SRI LANKA CASE STUDY MOH/UNICEF

EMERGENCY CONTEXT

- Conflict affected population
- SAM ranging from 3.2% to 6.5%.
- Program was initiated as a Nutrition Rehabilitation Program (NRP) in November 2006

INTERVENTION AREA

- Implemented in four districts affected by conflict: Jaffna, Batticaloe, Killinochchci and Mullatovi
- Initial phase was among the displaced population and later expanded district-wide.

CMAM SERVICE SITES

Screening conducted by preventive health staff. Inpatient care conducted at a hospital. Outpatient care conducted at routine child health clinics.

- Inpatient care: 4
- Outpatient care: 200
- Supplementary feeding or services for MAM: 200
- Active community outreach workers and volunteers: Volunteers assist in community mobilization program, screening and home visits

PROCESS OF INTEGRATION

- 2006: National protocol prepared by adopting WHO and Valid International protocols.
- 2007: Training conducted for preventive and hospital health staff by the steering committee with technical and financial assistance by UNICEF.
- Program was integrated into the routine health system in preventive and curative sectors.
  - Community mobilization through public health midwives (child welfare clinics and home visits) assisted by volunteers.
  - Screening at clinic centers as a special program
  - 85-95% of coverage: initially only IDP population, then resettled population, after six months the entire district.
  - MOH will extend the program to more districts in 2008.

PROGRESS AND CHALLENGES IN INTEGRATION

Enabling Environment for CMAM

- Sri Lanka has a strong, free national health care system. MOH is motivated to take up the responsibility of CMAM.
- CMAM was included as a strategy in the draft national nutrition policy.
- MOH does not allow NGOs to set up parallel systems.

Access to CMAM Services

- MOH conducting screenings, tracing defaulters, home visits through the routine preventive health system.
- Coverage of the program is good (95%) and early detection possible due to routine home visits by the public health midwife at least once a month and referrals to the weighing center at the village level once a month.
- Coverage for the supplementary feeding program is poor. UNICEF provides high energy biscuits to fill the deficit.
- CMAM linked with regular program for Vitamin A, de-worming, immunizations and health and nutrition education through child welfare clinics.
- MUAC is not accepted as a screening tool. Weight for height is used as a tool to detect SAM. When the program was extended district-wide, children with SAM were identified through routine growth monitoring sessions.

Access to CMAM Supplies

- Supplies provided by UNICEF, but MOH uses its own drugs and manages logistics by ordering and delivering supplies.
- Transport of RUTF was a great challenge within the conflict affected areas.
- Acceptability study conducted at the center confirmed that the taste of Plumpy'nut was unpopular among children. BP-100 used as RUTF.
- MOH manufactures supplementary food (Thriposha similar to CSB but fully cooked).

Quality of CMAM Services

- A MOH medical officer carries out supervision and monitoring database is maintained at the district health office and updated every month.

Competencies for CMAM

- Motivated MOH: No additional allowances were provided to health personnel for trainings and workshops.