State of Commitment to Universal Health Coverage
Civil Society Country Consultation – Sri Lanka

NOTE-TAKING TEMPLATE

Date of consultation:	08.08.2022	Lead organisation:	DAST
Number of focus group participants:	37 participants	Provide description of make-up for the focus group[1]:	Please see Annex 1
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Number of breakout rooms:	N/A	Composition of breakout rooms:	N/A

CATEGORY 1: ENSURE POLITICAL LEADERSHIP BEYOND HEALTH

1. **Does your government have a coordination government agency/mechanism/department that engages across sectors for the specific purpose of improving health or advancing UHC? If so, how well is this mechanism or department functioning**

The Ministry of Health (MOH) is the main responsible agency for improving Universal Health Coverage (UHC) in the country. The Sri Lankan healthcare system provides free-of-charge healthcare at the point of delivery. It comprises different systems of medicine including Western, Ayurvedic, Unani, Sidha, Homoeopathy and Acupuncture. Of these, Western or Allopathic medicine is the leading sector catering to the

[1] Provide information that describes the focus group participants. Be as descriptive as possible without identifying individuals by name. For example, what type of organization are they representing? Are they members of a specific community or population? Do they belong to a specific region or demographic?

needs of the majority. MOH is primarily responsible for the provision of comprehensive western healthcare in the public sector. Western medicine is provided through both the public and the private sectors in the country. The public sector delivers 90% of in-patient care. Out-patient care is delivered more equally between the public and private health sectors. The public sector is mainly divided into preventive and curative sectors. Both sectors reach the grass root level. The curative sector operates through 603 government sector medical institutions including two National Hospitals, nine Teaching Hospitals, 15 specialised hospitals, two Provincial General Hospitals, 20 District General Hospitals, 28 Base Hospitals (Type A), 52 Base Hospitals (Type B), 77 Divisional Hospitals (Type A), 139 Divisional Hospitals (Type B), and 259 Divisional Hospitals (Type C) in the country. Out-patient Department facilities are readily available in all these General hospitals.

The preventive health services of the public sector are provided mainly through the Medical Offices of Health with a catchment area of 60,000-100,000 people at the local level which has 346 units. These units provide a range of services relevant to communicable and non-communicable diseases including, antenatal care, natal care, postnatal care, family planning, well-women services, immunisation, nutrition services, communicable disease prevention, school health, environmental, and occupational preventive services by a primary health care team.

2. If you primarily conduct health advocacy, have you engaged with other government ministries or departments beyond health in your advocacy efforts? How so?

The community groups including the NGO sector have been involved in advocacy on various health issues with different departments of the MOH as well as with other government agencies such as the Social Services Department, The Ministry of Labour, Ministry of Education, Foreign Employment Bureau, and Ministry of Finance. These advocacy agendas are relevant to direct and indirect health issues.

Some of the recent successful national-level advocacy efforts include:

- Establishing primary health care institutions in certain rural areas
- Initiation of Pre Exposure Prophylaxis for vulnerable populations to HIV
- Needle exchange pilot project for people who use drugs
- Obtaining COVID 19 vaccinations for priority target groups at the early stage of the pandemic

At the same time, the following advocacy efforts are still ongoing and proving significantly challenging;

- Incorporation of age-appropriate comprehensive sexual education into the school curriculum,
- Repealing of vagrancy ordinance and 365 & 365A in the constitution, which is relevant to sex work and MSMs

- Implementation of a new tax formula for tobacco by the Ministry of Finance

3.

A. Which groups of people in your country struggle to gain access to health services? What are the main barriers for them to access health services?

Although Sri Lanka provides free health services at the point of delivery, some groups face challenges in accessing these government-provided services. Those groups include, but are not limited to:

- Differently-abled children with no visible physical markers, like Autism
- Children with learning disabilities
- Elderly people
- Cancer patients and chronic kidney failure patients who live at a distance from the treatment facilities
- Young people who seek sexual and reproductive health services
- Key populations
- People in the estate sector
- Single parents
- Single women
- People with mental health issues

Although there are country-level policies relevant to the elderly and disabled people, priority and separate counters and queues are not available for elders when they obtain health services. In addition, sign language interpreters are not available in hospitals. Moreover, some discrepancies in healthcare equality between urban, estate and rural can be observed due to some of the specialised services being available only in the main hospitals in Colombo and people who need specialised care needing to travel to Colombo. For instance, patients diagnosed with cancer, who need radiotherapy treatment or those who require specialised testing, need to travel to urban centres to receive their specialised treatment. In addition, stigma and discrimination, legal and policy barriers, and criminalization also prevent patients from accessing available services.

B. Considering the needs of the groups identified above, what are the specific health services that are under-prioritised?

Some of the under-prioritised areas include but are not limited to:

- The telemedicine field has not been developed to obtain specialised care for people who take treatment at primary health care institutions.
- Sexual and reproductive health services for young people, especially young women and girls.
- Specialised health services for people living with disabilities and people with mental health conditions.

4. Do you feel that UHC laws/policies/strategies that exist in your country are being adequately implemented?

One of the main strategies for the implementation of UHC is the strengthening of primary healthcare. Sri Lanka has streamlined the UHC process by developing the "Policy on Health Care Delivery for UHC in 2018". An action framework for the implementation of the UHC policy has also been developed as a policy implementation tool for the five years 2018-2024. The Ministry of Health is responsible for closely monitoring the implementation status of the action framework of the policy and is assigned to different sections.

One of the main strategies of UHC is primary healthcare reorganisation and it includes a wide range of activities including the cluster system linking apex base hospitals with primary healthcare organisations. The Sri Lanka Essential Services Package (SLESP) was developed in 2019 and it is an important tool to implement this reform. It describes the services that citizens of Sri Lanka are entitled to at each level from tertiary health care to primary health care. The Government remains committed to gradually scaling up the existing services to ensure the availability of these services and it was delayed due to the COCID-19 pandemic. This primary healthcare reorganisation is supported by the Health System Enhancement Project of the Asia Development Bank and the Primary Healthcare Strengthening project of the World Bank. It has also been delayed due to the COVID-19 pandemic. Currently, the Ministry of Health has sped up the activities.

5. Do you know any accountability or monitoring mechanisms for UHC in your country? If yes, please explain your answer.

The Ministry of Health introduced different tools for monitoring the primary healthcare delivery activities in the country. As an example, review and adaptation of the PHC supervision circular (General Circular No 02 166/2015 of November 30, 2015) and development of a mechanism for supervision of the cluster-linked facilities for the identified services. The Ministry of Health monitors the cluster performance using the results monitoring framework adopted from the results framework in the policy. As per the circular, a comprehensive comparative

evaluation should be carried out by 2023 to assess the performance of the cluster-based reforms introduced to strengthen the primary healthcare system to ensure UHC in the selected areas.

Progress of the large projects such as the Health System Enhance Project and Primary Healthcare Strengthening Project has been monitored by the Ministry of Health with provincial and District level health administrative teams and the Project Management section of the Department of the Ministry of Finance. Finally, the work performance report of the Ministry of Health should be submitted to Parliament. That report includes the financial and physical progress of all activities of the Ministry of Health including the progress of the implementation of the UHC.

6.

A. Do you think that health services in your country are of good quality? Can you elaborate and give examples?

The quality of health services should be assessed in two ways:

- Service side indicators, and
- Patient's side satisfaction with the quality

The service side indicators are assessed in two ways. Those are SDG indicator assessments including the UHC assessment and performance-based indicator assessment which were developed in 2018 by the Ministry of Health. This indicates the service quality. According to the WHO latest report, Sri Lanka ranked 76th out of 163 countries in the SDG country rank in 2022 compared to its ranking of 87 in 2021. The country SDG index score of Sri Lanka was 70, placing it as a front-runner in achieving the SDGs. The spillover Score was 93.7. However, when each SDG is individually assessed, Sri Lanka is “On track or maintaining SDG achievement” only in four SDGs including; no poverty (SDG 1), quality education (SDG 4), climate action (SDG 13), and responsible consumption and production. SDG 3 on good health and well-being indicated moderately improving together with Goals 2, 6, 7, 9, 11 and 14. Gender equity (Goal 5) is stagnating together with Goals 8, 16 and 17, and 15. There is no trend information available to see the reduced inequalities. In all other SDGs including, SDG 10 on reducing inequalities, and SDG 5 on gender equality, Sri Lanka is facing either major, significant or moderate challenges.

UHC includes a full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. Progress towards reaching SDG Target 3.8 on universal health coverage is tracked using two separate metrics; specifically, SDG indicator

3.8.1 on the coverage of essential health services and SDG indicator 3.8.2 on catastrophic health spending. SDG 3.8.1 coverage of essential health services is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged populations. The indicator is measured as an index reported on a unit-less scale of 0 to 100 which is computed as the geometric mean of 14 tracer indicators of health service coverage.

Table1-UHC index of Sri Lanka from 2000 to 2018

Year	**2000**	**2005**	**2010**	**2015**	**2017**	**2018**
UHC index	45	48	55	60	64	67

The UHC index shows it is progressing compared to the year 2000. Further to that, The Ministry of Health has identified 85 performance-based indicators at the national level and it is assessed by the relevant directorate or programme-specific units quarterly and yearly basis at the district level and national level. This monitoring system is mainly happening in preventive services through existing well-developed public health systems. Out of these indicators, some of the indicators are feeding to SDG indicators. However, a significant challenge is observed in the curative sector monitoring system. The Ministry of Health is currently working on a process to streamline this sector.

With regards to the patient satisfaction part, it is not implemented in a routine and structured manner. Although the Ministry of Health recommends for patient satisfaction surveys be set up at hospitals, it is not regularly implemented. It was observed that satisfaction-related data should be obtained from patients and caretakers in the wards and should be gathered by outside data collators to minimise bias. The existing patient satisfaction surveys do not cover the people who are going against medical advice. These surveys should be conducted among those who go against medical advice and among caretakers whose patients have died in the hospital to gather satisfaction data. It is also experienced that there is a long waiting list for surgeries and diagnostic tests in some hospitals which affects the quality of services.

B. What health services and what communities/population groups experience the gaps in quality?

Many vulnerable populations experience quality gaps in health services. It could be the service side as well as some service environmental factors associated with stigma. These populations include, but are not limited, to key population groups, disabled people, women who were sexually abused, and unmarried teenage pregnant women.

Many face quality gaps in accessing sexual and reproductive health services, treatment of cancer and kidney failures. Most often, the quality gap is linked with the inability to spend money as quality in private hospitals is generally considered to be average.

7. Where do you think your government should be spending more in terms of achieving UHC?

Sri Lanka identified 13 strategies for health care delivery in the UHC policy and some of the strategies have been already implemented. However, MOH has to prioritise more strategies like the Primary healthcare reorganisation system including the carder improvement and health information system. It was delayed in implementation due to the COVID-19 pandemic. The Ministry of Health is in the process of developing that.

8. At the national level: are there opportunities for people, civil society organisations, and the private sector in your country to be engaged in planning, budgeting, monitoring and evaluating the health sector?

A. If so, what are those opportunities and are they effective and efficient for the engagement of civil society, in particular, of the most vulnerable and marginalised populations and communities?

Although NGOs and civil society are participating in the "Hospital Development Committees" in the curative sector, civil society engagement in the preventive sector is minimum, except at several national-level advisory committees on some disease-specific subjects (National advisory committee for cancer Prevention and Control, National Advisory Committee for HIV prevention and Control, etc). However, in the HIV & TB programmes under the 'Global Fund to Fight AIDS, Tuberculosis and Malaria support', the government is expected to involve vulnerable and key population groups including PLHIVs at planning, implementing and monitoring levels. Although the "Country

Coordination Mechanism" (CCM) of the Global Fund project has a representation of civil society and key population groups, their voice at the forum is subdued due to many reasons. However, the deputy chair of that forum represents the NGO sector. In addition to that, Youth are represented at the national level in health planning for youth programmes and Elderly and Disabled secretariats facilitate contributions from NGOs and civil society for their planning process.

The involvement of the general public is mandatory when making national-level policies. This involvement is facilitated through newspaper and web publications to obtain comments on draft policies. The experience showed less contribution from the individuals of the public and a considerable number of engagement from the NGOs and CBOs which are working in specific fields.

9. Can you identify some of the major challenges for women and girls in their access to health services?

Young and teenage girls, trans women, female sex workers and lesbians among others face many challenges accessing existing health services; especially accessing sexual and reproductive health services.

Existing cultural taboos lead to problems in getting access to health services, contraceptive services and sexual health services. This is due to both external stigmas that exist in the society and internal stigma of the individual. The street-based sex workers face issues due to the vagrancy ordinance (*Soliciting sex in a public place is illegal).* However, the Police Department has issued an internal circular that mentions keeping condoms is not a proven strategy for sex work.

One of the main reasons for these challenges is the absence of age-appropriate, skills-based sexual education which is incorporated into the school curriculum. Teachers are reluctant to teach that subject that empowers students. Transwomen get discrimination from within the family as well as the society including the health facilities.

Sexual and Reproductive Health services are challenging for some women and girls: contraception and sexual health diseases, including abortions. Abortions are allowed only for women who have severe heart and mental diseases. It is not allowed even for pregnant women who have gotten pregnant due to sexual abuse. Trans clinics are available only in the National Hospital of Sri Lanka (Colombo) and Kandy and Karapitiya Teaching hospitals. Although the Ministry of Health has instructed the establishment of these clinics for transgender people, it has not been fully utilised. Therefore, they face difficulty in accessing the clinics, even when they need to, due to length in distances.

CATEGORY 1: ENSURE POLITICAL LEADERSHIP BEYOND HEALTH

1. During the COVID-19 pandemic, has your government made UHC a high priority?

At the initial stage of the 1st wave of COVID-19, The President of Sri Lanka and the Ministry of Health established several committees to guide the responses to COVID-19. One committee was the Presidential Task Force chaired by the President with multiple stakeholders. This task force has taken country-wide, high-level decisions. The 2nd committee was chaired by the Minister of Health and the Chief of Sri Lanka Army to discuss the joint implementation plans. Another technical committee consisting of higher officials in the ministry, implementing partners and development partners, including the professional colleges, was established and chaired by the Secretary of Health. This technical committee was responsible for making technical decisions while the Epidemiology Unit was responsible for the planning, implementation, monitoring and evaluation, information dissemination, and logistics management at the central level during the COVID-19 epidemic.

The Provincial/District Health Authorities as well as divisional level Medical officers of Health were responsible for the planning, implementation, monitoring and evaluation, information dissemination, and logistics management at the regional level as well as divisional level, respectively.

A few circulars and guidelines were issued by the Director General of Health Services (DGHS) based on the quarantine act, which gave the power to the post of DGHS by law. However, at the beginning of the epidemic, those who were attending the health clinics at government hospitals were not able to attend clinics due to lockdowns and curfews.

Later, all pharmacies belonging to the private and public sectors were opened during the lockdown and allowed people to go to the pharmacies even during curfew. The government also arranged several services like home delivery services of medication for patients registered in the government clinics via postal services and monthly compensation schemes as well as food assistance schemes for vulnerable groups. In addition to that, the NGO sector also came on board for this partnership to provide drugs for People living with HIV (PLHIV) confidentially. It was observed that vulnerable groups like people with special needs, key population groups, disability groups, and women-headed households were mainly affected. Also, social distancing was a problem in prisons due to overcrowding. District Administration was given the authority by the President and task forces to provide health care services as well as to coordinate with the responsible ministries and non-government organisations. Although non-essential surgeries were postponed, all essential urgent surgeries were done and necessary instructions were given by the Ministry of Health through circulars. Sri Lanka is one of the countries which achieved

high vaccine coverage during a short period and responded to the COVID-19 pandemic well. This has been acknowledged by the World Health Organisation (WHO).

CATEGORY 2: LEAVE NO ONE BEHIND

1. **Are there laws and frameworks in place in support of vulnerable groups accessing essential health services they need? How well do they work in practice?**

Sri Lanka does not have separate laws or policies that support vulnerable groups to access essential health services. However, some sections in the constitution support access to health services and Sri Lanka is a signatory to several international instruments that support health access for vulnerable groups, including key populations. However, the National Strategic Plan for HIV and Sexually transmitted diseases 2018-2022 has recognized the importance of providing sexual health services to key populations. The current NSP of the National STD, AIDS Control Program, for instance, includes a strategic pillar of enabling the environment and includes measures to address legal and policy barriers. In addition, many circulars relevant to key population groups on sexual health services have been issued by the Ministry of Health.

Based on the constitution, Attorney General has approved a Ministry of Health circular for facilitating access for adolescents to sexual and reproductive health services based on the best interest of the child. These services include contraception, HIV testing, and other SRH services.

2. **Does your country have a policy or program to reduce or eliminate patient fees (out-of-pocket spending on health)?**

The Ministry of Health has a responsibility to ensure that the private sector provides quality service and needs to regulate the private health system for financial risk protection of the patients, at the same time ensure patient rights. Therefore, the responsibility for the private sector regulation has been shifted to the Directorate of Private Health Sector Development (PHSD) of the Ministry of Health established in 1998, as well as to the Provincial Councils by the 13th Amendment to the Constitution.

The Private Hospitals and Nursing Homes Act which was established in the 1940s was replaced by the Private Medical Institutions (Registration) Act No. 21 of 2006(PMIR Act). It aims to develop and monitor quality standards to be maintained by the registered Private

Medical Institutions and acts as a method of evaluation of standards maintained by such Private Medical Institutions. The Private Health Regulatory Council (PHSRC) is a Council established to exercise, perform and discharge its powers, duties and functions under the same act.

After identifying the gaps by the Directorate of PHSD, the Ministry of Health has issued circulars for the financial risk protection of patients. The development of charges for various procedures is in the pipeline. Consumer Affairs Authority (CAA) also has published gazette notifications in this regard and some of the circulars for the private health sector are: Maximum retail price of a drug not to be exceeded by 20%, price caps for full blood counts and Dengue antigen, maximum cap of 2500 LKR for private channelling fees of consultants and 600 LKR for hospitals fees. Regulation of the indoor patient's hospital chargers should be done after grading of the hospitals, and grading of private hospitals is not completed yet. It is important to establish a proper private health care institution grading system, urgently.

Furthermore, a complaint handling system was established by the PHCRC. However, it was observed that internal complaint handling of private health institutions is not developed properly and there are long delays due to poor manual complaint handling system with understaffing of PHCRC.

3. Who is most impacted or what health services are most negatively impacted by out-of-pocket payments?

50% of total health expenditure in Sri Lanka is out-of-pocket expenditure. Although healthcare is free in the government sector, there are some instances where people have to buy drugs and devices due to a lack of stock in the public sector. Out-of-pocket expenditure includes transport costs and the loss of daily pay due to illness. People who need health services for chronic diseases, and those who need to travel significant distances for hospitals also face high OOP expenditure. Mainly, people who have chronic diseases like cancer and kidney diseases and disabled people are mostly affected by OOP expenditure.

CATEGORY 3: REGULATE AND LEGISLATE

1. **Are there laws and policies in place to ensure that people can engage in planning, budgeting and monitoring of health plans and budgets**

Health Planning of Sri Lanka is done on evidence-based scientific methods focusing on community health problems, identifying needs and resources, and establishing priority goals which are in line with the National Health Policy 2016 to 2025 and the sub-national disease-specific and programme-specific policies. Although policy development processes include engagement of civil society via stakeholder meetings, it is hard to observe any community engagement in the health sector other than in the National STD/AIDS Control Programme and youth health programmes.

There are no specific laws/policies to enable and guarantee civil society engagement in planning, budgeting and monitoring of health plans and budgets. However, community engagement is somewhat prevalent in the national HIV responses due to the requirements of the Global Fund. The rest of the health sector does not have such policies on community engagement.

CATEGORY 4: UPHOLD QUALITY OF CARE

1. **Does your country have adequate health workers, especially at the primary health care level? Are community health workers part of the health staff roster and are they paid adequately?**

Sri Lanka still faces certain challenges in filling an adequate health workforce, especially at the primary health care level. There are some gaps identified in the Health worker density that was identified in 2016 which impede Sri Lanka from achieving these by 2030. To achieve this target, the Ministry of Health has sped up the process of fulfilling the vacancies to achieve this target. For instance, recruitment criteria for nurses and midwives have been sped up, and the opening of the new Dental faculty will also fill the Dental Surgeons' gap.

Table –Health worker density per 100,000 population

Category	2016 density per 100,000 population	2030 SDG target per 100,000 population
Physicians	0.895	1.79
Dental surgeons	0.09	0.14
Midwives/ Nurses	2.428	3.82
Pharmacists	0.142	0.4

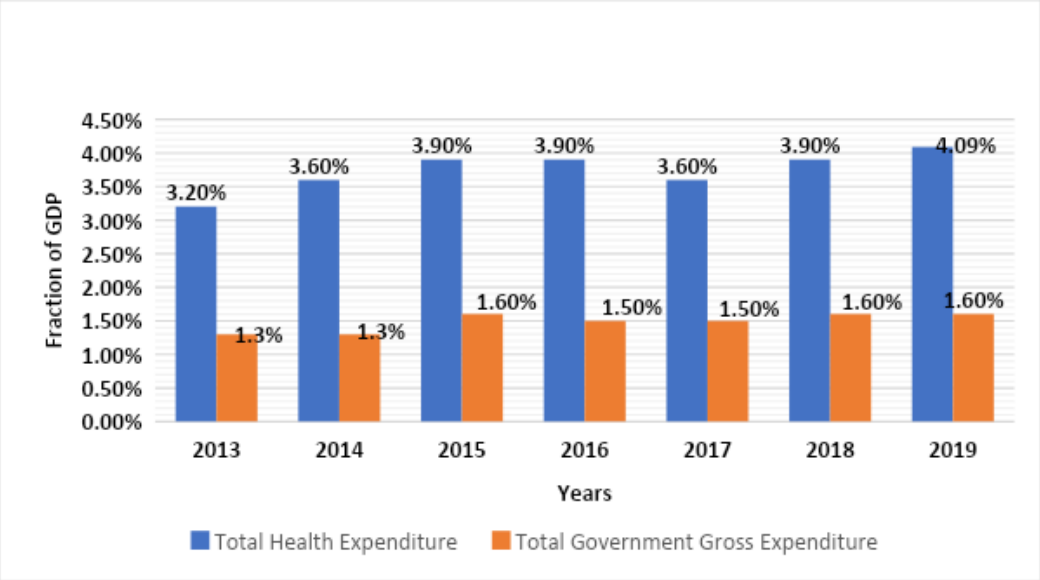
To overcome the gap in targets, the Ministry of Health is in the process of discussing and finalizing the task shifting and skill mixing. Necessary circulars have not been issued yet.

CATEGORY 5: INVEST MORE, INVEST BETTER

1. **A. Is the government spending enough on health services and is this increasing?**

   The government spending on health has been quite steady during the last few years, and it has been less than 2% (total government gross expenditure). However, these figures have doubled due to out-of-pocket expenditure, catastrophic expenditure, private insurance, workplace payment for health coverages, and foreign funds. The public health expenditure is mostly borne by domestic sources of financing. From 2013 to 2019, on average, 94% of public health spending was borne by domestic sources, while foreign sources accounted for 6%.

Figure 1 :Current Health Expenditure as a fraction of GDP from 2013 to 2019



2. **B. If the government is not increasing its spending on health services, what is preventing your government from investing more in health services?**

Usually, the preventive health sector gets around 20% and 80% of the curative sector from total government gross expenditure. If the total government gross expenditure is not increased, it always prevents the allocation of prevention services. That affects long-term disease prevention and long-term investment in the curative sector for treatment.

Similarly, if the government increases total government gross expenditure, it will affect other sectors like education. That also will negatively affect national development.

CATEGORY 6: MOVE TOGETHER

1. **A. Are there civil society forums or constituencies in your country to engage with decision-makers on health-related issues?**

   No. In the broader health sector, there aren't such civil society forums to engage with these decision-makers. This engagement is more prominent in the HIV response due to the requirements of the funding agencies.

2. **B. If so, how well does the existing civil society coordination function and what can be improved?**

There should be a government policy on the involvement of NGOs and Civil society in planning, monitoring and evaluation of large-scale projects and government health monitoring reviews. There should be a policy for the development partners to engage more comprehensively when they contribute to different health projects. Except for Global Fund, other developmental partners do not have a mandatory policy on community engagement when they implement their programmes. In addition to that, patient groups should be formed for chronic illnesses. Sri Lanka does not have active patient groups other than for PLHIV.

CATEGORY 7: GENDER EQUALITY

1.
   A. Can you identify some of the major challenges for women and girls in their access to health services?
   B. What kinds of health services are most challenging for women and girls to access?
   C. What are the primary challenges to access health care services for individuals who are non-binary?

Young women and girls, trans women, female sex workers, and lesbians among others experience many challenges in accessing Sexual and Reproductive Health services. Existing cultural taboos lead to problems in getting access to health services, especially contraceptive services and sexual health services. That could be due to both external stigmas that exist in society and internal stigma of a person. The street-based sex workers face issues due to the vagrancy ordinance (*Soliciting sex in public places is illegal)*. However, the Police Department has issued an internal circular that mentions keeping condoms is not a proven strategy for sex work. The main reason is the lack of age-appropriate skills-based sexual education incorporated into the school curriculum in Sri Lanka. Teachers are also reluctant to teach that subject in an empowering manner. Transwomen get discrimination from within the family as well as in society, including at health facilities.

Non-binary people face many issues because the health sector is mainly structured on the gender binary of men and women. The health sector is not accustomed to providing services to persons who identify as non-binary. They face challenges when they get admitted to the hospitals due to their identity not being recognised by the health care providers positively. Some health care workers stereotype non-binary individuals due to a lack of knowledge, which is the main barrier to acceptance.

CATEGORY 8: EMERGENCY PREPAREDNESS

1.

A. How has the primary health care system been affected by the ongoing COVID-19 pandemic?

The Primary Health Care (PHC) system was significantly affected during the COVID-19 pandemic, especially during curfew periods. Health staff absenteeism was observed during the pandemic due to transport issues. Even though transport was arranged for the health staff, it was not 100% effectively conducted. Minor and uncomplicated non-essential surgeries have been postponed during the pandemic. It was noted that the Triage system (*healthcare community categorises patients based on the severity of their injuries and, by extension, the order in which multiple patients require care and monitoring)* in each hospital, including the COVID-19 testing before the hospital admission, got negatively affected by health emergencies.

B. How do you think that PHC can be improved/evolved to be better prepared for future pandemic and other health emergencies?

WHO has released a position paper on "Building health systems resilience towards UHC and health security during COVID-19 and beyond" to reinforce the urgent need for renewed and heightened national and global commitment to make countries better prepared and health systems resilient against all forms of public health threats for sustained progress towards both UHC and health security in 2021. It includes seven policy recommendations. Many of these are satisfactorily implemented in Sri Lanka. It is important to train the health staff and strengthen the existing health system and invest in institutionalised mechanisms for whole-of-society engagement to face the situation in a better way.

Strengthening primary healthcare can be developed by improving the facilities for diagnosis and treatment by filling the necessary carders and linking to an apex cluster system. Some of the facilities for diagnosis and treatment cannot be established at the Primary Healthcare centres as they are not cost-effective. However, this can be overcome by suggesting a primary healthcare reorganisation cluster system without overburdening the patient's out-of-pocket expenditure.