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THE NINTH PARLIAMENT OF THE DEMOCRATIC SOCIALIST REPUBLIC OF SRI LANKA

(Fifth Session)

REPORT

OF

THE SELECT COMMITTEE OF PARLIAMENT TO LOOK INTO WHETHER THE CHILD MALNUTRITION ISSUE IN SRI LANKA IS AGGRAVATING AND TO IDENTIFY SHORT TERM, MEDIUM TERM AND LONG TERM MEASURES TO BE TAKEN IN THAT REGARD, AS WELL AS TO OVERSEE THE SPEEDY IMPLEMENTATION OF THE IDENTIFIED MEASURES

Presented by

Hon. Vadivel Suresh, M.P.

Chair of the Committee

Presented to the Parliament on 04th of September 2024

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Abbreviations

AR -Average requirement

BMI – Body Mass Index

DCS – Department of Census and Statistics

ENAP- Emergency Nutrition Action Plan

e RHMIS – electronic Reproductive Health Management Information System

ENAP – Emergency & Young Child Feeding

FAO - Food and Agriculture Organization

FHB – Family Health Bureau

GDP – Gross Domestic Production

HARTI- Hector Kobbakaduwa Agrarian Research and Training Institute

IYCF – Infants & Young Child Feeding

ID – Iron Deficiency

IDA – Iron Deficiency Anemia

MoH – Ministry of Health

MRI – Medical Research Institute

MsNAP- Multisector Nutrition Action Plan

MCH – Maternal & Child Health

MMN – Multiple Micro Nutrients

MCN – Maternal & Child Nutrition

MAM – Moderate Acute Malnutrition

NFSNC – National food Security and Nutrition Council

NCDs -Non-Communicable Diseases

RUTF – Ready – to – Use Therapeutic Food

SAM – Severe Acute Malnutrition

SSB- Sugar sweetened beverages

TPE – Total Public Expenditure

UNICEF- United Nations International Child Emergency Fund

WASH- Water, sanitation and hygiene

WFP- World Food Programme

WHO- World Health Organization

Chairman's note

The report of the Select Committee of Parliament to look into whether the child malnutrition issue in Sri Lanka is aggravating and to identify short term, medium term, and long term measures to be taken in that regard, as well as to oversee the speedy implementation of the identified measures is presented this day.

I do expect that the authorities responsible will take action to implement measures and recommendations outlined in this report without delay.

I express my gratitude to the members of this committee who contributed to the successful preparation of this report, especially the officials of the Ministry of Health, the officials of the Family Health Bureau, the officials of other ministries and institutions who provided the necessary information, and the committee staff including the Secretary General of the Parliament.

Vadivel Suresh
Chairman

REPORT

The following motion moved by the Leader of the House, on 19th January 2023 was approved by the Parliament, to appoint a Select Committee to look into whether the child malnutrition issue in Sri Lanka is aggravating and to identify short term, medium term and long term measures to be taken in that regard, as well as to oversee the speedy implementation of the identified measures.

Chapter 01

Terms of Reference

1. Select Committee of Parliament to look into whether the child malnutrition issue in Sri Lanka is aggravating and to identify short term, medium term, and long term measures to be taken in that regard, as well as to oversee the speedy implementation of the identified measures, Whereas the United Nations Children's Fund (UNICEF) has informed for the second time, that child malnutrition in Sri Lanka is aggravating;

And whereas there are different opinions and statistics regarding the actual situation of child malnutrition in Sri Lanka;

And whereas the number of acute malnourished children is reported in many areas;

And whereas long term malnutrition can cause serious consequences as far as the health, education and social development of future generation is concerned;

And whereas there are reports to the effect that 22 lakhs of additional number of children are likely to become malnourished in near future;

And whereas serious attention should be paid to the information contained in the report of the United Nations Children's Fund (UNICEF);

This resolves that a select committee of Parliament be appointed to look into whether child malnutrition issue in Sri Lanka is aggravating and to identify short term, medium term, and long term measures to be taken in that regard and to oversee the speedy implementation of the identified measures.

2. (a) that the Chair and Members of the Committee shall be appointed by The Speaker; and

   (b) that in terms of the provisions of Standing Order 101 of Parliament, the Committee shall consists of twenty one (21) Members.

3. That the Committee shall have the power to

   (a) fix its quorum;

   (b)summon any person to appear before it, to require any person to procure any document or record, to procure and receive all such evidence, written or oral, as the Committee may think it necessary for the fullest consideration of the matters referred to above;

   (c) obtain the services of specialists and experts in the relevant fields to assist the Committee; and

   (d) make interim reports from time to time and to sit notwithstanding any adjournment or prorogation of Parliament.

4. The Committee shall present its report to Parliament within a period of two months (02) from the first meeting of the Committee or within such further period as Parliament may grant.

Nomination of Members to the Committee

In terms of the motion approved by the Parliament the Hon. Speaker nominated the following Members of Parliament to serve in the Select Committee with the Hon.Vadivel Suresh as the Chair and such nominations were announced in the Parliament on 24th March 2023.

Hon. Vadivel Suresh (Chair of the Committee)
Hon. Nalin Fernando
Hon. (Dr.) (Mrs.) Seetha Arambepola
Hon. A. Aravindh Kumar
Hon. (Mrs.) Geetha Samanmale Kumarasinghe
Hon. (Dr.) (Mrs.) Sudarshini Fernandopulle
Hon. (Dr.) Gayashan Nawananda
Hon. Sivagnanam Shritharan
Hon. (Dr.) Kavinda Heshan Jayawardhana
Hon. (Mrs.) Rohini Kumari Wijerathna
Hon. (Dr.) Upul Galappaththi
Hon. Kins Nelson
Hon. (Mrs.) Muditha Prishanthi
Hon. Ali Sabri Raheem
Hon. Kumarasiri Rathnayaka
Hon. (Mrs.) Rajika Wickramasinghe
Hon. Weerasumana Weerasinghe
Hon. (Mrs.) Manjula Dissanayake
Hon. (Prof.) Charitha Herath
Hon. (Dr.) (Ms.) Harini Amarasuriya
Hon. Jagath Samarawickrama

While the Committee was in the process of obtaining information from experts in the field, the Committee was of the view that the time period allocated namely a period of 6 months was not sufficient to comprehensively study the subject and to make recommendations. Accordingly at the requests of the Committee on 05.10.2023, 05.03.2024, 05.06.2024 and 09.05.2024, Parliament extended the time period up to 05th of September 2024.

Chapter 02

Introduction

Malnutrition includes undernutrition, over nutrition and diet-related non-communicable diseases (NCDs) such as obesity, diabetes, cardiovascular disease and cancer (WHO, 2024). Malnutrition is caused by deficiencies, excesses or imbalances in a person's intake of energy and/or nutrients.

Child undernutrition can be presented in four forms:

1. stunting (low length/height for age),
2. wasting (low weight for length/ height or low BMI for age),
3. underweight (low weight for age) and,
4. micro nutrient deficiencies/ insufficiencies - a lack/ inadequacy of important vitamins and minerals.

Malnutrition in its all forms imposes direct and indirect impacts on individuals, families, societies and countries. It can affect health of people, human productivity as well as intergenerational human capital growth leading to economic loss. According to Food and Agriculture Organization of the United Nations (2013), estimated global economy impact of malnutrition in terms of direct health care cost and loss of productivity was US$3.5 trillion per year which was calculated as US$500 per individual. However, this cost increased after COVID 19 due to economic challenges incurred by the disease and loss of income resulting in difficulties in access to affordable healthy diet (UNICEF / WHO / World Bank, 2023).

Chapter 03

Nutrition Status of children

Children with optimum nutrition status will not only have good physical growth but also good mental development. Conversely, children with malnutrition are susceptible to infections and long-term development delays.

3.1. Low birth Weight

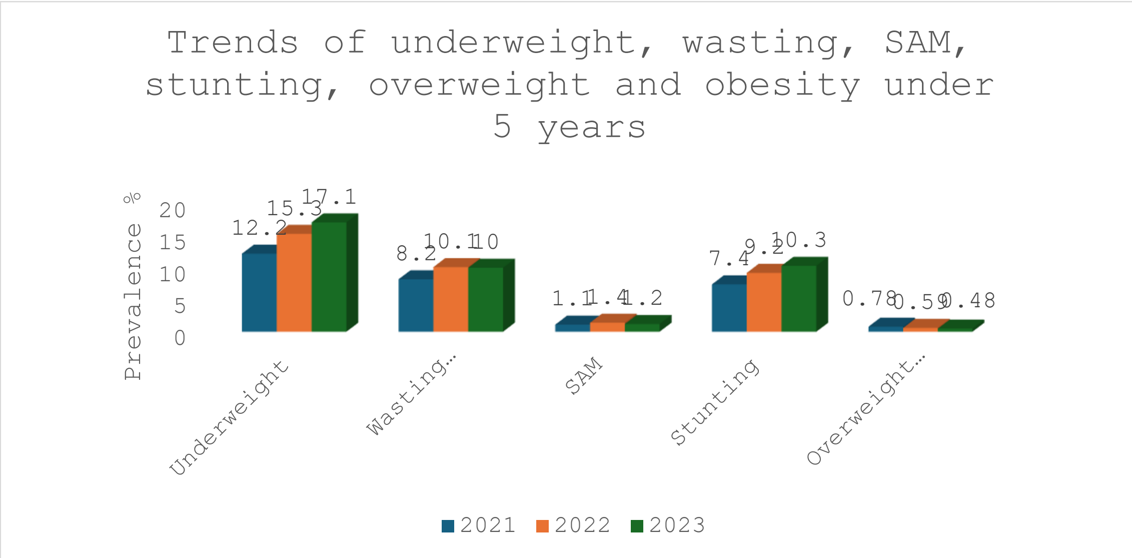
Babies born with a birth weight of 2500 g or less is considered as having a low birth weight and estimated 15% - 20% of babies born globally are low birth weight babies. This may be caused by reasons such as growth retardation of a baby due to poor maternal nutrition, teenage pregnancies or infections during pregnancy as well as parents' stature and parental underweight. Low birth weight rate in Sri Lanka in 2022 was 15.1%, with the highest low birth weight rate of 23.7% reported from Nuwara Eliya (FHB, 2023). According to the National Nutrition and Micronutrient Survey conducted in 2022, low birth weight prevalence (15.9%) in a nationally representative sample was slightly higher (MRI, 2023). Babies born with low birth weight are facing many risks including growth faltering, poor cognitive development as well as risk of having non communicable diseases such as diabetes and cardiovascular disease in later life.

3.2. Children under five years of age

In 2022, 6.8% (45 million) of children under 5 years worldwide were low weight-for-length/height (wasting, < -2SD of the growth chart,) with 2.1% (13.6 million) affected by severe acute malnutrition (SAM- very low weight for length/height, < -3SD of the growth chart). Around 75% of the global under age of 5 year population with SAM were from Asia while 22% were from Africa. Simultaneously, 22.3% (148.1 million) children under age 5 years of age globally were stunted and more than half of them were from Asia. It was revealed that 37 million children under five years of age are overweight around the world (UNICEF / WHO / World Bank, 2023).

Following the nutrition month assessment in June 2023, with 96.5 % assessment coverage of under five years olds registered with Public Health Midwives (PHM) Island wide, it was found that underweight (low weight - for-age), wasting (low weight for length/height) and stunting (low length/height-for-age) were 17.1%, 10% and 10.3% respectively. It was also observed that among infants and children up to two years, underweight and stunting have increased compared to 2022 data, wasting and overweight/obesity has decreased while among children 2-5 years, wasting is same as 2022 with increased underweight and stunting (FHB, 2023).

Figure 1: Nutrition status among children under 5 years over 2021- 2023



Sources: National Nutrition Month report 2022 & 2023, FHB

Before the economic crisis, median intake as a proportion of average requirement (AR) for carbohydrate was 89.6% while that of protein exceeded providing 12.5% of the total calorie needs (MRI, 2022). However, a study conducted after the crisis revealed that approximately one fourth of households investigated were moderately food insecure and having inadequate diet (WFP, 2023). These findings may be attributed to the increasing trends of wasting (immediate form of malnutrition) over last 3 years that may have led to increasing of stunting too.

3.2.1. Underweight among children under 5 years in Sri Lanka

It was observed that a child who is underweight may be having low weight for his/her height (wasted) and/or shorter than their counterparts of the same age (stunted). As per the nutrition month report 2023, compared to data in 2022, proportion of underweight has increased in almost all districts (except for Vavuniya) in 2023. An alarming highest underweight rate was reported in Nuwara Eliya (24.6%) with almost every fourth child is being moderately or severely underweight followed by Badulla, Ampara and Polonnaruwa districts where, every fifth child is moderately or severely underweight (FHB, 2023).

3.2.2. Wasting among children under 5 years in Sri Lanka

Wasting is usually representing the most immediate and visible form of malnutrition that may be life threatening if continued and become severe. It can be due to many reasons such as food insecurity, prolonged/ severe illness. Proportion of wasted children in Sri Lanka in June 2023 was 10% and it was almost the same as in 2022 (10.1%). However, approximately 135,768 children under five years of age in the country were wasted and Kilinochchi district had the highest increase in wasting (2%) with slight increases (1% or less) observed in Anuradhapura, Matale, Puttlam, Kalutara districts and Colombo Municipal Council area (MoH, FHB, 2023). However, number of children with wasting is many and cannot be neglected in addressing malnutrition. Moreover, out of all children under 5 years of age, 1.2% were affected by severe acute malnutrition (SAM) consisting of nearly 16,000 of children and in contrast to nutrition month data showed above where almost all children registered at the PHM were assessed, a nationally representative survey conducted in 2022 showed that 19.8% children of this age group were affected by wasting and 2.5% of the surveyed children were having SAM (MRI, 2023). These children can easily have suppressed immune system with frequent infections resulting in further impairment of growth and development.

3.2.3. Stunting among children under 5 years in Sri Lanka

Stunting or short stature when compared with the children of same age, occur over a period because of chronic malnutrition. It may be caused by several factors such as food insecurity in households due to poverty and escalated prices of food, malnutrition among pregnant mothers, frequent respiratory or diarrhoeal infections as well as congenital abnormalities. Nutrition month report (2023) shows that stunting was 10.3% among children under five years of age and it revealed 9.2% increase than the previous year. Nuwara Eliya had the highest stunting rate of 25.2% with a 2.4% increase of stunting from 2022 (FHB, 2023). However, a nationally representative survey conducted by MRI reported that 13.7% children 6-59 months are stunted in 2022 (MRI, 2023).

3.2.4. Overweight and obesity among children under 5 years in Sri Lanka

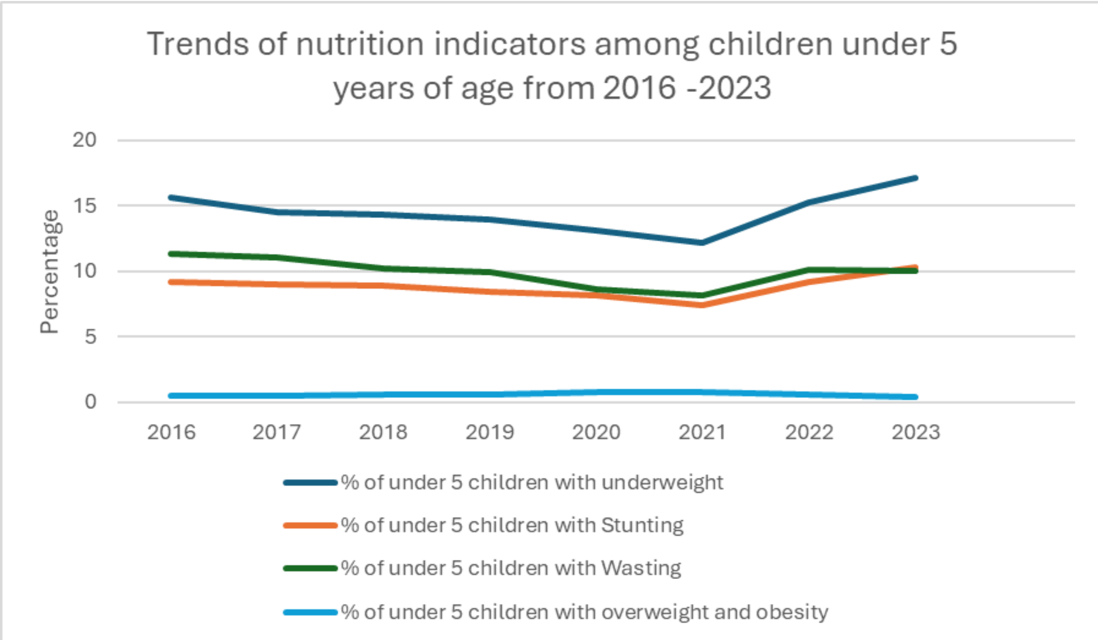
Prevalence of overweight and obesity rates in children under 5 years is low (0.43%) in the country in 2023 and it was lower than the previous year (0.59%) except for Vavuniya district where it has increased. However, it should be considered as an emerging problem for this age group since the overweight among children aged 6-59 months was 1.7% in a nationally represented survey conducted in 2022 (MRI, 2023).

Table 1: Underweight, stunting, wasting, overweight and obesity among children under 5 years from 2016 to 2023

Year	% of under 5 children with underweight	% of under 5 children with Stunting	% of under 5 children with Wasting	% of under 5 children with overweight and obesity
2016	15.6	9.2	11.3	0.5
2017	14.5	9.0	11.1	0.5
2018	14.3	8.9	10.2	0.6
2019	14.0	8.4	9.9	0.6
2020	13.1	8.2	8.6	0.8
2021	12.2	7.4	8.2	0.8
2022	15.3	9.2	10.1	0.6
2023	17.1	10.3	10	0.4

Source: Statistics, Family Health Bureau https://fhb.health.gov.lk/statistics/

Figure 2: Underweight, stunting, wasting, overweight and obesity among children under 5 years from 2016 to 2023



Source: Statistics, Family Health Bureau https://fhb.health.gov.lk/statistics/

Table 1 and figure 2 shows increasing trend of underweight, wasting and stunting among children under 5 years of age.

3.2.5. Micronutrient deficiencies among children under 5 years in Sri Lanka

Micronutrient deficiencies representing inadequate intake of vitamins and minerals results in susceptibility to infections, impaired growth and development causing poor physical and mental functioning. Globally, it is estimated that more than half (56%) of pre-schoolers have at least one of three micronutrient deficiencies namely iron, Zinc and Vitamin A (Stevens et al, 2022).

Significant improvement of micronutrient deficiencies was observed among under 5 years olds because of nutrition interventions over the last decade until 2022, achieving more than the expected targets of National Micronutrient Strategy 2017-2022. However, prevalence of anaemia among children aged 6-59 months was 14.6% with 10.6% of mild, 4.0% of moderate and 0.1% of severe anaemia. Although target of reducing prevalence of anaemia by 50% from the level of 2012 (15.1%) could not be achieved in 2022 due to multifaceted nature of anaemia, significant reduction of iron deficiency (ID - 84% reduction) and Iron Deficiency

Anaemia (IDA - 76% reduction) was observed (Unpublished report, ND, 2024). This picture was almost the same for the other age groups such as 5-9 years, adolescents, pregnant women and women of reproductive age with reducing prevalence of ID and IDA more than 50%. Therefore, other causes such as vitamin B deficiency, folic acid deficiency, thalassemia and chronic inflammation should be considered.

Table 2: Observed reduction and expected targets of National Micronutrient Strategy 2017-2022 as per 2022

Micronutrient Deficiency/ condition	Prevalence	Sector wise prevalence	Expected target and observed reduction	Provinces with higher prevalence than National	WHO Public Health (PH) significance level
Iron Deficiency	5.4%	Estate 12.1% Urban 5.0 % Rural 4.4%	84% reduction	Central and Sabaragamuwa	
Iron Deficiency anaemia	1.8%	Urban 3.6% Rural 1.2% Estate 2.3%	Expected target- 50% reduction 76% reduction	Sabaragamuwa, Northern, Western, Northcentral	Southern, Eastern and North western provinces - no PH significance All other provinces – ‘mild’ level

Vitamin A deficiency	3.6%		Expected target- 50% reduction. 87.6% reduction		Public Health problem at a 'mild' level
Zinc deficiency	15.3%	Urban 18.7 % Estate 15.3% Rural 14.8 %		Except for Uva and Sabaragamuwa all other provinces	'Moderate' level in Eastern province Uva and Sabaragamuwa – No 'Public health significance'

Source: National Nutrition and Micronutrient Survey, MRI, 2023; Review of implementation of National Strategy for Prevention and Control of Micronutrient Deficiencies in Sri Lanka 2017 – 2022 (unpublished)

According to National Nutrition and Micronutrient Survey conducted in 2022, the prevalence of Iron Deficiency (ID) and Iron Deficiency Anaemia (IDA- anaemia and iron deficiency together) among children of this age group was 5.4% and 1.8% with decreasing trend of prevalence observed with increasing age. The prevalence of Vitamin D Deficiency and Zinc deficiency among children aged 6-59 months were 26.2% and 15.3% respectively (MRI, 2023).

Median urinary iodine level among 6-59 months old children in Sri Lanka was 93.8 µg/L, which is lower than the iodine deficiency cut off value of 100 µg/L except for Southern, Eastern and North western provinces. Hence, it was identified as a problem of public health significance in 6 out of 9 provinces by the IGN/UNICEF (MRI, 2023).

Using existing evidence, Implementation of National Strategy for Prevention and Control of Micronutrient Deficiencies in Sri Lanka 2017 - 2022 was reviewed and this report revealed that Vitamin A deficiency levels among this age group has reduced to 3.6% representing problem at a mild level of public health significance (Unpublished report, ND, 2024). However, more than one fourth of children (26.2%) in this age group is deficient in vitamin D with the highest prevalence observed in the Estate sector where, every third child is vitamin D deficient (36.8%) followed by urban and rural sectors with 25% of Vitamin D deficiency. According to WHO public health significance levels, it has 'moderate' level of public health significance except for Northern, Eastern and North western provinces with observed higher prevalence than national level in Central, Southern, North Central and Western and Sabaragamuwa provinces.

The median energy intake and median protein intake was 89.6% and 260.1% of the average requirement (AR) for under 5 years children in pre-economic crisis while having adequate fibre consumption of 14.8 g (recommended intake of 10- 14g). However, even in last quarter of 2021, median Calcium was below AR at 41.3% (without considering the intake of breast milk) and iodine and iron intakes were around 80% of AR (79.4% and 86.9% respectively). Zinc and Selenium intakes exceeded the recommended AR for this age group (MRI, 2023).

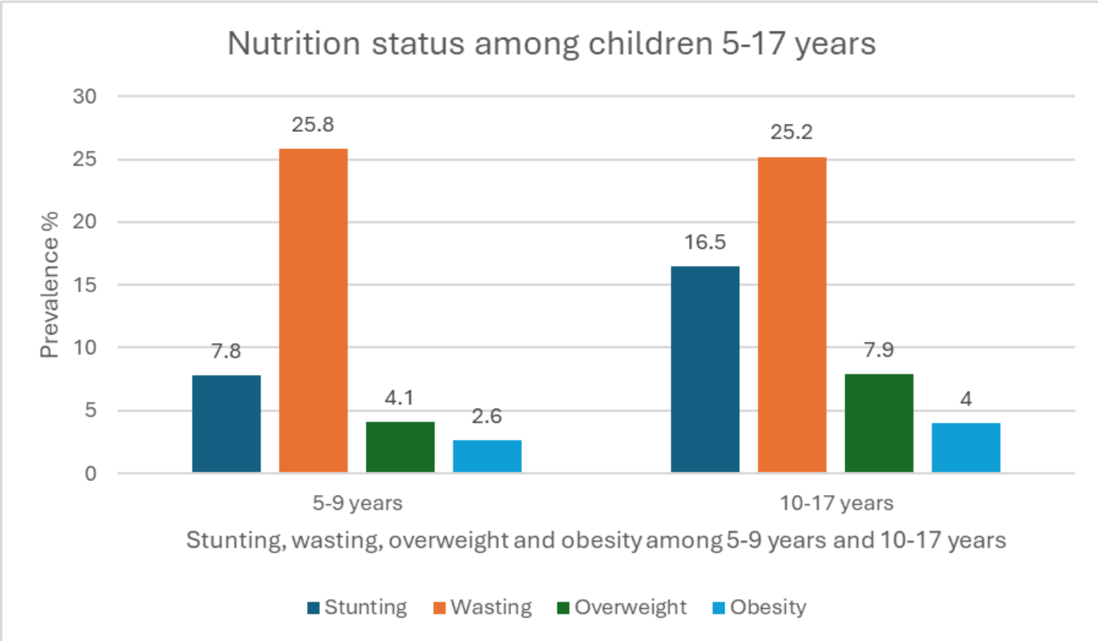
3.3. Nutrition status of children 5-19 years of age

Rapid growth during school ages (5-9 years in Primary schools and 10-19 years adolescents) requires special attention to their diets to enable them perform well in schools and for their wellbeing. Among South Asian children 5-19 years of age, prevalence of thinness ranges from 1.9% – 88.8%, wasting from 3% to 48%, underweight from 9.5% to 84.4% and stunting from 3.7% –71.7% (Choedon et al, 2023). National Nutrition and Micronutrient Survey in Sri Lanka conducted in 2022 revealed that one third of children 5-18 years (36.6%- 5-9 years; 37.4% -10-17 years) are either stunted, wasted, overweight or obese or having more than one poor nutrition condition (MRI, 2023).

According to this survey conducted in 2022, in a nationally representative sample of children 5-18 years revealed that stunting, overweight and obesity was increasing with age (MRI, 2023).

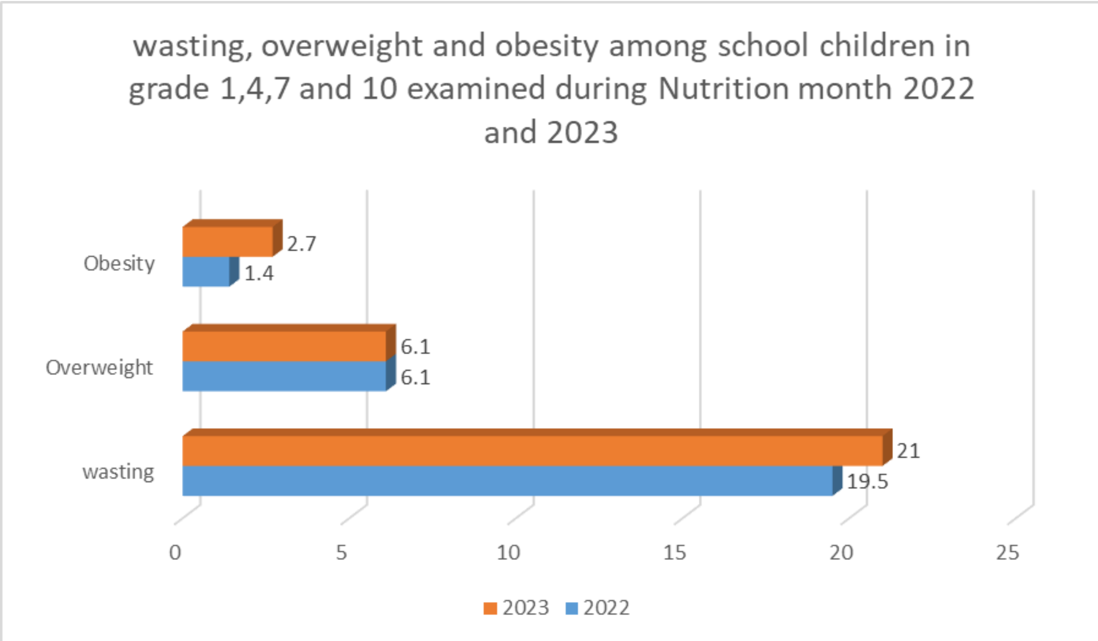
As a result of life styles adopted at school ages including poor dietary habits such as excessive intake of sugar sweetened beverages (SSB) and processed food instead of freshly prepared homemade food and insufficient intake of fruits and vegetables as well as sedentary behaviours such as increased screen time, not engaging in physical activity, overweight and obesity is increasing with age. Overweight in childhood may result in stigmatization, low self-esteem, and anxiety while increasing risk of developing NCDs in future leading to disability and premature death (UNICEF, 2023).

Figure 3: Nutrition status among nationally representative sample of children 5-17 years



Source of data: MRI, National Nutrition and Micronutrient Survey, 2023

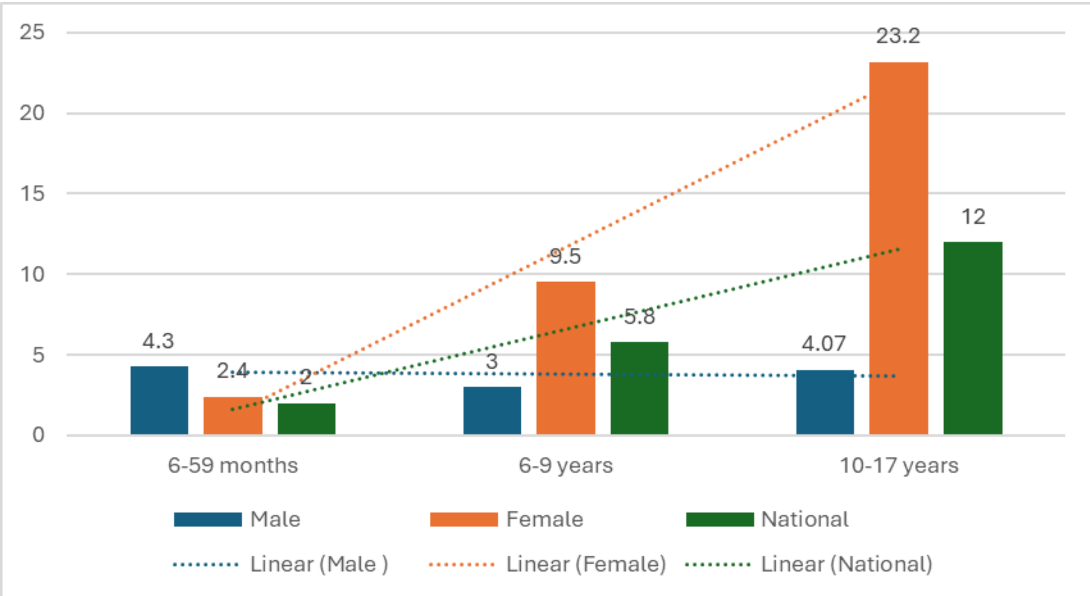
Figure 4: Wasting, overweight and obesity among grade 1,4,7 children in 2022 and 2023



Source of data: National Nutrition Month Report, 2023

During the nutrition month, nutrition assessment is carried out among school children in grade 1, 4, 7 and 10 island wide. As per the nutrition month report (2023), wasting and obesity increased in 2023 (21% and 2.7% respectively) than in 2022 (19.5% and 1.4% respectively) among examined students (FHB, 2023).

Figure 5: Iron deficiency as a cause for anaemia in children.



Source of data: Review of implementation of National Strategy for Prevention and Control of Micronutrient Deficiencies in Sri Lanka 2017 – 2022

The proportion of ID as a cause anaemia increases with age as well as among girls significantly.

As the prevalence of Vitamin A deficiency was 0.1% among children 5-17 years, vitamin A supplementation at school age is stopped at present. However, median intake of Vitamin A rich food as a proportion of AR was 56.8% and 45.2% among children aged 5-9 years and for children aged 10-17 respectively (MRI, 2021). This situation may even be worse after the economic crisis and need to promote intake of vitamin A rich food as it can become a problem of public health significance in future.

Among 5-9 years aged children vitamin D deficiency, vitamin B12 deficiency and Zinc deficiency was 23.9%, 1.7% and 3.5% respectively (MRI, 2023). As nearly one fourth of children are vitamin D deficient, it will affect the growth of children further. Therefore preventive programmes should be in place immediately.

Table 3: Median urinary iodine concentration µg/L among children in 2022

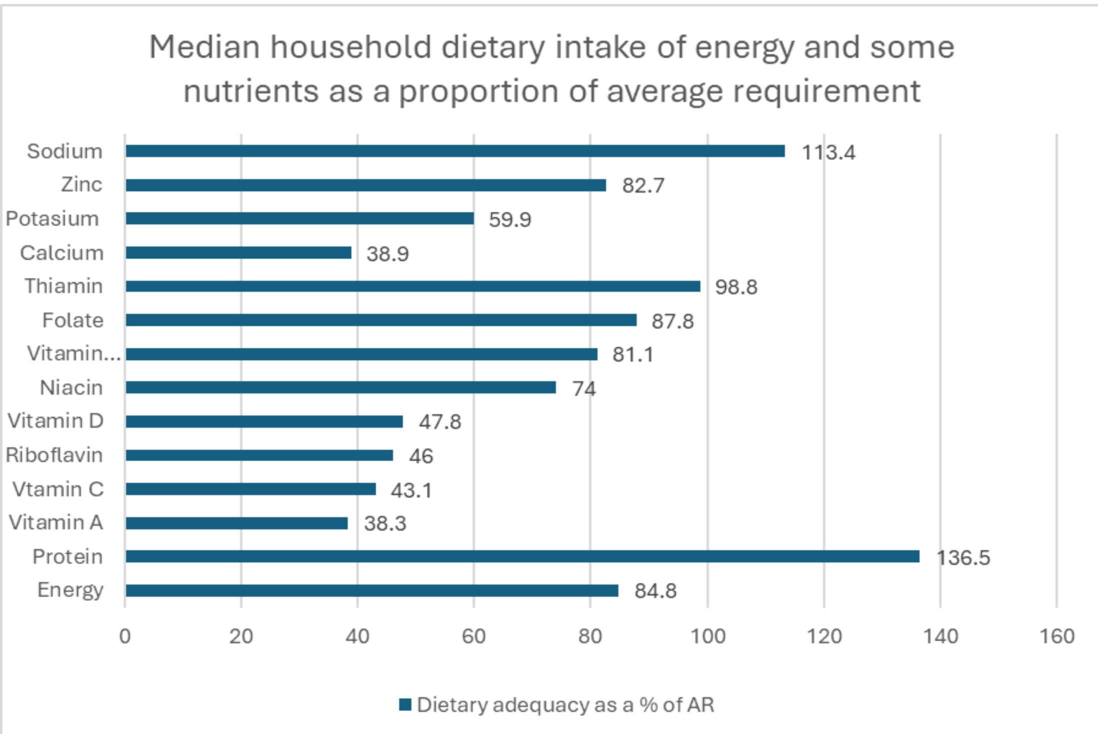
Cut-off points for iodine deficiency 100 µg/L

under 5 years	93.8
5-9 years	101.2
10-17 years	90.5

Source: MRI, 2023

Survey conducted in 2021 shows an increase in iodine deficiency levels with Median urinary iodine concentration lower than cut off in all age categories among under 5 years old and 10-17 years while proportion of households with adequately iodized salt was 71.7% (MRI, 2023).

Figure 6: Median household dietary intake of energy and some nutrients as a proportion of average requirement.



Source: MRI, MoH 2022

As per the survey conducted from September to December 2021, to identify the gaps in the diet of Sri Lanka revealed that median household intake of protein is exceeding the average requirement (MRI, 2022). However, this was much less after the economic crisis as dairy products, meat and fruits were consumed approximately three or less than three times per week while in estate sector significant reduction of consumption of meat, fish and eggs was observed in March 2023 (WFP, 2023). Meanwhile, household median intake of Vitamin A, Vitamin C, Riboflavin, Potassium and Calcium was well below the average requirement and household Sodium consumption was exceeding the average requirement (113.4%) (MRI, 2022) showing the need of consumption of more fruits and vegetables while reducing the intake of Sodium at the household level.

Chapter 04

Impact of malnutrition among children

Food security status, changes of food environments and insufficient nutrition actions contribute to malnutrition among children and its impact can occur in terms of three ways:

1. Mortality (Death)

Approximately 45% of all preventable child deaths are due to undernutrition as these children are more susceptible to infections such as diarrhoea, pneumonia, tuberculosis, and other illnesses (black et al, 2013). Severely undernourished children are 8.4 times more likely to die than children with good nutrition status while the mortality for moderate and mild anaemia was 4.6 to 2.5 times than well-nourished children (USAID, 1995). Evidence based interventions that are carried out by the MoH, Sri Lanka have proven their efficacy, for example the country has reduced neonatal mortality rates to 7 in 2023 (FHB, 2023) with significant improvement in breast feeding practices and perinatal care.

2. Sickness

Malnourished children are susceptible to infections such as diarrhoea, respiratory infections, poor physical and mental functioning and later in life onset of non-communicable diseases such as obesity, diabetes, hypertension etc causing financial burdens for families, societies and health care systems. For example, a Ready-to-Use Therapeutic Food (RUTF) to treat Severe Acute Malnutrition (SAM) alone costed 70 million LKR in 2018 (World Bank, 2020).

3. Impaired physical growth and/or cognitive development

This may contribute to poor performance in education, quality of life of an individual, loss of potential earning and productivity leading to economic losses (UNICEF, 2020).

Chapter 05

Determinants of and contributory factors for malnutrition

The double burden of malnutrition (undernutrition and overnutrition) is one of the major public health challenges in Sri Lanka. United Nations International Children's Emergency Fund (UNICEF) conceptual Framework on Maternal and Child Nutrition 2020, identifies following determinants to maternal and child nutrition;

1. Immediate determinants - Age appropriate nutrient rich food with proper feeding and dietary practices and good nutrition care services for mothers and children

2. Underlying determinants - safe and adequate drinking water and adequate nutrition, health, sanitation, education and social protection services for children

3. Enabling determinants - Political, financial, social involvements with good governance and sufficient resources, cultural and environmental conditions with gender, cultural and social norms of nutrition actions to ensure children's and women's right to nutrition

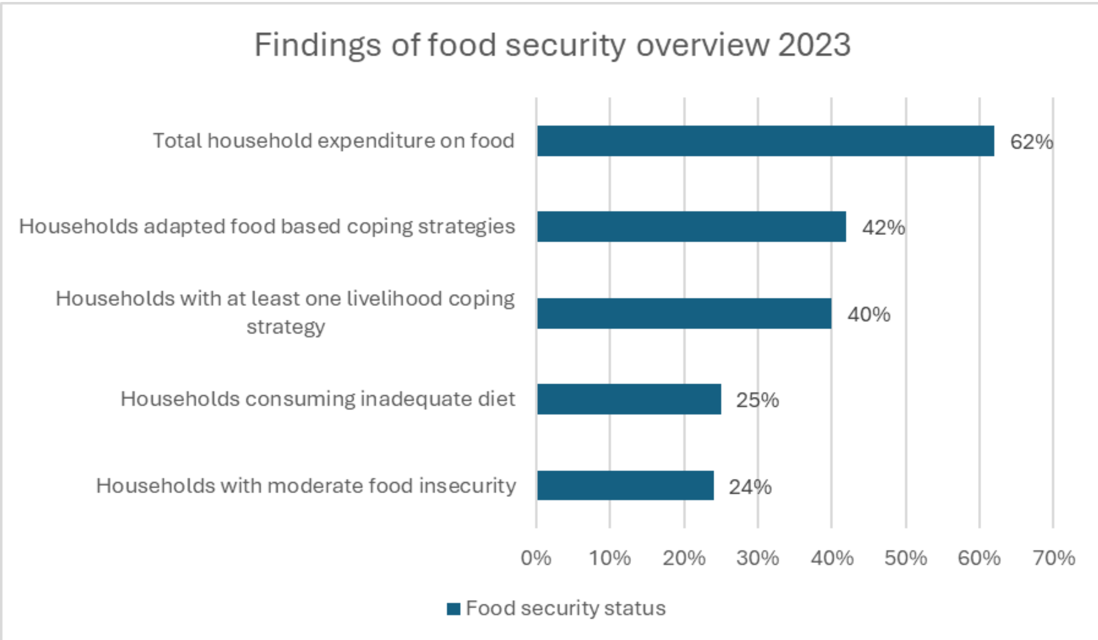
5.1. Food Security at household level

In Sri Lanka, before COVID 19 average household spent only 35% of the household income on food (DCS, 2019). According to the Hector Kobbakaduwa Agrarian Research and Training Institute (HARTI), World Food Programme (WFP) and Australian Aid joint report on economic crisis and food security in Sri Lanka 2022, proportion of expenditure on food has dropped to 29% from total household income due to economic crisis in 2022 probably due to income loss and as an adaptation of food based coping strategies (Samantha et al, 2023).

During the economic downturn in 2022, 64% of Sri Lankans faced reduction of their income especially, 82% of daily wage earners and 78% of farmers had to face income reduction while 98% of the population was affected by high food prices. At the latter six months in 2022, 74% of the households investigated, could not afford to buy food or daily essentials. As a coping strategy, 75% households changed their cooking practices by changing the type of food items cooked and 61% of the households reduced the frequency of cooking while minimizing eating out. One third of households examined (37%), limited their portion size and 25% borrowed food from their neighbourhood (Samantha et al, 2023).

During the third quarter in 2023, 24% of the households were food insecure compared to 17% in March 2023 with the highest food insecurity (51%) observed in the estate sector followed by rural (26%) and urban (15%) sectors. Between the first and the third quarter of 2023, the prevalence of food insecurity increased in all households with 8 percentage points increase in female headed households and 5 percentage points increase in male headed households (WFP, 2023).

Figure 7: Key findings of the food security status.



Source: Food Security Overview in Sri Lanka, WFP, 2023

An average cost of energy only diet (grains and grains-based products/ legumes, nuts and seeds/ sugars and confectionary/ fats and oils) for a household in 2022 was LKR 468 per day when diet consists of only 1-2 food groups. Out of the household cost, cost of a 6 –7-years old child's diet was 16% (LKR 74.88 per day) while for an adolescent girl it was 26% (LKR 121.68 per day). However, a healthy nutritious diet should consist of food from all food groups for the wellbeing and productivity of a child in the future. The average cost of a nutritious diet was LKR 1,707 per household per day and out of that nutritious diet for a child 6 -7 years costed on average, LKR 256.05 per day while adolescent girl's nutritious diet per day costed on average LKR 493.03. The average cost of an energy only diet and a nutritious diet was highest in the Colombo District (LKR 487/- per day and LKR 1,925/- per day). A cost of protein sources (57%) was the highest among food categories with animal sources of food consisting 43% of the cost of a nutritious diet and legumes, nuts and seeds costed 14%. Moreover, 28% price inflation of animal protein sources was observed in 2022 with escalating prices of eggs and fish. Vegetables and fruits share 14% of a nutritious diet. Grains and grain products are the major component of a Sri Lankan diet, and it costs only 16%. Therefore, people tend to get energy only diet with a low cost rather than taking a nutritious diet. Affordability of energy only diet in the population was 98 % and only 53% could afford a nutritious diet. Ratnapura, Badulla and Monaragala districts encountered the highest non affordability of a nutritious diet (HARTI, MoH, DCS, WFP, 2023).

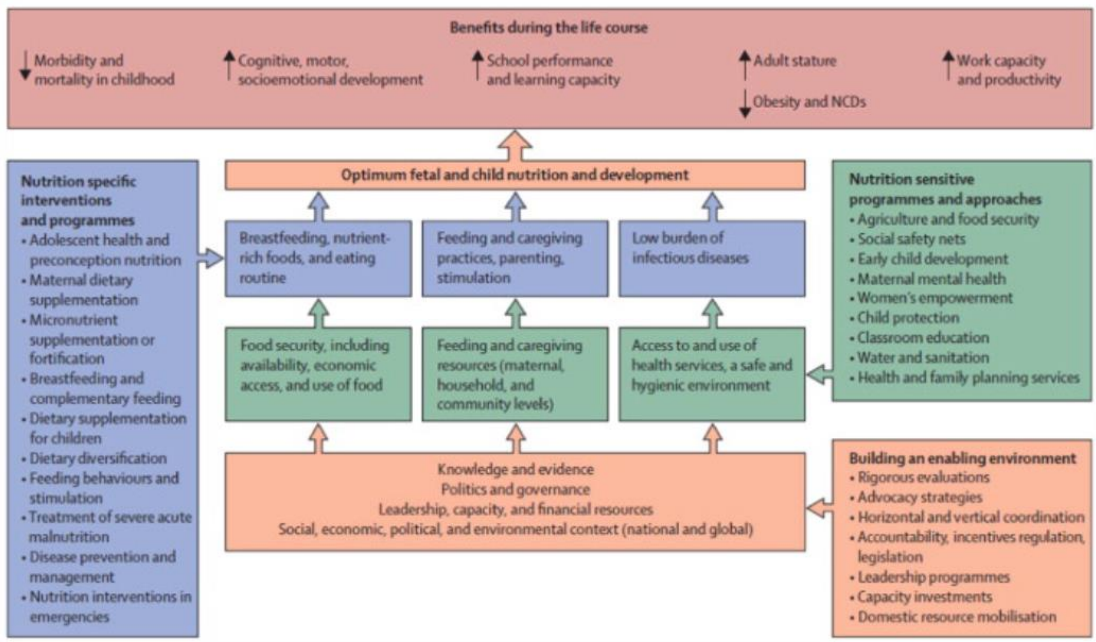
5.2. Nutrition Interventions

Government of Sri Lanka with relevant Ministries (Ministry of Health, Ministry of Agriculture, Ministry of Education, Ministry of Women and Child Affairs, Ministry of Finance and other relevant ministries etc.) implement many programmes to improve nutrition among children while National and sub national level governance structures are established for effective coordination of multi sectoral direct and indirect nutrition actions. National Food Security and Nutrition Council (NFSNC) as a higher-level authority functioning at the Presidential secretariat was established in 2022. It shows the higher-level political commitment to alleviate malnutrition in Sri Lanka. National Combined Mechanism on Food Security and Nutrition as an implementation arm of NFSNC at national and sub-national levels (Provincial, District, Divisional) coordinates the direct and indirect nutrition interventions at different levels. Maternal and Child Nutrition (MCN) subcommittee (a subcommittee of the Nutrition Steering Committee chaired by the Secretary Health) chaired by Deputy Director General of Public Health Services (II) provides technical expertise to the nutrition issues among mothers and children. Many other organizations including United Nations agencies (UNICEF, WHO, WFP, FAO etc.) and other development partners, non-governmental and civil society organizations support in numerous ways to improve food security and to combat malnutrition in Sri Lanka.

Direct nutrition interventions address the immediate determinants, and they are "nutrition-specific" actions such as support for early initiation of breast feeding, promotion and protection of breast feeding, promotion of age-appropriate complementary feeding, growth monitoring, management of SAM, nutrient supplementation (Vitamins and minerals, Thriposha). World Health Organization (2019) released an overview of the essential nutrition actions to address malnutrition in all its forms for wellbeing throughout the life-course indicating that the settings may deliver them depending on the context. Sri Lanka has adopted all relevant nutrition actions mentioned to prevent and control malnutrition among children and implemented at scale island wide.

Indirect interventions address the underlying determinants of malnutrition, and they are 'nutrition sensitive' actions like food security interventions, food safety, water, sanitation and hygiene (WASH) interventions, taxing sugar sweetened beverages (SSB).

Figure 8: Framework for interventions to achieve optimum foetal and child nutrition and development.



Source: Black et al, 2013

This framework was developed while formulating the nutritional conceptual framework of UNICEF and it identifies most important direct (nutrition specific) interventions and necessary indirect (nutrition sensitive) interventions, building an enabling environment for optimum foetal and child nutrition and development as well as benefits of optimum nutrition during the life course.

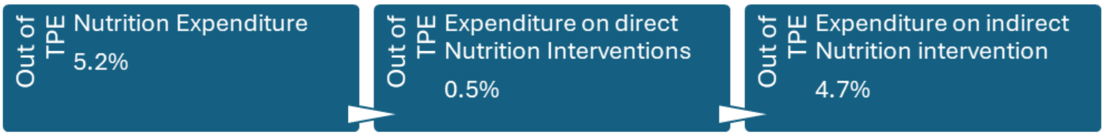
5.3. Expenditure on nutrition actions

In 2018, government disbursed LKR 6,441/- (approximately US$39.6 at the time) per person as nutrition expenditure. That is only 1% of the Gross Domestic Product

(GDP) while it was only 5.2% of the Total Public Expenditure (TPE) for that year. Moreover, some other countries in the region such as Nepal and Bangladesh spent 3% and 9% of their TPE of the same year. There was a clear reduction from 2015 where the nutrition expenditure was 188 billion LKR to 140 billion in 2018. Furthermore, share of indirect nutrition interventions was 90% of the nutrition expenditure and it may or may not have been spent for nutrition targeted interventions. Foremost share of nutrition expenditure for indirect nutrition interventions (around 92%) accounted for Samurdhi programme, fertilizer subsidy and WASH activities. In the same year 36,485 billion LKR was allocated for agriculture out of which 32.3 billion spent on fertilizer subsidy while only 2.5 billion was allocated for other nutrition sensitive activities. The Government of Sri Lanka (GOSL) has devoted approximately 200 million LKR to implement home gardening programme while 3.0 –3.5 billion LKR and 700 million were accounted for the fisheries and livestock sectors to implement nutrition - sensitive programs. Every year GOSL provides 30–50 billion LKR for WASH programs (World Bank, 2020). In view of protecting vulnerable families from consequences of economic downturn, 400,000 transitional beneficiaries were provided 2,500/- LKR per month until December 31, 2023, while 400,000 vulnerable beneficiaries were provided 5,000/- LKR per month until March 31, 2024. Out of the poor, 800,000 beneficiaries and extremely poor beneficiaries will receive 8,500/- LKR per month, and 5,000/- LKR per month for three years beginning from July 1, 2023 (Presidential Secretariat, 2023).

Only a trivial share of TPE (0.5%) was allocated for direct nutrition interventions including school and preschool feeding programmes (13, 358 million LKR in 2018). Out of that 96.7% accounted for provision of medicine and supplements through MCH programme, Thriposha programme and school meals programme. The government school meal program received 5 - 6 billion LKR and to include nearly 80% of all government schools covering one million beneficiaries in grade 1 to 5 accounting for 6,000/- LKR per child for the school meal program in 2018. In the same year GOSL spent 3,500/- per child for the preschool meal. Other nutrition specific programmes such as capacity building of health staff on maternal & child nutrition, promotion of optimal maternal nutrition and IYCF practices, nutrition programmes for vulnerable populations were assigned only 3.3% of the allocated budget for direct nutrition interventions. Government of Sri Lanka invests in nutrition - sensitive interventions 10 times more than the allocation for nutrition-specific interventions with proven evidence. Therefore, nutrition expenditure share for direct interventions should be increased as the cost of the direct nutrition interventions were with proven effects on malnutrition (World Bank, 2020).

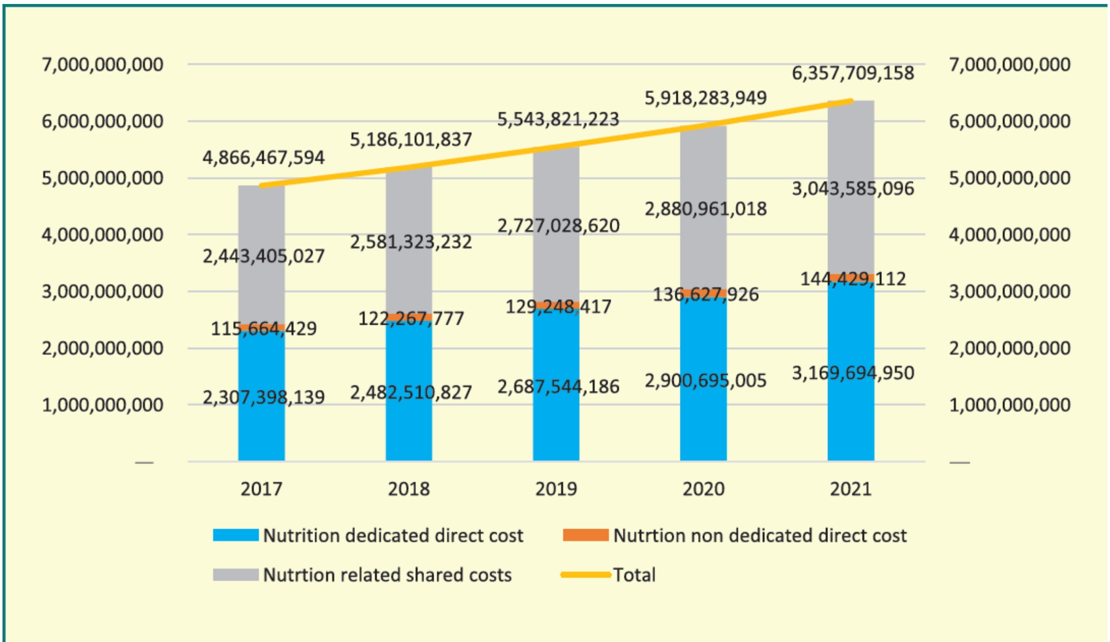
Figure 9: Share of Nutrition Expenditure out of Total Public Expenditure (TPE)



Source of data: World Bank, 2020, Assessing Public Financing for Nutrition in Sri Lanka (2014–2018)

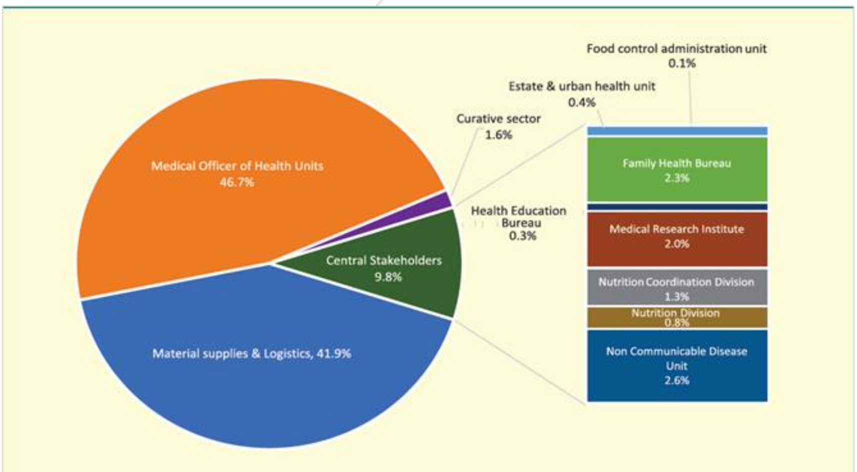
Cost of health sector component in National Nutrition Programme was estimated for 2017-2021 period and the total estimated cost for 5 years was 27.9 billion rupees with annual cost ranges from 4.9 billion in 2017 to 6.3 billion in 2021. The total cost included both direct costs that are absolutely committed to nutrition and shared costs (portion of the costs that are shared between other health costs and nutrition interventions). Estimated direct cost was 2.3 billion in 2017 to 3.2 billion in 2021 (Ministry of Health, 2017). Direct cost incorporated nutrition dedicated direct cost (specifically dedicated to nutrition programmes) and nutrition non dedicated direct cost that can be redistributed to other programmes if the nutrition programme is stopped. However, COVID 19 epidemic and economic recession may have changed these estimated costs.

Figure 10: Estimated total costs for health sector component of the National Nutrition Programme (NNP-HS) over 2017-2021



Source: Cost of NNP-HSC of Sri Lanka, MoH, 2017

Figure 11: Distribution of estimated costs for health sector component of the National Nutrition Programme for 5 years (2017-2021)



Source: Cost of NNP-HSC of Sri Lanka, MoH, 2017

5.4. Issues of inadequate nutrition expenditure

It was found that only 52.1% and 11.6% of six months to two years old children received Multiple Micro Nutrients (MMN) daily and every other day respectively during the last 6 months of survey. Thriposha was received by 55% of underweight children 6-59 months of age within six months in 2022 and 18% of 5–9 year olds and 27.8% of 10–17-year-olds had received iron folate supplements from school (MRI, 2023). This may be due to difficulties in obtaining supplements (except for MMN which was received through UNICEF) and production of Thriposha due to insufficient funds at the time.

Moreover, Maternal and Child Health (MCH) programme at the field level to provide quality services needs more field health staff as there are 1008 vacant Public Health Midwife (PHM) areas (15 - 20% of cadre positions) and 147 vacant Public Health Inspectors (PHI) areas and recruitment of new cadre is an issue due to relatively poor salaries and absence of career progression. Sri Lanka, achieved green status in breastfeeding of the World Breastfeeding Trends Initiative (WBTi) color - code with one of the top breastfeeding rates in the world with 90% of initiation of breastfeeding within the first hour of birth and 82% exclusive breastfeeding in the first six months in 2016 (WBTi, 2020; WHO, 2023 a). This was a result of efforts of staff in maternity wards and lactation management centres of hospitals and dedicated well trained field health staff. Inadequate health staff will negatively impact such achievements obtained over the years.

Chapter 06

Nutrition related policies, strategic and action plans, programmes and activities

6.1. Nutrition related Policies in Sri Lanka

The revised National Nutrition Policy (2021-2030) is intended to achieve and maintain the nutrition well-being of all Sri Lankans enabling them to contribute effectively towards sustainable development. This policy is coherent with all other nutrition - related national and provincial health and non - health policies such as maternal and child health, non-communicable disease (NCD), elderly health as well as non-health policies such as agriculture, national drinking water policy, trade, tariff policy etc supporting them under one umbrella. Implementation of the Policy is guided by the strategic framework for action with key action areas, expected outcomes and monitoring indicators under each strategic direction. The policy recognises the mechanism of coordination of Multi - sector Action Plan for Nutrition and Strategic Information Management. Out of the supporting policies, maternal and child health policy is aligned with the WHO recommended actions for maternal, newborn, young child, school age children and adolescents to implement the recommended evidence-based interventions to improve maternal and child nutrition and wellbeing. School Canteen Policy is implemented and monitored by the Ministry of Education in view of improving nutritional status of school children with ensuring the right of school children to have nutritious, culturally acceptable, hygienic food available at a reasonable cost within the school and to develop healthy dietary habits among school children by improving their knowledge, attitude and practices over diet. The Ministry of Agriculture and Plantation Industries (MoA) formulated the National Agricultural Policy 2022-2030 with the aim of achieving sustainable food security with improved food quality and promoting plant based and animal food production. Ministry of Fisheries launched the National Fisheries and aquaculture policy - 2018 with the aims of increased marine, aquaculture and inland fisheries production with minimized post-harvest losses and increased per capita consumption of fish.

6.2 Nutrition strategic plans

Ministry of Health has several strategic plans which addresses the prevention and control of malnutrition among children such as National Strategy for Infant and Young Child Feeding Sri Lanka 2015-2020, National Strategic Plan Maternal and Newborn Health 2017-2025, National Strategic Plan on Child Health in Sri Lanka 2018-2025, National Strategic Plan on Adolescent and Youth Health 2018-2025 as well as National Strategy for Prevention and Control of Micronutrient Deficiencies 2024-2030. Apart from these documents, Nutrition Communication Strategy, fisheries sector strategy - 2023 are also some other nutrition related strategies developed to improve community nutrition.

6.3 Action plans to combat malnutrition in Sri Lanka

Multi Sector Action Plan for Nutrition 2023–2030 aims to improve the multi sectoral collaboration and coordination with the intention of improving the nutritional status of Sri Lankan population and to achieve relevant Sustainable Development Goals (SDGs). It is developed in line with policy priority areas of the National Nutrition Policy (2021-2030) and includes results-based monitoring framework for all levels of actions. Guide to prepare District Nutrition Action Plan for health sector was formulated in 2013 to support managers at the district level to carry out evidence-based interventions to improve nutrition of populations.

During the economic crisis, Emergency Nutrition Action Plan 2022-2024 (ENAP) was developed to prevent further deterioration of nutrition status and to address three key issues:

(1). inequities in food access/ affordability;

(2). Health systems gaps in addressing children with SAM, MAM, and in providing services to vulnerable populations (e.g. Distribution problems due to lack of fuel, supply chain issues for BP 100, Thriposha and nutrition supplements, HR challenges in transport and data provision);

(3). Gaps in communication and empowerment of people towards preventing nutritional problems that are still within their means;

A mid-term plan of action for 2023-2027 for fisheries was developed to improve per capita fish production.

6.4 Guidelines and programmes to improve nutrition in children.

1. Infant and Young Child Feeding (IYCF) guidelines intended to promote age-appropriate child feeding practices from birth to two years and growth monitoring and promotion programme with nutrition counselling for regular assessment of nutrition status of under 5 children. This programme supply food supplement (Thriposha) to undernourished children. In addition, Vitamin A supplementation for children under five and MMN supplementation for infants and young children

are being carried out through the MCH programme. Management of SAM with therapeutic food is being carried out in hospital setting.

2. School health programme conducted by field health staff conducts nutrition assessment of children in grade 1, 4, 7 & 10 in schools with more than 200 students and all students are assessed in schools with less than 200 students. Micronutrient supplements (Weekly Iron folate supplement) are also given to children with nutrition education through this programme. Ministry of Education conducts school meal programme that provides healthy meal for one million school children supported by the GOSL while WFP supports school meals with provision of fortified rice and dry rations for school meals. The Ministry of Education (MoE) has issued guidelines and circulars on school nutrition programme ‘food for education programme’ and healthy canteen at school premises. Preschool meal programme also is being conducted by the Children’s Secretariat in vulnerable areas.

Food Based Dietary Guidelines provide guidance for healthy eating including recommended food groups for Sri Lankans and recommended serving sizes for under 5 years, primary school children and adolescents (MoH, ND, 2021a). Strategic marketing and Communication plan (2021) for FBDG was formulated in view of identifying marketing tools and tactics on promotion of healthy eating (MoH, ND, 2021).

Chapter 07

Conclusions

Evidence based interventions to improve nutrition among children were implemented over the years by the health sector at all levels. However, malnutrition among children is an unfinished agenda in the country. Some indicators such as underweight, stunting and wasting in under 5 years olds were improving gradually or stagnant until 2021 and since 2022, an increasing trend of these problems were observed. Percentage increase of wasting among children under five years may be negligible but number of children are many needing immediate attention before they become chronically undernourished. Furthermore, the MCH programme requires more field health staff with adequate competencies to provide quality maternal and child nutrition (MCN) services. Therefore, vacant areas need to be filled and capacity building programmes should be strengthened. Facilities to provide quality health and nutrition services (transport, communication etc) are also required by field health staff. Prevalence of overweight and obesity is increasing among school children and consumption of unhealthy diets and sedentary behaviours should be minimized to prevent NCDs in later life. Healthy diets with recommended servings of required food groups and improved physical activity can reduce overweight and obesity among children.

Micronutrient deficiencies such as vitamin D deficiency, Zinc deficiency and vitamin B12 deficiency and iodine deficiency are public health problems among older children. Vitamin A deficiency is not a public health problem at present due to vitamin A supplementation carried out among children under 5 years. Vitamin A rich food consumption is very low in school aged children, and this will become a problem again, as supplementation of vitamin A for school children has ended.

Food insecurity at household level increased with income losses and food inflation following economic crisis. During July - September 2023, nearly one fourth of the households were food insecure and it was a 7% increase when compared to March 2023 with half of the estate sector households being food insecure. Affected households have adopted many coping mechanisms to meet their essential needs. Three fourth of households examined have changed their cooking practices while one third of households reduced frequency of cooking or limited their portion size and one fourth depend on food from neighbourhood. This may negatively affect nutrition status of children further. Therefore, it is a felt need to take immediate actions to improve food security status of families with children under five (5) years. Only half of the population could afford a nutritious diet in 2023 and half of the population who could not afford it may have a low-cost energy only diet further deteriorating the malnutrition status.

Trend in share of nutrition expenditure was reduced from 2015 and in 2018 it was only 1% of the TPE indicating inadequate nutrition financing in the country. Moreover 90% of the nutrition budget was allocated for nutrition sensitive interventions. This shows inadequate funds distributed for nutrition specific interventions. Moreover, there is a need for distribution of more budget to improve availability of all food groups at affordable prices as per the recommendations of FBDG, out of nutrition sensitive budget.

Chapter 08

Recommendations

8.1 Immediate nutrition actions

1. Identification of economically vulnerable families with under 5 years old children and food insecurity and taking necessary actions without delay (mapping vulnerable and social protection programmes).

   - Use of existing (e.g. eRHMIS) Health Management Information Systems (data sharing platform) to identify hot spots of undernutrition in children and vulnerability mapping to identify the most vulnerable households and causal factors to address malnutrition.

   - Provision of food baskets / food vouchers with essential healthy food items (as per Ministry of Health recommendations) to vulnerable families with children under 5 years old. In case resources are limited, targeting vulnerable families with children under two (2) years can be considered.

   - Provision of cash vouchers to economically vulnerable households with preschool children to provide wholesome homemade mid-day meal to preschool or ensure provision of regular uninterrupted cash flow of 100/- LKR per child, for free healthy preschool meal to all children in preschools (as per Ministry of Health recommendations) in economically vulnerable Grama Niladhari (GN) areas with close monitoring by preschool teachers and ensuring accountability by Grama Niladhari.

2. Provision of nutrition supplements to pregnant mothers and undernourished children without interruption

   -Ensure provision of adequate regular cash flow to facilitate continuous Thriposha production with quality control measures and distribution to the target group (pregnant and lactating mothers and under nourished children aged 6 months to 5 years) at Medical Officer of Health level and hospitals. Funding support to Thriposha factory is required to procure required machinery to produce rice based Thriposha and improve storage facilities for raw materials to ensure quality of Thriposha produced.

-Adequate and regular funds for procurement of nutrition commodities; Multiple Micro Nutrients (MMN) for infants and young children/ Ready to Use Therapeutic Food (RUTF) for management of severe acute malnutrition among children 6 months to 5 years/ MMN for pregnant mothers, Weekly Iron Folic Acid supplementation for school children.

3. Expanding the preschool meal programme and school meal program to cover all vulnerable preschools, schools and all children in vulnerable schools including adolescents with provision of iron folate, fortified rice and adequate budgetary allocation for preschool and school mid-day meal programmes.

4. Advocate relevant authorities including the Ministry of Finance to improve service coverage and quality targeting undernourished children and reproductive age women at the field level with sustainable allowances such as fuel allowance and communication allowance to field health staff (Public Health Midwife, Public Health Inspector) and supervisory categories [Public Health Nursing Sister (PHNS) / Supervising Public Health Inspector (SPHI) / Supervising Public Health Midwife (SPHM), Regional Supervising Public Health Nursing Officer (RSPHNO), Supervising Public Health Inspector – Divisional (SPHI – D)].

5. Support grass root level health workers (PHM, PHI, SPHM, PHNS, SPHI) by increasing their transport, communication and office allowances to facilitate more home visits to vulnerable families. Advocate with Ministry of Finance and others relevant departments to increase their cadres where relevant, filling of existing vacancies and development of new career opportunities to attract these cadre positions.

6. Price control of selected essential food items (rice varieties including Nadu, animal source proteins such as eggs, small fish and sprats, pulses such as dhal, green gram, cow pea, chickpea, vegetables and fruits, nuts and seeds, oils) to make those available at affordable prices to make healthy and low cost meals.

7. Enhance nutrition communication to scale up messages on healthy eating and cash management.

   -raise awareness among public through mass media through dedicated daily airtime

- Community empowerment and mobilization for optimum consumption of all nutrients through dietary diversification.

8. Taxation of foods high in sugar, salt and fats (e.g. raise sugar tax, taxation of confectioneries, sugar sweetened beverages (SSB), ultra processed foods such as biscuits, commercial milk formulae) before the public health problem of obesity and NCDs among children escalate.

9. Immediate implementation and enforcement of protective food legislation (Food Labelling and Advertising Regulations 2022 of the Food Act) which prohibit food advertisements to children and formulation of Breastfeeding Protection Act.

10. Measures for Initiating Mass-Scale Production of Rice-Based Thriposha should be taken including provision of one More Blending Unit and necessary finances.

8.2 Medium term interventions

1. Take policy decisions to make all school children engage in physical activity outside under the sun for at least 30 minutes before the interval to prevent and control vitamin D deficiency.

2. Implement nutrition sensitive agriculture to make available healthy food at affordable prices (e.g. increase production of pulses such as green gram, Cow pea etc. vegetables and fruits, fish, egg and meat).

3. Establishment of surveillance programmes such as dietary behaviour surveillance, nutrition surveillance of reproductive age women and surveillance mechanism for unethical marketing of food.

4. Monitoring implementation of preschool meal and school meal programme and school canteen guidelines for quality meal provision.

5. Revisit nutrition financing.

   -a separate nutrition budget for relevant sectors to improve accountability

   - increase funds for direct nutrition interventions

   - provision of funds to improve resources for existing interventions with proven efficacy

6. Improve availability of high - quality Thriposha product addressing issues at the Farmers' and factory level including advocacy on proper drying methods and to provide drying machines for the farmers as well as improving storage and processing capacity at the Thriposha Factory Level.

8.3 Long term interventions

1. Ensure accountability of nutrition actions of all relevant partners

   - Monitoring of all nutrition activities to guarantee value for money and ensure food security.

2. Coordinated multi sector collaboration for effective nutrition actions.
3. Streamline food legislation systems throughout the food supply chain for safe and quality food.
4. Strengthen analytical capacity for assessment of food for safety and quality.

Annex 1

Officials Present at Committee Meetings

Institution	Personals
Ministry of Health	Dr. H.S.R. Perera Deputy Director General Dr. Lakmini Magodarathna Acting Director (Nutrition) Dr. S. Subaskaran Director (Estate and Urban Health Unit) Dr. Pubudu Ariyarathna Registrar in Health Information Dr. W. N. Sachintha Dilhani Consultant Community Physician Dr. Y.A.G.K. Gunawardhana Consultant Community Physician Dr. Chintha Gunerathne Director Dr. M. P. Wijerathne Director
Plantation Human Development Trust	Dr. S. Amunugama Director Health Mr. L.R. Perera Director General

Family Health Bureau	Dr. Chithramalee De Silva Dr. Ayesha Lokubalasooriya Dr. Hiranya S. Jayawickrama Dr. N. A. A. S. Thilakarathna Medical Officer
World Food Programme	Dr. Kalana Peiris Head of Nutrition Division Ms. Dilka Peiris Programme Policy Officer
Ministry of Women, Child Affairs and Social Empowerment	Mrs. K. P. C. Subhashini Director (Planning and Monitoring Division) Mrs. D. D. Varuni Rasadari Director (Planning and Monitoring Division) Ms. N. I. P. Liyanarachchi Assistant Director (Planning) Mr. J. P. S. Jayasinghe Director General (Planning & Monitoring)
UNICEF	Dr. Abner Elkan Daniel Manager (Health and Nutrition)
Medical Research Institute	Dr. Renuka Jayathissa Head of Department of Nutrition
Sri Lanka Thriposha Limited	Dr. Deepthi Kularathne Chairman Ms. Thanuja P. Alwis Senior Manager Mr. Nisshanka Walakuluarchchi Manager (Distribution)

Ministry of Education	Mr. P.W. Amaradiwakara Acting Director (School Health& Nutrition) Mr. P. Sudarshana Peiris Assistant Director Mrs. R. A. M. R. Herath Additional Secretary (Primary Education Development) Mr. P. W. N. P. Gunasekara Deputy Director Ms. P. C. K. Pirisyala Additional Secretary (Co-Curricular Activities & Primary Education Development) Ms. B. W. G. Dilhani Director of Education (Nutrition)
Finance Commission	Mr. Sumith Abeysinghe Chairman Mr. S. M. R. S. Bandara Director Mr. A. T. M. U. D. B. Tennakoon Secetary Mrs. W. G. Manoja Wasanthi Assistant Director
World Health Organization (WHO)	Dr. Manjula Danansuriya National Professional Officer
Ministry of Finance	Mrs. K. A. P. Damayanthie Deputy Director Mrs. Shiranthi Rathnayake Additional Director General

	Mrs. Ajitha Batagoda Additional Director General Mr. G. M. J. K. Gunawardhana Additional Director General Mr. W. M. D. Wijebandara Director
Department of Probation and Child Care Services	Mr. D. N. Gamage Deputy Director
Department of Samurdhi Development	Mr. P. V. Somasiri Samurdhi Manager
Department of National Planning	Mrs. L. A. Y. D. De Silva Director