

MATERNAL AND CHILD HEALTH AND FAMILY PLANNING SERVICES SERVICES IN SRI LANKA

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The first organised effort towards providing care and attention to the child bearing woman was made in 1879 with the establishment of the De Soysa Lying-in-Home now known as De Soysa Hospital for Women.

During the late 19th century, some of the important land marks that supported the MCH services were: the introduction of registration of births and deaths in 1887; registration of midwives in the same year (1887); inclusion of Maternal Mortality in the Registrar Generals Annual Report and the establishment of a Public Health Department in the Colombo Municipality in 1902.

Following an investigation report on the high rate of infant mortality within the Municipality, a Maternal and Child Health Department was set up in the Colombo Municipality. Six midwives were appointed in 1906 followed by two health visitors in 1913. The MCH services thereafter gradually expanded. The first antenatal clinic was started at the De Soysa Lying-in-Home in 1921.

An organised effort to provide maternal and child health services dates back to the mid 1920s with the introduction of the Health Unit System, which was to provide institutional and domiciliary, care for mothers and children. The first Health Unit was established in 1926 at Kalutara. This system was thereafter extended and by 1936, eight such health units were established.

The control measures adopted following the Malaria epidemic of 1935 led to the further expansion of the Health Unit system. Under the Malaria Control and Health Scheme, Field Medical Officers were appointed to implement the programme of preventive health and malaria control. The maternal and child health infrastructure which commenced through the Health Unit System was linked to the expanding malaria control programme. The medical officers recruited under this scheme provided MCH services at the health centres which proved to be very popular. Trained public health midwives were appointed to these Health Units. By 1950, 91 Health Units were established.

The above system provided domiciliary as well as clinic services during pregnancy, trained assistance at delivery through institutions or at home, domiciliary and clinic based services during the postnatal period and infancy. This contributed significantly to lowering of maternal and infant mortality in Sri Lanka. Maternal Mortality declined from 19.9/1000 live births in 1937 to 10.6 in 1947 and infant mortality from 170 per 1000 to 80 per 1000 live births during the same period.

Development of MCH infrastructure during the past six decades is illustrated in the above table. The number of hospitals with facilities for delivery has increased from 129 in 1941 to 452 in 1998. Similarly trained manpower for deliveries increased from 347 to 6745 during the same period.

Expansion of MCH services - 1941 to 1996

Years	Est. Popn.	No. of Hospitals *	Number of Mat. Homes #	Number of Midwives @	Number of Health Centers
1941	6178	129	12	347	NA
1945	6650	153	34	542	503
1950	7678	263	99	1053	701
1954	8385	270	104	1854	NA
1970	12516	NA	128	2680	1122
1980	14738	357	100	3350	1344
1986	16117	389	88	4652	1778
1989	16806	400	83	5030	1880
1993	17405	410	78	6533	1905**
1996	18336	426	60	6745	1915**
1998	18774	452	69	7007	1950**

* Includes Teaching, Provincial, Base, District, Peripheral Units and Rural Hospitals all of which have maternity unit facilities for deliveries.

Includes Central Dispensaries and Maternity Homes. Some of these have been upgraded as Rural Hospitals.

@ Includes both institutional midwives and field midwives.

** Estimated

Family Planning in Sri Lanka dates back to the early 1950s when an organized effort to introduce family planning was made in 1953 by the Family Planning Association of Sri Lanka. The Association's work was initially restricted to areas around the Colombo Municipality. Attention was mainly focussed on family welfare with a view to reducing maternal mortality, infant mortality and malnutrition. The work done by the association was given government recognition in 1954 in the form of a financial grant.

Though there was much opposition to family planning at the beginning, with time this gradually declined. Realising its importance, the government in 1958 entered into a bilateral agreement with the Royal Government of Sweden to conduct a pilot project in community family planning. The project was designed to investigate the prospects of family planning in Sri Lanka and study the attitudes of people towards family planning. The results of this project were encouraging. In the pilot areas, the crude birth rate showed a promising decline and an increasing positive attitude to family planning was seen within the community. The project also demonstrated that family planning could be successfully integrated with the existing MCH services, which were already widespread within the country.

The ten-year plan of 1959 highlighted the implications of post war increase in population growth and particularly its effect of diverting investment away from direct productive activities to social sectors. In 1960 a labour force survey conducted with the assistance of ILO showed that unemployment rate was over 10 percent. In view of the above it became evident to policy makers that the population growth rate needs to

be brought under control. Based on these experiences, the government accepted family planning as national policy in 1965. It was integrated with the already well-developed Maternal and Child health services provided through the Ministry of Health. Considering its national importance a separate division was established in 1968 within the ministry to implement the programme throughout the country. This was initially designated the *Maternal and Child Health Bureau*.

In 1970, the government made a positive statement towards family planning. It stated that "though family planning would not be a solution to the economic ills of the country, nevertheless family planning facilities should be made available on a more intensified scale." The government's five-year plan presented at the end of 1971 stated "family planning should be made available to all groups and not be confined to the privileged section of society". From 1972, the family planning programme had the necessary political endorsement. The government sought the assistance of International Organisations to financially support the expansion of services within the country.

In 1972, 100 pilot projects were started, one in each MOH area, to coordinate activities such as MCH, family planning, nutrition, immunization, health education etc. Based on the experience gained from these pilot projects, the MCH/FP programme received a new dimension with a more comprehensive approach towards the family. The Bureau was re-designated the Family Health Bureau in 1972 and the programme was named the Family Health Programme.

The Family Health Bureau was made the central organisation of the Ministry of Health responsible for planning, co-ordination, direction monitoring and evaluation of the family health programme. The staff at the Family Health Bureau was strengthened to man five units, namely, Training, Health Education, Plantations, Supplies and Services and Evaluation and Research, initially.

In 1977, the government policy on population was enunciated and the subject of population was gazetted as a function of the Ministry of Plan Implementation directly under the President. In August 1978 the first Project Ministry, the Ministry of Colombo Hospitals and Family Health was established. One important function of the Ministry was to improve the delivery of maternal care, child care and family planning services in the country particularly in the rural periphery. In 1989, the Population Division together with the Population Information Centre came under the Ministry of Health and Women's Affairs facilitating close co-ordination between the population division and the FHB.

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

Organisational structure for delivery of services

In the implementation of the RH programme, the Family Health Bureau (FHB) play the central role maintaining a close collaboration with the National Cancer Control Programme (NCCP) and the National STD/AIDS Control Programme (NSACP). In this role, the FHB undertakes, in-service training of health personnel in RH; offers technical assistance in programme management and service delivery; conducts relevant health services research to support and strengthen service delivery; and monitors and evaluates programme performance. In addition, the Bureau is responsible for the procurement and distribution of contraceptives, equipment and other supplies needed for family planning and maternal and child health services.

In the delivery of RH services, the Ministry of Health continues to utilize its well-developed health infrastructure consisting of a network of medical institutions (larger, intermediate and smaller peripheral institutions) and Health Units. The latter are responsible for preventive and promotive aspects of health including domiciliary services in MCH and family planning. Currently there are 258 Health Unit areas with populations ranging from 40,000 to 60,000.

The Health Unit area is a clearly defined area, which is congruent with the administrative divisions of the country. Health Units are managed by Medical Officers of Health, also referred as Divisional Directors of Health Services (DDHS) and are supported by a team of public health personnel comprising one or two Public health Nursing Sisters (PHNS), 4-6 Public Health Inspectors (PHI), one or two Supervising Public Health Midwives (SPHM) and 20-25 Public Health Midwives (PHMs).

Each Health unit area is subdivided into PHM areas, which constitute the smallest working unit in the government system. Currently there are approximately 5000 PHMs in service.

The PHM is the "front line" health worker for providing domiciliary MCH/FP services in the community. Each PHM has a well-defined area consisting of a population ranging from 2000-4000. Through systematic home visits, she provides care to pregnant women, infants and pre-school children and family planning services including counselling and provision of contraceptive pills and condoms to couples in the reproductive age. She also provides necessary education and advice to adolescents on RH where needed and educates women on the importance of screening for reproductive organ malignancies thus motivating them to attend the "Well Woman Clinics" for necessary check-up. She also assist routinely at the area MCH/FP clinics which are conducted fortnightly, linking the community with the institutional health system. Her activities are supported by a system of record keeping which enables her to plan and monitor her routine activities.

The Estate sector has its own health care system and provides MCH/FP services to the estate population with necessary support from the Ministry of Health. MCH//FP services are provided by the estate health staff (Estate Medical Assistants and Estate Midwives) similar to that provided by the government sector.

Since 1989, the country's administration has been decentralised with greater devolution of administrative powers to the provinces for certain subjects/areas. Health is one of the devolved subjects and practical issues in the working relationships between the centre and the provinces are sometimes ambivalent and strained. Each Provincial Council, has a Provincial Director of Health Services (PDHS) who is responsible for total health care within the province.

The non-governmental sector too provides an important supportive function to the government programme especially in the areas of family planning, adolescent health and STD/HIV prevention. Four non-governmental organizations namely the Family Planning Association of Sri Lanka (FPASL), Population Services Lanka (PSL), Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC) and Community Development Services (CDS) had been complementing the government family planning programme for 2 to 3 decades and are considered as partners in programme implementation.. Other NGOs like Sarvodaya, Mahila Samithi, CENWOR have also included IEC activities related to RH into their community development programmes, thus helping to take the concept of RH to the community.

The private sector, which includes private hospitals, nursing homes and independently practising general medical practitioners, also provide RH services of a varying degree. Although data is not available, it is known that a considerable proportion of patients with RH problems use services in the private sector.

Service delivery

The government of Sri Lanka is committed to provide a comprehensive system of health care to its people. Maternal and Child Health and Family Planning forms an important component of the prevailing health care system and is an integral part of the Primary Health Care service strategy. Maternal health, Child health and Family planning are closely integrated and the following services are provided through the well developed infrastructure of the Ministry of Health, which comprise a wide network of medical institutions and health units. The Family Health programme covers a wide spectrum of services comprising:

1. Maternal care
2. Infant and Child care which provides for–
 - Immunization against six common childhood diseases,
 - Monitoring growth and development
 - Psychosocial development of the child,
 - Control of Diarrhoeal Diseases, and
 - Acute Respiratory infections
3. Nutrition of the pregnant mothers and children
4. Care of the School child
5. Adolescent health
6. Family Planning

Appropriate maternal care is provided to all pregnant women during antenatal, intranatal and postnatal periods through the health care system.

Antenatal care is provided through a network of MCH clinics conducted in medical institutions and by Public Health personnel in the field. These clinics are usually

conducted once a fortnight. In addition domiciliary care is provide by Public health Midwives through routine home visiting. Pregnant women are registered for antenatal care early and a "Pregnancy Record" is maintained to facilitate proper follow-up. "High-risk" mothers are identified and special care is provided through out pregnancy and delivery. A system of referral exists for cases that need special care.

As a routine all pregnant women are provided immunization with tetanus toxoid. This together with clean delivery practices has reduced the incidence of neo-natal tetanus dramatically enabling Sri Lanka to achieve elimination levels.

Births in government medical institutions have increased steadily during the past four decades. Easy access to institutional care and regular contact with the PHM appears to have influenced the choice in favour of institutional deliveries. Of the deliveries that take place in government institutions, almost 68% occur in larger hospitals where specialist services are available.

Proportion of Institutional deliveries – 1960 to 1996

Year	Total Births	% in Govt Institutions
1960	361,702	53.0
1965	396,437	62.5
1970	367,901	66.3
1975	375,857	66.8
1980	418,373	75.6
1985	389,599	75.2
1989	357,964	79.4
1995	343,224	86.8
1998	323,926	88.8

Source: Medical Statistical unit, Ministry of Health

Still 4-5 percent of deliveries receives untrained assistance. This practice is confined mainly to the remote areas of Sri Lanka and areas subjected to conflict where the services of PHMs are not readily accessible and also to the plantation sector where line room deliveries are still reported to be high. It is likely that in these areas, elderly women who had been traditionally attending to deliveries are called for assistance at the time of need.

After delivery the mother and child are followed at home by the area PHM with necessary post partum care (including advice and guidance) being provided during these visits. Routine statistics reveal that approximately 65 percent of women receive post-natal care at least once during the first ten days after delivery (Annual Family Health Report - FHB)

Infant and child health is an important component of the programme. Monitoring growth and development, immunization against the six child hood diseases, psychosocial development, control of diarrhoeal diseases and acute respiratory infections are important activities targeted towards this group. Since the commencement of the Expanded Programme of Immunisation (EPI) in 1978 much has been achieved in the field of immunization against the EPI Diseases. Measles immunization was introduced on a national scale in 1985 and currently almost 92 percent are immunized yearly.

Improving of women's nutritional status, including that of the girl child and promotion of exclusive breast-feeding are two areas where much emphasis has been given in the recent past by the national authorities. The concept of the "Baby Friendly Hospital Initiative" has been actively promoted during the past four to five years with necessary measures taken to declare hospitals "Baby Friendly" according to the UNICEF/WHO criteria. All major hospitals and the majority of the District Hospitals have been declared "Baby Friendly".

The National Family Planning programme adopts a 'cafeteria approach' to family planning. The clients are given the option of selecting a family planning method of their choice from a wide range made available through the service centers. To facilitate decision making by the client, advice and counselling on family planning methods are provided by the health workers at all levels.

In the Government programme, family planning services are provided through medical institutions and Family Planning clinics and by public health personnel engaged in field activities. Currently there are more than 875 Family Planning Clinics providing temporary modern methods of contraception and over 100 medical institutions providing sterilization services in the country. In addition to the public sector, family planning services are also provided by certain non-governmental organizations (NGOs) such as the Family Planning Association of Sri Lanka (FPASL), Population Services Lanka (PSL), Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC) and Community Development Services (CDS).

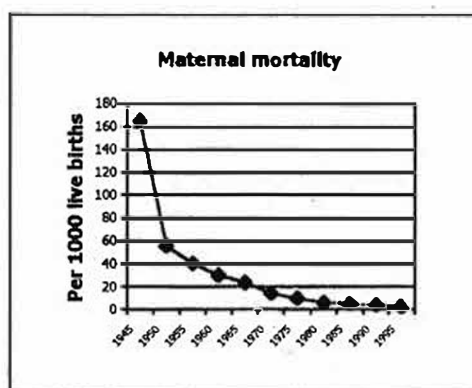
A screening programme for reproductive organ malignancies and certain other conditions have been introduced through the establishment of *Well Women's Clinics* in Health Unit areas. Trained medical officers conduct these clinics fortnightly or monthly. Women over 35 years of age could get themselves screened for conditions like hypertension, diabetes, breast malignancies and cervical cancers. If any abnormality is detected the clients are referred to the health care system where they would receive appropriate care through the specialist clinics. The PHM of the area will thereafter follow the cases in the field accordingly.

Achievements

- **Reduction in maternal mortality**

Maternal mortality showed a considerable decline during the past few decades from 1650 per 100,000 in 1945 to 58.5* per 100,000 live births in 1998

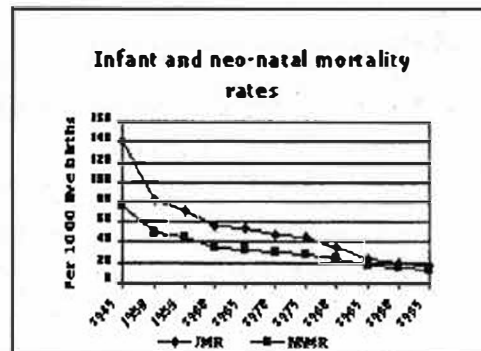
* Source: Maternal Death Investigation System - FHB



- ***A reduction in neonatal and infant mortality***

Infant mortality declined from 140 per 1000 live births in 1945 to 17.3 per 1000 in 1996. Similarly neo-natal mortality has declined from 75.5 per 1000 live births to 12.9 per 1000 in 1996.

Source : Registrar General's Department



- ***Reduction in peri-natal mortality***

Perinatal mortality has declined from 77 in mid 1940s to 66 in 1966. Since official RG data are not available, recent studies have shown that perinatal mortality is currently around 32* per 1000 births

*Source: Study on Low Birth Weight and Neonatal Morbidity and Mortality, FHB, 1988.

- ***Reduction child mortality***

Child mortality has declined considerably during the past few decades. Child Mortality Rate has declined from 24.7 per 1000 children under 5 years in 1950, to 2.8 per 1000 in 1981 and 0.9 per 1000 in 1996

- ***High coverage of Antenatal care – domiciliary and clinic***

More than 98 percent of pregnant women received antenatal care during pregnancy (DHS - 1993). More than 95 percent of deliveries receive trained assistance at delivery.

- ***High proportion of deliveries by trained personnel***

More than 94% receive trained assistance at the time of delivery (DHS 93). During 1998, 88.8 percent of births were in government hospitals.

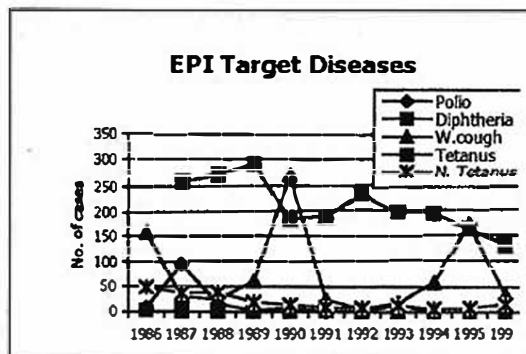
- ***High level of infant immunisation***

Sri Lanka achieved Universal Immunization status in 1989, where over 80 percent of infants were immunized with all six antigens.

- ***Marked decrease of EPI target diseases***

Morbidity due to immunizable diseases showed a marked decline since the introduction of the EPI programme.

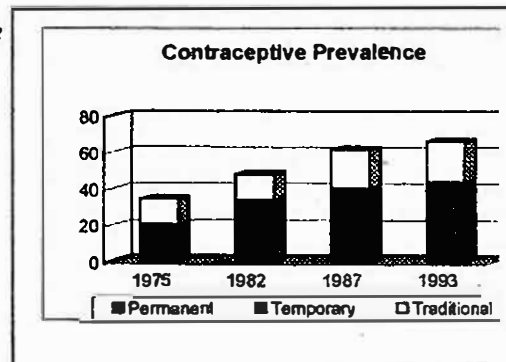
Confirmed cases of diphtheria have not been reported during the period 1993 to 1998, while confirmed cases of polio had not been reported during the period 1994 to 1998.



Neonatal tetanus too has decreased remarkably reaching almost elimination levels.

- ***High contraceptive prevalence with a rate of more than 66 percent.***

Contraceptive prevalence has increased from 34% in 1975 (WFS) to 66.1% in 1993 (DHS 93) with 44% using modern methods of contraception.



- ***Marked reduction in fertility almost reaching replacement level.***

Fertility has declined in all age groups reaching a Total Fertility Rate around 2.1. The crude birth rate declined from 38 per 1000 population in 1946 to 17.3 per 1000 in 1998.

Although Sri Lanka has achieved effective service coverage in MCH/FP, the quality of service delivery needs further improvement to face the challenges of the new millennium.

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