ANNUAL REPORT 2019

Family Health Bureau
Ministry of Health
Sri Lanka

Annual Report
of the
Family Health Bureau
2019

Family Health Bureau
Ministry of Health
Sri Lanka

FAMILY HEALTH BUREAU

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PREFACE

Family Health Bureau, Ministry of Health is pleased to present the 29th Annual Report for the year 2019. This report provides the progress made in the Reproductive, Maternal, New-born, Child, Adolescent and Youth Health (RMNCAYH) programme, and some of the special activities carried out by the Family Health Bureau to improve the National RMNCAYH programme in 2019.

The report consists of routine data reported through the Reproductive Health Management Information System (RHMIS) from all Medical Officers of Health areas and special surveillances such as Maternal Child Mortality and Morbidity Surveillance and Infants Death Surveillance. Information provided in this report would be utilized for programme redirection at National, Provincial and District levels and to identify areas that need special attention in order to provide quality services relevant to National RMNCAYH programme in Sri Lanka.

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ACKNOWLEDGEMENTS

I would like to extend my sincere gratitude to the Ministry of Health, Sri Lanka for the immense contribution made during year 2019 in strengthening the national reproductive, maternal, newborn, child, adolescent and youth health programme in Sri Lanka.

Secondly, I would also like to thank all the professional Colleges and academic bodies including the College of Obstetricians and Gynaecologists, College of Paediatricians and Perinatal Society of Sri Lanka for providing valuable technical inputs and involving actively in the national programme during 2018.

I greatly appreciate the technical and financial inputs provided by the World Health Organization, United Nations Children's Fund, United Nation's Population fund and World Bank in strengthening the national programme.

I am extremely thankful to Dr. Chithramalee de Silva, Director Maternal and Child Health and all Consultant Community Physicians in Family Health Bureau for their inputs in making this document. Completion of this document would have not been a possibility without the support given to me by Mr. Joseph Harriyaram, Assistant Director- ICT, FHB. I greatly appreciate him for his contribution.

I must also thank Dr. Wasana Samarasinghe and all the staff members in the Monitoring and Evaluation Unit, Family Health Bureau for their continuous support, commitment and hard work during the year and in preparation of this document.

Last but not least, I must thank all the Medical Officers of Health and their team members, district and provincial MCH teams for their continuous hard work and commitment even with limited resources and providing all data on time without which the national RMNCYH programme would have not been a success.

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Summary Statistics

Indicator	Data	Year	Source
Total population[1]	21,670,000	2018	Registrar General's Department
Age distribution ('000)[1] 0 -14 years 15 - 64 years 65 years over	5470 14499 1701	2018	Registrar General's Department
Live births[1] Total Male Female	328,112 166,946 161,166	2018	Registrar General's Department
Surface area (Sq. km)	62,705	1988	Survey General's Department
Population density (Persons per sq. km)[1]	346	2018	Registrar General's Department
Growth of mid-year Population (%)[1]	1.1	2018	
Rate of Natural Increase (per 1000)[1] population)	8.7	2018	Registrar General's Department
Crude Birth Rate (per 1000 population)[1]	15.1	2018	Registrar General's Department
Crude Death Rate (per 1000 population)[1]	6.4	2018	
Urban population (%)	18.2	2012	Department of Census & Statistics
Sex ratio at birth (No. of male births per 100 female births)	93.8	2012	Department of Census & Statistics 2012
Women in the reproductive age group (15-49 years) %	51.0	2012	Department of Census & Statistics 2012
Health and Nutrition			
Expectation of Life at Birth	75.5	2017	Central Bank Report
Neonatal Mortality Rate[1] (per 1000 live births)	6.0	2015	Registrar General's Department
Infant Mortality Rate [1] (per 1000 live births)	8.5	2015	
Under five Mortality Rate [1] (per 1000 live births)	10.1	2015	
Total Fertility Rate	2.2	2016	Demographic and Health Survey
Maternal Mortality Ratio (per 100000 live births)	32.0	2018	Family Health Bureau
Still Birth Rate (per 1000 total births)[1]	5.9	2018	Medical Statistics Unit
Low birth weight per 100 live births in Government Hospitals[1]	16.1	2018	

Indicator	Data	Year	Source
Pregnant women attending ANC more than 4 visits (%)	99.3	2016	Demographic and Health Survey
Average number of Antenatal clinic visits per mother (%)	13.5	2016	Demographic and Health Survey
Average number of antenatal home visits per mother by a PHM (%)	4.0	2018	Family Health Bureau
Pregnant women visited at least once by PHM at home (%)	91.9	2018	Family Health Bureau
Live births in government hospitals (%)	92.1	2018	Medical Statistics Unit
Births attended by skilled health personnel (%)	99.5	2016	Demographic and Health Survey
Mothers receiving at least 1 postpartum visit during 1st 10 days (Estimated Birth) (%)	84.6	2018	Family Health Bureau
Average number of postpartum visits by PHM during 1st 10 days (%)	1.8	2018	Family Health Bureau
Children ever breastfed of all children <5 years (%)	99.4	2016	Demographic and Health Survey
Breastfeeding initiation within 1 hour of birth (%)	90.3	2016	
Exclusive breastfeeding under 6 months (%)	82	2016	
Immunization coverage (%) BCG at birth (live births) Pentavalent 3rd dose Measles Containing Vaccine (MCV 1)	 99.0 99.0 99.0	2016	Epidemiology Unit
Children under five (%)			
Underweight (weight- for- age <-2SD) (%) Wasting (weight for height<-2SD)(%) Chronic malnutrition (height for age)	20.5 15.1 17.3	2016	Demographic and Health Survey
-Stunting<-2SD(%)			
Average Daily Calorie Intake (k Cal) (Both poor and non-poor)	2,095	2016	Central Bank Report
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

Water supply and sanitation			
Access to safe drinking water (%)	90	2016	Demographic and Health Survey
Access to improved, not shared sanitation facilities (%)	90	2016	

Indicator		Data	Year	Source
Socio-economic				
GDP per capita at market prices	Rs US $	666,817 4102	2018	Central Bank Report
GNI per capita at market prices	Rs US $	648,731 3,991	2018	
Human development index		0.770	2017	
Unemployment rate (15 year & over population)(%)			2018	Sri Lanka Labour Force Survey (Annual Report)
	Total	4.4		
	Male	3.0		
	Female	7.1		
Labor force (20 years & over population)		8,188,206	2018	Sri Lanka Labor Force Survey (Annual Bulletin)
Dependency ratio (%)		49.4	2018	Central Bank Report
Literacy rate %	Average	92.6	2017	Central Bank Report
	Female	93.6 91.7		
School going population (%)	Primary	42.0	2012	Ministry of Education
	Junior secondary	31.0		
	Senior secondary	15.0		
	Collegiate	12.0		
Median age at marriage (Female 25-49 years) (%)		23.7	2016	Demographic and Health Survey
Health Resources				
Government expenditure on health (% of GDP)		1.5	2017	Central Bank Report Department of Health Services Demographic and Health Survey
Government health expenditure as a % of total government expenditure		5.94	2017	Central Bank Report

Per capita health expenditure (Rs)	9081	2016	Demographic and Health Survey
Medical Officer per 100,000 populations (%)	90.8	2018	Medical Statistics Unit
Population per Medical Officer	1,101	2018	Medical Statistics Unit
Dental Surgeons per 100,000 populations (%)	7.22	2018	Medical Statistics Unit
Nurses per 10,000 population	210.7	2018	Medical Statistics Unit
Public Health Midwives per 100,000 populations (%)	28.7	2018	Medical Statistics Unit
Number of hospitals	641	2018	Medical Statistics Unit
Number of hospital beds	84,332	2018	Medical Statistics Unit
Hospital beds per 1,000 populations (%)	3.9	2018	Medical Statistics Unit
Number of Central Dispensaries (Primary Medical Care Units)	515	2018	Medical Statistics Unit
Number of MOH divisions (Established)	352	2018	Family Health Bureau

[1] **Provisional**

CHAPTER 01

INTRODUCTION

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

Reproductive, Maternal, Newborn, Child Adolescent and Youth Health programme (RMNCAYH) has been evolved over many decades. Origin of the programme dated back to 1926 in which the first field-based health unit system was established in Kalutara. Currently, RMNCAYH programme has reached almost all families in the country forming a well organized health care system with 354 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 order to achieve 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.

RMNCAYH programme in Sri Lanka includes provision of services in relation to reproductive, maternal, child, school, adolescent and youth health. It also includes gender and women's health components. The maternal component is further sub-divided into areas such as; Antenatal, Intrapartum, Postpartum and Maternal Morbidity and Mortality Surveillance entities. Child health component includes newborn care, child nutrition, child development and special needs, child morbidity and mortality prevention and surveillance elements. In addition, RMNCAYH programme includes maternal and child oral health care service component too. RMNCAYH programme provide services to about 54% of the population, which includes pregnant mothers, infants, children, adolescents, youth and women in the reproductive ages.

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 26 health districts called Regional Directors of Health Services (RDHS) areas. 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 focal point in the Ministry of Health responsible for planning, implementing, monitoring and evaluating the RMNCAYH programme. FHB provides technical guidance for provincial health care systems for implementation and monitoring of the RMNCAYH programme in the country. In addition, FHB advocates the Ministry of Health on matters related to policy, finance, infra-structure and other resource requirements relevant to RMNCAYH programme. Monitoring and evaluation of the RMNCAYH programme also come under the purview of FHB.

FHB has several units headed by a Consultant Community Physician (Public Health Specialist), to address the different components of the RMNCAYH programme. 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. 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 Unit
e. Child Nutrition Unit
f. School Health Unit
g. Adolescent and Youth Health Unit
h. Gender and Women's health Unit
i. Family Planning Unit
j. Oral Health Unit
k. Monitoring and Evaluation Unit
l. Research and Development Unit
m. Reproductive Health Center

Reproductive Health Centre services are 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.

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 RMNCAYH Programme in the district.

The implementation of the programme is carried out by the Medical Officer of Health (MOH) teams under the administrative super- vision of the Provincial and Regional Directorates of Health. In Sri Lanka, 354 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 principal 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. SPHMs are being supervised by the PHNS. 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

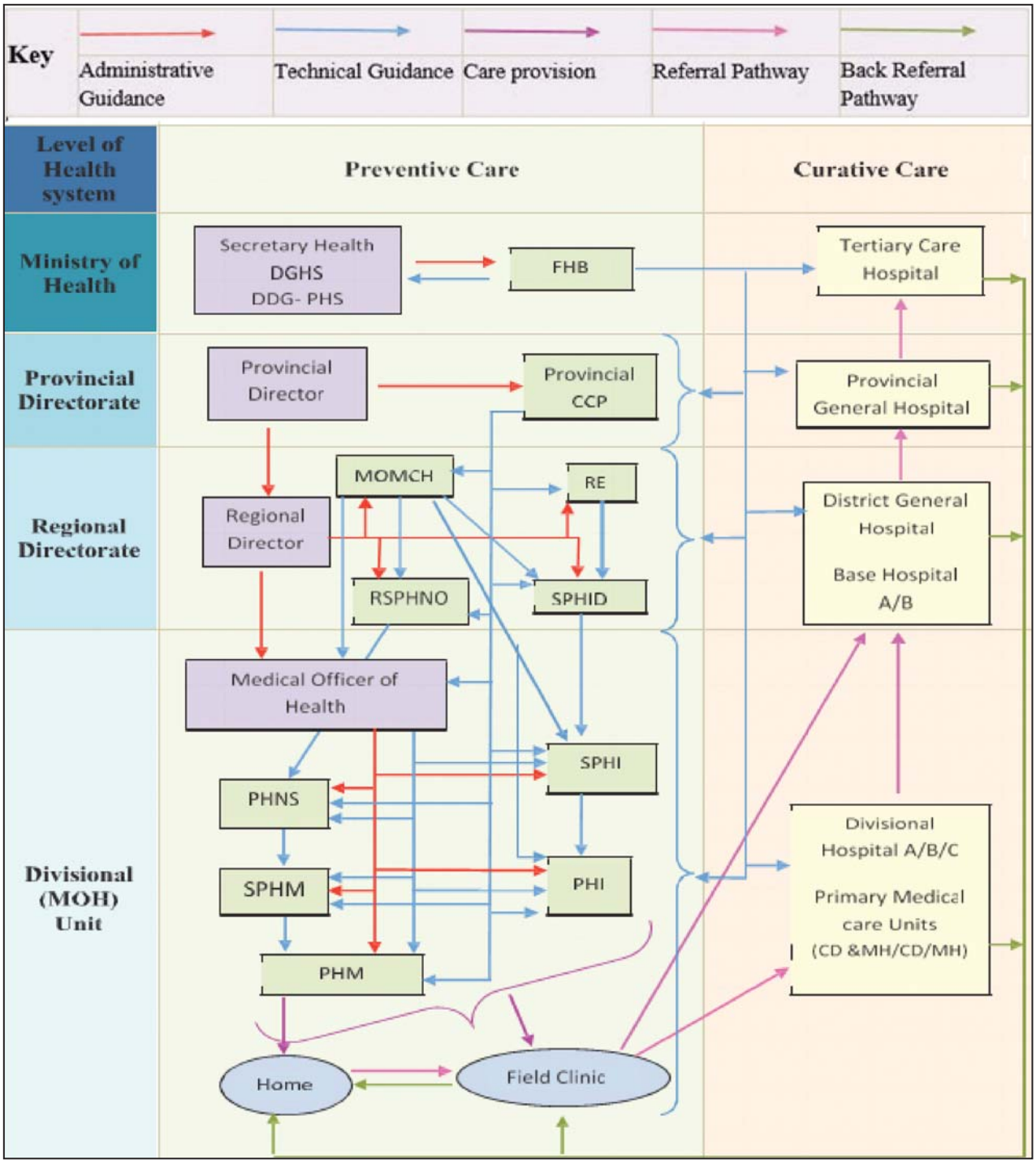


Figure 1.1: Organization of RMNCAYH Programme at Different Levels of Health System

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 68,000 population and one PHM for every 3500 population, district carder positions are maldistributed. There are inadequacies in staff categories such as PHNS, SPHM, SPHI and PHI could be noted.

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

Staff category	Approved cadre	Cadre in position	Ratio	Ratio (officers /100,000 population)
MOH	358	287	1:76303	1.3
AMOH	404	299	1:73241	1.4
PHNS	421	247	1:88660	1.1
SPHI	336	245	1:89384	1.1
SPHM	400	305	1:71800	1.4
PHM	6429	5321	1:4116	24.3
PHI	1638	1323	1:16553	6.0
SDT	441	274	1:79924	1.3

FHB, eRHMIS 2019

1.5 PURPOSE OF THE REPORT

The main purpose of the 29th 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 Minis tries, NGOs, INGOs, Professional bodies and researchers to learn the progress of RMN-CAYH programme in the country and the special activities carried out by FHB to improve the national programme.

1.6 DATA SOURCES

1.6.1 Routine RHMIS

Data and information collected through routine Reproductive Health Management Information System (RHMIS) are summarized and analyzed from the data received to the FHB from several sources. They include:

1. Web based eRHMIS
2. Family Planning Quarterly Return (H 1200 B)
3. Maternal Death Surveillance and Response System
4. National Feto-Infant Mortality Surveillance System
5. Annual Data Sheet of MOHs
6. Annual Nutrition Month Return
7. Monthly Return from Dental Therapists
8. Registrar General's Department and other relevant sources

1.6.1.1 Electronic Reproductive Health Management system (eRHMIS):

Field level MCH data is reported to the MOH Office by PHMs in their Monthly Returns (H524) and Monthly Clinic Return (H527). With the introduction of web based electronic reproductive health management information system in 2017, at MOH level all monthly returns by PHMs and all clinic returns are entered to the web-based system. The data elements in this return cover wide scope.

These include: information on eligible families, performances of maternal care, child care, well woman clinic and family planning services provided both at field and clinic settings. Several registers, records and returns maintained by PHM and in field clinics are used to compile PHMs monthly return and field clinic return. Following introduction of the electronic system, data is now available from each PHM level and from each field clinic (Figure 1.2).

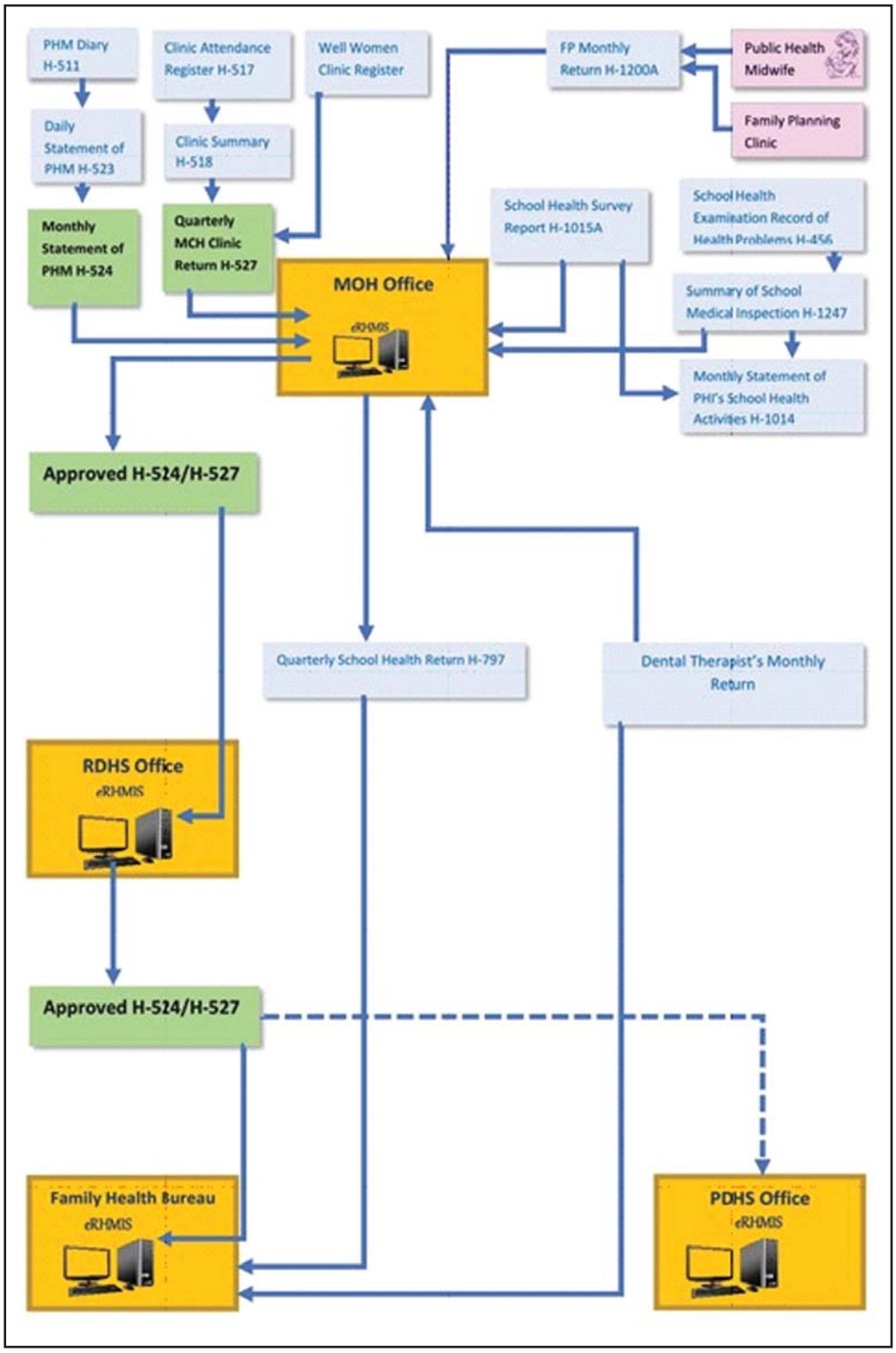


Figure 1.2: Sources and Pathways of Data used in the Annual Report

1.6.1.2 Family Planning Quarterly Return (H 1200 B)

H 1200 serves dual purpose of record and return of family planning new acceptors. Each family planning service provision point has to maintain a H 1200 A for new acceptors of all modern methods except for Condoms.

Each modern method except for Condoms. Each service delivery point is sending H 1200 A to the respective MOH office. Every MOH should send the H 1200 B, consolidated quarterly return compiled using all H 1200 A data to the FHB at the end of each quarter.

1.6.2 Special Surveillance System

1.6.2.1 Maternal Death Surveillance and Response System

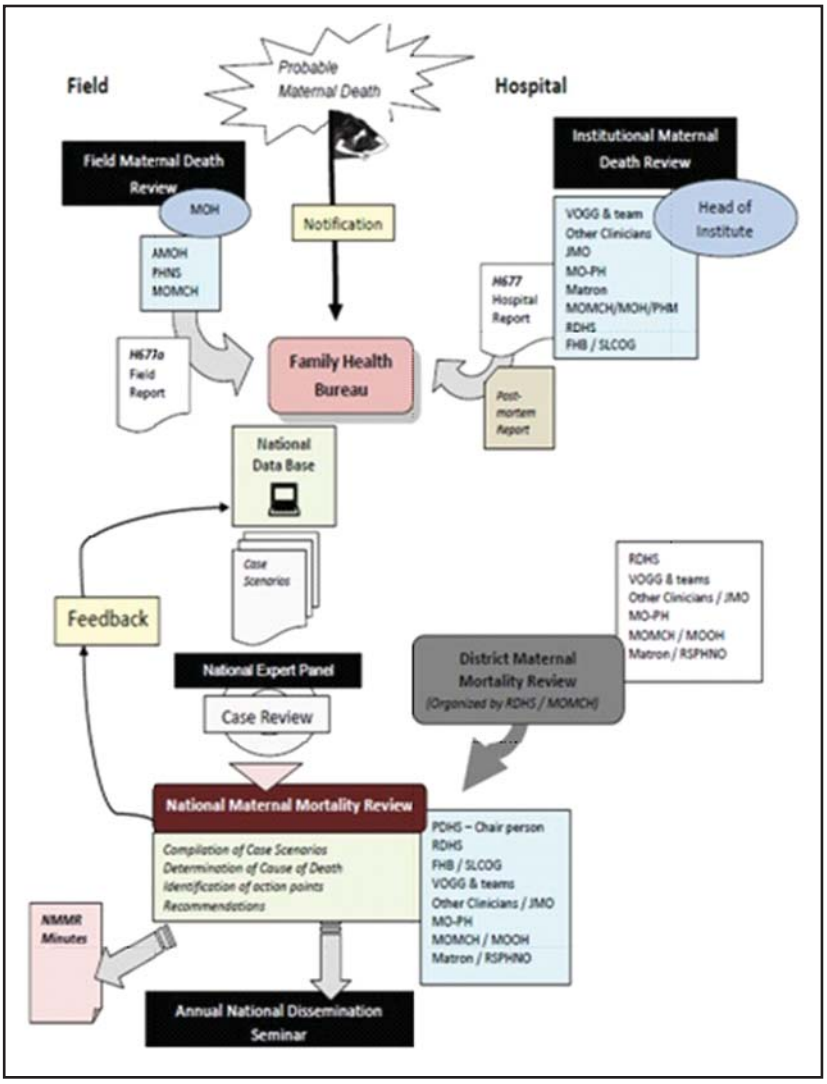


Figure 1.3: Information flow of National Maternal Mortality Surveillance System

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 record- ed 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 visits every district to conduct National Maternal Mortality Reviews and information is compiled by the FHB (Figure 1.3).

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 comprehensive and structured system was initiated in 2015 to include feto-infant deaths from both field and hospital sectors. 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 Heads of the institutions within 24 hours. Perinatal deaths occurred during each month are discussed at monthly perinatal mortality review meetings at hospital level and these reviews are attended by the MOMCH and relevant field staff. Following perinatal death reviews, a detailed report is sent to Family Health Bureau.

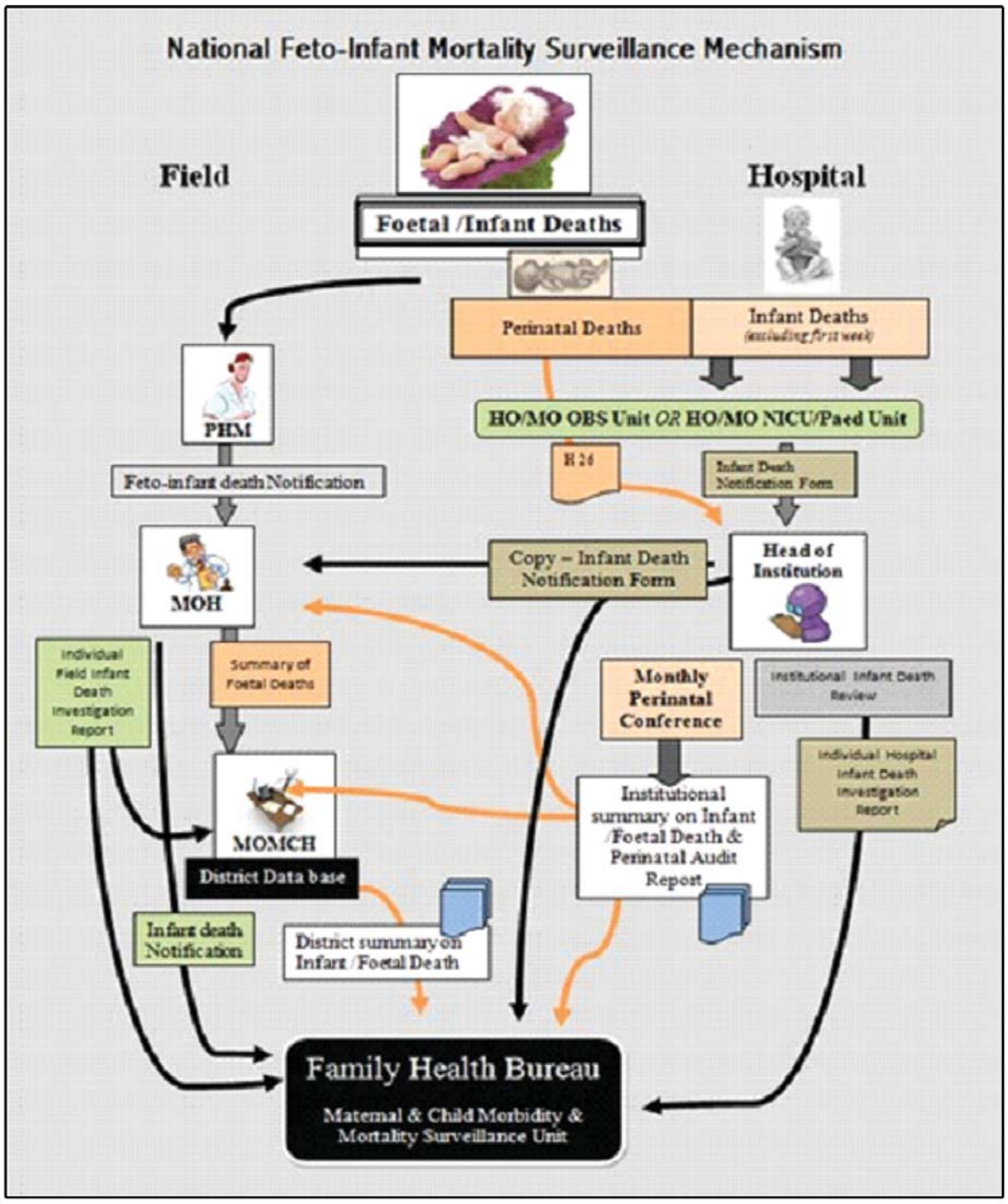


Figure 1.4: National Feto-Infant Mortality Surveillance System

1.6.3 Other Sources of Data

1.6.3.1 Annual Data Sheet on resource availability at MOH level

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

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 indictors included in this Annual Report as denominators.

1.7 QUALITY OF DATA

1.7.1 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.

1.7.2 Monthly Return from Dental Therapists

Newly introduced web based eRHMIS has many validations in relation to MCH data. In addition, a thorough monitoring is been carried out at the FHB level to verify data with random checks and giving feedbacks to each MOH and district monthly. Discrepancies are verified by contacting the MOHs over the phone and respective MOH is instructed to revise and re-enter to the system. 181 validation rules are included to the web-based system to improve quality of data.

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.

CHAPTER 02

TARGET POPULATION OF RMNCAYH PROGRAMME

2.1 TARGET POPULATION OF RMNCAYH PROGRAMME

RMNCAYH programme mainly caters for "Eligible Families" in the country. "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.

of target groups coming under the RMNCAYH Programme in the year 2018. The total population reported by PHMs slightly exceeded the estimated population given by the Medical Statistics Unit, Ministry of Health. Figure 2.1 presents the trends in the percent- age registration of eligible families in comparison to eligible families in the country.

The estimations for the figure 2.1 were based on population reported by Department of Census and Statistics and eligible families were taken as the 18.5% of the total population. Population given by the department of census for 2018 was 21,691,086. Based on that, the estimated eligible family number would be

Table 2.1: Size of the different target population of RMNCAH programme 2019

Indicator	Estimated/Actual#	Reported
Midyear population	21,899,100	22,221,284
Eligible families	4,051,333	3,897,346
Pregnant mothers	350,911	341,745
Births	319,010*	301,265
Infants under care	328,112**	306,250
1-2 years under care	326,052**	318,370
2-5 years under care	1,015,609**	950,220
Number of schools ≤ 200	5118***	5,079
Number of Schools ≥ 200	5047***	5,634
Total school children under care at the beginning of year	4,061,653***	4,210,039

Source: FHB, eRHMIS 2019

** 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 based on data from Medical Statistics Unit, Registrar General Department, and Ministry of Education

In addition, PHIs provide services for school children. All children in government schools with less than 200 students and also, those in. grades 1, 4, 7 and 10 in schools having enrolments more than 200 students are in the target population catered by the programme. Table 2.1 presents the sizes of various types

4,012,851. PHMs have registered a total of 3,909,165 eligible families (18.02%).

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 re assessed with the availability of detailed information on the demographic characteristics of the population from the census.

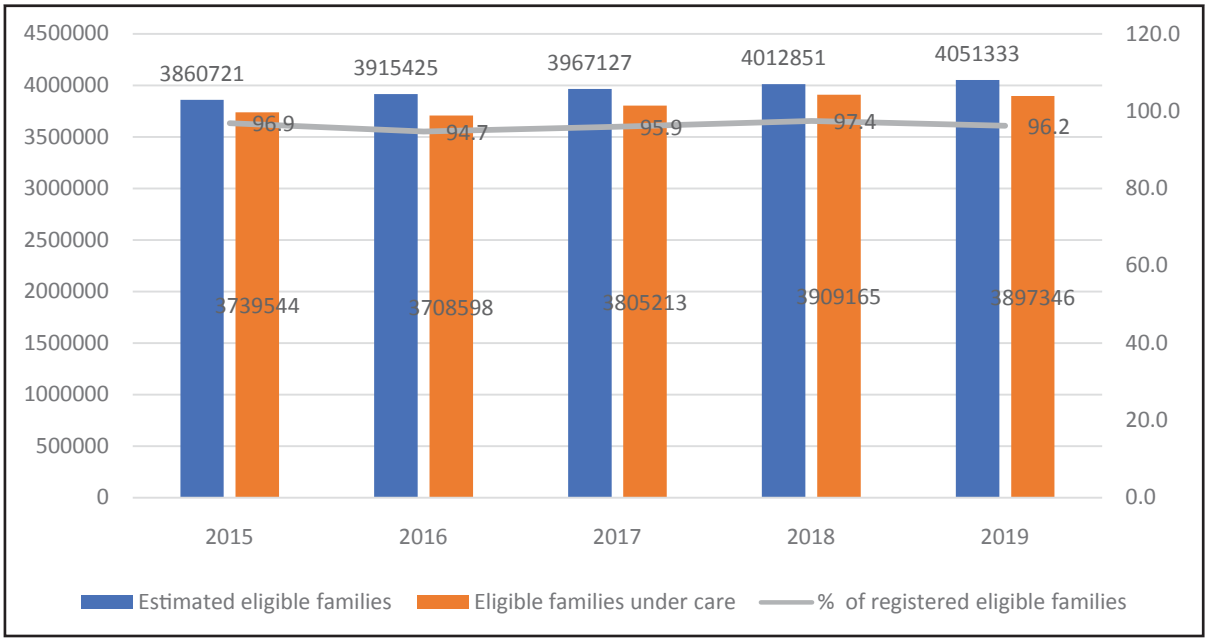


Figure 2.1: Comparison of numbers of estimated and registered eligible families

Source: RGD & FHB, eRHMIS 2019

CHAPTER 03

PRECONCEPTION, MATERNAL AND NEWBORN CARE

3.1 PRECONCEPTION CARE

Preconception care package was 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 all newly wedded couples receive preconception care services.
- 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 2019, there had been 163,378 marriages registered in Sri Lanka of which 100,331 couples had been registered in the eRHMIS with a percentage of 64.4%. However, newly married couples attended pre-conception care sessions seems to be low due to poor participation and also errors were noted in reporting data. In 2019, out of primi mothers registered by PHMs, 58% have under- gone preconception screening session and 41.7% of them had attended to both screening and education sessions.

3.2 ANTENATAL CARE

Provision of antenatal care services begins with the registration of antenatal women by a PHM, either in the field or at a clinic. A standard set of interventions is offered to all antenatal women following registration, which include:

- Preliminary clinical assessment and screening for risk factors
- Screening for anaemia, gestational diabetes mellitus, pre-eclampsia, eclampsia, syphilis and HIV
- Prevention and management of STIs and RTIs
- Prevention of mother to child transmission of HIV
- Assessment of fundal height and weight gain
- Monitoring of maternal and foetal wellbeing
- Tetanus toxoid immunization
- Provision of antihelminthics for needy women
- Micronutrient supplementation (iron, folic acid, vitamin C, calcium) and food supplementation (“Thriposha”)
- Providing information and counselling for pregnancy related issues (breastfeeding and family planning, birth and emergency preparedness)
- Referral of high risk pregnancies for specialist care

3.2.1 Registration of antenatal women

Field staff has registered 341,745 antenatal women during 2019 either at antenatal clinics or during field visits. (There have been 319,010 births registered with the Registrar General’s Department in 2019 (Source: RG). Considering the foetal wastage, the estimated number of pregnancies is approximately 350,911 of which RHMIS has reported 341,745. This indicates that a very high percentage of antenatal women in Sri Lanka are in contact with the services offered by the Maternal Care Programme and positive health seeking behaviours among Sri Lankan women. It could also be a reflection of the sound healthcare network in the country that facilitates the service provider-recipient

contacts. It further indicates the tremendous potential created to ensure the life cycle approach, where children of these women 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.

Maternal Care Programme promotes early and regular antenatal care. Registration before 8 weeks is considered as early registration, and 80.6% have been registered before 8 weeks of pregnancy in 2019. Only 6.4% have been registered after 12 weeks of pregnancy.

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

The percentage registrations over last 5 years indicates that PHMs have registered high proportions of estimated number of pregnancies. This high coverage seen in the antenatal women registration shows the efficiency of the primary health care services around the country.

3.2.2 Domiciliary Care

The clinic care given to antenatal women is expected to be complimented by domiciliary care offered by PHMs. During home visits, PHMs assess the health status of antenatal women by risk screening and examination and conducting simple investigations, and also educate antenatal women and their family members. In 2019, 94.3% of registered women have been visited at least once by a PHM.

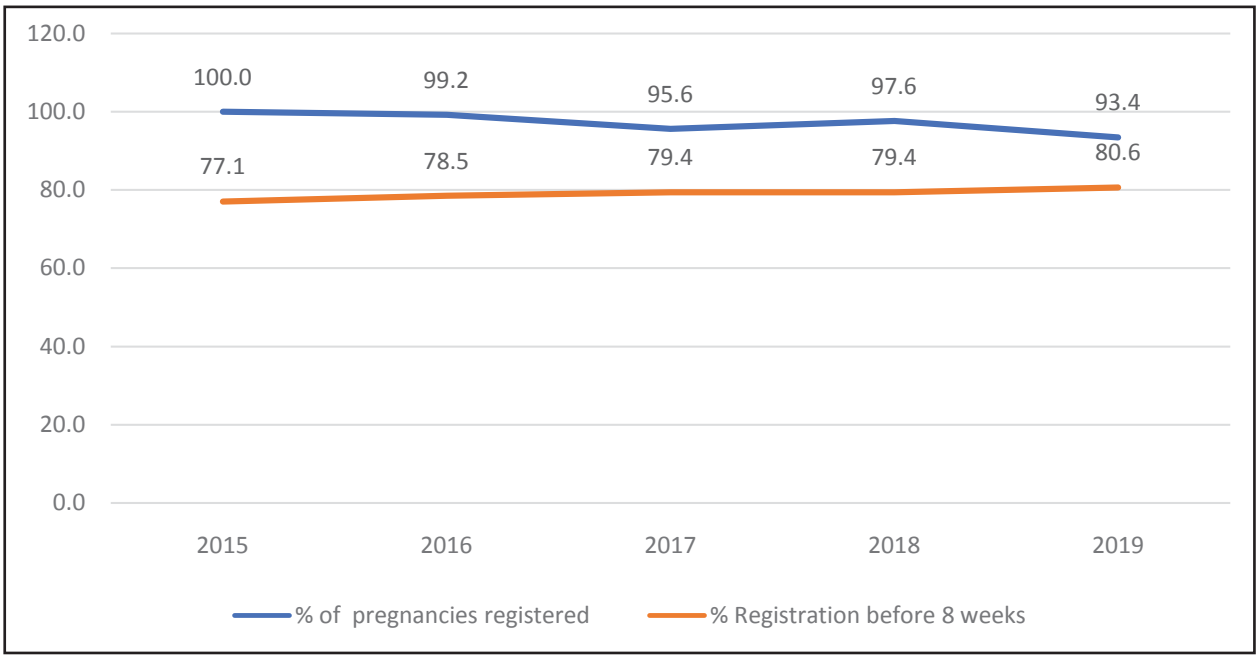


Figure 3.1: Registration of antenatal women and registration before 8 weeks 2015 to 2019

Source: FHB, eRHMIS 2019

According to guidelines, an antenatal woman is expected to receive at least 3 home visits by a PHM. In 2019, an average of 4 visits have been made by PHMM for an antenatal woman (Table 3.1).

3.2.3 Field Clinic Care

Following registration, antenatal women are referred to field antenatal clinics. During 2019, 95.4% of registered women have attended field antenatal clinics which are conducted by MOOH or at non-specialized institutions at least once. On average, an antenatal woman has made 6.5 field clinic visits during her pregnancy (Table 3.2). However, the total number of antenatal clinic visits by an antenatal women may be higher than this, as information on visits to specialist unit clinics and the private sector are not reported in eRHMIS.

Table 3.1: Percentage of antenatal women who were visited at least once and the average number of home visits by PHMM 2015 - 2019

	2015	2016	2017	2018	2019
% of registered pregnant women visited at least once at home by PHM	88.5	90.3	90.9	91.9	94.3
Average number of PHM field visits per pregnant woman	4.2	4.1	4.0	4.0	4.0

Source: FHB, eRHMIS 2019

Table 3.2: Percentage of antenatal women visiting field antenatal clinics (at least once) and average number of clinic visits 2015 - 2019

Indicator	2015	2016	2017	2018	2019
% of pregnant women making at least one field clinic visit out of registered pregnancies	94.6	94.3	96.3	95.8	95.4
Average number of clinic visits by pregnant women	6.4	6.4	6.4	6.5	6.4

Source: FHB, eRHMIS 2019

Out of antenatal women attending field clinics, only 86.2% and 86.1% were screened for VDRL and HIV at the field clinic respectively. This indicates only the blood samples taken at field clinics and sent for testing at government institutions. Rest of the pregnant women receive the service from specialized healthcare institutions at their booking visit or at subsequent clinic visits.

3.2.4 Antenatal screening

As reported by eRHMIS, the percentage of antenatal women who had been tested for VDRL by the time of delivery, as reported at the first post- partum visit, amounted to 99.5% in 2019. Almost all women had been tested for blood group and RH status by the time of delivery (99.7%). (Table 3.3)

3.2.4.1 Maternal Anaemia

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

The above coverage figures of VDRL and blood grouping and Rh testing as reported during first postpartum visit indicates that only a very small percentage of antenatal women fail to obtain these services either from the government sector or the private sector. Screening for HIV had been done in 99.3% of women at the time of delivery.

It is also notable that BMI of 83.8% of antenatal women attending clinics had been assessed before 12 weeks of pregnancy. (Table 3.3)

Of all antenatal women, 94.9% had been tested for Hb before 12 weeks of pregnancy. Among them 18.4% were having a Hb % below 11g/dl. This value was 30.7% at 26-28 weeks. (Table 3.5)

Table 3.3: Percentage of antenatal women screened at ANC 2015 - 2019

indicator	2015	2016	2017	2018	2019
% of antenatal women tested for VDRL at the time of delivery out of estimated deliveries	98.7	99.9	98.7	99.1	99.5
% antenatal women tested for HIV at field clinic	55.4	75.5	79.9	85.1	86.1
% of antenatal women whose blood is tested for grouping and Rh at the time of delivery out of reported deliveries	99.0	100	99.4	99.6	99.7
% of antenatal women whose BMI is assessed before 12 weeks out of total attending antenatal clinics	88.5	89.7	84.1	84.5	83.8
% of antenatal women screened for Hb at the field clinic out of total attending antenatal clinics	45.4	56.0	30.3	35.2	30.8
% of antenatal women tested for VDRL at field clinic out of total attending antenatal clinics	75.1	79.5	79.7	86.3	86.2
% of antenatal women whose blood Grouping and Rh tested at field antenatal clinic	28.8	29.2	29.6	31.4	29.7

Source: FHB, eRHMIS 2019

3.2.5 Protection from Rubella and Tetanus

In Sri Lanka, comprehensive efforts have been made to ensure all reproductive age women are immunized at field clinics. In 2019, 98.5% of antenatal women had been protected against Rubella. Almost all antenatal women (99.6% in 2019) had been protected with tetanus vaccine by the time of delivery (Table 3.4). High coverage of tetanus vaccination among antenatal women, along with safe delivery and newborn care practices, have contributed to elimination of neonatal tetanus from the country.

3.2.6 Maternal Nutritional status

3.2.6.1 Body Mass Index (BMI)

Undernutrition is considered as an important public health problem in Sri Lanka. Pre-pregnant BMI is considered as an important predictor of the birthweight of the newborn, which in turn affects the nutritional status of the child. BMI measured before 12 weeks of gestation is approximated for pre-pregnancy BMI. In order to assess that, antenatal women should be identified before 12 weeks of pregnancy.

Figure 3.2 indicates the BMI status of antenatal women whose BMI had been assessed before 12 weeks of gestation. Approximately 16% of antenatal women were found to be underweight, and this proportion seems to be reducing gradually over the last 5 years.

It is important to have targeted interventions to improve the nutritional status of low BMI women before pregnancy, and also to ensure the improvement of their nutritional status during pregnancy. Maternal undernutrition and prematurity are considered as main reasons behind the high rate of low birth weight in Sri Lanka.

Trend from 2015 shows that the burden over-weight is increasing gradually. BMI > 25 has increased from 21.3% to 29.9 % over the last five years. Special attention should be paid to address the issue of overweight among antenatal women.

3.2.7 Antenatal Morbidities

Antenatal morbidity reporting was included in the RHMIS from 2018. It was reported that 42% of antenatal women had at least one antenatal morbidity.

Table 3.4: Percentage of antenatal women who had been protected with rubella & tetanus vaccination 2015 - 2019

Indicator	2015	2016	2017	2018	2019
% of antenatal women protected against rubella out of registered pregnancies	97.6	96.5	98.2	98.5	98.5
% of antenatal women protected against tetanus out of total reported deliveries	99.3	100	99.3	99.5	99.6

Source: FHB, eRHMIS 2019

Antenatal morbidity reporting is increasing gradually. However, more emphasis should be paid to further improvement in reporting, and also to the quality of data reported.

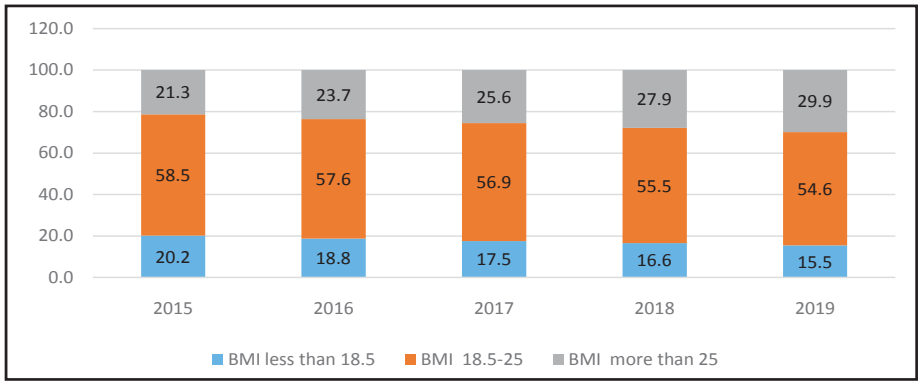


Figure 3.2: Percentage distribution of antenatal women according to their BMI status at booking visit (before 12 weeks) from 2015-2019

Source : FHB, eRHMIS 2019

Table 3.5: Haemoglobin levels of antenatal women

	Hb before 12 weeks			Hb after 12 weeks		
	<7g/dl	7g-11g/dl	>11 g/dl	<7 g/dl	7g-11g/dl	>11 g/dl
2016	0.34	19.41	73.77	0.40	24.58	62.81
2017	0.21	17.85	75.81	0.24	25.99	65.39
2018	0.2	19.2	80.6	0.2	30.1	69.7
2019	0.1	18.2	81.6	0.2	30.5	69.3

Source: FHB, eRHMIS 2019

Table 3.6: Number and rate of antenatal morbidities

	Number of cases	Cases per 10,00 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	Number of cases	Cases per 10,000 pregnancies	Number of cases	Cases per 10,000 pregnancies	Number of cases	Cases per 10,000 pregnancies
	2013		2014		2015		2016		2017		2018		2019	
Chronic High blood pressure	1,675	52	1,693	53	1,167	36	1,119	37	1,043	35	1,038	29	1043	31
Chronic Diabetes	2,053	64	2,371	74	2,341	73	2,526	83	2,691	89	3,358	92	3826	112
Heart Diseases	2,511	78	2,590	81	2,002	63	1,823	60	1,581	53	1,679	46	1620	47
Gestational Diabetes	6,393	199	7,062	221	10,718	335	11,801	389	13,340	443	16,470	453	18247	534
Pregnancy Induced	11,727	365	11,487	359	13,212	413	11,488	379	10,140	337	10,093	278	9696	284
Anaemia	33,661	1,049	36,277	1,133	50,358	1,575	65,665	2,166	76,330	2,536	89,377	2,460	92035	2693

Source: FHB, eRHMIS 2019

3.2.8 Teenage pregnancies

In 2019, 14,887 (4.4%) of total pregnancies registered by PHMs were women less than 20 years. Fig. 3.3 shows the trends in teenage pregnancies over the last 5 years.

The percentage of teenage pregnancies was highest in Trincomalee district followed by Batticaloa. (Fig. 3.5) Special attention should be made to identify the population groups and pockets reporting high teenage pregnancies and implement evidence-based interventions using the life cycle approach to address the underlying and root causes for teenage pregnancies in these areas.

3.2.9 Primies and multipara in 2019

Primies and grand-multipara (P5 and above) are considered to have relatively higher risk pregnancies than others. In 2019, about 32.3% of total pregnancies registered in the year were primies and 2.2% of the pregnancies were mothers with gravida 5 or more. Prevalence of grand multiparity also indicates the effectiveness of family planning services.

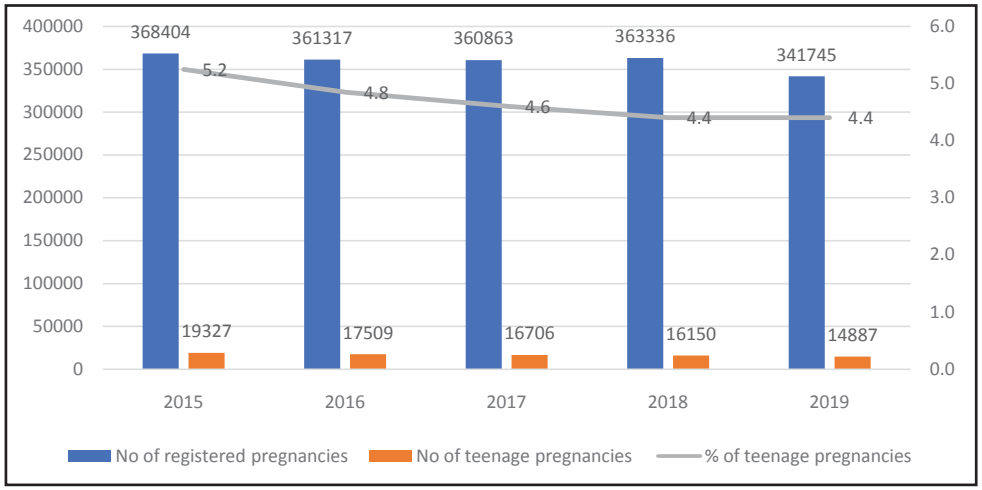


Figure 3.3: Number and rate of teenage pregnant women reported from 2015 to 2019

Source: FHB, eRHMIS 2019

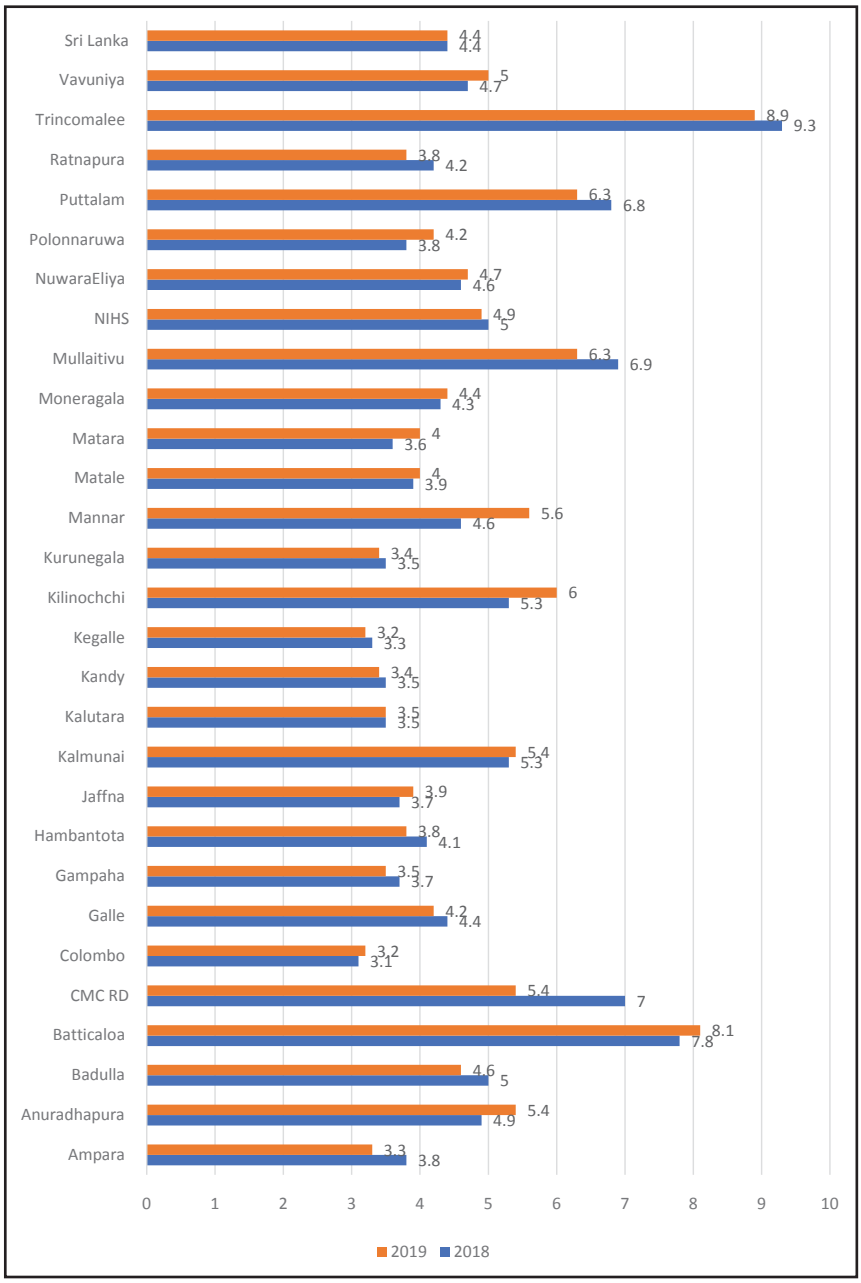


Figure 3.4: Number and rate of teenage pregnant women by district, reported in 2018 and 2019

Source: FHB, eRHMIS 2019

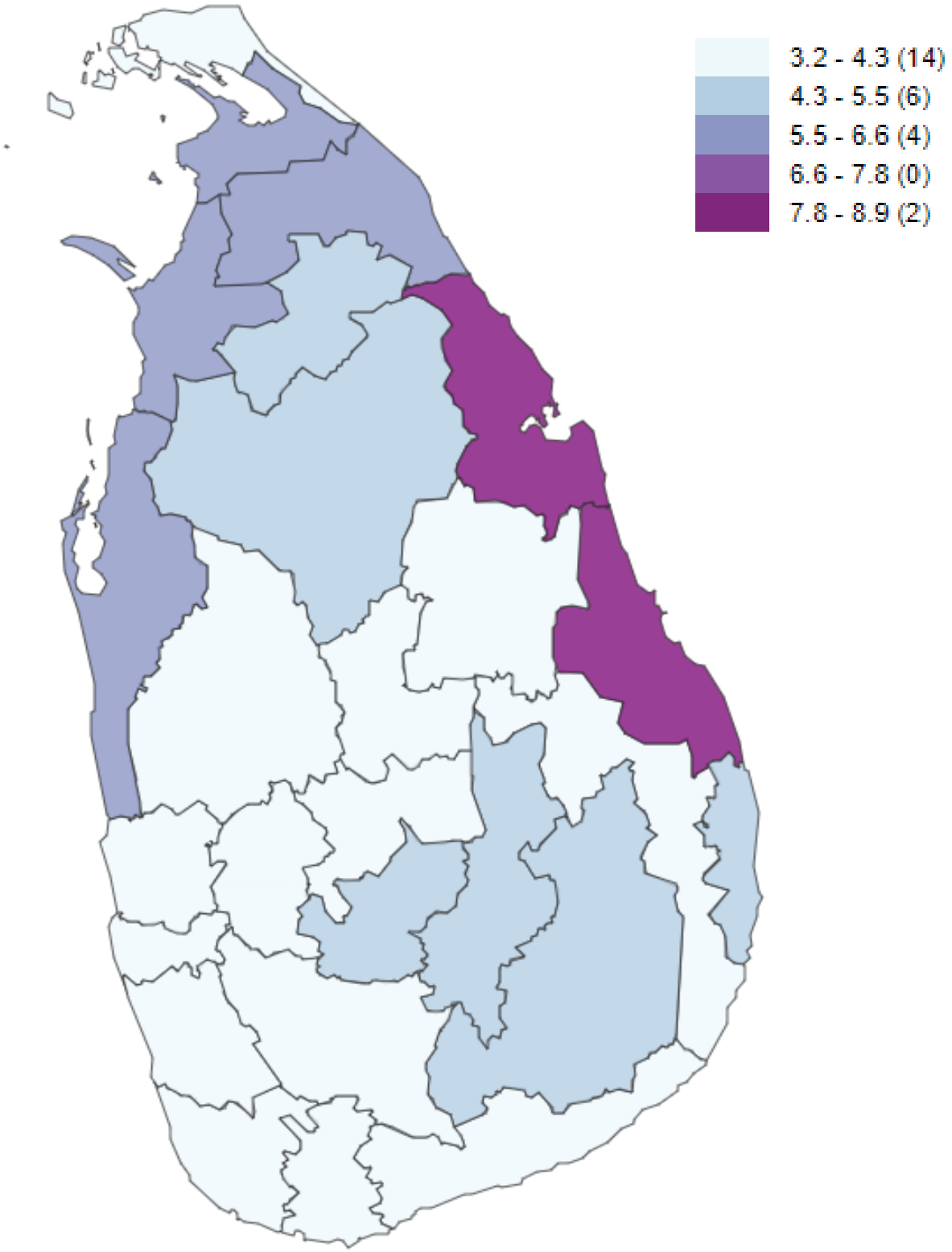


Figure 3.5: Percentage of teenage pregnancies by district in 2019

Source: FHB, eRHMIS 2019

3.3 Activities and achievements in 2019

1. MNH quality assurance programme in hospitals: Sri Lanka has achieved high coverages in most evidence-based interventions in maternal and newborn health. For further improvement in MNH care provision, it is essential to improve the quality aspects of services. MNH quality assessment tools were introduced to assess the quality of care in antenatal, postnatal, labour room and newborn units in hospitals that would enable to identify gaps in care provision.

In 2019, hands on training workshops were conducted on MNH quality assessment tools for 484 staff members in ten hospitals: DGH Matara, DGH Hambantota, BH Homagama, BH Negombo, BH Elpitiya, BH Horana, BH Balapitya, BH Puttalam, BH Kamburupitya and BH Tangalle.

The progress of implementation of quality assessment tools in MNH care was reviewed in 20 hospitals, with the participation of 70 staff members.

2. Elimination of mother to child transmission of HIV and Syphilis Programme: Sri Lanka received the WHO validation for Ending Mother To Child Transmission of HIV and Syphilis in 2019. In collaboration with National STD and AIDS Control Programme (NSACP), National Maternal Care Programme was able to achieve the targets required for the validation, in Sri Lanka. With recent improvements in detection and management of HIV and syphilis in pregnant women, rates of mother-to-child transmission (MTCT) for both diseases have fallen well below global elimination targets i.e., less than five per 100 ,000 live births. The performance of the EMTCT programme currently meets or

exceeds the 95% target for ANC attendance, early screening and treatment for both HIV and syphilis.

3. Emergency Obstetric Care skills based training for non-specialized staff in maternal care: The reduction of maternal mortality is one of the key goals of SDGs. An important intervention for reaching this is the provision of emergency obstetric care for pregnant women during labor, delivery and immediate postpartum period. Ministry of Health, with the support of SLCOG, conducted a two-day skills based training Programme in Emergency Obstetric Care for non-specialized staff (Medical Officers, Nurses and Midwives) in obstetric units, in hospitals.

In 2019 three such training programmes were conducted and 93 staff members were trained: 42 Medical officers, 40 Nursing Officers and 11 PHMs. Thirteen of them were identified as trainers.

4. Advocacy for hospital administrators and technical staff: An advocacy meeting for relevant technical and administrative staff from 35 hospitals were conducted at Water's Edge Hotel. They were sensitized on the available guides and tools of maternal and newborn care quality assurance programme and modes of implementation.

3.4 INTRANATAL AND NEWBORN CARE

Intranatal care is provided at the hospital setting in Sri Lanka.

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

Table 3.7 shows pregnancy outcomes and postpartum care for pregnant mothers registered from 2015-2019. Almost all reported deliveries (99.9%) had taken place in institutions. Number of home deliveries reported were 257 in 2019. The highest number of home deliveries were reported from Nuwaraeliya, Badulla and Puttalam districts respectively. A high caesarean section rate was observed (40.5%) in 2019 as well, with the highest reported rate of 47.4% in Matara district.

Table 3.7: Pregnancy outcome and postpartum care for mothers registered from 2015-2019

Indicator	2015	2016	2017	2018	2019
% Pregnancy outcome reported out of registered pregnancies	95.8	85.0	86.4	90.5	88.0
% of deliveries reported out of total live births registered by Registrar General	96.2	93.7	92.3	93.5	92.3
% of deliveries reported out of total estimated pregnancies	79.5	91.4*	83.9	85.0	83.7
% Institutional deliveries out of total reported deliveries	99.9	99.9	99.9	99.9	99.9
Number of home/non institutional deliveries	280	222	246	248	257
% of Home deliveries out of total reported deliveries	0.09	0.07	0.08	0.06	0.09
% of untrained deliveries out of total reported deliveries	0.06	0.07	0.06	0.04	0.06
% Caesarean sections out of total institutional deliveries reported	33.8	36.3	37.3	40.8	40.5
% Postpartum visits 1 - 5 days	-	-	63.0	66.6	66.0
% Postpartum mothers receiving at least 1 visit by PHM during 1st 10 days out of estimated births	73.6	76.2	80.8	83.8	85.9
% of PP visits by PHM around 42 days (out of estimated births)	63.3	79.0	77.5	76.5	73.5

Source: FHB, RHMIS 2019

3.4.1 Pregnancy outcomes

In 2019, PHMs around the country have reported 301,265 live births (either single- ton/ multiple) and 94.4% of all live births registered by the Registrar General's Department have been registered by the PHMs in 2019. Pregnancy outcome was reported for 88.0% of pregnancies registered with PHMs. Reported live births are categorized according to their birth weight (less than 2500gm and more than or equal to 2500 gm) and plurality (singleton or multiple). In addition, 1939 (6.1%) stillbirths and 36,565 abortions were also reported.

3.4.1.1 Low Birth Weight

Low birth weight (LBW) among newborns still remains a problem. Figure 3.7 reflects the LBW babies reported by MOHs as a proportion of the live births reported through eRHMIS system in comparison to percentage of LBW reported by hospitals. There is under reporting of LBW from the field. In 2019, 12.1% of the newborns were reported with low birth weight through the RHMIS whereas the figure reported through the maternity statistics return collated by the Medical Statistics Unit is 16.0% (figure 3.7. LBW rate of 15.7% was reported in DHS(2016). Therefore, supervisions in the field setting should be strengthened and focused on the quality of data collected.

3.4.2 Postpartum and Newborn Care

PHMs should pay at least 4 postpartum visits to a mother who has 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 - 21 days and around 42 days respectively. During these visits PHMs examine mothers and newborns for any postpartum and neonatal problems. In addition, they 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.

The table 3.8 shows the coverage of postpartum visits. During 2019, PHMs have visited 86.2% of postpartum mothers at least once during the first 10 postpartum days. On average 1.7 postnatal visits were made within the first ten days. Figure 3.8 depicts the percentage of the first postpartum visits within 10 days for reported deliveries and estimated births in 2015-2019.

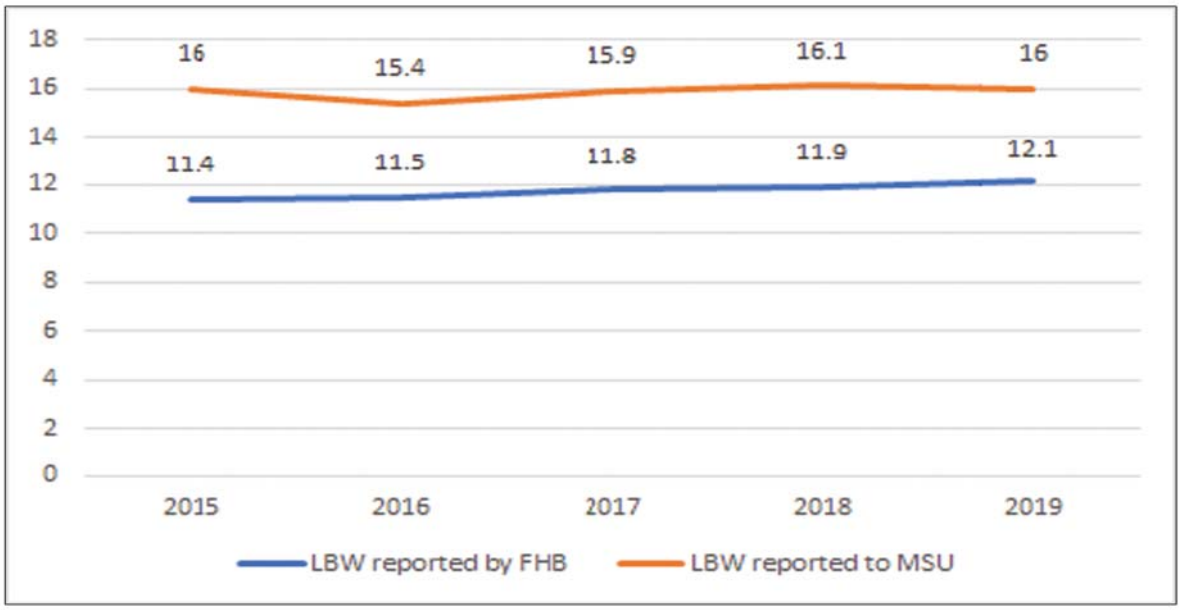


Figure 3.6: Low birth weight percentages among newborns from 2015-2019

Source: FHB, eRHMIS 2019

Table 3.8: Pattern of postpartum visits provided for mothers by PHMs 2015-2019

Indicator	2015	2016	2017	2018	2019
At least 1 visit during 1st 10 days out of actual birth reported	86.4	78.5	85.1	86.8	86.2
At least 1 visit during 1st 10 days out of reported deliveries	92.8	92.8	92.2	92.8	93.3
Postpartum visits by PHM at or around 42 days out of reported deliveries	75.6	79.0	77.5	79.2	83.0
Average number of home visits during first 10 postpartum days	1.7	1.7	1.7	1.8	1.7

Source: FHB, RHMIS 2019

3.4.2.1 Post-partum morbidity

PHMs report postpartum morbidities. In 2019, PHMs reported 35,381 mothers with postpartum morbidities. This amounts to 12.0% of the total reported deliveries.

Table 3.9 shows the cause specific postpartum morbidity rates for 10,000 reported deliveries.

Most common postpartum problems include infected LSCS scars, engorged breasts, separated episiotomy scars. The majority of reported morbidities could have been prevented by proper infection control and breastfeeding practices. However, high infection rate at episiotomy or caesarean scar also indicates the need for examining the PHM's ability to identify these morbidities objectively.

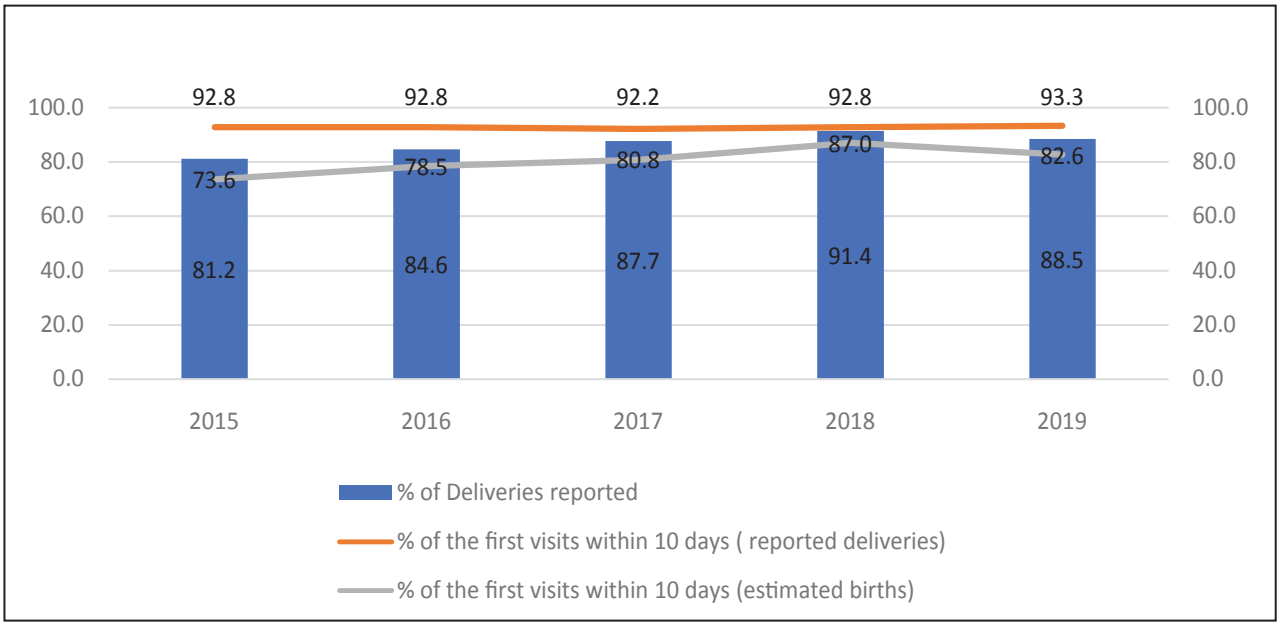


Figure 3.7: Percentage of deliveries reported, first post partum visit within ten days according to the reported deliveries and estimated births.

Source: FHB, eRHMIS 2019

Table 3.9: Number 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	Number Of cases	Cases / 10.000 deliveries	Number Of cases	Cases / 10.000 deliveries
	2015		2016		2017		2018		2019	
Heart Failure	99	3	66	2	72	2	61	2	90	3
Deep Vein Thrombosis	148	5	130	4	105	3	87	3	83	3
Postpartum Depression	281	9	357	12	318	11	325	11	403	14
Foreign material in vagina	347	11	231	8	222	7	197	7	151	5
Reproductive Tract Infections	471	15	439	14	43	1	301	11	270	9
Postpartum Psychiatric Illness	619	19	579	19	637	21	685	21	803	27
Diabetes Mellitus	698	22	746	25	650	22	877	22	847	29
Breast Abscess	717	22	590	19	465	15	394	15	344	12
Urinary Tract Infection	1725	54	1497	49	1115	37	1053	37	1050	36
Cracked Nipple	2053	64	2340	77	2260	75	2391	75	2529	86
Haemorrhage	2365	74	2184	72	2038	68	2040	68	1773	60
Hypertension	2608	82	2477	82	2341	78	2797	78	3007	102
Separated Epis	4410	138	4268	141	4237	141	4249	141	4174	142
Engorged Breast	5351	167	4657	154	4766	158	5236	158	5301	180
Infected LSCS scar	6411	200	6433	213	5965	198	6409	209	6593	224

FHB, eRHMIS 2019

3.4.3 Intranatal and postnatal care at hospitals

Of the pregnant mothers delivered in a hospital, most of the deliveries have taken place in hospitals with specialist facilities (92%). Number of deliveries in Divisional Hospitals are reducing every year. All pregnant mothers are monitored using the partogram during labour. Modified Obstetric Early Warning Signs (MOEWS) chart with colour codes is used for postpartum monitoring and monitoring of pregnant mothers with complications.

Mother baby centers to care for sick babies and mothers are available in 31 specialized hospitals and Lactation Management Centres (LMC) to support mothers with breastfeeding problems are available in 68 specialized hospitals. It is expected that all the specialist hospitals providing care for the newborn should have a mother baby centre and a LMC.

3.4.4 Activities and achievements in 2019

• Thirteen (13) participant training programmes on Breastfeeding Counselling/ Lactation Management were conducted for medical officers, nursing officers and midwives attached to obstetric and neonatal units at DMH, TH Anuradhapura, BH Marawila, CSHW, RDHS Hambantota, DGH Kalutara, DGH Nawalapitiya. A total of 378 health staff were trained.

• Two (02) Training of trainers programme on Breastfeeding Counselling/ Lactation Management were conducted at FHB for 28 post graduate trainees in MD Paediatrics and for the hospital and field health staff in Anuradhapura, Matara Puttalam and Ratnapura districts.

• Workshops on intrapartum care was carried out among 202 participants with the collaboration of Sri Lanka College of Obstetricians and Gynaecologists.

• Workshop to enhance skills on Kangaroo Mother Care was carried out for the hospital staff in the district of Jaffna where 104 participants attended.

• Workshops to streamline maternal and newborn information care system was carried out for 223 participants in hospitals.

• Activities to celebrate National Breastfeeding Week for the year 2019 were conducted.

• Media seminar for Breastfeeding week – 2019

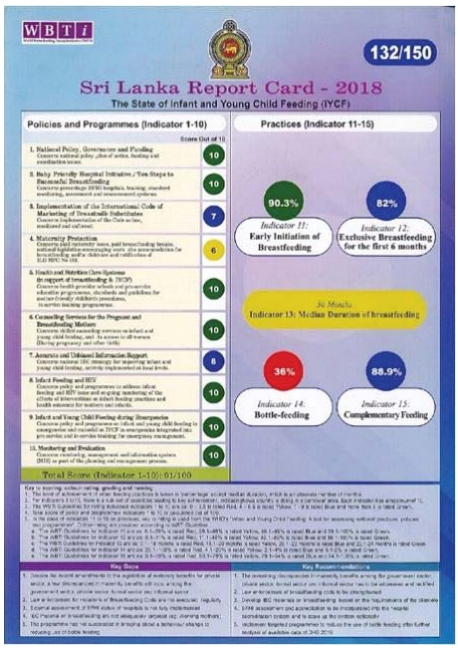
• Advocacy programme for National Breastfeeding week 2019 was conducted

• Development of tools to assesses the community based newborn care and assessment of community based newborn care in the Colombo district were conducted.

• Technical Advisory Committee for Newborn and child health was conducted bi-monthly over the year.

• Consultative meeting on revising labour room guidelines was held

• Completion of World Breast Feeding Trend Initiative (WBTi) for 2019. Sri Lanka was became the first ever nation to achieve green on policy and programmes for infant and young child feeding practices.



• Procurement of digital baby weighing scales, length measuring boards and standard weighing sets was done and distributed islandwide to labour rooms and neonatal care units.

• Conducting consultative meetings and review meetings for Congenital Neonatal Hypothyroidism Screening, Screening for Congenital deafness and Neonatal Retrieval System.

• Printing of formats of Modified Early Warning Signs Charts (MEWS) and Neonatal Formats (H – 1162) was done and delivered to hospitals island wide.

CHAPTER 04

INFANT AND CHILD CARE

4.1 INFANT AND CHILD CARE SERVICE DELIVERY

Registration of infants and home visits:- All infants are expected to be registered by PHMs in the field soon after birth during the first postnatal home visit in the government health system which facilitates provision of domiciliary and clinic care services through the MOH system. During the first 42 days after delivery a PHM pays home visits at assigned intervals (1-5 days, 6-10 days, 14-21 days and around 42 days) to provide home based care to the postpartum mother-baby pair. After 42 days of delivery, the home visits carried out by PHMs are mainly aimed at the infant.

Clinic based care:- Infants are brought to the field postnatal clinic at 4 weeks of age where both the mother and the baby are examined by the MOH. Subsequently at regular pre scheduled intervals the baby is brought to the Child Welfare Clinic for a package of evidence-based interventions which include health screening, growth monitoring and promotion, immunization, micronutrient supplementation, preventive deworming and development assessment and promotion. Ideally at least 5 clinic visits are made during infancy (the first postnatal examination at 1 month of age and subsequently for vaccinations, growth and developmental assessment and medical screening etc. at 2, 4, 6 and 9 months).

Growth monitoring and promotion:- Weight and length/height measurement of infants, young children and preschoolers are conducted at regular intervals as specified in national guidelines and age specific weights and length/heights are compared with that of WHO new growth standards in the CHDR. National guidelines recommend that children under two years to be weighed once a month. Accordingly, infants should have been weighed 12 times during infancy. Children above two years are to be weighed once in three months if they do not have any nutrition problems and if they have any nutritional issues, monthly weighing is recommended. Monitoring of weight for age is mainly done at the field weighing posts by PHMs and also at the Child Welfare Clinics (especially for infants). Monitoring of the length / height is carried out at the Child Welfare Clinics at 4, 9, 12 and 18 months and thereafter once in 6 months till the age of 5 years if they do not have any growth problem. If they have any growth problem length should be monitored every two months till the age of 2 years and the height should be monitored every 3 months for children aged more than 2 years. Nutrition counseling, more frequent growth assessment as described above and increased field and clinic follow up are indicated when growth faltering and/or any form of malnutrition is identified. PHMs are expected to carry out one to one intervention at the very onset of uncomplicated growth faltering and the complicated or longstanding problems are to be referred to a CWC to be managed by MOH with field follow up by PHM with guidance from MOH. Resistant cases are to be managed at the Nutrition clinics of the MOH. Paediatric/hospital nutrition clinic referral is being done as appropriate whenever it is indicated.

Supplementation:- Vitamin A supplementation for under 5 children (every six months from the age of six months onwards) to address vitamin A deficiency, Multiple Micronutrient (MMN) supplementation to combat anemia among infants and young children at the ages of 6, 12 and 18 months and provision of supplementary food “Thriposha” to undernourished children are implemented throughout the country through field care services. Zinc supplementation during diarrhoea for children receiving treatment from hospitals is also implemented throughout the country.

Institutional management of severe wasting (severe acute malnutrition / SAM) with therapeutic food is also implemented island

wide for children with SAM who are identified and referred through field care services to the institutions with paediatric / nutrition clinic facilities.

Preventive de-worming strategy to improve nutrition through prevention of soil transmitted helminthiasis infection was revised and scaled down based on the findings of the island wide survey conducted in 2017.

From January 2019, deworming programme was terminated in the low-risk districts of Anuradhapura, Batticaloa and Kurunegala. In the other districts the ages at which Mebendazole is given were confined to 1 ½, 2,3,4,5 years. Except for the high risk districts of Colombo and Nuwaraeliya, the programme will be terminated after 2020.

The other services offered to children under the age of 5 years to promote Early Child Care and Development (ECCD) are described in section 4.6.

Table 4.1: Infants, young children and preschool children under care out of actual number of births reported by RGD for the year.

Indicator	2015	2016	2017	2018	2019
% Infants undercare	95.0	94.4	94.3	96.1	93.3
% of young children undercare (1-2 years)	95.0	99.4	102.7	97.1	97.6
% of Preschoolers undercare (2 -5year)	96.4	95.5	94.8	95.4	93.6

Source: FHB, eRHMIS 2019

Table 4.2: Infant and childcare provided by the field staff from 2015- 2019

Indicator	2015	2016	2017	2018	2019
% Infants registered by PHMM out of Estimated Births	89.3	95.3	94.1	95.6	93.8
% Infants having at least 1 home visit after 42 days out of registered infants	53.7	53.4	50.3	50.7	51.4
Average number of home visits per infant	7.0	7.2	6.9	7	7.6
% of infants weighed	88.2	88.4	87.5	88.1	90.2
% of infants making at least one clinic visit (of registered infants)	100	100	100	110.4	110
Average number of clinic for an infant	4.5	4.7	4.7	4.9	5.1
% of estimated infants given Vitamin A at 6 months	71.6	80.5	78.7	84.5	78.9
% of young children (1-2 years) weighed	80.2	79.2	78.7	81.9	83.6
% of estimated children given Vitamin A at 18 months	74.9	80.6	86.1	86.1	78.6
% of 2 - 5-year-old children weighed	78.7	80.5	80.3	80.2	81.7
% of estimated children given Vitamin A at 3 years	74.5	90.5	91.2	92.9	83.1

Source: FHB, eRHMIS 2019

4.2 FIELD AND CLINIC CARE SERVICE DELIVERY

In year 2019, PHMs had 93.3% of infants, 97.6% of 1–2-year-old children and 93.6% of 2–5-year-old children registered under their care.

In year 2019 infant weighing had increased up to 90.2% and weighing of 1–2-year-old children to 83.6%. Average clinic attendance for infants also has increased (5.1). However, vitamin A supplementation at 6, 18 and 36 months (78.9%, 78.6%, 83.1% respectively) showed some decline when compared with the previous year while average number of home visits for infants (7.6) had increased slightly (table 4.2).

4.3 CHILD NUTRITION

Under nutrition in children remains a major public health problem in Sri Lanka. Although rates of under nutrition have gradually declined in Sri Lanka over the years, reducing under nutrition among children to be in par with other health and social indicators remains a challenge. Despite all relevant evidence-based interventions to improve nutrition being implemented through the RMNCAYH programme of the Ministry of Health, a significant improvement is not evident for the past decade. However, it must be noted that severe clinical forms of under nutrition are hardly seen in the country and mortality and morbidity rates of under five children are also low.

A key strategy in the RMNCAYH programme to address this issue is growth monitoring and promotion as described under section 4.1. Breastfeeding and appropriate complementary feeding is promoted at grassroot level through the PHM and in all MCH field clinics by the public health staff headed by Medical Officers of Health.

Table 4.3: Percentages of underweight in infants, young children and preschoolers from 2015 to 2019

Indicator	2015	2016	2017	2018	2019
% Moderately Underweight infants	5.7	5.4	5.1	5.2	5.3
% Severely Underweight infants	1.2	1.1	1.1	1.1	1.1
% Moderately Underweight young children (≥1-2 years)	12.1	11.9	10.8	10.6	10.6
% Severely Underweight young children (≥1-2 years)	2.3	2.4	1.9	1.8	1.8
% Moderately Underweight preschoolers (≥2 to 5th year)	18.3	18.0	17.5	16.9	16.9
% Severely Underweight preschoolers (≥2 - 5th year)	2.0	3.2	3.1	2.9	2.8

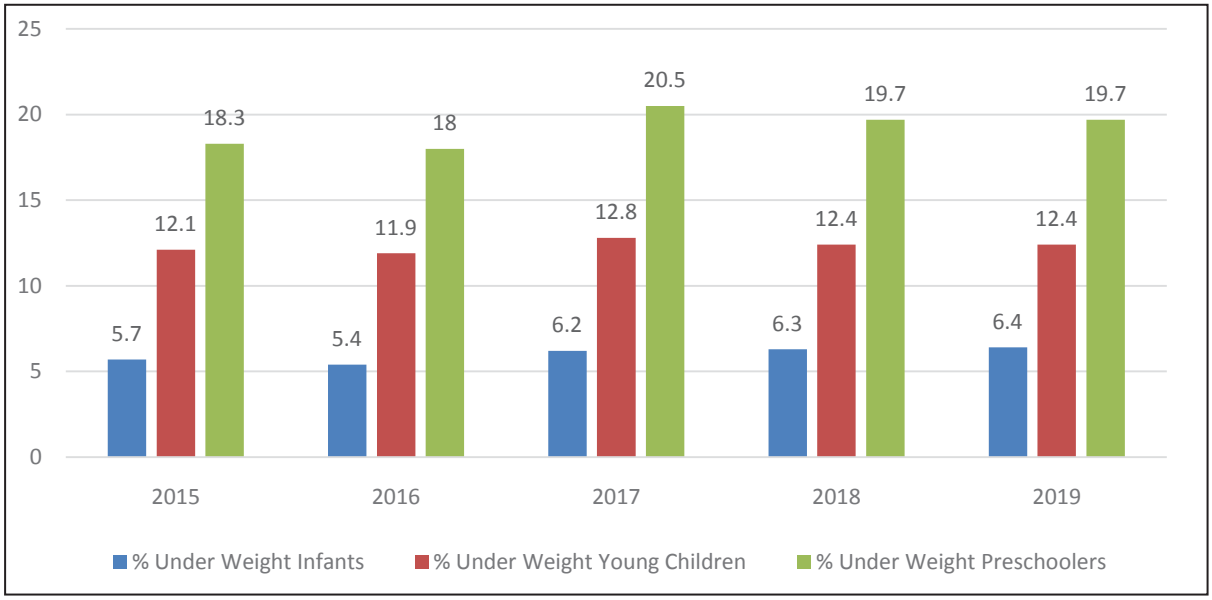
Source: FHB, eRHMIS 2019

Tables 4.3 and 4.4 show the different nutrition indicators reported through routine information system. According to the routinely collected data through the eRHMIS, in 2019, moderate (5.3%) and severe (1.1%) underweight remains more or less the same as in 2018. Underweight rates are rising across the age groups with 10.6% and 16.9% having moderate under weight in age groups 1-2 years and 2-5 years respectively. Severe underweight also shows a similar rising trend across age groups with 2.8% of 2-5-year-olds having severe underweight (table 4.3).

Reporting of length/height measurements of children at the ages of 4 months, 9 months, 18 months and 3 years of age through the routine RHMIS was started in 2015. In year 2019 stunting rates at the ages of 4, 9, 18 months and at 3 years were 1.1, 1.7, 2.1 and 1.8 respectively.

Even though stunting rates show a mild improvement, under nutrition among infants, 1-2 year and 2–5-year age groups remain a challenge over the years. As one of the measures to address this issue and to encourage the health care staff to take early action to prevent under nutrition monitoring of growth faltering was continued as a part of Nutrition Month activities in year 2019.

Figure 4.1: Trends in infant, young child and preschool underweight (moderate and severe) from 2015 - 2019



Source: FHB, eRHMIS 2019

Table 4.4: Trends in infant, young child and preschool stunting (moderate and severe) from 2016 – 2019

		4 Months	9 months	18 months	3 years
Stunting out of measured	2016	1.39	2.21	2.98	2.83
	2017	1.03	1.44	2.08	2.07
	2018	1.13	1.70	2.18	2.05
	2019	1.1	1.7	2.1	1.8

Source: FHB, eRHMIS 2019

4.4 NUTRITION MONTH 2019

The month of June is declared as the "Nutrition Month" annually to draw more attention to nutrition among all age groups, triple burden of malnutrition being a priority concern. The theme for 2019 nutrition month was "I know my BMI". Although intensive nutrition promotional activities focusing on pregnant mothers, all under five children, school children and adolescents are carried out during this month by the Family Health Bureau, in 2019 due to the prevailing situation at the time in the country, extensive activities were not possible.

Annually during nutrition month, an extra effort is made to reach the whole population of under five children to assess their weight for age, length/height for age and weight for length/height and a concerted effort is made to identify so far undetected growth/nutrition problems and address them. Hence, the assessment coverage of growth of this special survey carried out annually during the nutrition month is understandably higher than the routine assessment where these children are measured at assigned intervals only.

During the nutrition month of 2019, all MOH areas sent their returns on assessment of growth to the FHB and the assessment coverage (weight, length/height) of under 5 children was 95.2%.

The trends of under nutrition among under five children during the period from 2015 to 2019 according to nutrition month data are presented in Figure 4.2. It shows a declining trend albeit slow in all three indices, under weight (weight for age <-2SD), stunting (length/height for age <-2SD) and wasting (weight for length/height <-2SD) over the years.

PHMs were requested to identify and report children with growth faltering (both early and longstanding) among children growing in 'normal' zone of the weight for age chart as a part of the nutrition month data collection in 2019 as well, as a measure of addressing the stagnant indicators by paying special emphasis to early detection and prevention of growth faltering.

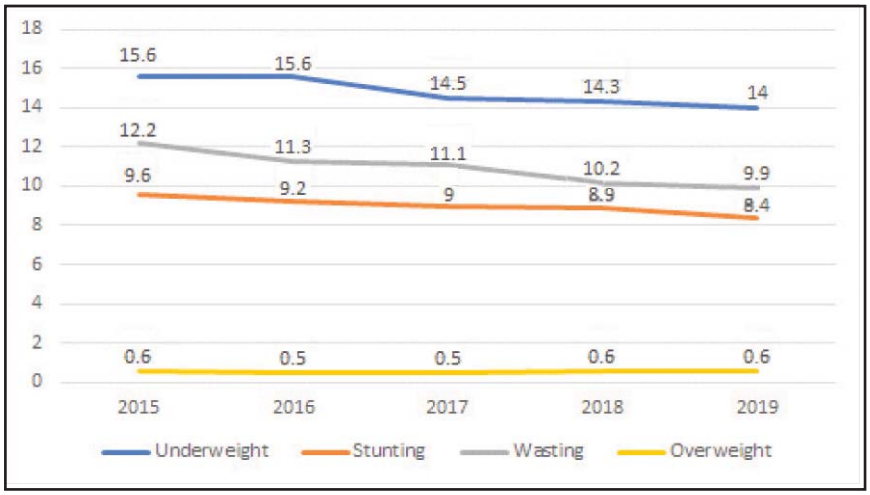


Figure 4.2: Under nutrition among under five children from 2015 to 2019 Source: FHB, NM 2019

The rate of growth faltering among under 5 children (who are growing in the 'normal' zone of the weight for age chart) reported for 2019 was 17.2% out of the total weighed. This figure showed a slight improvement in identification and reporting of growth faltering from the year 2018 (16.8%). Considering the other nutrition indicators, it is felt that this figure may be much higher as both early and longstanding growth faltering are included here. The objective is to increase awareness of the consequences of not detecting early growth faltering and sensitize the staff on early identification of growth faltering which is essential to take corrective action in order to prevent children from becoming under nourished.

4.5 SPECIAL ACTIVITIES CARRIED OUT DURING 2019

1. Training of Trainers on WHO Child Growth Standards and Child Growth Assessment: With the objective of ensuring that relevant health staff acquire adequate capacity to assess and interpret growth of children under the age of five years and provide targeted interventions, TOT programmes are conducted annually at national level. The master trainers trained at FHB are expected to replicate the training at district/MOH level to train the other health staff providing MCH services. Forty trainers from districts of Trincomalee, Nuwara Eliya, Ampara, Anuradhapura, Rathnapura including newly appointed MOMCHs were trained at this 4-day TOT programme in 2019.

2. Training of Trainers on Infant and Young Child Feeding Counselling: The objective of the training is to ensure that relevant health staff acquire adequate capacity to assess feeding practices, identify problems and counsel accordingly to provide targeted interventions. Thirty-three trainers were trained in 2019 from Colombo, Gampaha, Kalutara, Badulla, Monaragala, Galle, Rathnapura, Nuwara eliya, Ampara, Vavuniya, Anuradhapura and Trincomalee districts.

3. Workshops to update public health staff on Child Nutrition: Workshops were conducted for MOOH/AMOOH (91) in Colombo and Kalutara districts and CMC with the objective of revitalizing the child nutrition interventions at field level.

4. Formative study on determinants of IYCF and child care in rural, estate and urban populations: To determine drivers and barriers of IYCF practices to inform development of a social behavior change communication strategy, a qualitative research was initiated with UNICEF support.

5. Maternal and Child Nutrition Subcommittee meetings: Six meetings of the Subcommittee on Maternal and Child Nutrition, the technical advisory committee chaired by DDG PHS II were held during this year.

6.Procurement and distribution of anthropometric equipment and nutrition commodities: Procurement and distribution of; anthropometric equipment to MCH clinics to facilitate growth monitoring activities island wide (height rods 85, length boards 20, spring balance scales 370, infant beam scales 135) and nutrition commodities- Multiple Micro Nutrient Powder (MMN) as a strategy to prevent iron deficiency anaemia during infancy and young childhood and the therapeutic food BP100 for nutrition rehabilitation of children with Severe Acute Malnutrition.

7. Revision of De-worming strategy: The revised De-worming strategy to scale down the programme was implemented from January 2019. This was based on the findings of the National Survey of Intestinal Nematode Infections in Sri Lanka conducted for FHB by a team of researchers led by Prof. Nilanthi de Silva (Senior Prof. of Parasitology, Faculty of Medicine, University of Kelaniya) during the period February – April 2017.

8. National Nutrition Month: The island wide growth assessment of children under the age of five years continued in 2019 during the nutrition month. Under the theme "I know my BMI" special emphasis was given to improve child nutrition interventions at field level.

4.6 ACTIVITIES CARRIED OUT BY THE CHILD HEALTH, DEVELOPMENT AND SPECIAL NEEDS UNIT OF THE FAMILY HEALTH BUREAU IN 2019

1. Quality of care assessment tool for paediatric wards

The quality of care assessment in Paediatric wards in Sri Lankan Hospitals, Self- Assessment tool for Paediatricians was completed.

2. Report on Child Health Resource Mapping

The study "Health Care Resource Mapping on Child Care" was started and data collection throughout the country was completed in 2018. It included the relevant data of the existing resource outlook in Paediatric wards of all secondary and tertiary care hospitals. Data analysis and the preparation of a detailed report were completed in 2019

3. Guideline on Child Development Promotion and Development Screening for primary health care workers.

A guideline on child development promotion and development screening was developed for Primary Health care workers mainly targeting the Medical Officers of Health (MOH) and the Public Health Midwives (PHMs). It will help them to better organize their service routines and improve the quality of field child care within limited person hours.

4. Reprinting of the Child Development Manual

"Child Development: Concepts, Interventions, Assessments and Problems – Manual for Primary Health Care Workers of Sri Lanka" is the main reference material and the training guide on Child Development. This was published in 2014 and decided to reprint in 2019 in order to fulfil the increasing requirement of the primary health care staff of the country.

5. Stakeholder discussions on policy decisions regarding establishment of the Child Development Centre (CDC)

Discussions on establishment of child development centre were continued through a series of meeting with all the relevant authorities.

6. Rejuvenate the Child Development and Special needs national programme by having consensus of all the relevant stakeholders

Based on that series of discussions, it was decided to pilot a comprehensive child development promotion and special needs intervention package with the integration of primary and secondary levels of service provision. Considering the need, feasibility of implementation, monitoring and evaluation of the project, Family Health Bureau selected the Regional Directorate of Colombo to pilot this package.

7. Capacity building of the PHC staff on Child Development and Special needs in Colombo district

This included the training of Trainers (TOT) programme for the MOHs and the training programmes for PHMs in Colombo district.

8. Child Development Screening Checklist

Child Development Screening Checklist was designed to screen the children from 2 months to 5 years of age for developmental delays and desabilities. Public Health Midwives are expected to use this checklist at 2, 4, 6, 9, 12, 18, 24, 36, 48 and 60 months age points to assess the development of the children under their care as part of the child health programme.

9. Expansion of the Child Development components of the CHDR

10. Child Development Training for Primary Health care workers in Matara District

This training programme was conducted using the training guide - "Child Development Concepts, Interventions, Assessments and Problems - Manual for Primary Health Care Workers in Sri Lanka". It was expected that the trainees would have enhanced their knowledge and skills on the subject and used it to provide better service for children of their respective regions.

11. Coordination and finalization of the Job description of Consultant Community Paediatricians

"Community Paediatrics" is the newly added sub speciality to provide care for children with developmental problems and they will be based in proposed Child Development Intervention centres with a multidisciplinary team.

12. SOP on child abuse and neglect

The Standard Operational Prodedure (SOP) to be used for the management of child abuse and neglect in the hospital setting of Sri Lanka was finalised.

13. Development of the Child Care Package

Introduction of a comprehensive child care package (field component) to the MOH system was an identified gap within the child health programme of the country. In order to fill this gap, development process of the child care package was initiated and expected to finalize before 2021.

CHAPTER 05

OUTCOME OF MATERNAL DEATH SURVEILLANCE AND RESPONSE

Counting and reviewing maternal deaths contribute to further reducing such deaths. Maternal mortality is globally accepted as a quality indicator of the overall health of a population in a country depicting the status of women and the functioning of the healthcare delivery system.

A structured Maternal Death Surveillance and Response mechanism is in operation covering the entire country with data originating from both community and facility levels. This process was started way back in 1981. The review process evolvedover the years with the addition of numerous qualitydimensions. In the present system, when a probable maternal death is known, field and hospital health staff notify, conduct post-mortems, review the index death at field and hospital levels and send a detailed report to Family Health Bureau (FHB). At FHB, the Maternal & Child Morbidity and Mortality Surveillance Unit maintains a database and comprehensive case scenarios are developed. These cases are then desk reviewed by an expert panel comprised of different specialties related to maternal care service provision. A national team of experts from related specialties visit each and every district in the following year to conduct National Maternal Mortality Reviews (NMMR) at district level with the participation of all concerned stakeholders. Each maternal death is reviewed based on 3 delays – (deficiencies in seeking healthcare, reaching and treating), and lessons learnt are translated into practice, programs and policies at district and national levels.

Maternal Mortality Ratio (MMR) is the most widely used measure of maternal deaths. MMR assesses obstetric risk (i.e., the risk of dying once a woman is pregnant). It is calculated as the number of maternal deaths per 100,000 live births.

Sri Lanka reported an 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 MMR in the South Asian Region.

Definition of a Maternal Death

Maternal Death

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.

In the year 2019, the field health staff registered and cared for 3,903,306 eligible families all over the country and registered 341,745 pregnant mothers. Antenatal care was provided to 95.4% of them and 99.9% of women delivered in a hospital.

Family Health Bureau was notifiedof 169 probable maternal deaths during the year 2019. Comprehensive information from family, field, hospitaland medico-legal sectors were compiled to develop case scenarios. District-wise categorized cases were subjected to a national level district review with the participation of related experts. National Maternal Mortality Reviews at the district level (in physical modality) were conducted for 25 health regions despite the challenge of Covid19 pandemic situation. Review of maternal deaths of Colombo district was held as a desk review. Review of all maternal deaths (100%) was completed by September 2020.

In addition, seven (07) Immediate Response to Maternal Deaths meetings were conducted for 36 cases with issues chaired by Director General of Health Services for system improvements.

In the year 2019, out of reported probable maternal deaths, 93 deaths were categorized as maternal deaths giving a national Maternal Mortality Ratio (MMR) of 29.2 per 100,000 live births(Figure 1). Live births reported by the Registrar General's Department for the year 2019 was taken as the denominator (319,010). It is notable that there was a substantial reduction of live births (9,102) in the denominator (2018 - 328,112).

Figure 5.1: Calculation of MMR 2019

Figure 2 illustrates the number of reported and confirmed maternal deaths from 2001 – 2019. Though there is a gradual reduction in the number of maternal deaths over the years, the number has been almost stagnant during the period 2014- 2016. A significant rise was noted in the year 2017 mainly due to higher number of deaths of Dengue Haemorrhagic Fever (n=21) as a result of the country-wide epidemic contributing to the maternal death profile. It is noteworthy the substantial reduction of number of maternal deaths (n=35, 27%) over the years 2018 & 2019.

Sri Lanka's Maternal Mortality Ratio (MMR) reduced over the years to reach a level well below the MMR of other South Asian countries and to be on par with high income countries. Figure 3 shows the trend of MMR for the period 2001 – 2019. However, similar to the number of maternal deaths, the MMR has also been stagnant since 2010 to 2017. A sizeable reduction of MMR, by nearly 10 points, is visible from 2017 to 2019.

Figure 5.2: Number of Maternal Deaths (2001 – 2019)

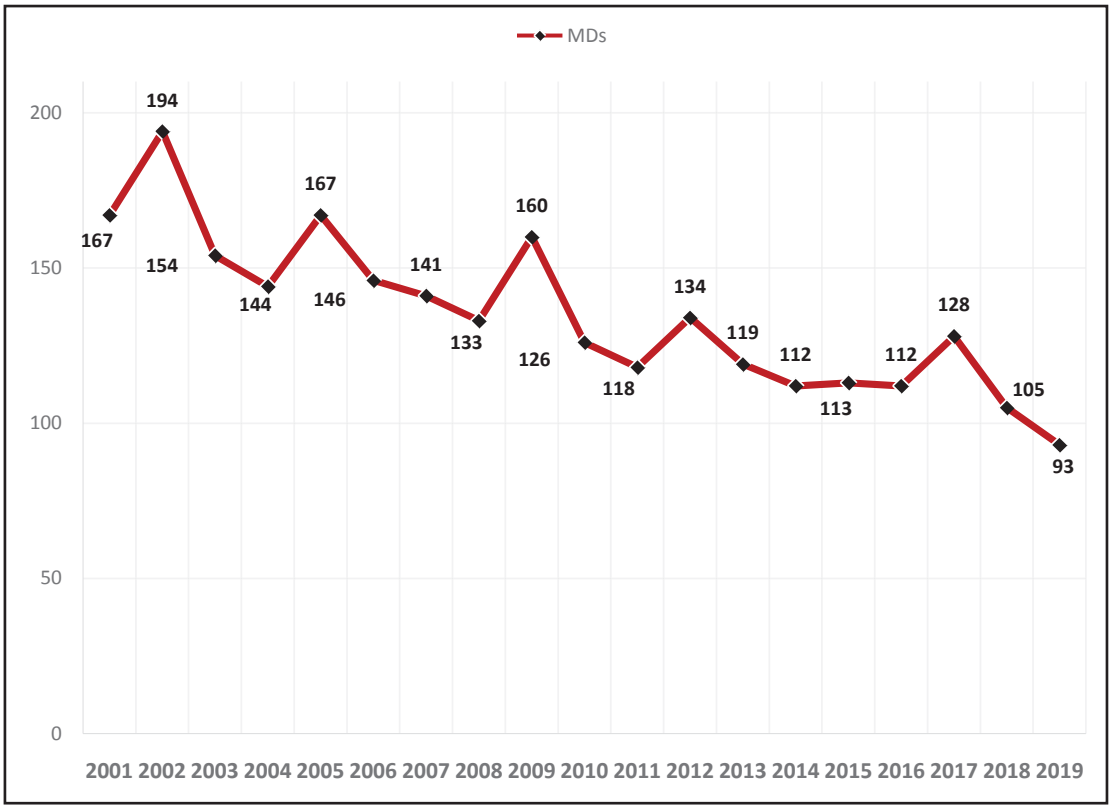
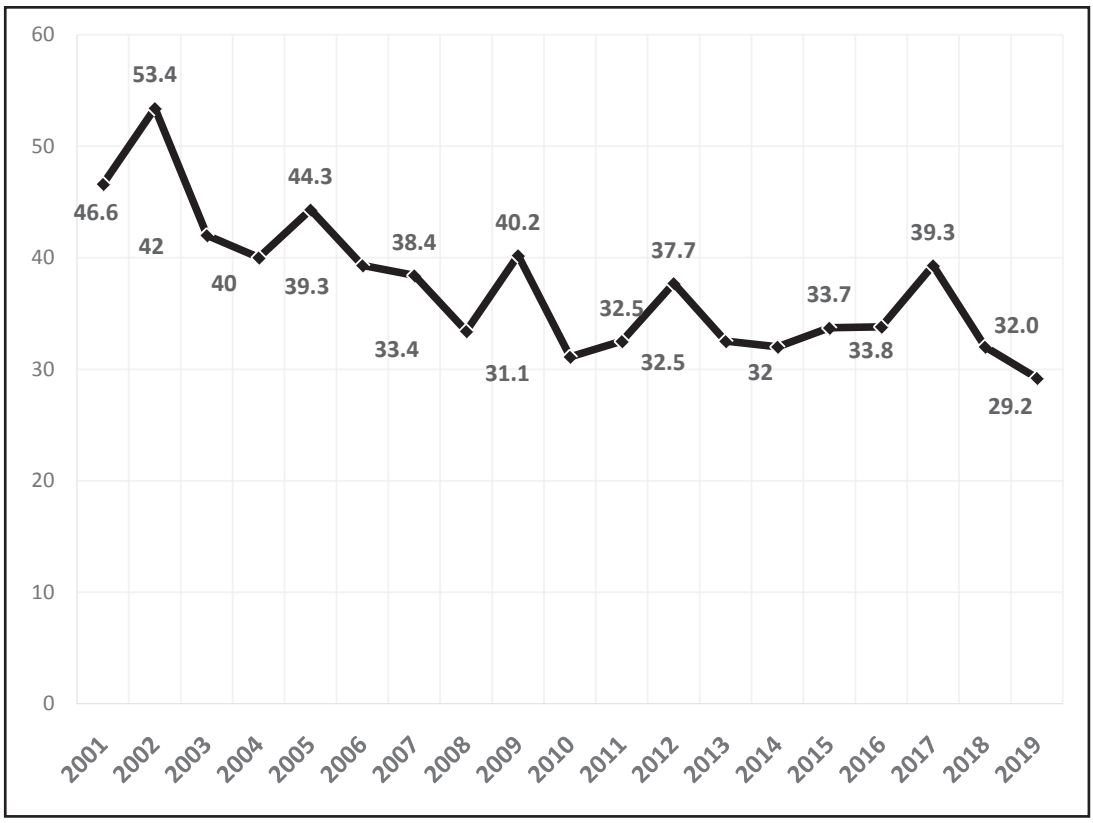


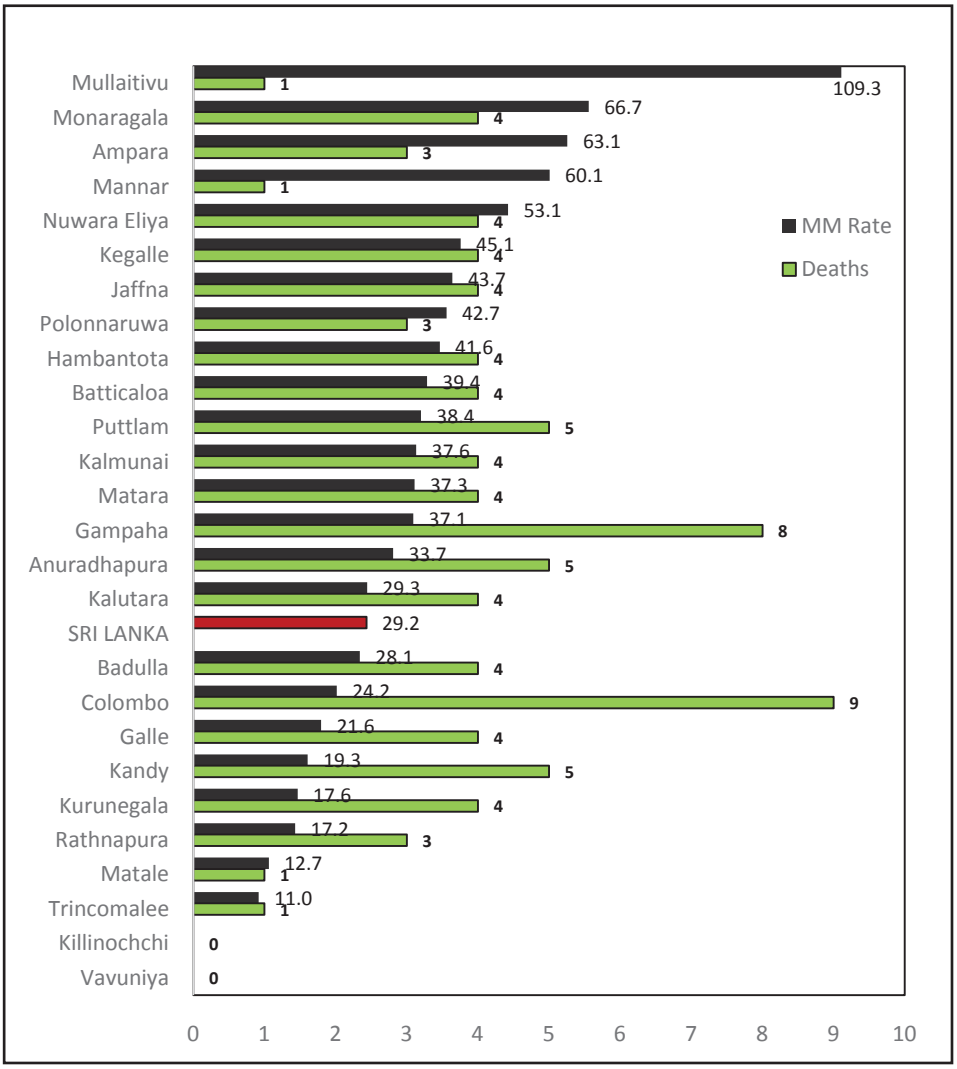
Figure 5.3: Maternal Mortality Ratio from 1995-2019



Source: Maternal & Child Morbidity & Mortality Surveillance Unit - Family Health Bureau

Figure 4 shows number of deaths and MMR of each district based on the live births reported by Registrar General's Department. A wide district disparity is evident with 16 districts reporting their district MMRs above the national value. The highest MMR was reported from Mulativu district (109.3 per 100,000 live births). Other leading districts are Monaragala, Ampara, Mannar and NuwaraEliya. Higher number of maternal deaths were reported from Colombo (9) and Gampaha (8) districts.

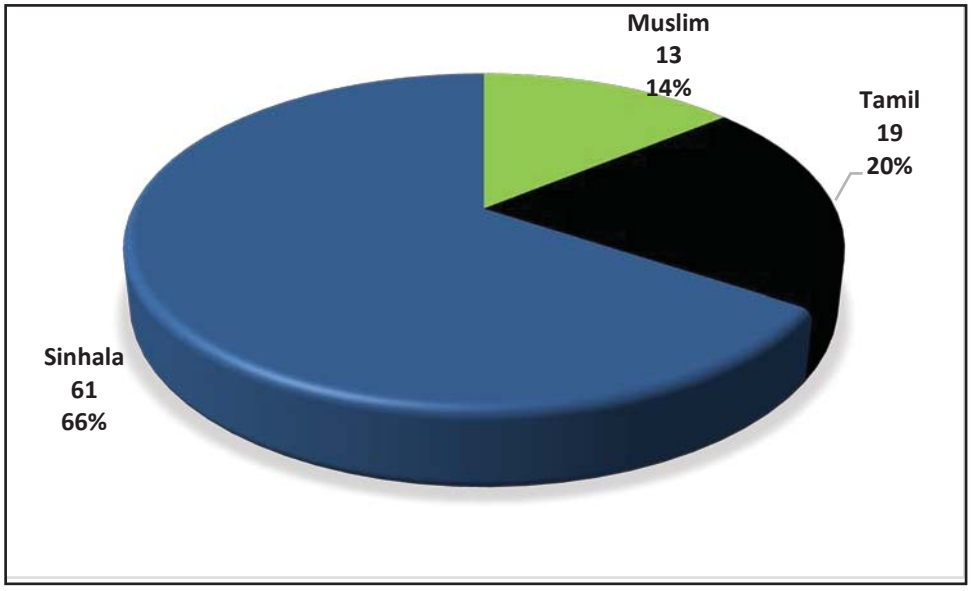
Figure 5.4: Maternal Deaths and MMR by District - 2019



Source: Maternal & Child Morbidity & Mortality Surveillance Unit - Family Health Bureau

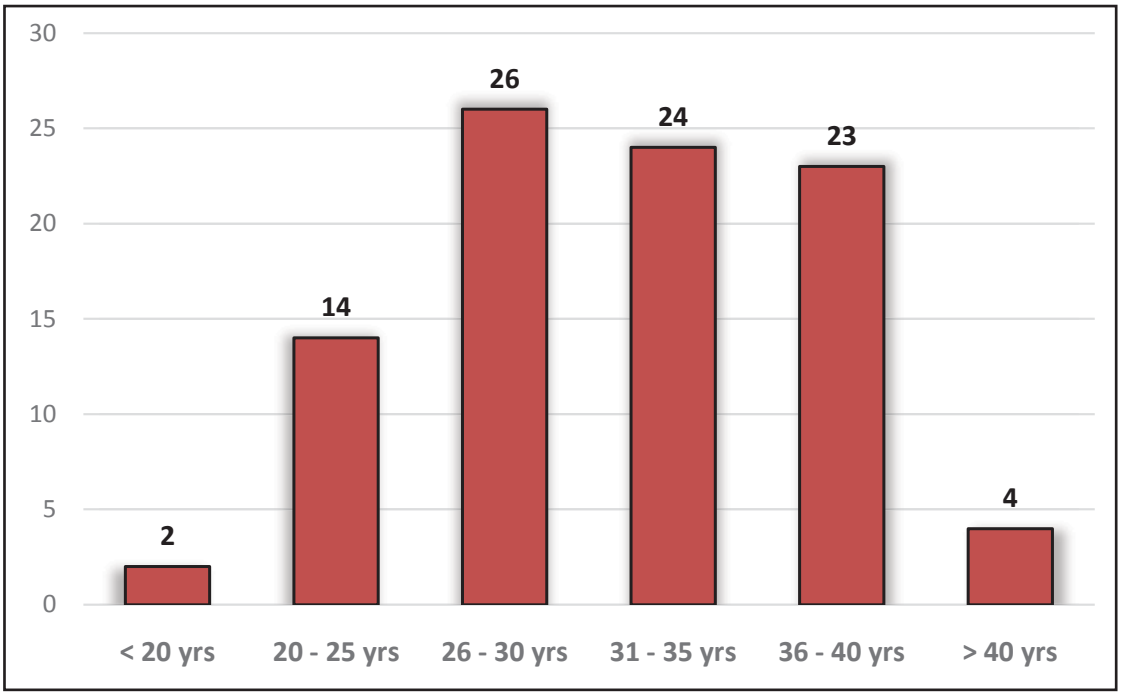
Dead women were located in rural (n=67, 72%), urban (n=21, 23%) and estate (n=5, 5%) sectors. Ethnic composition reveals: Sinhala (n=61, 66%), Tamil (n=19, 20%) and Muslim (n=13, 14%) women (Figure – 5).

Figure 5.5: Ethnicity of the dead women - 2019



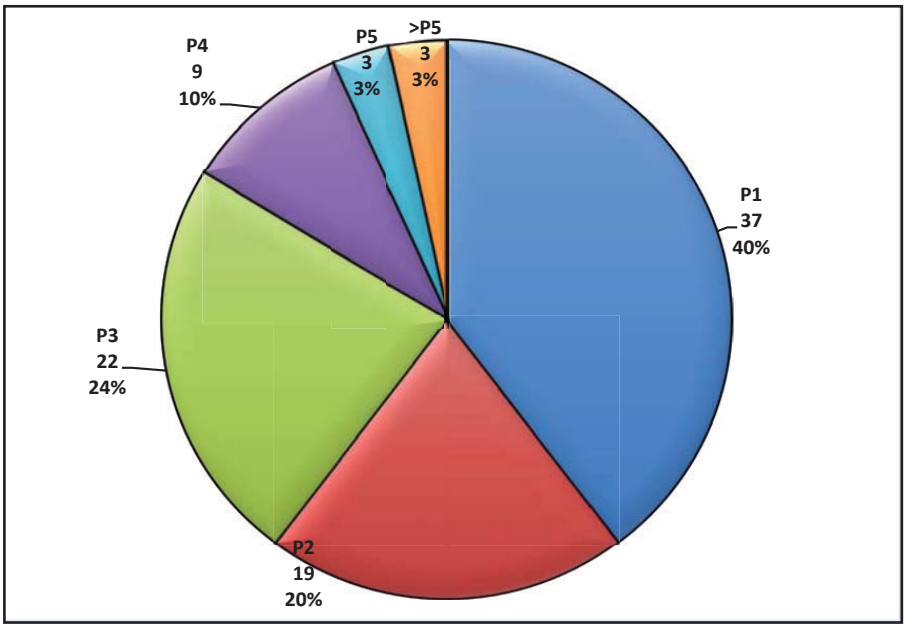
All except one woman was unmarried. There were only two (2) teenage maternal deaths. Majority (n=64, 69%) were in the 20 – 35 year age group. It is highly significant that twenty seven (29%) women were above 35 years of age (Figure 6).

Figure 5.6: Age of the dead women - 2019



Nearly forty percent (n=37, 39.8%) of the dead women were primies and an exactly a similar proportion (n=37, 39.8%) were in their 3rd or more pregnancy (Figure 7). Many (n=42, 45%) had no living children. Ten (11%) women had three or more children. Nineteen (20%) women reported unmet need of family planning.

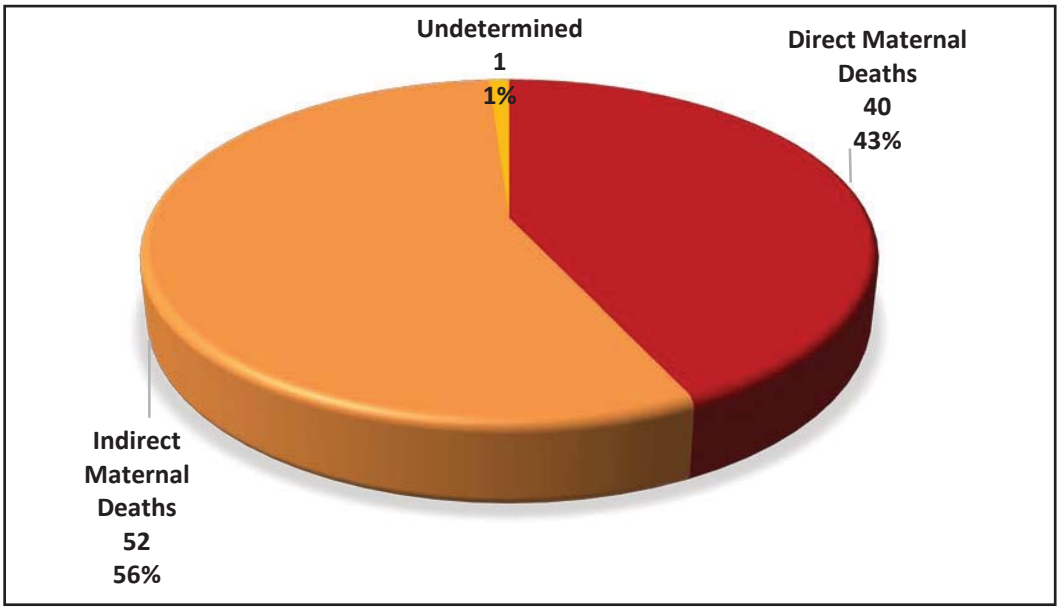
Figure 5.7: Parity of the confirmed maternal deaths - 2019



Maternal deaths are categorized into two groups, direct and indirect. Direct obstetric deaths result from obstetric complications of the pregnant state (pregnancy, labor, and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above. Indirect obstetric deaths result from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by physiologic effects of pregnancy.

A majority (n=52, 56%) of the deaths were indirect maternal deaths while 43% (n=40) were direct and 1% (n=1) were categorized as uncertain (Figure 8).

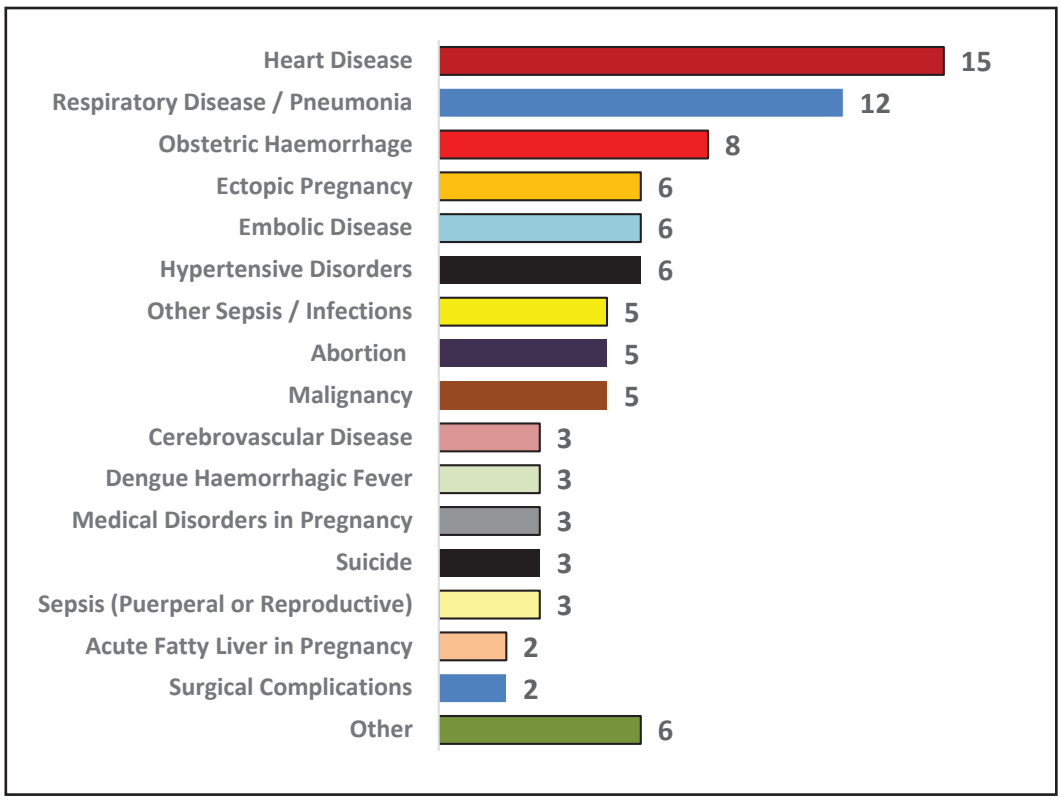
Figure 5.8: Category of maternal deaths - 2019



Conducting post-mortems on all probable maternal deaths is mandatory as governed by the circulars issued by Ministry of Justice to all coroners and Ministry of Health to all hospital heads. Availability of pathological features and underlying cause of death significantly support the final determination of the cause of death of the index case by the expert panel following a consensus reaching process. In the year 2019, the coverage of conducting post-mortems on

confirmed maternal deaths was 96% (n=89). Causes of the maternal deaths reported in 2019 are indicated in figure 9. The leading causes were heart disease (n=15, 16%), respiratory disease (n=12, 13%) and obstetric haemorrhage (n=8, 9%). These three causes were rotating over the past few years as the leading causes of maternal deaths in the country.

Figure 5.9: Causes of maternal deaths - 2019



Further analysis of deaths due to heart disease reveals that 6 & 3 deaths were due to Rheumatic Valvular Heart Disease and Ischaemic Heart Disease respectively. Of the 12 maternal deaths due to Respiratory Diseases, 10 were due to pneumonia. Influenza virus was attributed to 5 pneumonia deaths. Causes of deaths due to obstetric haemorrhage include four post-partum haemorrhage (one home delivery), two uterine rupture and two abnormally-adherent placentae.

A notable reduction of liver disease in the index year is apparent. Out of the maternal suicides reported in the index year (n=24), only indirect and direct cases which fulfiled the maternal death definition (n=3) were included in the analysis.

Figure 10 shows the progression of the cause-specific MMRs over the last two decades. Notably, many of the direct causes (obstetric haemorrhage, hypertensive disorders, liver disease and septic abortion) indicate a significant reduction. However, the indirect causes (mainly heart disease and respiratory disease) remain fluctuating at higher levels.

Figure 5.10: Cause-specific MMRs 2001 - 2019

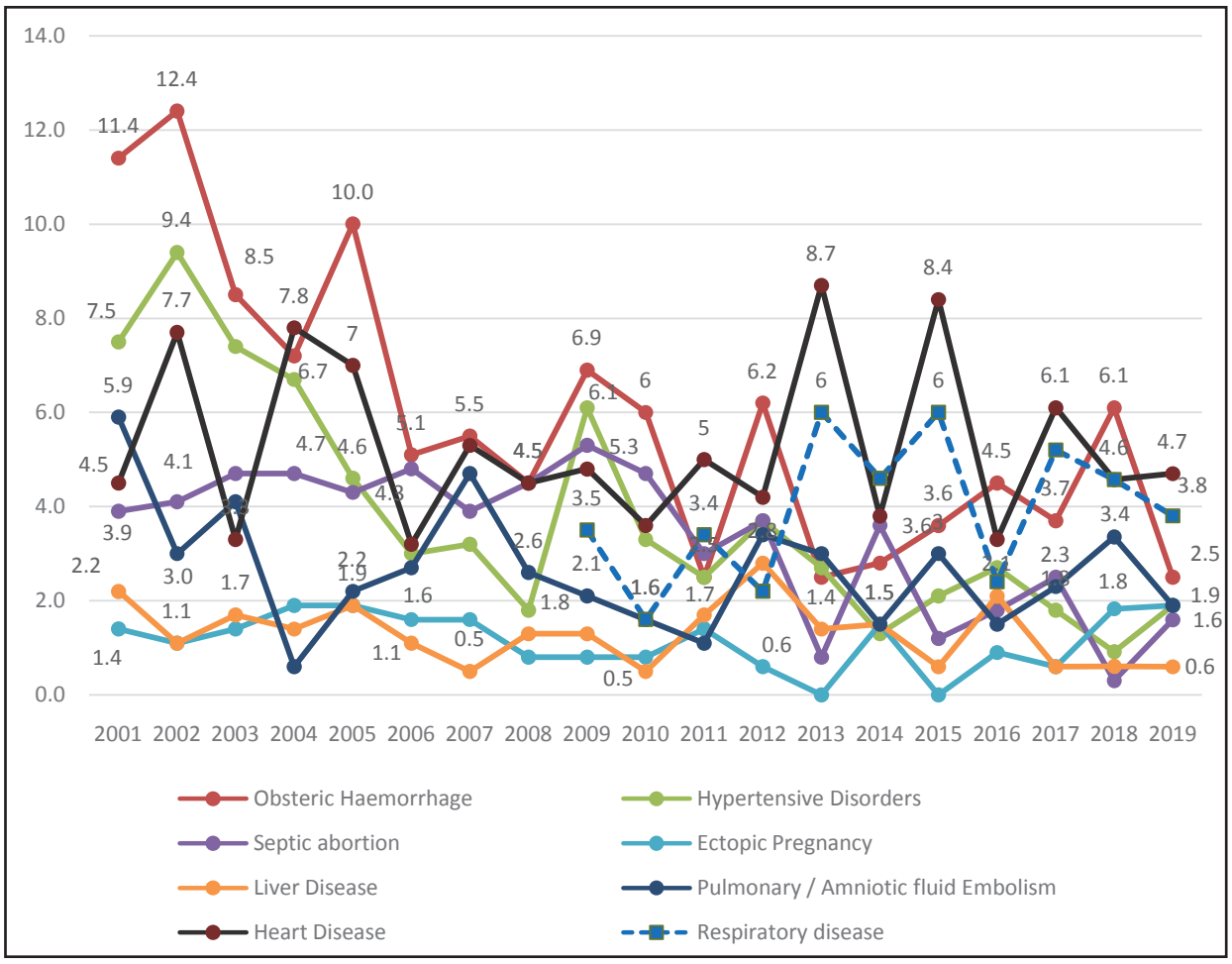


Table 1 shows the mode of delivery of the index women. They have undergone operative delivery in 41 (44.1%) cases and senior involvement in such situations is significant.

Table 5.1: Mode of delivery

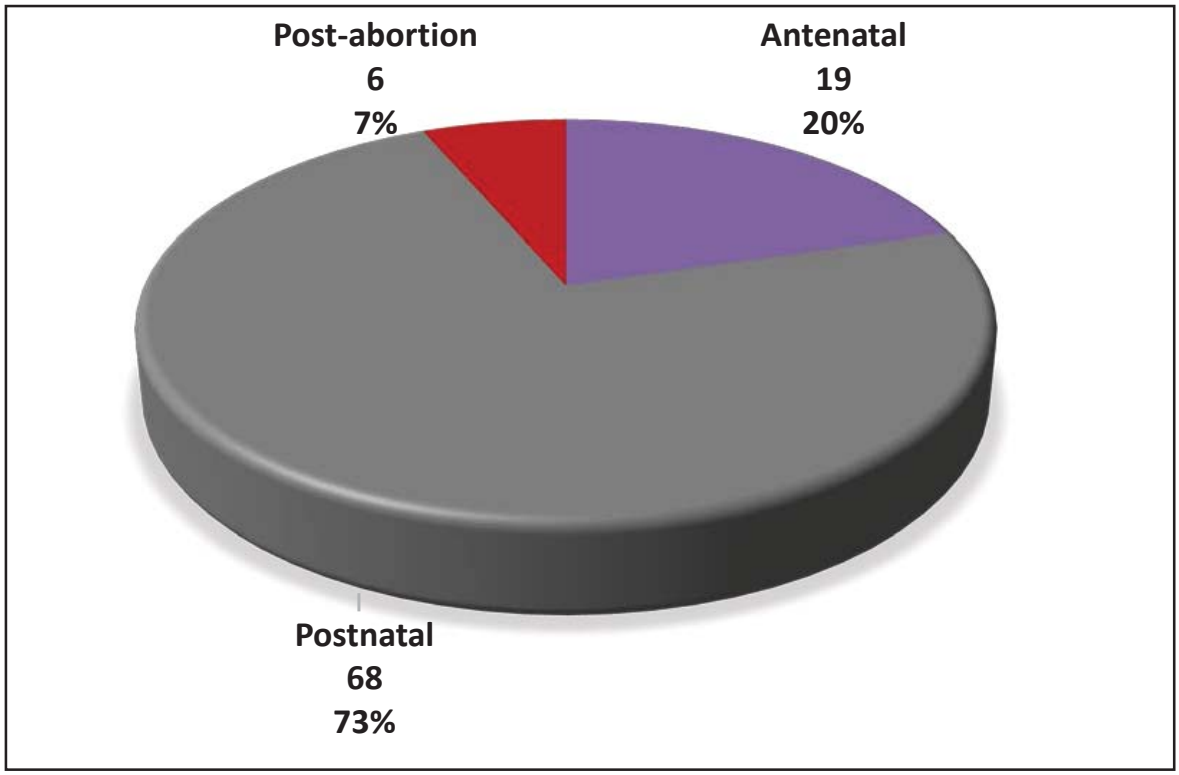
Mode of delivery	n	N	%
Vaginal Delivery		**28**	30.1
Forceps	3		
Routine	18		
Vacuum	2		
Unassisted	5		
Operative Delivery		**41**	44.1
LSCS - Elective	**8**		
Done by VOG	4		
Done by SHO	4		
Emergency Laparotomy	**1**		
Done by VOG	1		
Emergency Hysterotomy	**2**		
Done by VOG	1		
Done by Registrar	1		
LSCS - Emergency	**25**		
Done by VOG	13		
Done by Registrar	1		
Done by SHO	9		
Not mentioned	2		
LSCS - Perimortem	**5**		
Done by VOG	2		
Done by SHO	3		
Not Delivered		**24**	25.8
Total		**93**	100.0

A majority (n=75; 81%) of women were cared at a hospital before they died (Table 2). Eleven (11) women were pronounced dead on admission to a hospital. Out of the women died at a hospital, a majority (n=38; 41%) died at a teaching or a provincial general hospital and 36 (39%) at a base or a district general hospital. One death was reported from a private hospital.

Table 5.2: Place of death

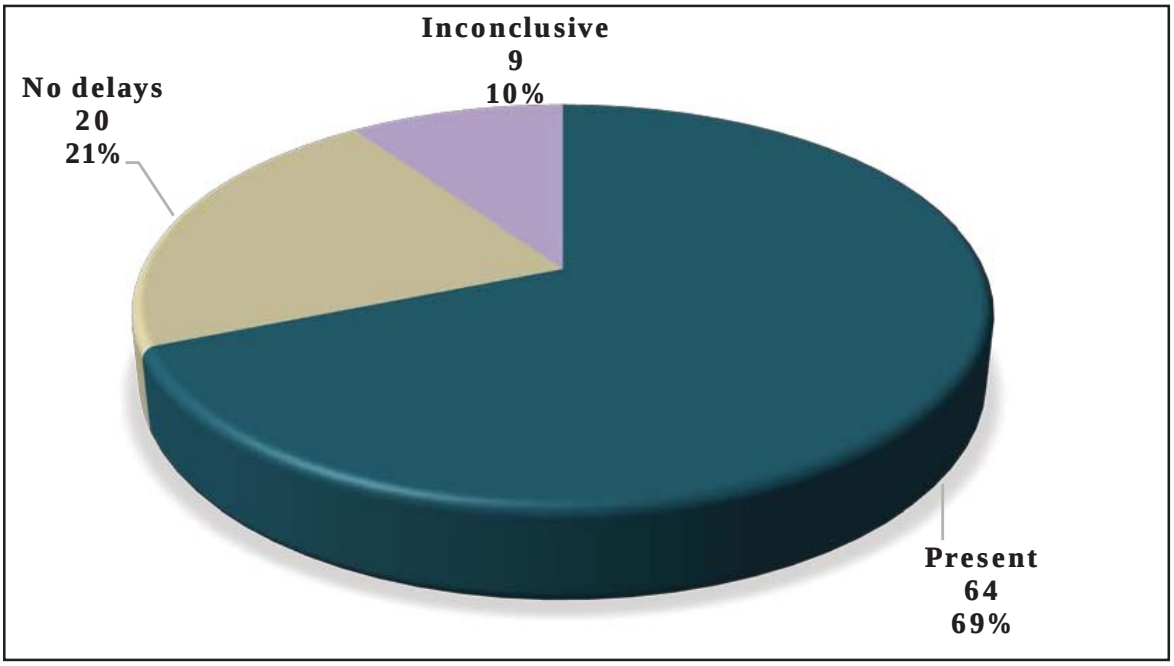
Place of death	N	%
Home	4	4.3
In transit	3	3.2
Death on Admission	11	11.8
Hospital	75	80.6
Base Hospital	14	15.1
District General Hospital	22	23.7
Provincial General Hospital	3	3.2
Teaching Hospital	35	37.6
Private Hospital	1	1.1
Total	**93**	**100.0**

Figure 5.11: Timing of maternal deaths- 2019



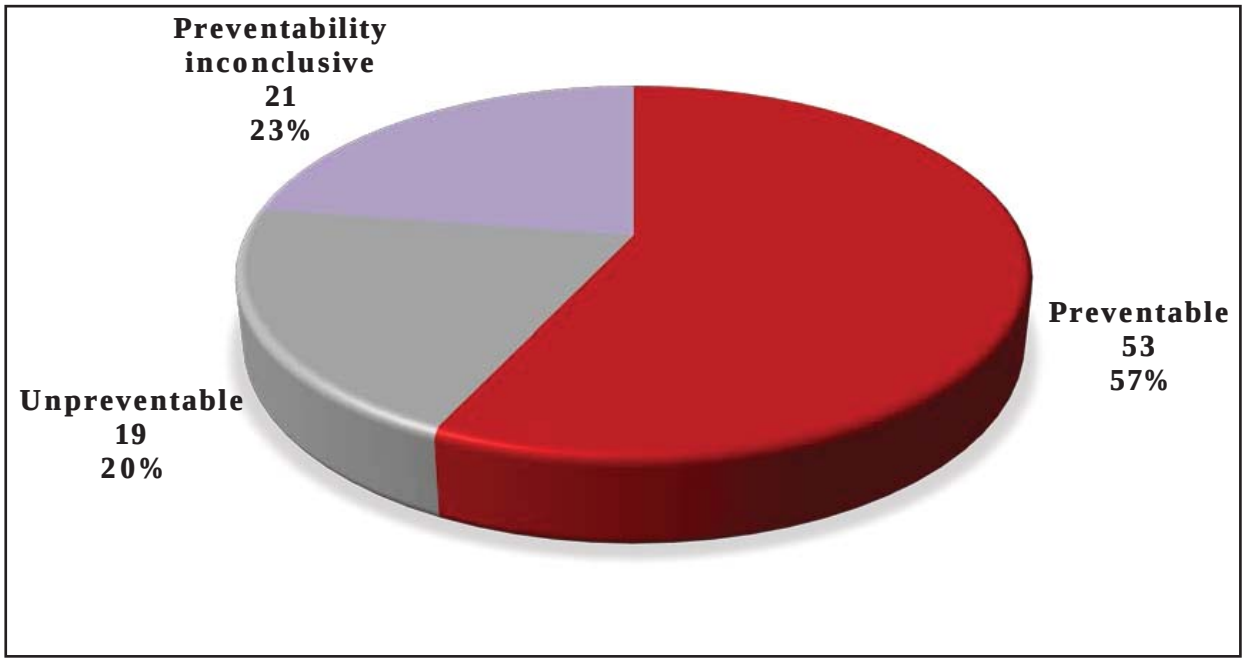
Delays in seeking, reaching and treating (Three delays) were assessed in confirmed maternal deaths. Delays were identified in 64 (69%) deaths (Figure 12). Delay in seeking care was attributable to 46 (50%) cases. Suboptimal care provision, both at field and hospital, was revealed in 39 (42%) cases.

Figure 5.12: Presence of delays



Preventability of the confirmed maternal deaths were assessed by the reviewing expert panel after reaching a consensus. Out of the 93 maternal deaths reported, 53 (57%) were categorized as preventable and 19 deaths (20%) as unpreventable (Figure 13).

Figure 5.13: Preventability of maternal deaths



At each district level national maternal mortality reviews, all the index cases (100%) were discussed, deficiencies were identified and the recommendations were formulated. Details were included in structured maternal mortality review minutes for all districts (100%) and disseminated to all stakeholders.

Acknowledgements:

Sri Lanka College of Obstetricians and Gynaecologists (SLCOG) played a pivotal role in contributing to reviewing cases at national level and expert review at district level. Professional colleges of Anaesthesiologists and Forensic Pathologists also contributed in the maternal death review process.

At the health region level, Regional Director of Health Services (RDHS), hospital heads, Medical Officer – Maternal & Child Health (MOMCH) and Medical Officer of Health (MOH) coordinated maternal mortality surveillance and conducting NMMRs.

Maternal and Child Morbidity and Mortality Surveillance Unit of FHB collated all documents related to index cases, compiled case scenarios, conducted national maternal mortality reviews, sent minutes of the reviews, processed data, analysed data and disseminated the outcome among all stakeholders.

CHAPTER 06

FAMILY PLANNING

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

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, 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.

Oral Contraceptive Pills (OCP), DMPA injections, Intra Uterine Devices (IUD), Condoms and Implants are the modern temporary methods offered by the present-day programme. The modern permanent method is the female sterilization, Ligation and Resection of Tubes (LRT). MOHs, MOs, PHNSs, PHMs and PHIs are being trained in providing awareness and counselling 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 rates. Two definitions are used in describing the indicators.

• 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 Contraceptive Prevalence Rate (CPR) among eligible families for a given year. Data is available in the routine Reproductive Health Management Information System (eRHMIS).

• 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 the national programme.

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 PHMM 66.9% had been using any method by the end of 2019. Proportion of modern methods and natural/traditional methods users were 58.4% and 9.2% respectively.

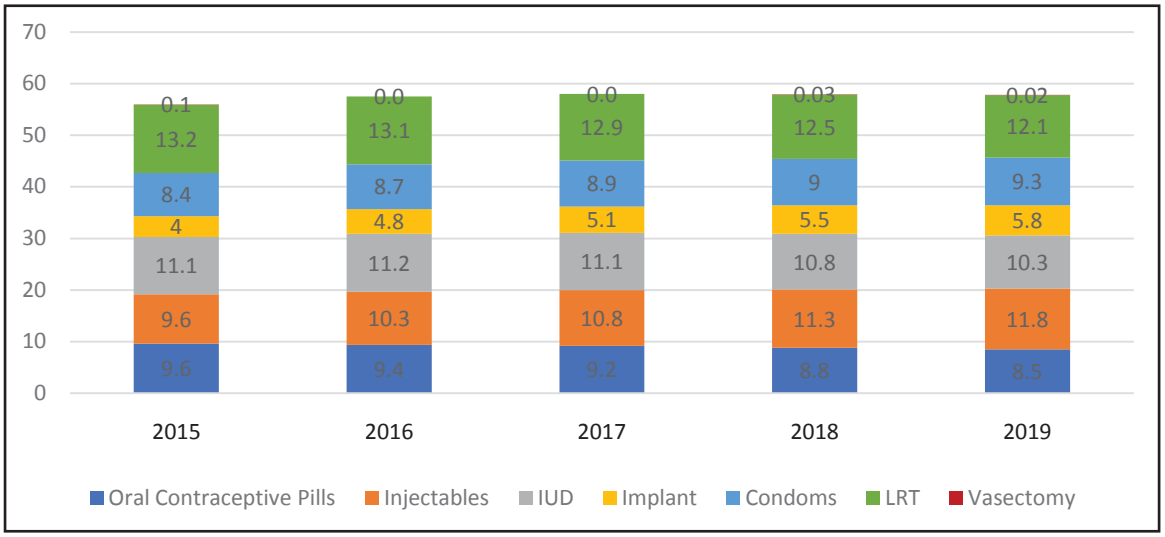
Table 6.1: Percentage of eligible families using all methods 2015 - 2019

Indicator	2015	2016	2017	2018	2019
Modern methods	55.9	57.0	57.3	**57.9**	**57.9**
Natural/Traditional	9.4	9.4	9.3	**9.1**	**9.0**
All	**65.3**	**66.5**	**66.6**	**67**	**66.9**

Source: FHB, eRHMIS 2019

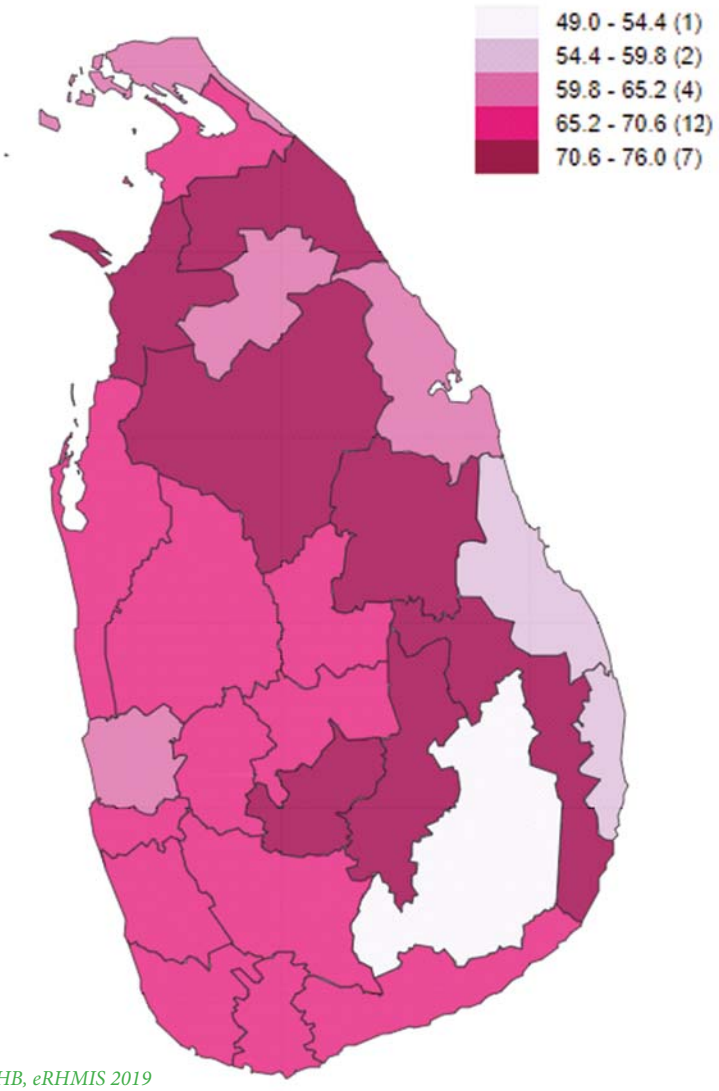
Figure 6.1 presents the trends in method preference since 2015 to 2019. The most popular temporary method of contraception in 2019 has been injectables (11.8%), followed by IUDs (10.4%), condoms (9.3%) and OCPs (8.5%). Approximately 12.1% of eligible families practiced female sterilization (LRT) for fertility control.

Figure 6.1: Current users of modern family planning methods, from 2015 - 2019



Source: FHB, eRHMIS 2019

Figure 6.2: Shows the district variation in CPR (All methods) in 2019



Source: FHB, eRHMIS 2019

6.2 NEW ACCEPTOR RATE

RHMIS has a special registration system to record the pattern of new acceptance of contraceptive methods by couples. In 2019, the number of couples newly recruited for modern contraceptive methods was 152,532 (Table 6.2) Out of this total new acceptor, 90.9% had accepted temporary methods as a new method from the programme in 2019.

6.2.1 New Acceptors by method

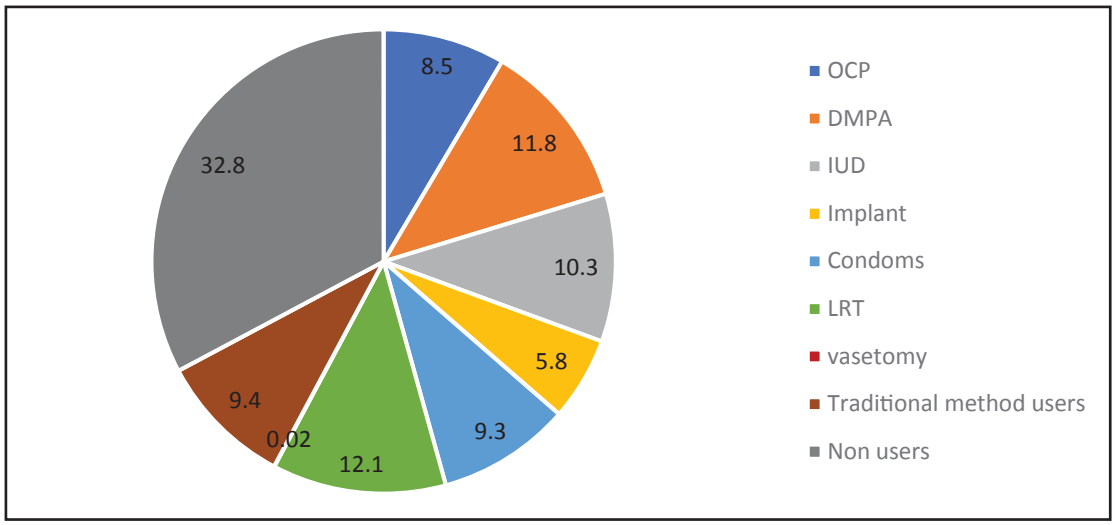
The number of new acceptors by method is given in table 6.2.

Table 6.2: Contraceptive methods new acceptors by method from 2015 - 2019

Item	2015	2016	2017	2018	2019
New Acceptors (No.)	153,901	157,191	168,120	171,397	152,532
IUD	44,916	37,517	32,986	29,382	24,214
Oral Pills	33,279	27,609	26,080	26,188	22,949
Sterilizations	14,919	14,806	16,106	15,783	13,883
Injectable	14,491	36,322	49,262	53,208	53,131
Implants	46,796	40,937	43,686	46,836	38,355

Source: FHB, eRHMIS 2019

Figure 6.3: Distribution of various contraceptive methods in 2019



Source: FHB, eRHMIS 2019

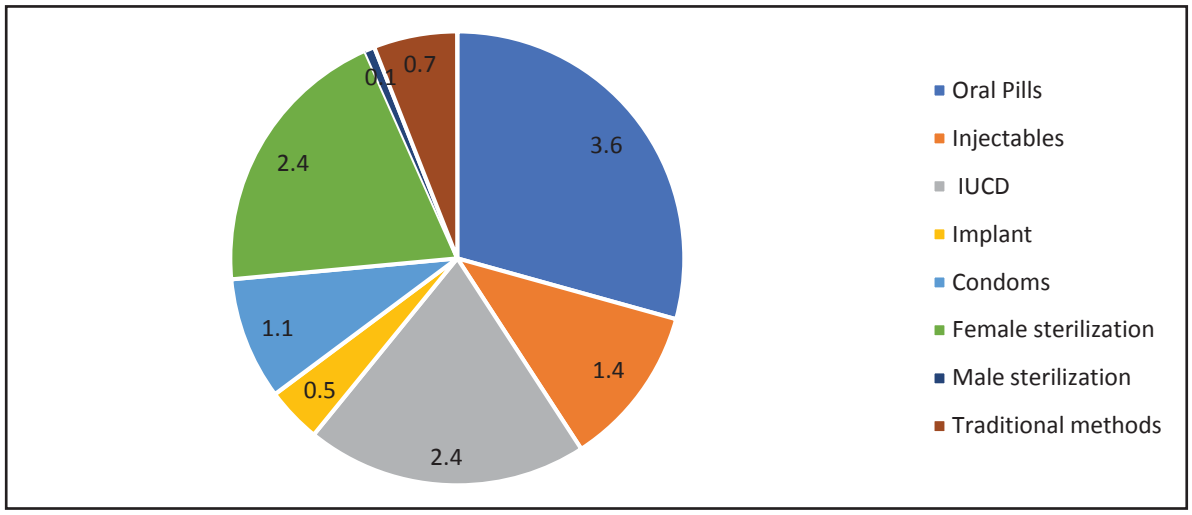
6.2.2 Contraceptive failure rate and com- plications

Contraceptive method failures are supposed to be reported through eRHMIS. Failure rates for different methods are given in Figure 6.4. The highest failure rate was among OCP users (3.6%). Failure rate reporting is an area need attention as there is under reporting.

6.2.3 Unmet need for Family Planning

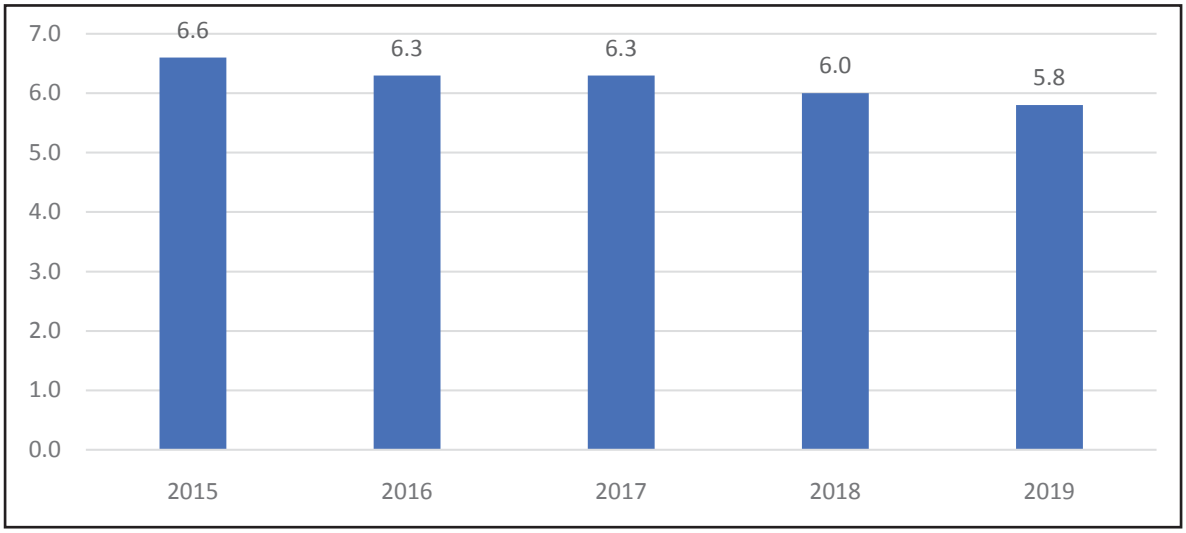
Unmet need for family planning means a fertile woman married or living in union, not using any contraception (modern, natural or traditional), yet not wanting any more children or wanting to postpone a pregnancy for at least 2 years. PHMs gather this information from their eligible families. Figure 6.5 presents the trends in unmet need for family planning from 2015 to 2019.

Figure 6.4: Contraceptive failure rate in 2019



Source: FHB, eRHMIS 2019

Figure 6.5: Percentage of eligible couples having unmet need for family planning 2015-2019



Source: FHB, eRHMIS 2019

Unmet need for family planning among eligible couples over last 5 years has dropped from 6.6% to 5.8%. However, under reporting needs to be excluded. A reduction in unmet need is important if the maternal deaths are to be reduced further.

6.3 Services for sub fertile couples

Provision of services for sub fertile 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 2019 it was only 3% which is again a grossly under reported value.

6.4 Activities and achievements in 2019

01 • National Family Planning Day was celebrated on 26th of September under the theme 'Healthy kids, happy family' to address birth spacing. The main function was held at Hotel Taj Samudra. The Chief Guest was Hon. Faizal Cassim, State Minister of Health, Nutrition and Indigenous Medicine.

02 • Two, 3-day ToT programmes on family planning for Medical Staff were conducted at Family Health Bureau. Thirty three Medical Officers were trained as district level Master Trainers.

03 • A Five 2-day ToT programmes on family planning were conducted at Family Health Bureau. During the programme 102 Public Health Nursing Sisters and Nursing Officers were trained as district level Master Trainers.

04 • As a collaborative effort between Sri Lanka College of Obstetricians and Gynaecologists and Family Health Bureau, awareness programmes on post- partum family planning for health staff were conducted in the Colombo district. More than 400 health staff comprising of Medical Officers, Nursing Officers and Public Health Mid-wives participated in these programmes.

05 • A 2-day training programme on reproductive health for 40 postgraduate trainees of Family Medicine was conducted.

06 • Technical and financial support was provided to Office of the Regional Director of Health Services at Puttalam and Gampaha to conduct 2-day district level training programmes to update the knowledge of the health staff including Medical Officers, Public Health Nursing Sisters and Public Health Midwives, on family planning.

07 • Technical support was provided for the pilot project on reproductive health education for school children, which was conducted in the Western Province by the Ministry of Education.

08 • Technical support was provided for civil society organizations to train their staff and volunteers on Family Planning.

09 • Production of a video on Reproductive Health for Advanced Level school children.

10 • Sensitization of school Principals in Colombo district on Reproductive Health

11 • Symposium on unplanned pregnancies was held at annual sessions of Sri Lanka Medical association

12 • An advocacy Meeting on the importance of Family Planning was conducted for religious leaders.

13 • Development of an educational video on IUD in Tamil language for the clients of FP services was initiated.

14 • Development of leaflets for general public on currently available Family Planning methods was initiated.

15 • A study to assess the community perception on reorienting the family planning commuuication stratergy was commenced.

16 • Modification of the curriculum of the TOT on family planning was done.

17 • Draft of the family planning curriculum for teacher trainees was prepared.

18 • Draft of Human Assisted Reproduction and Genetic Act (HARGA) was prepared.

19 • A draft Costed Implementation Plan for National Family Planning Programme was prepared.

20 • A research on "Awareness on services, accessibility to medical care, treatment seeking behaviour, quality of life and perceptions on sub fertility among a sample sub fertile couples" was conducted in Rathnapura district.

21 • A symposium on family planning was held at annual academic sessions of College Community Physicians' Sri Lanka.

22 • A draft of the family planning chapter for the guide for school teachers on FP was prepared.

CHAPTER 07

SCHOOL CHILD, ADOLESCENTS AND YOUTH

7.1 SCHOOL HEALTH PROGRAMME

School health is a shared responsibility of both the Health and the Education Ministries. FHB is the focal point for the School Health Programme in Sri Lanka and is involved in planning, providing technical guidance, monitoring, evaluating the programme activities, conducting research and management of logistics relevant to school health activities. The services are delivered through the primary health care staff in collaboration with the provincial health and education 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, Colombo, Anuradhapura, Gampaha, Kurunegala, Kegalle and Matara to conduct school health activities in urban areas.

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

The Medical Officer of Health (MOH) is responsible for implementation of the school health programme under the technical guidance of provincial /district consultant community physician and MO/MCHs 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, Anuradhapura, Gampaha, Kurunegala, Kegalle, Matara and Jaffna, School Medical Officers implement the school health programme.

At present the school health programme focuses on five major thematic areas. These include: School medical services include School Medical Inspection (SMI) of children and making relevant referrals. The PHI carries out the initial screening of children and the MOH conducts the medical inspections. In small schools (with equal or 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.

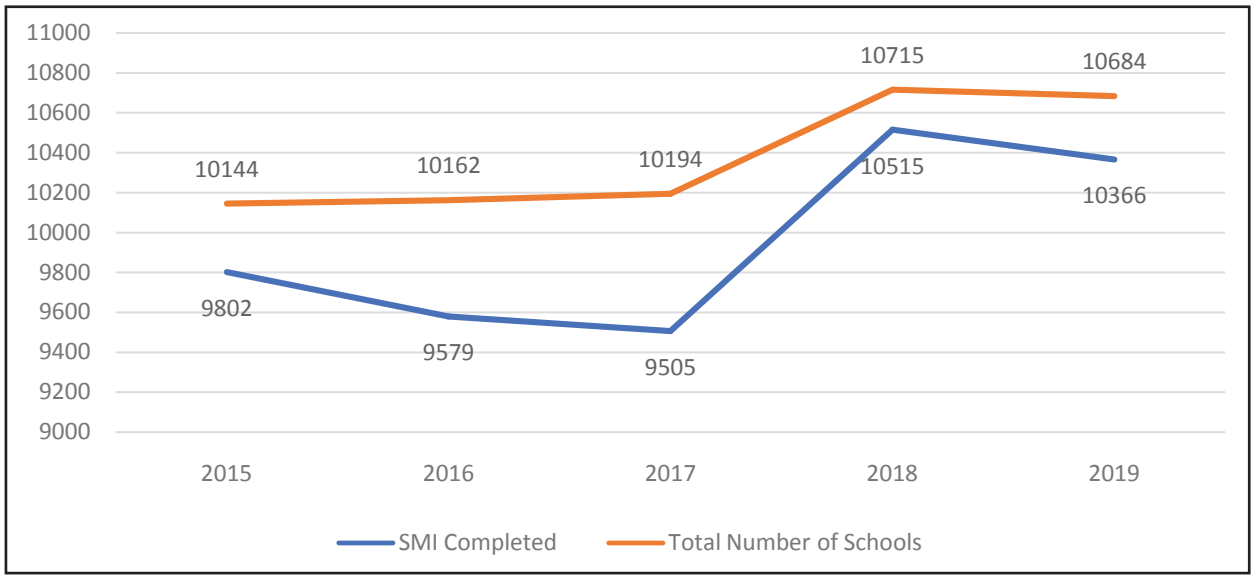
The children detected with defects are either treated locally or referred to the closest specialist clinic for necessary management. Thereafter, they are followed up by the PHIs to ensure the correction of defects. In addition, the MOHs organize Behaviour Change Communication programmes aimed at children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

Apart from the SMI, the PHIs conduct a school health survey in the schools annually, the findings of which are used to make 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 Waste management in the school premises.

There were 10684 schools and The SMIs were conducted in 10366 schools resulting in an overall school coverage of 97%.

Figure 7.1: Total number of schools versus number of schools where SMI were conducted 2015 to 2019



Source: FHB, eRHMIS 2019
** 2018 data included Government, Pirivenas and some international Schools as well*

7.1.1 SCHOOL HEALTH SURVEYS

It is the responsibility of the 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 2019, school health surveys of 99.6% of the schools had been conducted island wide. The proper sanitation, hygiene and use of safe water are vital in providing a safe school environment. Nearly 92.9% of schools had adequate toilet facilities while 77.8% of the schools had adequate drinking water sources.

7.1.2 MALNUTRITION AMONG SCHOOL CHILDREN

During the SMIs students are assessed for their nutritional status. Stunting is assessed in grades 1, 4, 7 and 10. In 2019, 7.6 % and 5.6% of children in grades 1 and 4 were stunted respectively.

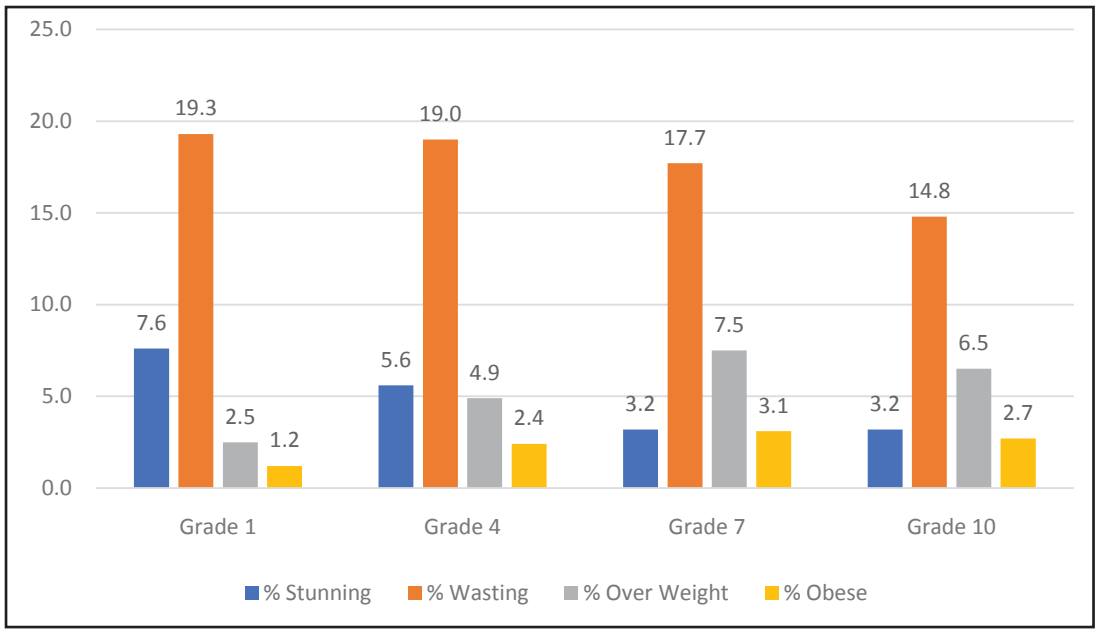
In 2019, wasting was more common among grade 1 and 4 students and it is nearly 19% in each age group. The highest rate of over weight was reported among children in grade 7 (7.5%), while among children in grade 10 it was 6.5% (Figure 7.2).

Highest rate of obesity was noted among grade 7 students and it was 3.1% and 2.7% among grade 7 and 10 students respectively. In addition, the Body Mass Index (BMI) of all students in grade 10 is assessed and the necessary nutritional interventions are done during the nutrition month each year.

During the year 2019, 121891 (85.6%) grade 10 students were assessed for their nutritional status and the trends of prevalence of over-weight and low BMI among male and female students are given in figure 7.3 and 7.4 respectively. The overall Low BMI among grade 10 students in 2019 was 18% with 21.9% among males while it is 14.1% among females

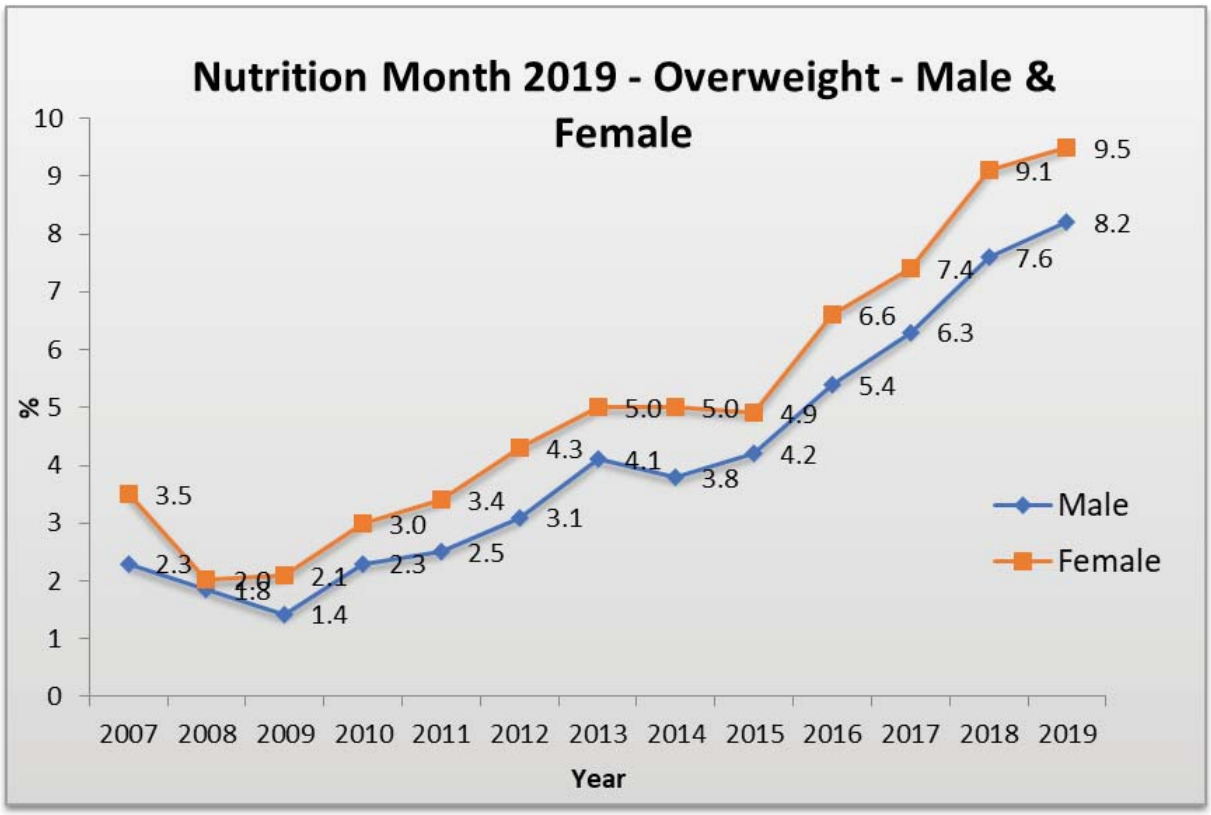
The overall overweight among grade 10 students in 2019 was 8.9% with 9.5% among females and 8.2% among males (Figure 7.3).

Figure 7.2: Frequency distribution of school children in different grades with stunting, wasting and overweight in 2019



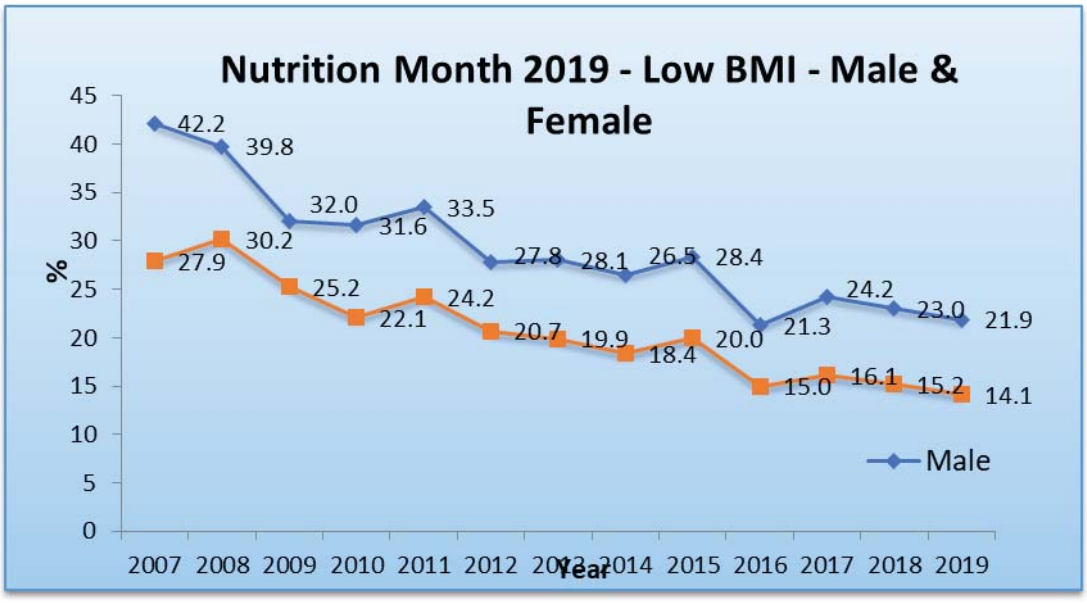
Source: FHB, eRHMIS 2019

Figure 7.3: frequency distribution of Grade 10 children with an overweight BMI 2007-2019



Source: FHB, eRHMIS 2019

Figure 7.4. Frequency distribution of Grade 10 children with a low BMI 2007 - 2019

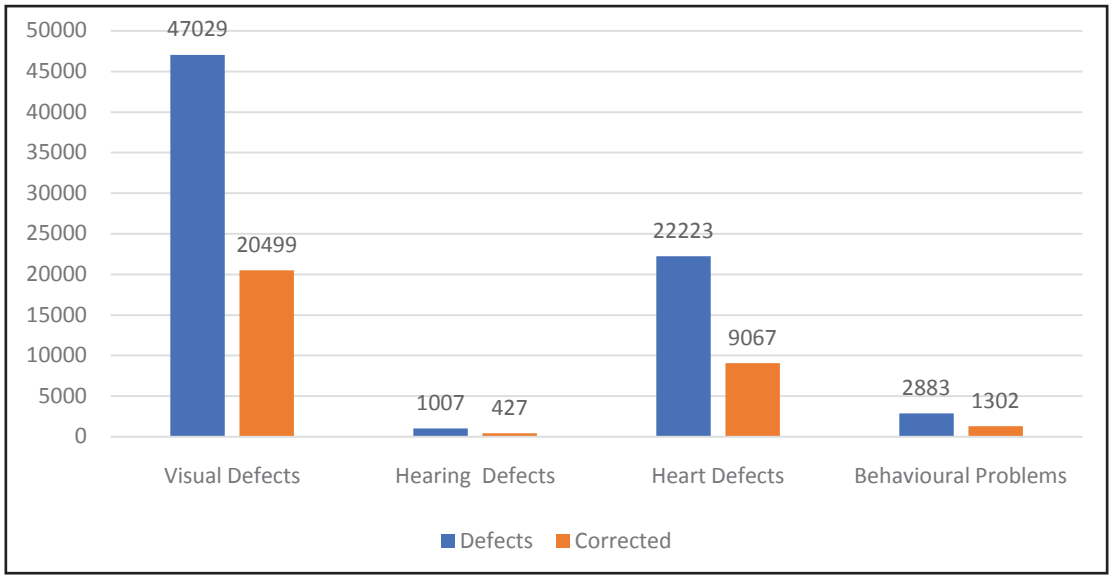


Source : FHB, eRHMIS 2019

7.1.3 STRENGTHENING FOLLOW UP OF DEFECTS DETECTED FOLLOWING SMI

The follow up of children with special needs, suspected heart disease, visual defects & hearing defects has been strengthened. The follow up visits by the PHI for the students identified with correctable defects should be closely monitored at the monthly MOH conferences in order to increase the number of corrected defects.

Figure 7.5: Total number of some selected defects among examined school children and corrected number of defects



Source: FHB, eRHMIS 2019

7.1.4. IMMUNIZATION

The expanded programme of Immunization (EPI) for school children showed nearly 100% immunization coverage for the aTD vaccine for children in grade 7 and the coverage of HPV1 vaccine for grade 6 girls was 85.6% while the coverage of the second dose was only 63.3%.

7.1.5. HEALTH PROMOTING SCHOOL INITIATIVE

This programme was launched in 2007 and an appreciable level of effort had to be made to implement the programme at schools. The necessary technical guidance for implementation was provided by the School Health Unit of the Family Health Bureau. During 2019, all the schools were evaluated using an evaluation tool developed by experts in the field. An expert team from the School Health unit of the Family Health Bureau randomly supervised the Gold level schools throughout the country via field visits during the year 2019.

7.1.6 WEEKLY IRON FOLATE SUPPLEMENTATION (WIFS)

WIFS is an evidence based intervention introduced to all the school children in 2003 to prevent anaemia among school children, in which weekly treatment with iron to late and vitamin C is given for a period of six months. This is preceded with an anti-helminthic for primary school children in all the districts except Anuradhapura, Batticaloa and Kurunegala where the worm prevalence is low.

The leaflet for WIFS programme was prepared, printed and distributed throughout the country. According to the recent research evidence done by the MRI in 2017 prevalence of anaemia is markedly reduced for the last 10 years of iron supplementation programme. Prevalence of anaemia among adolescent (10-18 years) were 8.8% (National Nutrition and Micronutrient Survey among school adolescents age 10-18 years in Sri Lanka 2017 MRI) while among school children 6-12 was 11.1% in 2016. (Nutrition status, Dietary practices and pattern of physical activity among school children aged 6-12 years 2016, MRI.

7.1.7 CONTRIBUTION TO NATIONAL POLICIES AND GUIDELINES

The school health unit had coordinated two National Coordinating Committee (NCC) meetings on School Health during the year 2019

The National Coordinating Committee (NCC) on School Health of the Ministry of Health is chaired by the Director General of Health Services and functions as the main executive body that takes decisions with regard to the school health activities and providing policy, guideline and technical directives to be taken up at the Steering committee of the 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 worked in coordination with environment and Occupation unit and the Nutrition Division of Ministry of Health to upgrade the status of school canteens in order to provide healthy food to school children.

While the road to ensuring healthy school children is not without challenges, particularly in an ever changing environment, the School Health unit remains committed to working with the education and health departments and national organizations to ensure that a continuum of support is available to meet the healthy development needs of all school children.

Table 7.1: Prevalence of health problems detected at SMIs 2015 - 2019 Cases per 1000 students examined)

Health problem	2015	2016	2017	2018	2019
Dental caries	228.7	231.9	220.8	211.4	202.4
Pediculosis	57.8	58.2	63.0	55.7	50.5
Malocclusion	27.9	29.6	27.0	27.4	25.9
Visual defects	27.6	31.0	30.7	32.3	32.5
Fluorosis	13.2	12.8	9.7	9.4	7.3
Heart disease	16.6	16.9	15.9	15.2	15.4
Skin diseases	13.4	16.1	15.7	13.4	13.5
Pallor	13.1	11.0	10.3	9.8	7.3
Gingivitis	3.7	2.8	2.9	-	
Asthma	3.01	5.3	4.8	5.1	4.3
Glossitis	1.2	1.4	1.4	0.3	0.3
Learning problems	2.8	2.8	2.7	3.6	3.2
Squint	1.8	1.9	2.1	1.6	1.5
Behavioural problems	2.1	2.2	2.2	2.3	2.0
Speech Defects	1.6	1.6	1.6	1.6	1.7
Scabies	1.6	1.2	0.9	0.7	0.6
ENT Problems	1.4	1.4	1.3	1.3	1.2
Lung disease	0.8	0.5	0.4	0.1	0.1
Hearing defects	0.8	0.8	0.7	0.7	0.7
Xerophthalmia	0.6	0.4	0.3	0.1	0.1
Goitre	0.7	0.6	0.5	0.6	0.6
Lymphadenopathy	0.5	0.3	0.4	0.3	0.3
Orthopaedic problems	0.4	0.5	0.5	0.4	0.4
History of fits	2.7	1.7	2.4	0.1	0.1
Bitot spots	0.2	0.1	0.1	0.1	0.1

Source: FHB, eRHMIS 2019

7.2 ACTIVITIES AND ACHIEVEMENTS IN 2019

1. Promotion of Psycho Social Health among School Children:

• The school health unit developed and published "psycho social health promotion among school children"- A hand book for teachers and trainer's manual on psycho social health promotion among school children

• Piloting of psychosocial health promotion package for school going adolescents. A quasi experimental study was designed to assess effectiveness of the psychosocial health promotion package for improving psychosocial wellbeing of school adolescents. Two consultative meetings were held to finalize the methodology and to develop and finalize the tools. Panadura MOH area of Kalutara District was selected as the intervention area and socio-economically similar Kelaniya MOH area of Gampaha district was selected as control area for the assessment of effectiveness of the package. Two training programmes were conducted to train data collectors in both areas. Grade 9 students (N=561) of the selected schools in Panadura and Kelaniya MOH areas participated in the baseline study. Post-intervention survey was conducted in the same schools after 3 months.

A 3-day master training programme was conducted at FHB for district level with the participation of 55 public health managers. A 3-day TOT programme was conducted for seventy-five MOH, AMOH, PHNS, SPHI, PHIs in Kalutara. Fifteen 2-day training programmes were conducted for the school teachers in Kalutara District. Trained teachers carried out activities to promote psychosocial wellbeing of students in grades 9. These training programmes were conducted as interactive sessions to fully engage participants and comprised of lecture-discussions, small group activities, discussion of case scenarios and participant presentations.

Post-intervention survey was conducted in the same schools after 3 months. The third consultative meeting was held to discuss the plan for analysis of results. Bullying among school children has decreased from 16.6% to 13% in Panadura MOH area. Compared with the baseline survey, a higher proportion of children stated that they like "being in the school" (95.6% vs 89.1%) and "enjoy activities in school" (97.8% vs 93%).

Key findings of focus group discussion with teachers trained under the peripheral teacher training programme:

• The training programme is highly appreciated by the teachers

• Teachers requested to expand this training for other teachers as well

• A considerable time period would be needed to see the expected output

• It is important to in cooperate this training to the basic training of all the teachers

• They believe that there is a significant attitudinal change among them with regard to Corporal punishment.

• Teachers are felt that the students are in more faith towards teachers and they are open to discuss their problems

• There is a remarkable behavioural change among the students following implementation of the programme at school level

• The school health unit of family health bureau had conducted six, 3-day TOT programmes on promoting Psycho social Wellbeing among school children during the year 2019 and trained master trainers from all the districts in the country.

A total of 200 master trainers were trained under this programme. These master trainers conducted five teacher training programmes at peripheries training nearly 300 teachers. School health unit have requested these master trainers to include this training programme to their 2020 action plan.

• The school health unit conducted, 13 life skills programmes (three days) island wide, including

Nuwara Eliya, Polonnaruwa, Gampaha,Ampara, Hambantota,Kandy, Vavunia, etc.

2. Managing Nutrition problems among adolescents: Following actions was taken by the School Health unit in coordination with the Ministry of Education in order to prevent obesity and premature deaths among these children in the future due to Non communicable diseases.

Six one day TOT programmes were conducted to health and educational staff on management of Nutritional problems among school children.

• Nutrition month activity was planned and implemented during the month of June. BMI of all the grade 10 children were assessed and necessary interventions were done for the children with impaired nutritional status

• Facilitating establishment of health corners in schools

• Providing weighing scales with height measuring rods worth of Rs 25,000 to National schools in Colombo Municipal Council area where the obesity prevalence is high.

• Providing IEC materials – BMI for age- (Gender Specific), Height for age- (Gender Specific), BMI management charts to schools

• School health unit together with the Environment and Occupational Health unit of the Ministry of Health played a major role in development of School Canteen Assessment format since the nutritional quality of food is not considered in H800 which is used now for the grading of food handling establishments. This new format was named as "Grading of Food Handling Institutions – for School Canteens" under H 1306. This format was pretested in Kurunegala and Rathnapura districts and amendments were done by the School Health unit of the family health bureau, Nutrition Division and the Ministry of Education. Only grade A are B canteens are recommended for schools according to this new school canteen format.

• Island wide school canteen survey using this new format was a timely felt need to assess the baseline situation of the school canteens in the country as school food environment is a key factor determining the food habits of school children. Nutrition division has successfully completed the responsibility of this task of school canteen assessment as an activity of the Nutrition Month 2019.
Ministry of Education (MoE) has identified and listed 2729 school canteens in the country. In this survey, 2336 school canteens have been assessed by the PHI
The analysis of those canteens identified from the list of MoE are presented in the table 7.2.

Table 7.2 Grading of school canteens

Grading of school canteens	Total Canteens
Grade A (75 or above)	**6.4%**
Grade B (74 -61)	**54.0%**
Grade C (60 or below)	**39.6%**

Source: Final Report-school canteen assessment- 2019 -Nutrition Division-Ministry of Health

It is utmost important to give this new school canteen assessment format a legal backbone for the better implementation. Therefore, request was made to E & OH to incorporate this to the food act which is in the process of amendment currently.

• School health unit directly worked at the ground level as well and conducted work- shops for school children and parents on Nutritional and promotion of physical activity.

3. Health promoting school

• Revision of Health promoting school evaluating criteria giving more weightage for psycho social wellbeing.
• Field visits for health promoting schools which was accredited as Golden level.

4. Training of teachers at National Institute of Education

Teachers were trained in Sexual and Reproductive health, Adolescent Health and Nutrition in both Sinhala and Tamil mediums. Nearly 8 such training programmes were conducted at NIE.

5. Health and Physical Education subject

Cabinet paper was forwarded by the Ministry of Health to make Health and Physical Education subject a Compulsory core subject for O/L and it was sent for the National Education Commission for concurrence. Awaiting concurrences.

7.3 ADOLESCENT AND YOUTH HEALTH SERVICES

Activities & Achievement in 2019

1. Launching of the National Strategic Plan on Adolescent and Youth Health

National Strategic Plan on Adolescent and Youth Health was developed and finalized through several consultative meetings on adolescent and youth health with health and non-health experts and young person over 2016-2018. National Strategic Plan on Adolescent and Youth Health and Standards on Adolescent and Youth Friendly Health Services were handed over to secretary health. Launching ceremony was held on 20.08.2019 at BMICH and was chaired Additional Secretary Public Health Services.

2. Capacity building of the staff to improve the adolescent and youth health

• Two training progrmmes for middle level managers in the preventive and curative sector health staff were conducted to highlight the importance of the implementation of the strategic plan and standards on adolescent and youth friendly health services in Sri Lanka. Two programmes were conducted covering national and middle level managers.

• Three Training of trainer programme(TOT) was conducted for health staff on ASRH (2days) Three TOT on ASRH were conducted for thirty five medical officers and nursing officer of Yowun Piyasa at hospitals by GoSL funds

• Three training of trainer programmes on adolescent and youth health were conducted for field health and hospital healthcare providers with 35 participants.

• Two TOT for public health staff in implementation of the intervention to strengthen parent- adolescent communication about adolescent sexual and reproductive issues were Conducted

• Two TOTs for teaching instructors and health staff on youth health were conducted on teaching youth health module for vocational trainees.

3. Training Programme on counselling on adolescent and youth health

It is essential that health care providers should have updated knowledge and necessary skills on counseling of adolescent and youth to strengthen the services on suicide management, stress management and early detection of psychological. Empowering adolescents and youth in promoting mental health wellbeing and timely identification of mental health conditions are to be strengthened.

Counseling programmes were completed for health care providers to develop counseling skills to improve the wellbeing of adolescent and youth. A TOT programme was conducted to develop counseling skills for medical officers of AYFHS centers and master trainers of public health staff by a Consultant Psychiatrist and specialist in counseling. Latest teaching and learning strategies were used. Role plays, lecture discussions, brain storming and case scenarios were included. Trainer once trained trained district and divisional level health staff.

4. Technical advisory committee meetings
Technical advisory committee meetings on young person's health were held quarterly with the participation of health as well as non- health sector stakeholders with youth participation for provision of guidance for adolescent and youth health activities within the country

6. National review on adolescent and youth health
National review on adolescent and youth health was held with the representation of public and curative sectors from all the districts of the country with the support from UNFPA. Best practices were appreciated and shared and implementation status of adolescent and youth friendly health services were reviewed. Total of 130 heath care providers consisting of MOMCHs, MOHs, RPHNOs, SPHIDs, PHNSs, SPHMs and doctors and nursing officers from the Yowun Piyasa centers from the hospital.

5. Seven district level awareness sessions for adolescent sexual and reproductive health (ASRH) services to law implementing agents in six districts were conducted. Advocacy and awareness were conducted for 700 police officers from six districts on the need of ASRH services with the objective of smooth functioning of the needed services

7. Assessment on adolescent and youth health

Baseline assessments on parent- adolescent communication on sexual and reproductive health was conducted in Kalutara District. Assessment of knowledge attitude and practices on youth health among youth trainers was conducted to see the need of futher improvement of training module on adolescent and youth for vocational trainees. Necessary modifications were done to the training module based on the findings of the assessment.

8. Youth and adolescent participation

Youth and adolescent participation were

ensured at planning, implementation and reviewing. Adolescent and youth are involved in decimation of health messages

9. Media workshop to ensure responsible reporting on adolescent and youth health related incidence.

This workshop was conducted with the participation of 130 participants with the media experts as well as health experts as resource personals

CHAPTER 08

GENDER AND WOMEN'S HEALTH

The Government of Sri Lanka was a signatory to the Programme of Action (PoA) adopted at the International Conference on Population and Development (ICPD) in Cairo in 1994. Following the ICPD, the concept of Reproductive Health (RH) was introduced to the Maternal and Child Health programme in Sri Lanka. Subsequently, separate programmes were launched to address specific reproductive health issues of women and gender equity, gender equality in RH.

8.1 Well Woman Program

Since 1996, Sri Lanka was able to successfully implement the Well Woman Programme at primary healthcare level with the aim of improving the health status of women. Services include screening women for obesity, hypertension, diabetes, breast, thyroid and cervical cancers (pap smears) and are offered through a network of about 1000 Well Woman Clinics (WWC) manned by Medical Officers of Health. In addition, WWCs provide family planning services and health education and counselling on issues related to reproductive tract infections, menstrual cycle and menopause. In the implementation of the Well Woman Programme, Family Health Bureau collaborates with the National Cancer Control programme, National STD AIDS Control Programme, College of Pathologists of Sri Lanka (CPSL) and Sri Lanka College of Obstetricians and Gynaecologists (SLCOG).

The main target population for well woman services are women aged 35 years and 45 years (since 2018). The Public Health Midwives(PHM) in the MOH area, identified women aged 35 (those born in 1984) and 45 years (those born in 1974) from the eligible families registers and motivated them to attend WWCs.

The table below shows the number of first visits of women attending WWCs by age 35 years, 45 years and other age groups from 2013 to 2019.

Table 8.1: Number of first visits to WWCs from 2013 to 2019 (by age group)

Data element	2013	2014	2015	2016	2017	2018	2019
35 Years (first visit)	73,359	74,871	94,089	111,798	114,314	132,691	129321
45 Years (first visit)						28,655	44,634
Other ages (first visit)	60,054	55,620	52,675	50,411	46,936	50,469	45,518
Total	**133,413**	**130,491**	**146,764**	**162,209**	**161,250**	**211,815**	**219,473**

Table 8.2: Well Woman Clinic attendance by women aged 35 years and 45 years (2013-2019)

Indicator	2013	2014	2015	2016	2017	2018	2019
Percentage of women aged 35 years who attended the WWC	33.9	34.6	45.1	52.8	53.3	61.6	59.1
Percentage of women aged 45 years who attended the WWC	-	-	-	-	-	16.6	25.5

Source: FHB, eRHMIS 2019

As mentioned above in Table 2, Well Woman activities were expanded gradually throughout the country. There has been a coverage of around 60% in respect of the 35 year age cohort and 25% in respect of the 45 year age cohort.

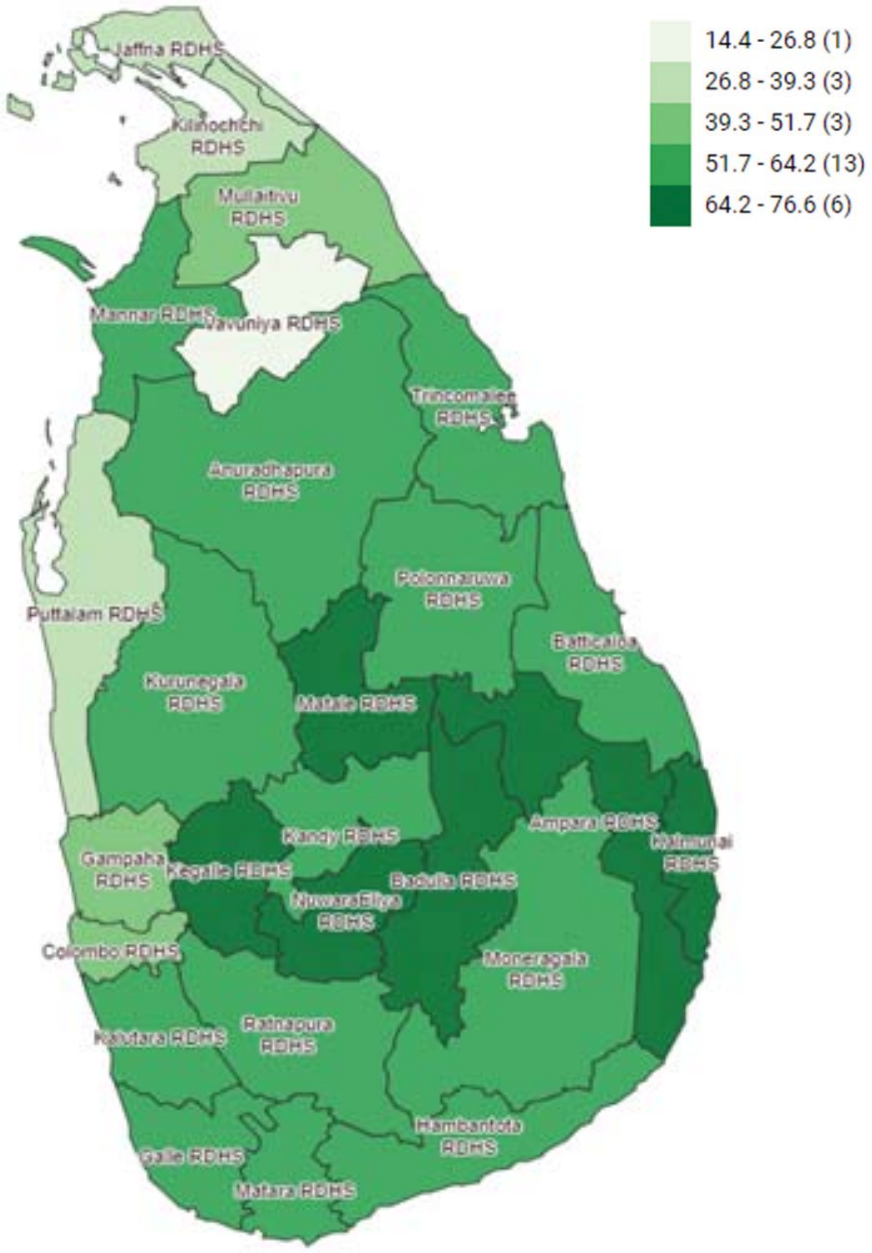
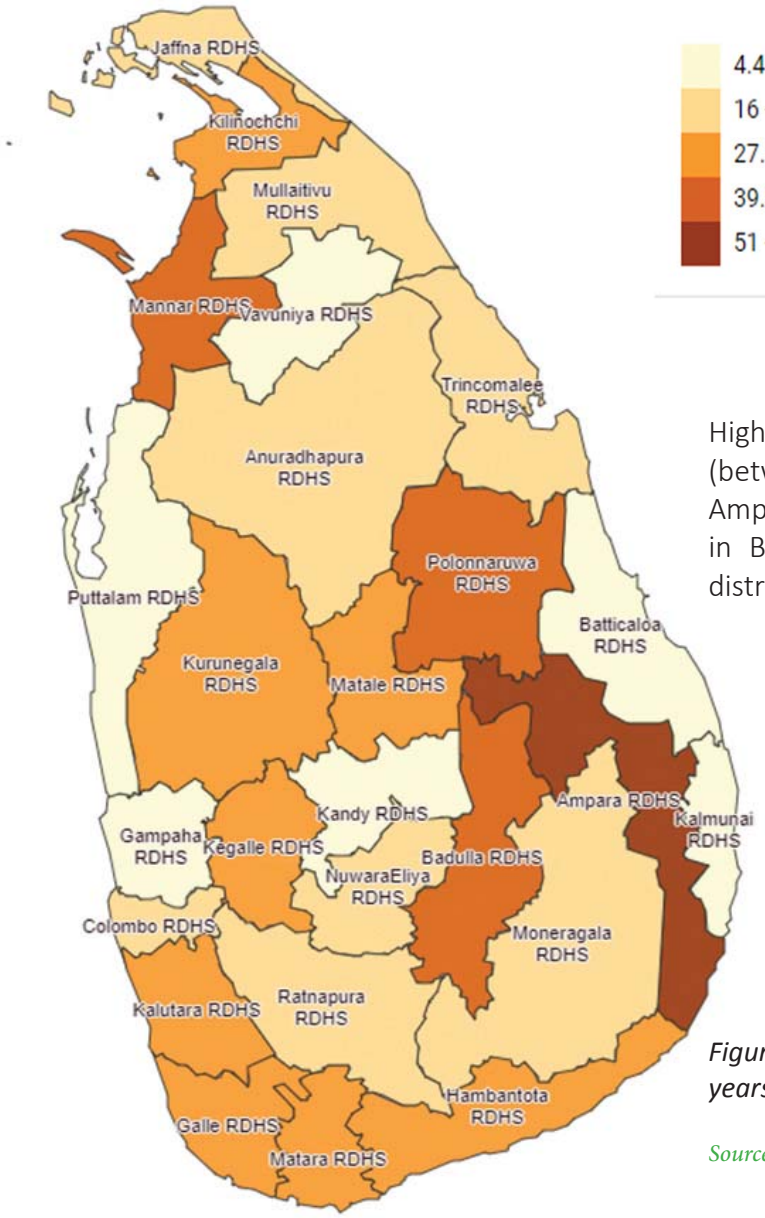


Figure 8.1: Map of the Coverage of the 35 years cohort by districts (2019)

Coverage between 64%- 76% has been seen in Nuwara Eliya, Matale, Badulla, Ampara, Kegalle and Kalmunai districts.

Source: FHB, eRHMIS 2019



Highest coverage for 45 year age cohort (between 51% - 62%) has been seen in Ampara district and between 39% - 51% in Badulla, Polonnaruwa and Mannar districts.

Figure 8.2: Map of the coverage of the 45 years cohort by districts (2019)

Source: FHB, eRHMIS 2019

Table 8.3: Clinic attendance (first visits) and morbidities detected (2015 - 2019)

Activity	2015	2016	2017	2018	2019
Number of 35 year women attending WWC clinics	94,089	111,798	114,314	132,691	129,321
Cervical smears reported as high and low grade lesions	505	665	513	520	704
Cervical smears reported as malignant (Carcinoma)	32	44	8	5	34
Breast abnormalities detected	2,652	2,697	3,807	3,706	3726
Diabetes Mellitus detected	2,780	3,741	4,518	4,602	5955
Hypertension detected	5,899	6,374	7,778	7,736	7618

Source: FHB, eRHMIS 2019

As in 2018, Family Health Bureau (FHB) obtained consumables needed for the Well Woman Clinics from the Medical Supplies Division (MSD), Ministry of Health and supplied the same to all MOH areas through the District Regional Medical Supplies Divisions (RMSD). The reagents for the labs were procured by FHB and distributed to all labs providing cervical cyto screening services for pap smears. Records of all consumables and reagents were maintained by using the inventory management software programme, 'Channel'.

8.1.1 Activities and achievements in 2019

1. **Disbursement Linked Indicator (DLI) :** In 2019, a total of160,938 women were screened for cervical cancer (118,672 women aged 35 and 42,266 women aged 45 years). Hence, Sri Lanka was successfully able to achieve the Disbursement Linked Indicator (DLI) 8.1total target of the World Bank funded Primary Healthcare System Strengthening Project (PSSP) in 2019.

2. **Technical Advisory Committee (TAC)**: A total of 2 Technical Advisory Committee (TAC) Meetings were in 2019, to discuss technical issues related to the Well Woman Programme.

3. **HPV DNA Program for Cervical Cancer Screening in Sri Lanka**

As it is well known, cervical cancer is one of the commonest cancers among Sri Lankan females, which accounts for nearly 10% of all female cancers. Every year about 600-700 women die of cervical cancer in our country with an incidence of more than 1100 cases per year (ICO/IARC HPV Information Centre 2018 December).

Although it is a common cancer, it is preventable and can be cured, if women are vaccinated, screened, detected and intervened early.

In Sri Lanka, the present method of screening for cervical cancer is the pap smear. However, one major disadvantage of the pap smear screening is the low sensitivity to detect cervical lesions.

3.1 2030 CONTROL TARGETS

In keeping with the World Health Organization's vision to eliminate cervical cancer by year 2030, Sri Lanka has already embarked on screening women at 35 and 45 years of age with the latest screening test called HPV DNA. In contrast to the conventional "Pap test", HPV DNA test has been found to be more than 90% sensitive and allows a long screening interval. It is expected to cover 70 % of target population of women with this high precision test by 2030. Along with vaccination and treatment facilities, Sri Lanka is expected to reach the interim targets of elimination < 4 cases of 100,000 woman-years as the elimination threshold.

As declared in Sustainable Development Goal Target 3.4, by 2030 Sri Lanka is expected to achieve a 30% reduction in mortality from cervical cancer.

3.2 HPV DNA Pilot Project in Sri Lanka

In this backdrop a pilot project was initiated in Kalutara district in the western province of Sri Lanka from 1st October/2018 to explore the feasibility of using HPV DNA, a PCR test, as a primary screening method for cervical cancer and precancer detection in the national cervical cancer screening program. It was planned to cover the target population of women aged 35 and 45 years , from about 1,000,000 population in the district. The primary screening modalities were HPV DNA screening and pap smear. Colposcopy services were arranged for pap smear and LBC positive women. Results of the Pilot Project showed thatof 9833 women screened 5042 belonged to 35 year age cohort and 4791 belonged to 45 year age cohort. Of those 6.2% and 4.7% were positive for HPV DNAin the 35 and 45 year age cohorts respectively.

The study concluded that the HPV DNA test is operationally and technically feasible as a primary cervical cancer screening method.

3.3 Advantages of HPV DNA for cervical screening program

HPV DNA has many advantages such as high detection rate of cervical lesions, a lengthy screening interval compared to pap screening with pap smears and reducing the workload of the cyto-screeners and Histopathologists. Self-collection of samples could also be arranged with this test in future.

In addition, there is no delay in reporting as one machine can test and generate reports on about 200 samples a day and about 50,000 samples annually. In the future, mortality rate among women of reproductive age will have indirect benefits on the family.

Therefore, as per WHO guidelines, and as a recommendation of the Technical Advisory Committee, HPV/DNA test is strongly recommended to screen women aged 35 and 45 years in the Cervical Cancer Screening Programme in Sri Lanka.

3.4 Where we are now and the way forward

Currently purchasing of a limited number of test kits and reagents is funded through the World Bank. While the screening program was piloted and continued in Kalutara district, screening of women with HPV DNA test was planned to be initiated in other districts. The World Bank funding is available to purchase a limited number of test kits until 2023.


HPV DNA Machine

Sample Collection Kit

8.2 Health Sector Response to 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 inequality. However, some give rise to gender inequalities and gender discrimination. Such discriminations will lead to power differences, and ultimately to Gender-based Violence.

Yet, gender norms and values are not permanent. They evolve with time, vary substantially from place to place, and subject to changes. Thus, the negative health consequences resulting from gender differences and gender inequalities can be changed. The knowledge and awareness of healthcare professionals regarding the presence of gender differences and inequalities, the effect of those on individuals' health status and, strategies to minimize gender inequalities might play a major role to address the prevailing toxic gender norms and values in a given society. 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 public health issue, that results in 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 recognized GBV as 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 (IPV). 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 the national level due to Domestic Violence (DV/IPV/GBV) is tremendous. 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, stillbirths, 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 an approach to achieving control and eventually have a greater chance of being a perpetrator. On the other hand, girls learn to accept violence as inevitable and have a higher chance of being survivors in their adult life.

It is also well recognized that women who present themselves to formal services 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.

The 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 reproductive health 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 crucial

response to GBV 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 the national level responsible for addressing GBV in the health sector. The programmes implemented by FHB include programmes which focus mainly on,

i. Prevention of GBV,

ii. Programmes centred mainly on the provision of care for survivors of GBV,

iii. Programmes concentrating on both prevention of GBV and provision of care for survivors of GBV,

iv. Activities and events set to create an enabling environment to strengthen the health sector response to GBV.

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

Setting up of Gender-based Violence Care Centres named "Mithuru Piyasa/ Natpu Nilayam" at hospitals, which are dedicated to providing essential medical care and basic emotional support to survivors of GBV is designed to respond to survivors effectively. These centres are operated by the medical staff working in the outpatient departments of the hospitals. The staff of Mithuru Piyasa is given an extensive training by FHB before the establishment of "Mithuru Piyasa/ Natpu Nilayam" centres.

GBV prevention activities at the individual, family, and community level and also providing care for survivors of GBV in the community is done through preventive health staff of Medical Officer of Health (MOH) areas.

Capacity building of curative and preventive health staff is also done at basic, in-service, and post-graduate levels on GBV. The 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.

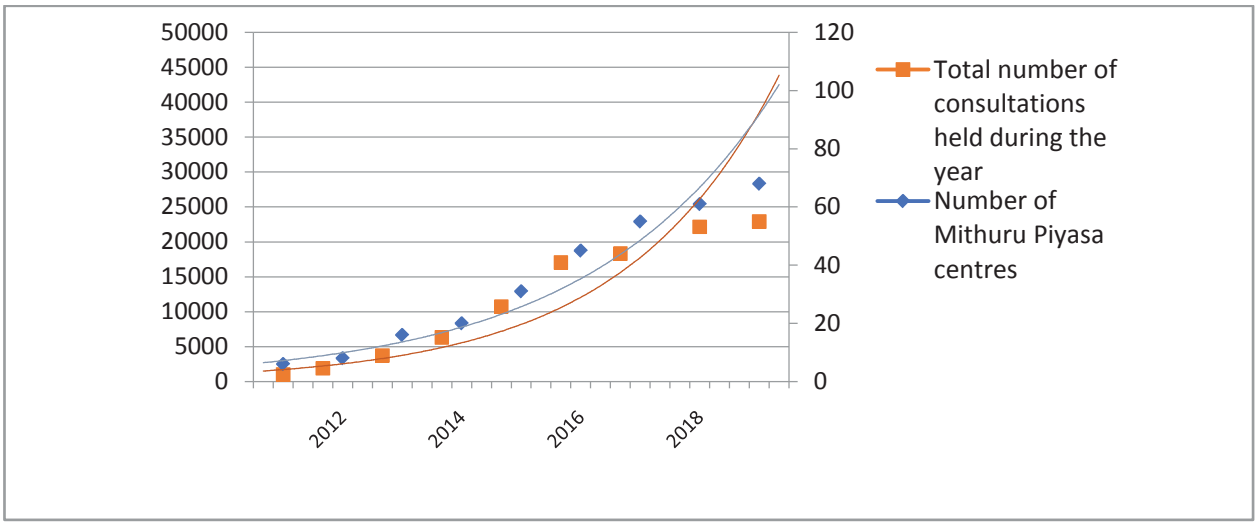
Table 8.4.: List of Mithuru Piyasa centres by the end of 2019

1. Akkareipattu- Base Hospital	35. Kaththankuddy Base Hospital
2. Ampara General Hospital	36. Kayts Base Hospital
3. Anuradhapura Teaching Hospital	37. Kegalle Teaching Hospital
4. Army Hospital- Minneriya	38. Kethumathi Maternity Hospital Panadura
5. Army Hospital Narahenpita	39. Kilinochchi- Base Hospital
6. Ashraff Memorial Hospital- Kalmunai	40. Kiribathgoda- Base Hospital
7. Avissawella- Base Hospital	41. Kurunegala Teaching Hospital
8. Badulla- Provincial General Hospital	42. Mahamodara- Teaching Hospital
9. Balangoda- Base Hospital	43. Marawila- Base Hospital
10. Bandarawela- Divisional Hospital	44. Matale- District General Hospital
11. Batticaloa- Teaching Hospital	45. Matara- District General Hospital
12. Bibila –Base Hospital	46. Meerigama Base Hospital
13. BOI- Katunayake	47. Mulative District General Hospital
14. Castle Street Hospital For Women	48. Nawalapitiya Base Hospital
15. Chankanai- Divisional Hospital	49. Nuwaraeliya District General Hospital
16. Chavakachcheri- Base Hospital	50. Peradeniya Teaching Hospital
17. Chenkaladi- Divisional Hospital	51. Pimbura Base Hospital
18. De Soysa Hospital For Women	52. Point Pedro Base Hospital
19. Dickoya- District General Hospital	53. Pottuvil Base Hospital
20. Diyathalawa- Base Hospital	54. Ragama Teaching Hospital
21. Elpitiya- Base Hospital	55. Rathnapura Provincial General Hospital
22. Embilipitiya- Base Hospital	56. Rikillagaskada Base Hospital
23. Eravur Base Hospital	57. Samanthurai Base Hospital
24. Family Health Bureau	58. Siyambalanduwa Base Hospital
25. Gampola- Base Hospital	59. Sri Jayawardhanapura General Hospital
26. Hambanthota General Hospital	60. Tangalle Base Hospital
27.Homagama Base Hospital	61. Thalangama District Hospital
28. Horana Base Hospital	62. Thambuththegama Base Hospital
29. Jaffna Teaching Hospital	63. Theldeniya Base Hospital
30. Kalmunai North Base Hospital	64. Trincomalee District General hospital
31. Kalubowila Teaching Hospital	65. Valachchenai Base Hospital
32. Kalutara General Hospital	66.Vavuniya District General Hospital
33. Kaluwanchikudy Base Hospital	67. Welimada Base Hospital
34. Kandy Teaching Hospital	68.Wellawaya Base Hospital

Table 8.5 : Services provided by Mithuru Piyasa centres from 2011 to 2019

Year	Number of Mithuru Piyasa centres	Total number of new survivors seeking care over the year	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 held during the year
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	31	4670	2683	2135	1261	10749
2016	45	7577	4131	3077	2243	17028
2017	55	7463	4743	3276	2834	18316
2018	61	8943	5579	4418	3205	22145
2019	68	9426	5966	4445	3049	22886

Figure 8.3 : Number of Mithuru Piyasa centres and total number of consultations done at centres from 2011-2019



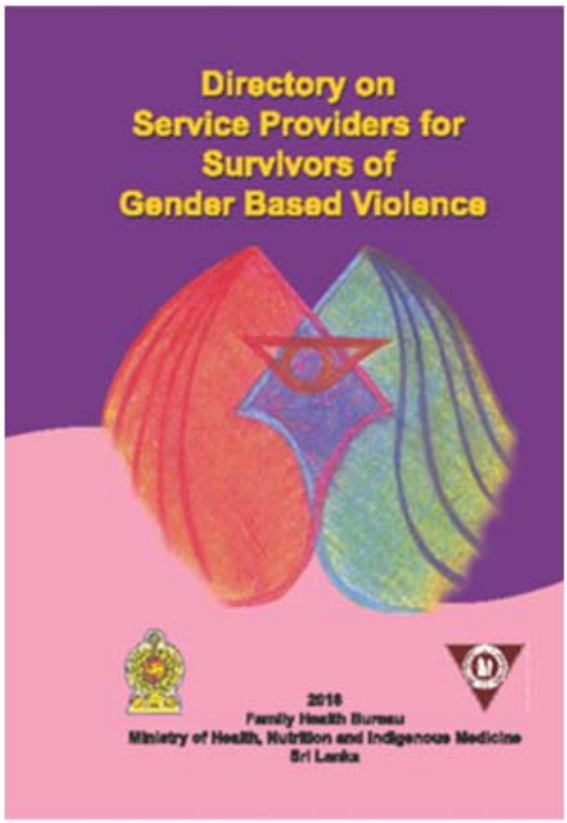
8.2 Some of the special activities carried out in 2019 to improve the health sector response to Gender Based Violence

01. Development of "Health Sector Response to Gender-based Violence- National Guideline for First Contact Point Healthcare Providers" and "Health Sector Response to Gender-based Violence- Standard Operating Procedures for First Contact Point Healthcare Providers"

The interaction of the GBV survivor with the first contact health care provider is a crucial interphase, which ensures service provision, and generates the first step of trust which promotes and encourages continuity of care. Affirming the importance and specific role that the first contact health care providers should play in responding to GBV survivors, National Guideline for First Contact Point Healthcare Providers and Standard Operating Procedures for First Contact Point Healthcare Providers were developed by the Gender and Women's Health Unit of Family Health Bureau.

02. Development of "Directory on Service Providers for Survivors of Gender-based Violence"

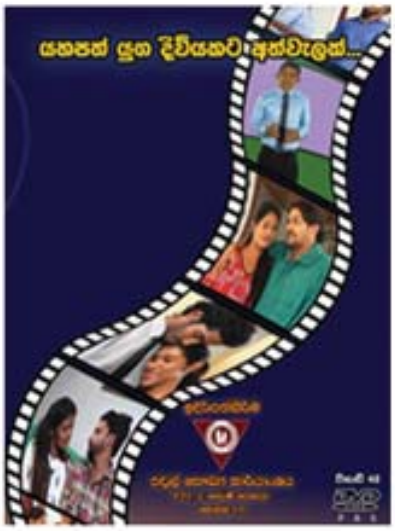
Effective management of a survivor of GBV requires a multi-disciplinary approach, which includes Health Services, Social Services, Police, and Legal services. Availability of a functional link between organizations providing these services is of paramount importance to provide uninterrupted holistic service to the client. With the objective of enriching the link, collaboration, and coordination between the multi-sectoral GBV service providers "Directory on Service Providers for Survivors of Gender-based Violence" was developed by the Gender and Women's Health Unit of Family Health Bureau. This directory comprises contact details of a variety of health and non-health services relevant to GBV services such as Mithuru Piyasa centres, MOH offices, Women and Child Development Units of Divisional Secretariat offices, Children and Women's Desks of Police stations, Legal Aids Commissions, and some Non-Governmental Organizations.



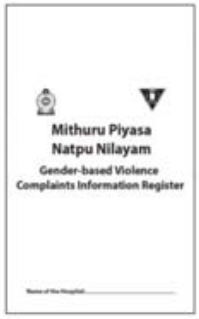
03. Development of "Yuga Diwiyata Athwelak" video to be used during Preconception care sessions

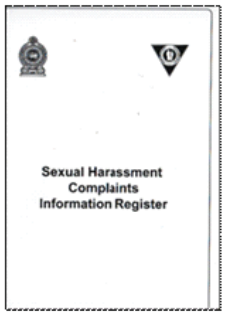
The Preconception Care Package for Newly Married Couples programme, mainly focuses on the prevention of GBV. One main component of this package is the sensitization of the newly married couples on some important topics which enable them to have a happy marital life. Within this video, most of these important topics are discussed interactively.

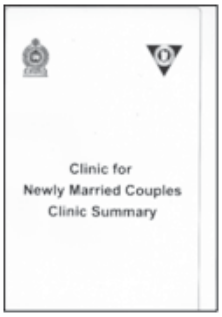
Displaying this video during the pre-conception care sessions enables the new couples to grasp the concept and content of a happy marriage and their roles and responsibilities as partners towards a happy family.



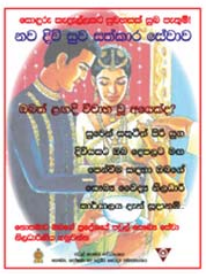
04. Development of five (05) important registers to further streamline the functions of health sector response to GBV in relation to both prevention and survivor care







05. Development of three (03) important posters to raise awareness of the public regarding GBV prevention and survivor care services of health sector



06. The launching ceremony of "Resource Pack on Health Sector Response to GBV"

The resource pack developed to strengthen the health sector response to GBV, by Family Health Bureau with collaboration of Health Promotion Bureau was launched ceremonially

07. Training of Trainers workshop on prevention & management of GBV (SOP & Guideline Training) for Consultant Community Physicians and Medical Officers- Maternal and Child Health

To overcome the challenges faced by the health care providers due to the inadequacy of knowledge and skills on the subject and the uncertainty on how to respond to a survivor of GBV effectively, while conforming to the ethical and legal standards, The Gender and Women's Health Unit of FHB developed "Health Sector Response to GBV: National Guideline and Standard Operating Procedures for First Contact Health Care Providers in Sri Lanka".

As the first phase of implementation of these documents, national level Training of Trainers workshops for Consultant Community Physicians of Provincial and District level and for Medical Officers- Maternal and Child Health were organized by FHB.

TOT workshop for Consultant Community Physicians

TOT workshop for Medical Officer- Maternal and Child Health

08. Training of Trainers workshops on prevention & management of GBV (SOP & Guideline Training) for Supervising Public Health staff

As the second phase of implementation of SOP and Guideline for First Contact Point Health Care Providers, a series of Training of Trainers workshops for supervising public health staff (MOH/AMOH, PHNS, SPHI, SPHM) were conducted in Colombo, Gampaha, Kalutara, Galle and Matara districts.

Public Health Training Kalutara

Public Health Training Gampaha

09. Workshop on multi-sectoral coordination on prevention & management of GBV for the officials of Ministry of Women & Child affairs.

10. Launching of new Mithuru Piyasa/ Natpu Nilayam centres in the country

In order to strengthen the health sector response to GBV in Sri lanka new "Mithuru Piyasa/ Natpu Nilayam" centres were launched at DGH Ampara, TH Anuradhapura, Army Hospital Minneriya, BH Eravur, BH Homagama, and BH Pottuvil.

Launching of Mithuru Piyasa at Base Hospital Homagama

Launching of Mithuru Piyasa at Teaching Hospital Anuradhapura

11. Sharing of Experiences workshops for Mithuru Piyasa/ Natpu Nilayam staff

Two experience sharing workshops were conducted for the staff of Mithuru Piyasa/ Natpu Nilayam centres in the country with the ultimate aim of strengthening the health sector response to GBV in Sri Lanka. 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 of the centres.

- Centres in Western, Sabaragamuwa, and Southern provinces participated in the sharing of experiences workshop held in Colombo.

- Centres in Central, North Central, North Western, Uva, Nothern, and Eastern provinces participated in the sharing of experiences workshop held in Kandy.

Sharing of Experiences workshop held in Kandy

Sharing of Experiences workshop held in Colombo

12. Refresher training for the staff of 'Mithuru Piyasa/ Natpu Nilayam"

Two refresher training workshops for the staff of "Mithuru Piyasa/ Natpu Nilayam" were conducted, covering all the centres in the country. The training programmes were conducted in Colombo and Kandy. The expected outcome was to strengthen the GBV response of the centres through effective implementation of the Mithuru Piyasa protocol and capacity building of the staff involved in service provision.

13. Supervisory visits and on-site trainings to Mithuru Piyasa centres

Supervisory visits, onsite training, and sensitization of the hospital staff on Gender, Gender-Based Violence, and 'Mithuru Piyasa ' activities were done in the following hospitals of the country.

National Hospital Kandy, Base Hospital Dikoya, General Hospital Kalutara, Kethumathi Maternity Hospital Panadura, Provincial General Hospital Badulla.

Supervisory visit to Kethumathi Maternity Hospital Panadura.

CHAPTER 09

ORAL HEALTH SERVICES

Family Health Programme is a collection of packages and interventions to promote the heath of the families with special emphasis on pregnant women 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 programme and oral health programme for the pregnant women. The outline of the activities carried out by the unit during the year 2019 is as follows;

9.1 School Dental Service

The main objective of the School Dental service is to reduce morbidity due to common oral diseases in preschool and school children between the age of 3y-13y. The services are delivered by 365 School Dental Therapists (SDTT) who work in School Dental Clinics (SDCC). Their target group includes students of grades 1, 4 & 7 and all the children below the age of 13 years, in schools where total number of students are less than 200. Stated below is the summary of annual performance of School Dental Services submitted by SDTT for the year 2019. (Table 9.1)

9.2 Work performances of the school dental Service -2019

All the School Dental Therapists around the country have collectively screened 79% of the total target group. Among screened children 70% had completed their treatments. However, out of screened grade 7 target group, 18% were identified as having untreated dental problems. This is a drawback in the system which need to be addressed in future.

There are vacant school dental clinics in many districts without School Dental Therapists. Most of these vacant areas are covered up by relief duty and by mobile clinics. Though the norm for SDTT population ratio is 1:2000 currently it is 1:3311 which is approximately 1.6 times. Hence, this coverage was achieved totally due to the high commitment of SDTTs.

Table 9.1 : Annual work performance of the School Dental Service 2015 - 2019

Year	No. of SDT	No. of students per SDT	Percentage of caries				Percentage of calculous			Screened[2] %	Coverage[3] %
			Gr 1	Gr4	Gr4[1]	Gr7[1]	Gr 1	Gr4	Gr7		
2015	383	3035	54%	55%	9%	19%	2%	13%	18%	75%	66%
2016	382	3163	56%	57%	9%	18%	1%	14%	18%	73%	63%
2017	393	3278	56%	56%	7%	15%	1%	13%	17%	77%	67%
2018	369	3326	57%	58%	9%	17%	1%	13%	18%	76%	68%
2019	365	3311	57%	58%	9%	18%	1%	13%	17%	79%	70%

Source: DHUFHB, RHMIS 2019

'Permanent teeth

Percentage of children screened out of the target group

** Percentage of children who are healthy or whose treatment has been completed out of the screened*

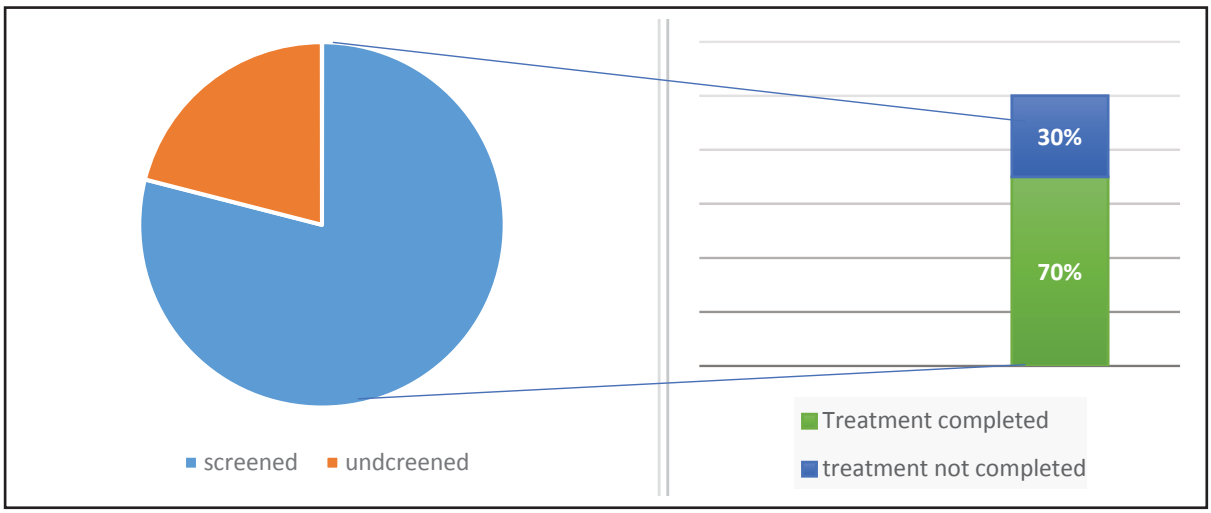


Figure 9.1: Figure: Percentage coverage of target population

Source : DHUFHB, RHMIS 2019

9.3 Other activities of the Oral Health

The national evaluation of School Dental Therapists selected by district performance evaluation committees were done, through a series of performance evaluation processes involving written examination, viva and spot test. The awarding ceremony was conducted in the presence of honorable minister of health, nutrition and indigenous medicine Dr. Rajitha Senarathne.

Purchased dental equipment (dental chairs and autoclaves and micro motors) to upgrade the school dental clinics.

School Dental Service annual review was conducted. It was a two-day programme, with the participation of all Regional Dental Surgeons, Supervising School Dental Therapists representing all 27 health regions.

Conducted an in-service training programme for School Dental Therapists around the country on "An update of Oral Health Service Delivery". Conducted a sixteen one day training work-shops to reinforce oral health knowledge of Public Health Midwives in Gampaha, Galle and Kalutara districts. Developed a set of Flash cards following sereral consultative meetings with the experts, on oral health education of pregnant mother, to be used by the public health midwives on pre - pregnancy Sessions, and these were distributed to all the MOH area of the country.

CHAPTER 10

MONITORING AND SUPERVISION

MONITORING AND SUPERVISIONS

Monitoring is a routine process assessing progress towards the programme objectives. It is vital to have a proper monitoring mechanism to understand clearly the progress of the national programme, usage of appropriate resources, whether the planned activities are going accordance to the plan and whether the set objectives are achieved. It would also help to identify how to make the programme more efficient and effective. In programme monitoring, data is collected on regular basis or in periodic basis to measure performance indicators.

RMNCAYH data, school health data and Family Planning new acceptor data is collected by FHB from all MOH are as in order to monitor the national programme. Reproductive Health management Information System which was a paper based information system for monitoring national RMNCAYH programme was transformed to an electronic system which is electronic Reproductive Health Management Information System eRHMIS in 2017.

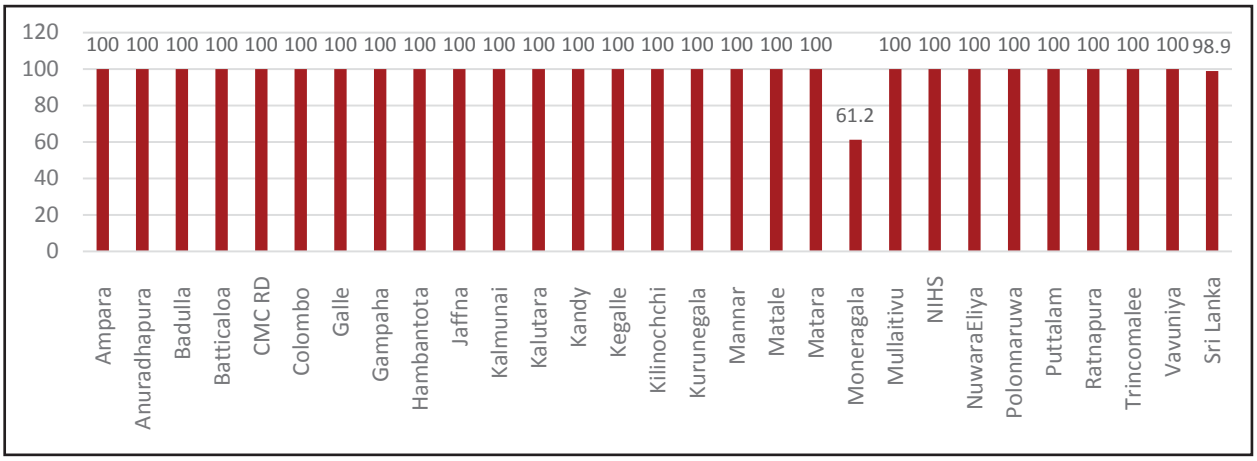
All districts except Monaragala was entered to the web based system with a reporting rate of 100%. Monaragala district data were not provided by the district staff from June 2019 due to a trade union action (Figure10.1).

Monthly clinic returns (H 527) from field clinics were also entered into the web based system by all MOHs except from District of Monaragala (Figure10.2). Commitment of all MOHs, PHNs, SPHMs and PHMs would be highly appreciated for sending timely and accurate data on time. Information received from the MOHs was the base for this Annual Report.

During the first quarter of 2018, FHB implemented phase II of the eRHMIS, the web based school health information system. This includes school health survey report (H1015 A) for all government and private schools and school medical inspection (SMI) reports (H 1247). In addition, all PHIs are expected to enter their monthly school health returns to the system which includes the follow up information on school health services.

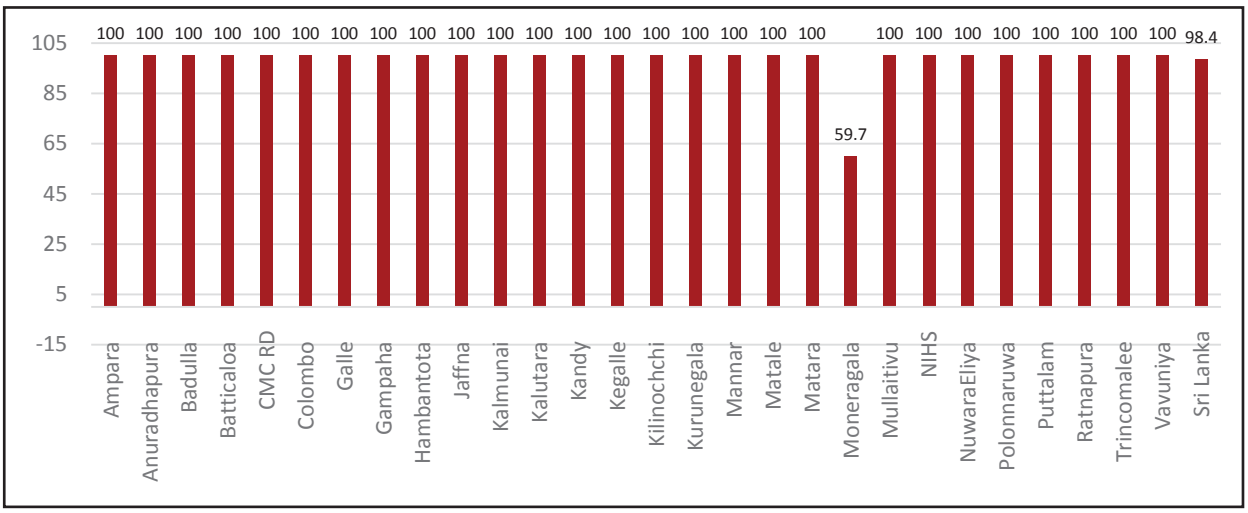
Following the implementation of eRHMIS phase II, School Health Returns H1015A, H1247 and H1014 have been received from 99.6%, 97% % and 81.6% respectively (Figure10.3 and 10.4). School health services were affected due to school closure following the Easter Bomb attack in April 2019.

Figure10.1:Reporting Rates of PHM Monthly Returns(H524)in 2019



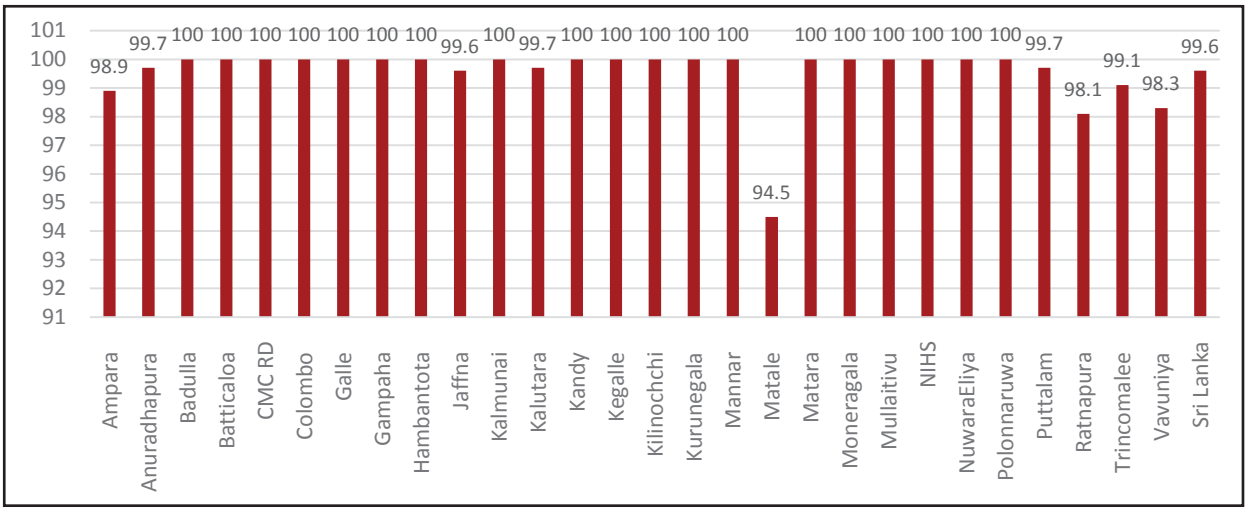
FHB,eRHMIS2019

Figure 10.2: Reporting Rates of Monthly Clinic Returns (H527) in 2019



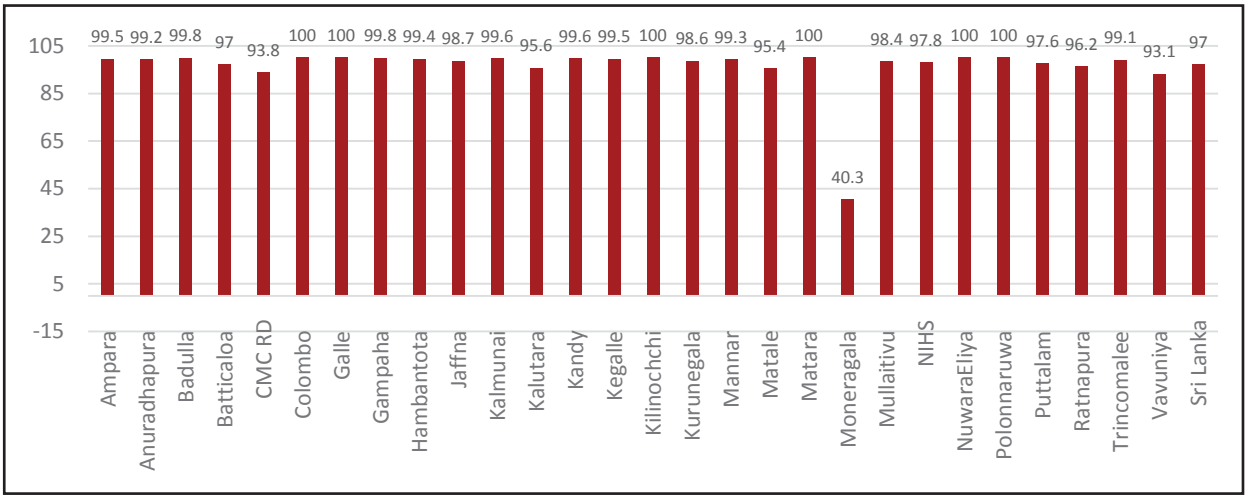
FHB,eRHMIS2019

Figure10.3: Reporting Rates of School Health Survey Report (H1015A) in 2019



FHB,eRHMIS2019

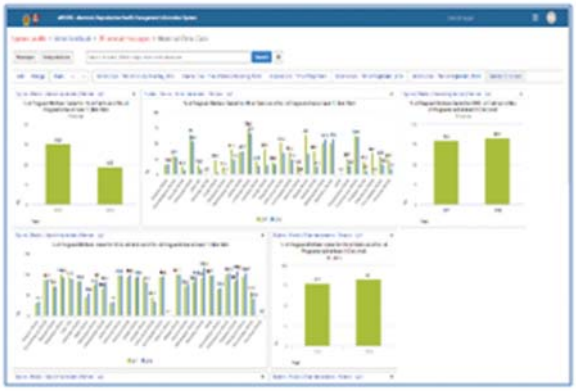
Figure10.4: Reporting Rates of School Medical Inspection (SMI) reports (H1247) in 2019



FHB,eRHMIS2019

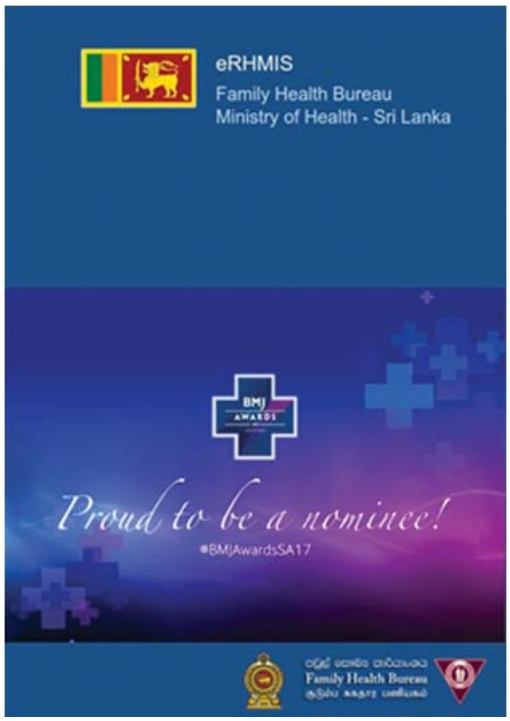
Family Planning new acceptors data has been received 91.0% in first quarter, 89.3% in second quarter, 87.9% in third quarter and 76.3% in fourth quarter.

All data entered to the system is scrutinized for completeness and accuracy of data at Monitoring and Evaluation Unit of the FHB. Discrepancies are verified by contacting the MOHs over the phone and allowing the MOHs to re-enter the inaccurate and incomplete data. eRHMIS system has an inbuilt capacity to analyse the data and essential indicators based on data were included into the system. Eight hundred and eighty four (884) such indicators can be calculated in the system. Dashboards are available at national, provincial, district and MOH level to monitor reporting rates and performances.



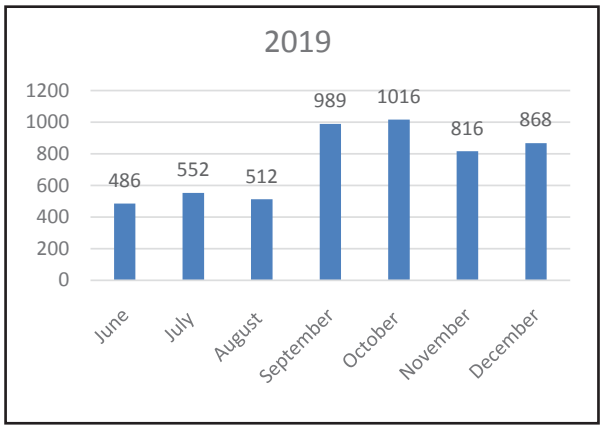
Activities and achievements in 2019

1. eRHMIS: For the successful development and implementation of eRHMIS, FHB continued to receive awards. eRHMIS was nominated for BMJ Southeast Asia Awards in 2018



In 2019, eRHMIS received **"eSwabimani"** national awards and nominated for Global Summit Awards.

2. eRHMIS 2 : It was identified that the non-availability of proper system to capture MCH data from private sector as a drawback in the National programme. Therefore, in 2019, eRHMIS2 a tracker system for health care institutions were initiated as a pilot in major private hospitals in Colombo.



3. eRHMIS refresher trainings – Covering all the provinces in the country, the Monitoring and Evaluation Unit of the Family health Bureau conducted refresher trainings to public health staff who are engaged in data visualization and analysis.

4. National MCH Reviews: RMNCAYHP is reviewed periodically at national and district levels to identify and improve the deficiencies and to assess whether the programis producing the results as prioritized in the strategic and operational plans. Family Health Bureau conducted national MCH reviews in all twenty six districts in 2019. Each district was visited by a team led by a Consultant Community Physician.

5. Annual MOMCH Reviews: Two MOMCH reviews were conducted in 2019, one in Anuradhapura and other in Colombo. Comprehensive field super vision was carried out in Anuradhapura district covering all MOH areas during this review.

All MOMCHs and national/ provincial level Consultant Community Physicians participated at this supervision. 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 improve mentin the district.

First Biannual MOMCH Review held in Anuradhapura

First Biannual MOMCH Review

Second Biannual MOMCH Review

MOH Office Supervision

Second Biannual MOMCH Review in Colombo

6. RSPHNO workshop: Three-day work-shop-for the Regional Supervising Public Health Nursing Officers (RSPHNOs) was conducted in Colombo in August 2019.

7. Launch of the FHB website

A new website was developed by the Monitoring and Evaluation Unit staff and was launched in April 2019 during the MOMCH Review held in Anuradhapura.

8. Survey Statistical Officers (SSO) work-shop: Three-day workshop was conducted for the Survey Statistical Officers (SSO) attached to the RDHS offices in order to improve the quality of RMNCAYH data reported from the districts. They were trained one RHMIS system and update donne wer MCH related developments.

9. Data visualization and analysis: To familiarize with the online information system and also to analyze their own data at regional and district level, a series of trainings were conducted covering 9 provinces in the country.

10. Supervisions: Supervision formats, format A–PHNS,format B–SPHM,1249/1248 of MOH and SPHIs were revised. Revised formats were introduced and a web based system was developed for all supervising staff categories to enter their data into the web based system. All MOMCHs, MOHs, / AMOHs, PHNSs, SPHMs and SPHIs are intended to enter their super vision data in to the new web based system from 2019.

Annexure

Annexure 1: Population, birth rates, eligible families, pregnant mothers, reported number of deliveries and first antenatal clinic visits by Health Districts

	Population Estimated (by MOH)	Estimated Eligible Families	Total number of eligible families registered	Total number of pregnant mothers registered	Total number of deliveries	Estimated Births	Birth Rate	Birth Registered
Ampara	281474	52073	53176	4673	4020	5686	20.2	3839
Anuradhapura	942028	174275	189254	15811	13704	15920	16.9	13228
Badulla	882573	163276	157686	13679	11653	14651	16.6	11280
Batticaloa	580277	107351	110550	11663	10520	10329	17.8	10443
CMC RD	589816	109116	75787	7034	5926	8081	13.7	5446
Colombo	1865553	345127	321322	24280	20618	25558	13.7	19710
Galle	1134830	209944	190668	16512	14533	17249	15.2	14216
Gampaha	2427344	449059	432884	34844	29349	30099	12.4	28553
Hambantota	663337	122717	118428	11654	10106	11675	17.6	10007
Jaffna	618233	114373	98400	9553	8219	9212	14.9	7976
Kalmunai	452456	83704	85064	10701	9468	9140	20.2	9464
Kalutara	984865	182200	168559	13917	12152	12803	13	11617
Kandy	1484469	274627	259788	23669	20427	23603	15.9	19466
Kegalle	890847	164807	148889	12825	11169	12294	13.8	10648
Kilinochchi	128252	23727	22572	2379	2014	2796	21.8	1910
Kurunegala	1728041	319688	312187	26858	23358	25229	14.6	22802
Mannar	110790	20496	21556	2536	2140	2172	19.6	2018
Matale	524166	96971	97998	8792	7499	7758	14.8	7366
Matara	864454	159924	145728	13226	11514	11497	13.3	10961
Monaragala *	497291	91999	99657	5881	5166	8454	17	4997
Mullaitivu	96733	17896	21767	1966	1780	1103	11.4	1683
NIHS	305662	56548	54670	5143	4601	3974	13	4412
NuwaraEliya	770044	142458	136566	12034	9659	11705	15.2	9286
Polonnaruwa	441485	81675	91642	7599	6526	7240	16.4	6257
Puttalam	836305	154716	160014	14040	12032	14552	17.4	11728
Ratnapura	1174323	217250	207008	18021	15369	18437	15.7	14943
Trincomalee	429387	79437	83382	9392	8466	8760	20.4	8132
Vavuniya	189928	35137	32144	3063	2516	3381	17.8	2344
Private Hospital **	-	-	-	-	-	-	-	5239
Sri Lanka	21894963	4050568	3897346	341745	294504	332803	15.2	306504

** Data available only up to June 2019*
*** Data available from June 2019*

Annexure 2 : Antenatal care 2019

	Percentage of pregnant mothers registered before 8 weeks	% of pregnant mothers registered between 8 – 12wks	% of total teenage mothers registered	Percentage of primi pregnant mothers registered	Percentage of pregnant mothers with gravida 5 or more	Percentage of pregnant mothers protected for Rubella	Percentage of pregnant mothers with antenatal morbidities	Percentage of mothers protected for Tetanus at the time of delivery	Percentage of mothers tested for blood group and Rh at the time of delivery	Percentage of pregnant mothers tested for VDRL	Percentage of pregnant mothers tested for blood sugar before 12 weeks of POA	Percentage of pregnant mothers abnormal blood sugar report before 12 weeks of POA
Ampara	88.2	8.3	3.3	28.7	1.6	99.4	58.6	99.7	99.8	99.6	97.1	3.9
Anuradhapura	82.1	13	5.4	27.6	2.3	99.3	51.7	99.7	99.8	99.6	93.4	3.4
Badulla	85.8	9.5	4.6	29.8	1.7	97.9	34.5	99.6	99.6	99.6	95.5	3
Batticaloa	80.7	13.9	8.1	37.1	2.5	98.8	33.6	99.7	99.8	99.7	96.4	6.3
CMC RD	56.1	26.8	5.4	35.4	2.8	91.3	44.6	98.9	99.6	98.2	90.1	3.9
Colombo	72.8	15.8	3.2	39.7	1.5	98.4	41.5	99	99.7	99.2	94.2	5
Galle	84.7	9.9	4.2	32.3	2.2	98.3	37.4	99.5	99.6	99	93.3	3.2
Gampaha	76.2	15	3.5	35.9	1.6	98.9	42.4	99.5	99.8	99.4	89.7	5.3
Hambantota	89.3	7.9	3.8	28	2.3	99.7	43	99.9	99.9	99.3	96.8	4.4
Jaffna	86.6	8.4	3.9	37.4	1.4	99.9	55.1	100	99.9	99.8	97	6.4
Kalmunai	85.4	10.6	5.4	31.8	4.6	97.9	42.4	99.9	99.8	99.7	97.6	8
Kalutara	80.4	12.9	3.5	33.9	2.1	99.3	44	99.6	99.8	99.7	93.1	3.9
Kandy	77.8	15.3	3.4	30.7	2.8	96.4	37.6	99.4	99.4	98.8	92.9	2.7
Kegalle	82.3	12.6	3.2	31.3	1.8	99.4	38.8	99.6	99.7	99.4	92.8	4.2
Kilinochchi	86.5	9.1	6	33.7	2.9	98.3	58.8	99.7	99.8	99.7	96.4	7.6
Kurunegala	84.2	11.4	3.4	29.4	1.8	99.5	49.7	99.9	99.9	99.9	96.4	2.9
Mannar	77.8	15.2	5.6	36.8	3.3	89.5	39.8	99.8	99.7	99.7	94.7	7.3
Matale	83.8	11.5	4	30.3	2	99.6	41.1	99.8	99.9	99.7	96.2	5
Matara	86.2	9.7	4	29	2.5	99.4	41.6	99.9	99.9	99.7	96.7	5.8
Monaragala *	88.5	8.2	4.4	27.9	2.3	99.4	38.9	99.7	99.8	99.4	96.4	3.8
Mullaitivu	80.1	13.5	6.3	35	2.7	97.9	42.3	99.8	99.8	99.6	92.8	3.1
NIHS	77.4	16.6	4.9	31.4	3.5	98.9	39.8	99.7	99.8	99.8	88.7	5.2
NuwaraEliya	71.3	18.9	4.7	31.6	1.6	97.8	26.4	98.7	99	98.9	85.4	2.6
Polonnaruwa	85.9	9.9	4.2	29.8	2.3	99.8	43.6	99.7	99.8	99.8	85.5	5.9
Puttalam	80.1	13.3	6.3	31.2	3	98.6	40.7	99.7	99.8	99.6	94.8	2.3
Ratnapura	81.1	13.4	3.8	30.8	1.6	99.1	42	99.6	99.7	99.5	91.7	3.5
Trincomalee	80.8	13.8	8.9	31.7	4.6	98.7	43.2	99.8	99.8	99.8	96.1	8.3
Vavuniya	79.1	14	5	35.1	2.1	95.5	37.2	99.5	99.8	99.7	94.6	3
Sri Lanka	80.6	13	4.4	32.3	2.2	98.5	42	99.6	99.7	99.5	93.6	4.4

** Data available only up to June 2019*

Annexure 3 : Indicators of clinic care, ante-natal screening and status of BMI among pregnant mothers in 2019

	Percentage of registered pregnant mothers made at least one clinic visit ::	Average number of clinic visits per mother	Percentage of pregnant mothers tested for VDRL at field clinic ::	Percentage of pregnant mothers with reactive VDRL ::	Percentage of pregnant mothers with Anaemia ::	Percentage of pregnant mothers tested for blood grouping and Rh at field clinic ::	Percentage of pregnant mothers whose BMI measured ::	Percentage of pregnant mothers with BMI < 18.5 ::	Percentage of pregnant mothers with BMI >25 ::
Ampara	93.3	6.8	17.3	0.1	51.6	15.3	88.9	17.7	28.3
Anuradhapura	96.4	7	87	0.15	43.4	27.6	87.7	15.9	30.7
Badulla	92.5	7.7	73.5	0.09	22.8	22.5	84.4	17.4	24.5
Batticaloa	98.3	6.7	98.3	1.3	21.6	54.8	88.9	16.7	31.7
CMC RD	101.3	5.1	90.1	0.27	33.6	6	72.1	10.5	44.2
Colombo	94.8	5	90.7	0.09	26.6	17	77.1	11.9	32.8
Galle	92.4	6	64.3	0.24	26.5	6.1	82.8	18	25.8
Gampaha	98.1	5.4	87.7	0.07	29.1	5.8	79.8	12.8	32.9
Hambantota	91.9	6.4	83.2	0.22	32.9	24.7	86.9	18.6	24
Jaffna	91.6	8	25.9	0	43	14.9	87.8	14.7	29
Kalmunai	93.6	6.6	102	0	32.3	48.5	87.8	11.8	35.1
Kalutara	96	5.8	97.9	0.11	33.5	39.9	83.8	14.2	32.4
Kandy	95.6	6.2	100.7	0.31	25.9	24.9	85.7	14.6	30.4
Kegalle	91	6.3	101.5	0.14	29.8	31.6	83.1	15.9	28
Kilinochchi	90	11.5	47.1	0	50.7	28	86.8	19.8	24.1
Kurunegala	93.6	6.9	100.6	0.25	40.7	33.1	86.6	15.7	27.9
Mannar	94	6.5	0	0.05	27.1	0.13	84.3	14.7	31.4
Matale	94.5	6.7	101.6	0.03	31.2	30.3	87.5	15.7	31.1
Matara	96.4	6.9	74	0.01	30.1	29.1	86.5	18.5	24.9
Monaragala *	97.9	7	99.4	0.27	28.6	48.3	88.7	19.8	26
Mullaitivu	128.6	6.4	50.4	0	31.6	47.9	84.7	19.3	23.8
NIHS	94.7	5.7	100.6	0.17	30.9	100.5	79.1	12.7	36.8
NuwaraEliya	103	6.7	86.8	0.16	15.4	14.6	78.2	17.9	23
Polonnaruwa	95.8	6.6	102.2	0.06	33.6	104.4	86.7	16	32.6
Puttalam	94.6	6.3	102.7	0.24	32.5	49.8	82.2	14.2	33.9
Ratnapura	94.4	6.8	100	0.09	32.9	52.3	82.2	18.5	24.4
Trincomalee	94.4	7.3	50.1	0.22	33.2	27.9	89.1	14.4	38.2
Vavuniya	94.2	9.5	27.1	0.16	30.1	18.8	82.5	17	27.4
Sri Lanka	95.4	6.4	86.2	0.19	31.3	29.7	83.8	15.5	29.9

** Data available only up to June 2019*

Annexure 4 : Natal care 2019

	Total number of deliveries	Percentage of Institutional deliveries	Percentage of home deliveries	Percentage of home deliveries by untrained attendants	Number of home deliveries by untrained attendants out of total deliveries	Percentage of LSCS deliveries	Percentage of deliveries reported for estimated births
Ampara	4020	99.9	0.15	50	3	37	70.7
Anuradhapura	13704	99.9	0.06	75	6	34.1	86.1
Badulla	11653	99.8	0.18	57.1	12	31.9	79.5
Batticaloa	10520	99.9	0.1	90	9	30	101.8
CMC RD	5926	100	0.02	0	0	34.2	73.3
Colombo	20618	100	0.05	60	6	47.3	80.7
Galle	14533	99.9	0.06	44.4	4	39.9	84.3
Gampaha	29349	99.9	0.05	56.3	9	45.4	97.5
Hambantota	10106	100	0.03	66.7	2	45.9	86.6
Jaffna	8219	100	0.07	100	6	37.7	89.2
Kalmunai	9468	99.9	0.11	80	8	44	103.6
Kalutara	12152	100	0.03	75	3	45.3	94.9
Kandy	20427	99.9	0.08	58.8	10	42.6	86.5
Kegalle	11169	99.9	0.06	57.1	4	46.4	90.9
Kilinochchi	2014	100	0.05	100	1	19.4	72
Kurunegala	23358	100	0.05	27.3	3	44.1	92.6
Mannar	2140	99.8	0.23	40	2	31.1	98.6
Matale	7499	99.9	0.05	50	2	45.6	96.7
Matara	11514	100	0.01	100	1	47.4	100.1
Monaragala*	5166	99.9	0.12	66.7	4	33.4	61.1
Mullaitivu	1780	99.9	0.06	0	0	21.6	161.4
NIHS	4601	99.9	0.07	66.7	2	41.9	115.8
NuwaraEliya	9659	99.6	0.39	65.8	25	29.9	82.5
Polonnaruwa	6526	99.9	0.08	40	2	43.5	90.1
Puttalam	12032	99.8	0.16	84.2	16	38.4	82.7
Ratnapura	15369	99.9	0.12	72.2	13	40.5	83.4
Trincomalee	8466	99.9	0.09	62.5	5	27	96.6
Vavuniya	2516	99.6	0.36	77.8	7	36.2	74.4
Sri Lanka	294504	99.9	0.09	64.2	165	40.5	88.5

** Data available only up to June 2019*

Annexure 5: Indicators of post natal care, post natal visits, Vitamin A supplementation, post natal complications by districts 2019

	Percentage of mothers received at least 1 postpartum visit during 1st 10 days for deliveries reported	Percentage of postpartum visits by PHM around 42 days for deliveries reported	Percentage of Vitamin A coverage in postpartum mothers	Percentage of mothers with postpartum morbidities	Percentage of pregnant mothers with Hb less than 11g/dl before 12 weeks of POA	Percentage of pregnant mothers with abnormal Hb less than 10.9 g/ dl in 26-28 weeks of POA	Percentage of babies with low birth weight (Permanent) - Regional
Ampara	97.7	98.7	98.6	9	24.7	48.68	12.3
Anuradhapura	94.8	83.2	92.5	16.2	22.7	41.26	12.5
Badulla	96.8	95.3	97.7	10.9	12.7	20.04	16.3
Batticaloa	97.6	82.8	98.6	6.9	13	22.88	12.7
CMC RD	71.9	52	96.3	7.3	21.7	33.91	12.5
Colombo	89.5	81.7	92.4	15.7	14.9	24.02	10.1
Galle	96.7	90.3	80.9	21.7	15.6	25.04	10.4
Gampaha	90.7	70.9	88	12.3	15.9	30.28	11.4
Hambantota	96.1	95.7	95	15.5	17.2	30.49	11.1
Jaffna	96	86	102.4	8.5	35.3	39.9	11
Kalmunai	94.4	86.7	78.2	9.3	17.4	34.94	9.7
Kalutara	92.4	84.4	80	9.5	14.6	30.66	12.2
Kandy	95.2	82	76.6	13.9	17.4	23.14	12.4
Kegalle	91.7	83.5	77.2	9.2	19.4	31.75	13.9
Kilinochchi	97.2	92.6	99.7	8.7	26	49.6	9.1
Kurunegala	90.7	79.3	79.3	11.6	24.9	39.35	11.6
Mannar	91.7	91.1	96.5	4.7	15.9	26.79	11
Matale	95.1	85.1	97.1	9.5	18	28.85	12.9
Matara	96.4	90.2	96.8	15.2	17.1	26.08	12.4
Monaragala *	93.7	87.2	96.8	10.9	15.8	29.3	13.1
Mullaitivu	89.8	86.2	97.9	3.9	27	37.63	12.2
NIHS	91.7	71.2	82.4	7.6	11.3	29.72	10.6
NuwaraEliya	93.6	84	93.6	10.4	13	14.6	18.1
Polonnaruwa	96.8	94.7	98.8	11.3	19.2	37.36	13.9
Puttalam	95.1	82.6	91.7	7.8	25.7	41.35	11.3
Ratnapura	94.9	80.2	78	15.2	18.3	32.17	14.3
Trincomalee	91.5	86.9	97.9	6.2	14.9	32.3	12.3
Vavuniya	94.4	71	92.7	9.9	20.5	29.22	12.5
Sri Lanka	93.3	83	88.6	12	18.4	30.69	12.1

** Data available only up to June 2019*

Annexure 6 : Indicators of child care service provision: infant registration, field visits and vitamin A supplementation 2019

	Percentage of infants registered	Average number of home visits per infants	Percentage of Vitamin A coverage in infants at 6 months at clinic	Percentage of Vitamin A coverage in young children at 18 months (at clinic + field)	Percentage of Vitamin A coverage in infants at 6 months at a field	Percentage of Vitamin A coverage in preschoolers at 3 years (at clinic + field)
Ampara	72.2	5.3	76.9	79.7	0.55	77.7
Anuradhapura	91.8	7	84	87.6	3.4	91.8
Badulla	93.2	9.1	85.5	91.2	4.6	95.9
Batticaloa	103.9	5.8	102.7	100.8	3.7	89.7
CMC RD	76.4	5.9	61.7	62.8	4.8	73.9
Colombo	86.6	5.8	61.8	71	7.7	81.3
Galle	90.7	7.7	58.9	60.2	3.2	64.1
Gampaha	102.8	6.1	86	89.4	1.9	96.8
Hambantota	89.7	7.7	81.6	83.4	1.9	90.5
Jaffna	92.9	13	86.3	81.3	0.58	75.7
Kalmunai	105.7	9.3	72.3	84.4	18.5	77.3
Kalutara	97.6	7.3	57.9	63.6	4.3	69.6
Kandy	92.4	8.8	45.4	50.3	6.5	54.8
Kegalle	98.4	9.3	54.3	58.8	3.7	63
Kilinochchi	84.6	8.9	77	73.3	2.8	71.5
Kurunegala	92.6	6.5	84.1	88.1	7.1	94.7
Mannar	113.7	24.1	97.6	95.1	1.7	88.5
Matale	104.1	9.2	81.9	87.7	4	91
Matara	109.1	7	83	83.8	4.1	91.7
Monaragala*	66.7	7.4	66.4	66.6	1.1	67.8
Mullaitivu	165	18	118.2	179.6	69.1	168.9
NIHS	123.8	4.9	55.3	57.4	1	56
NuwaraEliya	90	10.8	68.8	80.2	8	94.7
Polonnaruwa	97.7	6.8	89.8	95.9	4	100.5
Puttalam	86.4	6.6	84	94.4	7.5	103.9
Ratnapura	88	7	60.9	68.8	5.9	74.1
Trincomalee	96.8	7.2	99.3	99.1	1.8	91.2
Vavuniya	88.5	10.7	63	72.3	3.8	75.8
Sri Lanka	93.8	7.6	73.9	78.6	5.1	83.1

** Data available only up to June 2019*

Annexure 7 : Weighing coverage of children under 5 years 2015– 2019 | Nutrition Month

RDHS	2015	2016	2017	2018	2019
Ampara	97.9	99.0	99.7	99.8	100.0
Anuradhapura	91.9	93.4	92.4	93.0	94.3
Badulla	96.6	97.3	97.9	98.7	98.5
Batticaloa	94.7	95.7	95.7	96.5	96.1
Colombo	79.4	78.7	79.0	81.2	84.5
Galle	91.0	94.1	95.4	95.1	95.6
Gampaha	90.8	92.3	90.9	90.2	90.4
Hambantota	96.4	97.3	97.6	97.9	99.2
Jaffna	99.6	99.6	99.2	99.6	99.7
Kalmunai	96.5	98.2	97.5	97.4	97.9
Kalutara	91.4	93.0	93.5	94.6	95.2
Kandy	91.7	93.2	91.2	91.9	94.8
Kegalle	97.6	97.3	96.6	97.0	98.0
Killinochchi	99.1	99.2	99.2	99.9	99.9
Kurunagala	94.9	94.4	94.5	94.4	93.0
Mannar	98.9	94.5	97.0	97.6	99.0
Matale	96.2	97.0	97.4	97.9	97.8
Matara	96.5	96.9	98.4	98.5	98.7
Monaragala*	98.1	98.9	98.8	98.8	NO DATA
Mulativue	96.8	96.5	95.4	93.8	97.2
NIHS	93.8	96.5	93.5	91.7	91.8
Nuwara Eliya	92.8	94.3	94.6	95.2	96.7
Polonnaruwa	97.8	96.8	97.8	98.4	98.9
Puttalam	96.3	96.5	95.7	95.1	95.0
Rathnapura	97.5	97.4	96.6	97.2	98.1
Trincomalee	92.8	98.4	98.9	98.7	99.4
Vavuniya	96.1	98.1	95.9	95.9	95.6
Sri Lanka	93.2	94.0	93.8	94.3	94.8

** No data available for 2019*

Annexure 8 : Nutritional Status of Infants 2015– 2019 | Nutrition Month

	UW%					Stunting %					Wasting %				
	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019
Colombo	9.1	7.7	7.1	7.2	6.9	5.5	4.1	4.6	4.1	3.7	6.6	4.4	5.3	4.8	4.5
Gampaha	6.3	7.3	7.0	7.0	7.6	4.2	4.2	4.2	4.3	4.5	5.6	6.0	6.3	5.5	5.7
Kalutara	8.1	8.0	7.3	7.7	7.5	4.6	4.7	4.2	4.5	4.4	6.2	5.9	6.3	5.4	4.9
NIHS	7.8	8.6	7.6	8.1	8.5	4.0	4.6	4.0	4.4	4.8	7.4	7.1	6.7	5.5	6.4
Anuradapura	8.9	8.5	8.2	8.4	9.5	6.0	4.9	4.8	5.1	5.3	8.6	9.2	8.9	7.5	7.4
Polonnaruwa	9.5	9.1	9.6	8.8	9.7	5.6	4.9	5.7	5.6	5.8	9.9	7.5	8.3	6.8	7.4
Badulla	10.9	10.6	9.9	10.8	10.1	8.8	7.4	7.1	7.4	7.1	10.0	9.1	9.0	7.9	6.8
Monaragala *	7.9	6.9	6.6	7.3	NO DATA	4.4	4.0	4.6	4.9	NO DATA	7.2	5.5	5.9	5.2	NO DATA
Galle	8.0	8.1	7.1	7.6	7.2	4.9	4.6	4.6	4.6	4.3	7.1	6.7	6.7	6.5	6.2
Matara	9.2	8.3	7.8	7.9	8.6	5.8	4.2	4.5	5.0	4.5	8.7	8.6	7.8	6.8	7.5
Hambantota	7.3	7.5	6.8	6.3	6.3	4.1	4.5	4.4	3.9	3.7	7.1	6.3	5.6	5.2	4.7
Kandy	8.8	9.0	8.5	8.7	9.1	6.3	5.4	5.7	6.0	5.9	6.8	6.2	6.7	6.7	6.0
Matale	8.7	8.2	7.4	8.3	8.5	5.5	4.2	4.5	5.5	5.6	7.2	5.8	5.5	5.6	5.0
Nuwara Eliya	15.6	14.7	14.6	15.7	13.0	13.1	11.6	14.1	13.3	11.8	12.6	11.1	11.3	10.2	8.7
Kegalle	10.0	9.4	9.2	10.2	9.5	5.7	4.8	5.0	6.0	5.0	9.1	7.9	7.3	6.7	6.0
Ratnapura	9.2	9.1	8.9	9.9	9.5	5.8	5.6	5.7	7.2	6.1	7.3	6.9	7.1	7.3	6.3
Kurunagala	6.3	6.2	6.9	7.7	8.2	3.8	4.4	4.4	5.1	5.5	5.4	6.0	6.7	7.1	6.9
Puttalam	8.6	7.6	7.1	6.7	7.4	5.3	4.2	3.7	3.7	4.1	6.6	6.2	6.8	5.9	5.8
Ampara	10.1	9.9	8.9	8.3	8.8	5.2	5.7	4.7	5.0	5.3	8.0	7.3	5.7	5.2	5.1
Kalmunai	5.4	5.7	5.6	5.5	5.8	4.1	4.5	4.3	3.8	4.0	5.6	5.2	4.6	4.5	3.7
Batticaloa	7.3	6.1	4.9	5.2	5.3	4.7	4.0	4.0	4.1	3.7	5.4	4.5	3.9	3.8	3.7
Trincomalee	8.4	7.6	8.1	8.3	8.8	5.8	4.8	5.3	6.1	5.5	9.5	7.5	6.5	5.2	5.6
Jaffna	6.7	7.2	6.6	7.0	7.4	3.8	4.0	3.7	4.2	4.4	5.3	4.9	4.9	5.3	5.7
Killinochchi	5.8	4.6	4.8	4.7	5.5	3.0	2.7	2.8	3.3	3.1	2.6	2.2	2.1	2.4	2.6
Mullaitivue	7.8	6.1	5.7	5.6	6.6	5.4	4.2	3.1	3.3	2.6	5.1	2.8	3.0	1.5	3.1
Vavuniya	9.3	8.4	8.0	7.3	8.2	4.3	5.5	4.9	4.3	5.8	8.3	6.9	6.0	5.4	6.1
Mannar	4.9	6.0	4.8	5.1	4.5	3.2	3.1	3.0	3.5	2.5	2.3	3.8	3.2	3.5	3.9
Sri Lanka	8.4	8.2	7.8	8.1	8.1	5.5	4.9	5.1	5.3	5.0	7.2	6.6	6.7	6.1	5.8

** Data available only up to June 2019*

Annexure 9 : Nutritional status of young children 2015 - 2019 | Nutrition month

	UW%					Stunting %					Wasting %				
	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019
Colombo	13.6	11.2	10.0	9.5	9.1	8.7	7.6	7.1	6.4	6.0	9.3	6.1	7.1	6.5	6.0
Gampaha	11.6	11.8	11.0	10.7	10.7	7.7	8.1	7.6	7.5	7.6	8.3	9.0	9.3	8.5	8.6
Kalutara	13.7	13.8	11.7	11.2	11.2	8.8	8.9	8.0	7.9	8.4	10.7	10.7	9.0	8.4	7.3
NIHS	12.6	12.6	11.7	13.3	12.4	7.5	7.8	7.9	8.1	9.3	10.9	10.3	10.1	7.4	9.0
Anuradapura	17.2	15.3	15.0	14.8	16.6	11.4	10.1	9.8	9.4	10.5	14.7	12.8	12.9	11.9	11.9
Polonnaruwa	18.2	16.5	15.7	15.6	16.4	11.8	10.2	11.1	9.5	10.5	14.5	12.9	12.1	12.4	11.4
Badulla	19.6	17.7	16.1	16.6	15.7	17.0	15.8	15.3	14.6	14.0	14.9	13.6	11.5	11.0	10.1
Monaragala *	15.9	13.0	12.2	12.6	NO DATA	9.8	8.9	8.8	9.9	NO DATA	12.5	10.6	9.4	9.0	NO DATA
Galle	15.1	13.7	11.9	12.2	12.6	10.1	8.8	8.5	8.7	8.4	11.5	11.4	10.3	10.2	10.0
Matara	17.5	15.9	12.5	12.1	14.1	12.5	10.1	9.6	9.4	9.5	13.9	13.0	10.9	9.8	10.0
Hambantota	14.7	13.1	12.1	11.4	11.8	9.5	8.0	8.0	7.8	6.7	13.0	11.3	10.7	10.0	9.0
Kandy	15.5	15.2	13.6	13.4	14.2	13.1	11.7	11.2	11.1	11.7	11.0	6.9	9.8	9.1	9.0
Matale	15.5	13.5	13.4	13.5	14.7	10.7	9.4	9.6	10.3	10.9	11.4	11.2	9.5	9.3	9.2
Nuwara Eliya	24.1	21.9	20.4	21.1	19.1	23.7	22.2	23.3	25.0	20.8	16.0	15.3	14.3	12.6	11.1
Kegalle	17.2	16.4	15.1	15.4	14.3	10.9	10.5	9.9	10.8	9.4	13.3	11.8	10.4	9.9	9.7
Ratnapura	16.1	15.6	14.8	15.2	14.7	11.6	11.3	11.8	12.6	11.7	11.9	11.0	10.5	10.3	9.5
Kurunagala	13.1	13.0	12.7	13.1	13.9	10.4	8.7	8.8	8.2	9.2	10.3	10.4	11.3	11.4	12.1
Puttalam	15.0	13.9	12.5	11.6	12.5	10.4	8.7	8.8	8.2	8.7	10.6	9.8	10.6	9.0	9.4
Ampara	17.9	17.0	14.5	15.1	16.2	13.3	10.4	9.6	10.5	10.4	12.8	13.6	9.5	9.7	9.5
Kalmunai	11.5	10.5	10.2	9.1	9.7	10.3	8.7	8.8	8.0	7.5	7.8	8.2	6.1	5.4	6.1
Batticaloa	15.0	12.6	10.3	9.3	10.3	10.5	10.0	7.8	7.4	7.9	9.6	7.8	6.4	5.5	6.4
Trincomalee	17.2	18.3	15.5	15.8	17.0	13.7	12.3	11.6	12.2	12.2	14.6	13.6	11.1	10.1	9.9
Jaffna	13.4	13.5	12.4	12.4	12.0	8.7	9.1	8.1	8.9	8.6	10.4	10.2	9.5	9.1	8.4
Killinochchi	14.5	12.9	12.5	9.5	10.0	11.6	8.9	10.2	7.3	8.0	8.2	8.7	7.0	5.5	6.9
Mullaitivue	17.9	14.9	13.7	13.7	15.5	13.6	10.1	10.4	6.5	7.9	9.6	8.0	6.4	6.7	7.3
Vavuniya	16.4	16.4	15.9	13.6	16.9	12.7	11.6	12.9	9.9	12.2	13.3	12.3	10.3	7.5	9.7
Mannar	12.6	12.9	12.1	10.1	11.1	9.0	9.0	7.4	7.8	7.6	7.2	6.6	8.4	7.6	7.3
Sri Lanka	15.3	14.3	13.1	12.9	13.1	11.0	10.1	9.9	9.8	9.6	11.5	10.6	10.0	9.4	9.2

** Data available only up to June 2019*

Annexure 10 : Nutritional status of pre-school children 2015 - 2019 | Nutrition month

	Under weight %					Stunting %					Wasting %				
	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019
Colombo	15.6	13.5	12.3	11.2	10.5	8.4	7.2	7.1	6.4	5.6	10.9	9.5	8.8	7.9	7.3
Gampaha	12.7	14.0	13.3	12.8	13.3	6.7	7.1	6.7	6.4	6.4	17.1	10.8	12.0	11.2	11.4
Kalutara	16.3	15.7	15.2	14.6	14.1	8.9	8.2	8.2	8.1	7.8	12.4	11.8	12.1	10.9	10.3
NIHS	12.9	15.2	13.6	13.7	14.1	6.6	7.5	7.7	8.0	7.6	11.6	12.3	11.0	9.3	10.2
Anuradapura	21.4	20.5	19.8	19.7	20.3	11.0	10.4	10.0	10.3	10.6	16.3	16.1	16.0	14.3	14.5
Polonnaruwa	22.8	20.1	20.9	19.8	19.6	11.3	10.5	10.8	9.6	9.5	17.0	16.2	15.8	14.8	15.5
Badulla	25.6	23.7	22.1	21.8	20.8	13.6	14.8	13.8	14.2	12.7	17.0	17.6	16.1	14.8	14.1
Monaragala *	20.0	18.1	17.2	16.7	NO DATA	9.9	9.0	8.8	9.6	NO DATA	14.5	13.2	12.6	11.7	NO DATA
Galle	18.8	18.1	15.9	15.7	15.3	9.3	9.0	8.4	8.2	7.8	13.5	14.1	13.9	13.2	13.0
Matara	21.5	20.3	17.3	16.2	16.3	11.7	10.4	9.5	8.9	8.6	17.5	16.4	14.5	11.9	12.8
Hambantota	18.3	18.3	16.1	14.8	15.7	8.9	9.0	8.5	7.1	7.6	13.9	13.6	12.9	11.3	11.4
Kandy	20.1	19.0	17.7	17.0	17.2	11.8	11.8	11.5	11.4	11.2	11.8	11.7	11.9	11.3	10.7
Matale	17.7	19.1	17.4	18.0	17.8	11.1	10.6	10.7	10.7	10.2	12.8	12.2	11.4	11.2	11.6
Nuwara Eliya	26.4	25.9	23.9	26.5	23.8	18.3	21.8	20.1	23.4	20.5	16.9	16.5	15.0	13.3	11.9
Kegalle	22.3	21.1	20.3	19.3	18.2	11.1	10.3	9.7	9.4	9.0	16.9	15.2	15.7	14.4	13.3
Ratnapura	21.9	21.0	20.5	20.7	19.1	11.4	12.0	11.9	12.5	10.8	15.1	14.7	14.2	14.0	12.6
Kurunagala	16.9	16.7	16.5	17.1	17.1	8.8	8.1	8.5	8.8	8.5	12.9	12.8	13.7	14.1	14.1
Puttalam	18.6	17.6	16.1	16.2	16.5	11.4	9.3	8.9	9.1	8.5	12.2	12.1	12.4	11.3	12.0
Ampara	22.0	22.0	21.3	19.7	20.7	10.6	10.8	10.6	10.3	10.5	16.2	15.9	14.6	13.2	13.5
Kalmunai	15.0	13.0	12.7	12.6	11.5	10.1	8.2	8.5	8.6	7.8	9.5	7.7	7.3	6.7	6.6
Batticaloa	16.7	21.0	15.1	13.9	13.5	10.3	10.5	8.8	8.1	8.0	9.8	8.8	8.2	7.3	7.6
Trincomalee	21.1	23.0	21.2	20.8	20.8	13.0	13.8	13.3	12.3	13.0	15.2	15.6	13.3	12.2	11.7
Jaffna	17.2	17.1	16.1	15.8	15.0	9.4	9.9	9.9	10.0	8.9	12.2	12.2	11.2	10.9	9.9
Killinochchi	21.1	19.4	19.3	18.4	18.0	13.6	13.0	12.8	11.0	11.3	12.0	10.9	11.3	10.1	9.0
Mullaitivue	22.8	21.5	21.7	21.3	19.5	14.7	14.2	11.6	10.9	9.6	12.5	11.5	10.2	10.5	10.3
Vavuniya	21.4	21.0	20.4	18.2	19.9	11.2	12.4	13.1	11.4	10.7	16.1	14.3	12.7	11.5	12.7

** Data available only up to June 2019*

Annexure 11: Children Under the age of 5 years from 2015 - 2019 | Nutrition month

	Under weight%					Stunting %					Wasting %				
	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019
Colombo	13.0	11.7	10.7	10.0	9.4	7.7	6.6	6.5	5.9	5.3	9.4	7.7	7.7	6.9	6.4
Gampaha	10.6	12.2	11.5	11.2	11.5	6.4	6.7	6.4	6.2	6.2	8.6	9.4	10.2	9.4	9.6
Kalutara	13.6	13.8	12.9	12.5	12.2	8.0	7.6	7.4	7.3	7.3	10.7	10.4	10.3	9.3	8.6
NIHS	12.6	13.4	12.1	12.5	12.6	7.1	7.0	7.1	7.3	7.4	11.0	10.9	10.0	8.2	9.2
Anuradhapura	17.4	17.1	16.6	16.5	17.4	10.1	9.3	8.9	9.1	9.6	14.0	14.1	14.0	12.5	12.6
Polonnaruwa	18.6	17.2	17.7	16.8	17.0	10.3	9.3	9.8	8.8	9.0	15.1	13.8	16.9	12.7	13.1
Badulla	20.9	19.8	18.5	18.7	17.8	14.0	13.5	12.8	13.0	11.8	16.2	15.1	13.8	12.7	11.9
Monaragala *	16.2	14.9	14.2	14.1	NO DATA	8.8	8.0	8.0	8.7	NO DATA	12.6	11.2	10.7	9.9	NO DATA
Galle	15.3	15.2	13.4	13.4	13.1	8.6	8.1	7.7	7.6	7.2	11.8	12.1	11.7	11.2	11.0
Matara	17.7	17.1	14.6	13.8	14.3	10.7	9.1	8.6	8.3	7.9	15.0	14.2	12.5	10.5	11.2
Hambantota	14.9	15.2	13.5	12.6	13.1	8.1	7.9	7.6	6.6	6.7	12.4	11.7	11.0	9.9	9.6
Kandy	16.4	16.2	15.0	14.6	15.0	11.3	10.5	10.3	10.3	10.2	11.0	9.4	10.5	10.0	9.5
Matale	15.0	15.9	14.7	15.2	15.3	9.9	9.2	9.3	9.6	9.4	11.4	10.8	9.9	9.7	9.8
Nuwara Eliya	23.2	23.0	21.5	23.5	20.8	18.9	20.0	19.6	21.8	18.9	16.0	15.3	14.2	12.6	11.1
Kegalle	18.4	18.0	17.1	16.8	15.8	10.0	9.3	8.9	9.0	8.3	14.7	13.2	13.0	12.1	11.2
Ratnapura	17.8	17.6	17.2	17.5	16.3	10.4	10.6	10.7	11.5	10.1	12.9	12.5	12.1	12.0	10.7
Kurunagala	13.5	13.8	13.8	14.5	14.6	7.8	7.4	7.8	8.1	8.0	10.9	11.0	11.8	12.1	12.2
Puttalam	15.0	14.8	13.6	13.4	13.8	9.4	8.2	7.9	7.8	7.6	10.6	10.5	10.9	9.8	10.1
Ampara	19.2	18.7	17.6	16.7	17.5	10.5	9.8	9.3	9.3	9.5	14.7	13.8	11.9	11.0	11.1
Kalmunai	12.0	11.0	10.7	10.3	9.8	8.9	7.6	7.7	7.4	6.9	8.4	7.3	6.5	5.9	5.8
Batticaloa	13.9	15.8	12.1	11.1	10.9	9.3	9.2	7.7	7.1	7.0	9.0	7.8	7.1	6.2	6.5
Trincomalee	17.2	19.0	17.4	17.1	17.4	11.7	11.7	11.4	11.0	11.2	13.9	13.6	11.5	10.3	10.0
Jaffna	14.1	14.6	13.6	13.4	12.7	8.2	8.7	8.4	8.6	7.9	10.6	10.5	9.7	9.4	8.7
Killinochchi	17.0	15.7	15.2	13.8	13.4	11.6	10.6	10.4	8.7	8.7	9.8	9.0	8.7	7.6	7.0
Mullaitivue	18.4	17.6	17.5	16.8	15.9	12.8	11.7	9.9	8.6	7.7	10.5	9.3	8.3	8.0	8.1
Vavuniya	17.5	17.8	17.0	14.9	16.7	10.2	11.0	11.4	9.6	9.9	14.0	12.6	10.8	9.4	10.7
Mannar	12.6	13.8	13.1	12.2	11.3	9.0	9.0	7.8	7.5	6.9	6.3	7.3	7.5	8.1	7.4
Sri Lanka	15.6	15.6	14.5	14.3	14.0	9.6	9.2	9.0	8.9	8.4	12.2	11.3	11.1	10.2	9.9

** Data available only up to June 2019*

Annexure 12 : Nutritional status of infants and children (eRHMIS) 2019

	Percentage of babies with low birth weight (Permanent)	Percentage of infants weighed	Percentage of young children (1-2 years) weighed	Percentage of preschoolers (2-5 years) weighed	Percentage of moderately underweight (-2SD to -3SD) infants	Percentage of severely underweight (<-3SD) infants	Percentage of moderately underweight (-2SD to -3SD) young children (1-2years)	Percentage of severely underweight (<-3SD) young children (1-2years)	Percentage of moderately underweight (-2SD to -3SD) preschoolers (2-5 years)	Percentage of severely underweight (<-3SD) preschoolers (2-5 years)
Ampara	12.3	96.4	93.7	95.8	5.6	1.2	11.6	1.8	21.2	3.3
Anuradhapura	12.5	84.5	77.5	86.1	5.8	1.1	13	1.9	19.3	2.8
Badulla	16.3	94.3	90.7	96.7	7	1.6	12.8	2.5	19.7	3.4
Batticaloa	12.7	94.5	90.6	79.6	3.8	0.83	7.9	1.8	16.5	3.1
CMC RD	12.5	63.5	53.1	51.1	6.5	1.6	10.3	1.7	13.6	2.3
Colombo	10.1	86.3	78.4	62.5	3.8	0.69	7.1	1.1	10.3	1.8
Galle	10.4	89.9	79.3	77.2	5.1	0.88	10.7	1.5	16.3	2.6
Gampaha	11.4	86.4	74.3	68.8	4	0.7	9.3	1.5	12.7	2.2
Hambantota	11.1	93.6	93.4	81.8	4.1	0.86	9.3	1.3	17.7	2.5
Jaffna	11	98.4	96.3	67.3	5.9	1.1	10.4	1.3	21.4	2.9
Kalmunai	9.7	93.6	84.5	68.9	3.9	1	7.3	1.9	13.5	3
Kalutara	12.2	91.1	81.2	75.2	4.4	0.73	8.8	1.2	13.9	2
Kandy	12.4	89.1	81	79.8	5.6	1.3	10.9	2.1	16.2	3.1
Kegalle	13.9	89	88.8	89.3	6.4	1.3	12.2	1.6	18.2	2.6
Kilinochchi	9.1	98.7	96.9	81.7	3.3	0.78	8.7	1.1	26.2	3.1
Kurunegala	11.6	92.4	86	94	5.2	1.1	10.8	1.7	15.2	2.5
Mannar	11	95.5	90.1	116.8	3.4	0.82	8.9	1.3	12.9	2.2
Matale	12.9	93.4	91.1	91.2	5.4	1.3	11	1.8	17.6	2.8
Matara	12.4	94.2	86.4	80.4	5.3	1.1	10.6	1.5	16.9	2.6
Monaragala*	13.1	95.8	93.2	85.3	5	0.83	10.2	1.4	19.3	2.6
Mullaitivu	12.2	92.3	82.9	108	4.5	1	12.3	2.4	18.5	3.3
NIHS	10.6	81.4	69.2	70.1	5	0.87	9.4	1.3	13.1	1.7
NuwaraEliya	18.1	86.9	85.6	106.6	9.9	3	16.7	4.1	21.5	4.8
Polonnaruwa	13.9	93.7	88.1	86.4	6.6	1.4	12.3	2	21.7	3.3
Puttalam	11.3	92.1	83.5	80.5	4.6	0.95	10.1	1.6	16.5	2.9
Ratnapura	14.3	90.4	85.2	91.6	6.4	1.4	12.1	1.9	19.4	3
Trincomalee	12.3	92.5	87.6	87.5	5.7	1.3	13.3	2.5	22.2	3.8
Vavuniya	12.5	94.3	100.7	93.1	5	1.4	10.9	2	19.3	3.3
Sri Lanka	12.1	90.2	83.6	81.7	5.3	1.1	10.6	1.8	16.9	2.8

** Data available only up to June 2019*

Annexure 13 : Family Planning Performance 2019

	Percentage of eligible couples using modern family planning methods	Percentage of eligible couples using traditional family planning methods	Percentage of eligible couples using any family planning method	Percentage of eligible couples with unmet need of family planning	Percentage of eligible couples with subfertility	Gap in family planning	Percentage of couples with family planning method failure
Ampara	71	5	76	2.5	3.2	6738	0.19
Anuradhapura	64.5	7.2	71.7	4.2	2.2	30932	0.13
Badulla	69.7	4.9	74.7	4.7	2.4	19780	0.14
Batticaloa	49.8	7.6	57.4	5.3	2	31515	0.33
CMC RD	53.9	11.8	65.7	9.8	2.4	12396	0.17
Colombo	55.3	10.9	66.2	6.4	4.2	59325	0.04
Galle	59.2	9.6	68.8	5.7	3.4	31265	0.1
Gampaha	51.8	12	63.9	8	4.2	81415	0.06
Hambantota	60.6	7.2	67.9	5.6	3.9	19378	0.28
Jaffna	52.4	7.7	60.1	4	4.1	25255	0.12
Kalmunai	48.6	11.1	59.7	6.2	3.7	16974	0.21
Kalutara	57.3	10.1	67.5	5.9	3.9	29412	0.07
Kandy	57.5	8.7	66.2	6.8	2.3	48337	0.17
Kegalle	60.4	9.3	69.7	5.8	3.1	23276	0.07
Kilinochchi	65.9	3.5	69.4	1.7	3	4335	0.07
Kurunegala	58.6	9	67.6	5.3	3.4	56062	0.19
Mannar	55.8	15.8	71.5	5.9	2.6	2726	0.05
Matale	61.8	7	68.9	4.6	2.4	18018	0.1
Matara	60.5	8.7	69.2	6	3.4	22515	0.13
Monaragala*	44.3	4.7	49	2.6	2.2	42131	0.2
Mullaitivu	67.5	4	71.5	3.6	1.5	3829	0.02
NIHS	53	12.5	65.5	5.9	4.2	9910	0.06
NuwaraEliya	68.2	5	73.3	6.3	2	17581	0.12
Polonnaruwa	67	6.1	73.1	3.9	3.1	13371	0.16
Puttalam	57.5	10.7	68.2	6.5	2.5	27247	0.04
Ratnapura	58.5	10.3	68.8	6.2	3.1	33900	0.07
Trincomalee	55.8	8.9	64.7	4.3	2	18050	0.24
Vavuniya	52.7	12.4	65.1	8.4	1.6	6053	0.05
Sri Lanka	58	9	67	5.9	3.2	711725	0.12

** Data available only up to June 2019*

Annexure 14 : Family Planning Performance 2019

	Percentage of eligible couples using OCP::	Percentage of eligible couples using DMPA (Injectables) ::	Percentage of eligible couples using IUCD ::	Percentage of eligible couples using Implants ::	Percentage of eligible couples using Condoms ::	Percentage of eligible couples using female sterilization ::	Percentage of eligible couples using male sterilization ::
Ampara	8	26.1	9.9	9	4.3	13.7	0.01
Anuradhapura	10.2	20.7	11.6	6.2	5.7	10	0.02
Badulla	7.9	13.7	14	8.6	5.4	20.2	0.02
Batticaloa	6.4	20.3	3.5	3.7	6.4	9.5	0
CMC RD	5.2	6.9	7.5	10.7	13.8	9.7	0.01
Colombo	7.9	6.1	12.3	6.1	13.7	9.2	0.04
Galle	10	10.4	12.3	4.9	10.4	11	0.02
Gampaha	8.9	7.6	10	4.3	11.6	9.3	0.03
Hambantota	9.2	9.5	17.1	5.5	8.9	10.5	0.01
Jaffna	6.2	7.9	3.9	3.8	9.3	21.4	0.01
Kalmunai	6.2	15.2	3.4	3.3	9	11.4	0.01
Kalutara	7.5	9.3	11.8	4.4	11.4	12.8	0.03
Kandy	8.9	9.2	9.3	6	11.4	12.6	0.06
Kegalle	10.3	13.8	9.1	6.6	8.3	12.4	0.02
Kilinochchi	4.8	15.2	14	5.7	5.4	20.7	0.01
Kurunegala	9.1	10.6	14.4	4.9	10.7	8.9	0.01
Mannar	6.7	13	3.2	4.2	9.9	18.8	0.01
Matale	10.4	12.4	12.2	5	8.9	13	0.01
Matara	10.5	10.3	12.8	5.6	11.4	9.8	0.04
Monaragala *	5.5	10.8	11.2	5.2	3.7	7.9	0.01
Mullaitivu	9.2	19.4	7.5	12.4	3.9	15.1	0.02
NIHS	7.9	6.3	8	3.9	12.9	14	0.02
NuwaraEliya	6.1	9.4	8.6	10.8	4.9	28.5	0.05
Polonnaruwa	10.1	24.6	10.4	6.4	5.1	10.4	0.02
Puttalam	9.3	14.8	7.9	6.9	7.2	11.3	0.01
Ratnapura	9.9	12.6	10.1	5.3	8	12.5	0.02
Trincomalee	6.5	24	2.3	5.9	7.2	9.9	0
Vavuniya	7.9	11.7	2.4	5.9	6.7	18.1	0.01
Sri Lanka	8.5	11.8	10.4	5.8	9.3	12.1	0.02

** Data available only up to June 2019*

Annexure 15: Infant Child Mortality 2019

	Early neonatal mortality rate	Neonatal mortality rate	Infant mortality rate	Under 5 Child Mortality Rate	Still birth rate
Ampara	3.6	6.8	10.2	13	9
Anuradhapura	5.6	7.9	10.5	12.6	6.2
Badulla	5.9	7.8	11.4	12.4	4.9
Batticaloa	3.9	5.6	9.8	11.7	8
CMC RD	4.6	6.6	9.5	11.4	10
Colombo	4.6	6.5	9.2	10.1	5.3
Galle	4.2	5.8	8	9.7	7.1
Gampaha	4.9	6.8	9.6	10.8	5.5
Hambantota	4	4.9	7.4	8.6	6
Jaffna	6.1	8	12.5	14.9	7.3
Kalmunai	4.9	8.9	12.7	14.6	7
Kalutara	6.5	7.8	10.1	10.9	7.5
Kandy	5.6	7.6	11.5	12.9	8.8
Kegalle	3.9	5.2	8	9.4	5.9
Kilinochchi	7.9	9.4	13.1	16.2	4.7
Kurunegala	6.6	8.5	11.2	12.6	5.9
Mannar	3.5	4.5	9.4	11.9	5.4
Matale	5.2	6.4	9.8	11.4	5.3
Matara	3.4	5	6.8	8.8	6.6
Monaragala *	5	6.4	9.8	12.2	6.4
Mullaitivu	6.5	8.3	12.5	15.4	6.5
NIHS	9.5	11.3	13.6	14.5	6.5
NuwaraEliya	5.9	8.4	11.8	14.6	8.3
Polonnaruwa	4	6.6	11.3	13.6	7.6
Puttalam	6	7.4	10.4	11.9	5.9
Ratnapura	4.1	6.3	9.1	10.5	5.9
Trincomalee	5.3	6.1	9.6	11.2	6.1
Vavuniya	5.4	7.3	9.6	12	5
Sri Lanka	5.1	6.6	10.1	11.7	6.5

** Data available only up to June 2019*

Annexure 16 : Well Woman – 2019

	Percentage of 35 year age cohort attendance to WWC out of 1% of estimated population::	Percentage of 35 year age cohort coverage who had undergone Papsmear screening out of 1% of the population::	Percentage of unsatisfactory Papsmear specimens ::	WWC pap smears taken 35y	WWC pap referred	WWC identified breast abnormalities	WWC identified diabetes	WWC identified hypertension
Ampara	71.6	69.7	4.7	1961	214	45	42	75
Anuradhapura	58.4	56.4	1.7	5312	102	119	283	393
Badulla	70.5	67.1	0.84	5925	582	95	311	366
Batticaloa	58.9	57.6	5.4	3343	4	5	65	99
CMC RD	14.5	14.4	6.5	847	71	19	17	61
Colombo	56.9	46.2	2.3	8628	726	495	369	630
Galle	55.6	52.8	1.1	5994	377	192	343	416
Gampaha	50.3	43.7	2	10601	605	356	529	606
Hambantota	63.6	59.2	5.5	3925	53	147	183	172
Jaffna	47.5	37.3	4	2309	158	15	229	202
Kalmunai	74.4	73.2	7.7	3313	26	22	61	48
Kalutara	55.5	51.9	2.2	5112	137	293	179	337
Kandy	72.4	62.8	2.5	9322	438	298	400	513
Kegalle	78.3	74.1	6.7	6603	111	184	272	297
Kilinochchi	38.1	35.2	6.6	452	95	24	59	48
Kurunegala	57	53.7	10.7	9286	989	328	893	976
Mannar	62.3	61.4	4.8	680	33	31	60	69
Matale	81.8	74.7	3	3915	235	89	176	224
Matara	62.6	59	0.3	5104	143	142	132	212
Monaragala *	62	59.7	3.2	2969	49	72	118	113
Mullaitivu	47.9	46	11.5	445	34	3	18	22
NIHS	60.6	45.6	1.6	1393	252	129	125	176
NuwaraEliya	83.6	76.6	1.8	5899	312	85	240	385
Polonnaruwa	66.6	62.2	0.66	2745	191	168	86	395
Puttalam	36.7	35.5	0.77	2972	64	100	69	204
Ratnapura	58.3	56.2	2.6	6598	126	234	468	380
Trincomalee	61.1	60.2	0.43	2587	6	24	191	161
Vavuniya	23	22.7	0.3	432	7	12	37	38
Sri Lanka	59.1	54.2	3.2	118672	6140	3726	5955	7618

** Data available only up to June 2019*

Annexure 17 : School Health Performance – 2019

	School Medical Inspection Completed	% of students with defects	% of children stunted in Grade 01 (Total)	% of children stunted in Grade 04 (Total)	% of children wasted in Grade 01 (Total)	% of children wasted in Grade 04 (Total)	% of children wasted in Grade 07 (Total)	% of children wasted in Grade 10 (Total)	% of children overweight in Grade 01 (Total)	% of children overweight in Grade 04 (Total)	% of children overweight in Grade 07 (Total)	% of children overweight in Grade 10 (Total)
Ampara	100	48.8	8.2	5.9	29	26.3	25	18.7	1.5	4.6	8.4	7.5
Anuradhapura	99.2	28.1	7.4	5.6	19.9	19.1	15.6	13.2	1.9	4.4	9.7	7.8
Badulla	99.8	33	11.4	8.3	20.4	20.8	19.7	16.9	1.7	3.1	5.1	5
Batticaloa	97	36.2	8.6	6.7	13.3	13.8	13.4	9.5	4.6	5	6.1	5.7
CMC RD	93.8	36.6	3.8	2.4	19.2	18.7	16.3	10.1	5.3	10.6	15.4	15.5
Colombo	100	30.1	5.3	4.1	18.7	17.8	16.4	14.1	4	7.1	9.6	8
Galle	100	26.1	6	4.7	18.1	19.2	16.7	14	2.2	4.2	5.9	5.7
Gampaha	99.8	20.8	5.5	3.6	15.4	13.6	14.5	12.1	3.7	6.2	8.3	7.3
Hambantota	99.4	42.2	6	4.5	29.9	27	24.1	19.9	1.7	4.2	6.4	5
Jaffna	98.7	47.5	9.7	6.5	18.8	19.6	18.3	16.2	3.2	5.5	9.1	7.7
Kalmunai	99.6	47.7	7.8	5.7	14.9	15.5	15.8	13.9	2.7	4.6	6.2	5.8
Kalutara	95.6	29.9	5.9	4.5	18.2	18.6	19.7	15.7	2.9	6.7	10.2	8.6
Kandy	99.6	32.6	9	6.7	18.5	19.1	18	14.5	2.4	5.3	8.1	7.5
Kegalle	99.5	32.3	7	4.9	17	17.1	16.4	14	2.1	4.5	6.6	6.7
Kilinochchi	100	51.1	12.7	10.2	18.5	20.7	18.8	17.1	1.8	2.5	4.4	4.2
Kurunegala	98.6	23.4	7.2	5.5	20.4	19.1	16.6	13.4	1.9	4.2	6.8	6.2
Mannar	99.3	35.3	8.4	7.5	17.1	19.3	16.6	15.5	0.9	1.6	4.4	4.4
Matale	95.4	21.9	6.7	5	19.4	18.1	16.6	13.2	2.3	3.7	6.6	6.9
Matara	100	23.5	6.9	5.2	20.5	22.1	21.9	18.1	1.9	4.3	6.4	4.5
Monaragala*	40.3	40.1	7.3	5.8	22.4	23.6	23.2	16.7	1.4	4.1	6.6	5.2
Mullaitivu	98.4	38.8	9.7	7.9	18.3	16.7	19.8	14.8	0.82	1.9	4.6	3.8
NIHS	97.8	38.6	5.2	4.3	15	14	13.9	11.9	3.5	5.3	8.4	7.3
NuwaraEliya	100	28	15.6	13.8	21.5	21.1	17.9	16.5	1.1	2.2	2.9	2.6
Polonnaruwa	100	36.5	6.5	5	23.7	23.7	22.3	18.7	2	4.8	9.4	7.2
Puttalam	97.6	18.2	6.4	4.2	17.7	17.7	14.9	12.1	2.2	5.2	7.1	8.1
Ratnapura	96.2	36.1	8.4	6.9	22.5	22.9	21.2	18.4	1.9	3.7	6.2	5.6
Trincomalee	99.1	35.7	9.4	6.5	16.8	18.8	16.2	15.1	2.4	4	5.6	5.8
Vavuniya	93.1	35.8	14.7	8.3	21.5	17.5	19.5	18.6	1.9	2	4.2	4.2
Sri Lanka	97	31.1	7.6	5.6	19.3	19	17.7	14.8	2.5	4.9	7.5	6.5

** Data available only up to June 2019*

Annexure 18 : School Health Performance – 2019

	School Health Survey Completed	% of availability of usable toilets	% of schools with adequate drinking water	% of schools with safe drinking water	% of schools segregate garbage	% of schools properly dispose garbage	% of schools composting waste	% of schools with mosquito breeding sites	% of schools with fly breeding sites	% of schools with accident prone sites	% of schools with canteen	% of schools adopted canteen policy (Correct)	% of schools with unhealthy foods selling places
Ampara	98.9	76.8	83.2	82.1	56.8	76.3	60	16.8	11.6	37.9	28.4	21.1	1.6
Anuradhapura	99.7	91.3	72.2	72.4	39.3	65.4	42.1	16.4	11.7	16.6	31.6	12	4
Badulla	100	97.9	75.2	58	58.5	76.6	45.1	6.8	4.2	26	20.9	13.8	3.1
Batticaloa	100	95.3	74	66.9	59.7	72.9	17.4	4.1	2.5	8	27.3	22.9	2.2
CMC RD	100	95.3	92.4	90.3	91.7	91	37.2	14.5	4.8	6.2	56.6	31	4.8
Colombo	100	94	96.4	96.1	77.5	89.5	61.8	9.8	3.6	14.7	52.3	31.4	4.6
Galle	100	86.5	80.3	70.8	56.5	71.4	52.2	5.8	6.3	23.4	36.6	20.8	6.7
Gampaha	100	93.1	83.7	84.4	66.9	85.4	62.4	6.6	8.8	10.2	49.6	27.9	3.6
Hambantota	100	92.7	83.8	80.1	50.6	65.3	39.6	13.9	14.5	23.7	30.3	22	5.2
Jaffna	99.6	94.3	96.7	95.2	47.9	90.8	24.2	6.5	1.7	5	14.4	11.1	2
Kalmunai	100	96.5	88.8	88.8	31.3	79.5	14.3	6.2	3.5	12	40.5	35.1	4.6
Kalutara	99.7	94.4	86.7	71.2	65.7	71.5	57.3	15	10.8	23.3	39.9	23	5.8
Kandy	100	89.5	71.2	69.1	56.5	68.2	40.7	11.5	13.9	24.8	31.8	16.1	3.5
Kegalle	100	93.3	78.6	70.7	55.4	78.6	51.8	4.9	3.6	27.9	33	19.4	5.1
Kilinochchi	100	93.9	95.2	90.5	38.1	78.1	18.1	7.6	8.6	10.5	35.2	21.9	0.95
Kurunegala	100	90.3	75.9	76.5	44.4	72.7	48.4	8.8	8.7	13	35.8	19.7	3.6
Mannar	100	76.8	81.8	77.4	38.7	59.1	21.9	2.9	2.9	9.5	19.7	11.7	1.5
Matale	94.5	93.5	69.7	64.2	41.3	59.8	35	11	10.4	24.9	24.3	11.8	6.6
Matara	100	93.1	78.6	72.1	71.4	77.9	59.4	7.3	7.3	25.5	36.5	26.8	3.6
Monaragala *	100	98.1	69.5	78.1	49.3	67.2	42.4	14.2	9.6	27.8	35.1	22.2	15.9
Mullaitivu	100	92.5	84	76.8	25.6	80.8	7.2	16	1.6	8	23.2	16.8	0
NIHS	100	99.7	77.8	74.4	50	68.9	35.6	23.3	10	26.7	48.9	21.1	4.4
NuwaraEliya	100	94.7	45.4	33.1	28.8	39.5	15.9	13.9	15.3	25.1	12.1	6.8	2.3
Polonnaruwa	100	97.4	80.9	82	24.3	50.4	28.7	16.2	16.2	14.3	34.6	15.4	8.8
Puttalam	99.7	85.4	74.1	77.3	42.2	62.8	45.5	12.8	9.9	10.4	52.4	24.1	9.6
Ratnapura	98.1	97.7	79.1	61.3	76.6	81.6	65.8	6.9	6.6	30.9	37.7	26.1	3.9
Trincomalee	99.1	98.3	81.1	78.6	33.6	80.2	19.2	5.3	4.7	4.7	30.8	25.5	1.6
Vavuniya	98.3	84.7	78.9	67.9	32.1	58.9	28.4	7.9	3.7	8.4	9.5	4.7	1.1
Sri Lanka	99.6	92.9	77.7	72.5	51.8	72	42	9.8	8.2	19	32.7	19.6	4.4

** Data available only up to June 2019*

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