Intersectoral Action for Health in Sri Lanka
A case study commissioned by the Health Systems Knowledge Network

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The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity (www.equinetafrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social determinants of health at global, regional and country level.
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Abbreviations

AHF Annual Health Forums
CARE Corporative for American Relief Every where
CCM Country Coordinating Mechanism
CMH Global Commission on Macroeconomics and Health
CNAPT the Ceylon National Association for the Prevention of Tuberculosis
CSDH Commission on Social Determinants of Health
DDC District Development Councils
DHC District Health Councils
HFA health for all
FHW Family Health Worker
GFATM Global Fund to fight Aids TB & Malaria
HSDP health sector development project
HSKN the Health Systems Knowledge Network
IAH inter sectoral action for health
IRDP Integrated Rural Development Program
ISA intersectoral action
IVS International Voluntary Service
MDT Multi Drug Therapy
MDPU Management Development and planning Unit
MOH ministry of health
MoH medical officer of health
NCMH National Commission on Macroeconomics & Health
NHDC National Health Development Committee
PHC primary health care
PHM Public Health Midwife
PHRD Human Resources Development
SEDEC Social and Economic Development Centre
SHS Superintendent of Health Services
STDC Sexually transmitted Disease Control programme
YMCA young men’s Christian association
YWCA young women’s Christian association
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2. Executive summary
This paper attempts to capture the dynamics of Intersectoral Action for Health in Sri Lanka & the role played by such action in health development of the country. An attempt is made to identify mechanisms, structures, political and planning strategies etc. that the public health sector can adopt to lead and leverage inter-sectoral (cross-ministerial) action to promote health equity and address the social determinants of health.

The Declaration of Alma-Ata highlighted the vital contribution of heath related sectors, for improving the health of the population. Thus, intersectoral action for health (IAH) is one of the main principles of Primary Health Care (PHC). Successful intersectoral initiatives are, by their nature, challenging to achieve. However, over three decades of post Alma Ata experience has provided many lessons.

Sri Lanka’s significant improvements in the health indicators have been the outcome not only of the performances within the health sector itself but also of major socio-economic developments in the non-health sectors. Four phases can be discerned in the evolution of Sri Lankan IAH. They are pre independence, post independence, post Alma Ata & contemporary.

2.1. Pre independence phase
Universal franchise was granted in 1931, long before national independence in 1948. It is said that the reason for women in Ceylon (Sri Lanka) to be enfranchised was that women's services would be of special value in coping with the high infant mortality rate, the need for better housing and improved midwifery and prenatal services. A State
Council which consisted of a majority of elected representatives was established. A Board of Ministers assumed a substantial measure of executive responsibility for governance. The first Board of Ministers consisted of seven Ministers including the portfolio of Health. The elected representatives were able to lever for a larger allocation of resources for the provision of social services to the constituencies they represented. Direct taxation on income was introduced in 1932 and provided finances needed for the various welfare schemes. In 1945 the Government introduced a scheme for mass free education from the primary to the university level. Another important development was the food distribution system and the State subsidy on rice. By 1946, the expenditure on health, education and the subsidy on food taken together amounted to approximately 29 per cent of total recurrent expenditure.

2.2. Post independence phase

The welfare programme continued to be a constant element of public policies, and all political parties who came to power remained committed to it. However, for the health sector, the contribution of the non-health sectors to the realization of health goals (IAH) was not perceived and articulated by the health planners themselves, nor was it consciously incorporated as part of national health strategy. This era also saw the development of IA for the vertical disease control programmes. A number of laws were enacted to safeguard the health and well-being of workers, special attention being paid to women and young people. In the absence of any mechanism to promote community participation in health, such participation was left largely to the efforts of NGOs. There has been a growing realization on the part of NGOs that health is the base on which general human well-being can be promoted and strengthened and the key to human capacity and competence to lead socially and economically productive lives. In the late 1970s, the government of Sri Lanka launched the Integrated Rural Development Projects, which included direct & indirect health benefits. The initiative concentrated its projects in districts, some of them the country's poorest-that had not benefited from major government investments.

2.3. Post Alma Ata

A most significant event in the history of the health services was the signing of the Charter for Health Development in 1980. As a part of strategy for intersectoral action & coordination at all levels, the Government established the National Health Development Network with the National Health Council (NHC) as the apex body. The NHC sets out the policies of the Government in regard to health care, mobilization of non health sectors, the modalities of coordinating multi-sectoral action and measures for enlisting popular participation in health care.

2.4. The contemporary phase
The contemporary era is dominated by the challenges posed by the demographic and epidemiological transition & unhealthy life styles. Non-communicable diseases dominate the morbidity & mortality pattern of the country. IAH has been consolidated by addressing specific issues by formulation of policies & strategies & donor funded projects. One strategic objective of the draft 10 year master plan for health development is to empower communities towards more active participation in maintaining their health. This is to be achieved through improved participation of civil society and NGOs in promoting behavioural and lifestyle changes.

### 2.5. Decentralization

Decentralization provided an impetus to IAH. 1954 saw the appointment of 15 Superintendents of Health Services. The Provincial Councils were set up in 1987 by the 13th amendment to the constitution. The health administration was totally devolved and the line Ministry was given the responsibility of formulating policy, the management of Teaching Hospitals, Special Hospitals, Specialized Campaigns, technical training institutions and bulk purchases of medical supplies. The latest chapter in decentralization occurred in 1992, when Divisional Directorates of Health Services were created. All initiatives were in step with the devolution / decentralization of general administration.

### 2.6. Lessons learned from the Sri Lankan experiences in IAH & their applicability

It is extremely difficult to transplant Sri Lankan experiences to other societies in view of its unique socio cultural & political mix. However, some broad recommendations can be made for different stages of development of health systems. The overall approach would be IA to achieve millennium development goals.

**Fragile countries & those in transition**

IAH would be extremely difficult & essentially confined to small geographical areas. Sri Lankan experience of IAH in the prevailing conflict situation & some experiences in the pre independence era would be applicable. Most fragile countries have an ongoing conflict situation & there is some degree of pressure from international community to establish democracy as early as possible. Goal would be for the International Community, INGOs & Civil Society to catalyze broad political change for human development. Most practical would be INGO / local NGO & CBO led inter sectoral humanitarian action to provide PHC, food security, & basic education ensuring equal opportunity for girls. An integrated health system with emphasis on PHC needs to be developed. Donors support would be crucial at this stage. They should encourage a sector wide approach to formulation of policies & strategies.

**Least developed countries**
Post independence experience would be applicable. An all party commitment to support welfare measures would ensure continued development of health systems responsive to needs of the people irrespective of changes of government. Legislative enactments are required to ensure a legal environment to support the health system & governance. IAH to address priority diseases are needed. NGO participation need to be encouraged & facilitated.

**Other developing countries**

Post HFA experiences would be applicable. A health development network would ensure political commitment & facilitate IAH. A social marketing approach to diseases with stigma & those associated with life styles would yield rich dividends.

**Countries in advanced stages of demographic & epidemiological transition**

Issue specific policies & strategies with overtones of IA need to be developed at this stage. A national commission on macro economics & health would ensure commitment of resources for consolidation of gains in health development & maintenance of health systems. A donor commitment to address intersectoral issues would ensure IAH. A master plan for long term health development with an emphasis on IAH would be an appropriate road map for health systems development.

**National commissions on social determinants of health (NCSDH)**

Experience with NCMH suggests the need to establish NCSDH without waiting for the conclusions of CSDH. WHO support will facilitate such initiatives as shown by the CMH experience.
3. Introduction

This paper attempts to capture the dynamics of Intersectoral Action for Health in Sri Lanka & the role played by such action in health development of the country. An attempt is made to identify mechanisms, structures, political and planning strategies etc. that the public health sector can adopt to lead and leverage inter-sectoral (cross-ministerial) action to promote health equity and address the social determinants of health.

In 1977 the World Health Organization developed a vision for world health captured by the slogan “Health for All by the Year 2000” (HFA). The Declaration of Alma-Ata (1978) stated that PHC was the strategy to achieve that vision. The PHC strategy reordered priorities in the health sector in order to move from a medical model that was disease orientated and curative to one that emphasized the prevention of ill health, the removal of health risks and the promotion of health. Conceived in these terms the improvement of health required more than the services delivered by the health sector alone, the contribution of other sectors, education, housing, essential services and transport were explicitly recognized as vital for improving the health of the population. This approach calls on the health sector to move out and collaborate with other sectors in incorporating health goals and health criteria into their policies, strategies and programs. Thus, intersectoral action (ISA) is one of the main principles of PHC.¹

3.1. What is Intersectoral Action?

ISA means working with more than one sector of society to take action on an area of shared interest. Sectors may include government departments such as health, education, environment and justice; ordinary citizens; non-profit societies or organizations; and business.²

Two definitions are provided by Harris, E. et al, 1995 in their report “Working Together: Intersectoral Action for Health”:

a) Activities by part or parts of the health sector that involve a direct relationship or partnership with another sector and that involve joint planning or action as an issue of common concern. This definition was developed further during the review to read as follows:

b) A recognized relationship between part or parts of the health sector and part or parts of another sector that has been formed to take action as an issue or to achieve health outcomes in a way that is more effective, efficient or sustainable than could be achieved by the health sector working alone.³

WHO International Conference on Intersectoral Action for Health, 1997 defines IAH as “a recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone.”

3.2. Relevance to Commission on Social Determinants of Health (CSDH) & the Health Systems Knowledge Network (HSKN)

Intersectoral action for health is seen as central to the achievement of greater equity in health, especially where progress depends upon decisions and actions in other sectors, such as agriculture, education, and finance. A major goal in intersectoral action is to achieve greater awareness of the health consequences of policy decisions and organizational practice in different sectors, and through this, movement in the direction of healthy public policy and practice. Not all intersectoral action for health need involve the health sector. For example, in some countries the police and transport sectors might combine to take action to reduce road transport injury. Such action, although explicitly intended to reduce injury, will not always involve the health sector.

The current emphasis on intersectoral action to enhance population health is being driven by many factors, particularly a growing consensus about the importance of key determinants of health such as income, education, social support networks, employment and working conditions, which are the purview of many different sectors; the need to reduce persistent health status disparities; our increasing understanding of the conditions which enable effective intersectoral action; and a positive climate for action. There are significant potential benefits from a renewed emphasis on intersectoral action. These include an enhanced capacity to tackle and resolve complex health and social problems which have eluded individual sectors for decades; a pooling of resources, knowledge and expertise that will allow partners to address problems more effectively; reduced duplication of effort; and new ways of working together that will enable partners to contribute to improvements in social cohesion, increased opportunities for sustainable human development, and a more dynamic and vibrant society.

Successful intersectoral initiatives are, by their nature, challenging to achieve. However, almost three decades of experience have provided many lessons.

- Seek shared values and interests and alignment of purpose among partners and potential partners.
- Ensure political support; build on positive factors in the policy environment.
- Engage key partners at the very beginning, be inclusive.


5 http://www.sgh.org.sa/Glossary/i.htm#Intersectoral%20collaboration accessed on 03.05.06
• Ensure appropriate horizontal linking across sectors as well as vertical linking of levels within sectors.
• Invest in the alliance building process, work for consensus at the planning stage.
• Focus on concrete objectives and visible results.
• Ensure leadership, accountability and rewards are shared among partners.
• Build stable teams of people who work well together and have appropriate supports.

Although there is solid consensus on the need for intersectoral action to enhance population health and wellbeing, as well as a growing body of knowledge about what it will take to succeed and an evident commitment to action by many players, there is still a lack of effective follow through. To make further progress, action in the following four areas is necessary:
• Develop a strong information and evidence base to stimulate and enable effective intersectoral action.
• Ensure people and organizations in the health sector have the capacity to be effective catalysts, leaders and partners in intersectoral action.
• Assist senior decision and policy makers in all sectors to understand the benefits of, and to foster intersectoral action in research, policy and practice.
• Develop practical models, tools and mechanisms to support implementation of intersectoral action.  

4. Methodology

In addition to the traditional methods of internet & hand searches on the topic, the author made use of his knowledge, experience & expertise as a Health Systems Management Specialist. He counts over 37 years of service in the Health Ministry, with experience in management of health systems at the Primary, Secondary & Tertiary levels of care. He has expertise in management at the Divisional, District & National level. His National level experience was as Director (Medical Technology & Supplies), Deputy Director General (Medical Services), Director General of Health Services, Additional Secretary (Medical Services) & Secretary Health, Nutrition & Welfare.

He has conducted a number of research projects at the local as well as multi country collaborative level & served as a resource person for the WHO, JICA, & other international organizations. He was Vice Chairman, Regional Committee of the South East Asia Regional office of the WHO - 94 / 95 and Chairman 95/ 96, & Alternate member of the Executive Board of the WHO, Geneva from May 1997 to January 1998. He has led country delegations to & participated in, a number of international conferences.

He was President Sri Lanka Association of Community Medicine, (1993/1994), President, College of Medical Administrators of Sri Lanka, (1994), Vice President, Federation of

6 Inter sectoral action towards population health, report of the Federal / Provincial / Territorial advisory committee on population health, health Canada Communications Directorate, Ottawa, June 1999
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Professional Colleges of Sri Lanka, (1994), First Chairman, board of study in Medical Administration, of the Post Graduate Institute of Medicine, (April 1994 To April 1998). Currently, he is the Senior Associate of Health Policy Research Associates (Pvt) Ltd & a Director of the Institute for Health Policy.

His experience was particularly useful in locating grey literature on the subject. His long associations with key players in health systems management enabled him to tap the reservoir of anecdotal knowledge on the subject available with these individuals. This type of anecdotal evidence has limitations of recall & subjectivity.

5. IAH in Sri Lanka

5.1. Country profile

Sri Lanka is an island situated in the Indian Ocean with a land area of approximately 62,705 square kilometers. The country has a parliamentary democratic system of government in which, sovereignty of the people and legislative powers are vested in parliament. The executive authority is exercised by a Cabinet of Ministers, presided over by an Executive President. The President and Members of the Parliament are elected directly by the people. For purposes of administration, Sri Lanka is divided into 8 Provinces, 25 Districts, and 321 Divisional Secretary areas. The provincial administration is vested in the Provincial Councils, composed of elected representatives of the people, headed by a Governor who is nominated by the Central Government. The population of Sri Lanka for the year 2002 is estimated to be 19 million. The average annual growth rate is recorded as 1.1 for the island. Life expectancy at birth increased from 43 years in 1946, to 73 in 1996. The rapid increase in the average life span, together with the widening of the gap between males and females longevity, reflects a dramatic improvement in the survival of those groups that were most vulnerable and exposed to high risk of mortality, namely, infants and children in the age group 1-4 and women of the child bearing age. The literacy Rate for those 10 years & over in 2001 was 91.0% (92.4 for males & 89.7 for females)

Sri Lanka’s notable achievements in the sphere of social development can be considered exceptional in the context of her relatively low level of income, and a relatively weak economic performance. In sharp contrast to the economic performance, has been Sri Lanka's steady and exceptional improvement in the health and health-related social indicators. These significant improvements in the health indicators have been the outcome not only of the performances within the health sector itself but also of major socio-economic developments in the non-health sectors. Socio-cultural factors have played an important leverage role in the evolution of the modern health system and its adaptation. The culture of the country has been predominantly shaped by its adherence to

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7 Annual health bulletin 2002, Ministry of Health
8 Department of census & statistics [http://www.statistics.gov.lk/abstr/contents/chap03.htm](http://www.statistics.gov.lk/abstr/contents/chap03.htm) accessed on 02,05.06
the Buddhist way of life which accords a high place to human well-being and health. High priority was given to health service and health care in a value system in which the alleviation of pain and suffering and compassion towards all living creatures occupied a central place and in which religion, education and health also received high priority. These social and economic changes in Sri Lanka have taken place within a vigorous political process which in stages produced a representative form of government and political institutions over a considerable period of time. Universal adult franchise and the competitive political process have enabled the vast rural majority to make their demands on the system and secure their due share of the various social welfare benefits extended by the state. It also promoted the active involvement of women in the Political Process and gave them the political weight which enabled them to make the political elites respond to their concerns.

It may be difficult to quantify the exact impact of relations between interventions, public programmes in other sectors before & since independence. It has undoubtedly created positive synergies with the health sector. Free education since 1945 and high levels of female literacy have engendered attitudinal changes and created a knowledge base that has weathered periods of economic decline. The nutritional status of poor families has been improved through subsidized distribution of rice, and water and sanitation systems have been developed in parallel with the health system. There have been important health policy decisions, based on principles of equity and efficiency, from which some lessons may be drawn, while bearing in mind the wider context in which they are located:

- a) An emphasis on public financing
- b) Creation of a motivated and trained body of health personnel
- c) Rejection of cost recovery as a general financing policy.

5.2. Political and Social Context

Sri Lanka, formerly known as Ceylon, became an independent state in 1948. However, the country's history of more than 24 centuries has greatly influenced its culture, educational development, and ethnic composition as well as its current political situation. Sri Lankan culture places a high value on education. Buddhist culture and ideology have provided fertile ground for the welfare ideology that pervades the social sector of modern Sri Lanka and have supported the significant contribution women have made to social and human development in Sri Lanka. The colonial era began in 1505 and lasted almost 450 years; it consisted of successive rule by the Portuguese, Dutch, and finally, the British. This colonial heritage greatly influenced the modern-day political, legal, administrative, and health systems in Sri Lanka. Communication systems, an extensive network of roads and rail, Western medical services, and education in English were developed to support the plantation economy. A system of registration of

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9 Kirsty McNay, Regina Keith and Angela Penrose, Bucking the Trend, Save the Children 2004

vital events became operational in 1867 and drew attention to the common causes of death at that time. An important landmark in the socioeconomic development of Sri Lanka was the introduction of the elective principle as early as 1912, when "educated Ceylonese" were given the vote; universal franchise was granted in 1931, long before national independence in 1948. It is said that the reason for women in Ceylon to be enfranchised was that women's services would be of special value in coping with the high infant mortality rate in the island and with the need for better housing and improved midwifery and prenatal services. The elected representatives were able to bring pressure on the executive for a larger allocation of resources for the provision of social services to the constituencies they represented. Schools, rural hospitals, roads, and sub-post offices were the most common items in the list of demands. Direct taxation on income was introduced in 1932 and provided finances needed for the various welfare schemes. During this early phase, the government allocated substantial resources for expanding the state health system, including preventive and curative care. In 1928, 8 percent of government spending was for the health sector. Steady expansion of the system into rural areas, particularly in the early 1940s ensured access for the rural poor. Utilization of services was high, and it is believed that the use of health care services resulted in the rapid progress of social indicators during the subsequent post-independence era. The importance of education was acknowledged early and led to the rapid expansion of schools, especially in the first half of the 20th century, resulting in increasing levels of literacy. In 1945 education from school entry to university was declared free, stimulating unprecedented interest in education throughout the country. Education spread widely and contributed to health improvement. Expansion of education enhanced the health consciousness of the people and increased utilization of health services that were provided free.

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**Table 1 Vital Statistics 1945 – 2002**

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Mid-year Population '000</th>
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<th>Crude Death Rate</th>
<th>Maternal Mortality Rate Per 10,000 Live Births</th>
<th>Infant Mortality Rate Per 1,000 Population</th>
<th>Neo-natal Mortality Rate Per 1,000 Live Births</th>
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</table>

*Provisional  

Source: Registrar General’s Department

5.3. Historical perspectives of IAH

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The National Health Policy of Sri Lanka has been governed by the commitment to provide comprehensive health care to the entirety of its population, free of direct cost at the point of delivery. Four phases can be discerned in the evolution of Sri Lankan IAH. They are pre independence, post independence, post Alma Ata & the contemporary phases.

### 5.4. IAH in the pre independence era

Universal adult franchise was introduced in 1931 together with a measure of self-government. The constitutional reforms of this period established a State Council which consisted of a majority of elected representatives. The State Council selected a Board of Ministers who assumed a substantial measure of executive responsibility for the control and management of government. The first Board of Ministers consisted of seven Ministers. Among these the portfolio of Health constituted one Ministry. The Government made substantial investments in the health sector, expanding free public health services and in the health sector, expanding free public health services and extending the network of institutions for the delivery of health services which were now beginning to reach all segments of the population. An important aspect of the free education was the compulsory nature, which transcended gender boundaries. In fact, the education of future mothers is considered the single most significant contributory factor to the gains in health status of this country. Health literacy followed general literacy and the mothers made wise decisions when it came to safeguarding the health of their children, themselves and the family as a whole. They gave and still give their babies, a flying start in life. A third important development prior to Independence was the food distribution system and the State subsidy on rice. By 1946, the expenditure on health, education and the subsidy on food taken together amounted to approximately 29 per cent of total recurrent expenditure as per Ceylon Government's Accounts for 1945/ 46 financial year.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Main aim</th>
<th>Stakeholder/s that initiated intervention</th>
<th>Role of MOH</th>
<th>Main barriers that had to be overcome</th>
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<td>Universal adult franchise</td>
<td>Political voice to females &amp; males</td>
<td>National leaders / British Government</td>
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<td>A measure of self-government</td>
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<td>Board of Ministers</td>
<td>Do</td>
<td>State Council</td>
<td>MOH established</td>
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<td>Social welfare programmes</td>
<td>Social welfare</td>
<td>Board of Ministers / electorate</td>
<td>None</td>
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<tr>
<td>Free education &amp; health care</td>
<td>Social welfare</td>
<td>Board of Ministers / electorate</td>
<td>Establishment of health system</td>
<td>None</td>
</tr>
</tbody>
</table>
5.5. IAH in the post independence era

Despite several changes of Governments the welfare programme continued to be a constant element of public policies and all political parties who came to power remained committed to it. Thus, an “all party consensus” was reached by default. The core welfare programme outlined above was supported by several other poverty oriented programmes. These included a nation-wide village expansion programme which provided state land and subsidized housing to disadvantaged rural families. One of the investment programmes which had very high priority was the agriculture resettlement programme in the dry zone. It is seen that the remarkable improvement in the health indicators during this period have been the outcome of the continuation of the pre independence programme in which the health component was an integral part of a larger package of social welfare. Within it, improvements in health, education, food and nutrition and housing were closely interlinked and were mutually reinforcing. In such an approach the pursuit of health goals became a component of the larger strategy for the satisfaction of basic needs. However, for the health programme as a whole, the contribution of the non-health sectors to the realization of health goals was not perceived and articulated by the health planners themselves, nor was it consciously incorporated as part of national health strategy. The non-health sectors, each pursuing its own goals, interacted and contributed to the outcome in the health sector.

When development programmes result in adverse health impacts, action by the health sector to preempt or mitigate such effects becomes crucial. This became evident in the case of malaria and its effect on agricultural settlements. The health input into the development of the country through the eradication of malaria has been of immeasurable significance. For the most part the contribution of the health sector to other sectors is of a pervasive kind; in improving the physical well being of the population, it creates the conditions for increases in productivity and for more efficient participation in all sectors of economic and social activity. It would be useful to examine in some detail the factors which contributed to the success of the campaign for the control of malaria. It provides an example of how a specific health objective was linked to other major national objectives and how these links created the conditions for a major intersectoral action programme. The contribution of the health sector was vital to the success of the resettlement programme, the mobilization of national effort and the coordination of different sectoral inputs into the campaign. The development programme in the Dry Zone ranked very high in the national priorities.

The segment of the health services where elements of coordination was very evident was the specialized campaigns. They became a device for identifying an urgent health problem, giving it a special status within the health system and according high national priority so that other non-health sectors which were directly or indirectly linked to the problem had necessarily to commit themselves to it. The main diseases to which special attention was given in this manner were malaria, tuberculosis, filariasis, and to a lesser extent venereal diseases. The malaria campaign was in a very special category, as it was closely linked to the agricultural resettlement programme. The coordinating
machinery for the implementation of the campaign came to be established in a definite and highly visible form.

5.6. IA for other specialized campaigns

The post independent era saw the development of IA for other vertical disease control programmes. (NB it should be noted that the following paragraphs are taken from the publication at the end of the section. The nomenclature is what prevailed at that time).

5.6.1. Anti-tuberculosis campaign

A campaign which combined governmental activity with support from a large network of government & non-governmental agencies is the anti-tuberculosis campaign. Its strategies provide more relevant lessons for mobilizing the participation of the community and the target group for dealing with health problems.

5.6.1.1. The Ceylon National Association for the Prevention of Tuberculosis

CNAPT with a network of branch organisations has played a major role in control of TB. It has donated buildings and equipment to hospitals for the care of TB patients and continues to help maintenance of services. At one time, it co-operated with the campaign in the BCG vaccination programme by identifying the affected localities, recruiting vaccinators and volunteers for service, sending them to the affected areas and meeting the cost of the service. The association also co-operated in the Campaign's programme of health education. Village volunteers were recruited and trained to visit the villages and educate people in preventive and curative action against the disease. They identified cases which were either suspected or not reported and referred them to chest clinics for treatment, thereby helping to control the disease. The CNAPT also provides social assistance to low income patients until such time as the Social Services Department takes over.

5.6.1.2. Rural Development Societies

In collaboration with the local officers of the Campaign, these societies recruited and trained volunteers who assisted campaign officials in identifying cases for vaccination and for treatment at the nearest chest clinics. They also helped patients to obtain financial assistance from the Social Services Department.

5.6.1.3. The Sarvodaya Movement
This is an internationally recognized national NGO with a wide reach into all parts of the country. The Sarvodaya Movement co-operated with the Campaign in the same way as the Rural Development Societies.

5.6.1.4. Schools

Schools all over the country provided facilities to the Campaign in their health education programmes. School halls were made available for film shows, and lectures on the prevention and cure of tuberculosis.

5.6.1.5. Local Government Authorities

Some municipalities provide curative services through dispensaries and small medical institutions as well as refer detected cases of tuberculosis to the nearest chest clinic.

5.6.2. IA for anti filariasis Campaign

The Campaign's area of operation is the South and South West coastal areas, where the disease is prevalent.

5.6.2.1. Local authorities

The campaign operated mainly through local bodies to which reports were made of the health hazards of open pits and other infective areas so that action can be taken. The Colombo Municipality Council operates its own anti-filariasis campaign which includes a Vector Control Unit and several clinics in the city. The Campaign worked with local bodies on programmes of conversion of bucket latrines to water seal latrines, keeping drains clean, draining marshes and low-lying areas, repairing cesspits and removal of garbage and of receptacles which are mosquito-breeding grounds.

5.6.2.2. Schools

Heads of schools co-operated with local Campaign officials by making school halls available, free of charge, for health education programmes, film shows and lectures.

5.6.3. Sexually transmitted Diseases Control programme

The programme which was earlier known as the Anti Venereal Disease Campaign was directed by a Superintendent and operated through the normal medical institutions of the Health Department. The programme also had several horizontal linkages with other
government departments, public institutions, non-governmental organisations and voluntary associations:

5.6.3.1. District Administration

The Government Agents of the 24 Districts and the then Superintendents of Health Services of the 15 Health Divisions periodically reviewed the situation regarding the incidence and treatment of cases.

5.6.3.2. Social Services Department

Social Service workers and Marriage Guidance Counselors of the Social Services Department advised young people and motivated them to take action to avoid the occurrence of the disease. They also helped in detecting cases which were not reported and counseled the victims to take timely treatment. With the expansion of tourism a new penicillin-resistant strain of the disease was detected. The STDC Programme apprised the Government of the serious health hazard in areas where tourist hotels are located and enlisted the support of denominational organisations and community-level movements to warn people in the vulnerable areas to take precautions. Schools have included the teaching of the prevention and cure of the disease in the curriculum in certain grades. NGOs organized lectures and film shows on a routine basis in co-operation with the STDC Programme. The inmates of Prisons were regularly examined and prison staff given lectures. The courts refer cases of sexually transmitted diseases to the STDC Programme. Workers in the Ceylon Transport Board, tourist hotels, estates and large industrial concerns were regularly screened by the STDC Programme with the co-operation of trade unions and employers for detection of cases. Local authorities co-operated in the Programme by organizing health talks, exhibitions and blood surveys in their respective areas periodically. The Sri Lanka Broadcasting Corporation helped the programme with radio time for talks on sexually transmitted diseases.

5.6.4. Anti-Leprosy Campaign

At the national level, the Campaign organized intersectoral co-operation with government departments such as the Social Services and Education and with non-governmental organisations such as the Leprosy Association of Sri Lanka. The Campaign was administered by a Superintendent at the headquarters and 15 Regional Public Health Inspectors in each SHS Division.

5.6.3.1. Social Services Department

Persons identified by the Campaign as deserving of social security assistance were given
allowances by the Social Services Department ranging from Rs. 50 per month to an individual to Rs. 150 per month to a family dependent on a patient.

5.6.3.2. Schools

The Campaign carried out a regular leprosy survey of children in schools.

5.6.3.3. Sri Lanka Broadcasting Corporation (SLBC)

Radio time was made available to the Campaign for talks on leprosy.

5.6.3.4. Rural Development Societies, the Sarvodaya Movement and the Saukyadana Movement

These non-government organisations were helpful and liaised with the Campaign in the detection and treatment of cases.

5.6.3.5. The Leprosy Association of Sri Lanka

The Association collected funds from the public and assisted destitute patients financially. With the modern advances in curative treatment it became possible for most of the indoor patients to be discharged. They could be provided with domiciliary treatment and free drugs but most preferred to remain in hospitals so as to avail themselves of indoor care and maintenance for life. Much of the Campaign's resources were spent on such facilities for patients who are not in need of indoor care. The Leprosy Association worked in close collaboration with the Campaign to organize programmes for the rehabilitation of cured patients.

5.6.4. Legislation for IAH

Some legislative enactments have supported IAH:

5.6.5. Social Security Measures for Workers' Health

In furtherance of social welfare and security a number of laws have been enacted to safeguard the health and well-being of workers, special attention being paid to women and young people. The Shop and Office Employees Act which is applicable to the private sector, lays down that the period of work "in any week shall not exceed 45 hours and on any day shall not exceed 8 hours". There is also provision for annual compulsory
vacation leave with pay as well as sick leave with pay. Night work for women employees is prohibited in the larger interests of family welfare.

The Factories Ordinance sets out regulations regarding buildings in relation to standards of cleanliness, ventilation, lighting, and drainage and floor space. There are also prohibitions regarding work in confined spaces where there are toxic gases or harmful liquids without adequate safeguards. Similar provisions exist against exposure to injury to the worker's person and other occupational hazards.

The Maternity Benefits Ordinance with its subsequent Amendments stipulates that the liability of an employer to pay a sum of money as maternity benefits to a woman worker employed by him in any trade shall be a first charge on the assets of the trade. Expectant women employees are entitled to six weeks' maternity leave with pay; two weeks of such leave may be availed of before childbirth. The law also lays down that the employer of more than a prescribed number of women shall establish and maintain a creche for children under five years and that a woman worker nursing a child under one year shall be allowed nursing intervals at such times as she may require.

The Workmen's Compensation Ordinance provides for compensation for workers suffering personal injury caused by accidents in the course of their employment. This includes occupational diseases such as anthrax and lead poisoning.

There are also laws prohibiting the employment of children less than 12 years as well as laws prohibiting the employment of young persons in dangerous trades.

5.6.6. Transport facilities for access to medical institutions

Sri Lanka which has one of the cheapest transport systems in the world provides an island-wide network of rail and road services. This has enabled the majority of the people to have a convenient means of reaching hospitals, dispensaries, clinics and maternity homes. A State health care facility is situated at an average maximum distance of three miles from any habitation.

5.6.7. IAH in the education sector

The school curriculum has a health education component. In the primary school (grades 1 to 5) health is taught through a subject known as Environmental Studies. The child is given an introduction to food values and is also taught to become increasingly aware of the locality around the house and school. He is also given an elementary knowledge of sewage disposal and the consequences of living in unhygienic surroundings. From Grades 6 to 9 there is a Health Science programme which is compulsory for all pupils. The topics covered are, the anatomy of the body and the functions of the various organs; common infectious diseases; other diseases prevalent in Sri Lanka and their control; food and nutrition; housing - ventilation, drainage, Garbage disposal and criteria influencing
the selection of a house; community health - sources of water, immunization.

Home Science which is one of the pre-vocational subjects prescribes the study of the following topics which have a bearing on health: anatomy, food values, diseases, first aid and sick nursing, cleanliness of the house and surroundings, infant welfare and care of children, cookery.

The Social Studies programme requires the study of the environment, food and community health. In addition, pure science subjects entail a study of water, the atmosphere and the constituents of food.

The school's free mid-day meal, begun in 1945, was a measure which has to a limited extent helped to deal with the inadequate nutritional levels prevalent among children throughout the country. Generally the meal consisted of bread and vegetable curry, vegetable soup coconut sambol (salad) or jam. It is reported that, in up to 50 per cent of senior and bilingual schools and 25 per cent of junior schools, there was a full rice and curry meal subsidized by the Parent Teacher Association. In 1956 “Corporative for American Relief Every where” (CARE) milk and biscuits were distributed free in schools.

Schools also conduct extra-curricular activities which help to promote physical fitness and health. Within the curriculum itself provision is made for physical training.

5.6.8. The role of local level institutions, both governmental and non governmental, in IAH

The hierarchy of local government institutions - the Municipalities, the Urban Councils, the Sanitary Boards (later Town Councils) and the Village Councils date from as far back as the 1860s. Initially the membership of these institutions comprised both nominated officials as well as elected representatives of the people but later the entire membership was elected on the basis of adult franchise. These local bodies are charged with the responsibility of providing certain basic amenities which are required for the welfare, comfort and convenience of the residents within their areas of jurisdiction, such as roads, public wells, market places, fairs and sanitary facilities, maternity and child welfare clinics.

5.6.9. IAH by the community

Efforts have been made in the health sector to promote community participation at the local level in various activities through local level institutions such as the Rural Development Societies, the Women’s Societies, the Young Farmers’ Clubs, the Cooperative Societies, the Cultivation Committees, the Community Centres, the Conciliation Boards and the Parent-Teacher Associations. The activities of these institutions covered a wide range of functions which included a small component of health. But the overall objectives of their programmes are directed at achieving results
which also have a favourable impact on health in areas such as nutrition and health education. One of the stated objectives of the Rural Development Societies is to harness the enthusiasm and voluntary efforts of the people for the development of the village through diverse types of activities which include the improvement of environmental sanitation, personal cleanliness, maternity and child care services and the provision of milk-feeding schemes. The Women's Societies organize training classes in cookery, nutrition, health, First Aid, child care, sick nursing, personal and environmental hygiene and sanitation.

5.6.10. Role of NGOs in IAH

Up to the late 1950s there were only a few NGOs whose activities had a major and visible focus on aspects of health, namely the Red Cross Society, the St. John Ambulance Association, the Cancer Society, the Family Planning Association, and the indigenously motivated Saukyadana Movement. Since then however there has been a growing realization on the part of both the older and the more recently constituted NGOs that health is the base on which general human well-being can be promoted and strengthened and the key to human capacity and competence to lead socially and economically productive lives. A large number of NGO programmes have accordingly been formulated to deal with specific health needs or with a focus on health as an essential component in integrated efforts for human and social development. A Marga survey conducted on the health related activities of NGOs in Sri Lanka revealed that a large number of NGOs are engaged in some PHC activity or other. The most popular areas of intervention are health education and community organization for PHC, nutrition, child care and community development activities with health-related components. In the area of health education and community involvement in PHC two types of activity are discernible:

I. Broad-based programmes with emphasis on basic hygiene, nutrition and family health conducted by organisations such as the Boy Scouts, Girl Guides, Lanka Mahila Samithi, International Voluntary Service (IVS), Young Men’s Christian Associations, Young Women’s Christian Associations, Redd Barna, Sarvodaya, Save the Children’s Federation, Saukyadana, Social and Economic Development Centre (SEDEC), Muslim Women’s Conference, Red Cross and the St. John Ambulance Association.

II. Programmes directed towards specific areas of health and at the prevention and control of some of the major communicable and non-communicable diseases, such as those of the CNAPT, Family Planning Association, Nutrition Society of Sri Lanka, and the Sri Lanka Association for Voluntary Surgical Contraception, the Sri Lanka Cancer Society and the Chitra Lane School for the Special Child. Most NGOs disseminate knowledge about the causes of diarrhoeal diseases and the measures necessary for their prevention and control. Foremost in the field of nutrition was CARE with its programme for the distribution of “Thriposha” (a nutritional supplement) to nearly 300,000 children and mothers every month through a network of health clinics, estate clinics and voluntary agencies. Sarvodaya also has Substantial Island wide nutrition programmes which are implemented...
by its voluntary groups and, pre-school children and pregnant and lactating mothers. A special feature is the community kitchen which is an integral component of the Sarvodaya pre-school set-up. Other NGOs active in this field are the IVS, Mahila Samithi, Redd Barna, Save the Children's Federation, Muslim Women's Conference, the YMCAs and the YWCAs. Research on nutrition is carried out by the Nutrition Society of Sri Lanka.

NGO involvement in child-care programmes, with emphasis on the infant, pre-school child and the physically and mentally handicapped child, can be classified into three major types:

I. The provision of institutions for orphans - religious organisations like the All Ceylon Buddhist Congress, the Salvation Army and the National Christian Council as well as Service Civil international maintain institutions for orphans.

II. The provision of day-care centres, such as pre-schools and creches which is a high priority area in the activities of Sarvodaya. Special institutions for physically disabled and mentally retarded children, such as those maintained by certain religious organisations and interested groups of individuals, such as the Schools for the Deaf and Blind, the Madiwela House for mentally retarded children, the Preethipura Homes for the physically and mentally retarded, the National Christian Council's Home for mentally handicapped children, the Chitra Lane School for the special child and the Blue Rose School for children in need of special care in Kandy.

5.6.11. Community development with community participation

Community development with community participation is a popular area of activity of the large majority of NGOs. Comparatively significant in this field are the achievements of Sarvodaya, Redd Barna, the Lanka Mahila Samithi, Save the Children's Federation, SEDEC and Service Civil International. Community development subsumes other PHC priority areas like health education, nutrition, provision of safe water, sanitation, family health, maternal and child care, etc. and can thus facilitate the delivery of a package of interventions related to such areas. Community participation on its part has to be recognized as one of the key mechanisms for the promotion of PHC, especially in the rural areas and among the marginalized urban communities living in slums and shanties. For instance, whilst diseases like malaria, filaria, tuberculosis, leprosy and sexually transmitted diseases can be effectively handled through special campaigns and other government interventions, diseases such as diarrhea which stem from poverty, unsanitary living conditions and a deep malaise in the physical quality of life and to which the most vulnerable sections of the community are susceptible, need to be handled at the community and family levels, where NGO involvement can be more effective.  

17 Inter sectoral action for health, MARGA institute, Colombo, 1984
5.6.12. Integrated Rural Development Program (IRDP)

In the late 1970s, the government of Sri Lanka launched the IRDP with several ambitious objectives: to decentralize planning and implementation, increase rural incomes in districts with a large proportion of low-income rural residents, and create needed infrastructure to reduce disparities within districts. The initiative concentrated its projects in the poorest districts that had not benefited from major government investments. For example, the Kurunegala IRDP had the following sub-components:

- modernize irrigation and water management;
- rehabilitate and replant coconut holdings;
- improve agricultural extension services;
- increase supplies of agricultural inputs;
- expand credit operation and resources;
- improve rural roads and water and electricity supplies;
- upgrade educational and health facilities in rural areas; and
- establish project coordination and monitoring capabilities.

In an evaluation of the programme in three districts, inter alia, the following aspects came to light:

The infrastructure built and upgraded by the projects has had a positive impact on the quality of rural life in all three districts. The roads improved access to health and educational facilities. Many said that the time needed to fetch water had been significantly reduced and that the quality of the water had improved. The cleaner water had helped to improve health, especially among children.\(^\text{18}\)

\(\text{Table 3 Analysis of strategies and mechanisms for achieving IAH in Sri Lanka – Post independence era}\)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Main aim</th>
<th>Stakeholder/s that initiated intervention</th>
<th>Role of MOH</th>
<th>Main barriers that had to be overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public policies</td>
<td>Continuation of welfare programmes</td>
<td>Electorate &amp; political parties who came to power</td>
<td>None</td>
<td>All party consensus, which was achieved</td>
</tr>
<tr>
<td>Dry Zone development programme</td>
<td>Agricultural development / poverty alleviation</td>
<td>Government</td>
<td>Malaria control</td>
<td>Coordination of health activities which was achieved with experience</td>
</tr>
<tr>
<td>IA for specialized campaigns</td>
<td>Mobilizing participation of the community and the target groups for dealing with specific health problems.</td>
<td>Vertical disease control programme</td>
<td>Provision of leadership &amp; resources</td>
<td>Initial lack of ownership at operational levels, which was forth coming later on</td>
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</tbody>
</table>

\(^{18}\) http://lnweb18.worldbank.org/oed/oeddoclib.nsf/DocUNIDViewForJavaSearch/67235EEDA5A042DD852567F5005D4761, accessed on 24.05.06
Intersectoral action for health in Sri Lanka

Legislation for IAH | Provision of supporting legal environment | Trade unions, relevant Ministries | Support in implementation | Initial resistance from some employers, which was overcome by negotiation
---|---|---|---|---
IAH in the education sector | Promotion of healthy living | Relevant Directorate in Health Ministry | Lobbying with Education Ministry | Initial reluctance from Education Department overcome by persuasion
Support of local level institutions, both governmental and non governmental, in IAH | Community participation | Relevant Directorate in Health Ministry | Lobbying | Initial reluctance overcome by persuasion
Integrated Rural Development Program | Integrated development of backward Districts | Ministry of planning, donors | Implementation of health component | None

5.7. IAH – post HFA

A landmark in IAH was the signing of the Chanter for Health Development by the Prime Minister and the Minister of Health with the World Health Organization on 7 February 1980. The Government of Sri Lanka thereby committed itself to the attainment of an acceptable level of health for all its citizens by the year 2000 with PHC as the key approach to achieving this goal. As a part of this strategy the Government established the National Health Development Network for IAH. The apex is the National Health Council established in November 1980 with the Prime Minister as the chairman. Thus was born a formal mechanism to ensure political commitment for IAH at the national as well as sub national levels. The other members of the Council were, the Ministers of Health, Agricultural Development and Research, Higher Education, Education, Finance and Planning, Local Government, Housing and Construction, Home Affairs, Labour, & Rural Development.

The functions of the Council are:

I. To provide national level political leadership for health development;
II. To guide Ministries, departments and other organisations engaged in health activities;
III. To coordinate activities of Ministries and other organisations;
IV. To create greater awareness among people of the importance of health; and
V. To promote community participation and involvement.

The NHC sets out the policies of the Government in regard to health care, mobilization of non health sectors for the achievement of the goal of Health for All, the modes of coordinating multi-sectoral action and measures for enlisting popular participation in public and private sector programmes of health care. The Council has created awareness in Ministries and their departments that health is a concern of all of them and not only of the Health Ministry and that their activities in health related matters need to be centrally
coordinated. The Council is supported and serviced by the National Health Development Committee (NHDC) which is a committee of the senior officers of the relevant Ministries and other officers whose activities impinge on health.

The NHDC which was established in November 1979 has three principal functions:

1. To undertake continuing review of the activities in the health and health-related sectors with a view to identifying constraints and ensuring speedy implementation of programmes and projects;
2. To identify priority issues and recommend policy initiatives for formulation of national health policy; and
3. To promote and coordinate the health-related activities of the relevant Ministries and organisations.

With a view to promoting multi-sectoral action and intersectoral coordination at sub-national level, the Government established District Health Councils (DHCs) in each of the 24 administrative districts of Sri Lanka. Their functions are:

1. To propose programmes for the respective districts on the policy guidelines set out by the National Health Council;
2. To give leadership at the district level for health and health-related activities; and
3. To recommend, if they think fit, the establishment of divisional health committees and village level organisations to perform the same functions as the DHCs.

The mechanisms for intersectoral action are so structured that much of the initiative for action by the NHDC has to originate from the DHCs which actually face the day-to-day tasks and problems of delivery of health services to the people. Far reaching changes in the general administrative structure were made in order to decentralize the administration and enlist popular participation in regional administration. District Development Councils (DDC) was set up in July 1981 for planning, policy-making and development administration of each of the 24 districts. A DDC comprised the Members of Parliament of the District and elected representatives of the people. The District Minister, a Member of Parliament, was the head of the district administration. All activities of government departments and public sector organisations in the district came under the purview of the DDC and the control of the District Minister. Further, a proposal was adopted to bring this decentralized set-up closer to the village by setting up health committees at the level of the Gramodaya Mandalayas (Village Councils).

Prior to July 1981 there was an organization for the coordination of the activities of government departments and public sector organizations in each district known as the District Coordinating Committee (DCC) of which the Government Agent of the District was, the chairman & its members were the local heads of departments, Members of Parliament and the heads of local authorities in the district. It was largely an advisory body and did not have real powers of planning, decision-making and implementation. Matters pertaining to health, for example, were discussed and if they needed multi-sectoral action the DCC made appropriate recommendations to the relevant Ministries or
departments. The Government Agent coordinated any multi departmental action which was approved by the relevant Ministries. With the establishment of District Development Councils, there was a certain amount of devolution of political power and decentralization of the administration. The planning of PHC in the district, the achievement of the goal of HFA and the delivering of health services now fell within the competence of DDCs. In these functions, the District Health Councils played a leading role in preparing position papers, planning health services in the district and making recommendations to the DDC and the District Minister in regard to intersectoral action. They were also in a position to communicate effectively with the six standing committees of the NHDC on the district’s needs of PHC, health manpower, drugs, health and medical research, traditional medicine and appropriate technology. The NHDC set up six Standing Committees on each of these subjects. The progress of the National Health Development Network during the few months of its existence has been impressive. PHC is given priority in the activities of the network. The National Health Council has re-oriented health policies towards achieving the objective of Health for All through primary health care. The NHDC has discussed concrete programmes of action towards achieving the national objectives. It has commissioned the standing committee on PHC to identify areas of action and prepare guidelines for other sub-sectoral programmes.19

Table 4

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Main aim</th>
<th>Stakeholder/s that initiated intervention</th>
<th>Role of MOH</th>
<th>Main barriers that had to be overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chanter for Health Development</td>
<td>Commitment to HFA / PHC</td>
<td>WHO</td>
<td>Follow WHO initiative</td>
<td>None</td>
</tr>
<tr>
<td>Establishment of the National Health Development Network</td>
<td>Intersectoral cooperation for HFA / PHC</td>
<td>WHO</td>
<td>Implementation of WHO initiative</td>
<td>None</td>
</tr>
</tbody>
</table>

5.8. Decentralization & IAH

Decentralization, which spans all four phases, provided an impetus to IAH. When independence dawned, the Department of Medical & Sanitary Services was directing the Health Services of the country. It was soon realized that this relic of the colonial era was not responsive to the needs of a newly independent nation. Dr. J.H.L. Cumpston, the former Director General of Health Services of Australia studied the working of the Department in 1949. His report was published as Parliamentary sessional paper 10 of February 1950. He recommended reorganization of the Department and decentralization of administration, to be more responsive to the needs of the people. The legislators responded quickly with the Health Services Act No. 12 of 1952, to give legal effect to important recommendations. Thus was born the Department of Health. A Consultative Health Council, to guide the Department was set up. The setting up of Hospital Committees made community participation in hospital management possible.

19 Intersectoral action for health, Sri Lanka study, MARGA Institute, 1984
1954 saw the next step in decentralization, with the appointment of 15 Superintendents of Health Services (SHS). The vertical campaigns were decentralized & more authority was given to control diseases that were major threats to the people.

The Provincial Councils were set up in 1987 by the 13th amendment to the constitution. The health administration was totally devolved and the line Ministry was given the responsibility of formulating policy, the management of Teaching Hospitals, Special Hospitals, Specialized Campaigns, technical training institutions and bulk purchases of medical supplies.

In 1992, the Divisional Directorates of Health Services were created. This was in step with the decentralization of general administration to the Divisional Secretariat level. The Divisional Director was given the responsibility of providing comprehensive promotive, preventive, curative and rehabilitative care at a primary level to the people in the division. The people and the health staff are afforded the opportunity of presenting their problems to a health manager at the divisional level, well within their reach. This fact was borne out during the study into the working of the Divisional Directorates undertaken in 1995.20

Table 5 Analysis of strategies and mechanisms for achieving IAH in Sri Lanka – Decentralization

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Main aim</th>
<th>Stakeholder/s that initiated intervention</th>
<th>Role of MOH</th>
<th>Main barriers that had to be overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creation of Superintendents of Health Services</td>
<td>Decentralization of administration</td>
<td>MOH</td>
<td>Appointment of Superintendents of Health Services</td>
<td>None</td>
</tr>
<tr>
<td>Establishment of Provincial Ministries of Health</td>
<td>Devolution to Provinces</td>
<td>Ethnic conflict</td>
<td>Devolution of health care services</td>
<td>Resistance from staff of Line Ministry, overcome with time</td>
</tr>
<tr>
<td>Establishment of Divisional Directorates of Health</td>
<td>Decentralization to Divisional level</td>
<td>President</td>
<td>Support establishment</td>
<td>Initial resistance from doctors, compromised by excluding DDHS from the administrative control of the Divisional Secretary.</td>
</tr>
</tbody>
</table>

5.9. IA for leprosy elimination – social marketing

Sri Lanka has made much progress in eliminating leprosy. The introduction and expansion of Multi Drug Therapy (MDT) in 1982, and the launching of the awareness campaign; the Social Marketing Campaign in 1990 to educate the general public about early signs of leprosy and to dispel misconceptions surrounding the disease, have resulted in the achievement of the national level leprosy elimination target in 1995.21 Although,

20 Ministry of Health & Indigenous Medicine, health development in Sri Lanka, published to mark 50th anniversary of Sri Lanka’s independence, February, 1998
21 Ministry of Health, Administrative report of Director General of Health Services for 2002
all registered cases were receiving MDT within the short span of a year, transmission continued at a disturbing rate at the initial stages. It was clear that many hidden cases were not being reached. Active case detection via house to house searchers was considered far too expensive and, moreover, might actually increase the fear and stigma attached to the disease. The government looked for another solution. This came in 1990 when the Ministry of Health, assisted by a Swiss charity organization and the Novartis Foundation for Sustainable Development, launched a professional, powerful, and broad-based advertising campaign aimed at changing the public image of leprosy. By portraying leprosy as just another treatable disease, the campaign motivated people with suspicious lesions to come forward for early diagnosis and free cure. Apart from being much less costly, such “passive case detection” with its reliance on self-reporting, attracted strongly motivated patients who could be counted on to follow treatment carefully. Messages were beamed to the masses via radio and TV spots, serials, and popular soap operas. Billboards, buses, and walls were plastered with positive slogans and images. The grassroots level was secured through health education training for close to 5000 selected opinion-leaders. Letters and health education materials were sent to the nation's clergy. School-teachers were provided with flip charts to help them get the word out to children. In remote areas beyond the reach of radio and TV, week-long education sessions were held and supported by “skin camps” which combined leprosy detector activities with the lure of free treatment for skin ailments. The results were spectacular. In less than a year, case detection had increased by 150%. Even more impressive was the vast increase in self-reporting. While in the year prior to the campaign, only 9% of new cases were self-reported, the figure rose to 50% by 1991 and has remained high in subsequent years. Since the start of the campaign, more than 20,000 patients have been detected and treated. Awareness of the first signs of leprosy and the availability of a cure is now widespread. The image of leprosy has moved from one of fear and loathing to one of hope and cure. With greater self-reporting and strengthened services, Sri Lanka was gradually able to clear the backlog of cases and reduce the pool infection.22

Table 6 Analysis of strategies and mechanisms for achieving IAH in Sri Lanka – social marketing for leprosy elimination

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Main aim</th>
<th>Stakeholder/s that initiated intervention</th>
<th>Role of MOH</th>
<th>Main barriers that had to be overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advertising campaign using private sector advertising expertise</td>
<td>Changing the public image of leprosy</td>
<td>A Swiss charity organization and the Novartis Foundation for Sustainable Development</td>
<td>Led initiative</td>
<td>Reluctance to use expensive private expertise, overcome since Government did not fund initiative</td>
</tr>
</tbody>
</table>

5.10. Janasaviya / Suwasaviya / Samurdhi

22 WHO, Sri Lanka using mass media to change attitudes & increase case detection, learning from success, Geneva, 2001
Sri Lanka has a long tradition of providing income support and economic advancement assistance to poor groups. Nearly one-fifth of the Government’s current expenditures are used for transfers to households, a share of public spending normally witnessed only in upper-income nations. A state sponsored poverty alleviation programme, the Janasaviya, was introduced in 1989. The current Samurdhi programme provides cash grants to some 2.1 million families, including some 403,000 Janasaviya families transferred to the Samurdhi programme and separate cash grants to 82,000 families under the infant nutrition programme. It also operates a range of compulsory savings, a Samurdhi bank society, and national youth job creation and village development efforts.

The Sri Lanka Samurdhi Authority implements programmes at the districts and divisional secretaries and community levels jointly with the NGO "Sri Lanka Sumitrayo" to prevent people from committing suicide. The Authority has attached a Samurdhi Manager to "Sri Lanka Sumitrayo" to make an active contribution towards it through the Samurdhi structure. A Samurdhi Flag Day is launched from 1996 to date in respect of international anti smoking day each year. The intention is to get people to spend money wasted on cigarettes on divisional development activities.

5.11. Some innovative IAH in the contemporary era

In the contemporary era, IAH has been consolidated by addressing specific issues by way of formulation of policies & strategies, establishment of coordinating mechanisms & through donor funded projects:

5.11.1. IA for implementing policy on the aged

In 1998 the Ministry of Health appointed a Director (youth elderly, disabled & displaced). In 2000, a pilot project in active ageing was started in 50 MOH areas, using a multi sectoral approach to improve the well-being of the elderly. It was community driven to ensure sustainability. The strategies adopted include: improving the care-giving capacity of the family through trained health volunteers; strengthening the inter-sectoral collaboration within each MOH area; encouraging and improving community participation; conducting research and disseminating results; providing appropriate education and training; creating awareness on active ageing among all members of the community using identified advocacy target groups (such as public sector officials, school children, school teachers, formal and informal leaders in the community, elders and their family). The community identified the needs. It was made clear that the programme was there to help the community by coordinating resource requirements. The requirements were identified by a community survey undertaken by the PHM of the area, with the help of volunteers. A number of activities were carried out subsequently with the

23 http://www.treasury.gov.lk/EPPRM/crd/eprrmpublications/poverty/chapter4%20version%203.doc, accessed 31.05.06
24 Samurdhi Ministry, progress report 2001 to Parliament
help of all concerned to felicitate elders, recognize their talents & provide services. In some instances, the MOH initiated establishment of day care centres. 10 centres were established by one enterprising MOH. He also spearheaded a drive to collect funds & open an eye ward in the nearest secondary care hospital. Information was recorded in individual files which were used by care providers & researchers. Any care provided was recorded here & these used for follow up too. 26

5.11.2. World Bank funded health sector development project (HSDP)

The third component of HSDP aims at strengthening the capacity for stewardship of the Central MOH and increasing the credibility, transparency and accountability of the public health system. One activity is the Annual Health Forums (AHF) to encourage participation of different stakeholders in the policy making process. 27 AHF is a strategy to generate a process to create transparent, evidence based and impact oriented health plans both at the center and at the provinces. What are to be developed are concrete investment plans taking into consideration the priorities, optimization of inputs and benefit as defined by the outputs or impacts. Investment plans for health will allow all the stakeholders to review the health system for their interests, modes of prioritization and evidence-based policy formulation. In particular, the government, private investors and the donors will then have an opportunity to decide the best options for future investments in the health sector. The AHF will be held at an appropriate time within the budget cycle, as a two to three day programme. The stakeholders will consist of health activists, representatives of patient groups, politicians, trade union representatives, community leaders, health officials, international donor agencies, private sector representatives, Representatives of Ministries of Finance, National Planning, Finance Commission, Public Administration etc. At this meeting the following will be presented to the participants:

- Evidence of adoption of a sector-wide planning approach to health
- Health plans for the coming year
- Health sector performance of the previous year against selected indicators
- Papers for policy dialogue on selected issues that would guide preparation of future plans and actions based on external review and in-depth research
- New plans and strategies for the coming year
- Performance indicators (revised) for the coming year
- Procurement plan for the coming year
- Investment plan for the consideration by external and internal development partners

26 Perera, Deepthi, D(youth, elderly, disabled & displaced) Ministry of Health. Personal communication.

27 http://www.worldbank.org/external/default/WDSContentServer/IW3P/IB/2004/05/26/000160016_20040526102053/Rendered/INDEX/28915.txt, accessed on 18.05.06
Several outcomes are expected of the AHF. Out of these, the most important would be, a consensus can be reached regarding a sector wide planning approach to health. The presence of indicators which looks at sector wide performance will ensure the expected integration among various plans both vertically and horizontally. The second most important outcome would be the raising of issues for discussion by all stakeholders for policy direction. This policy dialogue will ensure transparency of decision making and accounting for the varied interests of the stakeholders. As this continues annually issues such as equity, quality standards and improving efficiency of the system can be openly discussed and agreements could be reached. Another advantage of this exercise would be to scientifically explore the validity of assumptions of existing policy (implicit or explicit) and change them for better, based on evidence. The external review and in-depth research will add the required credibility to the decision making process with regard to prioritizations and strategies embedded in health plans. The investment plan will assist both the external donors and the government to prioritize issues and have external development partners plays a useful role with in an integrated health development exercise by funding a component of the health plan instead of a project. Similarly, the presentation of the procurement plan at this open forum will ensure transparency of resource allocations, procurement procedures and the appropriateness of procured items.  

*5.11.3. Food and Nutrition Policy of Sri Lanka, 2004-2010*

A well formulated food and nutrition policy will assist in guiding partners in development to increase coordination between each other as well as permit the efficient allocation of resources within line Ministries, administrative structures and non-governmental organizations. It is with this intention that the present food and nutrition policy has been formulated. There are 18 policy recommendations embracing all relevant sectors. The basis is that food security and nutritional wellbeing of the people should be pursued as an essential development goal in all spheres of national development.  

*5.11.3. IAH for specific diseases - Global Fund to fight Aids TB & Malaria (GFATM)*

The Global Fund aims to attract, manage and disburse resources to fight AIDS, TB and malaria. The Country Coordinating Mechanism (CCM) model used by the Global Fund encourages innovative alliances among partners in recipient countries, drawing on the active participation of civil society, including the private sector. Such broad membership has helped to improve the quality of funding proposals, increased information sharing and trust between planners and health care workers, and contributed to a strong sense of shared ownership. CCMs are country-level partnerships that develop and submit grant

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28 Director (Organization & Development) Ministry of Health Care & Nutrition, personal communication.
29 Report of the Inter Ministerial Committee on Food Security, personal communication from Chairman, February 2005
proposals to the Global Fund based on the country’s priority needs. After grant approval, they oversee progress during implementation. CCMs are central to the Global Fund’s commitment to local ownership and participatory decision-making. They include representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, nongovernmental organizations, academic institutions, private businesses and people living with the diseases.\(^{30}\) Sri Lanka was one of the few countries successful at the first round of call for proposals from the GFATM & awarded grants for malaria & TB projects. This was a unique exercise in IA to address three specific diseases undertaken in early 2002 with the setting up of the CCM chaired by the Secretary, Health Ministry.

For instance, the GFATM malaria control project supplemented the already existing National Programme for Malaria Control and was in line with the Roll Back Malaria (RBMI) Initiative catalyzed by the WHO. Project assisted the rehabilitation programme carried out by the Government in the previously conflict-affected North-East Province. It strengthened the work of NGOs, private sector, civil society & other stake holders mobilized under the RBMI project. Major components of the project included preventive measures such as health education in the community, spraying, use of treated bed nets, etc., to be carried out by the partners. The Government and NGOs provided treatment and other curative, diagnostic and referral services to the patients suffering from malaria. Specific strategies included:

a) Creation of community based organizations to produce and sell low cost mosquito nets. This helped in generation of employment among the populations covered by the project.

b) The Private Medical Practitioners’ Association conducted a “Distant Education” module to improve the knowledge and skills of the Private Practitioners functioning in the conflict affected North-East Province, towards better detection & treatment of malaria patients.

c) A network of community-based centers for the breeding and distribution of larvivorous fish to mosquito breeding sites amenable for larval control by fish.

### 5.11.5. World Bank grant for HIV / AIDS project

The Project will assist the Government of Sri Lanka to curb the spread of HIV infection among its highly vulnerable subpopulations and the population at large, without stigmatizing those who are engaging in high risk behaviors. Furthermore, by acting now to revitalize and expand the tuberculosis control program, Sri Lanka can help reduce the risk of an emerging HIV-associated TB epidemic among the HIV-infected and the non-infected. There are three project components. The first expands prevention programs for highly vulnerable groups and the general population, in particular youth. The second component develops programs to sustain political and societal commitment to HIV/AIDS prevention and to reduce stigma and discrimination against people living with HIV/AIDS and expands coverage and quality of treatment services and develops research. The third

\(^{30}\) http://www.theglobalfund.org/en/about/publications/brochure/ accessed on 23.05.06
component strengthens multisectoral involvement and capacity, improves the information base for policy decisions and program management, and improves health care waste management.  

5.11.6. Population and reproductive health policy

The policy aims at achieving a higher quality of life for its people by providing quality reproductive health information and services, achieving gender equality, providing health care and social support for the elderly, promoting the economic benefits of migration and urbanization while controlling their adverse social and health effects and reaching a stable population size in the long term. Eight Goals constitute the policy. The strategies for achieving the Goals will be implemented through specific programmes developed by a multi sectoral task force of all stake holders. In the action plan, the roles and responsibilities of the national and sub-national administrations, NGOs including CBOs and the private sector have been identified. The development of mechanisms for coordination and the provision of adequate resources have been identified. The task force was appointed by the Ministry of Health and Indigenous Medicine on the 04th of March, 1997. The policy was approved on 23rd December, 1997 by the National Health Council. The Cabinet of Ministers approved same on 27th August, 1998.

5.11.7. National Commission on Macroeconomics & Health

The WHO Commission on Macroeconomics & Health aimed to develop strong political leadership and reinforce commitments at country level for sustainable investment in health, especially for the poor. This was to be achieved by interacting with political leaders, policy makers and opinion formers in order to influence their decisions. It also sought to create a national consensus based on coalitions built between stakeholders ranging from ministries of health, finance, planning and other public sector departments, international and bilateral agencies, private foundations, civil society, academia, the private sector and other partners. The aim is to review national policies and plans on the relationship between macroeconomics, health and poverty and to strengthen strategies and health systems through targeted interventions and increased investments in health. Sri Lanka was one of the first countries to realize the value of the report of the Global Commission on Macroeconomics and Health (CMH) for advocacy & charting a course for enhancing investment in health. In August 2002, the National Health Council (NHC) decided to set up the NCMH. The NCMH was set up in November 2002. It was co-

31 http://www.wds.worldbank.org/external/default/main?pagePK=64193027&piPK=64187937&theSitePK=523679&menuPK=6418751 0&searchMenuPK=64187511&siteName=WDS&entityID=000094946_02120304010866, accessed on 10.05.06
32 Ministry of health and Indigenous Medicine, population and reproductive health policy, 1998
33 WHO, Supporting global & country responses to the Commission on Macroeconomics & Health Macro Health Proposed Strategy, Plans and Work in Progress: a Summary, www.who.int/entity/macrohealth/documents, accessed on 01.06.06
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chaired by the Minister of Health and the Deputy Minister of Finance (an Economist) who was also the Minister for Rural Economy. It has a planning committee chaired by the Secretary Health with a secretariat to support two working groups (budgeting and financing issues). The Ministries of Finance and Planning have over the last few years acknowledged that resources for health constitute productive investment for development and do not constitute an item of consumption. The reasons for this change of perception are not known. With the NCMH in position, these ministries have expressed their commitment to increase investment in health from the current 1.6 % of GDP to 2.4 in the medium term, as a platform for socio economic development.

5.11.7.1. Institutional support mechanisms for NCMH - Planning Committee

Committee is chaired by the Secretary Health. Members are representatives from Institute for Policy Studies, WHO, Economics Department of the University of Colombo, Marga Institute (a prestigious NGO dealing with development issues) and Management Development and planning Unit (MDPU) of the Ministry of Health.  

Table 7 Analysis of strategies and mechanisms for achieving IAH in Sri Lanka – IAH in the contemporary era

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Main aim</th>
<th>Stakeholder/s that initiated intervention</th>
<th>Role of MOH</th>
<th>Main barriers that had to be overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementing policy on the aged</td>
<td>Coordinating health care to the elders</td>
<td>WB, Ministry of Social Services</td>
<td>Appointment of a Director</td>
<td>None</td>
</tr>
<tr>
<td>Health sector development project</td>
<td>Strengthening stewardship</td>
<td>WB</td>
<td>Implementing agency</td>
<td>None</td>
</tr>
<tr>
<td>Food and Nutrition Policy of Sri Lanka,</td>
<td>Ensure food security</td>
<td>Advisor to PM &amp; Nutrition Society</td>
<td>Provision of a Consultant</td>
<td>None</td>
</tr>
<tr>
<td>IAH for specific diseases</td>
<td>GFATM</td>
<td>Consortium of donors</td>
<td>Hosting of Country Coordinating Mechanism</td>
<td>None</td>
</tr>
<tr>
<td>WB HIV / AIDS project</td>
<td>Inter sectoral action to prevent HIV</td>
<td>WB</td>
<td>Leadership</td>
<td>None</td>
</tr>
<tr>
<td>Population and RH policy</td>
<td>Quality reproductive health services</td>
<td>MOH, UNFPA</td>
<td>Leadership &amp; hosting of task force</td>
<td>None</td>
</tr>
<tr>
<td>National Commission on Macroeconomics &amp; Health</td>
<td>Sustainable investment in health, especially for the poor</td>
<td>WHO, National Health Council</td>
<td>Leadership &amp; coordination</td>
<td>None</td>
</tr>
</tbody>
</table>

5.12 The impact of IAH on equity

34 www.who.int/entity/macrohealth/infocentre/presentations/en/9sri_lanka_backround.pdf
Sri Lanka invested in human development in preference to pure economic development. This multi-sectoral approach was crucial to equity. The health infrastructure in this country evolved mostly in response to the need of the community vocalized by the political leadership. Some innovative steps taken in response to economic difficulties enhanced equity. The concept of essential drugs and rational drug policy was the brainchild of late Professor Senaka Bibile. Important parts of this policy were the creation of the National Formulary Committee in 1958, which reduced the number of drugs to 500 (by generic name) for use in the hospitals. This was long before the WHO essential drugs list (1977). The country faced a crisis in the balance of payments in the late sixties. The government responded by rationalizing the import of drugs and creation in 1971, of the State Pharmaceuticals Corporation as the sole monopoly agency to import drugs for the public as well as the private sector.

5.13 Armed conflict, equity & IA

The two decades old armed conflict posed a major challenge to equity. Infrastructure was affected & human resources depleted. The situation was redeemed to a certain extent by innovative responses. Free food rations & medical supplies were sent uninterruptedly to uncleared areas, inspite of the fact that the supplies were being siphoned off by the militants. The medical leadership in the affected areas, who stuck to their positions & duties under extreme conditions, had sufficient clout with the militants to ensure a policy of non-interference with the health services & not targeting of health staff to achieve military & political ends. UNHCR, ICRC, Sri Lankan Red Cross, Other humanitarian organizations served these areas & the borderline areas unchallenged by both sides. In situations where Ministry officials could not visit conflict affected areas, regular meetings with staff in these areas in Colombo led to resolution of problems. A committee to coordinate NGO activities at the centre was very useful. Inter national & national NGOs supplemented human resources & augmented service delivery. There was major damage to infrastructure of the health system & mobile services were able to fill the breach to some extent & ensure delivery of services especially maternal & child care. UNICEF organized cease-fires on national immunization days.

Table 8 The impact of IAH on equity

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Aspect of equity it focused on</th>
<th>Main mechanism</th>
<th>Whether equity was a clear target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in human development</td>
<td>Access to education, health services &amp; food supplements</td>
<td>Free education, health services &amp; food supplements</td>
<td>Yes</td>
</tr>
<tr>
<td>Development of health infrastructure</td>
<td>Access</td>
<td>Need of the community vocalized by the political</td>
<td>Yes</td>
</tr>
</tbody>
</table>

6. Current & future challenges for equity & IAH

The demographic and epidemiological transition confounded by unhealthy life styles has resulted in non-communicable diseases dominating the morbidity & mortality pattern of the country. The increased requirement of drugs (life long) for these diseases constitutes a substantial and ever increasing demand. The demand for high tech and high cost interventions poses another problem. Sri Lanka is a low HIV prevalence country. However, most of the risk factors that led to the current epidemic in Africa, and which were visible in those countries a decade or two ago are visible at this point in time. Since there is universal accessibility to health care, improving quality of care is high priority. The 20-year war in the North East caused a rapid deterioration of the Health Status, Infrastructure and Human Resources. A major rehabilitation programme has been launched and needs huge amounts of resources. The country is committed to achieve the millennium development goals & has developed its own health sector indicators & targets. These challenges call for new initiatives for IAH & social mobilization.

6.1. Ten year master plan for health development

The presidential Task Force to formulate health policy appointed in 1997 was reviewed soon after, by Prof. Bill Hsiao on the request of the World Bank. While agreeing broadly with the report of the task force, Prof Hsiao was of the opinion that no major changes need to be made in Health Policy and strategy. There was an implicit indication for a Master Plan. The government of Sri Lanka made a request to the Government of Japan in 2001 to make available technical support to prepare a Master Plan. Around the same time the World Bank suggested a policy on Human Resources Development (PHRD) Study. The Master Plan study and the PHRD study were launched more or less simultaneously, in early 2002. The output of these two studies led to the strategic framework of the Ministry of Health, which was the basis for the Master Plan.

6.1.1. The Strategic Objectives of the master plan:

1. To ensure delivery of comprehensive health services which reduce the disease burden and promote health.
2. To empower communities towards more active participation in maintaining their health
3. To strengthen stewardship and management functions of the Heath System
4. To improve human resources for health development and management
5. To improve health financing, resource allocation and utilization

Second & third objectives have over tones of IAH. For example, to empower communities towards more active participation in maintaining their health, it is planned to improve participation of civil society and Non-Governmental Organizations in promoting behavioural and lifestyle changes. To strengthen stewardship, strengthening of coordination and partnerships with other sectors, is envisaged.

To empower communities towards more active participation in maintaining their health, it is proposed to achieve the following outputs:

1. Improved public awareness of their rights, responsibilities and options for care.
2. Improved participation of civil society and Non-Governmental Organizations in promoting behavioural and lifestyle changes.
3. Behaviour change communication for healthy living.

To strengthen stewardship and management functions of the health system it is proposed to achieve the following outputs:

- Strengthened managerial performance at national and decentralised levels
- Enhanced efficiency, effectiveness and accountability of the MOH & decentralised units.
- Performance management systems introduced.
- Established a system for regulating the services of public & private providers
- Strengthened management information system
- Strengthened coordination and partnerships with other sectors
- Strengthened capacity in health research and technology assessment

Table 9 Time line for some important landmarks in IAH

<table>
<thead>
<tr>
<th>Landmark</th>
<th>Date</th>
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<tbody>
<tr>
<td>Universal franchise granted</td>
<td>1931</td>
</tr>
<tr>
<td>Universal free education up to University level</td>
<td>1945</td>
</tr>
<tr>
<td>Independence</td>
<td>1948</td>
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<tr>
<td>Post independence</td>
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6.2 Some personal reflections on strategies to ensure IAH

Intersectoral coordination is one of the most difficult aspects of management. An official of the Health Ministry chairing a coordinating mechanism has no administrative control over the sectoral actors in case they are reluctant participants. IA necessitates commitment of resources of individual sectors which the participant may not be in a position to ensure if the decisions are made above his level. Such commitments often mean sacrificing of some resources from regular programmes of the sector concerned. When inviting participation, it is vital to indicate exactly the level & experience required. Coordinating meetings are most difficult to chair & conduct. The agenda can be a mine field if not properly planned in advance by the chair. The traditional first item is the confirmation of minutes of the previous meeting which goes off smoothly. The second traditional item, the matters arising from the minutes poses the greatest challenge. It is the author’s experience that hardly any body reads the minutes & comes prepared. At times it is painful to realize that the chair has not done his home work. Participants start reading minutes at the meeting & various matters then come to their minds. Wading through item by item is a recipe for disaster. A practical strategy which stood the test of time in the experience of the author is for the chair to take up some matters to be followed up & ask the participants whether they have anything else to comment on. Invariable hardly anybody takes up the offer. It is important to “clean up” the next minutes by removing all items that do not need follow up less the minutes keep growing in size! High level officials have very little time to spare for intersectoral cooperation. It is best to keep the

<table>
<thead>
<tr>
<th>Period</th>
<th>Event</th>
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<tbody>
<tr>
<td>1970s</td>
<td>Integrated Rural Development Programmes</td>
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<tr>
<td>Post HFA</td>
<td>Chanter for Health Development 1980</td>
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<td>1980</td>
<td>Establishment of National Health Development Council &amp; network</td>
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<td>1987</td>
<td>Establishment of Provincial Councils</td>
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<tr>
<td>1989</td>
<td>First poverty alleviation programme</td>
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<tr>
<td>1990</td>
<td>Social marketing for leprosy elimination</td>
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<td>1992</td>
<td>Establishment of Divisional Directorates of Health</td>
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<td>1992</td>
<td>Population &amp; Reproductive Health policy</td>
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<tr>
<td>1998</td>
<td>IA for Implementation of policy for aged</td>
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<tr>
<td>2000</td>
<td>National Commission on Macroeconomics &amp; Health</td>
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<tr>
<td>2002</td>
<td>GFATM</td>
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<tr>
<td>2002</td>
<td>10 year Master Plan for Health Development</td>
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<tr>
<td>2003</td>
<td>Food &amp; nutrition policy</td>
</tr>
<tr>
<td>2005</td>
<td>Health Sector Development Project</td>
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</table>
meetings short & sweet & ensure that trivia & especially in house matters are not discussed. If the participants get the impression that trivia are discussed, subsequent representations are likely be delegated to lower & lower level officials who have no decision making power. Intersectoral cooperation is a two way street & it is vital play an active reciprocal role in the coordinating exercises of the other sectors. It has to be personal commitment, to be established over a period of time. It helps if the chair has a good reputation in management circles. Rotating chairmanship of different sectors is a mechanism that can be tried but difficult to sustain in our experience. Co-chairing of the meetings especially on occasions where a substantial contribution & effort is needed from one sector is worth trying. It is best to discuss the commitments expected in advance, & not spring any surprises in front of colleagues.

6.3 A typology of opportunities for IAH

Going by the Sri Lankan experience, it is possible to categorize opportunities for IAH. One basis could be the state of development of the political systems that usually directs economic development & development of health systems of countries & their responses to challenges at different points in time.

6.3.1. At the stage of establishment of representative systems of government

The political Processes which evolve with a representative framework tend to promote policies and programmes which emphasize social welfare. IAH at early stages of development of representative systems is usually implicit & not explicitly spelt out. The electorates begin to articulate their demand for various forms of service and assistance from the Government through their elected representatives. Responses are measures in the fields of education, health, and related social services which put in place a social welfare package. Governments expand public health services and extend the network of institutions to be responsive & equitable. Compulsory education which transcends gender is also put in place. It may be necessary to formulate a non formal education programme for the older cohorts. The Minister of Health can play a pivotal role in orchestrating IAH as part of the social welfare programme. There usually are no barriers to be overcome other than persuading the Cabinet & especially the Minister of Finance to make resources available.

6.3.2. Developing countries with established representative systems of government

Specialized vertical disease control programmes are suitable for initial health sector driven IAH. They become a device for identifying an urgent national / sub national health problem, giving it a special status within the health system and according high national
priority so that other non-health sectors which are directly or indirectly linked to the problem has necessarily to commit themselves to it. The establishment of new settlements offer opportunities for identifying and implementing intersectoral programmes in the field of health which are of a more far-reaching nature as for example in the field of nutrition, sanitation and health education. Education sector is a most effective means available for fostering an awareness of health & has potential both directly and indirectly to make an important contribution to the health sector. The school curriculum can be used as a vehicle for health education. A school mid-day meal has potential to deal with the inadequate nutritional levels prevalent among children. Parent-Teacher Associations can be used to promote civil society participation. Local Government institutions have certain specific health-related functions to perform & could be used as a formal institutional framework for decentralized health activities and a facile entry point for local-level community participation.

**Challenges at this stage** - the welfare programme should to be a constant element of public policies despite changes of Governments which requires an all party consensus.

### 6.3.3 Integrated rural Project approach to IAH

At some stage in development of a country, the concept of IRDPs becomes popular to address regional inequities. This is akin to SWAPS but with the lead being taken by the requirements for overall socio economic development. It offers opportunities to incorporate substantial health system development.

### 6.3.4 National Health Development Network

Alma Ata paved the way for the health sector to set up a formal mechanism to ensure political commitment for IAH at the national as well as sub national levels. In our experience, this is a very good mechanism for IAH.

### 6.3.5 Poverty alleviation programmes & IAH

All developing countries will provide income support and economic advancement assistance to poor groups. The health sector has an opportunity to convince the lead agency for poverty alleviation programmes, of the viciousness of the cycle of poverty & ill health & that good health is a way out of poverty. Once the opening is created, an accelerated PHC programme with intersectoral collaboration can be built into the programmes.
6.3.6 Opportunities for formulation of inter sectoral strategies to implement specific policies

Examples are the policy for care of the aged, RH, nutrition policy.

6.3.7 Opportunities for IAH when global initiatives are institutionalized

Examples are the Role back Malaria Initiative, Stop TB, 4 by 4 initiatives, Global Commission on Macroeconomics & Health, GFATM.

7. Lessons learned from the Sri Lankan experiences in IAH & their applicability

It is extremely difficult to transplant Sri Lankan experiences to other societies in view of the unique socio cultural & political mix that existed historically in which milieu the IAH was nurtured. In the pre & post independence phases, the concept of IAH was not known. The leaders were committed to achieving human development goals. The policies to achieve same provided a good platform for IAH. The concept is well developed now & the implicit equity overtones of IAH are apparent. IAH needs political leadership whatever the stage of development & sustained commitment of the bureaucracy. Since health is deeply woven with the day to day life of the nations & politically very sensitive, Ministers of health have substantive lobbying power with Presidents / Prime Ministers / Cabinets of Ministers to mobilize resources & ensure support of their colleagues. Long term / catastrophic illness can push marginally poor to abject poverty & devastate the abject poor. Ensuring a safety net for this situation would go a long way to keeping social tension low & keeping a lid on social unrest. All avenues such as the Cabinet, the Parliament, and Parliamentary Consultative Committees on Health & other similar Committees can be harnessed for the purpose.

However, some broad recommendations can be made for different stages of development of health systems. The overall approach would be IA to achieve health related millennium development goals. This is in view of commitment of all Governments to achieving MDGs as well as the donor preference for all projects to be MDG focused. Country specific MD targets & indicators would provide the focus.

The MDG goals of reduction by two thirds the mortality rate among children under five, reduction by three quarters the maternal mortality ratio, halt and begin to reverse the spread of HIV/AIDS & halt and begin to reverse the incidence of malaria and other major diseases, all call for well functioning health systems.
7.1. Fragile countries & in those in transition

Fragile countries are those, where the government cannot or will not deliver core functions to the majority of its people, including the poor. In this milieu, IAH would be extremely difficult & essentially confined to small geographical areas. Sri Lankan experience of IAH in the prevailing conflict situation & some experiences in the pre independence era would be applicable. Most fragile countries have an ongoing conflict situation & there is some degree of pressure from international community to establish democracy as early as possible. Goal would be for the International Community, INGOs & Civil Society to catalyze broad political change for human development. Ultimate long term goal would be representative systems of democratic governments with universal franchise would be conducive to human development & responsive health systems. Compulsory education especially of girls would enhance health literacy of future mothers. Free education up to the highest affordable level would greatly improve enrolment. Health care free at point of delivery, funded by general government revenue would yield rich dividends in terms of health indices. An integrated health system with emphasis on PHC needs to be developed, backed by a system of graded curative care supported by a formal referral system. A population & need based template for locating of facilities on a geographical basis would prevent haphazard development of facilities. Donors should encourage a sector wide approach to formulation of projects.

Most practical would be INGO / local NGO & CBO led inter sectoral humanitarian action to provide PHC, food security, & basic education ensuring equal opportunity for girls. A forum to coordinate action needs to be established at the national & more importantly local levels. UNICEF & UNHCR are ideally placed to negotiate safety of health staff in situations of conflict.

7.2. Least developed countries

Post independence experience would be applicable. An all party commitment to support welfare measures would ensure continued development of health systems responsive to needs of the people irrespective of changes of government. Legislative enactments are required to ensure a legal environment to support the health system & governance. IAH to address priority diseases need to be developed. With regard to maternal & child health, priority should focus on advocacy to raise awareness of implications of high maternal mortality. Civil registration of vital events needs to be established to track MMR. An integrated approach to development of backward areas would ensure that all sectors develop in harmony in time & space & support the activities of each other. NGO participation in health development need to be encouraged & facilitated.

DFID (2005b), why do we need to work more effectively in fragile states?
7.3. Other developing countries

Post HFA Alma Ata experiences would be applicable. A health development network at the national & sub national levels, interconnected & supporting bottom up planning would ensure civil society participation, political commitment & facilitate IAH & the development of an appropriate health system. A social marketing approach to diseases with stigma & those associated with life styles would yield rich dividends.

7.4. Countries in advanced stages of demographic & epidemiological transition

Issue specific policies & strategies with overtones of IA need to be developed at this stage. A sectoral approach to health development needs to be adopted. A national commission on macro economics & health would help ensure commitment of resources for consolidation of gains in health development & maintenance of health systems. A donor commitment to address intersectoral issues would ensure IAH. A master plan for long term health development with an emphasis on IAH would be an appropriate road map for health systems development & ensure better health status for the populace.

8. National commissions on social determinants of health (NCSDH)

Experience with NCMH suggests the need to establish NCSDH without waiting for the conclusions of CSDH to be published with a formal recommendation to initiate action at the country level. WHO support will facilitate such initiatives as shown by the CMH experience.

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