Sri Lanka
State of the Economy Report 2011

Chapter 6
Education and Health Services for Sustainable Growth

by
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6. Education and Health Services for Sustainable Growth

6.1 Introduction

To achieve inclusive growth and spatial equity, it is essential to improve economic as well as social development of a country. In this respect, education and health services are crucial for enhancing human development, promoting equity and contributing to economic prosperity. Human capital formation and accumulation through education encourages innovation and productivity, and helps sustain long term economic development. Similarly, the 'health of a nation' is of central importance. Indeed, health and education are inter-linked, as the former is considered the basis for job productivity, the capacity to learn in school, and the capability to grow intellectually, physically, and emotionally.[1]

The distribution of education and health outcomes can be regarded as a key indicator of the inclusiveness of economic development in a country. Education is a universal right and an agent of upward socio-economic mobility that opens many social, economic, and political doors and increases access to income and employment opportunities. The levels and distribution in health outcomes can serve as proxies for concerns a government has regarding the health of its people.[2] While Sri Lanka has long been recognized for its achievements in human development, it faces new challenges in providing quality services and improved service delivery that will cater to the changing demands of a rapidly growing economy.

"There are wide disparities in both education and health services in terms of accessibility as well as resource availability across the country"

Although human capital is recognized as vitally important in leveraging Sri Lanka's vision to develop as a knowledge-based, middle income country, the quality of human capital, in general, has not kept pace with job market requirements. Most of the school

[1] WHO, 2001, "Macroeconomics and Health: Investing in Health for Economic Development", report of the Commission on Macroeconomics and Health, WHO, Geneva.

[2] Tandon A., Zhuang, J., 2007, "Inclusiveness of Economic Growth in the People's Republic of China: What Do Population Health Outcomes Tell Us?" Asian Development Bank, Manila.

leavers are ill-prepared, with lack of cognitive dimensions to fit into the world of work. Increasing the equity of access to quality education with required facilities is also a major challenge. As regards the country's health sector, there are wide ranging disparities in accessing health care services, facilities, resources, as well as health outcomes. This is particularly so with regard to maintaining and upgrading existing social services, while restoring services in previously conflict-affected areas.

This Chapter seeks to examine the gaps in education and health service delivery in the country and their recent trends, with a view to identifying inequities and making policy recommendations on improving access to better quality services in health and education. First, attention is paid to the present status of the country's education and health sector and its growth objectives. Thereafter, equity in education and health is discussed along the dimensions of access, outcomes and distribution of resources. Emerging needs and current policies of the two sectors are assessed in order to identify policy gaps, with key findings and policy recommendations suggested in the final section.

6.2 Education

6.2.1 Current Status and Objectives

Sri Lanka has long considered education as crucial for enhancing human development and contributing to economic growth. The education ordinances of 1939 and free education introduced in 1945 were among the earliest policies in achieving economic and social equity through universal and equal access to education at all levels. Sri Lanka is committed to supporting "Education for All", adhering to ethics and standards as proclaimed by provisions in international conventions.[3] Successive governments adopted strategic measures such as introducing free textbooks, scholarships for disadvantaged students, free uniforms, and subsidized transport facilities to encourage schooling amongst children.

Thus, Sri Lanka has often been cited as having high education achievements and learning when compared to counterparts in South Asia. This reputation has been largely built on the high literacy levels and the high levels of primary enrolment, as well as the gender parity in education access and achievements. Moreover, Sri Lanka is an early achiever of the Millennium Development Goals (MDGs) of universal primary education, and gender equity in education. In 2006, it attained a primary enrolment rate 97.5 per cent, gender parity index for primary education of 99 per cent, and 95.8 per cent literacy rate in the age group 15-24.[4]

While there is an encouraging improvement in literacy rates (92.7 per cent in 1996 to 95.8 per cent in 2006) and universal primary education in numerical terms, several gaps exist in the sector. Existing disparities in the provision of education services - regional discrepancies (geographical, economic and social), disparities in the quality of education imparted, unequal distribution of resources, exclusion in access and participation, etc., - can widen uneven economic development unless addressed. For instance, more than a half of the schools in the country are small schools with less than 200 students, with science education in grades 12-13 confined to only 7 per cent of schools with these grades.[5]

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[3] Regulations for compulsory education of 5-14 age group were approved by Parliament in 1997 and came into force in January 1998.

[4] IPS/UNDP, 2010, *Millennium Development Goals: Sri Lanka Country Report 2008/2009*.

[5] Ministry of Education, 2008, *School Census 2008: Preliminary Report*.

Information technology (IT) is still in the early stages of development in schools. Many children faced disruptions to education - through displacement, loss of family members, psychological impact, loss of school materials as well as the destruction of school buildings and infrastructure - through the conflict years. In these circumstances, simply providing basic service delivery of education is often a major challenge.[6]

6.2.2 Equity Issue

Increasing the equity of access to quality education with required facilities is a major challenge. Equity in education can be considered along the dimensions of access, outcomes and resources.

With regard to equity in access, primary education is almost universalized. However, disparities in access to education are higher beyond the primary education cycle (Table 6.1). According to the estimates of a recent study that assessed the equitability in education and health services in Sri Lanka, net enrolment rates in the upper secondary and collegiate levels were found to be only about 54 per cent and 19 per cent, respectively.[7] Moreover, disparities in access to education are higher across

Table 6.1
Net Enrolment Rates in Major Education Cycles by Economic Groups: 2006/07 (%)

	Primary (Grades 1–5)	Junior Secondary (Grades 6–9)	Upper Secondary (Grades 10–11)	Collegiate (Grades 12-13)
Economic groups				
Poorest quintile	95.7	82.6	47.6	11.0
2nd quintile	95.9	85.7	50.2	18.5
3rd quintile	96.5	89.5	50.0	15.7
4th quintile	96.8	89.8	59.1	23.4
Richest quintile	97.9	94.0	62.9	27.7
Gender				
Male	96.3	88.1	50.1	19.1
Female	96.6	87.9	57.2	19.6
Sector				
Estate	91.1	71.1	27.4	4.3
Rural	97.0	89.6	56.0	20.4
Urban	97.5	90.5	57.2	21.5
Province				
Western	96.2	88.6	52.5	19.9
Central	96.4	88.9	56.7	15.0
Southern	97.2	88.9	59.2	23.5
Northern	n.a	n.a	n.a	n.a
Eastern	96.7	85.9	44.8	13.7
North Western	97.6	87.4	44.1	17.0
North Central	97.3	94.1	62.0	19.3
Uva	95.9	85.1	58.4	20.5
Sabaragamuwa	94.0	84.3	48.8	19.6
Sri Lanka	**96.5**	**88.2**	**53.6**	**19.3**

Note: n.a. = not available.

Source: Arunatilake, N., N. Attanayake and P. Jayawardena, 2010, "Equitability in Education and Health Services in Sri Lanka", IPS, mimeo.

[6] IPS, 2010, "Protecting the Education Rights of Conflict-affected Children" in *Sri Lanka: State of the Economy* 2010.

[7] Arunatilake, N,, N. Attanayake and P. Jayawardena, 2010, "Equitability in Education and Health Services in Sri Lanka", IPS, mimeo.

economic groups, sectors, and provinces as the level of education advances.

Quality of education - learning-teaching process in the classroom - is reflected in completion rates in major education cycles as well as success rates at national public examinations. It is found that one-fifth of children who are in official age of completing grade 5, and 30 per cent of children who are in official age of completing grade 9 do not complete the education cycle appropriate for their age.[8] Further, wide disparities in school completion rates as well as public exam success rates across economic groups, gender, sector, and province were also to be found. The completion rates were lower for higher school cycles, and their disparities wider with the advancement of education level. Similar patterns were reflected in the O-Levels and A-Levels success rates.

Table 6.2
Completion Rates in Major Education Cycles and Exam Success Rates: 2006/07

	Completion Rates[a] %			Exams Success Rates[b] %	
	Grade 5	Grade 9	Grade 11	O-Levels	A-Levels
Income Group					
Poorest quintile	73.4	61.2	22.6	31	17
2nd quintile	81.3	69.2	35.4	44	17
3rd quintile	85.0	71.7	32.8	46	20
4th quintile	82.2	76.6	47.3	57	27
Richest quintile	87.4	75.4	60.6	68	44
Gender					
Male	81.9	67.7	35.3	45	22
Female	80.8	73.3	42.9	53	29
Sector					
Estate	64.2	46.1	7.9	14	8
Rural	83.3	74.5	42.7	51	26
Urban	84.9	72.0	42.3	56	31
Province					
Western	80.7	69.2	41.8	54	33
Central	79.4	75.3	33.1	45	25
Southern	86.3	74.8	45.5	54	24
Northern	n.a.	n.a.	n.a.		
Eastern	n.a.	n.a.	n.a.	41	23
North Western	82.8	69.9	28.8	44	25
North Central	89.9	78.4	37.4	48	24
Uva	71.0	55.8	28.4	38	18
Sabaragamuwa	79.3	67.2	45.1	51	21
Sri Lanka	**81.4**	**70.5**	**39.1**	**49**	**26**

Note: n.a. = not available; a: Completion rate is defined as percentage of children in the official age group completing the education cycle; b: Exam success rates are defined as percentage of children (in the official age of sitting the exam) who have passed the relevant exam. The sample for O-Levels comprises 17 and 18 year olds and the sample for A-Levels comprises 20 and 21 year olds at the time of the survey. Calculations consider all children in an age cohort, not only those who have sat for an exam.

Source: Arunatilake, N., N. Attanayake and P. Jayawardena, 2010, "Equitability in Education and Health Services in Sri Lanka", IPS, mimeo.

[8] *Ibid.*

With regard to the distribution of resources, resource constraints have led to a decline in the quality of education provided by schools. Many schools in the country experience disparities in the availability of libraries, science labs and computer labs across provinces. Only 7 per cent of state schools are found to have facilities to teach science subjects (Type AB) in GCE (A/L). Further, schools offering science subjects in GCE (A/L) are not rationally located, with a majority to be found in urban areas, with almost one-fourth of the Type AB schools located in the Western Province. This shows that only a limited number of students are privileged to follow the science streams up to GCE (A/L).

Rural children from poor families with financial constraints have no options other than to choose a resource-poor secondary school that offers only arts or arts/commerce streams located mainly in economically disadvantaged areas. For example, 56 schools in Vavuniya, 9 schools in Ratnapura, while 8 schools in each Mannar and Mulaittivu districts had one teacher per school. These figures, bad as they are, do not show the true picture of educational problems, which in reality is even more disturbing. These aggregates do not show the internal disparities within a district. Also, it is often the case that there may be an excess of teachers for certain subjects while there is a deficit of teachers for more demanding subjects such as English, science and IT.

6.2.3 Key Sector Challenges and Issues

Developing competencies to meet emerging needs: As Sri Lanka aims to move towards a knowledge-based economy, new configuration of skills, abilities and competencies to face the emerging needs of accelerating global competition will be required. The information and communication technologies (ICT) workforce is expected to increase from the current 50,000 to 186,000 by 2016.[9] Further, about 50,000-70,000 skilled people are needed annually with the planned large scale development activities in the naval, aviation, commercial, energy, road and transport, urban development, irrigation and knowledge sectors.[10] Information and knowledge-based economic development will require that learning-teaching methods become more competency-based and cater to skills demand. This means Sri Lanka must overcome prevailing constraints in access to ICT, proficiency in English language, and science and technical education, etc.

Addressing the mismatch between the skills acquired through the education system and the requirements of the labour market has been a key concern of current education policy.[11] Of more than 100,000 deserving students, only around 15 per cent who gain the necessary A/L qualification are able to enter into university due to the limited number of placements.[12] External degree programmes are generally marked by the absence of an accreditation system, poor quality, and weak administration. There is also a lack of a systematic Technical Education and Vocational Training (TEVT) link with secondary education, leaving a majority of school leavers with no access to skills development programmes. Overlooking the importance of TEVT is also partly responsible for the shortage of skilled manpower to match the dynamic needs of the labour market.

Protecting education rights of conflict-affected children: Improving access to edu-

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9 DNP, 2010, *Sri Lanka – The Emerging Wonder of Asia*, Ministry of Finance and Planning.

10 *Ibid.*

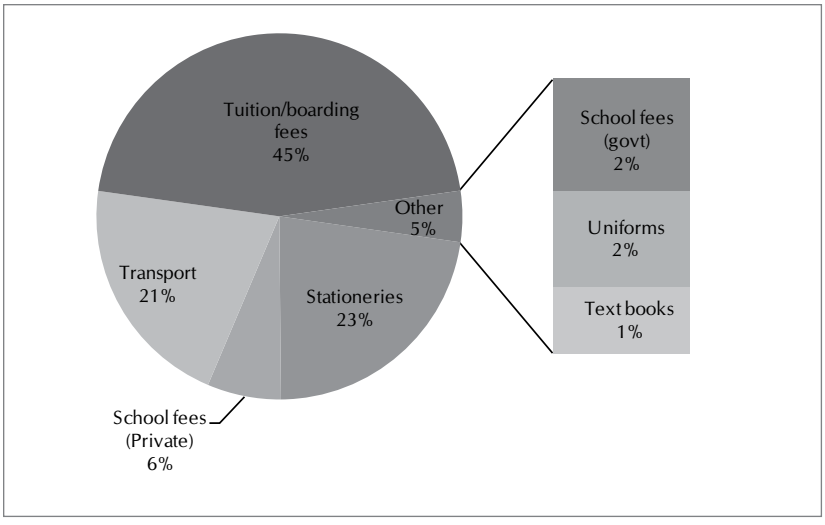
11 National Education Commission, 2003, *Proposal for a National Policy Framework on General Education in Sri Lanka*.

12 Ministry of Education, 2005, *Education for Development and Prosperity*.

cation in the conflict-affected areas remains a major challenge. According to available estimates, approximately 100,000 internally displaced persons (IDPs) and returnee school aged children, and 347 schools required rehabilitation in the Northern Province.[13] According to criterion-based learning assessment conducted by the Northern Province education authorities, there is an urgent need to implement remedial education programmes to improve learner competencies and ensure student retention. Further, an estimated 20,000 children and youth outside of the formal system were identified as requiring non- formal education programmes to develop their skills for income generating opportunities.[14]

Budgetary constraints and public investments in education sector: The public education system remains the predominant service provider while budgetary constraints have limited government investment in the education sector. Government expenditure on education as a percentage of GDP increased from 2 per cent in 2001 to 2.7 in 2006 but decreased gradually to 1.9 per cent in 2010 - constituting about 8 per cent of total government expenditure.[15] This figure is far behind that of South East Asian countries such as Malaysia (17.2 per cent) and the Philippines (16.9 per cent), as well as neighbouring South Asian countries such as Nepal (19 per cent) and Bangladesh (14 per cent).[16] The proportion of education expenditure devoted to recurrent expenditure is in the range of 80 per cent, with the major portion (75 per cent) devoted for teachers' salaries. The limited public capital expenditure in the education sector has resulted in resource poor schools and increased out-of-pocket expenditure.

Figure 6.1
Distribution of Out-of-Pocket Expenditure on Education



Source: Arunatilake, N., N. Attanayake and P. Jayawardena, 2010, "Equitability in Education and Health Services in Sri Lanka", IPS, mimeo.

[13] GOSL/UN, "Joint Plan for Assistance for the Northern Province – 2011", February 2011, http://ochaonline.un.org/humanitarianappeal/webpage.asp?Page=1942.

[14] *Ibid.*

[15] Central Bank of Sri Lanka, *Annual Report 2010*.

[16] Respective year of international estimates is 2008. Available at http://stats.uis.unesco.org/unesco/tableviewer/document.aspx?ReportId=143.

As revealed in a recent study, 2.6 per cent of total household income is spent on education related expenses.[17] This proportion is more or less the same across households from different income deciles. Further, the major portion (45 per cent) is found to be spent on tuition or boarding fees (Figure 6.1).

Strengthening management of the education sector services delivery: Management of education sector service delivery has been identified as a key challenge in relation to education service delivery.[18] Lack of proper supervision, administration and monitoring badly affects the growth objectives of the education sector service delivery. Further, inadequate management capabilities at local level have constrained decentralized management. Studies have revealed the necessity of improving capacity at all levels of the education sector to make decentralized planning and management more effective and efficient.[19]

6.2.4 Current Policies and Programmes

The Education Sector Development Framework and Programme (ESDFP) 2006-2010 formulated by the Ministry of Education with the support of the World Bank is being implemented currently. The major policy themes of the ESDFP are: (i) increasing equitable access to basic and secondary education, (ii) improving the quality of basic and secondary education, (iii) enhancing economic efficiency and equity of resource allocation, and (iv) strengthening the educational governance and service delivery, and monitoring and evaluation. The ESDFP is developed on a sector-wide approach, considered the most appropriate instrument to address system-wide needs. This strategy could pave the way to sustain development plans of the sector by mainstreaming and improving coordination of external donor investments with government budgeting across the central, provincial and school levels. The ESDFP has been incorporated into the planning process whereby targets have been set to raise the current GCE (O/L) pass rate from 52 per cent to 65 per cent, and GCE (A/L) pass rate from 60 per cent to 75 per cent by 2020.[20]

With regard to rehabilitation of education services in the previously conflict-affected areas, education facilities are estimated to have been restored to nearly all affected children in the Northern Province. The needs of 98 schools and 20 pre-schools in the resettlement areas have been fully met, while another 150 schools are targeted to be repaired in 2011. As a response to the criterion based assessment findings, teacher books for alternative learning programmes for primary and secondary grades for key subjects have also been developed.[21]

6.3 Health

6.3.1 Current Status and Objectives

Despite the fact that Sri Lanka is a low-spender on health, the country is regarded as a success story in achieving most of the vital health indicators much earlier than its regional counterparts. Most of the key health indicators for Sri Lanka are almost at the same level as that of developed economies (Table 6.3).

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17 Arunatilake, N., N. Attanayake and P. Jayawardena, 2010, "Equitability in Education and Health Services in Sri Lanka", IPS, mimeo.

18 DNP, 2008, *Public Investment 2008–2011*, Ministry of Finance and Planning.

19 Arunatilake, N., and P. Jayawardena, 2010, "Formula Funding and Decentralized Management of Schools – Has it Improved Resource Allocation in Schools in Sri Lanka?", *International Journal of Educational Development*. Vol. 30, No. 1.

20 DNP, 2010, *Sri Lanka – The Emerging Wonder of Asia*, Ministry of Finance and Planning.

21 GOSL/UN, "Joint Plan for Assistance for the Northern Province – 2011", February 2011, http://ochaonline.un.org/humanitarian appeal/webpage.asp?Page = 1942.

Table 6.3
Comparison of Select Key Health Indicators

Indicator	Sri Lanka	South-East Asia Region	Global
Life expectancy at birth (2009)	71	65	68
Infant Mortality Rate (IMR)[a] (2009)	13	45	42
Under-five mortality rate[b] (2009)	16	59	60
Maternal mortality rate (MMR)[c] (2008)	39	240	260

Notes: a: Probability of dying by age 1 per 1,000 live births; b: Probability of dying by age 5 per 1,000 live births; c: Per 100,000 live births.

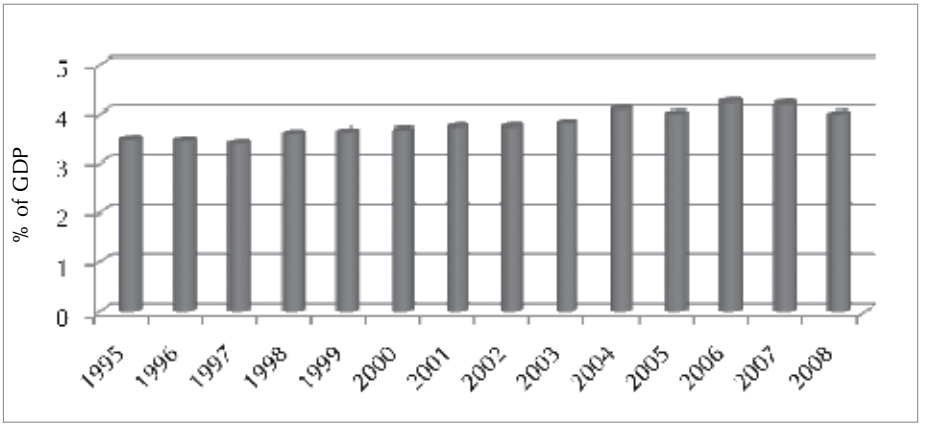
Source: WHO, *World Health Statistics 2011*.

As evident from Figure 6.2, total health expenditure as a percentage of GDP has been not more than 4.5 per cent over the years for Sri Lanka, whereas the global figure stood at 9.7 per cent in 2007.[22] General government expenditure on health as a percentage of total government expenditure is 8.5 per cent, while per capita health expenditure was US$ 68 for Sri Lanka in 2007.[23] The global figures read as 15.4 per cent and US$ 802, respectively.

At end 2009, the public sector health workforce was estimated at 107,560 (54,917 at Line Ministry Institutions and 52,643 at Provincial Institutions).[24] As at end 2007, there were 11,023 medical officers (MOs) and 31,466 nurses serving at 615 government hospitals with total bed strength of 68,694.[25]

In 2007, the Ministry of Healthcare and Nutrition published a Health Master Plan (HMP) for 2007-2016, with the aim of

Figure 6.2
Total Expenditure on Health: 1995-2008



Source: http://www.who.int/nha/country/lka.xls.

[22] This includes both public and private expenditure on health.

[23] WHO, *World Health Statistics 2010*.

[24] http://203.94.76.60/nihs/BEDS/Manpowersum-09-12-31.pdf .

[25] Ministry of Health, *Annual Health Bulletin 2007*.

providing the policy and strategic framework for the development of an innovative health system by 2016. The main objective is to improve the health status of the country and reduce inequalities. This is to be achieved through five strategies, namely:

- Ensure the delivery of comprehensive health services, which reduce the disease burden and promote health;
- Empower communities (including households) towards more active participation in maintaining their health;
- To improve the management of human resources for health;
- To improve health financing, resource allocation and utilization; and
- To strengthen stewardship and management functions of the health system.

The government's overall development framework also identifies some major challenges

Table 6.4
Distribution of Health Facilities by District: 2005 and 2007

District	Govt. Medical Institutions with Specialties[a]	Govt. Hospital Beds	Govt. Hospital Beds per 1,000 Population	Specialists in Curative Care	Medical Officers per 100,000 Population	Nurses per 100,000 Population
	2007				2005	
Colombo	9	12,126	4.9	229	128.2	230.1
Gampaha	4	6,078	2.8	75	39.2	73.5
Kalutara	4	2,773	2.5	32	40.1	77.1
Kandy	4	6,686	4.8	83	90.3	176.2
Matale	2	1,661	3.5	26	40.8	82.2
Nuwara Eliya	1	1,803	2.4	17	8.8	20.2
Galle	3	3,314	3.2	58	68.5	124.0
Matara	2	2,286	2.8	24	37.2	84.2
Hambantota	4	1,624	2.9	22	29.0	51.1
Jaffna	2	2,455	4.1	11	42.1	65.8
Kilinochchi	1	378	2.6	0	10.3	14.5
Mannar	1	481	4.7	0	33.3	40.4
Vavuniya	1	463	2.8	7	45.5	58.6
Mullaitivu	0	472	3.3	0	5.0	17.0
Batticaloa	3	1,484	2.8	15	26.4	72.5
Ampara	5	2,429	1.3	28	41.4	82.5
Trincomalee	3	1,185	3.3	12	36.9	48.5
Kurunegala	3	4,814	3.2	48	26.9	93.9
Puttalam	3	1,489	2.0	30	54.7	64.9
Anuradhapura	3	3,198	4.0	28	43.2	88.0
Polonnaruwa	2	1,291	3.3	16	51.2	110.6
Badulla	3	3,390	4.0	40	25.5	95.3
Monaragala	1	1,376	3.2	9	34.7	53.0
Ratnapura	4	3,193	2.9	19	32.9	81.0
Kegalle	4	2,245	2.8	23	36.8	52.8
Sri Lanka	72	68,694	3.4	852	45.6	95.8

Note: a: Teaching hospitals, provincial hospitals and base hospitals.

Source: Ministry of Health, *Annual Health Bulletin,* 2004/2005 and 2007.

Table 6.5
Sanitary Conditions and Mortality Rates by Sectors

Sector/ District	Percentage Distribution of Households by Safe Access to Drinking Water and Availability of Toilets (2006/07)					Mortality Rates (2003)	
	Main Source of Drinking Water		Availability of Toilets			Under 5 Mortality Rate[a]	Infant Mortality Rate[a]
	Safe (%)	Not Safe (%)	Exclusive for Household (%)	Sharing with Household (%)	No Toilet Facilities (%)		
Sri Lanka	84.8	15.2	89.1	7.3	3.6	21	15
Sector							
Urban	97.7	2.3	86.5	9.7	3.8	19	10
Rural	85.0	15.0	90.9	6.0	3.0	23	19
Estate	46.2	53.8	67.7	20.5	11.8	33	29

Note: a: Per 1,000 live births.

Sources: DCS, HIES 2006/07 and *Demographic and Health Survey 2006/07*.

in the health sector, namely: (a) responding to a changing disease and demographic pattern, (b) human resource management, (c) improving responsiveness, and (d) addressing the needs of vulnerable groups.[26]

6.3.2 Equity Issues in Health

Disparities in the distribution of health resources are prevalent despite the fact that ensuring equal opportunities in accessing health services across the country is a key component of inclusive growth. There are wide disparities in health resource availability (physical as well as human) between districts (Table 6.4). Colombo district, the richest district of the country with a PHCI of 5.4 per cent,[27] is well-served by having 9 medical institutions with specialties, nearly 20 per cent of total hospital beds and 25 per cent of the specialists in curative care. Further, Colombo district has the highest number of MOs and nurses per 100,000 population. However, the figures from the poorest districts (e.g., Nuwara Eliya, Monaragala and Ratnapura with a PHCI of 33.8, 33.2 and 26.6 per cent, respectively) and previously conflict-affected areas of the N&E indicate wide disparity in health service availability relative to other districts.

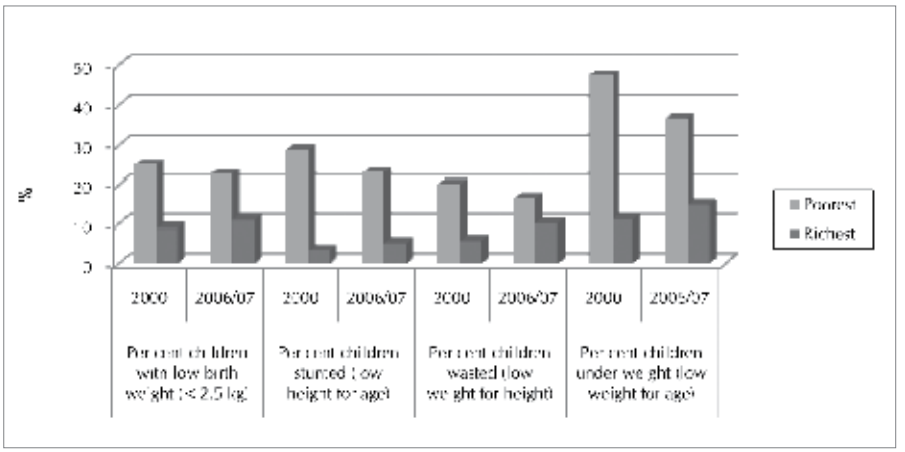
Sri Lanka is also seeing disparities in accessing basic sanitary needs. Here, access to safe drinking water and availability of toilets is considered a key indicator. Considering national level figures, it may be concluded that Sri Lanka is at a satisfactory level by achieving 85 per cent of access to safe water, 96 per cent in availability of toilets, and low rates of mortality (Table 6.5). However, the situation differs across sectors with the estate sector lagging behind other sectors in almost all indicators. More than a half of the estate population does not have access to safe water and 12 per cent are left without toilet facilities.

There are also disparities in health and nutritional outcomes to be found. Even though

[26] DNP, 2010, *Mahinda Chinthana; Vision for the Future*, Ministry of Finance and Planning.

[27] DCS, HIES 2006/07.

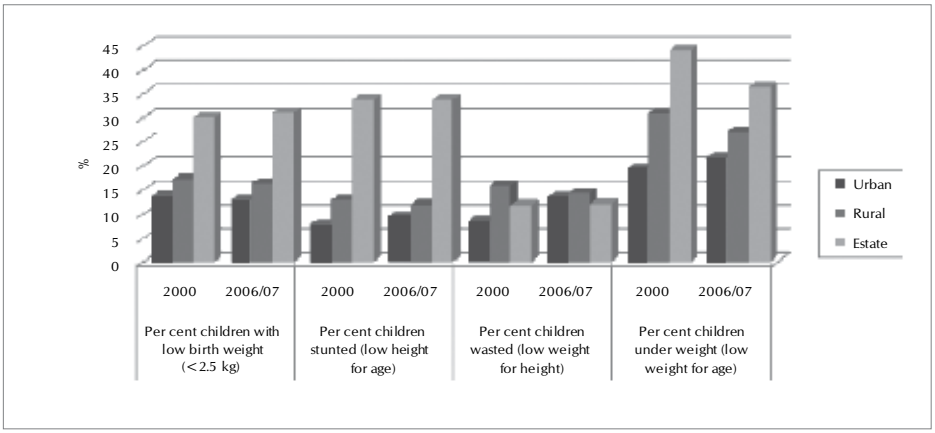
Figure 6.3
Child Nutrition and Health Status by Wealth Quintile: 2000 and 2006/07



Source: IPS/UNDP, 2010, *Millennium Development Goals Country Report 2008/09*.

Sri Lanka has implemented various nutritional programmes, 50.7 per cent of the country's population is estimated to receive below 2030 kilocalories (kcal) level of Daily Dietary Energy Consumption (DDEC).[28] Even the non-poor people in the urban and rural sector consume less than the required level. As evident from Figures 6.3 and 6.4 - depicting, respectively, the nutrition status of children by wealth quintiles and by sector - it is clearly observed that although the nutrition status of the poorest quintile has improved from 2000 to 2006/07, the gap between the poorest and the richest remains almost at the same levels for all the indicators. Another notable observation is that the nutrition status of the children from the richest quintile has deteriorated slightly over the same period

Figure 6.4
Child Nutrition and Health Status by Sector 2000 and 2006/07



Source: IPS/UNDP, 2010, *Millennium Development Goals Country Report 2008/09*.

[28] *Ibid.*

(despite a marginal increase in all the indicators in the richest quintile). This indicates the country as a whole is facing a nutrition problem regardless of the wealth status of individuals.

When child nutrition by sector is considered, the prevalence of being underweight, stunted and wasted is high among estate children (Figure 6.4). Further, the nutrition status of estate children has also not improved over the years in a significant manner. Even in the other sectors, a marked improvement cannot be observed.

6.3.3 Emerging Needs and Current Policies

Re-establishing health services in previously conflict-affected areas is one of the major challenges that the health sector faces at present, recognized by the Health Master Plan of 2007. Damage to health infrastructure, lack of human resources and other supportive facilities such as medical supplies and equipment, a breakdown of preventive and promotive services, etc., are major constraints. The health challenges are also more complex in view of conflict-related psycho-social problems that have to be taken into consideration. Development and allocation of human resources for health have being identified as one of the most crucial strategies for effective reconstruction of health service systems in conflict-affected areas of the country.[29]

In addition to specific needs of conflict-affected populations, Sri Lanka is also facing an epidemiological transition, experiencing a change in the pattern of causes for deaths. The number of deaths attributable to maternal and child health and infectious diseases have declined over the years, whereas deaths due to non-communicable diseases (NCDs) - such as ischaemic heart disease, strokes and cancer - have increased greatly. At present, nearly 90 per cent of the country's disease burden is attributed to NCDs. In the past half-century alone, the proportion of deaths due to circulatory disease (such as heart disease and strokes) has increased from 3 per cent to 24 per cent, while that due to infectious diseases has decreased from 42 per cent to 20 per cent.[30] Ischaemic heart disease was ranked as the number one leading cause for hospital deaths in 7 districts of the country in 2000, and by 2007, this had become the number one leading cause in hospital deaths in 15 districts.[31]

Health hazards due to natural disasters and climate change is another emerging challenge for the health sector. Apart from the deaths and disabilities caused by natural disasters, health issues related to climate change are reported more frequently than before. Problems in accessing safe drinking water, outbreaks of vector and water borne diseases (dengue, diarrhoea), increased rate of respiratory disorders (due to dust and cold waves), more communicable diseases (skin diseases, typhoid fever), and malnutrition (due to food inaccessibility) are some of the outcomes. Psychological problems due to the loss of dwellings, habitat and income and loss of family members could also arise. Sanitation issues and other social problems arise as populations are displaced due to extreme weather events.

Amidst emerging new sources of health concerns, Sri Lanka is also facing major

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[29] Mari Nagai, M., S. Abraham, M. Okamoto, E. Kita and A. Aoyama, 2007, "Reconstruction of Health Service Systems in the Post-conflict Northern Province in Sri Lanka", *Health Policy*, Vol. 83, pp. 84–93.

[30] Engelgau M., K. Okamoto, K.V. Navaratne, and S. Gopalan, 2010, "Prevention and Control of Selected Chronic NCDs in Sri Lanka: Policy Options and Action", Health, Nutrition and Population (HNP) Discussion Paper, World Bank.

[31] Ministry of Health, *Annual Health Bulletin*, 2000 and 2007.

demographic transitions that clearly hold implications for the health sector. The country is undergoing a demographic transition, where the population stabilizes at low birth rates and low death rates. If this trend persists, by year 2041, 25 per cent of Sri Lanka's population will be in the above 60 year age category.[32] This means that there will be more demand for health needs from the aged population in the future.

As such, private sector involvement is going to be very critical in providing effective and efficient health care service. However, in Sri Lanka, private sector involvement in health is largely concentrated in the Western Province with around 60 per cent of total private hospitals, and 75 per cent of total private hospital beds in 2008.[33] Whilst this 'urban bias' is understandable from a private sector perspective, it leaves many other parts of the country without access to private sector investment to develop health services.

6.3.4 Current Policies and Programmes

Sri Lanka has taken several initiatives to increase food consumption and ensure adequate nutrition intake among households and individuals. The main intervention has been the 'Thriposha' (a pre-cooked cereal based food) national programme, made available to pregnant and lactating women during the first 6 months and infants between 6-11 months of age. It is estimated to cater to nearly 580,000 beneficiaries.[34] Another major intervention by the government is food assistance to populations affected by the conflict in the N&E, including displaced persons. The value of food assistance ranges between Rs.336 for families consisting of one individual to Rs.1,260 for families of five persons per month.[35] A school-feeding programme under which poor children are given a hot meal in school, and provision of a food package for expectant mothers ('poshana malle') are some other interventions. In addition, a 'National Nutrition Surveillance System' was launched in 2008 to obtain timely data at provincial and central level. The government has already launched a 'National Nutrition Policy' for the period 2008-18.

The government has also identified the gravity of NCD-related health challenges and taken several policy initiatives. A 'National Policy and Strategic Framework for Prevention and Control of Chronic Non-communicable Diseases' was approved by the Cabinet in 2010. In the Budget 2011, an additional allocation of Rs. 900 million was made (approximately 1.5 per cent of total expenditure allocated to Ministry of Health in 2011) for a three year Action Plan targeting the control of NCDs, to be implemented from 2011 through improvements in the primary healthcare system.

6.4 Conclusion and Policy Implications

Ensuring equal opportunities in accessing education and health services across the country is a key component of inclusive growth. However, there are wide disparities in both the education and health sectors in terms of accessibility as well as resource availability that results in disparities in outcomes. As discussed in the previous sections, disparities have been identified in the education sector in terms of access quality as well as distribution of resources. Disparities in access to education are higher beyond the primary level, particularly at the

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[32] De Silva, W.I., 2007, "Beyond Twenty Million: Projecting the Population of Sri Lanka 2001-2081", Demographic Transition and Pension Series No.6, IPS.

[33] IPS, 2011, *Census of Private, Co-operative and Estate Hospitals 2010*.

[34] Ministry of Health, *Annual Health Bulletin 2007*.

[35] IPS/UNDP, 2010, *Millennium Development Goals Country Report 2008/09*.

secondary and collegiate levels. Despite high access, almost a fifth of the children do not complete primary education at the appropriate age. There are wide disparities in school completion rates in major education cycles across economic groups, gender, sector, and provinces, while disparities rise for higher education cycles. The estate sector and males register the poorest performance in completion of compulsory and secondary education cycles. Disparities in completion rates of higher education cycles are also reflected in the GCE (O/L) and GCE (A/L) success rates. Lack of resources and teacher shortages are worst for schools situated in less developed districts, particularly schools in previously conflict-affected areas and in remote plantations.

Sri Lanka needs to improve enrolment at the post-primary levels, particularly at the senior secondary level. Particular attention should be given to improving school cycle completion among poorer groups, males, and those in the estate sector. Private sector participation can bring benefits. For instance, private investment in university education - operated under state regulation and standards - could improve the quality of education through competition, enhanced access to university education and resource mobilization, etc. Sri Lanka also needs to pay greater attention to broader skills development through the TEVT sector and tertiary education.

In the health sector, disparities are observed in the distribution of health facilities and resources. Sectoral discrepancies are evident in accessing safe drinking water and availability of toilets, and in indicators such as IMR and Under 5 mortality rate. Prevalence of being underweight, stunted and wasted is high among poor and estate children.

The development of social infrastructure has been recognized as a key factor needed for sustainable economic growth. As Sri Lanka aims to accelerate growth, it is critically important that the human capital needed to compete globally is developed. This requires that special attention be paid not only to education but also to the country's health system. A rapid demographic transition resulting in an ageing population, and emerging health risks such as NCDs are major health sector challenges, amidst efforts to rehabilitate education and health services in a post-conflict environment. Although Sri Lanka has a decentralized health system, prevalence of regional/spatial disparities suggests that it has not been used effectively. Lack of resources in primary health care units - the dearth of health personnel and other facilities (i.e., medical equipment and essential drugs) - affects delivery of health care services, especially in rural areas. This suggests that the government should place greater emphasis on strengthening primary health care units, which in turn would avoid creating bottlenecks at the secondary and tertiary health care units.