

HANDBOOK FOR Sarvodaya Suvodaya Community Facilitators



சர்வோதய
சர்வோதயம்
Sarvodaya

unicef 

for every child

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Handbook for Sarvodaya Suvodaya Community Facilitators

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Introduction

Communities are at the forefront of responding to crisis and emergencies. Their collective efforts, togetherness under trying circumstances and resolve to build back better have been identified as pillars of strength during difficult times. However, modern day disasters like the COVID-19 pandemic have tested their resolve like no other. These complex emergencies have stretched the community networks to their limits, often having impacts beyond the immediate aftermath of the disaster. Basic human necessities like health and nutrition are the first victims under such dire circumstances. Sri Lanka, currently undergoing its worst socio-economic crisis, is no stranger to such disasters.

Therefore, it is essential to enhance the knowledge and strengthen the capacities of communities in preparing and responding to crisis. Communities empowered to identify, prioritize, and make solutions for their own issues, are a strength to every nation. An informed, empowered and engaged community is our biggest asset for the future.

Sarvodaya Shramadana Movement, the largest Community Based Organization in Sri Lanka, has been practicing these principles of community mobilization and engagement for decades. Their extensive network of societies, spread across the length and breadth Sri Lanka has made huge strides in empowering vulnerable and disadvantaged communities against poverty, discrimination, disease etc.

The latest such initiative, the 'Sarvodaya Suvodaya Communities' were established in 256 divisional secretariat areas across the country with the support of UNICEF. The objective of this committee, comprising of community volunteers and village leaders is to Strengthen the village level health promotion networks and empowering the communities to increase their preparedness and response to the COVID-19 pandemic, health and nutrition issues. These committees are formed in collaboration with grassroot level public health teams and coordinated through a community facilitator. These facilitators will train and educate village members on a multitude of health-related topics, so that they can initiate community led health promotion programmes and projects on their own.

This handbook has been developed with the intention of providing a basic outline of key principles of health and essentials of health-related issues prevailing at the grass root level for community facilitators and trainers of the 'Suvodaya' health committees. Special emphasis has been given to highlighting the issues prevailing in the country during the current crisis, particularly on health, nutrition, and food security. By understanding these key principles of health and health issues of public concern, facilitators/ trainers will be able to conceptualize, plan, develop, implement, and monitor numerous health interventions tailored to their local context.

Further, this handbook can be used as a guide to train Suvodaya health committee members at the villagers on different aspects of community health service delivery at the grass root level. Facilitators are expected to prepare presentations, role plays and scenarios on their own, with the technical inputs from local public health teams to educate village level Suvodaya committee members.

Handbook is comprised of eight chapters, namely,

1. Introduction to Health Promotion
2. Basic Concepts of Health Communication
3. Introduction to Maternal and Child Health Care (MCH) Service Provision at Community Level
4. Essentials on Infectious Diseases; COVID-19 and Dengue
5. Non-Communicable Diseases and Prevention
6. Introduction to Human Nutrition
7. Nutrition among Special Groups
8. Introduction to Food Security and Food Insecurity Assessment Tools at Community Level

Each chapter will cover the most essential technical points, practical attributes, and specific touchpoints that facilitators could refer to during their undertakings at the grass root level. Training material, templates for scenarios and roleplays and monitoring formats have been included in the annexures, which can be used by the facilitators for training and programme monitoring purposes. Although key principles on health and nutrition remain the same, it is important to note that some of the interventions highlighted can be modified according to the prevailing country context.

It is expected that the facilitators/ trainers will use this handbook to achieve the overall outcomes of empowering grass root level communities to be resilient during crises and emergencies and build sustainable community networks that thrive on community engagement and participation.

List of Contributors

Editor

- Dr. Vinya Ariyaratne MD, MSc (Com. Med), MPH, MD (Com. Med)

Editorial Team

- Dr. Lahiru Kodituwakku MBBS, MSc (Com. Med), MBA, PgD Health Sector Disaster Management
- Dr. Chintha Rupasinghe MBBS, MSc (Com. Med), PgD Health Sector Disaster Management
- Dr. Tehana Perera MBBS, MSc (Human Nutrition)
- Ms. Sasanka Darmasena PQHRM, Dip. Mass Com

Illustrations and Designs

- Eng. Chameera Randil BSc (Eng), MSc

How to use this handbook

- This handbook has eight main sections.
- Each section is designed to provide you with key concepts, terminology and content that are helpful for identification of health issues at the grass root level. It will also help with essential information for health-related programme conceptualization, development, design, implementation, and monitoring during the field work
- This handbook can also be used as a Training of Trainers manual (ToT) for training of Suvodaya community members and for refresher training.
- Under each section you will find separate text boxes, highlighting the key contents of each section. These are '**must know**' points for a facilitator. When you conduct programmes for the Suvodaya committee members these 'must know' components should be addressed.
- After each section another text box is available with a '**Take Home Message**'. This message has to be delivered during the trainings for wider information dissemination
- After each section a '**Trainer's tips**' section is included separately. These included expected deliverables/ touch points under each section for the trainings (Both regular and refresher trainings)
- In annexure 1, you will find training slides, roleplays, and scenarios. These formats can be used as a guide to create scenarios/ role plays tailored to your local context and ensure active engagement of the participants during the training.
- In annexure 2, you will find documents and charts that can be used in a nutritional assessment
- In annexure 3, you will find:
 - a. Reporting format for the training sessions held for Suvodaya committee members. you are expected to fill this format, after each training and keep them as a record at your district office.
 - b. Monitoring format for progress review on training conducted in your respective districts. You are expected to fill this format and send it to the Project Manager (Suvodaya Project) at Sarvodaya Headquarters quarterly. This format will be used for reporting the progress to our partners including the UNICEF.
 - c. Monitoring and evaluation format for the national level which will be filled by the project manager at HQ level and disseminated among the partners and stakeholders. This format has been made in accordance with Monitoring and Evaluation Framework for Community Engagement by UNICEF.

1. Introduction to Health Promotion

1.1. Health-Definition and its Meaning

The concept of health has significant consequences for practice, policy, health services, and health promotion, making it more than merely a theoretical debate. Health professionals are impacted by the understanding of health, and in turn, they have a serious influence on how modern societies socially construct health. The demands and expectations for health, the healthcare systems, the decision-makers, and many other important facets of health are all influenced by the social perceptions of health. In a nutshell, the definition of health is crucial across all of the health disciplines.

The foundations of modern Western medicine were laid in the late 19th and early 20th centuries, with an emphasis on a reductionist view of health based on the absence of diseases or infirmities and defined by physical criteria. Health was later redefined as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," thanks to the constitution of the World Health Organization (WHO). This definition was widely spread in the previous century, playing a significant influence in the evolution of national health care systems and encouraging countries to go beyond the traditional bounds of health care set by individuals' physical illnesses.

1.2. Social Determinants of Health

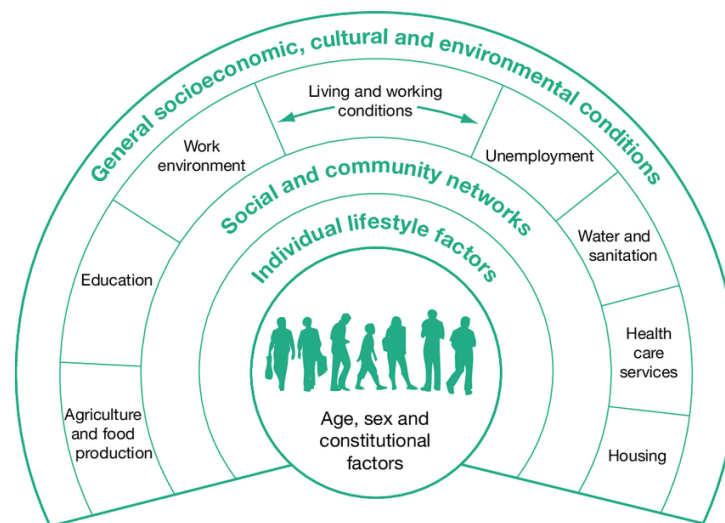


FIGURE 1. PARRY, YVONNE & WILLIS, EILEEN. (2019). THE SOCIAL CONTEXT OF BEHAVIOUR

Chapter 5, *Psychology for Health Professionals*, 3rd edition Pat Barkway and Deb O'Kane (Editors). Elsevier Australia.

Non-medical elements that influence health outcomes are referred to as social determinants of health (SDH). They are the circumstances under which people are born, grow, work, live, and age, as well as the larger collection of forces and institutions that shape the conditions of daily existence. Individual characteristics that affect a person's health include things like age, gender, genetic make-up and lifestyle factors such as dietary patterns and habits like smoking. In general, phrases like "social networks" and "social support" are used to refer to various facets of interpersonal interactions, such as defenses against the damaging effects of stress. Members of our social network—the neighbors we can always count on and who are eager to help us—provide social assistance. Economic policies and systems, development objectives, norms, social policies, and political systems are examples of these forces and systems.

1.3. Health Promotion

Health promotion is defined as a "process of enabling people to increase control over and improve their health".

To enhance the skills and capabilities of individuals as well as the social, environmental, and economic conditions in order to lessen their negative effects on public and individual health, health promotion constitutes a comprehensive social and political process. The practice of empowering people to exert more control over the factors that affect their health and consequently enhance is known as health promotion. To continue promoting health, participation is crucial.

1.4. Cure / Prevention or Health Promotion?

Health promotion assists governments, communities, and individuals in coping with and addressing health concerns as a fundamental component of public health. Building sound public policies, fostering positive settings, and enhancing community engagement and individual abilities are ways to achieve this. Disease prevention/ cure vary from health promotion in that as it focuses on targeted efforts to reduce the occurrence and severity of chronic diseases and other morbidities.

However, Social determinants of health, which influence modifiable risk behaviors, are frequently addressed in both health promotion and disease prevention programs.

1.5. Components of Health Promotion – Ottawa Charter



FIGURE 2. THE HEALTH PROMOTION EMBALM: FROM THE COVER PAGE OF THE OTTAWA CHARTER

The inaugural International Conference on Health Promotion, held in Ottawa in 1986, offered this Charter for Action in order to attain Health for All by the year 2000 and beyond. It built on the progress made by the Alma-Ata Declaration on Primary Health Care, the World Health Organization's Targets for Health for All declaration, and the World Health Assembly debate on intersectoral health action.

Five priority areas were designated as the "Health Promotion Action Areas" after this summit. Let's try to understand each one clearly one at a time.

1.5.1. Build Healthy Public Policy

Health care is only one part of health promotion. It puts health on the agenda of policymakers in all areas and at all levels, telling them to think about how their decisions affect health and to take responsibility for it.

Policy for promoting health uses a mix of different but complementary methods, such as laws, financial measures, taxes, and organizational changes. Health, income, and social policies that make things more fair are the result of people working together. Joint action helps make sure that goods and services are safer and healthier, that public services are healthier, and that the environment is cleaner and more enjoyable. As part of a policy to promote health, it is important to figure out what stops non-health sectors from adopting healthy public policies and how to get rid of them.

1.5.2. Create Supportive Environments

Our societies are intricately woven together. Health and other objectives go hand in hand. A socioecological approach to health is based on the interdependence of people and their environment. The need to promote reciprocal maintenance - to look after one another, our communities, and our natural environment - should be the overarching guiding principle for the world, nations, regions, and communities alike. The need of preserving natural resources worldwide should be emphasized as a shared duty.

For the public's health to improve, systematic assessment of the health effects of a fast changing environment is necessary. This is especially true in the fields of technology, work, energy production, and urbanization. Any strategy for promoting health must take into account the preservation of the natural and built environments as well as the protection of natural resources.

1.5.3. Strengthen Community Actions

To improve health, the community must take active, practical steps to identify priorities, make decisions, plan strategies, and put those strategies into practice. The empowerment of communities, their ownership and control of their own endeavors and destinies, is at the core of this process.

In order to improve social support and self-help, community development makes use of the existing people and material resources in the area. It also creates adaptable structures to increase public involvement in and control over health-related issues. This calls for complete and ongoing access to information, chances for health-related learning, as well as financial support.

1.5.4. Develop Personal Skills

Through informational assistance, health education, and the improvement of life skills, health promotion aids in social and personal growth. By doing this, it broadens the range of choices people have to make decisions that will improve their health and that of their environs.

It is crucial to give people the skills they need to prepare themselves for all of life's stages and to deal with chronic disease and injury. This needs to be supported in the contexts of the home, workplace, community, and school. The institutions themselves, as well as educational, professional, commercial, and voluntary entities, must take action.

1.5.5. Reorient Health Services

Individuals, community organizations, health professionals, health service organizations, and governments all share responsibility for health promotion in the healthcare system. They must cooperate to create a healthcare system that advances the goal of health. Beyond its obligation to deliver clinical and therapeutic services, the health sector's mission must expand to include health promotion. The enlarged mandate for health care must be considerate and respectful of cultural demands. This mandate should develop pathways between the health sector and larger social, political, economic, and physical environmental components and support people's needs for a healthier life.

In order to reorient health services, health research must also receive more focus, and professional education and training must shift. This must result in a shift in perspective and an organization of health care that puts the needs of the person as a whole back in the forefront.

MUST KNOW



Health Promotion is a "process of enabling people to increase control over and improve their health".

Health Promotion priority action areas include, building healthy public policy, creating supportive environment, strengthen community action, developing personal skills and reorientation of health services

Fundamental health promotion strategies are advocacy, enabling and mediation

1.6. Basic Strategies for Health Promotion - Advocacy, Enabling and Mediation

The Ottawa Charter lists three fundamental health promotion strategies. These include advocating for health in order to generate the above-mentioned essential conditions for health, enabling all individuals to realize their full health potential, and mediating between the many interests of society in the pursuit of health. As shown above, these initiatives are backed by five main action areas.

- **Advocate** - Optimal health is an essential resource for social, economic, and personal development, as well as an essential aspect of life quality. Political, economic, social, cultural, environmental, behavioral, and biological factors can all be beneficial or detrimental to human health. Through advocating for health, health promotion activities strive to improve these situations.
- **Enable** - To ensure that everyone has access to quality healthcare, health promotion efforts center on eliminating inequalities in health. Actions taken in the name of health promotion work on eliminating inequalities in people's existing health status and providing everyone with the tools they need to become as healthy as they can be. This entails having the resources necessary to build a solid foundation in a nurturing setting, as well as the knowledge, abilities, and freedom to make positive lifestyle decisions. Individuals will never be able to realize their full health potential until they learn to influence the factors that affect it. There can't be any exceptions; this is mandatory for everyone.
- **Mediate** - The health system cannot provide all of the conditions and opportunities for health. More crucially, health promotion necessitates coordinated effort from all parties involved, including local government, the health sector, other social and economic sectors, nongovernmental and volunteer organizations, industry, and the media. Every type of person participates as an individual, a family, or a community. Mediating between different societal interests for the sake of health is a major obligation of professional and social groups, as well as health professionals.

1.7. Practical Examples of Health Promotion – Mother Support Groups



FIGURE 3. UNICEF SRI LANKA - REVIEW OF THE FUNCTIONING AND IMPACT OF MOTHER SUPPORT GROUPS

In Sri Lanka, Mothers' Support Groups (MSG) are a community-based platform. Each midwifery area has a number of MSGs working to improve health and well-being at the village level.

MSG was first introduced to Sri Lanka in 2002, while its history dates back to 1950. Most MSGs around the world operate under the premise of "experienced mother assisting new mother." However, in Sri Lanka, the primary goal of an MSG is to improve community health, well-being, and dietary practices. MSG is made up of five to twenty participants. The Health Promotion Bureau of Sri Lanka serves as the national focal point for monitoring all MSG initiatives. This platform was extremely beneficial in risk communication and community empowerment initiatives during the COVID-19 Pandemic.

TRAINER'S TIPS

Emphasize on the importance of achieving overall health, not just lack of diseases.

Explain with examples on how social determinants of health can play a role in individual's, community's, and country's health profile

Engage the trainee in a discussion on role of Mother Support Group in health promotion

2. Basic Concepts of Health Communication

2.1. What is Communication?

Communication, which is a very important skill for field health workers, is generally defined as “the exchange of meanings between individuals through a common system of symbols” according to the encyclopedia Britannica.

Communication can be categorized mainly into two. First one is one-way communication, which can be described in a linear model.



Second one is two-way communication. It's a loop when the recipient responds, like in regular discourse. By allowing for feedback from the recipient, the sender may ensure that the message was received and can reinforce it as needed.



Negotiation is at the heart of two-way conversation. Successful communication between sender and receiver requires both parties to actively engage in listening, learning, and adapting. The two parties are in negotiations in the hopes of reaching an agreement that will satisfy both parties.

Health communication, according to the Centers for Disease Control and Prevention (CDC), is “the study and use of communication strategies to inform and sway individual decisions that improve health.” It has several essential steps that begin with problem identification and definition via a background analysis, then move on to setting communication objectives, identifying and segmenting the target audience, developing message concepts and pre-testing, identifying suitable communication channels, formulating messages/selecting ideal ones and pretesting, creating a promotion plan, implementing and evaluating the process, and concluding with outcome and impact evaluation.

2.2. Risk Communication

The World Health Organization defines risk communication as the “exchange of information, advice, and opinions in real time between experts or officials and people who face a threat (from a hazard) to their survival, health, or economic or social wellbeing”. The COVID-19 pandemic and the dengue outbreaks are examples of threats or hazards we are familiar with.

The goal of risk communication is to give people who are at risk the information they need to make decisions that will lessen the effects of a threat and help them take protective and preventive steps.

2.3. Community Engagement

Communities are made up of a large number of different people and groups who are linked by things like culture, age, gender, ethnicity, shared vulnerability or risk, shared interests or values, and location.

Community engagement, which is an essential part of the health risk response cycle, is the process of building relationships and structures that make communities equal partners in making emergency response plans that work for the people they affect. This process empowers communities to confidently share initiative leadership, planning, and implementation.

2.4. Infodemic

During a health emergency, people may be exposed to a lot of different kinds of information, such as news, public health guidelines, leaflets, infographics, rumors, myths, research papers, expert opinions, etc.

An infodemic is when there is too much information, especially false or misleading information, in both the real and digital worlds. This makes it hard for people to tell what is true and what is false. It can have a number of negative consequences, including the spread of uncertainty and fear, violence against frontline health care and other workers, social stigma, racism; a negative impact on preventive strategies such as vaccination; an increase in risky and harmful behaviors; poor adherence to public health guidelines, poor health-seeking behavior, and so on.

False information that has no malign intent is referred to as misinformation. Disinformation is the term for incorrect information that is spread with the intent to mislead, harm, or deceive individuals, groups, or nations. Information that stems from the truth but is frequently exaggerated in a way that misleads and potentially harmful is known as malinformation.

MUST KNOW



Infodemic or information epidemic is too much information, especially false or misleading information, in both the real and digital worlds.

There can be mis information, disinformation or mal information during an Infodemic

Risk communication is a vital tool in preventing and controlling any epidemic or health hazard that can impact human society

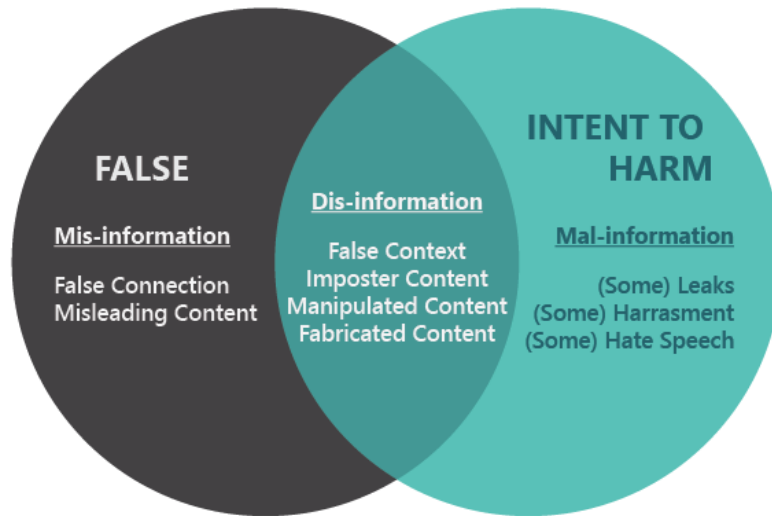


FIGURE 4. DIAGRAMMATIC REPRESENTATION OF MDM

2.5. Internet, Social Media and Infodemic

Misinformation has spread at an unparalleled rate and scale in recent years, attributable to the fast changing information environment, particularly on social media and online retail sites, as well as through search engines.



FIGURE 5. CURRENT INFORMATION ENVIRONMENT OF SRI LANKA: SOURCE - WEARESOCIAL

Misinformation and disinformation are frequently presented in a sensational and emotional way that can evoke strong feelings, warp memory, coincide with cognitive biases, and intensify psychological reactions. Technology platforms and their products have contributed to the proliferation of false information through the use of in-built capabilities. For instance, social media encourages users to post content in hopes of

receiving a "like," "comment," or some other sort of user interaction. Online content is typically ranked by algorithms depending on how popular it is or how similar it is to other material that people have already seen. Therefore, a user who is exposed to false information once may continue to encounter it in the future, adding to their level of confusion. Additionally, the abundance of sources for information has made it more challenging to identify and rectify misinformation and disinformation. In the absence of easily accessible, reliable information, misinformation and disinformation also thrive.

On social media, people typically do not knowingly spread false information. However, if they are not very vigilant, anyone can become the victim of false information and have a tendency to spread it on their own social media profile.

When there are reports of a miraculous or magical cure for a condition, you need to proceed with extreme caution. Before accepting and distributing it, it is preferable to give it a thorough analysis. Try to determine the reliability of the group or organization that contributed the information or the expertise in question. Before adopting specific facts, we may occasionally need to learn more about the objectivity of the expert or the group and conflicts of interest. The public should be extremely cautious of anecdotes, causality or association, and the strength of the evidence even if there are claims of scientific evidence.

Official and verified social media channels (HPB Sri Lanka Facebook page, Instagram, Twitter, YouTube and Viber) and the 1999 "Suwaweriya 24/7 Health Line" of the Health Promotion Bureau of the Ministry of Health can be considered as reliable local health information sources.



FIGURE 6. SOME OF THE LOCAL RELIABLE SOCIAL MEDIA INFORMATION SOURCES (WWW.HPB.HEALTH.GOV.LK)

It might not be possible to stop the spread of false information entirely in a society. However, we will be able to establish a health information environment around us by identifying local sources of misinformation and resolving them using locally adopted processes with the assistance of public health experts and community leaders.

TRAINER'S TIPS



Emphasize on the use of trusted sources for information collection and dissemination

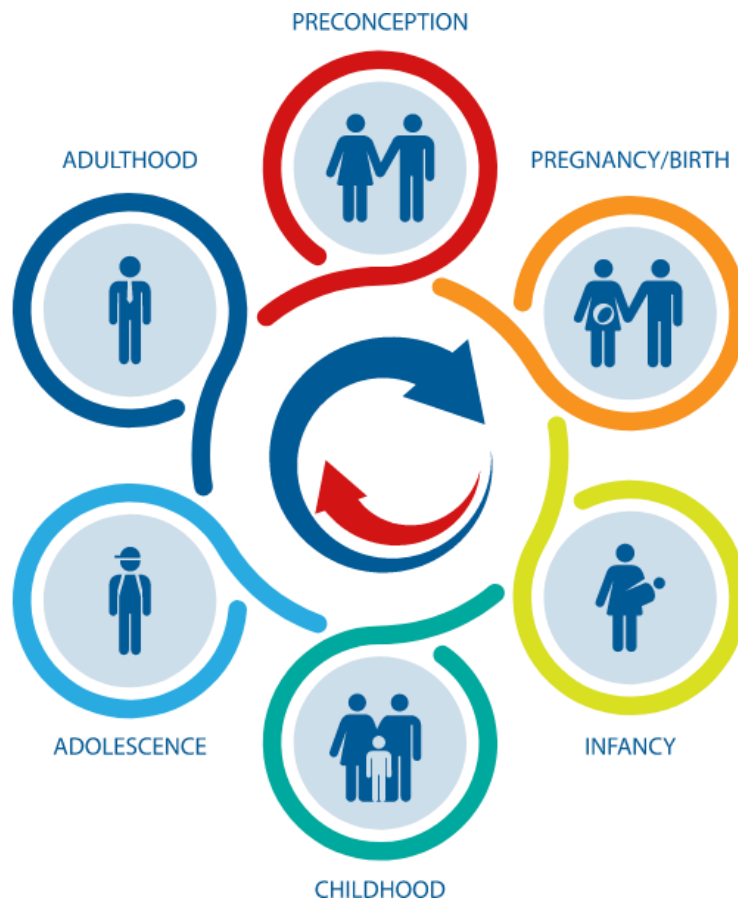
Introduce some trusted information portals in respect to health in Sri Lanka and abroad (e.g., Website and social media platforms of Health Promotion Bureau, Epidemiology Unit, World Health Organization, Centers for Disease Control (CDC) in USA)

Demonstrate some examples of misinformation, malinformation and disinformation (Available with training slides)

3. Introduction to Maternal and Child Health Care (MCH) Service Provision at Community Level

3.1. Life cycle approach and continuum of care in MCH

Maternal, Newborn and Child health interventions are treatments, technologies, and family practices that prevent or treat Maternal, Newborn and childhood illnesses and reduce deaths in mothers and children. Our MCH services target the life stages from pre pregnancy, pregnancy, the birth, the newborn period, infancy and childhood, adolescent period covering the whole life cycle.



MUST KNOW



Sri Lanka is identified as one of the countries with best networked and extensive maternal and child health care services (MCH) in the region.

Low Maternal Mortality Ratio, Neonatal Mortality Rate and Infant Mortality Rate compared to other countries in the region is a testament.

Public Health Midwife attached to Medical Officer of Health Office (MOH Office) is the community level MCH service provider

Family Health Bureau is the central level organization responsible for maternal and child health, under the Ministry of Health

TABLE 1. ROUTINE MCH SERVICES OFFERED BY THE MEDICAL OFFICER OF HEALTH (MOH) OFFICE

Clinic	Services
1) Pre-pregnancy clinic	<ul style="list-style-type: none"> ● Educate on Healthy diet, exercise, sexual health and parenting ● Examination by a doctor-Check blood pressure, BMI ● Introduction of Family Planning ● Folic acid for couples planning for a pregnancy ● Basic investigations- Hemoglobin levels, blood sugar etc.
2) Ante Natal Clinic	<ul style="list-style-type: none"> ● Examination by a Doctor ● Identification of danger conditions and appropriate referral for shared care to the hospital <p>Investigations</p> <ul style="list-style-type: none"> ● Urine: Check for glucose and protein ● Blood <ul style="list-style-type: none"> ○ HIV and VDRL testing as a screening test of AIDS and Syphilis ○ Blood grouping ○ Hemoglobin level <p>Tetanus toxoid Immunization Supplementation Folic acid, Iron tablets, Vitamin C, Calcium tablets and Triposha</p>
3) Well Baby Clinic	<ul style="list-style-type: none"> ● Examination by a Doctor ● Weighing the baby to monitor growth ● Provide Thriposha for babies with growth issues ● Age-appropriate immunization ● Give Vitamin A, Micronutrient satchels according to the age of the baby
4) Family Planning Clinic	<ul style="list-style-type: none"> ● Family planning counseling ● Provide Family planning- Depo-Provera injections, Loops, Jadelle [Arm rods] Oral pills, Condoms as per the selection of the couple
5) Post Natal Clinic	<ul style="list-style-type: none"> ● Examine by a Doctor- both mother and the newborn baby ● Assess breastfeeding and counsel appropriately ● Family planning counseling ● Provide Triposha

		<ul style="list-style-type: none"> • Postpartum mental state assessment using the Edinburgh Postpartum Depression Scale and manage appropriately
6)	Well Women Clinic	<ul style="list-style-type: none"> • Examination by a Doctor • Blood pressure measurement • Examine of urine for sugar to screen for diabetes • Breast examination and instruction on self-examination of the breast • Pap smear test to screen for cancer in the cervix of the womb and manage appropriately • Family planning counseling • Health education on menopause, STD/AIDS, nutrition and other relevant topics
7)	Poly Clinics	Combination of services offered by 1-6
8)	Combined Clinics	Combination of any 2 components of 1-6

(Family Health Bureau-Ministry of Health, 2011)

3.2. Role and responsibilities of the Public Health Midwife (PHM) in provision of MCH services

PHM is the “front line” health worker providing home care to women and children within the community and is the link between the community and health services.

- Equally and regularly provide service to ALL eligible families in all sectors (urban, rural and estate) within her area
- Participate, advice and guide health promotional activities organized by institutions, organizations, community leaders and volunteers in her area
- As far as possible the PHM should reside in the field and should maintain her office at a suitable place within the area easily accessible to the community
- Maintain registers and records according to departmental instructions and should submit data returns
- Assist in Maternal and infant Death investigations

(Revised Duty List of Field Public Health Midwife, 2006)

TABLE 2. INTRODUCTION TO FIELD ACTIVITIES IN RELATION TO MCH BY PHM

Area of Responsibility	Field Activities
Care for eligible families*	All eligible families must be registered. Visit each eligible family at least once in 6 months and identify their health needs
Pre-pregnancy care	<ul style="list-style-type: none"> • Identification of eligible women in pre-pregnancy period and referring them for counseling and other services to the pre-pregnancy clinic • Provision of family planning to delay the first child if desired by the couple • Provide folic acid for those who plan to get pregnant • Identify and refer sub fertile couples for treatment • Immunization for rubella for women who have not yet protected
Pregnancy	<ul style="list-style-type: none"> • Early registration of mothers before 08 weeks • Regular antenatal home visits (03 for low-risk mothers and increase the number depending on the risk factor of each mother) and organize clinic-based care (09 clinic visits)
Child birth	<ul style="list-style-type: none"> • Be ready to provide trained assistance at delivery • In case of an emergency field delivery take them to the hospital
After the child birth	<p>Minimum four home visits during first 42 days</p> <ul style="list-style-type: none"> • First visit- during 1-5 days of delivery, as soon as possible • Second visit - during the 5th -10th day • Third visit - during 14 - 21 day • Forth visit - around 42 days (between 6-7 weeks) <p>Care for the mother</p> <ul style="list-style-type: none"> • Assess and detect danger signs and act appropriately • Educate the mother, husband and other family members about possible issues • Assess and ensure successful breastfeeding • Instruct on proper nutrition of the mother • Counsel on family planning <p>Care for the baby</p> <ul style="list-style-type: none"> • Refer the Child Health Development Record (CHDR) and advice appropriately, if any high risk conditions exist • Practice proper infection prevention before examining the baby (hand washing with soap and water) • Examine carefully for any abnormalities or infections and advice appropriately • Ensure that the newborn is kept warm, in a protected place • Advice on common conditions/danger signs in the newborn to the care givers • Ensure registration of all babies in her area
Infant and Child care	<p>Home visits to children under 5 yrs</p> <ul style="list-style-type: none"> • Once a month- for infants, children of 1-2 years • Once in three months for 2-5 year children

	<ul style="list-style-type: none"> • Ensure age-appropriate immunization to all infants and children and follow up
	<p>Weighing of Children</p> <ul style="list-style-type: none"> • Once a month during first two years • Once in 3 months from 3-5 years • For underweight children - once a month • Counsel caregivers on breastfeeding and complementary feeding • Counsel on prevention of home accidents • Counseling on early child care development • Encourage the mothers to refer the CHDR and maintain appropriately
Family planning	<ul style="list-style-type: none"> • Identify family planning needs of the eligible families in her area, and provide FP services and counseling
Adolescent Health	<ul style="list-style-type: none"> • Register adolescents in her area and inform them about the services available and refer appropriately • Pay special attention to problems such as teenage pregnancies
School health	<ul style="list-style-type: none"> • Assist in School medical examinations • Do follow up visits to children found to be having diseases
Women's Health	<ul style="list-style-type: none"> • Refer all target aged women in her area to Well Women Clinic (WWC) • Assist in conducting WWCs according to the guidelines • Follow up women in the field after provision of services

**An eligible family is a family with a*

- *Married female (legally or customarily) of 15-49 yrs*
- *Pregnant woman at any age*
- *Married female below 15 years of age*
- *Child below 5 years of age*
- *Divorced woman or a widow below 49 years of age*

3.3. Introduction to Child Health Development Record

A detailed health record for the use of children from birth until 19 years of age. It has 2 parts; Part A is given to the mother and part B is kept with the PHM. Both parts are updated at Clinic and Home visits. In Part A there are entries that need to be done by parents such as developmental milestones and observations.

It contains:

- Identification details
- Newborn care record
- Immunization and nutritional supplement record
- Growth monitoring charts
- Psycho-social development records
- Dental records
- Medical history of the child
- Referrals done as appropriate

3.4. Introduction to community engagement platforms in MOH (Mother Support Groups)

Community involvement and participation has been a cornerstone in the maternal and child health care provision for a long time in the Sri Lankan health system. Mother support groups are community-based platforms for mothers of each PHM area. In these groups headed by the PHM, health promotion activities and projects are conducted. These activities are supported and supervised by the MOH and other health care workers.

TRAINER'S TIPS



Highlight the key achievements of maternal and child health indices in Sri Lanka (e.g., Low Maternal Mortality Rate/ use statistics available at Family Health Bureau website www.fhb.health.gov.lk)

Discuss the importance of life cycle approach and continuum of care in MCH

Scan through the important clinics and programmes available at a MOH setting

4. Essentials on Infectious Diseases; COVID-19 and Dengue

4.1. Introduction

Sri Lanka is no stranger to different kinds of infectious disease with varying origins, transmission dynamics and magnitude. Throughout our history we have experienced many outbreaks or epidemics of infectious diseases such as Cholera in 1851- 1860, influenza in 1918-1919, Malaria in 1934 and more recently measles in 1999 and dengue epidemic in 2017. Therefore, the relatively high susceptibility of our population to infectious diseases is very clear. This could be due to numerous factors. To understand this phenomenon, it is important to learn key terminologies and basic definitions in infectious disease epidemiology.

4.1.1. What is an infectious disease?

Infectious disease is an illness caused by either bacteria, virus, fungi or parasites that enter the body, multiply and can cause an infection. Some infectious diseases are contagious or communicable, meaning it can spread from one person to another. Other infectious diseases can spread by organisms carried via water, air, soil or food. They can also spread via vectors like mosquitoes or animals.

4.1.2. What is an epidemiological triad?

This is a model that explains the causation of a disease which is applicable to infectious diseases as well. It has three key elements.

- Agent- An infectious agent, pathogen or organism (e.g. virus, bacteria)
- Host- The human who can get the disease
- Environment- Extrinsic factors that affect the agent and the opportunity to expose (e.g. physical factors- climate, biological factors- insects that transmit disease, Socio economic factors- crowding, sanitation and availability of health services)

Any infectious disease results from an interaction between the agent and a susceptible host in an environment that supports the transmission of an agent from a source to the host. In some instances, there can be a vector that facilitates the transmission of the agent to a susceptible host (e.g. A mosquito that transmits dengue virus from an infected individual to another).

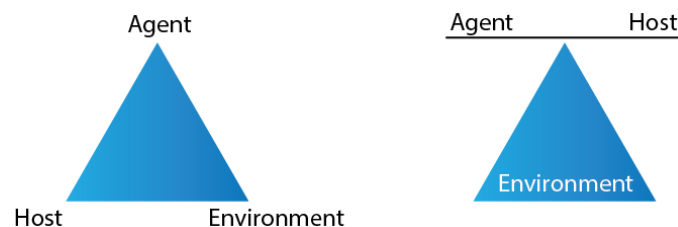


FIGURE 7. EPIDEMIOLOGICAL TRIAD (PIC COURTESY: CDC)

4.1.3. What is an epidemic?

An increase, often sudden, in the number of cases of a disease, above what is normally expected in that population in that area (*Outbreak carries the same definition but confined to a relatively smaller geographic area).

4.1.4. What is endemic?

Constant presence and/or usual prevalence of a disease or an infectious agent in a population within a geographic area (e.g., dengue is considered to be endemic in Sri Lanka)

4.1.5. What is a pandemic?

This refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people (e.g., COVID-19 pandemic)

4.1.6. What is PHEIC (Public Health Emergency of International Concern)?

An extraordinary event which is determined to constitute a public health risk to other countries through the international spread of disease and to potentially require a coordinated international response.

TABLE 3. THE LIST OF PHEIC (SOURCE: WORLD HEALTH ORGANIZATION)

Name of the PHEIC	Country of Origin	Year
Swine Flu (H1N1 Virus)	United States of America	2009
Polio	Pakistan	2019
Ebola	West African Region (Guinea, Liberia, Sierra Leone)	2014
Zika	Brazil	2016
Ebola	Kivu region, Congo	2019
COVID-19	China	2020
Monkeypox	Europe and United States of America (Introduced via travelers from Africa)	2022

It is evident from the aforementioned details that infectious diseases are a threat to our existence and the social norms. Moreover, emerging infectious diseases and consequences of climate change have further exaggerated the impact on public health and social fabric. In the next section we will be reading about some of the infectious diseases that have impacted our health and wellbeing in recent years, in Sri Lanka.

MUST KNOW



Epidemic is an increase, often sudden, in the number of cases of a disease, above what is normally expected in that population in that area

4.2. COVID-19 Pandemic and Public Health Security Measures

Coronavirus disease was first reported on December 31, 2019, from Wuhan province, PR China. It was initially reported to WHO as an unusual cluster of 'Viral Pneumonia' which then spread beyond the territories, continents and across the oceans to affect the entire globe. Initial cluster of cases thought to be emerging from sea food and an animal market in Wuhan, indicating an animal to human transmission of the disease. However, later when cases were reported from different countries spanning all geographical areas of the world, it was evident that disease could be transmitted from human to human.

As of mid-September 2022, nearly 605 million cases and 6.4 million deaths have been reported globally. Due to its global reach and impact to public health it was declared the disease as a PHEIC on 30th January 2020 and subsequently as a pandemic by the WHO.

4.2.1. Introduction to COVID-19 virus, basic structure, transmission, and variants

a. Basic Structure of Covid-19 virus

COVID-19 virus or Severe Acute Respiratory Syndrome Coronavirus 2 (SARS CoV 2) is a novel strain in the family of Corona viruses which also includes viruses of common cold, severe acute respiratory syndrome (SARS) and Middle Eastern Respiratory Syndrome (MERS). This virus is an unsegmented, single strand RNA virus. As any virus it is sub microscopic and size is nearly 0.1 micrometers (size of the average fine sand particle is around 90 micrometers).

COVID-19 virus is contagious and found to have many variants of different transmission and disease dynamics.

b. COVID-19 Viral Variants

Viruses like SARS CoV 2 continuously evolve as a result of changes in its genetic code during replication (either due to mutation or recombination). These changes result in formation of viral variants.

Why are viral variants important?

- Some might have comparatively increased transmissibility
- Some variants might cause severe forms of the disease or disease complications might be high
- They might interfere with known diagnostic methods
- Some variants might cause reduced protection from severe disease

MUST KNOW



Basic health precautionary measures on preventing COVID-19 transmission such as hand washing, keeping physical distance and wearing masks apply for all variants of COVID-19

c. Transmission of COVID-19 virus

Current evidence suggest that virus is transmitted in the following ways,

- From an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing, or breathe. Infectious particles that pass through the air are inhaled at short range (short-range aerosol / short-range airborne transmission).
- When infectious particles come into direct contact with the eyes, nose, or mouth (droplet transmission).
- In crowded, confined spaces where ventilation is limited and where people tend to spend longer periods of time. Aerosols can remain suspended in the air or travel farther distance (long-range aerosol or long-range airborne transmission).
- When people touch their eyes, nose or mouth after being in contact with a contaminated surface.
- Always avoid the **Triple C** - **Confined**/enclosed places, **Crowded** places, and **Close Contact** settings

MUST KNOW



Whether symptomatic or not, infected person can transmit the virus to another person

4.2.2. Signs and symptoms of COVID-19 infection

As with most of the viral diseases, the majority of the patients do not show symptoms (Asymptomatic). Symptoms can mimic any other common viral diseases at the initial stage of the infection.

Common symptoms include,

- Fever or chills
- Cough or shortness of breath/ difficulty in breathing
- New loss of taste or smell
- Sore throat and difficulty in swallowing
- Muscle or body aches
- Vomiting or diarrhea

MUST KNOW



COVID-19 is a wide spectrum disease. It can be asymptomatic, milder disease or can be deadly due to complications

4.2.3. Public Health Security Measures (PHSM) for preventing COVID-19 infection

Although there are numerous population, community, and individual level measures to prevent the transmission of COVID-19, the latest PHSM practiced in Sri Lanka and introduced by the Ministry of Health is known as **DReAM +V concept**. Additionally, the "**Bio Bubble**" concept will be introduced to you as well.

DReAM + V

D - Maintain physical **Distancing** of at least one meter

Re - **Respiratory etiquette** (Sneezing or coughing to bent elbow/covering your nose and mouth with a handkerchief or tissue)

A - **Aseptic** precautions (Washing your hands with soap at least 20 seconds or apply a disinfectant with at least 70% alcohol content)

M - Wear a proper fitting **Mask** to cover your nose and mouth

V - **Vaccination**

THE BIO BUBBLE CONCEPT

It is an arrangement where interaction with each other is limited to a certain group of individuals. For e.g., these group of people use the same transport, use the same office space, have meals together and limit their interactions to this identified group of individuals.

The objective is to if any infection happens, limit the spread within the group so that it does not spill over to the larger population,

This was successfully implemented in certain offices, construction sites and tourism sector during the COVID-19 pandemic in Sri Lanka



FIGURE 8. HOW TO WASH HANDS PROPERLY (PIC COURTESY: WORLD HEALTH ORGANIZATION)

TABLE 4. MEASURES TO ENSURE HEALTH AND SAFETY IN SCHOOLS AND WORKPLACES DURING THE PANDEMIC

In schools and other education institutes	In offices and other workplaces
<ul style="list-style-type: none"> ● Prepare a plan to make school 'COVID Free' with the participation of academic and nonacademic staff, Area MOH and PHI, parents, school development committee, Grama Niladhari, local police and CBOs 	<ul style="list-style-type: none"> ● Maintain an institutional COVID-19 prevention plan. ● Appoint a health and safety officer, dedicated to this task ● Liaise with local MOH/PHI in executing this institutional plan
<p>Maintain a secure school environment by ensuring,</p> <ul style="list-style-type: none"> ● Temperature screening at the entrance ● Hand washing facilities with running water and soap/ or disinfectant ● Strictly adhere to wearing face masks, hand washing and other hygiene methods during school time ● Disinfection of classrooms and commonly used surfaces (e.g., student tables and chairs) before school opening ● Maintain required distance between students at the class room or enable physical barriers ● Limit or restrict the visitors to school unless deemed essential ● First Aid facilities at the classroom or in a separate space 	<ul style="list-style-type: none"> ● Identify workers coming to work from high risk areas or vulnerable population groups. Limit or rotate their presence depending on the work requirement. ● Conduct a risk assessment to identify most hazardous or susceptible areas within the compound for disease transmission e.g., Front desk, Lunchroom ● Give priority to maintain proper ventilation
<p>Ensure the availability of the following,</p> <ul style="list-style-type: none"> ● A fever register to maintain details of the students with fever ● Contact details of parents or guardians in case of an emergency ● A fever corner/ isolation room if any student or staff member get symptomatic ● A communication channel with the local MOH/PHI to contact them in case of any emergency or anyone get symptomatic 	<ul style="list-style-type: none"> ● Ensure physical barriers, temperature screening, hand washing facilities and disinfection at all times and all levels ● Ensure adherence to DReAM + V at all times ● Maintain a fever corner, isolation room and first aid facilities ● Establish a communication channel with local MOH/PHI
<p>Prepare for worst case scenarios</p> <ul style="list-style-type: none"> ● Student rotation plan if services are interrupted ● Staff rotation plan ● Identify and have call up plan for non-academic staff in case of emergency ● Stepwise school reopening plan in case has to close due to an outbreak 	<ul style="list-style-type: none"> ● Ensure Bio Bubble Concept during work, transportation, and other related group activities ● Have an employee rotation plan ● Maintain institutional and worker registers that would help during contact tracing
<ul style="list-style-type: none"> ● Ensure no stigma or discrimination on COVID infected students or staff members. ● Support children and families during their isolation or quarantine period ● Welcome them back once they are fit to learn according to existing guidelines 	<ul style="list-style-type: none"> ● Maintain a stigma and discrimination free environment ● Support workers and families during their isolation or quarantine period ● Welcome them back once they are fit to work according to existing guidelines

4.2.4. Brief Introduction to COVID-19 Vaccination

Vaccines are one of the most effective and safest ways to prevent COVID-19 infection, its complications and mortality associated with the disease.

Vaccines allow us to,

- Reduce the transmission of the disease
- Reduce complications and mortality associated with the disease
- Protect those who are vulnerable and unable to vaccinate due to various reasons (by achieving 'Herd Immunity')
- Return to our normal routine and way of life

HOW VACCINES WORK?

Vaccines contain weakened or inactive parts of a particular organism (known as antigen) that triggers an immune response within the body.

This weakened version will not cause the actual disease in the person receiving the vaccine, but it will prompt their immune system to respond similar to its first reaction to the actual pathogen/ invading organism.

Then whenever the body encounters the real pathogen, it already knows how to respond to it

4.2.4.1. Herd Immunity

WHAT IS HERD IMMUNITY?

Indirect protection from an infectious agent that happens when a population gets immunity either due to vaccination or through previous infection.

When this happens vulnerable people and those who are unable to receive vaccination will be protected from the infection because the vaccinated majority will act as a shield protecting them.

This will break the chain of transmission of the infection thus reducing the number of infections and deaths

4.2.4.2. What are common side effects of COVID-19 vaccination?

Like any other drug or vaccine, COVID-19 vaccines could create mild side effects such as fever, headache, tiredness, muscle pain, chills, and/or pain or redness at the injection site and allergies in some individuals. It is important to disclose about any such past incidences you have experienced, before receiving the COVID-19 vaccine to your doctor. Severe or long-lasting side effects are extremely rare, for which medical attention must be sought

4.2.4.3. What is Vaccine Hesitancy?

It is the reluctance or refusal to vaccinate despite the availability of vaccines. There are three main causes for Vaccine Hesitancy as per the 3 C model

- *Confidence*: Do not have any confidence in vaccination
- *Convenience*: Always look for easy ways to get the vaccine or cite numerous reasons for not getting the vaccine
- *Complacency*: Do not consider vaccination as a priority

4.2.4.4. Who are Anti-Vaxxers?

People who produce conspiracy theories, misinformation, disinformation and are against vaccination, especially during mass vaccination campaigns. They are against the concept of vaccination due to various reasons, including political, religious, racial and etc. Some of them might use it to gain a financial benefit.

Anti-Vaxxers and vaccine hesitancy must be proactively confronted with evidence based, correct scientific facts or else it would be a barrier to achieve herd immunity.

MUST KNOW



Herd Immunity is the indirect protection from an infectious agent that happens when a population gets immunity either due to vaccination or through previous infection.

Achieving Herd Immunity is one way of preventing the transmission of infection and breaking the transmission chain.

4.3. Essentials of Dengue Prevention and Control

4.3.1. What is dengue?

Dengue is a viral borne infection transmitted through a bite of a mosquito. Almost half of the world's population is thought to be vulnerable to dengue, but it is predominantly found in tropical and subtropical regions of the globe. It is estimated that around 100-400 million dengue cases occur every year in the world. Severe forms of dengue are more commonly found in South Asia, Southeast Asia and Americas.



Dengue is endemic to Sri Lanka. First discovered in the island in early 60s, outbreaks of dengue have increased in both the magnitude and frequency in recent decades.

In 2017, Sri Lanka experienced it's biggest dengue outbreak with over 180,000 patients and nearly 400 deaths.

*Earlier confined to major cities, now dengue is prevalent in almost all provinces in Sri Lanka. **Nearly 50% from the total dengue patients in entire island are reported from Western Province.***

Dengue virus (Commonly known as DENV) has four serotypes namely, DENV 1, DENV 2, DENV 3 and DENV 4. A particular serotype does not provide any immunity for another serotype, meaning any person can get dengue four times during their lifetime. The secondary infection is thought to be associated with more complications.

4.3.2. *Dengue vectors*

There are two mosquito vectors namely,

- *Aedes aegypti*
- *Aedes albopictus*

Aedes aegypti is the primary vector and can be found mostly in urban and semi urban environments whereas *Aedes albopictus* is more common in rural settings. However, scientists have noticed a change in their typical habitats in recent times.

SPECIAL CHARACTERISTICS OF THE PRIMARY DENGUE VECTOR

Mostly container breeders (buckets, discarded containers and used tyres, water drains and gutters)

Peak biting time is in daytime (during early morning and late afternoon)

Needs to bite several times to complete a blood meal (only female mosquito bites for human blood)

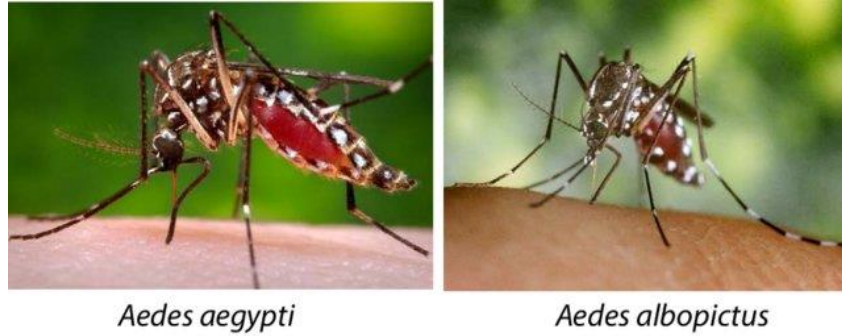


FIGURE 9. DENGUE MOSQUITO VECTORS (PICTURE SOURCE: ZIKA VIRUS THE EMERGING HEALTH GLOBAL HEALTH CHALLENGE INNOCENT ET AL 2016)

MUST KNOW

Dengue is a vector borne viral disease. Dengue virus has four sero types and if infected, only provide protection for that specific serotype. Hence, an individual can be infected with dengue, four times during their life span

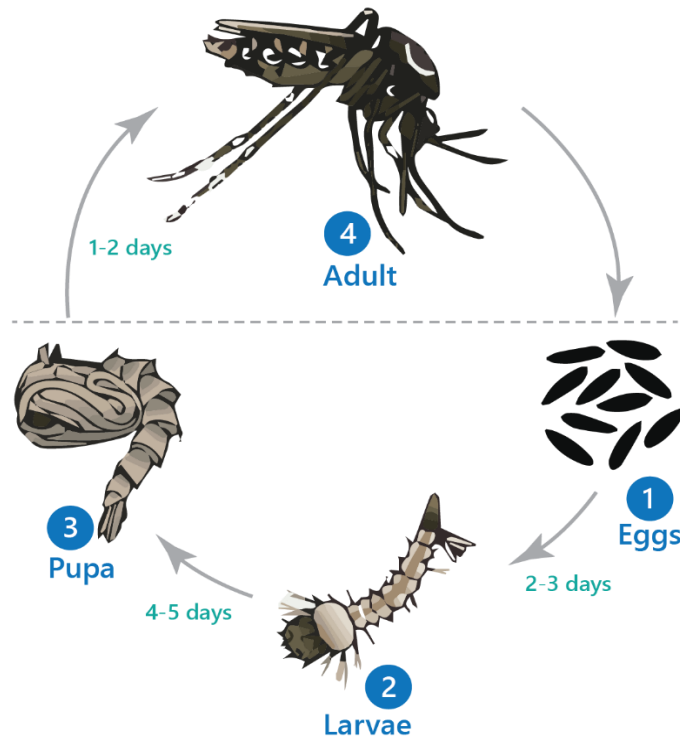


FIGURE 10. LIFE CYCLE OF A DENGUE MOSQUITO (3/4TH OF THE STAGES IS IN WATER) (PIC COURTESY: NATIONAL DENGUE CONTROL UNIT, MINISTRY OF HEALTH)

4.3.3. Dengue disease spectrum and symptoms

Dengue is a wide spectrum disease. Majority of the infections are asymptomatic. However, it can range from a simple febrile illness to a more lethal Dengue Hemorrhagic Fever (DHF). DHF can be associated with shock which is more deadly and called Dengue Shock Syndrome (DSS).

Common symptoms of dengue

- High fever (2-7 days duration)
- Muscle pain
- Joint pain
- Pain behind the eyes (Retro orbital pain)
- Nausea and Vomiting
- Rash

WARNING SIGNS OF DENGUE

Severe abdominal pain

Bleeding gums or nose

Restlessness

Blood in vomit or stool

Persistent vomiting

Fatigue

Refusal of feeds or continuous cry (of a child)

Reduced urine output or no urine for 4-6 hours

** If you have above-mentioned symptoms, you should consult a doctor or go to the nearest medical facility as soon as possible.*

COMMON DIAGNOSTIC TESTS IN DENGUE

Full Blood Count (FBC)- Ideally, after 48 hours of onset of fever

Dengue NSI Antigen Test- Within 18-72 hours of onset of fever

** You can still have dengue even if your NS I Antigen Test is negative*

** Do not forget to show your results to a doctor even though fever has subsided*

4.3.4. DOs and DONTs of dengue

DOs	DONTs
If fever is not subsiding or symptoms prevail for 48 hours following onset of fever, consult a medical practitioner	Do not take-home remedies and wait till fever goes down.
Have a good rest	Avoid strenuous exercises when you are sick
Use only Paracetamol in recommended dose and frequency for fever control	Do not use pain killers (e.g. Ibuprofen, diclofenac sodium, aspirin, mefenamic acid etc) for fever control and pain relief Avoid use of steroids like dexamethasone and prednisolone
Keep yourself hydrated. Fluids should include not only water but also fluids containing solutes like Jeewani, Rice porridge, King coconut etc	Avoid taking red/ brown colored drinks that could mimic bleeding
If you have appetite, take a soft light diet	Avoid red/brown color food items
Always wear long sleeved clothing or apply a recommended mosquito repellent during the peak biting times of the mosquito	
Use a mosquito net when resting during daytime	

MUST KNOW



If you have fever for more than 48 hours consult a doctor or visit your nearest hospital. This can be dengue!

4.3.5. Dengue breeding places and prevention and control of dengue

Since dengue mosquitoes are a container breeder and always associated with the presence of water, a tiny amount of water is enough for them to breed. Following are some of the most common indoor and outdoor breeding sites.



Saucepans and other utensils



Open trays



Water sumps



Open baskets, basins and other containers



Water tanks



Open drums



Fish tanks



Open tanks and baskets



Tires



Abandoned household items



Rainwater storages



Waste containers



Construction equipment



Toilets



Flower pot



Flower pot plate



Hardened soil of potted plants



Collar of the toilet bowl



Gully trap



Roof gutter



Roadside drain



Scupper drain



Tree hole



Plant axil



Air-con tray



BBQ pit



Canvas sheet



Discarded receptacle



FIGURE 11. COMMON INDOOR AND OUTDOOR DENGUE BREEDING SITES (PIC COURTESY: NATIONAL DENGUE CONTROL UNIT, MINISTRY OF HEALTH)

**Further, in Sri Lanka it is revealed that construction sites, government and public institutions, public places, schools, and religious places are major breeding sites.*

Essential Prevention Tips on dengue

- Spend at least 20 minutes per day clean your home environment both inside the house and outside.
- Remove water from collecting items inside the house including flower vases, refrigerator trays, ant traps and other receptacles. Make sure you clean their surfaces
- Routinely change water and clean the surface of bird baths, utensils used to feed pets and birds
- Cover discarded items under a roof so is to avoid water collection
- Inspect and clean your rain gutters on a routine basis
- Properly discard used receptacles and store them until disposal
- Make sure your child's school is free of dengue by regularly cleaning the environment (Special attention during reopening of schools following vacation)
- Keep your religious place free of litter and discarded items (e.g., Polythene bags etc)
- Maintain your office environment and store discarded items under a roof until condemning process begins
- Maintain your construction site dengue free. If it is difficult to remove water, consult MOH for necessary technical advice on larvicides and other interventions

**Fogging is not recommended for each and every case. Fogging is only effective against the adult mosquito but not other stages. If dengue breeding persists use of fogging is minimal. Always act according to the technical inputs from the public health staff of the MOH office.*

MUST KNOW



Spend at least 20 minutes per day to clean your household and the surrounding environment.

Wear long clothes that covers the exposed parts of your body or apply a repellent when you go out

Dengue mosquito bites during early morning and late evening hours

4.3.6. National, Regional and Local level platforms on dengue prevention and control

Presidential Task Force (PTF) on dengue prevention and control is a national level coordination platform on dengue which helps in coordination of national, regional and local level interventions against dengue. It is headed by HE The President and comprises all ministries related to dengue prevention including Health, Defense, Public Admin, Local Government, Environment, Fisheries and Harbor etc.

**Community Based Organizations (CBO) have a big role to play in assisting dengue control activities at grass root level, establishing dengue prevention village committees, public awareness and promoting dengue prevention and control among masses. Their contribution during special mosquito control campaigns and outbreak times are noteworthy and contribute immensely to reduce the disease burden and fatalities.*





FIGURE 12. SARVODAYA MEMBERS ENGAGED IN DENGUE PREVENTION ACTIVITIES AT THE GRASS ROOT LEVEL (PIC COURTESY: SARVODAYA SHRAMADANA MOVEMENT)

TRAINER'S TIPS

Highlight the key terminologies and must know components during the training

Always emphasize on the importance of prevention rather than cure

Promote early health seeking behaviour by addressing the importance of early referral to a health care professional/ institution

Reiterate on adhering to prevention and control measure even if the immediate threat is no longer prevalent

Promote a discussion among trainees on need to exercise individual and community responsibilities in preventing and controlling infectious diseases

5. Non-Communicable Diseases and Prevention

Noncommunicable diseases (NCDs) are diseases that are not transmissible directly from one person to another. They result from a combination of genetic, environmental and behavioral factors.

NCDs kill 41 million people each year, equivalent to 74% of all deaths globally

Problem of NCDs is they cause “Premature Deaths” of people between 30-69 years; nearly seventeen million per year (WHO, 2022). More than three quarters of these global NCD deaths occur in low- and middle-income countries. Furthermore, the Health-care costs for NCDs can quickly drain household resources. The costs of NCDs, including treatment, which is often lengthy and expensive, combined with loss of income, force millions of people into poverty annually and affect global development. (WHO, 2018) .

5.1. Types of common NCDs (Global and Country situation)

- The main types of NCD are cardiovascular diseases (such as heart attacks and stroke), cancers, lung diseases (such as asthma) and diabetes
- Ischemic heart disease is the leading cause of death in Sri Lanka
- In Sri Lanka cardiovascular diseases and diabetes contribute to the highest portion of NCDs

5.2. Aging population and NCD risk in Sri Lanka

- **Elderly population is expanding in our country**
- Occurrence of NCDs Increases Rapidly with Age
- After the age of 35 years, there is a sharp increase in risk of having NCDs, reaching around 60% after 70 years.

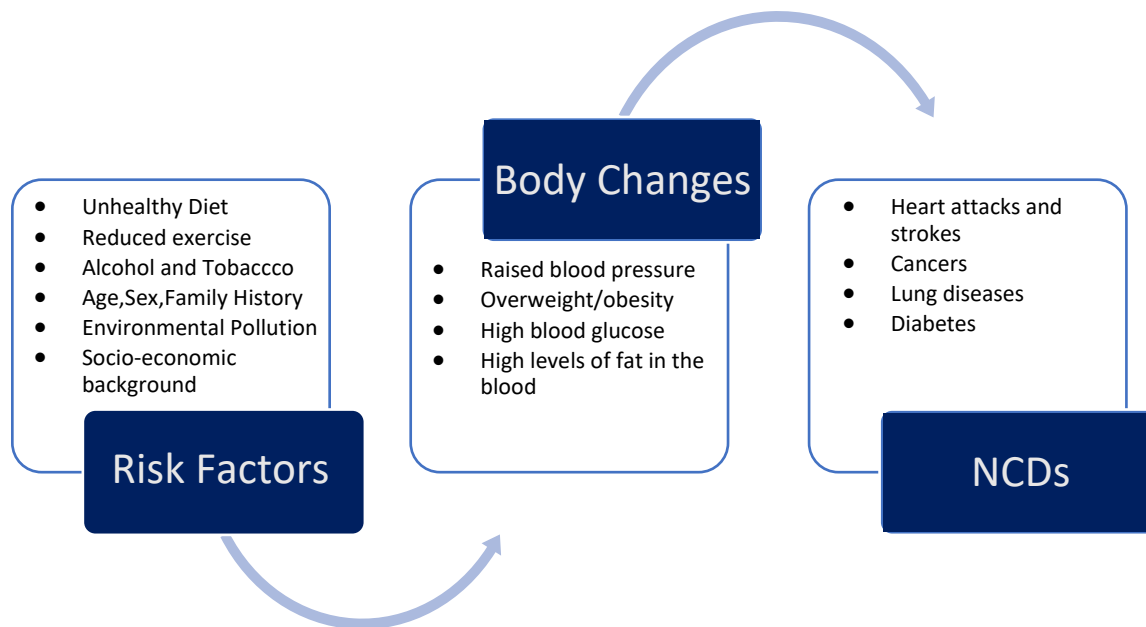
5.3. Risk factors for NCDs


Harmful behaviors, such as tobacco use, alcohol use, physical inactivity, unhealthy diet increase the risk of NCDs. Here the unhealthy diet includes high carbohydrate, sugar, salt and fat intake and not eating fruits and vegetables in adequate amounts. In addition to that the increasing age, female sex, and having family members affected by NCDs are some non-modifiable risk factors.

Poverty is closely linked with NCDs. Vulnerable and socially disadvantaged people get sicker and die sooner than better-off groups, especially because they are at greater risk of being exposed to harmful products, such as tobacco, or unhealthy dietary practices, and have limited access to health services.

All these risk factors will increase the possibility of following four major changes in our body which are root causes for many NCDs.

1. Raised blood pressure
2. Overweight/obesity
3. Hyperglycemia (high blood glucose levels); and
4. Hyperlipidemia (high levels of fat in the blood)



MUST KNOW 

There are modifiable and non-modifiable risk factors for NCDs

Modifiable risk factors include Harmful use of alcohol, use of tobacco, unhealthy diet, and lack of physical activity

Non modifiable factors include age, sex, and ethnicity

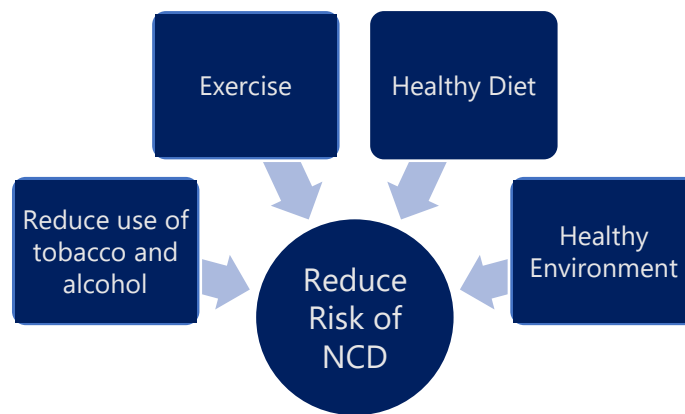
There are three main preventive methods used in NCD control.

Method	Primary prevention	Secondary prevention	Tertiary prevention
For whom?	People with one or more risk factors	People with disease	People with advanced disease
What we expect	Prevent developing the disease	Prevent progress of disease or recurrence	Prevent disability or complications

All these preventive methods are used collectively in our NCD control programs as an integrated approach.

5.4. Primary Prevention - Prevention and control of Risk factors

Controlling the risk factors associated with these diseases is an important way to control NCDs. These include reducing the use of tobacco and alcohol, maintaining an active lifestyle, living in a healthy environment and consuming a healthy diet.



5.5. Secondary prevention - Prevention and Control of NCDs

Proper management of NCDs is critical. This includes detection, screening and treatment of the diseases, as well as end-of-life care for those in need. The vast majority of premature deaths from NCDs occur in low- and middle-income countries, where people is often having limited health services. The development and promotion of “affordable quality health care for all” concept is therefore essential in tackling NCDs and working to reduce the number of preventable global deaths.

5.6. Tertiary prevention - Prevention of Complications

Tertiary prevention refers to the rehabilitation of patients with an established disease to minimize the disabilities and complications. This aims in giving the opportunity to enjoy the life for maximum possible number of years and to improve the quality of life in the presence of disease.

MUST KNOW



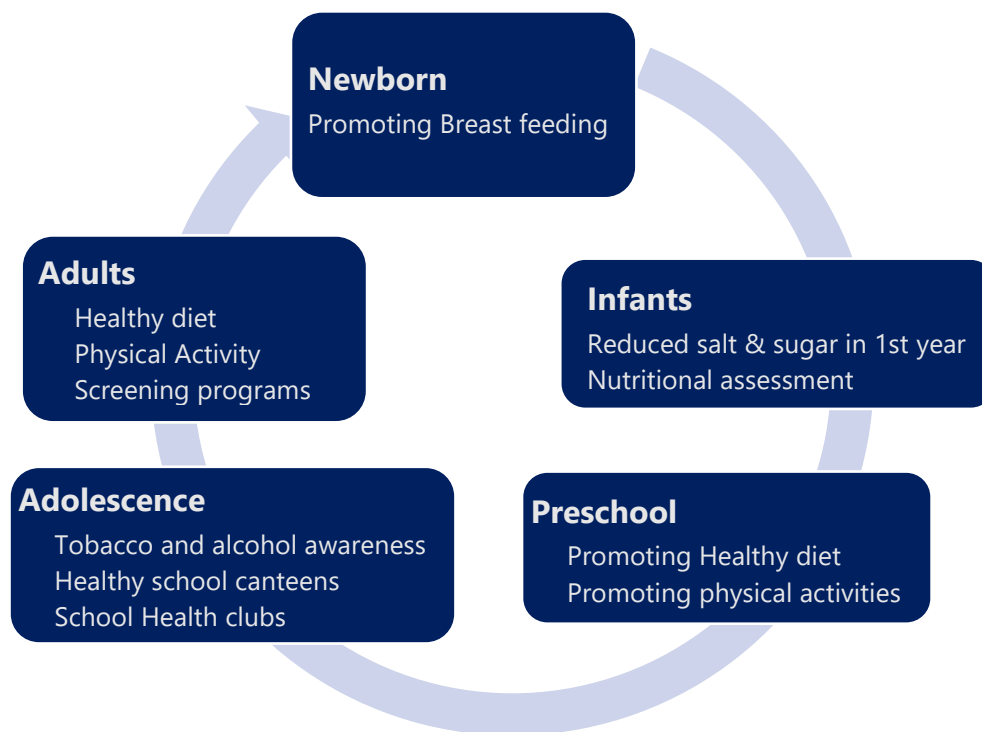
There are three levels of prevention

Primary prevention: Controlling risk factors for the disease

Secondary prevention: Detection, screening, and treatment of the disease

Tertiary prevention: Preventing complications and disability due to disease

We use the lifecycle approach in prevention of NCDs. That include health promotive activities targeting all stages of life.



5.7. NCD Targets of Sri Lanka by 2025

1. 25% reduction in premature deaths from NCDs by 2025 (17.6% 2012)
2. 10% reduction in the use of alcohol by 2025 (males 26% 2008) Sri Lanka
3. 10% reduction in physical inactivity by 2025 (25% 2008)
4. 30% reduction in salt/sodium intake by 2025 (baseline 8.4 g/day)
5. 30% reduction in tobacco use by 2025 (males 29.8% 2008)
6. 25% reduction in raised blood pressure by 2025 (16.1% 2008)
7. Halt the raise in diabetes and obesity by 2025
8. 50% of eligible people receive drug therapy to prevent cardiovascular diseases (CVD) by 2025
9. 80% availability of essential NCD medicines and basic technologies to treat major NCDs by 2025

5.8. Healthy Lifestyle Clinics

- Established In all health care institutes
- Aim for health guidance and risk factor screening
- For whom?
 - 35-65 aged people who are not having NCDs

- Do you need to go through the OPD?
 - No
- When?
 - Every week
- What are the services available
 - BMI assessment
 - Blood sugar testing
 - Blood pressure
 - Cholesterol testing

TRAINER'S TIPS



Reiterate the burden of NCDs and its importance in respect to Sri Lanka's aging population

Highlight the importance of primary prevention in controlling risk factors

Emphasize on the provision of health services for NCD prevention: e.g., Healthy Lifestyle Clinics at hospitals and cancer detection/screening programmes (Well Women Clinic) at MOH offices

6. Introduction to Human Nutrition

6.1. Introduction

6.1.1. *What is the importance of Nutrition to the life Cycle and impact to the society?*

An Individual can maintain adequate performance in many processes such as growth, pregnancy, lactation, physical work, resisting and recovering from a disease with adequate nutrition. Imbalance of Nutrition will result in impairment of physical and mental functions. Ultimately gives a negative effect for the productivity of the society.

6.1.2. *What is the current nutrition status in Sri Lanka?*

According to the National Nutrition Month survey 2022 conducted by Family Health Bureau, Ministry of Health, 15.3% were underweight, 10.1%-wasting (Acute malnutrition) and 9.2% were stunted. (Chronic Malnutrition) among under 5 children. All the parameters have increased compared to the year 2021.

Recent MRI survey done in selected districts in Sri Lanka, in 2021 showed that, among Children 5-9 years, 20.9% were with thinness (Acute Malnutrition) ,7.1% stunting (Chronic Malnutrition). Among adult women, 31.6% are overweight and 10.6% are with thinness.

Recent adult overweight trend, give rise to a double burden in health as most of them are micronutrient deficient due to the low-quality diet.

In WFP record on Sri Lanka Food Security monitoring August 2022 indicates "Four in ten households are not consuming Adequate meals per day". According to that, an average household consumes animal protein less than three days a week., the rate of fruit and dairy products consumption was even lower. Furthermore, there was a drop in food consumption from June 2022 to August 2022.

6.1.3. *What is malnutrition?*

It is a general term that refers to either overnutrition or undernutrition or both. Commonly the term of Malnutrition is used for Undernutrition.

6.1.3.1. Undernutrition

It is a broad range of clinical condition that results from deficiencies in one or more number of nutrients (Macro or Micronutrients).

There are two types of undernutrition.

- Acute Malnutrition
- chronic Malnutrition.

Acute Malnutrition

Identified by low weight for length/Height in less than 5 years children. Low BMI for age in older children and adults. Acute Malnutrition leads to immediate risk of morbidity and mortality. At the same time, a sick individual is more prone to become acutely malnourished.

Chronic malnutrition

Identified by low height for age and leads to increased risk of disease or eventual death due to inadequate nutrition over a longer period of time.

6.1.3.2. Overnutrition

It is a form of imbalanced nutrition arising from excessive intake of nutrients, leading to accumulation of body fat that impairs health. E.g., Overweight, Obesity

6.2. Balanced diet?

It is a sum of food that needs to be consumed by a person throughout the day in recommended amounts, including cereals, vegetables, green leaves, fruits, pulses, fish/egg/lean meat, nuts, and oily seeds to fulfill his/her energy and nutrient requirement.

6.2.1. What are the nutrition components of a balanced diet?

6.2.1.1. Macronutrients

- Carbohydrates (Including Fiber)
- Proteins
- Fat
 - Saturated Fat
 - Unsaturated Fat – Omega 3, Omega 6
 - Cholesterol
- Water

TABLE 5. FOOD SOURCES RICH IN MACRONUTRIENTS

	Sources	Function	Common deficiency features
1) Carbohydrate	Cereals and Legumes, Pasta, Oats, Bread Fruits-Banana Yams-Potato, sweet potato, Casava Milk and Milk products Honey-Sugar	<ul style="list-style-type: none"> • Produce energy for body function 	<ul style="list-style-type: none"> • Low energy • Reduced blood sugar level • Muscle pain • Lack of concentration
	Fiber Cereals and legumes, Vegetables-Carrot, ladies fingers, Bitter gourd, Snake gourd, Green leafy vegetables	<ul style="list-style-type: none"> • Maintain regular bowel habits • Lower absorption of sugar and lipids 	<ul style="list-style-type: none"> • Constipation

	Fruits-Banana, Passionfruit, Wood apple, Guava, Beli, Orange Nuts and seeds		
2) Protein	Cereals- Rice, Corn, Oats Pulses -Chickpea, Cowpea, Green gram, Kidney beans, dhal Meat, Fish, Egg, Milk and Milk products Soy and products-Tofu, Tempeh, Soy milk Mushrooms, Green leaves-Spinach	<ul style="list-style-type: none"> • Provide protection to the body • Regulate body function as enzymes and hormones 	<ul style="list-style-type: none"> • Body swelling • Skin, Hair, and nail problems • Poor growth in Children • Increased risk of infections
3) Fat	<p>Monounsaturated Fat - Cashew nuts, Peanuts, Kottang, Gingelly Vegetable oils-Canola, Olive, Safflower, Sunflower Avocado</p> <p>Polyunsaturated Fat- Omega 3 - Green leafy vegetables Vegetable oil-Soyabean, canola Oily fish (Mackerel, Tuna, Herring, Kumbalawa, Salmon) Egg, Meat, Poultry</p> <p>Omega 6 - Seeds and oils of gingelly pumpkin, corn, soy, sunflower</p> <p>Saturated Fat- Coconut milk and oil, Palm oil Full cream milk, thick creams, cheese, Butter Fatty meat, processed meat</p> <p>Cholesterol Meat,Sausages,Egg,Bacon,Full cream milk,Cheese,Butter,Liver</p>	<ul style="list-style-type: none"> • Lower LDL and triglycerides • Maintain HDL • Reduce coronary heart disease 	<ul style="list-style-type: none"> • Weak immune system • Dry Skin, Hair loss • Fat soluble vitamin deficiencies
		<ul style="list-style-type: none"> • Increase total cholesterol and LDL 	
		<ul style="list-style-type: none"> • Content of cell membrane • Build up plaques in arteries (Atherosclerosis) 	

6.2.1.2. Micronutrients - Vitamins, Minerals

TABLE 6. FOOD SOURCES RICH IN SOME IMPORTANT MICRONUTRIENTS

Common Vitamins			
	Sources	Function	Common deficiency features
A	Dark green leafy vegetables, Carrot, Yellow sweet potato, Tomato, Yellow pumpkin, Papaya, Mango, Orange, Egg, Whole milk, Cheese, Butter, Meat, Liver, Fish oil	<ul style="list-style-type: none"> • Important for vision • Keeps skin healthy • Protects against infections 	<ul style="list-style-type: none"> • Night blindness • Dry skin • Recurrent infections
B9 (Folate)	Dark green leafy vegetables, Plantain, Pineapple, Lime, Amberella, Orange, Beans, Soya bean, Mung, Ulundu, Chickpea, Cowpea, Peanuts	<ul style="list-style-type: none"> • Helps to form blood cells • Development of neural tube in neonates 	<ul style="list-style-type: none"> • Anaemia • Neural tube defects in newborns
C	Nelli, Guava, Cashew fruit, Star fruit, Citrus fruit, Papaya, Pineapple, Veralu, dark green leafy, vegetables, Drumstick, Capsicum, Bitter gourd, Tomato	<ul style="list-style-type: none"> • Helps to heal wounds • Keep teeth and gums healthy • Help in proper function of immune system 	<ul style="list-style-type: none"> • Poor wound healing • Gum bleeding • Recurrent infections
D	Mushrooms, Fortified cereals Fatty fish (Salmon), Fortified milk, Egg, Liver, Cod liver oil, Cheese	<ul style="list-style-type: none"> • Bone health • Help proper immune function 	<ul style="list-style-type: none"> • Bone pain and fractures • Recurrent infections
	Skin produces Vit D when expose to sunlight for 15-30 min between 10 am to 3 pm		
Common Minerals			
	Sources	Function	Common deficiency features
Iron	Dark green leafy vegetables, Carrot and beet leaves, Kalu-ala kola, Lotus stem, Beans, Soya bean, Mung, Ulundu, Chickpea, Cowpea, Lentil, Meat including organ meat, Fish, Egg	<ul style="list-style-type: none"> • Helps to form red blood cells • Maintain physical and cognitive functions 	<ul style="list-style-type: none"> • Anaemia • Lack of physical and cognitive function
Calcium	Dark green vegetables, Lotus stem, Potato, Wood apple, Gingelly seeds, Pulses-Soy bean, Chick pea Fish- Kunissa, Karalla, Kelawalla, Kumbalawa, Sprats, Canned fish, meat, Egg Milk / Milk products	<ul style="list-style-type: none"> • For strong bones, teeth, nail and hair • Proper function of nerves and muscles • Aids clotting blood and maintaining blood pressure 	<ul style="list-style-type: none"> • Bone pain and fractures • Poor muscle functions • Blood clotting problems

6.2.2. What are the 6 main Food groups?

1. Cereals and starchy food
2. Vegetables and green leaves
3. Pulses/Fish/Egg/Lean meat
4. Fruits
5. Fresh milk and its fermented products
6. Nuts, Oily seeds and oil

6.2.2.1. How much to eat from each food group?

- Serving size

It is a standardized amount of food that is recommended to be consumed from each food group.

TABLE 7. STANDARDIZED AMOUNT OF FOOD THAT IS RECOMMENDED TO BE CONSUMED FROM EACH FOOD GROUP

Food Group	Serving Size for a healthy adult
Cereals and Starchy Food	
Cooked rice/Pasta/Noodles/Pulses	1/2 Cup (65g)
Yams	1/2 cup
Bread	1 slice (30g)
String hoppers	2 (20g)
Pittu	1 piece (3cm height, 5cm diameter)
Hopper	1 (25g)
Rotti	1/2 (9cm diameter, 0.5 cm thick)
Dosai	1 (20-25g)
Vegetables	
Cooked leafy and fruit Vegetables	3 tbsp (1/2 cup)
Raw salads	1 Cup
Fruits	
Medium size fruits (Banana/Orange)	1
Avocado	1/3 (50g)
Anoda/Bael fruit	1/2
Cut fruits/Fruit Salad	1 Cup
Dried Fruits/raisins	4 tsp (20-30g)
Jambo/Grapes	10
Fish/Pulses/Egg/Poultry/Meat	
Cooked fish/Poultry/Meat	30g
Cooked pulses	3 tbsp/ 1/2 cup
Eggs	1
Dried fish/Sprats	15 g/10
Milk and Dairy Products	

Milk	1cup (200 ml)
Yogurt/curd	1/2cup (100 g)
Milk Powder	2 tbsp (30g)
Cheese	15g
Nuts and Oil seeds	1 tbsp (15g)
Peanuts/Gingelly/Cashews	1 tbsp (15g)
Oil	1 tsp (5g)
Coconut scrapped	1bs

TAKE HOME MESSAGES

Imbalance of Nutrition will result in impairment of physical and mental functions. Ultimately gives a negative effect for the productivity of the society.

According to the recent Sri Lankan health data, nutritional status of the population, needs special attention.

TRAINER'S TIPS

Always provide examples from locally grown and available food sources

7. Nutrition among Special Groups

7.1. Nutrition in Adults

7.1.1. Recommended daily servings for an adult

TABLE 8. RECOMMENDED DAILY SERVINGS FOR AN ADULT

Food Group	Number of Servings/day	Total Amount/day
Cereals and starchy food	8-13	4- 6 1/2 cups
Fruits	2-3	2-3 medium sized fruit (varies with the type)
Vegetables and green leaves	3-5	9-15 Tbsp
Pulse	3-5	9-15 Tbsp
Fish, Lean Meat	2-4	2-4 pieces of 30 g
egg	1	1
Milk and Milk Products	1/2-1	Fresh milk 100-200ml Yoghurt/Curd-100g Cheese -15g
Nuts, Oily Seeds and Oil	2	2 Tbsp
Oil	1-3	1-3 Tsp
Coconut (Scrapped, Kernel, Milk)	3-6	3-6 Tbsp

7.1.2. How to identify Malnutrition of an adult in the field?

BMI

It is a measurement, use to assess whether a person has an appropriate weight for height. It is calculated by dividing persons weight in Kilograms by Height, squared in meters.

$$\text{BMI (Kg m}^{-2}\text{)} = \text{Weight (Kg)} / \text{Height (m)} \times \text{Height (m)}$$

Severe Undernutrition	<16
Moderate Undernutrition	>= 16 to 16.9
Mild Undernutrition	>= 17 to 18.4
Normal	>= 18.5 to 24.9
Overweight	>= 25 to 29.9
Obese	>= 30

MUAC - Mid Upper Arm Circumferences

It is the measurement of the midpoint of the upper arm located between the tip of shoulder and elbow. Convenient for rapid screening of a large population.

Severe Undernutrition	< 18.5 cm
Moderate Undernutrition	>=18.5 to 21.9 cm
Mild Undernutrition	>= 22 to 25.3 cm
Normal	>=25.4 to 30 cm
Overweight	>= 30.1 to 31 cm
Obese	>= 31.1 cm

7.2. Infant and Young Children Nutrition

“Every Infant and child have the right to good nutrition” – Convention on the Rights of the child

7.2.1. What Is best meal for an Infant less than 6 months?

Breast Milk

7.2.1.1. What is exclusive breast feeding?

Giving only Breast milk to the infant, without any additional food or drink, not even water in the first six months of life, with the exception of mineral supplements, vitamins, or medicines.

7.2.1.2. What is the importance of breast feeding

To the baby

1. Provides all required nutrients in optimum amounts needed for growth and development
2. Easily digested and absorbed
3. Protects against infections eg: Diarrhoea, Respiratory Tract Infection, Ear Infections
4. Prevents Constipation
5. Clean and ready to have anytime
6. Leads bonding between baby and mother
7. Prevents allergies later in life such as asthma and eczema
8. Prevents Non-Communicable Diseases later in life

To the mother

1. Prevents development of breast cancer and ovarian cancer
2. Helps to reduce weight in mother
3. Economical

7.2.1.3. How long Breast feeding should continue?

Up to 2 years or beyond, along with age appropriate, safe, nutritious complementary food

7.2.1.4. How to store expressed breast milk?

- Can be kept in a clean, covered container for 4-6 hours at room temperature

- In the refrigerator nonfreezing compartment for 24 hours.
- Do not boil the refrigerated milk before feeding, keep the container dipped in warm water or keep it in the room air.

7.2.2. *What is complementary feeding and the importance?*

- It is the additional food other than breast milk
- After completion of 6 months, breast milk alone can't provide the increase energy and nutrient demand required by the growing baby.
- Therefore, additional food needs to be introduced. Furthermore, during this age, child is developmentally ready for other foods. This transition is known as complementary feeding.
- If Complementary foods are not introduced around 6 months, or if given inappropriately the child's growth may falter. Therefore, complementary food should be timely, adequate, safe, and properly fed.

7.2.2.1. *How to start and progress with complementary feeding?*

Rice is best to start with. It should be mashed and semisolid in consistency. Can add little amount of breast milk to it initially. Pulses, mashed potato, vegetables, and fruits to be added gradually. After the first week add animal proteins one by one. Introduce eggs after 2 weeks. Add one new food item at a time. For a non-breast-feeding child, can start fresh milk or fermented milk products at 7th month. Don't add salt or sugar during preparation of food in the first year.

7.2.3. *How to identify malnutrition in a child?*

Interpretation of the CHDR - Yellow and Red zones in

- Birth up to 2 years – Weight/Length Chart
- 2-5 years – Weight/Height chart
- 5-19 years – BMI/Age chart

7.2.3.1. *How to feed a child up to 2 years?*

TABLE 9. FEEDING GUIDE FOR A CHILD UP TO 2 YEARS

Age (Months)	Texture	Frequency	Amount for each meal
6-8	Well mashed	2-3 main meals 1-2 snacks Frequent breast feeds	Start with 2-3 tsp Increase gradually up to ½ cup of 200 ml
9-11	Coarsely chopped or mashed food	3-4 main meals 1-2 snacks Breast feeding after meals	¾ cup of 200 ml
12-24	Family food	3-4 main meals 1-2 snack Breast feeding after food	1 cup of 200 ml or bit more

7.2.3.2. How to feed a child 2-5 years?

TABLE 10. RECOMMENDED NUMBER OF DAILY SERVINGS FOR A CHILD 2-5 YEARS

Food Group	Servings	Amount/day
Cereals and starchy food	4 or more	2 Cups or more
Fruits	2	2 medium sized fruits
Vegetables	2	6 Tbsp
Green leaves	1	3 Tbsp
Fish/ Meat/Eggs	2	2 pieces of 30g
Pulses, lentils, nuts	1-2	3-6 Tbsp
Milk/Milk Products (Not essential for Breast feeding babies)	1-2	200-400ml
Fat based food	Small amount	
Salt	Use sparingly	

7.3. Nutrition in Pregnancy and Lactation

7.3.1. What is the importance?

During Pregnancy, the fetus act as a parasite and get the nutrition from mother. Some nutritional deficiencies of mother may cause adverse effects on the fetus. A balanced diet during pregnancy will ensure the fetus to get adequate supply of nutrients and mother will not suffer from any deficiencies after pregnancy. Prepregnant BMI has a profound influence on the outcome of pregnancy. Energy need is high during lactation more than in pregnancy.

7.3.2. What are the dietary recommendations during pregnancy and Lactation?

1. Sufficient calorie for adequate weight gain according to the prepregnant BMI
2. Variety of food from each food group every day
3. Sufficient amount of fluid (Minimum 8-10 cups/d)
4. Sufficient amount of fiber to prevent constipation (28 g of Fiber/day)
5. At least one glass of milk or a milk product/day
6. Avoid Alcohol and active or passive smoking

7.3.3. What are the Recommended number of daily servings during pregnancy?

Nutritional requirement increases with the progression of the pregnancy and peaks at 3rd trimester.

TABLE 11. NUTRITIONAL REQUIREMENT DURING THE PREGNANCY

Food Group	Number of servings	Amount/day
Cereals and Starchy food	8-10	4-5 cups
Fruits	3-4	3-4 medium sized
Vegetables & green leaves	4-5	12-15 Tbsp
Milk and Milk products	1/2-1	100-200ml
Fish/Lean meat	3-5	3-5 pieces of 30g
Egg	1	1 Egg

Pulses	3	9 Tbsp
Nuts, Oily seeds and oil	2	6Tbsp

7.3.4. *What are the food supplements recommended in pregnancy and Lactation?*

Thripasha is supplemented to fulfil the additional calorie requirement needed during pregnancy and lactation. It provides Carbohydrate, Protein, and important micronutrients. Recommended amount is 50g/d or 3 Tbs

7.3.5. *What are the micronutrients important in Pregnancy?*

1. **Folate**- Prevents Neural tube defects, start preconceptionally at least 3 months before and continue throughout pregnancy, Supplementation of 400 micrograms per day
2. **Vitamin C** – Enhances iron absorption and reduce the risk of Infection,3-4 servings of high Vit C food/day will provide the daily requirement. Vit C 100 mg is supplemented with iron supplementation.
3. **Iron** – Important for increased red cell production, growth of uterus, placenta, and fetus. Can be obtained from iron rich food and supplements. Need to continue till 6 months after delivery. Need supplementation of 30 mg elemental iron for non anaemic mothers and 120 mg of elemental iron for anaemic mothers
4. **Calcium** – For the skeletal development of the fetus and to maintain bone mass of the mother. Calcium supplementation with 600 mg daily during pregnancy. Need to continue till 6 months post-partum with 300 mg daily.
5. **Iodine** – For the brain development of the fetus, requirement fulfills with the intake of iodized salt

7.3.6. *How to identify Malnutrition in pregnancy and lactation?*

There are standard weight gain ranges according to the prepregnant BMI. Expected weight gain depends on the prepregnant BMI and the number of foetuses.

TABLE 12. STANDARD WEIGHT GAIN RANGES ACCORDING TO THE PREPREGNANT BMI

Prepregnant BMI (Kg/m²)	Expected Weight gain (Kg) for a single Pregnancy
<18.5 (Underweight)	12.5-18
18.5- 24.9 (Normal)	11.5-16
25-29.9 (Over weight)	7.0-11.5
>=30 (Obese)	<6.8

Appropriate weight gain during pregnancy will improve birth weight of the baby. Inadequate weight gain will lead to low-birth-weight baby and excessive weight gain will cause adverse pregnancy outcomes such as gestational diabetes, gestational Hypertension which affect the baby adversely. During lactation, Nutrition assessment of the mother should be done according to the normal adult BMI cut off values.

MUST KNOW



Identification of malnutrition in adult

Calculation of BMI: It is a measurement, use to assess whether a person has an appropriate weight for height. It is calculated by dividing persons weight in Kilograms by Height, squared in meters.

BMI (Kg m⁻²) = Weight (Kg)/Height(m) x Height (m)

Normal value >= 18.5 to 24.9

TAKE HOME MESSAGES



Identification of malnutrition and Recommendation of daily servings of each food group differs according to the age and physiological status of an individual

TRAINER'S TIPS



Trainer should be able to provide knowledge on Identification of malnutrition in an adult by BMI and children by using CHDR growth charts

8. Introduction to Food Security and Food Insecurity Assessment Tools at Community Level

8.1. Food Security Assessment Tools- For Field Level Practitioners

When all people, at all times, have physical and economic access to sufficient, safe and nutritious food that meet their dietary needs and food preferences for an active and healthy life, they are thought have achieved food security (Source: World Food Summit, 1996) Food security has three main dimensions, namely,

1. Food availability
2. Access to food
3. Utilization of food

Whenever either of these three components are compromised, food insecurity can be established within a community.

ABCs OF FOOD SECURITY

Food Availability: *the amount of food physically available to a household or at national level*

- Domestic production
- Imports
- Food Aid
- Reserves

Food Access: *Ability of a household to acquire adequate amounts of food*

- Own production
- Purchases
- Other means (Aid, assistance from relatives or friends)

Food Utilization: *Use of food, storage and preparation facilities at the household level and individual's ability to absorb and use nutrients*

- Food preparation knowledge and skills
- Health and hygiene
- Cultural appropriateness and acceptance

In crisis and emergency situations where there is increased risk of food scarcity, food security assessments are conducted using globally accepted and locally validated methods. Objectives of these assessments are to understand the type, degree, and extent of food insecurity and to identify those most impacted. Further, it would enable practitioners to identify the most appropriate response.

It is essential to consider the regional context when planning these assessments so that variations in livelihoods, food choices and coping mechanisms are best captured. However, basic knowledge and essential baseline data on livelihoods, food sources, food availability and coping mechanisms in case of a food insecurity crisis are warranted prior to any survey or assessment at the ground. Following are the areas one should consider before embarking on a food security assessment,

8.2. Food security and livelihoods assessment checklist

- a) Food security livelihood groups
 - Are there groups in the population who share the same livelihoods?
 - How can they be categorized according to their main sources of food and income?
- b) Food security pre-disaster (baseline)
 - How did different livelihood groups acquire food or income before the disaster? (What were their sources of food and income for an average year/ take a recent year as an example)
 - How would different sources of food and income vary between different months/seasons in a normal year? (In a Sri Lankan agricultural community, consider 'Yala or Maha' seasons). Constructing a seasonal calendar would be the best way to assess this activity.
 - For last five years how has the food security varied / What were the bad years? Constructing a timeline for the past five years would be beneficial.
 - What is the kind of assets, savings and other resources owned by different livelihood groups? (Land, savings, harvest, livestock, food stocks, credit etc.)
 - Over a period of one month, what do household expenditure include? What proportion is spent on food, transport, education of children, recreation etc.
 - Who is responsible for cash generation and management at the household?
 - Accessibility of the nearest market for obtaining basic goods? (Consider distance, transport, security etc.)
 - What is the availability and price of essential commodities, with special reference to food?
 - Before the disaster was there any instance that an asset exchanged to acquire food? (e.g., Pawning of jewelry to buy food)
- c) Food security during the disaster
 - How has this disaster affected the different sources of income and food for each livelihood group identified earlier?
 - How has this disaster affected the seasonal variations of food security for different livelihood groups?
 - How has this disaster affected the market access, availability, and prices of essential commodities?
 - What are the different coping strategies of different livelihood groups?
 - What are the short- and medium-term coping strategies of affected population? (With special reference to financial assets and other assets)
 - What are the risks associated with these coping strategies? (If any)
 - How have these coping strategies changed when compared to pre disaster situation?

- What are the population groups most affected? (e.g., most vulnerable groups)
- What are the effects of different coping strategies on health and wellbeing and dignity of the vulnerable and affected community?

IPC acute food insecurity phase description and response objectives

Phase	Technical description	Priority response objective
1 None/Minimal	Households are able to meet essential food and non-food needs without engaging in atypical and unsustainable strategies to access food and income.	Resilience building and disaster risk reduction.
2 Stressed	Households have minimally adequate food consumption but are unable to afford some essential non-food expenditures without engaging in stress coping strategies.	Disaster risk reduction and protection of livelihoods.
3 Crisis	Households either: <ul style="list-style-type: none"> • Have food consumption gaps that are reflected by high or above-usual acute malnutrition; <i>OR</i> • Are marginally able to meet minimum food needs but only by depleting essential livelihood assets or through crisis coping strategies. 	URGENT ACTION REQUIRED to protect livelihoods and reduce food consumption gaps.
4 Emergency	Households either: <ul style="list-style-type: none"> • Have large food consumption gaps, which are reflected in very high acute malnutrition and excess mortality; <i>OR</i> • Are able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation. 	URGENT ACTION REQUIRED to save lives and livelihoods.
5 Catastrophe/Famine	Households have an extreme lack of food and/or other basic needs even after full employment of coping strategies. Starvation, death, destitution and extremely critical acute malnutrition levels are evident. (For Famine classification, area needs to have extreme critical levels of acute malnutrition and mortality.)	URGENT ACTION REQUIRED to revert/prevent widespread death and total collapse of livelihoods.

FIGURE 13. INTEGRATED FOOD SECURITY PHASE CLASSIFICATION (AN INTERNATIONAL STANDARD TO ASSESS FOOD INSECURITY WITHIN A COMMUNITY)

Some of the ways to assess food access are listed below.

8.3. Household Dietary Diversity Score (DDS)

The number of different food groups consumed by a household over a given reference period of time. It provides an estimation on the quality of the diet.

The DDS considers seven food groups namely,

- Cereals, roots, and tubers
- Pulses and legumes
- Dairy products
- Meat, fish and seafood, and eggs
- Oils and fats
- Fruits
- Vegetable

To initiate the survey, firstly a Dietary Diversity Questionnaire is administered to the person who is responsible for meal preparation at the household level. The period of recall can be taken as last 24 hours.

The respondent is asked about the meals and snacks consumed (ate or drank) during the past 24 hours. All food eaten by any member of the family should be included. Food eaten outside the household should be excluded.

Breakfast	Snack	Lunch	Snack	Dinner	Snack
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When the respondent recall is complete, categorize the food according to the food groups mentioned above.

Food Groups	Example	Yes/No
Cereals, roots, and tubers	Rice, Oats, Manioc, Sweet Potatoes	
Pulses and legumes	Chickpea, Green Gram, Dhal	
Dairy products	Milk, Curd, Yoghurt	
Meats, fish and seafood and eggs		
Oils and fats	Butter, Coconut oil	
Fruits		
Vegetable		

For interpretation, following scale can be used,

6+: high = Good dietary diversity

4.5-6= medium dietary diversity

< 4.5= low dietary diversity

8.4. Food Consumption Score (FCS)

This is calculated by using the frequency of consumption of different food groups consumed by a household during the last week (last seven days) before the survey. 15 food groups are considered in the survey, however for analysis the foods are regrouped into eight (8) groups namely,

- Cereals
- Meat
- Vegetables
- Fruits
- Pulses
- Dairy
- Oil
- Sugar

FCS is calculated based on the frequency (number of days) the food is consumed (Range 0-7)

- Formula for calculation

$$\text{FCS} = (\text{Total cereal} \times 2) + (\text{Total meat} \times 4) + \text{Vegetables} + \text{fruits} + (\text{Pulses} \times 3) + (\text{diary} \times 4) + (\text{fat} \times 0.5) + (\text{Sugar} \times 0.5)$$

- Interpretation

Poor = 0-28

Borderline = 28-42

Acceptable = > 42

There are many adaptations of these surveys depending on the region, country context and different population groups (e.g., Minimum dietary diversity for women of reproductive age). Therefore, it is always advisable to contact local public health service providers (e.g., Public Health Midwife) or local expert on nutrition (e.g., Medical Officer Nutrition).

MUST KNOW



Food security has three main components.

- *Food Availability*
- *Food Accessibility*
- *Food Utilization*

There are important tools which can be useful in the assessment of food security at individual, family, and community level. These include,

- *Food Frequency Questionnaires*
- *24 Hour Dietary Recall*
- *Household Dietary Diversity Score*
- *Food Consumption Score*

Always liaise with your local public health service provider (MOH/PHI/PHM) or health professionals in nutrition (Consultant/ Medical Officer in Nutrition) for adapting such assessments to your local context

TRAINER'S TIPS



Always emphasize on liaising with local public health and nutrition professionals in adapting assessments to local context

Highlight the importance of local knowledge systems on food availability, access and utilization which is central to any assessment or intervention

Educate the trainees on importance of historical data and information to get a baseline about food security situation in the community

Discuss with the trainees on eliciting food security situation within a family through simple observations such as,

- *Whether the family is skipping meals on particular day*
- *Whether adults are sacrificing their quota in sake of children*
- *Whether the family is resorting to search for raw foods available in their environment rather than buying food*
- *Whether family is pawning or selling their property to buy food*

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10. Annexures

10.1. Annex 1 - Scenario Templates, Role Plays and Templates for Interactive Sessions

10.1.1. Essentials on infectious diseases

Scenario 1

Achala is a 35-year-old mother of two who is expecting her third child in two weeks time. One of her friend's told you that she has been complaining of a high fever, joint aches, headache and faintness for 4 days. Even though she has been advised by her friend to go to a hospital, she has refused, claiming that there is no one to look after her two children. Her husband works in a construction site in Colombo and has returned back to work one week ago, after spending his vacation with them.

As a member of the local Suvodaya Committee, Achala's friend requests you to intervene. Mention briefly how you can help Achala.

Scenario 2

Several devotees who visited the Vesak festival two weeks back, have been admitted to hospital due to a fever. Two members of the same family living just beside the temple premises have complained of similar symptoms and one has been rushed to hospital with complaints of high fever, severe lower abdominal pain, continuous vomiting, and drowsiness. People living around the temple premises have complained of increased mosquito nuisance. Chief prelate of the temple has convened the temple Dayaka Sabha and requested their assistance to convince people around the temple to clean their environment.

As the head of the village Suvodaya committee, Dayaka Sabha has requested your assistance to find a solution. How can you help them?

Scenario 3

You are the head of the local Suvodaya committee. You have been invited to the monthly conference of the MOH office as an observer. During the discussion it was revealed that the local youth were refusing the booster dose of the COVID-19 vaccination and only 15% of the youth between 19-30 yrs have taken the vaccine. PHIs have complained of numerous rumors spreading among youth groups, including false information on side effects. One WhatsApp group in which the majority of youth in the village are members, requests them not to vaccinate, stating that if they do, they might suffer from infertility in future.

The Medical Officer of Health has requested your support to counter these rumors and engage with local youth to get maximum vaccination coverage. He asked you to team up with his PHIs and come up with a community engagement programme. How can you help him?

Scenario 4

Our village was badly hit by a new wave of COVID-19 infections. Many people have been hospitalized and several households were quarantined. Vidyaloka Vidyalaya, largest school in your area, has been closed for a month due to COVID-19 outbreak. However, following a reduction of the number of COVID-19 cases, Zonal education officials have decided to reopen the schools next week. Principal and School development authorities have requested the help of the Suvodaya Committee to prepare the school for reopening. They have organized a planning meeting to discuss, and you as the head of the Suvodaya committee are supposed to present your plan during the meeting. What are the key points you are going to discuss and how can you help school authorities?

Scenario 5

Your village was inundated by a recent flood. Around 25 families have been displaced and provided temporary shelter in a local school. There are five pregnant mothers and 12 infants in the camp. Two differently able elders are among the displaced as well. After about a week of living in the shelter, many have fallen ill with complaints of fever, shortness of breath, cough, body aches and lethargy. Three people have been hospitalized and one transferred to a larger hospital for ICU care. People complain of lack of space within the school and overcrowding for recent illnesses.

Meanwhile meteorology department has predicted more rains in the area and all the gutters in the roof of the school are blocked. Garbage collection has been hampered due to bad weather. Regional Director of Health Services (RDHS) has appointed a support group to manage the situation at the camp and you are the representative from local Suvodaya Committee. This support group has been advised to come up with an action plan to resolve the issues in the camp. How Suvodaya committee can intervene to help and contribute to this action plan?

10.1.2. - Roleplay on measuring BMI and its interpretation

Create groups of 2 members

Step 1 – Ask to measure the weight of the partner with the weighing scale to the nearest 100g

(Check the error of the machine first and stay steady on it after removing the accessories)

Step 2 – Ask to measure the height of the partner with the help of Stadiometer/Measuring tape to the nearest 0.1 cm and convert it to meters (Make sure the five points-Back of the head, back of the shoulder, buttock, calf, and heel are touching the vertical plane and the Frankfurt horizontal plane is maintained between the lateral angle of the eye and the tragus of the ear)

Step 3 – Record the weight in Kg and Height in meters

Step 4 – Calculate the BMI using the equation

$$\text{BMI} = \frac{\text{Weight (Kg)}}{\text{Height (m)} \times \text{Height (m)}}$$

Step 5 – Categorize all participants into the following BMI groups

- BMI < 18.5 -Undernutrition
- BMI >=18.5 – 24.9 - Normal
- BMI >=25 – 29.9 - Overweight
- BMI >=30 - Obesity

Steps 6 – Write in chits, the benefits, or the complications of each BMI group beforehand and keep them folded. Ask each member to take one chit from the relevant BMI group and comment on it.

Eg: Obese group

- High BP, Sugar
- Risk of MI/Stoke
- Risk of Cancer
- Liver disease
- Depression
- Joint pain and less physical activity
- Infertility

Normal BMI group

- Normal BP, Sugar
- Low risk of MI/Stoke
- low risk of cancers
- low risk of Liver disease
- Good mental status
- No joint pains and physically active
- Fertility

Learning Points

- Method of measuring weight
- Method of measuring Height
- Method of calculating BMI
- Benefits or the complications of each BMI category and relation to non-communicable diseases

10.1.3. Interactive Session - Identifying Food sources, functions, and features in deficiency of Macro and Micronutrients

Create 3-5 groups from the participants (Each group with 5-10 members)

Step 1 – Introducing Macronutrients (Carbohydrate, Protein, Fat) and Micronutrients (Vitamins and Minerals) and point out important micronutrients

Step 2 – Distribute one macronutrient, two vitamins and two minerals among the groups and ask the participants to find out the sources, functions, and commonly identifiable features of deficiency.

Step 3 – Search and discuss with other group members

Step 4 – Present in Front of others and discuss with other groups

Learning Points

- Find out the low-cost food sources to provide important nutrients
- Idea on the importance of nutrients to the body and importance of having it as recommended
- What are the easily identifiable features of macro and micronutrient deficiency in the community

10.2. Annexure 2 - Documents and Charts Related to Nutrition Assessment

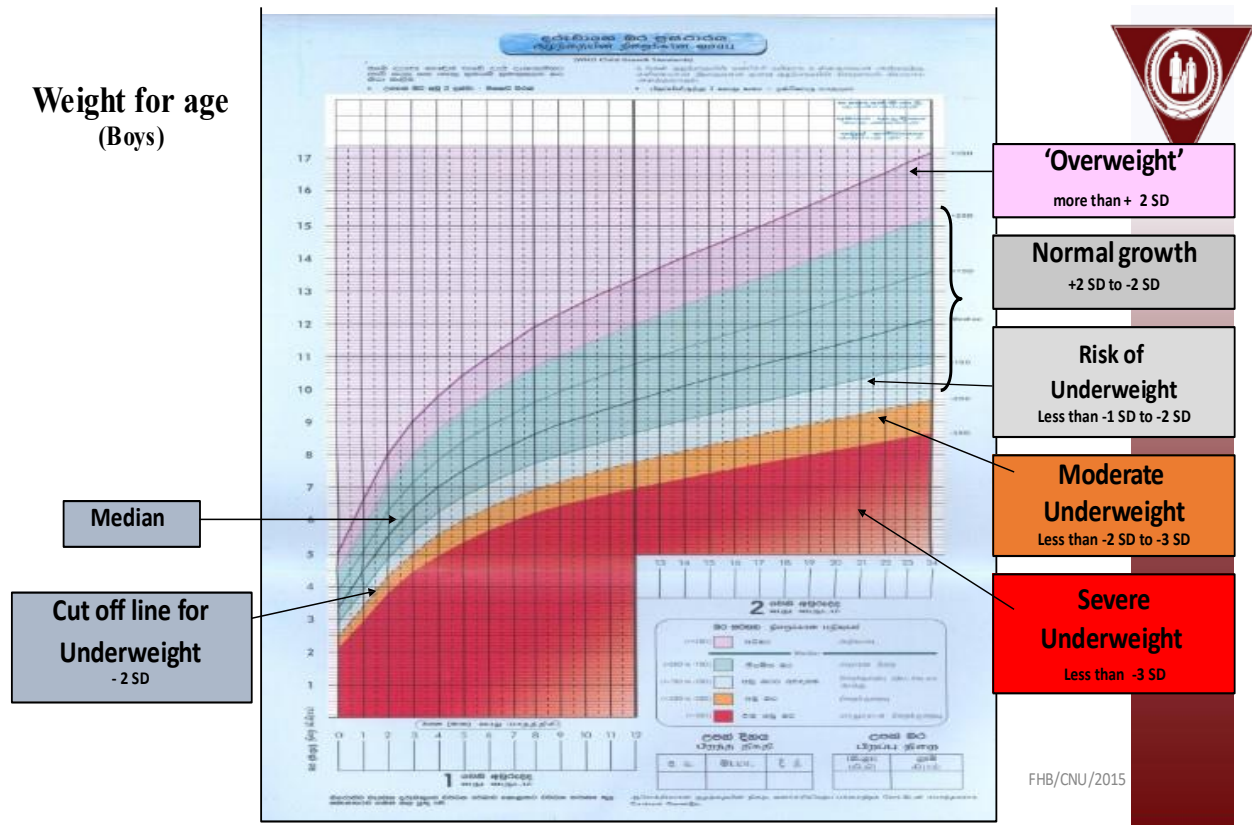
10.2.1. Healthy food plate



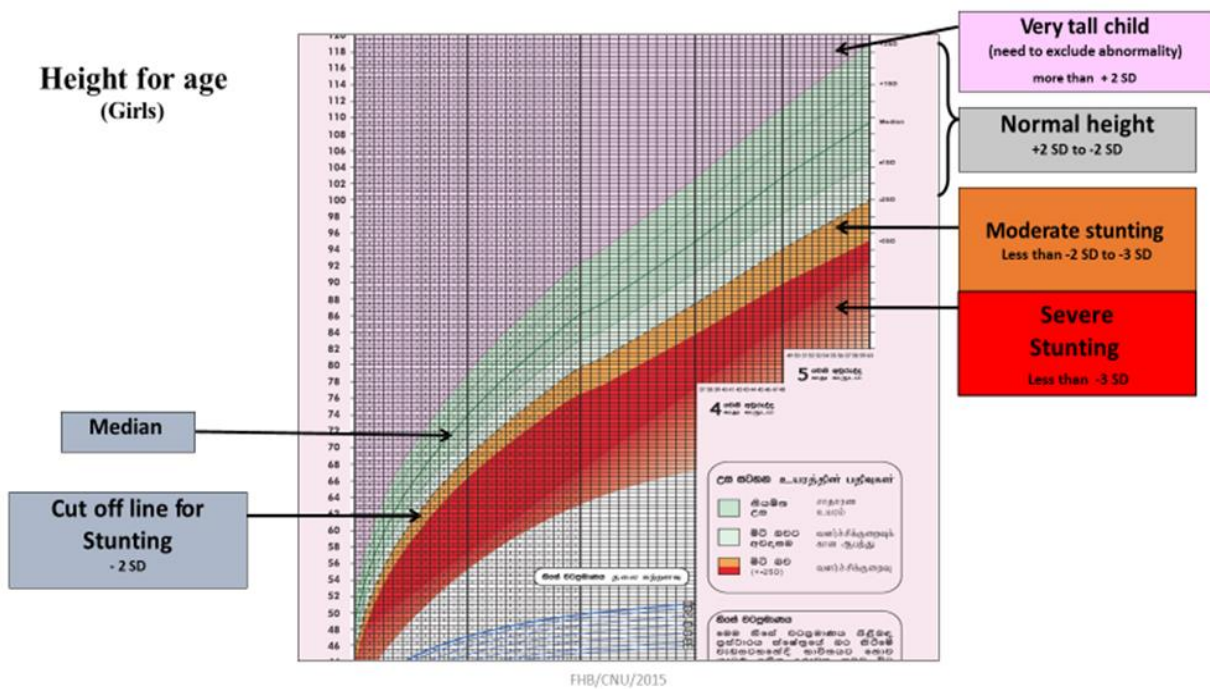
Model food plate for a healthy Sri Lankan adult

1. Serve half of the plate with cereals and starchy food (parboiled or less polished rice and boiled or curried yams/jack fruit/breadfruit as per preference). Some amount of carbohydrate will be provided from pulses too.
2. Fill approximately $\frac{2}{3}$ of other half of the plate with at least 2 vegetables and one green leafy vegetable.
3. Fill the rest of the plate ($\frac{1}{3}$ of the other half) with protein sources food. Out of which $\frac{2}{3}$ should be from plant sources of protein and $\frac{1}{3}$ from animal sources of protein.

10.2.2. Weight for Age Chart

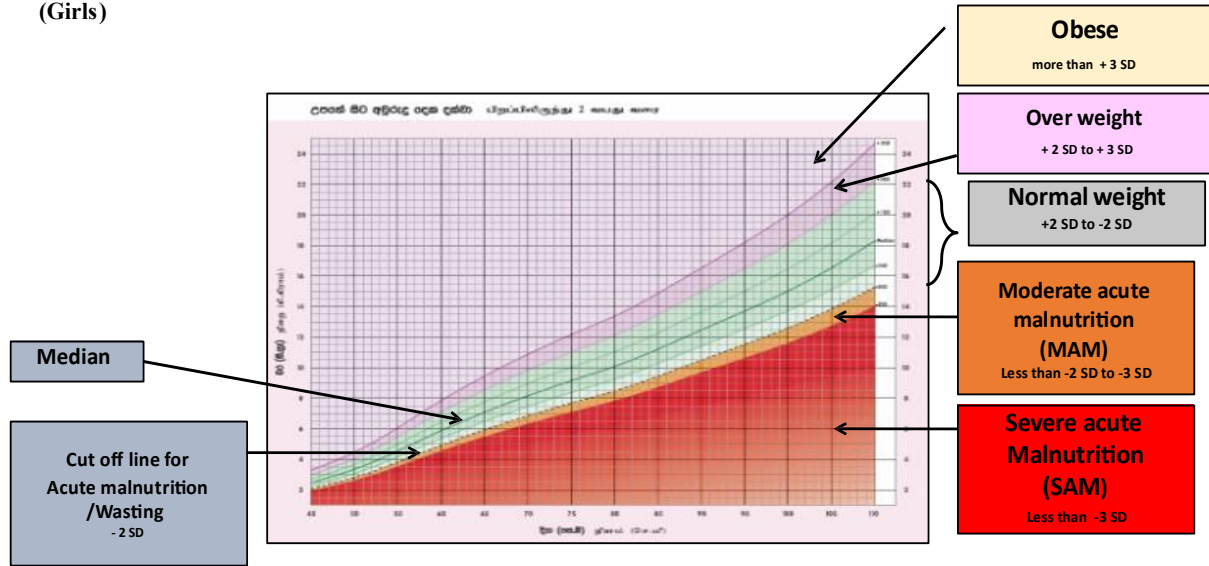


10.2.3. Height for Age Chart



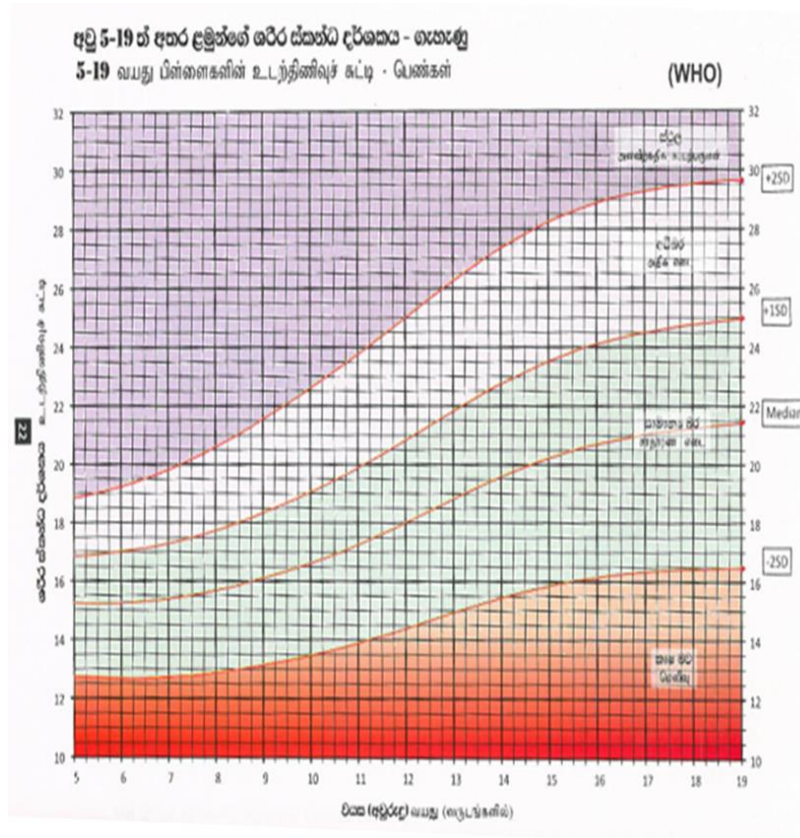
10.2.4. Weight for length Chart

Weight for Length (Girls)



FHB/CNU/2015

10.2.5. BMI for Age Chart



10.3. Annexure 3 - Sample templates for reporting, and monitoring of activities of Suvodaya Committees

10.3.1. Reporting format on trainings for Suvodaya Committees

Name of the training	Date of the training	Venue/ village/ community	Responsibility/ focal point for the training (Name/designation)	Method of delivery (Lecture/ discussion/ role play/ simulation / field work)	No of participants for the training	Topics covered during the training	Name and designation of the resource person/s	Name of the focal point for collaboration (DS/Grama Niladhari/ /MOH/ PHM/PHI)	Any other remarks/ important suggestions/ feedback

10.3.3. Monitoring and Evaluation Framework for Suvodaya Committees at National Level / HQ Level

Minimum Standard	Indicators	Response 01	Response 02	Response 03	Response 04	Response 05
1. Participation	1.1 No of Suvodaya committees established and operational within the district per month					
2. Empowerment and Ownership	2.1 No of meetings with local grass root level public health workers (MOH, PHI, PHM) per month 2.2 No of monthly conference meetings/ local development committee meetings participated per quota					
3. Inclusion	3.1 No of Suvodaya committee members trained in engagement with differently abled communities per year 3.2 No of economically disadvantaged families (Samurdhi social security beneficiary families) reached and engaged by Suvodaya committee per month					
4 Two-way Communication	4.1 No of focused group discussions, monthly meetings conducted between Suvodaya committee members and district coordinator per month					
5 Adaptability and Localization	5.1 No of home grown and indigenous community reach programmes developed by Suvodaya committees per annum					

10.3.4. Likert Scale Responses for Indicator Reporting

5	There has been considerable achievement, with the commitment and capacities to sustain efforts at all levels.
4	There has been substantial achievement, but with some recognized deficiencies in commitment, financial resources or operational capacities.
3	There is some institutional commitment and capacities to achieving the goal, but progress is not comprehensive or substantial.
2	Achievements have been made but are incomplete, and while improvements are planned, the commitment and capacities are limited.
1	Achievements are minor and there are few signs of planning or forward action to improve the situation

Handbook for
SARVODAYA SUVODAYA COMMUNITY FACILITATORS



சர்வோதய
சர்வோதயம்
Sarvodaya

unicef 

for every child

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