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FAMILY HEALTH BUREAU
MINISTRY OF HEALTH - SRI LANKA

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CONTENT

Message from the Director MCH 05

Acknowledgement 07

Who we are 09
Where we are in the health system 11
Implementation of National RMNCAYH Programme 12
What we do 17

Strategic directions 19

National programme performances 23
Data Sources for Performance 23
RMNCAYH Indicators 28
Preconception care for Newly Married Couples 30
Maternal and newborn health 32
Infant and child health 44
Adolescents and youth health including school health 50
Family planning 53
Gender and Women's Health including well woman programme 57
Oral Health of Pregnant Women and School Children 65

Maternal death surveillance and response (MDSR) system 68

Analysis of Under Five Child Deaths 2024 75

Special activities carried out during 2024 87

Maternal and new-born care 89
Child health - Child Nutrition 92
Child Health - Childcare, Development and Special needs 95
Child Health - School health 98
Adolescent and youth health 104
Family planning 113
Well woman programme 120
Oral Health of Pregnant Women and School Children 122
Planning and Development 127
Monitoring and Evaluation 130
Research Unit 141

Financial statement 143

Annexures 149

MESSAGE FROM
THE DIRECTOR MCH



Family Health Bureau, Ministry of Health is pleased to present the 34th Annual Report for the year 2024. This report provides a description of the progress made in Reproductive, Maternal, Newborn, Child, Adolescent and Youth Health (RMNCAYH) programme, including some details on the special activities National RMNCAYH status in 2024, 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 the challenging period of economic crisis.

Dr. Chandima Siritunga
Director Maternal and Child Health
Family Heath Bureau
Ministry of Health

ACKNOWLEDGEMENT



With the objective of providing feedback to all relevant stakeholders on effectiveness, strengths and challenges of RMNCAYH programme, this 34th 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 2024. 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 RMNAYCH programme in Sri Lanka is thankful to all relevant directorates in the Ministry of Health for the support extended to strengthen the national RMNAYCH 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, Perinatal Society of Sri Lanka, Sri Lanka Medical Nutrition Association and Sri Lanka College of Nutrition Physicians for providing valuable technical inputs and involving themselves actively in the National programme during 2024.

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

I am extremely thankful to Dr. Chandima Siritunga, 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 Mr. Lahiru Fernando. I greatly appreciate their contributions.

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
Monitoring and Evaluation Unit
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Ministry of Health

NATIONAL RMNCAYH PROGRAMME

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 comprehensive MCH and FP services, the Family Health Bureau [FHB] was established in 1968 within the Ministry of Health to implement the programme uniformly island wide. This institution was initially named as the Maternal and Child Health Bureau and 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 comes 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)

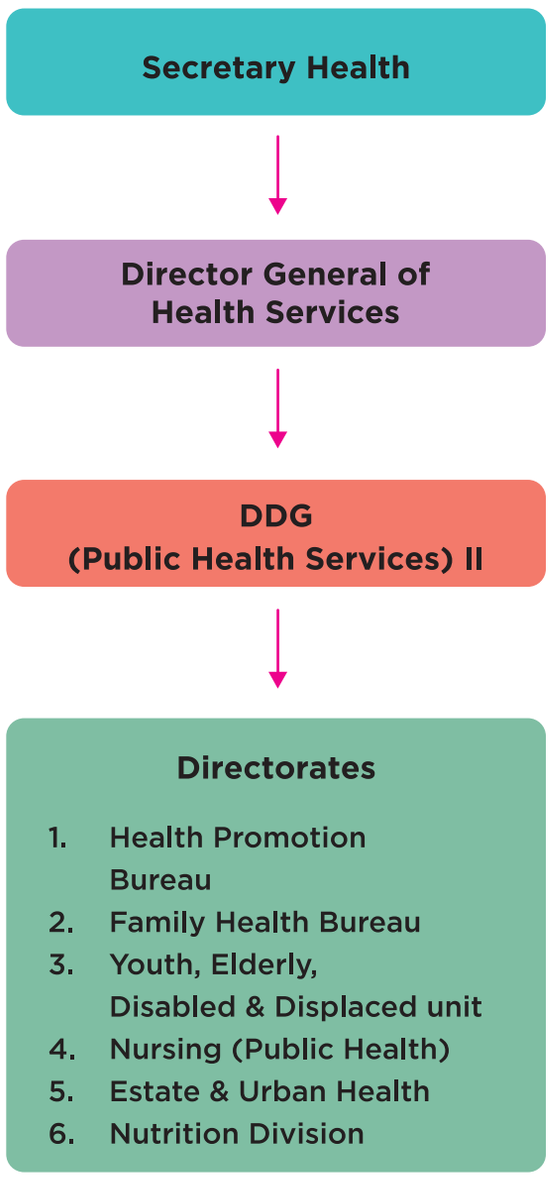
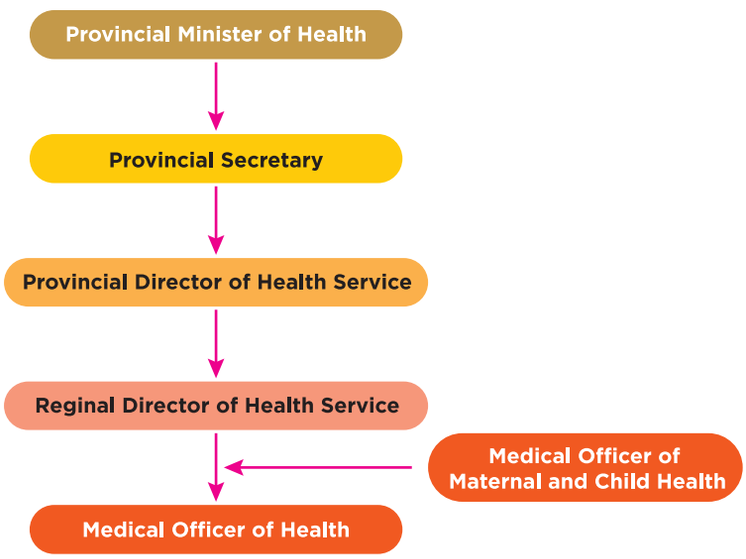


Figure 1.1:
Administrative hierarchy in the Ministry of Health
Source: MoH

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 that correspond to each of the districts in a given province (figure 1.2).



Source: MoH

Figure 1.2 Provincial Organizational Hierarchy

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.

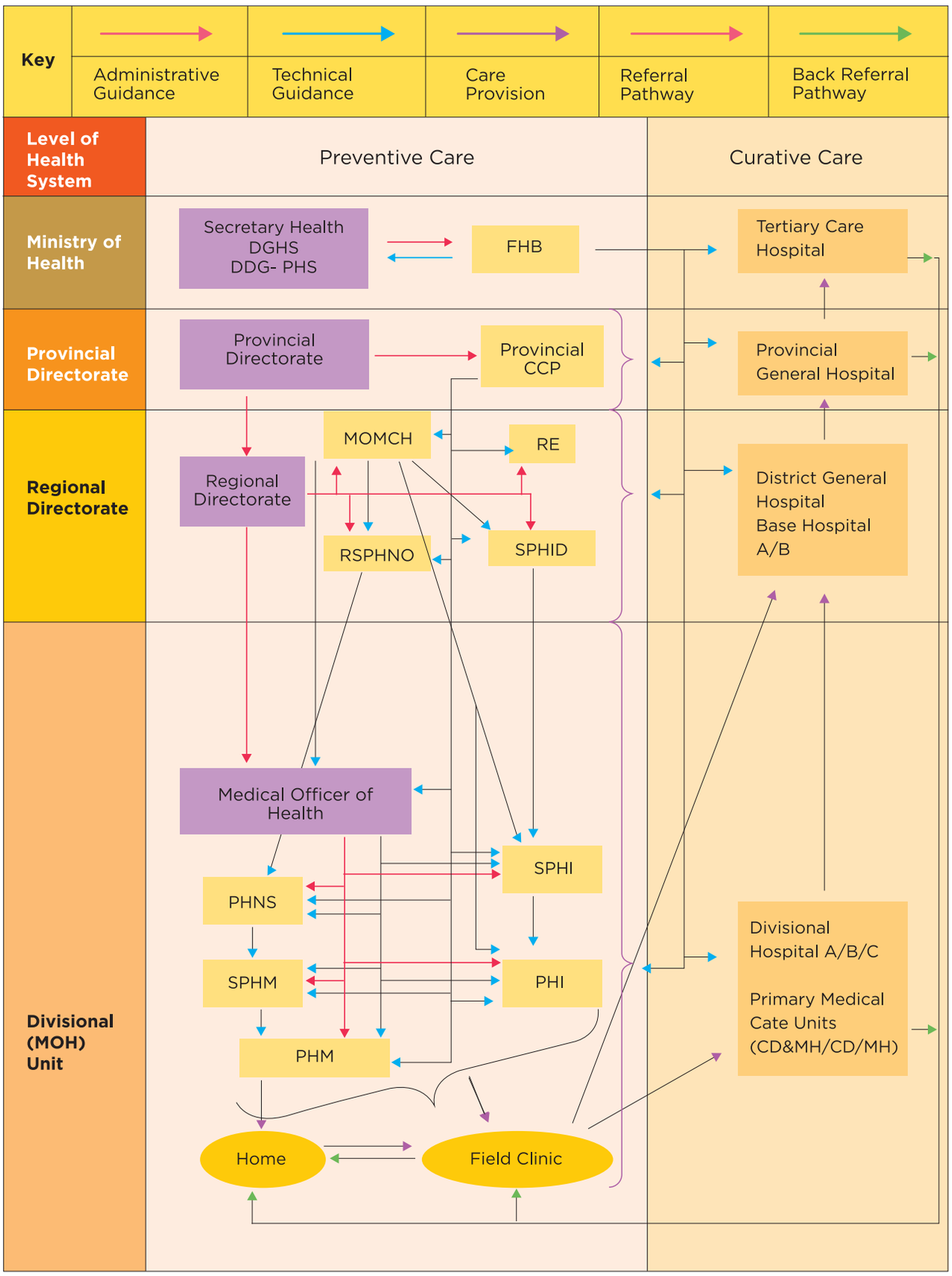
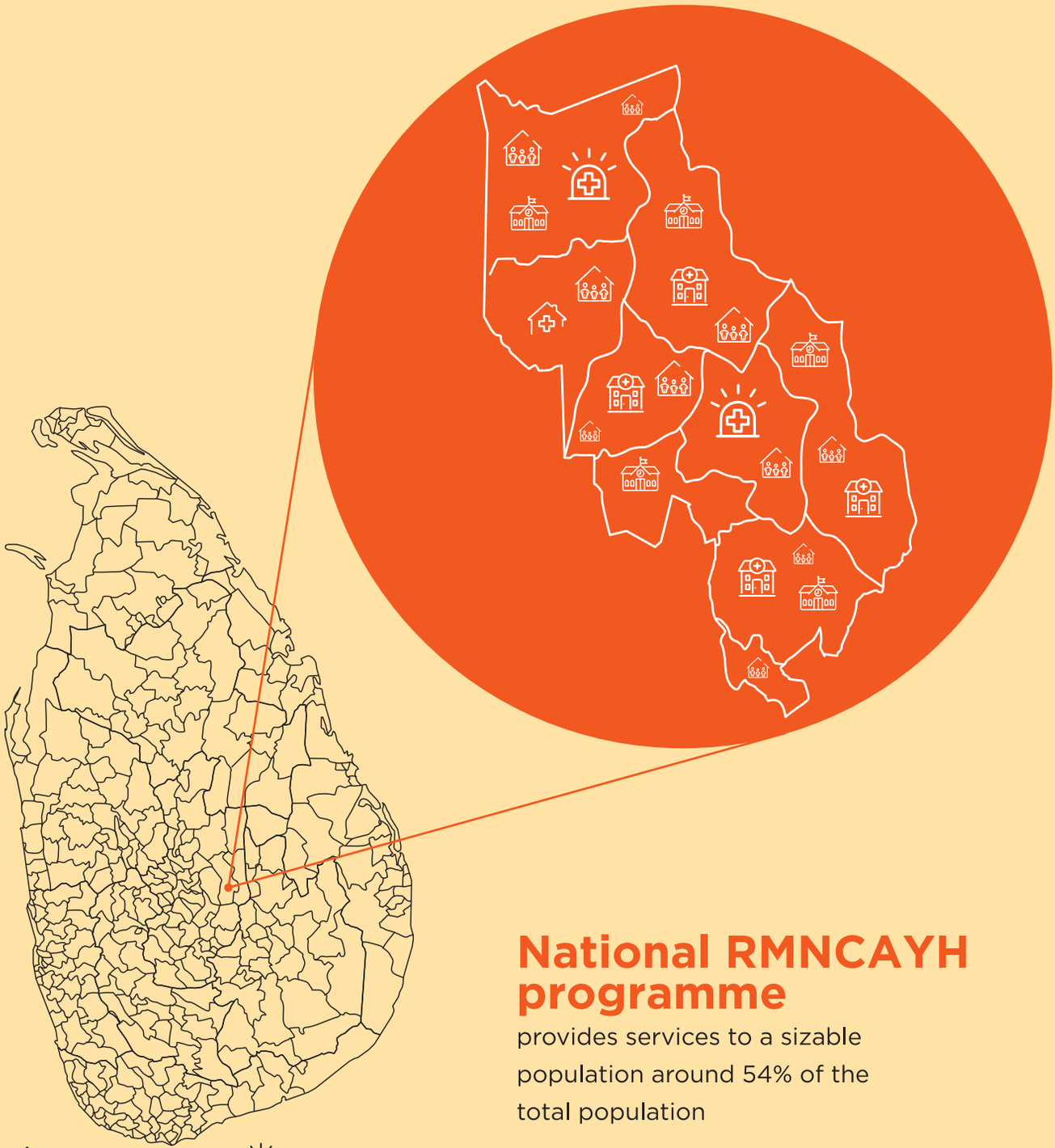


Figure 1.3: Organization of RMNCAYH Programme at Different Levels of Health System - *Source: FHB*

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.



National RMNCAYH programme

provides services to a sizable population around 54% of the total population

Households | Primary Care Hospital | MOH Office | Field Clinics | School

MOH Areas **361** | PHM Areas **6916** | PHI Areas **1863**

Clinics **4351** | Schools **10765**

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 qualified MBBS 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 principal 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 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 2024 is given in table 1.1

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

Staff category	Approved cadre	Cadre in position	Staff to population ratio	Staffing ratio (Staffing level per capita)
MOH	370	307	1:71316	1.4
AMOH	427	398	1:55012	1.8
PHNS	424	267	1:82002	1.2
SPHI	341	220	1:99521	1.0
SPHM	416	222	1:98624	1.0
PHM	6815	5813	1:3766	26.5
PHI	1833	1572	1:13928	7.2
SDT	474	346	1:63279	1.6

Source : eRHMIS, FHB 2024



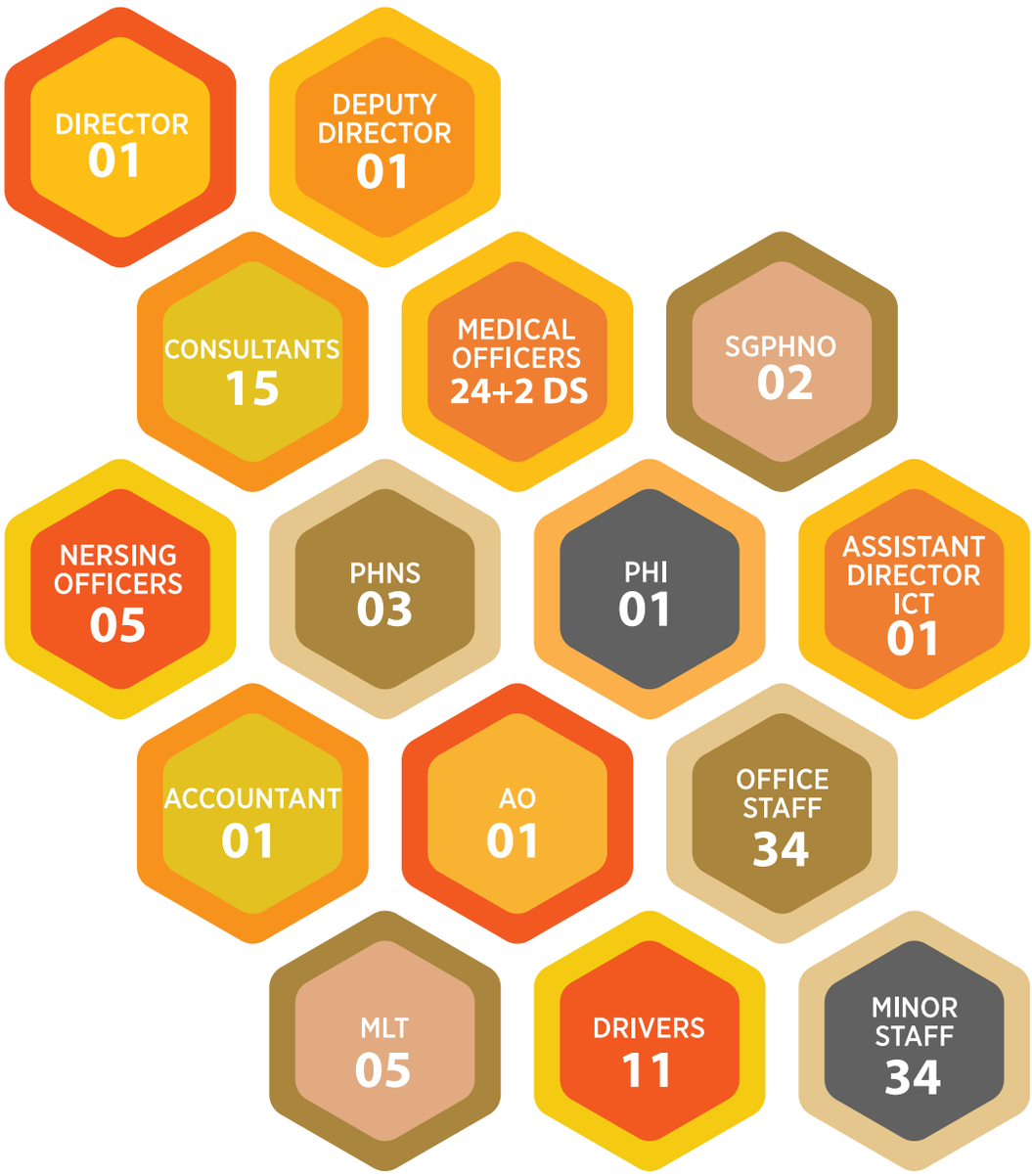


WHAT WE DO

FHB has sixteen units headed by Consultant Community Physicians (Public Health Specialists), a Consultant Community Dental Surgeon and a Consultant Obstetrician and Gynaecologists 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. The 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.



Source: FHB 2024

Figure 1.5: Distribution of staff at Family Health Bureau

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 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, the 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.

STRATEGIC DIRECTIONS

Maternal and Newborn Care

With the vision of a "country in which there are no preventable deaths of mothers, foetuses and newborns, where every pregnancy is planned and wanted, every birth celebrated and women, babies and children thrive and reach their full potential", the national strategic plan on maternal and newborn health 2017-2025 has been formulated.



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 people and reducing 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 woman service

With the vision of empowering Sri Lankan women to lead healthy and productive lives, and with the specific targets of increasing Well Woman Clinic (WWC) coverage to 80% among the 35-year age cohort and 60% among the 45-year age cohort by 2023, the National Strategic Plan for the Well Woman Programme (2019–2023) was developed. Provincial and district-level health managers are expected to strengthen the implementation of the programme within their respective jurisdictions by establishing at least one fully functioning WWC for every 15,000 population.

Furthermore, the National Action Plan for the Health Sector Response to the Prevention and Management of Gender-Based Violence in Sri Lanka was published in 2020 to guide a comprehensive and coordinated response to GBV within the health system. The plan aims to enhance public awareness of GBV, integrate GBV considerations into health policy, address GBV through reproductive health interventions in both curative and preventive sectors, and strengthen data management related to GBV. Effective implementation of activities related to GBV prevention and women's health must be systematically monitored at all administrative levels to ensure the achievement of the outlined objectives.

Family Planning

Family planning programme of Sri Lanka functions with the vision of enabling all couples to have the 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 the national programme are given in table 1.2.

Table 1.2: Family Planning targets for Sri Lanka

#	Indicator	Years											
		2016	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2030
1	CPR (%)	64.6	66.4	66.6	67	67	66	66.5	67.8	69.4	69.8	68	70
2	mCPR (%)	53.6	57	57.3	57.9	58	57	57.7	58.8	60.2	60.5	59	60
3	UMN (%)	7.5	6.2	6.3	6	5.9	5.7	5.6	5.4	5.4	5.2	5.7	5.5
4	Demand satisfied by modern methods (%)	74.3	78.5	78.6	79.3	79.6	79.5	80	80.3	80.5	80.7	80.0	81.0
Source		SLDHS 2016	HMIS	eRHMIS								FP 2030	SDG

Source: FHB

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 were used as denominators and for comparisons. In comparison to Registrar General's Department information and information from Department of Education, an attempt is made below [table 1.3] to identify where the national RMNCAYH programme stands in 2024.

Table 1.3: Size of the different target population of RMNCAYH programme in Sri Lanka 2024

Indicator	Estimated/Actual	Reported
Midyear population	21,763,170	22,206,603
Eligible families	4,026,186	3,942,436
Pregnant mothers	242,837	245,196
Births	220,761	224,656
Infants under care	247,900	241,358
1-2 years under care	275,321**	271,964
2-5 years under care	861,875**	887,150
Number of schools ≤ 200	4,372***	5,676
Number of Schools ≥ 200	4,724***	4,960
Adolescent	3,634,449	2,316,842
Preconception	139,290	99,794
Total school children under care at the beginning of year	4,020,557***	4,097,460

Source: RGD, MoE & FHB, eRHMIS 2024

*Births registered by Registrar General's Department

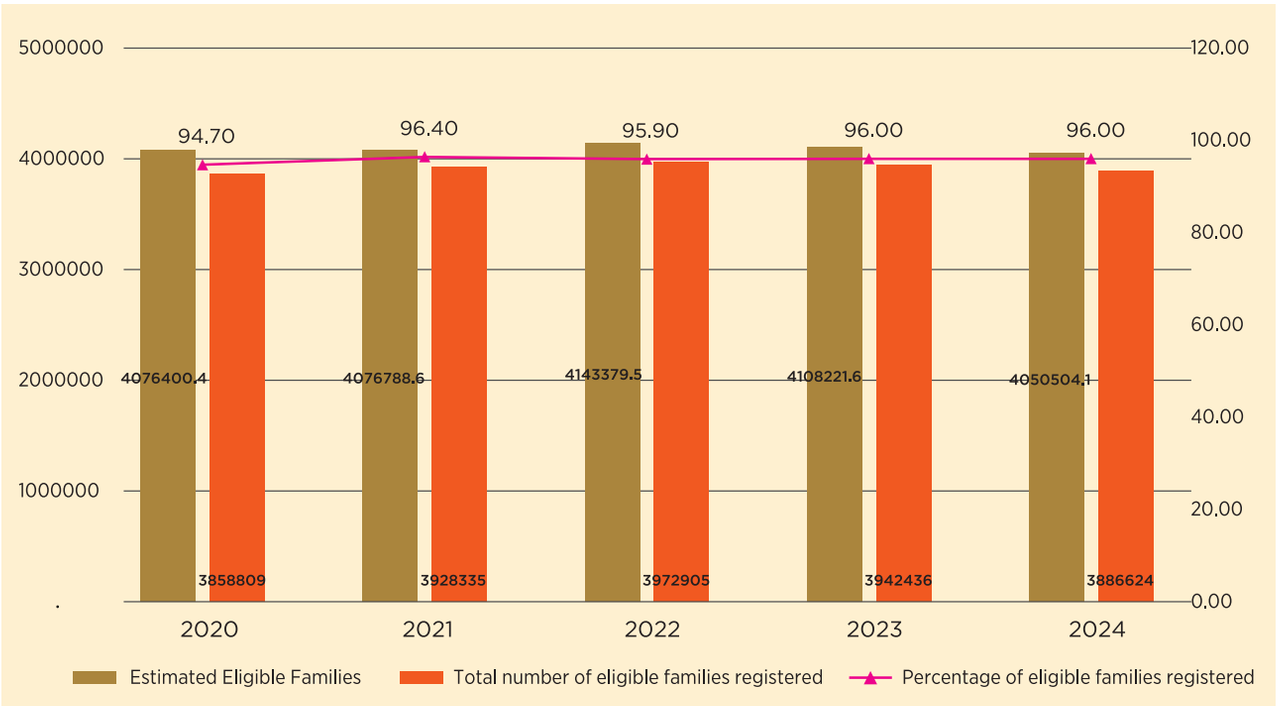
** According to Births reported by Registrar General's Department for relevant years

***As reported by Ministry of Education Annual School Census of Sri Lanka 2023(2024)

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.



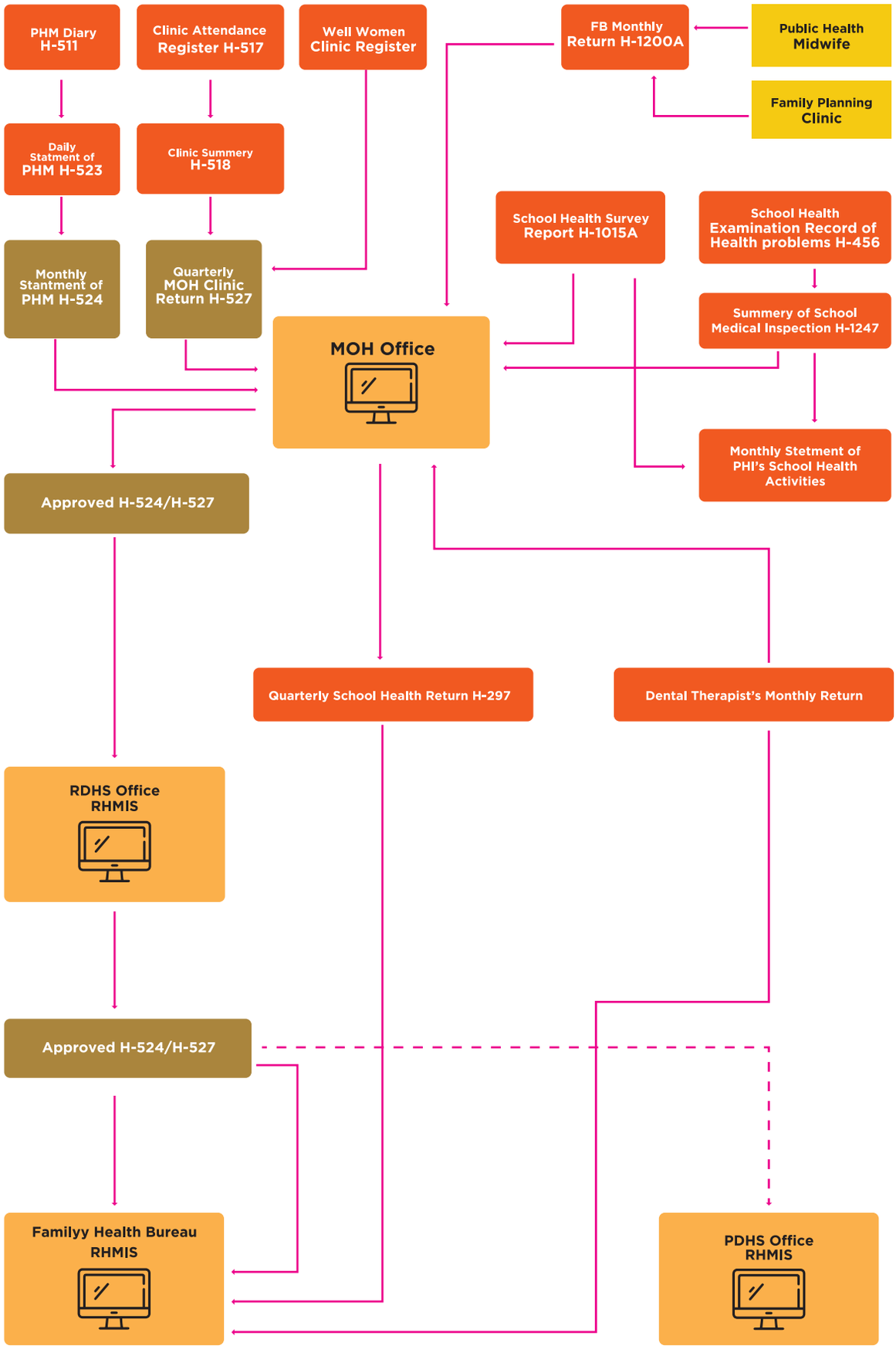
Source: RGD & FHB, eRHMIS 2024

Figure 1.6: Comparison of numbers of estimated and registered eligible families

Percentage of eligible family registration was within the national targets in 2024

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 into a web-based system. The data elements in these returns cover a wide scope. These include information on eligible families, performance of maternal care, childcare, 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 the introduction of the electronic system, data is now available for analysis and visualization by each PHM area and for each field clinic (Figure 1.7).



Source: FHB, 2024

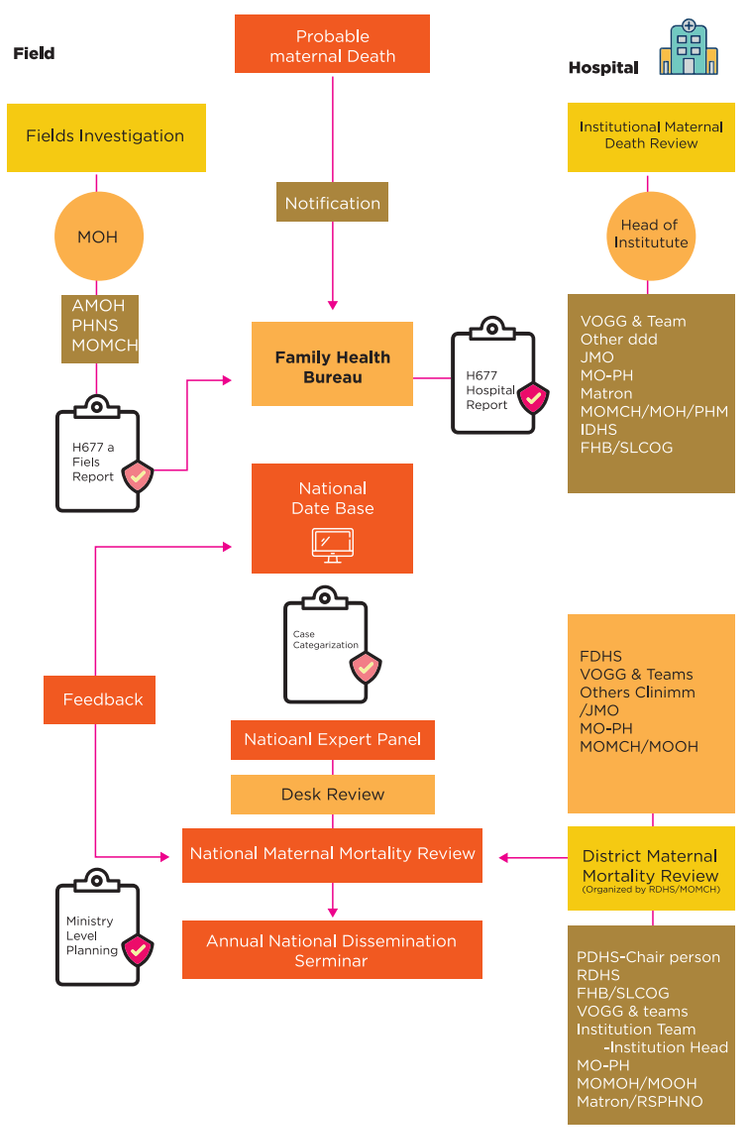
Figure 1.7: Sources & pathways of data used in the Annual Report

3. Electronic Reproductive Health Management Information System 2 [eRHMIS2]

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 identified or reported. To overcome this issue, the FHB introduced eRHMIS 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 Sri Lanka. A total of 19,792 live births were reported in 2024 from the private sector hospitals in Sri Lanka. This contributes to 8.97% of all live births registered in the Registrar General Department (220,761 live births) for year 2024.

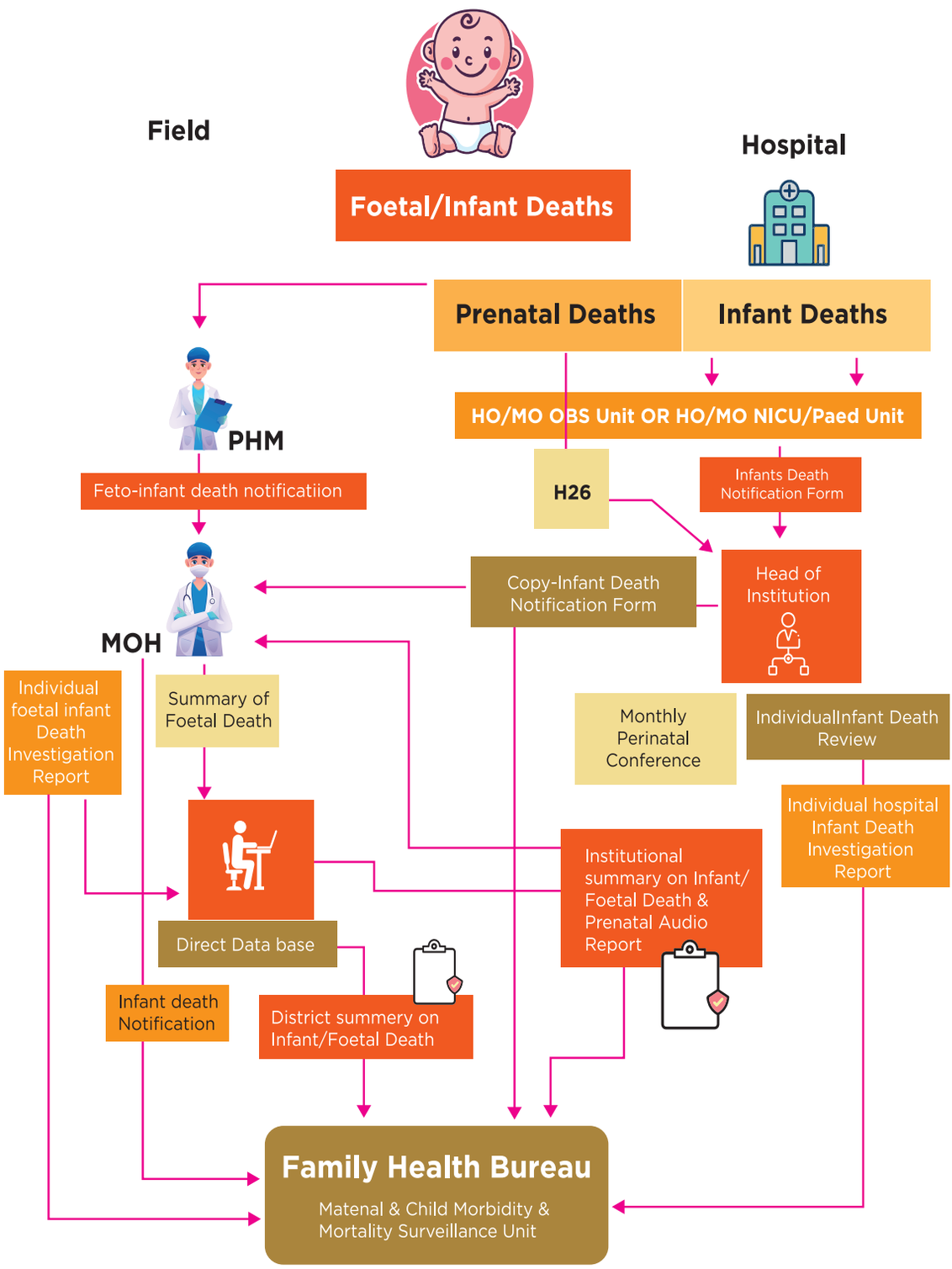
4. Special Surveillances

There are several special surveillance systems functioning under the FHB to gather information on maternal deaths, foeto-infant deaths and birth defects [figures 1.8 and 1.9].



Source: FHB, 2024

Figure 1.8: Information flow of national maternal mortality surveillance system

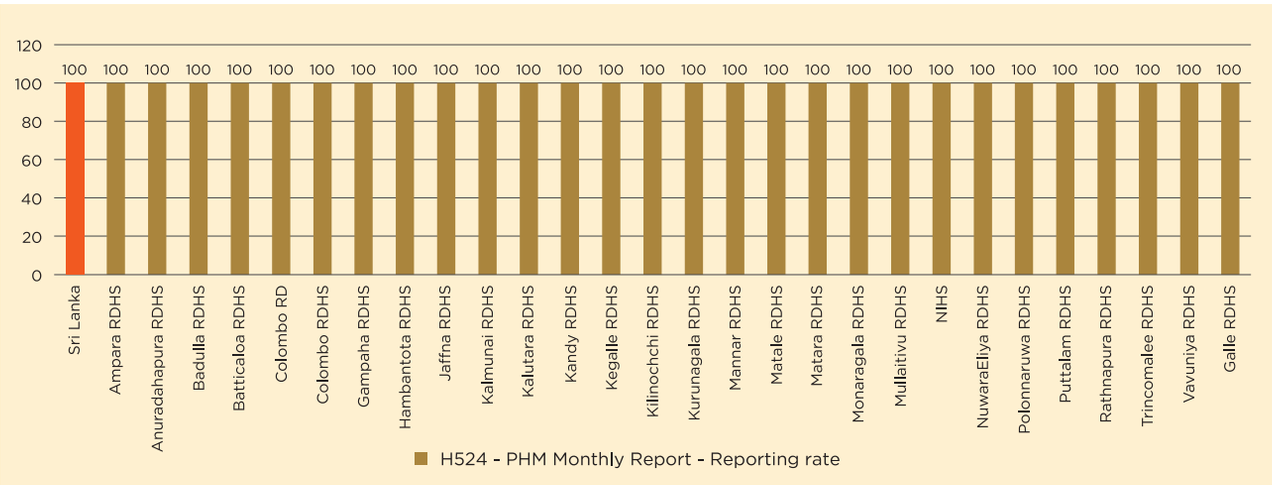


Source: FHB, 2024

Figure 1.9: National Feto-Infant Mortality Surveillance Mechanism

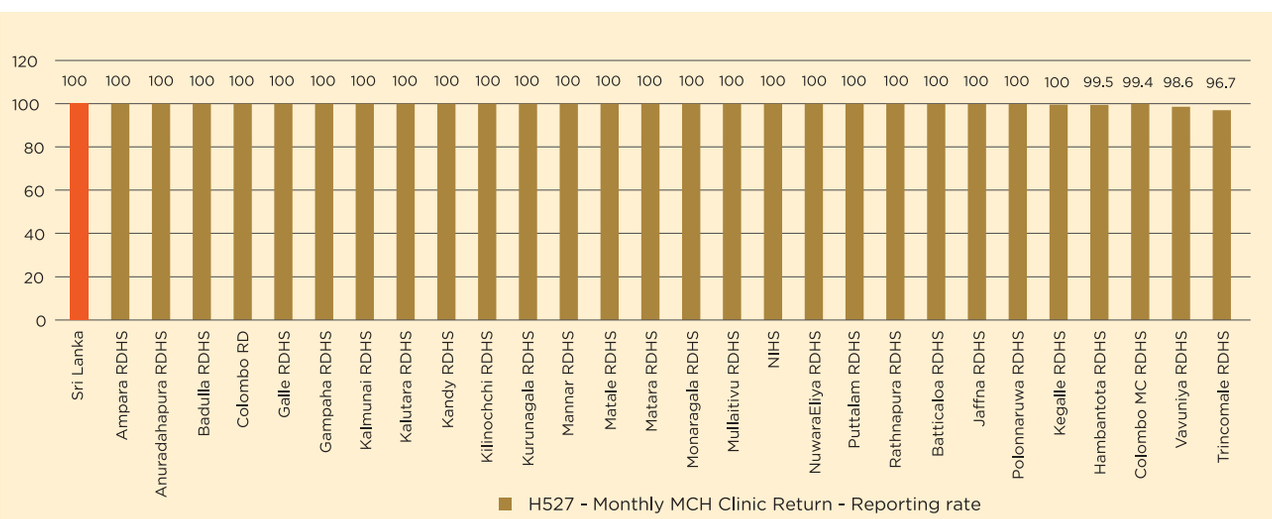
RMNCAYH INDICATORS

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.



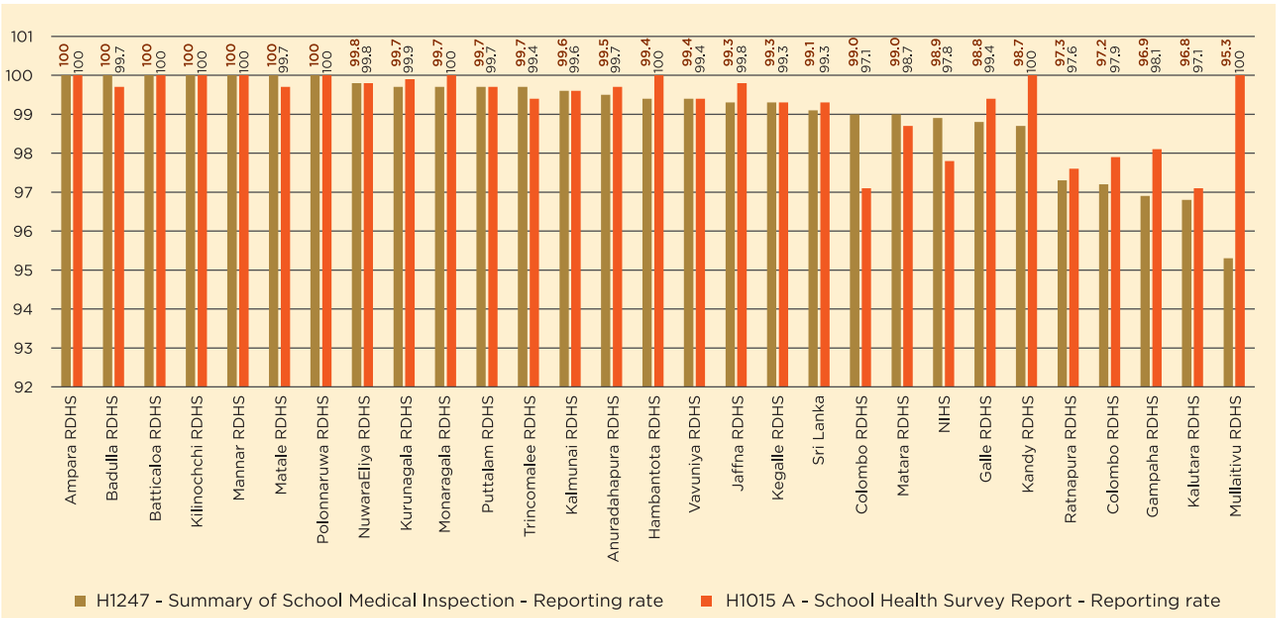
Source: FHB, eRHMIS 2024

Figure 2.0: Reporting Rates of Public Health Midwives' Monthly Return [H524] – 2024



Source: FHB, eRHMIS 2024

Figure 2.1: Reporting Rates of MCH Clinic Return [H527] - 2024

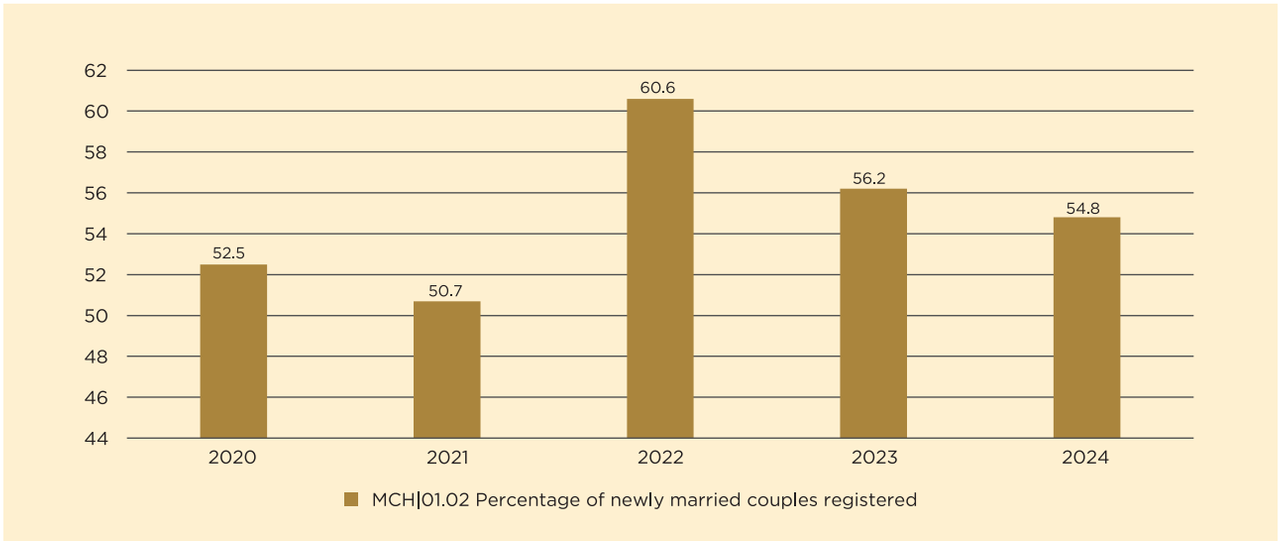


Source: FHB, eRHMIS 2024

Figure 2.2: Reporting Rate H1247 and H1015 in 2024

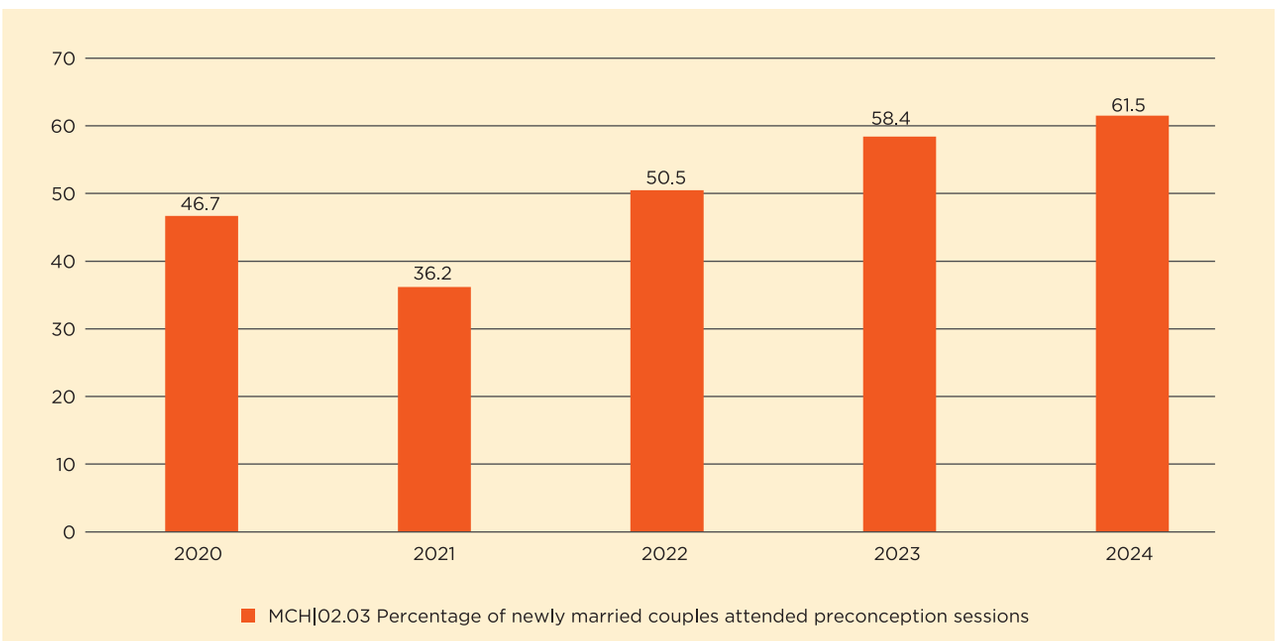
School health surveys were completed in 99.1 % of schools in the country and 99.3% School Medical Inspections were completed during 2024.

PRECONCEPTION CARE FOR NEWLY MARRIED COUPLES



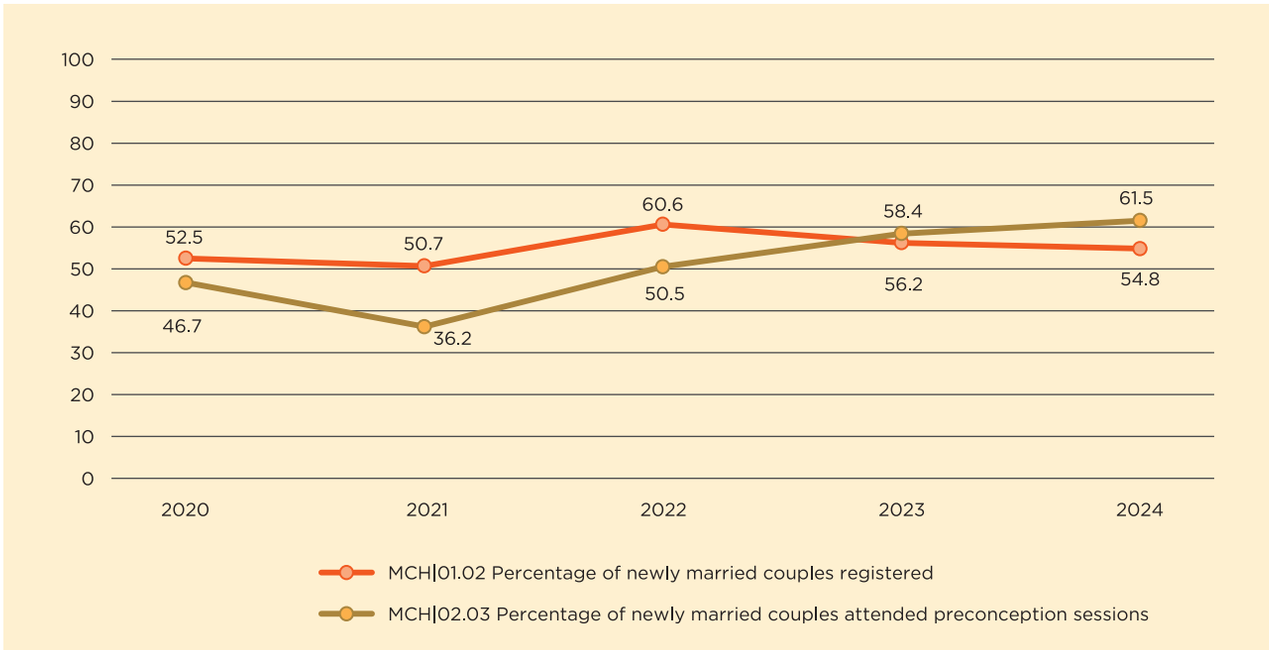
Source: FHB, eRHMIS 2024

Figure 2.3: Percentage of Newly married couples registered out of the estimated number of marriages 2020 to 2024



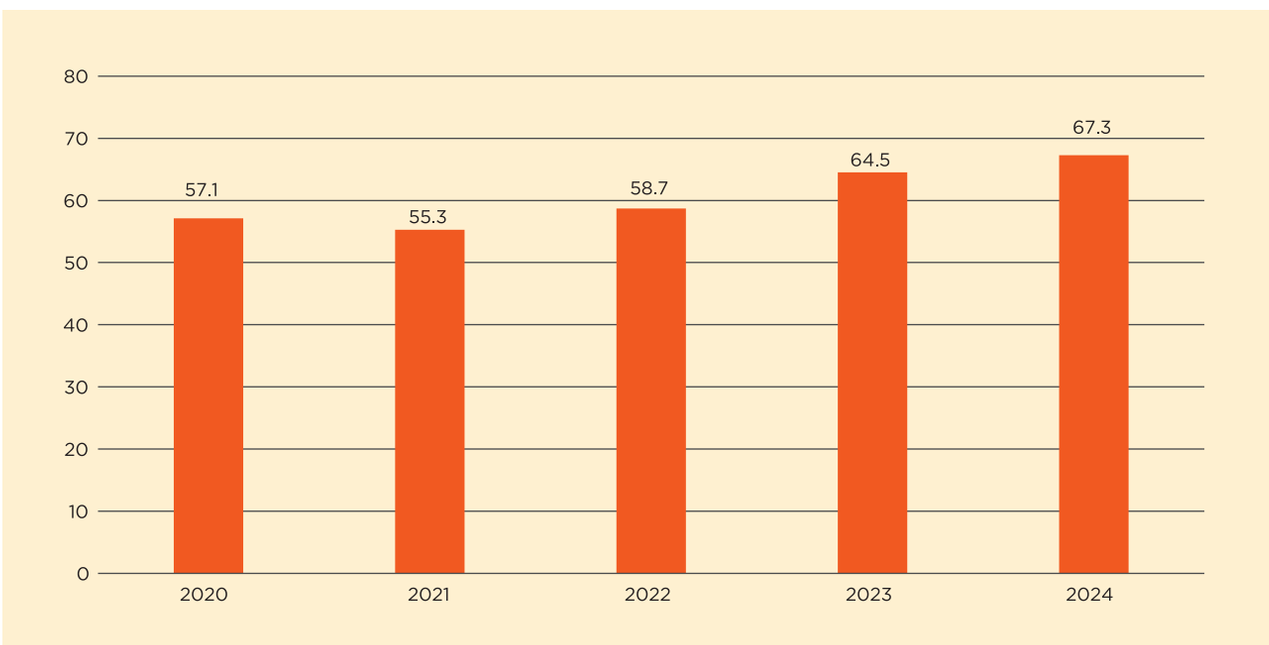
Source: FHB, eRHMIS 2024

Figure 2.4: Percentage of Newly married couples attended Preconception care sessions among registered 2020 to 2024



Source: FHB, eRHMIS 2024

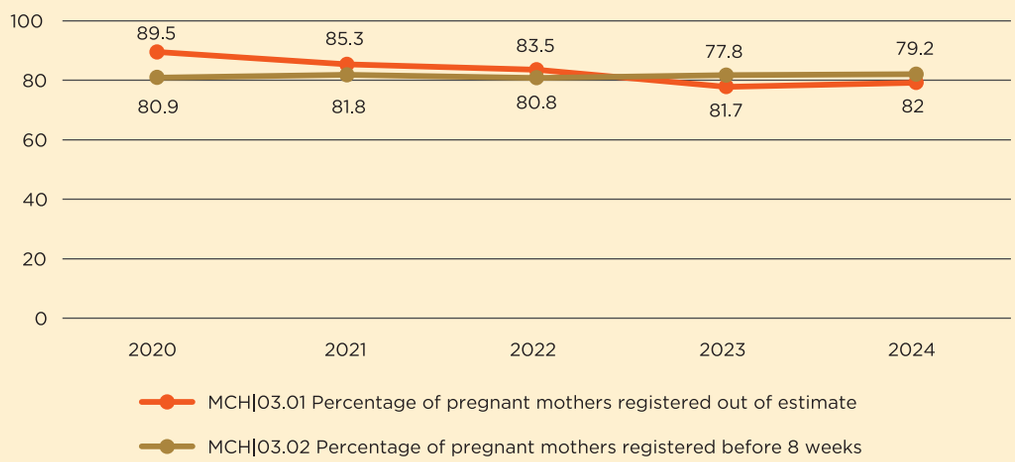
Figure 2.5: Newly married couples registered Vs Attended PCC sessions 2020 to 2024



Source: FHB, eRHMIS 2024

Figure 2.6: Percentage of Primi mothers undergone Preconception care 2020 to 2024

MATERNAL AND NEWBORN HEALTH



Source: FHB, eRHMIS 2024

Figure 2.7: Registration of antenatal women and registration before 8 weeks 2020 to 2024

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

Table 1.4: Percentage of antenatal women who were visited at least once and the average number of home visits by PHMs 2020 – 2024

Indicator	2020	2021	2022	2023	2024
% of registered pregnant women visited at least once at home by PHM	94.2	93.9	96.2	97.5	97.2
Average number of PHM field visits per pregnant woman	4.1	3.9	4	4.2	4.2

Source: FHB, eRHMIS 2024

Table 1.5: Percentage of antenatal women visiting field antenatal clinics (at least once) and average number of clinic visits 2020 – 2024

Indicator	2020	2021	2022	2023	2024
% of pregnant women making at least one field clinic visit out of registered pregnancies	95.6	95.2	96.9	96.6	95.8
Average number of clinic visits by pregnant women	5.7	5.6	5.9	6.3	6.3

Source: FHB, eRHMIS 2024

Table 1.6: Percentage of antenatal women screened at ANC 2020 – 2024

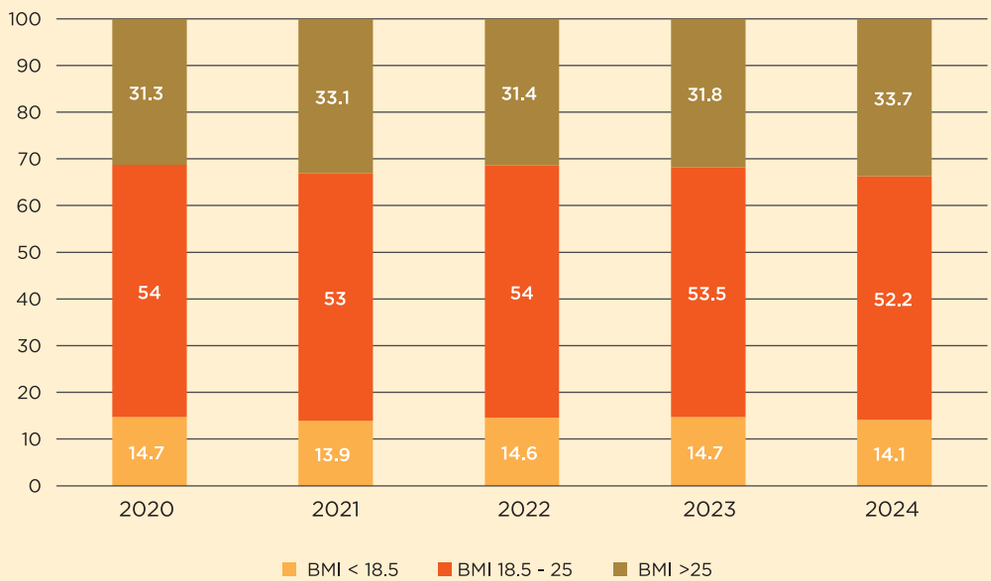
Indicator	2020	2021	2022	2023	2024
% of antenatal women tested for VDRL at the time of delivery out of estimated deliveries	99.4	99.4	98.5	98.7	99.5
% Antenatal women tested for HIV at field clinic	84.7	85	59	89.3	85.6
% of antenatal women whose blood is tested for grouping and Rh at the time of delivery out of reported deliveries	99.7	99.6	99.6	99.6	99.7
% of antenatal women whose BMI is assessed before 12 weeks out of total attending antenatal clinics	80.3	82.1	81.9	82.7	81.9
% of antenatal women screened for Hb at the field clinic out of total attending antenatal clinics	33.4	40.1	28.4	25.9	30.6
% of antenatal women tested for VDRL at field clinic out of total attending antenatal clinics	85.1	85.3	58.8	90.7	86.2
% of antenatal women whose blood Grouping and Rh tested at field antenatal clinic	28.8	30.4	25.3	27.9	29

Source: FHB, eRHMIS 2024

Table 1.7: Percentage of antenatal women who had been protected with rubella & tetanus vaccination 2020 – 2024

Indicator	2020	2021	2022	2023	2024
% of antenatal women protected against rubella out of registered pregnancies	98.5	98.5	98.7	99.1	99.2
% of antenatal women protected against tetanus out of total reported deliveries	99.6	99.5	99.4	99.5	99.5

Source: FHB, eRHMIS 2024



Source: FHB, eRHMIS 2024

Figure 2.8: Percentage distribution of antenatal women according to their BMI status at booking visit (before 12 weeks) from 2020 - 2024

Much emphasis should be made for high BMI among pregnant women. BMI more than 25 Kg/m2 has increased from 31.8% to 33.7% over a period of 5-years.

Table 1.8: Percentages of antenatal women whose haemoglobin level was tested at field clinic

Indicator	2020	2021	2022	2023	2024
% of pregnant women tested for Haemoglobin at field clinics	16.7	20.1	14.2	13	15.3

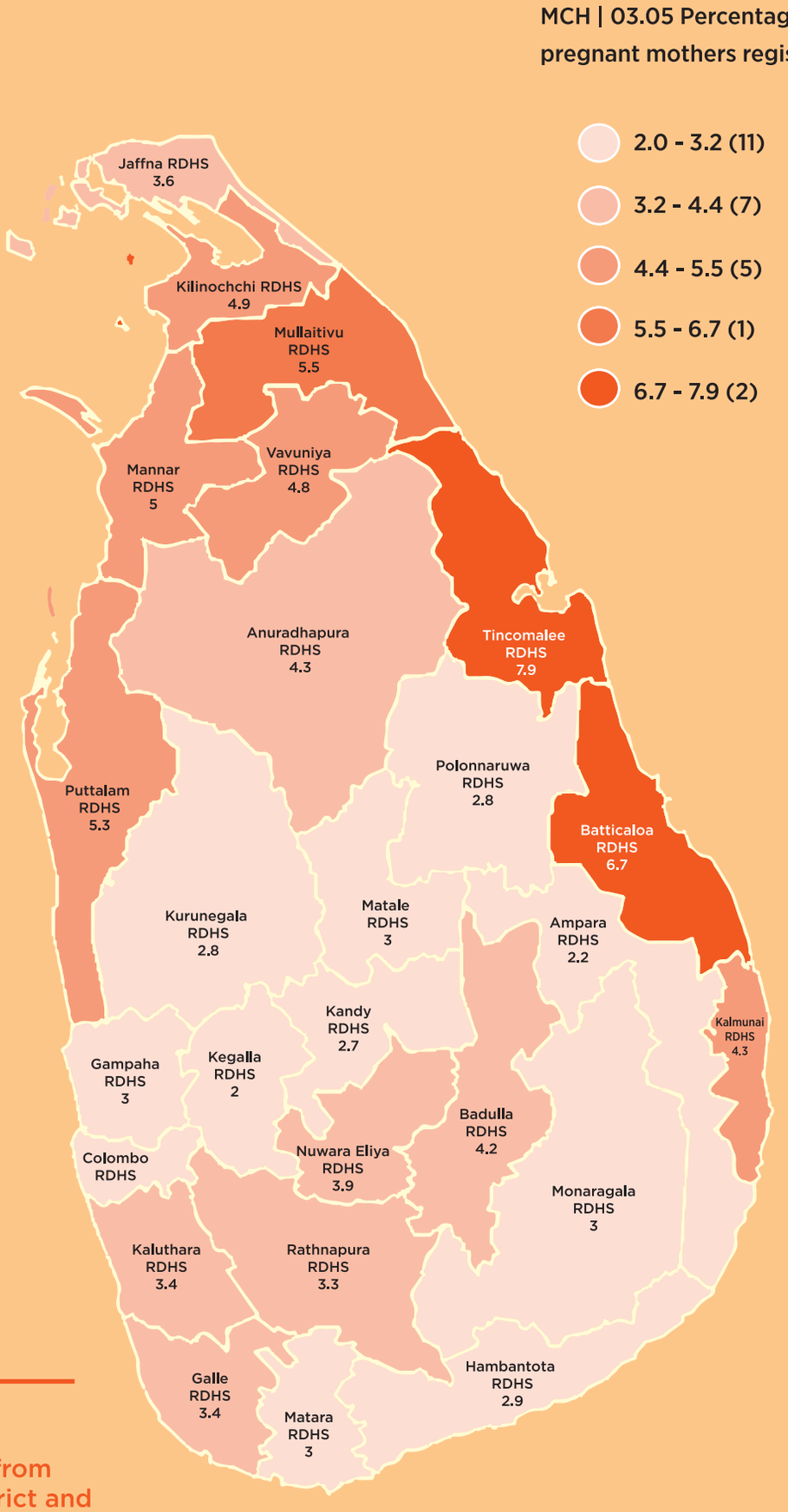
Source: FHB, eRHMIS 2024

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

Table 1.9: Number and rate of antenatal morbidities reported in 2024

Data Element	2020		2021		2022		2023		2024	
	Number of cases	Cases per 10,000 pregnancies	Number of cases	Cases per 10,000 pregnancies	Number of cases	Cases per 10,000 pregnancies	Number of cases	Cases per 10,000 pregnancies	Number of cases	Cases per 10,000 pregnancies
Chronic High Blood Pressure	1150	35	1206	40	1271	45	1172	48	1209	51
Chronic Diabeties	4220	128	4476	148	4406	155	4096	167	4417	186
Heart Diseases	1495	46	1220	40	943	33	967	39	1030	43
Gestational Diabeties	20608	627	18823	624	16608	585	15235	621	16441	693
Pregnancy Indused Hypertension	10302	314	9609	318	8973	316	8305	339	7975	336
Anaemia	83351	2537	66608	2207	56645	1994	54668	2230	48090	2027

Source: FHB, eRHMIS 2024



Highest teenage pregnancy rate (7.9%) reported from Trincomalee district and lowest teenage pregnancy rate (2%) reported Kegalle District with an overall 3.7% of teenage pregnancy rate in Sri Lanka for 2024.

Source: FHB, eRHMIS 2024

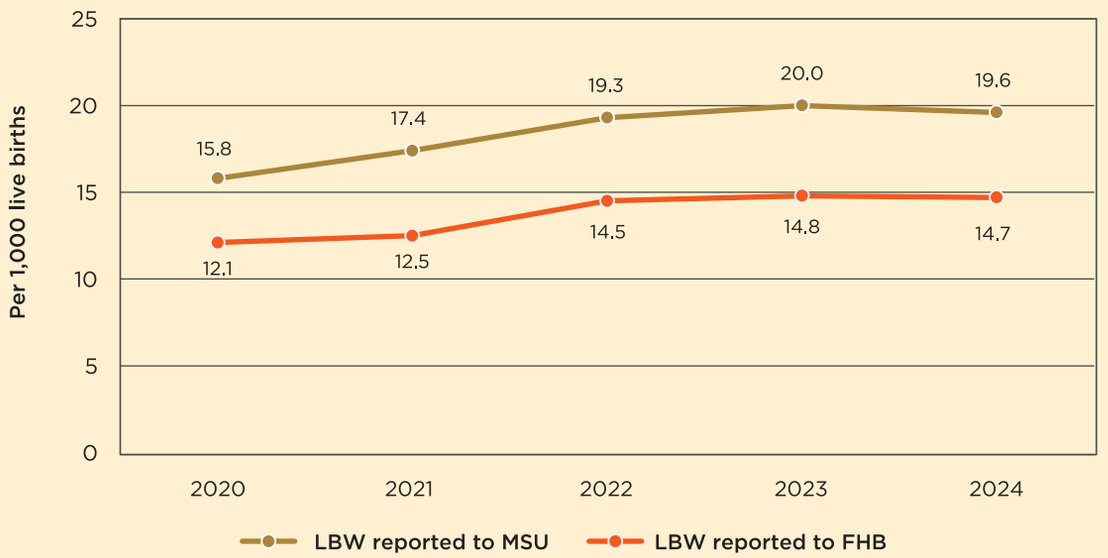
Figure 2.9: Percentage of teenage pregnancies by district in 2024

Table 2.0: Pregnancy outcome and postpartum care for mothers registered from 2020-2024

Indicator	2020	2021	2022	2023	2024
% Pregnancy outcome reported out of registered pregnancies	85.4	82	81.8	77.4	76.6
% of deliveries reported out of total live births registered by Registrar General	95	93.1	92.3	88.9	92.6
% of deliveries reported out of total estimated births	85.9	82.4	82.2	76.9	75.1
% Institutional deliveries out of total reported deliveries	99.9	99.9	99.9	99.9	99.9
Number of home/non-institutional deliveries	244	274	309	283	227
% of home/non-institutional deliveries out of total reported deliveries	0.09	0.1	0.12	0.13	0.11
% of untrained deliveries out of total	0.05	0.06	0.08	0.09	0.08
% Caesarean sections out of total	41.7	43.1	43.1	44.4	46
% Postpartum mothers receiving at least 1 visit by PHM during first 5 days out of estimated births	66.6	62.1	62.8	63.6	59.1
% Postpartum mothers receiving at least 1 visit by PHM during first 10 days out of estimated births	80.9	76	76.6	72.5	70.9
% Postpartum mothers receiving at least 1 visit during 1st 10 days out of reported deliveries	93.3	92.2	93.2	94.2	94.4
%Postpartum visits by PHM at or around 42 days out of reported deliveries	81.3	80.4	84.9	89.3	89.5
Average number of postpartum visits during first 10 days	1.7	1.7	1.7	1.8	1.7
% of Postpartum visits by PHM around 42 days (out of estimated births)	70	66.3	69.8	68.7	67.3

Source: FHB, RHMIS 2024

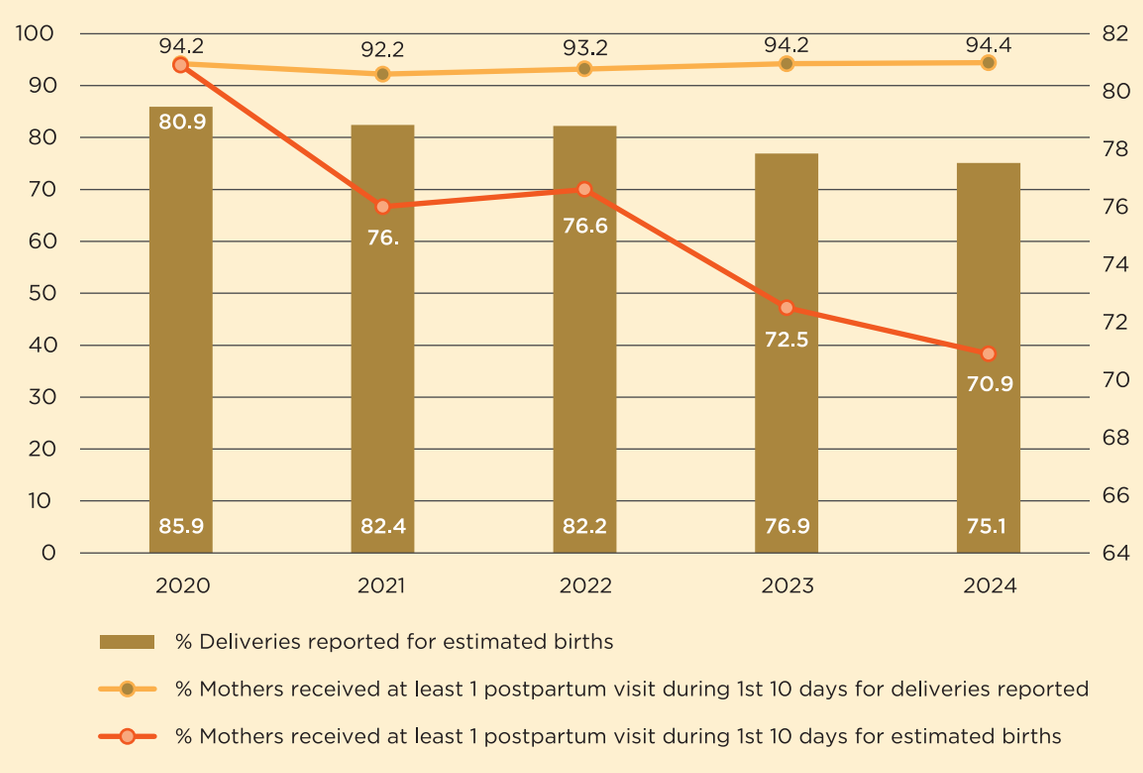
The Caesarean section rate is increasing from 44.4 in 2018 to 46% in 2024.



Source: FHB, eRHMIS 2024

Figure 3.0: Low birth weight percentages among newborns from 2020 - 2024

Low birth weight reporting from the field is lower than the value reported from healthcare institutions. Field level reporting need to be improved.



Source: FHB, eRHMIS 2024

Figure 3.1: Percentage of estimated births, who were receiving the first post-natal visit within the first 10 days of delivery in 2020 - 2024

There is a reduction in the delivery reporting and at least one visit within the first 10 days compared to the previous year.

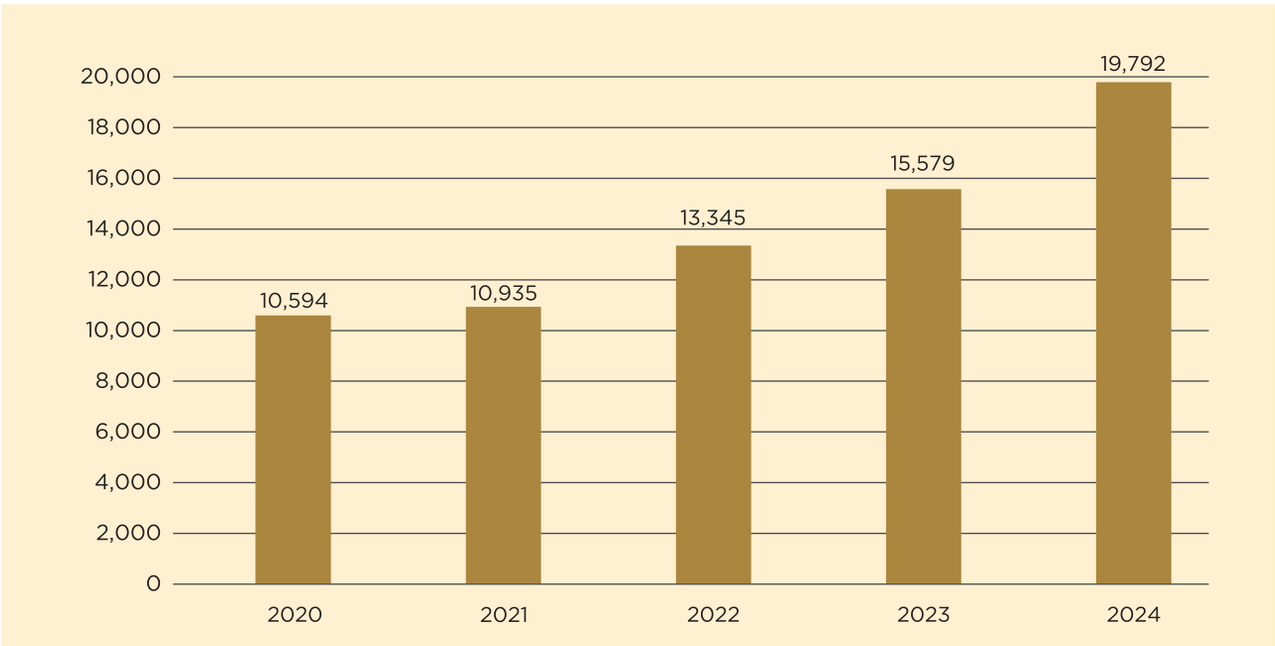
Table 2.1: Number of mothers reported with postpartum morbidities in 2024

Data Element	2020		2021		2022		2023		2024	
	Number of cases	Cases/10000 deliveries	Number of cases	Cases/10000 deliveries	Number of cases	Cases/10000 deliveries	Number of cases	Cases/10000 deliveries	Number of cases	Cases/10000 deliveries
Heart Failure	72	3	62	2	48	2	67	3	82	4
Deep Vein Thrombosis	98	3	71	3	70	3	88	4	63	3
Postpartum Depression	418	15	338	13	452	17	565	26	712	35
Foreign material in Vagina	156	5	118	5	130	5	139	6	107	5
Reproductive Tract Infections	14	0	166	6	169	7	175	8	195	10
Postpartum Psychiatric Illness	788	27	653	25	785	30	914	41	1126	55
Diabetes Mellitus	988	34	809	31	791	31	765	35	833	41
Breast Abscess	327	11	223	8	266	10	276	13	254	12
Urinary Tract Infection	981	34	806	30	821	32	868	39	820	40
Cracked Nipple	2714	95	2091	79	2405	94	2590	118	2761	135
Haemorrhage	1717	60	1445	55	1378	54	1476	67	1606	79
Hypertension	3191	111	2717	102	3049	120	3080	140	3385	166
Separated Epis	3578	125	2784	105	3485	137	3525	160	3381	165
Engorged Breast	5456	190	4210	159	4780	188	4875	221	4997	245
Infected LSCS scar	6241	218	5113	193	5208	205	5137	233	5573	273

FHB, eRHMIS 2024

Further improvement in postpartum morbidity reporting needs to be emphasized.

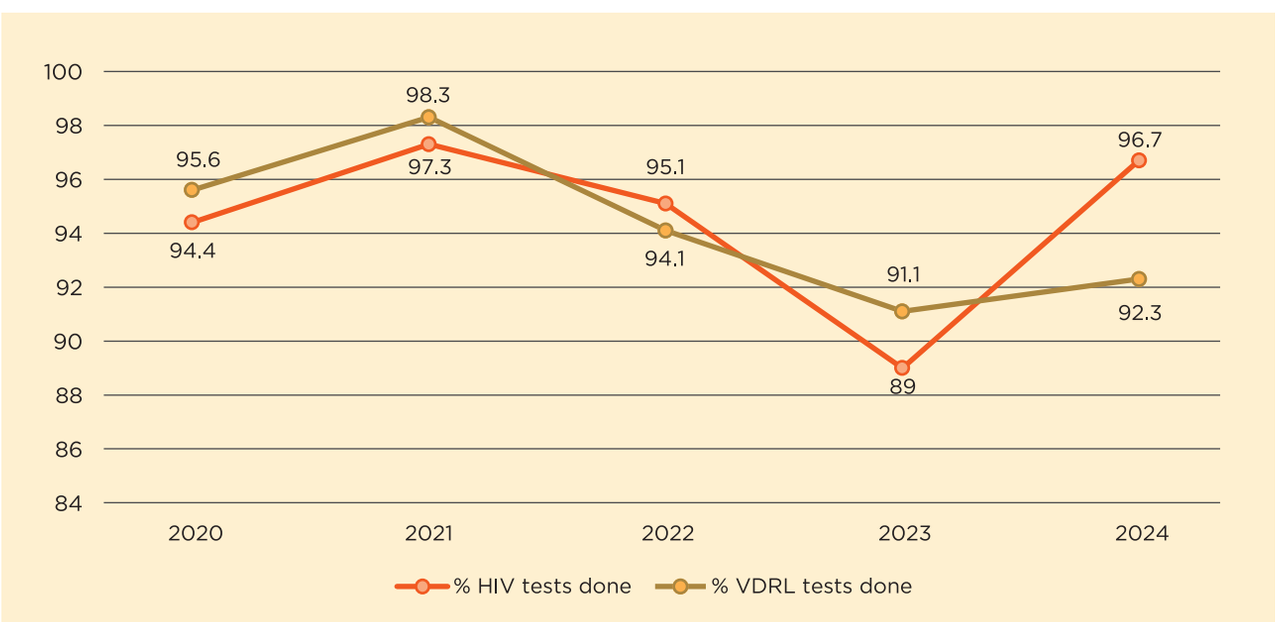
Private sector performances in maternal and new-born health



Source: FHB, eRHMIS2 2024

Figure 3.2: Number of live births by the years, Sri Lanka

Private sector - percentages of HIV and VDRL tests done

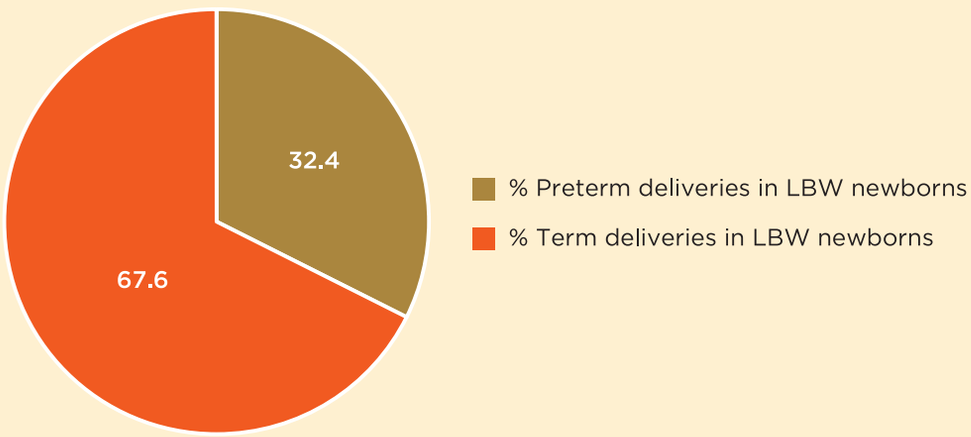


Source: FHB, eRHMIS2 2024

Figure 3.3: Percentages of HIV and VDRL tests done in private sector 2020 - 2024

HIV and VDRL screening coverages reported from private healthcare institutions in Sri Lanka were 96.7% and 92.3% respectively in 2024.

Private sector – low birth weight deliveries

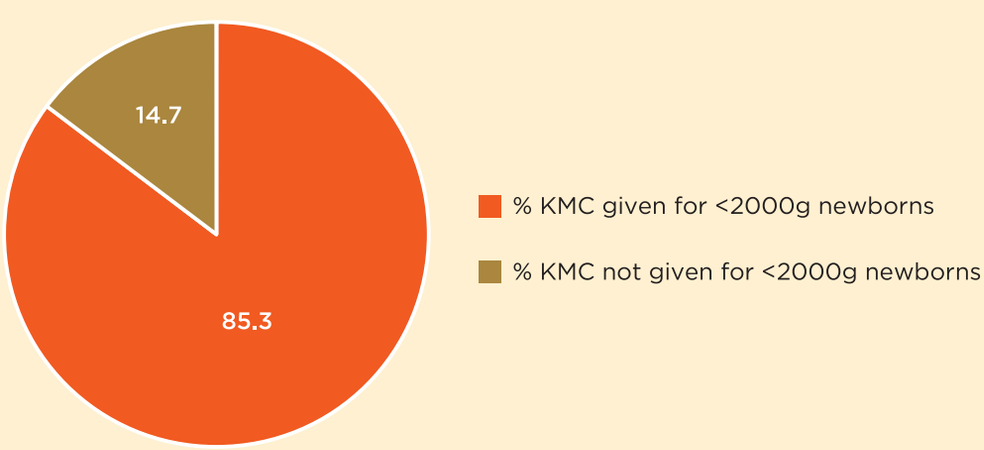


Source: FHB, eRHMIS2 2024

Figure 3.4: Private Sector, Sri Lanka - Low Birth Weight Deliveries

Out of reported live births, 15.5% were with low birth weights. Among the low-birth-weight newborns, 67.6% were term babies in 2024.

Private sector - Kangaroo Mother Care (KMC)

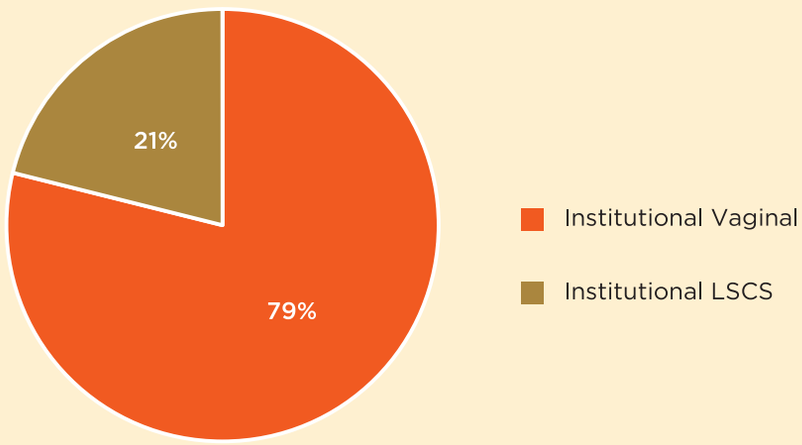


Source: FHB, eRHMIS2 2024

Figure 3.5: Private Sector- Sri Lanka, KMC

Kangaroo mother care [KMC] is a method of care for preterm infants involving infants being carried, usually by the mother, with skin-to-skin contact. 85.3% of newborns with birth weight less than 2000g were given KMC out of 89.8% KMC initiated in 2024.

Private sector – mode of delivery

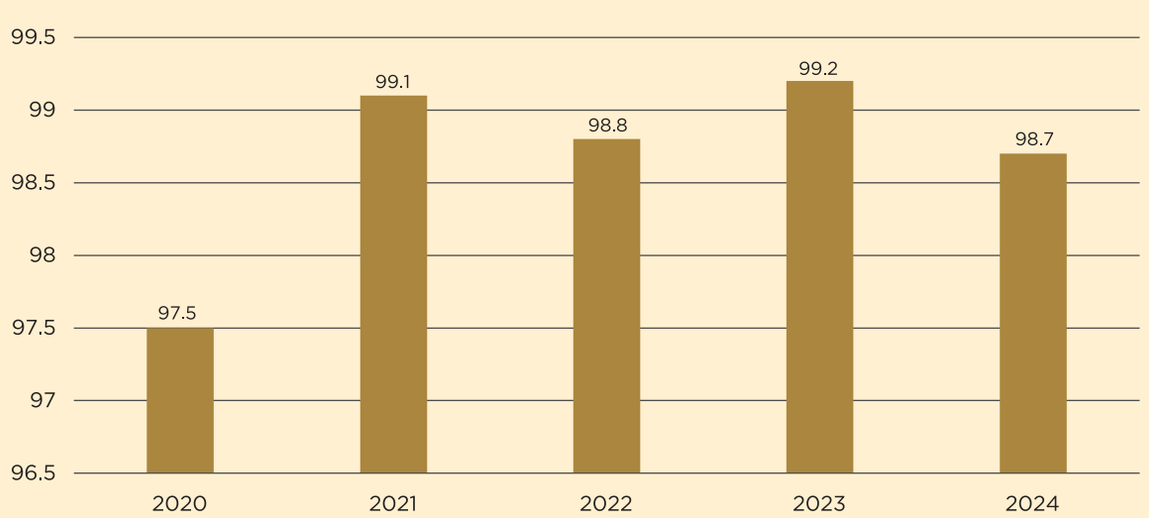


Source: FHB, eRHMIS2 2024

Figure 3.6: Delivery Mode

Considering the mode of delivery, the majority of the 79% were cesarean sections and normal vaginal deliveries were only 21%. Availability of health insurances and patient's preference contribute to this high trend of LSCS in the private sector and seems to be increasing.

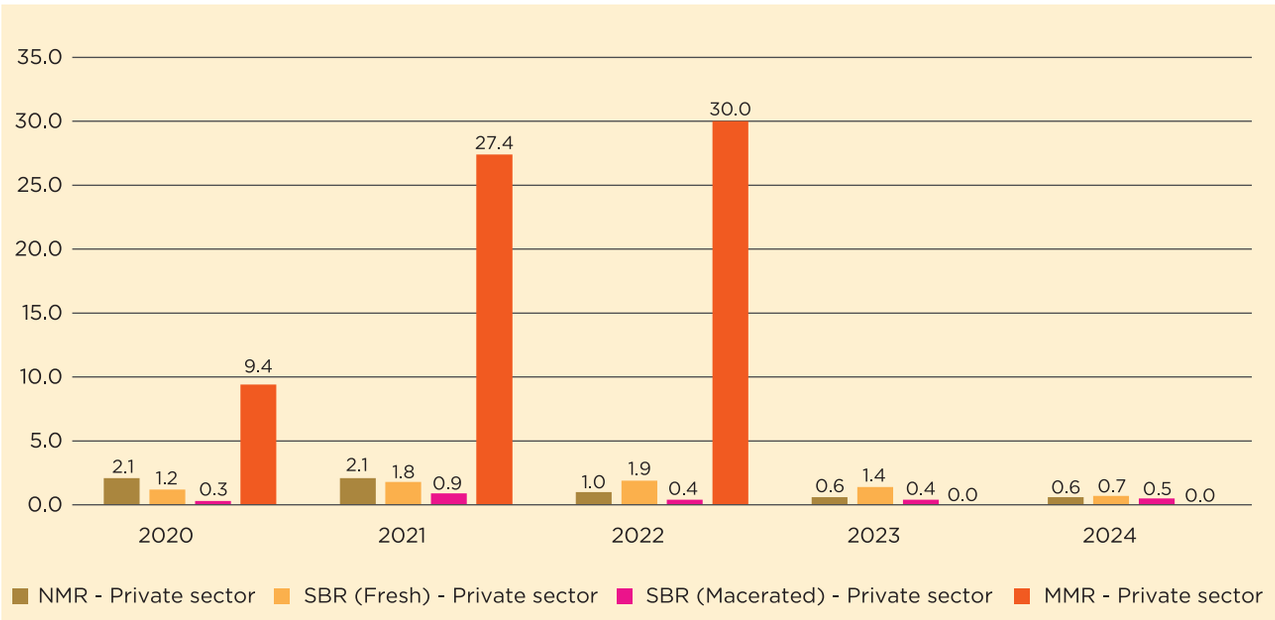
Private sector – Breastfeeding within one hour of birth



Source: FHB, eRHMIS2 2024

Figure 3.7: Proportion of newborns breastfeeding within one hour of birth.

Initiation of breast feeding within first hour in private healthcare institutions was 98.7% and has reduced when compared to 2023.



Source: FHB, eRHMIS2 2024

Figure 3.8: NNMR, SBR and MMR comparison of private sector hospitals in Sri Lanka

INFANT AND CHILD HEALTH

Table 2.2: Number of registered births from 2020 - 2024

	2020	2021	2022	2023	2024
No. of births (RGD)	301,706	284,848	275,321	247,900	220,761

Source: RGD 2024

Table 2.3: Infant and childcare provided by the field staff from 2020 – 2024

Indicator	2020	2021	2022	2023	2024
Infants registered by PHMM out of Estimated Births	90.8	85.9	86.3	81	76.8
% Infants having at least 1 home visit after 42 days out of registered infants	49.1	45.6	50.9	55	55.3
Average number of home visits per infant	7.5	7.6	7.7	8.6	8.6
% of infants weighed	67.8	68.3	83	90.1	92.1
Average number of clinic attendance for an infant	5.3	5.5	5.2	5.5	5.3
% of estimated infants given Vitamin A at 6 Months	78.6	81.5	76.3	77.5	73.3
% of young children (1-2 years) weighed	60.9	56.4	73	83.7	85.4
% of estimated children given Vitamin A at 18 Months	85	83.4	83.5	84.7	88.6
% of 2 - 5-year-old children weighed	62.3	55.9	70.6	82.3	85.5
% of estimated children given Vitamin A at 3 years	87.1	91.9	91.5	98.7	101.8

Source: FHB, eRHMIS 2024

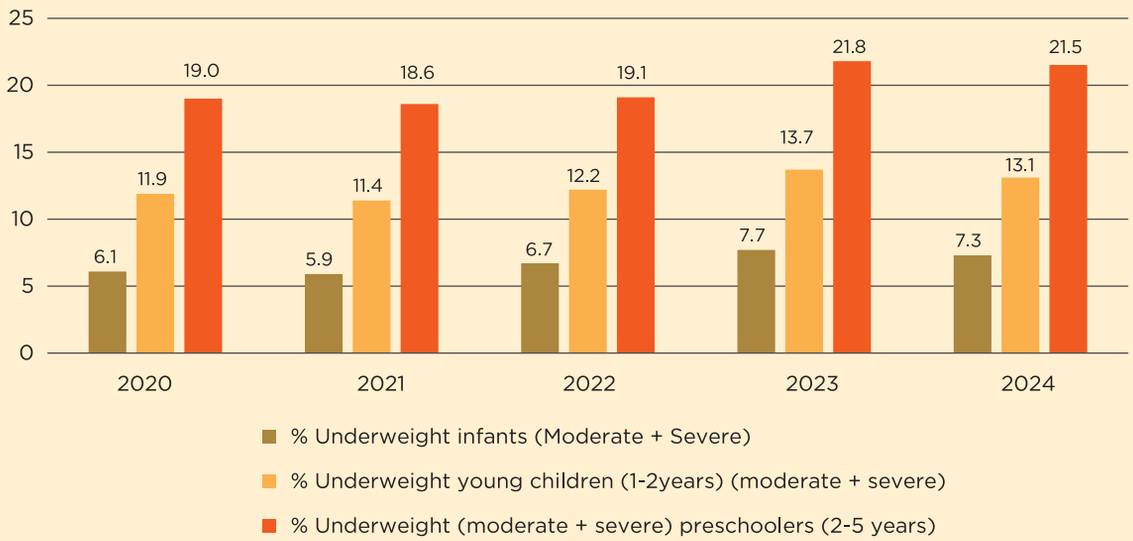
Table 2.4: Percentages of underweight in infants, young children and preschoolers from 2020 to 2024

Indicator	2020	2021	2022	2023	2024
% Moderately Underweight infants	5	4.9	5.5	6.2	5.9
% Severely Underweight infants	1.1	1	1.2	1.5	1.4
% Moderately Underweight young children (>1-2 years)	10.2	9.9	10.4	11.7	11.2
% Severely Underweight young children (>1-2 years)	1.7	1.6	1.8	2	1.9
% Moderately Underweight preschoolers (>2 to 5th year)	16.4	16.1	16.3	18.7	18.5
% Severely Underweight preschoolers (>2 - 5th year)	2.6	2.6	2.8	3.1	3

Source: FHB, eRHMIS 2024

The underweight rates of all age groups have slightly decreased in 2024.

Trends in infant, young child and preschool underweight



Source: FHB, eRHMIS 2024

Figure 3.9: Trends in infants, young children and preschool underweight (moderate and severe) from 2020 - 2024

An increasing trend of underweight with increasing age can be observed.

Table 2.5: Trends in infant, young child and preschool stunting (moderate and severe) from 2020 – 2024

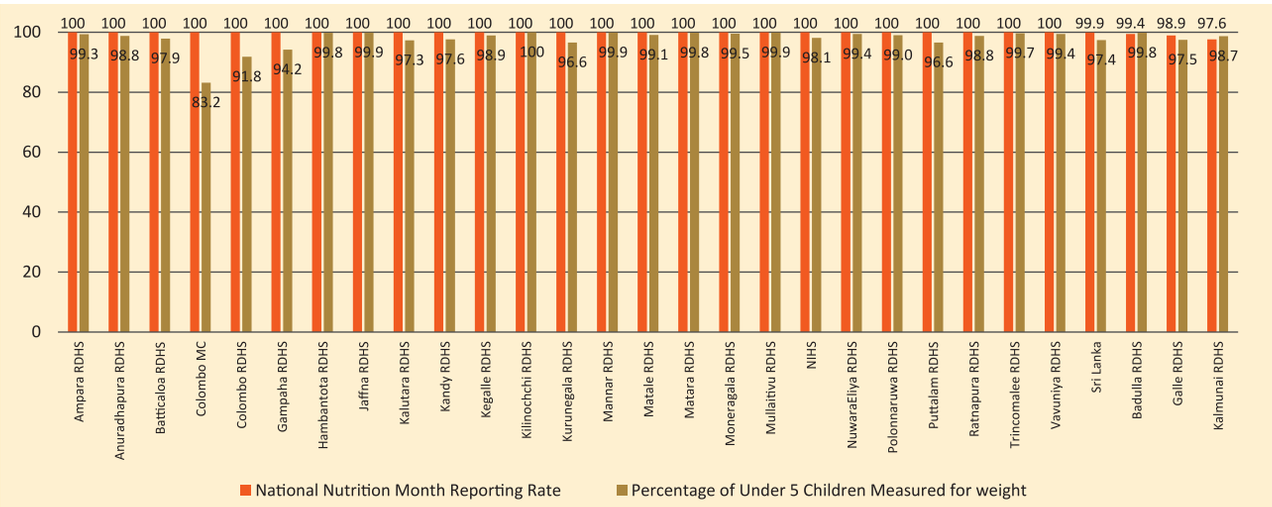
Year	4 months	9 months	18 months	3 years
2020	1.3	2	1.8	1.7
2021	1	1.5	1.7	1.5
2022	1.1	2.6	1.8	1.5
2023	1.7	2.4	3.0	2.7
2024	2.1	2.9	4	4.1

Source: FHB, eRHMIS 2024

Stunting rates obtained via eRHMIS appear to be grossly underreported. This issue is being addressed at MCH review meetings at district level.

Nutrition month data

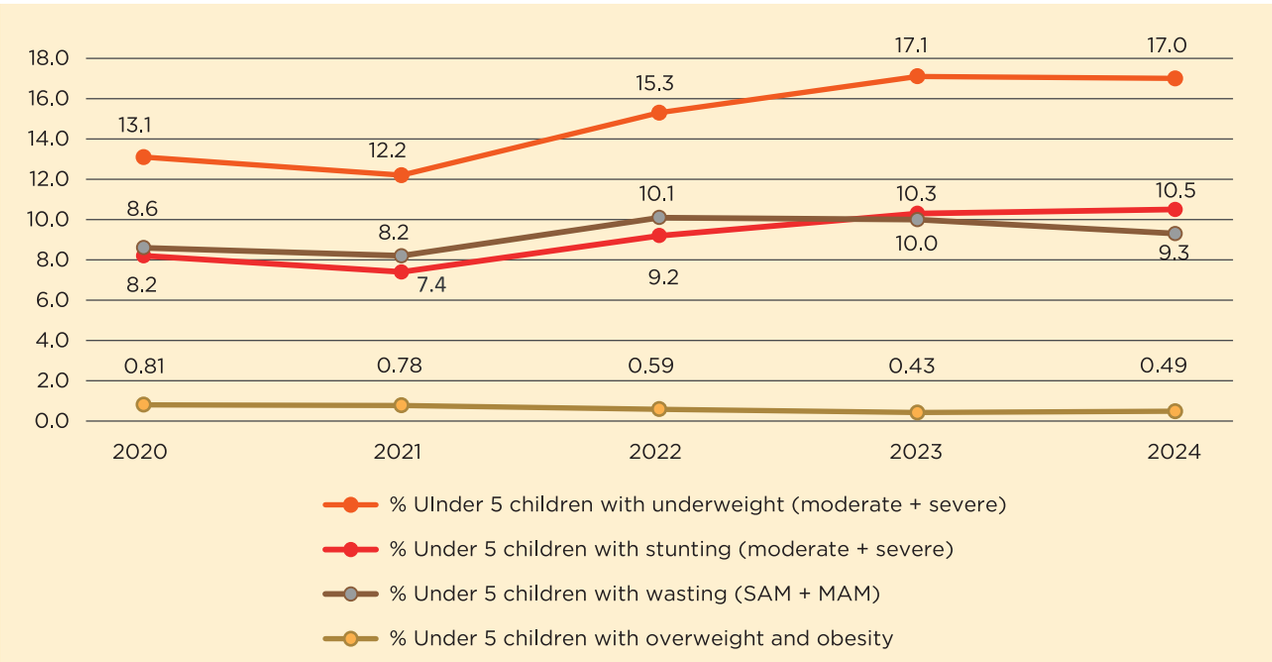
Nutrition month data reporting rates and the weighing coverage from all districts were as follows.



Source: FHB, NM 2024

Figure 4.0: Nutrition Month Reporting Rates and the weighing coverage by PHM Area - 2024

Under nutrition among under five children



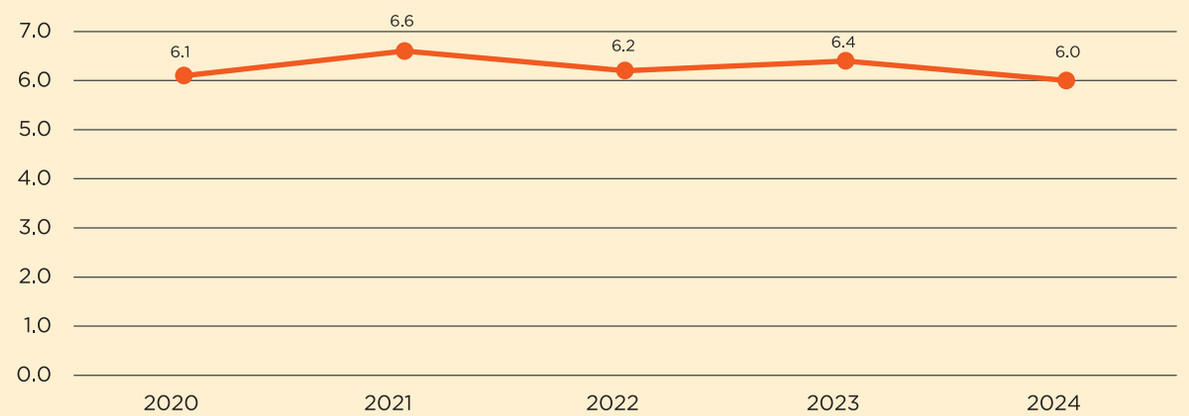
Source: FHB, FHB, NM 2024

Figure 4.1: Under nutrition among under five children from 2020 to 2024

According to the National Nutrition Month data, underweight is more or less stagnant and stunting has increased compared to the previous years. The prevalence of wasting has shown a decreasing trend whereas overweight has reduced by 0.32 from 2020 to 2024.

Infant & under 5 years mortality rates

Still Birth Rate

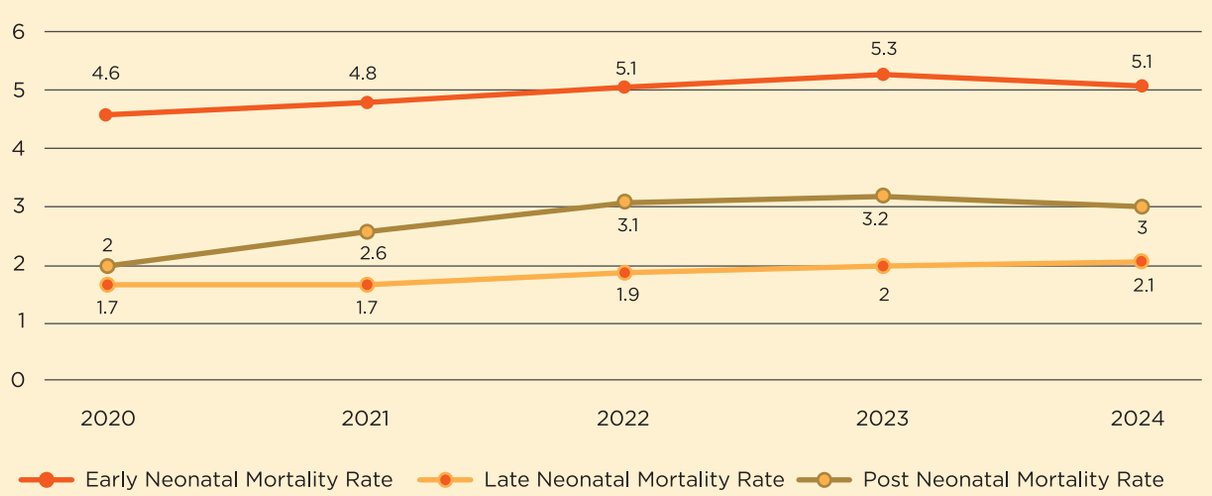


Source: FHB, eRHMIS 2024

Figure 4.2: Still Birth Rate from 2020 to 2024

Still birth rate is stagnant at around 6 per 1000 live births from 2020 to 2024.

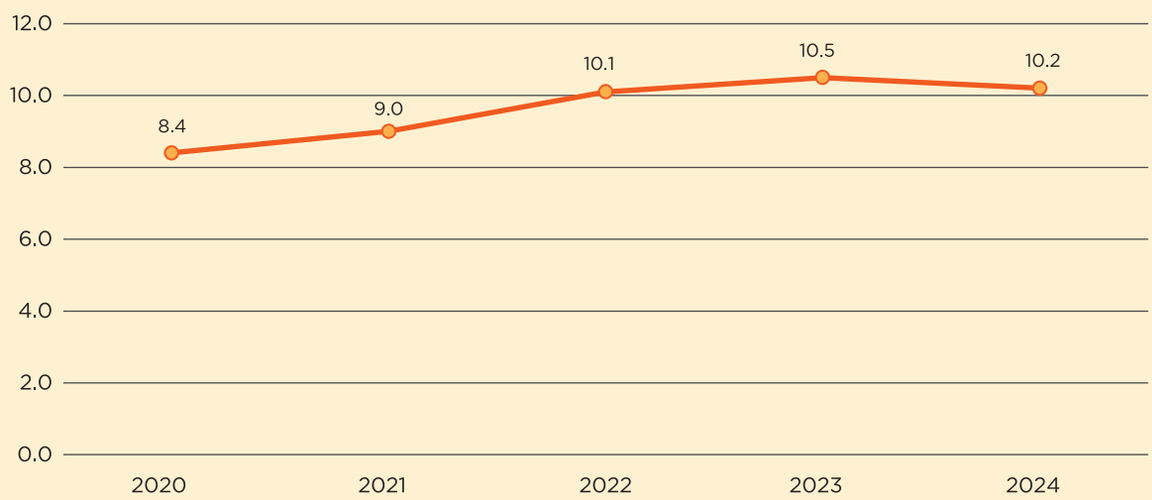
Neonatal Mortality Rates



Source: FHB, eRHMIS 2024

Figure 4.3: Neonatal Mortality Rates from 2020 to 2024

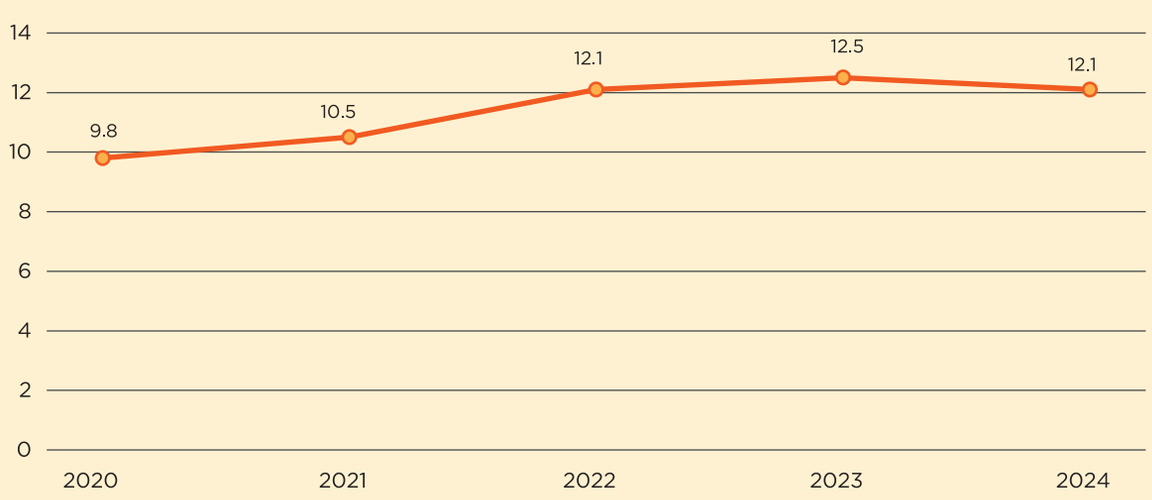
Infant Mortality Rate



Source: FHB, eRHMIS 2024

Figure 4.4: Infant Mortality Rates from 2020 to 2024

1- 5 Year Mortality Rate

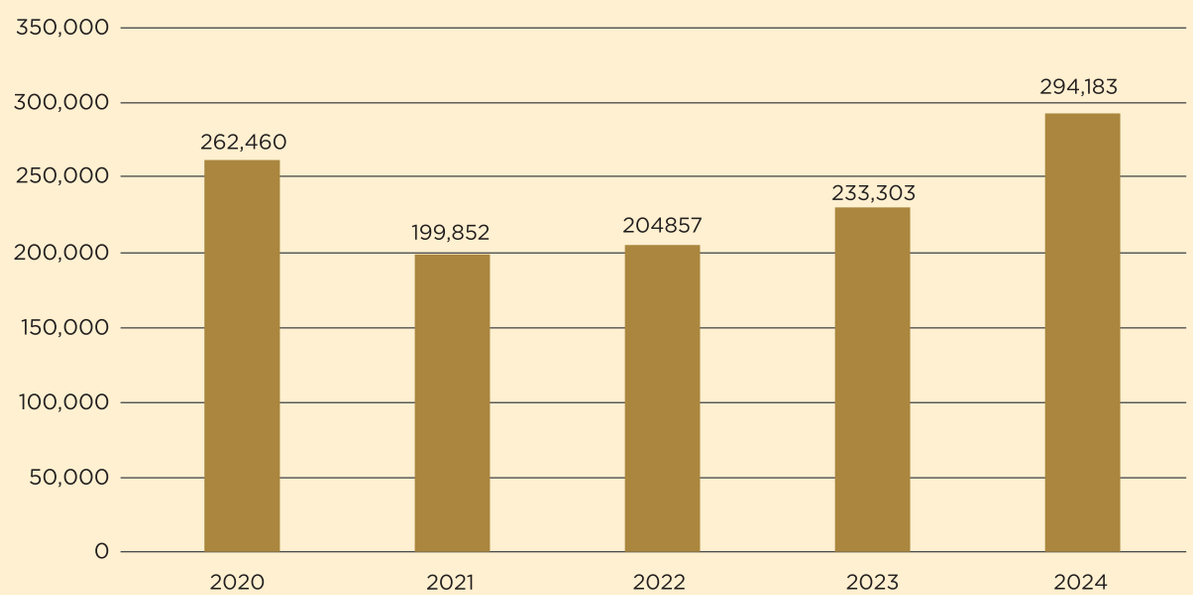


Source: FHB, eRHMIS 2024

Figure 4.5: 1 - 5-year Mortality Rates from 2020 to 2024

ADOLESCENTS AND YOUTH HEALTH INCLUDING SCHOOL HEALTH

Adolescents and Youth Health

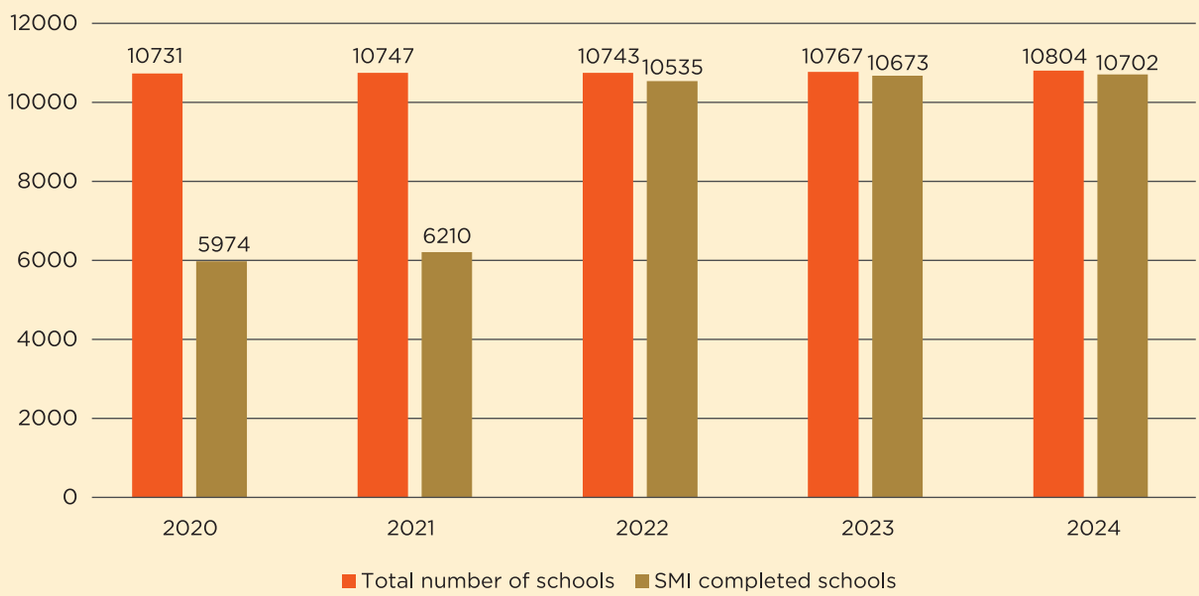


Source: FHB, eRHMIS 2024

Figure 4.6: Adolescents Newly Registered 2020 - 2024



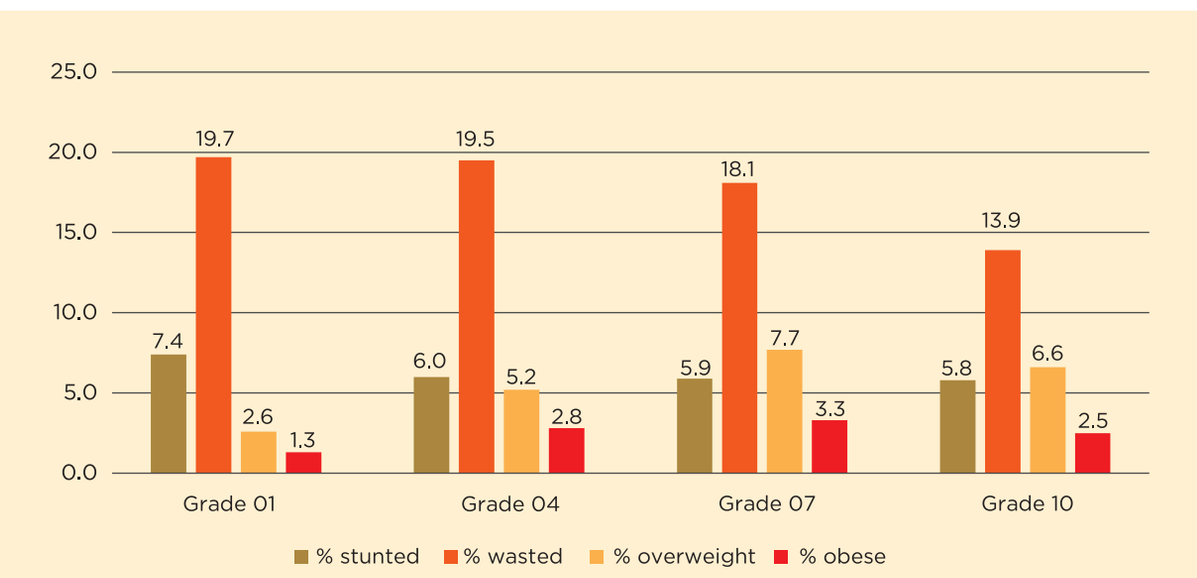
School Health



Source: FHB, eRHMIS 2024

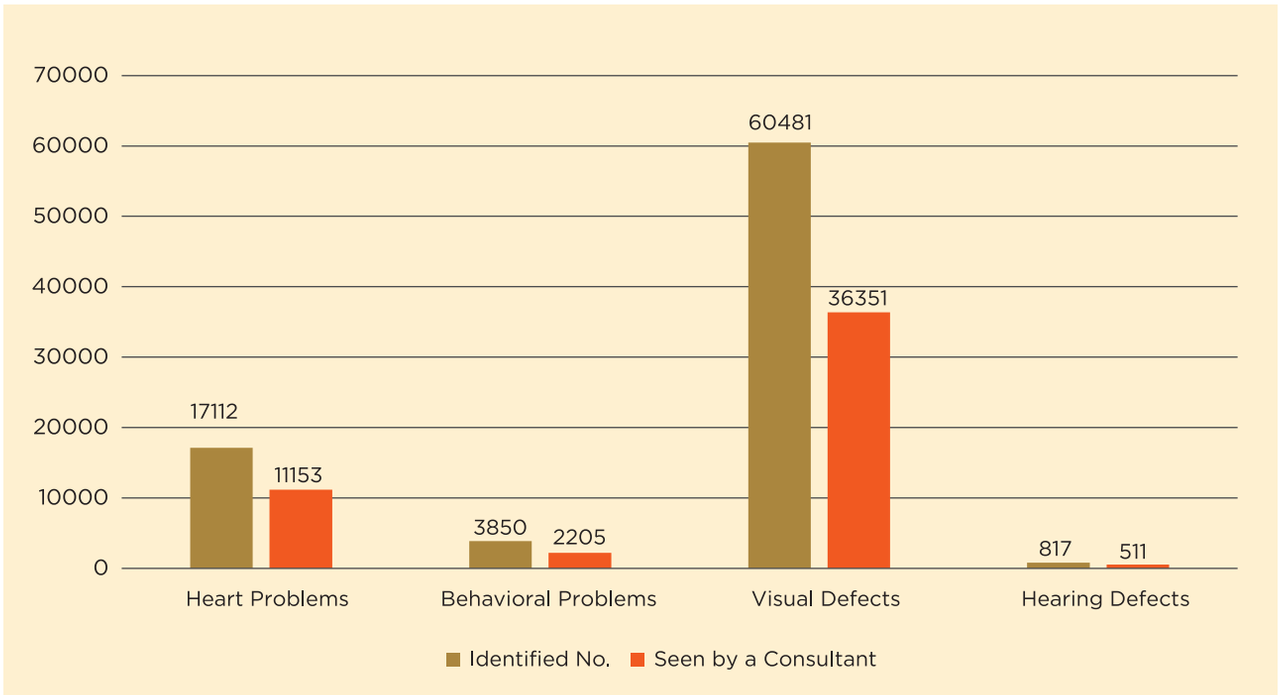
Figure 4.7: Total number of schools versus number of schools where SMI were conducted 2020 to 2024

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



Source: FHB, eRHMIS, 2024

Figure 4.8: Percentage Distribution of School Children in Grades 1, 4, 7 & 10 with Stunting, Wasting, Overweight and Obesity 2024



Source: FHB, eRHMIS, 2024

Figure 4.9: Total number of selected defects among examined school children Vs number seen by a consultant 2024

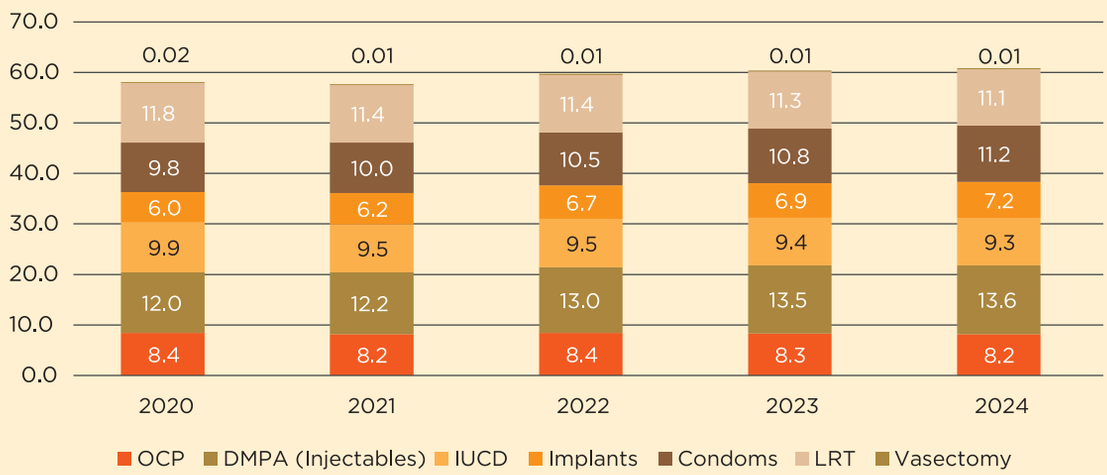
FAMILY PLANNING

Table 2.6: Percentage of eligible families using all methods 2020 – 2024

Indicator	2020	2021	2022	2023	2024
Modern methods	57.1	57.4	59.4	60.2	60.6
Natural/Traditional	9	8.9	9.1	9.2	9.3
All	66.1	66.3	68.5	69.4	69.8

Source: FHB, eRHMIS 2024

Current users of modern family planning methods



Source: FHB, eRHMIS 2024

Figure 5.0: Current users of modern family planning methods, from 2020 - 2024

There has been no significant change in the trends of family planning usage observed over the last 5 years.

Contraceptive methods new acceptors

Table 2.7: Contraceptive methods new acceptors by method from 2020 – 2024

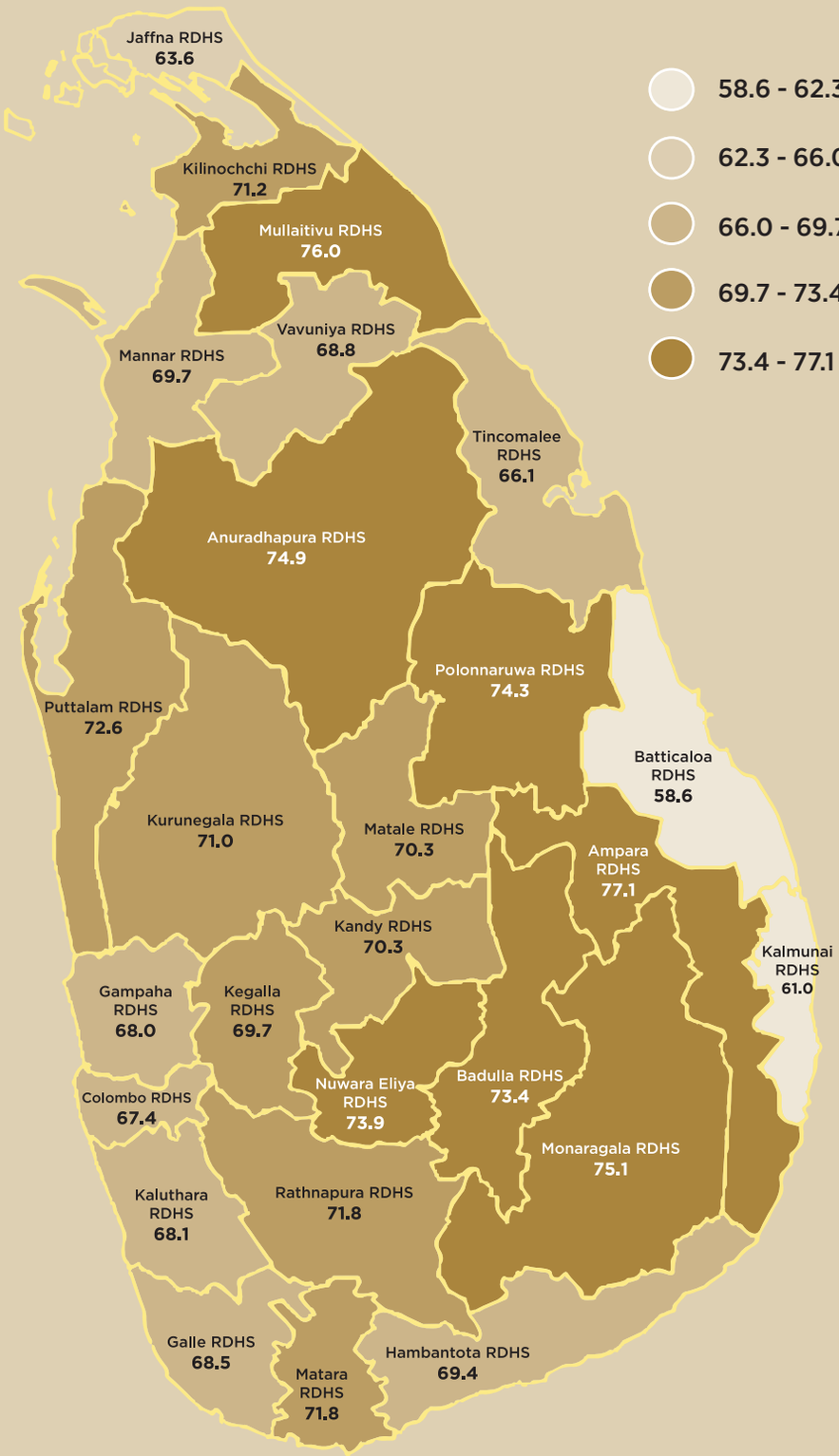
Data element	2020	2021	2022	2023	2024
New Acceptors (No.)	128,799	225,822	258,902	234,102	227,206
IUD	17,320	28,622	36,733	36,981	32,800
Oral Pills	22,902	44,480	50,459	43,860	42,427
Sterilizations	11,212	30,116	30,632	28,521	28,387
Injectable	40,295	79,700	86,824	81,539	70,949
Implants	37,070	42,904	54,254	43,201	52,643

Source: FHB, eRHMIS 2024

** 2020 New Acceptors (No.) data from the H1200B*

In 2024, new acceptors for each family planning method have decreased except for Implants.

MCH | 13.10 Percentage of eligible couples using any family planning method : 2024

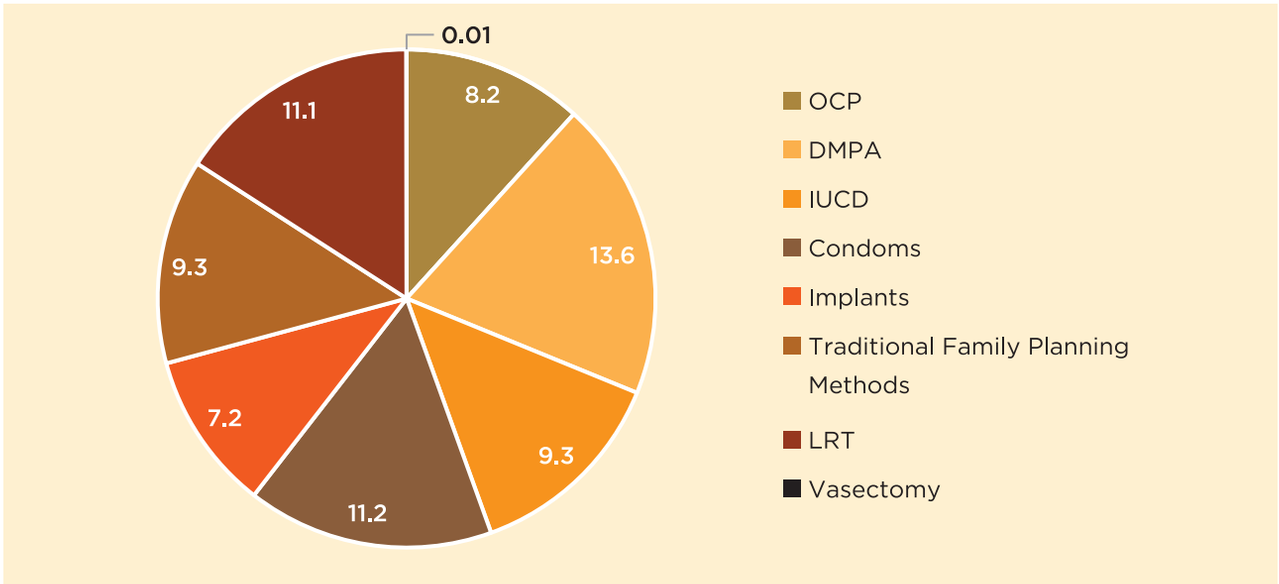


Highest family planning usage was reported from Ampara district (77.1) whereas lowest is reported from Batticaloa (58.6)

Source: FHB, eRHMIS 2024

Figure 5.1: Shows the district variation in CPR (All methods) in 2024

Various contraceptive Methods

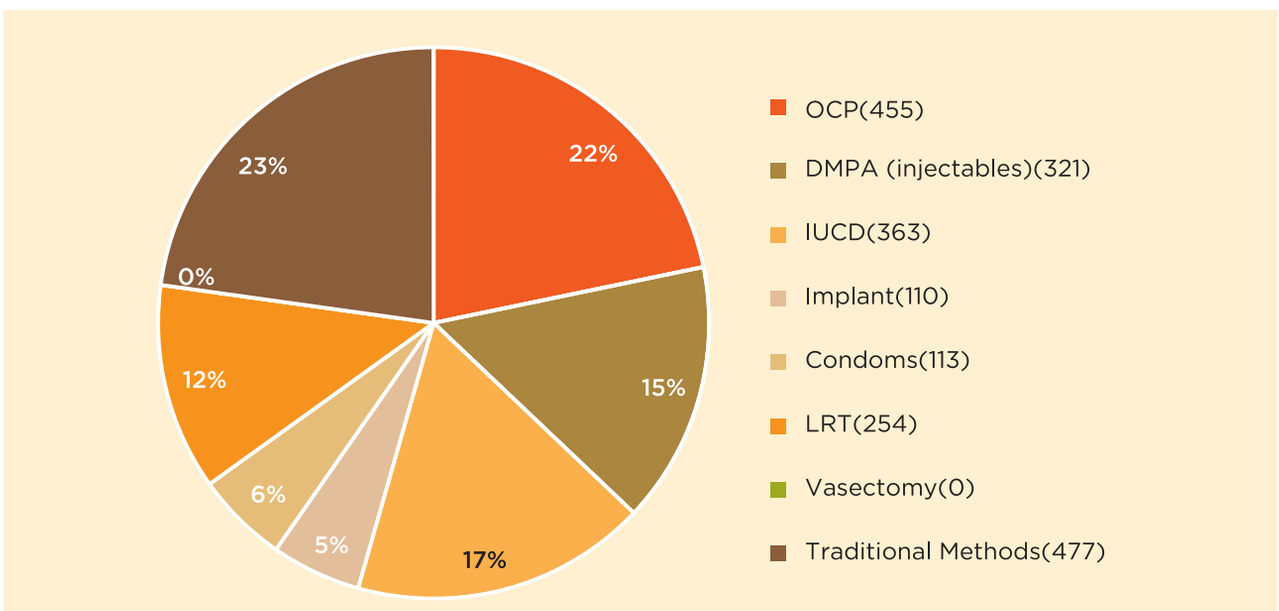


Source: FHB, eRHMIS 2024

Figure 5.2: Distribution of various contraceptive methods in 2024

The mostly used family planning method was DMPA with a rate of 13.6.

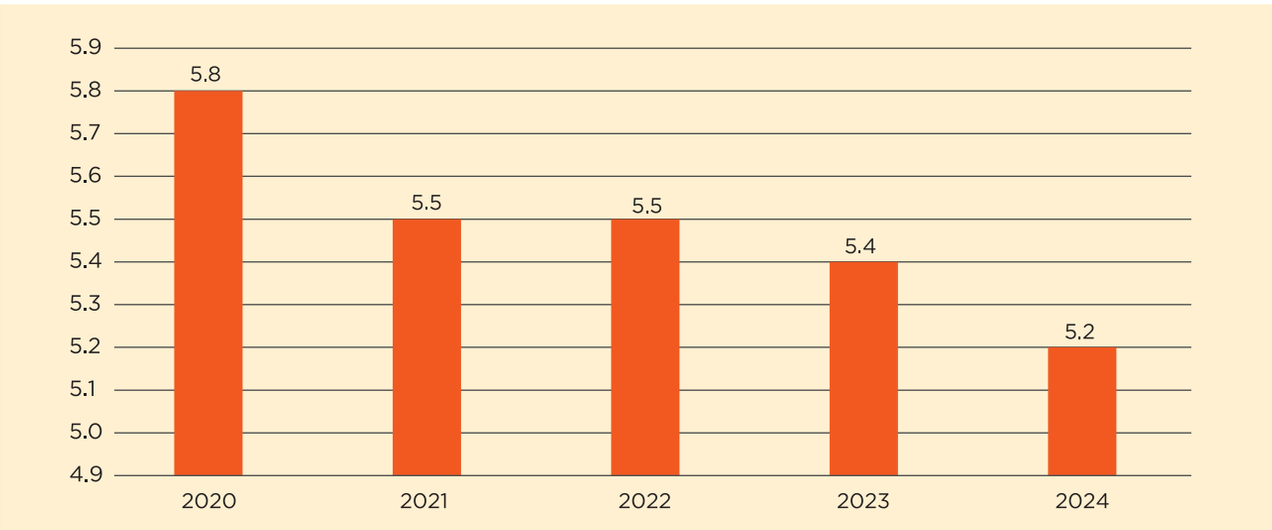
Contraceptive Failure Rate



Source: FHB, eRHMIS 2024

Figure 5.3: Contraceptive failure rate in 2024

Percentage of eligible couples having unmet need for family planning



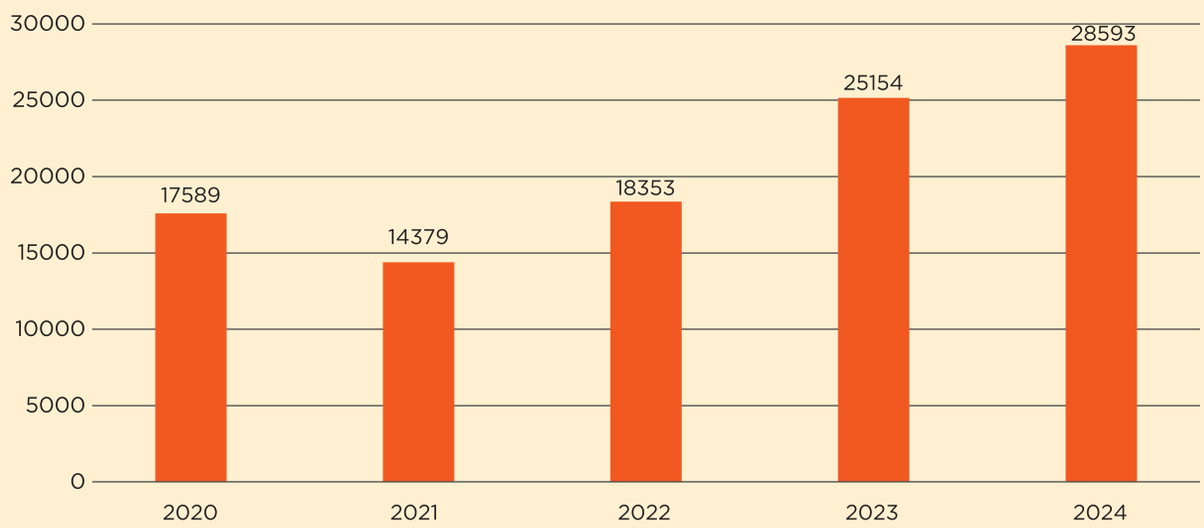
Source: FHB, eRHMIS 2024

Figure 5.4: Percentage of eligible couples having unmet need for family planning 2020 - 2024

Unmet need seems to be reducing over the years and in 2024, it is 5.2.

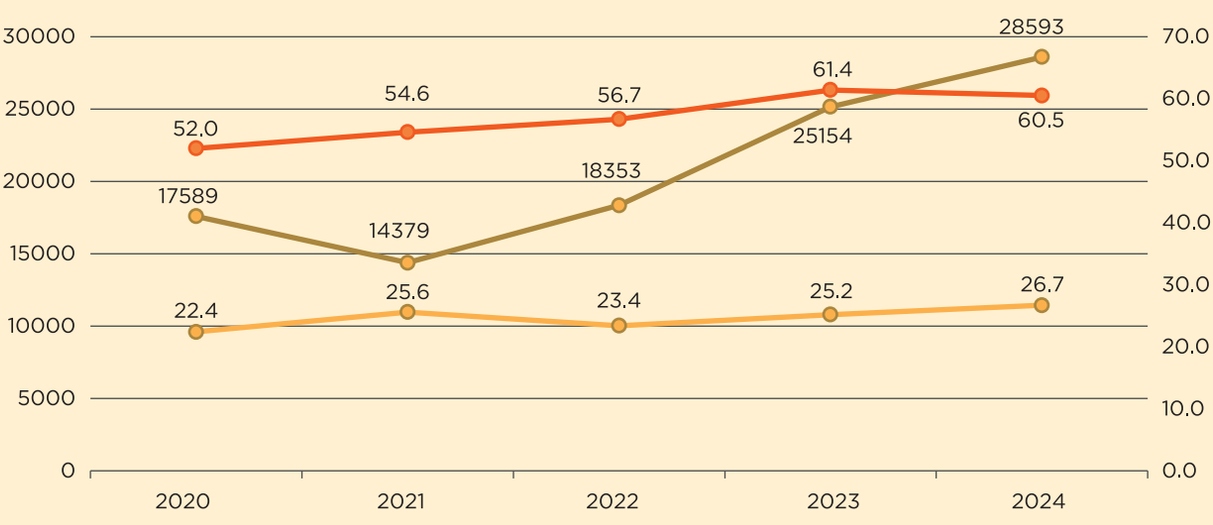
GENDER AND WOMEN'S HEALTH INCLUDING WELL WOMAN PROGRAMME

Health Sector Response to Gender-Based Violence



Source: FHB, eRHMIS 2024

Figure 5.5: Total number of GBV Survivors identified by the Public/ Field health staff (2020 - 2024)



Source: FHB, eRHMIS 2024

Figure 5.6: GBV Survivor care provided by the Public/ Field health staff (2020 - 2024)

Well Woman Programme

Table 2.9: Number of first visits to WWCs from 2020 to 2024 (by age group)

Data element	2020	2021	2022	2023	2024
35 Years (first visit)	102,389	76,890	98,835	116,456	109,406
45 Years (first visit)	36,841	31,640	53,863	83,007	81,575
Other ages (first visit)	22,592	11,016	25,153	32,258	27,786
Total	161,822	119,546	177,851	231,721	218,767

Source: FHB, eRHMIS 2024

Table 3.0: Well Woman Clinic attendance by women aged 35 years and 45 years (2020-2024)

Indicator	2020	2021	2022	2023	2024
Percentage of women aged 35 years who attended the WWC	58.1	43.6	55.2	65.6	62.5
Percentage of women aged 45 years who attended the WWC	20.9	17.9	30.1	46.7	46.6

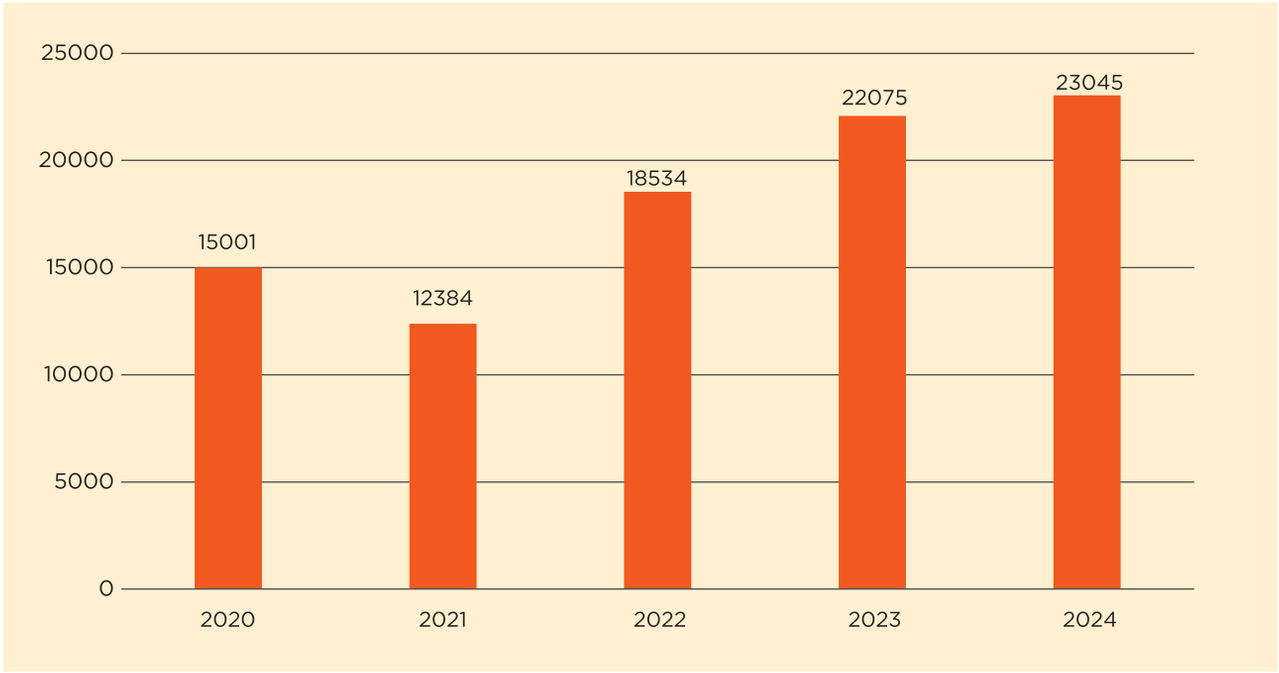
Source: FHB, eRHMIS 2024

Table 3.1: Clinic attendance (first visits) and morbidities detected (2020 - 2024)

Data element	2020	2021	2022	2023	2024
Number of 35-year women attending WWC clinics	102,389	76,890	98,852	116,456	109,406
Cervical smears reported as high- and low-grade lesions	347	378	565	589	910
Cervical smears reported as malignant (Carcinoma)	3	9	3	12	10
Breast abnormalities detected	2780	1848	3762	5278	5363
Diabetes Mellitus detected	4959	5255	8837	6079	6998
Hypertension detected	6259	4912	7729	10784	10214

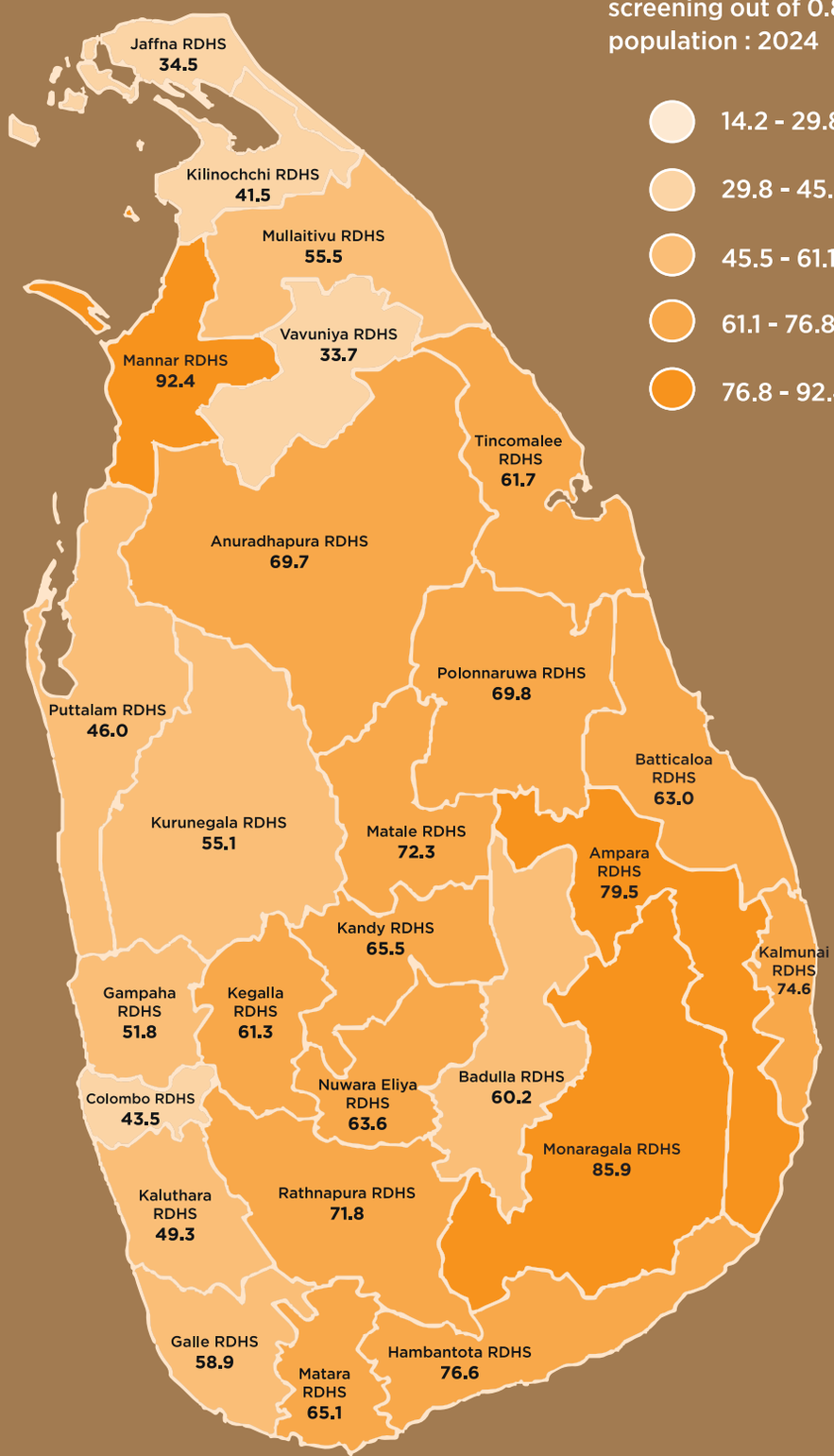
Source: FHB, eRHMIS 2024

Number of 35-year cohort women attendance has reduced and out of morbidities reported, diabetes has increased and hypertension has decreased 2024.



Source: FHB, eRHMIS 2024

Figure 5.7: Number of Well Woman Clinic sessions carried out during the past years

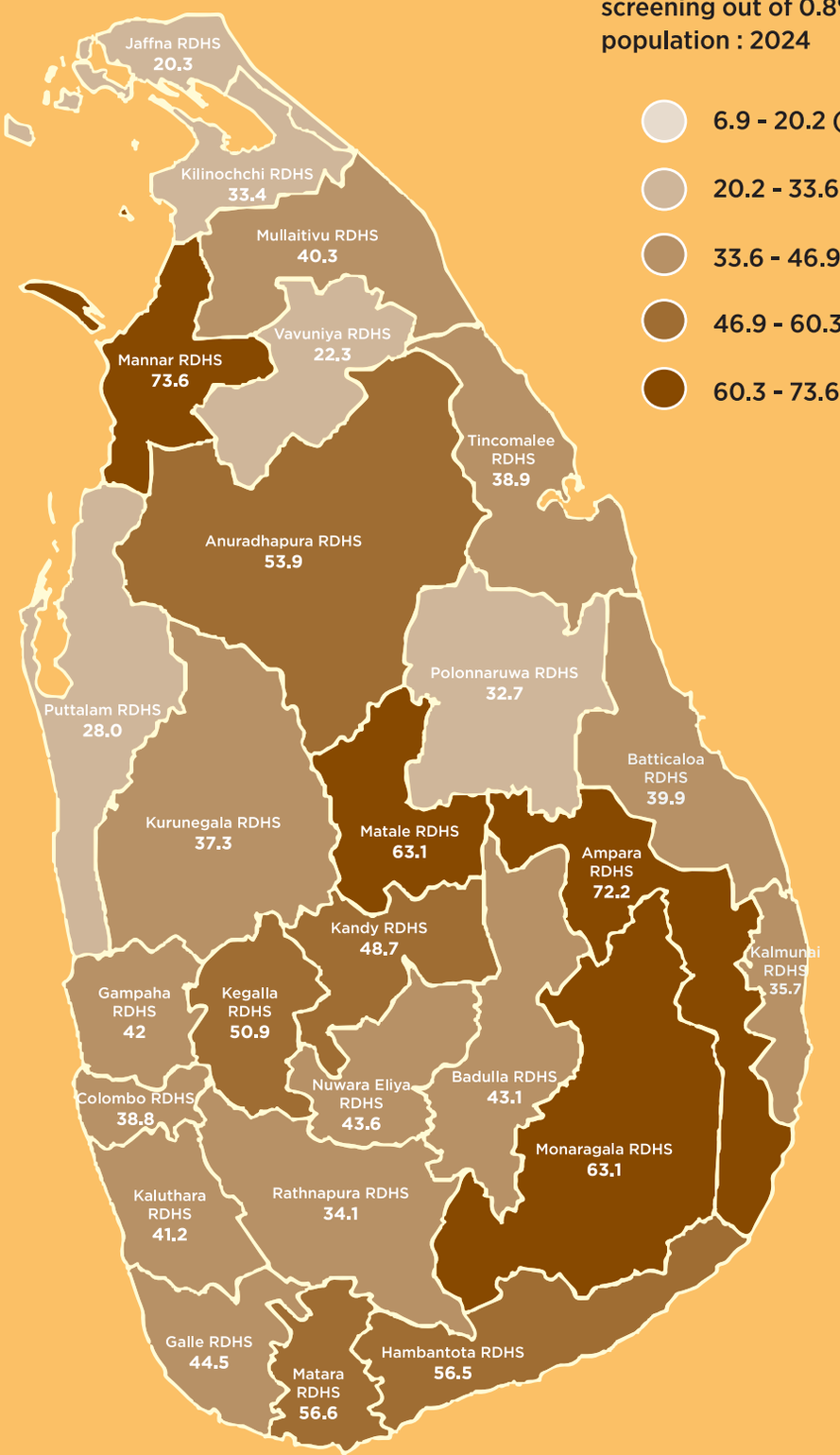


The highest 35-year pap smear coverage was reported from Mannar (92.4) and lowest CMC (14.2) reported from Jaffna District.

Source: FHB, eRHMIS 2024

Figure 5.8: Map of the Coverage of the 35 years cohort by districts (2024)

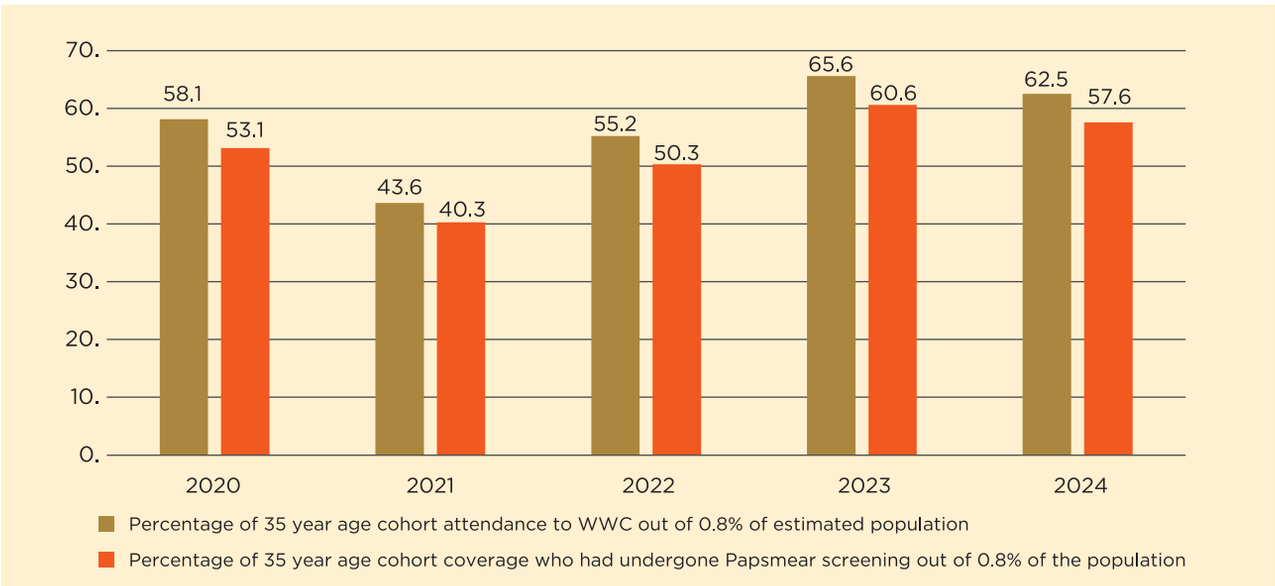
MCH | 15.05 Percentage of 45 year age cohort coverage who had undergone papsmear screening out of 0.8% of the population : 2024



Highest 45-year pap smear coverage was reported from Mannar district (73.6) and lowest from CMC (6.9).

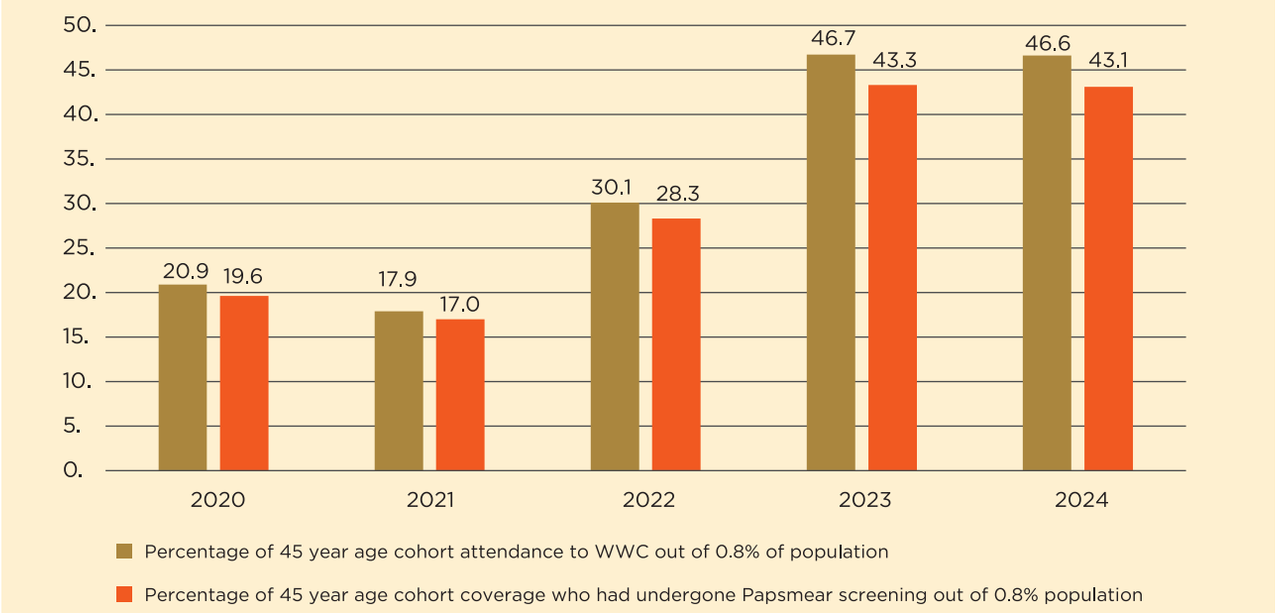
Source: FHB, eRHMIS 2024

Figure 5.9: Map of the coverage of the 45 years cohort by districts (2024)



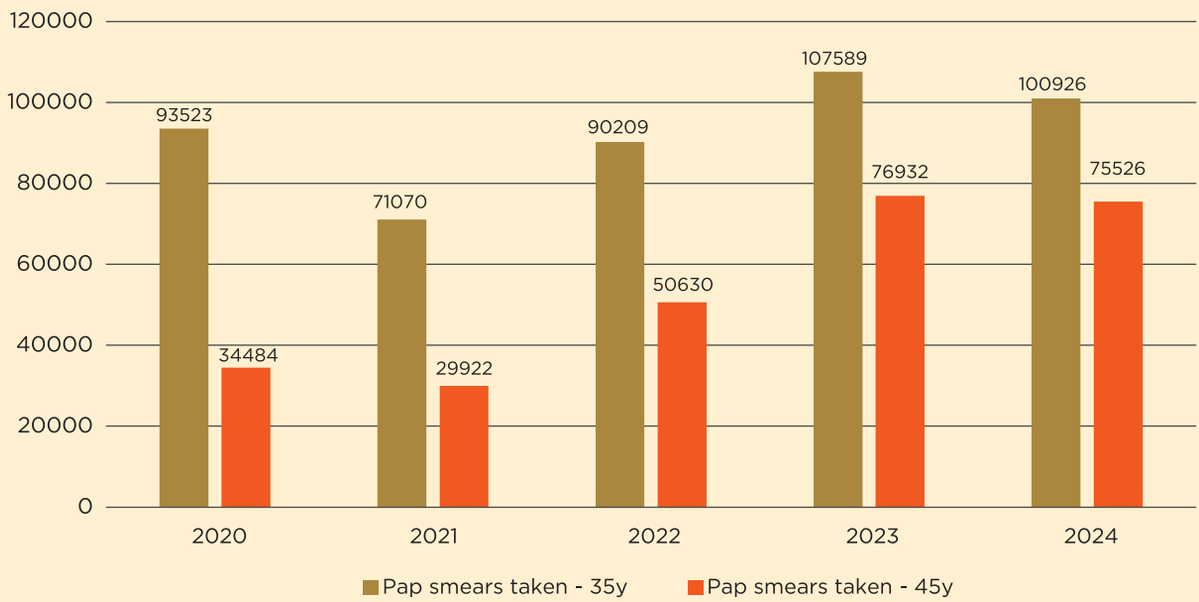
Source: FHB, eRHMIS 2024

Figure 6.0: Percentage 35-year age cohort attendance and cervical screening coverage



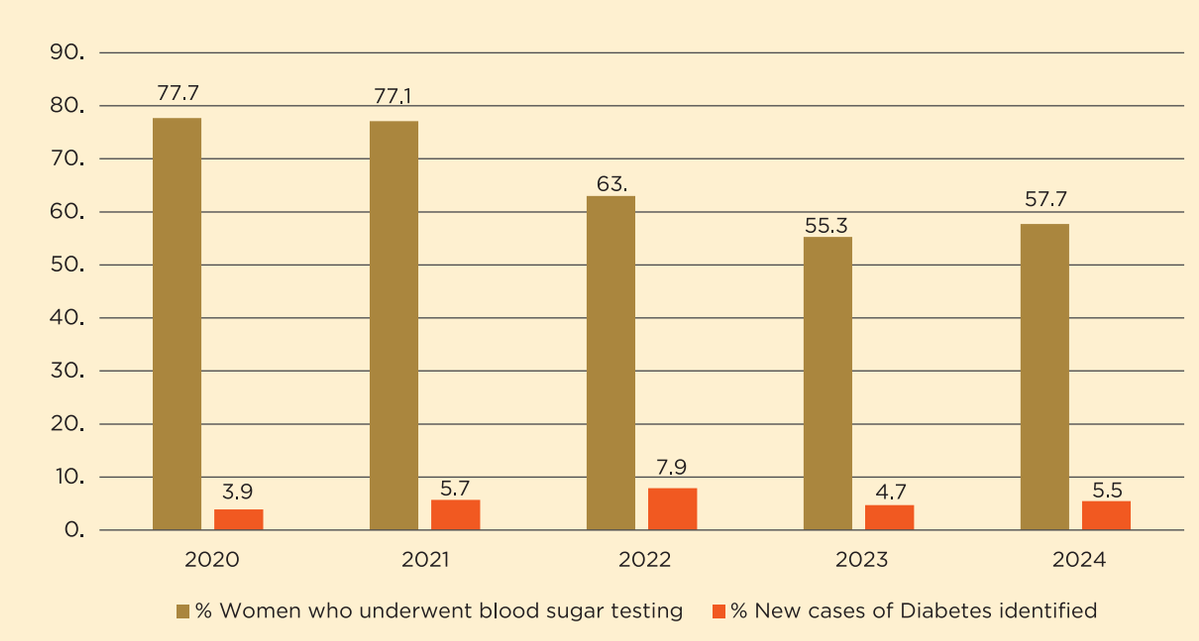
Source: FHB, eRHMIS 2024

Figure 6.1: Percentage 45-year age cohort attendance and cervical screening coverage



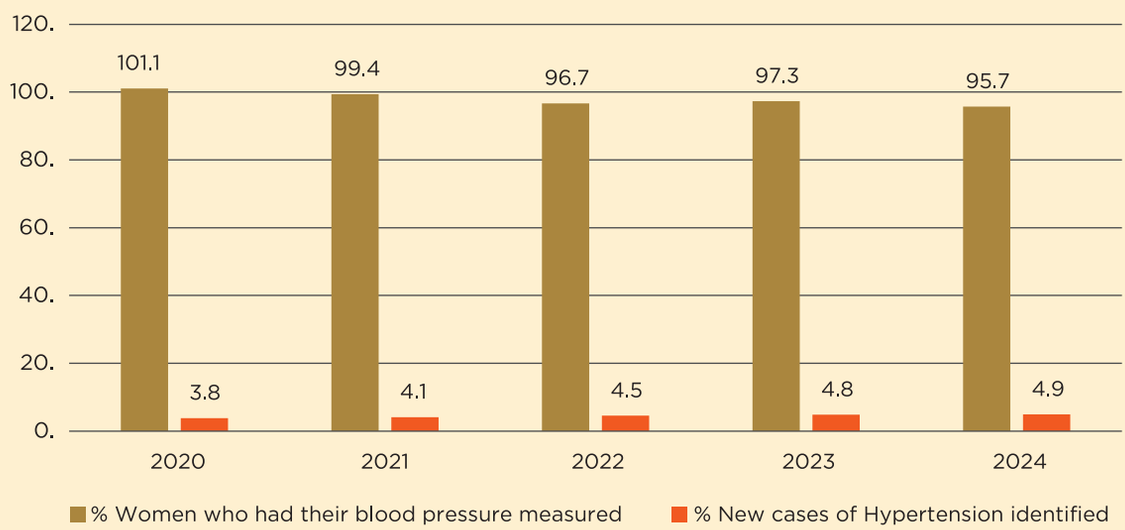
Source: FHB, eRHMIS 2024

Figure 6.2: Number of Pap smears taken in 35 and 45 age cohorts during the past five years.



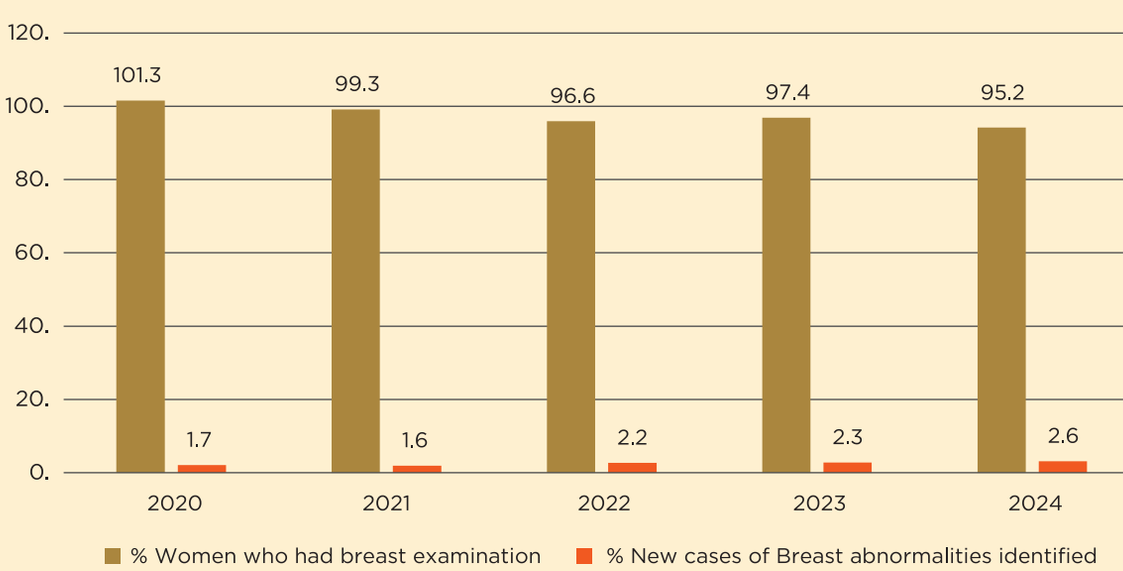
Source: FHB, eRHMIS 2024

Figure 6.3: Random blood sugar test coverage and detection of hyperglycemia in the past five years.



Source: FHB, eRHMIS 2024

Figure 6.4: Blood pressure measurement and detection of hypertensive patients, during the past five years.



Source: FHB, eRHMIS 2024

Figure 6.5: Clinical breast examinations conducted and percentage abnormalities detected during the past five years.

ORAL HEALTH OF PREGNANT WOMEN AND SCHOOL CHILDREN

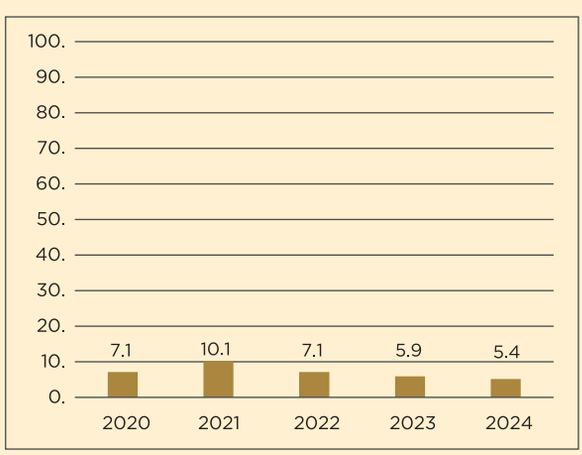
Oral health programme for pregnant mothers

Table 3.2: Percentage of pregnant mothers screened for dental problems

Year	Percentage of pregnant mothers screened for dental problems out of total registered pregnant mothers
2020	80.0
2021	65.0
2022	65.0
2023	87.7
2024	87.9

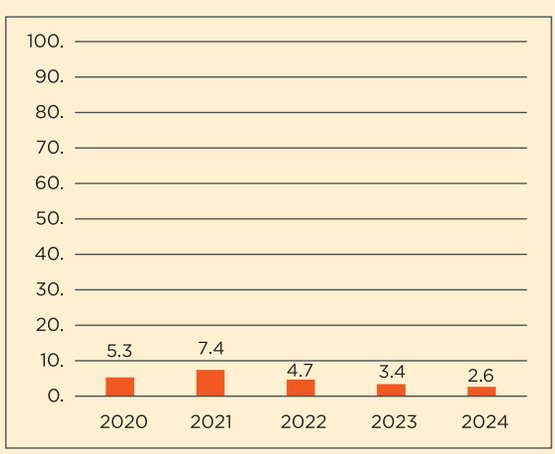
Source: eRHMIS, FHB

Oral health programme for school children



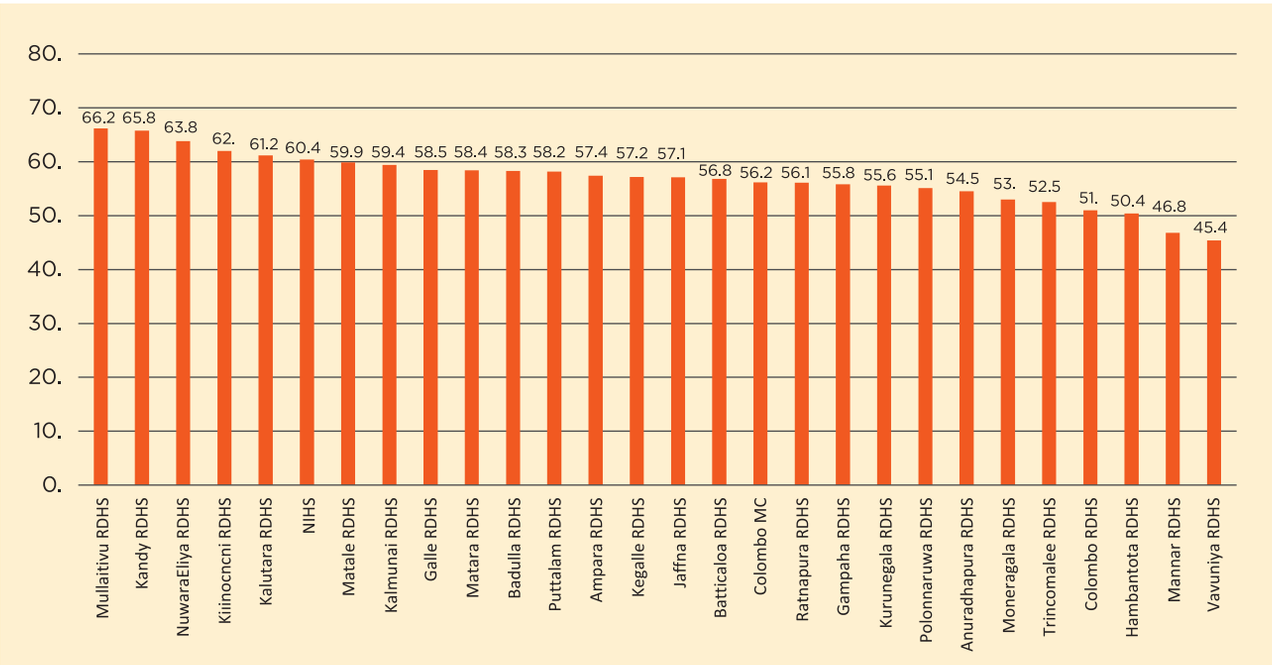
Source: FHB, eRHMIS 2024

Figure 6.6: Percentage of 12-year-olds with untreated caries (Grade 7)



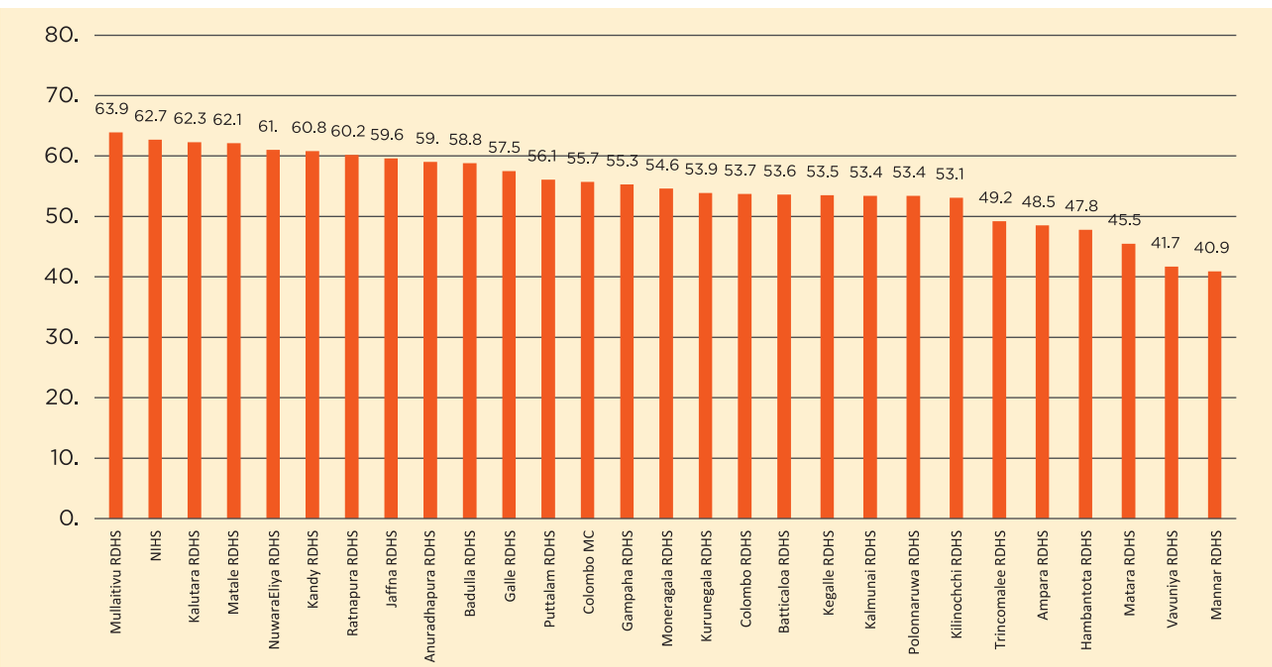
Source: FHB, eRHMIS 2024

Figure 6.7: Percentage of 12-year-olds free of calculus (Grade 7)



Source: FHB, eRHMIS 2024

Figure 6.8: Grade 1 Caries percentage



Source: FHB, eRHMIS 2024

Figure 6.9: Grade 4 Caries Percentage

Table 3.3: Oral health indicators of school dental services

	Indicator	2020	2021	2022	2023	2024
Outcome Indicators	% of 12-year-old children free from dental caries	82.8	81.3	81.7	82.0	81.5
	% of 12-year-old children free of calculus	94.7	92.6	95.3	96.6	96.7
	% healthy 12-year-old children	47.60	62.7	61.4	59.4	62.1
Process Indicators	Screening Coverage of 12-year-old children	43	35.1	74.9	80.6	71.8
	Coverage percentage of the 12-year-old children	37.5	28.6	67.3	73.6	65.7

Source: FHB, eRHMIS 2024

MATERNAL DEATH SURVEILLANCE AND RESPONSE (MDSR) SYSTEM

Sri Lanka pioneered its MDSR mechanism in 1959, later strengthening it in 1985 by introducing mandatory notification of probable maternal deaths. Since 2009, additional quality-focused elements have been incorporated, making the system more comprehensive. Sri Lanka's MDSR framework is recognized internationally as a well-structured model for maternal health surveillance and response.

Current MDSR system in Sri Lanka

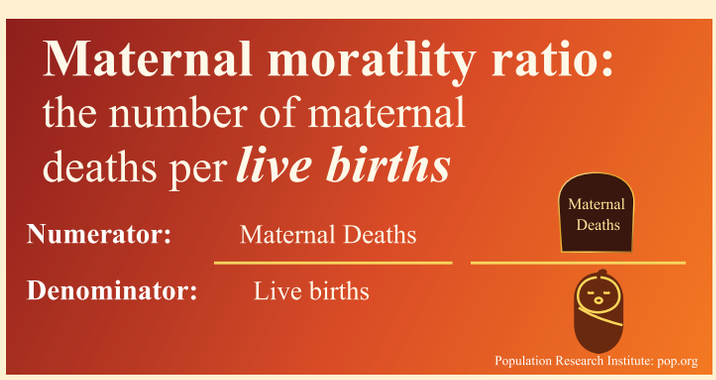
Maternal death notification is a legal requirement in Sri Lanka, mandating that all deaths of women of reproductive age during pregnancy or within one year postpartum be reported to the Family Health Bureau. These deaths are then reviewed at field, institutional, and national levels to identify gaps and prevent recurrence. Each case is analyzed using the three delays model through structured reviews, including national expert panel assessments, to inform improvements in maternal health services and policies. To strengthen this system, the Confidential Enquiry into Maternal Deaths (CEMD) was piloted from 2022 and implemented nationwide in 2025, introducing anonymized, confidential, and specialist-led reviews aligned with international best practices.

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 2024, out of all reported deaths, 55 deaths were categorized as maternal deaths giving a national Maternal Mortality Ratio (MMR) of 24.9 per 100,000 live births (Figure 7.0). Live births reported by the Registrar General's Department for the year 2024 was taken as the denominator (220,761) which showed a reduction from the 2023 figure of 247,900.

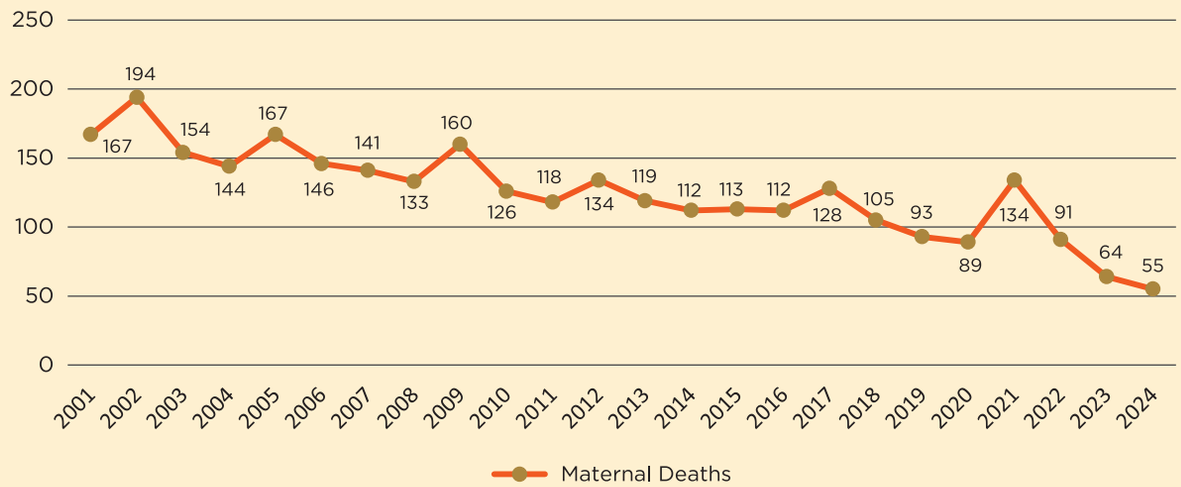
Live Births	=	220,761*
Maternal deaths	=	55
MMR	=	24.9 (per 100,000 live births)



*RGD data

Figure 7.0: Calculation of MMR

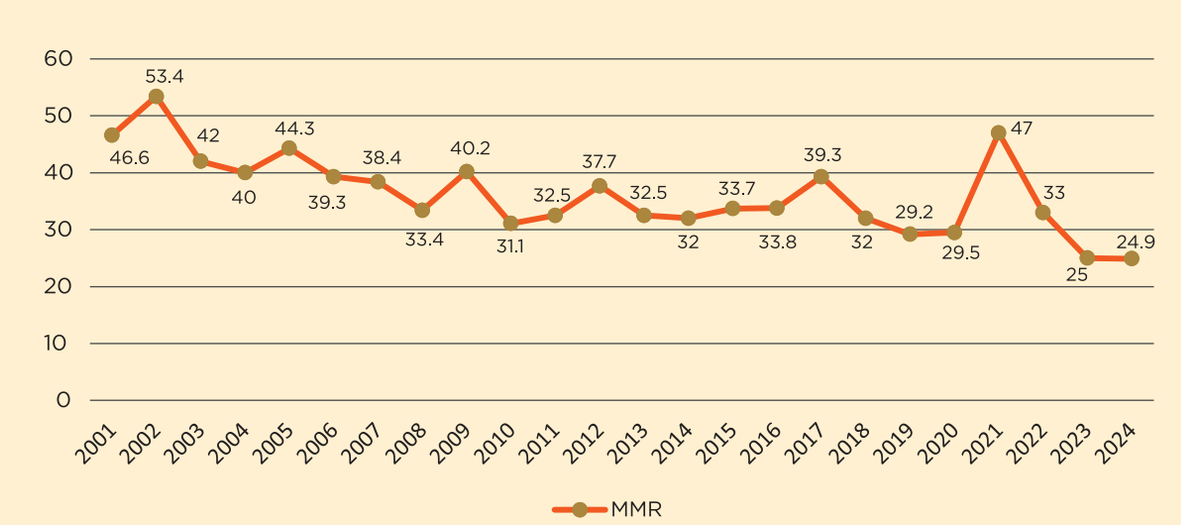
Figure 7.1 presents the number of confirmed maternal deaths in Sri Lanka from 2001 to 2024. A gradual decline is observed up to 2020. However, in 2021, during the peak of the COVID-19 pandemic, a sharp increase in maternal deaths occurred. By 2022, the numbers had returned to the pre-pandemic level, despite the ongoing post-pandemic challenges and the concurrent national financial crisis. In 2024, maternal deaths further declined, with seven (n=7) fewer cases compared to 2023, bringing the final confirmed total to 55.



Maternal Morbidity, Mortality Surveillance Unit – FHB

Figure 7.1: Number of maternal deaths (2001 – 2024)

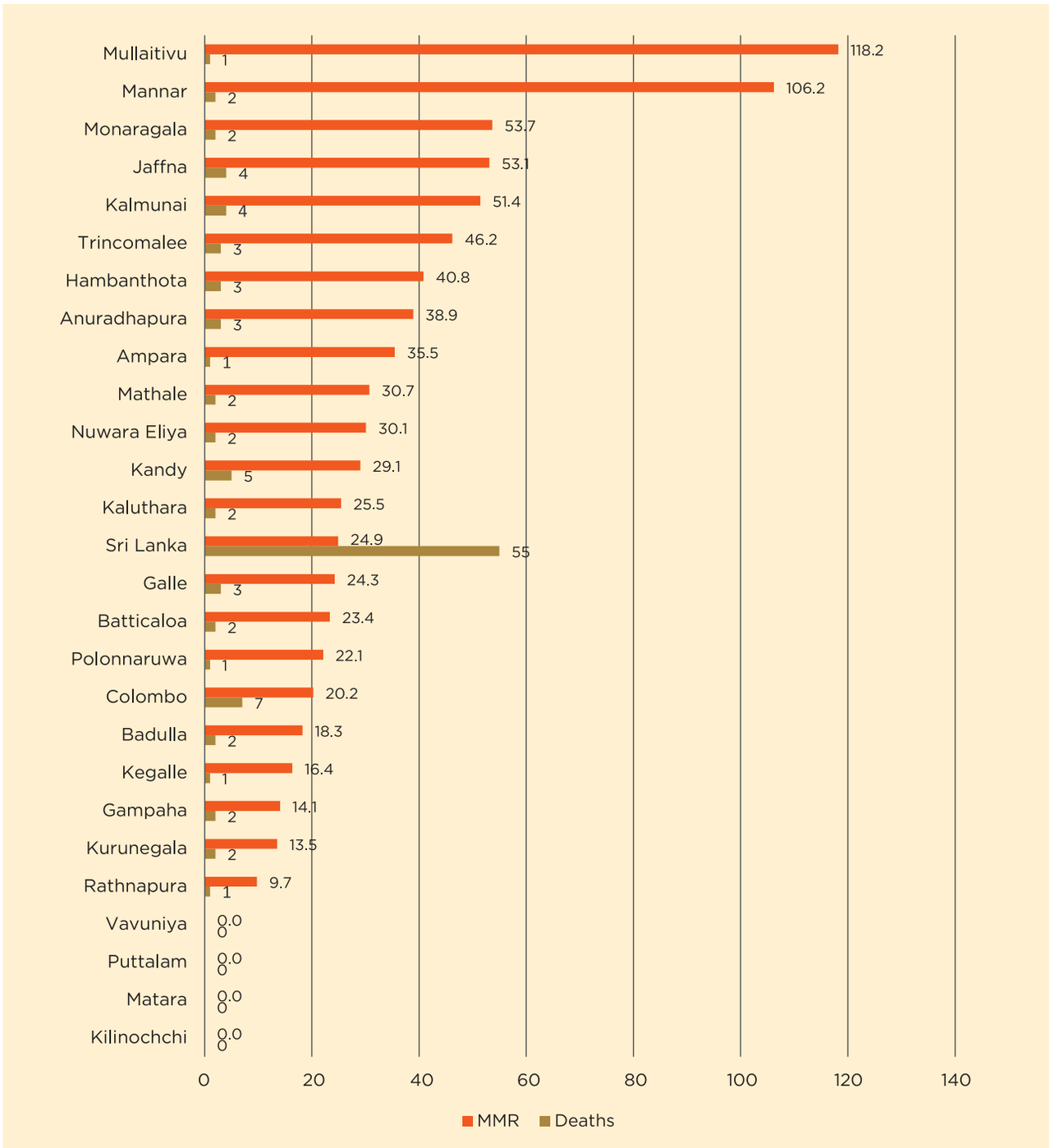
Although the absolute number of maternal deaths declined, the drop in the MMR was minimal in 2024 due to falling birth rates. Figure 7.2 illustrates the trend in MMR from 2001 to 2024. While the country's MMR showed a steady decline over the years, a sharp rise was recorded in 2021, coinciding with the impact of the COVID-19 pandemic. In 2022, the MMR returned to its previous downward trajectory. And by 2024, the MMR dropped slightly to 24.9 per 100,000 live births, which is marginally lower than the figure reported for 2023.



Maternal Morbidity, Mortality Surveillance Unit - FHB

Figure 7.2: Maternal Mortality Ratio (2001 – 2024)

Figure 7.3 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 Mullathiv as 118 per 100,000 live births (n=1). Other leading districts were Mannar and Moneragala each with 2 deaths. The highest number of deaths were reported from Colombo with 7 deaths followed by Kandy district with 5 deaths. Four districts (Vavuniya, Puttalam, Matara and Kilinochchi) reported zero maternal deaths.

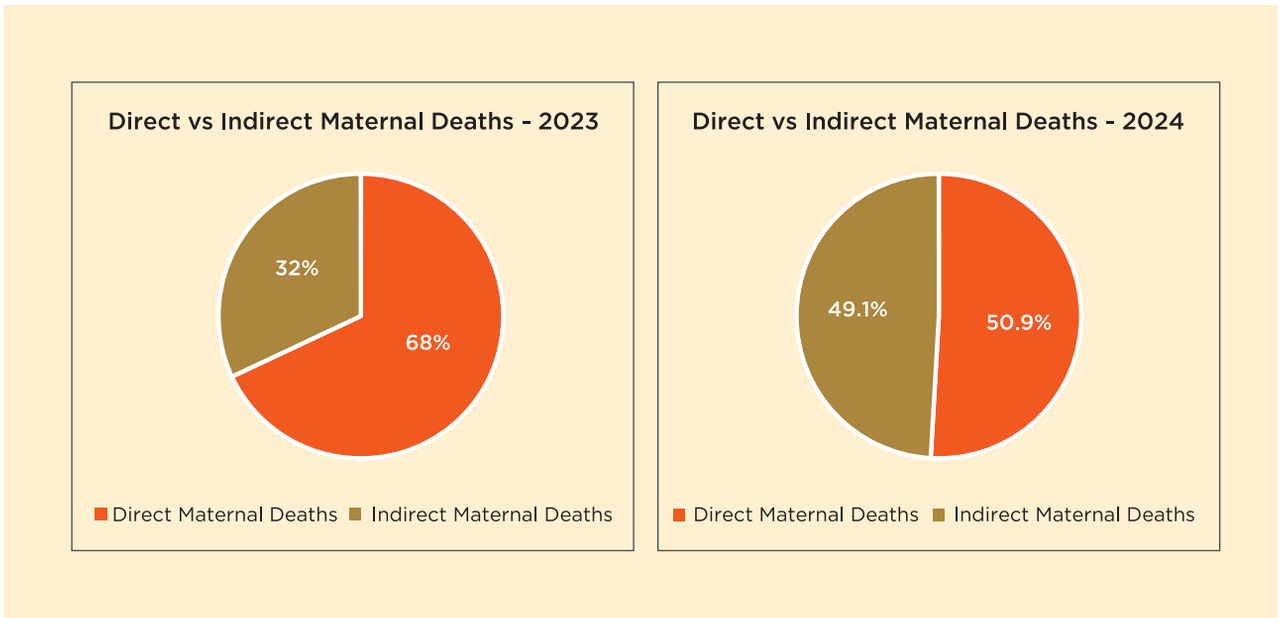


Maternal Morbidity, Mortality Surveillance Unit – FHB

Figure 7.3: Maternal Deaths and MMR by District – 2024

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

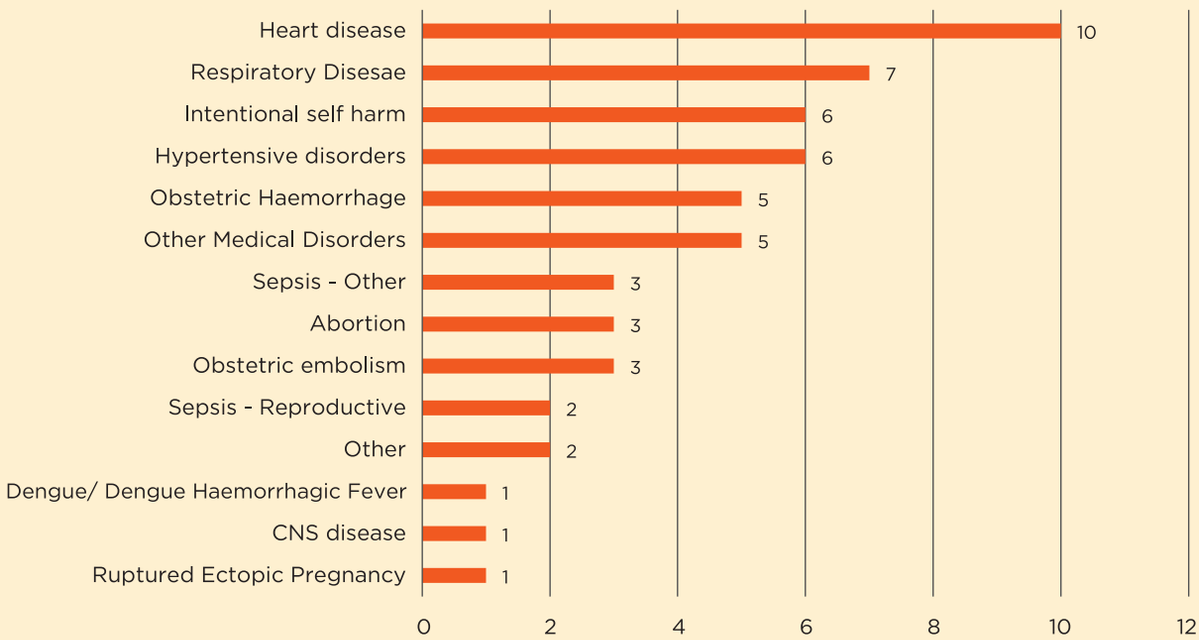
A majority of maternal deaths in 2024 were direct maternal deaths (n=28, 50.9%) while 27 (49.1%) were indirect maternal deaths. This is a reduction in the proportion of direct maternal deaths when compared with 2023 (Figure 7.4).



Maternal Morbidity, Mortality Surveillance Unit - FHB

Figure 7.4: Direct and Indirect Maternal Deaths – 2023 and 2024

Figure 7.5 shows the causes for maternal deaths reported in the year 2024 while figure 7.9 shows how selected causes of deaths have changed over the years from 2020 to 2024. The leading cause of maternal deaths was reported as heart disease (n=10, 18.2%). Heart disease was reported as the ninth commonest cause in 2023 with only 3 cases (4.8%) which shows a significant increase has happened in 2024. Obstetric haemorrahge which was the commonest cause in of maternal death in 2023 (n=12, 19.3%) is now the fifth commonest with only 5 cases (9.1%), among which there were only 3 cases where cause of death was postpartum hemorrhage. Respiratory disorders in pregnancy was ranked second commonest cause with 7 deaths (12.7%). Intentional self-harm and hypertension jointly were reported as the 3th commonest causes with six confirmed cases (10.9%), of which intentional self-harm showed an increase from the 2023 figure of 5 cases. When considering the change from 2022 to 2023, though the number of maternal death and the MMR has reduced significantly, the causality pattern of maternal deaths seems to have undergone a change as well.



Maternal Morbidity, Mortality Surveillance Unit – FHB

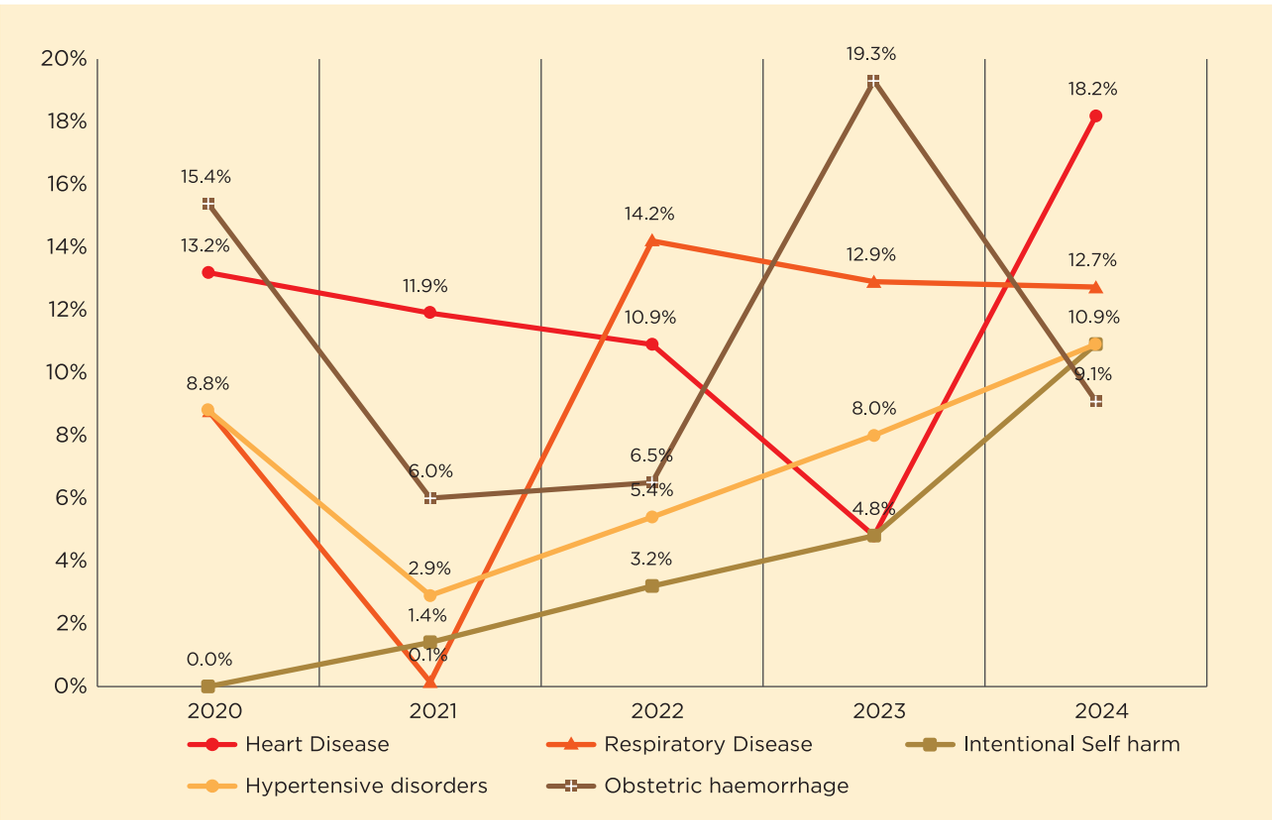
Figure 7.5: Causes of maternal deaths -2024

Among the deaths attributed to heart disease, cardiomyopathies accounted for the highest proportion (3 of 10; 30%). Two deaths were attributed to myocarditis and two to acute myocardial infarction. Single cases were recorded for congenital heart disease, aortic dissection, and myxomatous valve disease. Seven of these happened in the postpartum/ post abortion period while three happed in the antenatal period. Of the seven deaths due to respiratory causes, six were caused by pneumonia, while the remaining case was non-cardiogenic pulmonary edema in a patient with SLE. Out of the 5 other medical disorders 2 were due to renal diseases, 2 were due to gastroenterological diseases and was caused by diabetic ketoacidosis.



Maternal Morbidity, Mortality Surveillance Unit –FHB

Figure 7.6: Causes of maternal deaths due to heart diseases -2024



Maternal Morbidity, Mortality Surveillance Unit - FHB

Figure 7.7: Causes of maternal deaths as a percentage of total maternal deaths -2020 to 2024

Evaluation of Delays

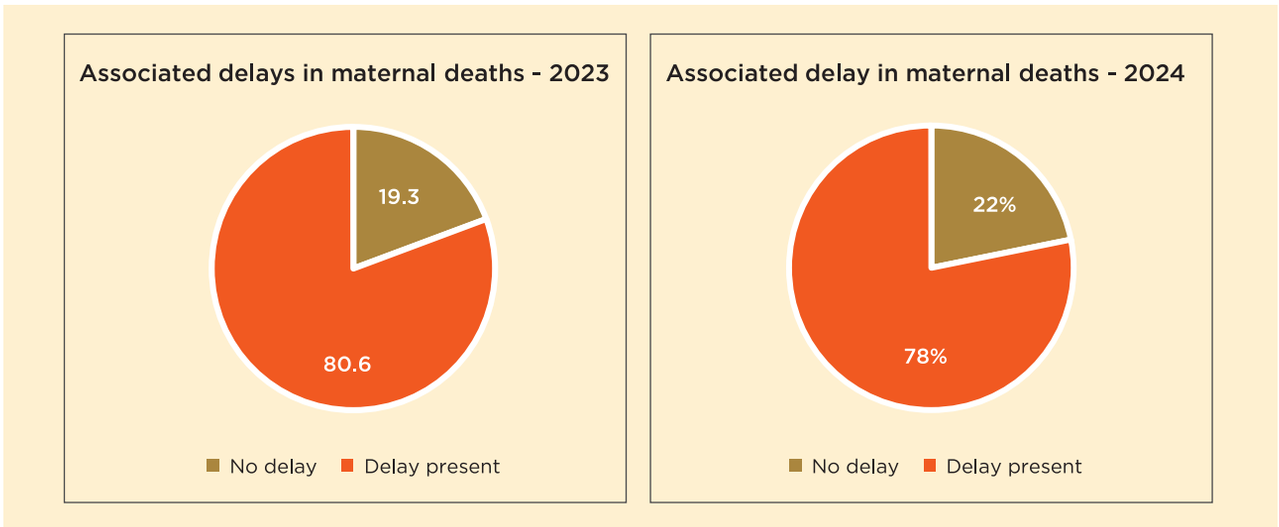
According to the three-delay model which is used in analysis, among all maternal deaths in the year 2024, 78.2%, (n=43) showed one or more delay types while 21.8% (n=12) reported no delays. This indicates a reduction in the proportion of maternal deaths associated with delays compared to 2023, when 50 cases (80.6%) involved a delay. When the specific delay types were considered among the maternal deaths, 43.6% reported delay one (delay in seeking care) either as the single delay or associated with other types of delays, while 54.5% reported delay three. Delay two (delay in reaching a health care institution) was only seen in 5.5% of maternal deaths.

Table 3.4: Analysis of delays

Delay	N	%
No delay	12	21.8
Delay present	43	78.2
Type of delay (n=55)		
Delay 1	24	43.6%*
Delay 2	3	5.5%*
Delay 3	30	54.5%*

**Note - Certain cases of maternal death had multiple delays associated with it, so percentages will total to more than 100%*

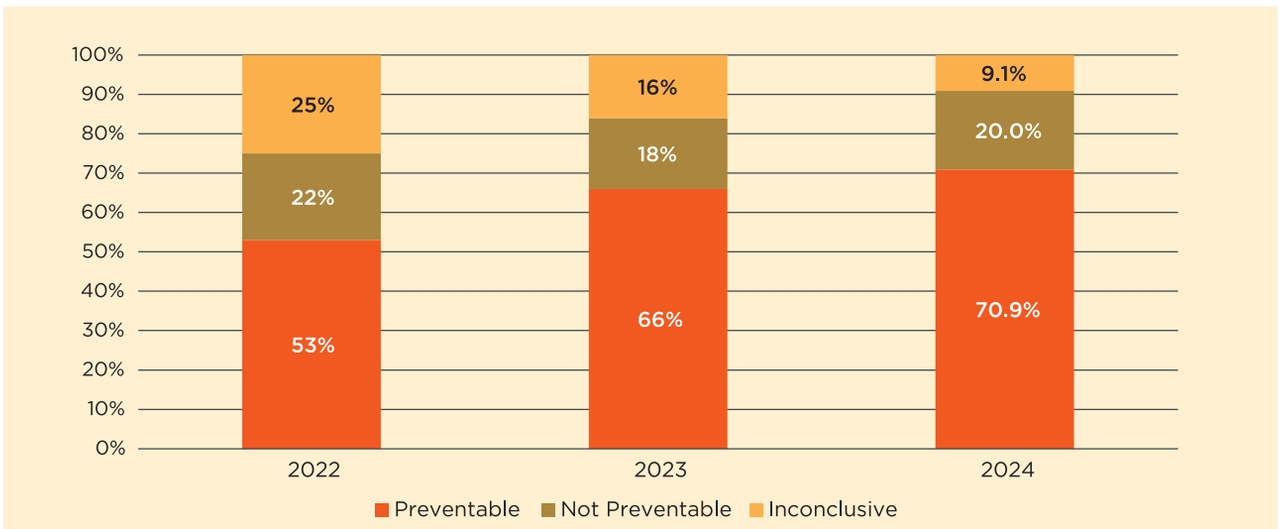
Figure 7.8 shows the proportion of maternal deaths with a delay in 2023 and 2024. This shows that the overall presence of delays has reduced slightly in 2024 compared to 2023.



Maternal Morbidity, Mortality Surveillance Unit - FHB

Figure 7.8: Presence of delays in maternal deaths –2023/2024

Not 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 2023, the percentage of preventable maternal deaths have increased up to 66.1% (n=41). In 2024, the proportion of preventable maternal deaths have further rose to 70.9% (n=39) of the reported maternal deaths. Only 11 deaths out of 55 maternal deaths (20%) were deemed to be not preventable and in 5 cases (9.1%) preventability could not be conclusively established.



Maternal Morbidity, Mortality Surveillance Unit – FHB

Figure 7.9: Preventability of maternal deaths – 2022 - 2024

ANALYSIS OF UNDER 5 CHILD DEATHS 2024

The under-five child deaths investigation system continues to function as a critical tool for monitoring child health outcomes and guiding evidence-based interventions at both national and regional levels. The findings presented in this report highlight key priority areas for public health action, including preventable deaths. The main challenge in presenting data is low coverage in some variables such as analysis of the delay models, preventability assessment and low coverage of hospital data. By presenting these, the report aims to support policymakers, health professionals, and other stakeholders in making informed decisions to reduce under-five mortality in Sri Lanka.

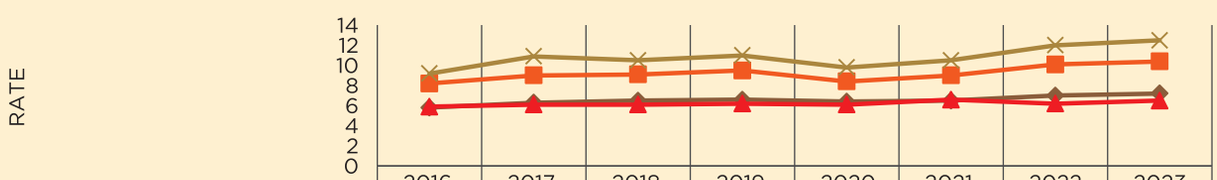
Mortality rates were calculated using data from the electronic Reproductive Health Management Information System (eRHMIS), while individual-level data were obtained from the National Fetal and Child Morbidity and Mortality Surveillance System (NFCMMS). Data in the NFCMMS are derived from field investigations conducted using the Field Under-Five Child Death Investigation Form (FS3) and hospital investigations conducted using the Hospital Under-Five Child Death Investigation Form (HS3).

The analysis focuses on the distribution and characteristics of deaths across key variables, including age at death, sex, place of death, birth weight, period of gestation and maternal factors. Major underlying causes of death, including prematurity, congenital abnormalities, infections, accidental deaths, malignancies, are examined in detail.

The report is organized into five main sections:

1. Socio-demographic characteristics of under-five child deaths.
2. Analysis of neonatal deaths (0–28 days).
3. Analysis of infant deaths (29–365 days).
4. Analysis of deaths among children aged 1– under 5 years.
5. Key Issues and recommendations from neonatal and under 5 child death desk reviews.

Socio-demographic characteristics of under-five child deaths

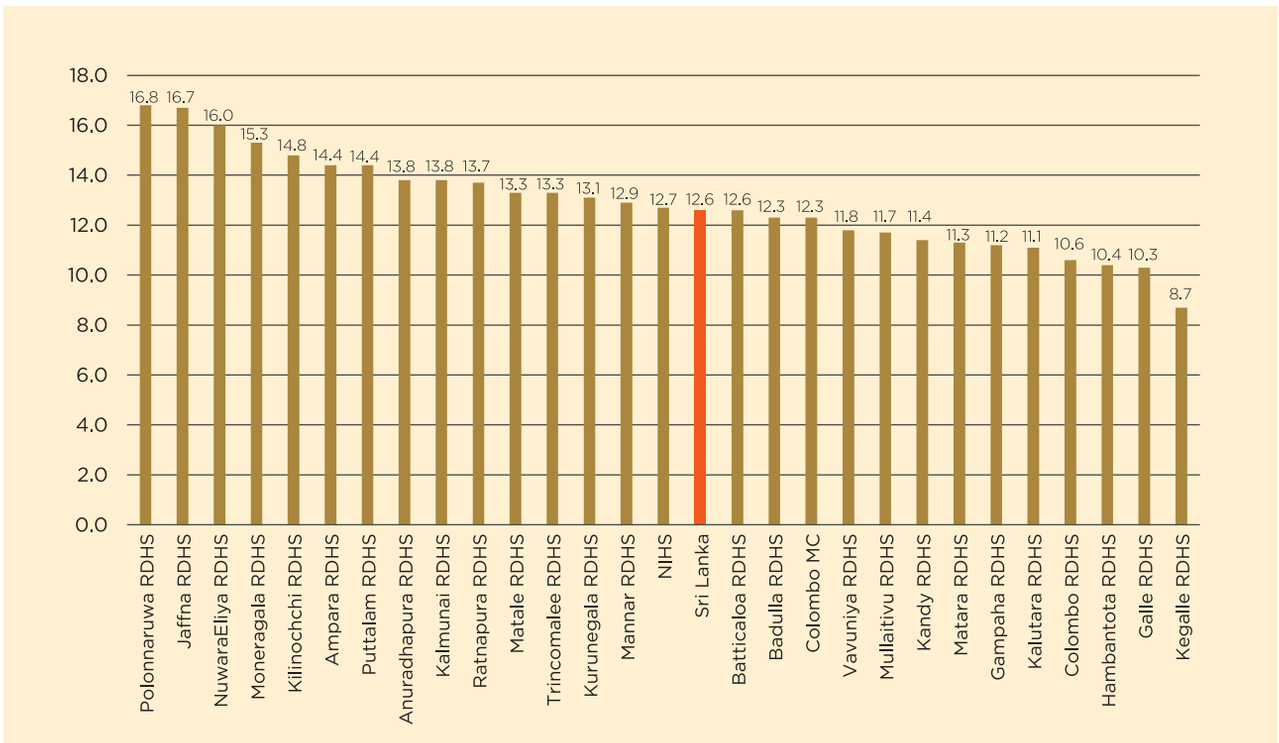


	2016	2017	2018	2019	2020	2021	2022	2023
Neonatal Mortality Rate	5.8	6.3	6.5	6.6	6.4	6.5	7	7.2
Infant Mortality Rate	8.2	9	9.1	9.5	8.4	9	10.1	10.4
Still Birth Rate	5.9	6.1	6.1	6.2	6.1	6.6	6.2	6.5
Under Five Mortality Rate	9.2	10.9	10.5	11	9.8	10.5	12	12.5

eRHMIS data-FHB

Figure 8.0: Neonatal, Infant and Under-five Mortality Rates: 2016-2024

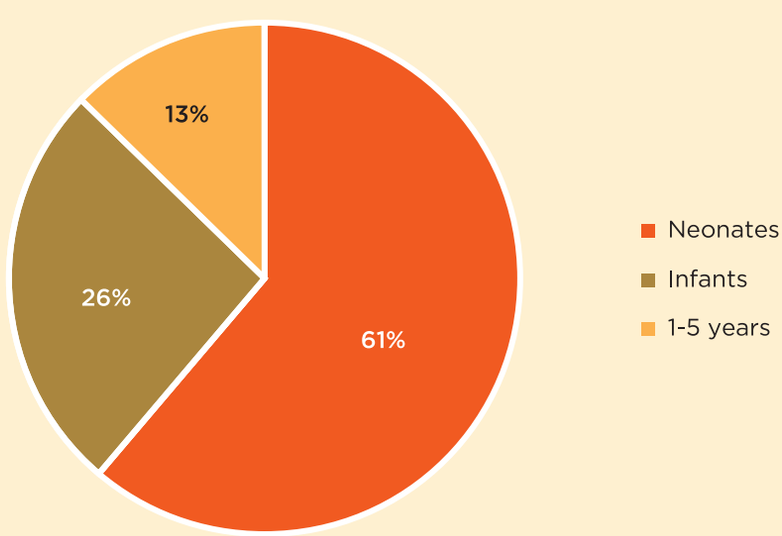
The neonatal, infant, and under-five mortality rates have shown a broadly similar pattern, with stagnation observed across all three indicators. Therefore, further reductions will require cause-specific interventions that address the underlying determinants of mortality, particularly in districts with relatively higher mortality rates.



eRHMIS data-FHB

Figure 8.1: RDHS Area wise distribution of Under-five Mortality Rates in 2024

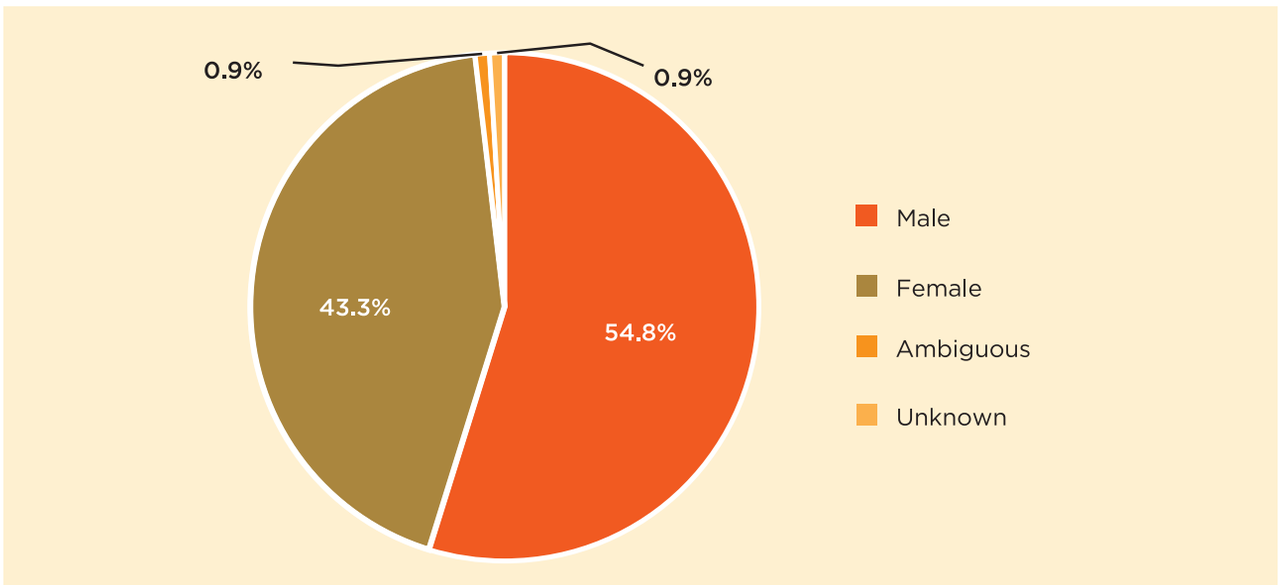
The RDHS areas of Polonnaruwa, Jaffna, Nuwara Eliya, and Monaragala reported the highest under-five mortality rates, each exceeding 14 deaths per 1,000 live births



NFCMMS data-FHB

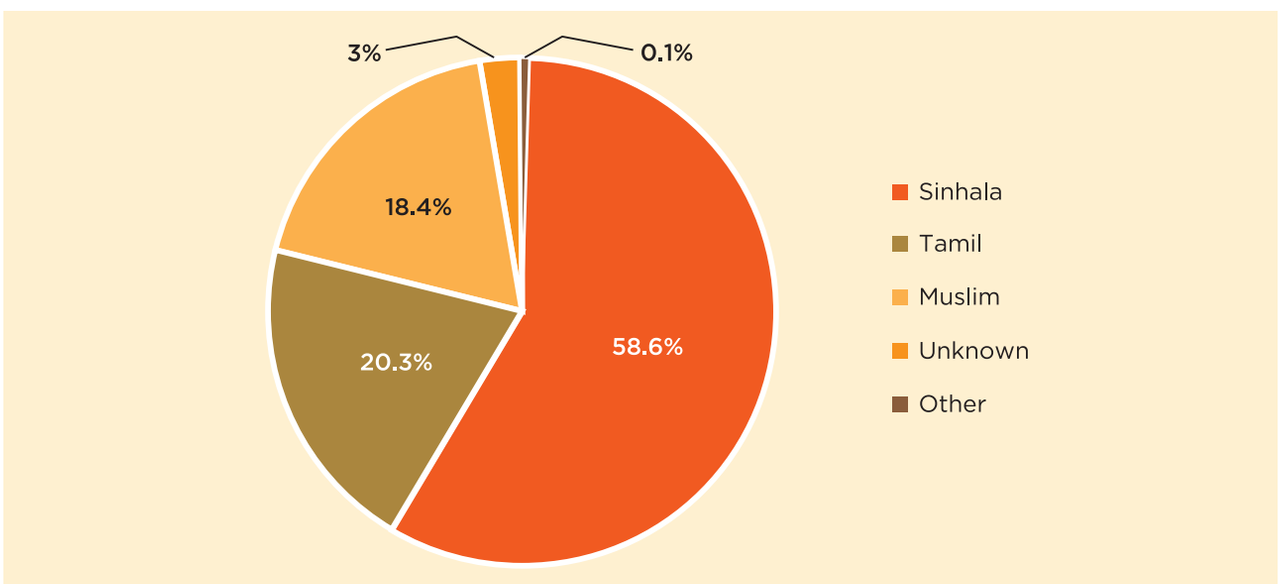
Figure 8.2: Age Distribution of Under-five Child Deaths: 2024

In 2024, out of all (n=2418) under five child deaths 1,480 (61%) were neonatal deaths (0–28 days). Infant deaths occurring between 29 days and 365 days accounted for 631 (26%) deaths, while 307 (13%) deaths were reported among children aged 1–5 years. However, there are regional disparities in the proportion of neonatal deaths reported. These findings indicate that nearly two-thirds of under-five child deaths occurred during the neonatal period, highlighting the critical importance of strengthening interventions focused on neonatal care and survival.



NFCMMS data-FHB

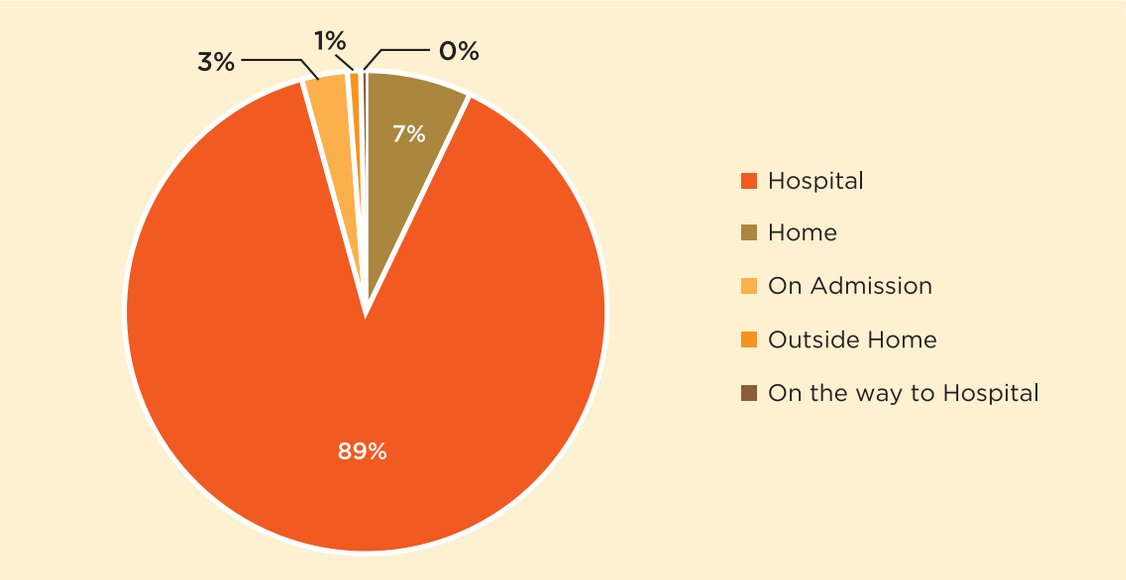
Figure 8.3: Sex Distribution of Under 5 Child Death-2024



NFCMMS data-FHB

Figure 8.4: Distribution of Under-five Child Deaths by Ethnicity: 2024

The majority of children were Sinhala (58.6%), followed by Tamil (20.3%) and Muslim (18.4%). However, these findings should be interpreted with caution, as meaningful comparisons require analysis in relation to the distribution of the under-five population within each ethnic group.

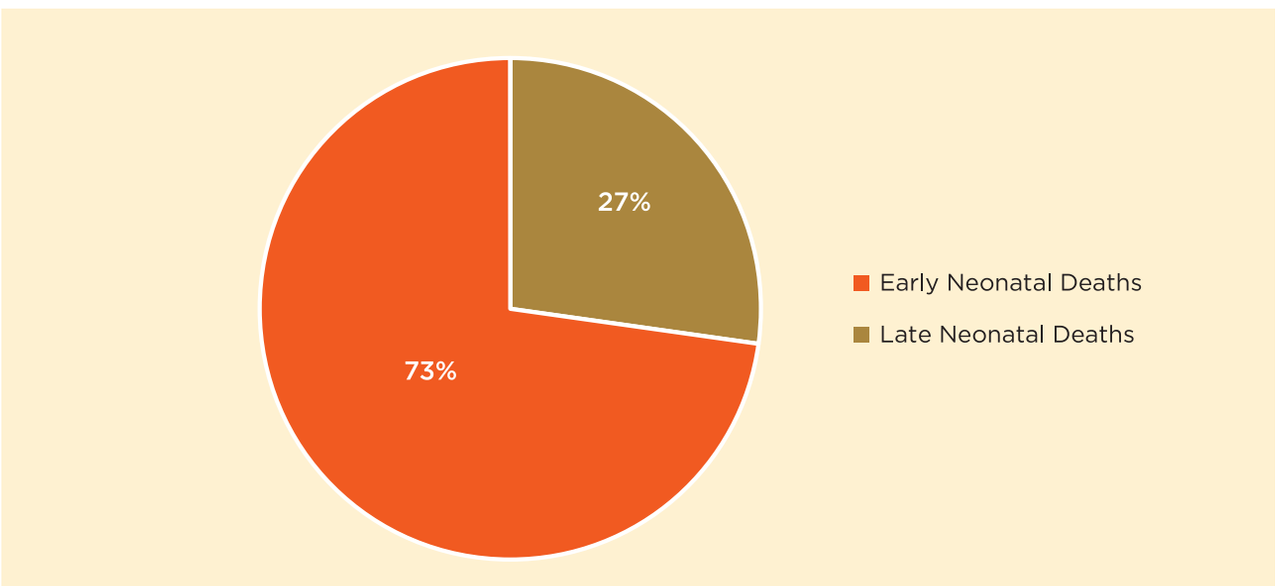


NFCMMS data-FHB

Figure 8.5: Distribution of Place of Death of Under-five Child Deaths: 2024 (n= 2379)

The majority of under-five child deaths in 2024 occurred in hospital settings (88.6%). Deaths occurring at home accounted for 7.0%, while deaths on admission represented 3.0%. Deaths occurring on the way to hospital and outside the home collectively constituted a smaller proportion.

Neonatal Deaths

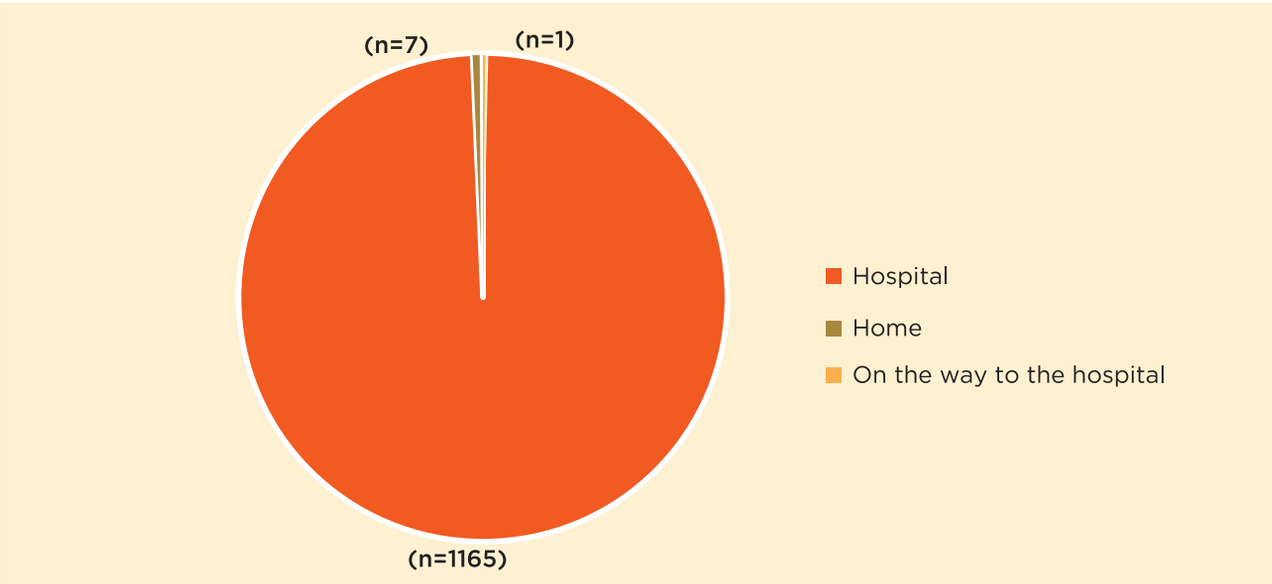


NFCMMS data-FHB

Figure 8.6: Distribution of Early and Late Neonatal Deaths: 2024

Out of 1480 neonatal deaths reported in 2024, 1077 (72.8 %) deaths occurred in the first 7 days of life, the early neonatal period. This highlights the importance of high-quality intrapartum care, immediate newborn care, and early postnatal follow-up.

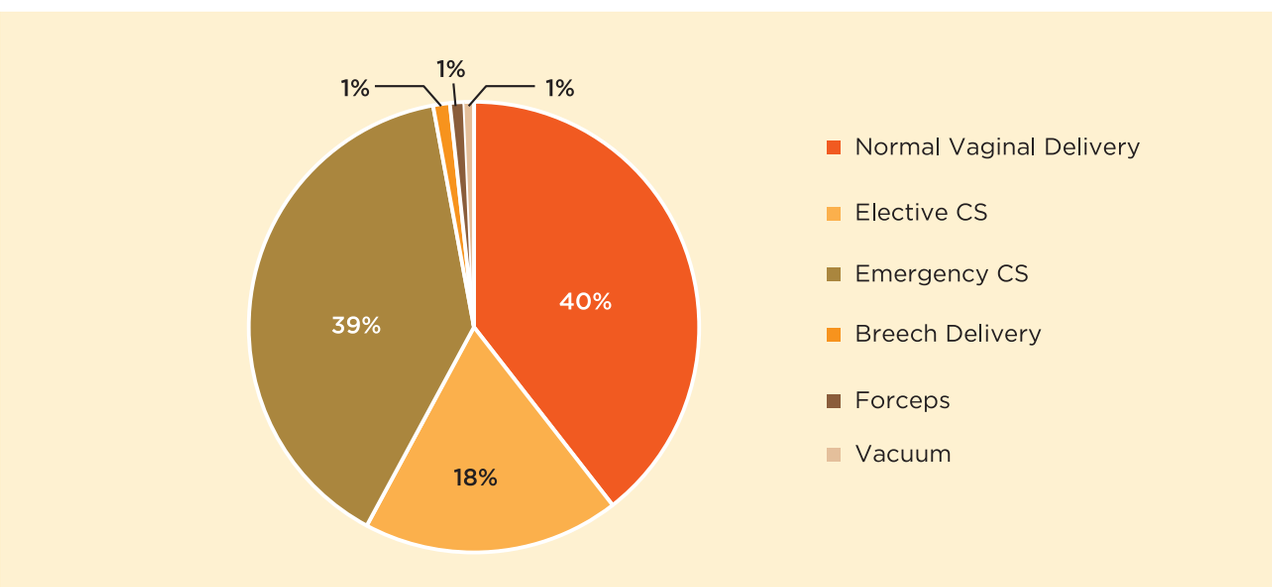
Distribution of Place of Delivery among Neonatal Deaths (n=1173)



NFCMMS data-FHB

Figure 8.7: Distribution of Place of Delivery among Neonatal Deaths: 2024

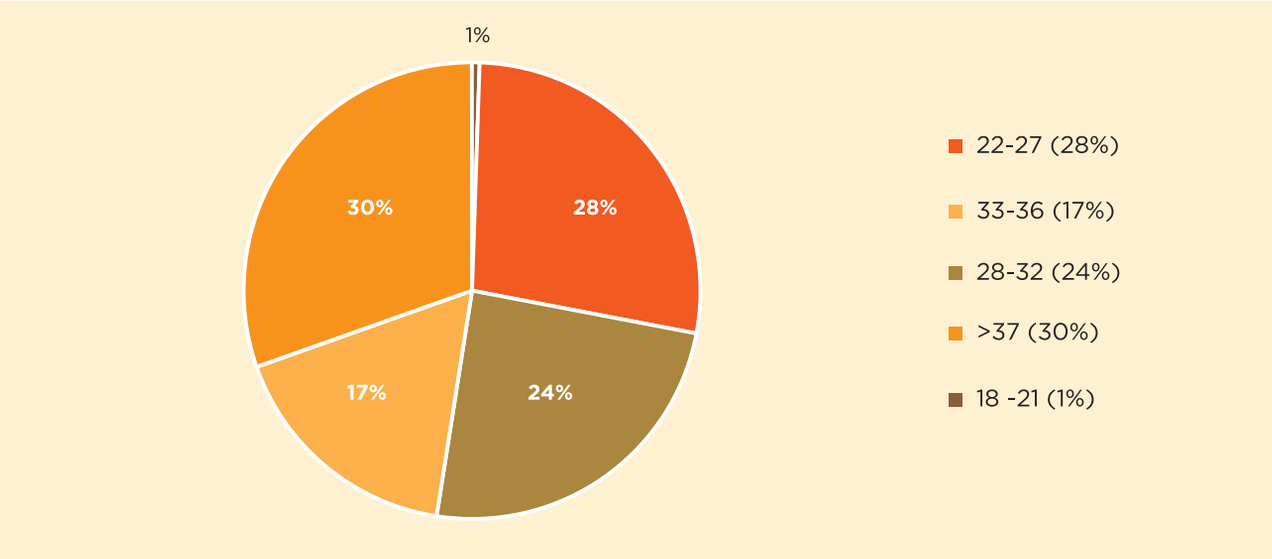
Only 79.2% of cases (n = 1,173) had information recorded on the place of delivery. Among neonatal deaths with available data, only 0.68% (8 out of 1,173) occurred at home or on the way to the hospital.



NFCMMS data-FHB

Figure 8.8: Distribution of Type of Delivery among Neonatal Deaths: 2024 (n=1168)

Only 78.9% of cases (n = 1,168) had information recorded on the type of delivery. Among these cases, 58.0% (675 out of 1,170) were delivered by caesarean section.



NFCMMS data-FHB

Figure 8.9: Distribution of Period of Gestation completed among Neonatal Deaths: 2024 (n=1128)

Out of 1,480 neonatal deaths, only 1128 (76.2%) entered the period of gestation. Out of entered data majority 41.6% (469/1128) occurred at 28–36 weeks.

Table 3.5: Distribution of the early neonatal deaths (0-7 days) by cause of death according to ICD-PM Classification (n=1077).

ICD-PM Classification	Number of Child deaths	Percentage %
N1 Congenital malformations, deformations and chromosomal abnormalities	296	27.5
N2 Disorders related to fetal growth	5	0.5
N3 Birth Trauma	0	0.0
N4 Complications of intrapartum events	13	1.2
N5 Convulsions and disorders of cerebral status	23	2.1
N6 Infection	42	3.9
N7 Respiratory and cardiovascular disorders	46	4.3
N8 Other neonatal conditions	15	1.4
N9 Low birth weight and prematurity	484	44.9
N 10 Miscellaneous	0	0.0
N11 Neonatal death of unspecified cause	2	0.2
Unknown	151	14.0
Total	**1077**	**100**

Source: NFCMMS data-FHB

The most frequently reported ICD-PM categories were N9 (Low birth weight and prematurity) 44.9%, followed by N1 (Congenital malformations, deformations, and chromosomal abnormalities) 27.4%.

Table 3.6: Analysis of specified causes of death: Congenital Anomalies in Early Neonatal Deaths of 0-7 days (n=296)

Deaths due to congenital anomalies in early neonatal period		
Congenital anomaly	**Number**	**Percentage**
Cardiovascular System		
Congenital Heart Disease	99	33.3
Respiratory System		
Lung hypoplasia	36	12.2
Bilateral pneumothorax	1	0.3
Severe pulmonary hypertension	2	0.7
Tracheal atresia	1	0.3
Congenital Diaphragmatic Hernia	43	14.5
Gastrointestinal System		
Duodenal atresia	1	0.3
Gastroschisis	1	0.3
Omphalocele	3	1
Tracheoesophageal fistula	2	0.7
Central Nervous System (CNS)		
Anencephaly	28	9.5
Hydrocephalus	5	1.7
Encephalocele	2	0.7
Microcephaly	2	0.7
Meningomyelocele	1	0.3
Spina bifida	1	0.3
Genitourinary System		
Congenital renal abnormalities	1	0.3
Hydronephrosis	1	0.3
Obstructive uropathy	2	0.7
Prune belly syndrome	1	0.3
Genetic / Chromosomal Disorders		
Down syndrome	2	0.7
Edward syndrome	6	2
Musculoskeletal System		
Skeletal dysplasia	1	0.3
Osteogenesis imperfecta	1	0.3
Thanatophoric dysplasia	1	0.3
Jeune syndrome	1	0.3
TOTAL	**296**	**100**

Source: NFCMMS data-FHB

Cardiovascular anomalies were the most common group, accounting for one-third of all cases (33.3%). This highlights the substantial burden of structural heart defects, which are among the leading contributors to neonatal mortality. Respiratory anomalies were the second most common category, accounting for 28.0% of cases. Congenital diaphragmatic hernia was the predominant condition within this group.

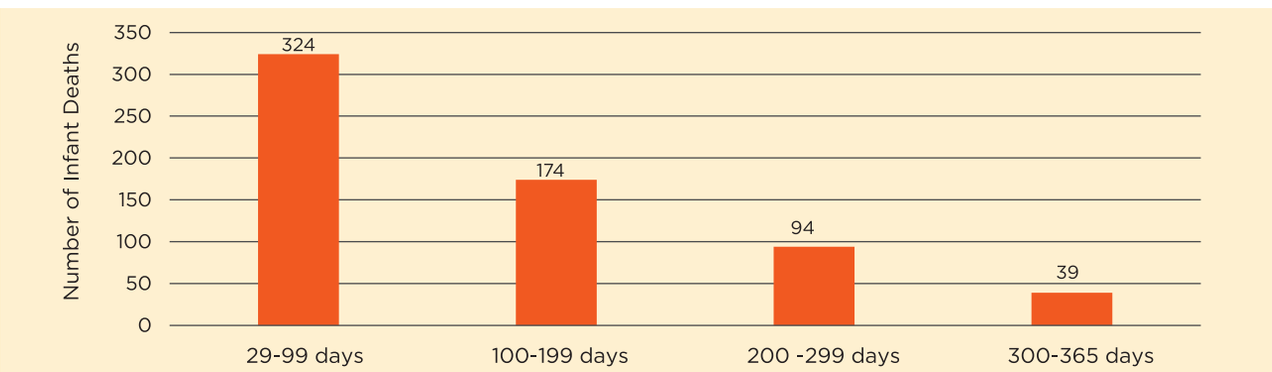
Table 3.7: Distribution of the late neonatal (8-28 days) deaths by cause of death according to ICD-PM Classification

ICD-PM Classification	Number of Child deaths	Percentage %
N1 Congenital malformations, deformations and chromosomal abnormalities	103	25.6
N2 Disorders related to fetal growth	1	0.2
N3 Birth Trauma	0	0.0
N4 Complications of intrapartum events	1	0.2
N5 Convulsions and disorders of cerebral status	6	1.5
N6 Infection	49	12.2
N7 Respiratory and cardiovascular disorders	16	4
N8 Other neonatal conditions	17	4.2
N9 Low birth weight and prematurity	165	40.9
N 10 Miscellaneous	1	0.2
Unknown	44	10.9
Total	403	100
Total	**1077**	**100**

Source: NFCMMS data-FHB

The most frequently reported ICD-PM categories were N9 (Low birth weight and prematurity) 40.9%, followed by N1 (Congenital malformations, deformations, and chromosomal abnormalities) 25.6%.

Infant deaths



NFCMMS data-FHB

Figure 9.0: Distribution of Infant Deaths (Aged 29-365 days) by Age at Death: 2024

The data highlights that more than half of deaths (51.3%) happened in the first 100 days of life.

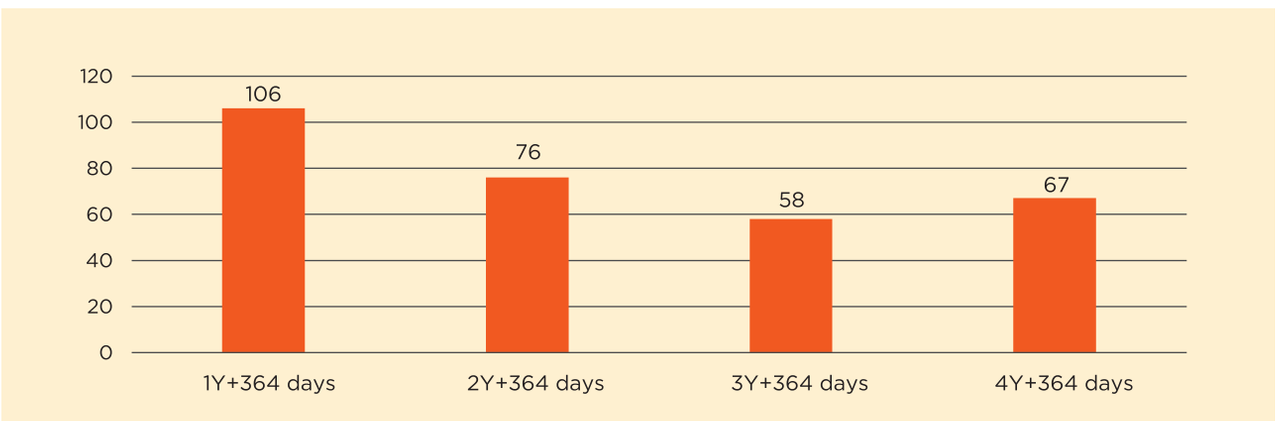
Table 3.8: Distribution of the causes of death in infant aged 29-365 days-2024 (Data Source: NFCMMS data-FHB)

Cause of death	Number of deaths	Percentage
Congenital anomalies	228	36.1
Unknown	113	17.9
Infections	111	17.6
Complications of Prematurity	84	13.3
Other	75	11.9
Hypoxic-ischemic encephalopathy (HIE)	10	1.6
Injuries	7	1.1
Total	**631**	**100**

Source: NFCMMS data-FHB

Cause of death for majority (36.1%) of the infant deaths aged 29-365 days were due to congenital abnormalities followed by infections (17.9%) and complications of prematurity (13.3%)

One to five years child deaths (1-5 years)- 2024



NFCMMS data-FHB

Figure 9.1: Distribution of age 1-5 Year Deaths by Age at Death: 2024

The age-specific distribution of deaths among children aged 1 to under 5 years showed the highest number of deaths at 1 year of age (106 deaths). Thereafter, the number of deaths gradually declined with increasing age, although a slight increase was observed among children aged 4 years.

Table 3.9: Distribution of the causes of death in 1-5 Year deaths-2024

Cause of death	Frequency	Percentage
Congenital/Genetic conditions	76	24.8
Infectious diseases	39	12.7
Injuries/external causes	45	14.7
Malignancy	36	11.7
Neurological disorders other than congenital disorders	15	4.9
Endocrine/Metabolic diseases	3	1.0
Other causes	34	11.1
Unknown	59	19.2
Total	**307**	**100**

Source: NFCMMS data-FHB

Congenital and genetic conditions are the leading cause of death (24.8%) followed by injuries/ external causes (14.7%) and infectious diseases (12.7%). Malignancies contributed 11.7% of deaths in age 1-5 years.

Main Issues and Recommendations in Neonatal and Under-five Child Death Desk Reviews for 2024 deaths

1. Over diagnosis of "milk aspiration" in cases where the exact cause of death is uncertain. Also, post-mortems are often not conducted to confirm the exact cause of death and it may due to underlying other pathologies such as myopathies or anatomical abnormalities

   Recommendation - As milk aspiration is considered an accidental death, a detailed postmortem examination with histopathological evaluation should be made mandatory. Such postmortems must be conducted by a Consultant Judicial Medical Officer to determine the underlying cause.

2. Delayed referrals of children with respiratory illnesses from primary care institutions

   Recommendation - Provide continuous medical education (CME) and regular refresher training for first-contact medical officers to strengthen their knowledge and skills in the early identification, stabilization, and timely referral of children with severe respiratory illnesses.

3. Delays in intubation and inadequate resuscitation in peripheral hospitals; limited ICU capacity for critically ill children

   Recommendation - Regular training of ETU and divisional hospital staff on pediatric resuscitation and intubation. Ensure the availability of essential equipment such as pediatric laryngoscopes and Ambu bags. Expand pediatric ICU bed capacity at secondary and tertiary care hospitals.

4. Deaths due to viral pneumonia and sepsis without adequate laboratory confirmation.

   Recommendation - Strengthen laboratory capacity at peripheral hospitals by establishing facilities for respiratory viral antigen detection and blood culture testing to facilitate timely diagnosis and appropriate management.

5. Inadequate investigation and management of meningococcal infections

   Recommendation - Strengthen surveillance and laboratory diagnosis of meningococcal infections and promote the uptake of meningococcal vaccination in high-risk areas.

6. Neonatal deaths associated with poor parental recognition of danger

   Recommendation - Educate both parents on neonatal danger signs prior to discharge.

7. Delayed discharge of mothers due to pending Post-Mortem reports

   Recommendation - Develop and implement a method to allow mothers to be discharged once clinically stable, without waiting for post-mortem results, while ensuring appropriate follow-up and communication of findings.

8. Lack of definitive Cause of Death and failure to conduct Post-Mortem Examinations in on-admission deaths

   Recommendation - Increase awareness among healthcare staff that post-mortem examinations are mandatory for on-admission deaths where a definitive diagnosis cannot be established, to ensure accurate determination of the cause of death and support quality improvement efforts.

SPECIAL ACTIVITIES CARRIED OUT DURING 2024

Special activities carried out during 2024

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

Maternal and newborn care

Maternal weight gain of pregnant women

Maternal weight gain is a key determinant of both maternal and neonatal pregnancy outcomes. In line with the Nutrition Month activities of 2024, a survey was carried out in all provinces in a representative sample. Data on maternal weight gain and related variables were collected from women who delivered in June 2024 (Nutrition Month). A total of 6,762 pregnancies were reported from selected Public Health Midwife (PHM) areas, resulting in 6,823 births.

The mean Body Mass Index (BMI) of women who attended their booking visit during the first trimester was 23.4 kg/m. At booking, 16.2% (n=951) of women were underweight, 25.8% (n=1,512) were overweight, and 9.1% (n=534) were obese, while nearly half (48.9%, n=2,864) were within the normal BMI range. The highest proportion of underweight pregnant women was observed in Sabaragamuwa Province (20.2%, n=108), overweight in the Western Province (29.8%, n=172), and obesity in the Eastern Province (11.2%, n=100).

Gestational weight gain was within the recommended range in 35.8% (n=2,093) of women, below the recommended range in 38.0% (n=2,222), and above the recommended range in 26.2% (n=1,533). Both inadequate and excessive gestational weight gain were associated with low birth weight. Factors associated with gestational weight gain below the recommended range included primi gravidity, maternal height ≤145 cm or ≤150 cm, and low BMI in early pregnancy. Women who were obese during the first trimester had a higher likelihood of excessive gestational weight gain, with 50.2% gaining more than the recommended amount.

Levels of Care in Obstetrics

With the objective of optimizing the utilization of Primary Healthcare Institutions, several consultative meetings were conducted in 2024 on the theme “Levels of Care in Obstetrics,” by the maternal care unit of Family Health Bureau under the guidance of the Secretary of Health. These meetings involved representations from Family Health Bureau, selected Regional Directors of Health Services, Divisional Hospitals as well as Teaching Hospitals, Patient Safety and Accreditation Bureau, Consultant Neonatologists, and representatives of the Sri Lanka College of Obstetricians and Gynaecologists. A circular titled “Strengthening of Equitable Maternity Care Services” was subsequently drafted. However, the Ministry of Health recommended that the circular be revisited once the results of the EmONC survey become available.




Developing an action plan to reduce maternal mortality rate

An initial consultative meeting aimed at developing an action plan to reduce maternal mortality in Sri Lanka was held on 13th November 2024, with the participation of relevant stakeholders. Preliminary discussions focused on identifying and prioritizing interventions to address maternal mortality across three key areas: maternal deaths due to respiratory diseases, obstetric haemorrhage, and cardiovascular conditions, including heart disease and hypertension.

National Maternal & Newborn Care Quality Assessment Tools

Fourteen hospitals were selected for the initial phase of strengthening the assessment of quality of care in maternal and newborn curative care settings. These institutions were instructed to send their monthly returns on 'Service provision', 'Outcome', 'Patient rights', 'Inputs', 'Support services', 'Clinical services', 'Infection control' and 'Quality management' areas in antenatal ward, labour room, postnatal ward and neonatal ward settings. Out of these selected hospitals Colombo North Teaching Hospital and Akkaraipattu Base Hospital were selected as the receivers of the National Maternal and Newborn Care Quality Awards at the National Patient Safety Day held at BMICH on 14th of October 2024.




Stillbirth & Bereavement Care program

Stillbirth remains a significant public health concern in Sri Lanka, with a rate of 6.5 per 1,000 births in 2023, showing stagnation at approximately 6.0 per 1,000 births over the past five years. In response, a full-day national workshop on the prevention of stillbirths

and bereavement care was conducted on 09th October 2024 by the Maternal Care Unit of the Family Health Bureau, in collaboration with the College of Community Physicians of Sri Lanka. The workshop brought together key stakeholders involved in maternal and newborn care, combining local expertise with global best practices. It was chaired by the Director General of Health Services and graced by the Acting Deputy Director General (Public Health Services) and Director of Maternal and Child Health, with technical input from Dr. Hannah Blencowe of the London School of Hygiene and Tropical Medicine. Participants included consultant community physicians, representatives from mental health services, district health administration, professional colleges, and postgraduate trainees. The workshop strengthened knowledge on evidence-based strategies for stillbirth prevention and highlighted the critical importance of bereavement care within the health system.



CHILD HEALTH

Child Nutrition

Workshops to update peripheral supervisory health staff on child nutrition

One day in-service refresher programmes to update and motivate the supervisory categories of health staff on child nutrition interventions were conducted in Kurunegala and Rathnapura districts. The participation was encouraging with 45 participants including 31 MOHs/AMOHs from Rathnapura and 98 including 38 MOHs/AMOHs from Kurunegala.



Breastfeeding week activities

The World Breastfeeding Week was commemorated in 2024 under the slogan "Closing the Gap -Breastfeeding support for all" highlighting the importance of creating a supportive environment by different stakeholders to promote, protect and support breastfeeding. 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. An assessment of mothers' breastfeeding needs was carried out by Public Health Midwives in MOH areas to identify areas requiring further support.

Annual child nutrition status surveillance during the National Nutrition Month 2024

National Nutrition Month anthropometric assessment of under 5 children was conducted in June 2024. Prior to commencement of NM activities, technical updates were conducted for health staff virtually. In year 2024, a detailed assessment of all children having severe acute malnutrition (SAM) was also carried out by the Public Health Midwives along with the annual assessment to gain an insight into the dietary and other vulnerability factors associated with

SAM in children under the age of 5 years. An in-depth analysis of this data is being carried out. The preliminary analysis revealed dietary issues as the key associated factor (among 96% of the SAM children) while illness was associated with < 25% of children. Low birth weight was found among 44% of SAM children but among them too dietary factors were observed in a majority. Mothers were the main primary caregiver (78.4%) with 82.7% of mothers being home makers which point towards the fact that mothers should be focused mainly when delivering the key nutrition interventions.

Revision of child nutrition related guidelines and protocols

In keeping with the current challenges and requirements of child feeding, revision of National Infant and Young Child Feeding and Growth Monitoring and Promotion guidelines were initiated based on the new guidelines published by the WHO in 2023.

Maternal and Child Nutrition Subcommittee meetings

The Subcommittee on Maternal and Child Nutrition (MCN) is established as the technical advisory body to make recommendations to the Nutrition Steering Committee (NSC) chaired by the Secretary, Ministry of Health. The MCN subcommittee is chaired by the Deputy Director General Public Health Services II. Six MCN Subcommittee meetings were conducted in 2024 which contributed to streamline and strengthen the MCN component of the MCH programme.

Dissemination of findings of the Retrospective study on growth faltering

The findings of the retrospective study on growth faltering titled “Timing and pattern of growth faltering in first 1000 days of life”, conducted by the Sri Lanka College of Paediatricians and UNICEF were disseminated and a stakeholder discussion was held to develop recommendations based on the findings with the support of UNICEF. Growth faltering was observed among nearly 40-45% of children from the first month to 6 months. Nearly half of the children aged 12-24 months had growth faltering. Poor dietary diversity was a key issue with inappropriate food such as sweets and biscuits being consumed by 66.2% and 79.4% respectively at one year of age. Responsive feeding practices were not optimum. The study highlighted the importance of detecting growth faltering early and timely interventions.





Breastfeeding Code made in to an Act of Parliament

With the objective of strengthening the existing provisions for monitoring and implementing actions to safe guard breastfeeding, drafting of an Act was carried out with the Legal Unit of MoH and the Department of Legal Draftsman. The observations of the Ministry of Health to the second draft of the Act was submitted to the Legal Draftsman.

Supportive activities for the continuation of the child nutrition interventions in the country

Procurement and distribution of nutrition commodities - Multiple Micro Nutrient Powder (MMN) as a strategy to prevent iron deficiency anaemia during infancy and young childhood and the therapeutic food BP100 for nutrition rehabilitation of children with Severe Acute Malnutrition.

Printing and distribution of essential Health Records (e.g. CHDR) and IEC materials.

Donor funds were mobilized to support continuation of these child nutrition services without disruption; UNICEF supported to procure the annual requirement of nutrition commodities, and warehouse facilities to store nutrition commodities with UNICEF support was continued in year 2024.

Incorporating nutrition commodities in to the SWASTHA system – the LMIS of Medical Supplied Division:

As a measure of streamlining logistic management of nutrition commodities and improving accountability, preliminary work to include the supplementary food - Thriposha, RUTF - BP 100 and MMN - P in to the SAWASTHA system was initiated together with the Nutrition Division.

Coverage drive to improve MMN supplementation among infants and young children

Several activities were implemented in 2024 to improve the coverage of multiple micronutrient (MMN) supplementation among infants and young children in the field. These included virtual meetings with health staff to enhance awareness, coordination, and follow-up.

CHILDCARE, DEVELOPMENT AND SPECIAL NEEDS

Primary prevention, improvement in health outcome

Child care, Development and Special needs unit of the Family Health Bureau initiated the Inclusive Early Childhood Development Programme (IncluDe) in 2020 from Colombo district and introduced to Kandy, Galle, Batticaloa, Kalutara and Gampaha districts subsequently. Objective of this programme is to screening all the children less than 5 years of age by PHMs for developmental issues and referring them to Child Development Intervention Centre (CDIC) of the district for early interventions and long-term care of Community Paediatrician and the multi-disciplinary team. Although the programme has shown successful results with significant improvements of the children cared by the centres, scaling up it island wide was delayed due to several bottle necks. Lack of human resources specially the Consultant Community Paediatricians and therapists and financial resources to develop CDICs were the major barriers. As a solution for that, tier system was introduced and Ministry of Health has Appointed Medical Officers and nursing officers to function CDICs in 20 apex hospitals. They were trained comprehensively by experts in the field by 5 days of lecture-based training and 2 weeks of practical training sessions in identified centres. Further a review meeting was conducted by the end of year to identify implementation status and discuss the way forward. However, moving out of trained medical officers due to annual transfers and post graduate exams were identified as a major barrier for this alternative.

National level programme strengthening

Adaptation and implementation of the UNICEF "Caring for the Caregivers" programme in Sri Lanka:

Early childhood development is considered a key developmental priority in the United Nations' Sustainable Development Goals, and nurturing care strengthens children's ability to develop and learn. Family Health Bureau as the focal point in achieving the SDG target 4.2.1 by 2030 has focused on optimizing early childhood development (ECCD) and help children to attain their full potential in development.

However, caregivers' potential in providing nurturing care for their children and promoting development are highly depend on caregivers' emotional well-being. Therefore, for optimum results in early child development, healthcare workers must focus on the well-being of the caregivers. Therefore, the FHB adapted the "Caring for the Caregiver" (CFC) training package for the local setting and started stepwise implementation in the country.

Following activities has been carried out in 2024 to achieve this target;

1. Situational analysis, adaptation and translation of the CFC package to Sinhala and Tamil languages.
2. Training of 40 in-country master trainers representing all the districts in Sri Lanka by the UNICEF technical experts from South Africa.
3. Printing all the manuals and materials of the CFC package (in both Sinhala and Tamil Languages).
4. Conducting 2 pilot training programmes in Galle and Polonnaruwa districts. Each 5-day training programme had 35 participants (which included Public Health Midwives as

majority and also SPHMs, PHNSs and MOHs). All the trainees participated enthusiastically and they were satisfied about the new learning experience with positive thoughts of incorporating CFC to their routine work.

This programme will be scaled up island wide in 2025.

To pilot the adapted version of "Arambh early moment matters" community-based parenting program at three rural communities

The most recent evidence suggests that countries should focus on initiatives to support parenting based on the nurturing care framework, and early childhood development would be the outcome of such programs. Designing a suitable parenting programme to Sri Lankan context was a challenge. Several parenting programs were identified through literature review in the region as best practices, and one of them is the "Arambh"—early moments matter program by the Mahatma Gandhi Institute of Medical Sciences in Maharashtra, India. UNICEF Sri Lanka supported a local team in observing this program, and after that, the FHB planned to adapt and pilot test it in three selected communities in the country.

As the initiation of this programme following activities were carried out in the year 2024;

1. **Consultative meetings with all the stakeholders**

   Four stakeholder meetings were conducted separately to conduct a situational analysis, resource mapping, identify implementation possibilities and plan the activities during the first half of the year 2024.

2. **Visit of the expert team from India**

   A team of experts from the "Mahathma Gandhi Institute of Medical Sciences (MGIMS)" in Maharashtra India, visited Sri Lanka and conducted stakeholder consultations and a mapping exercise from 26th to 31st of August 2024 in Kandy, Galle and Kegalle districts. This exercise was helpful in identifying the non-health sector resources and implementation points at the ground level and their detailed report is attached with this.

3. **Field visits in the Kandy, Galle, Kegalle and Ampara district by the local team**

   A team from the Family Health Bureau has visited above districts after the visit of the Indian team to conduct further discussions and resource mapping.

4. **Reviewing and comparing resource materials available with the "Arambh" resource materials**

   "Senehe Thataka", a resource book published by the national secretariat for early childhood development was reviewed in detail and compared with the "Arambh" resource materials. This exercise was carried out as a measure to minimize duplication and thereby to reduce the workload and save resources. It will also provide a sense of ownership to the non-health sector.

Piloting the WHO CST programme in Colombo district

The process on introducing the WHO "Caregiver Skills Training Module (CST)" which aims at training parents with disabled children on home-based interventions, was initiated in the year

2023 by training master trainers for the Sri Lanka. Then, all 3 modules of the CST (Participants' manual, Facilitators' manual, Home Visit Guide) were translated and customized to the local context. In 2024, those translated modules were further reviewed with the adaptation of pictures to the local context and started the pilot testing in Colombo district in collaboration with NAMASTE (Neurodevelopment and Autism in South Asia Evidence and Treatment) Sri Lanka.

Validating a screening tool to identify children with specific learning difficulties

This research was supported by the UNICEF Sri Lanka and was aimed at developing a screening tool to identify children with specific learning disabilities which can be easily used by the teachers. Tool adaptation and collecting data for validation was completed by the end of 2024.

SCHOOL HEALTH

Under the School Health Programme (SHP), health services are provided mainly through School Medical Inspection (SMI) which includes growth monitoring, detecting nutritional and other defects, referral/treatment, educational programmes and vaccination. The main intervention package of SHP is directed towards strengthening Health Promoting Schools (HPS) concept. Other services of SHP are health and educational staff training, educational material development and monitoring & evaluation.

Medical Officers of Health (MOH) and Public Health Inspectors (PHI) are the main responsible officers for School Health Programme supervised by Medical Officers of Maternal and Child Health (MOMCH) and Consultant Community Physicians (CCP) of respective districts and Provinces. Medical Officer of Health and PHII are ably supported by other members of the MOH team namely Public Health Nursing Sister (PHNS), Public Health Midwife (PHM) and Supervising Public Health Midwife (SPHM).

School Medical Inspection (SMI):

School Medical Inspection comprises of a wide-ranging activity conducted by the respective MOH teams annually in all Government, Semi Government and Private schools registered with the Ministry of Education (MoE). All students in above schools with less than 200 students and all in grades 1, 4, 7 and 10 in schools with more than 200 students are covered in SMI.

Coverage of SMI remained high at 99% in 2024 and this high coverage was achieved through continuous monitoring and necessary guidance.

Training of Health & Education Staff

Regular Training of Trainers (TOT) programmes on Psychosocial Wellbeing, Health Promoting Schools, Life Skills and School Medical Inspection were carried out in 2024. A total of 11 programmes were conducted in 2024.

The programme breakdown in detail is as follows:

1) Training of Trainers (TOT) programmes on Psychosocial Wellbeing

   Three (03) programmes were carried out in Colombo Municipal Council in March/April & August 2024 and 120 Health Promotion officials were trained as master trainers

   Three (03) programmes were carried out in Gampaha district in August 2024 and 150 health officials were trained as master trainers

2) Training of Trainers (TOT) programmes on Psychosocial Wellbeing/ Health Promoting School/Life Skills

   Three (03) programmes were carried out in Galle district in July and October 2024 and 150 education officials were trained as master trainers

3) Training of Trainers (TOT) programmes on Life Skills

   One (01) programme was carried out in Kurunegala district in October 2024 and 50 health officials were trained as master trainers

4) Training of Trainers (TOT) programmes on Health Promoting Schools & School Medical Inspection

A central programme was carried out at Family Health Bureau, Colombo in June 2024 and 60 public health officials covering all districts were trained as master trainers

Advocacy Measures

a. Food Legislation

Intense lobbying was carried out throughout 2024 in high level meetings and while coordinating with relevant agencies to activate revisions on 'Food (Labelling and Advertising) Regulations of 2022 from 1st January 2025.

b. Education Reforms

Concerns of Ministry of Health on proposed National Education Reform Policy Framework which had been developed after several rounds of expert meetings, was communicated to Ministry of Education through the Secretary, Ministry of Health. These recommendations were on making 'Health' subject mandatory up to Ordinary Level and implementing Parliamentary Sectoral Committee recommendations on Sexual & Reproductive Health.

Printing of Training Material and Formats

Following training materials were printed in 2024.

1) Handbook for parenting – used in education and training programmes by field health staff to promote good parenting among community - 10,000 copies were printed in Sinhala and distributed to all 26 districts with number of copies varying as per their request.

2) Psychosocial Training Manual - used in training of trainers programmes for health and education staff to educate on psychosocial wellbeing and to provide hands on training - 10,000 copies were printed in Sinhala and distributed to all 26 districts with number of copies varying as per their request.

3) H 1306 School Canteen Format – used in assessing and monitoring school canteens by the Public Health Inspectors – 5000 copies in Sinhala & 2000 in Tamil were printed and distributed to all 26 districts

Purchasing of Equipment

Following equipment were procured in 2024 to be used in growth monitoring activities of school children within SMI.

Bathroom scales - 600 items costing Rs 2,700,000.00

Height Measuring Tapes - 600 items costing Rs 1,320,000.00

These were also distributed to all 26 districts with number of items varying as per their request.

Special Activities

a. Assessment of Nutrition Environment in Schools

This activity was initiated in 2024 with UNICEF funding and included 2 major parts.

1) Adaptation of the Nutrition Environment Assessment Tool for Schools (NEAT-S) developed by UNICEF, to suit Sri Lanka
2) Survey to assess the nutrition environment in and around a sample of schools in 5 selected districts using the tool

First activity, adaptation of NEAT-S along with development to be used within local settings was completed and pilot testing was also carried out within Galle district by the end of the year.

b. Addressing Psychosocial Issues among School Going Adolescents

This activity was initiated in 2024. A series of consultative meetings of relevant experts were carried out and a study in 3 selected districts to assess prevalence of psychological issues in a selected sample of school children using appropriate tools including SDQ 33 was planned. The activity is ongoing.

c. Global School Health Survey (GSHS) Sri Lanka 2024 & Follow up Advocacy Activities

This is a globally designed research with an objective of providing data on health behaviors and protective factors among school children, including dietary behaviors, physical activity, mental health, tobacco and alcohol use. Global School Health Survey findings could be used to identify priorities, to obtain resources for school health programmes and to develop national level policies. Global School Health Survey is routinely conducted every 5 years worldwide under the technical guidance of World Health Organization (WHO). It had previously been conducted in Sri Lanka in 2008 and 2016.

In 2024, GSHS was conducted successfully in collaboration with the Ministry of Education. The study involved students in grades 8 to 12, utilizing a two-stage cluster sampling method for a nationally representative sample of 40 schools and 3,125 students. Sample size, participating schools and class rooms were selected with inputs from WHO. All survey material was developed as stipulated by WHO. After data cleaning, 2,912 responses were usable, resulting in a 75.8% response rate. The analysis following data entry and cleaning focused on those aged 13 to 17, yielding a sample size of 2,566 and preliminary results were obtained by the end of the year.

Table 4.0: Results of GSHS

	Percentage
Food Insecurity and Malnutrition	
Proportion with frequent/constant hunger due to non-availability of food at home in the past 30 days	4.3
Proportion of students who were underweight	21.4
Proportion of students who were stunted	10.9
Proportion of students who were overweight	12.1
Proportion of students who were obese	3
Food Consumption Patterns	
Proportion of students reporting daily consumption of high-sugar food	40.9
Proportion having meals/snacks from fast food outlets/street vendors at least once in past week	70.4
Proportion of students who had not consumed fruits in the week preceding the survey	24.9
Proportion of students who had consumed vegetables three or more times daily	26.1
Proportion of students who had consumed carbonated drinks daily	17.4
Proportion of students who had consumed sugar-sweetened beverages daily	28
Proportion of students who had consumed high-fat foods daily	29.3
Proportion of students who had consumed salty snacks daily	28.5
Physical Activity	
Proportion of students who met the daily recommended physical activity level	11.9
Proportion of students who were not active for at least 1 day during the past week.	29.9
Proportion who reported sedentary behaviour - spending ≥3 hours per day sitting or lying down (excluding school work and sleep)	43.9
Mental Health	
Proportion of students who had seriously considered attempting suicide in the past 12 months	15.4
Proportion of students who had made plans regarding how they would attempt suicide	9.6
Proportion of students who had felt lonely most of the time/always during the past 12 months	22.4
Proportion of students who didn't have close friends	7.5
Proportion who were worried about something so much that they couldn't sleep at night during the last 12 months	11.9
Proportion of students who felt down, depressed, helpless, had little interest in, or got little pleasure from doing things during the past year	18
Proportion of students reporting being bullied at school in the past 12 months	18.9

Proportion of students who had been bullied outside the school	8.8
Proportion of students who reported being subjected to cyberbullying during the past 12 months.	5.4
Substance Use	
Proportion of students who had tried smoking cigarettes at least once	12.8
Proportion of students who had initiated smoking before the age of 14 out of above	34.7
Proportion of students who reported current cigarette use within the past 30 days	5.7
Proportion of students who had used e-cigarettes	5
Proportion of students reporting that their first drink was taken before the age of 14 from those who had ever consumed alcohol	39.3
Proportion of students who had consumed alcohol in the 30 days before the survey	5.3
Proportion of students who reported using alcohol before the age of 14 from those who had ever used addictive drugs	47.7
Proportion of students who reported using cannabis at least once	3.1
Proportion of students who had reported of current cannabis use	2.1
Proportion of students who had used amphetamines or methamphetamines (ice) other than for medical purposes	1.5
Sexual & Reproductive Health	
Proportion of students who had reported having had sexual relationships	5
Proportion of students who had ever heard of HIV/AIDS	63
Proportion of students who had reported being educated on avoiding pregnancy	42.9
Proportion of students who had been taught what to do if someone was trying to touch them in a sexual way against their will, during this school year	57.7
Sleep Health & Device Use	
Proportion of students who slept less than 8 hours on an average school night	62.6
Proportion of students with high mobile phone use (3 or more hours/day) for social media or online communication or browsing in internet	28.4
Violence and Injuries	
Proportion of students who were subjected to physical violence in the past year	23.8
Proportion of students who experienced dating violence in the past year	10.1
Proportion of students who reported cyber-sexual harassment in the past 12 months	6.9
Proportion of students who were forced into unwanted sexual activities in the past 12 months	6.1

Table 4.1: Performance of School Health Programme 2024

Indicator	2023	2024
% of schools SMI completed	99.1	99
% of schools with sanitary surveys completed	98.8	99.3
% of students examined	91.8	91.2
% of children wasted	18.7	18.1
% of children stunted	5.8	6.5
% of children overweight	5.1	5.2
% of children obese	2.2	2.3
% Health Promoting Schools	72.6	74

ADOLESCENT AND YOUTH HEALTH

Within the life-course preventive health approach, adolescents and youth are recognized as a critical population group undergoing the transition from childhood to adulthood. This stage is characterized by rapid physical, psychological, and social development, making timely and appropriate health interventions essential. The Adolescent and Youth Health Unit (AYHU) of the Family Health Bureau (FHB) serves as the national focal point for planning, coordinating, and implementing health services for adolescents and youth in Sri Lanka.

In Sri Lanka, adolescents (aged 10–19 years) and youth (aged 15–24 years) account for approximately 16.7% and 15.6% of the total population, respectively. A substantial proportion of this population group nearly 71% is enrolled in the formal education system. Recognizing the demographic significance and unique health needs of this group, the National Adolescent and Youth Health Programme aims to ensure optimal health and well-being for adolescents and youth by providing evidence-based promotive, preventive, and curative health services, with active collaboration from relevant non-health sectors.

A key component of the programme is the Adolescent and Youth-Friendly Health Services (AYFHS), which focus on improving the accessibility, acceptability, and quality of health services for adolescents and youth. The programme emphasizes establishing national standards and service delivery criteria, alongside continuous capacity-building for healthcare personnel to provide age-appropriate, confidential, and respectful services across the country.

Adolescent and Youth-Friendly Health Service centres, known as "Yowun Piyasa," have been established in both preventive and curative health sectors as dedicated service delivery points. These centres promote healthy behaviours, enhance life skills, address health concerns of adolescents and youth, and facilitate timely referral for specialized care when required. In addition, Yowun Piyasa centres serve as platforms for adolescent and youth empowerment, engagement, and participation.

By the end of 2024, a total of 45 Yowun Piyasa centres had been established in hospital sector institutions island-wide. Furthermore, all Medical Officer of Health (MOH) offices are mandated to conduct Adolescent and Youth Friendly Health Service clinics at least once a month on a fixed date, ensuring sustained access to services at the community level. Strengthening other primary care settings as adolescent responsive health services was also initiated in the last quarter of 2024 as per WHO regional committee recommendations.

Adolescent and Youth Friendly Health Services (AYFHS) Implementation

The Adolescent and Youth Friendly Health Services (AYFHS) concept was introduced in Sri Lanka in 2005 to address the specific health needs of adolescents and youth through age-appropriate and responsive service delivery. Since its inception, national strategies and operational guidelines for AYFHS have undergone periodic revisions to address implementation challenges and to align services with emerging health priorities and evolving needs of adolescents and youth.

The "Yowun Piyasa" service delivery framework has been restructured into three implementation models, namely hospital-based, field-based, and center-based services, to improve service

coverage and effectiveness across diverse settings. This categorization has enabled better integration of adolescent and youth-friendly services within both preventive and curative health sectors.

AYFHS clinic centres have been strengthened to ensure the provision of accessible, equitable, and acceptable services, with particular emphasis on maintaining privacy and confidentiality for adolescents and youth. Physical infrastructure, service delivery processes, and provider competencies have been aligned with national AYFHS standards to create a safe and supportive environment for service users.

The adolescent and youth health service package has been further enhanced to provide comprehensive care, including counselling services, promotive and preventive interventions, and selected diagnostic and curative services. Mechanisms for referral, follow-up, and continuity of care have been strengthened, along with improved information dissemination and linkage with other relevant health and non-health sector services. These measures have contributed to improving service utilization and responsiveness of the AYFHS programme during 2024.

Yowun Piyasa Youth Groups, attached to hospitals and MOH areas and named "Y-hubs," were introduced in 2020 and strengthened within the year, ensuring meaningful youth engagement in AYFHS and health promotion in the community through them. Scaling up of the district model piloted in North Central Province in 2022-2023, with WHO support, has been conducted.

Conducting Technical Advisory Committee Meetings on Adolescent and Youth Health

During 2024, three Technical Advisory Committee (TAC) meetings were conducted at the national level under the chairmanship of the Director General of Health Services. These meetings brought together representatives from relevant health and non-health sectors, as well as youth representatives, to ensure a multisectoral, participatory approach.

The Technical Advisory Committee provided strategic guidance and technical expertise on key issues affecting adolescents and youth, with a focus on strengthening service delivery, aligning policies, and enhancing programme responsiveness. Recommendations from the TAC meetings informed decision-making and supported ongoing improvements in the planning and implementation of adolescent and youth health interventions.

Capacity Building and Training Programmes

Several Training of Trainers (TOT) programmes were conducted to strengthen the competencies of healthcare providers, youth leaders, and other relevant stakeholders in adolescent and youth health.

Two-day Training of Trainers programmes on Adolescent Sexual and Reproductive Health (ASRH) were conducted with the participation of 30 health personnel per programme, including Consultant Community Physicians, MOMCHs, MOHs, MO-Yowun Piyasa, Public Health Nursing Sisters, NO-Yowun Piyasa, Public Health Inspectors, and Public Health Midwives. These programmes were conducted across multiple curative and preventive sector institutions, including TH Kurunegala, BH Balapitiya, BH Dambadeniya, BH Theldeniya, BH Pimbura, DH Unawatuna, RDHS offices Galle, Kandy, and MOH offices Hambantota, Sooriyawewa.



In addition, one-day Training of Trainer programmes on Adolescent and Youth-Friendly Health Services (AYFHS) were conducted for service providers to enhance understanding of national AYFHS standards, service delivery models, and quality assurance mechanisms.



Furthermore, three-day Training of Trainer programmes on Adolescent and Youth Health were conducted, with youth leaders participating, fostering youth engagement and multisectoral collaboration in programme implementation.



Collaboration with the Police Department

As part of strengthening intersectoral collaboration, advocacy programmes on need of smooth implementation of adolescent sexual and reproductive health (ASRH) services without legal barriers and field visits on ASRH were conducted for police officers and supervisory public health officers in five districts, namely Kilinochchi, Jaffna, Kalmunai, Trincomalee, and Vavuniya. Each district programme engaged approximately 65 police officers, particularly from the Child and Women's Desk, to improve awareness, referral pathways, and coordinated responses to adolescent and youth health issues.





District-Level AYFHS Strengthening

A one-day Training of Trainer programme on AYFHS, combined with field visits, was conducted in Jaffna District, involving approximately 65 participants, including RDHS officials, Medical Officers, MOH teams, and youth leaders. This initiative aimed to strengthen district-level implementation of AYFHS and improve service delivery models.





Digital Health Promotion and Yowun Piyasa Website Enhancement

Significant efforts were undertaken to strengthen digital engagement with adolescents and youth through the Yowun Piyasa website. A series of consultative meetings was conducted with technical experts and service providers to review and update website content. Over 120 participants, including healthcare providers and youth leaders, contributed through consultative processes conducted at MOH offices, hospitals, and RDHS offices across multiple districts.

In addition, 25 resource persons reviewed the website content, and short educational videos and infographics on sexual and reproductive health were developed and uploaded. A total of 27 digital products were produced, comprising nine items each in Sinhala, Tamil, and English, to enhance accessibility and reach.



Consultative Meetings on Strengthening School Health and Adolescent and Youth-Friendly Health Services

Six consultative meetings were held at the Family Health Bureau, with approximately 40 stakeholders participating, including Consultant Community Physicians, MO-MCHs, MOHs, Medical Officers, PHNS, Nursing Officers, and youth leaders. These meetings focused on identifying gaps, sharing best practices, and strengthening coordination to improve the implementation of school health and adolescent- and youth-friendly health services.

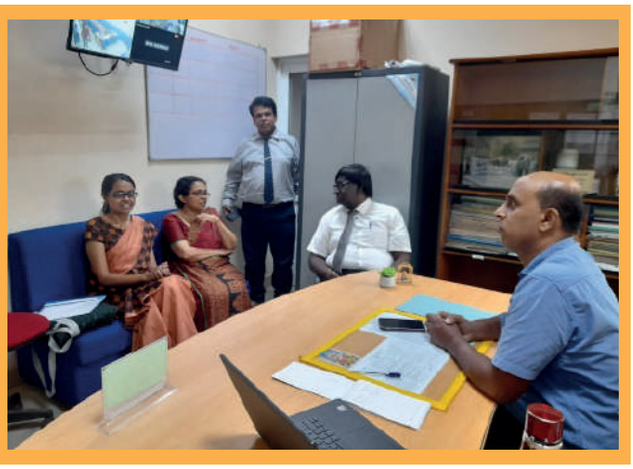
Conducting Meetings to Review the National Strategic Plan on Adolescent and Youth Health 2018- 2025

External review on the national strategic plan on adolescent and youth health in Sri Lanka 2018-2025 was conducted. Validation and dissemination of this external review of the National Strategic Plan on Adolescent and Youth Health were held at the Family Health Bureau, with 60 stakeholders per meeting. These meetings ensured stakeholder consensus, technical validation, and ownership of the revised strategic directions.

Review of the District Model

Following the external review of the AYFHS district model piloted in North Central province, review meetings were held in Anuradhapura and Polonnaruwa Districts. The meeting assessed implementation progress, identified challenges, and documented best practices to inform scale-up.





Assessment of Adolescent and Youth-Friendly Health Services in Sri Lanka

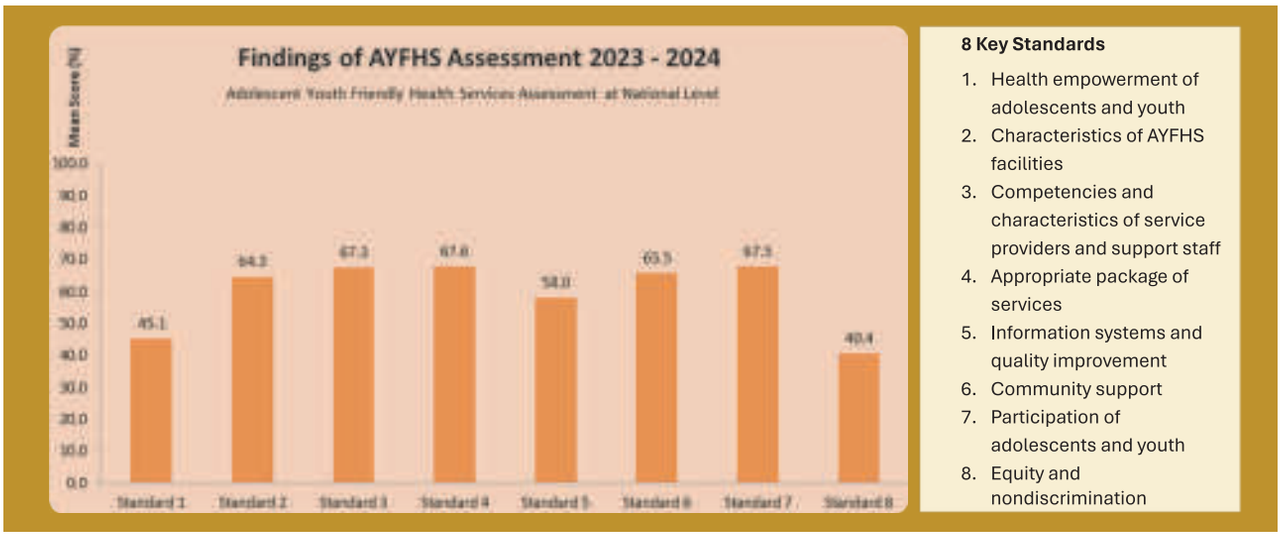
An assessment of Adolescent and Youth-Friendly Health Services, in line with eight national standards for AYFHs, was conducted at all hospital-based Yowun Piyasa centres across Sri Lanka over 2023-2024. The assessment evaluated service availability, quality, accessibility, and youth-friendliness, generating evidence to guide service improvement, standardisation, and future planning of AYFHS nationwide.





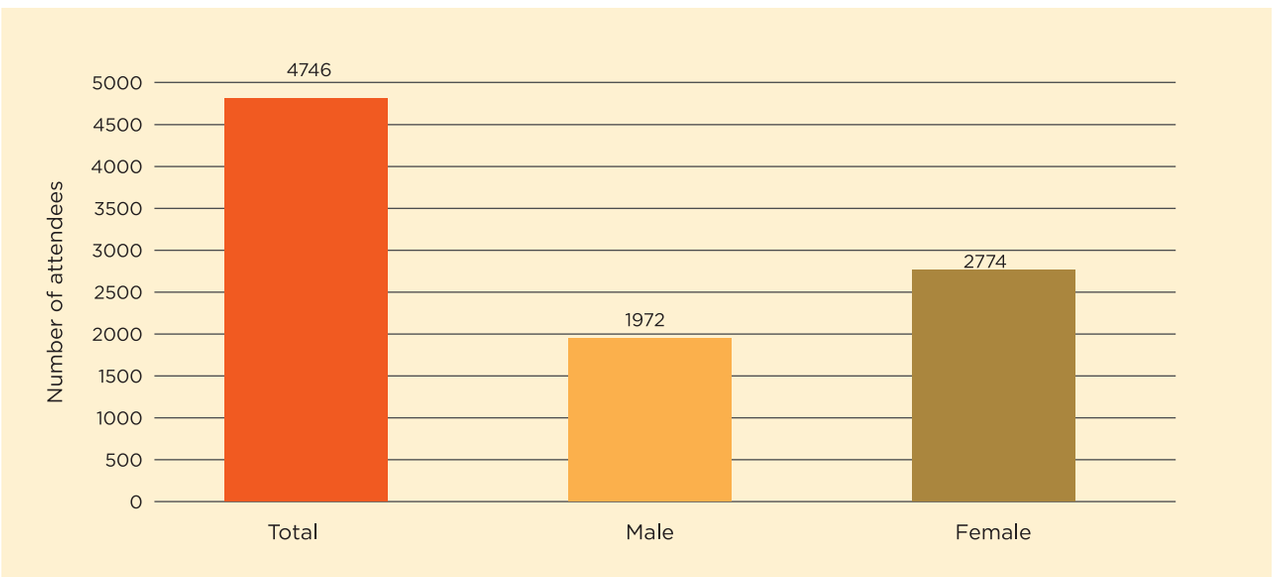






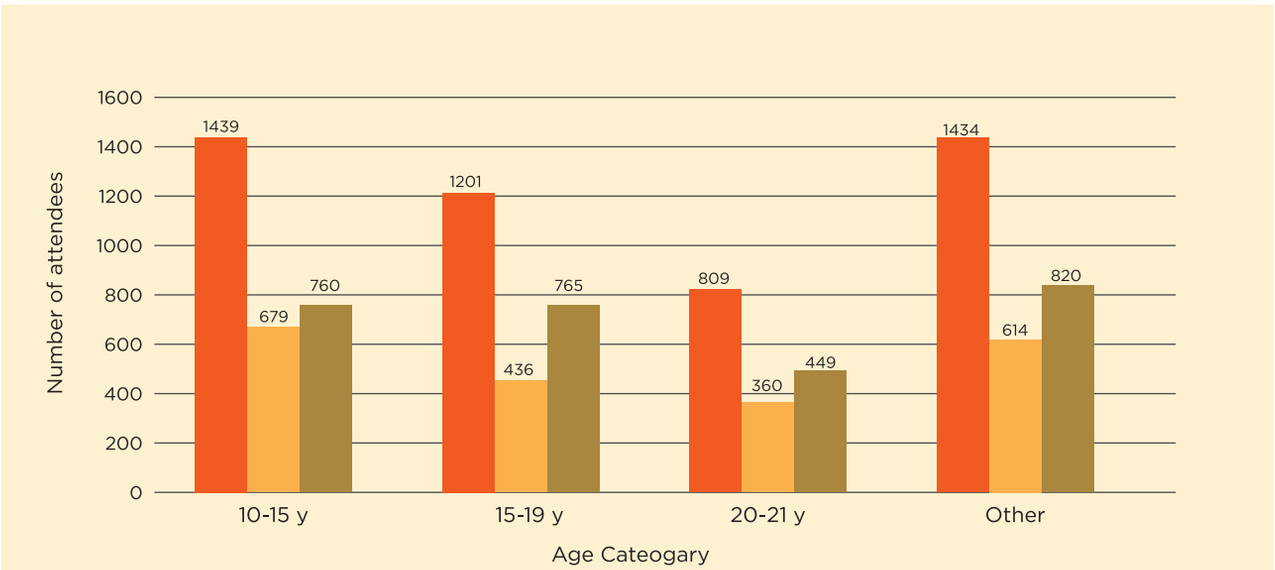
Source: Adolescent and youth health unit- FHB

Figure 9.2: Data from AYFHS Clinic Returns 2024(Attendance of Hospital - based Yowun Piyasa Centers 2024)



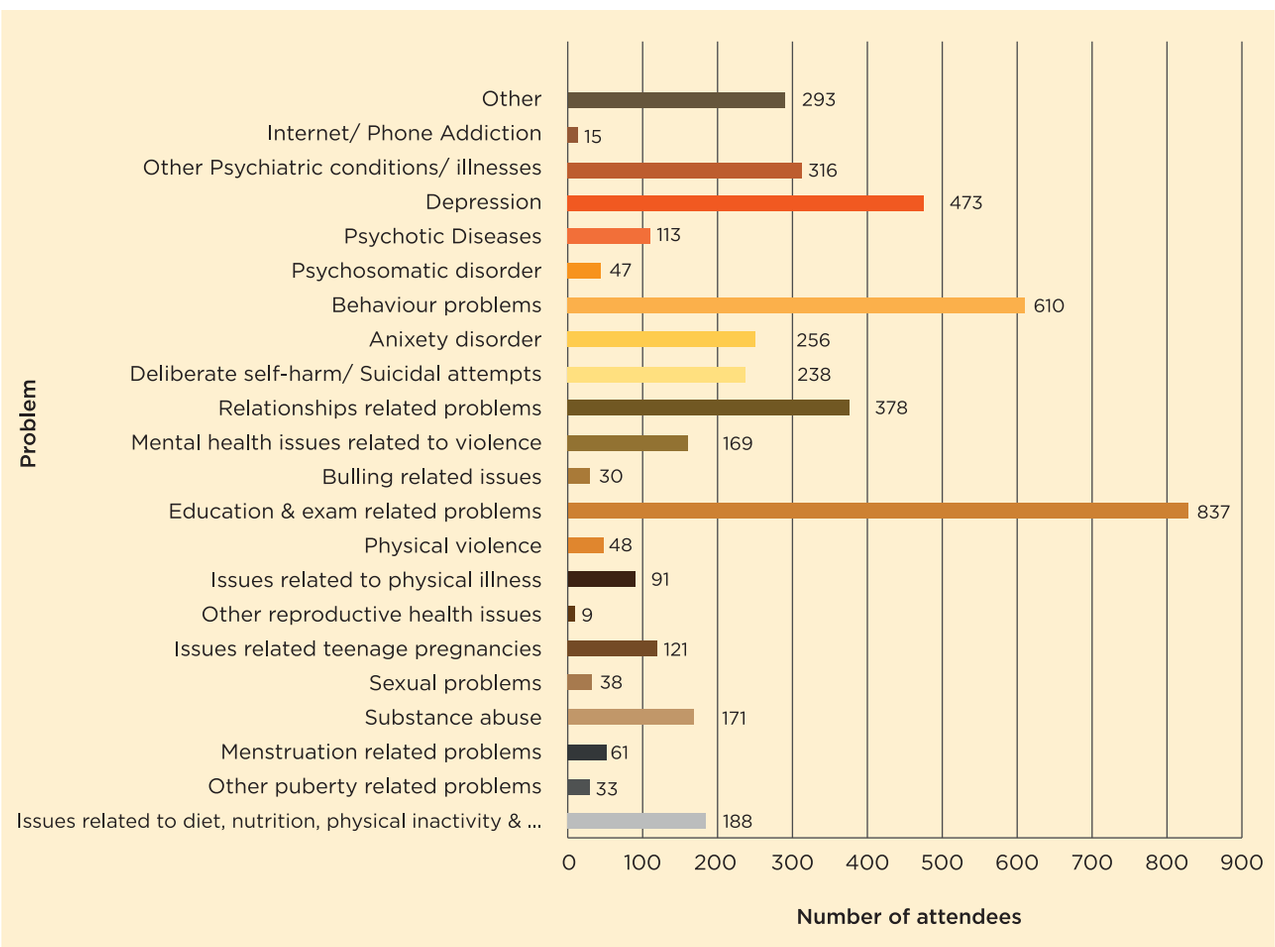
Source: Adolescent and youth health unit- FHB

Figure 9.3: Hospital-based Yowun Piyasa attendance in 2024



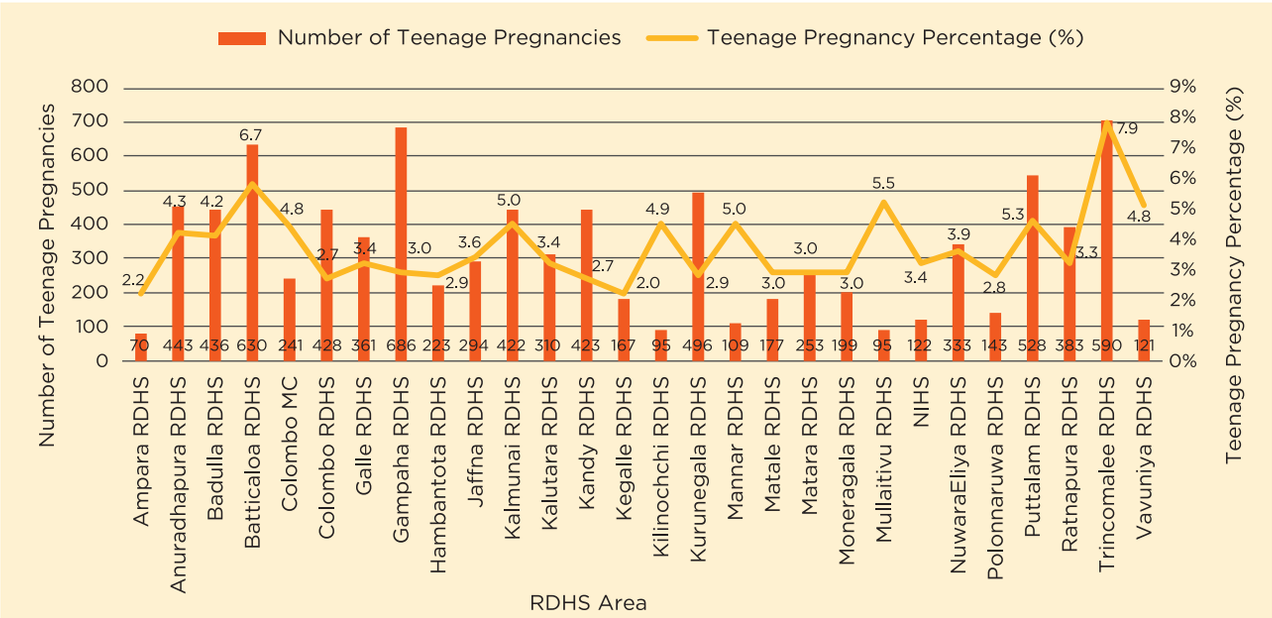
Source: Adolescent and youth health unit- FHB

Figure 9.4: Attendees to Hospital-based Yowun Piyasa centers by age groups 2024



Source: Adolescent and youth health unit- FHB

Figure 9.5: Identified problems at Hospital-based Yowun Piyasa centers 2024



Source: Adolescent and youth health unit- FHB

Figure 9.6: Teenage Pregnancies by RDHS Areas in 2024

FAMILY PLANNING

Reproductive health is an essential component of the MCH programme in Sri Lanka. Family Planning Unit is the focal point for the National Family Planning Program (NFPP). Family Planning services are provided through a network of 1863 Family Planning clinics that are in 361 Medical Offices of Health and Hospitals in national, provincial and district level.

The goal of family planning is to help all couples achieve their desired family size with optimal timing and spacing, while preventing unintended pregnancies. The programme objectives are as follows;

1. Ensure the availability and accessibility to modern contraceptive services including counselling for clients to make informed decisions on optimal timing and spacing of births.
2. Decrease the unmet need for contraception to reduce unintended pregnancies specially among older high-risk women and teenagers.
3. Ensure the availability of post-abortion family planning services.
4. Ensure the uninterrupted supply of quality contraceptive commodities (Contraceptive Commodity Security).
5. Strengthen services to manage sub-fertile couples in the public health sector.

There are 4 Key Performance Indicators (KPIs) to measure the family planning programme outcomes;

1. Contraceptive Prevalence Rate (Any method) %
2. Contraceptive Prevalence Rate (modern methods) %
3. Couples with unmet need for contraception %
4. Demand satisfied by modern contraceptive methods (%)

The timely distribution of the contraceptives to the districts and improved services contributed to the 0.4 % increase in the overall contraceptive prevalence rate for any method from 69.4% in 2023 to 69.8% in 2024. The modern contraceptive prevalence rate (mCPR) increased by 0.3% from 60.2 % in 2023 to 60.5% in 2024 and the unmet need reduced by 0.2% from 2023 to 2024. The Sustainable Development Goal (SDG) target 3.7.1; Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods increased by 0.2% from 80.5% in 2023 to 80.7% in 2024 (Table 3.4).

Table 4.2: Key performance indicators for the family planning programme

Key Performance Indicators	Progress				
	2020	2021	2022	2023	2024
1. Contraceptive Prevalence Rate (Any method) %	67.1	66.3	68.5	69.4	69.8
2. Contraceptive Prevalence Rate (Modern methods) %	58	57.4	59.4	60.2	60.5
3. Couples with unmet need for contraception %	5.8	5.5	5.5	5.4	5.2
4. Demand satisfied by modern contraceptive methods (%)	79.5	80.0	80.2	80.5	80.7

Source: eRHMIS, FHB

The following major activities carried out in 2024 contributed to the improved performance of the family planning programme.

Obtaining contraceptives and equipment for family planning services.

Contraceptive commodity security is a corner stone of the National Family Planning Programme. Timely availability of at least a choice of 5 contraceptives (e.g. Condoms, Oral Pills, Injectables, Implants and IUDs) at all Service Delivery Points (SDP) are necessary to provide clients with uninterrupted services.

The annual requirement and cost estimates of contraceptive commodities are given it Table 4.3.

Table 4.3: Contraceptives annual requirement and cost estimates

SR No	Item	Quantity (n)	Unit Price (Rs.)	Estimated Cost (Rs)
12401000	Condoms	6,000,000	11.8	70,800,000.00
1300501	Oral pill cycles	1,300,000	54.4	70,720,000.00
702601	DMPA vials	700,000	160	112,000,000.00
1300402	IUD	60,000	288	17,280,000.00
14003700	Implants	60,000	2660	266,000,000.00
12400502	AD syringes	700,000	12	8,400,000.00
Total				545,200,000.00

Source: Family planning unit - FHB

However, due to the economic crisis, only 44.7% of the contraceptive requirement was procured by Government of Sri Lanka funds for approximately Rs. 243.7 million (see Table 4.4).

Table 4.4: Contraceptives procured from Government funds

Year	Contraceptive Commodity	Quantity	Cost (Rs.)
2024	Oral pill cycles	650,010	27,936,537.00
	DMPA injectable vials	350,000	75,419,750.00
	Two rod Implants (Three-year Levoplant)	60,000	140,400,000.00
	Total		**243,756,287.00**

Source: Family planning unit - FHB

Also, a significant proportion of the contraceptive requirement was donated by United Nations Population Fund (UNFPA) for a sum of approximately Rs. 258 million (Table 4.5).

Table 4.5: Contraceptives donated by UNFPA

Year	Contraceptive Commodity	Quantity	Cost (Rs.)
2024	Oral pill cycles	1,324,512	83,444,256.00
	DMPA injectable vials	517,200	92,776,800.00
	Two rod Implants (Three-year Levoplant)	40,000	82,140,000.00
	Total		**258,361,056.00**

Source: Family planning unit - FHB

There was no shortfall in the other commodities (condoms, IUDs and AD syringes)

In the procurement of Oral pills for 2024, a significant step towards inclusivity was achieved by, revising the specifications to introduce a tactile arrow on the starting point of the oral pills' blister packs. This innovation was designed to assist visually impaired women, a frequently marginalized group, in independently managing their reproductive health.

In addition, to the procurement of contraceptives, instruments such as 1000 Mosquito Forceps, 100 Sponge Holders, 40 Long Artery Forceps and 05 Mini Autoclaves were procured from GoSL funds at a cost of Rs 3,562,000.00 for family planning clinics.







Capacity building of health staff for providing quality family planning services

Capacity building or training is one of the six building blocks in WHO's health system strengthening concept. A service provider should be well trained, skilled (competent) and motivated to provide quality services.

Service providers were trained to ensure human rights in contraceptive information and services, in keeping with the organizing principles;

1. Availability
2. Accessibility
3. Acceptability
4. Accountability
5. Informed decision making
6. Non-discrimination
7. Privacy and confidentiality
8. Participation
9. Quality

Training of Medical Officers and Public Health Nursing Sisters:

- In 2024, the Family Planning Unit conducted two 3-day workshops for Training of Trainers on Reproductive Health and Family Planning for 29 Medical Officers in 2024. Information provision, counselling on family planning, updating of knowledge on family planning methods, 'Hands on' training of IUD and Implant insertions on models and on patients were key features in the training.

- The College of Anaesthesiologists & Intensivists of Sri Lanka conducted a half-day session on anaphylaxis management during these workshops. This session was important to build confidence among the Medical Officers to face and respond to emergency situations including anaphylactic reactions, especially following DMPA injectables.

- Four, 2-day workshops on Reproductive Health and Family Planning were held to train 57 Public Health Nursing Sisters as Training of Trainer (ToT) programmes in 2024. Counselling on family planning, family planning methods, 'Hands on' training of IUD insertions on models and on patients were carried out as a part of the training programme. In addition, 12 senior grade nursing tutors were trained with the intention of disseminating the knowledge to a wider circle.

All trainees were encouraged to download the FHB 'Contraceptive Choices' and the WHO MEC Wheel app, in order to counsel clients to make informed decisions.



Training of Supply Chain Managers

- Capacity development of contraceptive Store Managers was imperative for the efficient management of the contraceptive supply chain at all levels for ensuring contraceptives at SDPs. The district stores (Regional Medical Supplies Division-RMSD) are managed by OIC/RMSD and it is important that they are fully updated on contraceptive supply chain management (Forecasting/Estimating, obtaining stocks between min-max levels, storage as per guidelines and stock issues to MOHs and Hospitals).

In 2024, 28 RMSD, OICs were trained with regards to supply chain management of contraceptives and the contraceptive return (H1158) in the eRHMIS.

Development of printed material for health staff and general public

Flashcards for Family Planning Counselling

- In order to counsel client on family planning, 3275 'Flash cards for Family Planning counselling were printed with the support of Family Planning Association and UNFPA. (i.e. 2275 Sinhala copies and 500 copies of Tamil and 500 copies of English). In addition, 500 copies of Self Breast Examination were also printed, and distributed among service providers.



Monitoring and Evaluation

Supportive supervision is a motivation factor for public health staff working in the districts. In 2024 supervisory visits were carried out in two low performing districts of the North Central Province and the Northen Province.

- A household survey was carried out in the Kekirawa MOH area and the district review was carried out at the RDHS office, Anuradhapura with the participation of RDHS, CCP, MOMCHs and all MOHs of the Anuradhapura district. A special discussion was held with the Medical Officers of Health on measures to evaluate the unmet need for contraception and the prevalence of use of modern contraceptives, with a view to reducing unwanted pregnancies and reducing maternal deaths.
- A supervisory visit was also made to the RMSD Anuradhapura
- A similar programme was carried out in Mullaitivu district with a fruitful discussion with the Provincial Director of the Northen Province and Regional Director and MOMCH of Mullativu district.



Code of Practice for Assisted Reproductive Techniques

The pressing need for a Code of Practice and Guidelines for Medically Assisted Reproductive Technology (MART) was addressed in 2024 through collaborative efforts with the Sri Lanka College of Obstetricians and Gynaecologists (SLCOG). A circular (No. 01-42/2024) in this regard was issued as an interim measure to guide healthcare professionals and institutions when providing MART services. The availability of this guideline marks a significant step in ensuring ethical, safe, and standardized ART services in the country, safeguarding the well-being of the clients and improving reproductive healthcare outcomes.



Installation of solar panels at Family Health Bureau

As part of efforts to promote sustainable energy solutions in healthcare, solar panels and a 50KW hybrid inverter were installed at the FHB to supplement the energy requirement of the contraceptive storage facilities through a generous donation from the UNFPA. This initiative aligns with the green energy concept, ensuring a reliable and eco-friendly power supply to supplement energy requirements.

WELL WOMAN PROGRAMME

The Ministry of Health introduced Well Woman Clinics (WWCs) in 1996 as a key public health intervention aimed specifically at women aged 35 to 60 years. These clinics were established to facilitate the early detection and management of selected NCDs and to promote overall women's health and wellbeing.

The primary objective of the Well Woman Clinics (WWCs) is to screen women for priority non-communicable diseases (NCDs), including diabetes mellitus, hypertension, and oral, breast, and cervical cancers. Early detection of these conditions is essential for timely intervention, downstaging of cancers, and reducing both mortality and long-term complications.

In addition to screening, the clinics provide care for menstrual, perimenopausal, menopausal, and postmenopausal health issues, offering individualized management. Women are also educated on lifestyle modification and empowered to take an active role in maintaining their health.

WWCs deliver comprehensive health education covering nutrition, healthy lifestyles, and, where relevant, family planning services. This holistic approach equips women with knowledge and fosters preventive health behaviors.

Since 2007, the programme has strategically prioritized screening in two key age cohorts—35 and 45 years—to maximize early detection and long-term health outcomes. Additionally, women who have initiated sexual activity during adolescence are offered cervical screening at 30 years of age. While Pap cytology remains the main method of cervical cancer screening, HPV DNA testing has recently been introduced, in a small scale, and is expected to play an increasingly important role in enhancing the effectiveness and efficiency of the screening programme.

More than 1500 Well Woman Clinics are now functioning island wide and the clinic services are delivered predominantly by the public health staff including Medical Officers of Health (MOH), Public Health Nursing Sisters (PHNS), and Public Health Midwives (PHM). Therefore, the capacity building of the relevant field health staffs is essential to maintain and strengthen quality of well woman services. Several capacity building programmes were conducted by visiting selected districts to improve the coverage and quality of the Well Woman Programme. These programmes were funded by the UNFPA.

In addition to routine programme activities, field visits were conducted during the year to assess the implementation and utilization of HPV DNA testing data at field level. These visits not only ensured that data were being accurately captured and reported but also facilitated on-site problem-solving and technical support for staff.

Recognizing the importance of maintaining an adequate and skilled workforce for cytology screening, a structured training programme for new Medical Laboratory Technologists (MLTs) as cytoscreeners has been continued. This initiative is essential in addressing the natural turnover of cytoscreeners within the system and ensures the uninterrupted provision of cytology services.

To further strengthen the technical capacity and uphold high standards of performance, annual refresher training programmes were conducted for all cytoscreeners. These refresher sessions

also serve as a mechanism of external quality assurance, enabling continuous professional development, peer learning, and harmonization of practices across laboratories.

Performance appraisal of Well Woman Programme activities conducted in 2023 was also carried out in 2024. The best performing Medical Officers of Health (MOOH), districts, and cytoscreeners were identified and awarded with tokens of appreciation. This recognition system has been instrumental in motivating staff and fostering a culture of accountability and excellence within the programme.

Complementing these technical interventions, Information, Education, and Communication (IEC) materials were developed and disseminated to enhance public awareness and improve client knowledge regarding Well Woman services. In addition, the updated **Well Woman Programme Guideline 2024** was finalized and printed, providing healthcare workers with an evidence-based and standardized reference to ensure uniform implementation of programme activities across the country.



ORAL HEALTH OF PREGNANT WOMEN AND SCHOOL CHILDREN

In 2024, the Oral Health Unit of the Family Health Bureau (FHB) continued its dedicated efforts to enhance the oral health of pregnant women and children through the Maternal and Child Health (MCH) programme. The unit played a key role in developing and updating evidence-based strategies, guidelines, and protocols in collaboration with professional bodies and development partners.

Providing technical guidance at national, provincial, and district levels, the unit also focused on capacity building by preparing and refining training materials for public health staff, while supporting programme implementation through logistics coordination.

The Oral Health Unit further contributed by convening the National Advisory Committee on Oral Health, chaired by DDG (PHS II), and by actively participating in undergraduate and postgraduate education. In addition, it took responsibility for monitoring, evaluation, and operational research to support continuous programme improvement.

As the focal point for National Oral Health Programmes targeting pregnant mothers and children, the unit also led the development of Information, Education, and Communication (IEC) materials tailored for these key groups.

Procurement and Distribution of Essential Supplies for School Dental Services:

The Oral Health Unit achieved several milestones in 2024, beginning with the Procurement and Distribution of essential supplies and equipment. The School Dental Programme benefited from the procurement of 250 packs of fissure sealants and 500 packs of fluoride varnish. Additionally, 20 micromotor units and LED dental examination lamps were purchased for school dental clinics (SDCs) following a facility survey to verify district-level requirements. Emergency bulk purchases of GIC filling materials were made to address stock shortages at the Medical Supplies Division (MSD).



Highlighting these efforts, a ceremonial distribution of micromotor units to Regional Dental Surgeons (RDSS) and School Dental Therapists (SSDT) took place during the World Oral Health Day celebration on 12th March 2024. The Secretary of Health participated as a chief guest of this event.



UNICEF-Funded Phase-Out Supervision of FV and FS Programmes – Western Province:

The UNICEF-funded Phase-Out Program for Fluoride Varnish and School-Based Sealants was a key focus in 2024. From September to November, 32 supervision visits were conducted to oversee the screening of children in preschools across the Western Province. These efforts ensured proper implementation and monitoring of the phase-out process.

District-Level Advocacy and Training for FV and FS Application under WHO-Supported Oral Health Initiatives:

Advocacy and Training Programs played a crucial role in 2024. Advocacy programmes in Gampaha, Colombo, and Kalutara districts engaged 138 regional stakeholders in the health and education sectors. The WHO-supported in-service training sessions further strengthened capacity by training 90 district oral health staff in fluoride varnish and fissure sealant applications, alongside two sessions held in August 2024.



Furthermore, 30 dental surgeons from OPD dental clinics in government hospitals with ETU facilities received specialized training on 2nd October 2024 to apply fluoride varnish and fissure sealants for children with medical conditions in hospital settings.





IEC Development and Dissemination:

The Development and Distribution of IEC Materials was another significant achievement. The unit designed and distributed a variety of resources, including leaflets, flashcards, banners, and videos on fluoride varnish and fissure sealant applications.








During advocacy programmes, 100 guideline books for each programme and 500 tri-lingual diet charts were distributed. Instructional videos on fluoride varnish and fissure sealant applications were uploaded to the FHB website and YouTube on 20th June 2024, expanding accessibility. A facility survey was conducted to identify data recording format requirements for SDCs, with input received from all 26 districts and NIHS Kalutara.

The Annual Review of School Dental Services:

The Annual Review of School Dental Services took place on 8th and 9th August 2024 at the Sri Lanka Foundation Institute, Colombo supported by UNICEF. This national review meeting revised data recording formats and targets for school dental services, reinforcing the unit's commitment to continual improvement in oral health care delivery.

Consultative Engagements for Strategic Planning and Strengthening School Dental Services:

Consultative Meetings contributed significantly to programme development. A key meeting on 12th June 2024 focused on the planning of phase-out programme of fluoride varnish programme for children six years and below in the Western Province with the regional dental surgeons and supervising school dental therapists in three districts including NIHS, Kalutara. Also, three additional consultative meetings were held to finalize the circular on "Strengthening School Dental Services in Sri Lanka," while three meetings addressed the revision of school dental service targets. Efforts to modernize data systems also advanced with updates to the e-RHIMS platform, guided by health informatics expert Dr. Yujwal from India.




Facility Surveys and Capacity Building activities:

Facility Surveys and Capacity Building activities in 2024 included district-level verification of school dental clinic requirements for 2025 and an urgent survey of SSDT needs, with data forwarded to the Additional Secretary Admin II and DDG (Dental Services).

The Oral Health Unit also engaged with third-year dental students at the Faculty of Dentistry, University of Sri Jayewardenepura, offering an orientation programme on oral health services under the Maternal and Child Health Programme.






Excersice programme

Finally, in promoting health and well-being, the FHB organized an Exercise Program with weekly aerobic sessions starting in May 2024, totaling over 40 sessions by year's end. Staff also participated in the "Capacity Building Program for Young Leaders for a Healthy Lifestyle," organized by the Ministry of Health on 5th April 2024, further emphasizing holistic health promotion.





PLANNING AND DEVELOPMENT

WHO Programme planning module was adopted and introduced to Sri Lanka in a phased manner, targeting all Consultant Community Physicians, Medical Officers of Maternal and Child Health (MOMCH) and Medical Officers of Planning (MO-Planning). One master Training on Programme planning was completed in 2024. 16 of newly appointed CCPs, CCD, MOMCHs, MO planning, and Doctors of FHB completed the training, covering up almost all key health staff members involved in RMNCAYH programme planning.

Table 4.6: Percentage of districts trained on programme planning

	Years		
Indicator	2022	2023	2024
% of districts trained on programme planning	ND	0.8	0.8

Source: FHB



- Duty lists of Public Health Nursing Sisters (PHNS) was being revised after having a series of virtual and physical meetings with all relevant stake holders, while a new guideline was developed and approved to identify and establish new Public Health Midwife areas (PHM areas) to regularize the process.

- Two Disaster preparedness meetings (for district staff) and Three post disaster meetings were conducted virtually. The number of pregnant mothers, mothers with New-born babies and women affected by natural disasters including floods were calculated and over 2000 maternity kits (MK) and dignity kits (DK) were distributed in 2024. The commodities were donated by UNFPA.

- An external consultant is hired, two workshops and eight virtual meetings conducted, and Training material for a TOT on Sexual and Reproductive Health (SRH) in Emergencies were developed in all three languages during 2024. This was directly funded by FPASL.

- One training Programme on Sexual and Reproductive Health in Emergencies was conducted for public health staff of Kandy RDHS area, in 2025, funded by UNFPA.

- Adoption of MISP Readiness Assessment (MRA) Toolbox to local context to prepare an action plan to handle SRH emergencies in disaster was conducted in December, 2024. This was done by an External consultant, with FHB support, and funded by UNFPA. Heather Loranz, the regional head of UNFPA participated throughout the MRA workshop, held in Colombo.



- Since MCH policy, compiled in 2011, needs re-visiting, A team of Experts conducted a policy gap analysis. 17 non-funded physical meetings were held, interviewing seven program managers of FHB in 2024.

- A one-day Training program was conducted to train FHB staff on English letter writing. The one-day workshop was facilitated by a qualified team from Skills Development Fund Limited (SDFL), a substitute of Ministry of Education. This was jointly Funded by GOSL and Welfare society of FHB.

- Preparation of Annual Action Plan for Family Health Bureau-2025 was completed and submitted to MOH. Further Capital Budget Estimates and annual and 3-year Procurement plans were compiled and forwarded to MOH.

- Review meetings conducted and quarterly progress of the annual action plan and UN funded programs were compiled and forwarded. Annual Performance report for budget debates, central bank reports, etc prepared and forwarded regularly throughout 2023 and 2024.

- TWO meetings of National Committee on Family Health (NCFH) conducted in 2024. The meetings, chaired by Secretary of Health, is the key flat form for seeking solutions to managerial problems in the field of MCH.
- Two laptops and 11 desktops were purchased and distributed for Needy units of FHB.
- Part of Essential furniture for FHB were purchased and distributed to needy units. This project is yet to be completed, due to technical disagreements.

MONITORING AND EVALUATION

- In order to assess the field level healthcare services a team lead by the Consultant Community Physician of the Monitoring and Evaluation Unit Family Health Bureau visited several field level clinics in the Colombo Municipal area in January 2024. Following clinic visits a discussion was held with the Medical Officers in CMC area and the administration

  Maligawatta clinic



- School Health Reviews conducted online - Provincial, Jan, Feb, March 2024

- RHMIS External Review – A comprehensive external review of reproductive management information system was done and several field visits to observe data utilization at grassroots level done in February – March.



Findings of the external review was disseminated among all stakeholders





- **First Bi Annual MOMCH Review workshop**

  To review the progress of the district MCH activities, a three-day workshop was held in Colombo, Sri Lanka Foundation Institute 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 April 2024 with the participation of the Secretary of Health, Director General of Health Services and the Deputy Director General of Health Services II.







- **Second Bi Annual MOMCH Review workshop**

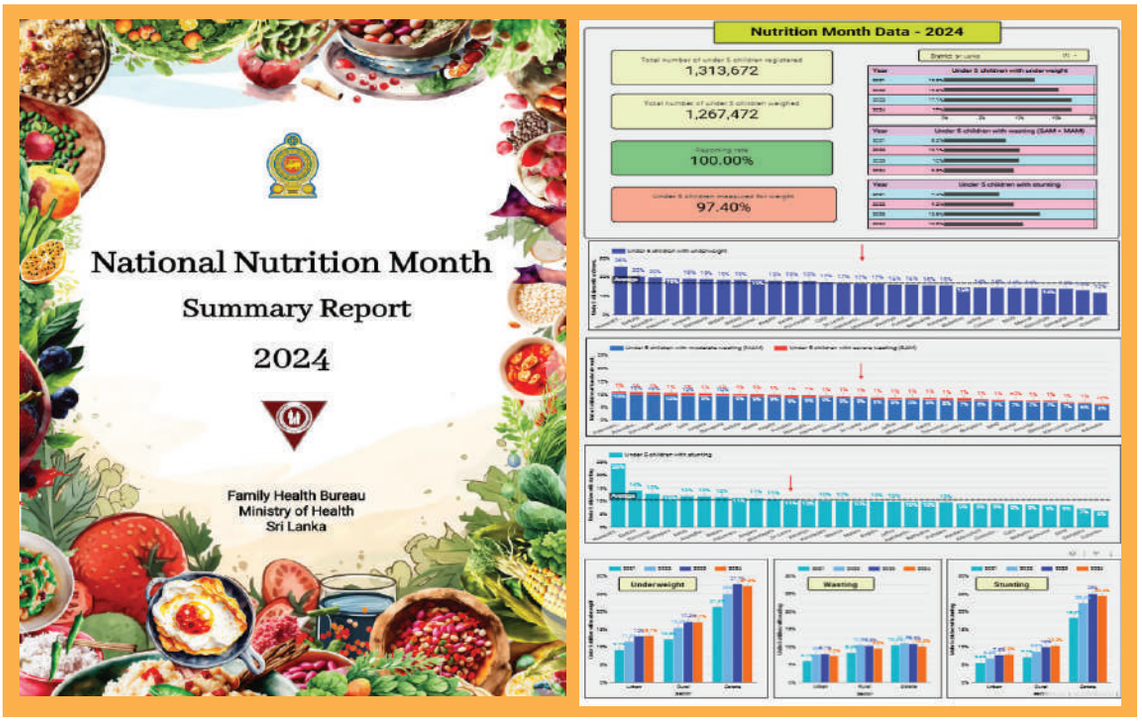
  The Second Bi Annual MOMCH Review workshop was also a three-day workshop held in Kaluthara, Waskaduwa at Citrus Hotel with the participation of all Medical Officers of Maternal and Child Health and Consultant Community Physicians from all 28 health districts in the country including CMC and the NIHS area. This was held in October 2024 with the participation of the Secretary of Health and the Director General of Health Services.

  As part of this workshop a field visit was conducted in selected PHM areas in NIHS area to conduct a household survey by the participants.

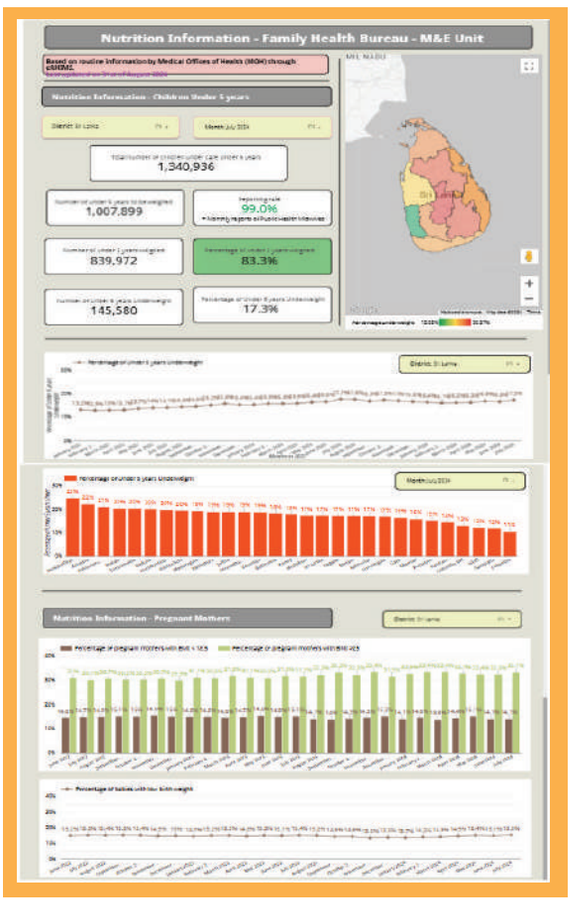


- **National Nutrition Month 2024**

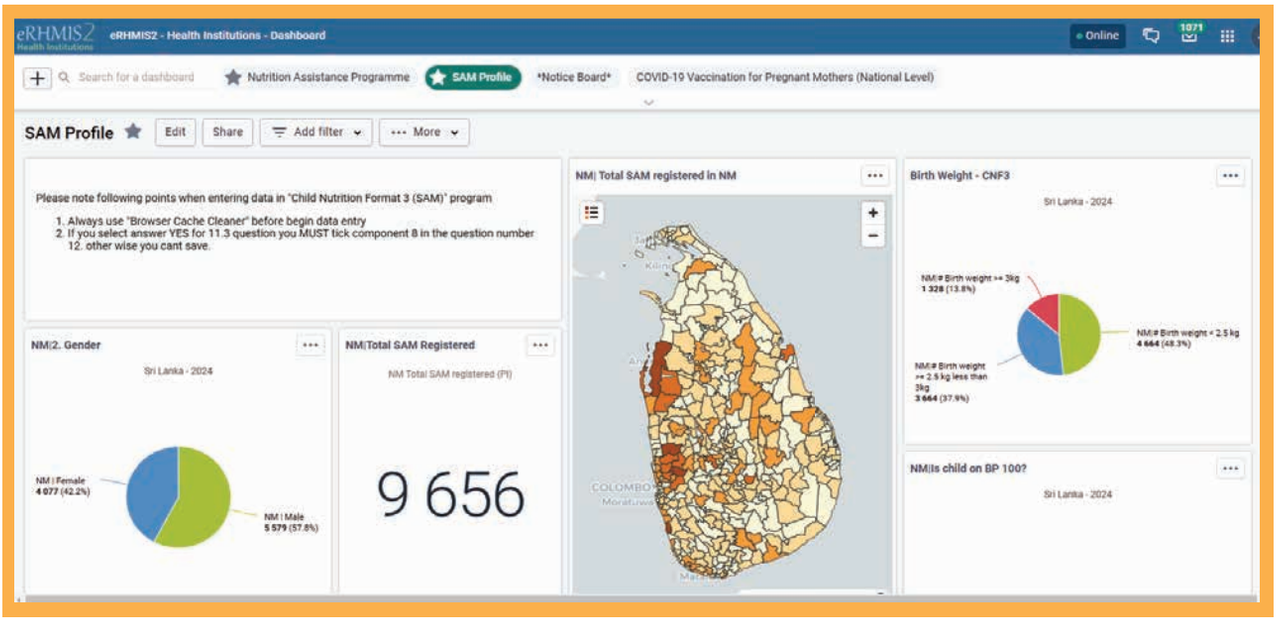
  National Nutrition Month activities were held in June 2024 and data were analyzed and presented to health ministry officials and the media as a dash board. Data were analyzed in details and a report was published. Both available in the FHB official website https://fhb.health.gov.lk/index.php/en/



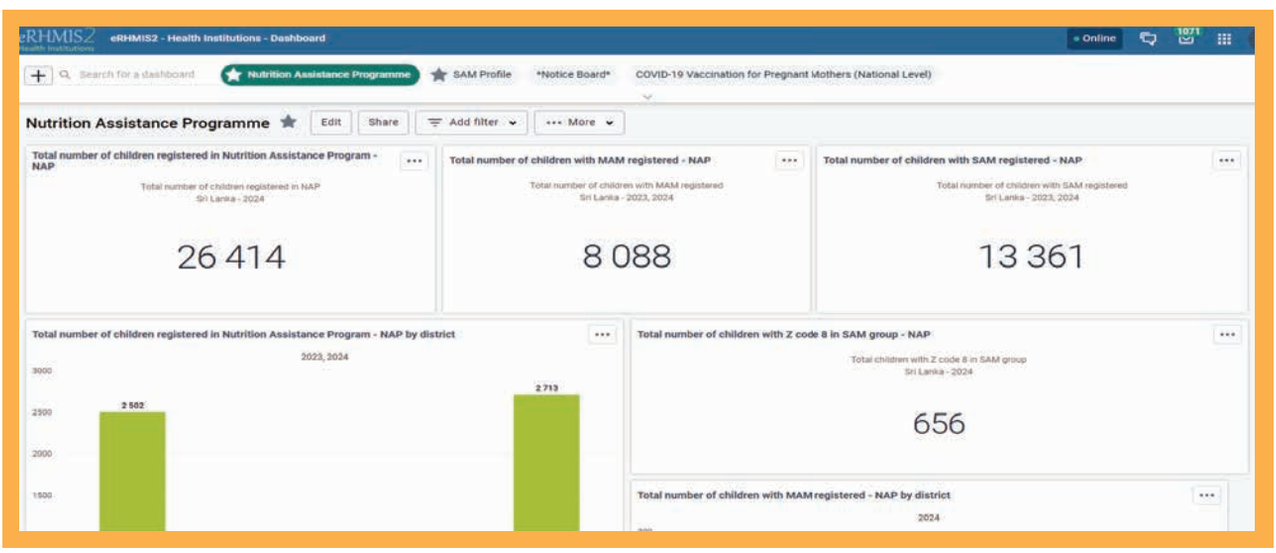
- Routine Nutrition Information Dashboard updated regularly and available in the FHB website



- To identify socio demographic status and profile of the households, a survey was carried out along with the NM 2024. Data were analysed and presented.



- Dashboards wre created and introduced to visualize the android based data collection from all midwives on tracking children with SAM and MAM



- **National MCH Reviews**

  National MCH reviews covering all districts were done using zoom technology as well as physical reviews

  MCH Review Jaffna -May





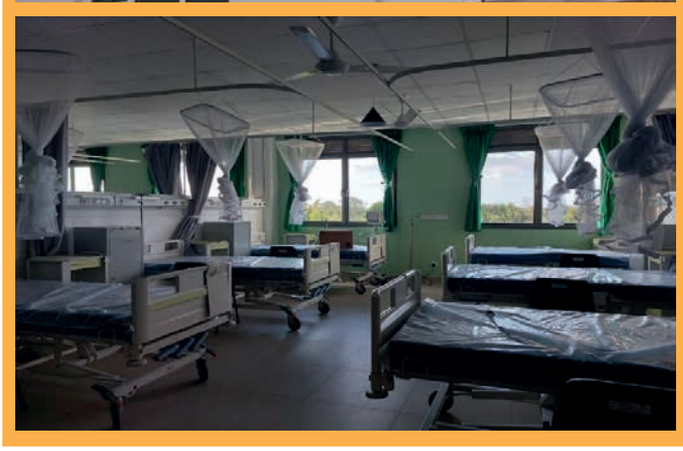


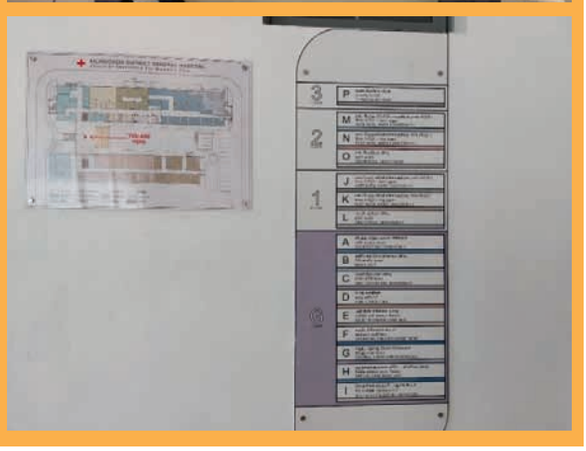
- Visit to Kilinochchi DGH - Maternity Hospital

  A field visit was done to newly constructed maternity hospital in Kilinochchi









- Capturing maternal and newborn health data through eIMMR – completed training 96 government hospitals and MNH module is introduced to capture MNH data from all government hospitals - up to September 2024



- Trainings were completed in 3 provinces on introduction to new supervision framework 2024. Other 6 provinces to be completed in 2025.

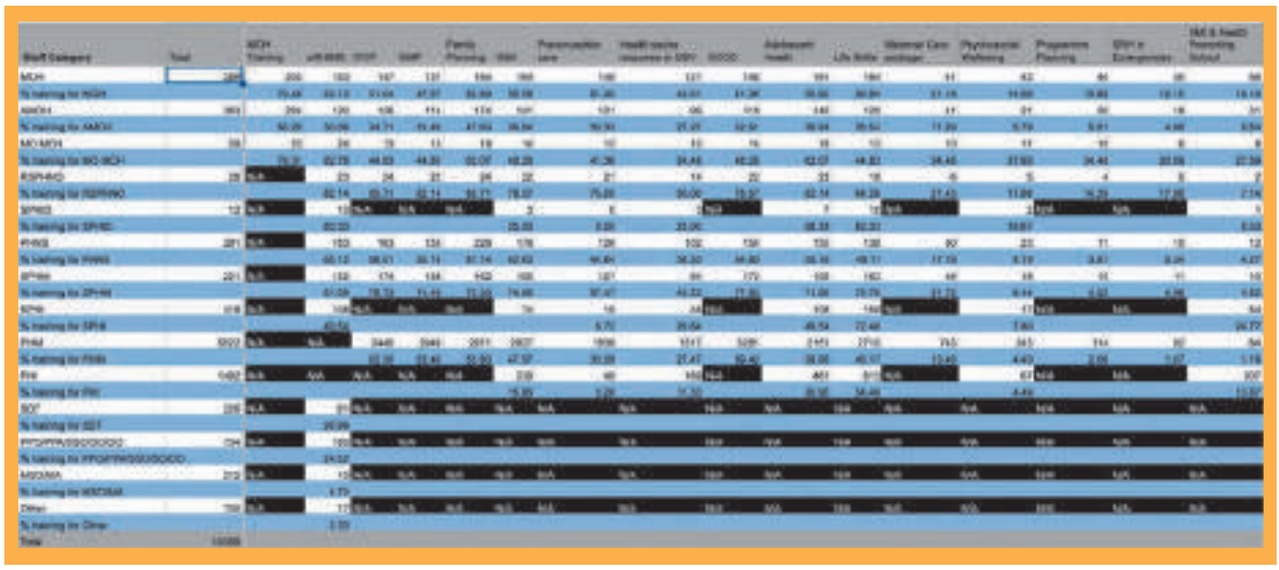




- MNH HMIS for Private Health Sector – all trainings were completed and system was established to capture all MNH data as event reporting from all private sector hospitals in Sri Lanka.



- A Training Database was introduced to be managed by all districts to identify their training needs.



RESEARCH UNIT

The Research Unit, is the focal of Research in the Family Health Bureau. The unit itself is responsible for policy formulation, advocacy, strategic direction, technical expertise, develop technical and managerial guidelines and protocols, capacity building, surveillance, monitoring and evaluation, implementation, direct, guide and coordinate with periphery (provincial, district and MOH levels), logistics, establishing partnerships networks within the government and outside to monitor and evaluate national programmes delivered in RMNCAYH & N care in Sri Lanka.

Development of a Maternal and Child Health research repository conducted by the Family Health Bureau: In this research repository all the Maternal and Child Health researches conducted by different technical units of the Family Health Bureau and Post Graduate dissertations funded by the Family Health Bureau will be included.

Initial Planning of National Survey on Emergency Obstetric and Newborn Care (EmONC) Needs Assessment:

After the initial EmONC needs assessment, 13 years have already passed. The country went through a global pandemic, economic downturn and many policy changes in health. The impact of the economic downturn was multifaceted on the health system. The health worker migration and reduction of the number of deliveries in the country has affected different aspects of the care. There is a need to conduct this survey to provide information on the adequacy of facilities, the skill mixes of health workers, equity and the quality of services.

To this end, Research Unit of the Family Health Bureau together with the UNFPA/UNICEF has planned to undertake a comprehensive EmONC needs assessment. The EmONC assessment will follow the standard methodology prescribed by the Averting Maternal Death and Disability (AMDD) of University of Columbia, USA (Averting Maternal Death and Disability Program (AMDD), 2024). This has to be adapted to the local setting.

The Ministry of Health approval to conduct this survey was obtained from the Secretary, Ministry of Health and Mass Media. The Terms of references for the Lead Public Health Specialist, Lead Consultant Obstetrician & Gynecologist and Lead Neonatologist were prepared.

The Terms of references (TOR) for the Research Committee (technical working group) chaired by the Director Maternal and Child Health to be signed by the Director General of Health Services and the Steering Committee chaired by the Deputy Director General/PHS II to be signed by the Secretary Ministry of Health and Mass Media were prepared.

Development of Audit guides for the selected tools of relevant Maternal and Child Health (MCH) National Programmes at the Family Health Bureau to enhance the quality of the relevant tool: Tools were identified in selected National programmes to be developed audit guides.

Table 4.7: National programmes and the tools to be developed

National Programme	Identified Tools to be developed Audit guides
Maternal Mortality and Morbidity Surveillance programme	1. Maternal Death Field investigation 2. Maternal Death Institutional Review
Well Woman programme	1. Well Woman Clinic 2. Well Woman Laboratory
Maternal Care programme	1. Domiciliary Antenatal Care 2. Domiciliary Postnatal Care 3. Antenatal classes 4.Antenatal Clinic Visit 5. Postnatal Clinic Visit 6. Completeness of H-512
Intranatal and New-born Care programme	1. Postnatal Clinic Visit

Source: Research unit, FHB

In addition, it was decided to develop 2 checklists on domiciliary antenatal care and postnatal care for Public Health Midwives.

FINANCIAL STATEMENT 2024

Financial Statement 2024

Family Health Bureau (FHB) is responsible for policy planning, coordination, monitoring and evaluation of Reproductive, Maternal, Newborn, Child, Adolescent and Youth Health Program (RMNCAYH) within Sri Lanka.

FHB lays the foundation for the implementation of qualitative and quantitate RMNCAYH services based on scientific evidences. These services maintain cultural, religious, ethnic, economic and gender sensitivity to maintain optimal effective service delivery, at central and peripheral levels.

Sri Lankan government (GOSL) provides funds for the overall functions and programs of FHB where as a minor proportion of the budget requirements are met by external resources (UN agencies). Medical Supplies Division of Ministry of Health purchases contraceptives, supplementary food, micronutrients for pregnant & lactating mothers and young children and school children, reagents, NICU /PBU and other logistics required for the functioning of the RNCAYH Programme; which is not included in the direct expenditure of Family Health Bureau.

As the country is successfully overcoming the economic crisis, the funding received by Family Health Bureau from Government of Sri Lanka increased significantly in 2024. But the global crisis and monitory restrictions vested upon UN agencies resulted in cutting down and censorship wested upon of foreign funding compared to 2023.

Funding for FHB

Ministry of Finance, Planning and Economic Development introduced ITMIS system to monitor financial flow of the Government of Sri Lanka. The FHB was absorbed into the system in 2023. GOSL financial allocations and expenditures are now to be observed as per the ITMIS system information.

According to the system and vote ledger data, the expenditure of funds for RMNCAYH in the year 2024 are as follows.

Table 4.8: Funding received from different agencies in 2024

Source		Allocation	Expenditure
GOSL	Capital	71,326,781.09	14,198,043.02
	Recurrent	309,911,682.80	304,528,813.10
	MCH, School Health	150,000,000.00	50,326,653.83
Foreign (UN)	UNFPA	27,781,653.95	19,884,420.57
	UNICEF	42,197,509.91	38,099,578.72
	WHO	13,568,443.95	12,789,943.26
Total		**764,786,071.70**	**490,154,106.33**

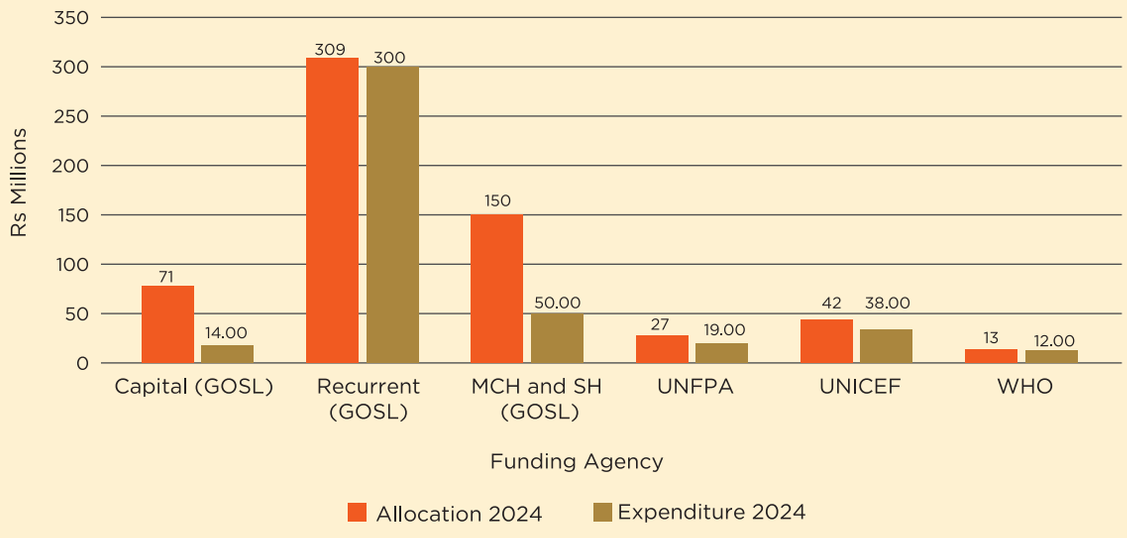


Figure 9.7: Total allocation and expenditure from GOSL, UNICEF, UNFPA and WHO for RMNCAYH programme 2024

Details on Aid / Assistance Received from International Agencies

Table 4.9: Total Allocation and Expenditure from UNICEF, UNFPA and WHO for RMNCAYH program 2024

Year	Total Allocation in RS millions	Total Expenditure in Rs millions
2020	331.56	358.41
2021	574.33	454.54
2022	21.8	21.503
2023	184.16	179.21
2024	83.55	70.77

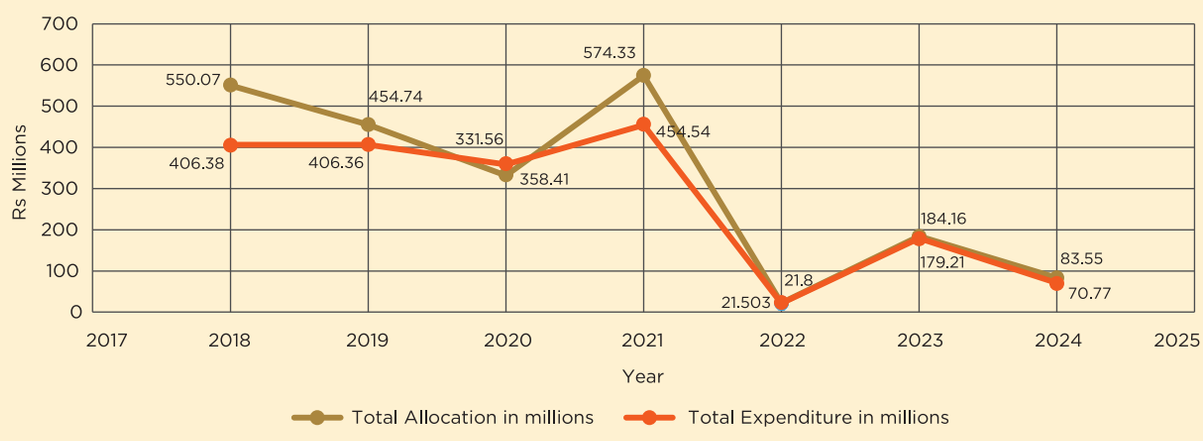


Figure 9.8: Total expenditure from UNICEF, UNFPA and WHO for RMNCAYH programme 2024

Table 5.0: Comparison of GOSL and foreign funding expenditure for Training programs - 2024

Fund Source	Amount
MCH, School Health	50,326,653.83
UNICEF	38,099,578.72
WHO	12,789,943.26
UNFPA	19,884,420.57

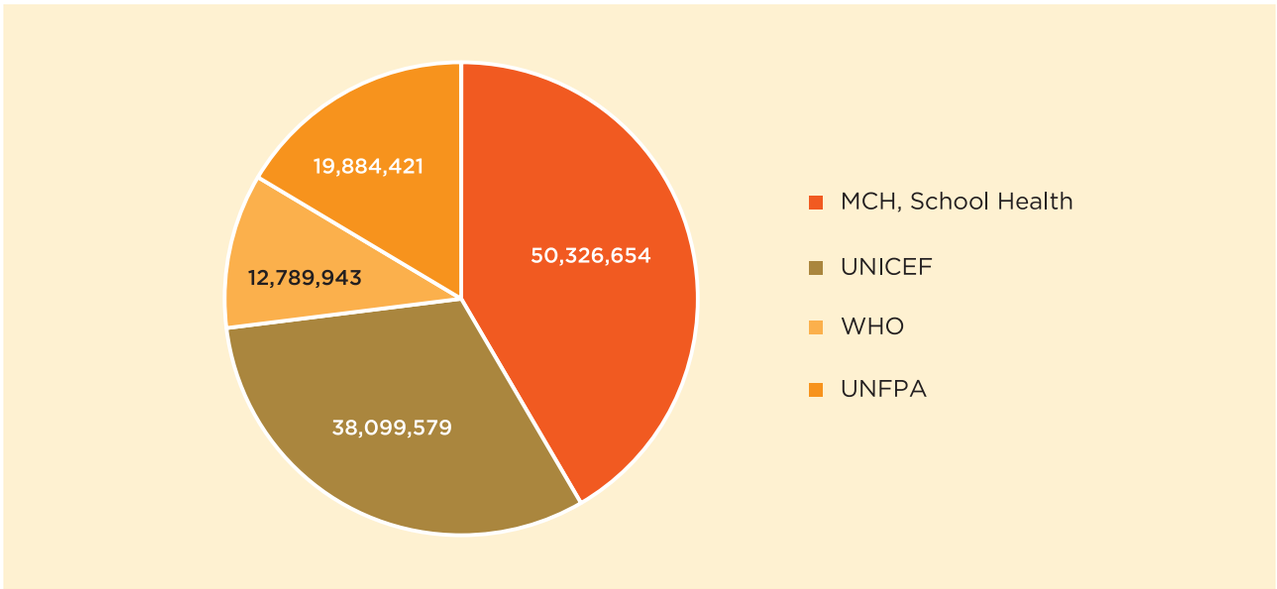


Figure 9.9: Comparison of GOSL and foreign funding expenditure for training programmes 2024

FHB received money only from MCH and School Health budget lines in 2024, but funds didn't receive from NCD, Children Action Plan or Nutrition.

The changing political landscape, anti-corruption act and practices, recovering from economic crisis, workforce migration, and Global crisis further manipulated fund mobilization for trainings, inspections, reviews and programs at central and peripheral sectors. The direction of the RMNCAYH program was observed to be re-covering in 2024.

The program received funding mainly from MCH and SH budget lines of GOSL. The recurrent expenditures included salaries, vehicle repair & maintenance, building maintenance and electricity & water bills.

Among UN agencies, UNICEF dispatched the maximum amount of funding. There were no significant direct donations from UN agencies, unlike Contraceptive commodities (UNFPA-Rs. 300 Million), multiple micronutrition supplies (Kirk Humanitarian, USA-72,964.80 USD), Fuel vouchers (Rs 1.4M), printing (Rs 77 M) and equipment such as spring balances, length charts, office stationaries received in 2023.

ANNEXURES

Annexure 01 - Population, birth rate, eligible families, pregnant mothers, and reported number of deliveries 2024

RDHS	Population Estimated (by MOH)	Estimated Eligible Families	Total number of eligible families registered	Total number of pregnant mothers registered	Total number of deliveries	Estimat-ed Births	Birth Rate	Total number of live births reported
Ampara	285300	52781	50941	3147	2694	5164	18.1	2569
Anuradhapura	942818	174421	183020	10356	8825	12068	12.8	8403
Badulla	893177	165238	158522	10486	8591	11433	12.8	8454
Batticaloa	574361	106257	116643	9388	8512	9592	16.7	8438
Colombo MC	589787	109111	66695	4974	4317	6547	11.1	3987
Colombo	1852464	342706	333891	15661	13519	20562	11.1	13160
Galle	1131342	209298	186051	10500	9448	14029	12.4	9251
Gampaha	2402709	444501	417835	22507	19233	24267	10.1	18843
Hambantota	679253	125662	119311	7622	6417	9645	14.2	6419
Jaffna	627610	116108	99082	8162	6903	8912	14.2	6640
Kalmunai	458605	84842	91135	8363	7424	8301	18.1	7447
Kalutara	966495	178802	171093	9164	7906	9278	9.6	7590
Kandy	1464941	271014	260021	15652	13509	18019	12.3	13342
Kegalle	885658	163847	144166	8424	7054	10539	11.9	6900
Kilinochchi	137494	25436	24233	1954	1672	2709	19.7	1551
Kurunegala	1711398	316609	310100	17079	14904	20537	12.0	15097
Mannar	116791	21606	23131	2167	1888	2184	18.7	1777
Matale	519734	96151	95021	5934	5150	6341	12.2	5107
Matara	864390	159912	146096	8410	7224	8730	10.1	7097
Moneragala	509360	94232	100507	6549	5572	6418	12.6	5363
Mullaitivu	99358	18381	21985	1717	1454	1172	11.8	1366
NIHS	299962	55493	53254	3638	3229	2880	9.6	3145
Nuwaraeliya	779675	144240	137339	8573	7565	9356	12.0	7442
Polonnaruwa	441170	81617	86606	5197	4361	5779	13.1	4282
Puttalam	839593	155325	161253	9881	8481	12426	14.8	8420
Ratnapura	1183074	218869	207825	11762	9996	13842	11.7	9866
Trincomalee	441732	81720	87972	7430	6426	8084	18.3	6166
Vavuniya	196366	36328	32952	2539	2078	3044	15.5	1866
Sri Lanka	**21894617**	**4050504**	**3886680**	**237236**	**204352**	**271493**	**12.4**	**208554**

Source: eRHMIS

Annexure 02 - Antenatal Care 2024

RDHS	Percentage of pregnant mothers registered before 8 weeks	Percentage of pregnant mothers registered between 8 – 12wks	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	90.7	5.9	2.2	31.9	2.2	99.5	45.8	99.7	99.7	99.7	97.3	4.3
Anuradhapura	83.1	11.5	4.3	33.0	2.7	99.7	39.3	99.8	99.8	99.6	94.8	4.3
Badulla	85.8	8.8	4.2	32.7	1.3	98.8	31.6	99.7	99.8	99.6	95.6	3.0
Batticaloa	81.1	12.8	6.7	36.9	2.3	99.5	34.2	99.8	99.8	99.6	96.5	5.6
Colombo MC	56.6	24.9	4.8	38.1	2.5	95.3	45.8	98.2	99.3	98.3	92.4	5.8
Colombo	73.2	14.2	2.7	42.3	1.3	98.1	40.9	98.6	99.6	99.2	94.1	5.2
Galle	83.3	10.7	3.4	35.0	2.4	98.2	36.9	99.7	99.7	99.6	94.6	4.7
Gampaha	75.9	14.5	3.0	39.4	1.8	98.8	40.5	98.9	99.6	99.3	91.3	5.2
Hambantota	87.3	8.6	2.9	29.4	2.9	99.8	43.1	99.8	99.9	99.7	97.0	5.0
Jaffna	86.0	9.2	3.6	35.4	1.6	99.7	53.2	99.8	99.7	99.7	97.5	8.7
Kalmunai	89.7	6.0	5.0	30.7	4.0	99.6	35.0	99.9	99.9	99.9	99.4	5.2
Kalutara	82.7	10.8	3.4	38.5	2.0	99.0	37.2	99.5	99.7	99.4	94.7	4.3
Kandy	80.3	12.4	2.7	33.7	2.3	99.3	35.8	99.4	99.5	99.4	94.5	3.4
Kegalle	84.0	10.4	2.0	34.9	2.1	99.8	35.3	99.6	99.6	99.2	94.0	3.4
Kilinochchi	87.7	8.0	4.9	34.7	2.1	99.7	52.7	99.5	99.6	99.6	97.5	24.3
Kurunegala	85.9	9.5	2.9	33.2	2.1	99.7	40.3	99.8	99.8	99.4	96.6	3.6
Mannar	83.3	11.7	5.0	34.2	2.8	99.5	48.1	99.8	99.7	99.6	97.4	16.4
Matale	85.6	9.1	3.0	33.4	2.0	99.7	40.3	99.8	99.9	99.8	96.2	4.3
Matara	86.1	9.1	3.0	32.7	2.2	99.5	39.0	99.7	99.8	99.7	97.1	4.4
Moneragala	88.9	7.5	3.0	29.1	2.3	99.5	36.6	99.8	99.8	99.8	96.1	3.3
Mullaitivu	81.7	14.3	5.5	35.7	1.9	98.6	50.2	99.6	99.7	99.8	95.7	19.3
NIHS	78.9	14.1	3.4	33.2	3.4	99.4	40.2	99.4	99.9	99.7	95.4	4.4
Nuwaraeliya	78.0	13.9	3.9	35.0	1.9	99.5	28.2	99.3	99.6	99.1	92.3	2.8
Polonnaruwa	86.3	9.1	2.8	31.5	2.4	99.8	36.8	99.7	99.8	99.7	94.9	4.0
Puttalam	80.4	12.5	5.3	33.3	2.7	99.5	37.5	99.6	99.7	99.6	95.6	3.4
Ratnapura	82.6	11.7	3.3	34.3	2.0	99.6	40.8	99.6	99.8	99.5	94.4	3.6
Trincomalee	87.1	8.4	7.9	32.6	3.7	99.3	33.7	99.6	99.6	99.5	97.8	6.8
Vavuniya	79.0	14.5	4.8	34.9	1.4	96.3	33.8	99.1	99.1	99.6	93.7	5.1
Sri Lanka	**82.0**	**11.4**	**3.7**	**34.8**	**2.2**	**99.2**	**38.7**	**99.5**	**99.7**	**99.5**	**95.1**	**4.9**

Source: eRHMIS

Annexure 03 - Indicators of clinic care, ante-natal screening and status of BMI among pregnant mothers in 2024

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	94.7	6.5	95.3	0.19	31.8	65.3	89.6	16.1	30.5
Anuradhapura	95.9	6.9	90.4	0.18	25.2	26.5	86.0	14.0	34.6
Badulla	93.1	7.3	98.1	0.06	17.7	28.6	83.0	15.5	29.3
Batticaloa	99.6	6.5	98.4	0.07	21.0	51.1	87.2	15.5	35.2
Colombo MC	101.9	4.8	87.1	0.52	31.5	No data	69.3	11.4	45.4
Colombo	93.0	4.8	89.4	0.25	22.3	13.7	71.4	11.2	36.3
Galle	91.2	5.9	50.0	0.22	22.0	5.2	79.5	15.8	30.7
Gampaha	94.8	5.3	91.1	0.19	22.8	4.6	77.2	11.4	36.3
Hambantota	91.5	6.3	89.1	0.03	29.1	28.6	83.4	16.3	29.5
Jaffna	87.9	7.2	28.0	0.20	33.4	24.1	84.2	13.4	32.8
Kalmunai	93.7	6.8	106.3	No data	22.4	56.8	88.1	12.4	36.3
Kalutara	95.4	5.5	94.3	0.43	21.5	41.0	83.2	13.0	35.3
Kandy	93.5	6.0	98.5	0.22	20.3	16.0	83.0	13.7	34.2
Kegalle	89.2	6.2	97.8	0.21	23.3	31.0	79.9	14.5	33.0
Kilinochchi	95.4	12.5	18.7	No data	23.6	8.6	91.3	16.6	27.7
Kurunegala	94.6	6.6	97.2	0.14	26.4	33.6	84.7	14.0	32.1
Mannar	96.1	6.7	10.2	0.21	28.3	8.4	88.7	14.1	37.2
Matale	94.0	6.6	102.2	0.68	25.5	36.5	87.4	14.2	35.5
Matara	100.4	6.2	83.3	0.06	25.3	33.8	83.1	16.3	28.9
Moneragala	94.4	6.8	98.3	0.05	23.7	46.8	88.0	15.6	31.3
Mullaitivu	151.0	6.2	57.1	No data	24.1	49.3	86.0	16.9	30.4
NIHS	92.9	5.3	99.4	No data	24.4	101.4	78.2	12.1	43.1
Nuwaraeliya	97.2	7.7	85.2	0.07	13.7	21.3	77.7	17.6	26.3
Polonnaruwa	95.6	6.4	113.4	0.05	23.5	50.1	86.4	14.1	37.1
Puttalam	93.9	6.1	99.8	0.06	24.4	41.1	79.5	14.2	37.2
Ratnapura	93.5	6.8	105.3	0.09	26.4	50.1	81.1	15.9	29.1
Trincomalee	104.5	6.3	43.7	0.14	20.4	24.0	85.8	12.7	39.3
Vavuniya	165.5	4.9	4.6	0.05	19.6	1.1	82.4	14.0	32.7
Sri Lanka	**95.8**	**6.3**	**86.2**	**0.17**	**23.5**	**29.0**	**81.9**	**14.1**	**33.7**

Source: eRHMIS

Annexure 04 - Natal Care 2024

RDHS	Total number of deliveries	Percentage of Institutional deliveries	Percentage of home deliveries	Home deliveries by untrained	Percentage of home deliveries by untrained attendants out of total deliveries	Percentage of LSCS deliveries	Percentage of deliveries reported for estimated births
Ampara	2694	100	0.04	1	0.04	43.4	52.0
Anuradhapura	8825	100	0.12	5	0.06	37.8	72.9
Badulla	8591	100	0.14	11	0.13	40.5	74.9
Batticaloa	8512	100	0.07	6	0.07	36.8	88.5
Colombo MC	4317	100	0.14	6	0.14	40.4	65.8
Colombo	13519	100	0.07	6	0.04	52.1	65.6
Galle	9448	100	0.07	3	0.03	47.0	67.2
Gampaha	19233	100	0.07	9	0.05	51.4	79.0
Hambantota	6417	100	0.06	3	0.05	50.9	66.3
Jaffna	6903	100	0.03	No data	No data	40.3	77.2
Kalmunai	7424	100	0.19	12	0.16	51.1	89.2
Kalutara	7906	100	0.08	5	0.06	47.0	85.0
Kandy	13509	100	0.06	5	0.04	47.8	74.8
Kegalle	7054	100	0.10	5	0.07	52.5	66.7
Kilinochchi	1672	100	0.18	No data	No data	28.6	61.6
Kurunegala	14904	100	0.03	3	0.02	50.8	72.4
Mannar	1888	100	0.05	1	0.05	39.4	86.2
Matale	5150	100	0.08	2	0.04	50.2	81.0
Matara	7224	100	0.04	3	0.04	53.8	82.5
Moneragala	5572	100	0.07	2	0.04	42.9	86.6
Mullaitivu	1454	100	0.07	1	0.07	27.6	123.7
NIHS	3229	100	0.12	2	0.06	46.2	111.8
Nuwaraeliya	7565	100	0.52	27	0.36	37.8	80.6
Polonnaruwa	4361	100	0.07	1	0.02	49.6	75.3
Puttalam	8481	100	0.38	29	0.34	45.4	68.1
Ratnapura	9996	100	0.10	8	0.08	50.2	72.0
Trincomalee	6426	100	0.08	5	0.08	28.5	79.3
Vavuniya	2078	100	0.29	5	0.24	40.3	68.1
Sri Lanka	**204352**	**100**	**0.11**	**166**	**0.08**	**46.0**	**75.1**

Source: eRHMIS

Annexure 05 - Indicators of Anaemia in pregnancy, Low birth weight, Post-natalcare - postnatal vists, vitamin A supplementation and postpartum morbidities by districts 2024

RDHS	Percentage of pregnant mothers with Hb less than 11g/dl before 12 weeks of POA	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	Percentage of mothers received at least 1 postpartum visit during 1st 10 days for deliveries reported	Percentage of postpartum visits by PHM around 42 days for deliveries reported	Percentage of Vitamin A coverage in postpartum mothers	Percentage of mothers with postpartum morbidities
Ampara RDHS	19.5	0.08	17.5	93.5	92.2	95.8	15.4
Anuradhapura RDHS	16.9	0.10	13.6	94.9	90.7	98.6	17.7
Badulla RDHS	11.8	0.05	18.8	94.7	92.3	92.5	11.6
Batticaloa RDHS	15.3	0.14	15.2	96.6	87.7	99.0	12.4
Colombo MC	21.7	0.27	14.3	76.8	55.4	90.6	10.0
Colombo RDHS	13.9	0.14	12.5	90.0	84.8	90.0	18.9
Galle RDHS	13.0	0.10	14.5	96.5	95.2	94.8	23.3
Gampaha RDHS	15.8	0.18	13.2	92.5	81.0	95.0	15.8
Hambantota RDHS	16.2	0.03	13.4	96.6	97.1	94.4	20.0
Jaffna RDHS	26.0	0.15	12.8	95.5	88.0	99.5	11.0
Kalmunai RDHS	12.2	0.18	11.6	108.0	94.2	98.9	7.8
Kalutara RDHS	13.7	0.01	13.7	94.6	92.1	94.9	16.1
Kandy RDHS	14.5	0.05	15.1	95.8	93.2	89.6	18.1
Kegalle RDHS	16.7	0.15	16.8	93.2	90.0	86.9	21.2
Kilinochchi RDHS	16.6	0.06	12.1	101.0	99.9	103.7	6.0
Kurunegala RDHS	19.2	0.09	14.9	92.7	90.4	95.1	14.8
Mannar RDHS	15.0	0.11	12.9	95.3	96.8	98.9	7.8
Matale RDHS	16.7	0.25	16.0	95.1	91.7	96.0	16.5
Matara RDHS	16.1	0.06	15.2	96.0	99.3	98.4	16.3
Moneragala RDHS	14.9	0.16	15.2	89.3	88.4	95.3	12.3
Mullaitivu RDHS	14.5	0.07	12.2	91.0	86.0	97.2	8.8
NIHS	12.9	No data	13.5	95.1	90.3	97.3	15.3
NuwaraEliya RDHS	11.5	0.18	23.8	92.8	89.8	91.9	15.2
Polonnaruwa RDHS	13.7	0.02	15.9	95.9	97.8	97.4	10.2
Puttalam RDHS	17.2	0.06	13.5	96.0	89.3	93.7	10.0
Ratnapura RDHS	15.1	0.10	16.3	96.9	89.4	93.5	18.5
Trincomalee RDHS	11.4	0.02	13.7	94.5	90.0	98.0	8.3
Vavuniya RDHS	16.8	0.05	13.5	93.1	82.9	95.6	13.2
Sri Lanka	**15.6**	**0.11**	**14.6**	**94.4**	**89.5**	**94.7**	**15.2**

Source: eRHMIS

Annexure 06 - Indicators of childcare service provision: Infant registration, field visits and vitamin A supplementation 2024

RDHS	Percentage of infants registered	Average number of home visits per infants	Percentage of Vitamin A coverage in infants at 6 months (at field + 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	53.1	6.3	50	58.7	77.1
Anuradhapura	74.3	6.7	68.9	89.1	113.0
Badulla	74.4	11.6	76.1	87.	106.0
Batticaloa	91.8	9.2	89.7	102.8	98.0
Colombo MC	67.0	7.0	58.7	63.3	74.1
Colombo	65.6	7.3	54	65.2	82.3
Galle	71.8	7.3	70.4	84.4	97.8
Gampaha	83.1	7.4	72.6	86.7	101.2
Hambantota	69.6	7.4	63.2	74.8	95.2
Jaffna	78.5	14.5	76.4	85.8	89.6
Kalmunai	91.2	6.9	88.5	104.5	94.6
Kalutara	88.8	9.3	80.7	98.3	113.6
Kandy	73.9	9.1	70.2	80.1	96.8
Kegalle	65.4	9.7	57.1	67.7	81.9
Kilinochchi	77.2	10.7	67.9	70.6	80.0
Kurunegala	73.3	7.5	75.8	91.8	109.0
Mannar	99.2	24.8	85	96.6	98.5
Matale	80.4	9.8	78.4	94.7	111.0
Matara	82.7	7.0	82.5	99.4	120.1
Moneragala	84.2	8.7	85.1	101.	125.9
Mullaitivu	131.8	20.4	130.8	144.1	159.9
NIHS	119.9	7.5	102.9	125.8	129.0
Nuwaraeliya	79.2	13.8	87	95.2	120.0
Polonnaruwa	76.0	8.1	74.8	96.6	118.6
Puttalam	69.8	7.5	73.5	90.9	108.1
Ratnapura	72.7	8.7	72	84.8	109.7
Trincomalee	80.5	8.0	79.3	90.5	98.8
Vavuniya	79.9	15.7	79.5	88.5	96.1
Sri Lanka	**76.8**	**8.6**	**73.3**	**86.6**	**101.8**

Source: eRHMIS

Annexure 07 - Weighing coverage of children under 5 years 2020 - 2024| Nutrition Month

RDHS	2020	2021	2022	2023	2024
Ampara RDHS	100.0	100.0	100.0	100.0	99.3
Anuradhapura RDHS	95.5	93.6	95.6	97.6	98.8
Badulla RDHS	99.4	99.1	99.4	99.8	99.8
Batticaloa RDHS	95.2	96.2	98.3	98.3	97.9
Colombo MC	62.0	61.6	69.8	71.8	83.2
Colombo RDHS	88.1	80.8	88.0	89.9	91.8
Galle RDHS	94.2	91.2	93.9	95.8	97.5
Gampaha RDHS	86.0	78.7	87.6	92.9	94.2
Hambantota RDHS	99.2	99.1	98.8	99.7	99.8
Jaffna RDHS	98.5	98.8	99.8	99.7	99.9
Kalmunai RDHS	98.4	97.9	98.4	99.1	98.7
Kalutara RDHS	94.2	91.9	95.7	96.8	97.3
Kandy RDHS	95.6	94.8	95.6	97.6	97.6
Kegalle RDHS	96.2	95.4	97.9	98.4	98.9
Kilinochchi RDHS	99.7	71.5	100.0	100.0	100.0
Kurunegala RDHS	93.2	91.6	94.3	95.4	96.6
Mannar RDHS	98.9	93.4	98.3	98.2	99.9
Matale RDHS	98.8	98.2	99.3	99.5	99.1
Matara RDHS	98.6	97.2	98.2	99.2	99.8
Moneragala RDHS	97.7	98.6	99.2	99.4	99.5
Mullaitivu RDHS	98.0	96.0	98.5	99.7	99.9
NIHS	93.3	90.4	94.1	97.5	98.1
Nuwaraeliya RDHS	98.3	97.8	99.0	99.3	99.4
Polonnaruwa RDHS	99.4	98.1	99.0	99.6	99.0
Puttalam RDHS	94.2	85.4	95.6	95.4	96.6
Ratnapura RDHS	98.4	No data*	97.1	98.2	98.8
Trincomalee RDHS	98.7	99.2	99.8	99.8	99.7
Vavuniya RDHS	97.6	96.1	95.4	97.8	99.4
Sri Lanka	**94.4**	**91.6**	**95.1**	**96.6**	**97.4**

*Data not provided due to trade union action

Source: NM Data, eRHMIS

Annexure 08 - Nutritional status of infants 2020 – 2024 | Nutrition Month

RDHS	Percentage of infants with underweight					Percentage of infants with stunting					Percentage of infants with wasting				
	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Ampara	7.9	8.1	10.5	11.1	11.3	5.2	5.5	7.1	7.9	7.5	5.1	3.7	4.7	3.7	2.6
Anuradhapura	7.1	7.4	10.6	11.6	10.1	4.3	4.5	6.7	7.9	5.9	5.2	4.8	5.9	6.2	4.6
Badulla	9.2	8.8	12.7	12.9	11.6	6.0	6.3	8.6	9.4	7.6	5.6	5.4	6.4	5.3	4.6
Batticaloa	5.1	5.9	6.2	8.6	8.0	4.8	4.5	3.8	5.6	5.4	3.6	3.8	4.6	3.8	3.3
Colombo MC	9.4	8.3	10.8	12.7	11.6	5.3	5.6	8.0	8.1	7.1	5.2	5.7	7.8	8.3	5.8
Colombo	5.8	6.1	7.7	9.0	8.8	3.1	3.1	4.0	4.5	4.6	3.6	3.9	4.5	4.0	3.9
Galle	7.5	6.9	9.7	10.7	10.4	4.0	4.0	4.6	5.8	5.5	5.8	5.2	6.7	5.5	5.2
Gampaha	6.8	6.3	8.6	9.6	9.2	3.8	3.4	4.8	4.7	4.9	4.8	4.2	5.3	5.0	5.1
Hambantota	5.9	6.1	8.8	9.5	8.3	3.8	4.0	5.5	6.6	5.5	4.5	4.9	5.9	4.0	3.3
Jaffna	6.8	6.6	8.6	8.2	8.3	4.4	3.3	4.9	5.3	5.4	5.5	6.0	6.7	5.4	5.3
Kalmunai	5.5	5.2	7.2	7.7	7.1	4.0	4.0	4.8	5.8	4.7	3.8	3.2	4.1	3.7	3.4
Kalutara	7.3	6.7	8.8	10.1	9.1	4.0	4.0	5.8	6.3	5.1	4.7	3.9	4.9	5.0	4.0
Kandy	8.3	8.3	11.1	12.3	11.5	5.2	5.6	7.1	7.7	6.8	4.9	4.8	5.8	4.9	4.1
Kegalle	8.1	7.9	10.5	12.2	11.4	4.5	4.5	5.9	6.7	6.3	4.6	4.5	6.2	4.7	4.2
Kilinochchi	3.8	5.9	4.4	5.7	5.7	2.1	3.3	3.5	4.3	4.1	1.5	2.5	2.4	3.4	2.5
Kurunegala	7.1	7.0	9.5	10.5	10.2	5.1	4.9	6.2	6.5	6.4	5.7	5.8	6.4	5.2	5.1
Mannar	4.5	3.5	5.5	5.6	5.7	4.4	2.7	4.9	4.7	3.8	4.3	3.3	5.0	3.9	2.6
Matale	7.0	7.4	10.8	11.6	10.7	4.7	5.1	7.2	8.1	7.1	4.4	3.9	5.6	5.8	3.9
Matara	8.2	8.2	11.0	11.7	11.5	3.8	4.1	5.7	6.7	6.2	6.4	5.6	6.0	5.2	4.3
Moneragala	6.4	6.4	9.0	9.6	8.4	3.9	4.3	6.2	6.4	5.4	4.7	4.0	4.7	4.7	3.2
Mullaitivu	6.5	4.9	7.3	6.3	5.5	4.3	2.8	4.3	4.6	2.9	4.0	2.5	7.0	4.0	3.6
NIHS	7.6	7.5	10.7	10.6	10.1	4.2	4.7	5.8	6.5	5.4	6.1	4.6	5.1	5.0	5.0
Nuwaraeliya	13.4	14.0	18.3	19.2	17.1	11.6	11.5	16.5	17.6	15.1	7.9	6.9	7.8	6.7	5.5
Polonnaruwa	7.4	7.8	9.9	11.5	10.1	4.2	5.1	6.8	7.9	7.0	5.0	5.6	6.6	5.3	4.1
Puttalam	6.1	6.2	8.5	9.3	9.0	3.5	3.6	5.1	5.6	5.5	4.5	4.7	5.9	5.5	4.6
Ratnapura	8.8	No data*	11.6	11.9	10.6	5.9	No data*	8.3	8.7	6.7	5.7	No data*	6.7	5.3	4.7
Trincomalee	6.5	6.7	8.5	8.7	8.1	5.2	5.6	6.8	7.2	6.0	3.6	3.5	4.7	4.1	3.6
Vavuniya	7.1	6.1	6.8	8.1	8.4	4.7	4.5	5.6	6.0	4.7	3.6	2.4	4.7	3.7	2.6
Sri Lanka	**7.4**	**7.2**	**9.7**	**10.6**	**9.9**	**4.7**	**4.7**	**6.2**	**6.9**	**6.1**	**5.0**	**4.7**	**5.8**	**5.0**	**4.3**

**Data not provided due to trade union action*
Source: NM Data, eRHMIS

Annexure 09 - Nutritional status of young children (1 – 2 years) 2020 – 2024| Nutrition Month

RDHS	Percentage of 1 to 2-year-old children with underweight					Percentage of 1 to 2-year-old children with stunting					Percentage of 1 to 2-year-old children with wasting				
	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Ampara RDHS	12.8	12.1	16.5	17.9	16.0	8.7	8.7	11.1	12.8	11.8	7.9	7.2	9.9	9.6	8.0
Anuradhapura RDHS	14.1	12.2	16.0	18.5	18.5	9.5	8.4	10.8	13.2	12.8	9.2	7.4	9.5	10.4	10.0
Badulla RDHS	13.7	13.0	17.5	18.9	18.2	11.9	11.6	14.5	17.6	16.7	8.0	7.6	9.8	9.0	7.8
Batticaloa RDHS	8.8	9.4	12.0	14.4	13.5	7.6	7.5	8.9	9.9	10.6	6.0	6.2	7.8	7.9	6.4
Colombo MC	10.6	10.4	11.6	11.5	12.3	8.4	8.6	10.3	10.9	10.3	6.2	6.7	8.5	8.6	6.9
Colombo RDHS	7.8	6.8	8.5	9.7	10.5	5.2	4.8	5.9	6.4	6.6	4.8	4.6	5.5	5.1	5.6
Galle RDHS	11.1	10.1	13.2	14.7	15.4	7.9	7.1	8.1	9.9	10.0	8.5	8.1	9.6	8.9	8.2
Gampaha RDHS	9.2	8.3	10.9	12.2	12.4	6.2	5.6	7.4	8.0	7.7	6.8	5.8	7.4	7.5	7.5
Hambantota RDHS	10.3	9.5	14.0	16.4	15.8	7.1	6.1	8.7	11.2	11.1	7.6	7.7	10.1	9.2	7.8
Jaffna RDHS	10.0	9.1	12.2	12.3	12.4	8.2	7.0	9.5	10.5	10.4	7.6	6.8	8.0	8.1	8.4
Kalmunai RDHS	9.3	9.0	11.8	12.5	12.3	7.7	7.1	10.8	10.3	9.0	5.1	5.0	6.7	6.0	6.0
Kalutara RDHS	9.8	8.9	11.7	13.5	13.5	7.4	6.3	8.8	10.0	10.2	6.4	5.6	6.7	7.4	7.4
Kandy RDHS	12.3	11.0	14.8	16.9	15.6	10.7	9.9	12.7	13.7	12.9	7.2	6.4	7.6	7.9	7.4
Kegalle RDHS	12.0	10.4	13.8	16.0	16.2	8.5	7.1	9.6	11.1	11.1	7.2	6.1	7.7	7.8	7.8
Kilinochchi RDHS	9.6	11.9	10.2	12.7	12.3	7.8	8.0	7.6	10.0	9.7	5.3	6.7	6.0	7.1	5.8
Kurunegala RDHS	12.2	10.7	13.8	16.3	16.3	9.6	8.6	10.4	10.8	11.7	9.6	8.7	10.2	10.0	9.1
Mannar RDHS	9.5	9.2	10.3	12.1	11.7	9.0	7.0	9.3	11.1	10.1	7.1	6.7	7.5	7.6	6.6
Matale RDHS	11.8	10.4	15.1	17.6	16.5	8.7	8.2	11.9	13.8	13.5	7.7	6.4	8.8	9.4	8.3
Matara RDHS	12.7	10.4	14.6	16.3	16.2	7.7	7.1	8.7	11.2	11.7	9.0	7.8	9.9	9.0	8.6
Moneragala RDHS	11.1	10.5	14.2	15.6	15.0	8.5	8.2	11.2	12.7	12.5	6.8	7.5	8.6	8.6	7.4
Mullaitivu RDHS	12.1	10.2	11.3	12.9	11.1	8.9	6.0	9.6	8.9	8.0	7.5	4.7	7.3	7.6	6.4
NIHS	10.0	9.6	10.7	13.4	12.9	6.6	6.7	8.5	10.6	9.0	7.2	6.2	6.1	7.2	7.2
Nuwaraeliya RDHS	18.9	18.6	22.7	24.8	24.3	23.3	20.1	28.7	30.8	28.2	9.5	9.0	9.7	9.1	9.4
Polonnaruwa RDHS	12.8	11.3	17.1	18.1	17.6	8.6	7.5	11.6	12.8	13.4	8.9	8.9	11.5	10.7	8.9
Puttalam RDHS	12.0	9.9	13.1	14.4	14.8	8.4	7.2	9.9	10.1	10.0	8.0	7.1	9.2	8.9	8.1
Ratnapura RDHS	13.2	No data*	15.6	17.5	16.5	10.9	No data*	12.6	15.2	14.2	8.5	No data*	9.6	9.2	8.3
Trincomalee RDHS	13.9	12.4	15.7	16.8	16.5	11.1	11.3	14.7	14.9	13.0	7.5	7.2	8.2	8.3	7.7
Vavuniya RDHS	13.3	11.0	13.6	12.6	13.2	10.0	9.1	11.8	11.4	10.4	7.8	6.2	7.7	7.5	6.2
Sri Lanka	**11.6**	**10.4**	**13.8**	**15.4**	**15.1**	**9.0**	**8.2**	**10.8**	**12.0**	**11.6**	**7.6**	**6.9**	**8.5**	**8.4**	**7.8**

*Data not provided due to trade union action

Source: NM Data, eRHMIS

Annexure 10 - Nutritional status of pre-school children 2020 – 2024 | Nutrition Month

RDHS	Percentage of 2 to 5-year-old children with underweight					Percentage of 2 to 5-year-old children with stunting					Percentage of 2 to 5-year-old children with wasting				
	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Ampara	18.1	16.7	20.8	23.1	21.6	8.9	8.0	9.7	11.3	11.9	12.4	12.0	14.5	14.6	12.7
Anuradhapura	18.2	17.4	20.6	22.9	22.4	9.3	8.4	10.1	11.8	12.8	12.0	11.7	13.6	14.2	12.7
Badulla	19.9	18.6	21.4	23.2	23.0	12.1	10.7	12.1	14.3	14.9	12.2	12.2	13.9	13.2	12.3
Batticaloa	13.4	12.7	15.3	18.3	18.5	8.5	7.4	8.4	10.2	10.7	7.1	7.1	9.9	10.2	9.4
Colombo MC	13.5	12.5	15.2	16.8	16.0	6.9	7.1	9.5	10.0	9.1	8.1	8.8	11.3	11.6	10.1
Colombo	9.3	8.3	11.0	12.5	13.2	5.0	4.4	5.1	6.1	6.7	6.1	5.6	8.0	8.2	8.2
Galle	15.4	14.3	18.0	19.3	19.7	7.8	6.9	8.4	9.2	9.4	12.3	11.4	14.5	13.2	12.6
Gampaha	12.2	11.1	13.7	15.7	15.6	5.9	5.4	6.3	7.1	7.5	10.0	9.1	11.6	11.8	11.2
Hambantota	14.5	14.3	17.8	19.8	19.1	7.8	6.9	8.2	9.6	10.3	11.0	11.2	14.5	13.3	11.5
Jaffna	13.9	13.1	15.0	16.2	16.8	8.9	8.3	9.1	10.0	10.9	9.3	8.7	10.4	10.3	9.8
Kalmunai	12.3	11.3	13.3	15.0	15.2	8.2	7.3	8.8	9.4	9.6	6.2	5.9	7.1	7.4	7.3
Kalutara	12.9	12.0	14.9	17.3	17.8	7.0	6.2	7.6	9.2	9.7	8.6	8.2	10.8	11.1	10.6
Kandy	15.3	14.1	18.0	20.7	20.4	10.1	9.2	11.0	12.5	12.8	8.7	7.7	9.9	10.8	10.1
Kegalle	16.0	15.5	17.4	20.3	20.4	9.0	7.0	8.5	10.1	10.4	10.3	10.4	12.3	12.7	11.9
Kilinochchi	16.3	25.3	14.3	17.0	16.8	11.3	16.2	8.0	11.4	10.3	9.8	15.0	7.9	10.5	8.9
Kurunegala	15.9	14.5	18.0	20.0	20.4	8.7	7.7	9.0	9.6	10.9	12.7	11.9	14.0	13.9	12.7
Mannar	13.8	13.9	15.7	16.6	17.4	9.0	8.4	9.8	10.8	12.0	9.2	8.4	9.5	9.5	9.6
Matale	16.8	14.9	19.6	21.3	21.1	9.5	8.4	10.1	11.6	12.1	11.0	9.9	13.7	14.0	12.2
Matara	16.2	15.6	19.1	20.8	20.8	8.6	7.8	9.0	10.2	10.5	11.2	11.4	13.9	13.5	12.5
Moneragala	15.7	15.2	18.6	19.8	19.2	8.3	8.0	9.6	11.0	11.6	9.3	10.1	11.9	11.1	10.4
Mullaitivu	19.3	17.7	17.9	17.6	18.3	11.1	7.8	10.5	10.4	10.8	11.6	9.7	12.7	11.5	10.0
NIHS	12.3	12.4	14.2	16.1	15.7	6.6	6.6	7.4	8.5	9.1	7.8	8.2	8.5	9.0	8.9
Nuwaraeliya	23.0	22.4	26.0	28.8	28.1	21.2	18.5	22.6	25.6	25.8	10.7	10.8	11.8	12.0	10.7
Polonnaruwa	17.3	16.2	20.7	22.2	21.9	8.8	7.8	9.1	10.5	11.8	12.9	11.6	16.0	15.1	13.5
Puttalam	15.1	13.2	16.4	19.1	18.4	9.2	6.8	8.5	9.8	10.6	10.5	9.8	12.5	12.9	11.4
Ratnapura	17.4	No data*	19.9	22.6	21.4	10.8	No data*	11.4	13.0	13.0	11.5	No data*	13.2	13.5	12.1
Trincomalee	19.3	17.5	20.3	21.0	22.0	12.1	11.3	13.3	13.8	14.6	10.1	9.6	11.1	10.3	10.2
Vavuniya	19.0	16.6	19.2	17.9	19.5	10.5	9.1	11.1	11.9	12.0	10.9	10.4	12.8	9.5	9.8
Sri Lanka	**15.5**	**14.4**	**17.5**	**19.5**	**19.4**	**9.1**	**8.0**	**9.5**	**10.8**	**11.4**	**10.2**	**9.7**	**12.0**	**12.0**	**11.1**

*Data not provided due to trade union action

Source: NM Data, eRHMIS

Annexure 11 - Children under the age of 5 years from 2020 - 2024 | Nutrition Month

RDHS	Percentage of under 5 children with underweight					Percentage of under 5 children with stunting					Percentage of under 5 children with wasting				
	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Ampara	15.1	14.2	18.2	20.2	19.1	8.2	7.7	9.6	11.0	11.2	10.1	9.5	11.9	11.9	10.4
Anuradhapura	15.3	14.5	17.8	20.1	19.8	8.4	7.7	9.6	11.4	11.8	10.1	9.5	11.4	12.1	11.0
Badulla	16.6	15.6	19.1	20.6	20.3	10.9	10.0	12.0	14.1	14.1	10.1	10.0	11.7	11.1	10.2
Batticaloa	10.6	10.7	12.9	15.6	15.6	7.5	6.9	7.6	9.2	9.7	6.2	6.3	8.5	8.5	7.7
Colombo MC	11.8	11.1	13.4	14.6	14.3	6.9	7.1	9.4	9.7	9.0	7.0	7.6	9.8	10.1	8.5
Colombo	8.2	7.5	9.8	11.2	11.8	4.6	4.2	5.1	5.8	6.3	5.3	5.0	6.8	6.8	6.8
Galle	12.9	12.0	15.5	16.9	17.3	7.1	6.3	7.6	8.7	8.8	10.2	9.5	12.1	11.0	10.5
Gampaha	10.4	9.4	12.1	13.8	13.8	5.5	5.0	6.2	6.8	7.1	8.2	7.3	9.5	9.6	9.4
Hambantota	12.0	11.8	15.5	17.5	16.8	6.9	6.2	7.8	9.4	9.7	9.1	9.3	12.1	11.0	9.6
Jaffna	11.6	11.0	13.2	13.9	14.4	7.8	7.1	8.4	9.2	9.8	8.1	7.8	9.2	8.9	8.7
Kalmunai	10.2	9.8	11.8	13.0	13.1	7.2	6.6	8.4	8.8	8.6	5.5	5.2	6.4	6.4	6.3
Kalutara	11.2	10.3	13.1	15.3	15.5	6.5	5.8	7.5	8.8	9.1	7.4	6.9	8.9	9.3	8.9
Kandy	13.3	12.4	16.2	18.5	18.0	9.3	8.7	10.7	11.9	11.9	7.6	6.9	8.7	9.3	8.6
Kegalle	13.7	13.1	15.5	18.1	18.2	8.0	6.6	8.3	9.7	9.9	8.6	8.4	10.3	10.4	9.9
Kilinochchi	12.3	16.8	11.5	14.0	13.8	8.6	10.6	7.0	9.8	9.0	7.1	9.5	6.5	8.5	7.1
Kurunegala	13.4	12.3	15.6	17.6	18.0	8.2	7.4	8.7	9.3	10.3	10.7	10.1	11.9	11.6	10.8
Mannar	11.0	10.7	12.6	13.6	14.2	8.0	6.9	8.8	9.7	10.2	7.7	7.0	8.2	8.0	7.8
Matale	14.0	12.7	17.2	19.0	18.6	8.5	7.7	9.9	11.4	11.6	9.1	8.1	11.3	11.8	10.2
Matara	14.0	13.1	16.8	18.4	18.5	7.5	6.9	8.4	9.8	10.1	9.8	9.6	11.8	11.2	10.5
Moneragala	13.0	12.7	16.0	17.2	16.7	7.5	7.3	9.3	10.6	10.8	7.9	8.5	10.0	9.5	8.7
Mullaitivu	15.1	13.5	14.4	14.5	14.6	9.3	6.4	9.0	9.0	8.8	9.2	7.2	10.4	9.2	8.1
NIHS	10.9	10.9	12.9	14.5	14.2	6.1	6.3	7.3	8.5	8.5	7.4	7.1	7.4	7.9	7.9
Nuwaraeliya	20.4	20.0	23.9	26.4	25.6	19.8	17.4	22.8	25.2	24.5	9.9	9.7	10.6	10.5	9.6
Polonnaruwa	14.5	13.7	18.1	19.6	19.3	7.9	7.2	9.2	10.5	11.3	10.6	10.0	13.5	12.6	11.2
Puttalam	12.7	11.2	14.2	16.3	16.1	7.9	6.3	8.1	9.1	9.6	8.8	8.2	10.5	10.7	9.6
Ratnapura	14.9	No data*	17.6	19.8	18.9	9.9	No data*	11.1	12.7	12.3	9.8	No data*	11.3	11.3	10.3
Trincomalee	15.6	14.4	17.2	17.9	18.5	10.5	10.2	12.4	12.8	12.8	8.2	7.9	9.4	8.8	8.6
Vavuniya	15.4	13.3	15.5	14.8	16.1	9.2	8.2	10.1	10.6	10.3	8.8	8.0	10.1	7.9	7.7
Sri Lanka	**13.1**	**12.2**	**15.3**	**17.1**	**17.0**	**8.2**	**7.4**	**9.2**	**10.3**	**10.5**	**8.6**	**8.2**	**10.1**	**10.0**	**9.3**

*Data not provided due to trade union action

Source: NM Data, eRHMIS

Annexure 12 - Nutritional status of infants and children (e RHMIS) 2024

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 (1-2years)	Percentage of severely underweight (<-3SD) young children (1-2years)	Percentage of moderately underweight (-2SD to -3SD) preschoolers (2-5 years)	Percentage of severely underweight (<-3SD) preschoolers (2-5 years)
Ampara	17.5	17.5	99.5	97.9	109.6	7.3	2.0	12.8	2.4	21.6	3.5
Anuradhapura	13.6	13.9	89.7	69.2	92.7	5.8	1.4	13.4	2.5	19.7	3.2
Badulla	18.8	18.6	97.0	93.1	100.1	7.3	1.9	13.5	2.4	20.8	3.6
Batticaloa	15.2	15.3	95.4	92.2	82.1	5.3	1.2	9.9	2.2	21.2	4.1
Colombo MC	14.3	14.3	71.2	55.7	61.8	6.0	1.5	8.9	1.6	13.7	2.6
Colombo	12.5	12.4	86.1	79.3	70.1	4.9	1.1	7.8	1.1	11.6	1.9
Galle	14.5	14.1	90.2	79.8	79.1	6.0	1.3	11.2	1.8	17.6	2.9
Gampaha	13.2	13.2	86.1	75.3	70.9	4.3	0.9	9.2	1.3	13.4	2.1
Hambantota	13.4	13.4	93.8	94.2	91.4	5.3	1.1	11.1	1.7	19.7	2.6
Jaffna	12.8	12.5	98.6	96.7	70.3	6.0	1.1	10.2	1.6	28.0	3.3
Kalmunai	11.6	11.6	96.0	95.5	70.5	4.9	1.2	9.8	2.0	20.4	3.6
Kalutara	13.7	13.7	92.5	82.9	77.5	5.1	1.0	9.9	1.5	15.6	2.3
Kandy	15.1	15.0	95.9	91.3	86.9	6.7	1.8	11.7	2.1	17.9	3.2
Kegalle	16.8	16.7	90.3	85.3	84.6	6.6	1.6	11.5	1.7	18.3	2.8
Kilinochchi	12.1	12.3	98.0	94.5	83.3	3.9	0.7	10.3	1.4	24.2	2.7
Kurunegala	14.9	14.5	93.0	84.6	95.0	5.6	1.5	11.5	1.9	16.7	2.6
Mannar	12.9	13.3	99.1	95.5	92.2	3.5	0.9	9.6	1.5	20.2	3.3
Matale	16.0	15.9	92.4	92.1	90.4	7.1	1.5	12.3	2.1	21.4	3.5
Matara	15.2	14.6	95.1	88.9	90.4	6.7	1.5	11.3	1.8	17.8	2.6
Moneragala	15.2	15.1	97.8	94.4	92.0	5.7	1.3	11.2	1.7	20.7	2.8
Mullaitivu	12.2	12.3	96.7	91.5	82.0	3.7	1.1	9.5	1.4	22.2	3.2
NIHS	13.5	13.3	81.8	68.0	69.9	5.2	1.1	9.0	1.3	13.8	2.1
Nuwaraeliya	23.8	23.4	94.8	91.3	108.8	11.2	3.4	17.5	4.4	22.7	5.0
Polonnaruwa	15.9	15.7	92.9	88.2	94.9	6.2	1.6	12.7	2.1	20.9	3.1
Puttalam	13.5	13.3	92.2	87.0	86.1	5.3	1.2	10.7	2.3	16.0	2.9
Ratnapura	16.3	16.0	92.3	86.8	92.8	6.5	1.6	12.1	2.0	19.6	3.1
Trincomalee	13.7	13.8	96.7	93.5	94.6	5.0	1.2	11.9	2.3	21.9	3.8
Vavuniya	13.5	14.0	96.4	91.9	92.6	5.7	1.3	10.3	1.9	21.9	3.1
Sri Lanka	**14.8**	**14.6**	**92.1**	**85.4**	**85.5**	**5.9**	**1.4**	**11.2**	**1.9**	**18.5**	**3.0**

Source: eRHMIS

Annexure 13 - Family Planning Performance 2024

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	72.6	4.5	77.1	1.6	3.4	7085.6	0.08
Anuradhapura	67.4	7.5	74.9	3.4	3.3	27224.4	0.16
Badulla	68.6	4.8	73.4	3.7	2.8	25322.1	0.07
Batticaloa	51.8	6.8	58.6	4.3	2.8	34071.3	0.05
Colombo MC	62.2	13.2	75.4	9.2	2.4	5605.1	0.03
Colombo	56.0	11.4	67.4	6.2	5.2	61395.1	0.01
Galle	59.2	9.3	68.5	6.0	4.1	32856.2	0.06
Gampaha	54.2	13.8	68.0	7.7	5.3	65414.2	0.03
Hambantota	62.7	6.7	69.4	4.8	4.8	20312.9	0.12
Jaffna	55.8	7.8	63.6	2.7	4.7	23648.5	0.08
Kalmunai	51.0	9.2	60.2	3.1	3.5	24841.4	0.15
Kalutara	58.1	10.1	68.1	4.8	5.2	31649.2	0.13
Kandy	61.4	8.9	70.3	5.3	3.2	45157.0	0.10
Kegalle	61.0	8.8	69.7	5.9	3.6	24583.4	0.05
Kilinochchi	67.7	3.4	71.2	1.9	3.0	4521.6	0.05
Kurunegala	61.5	9.4	71.0	4.8	3.8	52129.1	0.05
Mannar	55.0	14.7	69.7	3.4	4.0	3947.9	0.23
Matale	62.9	7.4	70.3	4.1	3.7	17031.1	0.04
Matara	64.0	7.8	71.8	5.9	4.1	21295.1	0.09
Moneragala	68.7	6.4	75.1	3.3	4.0	13524.4	0.26
Mullaitivu	71.5	4.5	76.0	2.3	2.2	3232.0	0.08
NIHS	56.9	10.7	67.7	5.6	4.8	9377.7	0.03
Nuwaraeliya	68.6	5.3	73.9	6.4	2.1	18654.9	0.10
Polonnaruwa	67.0	7.3	74.3	2.5	4.2	13184.3	0.25
Puttalam	61.8	10.8	72.6	5.7	2.8	24224.0	0.04
Ratnapura	60.6	11.2	71.8	5.9	3.8	31301.2	0.07
Trincomalee	58.8	7.3	66.1	2.9	2.2	20638.3	0.03
Vavuniya	56.1	12.7	68.8	7.3	1.8	5766.5	0.08
Sri Lanka	**60.6**	**9.3**	**69.8**	**5.2**	**3.9**	**667994.9**	**0.08**

Source: eRHMIS

Annexure 14 - Family Planning Performance 2024

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	7.8	28.6	8.1	10.6	5.2	12.3	0.02
Anuradhapura	10.8	22.6	10.	8.1	7.2	8.6	0.00
Badulla	6.9	15.9	13.5	8.9	6.7	16.6	0.01
Batticaloa	5.2	24.2	2.3	3.8	7.6	8.7	0.00
Colombo MC	5.1	9.4	7.6	14.	16.6	9.5	0.01
Colombo	7.1	6.4	10.8	7.9	15.7	8.	0.01
Galle	9.6	11.4	10.2	5.7	12.4	9.9	0.02
Gampaha	8.5	8.7	9.2	5.5	13.4	8.9	0.01
Hambantota	9.1	12.4	14.7	5.4	10.5	10.6	0.00
Jaffna	5.3	9.3	4.1	5.9	12.3	18.9	0.02
Kalmunai	5.4	15.5	3.6	3.4	11.6	11.6	0.00
Kalutara	6.9	9.4	10.7	6.5	13.1	11.5	0.01
Kandy	8.6	10.4	8.2	7.9	14.3	11.9	0.02
Kegalle	9.6	15.5	8.1	6.3	9.8	11.7	0.00
Kilinochchi	4.2	17.7	12.	10.5	6.7	16.6	0.00
Kurunegala	8.9	13.	12.6	6.2	12.4	8.4	0.00
Mannar	5.2	12.9	2.9	6.6	10.9	16.5	0.01
Matale	9.9	13.3	10.5	6.5	10.9	11.9	0.00
Matara	9.8	11.9	10.7	7.5	14.	10.	0.02
Moneragala	8.4	18.9	16.6	7.2	6.8	10.8	0.00
Mullaitivu	7.1	18.9	5.7	19.8	5.8	14.2	0.00
NIHS	7.1	7.7	7.6	6.	15.2	13.3	0.01
Nuwaraeliya	6.8	12.3	8.6	11.9	5.5	23.5	0.01
Polonnaruwa	10.3	25.4	9.1	7.2	6.4	8.6	0.00
Puttalam	9.2	17.5	6.8	8.9	8.7	10.8	0.00
Ratnapura	9.9	14.1	8.6	6.3	9.9	11.7	0.00
Trincomalee	5.4	26.6	2.3	6.9	9.	8.5	0.00
Vavuniya	6.7	14.9	2.5	7.2	7.7	17.2	0.02
Sri Lanka	**8.2**	**13.6**	**9.3**	**7.2**	**11.2**	**11.1**	**0.01**

Source: eRHMIS

Annexure 15 - Infant & Child mortality 2024

RDHS	Early neonatal mortality rate	Neonatal mortality rate	Infant mortality rate	Under 5 Child Mortality Rate	Still birth rate
Ampara	5.8	10.1	12.8	14.4	5.0
Anuradhapura	3.9	6.8	10.9	13.8	6.3
Badulla	4.1	6.0	10.3	12.3	6.5
Batticaloa	3.9	6.4	10.7	12.6	7.5
Colombo MC	6.0	7.5	10.5	12.3	7.5
Colombo	5.0	6.9	9.6	10.6	5.4
Galle	4.8	5.9	9.3	10.3	5.7
Gampaha	4.8	7.0	9.9	11.2	6.0
Hambantota	4.5	5.9	8.4	10.4	4.5
Jaffna	8.0	10.2	14.5	16.7	7.0
Kalmunai	5.9	8.9	11.8	13.8	5.2
Kalutara	5.9	7.5	9.6	10.9	7.5
Kandy	5.2	6.9	10.0	11.4	6.9
Kegalle	4.3	5.4	7.2	8.7	5.3
Kilinochchi	4.5	7.1	10.3	14.8	5.1
Kurunegala	6.7	8.9	11.2	13.1	6.0
Mannar	3.9	6.8	10.1	12.9	10.0
Matale	7.2	9.2	11.9	13.3	8.7
Matara	4.1	5.9	8.5	11.3	4.9
Moneragala	6.5	9.0	12.5	15.3	6.1
Mullaitivu	4.4	5.1	9.5	11.7	13.0
NIHS	6.4	8.3	10.8	12.7	6.9
Nuwaraeliya	4.8	8.7	12.8	16.0	7.3
Polonnaruwa	7.5	9.8	13.5	16.8	6.5
Puttalam	5.7	8.3	11.4	14.4	5.8
Ratnapura	6.7	9.3	11.5	13.7	4.9
Trincomalee	5.0	7.0	11.2	13.3	7.2
Vavuniya	2.7	4.8	9.1	11.8	9.0
Sri Lanka	**5.1**	**7.2**	**10.2**	**12.1**	**6.0**

Source: eRHMIS

Annexure 16 - Well Woman Clinic performance 2024

RDHS	Percentage of 35-year age cohort attendance to WWC out of 0.8% of estimated population	Percentage of 35-year-old cohort coverage who had undergone Pap smear screening out of 0.8% of the population	Percentage of unsatisfactory Pap smear specimens	WWC pap smears taken 35y	WWC pap referred	WWC identified breast abnormalities	WWC identified diabetes	WWC identified hypertension
Ampara	82.9	79.5	1.6	1814	113	50	101	245
Anuradhapura	72.7	69.7	6.3	5258	331	274	763	736
Badulla	63.3	60.2	3.5	4299	415	115	311	305
Batticaloa	63.6	63.0	1.0	2895	15	8	155	154
Colombo MC	14.9	14.2	3.4	671	29	29	86	30
Colombo	50.4	43.5	3.7	6450	692	876	315	677
Galle	61.0	58.9	2.3	5331	180	247	254	556
Gampaha	58.2	51.8	4.7	9963	721	458	511	1123
Hambantota	83.1	76.6	3.2	4165	195	214	352	370
Jaffna	38.8	34.5	9.4	1731	104	62	242	87
Kalmunai	79.0	78.3	0.8	2871	79	14	192	111
Kalutara	55.2	49.3	0.6	3815	89	213	126	337
Kandy	77.4	65.5	2.1	7678	478	361	575	665
Kegalle	67.8	61.3	0.9	4343	262	339	95	348
Kilinochchi	45.5	41.5	9.7	456	270	60	118	80
Kurunegala	58.7	55.1	7.3	7539	293	272	362	911
Mannar	95.9	92.4	1.4	863	109	3	167	138
Matale	80.3	72.3	1.6	3008	202	201	371	332
Matara	68.7	65.1	0.8	4501	374	325	277	547
Moneragala	90.9	85.9	2.2	3501	476	195	212	438
Mullaitivu	59.0	55.5	2.1	441	2	33	49	32
NIHS	61.9	53.4	0.4	1281	213	102	142	220
Nuwaraeliya	68.2	63.6	1.6	3966	285	132	166	415
Polonnaruwa	73.5	69.2	1.5	2442	263	263	161	448
Puttalam	48.3	46.0	0.5	3089	177	133	122	164
Ratnapura	64.8	61.8	0.4	5846	328	304	526	469
Trincomalee	63.0	61.7	0.8	2180	21	22	222	227
Vavuniya	35.0	33.7	No data	529	No data	58	25	49
Sri Lanka	**62.5**	**57.6**	**2.8**	**100926**	**6716**	**5363**	**6998**	**10214**

Source: eRHMIS