Priority setting in health in the Sri

Lankan context: process and mechanisms

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Abstract

The important role played by public health has only been realised in the last three decades. The Alma-Ata Conference in 1978 revolutionised the role that public health played. The concept of equity and the availability of health care for the poor and disadvantaged were emphasised. Health promotion and priority health setting were also defined. Priority health setting helps to rationalise health service delivery with scarce financial resources. Sri Lanka has, since independence, provided free education and free health to its people. However, with rising costs the country has realised that priority setting in health is essential. Sri Lanka is in the transition period. It has a double burden of disease both communicable and non-communicable. Although malaria, dengue haemorrhagic fever, Japanese encephalitis, diarrhoeas and acute respiratory infections still affect the community, emerging diseases such as ischaemic heart diseases, cerebro-vascular accidents, diabetes and cancer play a major role in morbidity patterns. Sri Lanka has also one of the highest suicide rates in the world. Pesticide poisoning of adolescents and young adults take a heavy toll. Changing socio-economic conditions and an increase in life expectancy have made the care for the elderly a problem. It is also affected by the conflict situation in the North East and smoking related diseases.

The country has achieved spectacular successes, which are indicated by the low vital health statistical parameters. It has provided its people with medical institutions within a five mile radius. Life expectancy especially for females has been substantially increased. Sri Lanka has eradicated smallpox, achieved universal child immunisation and should eradicate polio in the near future. Some of the failures have been the resurgence of malaria since 1967 due to logistical and administrative constraints.

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Local Government and community apathy to hygiene, clean water and sanitation have led to epidemics of DHF and diarrhoeal diseases. There is inadequate access to reliable health information.

The open market economy has had an adverse effect on health care delivery. Steps taken to cushion the effects of the WTO and TRIPS arrangements and provide Sri Lanka with drugs at affordable prices have also been recommended. The sectoral approach to health related problems has been emphasised focusing on inter-sectoral linkages, partnerships and community-based actions. Priority health areas such as the problems of HIV/AIDS, mental health, the tobacco free initiative and care for the elderly have been addressed. What the health services are presently doing to overcome these problems and future strategies to address them have been indicated.

Maximisation of resources available for health has also been described. Health expenditure is only 1.6% of the GDP. Of this, only 16% is allocated for preventive health. Sri Lanka must also maximise its resources through partnerships and more effective use of donor resources. The problems of lack of skilled managers, development of the second line of management, the mal-distribution of medical officers and the shortage of nurses, paramedical and public health personnel is also being addressed. The use of trained volunteers especially in conflict areas has been advocated. Regional cooperation on health priorities is carried out through the South-East Asia Regional Office of WHO and the South-Asia Association of Regional Cooperation.

Health is a fundamental priority for all societies in the world. For a long time, provision of health care largely confined itself to treating the sick and nursing them back to good health. That ill-health could be prevented was a concept which medical practitioners left to their less-revered colleagues – the public health workers who struggled despite their seemingly lower professional and social status, to improve water supply and sanitation, administer vaccines against preventable diseases and educate people how to remain healthy.

The Alma Ata conference in 1978 (1) declared that probably four-fifths of the world's population living mainly in rural areas and urban slums had no access to any permanent form of health care. Medical industries and sophisticated bio-medical technologies were not the answer to address such social injustices. Health had to be recognised as a

fundamental human right and its attainment, a social goal.

By the end of the last century, it was widely recognised that an acceptable level of health for all cannot be achieved by the health sector alone. It can only be attained through national political will and the coordinated efforts of the health and other social and economic development sectors. This was the beginning of a new public health movement which sought to secure for people the right to health.

At the first international conference on health promotion, health promotion was defined as a process of enabling people to increase control over and to improve their health (2). The five elements critical for health promotion was listed as:

- Healthy public policy
- Supportive environment
- Community action
- Development of personnel skills
- Reorientation of health services

A new perspective on health has emerged, whereby health is seen as an essential pre-requisite of sustainable development which requires concerted action by all sectors of society. The 21st Century calls for a new health system which is partnership-oriented, population-health based and proactive rather than reactive.

Health is created within the settings of everyday life. A healthy setting is one that is continuously creating and improving those physical and social environments and expanding those community resources which enable people to support each other in performing all the functions of life.

In developing countries like Sri Lanka with scarce financial resources health setting has to be prioritised. In any country, health sector priorities will vary from province to province and district to district depending on the major health problems affecting them.

Priority settings in health:

1) Process and mechanisms

Prioritising Health

Successive Governments of Sri Lanka have given high priority to health and education. Free health and free education is a right of the people of this country. But, due to economic and social factors,

as well as the advancement of medical technology and the high cost of drugs, prioritisation of health has now become essential. There has been a move however, through cost-benefit analyses to show that to improve the quality of life and development, Sri Lanka must have a healthy work-force. Especially in developing countries, diseases take toll of individuals. Sri Lanka too has begun to emphasise that health is a priority through a number of studies. Even when negotiating loans and grant aid, the Government has included the health sector as a primary component for assistance.

Considerations in Priority Setting in Health

In Sri Lanka the need for priority setting in health has been felt. Sri Lanka is in a transition period whilst still being affected by communicable diseases like malaria, other vector borne diseases like dengue haemorrhagic fever, Japanese encephalitis, diarrhoeas and acute respiratory infections, emerging diseases such as cardiovascular diseases (coronary and ischaemic heart diseases), cerebro-vascular illnesses, diabetes and cancer are playing a major role in the morbidity and mortality patterns in Sri Lanka. In fact coronary and ischaemic heart disease cause the highest mortality. Other components affecting health are pesticide poisoning. Sri Lanka has one of the highest suicide rates amongst adolescents and young adults. Malnutrition exist amongst disadvantaged populations (3).

With the increase in the life expectancy of Sri Lanka there is a shift of the population to the older age group. Although the care for the elderly was carried out by their children, the extended family system is fast breaking down due to a change in the socio-economic structure and the rapidly growing urban population. In a family both husband and wife are wage earners and they are unable to look after their elderly parents.

With the present conflict, populations have been displaced. Over a million refugees exist. Besides basic amenities such as food, clothing and shelter, health care has to be provided. Smoking related diseases have also increased in magnitude over the past two decades.

In the decentralised health system, districts are being encouraged to analyse their disease pattern and prioritise the major illnesses which cause high mortality and morbidity. This approach is essential due to scarce financial resources.

Successes and Failures

The successes achieved in the Sri Lanka health sector are well known. The vital health statistical parameters indicate the successes achieved by our country. The infant mortality rates, the maternal mortality rates and the crude death rates have been significantly lowered since the beginning of the last century. Sri Lanka has an excellent health infrastructure and has provided its people with medical institutions within a five mile radius.

Life expectancy for males and females is 71 and 75 years respectively. Sri Lanka although having a modest GDP has been held up as a country, which enjoys a good health status, which compares favourably with developed countries. Sri Lanka is a small island and enjoys a high literacy rate (3). Since the early 50s there was a population explosion in Sri Lanka. However, with an effective family health programme, Sri Lanka has been able to reduce its annual population growth rate to a minimum. Sri Lanka has eradicated smallpox and has now achieved Universal Child Immunisation. The country is also well on its way to eradicate polio.

However, there have been certain failures. Initially, after World War II with the introduction of DDT as an indoor residual insecticide, spectacular successes were achieved in malaria control. Sri Lanka launched its malaria eradication programme in 1958. By 1963 only 17 cases were reported out of which 11 were imported from abroad. However, due to logistical and administrative constraints, these successes could not be maintained and there was a resurgence of malaria since 1967 (4). Malaria still remains a major public health problem. The more realistic approach to control malaria has now been taken by Sri Lanka together with the rest of the malarious countries.

Another failure has been the lack of attention to hygiene, clean water and sanitation. Collections of water, lack of monitoring by local government authorities and community apathy have created localised epidemics of dengue haemorrhagic fever. Health information gathering has also been minimal both in the government and private sector. The need of the hour is to develop a good management information system. This should help in developing an early warning system in preventing or controlling localised epidemic outbreaks.

2) Impact of globalisation on health

Globalisation, Health and Development

i) Health : an investment for development

As Governments start to liberalise internal and external markets, the focus of policy dialogues at macro-level is to target increasingly on public expenditure management generally and most specifically, the role of Government in relation to the provision of core public services such as health. Within the health sector, there is increasing emphasis on health sector reform. In developing countries, there is a need for a sustained process of policy, institutional and systems development. Reform in the health sector should be linked with the reform of the public sector especially in regard to personnel and financial management. The decentralisation process of planning and management at provincial and district level should be strengthened and the correct allocation of funds made for the health sector. There is a need to promote a sectoral approach to health systems development (5).

ii) Globalisation and health care -access to drugs at affordable prices

Sri Lanka, through its public sector offers free health services. Due to the sharp increase of drugs in the open market, provision of drugs to patients at medical institutions has become a major problem. This has resulted in certain shortages. In the private health sector, prices of drugs which is passed on to the consumer is very high. Due to the open market economy and certain dictates by WTO and TRIPS, Sri Lanka like most developing countries is finding it difficult to provide drugs at affordable prices. At a workshop held in Indonesia in 2000 (6) it was indicated that in a number of developing countries, more than half the population lack regular access to essential drugs. This is due to the following factors.

- Public spending for health care in general and for drugs in particular is insufficient and decreasing.
- Health insurance is non-existent or has very limited coverage; most people, especially in developing countries, have to pay for drugs out-of-pocket
- New essential drugs are costly
- Supply systems are often unreliable and poorly managed, leading to wastage and shortages.

In most developing countries TRIPS standards have become enforceable only a short while ago.

- National Governments should adopt legislation specifying patentability criteria in order to ensure the protection of real inventions and to ensure the balance of rights and obligations of the patent holders and the end-users.
- National Governments including Sri Lanka should pass patent legislation providing compulsory licensing and parallel imports.
- Sri Lanka also joins in recommending an expert meeting on the impact of globalisation and trade liberalisation on the health sector. The Expert Committee should include WHO and relevant NGOs as partners.
- The TRIPS agreement does not include specific provisions related to the protection of traditional or indigenous knowledge (systems, practices, naturally occurring plants, products) and recommends that new methodologies and instruments be developed for this purpose. These should be based on the Convention on Biological Diversity (CBD) and other International Agreements currently available. In this context, trade marks, trade secrets, geographical indications and plant variety protection should also be taken into consideration.
- WTO should be prevailed on, to involve WHO in negotiations in relation to trade agreements having an impact on the health sector including the review of TRIPS agreements.

Impact of Market Forces on Health

The open market economy which Sri Lanka has adopted has certainly had an adverse effect on health care due to the high cost involved in procuring drugs, medical and laboratory equipment. For developing countries a cushioning effect should be developed, so that these countries have access to drugs and equipment at affordable prices.

Access to Research and Knowledge

Sri Lanka has inadequate resources to promote appropriate research. Access to research and knowledge is limited, especially in the government health sector due to financial constraints. Certainly, funds from donors should be made available for access to the internet to develop the research skills of our health personnel. The information and communication systems in Sri Lanka are inadequate. To develop a computerised MIS system

in Sri Lanka with the assistance of WHO, the overall health information system is being streamlined. A pilot project is being developed on MIS in Anuradhapura. Through the Roll Back Malaria Initiative with World Bank funding, a computerised MIS system and risk mapping is being developed for malaria control (7). This has already been completed in two of the five districts chosen for the Roll Back Malaria Initiative. It will be extended to all the malarious districts. As for tele-medicine, efforts are being made to promote this in the Government and Private health sectors.

Sri Lanka has an extremely good primary health care infrastructure. As indicated earlier however, a sectoral approach should be taken to improve the quality of primary health care.

iii) Inter-sectoral linkages and their impact on countries' capacity to deliver services; sector-wide approaches

Sri Lanka although it has been earlier remiss as regards inter-sectoral linkages and the sector-wide approaches has within the last few years intensified its efforts on these linkages. Good examples of these have been the development of the National Environmental Action Plan which was developed by coordination effected between a number of relevant ministries including the Ministry of Health with the focal ministry being the Ministry of Environment. In the Roll Back Malaria Initiative which commenced in Sri Lanka in August 1999, these inter-sectoral linkages have been established at National, Provincial and District levels.

With the revolution in communications and easy access to travel, certain priority areas should be addressed in regard to health.

HIV/AIDS Situation in Sri Lanka (8)

The National Task Force for Prevention and Control of AIDS (9) that was established in 1986, was chaired by the Director General of Health Services and comprised members from the Ministry of Health, the Ceylon Tourist Board, the Police and the Ministry of Education.

The subsequent formation of the first Medium Term Plan (MTP I) and the formation of the National AIDS Committee in 1988, the formulation of the Medium Term Plan II (MTP II) in 1994, the formation of the UNAIDS theme group in 1996 and the formulation of the National Integrated Work-plan in 1998 are some of the progressive

actions that have been taken. Currently Sri Lanka is developing its National Strategic Plan 2001-2005.

By the end of December 2000, a cumulative total of 358 HIV infections have been reported amongst Sri Lankans out of estimated 8500 persons. In addition a further 40 foreigners have also been reported as HIV positive. The number of new cases detected in 2000 was 54. Prevalence rate is not known. However, the positivity rate was 0.02/1000 for 1987-1999.

Of the Sri Lankans 216 were males and 132 females (male/female ratio 1.6:1). Since 1992, HIV infections amongst women have shown an upward trend.

Of the reported HIV patients 83% are in the age group 15 - 49 years with most cases (43%) in the 35-44 age group.

The predominant mode of transmission of AIDS cases has been sexual (82%). Transmission through the injecting rate has not been reported so far, while mother to child transmission (1 case) and transmission through blood (2 cases) have also been recorded. The mode of transmission was not known in about 15% of the cases. Almost all donated blood is tested for HIV. In 1999, no positives were detected amongst almost 135,000 units of blood issued by the National Blood Transfusion Services.

HIV sentinel surveillance according to WHO guidelines have been carried out since 1993 at six sites representing six of the provinces. Unlinked anonymous screening of sex workers, STD patients and TB patients are carried out at these sites annually.

Graph showing the upward trend of the HIV/AIDS situation in Sri Lanka

UNAIDS/ National Strategic framework and its objective

UNAIDS - the Joint United Nations programme on HIV / AIDS was formed in 1996. In Sri Lanka UNAIDS theme group consists of UNICEF, UNDP, UNFPA, the WHO, the World Bank and the FAO. The ILO has also expressed interest in actively participating in the UNAIDS theme group.

The objective of UNAIDS, Sri Lanka is to strengthen, direct and catalyse the unique expertise, resources and the networks of influence that each of these organisations offer. Working in unison with UNAIDS, the Cosponsors expand their outreach through strategic alliances with other United Nations agencies, national governments, corporations, the media, religious organisations, community-based groups, regional and country networks of people living with HIV/AIDS, and other non governmental organisations.

UNAIDS operates through its Theme Group (TG) and its Working Group (WG). The UN theme group on HIV/AIDS in Sri Lanka was first chaired by the UNDP, followed by the UNFPA and the WHO.

Funding for HIV/AIDS Programmes by UNAIDS Co-sponsoring agencies in Sri Lanka⁸ is substantial.

Mental Health

In Sri Lanka attention should be focussed on developing and modernising our approaches to reduce mental illness in Sri Lanka. The statistics in Sri Lanka reveal only the tip of the ice-berg as regards mental illness. There is a dearth of Psychiatrists in our country. Most developed countries have moved away from the institutionalising of mentally ill patients. Group and peer discussions amongst mentally ill patients is therapeutic. These should be guided by psychiatrists.

The primary health care workers should be trained to identify mental illness in the districts and help in referring them for treatment.

Tobacco Free Initiative

Sri Lanka has received the highest political commitment for this programme. In 1997, President Kumaratunga made a public declaration of her support to the issue of "Smoking". A special Presidential Unit on Tobacco and Alcohol was set up two years ago and this unit functions directly under the President. It is easier to solve issues which cuts through different ministries. The

programme in Sri Lanka is a joint effort. The government has two well established networks which reach every household in the country. These are the primary health care and poverty alleviation networks. They work closely with NGOs. The Sri Lankan society is a highly literate one and by using modern IEC and social marketing methods, the early propaganda carried out by the tobacco industry is being countered (10).

The national policy was accepted by the government in 1998. It aimed at banning all tobacco and alcohol advertisements and promotion. Smoking was banned in public places. A substantial increase in tobacco taxes, as well as enlarging the warning labels were also implemented.

Sri Lanka can show success in its programme at ground-level. In 2000 there was a 6% drop in the number of cigarettes sold in Sri Lanka. In the 1st quarter of 2001 there has been a drop of over 8%.

Care for the elderly

By 2001, more than 1000 million people aged over 60 years will be living in the world and 210 million of them will be from South and South-East Asia. By 2020, ageing related deaths would account for ¼ of all deaths. These will include cardio-vascular related deaths, cancer and diabetic complications, impairment of vision and hearing and mental illness will rise. Senile Dementia/Alzheimer's disease will exceed 55 million by 2020.

In Sri Lanka the National Committee on Ageing was formed in 1982. The Chairman is the Secretary of Ministry of Social Services. There is also representation from the Ministries of Health, Education, Cultural Affairs, Provincial Councils, Department of Pensions, NGOs and Pensioners' Association. Policy and decisions developed by the National Committee are implemented by the Dept. of Social Services. It prepares plans for the Provincial Councils, implements pilot projects, assist the provinces to improve the services for the aged, monitors activities of the provincial councils, conducts training programme and observes the 1st of October as the International Day for Old Programmes with awareness programmes and media publicity. The provincial councils provide residential facilities to the needy, assist NGOs who run homes for the elders, provide essential accessories such as spectacles, hearing-aid and wheel chairs and provide financial assistance to old persons suffering from TB, Leprosy, Cancer, etc.

For indigent elders, the provincial councils give assistance at the rate of Rs. 100.00 per person and Rs. 300.00 per family per month for maintaining indigent elders homes, the department allocates Rs. 1 – 5 million depending on the circumstances and need. These govt. funds are grossly inadequate. The assistance of the private sector and NGOs is essential.

Sri Lanka has at present only one geriatric specialist and no institution as such. A Director for the Care for The Elderly has recently been appointed by the Ministry of Health. Although the health service provides free medical care including drugs, very often the public are forced to purchase their drugs from the private sector due to shortages resulting from financial constraints.

Sri Lanka needs more geriatric specialists and institutions and it should gear itself with improved mobile and domiciliary services (meals on wheels) to look after the elderly in their domestic environment. Services must also be provided as regards psychiatric health, coverage of vision and hearing impairments and rehabilitation services for those physically disabled (11).

3) Resources for health

financial resources

i) Investment in health: health expenditures as a proportion of GDP

The responsibility for the funding of health services is shared with all levels of the Government and the non-governmental sector. Public expenditures at current market prices grew from Rs. 5.6 billion to Rs. 14.3 billion during the same period. Government and private sources accounted for approximately 50% each of total financing throughout the decade, or about 1.7% of GDP each.

Total Expenditure on Health at Current Market Prices – 1999 (12)

Total Public Sources (Rs. Billion)	- 19.2
Total Private Sources (Rs. Billion)	- 20.0
Total National Expenditures (Rs. Billion)	- 39.2

Health Allocation and Expenditure in 1999

Rs. In Million

Item	Recurrent	Capital	Total
Department in Rs. Million	8551.2	2705.6	11256.7
Provincial Council	4752.6	43.3	4795.9
Total health expenditure			
In Rs.	13303.8	2748.9	16052.7
In US\$	166.3	34.4	200.7

Item	Recurrent	Capital	Total
Ministry of Health and Indigenous Medicine	42.2	2253.4	2295.8
Department of Ayurvedic	98.6	34.4	133
Total Government Allocation in Rs.	200,842.7	138,391.3	339,234.0
Total Government Allocation in US\$	2,510.53	1,729.89	4,240.43
Total health allocation as % of total Government expenditure	6.6	2.0	4.7

Source: Management Development and Planning Unit

The percentage spent on community health services was only 16.1% of the total health budget.

Sri Lanka has also realised that the health budget has a disproportionately larger allocation for the curative health services, whereas the emphasis should be on preventative and public health. The Government of Sri Lanka has begun to address this disproportion in the allocations.

The ever burgeoning costs are being met inadequately by the Government. Although it is a sensitive political issue, governments in future have to address this problem. The private health sector has to be strengthened and monitored. Those who can afford to pay should be made to do so. Health insurance schemes which are in an embryonic form have to be strengthened in the country. The employer, be it government or the private sector and the employee should contribute to a comprehensive health insurance scheme. Free health services should be maintained for those poor, vulnerable and at risk groups. This would also help the public health sector to get a greater proportion of the government health budget and strengthen its delivery.

ii) Maximising resources through partnerships

A number of problems in the health sector have been created unwittingly by other elite disciplines and development schemes. The health sector has been fighting a lone war to control diseases like malaria and environmental health problems. It has now been recognised that the health sector cannot be given the sole responsibility in control of such problems. Both in the national environmental action plan and the 5 Year Strategic Plan for Roll Back Malaria the need for partnerships has been identified.

Partnerships should be established at all levels (13). These should be;

- within the health sector including within government sector and between government and private sector
- between the health sector and other sectors
- between government sector and other voluntary and international/bilateral agencies
- between the centre and the provinces

For effective Roll Back Malaria activities, partnerships must be built at District, Provincial and National levels.

To instil a sense of ownership, the partners must be actively involved in the Roll Back Malaria Initiative. The activities which each partner should perform, must be clearly defined. Sectors like Irrigation and Mahaweli and the Department of Education have key roles to play.

Roll Back Malaria is also a community based action. Community interventions at domestic level, to control mosquito breeding are important. Community co-operation is also necessary for residual spraying and for patients within the community, to take the correct treatment.

Media involvement and health education is necessary for community awareness and action. Media Involvement must be at District, Provincial and National levels.

NGOs and volunteers are needed to make the programme more effective. NGOs, Volunteers and International Agencies, like the Red Cross, MSF, Oxfam, Care and UNHCR will help to augment and supplement the programmes in the conflict areas, where Government human resources and activities are limited.

Private medical practitioners and Ayurveda also treat malaria cases. Their inclusion in the Core groups at district and provincial level is essential, both as regards correct treatment and in obtaining more information on the true malaria situation.

Service clubs, like Rotary, Lions and Jaycees can plan an important role at the district and provincial level in assisting the core groups in their activities, or by raising funds for the Roll Back Malaria Initiative. There is also a place for Sarvodaya and Women's Organisations in RBMI activities and also in training programmes at these levels.

This initiative should be used as a stepping stone to establishing partnerships as regards other coordinated health activities.

iii) How could donor resources be used more effectively to meet national health needs

Sri Lanka like most other developing countries has not been systematic in using its donor resources more effectively. This has now been recognised by the Ministry of Health. With the assistance of the World Health Organization the skills of Programme Directors at national level and mid level Managers (Provincial and District) are being strengthened to identify the gaps in financial resources. Training is being given to these categories of health personnel to identify priority health problems, additional finances required and more importantly the need to develop a good project proposal. The first such workshop was held in September 2001 and this will be followed by further training workshops and also meetings with donors.

Human resources

Some of the problems faced by Sri Lanka in the health sector is a lack of good managers. The health sector has not focussed attention on producing skilled managers. When senior managers retire, a second line of managers should be in place to take over. A good manager is one who shares his authority and responsibility with his subordinates. One encounters several types of managers:

- The manager who is over-bearing and abrasive. He is always correct. No one but he can contribute.
- The manager who is insecure, so he clings on to all the authority and responsibility. He is suspicious of everyone and sees an adversary at every corner.
- The manager who is proactive when he needs to be; interactive when necessary and believes in developing a team with shared responsibility and authority.

Management is an important component which should be incorporated in to the undergraduate and postgraduate medical education.

Although there has been an increase in the cadre of doctors there are still shortages of nurses, para-medical and public health personnel such as pharmacists, radiographers, public health inspectors, public health nurses and family health workers. The

brain-drain of medical officers which occurred over a decade ago has been reduced to a large extent. However, as regards distribution of medical officers there still exists a mal-distribution with a predominance of the skilled specialists in urban areas especially Colombo and Kandy. There is still a problem of staffing the rural areas in remote and inaccessible areas. This disparity should be addressed. Incentives such as housing and schooling for the doctors and their families should be provided. Some of the major shortages of human resources is in the North-East province due to the conflict. The government is addressing this through volunteers, NGOs and intensified training programmes for all categories of staff. The Planning Unit of the Ministry and Department of Health Services is developing a computerised Human Resource Management Information System for all categories of staff.

4) Improving efficiency and effectiveness of health systems

i) Regional co-operation on health priorities including shared services and Technical Assistance

The South-East Asia Region of the WHO has played a leading role in promoting cooperation in the neighbouring countries such as; India, Sri Lanka, Bangladesh, Bhutan, Nepal, Maldives, Thailand, Myanmar, Indonesia and DPR Korea. Technology is shared through periodic meetings at regional levels e.g. Health Ministers Conferences, Regional Committee Meetings, Programme Development Meetings and Advisory Committee on Health Research. Information on vector borne diseases and the Roll Back Malaria Initiative have further strengthened regional cooperation. The South Asian Association for Regional Corporation (SAARC) which comprises of Sri Lanka, India, Bangladesh, Pakistan, Bhutan, Nepal & Maldives have special programmes for the health sector and share their knowledge on health promotion, disease patterns and research.

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Abbreviations

GDP : Gross Domestic Product
 WTO : World Trade Organisation
 TRIPS : Agreement on Trade Related Aspects of Intellectual Property Rights
 WHO : World Health Organization
 NGO : Non Governmental Organisation
 CBD : Convention on Biological Diversity
 MIS : Management Information System
 UNICEF: United Nations Children's Fund
 UNDP : United Nations Development Programme
 UNFPA : United Nations Family Planning Association
 FAO : Food & Agriculture Organization
 IEC : Information, Education and Communications
 TB : Tuberculosis
 RBMI : Roll Back Malaria Initiative

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