Stop Stunting I No Time to Waste
Scaling up Care for Children with Severe Wasting in South Asia

Sri Lanka
Demographic, Nutrition & Health Indicators

- CBR 2016 – 15.6 /1000
- CDR 2016 – 6.2 /1000
- MMR 2015 – 33.7 / 100,000 LB
- IMR 2013 – 8.2 /1000 LB
- Life expectancy at birth 2016 – 75yrs

DHS 1993, 2000, 2006

MRI 2012
- Stunting - 13.1%
- Wasting - 19.6%
- Underweight – 23.5%
Trends in wasting 2013-2016

Routine data collected by FHB

- **Severe Wasting**
  - DHS 2006 – 2.8
  - MRI 2009 – 1.9
  - MRI 2012 – 2.3
National Policy Response to Maternal and Childhood Undernutrition

- National Nutrition Policy
- Maternal & Child Health Policy
- National Strategy for IYCF, Sri Lanka 2015-2020
- Sri Lanka Code
- LBW prevention strategy

National Nutrition Secretariat at Presidential Secretariat

All relevant evidence based interventions implemented through a well established preventive and curative health system across life cycle as an integrated package island wide.
National Policy and Programmatic Response to Childhood Wasting

- Promotion of appropriate IYCF practices
- Regular growth monitoring and promotion and referrals to specialists
  - At CWC
  - Field weighing posts
  - Nutrition Clinics
- Food supplementation – locally prepared SF “Thriposha” for under nourished children (including MAM) aged 6-59 months
- Identification of SAM children and referrals for RUTF at above GMP sessions
New Recommendations:

Made by Maternal and Child Nutrition Subcommittee chaired by DDG PHS II (08/07/2011)

Endorsed by the Nutrition Steering Committee chaired by Secretary Health on 23/11/2011

- Mx of SAM children to be confined to hospitals with consultant pediatricians
  
  (for outpatient/clinic based care, inpatient management)

- All institutions with consultant paediatricians in all 26 health districts
• Severe wasting identified in the field

• Referred to hospitals with consultant paediatrician for management

**Severe Wasting** Wt/Ht<-3SD

- **With complications**
  - Referred to hospitals for in-patient care

- **Without complications**
  - RUTF at hospital clinics
  - Discharge when Wt/Ht >-3SD

  Introduce to supplementary feeding Programme
  - Thriposha
  - Discharge when Wt/Ht >-2SD
Key Milestones in expanding care for children with severe wasting

Pilot - Batticaloa, Jaffna ..... 2007 ➔ IDP settlements - from April 2009

• Tent to tent screening by volunteers using MUAC – referred to MCH clinic centers

• PHMs assessed weight /height

• If SAM with no complications ➔ RUTF x every 2 weeks

• If SAM with complications ➔ hospital care with therapeutic feeding

• If MAM – Supplementary food x monthly

From 2010 ➔ CMAM in 13 selected districts through the preventive healthcare system
Challenges and Constraints

- Primary prevention to reduce SAM burden (reduce new cases and relapses)
- Secondary prevention with RUTF
  - Procurement of RUTF – high cost of RUTF, funding, distribution chain
  - Coverage (effective coverage 10.5%) and referral
  - Adherence to national guidelines and protocols by health staff
  - Since severe clinical forms (Kwashiorkor, Marasmus) not present, SAM as a condition requiring treatment not been perceived
  - Field follow up to detect defaulters and ensure compliance
  - Monitoring - Record keeping and submitting returns
  - Acceptability of RUTF by SAM children
  - Misuse of RUTF

(MRI survey and Operational research conducted by FHB in 2016 and issues identified)
Opportunities to improve care for severely wasted children

- Policy support
- National Nutrition Secretariat of Sri Lanka at the Presidential Secretariat
- Ownership and leadership by the Ministry of Health
- UN support i.e. Unicef
- Availability of infrastructure & technical expertise
  - Well established preventive healthcare structure with a trained group of health workers
  - Island wide network of hospitals with Pediatricians
  - Nutrition clinics being established in curative sector
  - Postgraduate training in Human Nutrition
- High literacy rate and female empowerment etc
Key lessons

- RUTF only a short term intervention
- More focus on strengthening primary prevention is crucial i.e. Growth faltering, feeding during illness and CF during 6-12 months
- For preventing relapses - on recovery with RUTF hand in hand IYCF counseling for dietary behavior change a must
- Referrals from the field needs to be improved
- Children referred to hospital received adequate care
- Prescription by pediatrician minimize misuse
- Issues in acceptability of RUTF by SAM children
- Monitoring individual child progress, in order to ensure improvement. Thereafter regular follow up at MOH clinic to prevent relapse.
- Referral back to MOH clinic for supplementation and dietary behavior change.
Next steps and the future of care for children with severe wasting

- Revisit the current guideline on management of SAM; use of a combination of locally available food and RUTF rather than commercial preparation alone due to high cost of RUTF/acceptability issues etc.

- Increasing hospital referral for treatment based on present experience and findings of survey by FHB in 2016.

- Explore mechanisms to increase treatment coverage – hospital vs community.

- Strengthen collaboration with relevant stakeholders especially with Sri Lanka College of Pediatricians.

- Streamlining logistics of RUTF including data management.

- Strengthen management of early stage of growth faltering as a measure of primary prevention:
  - Reporting and supervision
  - Strengthen programme to promote IYCF practices including feeding during illness to reduce SAM burden in the community.

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Team

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