

Consideration to health care and gender in Sri Lanka — mainly examined themes related to women's health —

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Abstract The authors report about health care and consideration of gender in Sri Lanka. The health system has positively provided regional medicine service with a central focus on prevention. As for Primary Health Care service for women, Public Health Midwives have offered care for pregnant women and children and Reproductive Health service to young people across the country under the supervision of Public Health Nursing Sister, assuming a central role of Community health care team. Therefore, the infant mortality has been maintained at a good level that is lower than the world average. Moreover, Well Women Clinics are introduced into family health service, providing women who are 35 years or older with quick inspection for non-infectious diseases. The result of investigation on the use of Well Women Clinics by female employees at the University of Peradeniya has revealed that 13.3% of them used it only once, suggesting the actual situation that the female employees are less aware of Well Women Clinics. Considering the situation that the health system for males have not established compared with women, it is necessary to take measures for it immediately. In order to enable both men and women to spend healthy life, it is necessary to build up a health care service system for which not only the influence by biologic diversity but also the socially formed gender is considered.

Introduction

Niigata University concluded the exchange agreement with University of Peradeniya in Sri Lanka in 2010. We are promoting academic exchange mainly for the field of health sciences and making an effort for understanding and development of the health situation of the two countries. The purpose of this study is to survey health situation of Sri Lanka based on existing statistical data, and to know the current health care service system and future health policy. In particular, clear progress is recognize in administrative measure for the recent maternal and child health. Therefore, the authors mainly examined themes related to women's health.

1. Health-related index and national health policy of Sri Lanka

The population of Sri Lanka is approximately 21,030,000 (2016)¹⁾, and the age hierarchy of 2013 is 25.0% for ages below 14, 62.0% for 15-59 and 13.0% for ages over 60. Total fertility rate is 2.3 (2013), average length of life is 75 years (2015), adults' literacy rate is 97% (2009-2014), and elementary education net enrollment ratio is that is 97% (2010-2014)²⁾. The rate of the poor is considered to be 10 percent-plus. Most of the rich people live in the suburbs of the capital, and the regional disparity is great³⁾. The health-related index is as shown below. The infant mortality is considerably lower than the world average, being a good value for a least among less-developed country⁴⁾ (Table 1).

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Table 1. Basic indicators by comparison with Sri-Lanka, South Asia, Japan and the world (expressed per 1,000 live births)

Countries and areas	Sri Lanka	South Asia	Japan	World
Under-5 mortality rate	10	53	3	43
Infant mortality rate (under1)	8	42	2	32
Neonatal mortality rate	5	30	1	19

Source: The State of The World's Children 2016, UNICEF ⁴⁾

Table 2. Nutrition indicators by comparison with Sri-Lanka, South Asia, Japan and the world (%)

Countries and areas	Sri Lanka	South Asia	Japan	World
Low Birthweight (2009-2013)	17	28	10	16
Early initiation of breast-feeding (2010-2015)	80	39	-	44
Exclusive breast-feeding(<6 months) (2010-2015)	76	46	-	39
Breast-feeding at age 2 (2010-2015)	84	75	-	49
Vitamin A supplementation, full coverage (twice a year) (2014)	72	62	-	67
Adequately iodized salt consumption (2009-2013)	92	69	-	75

Source: The State of The World's Children 2016, UNICEF ⁵⁾

The birth rate of premature babies is at a world average level and breast-feeding and nutritional management have also widely spread ⁵⁾ (Table 2). The average length of life of women is longer than that of males and the gender gap in education is also not great. Moreover, care at the time of birth is widely enforced and therefore the maternal mortality rate is also maintained at a fairly good level ⁶⁾ (Table 3). According to WHO, noninfectious disease are considered to be 75% of the cause of death in Sri Lanka, 40% for cardiac / circulatory diseases, 10% for cancer, 8% for chronic respiratory diseases, 7% for diabetes and 10% infection / malnutrition was 11%, trauma was 14% ⁷⁾. And, the cause of death in hospitals (2012) is high in order of ischemic heart disease, neoplasm malignant, pulmonary heart disease, cerebrovascular disease, respiratory disease except upper respiratory tract, and all are caused by noninfectious diseases ³⁾.

Since the death rate of young male is high in particular, from the viewpoint of economic development, measures against noninfectious disease are considered important ³⁾. Further, indices for risk factors of noninfectious diseases are hyperglycemia (9.3% for males, 8.6% for female), hypertension (31% for males, 26.2% for female), obesity (2.6% of males, woman 7.3%) and drinking (3.7%), and smoking rate (31% for males, below 1% for woman ⁸⁾. The ex-government attempted to reinforce the health sector in "Mahinda Chintana", the national development planning (2010-2016). In "Health Master Plan" (2007-2016) conducted by the support from Japan, five strategies ((1) Provision of comprehensive health service, (2) Reinforcement of community for health maintenance, (3) Reinforcement of the health human resources management, (4) Improvement of health finance, resource allocation and their use situation

Table 3 . Women's health indicators by comparison with Sri-Lanka, South Asia, Japan and the world (%)

Countries and areas	Sri Lanka	South Asia	Japan	World
Life expectancy: Females as a % of males(2015)	109	104	108	106
Adult literacy rate: Females as a % of males(2009-2014)	97	75	-	91
Secondary General Enrolment ratios: Females as a % of males(2010-2014)	105	94	100	97
Contraceptive prevalence (2010-2015)	68	47	54	53
Antenatal care(At least one visit) (2010-2015)	99	69	-	85
Antenatal care(At least four visits)	93	42	-	58
Delivery care(Skilled attendant at birth)	99	49	-	75
Delivery Care(Institutional delivery)	98	69	100	73
Delivery care(Caesarean section)	24	15	-	20
Maternal mortality ratio(expressed per 100,000 live births)(2015)	30	182	5	216

Source: The State of The World's Children 2016, UNICEF ⁴⁾

and (5) Reinforcement of surveillance and management function of the health system) were advocated. A plan aiming at the comprehensive reinforcement of the health sector was devised, with a central focus on reinforcement of the support ability for noninfectious disease, trauma and emergent infectious disease by the change of disease structure ³⁾. It has been taken over by the new administration from January 2015.

2 . Health care service system of Sri Lanka

Ministry of Health divides the health care sector into the prevention field and treatment field. The prevention field has established preventive doctor (Medical Officers of Health: hereinafter referred to as "MOH") offices at 337 places all over the country, one per 100,000 citizens, under the control of the public health bureau, at which Medical Officers, Public Health Inspectors and Public Health Midwives are

cooperated to provide preventive medicine service. For the treatment, Ministry of Health has jurisdiction over tertiary medical care facilities and part of secondary medical care facilities, and those below secondary medical care facilities are controlled by each state governor. At the state level, it is divided into the traditional medical station and the Western medical station, and prefectural health departments and local health departments are established under states ³⁾ (Table 4). The number of hospitals is 613 (2014) in the country ³⁾, the entire hospital bed capacity is 76,087 (2012) and the hospital bed capacity per 1,000 citizens is 3.5 (2011), which is almost the same level as the OECD countries (4.7) and 22 Asian countries (3.3). As for the healthcare workforce (2011), the number of doctors is 0.9 per 1,000 citizens, which is lower than those of OECD (3.3) and 22 Asian countries (1.3). The number of nurses is 1.9 for 1,000 citizens, which is again lower than those of OECD (9.1) and 22 Asian countries (3.2) ⁹⁾. The average length of stay for acute stage care in the

Table 4 . Field of treatment [Number of facilities] (2014)

<p>Tertiary medical care: Almost all clinical departments</p> <ul style="list-style-type: none"> ▸ National Hospital: NH [1] ▸ Teaching Hospital: TH [20] ▸ Provincial General Hospital: PGH [3] ▸ District General Hospital: DGH [18] <p>Secondary medical care: Main clinical department</p> <ul style="list-style-type: none"> ▸ Base Hospital: BH <ul style="list-style-type: none"> • Type A [22]: 2 main clinical department units Special medical treatment (otolaryngology, dermatology, psychiatry, radiology etc.) • Type B [46]: 4 main clinical departments (one consultant and anesthesiologist for each) <p>Primary medical care</p> <ul style="list-style-type: none"> ▸ Divisional General Hospital: DH (general practice, simple hospitalization function, normal childbirth) <ul style="list-style-type: none"> • Type A [42] : More than 100 beds • Type B [129]: 50-100 beds • Type C [332]: 50 beds or less ▸ Primary Medical Care Unit: PMCU [474] (for only outpatient) <p>* For the facilities for those below secondary medical care, in the case that Healthy Life-Style Center: HLC has risk factors of non-infectious diseases, screening examinations are to be performed.</p>
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(Note; Processed the article of reference 3)

hospitals is 3 days, which is extremely shorter than those of Japan (17.5), OECD countries (7.7) and 18 Asian countries (6.2). On the other hand, the number of hospital discharges per 1,000 citizens is 274 (2011), which is extremely higher than those of Japan in 2014 (124), OECD countries (154) and 16 Asian countries (116)⁹⁾. According to the report from the Health Support Net in Colombo established by specialists of medical health welfare living in Sri Lanka^{10, 11)}, patients are charged at private hospitals.

They are to tell which clinical department they wish to consult at a reception desk, pay consulting fee of 10,000-80,000 rupees (1 rupee ≒ 0.72081 yen: as of November 27, 2017) in advance, and then see a doctor, undergo an examination and receive treatment. In the case that they are hospitalized, room rent, payment to doctors and treatment fee are added to the above. In the cases that the patient receives emergency consultation, designate specialists, or is a foreigner, the consultation system and expenses change.

Unlike private hospitals, public hospitals are basically free of charge. However, they treat more patients than private hospitals do and therefore their procedure is complicated and time consuming, and waiting time is long in addition. Moreover, doctors or nurses hold strike occasionally. Since the public hospitals are capable of taking quick actions in emergency cases such as traffic accidents, incidents, disasters, being bitten by a poisonous snake and so on, the public hospitals mainly accept unconscious or unidentified patients. As for childbirth, pregnant women consult a doctor after finishing pregnancy tests usually by the 3rd month, and they undergo an ultrasound examination, receive tetanic vaccination, and are prescribed for folic acid and the vitamin compound. At the 5 month check-up, they undergo check-up (weight measurement, abdominal circumference measurement and so on), ultrasound examination and blood examination (OGTT, oral glucose-tolerance test). Furthermore, they receive consultation (to determine if vaginal delivery or

cesarean section is to be performed) at the 6 month check-up, receive consultation and ultrasound examination at the 7 month check-up, and receive consultation and ultrasound examination and estimate the expected date at the 8 month check-up. They receive consultation every week from the 9th month till before the delivery. As for the expenses, they pay approximately 1,000 rupees to their doctors as consultation fee and approximately 400 rupees as hospital fee. Moreover, the examination fee for ultrasound examination is approximately 7,000 rupees. For blood examination and urinalysis, the patients are charged for each test item performed for them. The expenses for delivery are 250,000-300,000 rupees at private hospitals and the cesarean section is more expensive than vaginal delivery by 30,000-40,000 rupee. Not all services are free in national hospitals and therefore patients are to pay certain amount of fee for the medical service they receive. The medical insurance system covers only 5-10% of the entire population involved in the field of industrial economy. In addition, the covered amount is small and its maximum amount is only approximately 400,000 rupees. Although the covering rate is low, the medical care in Sri Lanka is standing supported by the health service that provides medical care for free ³⁾.

3. Study on gender specified health

Today, the world is increasingly becoming aware of differences in men and women's health. Although this difference is caused by the influence of various factors, physiological difference emerges as a decisive factor among them. Hence differences between male and female in reproductive systems have always been an important point to be considered for healthcare delivery. Despite of the male reproductive health and its consequences, availability of high quality family planning and obstetric services enables women to realize their potential for health. In spite of the recent progress, around half a million women die each year as a direct consequence of pregnancy and childbirth, and more than 10 times the above population is seriously disabled in the world ¹²⁾. It is the centrality of these issues in women's lives that has led many of them to adopt the concept of sexual and reproductive rights as a major campaigning issue. On the other hand, there has also been a growing recognition that the biological differences between the sexes extend beyond the reproductive purposes. A wide range of genetic,

hormonal, and metabolic influences play a part in shaping distinctive male and female patterns of morbidity and mortality. Sex specific diseases such as cancers of the cervix and prostate are the most obvious examples.

Furthermore, women and men share a number of health problems. However, following problems may affect women differently. For example, women are more likely to die following a heart attack than men are, women are more likely to show signs of depression and anxiety than men are, the effects of sexually transmitted diseases may be more serious in women, osteoarthritis affects more women than men and women are more likely to have urinary tract problems. However, there is also a growing evidence of sex differences in the incidence, symptoms, and prognosis of many other health problems including HIV/AIDS, tropical infectious diseases, tuberculosis, autoimmune problems, and coronary heart disease ^{13, 14)}. One of the most important of these sex differences is the greater biological propensity of men to develop heart disease early in their lives. Hence, gender difference needs to be taken into consideration when delivering care.

Although there exist distinct differences in gender related caring considerations between Sri Lanka and other developed countries, the caring nature is almost the same within the South Asia. However, the extent of achievement of health indices in Sri Lanka is demarcated compared to other South Asia. It would have been possible to maintain this status supported by the presence of well-organized preventive health care service along with primary health care services throughout the country.

3.1. Primary Health care service in Sri Lanka

The history of current preventive health care service goes back to 19th century when the first community health center was established in 1926 at Koholana in Kalutara district Sri Lanka. It was delighted as the pioneering step in preventive health services of the country ¹⁵⁾. Since then, the health system in Sri Lanka has evolved under various governments with a number of long-term health plans. However, expected outcome of those long term plans were to enhance community health services via promotive and preventive health needs of the population. Hence, it has been evidenced that the success of Sri Lankan health systems upgrade into present status following such programs. Health sector activities are planned

upward from the district level so as to achieve a health master plan at the national level. Health units of each district are headed by MOH and they have set demarcated geographical areas for them. An organization structure of a health unit is described in Figure 1. Public Health Midwife (hereinafter referred to as “PHM”) is actively involved as a frontline community health care provider to deliver gender specified caring services in their PHM area.

3.2. Gender specified caring consideration in Sri Lanka

Primary health care services in Sri Lanka greatly concern about women’s health rather than men’s health. In every MOH area, PHM is responsible for providing women’s health services at a community level under supervision of Public Health Nursing Sister (hereinafter referred to as “PHNS”). Midwives are the closest health care persons that people in the community encounter. Any woman who needs service from a midwife can approach her. The PHM consist of active members of the community health care team and their service is immensely valued particularly by people

living in rural setups. In Sri Lanka, PHM provide basic family planning services, pre-pregnancy care, domiciliary care and clinic care for pregnant women and children less than five years of age to a defined community of 3000-5000 population¹⁶⁾.

3.3. Family Health Services

Family Health services are delivered mainly to upgrade health status of women thereby to achieve their good status in the country. It covers wide spectrum of services comprised of the following tasks. The most important activity is maternal care: it comprises Antenatal care, Intranatal care and Postnatal care. These three types of maternal care are delivered through domiciliary and clinical cares at the women’s residential MOH area. Maternal care services are conducted under supervision of Medical Officer of Health and Public Health Nursing Sister (PHNS). Moreover, women’s reproductive health services are considered as another main service provided by the PHM for women. It includes Family planning counseling and adolescent

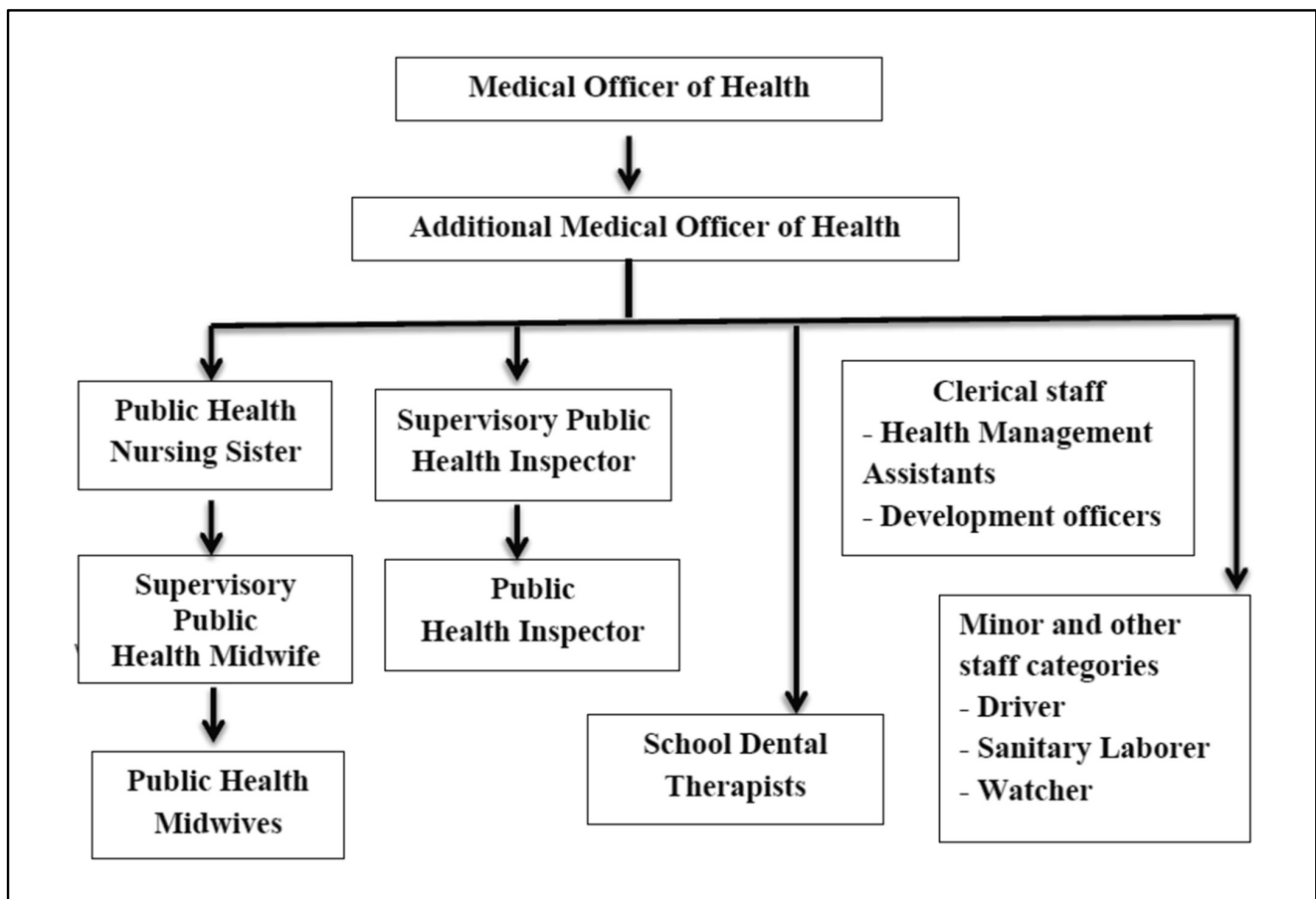


Figure 1 . Organizational structure of a Medical Officer of Health Office at Divisional level

Table 5 . Disease detection percentage through Well Women Clinics in Sri Lanka

Activity	2008	2009	2010	2011	2012	2013
Cervical smears reported as high and low grade lesions	0.2	0.3	0.5	0.3	0.2	0.3
Cervical smears reported as Human Papilloma Virus	0.3	0.2	0.5	0.2	0.1	0.1
Breast abnormalities detected	1.8	1.5	1.4	1.5	1.4	1.8
Diabetes Mellitus detected	2.2	2.1	2.0	1.8	2.0	2.0
Hypertension detected	4.4	3.9	4.0	4.0	3.7	4.1

(Note; The population parameters are all medical examines in all Well Woman Clinics)

Source: Family Health Bureau, Ministry of Health, Sri Lanka, Annual Report on Family Health 2013 ¹⁶⁾



Photo 1 . Visiting activities by Public Health Midwife

reproductive health as key tasks. These services are also mainly delivered during domiciliary visits. Aside from that, nutritional counseling for the pregnant mothers and children is one of the other services offered by the PHM. The Family Health Bureau (FHB) is the central organization responsible for the planning coordination, direction, monitoring and evaluation of maternal and child health and family planning (MCH/FP –Reproductive Health) programmes in the country (Photo 1).

3.4. Well Women Clinics

Well women clinics (hereinafter referred to as “WWCs”) were incorporated into the Family Health Services with the introduction of the concept of Reproductive Health in 1996. As of the end of 2013, 983 WWCs were functioning in the



Photo 2 . Well Women Clinics

country, mostly based at MOH offices. They offer screening services for women at ages of over 35 against common non-communicable diseases. The screened diseases are diabetes mellitus, hypertension, breast and cervical cancers. During the year 2013, 132,389 Pap smear samples were taken from WWCs throughout the country. Among them, 0.3% had a diagnosis of high and low grade lesions. Table 5 shows the other entire disease detection rates obtained from 2008 to 2013 in WWCs (Photo 2, Table 5).

3.5. Well Women Clinics utilization and knowledge on its services

In 2013, 51.7% of the participants among the total attendees were of the Age-35 Cohort. It has exceeded that of Over-35

Cohort (42.3%). This emphasizes that although the target population of this clinic is Age 35 Cohort, women in Over-35 Cohort were also receiving health services from the WWCs. Figure 2 presents the percentages of women participating WWCs by age groups from 2007 to 2013 ¹⁶⁾.

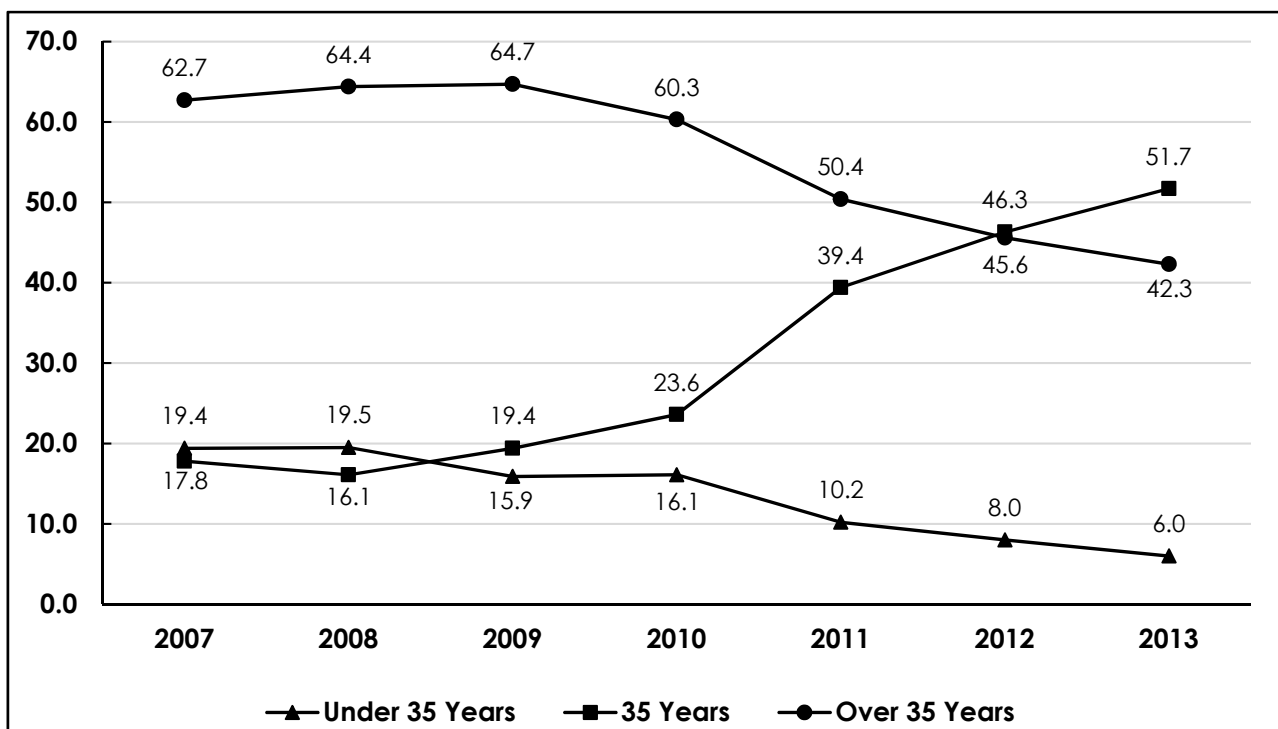
According to the health sector reports, women's participation in such WWCs has not reached to the expected level. Further, national and international research investigations showed that various factors such as knowledge on WWCs, socio-demographic factors, increased working mother's population have influenced immensely to WWCs attendance.

Various researchers are conducting surveys to evidence reasons for low participation in WWCs in different settings. As an example, one study has recruited 293 non-academic employees of University of Peradeniya and conducted self-administered questionnaire. Considering total participants, only 13.3% (n=39) women had attended to a WWCs at least once and only 10.9% (n=32) of women have undergone the pap smear test in the WWCs. The results emphasize underutilization of WWCs by female employees in the University of Peradeniya ¹⁷⁾.

3.6. Men's Health

The evidence from various sources clearly revealed that men tend to be in worse health than women in every country. The Global Burden of Disease study led by the Institute for Health Metrics and Evaluation in 2010 (GBD 2010 study) showed that throughout the period from 1970 to 2010, women had a longer life expectancy than men ¹⁸⁾. Over the above 40-year period, female life expectancy at birth rose from 61.2 to 73.3 years, whereas male life expectancy rose from 56.4 to 67.5 years. These figures indicate that the gap in life expectancy at birth has been widened between the sexes over the 40 years.

Similarly, the life expectancy of women from 1970 to present is higher than that of men in Sri Lanka. As an example, in 2015, the life expectancy of women was 78.3 while that of men was 71.7 ¹⁹⁾. Although such disparity exists in life indicators of male in Sri Lanka, there is no planned preventive or curative health services particularly arranged for men at present. However, available evidence suggested that urgency to commence directed care services for men to combat the disease burdens the country. Since it causes direct impacts on total productivity of the country, necessary actions need



Source: Family Health Bureau, Ministry of Health, Sri Lanka, Annual Report on Family Health 2013 ¹⁶⁾

Figure 2 . Percentages of women attending Well Women Clinics in different age groups from 2007 to 2013

to be taken in the near future to establish caring services for men.

If health services are to meet the needs of both women and men, all these sex differences need to be taken seriously in the planning and delivery of care. However, biological influences are only part of the complex of factors shaping the health of women and men. Socially constructed gender differences are also important in determining whether individuals can realize their potential for their long and healthy lives.

4. Future prospects in the health policy

The Sri Lankan government is showing wide strategic directionality as a health policy to be promoted in 10 years from 2016²⁰. It is promoting, as a health system led by the Sri Lankan citizens and patients, (1) Strengthening of service provision to achieve prophylactic health goals, (2) Provision of high quality treatment care that is appropriate and accessible to all Sri Lankan citizens, (3) Fair access to high quality rehabilitation care, (4) Establishment of strategic partnership by all health care workers and (5) Securement of comprehensive health system through better rebuilding, aiming at (1) Reinforcement of the service provision on the basis of scientific bases to provide support according to the continuity of the care and (2) Development of new strategy to reduce financial risks.

Conclusion

The citizen health statistics of Sri Lanka has revealed that Sri Lankan females have realized health conditions superior to those of the females in other Southern Asian countries. Its background is improvement of primary health care service that attaches great importance to women's health and spread of the non-communicable disease prevention service by enlargement of WWCs. It is considered a superior gender measure for which characteristics of females are considered well. On the other hand, bias has occurred between males and females in the health providing system and improvement in the health conditions of males has been delayed, indicating that there are health disparities between males and females. Improvement in the health level of males will be a task for the future health policy in Sri Lanka.

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