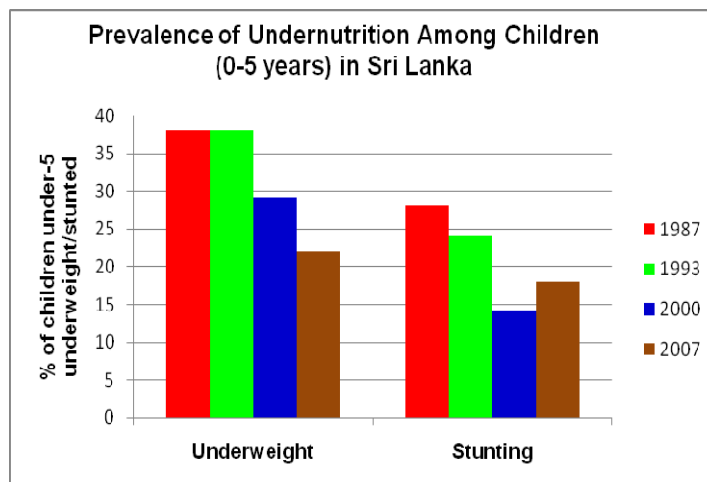


SRI-LANKA

Overview of Childhood Under-nutrition

Sri-Lanka has experienced marked improvements in the nutritional status of young children over the past 2 decades, with underweight and stunting rates declining significantly between 1987 and 2000 (**Figure 1**). Underweight rates declined by almost 25% in that time period from “very high” levels to “high” levels, according to WHO classification. Stunting rates, a measure of long term under-nutrition, declined even more, by about 75% to a “low” level classification from that of “high”. As a result, Sri Lanka has the lowest prevalence of underweight in South Asia. The aggregate trends (1993-2000) in underweight rates suggested that Sri Lanka was likely to achieve its Millennium Development Goal target of 19% prevalence of underweight in 2015.

However, there has been a slowdown in the rate of reduction of malnutrition in the past 7



years so that the country, which is still on track to achieving its millennium development goals for its health indicators, is now unlikely to achieve the nutrition target. However, despite the improvements in child nutrition, the underweight prevalence rates still remain high relative to global standards (as well as relative to many countries in Sub-Saharan Africa).

Considering Sri Lanka’s national income and her

remarkable achievements in the other indicators of health status, the nutrition indicators could be much better. Disaggregating the rates sub-nationally shows that under-nutrition rates are much higher among the rural population and especially the Estate Sector (where the prevalence of stunting and underweight are 42% and 30%, respectively underweight).

Micronutrient Deficiencies: Deficiencies in 2 of the 3 main micronutrients among children under 5 years old are of public health significance in Sri Lanka. A recent national-level survey of pre-school children (1996) found that the prevalence of sub-clinical Vitamin A Deficiency was 36.3%, which is high in comparison with other countries of South Asia. Iron deficiency anemia, which is generally lower than elsewhere in South Asia, is still high at 30%. Iodine deficiency disorders have been successfully addressed in Sri Lanka, where the overall prevalence rate of goiter among school children has declined from 20.9% in 2000-2001 to 5% in 2005

Causes of Undernutrition

In a recent report by the World Bank, household food insecurity, limited access to safe water and sanitation and poor maternal and child care practices were found to underlie the high levels of undernutrition in Sri Lanka. In addition, multivariate analyses showed

that low birth-weight and mother's nutritional status had a direct and statistically significant effect on child underweight. The rising income inequalities between and within regions is bound to have an impact on childhood malnutrition which could worsen in the absence of targeted/prop-poor interventions. However, it is important to understand the socio-cultural factors that cause malnutrition in South Asia, which can be addressed directly, while income poverty might take much longer to address.

Policy and Programmatic Responses to Malnutrition

The Government of Sri Lanka's (GoSL) has in place a National Food and Nutrition Policy (2006-2010) whose goal is to address the continuing problem of child undernutrition, regional disparities in nutritional indicators and emerging nutrition problems. Its programmatic response to malnutrition has consisted of three broad strategies: direct food assistance, the integrated package of maternal health and nutrition services under the Ministry of Healthcare and Nutrition (MOHN), and poverty reduction programs. In addition smaller micronutrient deficiency control and focused behavior change communication programs also exist.

Direct food assistance and supplementary feeding programs: Programs falling under this category include: the school feeding program targeted at poor children (coverage low, and nutritional impact is debatable though effect on school retention might be good); pre-school nutrition program targeted at children 3-5 years old attending *Sarvodaya* preschools; *Thripasha*, the government's major food supplementation program targeting pregnant and lactating mother, and children 6-60 months old, who have been identified as nutritionally vulnerable. The effectiveness of these programs has been questionable, in view of the challenges of targeting, consumption of the supplements by non-targeted members of the households and lapses in the supply of food supplements.

Integrated Maternal and Child Health (MCH) and Nutrition Program: This program is quite broad in scope; interventions with direct impact on nutrition include: midwife-provided nutrition education and counseling; weight gain monitoring during pregnancy; growth monitoring for children; provision of micronutrient supplements (iron, folic acid, calcium and vitamin C) during pregnancy; anthelmintic therapy for young children and; provision of *Thripasha*. Similar interventions are implemented in the estate sector by the Plantation Human Development Trust.

Poverty Alleviation Programs: The GoSL's current poverty reduction initiative *Samurdhi*, provides an income of Rs. 500-1000, depending on family size and household poverty level. This income supplement can be used to purchase food items such as grains, cereals, and legumes (nutritional impact debatable as the way in which households use the income supplement is not necessarily informed by nutritional needs).

Micronutrient control programs: These include the Iron deficiency anemia control (iron and foliate supplements and de-worming during pregnancy), Salt Iodization (80% of all salt supplies) and Vitamin A deficiency control (comprising a combination of food-based approaches and Vitamin A supplementation).

Institutional arrangements for Nutrition

Several departments of MOHN are involved with nutrition: *Family Health Bureau; Nutrition Coordination Division; Directorate of Nutrition; Medical Research Institute; Health Education Bureau;* and the *Epidemiology Unit*. Currently these are still somewhat uncoordinated and a streamlining of the institutional arrangements is warranted. Coordination with non-health sector is also weak, but recently a Nutrition Steering Committee has been established. The Public Health Midwives are the key implementation agents being the frontline MCH service providers. Institutional arrangements in the estate sectors differ significantly and are far from adequate in terms of service delivery.