeconomic scenarios with the purpose of instituting appropriate mitigation measures.

Programmatic risks

Sri Lanka is now a lower–middle-income country. This limits external funding. The government remains the major contributor to financing for health and does not rely on WHO for financial contribution. WHO is identified by the MoH as a provider of technical expertise of high quality with limited financial contribution. Efforts at resource mobilization by the Country Office will be leveraged through its partnerships with other UN agencies, international organizations and diplomatic missions, all working together for the cause of global good, peace and solidarity.

Institutional risks

The Country Office, jointly with the National Disaster Management Center, will monitor climatic and environmental changes at the national and subnational levels for early detection and warning of emergencies and disasters. In previous disaster and emergency situations, WHO obtained assistance to mitigate the situation from the United Nations Central Emergency Response Fund (CERF), South-East Asia Regional Health Emergency Fund (SEARHEF), United States Agency for International Development (USAID), UN Multi-Partner Trust Fund (MPTF) and Department of Foreign Affairs and Trade of Australia (DFAT).

Organizational risks

Uncertainty of fund flow and decreased funding allocation for Country Office operations in the face of rising costs may delay and constrain ability to support some of the planned activities. Planning and implementation should be carefully done to prioritize activities where WHO would have the technical advantage and avoid possible reputational risk resulting from not delivering what was planned.

Funding of the CCS

Funding is critical to the successful implementation of the CCS. The Strategy is the basis for the development of WHO biennium workplans. Thus, its funding is linked

with the biennium budget and additional resources from development partners and the government for the agreed areas of work.

In line with GPW 13, WHO Sri Lanka will strengthen its approach to resource mobilization for health, in collaboration with the government. Moreover, WHO will ensure a holistic value-for-money approach and foster an organizational culture driven by results and impact. Activities will be implemented in a manner that maximizes the health impact derived from every dollar spent. In doing so, WHO will consider economy, efficiency and effectiveness of interventions as well as equity and ethics.

WHO's partnership with UN agencies and other international organizations will be strengthened and leveraged for resource mobilization to ensure continuous and sustained implementation of strategic priorities under this CCS.

The Fourth Country Cooperation Strategy (CCS) outlines the medium-term strategic vision and provides a framework for collaboration on health between Sri Lanka and WHO over the next six years, 2018–2023.

This CCS is informed by review and analysis of the evolving health and development context, and the epidemiological and demographic transition within the country. It builds upon the lessons learnt from implementation of the previous CCS and is guided by the principles of equity, respect for human rights, value for money, people-centered care and results-driven approach.

The four strategic priorities respond to WHO's strategic advantage and value addition to further the health and development agenda in the country:

- Policy support for service delivery
- Addressing noncommunicable diseases and their determinants
- Resilience in the face of health threats
- Knowledge-based approach to health.

The WHO Country Office for Sri Lanka will use the CCS as a tool for multisectoral engagement and integrated approaches to achieve the health-related SDGs, and contribute to the health and well-being of the people in Sri Lanka.



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