

INTERSECTORAL ACTION FOR HEALTH THE SRI LANKAN CASE STUDY

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Summary

The purpose of this case study is to analyse the intersectoral synergic processes that contributed to the improvement of health in Sri Lanka and to draw lessons that would help to identify the scope for intersectoral action for health. The case study provides an overview of the intersectoral processes that produced the high health indicators during the period 1950 -1975 when Sri Lanka underwent a rapid health transition that prolonged life and reduced mortality and fertility. This transition is examined in relation to the improvement in other states of well-being which included education, housing, living conditions, livelihoods of the rural poor, and democratic political participation. The analysis demonstrates that the improvement in health occurred simultaneously with the improvement in other states of well being and this simultaneity of progress produced intersectoral links among them; these in turn created intersectoral synergies which were mutually supportive and advanced all the indicators together. The study argues that it is the policies that gave equal weight to all these social goals and the simultaneity of progress that enabled people to achieve and sustain the high health indicators that are recorded for this period.

Each sector simultaneously pursued its goals to improve the conditions for which it was responsible. The intersectoral processes did not lead to clearly articulated programmes of intersectoral action for health in which the sectors other than health identified their contribution to health and consciously coordinated their activities to produce a desired health outcome. Such intersectoral action could have improved on the outcomes. The study attributes this failure to the existing structures of decision making, the lack of capacity to identify intersectoral links and become proactive on them and the prevailing administrative culture.

The study selects two situations to demonstrate what happens in changed conditions. It analyses the health outcome which was higher than the national average in a programme of agricultural settlements where all the states of well-being coexisted from the inception of the settlement and where the intersectoral processes worked more effectively than in the rest of the country. The study contrasts this with the health situation in the plantation sector where the population of Indian origin suffered from relative exclusion from the national programmes. It follows this situation through changes in which the population is increasingly integrated into the mainstream processes. The study points to the lags and shortfalls in well-being - in health in particular - that occur in the early phase of exclusion resulting from the lack of simultaneous progress on all the indicators and shows how this situation is reversed when policy makers begin to act on all the critical states of deprivation simultaneously.

The concluding section of the study draws the lessons from the Sri Lankan experience and highlights the opportunities that were missed when the system did not develop the capacity to identify and act on the critical intersectoral links that would have improved the health outcome. The study concludes that a more intersectoral, community-based health strategy would be required to address the problems of regional inequality and malnutrition that persist as well as the new challenges of aging and non-communicable disease in a context in which poverty is relatively high.

Methodology .

The case study selects the period 1950 - 75 for analysis as it enables the study to focus on the health outcomes during the period when Sri Lanka underwent a rapid demographic transition and implemented a wide ranging social welfare programme covering health, education, improvement of living conditions and reduction of poverty within an orderly democratic system. The social outcomes during this period lends itself to more reliable and clearer analysis as they are not complicated by the developments that occurred after 1977 both in the economic as well as in the political sphere. The change of government in 1977 witnessed major economic reforms that moved the country in the direction of an open market economy. The ethnic conflict escalated, resulting in war which has continued up to the present day. Both have affected the implementation of the social welfare programmes.

The study uses five sets of indicators related to five conditions of well-being to track the simultaneity of progress made during the period 1950-1975. These are good health, educational attainment, living conditions, level of consumption and productivity and democratic political participation. What have been chosen are proven indicators that have been developed to evaluate progress and are being currently used in the relevant sectors. The data for the progress are shown for different points of time during the period and selected according to the year for which the most reliable data are available. Consequently the years for which the data are collected are not identical for all indicators and sets of data. The data, however, fall within a time span close enough to indicate the trend and the extent of progress. The study is based on the premise that what is needed for its purpose are the broadly indicative trends that establish that there has been substantial progress in each condition of well-being and that the progress has been of a simultaneous order.. What was needed for the purpose of the study was a methodology that would gather sufficient evidence to establish that there has been simultaneous progress on the main social indicators. This was adequate for the purpose of drawing the important policy conclusions relevant for the issues relating to intersectoral action in the study. It has not been the intention of the study to subject the data to more sophisticated statistical analysis in order to measure the progress made more precisely or to investigate the extent of the correlations among the different indicators and the progress made. This would have required the construction of more reliable and more comparable time series for each of the indicators. This could be done but would have taken much more time than was available for the study and gone beyond its intended scope to examine the more limited area of intersectoral action. A statistical analysis of the type indicated however could provide more quantitative information regarding the relationships between the different non-health variables and the health variable as they occurred during this time span and throw more light on critical relationships as they developed over time.

The methodology that has been used does not attempt prove that such simultaneous progress is essential in every situation. The study first goes on the normative premise that all the states of well-being signified by the five sets of indicators are “goods” in themselves and that they should therefore co-exist; none of them is merely the instrument to achieve some other good.. In a more positivistic sense the study attempts to demonstrate that simultaneous progress on the five sets of social indicators is beneficial for the state of well-being in health; it is at the same time beneficial for other states of well-being; they mutually reinforce and support each other. The methodology does not attempt to rank the states of well-being. The study makes the assumption that all states of well being need to co-exist to produce the best outcome for health and that in the best of situations there is no prioritizing or trade-offs among them. However in given situations one state of well being may require more attention than another but this should be only for the purpose of correcting lags and shortfalls and restoring the process on the path of simultaneity.

These assumptions are further tested empirically in two situations – one in a programme of agricultural settlements in which they coexist from the beginning and the other in the plantation sector where the population is excluded from participating in the process of simultaneous progress experienced in the rest of the country They are integrated subsequently into a programme which adopts the holistic

approach of dealing simultaneously with the main conditions of their deprivation- health, housing, water and sanitation, child care, knowledge and education. Here again in the two situations selected, the analysis is limited to the progress and trends as revealed in the data at different points of time.

For the gathering of the information the author has as far as possible taken the data from the original sources of data:

The Censuses 1946, 1953, 1963, 1971, 1981; the Household Income and Expenditure surveys of the Department of Census and Statistics (DCS)– 1969/70, 1990 and 2002; The Annual Statistical Abstracts of the DCS; Consumer Finance and Socio-Economic Surveys of the Central Bank (CB) 1953, 1963, 1973, 1978/79, 1981/8279, 2003/4; The Demographic and Health Surveys(DHS) 1986, 1993, and 2000 of the Ministry of Health and the DCS. The Administration Reports of the Directors of Health, Education and the Registrar General; ; Poverty Assessments 1994, and 2005 of the World Bank (WB) and The Poverty Reduction Strategy 2000 of the Government of Sri Lanka. The author also referred to a wide range of papers and studies by the Marga Institute and scholars. The main works are listed in the List of References.

1. Inter-sectoral Processes and the Improvement of Well-being .

1.1 The Health Transition

In the first two decades after independence, Sri Lanka underwent a transition in health which was unusual for a low income country at the early stages of socio economic development . Between 1950 and 1975 it added 11.5 years to average life expectancy raising it from 55.6 years to 67.1 years, reduced the crude birth rate from 39.7 to 27.8 and the death rate from 12.6 to 8.5. Infant mortality dropped from 82 to 45 and maternal mortality from 5.6 to 1.0 . Fertility declined from 5.0 in 1963 to 3.4 in 1974.

Table i Selected Health Indicators : Life Expectancy, Birth Rates, Mortality , Fertility

Indicator	1950	1955	1960	1965	1975
Life expectancy at Birth	55.6	58.2 (1953)	61.7 (1962)	63.9	67.1
Crude birth rate	39.7	37.3	36.6	33.1	27.8
Crude death rate	12.6	11.0	8.6	8.2	8.5
Infant mortality rate	82.3	72.4	57.0	53.2	45.1
Maternal mortality rate	5.6	4.1	3.0	2.4	1.0
Total Fertility Rate			5.0 (1963)		3.4 (1974)

Source : DCS: Censuses 1953, 1963,1971,1981

Snodgrass Ceylon An Export Economy in Transition 1965

Nadarajah: Trends and Differentials in Mortality - Population of Sri Lanka United nations 1976:

All students of the Sri Lankan experience are agreed that this remarkably rapid improvement in the health status of the population cannot be attributed to the efforts of the health sector alone. While the investments the country made in its public health system and the coverage of the health services were exceptional for a country at the level of Sri Lanka's resources, the improvement in health that took

place was integrally linked to improvements in other states of well-being. They were linked particularly to the rising levels of literacy and educational attainment, the improvement of living conditions which included housing water and sanitation, food security and livelihoods with adequate income. The health indicators advanced simultaneously with other indicators of well being. It is these links between health and other sectors that produced the synergies which improved health.

In the Sri Lankan study the intersectoral processes that led to health improvement were these synergies which resulted from social policies aimed at dealing with states of deprivation that were closely interlinked. The Sri Lankan success demonstrates the mutually reinforcing linkage between these different states of deprivation. Each major set of social policies and programmes had their specific goals which were pursued within the sector- whether it was education, health, food security or housing. What was special in the Sri Lankan case was that there was a high level of political commitment for each of the elements in the social welfare programme and the strategy was designed to mobilize human and material resources for each without neglecting any. It is the simultaneity of effort that produced the synergies that contributed to the rapid improvement in health as it did to the other conditions of well-being. Given this predominant character of the intersectoral processes that contributed to health, it is difficult to identify programmes that were consciously designed for the purpose of promoting intersectoral action for the specific objective of improving health. There were initiatives of an adhoc character where the health sector identified the specific inputs required from other sectors and sought their co-operation to deal with specific health problems such as the control of dengue or rabies. In these cases Municipalities, other agencies dealing with some of the hazards and causes associated with the diseases and the media for their role in raising public awareness are brought into the campaign. But these initiatives have not added up to a sustained intersectoral effort in the health strategy as a whole in which the social and economic determinants of health and the intersectoral links were identified, regularly acted upon, coordinated and monitored.

The purpose of the study is to analyse the intersectoral synergic process that contributed to the improvement of health in Sri Lanka and to draw lessons that would help to draw on the potential of intersectoral action for health and improve the strategies and mechanisms for such action. To do this the case study provides an overview of how these intersectoral processes worked to produce the high health indicators. Next it selects a situation within the overall system where the intersectoral processes received special attention- the land settlement programme and examines the outcome of these special conditions. In contrast to this the case study goes on to analyse a situation in which the population suffered from relative exclusion from the national intersectoral policies and programmes that produced the synergies for the improvement of health. It follows this situation through changes in which the population is increasingly integrated into the mainstream processes and evaluates the outcome. In the concluding section it examines some of main constraints to intersectoral action. It draws attention to a set of hard core problems in health that persist despite the success of the synergic process and explores the rationale of the intersectoral approach to deal with this hard core. Finally the study examines the need for intersectoral action to deal with the emerging challenges in the next stage of the health transition.

1.2 The Policy Environment

The multi-sectoral process of social development that is analysed in the study needs to be placed in its historical context and in the policy environment that had evolved at the time of independence and had been further strengthened thereafter. What follows is a brief overview.

The improvements shown in Table 1 have been the outcome of a process of development which combined a wide range of social and economic interventions. Most of the social welfare policies and programmes that are currently being implemented in Sri Lanka and are

in the process of undergoing modification and reform can be traced back to the period following the constitutional reforms of the early 1930's when the country was still under colonial rule. These policies were shaped by an ideology in which the state was expected to assume the major responsibility for the social and economic well-being of the citizens including the provision of education, health care, housing, and a well administered system of food security .¹ This ideology of development had grown over the 1930s and 1940s deriving its values from several both indigenous and Western approaches to society. The Buddhist concept of sharing and equity-oriented living was reinforced by the Fabian socialist values that coloured the British constitution makers who shaped the country's political future in the 1930s. Politicians referred frequently to Roosevelt's advocacy of the four freedoms stressing freedom from want and freedom from fear .The Marxist politicians championed social justice and the cause of the poor and oppressed The political manifestos that were produced by the main political group in the 1940s contain language which anticipates the basic needs strategy that emerged from the international discourse on development in the 1970s. One important manifesto of the time was that of the Ceylon National Congress outlined an agenda to eradicate hunger poverty illhealth and ignorance illiteracy and emphasised the need for the state to assume to provide health care, education food security and housing for all. The language of this agenda anticipated the basic needs strategy developed at the global level in the mid 1970s.

Universal adult franchise and the election of representatives on the basis of territorial constituencies under a competitive political system helped to articulate the demands at the community level and led to some measure of empowerment of the common people. As might be expected the demand for social services - schools, hospitals, maternity homes, central dispensaries - and common amenities such as roads and postal services figured prominently in the agenda of the local politicians whose record was usually judged by the success with which they procured these basic services for their constituencies. The elected representative became the intermediary between his constituency and the state which was acquiring many elements of a welfare state.

Both the main parties which held power after independence - the United National Party and the Sri Lanka Freedom Party - competed with each other in implementing the social policies that produced the outcomes that are analysed in the sections that follows . They showed equal commitment to its main elements . These included :

- Implementation of programmes for the expansion of free health and education services to cover the population as a whole ;
- The choice of priorities in health and education such as primary and secondary education, preventive health care and child and maternal health, all of which were able to raise literacy and life expectancy rapidly and at low cost;
- Allocation of resources adequate to finance free delivery of health care and education by the state
- The food subsidy and other safety nets to provide food security and alleviate poverty including supplementary feeding programmes for mothers and children;
- Programmes of agricultural settlements to relieve landlessness and poverty and promote import substitution in food.
- Programmes directed at improving the productivity and well-being of the large mass of the impoverished peasantry and fishing communities. This included the redistribution of state land to

¹ In granting universal adult franchise, the Commission "hoped that the constitutional changes will bring pressure on the legislature to give early and serious attention to providing facilities for primary and intermediate education for all the children of the island" *Report of the Special Commission on the Constitution* p 83 , 1928.

the rural poor, grants for improvement of fishing craft and assistance for housing domestic water supply and sanitation .

These policies and programmes which were the core of Sri Lanka's social development strategy were maintained virtually intact through numerous changes of government and shifts in economic policy. Up to 1977 , this social strategy was implemented within an economic policy regime which gave priority to import substitution and the role of the state in economic development. The economy was heavily regulated by the state and dominated by public sector enterprise. After 1977 the Government introduced wide ranging reforms; the economy was de-regulated and liberalized and the market and the private sector began to play the main role in economic development. Through all the structural adjustments that were made during these changes the government's commitment to the social welfare programme and its main components of free health, free education, food security and support to the small farmer was not weakened . Instead the policy makers moved to a new initiative for poverty reduction which was implemented in the Nineties.

After the manifesto of the Ceylon National Congress there are no similar national policy documents that make social development and social well being the focus of development. In the post independence period ,the main documents of national significance that were issued were of two types- the manifestos of the political parties issued at time of election and the series of national plans that governments issued from 1954 onwards. The manifestos were of some value as a frame of reference in policy formulation but since it contained unrealistic promises to the electorate much of what was contained in the manifestos became irrelevant . In regard to national planning Sri Lanka did not develop a sustained and consistent process of national planning as was done in India.. The two main plan documents which were prepared during the post –independence period were the Ten Year plan 1958-1967 and the Five Year Plan of 1971-1975. Although a great deal of professional effort went into the preparation of these plans they were not adopted as operational documents. Most of the national planning and policy documents that were produced in the post independence period focused mainly on economic development. The challenging problems for the policy makers in Sri Lanka were those pertaining to economic growth and employment creation. The achievements in the field of social development in response to the ongoing policies and programmes were quite exceptional. Therefore although the plan documents included the social sectors they did not emerge as central to the economic development effort. It is towards the end of the 1990s that we find attention being paid to the integration of social and economic development .At the end of the 1990s Sri Lanka was one of the developing countries which developed a strategy for the reduction of poverty integrating it with macro-economic policies aimed at rapid sustainable economic growth. The Mahinda Chintanaya , the development manifesto of the present government is an attempt to synthesise the social and economic policies that had evolved for achieving sustainable human development.

1.3 The Four Sets of Development Indicators

The mortality indicators that are shown in Table 1 were accompanied by similar progress in a number of other social and economic indicators. The discussion that follows analyses the social progress made in terms of the four sets of development indicators other than the health indicators in Table 1 and cover the main social economic and political constituents of well-being given below.

- Education
- Gender Equality
- Household Living Conditions- Housing Water and Sanitation
- Food Availability
- Household Consumption
- Socio-Political Participation

The study first attempts to demonstrate the simultaneity of progress made by an entire set of inter-related indicators and briefly assess their combined impact on the health of the population. Next, the study proceeds to analyse the mix of sectoral policies and programmes which produced the intersectoral synergies that contributed to the steady progress of the health indicators.

1.4 Educational Attainment and Gender

Table ii Educational Attainment and Gender – Related Indicators

Indicator	Unit	1950	1963	1975
Life Expectancy at Birth				
Male	Yrs	43.9 (1946)	63.0	65.3
Female	Yrs	41.6 (1946)	63.7	68.9
Literacy Level				
Male	%	75.9	79.3	91.1
Female	%	65.4	63.2	83.2
Total	%	53.4 (1953)	71.6	87.2(1981)
Proportion of the female population of reproductive age 15-19 with educational level.Grades-V - IX	%	28.2		50.9 (1971)
School Enrollment Rate			*	
Primary	%	95 (1960)	93 (1965)	93
Secondary	%	27 (1960)	35 (1965)	48
Total Fertility rate			5.0 (1963)	3.4

Sources: DCS Censuses 1946 1953, 1963 1981
DHS Surveys 1993, 2000
Administration reports Director of Education and School Censuses

When the increase in life expectancy shown in Table i is disaggregated by gender, we can recognize the far-reaching nature of the socio-economic and demographic changes that have taken place during the span of 25 years. The average life expectancy of females has overtaken that of males by approximately 3 years – a clear indicator of the improvement in the well-being of women and the changes in their social status signifying greater gender equality and the removal of forms of gender discrimination.

This is borne out in the indicators on literacy and school enrolment which had improved steadily for both males and females along with a rapid narrowing of the gaps between them. By 1975 the rate of enrolment in primary and secondary education was almost equal for both males and females. The data on the educational levels of women of reproductive age indicate the progressive increase in the level of education as women enter the child –bearing age during the period under review. The figures in the Table for the age group 15-19 based on the 1971 census data denote the progress as increasing numbers of each successive generation of females enter the school system. In 1950 only 28 % of the age cohort in the 15-19 age group had a secondary education. In 1971 the proportion had increased to 51%.

The policies which enabled the wide participation in the school system is briefly referred to in the next section. What is worthy of note at this point is that the system enabled the poor households in all parts of the country to send their children to state schools and keep a substantial proportion of them in school well beyond the primary stage . By the mid 1970s the country had almost reached the goal of universal primary education and almost half of those who entered the school system (48%) had entered the secondary level. Fertility declined , maternal mortality dropped , women were better able to control their reproductive life including the health risks of recurrent births without adequate

spacing.. The data confirm the close link between female education child health and reproductive health .

A longitudinal survey of pregnant women and their new born which included a sample of households adequately representative Sri Lanka's poorest rural areas was conducted by the Department of Census and Statistics and UNICEF in 1988. It provides some illuminating insights on the human capital that had been created as a result of the country's social welfare programme . The physical environment of the selected households – the quality of the housing , water supply and sanitation- was poor . The large majority of families lived in houses with mud walls, mud floors and palm thatched roofs. Slightly more than half had no toilets . More than 40% used unprotected water and 25% lived in abject poverty with periodic food shortages and lacking even basic consumable items such as rice, sugar and soap. Yet the rate of infant mortality, as revealed by the survey was 27.5 per thousand live births for the sample , a figure not significantly different from the rate reported for the entire region in 1986. In these deprived conditions female literacy was 83% and 24% of the women in the sample had some secondary education . 80% of the births had taken place in medical institutions and 88% had visited a clinic at least once, although the level of care and services received varied widely. Immunisation of children was quite high ... nearly 90%. More than two third of the women had basic knowledge of oral rehydration salts . Therefore, in this poverty-stricken environment, the availability of a basic health infrastructure, together with a literate generation of mothers with several years of formal education was producing an unusual capacity for survival. ²This is one exceptional example of the interaction of health and education on the survival capacity of a community . On the average the living conditions in other parts of the rural sector were better and programmes of housing water and sanitation were reaching out to them . As we would see later where the education and health combination was further supported by improvement in living conditions and reduction of poverty as in the agricultural settlements the progress was quicker and the level of human well-being was higher. Where the conditions of deprivation seen in the DCS/ UNICEF survey continued, a hard core of problems such as malnutrition persisted and prevented households from reaching beyond survival to higher levels of well-being including good health.

1.5 Living Conditions of Households- Housing, Water and Sanitation

The data on living conditions as manifested in the quality of housing, water and sanitation is available from the censuses of 1951, 1961 1971 and 1981. The data relating to the improvement in health indicators in Sri Lanka show that some of the health risks to which households were exposed such as diarrhoea and respiratory infections which were some of the commonest ailments that accounted for under five year morbidity and mortality were associated with substandard housing , particularly houses with mud floors mud walls and thatched roofs. The Marga Institute's study on seasonality and health has analysed these intersectoral links in detail for one District in Sri Lanka - Matale (see list of references).The structural classification of housing given in the censuses according to the building materials used and the quality of the structure – permanent semi-permanent or temporary according to the materials used - helps to track the improvements in living conditions of households that were critical for improvements in health.

As described more fully in the next section the government implemented policies and programme aimed at improving the quality of rural housing, water and sanitation . It encouraged and subsidized the construction of houses wells and toilets according to type plans. The data in the censuses provide useful information on the changes in the housing stock and provide data which throw light on how the incremental stock of housing improved in quality, particularly in the rural areas.

² Gunatilleke , G, Government Policies and Nutrition in Sri Lanka – Pew/ Cornell Lecture series , Cornell University Ithaca 1989.

**Table iii Changes in the National Housing Stock and the Rural Housing Stock
(All proportions in Percentages)**

	1971	1981	2003/04
National			
Permanent units in total stock	35.4	41.8	
Semi Permanent	57.3	51.8	
Temporary	7.3	8.4	
Rural			
Permanent	31.6	37.2	83.7
Semi permanent	61.0	56.1	
Temporary	7.4	6.5	
Tiled or asbestos roofs	37.9	41.7	91.5
Brick stone or cabook walls	34.6	39.5	83.7
Cement Floor	39.7	44.7	80.5
Domestic water supply – pipe borne water own well , common well		63.2	93.2
With toilets Flush, water seal, ,pit	48.5	67.9	94.4
No toilets	41.5	32.1	5.6
Owner occupied	76.9	79.5	89.2
Number of rooms	2.2	2.5	
Number of occupants	5.6	5.1	

*Sources - DCS Censuses 1971 1981
Central Bank Consumer Finance & Socio-Economic Survey 2003/2004
Housing In Sri Lanka – Marga Institute 1976
Housing Development in Sri Lanka 1971-1981 Marga Institute 1986*

The housing studies which have been done by the Marga Institute analyse construction during the period 1963 to 1971 and 1971 to 1981 showing how the new housing stock that catered for the growth of population and the increasing number of new households had a steadily growing proportion of permanent structures with roofs using tiles or asbestos sheets , bricks for walls and cement for floors. The proportion of toilets without houses and without access to safe source of domestic water supply also declined . The average living space in houses increased and the number of occupants declined. All of these contributed to a more healthy environment The mud floor could be probably the most critical variable related to health . This was a predominant feature of the housing units occupied by the Indian labour in the estate sector. Together with severe overcrowding this one feature contributed to the unsanitary conditions in the estate sector even though the walls and the roofs of these housing units were constructed with permanent materials. The importance of housing in the intersectoral processes contributing to health in both positive and negative form are seen more clearly in the situations described in the sections on the agricultural settlements and the plantation sector that follow.

Given the resource constraints on rural households the indicators relating to the quality of housing could not have advanced as rapidly as in health and education where the delivery of services was financed and undertaken by the state. Nevertheless the investments that went into new housing were substantial and the incremental structural improvements that took place in the existing stock, all of which are not fully captured in the census data were combining with the inputs from other sectors to raise the level of the living conditions of the poor households.

Two characteristics of the housing situation in Sri Lanka need to be emphasized. First a very high proportion of the occupants nearly 80% owned the housing units. Permanency of tenure and property rights motivated the house owner to invest in his house and improve its quality and imparted a sense of security and belonging. These factors together combined with the rural bias in the country's development strategy to avoid the disorderly processes of rural to urban migration as well as other forms of internal migration. Consequently Sri Lanka's problems of urban shanties with poor housing and other living conditions have been relatively manageable.

The growing importance that was assigned to the housing sector by the policy makers was gathering momentum during the period 1950 – 1975 and creating a popular awareness and consciousness of the house and its place in the total well-being of the household. Households began to realize the value of making investments on incremental improvements to their homes, whether it be a better toilet, a cement floor, a permanent roof or an additional room. It is the attention to housing given by policy makers and households that developed into the Million Housing Programme in the late 1970s and the 1980s. The last column of the table gives some of the latest indicators in the 2003/2004 Consumer Finance and Socio Economic Survey of the Central Bank. They indicate how the improvements in housing were accelerated in the last 20 years. However it has to be noted that the foundation for this process of acceleration was laid during the first few decades after independence even though the progress during that period was slower.

1.6 Food Availability, Productivity and Household Consumption

Another important set of variables that affected the capability of households to live a healthy life related to the availability of food and an adequate nutritional intake which in turn depended on the levels of household consumption that were supported by their livelihoods and other safety nets provided by the state. There are no reliable estimates of the extent and severity of poverty that prevailed in the period immediately preceding independence and the first two decades after independence. However some of the surveys conducted by government provide valuable information regarding the social and economic conditions of the rural population. In the late 1930s the government carried out a series of village studies that revealed that the large majority of the rural population lived in conditions which would fall into the category of absolute poverty. The studies defined poverty as a multi-dimensional phenomenon which contained states of deprivation of various types such as illiteracy, lack of access to proper health care, inadequate shelter, forms of social exclusion and discrimination and concluded that the strategy needed to bring the people out of their state of deprivation had to be multi-pronged and integrated.

This section examines the variables that relate to the hard economic core of poverty and how they behaved during the period following independence. The movement of the health indicators in Sri Lanka during this period would be highly sensitive to the improvement in the earning capacity and low levels of consumption of this poor majority. The Table below shows the movements of several relevant indicators.

Table iv Food Availability, Productivity and Household Consumption

		1950	1963	1975
Per Capita calorie intake		1944	2018	2127
Agricultural Growth Rate (from previous year)	%	8.1	8.7	0.9
Growth of output of paddy	Metric tons	459	1026	1447 (five year average)
Average Annual Rate of growth of paddy sector			6.2 (1950 – 1963)	4.5 (1963-1974)
Mean Per Capita Consumption per month at 1985 prices	Rs.	204	216	442 (1977)
Monthly Per capita consumption at Poverty level, in 1985 prices	Rs	242	242	242
Share of household Income				
Lowest decile	%	1.90 (1953)	1.50	2.61 (78/79)
Highest decile	%	40.60 (1953)	36.77	34.63 (78/79)
Income Decile in which poverty line is crossed.		Between 8 th and 9 th decile	Between 8 th and 9 th decile	Between 3 rd and 4 th decile
Growth of GDP in 1970 prices	%	2.5 (1955-1964)	3.5 (1965-1977)	
Growth of per capita income	%	00.0	1.6	
Rate of Unemployment	%	8.9	16.6 (1963)	19.7 (1975)

*Sources: DCS Food Balance Sheets 1950 -1975
 CB CF&SES 1953, 1963, 1973
 WB – Sri Lanka Poverty Assessment 1994, Sri Lanka Poverty Assessment 2007
 CB Annual Report, Special Statistical Appendix.
 T Savundranayagam- Estimates of Sri Lanka's Gross Domestic Product 1950- 1981*

The outcomes as revealed in the indicators are a mix of both positive and negative elements. On the positive side the overall situation regarding the food availability and the livelihoods of the poor as reflected in the trends in output and productivity of the paddy sector are favourable to the rural poor. The average calorie intake shows a slowly rising trend during this period and approximates to the norm in 1963 and 1975. In normal circumstances with an unequal income distribution an average per capita intake which is around the norm would have meant that the nutritional intake of the lower income groups would have been well below the norm. In the Sri Lankan context the state's responsibility for the administration of a subsidized food rationing scheme ensured a high degree of equity in the distribution of rice the staple food as well as other items of essential food. The average per capita intake has to be placed in a context where the distribution of food was relatively equitable with the state operating the supplies of rice and other essential items of food. The availability and the price of food played a dominant role in the democratic politics of the country. The food subsidy which was the equivalent of about 15% of the calorie intake also gave the poorest households the critical supplement needed to avoid conditions of severe undernutrition. Diseases of malnutrition such as kwashiorkor and marasmus were virtually eliminated early during this period.

The paddy sector accounted for the livelihoods and incomes of a large segment of the rural poor. The crop which absorbed the most amount of labour in the rural sector was paddy. The paddy sector was one of the fastest growing sectors of the economy, growing at 6.2% in the period 1950 to 1963 and 4.5 % during 1963-1974. Productivity had also risen steadily in this sector increasing from 30.85 bushels per acre in 1950 to 46.25 bushels per acre in 1974/5. The major share of the benefits from the increases in output and productivity would have gone to the small holding peasantry who cultivated this crop and marketed the surplus after retaining part for household consumption. Therefore the

prosperity of the paddy sector meant an adequate supply of food for poor households as well as an increase in their income. As will be seen in the discussion of the policies which propelled these changes, the development strategy was heavily biased towards the small holding peasantry. The progress of the paddy sector however was not always smooth and uninterrupted. Paddy which was heavily dependent on water was highly vulnerable to the weather and suffered from periodic crop failures causing severe hardships to the most vulnerable groups of farmers who were not served by major irrigation schemes.

The period under review also witnessed a significant reduction of poverty. The table puts together the indicators from the best estimates of consumption levels that have been made in recent studies. Fairly reliable estimates of private per capita consumption have been derived from the national income data. These indicate that private per capita consumption increased marginally between 1953 and 1963 and then more than doubled between 1963 and 1978. If we use the data on the income distribution of households given in the Central Bank surveys to determine how the average per capita consumption would have been distributed among households we are able to identify the broad trends in poverty reduction between 1950 and 1978. The proportion in absolute poverty in the early fifties would have been above 80% and would have declined marginally by 1963. It is in the period that follows that poverty is reduced substantially to a proportion between 30 and 40%. These estimates are subject to many qualifications as they mix income and consumption. First, total consumption has been generally higher than income and second, the distribution of consumption appears to have been generally less unequal than the distribution of income. Therefore a calculation based on the distribution of consumption may have produced lower proportions in poverty. However when all these qualifications have been made the declining trend and the substantial reduction of poverty during this period would remain. The World Bank in its analysis of poverty has this to say about the reduction of poverty in the period 1953 to 1985 in its Poverty Assessment (1994) : “ Since overall private consumption per capita in real terms increased by a factor of between 2.3 (using the GDP deflator) and 3.2 (using the CPI) deflator between 1953 and 1985, the per capita consumption in the lower deciles of the household consumption distribution in 1985 must have been two to three higher than the per capita consumption of households which were similarly positioned in the 1953 household consumption distribution. This in turn implies that there must have been a very significant decline in consumption poverty incidence in Sri Lanka between 1953 and 1985.”

The prevailing levels of food security, the improvement in living conditions and the decline in poverty combined to support and reinforce the capacity of households to access health and education and acquire these other elements of human capital. Nevertheless the proportion of absolute poverty that persisted at the end of the 1970s was still disproportionately high for a country with the high indicators in life expectancy, child survival and education. No reliable national level data is available for the nutritional status of the population for the period under review. Surveys of pre-school children in 1975/6 indicated a high level of chronic under-nutrition. The surveys carried out in the 1980s confirmed this finding and indicated that despite rapid reduction of infant and child mortality the levels of both child and adult malnutrition were unusually high. These negative features in the Sri Lankan health transition pointed to fundamental weaknesses and imbalances in the development strategy that was being pursued. The growth of the economy and per capita income was relatively slow for the entire period. The rate of unemployment rose to 19% in the mid 1970s. During the period 1956-63 there was hardly any growth of per capita income or per capita consumption. The weak performance of the economy and the slow growth of per capita consumption was reflected in the negative indicators of persistent poverty, unemployment and high under-nutrition. However what is worthy of note is that within this context a combination of social policies in health, education, housing and the livelihoods of the poor were able to promote and protect the human capital that produced the other high social indicators.

1.7 Socio-political Participation and Representative Institutions

The critically important underpinning of the process that has been described was a democratic political system and the representative institutions with broad based civic participation which from the outset evolved in a highly competitive form in Sri Lanka. There were crucial for the social achievements that have been presented in Tables 1 to 4. The institutional framework and the indicators relating to it given in the Table v below. The indicators relate to the fundamental components of democracy which functioned relatively well during the period under review.³

Table v: Some Indicators of Socio- Political Participation

Regularity of Elections	
Parliament	Held regularly in terms of the Constitution- 1956 , 1960, 1965, 1970
Local Government (4 tiers – municipal, urban, town , village)	Held regularly ; a few authorities dissolved for mismanagement and administered by a Special Commissioner for short periods
Freedom and Fairness	Generally free and fair during this period – post election violence was witnessed on a large scale for the first time in 1970
Democratic Changes of Parties in Government	1956, 1965, 1970.
Social Composition and turnover in elected organs of government	Representation of all social groups and considerable turnover and replacement of traditional elites as in 1956
Voter Participation	Turnout has been consistently high - over 70 %
Community-based organizations	Statutory bodies with citizen representation -,Rural development Societies , Cooperative Societies and Cultivation Committees
Good Governance	The implementation of the social programmes- health education food subsidy livelihoods for the poor were governed by a relatively high degree of transparency accountability non-discrimination and universality of coverage .

G.P.S.H.De Silva A Statistical Survey of Elections Sri Lanka 1911-1977 - Marga Institute 1979

Despite all its imperfections the system functioned in a manner that compelled the power holders to be constantly attentive to the needs of the people. The relationships that evolved between the rulers and the ruled were instrumental in creating what was almost a structure of rights and responsibilities. They placed well-defined obligations and responsibilities on the state for improving the well-being of the people. At the same time they generated expectations among the people concerning the state's responsibilities as the principal benefactor and provider of services . These benefits , particularly the food subsidy, free health care and free education soon assumed the character of entitlements. While most of these entitlements did not acquire the status of legally enforceable

³ There were however inherent shortcomings in the political processes which were manifested in the deterioration of inter –ethnic relations and the growth of youth violence. Without question, these developments had a strong and pervasive impact which affected all aspects of development including the social sectors. However these wider inter-relationships of the political and social-economic developments are not brought within the purview of the present study

rights, the political and administrative processes that governed them contained some of the elements of the rights-based approach to development. The administrative system which was developed by the British contained a plethora of rules and regulations which bureaucrats faithfully followed in their day to day administrative tasks. This provided a high degree of transparency and accountability which benefited the poor. For example in the delivery of rationed food or the distribution of land to the landless the beneficiaries had both the information and documentation which enabled them to claim their rights. The political and administrative processes were therefore able to develop some elements of the structures of rights and responsibilities as well as a system of accountability which became critically important for the social development strategy that was aiming at reducing vulnerability and empowering the vulnerable groups.⁴

The Table covers the institutions which can extend and deepen the democratic process to and hold the power. The institutional layer which promotes people's participation in development becomes the critical interface between the decision makers and power holders on the one hand and the subjects of decision making and the recipients of services on the other. They are the means by which the beneficiaries of the social policies can make the policy-makers accountable to them. At the time of independence Sri Lanka had several village level institutions which were elected and had a representative character. They provided a basis for the participation of rural communities in matters concerning their welfare and development. These included local government institutions which dealt with common amenities at the village level, rural development societies which undertook village works such as rural roads, co-operative societies which distributed the subsidized food ration and a certain range of essential goods. In 1950, Sri Lanka had 7 Municipal Councils 36 Urban Councils 36 Town Councils and 400 village Committees. In the mid 1950s the government established cultivation committees which enabled the farmers to co-operate in managing their cultivation activities, while protecting the rights of tenant farmers under the Paddy Lands Act. These four types of institutions covered a wide range of activities and had the potential to motivate and promote a systematic process of participation by rural communities in development activities and community affairs.

The co-operative societies were responsible for the distribution of the food ration and other essential goods, agricultural and marketing and credit. These functions were later combined in the multi-purpose co-operative societies which were established as a result of the reorganization of the co-operative movement after the new government took power in 1956. The scheme for the multi-purpose co-operative society was imaginatively designed to enable the co-operative society to become the key village level institution. The cooperative became the community's institution for the purchase of agricultural produce under the guaranteed price schemes, the distribution of the food ration, sale of essential items at controlled prices, provision of credit to farmers construction of village works and several other activities.

The rural development society evolved from the rural development centres that were established in the early 1940s. These centres were part of a special effort of the government to ameliorate the living conditions of poor rural communities. When the IBRD mission visited Sri Lanka it found more than 5000 such societies distributed in all parts of the country. Rural Development Societies undertook a variety of activities to which the rural community contributed their voluntary labour. In this way the rural development movement became a self help programme which included activities that ranged from the construction of roads wells, school buildings dispensaries and recreation facilities to organization of handicraft industries milk feeding centres formation of volunteer rural police patrols and conciliations boards for settlement of village disputes.. However the full potential of this institution was not realized. After the change of government in 1956 the programme declined in importance. This was partly due to the fact that the rural development movement was identified with the previous regime. The somewhat lukewarm support that the rural development societies received after 1956 illustrated the highly politicized environment in which public institutions had to work and thrive.

⁴ See Reflections on the Right to Development pages 155,156

The opportunity that the village- level institutions offered for developing a more community - based participatory system that would have promoted more self reliance at the community level was missed during the early phases of social development . The mix of democracy and social welfare that evolved encouraged an increasing state of dependence on the state. These trends were not conducive to strategies which required greater engagement and participation by communities in the improvement of their well-being. This aspect has relevance for the lack of intersectoral action at the community level. These issues are discussed when the constraints for intersectoral action are examined later in the paper.

2. Policy Links and Intersectoral Synergies

The foregoing discussion has surveyed how four sets of indicators - social , economic and political- moved forward concurrently to produce conditions of well-being that helped the population to achieve a health status which was relatively high for their level of income. The analysis tracks how over a period of 25 years people have moved out of their state of vulnerability that combined various states of deprivation in which existed in the early 1950s.

2.1 Inter-linked States of Vulnerability

In the conditions that were common to developing countries at Sri Lanka's income level , the concept of vulnerability of households draws attention to the inter-sectoral nature of the various states of deprivation . Vulnerability in relation to a household would normally denote a household with the following characteristics:

- inadequate food;
- lack of access to health care
- lack of access to educational facilities ;
- substandard housing ,
- lack of proper sanitation
- lack of access to a protected source of water
- a livelihood without an assurance of adequate income.
- Lack of participation in the processes of decision-making that will change their conditions

These conditions are closely interlinked, interacting on each other to worsen the condition of each. The health status of a household will suffer due to lack of access to health facilities ; poor water and sanitation will aggravate ill-health and in turn reduce productivity and income earning capacity ; illiteracy will reduce the capacity of a household for preventive health care and management of disease, the utilization of services available and the improvement of their livelihoods and the persistence of a low level of consumption with inadequate income will continue the cycle of deprivation.

The tables i-v and the discussion on each have examined how these conditions have changed over time for a substantial proportion of households in Sri Lanka during the period 1950 - 1975 and got transformed into a virtuous cycle. These outcomes were the product of the interactions that took place

between the processes which pushed each set of indicators forward and the synergies that resulted from such interaction. To what extent were these interaction the result of a conscious identification of the linkages and administrative efforts directed at acting on these linkages and exploiting their full potential? To what extent did it flow from the success of each set of policies – health, education, housing, poverty reduction - pursuing their objectives independently with the interactive processes occurring from the linkages that were inherent in these policies?

2.2 The Institutional Framework

During the period which witnessed the simultaneous progress of a wide range of social indicators the country was administered under a Parliamentary democracy with a Westminster-type Cabinet system. Under this system Ministers were assigned a clearly defined set of subjects and they gave the necessary policy directions to the government departments that came within their areas of responsibility, exercising overall supervisory authority over them. In all the Cabinets that were formed in the period 1950 to 1970 it is clear that governments gave a high status to the portfolios of health, education, land development, agriculture and food – the portfolios which were most concerned with the social goals of the government. These were generally assigned to the senior politicians. The Ministries of Health and Education were seldom combined with any other portfolio. Housing was combined with other related activities such as social services.

The Cabinet system ensured that all important policy decisions were taken collectively. Therefore the Cabinet was the forum in which inter-ministerial co-ordination took place. During this period the Cabinet did not establish any special inter-ministerial mechanisms such as Cabinet Committees to co-ordinate a group of inter-related Ministries. For example the Ministries that had major responsibilities for the implementation of the social welfare programme did not have any special mechanism outside Cabinet for intersectoral co-ordination and action to support the achievement of each other's goals. Where a Ministry in the course of implementing its own programme found that it had to obtain the services of another Ministry, the task allotted to such Ministry was clearly identified and assigned to it as in the case of the school health programme. This approach did not encourage a process in which there was a collective effort to identify the areas that needed inter-sectoral action. The lack of a consciously directed effort at intersectoral action did not generally result in situations where the actions of one Ministry seriously retarded the progress of another inter-related Ministry. This did not happen for the reason that all the relevant Ministries who were part of the larger social welfare programme shared an equally high political commitment to their goals.

From the outset policy makers recognised that the conditions of deprivation had to be dealt with simultaneously and designed programmes to attack all the major states of deprivation. The government had taken care to allocate the necessary human and financial resources for each programme and enable each programme to develop the capacity for effective delivery of services. The administrative infrastructures that were created island wide to provide universal coverage in health care, education and food distribution are outstanding examples. Health and education in particular had high priority in such a holistic approach and this is reflected in the way in which resources were allocated and the country wide infrastructure developed to reach the goal of health and education for all.

The programmes were linear in character flowing from the central government down to the village level. The chain of command extended from the centre to the small administrative unit administered by a divisional revenue officer. There was no devolution of power to a sub national unit which had the political authority to exercise a measure of self management. It was only in the 1980s that the government introduced a system of devolution by establishing the Provincial Councils. With the introduction of the Provincial Council System the delivery of health care has been devolved to the Provincial Councils.

2.3 Inter-sectoral Tools and Mechanisms

It can be argued that the country wide administrative apparatus that had grown could have produced a combined effort for sustained intersectoral action that would have accelerated social and economic development. The only inter-sectoral mechanism that functioned during this period was the District Coordinating Committee presided by the Government Agent the senior most administrative officer in the District. This Committee had representatives from all the government departments that were functioning in the District and included Health Education Agriculture Transport among others. This however became a large unwieldy body in which the local politicians participated. The Committee was used largely for the purpose of dealing with ad hoc problems and complaints including those brought by the politicians and provided no scope for sustained intersectoral co-ordination and action. Several efforts were made to establish mechanisms for inter-ministerial co-ordination for health at the national level such as the national Health Council in the 1980s. These too failed to achieve any purposive and sustained inter-ministerial co-ordination. The Ministry of Health itself did not have a clearly formulated agenda for intersectoral action. Consequently the energy of the national level bodies that were set up were dissipated in addressing ad hoc issues and problems as in the case of the District Coordinating Committee. The forms of intersectoral action that would have been possible based on the synergies that were being manifested in the simultaneous process of various social indicators would have required both different administrative and professional skills as well as a different administrative culture. These are discussed in the concluding section.

The Budgetary System and Allocation of Resources.

The national health care system managed by the state accounts for more than 75% of the health care of the population. The remaining 25% is handled by the private sector. In the recent past there has been a rapid expansion of the private sector, specially in the urban areas. The allocation of resources for health in the state sector came mainly from the central government budget. The Provincial Councils have as yet little capacity to raise revenues to finance their health services.

The national health care system has continued to receive an average of approximately 2% of GDP over the years with small fluctuations around this average. The financial allocations are made annually through an annual process of allocation through the government budget. The allocative process is controlled by the Ministry of Finance. These allocations go through the normal bargaining process which pays attention to prevailing patterns of expenditure and resists major deviations from that pattern. In the recent past the Ministry of Health has been more assertive and has been able to obtain some increases in its allocation. What is worthy of note however is that the allocation to the health sector did not suffer from any drastic cuts during the period of structural adjustment.

In the present system of budgetary allocation there has been no effort to recognize the cross cutting intersectoral nature of health and provide allocation for health related activities in other sectoral Ministries. Had there been an effective inter-sectoral programme in health, there could have been innovates modes of resource allocation that would have promoted intersectoral action.

4. The Special Case of the New Agricultural Settlements

The new agricultural settlements (generally referred to in Sri Lanka as colonisation schemes) that were established in the dry zone during the 1940s and 1950s present a special case where an intersectoral strategy implemented consciously from the outset produced outcomes that were better than the average. These settlements were part of a development strategy with several objectives. The settlements were designed to transfer poor landless peasants from the densely populated areas in the country to the sparsely populated dry zone and both relieve the increasing pressure of population on land as well as reduce poverty. The settlements were expected to spearhead the effort to achieve self sufficiency in rice - the staple food of the country. Import substitution in rice would also help to diversify and impart some measure of resilience to an economy which was heavily dependent on three primary commodities – tea,

rubber and coconut and very vulnerable to the price fluctuations in the international market. The new colonisation schemes also resulted in the resettlement and development of the region which had been the seat of the ancient Buddhist civilisation and the programme therefore appealed to national and religious sentiment. This region had been depopulated for a variety of reasons including the recurrent invasions by the South Indian kingdoms of the period. Malaria was rampant in the dry zone which was the main breeding ground of the vector. Therefore first and foremost, the resettlement required the eradication of malaria – a task which had begun with the use of DDT in the second half of the 1940s. The devastating malaria epidemic of the mid 1930s was still a part of living memory. The settlements were therefore at the heart of social economic and political problems. Consequently it received and demanded the highest attention of the policy makers.

The early efforts at establishing settlements were not successful due to the numerous hardships that the settlers had to undergo in a very inhospitable environment. Malaria was an ever present risk but the other conditions of poverty and undernutrition in which they had existed continued to afflict them in their new settlements. From 1939-1947 the number of new settlers were only 1,971. By 1953 the situation had changed dramatically; the total number of settlers had increased to 16,671 and with their families the total population in settlements had increased to over 100,000. The change was due primarily to the radical adjustments the policy makers made to their approach to the settlements. They decided that the schemes should be planned and developed as human settlements with all the amenities needed to satisfy the basic needs of the households living in them. The conditions of extreme deprivation which the settlers suffered prior to settlement – livelihoods below subsistence level and extreme poverty, substandard housing, lack of adequate access to health and education had to be eliminated right at the outset when the settlers were brought to their new habitat. The conceptualisation of the colonisation scheme as a human settlement resulted in a holistic approach to the needs of the settlers. The colonists were given type plan homes with permanent materials – tiles and sheets for roofs, bricks and cement blocks for walls and cement floors. Toilets and wells were constructed. central dispensaries maternity homes and branch dispensaries were established to provide health care, schools were provided, community centres were built to provide facilities for community based activities. An allotment for paddy cultivation(5 to 3 acres) cleared and ready for cultivation provided with irrigation and a highland allotment in which the house was located were given to enable the colonist to engage in paddy cultivation as well as highland cultivation and livestock farming and diversify his sources of income. The colonist was assisted during the period prior to the first cultivation with a subsistence grant until his new livelihood begins to yield income. Against the general background of social progress reflected in the indicators given in Tables 1-5. the settlements formed an inset in which the same indicators progressed more rapidly as shown in the Table below based on the data provided by the Director of Health Services. It is important to note that the Director of Health Services monitored the health conditions in the colonisation schemes and devoted a section of his administration report to a brief survey of the health of settlers and the services provided. Regrettably this was discontinued after 1958. The table contains information for the period 1951-1957. The data for 1958 has not been included as this was an atypical year. In that year the dryzone suffered from the worst floods it had experienced after resettlement and all reservoirs in the region were breached leading to severe distress of the settlers and higher rates of mortality. The infant mortality rate for that year was marginally

Table vi -Infant Mortality and Maternal Mortality in Colonisation Schemes- 1951-1957

Year	Population	Births	Infant Deaths	IMR	National average	Maternal Deaths	MM R	National Average
1951		2606	141	54.2	82	8	3.0	5.8
1952	91,000	3553	176	49.5	82	3	0.84	5.8
1953	107,000	3020	199	65.8	71	14	4.6	4.9
1954	118,000	4344	196	45.1	72	8	1.8	4.6
1955	166,399	4687	213	45.4	71	5	1.06	4.1
1956	187,000	5598	280	50.0	67	11	1.96	3.8
1957		6702	387	57.7	68.	2	0.29	3.7

Sources: Administration Reports of the Director of Health Services Government of Ceylon 1950-1960

The information on the incomes of settlers indicates that the average annual household income of colonists which was between Rs 1500 and Rs 3000 was higher than the average incomes of the rural poor which was estimated at Rs 1150.⁵ The productivity of the settlers was also higher than the average. The yields of the colonisation schemes in the Polonnaruwa District which contained the largest concentration of settlement has the highest for the country. In 1953 the yields in this district were in the region of 50 bushels per acre compared to the national average of 30 and in 1975 it had risen to 80 bushels as against a national average of 47 bushels. The increase in productivity was accompanied by the adoption of new cultivation practices and the use of high yielding varieties. Here too the information available clearly indicates that the settlers showed a greater receptivity to these methods. The agriculture settlements with wider use of practices such as transplanting were bringing more women into the workforce which would have had a positive impact on gender relations and the status of women.

The settlements demonstrate how health indicators move when a relatively complete intersectoral package to satisfy basic needs is in operation. Both infant mortality and maternal mortality are well below the national average. The seven year span also reveals an interesting trend. While the indicators in the settlements continue to be below the national average the gap appears to be narrowing. The time span is probably too small to draw any firm conclusions on the trends. In this table the colonists start at the level where all the basic needs are more or less satisfied and the rest of the country is still moving towards this level of satisfaction. It would seem that progress beyond the stage of satisfaction of basic needs in the case of the settlers is slower. This may probably indicate a tendency to slow down unless other aspects of well-being such as nutritional needs and higher living standards are met. The settlements at the early stages were highly dependent on the state and officialdom for all their needs. Studies of the early stages of settlement point out that settlements did not have the community ties of the traditional village. It took time for the settlements to develop greater self reliance and community participation. All these contributed to the outcomes that were less than what might have been expected given the high level of assistance the settlers received.

The settlements were not uniformly successful. There were a few failures. Provision of domestic water supply throughout the year together with water seal type latrines posed a problem as most wells ran dry during the dry season. The studies of the settlements indicate that a high level of child and adult malnutrition persisted. However it is likely that on the average these levels of malnutrition would have been less severe than the national average as the settlements were producing an agricultural workforce with higher productivity and a more intensive input of labour. Two crops were being cultivated for the year and transplanting was widely practised. What has to be noted is that the problems of the settlements received constant attention under the system that was operating. The efforts to find solutions to problems such as that of domestic water supply were not relaxed. The settlements were administered by colonisation officers to whom all the complaints and problems of the settlement were brought. While there were formal mechanisms for intersectoral co-ordination where officers with different sectoral responsibilities met to monitor and coordinate their work the system was such that the Colonisation Officer became the Ombudsman who contacted all the other officers and helped to correct any shortcomings in the delivery of services. Policy makers at the highest level were monitoring the performance of the settlements as the national expectations placed on were high. The Director of Health Services in his Administration Report for 1952 describes how the then Prime Minister who took over the Portfolio of Health on the resignation of the incumbent Minister examine the health situation in the colonies and directed that every settlement should be served by a peripheral health unit comprising a Central Dispensary Rural Hospital and Maternity Home.⁶

There was considerable criticism that the settlement programme was too costly and the assistance given to settlers was excessive. However the long term performance of the settlements belies this assessment. The settlements appear to have been successful even as an economic investment. They have become the

⁵ B.H.Farmer - Pioneer peasant Colonisation in Ceylon pps 260-262

⁶ Report of the Director of Health Services 1952

most prosperous small scale producers of rice achieving the highest levels of productivity and contributing a substantial share of the total national output. The success can be attributed to a policy that ensured that the settlers enjoyed the necessary conditions of well-being right at the outset. The policy of giving all the productive and other assets in the form of grants ensured that the settlers would not be burdened with debts and repayments which contributed in no small way to the prosperity they achieved. The lessons of the settlement schemes in relation to the intersectoral approach to health are many:

- The intersectoral package dealt with all the conditions of deprivation that reinforced each other and had serious adverse impacts on health.
- The level of political commitment was shared by all the sectoral stakeholders and the health contribution to the well-being of the settlement was supported by all
- The human settlement approach made the community the unit of attention and drew attention to all the interlinked needs of households and community
- The administration was structured in a manner which gave it a human face bringing household into close face to face interaction with the state official who then became the “intersectoral intermediary”

5. The Special Case of the Indian Labour in the Plantation Sector.

The conditions of the Indian Population in the plantation sector are in sharp contrast to those of the agricultural settlements. They demonstrate the outcomes in a situation where a population group is excluded from the mainstream of social development and deprived of the intersectoral synergies that benefited the rest of the country. The situation of the Indian population went through three stages prior to and after independence. Prior to independence when Sri Lanka was under British rule the Indian population enjoyed the rights of citizenship and were able to vote in elections. They constituted approximately 11% of the population before independence. In this stage the health indicators for the Indian population were a little ahead of the national averages and certainly better than those of the rural poor. The crude death rates of the estate population the large majority of whom were Indian ranged between 26.7 per 1000 in 1935 and 17.1 in 1945 compared with the national average between 36.6 and 21.9 for the same period. The corresponding rates of infant mortality were 198 and 126 for the Indian population and 263 and 140 for the whole of Sri Lanka.

Immediately after independence they lost their citizenship and became stateless without civic rights to participate in the political process and without any legitimate political representation in the democratic system. This stateless condition left the Indian population without access to all the state programmes which were transforming the rest of the country. This exclusion was reflected in the widening gap in the mortality rates after 1950. In 1955 the death rate and the infant mortality rate for the Indian population were 13.3 and 115 while the national averages had declined rapidly to 11 and 71.

Their status became the subject of negotiations with India and finally agreement was reached to repatriate a little more than half a million to India and grant Sri Lankan citizenship to 350,000. As a result of this agreement and the decision of the Sri Lankan government to grant citizenship to all workers and their families who still remained in Sri Lanka in the beginning of the 1980s, a little over million became entitled to citizenship. Meanwhile the foreign owned estates in which the large majority of the Indian population resided were nationalised and the state which became the owners of these plantation assumed responsibility for the working and living conditions of this group. The take over of the estates along with the grant of citizenship resulted in the steady integration of the population of Indian descent into the main social welfare system. The gaps in the social indicators began to narrow rapidly as the state began to improve the living conditions in the plantations and provide better access to health education and other community services.

The trends for some of the social indicators for the period 1950 – 2000 are given in the table below. The published data in the Registrar General's Reports contain information separately for infant deaths in the Estate Sector up to 1962. Thereafter the information is available for the estate sector as a whole and does not show the rates for the Indian population separately. Up to 1980 most of the information on the conditions relating to the Indian population has to be gleaned from the data classified according to zones and districts in the Surveys that have been conducted. After 1980 data concerning the progress made by the Indian population is gathered from various studies and reports. The data in the Table therefore refers in some cases to the estate sector as a whole such as for housing literacy and in others such as for infant mortality birth rates they refer specifically to the Indian population. The estate sector includes a small proportion of non Indians and the Indian population a small proportion of Indians who are not resident in the plantations but both cases the Indian population in the plantations constitute the large majority and the data given could be used as reliably representative of the Indian plantation population.

Table vii: Selected Social Indicators for the Indian Population
(Figures in brackets give the comparable national averages)

Indicators	1953	1971	1985-1987	2000 -2004
Crude Birth Rate	33(38.7)	25.7 (30.4)	30.6 (24.6)	17.1 (18.5)
Crude Death Rate	12.1(10.8)	13.4 (7.7)	10.7 (6.2)	5.8 (5.8)
Infant Mortality Rate	134 (72)	110 (43.7)	49.6 (24.0)	14.2 (11.2)
Maternal Mortality Rate Per 10,000 live births			1.5 (0.5)	0.9 (0.17)
Literacy % Male Female	63.9 (75.9) 27.6 (53.6)			82 (94.5) 72 (90)
Educational Attainment % of pop 5yrs and above				
NoSchooling		38.9 (17.5)	44.09 (24.5)	19.9 (7.9)
Primary		51.0 (44.6)	44.4 (37.9)	43.7 (29.9)
Secondary		08.8 (30.4)	8.4 (25.7)	29.9 (41.0)
Malnutrition Height for age Weight for age Birth weight		53.7 (23.8) 52.1 (37.7)	51.1 (20.8) 53.2 (32.6) 29.7 (18.7)	30.9 (11.7) 43.2 (26.7) 20.8 (16.7)
Poverty Head count			1990 20.5 (26.1)	30 (22.7)
Housing (% of stock) Permanent No of rooms per house Cement floors Domestic Water (well and tap)		12.1 (34.7) 1.4 (2.2) 13.1 (39.7)	23.4 (41.8) 1.7 (2.5) 24.5 (44.7)	69.6 (81) 68.4 (81.8)
		74 on tap sources contaminated (88.9)	81.9 (quality as for 1971)	91.1 (93.5)

Toilets				
Water seal		33.9 (14.3)		
Pit		38.2 (38.8)	29.1	75.1 (86.5)
None		13.4 (34.3)		17.8 (7.8)
			28.4	6.5 (5.6)

The agricultural settlements in the dry zone have some features in common with the settlements in the plantation sector. They are both organised as communities in well defined locations in a manner that makes the delivery of any programme or service relatively easy with full coverage of the community. They are both engaged in a mono-cultural agricultural occupation rice in one case and tea in the other. What becomes immediately evident in an analysis of the policies and programmes implemented in the plantations to improve the well-being of the Indian population is the intersectoral approach that was adopted. The data on the trends relating to poverty in the estate sector are a little intriguing. According to the surveys for 1985/86 and 1990 poverty is lowest in the estate sector. The position appears to have been reversed in 1995 and 2002. However the data when disaggregated according to race shows that the proportion in poverty that is the population with levels of consumption below the poverty line among the Indian Tamils is lower than among the Sri Lanka Tamils It is about 3 percentage points higher than the proportion in poverty among the Sinhalese and one percentage point higher than that of the Muslims. The conditions of employment and the regularity of income enjoyed by the Indian Tamils as wage earners has also to be taken into account. The gaps in poverty we observe in 1995/96 and 2002 do not explain the wider gaps that exist in mortality, educational levels and housing between the Indian Tamils and other communities. If we go back to the period between 1985 and 1990 we have a situation where the proportion of the poor are lower than those for the urban and rural and yet their rates of infant mortality levels of education and housing are lower. Therefore in the case of the plantation Tamils deprivation in income and consumption appears to rank below the deprivation in health education and housing ; the latter three variables appear to be contributing more to their total state of deprivation. Consequently the strategy for social development of the plantation sector adopted by the policy makers went beyond the income based approach. Taking the regular wage income as given there was great deal that had to be done. The strategy replicated part of the social welfare programme. Like the social welfare programme it was multi-sectoral in character and combined the contributions that had to be made by the different sectors. In designing the multi-sectoral programme the planners recognised and relied on the synergies that would be produced through the intersectoral links in the programme. The main elements of the multi-sectoral programme have been

- The improvement of child and maternal health to deal with the most vulnerable groups. Health education and family planning
- Child care Services and early childhood development
- Expansion of health care facilities
- Improving access to schooling
- Reduction the drop-out in schools
- Improvements in housing water and sanitation
- Additional sources of income such as livestock farming and vegetable cultivation

The data for the period 1985 -2006 reveals a transformation which is even more remarkable than what occurred through the implementation of the similar multi-sectoral programme in the rest of the country. In 1976 infant mortality in the estate sector had been 110 when the national average was 43. In 1985 However the integration of the Indian Tamil population into the mainstream of the country's social development starting from the mid seventies had the benefit of all the lessons of the past. It also had the support of international agencies like the UNICEF and WHO and the donor community. The 430 estates in which the majority of the Indian population resides and works is presently managed by private companies.. Recognising the need for a co-ordinating agency to direct and facilitate the programmes in the social sector the government established the Plantations Human Development Trust (PHDT) in 1992 as a non-profit company under the Company's Act with a Board of Directors which represented the Government, the Companies and the Trade Unions. The mandate of the company, according to its vision

and mission statements enables it to “ implement integrated and sustainable undertake programmes with a holistic approach in the fields of housing, health care, childcare, sanitation, education, recreation, mobility, communication and infrastructure.” As the multi-sectoral programme is under one authority it is well equipped to address intersectoral cross- cutting issues.

The data for the period 1985 -2006 reveals a transformation which is even more remarkable than what occurred through the implementation of the similar multi-sectoral programme in the rest of the country. This is strikingly demonstrated in the performance of one key indicator In 1976 infant mortality in the estate sector had been 110 when the national average was 43. In 1985 it had dropped to 49 when the national average had dropped to 24. In 2004 it was 14.2 with the national average at 11.1. The progress in the other social indicators such as those relating to education and living conditions as shown in the Table is equally impressive. The indicator on which the Indian plantation sector fares badly is malnutrition . Malnutrition emerges as a persistently hard core problem for the country as a whole but it is more severe and pervasive in the plantation community. What has to be noted is that the progress in these social indicators has occurred during a period when there has been no appreciable decline in the headcount in consumption poverty.

The speedy transformation that has taken place in the conditions of the Indian population in the plantations is the outcome of a combination of processes and initiatives. It was pointed that in the case of the agricultural settlements the programmes that reached the settlement as linear programmes from the centre already formed part of a social welfare programme which had been assembled at the national level. It was a programme in which all component parts were given almost equal weight and Ministries shared responsibility for it . we saw that in the agricultural settlement, this national programme had heightened importance for the nationally formulated objectives which had social, economic and ethno cultural dimensions. The programme came to be implemented in a well –defined community setting with an officer who was responsible for an identified group of households. He was positioned in a manner which required his attention to all the aspects that related to the well-being of the settler households in his charge. Within this framework some of the urgent intersectoral links in different parts of the system got attention This included health care but health was only one component among others which included the productivity of the settlers and the dissemination of new agricultural practices, educational facilities, community organisations water and sanitation.

The social political and economic incentives for the improvement of the estate population were very different from those that drove the development of the agricultural settlements. There were however strong incentives among which two stand out as critical. The policy makers were keen on the integration of the estate population and the improvement of their well-being in order to prevent the growth of discontent which would compound the already escalating ethnic conflict. A contented and productive workforce in the tea plantations was also essential as tea was still a major export and unrest in the plantation sector would have serious adverse repercussions on the economy. There were however some underlying features which the agricultural settlements and the plantation population shared. The conditions in both cases facilitated the implementation of a community-based programme. The households that were served by the various activities in the plantation sector lived in communities in housing provided by the management. As in the case of the settlements they could be reached easily. However the programme in the plantation sector was being implemented 25 years later when the lessons of Sri Lanka’s social welfare programme was available, a large body of knowledge on the inter-sectoral links in health and social development had been accumulated and international agencies and donor countries were ready to provide large scale assistance. The management of the plantations by large private companies was also another feature which distinguished it from the self employed rural communities in the agricultural settlements. The plantation community had been able to develop a strong trade union movement which had become the intermediary between the Indian population, the state and the management and this was similar to the place which the elected representatives enjoyed in the rest of the country. The bargaining power of the trade unions was of course different and more limited. They did not have the same access to government as the elected representatives.

In the situation described, it was not feasible to replicate the same process of implementation as in the case of the agricultural settlement through a simple extension of the government apparatus into the plantations. It was necessary to bring together all the key stakeholders and to develop and design a system in which there would be a sharing of responsibility among them to foster a self-reliant infrastructure for the estate community. It is in this context that policy makers designed a special mechanism- the PHDT- for the implementation of the programme to improve the well-being of the estate population. The emphasis that is given to human development in the very title signifies the holistic approach. The multi-sectoral programme is within one organisation which enjoys the authority and autonomy of a corporate body in implementing and co-ordinating programmes. All sectors are stakeholders in the organisation and participate in the decision making. The different programmes and their goals have an equal status. In such a multi –sectoral organisation with responsibilities for all the relevant sectors and with representation from all the relevant sectors, all the intersectoral links receive attention both during the formulation of the programme as well as its implementation. This has been evident in the mix of the programmes undertaken by the PHDT covering all the areas of vulnerability referred to above. The PHDT taking account of the high rate of participation of young mothers in the workforce gives high priority to child care maternal care and early childhood development . It had established 1014 Child development centre in the estates under its care and designed programmes specific to the needs of the plantation families. The same needs did not exist in the agricultural settlements. This having been said, it should also be mentioned that while each sectoral programme pursues its own objectives within one multi-sectoral programme, there is no evidence of any specific programmes of intersectoral action for health in which the intersectoral activities have been identified and are being co-ordinated to achieve a specific health objective.

6.The Lessons of the Past , Emerging Health Issues and the Scope for Intersectoral Action

What the Sri Lankan case and the special cases of the agricultural settlements demonstrate is that the health indicators progressed simultaneously with a wide range of other social indicators. The study thereafter examines the policies and approaches that made this simultaneity of progress possible. allocation of resources and the administrative structures. The two cases attempt to take the argument further and analyse what happens when the different states of well- being co-exist right from the beginning as in the case of the agricultural settlements or when a community is denied this simultaneity of progress.

The overview attempts to track this simultaneity of progress for five sets of indicators over a time span of approximately 25 years.. The study argues that the states of well-being signified by these different sets of indicators – well-being in education housing consumption socio-political participation – are closely interlinked and inter-dependent and that intersectoral synergies that are produced when they progress simultaneously were mutually supportive and beneficial to all. The positive outcomes in health were an integral part of this process of simultaneous progress. One conclusion that can be drawn from this line of argument is that it is in the interests of the health sector to track, monitor and promote this process of simultaneity.

There are a few main conclusions that can be drawn from the study that would be helpful in defining the scope for intersectoral action. First they relate to some of the fundamental conditions that need to be fulfilled if intersectoral action is to be purposive at the level of sectoral policies and programmes. Second they focus on some of the lessons and missed opportunities of the Sri Lankan case. Third they draw attention to the scope for intersectoral action for the future.

In the Sri Lankan case we do not discern the level of intersectoral integration where the links between sectors such as for instance agriculture and nutrition are clearly articulated and programmes are designed to bring the health agencies and agricultural agencies to act together to achieve specific health objectives or objectives of agricultural productivity.

What we observe in the Sri Lankan case are processes that for the most part act independently of each other but act simultaneously to improve well-being as a whole with health as an integral component. These processes produce the synergies that are needed for the purpose. These synergies require

- An overall social development strategy which enable a society to make simultaneous progress on all the key social indicators.
- A political process that evolves a high degree of national consensus for such a strategy
- As far as possible equal weight and commitment to be given to each of the key indicators
- Shared responsibility for the programme at the highest level of government

These fundamental conditions were fulfilled in the Sri Lankan case. The outcome was multi-sectoral action for the improvement of well-being. Within this context, the Sri Lankan strategy was one of co-operation and co-ordination to achieve an objective of well being to which all the sectors contributed. The relationship was therefore significantly different from the conventional models of intersectoral action in which sectors are co-ordinated for the purpose of achieving a specific health objective such as the control of a disease or improvement of the nutritional status of a vulnerable group.

Nevertheless intersectoral action directed more explicitly and purposively to promote uninterrupted progress on the health indicators can take place very effectively within a policy framework such as what evolved in Sri Lanka. The strategy that was implemented in Sri Lanka missed valuable opportunities for improving on the outcomes through such pro-active intersectoral action. Each sector simultaneously pursued its goals to improve the conditions for which it was responsible. These intersectoral processes did not lead to clearly articulated programmes of intersectoral action for health in which the sectors other than health identified their contribution to health and consciously co-ordinated their activities to produce a desired health outcome. There were ad hoc initiatives for particular health programmes. But these were at the sub-sectoral level to solve problems of implementation. They did not translate themselves into long term sustained programmes of intersectoral action at the level of sectoral policies and programmes that identified the medium and long term impact of developments in other sectors on the health outcome. There were several elements in the prevailing situation which hindered intersectoral action of the latter type:

- First the senior professionals and administrators would have had to develop the capacities to study and identify the intersectoral linkages in their activities. They would have to be proactive to search for the causes behind the persistence of problems such as malnutrition. This required an understanding of the different combinations of vulnerability in the different locations in Sri Lanka. The Marga Institute's study on Seasonality and Health gives examples of these different combinations in five different agro-climatic and socio-economic settings in a region in Sri Lanka.⁷ There was nothing in the system which promoted the development of such capacities on a systematic basis. Now and again an enterprising officer would draw attention to a chain of causality that cut across sectors. But there were no resources in the Ministries to make such inquiries a regular part of the work. Without this underpinning of evidence and knowledge of intersectoral links, there was no strong propensity for intersectoral action. Therefore a pre-requisite of intersectoral action is a resource base which continuously identifies and analyses the intersectoral process in health.
- Second the decision-making structures and the administrative culture were not conducive for intersectoral team work. With territorial boundaries tightly drawn among ministries and

⁷ Seasonality and Health – Marga Institute pages 1-3 and pages 117-135.

departments, issues of hierarchy and leadership constantly arose in any inter-ministerial arrangement. The opportunities for intersectoral action for improving on the social gains Sri Lanka had made through its social welfare programme were missed. What was needed was a model of intersectoral action of a more co-operative type where each sector was given an equal stake and status and worked collectively to identify the intersectoral links on which they needed to act together. Here the PHDT offers some lessons but these would have to be adapted to the vastly different conditions outside the plantation sector. What was needed was a model of intersectoral action of a more co-operative type where each sector was given an equal stake and status and worked collectively to identify the intersectoral links on which they needed to act together. Here the PHDT offers some lessons but these would have to be adapted to the vastly different conditions outside the plantation sector. The Inter-Ministerial bodies set up by the Ministry of Health failed to promote such action as all participating sectors did not share a sense of common ownership. It was perceived as primarily serving the functions of the Health Ministry and did not have similar matching intersectoral bodies for the other sectors to serve their purposes.. Intersectoral apex bodies have to be structured in a manner that gives a sense of collective ownership. An alternative model that might meet these criteria would be an Inter- sectoral Cabinet Sub Committee in which the Ministers rotate as Chairmen depending on the sectoral weight in any given agenda for a meeting. This model could be replicated at the different levels of implementation from national to divisional.

- Third ,not sufficient attention was paid to community- based, participatory approaches. The linear programmes which were top down worked each in their territory to achieve their objectives. They had to come together at the level of the community to co-ordinate their work and address the problems which cut across their sectors. This type of co-operation would have emerged and become institutionalized if the opportunities for community participation were seized. As pointed out earlier there were village level institutions which could have been readily employed for that purpose. Such a strategy of community-based implementation of programmes would have identified the problems that were needed for inter-sectoral action and set in motion a sustained intersectoral process. But such a process had to be genuinely intersectoral in which all the relevant sectors were stake holders ; it had to be holistic in that it had to be intersectoral action for dealing with all the conditions of deprivation and promoting the total well- being of the households and community with intersectoral action for health as a integral part of the full programme.

In the current situation, the case for intersectoral action for health is strongest in three areas where the health sector needs to take account of the impact that the processes in other sectors have on the health outcome

- First there are the regional disparities in health status that exist despite the equity oriented strategy for the provision of health care. Several recent studies have analysed these regional disparities in terms of the distribution of the states of vulnerability that have been referred to earlier in this paper. One of these studies has used the HIES 2002 and the DHS 2000 to identify the distribution of the vulnerable groups and the different combinations of vulnerability in different settings. In these settings poor health and undernutrition are embedded in this combination of vulnerable states. They provide the basis for developing a typology of intersectoral action for health in Sri Lankan conditions.
- Second there is the intriguing phenomenon of a persistently high level of undernutrition despite other relatively high social indicators. The focus has hitherto been on child and maternal malnutrition whereas malnutrition appears to be affecting the population as a whole with pervasive adverse impacts on productivity, consumption levels and health in general. While malnutrition declines with income, the poverty- malnutrition nexus is not clear. There is strong evidence that a large proportion of the households which are below the consumption poverty line are not malnourished and that higher income strata including the highest contain

malnourished persons. The management of nutritional resources within a household, which even in certain conditions of poverty can produce a positive outcome and in higher levels of income a negative one, appears to be governed by a complex intersectoral process. This situation needs intersectoral analysis and action.

- Third, Sri Lanka is entering a phase of the demographic transition which is unusual for a low income country. It is already moving into the category of an aging society with a per capita income that places it at the bottom of the low middle income countries. The disease profile has changed into one in which the non-communicable diseases have overtaken the communicable diseases but where the latter are emerging in new forms and still constitute a significant share of the disease burden.. The mix of aging , the new disease burden, persistently high levels of consumption poverty and malnutrition require far-reaching adjustments of the strategies which were successful in the past. The health care system had the capacity to manage the first phase of the health transition. In this phase maternal and child health as well as public health and remedial care for communicable diseases could be organized and delivered readily through a network of services to a receptive population. The non communicable diseases both in terms of cost and management of the diseases pose new challenges requiring greater interaction with communities and households and better control of the non-health variables. This would require a health strategy which is much more proactive in identifying the intersectoral links and acting on them than in the past.

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