ANNUAL REPORT

FAMILY HEALTH BUREAU 2014

Family Health Bureau
Ministry of Health
Sri Lanka

Annual Report
of
Family Health Bureau
2014

Family Health Bureau
Ministry of Health
Sri Lanka

Family Health Bureau

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Preface

The Family Health Bureau of the Ministry of Health, Sri Lanka is pleased to present the 24th Annual Report on Family Health Programme. The Programme is dedicated in embarking on its responsibilities to ensure optimal health for women, infants, children and families. It is predominantly operating through the public health service network possessing linkages with curative health services, concerned government departments, professional organizations, development partners and other relevant stakeholders.

Reproductive Health - Management Information System of the Family Health Programme routinely collects data on programme implementation and the outcome / impact which is also assisted with surveillance. The information generated is continuously being utilized for programme redirection at the central level and provides feedback to the grass root level public health staff on their untiring efforts. The stakeholders of the programme also receive feedback on their contributions to maintain the smooth conduct of the programme.

The succinct format of this report is intended to facilitate the use of the information as a snapshot of the programme's progress towards the goals set out in the national maternal and child health policy and strategic plans.

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Acknowledgments

This report provides the progress that the programme made over recent years and the stakeholders of the Programme need to be gratefully remembered.

The support given by the Government of Sri Lanka, Ministry of Health by identifying the Family Health Programme as a key element in the health system should be appreciated and it is this sustained strength that had made the Programme grow over the decades.

The continuous technical inputs given by the Professional colleges; Perinatal Society of Sri Lanka, Sri Lanka college of Obstetricians and Gynaecologists, Sri Lanka College of Paediatricians, College of Pathologists of Sri Lanka and College of Community Physicians of Sri Lanka should always be appreciated.

Technical as well as the financial supports rendered by the development partners; World Health Organization, United Nations Population Fund, United Nations Children's Fund, GAVI-HSS and the World Bank have always strengthened the Programme.

Dr. B. V. S. H. Benaragama, Director/Maternal and Child Health and Dr. Chithramalee de Silva, Deputy Director/Maternal and Child Health for their guidance and all Consultant Community Physicians for their inputs need to be thankfully remembered. A special word of appreciation to Dr. Neil Thalagala, Consultant Community Physician of the Family Health Bureau, for his assistance in editing this report. A special thanks also should go to Medical Officers, Dr Buddhika Samarawickrama, Dr. Sanjeewani Karunaratne and Dr. Priyanga Senanayake and Mrs. Lasantha Hapuarachchi, Programme Planning Assistant of Planning, Monitoring and Evaluation unit for their support in preparing this report.

The public health staff from all over the country who has always made immense efforts to send the completed timely returns should be highly regarded. Mr. Sarath Gamage, Former Assistant Director (IT), Mrs. Pushpa Munasinghe, Senior Statistician and the staff of the Planning, Monitoring and Evaluation unit deserves to be lauded for the effort they have taken to make the data management and quality assurance process smooth and efficient.

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Summary Statistics

Indicator	Data	Year	Source
Demographic			
Total population	20,771,000	2014	**Registrar General's**
Age distribution ('000) 0 -14 years **15 - 64 years** **65 years over**	5,222 13,834 1,687	2014	**Central Bank Report**
Live births[2] Total **Male** **Female**	349,715 177,840 171,875	2014	**Registrar General's Department**
Surface area (Sq. km)	62,705	2014	**Statistical Data Sheet 2014 Department of**
Population density (Persons per sq. km)	331	2014	**Department of Census and Statistics**
Population growth rate (%)	0.9	2014	
Rate of Natural Increase (per 1000 population)	11.7	2013	**Central Bank Report**
Crude Birth Rate (per 1000 population)[2]	16.9	2014	**Registrar General's Department**
Crude Death Rate (per 1000 population)[2]	6.2	2014	
Urban population (%)	18.2	2012	**Department of Census & Statistics**
Sex ratio at birth (No. of male births per 100 female births)	103.5	2014	**Department of Census & Statistics**
Child population (<5 year)%	8.6	2014	**Department of Census and Statistics 2012**
Women in the reproductive age group (15-49 years)%	51.0	2012	
Average house hold size (number of persons)[3]	3.9	2014	**Central Bank Report**
Health and Nutrition			
Life expectancy at birth (years) Total **Male[2]** **Female[2]**	74.3 70.5 79.8	2013 2011 2011	**Central Bank Report** **Department of Census and Statistics**
Neonatal Mortality Rate[2] (per 1000 live births)	5.8	2013	**Registrar General's Department**
Infant Mortality Rate [2] (per 1000 live births)	8.2	2013	
Under five Mortality Rate [2] (per 1000 live births)	10.0	2013	
Total Fertility Rate [2]	2.3	2006/2007	**Demographic and Health Survey[1]**
Maternal Mortality Ratio (per 100000 live births)	32.0	2014	**Family Health Bureau**
Still Birth Rate (per 1000 births)[2]	6.4	2013	**Medical Statistics Unit**
Low birth weight per 100 live births in Government Hospitals[2]	**16.7**	**2013**	

Indicator	Data	Year	Source
Pregnant women attending ANC more than 4 visits (%)	92.5	2006/2007	Demographic and Health Survey[1]
Average number of clinic visits per mother	6.3	2014	Family Health Bureau
Average number of antenatal home visits per mother by a PHM	4.1	2014	Family Health Bureau
Pregnant women visited at least once by PHM at home (%)	90.2	2014	Family Health Bureau
Live births in government hospitals (%)[2]	95.6	2012	Medical Statistics Unit
Births attended by skilled health personnel (%)	98.6	2006/2007	Demographic and Health Survey[1]
Mothers receiving at least 1 postpartum visit during 1st 10 days (out of reported deliveries)	90.7	2014	Family Health Bureau
Average number of postpartum visits by PHM during 1st10 days	1.7	2014	Family Health Bureau
Children ever breastfed of all children <5 years (%)	99.3	2006/2007	Demographic and Health Survey[1]
Breastfeeding initiation within 1 hour of birth (%)	79.9	2006/2007	
Exclusive breastfeeding under 6 months (%)	76.0	2006/2007	
Immunization coverage (%) BCG at birth (live births) Pentavalent 3rd dose Measles containing vaccine[1] (MCV 1)	 95.0 99.0 100.0	2014	Epidemiology Unit
Underweight (weight- for- age) <-2SD Acute Under nutrition (weight for height) -Wasting <-2SD Chronic malnutrition (height for age) -Stunting<-2SD	21.1 14.7 17.3	2006/2007	Demographic and Health Survey[1]
Average Daily Calorie Intake[3] (kCal) (Both poor and non-poor)	2,111	2013/2014	Central Bank Report
Current use of contraceptive methods among 15-49 year age married women (%) Any method Modern Method Traditional Method	 68.4 52.5 15.9	2006/2007	Demographic and Health Survey[1]
Water supply and sanitation			
Access to safe drinking water (%)[3]	89.7	2014	Central Bank Report
Access to pipe borne water (%)	44.3	2014	

Indicator		Data	Year	Source
Socio-economic				
GDP per capita at current prices	Rs US $	473,261 3,625	2014	Central Bank Report
GNP per capita at current prices	Rs US $	461,650 3,536	2014	
Human development index		0.750	2013	
Unemployment rate (15 year & over population) Total Male Female		4.3 3.1 6.2	2014	Sri Lanka Labour Force Survey (Annual Report)
Labour force (15 years & over population)		8,804,548	2014	Sri Lanka Labour Force Survey
Dependency ratio (%)		49.5	2014	Central Bank Report
Literacy rate %	Total Male Female	92.5 93.5 91.6	2013	Department of Census and Statistics
School going population (%)	Primary Junior secondary Senior secondary Collegiate	42.0 31.0 15.0 12.0	2013	Ministry of Education
Median age at marriage (Female 25-49 years)		23.3	2006/2007	Demographic and Health Survey[1]
Health Resources				
Government expenditure on health (% of GDP)		1.4	2014	Central Bank Report
Government health expenditure as % of total expenditure[2]		4.1	2012	Department of Health Services
Per capita health expenditure (Rs)[2]		4,392	2012	Medical Statistics Unit
Medical Officer per 100,000 population[2]		78.6	2012	Medical Statistics Unit
Population per Medical Officer[2]		1,278	2012	Medical Statistics Unit
Dental Surgeons per 100,000 population[2]		6.0	2012	Medical Statistics Unit
Nurses per 10,000 population[2]		180.3	2012	Medical Statistics Unit
Public Health Midwives per 100,000 population[2]		28.6	2012	Medical Statistics Unit
Number of hospitals[2]		621	2012	Medical Statistics Unit
Number of hospital beds[2]		76,087	2012	Medical Statistics Unit
Hospital beds per 1,000 population[2]		3.8	2012	Medical Statistics Unit
Number of Central Dispensaries[2]		487	2012	Medical Statistics Unit
Number of MOH divisions (Functioning)		338	2014	Family Health Bureau

[1] DHS 2006 / 2007 excludes Northern and Eastern provinces

[2] Provisional

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

1 Background

1.1 Family Health Programme

Family Health Programme is a collection of several packages of interventions that are aimed to promote the health of families around the country with special emphasis on mothers and children. The programme provides the most wide spread community based health care services enjoyed by Sri Lankan public. Present day Family Health Programme reflects more than 85 years of successful programme maturation. The origin of it dates back to 1926, when it was initiated in Kalutara, as the first field based health unit system of the country. Today, Family Health programme reaches almost all families throughout the country. It forms a well-organized health care system, Implementing services through 338 divisional health units called Medical Officer of Health (MOH) areas.

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

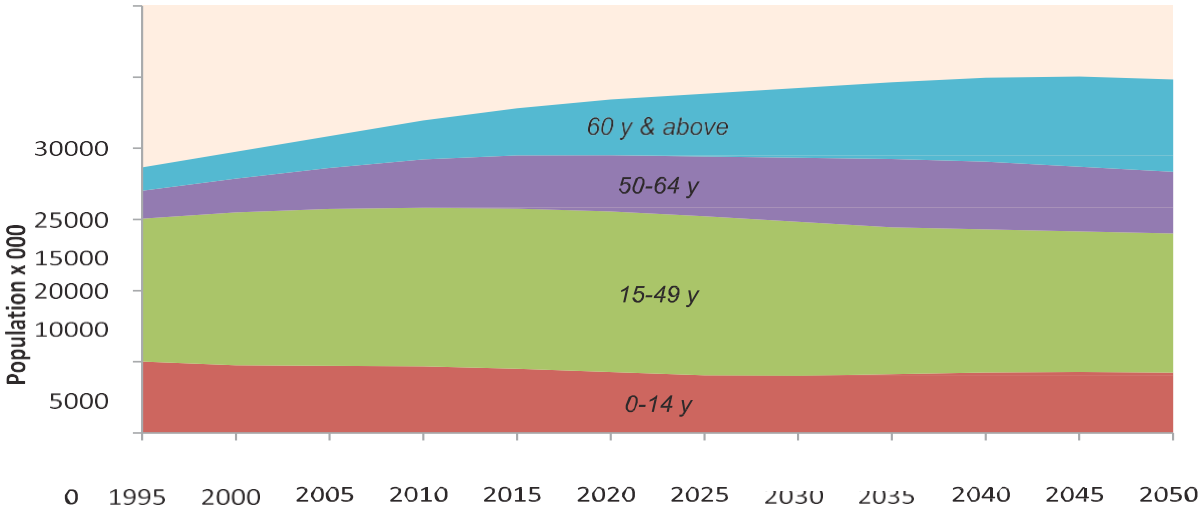
The Family Health Programme is comprised of several major components that aim to promote maternal, child, school and adolescent health. It also includes Family planning and Women's health components incorporating perimenopausal care and gender concerns. The maternal component is furthersub-dividedas; Antenatal, Intrapartum, Postpartum and Maternal mortality and morbidity surveillance entities. Newborn care, Child nutrition, Child development and special needs, Child morbidity and mortality prevention and surveillance elements comprise the Child health component. In addition, Family Health Programme includes an oral health component which focuses on maternal and child oral health care.

As a whole, Family Health Programme focuses on a sizable proportion (around 54%) of the population, which includes children, adolescents and those in reproductive ages. The population estimates show that these large numbers will remain so for several more years to come (Figure1). Estimates also indicate that nearly 15 million people come under the purview of Family Health Programme.

1.2 Health Administration of Sri Lanka

Sri Lanka has a devolved health system resulting in Ministry of Health at central level and separate provincial ministries of Health at nine provinces. The central ministry has the overall responsibility of maintaining the health services of the country, while the nine Provincial Ministries empowered with nine Provincial Directors of Health Services (PDHS) are responsible for effective implementation of the services in their respective provinces.

Figure 1 : Distribution of estimated population over broad age groups from 1995 -2050



Projected by using DemProj computer Programme

There are 26 Regional Directors of Health Services (RDHS) to assist the PDHSs. The RDHS areas are similar to administrative districts except in Ampara where the district is subdivided to Ampara and Kalmunai RDHS areas.

1.3 Organization and Delivery of Family Health Programme

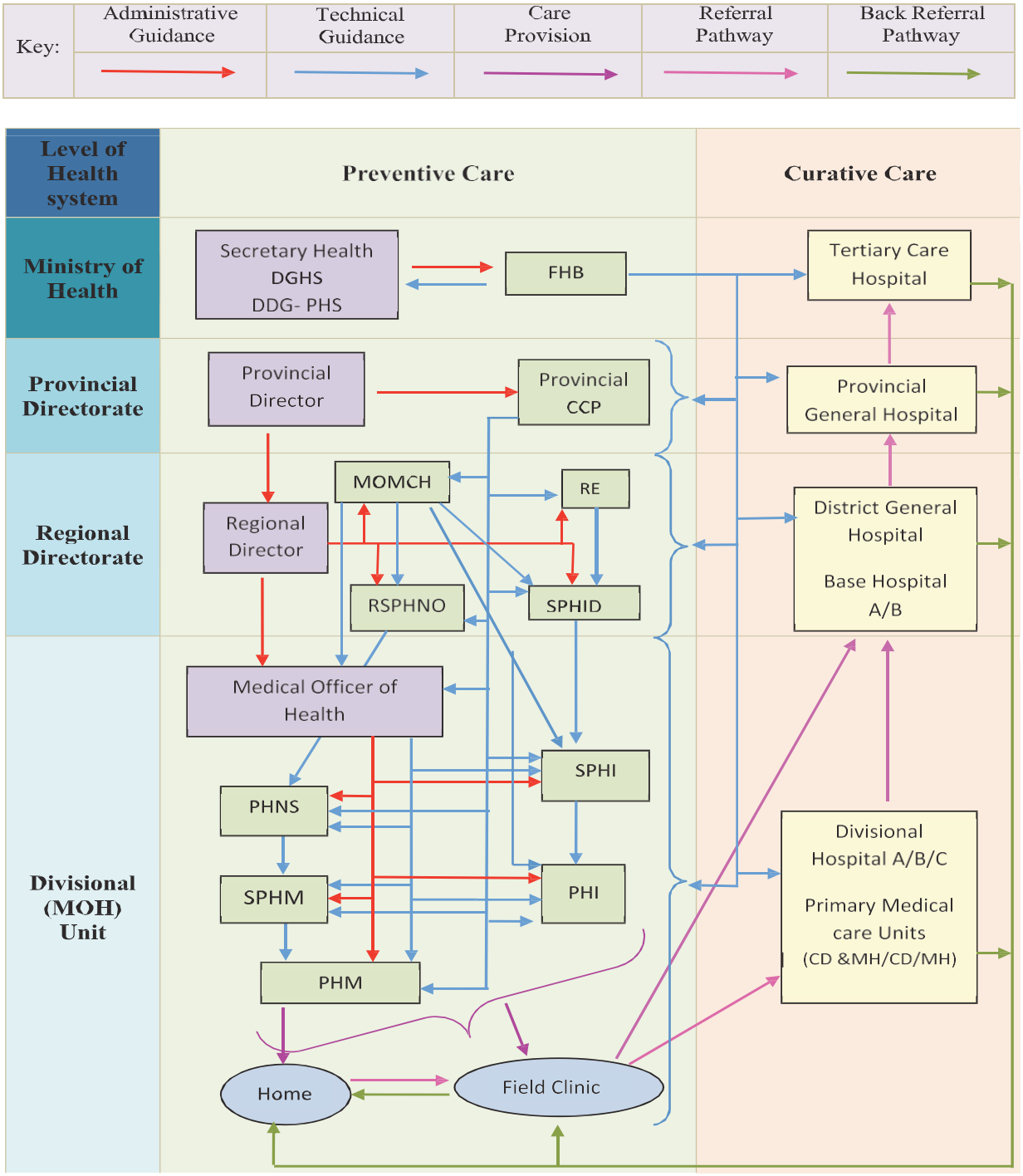
Family Health Programme collaborates with a number of partners in the process of its organization and delivery. Family Health Bureau (FHB), a central level institution of the Ministry of Health, is responsible for designing and planning of Family Health Programme. FHB also provides technical guidance for provincial systems on its implementation. In addition, FHB advocates the Ministry of Health on matters related to policy, finance, infrastructure and other resource requirements relevant to Family Health Programme. Quality control, monitoring and evaluation of the Family Health Programme also come under the purview of FHB.

FHB has several sub units that covers the different components of the Family Health Programme. These include: a) Maternal Health, b)Maternal Morbidity and Mortality Surveillance, c) Intrapartum and Newborn care, d) Child Development and Special Needs, e) Child Nutrition, f) School Health and Adolescent Health, g) Gender and Women's health, h) Family Planning, i) Planning, Monitoring and Evaluation, j) Oral Health and k) Research and Development. Each of these units is manned by a public health specialist, who is the national programme manager for areas under the unit's purview. Each unit is possessing a separate staff responsible for advocacy, policy and strategic analysis, programme development, technical guidance, evaluation and supervision related to the respective programme components.

Figure 2 shows the administrative and technical guidance pathways that facilitate the organization and implementation of Family Health Programme activities through the national health system.

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

Figure 2 : Organization of FHP at different levels of health system



Health Programme. The diagram also depicts the referral and back referral pathways available for people confronted by health conditions related to family health (Child birth, childhood illness etc.) in pink lines. The administrative and technical guidance relevant to the Family Health Programme is integrated into the usual multi-tier organizational arrangement of the Ministry of Health. Tiers include, Central Ministry of Health Institutions, headed by the Secretary of Health, 9 Provincial Directors, and 26 Regional Directors.

At Central Ministry of Health, policy making and financial allocation related to Family Health Programme become the responsibility of Secretary to the Ministry. The overall administration including logistical supply comes under the purview of the Director General of Health Services (DGHS). FHB is the main think tank behind the technical management of the Family Health Programme providing technical guidance for all levels of the health system. FHB provides policy and strategic advocacy to the Ministry of Health and Provincial and Regional directorates.

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

The implementation of the Family Health Programme is carried out by the Medical Officer of Health (MOH) teams under the administrative supervision of the Provincial and Regional Directorates of Health. In Sri Lanka 338 MOH areas are distributed within 26 health regions. The MOH areas are the smallest health unit in the public health network and it consists of a team comprising several categories of staff. MOH is the Manager of the MOH team. He/She is a MBBS qualified doctor who is given special orientation training on public health activities. Both technical and administrative supervision of the MOH team becomes the main responsibility of the MOH. At present most MOHs are assisted by Additional Medical Officers of Health (AMOHs). The Public Health Midwife (PHM) and Public Health Inspector (PHI) are the ultimate grass root level primary health care workers of the MOH team. On average one PHM is appointed for 3000 population while a PHI is appointed for 10,000 population. While the principle roles of the PHM lies around maternal and child health activities, the PHIs are principally held responsible for school and adolescent health programme, Environmental and Occupational health activities including control of communicable diseases, ensuring water and food safety, and sanitation related interventions. Several other categories of interim level supervisors are available in the MOH team. They are supposed to assist the MOH in supervision of activities of grass root level staff. Public Health Nursing Sisters (PHNS) and Supervising Public Health Midwives (SPHM) are responsible for supervising the PHMs. PHNS and SPHM have a hierarchical administrative relationship where PHNS is also supposed to supervise SPHM. Both of them are responsible for the MOH. Supervising Public Health Inspectors (SPHI) become immediate supervisors of PHIs. They are directly responsible for the MOH. MOH team is further potentiated by DA/PPA/DO/clerical and other categories of supportive staff such as drivers, labourers etc. MOH staff includes School Dental Therapists (SDT) who are responsible for providing routine dental care for school children. The following table presents the overall staff position of the MOH areas around the country.

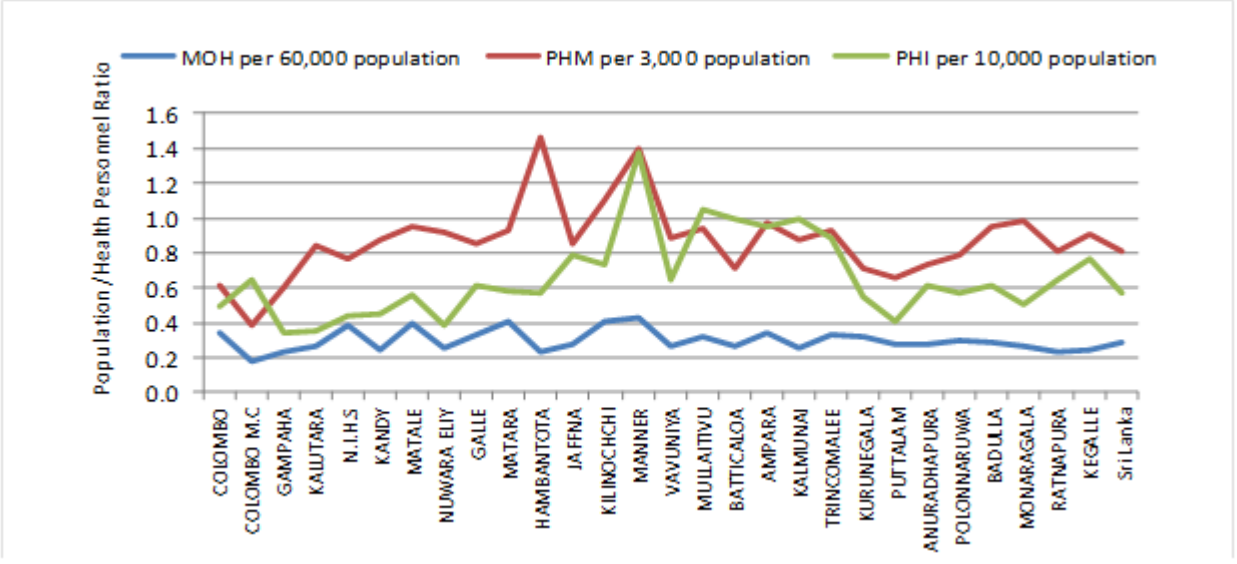
Figure 3 shows main three human resource availability indicators of Family Health

Programme. They include number of MOHs (including AMOHs) per 60,000 population, number of PHMs per 3,000 population and number of PHIs per 10,000 population. Until the carder of PHMs being filled according to the letter number FHB / DIR / GF / 2012 issued on 28-03-2012 3,000 to be considered as the standard average number of population allocated to a PHM. PHI is supposed to cover a population of 10,000. Figure 3 shows that there is a gross inadequacy in allocation of public health staff island wide based on the population alone although there are other factors also to be considered e.g. terrain. It should be noted that even if the district meets the standards of staff position, there is often a maldistribution of staff within districts. This seems to create notable inequities in service provision between the MOH areas within a district. The Colombo Municipal Council (CMC) does not employ MOHs and it follows a different system to provide MCH care.

Table 1 : Distribution of categories of staff personnel in the MOH teams of the country, 2014

Category of staff	Number of personnel	Staff target population (Officers/ 100,000 population)
MOH	308	1.4
AMOH	307	1.4
PHNS	247	1.1
SPHI	226	1.0
SPHM	233	1.1
PHM	5825	26.9
PHI	1227	5.7
SDT	379	1.7

Figure 3 : Number of MOHs / 60,000 population, number of PHMs / 3,000 population and number of PHIs / 10,000 population 2014



2 Purpose of the Report

This is the 24th Annual Report of the Family Health Programme. The main purpose of the report is to provide feedback to partners of Family Health Programme on successes and failures of their hard work during the recent past. The report includes information on background, and selected input, process, outcome and impact indicators relevant to the Family Health Programme. It also provides the platform for various outside agencies such as other Ministries, NGOs, INGOs, Professional bodies and researchers to learn the contemporary progress of Family Health Programme.

This report presents data by 28 health areas. These include 26 RDHS areas, National Institute of Health Science (NIHS) area and Colombo Municipal Council (CMC) area. Latter two are separately mentioned due to the unique nature of organization of services in these areas.

All maps show boundaries of 26 RDHS areas. Therefore the indicators of NIHS and CMC areas are separately shown in circles embedded in relevant districts in which they are located, whenever the performance of those areas are different to respective districts.

3 Data Sources and Indicators

Annual Report summarized and analyzed the data from several sources. They include:

1. H 509: Quarterly MCH return
2. H1200: Family Planning Monthly Return
3. H 797: Quarterly School Health Return
4. Maternal Mortality Surveillance system
5. Annual Data Sheet of MOHs
6. Annual Nutrition Month Return
7. Monthly Return from Dental Therapists
8. Registrar General's Department and other relevant sources

3.1 H 509: Quarterly MCH Return

H 509 provides a comprehensive set of data on the performance of Family Health Programme. It is a quarterly return compiled by the MOH office . The data items cover wider scopes. These include: information on target population, performances of maternal care, child care, well woman clinic, and family planning services provided both at field and clinic settings (MOH & hospital). Several registers, records and returns maintained in field and clinic settings are used to compile H 509. Each MOH is supposed to compile H 509 in 3 copies and send one to FHB, another one to RDHS Office before the 25th of the month following each quarter (Figure 4). The 3rd copy is retained at MOH Office.

3.2 H 1200: Family Planning Monthly Return

H 1200 serves dual purpose of record and return of family planning new acceptors. Each family planning service provision point has to maintain a H 1200 for new acceptors of all modern methods except for Condoms (H 1200 A). Each service delivery point is sending H 1200 A to the respective MOH office. Every MOH is required to send the H 1200B, consolidated monthly return compiled using all H 1200 A to FHB before the 20th of each month (Figure 4). From 2016 onwards, H 1200 B will be implemented as a quarterly return.

3.3 H 797: Quarterly School Health Return

H 797 summarizes the size of the target school population and the performance of school health programme. It covers the school medical inspections, immunizations and follows up of children identified to have problems. This quarterly return from each MOH office is expected to reach FHB before the 25th of the month following each quarter (Figure 4).

3.4 Maternal Mortality Surveillance system

Each maternal death is expected to be reported within 24 hours to the RDHS and FHB by the MOH of the field and or the Institutional Head, where the death occurred. There is a standard procedure to be followed and the information is recorded in a standard format (H 677, H 677a). Each year District and National Maternal Mortality Reviews are conducted and information is compiled by the FHB (Figure 5).

Figure 4 : Sources and pathways of data used in the Annual Report

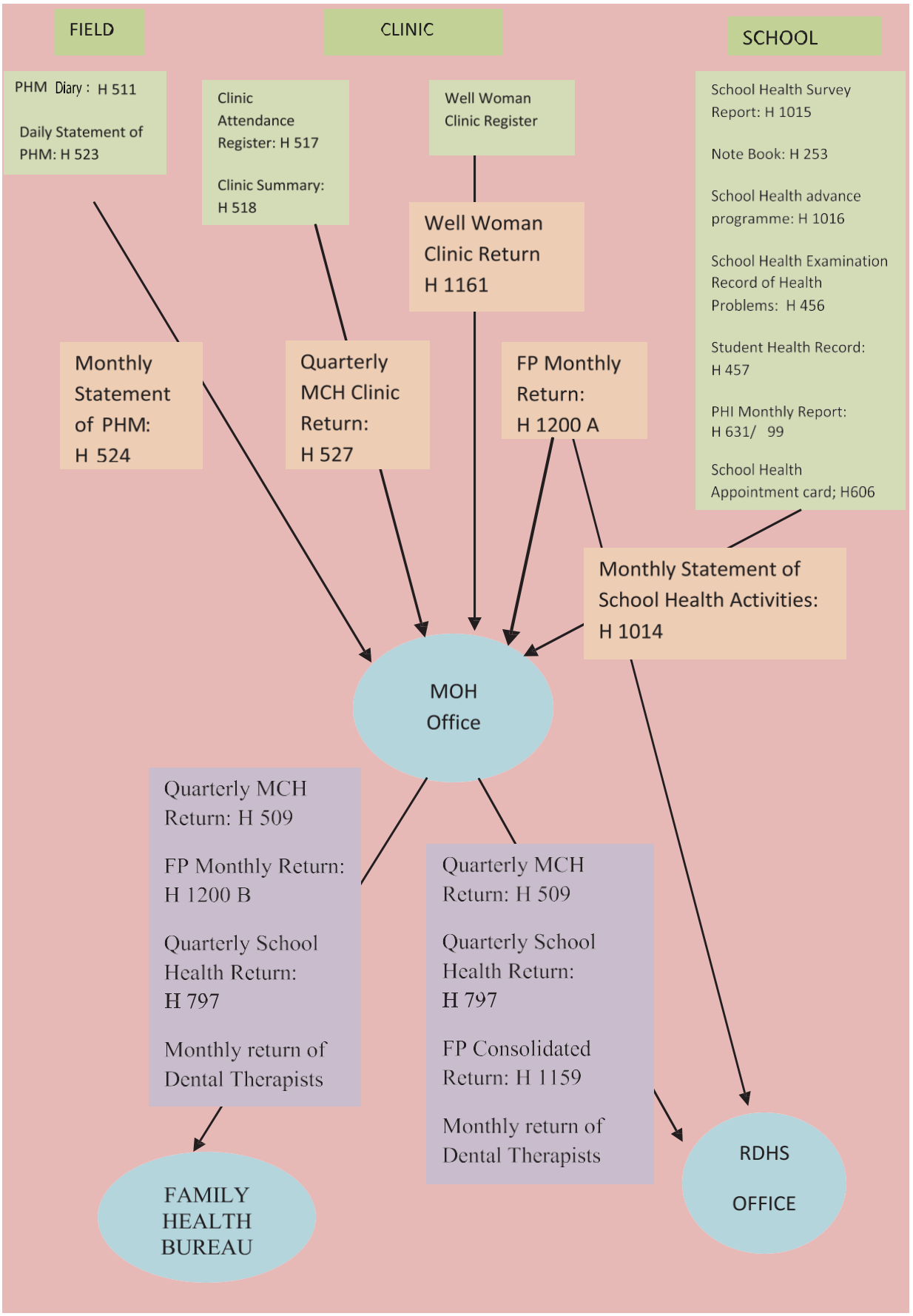
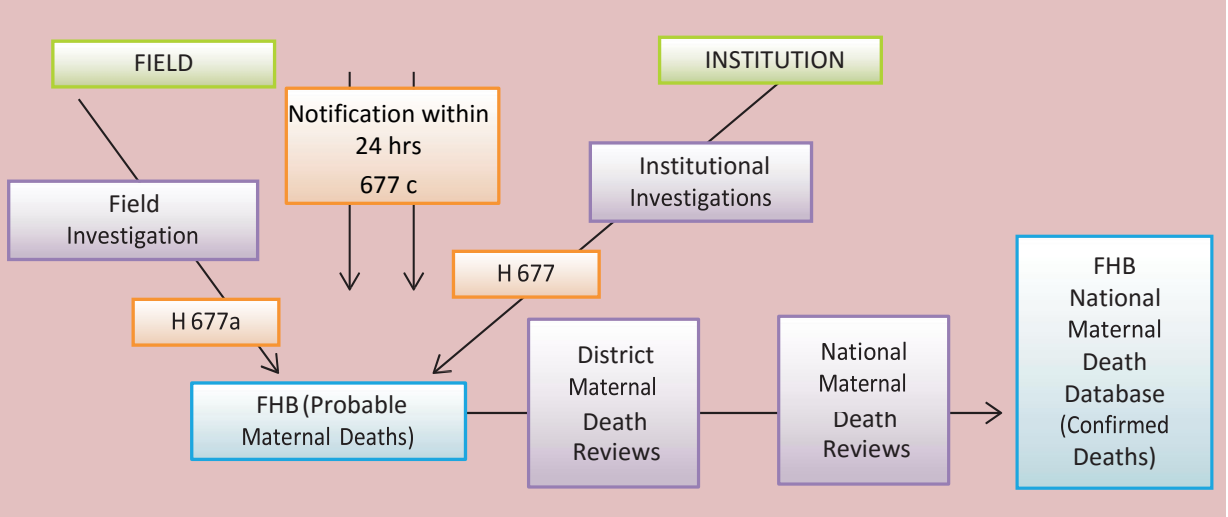


Figure 5 : Information flow of National Maternal Mortality Surveillance System



3.5 Annual Data Sheet of MOHs

This is a data sheet used to collect the basic information on MOH area such as staff positions, facilities, population data etc.

3.6 Annual Nutrition Month Return

Data related to nutrition month activities are reported annually once they are being received by the Family Health Bureau from each RDHS area. Nutritional status of children under five and Grade 1 - 10 students are to be provided by PHMs and PHIs respectively. Data compiled by MOH area is being sent.

3.7 Monthly Return from Dental Therapists

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

3.8 Registrar General's Department and other relevant sources

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

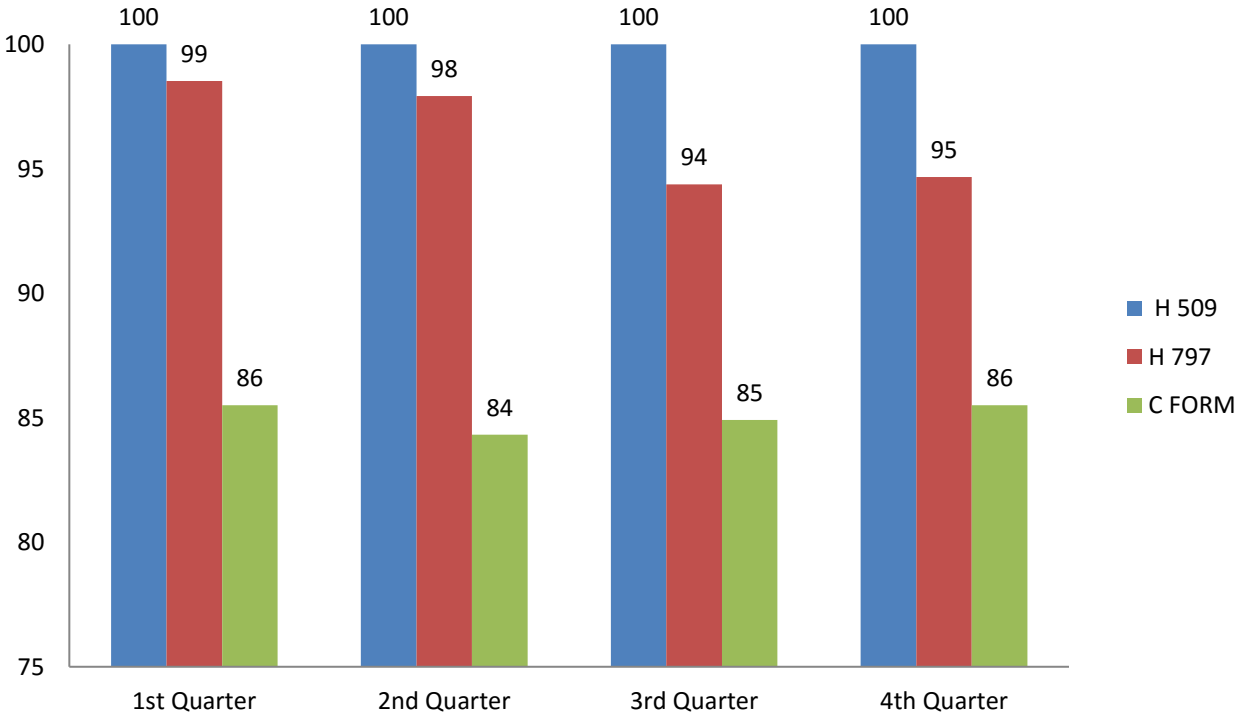
This Annual Report is based on data available for all 4 quarters of the year through quarterly and monthly returns sent by the field staff.

4 Data Quality

The quarterly returns are supposed to be received at FHB before the 25th of the month following each quarter. Monthly returns should be available before the 20th of following month.

Receiving of H 509 is much better than that of H 797 (Figure 6). Timeliness could not be analyzed due to trade union action in 2014. Each return is scrutinized for completeness and accuracy of data at FHB. Discrepancies are verified through the phone and in some cases the defaulted returns are sent back to the respective MOHs to revise and resubmit. Then these formats are entered into epi data based data entry format. The analysis is carried out using SPSS software. Data entry validation is done by re-entering 5% of the returns.

Figure 6 : Status of returns received 2014



5 Target Population of Family Health Programme

There are two mechanisms to identify the target populations by the grass root level workers. These include registration of eligible families by PHMs and identifying the schools under their care and the number of children in these schools who should be examined during the year by PHIs. PHMs are supposed to maintain an Eligible Family Register (H-526) for this purpose. The School Health Survey Report (H-1015) compiled by PHIs contains data on school population.

Eligible Family is defined as a family either legally married or living together where the woman is between 15 to 49 years and / or having a child under 5 years. A family with a pregnant or cohabiting woman irrespective of marital status and age and single women (widowed, divorced, separated) are also considered under eligible family. It is estimated that the number pertaining to 16 % of the population approximates the number of eligible families.

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

Table 2 presents the sizes of various types of target groups coming under the Family Health Programme in the year 2014. The total population reported by PHMs was compared with the estimated population.

The total population reported by PHMs exceeded the estimated population given by Registrar General's Department in 2014 by 4.3%. Figure 7 presents the trends in the percentage registration of eligible families in comparison to estimated eligible families in the country. The estimations for the figure 7 was based on population reported by

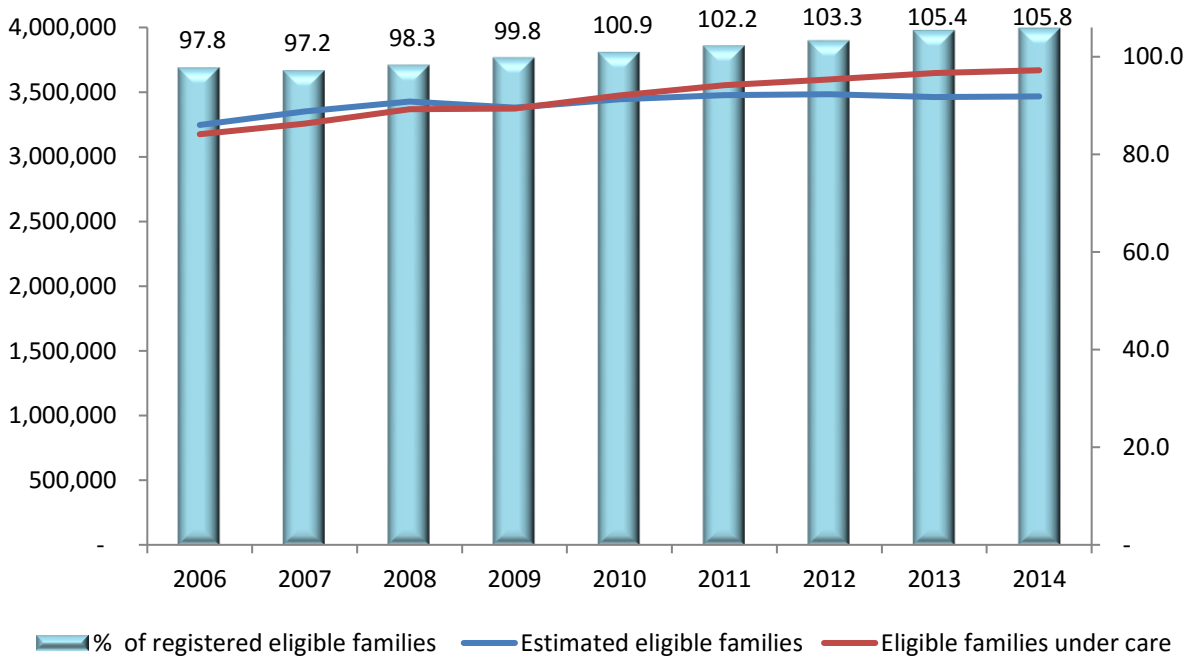
Table 2 : Sizes of different target populations of Family Health programme 2014

Indicator	Estimated	Reported
Midyear population	20,771,000	21,666,783
Eligible families	3,466,685	3,668,979
Pregnant mothers	384,687	367,528
Births	349,715	313,689
Infants under care	349,715	330,125
1-2 years under care	349,715	359,069
2-5 years under care	1,049,145	1,023,946
Number of schools ≤ 200	-	4944
Number of Schools ≥ 200	-	4882
Total school children under care at the beginning of year	-	36,722,119**

* Estimates are based on the mid-year population of 2014 given by the Registrar General's Department

**Only 94% of the data received for school children under care from H – 797 therefore school children under care reported is reduced

Figure 7 : Comparison of numbers of estimated and registered eligible families as a percentage of estimated families



PHMs and proportion of eligible families was taken as the 16% of the total population for that year. Population reported by PHMs for 2014 was 21,666,783. PHMs have registered a total of 3,668,979 eligible families (16.9%). It reflects either lack of efficiency in updating the Eligible Family Register or inaccuracy in the estimate we used for calculations as the proportion of eligible families in the population (16%) or both. These need to be re assessed with the availability of detailed information on the demographic characteristics of the population from the census.

Figure 7 shows that almost all eligible families were registered by the PHMs since 2006 to 2014.

A variation, 93.4 % - 125.3 %, was seen in the percentage of eligible mothers reported across districts. The districts from Northern Province reported the lowest percentages (Annexure1).

6 Preconception Care

Interventions in improving maternal and child health should be started from the pre-conception stage. A new package of interventions for "pre-conception care" has been piloted and introduced to the Family Health Programme in 2012 to promote health of women and their partners to enter pregnancy in optimal health, and to maintain it throughout the life course. The main strategy used to fulfil this is by ensuring women of childbearing age and their partners receiving a comprehensive package of pre-conception care. The care includes creating awareness, health promotion, screening and appropriate mediations to reduce risk factors that might affect future pregnancies of the reproductive aged women.

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

The new package would

- Improve knowledge and attitudes of men and women especially in relation to pre-conception health which would lead to behavioural changes.
- Assure that all newly wedded couples receive pre-conception care services. (health promotion, evidence based risk screening, interventions etc.)
- Improve the health of women before pregnancy by giving pre - conception care.
- Detect the health problems of the couple to prevent, minimize, treat or correct the health problems before they attain parenthood.

The package was introduced in 18 MOH areas by the end of 2014.

7 Maternal and Newborn Care

Maternal and newborn care component of the Family Health Programme includes interventions that focus the antenatal, intra natal and postnatal aspects of pregnancy.

This section describes some important characteristics of pregnant women registered for care either at field or clinic during 2014. It also presents the current and past trends of selected process and outcome indicators related to maternal care.

7.1 Antenatal Care

According to the Family Health Programme framework, antenatal care begins with the registration of pregnant woman by PHM either at field or clinic. After the registration, basic antenatal care is provided through clinic visits and home visits.

It is encouraged that all pregnancies are identified as soon as possible, and a standard package of interventions is offered to them. Standard package of interventions for pregnant women included preliminary clinical assessment and screening for risks factors, screening for Pre eclampsia, eclampsia and Syphilis, screening for Anaemia and Gestational Diabetes Mellitus and management, Tetanus Toxoid immunization, provision of antihelminthic, prevention and management of STIs and RTIs, prevention of mother to child transmission of HIV, intermittent presumptive treatment for malaria where relevant), monitoring of maternal and foetal wellbeing in subsequent visits, assessment of fundal height, Micronutrient supplementation, (iron, folic acid, vitamin C, calcium), food supplementation ("Triposha"), referral of high risk pregnancies for specialist care, providing information and counseling for pregnancy related issues (breast feeding and family planning, birth and emergency preparedness).

Revision for the standard package of maternal care was done in year 2012 with the objective of improving the quality of care and reducing the duplication of the services within the public health system. With this revision, clear guidelines are issued on the service provision for high risk and low risk pregnancies. The recommended number of clinic visits for low risk pregnancy is limited to 9 visits at any government health facility while 3 home visits are recommended for them. Introduction of three antenatal classes in each trimester for couples enhances their exposure to common health issues specific for that trimester and make them ready for the childbirth, postpartum, newborn care and emergencies. Number of postpartum home visits remained as four while a compulsory postnatal clinic visit was introduced by one month after delivery where the screening for Postpartum Depression using Edinburg Postnatal Depression Screening (EPDS) to be done. Implementation status of these has to be assessed by routine information in future.

The following section shows some of the indicators that reflect the trends of the status of antenatal care.

7.1.1 Registration of pregnant mothers

The RH-MIS makes provisions to record the number of pregnant mothers registered by PHMs along with the time of registration

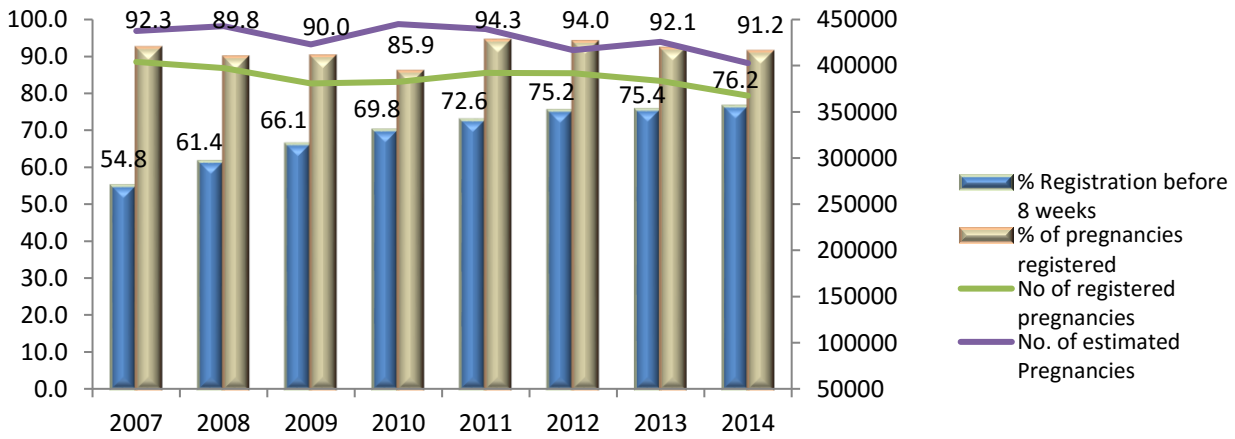
in relation to period of gestation (POG). In addition the number of teenage pregnancies, number of first pregnancies, number of pregnancies at fifth parity and above and whether the registered mother is protected from Rubella vaccine are also noted. PHMs have registered 367,528 pregnant mothers during 2014 either at antenatal clinics or during field visits. This accounted for 91.2% of expected pregnancies of 402,785 in that year.

This indicates that a very high percentage of pregnant women in Sri Lanka are in contact with the maternal care services offered by the Family Health Programme. There are notable differences in the percentages of pregnancies registered in different districts. Except Killinochchi (72%), Vavuniya (75%) and Hambantota (78%) all other RDHS areas registered more than 80% of the expected pregnant mothers during the year. Figure 8 and Table 3 show the trends in percentage of pregnant mothers registered out of expected pregnancies who came into contact with the maternal care programme over last 8 years.

The percentage registration over last 8 years indicates that PHMs have registered high proportions of estimated number of pregnancies. This high coverage seen in the pregnant mothers' registration not only shows the efficiency of the primary health care staff around the country, but also the positive health seeking behaviour among Sri Lankan mothers. It could also be a reflection of sound health care network of the country which facilitates the service provider recipient contacts. Further it indicates the tremendous potential that it creates to ensure the life cycle approach where the children of these mothers could also be brought in close contact with the health system through these initial linkages. This will ensure that they get exposed to similar kind of interventions at relevant points in life, promoting and protecting their health.

Family Health Programme promotes early and regular antenatal care. Registration before 8 weeks is considered as early registration and the percentage of pregnancies that are registered early has shown 21% increase over the past 8 years (Figure 8 and Table 3). The percentage of mothers registered early ranged from 44.6% (Colombo M.C.) to 88.6% (Kurunegala) (Annexure 2).

Figure 8 : Trends in estimated and registered pregnancies 2007-2014



7.1.2 Field clinic care

Following registration, a pregnant mother should receive clinic antenatal care as early as possible. During 2014, 95.5% of mothers attended field antenatal clinics which are conducted by MOH or at non-specialists institutions at least once. This high coverage has been present throughout the period since 2007. On average, a mother made 6 field clinic visits during her pregnancy (Table 4). However, the total number of antenatal clinic visits by a mother may be higher than this as information on specialist unit clinics and private sector are not reported in RH-MIS. The district variations of these indicators are given in the annexure 3.

Table 5 presents the trends in the coverage of these screening activities since 2007. As reported by PHMs at the first postpartum visit, percentage of mothers who were tested for VDRL at the time of delivery, amounted to 98.1% in 2014. However, out of antenatal mothers attending field clinics, 57.1% were tested for VDRL at the clinic. There were 1464 field clinics with facilities to draw blood for VDRL testing during the year 2014. Out of the 350,941 mothers attending antenatal clinics, in 2014 261 (0.08%) were reported to be reactive for VDRL test.

Table 3 : Pregnant mothers' registration with PHMs 2007-2014

Indicator	200	2008	2009	2010	2011	2012	2013	2014
% of pregnant mothers registered out of estimated pregnancies	92.3	89.8	90	85.9	94.3	94	92.1	91.2
% of pregnant mothers registered before 8 weeks out of registered pregnancies	54.8	61.4	66	69.8	72.6	75.2	75.4	76.2
% of pregnant mothers registered between 8-12 weeks out of registered pregnancies	34.3	28.5	25	22.6	20.3	18.3	17.7	17.4

7.1.3 Antenatal screening

In addition to clinical screening conducted by a Medical Officer of Health, every mother is Screend for prepregnancy anaemia (Serum Hb), Sexually Transmitted Infection (Syphilis antibodies-VDRL) and blood grouping and Rh. Several indicators are available for assessing the efficacy of antenatal screening for BMI, Hb, VDRL and blood grouping and Rh which are gathered from different sources. The data for BMI and Hb testing are available from field clinics. The data for VDRL and blood group testing are reported at the time of delivery and from field clinics.

A similar pattern is seen in testing the blood for grouping and Rh antibodies. Almost all mothers knew their blood group and Rh status at the time of delivery while 25.5% of mothers got the blood grouping done at field clinics. It is known that mothers who were tested their blood group at previous pregnancies may not repeat it.

The high coverage of VDRL and blood grouping and Rh testing as reported during first postpartum visit indicate that a considerable percentage of mothers may obtain these services directly from government hospital clinics or from private sector.

Table 4 : Percentage of pregnant mothers visiting field antenatal clinic at least once and average number of clinic visits since 2007

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
% of pregnant mothers making at least one field clinic visit out of registered pregnancies	97.1	96.1	95.6	94.7	95.9	95.2	94.8	95.5
Average number of clinic visits per mother	6.8	7	7.1	7	7.2	6.8	6.6	6.3

Table 5 : Percentage of pregnant mothers who got different types of screening done at field Antenatal Clinic

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
% of pregnant mothers tested for VDRL at the time of delivery out of reported deliveries	92	93.9	97.8	96	97	99.3	99.7	98.1
% of mothers whose blood is tested for grouping and Rh at the time of delivery out of reported deliveries	99	99.5	99.9	99.8	99.6	100	99.9	97.8
% of mothers whose BMI is assessed before 12 weeks out of total clinic attendance	85	85.4	85.5	85.6	85.9	82.7	83.1	79.9
% of mothers screened for Hb at the field clinic out of mothers attending antenatal clinics	72.2	72.4	62.7	57.8	56.1	52.3	50.6	57.1
No. of clinic with VDRL testing facilities	1290	1723	1495	1545	1375	1829	1840	1464
% of mothers tested for VDRL at field clinic out of mothers attending antenatal clinics	41.2	48	51	51.3	51.2	53.8	59.2	57.1
Number of mothers who was VDRL positive for 10,000 mothers attending antenatal clinics	3.5	5.5	4.3	6	6.7	3.1	4.8	8.3
% of mothers whose blood Gp and Rh tested at field antenatal clinic	39.3	28.4	26.1	27.3	25.9	24.8	27.3	25.5

VDRL coverage at the time of delivery reported to be relatively low in RDHS areas of Colombo(83.1%), Batticaloa (93.5%), and Kalutara (93.7%) (Annexure 2).

Approximately, 57.1% of the mothers attending field clinic had their Hb level tested. However, it should be noted that this may be an over estimation as according to guidelines each mother is supposed to be tested for Hb twice; both at booking visit and between 26 - 28 weeks of pregnancy.

It was also notable that BMI of 20 % of mothers attending clinics were not measured. Annexure 3 presents the district differential of the above parameters.

7.1.4 Domiciliary Care

The clinic care given to antenatal mothers is expected to be compliment by domiciliary care offered by PHMs.

During home visits , PHMs should assess the antenatal mothers' health status by risk screening and examination, conducting simple investigations such as urine sugar and albumin at first visit, educating pregnant mothers and family members and making necessary referrals. Table 6 presents the percentage of pregnant mothers who were visited at least once and average number of field visits paid to them by PHMs. Home visits for registered pregnant mothers at least once by PHMs had been gradually reducing for last 8 years. According to guidelines, pregnant mother is expected to receive at least 3 home visits by PHM. The district variations of these indicators are given in the annexure 2.

7.1.5 Characteristics of Pregnant Mothers

7.1.5.1 Protection from Rubella and Tetanus

In Sri Lanka, comprehensive efforts have been made to ensure all reproductive age women are protected for Rubella by immunizing them with rubella vaccine. The initial strategy was to immunize all women from 15 - 44 years of age with Rubella vaccine. Therefore, since 1995 to 2001, girls in 11 - 16 years were immunized at schools while other women in child bearing ages were immunized at field clinics. Then in 2001 the policy of Rubella immunization has been expanded to control Rubella infection in the community in addition to controlling Congenital Rubella Syndrome. Hence, since 2001 two doses of MR vaccine were administered to children at the ages 3 and 13 years. In 2010 MR vaccine was replaced by MMR vaccine and at present 2 doses of MMR vaccine are given to all children at 1 and 3 years of age.

Neonatal tetanus has been eliminated from the country. This success could be attributable to the high coverage of tetanus vaccination among antenatal mothers along with safe delivery and newborn care practices. Table 7 presents the percentages of mothers who have been protected for Tetanus and Rubella.

Rubella coverage has been very high over the time and in 2014, 98% mothers were protected for Rubella by the time they get pregnant. Almost all mothers were protected with Tetanus vaccine at the time of delivery.

Annexure 2 shows the district variations in Rubella coverage in 2014 and the coverage varied from 77.7% in Mannar to 103.9% in Gampaha district. The areas with coverage less than national average were, Nuwara Eliya (86.6%), Colombo Municipal Council (87.1%), Ratnapura (97.0%), all districts in Northern and Eastern provinces except Jaffna (99.5%) and Ampara (101.6%) .

Table 6 : Percentage of pregnant mothers who were visited at least once and average number of home visits paid to them by PHM 2007-2014

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
% of registered pregnant mothers visited at least once at home by PHM	97.1	96.1	94.4	92.9	91.7	90.2	91.3	90.2
Average number of PHM field visits per mother	4.8	5.1	5.0	4.9	5.2	5.0	4.5	4.1

Table 7 : Percentage of antenatal mothers who were protected with Rubella vaccination and Tetanus toxoid 2007-2014

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
% of pregnant mothers protected for Rubella out of registered pregnancies	100	93.3	94.8	95.4	95.9	96.8	97.0	98.2
% of pregnant mothers protected for Tetanus out of total reported deliveries	99.6	99.8	100	99.9	99.6	99.9	99.9	97.7

7.1.5.2 Teenage Pregnancies

Around 4.9% of total pregnancies registered by PHMs belong to mothers less than 20 years. There has been a definition change on the teenage pregnancy used in the RH-MIS in the year 2007, when it was changed from those under 19 years to those under 20 years. The following graph shows the trends in teenage pregnancies over the last 8 years. It shows that during last 8 years the percentage of teenage pregnancies remained more or less similar and stayed between 6 - 8 % where 2014 reported the lowest proportion of teenage pregnancy among pregnancies registered during that particular year.

The percentages of teenage pregnancies were higher compared to national average in almost all Northern and Eastern RDHS areas, except Jaffna (3.3%) and Mannar (5.6%) where RDHS Jaffna reported the lowest teenage pregnancy percentage in the country. RDHS areas Trincomalee (8.5%), Batticaloa (8.3%), Mullaitivu (8.2%), Killinochchi (7.8%), Puttlam (7.4%), CMC (6.3%) and Vavuniya (6.1%) recorded higher teenage pregnancy rates. Figure 10 shows the percentage of teenage pregnancies by RDHS areas for year 2014.

7.1.5.3 Primies and Multipara

Primies and multipara (P5 and above) are considered to have relatively higher risk pregnancies than others. Figure 11 shows that in 2014, about 32.7 % of total pregnancies registered in the year were primies and 63.6%

Figure 9 : Trends in percentages of teenage pregnancies 2007- 2014

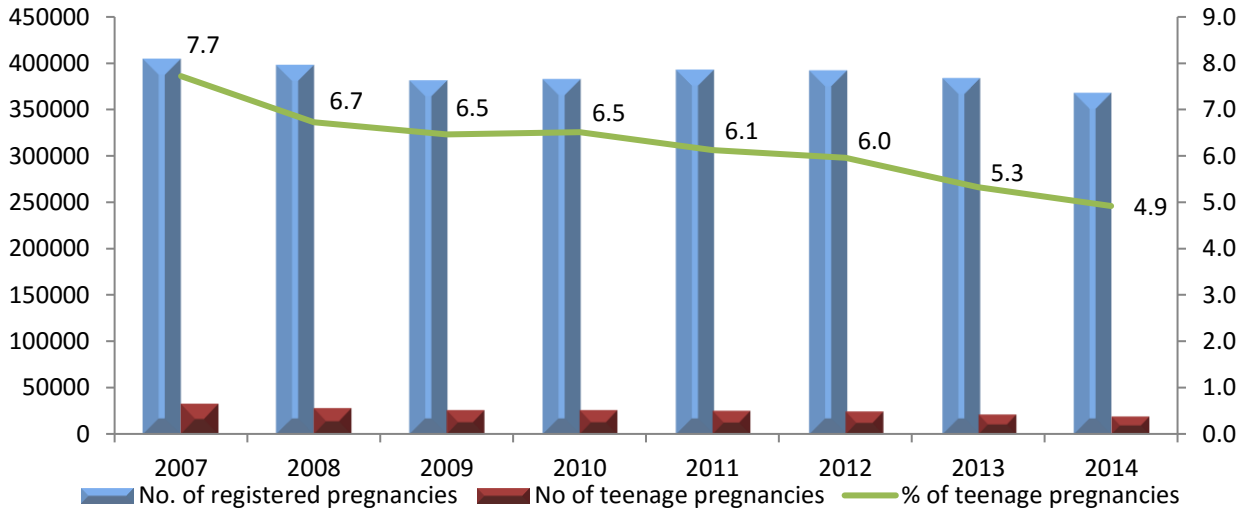
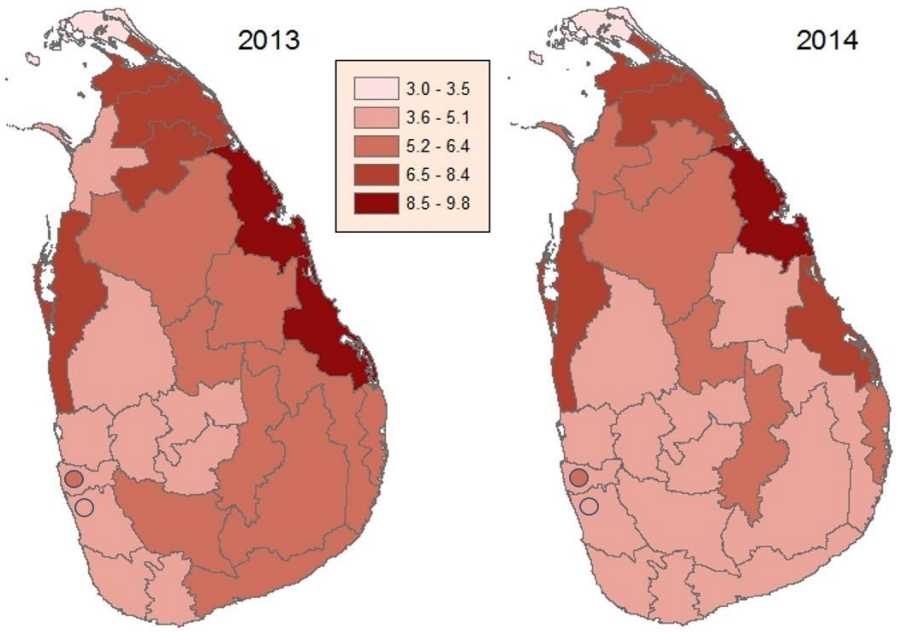


Figure 10 : Percentage of teenage pregnancies by district in 2014



were in the 2nd to 4th pregnancy. Only 3 .7% of pregnancies were 5th or higher order pregnancies. In addition to its importance as an accumulation of high risk set of pregnancies, presence of multi-para pregnancies indicates the efficiency of the family planning services.

Figure 11 : Distribution of registered pregnancies by parity in 2014

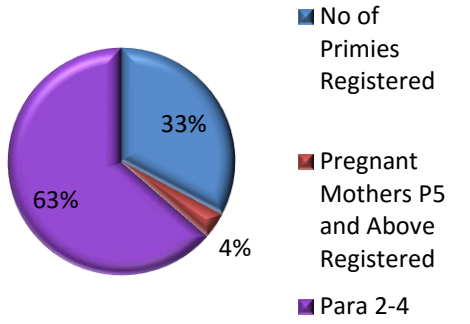


Figure 12 : Percentage of multi-para (≥P5) and teenage pregnancies by districts 2014

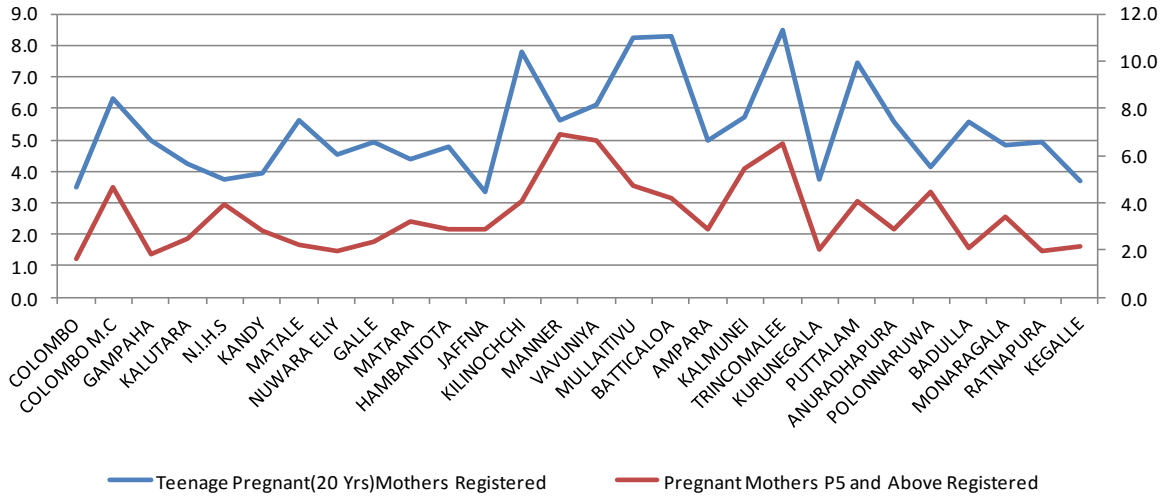


Figure 12 compares the percentage of multipara pregnancies, (≥P5) and percentage of teenage pregnancies by districts.

7.1.5.4 Antenatal Morbidities

The PHMs are expected to report selected types of morbidities and complications during antenatal period. These include: Hypertension (Chronic and Pregnancy Induced), Diabetes (Chronic and Gestational), Heart Diseases, Anaemia, Asthma, Malaria, Sexually Transmitted Infections, Liver diseases, Psychiatric illness, Epilepsy and any other significant illnesses.

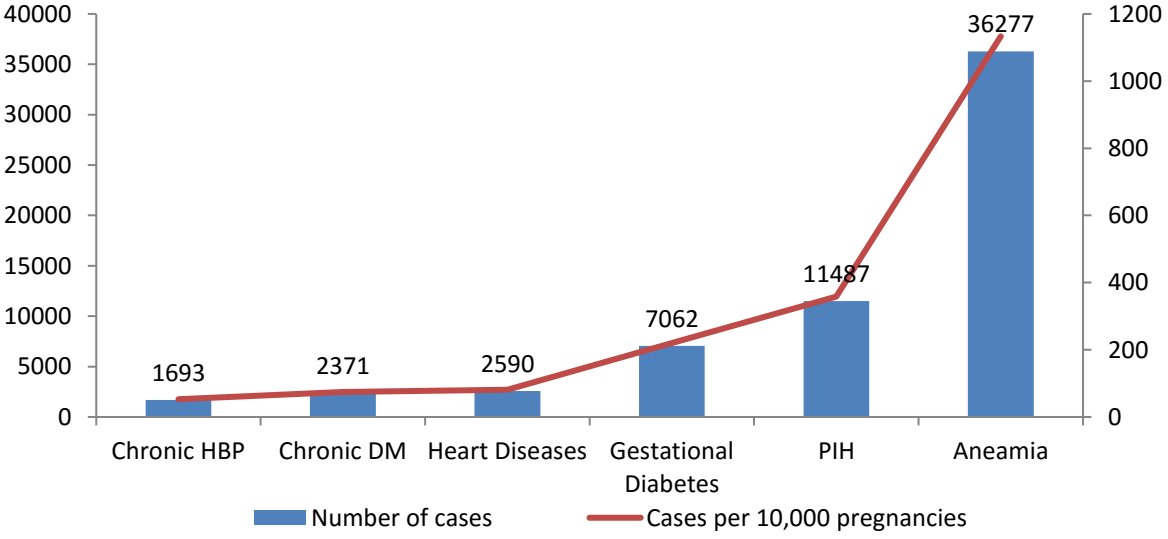
Therefore, absolute numbers of cases may be more than that was reported. Around 21% of pregnancies were associated with at least one of these conditions. The most commonly reported conditions include: Anaemia, Pregnancy Induced Hypertension (PIH) and Gestational Diabetes.

7.1.5.5 Maternal Nutritional Status

7.1.5.5a BMI

Under nutrition is considered as one of the most resistant public health problems in Sri Lanka. According to RH-MIS, around 12.2% newborns in 2014 weighed less than 2500 grams and hence became Low Birth Weight (LBW) babies. Maternal under nutrition is considered as one of the main reasons behind this high rate of LBW. Pre pregnant BMI is considered as an important associate of the birth weight of the newborn which in turn affect the child's nutrition. BMI measured before 12 weeks of gestation is approximated for pre pregnant BMI. In order to assess that, pregnant mothers should be identified before 12 weeks of pregnancy.

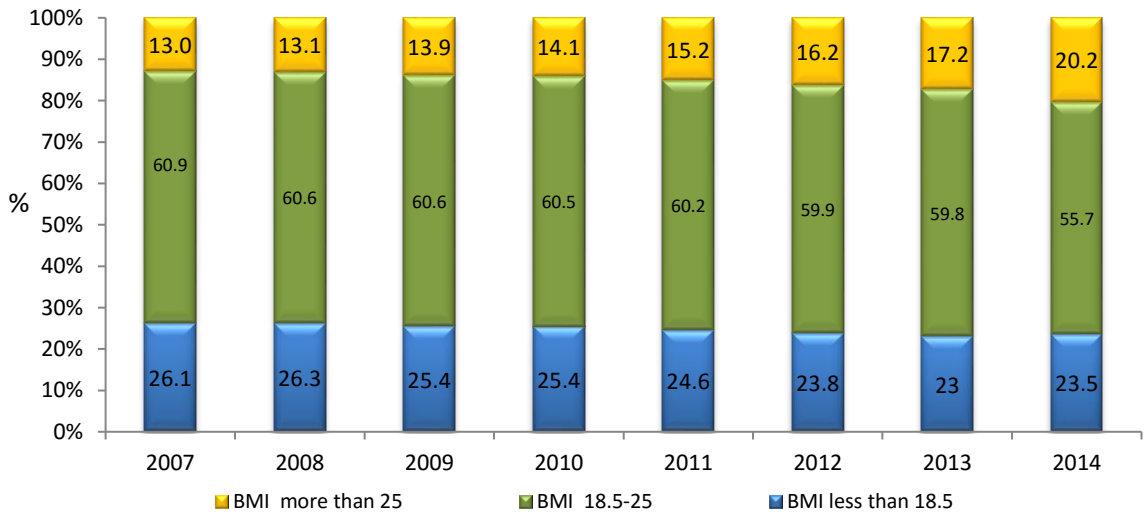
Figure 13 : Number of maternal morbidities and cases per 10,000 pregnancies 2014



These reportings are made during the first postpartum visit. Figure 13 shows the number of different types of antenatal morbidities that occurred during antenatal period and corresponding cases per 10,000 pregnancies.

This indicator is a relatively new addition and it is still taking the momentum in reporting.

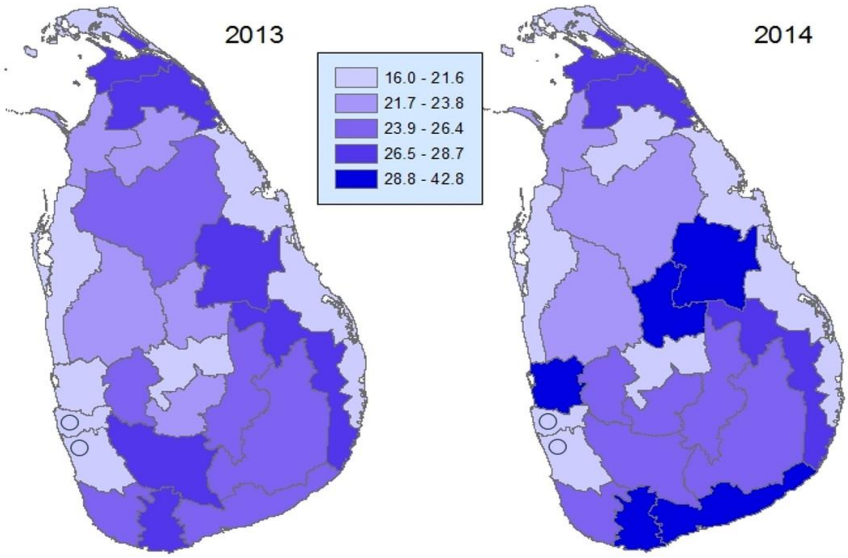
Figure 14 : Percentage distribution of pregnant mothers according to their BMI status at booking visit (before 12 weeks) since 2007



Hence, the percentage of mothers who have been examined for BMI will be dependent on their time of registration. The Figure 14 indicates the BMI status of pregnant mothers whose BMI was assessed before 12 weeks. Approximately 24.3% of pregnant mothers were found to be underweight and this proportion was remained more or less similar over past 8years.

Geographic variations are often prominent in nutritional indicators where Matale (34.3%), Matara (30.5%), Polonnaruwa (29.1%), Gampaha (28.9%), Mullaitivu (27.7%), Kilinochchi (26.6%), Hambantota (26.6%), Ampara (26.5%), and Monaragala (26.4%) RDHS areas reported the highest percentages of pregnant mothers with low BMI for year 2014 (annexure 3).

Figure 15 : Geographical variations in percentage of pregnant women with low BMI at booking visit 2013 and 2014



7.1.5.5b Maternal Anaemia

Anaemia as indicated by the serum Haemoglobin (Hb) level less than 11 g/dl is another important indicator of antenatal health. There are three indicators related to Haemoglobin status.

status reported here has based on different testing methods used in the field for last few years. Of 9.4% anaemic mothers in 2014, 9.0% were mild or moderately anaemic (Hb 7-11 g /dl) while only 0.4% was severely anaemic (Hb<7g/dl). As described in section 7.1.5.4 this could be an under reporting. As in the case of

Table 8 : Percentages of mothers whose Haemoglobin examined at field clinic and who were anaemic 2007-2014

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
% of mothers tested for Hemoglobin out of mothers attending antenatal clinics	72.2	72.4	62.7	57.8	56.1	52.3	50.6	57.1
% of pregnant mothers anaemic out of mothers attending antenatal clinics	5.1	6.1	6.4	8.3	9.1	9.3	9.8	9.4

Information for two of them is collected at field clinic visits and the other one describes the status as reported at first postpartum visit. Percentage of mothers who have had their blood tested in field clinics and the percentage of mothers who were anaemic use the number of mothers attending antenatal clinics as the denominator. Sometimes mothers get their Hb status tested from sources other than the field clinic. Low Hb reporting from the test done outside the field clinic centers were also counted in calculating the anaemic status.

Retrospective reporting of the anaemic status as an antenatal morbidity at first postpartum visit is given in the section 7.1.5.4. Table 8 includes the reporting on Hb assessments and prevalence of anaemia over last 8 years among the mothers attending field ANC.

The percentage of mothers who were tested for Hb at field clinics has been reduced while the percentage of mothers with anaemia has increased by 4.3 % during last 8 years. It is not appropriate to comment on the trend since Hb malnutrition, there is a notable geographical variation in prevalence of anaemia among mothers (Annexure 3).

7.2 Intra-Natal and Newborn Care

Almost all the deliveries around the country occur in institutions. It is the duty of the PHMs to report deliveries occurring to mothers who reside permanently in her area. The reporting is set to be optimized through 2 mechanisms. Almost all mothers are given a Child Health Development Record (CHDR) for their newly born children from the hospitals. CHDR includes instructions which request the mothers to inform area PHMs about her delivery. The PHMs also should maintain active surveillance on the deliveries occurring to mothers who have been under her care using the Pregnant Mother's Register (H 513) and Monthly Expected Mothers Register (H 515).In addition to number of deliveries, the reporting includes place of delivery, mode of delivery and type of personnel who assisted the delivery.

7.2.1 Delivery Reporting

Table 9 presents deliveries reported by PHMs in 2014 according to different perspectives.

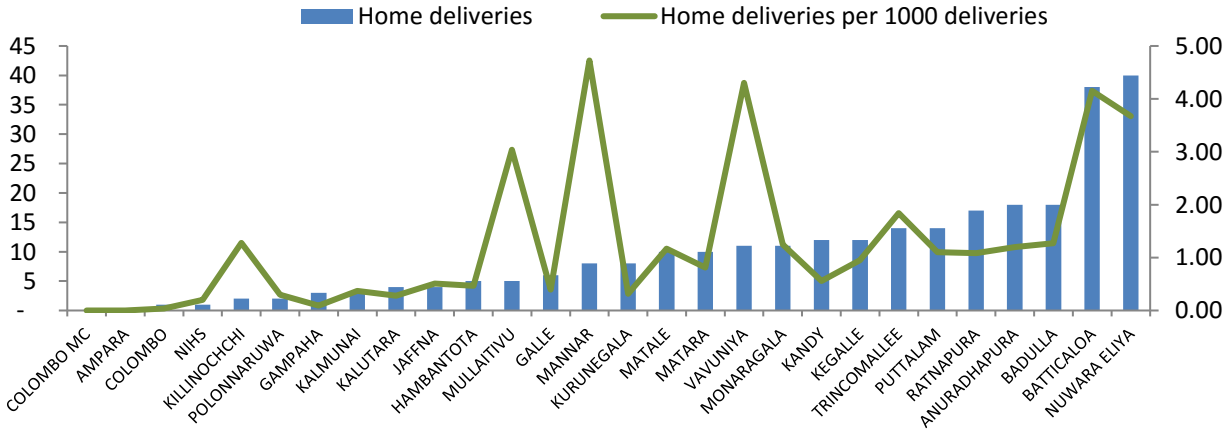
Approximately 13% of total pregnancies registered were not reported as deliveries. Not counting pregnancies that had ended up as abortion as delivery and gaps in delivery reporting may be possible reasons for this. Delivery reporting for estimated pregnancies was reported to be lowest in Kilinochchi (60.8%).

Some portion of mothers are exclusively cared by the private sector may be a reason for this gap other than the two reasons given above. Details are given in the annexure 4.

Table 9 : Patterns of delivery reporting by PHMs

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
Estimate number of pregnant mothers	437,729	442,828	423,109	445,081	415,869	416,747	425998	402785
Pregnant mothers registered by PHM	404,138	397,527	380,884	382,418	392,202	391,712	383383	367528
No. of deliveries reported by PHM	320,287	327,326	313,958	310,240	320,021	319,592	320943	320344
% of deliveries reported out of total estimated pregnancies	73.2	73.9	74.2	69.7	76.9	76.7	75.3	79.5
% of deliveries reported out of total registered pregnancies	79.3	82.3	82.4	81.1	81.6	81.6	83.7	87.2
% of institutional deliveries out of total reported deliveries	99.5	99.6	99.7	99.8	99.9	99.9	99.9	99.7
% of Home deliveries out of total reported deliveries	0.5	0.4	0.3	0.2	0.15	0.1	0.1	0.09
% LSCS out of total reported deliveries	24.3	25.8	27	27.7	28.7	30.5	31.1	32.1
% of untrained deliveries out of total reported deliveries	0.3	0.3	0.2	0.1	0.1	0.1	0.1	0.05

Figure 16 : Number of home deliveries and cases per 1000 deliveries reported by district in 2014



Almost all mothers were delivered in health institutions while only very few cases delivered at home (n=277). Only 0.05% of deliveries were conducted by untrained personnel.

Figure 16 shows the number of home deliveries and home delivery rate per 1,000 reported deliveries by RDHS area. The number of home deliveries were notably high in Nuwara Eliya (n=40), Batticaloa (n=38), Badulla (n=18,) Anuradhapura (n=18) and Ratnapura (n=17) districts. All the districts in the Nothern Province except Jaffna recorded a very high number of home deliveries compared to the total number of deliveries taken place in the respective districts.

7.3 Pregnancy Outcome

PHMs should report live births categorized according to their birth weight (less than or more than or equal to 2500 gm) and plurality (singleton or multiple). In addition number of abortions and still births are also reported.

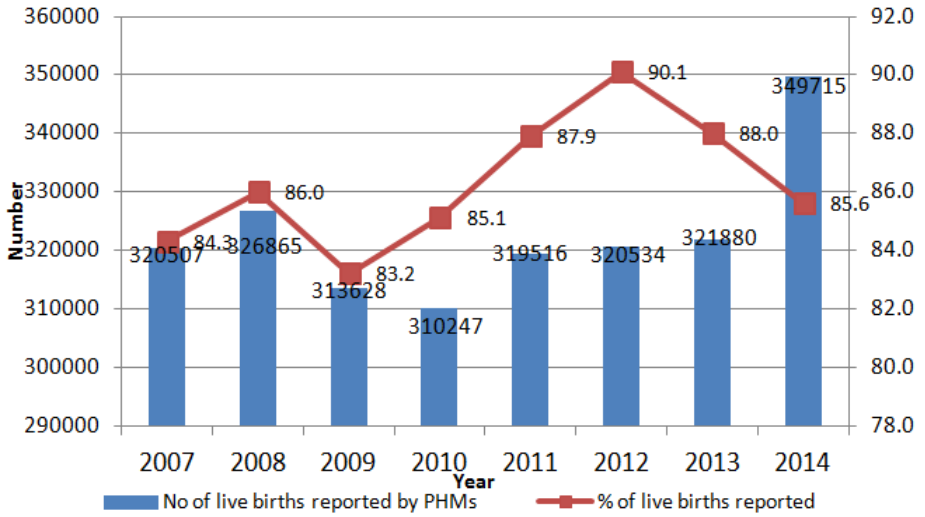
In 2014 PHMs around the country have reported 313,689 live births (either singleton/ multiple). In addition 1,874 stillbirths and 28,707 abortions were also reported. Figure 17 reflects the live births reported by PHMs as a proportion of the live births reported through the vital registration system.

It is observed that 12% of the live births occurred in the country is not captured by the field PHMs. This may be due to some portion of pregnant mothers not receiving health services through public health system. Under reporting of the birth by PHMs may also account for this to certain extent.

7.4 Postpartum and Newborn Care

Family Health Programme makes provision for PHMs to pay at least 4 postpartum visits to a mother who had an institutional delivery. Of these visits, one visit each has to be made during first 5 and 6 - 10 days following delivery and the other 2 during 14 to 28 days and around 42 days respectively following the delivery. During these visits PHMs examine mothers and babies for any postpartum and

Figure 17 : Live births reported by PHMs as a proportion of the live births reported through vital registration system 2007 -2014



newborn problems. In addition they should record antenatal and postpartum morbidities, support breast-feeding the newborn, counsel for family planning, advice on other health matters, administer vitamin A to mothers in case she missed it at the hospital and register the newborn for future care.

7.4.1 Postpartum Visits

Postpartum visits made by PHMs during postpartum period are reported though RH- MIS. The Table 10 examines the efficiency of these activities.

During 2014 PHMs around the country had visited 90.7% of postpartum mothers who were identified and reported by them at least once during the first 10 postpartum days. On average 2 postnatal visits were made within the first ten days. However, it should be noted that percentage of deliveries reported out of registered pregnancies for 2014 was only 87.2% (Table 9).

Figure 18 indicates that a considerable percentage of mothers may not receive their first postpartum visit during the

Table 10 : Pattern of postpartum visits provided for mothers by PHMs 2007-2014

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
At least 1 visit during 1st 10 days out of estimated births	77.9	79.4	75.9	75	77.4	77.3	78.2	79.3
At least 1 visit during 1st 10 days out of reported deliveries	88.8	90.6	89.2	90.8	91.4	91.6	92.2	90.7
Average number of visits during 1st 10 days	1.8	1.8	1.8	1.8	1.8	1.7	1.7	1.7
At least 1 visit during 11th to 28th day out of reported deliveries	20.7	17.9	16.3	15.5	14.6	14	13.8	13.4
Postpartum visits by PHM at or around 42 days out of reported deliveries	71.4	73.7	73.8	72.9	73.3	74.3	76.7	74.3

Figure 18 : Percentages of postpartum visits made within the first 10 days of delivery 2007-2014

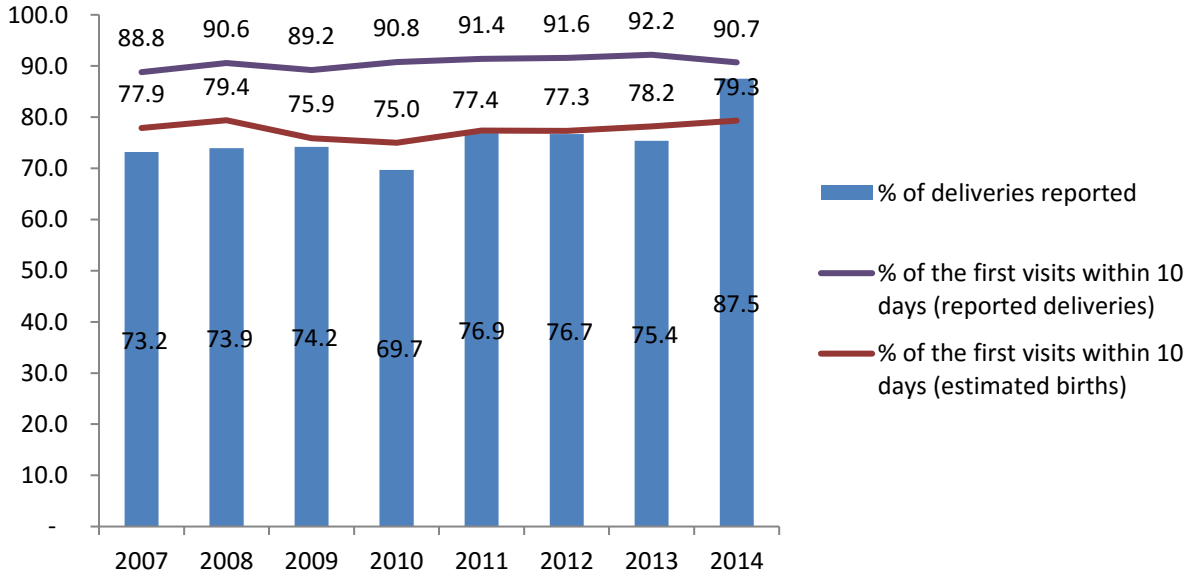
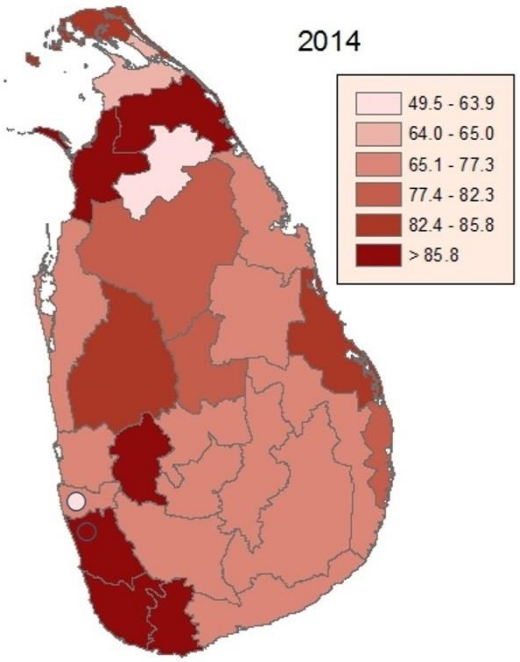


Figure 19 : Percentage of estimated births, who were receiving the first postnatal visit within the first 10 days of delivery in 2014



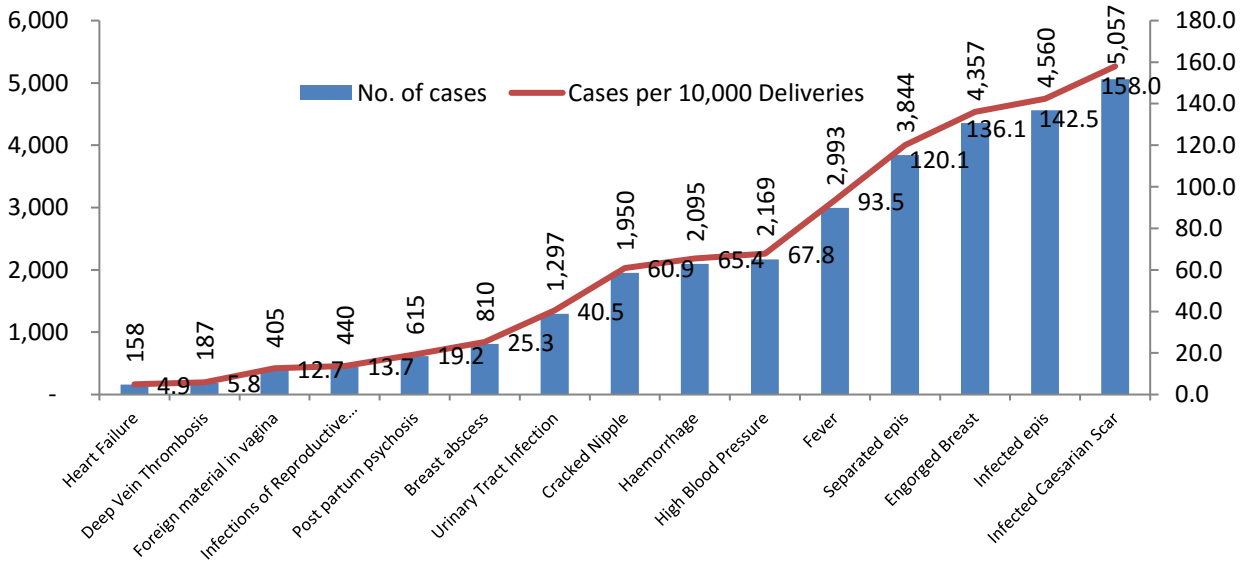
first 10 days following delivery. Only 79.3 % of mothers have received such care when assessed for the estimated births. Colombo MC (42.9%), Vavuniya (59.2%), Killinochchi (64.4%), Ratnapura (66.1%) and Nuwara Eliya (69.2%) were among areas with very low postpartum care reporting for estimated births.

The above analysis shows that domiciliary care provided during postpartum period is relatively poor compared to that during antenatal period. Annexure 5 and Figure 19 show the district disparities in the postpartum care provided to mothers with in first 10 days following delivery as a percentage of estimated deliveries.

7.4.2 Postpartum Morbidity

PHMs are instructed to record new cases of postpartum morbidities. In 2014, PHMs reported 32,542 mothers with postpartum morbidities. This amounts to 10.2 % of the total reported deliveries. Figure 20 shows the cause specific postpartum morbidity rates for 10,000 reported deliveries. Most common postpartum problems include infections

Figure 20 : Number of postpartum morbidities and cases per 10,000 deliveries reported in 2014



either in episiotomy or caesarean scar, engorged breast, separated episiotomy and fever. Infections were calculated for respective type of delivery. The mostly reported morbidities could have been prevented by proper infection control and breast feeding practices. However, high infection rate at episiotomy or caesarean scar also indicate the need for examining the PHM's ability to identify those.

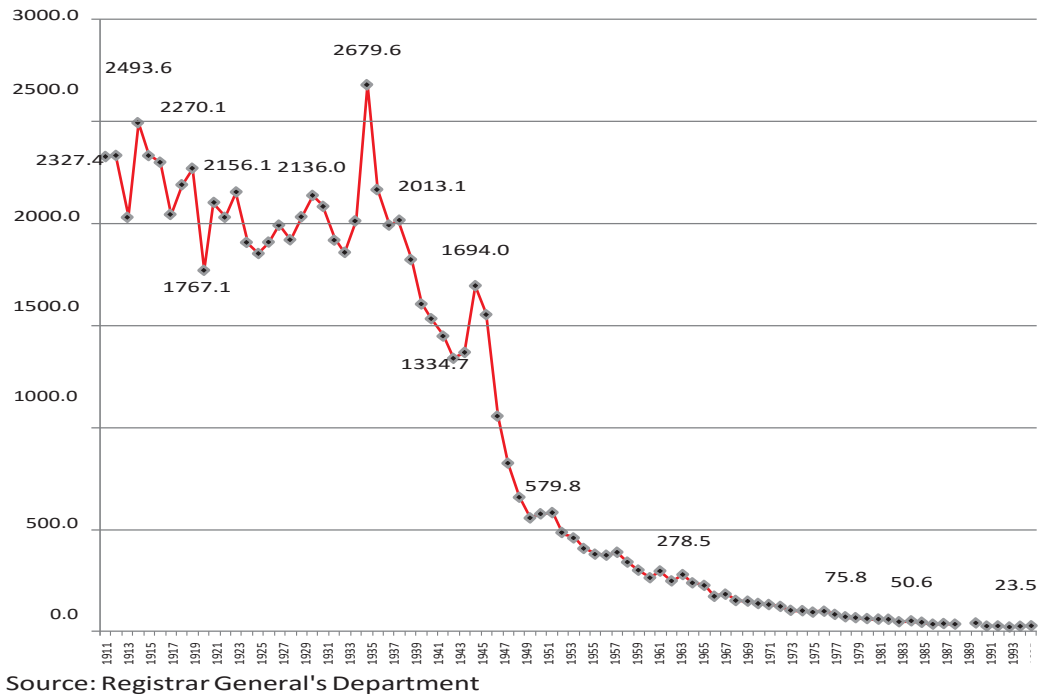
7.5 Maternal Mortality

Sri Lanka has shown a tremendous success in bringing down maternal mortality over the years. Around 2680 out of every 100,000 mothers died due to a cause related to pregnancy during early 19s. Various interventions have reduced this number to 32.03 per 100,000 live births in 2014. Factors such as socio-economic development, free education and related high literacy rate of population, free health services, better transport, control of communicable diseases, well organized primary health care systems etc have been attributed to this success. Currently Sri Lanka is on par with high-income countries with low levels of maternal deaths and the contribution made by the National FHP in this regard is substantial.

Following graphs demonstrate the gradual reduction of maternal mortality ratio (MMR) over the years, based on data from Registrar General's Department (1911-1995), when there was no organized surveillance system- (Figure 21) and from FHB data (1995-2013) after the systematic Maternal Death Surveillance system was established (Figure 22). The national MMR for the year is 32.03 per 100,000 live births. The denominator is the live births reported from the Registrar General's Department.

Maternal deaths were reported directly to the FHB since 1985, and by 1995 a methodical process was established to capture all maternal deaths in the country. FHB has been recognized as the official source of maternal mortality information thereafter.

Figure 21 : Maternal Mortality Ratios 1911—1995



Source: Registrar General's Department

Figure 22 : Maternal Mortality Ratio 1995 - 2014

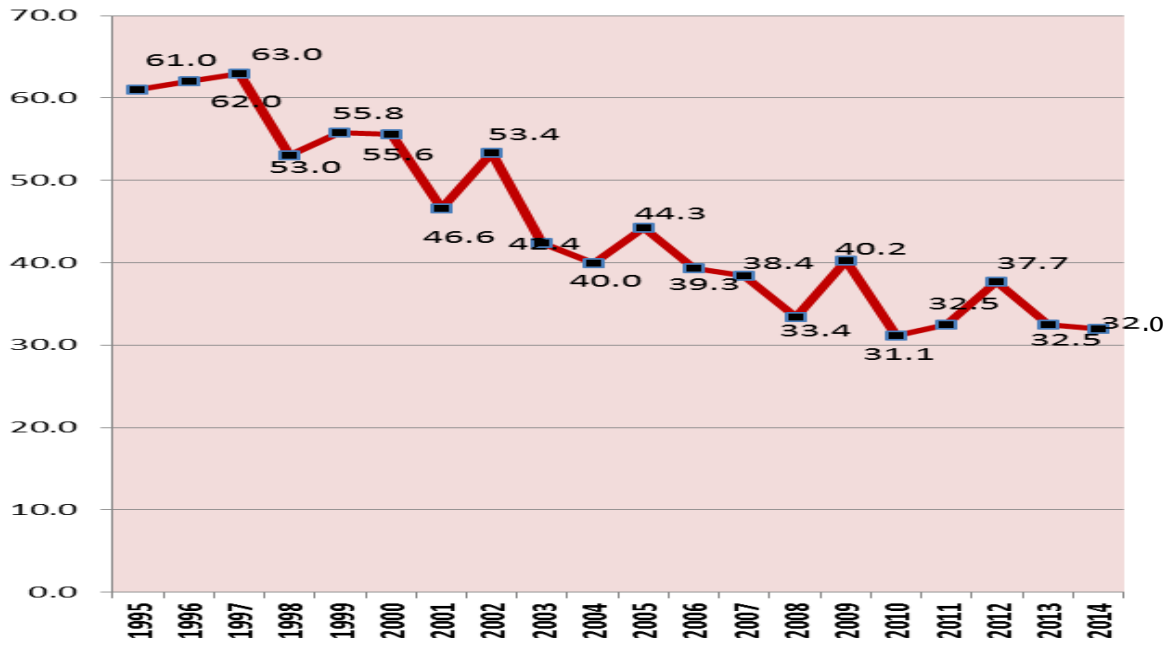
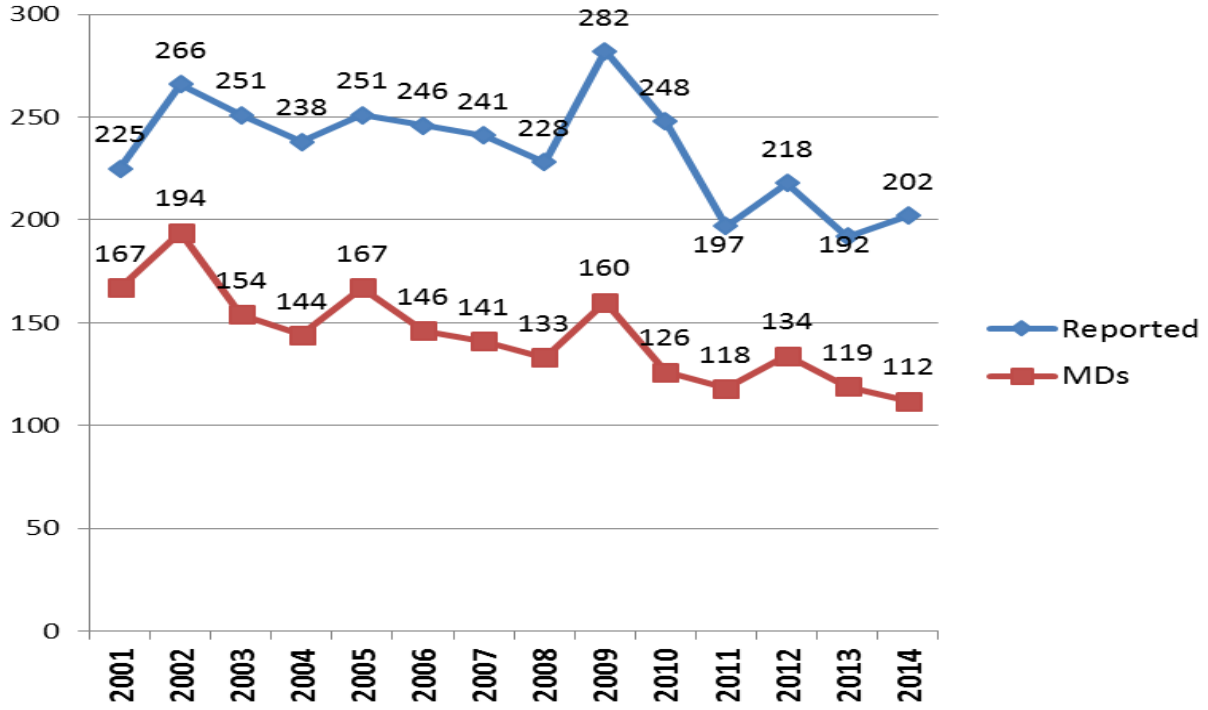


Figure 23 : Probable and confirmed maternal deaths 2001 - 2014

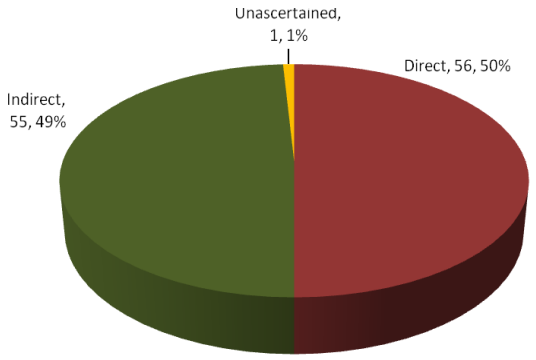


7.5.1 Maternal Death Surveillance and Response (MDSR) system of FHB

The present surveillance system identifies almost all maternal deaths in the country. Each and every probable maternal Death occurring throughout the country is notified to the Family Health Bureau within 24 hrs of occurrence which is reviewed at field, institutional, district and national levels subsequently. At the National Maternal Mortality Reviews conducted at district level by Family Health Bureau in collaboration with technical experts from the Sri Lanka College of Obstetricians and Gynaecologists and other relevant professional bodies, the cause of death is confirmed and the associated factors that may have contributed to the death are discussed to prevent such death in the future. This provides a platform to learn lessons from the mistakes and translate the findings into action both at national and sub-national levels.

The system is continuously reshaped to maintain the timeliness, data quality and coverage. FHB received 99% of field (H 677a) and institutional (H 677) maternal death investigation reports in 2014. Data quality of reports improved gradually with the introduction of a mechanism to obtain data gaps in a structured format to MOHs and hospital heads. Conducting post-mortems on maternal deaths were made mandatory with the circular issued by Secretary, Ministry of Justice and Law Reforms to all coroners in 2009. The process was further streamlined with instructions given by Director (Maternal and Child Health) in 2010. The dissemination of the above circular to all relevant personnel and close follow up by FHB, improved the coverage of conducting of post- mortems on maternal deaths from 94% (2011) to 95% in the year 2014. The national maternal mortality review meetings were restructured with presentation of case scenarios by FHB to initiate the discussion on the index maternal death leading to more in-depth discussion. A maternal death case scenario is a comprehensive account on maternal death developed for each and every notified death based on field (H 677a) and institutional (H 677) maternal death investigation reports, pregnancy records and other field records and post-mortem reports.

Figure 24: Maternal Deaths by type of cause



7.5.2 Analysis of Maternal Deaths 2014

All deaths (irrespective of cause) of women in reproductive age group during the pregnancy period and until one year after termination of pregnancy should be notified to FHB. Out of 202 probable maternal deaths reported to FHB during 2014, 112 were confirmed as maternal deaths after a consensus reaching process among experts. The figure 23 shows the progression of reported and confirmed deaths over the years.

A large majority of the women died due to a pregnancy-related cause in 2014 were either from rural (65%) or estate (10%) sectors.

The following figures (24 - 26) show the maternal deaths by direct/ indirect causes, antenatal / intranatal / postnatal period, and marital status.

There is no significant difference in direct (50%) and indirect (49%) categories of maternal deaths (Figure 24). Many of the maternal deaths occurred during postpartum period (64%), highlighting the of focusing on postpartum interventions to prevent such deaths (Figure 25).

It is also noticeable that a significant number of 'single' females (10%) contributes to maternal deaths.

Figure 25 : Timing of Maternal deaths

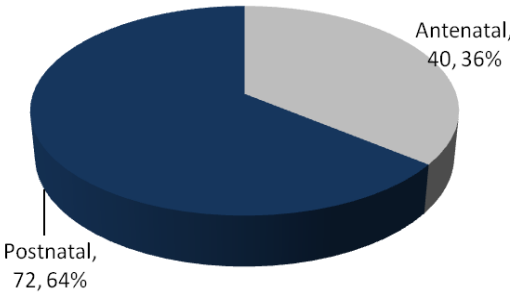


Figure 26 : Maternal Deaths by Marital Status

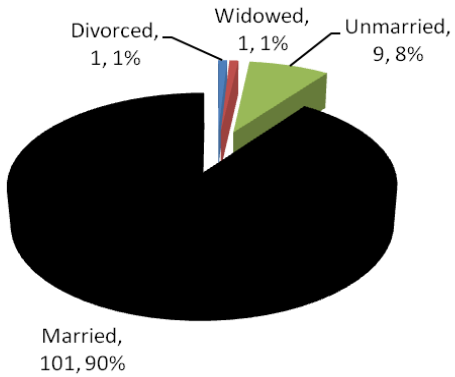
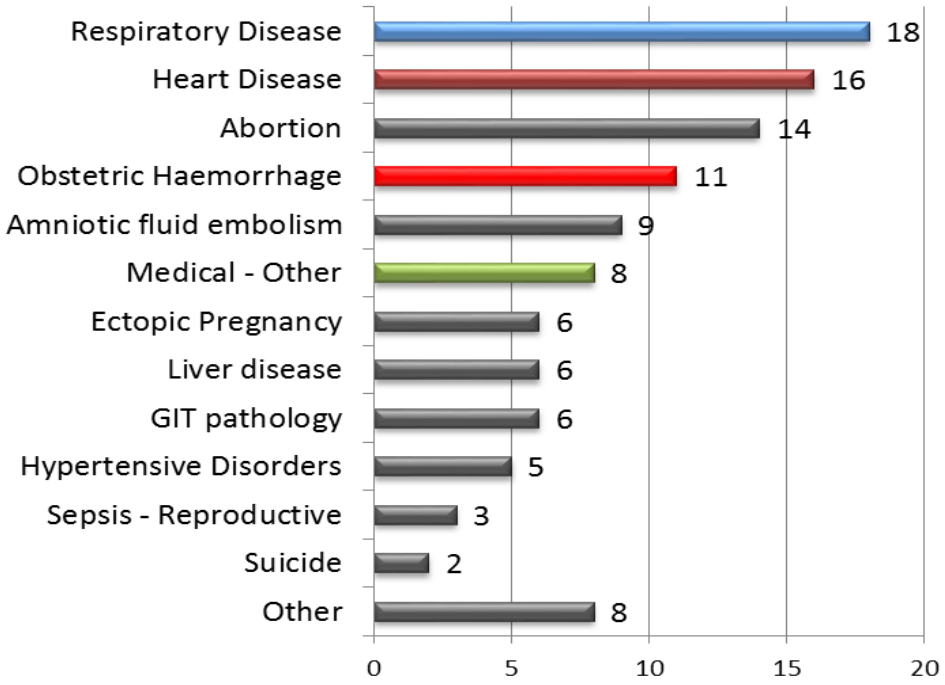


Table 11 : Maternal Mortality Ratio by type of cause, pregnancy period, parity and maternal age 2007-2014

Maternal Mortality Ratio by		2007	2008	2009	2010	2011	2012	2013	2014
Type of cause	Direct	25.7	17.8	25.2	18.0	19.3	23.6	14.5	16.0
	Indirect	10.4	14.3	14.6	12.8	12.7	14.0	18.0	15.7
Time	Antenatal	10.3	12.6	13.6	12.8	11.3	10.4	12.8	11.4
	Intrapartum	1.4	3.5	0.8	1.2	1.4	1.4	0.3	0.0
	Postpartum	14.1	18.0	23.7	17.0	19.8	25.8	18.9	20.6
Parity	P1	11.6	10.1	10.6	12.4	10.7	10.7	12.0	6.6
	P2 - 4	15.4	16.3	16.6	15.8	14.6	20.8	20.2	22.9
	>P5	6.5	3.0	2.8	3.0	2.5	3.9	0.3	2.6
Maternal age	<19	1.4	1.2	2.0	1.2	3.3	1.4	2.2	1.1
	20 - 35	27.3	24.4	27.4	21.5	20.9	27.0	24.6	23.7
	>36	9.2	7.2	10.6	8.4	8.3	9.3	5.7	7.1

Figure 27 : Number of maternal deaths from different causes - 2014



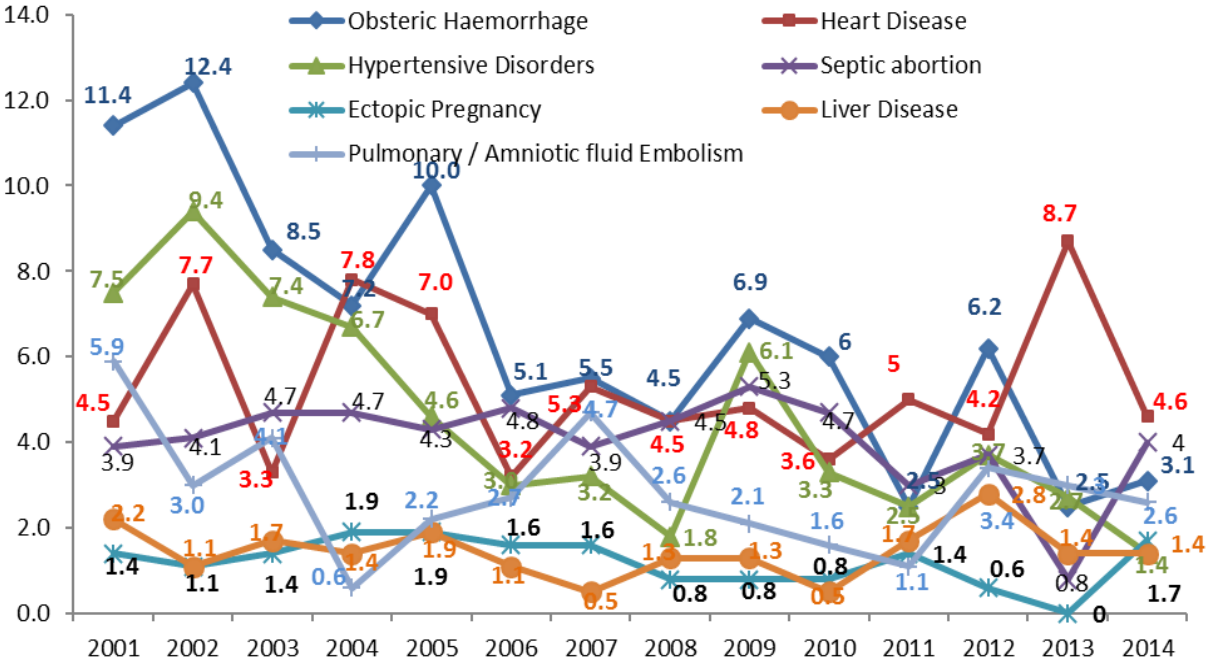
Primies accounted for 21% of deaths. A high proportion of maternal deaths occurred in second pregnancy (31%) while 48% occurred among mothers in parity 3 and above. Approximately one fourth (26%) of mothers died were in high risk age groups: more than 35 years (n=25) and less than 20 years of age (n=4). Ethnicity shows a disparity in maternal deaths with the majority (63%) of the diseased were Sinhalese followed by Tamils (26%) and Muslims (11%). This is reflected in estimated ethnicity specific MMRs (Sinhalese 28.9, Tamils 48.0 and Muslim 28.4).

Table 11 includes the trends in selected parameters related to maternal mortality over the past 8 years.

The leading causes of maternal deaths were respiratory disease, heart disease complicating pregnancy, abortion and obstetric haemorrhage. It is apparent that medical disorders are emerging as significant causes of maternal deaths. Figure 27 and 28 draw the attention for need for cause-specific preventive strategies to reduce maternal deaths further in the country.

Cause-specific maternal mortality ratios (CSMMR) also reduced over the years to lower levels in 2014 especially in obstetric hemorrhage (2.8), hypertensive disorders (1.3) and Amniotic fluid embolism (2.3). However CSMMRs for septic abortion, heart disease, respiratory disease and liver disease remain more or less stagnant over the years.

Figure 28 : Cause-specific Maternal Mortality Ratios 2001—2014



7.5.3 Care provision for the deceased mothers

Almost 80% all women died in the year 2014 died in hospitals (Table 11a). Of which 98% died at a base, general or a teaching hospital where specialized facilities are available (Figure 29). This indicates that there might have been an adequate opportunity for interventions.

Provision of family planning services to needy women is a priority in preventing unwanted pregnancies. However, Figure 30 shows that 35% of the maternal deaths in 2014 could have been prevented if unmet need for family planning had been addressed by relevant health care personnel.

Figure 33 shows the district variations in MMR in 2014 highlighting the need for district specific preventive strategies. The analysis of the maternal deaths in relation to the care received provides an opportunity to rectify deficiencies at different service delivery points.

At the National Maternal Mortality Review, the experts assessed the preventability of the index maternal death. It is significant that 62% of the maternal deaths were preventable in the year 2014 (Figure 31). Further analysis of maternal deaths based on modified three delay model "The original 3-delay model conceptualized by Thaddeus and Maine (1994) modified for Sri Lankan contexts as Delay 1 -non-using of ANC / not practicing family planning services or Delay 3 Health system failures in preventive and curative services" [whether there is a deficiency in seeking (D1), reaching (D2) or treating (D3)] revealed that delays were present in 72% of deaths in the year 2014 (Figure 32). Further analysis revealed that 57.1% women did not seek care in time (D1) for their illnesses and also health care workers (both field and hospital) did not provide adequate care (D3) in 33.9% of the cases. This should alarm health care workers and administrators in both preventive and curative sectors since making women

aware of health conditions which need timely care seeking is a fundamental in providing care for the reproductive age women and missed opportunities in receiving appropriate care once they accessed the health facility are of major concerns.

The unseen aspect of maternal death is that 188 children lost their mother and 101 husbands were left without the wife.

Table 11 a : Maternal Deaths by place of Death

Place of birth	No.	100%
Field	1	0.9
Home	3	2.7
On admission	14	12.5
Hospital	90	80.4
In transit between hospitals	4	3.6
Total	112	100.0

Figure 29 : Maternal Deaths by type of Hospital

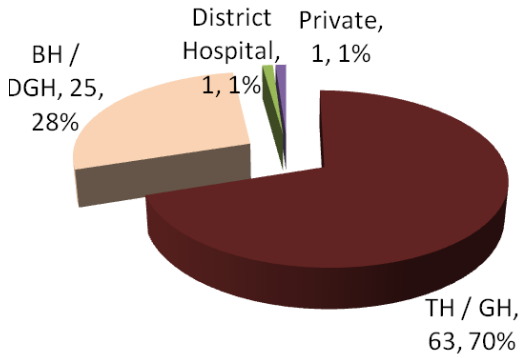


Figure 30 : Maternal Death by Unmet Need for Family Palnning

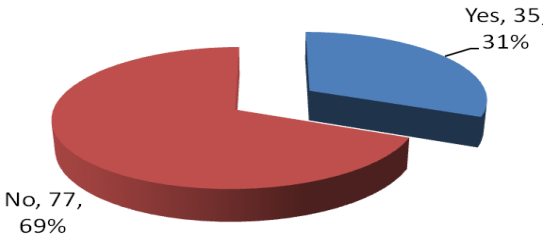


Figure 31: Maternal Death by preventability

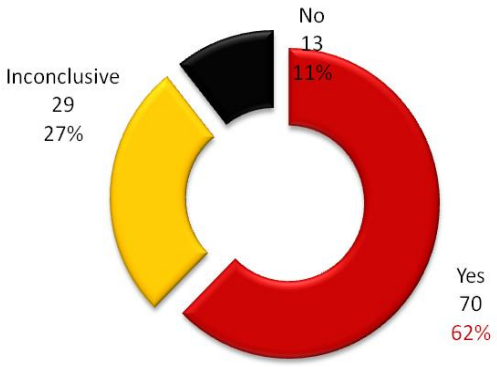


Figure 32 : Matrnal Death by three delays

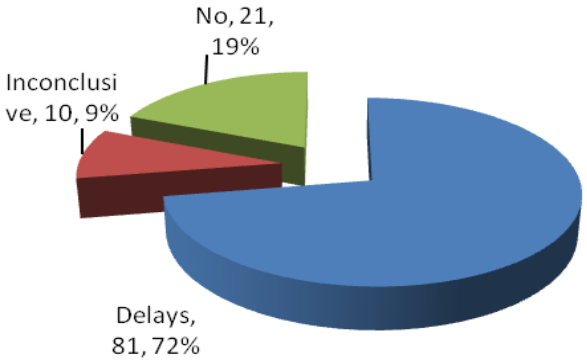
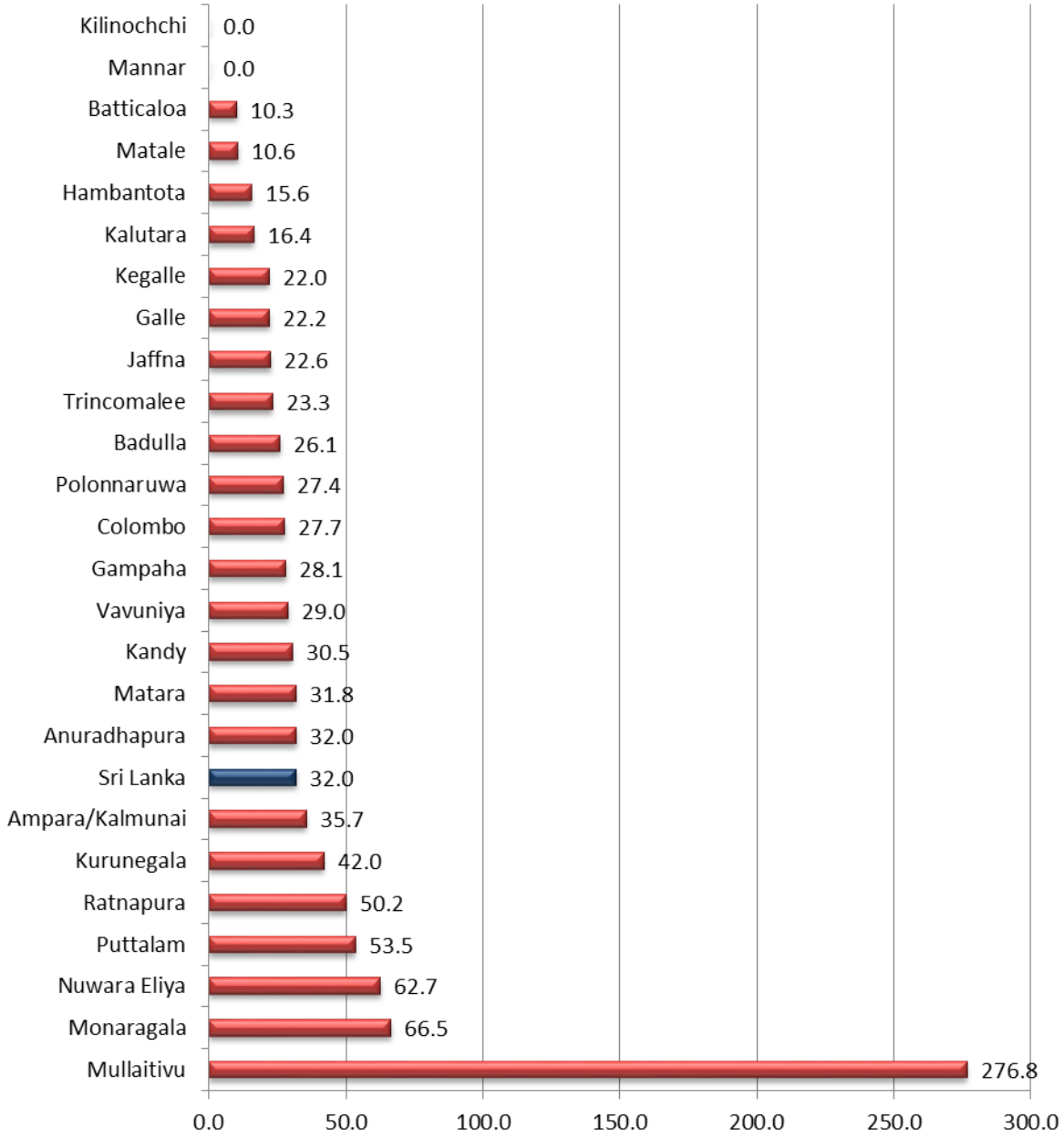


Figure 33 : Maternal Mortality Ratio by RDHS areas — 2014



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

Translating lessons learnt in to policies, programs and practice is a fundamental aspect of maternal death surveillance and response. The utilization of the findings which are of national and sub-national concerns to relavent technical and administrative groups and providing feedback to the all who provide services to women for corrective actions. Minutes of each national maternal mortality review of the relevant district is disseminated to a heterogeneous group of stakeholders. At present, several mechanisms are available to put the recommendations into action starting from the ground level (PHM level) up to national level through two advisory committees (Technical Advisory Committee on Maternal Health and Family Planning and Newborn Care and Child Health) and National Committee on Family Health chaired by the Secretary Health.

In the year 2014, recommendations of the maternal death reviews were transformed into action; improving competencies of several categories of healthcare workers (MOs, PHMs), introducing a “Red Book” to make visible highly vulnerable difficult cases, further expansion of rapid communication system, strengthening multidisciplinary care for critically-ill pregnant women, addressing human resource issues, regularizing 24/7 blood transfusion facilities etc.

8 Child Care

Family Health Programme is organized to ensure the continuum of care during pre pregnancy, pregnancy, neonatal period, infancy, young childhood, preschool, school and adolescent years. During postpartum visits conducted within first 42 days, the PHM provides basic domiciliary care to newborn children. These include, assessment of general health, breast feeding, screening for illnesses, followed by advising mothers accordingly and making necessary referrals. Subsequent interventions for children include immunization, growth assessment and promotion (which includes promotion of breast feeding and complementary feeding), assessment and promotion of development, food and vitamin supplementation, deworming and health education to mothers. In addition, all children are expected to be registered in the Birth and Immunization (BI) register (EPI 3/79) which is a unique document. It could be considered as one of the most comprehensive community based registers of the country, which records details of all children permanently residing in the PHM area.

8.1 Registration of Children

Ideally total number of infants registered (permanent residents of the PHM area) should approximate the total number of estimated births of the country. Figure 34 presents the percentage of total estimated children who were registered by PHMs, from 2007 to 2014. It shows that relative to the estimated births approximately 9% of newborns are not registered.

Table 12 shows infants and 1-5 year children under care of PHMs as a percentage of estimated births in corresponding years. Reaching the target group seems to be highest in the second year of life.

8.2 Field and Clinic care

Following infant registration, care is given to the infant until 5 years of age at clinic and in the field. Home visits carried out after 42 days of delivery are

Figure 34 : Trends of infant registration out of estimated births 2007 to 2014

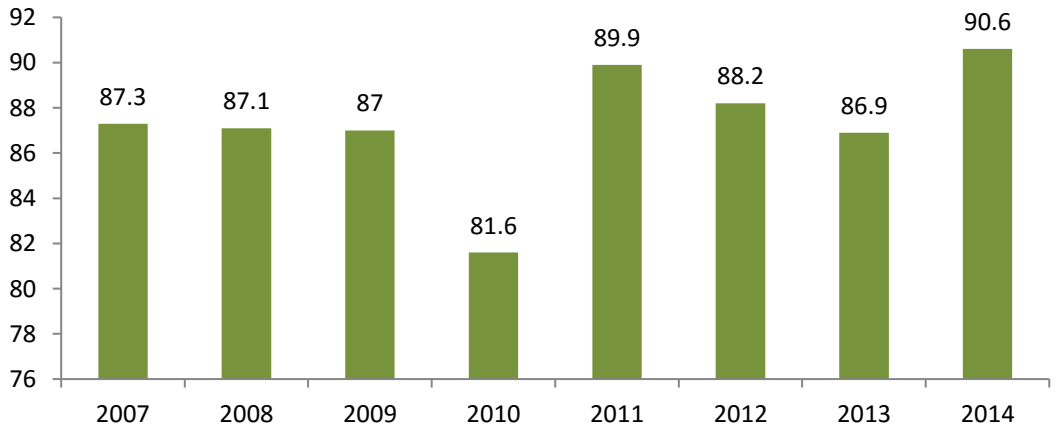


Table 12 : Percentages of infants and children under care out of estimated number from 2007 -2014

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
% Infants under care	87.3	87.6	81.8	81.7	82.4	88.4	94.6	93.7
% of young children under care (2nd year)	99	96.5	91.9	90.8	87.4	93.1	96.5	102.3
% of Preschoolers under care (3rd to 5th year)	80.1	81.7	82.3	84.7	86.1	90.2	92.8	97.2

specifically aimed at the infant. The infants are expected to be brought to the field clinic for postnatal examination by the MOH at 4 weeks and subsequently for health screening, growth monitoring, immunization and development assessment according to the schedule. The weighing is mainly done at child welfare clinics and field weighing posts conducted by PHMs which are for 30-50 children. During these health contacts, immunization, assessment of their growth and developmental status, vitamin supplementation and health awareness are being done. Table 13 presents some of the indicators that reflect the field care performances of PHMs.

The field visits made for infants during the year were not optimal. Nearly 42% of infants registered have not had at least a single home visit by the PHM after 42 days, which should be the visit dedicated for the infant. However, those who received home visits of PHMs had about 7 visits during first year of their life. More than 80% of registered infants in Kalmunai (80.4%) RDHS area had been visited at least once by PHM at home after 42 days postpartum and the lowest reported percentage was from the district of Mannar (15.1%). Colombo Municipal Council area (34.1%), Vavuniya (40.5%) and Puttlam (47.7%) had also reported very low coverage of infant home visits.

Children under two years should be weighed once a month. Accordingly, infants should have been weighed 12 times during infancy. Children above two years are weighed once in three months and if they are malnourished monthly weighing is recommended. However, the data for individual children are not included in the RH-MIS. What is available is the total numbers of infants and 1-5 year children weighed during the year. Hence, only an approximation of average number of weighing for a child per year could be obtained.

If an assumption is made that average number of infants under care is more or less equal throughout the year, average number of weighing for an infant remains around 8-10 per year during last 8 years. This could also be viewed as the percentage of total expected number of weighing carried out by PHMs. Table 13 shows around 84 % of total expected infants weighing were carried out by the PHMs. Every infant and young child is supposed to get their length measured at birth, 4, 9, 12 and 18 months and thereafter height every 6 months if growth occurs according to the recommended trends. If the child is malnourished during first two years of their life length measurements need to be done every two months and every three months height

Table 13 : Indicators of field and clinic care performance for under 5 children from 2007 – 2014

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
% Infants having at least 1 home visit after 42 days out of registered infants	63	63.9	64.3	61.8	72.3	69	63.9	58.0
Average number of home visits per infant	8.6	9	8.8	8.7	6.6	7.1	7.4	7.5
Average number of weighing per infant during a year	8.4	9	9.8	9.8	10.1	10.2	10.0	10.2
% of infants weighed	70	75.2	82	79.9	84	83.2	85.7	84.3
% of young children (1-2 years) weighed	63.7	67.8	73	72.7	77.1	76.1	79.3	77.1
% of infants making at least one clinic visit (of registered infants)	96.7	99.7	99.6	98.3	97.9	100	99.6	99.1
Average number of clinic attendance for an infant	4.8	4.7	5.2	5.2	5.2	5.3	5.2	5.3
% of estimated infants given Vitamin A at 6 months	93.3	93	79.5	75.4	80.3	76.4	68.9	68.8
% of estimated children given Vitamin A at 18 months	93.1	88.9	85.2	84	82	74.7	70.7	71.9
% of estimated children given Vitamin A at 3 years	87.2	86.5	83.7	87.5	85.3	78.8	71.4	73.1

Height measurement is recommended if the child continues to be malnourished after two years.

The clinic visits for infants are for the provision of a package of interventions; the first postnatal examination at 1 month of age, vaccinations at 2, 4, 6, and 9 months and growth and developmental assessments. This indicates, ideally at least 5 clinic visits are required during infancy. Table 13 shows the average number of clinic visits by an infant is around 5 during past 8 years. This reflects the almost universal health seeking behaviour of Sri Lankan mothers. Children under five years are being given Vitamin A mega dose every six months from the age of six months onwards. Considerably higher percentage of estimated infants and children received their Vitamin A mega doses. District differentials are given in annexure 6.

8.3 Child Nutrition

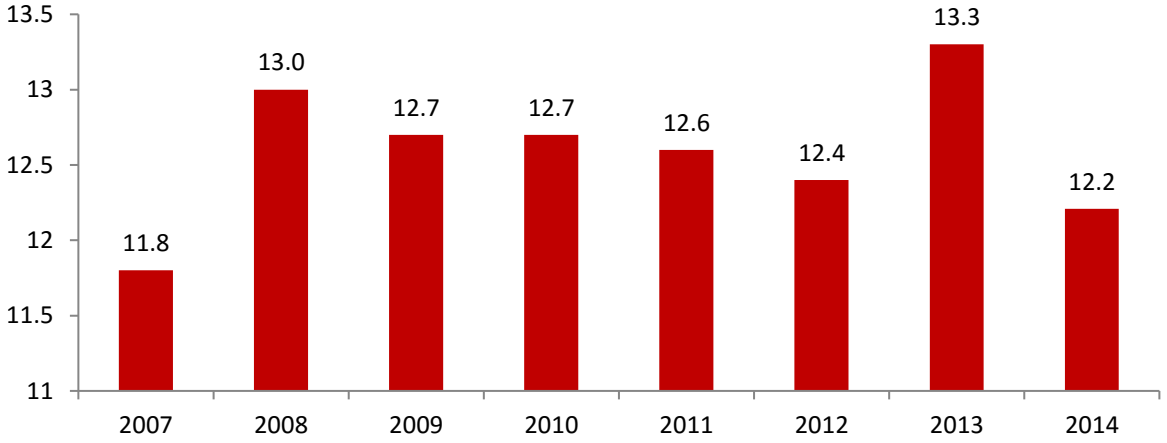
Child under nutrition is a major public health problem in Sri Lanka. RH-MIS gather data on low birth weight and weight for age of infants, young children and preschool children.

8.3.1 Low Birth Weight (LBW)

According to the reporting of PHMs throughout the country, since 2007 up to 2014, nearly 12-13 % of newborns weighed less than 2500 grams at birth (figure 35). This figure is lesser than the percentage of LBW; 16.6, reported by the Demographic and Health Survey (DHS) 2006/07.

Figure 35 shows the district disparities in LBW percentages. Nuwara Eliya (18.9%) reported the highest percentage of newborn with LBW. Districts with higher percentages

Figure 35 : Distribution of percentage of LBW since 2007-2014



of estate population (Badulla 16.8%, Kegalle 15.6%, Ratnapura 15.7%), along with Polonnaruwa (15.1%) and Ampara (14.4%) districts also reported higher percentage of newborns belonging to LBW category (Annexure 12). Percentage LBW was calculated for the number of singleton births reported through RH-MIS.

8.3.2 Malnutrition among Infants and preschool children

Growth monitoring is mainly done through serial weight measurement of infants, young children and preschoolers, comparing their age specific weights with that of WHO new growth standards in the CHDR. Nutrition counseling, more frequent weighing and increased field and clinic follow ups are indicated when any form of malnutrition is identified. Though the measuring of height / length is being done at the field, data with reference to length / height are not yet been collected through the routine information system except annually for nutrition month. Hence, only the percentage of children belonging to underweight category is being used as an indicator to assess the nutritional status of the children less than 5 years of age routinely. Table 14 shows the different under nutrition indicators. The percentage of LBW among singleton births remained more or less static around 12% - 13% during last 8 years. Reducing trends are seen in other malnutrition categories over the years. A cumulative effect is seen in the percentage of infants and children malnourished with advancing age. In 2014, the percentage of

Figure 36 : District disparities in LBW percentages 2014

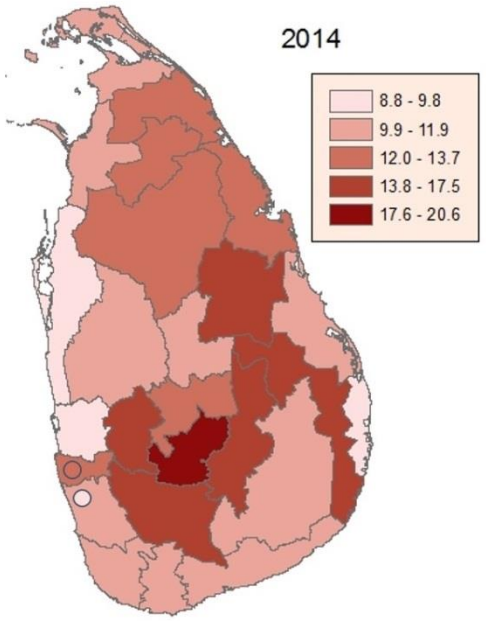
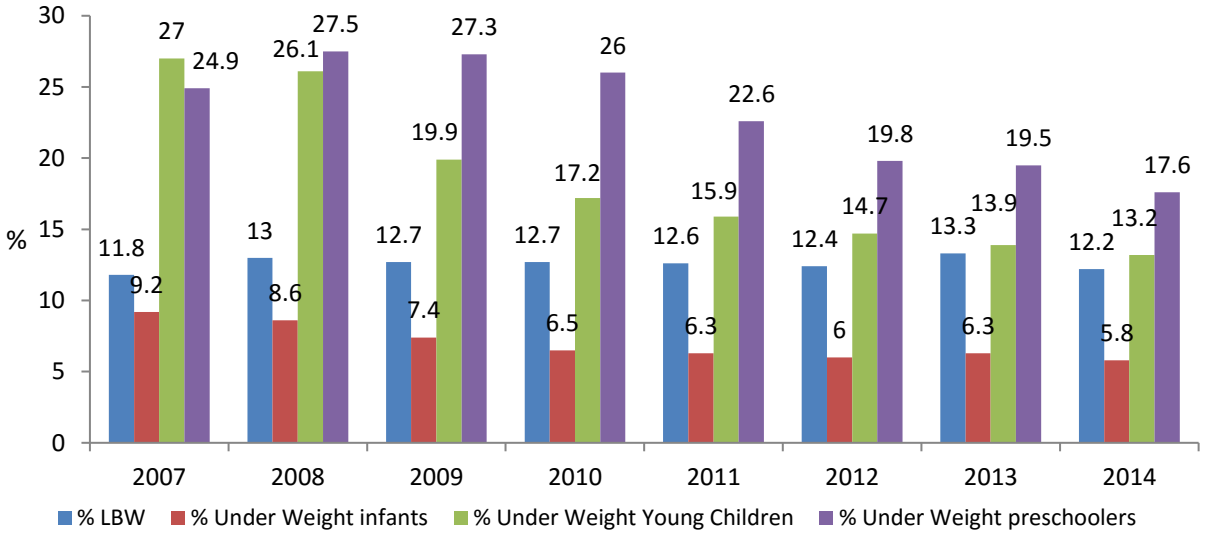


Table 14 : Percentages of LBW, underweight infants, young children and preschoolers from 2007 to 2014

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
% LBW	11.8	13	12.7	12.7	12.6	12.4	13.3	12.2
% moderately underweight infants	9.2	8.6	7.4	6.5	6.3	6	6.3	5.8
% severely underweight infants	1.5	1.6	1.4	1.2	1.2	1.3	1.3	1.2
% moderately underweight young children (1-2 years)	27	26.1	19.9	17.2	15.9	14.7	13.9	13.2
% severely underweight young children (1-2 years)	6.6	6.1	4.9	3.9	3.6	3.3	3.0	2.9
% moderately underweight preschoolers' (2+ to 5th year)	24.9	27.5	27.3	26	22.6	19.8	19.5	17.6
% severely underweight preschoolers' (2+ to 5th year)	7.2	6.7	5.4	4.8	4.2	3.9	3.8	3.4

Figure 37 : Trends in LBW, infant, young child and preschool underweight (moderate and severe) from 2007 - 2014

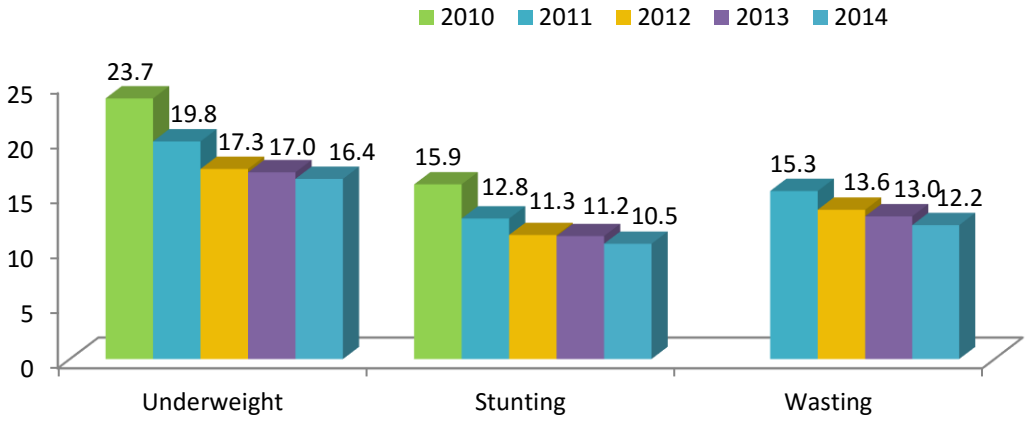


children belonging to underweight category (both moderate and severe) has increased from 7.0% in infancy through 16.1% in 2nd year to 21.0 % in 3rd to 5th year of life. District differentials of child malnutrition are given in annexure 12.

8.3.3. Nutrition Month 2014

Having understood the need to uplift the nutritional status of mothers and children, the concept of "Nutrition month" was introduced to the system by the Family Health Bureau in year 2006. Routine activities implemented through the Family Health Programme for

Figure 38 : Under nutrition status among under five children from 2010 to 2014



growth monitoring and promotion were given emphasis during the month and usually the month of June is declared as the "Nutrition Month" annually. The theme for Nutrition Month 2014 was "Iron rich food for health, strength and intelligence" and it was officially launched by the Nutrition Coordination Division of the Ministry of Health in collaboration with Family Health Bureau and other stakeholders. All MOHs are required to send a return on the summary of activities done during the month which is introduced to the Public Health Staff during a technical update for them at the FHB.

The nutritional status of the under five children whose weight and length/height was measured during the month are included in the standard formats given to the MOHs to submit data on child nutrition to FHB.

During 2014, 99.4% of the MOHs have sent their returns on nutrition month activities. Nutrition status of 92.5% under five children in these areas has been assessed during the month and figures for nutrition status for 2014 along with that for previous years are given in the Figure 38.

8.4 Child Development and care for children with special need

The concept of early child care and development (ECCD) has been introduced to the child health component of Family Health programme in 2000. Subsequent policy and strategic reviews indicated the need of a comprehensive revision of child development and special need care interventions. In response, initiatives were taken to revamp the relevant components of the child health component with the following objectives:

1. Enable all children under five year of age to reach their full potential for development through provision of optimal care

2. Enable children with special needs to optimally develop their mental, physical and social capacities to function as productive members of society

Family Health Programme aims to ensure that all children receive appropriate early child care and stimulation by their parents and other care givers, so that children have an optimal environment that facilitates the realization of their genetic potential. The programme also tries to address the health needs of children with special needs by incorporating a

package of intervention to existing child health program.

The main strategy used to achieve the aim is the enhancing of the capacity of parents on provision of appropriate early child care and psychosocial stimulation. This will be accomplished by providing the relevant knowledge and skills to parents through an instructional guide compiled in to a booklet given to each mother and interactive educational sessions conducted in mother's classes. PHC workers are supposed to boost these initial knowledge and skills in subsequent field visits.

Integrating a systematic development screening system to the present child care programme is the first strategy that initiates the care of children with special needs. Country specific development indicators, which are to be introduced, have been identified and measures are being taken to pilot test these indicators in Ampara district. These indicators once finalized will be included in the revised Child Health Development Record, and the screening check list for PHC workers. The second strategy relevant to special need care is the establishment and integration of a new institutional arrangement comprising of Primary and Secondary Child Development Centers. These institutions are supposed to provide appropriate care for the children diagnosed of social need conditions.

8.5 Birth Defects Surveillance

With the reduction of child and infant deaths in the country, birth defects has assumed a leading cause of infant mortality (18%). Availability of quality birth defects data, utilizing such data effectively at different levels and dissemination to all stakeholders, facilitate effective birth defects prevention and control.

FHB formulated a national birth defects prevention and control action plan and developed a national Birth Defects Surveillance mechanism. A pilot Birth Defects Surveillance was implemented in 2014 in the Southern Province (11 specialized hospitals) with the objective of scaling up to country-wide surveillance in coming years. Data are collected on to a web-based database maintained by Family Health Bureau. Preliminary data over one year has reported 419 cases up to 2 years of age. Leading causes were cardiac defects, chromosomal disorders, cleft lip/palate and gastro-intestinal defects with female predominance. Many mothers were in 20-35 year age group and a significant proportion (28 %) are >35 years.

8.6 Infant and Child Deaths

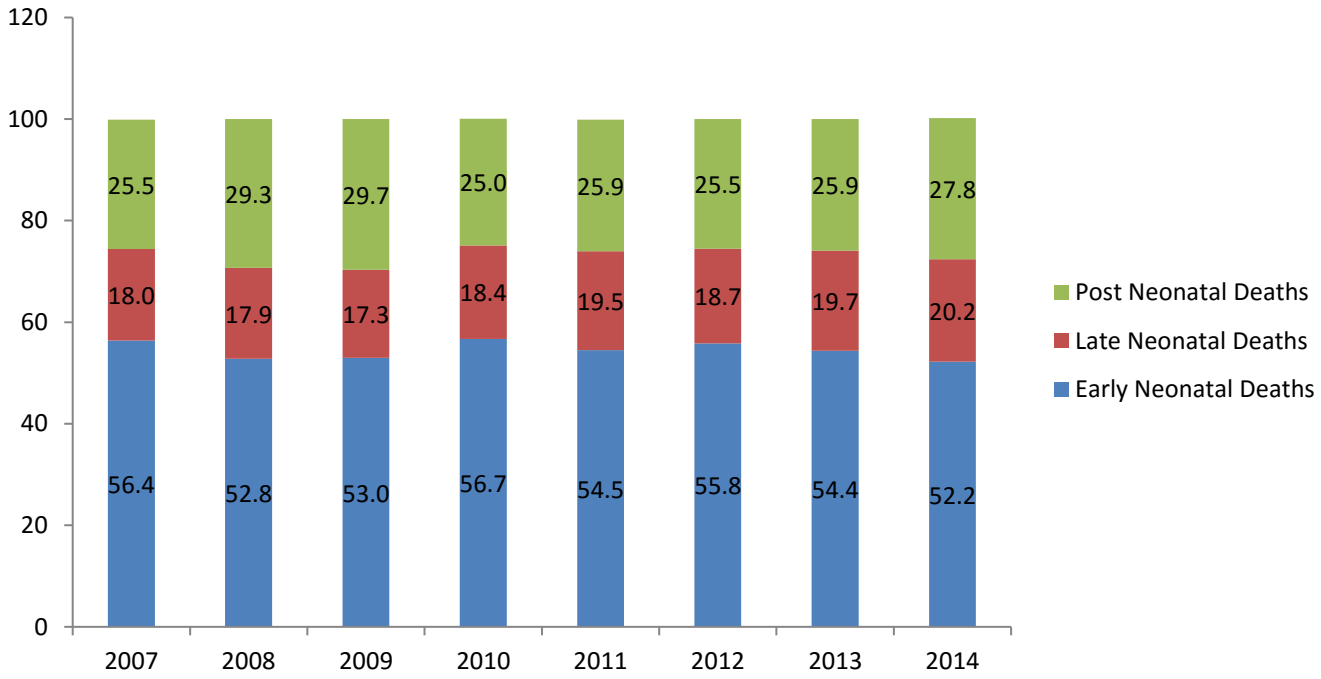
Family Health Programme gathers data on number of infants and under 5 years child deaths, whether or not infant deaths were investigated and if investigated the causes of deaths. PHMs report infant and under 5 years child deaths occurring in their field. Table 15 presents the infant and children under five mortality rates and the proportion of reported infant deaths investigated by PHNSs. Calculations were based on the number of deaths and live births reported through the RH-MIS. Nearly three quarter of infant deaths occurred during neonatal period (Figure 39).

Nearly 90 % of reported infant deaths were investigated by the PHNS. This investigation includes verbal autopsy, examination of death certificates and hospital documentation. Therefore reasonably accurate causes of death could be ascertained. Figure 40 presents the causes of deaths of investigated infant deaths in 2014. The most of the infants succumbed to the congenital abnormalities and prematurity.

Table 15 : Mortality rates based on reporting through RH-MIS and percentage of infant deaths investigated from 2007 to 2014

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
Neonatal mortality rate(1000 live births)	8.1	7.6	7.3	8	7.6	6.8	6.5	6.2
Post neonatal mortality rate (1000 live births)	2.8	3.1	3.1	2.6	2.7	2.4	2.3	2.4
Infant mortality rate (1000 live births)	10.9	10.7	10.4	10.6	10.2	9.2	8.8	8.6
Peri-natal mortality rate (1000 births)	14.6	14.3	13	13.7	12.6	12	11.2	10.4
Under five mortality rate (1000 live births)	12.6	12.4	12.2	12.2	11.6	10.4	9.9	9.9
Number of infant deaths reported	3500	3501	3263	3293	3269	2938	2835	2705
% of reported infant deaths investigated	89.9	93.5	93.4	89	92	96	89.8	81.0
Still birth rate (1000 births)	8.5	8.7	7.5	7.7	7.1	6.9	6.4	5.9

Figure 39 : Percentage distribution of infant deaths according to age at death from 2007 - 2014



Asphyxia happened to be the next common cause of infant deaths. Sepsis also contributed to one tenth of infant deaths (Figure 40). Congenital abnormalities remained the

Figure 40 : Percentage distribution of causes of infant deaths in 2014

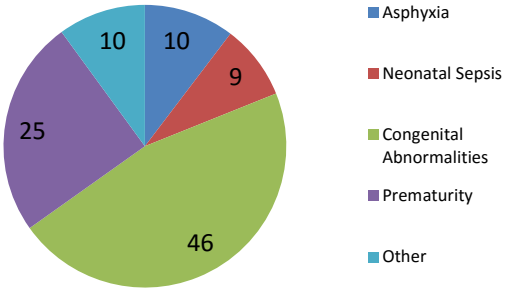
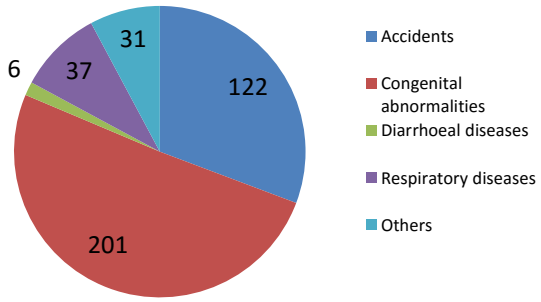


Figure 42 : Percentage distribution of causes of 1- 5 year child deaths 2014



most frequent cause of 1 to 5 year mortality as well. Accidents, respiratory illnesses and diarrhoeal diseases were identified as next common causes of 1-5 child mortality (Figure 42).

Reporting of infant deaths by PHMs during year 2014 has amounted to an Infant Mortality Rate of 8.6 per 1000 live births. The districts reporting very high mortality rate include Killinochchi (16.8) Jaffna (16.5), Matale(11.8), NIHS (10.8%), Kurunegala (10.6%), Batticaloa (10.5%), Nuwara Eliya (10.1%), Mannar (10.1%).

Figure 41 : Geographical variations in Infant Mortality Rate (RH-MIS)

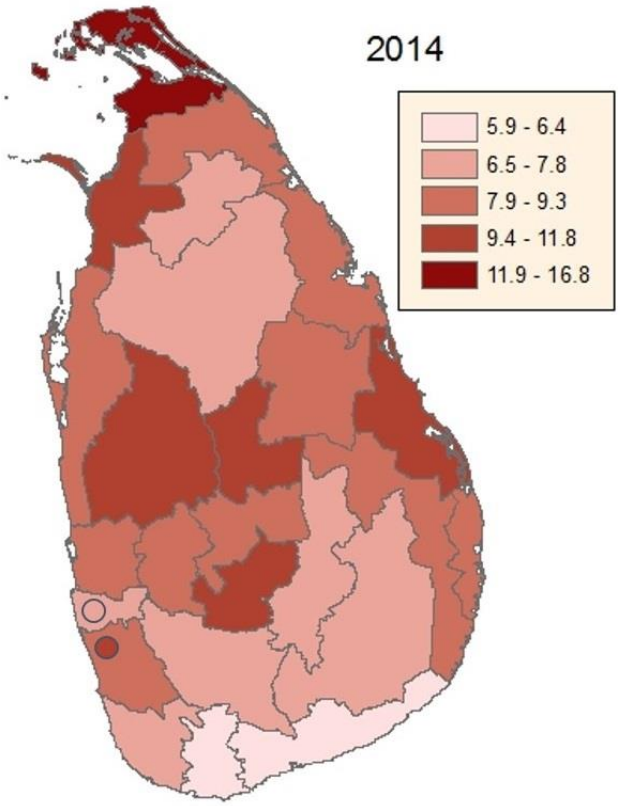
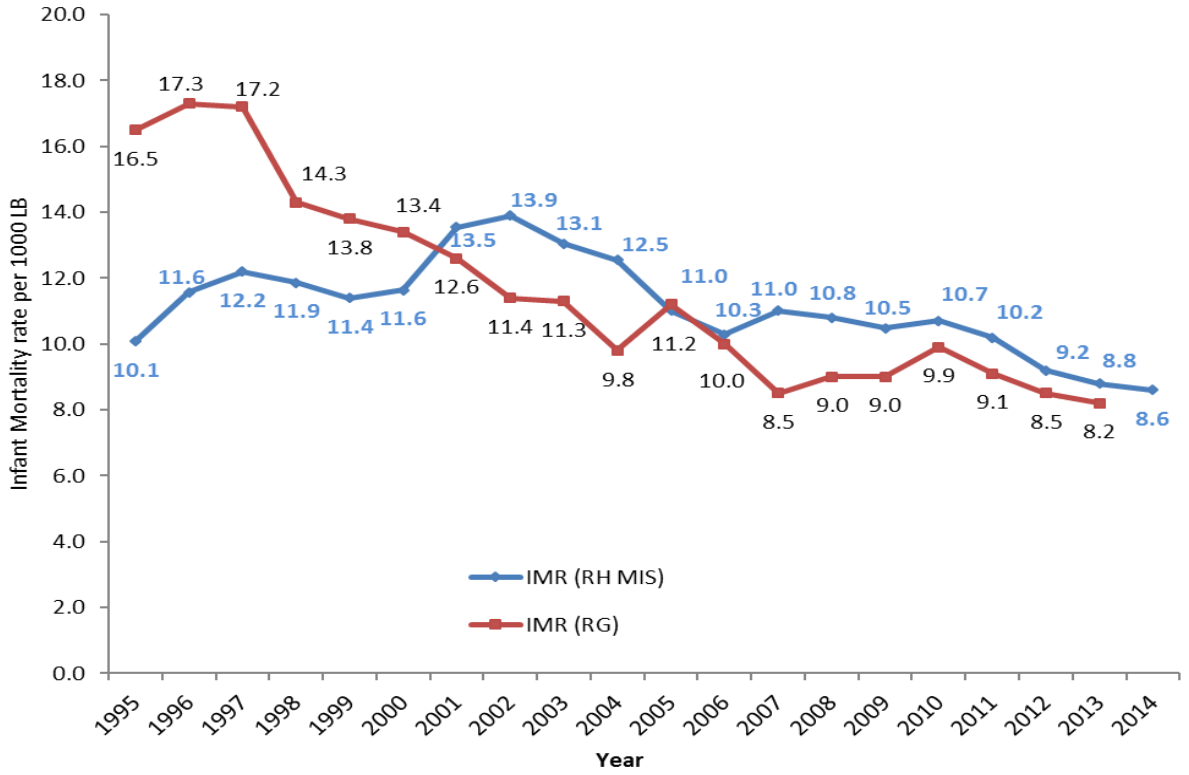


Figure 41 compares the National Infant Mortality Rate (IMR), calculated from the RH-MIS with the IMR reported by the Registrar General's Department. A clear difference is seen in the IMR calculated from 2 sources of information. Five years preceding 2001, the Registrar General's IMR reporting was systematically higher than that reported from

Figure 43 : Comparison of trends in National IMRs determined from RH-MIS and RegistrarGeneral's Department



RH-MIS. The trend had reversed since that year and both sources however, demonstrate a clear declining trend. Reporting of infant birth and deaths are low through RH-MIS compared to Registrar General's Department reporting (figure 43). However, the reporting gap between two sources was higher for birth compared to death. This could be a reason for the discrepancy in the mortality figures given by two sources. However, reporting of births through RH-MIS had been improving in recent years and in year 2014, 88.0% of the live births reported through Registrar General's Department, had been reported through RH-MIS. Infant death reporting could not be calculated due to non-availability of infant mortality data for year 2014 by Registrar General's Department.

8.7 Feto-Infant Mortality Surveillance

Review of perinatal deaths provides an opportunity to improve care for the pregnant mothers, their unborn babies and newborns. FHB started perinatal death audits at specialized hospitals (with either paediatric or obstetric units) in the year 2006 in collaboration with Sri Lanka College of Paediatricians, Sri Lanka College of Obstetricians & Gynaecologists and other related professional bodies. These death audit meetings are conducted every month with the participation of all relevant stakeholders from both preventive and curative sectors. Hospital perinatal death data and minutes of the meeting should be sent to Maternal and Child Morbidity Mortality Surveillance Unit (MCMMSU) of FHB. During the period 2010 to 2014, hospital reporting of perinatal deaths was streamlined with the introduction of a new user-friendly format. Each obstetric or neonatal unit completes individual format for each perinatal death. A tracking system was started to ensure timely receipt and completeness of monthly reports.

Perinatal deaths reported to MCMMSU were analysed, action points identified and discussed at national level technical advisory committees to translate lessons learnt into actions or policies.

Perinatal mortality information for the year 2014 is available from the National Perinatal Mortality Surveillance system. FHB received reports from 74 (100%) of the government health facilities.

For the year 2014, perinatal mortality data were collected in a special survey from all hospitals (both government and private sector) with labour rooms. The institutions that reported perinatal mortality data accounted for 348362 (99.61 % coverage / Live births reported by Registrar General's Department 349,715) live births and 3009 perinatal deaths (1386 still births and 1623 early neonatal deaths). As such country's still birth rate was 4.0 and perinatal mortality rate of 8.6 both per 1000 total births. Number of deaths with a valid cause of death was 1805 (60%). Leading causes include; Prematurity (30.1), Birth Defects (19.7), Sepsis (16.0), Acute Respiratory Distress Syndrome (9.4) and Birth Asphyxia (4.9).

This does not include any deaths during the early neonatal period that may have occurred in the community.

Service deficiencies identified include, issues in dating scans, delay in seeking care by pregnant mothers, shortage in supply of surfactants, inadequate capacity of medical officers in neonatal resuscitation and delays in transfer of newborns for more specialized care.

Table 16 : Perinatal mortality rates from perinatal mortality surveillance - 2014

	Specialized hospitals (TH/GH/DGH/BH)	Non-specialized peripheral hospitals	Private hospitals	Non weighted rate
No of hospitals	74	357	21	452
Live births	331152	10916	6294	348362
Stillbirths	1354	19	13	1386
Live births and Stillbirths	332506	10935	6307	349748
Early neonatal deaths	1593	18	12	1623
Perinatal deaths	2947	37	25	3009
Stillbirth Rate (SBR)	4.1	1.7	2.1	4.0
Early Neonatal Mortality Rate (ENMR)	4.8	1.6	1.9	4.7
Peri natal Mortality Rate (PNMR)	8.9	3.4	4.0	8.6

A pilot feto-infant mortality surveillance system is currently underway in the districts of Colombo and Gampaha since the year 2013.The system consists of perinatal death audits at all specialized units and individual infant death investigations at both institutional and field levels.

9 Care for School Children and Adolescents

Approximately four million children attend 10,012 government schools in the country. Primary school completion rate of these children reaches 97%, while only 89% complete up to grade 9. Adolescents (10-19 years) comprise 19% of total population in Sri Lanka and of them 70% attend schools.

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

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

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

The Public Health Inspector (PHI) organizes the school health activities at the local level. In the Municipality areas of Colombo, Kandy, Galle and Jaffna, School Medical Officers implement the school health programme.

The National Steering Committee on School Health and the National Coordinating Committee on School Health are the main governing bodies pertaining to planning and implementation of School Health activities at the central level, with the participation of Ministry of Health, Ministry of Education and other relevant stakeholders.

At present the School Health Programme focuses on five major thematic areas. These include:

- School medical services including counseling
- Maintenance of healthy school environment
- Life skills
- School community based health education (includes sexual and reproductive health) participation
- Healthy school policies

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

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

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

Weekly Iron Folate Supplementation (WIFS) programme is a recent initiative, in which treatment with anti-helminthic is followed by weekly treatment with iron, folic acid and vitamin C tablets for a period of six months.

Apart from the SMI, the PHIs conduct school sanitation survey in the schools annually, findings of which are used for making the school environment safe and healthy. The necessary recommendations are sent to the school principals for corrective actions. These officers work closely with officials of the Education Ministry and other Government and Non-Governmental Organizations to provide services such as safe water, sanitary facilities and refuse disposal in school premises.

The reporting of school health related data is not optimal. In 2014, only 300 (89.6 %) MOH areas have submitted Quarterly School Health Returns (H 797) for all four quarters. Hence, school health activities described in this report are limited to school health performance of MOH areas reported the progress. Annexure 14 shows the percentage of MOH areas sending H 797 in all four quarters.

9.1 School Health Surveys

It is a responsibility of range PHI to complete the school health survey annually. It is supposed to be completed preferably within the first two quarters of the year for timely action. During 2014, health surveys of 97.3% of the schools had been conducted islandwide. Health surveys were completed in all the schools almost all districts except Colombo Municipal Council (46.9%), Colombo (70.1%), Nuwara Eliya (76.5%) and Gampaha (99.4%) districts (Annexure 14).

9.2 School Medical Inspection Coverage

Table 17 presents the distribution of schools and number of students to be examined in all reported MOH areas.

MOH areas that submitted H 797 in all four quarters had 9,826 schools and 3,976,852 students. Of them 1,634,751 students were to be examined. In 2014, SMIs were conducted in 9,107 schools resulting in an overall school coverage of 92.7%.

The coverage of schools with less than 200 students and more than 200 students were 94.6 % and 90.7% respectively (Figure 44). Approximately, 79 % of the eligible students were examined during the SMI in 2014 (Table 17). Annexure 14 shows the geographical variations in SMI coverage.

9.3 Malnutrition among School Children

During SMIs, students are assessed for their nutritional status. Approximately, 7-8% of children in grades 1 and 4 were stunted. The percentage of wasting was higher compared to that of stunting which ranged from,the lowest in grade 10 (14.9%) and the highest (19.9%) in grade 7 (Figure 45).

9.4 Medical Problems detected at SMIs

School children are identified with a considerable number of health problems during SMIs. Table 18 shows the percentages of children who have been examined at SMI who were reported to have these problems.

Out of the total students examined in the SMI, 545,735 students (33.4%) had some form of a medical problem and 235,117 students (19.5%) were referred for further care.

Table 17 : Percentage of children examined during School Medical Inspection 2014

Less than 200		More than 200		Total	
Students to be examined	Students examined %	Students to be examined	Students examined%	Students to be examined	Students examined %
466,647	79.0	1,168,104	79.1	1,634,751	79.1

Figure 44 : Total number of schools available and number of schools where SMI were conducted 2014

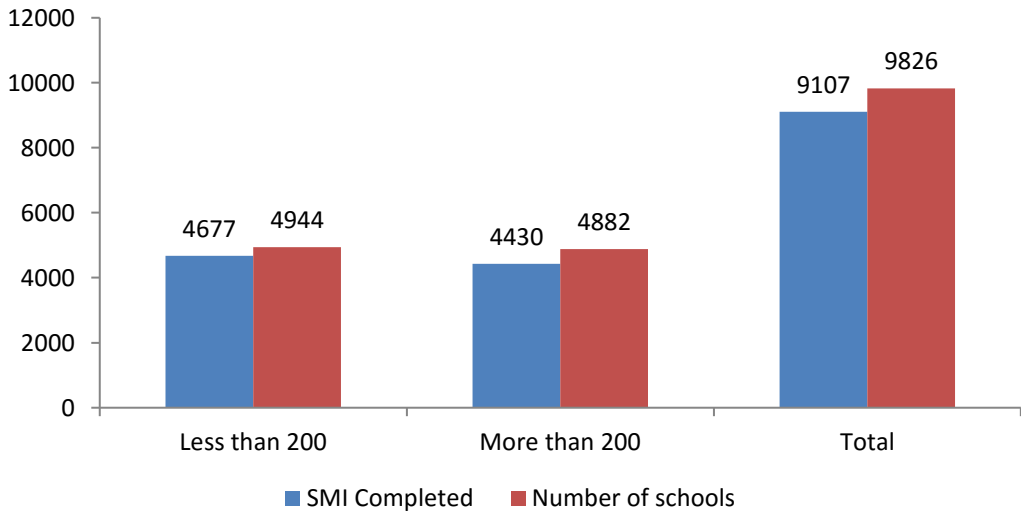


Figure 45 : Percentages of School children in different School Grades who are stunted, wasted and overweight 2014

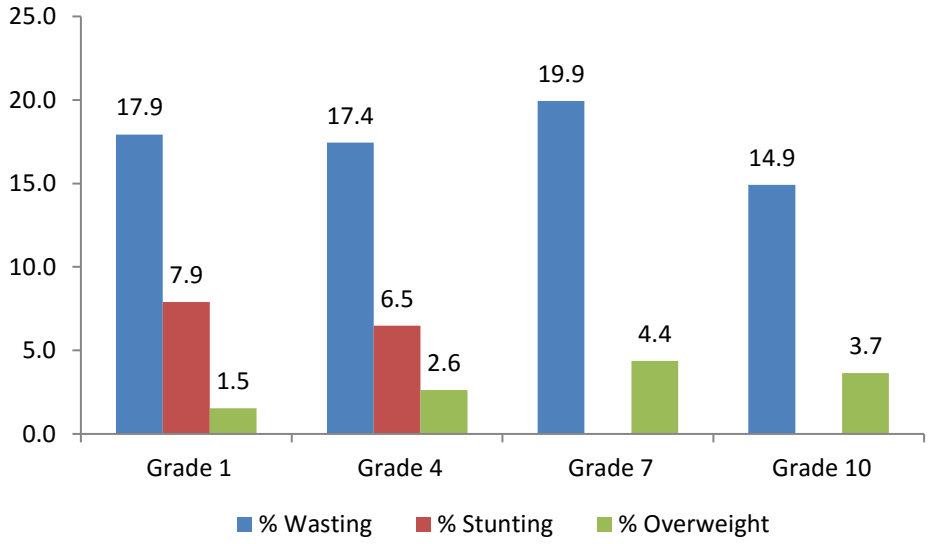


Table 18 : Prevalence of health problems detected at SMIs 2014 (Cases per 1000 students examined)

Health problem	Cases per 1000 student examined	Health problem	Cases per 1000 student examined
Dental caries	228.4	Scabies	1.4
Pediculosis	56.9	ENT Problems	1.2
Malocclusion	34.3	Lung disease	0.9
Visual defects	22.3	Hearing defects	0.9
Fluorosis	15.1	Xerophthalmia	0.8
Heart disease	12.7	Goitre	0.7
Skin diseases	11.9	Lymphadenopathy	0.5
Pallor	11.2	Orthopaedic problems	0.4
Gingivitis	3.7	History of fits	0.4
Asthma	2.8	Bitot spots	0.3
Glossitis	2.3	Hypo-pigmented/Anesthetic	0.2
Learning problems	2.0	Night blindness	0.2
Squint	1.8	Rheumatic Disorders	0.04
Behavioural problems	1.7	Other defects	5.6
Speech Defects	1.5		

Figure 46 : Percentages of Grade 10 children with low BMI 2007-2014 with overweight 2007-2014

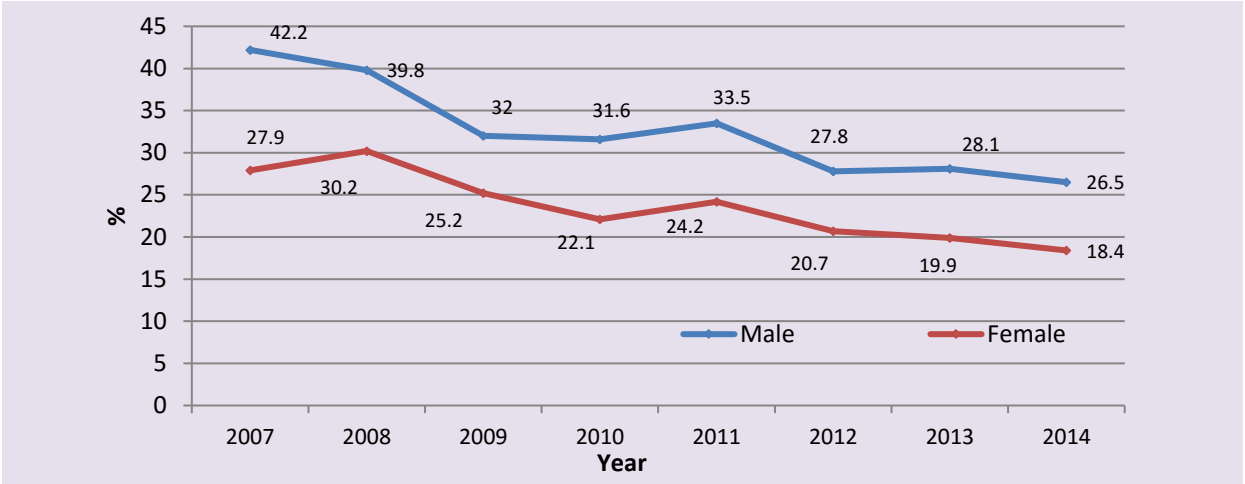
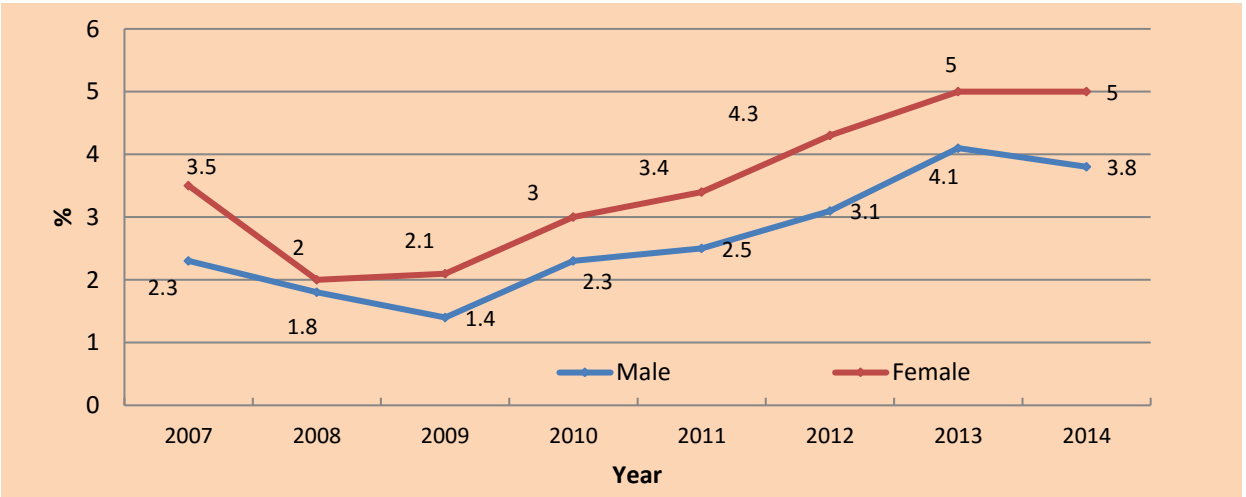


Figure 47 : Percentages of Grade 10 children with Overweight 2007-2014



9.5 Nutrition Month activities 2014

In addition to the nutrition month activities mentioned in section 8.3.3 BMI level of all students in grade 10 was assessed by PHII and necessary nutritional interventions were done during the nutrition month. Accordingly, prevalence of low BMI among male and female students was 26.5% and 18.4% respectively. Prevalence of overweight among male students was 3.8% while that for females was 5.0%.

9.6 Health Promoting Schools 2014

Out of 9826 schools, 4093 schools were identified as Health Promoting Schools (HPS). HPS were categorized as follows;

80 – 100 marks (Gold level) - 1769 schools
70 – 79 marks (Silver level) - 1580 schools
60 – 69 marks (Bronze level) - 744 schools

10 Family Planning Programme

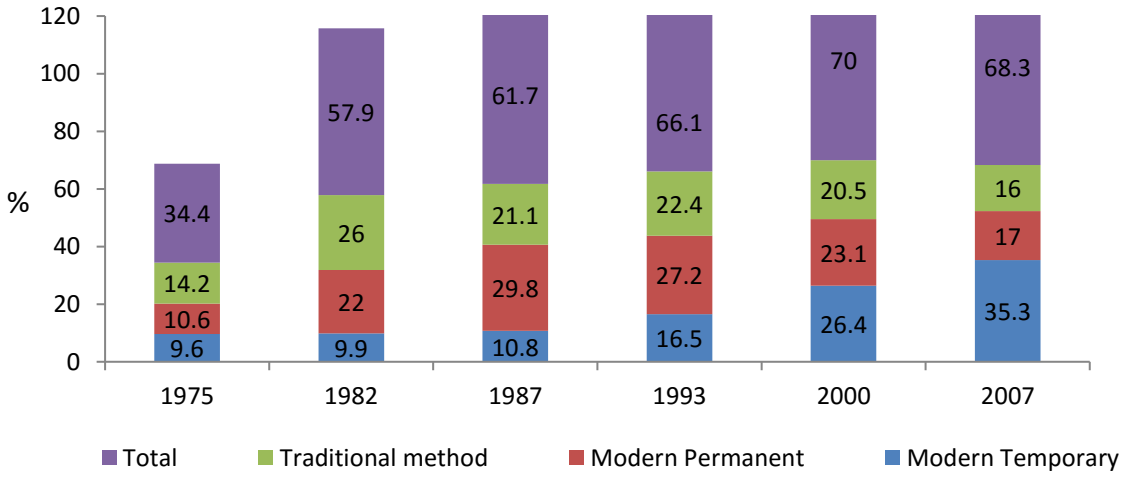
History of modern family planning services in Sri Lanka covers more than 60 years, where the services were introduced in 1953. In 1965 Family Planning was recognized as a responsibility of the Government and service delivery was strengthened by integrating Family Planning to Maternal and Child Health services.

Current goal of the National Family Planning Programme is to enable all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies. Therefore, it facilitates the families to make informed decisions on their desired number of children, spacing and timing. The cafeteria approach is being used to offer contraceptive methods.

Needs of community have changed over generations, so have the services the programme offers. Oral Contraceptive Pills (OCP), DMPA injections, Intra Uterine Devices (IUD), Condoms and Implants are the modern temporary methods offered by the present-day programme. Modern permanent methods include vasectomy and female sterilization (LRT). MOHs, MOs, PHNSs, PHMs and PHIs are being trained in providing awareness and counseling for clients on family planning supported with appropriate BCC material.

Sri Lanka records the best family planning performance in the region. Figure 48 presents the trends in Contraceptive Prevalence Rates (CPR) among married women of reproductive age in Sri Lanka over last three decades.

Figure 48 : Trends in Contraceptive Prevalence Rate in Sri Lanka



Source : Demographic and Health Survey 2006 - 07

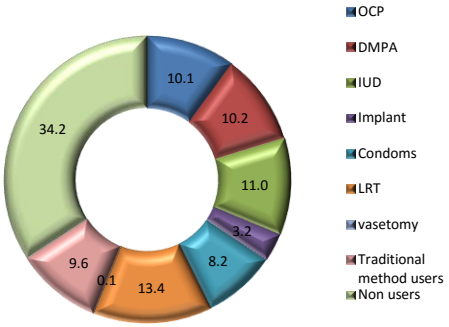
Since of late, a stagnation in the performance can be observed. The issues that may have contributed to it include insufficient supply of certain family planning methods.

Two main outcome indicators are used to assess the performance of the Family Planning Programme. These are new acceptor rates and current user rate. Two definitions are used in describing the indicators.

Current user is a woman/man (eligible family) who is using any method of contraception at a given point of time. This indicator provides the CPR among eligible families for a given year. Data reported in H 509 is used for calculation of this.

A new acceptor is defined as a woman/man using a particular modern contraceptive method for the first time from any service provider belonging to the national programme.

Figure 49 : Method mix of contraceptives in 2014



This indicates the change in the contraceptive method preference despite its limitation of counting the same person more than once with change in the method. Data on all modern methods except condoms are considered for this indicator and H 1200 provides data for this.

10.1 Current users: Contraceptive Prevalence Rate among eligible families

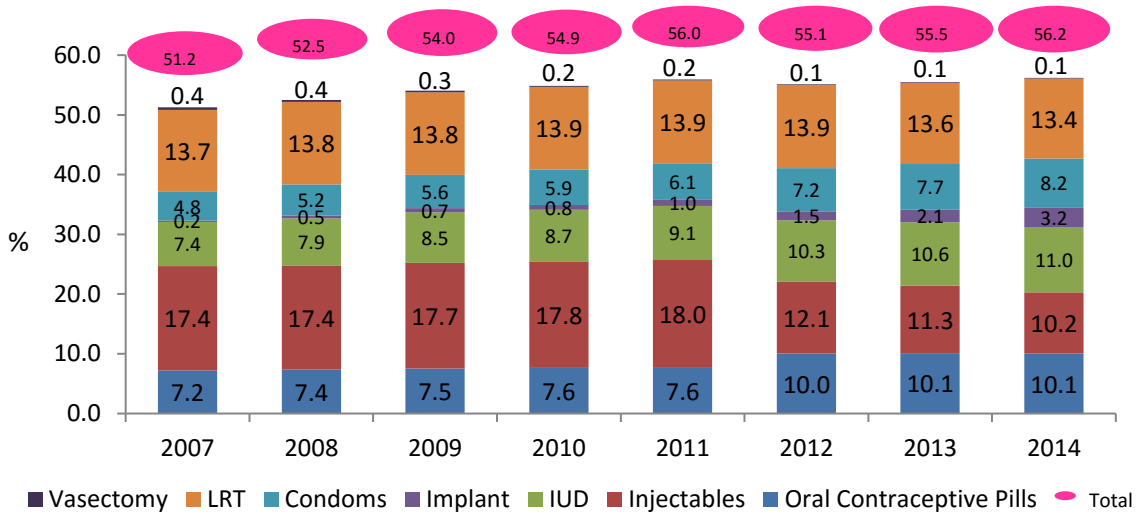
Percentage of eligible families using any contraceptive method is expressed as current user rate or CPR among eligible families. Of the eligible families registered by PHM (n=3,668,979) 65.8% had been using any method at the end of year 2014. Proportion of modern methods and traditional methods users were 56.2 % and 9.6% respectively. Current contraceptive user rate over past 8 years as reported by PHMs is given in Table 18. A 6% increase in contraceptive use (any) was observed from year 2007 to 2014. Traditional methods account for approximately one seventh of contraceptive prevalence. District differentials of CPR are given in annexure 17.

Preference to different methods of contraceptives varied, the variation seems to be consistent. Figure 49 presents method mix in 2014, while Figure 50 presents the trends in method preference since 2007 to 2014. The most popular temporary

Table 19 : Percentage of eligible families using a contraceptive method from 2007 to 2014 (RH-MIS)

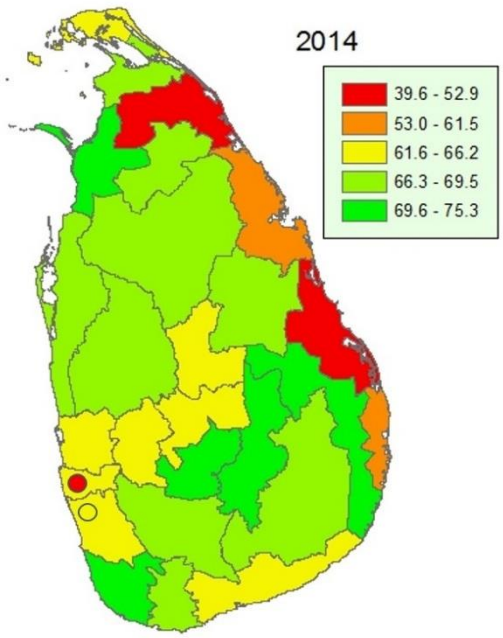
Indicator	2007	2008	2009	2010	2011	2012	2013	2014
Modern methods	51.2	52.5	53.8	54.9	56	55.1	55.4	56.2
Traditional methods	8.9	9.3	9.4	9.5	9.3	9.5	9.5	9.6
All	60.1	61.8	63.2	64.4	65.3	64.6	64.9	65.8

Figure 50 : Current users of modern family planning methods, from 2007 to 2014



method of contraception in 2014 has been IUD (11.0%), followed by DMPA injections (10.2%), OCPs (10.1%) and condoms (8.2%). Approximately 13.4% of eligible families practice female sterilization (LRT) for fertility control.

Figure 51 : Geographical variations in Contraceptive Prevalence Rate (CPR) (All methods) 2014



Injectables had been the most popular modern temporary method of contraceptive up to 2014. However there was a notable 6% drop in DMPA users in the year 2012, which may have been due to non-availability of the method at field clinic centers, and reactions reported for certain brands. A large percentage of users had shifted to OCP, IUD and Condoms in the absence of DMPA Injections. Implant users are also on the rise with the improved service availability for Implant through the government system due to availability of the method and staff training.

Figure 51 shows the district variation in CPR. The lowest ranking area (CPR less than 50) was Colombo M.C. (47.6%), while Ampara (74.6%) RDHS area reported the highest CPR (over 70%) in the country.-Current user rate by districts is given in the annexure 15.

10.2 New Acceptor Rate

RH-MIS has a special registration system to record the pattern of acceptance of contraceptive methods by couples. During

2014, family planning services throughout the country, had recruited 127,130 couples for various contraceptive methods.

Figure 52 shows that there is a gradual increase in the proportion of couples choosing modern temporary methods during last 24 years. An opposite trend is seen in the choice of permanent methods of contraception.

Out of total new acceptors, 94.1% had accepted temporary methods as a new method from the programme during 2014.

10.2.1 New Acceptors by method

The change in new acceptors as a percentage of eligible couples over time is given in figures 52 and 53.

Figure 52 : Relative proportions of newly accepted contraceptive methods from 1990 — 2014.

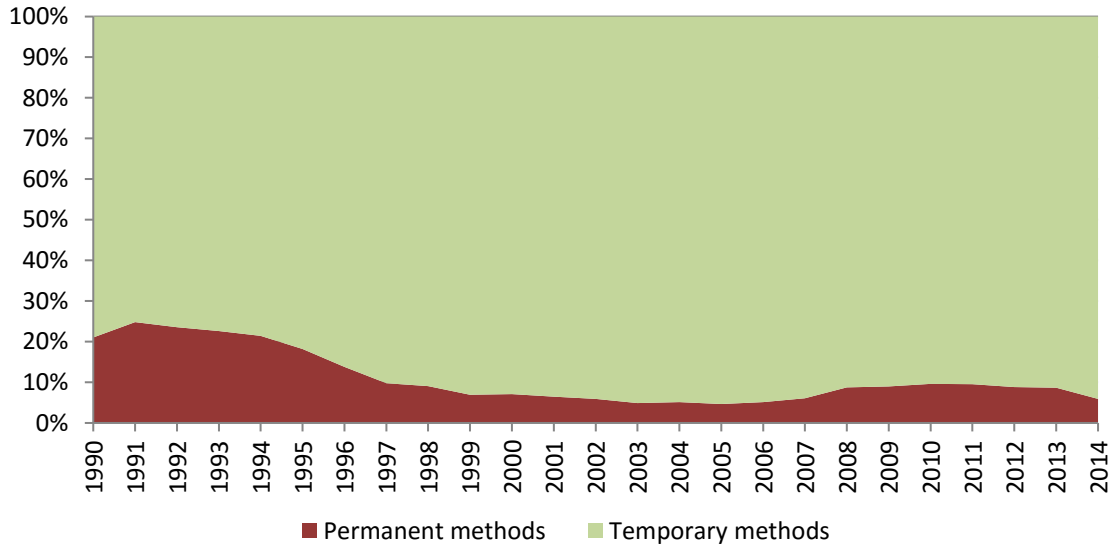
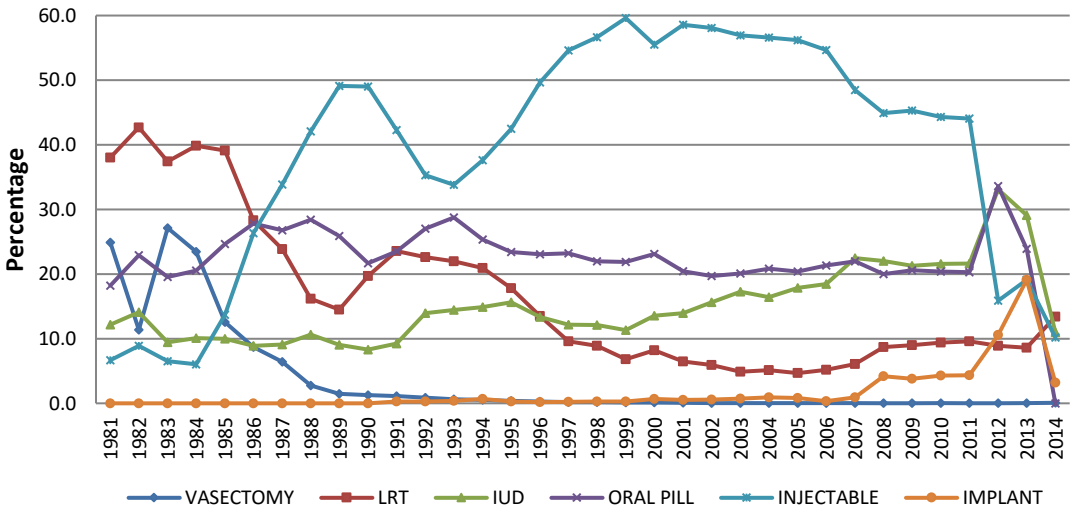


Figure 53 : New acceptors of contraceptives by method 1981 — 2014.



The injectable was the most widely accepted contraceptive method for the first time from the programme while IUD and pills following that with close approximation to each other until year 2011. In comparison with the trend in current users, there had been a dramatic drop in choosing DMPA among new acceptors in the year 2012. OCP and IUD had been the preffered temporary methods among new acceptors and tubectomy showed an increasing trend in 2014.

10.2.2 New Acceptors by Age

Figure 54 presents the age specific new acceptor rates from 2001 to 2014. There has been a notable reduction in contraceptive acceptance in 20-29 year and 30-39 year age groups after 2005. The contraceptive acceptance of teenage women has shown an improvement from 2006 to 2009. Overall new acceptor rate for modern contraceptives across all age groups shows a reduction towards the latter part of the decade.

There was a decline in new acceptors across all age groups from year 2013 to 2014.

10.3 Contraceptive Failure rate and Complications

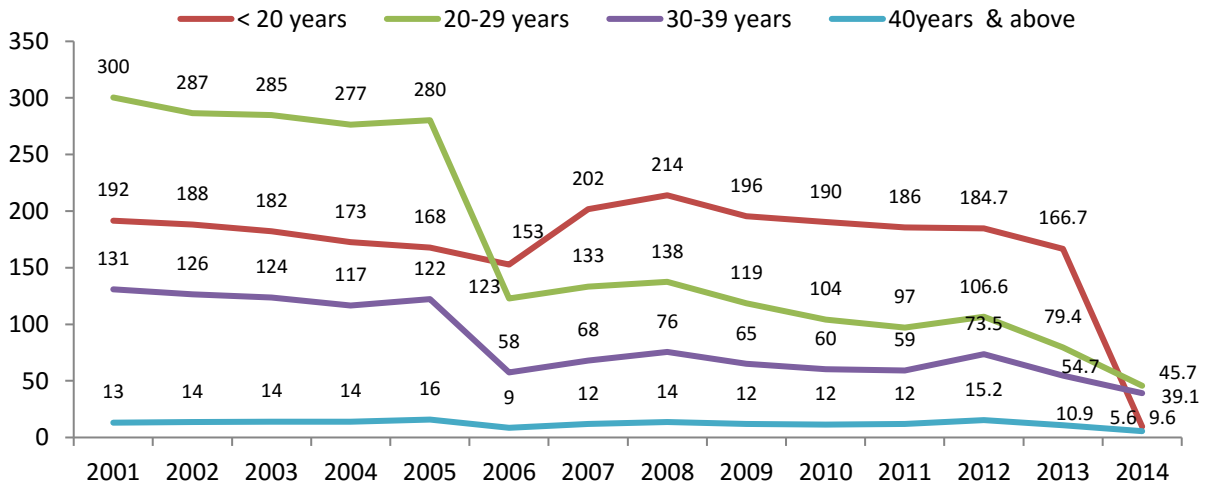
Contraceptive method failures are supposed to be reported through RH-MIS. Failure rates for different methods are given in Table 19. A total of 1013 method failures were reported and the highest failure rate was among IUD users which was 10 per 10,000 users.

10.4 Unmet Need for Family Planning

Unmet need for family planning means a fertile woman married or living in union, not using any contraception (modern,natural or traditional), not wanting any more children or wanting to postpone for at least 2 years. PHMs gather this information from their eligible families. Figure 56 presents the trends in unmet need for family planning from 2007 to 2014.

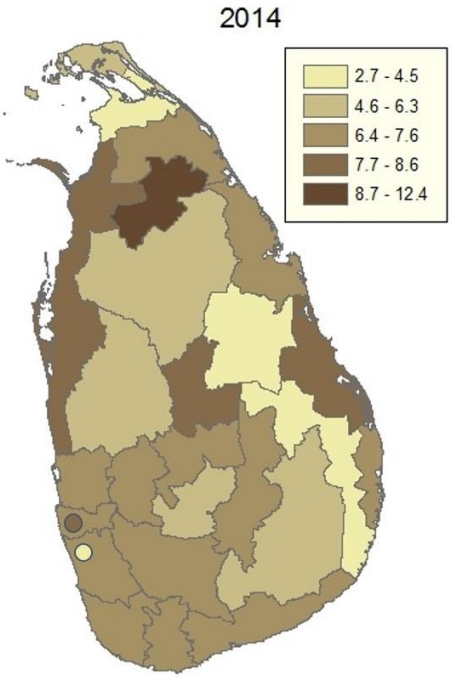
Unmet need for family planning among eligible couples over last 8 years has dropped from 9.2% to 6.8%. However, further reduction in unmet need is expected to reduce maternal mortalities attributed to this

Figure 54 : Age specific new acceptor rates for modern contraceptives: from 2001 to 2014 (H-1200 B)



District variation in unmet need for family planning is given in Figure 55 and Annexure 17.

Figure 55 : District variations in unmet need for Family Planning 2014



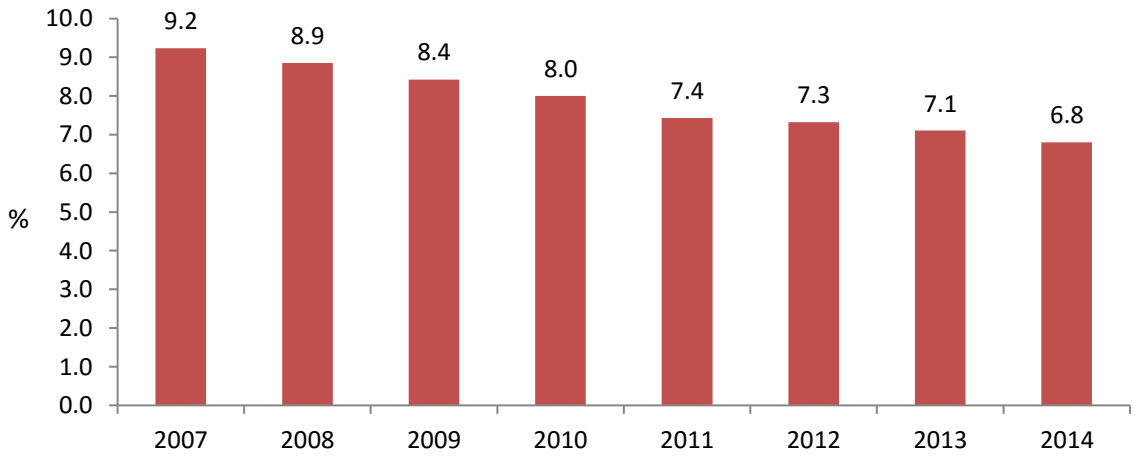
10.5 Services for Sub fertile Couples

Provision of services for sub fertile couples is an important competent of the Family Planning programme. However, field staff should identify sub fertile couples among the families registered in the Eligible Family Register. They are expected to refer the couples identified for further management. The couples with risk factors also need to be identified and refered for early interventions.

Table 20 : Contraceptive failure rates for different methods 2014

Contraceptive Methods	No of failures	Failure rate per 10,000 users
Injectables	192	5.1
Oral Pills	276	7.5
IUD	403	10.0
Condoms	73	2.4
Implants	15	1.3
LRT	54	1.1
Vasectomy	0	0

Figure 56 : Percentage of eligible couples having unmet need for family planning 2007-2014



11 Gender and Women's Health

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

11.1 Well Woman Clinic Services

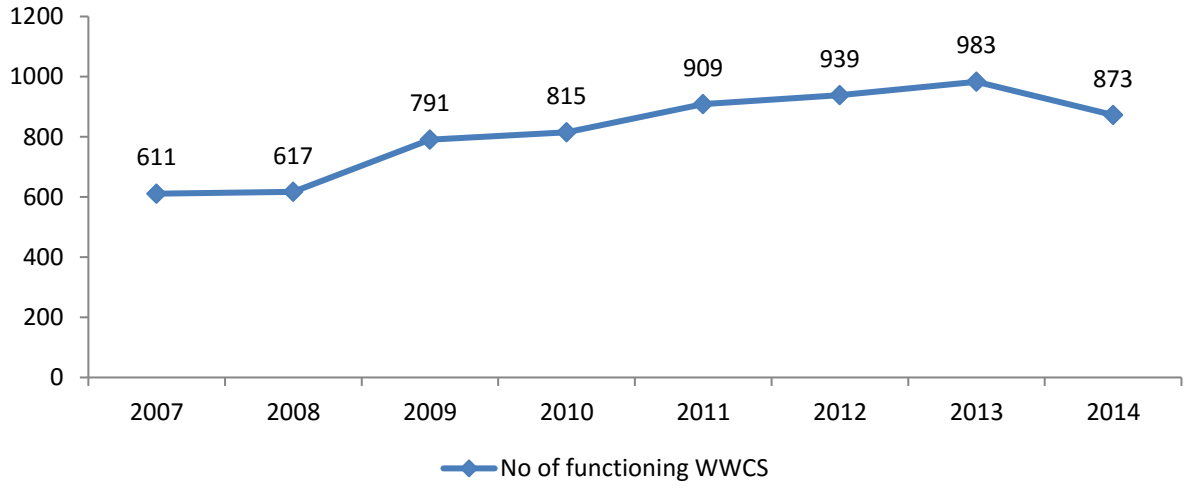
Well Woman Clinic (WWC) services were incorporated into the Family Health Programme in 1996. The aim was to screen peri menopausal women for reproductive illnesses. These included breast and cervical malignancies and non-communicable diseases; diabetes, hypertension. Obtaining cervical smears for cytology (PAP test), breast examination, testing urine for sugar and blood pressure measuring are being done for this. At its inception, women over 35 years were considered as the principal target group of WWCs. In 2007 focus of pap smear taking was changed to women at 35 years of age considering the epidemiological evidence of cervical cancer occurrence. Since that year, the PHMs are specifically supposed to recruit the women in 35-year age cohort in their area for WWC screening. However, the screening was not restricted to this cohort.

WWCs are held fortnightly or once a month. Trained Medical Officers screen the women attended the clinic for the above conditions. The identified problems are referred to appropriate centres in the health system. The follow up is carried out by area PHM.

11.1.1 Number of WWCs

Number of WWC has increased by 262 over 2007 to 2014 period. In 2014, there were 73 WWCs functioning throughout the MOH

Figure 57: Number of WWC from 2007 to 2014



divisions of the country. Figure 57 shows the trend in number of WWCs since 2007 to 2014.

11.1.2 Target Population Coverage

Though, the focus of target population of cervical cancer screening changed to 35 year age cohort in 2007, still women in wider age group obtain this service from WWC clinics. Table 20 and Figure 58 present the numbers and percentages of women participating WWCs by age groups for the first time respectively.

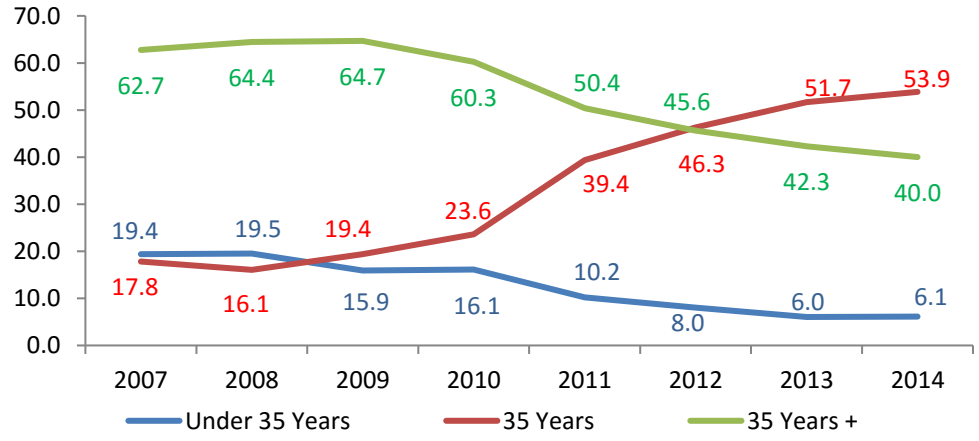
The target population of WWCs principally towards the 35-year age cohort has begun to take place. In year 2014, out of total attendees proportion of 35 year age cohort attending clinic (53.9%) has exceeded that of above 35 years (40.0%).

According to its new focus, the percentage of women in 35 year age cohort who were screened in WWCs for cervical malignancy with Pap smear becomes one of the main indicators of the WWC program coverage. Figure 59 presents the percentage coverage of 35 year age cohort with Pap smear in WWCs since 2007 to 2014.

Table 21 : Number of women attending WWCs for the first time since 2007 to 2014 by age groups

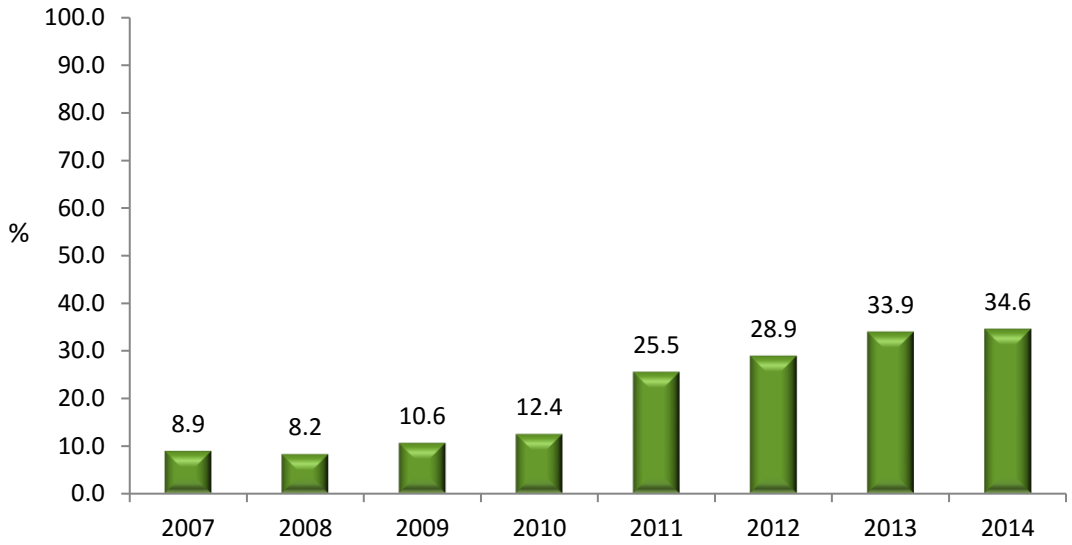
Indicator	2007	2008	2009	2010	2011	2012	2013	2014
Under 35 Years	20320	21818	18517	18281	14402	10884	8585	8585
35 Years	18669	17948	22490	26762	55413	62833	73359	74871
35 Years +	65665	72023	75127	68319	70841	61872	60054	55620
Total	104654	111789	116134	113362	140656	135589	141998	139006

Figure 58 : Percentages of women attending WWCs in different age groups from 2007 to 2014



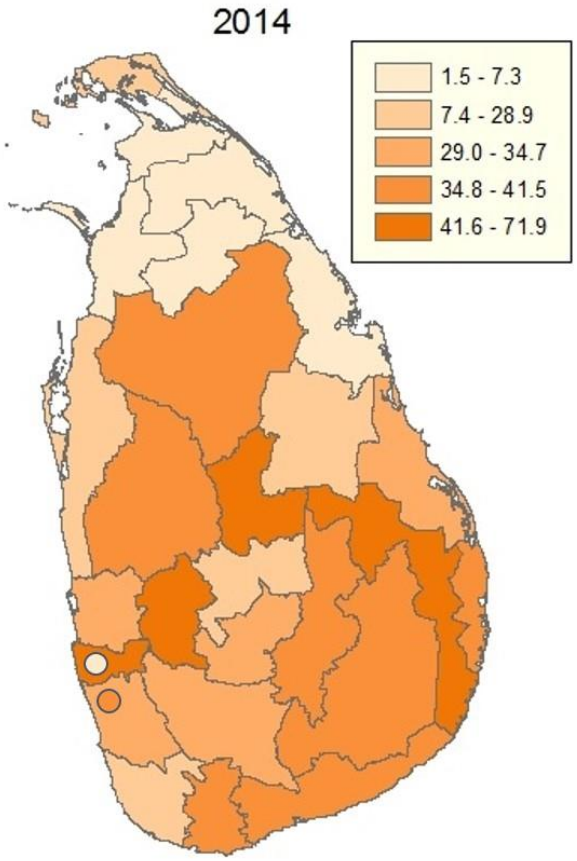
A gradual increase is seen from 2007 to 2014 in the percentage coverage of screening 35 year age cohort for cervical malignancy in WWCs. One percent of the population is considered as the target for this calculations. Only 34.6% of the national 35 year age cohort was subjected to screening in WWCs in 2014. This coverage ranged from 2.5% in Vavuniya to 71.9% in Ampara RDHS area (Annexure 14). However, the screening coverage of

Figure 59 : Percentage of 35 year age cohort screened with Pap Smear in WWCs since 2007



target group was less than twenty percent in 06 out of 28 health areas under concern.

Figure 60 : Percentage of 35 year age cohort subjected to pap smear testing 2014



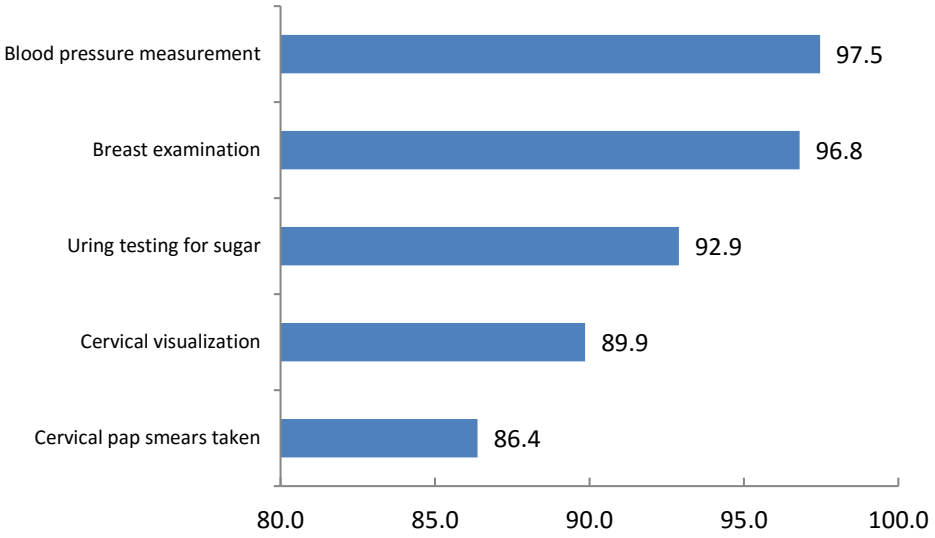
11.1.3 Screening Services at WWC

A group of 132,038 women attended WWCs around the country in 2014. Of them 122,484 were first visits. Figure 61 shows the percentages of women who are subjected to different types of examinations when they attended WWCs.

More than 96% of women attending WWCs were screened for Hypertension and breast problems. Only 90.0% women had their cervices examined visually and 86.4 % had Pap smears taken. Hypertension was found among 3.6 % of women while 1.8 % of them were identified having Diabetics.

In 2014, 131,295 pap smears were taken in WWCs throughout the country. Of them 3.6% was identified as unsatisfactory smears while 0.5% had a diagnosis [LSIL (n=434), HSIL (n=50), Glandular (n=35), ASCUS (106), Malignancies (N=75)].

Figure 61 : Percentage of women screened for different non- communicable diseases at WWC 2014



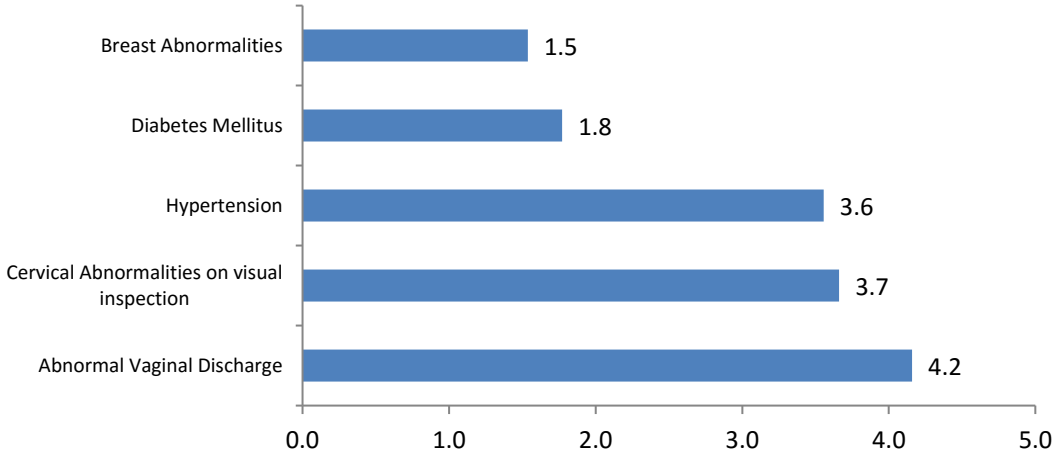
11.2 Care for Women with Special Needs

There is an important group of women with special needs, who do not have access to the routine reproductive health services, but requiring special attention and care. This group includes institutionalized women, migrant women, displaced and marginalized women etc. A programme has been developed to address the reproductive health issues of migrant women and their family members,and this programme will be implemented in the field by the primary health care team.

11.3 Health Sector Response to Gender-Based Violence (GBV)

Establishment of Gender-based Violence (GBV) care centres by the name of "Mithuru Piyasa" at state hospitals, which provides essential services for GBV survivors was a major step taken towards addressing Gender-Based Violence. The term "Mithuru Piyasa" in Sinhala means "Friendly Haven" and was selected after much thought, and the aim is to establish such centres in all the state hospitals throughout the island.

Figure 62 : Percentage of women with positive screening 2014



Also, the primary health care teams are trained on their roles and responsibilities on prevention and management of GBV. On this aspect, the team members are sensitized on gender issues and gender stereotyping and creating awareness among individuals, families and the community as a whole on these issues so as to prevent or minimize such issues, which would lead to the prevention of gender based violence. Further, the team members are trained on identifying GBV survivors and providing befriending services and referring them for other services.

Table 22 : Summary of monthly (WWC) returns for 2014

Name of the service point	Total number of new survivors seeking care over the year	Total number of subsequent consultation held with the survivors	Total number of consultation held with the family members	Tot number of consultation held with the perpetrators	Total
GH . Matara	339	110	127	78	654
TH. Kandy	151	34	97	17	302
BH. Marawila	118	55	67	32	272
DGH . Dickoya	8	4	2	2	16
TH. Mahamodara	178	147	76	24	425
BH . Thambuththegama	86	29	22	28	165
Kethumathie Maternity Hospital	157	138	77	73	445
GH. Nuwara Eliya	15	2	6	2	25
GH. Kaluthara	288	90	117	58	553
DGH. Vavuniya	187	77	79	30	373
Castle Street Hospital	102	50	48	18	218
BH. Awissawella	499	450	267	111	1327
TH. Batticaloa	343	52	159	90	644
De Zoyza Hospital for Women	76	10	15	11	112
BH. Valachchenei	92	47	76	60	275
BH. Kilinochchi	233	37	32	59	361
Family Health Bureau	5	4	3	3	15
NCTH. Ragama	15	4	5	2	26
GH. Badulla	17	3	7	1	28
AMH Kalmunai	3	6	11	4	24
BH. Kalmunai (North)	7	15	6	11	39
TH. Peradeniya	13	5	3	1	22
Total	**2937**	**1373**	**1305**	**718**	**6208**

12 Oral Health Services

Since 2007, an Oral Health component was integrated into the Family Health Programme and the services are delivered through Maternal and Child Health and School Health services. Advocacy for policy formulation, provision of technical expertise and national level monitoring and evaluation also comes under Oral Health Services.

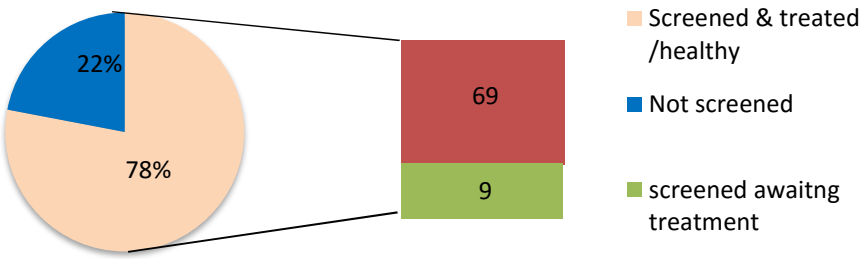
An outline of the activities carried out by the unit in the year 2014 is given below.

and all students below the age of 13 years in schools with less than 200 students.

SDCs are mainly situated in primary schools and it provides services for the base school as well as for other satellite schools in the vicinity. Out-reach clinics are conducted by the SDTs to cover schools in remote areas.

School Dental Therapists work under the administrative supervision of MOH. But their technical supervision and coordination of the service within the districts

Figure 63 : Percentage coverage of target population by SDTs 2014



12.1 School Dental Services (SDS)

The main objective of the School Dental Services is to reduce morbidity due to common oral diseases in preschool and school children between the ages of 3-13 years by provision of oral health care services with emphasis on prevention.

The services are delivered by the School Dental Therapists (SDTs) who work in School Dental Clinics (SDCs). At present around 420 School Dental Therapists (SDTs) are in service. Their target group includes students of grades 1, 4 and 7 in schools with more than 200 students

are carried out by the Regional Dental Surgeons (RDSs) and the Supervising School Dental Therapists (SSDTs).

12.1.1 Work performances of the School Dental Therapist - 2014

The 379 SDTs currently working in the country could screen 78% of the total children in the target group. Of the group, 69 % of children were identified as either healthy or their dental problems were successfully treated by SDTs. Therefore, the unmet need in terms of screening and those awaiting treatment after screening is around 31 % of the target group (Figure 63).

Table 23 : Provision of oral health care services to school children by SDTs – 2013 and 2014

Year	Number of SDTT	Number of children per SDT	% of schools screened	% of caries				% of calculus			% of children screened[2]	Coverage percentage[3]
				Gr 1	Gr 4	Gr 4[1]	Gr 7[1]	Gr 1	Gr 4	Gr 7		
2013	380	3323	62%	57%	59%	10%	19%	2%	15%	22%	64%	56%
2014	379	2846	76%	58%	57%	7%	18%	2%	12%	19%	78%	69%

[1] Permanent teeth

[2] Percentage of children screened out of the target group

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

Percentage of target children screened in each district is given in Figure 64.

Stated above in Table 23 is the summary of the annual statistics of the School Dental

Figure 64 : Percentage of students screened by School Dental Therapists 2014

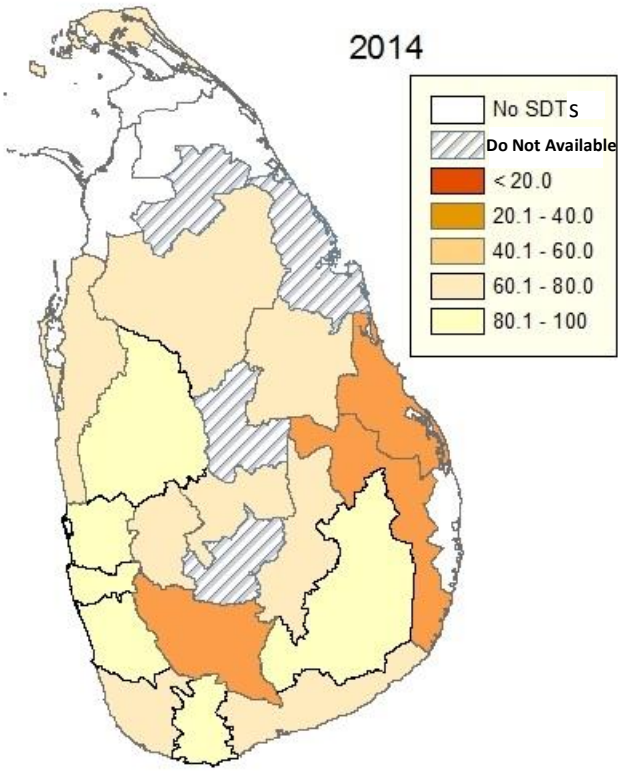
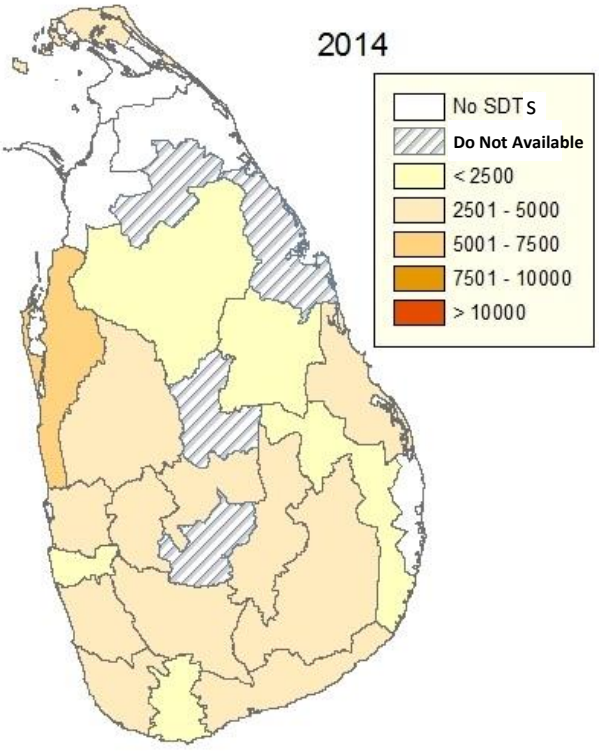


Figure 65 : SDT : Student ratio 2014



Service submitted by SDTs for 2013 & 2014. It shows that the disease pattern of school children remains same. However, the dental caries percentage of permanent dentition has been increased from grade 4 to grade 7 by 11% in 2013 has changed to 9% in 2013, which is a marginal improvement. However, the increase of caries in permanent dentition from Grade 4 to Grade 7 is still considered as a weakness of the programme, and is needed to be addressed in future. Gum diseases too show an increasing trend with age.

Increase of STDs in 2014

During the latter part of 2014, 61 new STDs were recruited. In the coming years the service will be improved by their contribution.

12.2 Provision of Oral Health Care services to Antenatal Mothers

Oral health care services to antenatal mothers was introduced to the FHP in the year 2009 with an objective of improving the oral health of mothers and young children by providing comprehensive care during the prenatal and antenatal periods, in order to reduce;

- Complications of dental diseases during pregnancy
- The risk of transmission of 'harmful' bacteria to the newborn (to minimize the risk of Early Childhood Dental Caries)

The coverage and treatment provision data on Oral Health provision to antenatal mothers are planned to obtain through the newly introduced MCH information system via PHM in 2016.

Figures given in Table 22 may reflect an underestimation of the screening percentage and an overestimation of disease prevalence since those calculations were done for the mothers who registered with PHM and for mothers who attended dental clinics respectively.

Inability to obtain an accurate assessment of population coverage of dental screening and prevalence of dental problems are main challenges for monitoring the programme. Including an 'oral health section' in the pregnancy record to elicit the percentage of antenatal mothers who get an oral screening done is proposed to overcome this problem.

12.3 Oral Health Care for Infants and early Childhood

It has been identified high burden of dental caries among children under 3 years. Hence it is planned to address this issue in the next year by introducing a screening programmes for infants and young children.

13 Milestones of Family Health Programme and Progress of Activities 2014

Several important activities related to Family Health Programme were carried out during 2014 on quality assurance. Health Programme were carried out during 2014 strengthening the programme further, focusing

13.1 Maternal Care

1. Finalized the volume II of the National Maternal care guidelines: Guidelines on management of medical disease complicating pregnancies. This includes guidelines on management of bronchial asthma, liver diseases, renal diseases, thyroid diseases, anti-phospholipid syndrome, rheumatoid arthritis, malaria, tuberculosis, syphilis and HIV.

2. Development and launching of a Mobile APP to access national guidelines on maternal care and newborn care.

3. High dependency units were established in the TH Anuradhapura, PGH Badulla, PGH Kurunegala, PGH Ratnapura and DGH Kalutara (each worth around Rs. 1.0 million) for close monitoring of highly complicated maternity cases with the objective of reducing Maternal Mortality and morbidity.

4. Nutrition data dissemination workshop on current nutrition status of mothers and children was held with the participation of relevant stake holders on 17th November 2014 under the patronage of Hon. Minister of Health Maithripala Sirisena.

5. Development of the Information, Education & Communication (IEC) material for antenatal classes.

6. Scaling up of the LBW prevention strategy.

7. Launch of institutional maternity care: norms for services, equipment and drugs.

13.2 Newborn Care

1. A Training Manual on Facility Based Care of the Sick Newborn to be used for training of health staff in neonatal care was adopted with a group of technical experts and the Sri Lanka College of Paediatricians and the Perinatal Society of Sri Lanka.

2. Newborn Care Clinical Management Guidelines (Volume I, II and III) were developed with a group of technical experts and the Sri Lanka College of Paediatricians and the Perinatal Society of Sri Lanka.

3. Newborn screening for congenital hypothyroidism was started in six districts in the country; Galle, Matara, Hambantota, Monaragala, Ratnapura and Kalutara. The Nuclear Medicine Unit of the Karapitiya Medical Faculty would provide laboratory services to these districts.

4. Workshops were conducted for the field staff on Neonatal Care in the field setting with a special focus on Kangaroo Mother Care.

5. Breastfeeding Counselling Training of Trainers (TOT) - 5 days and Essential Newborn Care TOTs (5 days) were conducted.

6. Completed infrastructure development (10 Neonatal Intensive Care Units, 29 Special Care Baby Units, 120 New born corners) distribution of equipment and consumables through the SAARC Development Fund.

7. Neonatal Intensive Care Unit bed availability system was initiated linking up the Neonatal Intensive Care Units of the Teaching Hospitals and Provincial General Hospitals to the centrally located Bed Manager System.

8. Neonatal surveillance system was developed. Data from this system could be used by the units themselves and for central monitoring and evaluation.

9. A bottle neck analysis to identify gaps and propose solutions to improve the neonatal care programme was initiated. This activity was started to support the development of the Every Newborn Action Plan for Sri Lanka to achieve Sustainable Development Goals for 2025 and 2035.

10. Supported the initiation of Neonatal Retrieval for the Western Province at the Lady Ridgeway Hospital.

13.3 Child Health - Child Nutrition

1. The National strategy on Infant and Young Child Feeding (IYCF) was finalized to provide guidance to relevant stakeholders in uplifting nutrition status of this important target group.

2. Capacity building of health staff on WHO new child growth standards was commenced using the new training material adapted and translated in to Sinhala and Tamil languages to enhance the capacities of health staff in detection and assessment of growth and nutrition problems among children under the age of five years.

3. Capacity building of health staff done on Infant and Young Child Feeding (IYCF) to improve knowledge and skills of field health staff in promoting appropriate IYCF practices and managing nutrition problems among children under the age of five years.

4. A two day Workshop on “Supportive Supervision, Mentoring and Monitoring of IYCF” was conducted for national and district level resource persons by an international expert.

5. Nutrition month activities were launched in June/July 2014 strengthening routine growth monitoring of children under the age of five years and adolescents. National level awareness programme was conducted at the FHB in May 2014.

6. Breastfeeding week was launched during first week of August at the BMICH under the patronage of Hon. Minister of Health and relevant activities conducted island wide.

7. A workshop on 'Achievements and way forward in Maternal & Child Nutrition' was held to disseminate national level data to relevant stakeholders and to introduce them the sources of information available at FHB, Ministry of Health regarding maternal and child nutrition under the patronage of Hon. Minister of Health.

8. Establishment of Nutrition clinics at field level was initiated with development and dissemination of guidelines in all three languages and provision of anthropometric equipment to provide targeted interventions to malnourished children, pregnant mothers and adolescents/school children as a mechanism to further address the issue of malnutrition in Sri Lanka.

9. Regular meetings of the Maternal & Child Nutrition (MCN) Subcommittee chaired by DDG PHS II held to resolve MCN issues and streamline MCN activities.

10. Child Health Development Record (CHDR) was updated, printed and disseminated to ensure that all newborns receive the CHDR before discharge from hospital.

11. Procurement and distribution of nutrition commodities required for nutrition interventions of the National Child Health programme (Vitamin A mega dose, MMN, BP100) were done.

12. Management of severe acute malnutrition with therapeutic feeding was strengthened in all hospitals with paediatric speciality throughout the country.

13.4 Child Health - Child Development and Special Needs

1. A special project on providing care for children with special needs was formulated. Plans were developed to establish a pilot special needs centre for the Western Province.

2. A strategic plan for child health is being developed for the period of 2015 to 2020.

3. FHB developed a new training package on Early Childhood Care and Development (ECD).

13.5 School Health

1. Advocacy programmes were conducted with the Ministry of Education for technical guidance and financial support to strengthen the school health programme.

2. In collaboration with Attorney General Department, School and Adolescent Health units of FHB were able to clarify the legal issues for provision of Sexual and Reproductive Health Services to underage children. Currently,

collaborative field services are ongoing with the National Child Protection Authority for provision of child protection and counseling services at MOH offices.

3. A Resource Book for school teachers on Health and Physical Education is being developed and at the final stage.

4. To strengthen the life skills among children, manual on Life skills was developed targeting school children and adolescents. In addition, revised WHO growth chart for nutrition assessment was developed to be distributed among public health staff. This book is to be used at School Medical Inspection to monitor growth standards.

5. A media seminar on school nutrition and WIFS was conducted at Health Education Bureau with the technical support from Faculty of Medicine-Colombo, Nutrition coordination division and Health and Nutrition division of Ministry of Education services in June 2014.

6. Mid-day meal programme was launched in Anuradhapura district with the technical and financial support of school health unit of the FHB. The initial programme was conducted by Ministry of Education at Thirrappene and Padaviya in 2014.

7. Field visits were done for the evaluation of Health Promoting schools in Kalutara district.

8. TOT programmes were conducted on "Life Skills" and "School Medical Inspection" for public health professionals.

9. Provided technical assistance to develop Health subject text books in the national curriculum revision of Ministry of Education in 2014.

10. Provided technical guidance through a lecture series for the authors of the "Teacher's Resource Book-Health" (Ministry of Education).

13.6 Adolescent Health

1. Documentary on adolescent nutrition "Jeewithaya Manaram" was developed in 2014 and telecasted in four television channels. This docudrama was distributed among all MOOH and youth corps to promote healthy life style among younger generation.

2. FHB developed Information, Education and Communication (IEC) material in both Sinhala and Tamil, to prevent teenage pregnancies. These leaflets were distributed to MOH offices and Youth Friendly Health Services (YFHS) clinics in view of educating teens and their parents at the field level.

3. To raise awareness on adolescent health and for personality development among youth, FHB is in the process of developing a youth health website.

4. Technical Advisory Committee on Young Person's Health was held once in

three months, chaired by the Director General of Health Services, which provides technical expertise on matters related to adolescents and youth specially targeting out of school adolescents and young persons.

5. Adolescent health unit was expanded to incorporate "Youth Health Programmes" and started to revamp Youth Friendly Health Services (YFHS) in hospitals. With this 3 day training of trainers programme for staff of Youth Friendly Health Service Centres and one day awareness programme for hospital staff was started.

6. Training of Trainers on Adolescent health, 3 day programmes were done for MOH staff and counselling officers of Ministry of Social Service.

13.7 Family Planning

1. Workshops in all 9 Provinces were conducted to update the knowledge of hospital staff and field staff in the catchment areas on Family planning.

2. Six Training of Trainers programmes were conducted on Intra Uterine Device insertion for health staff.

3. Five Training of Trainers programmes were conducted on Implant insertion for health staff.

4. Training of Medical Officers of Maternal and Child Health (MO/MCHs) was done on anaphylaxis management in collaboration with Sri Lanka College of Anesthesiologists.

5. Was facilitated on Workshops on management of anaphylaxis at district level for Medical Officers and other staff, in collaboration with Sri Lanka College of Anesthesiologists. (Total number trained 485)

6. Procurement of equipment required for Family Planning clinics was done.

7. Family Planning equipment were distributed to 30 hospitals and field clinics.

8. Development of a docu-drama on family planning in Sinhala and Tamil media.

9. First pilot project on development of surveillance system on adverse events following administration of contraceptives was completed.

10. Family Planning clinic supervision guide was finalized.

11. Development of health Education leaflets for clients on Family Planning methods.

12. Development of guidelines on Oral Contraceptive Pills, Depo-Medroxy Progesterone Acetate, Intra Uterine Device, Implants and Tubal Ligation for health staff.

13. Development of reproductive Health commodity security plan and dissemination to all stakeholders.

14. Development of action plan on Millennium Development Goal 5B and dissemination to all stakeholders.

15. Initiation of a pilot project on post-partum Intra Uterine Device insertion as a collaborative effort with Sri Lanka College of Obstetricians and Gynecologists.

16. Conduction of two Workshops for officers In charge of Regional Medical Supplies Divisions on supply chain management.

17. Procurement of contraceptive commodities for Sri Lanka and distribution of them to all districts.

18. Registration and supply of equipment to 24 new Family Planning clinics.

19. Review of Family Planning clinics (human resource and equipment) in the field and in hospitals.

20. Conduction of a workshop to train technicians on seminal fluid analysis.

13.8 Women's Health including Pre-pregnancy Care

1. A Facilitators' Guide to Sensitize Medical Undergraduates on Gender Based Violence was developed with the collaboration of Expert Committee on Women's Health of Sri Lanka Medical Association.
2. The Gender – based Violence (GBV) care centres by the name of " Mithuru Piyasa" at state hospitals provides essential services for GBV GBV survivors. The term "Mithuru Piyasa" in Sinhala means " friendly heaven". New "Mithuru Piyasa" GBV care centres were established in seven institutions. The establishment of these centres included provision of training to the staff, provision of furniture, stationary and other equipment.

3. All established "Mithuru Piyasa" GBV care centres were regularly monitored and performance appraisal provided and refresher training and experience sharing workshops were conducted. The below table describes the services rendered by the established "Mithuru Piyasa" centres in the country.

4. The preconception care package for newly married couples was scaled up to be carried out in all MOH areas in the country. This package include screening both partners for non-communicable diseases and other risk factors, and sensitizing them on important topics such as sexuality and sexual relationships, family with no violence, parenthood etc to improve their knowledge which would lead the change of negative attitudes, enabling them to change their behaviours so as to lead a happy healthy married life . At the end of the sessions the couple is given a booklet with take home message given a booklet with take home messages

5. A documentary film on prevention of GBV was developed. This film was used to sensitize and educate the health care team and general public on negative consequences of GBV and its prevention.

6. Performance evaluation of Well Women Clinic services were conducted with the objective to increase the motivation of the service providers which would improve coverage and effectiveness of the programme. An award ceremony for best performance was conducted in December 2014.

13.9 Planning, Monitoring and Evaluation

1. Management Information System (MIS) on Maternal and Child Health /Family Planning was updated, strengthened and implemented well at all levels. Existing Management Information System including all records and returns was revised and pilot tested in two districts including Gampaha and Matale. All public health staff island wide was trained on revised Management Information System in their respective districts.

2. Timely printing and regular distribution of revised registers returns and records of Reproductive Health Management Information System were completed island wide to be used from 2015.

3. A feedback report on timeliness and performances were sent to every MOH in each quarter. Annual Report on Family Health 2013 and MCH quarterly news bulletin are published on regular basis to give the feedback to the Provincial Health Authorities, Programme managers, implementers, all relevant stakeholders.

4. Redesigning and launching website of the Family Health Bureau (www.fhb.health.gov.lk) was completed.

5. Designing of Web-based Management Information System in place of paper based system is initiated and in progress.

6. To strengthen supervision and monitoring a set of new Supervision tools for supervising of Public Health Midwife, SPHM and PHNS were introduced to all districts after conducting trainings at district level workshops. Training programmes for Puttlam, Galle ,Hambantota and Matara districts were conducted.

7. Annual Review Workshops for Regional Supervising Public Health Nursing Officers (RSPHNO). The workshop for 2015 conducted supervising the MOH areas of Rathnapura district with the participation of Provincial Consultants and other relevant supervising officers.

8. Annual workshop for Programme Planning Officers (PPO/PPA/SSO) was also conducted. Focus for this workshop was Geographic Information Systems and the officers were given hands on training on this. GIS is to be integrated into the web base MIS and this training would be a useful exercise when executing this activity.

9. Performance Evaluation of the public health teams was completed and selection was done at regional, provincial and national level. 30 MOH areas selected for the final round was assessed by national level consultants to make the process standardized. This

evaluation was done mainly to motivate the public health staff. Awards ceremony of excellence in Maternal and Child Health was held in November 2014. Tools developed for the process are available for future used by provincial and regional level assessments.

13.10 Maternal and Child Morbidity and Mortality Surveillance

1. A poster was developed and distributed on child injury prevention in all three languages. A media seminar was conducted to introduce the above poster and child injury prevention program in Sri Lanka. Two days child injury prevention symposium was organized at national and regional level, with the participation of international level consultation.

2. All maternal deaths reported from hospitals & field covering the entire country (including conflict-affected districts) were reviewed annually. The system includes a systematic process at each level from field, hospital, district and national level reviews. Over the 2005 -2013, the system was added with several quality dimensions (case scenario development, mandatory conducting of post-mortems, structured dissemination of outcomes and establishment of technical advisory committees) to further improve the review process. Maternal mortality reviews were conducted in all the districts.

3. **Maternal Near Misses:** WHO Multi Country Survey on Maternal and Newborn Health- data was analysed and published as a country report and disseminated among all the stakeholders in district and national level. A consultative meeting was held to develop a format on near misses and national near miss enquiry system to implement in the country.

4. **Birth Defects Surveillance:** A process was initiated to capture birth defects in the country. Such defects contribute to 18% of infant deaths in Sri Lanka. Further reduction of birth defect related deaths and disability necessitates having a quality surveillance system. Pilot implementation of birth defects surveillance system was initiated in southern province. Equipment facilitating the above process (Desk top computers, digital cameras, pathological autopsy tools) were distributed among the hospitals in the above province. Web based system to register all the identified birth defects was introduced and it is monitored at national level, FHB.

13.11 Oral Health Unit

1. Job description for Dental Surgeons attached to Adolescent Dental Clinics, Community Dental Clinics and MOH was finalized after two consultative workshops and handed over to the Ministry Of Health for further progression.

2. Nine, three day training workshops were conducted on "application of health promotion principles in School Dental Clinic" all the School for dental Therapists.

3. Purchased and distributed 140 tooth brushing demonstration models among School Dental Clinics.

13.12 Research Unit

Research in Family Health

Operational research provides evidence for policy and programmatic concerns.

1. A National Survey on Adolescent and Youth health was conducted during 2012/2013 with the objective of obtaining a profile of Sri Lankan adolescents and youth in terms of selected aspects of their health with the support of GOSL, UNICEF and UNFPA.

2. An island wide Emergency Obstetric and Neonatal Care needs assessment survey was completed during 2013. This survey comprised of facility assessment, morbidity estimation and assessment of knowledge of relevant health workers.

3. A descriptive cross sectional study was conducted in all 13 Districts where the Multiple Micro Nutrient (MMN) supplementation program is being implemented since 2006. The objective was to assess the coverage, compliance, knowledge and their correlates for MMN supplementation among mothers of 6 to 24 months old children in the above Districts.

   Three cohorts aged 7-9, 13-15 and 19-21 months consisting of 804 children in each group were recruited to the study, using stratified cluster sampling method. A structured interviewer administered questionnaire was used to collect data.

   Compliance during last 2 months was 89.7% (n= 1025) among the group who received MMN. However, effective coverage of the programme was only 37.5%. In the 19-21 months age group only 134 children (16.7%) had received MMN according to the schedule. With regard to adherence to correct practice, 72.8% (n= 670) of the mothers had given MMN daily, 79.8% (n=735) had included the entire packet in one meal, 91.9% (n=846) added MMN just before feeding and 76.7% (n= 706) added MMN to the first 2 - 3 mouthfuls.

   Out of all mothers, 55.4% (n=1359) stated iron as the main nutrient in MMN while 46.4% (n=1138) stated MMN reduces iron deficiency aneamia. Over all 83.9% (n=2058) and 83.7% (n=2058) of mothers reported that MMN helps physical growth and brain development

respectively. Only 66.1% (n=1621) said that any food can be given with MMN while 65.9% (n=1616) said activities need not to be restricted while giving MMN. All knowledge variables were significantly associated with PHM home visits during last 3 months (p<0.001) while other socio demographic variables did not show any significant association.

This study reveals that the MMN intervention coverage is inadequate but compliance of those receiving MMN was high.

This study also recommends that the MMN availability should be increased at all levels. As MMN compliance is high this study recommends that the MMN supplementation program should be expanded to the rest of the Districts.

This study also reveals that due to the low level of intervention coverage, the programme impact of reducing anaemia in the target group will not be achieved.

4. Research to assess the adherence to evidence based interventions in the maternal care services. The research is planned for 2015 and the report will be available in March 2016.

13.13 Training programmes conducted and fund utilization by Family Health Bureau

Family Health Bureau conducts routine training programme to increase the capacity of the public Health staff to perform their tack efficiently. Training programmes conducted during year 2014 are given in Table 25.

Table 24 : Source of funding for activities conducted by FHB year 2014

Funding source	Total expenditure (Rs.)
GOSL	310,926,826.00
UNFPA	33,285,960.00
WHO	4,905,296.00
SAARC Development Project	49,972,669.00
UNICEF	3,136,480.00
GAVI-HSS	3,909,139.00

Table 25: Training Programs conducted by Family Health Bureau – 2014

No	Title of the Programme	No. of days	Year of commencing	No. of programmes per year	Category of participants e.g. (PHM, PHI, PHNS etc.)
1.	Preconception care - TOT	02	2013	14	MOH
2.	Maternal care package	02	2012	For all districts Refresher training thereafter	
3.	Essential Newborn care course with Neonatal Advanced life support - TOT	5	2007	4	Pediatricians, VOGs, Medical Officers, Nurses, Midwives
4.	Breastfeeding counselling course -TOT	5	2010	4	Pediatricians, VOGs, Medical Officers, Nurses, Midwives
5.	Baby friendly Hospital - TOT	3	2010	4	Pediatricians, VOGs, Medical Officers, Nurses, Midwives
6.	Labour Room Management -TOT	2	2011	4	Labour Room in charge Nurses, MOMCHs
7.	Infant and Young Child Feeding counselling - TOT	5 1/2	2008	02	CCPs, MOMCHs, MOHs, RSPHNOs,PHNSs,SPHMs
8.	Growth monitoring and promotion – TOT (child growth assessment)	04	2014	02 in 2014	do
9.	Complementary feeding training	02	2007	02	MOs, Nurses
10.	Training programme on Nutrition Rehabilitation	02	2009	02	Paediatrician, SHO, MO
11.	Early Child Development	03	2014	50	MOH ,PHNSs, PHMs
12.	Special Needs	02	2014	20	MOH/PHM
13.	Adolescent Health	03	2008	06-08	MOMCH,MOH, PHNS, SPHI,PHI, Counselling officers of social service Dept., Instructors of Youth Corp, ISA – Education Dept.

No	Title of the Programme	No. of days	Year of commencing	No. of programmes per year	Category of participants e.g. (PHM, PHI, PHNS etc.)
14.	Life Skills	03	2008	08	MOMCH,MOH, PHNS, SPHI,PHI, Counselling officers of social service Dept., Instructors of Youth Corp, ISA – Education Dept.
15.	School Medical Inspection	02	2011	08	MOH Staff, MOMH
16.	Application of health promotion principles in School Dental Clinic	03	2014	09	SDTs
17.	Insertion of IUDs -TOT	1		3	MOOH, MOO, RMOO, AMOO. PHNSS
18.	Insertion of implants-TOT	1		4	MOOH, MOO
19.	Updates on Reproductive Health – Hospital based - TOT	1	2013	6	MOO, MOOH, NSS, PHNSS, NOO
20.	Counseling on Family Planning - TOT	1	2014	4	MOOH, MOO, RMOO, AMOO. PHNSS
21.	Training Programmes (Mithuru Piyasa)	04	2013	07	Hospital staff
22.	Programme planning	5	2012	2	Provincial CCPs ,MOMCH,MO Planning, RE,
23.	Supervision	3	2011	For all districts Refresher training thereafter	MOMCH,MOH, RSPHNO,SPHID,PHNS, SPHI
24.	Training on Reproductive Health Management Information System (RH- MIS)	1	2014	For all districts Refresher training thereafter	MOMCH,MOH, RSPHNO,SPHID,PHNS, SPHI,PHM.PHI

ANNEXURE

Annexure 1 : Population, birth rates, eligible families, pregnant mothers, reported number of deliveries and first antenatal clinic visits byhealth district 2014

RDHS/Health Area	Population	Birth Rate	Estimated eligible families	Eligible families registered by PHMs		Estimated Births	Estimated pregnancies (Births × 1.1)	Pregnant mothers registered by PHM (out of estimated pregnancies)		Number of first antenatal clinic visits	Number of reported deliveries	Number of reported live births
				No.	%			No.	%			
Colombo	1739807	15.4	278369	281341	101.1	26793	29472	26635	90.4	24772	27535	22624
Colombo M.C	553239	15.4	88518	93303	105.4	8520	9372	7766	82.9	8295	6135	6117
Gampaha	2429580	16.4	388733	398965	102.6	39845	43830	36291	82.8	36986	32349	30883
Kalutara	993088	14.8	158894	164442	103.5	14698	16167	16091	99.5	14988	14371	14427
N.I.H.S	315342	14.8	50455	52153	103.4	4667	5134	5638	109.8	5182	4983	5008
Kandy	1461031	18.8	233765	245063	104.8	27467	30214	25950	85.9	24695	21623	21569
Matale	500336	19.8	80054	93156	116.4	9907	10897	9704	89.0	9100	8748	8068
NuwaraEliya	782353	17.5	125176	130732	104.4	13691	15060	14666	97.4	14453	10886	10904
Galle	1063453	16.7	170152	176234	103.6	17760	19536	17432	89.2	15555	15191	15010
Matara	839466	15.2	134315	137780	102.6	12760	14036	14640	104.3	13893	12303	12327
Hambantota	684639	20.9	109542	112231	102.5	14309	15740	12293	78.1	11225	10675	10740
Jaffna	587470	14.9	93995	91552	97.4	8753	9629	8858	92.0	7696	7856	7879
Kilinochchi	122563	19.1	19610	20002	102.0	2341	2575	1855	72.0	1626	1565	1725
Mannar	116267	15.4	18603	18531	99.6	1791	1970	2035	103.3	2029	1693	1688
Vavuniya	186593	19.6	29855	27890	93.4	3657	4023	3035	75.4	2869	2558	2570
Mullaitivu	124240	11.6	19878	19098	96.1	1441	1585	2104	132.7	1947	1645	1600
Batticaloa	575708	18.1	92113	95570	103.8	10420	11462	10290	89.8	9580	9156	9250
Ampara	262009	21.1	41921	51130	122.0	5528	6081	5097	83.8	4790	4261	4275
Kalmunai	441312	21.1	70610	74228	105.1	9312	10243	9107	88.9	8965	8093	8111
Trincomalee	397554	22.1	63609	70729	111.2	8786	9665	8472	87.7	7633	7599	7568
Kurunegala	1728449	16.0	276552	300730	108.7	27655	30421	29333	96.4	27771	25295	25390
Puttalam	846504	19.2	135441	149092	110.1	16253	17878	14971	83.7	14748	12704	12816
Anuradhapura	964859	17.8	154377	180864	117.2	17174	18892	18042	95.5	17055	15047	15110
Polonnaruwa	471307	17.7	75409	94525	125.3	8342	9176	8236	89.8	9214	6758	6824
Badulla	900063	18.4	144010	151690	105.3	16561	18217	15532	85.3	14551	14143	14122
Monaragala	531686	19.5	85070	92508	108.7	10368	11405	10095	88.5	10296	8805	8486
Ratnapura	1199698	18.0	191952	196647	102.4	21595	23754	18979	79.9	17492	15708	15757
Kegalle	848167	16.0	135707	148793	109.6	13571	14928	14381	96.3	13535	12659	12841
Sri Lanka	**21666783**	**16.9**	**3466685**	**3668979**	**105.8**	**366169**	**402785**	**367528**	**91.2**	**350941**	**320344**	**313689**

Annexure 2 : Indicators of field antenatal care and percentage of pregnant women protected by rubella vaccine 2014

RDHS/Health Area	% Pregnant mothers registered before 8 weeks	% Pregnant mothers registered 8-12 weeks	% Teenage pregnant mothers (less than 20 Yrs) registered	% of Primies registered	% Pregnant mothers P5 and above registered	% Registered pregnant mothers protected for Rubella	% Antenatal mothers having the first home visit	Average antenatal home visits by PHM	Mothers protected with T.T. at delivery	Mothers tested for Grouping Rh at delivery	Mothers tested for VDRL at delivery
Colombo	69.6	19.3	3.5	40.3	1.6	98.1	77.3	3.4	83.0	83.1	83.1
Colombo M.C	44.6	34.3	6.3	34.9	4.7	87.1	70.6	2.9	100.0	100.0	99.9
Gampaha	70.7	17.5	5.0	38.1	1.8	103.9	83.6	2.8	97.4	99.2	102.0
Kalutara	76.4	17.4	4.2	33.9	2.5	98.4	87.4	4.0	99.9	93.7	93.7
N.I.H.S	80.9	15.9	3.7	28.5	3.9	98.7	91.8	3.4	99.9	100.0	99.9
Kandy	72.1	21.4	4.0	30.5	2.8	103.1	92.6	3.9	99.9	100.3	100.3
Matale	78.7	16.8	5.6	32.1	2.2	98.8	101.6	2.8	95.9	97.3	96.8
NuwaraEliya	55.9	25.8	4.5	27.0	1.9	86.6	86.0	5.3	99.5	99.5	98.8
Galle	78.4	15.2	4.9	34.4	2.3	98.9	93.2	3.8	100.0	100.0	100.1
Matara	84.6	12.5	4.4	30.7	3.2	98.3	99.0	4.1	101.3	101.3	101.4
Hambantota	85.9	11.8	4.8	30.3	2.9	99.3	95.4	4.3	100.0	99.9	100.0
Jaffna	85.7	11.6	3.3	33.8	2.9	99.5	100.1	8.5	98.8	99.7	99.7
Kilinochchi	68.6	21.7	7.8	49.2	4.1	91.1	100.5	6.1	99.7	99.8	99.7
Mannar	66.9	23.1	5.6	28.9	6.9	77.7	99.4	5.6	99.2	99.3	99.3
Vavuniya	57.6	27.3	6.1	34.1	6.7	84.9	86.2	5.0	85.9	100.0	100.0
Mullaitivu	65.3	23.1	8.2	28.7	4.8	91.9	97.9	5.1	99.6	99.6	99.8
Batticaloa	77.5	15.8	8.3	34.9	4.2	96.5	98.2	4.7	99.1	99.1	93.5
Ampara	85.1	11.4	5.0	30.3	2.9	101.6	94.1	3.2	99.5	99.7	100.0
Kalmunai	84.8	13.1	5.7	33.4	5.5	93.4	95.9	5.0	100.0	99.6	99.5
Trincomalee	68.3	22.2	8.5	31.6	6.5	90.6	93.8	4.1	99.7	99.8	99.8
Kurunegala	88.6	10.9	3.7	31.9	2.0	99.5	93.8	4.3	100.0	99.7	100.0
Puttalam	76.6	17.2	7.4	31.2	4.1	98.5	93.4	3.7	94.9	95.4	99.8
Anuradhapura	78.8	15.9	5.5	28.3	2.9	99.5	95.5	4.0	100.3	100.1	100.5
Polonnaruwa	77.7	16.1	4.1	29.5	42.8	98.9	91.9	4.3	100.0	100.0	100.0
Badulla	76.7	19.1	5.6	31.2	2.1	98.6	87.8	4.9	99.6	99.4	98.0
Monaragala	82.9	13.2	4.8	27.6	3.4	102.4	93.4	4.0	96.5	96.5	97.0
Ratnapura	73.2	20.1	4.9	32.1	1.9	97.0	84.1	3.9	99.7	99.7	99.7
Kegalle	75.4	19.3	3.7	31.5	2.2	99.2	88.0	4.3	100.1	100.2	100.2
Sri Lanka	**76.2**	**17.4**	**4.9**	**32.7**	**3.7**	**98.2**	**90.2**	**4.1**	**97.7**	**97.8**	**98.0**

Annexure 3 : Indicators of clinic care, ante-natal screening, status of BMI, and anaemia by health district 2014

RDHS/ Health Area	% of registered mothers attending clinics at least once	Average number of clinic visits by a mother	VDRL clinics available	% of clinic attendees (ANC) screened for VDRL	% of mothers with reac-tive VDRL	% of clinic attendees (ANC) anaemic out of FV	% of clinic attendees (ANC) tested for blood grouping & Rh	% of mother s BMI measured	% of mothers with BMI less than 18.5	% of mothers with BMI more than 25
Colombo	93.0	5.4	98	53.2	0.04	5.5	7.7	75.7	18.4	24.3
Colombo M.C	106.8	5.0	80	72.7	0.05	18.1	43.0	61.1	16.1	33.3
Gampaha	101.9	5.6	0	0.0	0.00	0.0	0.0	55.7	28.9	34.2
Kalutara	93.1	5.9	45	28.1	0.01	3.7	15.8	82.5	21.1	19.9
N.I.H.S	91.9	5.7	36	40.0	0.00	5.4	12.9	79.4	16.7	26.0
Kandy	95.2	6.2	212	85.6	0.06	11.8	31.8	86.3	19.3	19.4
Matale	93.8	6.1	0	0.0	0.00	0.0	0.0	56.4	34.3	32.3
NuwaraEliya	98.5	6.3	112	64.3	0.01	5.6	26.1	65.2	24.4	15.1
Galle	89.2	6.3	36	29.4	0.01	5.1	6.4	81.6	25.3	16.4
Matara	94.9	6.7	30	68.0	0.00	5.9	36.9	92.9	30.5	16.6
Hambantota	91.3	6.8	19	81.2	1.25	6.0	41.2	84.7	26.1	13.8
Jaffna	86.9	8.0	10	34.6	0.00	19.3	22.4	84.0	18.5	19.2
Kilinochchi	87.7	6.3	2	48.3	0.00	39.2	36.1	84.0	26.6	15.2
Mannar	99.7	6.0	1	77.4	0.00	17.9	53.5	85.0	23.2	22.7
Vavuniya	94.5	9.6	0	0.0	0.00	10.1	0.0	75.9	21.6	20.4
Mullaitivu	92.5	6.7	3	68.1	0.06	37.2	57.9	86.6	27.7	12.3
Batticaloa	93.1	6.5	54	41.8	0.04	15.2	57.1	88.1	20.1	21.2
Ampara	94.0	6.7	3	26.3	0.00	16.1	31.3	89.2	26.5	15.4
Kalmunai	98.4	6.8	65	72.7	0.01	16.1	44.3	85.6	16.0	25.3
Trincomalee	90.1	7.2	3	31.3	0.00	8.6	25.6	76.0	19.6	24.4
Kurunegala	94.7	6.8	95	85.0	0.03	17.9	32.4	87.2	23.5	17.6
Puttalam	98.5	5.9	22	92.8	0.02	7.6	40.2	81.2	21.5	22.6
Anuradhapura	94.5	6.8	147	84.9	0.04	9.0	26.8	85.8	23.4	16.9
Polonnaruwa	111.9	5.7	69	81.3	0.00	21.9	37.7	82.8	29.1	19.4
Badulla	93.7	7.5	75	68.1	0.16	5.8	18.5	83.3	24.2	12.5
Monaragala	102.0	6.2	11	82.9	0.27	15.1	53.4	89.7	25.1	16.3
Ratnapura	92.2	6.7	191	90.8	0.00	6.5	40.9	78.2	26.2	14.8
Kegalle	94.1	6.1	45	52.2	0.24	15.8	21.1	87.5	25.6	19.3
Sri Lanka	**95.5**	**6.3**	**1464**	**57.1**	**0.08**	**9.4**	**25.5**	**79.1**	**23.5**	**20.2**

Annexure 4 : Natal care 2014

RDHS/Health Area	% of institutional deliveries out of total reported deliveries	% of home deliveries out of total reported deliveries	% LSCS out of total reported deliveries	% of untrained deliveries out of total reported deliveries	% of deliveries reported out of total estimated pregnancies	% of deliveries reported out of total registered pregnancies
Colombo	100.0	0.00	32.0	0.00	93.4	103.4
Colombo M.C	100.0	0.00	27.8	0.00	65.5	79.0
Gampaha	98.2	0.04	36.2	0.00	73.8	89.1
Kalutara	100.0	0.03	38.8	0.01	88.9	89.3
N.I.H.S	100.0	0.02	43.3	0.02	97.1	88.4
Kandy	99.9	0.06	35.1	0.05	71.6	83.3
Matale	97.7	0.11	36.4	0.07	80.3	90.1
NuwaraEliya	99.6	0.37	22.7	0.19	72.3	74.2
Galle	100.0	0.04	34.6	0.02	77.8	87.1
Matara	99.9	0.08	35.0	0.06	87.7	84.0
Hambantota	100.0	0.05	32.8	0.03	67.8	86.8
Jaffna	99.9	0.05	32.7	0.05	81.6	88.7
Kilinochchi	99.9	0.13	14.4	0.06	60.8	84.4
Mannar	99.5	0.47	29.8	0.47	86.0	83.2
Vavuniya	99.6	0.43	27.8	0.43	63.6	84.3
Mullaitivu	99.7	0.30	17.4	0.12	103.8	78.2
Batticaloa	99.6	0.42	24.2	0.22	79.9	89.0
Ampara	100.0	0.00	25.7	0.00	70.1	83.6
Kalmunai	100.0	0.04	34.4	0.02	79.0	88.9
Trincomalee	99.8	0.18	21.4	0.11	78.6	89.7
Kurunegala	100.0	0.03	34.0	0.00	83.2	86.2
Puttalam	99.9	0.11	33.1	0.10	71.1	84.9
Anuradhapura	99.9	0.12	26.5	0.06	79.6	83.4
Polonnaruwa	100.0	0.03	34.0	0.01	73.6	82.1
Badulla	99.9	0.13	24.1	0.06	77.6	91.1
Monaragala	99.9	0.12	26.1	0.12	77.2	87.2
Ratnapura	99.9	0.11	30.3	0.06	66.1	82.8
Kegalle	99.9	0.09	38.0	0.06	84.8	88.0
Sri Lanka	**99.7**	**0.09**	**32.1**	**0.05**	**79.5**	**87.2**

Annexure 5 : Indicators of post natal care: post natal visits, Vitamin A supplementation, post natal complications by districts 2014

RDHS/Health Area	% of mothers receiving the 1st post natal visit within the 1st 10 days out of reported deliveries	% of mothers receiving the 1st post natal visit within the 1st 10 days out of estimated births	Average number of post natal visits within first 10 days	% of postnatal visits to the mother around 42 days	% of mothers receiving Vitamin Amega dose for reported deliveries	% of estimated mothers who received Vitamin A	% of reported deliveries with post natal morbidities
Colombo	82.3	84.6	1.6	60.6	76.2	71.2	12.6
Colombo M.C	59.5	42.9	1.2	34.8	96.8	63.4	7.0
Gampaha	88.1	71.5	1.5	71.4	72.1	53.2	10.2
Kalutara	88.1	86.2	1.7	77.7	60.4	53.7	8.1
N.I.H.S	90.1	96.2	1.7	72.8	88.6	86.0	4.6
Kandy	89.7	70.6	1.7	72.4	83.0	59.4	8.1
Matale	90.1	79.6	1.7	70.7	92.5	74.3	8.6
NuwaraEliya	87.0	69.2	1.8	88.4	85.9	62.1	5.6
Galle	105.6	90.4	1.6	74.9	72.7	56.5	9.6
Matara	100.8	97.2	1.7	83.0	98.7	86.5	16.5
Hambantota	103.1	76.9	1.8	85.2	88.2	59.8	13.0
Jaffna	94.8	85.1	1.8	80.3	88.7	72.4	6.7
Kilinochchi	96.4	64.4	1.8	92.1	98.1	59.6	4.7
Mannar	96.3	91.0	1.8	78.7	91.7	78.8	9.1
Vavuniya	84.6	59.2	1.6	60.5	94.6	60.2	3.7
Mullaitivu	85.5	97.6	1.7	82.4	99.6	103.3	3.2
Batticaloa	97.0	85.2	1.9	80.2	95.9	76.6	5.6
Ampara	93.2	71.8	1.6	70.6	77.5	54.3	14.6
Kalmunai	92.2	80.1	1.9	84.1	96.6	76.3	12.7
Trincomalee	87.1	75.3	1.7	68.3	78.3	61.6	4.3
Kurunegala	91.5	83.7	1.7	84.6	72.0	59.8	14.2
Puttalam	92.3	72.2	1.7	75.7	87.8	62.4	9.2
Anuradhapura	90.3	79.2	1.6	73.2	94.4	75.2	9.4
Polonnaruwa	92.8	75.2	1.5	79.2	96.4	71.0	11.3
Badulla	87.5	74.7	1.8	75.2	79.6	61.8	6.7
Monaragala	86.3	73.3	1.7	73.3	95.1	73.4	8.6
Ratnapura	90.9	66.1	1.6	68.4	74.7	49.4	11.8
Kegalle	96.5	90.1	1.5	74.7	51.2	43.4	16.3
Sri Lanka	**90.7**	**79.3**	**1.7**	**74.3**	**80.9**	**64.4**	**10.2**

Annexure 6 : Indicators of child care service provision: infant registration, field visits 2014

RDHS/ Health Area	% of infants registered by PHM out of estimated births	% of registered infants received at least one field visit after 42 days	Average number of home visits per infant	Average number of weighing per infant	% of estimated infants supplied with vitamin A mega dose at 6 months	% of estimated children supplied with vitamin A mega dose	
						18 m	3 y
Colombo	89.7	58.6	6.0	9.7	69.2	68.3	73.6
Colombo M.C	82.3	34.1	5.0	4.3	73.5	71.8	77.1
Gampaha	85.0	47.7	7.9	10.2	38.5	54.0	50.1
Kalutara	104.0	63.7	7.3	10.5	47.2	51.4	52.1
N.I.H.S	111.4	67.5	5.7	9.7	97.8	95.0	93.2
Kandy	87.7	64.7	7.4	9.8	73.1	68.2	66.2
Matale	96.4	53.4	8.4	10.6	83.2	127.3	131.8
NuwaraEliya	98.0	56.1	7.2	10.4	84.6	84.1	83.4
Galle	90.7	60.2	7.5	10.3	51.0	49.3	52.6
Matara	98.4	76.8	7.5	10.9	95.6	96.4	102.5
Hambantota	74.3	58.5	8.3	10.4	67.2	66.7	67.3
Jaffna	89.3	68.0	13.1	12.2	63.8	63.7	64.4
Kilinochchi	69.2	56.6	9.5	12.5	67.3	69.9	71.9
Mannar	129.0	15.1	29.0	11.7	89.6	100.0	95.7
Vavuniya	73.7	40.5	5.7	7.9	86.2	85.1	84.0
Mullaitivu	110.3	70.4	8.5	11.5	143.2	144.9	147.1
Batticaloa	87.9	67.8	6.9	10.9	82.3	88.8	93.5
Ampara	76.1	56.6	4.9	11.4	58.8	58.7	62.3
Kalmunai	88.5	80.4	7.2	11.1	86.6	87.3	88.3
Trincomalee	90.1	54.4	7.1	9.4	63.3	62.3	67.0
Kurunegala	91.7	58.4	8.5	11.2	76.1	77.8	81.7
Puttalam	79.9	47.7	5.9	11.0	71.7	71.0	73.5
Anuradhapura	92.8	60.6	6.4	10.1	79.2	82.3	83.7
Polonnaruwa	84.8	53.2	6.7	9.4	72.5	76.0	75.0
Badulla	89.2	57.3	8.3	10.5	74.0	73.4	73.1
Monaragala	85.4	62.6	7.8	10.9	78.8	77.5	73.5
Ratnapura	76.4	53.0	6.7	9.9	48.7	50.4	51.4
Kegalle	96.2	55.5	9.3	10.2	49.4	51.8	53.8
Sri Lanka	**90.6**	**58.0**	**7.5**	**10.2**	**68.8**	**71.9**	**73.1**

Annexure 7 : Weighing coverage of children under 5 years 2010 – 2014 (Nutrition Month)

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

Annexure 8 : Nutritional status of infants 2014 (Nutrition month)

RDHS/Health Area	Underweight %					Stunting %					Wasting%			
	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014	2011	2012	2013	2014
Colombo	8.8	8	8	8.9	9.5	6	4.5	6.2	5.9	7	6.5	6.8	8.3	7.8
Gampaha	6.2	6	6.4	7	6.4	7.9	5	3.8	4.7	4.1	5.9	10.4	5.7	5.5
Kalutara	8.8	8.3	7.4	8	7.8	6.9	7.1	5.7	6.3	5.9	9.2	7	7.3	6.4
N.I.H.S	7.5	9.5	8	8.1	9.2	4.7	6.5	1.2	4.2	4.4	11	6.8	7.9	7.8
Kandy	9.5	10.5	10.1	9.8	9.2	9	9.4	8.6	8	7.1	11.2	9.8	8.1	7.2
Matale	8.8	9.1	8.4	8.2	7.8	7.1	7.9	7.3	6.7	5.5	10.2	8.5	7.3	7.2
NuwaraEliya	15.9	16	15	15.7	15	16.4	15.2	12.5	13.8	15.4	19.3	24	13.4	13.7
Galle	8.3	8.5	8.6	8.1	8.6	6.7	7.2	7	6.2	6.1	8.6	8.4	8.6	7.9
Matara	8.7	9.2	8.8	9.2	8.9	15.5	7.7	7.4	6.6	6.2	9.7	15.1	9	8.2
Hambantota	9	8.1	7	7.5	7.8	6	5.8	5.2	5.3	5.1	8.8	7.3	7	7.9
Jaffna	8.2	6.7	5.7	7.1	7.3	7	6.6	4.3	5.5	4.5	5.8	8.8	6.8	5.4
Kilinochchi	-	12.8	6.4	6.4	5.9	-	13.1	7.5	5.6	4	11	6	6.2	2.8
Mannar	-	5.6	6.1	5.3	5.2	-	6.4	4.6	2.9	2.2	3.5	5	3.3	3.1
Vavuniya	10	9.7	7.1	8.7	9.2	8.2	6.8	4.8	6.4	5.8	7.5	8.4	8.6	8.6
Mullaitivu	-	7.7	6.8	5.7	7	-	9	6	5.9	6.2	8.7	4.6	3.1	3.3
Batticaloa	12	10.2	8.3	7.1	7.4	8.9	7.2	6.3	6.1	5.7	9.6	7.4	6.2	5.6
Ampara	12.3	12.7	11.1	11	10.6	9.5	8.3	6	7.4	6	11.9	8.6	8.8	7.6
Kalmunai	9.2	8.8	8.5	7.9	7	7.3	8.3	7	6.3	6.1	7.6	8.8	6.7	6.6
Trincomalee	10.2	10.3	8.3	7.9	7.6	6.6	6.8	5.8	6.1	4.6	11.8	8.8	8	7.8
Kurunegala	7.9	7	6.7	6.7	6.8	6.3	6.3	5.2	5.7	4.9	7.8	15.6	6.5	6.2
Puttalam	7.4	8	7.1	7.3	8.5	5.9	5.3	5.3	5.1	5.5	8.4	6.9	4.7	6.4
Anuradhapura	9.5	9.6	9	9.1	9.1	8.3	7.6	7	8.2	6.6	11.5	10	9.7	8.6
Polonnaruwa	8.1	10	9.3	10.6	10.2	4.9	6.4	6.5	6.2	5.5	8.8	9.8	10.3	10.3
Badulla	12	12.2	11.8	11.6	12.4	14.9	10	10.3	9.4	9.4	11.2	10.9	9.2	11.6
Monaragala	10	9.6	7.6	8.8	9.2	6.4	6	4.4	5.4	5.1	9.7	8.5	9.4	8.6
Ratnapura	11.3	10.6	9.7	9.1	9.1	10.8	8.6	8.4	7.3	6	13.7	12.5	10.6	13
Kegalle	10.4	9.3	9.6	10.7	11.5	8	8.3	7.6	6.6	6.6	10.7	8.8	9.3	9.7
Sri Lanka	**9.3**	**9.5**	**8.5**	**8.7**	**8.8**	**8.5**	**7.3**	**6.6**	**6.6**	**6.3**	**9.8**	**8.6**	**8**	**7.9**

Annexure 9 : Nutritional status of young children 2014 (Nutrition month)

RDHS/Health Area	Underweight %					Stunting %					Wasting%			
	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014	2011	2012	2013	2014
Colombo	15.8	14.4	13	13.5	15	12.3	10.7	11	9.9	9.9	10.1	11.2	10.3	10.1
Gampaha	12.7	11.3	11.4	11.5	11.8	9.7	9.3	13.2	9	7.7	9.7	8.5	8.7	8.4
Kalutara	17.9	15.4	13.8	13.6	14.5	13.8	12.4	11.5	11.4	11.1	15.7	13	11.3	10.6
NIHS	12	11.4	11	13	12.7	10.7	13.1	5.7	8	8.3	10.4	9.6	9.4	10.7
Kandy	19.8	18.3	18.5	17.5	16.2	18.2	15.7	16.3	15.6	13.6	16.7	16.2	13.3	10.9
Matale	18.2	20	18	16.4	15.8	17.8	17.7	14.3	13.8	13.4	17.3	15	12.6	11.3
Nuwara Eliya	29	27	25.1	25.2	22.4	26.4	27	22.6	24.3	21.4	26.2	19.5	23.2	18.7
Galle	18.4	16.7	15.5	14.9	16.2	15.7	12.2	12.5	11.3	12.1	14.4	13.2	12.4	13.1
Matara	19	17.6	16.5	17.3	18.3	14.4	15	14.1	13.5	13.3	14.3	14.4	14	20
Hambantota	20.2	16	16.4	16	15.5	14.7	11	11	10.7	9.9	14.6	13.4	14.8	13.1
Jaffna	18.8	16.4	14.1	13.7	13.8	15.7	13.4	10.6	10.7	8.8	12.4	13.7	12.4	10
Killinochchi	-	30.7	20.2	14.7	14.6	-	27.2	18.3	14.3	8.7	19.5	12.2	10.9	8.2
Mannar	-	11.9	13	14	12.8	-	9.9	8.6	10	9.4	6.6	10	9.6	6.5
Vavuniya	20	18.5	16	17.7	16.6	19.5	15.3	11.3	11.6	13.4	14.7	14	14.7	15.3
Mullaitivu	-	23.8	17.2	17	17.1	-	24.7	13.8	12.7	12.5	15.8	10.4	9.3	8.7
Batticaloa	22.8	17.6	20.6	14.5	13.2	14.4	13.2	13.8	11.4	10.7	12.1	10	9.5	9.8
Ampara	25	21.5	22	20.5	19.2	19	15.3	14.5	13.7	10.9	18.3	14.1	15.1	13.3
Kalmunai	15.9	16.5	15.6	16.2	15.8	13.4	14.6	13.5	13.2	12.2	9.9	11	9.9	9.6
Trincomalee	18.2	19.2	19.8	24.6	16.4	13.3	13.1	9.2	14.4	9.7	18	12.2	16.7	13.3
Kurunagala	19.5	16.5	14.8	14.9	14.5	13.4	11.7	10.8	10.1	10.9	13.3	11.4	11.5	11
Puttalam	16.6	14.6	13.8	14.4	15.5	11.8	11	10.5	10.1	9.3	10.7	11.2	10.6	11.6
Anuradapura	21.7	19	18.7	18.9	17.9	18.7	15.7	14.7	14.1	13.8	17.7	15.6	14.6	13.1
Polonnaruwa	18.8	19.3	17.7	15.9	19.2	13.3	12	14	13.2	11.3	15.2	15	15.4	15.4
Badulla	23	21.4	21.2	20.4	19.9	23	20	19	17.9	16.9	15.8	14.6	15.7	15.3
Monaragala	22.7	18.3	16.2	16.1	17.9	13	12.8	10.4	11.2	10.9	16.7	14.2	15	13.8
Ratnapura	22.5	19.3	17.6	16.6	15.9	19.1	15.6	15.1	13.8	12	18.8	16.8	13.8	12.8
Kegalle	22.4	17.9	18.3	17.5	19.6	17.4	16.2	14	13.1	12.3	16.4	13.5	13.1	13.3
Sri Lanka	**19.4**	**17.3**	**16.3**	**16.1**	**16**	**15.6**	**13.6**	**13.5**	**12.6**	**11.7**	**14.3**	**13.2**	**12.7**	**12.1**

Annexure 10 : Nutritional status of preschool children 2014 (Nutrition month)

RDHS/Health Area	Underweight %					Stunting %					Wasting%			
	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014	2011	2012	2013	2014
Colombo	22.9	18	15.9	15.9	15.8	13.4	10.5	12.4	9.5	11.4	12	12.4	11.7	10.5
Gampaha	18.1	15.2	13.4	13.5	13.1	10.3	8.7	7.4	7.9	6.9	10.3	9.8	9.8	8.9
Kalutara	28.2	20	16.6	16.2	15.7	16	12.1	9.8	10.5	8.8	12.4	13.2	13.4	12.2
NIHS	22.5	17	13.8	14.5	14.7	14.4	10.7	10.2	8.3	7.9	10.7	10.2	10.6	11.6
Kandy	33.4	26.8	23.6	22.2	19.1	23	19.2	16.2	14.4	12.4	20.7	18.1	14.6	12.5
Matale	32.3	27.8	23	20.1	19.5	23	18	16.5	13.7	12.7	19.6	18	14.2	13.6
Nuwara Eliya	35.2	32.8	25.2	27.5	24.9	29.7	26	21.8	23.6	20.2	27.2	22.2	22.5	18.7
Galle	29.1	23.8	21.4	20.1	19.8	15.6	14.4	13.3	11.7	10.6	17.2	16.2	17.1	14.6
Matara	33.5	27.4	23.1	21.5	21.4	18.4	17.8	14.7	12.4	17.5	22	17.7	18.3	17.5
Hambantota	29.3	24.6	20.4	22.9	19.4	16.7	12.4	10.4	11.2	9.6	15.8	13.4	16.7	14.1
Jaffna	24.5	23.4	19.7	22	17.3	15.3	14.8	12	12.3	10	14.1	14	14.3	12.3
Killinochchi	-	33.2	28.7	26.3	23.9	-	19.9	17.4	18.1	15.3	18	17.4	19.4	13.6
Mannar	-	16.3	17.4	16.3	18	-	11.6	10.4	11.9	11.9	8.4	10.4	9.1	9.5
Vavuniya	36.6	24.9	20.6	23.5	24.5	25.8	15.8	16.3	14.6	12.8	15.1	16.3	17.8	17.9
Mullaitivu	-	24.2	26.1	23.9	22	-	18.1	16.6	15.1	14.2	13.4	12.6	13.4	12
Batticaloa	24.7	21.1	19.1	18.3	15.8	17.1	11	13	10.3	10.9	14.8	11.4	9.7	10.1
Ampara	44.7	35.1	28.3	25.8	23.8	26.2	19.8	19.1	13.7	11.2	23.8	19.1	19.5	17
Kalmunai	26.5	21.8	20.6	18.6	17.6	17.5	17.8	11.7	13.1	10.4	11.8	11.7	10.7	9.8
Trincomalee	30.3	24.7	18	23.3	20.8	17.7	12.9	10.4	13.7	12.7	17.2	12	17.3	15.3
Kurunagala	29.6	22.9	19.6	18.2	17.5	16.3	13.6	11.3	10.4	9.5	16.9	14	13.7	13.2
Puttalam	25.5	20.5	17.9	17.8	17.8	14.9	12.5	11.8	10.6	10.8	14.7	12.2	12.1	12.2
Anuradapura	36.1	28.4	24.6	23.2	21.5	20.3	18	14.6	13.6	12.1	23.8	24.4	16.9	15.3
Polonnaruwa	31.4	27	22	25.1	22.9	17.7	12.4	13.6	13	10.1	20	19.1	19.2	15.3
Badulla	38.4	31.5	26.2	27	24.9	26	22	17.6	17.4	16.8	19.2	17.6	18.5	18.2
Monaragala	36	29.3	22.6	24.9	23.5	22	16.5	12	12	11.1	20	17.4	18.2	16.8
Ratnapura	41	30.8	25.1	22.7	21.7	25.4	18.4	15.5	13.7	11.8	24.3	19.5	17	15.9
Kegalle	35.6	27.7	24.1	22.8	24.6	20.5	16.4	13.5	12.4	13.3	18.5	17.1	15.8	18
Sri Lanka	**30.5**	**24.2**	**20.8**	**20.4**	**19.3**	**18.7**	**15.1**	**13.2**	**12.4**	**11.6**	**17.4**	**15.6**	**14.9**	**13.7**

Annexure 11 : Nutritional status of under 5 children 2014 (Nutrition month)

RDHS/Health Area	Underweight %					Stunting %					Wasting %			
	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014	2011	2012	2013	2014
Colombo	18.1	14.9	13.7	13.7	14.1	11.4	9.3	10.3	8.7	10	10.2	11	10.6	9.8
Gampaha	14.4	12.7	11.5	11.6	11.3	9.7	8.7	5.1	7.4	6.4	9.3	9.6	8.7	8.1
Kalutara	22.1	16.8	14.2	13.9	13.8	13.7	15.3	8.8	9.7	8.7	15.6	12	11.6	10.6
NIHS	17.3	14.6	16.4	12.8	13.1	11.7	6.2	10.3	7.4	7.2	10.7	9.4	9.7	10.6
Kandy	25.6	21.6	19.8	18.6	16.3	18.9	17.7	13.7	11.5	11.5	17.4	16	12.9	11
Matale	24.1	22.2	17.2	16.7	16.4	18.4	16.6	14	12.2	11.4	17.2	15.3	12.4	11.8
Nuwara Eliya	30	28.1	21.5	24.5	22.2	26.4	24.8	18.8	21.7	19.5	24.3	22	20.7	17.7
Galle	22.8	19.2	17.5	16.4	16.6	13.8	13.1	11.8	10.4	9.9	15.2	14	14.2	12.8
Matara	25.5	21.8	18.9	18.1	18.2	17	16.3	11.7	11.5	14.3	18.6	16.5	15.5	16.1
Hambantota	23.3	19.6	16.9	18	16.2	14.2	11.7	9.5	9.9	8.7	14	12.2	14.4	12.6
Jaffna	21.6	18.4	15.2	16.7	14.5	13.8	12.8	10.1	10.6	8.6	12	13.4	12.4	10.4
Killinochchi	-	28.7	20.6	20.3	18.9	-	20.2	17.5	15.1	12.8	16.5	14.2	15.3	10.6
Mannar	27.2	19.2	10.4	13.5	14.4	20.7	13.6	11.4	9.6	9.5	12.8	13.8	8	7.6
Vavuniya	-	20.7	19.6	18.6	19.5	-	15.7	14.2	11.9	11	12.9	10.7	14.9	15.3
Mullaitivu	-	13.4	13.4	18.9	18	-	10.2	9.5	12.7	12.4	7.1	9.2	10.5	9.6
Batticaloa	20.8	18.2	16.5	14.9	13.5	14.6	14.4	13.7	9.8	9.8	10.4	11	9	9.2
Ampara	34.2	27	22.5	21.9	20.3	21.5	16.5	11	12.5	10.2	20.3	16	16.6	14.4
Kalmunai	21.9	18.3	15	16.1	15.1	15	12.8	10.3	11.8	9.9	12	9.8	9.8	9.2
Trincomalee	23.7	20.9	14.3	20.5	17.2	14.6	12.7	9.2	12.4	10.4	17.7	11.4	15.4	13.5
Kurunagala	22.7	18.2	14	15.1	14.7	13.5	12.2	10	9.5	8.5	14.2	13.8	11.7	11.3
Puttalam	19.8	16.7	13.3	14.8	15.3	12.4	11.2	11.2	9.3	9.7	11.3	10.3	10.2	10.8
Anuradapura	27.2	22.5	20	19.4	18.2	17.2	15.2	12.6	12.6	11.3	19.8	19.5	14.9	13.5
Polonnaruwa	23.8	22	18.5	20.2	19.6	14.1	12.4	12.2	11.7	9.4	16.7	16.3	16.6	14.3
Badulla	29.8	25.5	22.2	22.4	21.2	23	19.4	16.3	15.8	15.2	16.8	15.6	15.9	16.2
Monaragala	28	23.1	18.2	18.4	19.3	17.2	14	10.1	10.5	9.8	17.3	15	15.7	14.5
Ratnapura	31.1	24.4	19.4	18.6	17.9	21.1	16.7	14	12.4	10.7	21	17.5	15	14.7
Kegalle	28	22.3	18.5	19.2	20.9	17.5	15.5	12.4	11.4	11.7	17.7	14.7	13.9	15.3
Sri Lanka	**23.7**	**19.8**	**17.3**	**17**	**16.4**	**15.9**	**12.8**	**11.3**	**11.2**	**10.5**	**15.3**	**13.6**	**13**	**12.2**

Annexure 12 : Nutritional status of infants and children - (H509) 2014

RDHS/Healt Area	% LBW	% moderately underweight infants	% severely underweight infants	% moderately underweight young children (2nd year)	% severely underweight youngchildren (2nd year)	% moderately under- weight pre schoolars (3rd to 5th year)	% severely under-weight pre schoolars (3rd to 5th year)
Colombo	12.0	5.5	1.4	10.4	3.1	13.1	3.6
Colombo M.C	12.4	10.9	2.1	14.9	2.9	20.3	3.6
Gampaha	9.6	3.6	0.6	9.2	1.9	12.4	2.8
Kalutara	12.0	5.1	1.3	10.9	2.5	14.6	3.3
N.I.H.S	9.5	5.6	0.7	9.3	1.0	15.0	1.9
Kandy	12.7	6.6	1.2	15.5	4.2	16.9	4.2
Matale	10.0	5.2	1.2	11.9	2.7	18.5	3.4
NuwaraEliya	18.9	8.9	3.2	16.7	5.2	18.4	4.5
Galle	10.9	5.6	0.8	14.8	2.7	20.3	3.5
Matara	11.9	5.9	1.1	12.6	2.4	21.9	3.4
Hambantota	10.2	5.6	0.7	13.1	2.4	21.7	3.7
Jaffna	10.3	5.5	0.7	11.0	1.7	12.4	1.8
Kilinochchi	10.1	4.7	0.3	11.8	1.5	24.1	3.2
Mannar	11.8	3.2	0.7	10.7	2.2	12.4	2.4
Vavuniya	12.3	5.3	1.5	16.2	3.1	23.3	4.3
Mullaitivu	12.9	5.0	0.8	16.8	2.6	19.4	3.8
Batticaloa	10.5	5.6	2.0	10.7	3.6	15.8	3.9
Ampara	14.4	6.1	1.5	13.7	3.6	17.4	3.0
Kalmunai	8.8	5.1	1.3	12.4	3.8	21.5	5.2
Trincomalee	13.3	5.1	1.1	14.6	2.9	19.8	3.8
Kurunegala	11.0	4.3	0.9	11.4	2.4	15.5	3.0
Puttalam	9.8	5.6	1.5	13.7	3.6	18.5	4.6
Anuradhapura	12.8	7.1	1.9	16.3	3.1	22.3	3.7
Polonnaruwa	15.1	6.7	2.2	14.8	2.6	22.2	3.7
Badulla	16.8	7.8	1.7	17.8	4.4	23.0	5.0
Monaragala	11.8	5.7	1.2	13.6	2.1	25.2	3.5
Ratnapura	15.7	6.8	1.1	14.7	2.4	21.4	3.1
Kegalle	15.6	7.0	0.9	16.0	2.9	23.0	3.0
Sri Lanka	**12.2**	**5.8**	**1.2**	**13.2**	**2.9**	**17.6**	**3.4**

Annexure 13 : Weighing coverage of infants, young children and pre-schoolers - 2014 (H – 509)

District	Infants undercare	1-2 years undercare	2-5 years undercare	Infants weighed	1-2 years weighed	2-5 years weighed	% of infant weighing	% of 1-2 years weighing	% of 2-5 years weighing
Colombo	23,453	23,420	69,166	19,318	17,001	25,286	82.4	72.6	36.6
Colombo M.C	8,912	10,877	28,433	3,294	2,296	3,773	37.0	21.1	13.3
Gampaha	33,631	34,909	90,029	28,202	25,138	40,136	83.9	72.0	44.6
Kalutara	14,186	15,010	37,853	11,786	11,397	20,860	83.1	75.9	55.1
N.I.H.S	5,002	5,599	14,998	4,058	3,617	5,782	81.1	64.6	38.6
Kandy	22,232	25,629	69,830	18,273	17,401	34,186	82.2	67.9	49.0
Matale	8,594	9,058	26,345	7,690	7,391	14,482	89.5	81.6	55.0
NuwaraEliya	12,561	14,572	39,039	10,771	12,402	29,598	85.7	85.1	75.8
Galle	15,457	16,833	48,254	12,922	12,425	23,330	83.6	73.8	48.3
Matara	12,668	13,780	40,016	11,604	11,478	19,758	91.6	83.3	49.4
Hambantota	11,097	12,047	59,499	9,723	10,060	17,653	87.6	83.5	29.7
Jaffna	8,172	9,118	24,747	7,944	8,867	18,776	97.2	97.2	75.9
Kilinochchi	1,648	2,205	6,995	1,585	2,065	5,157	96.2	93.7	73.7
Mannar	1,803	1,986	5,602	1,744	1,842	5,238	96.7	92.7	93.5
Vavuniya	3,638	3,933	10,435	2,295	2,224	4,207	63.1	56.5	40.3
Mullaitivu	1,899	2,214	6,502	1,741	1,867	4,881	91.7	84.3	75.1
Batticaloa	9,751	10,580	28,947	7,729	9,463	18,576	79.3	89.4	64.2
Ampara	4,296	4,884	14,168	3,935	4,021	10,605	91.6	82.3	74.9
Kalmunai	8,173	8,811	25,680	6,942	8,013	10,995	84.9	90.9	42.8
Trincomalee	7,837	7,896	23,630	5,761	5,711	12,314	73.5	72.3	52.1
Kurunegala	25,137	27,748	80,381	23,460	24,618	55,775	93.3	88.7	69.4
Puttalam	13,568	14,592	40,811	12,407	11,946	19,039	91.4	81.9	46.7
Anuradhapura	16,355	17,641	52,396	13,049	13,166	27,852	79.8	74.6	53.2
Polonnaruwa	7,357	8,162	20,693	5,308	6,006	13,265	72.1	73.6	64.1
Badulla	14,136	15,140	40,582	12,485	12,263	23,954	88.3	81.0	59.0
Monaragala	9,043	9,596	25,643	8,250	8,369	14,834	91.2	87.2	57.8
Ratnapura	16,906	18,695	53,314	14,292	14,765	32,143	84.5	79.0	60.3
Kegalle	12,613	14,134	39,958	10,775	10,935	21,647	85.4	77.4	54.2
Sri Lanka	**330,125**	**359,069**	**1,023,946**	**277,343**	**276,747**	**534,102**	**84.0**	**77.1**	**52.2**

Annexure 14 : Infant child mortality and WWC performance 2014

RDHS/Health Area	NNMR based on PHM reporting	IMR based on PHMs reporting	Under 5 mortality rate based on PHM reporting	No. of functioning Well Woman Clinics	% of 35 year women screened for cervical carcinoma
Colombo	5.0	6.7	7.5	105	42.7
Colombo M.C	5.6	7.4	8.3	9	4.6
Gampaha	5.9	8.2	8.9	0	30.3
Kalutara	7.0	8.5	9.6	41	29.3
N.I.H.S	7.2	10.8	13.4	23	39.1
Kandy	6.1	8.6	10.0	66	27.9
Matale	8.7	11.8	13.0	0	61.5
NuwaraEliya	6.1	10.1	11.8	40	30.1
Galle	5.5	7.7	8.7	42	25.6
Matara	4.5	5.9	6.5	32	37.9
Hambantota	4.5	6.4	7.6	18	36.7
Jaffna	12.6	16.5	19.5	112	26.5
Kilinochchi	9.9	16.8	22.0	7	6.3
Mannar	5.3	10.1	13.0	1	3.6
Vavuniya	5.1	7.0	9.7	9	2.5
Mullaitivu	5.0	8.8	11.9	3	7.3
Batticaloa	7.8	10.5	12.8	19	34.7
Ampara	6.8	9.1	9.8	17	71.9
Kalmunai	5.3	8.9	9.9	22	40.6
Trincomalee	5.7	8.6	10.7	11	7.1
Kurunegala	8.2	10.6	11.7	89	41.5
Puttalam	6.9	8.3	9.1	43	28.9
Anuradhapura	5.7	7.8	9.0	25	38.7
Polonnaruwa	5.7	8.9	10.4	7	27.6
Badulla	5.0	7.1	7.9	46	38.3
Monaragala	6.0	7.2	8.6	23	41.2
Ratnapura	4.8	7.1	7.8	35	30.8
Kegalle	6.8	9.3	11.0	28	70.8
Sri Lanka	**6.2**	**8.6**	**9.9**	**873**	**34.6**

Annexure 15 : School Health Performances 2014

RDHS/Health Area	% of MOH areas sending H 797 (all 4 Q)	SMI coverage (Schools)	% of schools in which Sanitary Survey Completed	% of children with defects	% of defects detected (out of children examined)			% Underweight				% Stunting		% Overweight			
					Visual defects	Heart diseases	Pallor	Grade 1	Grade 4	Grade 7	Grade 10	Grade 1	Grade 4	Grade 1	Grade 4	Grade 7	Grade 10
Colombo	95.0	68.8	70.1	43.6	4.6	1.7	0.7	24.8	20.7	17.0	12.1	4.3	3.6	4.0	8.2	12.2	3.7
Colombo M.C	50.0	25.0	46.9	19.8	0.2	1.1	0.2	6.3	4.0	3.6	7.5	7.4	6.7	4.8	1.1	2.0	2.3
Gampaha	82.8	92.2	99.4	18.9	3.4	0.8	0.7	5.9	4.9	11.5	9.1	4.8	3.3	2.4	1.2	2.8	4.0
Kalutara	95.5	100.0	100.0	43.9	2.6	1.8	0.3	16.3	15.9	17.0	13.6	6.1	5.7	1.7	2.9	3.4	3.7
N.I.H.S	87.5	69.6	100.0	48.9	2.7	1.5	0.1	10.9	18.7	20.6	18.4	4.8	3.7	1.6	3.4	5.4	4.2
Kandy	97.7	94.8	100.0	43.5	3.0	1.1	0.3	25.1	20.8	23.3	13.4	9.9	6.4	1.6	3.7	6.8	6.2
Matale	95.8	86.8	100.0	29.2	1.7	1.8	2.1	22.2	22.0	24.8	17.9	10.5	7.9	1.2	2.5	4.8	4.9
NuwaraEliya	82.7	74.6	76.5	41.3	2.0	2.1	0.8	14.6	17.4	18.1	13.9	10.4	10.8	1.0	1.0	1.3	2.0
Galle	97.5	99.3	100.0	39.7	2.0	0.8	0.7	16.3	14.3	17.6	14.9	6.1	5.2	1.0	1.8	3.5	3.8
Matara	98.5	97.8	100.0	32.2	2.6	1.4	0.7	16.9	17.8	19.4	14.5	8.8	7.6	1.0	1.9	2.4	2.0
Hambantota	95.8	99.3	100.0	45.1	1.9	2.1	1.4	21.3	21.6	28.1	21.1	5.3	4.9	1.3	1.2	1.9	2.1
Jaffna	100.0	99.8	100.0	61.0	3.8	0.9	6.3	24.2	27.7	27.5	19.8	11.8	10.7	1.7	3.8	4.8	4.2
Kilinochchi	85.0	96.2	100.0	77.3	1.3	2.0	0.4	22.4	23.7	24.5	20.8	12.3	11.9	0.5	0.5	1.5	3.3
Mannar	100.0	93.8	100.0	47.6	1.5	0.8	2.3	19.4	16.7	16.7	19.0	8.0	5.8	0.9	1.6	1.3	2.9
Vavuniya	100.0	97.8	100.0	45.3	1.4	0.8	1.6	19.8	20.6	26.0	15.7	12.7	10.5	1.2	1.0	1.3	1.9
Mullaitivu	100.0	93.0	100.0	42.6	1.3	1.6	4.0	15.1	16.6	22.5	14.6	10.0	10.0	0.5	0.8	1.0	1.1
Batticaloa	88.5	99.3	100.0	22.1	0.7	0.1	3.7	8.1	7.5	8.6	7.7	6.0	5.2	1.1	1.6	1.9	2.4
Ampara	100.0	97.8	100.0	58.6	2.4	1.1	1.8	21.0	20.2	22.3	16.3	9.3	6.6	1.4	2.5	3.0	2.7
Kalmunai	96.2	74.1	100.0	49.0	1.9	0.6	4.5	13.0	13.6	22.7	16.8	8.1	7.5	1.1	1.4	2.3	2.8
Trincomalee	95.5	87.8	100.0	40.1	1.5	1.2	3.4	12.9	13.3	15.1	11.1	8.2	7.8	1.3	1.9	2.2	2.7
Kurunegala	94.4	97.8	100.0	22.5	1.7	1.4	0.4	17.2	19.0	21.3	16.0	8.3	6.6	1.2	2.5	4.2	4.0
Puttalam	100.0	90.9	100.0	26.8	2.0	1.0	0.3	18.6	16.0	21.3	14.5	7.6	6.7	1.7	3.0	5.7	5.5
Anuradhapura	98.7	98.1	100.0	35.4	1.5	1.7	0.5	16.2	18.3	23.0	18.4	8.5	6.5	0.8	1.9	5.0	5.0
Polonnaruwa	100.0	94.8	100.0	26.6	1.4	1.7	0.6	18.2	18.2	22.6	14.4	7.6	5.5	1.3	2.0	3.8	3.7
Badulla	98.4	94.4	100.0	51.3	3.0	1.1	0.4	20.7	20.5	25.5	16.3	14.8	11.7	0.9	1.1	2.3	2.6
Monaragala	100.0	100.0	100.0	55.7	2.4	1.1	1.4	21.0	21.8	19.5	15.6	8.1	6.4	1.2	2.3	3.5	3.1
Ratnapura	100.0	93.3	100.0	49.9	2.8	2.2	0.6	21.3	20.2	22.2	16.7	9.1	7.7	0.8	1.4	2.9	2.5
Kegalle	100.0	98.0	100.0	49.8	1.6	0.7	0.5	18.9	21.7	19.9	18.0	6.9	6.0	1.0	2.2	3.5	3.8
Sri Lanka	**95.7**	**92.7**	**97.3**	**39.3**	**2.4**	**1.3**	**1.2**	**17.9**	**17.4**	**19.9**	**14.9**	**7.9**	**6.5**	**1.5**	**2.6**	**4.4**	**3.7**

Annexure 16: Percentage of Health Promoting Schools - 2014

RDHS/Health Area	Total number of schools	Number of Health Promoting schools	% of Health Promoting Schools	Schools with 60 – 69 marks (Bronze Level)	Schools with 70 – 79 marks (Silver Level)	Schools with 80 – 100 marks (Gold Level)
Colombo	378	161	42.6	34	55	72
Colombo M.C	32	-	-	-	-	-
Gampaha	490	217	44.3	32	87	98
Kalutara	298	85	28.5	19	36	30
N.I.H.S	79	32	40.5	07	16	09
Kandy	610	276	45.2	65	114	97
Matale	319	225	70.5	16	58	151
NuwaraEliya	548	215	39.2	33	79	103
Galle	435	228	52.4	59	94	75
Matara	372	252	67.7	41	104	107
Hambantota	306	48	15.7	26	11	11
Jaffna	449	304	67.7	64	158	82
Kilinochchi	104	6	5.8	-	06	-
Mannar	130	68	52.3	18	24	26
Vavuniya	182	-	-	-	-	-
Mullaitivu	114	56	49.1	05	13	38
Batticaloa	285	153	53.7	18	48	87
Ampara	181	123	68.0	36	62	25
Kalmunai	251	132	52.6	45	49	38
Trincomalee	287	131	45.6	12	51	68
Kurunegala	819	348	42.5	59	137	152
Puttalam	362	51	14.1	14	22	15
Anuradhapura	526	178	33.8	23	77	78
Polonnaruwa	248	-	-	-	-	-
Badulla	590	156	26.4	23	59	74
Monaragala	292	132	45.2	17	46	69
Ratnapura	597	225	37.7	27	78	120
Kegalle	542	291	53.7	51	96	144
Sri Lanka	**9826**	**4093**	**41.7**	**744**	**1580**	**1769**

Annexure 17 : Family planning service performance 2014

RDHS/Health Area	Current FP user rate for modern methods	Current FP user rate for all methods	% Unmet need for family planning	Current users of IUD		Current users of Injectable	
				No	%	No	%
Colombo	56.3	67.9	7.0	36069	12.8	21002	7.5
Colombo M.C	41.4	47.6	8.0	6703	7.2	6321	6.8
Gampaha	52.5	65.1	7.1	41772	10.5	28425	7.1
Kalutara	55.2	65.1	6.8	18431	11.2	13427	8.2
N.I.H.S	52.4	66.2	4.2	4252	8.2	3019	5.8
Kandy	54.8	63.7	7.5	23695	9.7	18594	7.6
Matale	59.0	66.2	5.3	12773	13.7	8710	9.3
NuwaraEliya	66.3	70.5	6.1	10842	8.3	8669	6.6
Galle	60.9	71.5	6.6	22553	12.8	23652	13.4
Matara	58.2	68.3	6.9	18070	13.1	12223	8.9
Hambantota	57.2	65.9	7.6	19834	17.7	8960	8.0
Jaffna	52.6	61.8	5.7	3351	3.7	4736	5.2
Kilinochchi	65.5	68.9	2.7	2782	13.9	1536	7.7
Mannar	51.5	70.9	8.6	521	2.8	1722	9.3
Vavuniya	49.0	66.3	11.8	818	2.9	2036	7.3
Mullaitivu	49.7	51.9	7.3	1279	6.7	1994	10.4
Batticaloa	44.1	52.7	8.0	3710	3.9	14234	14.9
Ampara	69.7	74.6	4.1	6520	12.8	10606	20.7
Kalmunai	45.4	57.4	7.4	2353	3.2	10876	14.7
Trincomalee	50.0	60.0	7.6	2065	2.9	14748	20.9
Kurunegala	56.2	67.0	6.3	43278	14.4	25938	8.6
Puttalam	55.9	66.7	8.3	13302	8.9	21956	14.7
Anuradhapura	60.4	67.6	5.3	23870	13.2	32001	17.7
Polonnaruwa	61.6	66.8	4.5	10367	11.0	18900	20.0
Badulla	65.2	70.4	7.2	21616	14.3	12710	8.4
Monaragala	59.2	69.3	5.6	15734	17.0	9486	10.3
Ratnapura	57.7	67.9	7.4	21982	11.2	22577	11.5
Kegalle	54.9	65.4	7.4	13715	9.2	15422	10.4
Sri Lanka	**56.2**	**65.8**	**6.8**	**402257**	**11.0**	**374480**	**10.2**

Annexure 18 : Oral Health Services 2014

RDHS/ Health Area	No. of SDTT	No. of SDC	Total number of schools in the MOH	Number of pre schools allocated	Target group (1,4,7 & Other)	SDTT : Population ratio	% Schools screened	% of Schools completed	% Healthy				% Caries				% Calculus			Treatment Completed		Screening coverage %	Coverage* % (* Healthy & treatment completed out of target group)
									Pre School	Grade 1	Grade 4	Grade 7	Grade 1	Grade 4	Grade 4 (permanent teeth)	Grade 7 (permnent teeth)	Grade 1	Grade 4	Grade 7	Total (Gr 1,4,7 & other)	Grade 7		
Colombo	58	48	432	424	105697	1822	100	99	52	45	32	53	68	56	6	16	2	14	23	89	90	94	89
Gampaha	27	35	542	539	100798	3733	92	88	32	41	35	58	59	57	8	19	2	14	20	74	76	88	77
Kalutara	18	19	339	539	51506	2861	99	96	45	42	34	64	59	58	9	21	1	10	15	80	88	87	79
Kandy	25	32	652	756	86000	3440	71	67	38	36	28	43	62	61	8	19	2	14	22	86	84	64	58
Matale	10	11	10	319	32209	2928	77	71	46	37	24	41	59	57	10	19	6	19	27	72	78	72	62
NuwaraEliya	10	10	593	484	70993	7999	33	20	43	36	30	45	61	62	10	23	4	17	26	58	61	75	63
Galle	18	37	441	597	63304	3517	60	53	26	32	30	46	55	63	9	25	3	15	18	78	81	75	63
Matara	21	23	367	509	48954	2331	94	91	45	42	42	52	57	47	15	30	4	20	22	89	87	92	87
Hambantota	14	10	323	388	38935	2781	79	76	56	53	50	61	45	40	4	13	2	13	21	57	59	74	63
Jaffna	12	7		405	37394	3116	77	73	43	36	35	66	54	56	7	19	1	5	13	66	75	64	55
Kilinochchi	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mannar	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vavuniya	5	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mullaitivu	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Batticaloa	3	2	79	123	9600	3200	35	3	53	32	19	42	82	99	6	23	6	16	15	45	59	47	30
Ampara	4	4	175	98	2689	672	48	48	37	45	42	31	67	46	6	14	1	7	10	47	34	49	46
Kalmunai	3																						
Trincomalee	No data Available																						
Kurunegala	34	36	721	1082	88857	2613	81	78	52	49	41	64	51	52	5	12	1	10	17	83	88	83	78
Puttalam	9	11	363	439	51001	5667	68	64	40	40	32	54	58	67	5	13	1	12	20	81	74	62	55
Anuradhapura	19	13	19	547	15709	827	70	68	54	50	44	63	50	51	4	12	1	7	11	56	68	75	71
Polonnaruwa	13	13	247	349	23601	1815	69	60	50	38	27	43	50	59	7	17	4	12	20	65	68	77	59
Badulla	16	19	584	758	59222	3701	68	55	43	35	29	48	57	61	7	19	1	7	14	72	67	66	53
Monaragala	10	15	292	552	30439	3044	99	97	54	47	40	65	49	55	4	12	1	8	14	85	86	86	79
Ratnapura	20	21	586	883	71757	3588	62	55	47	44	35	56	56	60	9	21	1	8	10	62	58	55	46
Kegalle	16	23	540	649	54193	3387	74	70	34	39	26	46	64	60	6	20	2	16	22	79	83	75	68
Sri Lanka	**379**	**395**	**7373**	**10538**	**1035907**	**2733**	**76**	**70**	**46**	**42**	**34**	**54**	**58**	**57**	**7**	**18**	**2**	**12**	**19**	**72**	**79**	**78**	**69**

Annexure 19 : Population, birth rates, eligible families, pregnant mothers, reported deliveries and first antenatal clinic visits

Province	Population	Birth Rate	Estimated eligible families	Eligible families registered by PHMs		Estimated Births	Estimated pregnancies (Births×1.1)	Pregnant mothers registered by PHM (out of estimated pregnancies)		Number of first antenatal clinic visits	Number of reported deliveries	Number of reported live births
				No.	%			No.	%			
Western	6031056	16.8	964969	990204	102.6	101322	111454	92421	82.9	90223	85373	79059
Central	2743720	18.5	438995	468951	106.8	50759	55835	50320	90.1	48248	41257	40541
Southern	2587558	16.8	414009	426245	103.0	43471	47818	44365	92.8	40673	38169	38077
Northern	1137133	16.6	181941	177073	97.3	18876	20764	17887	86.1	16167	15317	15462
Eastern	1676583	20.9	268253	291657	108.7	35041	38545	32966	85.5	30968	29109	29204
North Western	2574953	16.9	411992	449822	109.2	43517	47868	44304	92.6	42519	37999	38206
North Central	1436166	18.6	229787	275389	119.8	26713	29384	26278	89.4	26269	21805	21934
Uva	1431749	17.6	229080	244198	106.6	25199	27719	25627	92.5	24847	22948	22608
Sabaragamuwa	2047865	16.1	327658	345440	105.4	32971	36268	33360	92.0	31027	28367	28598
Sri Lanka	**21666783**	**16.9**	**3466685**	**3668979**	**105.8**	**366169**	**402785**	**367528**	**91.2**	**350941**	**320344**	**313689**

Indicators of field antenatal care and percentage of pregnant women protected by rubella vaccine 2014

RDHS/Health Area	% Pregnant mothers registered before 8 weeks	% Pregnant mothers registered 8-12 weeks	% Teenage pregnant (less than 20 Yrs) mothers registered	% of Primies registered	% Pregnant mothers P5 and above registered	% Registered pregnant mothers protected for Rubella	% Antenatal mothers having the first home visit	Average antenatal home visits by PHM	Mothers protected with T.T. at delivery	Mothers tested for Grouping Rh at delivery	Mothers tested for VDRL at delivery
Western	69.8	19.3	4.5	37.1	2.2	99.5	81.9	3.2	93.5	93.2	94.2
Central	68.6	21.8	4.4	29.8	2.5	97.4	92.4	4.1	99.0	99.4	99.2
Southern	82.5	13.4	4.7	32.0	2.8	98.8	95.7	4.1	100.4	100.4	100.5
North	74.6	18.0	5.1	34.3	4.3	92.8	97.4	7.0	96.9	99.7	99.7
East	78.4	16.0	7.1	32.9	4.9	94.9	95.8	4.4	99.6	99.5	97.8
North Western	84.5	13.1	5.0	31.6	2.7	99.2	93.7	4.1	98.3	98.3	99.9
North Central	78.5	15.9	5.1	28.7	15.4	99.3	94.4	4.1	100.2	100.1	100.4
Uva	79.1	16.8	5.3	29.8	2.6	100.1	90.0	4.5	98.4	98.3	97.7
Sabaragamuwa	74.2	19.7	4.4	31.8	2.0	97.9	85.8	4.1	99.9	99.9	99.9
Sri Lanka	**76.2**	**17.4**	**4.9**	**32.7**	**3.7**	**98.2**	**90.2**	**4.1**	**97.7**	**97.8**	**98.0**

Annexure 20 : Indicators of clinic care, ante-natal screening, status of BMI and anaemia by Provinces 2014

Province	% of registered mothers attending clinics at least once	Average number of clinic visits by a mother	VDRL clinics available	% of clinic attendees (ANC) screened for VDRL	% of mothers with reactive VDRL	% of clinic attendees (ANC) anaemic out of 1st visits	% of clinic attendees (ANC) tested for blood grouping & Rh	% of mothers BMI measured	% of mothers with BMI less than 18.5	% of mothers with BMI more than 25
Western	97.6	5.5	259	28.3	0.02	4.1	9.4	68.0	22.1	27.3
Central	95.9	6.2	324	63.1	0.04	0.4	24.1	74.4	22.8	20.2
Southern	91.7	6.6	85	56.9	0.35	0.3	26.4	86.4	27.5	15.9
Northern	90.4	7.7	16	39.2	0.01	0.9	28.0	83.1	21.5	18.6
Eastern	93.9	6.8	125	45.7	0.01	0.4	41.6	84,5	19.9	22.1
North Western	96.0	6.5	117	87.7	0.03	0.1	35.1	85.1	22.8	19.2
North Central	100.0	6.4	216	83.7	0.03	0.2	30.6	84,9	25.2	17.7
Uva	97.0	6.9	86	74.2	0.20	0.5	33.0	85.8	24.6	14.1
Sabaragamuwa	93.0	6.4	236	74.0	0.11	0.4	32.3	82,2	25.9	16.8
Sri Lanka	**95.5**	**6.3**	**1464**	**57.1**	**0.08**	**9.4**	**25.5**	**79.1**	**23.5**	**20.2**

Natal care 2014

Province	% of institutional deliveries out of total reported deliveries	% of home deliveries out of total reported deliveries	% LSCS out of total reported deliveries	% of untrained deliveries out of total reported deliveries	% of deliveries reported out of total estimated pregnancies	% of deliveries reported out of total registered pregnancies
Western	100.0	0.0	35.6	0.01	76.5	92.3
Central	99.8	0.2	32.3	0.09	73.6	81.6
Southern	99.9	0.1	34.2	0.03	79.8	86.0
Northern	99.8	0.2	28.0	0.17	73.8	85.6
Eastern	99.8	0.2	26.5	0.10	75.5	88.3
North Western	99.9	0.1	33.7	0.04	79.4	85.8
North Central	99.9	0.1	28.8	0.05	74.2	83.0
Uva	99.9	0.1	24.9	0.09	82.8	89.5
Sabaragamuwa	99.9	0.1	33.8	0.06	78.2	85.0
Sri Lanka	**99.7**	**0.09**	**32.1**	**0.05**	**79.5**	**87.2**

Annexure 21: Indicators of post natal care: post natal visits, Vitamin A supplementation, post natal complications 2014

Province	% of mothers re-ceiving the 1st post natal visit within the 1st 10 days out of reported deliveries	% of mothers receiving the1st post natal visit within the 1st 10 days out of estimated births	Average number of post natal visits within first 10 days	% of postna- tal visits to the mother around 42 days	% of mothers receiving Vitamin A mega dose for reported deliveries	% of estimated mothers who received Vitamin A	% of reported deliveries with post natal morbidities
Western	84.4	71.0	1.6	66.5	74.3	56.8	10.1
Central	89.5	72.4	1.7	76.6	86.1	63.4	7.6
Southern	103.4	90.8	1.7	80.4	85.4	68.2	12.8
Northern	92.4	75.0	1.8	78.3	92.2	68.0	5.9
Eastern	92.5	76.9	1.8	76.8	88.8	67.1	8.6
North Western	91.8	80.2	1.7	81.6	77.2	61.3	12.5
North Central	91.1	74.4	1.6	75.1	95.0	70.5	10.0
Uva	87.0	79.2	1.8	74.5	85.5	70.8	7.5
Sabaragamuwa	93.4	80.4	1.6	71.2	64.2	50.2	13.8
Sri Lanka	**90.7**	**79.3**	**1.7**	**74.3**	**80.9**	**64.4**	**10.2**

Indicators of child care service provision: infant registration, field visits 2014

Province	% of infants regis-tered by PHM out of estimated births	% of registered infants received at least one field visit after 42 days	Average number of home visits per infant	Average number of weighing per infant	% of estimated infants supplied with vitamin A mega dose at 6 months	% of estimated children supplied with vitamin A mega dose at	
						18 m	3 y
Western	90.3	53.7	31.8	9.4	54.7	61.3	61.6
Central	92.1	59.9	23.0	10.1	78.1	83.9	83.5
Southern	87.6	65.0	23.3	10.5	68.9	68.3	71.5
Northern	89.2	54.8	65.8	11.2	77.7	79.0	79.1
Eastern	86.7	66.1	26.1	10.7	74.7	76.7	80.2
North Western	87.4	54.8	14.4	11.1	74.5	75.3	78.6
North Central	90.2	58.3	13.1	9.9	77.0	80.3	80.9
Uva	87.7	59.3	16.0	10.6	75.8	75.0	73.3
Sabaragamuwa	84.0	54.1	16.0	10.1	49.0	50.9	52.3
Sri Lanka	**90.6**	**58.0**	**7.5**	**10.2**	**68.8**	**71.9**	**73.1**

Annexure 22 : Weighing coverage of infants, young children and pre-schoolers - 2014 (H – 509)

Province	Infants undercare	1-2 years undercare	2-5 years undercare	Infants weighed	1-2 years weighed	2-5 years weighed	% of infant weighing	% of 1-2 years weighing	% of 2-5 years weighing
Western	85,184	89,815	240,479	66,658	59,449	95,837	78.3	66.2	39.9
Central	43,387	49,259	135,214	36,734	37,194	78,266	84.7	75.5	57.9
Southern	39,222	42,660	147,769	34,249	33,963	60,741	87.3	79.6	41.1
Northern	17,160	19,456	54,281	15,309	16,865	38,259	89.2	86.7	70.5
Eastern	30,057	32,171	92,425	24,367	27,208	52,490	81.1	84.6	56.8
North Western	38,705	42,340	121,192	35,867	36,564	74,814	92.7	86.4	61.7
North Central	23,712	25,803	73,089	18,357	19,172	41,117	77.4	74.3	56.3
Uva	23,179	24,736	66,225	20,735	20,632	38,788	89.5	83.4	58.6
Sabaragamuwa	25,519	32,829	93,272	25,067	25,700	53,790	84.9	78.3	57.7
Sri Lanka	**330,125**	**359,069**	**1,023,946**	**277,343**	**276,747**	**534,102**	**84.0**	**77.1**	**52.2**

Annexure 23 : Nutritional status of infants and children by Provinces 2014 (H – 509)

Province	% LBW	% moderately underweight infants	% severely under- weight infants	% moderately under-weight young children (2nd year)	% severely under-weight young children (2nd year)	% moderately under- weight pre schoolars (3rd to 5th year)	% severely under- weight pre schoolars (3rd to 5th year)
Western	11.0	4.9	1.0	10.1	2.3	13.0	3.0
Central	13.8	7.0	1.8	15.2	4.2	18.0	4.0
Southern	11.0	5.7	0.9	13.6	2.5	21.2	3.5
Northern	11.0	5.1	0.8	12.4	2.0	16.1	2.6
Eastern	11.3	5.4	1.5	12.5	3.5	18.3	4.0
North Western	10.6	4.8	1.1	12.1	2.8	16.2	3.4
North Central	13.5	7.0	2.0	15.8	2.9	22.3	3.7
Uva	14.9	7.0	1.5	16.1	3.4	23.8	4.5
Sabaragamuwa	15.6	6.9	1.0	15.3	2.6	22.1	3.0
Sri Lanka	**12.2**	**5.8**	**1.2**	**13.2**	**2.9**	**17.6**	**3.4**

Infant and child mortality and WWC performance 2014

Province	NNMR based on PHM reporting	IMR based on PHMs reporting	Under 5 mortality rate based on PHM reporting	No. of functioning Well Woman Clinics	% of 35 year women screened for cervical carcinoma
Western	5.9	7.9	47.7	178	31.8
Central	6.6	9.6	34.8	106	34.6
Southern	4.9	6.8	22.9	92	32.5
Northern	9.4	13.5	76.2	132	15.9
Eastern	6.4	9.3	43.1	69	35.5
North Western	7.8	9.9	20.8	132	37.3
North Central	5.7	8.2	19.4	32	35.1
Uva	5.4	7.1	16.5	69	39.4
Sabaragamuwa	5.7	8.1	18.8	63	47.4
Sri Lanka	**6.2**	**8.6**	**9.9**	**873**	**34.6**

Annexure 24 : School Health Performances 2014

Province	% of MOH areas sending H 797 (all 4 Q)	SMI coverage (Schools)	% of schools in which Sanitary Survey Completed	% of children with defects	% of defects detected (out of children examined)			% Underweight				% Stunting		% Overweight			
					Visual defects	Heart diseases	Pallor	Grade 1	Grade 4	Grade 7	Grade 10	Grade 1	Grade 4	Grade 1	Grade 4	Grade 7	Grade 10
Western	89.4	84.0	89.6	34.8	3.6	1.4	0.6	15.9	13.8	15.3	11.6	4.9	3.9	2.9	4.3	7.0	3.9
Central	93.1	85.6	91.3	39.9	2.4	1.5	0.8	21.7	20.1	22.1	14.4	10.2	7.9	1.3	2.7	4.9	4.9
Southern	97.4	98.8	100.0	38.4	2.2	1.3	0.9	17.7	17.1	20.6	16.1	6.8	6.0	1.1	1.7	2.8	2.8
Northern	97.5	97.4	100.0	57.1	2.7	1.1	4.3	21.8	23.8	25.4	18.7	11.4	10.2	1.3	2.4	3.1	3.4
Eastern	96.2	95.7	100.0	23.9	1.8	1.3	3.5	17.6	18.0	21.3	15.5	8.1	6.6	1.4	2.7	4.7	4.5
North Western	94.3	89.4	100.0	40.1	1.5	0.7	0.3	12.7	12.6	16.2	12.4	7.7	6.7	1.2	1.7	2.2	2.6
North Central	99.0	97.0	100.0	32.0	1.5	1.7	0.5	16.9	18.3	22.8	16.9	8.2	6.1	1.0	2.0	4.6	4.5
Uva	99.1	96.3	100.0	52.9	2.8	1.1	0.8	20.9	21.0	23.3	16.0	12.1	9.7	1.0	1.5	2.7	2.8
Sabaragamuwa	100.0	95.5	100.0	49.8	2.3	1.5	0.6	20.2	20.9	21.1	17.3	8.1	6.9	0.9	1.8	3.2	3.1
Sri Lanka	**95.7**	**92.7**	**97.3**	**39.3**	**2.4**	**1.3**	**1.2**	**17.9**	**17.4**	**19.9**	**14.9**	**7.9**	**6.5**	**1.5**	**2.6**	**4.4**	**3.7**

Percentage of of Health Promoting Schools - 2014

Province	Total number of schools	Number of Health Promoting schools	% of Health Promoting Schools	Schools with 60 – 69 marks (Bronze Level)	Schools with 70 – 79 marks (Silver Level)	Schools with 80 – 100 marks (Gold Level)
Western	1277	495	38.8	92	194	209
Central	1477	716	48.5	114	251	351
Southern	1113	528	47.4	126	209	193
Northern	979	434	44.3	87	201	146
Eastern	1004	539	53.7	111	210	218
North Western	1181	399	33.8	73	159	167
North Central	774	178	23.0	23	77	78
Uva	882	288	32.7	40	105	143
Sabaragamuwa	1139	516	45.3	78	174	264
Sri Lanka	**9826**	**4093**	**41.7**	**744**	**1580**	**1769**

Annexure 25 : Indicators for family planning services by Provinces

Province	Current FP user rate for modern methods	Current FP user rate for all methods	% Unmet need for family planning	Current users of IUD		Current users of Injectable	
				No	%	No	%
Western	52.9	64.3	8.3	107227	10.8	72194	7.3
Central	58.9	66.1	6.7	47310	10.1	35973	7.7
Southern	59.0	69.0	7.0	60457	14.2	44835	10.5
Northern	53.1	63.2	6.8	8751	4.9	12024	6.8
Eastern	50.3	59.5	7.1	14648	5.0	50464	17.3
North Western	56.1	66.9	6.9	56580	12.6	47894	10.6
North Central	60.8	67.3	5.0	34237	12.4	50901	18.5
Uva	62.9	70.0	6.6	37350	15.3	22196	9.1
Sabaragamuwa	56.5	66.9	7.4	35697	10.3	37999	11.0
Sri Lanka	**56.2**	**65.8**	**6.8**	**402257**	**11.0**	**374480**	**10.2**