

ANNUAL REPORT 2015



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குழு சுகாதார பணியகம்
FAMILY HEALTH BUREAU



Family Health Bureau
Ministry of Health
Sri Lanka



Annual Report of Family Health Bureau 2015



Family Health Bureau
Ministry of Health
Sri Lanka



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Preface

Family Health Bureau, Ministry of Health is pleased to present the 25th Annual Report in 2015. This report provides the progress made by the Reproductive, Maternal, New born, Child, Adolescent and Youth Health (RMNCAYH) programme of Sri Lanka in 2015.

Report consists of routine data reported through the reproductive health management information system (RHMIS) from all Medical Officers of Health areas on RMNCAYH, and major activities carried out by the Family Health Bureau during the year 2015 to improve RMNCAYH programme in the country.

Information provided in this report would be utilized for programme redirection at national level and would be useful for provincial and district health staff to identify the gaps and deficiencies that need to be addressed in providing services in their areas.

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Professional colleges including Sri Lanka College of Obstetricians and Gynaecologists, Sri Lanka College of Paediatricians, College of Community Physicians of Sri Lanka, Perinatal Society of Sri Lanka work hand in hand with Family Health Bureau to improve the services and system development right throughout the year. Their technical inputs are highly valued.

World Health Organization, United Nations Children's fund, United Nations Population Fund and World Bank have always been strengths behind the national programme. I appreciate their inputs. I am very thankful to Dr. Priyanee Senadeera, Director, Maternal and Child Health, Dr. Sapumal Dhanapala, Acting Deputy Director, Family Health Bureau and all other Consultant Community Physicians for their guidance and inputs. Special note of thanks extended to Mr. Joseph Hariyaram, ICT Officer, Family Health Bureau for the support rendered in preparation and editing the report and all other staff members of Monitoring and Evaluation unit, for their continuous support given during preparation of this report.

Finally, I must thank all the MOHs and their staff island wide, district MCH teams and all provincial supervising officers for their hard work right throughout the year without which the national programme will not be a success.

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Summary Statistics

Indicator	Data	Year	Source
Demographic			
Total population ²	20,966,000	2015	Registrar General's Department
Age distribution ('000)			
0 -14 years	5288		
15 - 64 years	14,030	2015	Registrar General's Department
65 years over	1,648		
Live births ²			
Total	334,821		
Male	169,918	2015	Registrar General's Department
Female	164,903		
Surface area (Sq. km)	62,705	1988	Survey General's Department
Population density (Persons per sq. km) ²	334	2015	Registrar General's Department
Growth of mid-year Population (%) ²	0.9	2015	
Rate of Natural Increase (per 1000 population)	9.7	2015	Registrar General's Department
Crude Birth Rate (per 1000 population) ²	16.0	2015	Registrar General's Department
Crude Death Rate (per 1000 population) ²	6.3	2015	
Urban population (%)	18.2	2012	Department of Census & Statistics
Sex ratio at birth (No. of male births per 100 female births)	103.5	2014	Department of Census & Statistics 2012
Child population (<5 year)%	8.6	2014	Department of Census and Statistics 2012
Women in the reproductive age group (15-49 years)%	51.0	2012	
Average house hold size (number of persons) ³	3.9	2015	Central Bank Report
Health and Nutrition			
Life expectancy at birth (years)			
Total	74.9	2015	Central Bank Report
Male ²	70.5	2011	Department of Census and
Female ²	79.8	2011	
Neonatal Mortality Rate ² (per 1000 live births)	5.6	2014	Registrar General's Department
Infant Mortality Rate ² (per 1000 live births)	8.0	2014	
Under five Mortality Rate ² (per 1000 live births)	9.4	2014	
Total Fertility Rate ²	2.2	2016	Demographic and Health Survey ¹
Maternal Mortality Ratio (per 100000 live births)	33.7	2015	Family Health Bureau
Still Birth Rate (per 1000 births) in Government Hospitals	6.0	2015	Medical Statistics Unit
Low birth weight per 100 live births in Government Hospitals ²	16.0	2015	

Indicator	Data	Year	Source
Pregnant women attending ANC more than 4 visits (%)	92.5	2006/2007	Demographic and Health Survey ¹
Average number of clinic visits per mother	6.4	2015	Family Health Bureau
Average number of antenatal home visits per mother by a PHM	4.2	2015	Family Health Bureau
Pregnant women visited at least once by PHM at home (%)	88.5	2015	Family Health Bureau
Live births in government hospitals (%) ²	94.1	2015	Medical Statistics Unit
Births attended by skilled health personnel (%)	98.6	2006/2007	Demographic and Health Survey ¹
Mothers receiving at least 1 postpartum visit during 1 st 10 days (out of reported deliveries)	90.4	2015	Family Health Bureau
Average number of postpartum visits by PHM during 1 st 10 days	1.7	2015	Family Health Bureau
Children ever breastfed of all children <5 years (%)	99.3	2006/2007	Demographic and Health Survey ¹
Breastfeeding initiation within 1 hour of birth (%)	79.9	2006/2007	
Exclusive breastfeeding under 6 months (%)	76.0	2006/2007	
Immunization coverage (%) BCG at birth (live births) Pentavalent 3rd dose Measles containing vaccine ¹ (MCV 1)	99.0 99.0 99.5	2015	Epidemiology Unit
Underweight (weight- for- age) <-2SD Acute Under nutrition (weight for height) -Wasting <-2SD Chronic malnutrition (height for age) -Stunting<-2SD	21.1 14.7 17.3	2006/2007	Demographic and Health Survey ¹
Current use of contraceptive methods among 15-49 year age married women (%) Any method Modern Method Traditional Method	64.6 53.6 11.0	2016	Demographic and Health Survey ¹

Indicator		Data	Year	Source
Socio-economic				
GDP per capita at market prices	Rs US \$	533,398 3,924	2015	Central Bank Report
GNI per capita at market prices	Rs US \$	521,412 3,836	2015	
Human development index		0.757	2015	
Literacy rate %	Total Male Female	93.3 94.2 92.6	2015	Central Bank Report
Median age at marriage (Female 25-49 years)		23.3	2006/2007	Demographic and Health Survey ¹
Health Resources				
Government expenditure on health (% of GNP)		1.66	2015	Department of Health Services
Government health expenditure as a % of total government expenditure ²		5.65	2015	
Per capita health expenditure (Rs) ²		8639	2015	
Medical Officer per 100,000 population ²		87.0	2015	Medical Statistics Unit
Population per Medical Officer ²		1,149	2015	Medical Statistics Unit
Dental Surgeons per 100,000 population ²		6.4	2015	Medical Statistics Unit
Nurses per 10,000 population ²		202.3	2015	Medical Statistics Unit
Public Health Midwives per 100,000 population ²		28.8	2015	Medical Statistics Unit
Number of hospitals ²		631	2015	Medical Statistics Unit
Number of hospital beds ²		80,581	2015	Medical Statistics Unit
Hospital beds per 1,000 population ²		3.8	2015	Medical Statistics Unit
Number of MOH divisions (Established)		341	2015	Family Health Bureau

¹ DHS 2006 / 2007 excludes Northern and Eastern provinces

² Provisional

³ Based on data of Household Income and Expenditure Survey 2012/2013, DCS

CHAPTER 01

INTRODUCTION

1.1 REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, ADOLESCENT AND YOUTH HEALTH PROGRAMME OF SRI LANKA

Reproductive, Maternal, Newborn, Child Adolescent and Youth Health programme (RMNCAYH) is a collection of several packages of interventions that are aimed to promote the health of families around the country with special emphasis on mothers and children. The programme provides the most wide spread community based health care services enjoyed free by the Sri Lankan public. Current programme reflects more than 85 years of successful programme implementation. The origin of the programme dated back to 1926 in which the first field based health unit system was established in Kalutara. At present, RMNCAYH programme has reached almost all families throughout the country. It forms of a well-organized health care system, implementing services through 338 divisional health units called Medical Officer of Health (MOH) areas.

The official mission of the RMNCAYH programme is “to contribute to the attainment of highest possible levels of health of all women, children and families through provision of comprehensive, sustainable, equitable and quality maternal and child health services in a supportive, culturally acceptable and family friendly setting.” In achieving this mission, the programme relies on evidence based public health interventions which are proven to be effective and delivered by multi-disciplinary team of health professionals. Major share of the RMNCAYH programme interventions are preventive in nature while some of them focus on secondary care by including interventions to ensure the standards and quality of care. A series of well-designed programme packages are available to deliver these interventions to target groups.

The RMNCAYH programme is comprised of several major components that aim to promote reproductive, maternal, child,

school, adolescent and youth health. It also includes women’s health components incorporating perimenopausal care and gender concerns.

The maternal component is further sub-divided into areas such as; Antenatal, Intrapartum, Postpartum and Maternal Morbidity and Mortality Surveillance entities. Newborn care, Child nutrition, Child development and special needs, Child morbidity and mortality prevention and surveillance elements comprise the Child health component. In addition, RMNCAYH programme includes an oral health component which focuses on maternal and child oral health care.

As a whole, RMNCAYH programme focuses on a sizable proportion (around 54%) of the population, which includes children, adolescents, youth and those in the reproductive ages. v

1.2 HEALTH ADMINISTRATION OF SRI LANKA

Sri Lanka has a partially devolved health care system. Ministry of Health at central level is responsible maintaining the health services of the country, while the nine Provincial Ministries are responsible for effective implementation of the services in their respective provinces. Nine Provinces consist of and 26 health districts called Regional Directors of Health Services (RDHS). RDHS areas are similar to administrative districts except in Ampara where the administrative district is subdivided to Ampara and Kalmunai RDHS areas.

1.3 FAMILY HEALTH BUREAU

Family Health Bureau (FHB), is the central level institution in the Ministry of Health that is responsible for planning, implementing, monitoring and evaluating the RMNCAYH programme. FHB provides technical guidance for provincial health care system on its implementation.

In addition, FHB advocates the Ministry of Health on matters related to policy, finance, infrastructure and other resource requirements relevant to RMNCAYH programme. Quality control, monitoring and evaluation of the RMNCAYH programme also come under the purview of FHB.

FHB has several units that covers the different components of the RMNCAYH programme. These include:

- a) Maternal Health Unit
- b) Intrapartum and Newborn Care Unit
- c) Maternal Morbidity and Mortality Surveillance Unit
- d) Child Health, Development and Special Needs
- e) Child Nutrition
- f) School Health
- g) Adolescent and Youth Health
- h) Gender and Women's health
- i) Family Planning
- j) Oral Health
- k) Planning, Monitoring and Evaluation
- l) Research and Development
- m) Reproductive Health Center

Each of these units is headed by a Consultant Community Physician (public health specialist), who is the national programme manager for areas under the unit's purview Reproductive Health Centre. Each unit is possessing a separate staff responsible for advocacy, policy and strategic analysis, programme development, technical guidance, evaluation and supervision related to the respective programme components. Reproductive Health centre services provided by a team lead by a Visiting Obstetrician & Gynaecologist.

Figure 1.1 shows the administrative and technical guidance pathways that facilitate the organization and implementation of RMNCAYH programme activities through the national health system.

The red and blue lines in the diagram depict the administrative and technical supervision pathways relevant to different levels of health system that are involved with the RMNCAYH programme.

The diagram also depicts the referral and back referral pathways available for people confronted by health conditions related to family health (child birth, childhood illness etc.) in pink lines. The administrative and technical guidance relevant to the RMNCAYH programme is integrated into the usual multi-tier organizational arrangement of the Ministry of Health. Tiers include, Ministry of Health headed by the Secretary of Health, nine Provincial Directors and twenty six Regional Directors.

At Ministry of Health, policy making and financial allocation related to RMNCAYH programme become the responsibility of Secretary to the Ministry. The overall administration including logistical supply comes under the purview of the Director General of Health Services (DGHS). FHB is the technical unit technically guiding the RMNCAYH Programme. FHB provides policy and strategic advocacy to the Ministry of Health and Provincial and Regional directorates.

1.4 IMPLEMENTATION OF RMNCAYH PROGRAMME AT PROVINCIAL AND DISTRICT LEVEL

Implementation of the RMNCAYH programme is technically guided and supervised by Provincial Consultant Community Physicians and Medical Officers of Maternal and Child Health (MOMCH) attached to regional (district) directorates. MOMCHs also act as the major link between FHB and the Provincial system. At the district level, MOMCH is supported by Regional Supervising Public Health Nursing Sister (RSPHNO) and Divisional Supervising Public Health Inspector (SPHID) in monitoring of the Family Health Programme in the district.

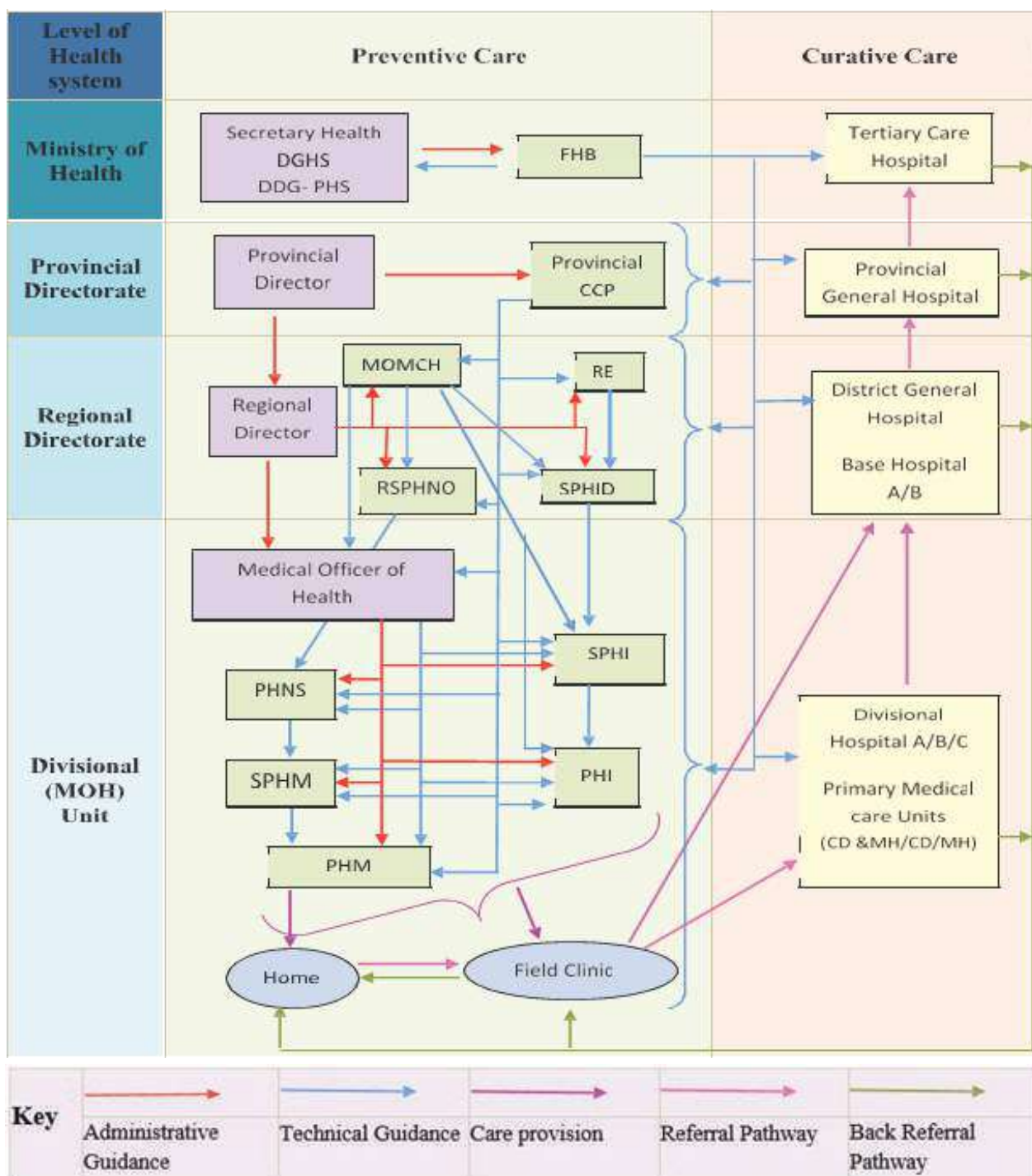


Figure 1.1: Organization of RMNCAYH Programme at Different Levels of Health System

The implementation of the RMNCAYH programme is carried out by the Medical Officer of Health (MOH) teams under the administrative supervision of the Provincial and Regional Directorates of Health. In Sri Lanka, 338 MOH areas are distributed within 26 health regions. The MOH areas are the smallest health unit in the public health network and it consists of a team comprising several categories of staff. MOH is the Manager of the MOH team.

He/She is a MBBS qualified doctor who is given special orientation training on public health activities. Both technical and administrative supervision of the MOH team becomes the main responsibility of the MOH. At present, most MOHs are assisted by Additional Medical Officers of Health (AMOHs). The Public Health Midwife (PHM) and Public Health Inspector (PHI) are the ultimate grass root level primary health care workers of the MOH team. On average one PHM is appointed for 3000

population while a PHI is appointed for 10,000 population.

While the principle roles of the PHM lies around maternal and child health activities, the PHIs are principally held responsible for School and adolescent health programme, Environmental and Occupational Health activities including control of communicable diseases, ensuring water and food safety, and sanitation related interventions. Several other categories of interim level supervisors are available in the MOH team. They are to assist the MOH in supervision of activities of grass root level staff. Public Health Nursing Sisters (PHNS) and Supervising Public Health Midwives (SPHM) are responsible for supervising the PHMs. PHNS and SPHM have a hierarchical administrative relationship where PHNS has to supervise SPHM. Both of them are responsible for the MOH. Supervising Public Health Inspectors (SPHI) are the immediate supervisors of PHIs. They are directly responsible for the MOH. MOH team is further supported by Development Assistants/ Programme Planning Assistants/ Development Officers/Management assistants and other categories of supportive staff such as drivers, saukya karya sahayaka etc. MOH staff includes School Dental Therapists (SDT) who are responsible for providing routine dental care for school children. Table 1.1 presents the overall staff position of the MOH areas around the country.

Even though the ratios in table 1.1 show that there are one MOH for every 65,000 population and one PHM for every 3500 population, district carder positions are maldistributed. There is an inadequacy in staff categories such as PHNS, SPHM, SPHI and PHI could be noted.

1.5 PURPOSE OF THE REPORT

The main purpose of the 25th Annual Report of the FHB is to provide feedback on effectiveness, strengths and weaknesses of RMNCAYH programme to its partners. The report includes information on background, and selected input, process, outcome and impact indicators relevant to the RMNCAYH programme. It also provides the platform for various outside agencies such as other Ministries, NGOs, INGOs, Professional bodies and researchers to learn the progress of RMNCAYH programme.

1.6 DATA SOURCES

1.6.1 Routine RHMIS

Data and information collected through routine RHMIS are summarized and analyzed from the data received to the FHB from several sources. They include:

Table 1.1: Distribution of MOH office staff categories according to population

Staff category	Approved cadre	Cadre in position	Ratio
MOH	353	320	1: 65214
AMOH	368	306	1: 68198
PHNS	443	232	1: 89951
SPHI	333	238	1: 87683
SPHM	413	342	1: 61019
PHM	6624	5927	1: 3521
PHI	1497	1265	1: 16497
SDT	457	347	1: 11901

- #### 1.6.1.1 Quarterly MCH Return (H 509)

1.6.1.2 Family Planning Quarterly Return (H 1200 B)

1.6.1.3 Quarterly School Health Return (H 797)

H 797 summarizes the performance of school health activities. It covers the school medical inspections, immunizations and follows up of children identified to have problems. This quarterly return from each MOH office is expected to reach FHB before the 25th of the month following each quarter.

1.6.2 Special Surveillance System

1.6.2.1 Maternal Death Surveillance and Response System

Each probable maternal death is reported within 24 hours to the RDHS and FHB by the MOH of the field and/or Head of the Institution, where the death occurred. The death should be reviewed at hospital and field level within 14 days. All the information is recorded in a standard format (Hospital- H 677, Field- H 677a). Each year Maternal Mortality Reviews are conducted at district level. An expert team comprised of all related professionals visit every district to conduct National Maternal Mortality Reviews and information is compiled by the FHB (Figure 1.3).

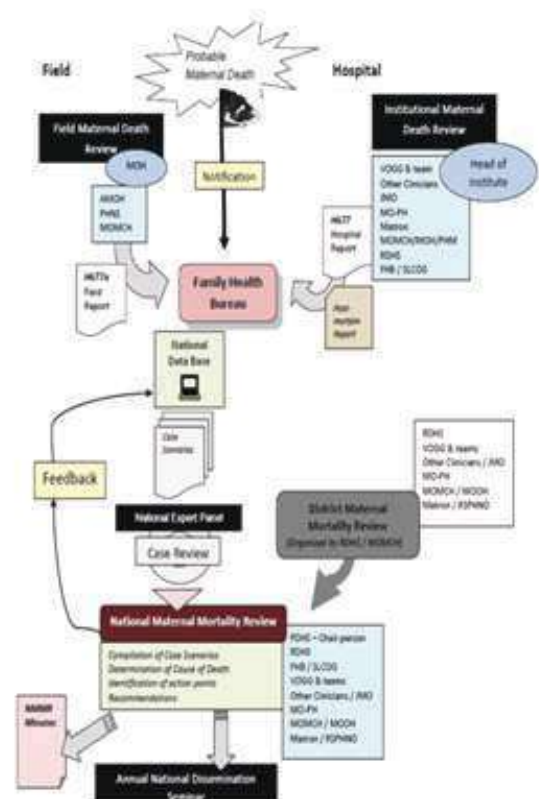


Figure 1.2: Information flow of National Maternal Mortality Surveillance System

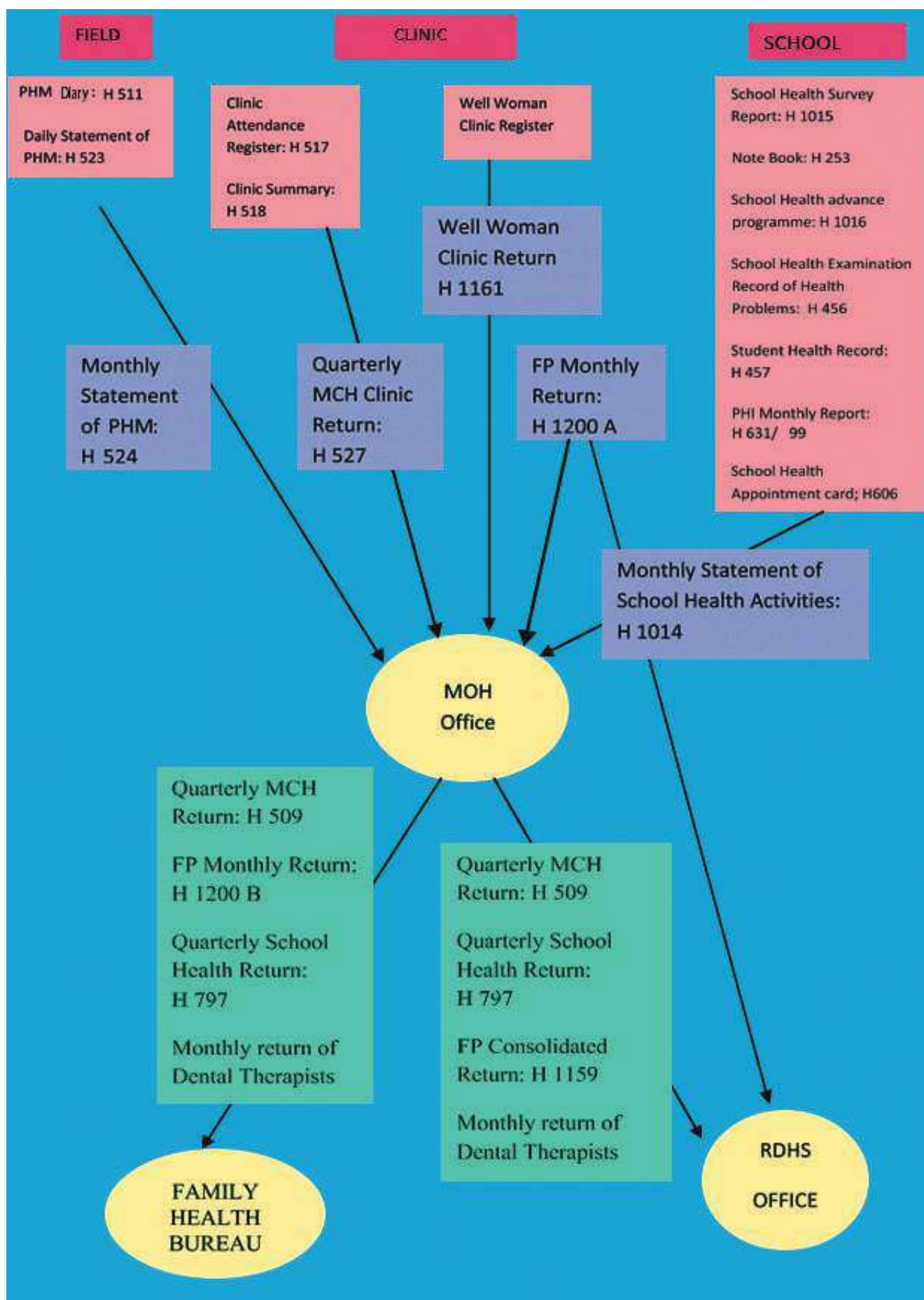


Figure 1.3: Sources and Pathways of Data used in the Annual Report

1.6.2.2 National Feto-Infant Mortality Surveillance System

Perinatal death audit system was established in the year 2006 to report all perinatal deaths from specialized hospitals. A more structured system was worked out in 2015 to include feto-infant deaths from both field and hospital sectors. A pilot implementation was carried out in Western Province in 2015. The mechanism is illustrated in Figure 1.4.

All perinatal deaths (stillbirths >28 weeks of period of gestation and early neonatal deaths) in specialized hospitals are reported to head of the institute within 24 hours. Perinatal deaths of each month are discussed at monthly perinatal mortality review meetings at

1.6.3 Other Sources of Data

1.6.3.1 Annual Data Sheet of MOHs

Annual Data Sheet as implied by the name is used to collect basic information from MOH including vacancies of staff positions, vehicles and other facilities, number of clinics annually.

1.6.3.2 Annual Nutrition Month Return

Data related to Nutrition Month activities are compiled annually by the FHB when data from each RDHS area is received and reviewed by FHB. Nutritional status of children under five and school children in Grade 1- 10 are being compiled by MOH areas.

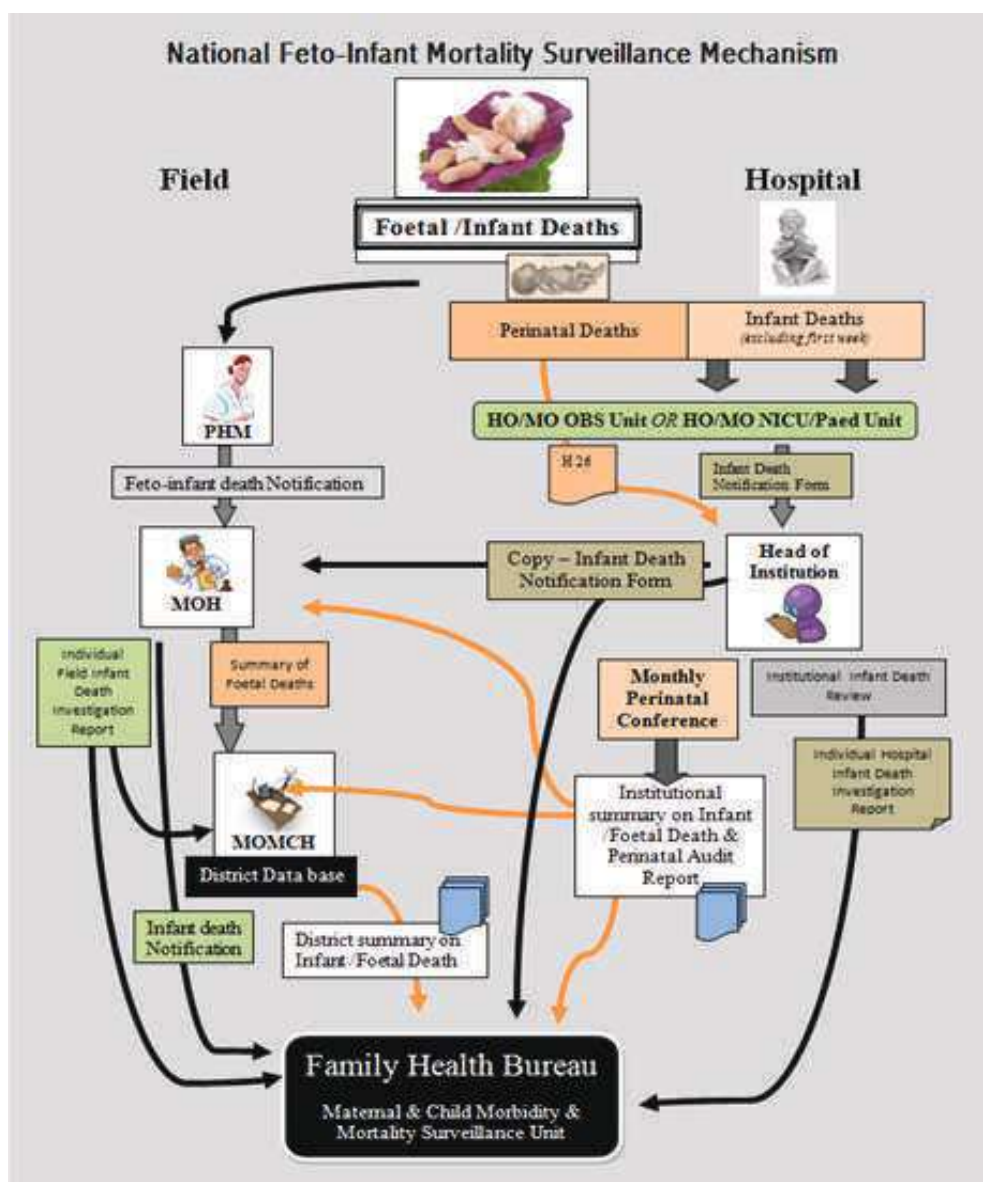


Figure 1.4: National Feto-Infant Mortality Surveillance System

1.6.3.3 Monthly Return from Dental Therapists

School Dental Therapists (SDTs) are sending returns on their monthly and quarterly performances and summary of this is available at District level. Island wide data is summarized at FHB, based on annual returns of each District.

1.6.3.4 Registrar General's Department and other relevant sources

The national population estimates, fertility and mortality rates published by the Registrar General are used in some of the indicators included in this Annual Report as denominators.

1.7 QUALITY OF DATA

Each return is scrutinized for completeness and accuracy of data at FHB. Discrepancies are verified by contacting the MOHs over the phone and in some cases the returns were sent back to the respective MOHs to revise

CHAPTER 02

TARGET POPULATION OF RMNCAYH PROGRAMME

Target population for RMNCAYH programme is identified by the grass root level health worker PHMs identify “Eligible Families” and register them in Eligible Family Registers (H-526). PHIs identify school children in the schools under their care.

“Eligible Family” is defined as a family with a female aged between 15- 49 years, either married legally or living together and/ or having a child under 5 years of age. A family with a pregnant or cohabiting woman irrespective of marital status and age and single women (widowed, divorced, separated) are also considered under eligible family. It is estimated that the number pertaining to 18.5% of the population approximates the number of eligible families.

All children in schools with enrolment less than 200 and those in grades 1,4,7 and 10 in schools having enrolments of over 200 are supposed to be subjected to medical examinations by MOH staff.

Table 2.1 presents the sizes of various types of target groups coming under the RMNCAYH Programme in the year 2015. The total population reported by PHMs was compared with the estimated population.

The total population reported by PHMs exceeded the estimated population given by Registrar General’s Department in 2015 by 5.0%. Figure 4 presents the trends in the percentage registration of eligible families in comparison to eligible families in the country.

Table 3.1: Size of the different target population of RMNCAH programme 2015

Indicator	Actual [#]	Reported
Midyear population	20,868,762	2,2013,973
Eligible families	3,860,721	3,739,544
Pregnant mothers	(368,303)	368,404
Births	334,821 [*]	320,201
Infants under care	349,715 ^{**}	318,099
1-2 years under care	365,792 ^{**}	347,631
2-5 years under care	10,83,880 ^{**}	1,044,772
Number of schools ≤ 200	5160 ^{***}	4926
Number of Schools ≥ 200	4984 ^{***}	4876
Total school children under care at the beginning of year	4,129,534 ^{***}	4,035,887

^{*} Births registered by Registrar General's Department

^{**} According to Births reported by Registrar General's Department for relevant years

^{***} As reported by Ministry of Education

[#] Estimated values are based on data from Medical Statistics Unit and actual values are based on data from Registrar General department.

The estimations for the figure 2.1 was based on population reported by census and statistics department (correct graph) PHMs and proportion of eligible families was taken as the 18.5% of the total population for that year. Population given by the Department of Census for 2015 was 20,868,762. PHMs have registered a total of 3,739,544 eligible families (17.91%).

It reflects either lack of efficiency in updating the eligible family register or inaccuracy in the estimate we used for calculations as the proportion of eligible families in the population (18.5%) or both. These need to be reassessed with the availability of detailed information on the demographic characteristics of the population from the census.

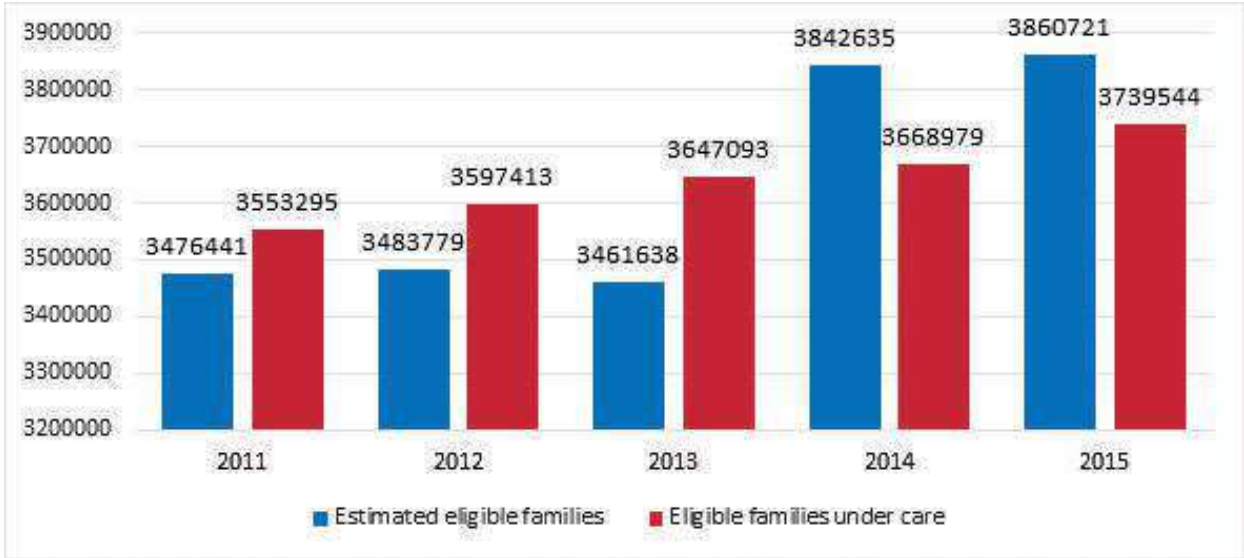


Figure 2.1: Comparison of numbers of estimated and registered eligible families

CHAPTER 03

PRECONCEPTION, MATERNAL AND NEWBORN CARE

3.1 PRECONCEPTION CARE

Interventions in improving maternal and child health should be started from the preconception stage. A preconceptional care package of interventions was introduced to the RMNCAYH programme in 2012 to promote health of women and their partners to enter pregnancy in optimal health and to maintain it throughout the life course. The main strategy used to fulfill this is by ensuring women of child bearing age and their partners receiving a comprehensive package of pre-conception care. Care includes creating awareness, health promotion, screening and appropriate interventions to reduce risk factors that might affect future pregnancies of the reproductive aged women.

This package is introduced to extend the maternal health continuum prior to pregnancy to reduce indices such as maternal mortality, infant mortality and low birth weight. The package focuses on the newly married couples and it would:

Improve knowledge and attitudes of men and women especially in relation to pre-conception health which would lead to behavioral changes.

Assure that all newly wedded couples receive preconception care services. (health promotion, evidence based risk screening, interventions etc.)

Improve the health of women before pregnancy by giving pre-conception care.

Detect the health problems of the couple to prevent, minimize, treat or correct the health problems before they attain parenthood.

In 2015, there had been 32.7% primi mothers registered by PHMs and out of which 49.3% have undergone preconception screening.

Twenty five percent (25%) of all primi mothers have attended both sessions in preconception care. Remarkable progress have been achieved in pre conception care during last couple of years, however this area need strengthening in many parts of the country. In 2015 these had been 175,939 marriages registered in Sri Lanka of which PHM here registered 87378 couples with a percentage of 49.7%.

3.2 ANTENATAL CARE

Antenatal care begins with the registration of pregnant woman by PHM either in field or in clinics. Standard package of interventions is offered to all pregnant mothers following identification of all pregnant mothers through home visits and field clinics. This package includes:

- preliminary clinical assessment and screening for risk factors
- screening for pre-eclampsia
- eclampsia and syphilis
- screening for anaemia and Gestational Diabetes Mellitus
- Tetanus Toxoid immunization
- provision of antihelminthic
- prevention and management of STIs and RTIs
- prevention of mother to child transmission of HIV
- monitoring of maternal and foetal wellbeing
- assessment of fundal height and weight gain
- Micronutrient supplementation, (iron, folic acid, vitamin C, calcium), food supplementation (“Triposha”)
- referral of high risk pregnancies for specialist care
- providing information and counseling for pregnancy related issues (breast feeding and family planning, birth and emergency preparedness)

3.2.1 Registration of pregnant mothers

PHMs have registered 368,404 pregnant mothers during 2015 either at antenatal clinics or during field visits. (There has been 334,821 birth reported in 2015 (RG data source) and the estimated would be 368,303 pregnancies. This indicates that a very high percentage of pregnant women in Sri Lanka are in contact with the maternal care services offered by the RMNCAYH Programme.

life cycle approach where the children of these mothers could also be brought in close contact with the health system through these initial linkages. This will ensure that they get exposed to similar kind of interventions at relevant points in life, promoting and protecting their health.

RMNCAYH programme promotes early and regular antenatal care. Registration before 8 weeks is considered as early registration, and

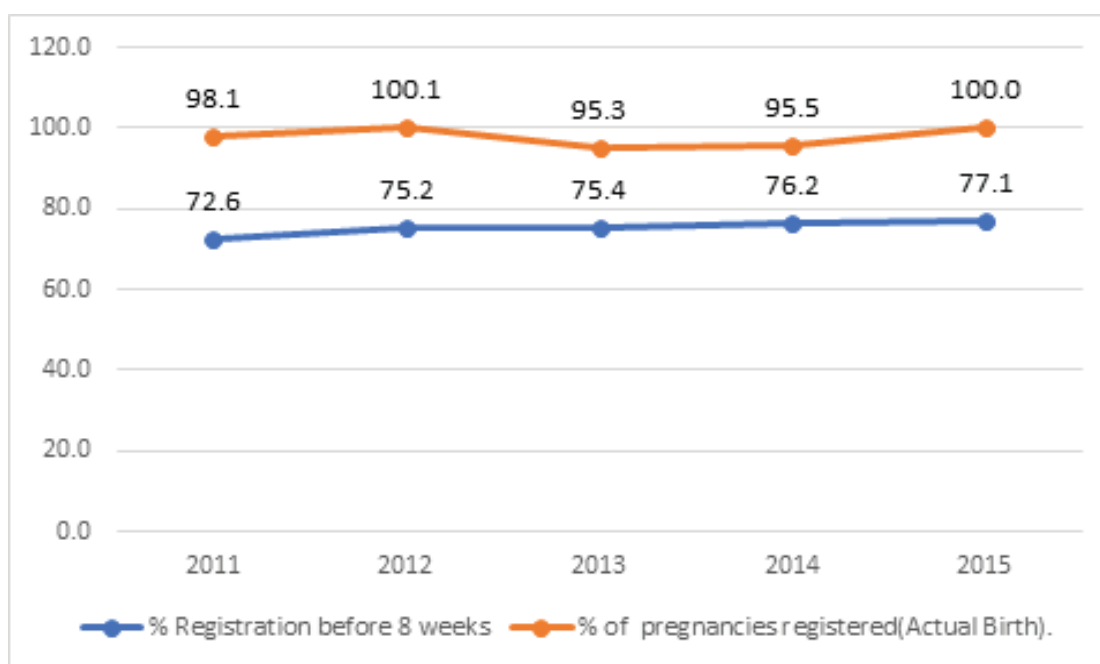


Figure 3.1: Pregnant mother registration and registration before 8 weeks 2011 to 2015

Figures 3.1 show the trends in percentage of pregnant mothers registered out of expected pregnancies who came into contact with the maternal care programme during the last 5 years.

High coverage seen in the pregnant mothers' registration not only shows the efficiency of the primary health care staff around the country but also the positive health seeking behavior among Sri Lankan mothers. It could also be reflection of the sound health care network of the country which facilitates the service provider recipient contacts. Further it indicates the tremendous potential that it creates to ensure the

77.1% have been registered before 8 weeks of pregnancy in 2015. Only 6.5% of mothers have been registered after 12 weeks of pregnancy.

3.2.2 Domiciliary Care

The clinic care given to antenatal mothers is expected to be complimented by domiciliary care offered by PHMs. During home visits, PHMs assess the antenatal mothers' health status by risk screening and examination, conducting simple investigations, educating pregnant mothers and family members. In 2015, 88.5% of registered mothers have been

visited at least once by a PHM. According to guidelines, a pregnant mother is expected to receive at least 3 home visits by a PHM. In 2015, average 4 visits have been done by PHM for a pregnant mother (table 3.1).

3.2.3 Field Clinic Care

Following registration, pregnant mothers are referred to field Antenatal clinics. During 2015, 94.6% of registered mothers have attended field antenatal clinics at least once which are conducted by MOH or at non-specialists institutions at least once. On average, a mother has made 6 field clinic visits during her pregnancy (Table 3.2). However, the total number of antenatal clinic visits by a mother may be higher than this as information on specialist unit clinics and private sector are not reported in RHMIS.

3.2.4 Antenatal screening

As reported by PHMs at the first postpartum visit, percentage of mothers who were tested for VDRL at the time of delivery, amounted to 98.7% in 2015. However, out of antenatal mothers attending field clinics, only 75.1% were tested for VDRL at the field clinic where as only 58.8% of HIV test were done of

field clinics. This includes the blood samples taken at the clinic and sending for testing at government institutions. Almost all mothers knew their blood group and RH status at the time of delivery (99.0%). The high coverage of VDRL and blood grouping and Rh testing as reported during first postpartum visit indicate that a considerable percentage of mothers

Table 3.1: Percentage of pregnant mothers who were visited at least once and average number of home visits by PHM 2011 - 2015

Indicator	2011	2012	2013	2014	2015
% of registered pregnant mothers visited at least once at home by PHM	91.7	90.2	91.3	90.2	88.5
Average number of PHM field visits per mother	5.2	5.0	4.5	4.1	4.2

Table 3.2: Percentage of pregnant mothers visiting field antenatal clinics (at least once) and average number of clinic visits 2011 - 2015

Indicator	2011	2012	2013	2014	2015
% of pregnant mothers making at least one field clinic visit out of registered	95.9	95.2	94.8	95.5	94.6
Average number of clinic visits per mother	7.2	6.8	6.6	6.3	6.4

Table 3.3: Percentage of pregnant mothers screened at ANC 2011 - 2015

Indicator	2011	2012	2013	2014	2015
% of pregnant mothers tested for VDRL at the time of delivery out of reported deliveries	97	99.3	99.7	98.1	98.7
% of mothers whose blood is tested for grouping and Rh at the time of delivery out of reported deliveries	99.6	100	99.9	97.8	99.0
% of mothers whose BMI is assessed before 12 weeks out of total clinic attendance	85.9	82.7	83.1	79.9	88.5
% of mothers screened for Hb at the field clinic out of mothers attending antenatal clinics	56.1	52.3	50.6	57.1	45.4
% of mothers tested for VDRL at field clinic out of mothers attending antenatal clinics	51.2	53.8	59.2	57.1	75.1
% of mothers whose blood Grouping and Rh tested at field antenatal clinic	25.9	24.8	27.3	25.5	28.8

may obtain these services directly from government specialist hospital clinics or from the private sector. Screening for HIV was done in 61.8% of mothers at the time of delivery.

In 2015, only 45.4% of the mothers attending field clinic had their Hb level tested in field clinics. Haemoglobin testing meters were provided in 2015 to all field clinics and this coverage could be expected to increase in 2016. However, 88.8% of all mothers tested for Hb before 12 weeks of pregnancy and among them 20.9% were having Hb % below 11g/dl. This value was 21.4% during 26-28 weeks.

It was also notable that BMI of 88.5% of mothers attending clinics were measured before 12 weeks of pregnancy. Low BMI was observed in 20.2% of the mothers.

3.2.5 Protection from Rubella and Tetanus

In Sri Lanka, comprehensive efforts have been made to ensure all reproductive age women were immunized at field clinics. Out of pregnant mothers in 2015, 97.6% were protected for Rubella. Almost all mothers (99.3% in 2015) were protected with Tetanus vaccine at the time of delivery (Table 3.5). High coverage of tetanus vaccination among antenatal mothers along with safe delivery and newborn care practices have attributed to elimination of neonatal tetanus from the country.

3.2.6 Maternal Nutritional status

3.2.6.1 Body Mass Index (BMI)

Under nutrition is considered as one of the most resistant public health problems in Sri Lanka. Pre pregnant BMI is considered as an important associate of the birth weight of the

newborn which in turn affect the child's nutrition. BMI measured before 12 weeks of gestation is approximated for pre pregnant BMI. In order to assess that, pregnant mothers should be identified before 12 weeks of pregnancy.

The Figure 3.2 indicates the BMI status of pregnant mothers whose BMI was assessed before 12 weeks. Approximately 20% of pregnant mothers were found to be underweight and this proportion remained more or less similar over the past 6 years.

It is important to have targeted interventions to improve the nutrition status of the low BMI

address the issue of overweight among pregnant mothers.

3.2.6.2 Maternal Anaemia

Anaemia as indicated by the serum Haemoglobin (Hb) level less than 11g/dl is another important indicator of antenatal health. There are three indicators related to Haemoglobin status. Status reported here are based on different testing methods used in the field during the last few years.

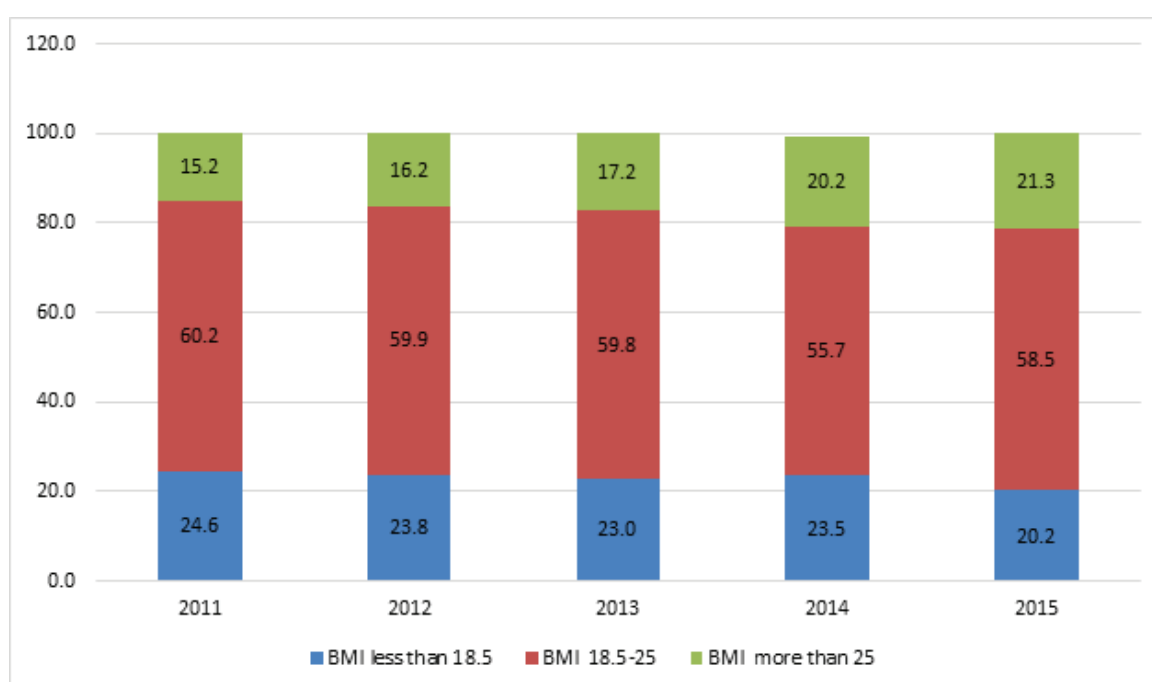


Figure 3.2: Percentage distribution of pregnant mothers according to their BMI status at booking visit (before 12 weeks) from 2011 – 2015

women before pregnancy and also ensure the improvement of nutrition status of these mothers during pregnancy. Maternal under nutrition and prematurity is considered as the main reasons behind the high rate of LBW in Sri Lanka.

Trends from 2011 shows that the burden overweight is increasing gradually. BMI > 25 has increased from 15.2 to 21.3 over the last five years. Special attention should be made to

3.2.8 Teenage pregnancies

In 2015, 19,327 (5.2%) of total pregnancies registered by PHMs were mothers less than 20 years. The following graph shows the trends in teenage pregnancies over the last 6 years. Out of total teenage mother, 509 (2.6%) were less than 16 years of age. The percentages of teenage pregnancies were highest in Trincomalee district followed by Batticaloa and Puttlam districts. The teenage pregnancies in 2015 have increased by 0.3 despite a declining trend seen over the years.

Table 3.4: Percentages of mothers whose Haemoglobin was tested at field clinic

Indicator	2011	2012	2013	2014	2015
% of mothers tested for Hemoglobin out of mothers attending antenatal clinics	56.1	52.3	50.6	57.1	45.4

Table 3.5: No. of mothers reported with the Antenatal morbidities

	2013		2014		2015		2016	
	Number of cases	Cases per 10,000 pregnancies	Number of cases	Cases per 10,000 pregnancies	Number of cases	Cases per 10,000 pregnancies	Number of cases	Cases per 10,000 pregnancies
Chronic High blood pressure	1675	52	1693	53	1167	36	1119	37
Chronic Diabetes	2053	64	2371	74	2341	73	2526	83
Heart Diseases	2511	78	2590	81	2002	63	1823	60
Gestational Diabetes	6393	199	7062	221	10718	335	11801	389
Ppregnancy Induced	11727	365	11487	359	13212	413	11488	379
Aneamia	33661	1049	36277	1133	50358	1575	65665	2166

Special attention should be made to identify the villages reporting high teenage pregnancies and implement evidence based interven

tions using the life cycle approach to address the underlying and root causes for teenage pregnancies in these areas.

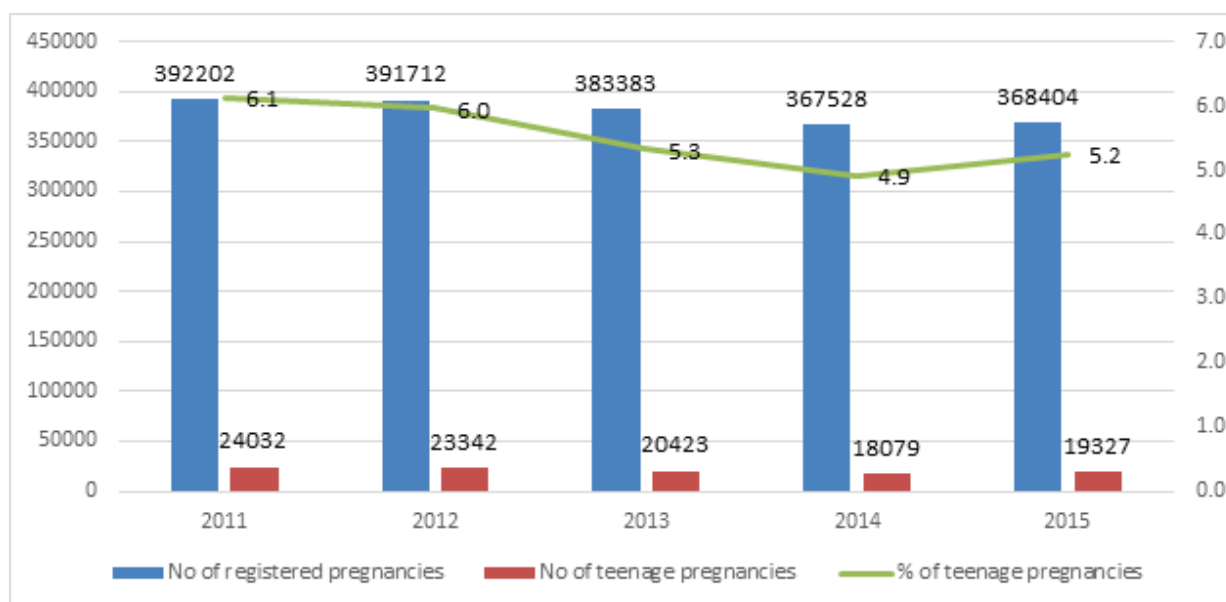


Figure 3.3: No. of teenage pregnant mothers reported

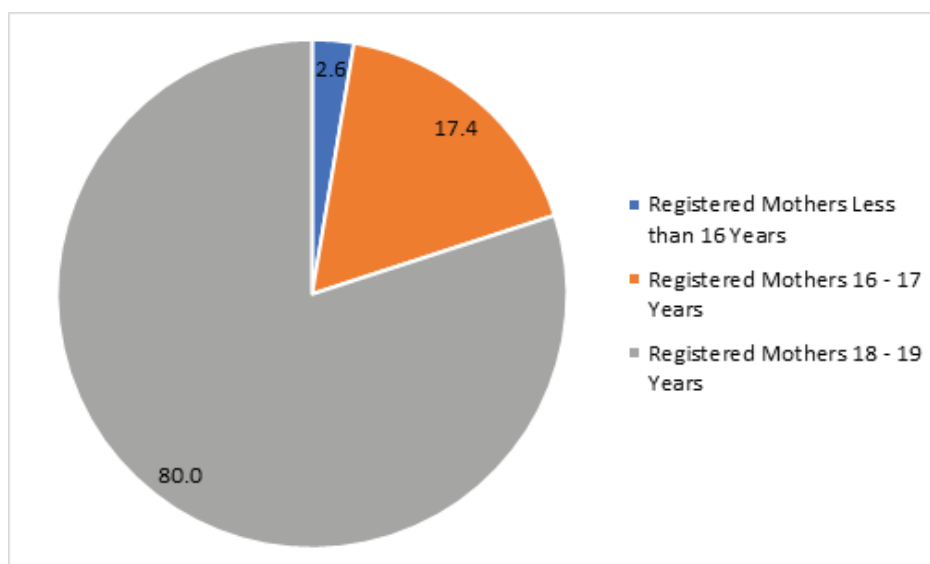


Figure 3.4: Age group wise percentages of teenage pregnancies among Pregnant Mothers in 2015

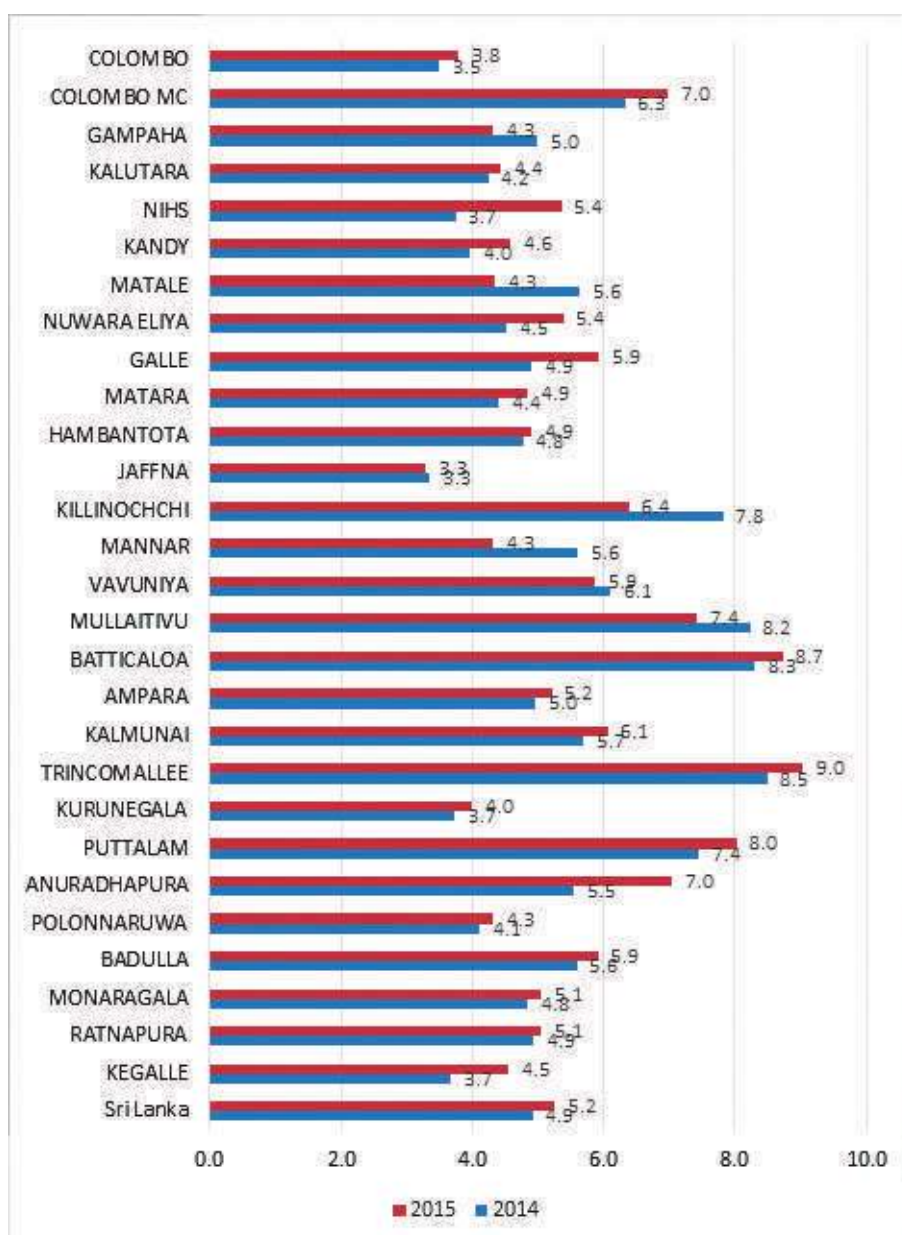


Figure 3.5: Percentage of Teenage pregnancies by district 2014 - 2015

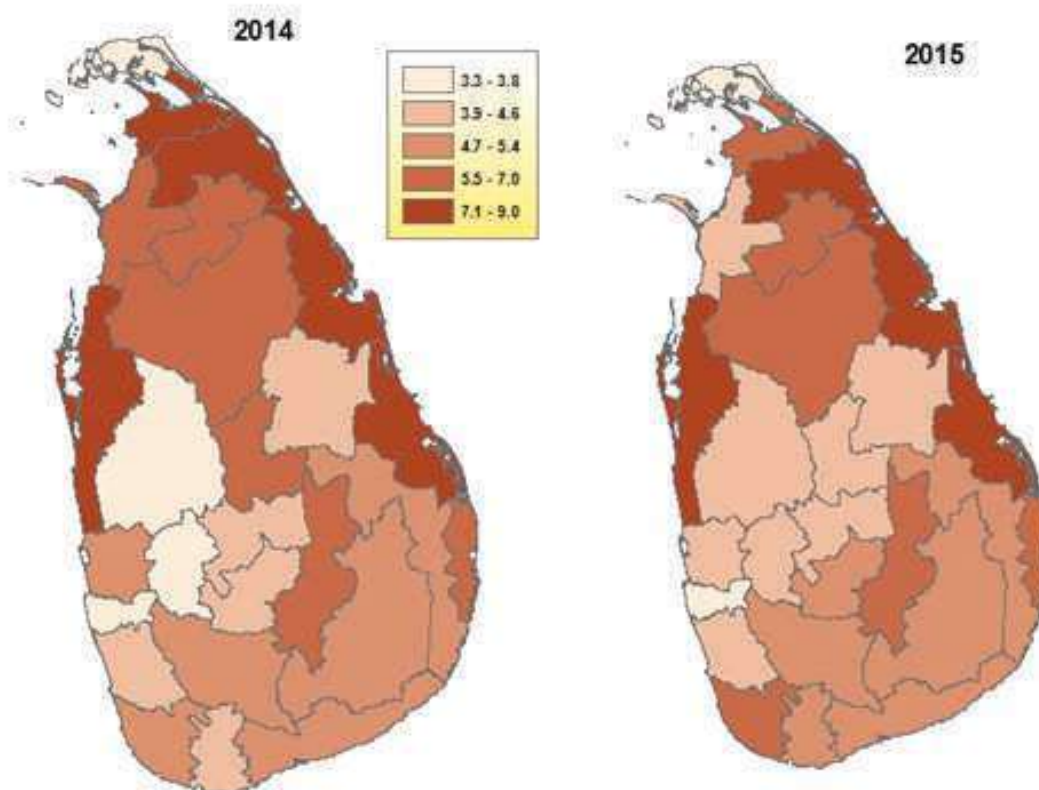


Figure 3.6: Percentage of teenage pregnancies by district in 2014 and 2015

3.2.9 Primies and Multipara

Primies and multipara (P5 and above) are considered to have relatively higher risk pregnancies than others. In 2015, about 32.7 % of total pregnancies registered in the year were primies and 2.4% of the pregnancies were mothers with gravida 5 or more (figure 3.7). In addition to its importance as an accumulation of high risk group of pregnancies, presence of multi-para pregnancies indicates the efficiency of the family planning services.

3.3 FAMILY HEALTH BUREAU CARRIED OUT VARIOUS ACTIVITIES TO STRENGTHEN IN THE MATERNAL CARE PROGRAMME IN 2015

- Development and pilot testing of quality assessment tools- In the view of achieving Sustainable Development Goals and further reduction of morbidity and mortality , FHB together with the relevant professional colleges developed a quality assurance system for institutional maternal care and pilot test was initiated in 2015

- Published standards of maternal care- Standards of maternal care document was published to ensure the sustainability of current achievements and move towards the future targets in maternal care.

- Completed the mobile application for MNH guidelines- Mobile application was developed for doctors to improve the accessibility of national guidelines on maternal care which address the relatively rare but important disease entities matches with epidemiological transition of causality of maternal deaths from direct and indirect causes.

- Published the maternal care guideline Volume 2- National Guidelines on Maternal Care were developed with the collaboration of relevant professional colleges for improving the quality of maternal care services for further reduction of maternal mortality and morbidity in Sri Lanka.

- Initiated the procurement for blister combined micronutrient tablets for maternal care programme from 2017. Micronutrient supplementation in field care is one of the interventions in maternal care programme for prevention and control of anaemia and other micronutrient deficiencies. In order to improve the quality the intervention, procurement of iron/folate combined tablets in blister packs was initiated in 2015.

3.3 INTRANATAL AND NEWBORN CARE

3.3.1 Pregnancy outcome and Postpartum care

PHMs report the pregnancy outcome of all pregnant mothers registered by them and visit them to provide postpartum care to ensure the health and wellbeing of the post-partum mothers and the newborns.

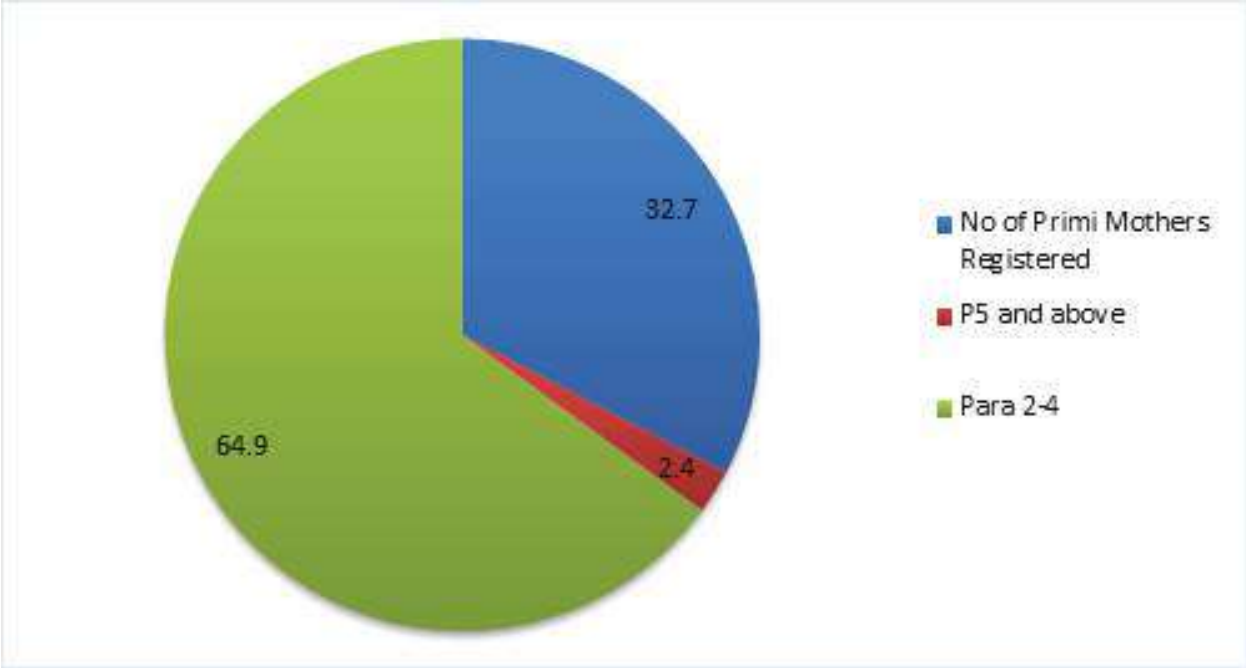


Figure 3.7: Distribution of registered pregnancies by parity in 2015

- Provided 35 Doppler's and 20 infusion pumps for maternity units based on assessment. According to the findings of the National Emergency Obstetric and Neonatal Care Survey 2012, it was found that many labour rooms in specialist units are lacking necessary equipment and it was identified as a barrier for providing quality maternal care services. Therefore, FHB supported to equip labour rooms in specialist based hospitals by providing Infusion pumps, and Hand Held Dopplers.

During these field visits mothers and newborns are assessed for general health, establishment of breast feeding, signs of postpartum complications and common illnesses. Mothers are provided with relevant advice and referrals if necessary.

In 2015, 95.8% of all live births registered by the Registrar General's Department have been registered by the PHMs. Pregnancy outcome was reported for 95.8% of pregnancies registered with PHMs. Almost all reported deliveries (99.9%) had taken place in institutions. Number of home deliveries has gone down drastically over the years and only 280 have taken place in 2015.

The highest number of Home deliveries were reported from Nuwara Eliya district. More than three out of ten reported deliveries were Caesarean sections (table 3.6). a rise in the caesarean sections is noted with concern. Approximately 74% of mothers were visited at home by PHMs at least once during the first ten days of postpartum and the average number of of postpartum home visits was 2 per mother.

pregnancies. The shortage of 697 field PHM posts should be filled early to ensure that quality and equity care could be provided in thr field setting.

3.3.2 Pregnancy Outcome

PHMs should report live births categorized according to their birth weight (less than or more than or equal to 2500 gm) and plurality

Table 3.6: Pregnancy outcome and postpartum care for mothers registered from 2011 – 2015

Indicator	2011	2012	2013	2014	2015
Pregnancy outcome reported out of registered pregnancies	88.7	88.8	91.5	93.7	95.8
% of deliveries reported out of total live births registered by Registrar General	88.1	89.8	87.7	91.6	96.2
% of deliveries reported out of total estimated pregnancies	69.7	76.9	76.7	75.3	78.4
Institutional deliveries out of total reported deliveries	99.9	99.9	99.9	99.7	99.9
Number of home deliveries	478	312	336	525	280
% of Home deliveries out of total reported deliveries	0.15	0.10	0.10	0.09	0.09
% of untrained deliveries out of total reported deliveries	0.1	0.1	0.1	0.05	0.06
Caesarean sections out of total institutional deliveries reported	27.7	28.7	31.8	32.1	33.8
Postpartum mothers receiving at least 1 visit by PHM during 1st 10 days out of estimated births	77.4	77.3	80.6	79.3	73.6
% of PP visits by PHM around 42 days (out of estimated births)	58.5	62.7	63.5	65.0	63.3
Average number of home visits during first 10 postpartum days	1.8	1.7	2.0	1.7	1.7

During these postpartum visits, PHMs have reported antenatal morbidities in 27% of pregnant mothers and 11.3% of postpartum morbidities among mothers following deliveries. These morbidity rates could be higher than the reported figure and need more attention in 2016. Give the PP morbidities reported by number and rate (per 1000 PM) Out of total pregnancies registered, 4.2% were not reported as outcomes. Therefore special emphasis should be made for PHMs to report all outcomes of their regisrered

(singleton or multiple). In addition number of abortions and still births are also reported.

In 2015, PHMs around the country have reported 320,201 live births (either singleton/multiple). In addition 1961 (6.1%) stillbirths and 30787 abortions were also reported. Table 3.7 reflects the live births reported by PHMs as a proportion of the live births reported through the vital registration system.

It is observed that 4.4% of the live births occurred in the country is not captured by the field PHMs. This may be due to some proportion of pregnant mothers not receiving health services through public health system. Under reporting of the birth by PHMs due to shortage of 697 PHMMs may also account for this to certain extent.

3.3.3 Low Birth Weight

Low birth weight among newborns is still a problem encountered even though the percentage has gone down slightly during last three years. In 2015, 11.4 % of the newborns were reported with low birth weight through the RHMIS (figure 3.9). There is an under

Table 3.7: No. of mothers reported with postpartum morbidities

	Number Of cases Cases / 10.000 deliveries		Number Of cases Cases / 10.000 deliveries		Number Of cases Cases / 10.000 deliveries	
	2013		2014		2015	
Heart Failure	109	3	158	5	99	3
Deep Vein Thrombosis	174	5	187	6	148	5
postpartum depression		0		0	281	9
Foreign material in vagina	407	13	405	13	347	11
Reproductive Tract Infections	494	15	440	14	471	15
Postpartum psychiatric illness	711	22	615	19	619	19
Diabetes Mellitus	N/A	N/A	N/A	N/A	698	22
Breast abscess	919	29	810	25	717	22
Urinary Tract Infection	1580	49	1297	40	1725	54
Cracked Nipple	2145	67	1950	61	2053	64
Haemorrhage	1994	62	2095	65	2365	74
hypertension	2419	75	2169	68	2608	82
Separated epis	3916	122	3844	120	4410	138
Engorged Breast	4794	149	4357	136	5351	167

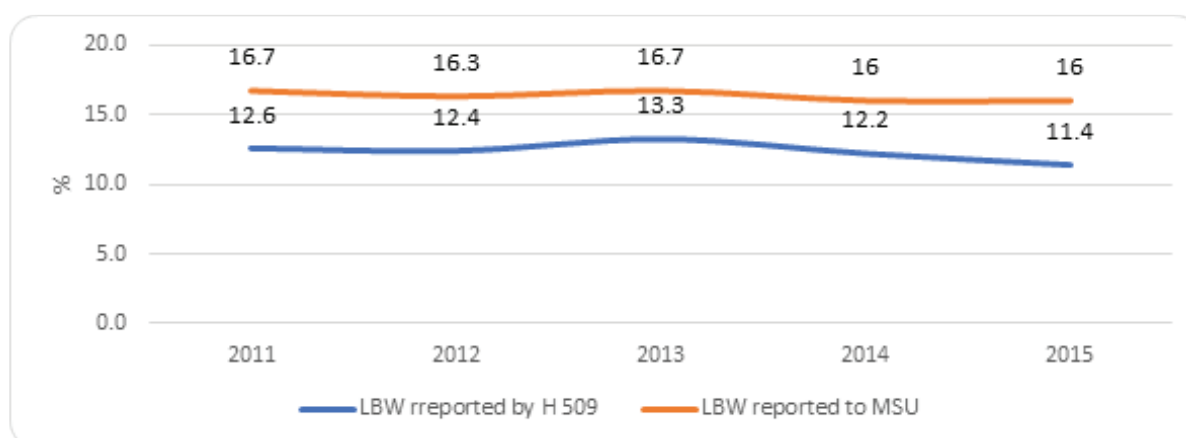


Figure 3.8: Low birth weight percentages among newborns from 2011– 2015

reporting of this figure due to inadequate postpartum care and the LBW figure reported through the maternity statistics return collated by the Medical Statistics Unit is 16.0%.

3.3.4 Postpartum and Newborn Care

RMNCAYH Programme makes provision for PHMs to pay at least 4 postpartum visits to a mother who had an institutional delivery. Of these visits, one visit each has to be made during first 5 and 6-10 days following delivery and the other 2 during 14 - 28 days and around 42 days respectively following the delivery. During these visits PHMs examine mothers and babies for any postpartum and newborn problems. In addition they should record antenatal and postpartum morbidities, support breast-feeding of the newborn, counsel for family planning, advice on other health matters, administer vitamin A to mothers in case she missed it at the hospital and register the newborn for future care.

3.3.5 Post partum visits

The table 3.9 shows the coverage of postpartum visit activities. During 2015, PHMs

around the country had visited 92.8% of postpartum mothers who were identified and reported by them at least once during the first 10 postpartum days. On average 2 postnatal visits were made within the first ten days. However, it should be noted that percentage of deliveries reported out of actual births reported for 2015 was only 93.4 %.

3.3.6 Post partum morbidity

PHMs are instructed to report postpartum morbidities. In 2015, PHMs reported 35270 mothers with postpartum morbidities. This amounts to 11.3% of the total reported deliveries. Figure 3.7 shows the cause specific postpartum morbidity rates for 10,000 reported deliveries. Most common postpartum problems include infections either n episiotomy or caesarean scar, engorged breast, separated episiotomy and fever. Infections were calculated for respective type of delivery. The mostly reported morbidities could have been prevented by proper infection control and breast feeding practices. However, high infection rate at episiotomy or caesarean scar also indicate the need for examining the PHM's ability to identify these morbidities objectively.

Table 3.8: Pattern of postpartum visits provided for mothers by PHMs 2011-2015

Indicator	2011	2012	2013	2014	2015
At least 1 visit during 1st 10 days out of actual birth reported	80.5	82.3	80.9	83.1	86.4
At least 1 visit during 1st 10 days out of reported deliveries	91.4	91.6	92.2	90.7	92.8
Average number of visits during 1st 10 days	1.8	1.7	1.7	1.7	1.7
Postpartum visits by PHM at or around 42 days out of reported deliveries	73.3	74.3	76.7	74.3	75.6

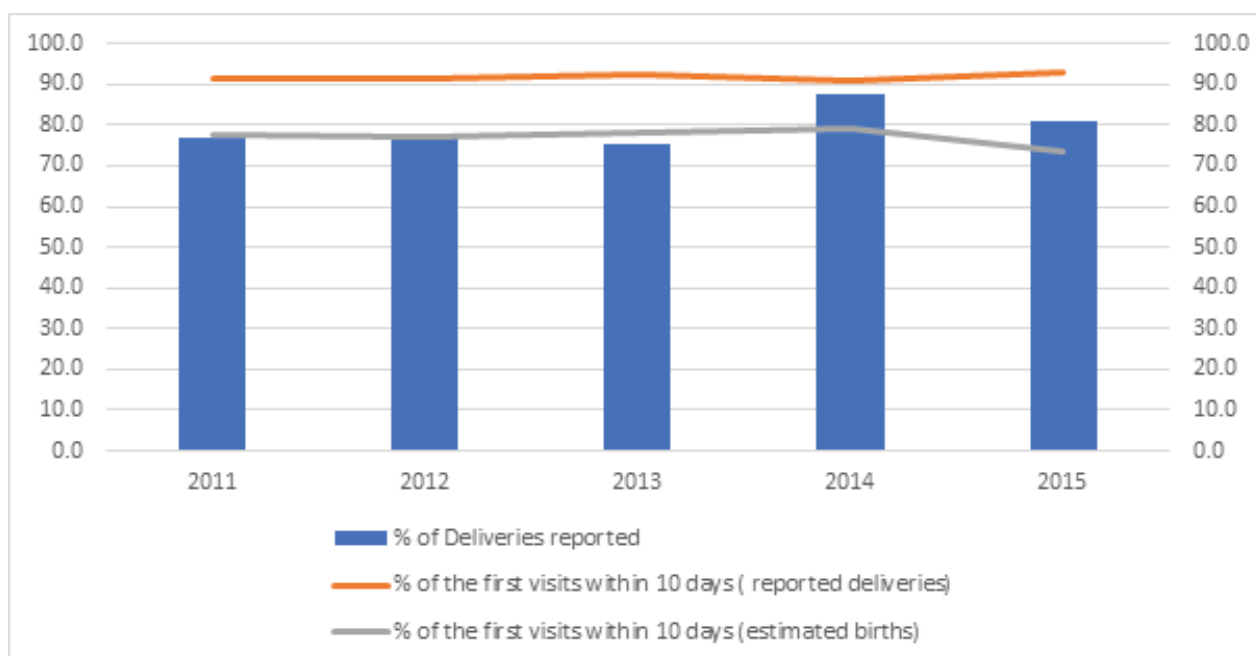


Figure 3.9: Percentage of estimated births, who were receiving the first post natal visit within the first 10 days of delivery in 2011 -2015

3.3.7 Care for the mother and newborn

Of the pregnant mothers delivered in a hospital (99.9%; RHMIS), many delivered in hospitals with specialist facilities (92%). Number of deliveries in Divisional Hospitals are reducing every year. In 2011, there were 17,252 deliveries reported from Divisional Hospitals and it has reduced to 9809 in 2015).

Hospitals providing maternal and neonatal care are dispersed widely throughout the country. With the development of road networks delivery facilities are available within easy access.

Mother baby centers to care for sick babies and mothers are available only in 18 specialized hospitals. It is expected that all the specialist hospitals providing care for the newborns should have a mother baby centre. Lactation Management Centres (LMC) to support mothers with breastfeeding problems are available in 46 specialized hospitals. LMC should also be available in all the specialized hospitals.

3.4 SPECIAL ACTIVITIES CARRIED OUT BY THE FAMILY HEALTH BUREAU IN 2015 RELEVANT TO NEWBORN CARE

3.4.1 Bottle Neck Analysis on Newborn Care in Sri Lanka

In preparation for the beyond MDG agenda, the Every Newborn Action Plan was presented at the World Health Assembly in 2014 and the countries were recommended to follow suit. Prior to development of the Every Newborn Action Plan for Sri Lanka, on the recommendation of the Technical Advisory Committee a Bottle Neck Analysis (BNA) on Newborn Care in Sri Lanka was conducted in 2015. The adopted version of the WHO UNICEF tool for BNA was used and information was gathered based on seven health system building blocks. Recommendations from the Bottle Neck Analysis will be used in the development of the Sri Lanka Every Newborn Action Plan 2017-2020.

3.4.2 Development of the Sri Lanka Every Newborn Action Plan

The consultative process for the development of the Sri Lanka Every Newborn Action Plan (SLENAP) to end preventable neonatal morbidity and mortality was started in 2015.

An advisory committee was appointed under the chairmanship of the Deputy Director General Public Health Services II. The recommendations from the Bottle Neck Analysis on Newborn Care in Sri Lanka, findings from the desk reviews and recommendations by the Technical Advisory Committee were referred in development of the SLENAP.



Figure 3.10: Distribution of Special Care Baby Units and Neonatal Intensive Care Units in the country

3.4.3 Introduction of Newborn Guidelines to all the districts

As part of the road map to improve quality of neonatal care, Clinical Guidelines on Newborn Care were developed by an expert panel. To complement the successful utilization of guidelines by health care workers at bed side, a mobile application was developed in collaboration with the University of Moratuwa. Three volumes of Clinical Guidelines on Newborn Care were introduced to hospitals in all the districts in the country during the year 2015.

3.4.4 Scaling up Newborn Screening for Congenital Hypothyroidism

Newborn Screening for Congenital Hypothyroidism was started in the Southern Province with the laboratory support from the Nuclear Medicine Department of the Faculty of Medicine Karapitiya. In 2015 it was decided to expand the services nationally. The new laboratory facilities for Newborn Screening for Congenital Hypothyroidism was set up at the

Medical Research Institute. Four provinces namely Western, North Western, North Central and Northern Provinces would send samples to the MRI laboratory. Southern, Central, Sabaragamuwa, Uva and Eastern Provinces would send samples to the Nuclear Medicine Unit, Faculty of Medicine, Karapitiya.



Figure 3.11: Nurse performing the heel prick test for newborn screening for congenital hypothyroidism at DGH Vavuniya

3.4.5 Scaling up of Newborn Screening for Critical Congenital Heart Diseases

In order to further improve quality of neonatal care, screening for critical congenital heart diseases to detect heart diseases that can be missed at the routine newborn examination was introduced and was scaled up throughout the country in 2015. Pulse oximetry test is performed in the postnatal ward before the baby is discharged and babies with abnormal test results are referred to Paediatric Cardiologist for conformation and further management.



Figure 3.12: Screening for critical congenital heart diseases in TH Mahamodara

3.4.6 Scaling up Neonatal Transport Training to other provinces

Transport of sick newborn to higher level institutions should be done with precision, and nine centers to set up Neonatal Retrieval Teams are identified for the nine provinces. The first ever Neonatal Retrieval team was established for the Western Province at Lady Ridgeway Hospital under the guidance of Dr Ramya de Silva, Consultant Paediatrician in-charge of the Neonatal Unit. This team was trained by Drs Amith Guptha and Charlotte Bennett from John Radcliff Hospital in United Kingdom. Following the successful pilot test, staff training on neonatal retrieval for the other centres in the respective provinces are planned. First regional training was conducted in TH Karapitiya in the Southern Province 2015. Other Regional Centres are; TH Peradeniya; Central Province, PGH Badulla; Uva Province, PGH Ratnapura; Sabaragamuwa Province, PGH Kurunegala; North Western Province, TH Anuradhapura; North Central Province, TH Jaffna; Northern Province and TH Batticaloa; Eastern Province will be done in 2016.



Figure 3.13: Neonatal Retrieval Team – Lady Ridgeway Hospital following the training programme

3.4.7 Training on Essential Newborn Care and Breastfeeding Counseling

For the third successive year all the Medical Officers passing MD Paediatrics Part I were trained as trainers in Essential Newborn Care and Breastfeeding Counseling Course. One batch of Medical Officers passing MD Part I in Paediatrics (24 Nos) were trained. In addition Family Health Bureau Supported the Districts

to conduct 20 in-service training programmes in Breastfeeding counseling and 3 Essential Newborn Care courses.



Figure 3.14: Medical Officers passing MD Paediatrics Part I in June 2015 following ENCC and BF Counseling

3.4.8 Technical Advisory Committee on Newborn and Child Health

The TACNCH was convened once in two months during the year 2015 under the chairmanship of DDG PHS II. A new committee was appointed by the Secretary Health in January for 2015/2016. Many new recommendations for the improvements in neonatal and child health were made at the committee meetings.

3.4.9 Breastfeeding Week 2015

The theme for Breastfeeding Week in 2015 was 'Breastfeeding and work; Let's make it work'. This was a very appropriate theme for the National Programme on Breastfeeding promotion, protection and support as breastfeeding rates among working mothers are lower and they need support to continue breastfeeding after returning to work. The Breastfeeding Week was celebrated from 1-7 September 2015. A media seminar was conducted at the Health Education Bureau auditorium on the above theme to sensitize the media personal on the theme. Wide publicity was given in print and electronic media on the above theme. Main advocacy workshop on the above theme was conducted at the auditorium of the Family Health Bureau for the field health staff as they are the key agents supporting working mothers to continue breastfeeding and also they are in contact with work places in their respective areas.

CHAPTER 04

INFANT AND CHILD

4.1 INFANT AND CHILD CARE: SERVICE DELIVERY

PHM should register infants for domiciliary and clinic care which includes immunization, growth assessment and development. In 2015, nearly 89% of infants have been registered by PHMs and out of registered infants, 75% have been visited by PHM at least once with an average of 7 visits per infant (Table 4.1).

Eighty-eight percent of the infants have been weighed by PHMs and 100% of the infants registered have been seen by a MOH in their clinics. Eighty percent of the 1-2year age

should be paid to increase the coverage of the 2-5 year weighing coverage by all field staff.

Children receiving Vitamin A mega dose at selected age groups are given in table 4.1 ..., where approximately three fourth of estimated children in specified age groups had received it. The under reporting of vitamin A coverage needs to be addressed at all levels.

Table 4.1 shows infants and 1-5 year children under care of PHMs as a percentage of

Table 4.1: Infant and childcare provided by the field staff from 2011-2015

Indicator	2011	2012	2013	2014	2015
Infants registered by PHMM	89.9	88.2	91.7	90.6	89.3
% Infants having at least 1 home visit after 42 days out of registered infants	72.3	69	63.9	58.0	53.7
Average number of home visits per infant	6.6	7.1	7.4	7.5	7.0
% of infants weighed	84	83.2	85.7	84.3	88.2
% of infants making at least one clinic visit (of registered infants)	97.9	100	99.6	99.1	100
Average number of clinic attendance for an infant	5.2	5.3	5.2	5.3	4.5
% of estimated infants given Vitamin A at 6 months	80.3	76.4	68.9	68.8	71.6
% of young children (1-2 years) weighed	77.1	76.1	79.3	77.1	80.2
% of 2 - 5 years children weighed	78.3	78.8	77.8	63.0	78.7
% of estimated children given Vitamin A at 18 months	82	74.7	70.7	71.9	74.9
% of estimated children given Vitamin A at 3 years	85.3	78.8	71.4	73.1	74.5

** calculated out of first visits by PHM*

group had been weighed by the PHMs in the weighing posts and among 2-5year group only 78.7% % had been covered. More attention

estimated births from 2011 to 2015. Data showed that around 12% of 2-5 year group is not been registered with the midwives.

4.2 FIELD AND CLINIC CARE

Following infant registration, care is given to the infant until 5 years of age at clinic and in the field. Home visits carried out after 42 days of delivery are specifically aimed at the infant. Infants are brought to the field clinic for postnatal examination by the MOH at 4 weeks and subsequently for health screening, growth monitoring, immunization and development assessment according to the schedule. The weighing is mainly done at child welfare clinics and field weighing posts by PHMs.

The clinic visits for infants are for the provision of a package of interventions; the first postnatal examination at 1 month of age, vaccinations at 2, 4, 6, and 9 months and growth and developmental assessment and medical screening. This indicates, ideally at least 5 clinic visits are required during infancy. Table 4.1 shows the average number of clinic visits by an infant is 4.5 in 2015. Children under five years are being given Vitamin A mega dose every six months from the age of six months onwards. Considerably higher percentage of estimated infants and children received their Vitamin A mega doses.

Table 4.2: Percentages of infants and children under care out of actual number of births reported by RGD

Indicator	2011	2012	2013	2014	2015
% Infants under care	82.4	88.4	94.6	93.7	95.0
% of young children under care (1-2 years)	87.4	93.1	96.5	102.3	95.0
% of Preschoolers under care (2 -5 year)	86.1	90.2	92.8	97.2	96.4

Children under two years should be weighed once a month. Accordingly, infants should have been weighed 12 times during infancy. Children above two years are weighed once in three months if they do not have any nutrition problems and if they have any nutritional issues monthly weighing is recommended. However, the data for individual children are not included in the RH-MIS.

Table 4.1 shows around 80% of total expected 1-2 year weighing were carried out by the PHMs. The coverage of vitamin A supplementation at 18 months and 3 years 74.9% and 74.5% accordingly for 1-2 years and 3-5 year groups. These figures could be under reported as Vitamin A is given in clinics as well as in the field.

4.3 CHILD NUTRITION

Undernutrition in children is a major public health problem in Sri Lanka. Growth monitoring is conducted through serial weight and length/height measurement of infants, young children and preschoolers, comparing their age specific weights and length/heights with that of WHO new growth standards in the CHDR. Nutrition counseling, more frequent growth assessment and increased field and clinic follow up are indicated when growth faltering and/or any form of malnutrition is identified.

Table 4.3 shows the different under nutrition indicators. Measuring length started in 2015 in clinics at 4 months, 9 months, 18 months and 3 years of age.

Table 4.3: Percentages of, underweight and stunting in infants, young children and preschoolers from 2011 to 2015

Indicator	2011	2012	2013	2014	2015
% moderately underweight infants	6.3	6	6.3	5.8	5.7
% severely underweight infants	1.2	1.3	1.3	1.2	1.2
% moderately underweight young children (≥ 1 -2 years)	15.9	14.7	13.9	13.2	12.1
% severely underweight young children (≥ 1 -2 years)	3.6	3.3	3.0	2.9	2.3
% moderately underweight preschoolers' (≥ 2 to 5th year)	22.6	19.8	19.5	17.6	18.3
% severely underweight preschoolers' (≥ 2 to 5th year)	4.2	3.9	3.8	3.4	2.0

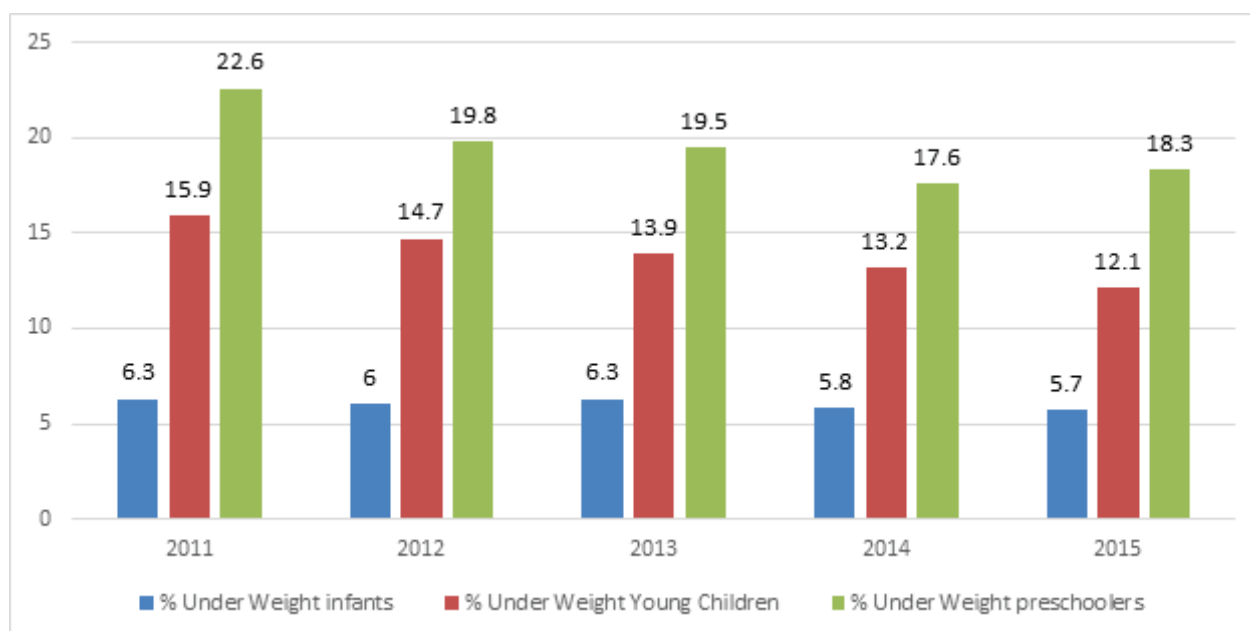


Figure 4.1: Trends in infant, young child and preschool underweight (moderate and severe) from 2011 -2015

Table 4.4: Trends in infant, young child and preschool underweight (moderate and severe) from 2011 -2015

	4 Months	9 months	18 months	3 years
Stunting out of measured	2.20	3.48	4.50	4.47

4.3.1 Under nutrition among children under the age of five

Over the years, rates of under nutrition have gradually declined and Sri Lanka showcase better nutrition indicators compared to many of the South East Asian countries. However, reducing under nutrition among children under the age of five years to be in par with other health and social indicators remains a challenge despite all relevant evidence based interventions to improve nutrition status being implemented through the RMNCAH programme of the Ministry of Health.

Breastfeeding and appropriate complementary feeding is promoted at community level through the PHM and in all MCH field clinics by the public health staff headed by Medical Officers of Health. Growth monitoring and promotion of children under five is of priority concern and PHMs assess the length/height and weight of under five children at assigned time intervals in the routine programme to monitor growth in order to detect nutritional problems early and provide timely interventions. According to the routinely collected data through the RHMIS, in 2015, 5.7% of infants had moderate underweight and 1.2% had severe underweight. Among 1-2 year age group, 12% of children were underweight with a severe under weight of 2.3%. Among 2-5 year age group, 18% were having moderate underweight whereas 2% had severe underweight (table). Over the years severe underweight among 1-2 year age group and under 5 year age group has reduced slightly. Stunting rates at the ages of 4, 9, 18 months and at 3 years are 2.20, 3.48, 4.50 and 4.47 Respectively. However, under nutrition among infants, 1-2 year and 2-5 year age groups remain a challenge over the years.

Therefore, need to assess if the evidence based interventions are reaching the children especially the multisectoral actions to address the nutrition sensitive interventions and also think of innovative approaches of addressing the issue.

Vitamin A supplementation, Zinc supplementation during diarrhoea, de-worming, provision of supplementary food “Thripasha” to undernourished children and management of severe acute malnutrition with therapeutic food are implemented throughout the country.

In 2015, a policy decision was taken to scale up the Multiple Micronutrient (MMN) supplementation programme island wide from 2016 based on a national compliance study

In 2015, a policy decision was taken to scale up the Multiple Micronutrient (MMN) supplementation programme island wide from 2016 based on a national compliance study conducted by Family Health Bureau. and an evaluation report by Nutrition Coordination Division, MRI and Unicef. In 2015, thirteen health districts were covered by the MMN programme to combat anemia among infants and young children.

Special nutrition clinics have been established in the field to implement targeted interventions to malnourished mothers and children.

To further strengthen the implementation of nutrition interventions, the ‘National Strategy for Infant & Young Child Feeding, Sri Lanka 2015-2020’ was finalized to provide guidance to all relevant stake holders in improving nutrition status of children.

Child Health Development Record (CHDR) is being updated every year, and in 2015 new additions were made to include the new fields added to the programme. In addition to this, in 2015 preliminary work was undertaken successfully to incorporate the preterm growth charts developed by INTERGROWTH 21st study team of the Oxford University, UK to the CHDR.

District level trainers from Kandy, Matale, Puttalam, Anuradhapura, Matara, Badulla, Galle, CMC, Hamabantota and Gampaha and master trainers competent in Tamil/Sinhala were trained on new WHO growth standards

and Growth Monitoring and Promotion. Teaching staff from Regional Training Centres and Nursing Training Schools island wide were also trained on new WHO growth standards and Growth Monitoring and Promotion.

Master training on Infant and Young Child Feeding was conducted for Consultant Community Physicians from Provinces and NIHS in Sinhala medium and refresher training on IYCF in Tamil was conducted for district level trainers from Northern and Eastern provinces.

3.4 NUTRITION MONTH 2015

To draw more attention on nutrition, every year the month of June is declared as the “nutrition month”. Intensive nutrition promotional activities are being carried out during this month focusing more on pregnant mothers, children and adolescents and all under five children.

The theme for 2015 nutrition month was “Healthy food for better strength, capacity and productivity”. During this month, an extra effort is made to reach the whole population of under five children. Hence, the assessment coverage of nutrition month is understand

ably higher than the routine assessment where these children are measured at assigned intervals only. During the nutrition month of 2015, all MOH areas have sent their returns on assessment of growth to the FHB and 93.2% of all under five children had been assessed for their growth status (weight, length/height).

The trends of under nutrition among under five children during the period from 2011 to 2015 according to nutrition month data which had a significantly high weighing coverage than routine programme are shown in Figure 4.2 . It shows a declining trend albeit slow in all three indices, underweight (weight for age <-2SD), stunting (length/height for age <-2SD) and wasting (weight for length/height <-2SD) over the years.

The annual National Nutrition Review was conducted at FHB with the participation of all relevant stakeholders in Nutrition including Nutrition Division, Nutrition Coordination Division , Health Education Bureau and Department of Nutrition, MRI in the Ministry of Health. MOOMCH representing the districts made their presentations on data collected and special nutrition activities conducted during the nutrition month 2015 (Annex – District wise nutrition data).

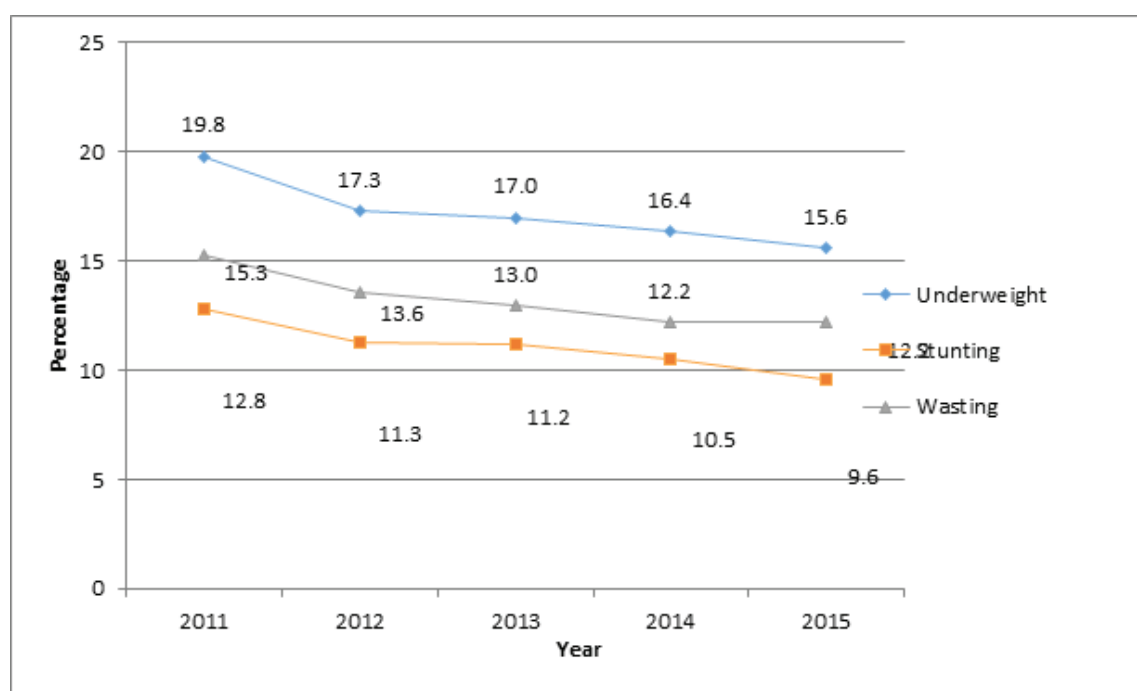


Figure 4.2: Under nutrition among under five children from 2011 to 2015

4.5 CHILD HEALTH, DEVELOPMENT AND CARE FOR CHILDREN WITH SPECIAL NEED

The Early Child Care and Development (ECCD) component was introduced to the Family Health programme in the year 2000. Currently, the main goals of the programme are to enable all children under five years of age to reach their full potential for development through the provision of optimal care and enable children with special needs to optimally develop their mental, physical and social capacities to function as productive members of society.

To achieve these goals, the child development and special needs programme operates through a wider scope of activities which has been drafted to be inline with National MCH policy. The main action areas are;

1. Designing, testing and scaling up child development intervention packages,
2. Building of capacity of primary caregivers, service providers, and community on child development and stimulation,
3. Strengthening supportive environments and multi-sectoral collaboration in related to early child development & care,
4. Establishing early identification /screening programmes to detect developmental delays & disorders,
5. Establishing special need care services

4.5.1 Designing, testing and scaling up child development intervention packages

A child development program intervention package is drafted and reference /training materials on child development were developed. Special need care package was developed and submitted for Ministry of Health approval

4.5.2 Capacity building of primary caregivers, service providers, and community on child development and stimulation

Child development master training is conducted and a comprehensive training guide –“Child Development Concepts, Interventions, Assessments, and Problems – Manual for Primary Health Care Workers of Sri Lanka” is disseminated among health care service providers. This is supplemented by a training guide book – “Training Programme on Early Child Development – Instructions for Participants” which guide the field training. Currently, ten districts are trained and the above training package has been distributed. It is expected that the PHC workers will enhance their knowledge and skills in child development and disseminate this knowledge to the primary caregivers. This will be accomplished through interactive educational sessions conducted in mother’s classes and subsequent field visits. Further, IEC materials will be developed to capacitate the primary caregivers. These include the instructional guide compiled into a booklet given to each mother, flex charts displaying key child development messages and docudrama demonstrating child development stimulation.

4.5.3 Creating supportive environments and multi-sectoral collaboration in ensuring

To optimize the development of children and to facilitate screening and early diagnosis of developmental disorders it is mandatory to create supportive environments. The child development communication strategy aims to enhance the community awareness and advocate on policy and strategic directions. This is facilitated by networking and engaging in collaborative programming with education, social service, child secretariat, and Presidential Secretariat and other Governmental and non-Governmental organizations interested in ECCD.

Currently, the technical contribution was provided to the National ECCD Committee work conducted by the Child Secretariat, in developing the National ECCD policy. In addition, technical expertise is provided for the training of island-wide ECD officers and for the development of “Child Development Training Manual for ECD Workers”. The “Autism Manual for Preschool Teachers” was developed in collaboration with the Child Secretariat. These collaborative efforts attempt to create community awareness and supportive environments that sustain optimal care for children.

4.5.4 Screening and early identification of developmental disorders

Integrating a systematic development screening system to the present child care programme is a strategy used for early identification of developmental disorders. Measures are being taken to develop a series of country specific developmental indicators that will be included in the Child Health Development Record. Series of CHDR revision workshops were conducted in order to finalize the development indicators. The revised CHDR will enable parents to screen their children at home and PHMs could confirm the screening. Additionally, a screening checklist will be provided for the PHC workers, which will be sensitive and more specific and screen-positive children will be referred for further assessment.

4.5.5 Provision of care for children with special needs

Establishment and integration of a new institutional arrangement comprising of Primary and Secondary Child Development Centres is a strategy that will be used to enable children with special needs to optimally develop their mental, physical and social capacities. A model secondary child development center is planned to establish in Colombo East base Hospital premise and the initial plan and design were completed.

In addition to the above main action areas, the Child Development and Special Needs unit is currently finalizing the National Strategic Plan on Child Health for (NSPCH) 2017-2022. The National Child Health Programme (NCHP) of Sri Lanka is operational since 1926. Over past 8 decades, many strategic elements have been added to the programme making its scope much wider than that at the programme inception. The NSPCH 2017-2022 will improve and address this scope.

4.6 infant and Child mortality

PHMs are expected to report all under 5 deaths happening in her area through the routine RHMIS system. PHMs have reported number of still births in their routine reports and the still birth rate is 6.5 per 1000 births in 2015. Out of all infant deaths reported

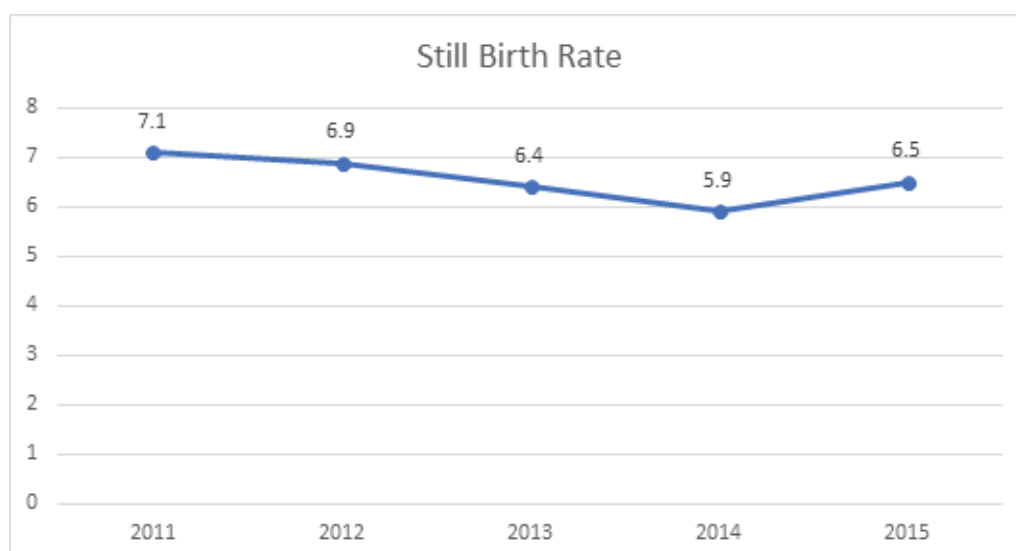


Figure 4.3 : Still birth rates reported through RHIS from 2011-2015

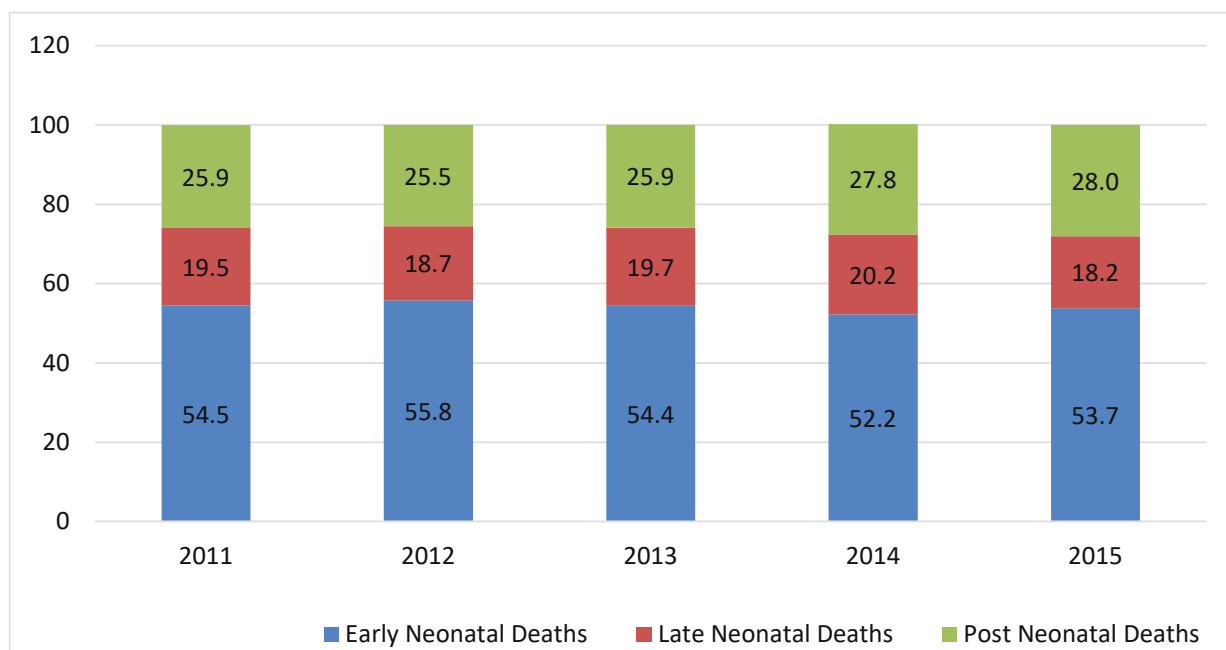


Figure 4.4 : Infant deaths by category reported from 2011 -2015

through the RHMIS, majority (53.7%) were due to early neonatal deaths (figure). Total of Infant deaths (9.1 per 1000 live births) were reported in 2015 through the RHMIS (Figure).

Majority of infant deaths were due to congenital abnormalities (46.5%) followed by prematurity (24.7%). RHMIS has reported a under 5 mortality rate of 10.8 in 2015.

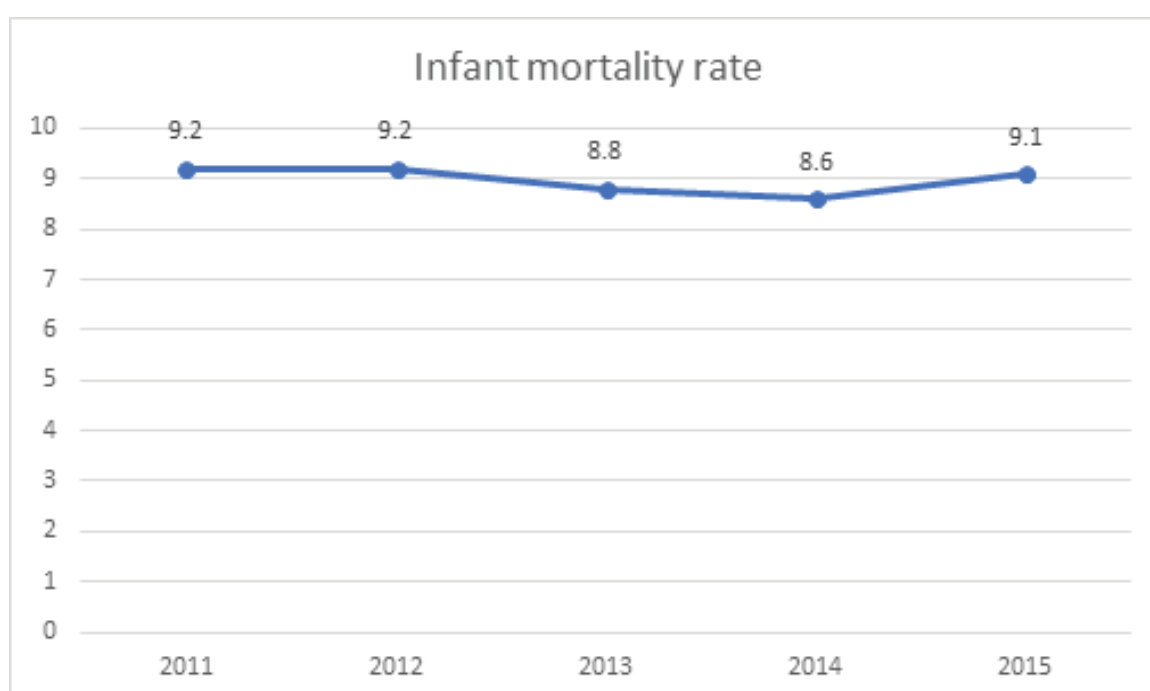


Figure 4.5: Infant Mortality Rates reported through RHMIS 2011 to 2015

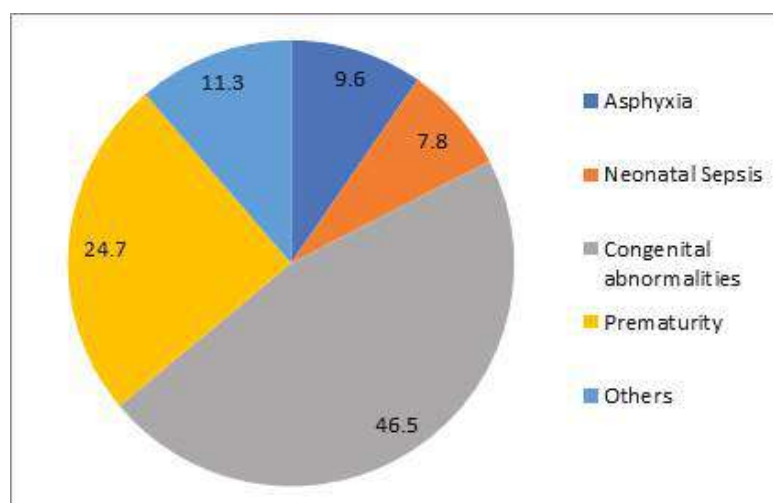


Figure 4.6 : Percentage distribution of cause of infant deaths 2015

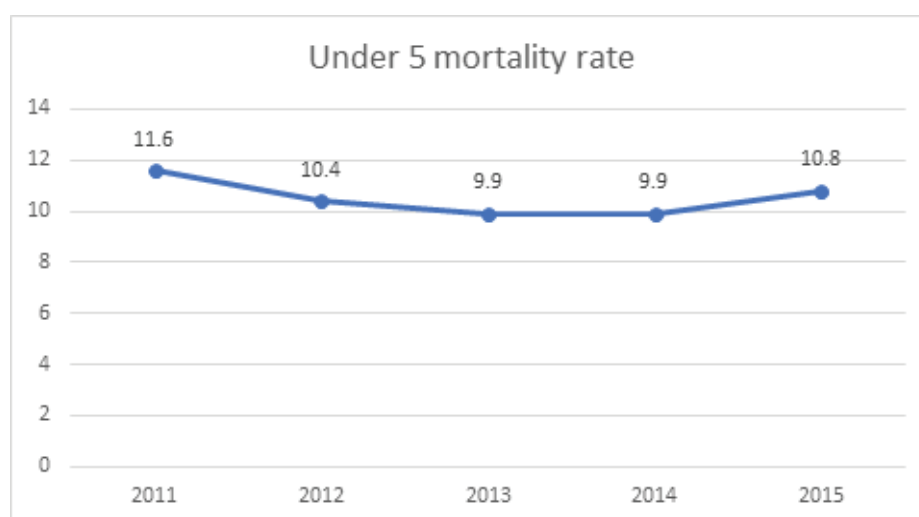


Figure 4.7 : Under 5 mortality rates reported by RHMIS from 2011 to 2015

Congenital abnormalities remained the most frequent cause of 1 to 5 year mortality as well. Accidents, respiratory illnesses and

diarrhoeal diseases were identified as next common causes of 1-5 child mortality (Figure).

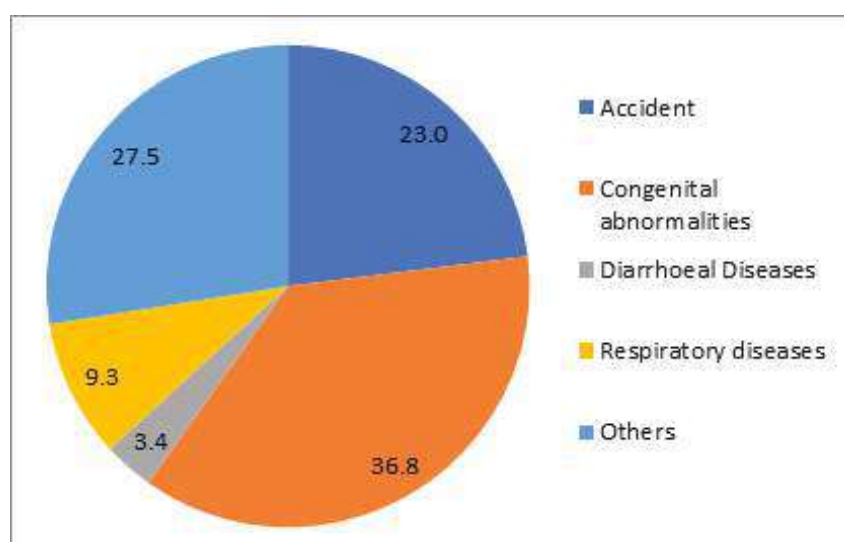


Figure 4.8 : Percentage distribution of cause of 1-5 year child deaths 2015

CHAPTER 05

Maternal Child Mortality and Morbidity Surveillance

5.1 MATERNAL DEATH SURVEILLANCE AND RESPONSE SYSTEM

Review of maternal deaths has shown to be a best practice effective in further preventing such deaths and improving maternal care service delivery. Sri Lanka implements a systematic maternal death surveillance with the involvement of key partners to further reduce deaths and improve care. Sri Lanka's system has been recognized even at international level as a role model system replicable in any setting. Maternal Mortality Ratio (MMR) is an overall quality index of a country's socio-economic development and healthcare. Sri Lanka reported a MMR of 1694 per 100,000 live births in the year 1947 and gradually reduced the same over the last few decades to achieve the best in the South Asian Region.

'Death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy-from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes' is considered as a maternal death. In Sri Lanka, maternal deaths were made notifiable in 1985, case reporting to central level started in 1986 and systematic maternal death surveillance and response started in 1995. Family Health Bureau (FHB), at national level, coordinates the surveillance process all over the country with the expertise contribution from professional colleges of obstetricians, anaesthesiologists, community physicians, administrators and forensic pathologists.

Field and hospital health staff notify, conduct post-mortems, investigate and report to the national level with regard to each and every maternal death. At FHB, a database is maintained and comprehensive case scenarios are developed to be reviewed by an expert panel.

At district level, each maternal death is reviewed based on 3 delays- deficiencies in seeking healthcare, reaching and treating. A "no-name no-blame" strategy in a confidential frame-work is adopted. A team lead by FHB with an expert review group (representatives from Sri Lanka College of Obstetricians & Gynaecologists and other professional colleges) visited all 28 health regions in the country from February to August 2016. They facilitated confirming maternal deaths and local health staff to suggest strategies for change and improve service delivery.

In the year 2015, timely notification of maternal deaths improved to 90%. Coverage of conducting post-mortems was 96%. Receipt of death audit reports achieved 100% prior to conducting national maternal death reviews. Review of all 200 probable maternal deaths reported during the year was 100%. Finally, 113 maternal deaths were identified to calculate the national maternal mortality ratio of 33.7 per 100,000 live births. Figure x and x show the number of maternal deaths (2001 – 2005) and the Maternal Mortality Ratio (1995 to 2015) respectively. A multitude of interventions, both health and non-health, have contributed to the reduction of maternal mortality in the country. Factors such as socio-economic development, free education and related high literacy rate of population, improved transport services, free health services, improved quality of obstetric care, control of communicable diseases, well organized PHC systems have been attributed to this success. The significant reduction of the denominator, live births (14894 in 2015) contributed to the stagnating level of MMR. However, Sri Lanka is well-placed with regard to maternal mortality on par with high income countries.

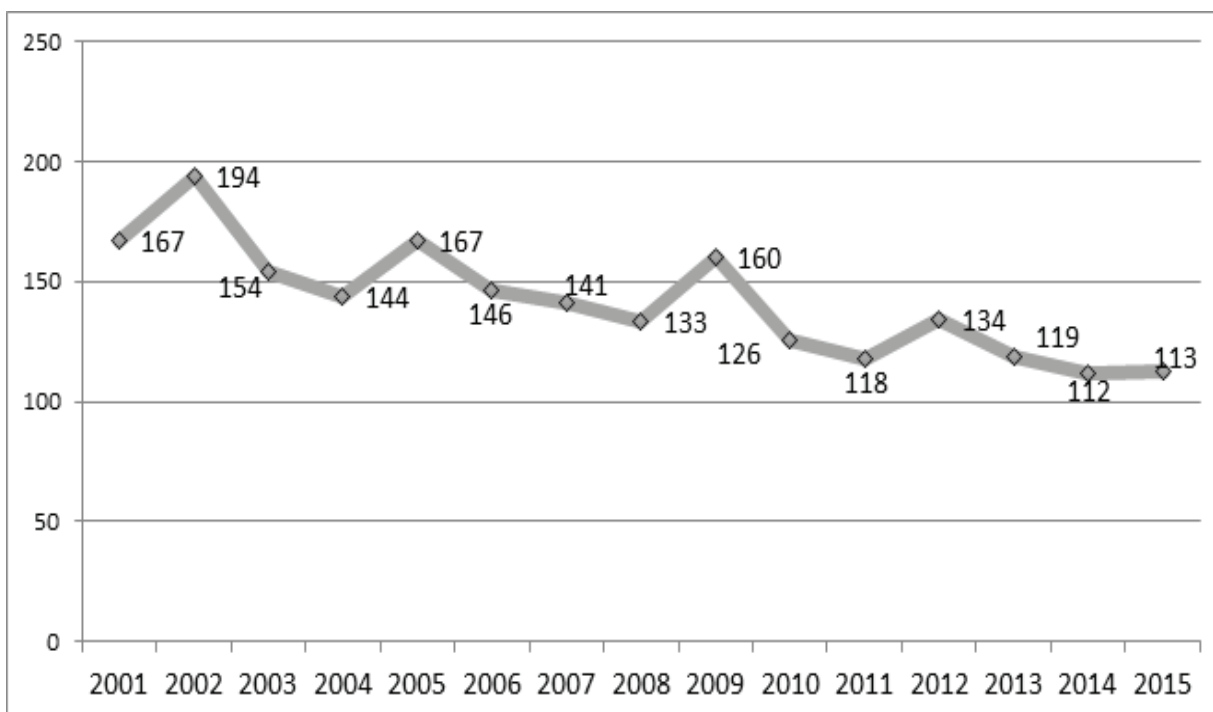


Figure 5.1: Number of maternal deaths from 2001- 2015

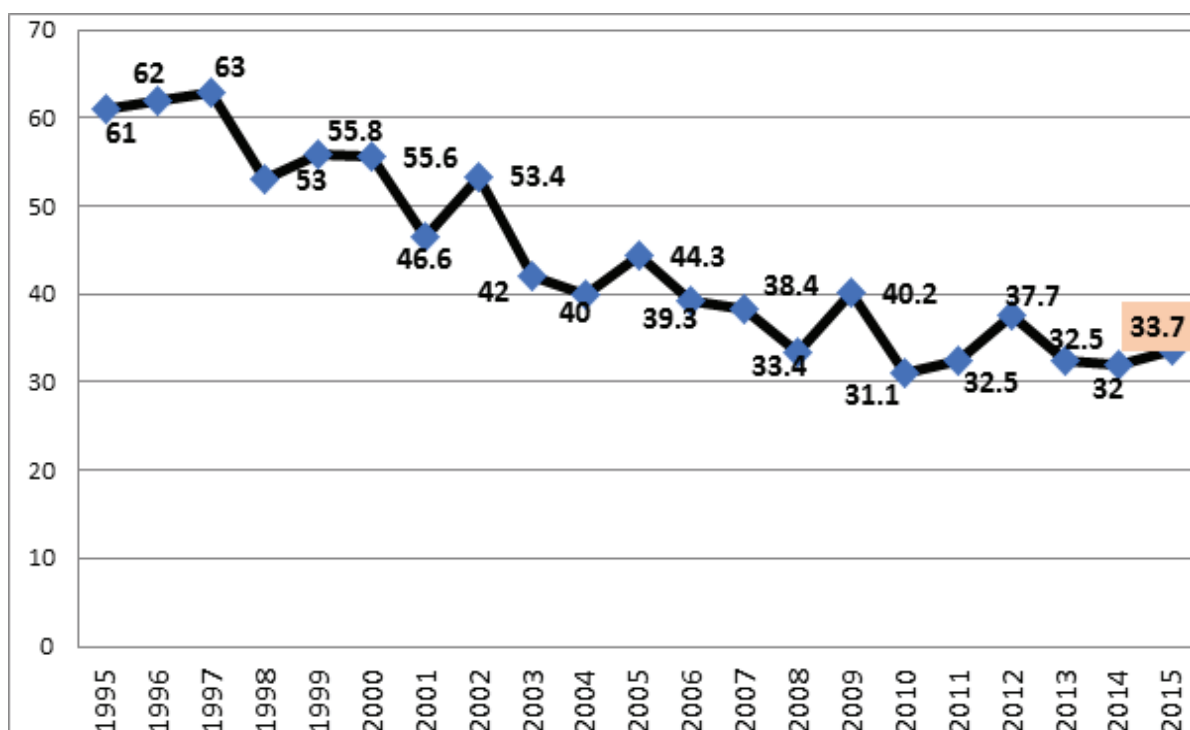


Figure 5.2: Maternal Mortality Ratio from 1995-2015

In 2015, sixty-four percent of maternal deaths (n=72) were due to indirect causes whereas 41 (36%) were direct maternal deaths.

The leading causes of maternal deaths were heart disease, respiratory diseases and obstetric haemorrhage (Figure 5.3).

It is a notable change in the causality profile from direct obstetric causes to indirect medi

cal causes. Cause-specific mortality ratios for almost all direct causes have come down (Figure x).

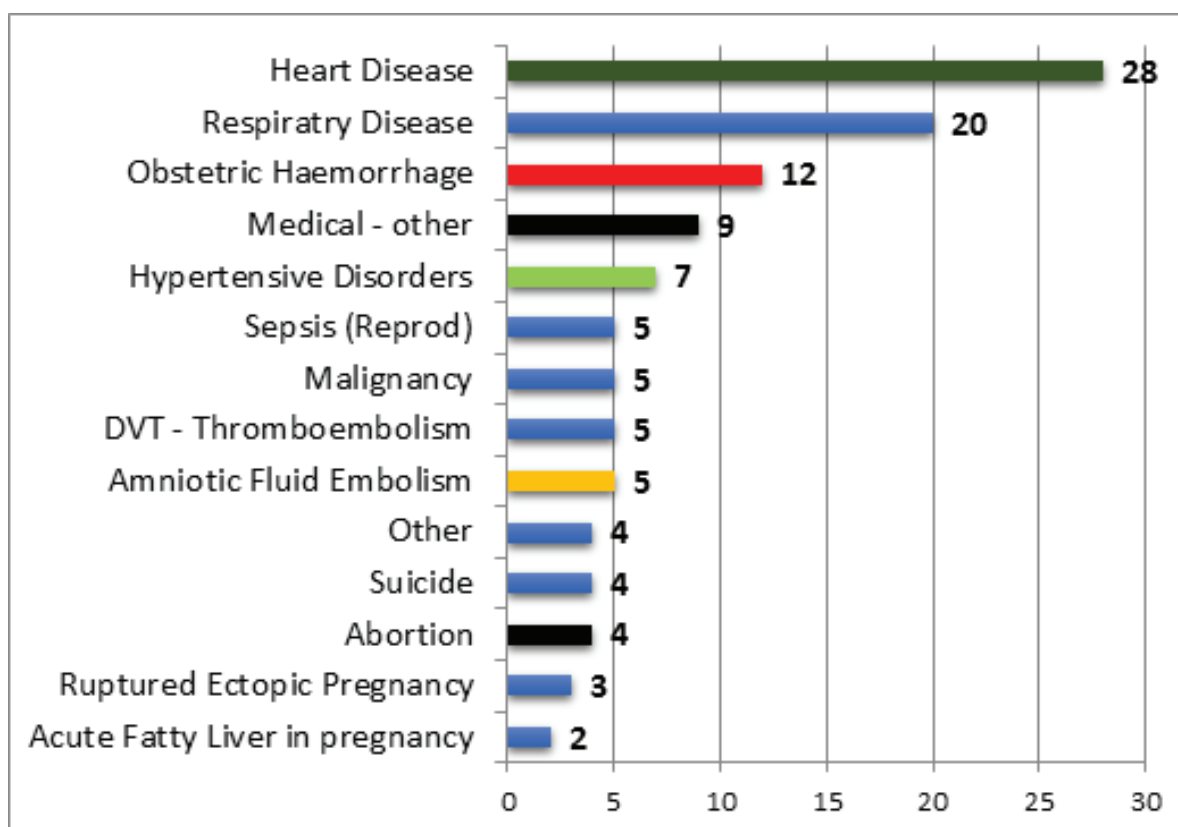


Figure 5.3: Leading causes and number of maternal deaths 2015

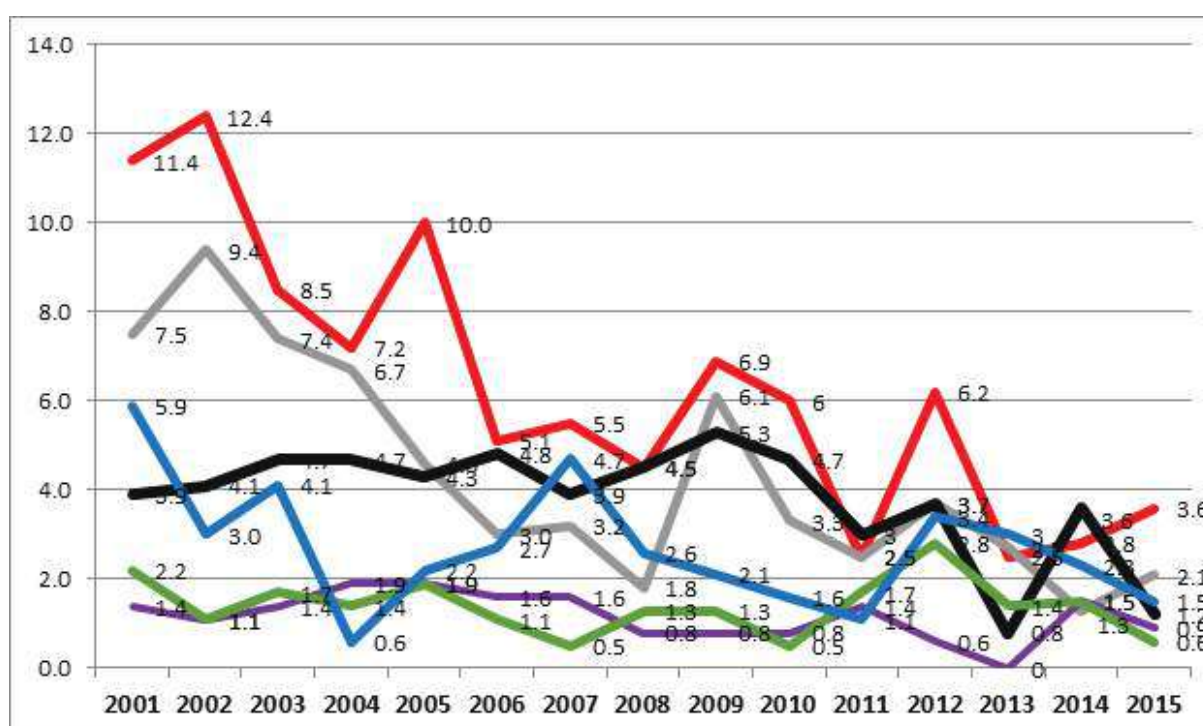
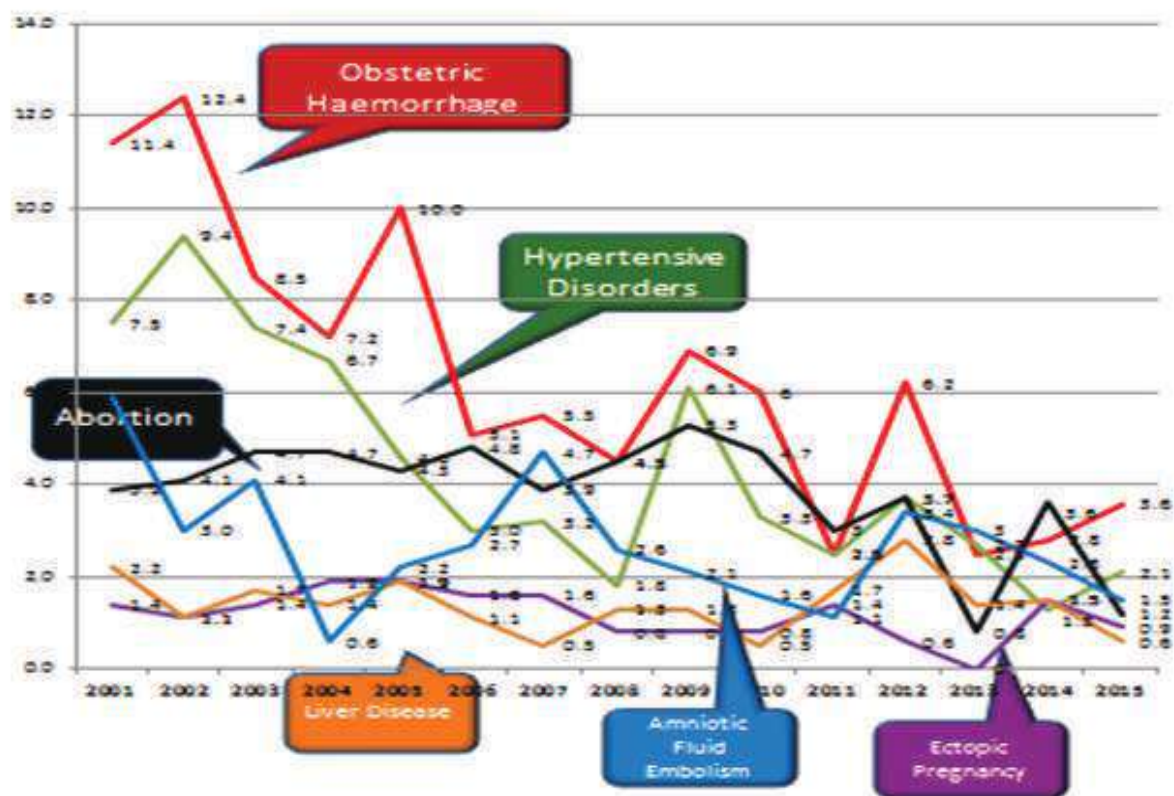


Figure 5.4: Cause Specific Maternal Mortality rates (Direct causes) 2001- 2015

Table 5.1: Pattern of deaths reported throughout the year – 2015

Month	No of MDs
January	4
February	4
March	8
April	10
May	14
June	11
July	11
August	8
September	13
October	9
November	14
December	7
Total	113



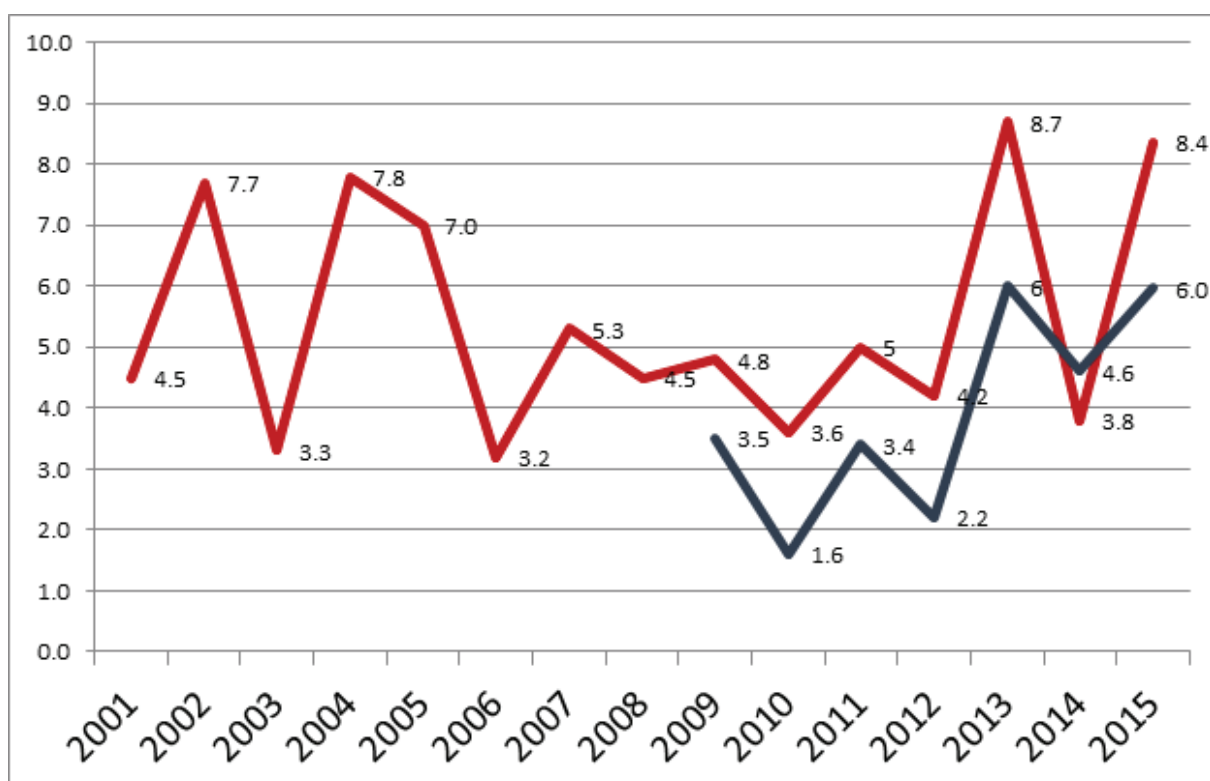


Figure 5.5: Cause Specific Maternal Mortality rates (Indirect causes) 2001- 2015

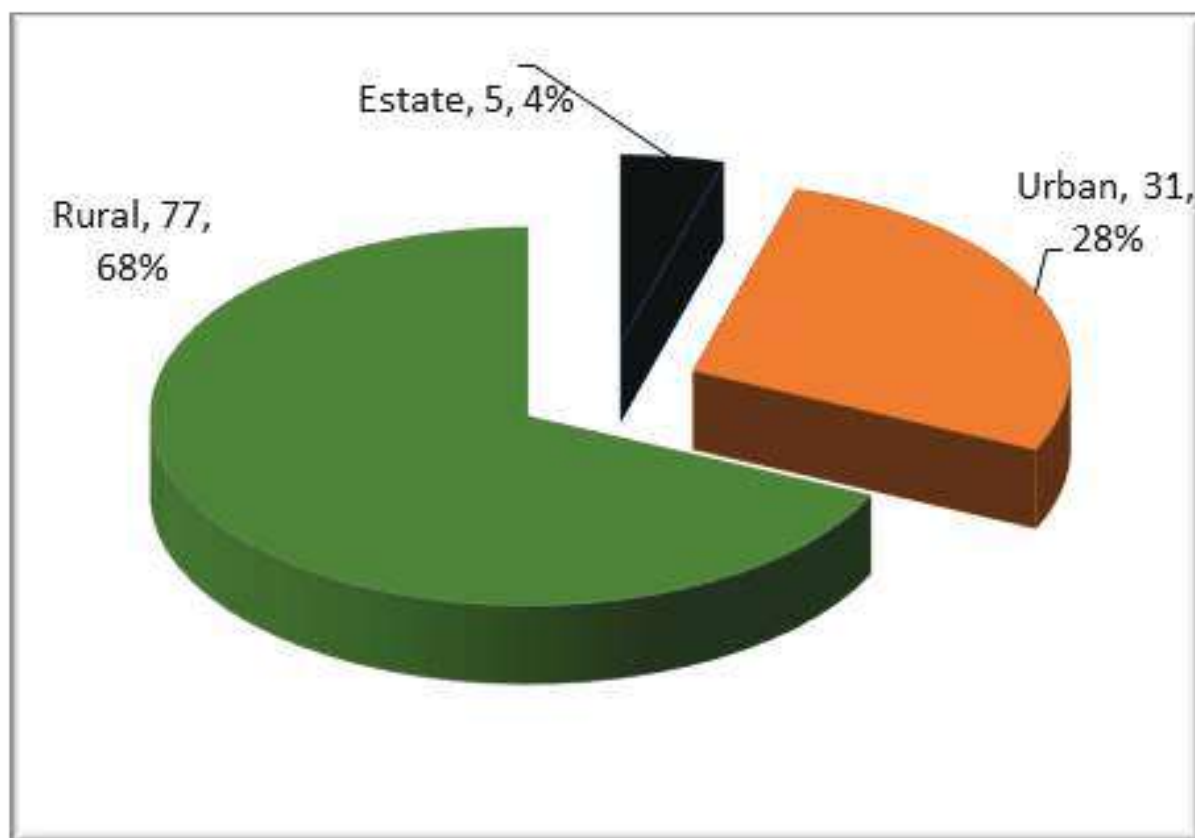


Figure 5.6: Sector of the women died- 2015

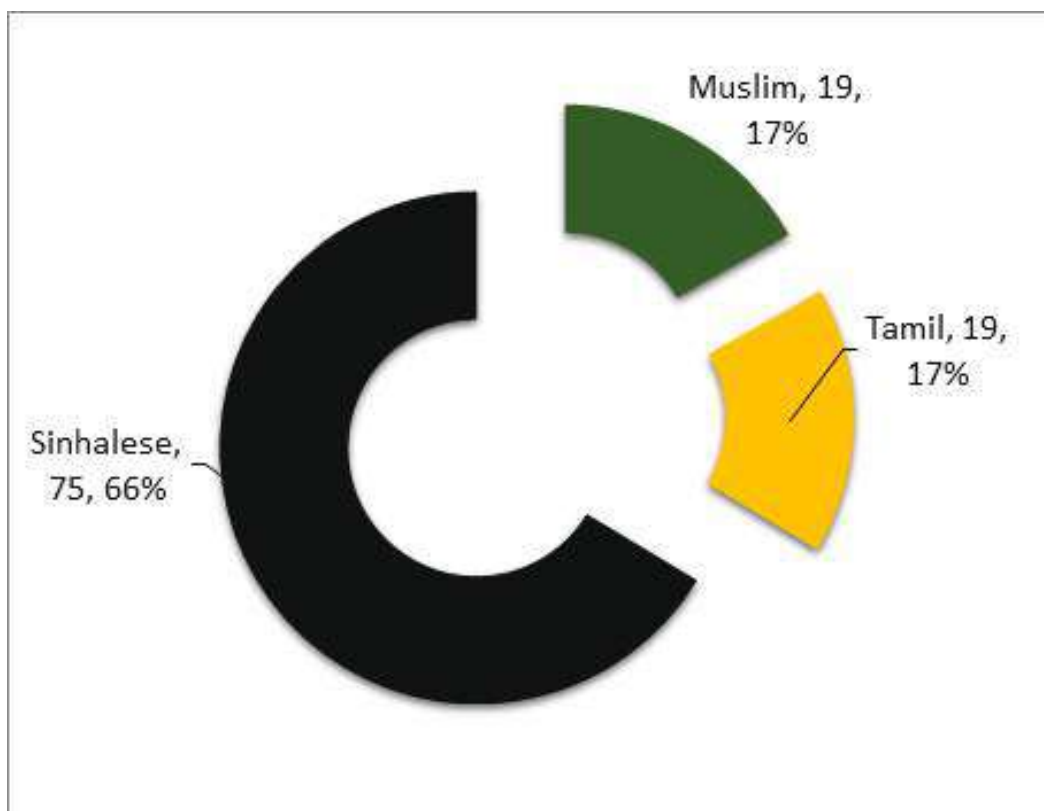


Figure 5.7: Ethnicity of the maternal deaths - 2015

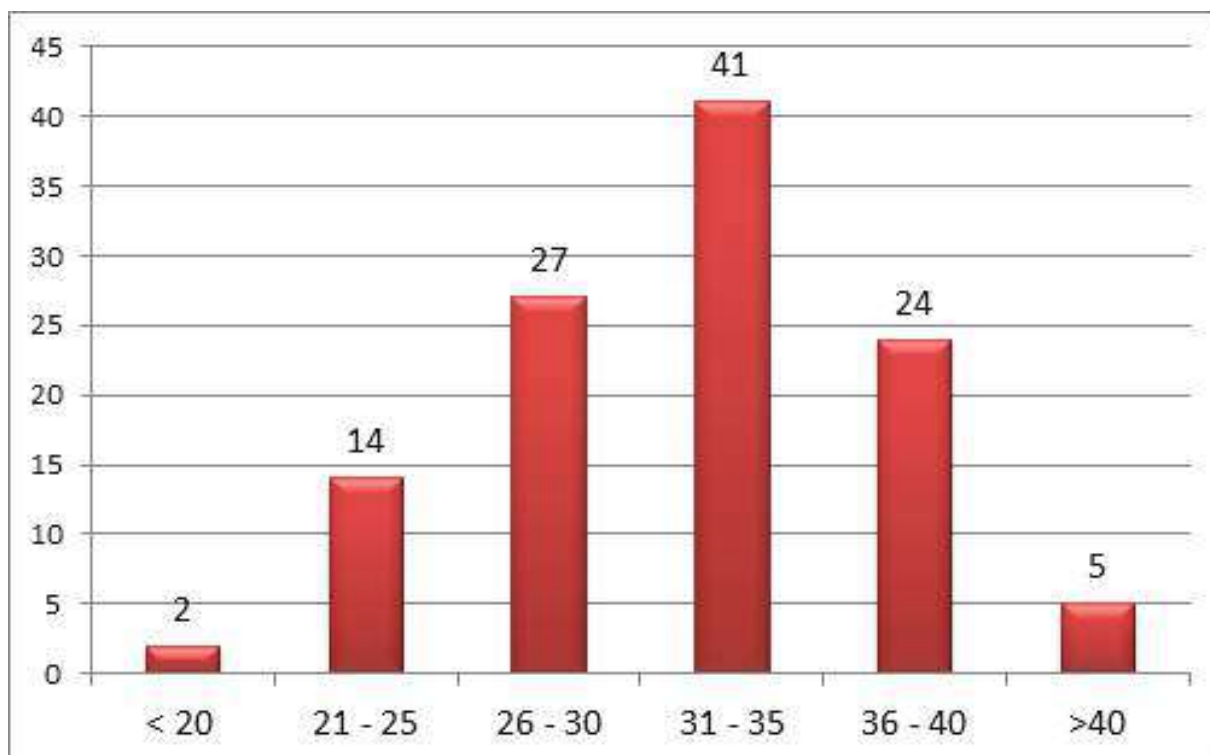


Figure 5.8: Age pattern of the women died - 2015

However, the highest MMR was reported from Mullativu district (02 deaths and live births 1120). Kegalle, Trincomalee and Mannar are the other districts with higher MMRs. There are 11 districts reporting a MMR higher than the national MMR (Table 5.2).

H1N1 vaccine for pregnant mothers, addressing delay 1, reorganization of 24/7 blood transfusion facilities, rectification of human resource deficiencies, rapid communication system among field and hospital care givers, introduction of a RED (Register of Eligible

Table 5.2: Live births, maternal deaths and Maternal Mortality Ratios by RDHS area 2015

District	Live births	Maternal Deaths	MMR
Ampara / Kalmunai	13,297	6	45.1
Anuradhapura	15,376	6	39.0
Badulla	15,076	3	19.9
Batticaloa	9,201	3	32.6
Colombo	50,894	11	21.6
Galle	19,220	5	26.0
Gampaha	24,271	10	41.2
Hambantota	10,750	2	18.6
Jaffna	7,855	3	38.2
Kaluthara	15,289	5	32.7
Kandy	28,099	9	32.0
Kegalle	9,605	7	72.9
Kilinochichi	2,026	0	0.0
Kurunegala	23,231	12	51.7
Mannar	1,677	1	59.6
Matale	9,342	3	32.1
Matara	11,224	3	26.7
Monaragala	7,065	3	42.5
Mullativu	1,120	2	178.6
Nuwara-Eliya	9,090	5	55.0
Polonnaruwa	7,038	2	28.4
Puttalam	13,720	4	29.2
Ratnapura	18,866	2	10.6
Trincomalee	7,790	5	64.2
Vavuniya	3,690	1	27.1
Sri Lanka	334,821	113	33.7

5.1.1 Response

Learning lessons from the deaths, several outcomes were translated in to action. Knowledge transfer workshops on heart disease in pregnancy for obstetricians, cardiologists and anaesthesiologists, preventive activities on H1N1 influenza in pregnancy, lobbying for

women in Danger) book to make visible “bad” cases at field level and strengthening multi-disciplinary care for critically-ill pregnant mothers were key activities.

5.2 PERINATAL MORTALITY SURVEILLANCE

With the reduction of infant mortality rate to a single digit (8.2 per 1000 live births) and a larger proportion (60%) of such deaths being early neonatal deaths (END), perinatal deaths (PND) emerge as a priority area in Sri Lanka-a low and middle income country in South Asia.

National Perinatal Mortality Surveillance system was implemented in 2006. All specialized hospitals (with an obstetrician/paediatrician) are required to document all PNDs, review them monthly at a hospital stakeholder meeting and send a report to Ministry of Health. Structured data collection formats, monthly reporting formats and guidelines are available.

A new National Perinatal Death Surveillance System with revised individual PND data collection format based on World Health Organization's ICD – Perinatal Mortality (ICD-PM) and a user-friendly Monthly Hospital Reporting Format was introduced in the year 2016.

In 2015, data were collected retrospectively using a special data collection format

with ICD-PM minimal variable set. Data were received from all hospitals (both government and private sector) with labour rooms from a total of 590 hospitals (81 Specialized government hospitals, 494 Non-specialized peripheral hospitals, 11 Private hospitals and 4 armed forces hospitals). Considering total live births reported by Civil Registration System in 2015 (334821), coverage of live births in this study was 96.2% (n= 322007) (Table 5.3)

In the year 2015, there were 1728 (46%) stillbirths and 1555 (54%) ENDs (Total 3283 PNDs). Stillbirth and early neonatal mortality rates were 5.3 per 1000 total births and 4.8 per 1000 live births respectively. The perinatal mortality rate was 10.1 per 1000 total births. This translates that for every 100 pregnant women, one experience death of her baby during pregnancy or immediately after delivery.

Lessons learnt were translated into action at hospital, district and national levels. Actions included; prevention strategies on premature deliveries, expansion of premature baby units, strategies on birth defects prevention, early neuro-developmental care, neonatal retrieval systems and introducing therapeutic body cooling.

Table 5.3: Epidemiology of Perinatal Deaths in 2015

	Specialized hospitals	Non-specialized / peripheral hospitals	Private hospitals	Hospitals of Forces	Non-weighted rate
No.of Hospitals	81	494	11	4	590
Live births	303705	8760	9129	413	322007
Stillbirths	1694	9	22	3	1728
Total births	305399	8769	9151	416	323735
ENND	1540	1	14	Nil	1555
PND	3234	10	36	3	3283
Stillbirth rate	5.5	1.0	2.4	7.2	5.3
ENNMR	5.0	0.1	1.5	Nil	4.8
PNMR	10.5	1.1	3.9	7.2	10.1

CHAPTER 06

FAMILY PLANNING

Family planning (FP) is an essential pre-requisite for development of any country. It has been identified family planning emerged as the second most cost effective intervention in all sectors, being second only to free trade.

Sri Lanka records the best family planning performance in the region and has experienced tremendous improvement in family planning practices, which immensely contributed to the impressive health indicators and socioeconomic development. However in the recent past, a stagnation could be observed in the family planning practices and services. This will have far reaching adverse consequences in health and non-health sectors. A number of factors ranging from non-availability of certain family planning methods to negative social perception may have contributed to this stagnation.

Family planning was accepted as a part of the national health policy in 1965, and was integrated into MCH services. The programme offers a wide range of modern family planning methods enabling all couples to have a desired number of children with optimal timing and spacing. It also includes services for sub-fertile couples.

Needs of the community have changed over generations, so have the services the programme offers. Oral Contraceptive Pills (OCP), DMPA injections, Intra Uterine Devices (IUD), Condoms and Implants are the modern temporary methods offered by the present-day programme. Modern permanent

methods include vasectomy and female sterilization (LRT). MOHs, MOs, PHNSs, PHMs and PHIs are being trained in providing awareness and counseling for clients on family planning, supported with appropriate BCC material.

Two main outcome indicators are used to assess the performance of the Family Planning Programme. These are new acceptor rates and

- Current user is a woman/man (eligible family) who is using any method of contraception at a given point of time. This indicator provides the CPR among eligible families for a given year. Data reported in H 509 is used for calculation of this.
- A new acceptor is defined as a woman/man using a particular modern contraceptive method for the first time from any service provider belonging to

6.1 CURRENT USERS: CONTRACEPTIVE PREVALENCE RATE AMONG ELIGIBLE FAMILIES

Percentage of eligible families using any contraceptive method is expressed as current user rate or CPR among eligible families. Of the eligible families registered by PHM

(n= 3,739,544) 65.3% had been using any method at the end of year 2015. Proportion of modern methods and traditional methods users were 55.9 % and 9.4% respectively.

Table 6.1: Percentage of eligible families using all methods 2011 - 2015

Indicator	2011	2012	2013	2014	2015
Modern methods	56	55.1	55.4	56.2	55.9
Traditional methods	9.3	9.5	9.5	9.6	9.4
All	65.3	64.6	64.9	65.8	65.3

Figure 6.1 presents the trends in method preference since 2011 to 2015. The most popular temporary method of contraception in 2015 has been IUD (11.1%), followed by

DMPA injections (9.6%), OCPs (9.5%) and condoms (8.4%). Approximately 13.2% of eligible families practice female sterilization (LRT) for fertility control.

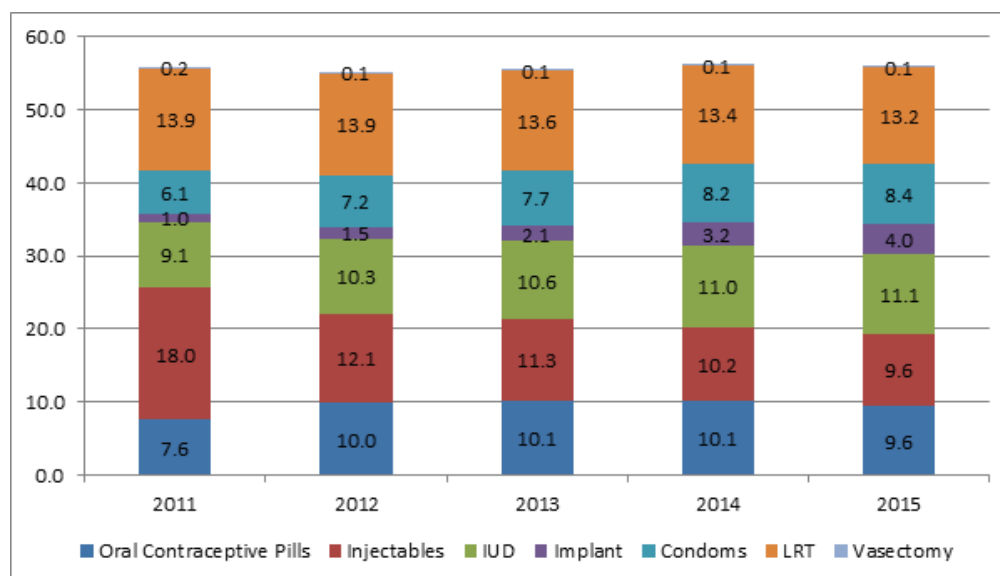


Figure 6.1: Current users of modern family planning methods, from 2011 - 2015

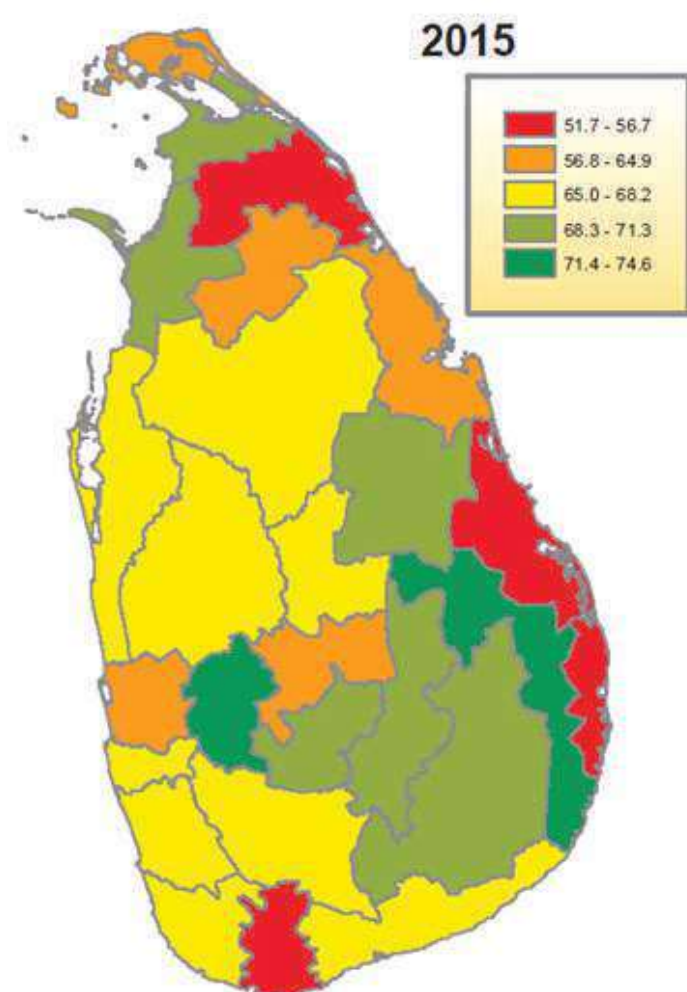


Figure 6.2: Geographical variations in Contraceptive Prevalence Rate (CPR) (All methods) in 2015

6.2 NEW ACCEPTOR RATE

RHMIS has a special registration system to record the pattern of acceptance of contraceptive methods by couples. During 2015, 153,901 couples had been recruited for various contraceptive methods. (Table 6.2)

Out of total new acceptors, 90.6% had accepted temporary methods as a new method from the programme during 2015.

6.2.1 New Acceptors by method

The change in new acceptors as a percentage of eligible couples over time is given in figures

Table 6.2: Contraceptive methods new acceptors by method from 2012 - 2015

Item	2012	2013	2014	2015
New Acceptors (No.)	238,016	181,645	127,130	153,901
IUD	73,932	52,917	40,813	44,916
Oral Pills	79,957	43,556	26,644	33,279
Sterilizations	21,109	15,771	11,657	14,919
Injectables	37,886	34,713	8,195	14,491
Implants	25,132	34,688	39,821	46,796

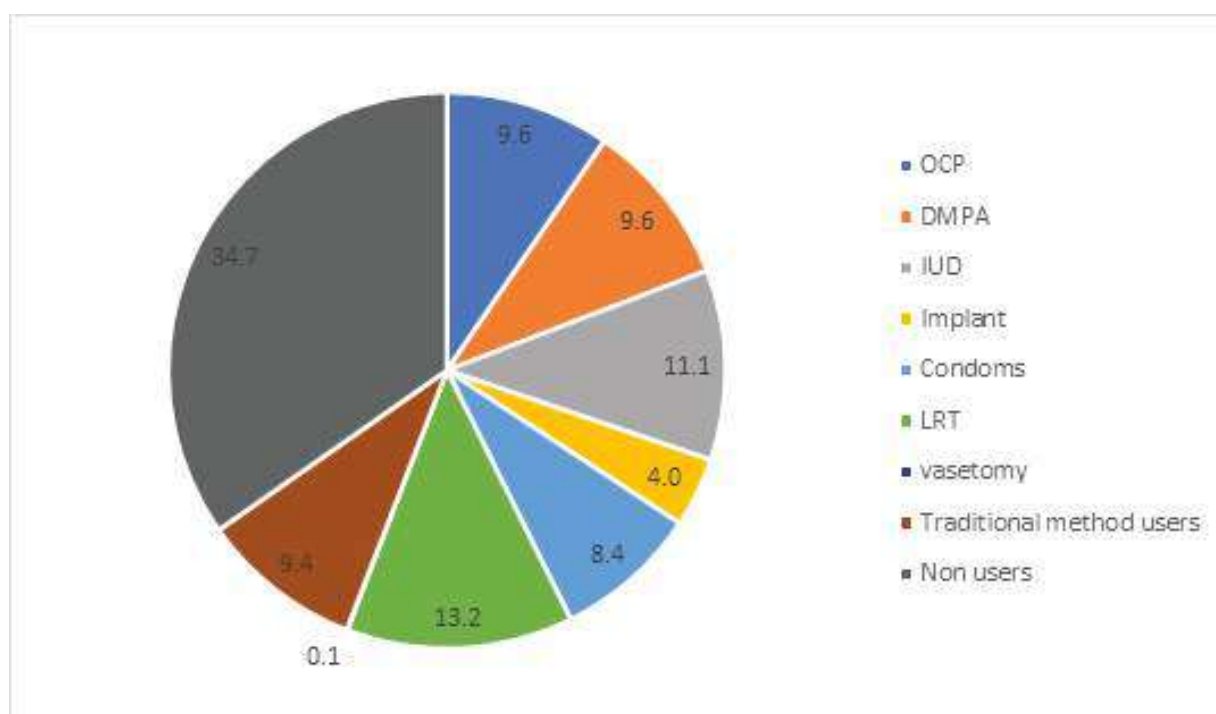


Figure 6.3 : Distribution of various contraceptive methods in 2015

6.2.2 Contraceptive failure rate and complications

Contraceptive method failures are supposed to be reported through RHMIS. Failure rates for different methods are given in Table 6.2. A total of 1872 method failures were reported and the highest failure rate was among IUD users which was 18.4 per 10,000 users.

6.2.3 Unmet need for Family Planning

Unmet need for family planning means a fertile woman married or living in union, not

using any contraception (modern, natural or traditional), not wanting any more children or wanting to postpone for at least 2 years. PHMs gather this information from their eligible families. Figure 6.4 presents the trends in unmet need for family planning from 2011 to 2015.

Unmet need for family planning among eligible couples over last 8 years has dropped from 9.2% to 6.8%. However, further reduction in unmet need is important if the mater-

Contraceptive Methods	2011	2012	2013	2014	2015
Injectables	384	307	201	192	280
Oral Pills	228	309	386	276	557
IUD	430	471	580	403	760
Condoms	64	51	78	73	143
Implants	2	3	4	15	67
LRT	61	82	72	54	65
Vasectomy	1	0	0	0	0

Table 6.3: Contraceptive failures for different methods 2015

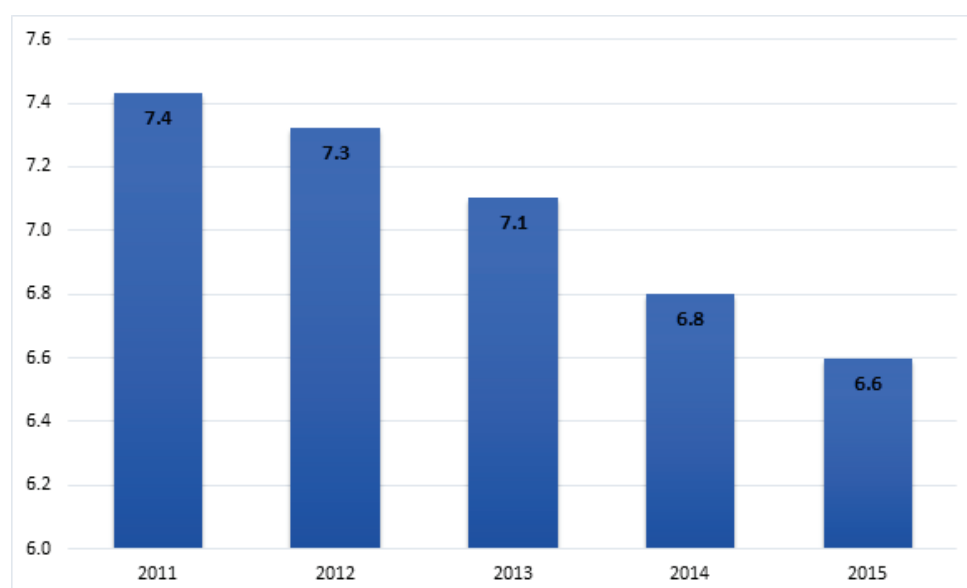


Figure 6.4: Percentage of eligible couples having unmet need for family planning 2011-2015

6.2.4 Services for subfertile couples

Provision of services for subfertile couples is an important component of the National Family Planning programme. Field staff should identify sub fertile couples among the families registered in the Eligible Family Register. They are expected to refer the couples identified for further management. The couples with risk factors also need to be identified and referred for early interventions. Reporting of subfertility is low and in 2015 it was only 2.7%.

6.3 MAIN ACTIVITIES CONDUCTED BY FAMILY PLANNING UNIT 2015:

Main Activities

A number of major activities for the National Family Planning Programme were initiated in 2015

I. Since the introduction of modern family planning services in Sri Lanka in 1953, and the establishment of the National Family Planning Programme, the country has made considerable progress in providing a wide array of services. The Ministry of Health, Nutrition & Indigenous Medicine has reaffirmed the importance of family planning in the National Health Strategic Master Plan 2016-2025. In recent years the National Family Planning Programme is facing considerable challenges both programmatic and from external environment. Hence the need for a review of the programme was thought to be timely and it was initiated in 2015 with the following objectives.

Conduct an objective assessment of the existing services in relation to family planning.

Identify the current needs related to family planning.

Review the extent to which the family planning services meet the need of the population.

Determine the gaps in existing family planning services.

Suggest strategies and services in order to address the gaps identified.

The review was entrusted with an external consultant, and guided throughout by an expert group of representing the government, development partners and non-governmental organizations, and chaired by the Deputy Director General Public Health Services II.

A stakeholder workshop was conducted and study instruments were pretested and finalised in 2015.

II. The intra uterine contraceptive device has been in use for reversible contraception for over five decades as a method of interval family planning. More recently it has been used on the menu for immediate postpartum insertion as it is convenient for the mother due to the timing of insertion. Sri Lanka College of Obstetricians and Gynaecologists, in collaboration with Family Health Bureau implemented the pilot project on institutionalization of immediate postpartum IUD services in eighteen hospitals in Sri Lanka. In 2015, eight training programmes were conducted for 1,425 medical, nursing and midwifery staffs on PPIUD and monitoring activities of the project were implemented.

III. Unsafe abortion is currently considered a major health and social concern in Sri Lanka, though there are no accurate data on abortions. Women presenting following abortions can have life threatening complications which need to be attended promptly. They need family planning and other reproductive health services and psychological support.

As a collaborative effort of Sri Lanka College of Obstetricians & Gynaecologists and Family Health Bureau National guidelines on post abortion care were finalised, printed and launched in 2015. The purpose of this guideline is to provide healthcare providers with essential information and guidance on the

management of women presenting with an abortion, in order to provide comprehensive high quality post abortion care services to them, which include management of abortion and its life threatening complications, providing emotional support, family planning counseling and services, and thereafter ensuring appropriate referral.



IV. The Family Planning Unit introduced a 3-day, in-service, training of trainers (ToT) programme for service providers in 2015 with the aim of improving their knowledge, attitudes and skills in all aspects of family planning service provision, including counseling and emergency management.

Four ToTs on family planning were conducted at FHB for MOMCHs, MOs, MOHs, CCPs and other Consultants .The total number trained was 97.

Seven (07)awareness programmes on family planning were conducted in seven districts in seven provinces(Central, North Central, Eastern, Northern, Southern, North Western and Uva)were conducted in 2015.

Family planning unit facilitated 08 two day training programmes at district level targeting medical, nursing and midwifery staffs in 2015.These were conducted by Master Trainers trained at Family Health Bureau in the 3 day ToT. The total number trained was 223.

One 1- day programme for PHNSS was conducted and total number trained was 21.

V. Goal of the National Family Planning programme is to enable all couples in Sri Lanka to have a desired number of children with optimal spacing. This is to be achieved by providing safe and effective family planning services. Behaviour change communication (BCC) material for clients as well as for health staff is required to achieve this objective. In 2015, 05consultative meetings were



VI. Videos are extremely effective in delivering BCC messages. Also they are effective in delivering messages to a group of people at a single time. Family Health Bureau developed a video documentary on family planning, "Ada HondamaDawasa", which can be shown at places such as hospitals, MOH offices etc; to educate the staff.



VII. Necessary equipment are an essential pre-requisite for family planning clinics to provide a quality service to clients. Family Planning Unit compiled a comprehensive database on family planning clinics, both in the preventive and curative sectors, so that gaps can be identified and addressed.

VIII. Equity, accessibility and affordability for family planning services are important in improving the modern contraceptive prevalence rate. So each year a number of new family planning clinics are established with modern equipment and registered to achieve accessibility and equity to all Sri Lankans. In 2015, eighteen new clinics were registered and equipped with necessary items. Director General of Health Services issued instructions on the necessity of having dedicated family planning clinics in all hospitals to ensure accessibility and equity.

IX. To monitor complications for family planning methods the formats for notification and investigation of adverse events and failures to family planning methods were revised and introduced island wide.

Equity, accessibility and affordability for family planning services are important in improving the modern contraceptive prevalence rate. So each year a number new family planning clinics are established with modern equipment and registered to achieve accessibility and equity to all Sri Lankans.

In 2015, FHB has given registration to 18 new family planning clinics in MOH areas island wide. For smooth function of these clinics, FHB has provided all necessary equipment.

CHAPTER 07

SCHOOL CHILD, ADOLESCENTS AND YOUTH

7.1 SCHOOL HEALTH PROGRAMME

School health is a shared responsibility of both Health and Education Ministries. FHB is the focal point for School Health Programme in Sri Lanka. The services are delivered through primary health care staff in collaboration with provincial health and educational ministries. The Medical Officer Maternal and Child Health (MOMCH) is the coordinating officer at regional level. Designated officers are being assigned as School Medical Officers (SMO) in Kandy, Galle, Jaffna and Colombo to conduct school health activities in urban areas.

Family Health Programme includes preventive health care needs of school children and adolescents. Ministries of Health and Education share a joint responsibility of implementing the school health interventions. The target group of the School Health Programme is children and adolescents attending government schools.

Family Health Bureau, being the focal point of the school health programme, is involved in planning, providing technical guidance, monitoring, evaluating the programme activities, conducting research and management of logistics relevant to school health activities. However, a successful programme to reach out-of school adolescents is yet to be established.

The Medical Officer of Health (MOH) is responsible for implementation of the school health programme in collaboration with the Zonal Educational Officers and School Principals.

The Public Health Inspector (PHI) organizes the school health activities at the local level.

In the Municipality areas of Colombo, Kandy, Galle and Jaffna, School Medical Officers implement the school health programme.

At present the school health programme focuses on five major thematic areas. These include:

1. School medical services including counseling
2. Maintenance of healthy school environment
3. Life skills based health education (includes sexual and reproductive health)
4. School community participation
5. Healthy school policies

School medical services include School Medical Inspection (SMI) of children and making relevant referrals. PHIs carry out the initial screening of children and MOHs conduct medical inspections. In small schools (with less than 200 students) all the children are examined once a year, while in the larger schools (with more than 200 students) all students in grades 1, 4, 7 and 10 are examined annually.

Assessment of nutritional status, detection and correction of health problems, providing immunization and worm treatment, provision of micronutrient supplementations to children are the main activities conducted during the SMI.

The children detected with any defects are either treated locally or referred to the closest specialist clinics for necessary management. Thereafter, they are followed up by the PHIs to ensure the correction of defects. In addition, MOHs are supposed to organize Behaviour Change Communication programmes aimed at children with a view to promote their health with special reference to sexual and reproductive health concerns, reduction of risk behaviours for tobacco, alcohol, drugs abuse and HIV/AIDS.

Apart from the SMI, the PHIs conduct school sanitation survey in the schools annually, findings of which are used for making the school environment safe and healthy. The necessary recommendations are sent to the school principals for corrective actions. These officers work closely with officials of the Education

Ministry and other Government and Non-Governmental Organizations to provide services such as safe water, sanitary facilities and refuse disposal in school premises.

In 2015, only 332 out of 337 MOH areas (97.6%) submitted Quarterly School Health Returns (H 797) for all four quarters. (Summary of H797 not received is attached with Annexure: There were 10144 schools and 1,729,268 children to be examined out of the enrolled 4,041,559 children. The SMIs were conducted in 9,802 schools resulting in overall school coverage 96.7%. The coverage of schools with less than 200 and more than 200 students were 98.8% and 94.5% respectively (Figure 7.1).

Nearly 85 % of the schools are with a drinking water source. The School Health unit of the Family Health Bureau and Ministry of Education facilitated the International Water Sanitation and Hygiene conference in June 2015.

7.1.1.2 Malnutrition among School Children

During SMIs students are assessed for their nutritional status. Stunting is assessed in grades 1 and 4 only. In 2015 8.7% and 6.9% of children in grades 1 and 4 were stunted respectively. Wasting was higher compared to stunting in both grades. (20.3%) In 2015 20.8% and 16.4% of children in grades 7 and 10 were wasted respectively.

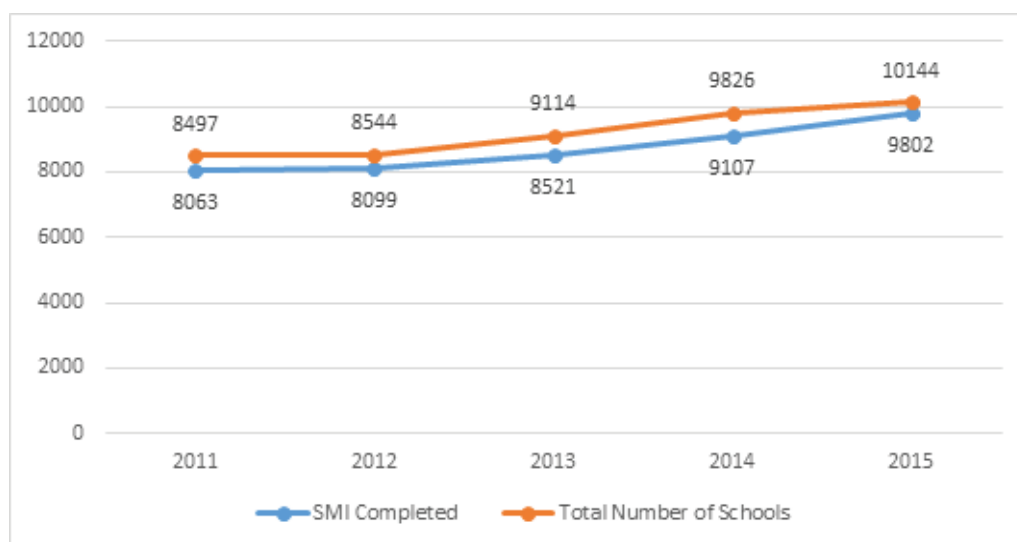


Figure 7.1: Total number of schools versus number of schools where SMI were conducted 2011 to 2015

7.1.1 School Health Surveys

It is a responsibility of range PHI to complete the school health survey annually. It should be completed preferably within the first quarter of the year for timely action. During 2015, health surveys of 97.6 % of the schools had been conducted island wide.

7.1.1.1 Water, Sanitation and Hygiene

The proper sanitation, hygiene and use of safe water are vital in providing a safe school environment. Ninety eight percentage (98.7%) of schools had adequate toilet

The highest rate of over weight was reported among children in grade 7 (4.3%), while its 4.4% in grade 10 children. (Figure 7.2).

In addition, Body Mass Index (BMI) of all students in grade 10 is assessed and necessary nutritional interventions are done during the nutrition month each year. During year 2015, 97,279 (89.4%) grade 10 students were assessed for their nutritional status and trends of prevalence of low BMI and overweight among male and female students were given in figure 12 and 13. Low BMI among grade 10 students in 2015 was 23.9%, whereas overweight among grade 10 students in 2015 was 4.2%.

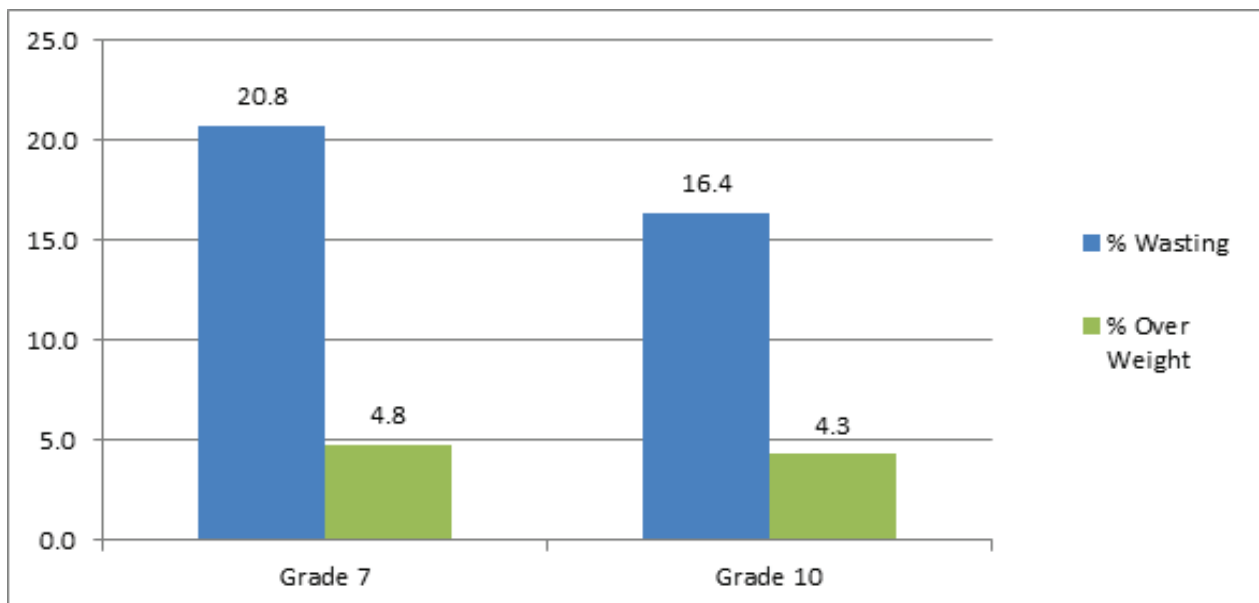


Figure 7.2: Percentages of school children in Grade 7 and 10 with wasting and overweight in 2015

7.1.1.3 Strengthening follow up of defects

Following up of children with special needs, suspected heart disease, visual defects & hearing defects has been strengthened. Follow up visits by the PHI for the students

identified with correctable defects were closely monitored at the monthly MOH conferences and this has resulted in significant number of identified defects being corrected (Figure 7.3).

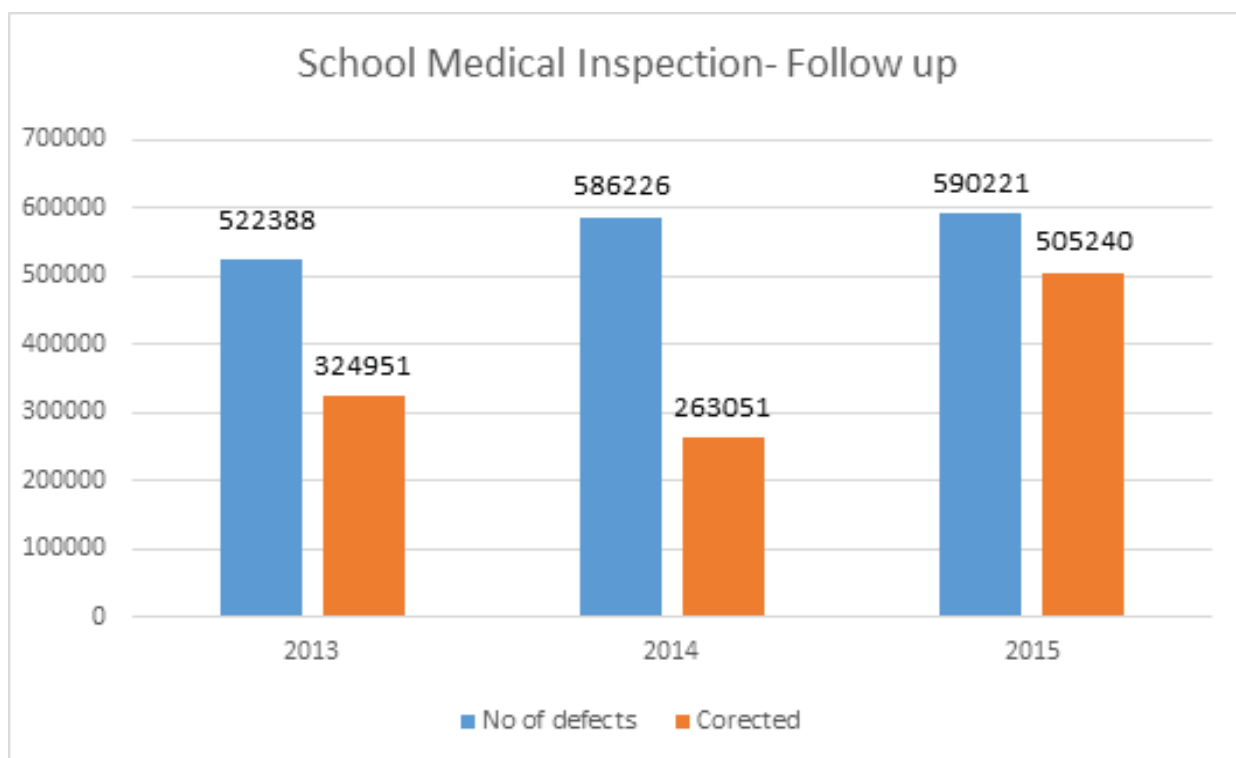


Figure 7.3: Progress of the SMI follow up from 2013 - 2015

Table 7.1: Prevalence of health problems detected at SMIs 2015 (Cases per 1000 students examined)

Health problem	2011	2012	2013	2014	2015
Dental caries	246.5	249.0	245.8	228.4	228.7
Pediculosis	57.6	59.5	60.6	56.9	57.8
Malocclusion	31.9	31.1	34.6	34.3	27.9
Visual defects	23.3	25.9	25.8	22.3	27.6
Fluorosis	20.0	17.8	14.9	15.1	13.2
Heart disease	11.6	12.1	12.9	12.7	16.6
Skin diseases	14.1	13.3	13.5	11.9	13.4
Pallor	18.0	16.0	15.1	11.2	13.1
Gingivitis	5.7	4.0	4.0	3.7	3.7
Asthma	3.0	2.7	3.4	2.8	3.01
Glossitis	4.7	6.0	2.6	2.3	1.2
Learning problems	2.7	2.9	2.5	2.0	2.8
Squint	2.0	2.2	2.0	1.8	1.8
Behavioural problems	1.9	1.6	1.8	1.7	2.1
Speech Defects	1.5	1.4	1.6	1.5	1.6
Scabies	2.1	1.9	1.7	1.4	1.6
ENT Problems	1.4	1.3	1.4	1.2	1.4
Lung disease	1.7	1.5	1.0	0.9	0.8
Hearing defects	1.1	1.1	0.8	0.9	0.8
Xerophthalmia	2.4	1.2	2.7	0.8	0.6
Goitre	1.5	1.3	0.6	0.7	0.7
Lymphadenopathy	0.6	1.0	0.7	0.5	0.5
Orthopaedic problems	0.4	0.4	0.4	0.4	0.4
History of fits	0.6	1.0	0.6	0.4	2.7
Bitot spots	0.7	0.7	0.5	0.3	0.2

7.1.2 Immunization

The expanded programme of Immunization (EPI) has performed well with immunization coverage of 113.9% for aTD vaccine for children in grade 7.

7.1.3 Strengthening the school curriculum

School Health Unit together with National Institute of Education designed the new “Health and Physical Education” curriculum for students giving special attention to health promotion, life skills development and strengthening of physical activity. Ministry of Education together with Family Health Bureau designed a training programme for teachers on “health and physical education” and developed a resource guide. Two thousand and thirty teachers have already been trained in the above training programme, working in conjunction with National Institute of Education.

7.1.4 Health promoting school initiative

This programme was launched in 2007 and appreciable level of effort had to be made to implement the programme at schools. The necessary technical guidance was provided by the School Health Unit of the Family Health Bureau for implementation. During 2015, all the schools were evaluated using an evaluation tool developed by experts in the field.

Out of 10144 schools, 3202 schools were identified as Health Promoting Schools (HPS). HPS were categorized as follows;

80 – 100 marks (Gold level) – 720 schools
70 – 79 marks (Silver level) – 1101 schools
60 – 69 marks (Bronze level) – 1381 schools

7.1.5 Training of public Health Staff

School Health unit is responsible for capacity building of the health work force through training programmes. Almost 750 public health staff members were trained as master trainers by the (ZZ add number of TOTS)

training of trainers programmes of Life Skills and School Medical Inspection during the year 2015.

7.1.6 Weekly Iron Folate Supplementation

WIFS is an evidence based intervention to prevent anaemia among school children, in which treatment with anti-helminthic is followed by weekly treatment with iron, folic acid and vitamin C for a period of six months. According to the study done on coverage of interventions and the feasibility of methodology done by Family Health Bureau in 2015, 90% of schools have started the WIFS programme, while 61% of schools have completed 24 weeks therapy. Leaflet for WIFS programme targeting primary school children was prepared, printed and distributed throughout the country.

7.1.7 Contribution to National Policies and Guidelines

The school health unit had coordinated five National Coordinating Committee (NCC) on School Health committees during year 2015. National Coordinating Committee (NCC) on School Health of the Ministry of Health is chaired by the Director General of Health Services and function as the main executive body taking decisions with regard to the school health activities providing policy, guideline and technical directives to be taken up at the Steering committee of Ministry of Education.

School is a place where healthy practices can be rooted into adolescent behavior. Further considering the fact that a student spends nearly one third of a day at school, the school has been identified as a place where healthy practices such as physical activity and consumption of healthy food, can be practiced among students. The School Health Unit of the Family Health Bureau assisted Ministry of Education to advocate healthy canteen policy and issuing a circular describing the healthy food items that should be available in a school canteen has been issued.

7.2 CARE FOR ADOLESCENTS AND YOUTH

Adolescent and Youth Health component was incorporated into the RMNCAYH programme in 2014 which includes the health needs of the 10-24 years age group. PHMs are supposed to register adolescents in her area and provide home visits and identify problems for those who are under care. These activities were initiated few years ago and data collection on adolescent care into routine RHMIS system was introduced in 2015. As reported through H 509 in 2015, only 14.5% of the adolescents were under the care of PHMs. Out of under care adolescents, only 46.3% were been visited by the PHMs. Among the adolescents under care, 0.7% were identified as having problems and out of them 23.7% had been referred for services.

For provision of services to adolescents and youth, Adolescent Youth Friendly Health Service (AYFHS) Centers under the name of “Yowun Piyasa” were being established in government hospitals. There were only nine AYFHS centers functioning in the country by 2014. In 2015, national review of AYFHS was conducted with the participation all relevant stakeholders to identify the gaps and barriers that had affected the programme. Nine existing AYFHS centers were visited and revamping process was initiated. First provincial level review was conducted in the Western Province and followed by strengthening of AYFHS in the province. By the latter half of 2015, ten new AYFHS centers were established in Western Province. Plans have been developed to establish AYFHS centers all over the country in phased out basis.



Programmes to create awareness among hospital staff on AYFHS was conducted in parallel to the expansion of adolescent services. Five new “Yowun Piyasa” centers will be established in the Southern Province in 2016.

Revision of standards for AYFHS was initiated with the participation of the international expert with the support from World Health Organization. Quality assessment tools for AYFHS were developed with the technical support from the same expert. Field-testing of these tools and the development of service implementation guideline on AYFHS is planned to be carried out in 2016.



Circular on adolescent sexual and reproductive health service provision has been issued after obtaining legal clarification from the Attorney General to address the issues encountered by the public health staff in provision of adolescent sexual health services in the field. Guideline for public health staff on adolescent sexual and reproductive health service provision has been drafted, targeting the reduction of teenage pregnancies which was 5.3 % in 2014. Advocacy programme for honourable judicial members was conducted on the importance the provision of adolescent sexual reproductive health services for the needy groups with the participation of Director General of Health Services. Sexual and reproductive health package for public health midwives, as an aid on provision of adolescent sexual reproductive health education for young persons in the field was developed.



IEC materials on teenage pregnancy prevention and tele-film on adolescent health and nutrition were developed. Development of youth health web site for 15-24 years age group was initiated which includes youth friendly content in all three languages.

Training of trainers were conducted to improve capacity building of primary health care workers and other officers who are dealing with young persons at AYFHS Centers. Capacity building of the staff of newly established AYFHS centers was conducted parallel to it. Steps were taken to strengthen the field health component of AYFH service provision through training of the trainers from the district level.

Analysis of the National Youth Health Survey 2012-2013 was completed in 2015. This survey was conducted in a nationally representative sample of 8820 of Sri Lankan youth of 15-24 years to obtain a profile of Sri Lankan youth in terms of selected aspects of their health, personal, home and environmental factors affecting their health.

Key findings as follows:

1. Education and productive engagement at present

A majority were Sinhalese (78.5%) and Buddhists (75.4%). One third of the sample were school going while another one third were staying at home without productive involvement.

2. Family

Majority of youth (83%) live with their parents and 33% with their grandparents. Only a minority had issues of parental separation, single parent families and high paternal deprivation which was noted among the youth from North East (N-E) areas. Nearly 88% of youth perceived their families as “sweet and warm” or “good”.

3. Physical health

Nearly 20-25% of youth experienced acute illnesses preventing them from attending productive work during the preceding month. The commonest cause of acute illness was fever with or without a cough and cold (17.9%). Young males experienced injuries /accidents as one of the leading causes for absenteeism.

4. Lifestyles

Half of the males and three quarter of females had not done manual work in the preceding week. Approximately 44% of total youth were spending five or more days in the preceding week as “screen time” with a higher female preponderance. Male youth were prominently engaged in formal exercise (17%) compared to 4.5% of females.

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did not have access to internet facilities. Nearly 80% of males and 60% of females had their own mobile phone. In assessment of reaction to an invitation from an unknown person who made contact through a missed call, nearly 10% reported that they would go and meet that person with or without a friend.

6. Knowledge and skills on sexual and reproductive health (SRH)

SRH related knowledge among youth was not satisfactory. Nearly 50% were unaware about most aspects of basic physiology and common SRH issues. Knowledge on the SRH system of the opposite sex was poor among both males and females. With regard to knowledge on sexually transmitted infections (STI), more than half of the youth correctly identified the risk of STI even after a single sexual intercourse and 48% knew that genital ulcers could be a symptom of STI.

7. Diet and nutrition

Over 50% boys had consumed carbonated /cola drinks during the preceding week verses 36% of females. One fifth consumed pre-cooked food like sausages while one fourth had taken food with high salt. Nearly 6% of youth were taking energy formulas. Only half of the youth, have heard about the BMI concept.

8. Psychosocial health

Study revealed a positive picture with regard to mood where 83.1% of youth reported a happy mood during the preceding two weeks. Reasons for worry, differed depending on the sex where boys were worried about finding a job, current job, relationship issues while girls were worried about exams, parental conflicts/family disputes. Significantly, more females were having the feeling that their life is not worth living. Nearly one fifth of youth were feeling sad or helplessness and had stopped their routine work for a while and 6.4% felt like the above for two weeks or more. Nearly 6.5% seriously thought about committing suicide during the preceding 12 months, 4.0% had made plans

and only 3.0% sought some help.

9. Substance abuse

Ever and current smoking was 30.5% and 17.6% for males and 1.6% and 0.7% for females respectively. Significantly, more non-schooling males (23.9%) had smoked during the preceding week compared to schooling males (4.3%). Betel chewing during the preceding week was 6.3% with male and rural strata predominance. Significantly, more non-schooling males reported of alcohol ever use (43.4%) as well as current use (13.8%) compared to schooling males (17.0% and 2.6%).

10. Violence n relationships

The reported past experience of rape among youth was 3.0%. Neighbors, relatives and strangers were abusing youth irrespective of their strata or schooling status. More females reported unpleasant experiences with gender based harassment in public places predominantly among the urban, rural strata and among the non-schooling group. Setting barriers on relationships; blaming /scolding and physical violence by the partner were reported as experiences of intimate partner violence.

11. Sexual behavior

One third of the total sample and one fifth of the unmarried youth reported in engaging in some sexual activities during the preceding year with higher proportions among the urban and rural youth.

Youth had their first sexual intercourse with their regular partner or spouse (64%), girl /boyfriend (20%), relative/friend (5%), casual partner (2.7%) and with a commercial sex worker (2.3%). Of the total, 14.7% were sexually active (engaged in sexual intercourse during the preceding year) with higher proportions reported among the non-schooling youth, urban and rural youth. Out of school going youth, 1.3% youth admitted to having sexual intercourse during the preceding year.

12. Contraceptives and pregnancy details

Nearly 5% of the total youth and 30.4% of the sexually active youth, reported using condoms during the preceding year mostly with their spouse /regular partner, boy/girlfriend and commercial sex partners. The common reasons for non-use of condoms by the sexually active youth were, practicing another contraceptive method (20.8%), expecting a child (16.3%), other reasons (13.7%), non-availability of condoms (3.8%) and unawareness (3.1%). Unavailability was cited as the main reason for non-use, by the unmar-

ried sexually active youth. Only 40.7% of married and sexually active youth were practicing a family planning method. Popular methods of contraceptives were oral contraceptives followed by Depo Provera.

13. Youth friendly health services

Nearly half of the youth (51.0%), reported the need of youth specialized health services and preferred opening times of Sunday morning and Sunday evening highlighting the importance of reorientation of health services to meet the needs of youth.

GENDER AND WOMENS' HEALTH

The Government of Sri Lanka was a signatory to the Program of Action adopted at the International Conference on Population and Development (ICPD) in Cairo in 1994. The concept of Reproductive Health (RH) has been introduced to the RMNCAYH programme since then and the programme was reorganized to address gender equity and equality in RH and specific reproductive health issues of women and their partners throughout the life course and women with special needs.

8.1 WELL WOMAN CLINIC SERVICES

The concept of Well Woman Clinic (WWC) services were introduced in 1996 to screen women of reproductive age for selected health conditions. Those were, diabetes, hypertension, malnutrition, breast and cervical malignancies. A WWC offers a general physical examination, measuring height, weight and blood pressure, breast and cervical examination (including taking of a pap smear) and basic investigations like checking for blood sugar.

8.1.1 Number of WWCs

By the end of 2015, the number of functioning Well Women Clinics have increased to 980 from 611 in 2007. This is a 60% increase in number of WWCs.

8.1.2 Target population coverage

Since 2007, women aged 35 were considered as the principal target group for WWC services, especially for screening of cervical malignancies. WWC are usually held fortnightly or once a month by MOH offices and women of other age groups (up to 60 years of age) were also encouraged to access services. Women who were identified with problems were referred to appropriate centres for further management and they were followed up in the field by the area PHM.

Table 8.1 shows the number of women attending WWCs by age groups. The attendance of 35 year age cohort of women to the WWCs in 2015 was 45.1% (n = 94,089 out of 1% of total population (208,687.62).

In order to increase the coverage of WWC services, an annual award ceremony for best performance was initiated in 2011 with the aim of motivating and encouraging the staff. In 2011, only 3 MOH areas had a coverage of over 50% for the 35-year cohort of women where as by 2015 there were 147 MOH areas with a 50 % coverage. Districts of Ampara, Kegalle, Matale, Monaragala, Colombo, Hambanthota, Polonnaruwa and Kalutara had an overall coverage of over 50%.

Table 8.1: Number of first visits to WWCs from 2011 to 2015 (by age groups)

Indicator	2011	2012	2013	2014	2015
Under 35 Years	14402	10884	8585	8585	15066
35 Years	55413	62833	73359	74871	94089
35 Years +	70841	61872	60054	55620	52675
Total	140656	135589	141998	139006	161830

Full time cytoscreeners were appointed to hospitals following a 14-day training at FHB and at the end of year 2015, twenty five full time cytoscreeners were engaged in screening pap smears. In 2015, cyto screeners in 32 hospital laboratories screened a total of 188,673 pap smears (Annex...) In addition, Family Health Bureau procured and supplied medical equipment (such as microscopes), surgical items (such as vaginal speculums), consumables for fixing and staining pap smears (e.g. Alcohol, Xylene, DPX mountant, EA 50, Orange G etc) and all stationary required for the WWC programme, to hospital labs and MOH offices. In 2016, Family Health Bureau will use a dedicated software programme to streamline the logistics and supply chain management of all WWC items.

Figure 8.1 shows the percentages of women who are subjected to different types of examinations when they attended WWCs.

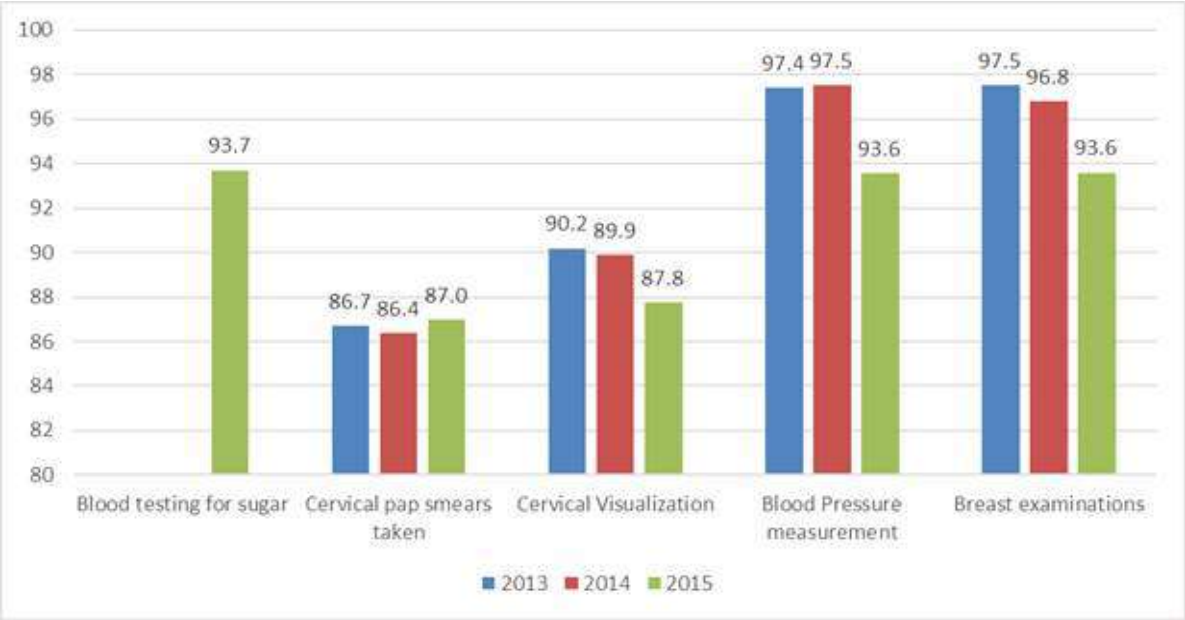


Figure 8.1: Percentage of women screened for different non-communicable diseases at WWC in 2015

In 2015, More than 93% of women attending WWCs were screened for Hypertension and breast problems. Only 87.8% women had their cervixes examined visually and 87% % had Pap smears taken. Blood sugar testing was introduced in 2015 instaed of the urine sugar analysis done in previous years. Blood sugar testing has been carried out in 93% of attendees and among them 1.6% were iden

tied having diabetes mellitus. Hypertension was found among 3.4% of women.

8.2 GENDER BASED VIOLENCE

The distinct roles and behaviours of men and women in a given culture, dictated by that culture's gender norms and values, give rise to gender differences. Not all such differences between men and women imply inequity, however some give rise to gender inequalities.

Yet, gender norms and values are not fixed. They evolve over time, vary substantially from place to place, and are subjected to change. Thus, the poor health consequences resulting from gender differences and gender inequalities can be changed. The knowledge regarding the presence of gender differences and inequalities, effect of those on individuals' health status and, strategies to minimize

gender inequalities through healthcare settings among healthcare professionals is important to change the prevailing norms and values.

Gender-based Violence is the major negative consequence of gender inequality which results in great negative health impacts.

Gender Based Violence (GBV) is recognized as a major health issue with a wide range of consequences to the survivors creating a negative impact on children, and acting as an inhibiting factor towards the family wellbeing. The World Health Organization in a world report in 2004 has stated that GBV is a major cause of disability and death among women, and that every one-in-third woman all over the world suffers from intimate partner violence. Although this is a common problem, it is also considered a hidden problem as most of the women do not reveal about their sufferings due to reasons such as culture, fear of reprisal, and concern over children, shame and internalizing the violence. It is also an ever increasing burden to the health care services of the country. In addition, the social and economic burden to the country at national level due to Domestic Violence/GBV is tremendous and it is currently estimated to be more than that due to malignancies.

Gender Based Violence during pregnancy which is a common occurrence leads to many negative pregnancy outcomes including miscarriages, still births and maternal deaths. Also, GBV in one generation can influence the behaviour of the next generation by a process of learned behaviour. When children are exposed to violence between their parents, boys learn violence as a mean of achieving control and eventually have a greater chance of being a perpetrator. On the other hand girls learn to accept violence as an inevitable helplessness and have a higher chance of being survivors in adult life.

It is also well recognized that women who present themselves to formal service delivery points such as health institutions or police posts are the minority, while many more suffer in silence and do not seek assistance due to the stigma and other social constraints related to Gender.

Health system and its providers are strategically placed and are very likely to come across these survivors and have a unique

opportunity to provide solace and assistance to them because :

- Women are more likely to visit the health facilities more often than men for other RH service needs, such as maternity care, contraceptive services or immunization services.
- Health care providers are more likely to be entrusted with confidential and sensitive information.
- They are more likely to recognize some injuries ,occult and hidden instances of abuse even when it is not declared by the survivor.
- Health facilities are spread cross cutting geographical and all social boundaries which links up to a wide network of service points

Therefore, health sector response within a country is often the initial, and a crucial response from governments. As such, all countries in the region, including Sri Lanka, have addressed this issue through the health sector to a varying extent.

The health sector in Sri Lanka has responded favourably by addressing GBV in the areas of prevention as well as in the response to the survivors, in an effective manner, cross cutting the health sector. Gender and Women's Health Unit of the Family Health Bureau (FHB) is the nodal agency at national level responsible for addressing GBV in health sector. The programmes implemented by Family Health Bureau include programmes which focus mainly on prevention of GBV, programmes concentrating on prevention and response to survivors of GBV and programmes centered mainly on provision of care for survivors of GBV.

The package for newly married couples is a newly added such programme, which focuses mainly on prevention. One main component of this package is sensitization of the new couples

Table 8.2: Clinic attendance and morbidities detected at Well Woman Clinics from 2011 to 2015

Activity	2011	2012	2013	2014	2015
First time attendees					
Under 35 years	10.2	8.0	6.0	6.1	9.3
35 years	39.4	46.3	51.7	53.9	58.1
Above 35 years	50.4	45.6	42.3	40.0	32.5
Number of 35 year cohort attending WWC clinics	55,413	62,833	73,359	74,871	94,089
Coverage of 35 year cohort attending WWC	25.5	28.9	33.9	34.6	45.1
Cervical smears reported as high and low grade lesions	0.25	0.2	0.25	0.2	0.3
Cervical smears reported as malignant (Carcinoma)	0.04	0.02	0.04	0.03	0.02
Cervical smears reported HPV	0.2	0.1	0.1	0.2	0.2
Breast abnormalities detected	1.5	1.4	1.8	1.5	1.5
Diabetes Mellitus detected	1.8	2.0	2.0	1.8	1.6
Hypertension detected	4.0	3.7	4.1	3.6	3.4

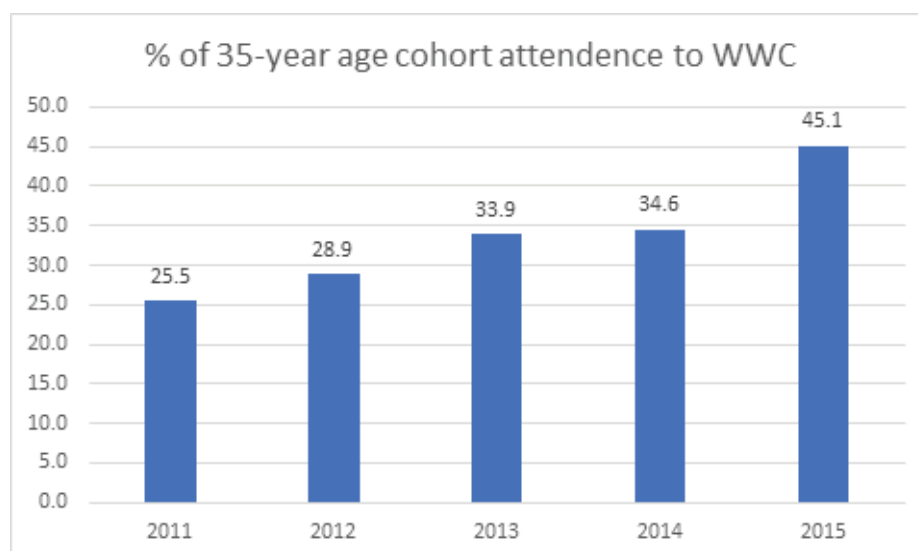


Figure 8.2: Percentage coverage of women in 35 years cohort attending WWC clinics from 2011 to 2015.

on some important topics which would enable them to have a good marital life. This sensitization would empower the couple to improve their marital relationship without violence which would improve the health and wellbeing of the couple and the family.

Capacity building of curative and preventive health staff is also done at basic, in-service and post graduate level on GBV. Inclusion of a module on GBV in the curriculum of Medical Undergraduates on the responsibilities of a Medical Officer in responding to Gender

Based Violence is one such programme done in 2015.

Setting up of Gender Based Violence Care Centres named “Mithuru Piyasa” at hospitals, which are dedicated to provide emotional and medical support to survivors of Gender Based Violence is designed to respond to survivors of GBV. They are operated by the hospital staff working in the out patient’s department. The staff at Mithuru Piyasa are given a training conducted by FHB .

Table 8.3: Services provided by Mithuru Piyasa centres in 2015

YEAR AND [No. OF CENTRES]	No. of centers	TOTAL NUMBER OF NEW SURVIVORS SEEKING CARE OVER THE YEAR 2015	TOTAL NUMBER OF SUBSEQUENT CONSULTATION HELD WITH THE SURVIVORS	TOTAL NUMBER OF CONSULTATION HELD WITH THE FAMILY MEMBERS OF SURVIVORS	TOTAL NUMBER OF CONSULTATION HELD WITH THE PERPETRATORS	TOTAL NUMBER OF CONSULTATIONS OF 2015
2011	06	447	230	232	101	1010
2012	08	870	355	432	249	1906
2013	16	1722	726	827	471	3746
2014	20	2949	1360	1309	717	6335
2015	30	4670	2683	2135	1261	10749

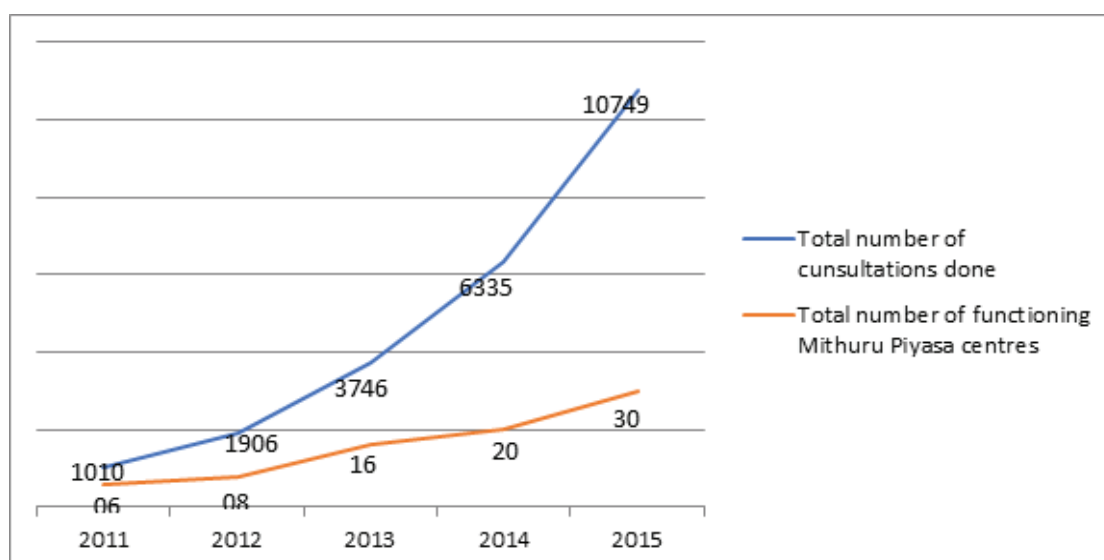


Figure 8.3: Number of functioning Mithuru Piyasa Centers & consultations

8.3 SOME OF THE SPECIAL PROGRAMMES CONDUCTED IN 2015 RELEVANT TO GENDER AND WOMENS' HEALTH

In 2015, the following activities were done by FHB to strengthen the Well Women Clinic programme.

In the view of improving the quality of cervical cancer screening programme, which is a vital component of Well Women Clinic programme a refresher training for cytoscreeners was conducted. This training was conducted in order to ensure a high quality and efficient service render by cytoscreeners while expanding the service of pap smear screening in the country. The training was conducted by Family Health Bureau in collaboration with Sri Lanka College of Pathologists. The cytoscreeners were trained according to the latest techniques which are in practice in developed countries.



Four community awareness programmes were conducted in the districts of Gampaha, Puttalam, Galle and Hambanthota targeting the community leaders of the districts. The main aims of the activities were to ensure the sustainability of the Well Women Clinic



programme through improving the coverage of the target population.

A national review on cytoscreening was conducted by the Family Health Bureau. The meeting was chaired by the Director General of Health Services. Consultant Pathologists, Cheaf Medical Laboratory Technologists and Cytoscreeners from different institutions of the country participated in the review programme. The final goal was to improve the quality of the programme on cervical cancer screening , which is a vital component of the well women clinic programme.



The fifth annual awards ceremony on best performance in WWC programme was held, in order to motivate and encourage all the categories of staff in both, public health and laboratory services who are the share-holders of the success achievements of the Well Women Clinic programme of 2014. The districts of Ampara (78.5%), Kegalle(74.6%) and Matale(63.9%) won the first, second and third places for the highest coverage of 35 year



cohort attendance to WWC services. Lahugala (90.4%), Naula (87.6%), Biyagama (87.1%), Rambukkana (86.9%), Kareithivu (79.2%), Deraniyagala (79.1%), Uhana (79.1%), Dehiowita (78.7%), Hingurakgoda (78.5%), Ampara (78.5%) and Pallepola (78.5%) MOH areas were awarded a place from first to tenth for the highest coverage of attendance of 35 year cohort of women for WWC services.

8.4 ACTIVITIES CARRIED OUT IN 2015 TO IMPROVE HEALTH SECTOR RESPONSE TO GBV

In 2015, the following activities were done by FHB to strengthen the health sector response to Gender Based Violence.

1. Prior to establishment of Mithuru Piyasa centres in the hospitals, the staff members of the the hospitals were trained for 04 days on prevention and management of GBV and Mithuru Piyasa. During the year 2015, 04 extensive and comprehensive training programmes were conducted covering 14 hospitals in the country.

- i. BH-Homagama, BH-Kiribathgoda, DH-Neboda, GH-Sri J'pura, BH-Meerigama
- ii. DGH-Hambanthota, DGH-Monaragala, BH-Tissamaharama
- iii. Army Hospital- Narahenpita, Maternity Home-New Bazar, DH-Thalangama
- iv. PGH-Rathnapura, BH-Embilipitiya, BH-Balangod



2. In order to strengthen the health sector response to GBV in Sri Lanka, 07 "Mithuru Piyasa/ Natpu Nilayam" centres were launched in Provincial General Hospital-Rathnapura, Maternity Home-New Bazar, Base Hospital- Balangoda, Base Hospital-Embilipitiya, District General Hospital-Hambanthota, Base Hospital-Tissamaharama & in Teaching Hospital-Kegalle.



3. Two experience sharing workshops were conducted for the staff of "Mithuru Piyasa/ Natpu Nilayam" covering all the centres in the country.

- Workshop in Colombo – Centers in Western, Uva, Sabaragamuwa, Eastern, Northern & Southern Provinces
- Workshop in Kandy – Centers in Central, North Central, & North Western

The main aim was to share and learn from the experiences of different "Mithuru Piyasa/ Natpu Nilayam" centres in the country and to give an opportunity to

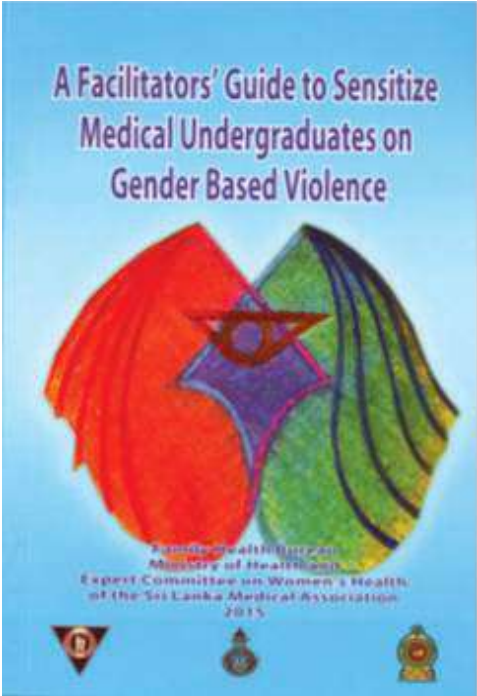
members of the staff of the centres to establish the networking and linkage with each other with the final goal of strengthening the health sector response to GBV in Sri Lanka.



4. Refresher trainings for the staff of “Mithuru Piyasa/ Natpu Nilayam” were conducted. Covering all the centres in the country 04 training were held in Colombo, Kandy, Batticaloa and Anuradhapura. The expected outcome was to prevent and manage GBV in Sri Lanka in an efficient manner through effective implementation of the guideline on “Mithuru Piyasa/ Natpu Nilayam” and through capacity building of the staff involved in the service provision.



5. “A Facilitators’ Guide to Sensitize Medical Undergraduates on Gender Based Violence” was published. Capacity building of medical undergraduates on the responsibilities of a medical professional in responding to GBV is considered as vital in order to strengthen the health sector response to GBV. This guide was developed by the Family Health Bureau in collaboration with the Expert Committee on Women’s Health of the Sri Lanka Medical Association.



6. The documentary on GBV- “Samanala Palama” was launched. This documentary was produced with the aim of raising the community awareness and as a material to be used in advocacy and sensitization programmes on gender, GBV and on health sector response to GBV.



CHAPTER 09

ORAL HEALTH SERVICES

The administration of the entire oral health care delivery system of the Ministry of Health of Sri Lanka was brought under the authority of the Deputy Director General Dental Services (DDG / DS) from 2002.

Oral Health Services are provided to the public by both Government & private sector. However, nearly 60-65% of services are provided by the government sector in both urban & rural set ups. Moreover majority of the dental surgeons who work in the government sector are involved in part time private practice. Nearly 2% of the oral health services provided through Universities, tri forces, police and nongovernmental organization to their employees and families.

Oral health services in public sector provided by the government services are mainly consist of two components.

Curative care services – provided through the clinics located in peripheral units, district hospitals, base hospitals, district general hospitals and teaching hospitals.

Preventive care services – provided through School Dental Clinics (SDC), Adolescent Dental Clinics(ADC) and Community Dental Clinics (CDC).

Family health Programme is a collection of packages and interventions to promote the health of the families with special emphasis on mothers and children. Oral Health Unit (OHU) of the Family Health Bureau is responsible for provision of essential oral health care services through existing maternal and child health programme. This mainly includes School Dental program and special community oral health care programmes.

The outline of the activities carried out by the Family Health Bureau during the year 2015 are as follows;

9.1 School Dental Service/ Community Dental Services

Oral health care for school children is provided by School Dental Therapists (SDT) working in School Dental Clinics (SDC) and dental surgeons working in the Adolescent Dental Clinics (ADC) with a discernible preventive component.

School Dental Clinics (SDC) are located in school premises providing oral health care to children between 3-13 years. Their target group includes students of grades 1, 4 & 7 and, in schools with more than 200 students in the base school, all children below the age of 13 years with less than 200 students at the base school and 500 preschool children. During the year 2015, there were 488 SDC manned by 383 SDTs. Twenty nine School Dental Therapist were recruited during the year 2015 to the government sector.

Sixty two ADC's which are located in school premises were manned by Dental Surgeons catering to the children above 13 years of age and special groups. Community Dental Clinics (CDC) are located in highly populated metropolitan areas and dental surgeons working in these clinics focusing on preventive care to specialized groups like pregnant mothers and children below 3 years of age. Any data on ADC?

Stated below is the summary of annual statistics of School Dental Services submitted by SDTT for the year 2015.

9.1.1 Work performances of the School Dental Service – 2015

All the School Dental Therapists around the country collectively have screened 75% of the total target group in 78% of the schools. Among screened 66% was identified as healthy or had completed their treatments. However out of screened population 44% are awaiting treatments which need to be addressed.

Though 29 new appointments of School Dental Therapists were given in 2015 there are still around 50 vacancies which needs to be filled as early as possible. Though the norm for SDT population ratio is 1:2000 currently it is 1:3025 which is approximately 1.5 times. Hence this coverage was achieved totally due to the high commitment of SDTs.

deficiencies at the ultimate level of service provision.

Oral health unit of the family Health Bureau with the support and coordination of Deputy Director General Dental Services was able to secure Rs. 250 million to renovate and built new school dental clinics from the national

Table 9.1: Performance of school dental therapists

Year	No. of SDT	No. of students per SDT	% of schools screened	% of caries				% of calculus			% of children screened ²	Coverage percentage ³
				Gr 1	Gr4	Gr4 ¹	Gr7 ¹	Gr1	Gr4	Gr7		
2014	379	3733	76%	58%	57%	7%	18%	2%	12%	19%	78%	69%
2015	383	3035	72%	54%	55%	9%	19%	2%	13%	18%	75%	66%

1Permanent teeth

2 Percentage of children screened out of the target group

3 Percentage of children who are healthy & whose treatment has been completed out of the screened group

The 382 SDTs in the country had screened 75% of the total children in the target group & out of the screened 66% of children were identified as healthy or their dental diseases were successfully treated by SDT.

Therefore the unmet need in terms of screening and awaiting treatment after screening is nearly 44%.

9.2 SOME OF OTHER SPECIAL ACTIVITIES RELATED TO OREL HEALTH.

A Special oral health education programme was organized for public Health staff namely Medical Officers of Health, Public Health Nursing Sisters and Supervising Public Health Midwives at District level. This was successfully conducted in 18 Districts with over 95% attendance.

OHU carried out central level supervision by visiting 70 School Dental Clinics all over the country with the Consultant of the unit and by three dental Surgeons attached to the unit. This covered 14 Districts of the country. This was done mainly to encourage the School Dental Therapists and to identify the

budget presented in the parliament for 2 016.

In 2015 OHU purchased 37 School Dental Chairs and 33 micro-motors and were distributed to School Dental clinics throughout the country.

9.2.1 Special Community Oral Health Care Programmes conducted by dental surgeons attached to ADC/CDC

There are four main ongoing special community oral health programmes conducting successfully Island wide.

They are oral health care services to pregnant mothers, early childhood caries prevention programme/ Fluoride Varnish programme, Save Molar programme and Oral Potentially Malignant disorder (OPMD) and Oral Cancer Prevention and Early Detection programme.

Oral health care programme for pregnant mothers is geared to provide comprehensive oral health care to pregnant mothers in order to improve the oral health by reducing the complications of dental decay during pregnancy and prevent worsening of the existing oral

disease. This will result in reducing the risk of transmission of caries causative bacteria to the new born and thereby reducing the possibilities of adverse pregnancy outcomes.

Identifying Oral diseases at early stages enables curing them with simple interventions. Primary health care providers are advised to examine the children's teeth at the age of 12 & 18 month & requested to refer them for dental advice and treatment if they detected any abnormalities during the screening. Ministry of health decided to introduce Fluoride varnish in to ADC, CDC and to the dental surgeons attached to the MOH offices in Sri Lanka in order to prevent and control the developing dental caries among young children.

Ministry of health started the Save Molar programme in the year 2013 to strengthen the primary oral health care services in Sri Lanka. The school children are screened and the high risk children were identified to seal the molar teeth with a sealant material which will protect the occlusal surfaces for carious attack.

Ministry of health with the collaboration of National Cancer Control Programme has commenced early detection and prevention of OPMD and Oral Cancer to strengthen the primary oral health care in Sri Lanka. In this programme high risk groups for OPMD are identified by applying the risk factor model. This strategy used for screening for OPMD and referring all those people who score more than 12 in the risk factor model, to a dental surgeon at the nearest hospital.

CHAPTER 10

MONITORING, SUPERVISION AND RESEARCH

10.1 MONITORING AND SUPERVISIONS

Monitoring is a routine process of data collection and measurement of progress towards programme objectives. Monitoring of overall RMNCAYH programme is vital as to understand clearly about the national programme progress, whether the resources are used appropriately, activities are happening as per plan, achieving the set objectives and factors contributing for good performers or not so good performances. It also helps to identify how we could make the programme more efficient and effective.

In programme monitoring, data is collected on regular basis or in periodic basis to measure performance indicators. MCH data, school health data and FP new acceptor data is collected by FHB quarterly from all MOH offices in order to monitor the national programme.

In 2015, H 509 has been received from all MOH areas in the country. School Health Returns have been received from 99% of MOH areas in first quarter, 98% in second quarter, 94% in third quarter and 95% in fourth quarter.

Family planning new acceptor data has been received 39.6% in first quarter, 74.6% in second quarter, 81.1% in third quarter and 74% in fourth quarter (Figure 10.1).

Each return is scrutinized for completeness and accuracy of data at Monitoring and Evaluation Unit at the FHB. Discrepancies are verified by contacting the MOHs over the phone and in some cases the returns were sent back to the respective MOHs to revise and resubmit. At FHB, these returns are entered into Epi data based data entry format. The analysis is carried out using SPSS version 21 software. Data entry validation is done by re-entering 5% of the returns.

Quarterly feed backs were sent to all RDHS on timeliness and completeness of returns received. However, completeness and timeliness of returns received by the FHB has to be closely followed up and need improvement from next year. In order to do so, totally paper based RHMIS information system should be digitalized. This was discussed and will be initiating to develop a web based system from 2016.

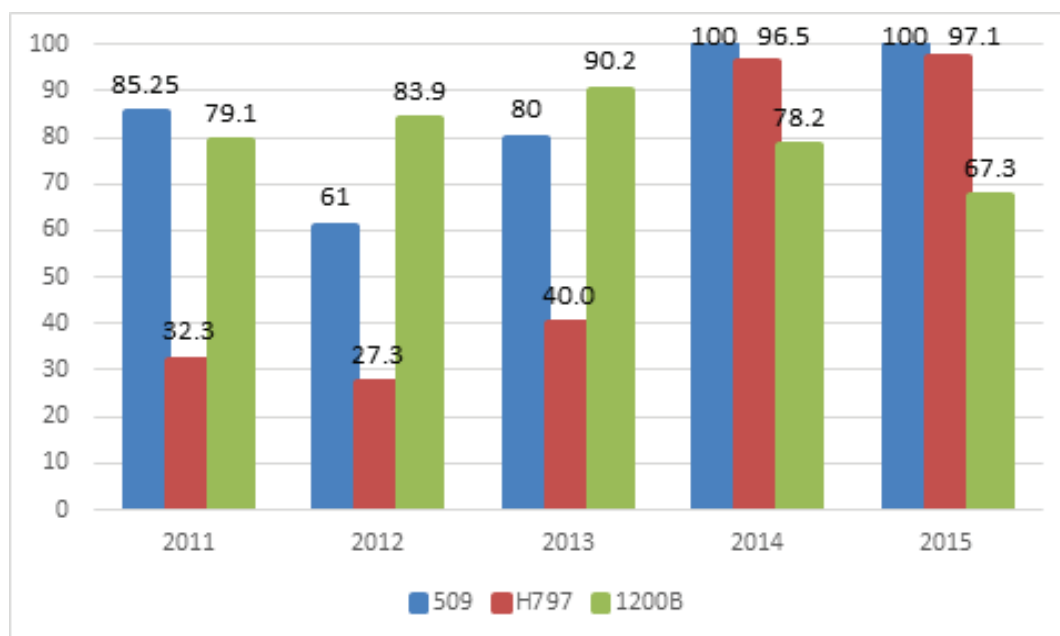


Figure 10.1: Status of Returns received from 2011 to 2015

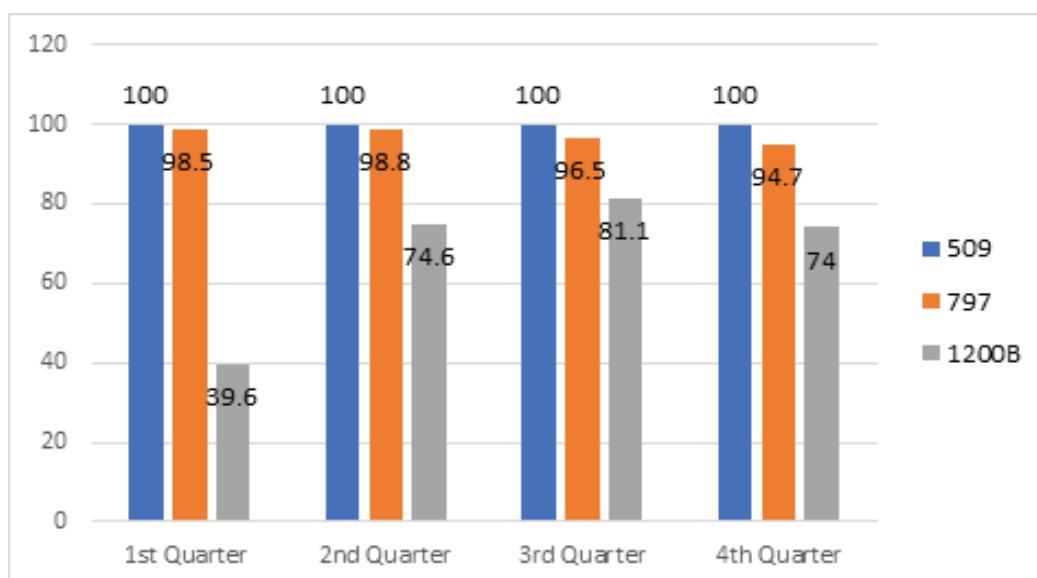


Figure 10.2: Status of the Returns received in 2015

Quarterly feed backs were sent to all RDHS on meliness and completeness of returns received. However, completeness and meliness of returns received by the FHB has to be closely followed up and need improvement from next year. In order to do so, totally paper based RHMIS information system should be digitalized. This was discussed and will be initiating to develop a web based system from 2016.

10.1.1 National MCH Reviews

RMNCAYHP is reviewed periodically at national and district levels to identify and improve the deficiencies and to assess whether the program is producing the results as prioritized in the strategic and operational plans. Family Health Bureau conducted national MCH reviews in all twenty-six districts in 2015. Each district was visited by a team led by a Consultant Community Physician.

10.1.2 Annual MOMCH reviews

Bi annual MOMCH reviews were conducted in 2015 in Badulla and Colombo. Field supervisions were carried out in Districts of Badulla covering all MOH areas following the MOMCH review with the participation of all MOMCHs and Provincial Consultant Community Physicians. All MOH offices were supervised and it was highlighted that the maternal, intranatal

and child care provisions were satisfactory while the school health, adolescent health and family planning services needed improvement in the district.



10.1.3 RSPHNO workshop

Three-day workshop for the Regional Supervising Public Health Nursing Officers (RSPHNOs) was conducted in Rathnapura followed by a field supervision covering all MOH areas in the district.

10.1.4 Annual Nutrition Review

Annual Nutrition Review was conducted in December 2015 to review nutritional indicators in all districts. MOMCHs presented their district nutrition data on maternal, under five, adolescent, school children and activities carried out during nutrition month of 2015.

10.1.5 Survey Statistical Officers (SSO) workshop

Three-day workshop was conducted for the Survey Statistical Officers (SSO) attached to the RDHS offices in order to improve the quality of RMNCAH data reported from the districts.

10.1.6 Supervisions

Supervision from each supervising categories of public health staff was monitored by the Family Health Bureau using the information received from the format C on supervisions. Format C have been received from 275 MOH offices out of all 338 MOH offices in 2015. As reported in H 509, there were 626 MOOH/A-MOOH serving in the field. According to the return on supervision, they have done a total of 22,460 supervisions of expected 45,072 supervisions to be done annually. Therefore, out of expected supervisions, only 49.8% have been covered by the MOOH/AMOOH. However, reports have been submitted only for 4021 supervisions giving only 8.9% of completed supervisions.

Number of supervision to be done by 232 PHNSS were 16,704 for the year. Only 11,968 have been carried out during the year giving rise to a percentage of 71.6%. Reports have been submitted for only 9493 with a percentage of 56.8% of completed supervisions.

Number of supervisions to be carried out by 342 SPHMM were 41,040 of which only 21,815 were reported to be carried out. This gives rise to a percentage of 53.1%. Reports have been submitted for only 16,196 with a 39.5% of completed supervisions.

MOMCHs are expected to send their monthly MOMCH returns to FHB. During 2015, FHB has received 215/360 (59.7%) number of returns from MOOMCH. (give trends from 2011- 2015. Please name the good Districts and also over all summary of performance.

The field visits revealed that the reports submitted were far less than the supervisions reported in the format C. Overall, supervisions are inadequate and need close monitoring at Divisional level, District level, Provincial level and at National level.

10.2 RESEARCH

Family Health Bureau has also conducted several operational researches in 2015, which included a study to assess the adherence to the implementation of the revised maternal care package and a rapid assessment on school health activities to evaluate the coverage of new interventions such as weekly iron folate supplementation and evaluation of school health activities through the education sector.

10.2.1 Adherence to the implementation of revised maternal care package on service delivery

This study was conducted as an operational research to assess the level of adherence to the revised package in two components.

Component one was conducted at specialist obstetric units in the hospitals and it was among antenatal mothers who were admitted to the ward after 36 weeks of POA. Second component was conducted among post-natal mothers and their husbands 2 months after child birth. Following key findings were observed.

Registration of the pregnancy with the field health services was 92.4% among the pregnant mothers. The average number of clinic visits was 10.7. The average number of home visits by public health midwife per mother was 3.1 while 13.3% had not received even a single home visit. The registration and clinic attendance before 8 weeks of gestation was 47.7% and 35.1% respectively. Majority of the mothers (92.1%) reported that the booking visit was to a field clinic or primary care hospital while 3.7% reported attending to a private clinic before reaching the government health care.

Pre-pregnancy folic acid was reported by 61.5% while 92.8% and 90.3% of mothers reported taking iron and calcium tablets during the previous one week.

With regard to record keeping in the pregnancy record, correct management of blood pressure chart and fundal height chart was observed only in 73.7% and 37.4% of pregnancy records respectively. Among the participants 89.7% and 88.0% had at least a single measure of blood sugar and haemoglobin respectively. Ultra sound scan before 20 weeks of gestation was done among 87.5% of mothers. However, breast examination was done only in 52.3% of mothers.

Initiation of breast feeding within first 1 hour was 90.2%. Neonatal examination was performed among 98.8% of babies before the discharge. Coverage of two home visits during first ten days was 31.9%. Postnatal clinic visits were made by 83.9% of mothers and Postpartum Depression screening was performed among 36.2% mothers. Medical officer had examined only 59.1% of mothers after the hospital discharge. There was a significant gap in the document maintenance during the postpartum care .

It was noted that Antenatal sessions and level of knowledge on maternal care among mothers and fathers were low.

10.2.2 Rapid assessment on school health activities

Rapid assessment for school health activities was performed to evaluate the coverage of new interventions for the school health program such as weekly iron folate therapy and as a self-evaluation of school health activities from the education sector using a postal questionnaire.

This study was done in 1363 government schools. Response rate wasThe key findings include;

Health promotion committees were established only in 87.8% of which 83% had completed the self – assessment. A canteen was available in 57.5%. The Public Health Inspector(PHI) had supervised the preparation of mid-day meals in 93.6% of schools. Health Survey was conducted in 91.6% and the report was received by 60.8%. School Medical Inspection completed in 92.2%. Water quality surveillance completed in 46.8%. The WIFS initiated in 94.6% of which 90.4% conducted for 2015.

10.2.3 Training on basic research training for field level health care workers:

Health workers including MOH, PHNS and PHM were trained on conducting basic research methodology in six districts. Further training programs will be conducted in 2016 to improve the island wide coverage.

10.2.3 Training on basic research training for field level health care workers:

- Compliance to therapeutic feeding and the level of service delivery for children with severe acute malnutrition will be studied in 2016.
- Operational research on child care program will also be conducted in 2016.
- The final reports of the study on multiple micronutrients, adherence to implementation of revised maternal care package and rapid assessment of school health activities will be published in 2016.

ANNEXURE

Annexure 1 : Details of government budget allocation and expenditure for 2015 is given below: 11.69 8.27

Recurrent Expenditure						
Code	Details	Allocations 2015	Revised Allocations 2015	Total Expenditure	Balance / Excess	%
1001	Salaries and Wages	41,000,000.00	41,000,000.00	43,417,693.90	(2,417,693.90)	106
1002	Overtime	12,000,000.00	12,000,000.00	21,086,273.75	(9,086,273.75)	176
1003	Other Allowances	40,000,000.00	40,000,000.00	68,918,773.26	(28,918,773.26)	172
1101	Travelling Expenses- Local	1,200,000.00	1,200,000.00	1,188,098.00	11,902.00	99
1201	Stationery & office requisites	900,000.00	900,000.00	803,242.55	96,757.45	89
1202	Fuel	3,000,000.00	3,000,000.00	2,089,283.00	910,717.00	70
1203	Diets & Uniforms	150,000.00	150,000.00	1,791.00	148,209.00	1
1204	Medical Supplies	680,000,000.00	680,000,000.00	38,120,575.00	641,879,425.00	6
1205	Other	300,000.00	300,000.00	94,516.30	205,483.70	32
1301	Vehicles	2,500,000.00	2,500,000.00	3,455,217.89	(955,217.89)	138
1302	Plant, Machinery & Equipment	900,000.00	900,000.00	1,242,157.93	(342,157.93)	138
1303	Buildings & Structures	1,000,000.00	1,000,000.00	466,027.86	533,972.14	47
1402	Postal & Communication	1,800,000.00	1,800,000.00	1,077,289.49	722,710.51	60
1403	Electricity & Water	16,000,000.00	16,000,000.00	11,717,776.97	4,282,223.03	73
1404	Rents & Local Taxes	1,000,000.00	1,000,000.00	993,446.72	6,553.28	99
1405	Other	50,000,000.00	50,000,000.00	43,913,537.59	6,086,462.41	88
1506	Property Loan Interest to P.S.	1,300,000.00	1,300,000.00	1,330,500.34	(30,500.34)	102
	Total	853,050,000.00	853,050,000.00	239,916,201.55		

Annexure 2 : Details of government budget allocation and expenditure for 2015 is given below: 11.69 8.27

Capital Expenditure						
Code	Details	Allocations 2015	Revised Allocations 2015	Total Expenditure	Balance / Excess	%
111-02-14-29-2502-01(12) World Bank	Development of Facilities	40,000,000.00	40,000,000.00	17,890,851.15	22,109,148.85	45
111-02-14-30-2502(13) UNFPA	Planned Activities	23,800,000.00	23,800,000.00	2,992,268.25	20,807,731.75	13
111-02-14-31-2502(13) UNCEF	Planned Activities	12,550,000.00	12,550,000.00	2,800,280.06	9,749,719.94	22
111-02-14-32-2502(13) WHO	Planned Activities	16,000,000.00	16,000,000.00	7,835,757.90	8,164,242.10	49
111-02-14-33-2502(13) SAARC	Activities	10,000,000.00	10,000,000.00	-	10,000,000.00	0
111-02-14-26-2502(13) UNFPA	Reproductive Health Programme	176,000,000.00	176,000,000.00	-	176,000,000.00	0
111-02-16-3-2502(11)	Nutrition Unit	10,000,000.00	10,000,000.00	5,872,765.76	4,127,234.24	59
111-02-16-4-2502(11)	Nutrition Unit	20,000,000.00	20,000,000.00	14,222,724.25	5,777,275.75	71
111-02-14-4-2103(13)	Machinery and spare parts	20,000,000.00	20,000,000.00	7,439,092.33	12,560,907.67	37
111-02-13-11-2103	Machinery and spare parts	10,000,000.00	10,000,000.00	10,000,000.00	-	100
111-02-14-4-2401(11)	Training of Staff	10,500,000.00	10,500,000.00	9,145,564.75	1,354,435.25	87
111-02-14-15-2401(11)	Training of Staff		-	-	-	
111-02-14-15-2502(11)	School Health Programme	15,000,000.00	15,000,000.00	8,683,367.87	6,316,632.13	58
111-02-14-19-2502(11)	activity planning for children	25,000,000.00	25,000,000.00	14,801,582.91	10,198,417.09	59
111-02-13-70-2103	Supply of Equipment	20,000,000.00	20,000,000.00	11,235,883.88	8,764,116.12	56
Total			408,850,000.00	112,920,139.11		

Annexure 3 : Details of government budget allocation and expenditure for 2015 is given below: 11.69 8.27

	MOH AP	MOH AV	SPHI AP	SPHI AV	SPHM AP	SPHM AV	SDT AP	SDT AV	AMOH AP	AMOH AV	PHNS AP	PHNS AV	PHI AP	PHI AV	PHM AP	PHM AV
COLOMBO	14	13	14	9	22	15	45	35	25	45	37	15	98	90	379	357
COLOMBO MC	12	10	6	6	12	4	0	0				5		36	160	101
GAMPAHA	15	15	15	11	31	15	43	32	43	44	57	23	122	82	548	494
KALUTARA	11	11	10	6	15	11	26	20	19	18	24	16	69	43	337	319
NIHS	2	2	2	1	6	3	9	7	11	11	18	8	19	14	86	74
KANDY	23	19	21	5	24	13	24	19	26	20	28	16	76	71	500	430
MATALE	13	8	10		11	7	15	9	11	10	13	11	39	31	171	158
NUWARA ELIYA	13	10	11	3	14	11	11	10	13	9	13	3	40	34	320	294
GALLE	20	19	20	10	21	15	30	21	20	18	20	15	98	69	355	317
MATARA	17	17	17	13	17	28	24	20	17	19	16	12	70	50	289	267
HAMBANTOTA	12	10	12	11	13	17	17	14	12	8	12	10	51	34	233	206
JAFFNA	12	12	12	12	14	12	11	8	8	2	11		74	53	215	135
KILLINOCHCHI	5	4	4	3	4	5	3	1	1	1	3	0	13	8	53	41
MANNAR	5	5	4	3	6	5	2	1	1	1	4	1	17	15	58	54
VAVUNIYA	4	4	4	13	3	4	7	4	1	2	4		17	12	67	63
MULLAITIVU	5	4	5	4	5	3	3	1	5	2	4	0	18	15	65	40
BATTICALOA	13	14	13	14	14	15	6	3	7	1	15	14	54	52	160	157
AMPARA	7	7	7	6	11	14	7	3	6	3	7	0	30	26	109	106
KALMUNAI	12	13	13	12	14	12	6	4	8	1	12	6	48	42	146	142
TRINCOMALLEE	12	9	11	7	12	11	9	2	10	3	11	0	44	35	145	145
KURUNEGALA	35	27	27	21	32	23	39	31	28	23	35	22	99	94	448	397
PUTTALAM	12	12	11	7	13	12	14	12	12	13	13	5	48	43	173	189
ANURADHAPURA	19	18	21	14	21	20	21	16	22	8	19	8	67	64	297	226
POLONNARUWA	7	7	7	5	10	8	11	11	10	6	9	4	36	26	137	121
BADULLA	15	16	14	9	15	12	18	19	14	9	16	13	58	52	329	307
MONARAGALA	10	10	12	7	15	12	10	11	10	4	12	11	38	30	195	182
RATNAPURA	16	15	18	15	22	22	22	18	17	16	19	9	84	80	336	341
KEGALLE	12	9	12	11	16	13	24	15	11	9	11	5	70	64	313	264
TOTAL	353	320	333	238	413	342	457	347	368	306	443	232	1497	1265	6624	5927

Annexure 4 : Population, birth rates, eligible families, pregnant mothers, reported number of deliveries and first antenatal clinic visits by health district 2015

RDHS/Health Area	Population	Birth Rate	Estimated eligible families	Eligible families registered by PHMs		Estimated Births	Estimated pregnancies (Births × 1.1)	Pregnant mothers registered by PHM (out of estimated)		Number of first antenatal clinic visits	Number of reported deliveries	Number of reported live births (Actual from RG)
				No.	%			No.	%			
Colombo	1792340	16.1	331583	284510	81.9	28857	33270	26366	79.2	24250	22265	
Colombo M.C	567272	16.1	104945	97693	95.5	9133	9798	8028	81.9	8728	6464	50894
Gampaha	2343587	14.6	433564	401049	88.7	34216	39270	37383	95.2	36232	31216	24271
Kalutara	949903	15.8	175732	164481	89.3	15008	17312	15510	89.6	14877	13481	
N.I.H.S	295126	15.8	54598	52464	89.1	4663	5532	5489	99.2	5498	4939	15289
Kandy	1409882	19.6	260828	246822	90.3	27634	31868	25540	80.1	24014	21850	28099
Matale	499265	19.4	92364	93403	98.5	9686	10934	9590	87.7	9170	8151	9342
NuwaraEliya	737011	20.5	136347	133468	85.8	15109	18956	13145	69.3	13874	11338	9090
Galle	1086176	17.1	200943	185780	89.8	18574	21038	18264	86.8	16782	16062	19220
Matara	833412	16.2	154181	185895	118.1	13501	15163	14514	95.7	13689	12313	11224
Hambantota	625405	20.7	115700	111746	90.9	12946	15128	12564	83.1	11581	10404	10750
Jaffna	597232	17.3	110488	92454	84.8	10332	11209	8834	78.8	7913	7409	7855
Kilinochchi	120276	25.5	22251	20414	86.8	3067	3564	1942	54.5	1740	1564	2026
Mannar	103169	19.5	19086	19074	75.6	2012	2926	2134	72.9	2067	1795	1677
Vavuniya	178314	20.3	32988	28148	82.1	3620	4140	2911	70.3	2688	2475	3690
Mullaitivu	93715	11.9	17337	19421	84.7	1115	1621	1861	114.8	1677	1626	1120
Batticaloa	538324	20.0	99590	97534	92.9	10766	12481	10340	82.8	9729	9022	9210
Ampara	258103	22.6	47749	51634	106.4	5833	6524	5236	80.3	4749	4506	13297
Kalmunai	416527	22.6	77057	76084	93.4	9414	10948	9462	86.4	9460	7937	
Trincomalee	394122	20.8	72913	73142	99.3	8198	9112	8822	96.8	8035	7331	7790
Kurunegala	1648014	17.0	304983	300821	93.3	28016	32589	29102	89.3	27024	25295	23231
Puttalam	786471	21.1	145497	149911	93.8	16595	20060	15953	79.5	14515	12425	13720
Anuradhapura	889435	19.3	164545	182786	102.7	17166	20417	17732	86.9	16745	15044	15376
Polonnaruwa	416416	18.6	77037	90622	108.8	7745	9209	8360	90.8	7869	6865	7038
Badulla	840387	18.7	155472	152462	90.9	15715	18658	15537	83.3	15100	13363	15076
Monaragala	469776	19.6	86909	93899	94.7	9208	11549	10355	89.7	9697	8686	7065
Ratnapura	1122778	18.5	207714	197719	88.9	20771	24456	18997	77.7	17760	16331	18866
Kegalle	856125	16.3	158383	136108	85.1	13955	15498	14433	93.1	13214	12539	9605
Sri Lanka	20868762	17.9	3860721	3739544	91.8	373551	433455	368404	85.0	348677	312696	334821

Annexure 5 : Population, birth rates, eligible families, pregnant mothers, reported number of deliveries and first antenatal clinic visits by health district 2015

RDHS/Health Area	% Pregnant mothers registered before 8 weeks	% Pregnant mothers registered 8-12 weeks	% Teenage pregnant mothers (less than 20 Yrs) registered	% of Primies registered	% Pregnant mothers P5 and above registered	% Registered pregnant mothers protected for Rubella	% of pregnant mothers with antenatal morbidities	Average antenatal home visits by PHM	Mothers protected with T.T. at delivery	Mothers tested for Grouping Rh at delivery	Mothers tested for VDRL at delivery
Colombo	71.0	18.3	3.8	39.8	1.4	98.5	34.3	3.4	99.4	99.6	99.2
Colombo M.C	49.1	30.6	7.0	35.7	3.8	88.5	26.8	2.7	100.0	100.0	102.5
Gampaha	75.2	15.9	4.3	36.3	1.6	98.8	28.3	3.7	99.4	99.7	98.6
Kalutara	76.0	17.0	4.4	33.8	2.1	98.6	30.8	3.9	98.8	98.7	96.7
N.I.H.S	81.7	12.5	5.4	32.0	2.9	99.1	20.6	3.3	98.6	98.7	98.6
Kandy	74.4	19.9	4.6	30.5	2.8	97.7	20.9	3.9	98.4	98.4	98.8
Matale	82.0	13.3	4.3	30.6	1.5	99.3	26.9	4.3	100.1	100.1	100.0
NuwaraEliya	62.4	27.0	5.4	32.3	2.1	97.4	13.6	5.5	99.3	98.1	96.2
Galle	78.8	15.7	5.9	32.9	2.1	97.3	22.3	3.7	99.2	99.2	101.2
Matara	84.1	12.8	4.9	31.9	2.2	98.3	26.2	4.1	98.8	98.9	99.9
Hambantota	86.1	11.3	4.9	28.6	2.5	98.8	22.7	4.0	98.9	98.9	99.2
Jaffna	85.8	9.7	3.3	37.0	1.9	99.2	44.1	8.5	100.1	100.3	100.3
Kilinochchi	75.6	18.3	6.4	34.0	3.1	93.8	36.9	6.3	99.7	99.8	99.8
Mannar	75.5	18.3	4.3	33.6	4.6	85.1	17.3	5.5	97.8	98.0	97.6
Vavuniva	68.4	19.3	5.9	32.3	3.7	88.3	19.6	4.7	99.9	99.8	99.6
Mullaitivu	69.4	20.0	7.4	30.1	4.8	93.9	37.3	5.8	99.0	98.8	99.9
Batticaloa	75.9	17.5	8.7	36.9	3.4	96.1	15.1	4.2	99.8	94.4	91.0
Ampara	82.0	14.4	5.2	29.8	1.6	94.7	29.2	3.4	100.2	100.2	100.1
Kalmunai	82.3	15.1	6.1	33.3	5.7	96.2	22.0	4.4	99.9	100.0	95.2
Trincomalee	67.7	24.0	9.0	32.2	5.5	95.2	24.2	4.0	99.2	99.2	99.2
Kurunegala	85.8	10.7	4.0	31.6	1.9	100.0	34.9	4.2	100.3	100.1	100.4
Puttalam	74.7	18.0	8.0	28.4	3.8	93.6	31.2	3.7	99.6	96.3	99.6
Anuradhapura	81.3	13.9	7.0	28.0	2.5	99.3	23.1	4.2	100.2	100.2	99.9
Polonnaruwa	82.1	13.1	4.3	28.4	1.8	99.0	38.1	4.4	99.8	99.6	100.2
Badulla	78.1	16.8	5.9	32.1	1.9	98.9	22.3	4.8	99.8	99.9	98.9
Monaragala	84.0	12.9	5.1	28.1	2.5	96.5	25.2	3.9	100.1	100.1	99.9
Ratnapura	74.8	19.0	5.1	32.8	1.6	97.0	27.1	4.0	98.3	97.6	96.7
Kegalle	78.9	15.8	4.5	31.8	2.2	98.0	31.0	4.3	96.6	97.2	94.8
Sri Lanka	77.1	16.5	5.2	32.7	2.4	97.6	27.0	4.2	99.3	99.0	98.7

Annexure 6 : Indicators of clinic care, ante-natal screening, status of BMI, and 2015

RDHS/ Health Area	% of registered mothers attending clinics at least once out of total pregnant	Average number of clinic visits by a mother out of 1 st visit	% of clinic attendees (ANC) screened for VDRL	% of mothers with reac- tive VDRL	% of clinic attendees (ANC) tested for blood grouping & Rh	% of mothers BMI measured	% of mothers with BMI less than 18.5	% of mothers with BMI more than 25
Colombo	92.0	5.2	35.0	0.4	12.8	79.7	17.4	26.9
Colombo M.C	108.7	5.3	45.6	1.2	53.2	77.2	14.9	33.8
Gampaha	96.9	5.8	34.2	0.1	9.9	82.0	17.0	24.6
Kalutara	95.9	5.8	42.0	0.1	31.4	84.8	19.3	23.3
N.I.H.S	100.2	5.6	37.0	0.1	14.9	84.3	16.3	28.9
Kandy	94.0	6.4	45.5	0.3	33.4	83.7	18.5	21.9
Matale	95.6	6.5	43.8	3.8	35.8	90.1	19.8	22.5
NuwaraEliya	105.5	6.5	30.4	0.1	24.8	75.3	22.5	15.7
Galle	91.9	6.5	19.9	0.3	7.1	85.2	22.5	18.0
Matara	94.3	6.7	33.1	0.0	32.3	86.9	24.1	16.8
Hambantota	92.2	6.2	38.6	0.3	34.4	86.5	24.8	15.8
Jaffna	89.6	7.7	14.5	1.8	16.3	87.6	17.6	21.3
Kilinochchi	89.6	6.1	21.5	0.2	23.0	87.6	26.0	15.1
Mannar	96.9	6.4	7.1	2.6	6.1	92.2	19.2	23.8
Vavuniya	92.3	9.5	0.2	0.0	0.4	77.4	21.5	20.9
Mullaitivu	90.1	7.0	42.8	0.1	75.5	85.3	22.2	16.2
Batticaloa	94.1	6.4	38.0	4.3	47.4	85.9	18.5	22.8
Ampara	90.7	6.6	7.1	0.9	11.8	84.8	24.3	17.6
Kalmunai	100.0	6.3	32.1	0.0	31.9	84.2	14.7	26.1
Trincomalee	91.1	7.3	28.3	0.0	44.0	80.6	17.7	27.0
Kurunegala	92.9	7.1	47.6	0.1	38.2	87.2	20.7	20.1
Puttalam	91.0	5.9	47.0	0.1	42.2	75.5	19.3	24.8
Anuradhapura	94.4	7.0	42.6	0.1	30.9	86.4	21.7	19.3
Polonnaruwa	94.1	6.9	49.8	0.3	39.6	86.6	22.8	22.3
Badulla	97.2	7.1	35.0	0.4	17.9	87.7	20.7	14.3
Monaragala	93.6	6.5	48.7	1.4	48.0	87.1	24.2	17.9
Ratnapura	93.5	6.9	49.9	0.1	47.6	82.5	24.8	15.6
Kegalle	91.6	6.2	37.3	0.4	30.3	84.3	21.0	21.0
Sri Lanka	94.6	6.4	37.5	0.5	28.8	83.8	20.2	21.3

Annexure 7 : Natal care 2015

RDHS/Health Area	% of institutional deliveries out of total reported deliveries	% of home deliveries out of total reported deliveries	% of untrained deliveries out of total reported deliveries	% LSCS out of total reported deliveries	% of deliveries reported out of total estimated pregnancies	% of deliveries reported out of total registered pregnancies
Colombo	100.0	0.02	0.02	40.3	70.9	84.4
Colombo M.C	99.9	0.06	0.03	29.2	64.6	80.5
Gampaha	100.0	0.01	0.01	40.1	86.2	83.5
Kalutara	100.0	0.03	0.02	39.0	82.6	86.9
N.I.H.S	100.0	0.00	0.00	42.1	97.0	90.0
Kandy	99.9	0.12	0.09	38.3	75.5	85.6
Matale	99.8	0.16	0.11	42.4	76.0	85.0
NuwaraEliya	99.5	0.49	0.32	25.5	71.3	86.3
Galle	100.0	0.04	0.03	32.8	78.3	87.9
Matara	100.0	0.03	0.02	36.8	82.6	84.8
Hambantota	100.0	0.03	0.02	36.7	74.1	82.8
Jaffna	99.9	0.08	0.05	33.5	65.0	83.9
Kilinochchi	99.7	0.32	0.25	12.5	46.9	80.5
Mannar	99.7	0.28	0.27	26.1	83.5	84.1
Vavuniya	99.6	0.40	0.41	31.0	61.1	85.0
Mullaitivu	99.8	0.18	0.19	15.8	130.9	87.4
Batticaloa	99.9	0.12	0.09	24.8	76.1	87.3
Ampara	99.9	0.07	0.04	28.1	70.2	86.1
Kalmunai	99.9	0.11	0.06	36.3	75.8	83.9
Trincomalee	99.9	0.14	0.08	24.7	83.5	83.1
Kurunegala	100.0	0.03	0.01	36.1	86.8	86.9
Puttalam	99.8	0.19	0.13	32.6	69.7	77.9
Anuradhapura	99.9	0.09	0.07	29.4	81.0	84.8
Polonnaruwa	99.9	0.10	0.09	32.8	82.1	82.1
Badulla	99.9	0.13	0.09	26.5	80.9	86.0
Monaragala	100.0	0.03	0.03	28.1	86.7	83.9
Ratnapura	99.9	0.08	0.05	33.8	71.7	86.0
Kegalle	99.9	0.07	0.03	41.1	87.5	86.9
Sri Lanka	99.9	0.09	0.06	34.5	77.8	84.9

Annexure 8 : Indicators of post natal care: post natal visits, Vitamin A supplementation, post natal complications by districts 2015

RDHS/Health Area	% of mothers receiving the 1st post natal visit within the 1st 10 days out of estimated births	% of mothers receiving the 1st post natal visit within the 1st 10	% of postnatal visits to the mother around 42 days	% of mothers receiving Vitamin A dose for reported deliveries	% mothers who received Vitamin A for of estimated pregnancy	% of reported deliveries with post natal m orbidities
Colombo	67.6	86.6	75.4	94.7	85.2	12.4
Colombo M.C	49.7	69.9	34.0	92.5	83.8	15.7
Gampaha	81.1	85.6	68.5	90.1	78.8	12.1
Kalutara	82.0	90.2	80.3	93.0	83.6	10.1
N.I.H.S	96.4	90.4	71.8	96.3	86.9	5.4
Kandy	79.4	95.6	71.8	90.3	78.2	11.4
Matale	77.9	93.3	74.6	96.3	88.1	12.0
NuwaraEliya	76.4	97.4	76.4	85.6	74.5	8.6
Galle	82.3	95.6	74.9	92.1	84.1	10.7
Matara	84.9	93.5	79.4	97.2	88.7	16.2
Hambantota	74.4	91.3	82.4	96.9	86.9	12.0
Jaffna	71.2	99.7	80.4	98.7	90.0	8.0
Kilinochchi	44.9	87.1	86.7	97.6	87.7	3.0
Mannar	80.8	88.0	77.5	98.7	87.2	5.3
Vavuniya	55.3	82.3	61.3	93.8	86.8	6.0
Mullaitivu	135.6	94.1	78.9	94.4	86.9	5.1
Batticaloa	82.8	99.0	77.5	99.1	90.2	5.3
Ampara	73.8	95.5	85.1	92.7	84.3	11.0
Kalmunai	78.3	93.9	81.1	97.7	89.8	10.7
Trincomalee	83.5	90.9	78.1	97.4	86.2	6.3
Kurunegala	82.7	86.7	84.7	87.7	75.4	14.9
Puttalam	69.7	90.9	76.5	95.1	84.4	8.9
Anuradhapura	82.2	92.2	76.1	97.8	87.5	10.5
Polonnaruwa	82.7	91.6	86.5	97.0	86.5	12.5
Badulla	80.0	89.9	79.5	99.3	86.3	10.1
Monaragala	85.5	89.6	76.5	99.4	89.4	9.9
Ratnapura	71.5	90.7	69.3	88.9	80.6	12.2
Kegalle	81.4	84.6	75.8	87.0	73.9	15.4
Sri Lanka	77.4	90.4	75.6	93.3	83.0	11.3

Annexure 9 : Indicators of child care service provision: infant registration, field visits 2015

RDHS/ Health Area	% of infants registered by PHM <i>out of estimated</i>	Average number of home visits <i>per infant</i>	% of estimated in- fants supplied with vitamin A mega dose at 6	% of estimated children supplied with vitamin A mega dose at	
				18 m	3 y
Colombo	80.9	5.6	58.5	62.0	61.4
Colombo M.C	77.5	3.8	76.0	71.0	77.9
Gampaha	96.5	6.0	71.2	72.6	74.7
Kalutara	91.1	6.7	81.2	86.1	86.8
N.I.H.S	110.8	4.8	96.7	99.4	95.9
Kandy	80.4	7.5	68.1	71.3	64.7
Matale	86.9	7.7	84.9	89.4	93.8
NuwaraEliya	115.4	7.1	48.3	50.5	54.8
Galle	88.5	7.0	73.7	77.3	78.7
Matara	91.1	7.2	84.7	84.6	86.5
Hambantota	83.0	6.8	64.6	66.8	62.6
Jaffna	99.2	12.4	59.7	67.6	67.8
Kilinochchi	58.5	8.7	47.9	59.1	64.8
Mannar	97.6	24.2	64.7	65.0	75.8
Vavuniya	68.4	8.9	69.7	82.3	72.5
Mullaitivu	207.3	10.7	70.3	83.1	80.1
Batticaloa	83.8	7.0	75.3	85.0	82.3
Ampara	76.6	4.7	72.0	74.5	73.2
Kalmunai	83.7	8.5	79.8	81.3	82.2
Trincomalee	91.5	6.4	87.9	95.6	88.0
Kurunegala	93.0	6.4	75.7	81.3	81.0
Puttalam	77.8	6.2	70.0	72.5	73.2
Anuradhapura	91.5	6.4	78.1	81.9	82.4
Polonnaruwa	98.0	6.1	85.2	84.0	86.8
Badulla	93.7	7.9	71.2	73.9	71.8
Monaragala	98.8	7.7	75.6	80.3	75.0
Ratnapura	82.9	6.4	64.6	66.6	65.5
Kegalle	94.2	8.3	78.4	81.1	78.3
Sri Lanka	89.4	7.0	71.6	74.9	74.5

Annexure 10 : Indicators of post natal care: post natal visits, Vitamin A supplementation, post natal complications by districts 2015

RDHS/Health Area	% of mothers receiving the 1st post natal visit within the 1st 10 days out of estimated births	% of mothers receiving the 1st post natal visit within the 1st 10 days out of reported deliveries	% of postnatal visits to the mother around 42 days	% of mothers receiving Vitamin A mega dose for reported deliveries	% mothers who received Vitamin A for of estimated pregnancy	% of reported deliveries with post natal m orbidities
Colombo	67.6	86.6	75.4	94.7	85.2	12.4
Colombo M.C	49.7	69.9	34.0	92.5	83.8	15.7
Gampaha	81.1	85.6	68.5	90.1	78.8	12.1
Kalutara	82.0	90.2	80.3	93.0	83.6	10.1
N.I.H.S	96.4	90.4	71.8	96.3	86.9	5.4
Kandy	79.4	95.6	71.8	90.3	78.2	11.4
Matale	77.9	93.3	74.6	96.3	88.1	12.0
NuwaraEliya	76.4	97.4	76.4	85.6	74.5	8.6
Galle	82.3	95.6	74.9	92.1	84.1	10.7
Matara	84.9	93.5	79.4	97.2	88.7	16.2
Hambantota	74.4	91.3	82.4	96.9	86.9	12.0
Jaffna	71.2	99.7	80.4	98.7	90.0	8.0
Kilinochchi	44.9	87.1	86.7	97.6	87.7	3.0
Mannar	80.8	88.0	77.5	98.7	87.2	5.3
Vavuniya	55.3	82.3	61.3	93.8	86.8	6.0
Mullaitivu	135.6	94.1	78.9	94.4	86.9	5.1
Batticaloa	82.8	99.0	77.5	99.1	90.2	5.3
Ampara	73.8	95.5	85.1	92.7	84.3	11.0
Kalmunai	78.3	93.9	81.1	97.7	89.8	10.7
Trincomalee	83.5	90.9	78.1	97.4	86.2	6.3
Kurunegala	82.7	86.7	84.7	87.7	75.4	14.9
Puttalam	69.7	90.9	76.5	95.1	84.4	8.9
Anuradhapura	82.2	92.2	76.1	97.8	87.5	10.5
Polonnaruwa	82.7	91.6	86.5	97.0	86.5	12.5
Badulla	80.0	89.9	79.5	99.3	86.3	10.1
Monaragala	85.5	89.6	76.5	99.4	89.4	9.9
Ratnapura	71.5	90.7	69.3	88.9	80.6	12.2
Kegalle	81.4	84.6	75.8	87.0	73.9	15.4
Sri Lanka	77.4	90.4	75.6	93.3	83.0	11.3

Annexure 11 : Nutritional status of infants 2015 (Nutrition month)

RDHS/Health Area	Underweight %					Stunting %					Wasting%				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Colombo	8	8	8.9	9.5	9.1	4.5	6.2	5.9	7	5.5	6.5	6.8	8.3	7.8	6.6
Gampaha	6	6.4	7	6.4	6.3	5	3.8	4.7	4.1	4.2	5.9	10.4	5.7	5.5	5.6
Kalutara	8.3	7.4	8	7.8	8.1	7.1	5.7	6.3	5.9	4.6	9.2	7	7.3	6.4	6.2
N.I.H.S	9.5	8	8.1	9.2	7.8	6.5	1.2	4.2	4.4	4.0	11	6.8	7.9	7.8	7.4
Kandy	10.5	10.1	9.8	9.2	8.9	9.4	8.6	8	7.1	6.0	11.2	9.8	8.1	7.2	8.6
Matale	9.1	8.4	8.2	7.8	9.5	7.9	7.3	6.7	5.5	5.6	10.2	8.5	7.3	7.2	9.9
NuwaraEliya	16	15	15.7	15	10.9	15.2	12.5	13.8	15.4	8.8	19.3	24	13.4	13.7	10.0
Galle	8.5	8.6	8.1	8.6	7.9	7.2	7	6.2	6.1	4.4	8.6	8.4	8.6	7.9	7.2
Matara	9.2	8.8	9.2	8.9	8.0	7.7	7.4	6.6	6.2	4.9	9.7	15.1	9	8.2	7.1
Hambantota	8.1	7	7.5	7.8	9.2	5.8	5.2	5.3	5.1	5.8	8.8	7.3	7	7.9	8.7
Jaffna	6.7	5.7	7.1	7.3	7.3	6.6	4.3	5.5	4.5	4.1	5.8	8.8	6.8	5.4	7.1
Kilinochchi	12.8	6.4	6.4	5.9	8.8	13.1	7.5	5.6	4	6.3	11	6	6.2	2.8	6.8
Mannar	5.6	6.1	5.3	5.2	8.7	6.4	4.6	2.9	2.2	5.5	3.5	5	3.3	3.1	7.2
Vavuniya	9.7	7.1	8.7	9.2	15.6	6.8	4.8	6.4	5.8	13.1	7.5	8.4	8.6	8.6	12.6
Mullaitivu	7.7	6.8	5.7	7	10.0	9	6	5.9	6.2	5.7	8.7	4.6	3.1	3.3	9.1
Batticaloa	10.2	8.3	7.1	7.4	9.2	7.2	6.3	6.1	5.7	5.8	9.6	7.4	6.2	5.6	7.3
Ampara	12.7	11.1	11	10.6	6.3	8.3	6	7.4	6	3.8	11.9	8.6	8.8	7.6	5.4
Kalmunai	8.8	8.5	7.9	7	8.6	8.3	7	6.3	6.1	5.3	7.6	8.8	6.7	6.6	6.6
Trincomalee	10.3	8.3	7.9	7.6	10.1	6.8	5.8	6.1	4.6	5.2	11.8	8.8	8	7.8	8.0
Kurunegala	7	6.7	6.7	6.8	5.4	6.3	5.2	5.7	4.9	4.1	7.8	15.6	6.5	6.2	5.6
Puttalam	8	7.1	7.3	8.5	7.3	5.3	5.3	5.1	5.5	4.7	8.4	6.9	4.7	6.4	5.4
Anuradhapura	9.6	9	9.1	9.1	8.4	7.6	7	8.2	6.6	5.8	11.5	10	9.7	8.6	9.5
Polonnaruwa	10	9.3	10.6	10.2	6.7	6.4	6.5	6.2	5.5	3.8	8.8	9.8	10.3	10.3	5.3
Badulla	12.2	11.8	11.6	12.4	5.8	10	10.3	9.4	9.4	3.0	11.2	10.9	9.2	11.6	2.6
Monaragala	9.6	7.6	8.8	9.2	7.8	6	4.4	5.4	5.1	5.4	9.7	8.5	9.4	8.6	5.1
Ratnapura	10.6	9.7	9.1	9.1	9.3	8.6	8.4	7.3	6	4.3	13.7	12.5	10.6	13	8.3
Kegalle	9.3	9.6	10.7	11.5	4.9	8.3	7.6	6.6	6.6	3.2	10.7	8.8	9.3	9.7	2.3
Sri Lanka	9.5	8.5	8.7	8.8	8.4	7.3	6.6	6.6	6.3	5.5	9.8	8.6	8	7.9	7.2

Annexure 12 : Weighing coverage of children under 5 years 2010 – 2015(Nutrition Month)

RDHS/ Health Area	2010	2011	2012	2013	2014	2015
Colombo	77.8	79.0	70.5	76.1	75.4	79.4
Gampaha	89.3	91.4	89.3	90.4	89.6	90.8
Kalutara	92.2	90.4	93.5	90.6	91.9	91.4
NIHS	92.7	97.0	97.3	95.8	96.0	93.8
Anuradhapura	87.5	89.2	90.0	91.5	91.2	91.9
Polonnaruwa	87.7	88.3	88.4	91.5	91.7	97.8
Badulla	94.0	94.8	96.2	96.7	96.2	96.6
Monaragala	94.6	99.7	96.6	99.4	88.9	98.1
Galle	90.0	83.8	87.7	87.6	90.2	91.0
Matara	94.1	94.2	95.2	94.5	96.7	96.5
Hambantota	93.8	95.8	95.8	95.8	96.2	96.4
Kandy	91.1	92.5	92.0	90.4	91.5	91.7
Matale	90.7	90.7	91.7	94.1	95.7	96.2
Nuwara Eliya	92.0	86.8	93.0	90.7	91.2	92.8
Kegalle	95.2	96.1	94.4	96.2	96.4	97.6
Rathnapura	91.5	93.2	95.0	95.7	97.4	97.5
Kurunagala	87.6	88.5	89.0	93.5	94.3	94.9
Puttalam	90.1	94.7	93.1	94.6	95.5	96.3
Ampara	92.0	93.5	94.8	96.4	98.0	97.9
Batticaloa	87.9	88.8	89.5	95.2	96.8	96.5
Kalmunai	84.7	90.5	95.2	91.5	93.6	94.7
Trincomalee	90.1	88.3	86.8	89.6	92.4	92.8
Jaffna	99.3	96.2	99.2	99.4	99.4	99.6
Kilinochchi	-	90.4	90.0	97.7	99.6	99.1
Vavuniya	72.4	45.0	64.8	93.8	91.4	96.8
Mullaitivu	-	80.4	90.0	75.1	94.2	96.1
Mannar	-	92.4	94.8	95.2	97.1	98.9
Sri Lanka	90.0	98.3	90.2	91.3	92.6	93.2

Annexure 13 : Nutritional status of young children 2015 (Nutrition month)

RDHS/Health Area	Underweight %					Stunting %					Wasting %				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Colombo	14.4	13	13.5	15.0	13.6	10.7	11	9.9	9.9	8.7	10.1	11.2	10.3	10.1	9.3
Gampaha	11.3	11.4	11.5	11.8	11.6	9.3	13.2	9	7.7	7.7	9.7	8.5	8.7	8.4	8.3
Kalutara	15.4	13.8	13.6	14.5	13.7	12.4	11.5	11.4	11.1	8.8	15.7	13	11.3	10.6	10.7
NIHS	11.4	11	13	12.7	12.6	13.1	5.7	8	8.3	7.5	10.4	9.6	9.4	10.7	10.9
Kandy	18.3	18.5	17.5	17.9	17.2	15.7	16.3	15.6	13.6	11.4	16.7	16.2	13.3	10.9	14.7
Matale	20	18	16.4	19.2	18.2	17.7	14.3	13.8	13.4	11.8	17.3	15	12.6	11.3	14.5
Nuwara Eliya	27	25.1	25.2	19.9	19.6	27	22.6	24.3	21.4	17.0	26.2	19.5	23.2	18.7	14.9
Galle	16.7	15.5	14.9	17.9	15.9	12.2	12.5	11.3	12.1	9.8	14.4	13.2	12.4	13.1	12.5
Matara	17.6	16.5	17.3	16.2	15.1	15	14.1	13.5	13.3	10.1	14.3	14.4	14	20	11.5
Hambantota	16	16.4	16	18.3	17.5	11	11	10.7	9.9	12.5	14.6	13.4	14.8	13.1	13.9
Jaffna	16.4	14.1	13.7	15.5	14.7	13.4	10.6	10.7	8.8	9.5	12.4	13.7	12.4	10	13.0
Killinochchi	30.7	20.2	14.7	16.2	15.5	27.2	18.3	14.3	8.7	13.1	19.5	12.2	10.9	8.2	11.0
Mannar	11.9	13	14	15.8	15.5	9.9	8.6	10	9.4	10.7	6.6	10	9.6	6.5	11.4
Vavuniya	18.5	16	17.7	22.4	24.1	15.3	11.3	11.6	13.4	23.7	14.7	14	14.7	15.3	16.0
Mullaitivu	23.8	17.2	17	19.6	17.2	24.7	13.8	12.7	12.5	10.9	15.8	10.4	9.3	8.7	13.3
Batticaloa	17.6	20.6	14.5	15.9	16.1	13.2	13.8	11.4	10.7	11.6	12.1	10	9.5	9.8	11.9
Ampara	21.5	22	20.5	14.5	13.1	15.3	14.5	13.7	10.9	10.4	18.3	14.1	15.1	13.3	10.3
Kalmunai	16.5	15.6	16.2	15.5	15.0	14.6	13.5	13.2	12.2	10.4	9.9	11	9.9	9.6	10.6
Trincomalee	19.2	19.8	24.6	19.2	17.9	13.1	9.2	14.4	9.7	13.3	18	12.2	16.7	13.3	12.8
Kurunagala	16.5	14.8	14.9	15.8	11.5	11.7	10.8	10.1	10.9	10.3	13.3	11.4	11.5	11	7.8
Puttalam	14.6	13.8	14.4	13.2	15.0	11	10.5	10.1	9.3	10.5	10.7	11.2	10.6	11.6	9.6
Anuradapura	19	18.7	18.9	16.4	17.2	15.7	14.7	14.1	13.8	13.7	17.7	15.6	14.6	13.1	14.6
Polonnaruwa	19.3	17.7	15.9	13.8	13.4	12	14	13.2	11.3	8.7	15.2	15	15.4	15.4	10.4
Badulla	21.4	21.2	20.4	14.6	14.5	20	19	17.9	16.9	11.6	15.8	14.6	15.7	15.3	8.2
Monaragala	18.3	16.2	16.1	17.1	17.9	12.8	10.4	11.2	10.9	13.6	16.7	14.2	15	13.8	9.6
Ratnapura	19.3	17.6	16.6	16.6	16.4	15.6	15.1	13.8	12	12.7	18.8	16.8	13.8	12.8	13.3
Kegalle	17.9	18.3	17.5	12.8	12.6	16.2	14	13.1	12.3	9.0	16.4	13.5	13.1	13.3	7.2
Sri Lanka	17.3	16.3	16.1	15.5	15.3	13.6	13.5	12.6	11.7	11.0	14.3	13.2	12.7	12.1	11.5

Annexure 14: Nutritional status of infants and children - (H 509) 2015

RDHS/Health Area	% LBW	% moderately underweight	% severely underweight infants	% moderately underweight young children	% severely underweight young	% moderately underweight pre schoolers	% severely underweight pre schoolers (3rd to 5th year)	% of infant weighing	% of 1-2 years weighing	% of 2-5 years weighing
Colombo	10.5	5.5	1.2	9.6	2.4	13.2	2.4	80.4	72.6	61.0
Colombo M.C	10.4	5.6	1.3	12.2	2.5	17.7	2.0	54.9	32.2	26.2
Gampaha	10.8	3.9	0.7	9.5	2.0	12.6	2.2	90.0	75.6	66.0
Kalutara	10.8	5.2	1.0	10.7	2.0	16.1	1.9	87.5	76.3	68.6
N.I.H.S	8.2	4.8	0.8	8.5	1.2	14.4	1.5	83.8	69.4	62.1
Kandy	11.4	6.1	1.3	13.1	2.7	17.8	2.2	89.5	74.3	73.8
Matale	11.9	5.9	1.1	10.9	2.2	17.7	1.9	90.5	87.3	85.8
NuwaraEliya	17.8	10.1	3.0	17.7	4.8	21.3	2.4	86.0	82.5	102.0
Galle	9.9	5.8	1.1	12.7	1.9	19.1	1.7	83.3	76.5	78.6
Matara	10.9	6.1	1.0	13.1	2.2	21.0	1.8	91.6	82.7	82.5
Hambantota	9.8	4.7	0.8	11.1	1.7	19.0	1.7	93.0	86.7	49.3
Jaffna	8.9	5.2	0.8	10.5	1.5	16.2	1.5	98.7	99.6	79.9
Kilinochchi	10.2	3.8	0.6	11.1	1.5	28.6	1.6	93.4	105.0	82.4
Mannar	11.9	2.8	1.0	9.7	2.0	11.6	2.0	94.4	94.0	133.1
Vavuniya	13.3	7.5	1.5	13.0	2.3	22.5	1.6	83.9	79.9	82.3
Mullaitivu	10.0	5.6	0.9	13.9	2.5	20.8	2.1	91.9	90.1	101.7
Batticaloa	10.5	5.1	1.3	11.4	2.7	17.2	2.3	91.1	90.9	81.7
Ampara	13.3	6.1	1.4	12.9	2.5	18.6	2.0	92.3	90.2	109.7
Kalmunai	8.5	4.9	1.2	10.2	2.6	17.4	2.3	85.5	88.5	68.6
Trincomalee	10.9	5.4	1.3	13.2	2.4	19.5	1.9	84.5	77.7	90.7
Kurunegala	10.6	4.6	0.9	10.5	1.9	15.6	2.0	94.3	90.7	101.3
Puttalam	9.6	5.3	1.2	11.9	2.8	17.6	2.4	99.9	86.0	74.9
Anuradhapura	11.0	6.2	1.2	14.1	2.4	21.0	1.7	85.2	79.2	86.7
Polonnaruwa	13.8	6.7	1.6	13.8	2.3	22.0	1.8	84.8	59.8	89.3
Badulla	14.6	8.5	2.0	16.1	3.2	23.2	2.2	84.4	84.1	87.9
Monaragala	10.8	5.3	1.1	12.5	1.8	22.9	1.4	92.5	86.6	81.4
Ratnapura	13.9	6.7	1.3	13.5	1.9	21.1	1.6	86.3	81.5	91.5
Kegalle	13.8	6.8	1.1	14.1	1.8	22.4	1.5	93.3	86.6	88.9
Sri Lanka	11.4	5.7	1.2	12.1	2.3	18.3	2.0	88.2	80.2	78.7

Annexure 15 : Family planning service performance 2015

RDHS/Health Area	Current FP user rate for modern methods	Current FP user rate for all methods	% Unmet need for family planning	Current users of IUD		Current users of Injectable	
				No	%	No	%
Colombo	56.9	68.2	7.1	37800	13.3	18516	6.5
Colombo M.C	33.8	41.0	7.6	6215	6.36	3547	3.6
Gampaha	52.0	64.7	8.2	43107	10.7	25848	6.4
Kalutara	55.7	65.9	6.9	19279	11.7	12521	7.6
N.I.H.S	52.7	66.6	4.1	4205	8.02	2855	5.4
Kandy	55.8	64.9	7.0	24360	9.87	19316	7.8
Matale	59.8	67.2	5.0	12491	13.4	8897	9.5
NuwaraEliya	66.8	71.2	6.3	11583	8.68	8032	6.0
Galle	56.9	67.3	5.8	24107	13.0	16277	8.8
Matara	44.4	51.7	5.1	18889	10.2	11971	6.4
Hambantota	58.4	66.8	7.3	20234	18.1	8459	7.6
Jaffna	52.9	61.6	5.2	3541	3.83	5194	5.6
Kilinochchi	66.4	70.0	2.4	2948	14.4	1802	8.8
Mannar	52.0	71.0	7.3	547	2.87	1741	9.1
Vavuniya	50.3	63.4	10.2	822	2.92	2434	8.6
Mullaitivu	52.3	55.0	8.1	1342	6.91	2422	12.5
Batticaloa	44.8	53.2	6.9	3930	4.03	14390	14.8
Ampara	69.8	74.6	3.6	6291	12.2	10759	20.8
Kalmunai	45.4	56.7	7.3	2492	3.28	10496	13.8
Trincomalee	52.0	62.0	5.9	2132	2.91	15023	20.5
Kurunegala	57.0	67.2	6.1	44875	14.9	25517	8.5
Puttalam	56.2	67.0	8.4	13551	9.04	21151	14.1
Anuradhapura	60.3	67.6	5.0	23955	13.1	31462	17.2
Polonnaruwa	65.9	71.2	4.4	10373	11.4	19855	21.9
Badulla	65.3	70.3	6.9	21857	14.3	13291	8.7
Monaragala	61.9	71.3	5.1	16173	17.2	11112	11.8
Ratnapura	57.6	67.6	7.1	22082	11.2	21692	11.0
Kegalle	63.1	74.4	6.7	14414	10.6	16278	12.0
Sri Lanka	55.9	65.3	6.6	413595	11.1	360858	9.6

Annexure 16 : Pap smear screening by laboratories in 2015

Number of pap smears screened by laboratories in 2015														
Institute	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average per month
1 Colombo NHSL	382	372	388	354	408	357	422	692	543	312	357	-	4,587	382
1 Anuradhapura TH	662	610	120	540	580	560	675	1105	760	1240	1250	1159	9,261	772
2 Awissawella BH	296	203	134	212	251	210	168	170	142	152	169	172	2,322	194
3 Badulla GH	433	556	619	431	403	567	471	647	208	841	403	555	6,134	511
4 Batticaloa BH	141	201	175	130	233	128	118	170	140	132	200	227	1,436	120
5 Chilaw BH	376	406	416	442	406	555	582	583	549	462	443	410	5,630	469
6 Colombo Faculty of Medicine, Dep. of Pathology	68	37	55	30	38	46	42	54	112	56	186	158	882	74
7 Colombo FHB- RH Laboratory	1393	1310	1835	1295	1631	1701	1800	1405	1390	1450	1486	2030	18,726	1561
8 Colombo NHSL	382	372	388	354	408	357	422	692	543	312	357	-	4,587	382
9 Hambantota BH	413	487	487	377	492	472	462	471	464	374	461	328	3,190	266
10 Kalubowilla TH	108	100	112	118	100	120	115	147	120	160		180	1,380	115
11 Kalutara GH	307	250	205	329	312	209	413	269	312	162	630	220	3,618	302
12 Kalutara NIS	420	400	380	260	520	650	356	469	450	400	630	0	5,395	450
13 Kandy TH	238	245	253	223	254	257	250	237	260	288	218	205	2,928	244
14 Kegalle TH	640	596	619	602	662	556	530	596	559	802	827	909	7,898	658
15 Kuliyaipitiya BH	596	367	526	309	362	300	312	309	356	529	402	436	4,804	400
16 Kurunegala TH	524	841	802	636	762	731	799	576	767	937	600	605	7,375	615
17 Mahamodara TH	567	710	684	609	628	562	374	444	439	486	641	600	6,144	512
18 Maharagama NCI	1240	1384	1300	1150	1400	1238	1080	1430	1510	1442	930	1281	14,104	1175
19 Matale DGH	448	466	452	477	394	547	350	188	882	599	615	545	5,963	497
20 Matara GH	428	496	612	389	456	493	505	512	472	472	629	520	5,464	455
21 Monaragala DGH	440	-	472	437	572	598	998	813	584	532	501	414	6,361	530
22 Nawalapitiya BH	162	183	200	193	220	209	212	188	229	123	255	372	2,394	200
23 Negombo DGH	321	314	405	303	402	210	308	248	214	203	223	339	3,490	291
24 Nuwara-Eliya GH	420	360	790	520	580	320	370	520	620	900	300	300	6,000	500
25 Peradeniya TH	100	110	100	100	200	453	244	168	251	332	117	113	2,175	181
26 Peradeniya, Sirimawo Children	320	300	300	250	170	180	300	130	150	600	550	260	3,510	293
27 Polonnaruwa GH	125	448	633	228	316	383	311	150	150	312	250	264	3,570	298
28 Ragama TH	157	144	70	238	208	211	133	155	261	424	226	392	2,001	167
29 Ratnapura GH	259	376	403	413	549	509	629	1224	1306	991	850	1095	8,104	675
30 Trincomalee GH	450	450	450	175	175	175	94	94	98	166	209	209	2,745	229
31 Vavuniya DGH	61	52	57	185	205	315	240	302	286	269	124	136	2,233	186
32 Wathupitiwala BH	180	150	110	150	200	200	150	250	200	250	268	228	2,336	195
Total	13,057	18,620	20,339	12,459	20,540	13,839	14,235	14,622	15,327	16,232	14,741	14,662	188,673	15,723

Annexure 17 : Children Under the age of 5 years

DISTRICT	Under weight % (weight for age < -2SD)					Stunting % (height for age < -2SD)					Wasting % (weight for height < -2SD)				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
COLOMBO	14.9	13.7	13.7	14.1	13.1	8.5	10.3	8.7	10.0	7.8	10.2	11.0	10.6	9.8	9.6
GAMPAHA	12.7	11.5	11.6	11.3	10.6	8.7	5.1	7.4	6.4	6.4	9.3	8.6	8.7	8.1	8.6
KALUTARA	18.1	14.2	13.9	13.8	13.6	15.3	8.8	9.7	8.7	8.0	15.6	12.0	11.6	10.6	10.7
NIHS	14.6	16.4	12.8	13.1	12.6	6.2	6.0	7.4	7.2	7.1	10.7	9.4	9.7	10.6	11.0
A' PURA	22.5	20.0	19.4	18.2	17.4	15.2	12.6	12.6	11.3	10.1	19.8	19.5	14.9	13.5	14.0
POLONNARUWA	22.0	18.5	20.2	19.6	18.6	12.4	12.2	11.7	9.4	10.3	16.7	16.3	16.6	14.3	15.1
BADULLA	25.5	22.2	22.4	21.2	20.9	19.4	16.3	15.8	15.2	14.0	16.8	15.6	15.9	16.2	16.2
MONARAGALA	23.1	18.2	18.4	19.3	16.2	14.0	10.1	10.5	9.8	8.8	17.3	15.0	15.7	14.5	12.6
GALLE	19.2	17.5	16.4	16.6	15.3	13.1	11.8	10.4	9.9	8.6	15.2	14.0	14.2	12.8	11.8
MATARA	21.8	18.9	18.1	18.2	17.7	16.3	13.1	11.5	14.3	10.7	18.6	15.3	15.5	16.1	15.0
HAMBANTOTA	19.6	16.9	18.0	16.2	14.9	11.7	9.5	9.9	8.7	8.1	14.0	12.2	14.4	12.6	12.4
KANDY	21.6	19.8	18.6	16.3	16.4	17.7	13.7	13.3	11.5	11.3	17.4	16.0	12.9	11.0	11.0
MATALE	22.2	18.8	16.7	16.4	15.0	16.6	14.0	12.2	11.4	9.9	17.2	15.3	12.4	11.8	11.4
Nuwara Eliya	28.1	23.1	24.5	22.2	23.2	24.8	18.8	21.7	19.5	18.9	24.3	20.0	20.7	17.7	16.0
KEGALLE	22.3	17.9	19.2	20.9	18.4	15.5	12.4	11.4	11.7	10.0	17.7	14.7	13.9	15.3	14.7
RATHNAPURA	24.4	20.4	18.6	17.9	17.8	16.7	14.0	12.4	10.7	10.4	21.0	17.5	15.0	14.7	12.9
KURUNAGALA	18.2	15.8	15.1	14.7	13.5	12.2	9.8	9.5	8.5	7.8	14.2	12.0	11.7	11.3	10.9
PUTTALAM	16.7	14.8	14.8	15.3	15.0	11.2	10.2	9.3	9.7	9.4	11.3	10.8	10.2	10.8	10.6
AMPARA	27.0	23.2	21.9	20.3	19.2	16.5	11.0	12.5	10.2	10.5	20.3	16.0	16.6	14.4	14.7
KALMUNAI	18.2	17.4	16.1	15.1	12.0	14.5	13.6	11.8	9.9	8.9	10.4	11.0	9.8	9.2	8.4
BATTICALOA	18.3	16.7	14.9	13.5	13.9	12.8	10.3	9.8	9.8	9.3	11.9	9.9	9.0	9.2	9.0
TRINCOMALEE	20.9	15.8	20.5	17.2	17.2	11.8	9.2	12.4	10.4	11.7	17.7	11.4	15.4	13.5	13.9
JAFFNA	18.4	15.3	16.7	14.5	14.1	12.8	10.1	10.6	8.6	8.2	12.0	13.4	12.4	10.4	10.6
KILLINOCHCHI	28.7	22.8	20.3	18.9	17.0	20.2	17.5	15.1	12.8	11.6	16.5	14.2	15.3	10.6	9.8
MULATIVUE	20.6	20.8	18.9	18.0	18.4	15.6	14.2	12.7	12.4	12.8	12.9	10.7	10.5	9.6	10.5
VAVUNIYA	19.2	16.1	18.6	19.5	17.5	13.6	11.4	11.9	11.0	10.2	12.8	13.8	14.9	15.3	14.0
MANNAR	13.4	14.1	13.5	14.4	12.6	10.3	9.5	9.6	9.5	9.0	7.1	9.2	8.0	7.6	6.3
SRI LANKA	19.8	17.3	17.0	16.4	15.6	12.8	11.3	11.2	10.5	9.6	15.3	13.6	13.0	12.2	12.2

District	Under weight %					Stunting %					Wasting%				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Colombo	18.0	15.9	15.9	15.8	15.6	10.5	12.4	9.5	11.4	8.4	12.0	12.4	11.7	10.5	10.9
Gampaha	15.2	13.4	13.5	13.1	12.7	8.7	7.4	7.9	6.9	6.7	10.3	9.8	9.8	8.9	9.9
Kalutara	20.0	16.6	16.2	15.7	16.3	12.1	9.8	10.5	8.8	8.9	12.4	13.2	13.4	12.2	12.4
NIHS	17.0	13.8	14.5	14.7	14.9	10.7	10.2	8.3	7.9	7.9	10.7	10.2	10.6	11.6	12.3
Anuradapura	28.4	24.6	23.2	21.5	21.4	18.0	14.6	13.6	12.1	11.0	23.8	24.4	16.9	15.3	15.6
Polonnaruwa	27.0	22.0	25.1	22.9	22.8	12.4	13.6	13.0	10.1	11.3	20	19.1	19.2	15.3	17.0
Badulla	31.5	26.2	27.0	24.9	26.1	22.0	17.6	17.4	16.8	14.7	19.2	17.6	18.5	18.2	18.8
Monaragala	29.3	22.6	24.9	23.5	20.0	16.5	12.0	12.0	11.1	9.9	20.0	17.4	18.2	16.8	14.5
Galle	23.8	21.4	20.1	19.8	18.8	14.4	13.3	11.7	10.6	9.3	17.2	16.2	17.1	14.6	13.5
Matara	27.4	23.1	21.5	21.4	21.5	17.8	14.7	12.4	17.5	11.7	22	17.7	18.3	17.5	17.5
Hambantota	24.6	20.4	22.9	19.4	18.3	12.4	10.4	11.2	9.6	8.9	15.8	13.4	16.7	14.1	13.9
Kandy	26.8	23.6	22.2	19.1	20.4	19.2	16.2	14.4	12.4	12.4	20.7	18.1	14.6	12.5	12.5
Matale	27.8	23.0	20.1	19.5	17.7	18.0	16.5	13.7	12.7	11.1	19.6	18.0	14.2	13.6	12.8
Nuwara Eliya	32.8	25.2	27.5	24.9	27.0	26.0	21.8	23.6	20.2	19.1	27.2	22.2	22.5	18.7	17.1
Kegalle	27.7	24.1	22.8	24.6	22.3	16.4	13.5	12.4	13.3	11.1	18.5	17.1	15.8	18.0	16.9
Ratnapura	30.8	25.1	22.7	21.7	21.9	18.4	15.5	13.7	11.8	11.4	24.3	19.5	17.0	15.9	15.1
Kurunagala	22.9	19.6	18.2	17.5	16.9	13.6	11.3	10.4	9.5	8.8	16.9	14	13.7	13.2	12.9
Puttalam	20.5	17.9	17.8	17.8	18.1	12.5	11.8	10.6	10.8	10.5	14.7	12.2	12.1	12.2	12.0
Ampara	35.1	28.3	25.8	23.8	23.5	19.8	19.1	13.7	11.2	11.3	23.8	19.1	19.5	17.0	17.4
Kalmunai	21.8	20.6	18.6	17.6	15.0	17.8	11.7	13.1	10.4	10.1	11.8	11.7	10.7	9.8	9.5
Batticaloa	21.1	19.1	18.3	15.8	16.7	11.0	13.0	10.3	10.9	10.3	14.8	11.4	9.7	10.1	9.8
Trincomalee	24.7	18.0	23.3	20.8	21.1	12.9	10.4	13.7	12.7	13.0	17.2	12.0	17.3	15.3	15.2
Jaffna	23.4	19.7	22.0	17.3	17.2	14.8	12.0	12.3	10.0	9.4	14.1	14.0	14.3	12.3	12.2
Killinochchi	33.2	28.7	26.3	23.9	21.1	19.9	17.4	18.1	15.3	13.6	18.0	17.4	19.4	13.6	12.0
Mulatiivue	24.2	26.1	23.9	22.0	22.8	18.1	16.6	15.1	14.2	14.7	13.4	12.6	13.4	12.0	12.5
Vavuniya	24.9	20.6	23.5	24.5	21.4	15.8	16.3	14.6	12.8	11.2	15.1	16.3	17.8	17.9	16.1
Mannar	16.3	17.4	16.3	18.0	15.6	11.6	10.4	11.9	11.9	10.8	8.4	10.4	9.1	9.5	7.2
Sri Lanka	24.2	20.8	20.4	19.3	19.0	15.1	13.2	12.4	11.6	10.5	17.4	15.6	14.9	13.7	13.5

