

Sustaining Sri Lanka's Preventive Health Achievements: Emerging System Challenges and Policy Directions - A Narrative Review

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Abstract:

Sri Lanka has achieved health outcomes that have historically compared favourably with countries at similar or higher levels of economic development, supported by a tax-funded health system, geographically defined preventive health services, strong maternal and child health programmes, and established communicable disease control mechanisms. However, sustaining these gains requires adaptation to a changing health-system environment. This narrative review examines evidence relevant to five interrelated challenges: the growing role of the private sector, health misinformation and socially networked beliefs, population mobility, decentralised governance, and fragmentation between services and information systems. A targeted literature search prioritised peer-reviewed publications indexed in major biomedical databases, with additional use of authoritative national and international health-system reports where needed for current indicators and institutional context. The reviewed evidence suggests that Sri Lanka's historical strengths remain important, but emerging pressures related to mixed public-private care, economic shocks, health-worker migration, information disorder, and coordination gaps can weaken continuity, equity, surveillance, and accountability. Policy priorities include stronger public-health functions within curative institutions, interoperable person-level health information systems, workforce-retention measures, clearer governance arrangements across central, provincial and local authorities, and stronger national stewardship to reduce duplication and fragmentation. Sustaining Sri Lanka's preventive-health achievements will depend less on preserving existing structures unchanged than on modernising their coordination, information architecture and accountability while retaining universal and community-oriented principles.

Keywords: Health systems, Narrative review, Preventive health services, Primary health care, Sri Lanka, Universal health coverage

1. Introduction

Sri Lanka has long been cited as an important example of achieving comparatively strong population-health outcomes with a resource-constrained, publicly financed health system. Its health-service architecture combines hospital-based curative care with geographically defined preventive services delivered through Medical Officer of Health (MOH) areas. The preventive network, together with long-standing maternal and child health programmes, communicable-disease control activities, and community-based public-health staff, has contributed to broad service reach and favourable health indicators [1]-[4].

The country's historical performance should nevertheless not be interpreted as evidence that the system can remain static. Sri Lanka has undergone epidemiological, demographic, social, technological and economic transitions, while

public and private health-care use has become increasingly interdependent. The severe economic crisis that began in 2022 also exposed vulnerabilities related to access, medicines, workforce stability and service continuity [5], [6]. In July 2026, Sri Lanka was reclassified by the World Bank as an upper-middle-income economy, but this change in income category does not in itself resolve health-system constraints or guarantee the sustainability of preventive-health gains [7].

Current national maternal and child health statistics continue to demonstrate important achievements. The Family Health Bureau reports a maternal mortality ratio of 25.0 per 100,000 live births, neonatal mortality of 7.2 per 1,000 live births, infant mortality of 10.2 per 1,000 live births, and teenage pregnancy of 3.7% in its latest published statistics [8]. These outcomes coexist with emerging pressures that require new forms of governance, information management, workforce policy and public communication.

This narrative review therefore examines the principal system-level challenges that may affect the sustainability of Sri Lanka's preventive-health achievements and proposes policy directions that build on the strengths of the existing system without assuming that existing institutional arrangements are sufficient for future needs.

2. Method

A targeted narrative literature review was undertaken to strengthen and contextualise the issues identified in the original policy-focused manuscript. Searches were conducted in September 2026 using PubMed and publisher-indexed web databases, supplemented by authoritative publications from the World Health Organization, the Ministry of Health of Sri Lanka and the World Bank. Search concepts included combinations of "Sri Lanka", "primary health care", "preventive health", "universal health coverage", "private sector", "health information systems", "decentralization", "health workforce migration", "social media", "misinformation", "vaccine hesitancy", and "communicable disease surveillance".

Priority was given to peer-reviewed literature from internationally indexed journals and to publications directly addressing Sri Lanka or providing highly relevant health-systems evidence. Institutional reports were used selectively for current national indicators, health-system structure and surveillance context. Because the purpose was interpretive and policy-oriented rather than to estimate pooled effects, no formal meta-analysis or risk-of-bias synthesis was undertaken. Evidence was organised around the manuscript's pre-specified themes: established strengths, emerging challenges, and potential system responses.

3. Results and Discussion

3.1 Foundations of Sri Lanka's preventive-health achievements

Sri Lanka's preventive-health system has deep institutional roots. Organized health units were introduced in 1926 and progressively expanded, linking community-based preventive work with institutional health services. Historical analyses of maternal-health progress highlight the importance of political commitment, free public provision, field-based services, public health midwives, referral pathways, and routine review of maternal deaths [4]. Contemporary

descriptions of South Asian primary health care likewise identify Sri Lanka's geographically defined preventive network as a notable structural strength [1].

The MOH-area model provides a defined population base for maternal and child health, communicable-disease prevention, environmental health and other public-health functions. The Sri Lanka Health System Review describes preventive services as geographically organised and supported by supervisory structures, while the public sector remains central to service delivery [2]. These arrangements create an important platform for population-based accountability because households and communities can be linked to defined service areas rather than relying solely on episodic facility attendance.

Sri Lanka has also demonstrated the ability to sustain high-priority programmes after reductions in external assistance. Experience from immunisation and malaria programmes suggests that domestic financing, integration into the wider health system, central stewardship, and established delivery structures can support continuity when donor funding declines [9]. These features are important assets for future reform.

3.2 Increasing involvement of the private sector

The growing role of private health care creates both opportunities and governance challenges. Sri Lanka retains a dominant public system, but private outpatient care and mixed public-private pathways are increasingly important. Research on Sri Lanka's mixed health system shows that patients may move between public and private providers according to affordability, waiting time, access and perceived convenience, and that these hybrid pathways can generate inequities [10], [11].

For preventive-health programmes, the central concern is not simply whether private-sector use increases, but whether essential public-health information and responsibilities follow the patient across sectors. Maternal and child health events, notifiable diseases, immunisation, screening outcomes and other public-health information can become incomplete if reporting from private providers is inconsistent or poorly integrated. Therefore, engagement with the private sector should include standardised reporting obligations, interoperable data exchange, referral mechanisms and clear accountability for public-health functions, rather than relying only on voluntary cooperation.

3.3 Social media, misinformation and socially networked beliefs

Digital communication has transformed how communities obtain and interpret health information. Social media can support rapid communication and public engagement, but it can also amplify inaccurate or misleading health claims. A Lancet Digital Health scoping review identified misinformation and infodemics as major public-health themes associated with social-media use, while a Lancet Public Health framework argues that information ecosystems should be managed proactively rather than only reacting to individual false claims [12], [13].

Sri Lankan evidence demonstrates the local relevance of this problem. Analysis of comments on COVID-19 booster-related Facebook posts found substantial anti-vaccination content and highlighted the value of timely social listening

to identify emerging narratives [14]. This is particularly relevant to preventive services because confidence and participation are central to vaccination, screening, maternal-child services and outbreak control.

A sustainable response requires an institutional capability for social listening, rapid risk communication, trusted spokespersons, community engagement and digital-health literacy. Public-health agencies should monitor emerging concerns without treating all disagreement as misinformation. Communication should instead distinguish legitimate uncertainty, value-based concerns, misinformation and deliberate disinformation, and respond proportionately.

3.4 Population mobility and continuity of preventive care

Internal and international mobility can weaken a health system that depends on geographically defined responsibility if information does not move with the person. Temporary workers, students, displaced families and people who frequently change residence may not remain continuously connected to one MOH-area team. This can affect follow-up for maternal care, childhood services, chronic disease prevention, communicable-disease contact management and other longitudinal activities.

The response should not be to abandon geographic accountability, which remains one of Sri Lanka's strengths, but to complement it with person-level information systems that allow authorised health workers to identify prior care, update current location and transfer responsibility when needed. Such systems are especially important as urbanisation and labour mobility increase.

3.5 Decentralisation, governance and accountability

Sri Lanka's health governance is distributed across central and provincial structures, while some public-health responsibilities also involve local-government and non-health authorities. This distribution can support responsiveness to local needs, but it can also produce ambiguity when responsibilities, financing authority, regulatory powers and reporting lines do not align.

Experience from donor-transition programmes shows that preventive service delivery may be decentralised while policy development, monitoring, procurement and stewardship remain centralised [9]. Such arrangements can function well when roles are explicit and coordination mechanisms are strong. Problems arise when legislation, administrative practice and programme expectations are inconsistent, creating uncertainty over who is responsible for enforcement or follow-up.

Periodic review of public-health legislation and administrative instruments is therefore necessary. Reform should focus on clarifying operational authority, escalation pathways, data-sharing duties and accountability across central, provincial and local levels, while preserving the capacity for national standards and coordinated responses to risks that cross administrative boundaries.

3.6 Fragmentation of service delivery and information systems

Fragmentation can occur both between preventive and curative services and among vertical programmes. When multiple programmes collect similar but differently defined data, frontline staff may face duplicate reporting,

inconsistent denominators and limited ability to triangulate information. Fragmentation also creates clinical and public-health risks when a hospital-based diagnosis does not trigger timely community follow-up or when preventive-service information is not available to curative providers.

The broader primary-health-care literature increasingly emphasises integrated delivery, accountable governance and strong links between patients and primary-care systems [1], [15]. Sri Lanka's recent communicable-disease surveillance assessment similarly focuses on the need for more harmonised, resilient and responsive surveillance and strategic information systems [16]. The implication is that digitalisation alone is insufficient: information architecture, definitions, interoperability, governance and use of data for action must be addressed together.

4. Potential Way Forward

4.1 Strengthen public-health functions within curative institutions

Hospitals and other curative institutions contribute to many activities with direct public-health implications, including disease notification, screening, health promotion, infection prevention, referral and continuity of care. These functions should be mapped systematically and coordinated through clearly designated public-health mechanisms within curative institutions. Where feasible, leadership by appropriately trained public-health physicians can strengthen links with MOH-area teams, programme directorates and district or provincial health authorities.

The objective should not be to create another parallel bureaucracy. Rather, the purpose is to make existing public-health responsibilities visible, accountable and connected to field services. Standard operating procedures should define which events require notification or referral, expected timelines, responsible officers and feedback mechanisms.

4.2 Develop interoperable person-level health information systems

Sri Lanka's preventive system has traditionally relied heavily on registers and aggregate reporting. Aggregate indicators remain valuable for programme management, but they are insufficient for ensuring continuity when people move between areas or sectors. A phased move toward interoperable person-level records would allow authorised providers to connect preventive, primary and relevant curative information while preserving confidentiality and data-protection safeguards.

Priority should be given to a shared national data architecture rather than creating new stand-alone databases for each programme. Common identifiers, agreed data definitions, interoperability standards, role-based access, audit trails and data-quality governance are necessary. Implementation should proceed incrementally, beginning with use cases where continuity and public-health action are most dependent on timely person-level information.

4.3 Retain and support the preventive-health workforce

Health-worker migration has become a major health-system concern following the economic crisis. Recent analysis documents substantial migration of Sri Lankan doctors and describes consequences for service capacity, training and equity [6]. Although this evidence is not limited to preventive-health staff, the same system-level pressures, income differentials, workload, professional opportunities and working conditions can affect the preventive sector.

Retention strategies should therefore extend beyond financial incentives. They should include appropriate staffing norms, manageable administrative workload, career development, postgraduate and continuing professional development opportunities, supportive supervision, recognition of field responsibilities, occupational support, and fair access to advancement. Digital reforms should reduce repetitive reporting rather than add another layer of work.

4.4 Align legislation and governance with contemporary public-health practice

Public-health laws and administrative arrangements should be reviewed against current patterns of urbanisation, private-sector growth, digital information exchange, decentralised administration and modern public-health threats. Reform should define responsibilities clearly across sectors and levels of government and provide realistic enforcement and escalation mechanisms. Legal modernization should be accompanied by operational guidance so that frontline staff understand what action is authorised when recommendations are not followed.

4.5 Strengthen national stewardship and reduce fragmentation

The original manuscript proposed a national public-health agency as a mechanism to reduce fragmentation. The reviewed evidence supports the underlying need for stronger stewardship, integration and accountability, but it does not establish that one specific institutional model is necessarily optimal for Sri Lanka. The policy objective should therefore be framed functionally: create or designate a national stewardship mechanism with authority to coordinate major public-health programmes, harmonise data standards, reduce duplicate reporting, oversee cross-sector preparedness, and ensure accountability across preventive and curative interfaces.

Whether this is achieved through a new agency, a strengthened existing structure, or another governance model should follow a formal options appraisal that considers legal feasibility, cost, provincial responsibilities, institutional overlap and transition risks. Structural reform should only be pursued if it demonstrably improves coordination and service delivery rather than simply adding another organisational layer.

5. Limitations

The literature search was targeted to the themes identified in the policy manuscript and was not designed to retrieve every publication on Sri Lanka's health system. The evidence base is also uneven across themes: maternal and child health, universal health coverage and health-system organisation are comparatively well documented, while some operational issues, particularly cross-sector information exchange, local governance ambiguities and the proposed institutional solutions have less direct empirical evaluation. Accordingly, the proposed policy directions should be interpreted as evidence-informed options requiring further stakeholder consultation, feasibility assessment and implementation research.

6. Conclusion

Sri Lanka's preventive-health achievements were built on geographically accountable public-health services, strong maternal and child health programmes, communicable-disease control, community-based staff and sustained public provision. These foundations remain valuable, but they now operate within a more complex environment shaped by

mixed public–private care, social-media information ecosystems, population mobility, decentralised governance, economic pressure, workforce migration and increasingly fragmented information flows.

The central policy challenge is therefore not to replace the preventive-health system, but to modernise the mechanisms that connect its parts. Stronger public-health functions in curative institutions, interoperable person-level information systems, workforce retention, clearer governance, and stronger national stewardship can help preserve the principles that produced Sri Lanka’s earlier achievements while making the system more resilient to contemporary risks.

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Author Contributions

Udayi Gunawardana conceived the article, identified the policy issues, conducted the narrative synthesis, drafted the manuscript, critically revised it, and approved the final version.

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Conflicts of Interest

The author declares no conflict of interest.

Ethics Statement

This article is a narrative review and policy analysis based exclusively on published literature and publicly available institutional information. It did not involve recruitment of human participants, collection of identifiable personal data, or animal research; therefore, ethics committee approval was not required.

Data Availability

No primary dataset was generated or analysed for this article.

References

- [1] S. Prinja, N. Purohit, N. Kaur, L. Rajapaksa, M. Sarker, R. Zaidi, S. Bennett, and K. D. Rao, “The state of primary health care in south Asia,” *The Lancet Global Health*, vol. 12, no. 10, pp. e1693–e1705, 2024, doi: 10.1016/S2214-109X(24)00119-0.
- [2] L. Rajapaksa, P. De Silva, A. Abeykoon, L. Somatunga, S. Sathasivam, S. Perera, et al., *Sri Lanka Health System Review*. New Delhi, India: World Health Organization Regional Office for South-East Asia, 2021.
- [3] A. R. Chapman and S. D. Dharmaratne, “Sri Lanka and the possibilities of achieving universal health coverage in a poor country,” *Global Public Health*, vol. 14, no. 2, pp. 271–283, 2019, doi: 10.1080/17441692.2018.1501080.

- [4] R. Haththotuwa, L. Senanayake, U. Senarath, and D. Attygalle, “Models of care that have reduced maternal mortality and morbidity in Sri Lanka,” *International Journal of Gynecology & Obstetrics*, vol. 119, suppl. 1, pp. S45–S49, 2012, doi: 10.1016/j.ijgo.2012.03.016.
- [5] A. I. Nilaweera, D. R. Fernando, P. R. Adikaranayake, et al., “Impact of the economic crisis on general health-seeking behavior and chronic disease management: a comparative study of public perceptions in the Western and Uva Provinces of Sri Lanka,” *BMC Health Services Research*, vol. 26, art. 830, 2026, doi: 10.1186/s12913-026-14599-8.
- [6] M. Niriella, K. Prabagar, P. Premaratna, R. Premaratna, S. Jayasinghe, T. de Silva, N. de Silva, and J. de Silva, “The Exodus and Its Toll: Sri Lanka’s Economic Crisis and the Migration of Doctors,” *The International Journal of Health Planning and Management*, vol. 40, no. 6, pp. 1317–1325, 2025, doi: 10.1002/hpm.70011.
- [7] World Bank Group, “Who moves up and why? A closer look at the 2026–2027 World Bank Group Country Income Classifications,” Jul. 1, 2026.
- [8] Family Health Bureau, Ministry of Health, Sri Lanka, “Maternal & Child Health Statistics: 2024 Annual Data,” 2026.
- [9] P. N. Perera, S. N. Amarasinghe, S. H. Fonseka, N. Abeysinghe, and R. P. Rannan-Eliya, “Factors impacting sustained coverage in the context of donor transitions: experience from Sri Lanka,” *Health Policy and Planning*, vol. 39, suppl. 1, pp. i33–i49, 2024, doi: 10.1093/heapol/czad099.
- [10] R. Kumar, “Public–private partnerships for universal health coverage? The future of ‘free health’ in Sri Lanka,” *Globalization and Health*, vol. 15, suppl. 1, art. 75, 2019, doi: 10.1186/s12992-019-0522-6.
- [11] R. Kumar, A.-E. Birn, R. Bhuyan, and J. P.-H. Wong, “Universal health coverage and public-private arrangements within Sri Lanka’s mixed health system: Perspectives from women seeking healthcare,” *Social Science & Medicine*, vol. 296, art. 114777, 2022, doi: 10.1016/j.socscimed.2022.114777.
- [12] S.-F. Tsao, H. Chen, T. Tisseverasinghe, Y. Yang, L. Li, and Z. A. Butt, “What social media told us in the time of COVID-19: a scoping review,” *The Lancet Digital Health*, vol. 3, no. 3, pp. e175–e194, 2021, doi: 10.1016/S2589-7500(20)30315-0.
- [13] A. Ishizumi, J. Kolis, N. Abad, D. Prybylski, K. A. Brookmeyer, C. Voegeli, C. Wardle, and H. Chiou, “Beyond misinformation: developing a public health prevention framework for managing information ecosystems,” *The Lancet Public Health*, vol. 9, no. 6, pp. e397–e406, 2024, doi: 10.1016/S2468-2667(24)00031-8.
- [14] P. Fernando, R. A. D. L. M. K. Ranwala, M. de Silva, and I. K. R. Ashoranga, “Exploring the Importance of Social Listening to Mitigate Anti-Vax Propaganda: A Retrospective Analysis,” *Studies in Health Technology and Informatics*, vol. 323, pp. 439–443, 2025, doi: 10.3233/SHTI250128.

- [15] H. Thomas-McLean, R. Mak, C. M. Noonan, and W. Yip, “Global Progress Toward Universal Health Coverage: Learning from Successes and Failures,” *Annual Review of Public Health*, vol. 47, pp. 459–477, 2026, doi: 10.1146/annurev-publhealth-100824-103712.
- [16] World Health Organization Regional Office for South-East Asia, *Overview and Assessment of Communicable Disease Surveillance Systems and Strategic Information Sources in the South-East Asia Region: Sri Lanka Country Report*, 2023. New Delhi, India: WHO SEARO, 2026.