Civil Society Findings of the National Nutrition Policy Implementation

Sri Lanka

Are we on track?

Scaling Up Nutrition
People's Forum

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2016

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Acknowledgements

Scaling-Up Nutrition People's Forum would like to thank the following individuals and organisations for their time and effort in making this study a successful one.

We appreciate Mr. Anura Jayawickrama, Secretary Ministry of Health for acknowledging the civil society efforts to undertake this study and for approving the conduction of stakeholder interviews.

We thank the members of the expert panel of phase 1 who contributed towards developing a foundation for this study. Special thanks to Dr. Renuka Jayatissa for extending continuous support throughout the study.

Thank you to all officials at the national, provincial and districts levels, from government and non-govt. organisations that cooperated in the midst of their busy schedules, allowing us to successfully complete stakeholder interviews.

We appreciate the efforts of all officials and their organisation that assisted the information collection at the community level.

We extend a special thank you to all community members who organised and participated in the Focus Group Discussions.

We greatly appreciate the efforts of all Council and Board Members of the SUN Civil Society Alliance for their advice and support.

A special thank you goes to the senior management of Save the Children International and World Food Programme for their continuous support and assistance to sustain the SUN Global Movement in Sri Lanka.

Finally, we thank the staff of SUN PF Secretariat who extended a great level of support throughout the study.

Panel of Experts (Phase 1)

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Dr. Shanthi Gunawardena	Ministry of Health
Ms. R.P.M Sandamali	ChildFund Sri Lanka
Dr. D.S.N Jayasundera	Save the Children (2015)
Mr. Chamindha Rajakaruna	Sarvodaya
Mr. Saman Kalupahana	World Food Programme
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Dr. Dula de Silva	Scaling-Up Nutrition People's Forum
Mr. Dave Maurice	Nucleus Foundation
Mr. Asanga Ranasinghe	Plan International Sri Lanka

Stakeholder Organisations (Phase 2)

Organisations
Ministry of Health
Family Health Bureau
Health Education Bureau
Nutrition Division
Nutrition Coordination Division
Medical Research Institute
Food Control and Administration Unit
Youth Elderly and Disabled Division
Other Related Ministries and Departments
Ministry of Education
Children's Secretariat, Ministry of Women's and Child Affairs
Department of Census and Statistics
Ministry of Agriculture
Sri Lanka Customs
Colombo Municipal Council

National Nutrition Secretariat
Officials at the provincial/district level
All Provincial Directors of Health Services (or representative)
Government Agents (or representative) of Mullaitivu, Kilinochchi, Anuradhapura and Nuwara Eliya Districts
Officials of UN organisations
World Food Programme
Food and Agriculture Organisation
World Health Organisation

Officials who assisted the field level data collection (Phase 3)

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Staff Members of SUN PF Secretariat who contributed to successfully complete the study

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Ms. Lakshmi Madhuwanthi	Finance and Administration Coordinator
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Executive Summary

Sri Lanka developed her first National Nutrition Policy (NNP) in 1986. This was later revised which resulted in the current NNP, endorsed by the parliament in 2010.The Ministry of Health, Nutrition & Ingenious Medicine (MoH) is currently examining the policy to assess the progress of the interventions. The findings of the review will contribute to the policy revisions in 2018. To compliment these future revisions, Scaling-Up Nutrition People's Forum conducted this study to present civil society recommendations. The study was carried out in 3 phases over 8 months. More than 350 stakeholders participated in the study.

Policy Objective 1: Ensuring optimal nutrition throughout the lifecycle

Study found concerning gaps in knowledge dissemination as to why consuming nutrition supplements is important. Accordingly, increasing public awareness to trigger responsiveness to national interventions was recommended. In general, mothers exercised good level of care during pregnancy which was not evident during pre-pregnancy and post-delivery. The Thriposha food supplement still standing to be a great national treasure, need to be distributed in a different manner to reduce family sharing, therefore to increase its effectiveness in reaching the expected outcome. The Rs. 20,000 food allowance programme to all pregnant mothers is experiencing structural changes to improve the quality of delivery. The study found 100% delivery of screening pregnant mothers for pregnancy induced conditions. In addition, high risk pregnancies receive special care – through the Visiting Obstetrician and Gynecologist and hospital referrals. All interventions implemented with the aim of reducing low birth weight prevalence have seemingly been successful given the unpublished national average of LBW rate at 12.1% in 2014. Thus the 11% target for 2018 *looks doable.* In contrast, the target of 90% Exclusive Breastfeeding at 6 months seems rather impractical given the common behaviour among mothers to feed their children fruit juice and water at 4 months, to complement breastfeeding. Limited paternal engagement in promoting child nutrition and well-being persist to be a pressing issue. The study recommended the establishment of clinics for men, to educate them about the critical role they can play in attaining higher standards.

Underweight, Stunting and Wasting among under-5 children have experienced some progress; however the study suspects Sri Lanka to fall behind in achieving these indicator-specific targets for 2018. Wasting continues to be a major concern. Public health staffs have been trained on the Infant and Young Child Feeding strategy. However, this training is yet to pass on to the medical faculty staff. Field midwives have been recognised as the key strength of health care delivery at the primary level – all mothers interviewed responded very positively about their area midwife and about the services she deliver.

The degree of integration of nutrition in the National Early Childhood Care and Development programme is highly commendable. Increased efforts are required to curb the level of water borne diseases. Compliance with minimum standards when building toilets and water sources is suggested. The school nutrition programme shows signs of smooth implementation. However, the poor knowledge among students and parents about the supplements they consume is an outstanding apprehension. Similarly, the response of *we receive nothing* by out of school adolescents too is a demanding issue which need to be addressed effectively. Another demographic segment yet to receive special attention is the adults and the elderly. Regardless of existing strategies and action plans, promotion of nutrition among these groups is limited.

Policy Objective 2: Enhancing capacity to deliver effective and appropriate interventions

State effort to enhance capacity of health care workers is evident through the positive responses garnered during FGDs. However some districts still experience communication barriers which disallow them to serve and receive the best possible service. Behaviour Change Communication plans is yet to be effected. Likewise, a business network in promoting good nutrition too is yet to be mainstreamed in the national strategy. The country's current media surveillance system demands revisions to prevent media damage to nutrition behaviour. Upwards trends evident in formulating provincial-specific strategies based on needs assessments. The study calls for state engagement with community based organisations to enable them to become change agents and take responsibility to monitor the progress of the interventions at the community level.

Improving mobile facilities for midwives and other health field staff is crucial given the increasing demand for midwife duties to be carried out effectively and efficiently. The dearth of 1750 midwives needs to be urgently addressed possibly through the appointment of social workers to care for the elderly and disabled.

Policy Objective 3: Ensuring effective management of adequate nutrition to vulnerable populations

The recognised vulnerable areas continue to report the highest numbers of under-5 Stunting and Wasting. State and non-state efforts have been streamed to uplift the nutrition status of communities in the plantation sector and conflict affected areas. However, the study did not identify any special interventions targeting the urban poor. The study calls for targeted interventions, to streamline national resources to focus on those who need to be *rescued* as opposed to, on people who are already above the expected standards. The definition of 'vulnerable populations' should be broadened to include the elderly without children and the disabled.

Policy Objective 4: Ensuring food and nutrition security for all citizens

The country's ability to ensure access to nutritious food is mainly determined through the level of production of such and the proportion of this production catering the domestic market. In 2013, only 3% of the vegetable and 6.2% of fruit production was exported. However, regardless of majority of the produce catering the domestic market, higher prices and unequal distribution incapacitates the poor to purchase nutrition-rich foods. Several UN and I/NGO partners work alongside the govt. to enhance country's food production. Still, ensuring nutrition values in production is yet to be integrated. Study calls for the development of minimum buyer standards by all - wholesalers, retailers and more importantly the consumers. The MoH is currently considering the plausibility of rice fortification. Given more flour consumption by estate communities (as opposed to rice), the study identified flour to be a better vehicle to reduce micronutrient deficiencies in the plantation sector.

Policy Objective 5: Strengthening advocacy, partnerships and networking

The degree of reference and integration of nutrition in relevant policies and strategies developed since 2010 is certainly refreshing. Multi-sector platforms have been established by the national govt., UN bodies and civil society, to work in harmony in upgrading Sri Lanka's nutrition profile. Similar platforms are evident at the provincial and district levels. Yet, the functionality of these associations especially at the provincial level needs to be upgraded.

Policy Objective 6: Strengthening research, monitoring and evaluation

The National Nutrition Surveillance System is currently subjected to revisions to facilitate timely information and to act as an *early warning system.* The study recommends the system to the operated at the National Nutrition Secretariat given the systems' representation of multi-ministerial data and information. Sri Lankan collects and reports information through 4 key data sources which signify evidence on data collection. However, when it comes to data reporting, the country lags way behind of what can be viewed as 'acceptable delays'. Revisions are called for to minimise this gap. In addition, the study highlights the need to recognise researchers from all sectors to encourage quality research for information sustainability.

Overall, the NNP is a comprehensive document which covers almost all vital aspects to reach high levels of human and therefore economic development. Although accessibility of interventions vary between districts, national efforts to implement the policy are highly commendable. There is now a call for greater coordination and cooperation among all stakeholders – govt., non-govt., civil society, businesses and more importantly the people, to eliminate the existing gaps and realise the set outcomes.

About SUN

Scaling-Up Nutrition, or SUN is a unique Movement founded on the principle that all people have a right to food and good nutrition regardless of their socio-economic backgrounds. It unites people – from governments, civil society, the United Nations (UN), donors, businesses and researchers – in a collective effort to improve nutrition (SUN Website, 2016). Currently, 57 countries are working together as one global movement to unleash the potential of millions of people, using nutrition as an entry point.

The Government of Sri Lanka (GoSL) recognised the importance of nutrition and joined the Global SUN Movement in 2012. In 2013, the GoSL launched a Multi-sectoral Action Plan to reduce malnutrition which was followed by the formation of the country's SUN Civil Society Alliance as 'SUN PF'; Scaling-Up Nutrition People's Forum in 2014. SUN PF is registered as a non-profit guaranteed limited company at the Company of Registrar. It has a governing board drawn from leading nutritionists and medical professionals representing the government, UN and International/Non-Governmental Organisations (I/NGOs). The Multi-Partner Trust Fund funded SUN PF activities in 2014, 2015 and 2016 through Save the Children International (SCI) and World Food Programme (WFP).

The purpose of SUN PF is to augment national efforts to improve nutrition interventions and facilitate global recommendations of the SUN movement. During 2014 and 2015, SUN PF reached 13 (of 25) districts and enrolled 283 Civil Society Organisations (CSOs) to join the SUN movement. Further, SUN PF executed 16 training programmes targeting nearly 2,000 village leaders of Community Based Organisations (CBOs) across the 13 districts and garnered positive feedback. The core activities concentrated on building civil society capacity and mobilising them to engage in improving nutrition and food security. SUN PF provides a platform for its member CSOs and I/NGOs to work collaboratively, to complement each other's activities and share resources. As a result, one voice to scale-up nutrition has been built.

Introduction

Sri Lanka developed her first National Nutrition Policy (NNP) in 1986. This was later revised which resulted in the current NNP, endorsed by the parliament in 2010. The policy serves as a base document to strategise all nutrition related interventions and is implemented in all 25 administrative districts of Sri Lanka, envisaged to have national impact. The vision of the NNP is to ensure access of all Sri Lankans to appropriate and adequate food and nutrition irrespective of their geographical location and socio-economic status.

Six policy objectives outlined in the NNP:

1. To ensure optimum nutrition throughout the life cycle
2. To enhance capacity to deliver effective and appropriate interventions
3. To ensure effective management of adequate nutrition to vulnerable populations
4. To ensure food and nutrition security for all citizens
5. To strengthen advocacy, partnerships and networking
6. To strengthen research, monitoring and evaluation

The NNP is expected to reach its 37 targets by 2018. Therefore, conducting a mid-term evaluation can be considered a prudent and timely activity to aid better understanding of the efficiency and the effectiveness of interventions stipulated in the policy. By doing so, Sri Lanka stands at a convenient platform to ensure the achievement of the expected outcomes. The Ministry of Health, Nutrition & Ingenious Medicine (MoH) is currently examining the policy to assess the progress of the interventions. Based on these findings, the policy document is expected to be revised in 2018. To compliment these future revisions, Scaling-Up Nutrition Civil Society Alliance (SUN CSA), as a responsible stakeholder conducted this review study to facilitate greater understanding of the entitlements of the people and to assess the degree of implementation of the interventions. Additionally, the study presents a series of recommendations as per the National Nutrition Secretariat's request. It is important to note that the recommendations greatly reflect the voice of the civil society and we hope that the state will seriously consider them in strengthening the nutrition policy implementation.

Methodology

The review study was carried out in three phases;

Phase 1: Review of policy implementation by a panel of experts

Phase 2: Key stakeholder interviews

Phase 3: Community interviews and case studies

Phase 1

SUN PF appointed a committee consisting 15 health & nutrition experts representing the GoSL, Academia, UN organisations and I/NGOs to review the policy. At the preliminary meeting, the members agreed to work in six sub groups where each group was responsible to review the implementation of one of the six policy objectives of the NNP. The Terms of Reference (ToR) (presented below) drafted by the SUN PF Secretariat for the sub committees was finalised at this meeting. Each group appraised the expected outcomes and activities defined under each objective against the ToR. Key assessments of each group were collated in to a single document.

Terms of Reference
Topics the NNP cover
How are they being implemented?
What is the implementation coverage?
Who are the stakeholders?
What are the existing coordination mechanisms?
Resource Allocation and Mobilisation
What at the monitoring and evaluation mechanisms in place?
Identify the gaps in the design, contents and implementation
Recommendations to decision makers

Phase 2

Phase 2 was commenced with the identification of key stakeholders – both govt. and non-govt. institutions responsible for the implementation of the NNP. Key officials representing these organisations at the national, provincial and district levels were interviewed about their role in the execution of the policy. General questions included:

- Do you use the NNP when planning your strategies and activities?
- How much have you allocated towards nutrition-sensitive and nutrition- specific activities?
- What are your contributions towards carrying out activities in the policy?

- What is the nature of coordination and communication with other relevant stakeholders?
- What are your plans for the next two years?

The analysis also includes community specific information raised by I/NGO officials working at the community level.

Government bodies at national level		***Government officials at provincial and district levels***	***UN Organisations and I/NGOs***
Ministry of Health Family Health Bureau (FHB) Health Education Bureau (HEB) Food Control and Administration Unit Nutrition Division Nutrition Coordination Division Medical Research Institute (MRI) Youth, Elderly and Disabled Persons Unit Midwives	**Other national ministries/ departments** Ministry of Education Children's Secretariat, Ministry of Child and Women's Affairs Department of Census and Statistics Ministry of Agriculture Sri Lanka Customs Colombo Municipal Council National Nutrition Secretariat of the Presidential Secretariat	The 9 Provincial Directors of Health Services (or representative) Government Agents (or representative) of 4 districts	***UN Organisations*** World Food Programme Food and Agriculture Organisation ***INGO officials at the community level*** ChildFund Sri Lanka World Vision Lanka Save the Children International ***NGO officials at the community level*** Sarvodaya

Phase 3

To gain a perspective of the degree of implementation of the NNP at the community level, SUN PF Secretariat along with ChildFund, World Vision Lanka, Save the Children International and Sarvodaya conducted 33 Focus Group Discussions (FGDs) across 9 districts. The aim of the community interviews was to understand the level of knowledge and awareness among the people

about the specified interventions and the importance of them in upgrading the nutrition status of Sri Lanka. 308 (281 female and 27 male) community members were interviewed specifically about the special packages outlined in Policy Objective 1. The districts were selected based on the (unpublished) district level Low Birth Weight (LBW) data of 2014 obtained from the FHB. The districts with the highest LBW prevalence - Ampara and Badulla and the lowest LBW prevalence; Puttalam and Hambantota were included in the sample. The objective was to identify the correlation of the degree of implementation of NNP against the district nutrition status. Other districts included Mathale, Nuwara Eliya, Kilinochchi, Mullaitivu and Colombo.

Categories of the FGDs:

- Pre-pregnant women
- Pregnant mothers
- Lactating mothers
- Mothers with primary school-going children
- Fathers
- Adolescent girls: in-school and out of school
- Adolescent boys: in-school and out of school

Field level data collection was carried out using questionnaires, pre-tested at the preliminary FGD in Weli Oya, Mullaitivu district. SUN PF discussed the value of the nutrition interventions after collecting the data (to avoid bias) in order to educate the public.

Time Frame

Phase 1: May 2015 – July 2015 (2 months)

Phase 2 & 3: Jan 2016 – June 2016 (6 months)

Limitations

1. Restricted Sample Size – although the sample captures the feedback of all key sectors, state disproval to conduct the review study disabled SUN PF to speak to a larger number of officials especially at the provincial and district level including (a considerable number of) midwives, hospital staff and in some cases government agents who requested for a letter of approval to cooperate.
2. Limited availability of resources which confined the community interviews to just 12 divisions.
3. Unavailability of recent data – the analysis was limited to using published data which bounded the quality of assessment on the progress of most outcome indicators.
4. Community Interviewee Bias – element of bias when responding in groups was evident (in some focus groups). For instance if one mother responded saying she has practiced EBF/ consumed the package after delivery, the rest of the group had a slight tendency to follow the initial response.

Policy Objective 1: Ensuring Optimal Nutrition throughout the lifecycle

Expected outcome	Key action areas	Major activities	Degree of implementation	Outcome indicators	Baseline	Target	Target status	Responsible Organisations
1.1 Low birth weight prevalence reduced	1.1.1 Reducing under nutrition and micronutrient deficiencies among women in reproductive age	1.1.1.1 Implementation of a package of interventions to pre-pregnant women (implementation of Integrated Nutrition Package)		Low Birth Weight Rate	16.6% (DHS 2006)	11%		MRI, HEB, Ministry of Education, Food and Drug Control Authority, Ministry of Youth Affairs, Ministry of Labour, UN Agencies and NGOs
		1.1.1.2 Strengthening the implementation of the intervention package delivered to the pregnant women through the MCH programme						
		1.1.1.3 Implement a special package of interventions to high risk mothers as defined in H512						
	1.1.2 Controlling and managing antenatal causes of fetal malnutrition	1.1.2.1 Strengthening screening for Pregnancy Induced Hypertension, Diabetes Mellitus, Heart Diseases and other conditions causing fetal malnutrition						
		1.1.2.2 Promote specialized institutional care						
1.2 Malnutrition among children under 5 years of age reduced	1.2.1 Promoting, protecting and supporting exclusive breastfeeding for the first six months of life and continuation of breast feeding for 2 years and beyond	1.2.2.1 Antenatal preparation to ensure proper breast feeding practices		Exclusive Breast Feeding Rate at 6 months	75.8% (0-5 months DHS 2006)	90% (0-6 months)		
		1.2.1.2 Promote supportive family environment and services and ensure regulatory safety nets (Full implementation of Breast Feeding Code and BFHI, maternity leave etc.) to mothers to provide optimal breast feeding						
		1.2.1.3 Provide and implement a set of guidelines for optimal nutrition for lactating mothers including counseling services for breast feeding problems						
	1.2.2 Strengthening complementary feeding practices	1.2.2.1 Develop and implement a country specific IYCF strategy		% underweight	21.1%	11.1 %		
		1.2.2.2 Improve family capacity for timely, appropriate and safe complementary feeding for infants and young children while continuing breast feeding		% stunting	17.3%	7.3 %		
		1.2.2.3 Strengthening food and micronutrient supplementation programs		Prevalence of	Iron deficie			
		1.2.2.4 Building capacity of health						

		workers and care givers on feeding sick children		iron deficiency anemia among infants in 6-11/12	ncy 57% (MRI 2001)	27%		
		1.2.2.5 Introduce and sustain nutrition rehabilitation programs to manage children with moderate and severe wasting						
	1.2.3 Strengthening growth monitoring and promotion	1.2.3.1 Improve coverage and capacity of growth monitoring		% wasting	15%	5%		
		1.2.3.2 Improve capacity of health workers and care givers in correct interpretation of growth curves and other related information						
		1.2.3.3 Strengthen capacity of health and community workers for nutritional interventions						
	1.2.4 Promote psychosocial development of children during early childhood years	1.2.4.1 Sustain and strengthen psycho-social development activities of ECCD programme						
1.3 Morbidity due to ARI and diarrhea among children under 5 years reduced	1.3.1 Strengthen Integrated Management of Childhood Illnesses	1.3.1.1 Enhance capacities of healthcare providers to practice integrated management of childhood illnesses protocols		% under 5 children with acute respiratory track infections	4.4%	-		MRI, HEB, MoE, Food and Drug Control Authority, Ministry of Youth Affairs, Ministry of Labour, UN Agencies and NGOs
		1.3.1.2 Improving hygiene and sanitation in households and pre-schools		% under 5 children with diarrhea	3.5%	-		
		1.3.1.3 Strengthening access to safe drinking water						
1.4 Malnutrition among school age children, adolescents and youth reduced	1.4.1 Create a good nutrition enabling environment in schools	1.4.1.1 Enhancing awareness and capacity building of the school community		% Stunting (Adolescents)	15%	14%		
				% Overweight (Adolescents)	4.9%	<1%		
		1.4.1.2 Providing supportive school nutrition and health services (school canteen policy, health promoting schools/healthy schools/nutrition friendly schools concepts to be rationalized)		% Anemic (School going children)	20%	15%		
		1.4.1.3 Improve the nutrition and health-promoting school curriculum		% Under-weight	48%	35%		
	1.4.2	1.4.2.1 Identify institutions and for a that						

	Enhance delivering nutrition services to non-school going adolescents	provide services to non-school going adolescents and device and implement a nutrition promotion program		(School going children)				
		1.4.2.2 Launch an effective communication campaign on healthy life styles						
	1.4.3 Regular nutritional status assessments of non-school going adolescents and youth	1.4.3.1 Carry-out regular nutritional status assessments targeting non-school going adolescents and youth						
1.5 Nutrition related disorders among adult population reduced	1.5.1 Regular nutritional status assessments of adults and elderly	1.5.1.1 Carry-out regular nutrition status assessment targeting adults		% of reproductive age women under-weight	16.2%	6.2 %		
	1.5.2.1 Updating and implementing national food-based dietary guidelines	1.5.2.1 Implementing the updated national food-based dietary guidelines		% of reproductive age women over-weight	31.2%	21.2 %		MRI, HEB, MoE, Food and Drug Control Authority, Ministry of Youth Affairs, Ministry of Labour, UN Agencies and NGOs
	1.5.3 Promoting healthy workplace	1.5.3.1 Formulate, disseminate and implement guidelines for healthy work place which includes an effective component in nutrition		% of reproductive age women anemic	31.6%	21.6 %		

Activity Implementation Colour Codes

Activity Completed

Activity Ongoing

Activity yet to be implemented

Degree of implementation of the activity cannot be determined

Target Status Colour Codes

Target achieved

Target likely to achieve

Target unlikely to achieve

Target highly unlikely to achieve

Cannot be determined

(determined based on a simple forecast calculation of the available data)

Expected Outcome 1.1: Low birth weight prevalence reduced

Outcome Indicator: Low Birth Weight (LBW) Rate

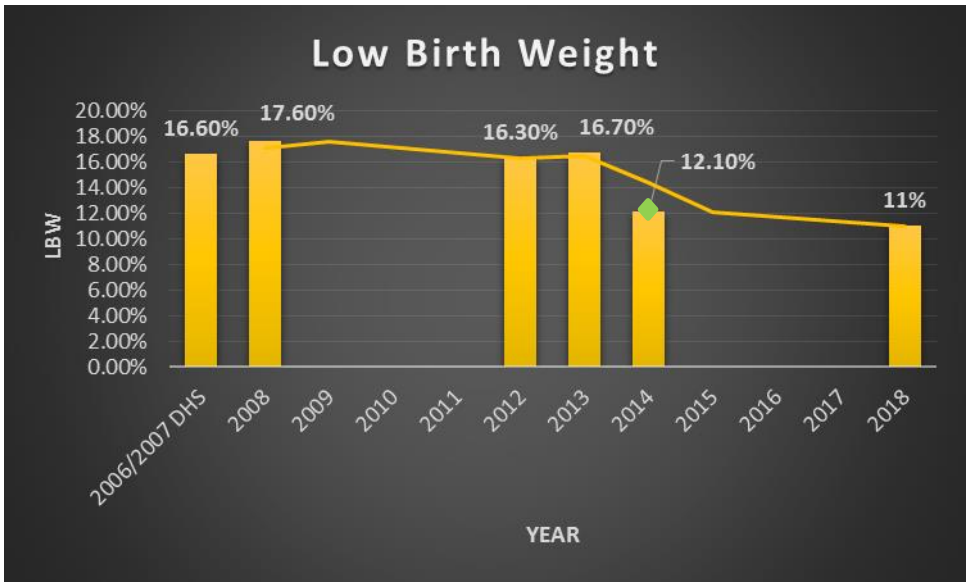


Figure 1: Low Birth Weight Trend *Data source: FHB Annual Reports (2014 figure – unpublished)*

Target for 2018 ◆

Key action area 1.1.1: Reducing under nutrition and micronutrient deficiencies among women of reproductive age

Target audience

- Pre-pregnant women
- Pregnant mothers (with special attention to high risk pregnancies)

Pre-pregnant women

According to the *Maternal Care Package – A Guide to Field Healthcare Workers*, a married couple planning for a pregnancy is categorised as 'pre-pregnant'.

The intervention package introduced in 2012 for pre-pregnant women includes:

- Rubella Immunization
- Preconception Folic Acid supplementation (5 µg (micrograms) dose for daily consumption)
- Screening for medical condition and nutritional assessment
- Family planning services (if required)
- Education on pregnancy symptoms and importance of early initiation of antenatal care
- Education on when and how to inform Public Health Midwife (PHM) once they get pregnant

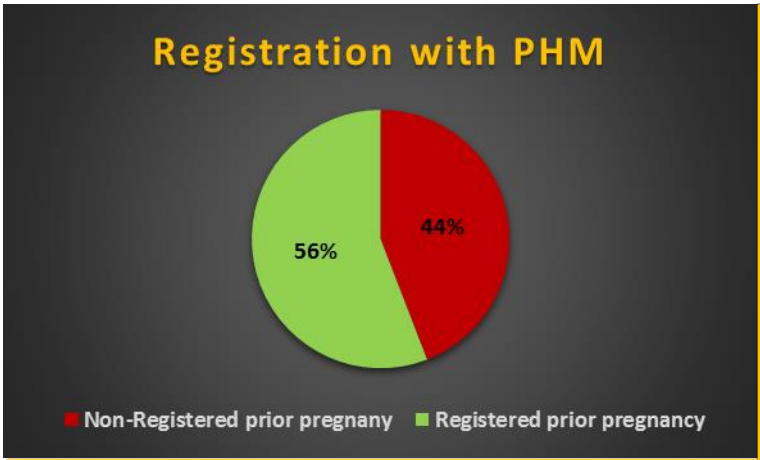
To assess the degree of implementation of the above, the study interviewed 29 pre-pregnant women across the 9 districts. In addition, the pre-pregnant questionnaire (refer Box 1) was also presented to 73 pregnant mothers to gain an insight to their pre-pregnancy behaviour and services received at the time. In total, 102 women (both pre-pregnant and pregnant) provided answers to the following questionnaire:

Pre-pregnant Questionnaire

1. Have you registered with your area PHM? If not, why?
2. Post-registration, did the midwife measure your height and weight? Were you informed about these measurements and the necessary action you had to take in order to correct for instance – underweight/overweight?
3. Did you receive education and services on family planning?
4. Have you being tested for anaemia/haemoglobin?
5. Were you provided with a daily dose of 5mg Folic Acid? Do you consume it? If not, why?
6. Are you immunised against Rubella?

Box 1: Pre-pregnant Questionnaire

Results



57 of 102 (56%) were registered with the area PHM prior to their pregnancy leaving 44% (45 women) who didn't/haven't registered. The key reason behind this non-registration was found to be **their lack of need** to do so – *'we don't have a need to register before becoming pregnant'*

Few mothers also communicated that they were unaware of the requirement to register with the PHM.

- Non-measurement of height and weight of **5 registered** pre-pregnant women potentially limits the validity of their nutritional assessments.
- All registered women received education on family planning.
- 2 of 29 women have not been tested for haemoglobin levels (not even in a private clinic).
- **11 registered** pre-pregnant women **did not receive Folic Acid** from their area PHM. Of this 11, 7 women have been asked to purchase from the pharmacy and consume. Only 3 of them did so.
- All 102 women have been immunised against Rubella during their school days – on par to the Annual Health Bulletin' 96.8% (2012) pregnant mothers being protected against Rubella at the time of registration.

The objective of introducing a care package for pre-pregnant women is to encourage women and their partners to enter pregnancy in optimal health. Although the sample represents an insignificant number of pre-pregnant women, 44% women's non-registration prior to their pregnancy highlights a key issue. Poor coverage of raising awareness about the importance of seeking for necessary health and nutrition related services evidenced to be the fundamental hindering factor. This is particularly marked among this group as the discussions revealed that majority of the women (regardless of consumption) were not enlightened about the importance of consuming folic acid if they were planning to have a child. Thus, it is sensible to determine that these women have been advised to consume the supplement without the required education on the reasons to do so.

Furthermore, the non-receipt of Folic Acid by 11 (38%) registered women indicates a gap in the delivery of the package. In turn, this could potentially demotivate other women to register and receive the services and care they require to give birth to a child well above 2.5kg.

Despite the above issues, we commend the govt.'s efforts in recognising this category as one which requires special care, followed by the implementation of a comprehensive package. All registered women receiving education of family planning and the *close to 100%* coverage of the Rubella Immunisation Programme are proof which signals continuous progression in the years to come.

Recommendations

- Public awareness campaign to ensure all pre-pregnant women are knowledgeable about the state package offered and the critical importance of its consumption.

- Pre-pregnant registration is limited to married couples. However, given today's increased average age of marriage, there is a tendency among such women to conceive as soon as they enter marriage. As a result, this cluster of women could potentially miss out on pre-pregnant care. Given the possible resource limitations to reach out to this group separately, increasing awareness among young girls – possibly via their work places is critical in order to address one of the root causes of Low Birth Weight (LBW).

- Ensure uninterrupted delivery of the **total package** including measurement, nutrition supplementation and advice. Midwives ought to be given regular training on this regard in line with the changing demographics and socio-economic behaviour.

Pregnant mothers

The national maternal care package was revised in 2012 to improve the quality of services and delivery. All registered pregnant mothers are entitled to receive the following interventions:

- Preliminary clinical assessment and screening for health and clinical risk in pregnancy
- Monitoring of maternal and foetal wellbeing in subsequent visits
- Tetanus immunization – two shots during 1st pregnancy, one shot during 2nd, 3rd and 4th and none during 5th and beyond
- Referral of high risk pregnancies for specialist care
- Providing information and counselling for pregnancy related issues and delivery planning
- Nutrition supplementation

Supplement	Frequency	Quantity
Iron	Daily dose	200 milligrams
Folic Acid	Daily dose	1 milligram *400 micrograms (*recommended dosage)
Calcium	Daily dose	600 milligrams
Vitamin C	Daily dose	100 milligrams
Mebendazole	Once in 3 months	100 milligrams
Thriposha	Daily dose	50 grams 2 packs per month (750 grams per pack)

Table 1: Nutrition supplementation package for pregnant mothers

The FGDs with 73 pregnant mothers (ref. box 2 for questionnaire) from 9 districts mainly focused on determining the degree of implementation of the nutrition supplementation package.

Questionnaire for pregnant mothers

1. How long did you take to identify your pregnancy?
2. Are you aware of the package offered to pregnant mothers by the govt.? If so, how did you hear about it? (PHM, hospital, family/friends etc.)
3. What have you received from the govt. during your pregnancy? Have you consumed these?

Package Content	**Dosage**	**Frequency**	**Received (Y/N) (All or score e.g. 4/5)**	**Consumed (Y/N), when do you drink it?**	**Reasons for non-consumption**
Iron	200 milligrams	Daily Dose			
Folic Acid	400 micrograms	Daily Dose			
Calcium	600 milligrams	Daily Dose			
Vitamin C	100 milligrams	Daily Dose			
Mebendazole	100 milligrams	3 days (once in 3 months)			
Tetanus	0.5 ml	2 Doses at first pregnancy			

4. What are the food supplements you receive?
5. How do you consume these food supplements? (For instance, do you use it to make dinner or do you consume it just as you would consume your other medicine)
6. Do you share your food supplements (Thriposha) with your children and other family members? If so, for how long does the packet last?
7. Have you faced any difficulties in obtaining these benefits?
8. In your opinion, how can the govt. improve this package? (E.g. In terms of its ingredients, timely delivery, more education on the importance of intake)
9. In your village, do you believe in any myths about consuming certain food items, especially during pregnancy?
10. Have you been screened for – pregnancy induced hypertension, Diabetes Mellitus, Heart diseases etc.?

Box 2: Questionnaire for pregnant mothers

Results

- 100% of the interviewed pregnant women are registered with the area PHM and are aware about all interventions they are entitled to receive. This is on par with Annual Health Bulletin's 95% in 2013.

- On average, mothers took 2 months to identify their pregnancy while few women recognised their pregnancy only during the 3rd month.

On a very positive note;

- All mothers interviewed were aware about the total nutrition supplement package, mostly informed by the area PHM.
- All mothers received and consumed all supplements offered in the package. Mothers with low levels of haemoglobin consumed two daily doses of iron.
- Majority possess the necessary knowledge on the importance of consuming each supplement, in addition to being aware that consuming iron with folic acid maximizes absorption while consuming calcium at the same time reduces the benefits of the supplements. Accordingly, they consume iron and folic acid together at night and the calcium supplement in the morning.
- Most mothers are aware about their BMI, in addition to knowing that BMI of less than 18.5 and more than 25 requires correction.

Difficulties;

- Long distance to clinics was identified as the key difficulty in obtaining the package, common to most mothers; 64 of 73 to be precise. For example, most mothers in Kilinochchi, Mullaitivu and Ampara districts walk 3-4 km to the clinic centre.

- Objective of question 9 (In your village, do you believe in any myths about consuming certain food items, especially during pregnancy?) was to identify if mothers miss-out on essential nutrients from food items. Most mothers have been advised to avoid foodstuff ranging from fruits including Pineapple, Papaw and Anoda (Soursop) to vegetables including Tomatoes, Eggplant, Mushrooms and a range of Seafood too. However, mothers in some focus groups (particularly in Hambantota and Nuwara Eliya districts) emphasized that their midwives have explicitly advised them to *eat everything* in moderation. As a result, such village myths are likely to be experiencing a downward trend.

The degree of implementation of the nutrition supplementation package in terms of quality and coverage evidenced to be at a very satisfactory standard. Further, the PHM's and therefore the govt. efforts to increase and enhance the level of knowledge among pregnant mothers are praiseworthy.

Those being said taking 2-3 months to identify, register and receive care highlights a critical gap in the system. This can be a fundamental contributor to the slow progress of reducing LBW prevalence. Lack of effective care throughout the entire first trimester will lead to interventions having *little* impact during the rest of the pregnancy. This serious gap once again captures the grave need for an effective system of pre-pregnancy care.

An interview with the Family Health Bureau (FHB) revealed that although the daily requirement of Folic Acid supplementation is 400 micrograms, eligible women receive 1 milligram. Even though this represent to be a harmless dosage, if given the appropriate dose either by prescribing to consume every other day (1 milligram) or purchasing the right dosage, it likely to reduce the cost of supplying the Folic Acid supplement substantially.

In efforts to improve the quality of the nutrition supplements, the FHB has decided to replace Iron and Folic Acid with Iron Folate – for all pregnant and lactating mothers from the beginning of 2017.

Recommendations

- Consider the possibility of establishing a clinic centre in each PHM area in response to a key difficulty experienced by majority of the pregnant and lactating mothers.

Results (continued)

Thriposha (a food supplement)

With reference to question 4 (what are the food supplements you receive?), objective of the National Thriposha Programme is to provide energy and reference proteins with all required micronutrients as a supplement. The key beneficiaries of Thriposha include pregnant and lactating mothers and children between 6 months and 5 years of age who are malnourished (-2SD of the growth reference curve and growth faltering).

All pregnant mothers in the sample receive Thriposha. However there is clear district disparity in terms of quantity and frequency. For instance, mothers in Badulla and Ampara districts receive one packet instead of two while some receive it once in two months as opposed to the monthly receipt. We were also informed that underweight mothers are prioritised while others receive Thriposha based on availability. This in fact can potentially have a detrimental effect on the progress of achieving the expected outcome, since limited distribution leaves mothers with a good nutrition status little incentive to maintain.

Thriposha is commonly consumed with coconut scrapings and sugar as 'Aggala' as a morning/evening 'snack'. All mothers admitted to sharing this food supplement with the rest of the family. As a result, both packets on average last only for 2 weeks as opposed to 4 weeks.

When analysing state's response to address these supply gaps, according to the Annual Health Bulletin (2013), the production of Thriposha has increased to 57,000 master bags per month from 35,000-40,000. Accordingly, the reach of beneficiaries has increased to 85% (from 68%). These figures indicate that effort has been rendered to address the key issue of shortage in production. Additionally, the National Nutrition Coordination Division is supporting to upgrade and maintain storage facilities in the peripheries (Rs.1-2 million has been allocated to each district).

While we pleasingly acknowledge all actions with regards to increasing supply of Thriposha, the findings of this study as well as many other studies (including the recent (2015) micronutrient survey) indicate that increasing the coverage through higher level of production has a mere effect on reducing LBW. This is because regardless of the amount of Thriposha received, family sharing of Thriposha will *not stop*. Even if mothers don't admit to sharing their Thriposha, it is highly unlikely for any mother to consume the tasty Thriposha by herself. This specially holds true given the fact that Thriposha is identified as a national pride and treasure which has been in circulation for more than 30 years, in limited supply. In addition, many recipes and food demonstrations using Thriposha have encouraged family sharing. Therefore, in order for Thriposha to have a quantifiable effect on reducing LBW, a different strategy must to be adopted – the current system may have worked in the past, however reaching that 11% (target for 2018) and eventually 0% need to be addressed differently.

At present, increasing production and therefore distribution (increasing per capita quantity) may not be a practical solution. Instead, changing the branding and marketing of Thriposha can do some justice as a workable strategy. The name, packaging and possibly the taste (therefore the recipe) ought to be changed. The new product need to be introduced as a strict form of therapeutic feeding with specific instructions; *two table spoons to be mixed in hot water and consumed between 9-11AM.*

Another option is to enter into a partnership agreement with a local private sector manufacturer to increase production which would allow marketing the product. This form of income generation will aid to increase the supply to the target segment who can't afford to purchase. In turn, the daily ration of Thriposha which currently only provides 200 Kcal can be increased to foresee the expected outcome. Increased and continuous national efforts along with substantial investments to secure Thriposha as fundamental strength in increasing the nutrition status of all beneficiaries, at the end of the day need to have a quantifiable impact on achieving the set target. In the absence of such measurable impact, the entire intervention is considered to be futile.

Recommendations

- Repackage and rebrand Thriposha. Accordingly, train midwives to identify and distribute it as an exclusive therapeutic food.
- Increase production through a private sector partnership to ensure uninterrupted supply.
- Increases awareness among fathers on the importance of intra-uterine growth and the need for additional calories. This may deter family sharing to a certain extent.
- If the above options of rebranding and entering into a private sector partnership are not feasible, recognise Thriposha as a medicine to strictly target mothers and children who need it. Accordingly, increase the supply of the supplement to these individuals. Ensure uninterrupted supply until they reach the expected outcome.
- Give away an appreciation pack (instead of Thriposha) for mothers who maintain adequate weight gain e.g. an album for the first 1000 days of their new born, a starter pack for the new born etc.

Rs. 20,000 worth Food Assistance Allowance for pregnant women

In 2015, the Minister of Women and Child Affairs initiated this intervention which stipulated the entitlement of all pregnant mothers to food stamps worth Rs. 20,000 in 10 installments (each food stamp worth Rs. 2000); 6 during pregnancy and 4 during the first six months after delivery. The intervention is under the direct purview of the National Children's Secretariat with an allocated budget of Rs. 7000 million. The FHB and the Nutrition Coordination Division assist the National Children's Secretariat in designing the food package and its implementation. The distribution is processed through the Divisional Secretariat's office.

The composition of the nutritious food bag recommended by the MoH includes the following:

- **Grains:** Rice and Undu Flour
- **Dairy products:** Curd, Fresh Milk
- **Protein Items:** Dhal, Cowpea, Green Gram, Chickpea, Soya
- **Fats:** Ground nuts, Sesame seeds, Coconut
- **Animal products:** Meat, Fish, Dried fish, Salmon, Sprats, Eggs
- **Local fruits and vegetables**

The state initiated this programme to uplift the nutrition status of women during pregnancy. However, the interviews revealed that all (interviewed) mothers did not receive the food stamps on time and therefore were unable to obtain food from out-dated stamps. In some areas (particularly Ampara district), the intervention is non-existent; of the 12 mothers interviewed in Ampara, only one mother

has received it a few times. Additionally in Badulla and Colombo (Wattala) districts, pregnant mothers have to travel about 25 km in a hired vehicle to collect their food stamps and bag, which is very costly for them. A critical complaint reported from all districts was the inclusion of expired food – eggs and sprats in particular '*sometimes no eggs and other times, they are rotten'.* Another equally important concern is that majority of the mothers have only received the food bag on 1-2 occasions – they say they'd be lucky to receive it more than 5 times.

An interview with the National Children's Secretariat revealed that the responsible parties are very much aware about these shortcomings and informed us that they have taken measures to address them. From June 2016, the previously distributed food stamps will be called 'vouchers' where all 10 vouchers will be given to the mothers at once. They can claim each voucher at the beginning of the month. The trader will then bring in the voucher and claim for the money from the Divisional Secretariat office. The National Children's Secretariat is responsible for the timely dispersion of finances to the DS offices in all districts.

It is prudent to identify that this intervention was in its pilot/trial period and the response rate to correct the shortcomings is commendable. The National Children's Secretariat also plans to target the neediest instead of the currently practiced blanket coverage to ensure the continuity of the intervention.

Recommendations

- The Children's Secretariat should work with the Food Control and Administration unit of Ministry of Health to ensure compliance to minimum standards of food in retail shops.
- Ensure efficient reimbursement of funds to the shop owners to sustain the programme. This will also increase the credibility of the ministry and the state.
- FGDs revealed that people prefer Cowpea and Green Gram instead of Soya. Cultural acceptance should be considered.

High risk pregnancies

According to *H512 definition of High Risk Mothers,* risk factors can be divided into maternal and foetal.

Maternal factors include:

- Age: younger than 15, older than 35
- Weight: pre-pregnancy weight under 100lb or obesity
- Height: under 5ft

- History of complications during previous pregnancies (including stillbirth, foetal loss, preterm abortion, preterm delivery, small-for-gestational baby, large baby, preeclampsia or eclampsia)
- More than five previous pregnancies
- Bleeding during the third trimester
- Abnormalities of the reproductive tract, uterine fibroids, hypertension, Rh incompatibility
- Gestational diabetes
- Infections of vagina and/or cervix, kidney infection, fever
- Acute surgical emergency (appendicitis, gallbladder disease, bowel obstruction)
- Post-term pregnancy
- Pre-existing chronic illness (such as asthma, autoimmune disease, cancer, sickle cell anaemia, tuberculosis, herpes, AIDS, heart disease, kidney disease, Crohn's disease, ulcerative colitis, diabetes)

According to the FHB, mothers suffering from one or more of the above are referred to receive specialised institutional care. A new circular issued directs that pregnant mothers with even a one day fever need to be admitted to the nearest general hospital to receive specialised care. Further, a double dose of iron is given to all high risk mothers (depending on their anaemic level of course).

Refer Chapter 7: Domiciliary Care for High Risk Pregnancies of the *Maternal Care Package – A Guide to Field Healthcare Workers* for health related interventions specific to each of the above conditions.

In addition to the questions in Box 2, pregnant mothers were asked the following question:

> In your village, do you know of anyone who had/have a high-risk pregnancy? Did they receive special attention from the midwife/additional support from health services (hospitals)?

4 of 14 pregnant mothers (interviewed) from Puttalam district were identified as high risk pregnancies. We were informed that midwives exert tailored efforts to increase the level of care given to them. Their husbands are advised to engage heavily in upgrading the nutrition status of their wives and to reduce their stress levels from family and other social issues. Likewise, mothers from Mahagastota estate, Nuwara Eliya district informed that 2 mothers identified as high risk pregnancies were given special attention via govt. hospitals and referrals to the VOG - Visiting Obstetrician and Gynaecologist.

Case Study

A risky pregnancy with a happy ending…

I got married again after my first husband passed away. Soon after my marriage, I started taking the birth control pill. Shortly after, my period stopped – this was the only symptom for me to think I was pregnant because I'm quite fat. I informed this to my midwives but I was told that my period stopped because of the birth control pill. So I went on with my life, I didn't have any sickness or side effects of pregnancy. After 7 months, I was asked to do a urine test and it identified that I was pregnant. My midwife immediately referred me to the VOG. My husband and I were very worried and sad that our baby will be deformed because I continued birth control tablets until they informed me of my pregnancy. I was mentally stressed. After a scan, they said my baby is normal and predicted the due date. On the 12th of May 2011, I delivered my baby weighing 3.18 Kg and I was 74 Kg.

I didn't drink Iron, Vitamin C and Calcium during the first 7 months of my pregnancy. But I always made sure to have a wholesome diet. I didn't have any special preferences during this time, but I always consumed 3 full meals with fish, vegetables and green leaves – especially passion leaves and occasionally some meat. I do all the house work from washing clothes to chopping the wood which gives me good exercise and keeps me fit. I have a very supportive family; my husband always came with me to the clinic and to meet the doctor. He is still very supportive.

Now, at age 5, my child weighs 20 Kg and he's the tallest child at his school. I am still very thankful that I was blessed with a healthy baby!

Kumudhuni from Sooriyawewa Hambantota District

Key action area 1.1.2: Controlling and managing antenatal causes of fetal malnutrition

The final question in box 2 aimed to understand the practice of screening pregnant mothers for pregnancy induced diseases including hypertension, diabetes mellitus, heart diseases etc.

All 73 mothers have been screened. Mothers with issues are referred to the VOG and are required to travel to the nearest general hospital for special care.

Recommendations

- ❖ Although most mothers (more than 90%) are seeing by a doctor/nurse/midwife, at least 4-5 times or more during pregnancy, the country is experiencing slow progress in achieving the expected outcome of reducing LBW. One of the effective ways to address LWB would be to detect Intra-uterine Growth Retardation (IUGR) early as possible through scanning
- ❖ Conduct LBW reviews at district level to identify local issues for IUGR
- ❖ Engagement of civil society and Mothers Support Groups to support each other during pregnancy

The review of the interventions outlined in the early sections of the NNP with an expected outcome of reduced LBW prevalence signposts to be satisfactory. This is especially with reference to the unpublished statistic of 12.1% LBW rate in 2014 which indicates success of the govt. efforts rendered to realise such progress. However when analysing the more credible (published) data, it questions the effectiveness of the current maternal package (and even the previous one before the revisions in 2012) given the persistent rates – 16.6% in 2006/07 and 16.7% in 2013. Therefore going by the published data, it is vital for the govt. as well as non-govt. actors to work together – to draw upon all technical knowledge and practical know-how the country endows, to identify the deeper hindrances and formulate one which works! As discussed among the key stakeholders at the presentation of the latest micronutrient survey (2015) results, the country calls for urgent revisions to the existing nutrition interventions aiming to reduce LBW prevalence.

Expected Outcome 1.2: Malnutrition among children under 5 years of age reduced

Outcome Indicator: Excusive Breastfeeding Rate at 6 months

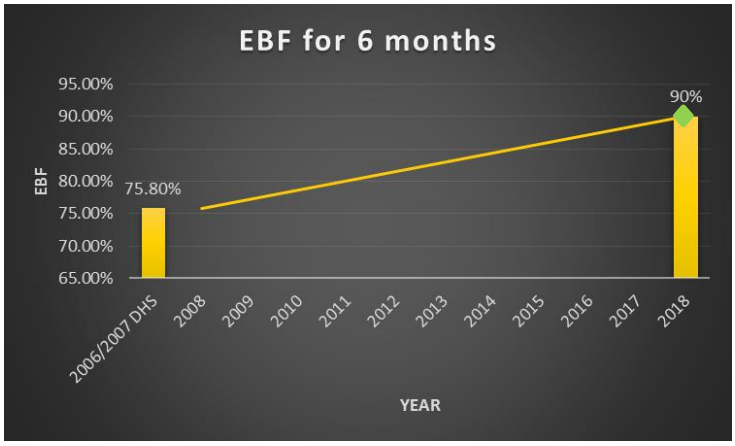


Figure 3: Exclusive Breastfeeding for the first 6 months *Target for 2018* ◆

Key action area 1.2.1: Promoting, protecting and supporting exclusive breastfeeding for the first six months of life and continuation of breast feeding for 2 years and beyond

Target audience:

- Lactating mothers

The nutrition supplementation package offered to lactating mothers includes the following:

Supplement	Frequency	Quantity
Vitamin A	Mega dose within 4 weeks of delivery	200,000 IU
Iron	Daily dose for 6 months after delivery	200 milligrams
Folic Acid	Daily dose for 6 months after delivery	1 milligram *400 micrograms (*recommended dosage)
Calcium	Daily dose for 6 months after delivery	600 milligrams
Vitamin C	Daily dose for 6 months after delivery	100 milligrams
Thriposha	Daily dose for 6 months after delivery	50 grams 2 packs (750 grams each)

Table 2: Nutrition supplementation package for lactating mothers

The sample included 94 lactating mothers. The following questions guided the FGDs:

Questionnaire for lactating mothers

1. What have you received from the govt. during first six months of post-pregnancy? Have you consumed these?

Package Content	**Frequency**	**Received (Y/N) (All or score e.g. 4/5)**	**Consumed (Y/N), when do you drink it?**
Vitamin A	Mega dose within 4 weeks of delivery		
Iron Folate/ Iron + Folic Acid	6 months after delivery		
Vitamin C	6 months after delivery		
Calcium	6 months after delivery		

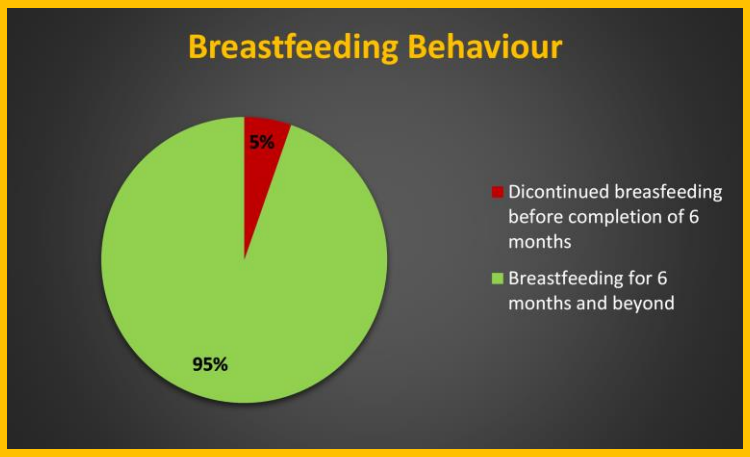
Exclusive Breastfeeding (EBF):

2. Do you know what EBF is? If so, do you know the importance of EBF?
3. Who here has practiced/is practicing EBF?
4. What sort of antenatal support have you received to EBF? From whom?
5. Has your family received education, advice on the importance of building a supportive family environment to practice EBF? (BFHI and maternity leave)?
6. What food supplements do you receive?
7. Do you share your food supplements (e.g. Thriposha) with children and other family members? If so, for how long does the packet last?
8. Have you/ (do you) receive/d any other food assistance? If so, who is/was the donor?

Box 3: Questionnaire for lactating mothers

Results

- All mothers received and consumed the Vitamin A mega dose supplementation in the hospital following their delivery.
- Only 29 of 94 (31%) consumed/plans to consume all supplements for 6 months post-delivery. Most mothers who reported consumption throughout the 6 months period were from Nuwara Eliya (Mahagastota estate (all mothers) - refer case study) and Hambantota districts.
- That leaves 65 (69%) mothers who have failed/failing to care for their nutrition status post-pregnancy. Reasons for non-consumption include unawareness about the importance of consumption post-delivery while some mothers forgot to drink these supplements for a few days resulting in permanent discontinuation.
- District disparity was clearly identified – for example, 8 mothers in Wattala, Colombo have not received Iron and Folic Acid/ Iron-Folate while mothers in some areas of Mullaitivu have not received Calcium and Vitamin C.



- All mothers are fully aware about the EBF period and the importance of practicing EBF; that mother's milk contains all vital nutrients the child needs and that it is easy to digest.
- With reference to figure 4, **technically** no one has practiced EBF for 6 months. This has become a common practice as midwives have advised mothers to give food supplements from 5 months if the mothers think breast milk is inadequate. Accordingly, all mothers have started giving their children water at 4 months and fresh fruit juice at 5 months to compliment breast milk. However, none of the mothers have given formula feeds.

Results (continued)

- Antenatal support on ensuring proper breastfeeding practices has been delivered by their area midwife who has educated the mothers about the importance of EBF. Hospital nurses acted as the initial postnatal advocators. In most cases, grandmothers of the new-born were also a strong pillar of support.
- In some areas, there are improving signs of male engagement – Mahagastota and Glassow Estates in the Nuwara Eliya district reported the highest number of husbands participating in household work and looking after older children. In contrast, mothers in areas of Ampara district receive minimum support from their husbands due to distant work stations. Mothers in Wattala received minimum support from all – husband, mother and mother-in-law.

To clarify the issue of limited paternal participation, the study interviewed a total of 19 fathers from Kilinochchi, Nuwara Eliya and Ampara districts. The questions in box 2 and box 3 – questionnaires for pregnant and lactating mothers were presented to them accordingly– for e.g. *are you aware about the package your pregnant/lactating wife is supposed to receive from the state?*

Most fathers in the FDGs demonstrated good level of knowledge and awareness about what their pregnant wife is supposed to receive and consume. In contrast, the level of awareness among them about the package for their lactating wife was very limited. Further, most husbands with pregnant wives accompany them to the clinic center and constantly remind them to consume the nutrient supplements and encourage them to obtain the required immunization on time. However, this sort of support to their breastfeeding wife was not evident, confirmed by both – the husband and the wife (lactating mothers).

Clearly the level of love and care women receive from family while pregnant is much greater compared to postnatal family support. This can be one of the key reasons why lactating mothers have a tendency to care less for their nutrition status displayed through the non-consumption of nutrient supplements.

More results

- All fathers admitted to sharing the Thriposha given to their wife.
- Question 5 in box 3 aimed to determine the level of support working mothers receive to facilitate EBF. However, only 2 of the 94 lactating mothers were working (reported from Kilinochchi and Nuwara Eliya districts). They received 84 days of paid maternity leave and thereafter one hour off (either in the morning or after lunch) for breastfeeding. The mother from Nuwara Eliya district was given a nearby estate to her home and Child Development Centre to work in.
- These 2 mothers informed us that all lactating mothers at their workplace are heavily engaged in breastfeeding their babies on time. All other lactating mothers in the sample engage in farming activities as their livelihood which allows them to breast feed freely.
- As highlighted in the previous section, FDGs revealed clear district disparity in the receipt of Thriposha. Once again, widespread of family sharing practices results both packets to last for only 10-15 days.
- Lactating mothers are entitled to receive 4 nutritious food bags during the first 6 months post-delivery. However, almost all mother informed that they rarely receive the bag. Refer previous section on the programme for govt. response.

Other govt. efforts towards promoting Exclusive Breastfeeding

- The marketing code of breast milk substitutes
- Baby Friendly Hospital Initiative – an average score of 7/10 (2012) (refer the country report of the World Breastfeeding Trends initiative 2012)
- Breastfeeding week – special workshops to promote EBF including media seminars
- Counselling clinics on breastfeeding – confirmed by all lactating mothers
- Health Circular (01-48/2012) issued on September 2012 outlines recommendations on breastfeeding within health institutions. Available at: http://203.94.76.60/cms/upload/english/01-48-2012-eng.pdf

A critical issue identified through group discussions is the non-consumption of the nutrition supplements during the first 6 months post-pregnancy. In addition to this having an immediate negative impact on the mother's health and nutrition status, it can also threaten that of the future foetus in potential pregnancies. This especially holds true given the poor level of care exercised during pre-pregnancy. Thus, the efforts exerted on delivering a comprehensive pregnancy care package to reduce LBW may be futile in the absence of similar level of effective care during pre and post pregnancy.

Although the (restricted) sample evidenced some level of paternal engagement, limited male engagement still persist to be a shortcoming to reduce malnutrition. Therefore, even though it poses to be challenging to promote more paternal engagement, it is vital to have a separate action plan to do so. This may in fact address the issue of lactating mothers not consuming the supplements as their husband would now be more engaged in ensuring good health and nutrition of their wife.

Recommendations

- Continuously communicate the importance of postnatal care to both mothers and fathers.
- Consider the possibility of establishing clinics for men which can be an effective platform not just to address their own health and nutrition concerns, but also to continuously raise awareness among them about the critical role they play in reducing child malnutrition. This could in turn encourage them to facilitate their female-counterparts to raise a happy and healthy family. Having separate clinics for the males (monthly or fortnightly) will also pose an incentive for them to view themselves as much needed contributors to establishing a productive and friendly community. Given the absence of interventions targeting males in general (who contribute immensely to county's productivity), this would pose as an effective platform to *reach the unreached*.

Lack of data availability restricts the scope to determine if Sri Lanka is on that upward track to realise the 90% EBF at 6 months. However given the study findings, it is understandable to accept the challenge in foreseeing the achievement of such high target by 2018.

The focus groups revealed high tendency for spiraling common behaviour and practice of mothers. All mothers would certainly want to ensure their child receives equal or higher level of nutrition compared to the level received by other babies in their communities. Therefore, if one mother starts giving their baby some juice or water, it is likely for others to follow this trend. This especially holds true given our tropical climate.

The challenging issues commonly identified to improve the EBF rates are;

- Maternity leave (maximum of 84 days of paid leave which incapacitates continuity of EBF)
- Mother migration to distant areas for employment
- Minimum family and workplace support

The strengths of EBF;

- Healthy, nourished babies
- Cost savings

Recommendations

- Explore avenues to increase maternity leave while enabling mothers to still contribute to the economy, both in the private and public sector – e.g. options to work from home.
- Increase awareness of cost savings born from breastfeeding as well as its short and long-term health benefits.

Key action area 1.2.2: Strengthening complementary feeding practices &

Key action area 1.2.3: Strengthening growth monitoring and promotion

Outcome indicators: % Underweight, % Stunting and % Wasting among children under 5 years

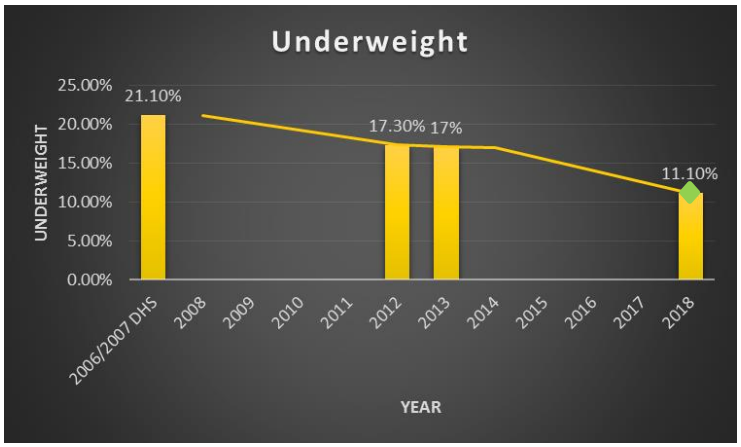


Figure 5: Underweight children under 5 years

Figure 6: Stunted children under 5 years

Figure 7: Wasted children under 5

Targets for 2018 ◆ (calculated based on baseline figures, given the absence of the 2010 data)

Data source: FHB Annual Reports and Annual Health Bulletins

Based on the available data, a simple forecast calculation indicates the current rate of progress will not be able to achieve the set the targets for 2018. However, the steady reduction in both under-5 Stunting and Underweight signals some possibility of achieving the expected outcomes in the near future. Wasting among children still persist to be a concerning health and nutrition issue.

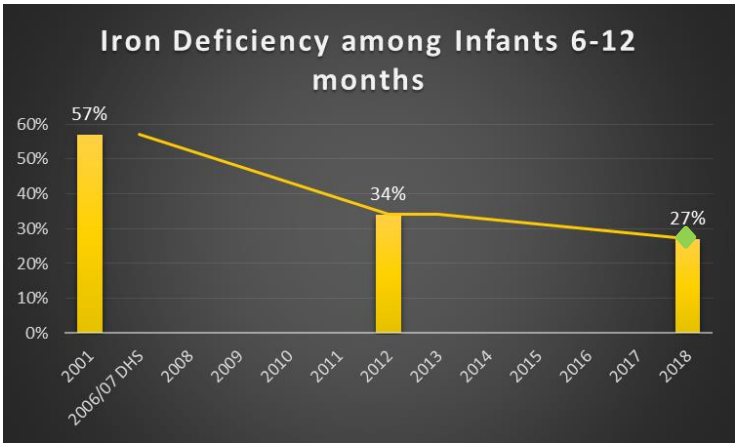


Figure 8: Prevalence of Iron Deficiency Anaemia among infants at 6-11/12 months

Targets for 2018 ◆ (calculated based on 2001 figure)

Data source for 2012 figure – Micronutrient Survey 2012 (sample- 535 children)

Infant and Young Child Feeding (IYCF)

The IYCF country-specific strategy has been developed but is yet to be launched. According to the FHB, the launch will take place in August 2016 during the breastfeeding promotion week. However, public health staff island-wide have been trained based on the IYCF guidelines developed in 2012. Accordingly, field midwives have received the IYCF training and child feeding issues are being discussed at monthly meetings. The training is yet to reach hospital staff which presents a major gap as the first encounter of the mother following the birth of their child happens in the hospital.

Also, the IYCF training is not currently conducted for the medical faculty staff. This in turn can result in unfamiliarity of the strategy among medical students; the future curative staff.

Visit the following link for country-specific IYCF guidelines developed in 2012:

http://www.kln.ac.lk/medicine/depts/publichealth/Fixed_Learning/Nutrition/Guidelines%20on%20Infant%20and%20Young%20Child%20Feeding.pdf

Improving growth monitoring capacity

Public Health Midwives have been trained on both - growth measuring and monitoring. All children are measured for height and weight at the monthly clinic. This was also confirmed by all mothers in the sample. Children suffering from Severe Acute Malnutrition (SAM) are referred to a pediatric clinic for therapeutic feeding.

To understand the capacity of the public health midwives in promoting complementary feeding and growth monitoring, the study planned to present the following questions to all midwives in the areas

covered in the study. However due to study limitations, the sample was limited to just 4 midwives (2 each from Nuwara Eliya and Vavuniya districts).

Questionnaire for Public Health Midwives (PHM)

How often do you receive training on delivering health services to communities?

Have you received training on the following areas?

Training programme	**Yes/No – when, who conducted it? Were they effective?**
Training on feeding sick children (IYCF)	
Growth monitoring and analysis	
Conducting nutritional interventions	
Effective communication	

Box 4: Questionnaire to Public Health Midwives

Results

- All 4 midwives have received the training on IYCF
- Growth monitoring training is conducted yearly
- Annual training is given on conducting nutritional interventions
- Effective communication – daily Tamil language lessons for midwives in the estates (Nuwara Eliya district) conducted by Estate Lanka

To gain further insight, the study interviewed 157 pregnant and lactating mothers on the services received from the PHM. The above questionnaire (Box 4) was restructured and presented to them, for example; *have you received education and training on how to feed your child when he/she is ill?* In addition, the following questions were also presented to them.

- How helpful is your midwife? Are you satisfied with her services?
- How often does she visit you at home and when did you she visit you last?

All 157 mothers communicated that they have been educated on feeding their children when they are ill, that is to give them plenty fluids including 'Koththamalli' and fresh fruit juice. *Is this advice good enough?*

Moreover, although children's growth is measured and monitored in clinics by the midwife, mothers are not given the required knowledge to read their own child's growth card.

Educating mothers on feeding their infants during illness should not be limited to advocating for more liquids to be given. Larger amounts of more nutrition-upgrading knowledge should spill over among the general community, especially because the mother is the first carer who treats the patient at home. That being said, all mothers' responses were very positive when questioned about their experience with the PHM.

Recommendations

- As per the previous recommendation, the issue of lack of complimentary food across the country needs to be addressed urgently through private sector partnerships, to increase production and promote standardisation.
- Monitoring should not limit to children receiving complementary food. Other important areas including minimum diet requirement, dietary diversifications should be focused upon; essentially focusing on the food plate.
- Knowledge and awareness about the IYCF strategy should spill over to all concerned stakeholders including the medical community in academia and the curative sector.
- Higher levels of knowledge should be passed on to mothers – to enable them to study their own child's growth card, to ensure they follow the correct practice when their child fall ill etc.

Case study

A dedicated midwife serving her community to reach high levels of human development…

We met Kanthi during a visit to the Mahagastota estate hospital where we received a warm traditional welcome followed by a tour of the hospital. It was extremely refreshing to see the level of effort exerted by the midwife, staff and the estate community members to maintain high quality standards of order and cleanliness in the hospital.

A separate room (in the hospital) has been reserved for mothers and late adolescent girls in the estate to run a small scale livelihood initiative. We spoke to the girls who were busy at the time making recycled paper bags. Rebecca, a girl who was involved in the initiative informed us about the process; that 6 of them can make 20 bags per hour. At the time, they have completed producing 800 bags of which 100 were sold to the Kelani Valley Tea Centre for Rs. 8 per bag. The bag is made using the Thriposha bags which are been discarded by the mothers in the estate, hard board (to support the bottom of the bag) and some glue. In addition to the paper bag project, the hospital has reserved space for a garden to grow strawberries and flowers. All of this has been initiated under the leadership of Kanthi who knows that upgrading nutrition and sustaining it need to be complemented with enhanced levels of income, especially for women. She also informed us that such initiatives are important to educate and empower adolescent girls who are out of school, to focus them on building better lives for themselves through further education and entrepreneurship.

The FGDs with the mothers and adolescent girls in the estate confirmed the level of care and support rendered by Kanthi who has been a great support system time and time again! The level of concrete education and advice given by Kanthi was evident in the answers provided by the mothers – all 10 lactating mothers interviewed knew the importance of consuming all nutrient supplements during the first 6 months post-pregnancy. The interviews also revealed that pregnant and lactating mothers recognise Thriposha as a Therapeutic food which deterred them from using it to make ‘Aggala’ or any other snack.

Kanthi was proud to show her Tamil proficiency certificate. Her ability to communicate effectively with the community members was confirmed through the group discussions. Her commitment to deliver the best possible service is clear and her words on how she loves what she does ensures prosperity to the people she serves.

Kanthi, PHM – Mahagastota Estate Nuwara Eliya District

Key action area 1.2.4.: Promote psychosocial development of children during early childhood years

The Early Childhood Care and Development (ECCD) programme under the direct purview of the National Children's Secretariat has implemented the following interventions, to recognise nutrition as an integral segment of early childhood.

The development and distribution of nutrition related material for ECCD:

- A child-friendly booklet for pre-school children on nutrition
- A teacher's guide to promote good nutrition habits among children and parents, to be published and distributed in June 2016
- Guidelines to educate and increase awareness among communities and parents on the importance of child nutrition
- Re-printing and distributing educational material (including posters and leaflets) developed by the Nutrition Coordination Division

The National Children's Secretariat plans to conduct pre-school teacher training programmes to facilitate them to grow a pre-school garden. The programme targets to cover all divisions. Cooking demonstrations are included in these trainings.

The Nutrition Coordination Division is currently conducting a national training programme on nutrition education for master teachers and district Medical Officers of Maternal and Child Health (MOMCHs). These officials are expected to pass down the training to pre-school teachers who would then disseminate the knowledge to parents.

To ensure coordinated design and implementation of the ECCD programme, the National Coordination Committee consisting 25 key stakeholders including the FHB, MoH, Ministry of Social Services (MoSS), Children's Secretariat, Nutrition Division, Nutrition Coordination Division etc. is expected to meet once every four months.

It is most certainly refreshing to know about the above interventions and the link other sectors have built to integrate nutrition as a critical call in their strategies. Yet, to ensure the positive impact of these activities, it is important to have a back-referral system in place to monitor the progress of interventions – for instance, a pre and post training test for all master trainers, trainers and community members including parents. In order to encourage nutrition-rich positive behaviour among pre-school children, teachers ought to engage the children in daily fun activities - such as art work on the food plate, food groups, and daily exercise etc. Such interventions can garner a lifetime of positive behaviour since engraving good behaviour is most effective when children and young persons are targeted.

Recommendations

- ❖ Distribute a list of combination of foods children need to bring in their lunch boxes, each tailored according to the district/divisional-specific availability of foodstuff.
- ❖ Engage children in daily fun activities to promote nutrition behaviour. Behaviour change can only really be achieved in the long-term and that is by educating and altering the behaviour of small children and young persons.

Expected outcome 1.3: Morbidity due to ARI and diarrhoea among children under 5 years reduced

Outcome indicators: % Respiratory track infections and % Diarrhoea among children under 5 years

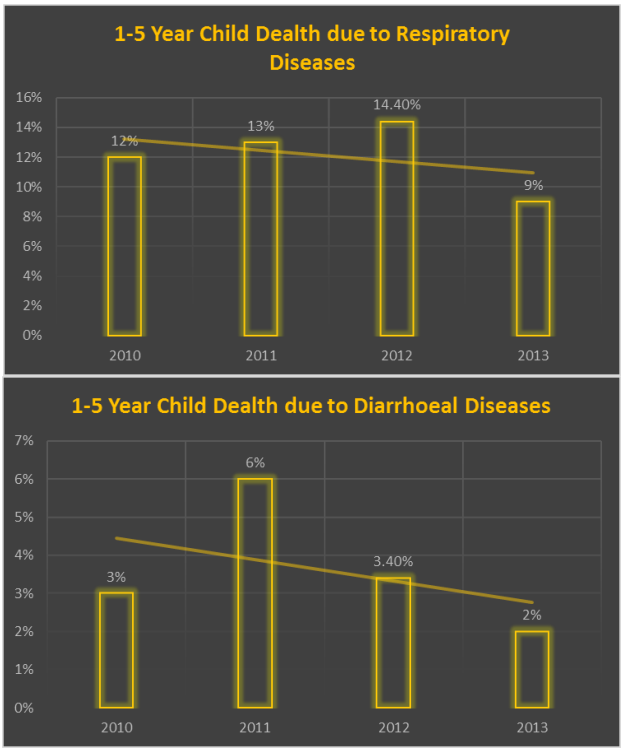
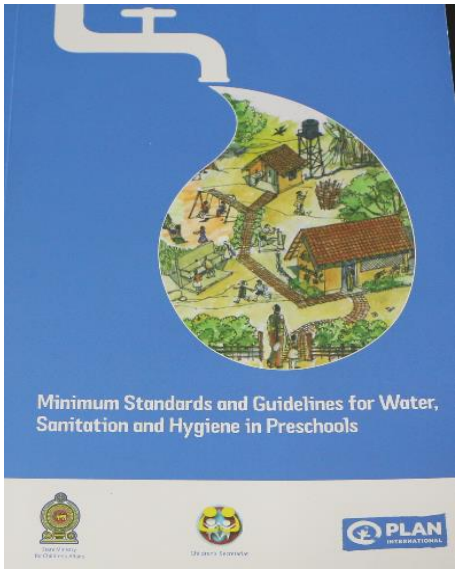


Figure 9: Child deaths due to Respiratory Diseases and Diarrhoeal Diseases

Data source: Annual Health Bulletin Reports

Key action area 1.3.1: Strengthening Integrated Management of Childhood Illness

The National Children's Secretariat in partnership with Plan International has developed a set of minimum standards and guidelines for Water, Sanitation and Hygiene in Preschools. This was launched in December 2015 and is yet to be translated and distributed among preschool teachers.



At the provincial and district level, a total of 100 officers of the Children's Secretariat and the MoH are appointed to conduct the training on these guidelines.

Protected wells, pipe born water, tube wells and bottled water are considered as safe drinking water sources. According to the Census of Population and Housing (2012), 80% households in the country have access to safe drinking water. Moreover, (based on 5% of the sample of the Census of Population and Housing in 2012) 98% of the households have their own toilet facilities with only 1.7% households not using toilets at all.

Picture 1: Front cover of Minimum Standards and Guidelines for Water, Sanitation and Hygiene for Preschools

Regardless of these impressive figures, the officials at the provincial and district level are unhappy about the degree of access to quality water. Further, the officials informed that non-compliance to minimum standards when constructing toilets and water sources stands to be a major cause for concern.

Recommendations

- Distribute the minimum standard guidelines to preschools as soon as possible.
- Ensure the compliance to minimum standards when constructing toilets and water sources.

Expected Outcome 1.4: Malnutrition among school age children, adolescents and youth reduced

Outcome Indicators:

Figure 10: % Stunting and Overweight among Adolescents

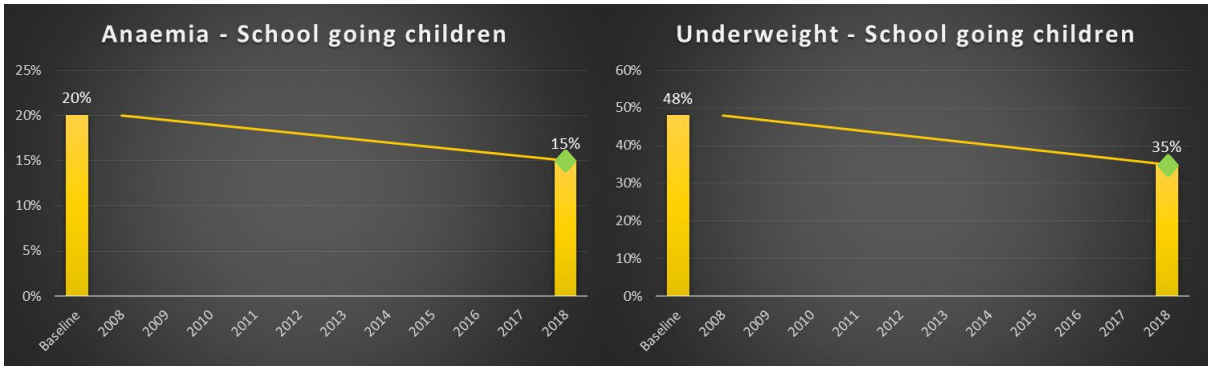


Figure 11: % Anaemia and Underweight among school going children

Targets for 2018 ◆

The study was not able to find data for any of the above indictors.

Key action area: 1.4.1: Create a good nutrition enabling environment in schools

Target group

- School going children

Following are the nutrition-specific and nutrition-sensitive interventions implemented by the Ministry of Education (MoE) in partnership with the Ministry of Health and other relevant stakeholders.

Nutrition-specific Interventions

School Midday Meal Programme - a midday meal to primary school students in selected schools. Currently, the intervention is reached by 1.4 million primary school students representing 55% of the primary school population. School selection criterion is mainly based on the level of malnutrition among children in the respective school. In addition, schools in districts with a high percentage of vulnerable populations, recommended by the Central Bank and the Treasury are also reached. The programme is also supported by WFP.

Milk Glass Programme

Micronutrient Supplementation Programme *is* a 24 week treatment to all school-going children. This intervention was initiated after a study conducted by the Ragama Medical Faculty revealed that iron supplementation maximises the child's cognitive skills. The following supplements are given to all school children in grades 1-13.

Supplement	Quantity	Frequency
Iron	6 milligrams	Once a week
Folic Acid	1 milligram	Once a week
Vitamin C	100 milligrams	Once a week
Mebendazole	500 milligrams	Once in 3 months

Nutrition-sensitive Interventions

Access to safe drinking water, hygiene and sanitation in schools

Currently, 83% schools have access to safe drinking water.

On average, 55% of school's need for toilets has been met. To fulfill the outstanding requirements, the MoE has submitted a proposal to the National Budget which has been approved. Accordingly, the resources have been allocated and the construction of the toilets is underway. Nonetheless, 74 schools island-wide are yet to receive any sort of toilet facilities.

Other health related interventions for school children carried out by Public Health team are outlined in the Public Health Inspector manual and School Health Guidelines.

To review the degree of implementation of the above (especially that of the midday meal and the receipt of the nutrition supplements), the study interviewed 59 mothers and 5 fathers with children in primary school.

Questionnaire to parents with children in primary school

What are the govt. nutrition interventions your child receives in school?

Component	**Quantity**	**Target group**	**Frequency**	**Received (Y/N) (All or score e.g. 4/5)**
Midday Meal	One meal	Primary school students	Daily	
Iron	6 milligrams	All students (from year 1-13)	Once a week for 24 weeks (half a year)	
Folic Acid	1 milligram	All students	Once a week for 24 weeks (half a year)	
Vitamin C		All students	Once a week for 24 weeks (half a year)	
Mebendazole	500 milligrams	All students	Once in 3 months	

Do they receive any other nutrition specific/sensitive interventions in school?

Box 5: Questionnaire to parents of primary school children

Results

- ❖ Majority of the mothers communicated that their children receive diversified, good quality meals. Most schools have a pre-set weekly menu. Meals vary from rice and curry to noodles with gravy and egg, milk rice, string hoppers, roti with sambol etc. In most schools, students enjoy these meals.
- ❖ It was interesting to find that children in one school in Wattala receiving the midday meal while another close-by school with students from similar socio-economic backgrounds not receiving it.
- ❖ Iron supplement is received by students and are expected to drink in school itself. Students in some areas of Mullaitivu district however do not receive this supplement.
- ❖ Vitamin C is received by schools in some areas although most mothers from Mathale and Puttalam weren't aware about the distribution of this supplement in schools.
- ❖ Mebendazole is not received in some schools in Mathale, Puttalam and Kilinochchi. Instead they purchase it from a pharmacy every 3 months for their children. Other districts duly receive it.
- ❖ According to the FHB, the micronutrient supplements are also reached by students in private schools and plans are underway to incorporate this programme into international schools.
- ❖ PHI measures weight and height of children every year and refers the child if these measures need correction. Currently, efforts of the FHB concentrate to empower children to monitor their own growth potentially through the use of BMI calculators. Accordingly, school children will be educated about the indicators and how they (and their families) can take action to correct any inadequacies.

The biggest issue identified was the lack of knowledge among mothers about the micronutrients their children receive and consume in school. Discussions also revealed the gap in knowledge about the importance of their child consuming these supplements. On a more serious note, only 1 of 59 mothers was aware about their child's height and weight and therefore their BMI. Unawareness about these key measures of their child provides parents little indication about the nutrition status of their child. This in turn disables them to take necessary action to correct possible nutrition insufficiencies.

The study also interviewed school going adolescents to determine the degree of implementation of interventions targeting them. In addition to the questions in box 5, the following were presented to 19 school-going adolescents in Ampara, Kilinochchi, Badulla and Nuwara Eliya districts:

1. Are there any health and nutrition related interventions you receive in schools?
2. What is the hygiene and sanitation condition in your school?
3. What can the govt. and other I/NGO partners do to improve your health and nutrition status?

Box 6: Questionnaire to school going adolescents

Results

- Students receive Iron, Folic Acid, Vitamin C and Mebendazole with some district disparity; Folic acid has not reached some schools in Badulla while Mebendazole has not been distributed in Ampara.
- Vitamin C is only received once a month by students in some areas of Badulla.
- Adolescents from Ampara informed us that the PHI screens them for longer term diseases every three years (as per the National Strategy on Adolescent Health).
- All students interviewed expressed that the level of hygiene and sanitation facilities in schools remains to be at a very poor standard.
- During the nutrition month a number of exhibitions including art competitions are hosted in schools to promote good nutrition.

It was evident from the group discussions that children possess minimum knowledge about the micronutrient supplements and their importance. For example, all 8 boys from Ampara had zero knowledge about the names of the supplements and so described them by their colour. This can be the fundamental reason behind the lack of knowledge among parents about these supplements. All students also informed about the poor sanitation conditions in their schools.

The absence of macronutrient distribution to school-going adolescents can be considered a shortcoming to optimising the nutrition status of this category.

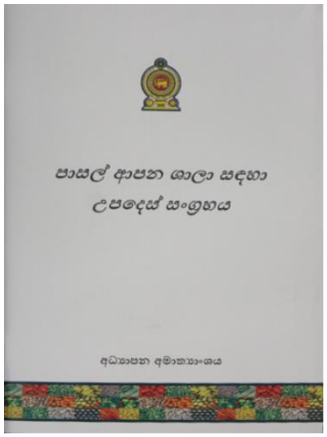
Recommendations

- Educate teachers and thereby students on the importance of consuming micronutrient supplements, especially given the absence of monitoring consumption. This will also aid greater knowledge dissemination among parents.
- Consider the financial and logistical feasibility to extend the school midday meal programme to reach school-going adolescents in selected schools, at least for grades 10-13 to provide children with greater incentive to continue school. If this is out of reach, ensure availability of nutritious and diversified meals at subsided rates in school canteens. In effect, ensure compliance to school canteen policy/guidelines.

As a major activity outlined in the policy, a new circular and guidelines have been developed on the School Canteen Policy which have been distributed to school principals island-wide.

In line with another policy call, the Health and Nutrition Promoting
School Curriculum is subjected to revisions, to include more nutrition related content.

- In 2015, the revised version of the curriculum for grades 6 and 10 have been printed and distributed to all schools.
- Currently (in 2016), the revisions for grades 7 and 11 are underway.
- In 2017 and 2018, curriculums of grade 8 and 9 are expected to be revised and distributed, respectively.



Picture 2: Front page of guidelines for school canteens

Key action area 1.4.2: Enhance the delivery of nutrition services to non-school going adolescents & Key action area 1.4.3: Regular nutritional status assessments of non-school going adolescents

Target group

- Out of school children and adolescents

A non-school going adolescent can be defined as a child between ages 10-18 who is not attending a registered school.

The sample included 15 non-school going adolescents who are currently not registered at any other institution including university, training college or work place. The study questioned them about the nutrition related interventions they receive from the state and other organisations. All 15 children communicated that they receive '*nothing'*.

A stakeholder interview with the FHB revealed the absence of a standardised and systematic national level intervention for non-school adolescents. Instead, the intervention for this target group is currently limited to be processed during the national nutrition month of June. Nonetheless, the intervention can be considered as a pilot step towards designing a national level nutrition programme for non-school going adolescents.

The following forms (see below) present the guidelines for midwives to carry out the intervention in June 2016.

During June, midwives are advised to identify and track non-school going adolescents when carrying out their daily jobs and intervene accordingly. This year's programme aims to correct inappropriate BMI of the targeted adolescents. In most instances, such children will be recognised during home visits and in clinics. This intervention which has been carried out for the past 3 years has had limited

success in receiving replies (completed forms). However, increased efforts of the FHB expect a higher response rate this year.

Guideline for Nutrition Month – June 2016

Format 10 and 11:

Activity 01 - Weekly Iron Folate Supplementation

- Conduct awareness programs for adolescents to encourage consumption iron rich foods (especially animal food) as a measure of prevention of anaemia.
- **Iron, folate, Vitamin C supplementation (WIFS) should be given to all non-school going children 10-19 years of age.**

One tablet of Ferrous sulphate	**200mg**
One tablet of Folic acid	**1mg**
One tablet of Vit C	**100mg**

- **It should be given weekly, for a period of 24 weeks, to all children 10-19 years.**
- **Before starting the supplementation, one tablet of Mebendazole (500mg) should be given to all children.**
- **Additional tablet of Mebandazole (500mg) should be given to children at the end of 6 months, at Uva, Sabaragamuwa, Northern, Eastern and Central provinces where worm infestation is more common.**
- Iron folate vitamin C supplementation should be provided for all non-school going children of 10-19 years, **irrespective of BMI** and record the number of children who received the WIFS in the **format 10.**

Activity 02 - Nutritional Assessment:

- PHM should identify ten (10) non-schooling children (Boys and Girls – Mixed Group) between 15-19 years in her PHM area.
- PHM should measure height and weight of those 10 children and calculate BMI
- Interpret their BMI using WHO Nomogramme /Chart in the new CHDR and fill the format 10.
- Carry out appropriate interventions for those children with low BMI **(BMI in Orange and red Zone)** and high BMI **(BMI in pink and purple zone)** and should encourage

them to improve their nutritional status during her follow up visits. Educate how to maintain the ideal BMI, children with normal BMI.

- Health Education for those identified adolescents and their parents by PHM
    a. Locally available nutritive foods
    b. Ways of improving the quality/ calorie content of food.
    c. Health risks associated with junk foods/ carbonated drinks etc....
    d. Importance of giving a balanced diet to adolescent children.
    e. Positive relationship between nutritional status and academic performance.
    f. Promoting exercise and physical activities in both parents and children.
- All the activities carried out should be reported to MOH at months conference and information should be shared among other PHMs.
- MOH should monitor and evaluate these interventions at monthly conferences.

    - PHM should fill up **Format 10** and send it to MOH before **15th September 2016.**
    - MOH summarize the data of format 10 and fill the **format 11.**
    - Send the completed Format 11 to MOMCH/RDHS and Adolescent Health Unit, Family Health Bureau **on or before 31st October 2016.**

- If the RDHS does not supply the micronutrients, self purchasing of iron folate should be encouraged.
- The prescriptions should be provided by the MOH for those who need to get supplements from outside.

Format 10

Nutrition Month – 2016 June

RDHS Area: ..... MOH Area: .....
PHM Area: .....

Activity 01:

- PHM should distribute 24 weeks Iron Folate therapy among **all out of school children** (who haven't received Iron supplementations this year) **age 10-19 years,** in your area and fill the table below.
- **Iron, folate, Vitamin C supplementation (WIFS) should be given to all non-school going children 10-19 years of age.**

One tablet of Ferrous sulphate	**200mg**
One tablet of Folic acid	**1mg**
One tablet of Vit C	**100mg**

- **It should be given weekly, for a period of 24 weeks, to all out of school children of 10-19 years.**
- **Before starting the supplementation, one tablet of Mebendazole (500mg) should be given to above all children.**
- **Additional tablet of Mebandazole (500mg) should be given to children at the end of 6 months, at Uva, Sabaragamuwa, Northern, Eastern and Central provinces where worm infestation is more common.**
- **Please make a follow up visit after 3 months and inquire about compliance, side effects/any problems and inform MOH or FHB if any,**

No. of Male children (out of school) received iron supplementation.	
No. of Female children (out of school) received iron supplementation.	

Remarks on drug availability/ side effects/ issues related to compliance:

.....
.....
.....

Activity 02:

- PHM should select **10 non-school going adolescents (Boys and girls-mixed group) in the age group of 15-19 years** in her MOH area.
- Measure height & weight, calculate BMI and record it.
- Teach and empower them how to calculate BMI and how to interpret and record them. (Use adolescent growth charts in the new CHDRs or WHO Nomograme to interpret BMI)

  Eg.- Low BMI **(BMI in Orange and red Zone)**

  High BMI **(BMI in pink or purple zone)** –Refer to hospital for Metabolic Screening.

- Do the recommended nutrition interventions (WIFS) for **all 10 of them** and complete the following table.

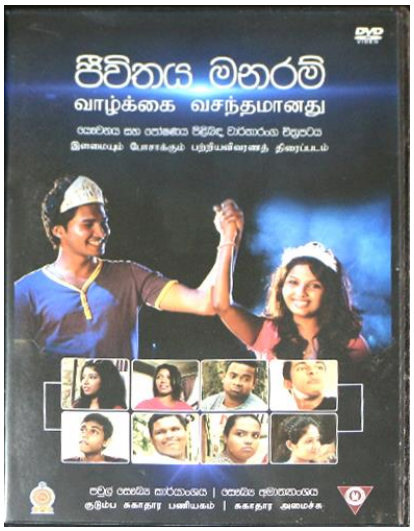
Males			**Females**		
Low BMI	Normal BMI	High BMI	Low BMI	Normal BMI	High BMI

....

Signature of PHM Date

PHM should fill this format and **send to MOH** before **15th September 2016.**

Furthermore, the FHB has produced a short film to promote nutrition among youth and adolescents which is telecasted on several TV channels during the nutrition month.



Picture 3: DVD of a short film to promote nutrition among adolescents and youth

Recommendations

- Develop a systematic strategy based on the current intervention to ensure optimum nutrition of the non-school going adolescents.
- Effectively increase the use of social media and mobile text messages to reach adolescents and school leavers.

Expected Outcome 1.5: Nutrition related disorders among adult population reduced

Outcome Indicators:

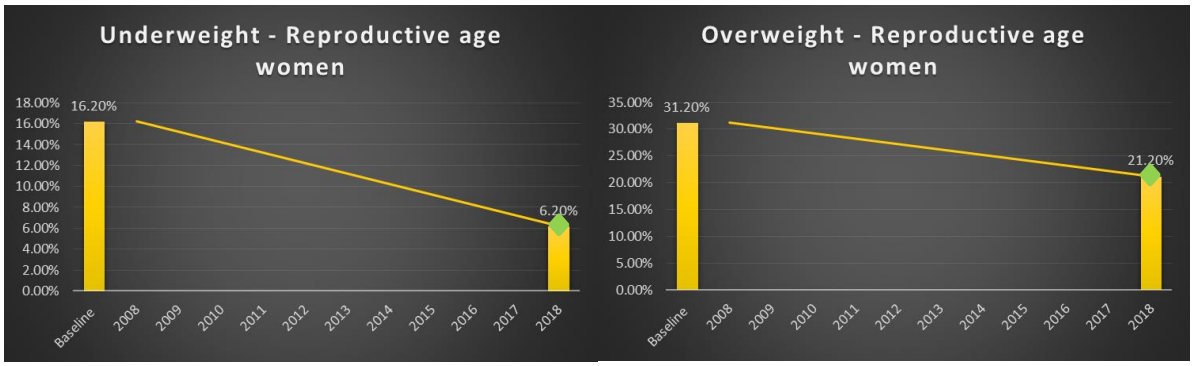


Figure 12: Percentage of reproductive age women Underweight and Overweight

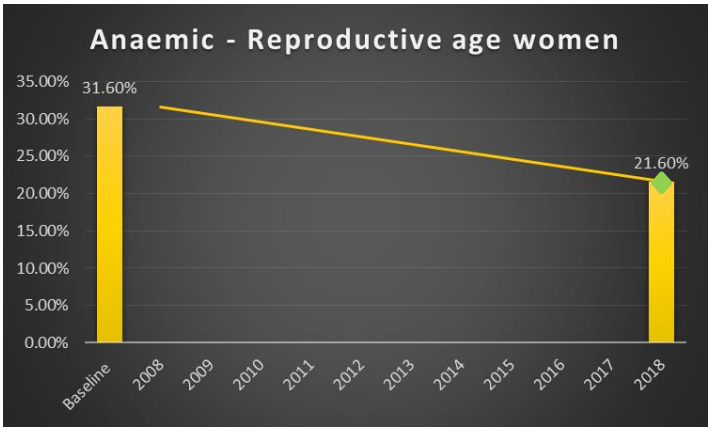


Figure 13: Percentage of reproductive age women Anaemic

Targets for 2018 ◆

The study was not able to find data for any of the above indicators.

Key action area: 1.5.1: Regular nutritional status assessments of adults and elderly

The Ministry of Health recently (in 2016) published the Non-communicable Diseases Strategy which outlines the plan of action for 2016-2020 to reduce the level of non-communicable disease prevalence in the country. The strategy outlines a number of interventions to adjust adult behaviour on the modifiable risk factors including diet and exercise.

An interview with Youth, Elderly and Disabled Division of the MoH revealed that the country currently lacks systemic nutrition interventions reaching the elderly. The action plan to promote nutrition through the Elderly Health Policy too is yet to be implemented. Further, there are no IEC

materials developed to promote good nutrition among this target group and district officers responsible for the health and nutrition of the elderly are non-existent.

Enhancing good nutrition in elderly homes is challenged given tight budgetary allocations by the state. As a result, these elders mainly depend on private donations and 'alm givings'. Sri Lanka Standards Institute (SLSI) has developed minimum standards for elders' homes to ensure the supply of nutrition-rich foods. The degree of compliance to these standards is yet to be determined.

Recommendations

- Assess the diet of people in institutions including elders' homes, rehabilitation centers etc. to ensure the consumption of vital food groups.
- Conduct a detailed study to identify the nutrition status of the elderly and the systems available to support them.

Key action area 1.5.2: Updating and implementing national food-based dietary guidelines

Sri Lanka first published her food-based dietary guidelines in 2002. The Nutrition Division of the MoH in partnership with the World Health Organisation revised these guidelines and published the second edition in 2011 which is available at:

http://203.94.76.60/departmnt/NutritionDivision/Nutrition%20Guidelines/FBDG-English.pdf

Other publications by the Nutrition Division include:

- Booklet for Buddhist priests to lead a nutrition-rich life
- Nutrition Education Guide for Health Volunteers in 2014 in partnership with World Vision Lanka

Key action area 1.5.3: Formulate, disseminate and implement guidelines for healthy work place which includes an effective component on nutrition

In 2013, the Nutrition Division in partnership with the WHO developed and published a set of guidelines for canteens at work places to ensure the availability of nutritious food. These are however yet to be disseminated and implemented on a full-scale.

Picture 4: Front cover of guidelines for canteens at work places

The Nutrition Division informed about their plans to carry forward the training for food and drug inspectors to monitor compliance.

Recommendations

- Work alongside the private sector businesses to encourage and facilitate the implementation of nutrition-rich canteens while emphasising the grave need to so (the increasing prevalence of non-communicable diseases) and the long-term benefits to them (financial and reputational) and the society.
- Make it mandatory for state organisations to implement and comply with the canteen guidelines.

Policy Objective 2: Enhancing capacity to deliver effective and appropriate interventions

Expecte -d outcome	Key action areas	Major activities	Degree of implement -ation	Outcome indicators	Baseline	Target	Targe -t status	Responsi- ble Organisa tions
2.1 Stakeholder capacities on delivering nutrition services improved	2.1.1 Promote behaviour change among all sections of population and enabling them to make right food choices and care practices	2.1.1.1 Building capacity on nutrition promotion in the preventative and curative sector and health and nutrition workers on effective communication		% of health workers (PHM, PHI, HENO) reached competence level	N/A	85%		HEB, FHB, MRI
		2.1.1.2 Promote development of behaviour change communications plans at district, divisional and health worker level		% of BCC plans being implemented	N/A	80%		
		2.1.1.3 Build partnerships with the corporate sector to promote good nutrition						
		2.1.1.4 Implement a media surveillance programme to ensure an ethical advertising		No of media channels reviewed monthly	N/A	40%		
	2.1.2 Build and empower the community organisations, in programme planning, implementation and monitoring of nutrition intervention programmes	2.1.2.1 Implement an evidence based community nutrition package through community workers		No GSN divisions implement the package	N/A	60%		Provincial Health Administration
	2.1.3 Improving infrastructure facilities at all levels	2.1.3.1 Increasing infrastructure facilities available for nutrition promotion activities		% of resources centers at MCH clinics hospitals developed	N/A	60%		
		2.1.3.2 Improving tools and media for effective communication		No. of communication materials developed	N/A	100		
		2.1.3.3 Improving mobility to deliver effective nutrition programmes		% of transport available – PHM, PHI, PHNS, MOH, HEO	N/A	100%		
	2.1.4 Effect a behaviour system at all levels	2.1.4.1 Implement an evidence based nutrition related behaviour surveillance system for different levels of the community		% of behaviour surveillance programs conducted annually at community, PHM & MOH level	N/A	60%		

Activity Implementation Colour Codes	*Target Status Colour Codes*
Activity Completed	Target achieved
Activity Ongoing	Target likely to achieve
Activity yet to be implemented	Target unlikely to achieve
Degree of implementation of the activity cannot be determined	Target highly unlikely to achieve
	Cannot be determined (determined based on a simple forecast calculation of the available data)

Expected Outcome 2.1: Stakeholder capacities on delivering nutrition services improved

Key action area 2.1.1: Promote behaviour change among all sections of population & enabling them to make right food choices and care practices

Building capacity of health and nutrition workers for effective communication

The Health Education Bureau (HEB) has made it a priority action to render effort to enhance the communication capacity of midwives amongst other healthcare workers. Master trainers; *the trainers of trainers* are required to participate in the training programme conducted by HEB, which is later carried forward into communities. The training for midwives and thereafter the communities are supervised by Health Education Officers in all 25 districts. Further support to midwives is extended through the Information, Education and Communication (IEC) materials developed by the HEB.

Moreover, midwives in the estate sector (Nuwara Eliya district in particular) are expected to attend Tamil Language lessons conducted by Estate Lanka followed by a year-end examination. Successful candidates are awarded a proficiency certificate. The aim is to facilitate Sinhala speaking midwives to communicate more effectively with local communities when serving them. In fact, the requirement to obtain the Tamil Language proficiency certificate has been widespread to all govt. servants.

It is fair to say that aforementioned efforts have been justified through the responses gained during the FGDs where all interviewed pregnant and lactating mothers expressed their appreciation towards their midwives who communicate with them in a friendly and effective manner. The community interviews also evidenced that much of the nutrition related knowledge they possess was passed on by their area PHM as opposed to other sources including mass media. Nonetheless, it was noted that language barriers persist to be a pressing issue in delivering a quality service to the people. For instance, the FGDs in the Ampara district (predominantly consisting Tamil speaking communities) revealed that all 3 doctors in the divisional hospital are Sinhala speakers. The doctor who is deemed to be trilingual seemingly finds it difficult to comprehend patient issues. Additionally, the group discussions also

revealed the limited availability of doctors in the hospital during convenient hours for the people who are daily-wage earners and labourers.

Recommendation

- ❖ Ensure that doctors' and other health care providers' working hours tally with the health seeking behaviour of the community.

In a country with just 2 national languages, it is plausible to expect proficiency is both Tamil and Sinhala by the health service deliverers; to understand people's health issue which is fundamental to ensuring people's right to good health.

Promoting Behaviour Change Communication (BCC) plans

According to all Provincial Directors of Health Services and three Government Agents, there is no information gathered in the existing information systems on behaviour changes related to nutrition. Social Marketing to improve food and nutrition behaviour is yet to be implemented. This can be considered a major gap in the implementation of the national policy given Sri Lanka's crucial demand for positive behaviour to ensure effective responsiveness to the nutrition interventions delivered - positive responsiveness by the people is the only way to identify the workable from the impracticable interventions.

Building partnerships with the corporate sector

A business network on promoting good nutrition is yet to be mainstreamed in the national strategy. Nevertheless, country programmes of several I/NGOs have taken the initiative to build partnerships with the corporate sector to scale up the nutrition status of Sri Lanka. For example, Save the Children International currently partners with 4 corporate sector organisations to promote good nutrition through good business in the tea estates across seven districts.

Engaging with the business community (i.e. the private sector) has become increasingly important to mainstream good nutrition in to people's lives. Today media plays a significant role in promoting unhealthy eating habits and foods, and the degree of media surveillance in the country is an outstanding grey area. To promote the production and availability of more nutritious foods, it is vital for the government to work closely with the private sector. This way the education and awareness disseminated among the people will actually be put in to practice with consumers changing their buying behaviour to include more nutrition-rich foods and less unhealthy foods in their shopping baskets. Understandably, this is not something which can be achieved during a short time period. Nonetheless, setting up the business network to engage with food companies is urgently called for. Remember!, is it impossible to promote healthy behaviour in the absence of tools – good food need to

be made available abundantly at the right price for people to easily access and consume them. Engagement with the business world is integral to achieving this and such is also important to realise the effectiveness of the national nutrition interventions.

Policy objective 1 recommendations for enhancing the Thriposha programme presents a good opportunity to initiate a coherent and strategic partnership with the business sector.

Such partnerships are also critical for CSOs and other development organisations, especially given the current context of declining external funds flowing in to the country for development. More crucially, the partnerships can also promote increased responsibility within the corporate world to engage in ethical trade.

Implement a media surveillance system

Sri Lanka currently lacks a systematic media surveillance system. The Food Advisory Committee (FAC) of the Food Control and Administration Unit (FCAU) acts as the key responsible body in ensuring ethical advertising. However, according to the current system the FAC will initiate to screen an advertisement/show only if they receive a complaint. Following a complaint, it takes on average 2-3 months and during that time; *the advertisement has done its damage!*

Since media is *money driven*, it is understandable that building a uniform and regular process is rather a challenging task. Absence of clear margins as to what is good food and bad food complexes this challenge. The HEB however did admit that the existing system demands for a review in the near future.

The FCAU also informed about the presence of officers island-wide to monitor advertising.

Recommendations

- ❖ Design and implement workable Behaviour Change Communication Plans to promote healthy behaviour and lifestyles.
- ❖ To eliminate the language barrier, explore the possibility of re-testing the language ability as opposed to a one time test in order to improve the quality of the service delivery.
- ❖ Recognise the important role the private sector play in promoting nutrition and their capacity to advertise. Establish business partnerships to ensure the production of differentiated nutrition food – to ensure the availability of them at affordable prices. The businesses who agree to do so can be incentivised financially – possible tax cuts? Recognition awards for best practice – for improved marketing image
- ❖ Revise the media surveillance system –this need to be a continuous monitoring process – allocate human resources responsible specifically to carry out this task. The media unit of the MoH should work closely with the FCAU.

Key action area 2.1.2: Build and empower the community organisations, in programme planning, implementation and monitoring of nutrition intervention programme

Implementing evidence based community nutrition package

All provinces follow the national guidelines based on evidence collected from the quarterly 509 data and the data collected during the nutrition month. Progress is being analysed against the national and provincial indicators. Based on needs assessments, tailored interventions are carried out at the district and provincial levels. These special interventions also depend on the donor required outcomes. Approval to carry out special district level interventions is obtained at the national level, that encourages the provincial and district level officials to be leaders in the design and implementation process.

On the topic of empowering community organisations, the HEB along with a number of I/NGOs and CSOs exert effort in to building capacity of Mother Support Groups who act as key change agents within their communities in promoting healthy lifestyles. The Provincial Director of Health Services of North Central Province communicated how the midwife liaises with Mother Support Groups in the periphery to widespread nutrition-related messages, to disseminate more knowledge among communities. More than 300 mother support groups in the province, each consisting 10-15 mothers' advices communities on quality food consumption, complementary feeding etc. and even monitors under-5 children and identify their nutritional status.

However, monitoring of key interventions even by community organisations is yet to be effected.

Recommendations

- ❖ Capacity building of CBOs to become change agents and take the responsibility to monitor the progress of the interventions at the community level.
- ❖ Expand the Mother Support Group concept island-wide and include men in these groups and rename it as Family Support Groups.

Key action area 2.1.3: Improving infrastructure facilities at all levels

Increasing infrastructure facilities available for nutrition

According to the PDHS of the Western Province, the province's health system is currently facing a pressing issue of declining quality and safety of clinic centers. The central contributor to this issue is the external ownership of these centers - they are not owned by the MOH. Therefore when infrastructure facilities require renovation, it is outside the mandate of the provincial ministry to carry out the needful, to undertake the demanded renovations. As a result, the province is endowed with poor quality clinics. Further, moving the clinic to another location does not pose as a plausible solution given the budgetary restrictions coupled by the potential difficulties mothers and children could face in visiting the new centre.

Moreover the PDHS of the North Central Province informed that although a fair amount of funding has been allocated to improve the infrastructure, his concerns lie with the non-compliance to minimum standards when constructing certain buildings and other health infrastructure facilities. In other provinces (according to the respective PDHS), development of infrastructure related to health and nutrition are viewed to be at a satisfactory level which are experiencing continuous improvements.

Recommendations

- ❖ Improve access to clinics. In response to the gravest difficulty faced by mothers and children, consider the possibility of having clinics in each PHM area.
- ❖ Revise contract agreements with lessors of the property used for clinics, to clearly outline the responsibilities of renovation which pose to be safety hazards.

Improving tools and media for effective communication

The Health Education Bureau is the primary body responsible for the development of IEC material to promote health and nutrition education. In addition to the various number of IEC materials developed, the bureau has also produced 3 short films which targets to promote good nutrition among communities in the estate (plantation) sector. Further efforts have been rendered to integrate mass media to communicate good health and nutrition practices. For example, the HEB have invested in television spots to communicate the benefits of iron intake. Additionally, in 2014 the HEB developed 9 stickers each promoting the importance of reducing salt, sugar and fat intake, drinking water instead of soft drinks, eating more vegetables and fruits, the importance of the family having meals together and daily exercise among adults and children. The stickers were displayed on public transport vehicles including buses and trains. The campaign will follow-up this year (2016) with HEB planning to reprint the stickers.

Furthermore, during the annual nutrition month and the breastfeeding week, HEB makes it a priority action to host media seminars, to educate media organisations on the importance of disseminating knowledge to the public on certain health and nutrition related issues.

Improving mobility to deliver effective transportation

A circular issued was issued outlining the entitlement of midwives to a motorbike, to facilitate them to carry out their duties more efficiently. However, owing to political and resource limitations at the time only few midwives received the motorbike through their local govt. Stakeholders confirmed that many midwives to-date have not received this entitlement. The study was unable to find the availability of transport facilities to other health professionals.

Improving mobile facilities for midwives and other health field staff is crucial given the increasing demand for midwife duties to be carried out effectively and efficiently. The Western Province Director of Health Services revealed that the province lacks 450 midwives that hardly replenishes. As a result, the existing staffs are over-worked. Regardless of the ministry mandate to appoint midwife staff from *in and around* the community itself, the severe dearth of officers disallows the province to comply with this clause. Further, given the rare appointments of new staff, the midwives are hardly awarded transfers – in most instances, leading to job frustration resulting in poor quality service delivery. Currently a midwife in the urban area serves a 7000-8000 population as opposed to the set norm of 3000. *You cannot expect them to deliver quality work and results if they are overloaded.* A similar situation was revealed by the PDHS of the North Central province which reports a shortage of 182 midwives leaving the existing carder to serve an average population of 6000. Phase 1 of the study revealed the total deficiency of 1750 midwives which pose a serious issue.

Majority of the FGDs proved that field midwives stand to be the key primary level strength of the govt. healthcare programme. Therefore it is important to ensure that this cluster is *taken care of* in terms facilitating them to carry out their job neatly – access to transport facilities and other hardware, followed by rewards and incentives for good performance. Studies indicate that performance-related pay contributes to much greater efficiencies in delivering high quality services.

It is also important for the PHMs to understand the credibility of their service lies on home visiting and tailored-care given to women and children. Therefore regardless of the facilities available, the PHM should continue to deliver quality care through home visits.

Recommendations

- Assess and re-design the training of the PHM against their field duties.
- Either demarcate lesser population to the PHM or appoint a social worker to each GN division who can care for the elderly and disabled so the PHM will only focus her efforts on mothers and children.

Key action area 2.1.4: Effect a behaviour surveillance system at all levels

Implementing evidence based nutrition related behaviour surveillance system for different levels of the community

To-date Sri Lanka has limited its behaviour surveillance surveys to monitoring HIV and AIDS related behaviour. Thus an *evidence based nutrition related behaviour surveillance system* is yet to be implemented. The ministry can utilise the experience of BCC of HIV to establish a nutrition behaviour surveillance system. However, some cross-sectional data and information have been extracted while conducting general nutrition surveys and pilot studies. The HEB extracts some information through FGDs which are evaluated against selected behaviour indicators. Overall however, behavioural communication plans and the behaviour surveillance system is yet to be fully integrated into the national and provincial strategies and plans.

Policy Objective 3: Ensuring effective management of adequate nutrition to vulnerable populations

Expected outcome	Key action areas	Major activities	Degree of implementation	Outcome indicators	Baseline	Target	Target status	Responsible Organisations
3.1 Disparities in national status reduced	3.1.1 Ensure targeting of nutritional interventions to underserved areas, plantation community, urban poor and conflict affected areas	3.1.1.1 Baseline surveys for vulnerable populations to identify causes for vulnerability		Under 5 year wasting and stunting % at district level	District specific levels published in DHS 2006	Districts with higher levels of stunting and wasting than the national average to reach national levels		Director E&U Health, Director Nutrition Division, MRI
		3.1.1.2 Strengthen nutrition surveillance system in order to obtain timely information on vulnerable populations						
		3.1.1.3 Build capacities and formulate mechanisms to access resources to target specific nutrition intervention programs to vulnerable communities						Provincial Health Administration
3.2 Quality of life of patients improved through optimum nutrition interventions	3.2.1 Establishing an effective hospital nutrition system	3.2.1.1 Formulate and disseminate nutrition guidelines for in and out patients as well as patients living with chronic non-communicable diseases including HIV and AIDS		Percentage of hospitals using nutrition guidelines	0%	50% of each category of hospitals using nutrition guidelines		
		3.2.1.2 Ensuring optimal hospital based diet for in patients						
		3.2.1.3 Develop human resources and infrastructure capacities within hospitals from nutrition promotion to palliation						

Activity Ongoing Cannot be determined

Expected outcome 3.1: Disparities in nutritional status reduced

Outcome indicator – under 5 wasting and stunting % at district level

Table 12. Nutritional status of children (Excluding Northern Province)

Percentage of children under five years classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, by background characteristics, Sri Lanka 2006/7

Background characteristic	Height-for-age		Weight-for-height		Weight-for-age		Number of children
	Percentage below -3 SD	Percentage below -2 SD	Percentage below -3 SD	Percentage below -2 SD	Percentage below -3 SD	Percentage below -2 SD	
Age in months							
<6	2.5	9.7	6.8	15.8	2.8	12.1	548
6-8	2.2	9.5	2.6	10.4	1.9	12.0	309
9-11	4.5	15.6	2.2	11.9	4.7	15.6	398
12-17	5.0	18.6	1.8	13.4	2.3	18.5	695
18-23	5.3	22.7	2.9	15.9	4.2	22.9	677
24-35	5.1	21.9	3.1	14.6	4.2	23.4	1,339
36-47	3.8	19.8	2.4	15.1	4.0	24.9	1,363
48-59	3.6	15.7	2.7	17.5	4.3	25.3	1,318
Sex							
Male	5.0	18.7	3.2	16.4	3.9	22.3	3,436
Female	3.3	17.2	2.7	13.6	3.6	20.8	3,212
Residence							
Urban	2.9	13.7	3.4	14.9	3.0	16.6	855
Rural	3.5	16.7	2.8	15.2	3.5	21.7	5,348
Estate	15.3	42.2	3.6	12.6	8.7	29.7	446
District							
Colombo	1.4	8.4	2.1	13.2	1.5	14.1	831
Gampaha	1.2	10.0	2.4	10.9	2.3	11.6	675
Kalutara	3.1	15.9	1.8	12.1	4.3	16.9	357
Kandy	2.4	18.1	2.1	15.7	4.4	25.3	449
Matale	6.7	19.2	2.5	11.8	4.8	23.2	188
Nuwara Eliya	13.5	40.8	2.0	10.5	5.4	25.3	346
Galle	2.5	16.0	1.1	14.3	2.0	23.2	319
Matara	2.7	14.8	2.9	17.4	2.0	23.3	320
Hambantota	5.8	18.8	3.7	20.9	4.2	23.8	206
Batticaloa	7.7	24.4	6.7	19.4	5.5	27.5	272
Ampara	2.7	14.1	4.7	19.3	2.1	22.0	322
Trincomalee [1]	11.3	30.5	10.2	28.1	6.4	27.8	192
Kurunegala	4.2	18.6	2.8	13.3	3.9	20.6	381
Puttalam	1.4	14.0	1.2	11.7	1.9	19.2	236
Anuradhapura	2.5	15.3	3.4	14.6	2.9	25.0	264
Polonnaruwa	0.6	16.0	3.2	17.9	5.3	25.6	188
Badulla	8.7	33.1	3.7	17.5	7.0	32.8	352
Moneragala	7.4	21.7	3.9	19.8	7.8	26.6	230
Ratnapura	5.5	19.3	2.9	12.3	5.5	23.9	292
Kegalle	2.8	17.5	1.2	15.6	4.0	23.3	230

Data Source – DHS 2006

Table 6: Prevalence of under nutrition: stunting, wasting, underweight, overweight among children aged 6-59 months, by districts

Background characteristic	Height-for- age (%)		Weight-for-height (%)			Weight-for-age (%)		Total No of Children
	<-3SD severe	<-2SD stunting	<-3SD SAM	<-2SD Wasting	≥+2SD Over weight	<-3SD severe	<-2SD underwt	
Colombo	1.7	8.0	0.7	17.0	1.0	2.4	16.3	288
Gampaha	1.0	9.4	1.0	18.5	0.3	0.7	21.7	286
Kalutara	1.4	**6.8**	0.4	15.8	**1.8**	1.8	**15.8**	278
Kandy	2.1	15.7	1.7	20.2	0.3	3.5	24.7	287
Matale	2.1	14.9	3.1	22.2	0.3	5.9	28.5	288
NuwaraEliya	**4.9**	**23.8**	1.4	16.4	0.3	7.0	26.6	286
Galle	2.6	13.6	2.9	18.8	0.7	3.7	22.4	272
Matara	0.7	13.6	3.1	20.4	1.0	3.1	25.2	294
Hambantota	1.4	9.5	3.1	24.4	0.3	4.4	20.3	295
Jafna	1.0	10.1	2.3	18.8	0.7	4.0	19.8	298
Mannar	3.0	17.4	4.7	22.1	0.0	5.4	28.2	298
Vavuniya	2.4	19.9	1.4	21.9	0.3	6.8	28.4	292
Mullaitivu	2.4	17.6	6.1	27.8	0.7	7.8	35.6	295
Kilinochchi	2.3	18.1	**5.0**	**34.9**	0.0	**8.1**	**40.9**	298
Batticaloa	2.7	14.5	4.7	20.2	1.3	5.7	27.9	297
Ampara	4.3	19.3	5.3	20.7	0.7	7.3	28.7	300
Trincomalee	2.0	18.8	5.8	25.6	0.0	7.5	32.8	293
Kurunegala	2.7	14.5	2.0	20.6	0.7	4.4	24.7	296
Puttlam	1.4	11.3	1.4	**14.0**	0.7	2.7	18.8	292
Anuradhapura	0.7	10.4	3.4	18.5	0.7	4.7	22.2	297
Polonnaruwa	0.3	14.8	4.4	25.9	0.0	5.1	30.6	297
Badulla	3.4	22.3	2.1	16.4	0.7	5.1	26.7	292
Moneragala	2.0	14.2	3.7	28.8	0.3	4.4	30.2	295
Rathnapura	1.3	13.8	2.7	21.5	0.3	2.7	28.3	297
Kegalle	2.0	12.5	3.4	20.3	1.0	5.8	25.8	295
Sri Lanka*	**2.0**	**13.1**	**2.3**	**19.6**	**0.7**	**3.8**	**23.5**	**7306**

Data Source – Micronutrient Survey 2012

A brief analysis of the above tables indicate Nuwara Eliya district (plantation community) that reported the highest under-5 Stunting prevalence at 40.8% in 2006 (well above the national average of 17.3%) also reported the highest in 2012 at 23.8%, once again above the national average of 13.1%. Highest number of Wasting of 34.9% (almost two times the national average) was reported from the Kilinochchi district (a conflict affected area) in 2012. Further, all conflict affected districts (except Jaffna) reported higher averages of both Stunting and Wasting in 2012 compared to the national average. The Colombo district (urban areas) too reported a high Wasting prevalence of 17% in 2012 although the Stunting prevalence in the district seems to be *under control* (8% in 2012 compared to the national average of 13.1%).

3.1.1. Ensure targeting of nutritional interventions to underserved areas, plantation community, urban poor and conflict affected areas

Baseline surveys for vulnerable populations to identify causes for vulnerability

According to the Medical Research Institute (MRI), there are no specific National Surveys and Causal Analyses carried out in areas with vulnerable populations. Such data is extracted and processed when conducting the overall data surveillance system. The UN organisations fund the MRI to carry out island wide baseline surveys which in deed covers all areas including those with vulnerable populations. For instance, the recently concluded Pregnant and Lactating Mothers Micronutrient Survey 2015 conducted by MRI and funded by the UN covered all 25 administrative districts. Moreover, plans are underway to conduct a baseline survey for school children, once again funded by the Sustainable Development Goals project of the UN in Sri Lanka. Nevertheless, a number of international organisations have carried out several baseline surveys specifically in the post-conflict reconciliation areas and the estate sector. The World Bank Group's recent (2015) nutrition survey in the estate sector is a good example.

This study however did not find any baselines surveys carried out specifically in the urban slum area.

Strengthening the nutrition surveillance system

The National Nutrition Surveillance System launched in 2012 is currently under revision to strengthen data collection, analysis and reporting. A pilot programme under the direct purview of the Nutrition Coordination Division is currently underway in the Nuwara Eliya district which plans to train officials from all related sectors on data reporting. The aim is to make timely data available to all stakeholders, to promote utilising data when planning and developing nutrition related strategies and action plans.

Also refer Policy Objective 6 analysis.

Targeting specific nutrition intervention programmes

The Monaragala district is identified as one of the lowest performers in development both in terms of income and multidimensional poverty indicators. Thus vulnerability in this district can be considered at its highest. In response, the MoH in partnership with other sectoral ministries has intervened to implement tailored community empowerment programmes in the most vulnerable areas in the district. These programmes aim to educate and train the local communities to build livelihoods utilising the resources they endow, therefore support income generation. In addition, knowledge and awareness of good health and nutrition is disseminated throughout the district. Moreover in 2011, the Multi-Sectoral Action Plan (MSAP) was piloted in Monaragala and Nuwara Eliya districts to ensure the effectiveness of interventions in having a concrete impact in these underserved areas. Following its implementation, an evaluation study was conducted to determine the effectiveness.

Similarly, much of state and non-state efforts have been streamed to uplift the development status of communities in the post-conflict reconciliation areas in the Northern and Eastern parts of Sri Lanka. For example, the UN organisations including WFP and FAO jointly with the government have invested substantially in upgrading the food and nutrition levels of people in the most affected areas of these provinces. Many I/NGOs including Save the Children International, World Vision Lanka and ChildFund have worked alongside the govt. to upgrade the nutrition status of plantation communities. In contrast, the level of tailored nutrition interventions going in to the vulnerable people in the urban slum areas is perceived to be at is minimum or possibly non-existent.

As a whole, Sri Lanka calls for much greater efforts to target many current interventions which currently follow a blanket approach. For instance, the Rs. 20,000 food allowance intervention for pregnant mothers can be made more effective if distributed to the neediest mothers – they can be given the allowance more regularly and even can increase the per capita amount which will enable the most disadvantaged mothers to purchase more nutrition-rich foods. In effect, all national resources should be allocated in a manner to achieve the expected target and so efforts need to focus on those who need to be to be *rescued* and not on those who are already stand above the expected standards.

Expected outcome 3.2: Quality of life of patients improved through optimum nutrition interventions

Guidelines to patients on non-communicable diseases

The Nutrition Division in partnership with UNICEF published Dietary Guidelines and Nutrition Therapy for Specific Diseases in 2014 found at http://www.health.gov.lk/en/publication/Dietaryguidlines.pdf. Given the absence of a monitoring mechanism to identify if the guidelines are used, the dissemination of this knowledge among hospital staff and therefore patients is suspected to be limited.

Ensuring optimal hospital based diet for in patients

Although the study group recognises the importance of the hospital diet, study limitations constrained the investigation of this activity's degree of implementation.

Human resources and infrastructure capacities within hospitals from nutrition promotion to palliation

In 2015 much of Nutrition Division's efforts were focused on developing and establishing 10 nutrition clinics in hospitals with 15 more to follow in 2016. The clinics offer nutrition counseling, screenings and other nutrition related services. In order to increase the human resource capacity within these clinics, the govt. conducts an MSc programme in Human Nutrition exclusive for doctors. Once the

proficiency is attained, the doctors gain the Medical Officer Nutrition (MON) title. Currently the country endows 60 qualified MONs who are appointed to these nutrition clinics throughout the island.

Furthermore, Public Health Guidelines have been developed on 3 selected non-communicable diseases including heart diseases, cancer and diabetes. The guidelines have been distributed to hospital staff and training has been provided in a limited number of hospitals. The Nutrition Division plans to carry forward the training to other hospitals.

Recommendations

- Elderly without children and the disabled need to be considered as vulnerable groups. With the foreseen demographic transition (increasing elderly population), the system ought to adjust accordingly.
- The responsible parties who are accountable of vulnerable groups need to be clearly identified.
- Establish a vulnerability index to map the **vulnerable families**. For example, a family with 3 under age 5 children below a specified income level can be considered as vulnerable.
- Consider a broader vulnerability criteria (and not merely the level of population) when allocating healthcare workers and other resources – equity as opposed to equality.
- Conduct a survey in the urban slum area to identify the changing causes for vulnerability. Accordingly, implement tailored interventions.
- In general, explore the possibility of targeting all interventions to achieve the expected outcomes.

Policy Objective 4: Ensuring Food and Nutrition Security for all citizens

Expected outcome	Key action areas	Major activities	Degree of implementation	Outcome indicators	Baseline	Target	Target status	Responsible Organisations
4.1 Accessibility and consumption of adequate, safe and nutritious foods at the household level improved	4.1.1 Ensure access to adequate, nutritious, and quality food at affordable prices throughout the year	4.1.1.1 Implementing skills enhancing training through nutrition education/behaviour change programmes to related aspects of nutrition through organized sessions about importance of nutrition in relations to dietary diversification, cooking and storage		Proportion of population below minimum level of dietary energy	50.7% (DHS 2006/07)	25%		Nutrition Coordination Division Provincial Health Administration
		4.1.1.2 Support implementation of other related policies e.g. agriculture, poverty alleviation, Gamanaguma						
	4.1.2 Ensure provision of safe food	4.1.2.1 Implement 10 steps of food safety policy		Anaemia prevalence (< 5yr)	29.9% (MRI 2001)	24%		
		4.1.2.2 Mainstream nutrition in food production and importation						
		4.1.2.3 Facilitating access to adequate, nutritious, safe and quality foods						
4.2 Improvement of quality in commonly consumed food through nutrient enhancement is ensured (food fortification)	4.2.1 Ensuring intake of all macro and micronutrients to prevent deficiency disorders and diet related chronic diseases	4.2.1.1 Strengthen Iodine deficiency disorders elimination program		Total goitre rate	3.8% (MRI 2005)	3.5%		MRI Provincial Health Administration
		4.1.1.2 Assess and implement other micronutrient deficiency disorders programs		Prevalence of Vitamin A deficiency	29.3% (6-71 months, MRI 2006)	19.3% (based on the baseline)		

Target Status Colour Codes	*Target Status Colour Codes*
Activity Completed	Target achieved
Activity Ongoing	Target likely to achieve
Activity yet to be implemented	Target unlikely to achieve
	Target highly unlikely to achieve
	Cannot be determined

Expected Outcome 4.1: Accessibility and consumption of adequate, safe and nutritious foods at the household level improved

Outcome indicator – Proportion of population below minimum level of dietary energy

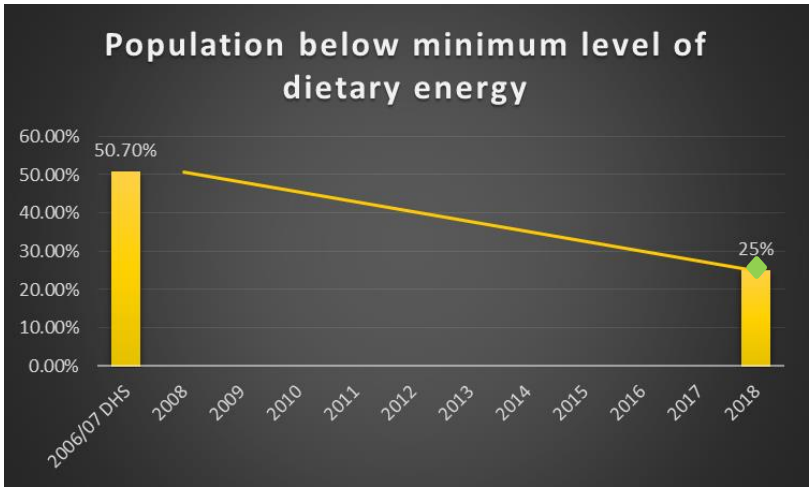


Figure 14: Proportion of population below minimum level of dietary energy

Target for 2018 ◆

Key action area 4.1.1: Ensure access to adequate, nutritious, safe and quality food at affordable prices throughout the year

The 2014 Socio-Economic Data Report of the Central Bank Sri Lanka reported the following of the country's total production of major and subsidiary crops, fish and livestock between 2008 and 2013:

PRODUCTION AND PRICES OF MAJOR CROPS

Item	Unit	2008	2009	2010	2011	2012	2013(a)
Production Volume							
Paddy	'000 MT	3,875	3,652	4,301	3,894	3,846	4,621
	'000 Bushels	185,690	175,004	206,103	186,620	184,319	221,435
Tea	Mn. kgs.	319	291	331	328	328	340
Rubber	Mn. kgs.	129	137	153	158	152	130
Coconut	Mn. Nuts	2,909	2,853	2,584	2,808	2,940	2,513

ANNUAL PRODUCTION VOLUME – SUBSIDIARY FOOD CROPS

Metric tonnes

Item	2008	2009	2010	2011	2012(a)	2013(b)
Manioc	240,731	277,847	282,759	292,741	291,354	301,182
Potatoes	74,814	61,705	51,933	59,360	72,186	78,768
Sweet Potatoes	n.a.	47,272	46,460	47,269	43,613	51,465
Chillies (green)	51,003	46,414	49,003	44,398	61,541	72,034
Red Onions	49,290	46,234	61,811	72,339	73,970	55,608
Big Onions	57,371	81,707	58,930	45,682	83,561	69,638
Maize	112,287	129,769	161,694	137,797	202,315	208,275
Cowpea	11,952	13,485	11,609	10,453	14,812	15,415
Green Gram	8,878	9,258	11,703	10,838	11,956	14,130
Black Gram	9,477	7,071	9,991	5,782	10,180	9,172
Kurakkan	6,511	6,433	7,307	5,411	5,984	6,946
Ground Nuts	10,251	13,077	14,354	16,903	21,953	27,407
Ginger	n.a.	10,780	12,052	13,663	14,911	14,075
Gingelly	6,337	8,525	16,947	11,293	12,435	14,142
Turmeric	n. a	7,747	8,304	9,308	8,708	11,282
Soya Beans	3,032	3,788	7,521	3,847	1,671	13,316
Sorghum	n.a.	173	101	96	89	138
Mustard	n.a.	303	413	174	152	184
Meneri	30	20	17	18	26	33

(a) Revised (b) Provisional n.a. – Not available *Source* : Department of Census and Statistics

NATIONAL LIVESTOCK STATISTICS

'000

Type of Livestock		2008	2009	2010	2011	2012	2013(a)
Neat Cattle (No.)							
Milk Cows – Milking at present		249	238	249	251	280	299
Not milking at present		283	269	276	281	287	n.a.
Total Cattle		1,196	1,137	1,170	1,192	1,236	1,140
Buffaloes (No.)							
Milk Cows – Milking at present		63	78	90	86	94	99
Not milking at present		51	59	80	78	77	n.a.
Total Buffaloes		319	372	423	405	415	370
Goats	(No.)	377	377	373	375	384	326
Sheep	(No.)	10	8	8	8	9	9
Pigs	(No.)	89	81	84	82	89	80
Poultry	(No.)	14,331	13,615	14,018	14,199	14,039	17,788
Ducks	(No.)	18	15	13	12	13	14
Average Monthly Production							
Cow Milk	(Litres)	14,370	15,339	15,993	16,955	19,803	21,504
Buffalo Milk	(Litres)	2,971	4,104	4,636	4,570	5,134	5,144
Total Milk	(Litres)	17,341	19,443	20,630	21,105	24,937	26,648
Eggs	(No.)	86,651	95,187	94,995	98,776	121,425	161,848

(a) Provisional n.a. – Not available *Source* : Department of Census and Statistics

*2013 – Provincial Data

The country's ability to ensure access to nutritious food is mainly determined through the level of production of such and the proportion of this production catering the domestic market. Therefore the above data indicates Sri Lanka's actual ability or disability to do so. While the production of some crops have consistently increased, many of the vital crops with high nutrition values including Cowpea, Black Gram and Kurakkan have shown signs of critical fluctuations which can likewise distort the household ability to consume these. However, it is encouraging to note the steady increase in production of some crops including Manioc and Ground Nuts. What is needed is to raise awareness on the possibility of using these to prepare food differently, in a creative manner.

SELECTED EXPORTS

Item	2008	2009	2010	2011	2012	2013(a)
Agricultural Commodities						
Tea, MT '000	320	290	328	323	320	320
Rubber, MT '000	49	56	52	43	37	24
Coconut, Mn. Nuts (b)	380	384	247	386	351	379
Minor Agricultural Commodities, MT						
Vegetables	12,279	15,670	20,994	13,446	10,814	22,737
Fruits	14,362	13,032	17,072	20,007	26,592	33,532

According to the Export Development Board, the country on average produces 710,000 metric tons of vegetables and 540,000 metric tons of fruits annually. Of this, in 2013 about 3% of the vegetable and 6.2% of fruit production was exported. This reveals that much of the domestic produce caters the local market. However the high price and unequal distribution incapacitates the poor and the lower-middle class to purchase these perishable items.

PRICES OF SELECTED FOOD ITEMS

Rs. per kg.

Item	Producer Price (Average)			Retail Price (Average)					
	All Island			All Island			Colombo City		
	2011	2012	2013(a)	2011	2012	2013(a)	2011	2012	2013(a)
Rice									
Samba	31.09	31.37	33.22	71.82	70.33	71.90	66.60	69.76	70.48
Par-Boiled	28.63	28.12	29.96	60.51	60.09	62.04	56.20	60.68	60.61
Kekulu	29.33	28.34	30.16	55.33	56.63	58.33	53.80	59.15	59.71
Vegetables									
Green Beans	98.28	72.98	76.95	144.69	125.45	130.31	138.13	123.45	134.40
Carrot	67.60	68.95	80.06	124.06	121.12	131.03	121.75	115.94	133.40
Leeks	52.66	65.04	70.06	96.23	110.93	115.73	64.81	107.87	103.47
Tomatoes	57.33	50.40	57.35	102.35	97.61	97.44	107.99	108.69	97.14
Ash Plantains	39.38	34.81	38.78	74.88	67.87	75.01	69.56	75.84	83.30
Pumpkin	31.28	33.26	31.85	59.84	64.30	63.00	53.05	66.54	57.70
Bitter Gourd	64.15	65.65	66.83	109.12	109.18	109.07	112.18	114.73	112.40
Brinjals	47.14	43.72	43.39	82.20	76.17	76.83	73.06	79.68	80.80
Leafy Vegetables									
Gotukola	54.61	55.67	58.71	17.87	18.39	19.34	20.38	27.72	20.00
Mukunuwenna	43.31	44.80	47.49	18.14	19.35	20.71	16.97	24.28	20.00
Potatoes	79.02	76.52	84.62	108.12	110.60	117.42	105.82	113.92	117.35
Manioc	27.64	28.11	28.91	47.21	49.85	50.44	56.50	58.51	60.10
Sweet Potatoes	34.02	35.07	36.06	58.34	59.68	64.33	63.74	65.83	73.40

(a) Provisional

(Continued)

The above table outlines the prices of selected foods items. With 6.7% of country's population living on less than $1.25 (Rs. 188) a day, the obvious is question lies on the affordability of these foods to the less fortunate. As a result, people with poor socio-economic backgrounds are forced to purchase cheap substitutes with poor nutritional values.

Recommendations

- Explore avenues to increase production of important crops - to increase supply and therefore to reduce the price.
- Conduct a study to learn about the purchasing power and the standard menus of lower-income households. Use this information to develop a programme to address issues.
- Provide a platform for local communities to use the local products more creatively, to cook different dishes from a single crop using different parts of the plant. This way, food wastage too can be reduced.

To complement state efforts, the Food and Agriculture Organisation (FAO) has allocated US$ 2.4 million to enhance country's food security. A further investment of $16 million has been made to establish irrigation tanks, develop aqua culture, improve farmer capacity and on waste reduction systems, thus covering the entire value chain. However, it is important to note that FAO's current efforts focus on increasing food production. Therefore ensuring nutrition values in production is yet to be integrated, to which the govt. should urgently allocate their efforts.

When mainstreaming food production, the critical success factor is to ensure that farmers have an incentive to comply with quality and nutritional standards – that is through higher income. Thus, the solution lies at setting *minimum buyer standards* by buyers themselves – wholesalers, retailers and more importantly the consumers.

Going forward, FAO aims to extend more technical/advisory support to mainstream food production to include adequate nutrients with special attention to farmer's income generation. The state ought to instigate their efforts to do the same, to collaborate with FAO and other stakeholders in the near future.

Implementing skill enhancing training on nutrition education

Key stakeholder interviews revealed the following training programmes on nutrition education:

- The Nutrition Coordination Division has allocated Rs. 1-2 million to each district to carry out trainings for master teachers on nutrition education including cooking demonstrations, home gardening etc. The training is expected to pass down to pre-school teachers who would then disseminate the knowledge and know-how to the communities.
- The Nutrition Coordination Division in partnership with the Ministry of Education (MoE) plans to develop 3500 school gardens to encourage communities to increasingly engage in home gardening.

- The World Food Programme (WFP) conducts nutrition-sensitive and nutrition-specific capacity building training programmes in North, East and Uva Provinces.
- The Health Education Bureau conducts training to build capacity and promote leadership among women through Mother Support Groups. The members of the groups will in turn be advocators of good health and nutrition in their communities.

Support to implement other related policies (including agriculture and poverty alleviation)

The Nutrition Coordination Division collaborates with other related ministries in formulating and updating relevant policy guidelines. However there is no explicit coordination when it comes to implementing these policies. An interview with the Ministry of Agriculture confirmed this limited inter-ministerial integration and support extended in the implementation of the related policies. As the key UN organisation who works in the sector of agriculture, FAO ought to explicitly refer to the agriculture and other relevant policies when developing strategy and action plans. This in fact applies to all I/NGOs.

Recommendations

- Promote the livelihood capacity and competitiveness of the poor. More focus need to be placed on educating the communities about building a competitive edge; home produce/organic produce – to offer something different to consumers. Empowering is more important than merely facilitating, which can also guarantee sustainability.

To I/NGOs and CSOs:

- Proactively recognise the existence of relevant govt. policies when developing own country programmes, strategies and actions. This way, it would be easy to gain govt. cooperation while promoting uniformity of all interventions by different stakeholders.

Key action area 4.1.2: Ensure provision of safe food

Outcome indicator - Anaemia prevalence among the under 5

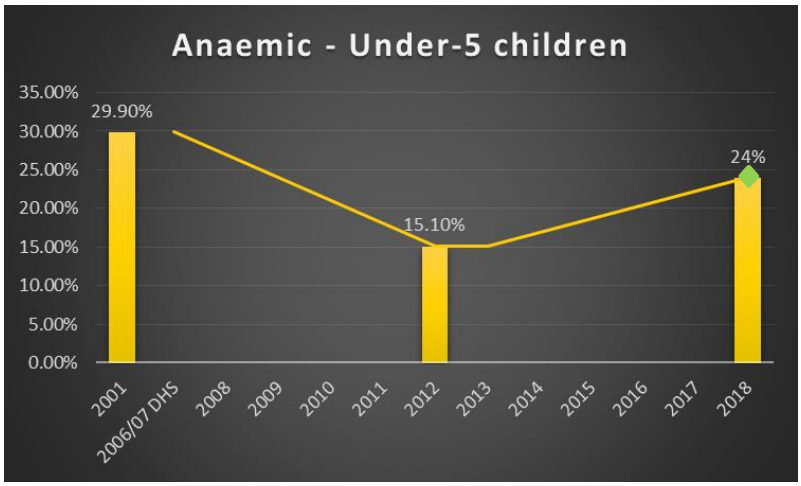


Figure 15: Anaemia prevalence among under-five children

Target for 2018 ◆

Data source for 2012 figure – Micronutrient Survey 2012 (sample- 7050 age 6-59 months' children)

10 steps of food safety policy

The policy document is still in its draft stage and currently subjected to discussion. The Food Control and Administration Unit plans to finalise the document and submit for cabinet approval in the near future.

Mainstreaming nutrition in food production and importation and ensuring access to safe and quality food

The Food Control and Administration Unit (FCAU) of Ministry of Health is the key governing body of the country to ensure that food production and importation is processed with minimum standards. The FCAU adopts the Food Act 1980 and its regulations which dictate standards on health and safety of food production and importation. In addition, the ministry also adopts 110 items (which are not covered in the 1989's standard regulations) from the Sri Lanka Standards Institute (SLSI) which has been developed based on the International Standards Organisation (ISOs).

To mainstream nutrition in production and ensure availability of quality and safe food, SLSI operates a Good Manufacturing Practices (GMP) certification based on the Sri Lanka Standards and codes of practice available in the related discipline.

Areas monitored when awarding the GMP Certification:

- Establishment - Design, facilities, equipment and maintenance
- Control of operations
- Cleaning and sanitation
- Personal hygiene
- Transportation
- Training
- Product certification
- Pest control
- Waste management
- Packaging and labeling etc.

The FCAU conduct training programmes for consumers on buyer-awareness throughout the country, implemented and monitored by 2000 authorised officers at the grassroot level. It is important to note that the FCAU's agenda is to ensure the safety and quality in food production - it is not their job to promote and facilitate production. Thus to ensure adequacy of safe food, collaborated efforts are called for between parties who promote and facilitate food production and those who ensure safety and nutrition values of this production.

The FAO conducted a workshop (in 2016) to identify the systems in place to monitor food safety. The workshop reached a final consensus on the absence of coordination between stakeholders including the Customs Unit, MoH, Colombo Municipal Council etc. to ensure the production and importation of safe food. The interview also revealed that although the country endows the laboratories and other infrastructure to integrate high levels of food safety, lack of coordination stands to be the hindering factor.

Recommendations

- Food Security should be given considerable attention and be recognised as a critical element of national security – history indicates lack of food has ignited global riots and violence. This is particularly important given the increasing effects of climate change.
- Develop a country-specific food security index to gain an insight about communities susceptible to food insecurity. Link this so the vulnerability index proposed under policy objective 3.
- The govt. should take action to promote collaboration among all stakeholders and therefore consistency in ensuring the 3As – Adequacy, Accessibility and Affordability.

Expected outcome 4.2: Improvement of quality in commonly consumed food through nutrient enhancement is ensured (food fortification)

Key action area 4.2.1: Ensuring intake of all macro and micronutrients to prevent deficiency disorders and diet related chronic diseases

Outcome indicator - Total goiter rate

Strengthening Iodine deficiency disorders elimination programme

Undoubtedly, the work carried out in the past to strengthen the iodine deficiency elimination programme through fortification of salt is commendable. However, the study was unable to access data on goiter rates.

The MoH piloted double fortification of salt with iron and iodine to address their deficiencies. The study proved good acceptability and efficacy. However due to increasing Non-communicable Diseases, the ministry has advised the public to consume less salt. Therefore, currently the MoH has changed the vehicle to rice. To this regard, trials are undertaken to facilitate greater understanding of the effectiveness of rice fortification.

Recommendation

- Rice fortification to address micronutrient deficiency in the urban slums may be effective. However, it is unlikely to achieve much progress in the estate sector that consumes flour in most instances; for breakfast, lunch and dinner. Flour could be a better vehicle to address micronutrient deficiency in the estate sector. Therefore, both flour and rice should be fortified.

Outcome indicator - Prevalence of Vitamin A deficiency

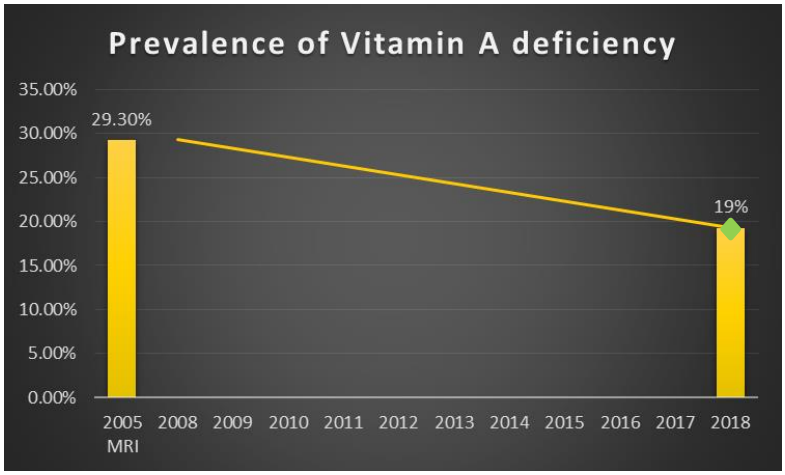


Figure 16: Prevalence of Vitamin A deficiency

Target for 2018 ◆(calculated based on the baseline given the absence of 2010 data)

Vitamin A deficiency elimination programme

As mentioned under policy objective 1, the following is processed to reduce the level of Vitamin A deficiency particularly among lactating mothers, children under 5 years and school children:

- Vitamin A mega dose (200,000 IU) supplement to all registered lactating mothers (within 4 weeks of delivery).
- Vitamin A mega dose (100,000 IU) supplement to all children under 5 years – every 6 months, starting at age 6 months until 5 years.
- Vitamin A mega dose (100,000 IU) supplement to all school children (grades 1-13) annually.

A survey has been carried out by MRI to determine the current Vitamin A prevalence. The data is yet to be resealed.

Suggestions for Policy Amendments

- 4.1.1. *'Support the implementation of other related policies'* – The word 'support' entails no sense of direction. Thus more clarity is required on how to support. This is a very critical activity which initially need to identify the relevant stakeholders and policies in place
- 4.1.1.1. ought to be listed under 4.2
- 4.1.2.3 ought to be listed under 4.1.1
- Wording in 4.1.2.2 ought to be changed to *'monitoring and maintaining food safety in food production and food importation*' Accordingly, the outcome indicator should change to *% food produced meeting SLSIs*
- Food fortification should be a presented as a separate activity. Accordingly, 4.2 should include '*improving micronutrient food intake through food fortification'*
- Consequently, the Anaemia prevalence indicator should be presented under food fortification
- A call for a new activity under 4.2. – *Evaluation on iron deficiency disorders*
- Dietary Diversification is an important aspect which requires greater attention, subsequently calling for another expected outcome; *4.3. Greater food diversification promoted*
- Recognise the Food Control and Administration Unit of MoH as a responsible organisation

Policy Objective 5: Strengthening advocacy, partnerships and networking

Expected outcome	Key action areas	Major activities	Degree of implementation	Outcome indicators	Baseline	Target	Target status	Responsible Organisations
5.1 Nutrition components included into other relevant national and provincial policies and strategic plans	5.1.1 Mainstreaming nutrition in other related national and provincial policies	5.1.1.1 Include nutrition components in relevant national and provincial policies and strategies (i.e. Development, poverty reduction, agriculture, education, transport)		% of other relevant policies formulated in line with nutrition policy & strategic plan	0%	75%		DDG/PHS, FHB, MRI, D/Nutrition, HEB/D/Planning, D/Nutrition Coordination Division, Provincial Health Administration
5.2 Coordinated action for nutrition within the Ministry of Health is strengthened	5.2.1 Establishing an effective coordinating system	5.2.1.1 Establishing a central management unit within the MoH bringing together related divisions, bureaus and units who are responsible for food and nutrition		Availability of a central management unit	None	Available		
5.3 Inter-sectoral coordination for nutrition is strengthened	5.3.2 Establish a high-level inter-sectoral coordination mechanism	5.3.1.1 Establishment of a high level inter-sectoral & inter-ministerial steering committee for nutrition involving concerned ministries		Availability of an inter-ministerial committee	None	Available		
	5.3.2 Enhance coordination and harmonization of partners and stakeholders who work for food and nutrition in the country (UN agencies, NGOs/civil societies)	5.3.2.1 Establish a food and nutrition coordination committee including UN agencies, bilateral agencies, NGO/Civil societies & universities						
	5.3.3 Strengthen partnerships and networking with relevant	5.3.3.1 Promoting development of nutrition improvement strategies at provincial level						

	sectors and stakeholders for undertaking collaborative programmes at Provincial, District, Divisional & community level to improve nutrition of the community	5.3.3.2 Promote planning, implementing district, divisional agencies to formulate integrated nutrition improvement communication plans with all relevant stakeholders						

Target Status Colour Codes	***Target Status Colour Codes***
Activity Completed	Target achieved
Activity Ongoing	Target likely to achieve
Activity yet to be implemented	Target unlikely to achieve
	Target highly unlikely to achieve
	Cannot be determined
	(determined based on a simple forecast calculation of the available data)

Expected outcome 5.1: Nutrition components included into other relevant national and provincial policies and strategic plans

Key action area 5.1.1: Mainstreaming nutrition in other related national and provincial policies

The study identified the following related national policies and strategies which were formulated between 2010 and 2016:

- National Health Development Plan (2013-2017)
- National Strategic Plan on Adolescent Heath (2013-2017)
- Early Childhood Development Policy
- Work Bank Country Partnership Strategy (2012-2016)
- Mahinda Chinthana (2010-2016)
- National Multi-sectoral Action Plan for the Prevention and Control of Non-Communicable Diseases (2016-2020)

Although there is no direct reference to the NNP, all aforementioned policies and strategies include components concentrated to reduce malnutrition. However, going-forward it would be extremely useful for all related ministries and departments to examine the NNP proactively, in order to ensure uniformity of all nutrition related interventions. In retrospect, the MoH must refer to the existing

relevant policies when revising the NNP. This will allow strengthening strategic inter-ministerial partnerships which prove to be more efficient and cost-effective.

Expected outcome 5.2: Coordinated action for nutrition within the MoH is strengthened

Key action area 5.2.1: Establishing an effective coordinating system

Stakeholder interviews revealed the ministerial (MoH) plan to establish a Nutrition Bureau which will bring together related intra-ministerial divisions working towards scaling up nutrition. The divisions include the Nutrition Division, the Nutrition Coordination Division, FHB, HEB, MRI (Nutrition Unit) and Estate and Urban Health Unit. The discussions are well underway and the ministry targets to launch the Bureau before the end of 2018.

Expected outcome 5.3: Inter-sectoral coordination for nutrition is strengthened

Key action area 5.3.1: Establish a high-level inter-sectoral coordination mechanism

In 2012, the following national bodies were formed;

- The National Nutrition Council – formed under the leadership of the President of Sri Lanka.
- The National Steering Committee – represented by relevant ministries.
- Technical Advisory Group – consisting national experts on food and nutrition from all sectors, appointed to advice the National Steering Committee.
- District Nutrition Committees – represented by local stakeholders.

In 2013, the Multi-sector Action Plan on Nutrition was launched. The govt. allocated resources to implement this plan of action. The National Nutrition Secretariat was established to monitor the progress of implementation. In addition, the MoH has its own Nutrition Steering Committee chaired by the Secretary and is expected to meet once a month. The Maternal and Child subcommittee discuss nutrition related activities concerning MCH and contribute to the Nutrition Steering Committee.

Key action area 5.3.2: Enhance coordination and harmonization of partners and stakeholders who work for food and nutrition in the country (UN agencies, bilateral agencies, NGO/Civil Societies)

To complement their membership at the National Nutrition Steering Committee, the UN organisations have established an intra-country network connecting UNICEF, WFP, WHO and FAO. Together, they have launched the Scaling-Up Nutrition (SUN) UN network to work together towards uplifting Sri Lanka's nutrition status. Various joint projects are formulated and implemented through this network including the on-going Sustainable Development Goals Project.

Scaling-Up Nutrition People's Forum (SUN PF) is the umbrella of the civil society organisations and I/NGOs working towards improving nutrition of the people in Sri Lanka. SUN Civil Society Alliance

is made up of World Vision Lanka, ChildFund, Nucleus Foundation, Sevalanka Foundation, Sarvodaya, Save the Children International, Nutrition Alliance, Plan International and the Palm Foundation. Monthly council meetings are hosted by the SUN PF Secretariat. The coordinator of the National Nutrition Council and WFP too attends the meetings to represent the govt. and the UN.

Key action 5.3.3: Strengthen partnerships and networking with relevant sectors and stakeholders for undertaking collaborative programmes at Provincial, District, Divisional and community level to improve nutrition of the community

Promoting development of nutrition improvement strategies at provincial level and implementing communication plans with all relevant stakeholders at all levels

The Provincial Directors of Health Services (PDHSs) revealed elements of collaboration between key officials serving at the provincial, district and divisional levels. It is evident that the national level encourages the alignment of such strategic partnerships to ensure that provincial governments too exercise collaborative efforts towards increasing their provincial nutrition status. Nonetheless, regardless of the presence of separate provincial nutrition committees, the functionality of them varies between provinces. For instance, although the Sabaragamuwa province's Nutrition Committee headed by the Chief Secretary is expected to meet once every three months, it is not recognised for its regular functionality. In contrast, the Easter province was proud to communicate about their consistent provincial gatherings and effective functionality. In some provinces, their provincial govt. still lacks a separate committee dedicated to solve provincial-specific nutrition issues. For instance, to-date the Western province has not been able to establish a provincial nutrition committee.

On a positive note, district committees headed by the District Secretariats and Regional Directors of Health Services (RDHS) are known to be functioning effectively in almost all districts. Interviews with Government Agents (GA) representing Kilinochchi and Mullaitivu confirmed the inter-sectoral collaboration between agriculture, education, health, early child development etc. on solving district-specific nutrition issues. Furthermore, it was reassuring to find the presence of divisional committees headed by the Divisional Secretariat and the Medical Officer of Health (MOH) with community leaders and parents acting as useful committee members. What is noteworthy is that the formation and the functionality of such committees depend a great deal on the will and interest of the MOH - to form a common platform for all communities in the division to raise their concerns and solve these through joint efforts.

The North Central Province endows a Health Development Committee where *some* nutrition issues are discussed while the Central Province limits its nutritional upgrading efforts to Maternal and Child Healthcare. Thus it is clear that further efforts are strongly called for to make these established platforms more effective and therefore impact-worthy, which covers all spectrums of good nutrition.

The provincial governments also exercise regular communication with the national bodies that encourage them and provide technical support to implement provincial-specific nutrition improvement strategies and plans. Although all provinces follow the national guidelines, there is an upward trend for provinces to formulate their own evidence-based programmes. In addition, provinces are also planning to undertake surveys to increase the level of concrete data they possess. By doing so, provinces are now able to focus their efforts to most vulnerable pockets. MOHs provide a great deal of technical and logistical support to carry out these targeted interventions. Of course, such programmes also integrate donor specifications; UN organisations and other development agencies including I/NGOs play a vital role in promoting the implementation of province and district specific programmes.

Recommendations

- Ensure the regular functionality of the established platforms at all levels. Key decisions made at these forums need to be communicated to the public and other key stakeholders to ensure transparency.
- Proactive partnerships with I/NGOs and CSOs. Recognise these institutions as vital contributors to development.

Policy Objective 6: Strengthening Research, Monitoring and Evaluation

Expected outcome	Key action areas	Major activities	Degree of implementation	Outcome indicators	Baseline	Target	Target status	Responsible Organisations
6.1 Timely availability of evidences for decision making	6.1.1 Strengthening National Nutrition Surveillance System	6.1.1.1 Expand the National Nutrition Surveillance System to the whole island		% provincial/local authorities using surveillance data for planning nutrition programs	None	50%		Nutrition Coordination Division, District development committee/ Agricultural committee, Department of Census and Statistics
		6.1.1.2 Strengthen the utilisation of the reports for decision making at national and divisional level						
		6.1.1.3 Effect an appropriate behaviour surveillance mechanism		Number of behaviour research conducted annually	0	2		HEB
	6.1.2 Establish National Nutrition Management Information System	6.1.2.1 Link surveillance data to National Nutrition Information System		Availability of periodical reports	None	Periodical reports available		MRI
		6.1.2.2 Consolidate nutrition related data being collected by various organisations (i.e. MRI, FHB, NCD etc.)						
		Generate national nutrition reports in regular intervals for decision making						
	6.1.3 Strengthen the support for research in nutrition and the use of its outcomes	6.1.3.1 Identifying the gaps in nutrition knowledge and set research priorities leading to formulation of a research agenda		% completion of the formulated research agenda	Not available	75%		
		6.1.3.2 Strengthening the research capabilities of concerned institutions						
		6.1.3.3 Ensure effective utilization of research findings for nutrition program designing and policy and strategy development						
	6.1.4 Strengthen monitoring and evaluation of the impacts of nutrition interventio	6.1.4.1 Undertake periodical review and evaluation of the impact and effectiveness of nutrition intervention programs		% provincial & divisional bodies with laid-down evaluation programs	Information not available	75%		Provincial Health Administration
		6.1.4.2 Support measures to establish and for the functioning of national,						

	n programmes	provincial and divisional steering/coordinating committees including developing TORs						
		6.1.4.3 Capacity building of provincial health system for planning nutritional programs and support identifying targets relevant to each province/divisions						

Target Status Colour Codes	***Target Status Colour Codes***
Activity Completed	Target achieved
Activity Ongoing	Target likely to achieve
Activity yet to be implemented	Target unlikely to achieve
	Target highly unlikely to achieve
	Cannot be determined (determined based on a simple forecast calculation of the available data)

Expected outcome 6.1: Timely availability of evidence for decision making

Key action area 6.1.1: Strengthen National Surveillance System

Expansion of the National Nutrition Surveillance System (NNSS) island-wide and strengthening utilisation of data reports

The National Nutrition Surveillance System (NNSS) was designed with the objective of providing timely information; to act as an *early warning system* by identifying issues and the parallel underlining causes. Hence the system was expected to provide valuable information to policy makers and programme managers to design and intervene in a timely manner.

The official website of the NNSS was launched in 2012 by the Nutrition Coordination Division of the MoH. A visit to this website will however provide little indication about the scope of the system and its progressive implementation. Currently, the website gives access to limited information on selected indicators from 34 Divisional Secretariats, of which 10 have been updated in 2013. Although the current software evidences to be competent to capture and collate necessary information, poor timeliness and limited coordination in data collection and compilation has hampered the effectiveness of the system. An interview with the Nutrition Coordination Division explained the prevailing red tape on obtaining timely data and information from other related ministries.

In response to correct the current deficiencies, the Nutrition Coordination Division is currently conducting a pilot study in the Nuwara Eliya district which targets to train district level relevant ministerial officers on collecting, collating and analysing data which could be sent in on a timely manner. Other ministries include Agriculture, Fisheries, Livelihoods and Economic Development and Education etc. The training is also expected to cover the process of feeding own data into the system.

Recommendations

- NNSS is designed to capture information from several ministries. Therefore, it should be operated at the National Nutrition Secretariat.
- Identify outcome indicators for which the data can be submitted and determine how frequently the system can be fed with data and information. Accordingly revise the software for more effective use.
- Promote utilisation of nutrition data for national and local planning. This will improve timeliness and validity.

Utilisation of reports for decision making at national and divisional levels

Although the policy calls for strengthening the utilisation of data reports for decision making, the absence of timely information have hampered the effective utilisation of data. The PDHSs confirmed that they hardly ever refer to the NNSS for data when planning strategy. Nevertheless, all officials did admit to using some level of data collected quarterly through the 509 and during the nutrition month when conducting the needs based assessment. The assessment is followed by tailored interventions. Thus some level of data utilisation is evident at provincial levels. However, when it comes to the national level, the absence of targeted interventions indicates minimum use data and information. The dispersion of equal funds by the Nutrition Division and Nutrition Coordination Division to all districts, to carry out nutrition-related interventions is a good example to specify the practice of equality as opposed to equity.

Behaviour Surveillance Mechanism

As mentioned before, Sri Lanka is yet to implement a behaviour surveillance mechanism and the timeline of this activity is likely to be furthered given the lack of consensus among stakeholders on what ‘behaviour surveillance’ should entail. The study’s panel of experts forwarded the following potential areas for the behaviour surveillance:

- Behaviour on breastfeeding
- Behaviour on Hygiene
- Behaviour of mothers and children

- Behaviour of doctors and nurses
- Behaviour of media etc.
- Behaviour of the private sector food industry
- Behaviour of farmer groups and livestock producers

On this regard, the key responsible organisation mandated to promote behaviour change in health and nutrition; the Heath Education Bureau was interviewed. We were informed that information on nutrition behaviour is extracted primarily from Mother Support Groups – one of HEB's key interventions. Nonetheless, information gathered from all stakeholder interviews confirmed that Sri Lanka is yet to launch a standardized behaviour surveillance mechanism to monitor people's health and nutrition behaviour change. That being said, it is worthy to note that the STD/AIDS Control Programme under the Ministry of Health has conducted a series of surveys and research on health behaviour of populations at higher risk of HIV (in 2006/07 and 2015).

A country that primacies health and nutrition as a frontrunner in economic development, with an annual investment of approximately Rs. 100 million, funding a set of core nutrition interventions reaching the people across all districts, the obvious question is why malnutrition persist to be a public health issue. The key factor attributable to this persistency can be the absence of a positive social marketing campaign. For example, the media influences behaviour in spending patterns which may not be desirable for optimum nutrition. The conflicting messages lead to confusion among people who then adopts the most convenient path. Negative behaviour in spending patterns may be why people still suffer from multidimensional poverty. Thus, the need for a behavioral surveillance mechanism is rather critical. However, the launch of such system should be a well-structured one which can clearly identify what behaviours are contributors and hinderers to achieving the expected outcomes.

Recommendation

- Design and implement a BSS

Key action area 6.1.2: Establish National Nutrition Management Information System

According to the MRI and FHB, Sri Lanka's nutrition related data are gathered through the following primary sources;

- **Every 5 years**, the Department of Census and Statistics conduct the Demographic and Household Survey (DHS) which reports data on selected nutrition indicators.
- **Every year** during the national nutrition month (June), all under-5 children across the island are measured for height and weight. End of August is set as the deadline for all districts to send in the analysed data.

- **Every quarter**, Maternal and Child Health returns through the 509 collected by the midwife flows through the Medical Officer of Health (MOH), Regional Director Health Services (RDHS) and reaches the national level.
- **Special surveys and studies**, **every 2-3 years** MoH partners with the UN to conduct special nutrition related surveys e.g. the micronutrient survey in 2012 and the latest in 2015.

The above sources signifies ample evidence that Sri Lanka in fact collects a significant amount of data to continuously monitor progress and identify changing contributing and hindering factors through causal analyses. However, when it comes to data reporting, the country lags way behind of what can be viewed as 'acceptable delays'. When questioned about the considerable time lag between data collection and reporting, the hierarchy of the dataflow was identified as a key hindering factor. Data collected by field staff is processed in 3 tiers; from the MOH (divisional) to the RDHS (district) to the national level. This process can usually takes between 4-6 months. Once the data is reached by the center, it is estimated to take (on average) another 6 months to enter, clean and analyse. Management issues including staff transfers add to the delay. Additionally, fair amounts of underreporting of data from the MOH level is identified as a key contributing factor to the delay. Nevertheless, this process still does not justify why the latest data currently available (in 2016) dates back to 2013.

At the same time however, we do commend state efforts to collect, process and publish data which is why we have by least the 2013 data available for public reference. Yet, the fact that efforts are exerted at the community level to collect the data from the aforementioned sources raise the question of why data is not made available sooner.

The collection of data by the implementers themselves; the midwives, is seeing as a violation of the fundamental principle of research which can lead to an element of bias and therefore invalidity of data. Thus it is important to carry out regular surveys (at least once every 2 years) by external parties from the national level to ensure the accuracy of the progress monitors. Moreover, contradicting to what is called for by the policy; the stakeholder interviews confirmed the absence of consolidating data collected by different bodies to a central database/system.

Recommendations

- Increase resourcing for data reporting – especially human resources.
  If efforts are undertaken at the field level to collect the data, it must be reported and made available to all stakeholders. Failing to do so would make data collectors' efforts futile. To ensure timely availability of data, increase the department's resource capacity.
  What is also important to remember is that data is a property of people which should not be politically influenced. Therefore, public access to all unclassified **timely** information is essential
- Conduct an external evaluation of all districts (at least every 2 years) to ensure accuracy of the progress monitors.
- Set mandatory deadlines at divisional and district levels on reporting data. Performance related resource allocations can provide them an incentive to be more active in data collection and reporting.

Key action area 6.1.3: Strengthen the support for research in nutrition and the use of it in outcomes

National Research Agenda

The Medical Research Institute's (MRI) research agenda is primarily based on country priorities. Key focus areas of research include micronutrient deficiencies, food systems and food composition which are in fact utilised and operationalized in decision making (given research is carried out on ministerial demands). The MRI also develops best practice models which are used to design and develop interventions. Nonetheless, there have been instances in the past where research has been influenced by political agenda.

In general however, the absence of a standardized mechanism to identify gaps in nutrition knowledge can be identified as a major setback. This curbs the amount of vital country-specific information required to upgrade existing interventions or even formulate new ones in response to the changing demographics, psychosocial and socio-economic atmosphere. Such knowledge is of particular use to Sri Lanka given the slow progress in achieving certain nutrition targets including Wasting, Anaemia prevalence etc. regardless of the delivery of interventions. The absence of a behaviour surveillance mechanism compounds the issues.

Moreover, the absence of a mechanism to utilise local research conducted by Academia and other sectors limits the level of incentive for researchers to invest and dedicate their efforts to conduct quality research. In totality, lack of recognition and value placed on quality research would negatively impact Sri Lanka's capacity to undertake eminent research.

Strengthening research capabilities of concerned institutions

The study found that budgetary allocations for research being quite poor leading to constrained human resources to process research on a timely manner. For example, the Nutrition Unit of MRI currently only employs 1 technician to check 16,000 blood samples. With a problem so big, how can we possibly expect these institutions to release accurate data on a timely manner? Furthermore, the transfer of trained technicians and research assistants once again compounds these capacity constraints.

Recommendations

- A mandatory clause to offer employment to researchers on longer-term contracts – at least 5 years – to avoid the wastage of resources on training just to have them leave soon after.
- Invite researchers from civil society, business sector, academia, individuals to present their current research on a regular-basis (at least every year) – to ensure they are recognised for their hard work therefore increasing the incentive to conduct quality research.

6.1.4: Strengthening monitoring and evaluation of the impact of nutrition intervention programmes

Evaluating the impact and effectiveness of nutrition intervention programmes and enhancing the capacity of the provincial authorities to achieve their set targets

The Provincial Directors of Health Services communicated that there is *some sort of evaluation* being conducted, which however is not a uniform process. In general, the Consultant Community Physician conducts an evaluation annually. Further, there is said to be some technical assistance from the national level to evaluate provincial programmes. Nonetheless, conducting an evaluation is yet to be standardised and made mandatory.

Recommendation

- Develop a standardised evaluation procedure to be followed when conducting the evaluation.
- Make it compulsory for all districts to submit an evaluation report of the nutrition interventions.

Final Recommendations and Conclusion

1. Revise the outcome indicators to ones which can be monitored and reported regularly. To-date, of the 37 targets, 24 (shown by the grey boxes in the log frames) have not been reported on (or at least the study was not able to find published data on these). Set clear and plausible targets – *10% reduction from the current level* does not spell out clarity.

   The study calculated the targets based on the baseline data provided given the absence of 2010 data in most instances.
2. Make the conduction of the Demographic and Household Survey every 5 years compulsory. This activity need to be incorporated in the planning process to obtain financial resources. Carefully plan out the structure prior to its commencement to ensure the collection and reporting of accurate information. Failing to undertake a rigorous planning phase can lead to significant wastages of national resources. A good example is the DHS conducted in 2010/2011 which remains to be unpublished.
3. Incorporate assumptions and a timeline for all key action areas and activities.
4. Integrate Monitoring and Evaluation (M&E) processes at all levels. M&E of all interventions should be made mandatory.
5. Accept the civil society as valuable contributors to achieving the expected outcomes.
6. Incorporate a separate pillar/objective on building resilience to climate change and disasters – the recent (2016) floods indicated a degree of susceptibility to food insecurity.
7. Respond to requests and complaints of the public service delivery in a timely manner.
8. Ensure timely data reporting if efforts are undertaken to collect the data.

Make the policy – a document of the people! Information on decisions made and its implementation need to be made available to the public. The National Nutrition Policy should be co-owned by all other relevant ministries. Therefore, it should be governed by the Presidential level.

Overall, the National Nutrition Policy of Sri Lanka is a comprehensive document which covers almost all vital aspects to reach high levels of human and therefore economic development. National efforts to implement the policy are highly commendable. There is now a call for greater coordination and cooperation among all stakeholders – govt., non-govt., civil society organisation and more importantly the people, to eliminate the existing gaps and realise the set outcomes.

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