

HiAP: SRI LANKA



A summary of the Alawwa Health project in Sri Lanka

Background

The Alawwa Health Project offers a bottom up example of a Health in All Policy (HiAP) approach, despite the lack of a national mandate. The project shows the strength of a community driven participatory response to health - a defining feature of HiAP.

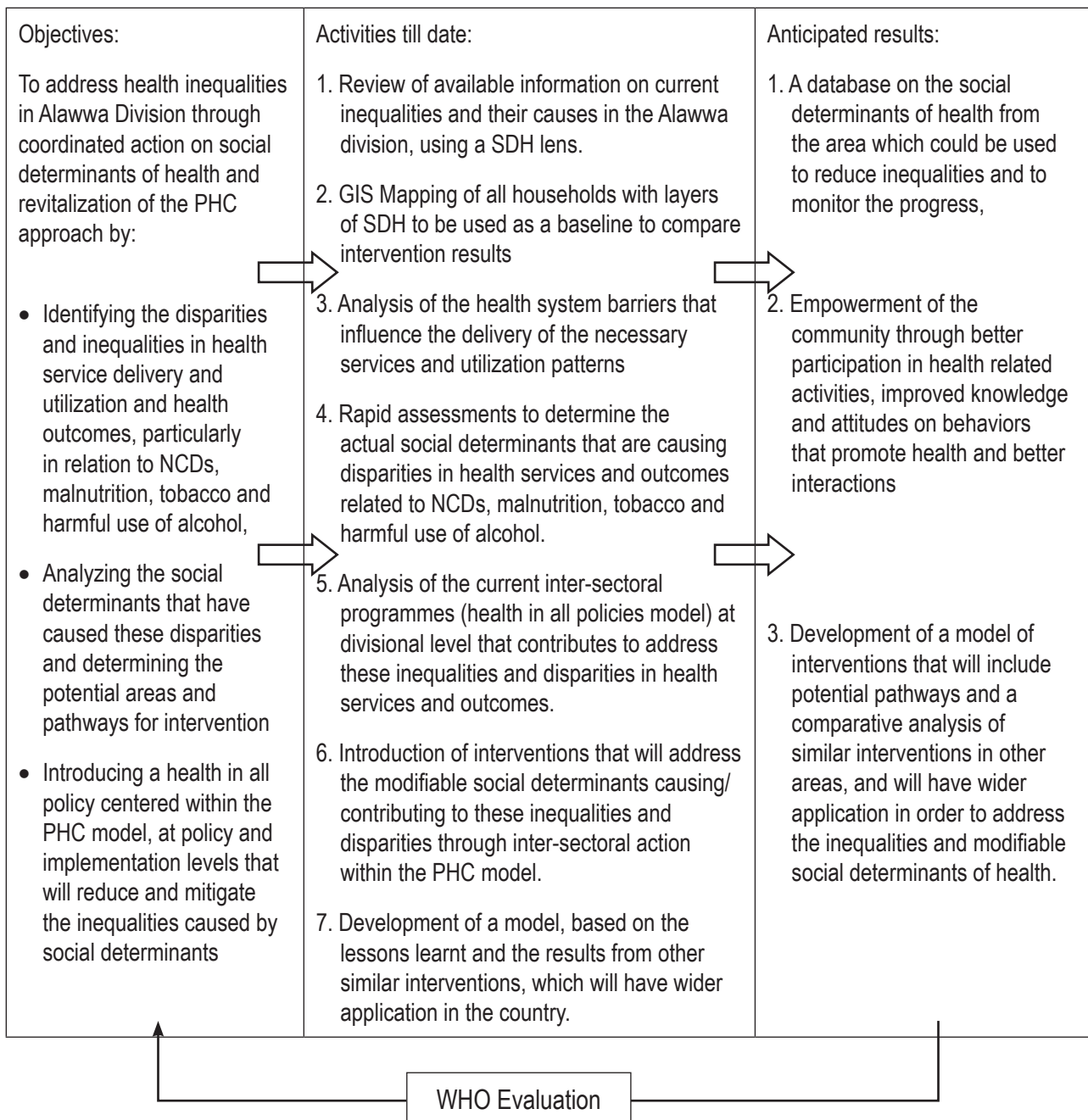
The project was initiated in the rural Alawwa Division (whose 63,000 people were primarily dependent on agriculture for their income) with the goal of reducing health inequities through coordinated actions on social determinants of health and the revitalization of the primary healthcare (PHC) approach. It had the political will of local government authorities and the international support of the WHO. The projects overview is provided below.

Examples of activities of the wider community, health and non-health sectors

1. Some retired public servants joined the project and produced a play on the

health promotion of services for NCDs, in particular motivating villagers to attend primary care services and maintain treatment compliance. The play has been staged in schools, government offices and in adjoining villages.

2. Every Saturday a NCD screening clinic is conducted by the MOH at various accessible sites. The clinics are funded by the Provincial Health Authority. Approximately 15-20 patients are seen and where necessary, patients are referred to hospitals.
3. As an active member of the organizing committee, Pradeshiya Sabha (divisional councils) have made a major contribution to the project including the facilitation of a NCD clinic at its offices. The Cooperative Society conducted programs for mothers of pre-school children including information on nutrition and the distribution of food supplements.



Lessons learned by introducing a HiAP approach to a PHC model (based on case-study interviews):

1. It is easy to get other sectors involved in health related projects as was the case in this study. This may be used as an entry point to consider “health” in all policy development

2. There is the potential to engage the health sector in the policies and activities of other sectors, though these are not pursued in the normal day to day activities at local government level.

3. PHC is an excellent medium to get other sectors involved as sectoral improvements have an impact on health.

4. PHC at grassroots level is closely engaged with the community. Community ties and bonds at a village level can be harnessed to show results and potentially may be sustainable. This may also be used to sensitize policy makers on the need to, and the benefits that can be accrued by, considering “health” in all policies.
5. Working with local government authorities is relatively easy as less coordination is required. Most of the time coordination of activities is done by an interested and motivated person.
6. Good leadership, governance and strong political commitment are essential. This project had the support of the local government authority. The commitment is also evident in the Pradeshiya Sabha allocating approximately 23% of the annual budget for health related activities.
7. Trust between sectors has to be established. This is easily done at grass roots level. The PHC approach is likely to assist in its success and as a stepping stone in the consideration of “health” in all policies.
8. The community has to create the demand for services that would benefit them as individuals and as a community. This requires empowerment of the community. Community demand for consideration of health in all policies may be a better option for considering health in all policies as opposed to a top-down approach.
9. The pioneer of the project is generally an extremely motivated person. In these situations it is usually individuals who pioneer activities. In order to ensure sustainability, institutionalization is required. This is much easier at the grass roots level.

Recommendations:

1. A formal mechanism at the national level to foster a HiAP approach to health should be established and would include the mandatory inclusion of health concerns in policies to be addressed.
2. Trust between sectors has to be established and officials from other sectors need to be sensitized to the importance of HiAP. The health sector should take the lead role in this regards. Inter-sectoral committees at the local, district, provincial and national level governments would facilitate this. Strong political commitment and leadership is required to ensure that these strategies are sustainable.
3. Demand for services has to be created through community empowerment and to ensure HiAP. This needs to be done through education, such as schools. Community groups should be provided with sufficient information to identify problems and solutions with assistance from all sectors.
4. The PHCs approach should be used as an example to promote HiAP, particularly as an entry point to engage other sectors.

Note: *The information for this summary is based on the case study commissioned by WHO-SEARO, written by Professor A.R. Wickremashinghe and Dr A. Kasturiratne. The case study included information from direct observations and interviews with key informants in Sri Lanka. The case study was presented at a WHO meeting in Helsinki in June 2013. This is simply a summary of the case study and uses much of the original content. Summary prepared by Elizabeth Owen, MPH of Gharkamai Health Consultants.*



**World Health
Organization**

Regional Office for South-East Asia

World Health House
Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi-110002, India
www.searo.who.int