5. POLITICAL ECONOMY OF MALNUTRITION IN SRI LANKA

This chapter attempts to outline the complex political economy of nutrition in Sri Lanka. The political discourse in post-colonial Sri Lanka has led to divergent views about nutrition, its causes, and potential solutions. Under the circumstances, the policy choices adopted have not always been based on evidence of what works. Policy-makers and program designers rarely appreciate the multifaceted causes (and potential demand-side solutions) for undernutrition.

Food subsidies, free education and health services, and government employment with social security were the dominant expressions of social justice in post-independent Sri Lanka. The country’s predominant paradigm is that malnutrition is caused by food insecurity. Nevertheless, the health sector implements most efforts to address malnutrition and they follow a medicalized approach combined with hand-outs of supplementary food—a legacy from the social justice era. This mismatch may have been unfortunate. However, with the tremendously successful improvements in infant and maternal mortality rates in recent years, the health system is now poised to maximize a new opportunity to redirect its focus on nutrition. This institutional and political opportunity must be seized.

5.1. NATIONAL STAKEHOLDERS AND THE POLICY-MAKING PROCESS

Nutrition in Sri Lanka has traditionally been assigned to the medical profession. After the recent 2001 elections, the government elevated nutrition to a ministerial level and created the Ministry of Healthcare and Nutrition (MOH). Several departments are involved with nutrition in this ministry: the Nutrition Coordination Division, Directorate of Nutrition, Family Health Bureau, Medical Research Institute, Health Education Bureau, and Epidemiology Unit. All but one of these agencies are under the Deputy Director General of Health Services-Public Health (DDGPHS). The Medical Research Institute functions under the Deputy Director General of Health Services-Education, Training and Research (DDGET and R). The primary responsibility for nutrition lies with the Family Health Bureau (FHB), which makes most decisions regarding policy and strategy. The Public Health Midwives (PHMs) are the key implementation agents. The Nutrition Coordination Division coordinates among agencies external to the MOH, and the Directorate of Nutrition coordinates all nutrition-relevant activities within the MOH. However, many agree that there is little functional coordination among these units, as is the case in other countries. In the Estate sector, most service delivery for the social sectors, including health and nutrition, is through the Plantation Human Development Trust which is not linked or accountable to the public sector.
Several other ministries—Ministry of Livestock, National Water Supply and Drainage Board, Ministry of Agriculture, Department of Agriculture, Department of Fisheries and Aquatic Resources, Ministry of Samurdhi and Poverty Alleviation, Department of Census and Statistics—together with the Medical Research Institute and the Family Health Bureau of the MOH, participate on the steering group of the national nutrition surveillance system, which is implemented by the Nutrition Coordination Division. The surveillance system is supported under the World Bank’s Health Sector Development Project, and is expected to contribute to the dissemination and use of the data collected by the system for nutrition-related planning and action.

This analysis included extensive interviews and discussions with academicians, researchers, trainers, government officials, and administrators at central and local levels, nutritionists, and staff in the community. These consultations revealed widely held concerns. First, the views of professionals with field experience and from non-MOH professionals were not sufficiently represented in the nutrition policy-making process. Second, there is no systematic process established to learn from assessing the impacts of existing programs. Policy advisory board selections are often ad hoc, which often leads to contradictions. For example, the nutrition policy document published in 2004 emphasized the need to create stronger implementation structures at the national and village levels, as well as to consider the wider dimensions of Sri Lanka’s food...
and nutrition issues. In contrast, recent efforts essentially focus on strengthening existing services and structures. The former adopted a “life cycle approach,” while the latter focused on a much more medical approach.

5.2. PERCEPTIONS OF NUTRITION PROBLEM AND CURRENT APPROACHES

Poverty and food insecurity are traditionally accepted as the most common causes of undernutrition. However, these assumptions are untested by data, even though poverty and food insecurity maps are available at the Department of Statistics (DS) division level (Department of Census and Statistics, or DCS).

Despite this lack of analysis, a food-centered approach to nutrition has dominated policy-making. In post-independent Sri Lanka, food subsidies, free education and health services, and government employment with social security were the dominant expressions of social justice. The legacy of colonial socialism continues, and food assistance is often provided as a political gift, decades after the country adopted a market-oriented open economy in the late 1970s. This doctrine sustained the Thriposha—the national food supplementation program—through changes of government, because it gained popularity as the only program for the poor and as a response to undernutrition. Demand for Thriposha remains high, and it is used as an incentive to mothers to visit clinics for immunization and growth monitoring and promotion.

Undernourished children are either advised to eat more food, or referred to a clinic if illnesses are detected, and there, Thriposha is prescribed as the remedy. However, irregular supplies and the tendency to share food supplements with the family results in some children and mothers receiving insufficient amounts of the food supplement. Health professionals are not equipped to provide counseling and to assess other potential causes of undernutrition. This deficiency is partially explained by a medical incentive system that rewards medical professionals for treating patients and that dissuades medical students from focusing on preventive health issues. Yet, most medical professionals are unwilling to accept that nutrition issues need to be addressed by other, perhaps non-medical, professionals. As a result of these rigid attitudes, there is little cross-sectoral collaboration at the community level across health, agriculture, education, and poverty reduction/social development sectors.

The adverse effects of undernutrition on children’s psychosocial development are not fully appreciated by policy-makers and nutrition practitioners. Many feel (incorrectly) that the use of international growth standards to assess a child’s growth inflates the size of the nutrition problem in Sri Lanka.

At the community and household levels, PHMs attribute undernutrition to poor “weaning foods,” the practice of sending young children to day-care, and diseases and other causes. Overall, the emphasis has been on service delivery rather than on the demand side of the service, and understanding the causes and consequences of undernutrition is very weak at all levels.

5.3. FAMILY HEALTH BUREAU AND PUBLIC HEALTH MIDWIFE

Nutrition services in Sri Lanka are delivered through the Maternal and Child Health (MCH) package managed by the Family Health Bureau (FHB). The MCH program is responsible for children under-five years of age, mothers, and school children. The frontline MCH service providers are the public health midwives (PHMs). Through the clinics, the system captures approximately 95 percent of children between birth and age one year, approximately 60 percent between one and two years of age, and 50 percent between two and three years of age.
Opinions about the effectiveness of PHMs in addressing nutrition at the community level are mixed, especially vis-à-vis the behavioral and lifestyle issues. PHMs have weak communication and analytical skills. They lack specific applied nutrition training and have heavy workloads, making them poor counselors for mothers and undernourished children.

Although PHMs have recently been renamed “family health workers,” their training consists of one year of midwifery at a nursing school, since many work as midwives in hospital maternity units, and an additional six months of public health training at the National Institute of Health Science. They receive little training in preventive management of malnutrition at the household level. This medicalized training is unsuitable for their job responsibilities since all childbirths are institutionalized. Nor does their training prepare them for the community-based services they are supposed to deliver. Attempts by the National Institute of Health Sciences to extend the public health training to one year and limit the midwifery training to six months have failed due to trade union pressures. Some curricula changes are being made to incorporate a greater focus on community work, but both the trainers and the supervisors are weak on such topics. After graduation, no continuing education for midwives exists.

Midwives maintain multiple registers and records including a daily activity report, pregnant women and family planning monthly report, records of immunization, eligible new couples’ registry, and expectant women’s registry. However, they rarely use the collected data to identify issues or to develop action plans because PHMs are only evaluated on the basis of routine procedures only not by their actions or health outcomes. Their supervision is weak and not outcome based. In addition, PHMs have few career enhancement opportunities, and they are increasingly overburdened by additional tasks.

5.4. INSTITUTIONAL OPPORTUNITIES AND CONSTRAINTS TO INTEGRATE NUTRITION INTO EXISTING PUBLIC HEALTH SYSTEM

Nutrition has not been the primary focus of the FHB or the PHMs. However, with the successful improvements in infant and maternal mortality rates, the FHB are afforded a new opportunity to redirect its focus on nutrition. This institutional and political opportunity must be seized.

5.4.1. Potential for Continued Role of PHMs

The existing structure enables the PHMs to reach households in the community. The PHMs are well-respected by the community. Her presence in the village justifies the health ministry’s ability to undertake community level programs. There are a total of 7,000 PHMs nationwide. The MOH has recently recruited an additional 2,000 PHMs. Nevertheless in the field a PHM commonly serves a population of 5,000, instead of the designated ratio of one PHM for every 3,000 population.

The PHC/MCH system was successful in reducing mortality but is currently unsuitable to improving nutrition. The PHMs’ approach is often criticized as not participatory or community oriented, even though they live and work in the villages. The mismatch between the PHMs’ training and the nutrition services they are expected to deliver is perhaps one major reason for the continuation of this medicalized approach. PHMs need different skills to identify households

25 The PHMs trade union wants to continue using the “midwife” designation and wants PHM training to be more “medicalized” so these workers are marketable overseas.
with malnourished women and children and to analyze causes of undernutrition. However, this paradigm change must be supported with appropriate PHM training and supervision changes, a functional management information system (MIS), a monitoring and evaluation system, and appropriate accountability mechanisms.

While there is no denying the need to strengthen and improve the package of nutrition services that PHMs provide, it is also important to recognize the resource constraints faced by the public health sector in Sri Lanka and therefore the MCH program. The discussion in Chapter 2 showed that Sri Lanka spends significantly less on health care as a share of GDP compared to other countries at a similar level of development or with similar health outcomes. The same applies to maternal and child health. In the late 1990s, public sector spending on reproductive health in Sri Lanka as a share of GDP (0.2 percent) was similar to that in Bangladesh (0.2 percent) and lower than that in some Indian states (0.3 percent in Rajasthan and 0.4 percent in Andhra Pradesh) (World Bank 2007). Yet, the volume of services provided by the public health sector in Sri Lanka was substantially larger than in Bangladesh or India. For instance, the public sector accounts for 80-90 percent of all deliveries in Sri Lanka compared to less than 5 percent in Bangladesh. In short, the public health sector in Sri Lanka is quite stretched in the volume of services that it provides with the available resources.

Future programs envisage the PHMs playing a more prominent role in providing nutrition services. To be successful, these programs need to significantly expand their resources to have any impact or the status quo will continue with PHMs tasked with providing a range of nutrition services in addition to the maternal and child health services but falling short due to time and resource constraints. To achieve the envisaged programs, the number of midwives needs to be increased to one PHM per 1,000 population.

5.4.2. A Role for Indigenous Medicine Professionals?

The Ministry of Indigenous Medicine and its provincial departments also provide nutrition services. It is developing a parallel system for its Medical Officer of Health and is targeting preschoolers, a captive audience not covered by other government programs until very recently. Its frontline workers are the Community Health Development Officers, who are trained at the National Institute of Traditional Medicine (NITM), which is Indigenous Medicines’ counterpart to the National Institute of Health Services, where PHMs, Medical Officers of Health and all other public health staff under MOH are trained. This group also is experimenting with reaching pregnant women with indigenous medicinal interventions for the undernourished. Their approach to include nutrition within a wider program of “return to tradition and spirituality” may have certain advantages over the MOH’s MCH program. Indigenous medicine’s service is culturally more acceptable for some and has the potential to be modernized with growth charts etc., to appeal to both politicians and the average citizen. The government supports both these competing and sometimes conflicting programs. For example, some conflicts have arisen with regard to a medical paste *rathe kalke* given to infants which is discouraged by the PHMs and heavily encouraged by the indigenous practitioners. More positively though, there is a general view among biomedical practitioners that the contribution of indigenous medicine could be an asset in curbing non-communicable diseases. But whether the MOH and the indigenous sector can work together on nutrition is yet to be seen.

Two caveats are worth noting with regard to the role of the indigenous medicine sector in promoting good nutrition. They relate to the declining demand for indigenous medicine among Sri Lankan households and to the potential confusion that may arise between the types of messages that are given to the population by the two sectors.
First, although there is a well-established indigenous medicine program in Sri Lanka which includes training institutions and health facilities; the use of these services for health care has declined quite substantially. Health utilization surveys during the 1990s showed a consistent shift by households from indigenous medical providers to Western medical providers (Central Bank Consumer Finance Survey, 1996/97, 2003/04; World Bank Household Health Survey 1991). In addition, older household members are most likely to use these services and not young women and children, who are the target population for nutrition interventions. The indigenous medicine program therefore is an unlikely vehicle for spreading knowledge and information about good nutritional behaviors, though the potential role of older generations in South Asia in promoting nutrition health must not be underestimated.

Second, because nutrition behavior is complex, the health sector must provide one consistent set of messages to provide effective nutrition interventions. Currently, the MCH program’s information about the duration of exclusive breastfeeding is inconsistent and causes confusion. Any intervention through the indigenous medicine program must not add to this confusion, as in the rathe kale example mentioned above.

5.4.3. Learning Lessons from Small-Scale Experiences?

Small community-based nutrition projects have been piloted at village and district levels to address the various causes of undernutrition. Communities and health workers have often identified the health and socioeconomic problems together and discussed potential actions to address them through participatory approaches. These activities have supposedly lead to more sustainable behavior changes. However, such initiatives have been undertaken at local levels by individual functionaries and are usually completed after they leave. Such local experiences have rarely been recognized by the health system and no mechanism exists to document their impact, learn lessons from these experiences, or to scale them up. A system is needed so these valuable experiences can feed into the basis for evidence-based policies and scaling-up.

5.5. COORDINATION AND COLLABORATION ACROSS SECTORS AND THE NEED FOR CAPACITY STRENGTHENING

Policy makers and practitioners widely express the belief that a strong coordinating body from the central government down to the grassroots level is needed to improve nutrition in Sri Lanka. Several cited the previous model of a high level National Nutrition Council as an effective mechanism to harness commitment from relevant ministries. PHMs could potentially work with extension workers from other sectors such as agriculture and fishery. While PHMs counsel caregivers, the other sectors could provide complementary services such as formation of mothers’ clubs and agricultural extension services.

However, the feasibility of such a model at scale will require strong inter-sectoral coordination and a functional information feedback system that depends on extensive data sharing and analysis among the health, agriculture, fishery and Samurdhi (to name only a few), potentially in partnership with the Department of Census and Statistics, and a strong monitoring and evaluation data-base.

For the Estate sector, the Plantation Human Development Trust (PHDT) oversees the delivery of health and nutrition services in the estates.
In addition to the above, a clear system of accountability at all levels is necessary. Sri Lanka’s health system is not totally decentralized. Therefore, the provincial councils’ relative accountability is not always clear. Three factors are important for accountability: policy guidance from the central government, financing by the provincial councils, and the extent to which the districts or provinces are allowed to experiment or deviate from the national plan to respond to contextual issues. The Bank’s Health Sector Development Program funds district health plans through the Finance Commission and district level plans are expected to be developed for improvements in health and nutrition. Province or district level capacity will be necessary to innovate and counter politicians’ demands for simple solutions such as dispensing food and subsidies.

Based on the above review, it is evident that nutrition training by the Post-Graduate Institute of Medicine (PGIM), which produces high level officials for the Ministry of Healthcare and Nutrition and for the MCH program, also needs to be reviewed and strengthened. Nutrition research is conducted at the PGIM, MRI, FHB and the Nutrition Coordination Division but is not sufficient to meet the needs for evidence-based policymaking. Of a total 1,214 publications only 29 were nutrition related studies, and the word “nutrition” appeared in the titles or in the summarized findings in only six of them. And most of the studies were on the medical aspects of pregnancy and child health. There are reportedly no nutritionists in the MOH, and the managers of nutrition themselves were trained as researchers and have little nutrition or program management skills. All these issues need to be addressed.

5.6. CONCLUSIONS

The political discourse in post-colonial Sri Lanka has lead to divergent views about nutrition, its causes, and potential solutions. Under the circumstances, the adopted policy and programmatic investment choices have not always been based on the evidence of what works. The training and skills of health workers, the focus on a medicalized approach, and the success in attaining health goals may have contributed to the adherence to the policies. However, the continuing high rates of undernutrition are evidence that new paradigms and policy shifts may now be necessary. This will require changes in the institutional mandates, and in the training and skills of frontline workers and program managers, and stronger leadership and political commitment at the highest levels in Sri Lanka. One functionary aptly described the current situation: “Since nutrition will most likely remain the primary job of the PHMs, the interaction between health professionals and their clients at the grass-root level are of foremost importance for successful improvement of nutrition in the country. We are happy about our past. However, too much emphasis has been placed on the supply side; now we have to focus on the behavioral aspects and the demand side issues of caregivers.”

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In the Estate sector, the Plantation Human Development Trust (PDHT) is inadequately positioned and lacks the capacity to provide high quality social services (such as health and nutrition services) to the Sri Lankan populations most in need. Other studies have recommended that these services should be transferred to the provincial government in close coordination with the respective line ministries (World Bank, 2007). Since the MOH has been able to deliver much higher quality and more accessible health services in the rest of the country, the potential for success of this expansion into the Estate sector is relatively high.