



Annual Report 2022



Family Health Bureau
Ministry of Health
Sri Lanka





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CONTENTS

Message from the Director MCH	5
Acknowledgement	6
Who we are	8
Where we are in the health system	10
Implementation of the national RMNCAYH programme	11
What we do	15
Strategic directions	17
National programme performances	20
RMNCAYH Indicators	25
Preconception Care for newly married couples	27
Maternal and Newborn Health	28
Private sector performances in Maternal and Newborn Health	37
Infant and Child Health	40
Family planning	47
Adolescents and youth health including school health	52
Gender and Women's Health including Well Women Care Services	53
Outcome of Maternal death surveillance and response (MDSR) 2022	58
Special activities carried out during 2022	74
Maternal and newborn care	76
Child health	77
School health	78
Adolescent and youth health	81
Family planning	91
Gender and women's health	95
Well woman programme	99
Oral Health	99
Planning and development	100
Monitoring and Evaluation	101
Financial Report	107
Annexures	112



MESSAGE FROM THE DIRECTOR MCH

Family Health Bureau, Ministry of Health is pleased to present the 32nd Annual Report for the year 2022. This report provides a description of the progress made in Reproductive, Maternal, New-born, Child, Adolescent and Youth Health (RMNCAYH) programme, including some details on the special activities carried out by the Family Health Bureau in improving the National RMNCAYH status in 2022, in Sri Lanka.

Information provided in this report could be utilized for programme redirection at the National, Provincial and District levels and to identify areas that need special attention in order to provide further improvements of quality among the services relevant to National RMNCAYH programme in Sri Lanka.

I take this opportunity to thank all the Medical Officers of Health and their teams, district MCH teams and the directorates of district and provincial level for their commitment in maintaining the maternal and child health services during this challenging pandemic.

Dr. Chithramalee de Silva

Director Maternal and Child Health



I greatly appreciate the technical and financial inputs provided by the World Health Organization, United Nations Children's Fund, United Nations Population Fund, World Food Programme 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 compilation of this report. Completion of this document would not have been possible without the support given to me by Dr. Widarshi Kalehewatta and Ms. Isuri Priyananda and Mr. Lahiru Fernando. I greatly appreciate their contribution.

Finally, I must thank all the staff members in the Monitoring and Evaluation Unit, Family Health Bureau for their immense support, commitment and continuous hard work during these challenging years.

Dr. Kaushalya Kasturiaratchi
 Consultant Community Physician
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 Ministry of Health

ACKNOWLEDGEMENT

With the objective of providing feedback to all relevant stakeholders on effectiveness, strengths and challenges of RMNCAYH programme, this 32nd Annual Report is compiled and published by the Monitoring and Evaluation Unit of the Family Health Bureau. The report includes information on selected indicators regarding input, process, output, outcome and impact indicators relevant to the RMNCAYH programme performance in 2022. This report would reflect upon the progress of RMNCAYH programme in the country and enlighten on several special activities carried out by the Family Health Bureau to improve the National programme.

Family Health Bureau of the Ministry of Health being the national focal point of the RMNCAYH programme in Sri Lanka is thankful to all relevant directorates in the Ministry of Health for the support extended to strengthen the national RMNCAYH programme.

I would also like to thank all the professional Colleges and academic bodies including the Sri Lanka College of Obstetricians and Gynaecologists, College of Community Physicians of Sri Lanka, Sri Lanka College of Paediatricians and Perinatal Society of Sri Lanka for providing valuable technical inputs and involving themselves actively in the National programme during 2022.

WHO WE ARE



In Sri Lanka, the Health Unit System was introduced in 1926 as an organized effort to provide maternal and child health [MCH] services. The first health unit was established in Kalutara with a Medical Officer of Health [MOH] appointed as the in charge of the unit. By establishing these units, an effort to provide comprehensive maternal and child health services was established which later resulted in demonstrating a drastic improvement in MCH services in the country. In 1965, the Government accepted family planning [FP] as a national policy and it was integrated with the already existing MCH services.

Recognizing the national importance of providing a comprehensive MCH and FP services, Family Health Bureau [FHB] was established in 1968 within the Ministry of Health in order to implement the programme uniformly island wide. This institution was initially named as the Maternal and Child Health Bureau and was later, in 1972, named as the Family Health Bureau. In 2012, Cabinet approved the national

MCH policy and FHB took the lead in implementing national strategies in collaboration with other national programmes and stakeholders.

FHB: NATIONAL FOCAL AGENCY IN THE MINISTRY OF HEALTH RESPONSIBLE FOR REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, ADOLESCENT AND YOUTH HEALTH PROGRAMME IN SRI LANKA

As the focal point in the Ministry of Health, FHB is responsible for planning, implementing, monitoring and evaluating the reproductive, maternal newborn, child, adolescent and youth [RMNCAYH] health programme. FHB provides technical guidance for provincial health care systems in implementing and monitoring the RMNCAYH programme. In addition, FHB advises the Ministry of Health on matters related to policy, finance, infra- structure and other resource requirements relevant to RMNCAYH programme. FHB works in collaboration with many

stakeholders in achieving Sustainable Development Goals [SDG] in 2030. Further, monitoring and evaluation of the RMNCAYH programme also come under the purview of the FHB.

WHERE WE ARE IN THE HEALTH SYSTEM

The administrative and technical guidance relevant to the RMNCAYH programme has been integrated into a multi-tier organizational arrangement of the Ministry of Health. FHB functions under the administrative authority of Director, Maternal and Child Health [D/ MCH]. D/ MCH directly reports to the Deputy Director General Public Health Services II [DDG PHSII] and through the DDG PHSII to the Director General of Health Services [DGHS]. Secretary Health is the overall administrative head in the Ministry of Health (figure 1.1)

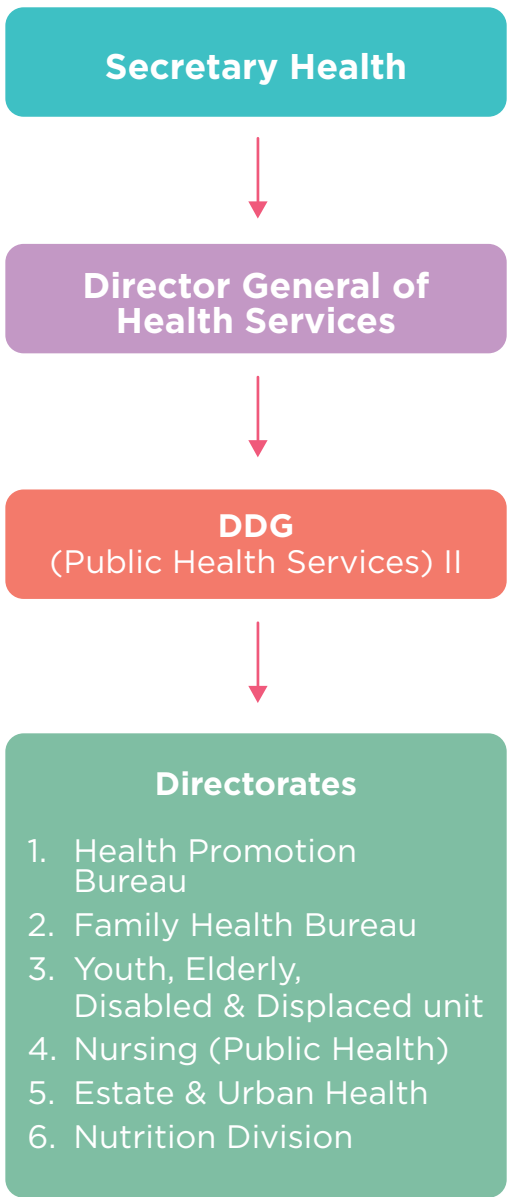


Figure 1.1: Administrative hierarchy in the Ministry of Health
Source: MoH

Following the partial devolution of political power with the 13th amendment to the Sri Lankan constitution, provincial health service became a responsibility of the Provincial Health Ministries. Provincial Director of Health Services [PDHS] is the technical and administrative head in the province responsible for health care provision. Under the PDHS, there are several district directorates of health functioning that correspond to each of the districts in a given province (figure 1.2).

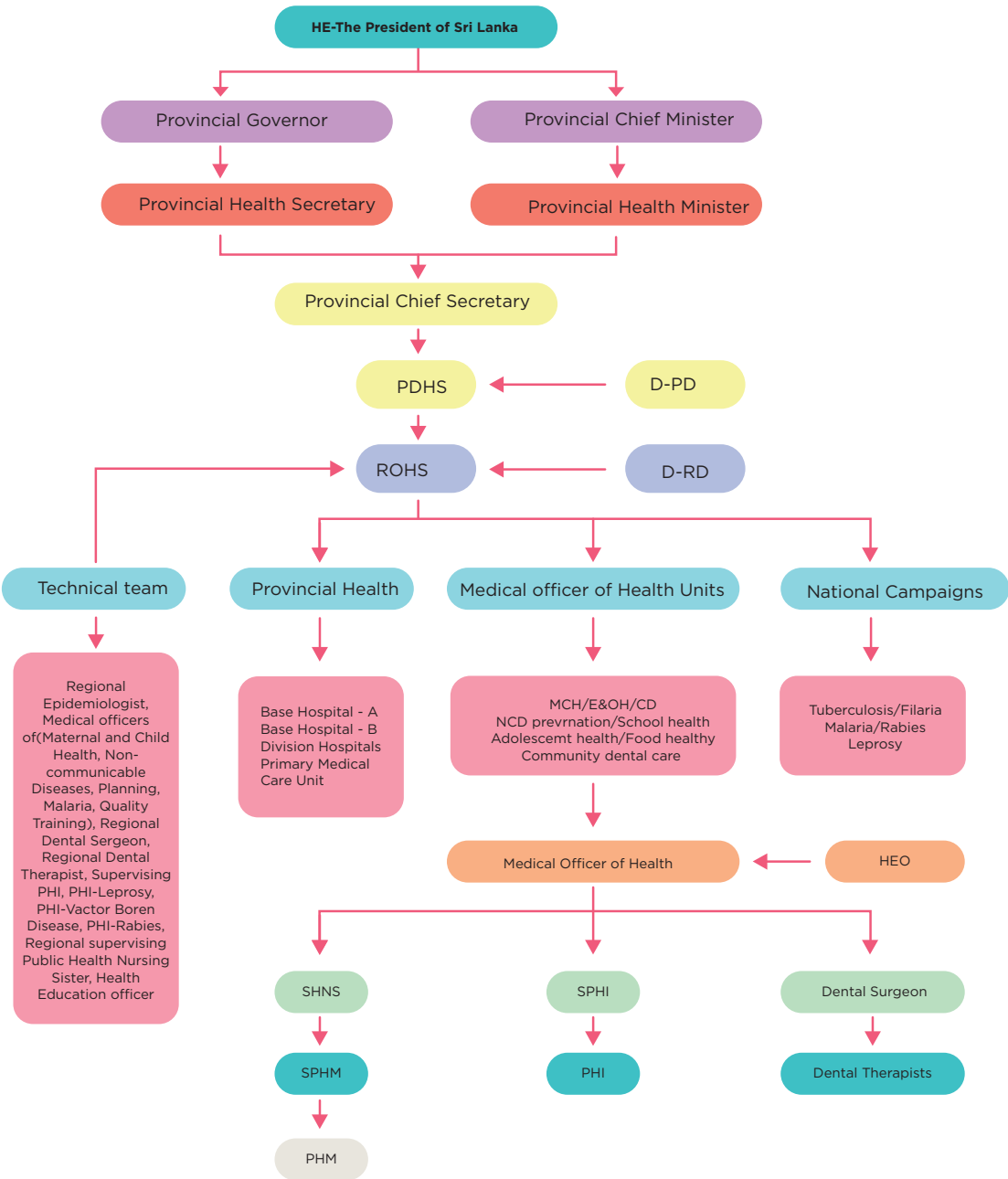


Figure 1.2: Administrative hierarchy of the Provincial health system
Source: MoH

IMPLEMENTATION OF THE NATIONAL RMNCAYH PROGRAMME

Figure 1.3 summarizes the organizational hierarchy of the national RMNCAYH programme. It also depicts the referral and back referral pathways available for conditions related to RMNCAY health.

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

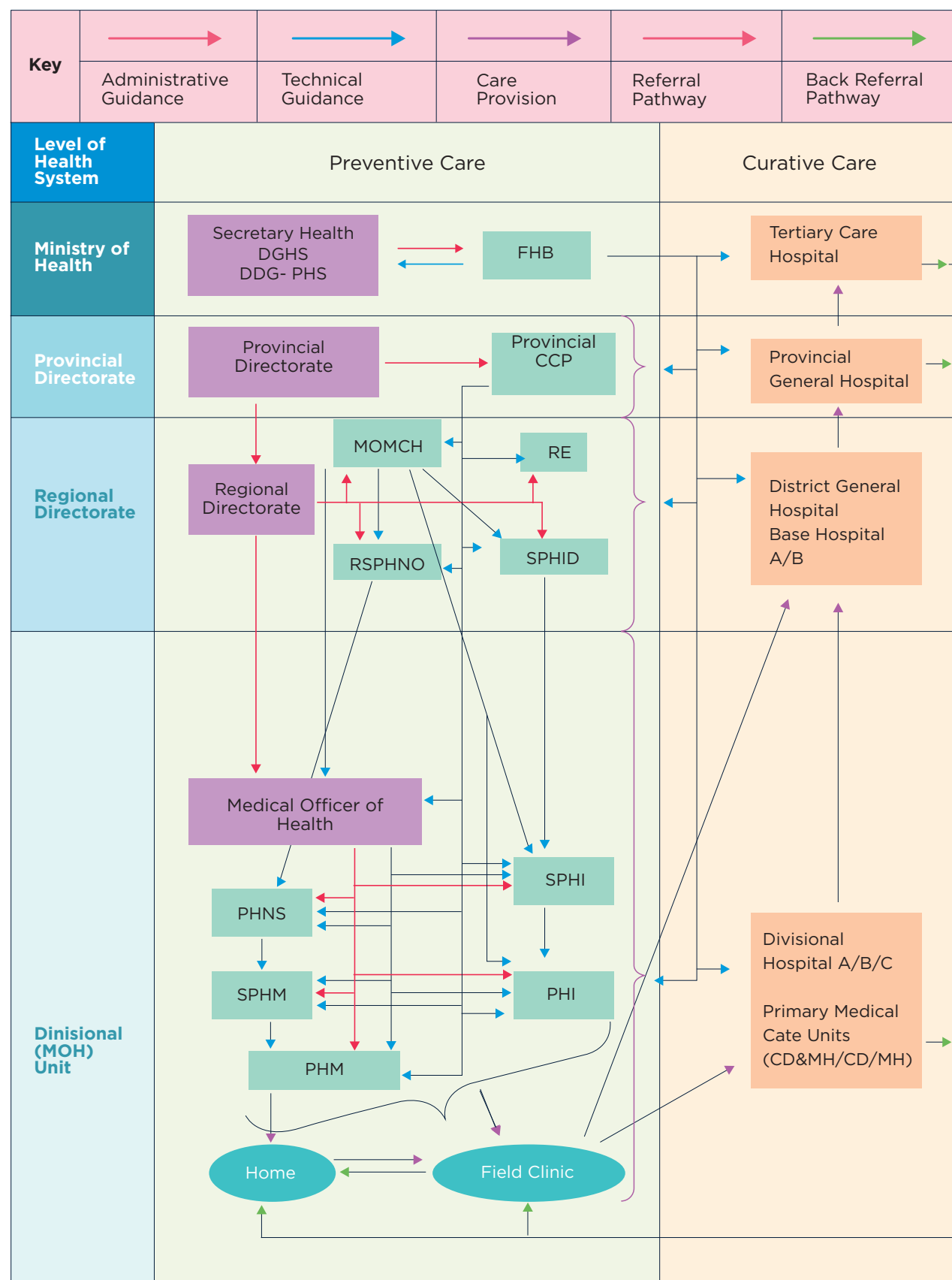


Figure 1.3: Organization of RMNCAYH Programme at Different Levels of Health System

Source: FHB

The grass root level implementation of the programme is carried out by the Medical Officers of Health (MOH) teams under the administrative supervision of the Provincial and Regional Directorates of Health. In Sri Lanka, the 361 MOH areas are distributed within the 26 health districts.

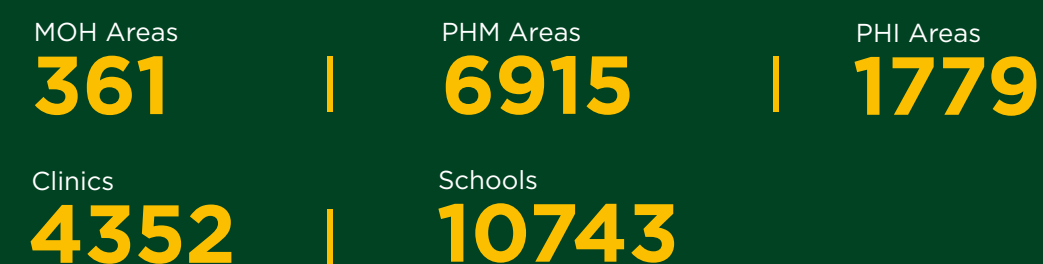
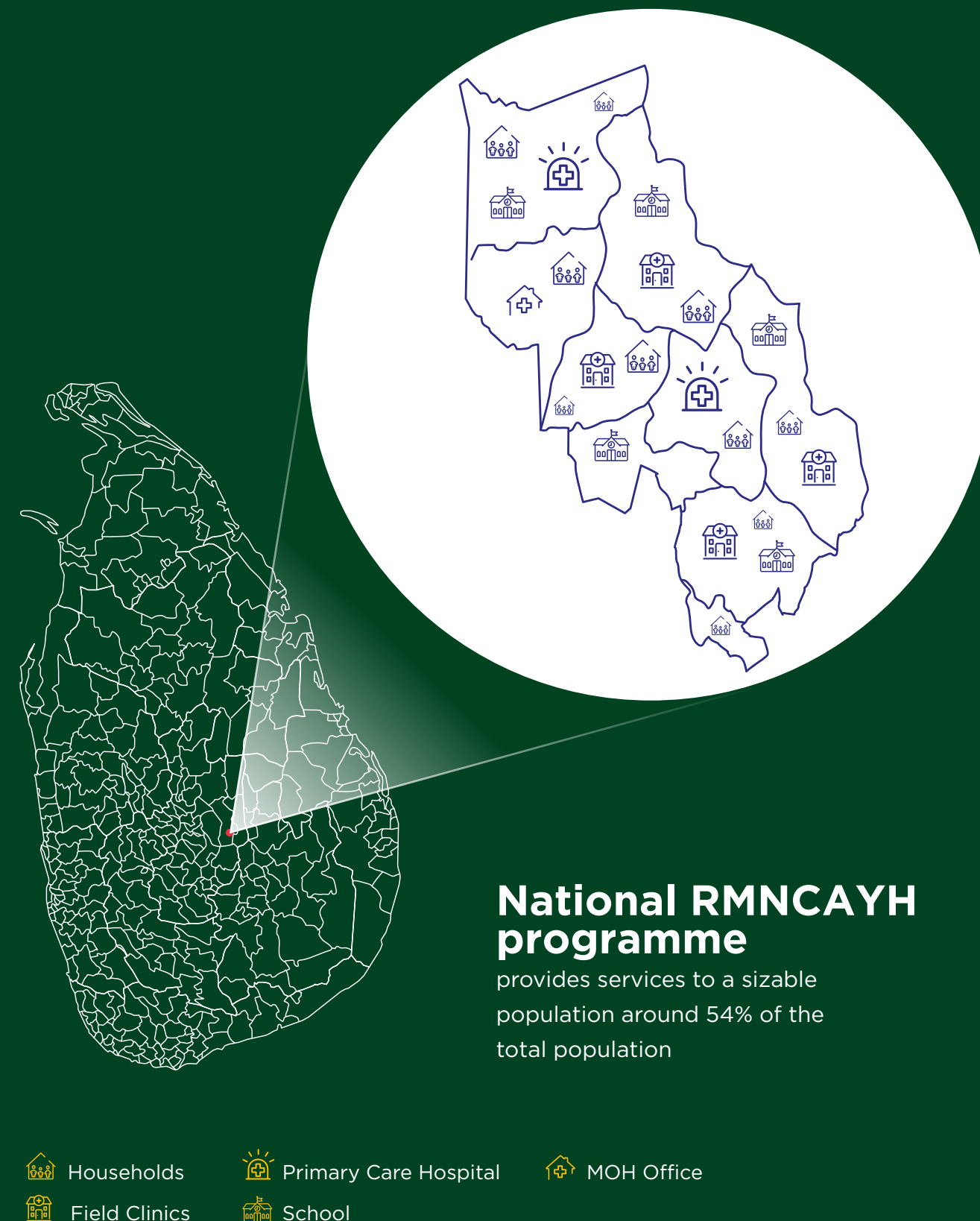


Figure 1.4: Geographical distribution of a MOH area

Source: FHB

In the public health network, the MOH area is the smallest health administrative unit and it consists of a team comprising several categories of staff. MOH is the manager of the MOH team and the technical and the administrative head of the area. He /She is a MBBS qualified doctor who is given special orientation training on public health activities. 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 (figure 1.4). While the main

responsibility of the PHM centers around maternal and child health activities, the PHIs are primarily responsible for school and adolescent health programmes, environmental and occupational health activities including control of communicable diseases, ensuring water and food safety and sanitation related interventions.

Several other intermediate level supervisors are available in the MOH team. They assist the MOH in supervision of activities of grass root level staff. While the Public Health Nursing Sisters (PHNS) are responsible for supervising the activities of the PHMs, SPHMs in turn, activities of all these categories are supervised by the MOH. Supervising Public Health

Inspectors (SPHI) are the immediate supervisors of PHIs. They are directly responsible to the MOH. MOH team is further supported by Development Assistants/ Programme Planning Assistants/ Development Officers/ Management Assistants, clerical and supporting staff. Distribution of MOH office technical staff categories in 2022 is given in table 1.1

Table 1.1: Distribution of MOH office staff categories according to the population
Source: e-RHMIS, FHB 2022

Staff category	Approved cadre	Cadre in position	Ratio for population	Ratio (Officers /100,000 population)
MOH	367	303	1:72721	1.4
AMOH	430	334	1:65972	1.5
PHNS	425	253	1:87093	1.1
SPHI	348	238	1:92582	1.1
SPHM	411	284	1:77587	1.3
PHM	6714	5742	1:3837	26.1
PHI	1747	1518	1:14516	6.9
SDT	449	315	1:69951	1.4



WHAT
WE
DO

FHB has sixteen units headed by Consultant Community Physicians (Public Health Specialists), a Consultant Community Dental Surgeon and a Consultant Obstetrician and Gynecologist corresponding to sixteen areas of work. The staff of each unit is responsible for advocacy, policy and strategic analysis, programme development, technical guidance including capacity development, evaluation and supervision related to the respective programme components.

These units are; Maternal Health Unit, Intrapartum and Newborn Care Unit, Maternal Morbidity and Mortality Surveillance Unit, Child Morbidity and Mortality Surveillance Unit, Child Health, Development and Special Needs Unit, Child Nutrition Unit, School Health Unit, Adolescent and Youth Health Unit, Gender and Women’s Health Unit, Well Women Unit, Family Planning Unit, Oral Health Unit, Monitoring and Evaluation Unit, Planning and Development Unit, Research Unit and Reproductive Health Center. Reproductive center is functioning under a Consultant Obstetrician and Gynecologist. Under the directorate of Maternal and Child Health, more than 160 staff members are functioning in various capacities.

STRATEGIC DIRECTIONS

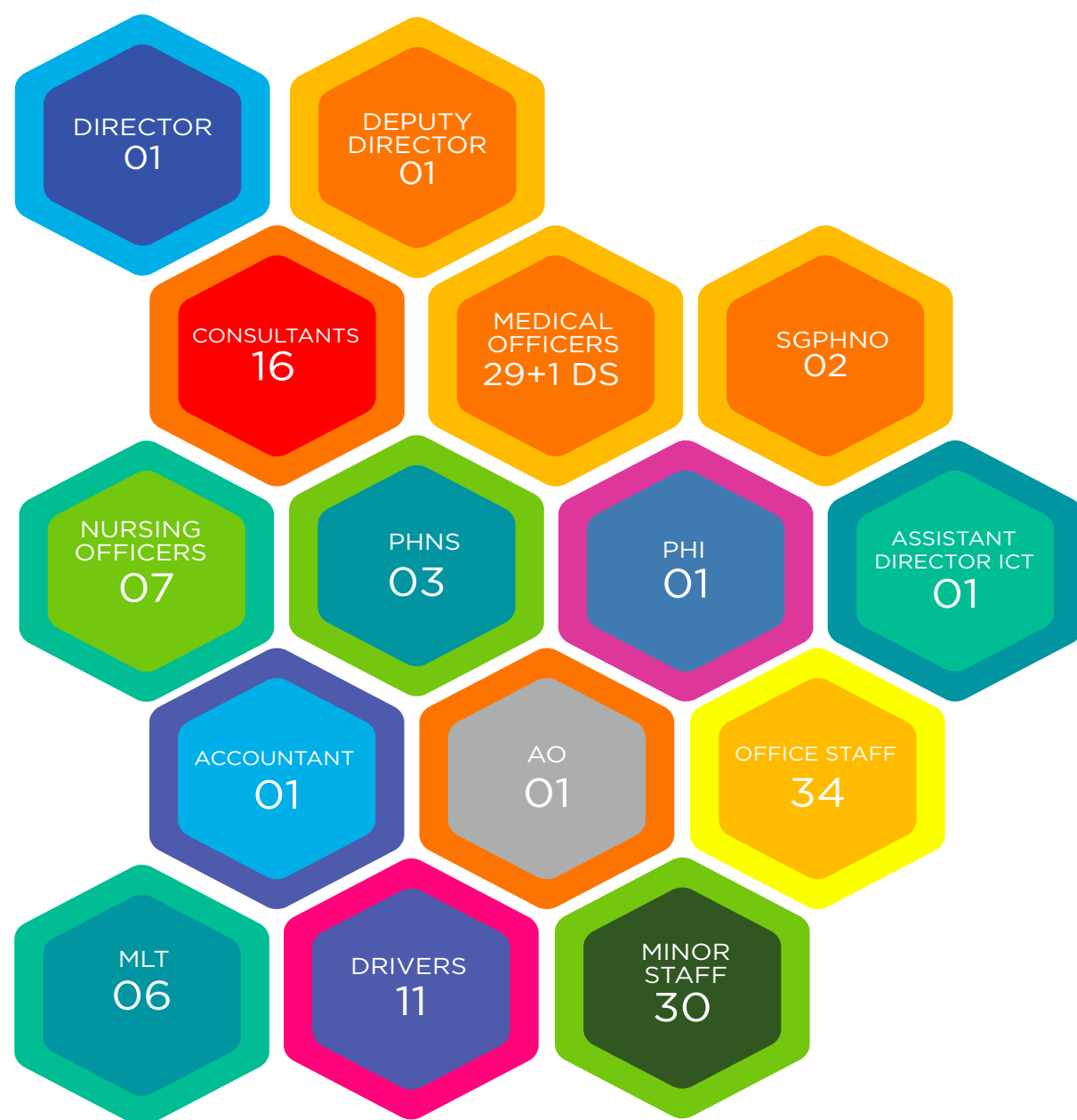


Figure 1.5: Distribution of staff at Family Health Bureau

Source: FHB

There are several advisory bodies for the National RMNAYCH programme including Technical Advisory Committees (TAC) on Newborn and Child Health, Maternal Health and Family Planning, Well Woman programme, Maternal and Child Nutrition and Adolescent Health and Maternal and Child Nutrition Sub Committee (MCNSC) established under either the DGHS or DDG PHS II. All these TACs report to the National Committee on Family Health (NCFH) and MCNSC to the National Steering Committee, which are conducted quarterly and chaired by the Secretary Health.

All strategic decisions are taken at these committees and the directions for action are given by the Director General of Health Services.

With the aim of reaching the SDGs in 2030, national RMNCAYH programme has developed strategic plans covering all programmatic areas. National targets are set for five-year periods and they are being closely monitored



CHILD HEALTH AND NUTRITION

Aiming at availing universal access and ensuring utilization of health care by all children, the national strategic plan on child health in Sri Lanka 2018-2025 had been developed. Nutrition promotion and growth monitoring, childcare development and monitoring children with special needs, prevention of disease and injuries, caring for vulnerable children and children in underserved areas have been incorporated into this strategic plan. In addition to the national strategic plan on child health, national strategy for infant and young child feeding in Sri Lanka 2015 - 2020 was developed targeting improving child nutrition.

ADOLESCENT AND YOUTH HEALTH INCLUDING SCHOOL HEALTH

National strategic plan on adolescent and youth health 2018-2025 has been formulated to ensure adolescent and youth empowerment with knowledge, attitudes, skills and opportunities enabling optimum development in safe, supportive and promotive environment at home, school and community which facilitate healthy transitions into adulthood and provide quality healthcare. Strategic directions aiming at reducing mortality due to accidents and suicides among young persons and reduce prevalence of wasting, overweight/ obesity and anaemia, reducing adolescent fertility rate and new HIV/Sexually Transmitted Infections among the adolescent and youth are included.



GENDER AND WOMEN’S HEALTH INCLUDING WELL WOMEN SERVICE

National action plan for health sector response on prevention and management of gender-based violence [GBV] in Sri Lanka (2017-2021) was published to ensure a holistic health sector response to GBV. The action plan consists of the strategic plan, the operational plan, and the budget plan and is presented within an overarching framework of a three-pronged approach; Prevention of GBV (primary prevention), Interventions (secondary and tertiary prevention of GBV), and Policy and Advocacy. Foresaid action plan aligned with the health sector strategic plan in the Policy Framework and National Action Plan to address Sexual and Gender-Based Violence (SGBV) in Sri Lanka (2016-2020). The implementation of proposed strategies and activities was monitored closely at each level to achieve the objectives, and the results were reviewed in 2022 to assess progress. The percentage implemented was 86.5% in the prevention approach, 90% in the intervention, and 82% in policy advocacy.

With the vision of empowering Sri Lankan women to live healthy and productive lives and increasing the Well Woman coverage of 35-year cohort to 80% and 45 age cohort to 60% by 2023, the national strategic plan for Well Woman programme 2019-2023 had been formulated. All provincial/ district health managers are expected to strengthen the programme in their respective area by establishing at least one functioning WWC for every 15,000 population.

FAMILY PLANNING

desired number of children with optimal spacing whilst preventing unintended pregnancies. Objectives of the programme include ensuring the availability and accessibility to quality modern contraceptive service, addressing the unmet need for contraception to reduce unintended pregnancies and teenage pregnancies, ensuring availability of male & female sterilization services in hospitals, ensuring post-abortion care services, ensuring supplies of contraceptive and strengthening services for sub-fertile couples in the public health sector. Targets set for national programme is given in table 1.3.

Table 1.3: Family Planning targets for Sri Lanka

Source: FHB

#	Indicator	2015	2016	2017	2018	2019	2020	2021	2022	2025	2030
1	CPR (%)	64.6	66.4	66.6	67	66.9	66	66.5	67.8	66.4	
2	mCPR (%)	53.6	57	57.3	57.9	57.9	57	57.7	58.8	57.2	
3	UMN (%)	7.5	6.2	6.3	6	5.8	5.7	5.6	5.4	5.7	
4	Demand satisfied by modern methods (%) *	74.3	78.5	78.6	79.3	79.6	79.5	80.1	80.3	79.0	81.0
	Source	SLDHS 2016		HMIS		FP 2022				SDG	

NATIONAL PROGRAMME PERFORMANCES

The report includes information on selected indicators regarding input, process, output, outcome and impact relevant to the RMNCAYH programme. During preparation of this report, several sources of information were used.

DATA SOURCES FOR PERFORMANCE MONITORING

1. Registrar General’s Department

The national population estimates, fertility and mortality rates published by the Registrar General’s Department was used as denominators and also for comparisons. In comparison to Registrar General’s Department information and information from Department of Education, an attempt is made below [table 2.1] to identify where the national RMNCAYH programme stands in 2022.

Table 2.1: Size of the different target population of RMNCAYH programme in Sri Lanka 2022

Indicator	Estimated/Actual	Reported
Midyear population	22,181,000*	22,396,646
Eligible families	4,143,379	3,972,905
Pregnant mothers	302,853	284,008
Births	275,321*	257,953
Infants under care	284,848*	267,531
1-2 years under care	301,706**	300,763
2-5 years under care	905,564**	919,726
Number of schools ≤ 200	5,204***	5,568
Number of Schools ≥ 200	4,922***	5,002
Adolescent	3,740,241	2,185,100
Preconception	171,136	108,642
Total school children under care at the beginning of year	4,272,289***	4,197,674

* Births registered by Registrar General’s Department
** According to Births reported by Registrar General’s Department for relevant years
***As reported by Ministry of EducationSource: RGD & FHB, eRHMIS2022

A difference was observed in estimated pregnancies and births vs. reported pregnancies and births. Also, a notable difference was observed in estimated adolescent population and Preconception age population vs reported population

National RMNCAYH programme provides services to a sizable population (around 54% of the total population) in Sri Lanka which includes pregnant mothers, infants, children, adolescents, youth and women in the reproductive ages.

Eligible family registration is the entry point for the national RMNCAYH programme and service provision is planned around the eligible families.

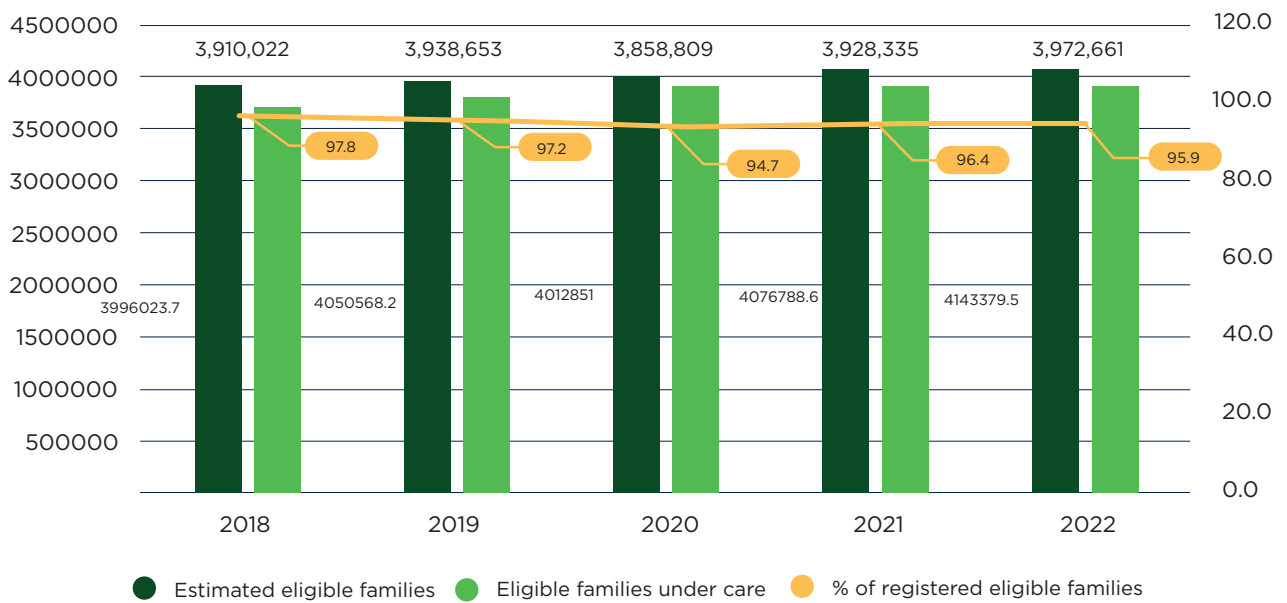


Figure 2.1: Comparison of number s of estimated and registered eligible families

Source: RGD & FHB, eRHMIS 2022

Percentage of eligible family registration was within the national targets in 2022

2. Electronic Reproductive Health Management System (eRHMIS):

Field level RMNCAYH data is reported to the MOH Office by PHMs in their Monthly Returns (H524) and Monthly Clinic Returns (H527). With the introduction of web based electronic reproductive health management information system [eRHMIS] in 2017, all monthly returns by PHMs and all clinic returns from field clinics were digitalized and entered in to a web-based system. The data elements in this return cover a wide scope. These include: information on eligible families, performance 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 PHMs 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 for analysis and visualization by each PHM area and for each field clinic (Figure 2.2).

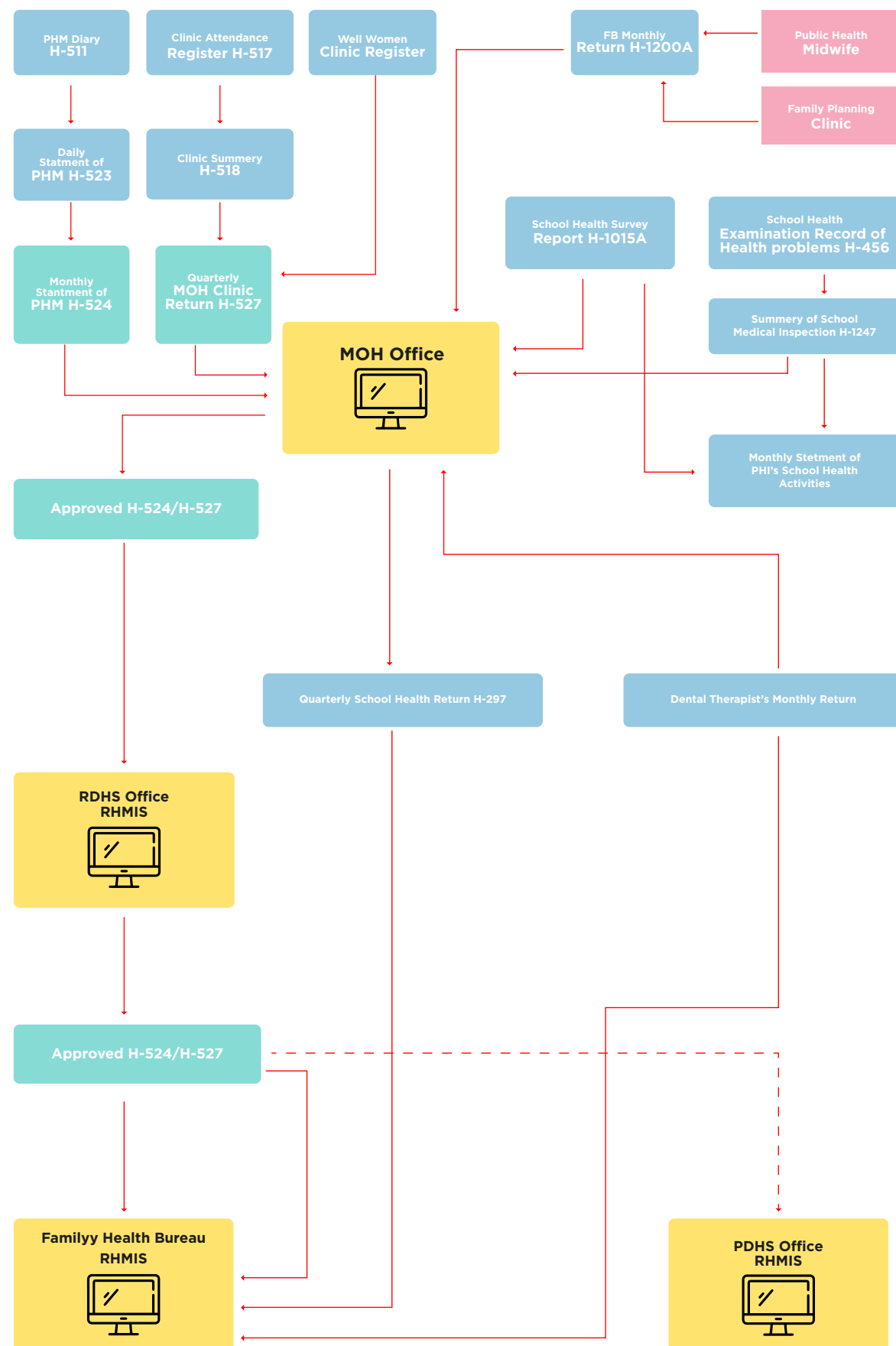


Figure 2.2: Sources & Pathways of Data used in the Annual Report

Source: FHB, 2022

3. Electronic Reproductive Health Management Information System 2 [eRHMS2]

It was evident that the private health sector in Sri Lanka is fast growing and becoming popular among the clients. Private sector contribution in providing MCH specially the maternal and new-born health services are not been identified or reported. To overcome this issue, the FHB introduced eRHMS 2 in mid-2019 as a pilot project in major private hospitals in Colombo. This system was designed to capture individual level maternal and new-born health information and was readily accepted by all leading private hospitals in Colombo. A total of 10,372 live births were reported in 2022 from these major private hospitals in Colombo which includes Asiri Hospital, Durdans Hospital, Hemas Hospital, Lanka Hospital, Nawaloka Hospital and Ninewells Hospital. This contributes to 25.2% of all live births registered in Colombo district by the Registrar General for year 2022.

4. Special surveillances

There are several special surveillance systems functioning under the FHB to gather information on maternal deaths, foeto infant deaths and birth defects [figures 2.4].

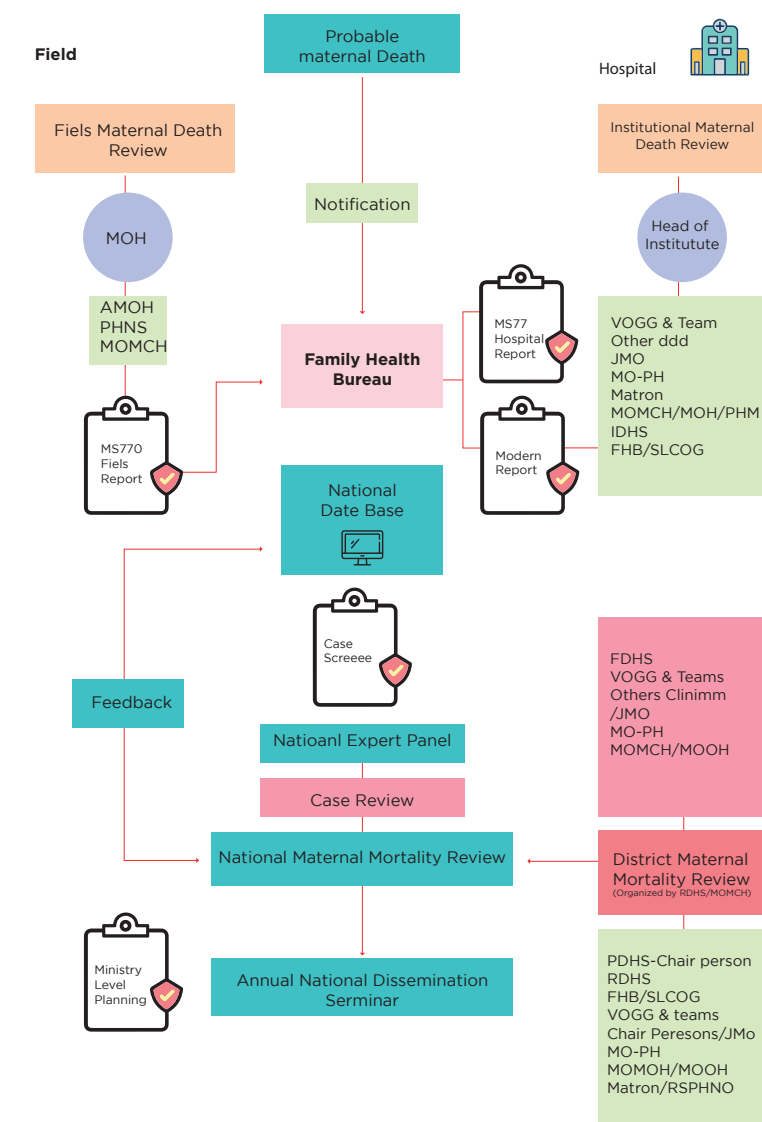


Figure 2.3: Information flow of national maternal mortality surveillance system

Source: FHB, 2022

National Feto-Infant Mortality Surveillance Mechanism

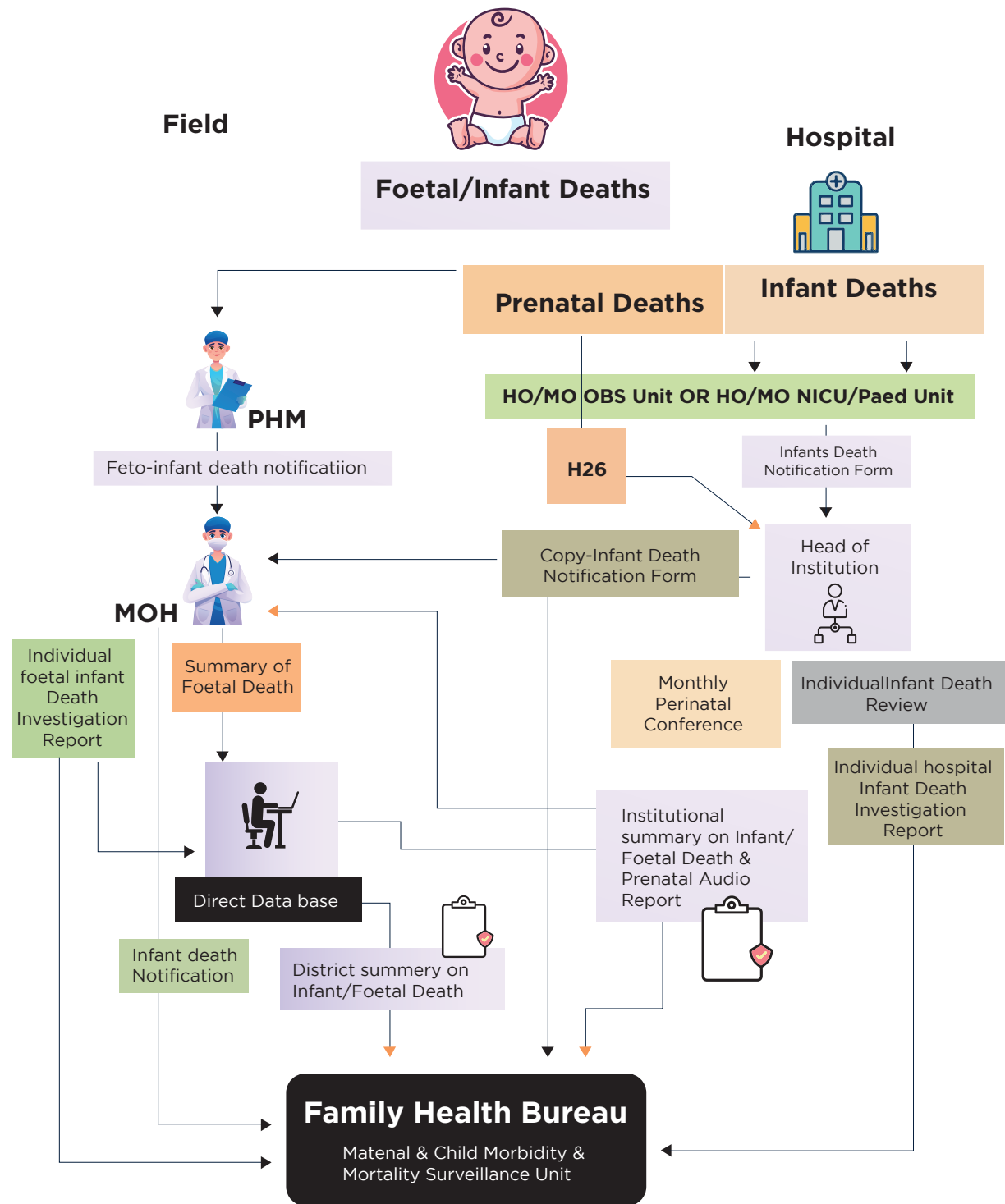


Figure 2.4: National Feto-Infant Mortality Surveillance Mechanism
Source: FHB, 2022

RMNCAYH INDICATORS

All districts in the country provided MCH data with a reporting rate of nearly 100%. MOH and their teams need to be appreciated for their hard work and commitment.

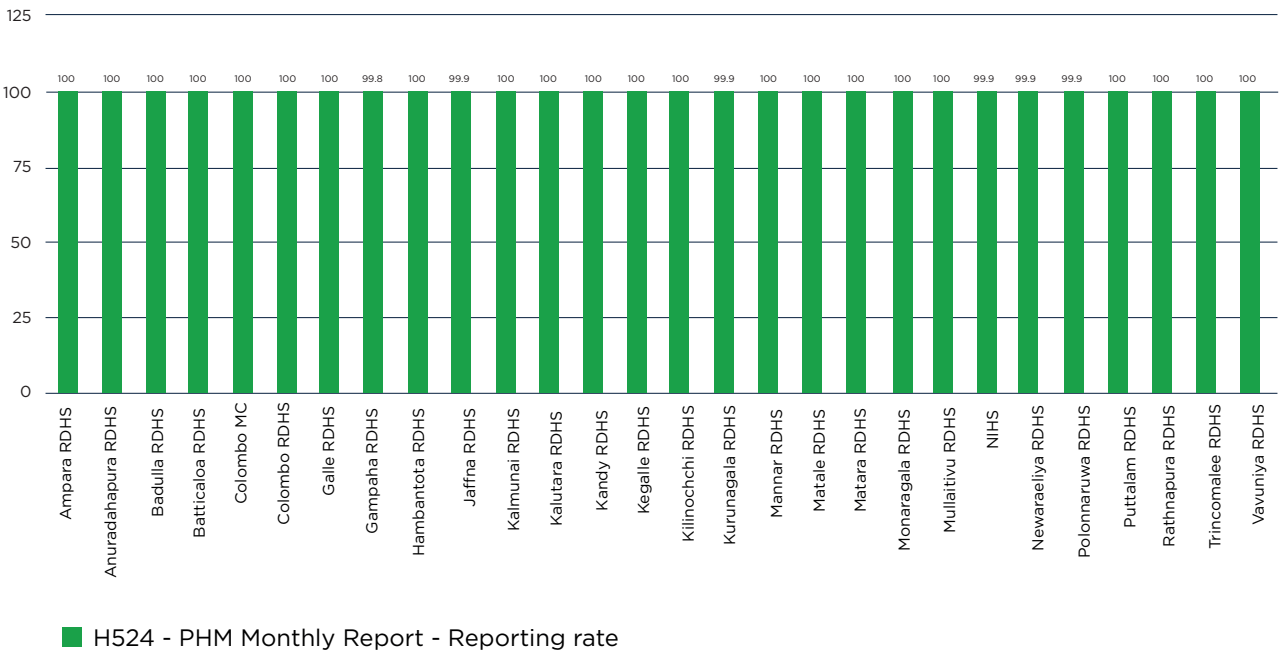


Figure 3.1 Reporting Rates of Public Health Midwives' Monthly Return [H524] - 2022
Source: FHB, eRHMS 2022

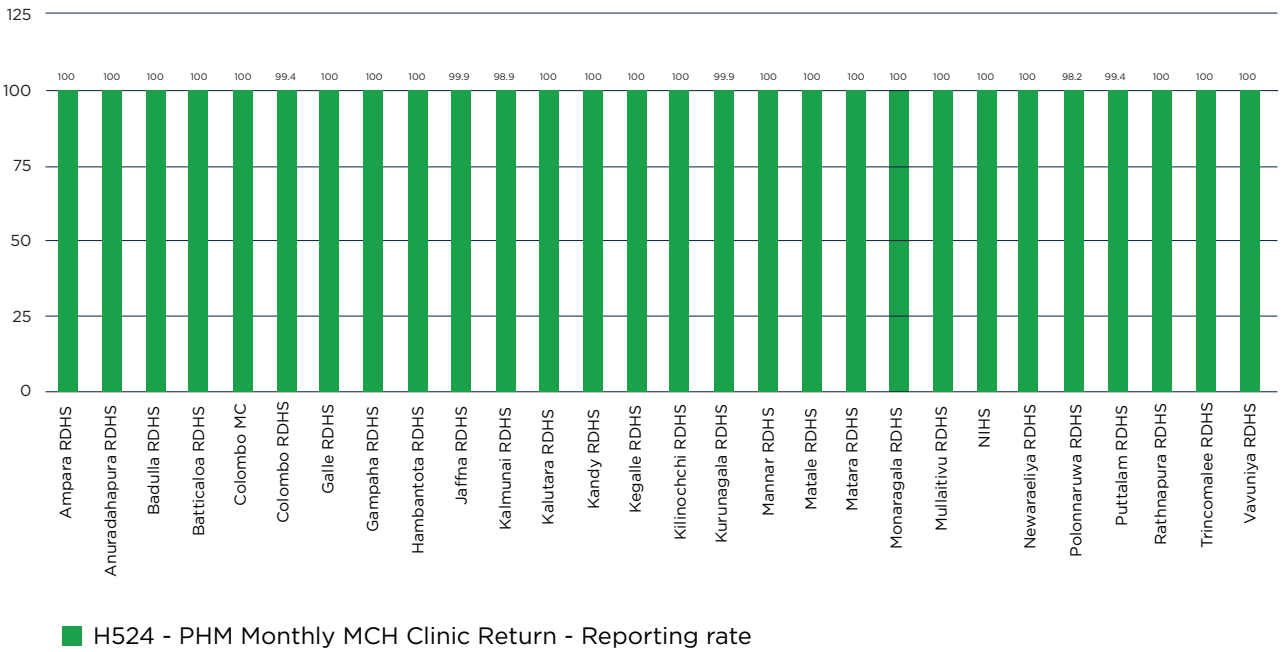


Figure 3.2: Reporting Rates of MCH Clinic Return [H527] - 2022
Source: FHB, eRHMS 2022



School health surveys were completed in 98.1 % of schools in the country and 98.5% School Medical Inspections were completed during 2022.

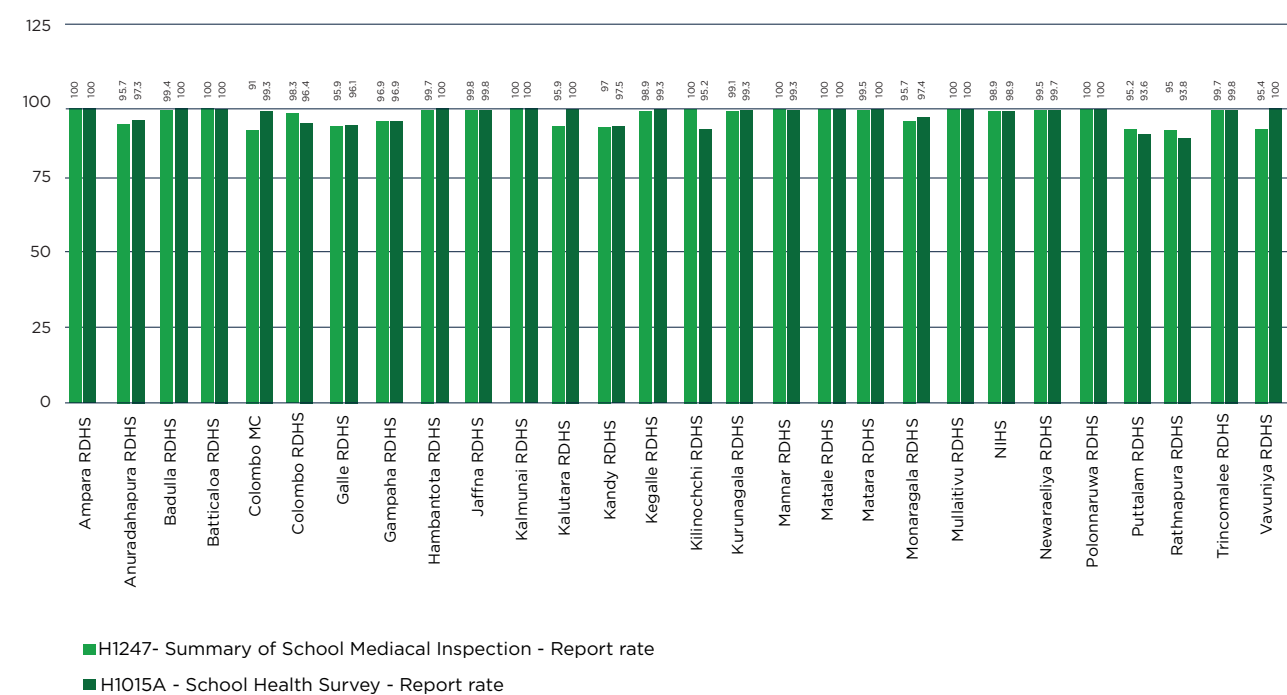


Figure 3.3: Reporting Rate H1247 and H1015 in 2022

Source: FHB, eRHMS 2022

PRECONCEPTION CARE FOR NEWLY MARRIED COUPLES

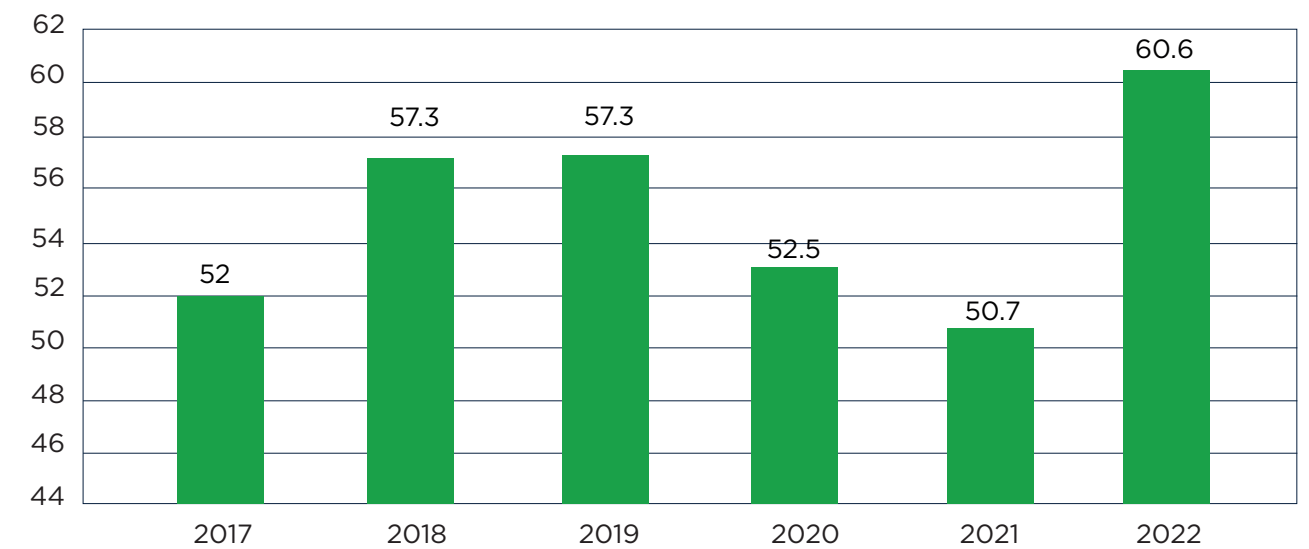


Figure 3.4: Percentage of Newly married couples registered out of the estimated number of marriages 2017 to 2022

Source: FHB, eRHMS 2022

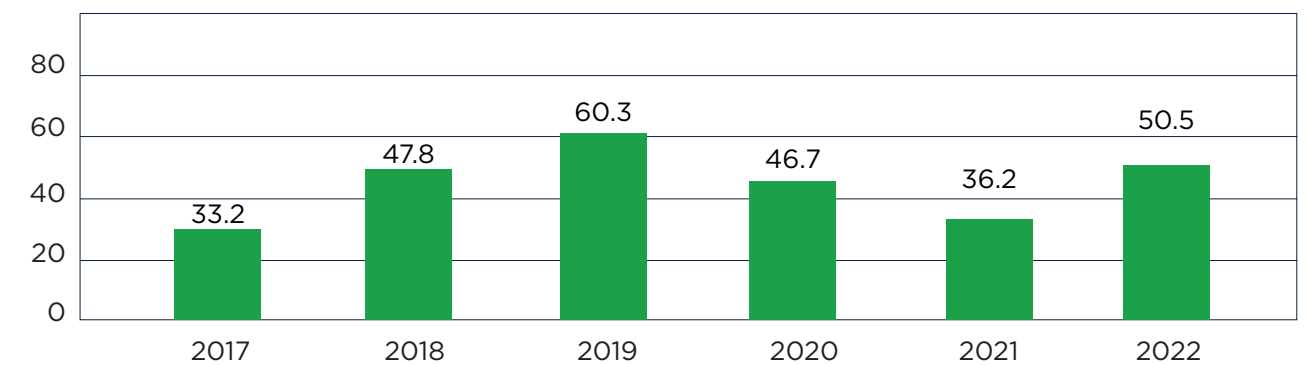


Figure 3.5: Percentage of Newly married couples attended Preconception care sessions among registered 2017 to 2022

Source: FHB, eRHMS 2022

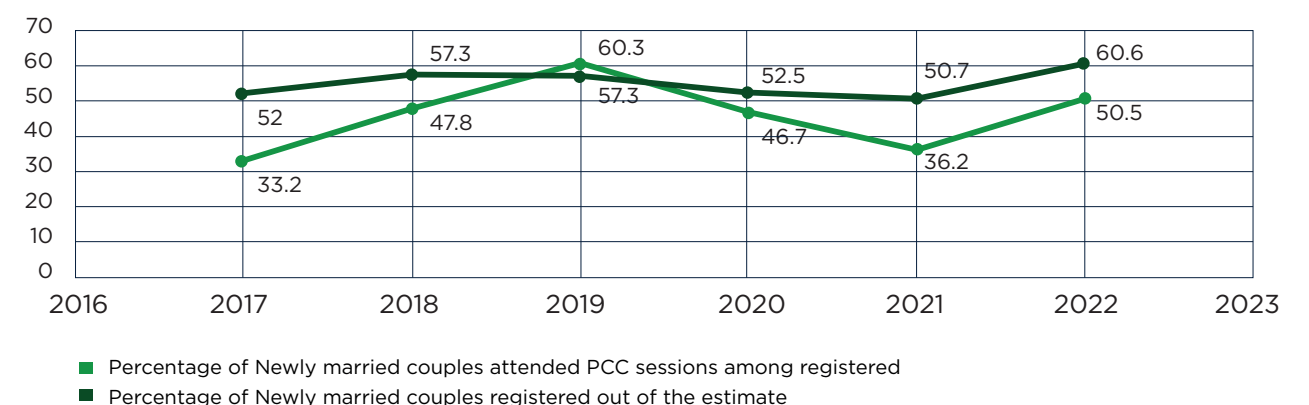


Figure 3.6: Newly married couples registered Vs Attended PCC sessions 2017 to 2022

Source: FHB, eRHMS 2022

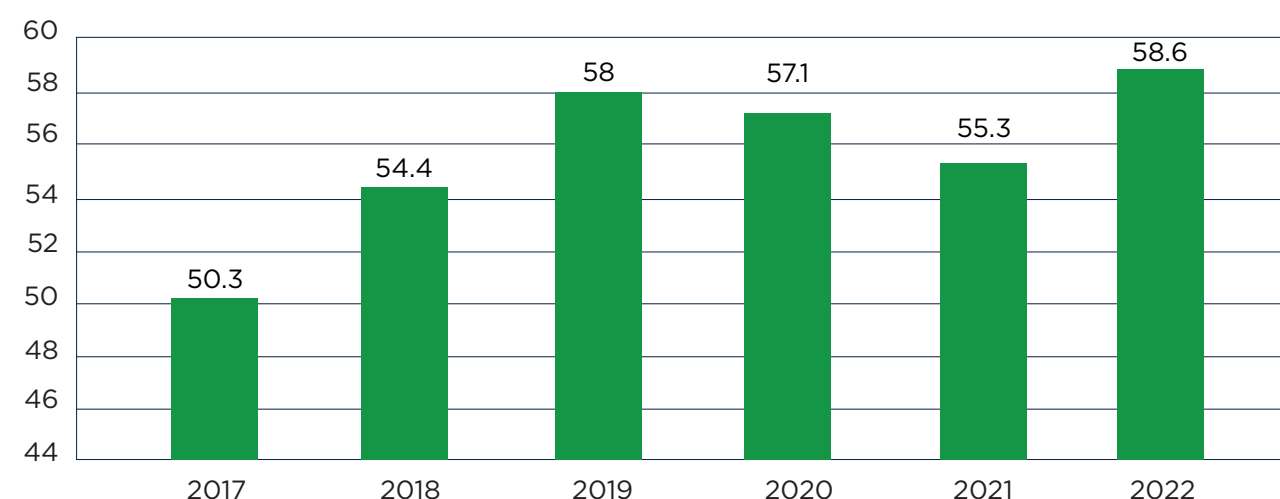


Figure 3.7: Percentage of Primi mothers undergone Preconception care 2017 to 2022

Source: FHB, eRHMS 2022

MATERNAL AND NEWBORN HEALTH

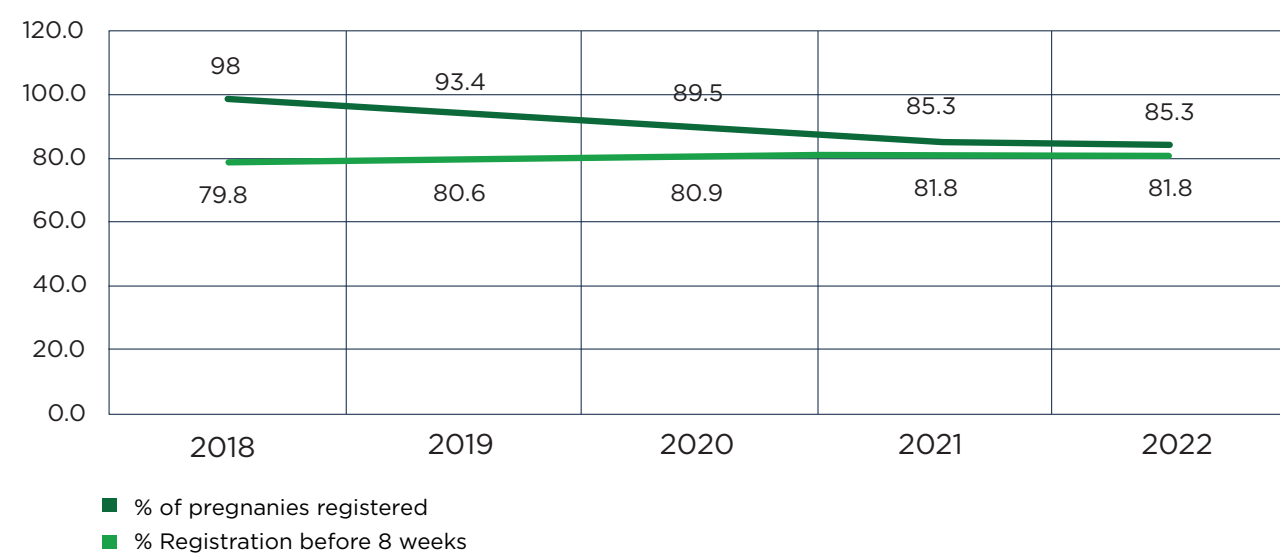


Figure 3.8: Registration of antenatal women and registration before 8 weeks 2018 to 2022

Source: FHB, eRHMS 2022

Over the last 5 years, pregnant mother registration is reducing whereas registration before 8 weeks of pregnancy remained at more than 80%

Indicator	2018	2019	2020	2021	2022
% of registered pregnant women visited at least once at home by PHM	91.9	94.3	94.2	93.9	96.2
Average number of PHM field visits per pregnant woman	4.0	4.0	4.1	3.9	4

Table 3.1: Percentage of antenatal women who were visited at least once and the average number of home visits by PHMs 2018 - 2022

Source: FHB, eRHMS 2022

It is interesting to note that even during the pandemic situation and subsequent economic crisis, field health staff managed to maintain the field healthcare as before.

Indicator	2018	2019	2020	2021	2022
% of pregnant women making at least one field clinic visit out of registered pregnancies	95.8	95.4	95.6	95.2	96.9
Average number of clinic visits by pregnant women	6.5	6.4	5.7	5.6	5.9

Table 3.2: Percentage of antenatal women visiting field antenatal clinics (at least once) and average number of clinic visits 2018 - 2022

Source: FHB, eRHMS 2022

Average number of clinic visits by a pregnant woman has gone down due to travel restrictions and quarantine curfew imposed due to pandemic and due to fuel shortage during the economic crisis in 2022.

Indicator	2018	2019	2020	2021	2022
% of antenatal women tested for VDRL at the time of delivery out of estimated deliveries	99.1	99.5	99.4	99.4	98.5
% Antenatal women tested for HIV at field clinic	85.1	86.1	84.7	85	59
% of antenatal women whose blood is tested for grouping and Rh at the time of delivery out of reported deliveries	99.6	99.7	99.7	99.6	99.6
% of antenatal women whose BMI is assessed before 12 weeks out of total attending antenatal clinics	84.5	83.8	80.3	82.1	81.9
% of antenatal women screened for Hb at the field clinic out of total attending antenatal clinics	35.2	30.8	33.4	40.2	28.4
% of antenatal women tested for VDRL at field clinic out of total attending antenatal clinics	86.3	86.2	85.1	85.3	58.8
% of antenatal women whose blood Grouping and Rh tested at field antenatal clinic	31.4	29.7	28.8	30.4	25.3

Table 3.3: Percentage of antenatal women screened at ANC 2018 - 2022

Source: FHB, eRHMS 2022

Even though, services received by pregnant women reported at the time of delivery has not been affected much, it was evident that the clinic services were not optimal during the pandemic and the subsequent economic crisis.

Indicator	2018	2019	2020	2021	2022
% of antenatal women protected against rubella out of registered pregnancies	98.5	98.5	98.5	98.5	98.7
% of antenatal women protected against tetanus out of total reported deliveries	99.5	99.6	99.6	99.5	99.4

Table 3.4: Percentage of antenatal women who had been protected with rubella & tetanus vaccination 2018 - 2022

Source: FHB, eRHMS 2022

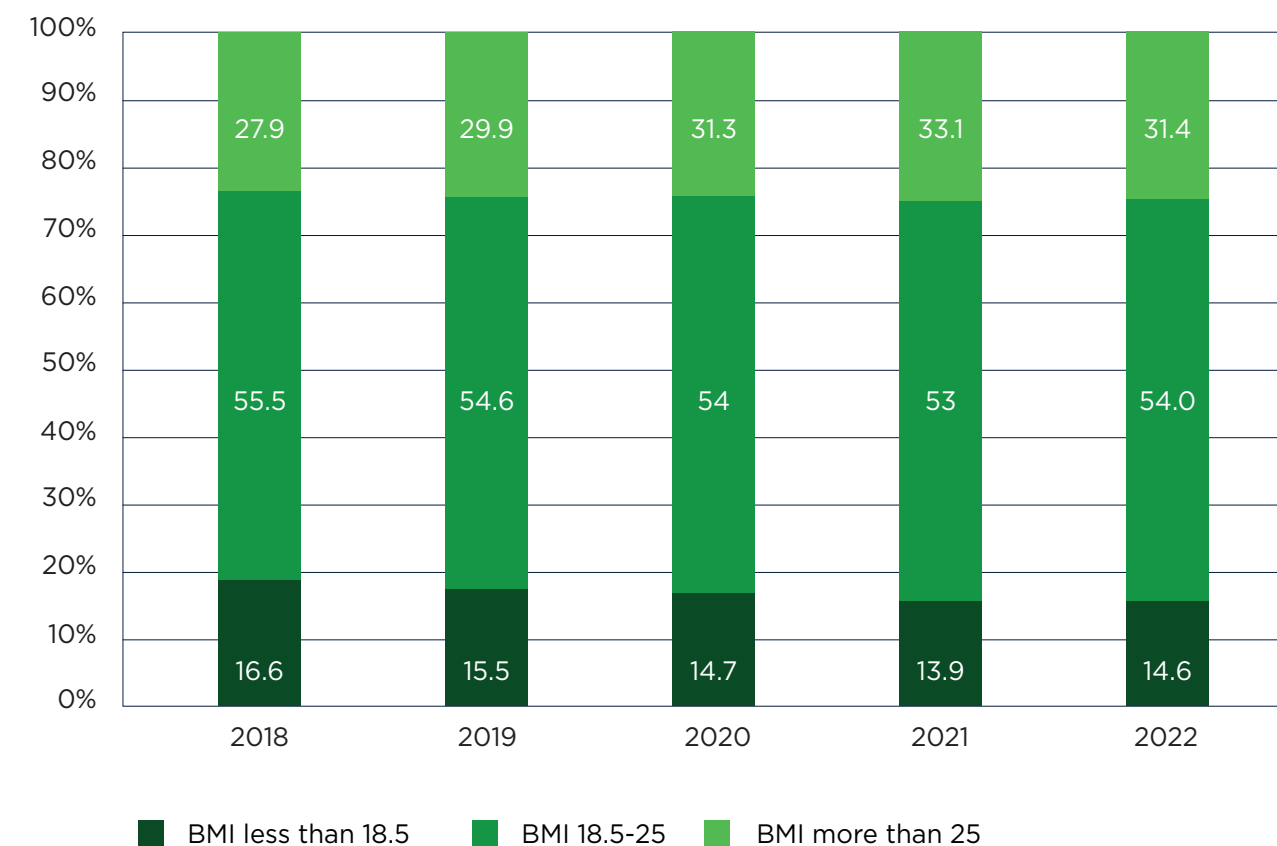


Figure 3.8: Percentage distribution of antenatal women according to their BMI status at booking visit (before 12 weeks) from 2018 - 2022

Source: FHB, eRHMS 2022

Much emphasis should be made for high BMI among pregnant women. BMI more than 25 Kg/m2 has increased from 27.9% to 31.4% over a period of 5-years.

Indicator	2018	2019	2020	2021	2022
% of pregnant women tested for Haemoglobin at field clinics	17.6	15.4	16.7	20.1	14.2

Table 3.5: Percentages of antenatal women whose haemoglobin level was tested at field clinic

Source: FHB, eRHMS 2022

Investigations carried out in the field clinics are reducing gradually which need to be considered by the district health authorities.

	Number of cases		Cases per 10,000 pregnancy		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	
	2018		2019		2020		2021		2022											
Chronic High blood pressure	1,038	29	1043	31	1150	35	1206	40	1271	45										
Chronic Diabetes	3,358	92	3826	112	4220	128	4476	148	4406	155										
Heart Diseases	1,679	46	1620	47	1495	46	1220	40	943	33										
Gestational Diabetes	16,470	453	18247	534	20608	627	18823	623	16610	585										
Pregnancy Induced	10,093	278	9696	284	10302	314	9609	318	8972	316										
Anaemia	89,377	2,460	92,035	2,693	83,351	2,537	66608	2207	56642	1994										

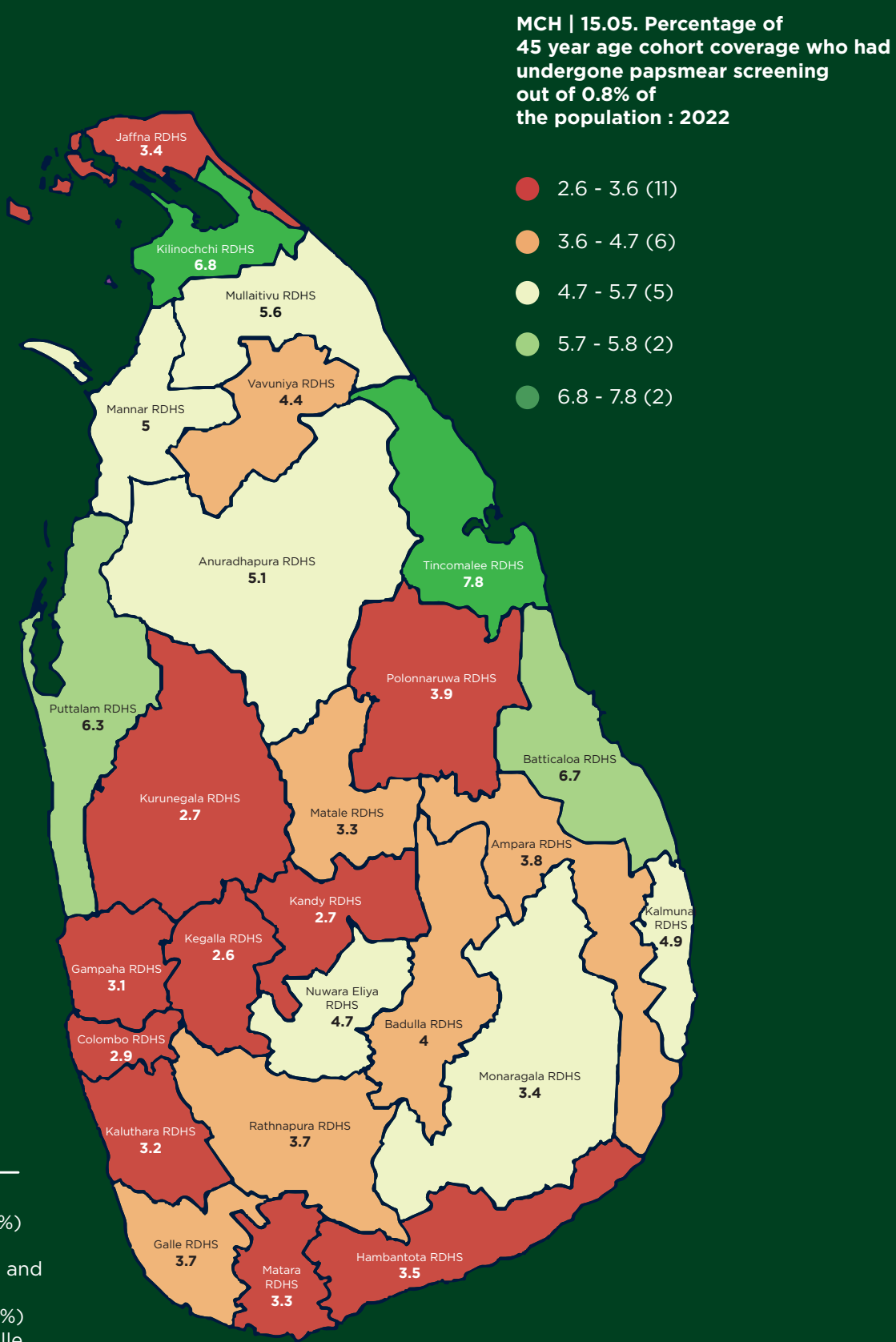
Table 3.6: Number and rate of antenatal morbidities reported in 2022

Source: FHB, eRHMS 2022

Antenatal morbidities such as anaemia and gestational diabetes seem to be reducing over the last 5 years

Highest teenage pregnancy rate (7.8%) reported from Trincomalee district and lowest teenage pregnancy rate (2.6%) reported from Kegalle District with an overall 3.9% of teenage pregnancy rate in Sri Lanka for 2022.

Figure 3.9: Percentage of teenage pregnancies by district in 2022
Source: FHB, eRHMS 2022



Indicator	2018	2019	2020	2021	2022
% Pregnancy outcome reported out of registered pregnancies	90.5	88.0	85.4	82	81.8
% of deliveries reported out of total live births registered by Registrar General	93.5	92.3	95.0	93.1	92.3
% of deliveries reported out of total estimated pregnancies	85.0	83.7	85.9	82.4	82.2
% Institutional deliveries out of total reported deliveries	99.9	99.9	99.9	99.9	99.9
Number of home/non institutional deliveries	248	257	244	274	309
% of home/non institutional deliveries out of total reported deliveries	0.06	0.09	0.09	0.1	0.12
% of untrained deliveries out of total reported deliveries	0.04	0.06	0.05	0.06	0.08
% Caesarean sections out of total institutional deliveries reported	40.8	40.5	41.7	43.1	43.1
% Postpartum visits 1 - 5 days	66.6	66.0	66.6	62.1	62.8
% Postpartum mothers receiving at least 1 visit by PHM during 1st 10 days out of estimated births	83.8	85.9	80.9	76	76.6
At least 1 visit during 1st 10 days out of reported deliveries	92.8	93.3	93.3	92.2	93.2
Postpartum visits by PHM at or around 42 days out of reported deliveries	79.2	83.0	81.3	80.4	84.9
Average number of home visits during first 10 postpartum days	1.8	1.7	1.7	1.7	1.7
% of PP visits by PHM around 42 days (out of estimated births)	76.5	73.5	70.0	66.3	69.8

Table 3.7: Pregnancy outcome and postpartum care for mothers registered from 2018-2022

Source: FHB, RHMIS 2022

Caesarean section rate is increasing from 40.8% in 2018 to 43.1% in 2022.

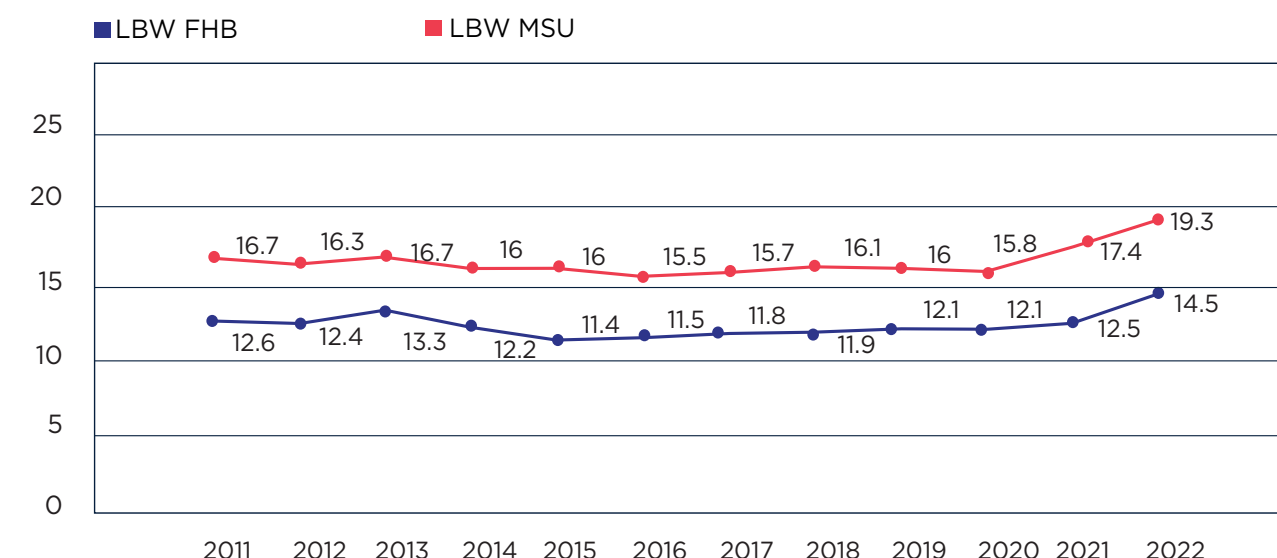


Figure 3.10: Low birth weight percentages among newborns from 2018-2022

Source: FHB, eRHMIS 2022

Low birth weight reporting from the field is lower than the value reported from healthcare institutions. As observed, figure is under reported from the field level.

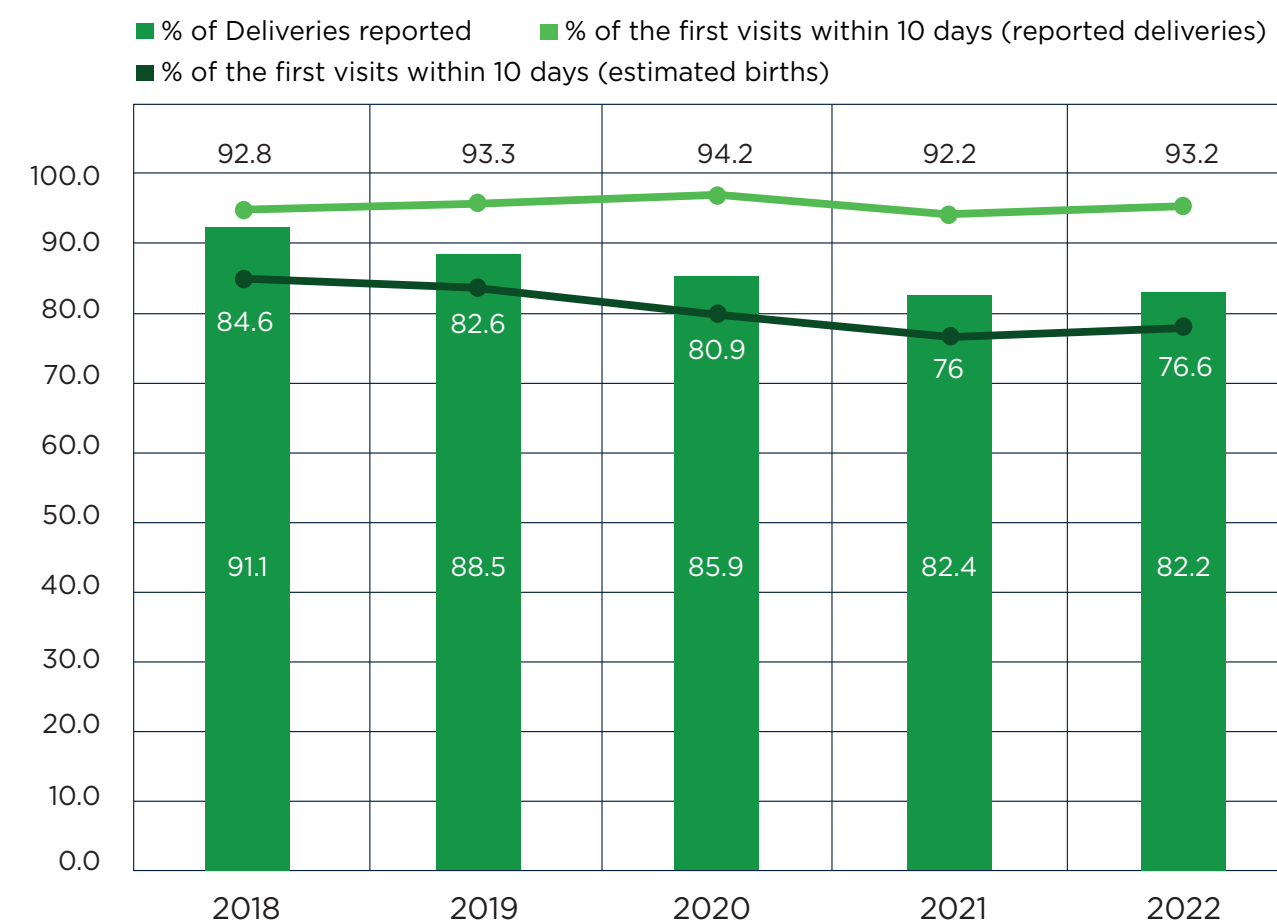


Figure 3.8: Percentage of estimated births, who were receiving the first post-natal visit within the first 10 days of delivery in 2018-2022

Source: FHB, eRHMIS 2022

Compared to 2021, delivery reporting and receiving at least one visit within 1st 10 days both remain same

	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	
	2018		2019		2020		2021		2022	
Heart Failure	61	2	90	3	72	3	62	2	48	2
Deep Vein Thrombosis	87	3	83	3	98	3	71	3	70	3
Postpartum Depression	325	11	403	14	418	15	338	13	452	17
Foreign material in vagina	197	7	151	5	156	5	118	5	130	5
Reproductive Tract Infections	3011	1	270	9	14	0	166	6	169	7
Postpartum Psychiatric Illness	685	21	803	27	788	27	653	25	785	30
Diabetes Mellitus	8772	2	847	29	988	34	809	31	791	31
Breast Abscess	394	15	344	12	327	11	223	8	266	10
Urinary Tract Infection	1053	37	1050	36	981	34	806	30	821	32
Cracked Nipple	2391	75	2529	86	2714	95	2091	79	2405	94
Haemorrhage	2040	68	1773	60	1717	60	1445	55	1378	54
Hypertension	2797	78	3007	102	3191	111	2717	102	3049	120
Separated Epis	4249	141	4174	142	3578	125	2784	105	3485	137
Engorged Breast	5236	158	5301	180	5456	190	4210	159	4780	188
Infected LSCS scar	6409	209	6593	224	6241	218	5113	193	5208	205

Table 3.8: Number of mothers reported with postpartum morbidities in 2022

Source: FHB, eRH MIS 2022

Further improvement in postpartum morbidity reporting needs to be emphasized.

PRIVATE SECTOR PERFORMANCES IN MATERNAL AND NEWBORN HEALTH

Number of live births by the years

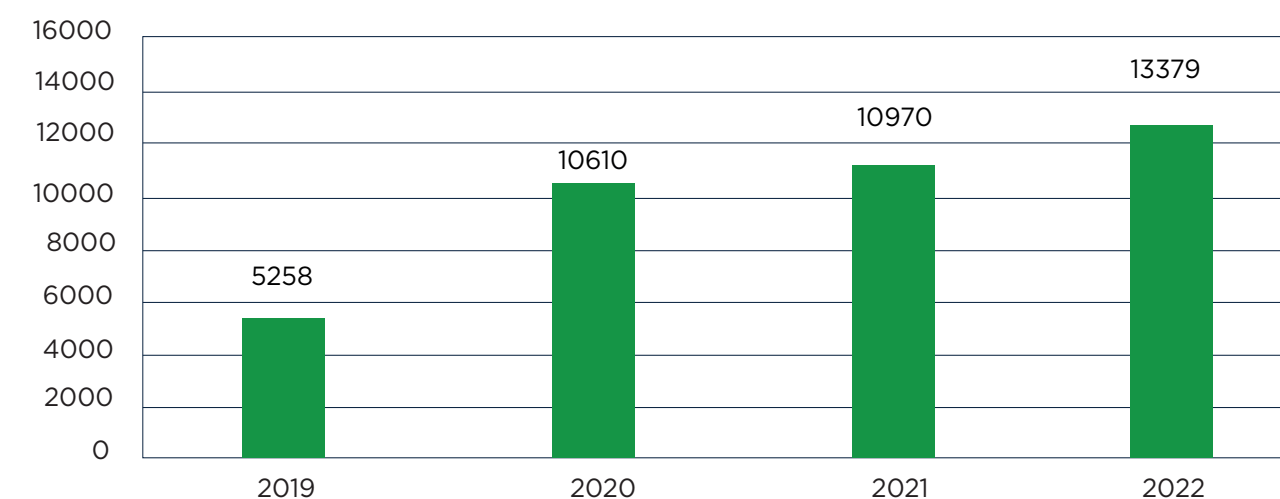


Figure 3.11: Number of live births by the years-private sector, Sri Lanka

Source: FHB, eRH MIS 2022

A total of 13379 Live births were reported from private healthcare institutions in Sri Lanka in 2022.

Private sector - Percentages of HIV and VDRL tests

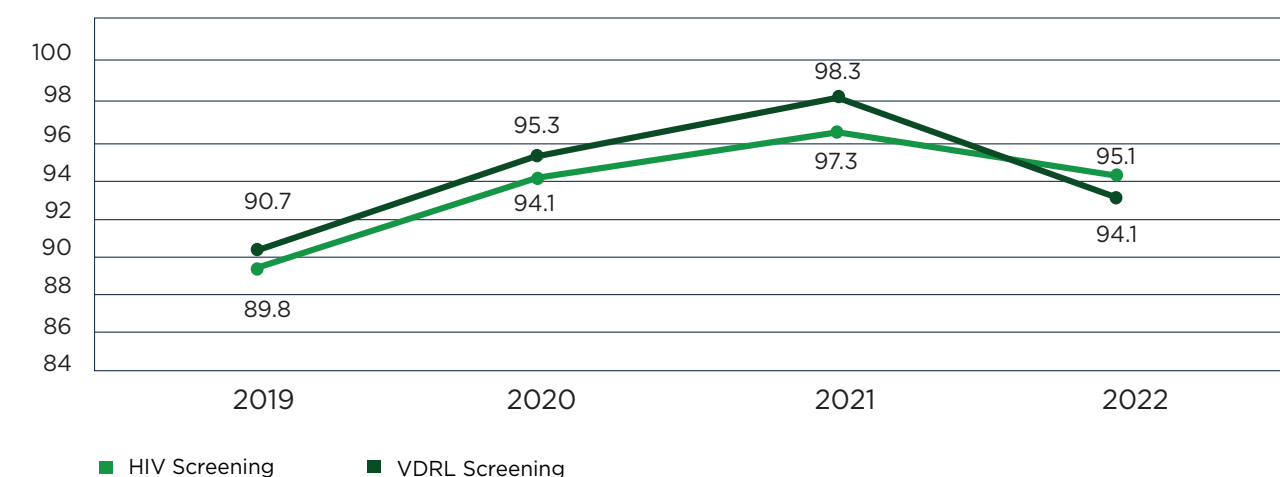


Figure 3.12: Percentages of HIV and VDRL tests done in private sector 2019- 2022

Source: FHB, eRH MIS 2022

HIV and VDRL screening coverages reported from private healthcare institutions in Colombo district were 95.1% and 94.1% respectively in 2022

Low birth weight reported from the private sector - Term and preterm

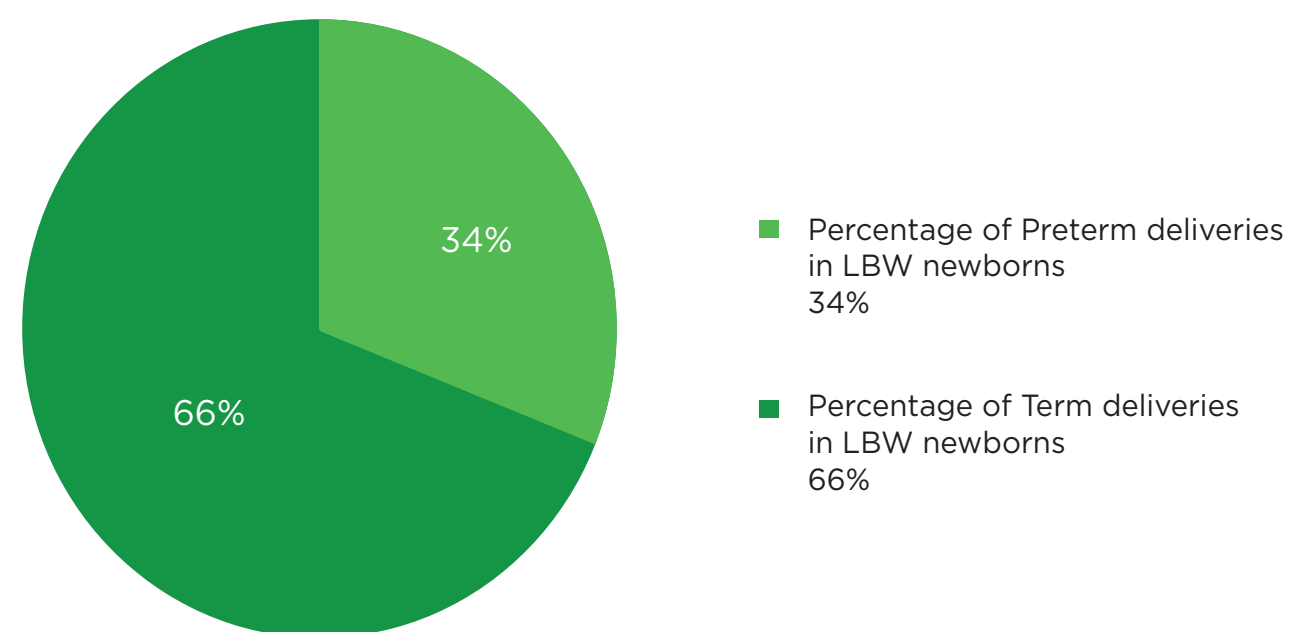


Figure 3.13: Percentage of Low Birth Weight newborns - term and preterm reported from private sector hospital

Source: FHB, eRHMS2 2022

Out of reported live births, 12.7% were with low birth weights. Among the low-birth-weight newborns, majority 66 % were term babies

Kangaroo Mother Care

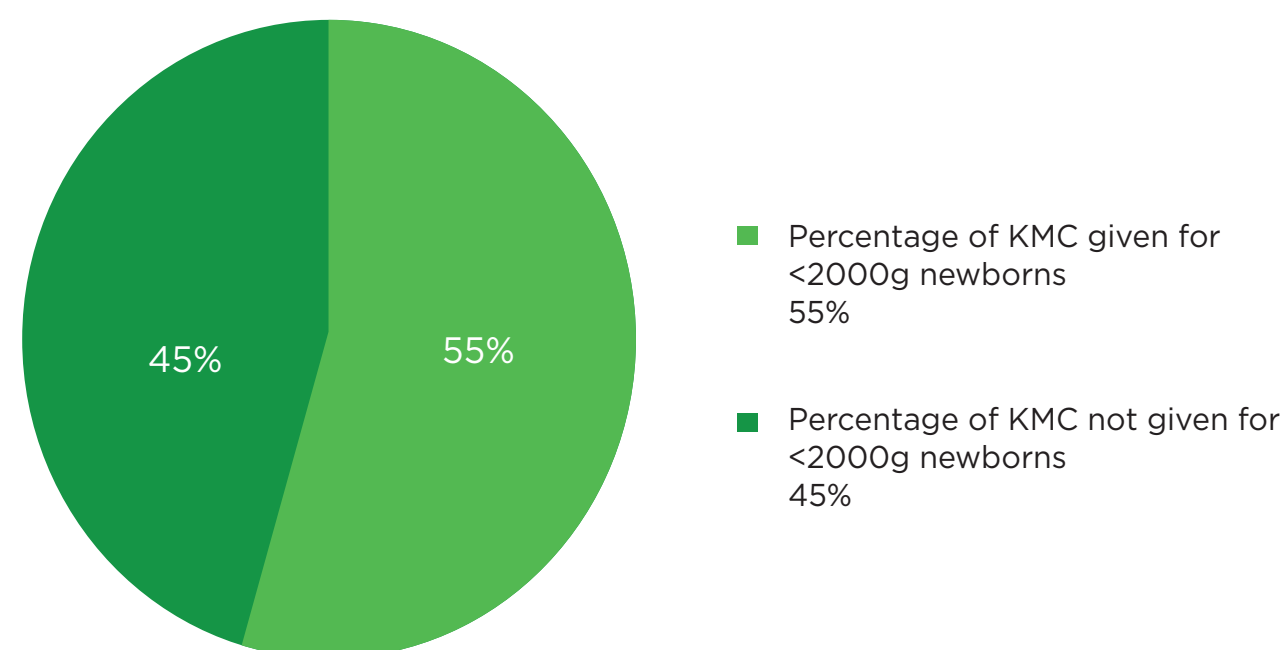


Figure 3.14: Kangaroo Mother Care at private sector hospitals

Source : FHB, eRHMS2 2022

Kangaroo mother care [KMC] is a method of care of preterm infants involving infants being carried, usually by the mother, with skin-to-skin contact. Only 55% of newborns with a birth weight less than 2000g were given KMC which could be improved more.

Mode of Delivery

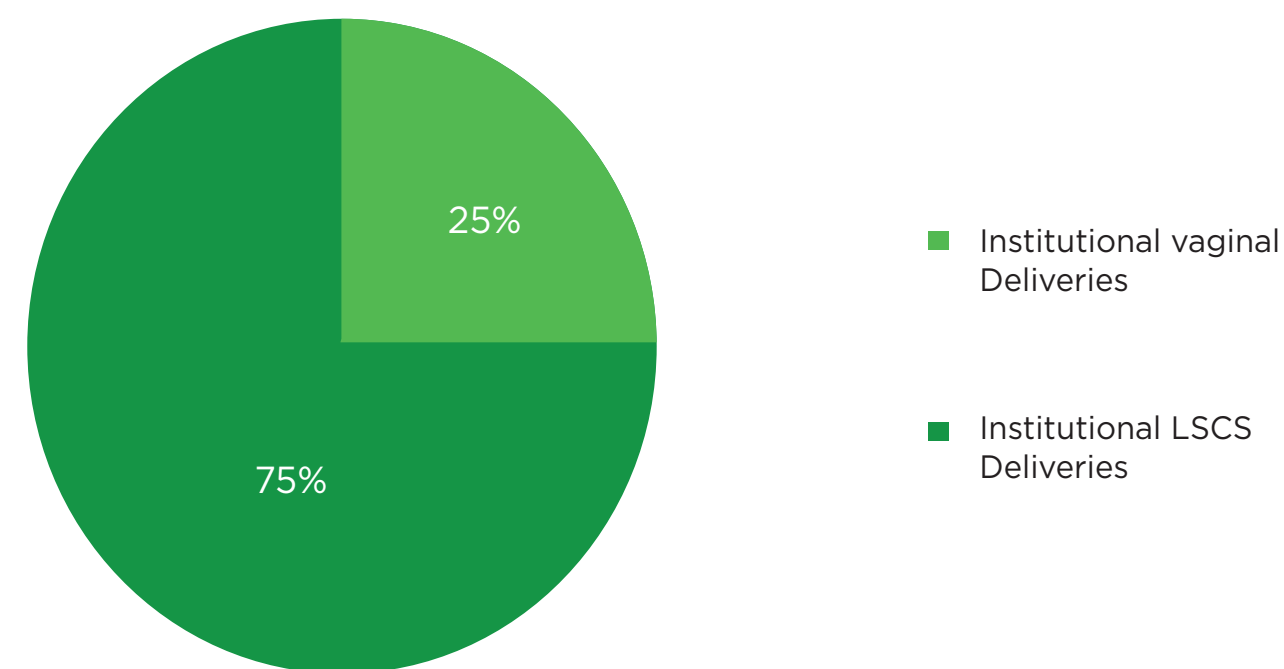


Figure 3.15: Mode of delivery in private sector hospitals

Source: FHB, eRHMS2 2022

Considering the mode of delivery, majority 75% were elective cesarean sections and normal vaginal deliveries were only 25%. Availability of health insurances and patient's preference contribute to this high trend of LSCS in private sector.

Breastfeeding within one hour

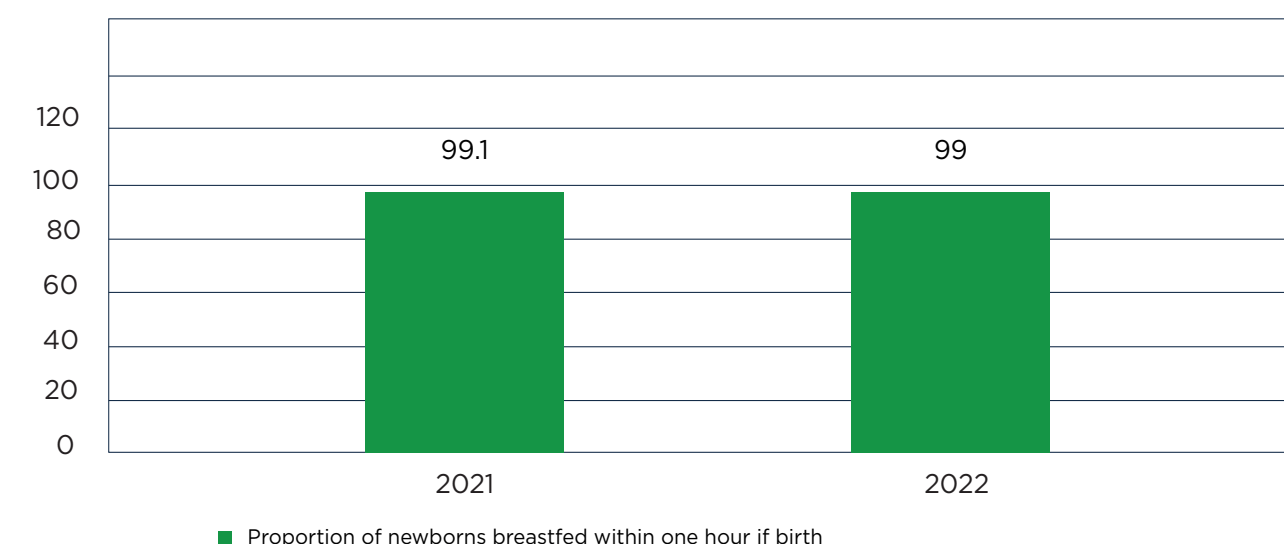


Figure 3.16: Breastfeeding within one hour in private sector hospitals

Source: FHB, eRHMS2 2022

It was encouraging to observe that the initiation of breast feeding within first hour in private healthcare institutions were 99% in 2022.

Neonatal Mortality Rate, Still Birth Rate and Maternal Mortality Ratio

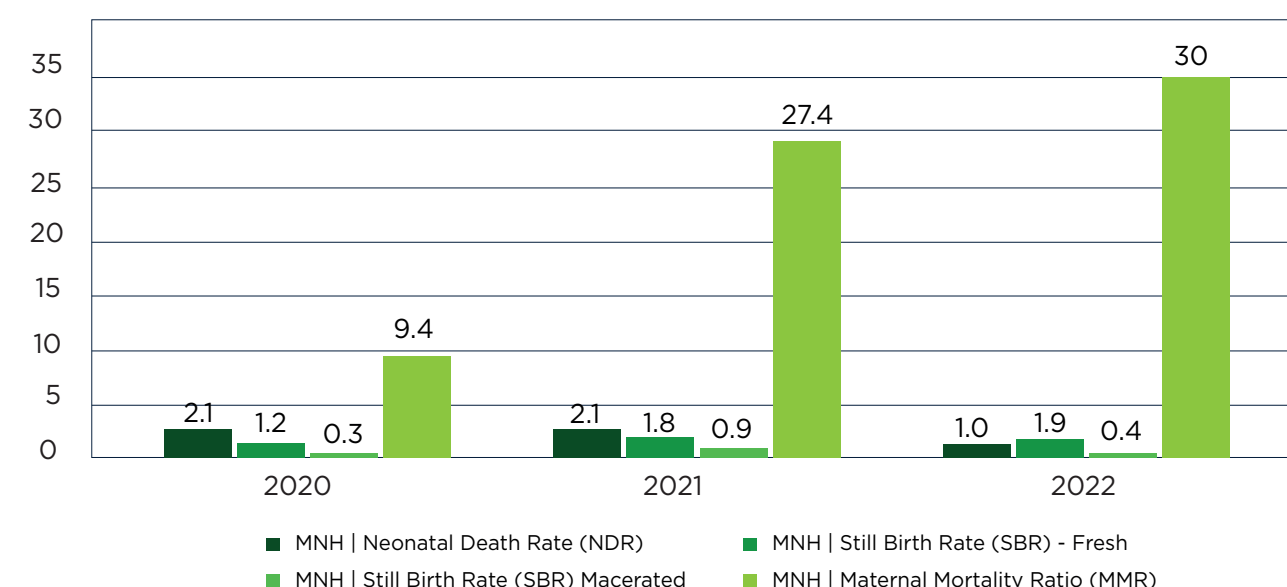


Figure 3.17: NNMR, SBR and MMR comparison of private sector hospitals in Sri Lanka

Source: FHB, eRHMS2 2022

INFANT AND CHILD HEALTH

Indicator	2018	2019	2020	2021	2022
No. of births (RG)	328,112	319,010	301,706	284,848	275,321

Table 3.10 Number of registered births from 2018 - 2022

Source: RGD 2022

	2018	2019	2020	2021	2022
Infants registered by PHMM out of Estimated Births	95.6	93.8	90.8	85.9	86.6
% Infants under care	96.1	93.3	90.6	81.6	86.3
% Infants having at least 1 home visit after 42 days out of registered infants	50.7	51.4	49.1	45.6	50.9
Average number of home visits per infant	7	7.6	7.5	7.6	7.7
% of infants weighed	88.1	90.2	67.8	68.3	83
% of infants making at least one clinic (out of registered infants)	10.4	110	90.4	82.1	71.7
Average number of clinic attendance for an infant	4.9	5.1	5.3	5.5	5.2
% of estimated infants given Vitamin A at 6 months	84.5	78.9	78.6	81.5	76.3
% of young children under care (1-2 years)	97.1	97.6	98.1	90.6	91.7
% of young children (1-2 years) weighed	81.9	83.6	60.9	56.4	73
% of estimated children given Vitamin A at 18 months	86.1	78.6	85	83.4	83.5
% of Preschoolers under care (2 -5year)	95.4	93.6	92.8	98.1	94.5
% of 2 - 5 year old children weighed	80.2	81.7	62.3	55.9	70.6
% of estimated children given Vitamin A at 3 years	92.9	83.1	87.1	91.9	91.5

Table 3.11: Infant and childcare provided by the field staff from 2018 - 2022

Source: FHB, eRHMS 2022

Indicator	2018	2019	2020	2021	2022
% Moderately Underweight infants	5.2	5.3	5.0	4.9	5.5
% Severely Underweight infants	1.1	1.1	1.1	1	1.2
% Moderately Underweight young children (>1-2 years)	10.6	10.6	10.2	9.9	10.4
% Severely Underweight young children (>1-2 years)	1.8	1.8	1.7	1.6	1.8
% Moderately Underweight preschoolers (>2 to 5th year)	16.9	16.9	16.4	16.1	16.3
% Severely Underweight preschoolers (>2 - 5th year)	2.9	2.8	2.6	2.6	2.8

Table 3.12: Percentages of underweight in infants, young children and preschoolers from 2018 to 2022

Source: FHB, eRHMS 2022

Underweight rates of all 3 age groups have increased in 2022 compared to 2021, but this is not conclusive due to the poor weighing coverage observed in 2021

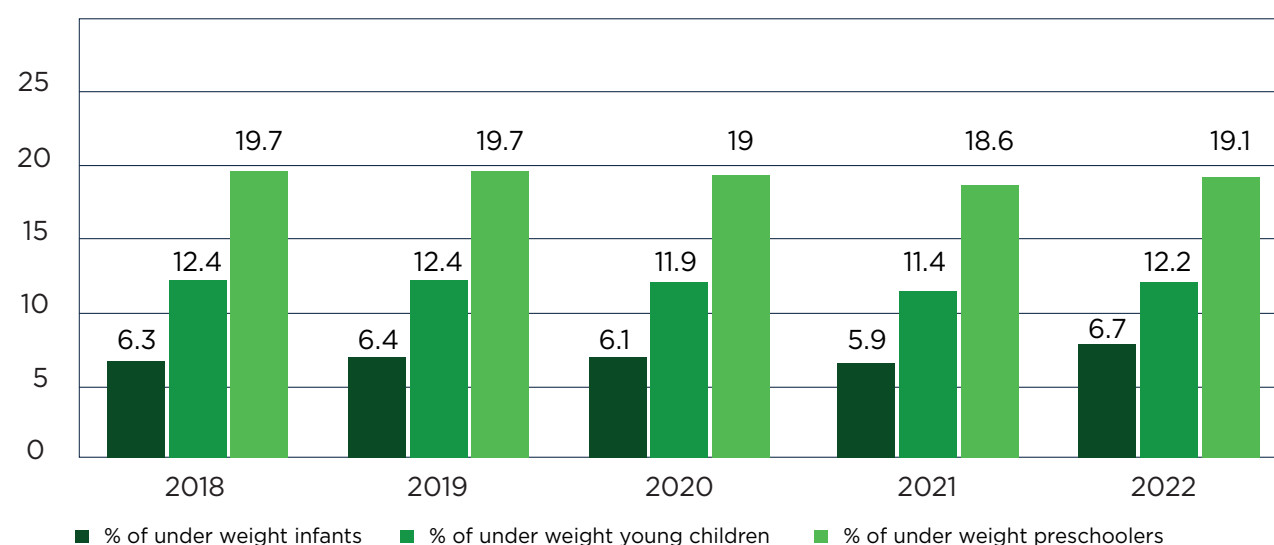


Figure 3.18: Trends in infant, young child and preschool underweight (moderate and severe) from 2018 - 2022

Source: FHB, eRHMS 2022

Indicator		4 months	9 months	18 months	3 years
Stunting out of measured	2018	1.13	1.70	2.18	2.05
	2019	1.1	1.7	2.1	1.8
	2020	1.3	2	1.8	1.7
	2021	1	1.5	1.7	1.5
	2022	1.1	1.5	1.8	1.5

Table 3.13: Trends in infant, young child and preschool stunting (moderate and severe) from 2018 - 2022

Source: FHB, eRHMS 2022

Gross underreporting is observed which is an area that needs to be addressed.

Nutrition month data

Nutrition month data reporting rates from all districts were as follows; Except Ratnapura and Jaffna, all other districts have reported 100% data.

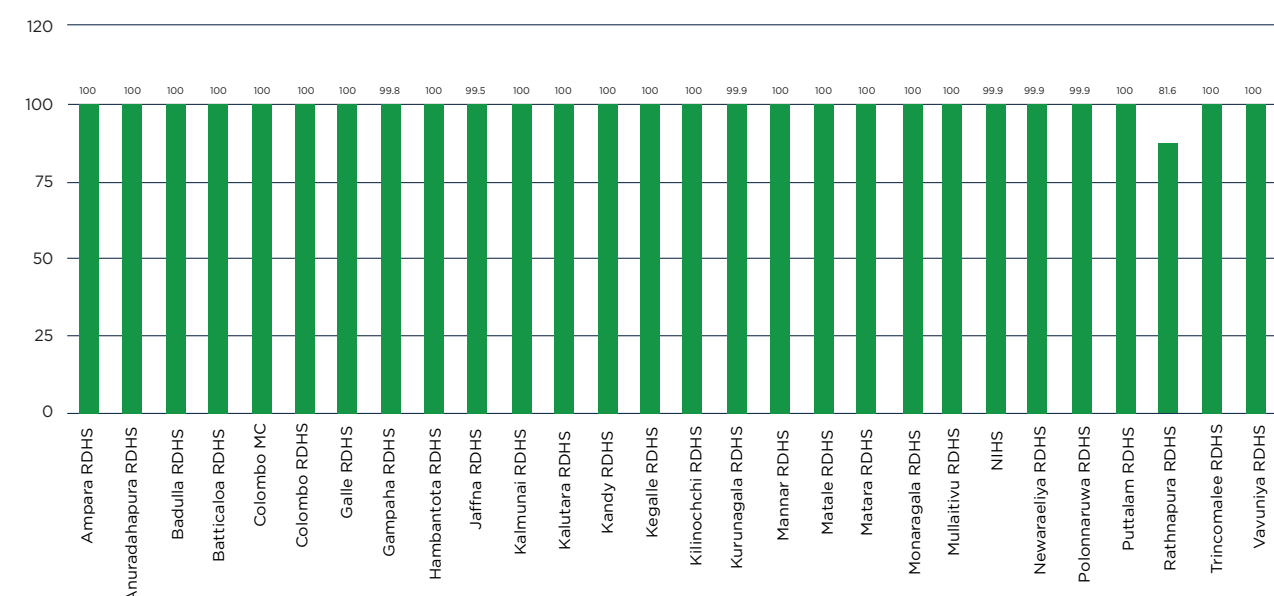


Figure 3.19: Nutrition Month Reporting Rates - 2022

Source: FHB, eRHMS-NM 2022

Undernutrition among under five year children

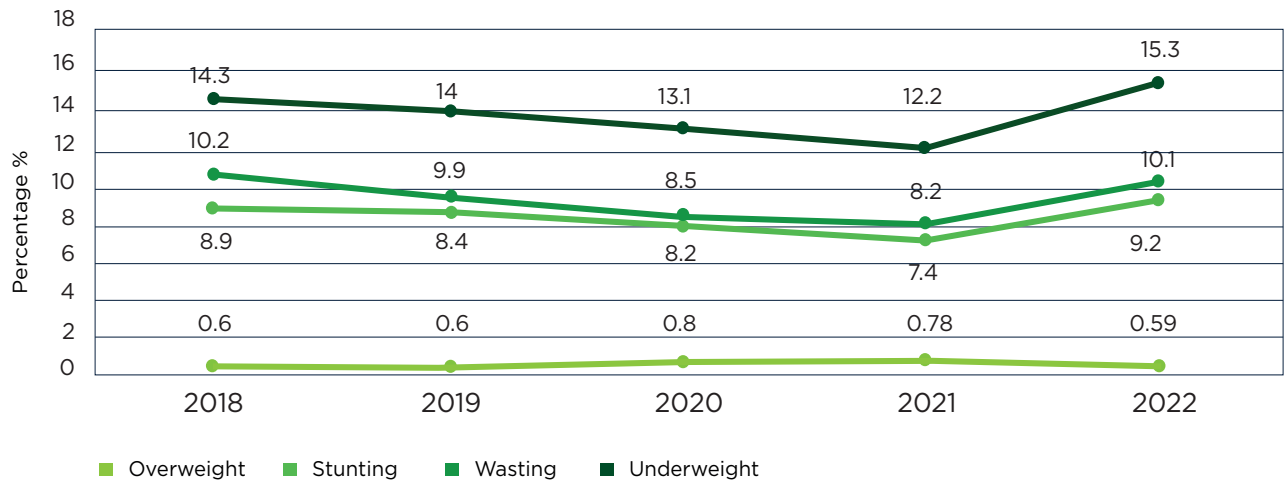


Figure 3.20: Under nutrition among under five children from 2018 to 2022

Source: FHB, eRH MIS-NM 2022

According to the National Nutrition Month data, underweight, wasting and stunting have increased compared to the previous years. Overweight has remains more or less stagnant over the years

Neonatal Mortality Rate

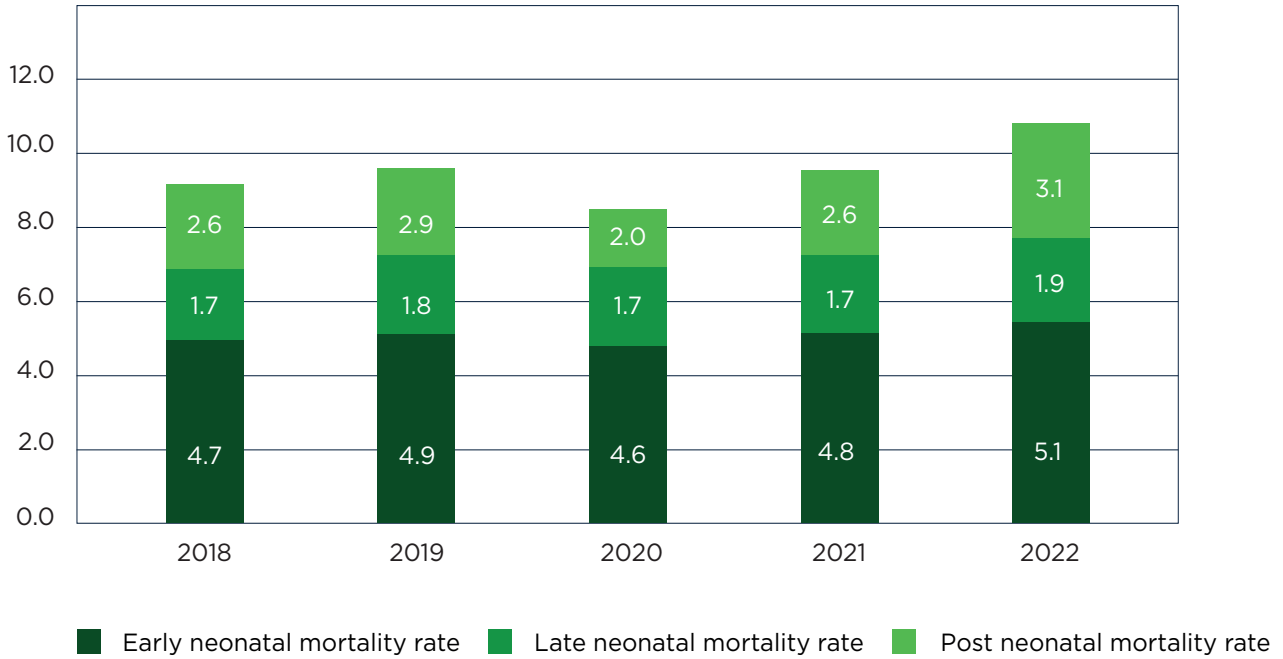


Figure 3.22: Neonatal Mortality Rates from 2018 to 2022

Source: FHB, eRH MIS 2022

Infant & under 5 year child mortality Still Birth Rate

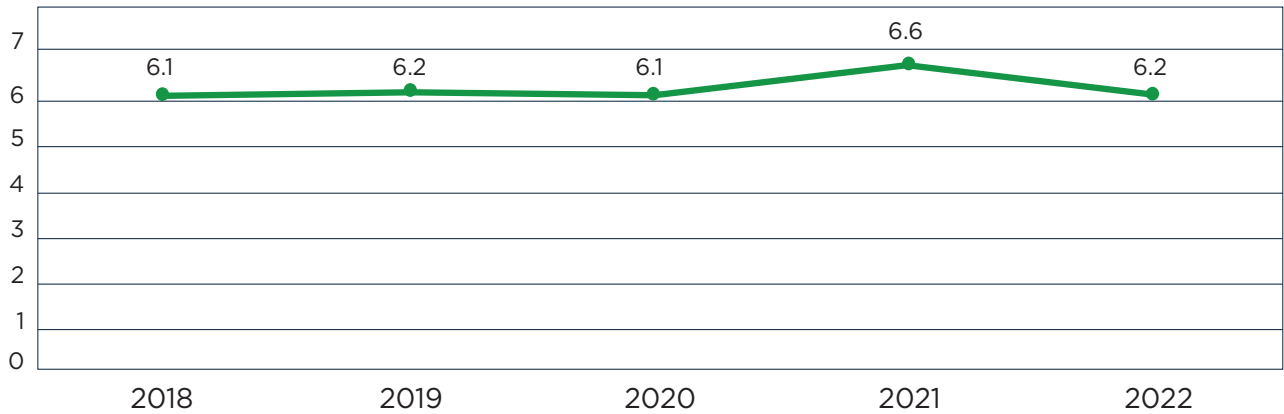


Figure 3.21: Still Birth Rate from 2018 to 2022

Source: FHB, eRH MIS 2022

Still birth rate is stagnant around 6 per 1000 live births since 2018 to 2022

Infant Mortality Rate

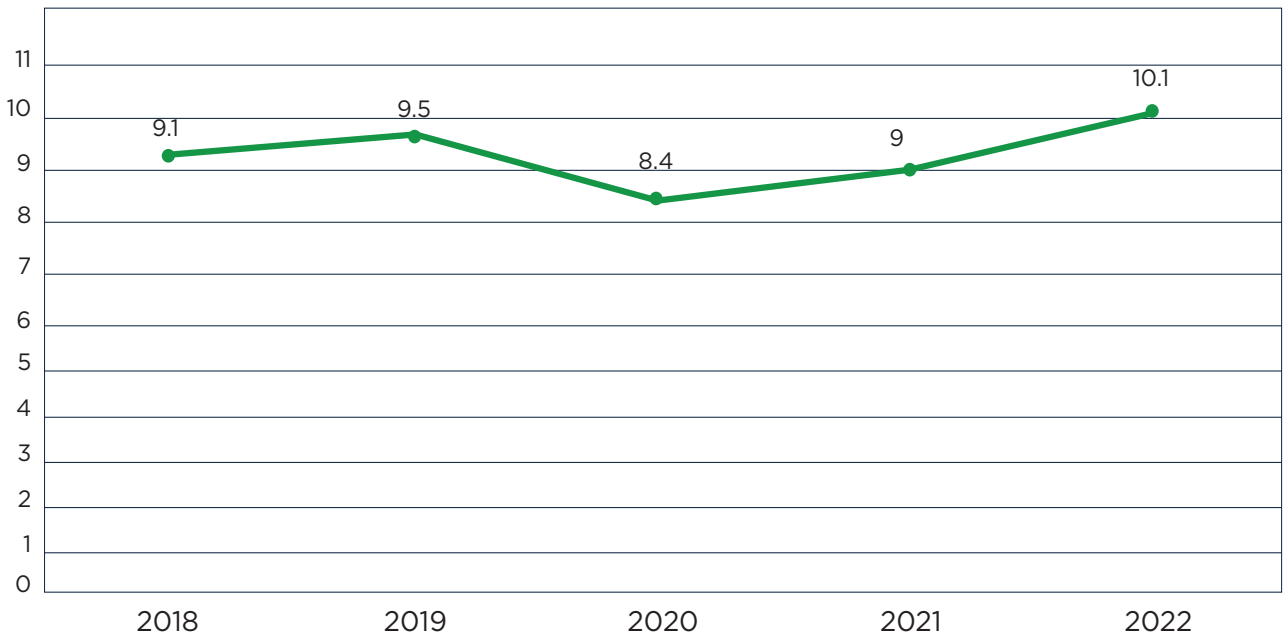


Figure 3.23: Infant Mortality Rates from 2018 to 2022

Source: FHB, eRH MIS 2022

Causes of Infant Deaths

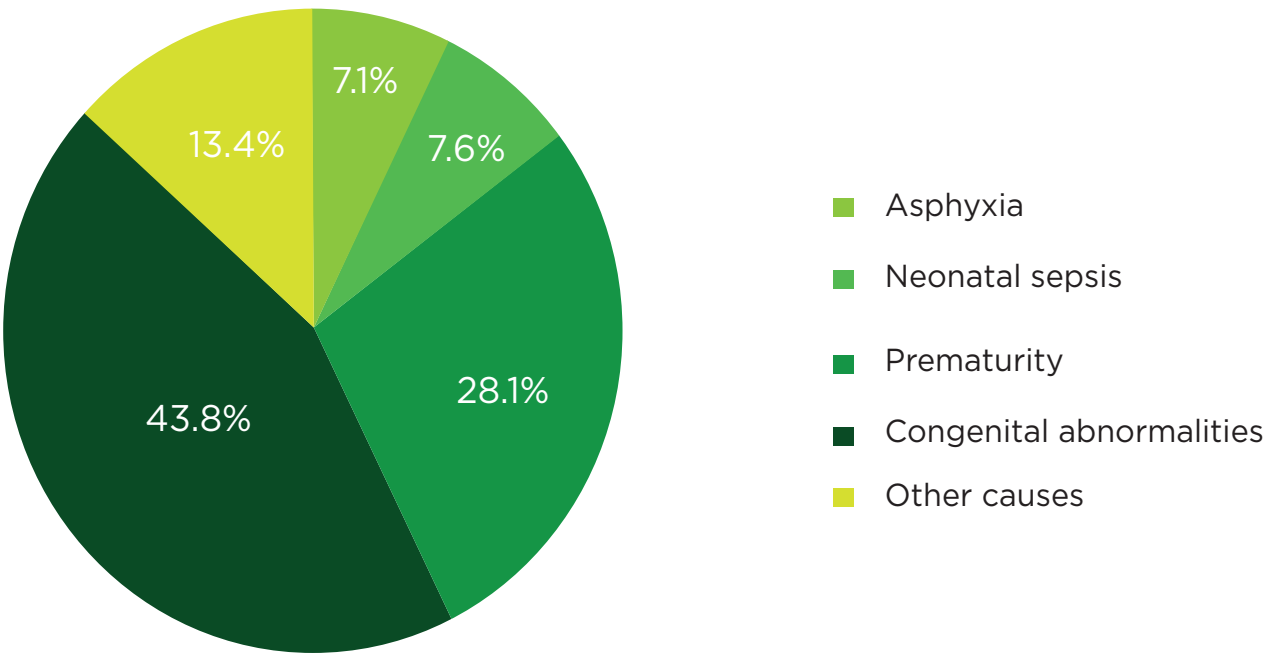


Figure 3.24: Causes of Infant deaths
Source: FHB, eRH MIS 2022

Causes of Death for under 5 year Child Mortality

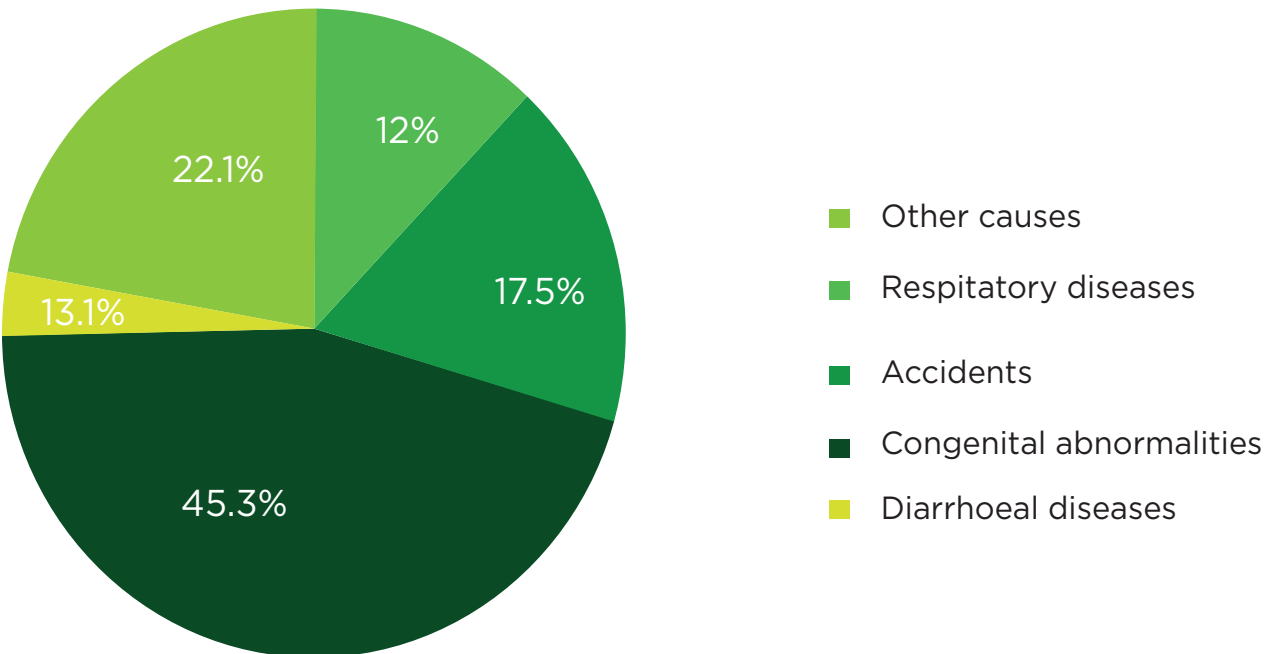


Figure 3.26: Cause of death for under 5 years mortality
Source: FHB, eRH MIS 2022

Under 5 year Child Mortality Rate

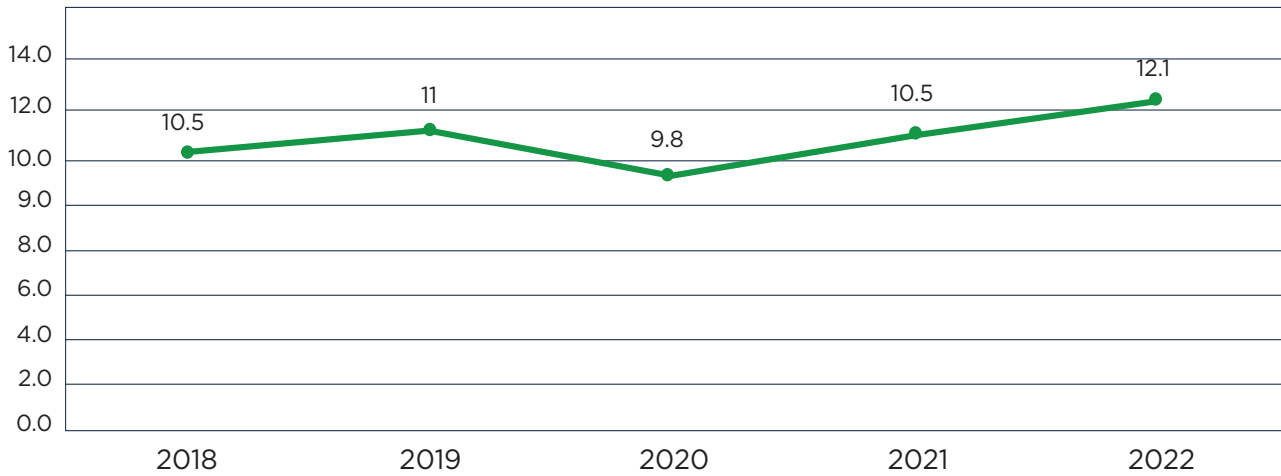


Figure 3.25: Under 5 years Child Mortality Rates from 2018 to 2022
Source: FHB, eRH MIS 2022

FAMILY PLANNING

Indicator	2018	2019	2020	2021	2022
Modern methods	58.4	57.9	57.1	57.4	59.4
Natural/Traditional	9.2	9.0	9.0	8.9	9.1
All	67.7	66.9	66.1	66.3	68.5

Table 3.14: Percentage of eligible families using all methods 2018 – 2022
Source: FHB, eRH MIS 2022

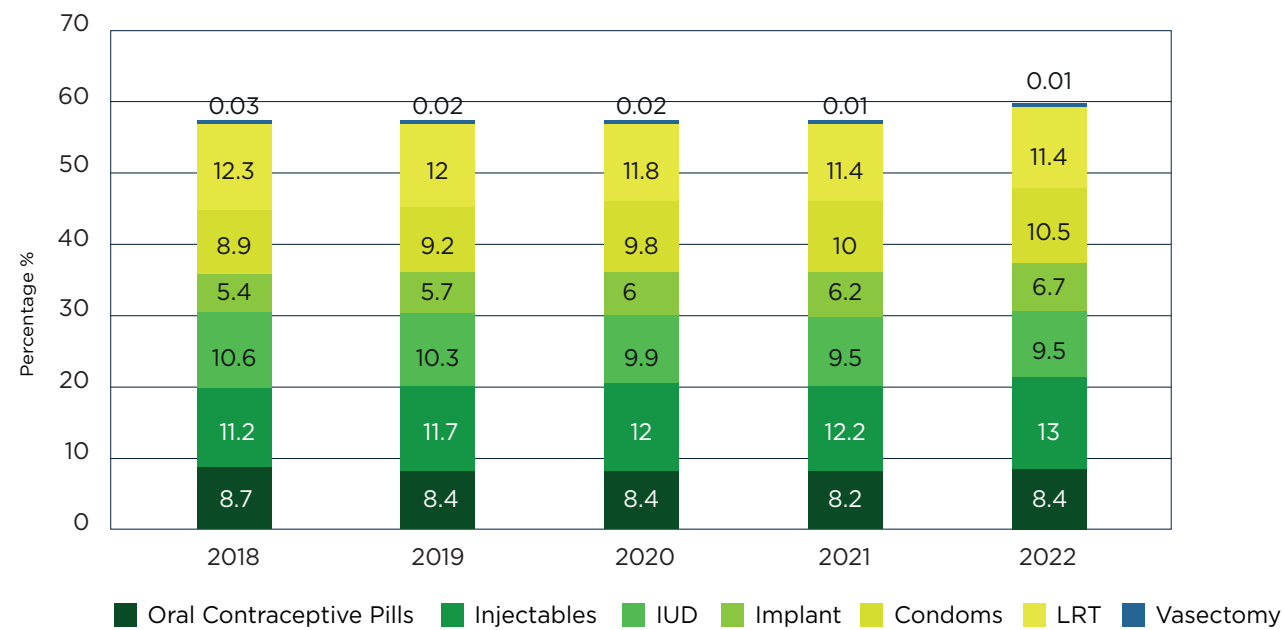
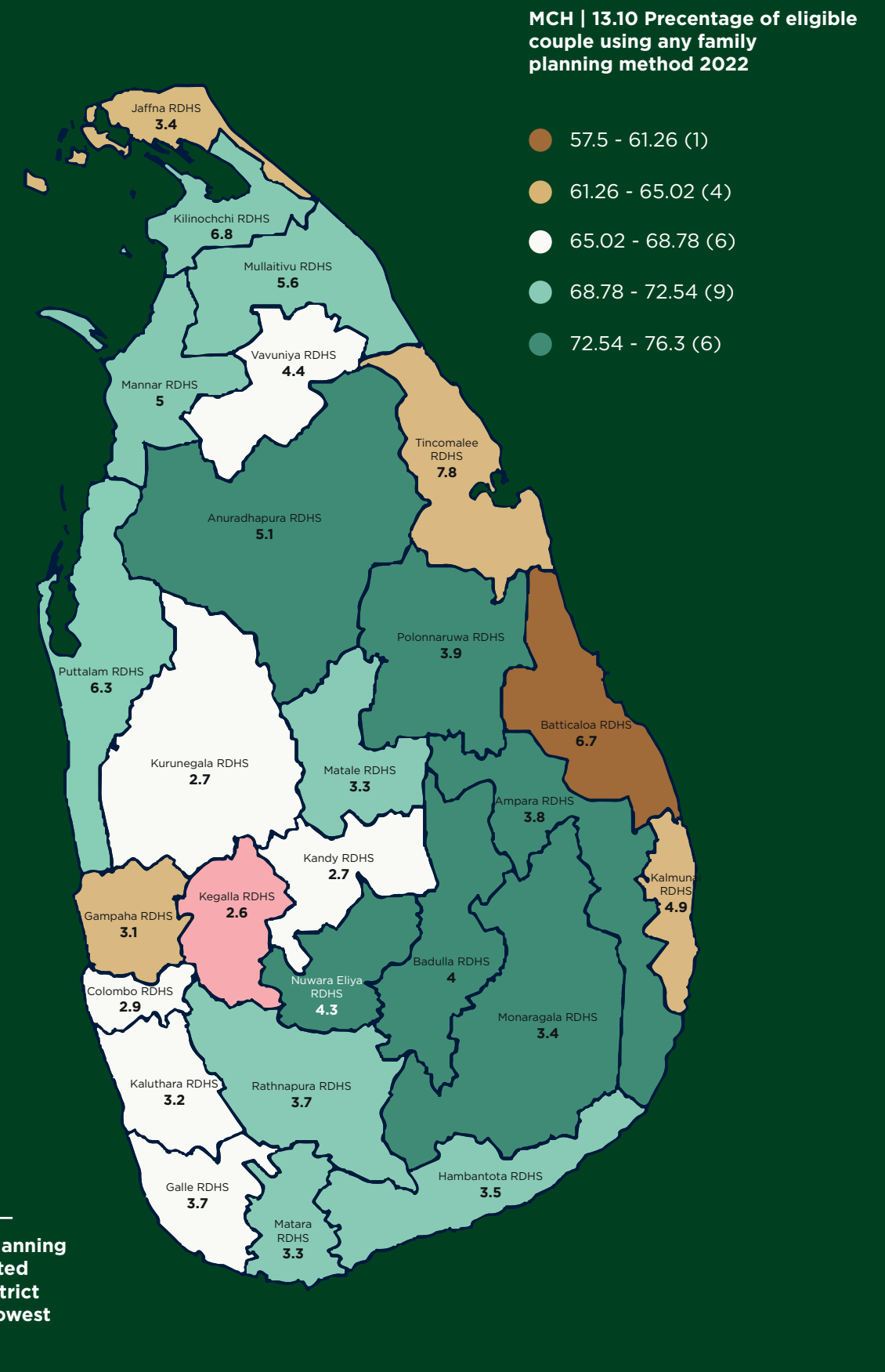


Figure 3.27: Current users of modern family planning methods, from 2018 - 2022

Source: FHB, eRHMS 2022

No significant change in the trends of family planning usage observed over the last 5 years.



Highest family planning usage was reported from Ampara district (76.3) whereas lowest is reported from Batticaloa (57.5)

Figure 3.28: Shows the district variation in CPR (All methods) in 2022
Source: FHB, eRHMS 2022

Indicator	2018	2018	2020	2021	2022
New Acceptors (No.)	171,397	152,532	128,799	225,822	258,902
IUD	29,382	24,214	17,320	28,622	36,733
Oral Pills	26,188	22,949	22,902	44,480	50,459
Sterilizations	15,783	13,883	11,212	30,116	30,632
Injectable	53,208	53,131	40,295	79,700	86,824
Implants	46,836	38,355	37,070	42,904	54,254

Table 3.15: Contraceptive methods new acceptors by method from 2018 – 2022

Source: FHB, eRH MIS 2022

*Data source H1200 from government clinics was changed to midwife’s monthly report in 2021

In 2022, new acceptors for each family planning method have increased

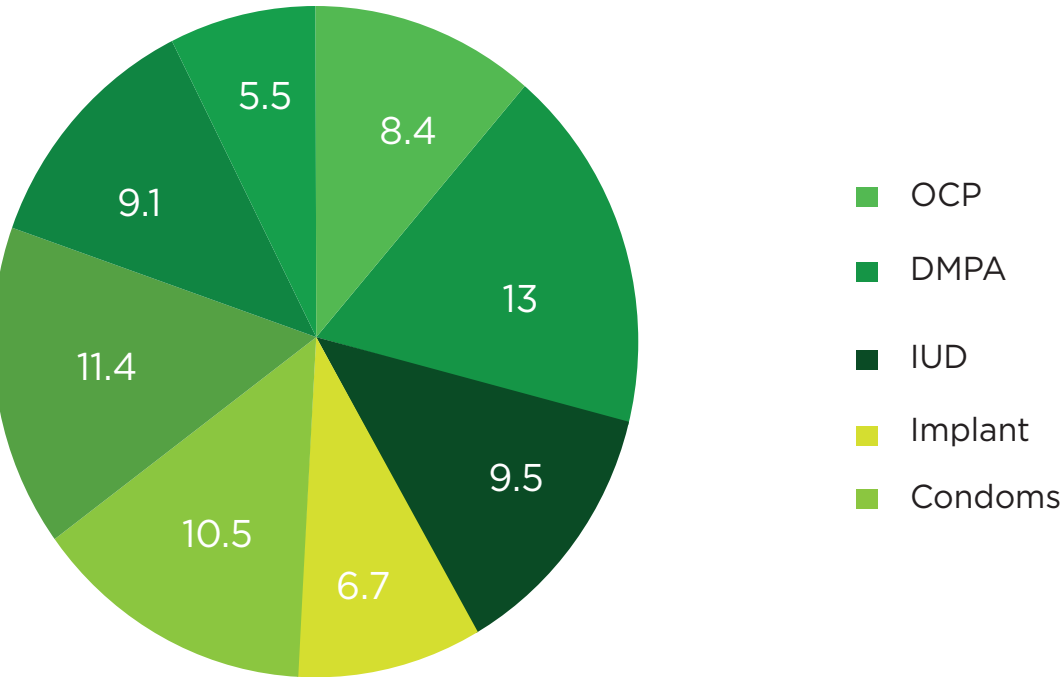


Figure 3.29: Distribution of various contraceptive methods in 2022

Source: FHB, eRH MIS 2022

Mostly used family planning method was DMPA with a rate of 13

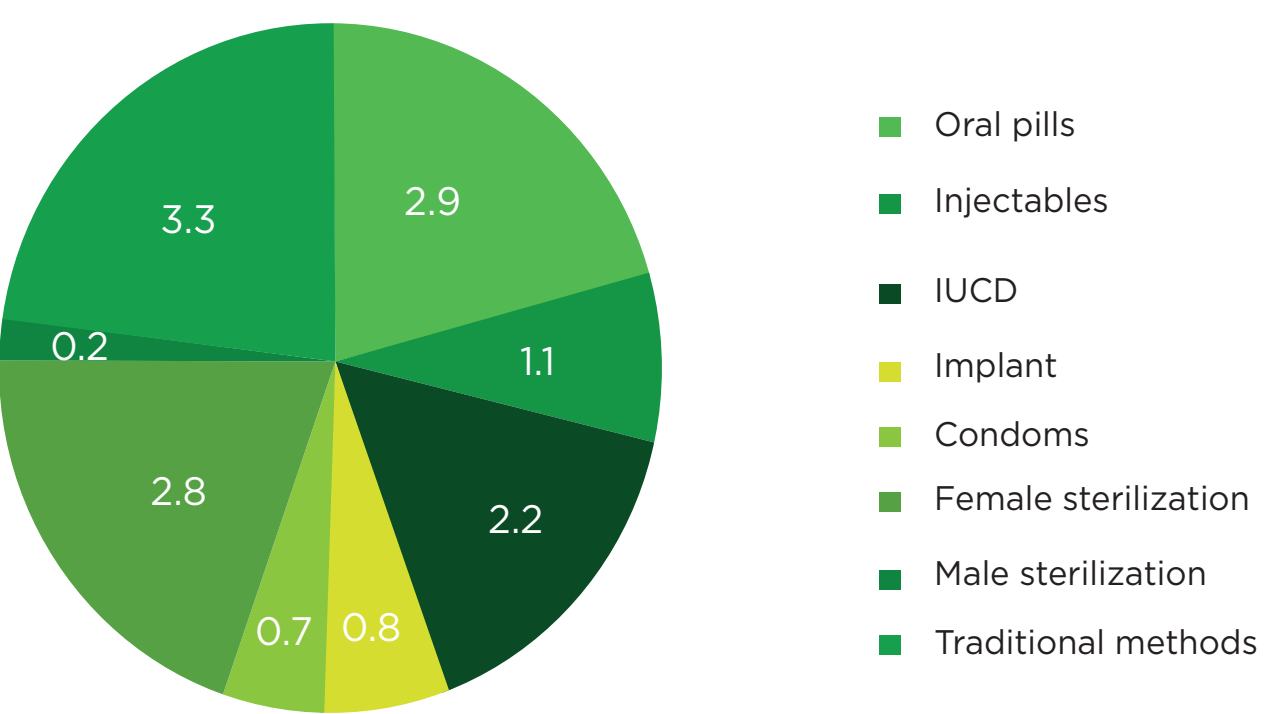


Figure 3.30: Contraceptive failure rate in 2022

Source: FHB, eRH MIS 2022

Mostly used family planning method was DMPA with a rate of 13

Indicator	2018	2018	2020	2021	2022
New Acceptors (No.)	171,397	152,532	128,799	225,822	258,902
IUD	29,382	24,214	17,320	28,622	36,733
Oral Pills	26,188	22,949	22,902	44,480	50,459
Sterilizations	15,783	13,883	11,212	30,116	30,632
Injectable	53,208	53,131	40,295	79,700	86,824
Implants	46,836	38,355	37,070	42,904	54,254

Figure 3.31: Percentage of eligible couples having unmet need for family planning 2018-2022

Source: FHB, eRH MIS 2022

In 2022, new acceptors for each family planning method have increased

ADOLESCENTS AND YOUTH HEALTH INCLUDING SCHOOL HEALTH

Adolescents and Youth Health

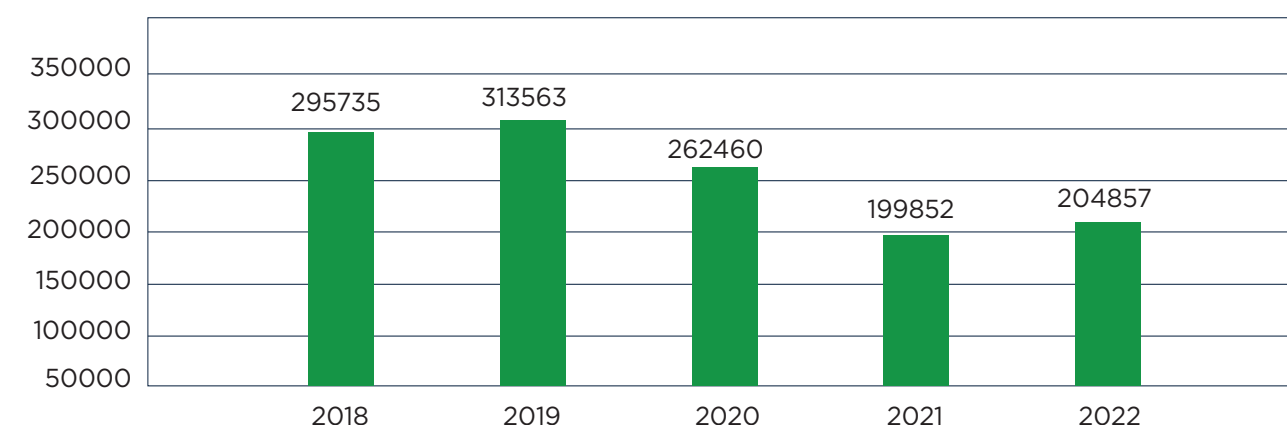


Figure 3.32: Adolescents newly registered 2018-2022

Source: FHB, eRHMS 2022

Adolescent coverage remains more or less the same for 2021 and 2022 years.

School Health

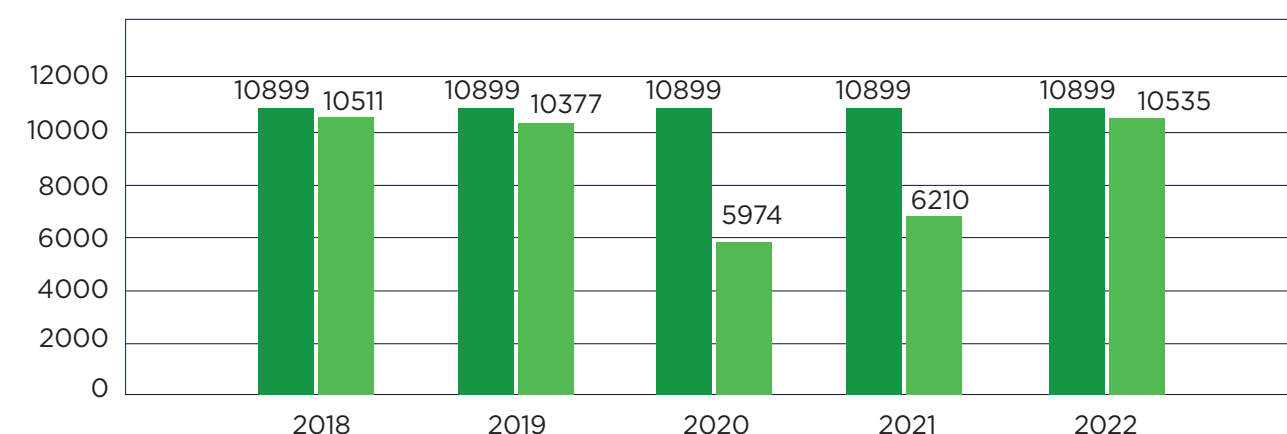


Figure 3.33: Total number of schools versus number of schools where SMI were conducted 2018 to 2022

Source: FHB, eRHMS 2022

* From 2018 data included Government, Pirivenas and some international Schools as well

Due to COVID-19 pandemic situation, schools were not conducted for many months in 2021. As a result school health services were affected severely but in 2022 remarkable improvement has been achieved.

GENDER AND WOMEN'S HEALTH INCLUDING WELL WOMEN CARE SERVICES

Gender and Women's Health

The following is a List of Mithuru Piyasa; hospital based GBV care centres available by the end of 2022

01. Akkareipattu-Base Hospital	43. Kilinochchi- District General Hospital
02. Ampara- General Hospital	44. Kiribathgoda- Base Hospital
03. Anuradhapura- Teaching Hospital	45. Kurunegala -Teaching Hospital
04. Army Hospital- Minneriya	46. Mahamodara- Teaching Hospital
05. Army Hospital- Narahenpita	47. Marawila- Base Hospital
06. Ashraff Memorial Hospital- Kalmunai	48. Matale- District General Hospital
07. Avissawella- District General Hospital	49. Matara- District General Hospital
08. Badulla- Provincial General Hospital	50. Meerigama- Base Hospital
09. Balangoda- Base Hospital	51. Mulaitivu- District General Hospital
10. Bandarawela- Divisional Hospital	52. Nawalapitiya- Base Hospital
11. Batticaloa- Teaching Hospital	53. Nuwaraeliya- District General Hospital
12. Bibila -Base Hospital	54. Peradeniya-Teaching Hospital
13. BOI- Katunayake	55. Pimbura- Base Hospital
14. Castle Street Hospital for Women	56. Point Pedro- Base Hospital
15. Chankanai- Divisional Hospital	57. Pottuvil- Base Hospital
16. Chavakachcheri- Base Hospital	58. Ragama- Teaching Hospital
17. Chenkaladi- Divisional Hospital	59. Rathnapura- Provincial General Hospital
18. De Soysa Hospital for Women	60. Rikillagaskada- Base Hospital
19. Dickoya- District General Hospital	61. Samanthurai- Base Hospital
20. Diyathalawa- Base Hospital	62. Siyambalanduwa- Base Hospital
21. Elpitiya- Base Hospital	63. Sri Jayawardhanapura- General Hospital
22. Embilipitiya- District General Hospital	64. Tangalle- Base Hospital
23. Eravur- Base Hospital	65. Thalangama- District Hospital
24. Family Health Bureau	66. Thambuththegama- Base Hospital
25. Gampola- Base Hospital	67. Theldeniya- Base Hospital
26. Hambanthota- District General Hospital	68. Trincomalee- District General hospital
27. Homagama- Base Hospital	69. Valachchenai- Base Hospital
28. Horana- Base Hospital	70. Vavuniya- District General Hospital
29. Jaffna-Teaching Hospital	71. Welimada- Base Hospital
30. Kalmunai North- Base Hospital	72. Wellawaya- Base Hospital
31. Kalubowila- Teaching Hospital	73. University of Sri Jayawardhanapura
32. Kalutara- General Hospital	74. Tissamaharama- Base Hospital
33. Kaluwanchikudy- Base Hospital	75. Dambulla- Base Hospital
34. Kandy- Teaching Hospital	76. Gampaha- District General Hospital
35. Kaththankuddy- Base Hospital	77. Mannar- District General Hospital
36. University of Jaffna	78. Padaviya- Base Hospital
37. Panadura- Base Hospital	79. Mulleriyawa- Base Hospital (CEBH)
38. Negombo- District General Hospital	80. Modara- Maternity Unit
39. Dambadeniya- Base Hospital	81. Katugahahena- District Hospital
40. Kayts- Base Hospital	82. Kahawatte- Base Hospital
41. Kegalle- Teaching Hospital	83. Polonnaruwa- District General Hospital
42. Kethumathi Maternity Hospital- Panadura	84. Asiri Medical Private Hospital

Year	Number of Mithuru Piyasa centres	Total number of new GBV survivors seeking care over the year	Total number of follow-up sessions held with survivors	Total number of sessions held with the family members of survivors	Total number of sessions 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
2020	76	9735	5581	4003	3229	22548
2021	81	7309	7005	3631	2905	20850
2022	84	10871	7772	4847	5687	29177

Table 3.16: Number of Mithuru Piyasa centres Vs New GBV survivors seeking care over the years

Source: Consolidation of monthly returns sent from Mithuru Piyasa centres, FHB

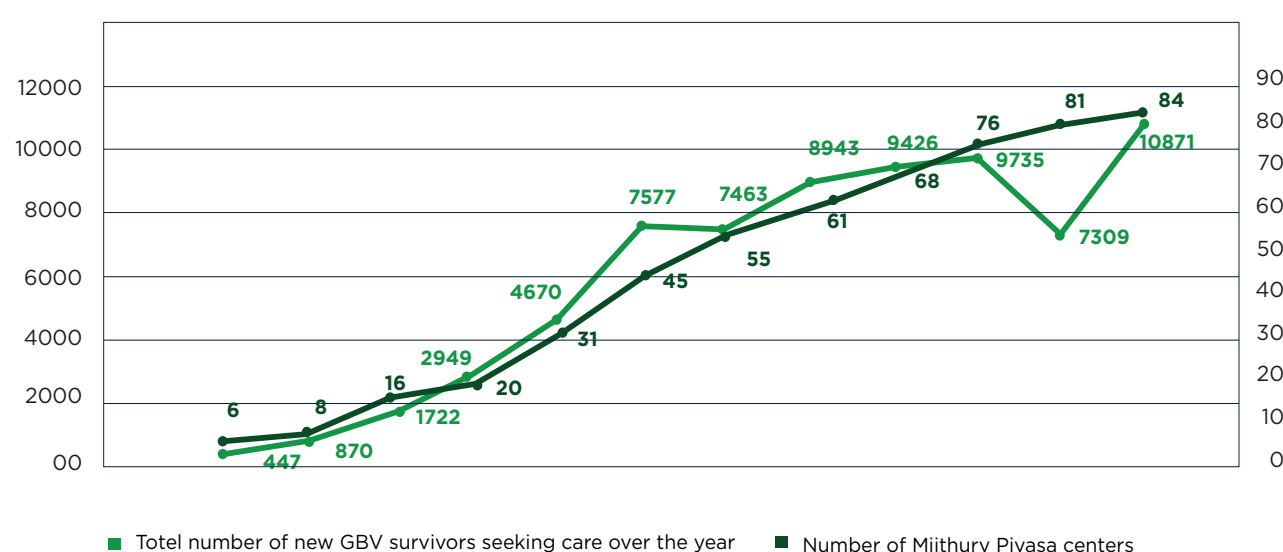


Figure 3.34: Number of Mithuru Piyasa centres Vs New GBV survivors seeking care over the years

Source: Consolidation of monthly returns sent from Mithuru Piyasa centres, FHB

Well Woman Care Services

Data element	2018	2019	2020	2021	2022
35 Years (first visit)	132,691	129,321	102,389	76,890	98,835
45 Years (first visit)	28,655	44,634	36,841	31,640	53,863
Other ages (first visit)	50,469	45,518	22,592	11,016	25,153
Total	211,815	219,473	161,822	119,546	177,851

Table 3.17: Number of first visits to WWCs from 2018 to 2022 (by age group)

Data element	2018	2019	2020	2021	2022
Percentage of women aged 35 years who attended the WWC	61.6	59.1	58.1	43.6	55.2
Percentage of women aged 45 years who attended the WWC	16.6	25.5	20.9	17.9	30.1

Table 3.18: Well Woman Clinic attendance by women aged 35 years and 45 years (2018-2022)

Source: FHB, eRHMS 2022

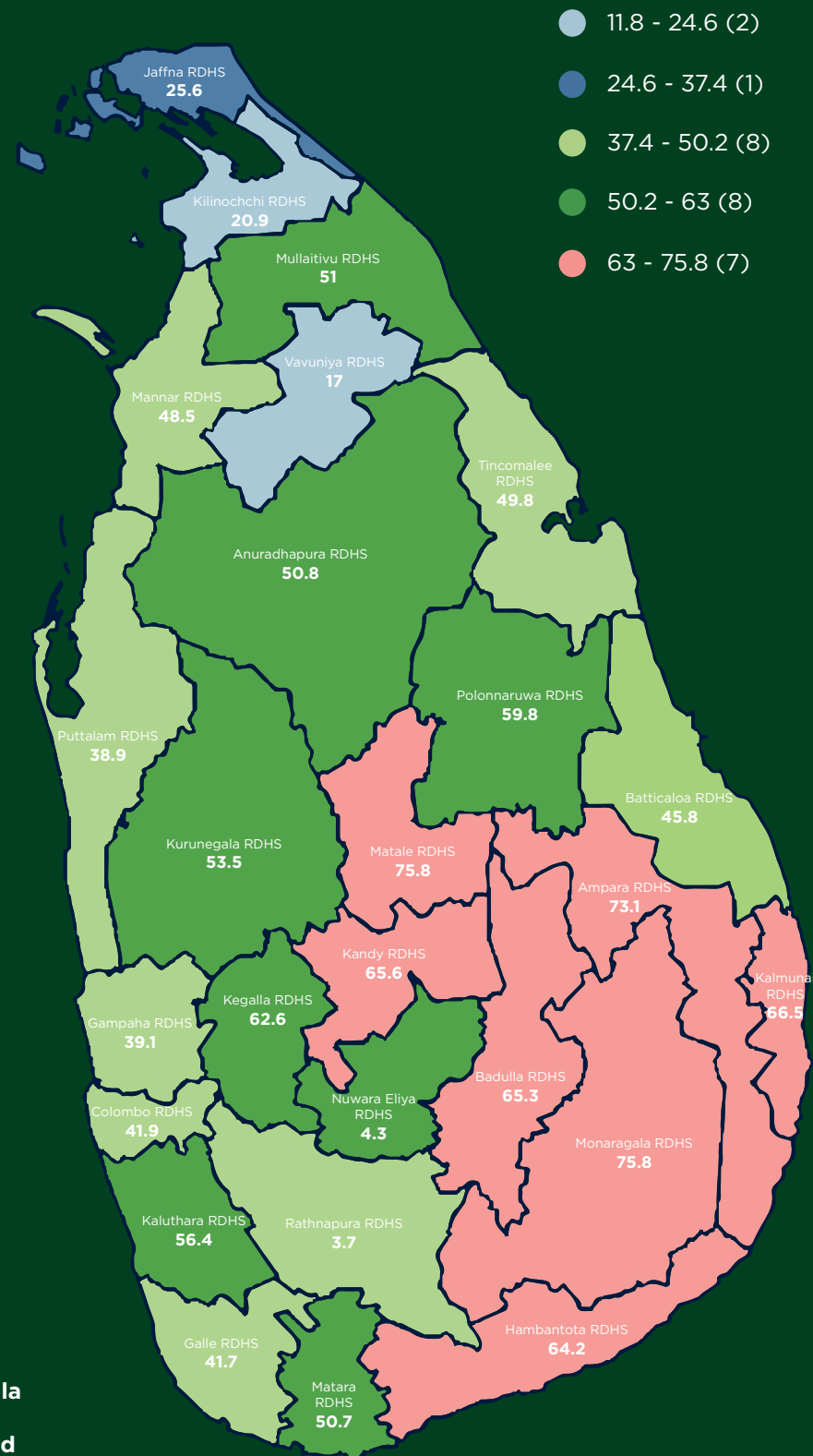
Activity	2018	2019	2020	2021	2022
Number of 35-year women attending WWC clinics	132,691	129,321	102,389	76,890	98,852
Cervical smears reported as high- and low-grade lesions	520	704	347	378	565
Cervical smears reported as malignant (Carcinoma)	8	34	3	9	3
Breast abnormalities detected	3,706	3726	2780	1848	3762
Diabetes Mellitus detected	4,602	5955	4959	5255	8837
Hypertension detected	7,736	7618	6259	4912	7729

Table 3.19: Clinic attendance (first visits) and morbidities detected (2018-2022)

Source: FHB, eRHMS 2022

Number of 35 year cohort women attendance and morbidities reported were comparatively higher in 2022

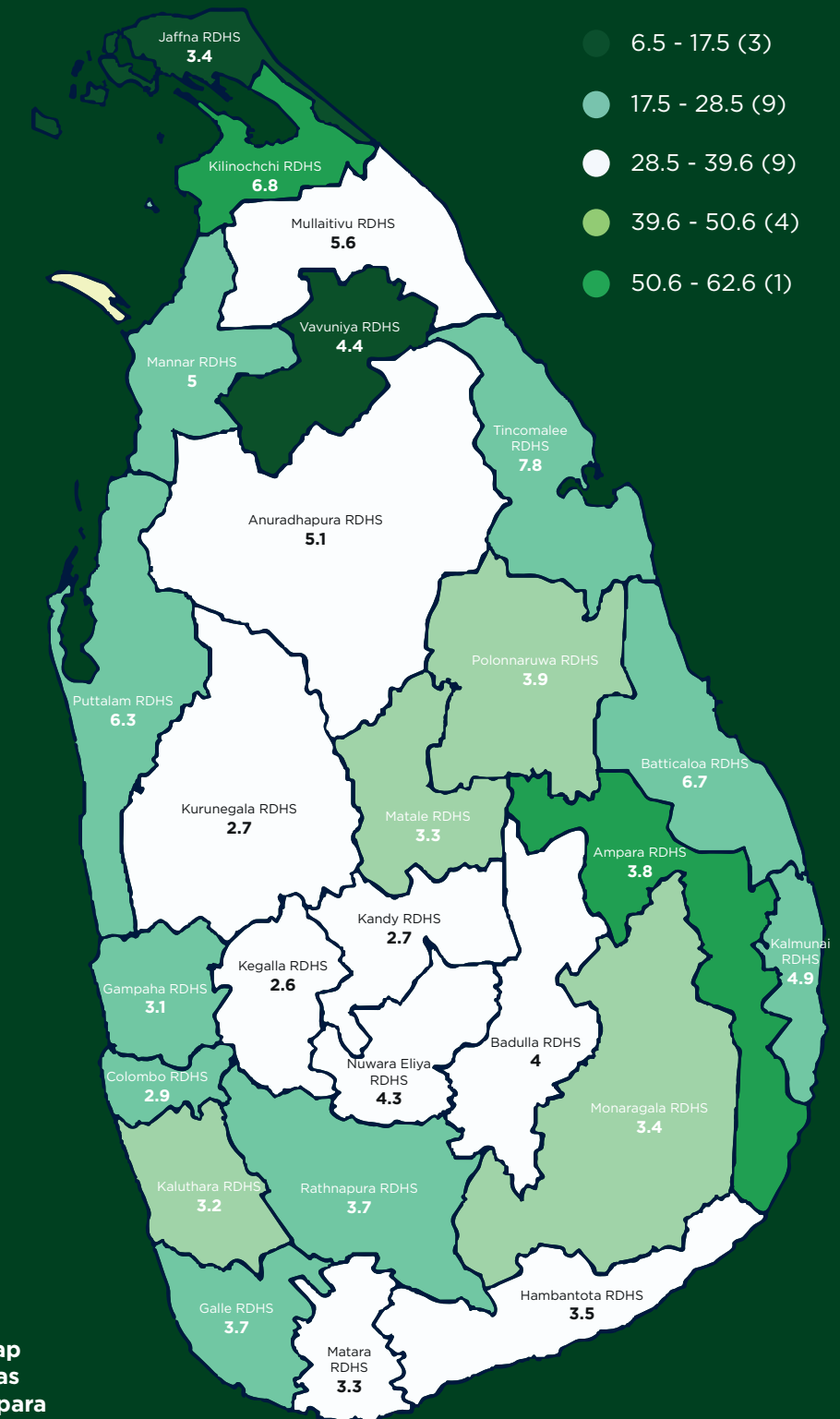
MCH | 15.04.02 Percentage of 35 year age cohort coverage who had undergone papsmear screening out of 0.8% of the population : 2022



Highest 35-year pap smear coverage was reported from Badulla district (65.3) and lowest (11.8) reported from Colombo MC.

Figure 3.35: Map of the Coverage of the 35 years cohort by districts (2022)
Source: FHB, eRHMS 2022

MCH | 15.05. Percentage of 45 year age cohort coverage who had undergone papsmear screening out of 0.8% of the population : 2022



Highest 45-year pap smear coverage was reported from Ampara district (61.6) and lowest from Colombo MC (6.5)

Figure 3.36: Map of the coverage of the 45 years cohort by districts (2022)
Source: FHB, eRHMS 2022

OUTCOME OF MATERNAL DEATH SURVEILLANCE AND RESPONSE 2022

Maternal mortality remains a critical indicator of a nation's health care system effectiveness, reflecting the overall health of women during pregnancy, childbirth and the post-partum period. It is also a key indicator of the health and well-being of women and girls, reflecting their overall health status, access to healthcare, and the responsiveness of the country's healthcare system to their needs.

Maternal Death Surveillance and Response (MDSR) system - as a critical component of public health infrastructure aims at reducing preventable maternal deaths by identifying, investigating and response planning based on issues identified. Sri Lanka introduced its MDSR mechanism in 1959, followed by a mandatory notification regulation for probable maternal deaths in 1985. Since 2009, numerous quality dimensions have been added to the MDSR process. Today, Sri Lanka has a well-structured MDSR system that is recognized as a global model.

Process of MDSR

Notification of maternal deaths has been established as a legal obligation through the issuance of a gazette notification to all practitioners providing care to women in Sri Lanka. All deaths (irrespective of cause) of women in the reproductive age group (15 – 49 years), during the pregnancy period and until one year after termination of pregnancy should be notified to the Family Health Bureau (FHB). Following this a detailed review of the case is done at field level and institutional level where the index mother has received care. At FHB, the Maternal Morbidity and Mortality Surveillance Unit maintains a database and comprehensive case scenarios are developed. Institutional death reviews are held for all direct and indirect maternal deaths at the institution where the maternal death took place with the participation of institutional and field health staff involved in the care of the index case and the representatives from the Ministry of Health and Family Health Bureau. These reviews serve as platforms for healthcare professionals involved in the care of the deceased patients to come together and discuss the findings of their investigations and generate recommendations for prevention of similar cases in the future. These cases are then desk reviewed by an expert panel comprised of different specialties related to maternal care service provision. Each maternal death is reviewed based on 3 delays – (deficiencies in seeking healthcare, reaching and treating), and the lessons learned from these reviews are then used to improve maternal health practices, programs, and policies at the district and national levels.

Definition of a Maternal Death

Sri Lanka adopts the WHO definition on maternal deaths: The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (WHO).

Review Methodology

Family Health Bureau was notified of 174 probable maternal deaths during the year 2022. The Maternal Morbidity & Mortality Surveillance Unit gathered comprehensive information from family members, field workers, hospital staff, and medico-legal experts to create case scenarios for analysis. Institutional maternal death reviews were held for these cases with the participation of institutional and field health staff involved in the care of the index mother and the representatives from the Ministry of Health and Family Health Bureau.

Out of the notified deaths 91 deaths were identified as true maternal deaths due to direct or indirect causes. Central level desk reviews (n=8) were conducted for these 91 cases categorized according to major disease entities (eg. Obstetric Hemorrhage, Heart Disease, Disease etc.) during the period 2022 –2023. A panel of experts comprised of representatives from Sri Lanka College of Obstetricians and Gynecologists, College of Anesthesiologists and Intensivists of Sri Lanka, Sri Lanka College of Internal Medicine, College of Forensic Pathologists of Sri Lanka, National Program Managers of maternal care, relevant Consultant Community Physicians and representatives from other related professional bodies reviewed the cases. For each index death, the desk review included;

1. Confirmation as a maternal death
2. Determination of the underlying cause of death
3. Determination of the category of maternal death (direct / indirect / incidental)
4. Identification of service deficiencies / provision of care and other issues
5. Formulation of recommendations

In the year 2022 as a further development in maternal mortality surveillance, Confidential Enquiry into Maternal Deaths (CEMD) was introduced as a pilot project for the Western and Southern provinces of Sri Lanka. The 24 pilot settings 24 maternal deaths reported from these pilot areas were reviewed under the CEMD methodology while the remaining 67 maternal deaths were subjected to the routine MDSR methodology.

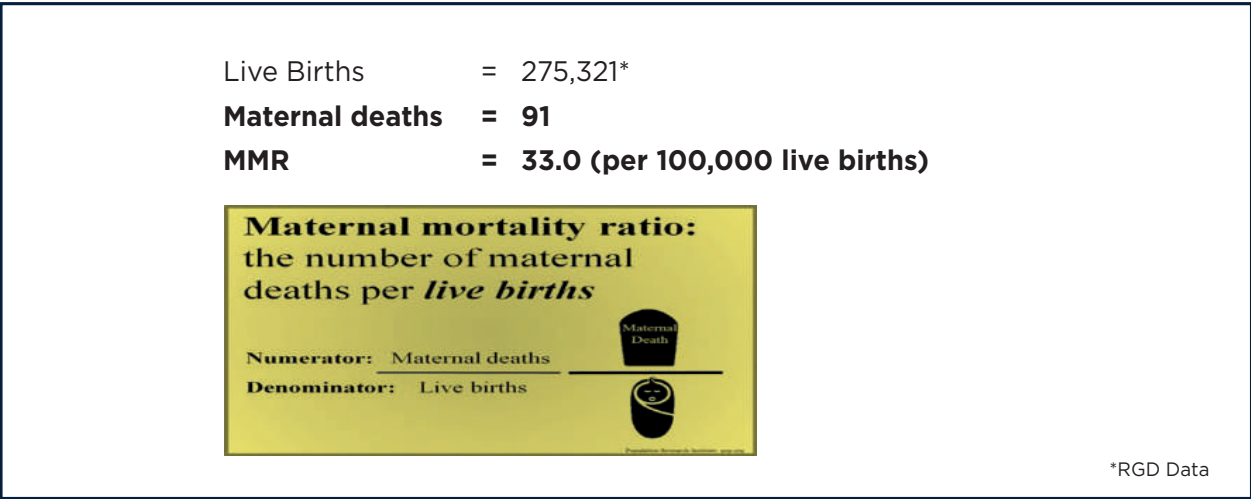


Maternal Mortality Metrics

Maternal Mortality Ratio (MMR) is the globally accepted indicator to quantify the burden of maternal deaths in a country. MMR evaluates obstetric risk, or the possibility that a woman could die during pregnancy. It is calculated as the number of maternal deaths per 100,000 live births. MMR is also used as an indicator to assess the overall maternal health and the health status of a country.

In the year 2022, out of all reported deaths, 91 deaths were categorized as maternal deaths

giving a National Maternal Mortality Ratio (MMR) of 33.0 per 100,000 live births (Figure 1). Live births reported by the Registrar General’s Department for the year 2022 was taken as the denominator (275,321) which showed a reduction from the 2021 figure of 284,848 (9527). It is notable that, experiencing post COVID and economic crisis implications may have led to the inability to reach the pre COVID level of MMR in 2022. There were no maternal deaths due to COVID -19 in the year 2022.



A graph depicting the number confirmed maternal deaths from 2002 – 2022 is included in Figure 3.37. A gradual reduction in the number of maternal deaths can be seen up to 2020 however 2021 with the height of the COVID-19 pandemic in Sri Lanka, there was a sudden and drastic uptick in the number of maternal deaths. In 2022 the number dropped back to the pre COVID trend despite the post pandemic effect and the financial crisis effect in the country.

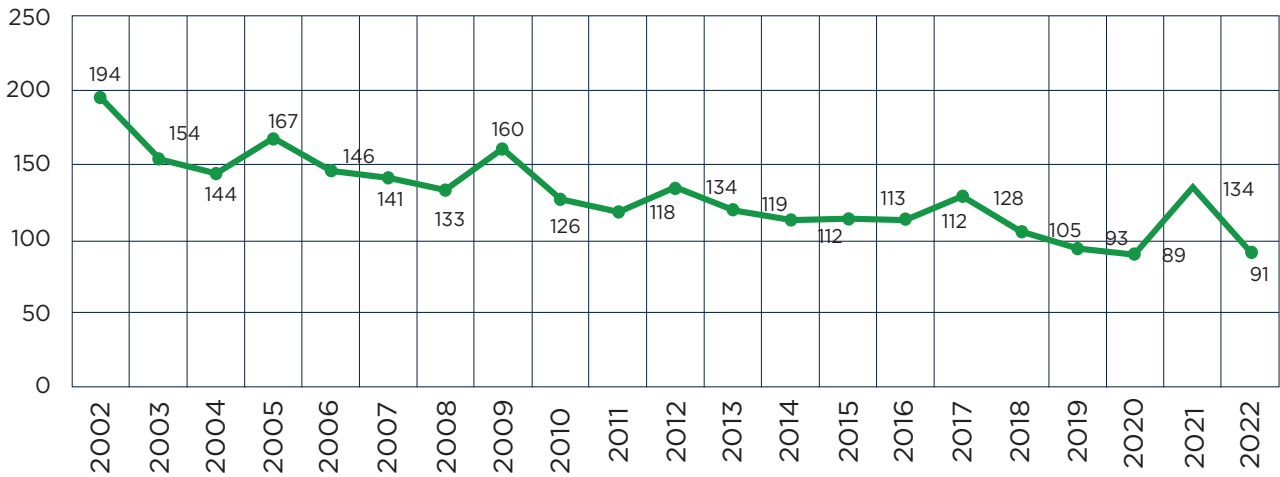


Figure 3.37: Number of maternal deaths (2002 – 2022)

Source: Maternal Morbidity, Mortality Surveillance Unit ,FHB

A graph depicting the number confirmed maternal deaths from 2002 – 2022 is included in Figure 3.37. A gradual reduction in the number of maternal deaths can be seen up to 2020 however 2021 with the height of the COVID-19 pandemic in Sri Lanka, there was a sudden and drastic uptick in the number of maternal deaths. In 2022 the number dropped back to the pre COVID trend despite the post pandemic effect and the financial crisis effect in the country.

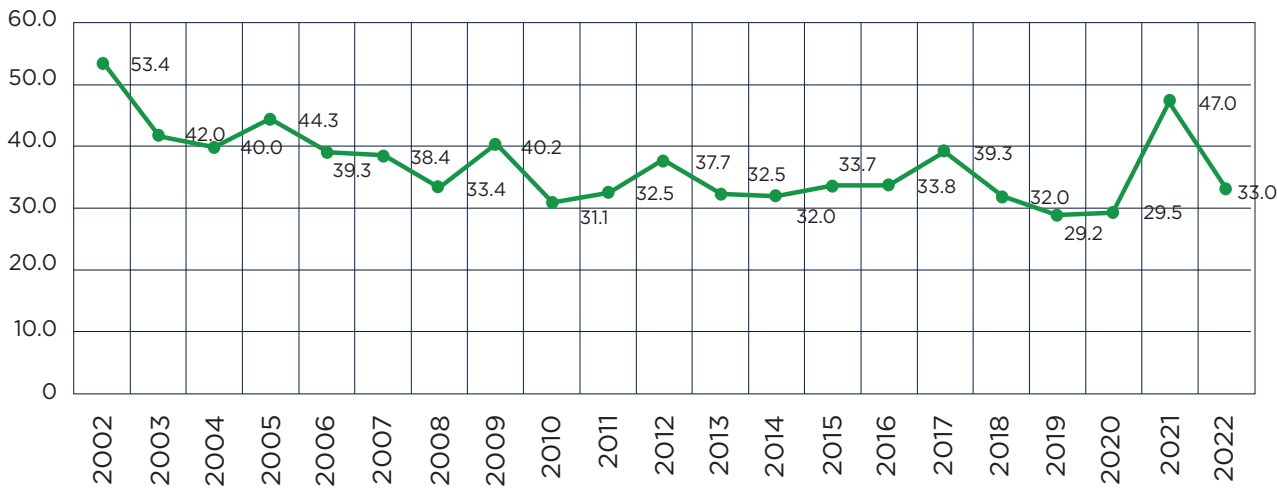


Figure 3.38: Maternal Mortality Ration from 2002- 2022
Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

Figure 3.39 shows the number of deaths and MMR of each district calculated based on the number of live births reported by Registrar General’s department for each district. When considered the district variability of MMR, the highest MMR was reported from Mathale as 101.7 per 100,00 live births (n=7). Other leading districts were Monaragala, Kaluthara, Nuwara Eliya and Gampaha. Mullaitivu districts reported zero maternal deaths. While lowest MMR was reported in Kalmunai as 11.1(n=1) as a number, Gampaha reported the greatest number of maternal deaths with 11 compared to the 18 deaths reported in 2021.

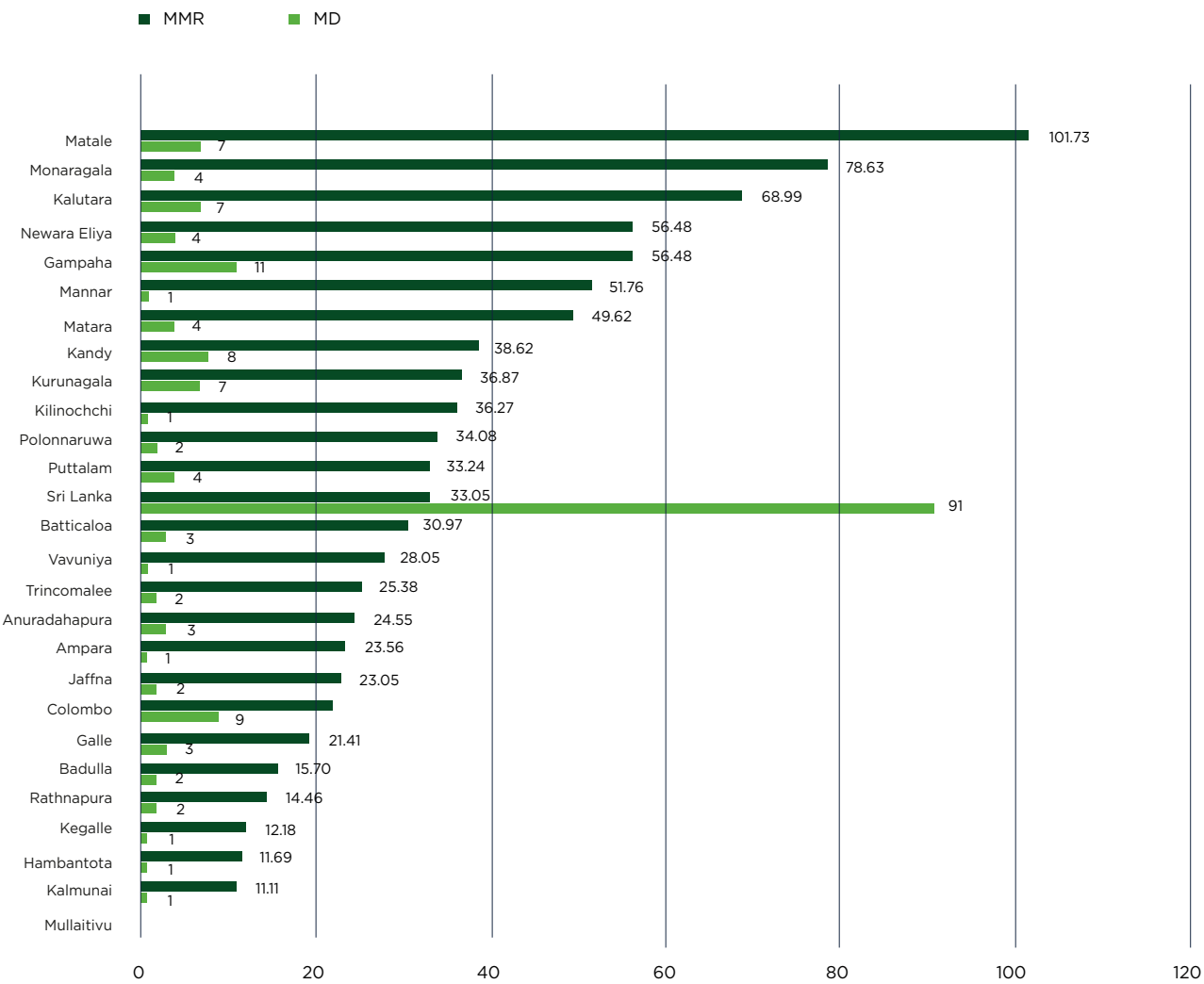


Figure 3.39: Maternal Deaths and MMR by District – 2022
Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

Maternal deaths are classified into two distinct categories: direct and indirect. Direct obstetric deaths arise from complications related to the pregnant state, encompassing pregnancy, labor, and the puerperium. These fatalities may stem from interventions, omissions, incorrect treatment, or the cascading consequences of any such actions. Indirect obstetric deaths occur due to pre-existing diseases or conditions that emerged during pregnancy, independent of direct obstetric causes, but exacerbated by the physiological effects of pregnancy.

A majority of maternal deaths in 2022 were indirect maternal deaths (n=55, 60%) while 36 (40%) maternal deaths were classified as direct maternal deaths. Figure 3.40 shows the causes for maternal deaths reported in the year 2022. The leading cause of maternal deaths was reported as respiratory diseases (n=13, 14.2%) including viral and bacterial pneumonias. Heart disease and CNS related disease conditions reported 10 cases (10.9%) each. The comparative increase of CNS diseases related maternal deaths from n=3 in 2021 to n=10 in 2022 became a notable issue. Obstetric Hemorrhage reported as the fourth commonest cause (n=8, 8.8%). Compared to 5 cases in 2021 sepsis other than reproductive sepsis reported 7 cases falling at the 5th place. There were no deaths reported due to COVID 19 infection in 2022.

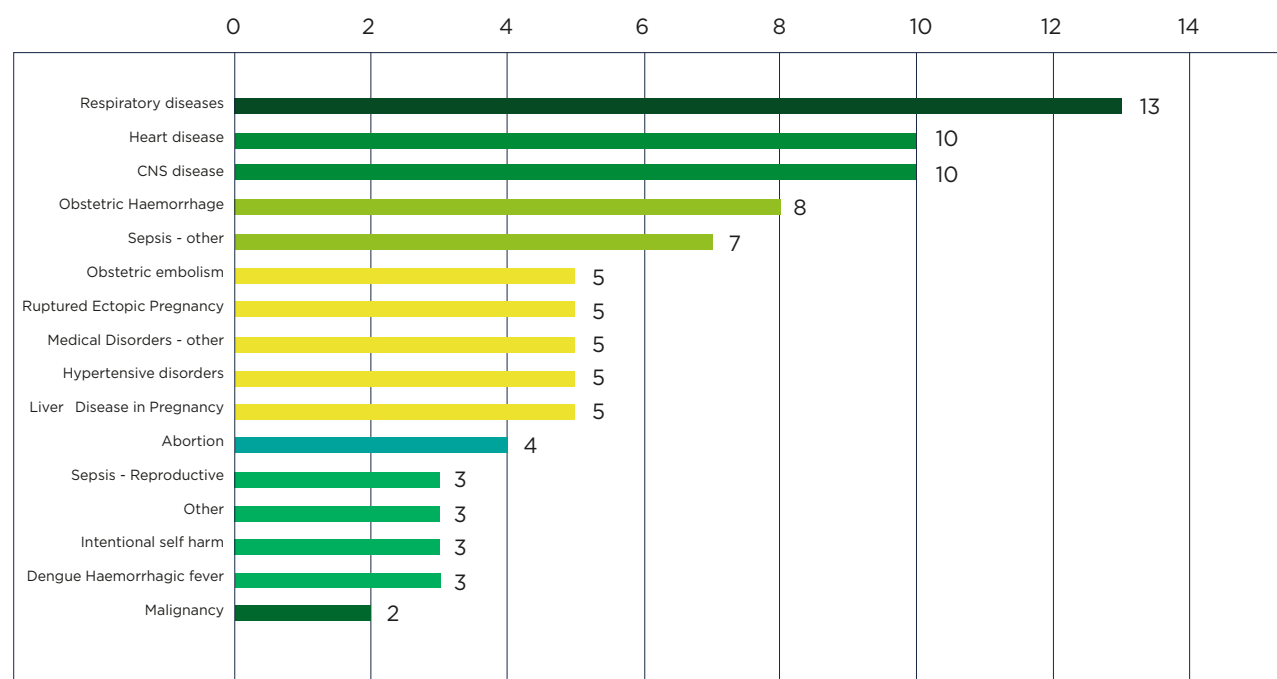


Figure 3.40: Causes of maternal deaths -2022

Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

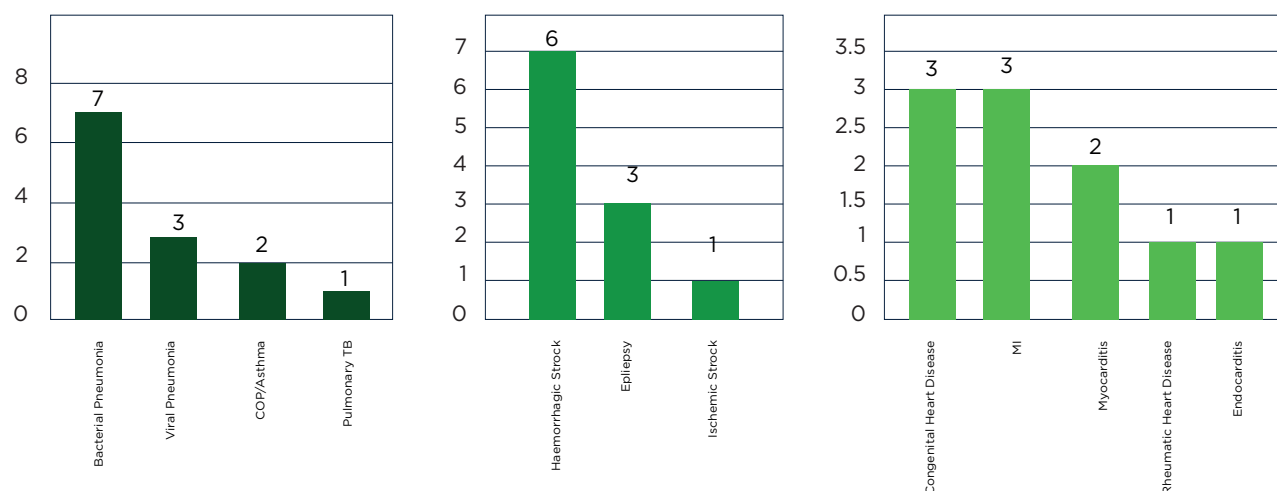


Figure 3.41: Breakdown of Causes of maternal deaths -2022

Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

Among the reported deaths, 64 deaths (70%) were reported from urban sector while 25 deaths (27.5%) and 2 deaths (2.2%) were reported from rural and estate sectors respectively. The ethnic composition included; Sinhala (n=61, 66.3%), Tamil (n=10, 11%) and Muslim (n=20, 22.7%). A majority were married (n=86, 94.6%) while a minority were unmarried (n=5, 5.4%). Considering the age distribution of the maternal deaths there were 2 deaths 20 years of age, while the majority of deaths occurred within the age range of 26 to 30 years (n=23, 25.2%) (Figure 3.42).

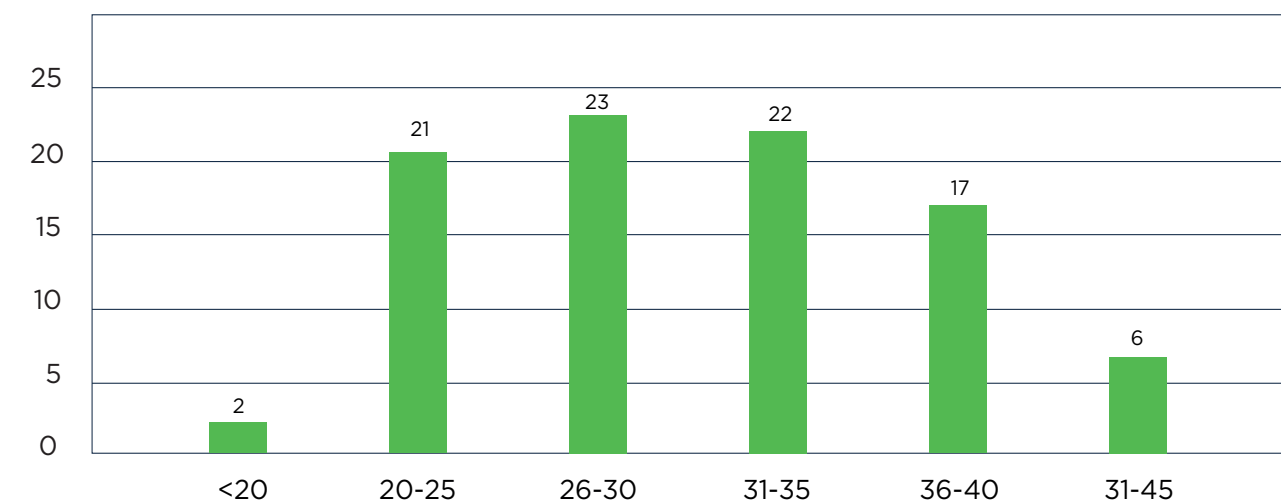


Figure 3.42: Age category of Maternal Deaths - 2022

Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

Of all the maternal deaths 23 mothers were primi mothers (25.3%) while 68 were multiparous (74.7%).

Figure 3.43 shows the parity of the maternal mortality cases.

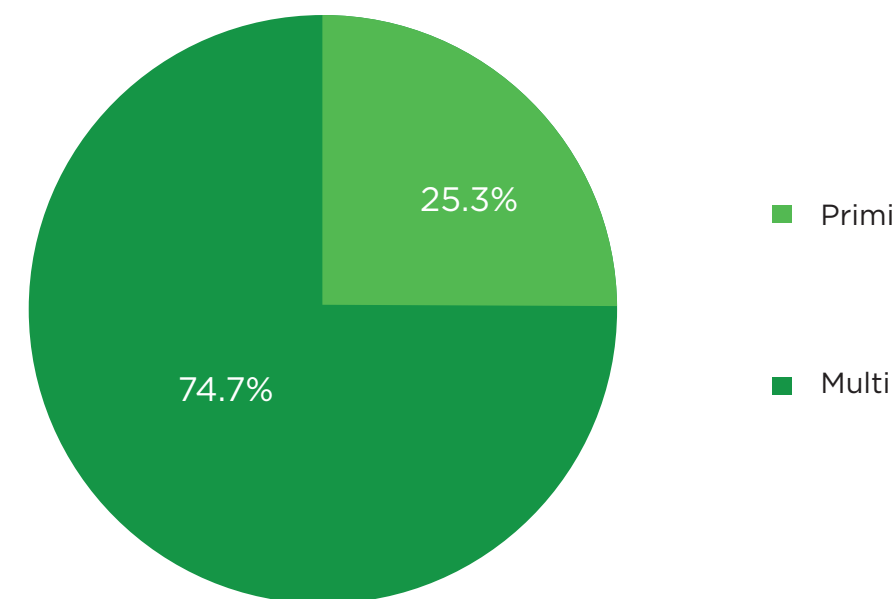


Figure 3.43: Parity of maternal deaths - 2022

Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

Considering the timing of the maternal death, antenatal period deaths were much less in proportion 32.6% (n =30) compared to the postpartum 59.8% (n =54) and post abortion 6.5% (n =7). Out of the post-partum and post abortion maternal deaths 24% occurred within the first 24 hours while majority 76% occurred during the period between postpartum day 02 - day 42.

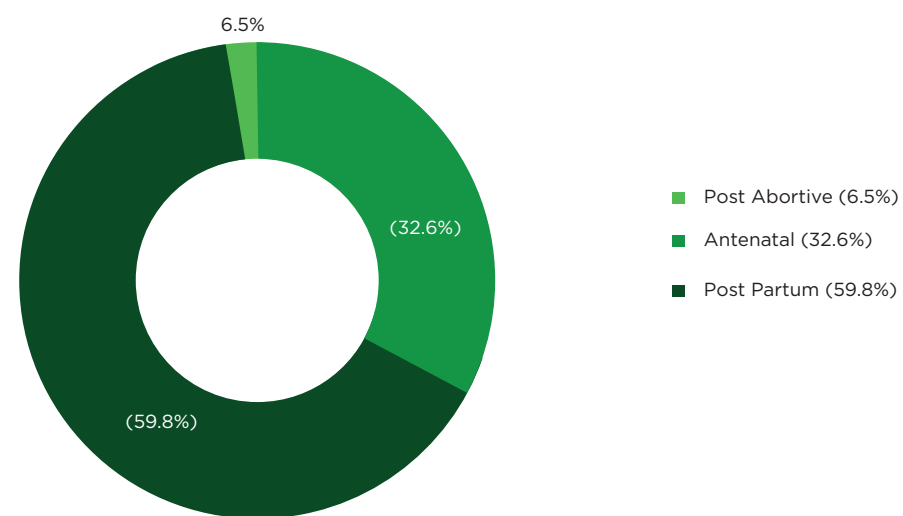


Figure 3.44: Timing of death of Maternal deaths - 2022

Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

The majority of maternal deaths happened in a hospital (n=80, 87.9%) while in n=11 mothers (11.1%) the death had occurred at home, while on transit or as an on-admission death. Majority of the death occurred in a tertiary care institution (n=64, 70%)

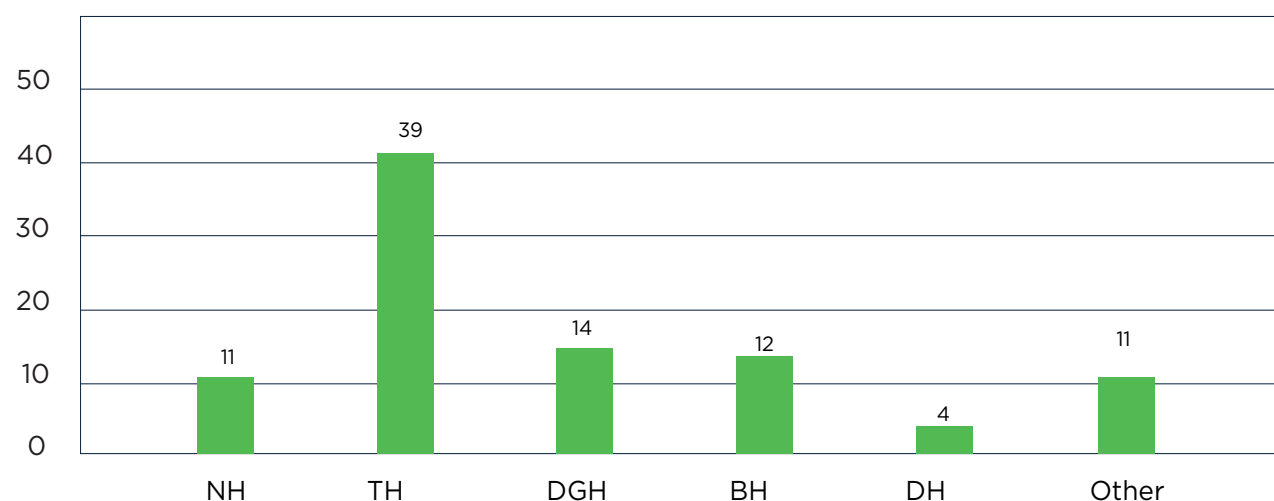


Figure 3.45: Place of death of Maternal deaths - 2022

Source: Maternal Morbidity, Mortality Surveillance Unit - FHB

The graph in Figure 3.46 illustrates the monthly distribution of maternal deaths throughout the year 2022. Notably, the month of May reported the lowest number of maternal deaths which was 03 while January reported the maximum number which was 11.

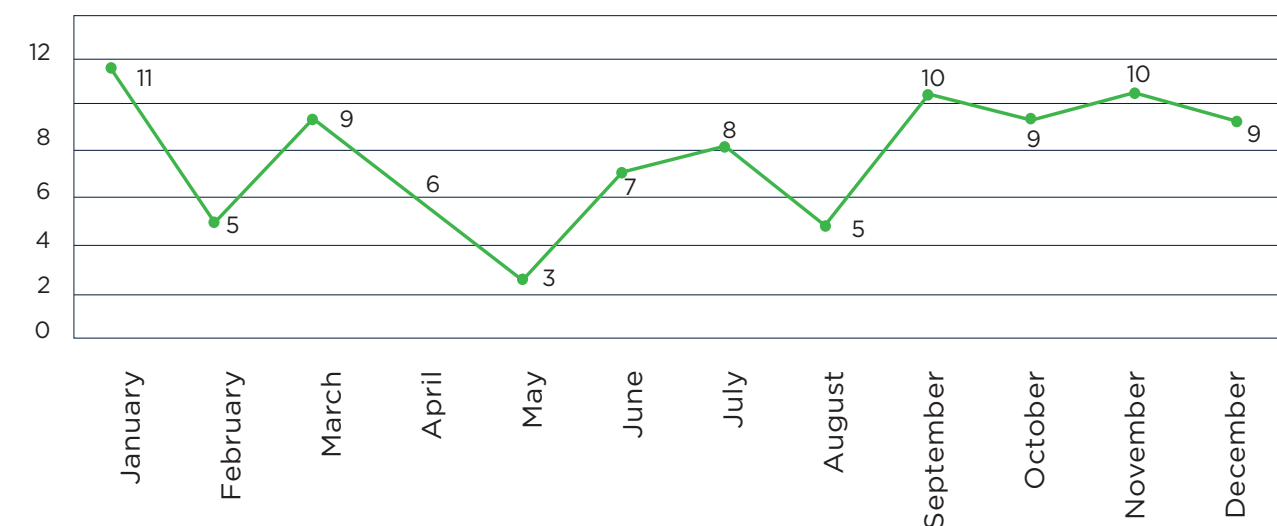


Figure 3.46: Monthly Frequency of maternal deaths - 2022

Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

Figure 3.47 shows the mode of delivery which the deceased mothers had undergone. Cesarean section (40.2%, n =37) was reported as the commonest mode of delivery among the mothers who ended up as a maternal death, out of while n= 23(62%) were reported as emergency and n=14 (38%) were performed as elective sections. while another 3.3% (n =3) mothers underwent hysterotomy.

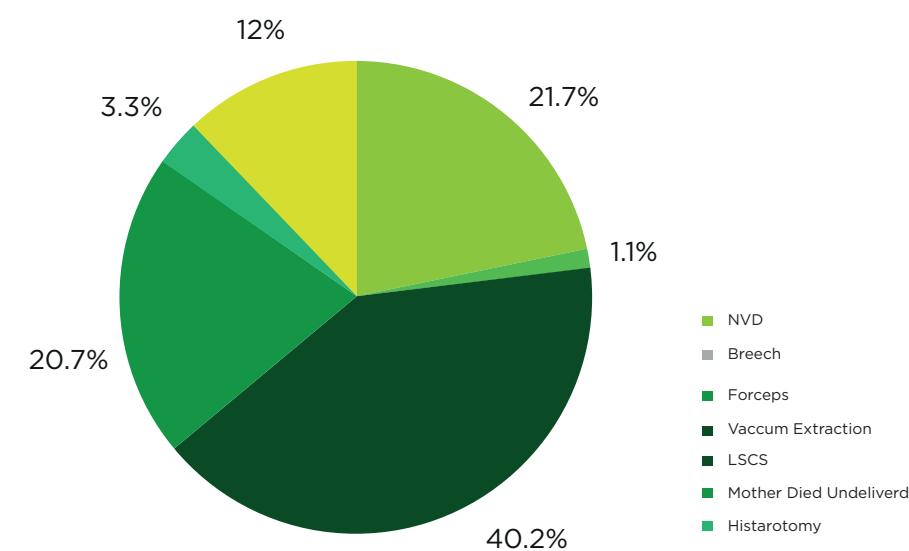


Figure 3.47: Mode of Delivery - 2022

Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

In a majority of maternal death cases the present pregnancy ended up in a live birth (n=47, 51.1%) and in n=15, 16.3% cases it ended in a still birth. Of all maternal deaths n=18, 19.1% of mothers died without delivering a baby.

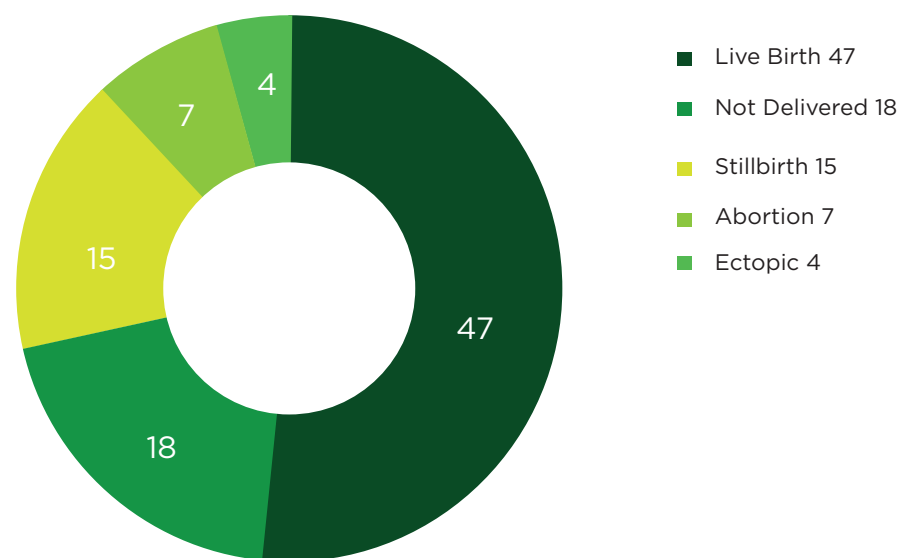


Figure 3.48: Outcome of pregnancy - 2022

Source: Maternal Morbidity, Mortality Surveillance Unit ,FHB

Majority of deaths (90%) occurred at a health care institution while only 4% were reported as home deaths. A group of mothers (6%) died while on transit and reported as an on-admission deaths.

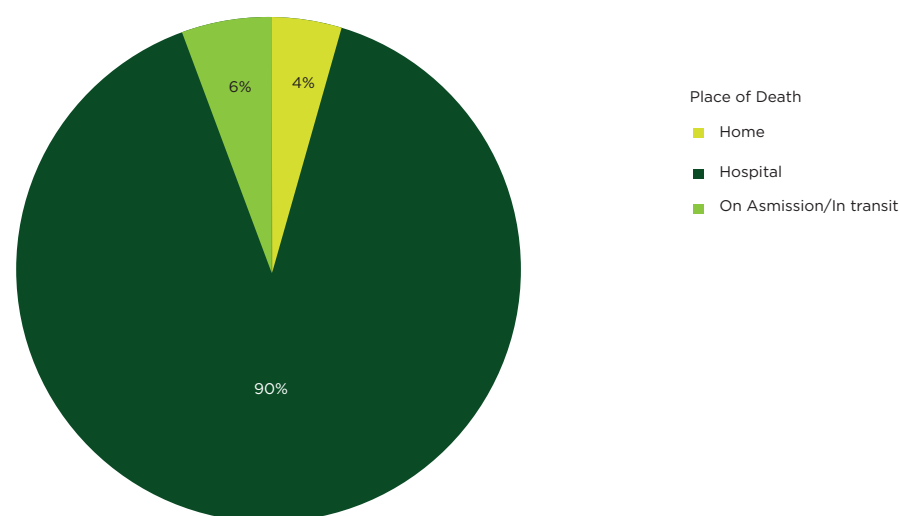


Figure 3.49: Place of occurrence of death - 2022

Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

According to the three-delay model which is used in analysis, among all maternal deaths in the year 2022, 70%, (n=63) showed one or more delay types while 30% (n=28) reported no delays in the process of management. When the specific delay types were considered among the maternal deaths with delay identified, 47.3% reported delay one (delay in seeking care) either as the single delay or associated with other types of delays, while 45.1% reported Delay three (delay in receiving care) either as a single delay or associated with one or more delays. Remarkably delay two (delay in Reaching a Health care institution) was only seen in 5.5% of maternal deaths.

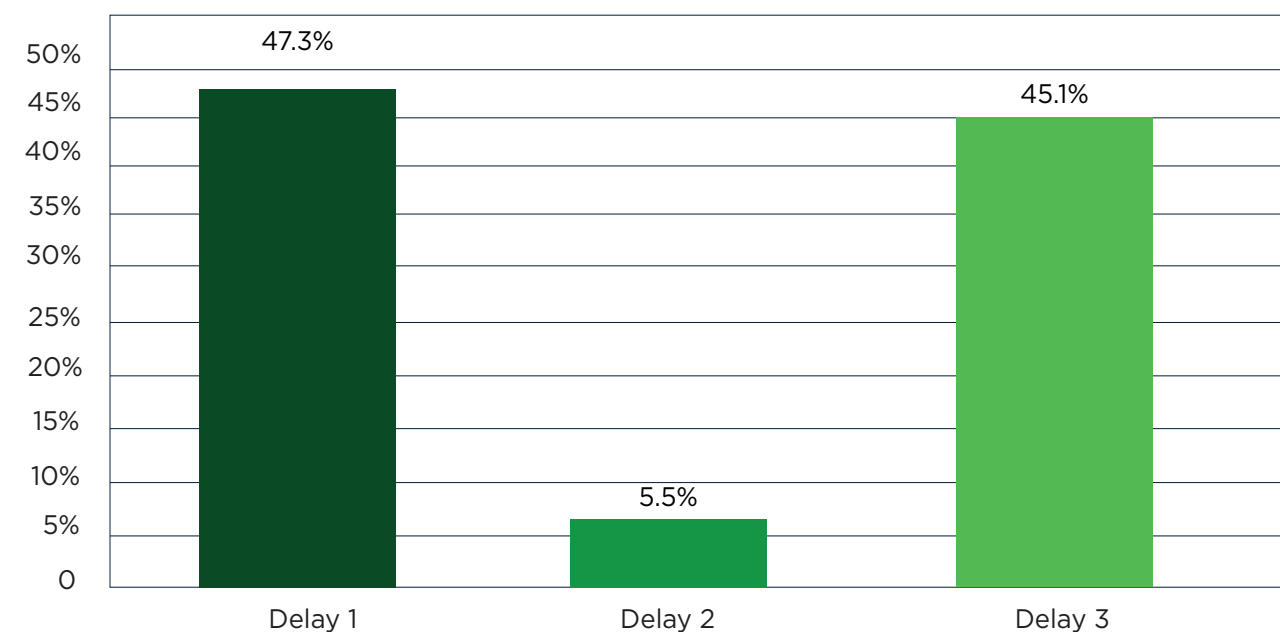


Figure 3.50: Types of delay in maternal deaths - 2022

Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

All maternal deaths are non-preventable. One of the main objectives of maternal mortality surveillance is to identify the preventability of maternal deaths. The national and global target is to achieve zero prevalence of preventable maternal deaths. Over the years the preventable portion of maternal deaths was in a reducing trend till 2021 when COVID maternal deaths increased the preventable portion to a very high figure. In 2022 the preventable portion of maternal deaths had reduced to 53 % while the non-preventable causes contributed to 22% of the maternal deaths. In 25% of the maternal deaths the preventability was inconclusive. The preventability was assessed using criteria and by a multidisciplinary team of experts considering all aspects of the cause of death and the sequence of events.

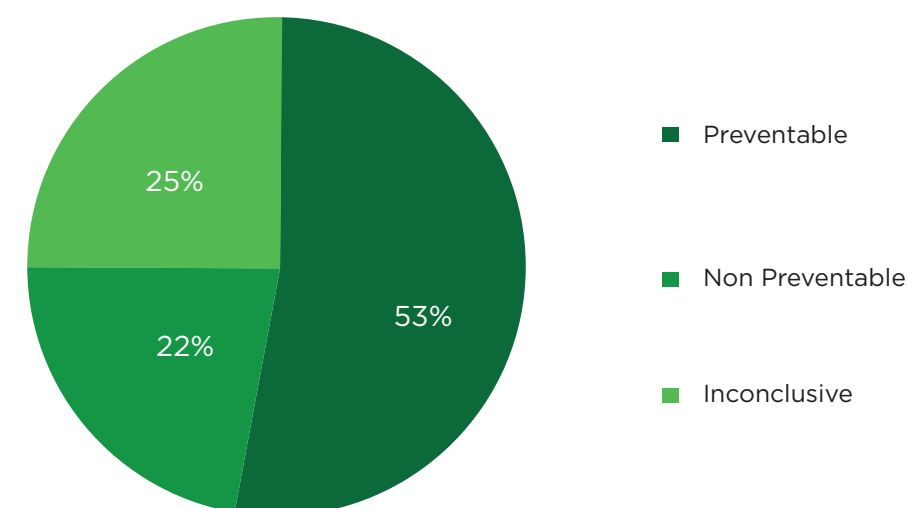


Figure 3.51: Preventability of maternal deaths - 2022

Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

The service provision for maternal care is an important area to follow as the pregnancy outcome is greatly influenced by it. Unmet need of family planning is one indicator to assess the service provision in Maternal health. Unmet need of family planning is defined as a woman or couple who are sexually active but do not practice a credible family planning method despite the fact that they do not intend to conceive and have a baby for a period of at least two years. Considering the maternal deaths in 2022, 27.5% (n =25) displayed unmet need of family planning while 72.5% (n =66) deaths did not show any unmet need of family planning. This figure is much higher compared to the prevalence of unmet need of family planning among the eligible families in Sri Lanka for the year 2022 which is 5.5% (FHB data)

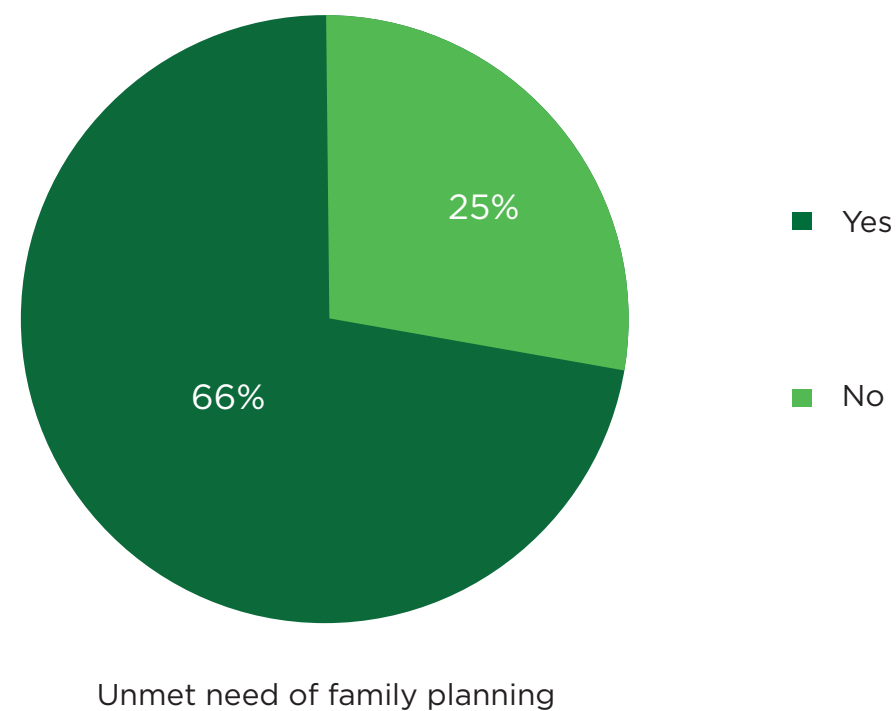


Figure 3.51: Preventability of maternal deaths - 2022
Source: Maternal Morbidity, Mortality Surveillance Unit , FHB

Considering service provision, the relevant field Public Health Midwife (PHM) area was vacant in 10% of mothers who ended up as maternal deaths while in 90% of mothers were from areas where PHM was available.

Confidential Enquiry in to Maternal Deaths (CEMD)

This system of maternal death review was introduced as a pilot project in 2022 with the collaboration with the Sri Lanka College of Obstetricians and Gynecologists (SLCOG). The pilot areas being the Western and Southern provinces covered six districts. During the year 2022, there were 24 maternal deaths reported from the pilot areas. All 24 maternal deaths were subjected to CEMD expert panel meetings and covered at seven meetings conducted at central level. Recommendations made had been communicated to the national level and also the regional and institutional level.

Maternal and Perinatal Death Surveillance and Response (MPDSR) system

As a World Health Organization guided new initiative, MPDSR system was introduced to Sri Lanka in the year 2022. As an initial step it was introduced to the western and southern provinces by conducting training of trainer’s program and the institutional level training through the MMMS unit of the Family Health Bureau. On the directions of the Director General of Health Services MPDSR committees are expected to be established in all hospitals to the level of base hospital (A) to ensure implementation of recommendations made through maternal and perinatal death review process.

Issues

Following key issues were identified during the review of the cases;

1. Poor socio economical background leading to delay in seeking care due to family commitments lack of support leading to delay one and also lack of compliance by patients to attend necessary referrals and follow up
2. Poor awareness of the mother and the family members regarding high-risk conditions danger sign identification and the emergency actions to be taken in case of danger signs
3. Inadequate pre-pregnancy and interpregnancy period preparation of high-risk mothers especially inappropriate family planning methods used resulting in unwanted pregnancies and poorly controlled chronic illnesses due to poor referral systems and follow up mechanisms.
4. The sub optimal postpartum care services received by mothers specially related to quality of the postpartum visits.
5. Delayed recognition, diagnosis, initiation of treatment and delayed escalation of management of medical and obstetric emergencies including obstetric haemorrhage sepsis, preeclampsia and amniotic fluid embolism.

6. Lack of adequate number of specialist staff including Obstetricians and Gynaecologists anaesthesiologists, paediatricians and neonatologists specially in the peripheral health care institutions.
7. Human resource inadequacy, skilled trained staff including medical officers nursing staff midwifery and other staff categories to provide a quality care to the public in both field and institutional level.
8. Service availability and provision for pregnant women with special needs like psychological issues physical disabilities.
9. Shortage of some essential medications, facilities or other logistics at hospital level in managing sick women, specially at the first contact institutions.
10. Inappropriate and inadequate management of critical symptoms such as shortness of breath (SOB) at GP level.
11. Certain mothers have not registered at field level and continued management exclusively at private sector causing them to be missed by the field staff.
12. Late or inadequate multidisciplinary team (MDT) approach to patient management.

Recommendations

Main recommendations formulated are as follows:

1. All pregnant women and their relatives should be educated on the danger features during the pregnancy and post-partum periods and the need for attending to the nearest hospital early this planning should be done considering the social and environmental conditions of the individual.
2. High-risk mothers should be observed more frequently and be advised regarding danger signs and symptoms and the referral and the follow up mechanism need to be strengthened.
3. Protocols and guidelines should be prepared on management of medical and obstetric emergencies and all staff should have in service training sessions to update their knowledge and practices based on the protocols and guidelines.
4. Pre-pregnancy counseling and preparation of mothers with medical conditions should be initiated at the field level specially if the condition is contra indicated for pregnancy.
5. Introducing an appropriate family planning method, considering the requirement of the client as well as medical conditions, and following uptake of a method, ensure regular and responsible follow up to be done by the field staff.

6. Develop short videos and posts on danger signs in pregnancy and steps to be taken if noted, to be used at antenatal clinic settings and through social media.
7. Introducing a checklist for PHM's for observation of postpartum mothers in their postnatal home visits and a methodology to plan the postpartum visit based on the history of the relevant mother. specially including PR and RR with the expected ranges.
8. MOs attached to MOH offices, peripheral hospitals and GPs should be given an opportunity on continues learning process to update and revise their knowledge on important areas in clinical medicine and link it to CPD point system
9. Patients with critical medical conditions on discharge should have a comprehensive follow plan which should be agreed by a Multi-Disciplinary Team of Consultants who cared for the mother at the hospital and should be communicated to the mother and the field team clearly.
10. Circular to be issued on registering all mothers attending private sector antenatal clinics in the field clinic to ensure proper antenatal and post-natal follow up.
11. Ensure adequate human resources including consultants, medical officers, nursing and midwifery staff and other staff for smooth functioning of the health care institutions

SPECIAL ACTIVITIES CARRIED OUT DURING 2022

To uplift the quality and coverage of RMNCAYH services in the country, FHB carried out various special activities;

Maternal and newborn care

Basic Maternal Care manual: Maternal care package that was introduced in 2011 needed revision as some of the content in the package was outdated and a need for a guide for curative sector staff on management of the normal pregnancy was also highlighted. In order to fulfil the above gap, a consultant was commissioned by the UNICEF and a new guide has been drafted and reviewed by relevant stakeholders. This process was overseen by a technical committee. The English version of the guide for medical staff on basic maternal care was finalized. The Sinhala version of the guide for nursing and midwifery staffs on basic maternal care was also finalized. The Tamil version of the guide for nursing and midwifery staffs on basic maternal care was planned to be drafted in 2023.

Supply of essential equipment: Carried out a survey on HDU facilities in antenatal and postnatal wards of specialist hospitals to identify any gaps in HDU facilities and distributed equipment to establish 22 numbers of HDUs in 11 selected maternity institutions with financial assistance from UNICEF. 720 digital blood pressure apparatuses were procured for the field staff with the support of PSSP to reduce their risk of contracting COVID-19 during examinations. A request was made to Director, MSD to procure and distribute 'postpartum kits' carried by Public Health Midwives during their postnatal home visits to provide essential postpartum services.

Development of a package on psychosocial assessment in maternal care: FHB, in collaboration with the Sri Lanka College of Psychiatrists, has drafted a Psychosocial Screening Tool (PST) that is expected to standardize the said screening process. Successfully completed Phase One of the validation study of the development of the psychosocial screening tool and completed the data collection of Phase One of it.

Capacity building of health staff on maternal mental health via Zoom webinars was conducted for curative and preventive health staffs by Dr. Neil Fernando and Dr. S. Sivadas, Consultant Psychiatrists, in Sinhala and Tamil mediums respectively.

Relief programmes for pregnant women affected by the economic downturn: Technical inputs were provided to prospective donors regarding the best approach for granting assistance to pregnant women affected by the economic downturn.

Drafting of national obstetric clinical care guidelines: The guide on management of PPH was finalized and circulated island wide under the signature of the DGHS.

Maternal supplements: An expert consultation was conducted on introduction on MMN for pregnant women and discontinuation of postpartum vitamin A supplementation. The panel of experts recommended introduction of MMN for non-anaemic pregnant women in Sri Lanka, after reviewing the evidence and evaluating the cost-benefit.

Arrangements were made with the MSD to include new maternal iron folate supplement

(Ferrous Fumarate and Folic Acid tablet BP 91.2mg + 400mcg equivalent to 30 mg of elemental iron) to the Formulary, as the guideline to prevent maternal anaemia changed. Informed the periphery to request 30 mg elemental iron to supplement non-anaemic pregnant women, when submitting their annual requirement of maternal micronutrients for year the 2023 onwards.

Requested SPMC to manufacture 400 µg folic acid tablets for pre-conceptional and first trimester supplementation. SPMC had completed the stability tests of this new commodity and was in the process of manufacturing this supplement.

BCC material: BCC material on maternal danger signals were developed in collaboration with the Health Promotion Bureau, which included posters and social media posts.



Addressing the issue of organized refusal of maternal care services: Discussions were held with Sri Lanka Medical Council, Technical advisory Committee on Maternal Health and Family Planning and Chief Legal Officer of the Ministry of Health regarding amending the Medical Ordinance to address the issue of organized refusal of maternal care services, and draft modifications were prepared.

Drafting of standards for highly specialized maternity centres: In order to provide optimum possible care for AN and PN mothers with highly complicated morbidities, it has been decided to establish highly specialized maternity centres. The process of drafting guidelines was initiated in 2022.

Child health

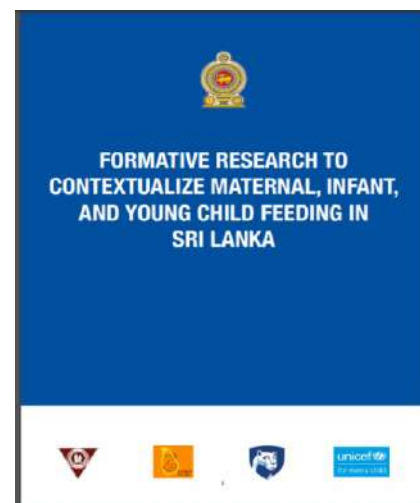
Breastfeeding week activities; The World Breastfeeding Week was commemorated in 2022 under the slogan “Step up for breastfeeding; Educate and Support” highlighting the importance of creating a supportive environment by different stakeholders to promote, protect and support breastfeeding especially during economic crisis. A webinar was conducted for the peripheral staff and a press conference was conducted together with the Health Promotion Bureau. Social media posts, fact sheets and education material for health staff and media were developed and circulated.

Development of necessary guidelines for health staff for provision of child nutrition services during the crisis situation; Guidelines on safeguarding child nutrition during economic crisis for health staff and caregivers (in all 3 languages)

Addendum to General circular 01-13/2020 on “Management of Severe and Moderate Acute Undernutrition of Children under Five Years of Age - Manual for Health Workers in Sri Lanka” focusing on establishment of outreach clinics to ensure services are easily accessible for the target groups.

Development of an online training package for capacity building of health staff on Growth Monitoring and Infant and Young Child Feeding (IYCF) Counseling in Sinhala medium (in the last stage of development), supported by UNICEF. The development of the Tamil training package continued during 2022.

Formative study on determinants of IYCF and child care in rural, estate and urban populations; Key findings of the formative research on IYCF were presented to higher officials of the Ministry of Health by Prof. Stephen Kodish from Penn State University and Prof. Upul Senarath from Faculty of Medicine - Colombo. Evidence generated from the formative research on IYCF to identify drivers and barriers on feeding practices and child nutrition is being used in the development of strategies and actions to strengthen and streamline the child nutrition component of the maternal and child health programme.



Annual child nutrition status surveillance to mark the National Nutrition Month; Nutrition Month anthropometric assessment of under 5 children was conducted in the month of October within a very short period of time despite the immense challenges faced throughout due to the economic crisis.

Procurement and distribution of nutrition commodities - Multiple Micronutrient 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.

Procurement and distribution of anthropometric equipment for under 5 children (Beam Balance Scales - 150, Spring Balance Scales - 200, Height and Length measuring systems - 200, 50 packs of trousers (70 in each) for spring balance scales)

Breastfeeding Code; Work on drafting an Act of Parliament continued with the Department of Legal Draftsman. Support of international experts and UNICEF received to address bottlenecks identified in implementation of legal measures, monitoring and enforcement systems to protect breastfeeding.

School health

School Health is an important of maternal and child health programed covering 1/5 of total Sri Lankan population. SHP is a joint programme carried out with the Ministry of Education (MoE) and many other stakeholders where FHB is the focal point for Ministry of Health (MoH) and Directorate of Health and Nutrition is the focal point from MoE.

Main Achievements

- Completion of school health policy.
- Jointly prepared the activity based new health and physical education curriculum 2023 - 2030, for school grades 6 to 11.
- Completion e learning module on Parenting in Sinhala, English and Tamil medium.
- Completion of e learning module on Psychosocial wellbeing of School going adolescents in Sinhala medium.

Continued with rice-based school mid- day meal programme for 1 million school children. Per head allocation of school meal was increased to Rs.100.00 from Rs. 31.00 to combat elevated food prices

Continued supply of Fe folate supplementation to all 40.2 million school children.

Revamped school medical inspection activity following covid-19, achieving 98.1 % coverage island wide. The national SMI program covers all government schools, all semi government schools and consenting private and religious schools (including Pirivena, Madrasa and Catholic schools)

Development of e learning module for teachers on Health Promoting Schools was started. The curriculum of the module made, Script for live videos made with relevant stakeholders and finalized, actors selected, school selected and permission obtained, and 10 out of 16 explanatory video PPTs made.



Implementation of emergency nutrition plan, assessment of nutritional status of school children and triangulated with other studies to identify hot spots.

Facilitated STD/AIDS program to develop strategic plan for HIV/AIDS

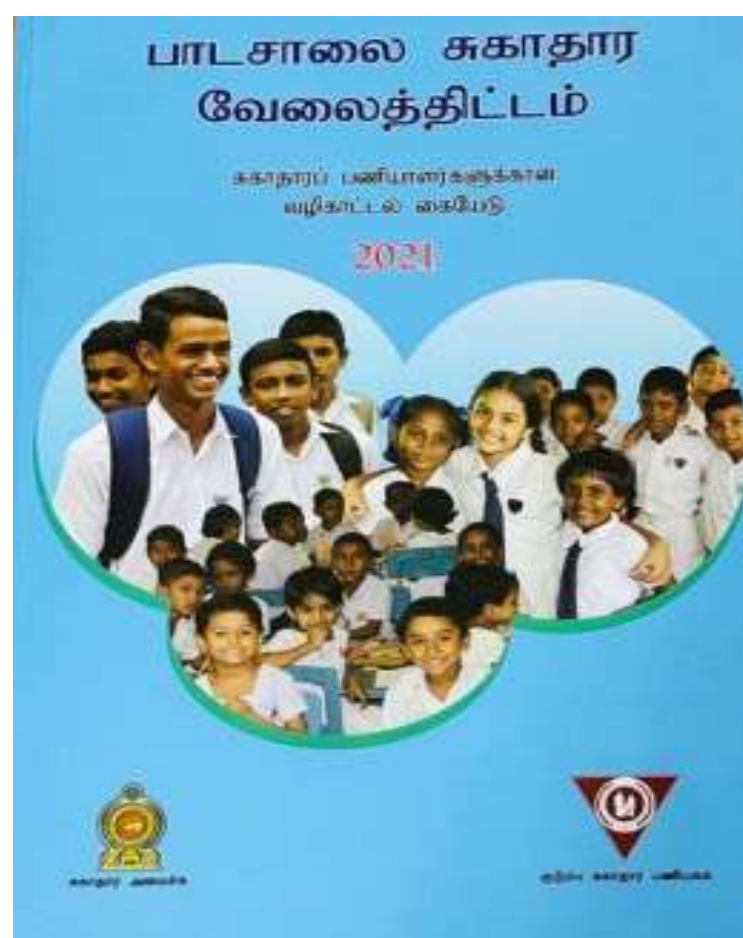
Capacity Building

- TOT on psychosocial wellbeing – Two online trainings done using newly developed LMS e module
- Training on HPS – Three teacher trainings programmes done, at Dehiovita (Kegalle) and Zonal Education Office (Gampaha), Together with Health and Nutrition branch of MOE
- TOT on Nutrition and school feeding programme together with MOE - one physical training done at Angampitiya KV.

Adoption of eight WHO standards of Health Promoting Schools into Sri Lankan context initiated; by an external expert

Updated Health guidelines to conduct ‘Team Sports events’ in Schools and handed over to Ministry of Education

Printing of the book “Parenting” in Tamil Medium



Adolescent and Youth Health Programme

The Family Health Bureau assumes the responsibility for overseeing the Adolescent and Youth Health Programme in Sri Lanka as the national-level focal point. This initiative addresses the healthcare needs of adolescents and youth aged between 10 and 24, constituting nearly one-fourth of the Sri Lankan population, with 16% falling within the 10-19 age bracket. Among them, 71% are enrolled in schools, while 29% are not. The Family Health Programme extends field health services and curative healthcare facilities to cater to this demographic.

The primary objectives of the programme are to enhance the accessibility and acceptability of healthcare services for adolescents, establish national standards and criteria for adolescent healthcare across clinics nationwide, and enhance the capacity of healthcare personnel to deliver high-quality services. The establishment of Adolescent and Youth Friendly Health Service (AYFHS) centers aims to provide quality healthcare services at the primary care level and bolster the public sector's capacity to address adolescent health concerns. It emphasizes the promotion of healthy behaviors, timely intervention in adolescent issues, and safeguarding them against health risks.

The Adolescent and Youth Friendly Health Service (AYFHS) concept was introduced in Sri Lanka in 2005. Under the “Yowun Piyasa” framework, AYFHS was restructured into three models: Hospital-based, Field-based, and Centre-based. National standards for AYFHS were revised to overcome obstacles and facilitate its implementation. These clinics and centers offer essential services in a manner that is accessible, acceptable, and equitable, ensuring privacy and confidentiality. They effectively provide a comprehensive package of services, including information dissemination, counselling, and preventive and diagnostic healthcare, with provisions for referral, follow-up, and integration with other services. As of 2022, there were 39 hospitals based Yowun Piyasa centers nationwide, with MOH offices conducting Yowun Piyasa clinics monthly.

The Youth Volunteerism model was implemented with the aim to equip adolescents and youth with knowledge regarding their health and healthy behaviors, and guide them on accessing relevant services through a youth working group engaged at the MOH level.

- Establishment and strengthening of Yowun Piyasa centers based on MOH areas

The establishment and strengthening of Yowun Piyasa centres involved setting up new healthcare facilities equipped with Information Communication Technology (ICT) infrastructure and suitable furniture. These centers aimed to enhance healthcare services and accessibility in various regions, thereby supporting the strengthening of MOH areas.

- Capacity building of direct-level trainers on AYFHS

Capacity building involved ensuring that healthcare staff, non-health staff, and youth leaders were adequately trained to provide efficient, effective, and high-quality services. Three hundred and forty health care staff, non-health staff, and youth leaders were trained to improve their competencies following the training sessions held during the year 2022. Training

trainer workshops for Health staff were held in MOHs Homagama, Battaramulla, Piliyandala, Boralessgamuwa, Maharagama and MOHs in Ratnapura and Trincomalee districts. This training aimed to improve their competencies in addressing the healthcare needs of adolescents and youth. Workshops and training sessions were held across different locations, including various MOHs and districts, to enhance the skills and knowledge of healthcare personnel.

• Implementation of Pilot Programmes of district model on AYFHS

The pilot programmes conducted in the Anuradhapura and Polonnaruwa districts aim to engage young individuals in the planning, monitoring, and evaluation of health services. By involving youth in decision-making processes regarding their own care and service provision, these programmes sought to improve the acceptability and effectiveness of healthcare services at Yowun Piyasa Centers. The objective was to promote adolescent and youth-friendly clinic services among the target population.

Two pilot programmes were held at Anuradhapura and Polonnaruwa under the district model where young persons are involved in the planning, monitoring and evaluation of health services and in decision-making regarding their own care, as well as in certain appropriate aspects of service provision to improve the acceptability of service provision at Yowun Piyasa Centers and for publicizing adolescent and youth friendly clinic services among young persons. This activity was supported by the World Health organization.

Parallel to the above district model, technical working group meetings were successfully carried out with the participation of district stakeholders and experts from the university of Rajarata and, managers from the National Level.

Awareness programmes and field visits in RDHS area Anuradhapura including MOHs Medawachchiya, Mihintale, Nuwaragampalatha Central, Nochchiyagama, Galnewa, Palagala and MOH Horowpathana and hospital visits to Yowun Piyasa Centers at Teaching Hospital Anuradhapura, Base Hospital Kekirawa, BH Medawachchiya and DH Thalawa while field visits to MOH areas Thamankaduwa, Hingurakgoda, Lankapura Medirigiriya at RDHS area Polonnaruwa and visiting of the Yowun Piyasa Centers at District General Hospital Polonnaruwa and Base Hospital Medirigiriya were successfully completed.

• Capacity Building of Youth Leaders

The training programmes for youth leaders aimed to empower them with the necessary knowledge and skills to advocate for youth health issues effectively. By enhancing their capacity through workshops and training sessions, youth leaders were better equipped to engage with their peers and communities on matters related to healthcare and well-being. A four-day training programme was held for the Youth leaders at the central level. Further, a hundred and thirty youth leaders were trained in one-day and two-day programmes., such programmes were held at Kantale, Colombo, etc.

• Youth-Initiated Projects

The progress in youth-initiated projects indicated the successful implementation of initiatives led by young individuals to address specific health challenges or promote healthy behaviours

within their communities. The youth project initiated by Youth Action Network was successfully implemented based on Panadura Yowun Piyasa. Functioning Youth Hub in Kanthale MOH area also implemented youth-initiated health interventions in respective area.

• Youth Working Group Formation

The initiation of youth working groups at MOH levels aimed to create platforms for collaboration between youth leaders and healthcare professionals. These groups facilitated the exchange of ideas, coordination of activities, and implementation of youth-focused health interventions. Y hub activities are ongoing at Panadura Hospital and MOH Kantale by the youth group.

• Advocacy Programmes to Law Implementing Agencies

Advocacy programmes targeted law-implementing agencies, such as the police, with the aim of raising awareness about youth health issues and fostering cooperation in addressing them. These programmes involved training sessions and workshops to equip police officers and public health staff with the knowledge and skills to support youth-friendly policies and initiatives. During the year 2022, four advocacy programmes were held mainly at Women and Children's desks, including other divisions of Sri Lanka Police in Anuradhapura, Polonnaruwa, Ratnapura and Kegalle districts covering 335 police officers. Funding support was provided by the UNFPA.

• Monitoring and Evaluation

The monitoring and evaluation process involved collecting quarterly returns from Yowun Piyasa Centers to assess the effectiveness and efficiency of Adolescent and Youth Health Services. This data collection and analysis facilitated ongoing improvements in service delivery and helped identify areas requiring further attention or intervention. Hospital-based Yowun Piyasa centers provided services to 9192 young persons in 2022.

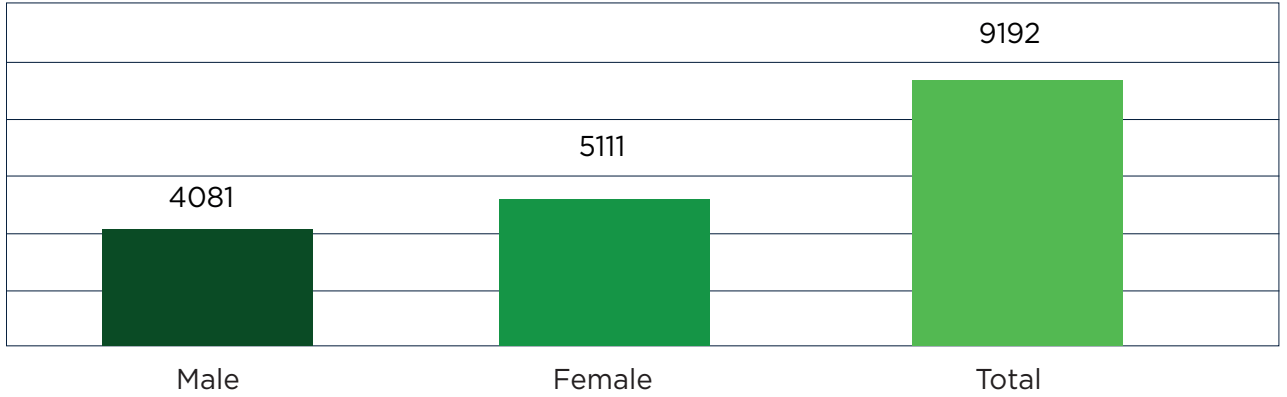


Figure 3.53: Number of attendees according to Sex in 2022

Source: FHB

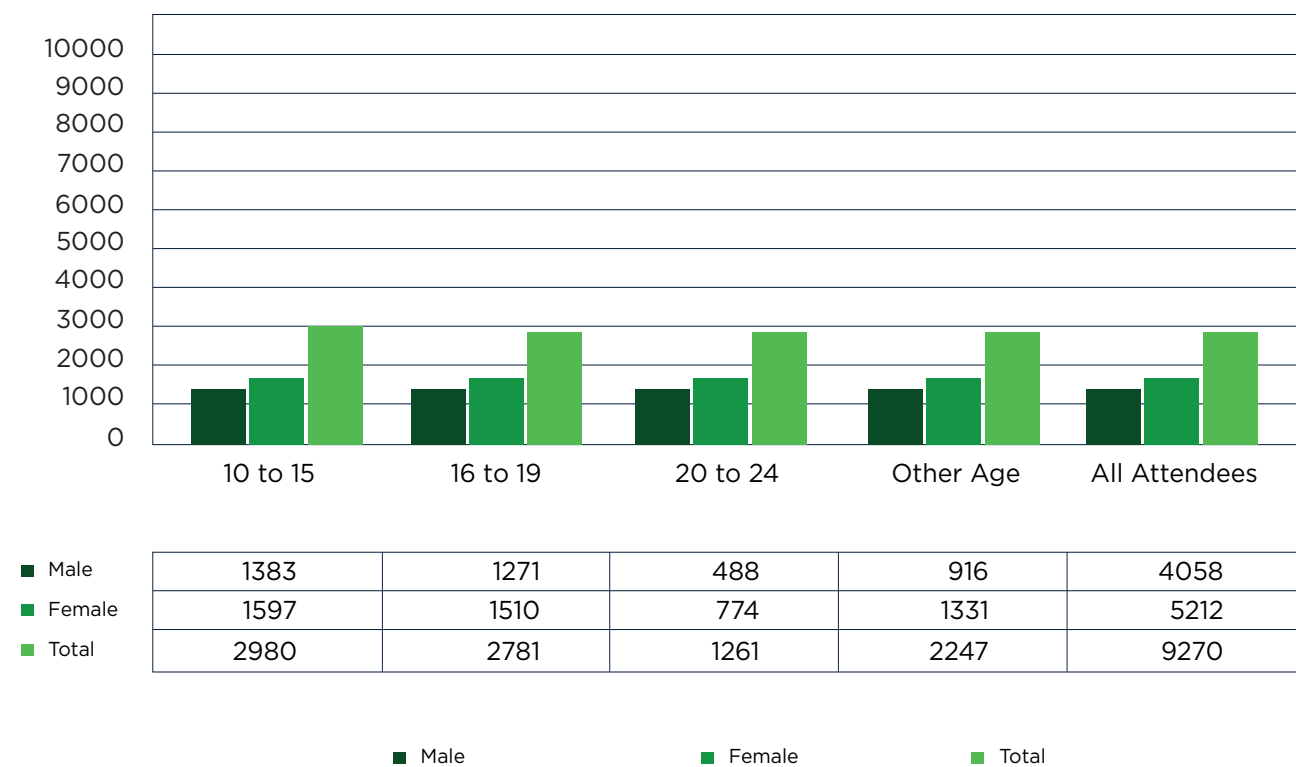


Figure 3.54: Attendees according to age groups

Source: FHB

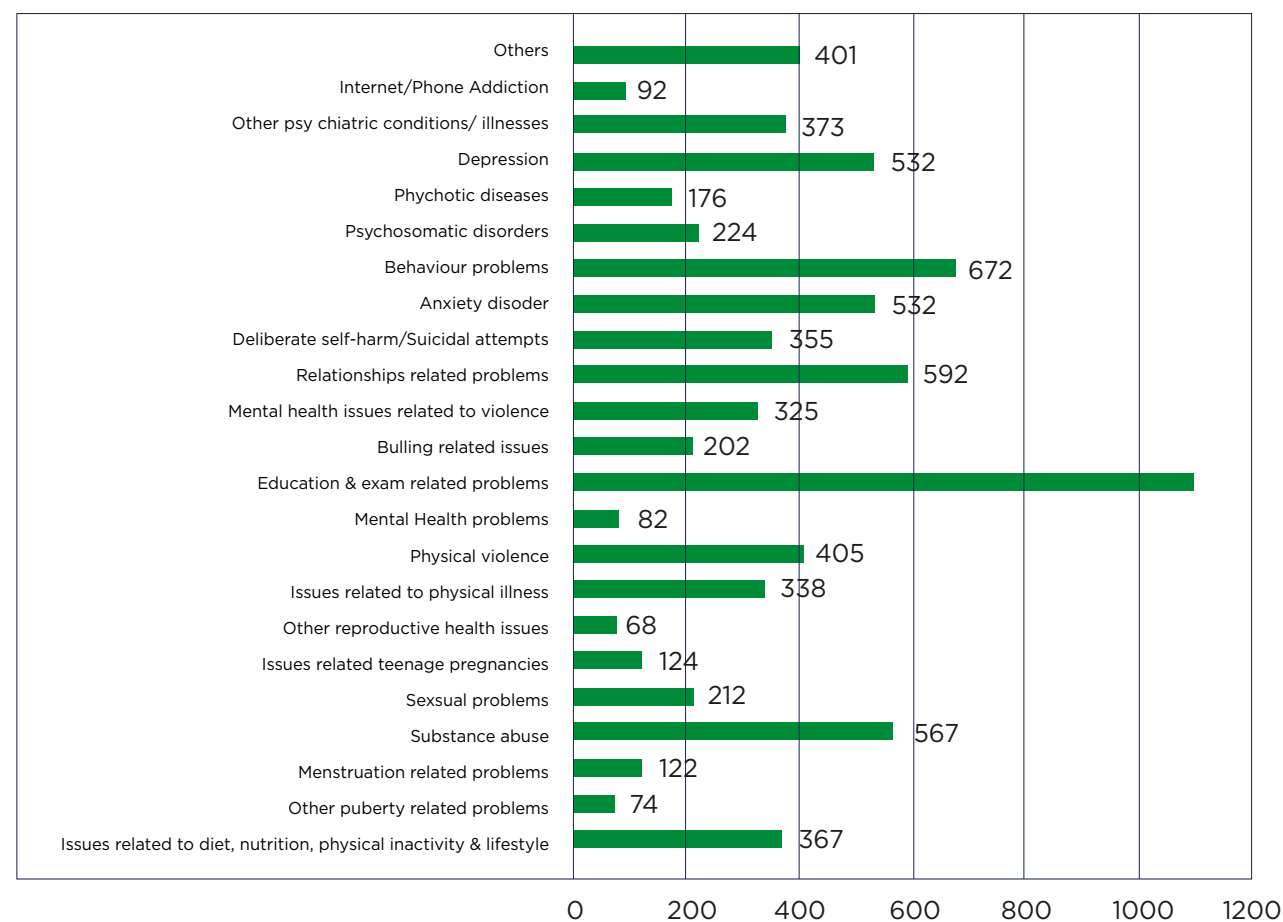


Figure 3.55: Identified problems at Yowun Piyasa in 2022

Source: FHB







Technical working group meetings were successfully carried out with the participation of district stakeholders and experts from the university of Rajarata and, managers from the National Level.



Family planning

Reproductive health is an essential component of the maternal and child health (MCH) programme in Sri Lanka. Family planning unit is the focal point for the National Family Planning Program (NFPP), and its goal is to “enable all couples in union to have a desired number of children with optimal spacing and timing whilst preventing unintended pregnancies”. Providing family planning services (including counselling) and subfertility management are major activities of the National Family Planning Programme. Family Planning services are provided through 361 MOH offices and regional hospitals

- Procurement of contraceptive commodities and equipment for family planning in 2022 was compromised due to an unforeseen economic, political and fuel crises and as a result there was a shortfall in contraceptives for the Family Planning programme. As an emergency response to a request made by the Family Health Bureau, to Family Planning Association, UNFPA and Baur & Company contraceptives were donated to bridge the contraceptive requirement gap and maintain FP services.
- The timely distribution of contraceptive supplies to the districts contributed to the 1.1% increase of the modern contraceptive prevalence rate (mCPR) from 57.7% in 2021 to 58.8 % in 2022.
- High quality equipment was procured for family planning clinics with GoSL funds and distributed to selected MOHs. Equipment procured in 2022 included Mini Autoclaves (4), medium vaginal cusco speculums (218), large vaginal cusco speculums (150), small vaginal cusco speculums (76) and uterine vulsellum forceps (192) were procured. The availability of FP equipment and FP commodities enhanced services in the FP clinics contributing to the increase in overall modern Contraceptive Prevalence Rate (mCPR).
- National Family Planning Month Activities; the ‘World Contraceptive Day’ falls on 26th of September annually. In lieu of the world contraceptive day specific FP activities are identified for the month of September. In 2022, all MOHs were asked to update the eligible family register to identify women with unmet need and also to improve service provision of Long-acting Reversible Contraceptive (LARC) methods.
- Capacity building of health staff on family planning services;
 - The Family Planning Unit conducted a 3-day workshops for Training of Trainers on Reproductive Health for 30 Medical Officers in 2022.
 - Five, 2-day workshops on Reproductive Health and Family Planning were held and 71 Public Health Nursing Sisters were trained in 2022 on family planning counselling, family planning methods, and practical training of IUD insertions on models and patients.
 - In 2022, three onsite trainings were conducted in Kandy and Badulla districts and in

Battaramulla MOH area respectively on FP services with practical training on Intra Uterine Device insertions and removals. A total of 150 service providers were trained.



- Efficient management of the contraceptive supply chain at the central level is necessary to maintain the continuity of effective FP services in the periphery. The district stores (Regional Medical Supplies Division -RMSD) are managed by Officers in Charge of respective RMSDs and it is important that they are fully capacitated on contraceptive supply chain management (i.e. forecasting, estimating, obtaining stocks, storage and issuing stocks to MOH and Hospitals) Therefore, representatives from all districts were updated and trained with regards to supply chain management and the eLMIS in the eRHMS.

- Development of IEC materials on FP and Subfertility for Health Staff and General Public; in order to update knowledge on contraceptive technology and subfertility management, the Family Planning Unit developed a set of Flash Cards for Family Planning Counselling (Sinhala) and printed a limited quantity (750) in 2022 with support from UNFPA. The flash cards were distributed among the health staff in selected MOH areas in 4 provinces (Central, Eastern, Northern and Southern).
- The Family Planning Unit pioneered in developing a mobile app on 'Contraceptive Choices' for healthcare providers and the general public in all 3 languages in 2022. This activity was supported by UNFPA's 'Promises Project'.
- A documentary video was developed by the Health Promotion Bureau with technical inputs from Family Health Bureau based on the success stories in FP services provision in the Kandy District. This video was developed in 2022 with the aim of motivating health staff and all stakeholders to provide quality FP services.



- Overseas Training; gathering knowledge and experience from regional countries is important to strengthen the FP programme in Sri Lanka. A Consultant Community Physician (CCP) from NIHS, a MO from the FP unit/FHB and 2 MOMCHs from Galle and Matara districts participated in the International Training Programme on 'Family Planning and Reproductive Health Commodity Security (FP-RHCS)' which was organized by Indian Institute of Health Management Research (IIHMR) University, Jaipur, India in collaboration with UNFPA, at the IIHMR University in Jaipur India from 22nd August to 2nd September 2022.
- Director Maternal & Child Health, the CCP/FP unit and 2 MOMCHs (Ampara and Badulla) participated in the International Conference on Family Planning (ICFP) in Thailand from 14th to 17th November 2022 (Sponsored by WHO and UNFPA).



- Supportive supervision is welcome by many of the public health staff in the districts. In 2022, supervisory visits were carried out in two low performing districts in the northern province; Kilinochchi district and Jaffna district respectively. A special discussion was held on measures to be taken by MOHs to lower the teenage pregnancies and also to improve contraceptive prevalence of methods contraceptive methods.



- Establishment of a National Subfertility Management Centre; the Family Planning Unit coordinated the establishment of first subfertility management center at Castle Street Hospital for Women at an estimated cost of Rs. 336 million is due to be completed by 2024.

Gender & women's health

Gender & Women's Health unit is the focal point of the National Gender & Women's Health Programme under the Ministry of Health. One of the key responsibilities of the unit is the effective implementation of the health sector response to Gender Based Violence (GBV) through policy formulation and advocacy, guidance and technical expertise, coordination, capacity building, mobilization of funds, and other support from GoSL and international sources, monitoring and evaluation of the programme, and conducting research. 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. Also, GBV is a well-known cross-cutting issue that negatively affects RMNYACH outcomes. Planning, implementing, monitoring and evaluating the health sector response to Gender -based Violence; Domestic violence, Sexual harassment at work place and harmful traditional practices targeting primordial, primary, secondary and tertiary prevention Health Sector Response to GBV is implemented through different strategic arms

- Planning, implementing, monitoring and evaluating the components of health sector response to Gender -based Violence including Domestic violence, Sexual harassment at work place and harmful traditional practices
- Primordial prevention of GBV by effectively responding to toxic and harmful gender stereotypes and practices at individual, domiciliary and community level through the public health staff of MOHs
- Primary prevention of GBV as one objective of the Preconception care package for newly married couples. A behavioural change and a community mobilization are targeted towards zero acceptance to GBV
- Secondary and tertiary prevention of GBV/ responding to GBV survivors through Mithuru Piyasa/ Natpu Nilaiyam; hospital based GBV care centres, and public health staff of MOHs
- Capacity building of curative and preventive health staff at basic (PHM, Nurses, Medical Undergraduates), in-service, and post-graduate (Community Medicine, Medical Administration, Family Medicine) levels on GBV. Some specific activities completed to improve the health sector response to Gender-Based Violence in 2022:
 - "Mithuru Piyasa/Natpu Nilayam" centres were newly established in DGH Polonnaruwa, and BH Kahawaththa.



- Extension of Mithuru Piyasa services to Private Sector; according to Public Private Partnership, the necessity of extension of GBV care services to the private sector was discussed at many forums and therefore, initial 4day training on Gender and GBV was given to health staff at Asiri Medical Hospital, Narahenpita and the process initiated with the necessary guidance by Family Health Bureau.



- Development of a Module on Gender and Health to be incorporated in to the Basic Nursing Curriculum; As introducing a module on Gender and Health to the Nursing Basic curriculum was recognized as an essential and timely need at the Technical Advisory Committee of Maternal and Child Health and Family Planning, initial steps were taken to introduce a module to the basic Nursing Curriculum. A Technical working team was appointed by Director Maternal and Child Health together with Director, Nursing Education for this purpose. Two consultants were assigned the task of developing the module with the concurrence of the Technical Working Team. W.H.O provided the technical and financial assistance for this task.

A two-day Training of Trainers workshop was conducted for selected number of tutors from Nursing schools covering island -wide and their opinions at the end of the workshop were helpful in finalizing teaching and learning materials as well. It was followed by an orientation workshop conducted for nursing school principals in order to sensitize them to the module and enhance the positive response.



- Capacity building of health staff for Health Sector Response to GBV survivors
 - To update and refresh the knowledge and skills on the subject, as well as to overcome the uncertainty of how to respond to a survivor of GBV in an effective manner a virtual Refresher Training programme was conducted for the service providers of “Mithuru Piyasa / Natpu Nilayam” centres.
 - Sharing of Experiences workshops for Mithuru Piyasa /Natpu Nilayam staff were conducted online in order to motivate & capacitate the staff to gain knowledge by sharing their experiences on how to face existing and emerging challenges.
 - Public Health staff in Hambanthota, Kegalle, Rathnapura, Badulla, Moneragala,Puttlam districts were trained to overcome the challenges due to the inadequacy of knowledge and skills, while conforming to the ethical and legal standards through the use of National Guideline and Standard Operating Procedures for First Contact Health Care Providers.

- Onsite supportive supervision visits to Mithuru Piyasa Centres in TH Kurunegala/ DGH Negombo/ BH Dambadeniya/ GH Kalutara/ BH Horana/ Kethumathi Maternity Hospital Panadura// NH Kandy/ TH Peradeniya/ BH Teldeniya/ CSTD Kalubowila



- Digitalization of Mithuru Piyasa centres; Laptops were provided to Mithuru Piyasa centres with the support of UNFPA as a part of digitalization of the Mithuru Piyasa centres.



Well Woman Programme

Since 1996 Sri Lanka successfully implemented the Well Woman Programme at primary healthcare level with the aim of improving the health status of women. Family Health Bureau is the focal point at the national level in the Ministry of Health for the Well Woman Programme. Well woman services are offered through a network of Well Woman Clinics. Well Woman Clinics (WWC) are mostly conducted by Medical Officers of Health (MOH) who provide screening services for hypertension, diabetes, breast, and cervical cancers (pap smears or HPV DNA). In addition, WWCs provide family planning services and health education on menstrual problems, Reproductive tract infections, and menopause. In the implementation of the Well Woman Programme, Family Health Bureau works very closely with the National Cancer Control programme, College of Pathologists of Sri Lanka and Sri Lanka College of Obstetricians and Gynaecologists.

- Capacity Building programs; during the year 2022, twenty-four health districts were visited and capacity building training programs conducted for MOOH and PHNSs. Annual refresher training program for cytoscreeners was conducted in collaboration with The Sri Lanka College of Histopathologists.

Oral Health

In accordance with the existing maternal and child health programme of the Family Health Bureau, the Oral Health unit provides oral health care to the public. These services mainly cater for pregnant mothers and preschool and school children. In this programme, eligible women and pregnant mothers are referred to dental clinics, where they are screened for oral diseases and treated for identified ones. School dental services provide preventive dental services for school and preschool children between the ages of 3 and 13 and provide treatment for their oral diseases.

As the national coordinator of these programmes, the oral health unit conducted the following activities during 2022.

- In the second quarter of 2022, the Family Health Bureau conducted a two-day orientation program for the newly graduated batch of School Dental Therapists. This mainly aimed to adapt them to the service, educate them on their job and the national targets of the school dental service and make them aware of the functions of the family health bureau. Twenty-four participants participated in the webinar, with Community Dentistry Consultants, Regional Dental Surgeons, and School Dental Therapists serving as resource persons.
- For the first time, the eRHMS system was used to conduct the annual review of school

dental services in 2020. Likewise, the 'Annual Review of School Dental Services-2021' was also conducted in the second quarter of 2022 using data from eRHMS. As a result of the COVID-19-related school closure, the review for the year 2021 was delayed. Both national reviews were conducted virtually, with representatives from every district of the country participating.

- Midyear Provincial Review Meetings were held virtually in the fourth quarter of 2022. It helps to identify the drawbacks of school dental service at the regional level across all nine provinces. Expect to find solutions for these by discussing them with relevant stakeholders.
- With PSSP funds worth Rs. 3.4 million, 21 micromotors were purchased to enhance the performance of School Dental Services. School Dental clinics across the island received these instruments based on a need assessment. Ten autoclaves were purchased and distributed to selected School Dental Clinics to strengthen the sterilisation process.

Planning and Development

The Planning and development unit is responsible for the planning and development activities of RMNCAYH at Family Health Bureau and family health programme. Scope of work include policy, advocacy, strategic planning for RMNCAYH program in general, coordination of implementation planning at national and peripheral level, human resources and capacity development activities and coordination, monitor implementation and coordinate achievement of SDGs of special donor funded projects, disaster preparedness and response coordination activities with regard to reproductive and child health in emergencies and assistance in general management and logistics management.

- Periodic highest-level policy making and decision-making meetings were organized to discuss family health related problems and issues. Multiple meetings were organized and coordinated with different stakeholders to continue services through the economic down turn.
- Developed and followed up the emergency action plan to sustain through the economic downturn
- Review meetings were conducted on annual action plans and periodic reporting was made to all levels regularly throughout 2022.
- Unit coordinated participation at multiple different global and local platforms. Organization, coordination of the MOH training, medical student clerkship programme and the post graduate trainee programmes within the Family Health Bureau

- World Health Organization Country survey on implementation of recommendations of antenatal care, intra-partum care, maternal and newborn care, birth defect prevention & management at national and sub-national level.

- Training programme on creating a policy dialogue for central level programme managers - a pilot programme following the WHO training programme

- Workshops - Cash management for household of public health staff workshop in collaboration of Directorate and Estate and Urban health. This was conducted in both Sinhala and Tamil language for all the public health staff in Sri Lanka

- WHO master trainer programme to expand national training pool of programme planning and adapted the training programme to national context.

- WHO supported second round of RMNCAHY policy survey to Established a RMNCAH database and a document repository as a central source for global and regional RMNCAH data and generating a country profile.

- Preparation of draft version of SPHM and PHNS duty lists in view of Job description formation following consultative meetings with the participants from national, provincial, district and divisional level by obtaining issues, suggestions and recommendations to the present duty list.

- Development of continuity plan for FHB during economic crisis to ready the prioritization plan to survive in the economic crisis.

- Preparation of new PHM area demarcation guideline

Monitoring & Evaluation

- MOMCH Review workshop -

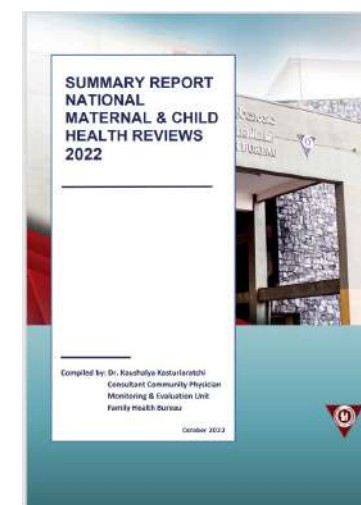
To review the progress of the district MCH activities, a two-day workshop was held in Negombo with the participation of all Medical Officers of Maternal and Child Health and Consultant Community Physicians from all 28 health districts in the country including CMC and the NIHS area. This was held in October 2022 with the participation of the Director General Health Services and the Deputy Director General of Health Services II



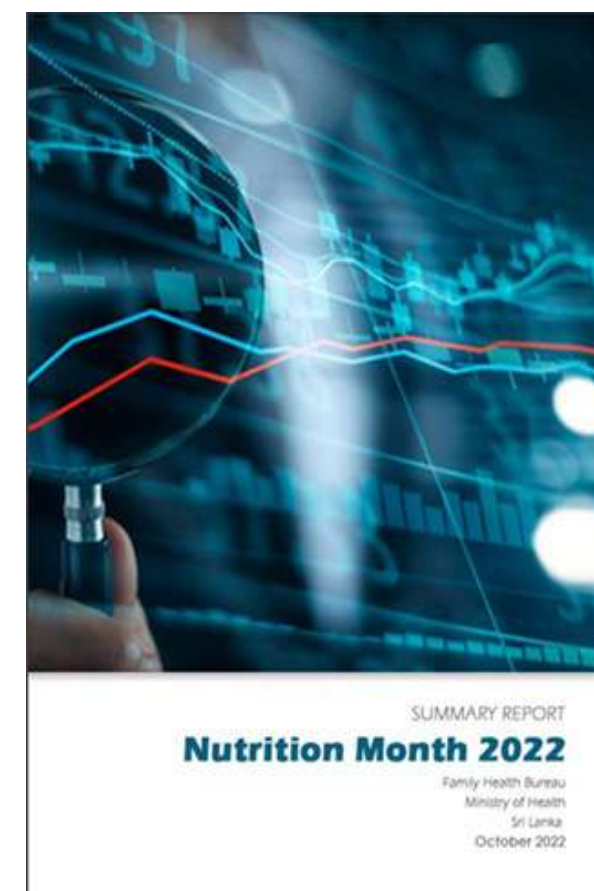
- RSPHNO workshop – an online two-day programme was done in November 2022 to further strengthen the district level supervision activities
- Survey Statistical Offices/PPO/DA training – one day virtual review meeting for all district PPOs/DAs handling data at district level and MOH level was held in October 2022. They were

being trained to manage a district and MOH level training databases and to manage the online information systems.

- National MCH Reviews of all 28 districts including CMC and NIHS were conducted virtually and a report based on the issues identified was prepared and handed over to the Director General of Health Services for necessary actions



- With the economic crisis situation in the country, nutrition issues were risen in all parts of Sri Lanka which need to be assessed properly for necessary interventions. Nutrition month activities were held in October 2022 and data were analyzed and presented to health ministry officials and the media as a dash board. Data were analyzed in details and a report was published. Both available in the FHB official website <https://fhb.health.gov.lk/index.php/en/>



- Routinely collected information on nutrition status of pregnant women and under 5 years old children were visualized in dashboards developed and public can access for the data in FHB website <https://fhb.health.gov.lk/index.php/en/>



- To closely monitor the under 5 years old children with severe acute malnutrition in the country, a mobile application was developed and introduced for the Public Health Midwives in the country. This is the first such attempt to collect information digitally using an android app from PHMs island wide.



- Annually, FHB spends considerable amount of funds for capacity building of field healthcare providers. To streamline the trainings and to identify the training needs. An online system was developed and introduced for all districts which need to be updated annually.



- Several field visits were conducted in 2022 for selected districts including Rathnapura, Kilinochchi and Mullaitivu with the participation of Consultants from the FHB. Recommendations for the issues identified were provided in reports

Public Health Staff Training Database - National Level													
File Edit View Insert Format Data Tools Extensions Help													
A1	Staff Category												
	Staff Category	Total	MOH Training	eRHIMS	YCF	GMP	Family Planning	GBV	Preconception care	Health sector response to GBV	ECCD	Adolescent Health	Life Skills
1	MOH	269	185	132	128	124	172	146	137	117	140	146	155
2	% training for MOH		70.26	49.07	47.58	46.10	63.94	54.28	50.93	43.49	52.04	54.28	57.62
3	AMOH	345	185	111	120	108	162	130	111	91	117	130	124
4	% training for AMOH		54.62	32.08	34.68	31.21	46.82	37.57	32.08	26.30	33.82	37.57	35.84
5	MO MCH	28	19	24	9	9	13	12	10	9	10	11	11
6	% training for MO MCH		67.86	65.71	32.14	32.14	46.43	42.86	35.71	32.14	35.71	39.29	39.29
7	RSPHNO	29	N/A	24	26	25	26	24	24	15	25	23	16
8	% training for RSPHNO		N/A	82.76	65.66	66.21	69.66	82.76	82.76	51.72	66.21	79.31	62.07
9	SPHID	13	N/A	11	N/A	N/A	N/A	6	6	5	N/A	6	11
10	% training for SPHID		N/A	84.62	154	155	223	38.46	0.00	23.08	151	61.54	84.62
11	PHNS	281	N/A	183	154	155	223	175	126	105	151	159	136
12	% training for PHNS		N/A	65.12	58.36	55.16	79.36	62.28	44.64	37.37	53.74	56.58	48.40
13	SPHM	234	N/A	141	185	165	171	165	130	100	180	163	164
14	% training for SPHM		N/A	60.26	79.49	70.94	73.08	70.51	55.56	42.74	76.92	89.66	70.09
15	SPHI	213	N/A	104	N/A	N/A	N/A	67	16	44	N/A	103	155
16	% training for SPHI		N/A	48.83	32.46	32.46	32.46	32.46	7.51	20.68	48.36	72.77	72.77
17	PHM	5337	N/A	N/A	3250	2748	2890	2409	1690	1372	3073	2070	2561
18	% training for PHM		N/A	N/A	60.90	51.45	54.15	45.14	31.67	25.71	57.58	38.70	47.99
19	PHI	1476	N/A	N/A	N/A	N/A	N/A	205	41	132	N/A	446	778
20	% training for PHI		N/A	N/A	N/A	N/A	N/A	13.89	2.78	8.94	N/A	30.22	52.71
21	SDT	228	N/A	74	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
22	% training for SDT		N/A	32.46	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	PPO/PPA/SSO/DO	765	N/A	181	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
24	% training for PPO/PPA/SSO/DO		N/A	23.66	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	MSO/MA	215	N/A	12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
26	% training for MSO/MA		N/A	5.58	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	Other	621	N/A	7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
28	% training for Other		N/A	1.13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
29	Total	10955											

- Six eRHMS refresher trainings in Sinhala & Tamil mediums for newly recruited PHNS and SPHMS were conducted
- Orientation for newly appointed MOMCHs on RMNCAH programme was organized and conducted in March 2022
- Revision of Supervision tools and development of a training module initiated with the support of WHO which was completed in the end of the year. Trainings based on the new tool will be conducted in 2023.
- Online CME course via eBRIDGE learning management system was conducted and 60 MOHs completed the online course successfully were issued with the certificate which is accredited with 13 CME points.
- Nine refresher eRHMS trainings for PHNS and SPHMs were conducted as online trainings covering all 9 provinces
- Private sector MNH hospital data capturing through the eRHMS 2 was expanded to the Southern province after training major private sector hospitals in the province where there are deliveries happening

FINANCIAL STATEMENT

FHB is responsible for planning, coordinating, monitoring and evaluating the Reproductive, Maternal, Child, Adolescent and Youth Health [RMNCAYH] programme in Sri Lanka.

In 2022, as previous years, Family Health Bureau received funding from the treasury (GoSL budget lines), Primary Health Sector Strengthening Project and development partners. Medical Supplies Division of Ministry of Health purchased contraceptives, micronutrients for pregnant, lactating mothers and children, reagents and other logistics required for the functioning of the Family Health Programme which is not included in direct expenditure of Family Health Bureau.

The funding received by Family Health Bureau was less compared to previous years to carry out activities like printing of documents pertaining to monitoring and evaluation, guidelines, IEC material and individual client records (CHDR, pregnancy records, obstetric and neonatal records), procurement of commodities pertaining to child nutrition, procuring essential equipment for delivery of services in the hospitals and field services and for reviews and consultative meetings to maintain essential functions of the RMNCAYH programme.

Sources of funding for FHB in 2022

The following table shows the funding received from different agencies for the Family Health Programme in the year 2022 with how much of it being spent.

Source	Allocation	Expenditure	Savings/Excess	Expenditure %
Capital (GOSL)	7,031,583.88	1,079,052.41	5,952,531.47	15.35
PSSP	147,350,000.00	100,825,496.07	46,524,503.93	68.43
UNFPA	6,850,000.00	6,796,594.56	53,405.44	99.22
UNICEF	6,500,000.00	6,499,090.20	909.8	99.99
WHO	8,446,894.00	8,216,896.00	229,997.15	97.28
Total	176,178,477.88	123,417,129.24	52,761,347.79	70.05

Table 3.20: Funding received from different agencies in 2022
Source: FHB

The financial utilization was maximum with the donors' funds, although the proportion received from donors was less. The lack of expenditure observed from GOSL funds was pertaining to the poor cash flow from the capital budget lines. The above calculation does not include recurrent expenditures such as salaries, vehicle and building maintenance and bills.

In 2022, majority of the funding was from PSSP with some contributions coming from Government of Sri Lanka budget lines and donors.

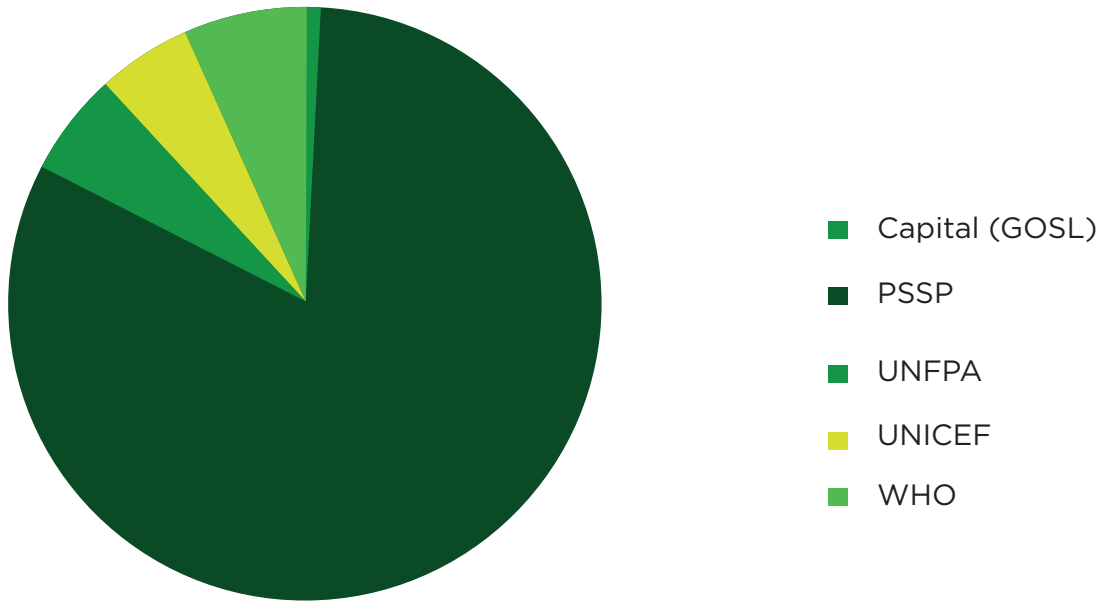


Figure 3.56: Expenditure proportions in different categories of funding in 2022

Total financial allocation as well as expenditure for Family Health Bureau reduced over the years. Despite the allocation in GOSL funds, poor cash flow resulted in less expenditure of funds.

Year	Total Expenditure in million	Total Expenditure in million
2018	550.07	406.38
2019	454.74	406.36
2020	331.56	358.41
2021	268.12	199.15
2022	176.18	123.42

Table 3.21: Allocations and expenditures 2018 to 2022

Source: FHB

The differences in total allocation and the expenditure from 2018 to 2022 are plotted in the graph. The allocated amount is indicated in rupees millions

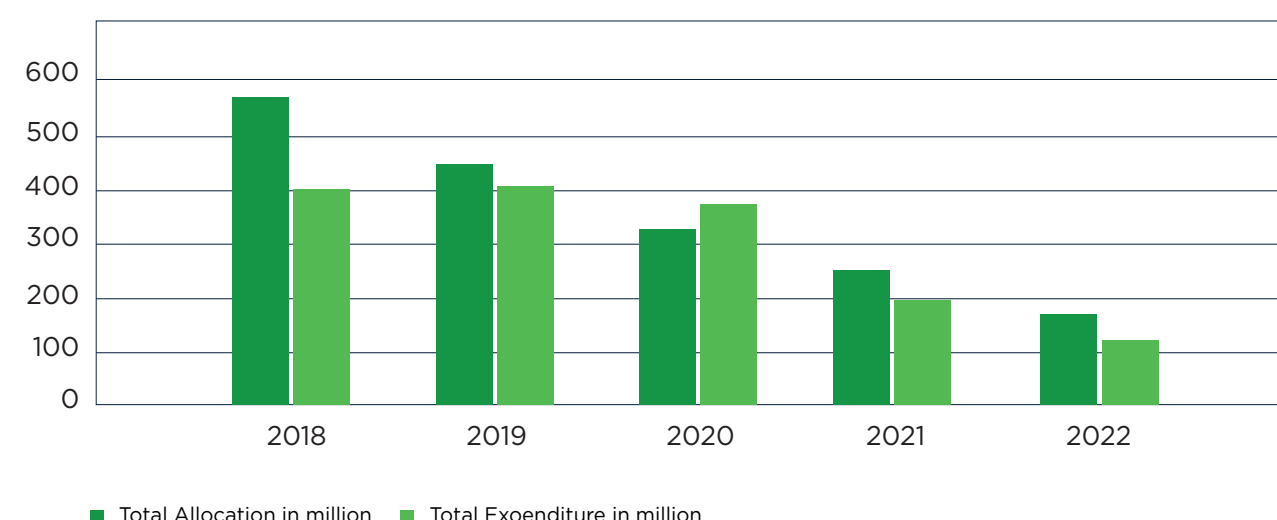


Figure 3.57: Comparison of total allocation and expenditure in millions over last 5 years

Source: FHB

It is well evident that total financial Allocation and total Expenditure were progressively reduced over the years.

Challenges faced in relation to financial issues

In 2022, global challenges with rising costs, pandemics and climate change crisis impacted the most vulnerable members of the community, namely mothers and children. The global challenges also affected Sri Lanka in addition to local threats with the impact from the COVID -19 pandemic and the economic downturn. The high inflation, lack of foreign currency and multiple measures to reduce government expenditure affected the program in variety of ways. Subsequent changing political landscape, fuel crisis, limited health finances due to austerity measures, poor cash flow and changes in human resource availability for health affected the country's response to reduce the maternal and child mortality & morbidity.

To overcome these challenges a business continuity plan was adapted and support from donor agencies were sort at the central level. Activities were prioritized and layers were identified in a pyramid with most important activities were at the apex and the activities with least impact were at the base. In addition to given layers, already planned, foreign funded activities and non-cost incurring program strengthening activities were continued. As a result, essential activities could be continued. Donor support ensured the supply chain in essential commodities in family planning and nutrition was continued despite of delays in the government routine procurement processes.

ANNEXURES

Annexure 01

Population, birth rate, eligible families, pregnant mothers, and reported number of deliveries 2022

RDHS	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	Total number of live births reported (regional)
Ampara	294553	54492.3	52781	3510	3320	5979.4	20.3	3171
Anuradhapura	965230	178567.6	183596	12475	11896	14478.5	15	11329
Badulla	904176	167272.6	160086	11177	9983	13472.2	14.9	9738
Batticaloa	601858	111343.7	117639	10905	10230	10111.2	16.8	10121
Colombo MC	604921	111910.4	76414	6198	5381	7017.1	11.6	4953
Colombo	1900004	351500.7	333100	19460	16689	22040.0	11.6	15974
Galle	1158411	214306.0	189224	13628	11909	16565.3	14.3	11502
Gampaha	2463361	455721.8	438060	28727	24373	25372.6	10.3	23512
Hambantota	684641	126658.6	120239	8718	8053	11433.5	16.7	7916
Jaffna	631218	116775.3	101456	8969	7602	8900.2	14.1	7392
Kalmunai	473483	87594.4	90196	9560	9126	9611.7	20.3	9127
Kalutara	996087	184276.1	176053	11679	10286	10757.7	10.8	9815
Kandy	1519425	281093.6	265945	18846	16853	22031.7	14.5	16015
Kegalle	905936	167598.2	148922	10327	9145	11596.0	12.8	8541
Kilinochchi	135470	25062.0	24341	2186	1823	2695.9	19.9	1689
Kurunegala	1760165	325630.5	317532	21915	19848	23058.2	13.1	19429
Mannar	116072	21473.3	23468	2369	2044	2217.0	19.1	1889
Matale	535433	99055.1	98341	6932	6445	7442.5	13.9	6315
Matara	879047	162623.7	147680	10206	9226	10724.4	12.2	8743
Moneragala	510075	94363.9	103364	7307	6762	7294.1	14.3	6454
Mullaitivu	98866	18290.2	23198	1965	1633	1057.9	10.7	1539
NIHS	309146	57192.0	54409	4412	3882	3338.8	10.8	3712
NuwaraEliya	786973	145590.0	136939	9521	8445	11332.4	14.4	8120
Polonnaruwa	453364	83872.3	90586	6103	5595	6891.1	15.2	5408
Puttalam	860799	159247.8	165492	12486	10859	13342.4	15.5	10641
Ratnapura	1200638	222118.0	212160	13261	12451	17289.2	14.4	12047
Trincomalee	450676	83375.1	88893	8219	7839	9103.7	20.2	7425
Vavuniya	196618	36374.3	32680	2954	2491	3283.5	16.7	2280
Sri Lanka	22396646	4143379.5	3972794	284015	254189	309073.7	13.8	244797

Annexure 02

Antenatal Care 2022

RDHS	Percentage of pregnant mothers registered before 8 weeks	Percentage 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 any 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 with abnormal blood sugar report before 12 weeks of POA
Ampara	89.9	3.8	33.3	1.8	98.6	46.1	99.7	99.9	98.1	98.0	4.2
Anuradhapura	80.8	5.1	33.0	2.2	99.3	38.4	99.6	99.5	99.1	93.9	3.6
Badulla	86.1	4.0	34.7	1.6	98.6	25.6	99.5	99.7	98.9	96.6	2.8
Batticaloa	83.5	6.7	37.5	2.2	99.3	29.1	99.8	99.8	99.2	96.1	4.7
Colombo MC	54.3	5.6	39.8	3.0	91.9	42.0	98.3	99.4	98.0	88.6	5.9
Colombo	72.8	2.9	40.9	1.4	96.2	34.7	98.8	99.6	98.9	94.4	4.7
Galle	84.4	3.7	35.7	1.9	98.2	32.9	99.5	99.4	98.8	95.0	4.4
Gampaha	74.9	3.1	39.4	1.6	98.7	36.1	99.2	99.7	98.8	90.8	4.8
Hambantota	87.0	3.5	31.1	2.7	99.6	36.0	99.8	99.6	99.5	97.0	5.0
Jaffna	86.9	3.4	39.0	1.2	99.4	44.7	99.7	99.5	98.8	96.9	6.0
Kalmunai	86.4	4.9	33.0	4.1	99.0	36.6	99.9	99.8	99.8	98.6	5.5
Kalutara	83.7	3.2	38.8	1.8	99.1	36.1	99.6	99.7	99.5	94.7	4.1
Kandy	80.6	2.7	34.8	2.2	98.6	32.2	99.1	99.3	93.9	94.4	3.1
Kegalle	80.9	2.6	35.0	2.0	99.2	31.3	99.3	99.4	98.5	93.6	4.1
Kilinochchi	86.7	6.8	40.1	1.9	99.5	47.6	99.6	99.7	99.4	98.4	16.0
Kurunegala	85.4	2.7	33.7	1.7	99.6	39.2	99.7	99.7	98.9	96.9	3.4
Mannar	78.2	5.0	37.1	2.8	96.3	50.2	99.7	99.8	98.0	95.5	19.4
Matale	83.9	3.3	33.7	1.9	99.8	33.2	99.9	99.8	99.8	96.4	4.2
Matara	84.7	3.3	33.4	2.3	99.6	34.7	99.9	99.9	99.7	96.7	4.2
Moneragala	87.2	3.4	30.9	2.1	99.2	32.8	99.6	99.5	99.4	96.1	2.9
Mullaitivu	79.6	5.6	40.9	1.7	98.4	51.1	99.4	99.7	99.6	94.0	25.0
NIHS	78.1	3.7	35.9	2.8	99.6	33.2	99.8	99.9	99.8	93.6	3.7
NuwaraEliya	72.4	4.7	34.4	1.9	98.3	25.5	98.5	98.8	97.4	89.8	3.4
Polonnaruwa	84.7	3.9	32.0	2.0	99.6	32.5	99.8	99.8	98.5	94.9	4.1
Puttalam	79.1	6.3	34.3	2.8	99.2	34.0	99.6	99.5	96.0	95.3	3.3
Ratnapura	79.7	3.7	34.6	1.9	99.1	37.2	99.5	99.5	99.1	93.4	3.4
Trincomalee	84.9	7.8	35.0	4.0	98.8	30.5	99.7	99.5	99.3	97.1	6.7
Vavuniya	79.0	4.4	36.0	1.6	97.7	40.5	99.1	99.1	99.2	93.9	3.2
Sri Lanka	80.8	3.9	35.7	2.1	98.7	35.0	99.4	99.6	98.5	94.8	4.5

Annexure 03

Indicators of clinic care, ante-natal screening and status of BMI among pregnant mothers in 2022

RDHS	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 reported in antenatal morbidities	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	91.0	6.7	38.7	0.34	34.5	39.9	86.8	16.0	30.4
Anuradhapura	97.2	6.8	74.1	0.25	27.6	25.3	87.0	14.6	32.6
Badulla	94.1	7.5	61.9	0.12	13.6	17.9	84.2	16.3	27.6
Batticaloa	96.0	6.9	76.6	0.35	18.0	49.1	88.0	15.2	33.5
Colombo MC	102.0	4.8	60.5	0.32	29.9	No data	70.4	11.0	42.7
Colombo	93.7	4.3	75.8	0.15	19.0	14.4	72.2	11.5	34.2
Galle	98.1	5.2	43.7	0.25	19.1	2.5	80.8	16.4	26.9
Gampaha	95.7	4.8	53.4	0.09	22.0	2.9	77.0	12.1	33.5
Hambantota	92.5	5.9	80.5	0.15	24.3	25.9	85.3	17.2	26.1
Jaffna	91.8	6.8	19.6	0.65	29.4	23.9	86.2	14.2	30.6
Kalmunai	94.2	6.3	77.9	No data	25.1	39.6	86.5	12.1	36.1
Kalutara	95.1	5.0	70.5	0.02	20.7	36.1	79.8	13.6	33.5
Kandy	92.5	5.8	39.4	0.61	18.6	14.6	81.4	13.6	31.2
Kegalle	91.1	5.7	47.3	0.16	19.8	21.0	80.0	15.3	29.6
Kilinochchi	90.3	13.6	13.6	0.06	30.2	13.2	86.0	17.5	25.9
Kurunegala	95.9	6.3	57.9	0.19	28.1	23.0	83.9	14.5	30.4
Mannar	95.3	6.5	No data	0.15	26.8	No data	86.9	15.1	34.8
Matale	94.7	6.3	100.5	0.16	21.2	33.6	87.7	14.4	32.7
Matara	110.3	5.3	49.5	0.03	21.7	23.5	85.0	17.3	26.4
Moneragala	96.0	6.2	66.2	0.21	21.2	43.9	88.1	18.2	28.1
Mullaitivu	153.9	5.8	53.9	0.12	24.9	47.7	86.7	18.4	29.3
NIHS	94.8	5.0	86.0	No data	21.7	104.2	81.2	13.9	37.4
NuwaraEliya	96.1	7.3	48.4	0.47	13.4	15.6	76.5	17.2	24.3
Polonnaruwa	99.7	6.0	62.8	0.13	21.3	65.2	85.8	15.5	35.5
Puttalam	100.3	5.6	51.2	0.29	24.0	40.2	81.6	14.1	34.7
Ratnapura	99.6	6.6	94.8	0.15	25.6	51.3	81.1	17.4	24.8
Trincomalee	108.7	6.1	25.7	0.01	18.8	19.3	88.0	14.1	38.0
Vavuniya	102.0	7.8	20.3	No data	29.7	17.9	81.9	14.6	30.6
Sri Lanka	96.9	5.9	58.8	0.21	22.3	25.3	81.9	14.6	31.4

Annexure 04

Natal Care 2022

RDHS	Total number of deliveries	Percentage of Institutional deliveries	Percentage of home deliveries	Percentage of home deliveries by untrained attendants	Home deliveries by untrained	Percentage of LSCS deliveries	Percentage of deliveries reported for estimated births
Ampara	3320	100.0	0.03			39.7	55.5
Anuradhapura	11896	99.9	0.14	0.11	13	34.1	82.2
Badulla	9983	99.7	0.29	0.11	11	38.1	74.1
Batticaloa	10230	99.9	0.13	0.11	11	33.8	101.2
Colombo MC	5381	99.9	0.07	0.06	3	38.0	76.7
Colombo	16689	99.9	0.06	0.04	7	49.6	75.7
Galle	11909	99.9	0.12	0.05	6	41.9	71.9
Gampaha	24373	99.9	0.09	0.05	13	49.7	96.1
Hambantota	8053	100.0	0.01	0.01	1	48.3	70.4
Jaffna RDHS	7602	99.9	0.09	0.08	6	37.2	85.4
Kalmunai	9126	100.0	0.02	No data	No data	45.5	94.9
Kalutara	10286	99.9	0.13	0.1	10	46.3	95.6
Kandy	16853	99.9	0.11	0.05	8	45.1	76.5
Kegalle	9145	99.9	0.12	0.11	10	49.2	78.9
Kilinochchi	1823	99.9	0.11	0.11	2	21.4	67.6
Kurunegala	19848	99.9	0.07	0.05	9	48.4	86.1
Mannar	2044	100.0	0.05	0.05	1	33.5	92.2
Matale	6445	99.9	0.14	0.12	8	45.9	86.6
Matara	9226	100.0	0.03	0.01	1	52.0	86.0
Moneragala	6762	99.9	0.07	0.04	3	39.7	92.7
Mullaitivu	1633	99.8	0.18	0.12	2	25.8	154.4
NIHS	3882	99.9	0.08	0.05	2	42.0	116.3
NuwaraEliya	8445	99.5	0.5	0.32	27	34.2	74.5
Polonnaruwa	5595	99.9	0.14	0.13	7	45.1	81.2
Puttalam	10859	99.8	0.23	0.16	17	41.7	81.4
Ratnapura	12451	99.9	0.14	0.1	12	44.3	72.0
Trincomalee	7839	99.9	0.05	0.05	4	28.1	86.1
Vavuniya	2491	99.7	0.28	0.24	6	40.1	75.9
Sri Lanka	254189	99.9	0.12	0.08	200	43.1	82.2

Annexure 05

Indicators of post-natal care, post-natal visits, Vitamin A supplementation, post-natal complications by districts 2022

RDHS	Percentage of mothers received at least 1 postpartum visit during 1 st 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 between 7 to 10.9 g/dl in 26-28 weeks of POA (before 2022)	Percentage of pregnant mothers with abnormal Hb less than 7 g/dl in 26-28 weeks of POA	Percentage of babies with low birth weight - National	Percentage of babies with low birth weight (Permanent) - Regional
Ampara	89.6	93.3	95.4	8.1	20.7	30.7	0.12	15.9	16.1
Anuradhapura	93.3	83.0	97.0	12.5	17.9	32.1	0.12	16.1	16.2
Badulla	97.0	94.0	92.5	8.0	9.2	14.0	0.13	18.2	18.5
Batticaloa	96.5	85.7	97.6	8.1	11.0	18.9	0.12	15.0	14.9
Colombo MC	71.5	43.6	84.2	7.7	21.7	28.0	0.47	13.0	13.1
Colombo	89.6	79.8	89.4	15.3	13.1	17.2	0.16	11.6	11.6
Galle	97.4	94.2	90.0	19.5	11.7	17.2	0.27	12.9	13.0
Gampaha	90.5	70.6	92.0	11.9	14.5	20.9	0.2	13.1	13.3
Hambantota	96.3	96.8	91.8	13.0	13.1	22.0	0.14	14.3	14.1
Jaffna	95.9	85.0	97.7	7.5	24.1	26.0	0.08	12.7	12.8
Kalmunai	96.5	88.1	98.6	6.4	13.9	28.2	0.08	11.3	11.3
Kalutara	93.6	91.1	93.5	14.5	12.1	17.7	0.14	14.0	13.9
Kandy	93.8	91.7	77.8	20.0	11.7	17.3	0.15	14.4	14.7
Kegalle	92.5	83.2	69.3	9.9	14.4	23.9	0.13	16.7	16.8
Kilinochchi	99.3	96.7	102.9	4.1	16.2	27.5	0.05	10.8	10.3
Kurunegala	90.6	84.6	88.4	10.9	19.1	25.7	0.25	14.1	14.4
Mannar	94.1	94.2	97.5	4.2	14.5	26.6	0.1	14.0	14.2
Matale	96.2	86.0	97.3	12.7	11.6	22.0	0.28	15.7	15.4
Matara	96.8	92.7	98.6	15.3	12.5	20.5	0.02	15.1	15.5
Moneragala	88.7	88.4	94.0	8.9	12.3	19.6	0.05	15.5	15.6
Mullaitivu	89.7	82.5	98.2	8.3	16.3	25.4	0.18	13.7	14.1
NIHS	91.8	81.7	97.0	5.8	10.6	20.6	0.06	12.7	12.9
NuwaraEliya	95.2	84.6	93.8	9.5	11.4	13.6	0.23	22.6	23.0
Polonnaruwa	96.2	93.4	97.6	8.9	13.3	22.7	0.02	15.0	15.4
Puttalam	93.5	80.7	88.5	6.0	17.6	27.3	0.1	11.7	11.9
Ratnapura	96.2	87.7	92.3	12.5	13.3	26.5	0.11	16.6	16.8
Trincomalee	93.3	88.4	98.4	6.4	10.6	17.7	0.17	16.7	16.7
Vavuniya	93.3	71.3	94.7	9.2	22.3	24.6	0.08	13.3	13.0
Sri Lanka	93.2	84.9	91.4	11.5	14.3	21.9	0.15	14.5	14.6

Annexure 06

Indicators of child care service provision: Infant registration, field visits and vitamin A supplementation 2022

RDHS	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 preschoolers at 3 years (at clinic + field)
Ampara	56.6	5.3	62.2	71.2	71.5
Anuradhapura	82.6	6.8	86.5	92.5	99.2
Badulla	74.8	10.7	85.1	92.8	95.3
Batticaloa	103.7	7.0	90.5	97.4	104.3
Colombo MC	80.4	5.4	43.4	46.0	56.5
Colombo	81.4	6.3	61.2	70.2	83.1
Galle	78.2	7.4	63.8	72.2	79.4
Gampaha	102.3	6.3	76.2	83.6	97.0
Hambantota	74.6	7.6	68.2	75.9	79.0
Jaffna	96.3	12.1	89.57	88.8	93.5
Kalmunai	95.1	6.5	84.62	88.8	100.5
Kalutara	99.8	8.2	83.8	89.2	99.4
Kandy	80.3	9.3	75	83.8	96.8
Kegalle	83.9	9.6	25.6	27.5	29.4
Kilinochchi	76.4	9.2	76.22	79.0	82.5
Kurunegala	85.3	6.5	76.7	83.9	93.8
Mannar	102.8	12.9	93.6	102.3	104.1
Matale	92.6	8.3	85.5	95.0	101.9
Matara	89.3	6.6	88.2	98.0	108.9
Moneragala	95.5	8.0	100.6	109.0	113.4
Mullaitivu	164.8	20.6	176.5	170.0	175.4
NIHS	128.3	5.6	104.43	111.9	131.7
NuwaraEliya	83.8	11.9	86.6	100.2	103.5
Polonnaruwa	84.8	6.0	84.3	95.5	96.5
Puttalam	83.4	7.0	75.4	82.3	90.5
Ratnapura	75.1	7.8	79.7	89.8	96.0
Trincomalee	86.8	6.7	84.93	88.7	94.4
Vavuniya	97.4	11.8	83.2	79.7	84.4
Sri Lanka	86.3	7.7	76.3	83.5	91.5

Annexure 07

Weighing coverage of children under 5 years 2018 - 2022 | Nutrition Month

	2018	2019	2020	2021	2022
Colombo	84.2	88.3	88.1	80.8	88
CMC	71.6	71.5	62	61.6	69.8
Gampaha	90.2	90.4	86	78.7	87.6
Kalutara	94.6	95.2	94.2	91.9	95.7
NIHS	91.7	91.8	93.3	90.4	94.1
Anuradapura	93	94.3	95.5	93.6	95.6
Polonnaruwa	98.4	98.9	99.4	98.1	99
Badulla	98.7	98.5	99.4	99.1	99.4
Monaragala	98.8	No data	No data	98.6	99.2
Galle	95.1	95.6	94.2	91.2	93.9
Matara	98.5	98.7	98.6	97.2	98.2
Hambantota	97.9	99.2	99.2	99.1	98.8
Kandy	91.9	94.8	95.6	94.8	95.6
Matale	97.9	97.8	98.8	98.2	99.3
Nuwara Eliya	95.2	96.7	98.3	97.8	99
Kegalle	97	98	96.2	95.4	97.9
Ratnapura	97.2	98.1	98.4	No data	97.1
Kurunagala	94.4	93	93.2	91.6	94.3
Puttalam	95.1	95	94.2	85.4	95.6
Ampara	99.8	100	100	100.0	100
Kalmunai	97.4	97.9	98.4	97.9	98.4
Batticaloa	96.5	96.1	95.2	96.2	98.3
Trincomalee	98.7	99.4	98.7	99.2	99.8
Jaffna	99.6	99.7	98.5	98.8	99.8
Killinochchi	99.9	99.9	99.7	71.5	100
Mullaitivu	93.8	97.2	98	96.0	98.5
Vavuniya	95.9	95.6	97.6	96.1	95.4
Mannar	97.6	99	98.9	93.4	98.3
Sri Lanka	94.3	94.8	94.4	91.6	95.1

Annexure 08

Nutritional status of infants 2018 - 2022 | Nutrition Month

	UW%					Stunting%					Wasting%				
	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022
Colombo	6.2	6.0	5.8	6.1	7.7	3.6	3.1	3.1	3.1	4.0	3.9	3.8	3.6	3.9	4.5
CMC	10.8	10.2	9.4	8.3	10.8	5.5	5.8	5.3	5.6	8.0	7.7	7.4	5.2	5.7	7.8
Gampaha	7.0	7.6	6.8	6.3	8.6	4.3	4.5	3.8	3.4	4.8	5.5	5.7	4.8	4.2	5.3
Kalutara	7.7	7.5	7.3	6.7	8.8	4.5	4.4	4.0	4.0	5.8	5.4	4.9	4.7	3.9	4.9
NIHS	8.1	8.5	7.6	7.5	10.7	4.4	4.8	4.2	4.7	5.8	5.5	6.4	6.1	4.6	5.1
Anuradapura	8.4	9.5	7.1	7.4	10.6	5.1	5.3	4.3	4.5	6.7	7.5	7.4	5.2	4.8	5.9
Polonnaruwa	8.8	9.7	7.4	7.8	9.9	5.6	5.8	4.2	5.1	6.8	6.8	7.4	5.0	5.6	6.6
Badulla	10.8	10.1	9.2	8.8	12.7	7.4	7.1	6.0	6.3	8.6	7.9	6.8	5.6	5.4	6.4
Monaragala	7.3	No data	No data	6.4	9.0	4.9	No data	No data	4.3	6.2	5.2	No data	No data	4.0	4.7
Galle	7.6	7.2	7.5	6.9	9.7	4.6	4.3	4.0	4.0	4.6	6.5	6.2	5.8	5.2	6.7
Matara	7.9	8.6	8.2	8.2	11.0	5.0	4.5	3.8	4.1	5.7	6.8	7.5	6.4	5.6	6.0
Hambantota	6.3	6.3	5.9	6.1	8.8	3.9	3.7	3.8	4.0	5.8	5.2	4.7	4.5	4.9	5.9
Kandy	8.7	9.1	8.3	8.3	11.1	6.0	5.9	5.2	5.6	7.1	6.7	6.0	4.9	4.8	5.8
Matale	8.3	8.5	7	7.4	10.8	5.5	5.6	4.7	5.1	7.2	5.6	5.0	4.4	3.9	5.6
NuwaraEliya	15.7	13.0	13.4	14.0	18.3	13.3	11.8	11.6	11.5	16.5	10.2	8.7	7.9	6.9	7.8
Kegalle	10.2	9.5	8.1	7.9	10.5	6.0	5.0	4.5	4.5	5.9	6.7	6.0	4.6	4.5	6.2
Ratnapura	9.9	9.5	8.8	No data	11.6	7.2	6.1	5.9	No data	8.3	7.3	6.3	5.7	No data	6.7
Kurunagala	7.7	8.2	7.1	7.0	9.5	5.1	5.5	5.1	4.9	6.2	7.1	6.9	5.7	5.8	6.4
Puttalam	6.7	7.4	6.1	6.2	8.5	3.7	4.1	3.5	3.6	5.1	5.9	5.8	4.5	4.7	5.9
Ampara	8.3	88	7.9	8.1	10.5	5.0	5.3	5.2	5.5	7.1	5.2	5.1	5.1	3.7	4.7
Kalmunai	5.5	5.8	5.5	5.2	7.2	3.8	4.0	4.0	4.0	4.8	4.5	3.7	3.8	3.2	4.1
Batticaloa	5.2	5.3	5.1	5.9	6.2	4.1	3.7	4.8	4.5	3.8	3.8	3.7	3.6	3.8	4.6
Trincomalee	8.3	8.8	6.5	6.7	8.5	6.1	5.5	5.2	5.6	6.8	5.2	5.6	3.6	3.5	4.7
Jaffna	7.0	7.4	6.8	6.6	8.6	4.2	4.4	4.4	3.3	4.9	5.3	5.7	5.5	6.0	6.7
Killinochchi	4.7	5.5	3.8	5.9	4.4	3.3	3.1	2.1	3.3	3.5	2.4	2.6	1.5	2.5	2.4
Mullaitivu	5.6	6.6	6.5	4.9	7.3	3.3	2.6	4.3	2.8	4.3	1.5	3.1	4.0	2.5	7.0
Vavuniya	7.3	8.2	7.1	6.1	6.8	4.3	5.8	4.7	4.5	5.6	5.4	6.1	3.6	2.4	4.7
Mannar	5.1	4.5	4.5	3.5	5.5	3.5	2.5	4.4	2.7	4.9	3.5	3.9	4.3	3.3	5.0
Sri Lanka	8.1	8.1	7.4	7.2	9.7	5.3	5.0	4.7	4.7	6.2	6.1	5.8	5.0	4.7	5.8

Annexure 09

Nutritional status of young children (1 – 2 years) 2018 – 2022| Nutrition Month

	UW%					Stunting%					Wasting%				
	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022
Colombo	8.7	8.2	7.8	6.8	8.5	5.7	5.5	5.2	4.8	5.9	5.5	5.3	4.8	4.6	5.5
CMC	12.6	12.5	10.6	10.4	11.6	9.2	7.8	8.4	8.6	10.3	9.9	8.8	6.2	6.7	8.5
Gampaha	10.7	10.7	9.2	8.3	10.9	7.5	7.6	6.2	5.6	7.4	8.5	8.6	6.8	5.8	7.4
Kalutara	11.2	11.2	9.8	8.9	11.7	7.9	8.4	7.4	6.3	8.8	8.4	7.3	6.4	5.6	6.7
NIHS	13.3	12.4	10	9.6	10.7	8.1	9.3	6.6	6.7	8.5	7.4	9.0	7.2	6.2	6.1
Anuradapura	14.8	16.6	14.1	12.2	16	9.4	10.5	9.5	8.4	10.8	11.9	11.9	9.2	7.4	9.5
Polonnaruwa	15.6	16.4	12.8	11.3	17.1	9.5	10.5	8.6	7.5	11.6	12.4	11.4	8.9	8.9	11.5
Badulla	16.6	15.7	13.7	13	17.5	14.6	14.0	11.9	11.6	14.5	11.0	10.1	8	7.6	9.8
Monaragala	12.6	No data	No data	10.5	14.2	9.9	No data	No data	8.2	11.2	9.0	No data	No data	7.5	8.6
Galle	12.2	12.6	11.1	10.1	13.2	8.7	8.4	7.9	7.1	8.1	10.2	10.0	8.5	8.1	9.6
Matara	12.1	14.1	12.7	10.4	14.6	9.4	9.5	7.7	7.1	8.7	9.8	10.0	9	7.8	9.9
Hambantota	11.4	11.8	10.3	9.5	14	7.8	6.7	7.1	6.1	8.7	10.0	9.0	7.6	7.7	10.1
Kandy	13.4	14.2	12.3	11	14.8	11.1	11.7	10.7	9.9	12.7	9.1	9.0	7.2	6.4	7.6
Matale	13.5	14.7	11.8	10.4	15.1	10.3	10.9	8.7	8.2	11.9	9.3	9.2	7.7	6.4	8.8
Nuwara Eliya	21.1	19.1	18.9	18.6	22.7	25.0	20.8	23.3	20.1	28.7	12.6	11.1	9.5	9.0	9.7
Kegalle	15.4	14.3	12	10.4	13.8	10.8	9.4	8.5	7.1	9.6	9.9	9.7	7.2	6.1	7.7
Ratnapura	15.2	14.7	13.2	No data	15.6	12.6	11.7	10.9	No data	12.6	10.3	9.5	8.5	No data	9.6
Kurunagala	13.1	13.9	12.2	10.7	13.8	8.2	9.2	9.6	8.6	10.4	11.4	12.1	9.6	8.7	10.2
Puttalam	11.6	12.5	12	9.9	13.1	8.2	8.7	8.4	7.2	9.9	9.0	9.4	8	7.1	9.2
Ampara	15.1	16.2	12.8	12.1	16.5	10.5	10.4	8.7	8.7	11.1	9.7	9.5	7.9	7.2	9.9
Kalmunai	9.1	9.7	9.3	9	11.8	8.0	7.5	7.7	7.1	10.8	5.4	6.1	5.1	5.0	6.7
Batticaloa	9.3	10.3	8.8	9.4	12	7.4	7.9	7.6	7.5	8.9	5.5	6.4	6	6.2	7.8
Trincomalee	15.8	17.0	13.9	12.4	15.7	12.2	12.2	11.1	11.3	14.7	10.1	9.9	7.5	7.2	8.2
Jaffna	12.4	12.0	10	9.1	12.2	8.9	8.6	8.2	7.0	9.5	9.1	8.4	7.6	6.8	8.0
Killinochchi	9.5	10.0	9.6	11.9	10.2	7.3	8.0	7.8	8.0	7.6	5.5	6.9	5.3	6.7	6.0
Mullaitivu	13.7	15.5	12.1	10.2	11.3	6.5	7.9	8.9	6.0	9.6	6.7	7.3	7.5	4.7	7.3
Vavuniya	13.6	16.9	13.3	11	13.6	9.9	12.2	10.0	9.1	11.8	7.5	9.7	7.8	6.2	7.7
Mannar	10.1	11.1	9.5	9.2	10.3	7.8	7.6	9.0	7.0	9.3	7.6	7.3	7.1	6.7	7.5
Sri Lanka	12.9	13.1	11.6	10.4	13.8	9.8	9.6	9.0	8.2	10.8	9.4	9.2	7.6	6.9	8.5

Annexure 10

Nutritional status of pre-school children 2018 – 2022 | Nutrition Month

	UW%					Stunting%					Wasting%				
	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022
Colombo	10.2	9.7	9.3	8.3	11.0	5.6	5.1	5.0	4.4	5.1	7.1	6.6	6.1	5.6	8.0
CMC	15	14.1	13.5	12.5	15.2	9.7	7.7	6.9	7.1	9.5	11.2	10.1	8.1	8.8	11.3
Gampaha	12.8	13.3	12.2	11.1	13.7	6.4	6.4	5.9	5.4	6.3	11.2	11.4	10	9.1	11.6
Kalutara	14.6	14.1	12.9	12.0	14.9	8.1	7.8	7.0	6.2	7.6	10.9	10.3	8.6	8.2	10.8
NIHS	13.7	14.1	12.3	12.4	14.2	8.0	7.6	6.6	6.6	7.4	9.3	10.2	7.8	8.2	8.5
Anuradapura	19.7	20.3	18.2	17.4	20.6	10.3	10.6	9.3	8.4	10.1	14.3	14.5	12	11.7	13.6
Polonnaruwa	19.8	19.6	17.3	16.2	20.7	9.6	9.5	8.8	7.8	9.1	14.8	15.5	12.9	11.6	16.0
Badulla	21.8	20.8	19.9	18.6	21.4	14.2	12.7	12.1	10.7	12.1	14.8	14.1	12.2	12.2	13.9
Monaragala	16.7	NA	NA	15.2	18.6	9.6	NA	NA	8.0	9.6	11.7	No data	No data	10.1	11.9
Galle	15.7	15.3	15.4	14.3	18.0	8.2	7.8	7.8	6.9	8.4	13.2	13.0	12.3	11.4	14.5
Matara	16.2	16.3	16.2	15.6	19.1	8.9	8.6	8.6	7.8	9.0	11.9	12.8	11.2	11.4	13.9
Hambantota	14.8	15.7	14.5	14.3	17.8	7.1	7.6	7.8	6.9	8.2	11.3	11.4	11	11.2	14.5
Kandy	17.0	17.2	15.3	14.1	18.0	11.4	11.2	10.1	9.2	11.0	11.3	10.7	8.7	7.7	9.9
Matale	18.0	17.8	16.8	14.9	19.6	10.7	10.2	9.5	8.4	10.1	11.2	11.6	11	9.9	13.7
Nuwara Eliya	26.5	23.8	23	22.4	26.0	23.4	20.5	21.2	18.5	22.6	13.3	11.9	10.7	10.8	11.8
Kegalle	19.3	18.2	16	15.5	17.4	9.4	9.0	9.0	7.0	8.5	14.4	13.3	10.3	10.4	12.3
Ratnapura	20.7	19.1	17.4	No data	19.9	12.5	10.8	10.8	No data	11.4	14.0	12.6	11.5	No data	13.2
Kurunagala	17.1	17.1	15.9	14.5	18.0	8.8	8.5	8.7	7.7	9.0	14.1	14.1	12.7	11.9	14.0
Puttalam	16.2	16.5	15.1	13.2	16.4	9.1	8.5	9.2	6.8	8.5	11.3	12.0	10.5	9.8	12.5
Ampara	19.7	20.7	18.1	16.7	20.8	10.3	10.5	8.9	8.0	9.7	13.2	13.5	12.4	12.0	14.5
Kalmunai	12.6	11.5	12.3	11.3	13.3	8.6	7.8	8.2	7.3	8.8	6.7	6.6	6.2	5.9	7.1
Batticaloa	13.9	13.5	13.4	12.7	15.3	8.1	8.0	8.5	7.4	8.4	7.3	7.6	7.1	7.1	9.9
Trincomalee	20.8	20.8	19.3	17.5	20.3	12.3	13.0	12.1	11.3	13.3	12.2	11.7	10.1	9.6	11.1
Jaffna	15.8	15.0	13.9	13.1	15.0	10.0	8.9	8.9	8.3	9.1	10.9	9.9	9.3	8.7	10.4
Killinochchi	18.4	18.0	16.3	25.3	14.3	11.0	11.3	11.3	16.2	8.0	10.1	9.0	9.8	15.0	7.9
Mullaitivu	21.3	19.5	19.3	17.7	17.9	10.9	9.6	11.1	7.8	10.5	10.5	10.3	11.6	9.7	12.7
Vavuniya	18.2	19.9	19	16.6	19.2	11.4	10.7	10.5	9.1	11.1	11.5	12.7	10.9	10.4	12.8
Mannar	15.2	13.9	13.8	13.9	15.7	8.7	8.2	9.0	8.4	9.8	9.8	8.6	9.2	8.4	9.5
Sri Lanka	16.9	16.4	15.5	14.4	17.5	9.8	9.2	9.1	8.0	9.5	11.9	11.6	10.2	9.7	12.0

Annexure 11

Children under the age of 5 years from 2018 - 2022 | Nutrition Month

	UW%					Stunting%					Wasting%				
	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022
Colombo	7.7	8.6	8.2	7.5	9.8	6.6	4.8	4.6	4.2	5.1	6.1	5.7	5.3	5.0	6.8
CMC	13.5	12.8	11.8	11.1	13.4	8.6	7.3	6.9	7.1	9.4	10.1	9.2	7	7.6	9.8
Gampaha	11.2	11.5	10.4	9.4	12.1	6.2	6.2	5.5	5.0	6.2	9.4	9.6	8.2	7.3	9.5
Kalutara	12.5	12.2	11.2	10.3	13.1	7.3	7.3	6.5	5.8	7.5	9.3	8.6	7.4	6.9	8.9
NIHS	12.5	12.6	10.9	10.9	12.9	7.3	7.4	6.1	6.3	7.3	8.2	9.2	7.4	7.1	7.4
Anuradhapura	16.5	17.4	15.3	14.5	17.8	9.1	9.6	8.4	7.7	9.6	12.5	12.6	10.1	9.5	11.4
Polonnaruwa	16.8	17.0	14.5	13.7	18.1	8.8	9.0	7.9	7.2	9.2	12.7	13.1	10.6	10.0	13.5
Badulla	18.7	17.8	16.6	15.6	19.1	13.0	11.8	10.9	10.0	12.0	12.7	11.9	10.1	10.0	11.7
Monaragala	14.1	No data	No data	12.7	16.0	8.7	No data	No data	7.3	9.3	9.9	No data	No data	8.5	10.0
Galle	13.4	13.1	12.9	12.0	15.5	7.6	7.2	7.1	6.3	7.6	11.2	11.0	10.2	9.5	12.1
Matara	13.8	14.3	14.0	13.1	16.8	8.3	7.9	7.5	6.9	8.4	10.5	11.2	9.8	9.6	11.8
Hambantota	12.6	13.1	12.0	11.8	15.5	6.6	6.7	6.9	6.2	7.8	9.9	9.6	9.1	9.3	12.1
Kandy	14.6	15.0	13.3	12.4	16.2	10.3	10.2	9.3	8.7	10.7	10.0	9.5	7.6	6.9	8.7
Matale	15.2	15.3	14.0	12.7	17.2	9.6	9.4	8.5	7.7	9.9	9.7	9.8	9.1	8.1	11.3
Nuwara Eliya	23.5	20.8	20.4	20.0	23.9	21.8	18.9	19.8	17.4	22.8	12.6	11.1	9.9	9.7	10.6
Kegalle	16.8	15.8	13.7	13.1	15.5	9.0	8.3	8.0	6.6	8.3	12.1	11.2	8.6	8.4	10.3
Ratnapura	17.5	16.3	14.9	No data	17.6	11.5	10.1	9.9	No data	11.1	12.0	10.7	9.8	No data	11.3
Kurunagala	14.5	14.6	13.4	12.3	15.6	8.1	8.0	8.2	7.4	8.7	12.1	12.2	10.7	10.1	11.9
Puttalam	13.4	13.8	12.7	11.2	14.2	7.8	7.6	7.9	6.3	8.1	9.8	10.1	8.8	8.2	10.5
Ampara	16.7	17.5	15.1	14.2	18.2	9.3	9.5	8.2	7.7	9.6	11.0	11.1	10.1	9.5	11.9
Kalmunai	10.3	9.8	10.2	9.8	11.8	7.4	6.9	7.2	6.6	8.4	5.9	5.8	5.5	5.2	6.4
Batticaloa	11.1	10.9	10.6	10.7	12.9	7.1	7.0	7.5	6.9	7.6	6.2	6.5	6.2	6.3	8.5
Trincomalee	17.1	17.4	15.6	14.4	17.2	11.0	11.2	10.5	10.2	12.4	10.3	10.0	8.2	7.9	9.4
Jaffna	13.4	12.7	11.6	11.0	13.2	8.6	7.9	7.8	7.1	8.4	9.4	8.7	8.1	7.8	9.2
Killinochchi	13.8	13.4	12.3	16.8	11.5	8.7	8.7	8.6	10.6	7.0	7.6	7.0	7.1	9.5	6.5
Mullaitivu	16.8	15.9	15.1	13.5	14.4	8.6	7.7	9.3	6.4	9.0	8.0	8.1	9.2	7.2	10.4
Vavuniya	14.9	16.7	15.4	13.3	15.5	9.6	9.9	9.2	8.2	10.1	9.4	10.7	8.8	8.0	10.1
Mannar	12.2	11.3	11.0	10.7	12.6	7.5	6.9	8.0	6.9	8.8	8.1	7.4	7.7	7.0	8.2
Sri Lanka	14.3	14.0	13.1	12.2	15.3	8.9	8.4	8.2	7.4	9.2	10.2	9.9	8.6	8.2	10.1

Annexure 12

Nutritional status of infants and children (e RHMS) 2022

RDHS	Percentage of babies with low birth weight (Permanent) - Regional	Percentage of babies with low birth weight - National	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 (1-2 years)	Percentage of severely underweight (<-3SD) young children (1-2 years)	Percentage of moderately underweight (-2SD to -3SD) preschoolers (2-5 years)	Percentage of severely underweight (<-3SD) preschoolers (2-5 years)
Ampara	16.1	15.9	96.8	92.2	98.4	6.6	1.7	12.2	2.1	19.8	3.4
Anuradhapura	16.2	16.1	76.1	68.7	72.8	5.7	1.2	12.2	2.0	18.5	2.9
Badulla	18.5	18.2	90.3	82.6	88.2	7.2	1.9	12.7	2.6	19.2	3.7
Batticaloa	14.9	15.0	94.5	89.1	72.3	4.4	0.99	8.7	2.1	16.9	3.6
Colombo MC	13.1	13.0	51.1	40.8	37.7	6.6	1.7	9.3	1.8	12.9	2.4
Colombo	11.6	11.6	75.4	66.7	54.9	4.1	0.81	7.0	1.0	9.5	1.6
Galle	13.0	12.9	78.8	69.8	66.3	5.2	0.99	10.3	1.5	15.1	2.6
Gampaha	13.3	13.1	74.4	58.9	51.2	3.9	0.66	9.0	1.3	11.9	2.0
Hambantota	14.1	14.3	88.0	84.7	75.3	5.4	1.0	10.2	1.5	17.6	2.7
Jaffna	12.8	12.7	94.0	89.2	64.7	5.8	1.1	9.4	1.1	21.9	2.8
Kalmunai	11.3	11.3	91.3	87.4	63.9	4.0	0.94	8.2	1.6	14.3	2.5
Kalutara	13.9	14.0	84.8	71.5	65.9	4.3	0.82	9.3	1.1	12.8	2.0
Kandy	14.7	14.4	86.4	78.7	73.6	6.0	1.5	10.9	1.8	15.8	2.8
Kegalle	16.8	16.7	78.1	71.0	70.1	6.2	1.4	10.6	1.5	16.1	2.6
Kilinochchi	10.3	10.8	86.7	84.1	71.6	3.7	0.92	9.5	1.0	24.1	3.2
Kurunegala	14.4	14.1	83.5	58.0	78.4	5.3	1.1	10.4	1.7	14.1	2.4
Mannar	14.2	14.0	90.6	84.5	96.8	3.6	0.81	7.4	1.3	13.5	2.2
Matale	15.4	15.7	87.8	82.3	77.9	5.9	1.5	10.2	1.9	17.6	3.0
Matara	15.5	15.1	83.2	69.4	67.3	6.2	1.3	11.5	1.6	17.3	2.5
Moneragala	15.6	15.5	91.7	86.6	78.7	5.2	1.1	10.7	1.4	19.1	2.7
Mullaitivu	14.1	13.7	88.6	78.7	87.0	4.2	0.95	9.2	1.2	16.9	2.5
NIHS	12.9	12.7	74.4	60.5	58.0	4.8	0.96	8.7	1.3	12.7	1.8
NuwaraEliya	23.0	22.6	81.0	78.7	93.5	10.9	3.3	16.1	4.3	21.1	4.6
Polonnaruwa	15.4	15.0	86.0	79.5	78.8	6.1	1.3	11.8	1.9	19.9	3.2
Puttalam	11.9	11.7	83.1	74.6	68.6	5.0	0.99	10.3	1.8	14.8	2.6
Ratnapura	16.8	16.6	82.9	75.1	76.2	6.5	1.5	11.8	1.9	17.8	3.0
Trincomalee	16.7	16.7	94.1	87.4	80.3	5.0	1.3	10.6	2.2	19.6	3.6
Vavuniya	13.0	13.3	87.4	75.7	73.2	4.8	0.99	10.2	1.8	18.2	3.1
Sri Lanka	14.6	14.5	83.0	73.0	70.6	5.5	1.2	10.4	1.8	16.3	2.8

Annexure 13

Family Planning Performance 2022

RDHS	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	71.8	4.5	76.3	1.8	3.3	7488.0	0.05
Anuradhapura	67.6	7.6	75.2	3.9	2.9	24220.8	0.13
Badulla	69.8	5.0	74.8	3.9	2.6	22526.2	0.08
Batticaloa	50.6	6.9	57.5	5.0	2.4	34019.0	0.17
Colombo MC	59.1	11.9	71.0	9.7	2.3	9150.6	2.2
Colombo	54.9	11.2	66.2	6.5	4.8	62869.8	0.03
Galle	59.4	9.3	68.7	5.7	3.8	32462.4	0.08
Gampaha	52.0	12.6	64.6	8.0	4.6	81657.7	0.03
Hambantota	62.2	6.8	69.0	5.1	4.5	19765.8	0.1
Jaffna	54.2	7.7	62.0	2.7	4.2	25850.5	0.04
Kalmunai	51.4	10.3	61.7	4.5	3.6	20649.1	0.04
Kalutara	56.9	9.8	66.7	4.8	4.7	34163.6	0.06
Kandy	59.4	8.8	68.1	5.8	2.9	48916.0	0.11
Kegalle	59.8	9.3	69.1	5.9	3.3	25304.5	0.05
Kilinochchi	65.7	3.6	69.3	1.8	2.9	4907.2	0.05
Kurunegala	59.4	9.3	68.7	5.1	3.6	56798.1	0.06
Mannar	55.3	13.6	68.9	5.0	2.9	3929.9	0.04
Matale	62.5	7.1	69.6	4.6	3.2	17670.9	0.06
Matara	62.7	8.3	71.0	6.2	4.1	20840.5	0.06
Moneragala	66.4	6.4	72.8	3.6	3.8	15542.3	0.08
Mullaitivu	66.5	4.8	71.4	2.6	1.9	4401.9	0.12
NIHS	54.9	11.2	66.1	6.2	4.5	9727.4	0.04
NuwaraEliya	69.6	5.5	75.1	6.3	2.1	15885.5	0.04
Polonnaruwa	67.2	6.8	74.0	3.1	3.8	13189.6	0.06
Puttalam	59.3	10.3	69.6	5.9	2.6	27920.9	0.03
Ratnapura	59.6	10.7	70.2	6.1	3.5	34036.7	0.06
Trincomalee	56.8	8.2	65.0	3.6	2.1	20526.9	0.03
Vavuniya	55.6	12.7	68.3	7.9	1.5	5383.5	0.03
Sri Lanka	59.4	9.1	68.5	5.5	3.6	699805.3	0.1

Annexure 14

Family Planning Performance 2022

RDHS	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	7.7	27.8	8.4	10.2	5.0	12.8	0.01
Anuradhapura	10.8	22.6	10.5	7.6	6.8	9.3	0.01
Badulla	7.5	15.2	13.0	10.3	6.3	17.5	0.01
Batticaloa	5.5	23.0	2.7	3.5	7.1	8.8	0.0
Colombo MC	5.3	8.7	7.6	12.8	15.3	9.4	0.01
Colombo	7.2	6.3	11.2	7.0	14.7	8.5	0.02
Galle	10.1	11.2	10.9	5.1	11.7	10.4	0.01
Gampaha	8.5	8.0	9.2	4.9	12.5	8.9	0.01
Hambantota	9.3	11.2	15.6	5.5	10.1	10.6	0.01
Jaffna	5.8	8.7	4.1	4.9	11.2	19.5	0.03
Kalmunai	6.0	15.8	3.6	3.4	11.3	11.4	0.0
Kalutara	7.2	9.3	10.6	5.6	12.4	11.8	0.03
Kandy	8.7	9.9	8.2	7.5	13.1	12.0	0.02
Kegalle	9.7	14.6	7.9	6.6	9.1	11.9	0.01
Kilinochchi	4.1	16.3	12.4	9.0	6.2	17.7	0.01
Kurunegala	8.8	12.1	12.8	5.7	11.7	8.4	0.01
Mannar	6.2	13.7	3.1	5.3	9.9	17.1	0.02
Matale	10.4	13.3	10.8	5.5	10.3	12.3	0.0
Matara	10.3	11.4	11.2	6.8	13.1	9.9	0.03
Moneragala	8.3	18.3	15.7	6.9	6.4	10.8	0.01
Mullaitivu	7.5	16.9	5.8	17.0	4.7	14.6	0.03
NIHS	7.5	7.6	7.5	5.1	13.9	13.4	0.01
NuwaraEliya	7.0	12.0	8.3	11.7	5.4	25.2	0.02
Polonnaruwa	10.5	25.1	9.3	7.3	5.9	9.1	0.01
Puttalam	9.2	16.1	7.0	8.0	8.1	10.9	0.0
Ratnapura	10.0	13.8	9.0	5.6	9.2	12.0	0.01
Trincomalee	5.7	24.9	2.0	7.0	8.3	8.9	0.0
Vavuniya	7.2	13.7	2.3	7.0	7.5	17.9	0.04
Sri Lanka	8.4	13.0	9.5	6.7	10.5	11.4	0.01

Annexure 15

Infant & Child mortality 2022

RDHS	Early neonatal mortality rate (regional)	Early neonatal mortality rate (national)	Neonatal mortality rate (regional)	Neonatal mortality rate (national)	Infant mortality rate (regional)	Infant mortality rate (national)	Under 5 Child Mortality Rate (regional)	Under 5 Child Mortality Rate (national)	Still birth rate - Regional	Still birth rate (National)
Ampara	6.6	6.3	9.8	9.3	14.5	13.8	17.0	16.2	7.2	6.8
Anuradhapura	5.9	5.5	7.2	6.7	11.4	10.6	13.7	12.7	6.3	5.9
Badulla	6.0	5.5	8.9	8.3	13.5	12.5	15.2	14.1	6.1	5.7
Batticaloa	3.8	3.8	4.9	4.9	9.5	9.5	11.3	11.3	7.3	7.3
Colombo MC	4.6	4.6	6.9	6.7	9.7	9.5	13.1	12.9	6.4	6.3
Colombo	5.6	5.5	7.8	7.5	10.3	10.0	11.3	11.0	4.3	4.2
Galle	4.9	4.5	6.5	6.0	9.2	8.5	11.1	10.3	6.7	6.2
Gampaha	5.7	5.5	7.8	7.5	10.1	9.6	11.3	10.8	5.6	5.3
Hambantota	5.2	4.9	6.7	6.3	10.0	9.4	10.9	10.3	4.4	4.2
Jaffna	4.3	4.1	6.2	5.9	11.1	10.6	14.6	13.9	6.3	6.0
Kalmunai	5.7	5.7	7.5	7.4	10.6	10.6	13.1	13.1	6.9	6.8
Kalutara	6.3	6.0	7.8	7.5	9.9	9.4	12.4	11.8	7.2	6.8
Kandy	5.2	4.8	7.4	6.8	10.8	10.0	13.1	12.1	8.4	7.7
Kegalle	4.1	3.8	5.9	5.4	8.7	7.9	10.5	9.6	6.2	5.6
Kilinochchi	8.9	8.0	9.5	8.5	14.2	12.8	18.4	16.5	9.4	8.4
Kurunegala	5.9	5.7	7.9	7.7	10.6	10.3	13.0	12.6	7.0	6.8
Mannar	4.2	3.9	5.8	5.4	11.1	10.4	13.2	12.3	6.3	5.9
Matale	4.8	4.7	6.3	6.3	9.5	9.4	11.1	11.0	6.6	6.6
Matara	4.5	4.1	5.9	5.5	9.2	8.5	11.0	10.2	5.5	5.1
Moneragala	4.2	4.0	5.6	5.3	10.1	9.6	11.9	11.4	5.7	5.5
Mullaitivu	6.5	6.1	6.5	6.1	9.1	8.6	11.7	11.0	12.8	12.1
NIHS	8.6	8.2	11.3	10.7	14.0	13.3	16.4	15.6	5.6	5.3
NuwaraEliya	5.7	5.2	9.2	8.5	14.4	13.2	17.0	15.6	8.4	7.7
Polonnaruwa	5.2	4.8	7.4	6.9	10.4	9.7	13.1	12.3	7.5	7.0
Puttalam	5.9	5.6	9.3	8.7	11.8	11.1	13.2	12.3	7.2	6.7
Ratnapura	4.6	4.3	6.6	6.2	9.4	8.8	11.2	10.5	5.8	5.4
Trincomalee	4.6	4.4	6.9	6.6	11.6	11.2	14.8	14.3	8.7	8.4
Vavuniya	9.2	8.4	10.5	9.6	14.5	13.1	18.4	16.7	7.0	6.3
Sri Lanka	5.4	5.1	7.4	7.0	10.7	10.1	12.7	12.1	6.6	6.2

Annexure 16

Well Woman Clinic performance 2022

RDHS	Percentage of 35 year age cohort attendance to WWC out of 0.8% of estimated population	Percentage of 35 year age cohort coverage who had undergone Papsmear screening out of 0.8% 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	75.6	73.1	2.4	1723	61	32	138	136
Anuradhapura	55.0	50.8	4.5	3920	88	153	536	441
Badulla	68.3	65.3	2.4	4720	214	113	577	490
Batticaloa	46.4	45.8	3.9	2204	20	27	279	101
Colombo MC	11.9	11.8	8.2	569	37	30	148	31
Colombo	53.0	41.9	3.9	6363	385	547	641	664
Galle	44.4	41.7	2.4	3862	203	309	307	284
Gampaha	46.8	39.1	2.4	7705	319	349	487	745
Hambantota	69.4	64.2	3.5	3518	76	306	356	354
Jaffna	29.6	25.6	6.1	1292	194	30	174	82
Kalmunai	68.1	66.5	9.4	2518	43	2	135	64
Kalutara	60.5	56.4	0.86	4492	161	303	142	369
Kandy	74.1	65.6	1.5	7975	216	280	1097	607
Kegalle	66.9	62.6	4.8	4534	146	145	279	256
Kilinochchi	23.0	20.9	4.9	227	52	3	42	31
Kurunegala	57.7	53.5	6.6	7532	225	196	494	687
Mannar	51.5	48.5	6.8	450	80	22	100	38
Matale	83.0	75.8	7.2	3249	202	44	495	242
Matara	54.0	50.7	1.1	3567	127	76	283	240
Moneragala	79.4	75.8	5.7	3095	102	90	110	271
Mullaitivu	54.7	51.0	9.0	403	85	12	8	8
NIHS	64.1	52.4	1.0	1295	167	119	177	215
NuwaraEliya	60.1	57.5	1.6	3623	402	88	218	318
Polonnaruwa	64.2	59.8	3.8	2170	116	147	157	311
Puttalam	40.1	38.9	0.46	2681	79	82	216	124
Ratnapura	48.8	46.4	0.54	4457	55	225	1062	473
Trincomalee	50.3	49.4	1.1	1782	8	17	130	119
Vavuniya	19.6	17.0	No data	268	10	15	49	28
Sri Lanka	55.2	50.3	3.3	90194	3873	3762	8837	7729

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