

Sri Lanka

Country Profile

- **Population:** 18.46 Million (1998)
- **Life Expectancy:** 71 years males, 75 years females (1998)
- **Crude Birth Rate:** 20 per 1000 population (1995)
- **Death Rate (Age/sex standardised):** 6 per 1000 population (1997)
- **IMR:** 18 (per 1000 live births) (1998)
- **< 5 MR:** 18 (1997)
- **Maternal Mortality Ratio:** 24 (per 100,000 live births) (1995)
- **Adult Literacy:** 90.2 (1995)
- **Total Fertility Rate:** 2.1 (1998)
- **Measles:** 158 reported cases (1996)
- **TB:** 5,439 reported cases (1996)
- **Human Development Index:** 0.711 (1994)
- **Per Capita GNP:** US\$ 700 (1995)

Sri Lanka is an island nation with a population of 18.5 million. The human development indicators in Sri Lanka are among the highest, almost equalling levels achieved by the developed regions. The achievements in the area of social welfare are considered to be remarkable for a developing country. Several social welfare measures implemented over the last few decades have yielded rich dividends. The national literacy rate has reached 90 percent and the differences in male and female literacy rates has been narrowed down to six percent. The IMR in the country is 18 and life expectancy is 71 years (males) and 75 years (females) (Table 1).

Nutritional Status

Protein-Energy Malnutrition (PEM)

Despite considerable social development in the country, prevalence of malnutrition continues to be high. Nearly 16 percent of children under five years suffer from moderate and severe stunting and 30.7 percent are underweight (12 & 13). A clear pattern of geographical differential of childhood undernutrition was observed. The eastern sector in south-central hills of the

Nutritional profile of Sri Lanka

- **Per capita energy supply:** 2262 kcal/day (1994-96) (38)
- **Per capita energy supply:** 2262 kcal/day (1994-96) (38)
- **Energy from cereals:** 57% (1994-96)
- **Per capita total protein supply:** 49 g/day (1994-96)
- **Per capita fat supply:** 44g/d (1990-92)
- **Children < 5 years underweight:** 30.7% (1993)
- **Children < 5 years stunted:** 16.1% (1996)
- **LBW babies (<2500g):** 18% (1995)
- **Prevalence of TGR in school children:** 14.4% (1997)
- **Prevalence of anaemia in pregnant women:** 58% (1994)
- **Prevalence of anaemia in children <5:** 45% (1994)
- **Prevalence of Bitot spots due to vitamin A deficiency :** 0.6% (1995)
- **Exclusive breast-feeding in infants 0-3 months:** 24% (1990-96)
- **Breast-fed with complementary food in infants 6-9 months:** 60% (1990-96)

country was worst affected, while Colombo and south-western coastal lowlands showed relatively better standards. Undernutrition as indicated by wt/age has improved during the decades together with per capita energy consumption and probably reflects the impact of numerous nutrition intervention programmes. On the other hand, in rural areas, stunting has remained almost static, whereas wasting or short duration malnutrition as indicated by weight-for-height has increased. The data on trends indicate that prevalence of stunting remained high for a long period and showed a decrease only in 1993. Overall, the nutritional level for both height-for-age and weight-for-age has improved between 1987 and 1993. But wasting (weight-for-height) showed a slight deterioration. Wasting or acute malnutrition is due to sudden inadequacy of food usually accompanied with infection. The increase in wasting may therefore be due to the increase in the cost of living and consequent lower purchasing power. The prevalence of low birth weight is 18 percent indicating maternal malnutrition.

Iodine Deficiency Disorders (IDD)

Iodine deficiency exists in all segments of the population. About 70 percent of the population are at risk of developing IDD.

The prevalence of TGR in 1997 was reported to be 14.4 percent. Sri Lanka has adopted the strategy of universal salt iodisation for elimination of IDD. The main constraint in implementing this programme is grossly inadequate production of iodised salt (only 15 percent of its requirement).

Anaemia

In spite of numerous intervention programmes launched through MCH clinics, the prevalence of anaemia has been reported as 58 percent in pregnant women, and 45 percent in children below five years (3). Nutritional deficiency, worm infection and malaria are considered to be the major causes of anaemia. Anaemia control programme of distribution of iron and folic acid tablets is implemented through MCH services. Routine deworming and health education for improving personal hygiene are promoted.

Vitamin A Deficiency (VAD)

Studies done in 1975 showed that in some pockets of Sri Lanka, the prevalence of Vitamin A deficiency was (1.10) high. The results of recent survey undertaken by Medical Research Institute in 1995 shows a prevalence of Vitamin A Deficiency as 0.6 percent (Bitot spot). VAD, although reduced, is still a public health problem in Sri Lanka.

Feeding Status of Infants and Young Children

Breast-feeding is nearly universal in Sri Lanka. At the overall level, 98 percent of children were ever breast-fed and the mean duration of breast feeding is 3-4 months (12). Exclusive breast-feeding till three months is 24 percent. At the age of 4-5 months, majority of infants receive complementary food in addition to breast milk. These consist of other milk, fruit juice, solid or mashed food. A national level committee has been constituted for monitoring breast-feeding in the country.

Constraints & Actions for the Future

Although the programmes of food supplementation have been in operation for about three decades, there is no significant reduction in the prevalence of malnutrition among children below 36 months. Cost-effectiveness and sustainability of supplementary “Tripusha” foods used in feeding programmes need to be evaluated. There is a scope of building in more effective and intensive antenatal and postnatal services, since incidences of anaemia in pregnancy and low birth weight are still high. A major hurdle in enforcement of legislation for salt iodisation is the inadequate capacity of small provinces to manufacture iodised salt. Until this problem is overcome, iodised salt may have to be imported.

There is an uneven geographical distribution of health resources and facilities. Services do not reach socially and economically marginalised segments of people. Community involvement needs to be encouraged in planning, management of nutrition services at local level. For strengthening food safety programmes, adequate training of laboratory technicians and food inspectors is required. WHO and other UN agencies could possibly extend the necessary support in this regard.

A major constraint in achieving the nutritional goals in the country is the armed conflict in northern and eastern areas. The continuous state of violence has not only strained the national economy, but also severely limited access to health and nutrition services for women and children. Due to budgetary constraints, welfare expenditure as percentage of total expenditure has been reduced considerably (29).