

**ANNUAL REPORT
ON
FAMILY HEALTH**

SRI LANKA

2004 – 2005

**FAMILY HEALTH BUREAU
MINISTRY OF HEALTH
SRI LANKA**

Annual Report
on
Family Health
Sri Lanka

2004 – 2005

Evaluation Unit
Family Health Bureau
231, De Seram Place
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VOL 17
2007.02.22

Foreword

The Family Health Bureau has been publishing national data on Maternal and Child Health and Family Planning regularly. This is the 17th in a series of Annual Report on Family Health.

The information contained in this report is essential for monitoring and evaluation of the performance at district level and would assist health managers in programme implementation. The data published would also be a valuable source of information to policy makers, programme managers, service providers as well as all others interested in family health activities.

We wish to thank the UNFPA for the financial support provided for printing this document.

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22nd February 2007

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1.0 Introduction

An organised effort to provide maternal and child health services dates back to the mid 1920's with the introduction of the Health Unit System which was to provide institutional and domiciliary care for mothers and children. The 1st Health Unit was established in 1926 at Kalutara. This system was thereafter extended and currently 258 Health Units are established within the country.

Family Planning was introduced to Sri Lanka in the early 1950's by the Family Planning Association of Sri Lanka, which is a non-governmental organization and family planning was accepted as a national policy in 1965. It was integrated with the already well developed Maternal and Child health services provided through the Ministry of Health. Considering its national importance a separate division was established in 1968 within the ministry to implement the programme throughout the country. This was initially designated as the Maternal and Child Health Bureau and was later re-designated the "Family Health Bureau".

Since early 1970's, maternal and child health services received greater emphasis and was given priority in the overall health delivery system. This led to a more concerted effort to strengthen the service infrastructure to provide an efficient family health service throughout the country.

The Government of Sri Lanka is committed to provide a comprehensive system of health care to its people. Maternal health, child health and family planning form an important component of the prevailing health care system and the services are provided through the well developed infrastructure of the Ministry of Health which comprise a wide network of medical institutions and health units.

Since 1989, the country's administration has been decentralized with devolution of administrative powers to the Provincial Councils. The Provincial Director of Health Services (PDHS) is responsible for the health care provided within the province and is supported by the Deputy Provincial Directors (D/PDHS) who are in charge of the Health Districts. At the district level, the Medical Officer MCH (MO.MCH), Regional Epidemiologist (RE), Regional Supervising Public Health Nursing Officer (RSPHNO), 2-3 Health Education Officers, a Statistical Survey Officer (SSO) or a Programme Planning Officer (PPO) support the D/PDHS.

Each Health District comprises of seven to twenty Health Divisions (7-20) which are managed by the Divisional Director of Health Services (DDHS)/Medical Officer of Health (MOH). The DDHS/MOH is supported by a team of public health personnel comprising Public health Nursing Sisters (PHNS), Public Health Inspectors (PHI), Supervising Public Health Midwives (SPHM) and Public Health Midwives (PHMs).

The Health Division has a network of medical institutions and Health Units, which provide institutional, and clinic based maternal health, child health and family planning services. The Public Health Midwife (PHM) is given a well-demarcated area with a population ranging from 2000 to 5000 and provides domiciliary care through systematic home visiting to mothers and children within the community. She provides education and advice on health and health related activities and necessary counseling on family planning to potential clients within her area. She distributes contraceptives (orals and condoms) and regularly follows-up contraceptive users within her area. She also participates in the area MCH/FP clinic linking the community with the health care system.

The Public Health Nursing Sister/officer and the Supervising Public Health Midwife have mainly a supervisory role ensuring the quality and coverage of the MCH services within the division. They also participate at the MCH/FP clinics conducted within the division.

The Family Health covers a wide spectrum of services comprising:

1. Maternal care – antenatal, intra-natal and postnatal
2. Infant and Child care which provides for
 - Immunization against common childhood diseases
 - Monitoring growth and development
 - Psychosocial development of the child
 - Management and control of common childhood illnesses
3. Nutrition of pregnant mothers and children
4. Care of the School child
5. Adolescent reproductive health
6. Family Planning.
7. Women's health

Since the International Conference on Population and Development in Cairo in 1994, the concept of reproductive health has been introduced addressing reproductive health issues of the adolescent, the post-adolescent before they become mothers and after menopause thus extending a life cycle approach to family health. Some of the reproductive health issues that have received emphasis in the programme are RH problems in the adolescents, early identification of reproductive organ malignancies, prevention of reproductive tract infections including sexually transmitted diseases/HIV-AIDS, concept of women's empowerment and male involvement in RH activities.

At national level, the Family Health Bureau is the central organization of the Ministry of Health responsible for planning, coordination, monitoring and evaluation of maternal and child health and family planning programmes within the country. The Bureau is the focal point for School Health and Well Woman Clinic programmes. In this role the Bureau provides necessary guidance and direction for effective implementation of programmes at the periphery and also implements special projects funded by international agencies. The Family Health Bureau works in close collaboration with the Epidemiological Unit, Health Education Bureau, National Cancer Control Programme (NCCP), National STD/AIDS

Control Programme (NSACP), Population Division of the Ministry of Health and with other related Government and Non-Governmental Organizations and International Organizations like the UNICEF, UNFPA and WHO. The Bureau also undertakes in-service training in family health and provides reproductive health services at its clinic center. It is also responsible for procurement and distribution of contraceptives and some of the essential equipment and supplies needed for family planning and maternal and child health activities at the periphery.

The Research and Evaluation Unit monitors MCH/FP programme implementation at the periphery and is responsible for processing and analysis of MCH/FP data collected through the health information system. It also conducts relevant health service research.

2.0 Maternal and Child Health

This report contains information on Family Health activities conducted by Public Health Staff in the field and at Maternal and Child Health (MCH) and Family Planning clinics conducted in the field and in the peripheral institutions. The information published in this section is based on the data collected through the routine MCH Information System of the Ministry of Health, which was revised in 2000 to include certain data on reproductive health services implemented through the programme. This is the second annual report based on the data received through this revised system.

It needs to be noted that statistics from MCH clinics in the larger medical institutions where specialist clinics are conducted (Teaching Hospitals, Provincial Hospitals, Maternity Hospitals and Base Hospitals) have not been included, since the majority of pregnant women and children attending the specialist clinics would also have attended the area MCH clinics. This is been done to prevent duplication of data.

The estimates are based on the populations in the urban, rural and estate sectors including the Municipalities. The statistics are based on data collected through the revised Maternal and Child Health Return (H 509) from DDHS/MOH Divisions and from the Municipalities.

Table 2.1
Population Statistics and Estimates – 2004 and 2005

Population estimates	Sri Lanka	
	2004	2005
Total Population – 000'	19,504	19,668
Estimated Eligible Families	3.12 million	3.14 million
Reported births *	360,220	370,424
Estimated infant deaths **	4394	4149
Estimated maternal deaths ***	154	159

2.1 Maternal care in the field

* Reported births by Registrar General's Department in respective years (Crude Birth Rate of 19.13 and (2002) 18.87 per 1000 population (2003)

** Infant Mortality Rate of 12.2 and 11.2 per 1000 live births (2002 & 2003 respectively)

*** Estimated Maternal Mortality Ratio of 43.0 per 100,000 live births (2002) which is the rate computed from data received through the Maternal Death Investigation System of FHB.

During the year 2004 and 2005, the staff position in the MOH areas providing MCH services is indicated in the table 2.2.

Table 2.2
Staff position – 2004 and 2005

Staff category	2004	2005
Divisional Director of Health Services	188	161
Medical Officers of Health	245	264
Public Health Nursing Sisters	257	266
Supervising Public Health Midwives	118	141
Public Health Inspectors	1257	1198
Public Health Midwives	4762	4720

Of the approved cadre of PHM of 5689 only 4762 and 4720 were available in 2004 and 2005 respectively. Approximately 17 percent of PHM areas being reported as vacant in the MOH divisions in the respective years. The areas most affected were Colombo MC, Vavuniya, Trincomalee, Jaffna, Batticaloa, Kilinochichi, and Mullathivu. It should also be noted that, the conflict situation, which prevailed in the North and East, would have affected the proper implementation of programmes in those areas.

Table 2.3
Antenatal care provided by Public Health Midwives

Indicator	2004		2005	
	Number	Percentage	Number	Percentage
Eligible families under care	3016589	96.0	3111608	99.0
Pregnant mothers Registered by PHMs	367074	101.0	371555	100.0
Pregnant Mothers Registered at home (Est. Preg. Mothers)	336186	91.6	338574	91.1
< 12 weeks	272709	81.1	280289	82.8
> 20 weeks	10381	3.1	9704	2.9
Registered at clinic	30888	8.4	32981	8.9
Pregnant mothers under care (Average for each month)	187909		195071	
Teenage pregnancies under care	12246	6.5	12029	6.2
Prime under care	71510	38.2	74257	38.0
Pregnant mothers protected with Rubella	158418	84.3	170360	87.3
Pregnant mothers tested for VDRL	121154	64.5	130392	66.8
Pregnant mothers blood grouping done	138616	73.8	147706	75.7

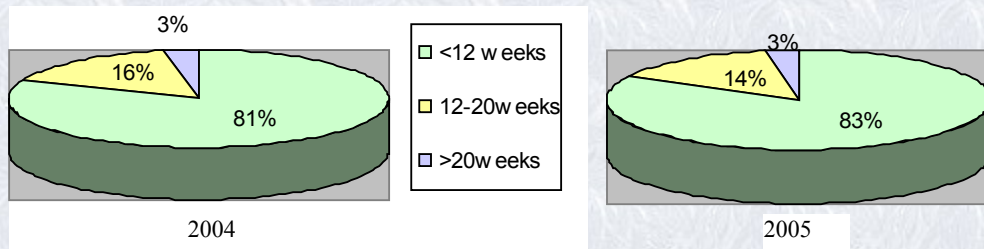
Source: MCH Quarterly return - H 509

The reported data in 2004 and 2005 indicates that, approximately 96 and 99 percent of the eligible families in the population were under care of the Public Health Midwives respectively. The estimate of eligible families was based on 16 percent of the total population.

Public Health Midwives have registered 367,074 pregnant mothers during 2004 and 371,555 mothers in 2005 which is almost 100% of the registered births in the respective years. The high registration could have been resulted from clinic registration where

mothers from vacant PHM areas or from outside PHM areas attend antenatal clinics for basic care.

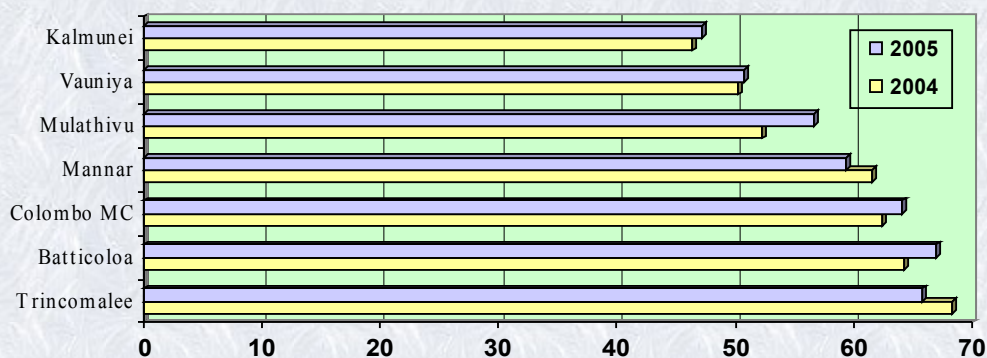
Figure 2.1 Time of Registration of pregnant mothers registered at home



Of the mothers registered in 2004, 92 percent were registered at home by the PHMs with almost 81 percent being registered before 12 weeks of pregnancy. Only 3 percent were registered after 20 weeks; the balance being registered between 12-20 weeks. In the year 2005 nearly 91% of the pregnant mothers have been registered by PHM at home while 83% being registered before 12 weeks (figure 2.1). It is commendable that more than four-fifths of the mothers had been registered for antenatal care as early as the 12th week.

As shown in figure 2.2, early registration was low (less than 60%) in DPDHS Divisions of Vavuniya, Kalmunai, Mannar and Mullathivu; while late registration i.e. after 20 weeks was high (more than 8%) in the same DPDHS Divisions and Trincomalee.

Figure 2.2 Districts with Low rate of early registration



Since early registration of pregnant women is a pre-requisite to early commencement of antenatal care, peripheral level programme managers especially in the above DPDHS Divisions should look into this more closely and take appropriate measures to improve early identification of pregnant women within their areas. In all areas, attempts should be made to register pregnant mothers as early as possible preferably before 8 weeks of gestation.

In several districts, the reported registration of pregnant mothers exceeded 105 percent in DPDHS Divisions of Kegalle, Matara, Matale, Puttalam, Rathnepura, Moneragala, Gampaha and Kalutara. This may be due to inaccuracies of the reported district population or birth rates; or may be even due to incorrect reporting by the Public Health staff. **The supervising health staff should specifically look into this and ensure that accurate data is submitted by field health staff in their performance reports.**

It must be also stated that in certain districts reported registration of pregnant women was poor. Districts of Nuwara Eliya, Mannar and Mullathivu recorded low rates (less than 65%) and this could be attributed to the acute shortage of Public Health Midwives in most of the MOH areas within the districts and also to the conflict situation that prevailed during the years under review.

As seen in table 2.3, in 2004, an average of 187,909 pregnant mothers were under care of the PHMs at the end of each month and in 2005 the pregnant mothers under care were 195,071. Of the pregnant mothers under care of the Public Health Midwives, 6.5 percent and 6.2 percent were teenage mothers (less than 20 years of age) in 2004 and 2005 respectively (table 2.3). Approximately 38 percent were prime gravida in both years. The proportion of teenage pregnancies was high (9% and more) in Ampara, Batticaloa, Puttalam, Moneragala and Trincomalee, Jaffna DPDHS Divisions in 2005. The teenage pregnancies were high in DPDHS divisions bordering most of the conflict affected areas. This is an area that warrants educational intervention since teenage pregnancies have a higher risk of maternal morbidity and mortality. **The programme managers should conduct special reproductive health education programmes for adolescents in school and out of school on ill effects of teenage pregnancies and the need to postpone pregnancy till the women are matured enough to go through a safe pregnancy and childbirth.**

Public Health Midwives reports data on the coverage of pregnant mothers with rubella immunization, body mass index (BMI) and some important service indicators. The data for 2004 revealed that, of the pregnant mothers under care, 64.5 percent had been tested for VDRL, 73.8 percent had got their blood group tested and 84.3 percent had received Rubella immunization before their pregnancy. In 2005, VDRL and blood group testing and Rubella immunization coverage among pregnant mothers have been increased to 66.8, 75.7 and 87 percent respectively (Figure 2.3).

Figure 2.3: VDRL, Blood group testing and Rubella coverage among pregnant mothers

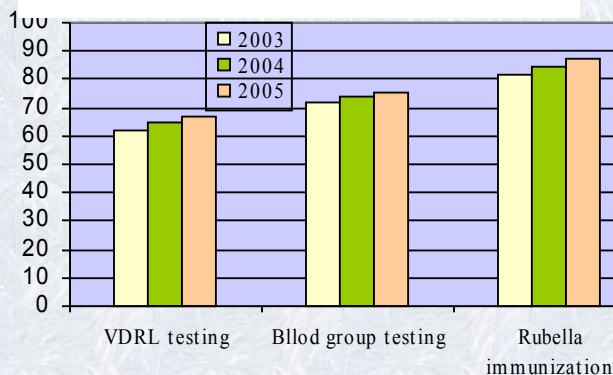


Figure 2.4: Districts with lower coverage of VDRL and blood group testing in 2005

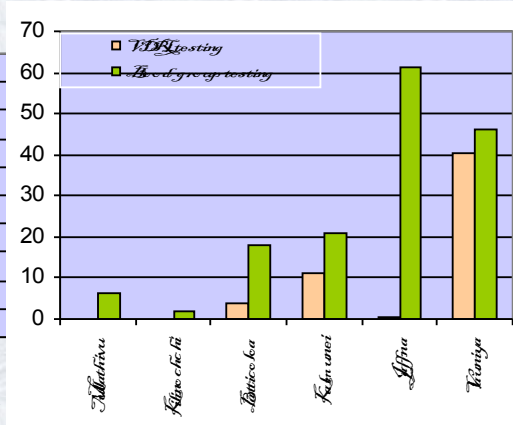


Figure 2.4 shows the areas with lower coverage of VDRL and blood group testing in 2005. Most of these DPDHS divisions are conflict affected areas which are deficient in infrastructure facilities and as well as human resources.

Public Health Midwives have visited 93 percent of the pregnant mothers registered in 2005. A total of 1,725,036 home visits were made by the PHMs giving an average of 5 visits for each pregnant mother in 2005.

Table 2.4 shows that, PHMs reported a total of 283,793 and 289,889 deliveries during 2004 and 2005 accounting for 79.0 and 78.0 percent of the estimated deliveries for the respective years. Reporting of deliveries was poor from Kalmunei, Mannar, Mullathivu, Vavuniya and Trincomalee where less than 60.0 percent of the estimated deliveries were reported. This low reporting from DPDHS areas may be due to poor home visiting which could be the result of large number of PHM vacancies exists in these districts.

Of the deliveries reported in 2004, 0.6 percent (1613) were home deliveries with 42 percent (669) receiving either untrained assistance or delivering without any assistance. The proportion of home deliveries has been decreased in the year 2005, however, of the 1603 home deliveries reported (0.5% of all reported deliveries) 48% had received untrained assistance which is higher than the preceding year. In 2005, the proportion of reported home deliveries were high in Batticaloa (5.2%), Trincomalee (4.6%), Vavuniya (3.6%), Mannar (2.7%), Mullathivu (1.6%), Kalmunai (1.4%), Nuwara Eliya (1.3%), Kilinochchi (1.2%) and Polonnaruwa (1.1%) districts. Public Health staff should ensure that all deliveries occur in institutions and efforts should be made to discourage home deliveries at every setting.

Table 2.4
Deliveries and outcome reported by Public Health Midwives

Indicator	Performance in 2004		Performance in 2005	
	Number	Percent	Number	Percent
Deliveries reported by PHMM (Institutional & field)	283793	78.8	289889	78.2
Home deliveries	1613	0.6	1603	0.5
Home deliveries receiving untrained assistance	669	41.5 (of reported home deliveries)	771	48.1 (of reported home deliveries)
Live births reported	288443	80.0	291415	78.7
Single live births	284783	98.7 (of reported live births)	287286	98.6 (of reported live births)
Multiple Births	3660	1.3	4129	1.4
Still births reported	2632		2651	
Abortions reported	16268	4.4 (of total pregnancies)	17822	4.8 (of total pregnancies)
Low birth weight babies	33304	11.7 (of single live births)	32916	11.5 (of single live births)

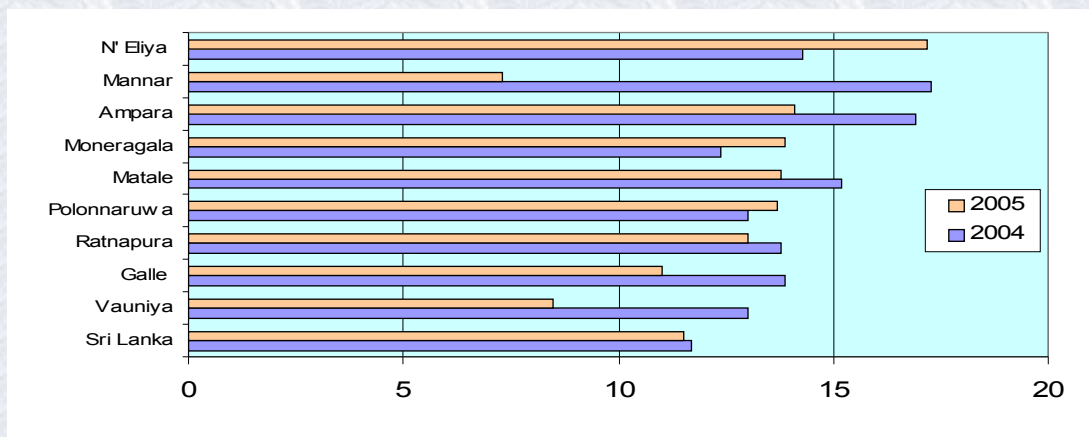
Source: MCH Quarterly return - H 509

The proportion of untrained deliveries were high in Batticaloa, Kalmunei, Mullathivu, Vauniya and Trincomalee. Most of these are conflict-affected areas and it is likely that poor accessibility to trained assistance at the time of need (either for an institutional delivery or

at least to obtain the services of a trained midwife) would have resulted in obtaining only untrained assistance for the delivery. Another contributory factor may be that PHMM are not residing in their areas as such their assistance is not available to mothers when they need emergency care. Since transport is a major problem in the conflict affected areas and in remote rural areas, it is essential that the programme managers make suitable arrangements for mothers to have early access to medical institutions if such situations are to be prevented.

In both years under review approximately 1.3 percent of the deliveries reported were multiple births. Of the single live births reported, in 2004 and 2005, 11.7 percent and 11.5 percent were low birth weight babies respectively. The incidence of low birth weight was highest in Nuwara Eliya (17%) in 2005 while Amapra (14%) and Moneragala (13.9%) districts reported higher rates in 2005 (Figure 2.5). **The supervising staff should ensure that the reporting of the birth weight of new born is correctly done by PHMM since there is a discrepancy in reporting of low birth weight rate by public health staff compared to the hospital reporting system which gives a rate of 16.9 percent in 2003.**

Figure 2.5 Districts with high rate of reporting of Low birth weight



Approximately 1.0 percent of the deliveries ended with a stillbirth providing a still birth rate of 9.2 and 9.0 per 1000 total births in the years 2004 and 2005 respectively. In 2004, 16,268 abortions were reported by the PHMs computing an abortion rate of approximately 44.0 per 1000 registered pregnancies. In 2005 the reported abortion rate increased to 48.0 per 1000 pregnancies reported. It needs to be mentioned that the abortions reported by the PHMs are only those that have occurred after being registered for antenatal care and is therefore likely to be spontaneous abortions. Also it should be noted that these rates are based on statistics reported by the PHMs and therefore, does not reflect the true situation in the country.

Currently data is collected on postpartum visits made by PHMs during the first ten days after partus and also on visits made during the eleventh to the twenty-eighth day and visits at or around the forty-second day of delivery. Table 2.5 shows that in 2004, 86 percent of the reported deliveries had received postpartum care during the first ten days of delivery giving an overall postpartum coverage of 69.2 percent. This coverage has

marginally decreased in 2005 where 85.3% of reported deliveries and 67% of the estimated deliveries had received post partum care at least once during 1st ten days. This overall coverage is very low and should be of concern to all peripheral programme managers. The PHMs made an average of 2.1 visits per mother during the 1st 10 days after delivery in the years under review.

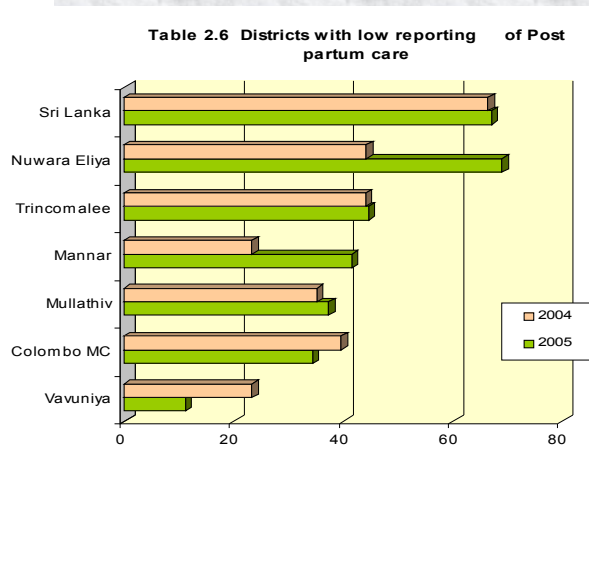
Table 2.5
Postpartum care provided by the Public Health Midwives

Post natal care provided by PHM	2004		2005	
	No. of visits	Percent	No. of visits	Percent
At least 1 visit during 1 st 10 days	243959	69.2 (of the estimated deliveries) 86.0 (of reported deliveries)	247367	66.8 (of the estimated deliveries) 85.3 (of reported deliveries)
At least 1 visit during 11 th to 28 th day	73511	25.9 (of reported deliveries)	70775	24.4 (of reported deliveries)
Post natal care by PHM at or around 42 days	152522	53.7 (of reported deliveries)	164844	56.8 (of reported deliveries)
Mothers with complications	10624	4.35 (of mothers received post natal care)	14153	5.7 (of mothers received post natal care)
Fever	2621	24.7 (of mothers with complications)	2961	21.0 (of mothers with complications)
Offensive discharge	1715	16.1 (of mothers with complications)	1930	13.6 (of mothers with complications)
Bleeding	732	6.9 (of mothers with complications)	843	5.9 (of mothers with complications)
Dysuria	1300	12.2 (of mothers with complications)	1512	10.7 (of mothers with complications)
Infected epis	1200	11.3 (of mothers with complications)	2383	16.8 (of mothers with complications)
Other complications	3056	28.8 (of mothers with complications)	4524	32.0 (of mothers with complications)

Source: MCH Quarterly return - H 509

Approximately 26 percent and 24 percent of mothers had been seen during the 11th to the 28th day in 2004 and 2005 respectively. The post natal care coverage at or around the 42nd day of delivery was 54 percent in 2004 while in 2005 it was 57 percent.

Over 4 percent of mothers receiving postnatal care had experienced complications in 2004. The percentage has been increased to 5.7 in 2005 which shows a significant increase in reporting when compared to the figure of 4 percent in 2004. Of those having complications, the commonest was fever, offensive discharge being 2nd and dysuria ranking third in 2004. However in 2005, infected episiotomies ranked the 2nd place while offensive discharge being the 3rd. **Since the reporting of post partum complications has been increased over the past few years, the staff should be motivated to detect and report complications more during this vulnerable period. The programme managers should pay attention to the types of complications reported in order to take preventive actions to reduce morbidities in future.**



Postpartum care during the first ten days were reported to be less than 50 percent in DPDHS Divisions of Vavuniya, Mannar, Mullathivu, Trincomalee and in Colombo MC. It needs to be reiterated that the above DPDHS divisions and MC area Colombo are acutely short of staff and hence the health authorities should take appropriate measures to improve the staff situation within their areas if the maternal care services are to be improved.

Considering the importance of postpartum care for prevention of maternal mortality and morbidity, all programme managers and their supervisory health staff should improve supervision and closely monitor postpartum activities within their divisions so that postpartum care by the PHMs could be improved. Also necessary measures should be taken to improve the quality of postpartum care so that any complications could be detected early and referred for necessary treatment.

2.2 Infant care in the field

Statistics revealed that in 2004 PHMs have registered approximately 82 percent of the estimated infants for routine infant care (296,687). This percentage has been decreased to 80% in 2005. However only 62 percent of the registered infants had been visited at home in 2004 and 2005. It should be noted that both infant registration and field visits made by PHMM to infants have been decreased in 2005 compared to that of the previous year. This shows that adequate attention is not paid by PHMM for infant and child care in the field.

The reported infant registration was less than 70 percent in DPDHS Divisions Vavuniya, Mannar, Mullathivu, Kilinochchi, Trincomalee and Colombo MC. This low coverage of

infant registration is mainly due to the large number of PHM vacancies in above DPDHS divisions.

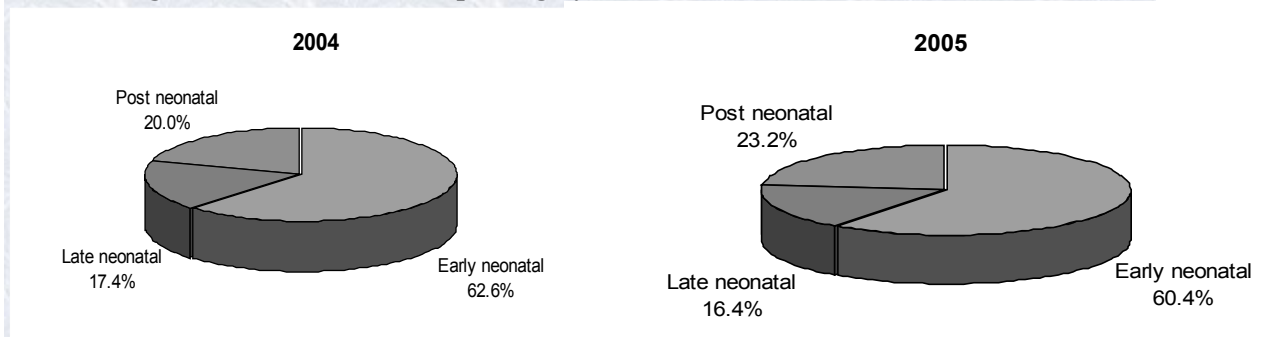
Table 2.6
Infant care provided by Public Health Midwives

Indicators	Performance in 2004		Performance in 2005	
	Number	Percentage	Number	Percentage
Infant Registered by PHMM	296687	82.4	297662	80.3
Home visits made to infants	185854	62.0	184905	62.0
Infant Deaths Reported by PHMM	3528	80.3	3164	76.2
Infant Deaths Investigated by PH staff	2835	80.4	2822	89.2
Neonatal deaths reported	2821	80.0 (of reported infant deaths)	2431	76.8 (of reported infant deaths)
Post neonatal deaths reported	707	20.0 (of reported infant deaths)	733	23.2 (of reported infant deaths)
Perinatal deaths reported	4838		4564	
Child deaths reported (1 year – up to 5 yrs)	804		800	

During 2004, 80 percent of the estimated infant deaths were reported by PHMs of which only 80 percent had been investigated by the public health staff. However, the reporting has been decreased in 2005 where only 76 percent of estimated infant deaths were reported and of which 89 percent was investigated by the health staff. Infant death reporting is a reflection of the care provided by PHMs in the field and the quality of supervision provided by the area supervisors, therefore needs improvements in the future. **Programme Managers should look into this more closely and ensure that all infant deaths are identified and reported by the Public Health Midwives and are thereafter investigated.**

Approximately 80 and 77 percent of the reported infant deaths have occurred during the neonatal period in the years 2004 and 2005 respectively with 63 and 60 percent occurring during the first seven days (early neo-natal period) in the respective years.

Figure 2.7 Infant deaths reporting by PHMM – 2004 and 2005

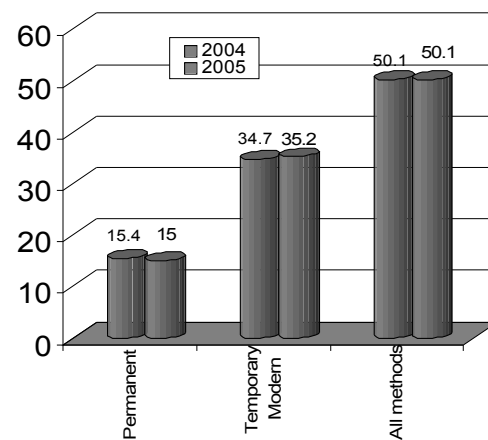


PHMM have reported 4838 and 4564 perinatal deaths in 2004 and 2005 respectively. These data computed a Perinatal mortality rate of 16.6/1000 reported births in 2004 and 15.5/1000 in 2005. The rate reported by public health staff over last four years shows a declining trend. However, efforts should be taken to improve reporting of perinatal deaths with a view to obtaining a realistic estimate of perinatal mortality rate in Sri Lanka.

2.3 Contraceptive use

Ninety eight percent of estimated eligible families were under care of the PHMs by the end of 2005 (3,111,608). Of the eligible couples, 1,509,973 were reported as currently using a modern contraceptive method at the end of 2004 thus computing a current user rate of 50.1 percent for modern methods. This percentage has been the same in 2005 as well (Figure 2.8).

Figure 2.8 Percent of Family planning



The data on current users of FP methods reported by field staff should be interpreted in caution due to existing vacancies of PHMM. Therefore percent of current users was calculated considering the eligible families under care. Almost two thirds (70%) of the reported current users were using a temporary modern method while the balance third (30%) were using permanent methods.

Of the temporary modern methods injectables had the highest use rate followed by the oral pill and the IUD. A slight increase is seen in the number of DMPA and IUD users in the year 2005 compared to 2004. The public health staff had distributed 1,75,9694 and 1,825,982 packets of oral pills and 5040939 and 5250309 condoms in 2004 and 2005 respectively.

Family Planning New Acceptors recruited by the programme during 2004 and 2005 will be discussed in the second part of this report.

Table 2.7
Current users in Family Planning – 2004-2005

Method	Current users of Family Planning			
	2004		2005	
	Number	Percent (of eligible couples)	Number	Percent (of eligible couples)
Temporary Methods: Injectables	523257	17.3	546512	17.6
Oral pills	206863	6.9	214814	6.9
IUD	195635	6.6	205508	6.6
Condoms	115431	3.8	123394	4.0
Implants	5489	0.2	6166	0.2
All Modern temporary methods	1046675	34.7	1096394	35.2
Permanent methods: LRT	440570	14.6	443720	14.3
Vasectomy	22728	0.8	19947	0.6
All Methods	1509973	50.1	1560061	50.1

2.4 Clinic activities

The data published in this section is only in respect of pregnant mothers, infants and pre-school children attending clinics that are conducted in the field and in medical institutions without specialist services. Data from clinics conducted by specialists at the larger medical institutions (Teaching, Provincial and Base Hospitals) are not reported through the routine MCH information system since mothers, specially from areas in close proximity to larger institutions, may attend both the area MCH clinic, as well as the specialists clinic. This would lead to a duplication of statistics. During the years under review, approximately maternal and child care services have been provided through 4032 antenatal clinics and 3302 child welfare clinics. The statistics published under this section are based on the data reported from these clinics.

Table 2.8 Types and Distribution of MCH/ FP Clinics at the end of 2005

Type of clinics	No. of Clinics
Antenatal clinics	
- Single clinics	1197
- Combined clinics	1400
Child welfare clinics	
- Single clinics	809
- Combined clinics	798
Poly clinics	1695
Family planning clinics	1340

Table 2.9 indicates the services provided in MCH clinics at periphery in 2004 and 2005. Approximately 98 percent of the registered pregnant mothers have attended the area

antenatal clinics at least once for antenatal care in both years under the review. An average of 6.5 clinic visits has been made by them during the antenatal period.

On an average, 85 percent of the estimated infants have been brought monthly for infant care to the area Child Welfare clinics in both years under review. However, pre-school children receiving clinic care at least once have been comparatively low with 69 percent in 2005.

Data of infants and children weighed at the village level “field weighing centres” have also been included in order to get a more complete picture of growth monitoring activities in the country. Averages of 77 and 79 percent of infants under care have been weighed at the MCH clinics and at the "field weighing centres” during 2004 and 2005 respectively. Of the infants weighed 9 percent were below 3rd centile in 2004. This proportion has been decreased to 8 percent in 2005 which shows a significant decline compared to the percentage in 2003 (12%).

Table 2.9
Maternal and Child Health Care provided through
field clinics and clinics conducted in smaller medical institutions

Indicators	Performance			
	2004		2005	
	Number	Percent	Number	Percent
Pregnant mothers receiving antenatal Clinic care at least once (first visits)	351686	97.0	363866	98.0
Infants receiving care at clinics At least once (first visits)	304683	84.0	318550	85.0
Pre-school children receiving clinic Care at least once (first visits)	247325	68.0	258184	69.0
Average monthly weighing of infants at clinics and field weighing centres*	252450	77.0	259237	79.0
Infant weighing below 3 rd centile	24143	9.0	23149	8.0
Infants with growth faltering	17581	6.0	17270	6.0
Average monthly weighing of preschoolers (1-3 years)*	359921	57.0	366292	56.0
Weighing below 3 rd centile (1-under 3 years)	94904	26.0	91215	24.0
Weighing showing growth faltering (1-under 3 years)	44241	12.0	43882	11.0
Average monthly weighing of preschoolers (3-5 years)*	283569	45.0	293566	45.0
Weighing below 3 rd centile (3-5 years)	83742	29.0	80558	27.0
Preschoolers with growth faltering (3-5 years)	36482	12.0	36132	12.0
Pregnant mothers BMI tested	86433	27.1	84072	26.6
BMI status <18.5				
BMI 18.5-25	193435	60.6	194290	61.5
BMI >25	39317	12.3	37459	11.9
No. of ANC clinics performing VDRL testing	911		969	
No. of specimens taken for VDRL	118994		137848	
No of VDRL tests reported as reactive	2870	2.4	3099	2.2

(Source: FHB/MCH Quarterly Return: H-509)

* This may have some over reporting since weighing in the clinics and field are amalgamated

In 2004, 26 percent of the pre-schoolers age 1-3 years were below the 3rd centile and 12 percent showed growth faltering while the corresponding figures for 2005 were 24 and 11 percent respectively. Among pre-schoolers aged 3-under 5 years, who weighed below 3rd centile was 29 percent in 2004 compared to 27 in 2005. In the same age group, nearly 12 percent had growth faltering in both years under review. These statistics indicate that the proportion of children with under-nutrition in all three age groups had been decreased from 2003.

Figure 2.9 Percent of under five children children weighed below 3rd centile

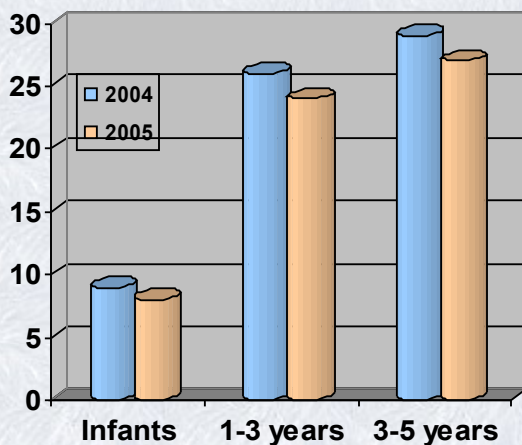
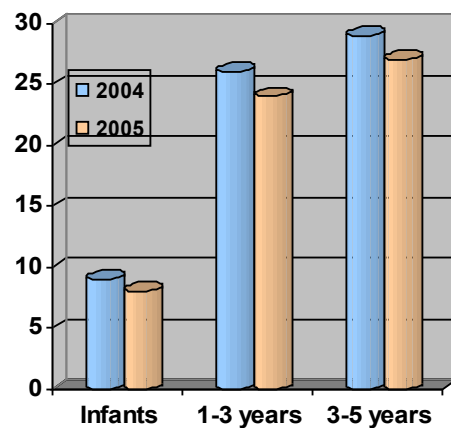


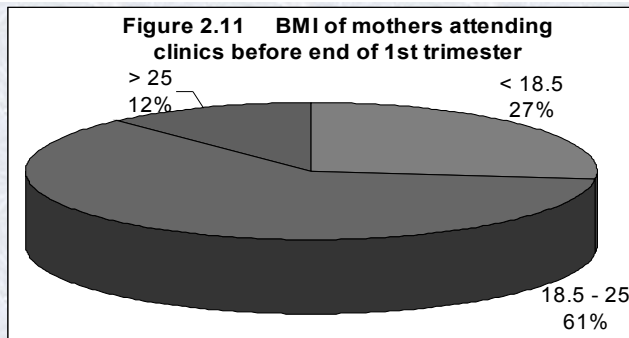
Figure 2.10 Percentage of under five with Growth faltering



The above proportions only give an idea of the nutritional status of infants and children attending the MCH clinics and the village “weighing centres” and will not provide a true picture of the nutritional status of the corresponding groups in the community.

It is essential that area PHMs should ensure that infants and pre-school children within her area are brought either to the clinics or field weighing centres as per instructions given so that their growth patterns could be effectively monitored and mothers advised accordingly.

Of the mothers attending the antenatal clinics in 2004 and 2005, the “Body Mass Index” (BMI) was calculated; majority (61%) had a BMI ranging from 18.5 to 25 which is considered as normal, while 27 percent had a BMI less than 18.5 indicating that they were undernourished at the time of the first visit to the clinic. The balance 12 percent had BMI index more than 25 (Figure 2.11). **The area PHM should make note of these cases and provide necessary advice and guidance on nutrition and food intake during pregnancy and lactation and personally see that the mothers follow the given advice.**



VDRL testing was routinely done in 911 and 969 antenatal clinics during the years 2004 and 2005 respectively. This figure has significantly increased compared to 2003 where only 700 clinics were performing VDRL testing. From these clinics 118,994 and 137,848 blood samples were taken during the respective years. About 2.2 percent of the specimens have been reported as 'reactive' and these cases would have been referred to the regional STD clinic for further investigations and management. The numbers of VDRL testing centres have been increased in 2005 compared to 2004 and it is hoped that more clinics will provide this facility in the years to follow with total coverage seen in the near future.

The above analysis is based on the data forwarded by the DDHS/MOH through the revised Quarterly Maternal and Child Health Return (H 509) which in turn is based on the data provided by the PHM and from the clinics. As such it gives a more comprehensive picture of the MCH activities within the DDHS/MOH divisions. Data compiled according to the Health Regions (DPDHS Areas) are given in Annexe C.

Although data on immunization is received through the Maternal and Child Health Return (H 509), it is used mainly for monitoring district level performance by the Family Health Bureau. Statistics on immunization are published by the Epidemiological Unit of the Ministry of Health and as such is not included in this report.

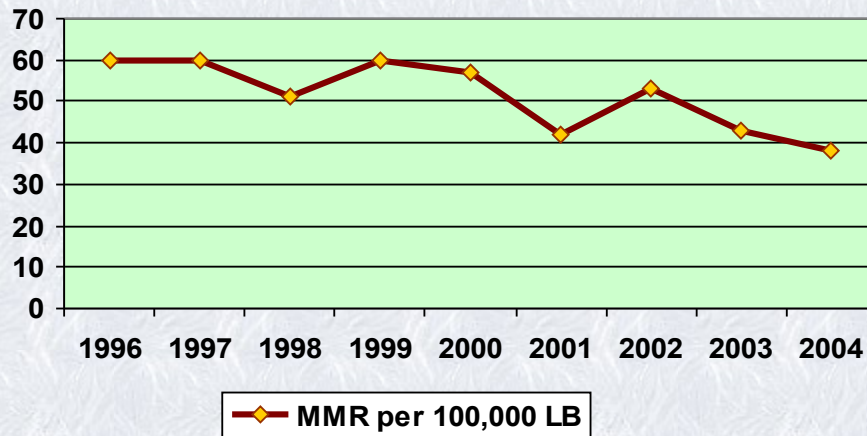
3.0 Maternal Mortality

The statistics published in this section of the report is based on data collected by the Family Health Bureau through the Maternal Death Surveillance System. Although data on maternal deaths is collected by other sources (Registrar General Department, Medical Statistical Unit of the Ministry of Health), data collected through the Maternal Death Surveillance System is considered as more reliable and complete since the deaths are directly notified by the institutions concerned (medical institutions and Health Units) and includes all deaths occurring in the hospitals and the community and also in the estates sector. The relevant authorities thereafter investigate these deaths and are reviewed at the district level and at national level before finalisation.

At the national level, all maternal deaths are annually reviewed and discussed in detail at the Maternal Death Reviews conducted by Family Health Bureau in Collaboration with the College of Obstetricians and Gynaecologists. The probable cause of death is confirmed and the associated factors that may have contributed to the deaths are discussed to prevent such

deaths in the future. It is encouraging to note that there has been a marked improvement in the reporting of maternal deaths through the present surveillance system. In this report maternal mortality statistics of the year 2004 is published as confirmed data on maternal deaths in all districts for 2005 is not available for publication.

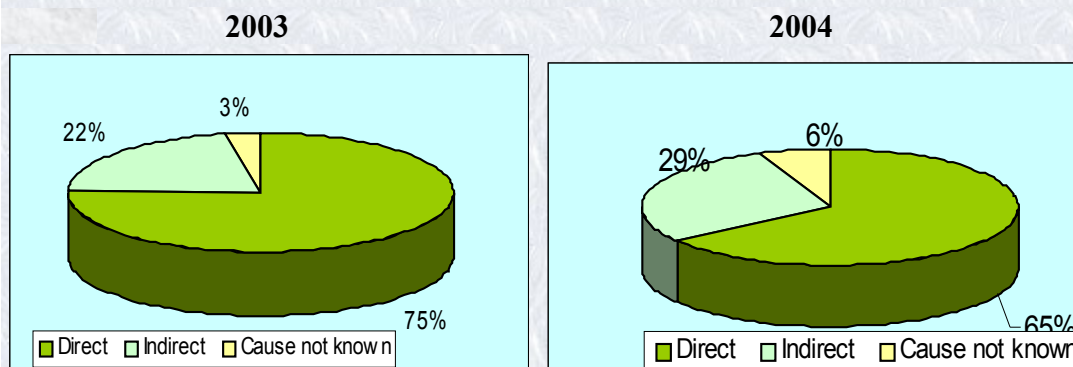
Figure 3.1 Maternal Mortality Ratios 1996 to 2004



During 2004, 239 maternal deaths have been reported by the health staff. Of which only 145 deaths were confirmed at the national reviews as maternal deaths computing a maternal mortality ratio of 38 per 100,000 live births. This was the lowest recorded for last few years (Figure 3.1).

Of the 145 confirmed maternal deaths, ninety four deaths (64.8%) were classified as direct maternal deaths and forty two (29.0 %) as indirect maternal deaths. The classification was uncertain in 9 (6.2 %) confirmed maternal deaths. Respective figures for year 2003 were 75 %, 22 % and 3 %. It should also be noted that the proportion of maternal deaths due to direct causes is less in 2004 when compared to 2003 (75 %) and 2002 (70%). This reflects the advancement in the quality of services provided specially in the larger institutions. It was also noted that during last few years proportion of maternal deaths due to indirect causes has risen and it implies that the different preventive strategies need to be implemented to reduce the MMR further.

Figure 3.2
Proportion of Maternal Deaths due to Direct and Indirect causes 2003 and 2004



The table below indicates the distribution of maternal deaths according to causes for 2003 and 2004.

Table 3.1
Causes of Maternal Deaths

Cause of death	2003		2004	
	No	%	No	%
Haemorrhage (APH, PPH)	30	19.11	32	22.07
Eclampsia & PIH	30	19.11	25	17.24
Heart disease complicating pregnancy	15	9.55	25	17.24
Septic abortion	19	12.10	17	11.72
AF/embolism P/embolism	16	10.19	3	2.07
Ectopic Pregnancy	5	3.18	7	4.83
Postpartum Septicemia	8	5.10	6	4.14
Liver Disease/Viral Hepatitis Complicating pregnancy	7	4.45	6	4.14
Pneumonia / TB	7	4.46	2	1.38
Uterine rupture	6	3.82	2	1.38
Diabetics Mellitus	1	0.64	2	1.38
Bronchial Asthma	0	0.00	2	1.38
Anemia complicating pregnancy	1	0.64	2	1.38
Cause inconclusive	5	3.18	6	4.14
Other causes	8	5.09	8	5.52
Total	157	100.00	145	100.00

Similar to the pattern observed in last few years, in 2004, haemorrhage (antepartum and postpartum) was the leading cause of maternal death followed by eclampsia / PIH and heart disease complicating pregnancy. Emerging of heart disease complicating pregnancy as the 2nd cause of maternal deaths was the most striking feature in 2004. Of the 25 mothers died of heart diseases complicating pregnancy, 15 have had valvular heart disease. **This should be a major concern for the health care providers especially in**

curative sector since these deaths would have been prevented by appropriate screening and case management.

Although there was a slight reduction in the proportion of deaths due to septic abortion and postpartum Septicemia in 2004 as compared to 2003, still a relatively high number of deaths were observed due to these causes. However, air and fat embolism / pulmonary embolism became less significant as a cause of death in 2004 where proportion of death due to this cause has been reduced from 10.2 in 2003 to 2.1 % in 2004.

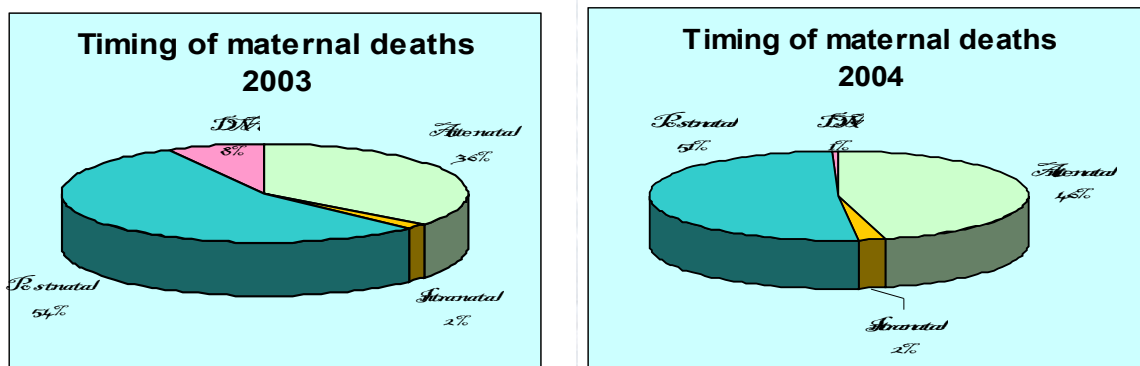
Table 3.2
Distribution of maternal deaths by age and parity

Categories	2004	
	Number	Percent
Age Group		
< 20 Years	12	8.28
20 – 35 Years	99	68.28
> 35 Years	34	23.45
Parity		
Primi	50	34.48
Para 2 to 4	76	52.41
Para > 5	19	13.10
Total	145	100.00

Detailed analysis of maternal deaths revealed, that majority of mothers who died were in the age group of 20–35 years. Approximately 8 percent were teenage mothers which should be taken into account by programme managers as the corresponding figure for 2003 was only 3 percent.

Thirty four percent of maternal deaths in 2004 were in para one while 13 percent of mothers had 5 or more pregnancies. The percentage of mothers died in high risk para shows an increase in 2004 compared to 2003 (P1-30% and P5 and above 11% in 2003) This difference in the two years should be noted by all those involved in provision of comprehensive maternity care.

Figure 3.3 Timing of Maternal deaths – 2003 and 2004

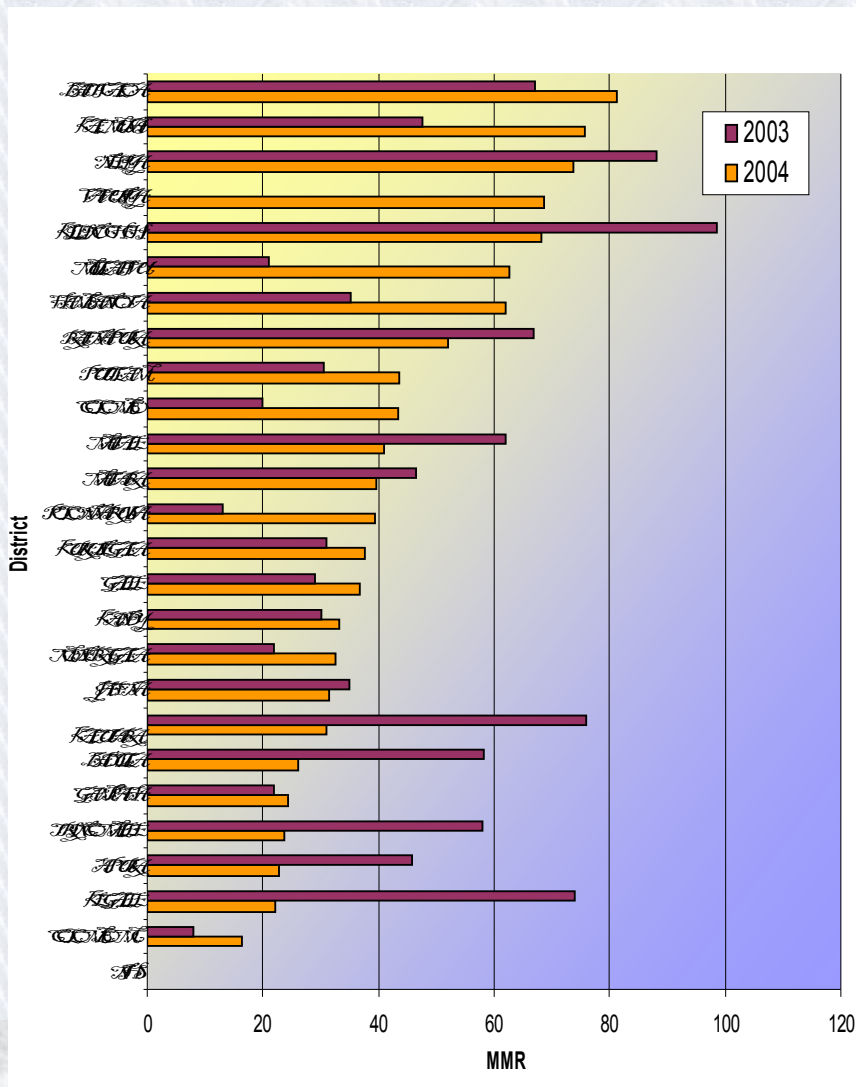


would have been a reflection of improved postnatal care provided by the health staff. It

was also revealed that the proportion of deaths in the antenatal period was increasing, with the figures of 26% from year 2001 to 46% in year 2004. Hence, it is very clear that the care during the antenatal period should be strengthened by all service providers.

Maternal mortality ratios compiled by districts in 2004 is illustrated in the figure 3.4.

District maternal mortality ratios were estimated using the number of reported maternal deaths and estimates of live births for the district. Batticaloa district recorded the highest MMR for the year 2004 while districts Kalmunai, Nuwara Eliya, Vauniya and Killinochchi also recording higher rates. Since maternal mortality ratio is an indicator of the quality of services provided, high ratios would be a reflection of the maternal care services provided in the respective districts. **The Programme managers and administrators should take note of the trend during the years under review and ensure that the quality of maternal care services is improved within the district. Action should be taken to rectify the deficiencies highlighted at the maternal mortality reviews at the district level.**



4.0 School Health Programme

The school population in Sri Lanka is approximately 3.9 million and there are 9766 schools in the country with 47 percent having less than 200 children. More than 60 percent of children in schools are in the adolescent age group of 10 – 19 years.

The implementation of school health programme is the responsibility of both Health and Education Ministries. The Family Health Bureau is the focal point for the school health programme in the Ministry of Health and the services are delivered through Primary Health Care infrastructure. The Family Health Bureau works in close collaboration with the Ministry of Education and other relevant ministries and organizations. The Bureau is responsible for planning, providing guidance, monitoring, evaluation, conducting relevant research and provision of logistics. The provincial education and health authorities are responsible for implementation of the programme in the decentralized system.

The National Working Group on School Health was established in 2001 with the participation of relevant officials from the central and provincial health and educational ministries. Regular meetings of the working group are held where issues related to the School Health Programme are discussed and addressed.

At the district level the overall responsibility of School Health Programme is vested with the Deputy Provincial Directors of Health Services. Medical Officer-Maternal and Child Health is responsible for coordination of school health activities with Family Health Bureau and district health staff.

At the divisional level, the Medical Officer of Health is the responsible officer for implementation of the programme in collaboration with the Ministry of Education. The Public Health Inspector is responsible for organizing the health activities at the local level. In the Municipality areas of Colombo, Kandy and Galle, School Medical Officers have been appointed to implement the School Health Programme.

Advocacy programmes were carried out for policy makers in the Ministry of Education to establish health promoting schools according to WHO criteria. The five major components of this package are as follows;

1. School medical services including counselling services
2. Maintenance of Healthy School Environment
3. Health Education and Development of Life Skills
4. School Community Participation
5. Healthy school policies

School medical services include medical inspection of children, detection and correction of health problems, providing immunization worm treatment, provision of micronutrients to needy children and providing necessary advice on health related issues. Screening is done by the Public Health Inspectors, which is followed by a medical inspection carried out by a Medical Officer. The children are examined and any abnormalities are either treated locally or referred to the closest relevant specialist clinics for necessary management. Thereafter, they are followed up by the Public Health Inspectors to ensure

the correction of defects. In small schools (with enrolment less than 200) all the children are examined once a year while in the larger schools (with enrolment more than 200 children) only students in grades 1, 4 and 7 are routinely examined every year. However, in case of any health problem, children of other grades too could be referred by the class teacher for examination and necessary advice on the day of the SMI. This service was extended to children in Grade 10 to provide health care to adolescent school children in selected districts.

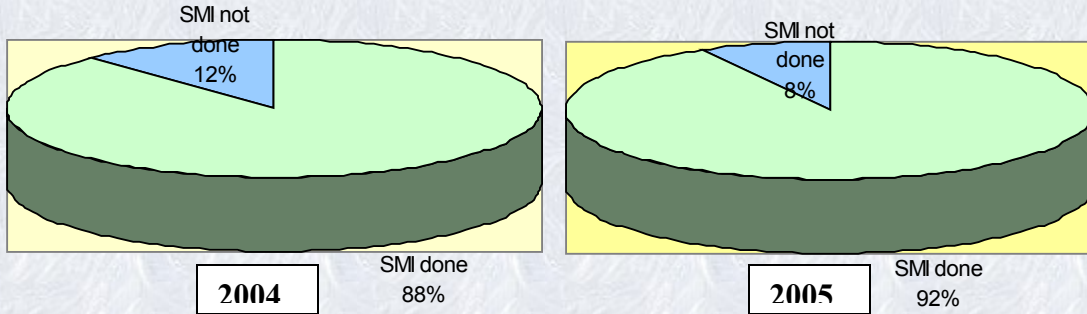
Educational programmes on health and health related subjects are conducted by the health staff to educate the school children on current health problems including HIV/AIDS and other reproductive health problems. Several training programme were conducted for teachers and health staff in collaboration with the Educational authorities, Health committees (eg. School Health Club, Kandurata Suwa kekulu Committee) have been established in schools to organise health programmes within the school and assist children with health related problems.

The Public Health Inspectors conduct an annual sanitation survey in the schools within their ranges. The necessary recommendations are thereafter sent to the school principals for corrective actions. These officers work closely with officials of the Education Ministry and other Government and Non Governmental Organisations to provide services such as safe water, sanitation and refuse disposal.

Special programmes are also conducted for school children on immerging health issues such as anemia, HIV/AIDS, tobacco, alcohol, drug abuse, reproductive health problems, and nutrition. Treatment with antihelminthics followed by weekly treatment with iron, folic acid and vitamin C tablets for a period of six month with the assistance of the class teachers of Grade 7 and 10 and nutrition education were carried out in the districts of Ampara, Ratnapura, Vavuniya, Hambanthota, and Moneragala with very successful results. Programmes were conducted to develop life skills of adolescent school children to reduce risk behaviors for tobacco alcohol, drugs abuse and HIV/AIDS The Family Health Bureau work in close collaboration with the Ministry of Education & Provincial Health & Education staff in the mid day meal programme implemented by the Ministry of Education.

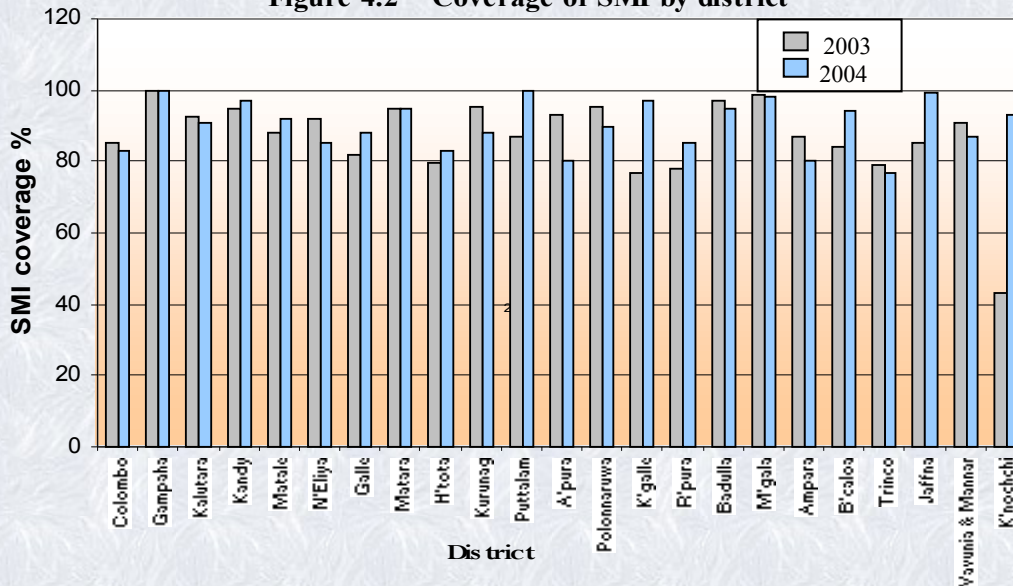
The information presented in this section is based on data reported through the Quarterly School Health Return (H 797). During 2005, medical inspections (SMI) were conducted in 8984 schools giving a total coverage of 92 percent. This shows an increase of 4 percent over that of the previous year.

Figure 4.1 Coverage of School Medical Inspection – 2004 and 2005



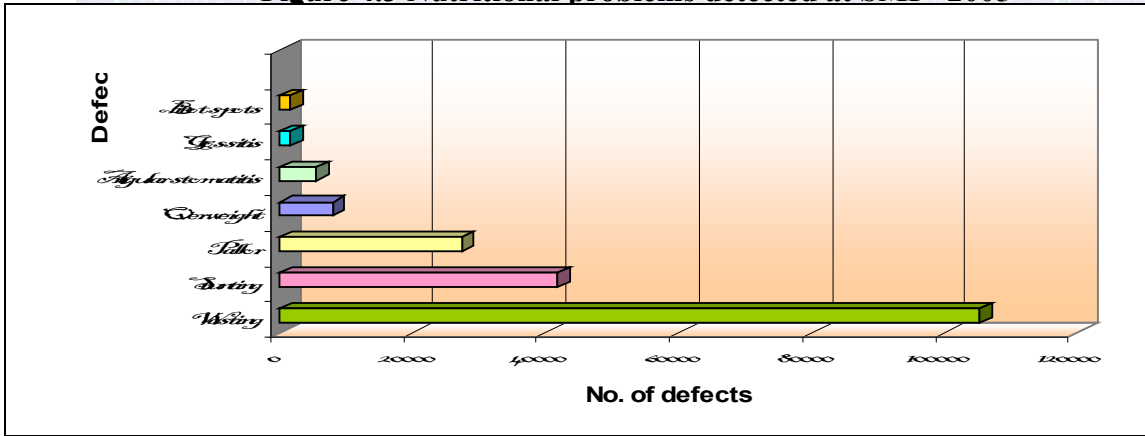
It is encouraging to note that the school medical inspection coverage has improved in many DPDHS divisions. However a reduction in coverage was seen in DPDHS divisions of Kegalle, Ratnepura, Ampara, Trincomalee and Kilinochchi.

Figure 4.2 Coverage of SMI by district



Although a significant increase is seen in the school medical inspections conducted during the year under review, still the reported performance is below the expected target. School medical inspections were low in DPDHS division of Kilinochchi where SMI were conducted only in 43% of the schools. The programme managers should make every effort to improve the coverage of school health activities including school medical inspections since health problems directly influence educational performance.

Figure 4.3 Nutritional problems detected at SMI - 2005



During the SMI, a total of 1007594 children were examined. Dental caries were the commonest health problem with almost 25 percent of the children being affected (MIS-FHB). Wasting was the commonest nutritional problem affecting 10 percent of the children while stunting and pallor ranked next. Percentage of the children reported as overweight for their age was 0.78%. Among the other health problems nearly 15570 children (1.5%) suffered from visual defects and 8726 (0.86%) from cardio-vascular problems.

Figure 4.4 Dental problems detected at SMI

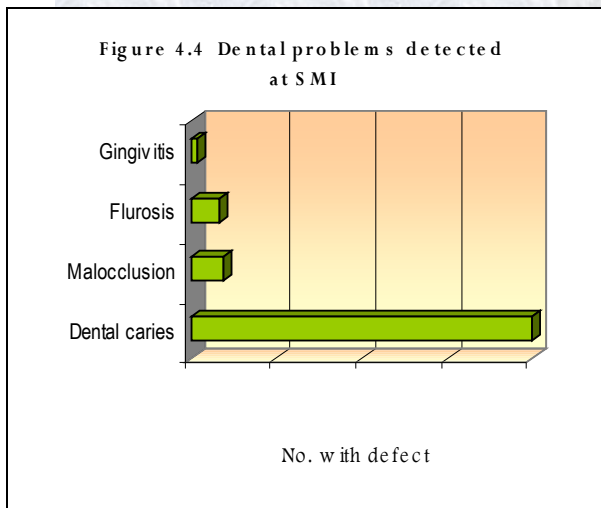
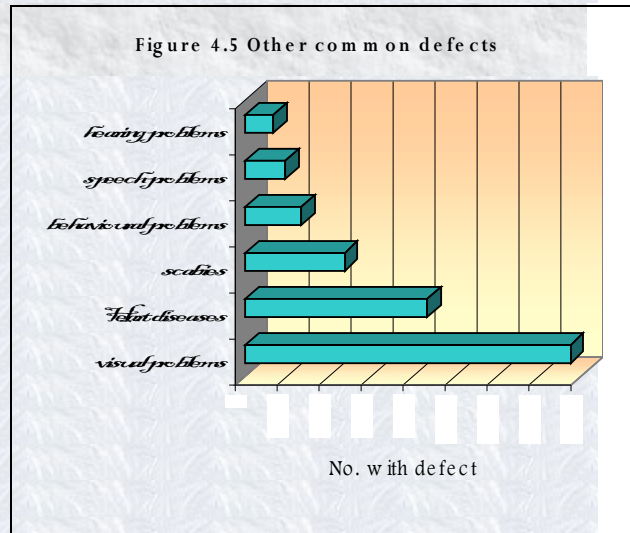


Figure 4.5 Other common defects

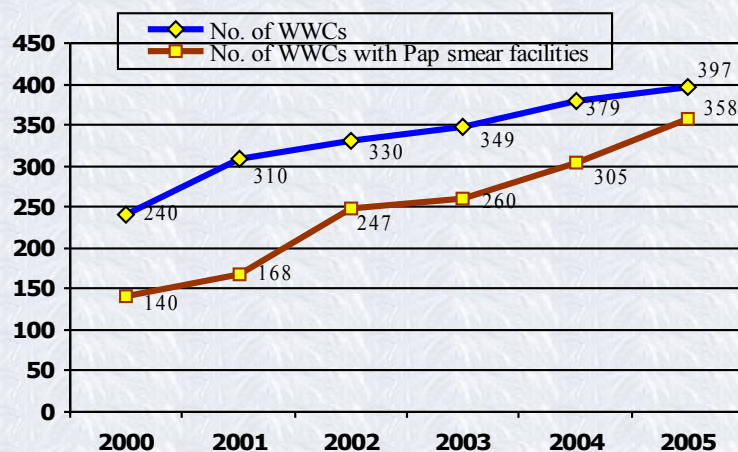


The service providers and programme managers should assess the facilities available for treating these children with specific health problems and strengthen the referral system within the district. **The health staff should make regular follow up visits to the schools as well as follow-up the cases in the field (at home) and ensure that the instructions and advice given are followed.**

5.0 Well Woman Clinic Services

The concept of Well Woman Clinics was introduced in 1996 to screen women for reproductive organ malignancies as part of a reproductive health programme promoted by the international agencies at the International Conference on Population and Development in Cairo in 1994. The screening programme for reproductive organ malignancies (Breast and cervical cancers, and certain other conditions like hypertension and diabetes) was started with the support from UNFPA and “Well Woman Clinics” were established in the Health areas through out the country. At the end of year 2005, 397 Well Women Clinics were functioning in the country, mostly based at MOH offices. These clinics are conducted fortnightly or monthly by trained medical officers and women over 35 years of age could get themselves screened for hypertension, diabetes, breast malignancies and cervical cancers. If any abnormality is detected the clients are referred to the health care system where they would receive appropriate care through the specialist clinics. The PHM of the area will thereafter follow the cases in the field and ensure that the necessary instructions are followed by the clients.

Figure 5.1 Expansion of Well woman clinic services from 2000 to 2005

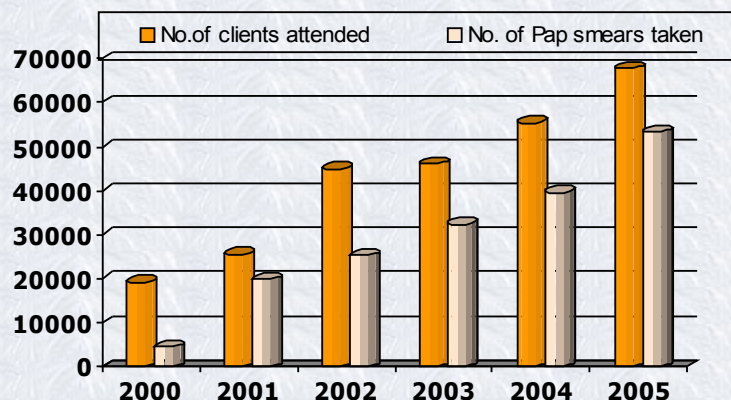


Of the 397 clinics functioning, during 2005 and 358 clinics had provided Pap smear screening facilities. The performance during 2004 and 2005 is indicated in Table 5.1.

Figure 5.2 Population served in Well woman Clinics from 2000 to 2005

Table 5.1 Performance in WWCs in 2004 & 2005

Activity	2004		2005	
	Number	Percent	Number	Percent
Total attending clinics	61707		74165	
1 st visits to clinic	55344	89.7	67820	91.4
under 40 years	19685	35.6	24406	36.0
40 to 60 years	30957	55.9	38659	57.0
Over 60 years	4702	8.5	4755	7.0
No. of women subjected to breast examination	56815	92.1	68816	92.8
Breast abnormalities detected	1222	2.2	1231	1.8
No. of women subjected to cervical visualisation	45064	73.0	59104	79.7
Number of pap smears taken	39719	64.4	53408	72.0
Number of reports received	23363	58.8	30382	56.9
Cervical smears reported as CIN Positives	225	1.0	184	0.6
No. of cases reported as malignant (Carcinoma)	43	0.2	19	0.1
No. with HPV infection	227	1.0	94	0.3
No. with inflammatory change	2227	9.5	2935	9.7
Diabetes mellitus detected	1621	2.9	1968	2.9
Hypertension detected	3702	6.6	4462	6.6



A total of 61,707 women attended the 379 functioning Well Woman's Clinics during 2004. The number of women attended has been increased in 2005 to 74,165. Of the total number attending clinics, nearly 90 percent had attended for the first time. It is encouraging to note that number of clinics and also the attendance have been increased over past few years as a result of the interest paid by the service providers.

At the clinics more than 92 percent of the women were subjected to breast examination with breast abnormalities being detected in 2.2 percent and 1.8 percent in 2004 and 2005 respectively. Women who subjected to cervical visualization has increased up to 79.7 percent in 2005, where that of 2004 was 73 percent. There has been approximately 8 percent rise in the percentage of women who underwent Pap smear testing too.

However the Pap smear reports were received only in 58.8 and 56.9 percent in 2004 and 2005 respectively. Of the reports received nearly one percent were CIN positives and another 10 percent had inflammatory changes. The evidence of malignancy was seen among 43 women (0.2%) in 2004 and in 19 (0.1%) during 2005. All cases showing abnormality would have been referred to the closest Gynaecology clinics for appropriate management and follow-up.

In both years 2.9 and 6.6 percent of the clients were detected as suffering from diabetes and hypertension respectively.

It is encouraging to note that more women are beginning to utilize the services of Well Woman Clinics, therefore clinic attendance has been increased in 2005 as compared to the previous years.

Although the total screened is still only a fraction of the target population, it is hoped that more women would seek the services of these clinics for routine screening against non-communicable illnesses in the future.

Figure 5.3 Areas with low performance of WWC services

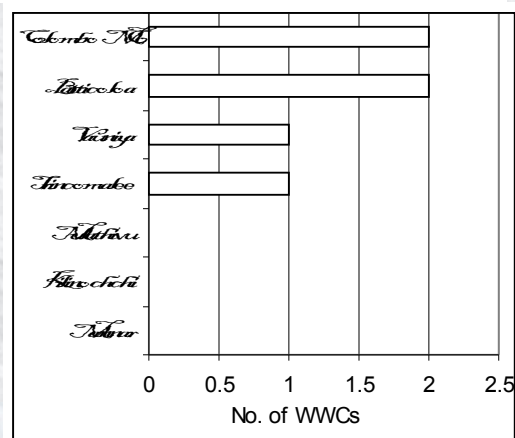


Figure 5.2 shows that, number of functioning clinics in Trincomalee, Mannar, Batticaloa, Vavuniya, Kilinochchi, Mullathivu and Colombo MC are inadequate and **it is essential that the programme managers of these districts take necessary action to establish a few more clinics making the screening services more accessible to women in the districts.**

The programme authorities both at the centre as well as the periphery should take appropriate measures to further expand the Well Woman Clinic services to meet any additional demand that may arise in the near future. Also it needs to be emphasised that adequate facilities for examining ‘Pap smear’ should be made available and the reporting improved if the anticipated benefits are to be achieved. The performance in well woman clinic activities in districts is tabled in the Annex B II.

6.0 Activities conducted by the Family Health Bureau

6.1 Foreign funded projects

The following foreign funded projects were implemented by the Family Health Bureau during 2004 and 2005 in close collaboration with the Provincial Health Authorities and other relevant divisions of the Ministry of Health.

Table 6.1
Foreign funded projects

Project	Funding Agency
Reproductive Health Services	UNFPA
Reproductive Health Services in Conflict Affected areas	UNFPA
Development of Family Health Programme	WHO
Safe Motherhood	UNICEF
Women's Right to life and Health	UNICEF
Early Childhood care and Development	UNICEF
Expanded Programme on Immunization	UNICEF

6.2 In-service training programmes conducted by FHB

A large number of training programmes had been conducted either at the Family Health Bureau or at the periphery with necessary support from the Family Health Bureau for different categories of health staff. In addition to training, twenty-two maternal death reviews were conducted in the provinces in collaboration with the provincial/district health authorities.

6.3 Clinical Services provided at the FHB

The clinic centre at the Family Health Bureau functions daily and provides family planning services and services for management of sub-fertility. The activities carried out at the above centre during the period 2004 - 2005 are listed below.

During 2004 and 2005, the number of clients utilising services at FHB has been increased. In 2005, 2101 Laparoscopic Sterilisations, 20 Vasectomies have been performed and 187 new IUD acceptors have been recruited. Couples seeking treatment for infertility has also been increased over the years.

Table 6.2
In-service training programmes conducted by FHB

Training Programme	Duration	No. of Programs conducted in 2005
Lactation Management Training for Field and Institutional Staff	5 days	44
Lactation Management Training - Training of Trainers(TOT)	1 day	02
TOT on family planning counseling	1 day	01
Training on IUD insertion and Depo Provera	5 days	09
Perinatal mortality and morbidity reduction programme	1 day	01
Training on Revised RH Management Information System for PH supervisory staff	2 days	03
Training of School Teachers	1 day	04
Training of trainers on Health promoting schools	1 day	04
Training of trainers on School Health	1 day	01
Integrated management of childhood infections	1 day	08
Emergency obstetric care training	5 days	06
Training of PHC staff on Group counselling	2 days	22
Training of trainers on Early Childhood care and Development	5 days	03
Training of labour room staff on birth weight surveillance	1 day	06
MLT training programme on cervical cytology screening	21day	01
Training of central staff in Neonatalgy	1 day	03
Complimentary feeding programme	1 day	03
Training of trainers on Growth monitoring and promotion	2 days	01
Training of district and central level managers on management	1 day	01
Logistic management training	1 day	03
Maternal Death Reviews	1 day	24

Table 6.3
Clinical Services provided at the FHB

Services provided	2001	2002	2003	2004	2005
Laparoscopic Sterilization	1367	1635	1768	1863	2101
Vasectomy	9	8	20	08	20
IUD Insertion – New	217	223	200	175	187
Injectable - New	84	22	42	18	30
Implant - New	215	212	278	250	140
Infertility - New	374	498	787	325	320
-Re visits	15	8	8	633	507
Diagnostic Laparoscopy	15	8	8	05	-
Artificial Insemination by Husband				132	136

In addition to the above a Well woman clinic and an immunization clinic too are being held once a week at the Family Health Bureau.

7.0 Family planning

This section of the report presents data on new acceptors of modern contraceptive methods recruited by the National Family Planning Programme in 2004 and 2005. The information is based on data collected by the Family Health Bureau through the routine reporting system of the Ministry of Health and includes statistics of new acceptors recruited by both government and non-governmental organizations. Data in respect of new acceptors for modern family planning methods is routinely forwarded to the Research and Evaluation Unit of the Family Health Bureau by all Government Health Institutions providing family planning services, Public Health Staff and Non Governmental Organizations (NGOs) providing family planning services under the national programme (FPASL, PSL, and SLAVSC).

Family Planning Acceptance

During 2005, a total of 221,016 new acceptors¹ were recruited by the programme recording an increase of 4.5 percent compared to 2004. The temporary methods accounted for 95.3 percent of the acceptors during 2005 while sterilizations accounted for only 4.7 percent. As compared to the previous year, a 5.0 percent increase was recorded for modern temporary methods where as a 5.9 percent reduction is observed in permanent methods. However, the upward trend of new acceptors from 2004 to 2005 has been mainly due to increase in acceptance of modern temporary family planning methods.

Table 7.1
Distribution pattern of new acceptors by method 2004 and 2005

Method	2004		2005		Percent change
	Number	%	Number	%	
Tubectomy	10879	5.1	10228	4.6	-6.0
Vasectomy	97	0.1	99	0.0	2.1
Permanent methods	10976	5.2	10327	4.7	-5.9
I.U.D	34785	16.4	39109	17.7	12.4
Orals Pills	44094	20.8	46688	21.1	5.9
Injectables	119714	56.6	123101	55.7	2.8
Nor-Plant	1985	0.9	1791	0.8	-9.8
Temporary Methods	200578	94.8	210689	95.3	5.0
All modern methods	211554	100.0	221016	100.0	4.5

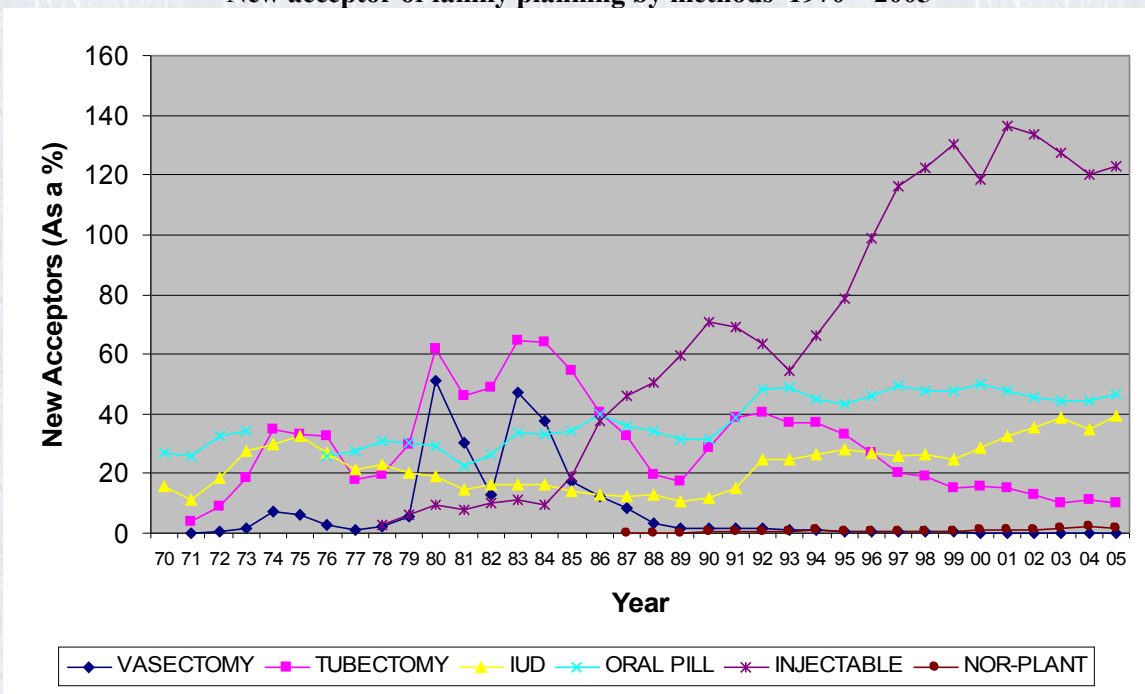
¹ New acceptors in this report refer to those accepting the particular contraceptive method for the first time from the national programme.

In 2005, the injectable was the most widely accepted contraceptive accounting for 55.7 percent of the total new acceptors while the Oral pill, IUD and Norplant accounted for 21.1, 17.7 and 0.8 percent respectively.

Acceptance of all temporary modern methods has increased except Norplant in year 2004 as compared to 2005. Intra uterine device recorded the highest increase of 12.4 percent while injectables showed the lowest increase of 2.8 percent. This increase in the acceptance of IUD is commendable and is probably the result of the continued emphasis given for its use by the national and provincial authorities. There was 9.8 percent reduction in Norplant acceptance. This should be considered in the context of limited services. Norplant is currently available only at certain clinic centres where the Medical Officers have been trained in its insertion and therefore the numbers accepting still remains small.

The change in the number of new acceptors over the past 3 decades was showed in figure 7.1.

Figure 7.1
New acceptor of family planning by methods 1970 – 2005



Number of new acceptors of injectables has increased from 2004 to 2005 in almost all districts where the rise in Kilinochchi and Batticaloa was prominent. New acceptors of IUD have significantly increased in the year 2005 in districts of Anuradhapura and Kurunegala, Polonnaruwa and Ampara compared to the previous year. In the North and East, IUD acceptance had been low for a considerable period of time (Annex AII). It is essential that the programme managers look into this closely and take necessary action to improve facilities, and trained man power for IUD services at the peripheral family planning clinics. This is very important in today's context since IUD is the most cost-effective method of family planning in Sri Lanka.

The permanent methods accounted for only 4.7 percent of the new acceptors with only 10327 sterilizations performed during 2005. This shows a decrease of 5.9 percent over that of the previous year. This low level is probably due to the lack of facilities and inadequate motivation among the service providers. Provincial health administrators and Medical Officers Maternal and Child Health should assess the situation in their respective districts and make necessary arrangements to improve the service delivery system within their areas. Only 99 vasectomies were performed during 2005 in contrast to the large numbers performed during the early eighties. **It is also important to identify reasons for poor male motivation and develop appropriate strategies to improve its acceptance.**

Acceptor rates per 1000 married women in the reproductive age group from 1990 to 2005 are shown in Table 7.2.

Table 7.2

New acceptor rates per 1000 married women 1990 - 2005

Year	Permanent Methods		Temporary Methods		All Methods	
	Number	Rate	Number	Rate	Number	Rate
1990	30332	12.1	114316	45.5	144648	57.6
1991	40542	16.0	123330	48.5	163872	64.5
1992	42031	16.4	136904	53.3	178935	69.7
1993	38315	14.8	131374	50.7	169689	65.5
1994	37839	14.4	138450	52.7	176289	67.1
1995	33625	12.6	150101	56.6	183726	69.3
1996	27454	13.8	172059	86.2	199513	74.6
1997	20816	9.8	191819	90.2	212635	78.6
1998	19526	7.2	196631	72.0	216137	79.3
1999	15186	5.5	203087	74.1	218273	79.6
2000	15741	5.5	198886	72.4	214627	78.2
2001	15217	5.2	218105	75.2	233322	80.4
2002	13743	4.7	215619	74.6	229362	79.4
2003	11056	3.8	212622	73.6	223678	77.4
2004	10976	3.7	200578	68.6	211554	72.3
2005	10327	3.5	210689	71.5	221016	75.0

The acceptor rate for all methods increased from 57.6 per 1000 in 1990 to 80.4 in 2001. Thereafter the rate was declining until the year 2004. In 2005 there was an increase in new acceptor rate (75/1000MWRA) compared to rate of 72.3 per 1000 married women in 2004. It should be noted that in general there was an increase in the acceptance of temporary modern methods during the last 15 years whilst acceptance of permanent methods recorded a significant decrease since 1992.

Acceptance according to Age

Acceptance according to age group is shown in Table 7.3. There was a gradual reduction in the acceptance of modern methods with the increase in the age categories in both year 2004 and 2005 where the highest rates of 172.7/1000MW and 167.8/1000 MW were reported in the age group 15-19 years respectively. This pattern is similar to that of the previous years. When compared to the previous year, in 2005 a decrease in acceptance rates were seen in the age groups of 15- 19 and 20-24 years. Comparatively, the acceptance rate of older age groups (35 years and above) has shown an increasing trend over past five years.

Table 7.3

New acceptor rate per 1000 married women for all modern methods by age group 1999 to 2005

Age Group	1999	2000	2001	2002	2003	2004	2005
15-19	195.4	190.6	191.6	188.0	182.3	172.7	167.8
20-24	162.3	163.7	177.3	170.0	171.4	163.4	160.3
25-29	120.6	115.5	123.1	116.7	113.6	113.1	119.9
30-34	79.6	78.7	85.7	82.3	81.1	75.4	76.6
35-39	42.5	43.1	45.2	44.1	42.6	41.2	45.6
40-44	10.7	10.4	11.9	12.4	12.5	12.5	13.8
45-49	1.1	1.0	1.3	1.3	1.4	1.4	2.0
Total	79.6	78.2	80.4	79.4	77.4	72.3	75.0

The acceptance rate for permanent and temporary methods by age groups for year 2004 and 2005 are shown in Table 8.4 and Table 7.5.

Table 7.4

New acceptor rate per 1000 married women for Permanent and Temporary methods by age group - 2004

Age Group	Permanent Methods		Temporary Methods		Total	
	Number	Rate	Number	Rate	Number	Rate
15-19	4	0.0	17176	172.7	17180	172.7
20-24	196	0.5	61134	162.9	61330	163.4
25-29	2930	5.3	59906	107.8	62836	113.1
30-34	4498	7.8	39210	67.6	43708	75.4
35-39	2583	5.6	16423	35.6	19006	41.2
40-44	698	1.8	4211	10.7	4909	12.5
45-49	30	0.1	422	1.3	452	1.4
Unspecified	2096		2133		37	
Total	10976	3.8	200578	68.6	211554	72.3

Table 7.5
New acceptor rate per 1000 married women for Permanent and Temporary methods by age group - 2005

Age Group	Permanent Methods		Temporary Methods		Total	
	Number	Rate	Number	Rate	Number	Rate
15-19	2	0.0	16812	167.7	16814	167.8
20-24	142	0.4	60489	159.9	60631	160.3
25-29	2645	4.7	64486	115.2	67131	119.9
30-34	3989	6.8	40797	69.8	44786	76.6
35-39	2688	5.8	18519	39.8	21207	45.6
40-44	715	1.8	4732	12.0	5447	13.8
45-49	52	0.2	609	1.9	661	2.0
Unspecified	94		4245		4339	
Total	10327	3.5	210689	71.5	221016	75.0

The highest acceptance was recorded in the 30 to 34 age groups for permanent methods and the acceptance rate has come down towards the extremes of the age in both years under review.

For temporary modern methods, the acceptor rate was highest in the age group 15-19 years and it has been gradually decreased with the increasing age in both 2004 and 2005. It was also noted that the increase in acceptance of modern family planning methods in 2005 as compared to 2004 was mainly due to the increase in acceptance of temporary modern methods.

Table 7.6
Distribution of new acceptors of Permanent method by age of female 2001 to 2005

Age Group	2001		2002		2003		2004		2005	
	Number	%	Number	%	Number	%	Number	%	Number	%
15-19	5	0.0	3	0.0	4	0.0	4	0.0	2	0.0
20-24	301	2.0	281	2.0	199	1.8	196	1.8	142	1.4
25-29	4685	30.8	3790	27.6	2666	24.1	2930	26.7	2645	25.6
30-34	6019	39.6	5528	40.2	4577	41.4	4498	41.0	3989	38.6
35-39	3374	22.2	3252	23.7	2822	25.5	2583	23.5	2688	26.0
40-44	719	4.7	773	5.6	694	6.3	698	6.4	715	6.9
45-49	41	0.3	53	0.4	44	0.4	30	0.3	52	0.5
Unspecified	73	0.5	63	0.5	50	0.5	37	0.3	94	0.9
Total	15217	100.0	13743	100.0	11056	100.0	10976	100.0	10327	100.0

Table 7.6 shows that approximately 64.0 percent of sterilizations were performed on women between 25-34 years or on men whose spouses were in the 25-34 age group. However, the percentage of families who accepted permanent methods has increased in all age groups above 35 years in 2005 compared to the previous year. One point four

percent of sterilizations (144) had been performed in 2005 on families with a women aged below the eligible age for sterilization in Sri Lanka.

Table 7.7
New acceptors of temporary modern methods by age of female
2001 to 2005

Age Group	2001		2002		2003		2004		2005	
	Number	%	Number	%	Number	%	Number	%	Number	%
15-19	19216	8.8	18446	8.6	17899	8.4	17176	8.6	16812	8.0
20-24	66799	30.6	65750	30.5	65011	30.6	61134	30.5	60489	28.7
25-29	64266	29.5	63224	29.3	62719	29.5	59906	29.9	64486	30.6
30-34	44080	20.2	43842	20.3	42702	20.1	39210	19.5	40797	19.4
35-39	17665	8.1	17812	8.3	17534	8.2	16423	8.2	18519	8.8
40-44	3983	1.8	4258	2.0	4403	2.1	4211	2.1	4732	2.2
45-49	392	0.2	399	0.2	424	0.2	422	0.2	609	0.3
Unspecified	1704	0.8	1888	0.9	1930	0.9	2096	1.0	4245	2.0
Total	218105	100	215619	100	212622	100.0	200578	100.0	210689	100.0

Among acceptors of temporary modern methods, the highest proportion was in the age group 20 to 24 years, being closely followed by women in 25 to 29 age group in year 2004 while the reverse is observed in year 2005. It is seen that acceptance of temporary modern methods has been decreased with the advancement of the age of females (Table 7.7).

Table 7.8
Mean age at acceptance according to method
1997 to 2005

Method	Mean Age									
	1997	1998	1999	2000	2001	2002	2003	2004	2005	
Tubectomy	31.2	31.4	31.6	31.7	31.8	32.3	32.6	32.4	32.7	
Vasectomy	32.6	33.6	33.0	34.2	34.4	35.5	35.9	35.9	35.8	
IUD	27.0	27.4	26.6	27.7	27.8	28.0	28.2	28.5	28.8	
Oral Pill	26.9	26.9	27.1	27.1	27.2	27.1	27.1	27.2	27.3	
Injectable	26.0	26.7	26.3	26.2	26.5	26.6	26.7	26.8	27.1	
Norplant	27.0	26.5	27.8	26.9	26.4	26.7	27.7	26.9	26.9	

In 2005, the mean age at the time of acceptance of tubectomy was 32.7 years while that of the spouses of those vasectomized was 35.8 years. The mean ages computed for temporary modern methods: IUD, Oral Pills, Injectables and Norplant were 28.8, 27.3, 27.1 and 26.9 respectively in 2005. This shows that in general there was no much difference in the mean age at the time of acceptance of modern methods over last few years (Table 7.8).

Acceptance according to the Number of Living Children

The acceptance pattern of modern contraceptives by number of living children is shown in Tables 7.9 and 7.10.

Table 7.9

**New acceptors of permanent method by number of living children
2002 to 2005**

Number of Living Children	2002		2003		2004		2005	
	Number	%	Number	%	Number	%	Number	%
1	60	0.4	50	0.5	57	0.5	89	0.9
2	1312	9.5	1301	11.8	1205	11.0	1495	14.5
3	7442	54.2	5430	49.1	6056	55.2	5344	51.7
4	2760	20.1	2377	21.5	2294	20.9	2029	19.6
5	1357	9.9	1218	11.0	869	7.9	872	8.4
6	453	3.3	391	3.5	294	2.7	215	2.1
7+	281	2.0	234	2.1	149	1.4	123	1.2
Unspecified	38	0.3	16	0.1	36	0.3	89	0.9
Total	13743	100.0	11056	100.0	10976	100.0	10327	100.0

Table 7.9 shows that, in 2005 approximately 50 percent of the families had three living children at the time of sterilization while another 19.6 percent had four. In both 2004 and 2005 more than 85 percent of families resorted to sterilization only after having three or more living children and more than 12 percent even had five or more living children at the time of sterilization. It is surprising to note that there were 89 clients who have undergone sterilization after the first child in 2005, which cannot be considered as a suitable method for such couples.

**Table 7.10
Acceptors of temporary modern methods by number of living children
2002 to 2005**

Number of Living Children	2002		2003		2004		2005	
	Number	%	Number	%	Number	%	Number	%
0	9222	4.3	9128	4.3	8621	4.3	8988	4.3
1	107382	49.8	107027	50.3	102513	51.1	106661	50.6
2	65193	30.2	64270	30.2	59870	29.8	63775	30.3
3	22931	10.6	22057	10.4	20319	10.1	21016	10.0
4	6745	3.1	6283	3.0	5500	2.7	5382	2.6
5	2374	1.1	2116	1.0	1766	0.9	1741	0.8
6	819	0.4	729	0.3	576	0.3	609	0.3
7+	645	0.3	582	0.3	548	0.3	527	0.3
Unspecified	308	0.1	430	0.2	865	0.4	1990	0.9
Total	215619	100.0	212622	100.0	200578	100.0	210689	100.0

In both years under preview, almost 50 percent of acceptors of temporary modern methods had commenced using the method after the birth of the first child. Almost one third of the temporary method acceptors had two living children. It is worthy of note that only 4.3 percent had commenced using a temporary modern method to postpone their first pregnancy.

Nearly 15 percent of the acceptors of temporary modern methods had three or more living children although ideally they should have accepted a permanent method. It may be that either these clients did not have ready access to sterilization facilities, or they did not want to select a permanent method to control their fertility. **This reiterates the importance of providing adequate facilities for sterilization making the services easily accessible to**

the local population and to adequately counsel those couples with more children so that they would be motivated to accept a permanent method of contraception rather than resorting to temporary methods.

Average number of children at the time of accepting contraception is shown in Table 7.11.

Table 7.11
Average number of children at the time of accepting contraceptive method – 2000 to 2005

Method	2000	2001	2002	2003	2004	2005
Vasectomy	2.8	2.8	3.0	2.6	2.6	2.7
Tubectomy	3.4	3.5	3.8	3.5	3.4	3.3
IUD	1.7	1.8	1.9	1.8	1.8	1.8
Orals Pills	1.6	1.5	1.6	1.4	1.4	1.4
Injectable	1.6	1.7	1.8	1.7	1.6	1.6
Norplant	1.9	1.8	1.9	1.9	1.8	1.9

In 2005, the average number of children among clients undergone vasectomies was 2.7 whereas for tubectomy it was 2.7. The average number of children among females at the time of accepting temporary methods was lesser than those accepted permanent methods.

Acceptance according to Level of Education

Statistics revealed that, greater majority of acceptors of modern methods, both temporary and permanent had either a primary or secondary level of education while only a negligible proportion has had an education of GCE/ A level and over. The distribution of new acceptors of modern contraceptives by level of education in 2004 is shown in Table 7.12.

Table 7.12
Acceptors of permanent and temporary modern methods by level of Education – 2004

Education	Permanent Methods		Temporary Methods	
	Number	%	Number	%
No schooling	678	6.2	4366	2.2
Grades 1 – 5	2762	25.2	16941	8.4
Grades 6 – 10	7250	66.1	177914	88.7
GCE A Level & Over	4	0.0	131	0.1
Unknown	282	2.6	1226	0.6
Total	10976	100.0	200578	100.0

As shown in Table 7.13, of the new acceptors of permanent methods in 2004, 6.2 percent had no schooling while 25.2 percent and 66.1 percent had studied up to grade 1 - 5 and grade 6 - 10 respectively. Majority of the clients (88.7 %) who are using temporary method had studied up to grade 6 -10. Only 131 clients had an education of GCE Advance Level and above.

The pattern of level of education among acceptors is more or less similar in 2005, where most number of clients of both temporary and permanent methods had been educated up to Grade 6-10 (Table 7.13). In both years under review, similar to previous years temporary method acceptors had a better educational status compared to that of permanent method acceptors.

Table 7.13
Acceptors of permanent and temporary modern methods
by level of Education - 2005

Education	Permanent Methods		Temporary Methods	
	Number	%	Number	%
No schooling	755	7.3	4178	2.0
Grades 1 – 5	2305	22.3	16792	8.0
Grades 6 – 10	6998	67.8	187566	89.0
GCE A Level & Over	11	0.1	976	0.5
Unknown	258	2.5	1177	0.6
Total	10327	100.0	210689	100.0

Performance of DPDHS Divisions

The acceptor rates per 1000 married women in the reproductive age (MWRA) according to DPDHS Divisions are shown in Annex B (Table II).

Acceptors reported by the Family Health Bureau (FHB), Population Services Lanka (PSL) and the Family Planning Association of Sri Lanka (FPASL) are included under DPDHS Colombo although they do not come under the purview of the Provincial administration.

A considerable number of clients who obtained services at the above institutions come from areas outside the Colombo District. As such the acceptor rate computed for DPDHS Colombo is not a reflection of the services provided by the DPDHS Division or the acceptance within the Colombo District.

Monaragala district showed the highest acceptor rate in both 2004 and 2005; 105.0/1000 MWRA and 121.2/1000 MWRA respectively and it is commendable in view of the availability of facilities. The district of Polonnaruwa reported the second highest rate of 92.1/1000 MWRA in year 2004 and became the third highest in year 2005 (96.6/1000 MWRA).

Mannar (42.7/1000MW), Kalmunai(39.2/1000 MW) and Kilinochchi (30.1/1000 MW) have recorded low acceptance rates in year 2005.

Annex A I shows the trend of the pattern of acceptance of family planning methods over the last few years. Annex A II illustrates new acceptor pattern by districts – A VI show certain demographic characteristics of the FP acceptors of 2004 and 2005. Annex B I and B II show progress of school medical inspection and Well woman clinic activities.