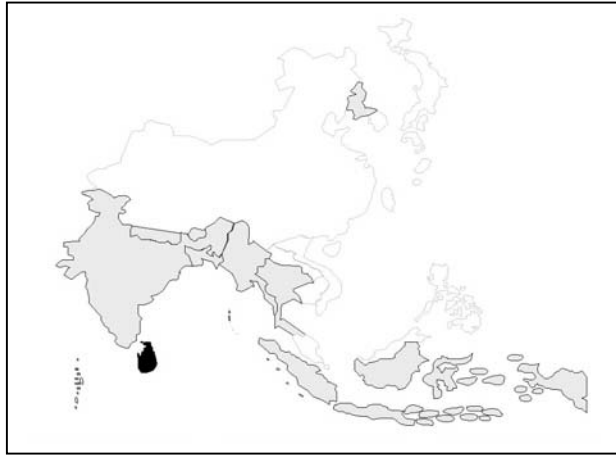


COUNTRY HEALTH PROFILE

SRI LANKA



The boundaries shown on the above map do not imply official endorsement or acceptance by the World Health Organization.

SECTION 1: TRENDS IN POLICY DEVELOPMENT

In 1978 Sri Lanka witnessed a major political change with the establishment of an executive presidency. Legislative powers continued to be vested in parliament but executive authority was exercised by the president and a cabinet of ministers. In 1989 significant decentralization took place with the introduction of provincial councils. This process was further enhanced in 1991 by the establishment of divisional secretariats within each of the provinces. Intersectoral collaboration in health development is demonstrated in national health policy through multisectoral councils and committees at different levels.

Sri Lankan policy, irrespective of the government in power, has always regarded education and health as crucial to socioeconomic development, while the concept of equity and social justice in favour of the underprivileged has also been a feature of state policy. This has resulted in a high literacy rate of 90.1% (1994) and a life expectancy at birth of 70.7 for males and 75.4 for females (1996/2001). There is also substantial investment in poverty alleviation. The overall social status of women is satisfactory and women constitute 42% of the occupational workforce (1985-86).

Within the context of the more recent liberal, market-oriented economic policies, the overall principle has been to promote both equity and efficiency, adopting social safety network measures where necessary. During the mid 90s a Presidential Task Force was constituted to develop a strategic framework for implementation of the national health policy, which retains current policies, consolidates the gains achieved, and prepares to meet new challenges.

SECTION 2: TRENDS IN SOCIOECONOMIC DEVELOPMENT

2.1 Economic trends

The economy has witnessed a moderately high growth since 1989/1991. The annual growth rate of the GNP increased from 4.6% in 1991 to 5.9% in 1995. The GNP per capita increased from US \$345 in 1989 to US \$856 in 2000. This moderately high growth was supported by continuity in reforms towards a market-oriented policy environment, a strong export performance, and an improvement in primary commodity prices. Economic growth in 1995 was spearheaded by the manufacturing sector while other major contributing sectors were trade, agriculture, transport and communication, and financial services. The unemployment rate in 1995 was around 12% as against 13.8% in 1991. Increased foreign employment contributed to easing the labour market pressure. Women have entered the labour force at a faster rate than men but take on lower paid and less prestigious jobs. Until recently, most key infrastructural facilities were operated by the parastatal sector that relied heavily on budgetary support from the central government to cover some of their operating costs. Infrastructural deficiency has been a serious impediment and the government has accepted in principle the need for wider private sector participation. The public sector health services are almost fully financed by the government, with the services available free of direct cost to the consumer.

2.2 Demographic trends

The last census in 1981 recorded a population of 14.85 million. The mid-year population in 2000 was estimated to be 19.35 million. The annual population growth rate in 2000 was 1.16%. Sri Lanka has passed through the classical phases of demographic transition to reach the third phase of a declining birth rate and a relatively stable low death rate. The base of the population pyramid is contracting and the proportion of the population over 65 years is projected to be 8% and 12% by the years 2000 and 2020 respectively.

2.3 Social trends

The thrust of the overall state policy in Sri Lanka has been on social development as reflected by the relatively high resource allocation for education, health and other social measures. The literacy rate in 1994 was 92.5% for men and 87.9% for women. Gender inequality in education is gradually narrowing. The proportion of males attaining secondary or higher education in 1986/87 was 43.8% compared to 42.4% for women.

2.4 Food supply and nutritional status

The nutritional status of children has not significantly improved over the years. About 16.7% of newborns at government hospitals have a birth weight of less than 2500 grams, largely associated with maternal undernutrition (2000). Health Survey 2000 reported that 29.4% of children below five years suffered from underweight (low weight-for-age), 13.5% from stunting (low height-for-age). A high proportion of pregnant and lactating women suffer from iron deficiency anaemia (haemoglobin less than 11 g/dl). Malnutrition is probably a reflection of the increased cost of living that has affected the purchasing power of families. Wasting was, however, significantly lower in the first year of life and this is due to the strong emphasis being given to improved breast-feeding practices. Seventy percent (70%) of the population live in areas where iodine deficiency exists and some areas (districts) have shown goitre prevalence among school children 5-18 years as high as 25-30%. In response, the government has initiated a programme for the universal iodization of salt. Vitamin A deficiency exists in pockets and more data are being elicited. The main constraints have been a lack of general awareness about issues pertaining to nutrition, a rising cost of living and therefore reduced purchasing power of families, and the heavy government expenditure incurred on the current armed conflict in the northern and eastern regions of the country.

2.5 Lifestyle

There is an increasing awareness of lifestyle-related health problems associated with alcohol and tobacco use, substance abuse, diseases of affluence and nutrition, and sedentary lifestyles. About 35% of males are current smokers. Smoking is rare among females. Integrated approaches to alcohol, tobacco and drug prevention programmes have proved viable, with the necessary impetus being given by nongovernmental organizations that play the role of catalyst in motivating organizations and institutions to integrate tobacco and drug prevention programmes into their own activities. Newspapers and the radio have been particularly active in promoting positive lifestyles.

SECTION 3: HEALTH AND ENVIRONMENT

3.1 General protection of the environment

Sri Lanka has an impressive portfolio of environmental legislation and a set of standards for the quality of air, water, food safety and the workplace. Under the National Environmental Act of 1980, an Environmental Council was established in 1982 with representation from different ministries, including health that have functions related to the environment. Under the guidance of the council, a central environmental authority is responsible for implementation of activities that include development of standards and guidelines for pollution control, monitoring major water bodies, control of toxic chemicals, hazardous waste management, chemical and microbiological impact assessment of major development activities, and public information and education utilizing the mass media, schools, NGOs and other community-based organizations. A National Environmental Action Plan was prepared in 1991 and a set of policy measures for environmental health suggested by a Presidential Task Force in 1992.

3.2 Water supply and sanitation

There has been some improvement in the availability of safe drinking water during the past decade. In 2000 the overall percentage of the population with safe drinking water available at home or in the vicinity was 75.4% (74.6% rural and 96-99% urban). The proportion of the population with latrine facilities in 2000 was 72.6% (68.3% rural and 87% urban).

SECTION 4: HEALTH RESOURCES

4.1 Human resources for health

In 1992 the process for developing a National Health Policy was initiated and this policy was formally presented in 1997. A perspective plan for health development (1995-2004) was formulated in 1994 and supported by annual health plans. A human resources development council was created to advise the cabinet of ministers on human resource development needs. A study in 1993 revealed that planning for human resource development was episodic and limited in scope, without consideration of the private sector, the demand pattern for services, and technological changes. There have been significant increases in the various categories of medical and paraprofessionals, though the increase has not been uniform across the various categories. The precise picture for the private sector is not available and information regarding the availability of health personnel by population is available only for those employed in the government (public) sector. Human resource figures reported for 2000 were number of physicians 7,963, population per physician 2,432, physicians per 10,000 population 4.11, number of nurses 14, 716 and number of public health nurses and midwives 5,068. Training is provided in the following institutions: one faculty of dental services, 11 schools of nursing, one national institute of health sciences, one medical research institute, and other institutions for health paraprofessionals. A plan for human resources in health is currently under preparation.

4.2 Financial resources for health

Financial resources for health care are mainly from the government, which provides the health care needs of the vast majority of the population. Service provision in the public sector is mostly free of cost to the consumer. The private sector contribution has been comparatively small in terms of service provision and financing, but has been growing, mainly in urban areas. In 1998 the total health expenditure as a proportion of the GNP amounted to 3.4%, and the government health expenditure formed 51.3% of total health expenditure. The per capita government health expenditure was US \$29. In 1998, the recurrent government health expenditure as a proportion of the total government health expenditure was 80.3%, of which 55% was spent on salaries.

4.3 Physical infrastructure

There is a comprehensive network of health centers, hospitals and other medical institutions located countrywide, with about 57,027 (2000) hospital beds and a large workforce engaged in curative and public health activities. Over a 20-year period hospital beds have increased by about 15,000.

4.4 Essential drugs and supplies

All drugs on the essential drug list are available in state hospitals free of cost, but no revision in the list has taken place since 1988. An educational programme ensures that medical and paramedical personnel are informed regarding the use of essential drugs. Local manufacturers are encouraged to manufacture essential drugs, with priority given to essential drugs at the time of registration. Major constraints include the promotional activities of pharmaceutical companies towards the use of expensive brand names that have higher profit margins, and lack of knowledge among consumers. Currently the essential drugs list is being revised and more emphasis is being given to educating health professionals and the public on the essential drugs concept.

4.5 International partnerships for health

Foreign assistance amounted to 4% of the government health expenditure in 1998. The major partners are UN agencies, development banks and bilateral agencies. Health economics is being introduced as a management tool for more efficient utilization of resources with more awareness creation on the critical importance of productivity. The main constraints include differing priorities at times between donors and the government, and the lack of flexibility on the part of donors to meet changing situations that would allow for mid-course corrections during implementation.

SECTION 5: DEVELOPMENT OF THE HEALTH SYSTEM

5.1 Health policies and strategies

A new national health policy has been formulated that seeks to consolidate what has already been achieved, as well as address new health challenges, such as the increasing prevalence of noncommunicable diseases, HIV/AIDS, substance abuse and the high incidence of suicides, particularly among youth. Though a countrywide network of health

facilities has been developed with health care provided free of cost, relatively underserved geographical areas and population groups still exist. These groups have specific health needs, such as the urban and rural poor, estate workers and displaced populations. National strategies include the poverty alleviation programme and targeted interventions to meet the specific health needs of disadvantaged groups.

5.2 Intersectoral cooperation

The health policy in Sri Lanka clearly identifies intersectoral action for health as an important element in the health development process. A national health council presided over by the prime minister has been established. It is supported by a national advisory committee and task forces of experts to deal with specific health concerns. A secretariat has also been established to coordinate NGO activities. A constraint to intersectoral coordination has been the weak horizontal linkages between health-related ministries and the Ministry of Health, as well as the lack of appreciation of its importance. New strategies that have proved successful have been the integration of health care into rural development projects and programmes.

5.3 Organization of the health system

In 1989 a major organizational change took place with the devolution of certain powers and functions from the centre to provincial councils. In the health sector, the management of all health care institutions (other than teaching hospitals and special hospitals) and public health services became the responsibility of provincial councils and the respective provincial health ministry. The next level of administration was the division, and medical officers of health were designated Divisional Directors of Health Services (DDHSs) responsible for provision of comprehensive health care (preventive and curative) to a population ranging from 60,000 to 80,000. The constraints have been the shortage of experienced medical staff to take on the positions of DDHSs and the paucity of financial resources for improving physical infrastructure and for providing supplies and equipment.

5.4 Managerial process

The managerial process for health development is in place at different levels of the administration. The Ministry of Health is responsible for specific functions, such as developing health policy, bulk purchase of pharmaceuticals and equipment, enforcement of health legislation, mobilization of resources, intersectoral and international coordination, etc. At provincial level, mechanisms for policy planning, coordination and development are in place. The main constraints are inadequate intersectoral coordination in planning and programme management.

5.5 Health information system

A health information system (HIS) is in place consisting of management information data (resources available and service data) and epidemiological information, including routine surveillance data for communicable diseases. A system to routinely monitor trends in noncommunicable diseases and their risk factors has still to be established. The data reported are not up to the desired quality, particularly those from hospital medical records, which are incomplete in many cases. World Bank and Asian Development Bank support has been

received to address some of these issues. The appointment of a Director for Health Information has administratively strengthened the process of HIS development. A steering committee has also been set up to network institutions and programmes for data collection, analysis, use and feedback.

5.6 Community action

National health policy recognizes community participation as an important component of the health development process, as evidenced by the participation of about 15,000 young volunteer health workers who assist in PHC activities. Community financing of health activities by philanthropists and voluntary groups in the community is not an unusual practice. However, community participation in the planning process leaves much room for improvement.

A negative feature appears to be the gradual erosion of the value system of mutual self-help, which is a part of the national culture. For the renewal of the HFA strategy, a bottom-up approach in health development is being advocated, with revitalization of village health committees, supported by health systems research.

5.7 Emergency preparedness

A multisectoral disaster preparedness committee is in place and guidelines have been issued to different departments and agencies for management of emergencies at different levels. A multidisciplinary health emergency management committee is also in place and guidelines for emergency preparedness in the health sector have been issued. Emergency preparedness training and education programmes are ongoing activities.

5.8 Health research and technology

The importance of health research is recognized in Sri Lanka and research activities have expanded considerably during the last few years. Institutions and organizations involved include the National Institute of Health Sciences which is the focal point for HSR, the Medical Research Institute which is mainly involved in biomedical research, the Faculties of Medicine of the Universities, operational units of the Ministry of Health such as the Family Health Bureau, Epidemiology Unit, etc., professional organizations such as the Sri Lanka Medical Association, other ministries and institutions, NGOs and the Traditional Medicine Institute. The National Resources, Energy and Science Authority (NARESA) promotes health research by awarding grants and disseminating research information. The recent appointment of a Deputy Director General of Health Services (Education, Training and Research) in the Ministry of Health has administratively strengthened the promotion of research activities, and steps are underway to establish a National Health Research Council with wide-ranging terms of reference. The main constraints have been inadequate funding, minimal health research utilizing a multidisciplinary and intersectoral team approach, and the absence of a mechanism for adequate dissemination of information and utilization of research findings.

SECTION 6: HEALTH SERVICES

6.1 Health education and promotion

The health policy of Sri Lanka emphasizes health education and promotion as important strategies for improving the health of the people. A Health Education Bureau (HEB) at central level is responsible for services, with health educators operating at provincial and divisional levels. The main activities of the HEB include education and training, dissemination of health related information, advocacy for health, social mobilization, and production and dissemination of IEC materials. Constraints include the lack of emphasis on health education in teaching institutions, the exorbitant cost of utilizing even state run TV channels, and inadequate financial resources. Strategies have been planned for more comprehensive health education programmes in the years ahead.

6.2 Maternal and child health/family planning

The total fertility rate (2.3 in 1993) has progressively decreased over the years and has reached 2.0 by the year 2000. Studies have revealed a relatively high incidence of induced abortion, which may be a reflection of unmet demand and/or family planning method failure. The MCH/FP programme receives high priority and has now been expanded to take on the broader concept of reproductive health for which additional resources will be required. The coverage of MCH/FP services is reflected by the following service indicators: 98% of pregnant women attended by trained personnel, 97% of deliveries attended by trained personnel, 98% of infants attended by trained personnel, and 71% of married women of childbearing age using family planning. Issues that still need to be addressed more intensively include the provision of services to isolated rural families where accessibility is difficult, vulnerable groups of young women workers employed in industrial promotion zones, women who seek employment abroad and the families they leave behind, and services that would specifically address the needs of adolescents and youth.

6.3 Immunization

High immunization coverage against the six diseases under the expanded programme on immunization (EPI) has been achieved and maintained even in very remote areas. In 2000 the reported national coverage of infants reaching their first birthday with all EPI vaccines (based on routinely reported data) was 81%. The details of immunization coverage are as follows: DPT3 88%, OPV3 88%, measles vaccine 81%, BCG 100%, and pregnant women immunized with tetanus toxoid (TT) 90%. National immunization days for polio have been held. No cases of poliomyelitis have been reported since 1993. Hepatitis B vaccination is not routinely administered to children but is available to high-risk categories of health workers. Constraints in implementing the EPI have only been encountered in the areas of armed conflict in the country.

6.4 Prevention and control of locally endemic diseases

Sri Lanka has 22 notifiable diseases. Strategies for prevention and control include immunization against the vaccine-preventable diseases, enhanced disease surveillance and control actions, training of medical officers and public health staff, a computerized database at central level, and environmental interventions with regard to safe water, sanitary latrines,

reduction of smoke pollution and vector control activities. The main constraints have been the inadequacy of the environmental interventions, poor socioeconomic conditions, and the nutritional status of marginalized segments of the population.

6.5 Treatment of common diseases and injuries

The major causes of mortality due to communicable diseases as reported by the Registrar General's Department for 1991 showed acute respiratory infections (ARIs) as the leading cause, with a mortality rate of 26.6 per 100,000 population, followed by diarrhoeal diseases with a rate of 7.7. As a consequence of the EPI, no deaths were reported for measles or neonatal tetanus during 1996, while dengue haemorrhagic fever (DHF) and Japanese encephalitis (JE) had reported mortality rates of 0.06 and 0.18 per 100,000 population respectively (1995). Morbidity rates reported for 1995, in rank order, were diarrhoeal diseases at 676.1 cases per 100,000 population followed by ARI 143.2, DHF at 2.4 and JE at 1.

During the period 1985-1994, the morbidity rate for diarrhoeal diseases (based on hospital admissions) decreased by only 10%, while the mortality rate showed a 75% reduction and the case fatality rate a 77% reduction. This was mainly due to improved case management practices and the early use of oral rehydration therapy (ORT) at the home level. Severe dehydration due to diarrhea is rarely seen, and a WHO sponsored survey in 1992 revealed that, in the survey district, the ORT use rate was 76% and the oral rehydration salts (ORS) access rate 100%. The main strategies are standard case management, improved MCH practices, and improvement in environmental sanitation.

The basic strategy for ARI has been the use of standard case management based on WHO recommendations, reduction of risk factors, and development of skills of health personnel (and the community) in the early detection of pneumonia.

In 1996 an outbreak of DHF occurred in the capital city of Colombo, with 625 suspected cases and 35 deaths. The 3,343 cases and 37 deaths of DHF were reported for 2000. Elimination of vector breeding places by the public health authorities, strengthened vector surveillance, public education and community action combined to bring the epidemic under control.

JE, which is also a notifiable disease, tends to occur seasonally in certain parts of the country. Immunization of children 1-10 years is carried out in high-risk areas. A programme for the immunization of pigs is also carried out in some areas by the Department of Animal Husbandry. Medical officers and public health inspectors have been trained in the prevention and control of JE and in health education activities.

SECTION 7: TRENDS IN HEALTH STATUS

7.1 Life expectancy

There has been a steady improvement in life expectancy over the last several decades. The life expectancy in 1981 was 67.8 years for males and 71.7 years for females, and had increased to 70.7 years for males and 75.4 years for females in 1996-01. These improvements are the result of many factors, among which was the priority given to health, education and social welfare measures by successive governments. As a consequence of

enhanced life expectancy, the proportion of older persons in the population is on the increase, which will require changes in health service provision to meet the needs of this age group.

7.2 Mortality

There has been a declining trend in mortality in Sri Lanka. The crude death rate (CDR) was 5.7 per 1000 population in 2000. The maternal mortality ratio was reported to be 59.6 per 100,000 live births in 1999. The infant mortality rate per 1000 live births was 15.4 (1998) and neonatal mortality rate 12.9 (1995). Mortality data in respect of selected diseases during 1995 are as follows: 165 deaths due to diarrhoeal diseases in children under five years, 36 deaths from malaria, no deaths from measles, 509 deaths from tuberculosis, 4866 deaths from cardiovascular diseases (all types), 2100 deaths from cancer (all types), and 1800 deaths from traffic accidents. There were 102 reported deaths due to malaria in 1999 and 6,441 due to cancer in 1998.

7.3 Morbidity

Overall morbidity, based on inpatient and outpatient records, has shown a decrease. However, this decline has been due solely to a drop in outpatient attendance, while inpatient care has increased. The latter may be due to wider service provisions for curative care and the increasing proportion of the elderly. Remarkable achievements have been made in the reduction of mortality in respect of the EPI-target diseases. All other communicable diseases have also shown a decline since 1991, but noncommunicable diseases have shown a two-fold increase during the past two decades. Injuries and poisoning have increased since early 1990s.

7.4 Disability

No up-to-date information is available about the extent and type of disabilities. In 1981 an estimate of the number of persons with disabilities by the department of social services was around 80,000. The percentage of disability due to trauma is on the increase, due to bomb blast and land mine injuries caused by the ongoing separatist conflict situation.

SECTION 8: OUTLOOK FOR THE FUTURE

8.1 Overall assessment and strategic issues

The emphasis of state policy has been on social justice, equity and economic well-being. Recently, the economic policy is being oriented towards free market mechanisms aimed at improving efficiency as well as preserving gains in social well-being. Life expectancy has increased and outstanding success has been achieved in literacy rates and overall health status. In addition, the differences between male and female literacy and life expectancy have consistently narrowed over the years. The population growth rate continues to decline and a total fertility rate (TFR) of 2.0 has been achieved (1995-2000). Maternal, infant and neonatal mortality rates are relatively low and show a declining trend. Infectious and parasitic diseases have declined, with outstanding success achieved with the EPI-target diseases of childhood. Ironically, the nutritional status of children has not significantly improved over the years. With a rise in the older aged population consequent to the increase in life expectancy, there is a rising trend in the incidence of noncommunicable diseases. Improvements in communication and a shift towards urbanization and industrialization have

resulted in more injuries and trauma. Changing lifestyles have created a high potential for increases in substance abuse, violence and suicide. Health resource flows have increased in recent years and have been able to sustain the health infrastructure that has been developed over time. The ongoing separatist war has been a major strain on the economy and a set back to health development.

8.2 Futures vision

The future health scenario in Sri Lanka desired by the year 2020 encompasses the following ten dimensions:

- ◆ Disease elimination/eradication (polio, neonatal tetanus, measles, leprosy, etc.)
- ◆ Mortality reduction (mainly communicable diseases)
- ◆ Disease containment (mainly noncommunicable diseases, HIV/AIDS and hepatitis)
- ◆ Mitigation of specific concerns (substance abuse, alcoholism, suicide, poisoning and accidents)
- ◆ Improvement in health status indicators (life expectancy, infant mortality rate, neonatal mortality rate, under-five mortality rate, crude death rate, maternal mortality ratio, contraceptive prevalence rate and socioeconomic productivity)
- ◆ Improvement in nutritional status
- ◆ Issues relating to health and environment
- ◆ Health planning and management
- ◆ Socioeconomic aspects related to health
- ◆ Improvement in health systems management

8.3 Proposed strategies

The proposed strategies for future national health development, which will constitute a renewed commitment to health for all, are as follows:

- ◆ To consolidate the achievements in infrastructure development, service provision and disease prevention.
- ◆ To meet the challenges to health posed by new, emerging and re-emerging diseases and noncommunicable/degenerative diseases, substance abuse and environmental degradation.
- ◆ To sustain the process of health development, emphasizing the quality of care and equity and efficiency issues, particularly in the context of a free market economy.
- ◆ To sustain and strengthen programme planning and management.

Country reported data on basic health indicators*

Indicator	Latest available data	Year	Source	Remarks	
Population and Vital Statistics					
Total population (in thousands)	19,359	2000	1		
Population density (persons per sq km)	309	2000	1		
Sex ratio (males per 100 females)	97.4	1994	1		
Population under 15 years (%)	29.5	1994	1	} Computed value	
Population 65 years and above (%)	5.5	1994	1		
Crude birth rate (per 1000 population)	17.3	2000	1		
Crude death rate (per 1000 population)	5.7	2000	1		
Annual population growth rate (%)	1.16 ^a	2000	1	Natural growth rate	
Total fertility rate (per woman)	2.0	1995-2000	3	From Health Survey 2000	
Urban population (%)	15.5 ^b	1994	1		
	22.4	1995	2		
Socioeconomic Situation					
Gross domestic product per capita	Rs 64,855 US\$ 856	2000	1	} At market price	
Adult literacy rate (%): Total	90.1	1994	1	} Excludes North-East provinces	
Male	92.5	1994	1		
Female	87.9	1994	1		
Prevalence of low birth weight (weight <2500 grams at birth) (%)	16.7	2000	1	At Govt hospitals	
Prevalence of underweight (weight-for-age) in children <5 years of age (%)	29.4	2000	3	From Health Survey 2000	
Prevalence of stunting (height-for-age) in children <5 years of age (%)	13.5	2000	3		
Environment					
Population with safe drinking water available in the home or with reasonable access (%)	Total Urban Rural	75.4 96 - 99 74.6	2000 2000 2000	3 3 3	Health Survey 2000
Population with adequate excreta disposal facilities available (%)	Total Urban Rural	72.6 87 68.3 ^c	2000 2000 2000	3 3 3	
Health Resources					
<i>Facilities</i>					
Number of hospital beds	57,027	2000	1	} Computed value	
Population per hospital bed	340	2000	1		
Hospital beds per 1,000 population	2.9	2000	1		
Number of central dispensaries	404	2000	1		

* Note: Footnotes and source documents are listed at the end of this table

Indicator	Latest available data	Year	Source	Remarks
<i>Human resources</i>				
Number of physicians	7,963	2000	1	Computed value
Population per physician	2,432	2000	1	
Physicians per 10,000 population	4.11	2000	1	
Number of nurses	14,716	2000	1	
Number of public health nursing sisters and public health midwives	5,068	2000	1	
<i>Budgetary resources</i>				
Total Expenditure on Health (THE) as % of Gross Domestic Product (GDP)	3.4 %	1998	4	
Public Expenditure on Health (PHE) as % of Total Expenditure on Health (THE)	51.3 %	1998	4	
Private Expenditure on Health (PvtHE) as % of Total Expenditure on Health (THE)	48.7 %	1998	4	
Public Expenditure on Health (PHE) as % of General Government Expenditure (GGE)	5.8 %	1998	4	
Social Security Expenditure on Health (SSHE) as % of Public Expenditure on Health (PHE)	0.0	1998	4	
Tax funded Health Expenditure (TaxFHE) as % of Public Expenditure on Health (PHE)	96.0 %	1998	4	
External Resources for Health (Ext Res HE) as % of Public Expenditure on Health (PHE)	4.0 %	1998	4	
Private Insurance for Health Risks (Pvt ins HE) as % of Private Expenditure on Health (PvtHE)	1.0 %	1998	4	
Out-of-Pocket Spending on Health (OOPS) as % of Private Expenditure on Health (PvtHE)	99.0 %	1998	4	
Per capita Total Expenditure on Health (THE) at official Exchange rate (X-Rate per US\$)	29	1998	4	
Per capita Public Expenditure on Health (PHE) at official Exchange rate (X-Rate per US\$)	15	1998	4	
Per capita Total Expenditure on Health (THE) in international dollars (int'l \$)	99	1998	4	
Per capita Public Expenditure on Health (PHE) in international dollars (int'l \$)	51	1998	4	
Health Services				
Pregnant women attended by trained personnel during pregnancy (%)	98	2000	3	Health Survey 2000
Deliveries attended by trained personnel (%)	97	2000	3	- d0 -
Infants attended by trained personnel (%)	98	1996	2	

Indicator	Latest available data	Year	Source	Remarks
Women of childbearing age using family planning (%)	71	2000	3	Health Survey 2000
Eligible population (i.e. infants reaching their first birthday) that has been fully immunized according to national immunization policies	81	2000	3	Health Survey 2000
Infants reaching their first birthday that have been fully immunized against diphtheria, tetanus, and whooping cough (%)	88	2000	3	- do -
Infants reaching their first birthday that have been fully immunized against poliomyelitis (%)	88	2000	3	Health Survey 2000
Infants reaching their first birthday that have been fully immunized against measles (%)	81	2000	3	- do -
Infants reaching their first birthday that have been fully immunized against tuberculosis (%)	100	2000	3	- do -
Women that have been immunized with tetanus toxoid (TT) during pregnancy (%)	90	2000	3	At least two doses
Health Status				
Life expectancy at birth (years): Total	73.0	1996-01	1	Projections
Male	70.7	1996-01	1	
Female	75.4	1996-01	1	
Infant mortality rate (per 1000 live births)	15.4	1998	1	
Under-five mortality rate (per 1000 live births)	22.6	1991	2	
Maternal mortality ratio (per 100,000 live births)	23	1996	1	From Vital registration system
	59.6	1999	5	From Maternal mortality surveillance system

^a Natural annual population growth rate

^b Data from the demographic survey in 1994 in which town councils were treated as rural

^c Rural 72.6% and Estate 35.5%

- Sources:**
1. Sri Lanka, Department of Health Services, Ministry of Health, *Annual Health Bulletin 2000*
 2. Sri Lanka, Country report on the third evaluation of the implementation of HFA strategy, 1997
 3. Sri Lanka, Department of Census & Statistics, Ministry of Finance & Planning, *Demographic and Health Survey 2000*, Colombo, May 2001
 4. Adapted from "WHO Geneva, *The World Health Report 2001 : Mental Health, New Understanding, New Hope*", October 2001
 5. Government reply to fax of HO/SEARO, CHS Department, dated 20 December 2001.