National Nutrition Month 2026

SUMMARY REPORT









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SUMMARY REPORT

National Nutrition Month

2026

“Rethink Snacks
Choose Healthy and Natural Snacks”

Family Health Bureau

Ministry of Health
Sri Lanka

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1. Introduction

National Nutrition Month (NNM) is an annual initiative conducted by the Ministry of Health, Sri Lanka, to raise public awareness of current nutrition issues, promote healthy dietary practices, and strengthen nutrition-related interventions across the country.

The concept of NNM was introduced in 2006 by the Family Health Bureau (FHB), primarily to facilitate a comprehensive assessment of the nutritional status of children under five years of age. The initiative aimed to generate nationally representative data on childhood nutrition, enabling the assessment of nutritional trends over time and supporting evidence-based planning, implementation, and evaluation of nutrition interventions. As part of this initiative, anthropometric measurements, including weight and length or height, were obtained from children under five years of age through an island-wide assessment. These assessments were conducted irrespective of the routine measurement schedules recommended under the Growth Monitoring and Promotion programme. Over the years, this initiative has contributed significantly to the availability of comprehensive nutritional data, facilitating the monitoring of trends and identification of priority areas for targeted interventions.

Subsequently, the scope of activities conducted by FHB through the National Maternal and Child Health Programme during the NNM was expanded to include pregnant women and schoolchildren, recognizing the importance of addressing nutritional needs across different stages of the life course. Accordingly, special nutrition assessments are conducted annually during June to evaluate the nutritional status of these population groups, in addition to children under five years of age.

In 2026, National Nutrition Month was conducted under the theme *"Rethink Snacks – Choose Healthy and Natural Snacks,"* highlighting the importance of promoting healthier snacking practices and encouraging the consumption of nutritious, natural food choices.

The primary objectives of FHB activities for the NNM 2026 were to assess the nutritional status of children under five years of age and schoolchildren at national and subnational levels, and to disseminate updated nutrition data to inform evidence-based decision-making. Additionally, in May 2026, two nationwide cross-sectional assessments were carried out among antenatal women to assess knowledge, attitudes and beliefs on micronutrient and to assesses practices related to micronutrient supplementation. The initiative aimed to identify gaps in maternal knowledge and supplementation practices, improve awareness among antenatal women, and strengthen the knowledge and counselling capacity of field healthcare workers.

The findings are intended to strengthen nutrition service delivery, streamline interventions, identify priority populations, and facilitate the implementation of targeted strategies to address prevailing nutritional challenges.

2. Methods

Preparatory Activities for National Nutrition Month 2026

Preparatory activities for NNM 2026 commenced in May 2026. As part of these preparations, the Family Health Bureau (FHB) conducted technical update sessions on 8 May 2026 for Medical Officers of Maternal and Child Health (MOMCHs), Medical Officers of Health (MOHs), other supervisory public health staff at provincial, district and MOH levels and Public Health Midwives (PHMs). These sessions were conducted virtually in both Sinhala and Tamil languages to facilitate the dissemination of updated technical guidance and ensure uniform implementation of planned activities across the country.

2.1 Assessment of Children Under Five Years of Age

PHMs were instructed to inform and encourage parents/caregivers of all children under five years of age in their respective areas to present their children for anthropometric assessment during the month of June.

Refresher training sessions were conducted for relevant healthcare personnel to reinforce standardized anthropometric measurement techniques in accordance with established guidelines. These sessions aimed to ensure the accuracy, reliability and consistency of measurements, maximize assessment coverage, and facilitate the early identification of growth faltering and other deviations from expected growth patterns, enabling timely and appropriately targeted interventions.

To ensure uniformity in methodology, data collection and reporting, revised data collection formats and written guidelines were disseminated in all three languages through MOMCHs and MOHs. These measures were intended to strengthen data quality and ensure consistency in the implementation of anthropometric assessments across the country.

All MOHs were instructed to maximize assessment coverage among all children under five years of age. Particular emphasis was placed on promoting parental participation and improving accessibility to growth assessment services to ensure the inclusion of as many eligible children as possible.

In addition, the FHB, with the support of UNICEF, developed and disseminated public awareness materials through social media platforms. These initiatives aimed to increase awareness among parents and caregivers of the importance of regular growth assessment, encourage their active participation and thereby improve the coverage of anthropometric assessments during National Nutrition Month 2026.

2.2 Assessment of school children:

Assessment of nutrition of school children was carried out using a cross-sectional study design. A nationally representative sample of schools registered under the Ministry of Education was selected covering all nine provinces and 26 health districts of Sri Lanka. The study population comprised students in Grades 1, 4, 7 and 10, corresponding to the grades routinely assessed under the School Medical Inspection (SMI) programme.

Of the 10,047 schools registered under the Ministry of Education, a fixed sampling fraction of 15% was applied in each province. This sampling strategy was adopted to obtain precise national estimates while ensuring adequate representation of schools and students within each province to facilitate provincial-level and subgroup analyses. The sampling approach also took into consideration the available field capacity and operational feasibility during National Nutrition Month.

The final sample comprised 1,501 schools across 362 Medical Officer of Health (MOH) areas. Data were collected in the selected schools during Nutrition Month 2026 by the Public Health Inspectors (PHIs) of the MOH area in which each school was located. Field work was supervised by the MOH at the divisional level and coordinated by the Medical Officer – Maternal and Child Health (MO-MCH) at the regional (RDHS) level. Dates for measurement were agreed in advance with the principal of each school. Before starting the survey, awareness was created among MOMCH and MOH via Zoom training sessions. All supervising officers were instructed and encouraged to supervise these activities continuously in order to assure the quality of measurements and services. Each student's height was plotted on the WHO height-for-age chart and body mass index (BMI) was calculated and plotted on the WHO BMI-for-age chart to identify the nutritional status of the children.

The collected data were recorded and reported to Family Health Bureau through the eRHMIS system.

2.3 Assessment of maternal micronutrient supplementation among antenatal women

Two nationwide cross-sectional assessments were conducted among antenatal women in May 2026. One assessment was conducted to assess the knowledge, attitudes and beliefs on micronutrient supplementation among antenatal women, whereas the other was to assess practices related to micronutrient supplementation. Five antenatal women in their third trimester from each MOH area were selected for knowledge, attitudes and beliefs assessment. For the micronutrient supplementation practices assessment, each PHM was asked to interview one antenatal woman in her third trimester during the month of May 2026 during her domiciliary visit.

Knowledge, attitudes and beliefs were assessed among 1,835 antenatal women whereas supplementation practices were assessed among 5,784 antenatal women. Data were collected by Public Health Nursing Sisters (PHNS), Supervising Public Health Midwives (SPHM) and Public Health Midwives (PHM), using structured interviewer administered questionnaires prepared by Family Health Bureau.

3. Results

3.1 Nutritional status of children under 5 years of age

3.1.1 Reporting rates

All 362 MOH areas covering 6,922 PHM areas in the country provided data with a national reporting rate of 100% (Figure 1).

100%	97.7%	1,101,438
National reporting rate	Assessment coverage	Children measured

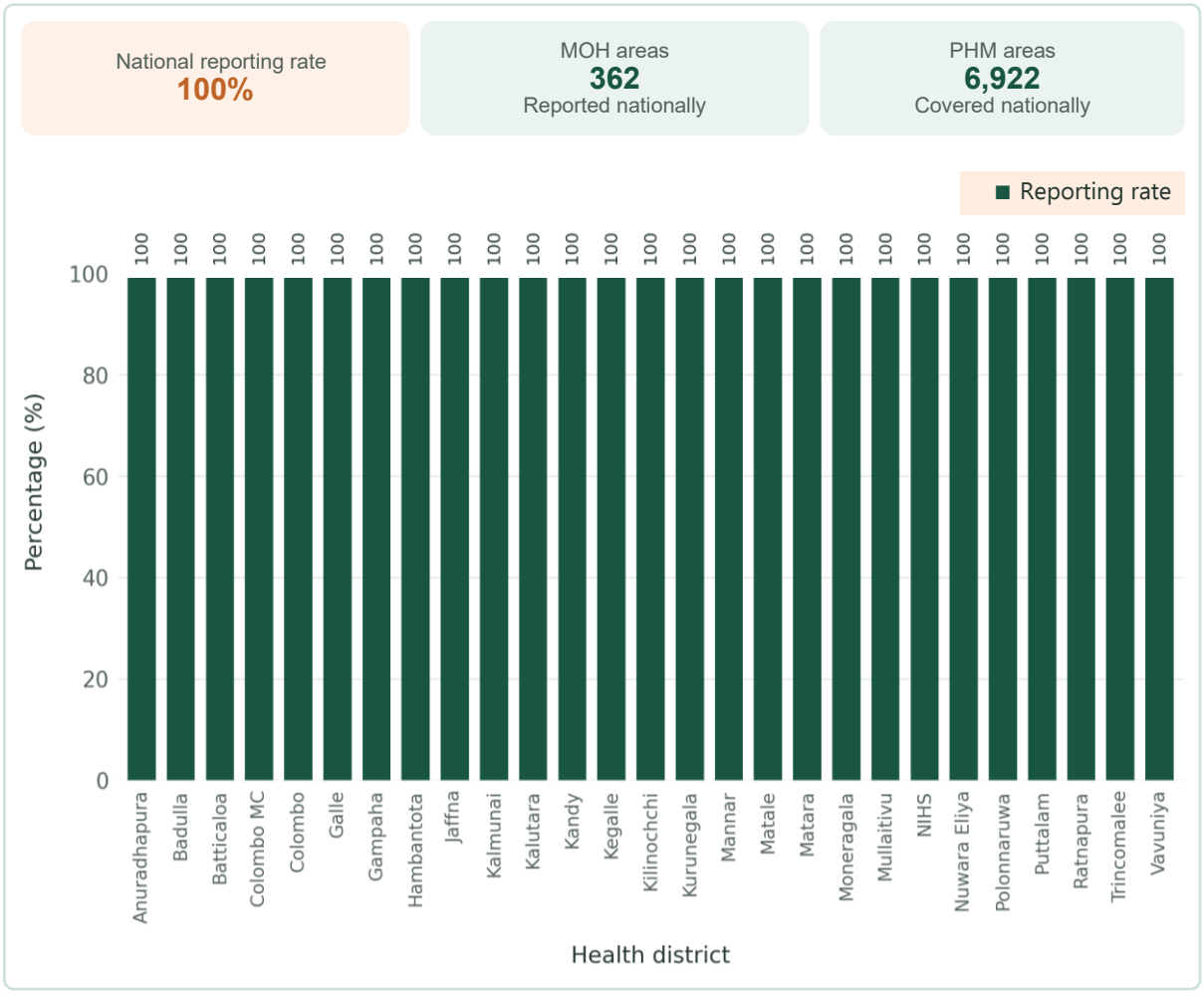


Figure 1: National Nutrition Month Reporting Rate 2026

Source: eRHMIS 2026

3.1.2 Assessment coverage of children under 5 years

A total of 1,127,102 children under 5 years of age have been registered with Public Health Midwives in Sri Lanka of which 1,101,438 children were measured during the month of June with an assessment coverage of 97.7%. Highest coverages (100%) were achieved by the districts, Ampara, Badulla, Kilinochchi, Mannar followed by districts of Hambantota, Jaffna, Nuwaraeliya, Moneragala and Trincomalee (99.9%). Lowest assessment coverage was reported from Colombo Municipal Council area, which was 84.1% (Figure 2). All districts have shown an improvement in assessment coverage except in Matara, Galle, Kandy, Kalutara and Puttalam districts where a slight reduction of the coverage was observed when compared to 2025.

National assessment coverage
97.7%
Children under 5 years

Children registered
1,127,102
Public Health Midwives

Children measured
1,101,438
June 2026

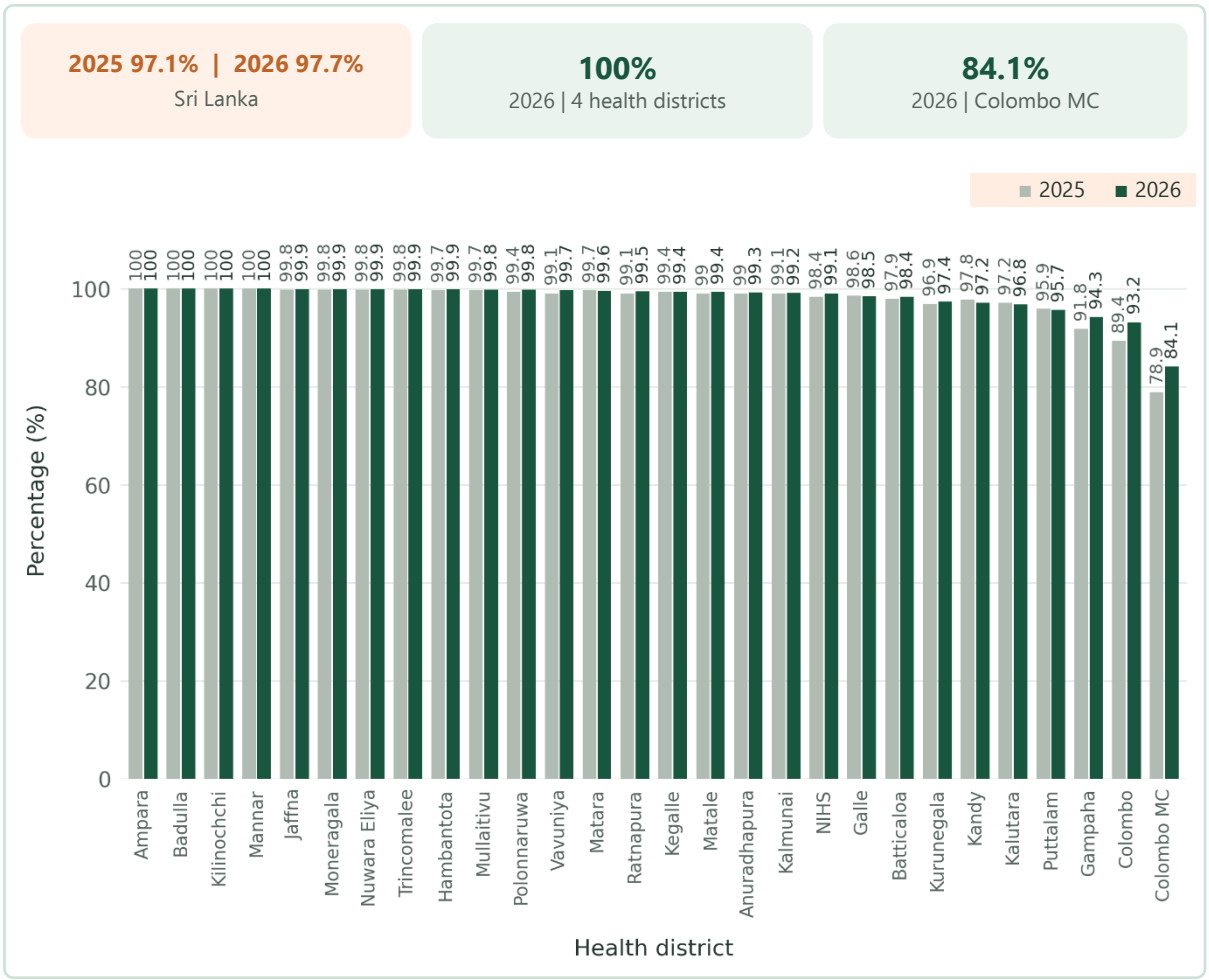


Figure 2: Percentage of children under 5 years measured for growth out of number registered

Source: eRHMIS 2026

3.1.3 Children under 5 years with underweight

Underweight is defined as low weight-for-age (less than -2SD). A child whose weight is in the orange or red zones in the weight for age chart in the Child Health and Development Record (CHDR) is considered as underweight. A child could be categorized as underweight due to stunting, wasting or due to both conditions or due to low birth weight.

Percentage of children under 5 years with underweight was 15.1% in 2026, which is an improvement from the reported rate of 16.1 % in 2025. Highest underweight percentage was reported from Nuwara Eliya district in 2026 i.e. 23.1%. However, it has reduced from 24.1% in 2025. Most of the districts have reported a slight decrease in their underweight prevalence except Mullaitivu, Mannar and Kilinochchi which reported higher rates when compared with the last year (Figure 3).

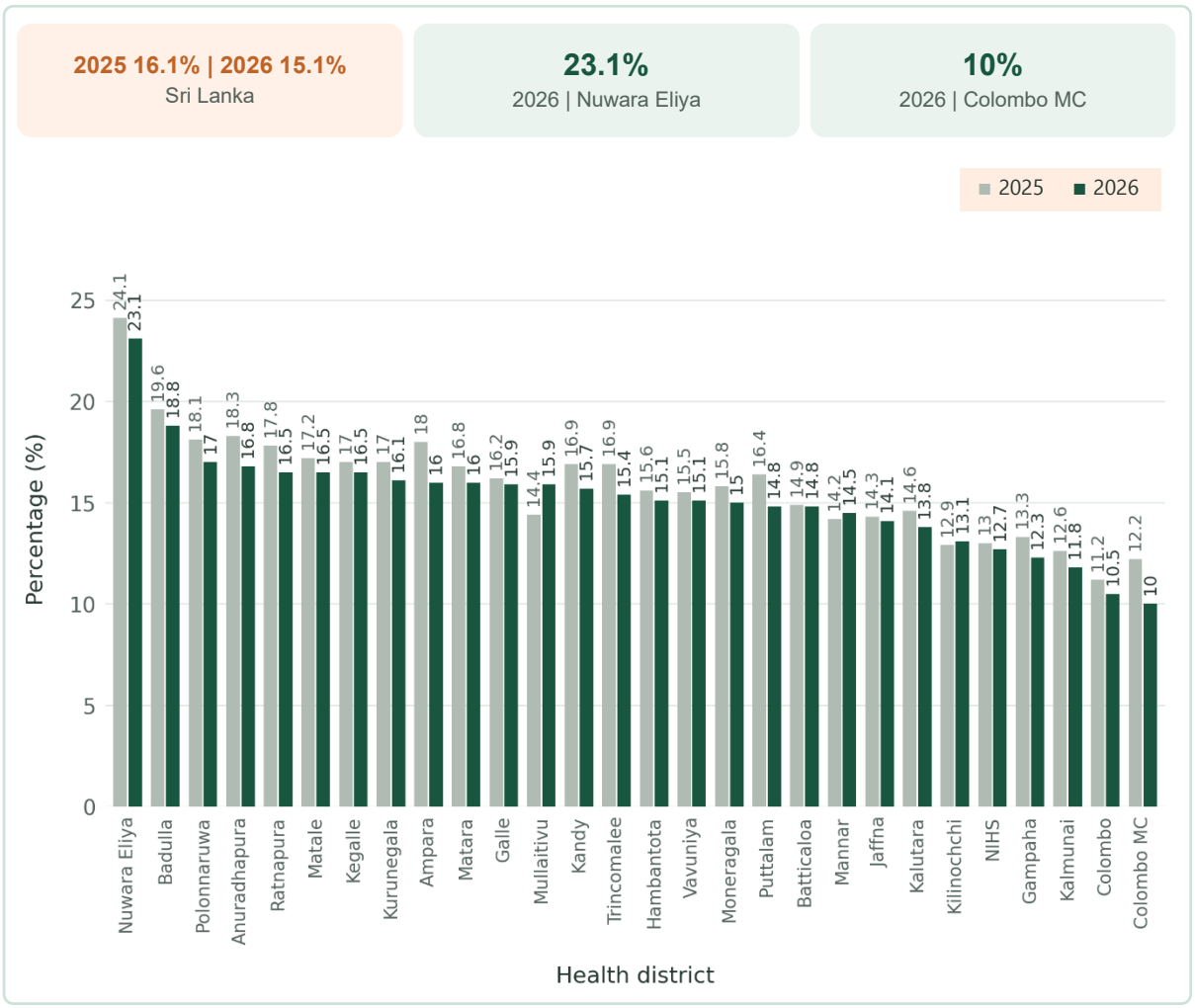


Figure 3: Percentage of children under 5 years with underweight (moderate + severe) by district

Source: eRHMIS 2026

Sector-wise reporting of underweight showed a reduction in the prevalence of underweight in all three sectors. The estate sector has shown higher rates of decline during 2024-2026 than the other two sectors. (Figure 4).



Figure 4: Percentage of children under 5 years with underweight (moderate + severe) by Sector

Source: eRHMIS 2026

3.1.4 Children under 5 years of age with wasting (acute malnutrition)

Wasting is defined as low weight-for-length/height (< -2SD). It often indicates recent and significant weight loss, although it could also persist for a long time. This condition usually occurs due to dietary inadequacies and/or illness.

Percentage of wasting among children under 5 years was reported as 8.1% in 2026. It has decreased when compared to the last year (8.6%). This reduction is seen in most of the districts except Mullaitivu, Mannar, Batticaloa and Kilinochchi districts which reported an increase and Kalutara and Matara which remained at the same level. The highest rate of wasting was reported from Mullaitivu (10.4%). The district of Polonnaruwa which reported the highest wasting percentage in 2025 (10.7%), has shown a noteworthy reduction (8.8%) in 2026 (Figure 5). Galle, Jaffna and Kandy have not shown notable reductions compared to 2025.

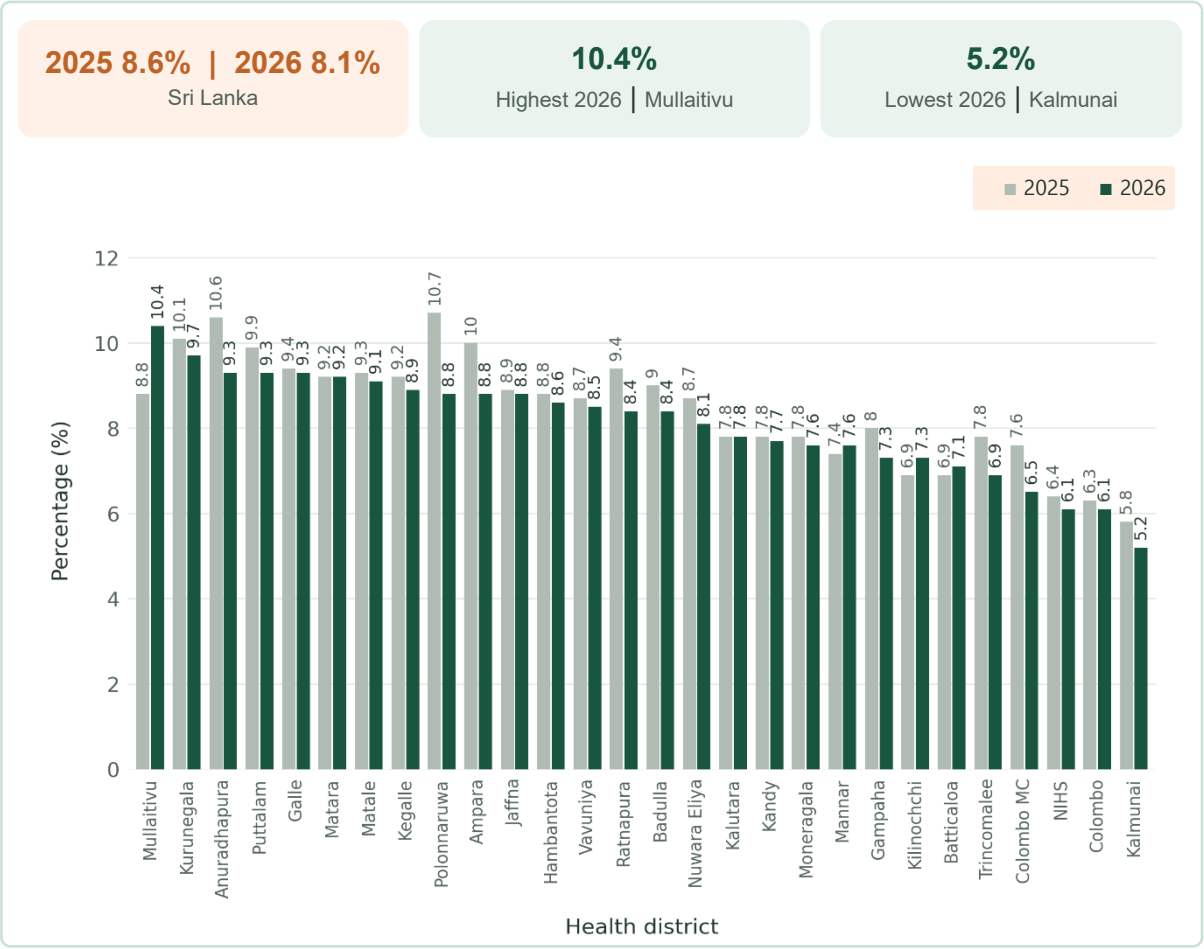


Figure 5: Percentage of children under 5 years with wasting (SAM + MAM) by district

Source: eRHMIS 2026

Wasting continues to show a declining trend from 2024 to 2026 in all three sectors (estate, rural and urban) in 2026 (Figure 6). Urban sector shows a low rate of decline in 2025-2026 when compared with 2024-2025.

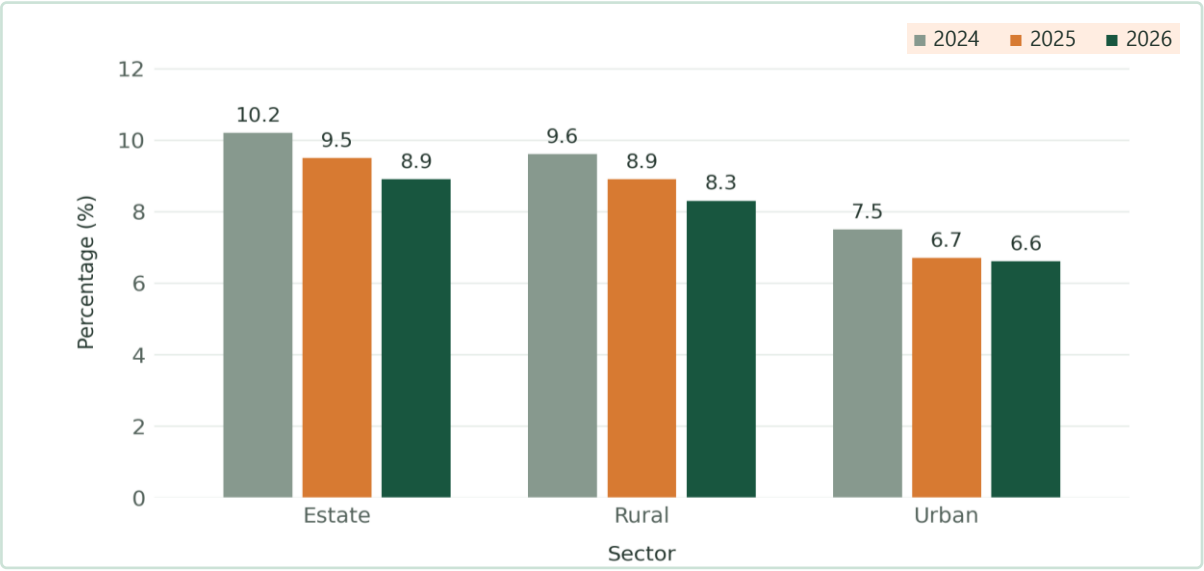


Figure 6: Percentage of children under 5 years with wasting by sector

Source: eRHMIS 2026

3.1.5 Children under 5 years with moderate wasting (Moderate acute malnutrition - MAM)

MAM is defined as **moderately low weight for length/height (-2SD to -3SD).** MAM has reduced from 7.7% in 2025 to 7.3% in 2026 nationally and the same trend was observed in most of the districts except in Mullaitivu, Mannar, Matara, Batticaloa and Kilinochchi which reported an increase and Vavuniya which remained at the same level (7.7) when compared with 2025.

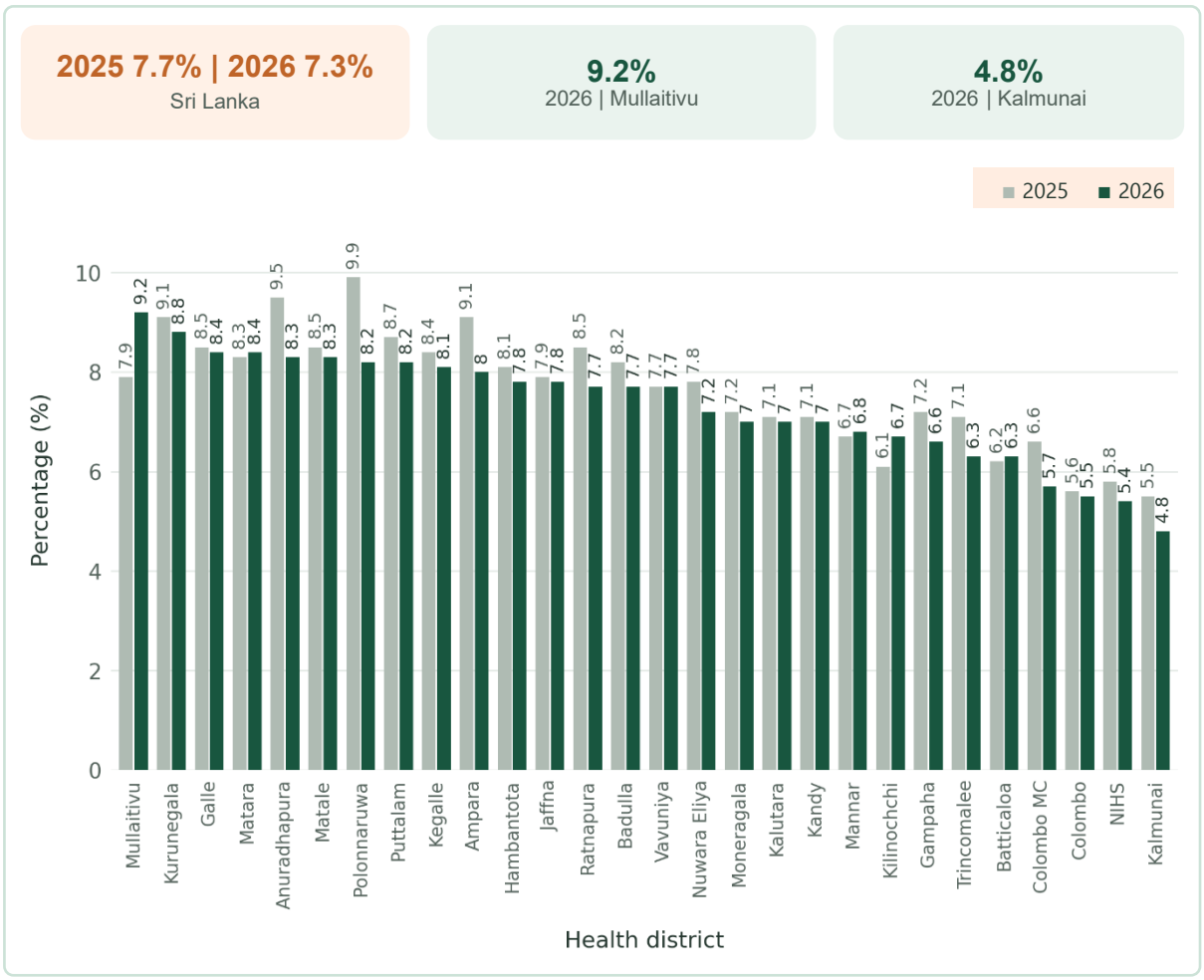


Figure 7: Percentage of children under 5 years with moderate wasting (MAM) by district

Source: eRHMIS 2026

Similar to the trend in wasting, the sector wise comparison of MAM trend shows a decreasing rate in all three sectors over the years (Figure 8). However, Urban sector shows a low rate of decline in 2025-2026 when compared with 2024-2025.

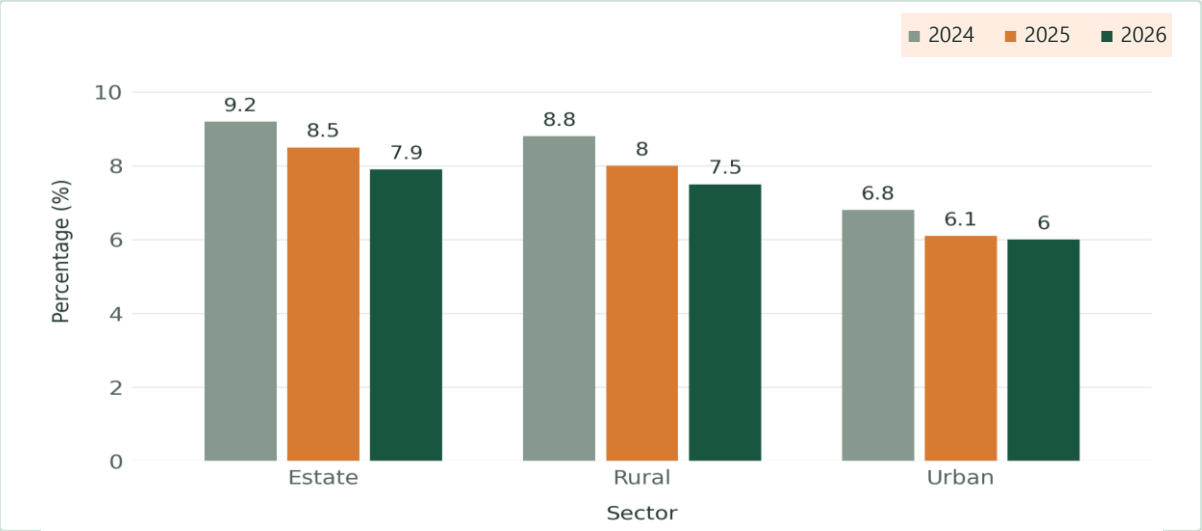


Figure 8: Percentage of children under 5 years with moderate wasting (MAM) by sector

Source: eRHMIS 2026

3.1.6 Children under 5 years with severe wasting (Severe acute malnutrition -SAM)

SAM is defined as **a severely low weight for length/height (< -3SD).** A total of 8,558 (0.78%) SAM children were reported in 2026 compared to the 9,554 (0.82%) in 2025 (Annexure 1). In 2026, percentages of SAM children have increased in Mullaitivu, Matale, Kegalle, Kandy, Mannar, Hambantota, Kalutara, Kalmunai and NIHS areas compared to 2025 while in Batticaloa it remains static (7.6%) (Figure 9).

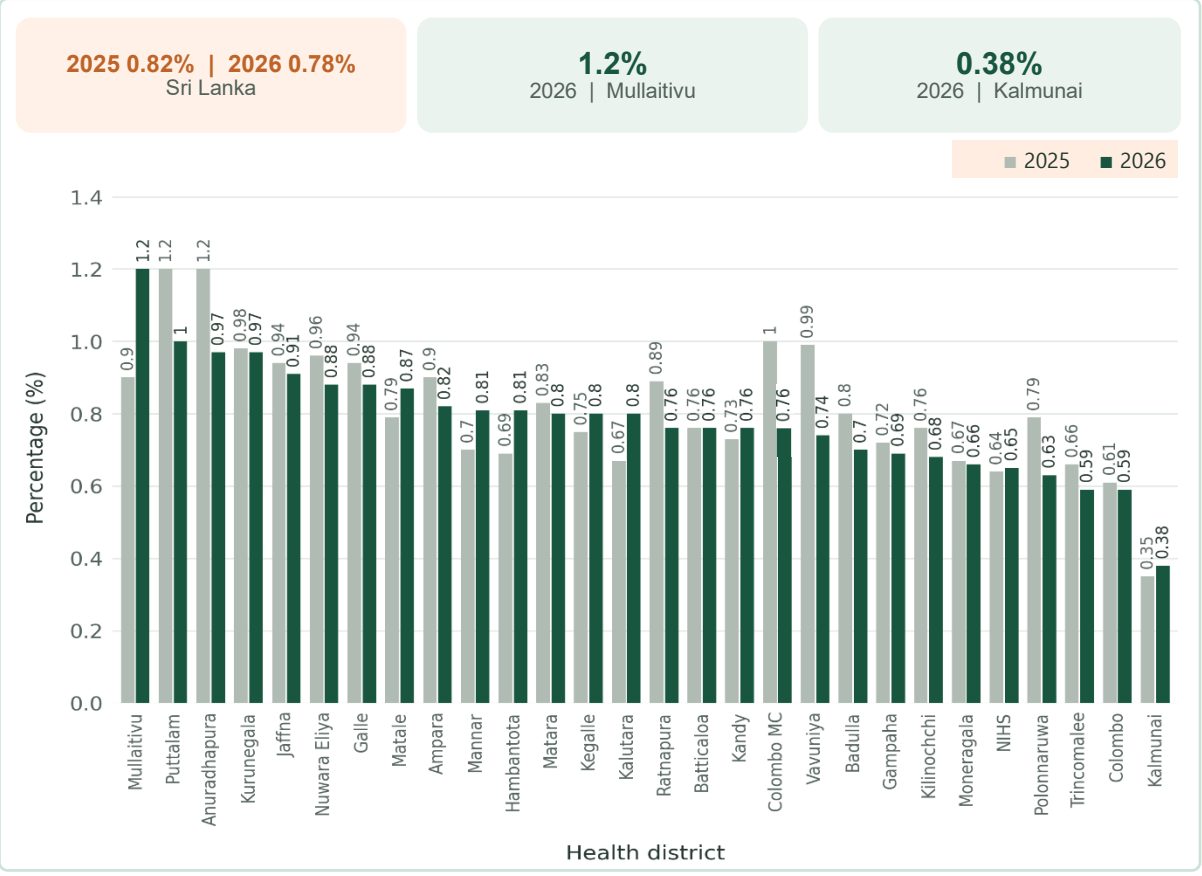


Figure 9: Percentage of children under 5 years with severe wasting (SAM) by district

Source: eRHMIS 2026

Prevalence of SAM which remained static in 2024-2025 has slightly reduced in all 3 sectors in 2025-2026.



Figure 10: Percentage of children under 5 years with severe wasting (SAM) by sector
Source: eRHMIS 2026

3.1.7 Services received by SAM children

Identification of SAM children outside the NNM needs improvement. The percentage referred for specialized care (85.6%), specialized clinic attendance after being referred (76%) and the receipt of BP 100 on attending the specialized clinic (49.9%) have improved when compared with 2025 but in need of further improvement, especially the receipt of BP100.

Table 01 : Identification, referral and receipt of services by SAM children

Indicator	2025		2026	
	Number	(%)	Number	(%)
Under 5 children identified with SAM	9554	0.82	8558	0.78
SAM children identified before this nutrition month	*	*	4018	47.0
SAM children identified during this nutrition month	*	*	3901	45.6
SAM children referred by MOH for specialist's care	6929	72.5	7327	85.6
SAM children attended specialized clinic after referral	5669	59.3	5572	76.0
SAM children receiving BP 100 (out of attended specialized clinic)	2800	29.3	2782	49.9

Source: eRHMIS 2026

**These data elements were introduced from 2026 with National Nutrition Month Child Nutrition – 2026 format revision.*

3.1.8 Children under 5 years with stunting

Stunting is defined as low length/height-for-age (<-2SD). It could be a result of nutritional inadequacy (longstanding inadequacy or repeated acute inadequacy). Stunting prevents children from reaching their full physical and cognitive potential.

It was noted that the overall stunting percentage has reduced from 10.1% in 2025 to 9.5% in 2026. The highest percentage of stunting was still reported from the district of Nuwaraeliya even though it has reduced to 21.1% in 2026 from 22.4% in 2025 (Figure 10). The district of Badulla is still the second highest with a reduction from 14.5% in 2025 to 13.2% in 2026. Stunting rate has increased in the district of Mannar, Jaffna, Mullaitivu and Gampaha, and has remained static in Batticaloa, Kegalle and Kilinochchi compared to 2025.

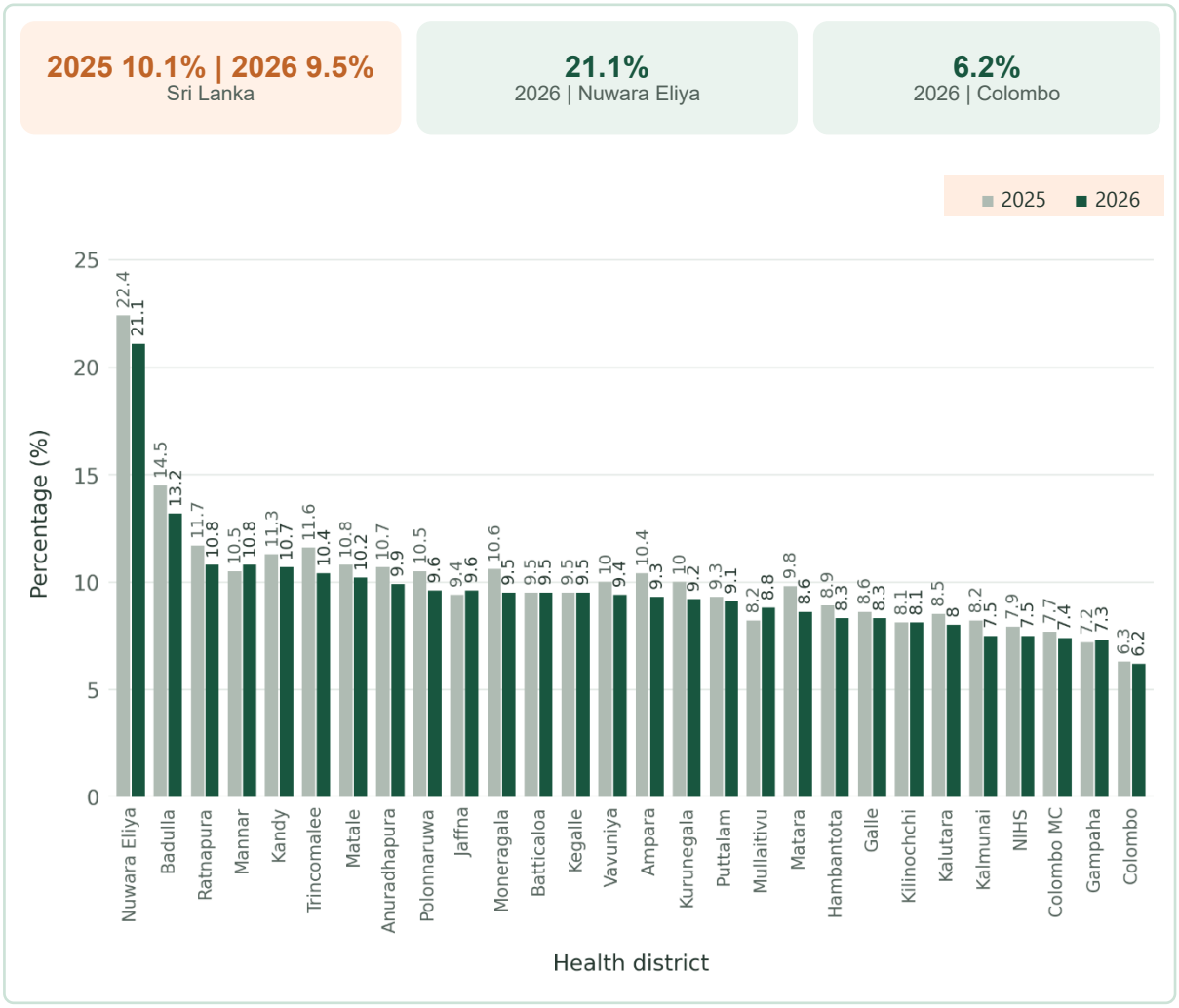


Figure 11: Percentage of under 5 children with stunting (moderate + severe) by district

Source: eRHMIS 2026

In all three sectors, a reduction of the rate of stunting is observed. The rate of decline in 2025-2026 is also higher for all 3 sectors than 2024-2025. (Figure 12).

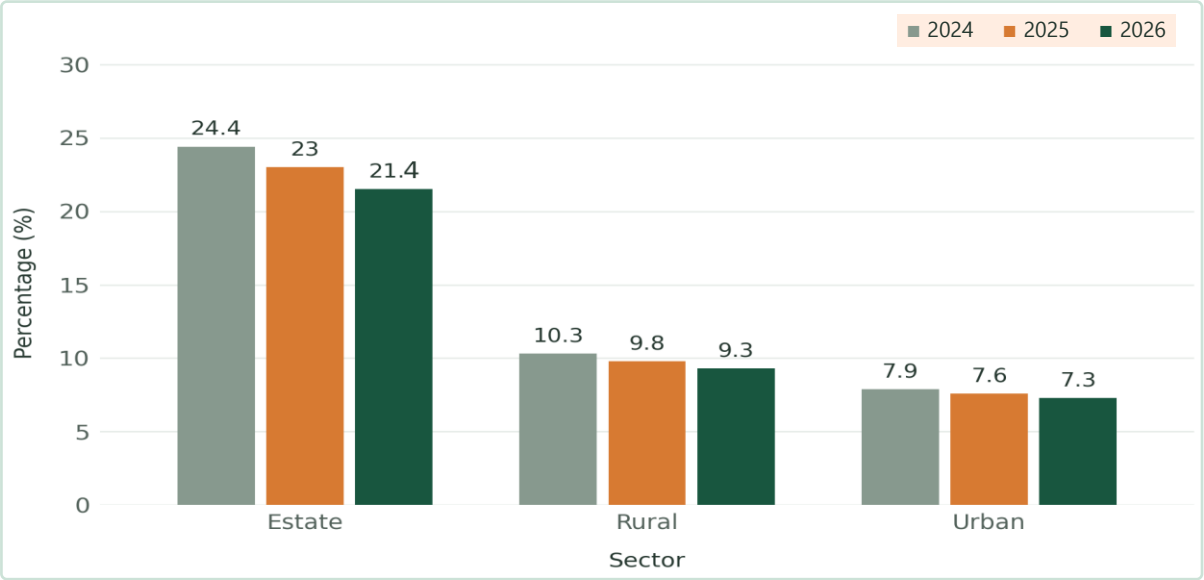


Figure 12: Percentage of children under 5 years with stunting (moderate + severe) by sector

Source: eRHMIS 2026

3.1.9 Children under 5 years with overweight and obesity

Overweight/ obesity (weight for length/height > +2SD) has increased from 0.57 % in 2025 to 0.62% in 2026 among children under 5 years of age (Figure 13). Most of the districts show an increase in overweight and obesity compared to 2025.

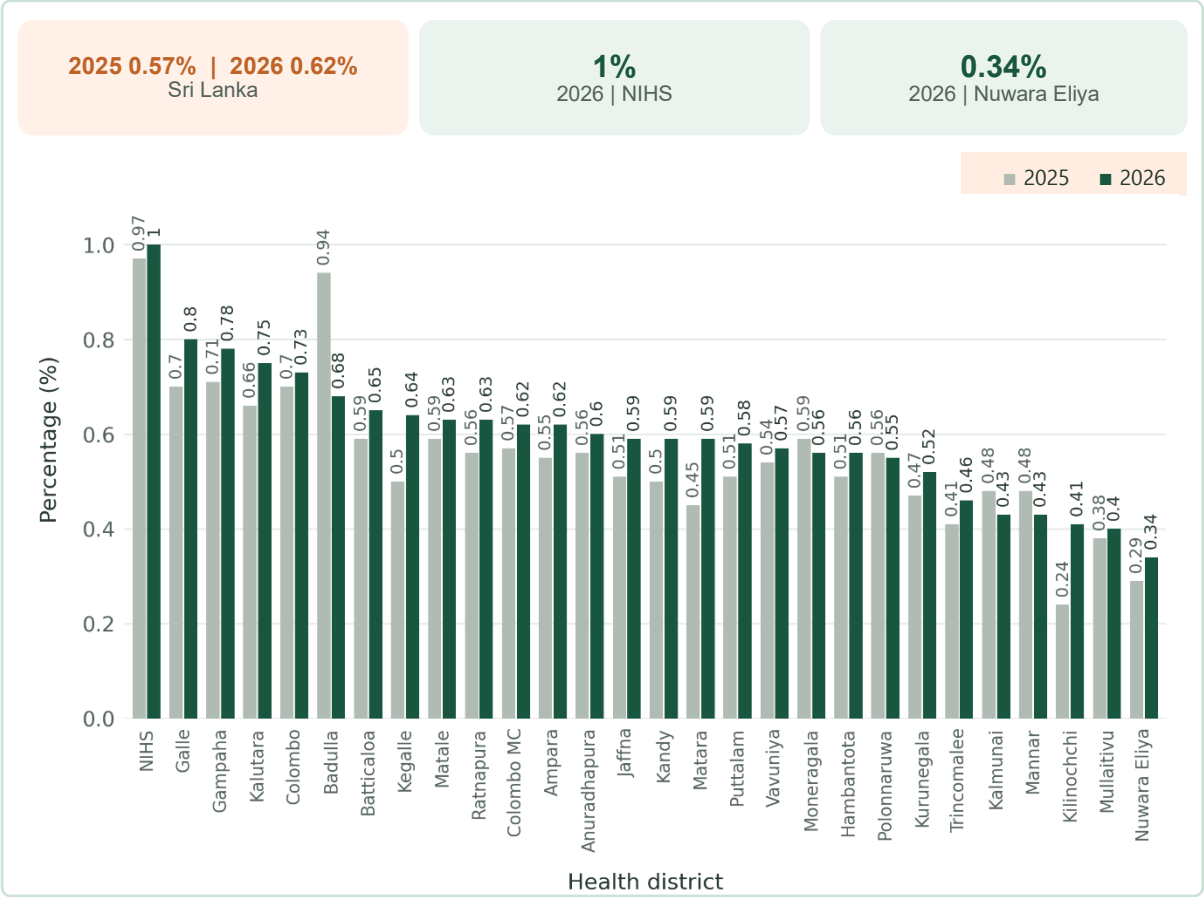


Figure 13: Percentage of children under 5 years with overweight and obesity by district

Source: eRHMIS 2026

In 2026, overweight/obesity prevalence has slightly increased in urban and rural sectors compared to 2025 however, it remains the same in estate sector.

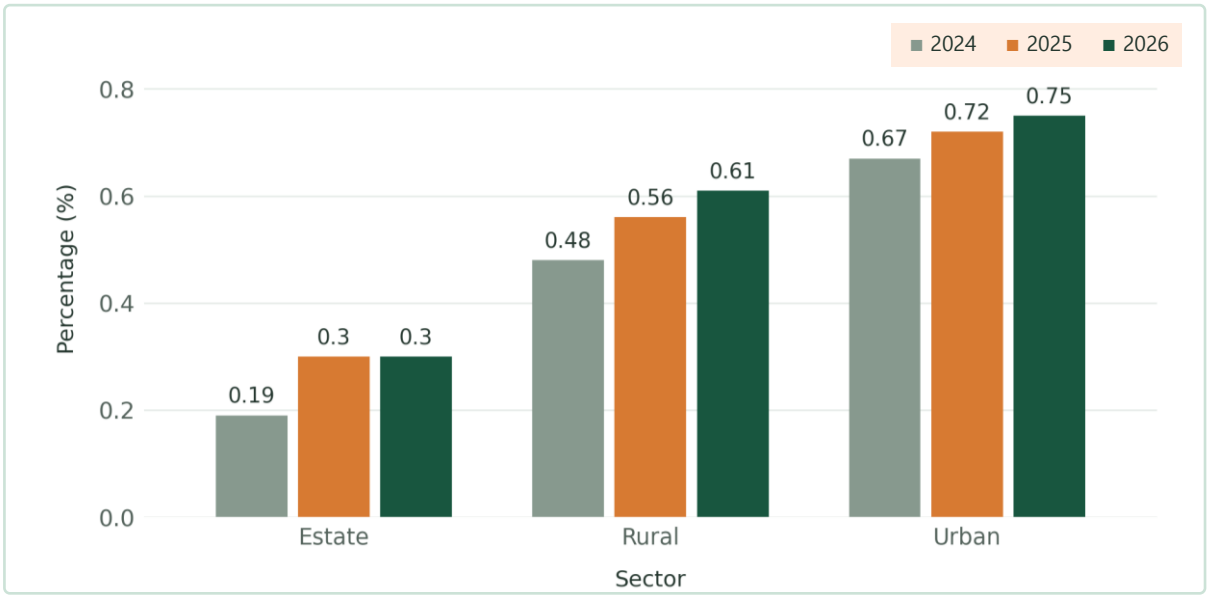


Figure 14: Percentage of children under 5 years with overweight and obesity by sector

Source: eRHMIS 2026

3.1.10 Nutrition status of children under 5 years by age categories

Infants (under 1 year of age)

Prevalence of underweight among infants remains the same in 2026 compared to 2025. Wasting and overweight has slightly reduced while stunting has increased in 2026 compared to 2025 (Figure 15).

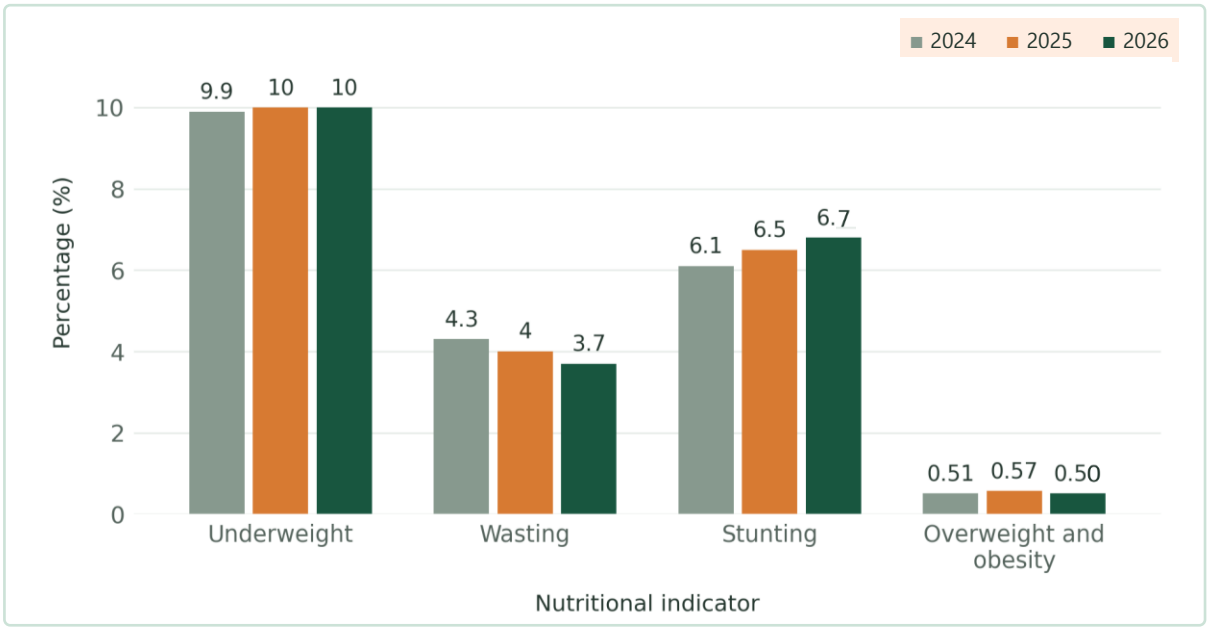


Figure 15: Nutrition status of infants under 1 year

Source: eRHMIS 2026

Children 1-2 years of age

In the 1-2-year age group, underweight, wasting and stunting have reduced compared to 2025 and a slight increase is observed in overweight/obesity (Figure 16).

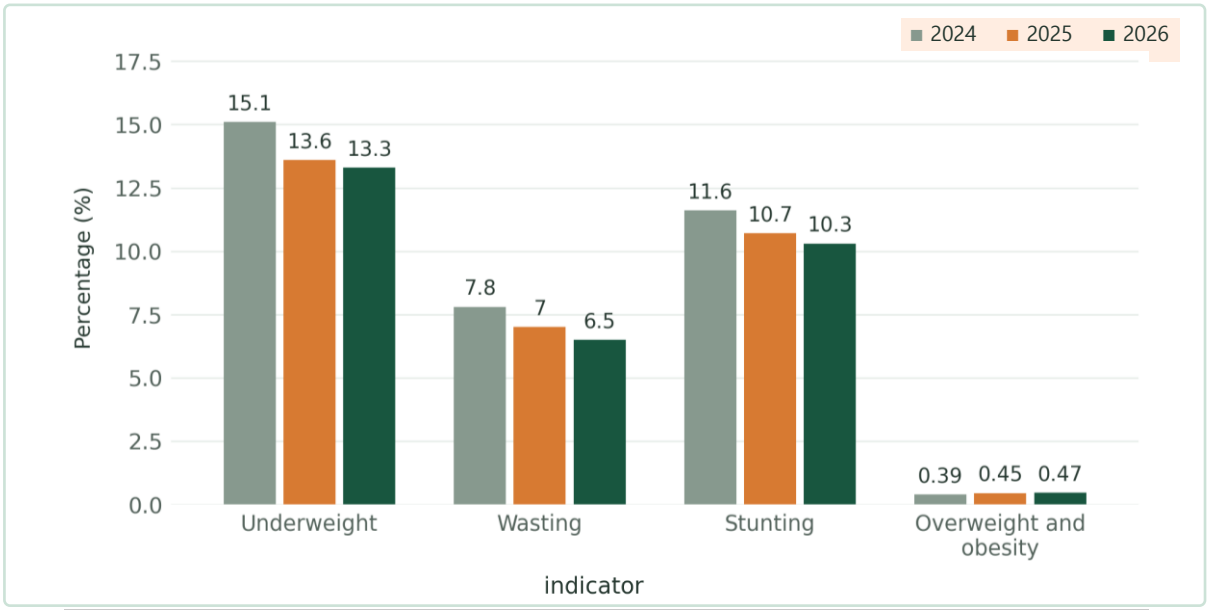


Figure 16: Nutrition status of young children between 1 to 2 years

Source: eRHMIS 2026

Children 2-5 years of age

Similar to the 1-2-year group, underweight, wasting and stunting among the preschoolers (2-5 years old) has reduced compared to 2025, while the increase in overweight/obesity is more marked in this age group (Figure 17).

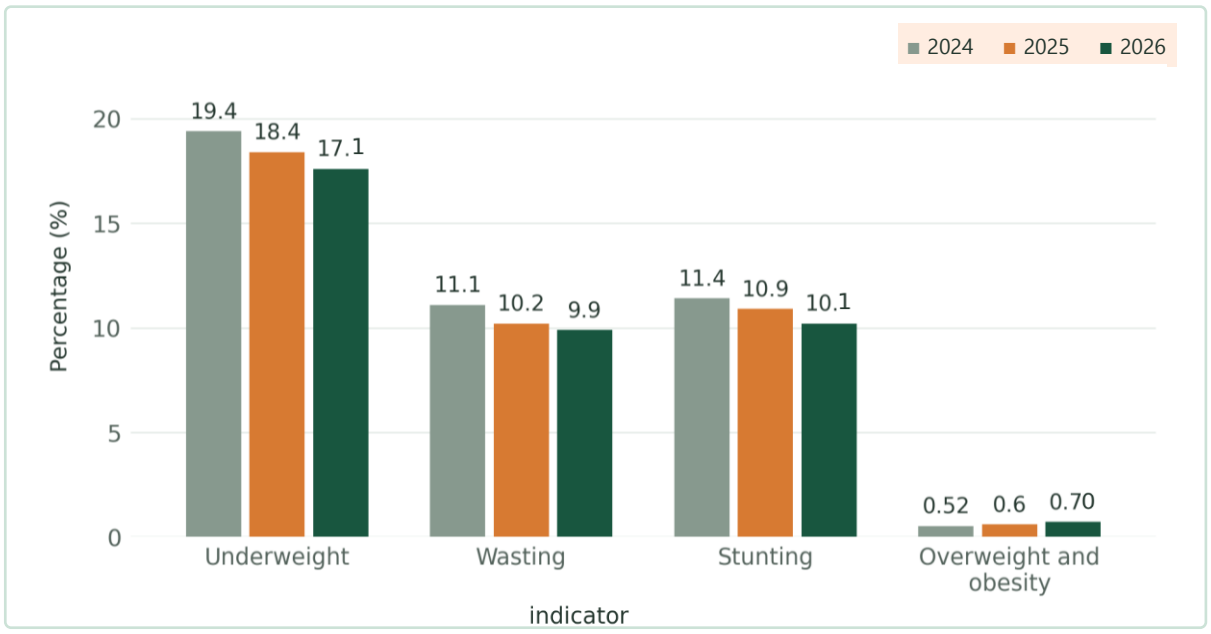


Figure 17: Nutrition status of children between 2 to 5 years

Source: eRHMIS 2026

3.1.11 Sex disaggregation of nutrition status of children under 5 years

There were more boys than girls registered by PHMs (51% boys vs. 49% girls). Wasting, stunting and overweight rates are higher among boys than in girls, while underweight, growth faltering and any growth problem rates are higher among girls than in boys.

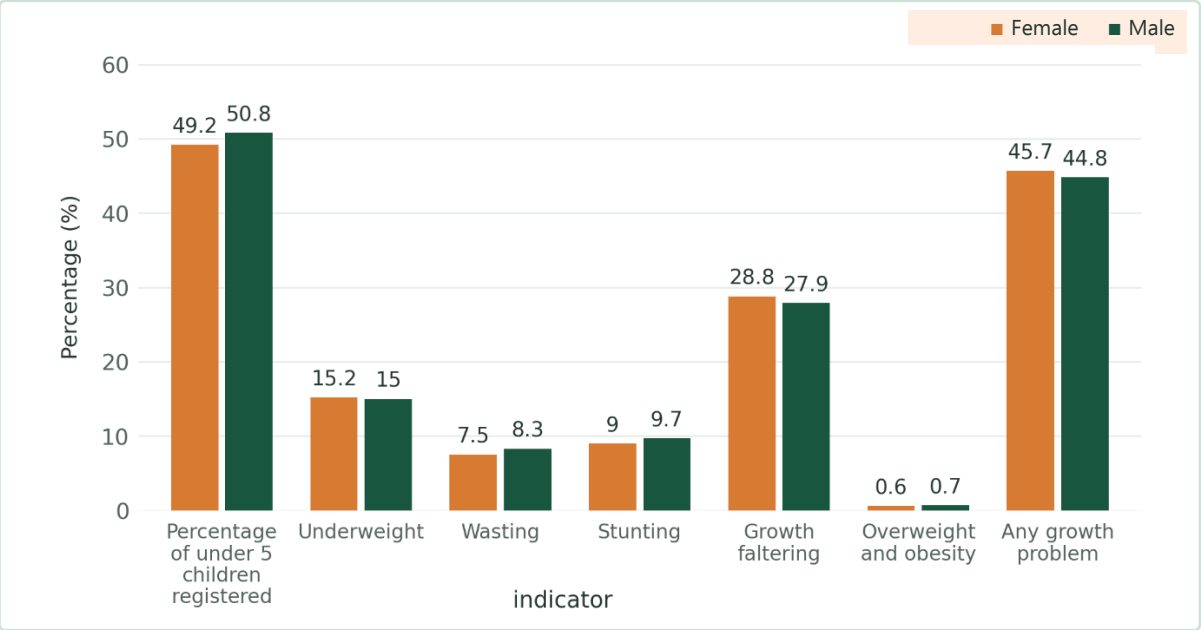


Figure 18: Nutrition status of children under 5 years by sex

Source: eRHMIS 2026

3.1.12 Sector wise sex disaggregation of nutrition status of children under 5 years

Growth faltering percentage of boys was lesser than the girls in all three sectors. Boys had higher rates of stunting and wasting than girls in estate and urban sectors but the pattern in the rural sector was similar to the overall pattern at national level.

Estate sector

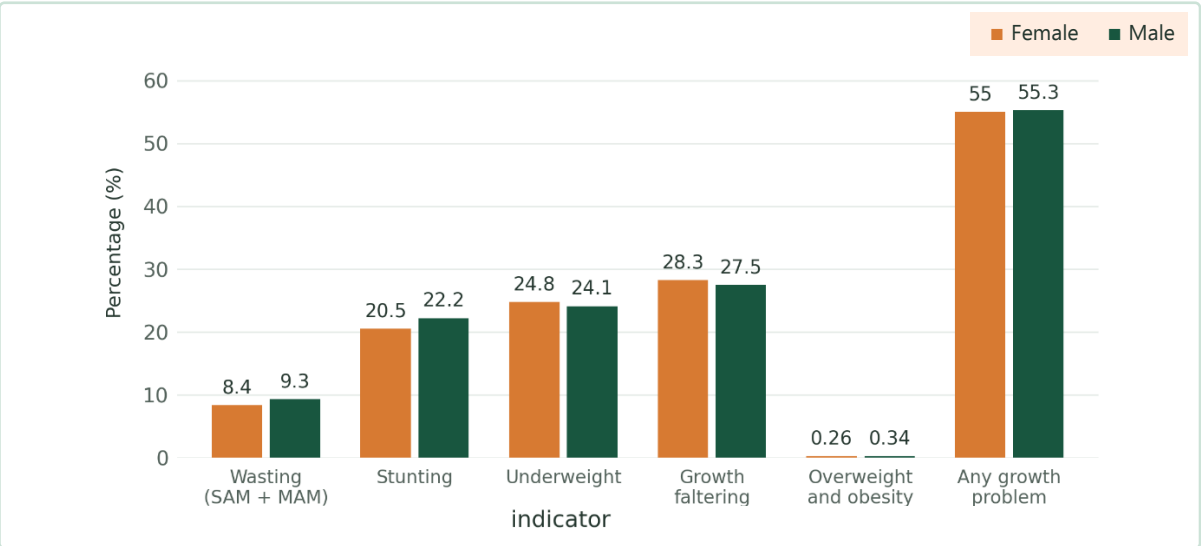


Figure 19: Nutrition status of children under 5 years in Estate sector

Source: eRHMIS 2026

Rural sector

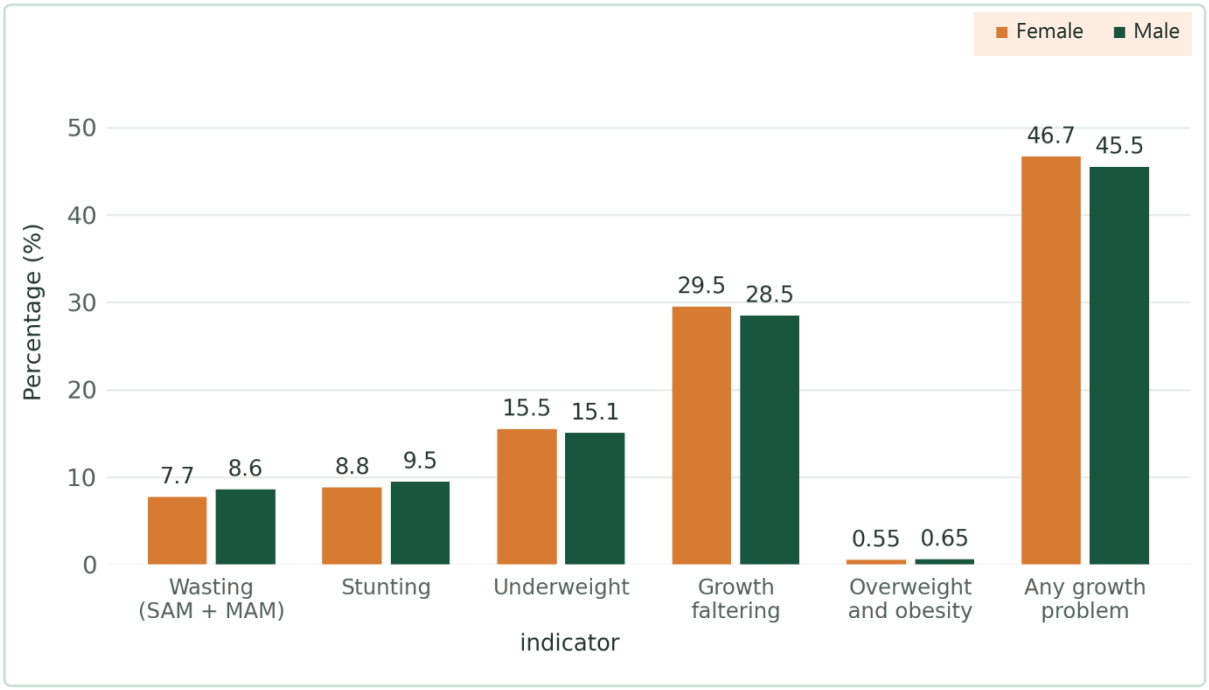


Figure 20: Nutrition status of children under 5 years in Rural sector

Source: eRHMIS 2026

Urban sector

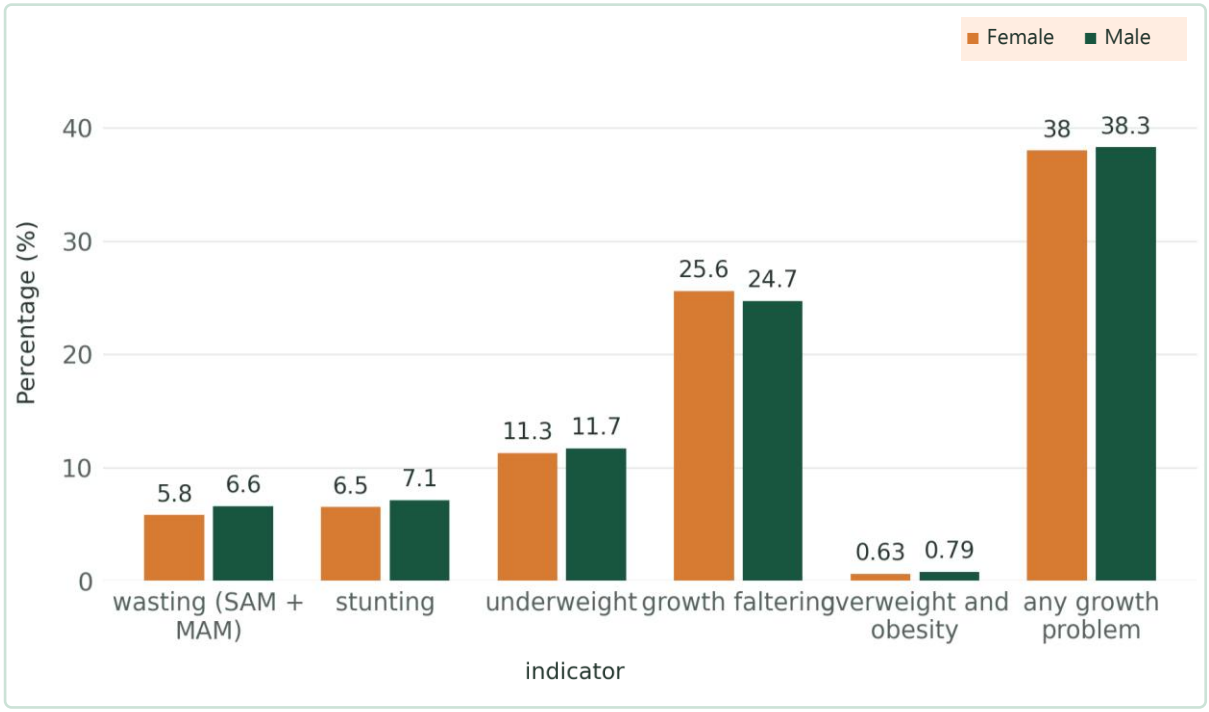


Figure 21: Nutrition status of children under 5 years in Urban sector

Source: eRHMIS 2026

3.1.13 Comparison of stunting and wasting 2025 and 2026 by MOH Areas

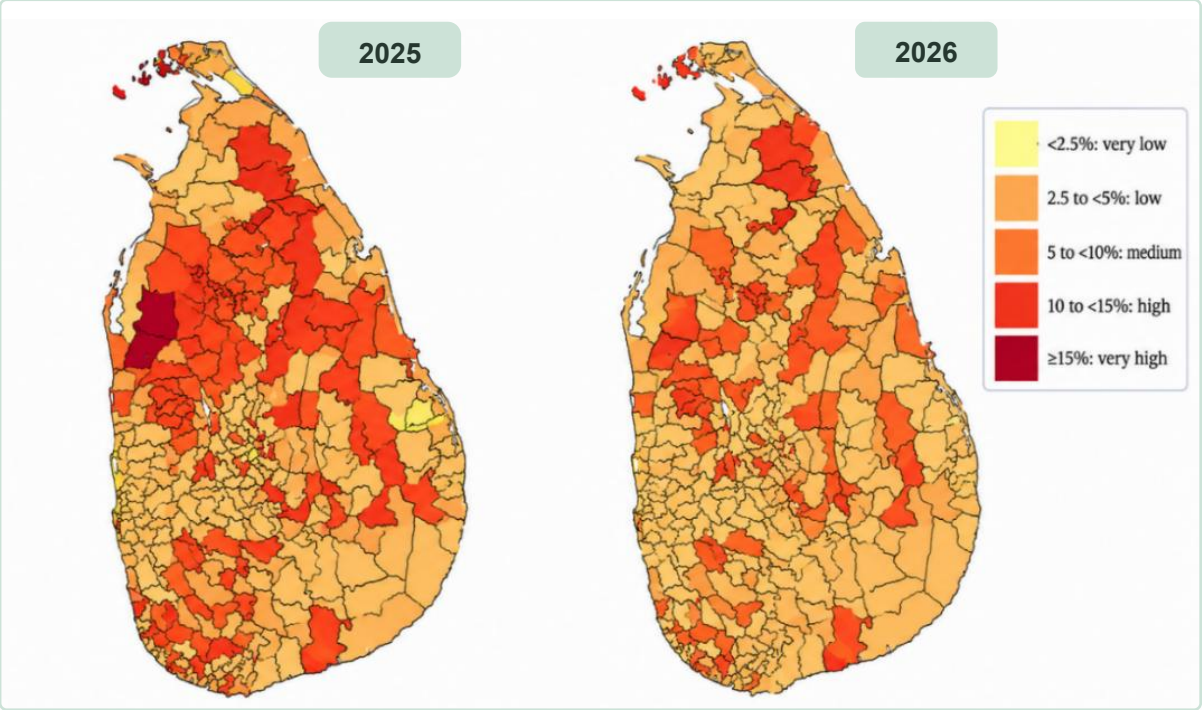


Figure 22: Comparison of wasting among children under 5 years 2025 & 2026 by MOH area

Source: eRHMIS 2026

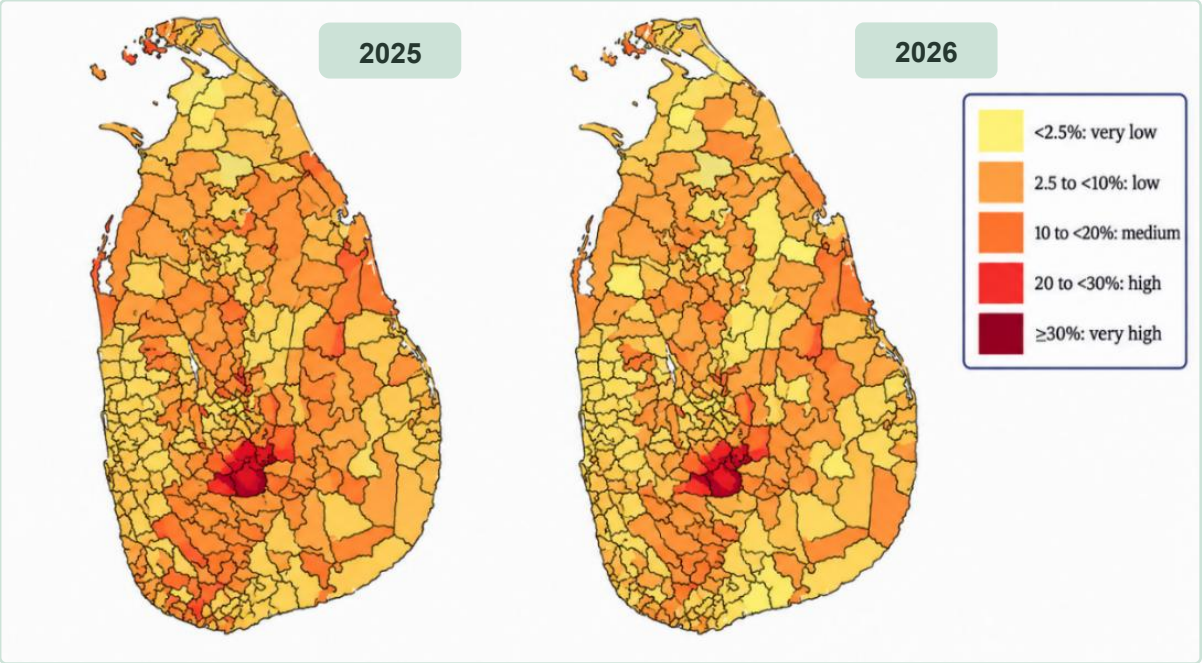


Figure 23: Comparison of stunting among children under 5 years 2025 & 2026 by MOH areas

Source: eRHMIS 2026

Maps were based on the WHO cut-off values for public health significance [Annexure]

3.1.14 Percentage of children under 5 years with growth faltering in green/ light green zones (between +2 to -2SD in weight for age chart)

Faltering of weight for age (i.e. growth faltering) can occur due to a number of causes including inappropriate feeding practices, acute deprivation of food, illness or acute changes in the socio-emotional environment. Acute faltering if not corrected on time may lead to wasting, while prolonged or recurrent growth faltering may affect the length/height of a child and may result in stunting. Therefore, improved early detection of growth faltering followed by timely and appropriate interventions to address the underlying causes is considered as a key intervention for preventing growth problems.

In 2026, most of the districts have reported an increase in growth faltering. This could be attributed to an improvement in detection and reporting of the condition following repeated trainings and the guidance provided to field health staff but these rates need to be increased further with further improvement in detection. The highest prevalence of growth faltering was reported from the district of Badulla (47.4%) as well as a notable increase from 2025, while the districts of Kilinochchi, Polonnaruwa, Mullaitivu and Kalutara also reported a notable increase which may be attributed to improved reporting.

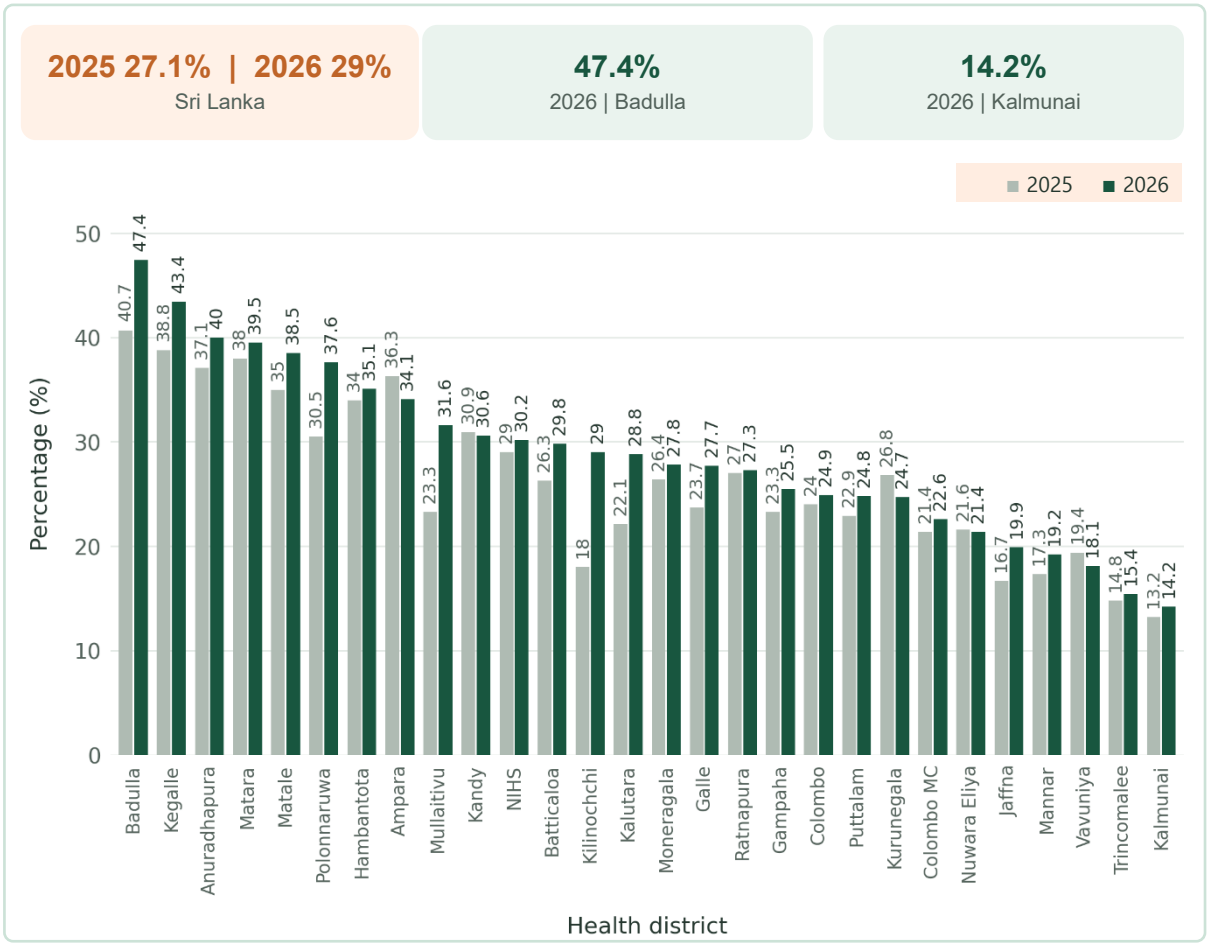


Figure 24: Percentage of children under 5 years with growth faltering in green/ light green zones

Source: eRHMIS 2026

3.1.15 Percentage of children under 5 years with any growth problem

Children who were having one or more of given growth problems were considered for this indicator as an approximate assessment of the burden for child specific nutrition interventions; the conditions considered this year were growth faltering in the green zone of the weight for age chart, underweight, stunting, wasting and overweight/obesity.

In 2026, 46.3% of children had one or more of the above stated growth conditions which was marginally higher than the 2025 value (46.2%). Growth faltering in the green zone has contributed to a major proportion of "any growth problem". Source: eRHMIS 2026

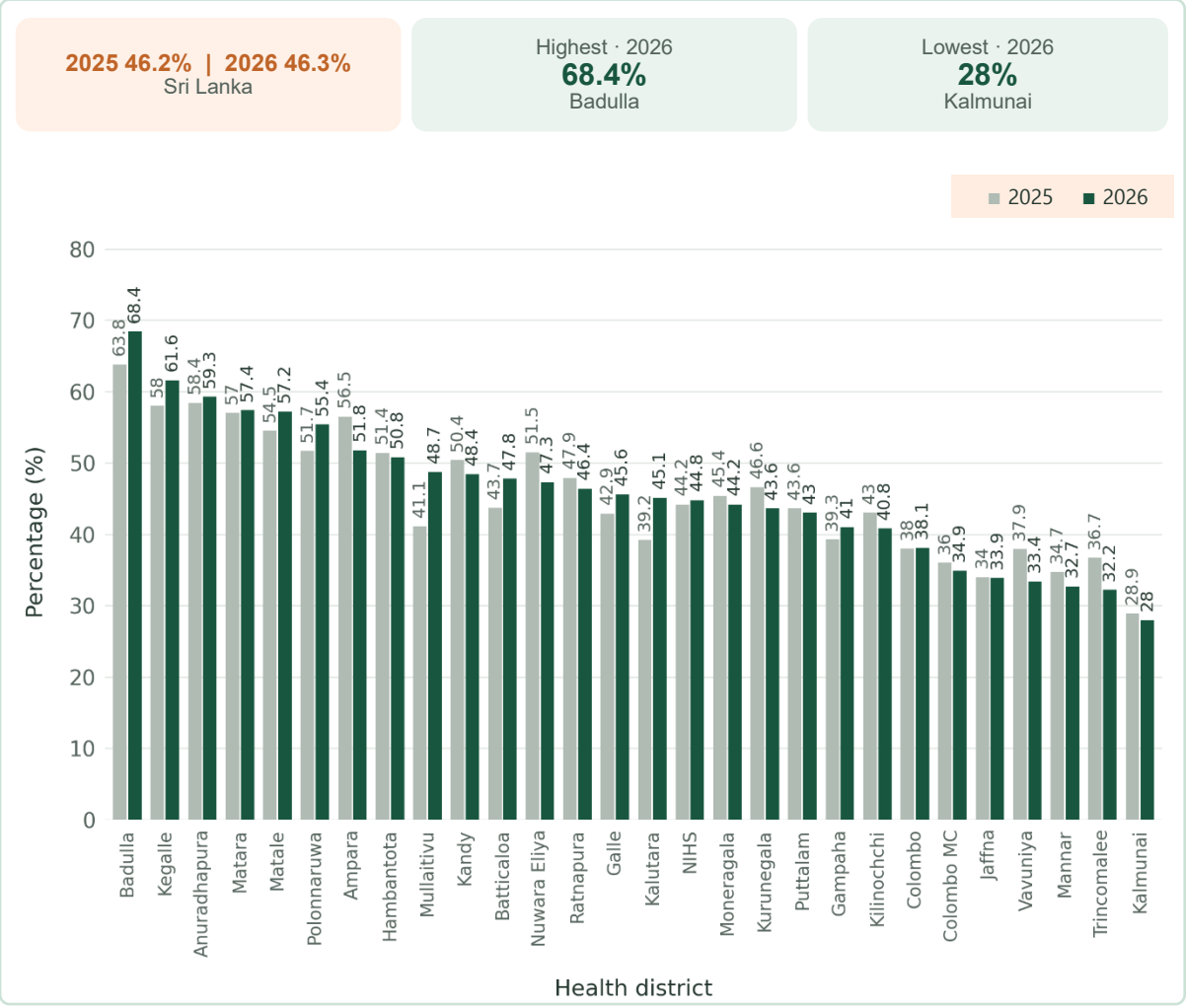


Figure 25: Percentage of children under 5 years with any growth problem by districts

Source: eRHMIS 2026

3.2 Nutritional status of school children

A total of **151,079 students** in Grades 1, 4, 7 and 10 in selected 1,501 schools were examined during the nutrition month, providing a comprehensive overview of the nutritional status of school-aged children.

Students examined	Schools selected	National reporting rate
151,079	**1,501**	**98.3%**
Grades 1, 4, 7 and 10	Nutrition Month 2026	School health assessment

3.2.1 Reporting rates

Reporting rates from districts averaged to **98.3% nationally**, with 100% reporting rate in 20 districts out of 28 RDHS areas. All RDHS areas have achieved more than 90%reporting rates.

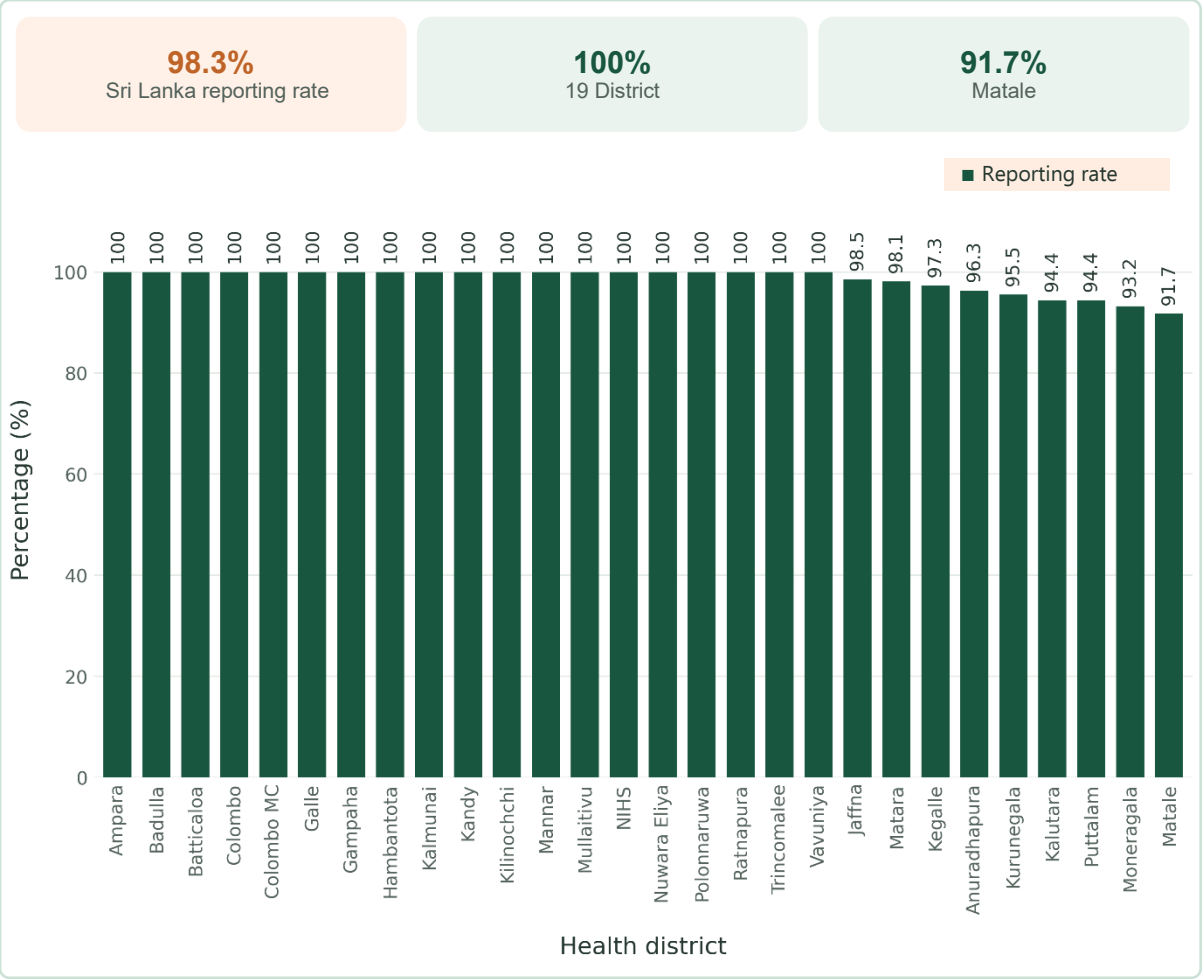


Figure 26: H1247 school health activities – Reporting Rate by district 2026

Source: eRHMIS 2026; School Health NM

3.2.2 Wasting among school children

Wasting is defined as a BMI-for-age Z-score below −2 standard deviations (SD) on the WHO sex-specific reference curves for children and adolescents aged 5–19 years and is an indicator of acute undernutrition.

The assessment revealed that wasting remains a concern among Sri Lankan school children, with prevalence varying across districts.

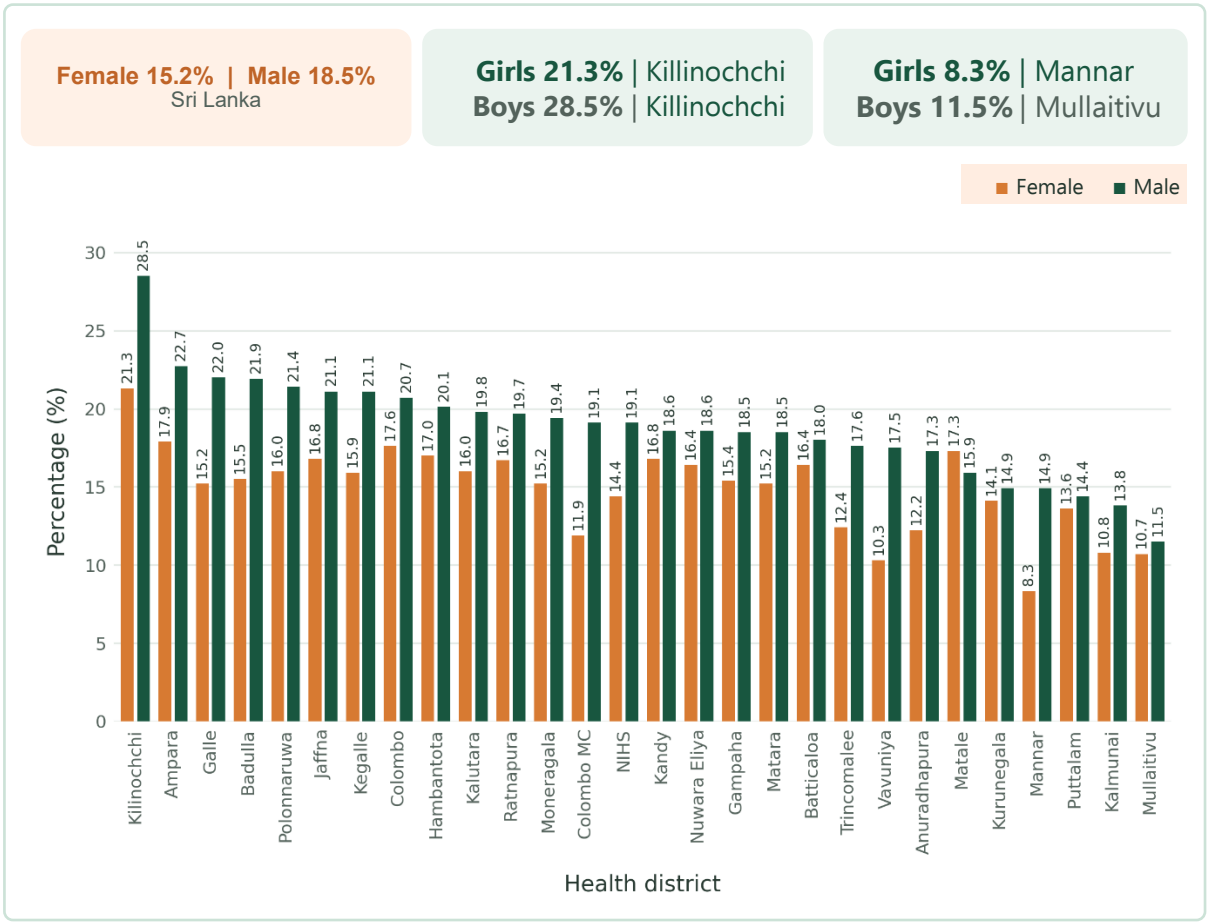


Figure 27: Students wasted in grade 1,4,7,10 sex disaggregation district wise NM 2026

Source: eRHMIS 2026; School health NM

Nationally, approximately one fifth (18.5%) of male students were acutely undernourished compared to approximately one sixth (15.2%) of female students. This male preponderance was seen in all RDHS areas except in Matale area. The highest proportion of wasting in male students was seen in Kilinochchi RDHS area (28.5%) followed by Ampara (22.7%). Among female students, the highest prevalence of wasting was recorded in Kilinochchi (21.3%). Only one twelfth (8.3%) of female students had wasting in Mannar RDHS area which was the lowest for the country.

3.2.3 Stunting among school children

Stunting, defined as height-for-age Z-score below −2 SD on the WHO sex-specific reference curves for children and adolescents aged 5–19 years, reflects long-term nutritional deprivation. It may indicate the lasting effects of inadequate maternal and early childhood nutrition which are difficult to correct in later years as well as prolonged nutritional deprivations during the later years including the secondary growth spurt.

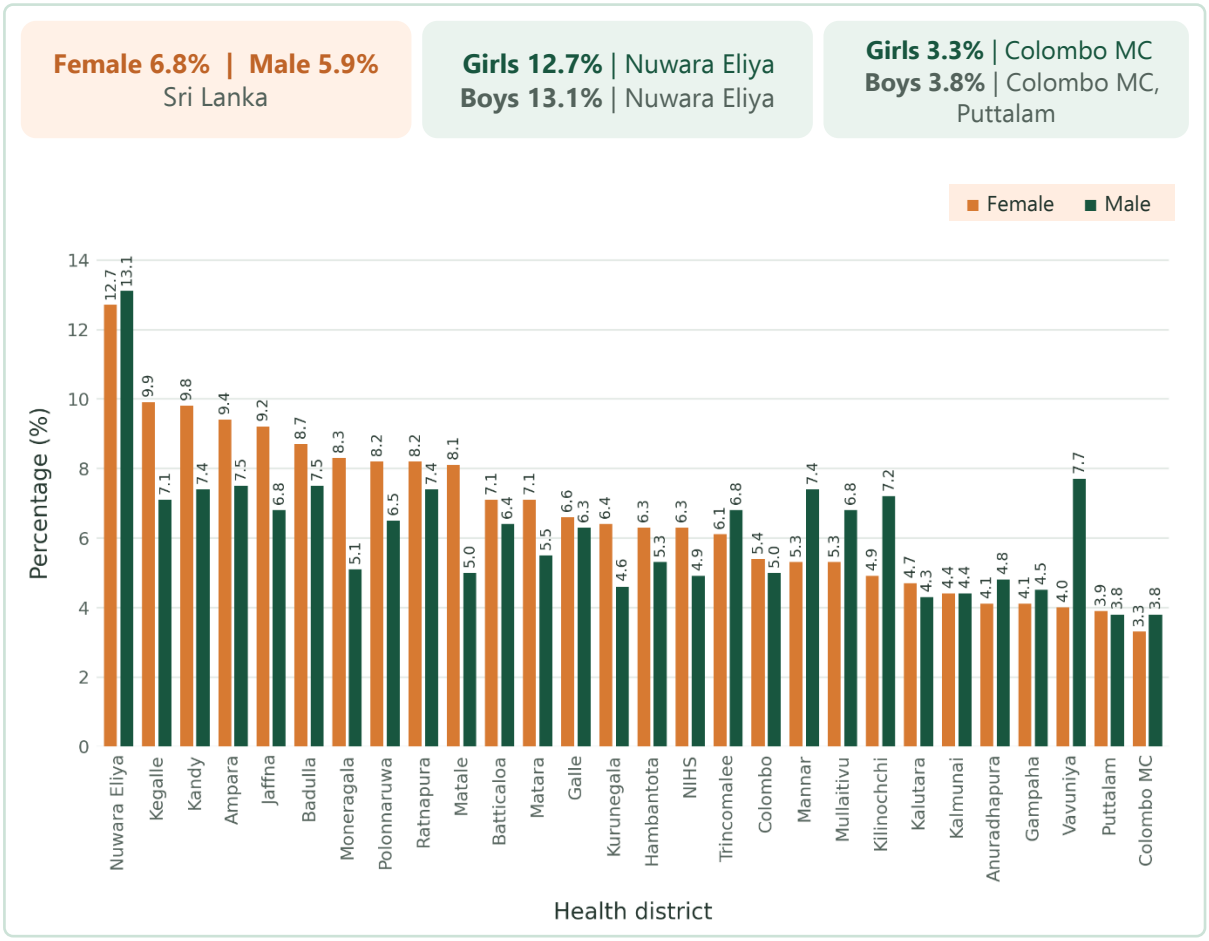


Figure 28: Students stunted in grade 1,4,7,10 sex disaggregation district wise NM 2026

Source: eRHMIS 2026; School health NM

Quite interestingly, female students (6.8%) were more chronically undernourished than boys (5.9%) as shown by National figures which necessitates to be taken as a warning sign. Out of all RDHS areas 64.3% showed this pattern. Colombo Municipal Council (CMC) area had the lowest stunting figures for both boys (3.8%) and girls (3.3%) and Nuwaraeliya RDHS area had the highest (boys – 13.1% & girls – 12.7%) which signifies a social issue of a larger scale.

3.2.4 Overweight among school children

Overweight, defined as BMI-for-age Z-score above +1SD and equal or below + 2SD on the WHO sex-specific reference curves for children and adolescents aged 5–19 years, is emerging as an increasing concern among school children. The highest prevalence was reported from the Colombo Municipal Council area, where nearly one in eight female and one in twelve male students were overweight. As one of the most urbanized areas in the country, this finding reflects the influence of changing dietary patterns, reduced physical activity, and rising sedentary behaviours. These findings are consistent with the nutrition transition observed in many middle-income countries, where traditional diets are being replaced by energy-dense foods, often coupled with lifestyle changes that reduce daily activity.

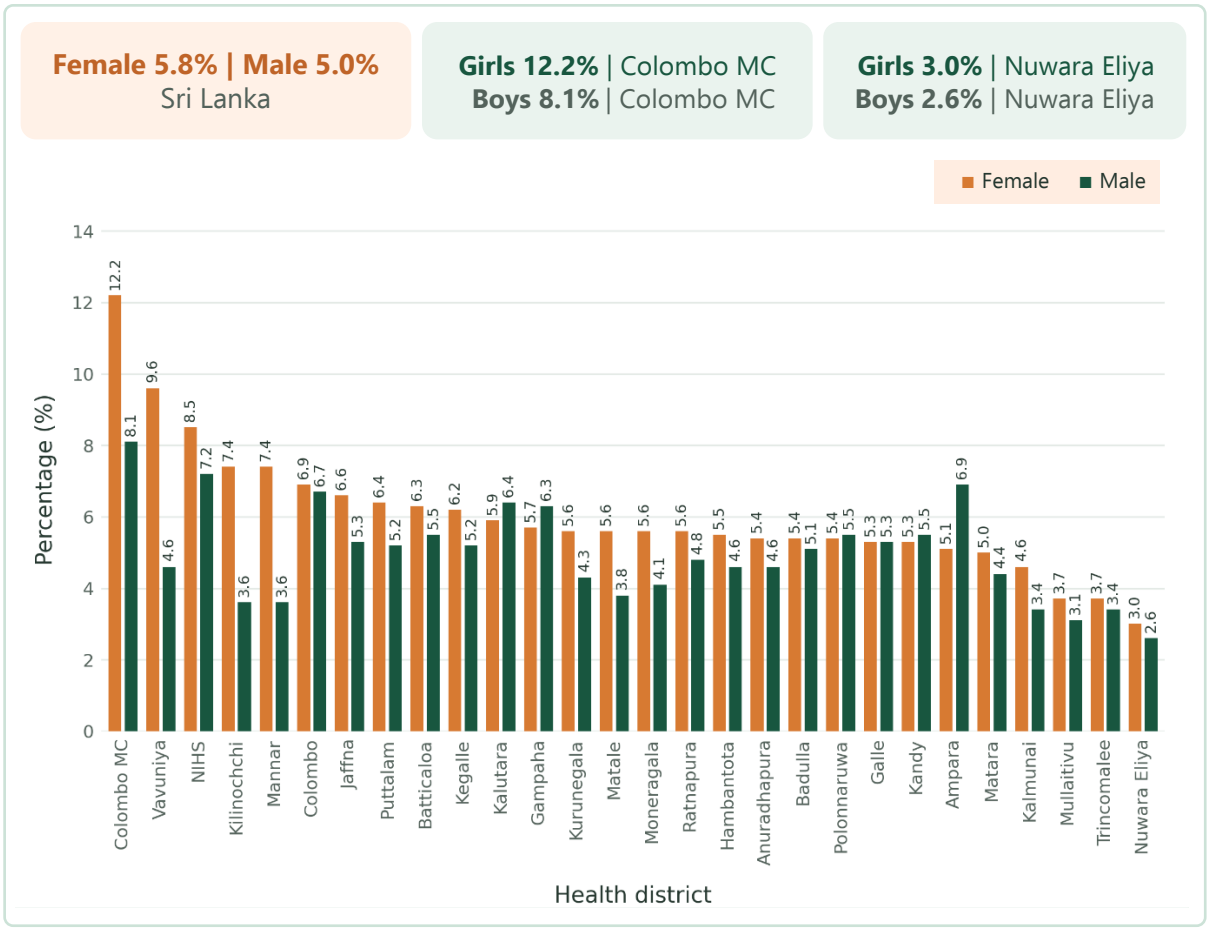


Figure 29: Students with overweight in grade 1,4,7,10 sex disaggregation district wise NM 2026
Source: eRHMIS 2026; School Health NM

A vast majority of RDHS areas (82.1%) showed more female students being overweight than male students which reflected the overall pattern for Sri Lanka (Girls 5.8% vs Boys 5.0%). This female preponderance was marked in Colombo MC area with 12.2% of girls being overweight compared to 8.1% of boys being categorized as overweight. RDHS areas of Gampaha, Polonnaruwa, Galle, Kandy and Ampara had more male students being overweight than girls and this difference was marked in Ampara RDHS area (Boys 6.9% vs Girls 5.1%).

3.2.5 Obesity among school children

Obesity, defined as BMI-for-age Z-score above +2SD on the WHO sex-specific reference curves for children and adolescents aged 5–19 years, is an emerging concern among school children.

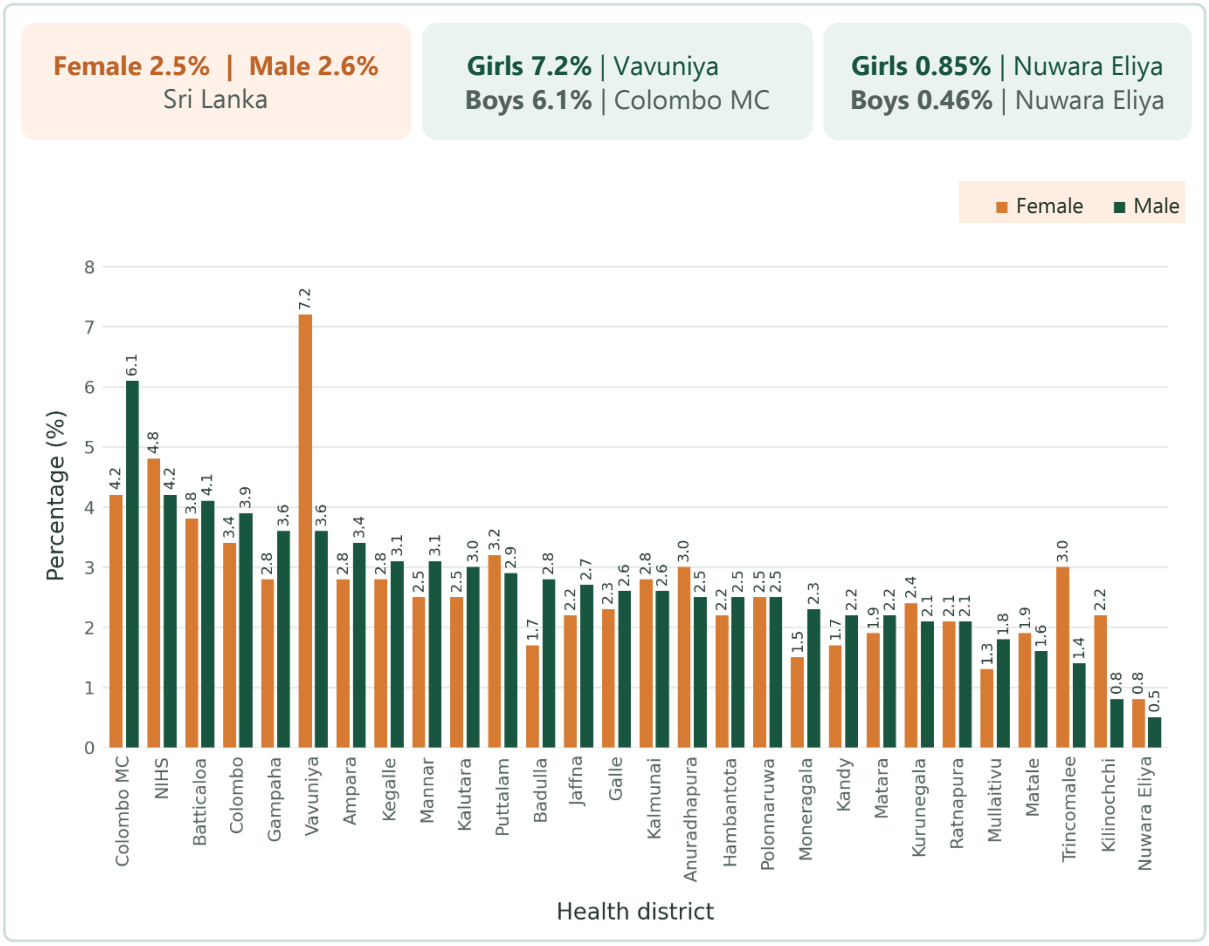


Figure 30: Students with Obesity in grade 1,4,7,10 sex disaggregation district wise NM2026
Source: School health NM 2026, eRHMIS

In contrast to the higher prevalence of overweight among female students, obesity was more prevalent among male students (2.6%) than female students (2.5%) at the national level. This pattern was reflected across majority of RDHS areas (60.7%) in the country. The largest sex difference was reported from Vavuniya RDHS (Boys 3.6% vs Girls 7.2%). Only one fourth of all RDHS areas (39.3%) had more girls being obese than boys. Vavuniya RDHS area reported the highest proportion (7.2%) of obese female students while Colombo MC area reported the highest proportion (6.1%) of obese male students.

3.3 Maternal micronutrient supplementation among antenatal women

3.3.1 Knowledge regarding micronutrient supplementation among antenatal women

The mean knowledge score among participants was 4.65 ± 1.35, with a median score of 5.0 (out of a total of 8), indicating considerable variability in participants' understanding of maternal micronutrient supplementation. Nearly half of participants (46.5%) scored four or less out of eight. Only 7.6% achieved scores of seven or eight. Important knowledge gaps remained, particularly regarding MMS and recommended supplementation practices.

3.3.2 Attitudes and beliefs

Antenatal women responded to twelve statements regarding maternal micronutrient supplementation using a five-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. Overall, the responses demonstrated a predominantly positive attitude and favourable beliefs towards maternal micronutrient supplementation among antenatal women. A large majority of respondents agreed or strongly agreed that micronutrients should be taken daily as recommended (88.1%, N=1,617), that micronutrient supplementation is beneficial for their own health (91.8%, N=1,683), and that it is beneficial for their baby's health (93.3%, N=1,712). For most negatively worded statements, the majority of participants either disagreed or strongly disagreed, indicating that misconceptions regarding micronutrient supplementation were relatively uncommon. For example, 1,261 (68.8%) respondents (excluding primi antenatal women) strongly disagreed or disagreed that micronutrient supplementation is unnecessary because they had not taken it during a previous pregnancy, while 1,664 (90.6%) strongly disagreed or disagreed that micronutrients provided free of charge were of low quality. Similarly, 1,500 (81.7%) strongly disagreed or disagreed that supplementation should be discontinued due to minor side effects, 1,437 (78.3%) strongly disagreed or disagreed that family approval was required before taking micronutrients, and 1,613 (87.9%) strongly disagreed or disagreed that taking micronutrients was difficult to incorporate into their daily routine.

In addition, 1,636 (89.2%) strongly disagreed or disagreed with the incorrect belief that multiple micronutrient supplements reduce haemoglobin levels, while 1,499 (81.7%) strongly disagreed or disagreed that a healthy pregnancy could be achieved without micronutrient supplementation. Only 1,048 (58.4%) agreed or strongly agreed on having sufficient knowledge regarding maternal micronutrient supplementation, whereas 550 (30.6%) were neutral and 198 (11.0%) disagreed or strongly disagreed, suggesting uncertainty regarding their own knowledge despite generally positive attitudes and beliefs.

3.3.3 Supplementation practices

A total of 5,784 pregnant women in their third trimester during the month of May 2026 participated in the practice assessment, with a response rate of 93.1% among eligible antenatal women across all PHM areas in the country. The assessment evaluated adherence to national recommendations on maternal micronutrient supplementation, including appropriate use of iron-folic acid (IFA), calcium, and multiple micronutrient supplements (MMS), as well as compliance with recommended dosing schedules.

- **Calcium Supplementation Practices**

  Calcium supplementation practices were assessed by evaluating the number of tablets consumed daily, the preferred time of administration, and adherence during the week preceding the survey. Majority (88.4%, n = 5,008) of antenatal women reported taking calcium supplements in the morning and majority (94.1%, n = 5,361) of women reported taking calcium tablets every day during the previous week.

- **Multiple Micronutrient Supplement (MMS) Practices**

  Among third-trimester antenatal women who were non-anemic mothers in the second trimester, practices relating to Multiple Micronutrient Supplement (MMS) use were assessed. Analysis was based on 4,300 women with valid responses. A total of 1,868 (43.4%) women reported not taking MMS tablets, 2,332 (54.2%) reported taking one tablet daily as recommended whereas 100 (2.3%) reported taking more than one tablet per day. Of the women who were reported taking MMS, 2,014 (82.8%) women reported taking MMS before going to sleep at night.

- **Iron-Folic Acid and Vitamin C Supplementation among Anaemic Mothers**

  Out of third trimester antenatal women who were detected to have anaemia according to the second full blood count (FBC), responses of 895 women were analyzed. The majority of women (92.5%, n =828) reported taking vitamin C with every iron-folic acid (IFA) tablet. Based on the analysis of 877 women with valid responses, 722 (82.3%) reported taking IFA two tablets daily as recommended.

4. Summary

In summary, **among children under five years of age**, underweight, wasting and stunting has reduced in 2026 when compared with 2025, while overweight and obesity percentage has risen slightly. At national level, identification and reporting of growth faltering showed an increase in year 2026 (Figure 31).

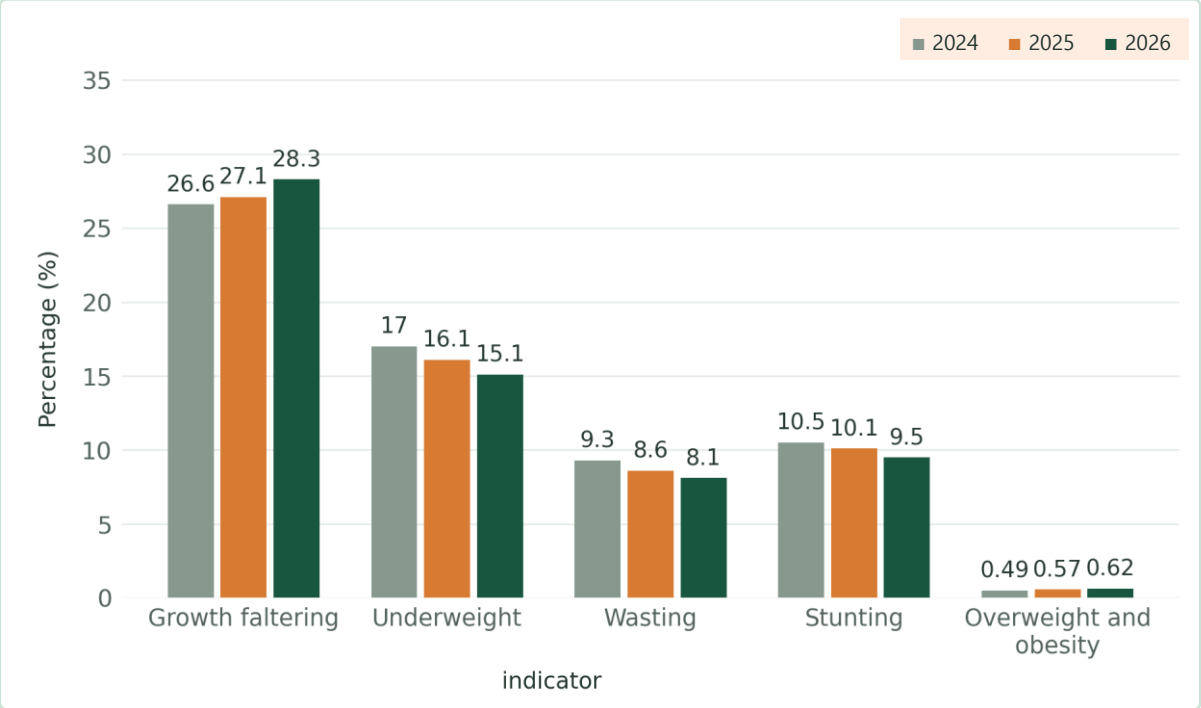


Figure 31: Nutrition status of Children under 5 years of age

Source: eRHMIS 2026

When the trends over the last 7 years are considered (2020 to 2026), underweight which was increasing from 2022 to 2023, has shown a gradual reduction over the last 3 years but has not reached the pre-COVID-19 level of year 2021 (12.2%) yet. Wasting rate which has been decreasing from 2022 onwards has now reached the 2021 level (8.1% against 8.2% in 2021). Stunting which showed an increase from 2022 to 2024, has started to come down from 2025 onwards even though the rate of decline is slower than other indicators and has not reached the pre-COVID - 19 level still. Overweight and obesity which had declined from year 2022 to 2023 is on the increase over the last 3 years and stand at 0.62% at present. (Figure 32).

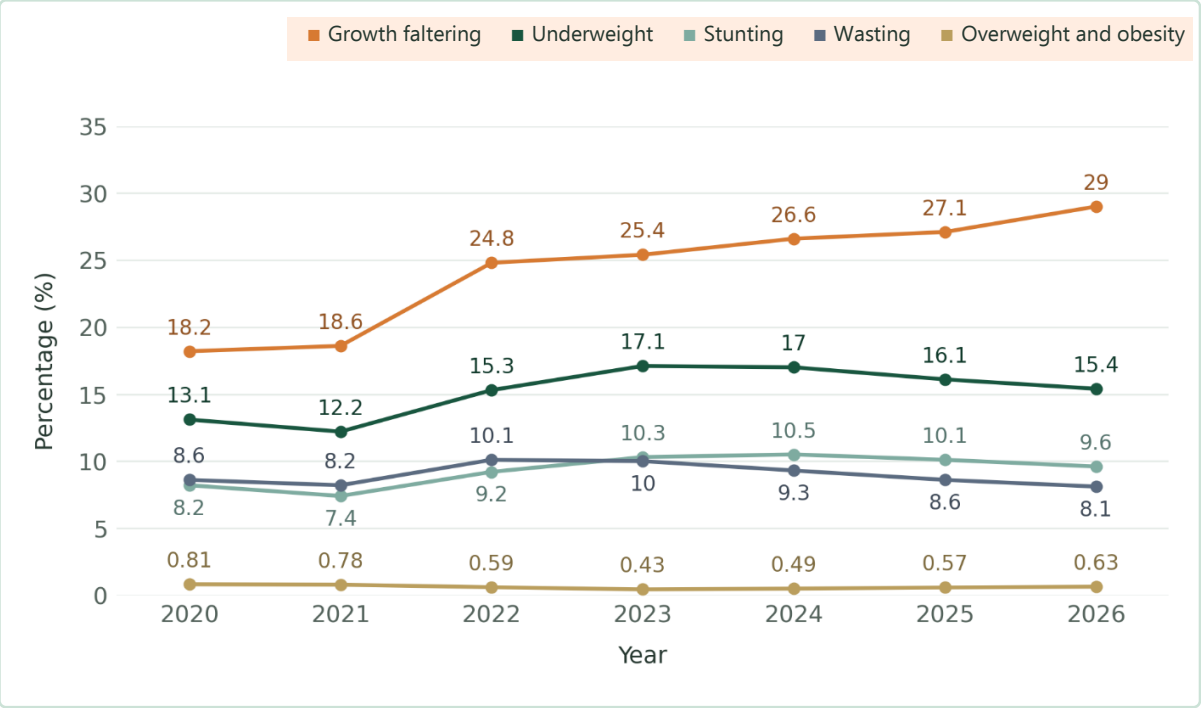


Figure 32: Underweight, wasting, stunting and overweight trends of children under 5 years from 2020 to 2026

Source: eRHMIS 2026

Looking at the **nutrition status of school children**, overall, the findings confirm that chronic undernutrition continues to be a significant challenge while overweight and obesity are in rise specially among urban school children.

Considering the **Maternal micronutrient supplementation among antenatal women, they** generally demonstrated a positive attitude and favorable practices regarding maternal micronutrient supplementation. However, knowledge regarding several key components of supplementation, particularly MMS supplementation, remained inadequate. Although early initiation and daily adherence to calcium and therapeutic iron-folic acid supplementation were high, the findings indicated substantial gaps in adherence Hb-based supplementation recommendations and MMS.

5. Conclusions and recommendations

5.1 Child nutrition

- The trends in underweight, wasting and stunting prevalence show a gradual decline with wasting rate reaching the pre-COVID level.
- The increasing trend in the proportion of children identified with growth faltering in the normal zone of the weight for age chart may reflect improved identification of deviations from the expected growth trajectory. Early identification provides an opportunity for timely assessment and appropriate intervention before growth faltering progresses to undernutrition. Therefore, strengthening early identification of growth faltering and responding to early growth faltering remains a key strategy for improving child nutrition outcomes.
- The sex-disaggregated data at national level indicate that stunting and wasting are slightly more prevalent among boys, whereas underweight, growth faltering and overall growth problems are more prevalent among girls. In the estate sector, the burden of all growth problems except underweight and growth faltering are higher among boys than girls.
- In 2026, the percentage of SAM children has come down from 0.82% in 2025 (n=9554) to 0.78% in 2026 (n=8558) and the referral to hospitals, hospital clinic attendance as well as receipt of BP 100 has improved.
- Overweight/obesity, although remaining at a relatively low level over these seven years, has slightly increased from 2025 level but not as high as the 2021 level. Even then, this increasing trend is a concern because this reflects a higher number of children displaying a risk for becoming overweight in the community even though the 'risk of overweight' is not reported through this activity. Therefore, similar to growth faltering, strengthening the early identification of the risk for overweight and responding to early reversal of this risk has surfaced as a timely intervention to address this rising trend.
- Increasing trend of overweight/obesity points towards a return to an unhealthy lifestyle with intake of unhealthy food.
- Extreme caution should be exercised to refrain from including inappropriate food items such as commercial milk-based products and other ultra-processed food items in food aid programmes which can cause long-term irreversible damage both to health and the economy.
- Imposing restrictions on marketing and promotion of excessively calorie dense or ultra-processed food and carrying out intensified efforts to promote healthy lifestyles and healthy food behaviours is important.
- General public and health staff should be vigilant to detect and not to be misled by indirect promotions of unhealthy food/lifestyles via various media content including mass media, audiovisual media and digital media (e.g. television, radio, newspapers and tabloids, social media, digital apps etc.). The main thrust should be to inculcate healthy

dietary behaviours (and lifestyles) from the very onset starting from optimum breastfeeding from birth and optimum complementary feeding practices.

- The findings highlight the need to streamline well-intentioned nutrition interventions implemented by non-health sector stakeholders, particularly those that focus broadly on increasing the weight of children as a measure to address undernutrition. Such interventions should be implemented with appropriate technical guidance and supervision to ensure that they do not inadvertently contribute to the increasing risk of overweight. It is important to recognize that undernutrition encompasses different conditions, including growth faltering, wasting and stunting, which can have different underlying causes and require appropriately targeted interventions rather than blanket feeding programmes targeting underweight children.
- The health administrators at all levels should take necessary steps to empower the health staff to address the specific nutritional problems of affected children being responsive to the specific nutritional needs and in alignment with evidence-based recommendations of the national child health programme. Strengthening the capacity of health staff is essential to improve the early identification, assessment and effective management of nutrition problems among children and to ensure the consistent delivery of high-quality nutrition services.
- A blended approach is recommended to improve the knowledge, practical competencies and confidence of health staff, promote standardized practices across service delivery settings, enhance the quality of nutrition assessment and management; i.e. all health staff to receive uniform training through the online training course through the FHB eBridge platform which provides standardized knowledge and strengthen the capacity of health staff in managing nutrition problems followed by physical training at district/institutional level by master trainers focusing on practical skills, including accurate anthropometric assessment, interpretation of growth and nutrition indicators, correct identification of caused, targeted counselling, management and appropriate referral.

5.2 Nutrition status of school children

The findings of nationwide assessment of school children in nutrition month highlight the double burden of malnutrition in Sri Lanka. While acute and chronic undernutrition remain significant public health concerns in many parts of the country, overweight and obesity are emerging as important health challenges, particularly in urban areas.

- **Improve the coverage and completeness of nutrition assessment and reporting**

  Although an overall reporting coverage of 96.9% was achieved in 2026, lower reporting rates in certain districts highlight the need to further strengthen school health services.

Efforts should be made to achieve 100% coverage and complete, timely reporting of school nutrition data across all districts.

- **Strengthen referral and clinical management of children with stunting and obesity**

  Ensure timely referral of children identified with stunting and obesity to Paediatricians, endocrinologists or physicians, as appropriate, for further clinical assessment, investigation and management.

- **Establish a systematic follow-up mechanism for children with nutritional problems**

  Strengthen follow-up mechanisms to regularly monitor the nutritional status and progress of children identified with nutrition problems. Appropriate interventions should be implemented and reviewed periodically, rather than limiting services to a one-time nutritional assessment.

- **Develop district-specific nutrition improvement plans**

  Develop and implement district-specific nutrition improvement plans based on the findings of the nutrition assessment. These plans should include targeted interventions, measurable objectives and regular monitoring of progress.

- **Promote self-monitoring of nutritional status and healthy lifestyles among schoolchildren**

  Empower schoolchildren to understand and monitor their nutritional status, with appropriate guidance from teachers, parents and healthcare professionals. Encourage healthy dietary practices, regular physical activity and reduced sedentary behaviours, including prolonged screen time and excessive social media use.

- **Strengthen nutrition literacy among schoolchildren**

  Improve nutrition knowledge and practical skills among students to enable informed food choices and healthy eating behaviours. Particular attention should be given to addressing misconceptions regarding body image, unhealthy dieting practices and inappropriate weight-control methods.

- **Strengthen implementation of the school canteen circular**

  Ensure effective implementation and regular monitoring of the Ministry of Education school canteen circular in all schools. Promote the transformation of school canteens into healthy school canteens that consistently provide safe, nutritious and affordable food choices while discouraging the availability of unhealthy foods and beverages.

- **Expand the school meal programme**

  Consider extending the existing school meal programme to secondary grades, particularly in schools with a high prevalence of undernutrition. Ensure that meals provided are nutritionally balanced and appropriate for nutritional requirements of students.

- **Strengthen implementation of the Weekly Iron and Folic Acid Supplementation (WIFS) Programme**

  Strengthen the implementation, supervision and monitoring of the WIFS Programme at national, provincial, district, MOH and school levels to ensure regular supplementation, adequate coverage and adherence among students.

- **Ensure implementation of the Ministry of Education circular on physical activity**

  Strengthen the implementation of the Ministry of Education circular on physical activity in all schools to ensure that students have regular opportunities to engage in physical activities. Promote active lifestyles through physical education, sports and other school-based activities to prevent overweight, obesity and related noncommunicable diseases.

- **Strengthen the Health-Promoting Schools Programme**

  Accelerate the implementation of the Health-Promoting Schools (HPS) Programme, with the aim of transforming every school into a Health-Promoting School. Integrate nutrition promotion, healthy eating, physical activity and supportive school environments into routine school activities.

5.3 Maternal micronutrient supplementation among antenatal women

- Pregnant women in Sri Lanka generally demonstrated positive attitudes and favourable practices regarding maternal micronutrient supplementation. However, knowledge regarding several key components of supplementation, particularly MMS supplementation, remained inadequate. Although early initiation and daily adherence to calcium supplementation was high, the findings indicated substantial gaps in adherence to MMS.
- **The findings supported strengthening routine antenatal health education by field healthcare workers on the purpose of each supplement, dosage and timing and the importance of consistent use in accordance with national guidance**

6. Acknowledgement

- All Medical Officers of Health and their teams for their prompt response and successful completion of the task amidst many hardships.
- All provincial and district directorates for their continuous support and leadership.
- District MCH teams for their guidance, supervisions and close monitoring of whole task.
- Director MCH and the team at FHB for the guidance.
- All staff members in the Child Nutrition Unit, Maternal Care Unit, School Health Unit and Monitoring and Evaluation Unit for providing the technical guidance, managing online database and timely analysis of data.

7. Annexure

7.1 Number of children under 5 years with nutrition issues reported in each district 2026

RDHS Area	NMCN|#01 Total number of under 5 children measured for weight	NMCN|#05.03 Total Number of under 5 children with underweight (moderate + severe)	NMCN|#05.04 Total Number of under 5 children with stunting (moderate + severe)	NMCN|#05.01 Total number of children with moderate wasting (MAM)	NMCN|#05 Total number of children with SAM	NMCN|#05.02 Total number of under 5 children with wasting (SAM + MAM)	NMCN|#05.06 Number of under 5 children with overweight and obesity
Ampara	14804	2369	1382	1183	121	1304	91
Anuradhapura	51849	8751	5142	4303	502	4805	310
Badulla	47569	8940	6284	3669	333	4002	323
Batticaloa	44585	6712	4252	2820	339	3159	291
Colombo MC	18731	2219	1384	1050	135	1185	116
Colombo	65928	7414	4057	3629	386	4015	484
Galle	51366	8274	4271	4302	453	4755	411
Gampaha	99489	12995	7298	6538	681	7219	776
Hambantota	36104	5472	2971	2757	287	3044	200
Jaffna	36639	5185	3516	2868	333	3201	215
Kalmunai	39120	4664	2955	1890	150	2040	169
Kalutara	43267	6159	3463	3032	344	3376	323
Kandy	71009	11465	7545	4936	536	5472	421
Kegalle	39861	6605	3785	3230	318	3548	254
Kilinochchi	9471	1244	770	631	64	695	39
Kurunegala	83309	13736	7688	7290	806	8096	432
Mannar	9727	1406	1053	661	79	740	42
Matale	27490	4557	2812	2274	240	2514	173
Matara	40351	6499	3488	3380	322	3702	239
Moneragala	31117	4663	2962	2173	205	2378	174
Mullaitivu	8087	1291	715	745	95	840	32
NIHS	17112	2191	1278	926	112	1038	179
NuwaraEliya	41034	9493	8671	2951	362	3313	138
Polonnaruwa	25468	4332	2432	2082	161	2243	140
Puttalam	46310	7150	4195	3799	483	4282	267
Ratnapura	55248	9186	5938	4243	418	4661	350
Trincomalee	34575	5343	3596	2178	205	2383	159
Vavuniya	11818	1787	1106	914	88	1002	67
Sri Lanka	**1101438**	**170102**	**105009**	**80454**	**8558**	**89012**	**6815**

Source: eRHMIS 2026

7.2 Number of school children measured in 2026

RDHS Area	Students examined during National Nutrition Month school health activities in selected schools			
	Grade1	Grade4	Grade 7	Grade 10
Ampara	742	770	892	965
Anuradhapura	1571	1737	1813	1772
Badulla	1880	2009	2519	2239
Batticaloa	1379	1472	1288	1167
Colombo	699	876	1375	1084
Colombo	1517	1751	1157	1201
Galle	1143	1328	2361	2343
Gampaha	2456	2868	3130	3051
Hambantota	1214	1258	1398	1381
Jaffna	875	861	764	857
Kalmunai	986	1014	850	921
Kalutara	1075	1292	1598	1642
Kandy	1805	2188	2618	2523
Kegalle	923	1074	1609	1713
Kilinochchi	247	243	128	142
Kurunegala	2124	2374	3123	3363
Mannar	263	212	161	176
Matale	610	592	921	951
Matara	1734	1974	1710	1489
Moneragala	849	1002	1037	937
Mullaitivu	244	202	156	139
NIHS	370	439	534	465
Nuwaraeliya	1079	1244	1415	1446
Polonnaruwa	640	688	891	860
Puttalam	1767	1883	1704	1586
Ratnapura	2292	2488	1950	2067
Trincomalee	882	1007	759	774
Vavuniya	206	232	282	282
Sri Lanka	**31572**	**35078**	**38143**	**37536**

Source: eRHMIS 2026

7.3 Sector wise sex disaggregation of the number of under 5 children registered during Nutrition month 2026 (*Based on data only from the Estate/Rural/Urban 100% populated PHM areas)

RDHS Area	Total number of under 5 children registered - Estate	Total number of under 5 female children registered - Estate	Total number of under 5 male children registered - Estate	Total number of under 5 children registered - Rural	Total number of under 5 female children registered - Rural	Total number of under 5 male children registered - Rural	Total number of under 5 children registered - Urban	Total number of under 5 female children registered - Urban	Total number of under 5 male children registered - Urban
Ampara				13500	6626	6874	1305	645	660
Anuradhapura				50263	24668	25595	1949	925	1024
Badulla	8846	4318	4528	35361	17360	18001	3362	1658	1704
Batticaloa				32288	15723	16565	13023	6379	6644
Colombo MC							22276	11000	11276
Colombo	371	173	198	24158	12048	12110	46218	22890	23328
Galle	797	369	428	44947	22126	22821	6421	3128	3293
Gampaha				90220	44536	45684	15319	7589	7730
Hambantota				34531	17044	17487	1594	782	812
Jaffna				30159	14870	15289	6514	3182	3332
Kalmunai				27906	13466	14440	11525	5649	5876
Kalutara	1600	770	830	42608	21106	21502	509	263	246
Kandy	4426	2273	2153	61258	30019	31239	7363	3727	3636
Kegalle	2721	1312	1409	36726	18026	18700	635	297	338
Kilinochchi				9471	4635	4836			
Kurunegala	201	90	111	83961	41339	42622	1396	636	760
Mannar				8415	4153	4262	1312	646	666
Matale	883	453	430	23390	11443	11947	3382	1671	1711
Matara	894	446	448	35219	17366	17853	4382	2225	2157
Moneragala	671	306	365	30484	15167	15317			
Mullaitivu				8101	4057	4044			
NIHS	14	8	6	10440	5192	5248	6806	3316	3490
Nuwaraeliya	23673	11448	12225	15167	7417	7750	2241	1077	1164
Polonnaruwa				23481	11601	11880	2029	1001	1028
Puttalam				42965	21262	21703	5443	2648	2795
Ratnapura	5269	2565	2704	44843	22077	22766	5412	2675	2737
Trincomalee				28073	13566	14507	6524	3169	3355
Vavuniya				9915	4954	4961	1939	940	999
Sri Lanka	**50366**	**24531**	**25835**	**897857**	**441854**	**456003**	**178879**	**88118**	**90761**

Source: eRHMIS 2026

No 100% Estate PHM Areas *No 100% Rural PHM Areas* *No 100% Urban PHM Areas*

7.4 WHO Prevalence threshold levels

LABELS	PREVALENCE THRESHOLDS (%)		
	WASTING	OVERWEIGHT	STUNTING
Very low	< 2.5	< 2.5	< 2.5
Low	2.5 – < 5	2.5 – < 5	2.5 – < 10
Medium	5 – < 10	5 – < 10	10 – < 20
High	10 – < 15	10 – < 15	20 – < 30
Very high	≥ 15	≥ 15	≥ 30

WHO, Global database on child growth and malnutrition (http://www.who.int/nutgrowthdb/en/)

National Nutrition Month

SUMMARY REPORT

2026