MEDIUM TERM PLAN

FAMILY HEALTH PROGRAMME 1985 – 1989

FAMILY HEALTH BUREAU
MINISTRY OF HEALTH
SRI LANKA

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1985 – 1989

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FOREWORD

During the past two decades the Family Health Programme has achieved considerable progress in the delivery of Maternal, Child Health and Family Planning Services. Significant gains have been achieved both in terms of service coverage and impact. Further improvements however will require a more selective and precise approach if future strategies and efforts are to succeed. Towards this end, prevailing strategies would need to be reviewed in order to strengthen existing mechanisms or new strategies developed that would meet desired levels of implementation. It is in this context that the preparation of a Medium Term Plan for Family Health was undertaken, to cover the period 1985 to 1989.

It is envisaged that this plan would provide some direction to the Family Health Programme during the plan period, and would improve decision-making related to priority problems, target groups, choice of technologies and resource allocations, eventually leading to improvement in the efficiency and effectiveness of the Family Health Services.

As far as the Family Health Programme is concerned, this is the first time that a plan involving all components has been developed and it is not without a certain amount of trepidation that this task was undertaken. In this regard I must make mention of the encouragement given by Dr. S. D. M. Fernando, Director General of Health Services, the quiet insistence of Dr. K. H. Notaney WHO Programme Co-ordinator & Representative for such a plan to be developed and the support extended by Dr. R. Liyanage Director (Planning), Ministry of Health. Finally my thanks are due to those colleagues at the Family Health Bureau and the Nutrition Department, Medical Research Institute for their willing co-operation in the preparation of this plan.

Dr. N. W. Vidyasagara
Director (MCH)

Family Health Bureau,
231, De Saram Place,
Colombo 10.
10th July, 1984.

CONTENTS

1. INTRODUCTION

In Sri Lanka a wide range of maternal and child health services is provided by the Government through a well developed health infrastructure which has grown steadily during the past four to five decades. These services are made available through a net-work of institutions comprising, hospitals with specialised services, district hospitals, peripheral units, rural hospitals, central dispensaries and maternity homes. This institutional net-work is linked to a system of health units that are primarily responsible for the preventive aspects of health and the domiciliary care of mothers and children.

The introduction of family planning by the national authorities commenced in the mid 1950's as a pilot project, designed to study the prospects for family planning in Sri Lanka and its acceptance by the people. Based on the experiences of this project, family planning was accepted as a part of national policy and integrated with the existing maternal and child health services. An organizational mechanism within the Ministry of Health was created at national level, to execute this decision.

The Family Health Bureau* is the central organization of the Ministry of Health that is responsible for the planning, implementation and evaluation of the family health programme. This Bureau also undertakes in-service training in family health for various categories of health functionaries, relevant health services research and extends technical support to programme administration. In addition the Bureau is responsible for the implementation of a number of MCH/FP projects funded by UN and other International agencies. The delivery of family health services is based on an integrated approach to maternal health, child health and family planning.

The post-war period has witnessed an improvement in the health status of mothers and children, as evidenced by the marked decline in maternal and childhood mortality during the last four decades. Though some of the concepts of the Primary Health Care approach have been a part of the health strategy in Sri Lanka, Primary Health Care has received an impetus after the Government became a signatory to the Health Charter of 1980, thus committing itself to the accomplishment of "Health for All by the Year 2000". Family Health consititutes an important and central element of the PHC strategy of the Government.

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*This Bureau was originally designated the Maternal and Child Health Bureau. In 1973, with the widening of its scope of activity the present name was adopted.

2. HEALTH AND POPULATION POLICIES

The Government of Sri Lanka is committed to provide a comprehensive system of health care to the people. In keeping with this committment a National Health Policy has been formulated. The policy will be:

(i) "To ensure that the provision of comprehensive health care is an integral component of the socio-economic development of the country.

(ii) To mobilise the necessary resources from both the public and private sectors.

(iii) To promote and sustain inter-sectoral and intra-sectoral co-ordina- for effective resource utilization.

(iv) To promote, mobilise and sustain community participation in health activities.

(v) To provide the necessary authority, technological capacity and resources to the relevant executive agencies, chiefly the Ministry of Health and vest them with the powers of implementation.

(vi) To review the current health situation at regular intervals and amend national health strategy accordingly.

(vii) To encourage self reliance among individuals to enable them to make the best use of community resources.

(viii) To encourage and promote research in health and health related subjects."

The policies of health-related sectors such as Agriculture, Food, Water-supply, Sanitation, Education and Local Government have been so formulated to permit their development individually and also be mutually supportive to health policies. The major thrust of these policies is oriented towards:

(a) Underserved population groups;
(b) Economically and socially disadvantaged groups in the population;
(c) Those sections of the population at higher risk of disease and death, namely children (0–4 years), pregnant and lactating women and others in the child bearing age;

The national policies on Population and Family Planning state that:–

(i) "All meaningful steps will be taken to curb unplanned growth of population;

(ii) Enhanced family planning services will be provided by the state and financial incentives with a view to controlling the population explosion; and

(iii) Emphasis will be in the field of service-oriented programmes to enable motivated couples and individuals to receive family planning services. and to undergo sterilization voluntarily."

In the context of policies and in the earnest desire to accomplish higher standards of living and acceptable levels of health, maternal and child care services including family planning have received considerable emphasis.

3. ANALYSIS OF THE CURRENT SITUATION

3.1. Demographic situation

The population of Sri Lanka at the 1981 census was 14.85 million. The crude birth rate and crude death rate were 28.0 and 6.0 per thousand population respectively, during 1981. The rate of natural increase declined during the last few decades and has averaged 2 percent per year for the period 1971–81. The registration system in Sri Lanka is complete to the extent of 98 percent in the case of births and 89 percent on the case of deaths.[1] An examination of the trend in birth and death rates indicates that while the birth rate remained almost stable during the period 1974–1980, the death rate recorded a gradual decline. The result has been a larger number of net additions to the population each year, which increased from 245,754 in 1974 to 329,736 in 1981. Projections indicate that the total population of Sri Lanka would be approximately 15.76 million during 1988, 17.52 million during 1991 and 19.70 million by 2001.[2]

Although the net addition to the population has increased, it is worthy of note that the Total Fertility Rate has declined gradually over the years and so also have the Age–Specific Marital Fertility Rates in each of the age-groups (Tables 1 and 2)

TABLE 1

Fertility Patterns in Sri Lanka

	1953	1963	1971	1977
General Fertility Rate	189.5	166.5	138.7	108.8
Marital Fertility Rate	256.2	239.4	215.0	187.3
Total Fertility Rate	5.3	5.0	4.2	3.8
Gross Reproduction Rate	2.6	2.5	2.1	1.9
Crude Birth Rate	38.7	34.1	30.1	28.4*

Source: Department of Census and Statistics

1. Post-enumeration Survey of the Population and Housing Census in 1981 – Department of Census and Statistics. (Personal communication)

2. A. T. P. L. Abeykoon. *"A Population projection for Sri Lanka* 1981–2001" PROGRESS, Vol. 2, Issue 4, Ministry of Plan Implementation, December 1982.

*Provisonal Crude Birth Rate for 1981 is 28.0
1982 is 26.8
1983 is 26.2 (Registrar General)

Age Specific Marital Fertility Rates in all age groups except 40–44 declined during the period 1963 to 1974. The decline was sharpest in the age group 25–34. During the period 1974 to 1978 the marital fertility in the age group 15–29 increased while it continued to decline in the higher age groups.

TABLE 2

Age Specific Marital Fertility Rates

1963 – 1978

Age	1963	1971	1974	1978	*Percentage Change*	
					1963–74	1974–78
15–19 ..	354	418	339	388	– 4.2	+ 14.5
20–24 ..	396	388	357	397	– 9.8	+ 11.2
25–29 ..	344	313	240	309	– 30.2	+ 28.8
30–34 ..	270	237	189	182	– 30.0	– 3.7
35–39 ..	175	157	139	107	– 20.0	– 23.0
40–44 ..	53	49	53	32	0.0	– 39.6
45–49 ..	8	8	7	4	– 12.5	– 42.8

Source: Department of Census and Statistics

Despite a significant reduction in the Total Fertility Rate, the population is expected to increase because of the decline in mortality and the rise in the number of births due to the increasing cohorts of women in the reproductive age groups. It should be noted that the number of women in the age group 15–49 increased from 2.997 million in 1971 to 3.792 million in 1981, and is expected to increase to about 4.283 million by 1986.

According to the 1981 census, 12.5 percent (1.86 million) of the total population constituted children below the age of 5 years and 25.5 percent (3.79 million) of the population constituted women in the reproductive age (15–49 years). While the former constitutes the target group for child health services, the latter constitutes the target group for maternal care and family planning. The numbers in these target groups are estimated to increase to 1.97 million and 4.28 million respectively by 1986. The detailed age distributions are presented in Table 3.

TABLE 3

Age Distribution of Children and of Females in Reproductive age 1971, 1981, & 1986

	1971		1981		1986	
	No. (in 1000)	*% of Total*	*No. (in 1000)*	*% of Total*	*No* (in 1000)*	*% of Total*
Children . .						
Under 1 year	365	2.9	406	2.7	421	2.4
1 – 4 . .	1,290	10.3	1,451	9.8	1,552	9.5
5 – 9 . .	1,663	13.2	1,689	11.4	1,834	11.2
10 – 14 . .	1,599	12.7	1,690	11.4	1,686	10.3
SUB TOTAL	4,917	39.0	5,236	35.3	5,493	33.7
Women (15–49)						
15 – 19 . .	667	5.3	792	5.3	822	5.0
20 – 24 . .	627	5.0	756	5.1	787	4.8
25 – 29 . .	472	3.7	636	4.3	750	4.6
30 – 34 . .	350	2.8	553	3.7	631	3.9
35 – 39 . .	357	2.8	416	2.8	549	3.4
40 – 44 . .	270	2.1	338	2.3	411	2.5
45 – 49 . .	254	2.0	301	2.0	333	2.0
SUB TOTAL . .	2,997	23.8	3,792	25.5	4,283	26.3
TOTAL POPULATION	12,608	100.0	14,848	100.0	16,293†	100.0

Source for 1971 & 1981 – Department of Census and Statistics

* Estimates derived by moving the size in one age group to the next after adjusting for the mortality experience.

† A.T.P.L. Abeykoon, *"A Population Projection For Sri Lanka,* **1981 – 2000**

Table 3 shows that while the number in the population in need of infant care services is expected to increase only marginally, the population in the pre–school and school age would increase significantly. The cohorts of women in the reproductive ages will record a significant increase in all age groups. Therefore the number that have to be provided with family planning services will increase over the plan-period. When reviewing the demographic situation it is worthy of note that significant fertility and

mortality differentials yet exist between socio-economic groups, as well as between geographical regions. (Table 4)

TABLE 4
Vital Statistics by Districts

District	*Crude Birth Rate** (1981)	*Crude Death Rate** (1981)	*Maternal Mortality Rate* (1979)	*Infant Mortality Rate* (1979)
SRI LANKA	28.0	6.0	0.8	37.7
Colombo	27.7	9.0	0.5	49.5
Gampaha	20.7	6.3	0.3	26.0
Kalutara	27.2	5.5	0.5	34.3
Kandy	25.6	6.9	1.2	60.3
Matale	30.3	5.2	0.6	31.0
Nuwara Eliya	27.9	7.0	1.7	79.2
Galle	24.0	6.0	0.9	38.4
Matara	29.0	5.6	1.1	35.7
Hambantota	30.8	4.5	0.4	23.7
Jaffna	27.9	5.2	0.2	18.0
Mannar	40.4	5.9	1.4	25.1
Vavuniya	45.1	5.2	1.2	26.3
Mullativu	32.6	2.9	0.0	17.5
Batticaloa	34.7	8.0	1.3	35.2
Ampara	30.6	4.7	1.2	23.5
Trincomalee	36.4	4.1	0.9	18.9
Kurunegala	26.4	5.4	0.6	32.4
Puttalam	32.8	5.5	0.5	21.9
Anuradhapura	36.7	4.9	0.6	21.1
Polonnaruwa	35.1	4.8	0.7	17.8
Badulla	26.0	5.9	0.9	56.6
Moneragala	38.7	3.5	1.2	22.4
Ratnapura	33.2	6.1	1.0	55.0
Kegalle	22.7	5.2	0.6	33.6

* Provisional

Source: Registrar General's Department

3.2. Health Problems of Children (0–4 years), Mothers (15–49 years) and Current Status of Contraception

Sri Lanka has achieved significant results in the control of disease and reduction of mortality. The crude death rate declined from 19.8 in 1946 to 6.0 in 1981.

3.2.1. *Children:* The Infant Mortality Rate of 141 in 1946 declined to 101 in 1947 and thereafter recorded a steady gradual decline reaching a level of 37.7 in 1979. (Table 5)

There is reason to believe that the Infant Mortality Rate is under-reported in some districts. However no studies have been conducted in this field.

TABLE 5
Trends in Infant Mortality Rates
1948 – 1979

Period	*Infant Mortality Rate (Registered)*
1948 – 1952	84.0
1953 – 1958	69.0
1959 – 1964	55.0
1965 – 1970	52.0
1971 – 1976	46.0
1977	42.4
1978	37.1*
1979	37.7*

*Provisional

Source: Registrar General

The cause of infant deaths during 1979 based on registration data (Table 6) indicate that perinatal disorders (41.4%), diseases of the respiratory system (14.3%) and infectious diseases (12.6%), together account for 68.3% of all infant deaths.

Among all children aged 1–4 years there were 4748 deaths during 1979, contributing to a mortality rate of 3.0 per 1000 population in this age group.

The cause of deaths of children aged 1–4 and 5–9 by major cause (Table 6) reveals that a large segment of mortality was due to communicable diseases, respiratory diseases, external injuries and nutritional deficiencies.

TABLE 6

Child Mortality by Major Cause According to Age Groups

1979

Causes	0 – 1		1 – 4		5 – 9		10 – 14		0 – 14	
	No. of Deaths	%	*No. of Deaths*	%	*No. of Deaths*	%	*No. of Deaths*	%	*No. of Deaths*	%
1. Infectious Diseases	1,987	12.6	1,154	24.3	470	21.5	270	17.9	3,881	16.0
2. Respiratory Diseases	2,255	14.3	1,011	21.3	236	10.8	114	7.6	3,616	14.9
3. External Causes of Injury	0	0	404	8.5	433	19.8	492	32.7	1,329	5.5
4. Avitaminosis and other nutritional deficiencies	284	1.8	351	7.4	98	4.5	26	1.7	759	3.1
5. Diseases of Nervous System and sense organs	473	3.0	328	6.9	195	8.9	113	7.5	1,109	4.6
6. Circulatory system Diseases	315	2.0	119	2.5	74	3.4	111	7.4	619	2.6
7. Gastrointestinal tract diseases	158	1.0	95	2.0	77	3.5	50	3.3	380	1.6
8. Haemotologic Abnormalities	63	0.4	76	1.6	31	1.4	20	1.3	190	0.8
9. Malignancies	32	0.2	57	1.2	50	2.3	32	2.1	171	0.7
10. Diseases of the Skin	315	2.0	38	0.8	11	0.5	5	0.3	369	1.5
11. Genitourinary tract diseases	32	0.2	38	0.8	35	1.6	26	1.7	131	0.5
12. Congenital Abnormalities	300	1.9	33	0.7	24	1.1	14	0.9	371	1.5
13. Psychiatric Disorders	16	0.1	24	0.5	13	0.6	7	0.5	60	0.3
14. Endocrinal Abnormalities	0	0	5	0.1	2	0.1	7	0.5	14	0.1
15. Diseases of Musculo skeletal System	16	0.1	5	0.1	15	0.7	6	0.4	42	0.2
16. Infant Perinatal Disorders	6,527	41.4	0	0.0	0	0.0	0	0.0	6,527	27.0
17. Other ill-defined causes	2,822	17.9	1,010	21.3	420	12.2	214	14.2		
All Causes	15,766	100.0	4,748	100.0	2,188	100.0	1,506	100.0	24,208	100.0

Source: Department of Census and Statistics

These conditions are largely preventable, provided specific and selective strategiesare designed and implemented as an integral part of child health services.

It is hard to obtain data on morbidity, particularly by age. The only two available sources of data are hospital based in-patient statistics and notifiable disease statistics. Both sources however provide an under-estimation of the actual morbidity in the population. However some recent prevalence surveys on nutritional status of infants and pre-school children conducted on a nation-wide basis indicate that acute under-nutrition and chronic under-nutrition are serious problems among sizable groups in the population. (Table7)

TABLE 7

The Percent Prevalence of Protein–Energy Malnutrition in Sri Lanka by Districts (F & NPPD Surveys)

District (Rural Sector)	*Acute Undernutrition*	*Chronic Undernutrition*	*Acute & Chronic (Concurrent) Undernutrition*
Hambantota ..	6.7	21.3	1.4
Matara ..	5.8	19.0	2.0
Nuwara Eliya ..	5.6	34.6	2.6
Matale ..	4.7	22.1	2.0
Moneragala ..	8.7	17.9	2.8
Puttalam ..	10.2	15.0	4.0
Vavuniya ..	4.6	22.0	4.3
Kurunegala ..	8.3	15.5	2.6
Ratnapura ..	8.1	22.5	0.7
Kegalle ..	6.4	22.6	2.4
Kandy ..	6.1	31.1	3.5
Ampara ..	9.7	26.9	3.2
Mullativu ..	4.9	28.1	1.0
Badulla ..	7.0	31.6	2.9
Gampaha ..	7.7	13.9	1.6
Galle ..	8.0	17.7	2.7
Kalutara ..	7.9	15.6	1.6
Mannar ..	6.4	26.7	4.1
Batticaloa ..	10.3	27.4	7.8
Trincomalee ..	11.8	22.4	4.2
Colombo ..	7.6	9.5	1.8
Anuradhapura ..	9.4	19.4	3.4
Polonnaruwa ..	7.7	14.6	3.7
Jaffna ..	4.9	25.0	1.6

Source: Nutritional Status, Its Determinants & Intervention Programmes Final Report, F & NPPD, Ministry of Plan Implementation Publication No. 12 (January 1983)

It follows from the definition of "Acute" Undernutrition (Table 8) that the respective magnitudes of the condition in the different districts represent the prevalence of the condition due to causative influences operating at or proximal to the time of survey.

The data should therefore be viewed against the respective period of survey. (Annexe IV)

TABLE 8
Categorization of Nutritional Status

Nutritional Status Category	*Height-for-age*	*Weight-for-Height*
"Normal" Nutrition	"Normal"	"Normal"
Acute Undernutrition ("Wasting")	Normal	Low[(a)]
Chronic Undernutrition ("stunting")	Low[(b)]	Normal
Concurrent Acute and Chronic Undernutrition (concurrent "wasting" and "stunting")	Low[(b)]	Low[(a)]

(a) Defined as less than 80% of Reference median weight-for-height
(b) Defined as less than 90% of Reference median height-for-age

Figures of Chronic Undernutrition on the other hand represent point prevalence. The causative influences of this condition, by definition, have been in operation for relatively long periods prior to the survey. It is not possible however to determine whether the influences were uniform in their intensity or not during such period.

The incidence of certain immunizable diseases relating to children shown at Table – 9, reveals that there has been a significant decline in the incidence of diphtheria, pertussis, tetanus, neo-natal tetanus, and poliomyelitis consequent to the commencement of an Expanded Programme on Immunization in 1978.

Waterlow, J.C., and I.H.E. Rutishauser (1974) Malnutrition in Man, in Early Malnutrition and Mental Development, Symposium of the Swedish Nutrition Foundation. XII, Ed. by Cravioto, J., Hambraeus, L., Vahlguist and Wiksell, Uppsala. pp. 13–26.

TABLE 9

Incidence of Immunizable Diseases in Childhood

Year	Diphtheria		Pertussis		Tetanus		Poliomyelitis		Measles		Tuberculosis*		Tetanus	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
1951	772	9.8	1236	15.7	970	12.3	239	3.0	2609	33.1				
1952	560	6.9	1146	14.2	873	10.8	255	3.2	1650	20.4				
1953	768	9.3	813	9.8	1033	12.5	226	2.7	1571	19.0				
1954	1057	12.4	1674	19.6	908	10.7	159	1.9	2424	28.5				
1955	1179	13.5	1941	22.3	873	10.0	102	1.2	3499	40'1				
1956	1323	14.8	1295	14.5	937	10.5	72	0.8	4273	47.0				
1957	929	10.1	1409	15.4	1007	11.0	334	3.6	3862	42.1	8854	96.6		
1958							201	2.1			9369	99.8		
1959	780	8.1	1955	20.3	959	10.0	321	3 3	2736	28.4	8321	86.5		
1960	1042	10.5	1786	18.0	1435	14.5	219	2.2	3060	30.9	10519	106.3		
1961	1041	10.2	1947	19.1	1621	15.9	306	3.0	3127	30.6	8411	82.7		
1962	740	7.3	1677	16.1	1181	11.3	1810	17.8	2567	24.6	9135	87.5		
1963	1040	9.9	2431	22.8	1067	10.0	166	1.6	3403	31.9	8135	76 4		
1964	953	8.9	1761	16.2	1972	18.1	223	2.1	3033	27.8	7774	71.3		
1965	1232	11.3	2109	18.9	1812	16.2	382	3.2	2037	18.2	6927	62.0		
1966	1436	12.6	2185	17.2	1323	11.6	332	2 9	3070	27.0	6168	54.4	280	75.0
1967	1453	12.5	1218	10.5	1994	17.2	144	1.2	2104	18.2	6304	54.5	458	123.9
1968	1148	9.7	1461	12.3	1825	15.4	1009	8.8	4544	38.4	6404	54 2	819	213.2
1969	972	8.0	2348	19.4	2013	16.7	186	1.5	3450	28.6	6261	51.9	623	167.1
1970	986	7.9	1651	13.4	2288	18.5	121	1.0	4086	33.1	5762	46 7	847	230.2
1971	715	5.7	1696	13.4	1961	15.5	330	2.6	4549	35.9	5650	44.7	647	169.2
1972	755	5.8	1984	15.0	2137	16.5	297	2.3	2712	20.9	6441	49.7	871	226.8
1973	496	3.7	968	7.3	2138	16.1	366	2.8	4923	37.2	5970	45.0	961	262.4
1974	251	1.8	525	3.8	2012	14.8	603	4.4	1577	11.7	6074	45.7	809	221.2
1975	310	2.3	1341	9.7	1998	14.5	190	1.4	4997	36.1	7324	54.2	812	222.0
1976	152	1.1	1040	8.0	2027	14.9	258	1.8	5631	39.8	6823	49.7	642	169.4
1977	147	1.0	1078	7.6	1927	13.7	127	0.9	5794	41.3	5994	42.9	821	216.7
1978	216	1.5	703	4.9	2028	14.2	153	1.0	6138	42.9	6360	44.8	874	217.0
1979	101	0.7	803	5.5	1486	10.2	143	1.0	8126	49.0	6152	42.0	423	107.8
1980	37	0.3	542	3.7	1243	8.5	264	1.8	5032	34.3	6212	42.4	339	82.8
1981	36	0.2	501	3.4	915	6.1	254	1.7	6185	41.4	6288	42.4	185	45.9
1982	20	0.13	271	1.8	633	4.2	84	0.56	13250	87.7	7334	48.6	169	40.5

Rate – per 100,000 population except in Neonatal Tetanus where Rate is per 100,000 births.

*all Age Groups

(*Source:* Epidemiology Unit, Ministry of Health)

However measles continues to be a significant cause of childhood morbidity in the absence of an immunization programme. Steps are being taken to remedy this situation by introducing measles vaccine into the immunization programme from 1984.

3.2.2. *Mothers* (15–49)

There has been a decline in maternal mortality from 1.4 per 1000 live births in 1971 to 0.8 in 1979. (Maternal deaths also decreased in absolute terms from 521 in 1971 to 316 in 1979).

TABLE 10
Maternal Mortality
1971 – 1979

Year	*Number of Maternal Deaths*	*Maternal Mortality Rate*
1971	521	1.4
1972	514	1.3
1973	444	1.2
1974	375	1.0
1975	385	1.0
1976	355	0.9
1977	383	1.0
1978	341	0.8
1979	316	0.8

It is worthy of note that there are significant differentials in Maternal Mortality by districts as shown in Table – 4. No data is available regarding differentials in maternal mortality by social class.

TABLE 11
Maternal Deaths by Age – 1973 & 1978

	1973		1978	
Age	*No. of Maternal Deaths*	*Rate per 1000 live Births*	*No. of Maternal Deaths*	*Rate per 1000 Live Births*
15 – 19	19	0.8	27	0.9
20 – 24	107	1.0	81	0.6
25 – 29	106	1.0	87	0.7
30 – 34	82	1.2	65	0.9
35 – 39	89	2.1	62	1.7
40 – 44	30	3.0	12	1.4
45 – 49	7	5.2	6	5.2
All Ages (15–49)	444	1.2	340	0.8

Source: Department of Census and Statistics – Vital Registration data.

In the period 1973 to 1978, maternal mortality declined in all age groups except in those aged 15–19 and 45–49. Analysis of data on the cause of maternal deaths indicates certain potential areas for intervention.

TABLE 12

Cause of Maternal Deaths – 1978

Causes of Maternal Deaths	*Number*	*Percent*
1. Toxaemia of pregnancy and puerperium . .	88	25.9
2. Haemorrhage of pregnancy and child birth . .	114	33.5
3. Abortion	22	6.5
4. Sepsis of child birth	20	5.9
5. Other complications of pregnancy, child birth and puerperium	95	27.9
6. Delivery without mention of Complications . .	01	0.3
All Deaths	340	100.0

Registrar Generals Department

Two specific conditions namely haemorrhage and toxaemia of child birth and the puerperium, accounted for 59 percent of all maternal deaths during 1978. When sepsis due to child birth is added, the three conditions together account for about 65 percent of all maternal deaths. This would mean that about two thirds of maternal deaths that occurred in 1978 had a strong potential for reduction if specific interventions were designed and directed towards these three conditions.

With decline in fertility, a higher proportion of pregnancies will be those of primigravidae. Since risk of maternal mortality is higher among primigravidae, efforts should be directed towards providing this group with total service coverage. Since conditions associated with pregnancy such as anaemia could also be dealt with by such service coverage, this in turn would also contribute to an improvement in the health of the new-born.

3.2.3 Contraception

Contraceptive use in Sri Lanka has increased since the early 1970s. Contraceptive prevalence increased from 32% in 1975 (WFS) to 47.7% in 1982 (FHIS), the increase being mainly due to the greater use of modern methods. (Table – 13)

WFS: World Fertility Survey
FHIS: Family Health Impact Survey

TABLE 13
Percentage of Respondents by Type of Contraceptive Method used

Method	*WFS* 1975	*FHIS* 1981/82
Permanent Methods	9.9	23.9
Temporary Methods	8.9	9.8
Traditional Methods	13.2	14.0
Total	32.0	47.7

A predominant feature during the period 1975 to 1981 is a shift towards the use of sterilization as a method of contraception. The proportion of respondents resorting to sterilization increased dramatically from 9.9% in 1975 to 23.9% in 1981/82, whereas the use of temporary modern methods showed only a marginal increase.

This shift towards sterilization is also reflected in the routine statistics processed monthly by the Family Health Bureau. (Table – 14).

TABLE 14
New Acceptors of Family Planning by Method 1971 – 1983

Year	*Tubectomy*	*Vasectomy*	*IUCD*	*Pill*	*Injectable*
1971	4,090	245	11,446	25,828	—
1972	9,078	498	18,599	32,300	—
1973	18,398	1,850	27,558	34,214	—
1974	34,942	7,292	29,693	NA	—
1975	33,130	6,034	32,755	NA	—
1976	32,664	2,924	27,030	25,597	—
1977	17,753	1,302	21,321	27,514	—
1978	19,624	2,325	23,085	31,146	3,046
1979	30,003	5,640	21,187	30,394	5,932
1980	61,642	51,284	19,232	29,296	9,706
1981	46,300	30,333	14,833	22,189	8,142
1982	48,873	13,048	16,115	26,231	10,211
1983*	64,798	46,979	16,329	33,821	11,271

3.3. Organization of Family Health Services

Sri Lanka has a well developed health infrastructure with a capacity to provide comprehensive health services throughout the country.

For purposes of health administration, the country is divided into 20 Health Divisions (Regions), each division in charge of a Regional Director of Health Services (RDHS) who is responsible for total health care within the division. Each Health Division is further sub-divided into Health Unit Areas and each Health Unit Area is in charge of a Medical Officer of Health (MOH) who is responsible for all promotional and preventive health activities within a defined area. The MOH is supported by a team of para-medical staff comprising of Public Health Nurses (PHN), Public Health Inspectors (PHI), and Public Health Midwives (PHM). The Health Unit area (MOH area) is further sub-divided into Public Health Midwife areas. Each health area is also provided with a net work of medical institutions and health centres which provide institutional and clinic based maternal and child health (MCH) services. The estate (plantation) sector is also serviced by MCH clinics, conducted on the estates either by visiting medical officers or by estate health staff and is of recent origin, following the nationalization of the larger estates in the plantation sector.

The Family Health Bureau at national level serves a 'staff' function with regard to family health and is responsible to the Ministry of Health for the planning, co-ordination, monitoring and evaluation of MCH/FP services. In addition this Bureau also provides central support services by way of training and the provision of nesessary supplies & equipment. The Organization of the Family Health Services is illustrated in Annex I.
In support of Primary Health Care, a decision has recently been taken to re-organize the health care delivery system at the periphery, based on a three-tier model (PHC complex). Annex II.

Based on this model, there will be a Gramodaya Health Centre served by a PHM for a population of 3000. The Gramodaya Health Centre will provide elementary clinic facilities at village level and would also provide suitable accommodation for the PHM, to reside in the area in which she works, thereby facilitating a closer link with the community.

The next level of care in this model would be a Sub-Divisional Health Centre serving a population of 20,000. This would be staffed by one Assistant/Registered Medical Practitioner, two Public Health Inspectors and one Supervising Public Health Midwife.

At the apex of the PHC Model would be the Divisional Health Centre (DHC) that would serve a population of approximately 60,000. This centre would include a 60 bed hospital with a full complement of medical, nursing and paramedical staff. The DHC would also be responsible for the supervision and support services needed by the lower levels of the PHC complex. Each PHC complex will thus have 1 Divisional Health Centre, 3 Sub–Divisional Health Centres and 18 to 20 Gramodaya Health Centres. It is intended to have 202 such PHC complexes throughout the country. The establishment of such

a re-organized health care delivery system has already commenced. Annex III depicts the range of services provided at each level of the complex.

Above the PHC complex would be the higher levels of health care which would provide specialised services.

3.4. Service provision and population coverage

The MCH/FP programme covers a wide spectrum of services which include:–

- — Prenatal, natal and post natal care
- — Child care with emphasis on the Infant and Pre-school child
- — Immunization against common diseases of childhood
- — Family Planning
- — School Health
- — Maternal and Child Nutrition
- — Child Mental Health

TABLE 15
Coverage of MCH Services

Service provision indicators	1981	1982
(A) *Through Routine Service Statistics*		
1. *Maternal Care*		
a) Percent of Pregnant women receiving Antenatal Care* at Government Clinics	64.5	68.5
b) Percent of Pregnant women receiving domiciliary antenatal care† by PHM.	45.0	53.8
c) Percentage of deliveries conducted in Government Medical Institutions	76.8	77.8
d) Percent of deliveries conducted by trained health personnel (PHM.) at home	3.6	2.6
(The sum of (c) and (d) would indicate the percent of trained assistance by Govt. personnel).		
2. *Infant Care*		
Percent of infants cared for through Govt. MCH Clinics that are linked to the field MCH services	58.3	62.3
3. *Immunization*		
a) Percent of infants immunized with		
DPT — 3 doses	46.3	56.0
Polio — 3 doses	47.2	55.5
BCG —	58.1	63.8
b) Percent of Pregnant women who received 2 doses/booster dose of tetanus toxoid	47.5	47.1
4. *Family Planning*		
Percent of target achieved in respect of new FP acceptors ‡	82.0	77.1
(B) **Through Surveys**		
Current use of family planning methods (FHIS 1981/82)		
Permanent		23.9
Temporary Modern		9.8

*At least one visit to a MCH Clinic
†At least one visit by a PHM.
‡An individual who accepts a particular contraceptive method for the first time.

4. Programme Obstacles and Constraints

There are three major areas in Family Health which need to be addressed if objectives are to be achieved.
They are;

(i) The early detection and follow-up of;
   — Women during pregnancy and the post natal period
   — Infants and pre-school children

(ii) Improvement in the quality of maternal & infant care and care of the pre-school child.

(iii) Improvement of the Services directed at the School Child.

Deficiencies in these areas have been the result of many factors and sustained efforts are needed to correct them. Table 17 presents the factors responsible for each of the deficiencies and the remedies proposed. These remedial measures form part of the managerial process and are incorporated into the proposed strategy. The system of monitoring will be strengthened at each of the levels viz:national, district/regional, divisional/MOH and peripheral levels. This system would operate as a continuing process such that the managerial as well as technical deficiencies will be identified early and viable corrective actions taken.

TABLE 16

Programme Obstacles and Constraints

Deficiency	*Underlying Obstacles*	*Proposed Remedies*
Incomplete detection and follow-up of pregnant women, infants and pre-school children.		
(1) Insufficient active casefinding through routine home visits	— Lack of appreciation by Health Workers to have their work programme based on a quantified target population. — Lack of knowledge to be able to quantify target population. — Lack of supervision. — Lack of skills to be able to develop an informal alerting system within the community for early identification of individuals in the target groups.	Conduct task oriented training programmes for health workers and supervisory staff at local level. Establish a regular review mechanism at local level.
(2) Records not maintained systematically and inaccurate/incomplete reporting.	— Lack of appreciation of the importance and usefulness of accurate and complete data (and analysis) for: — Planning work programme and self assessment — Planning and evaluation at higher levels — Comparison of work performance and corrective actions at the various levels of the health system.	To provide appropriately designed inservice training-specifically directed towards on the job/experience oriented learning where participants will re-discover the practical use of the system.
(3) Poor back-referral from Medical Institutions after delivery	— Lack of knowledge and concern among institutional staff regarding patient care beyond the confines of the institution, although administrative provision for back-referral exists.	Strengthen administrative procedures to ensure and maintain adequate back-referral.
(4) Failure to establish the prescribed number of contacts between the target groups and the health system	— Inadequate knowledge and skills on work orgnization with specific reference to determining priorities within the target groups.	Within the system to develop selective approaches to high risk groups. More frequent supervision.
(5) Lack of initiative by the target groups to *maximize* use of available services.	— Inadequate information and understanding about specific elements of MCH and the timely utilization of services.	Introduce a Home Based Mother's Card and a Child Health Development Card with emphasis on the education of mothers in the use of these cards.

TABLE 16 *(Continued)*

Programme Obstacles and Constraints

Deficiency	*Underlying Obstacles*	*Proposed Remedies*
Inadequate Quality of Care	— Inadequacies in training — Inadequate supervision	Revision of training content with emphasis on a task oriented approach to training.
	— Inadequacies of basic clinic requirements in respect of accommodation, equipment and basic consumable items.	Design and establish a system for periodic review to implement corrective action at all levels.
	— Shortage of Health personnel – especially Medical Officers and Public Health Nurses.	Maximize the use of existing resources.
	— Inadequacies in repair and maintenance facilities for equipment.	Examine patterns of available funding and attempt reallocation according to priorities.
	— Inadequacies in transport due to shortage of vehicles, and insufficient funds for proper vehicle maintenance. — Inadequate funds for travel of field health staff.	Seek other avenues to meet shortfalls in available resources.
Inadequate Health Service provision for the School Child.	— Shortage of Medical Personnel — Inadequacies in travel requirements of medical personnel — Inadequacies in necessary equipment and supplies	Training of para medical staff to screen and detect abnormalities among school children with referral where necessary. Provide necessary equipment and supplies.

5. OBJECTIVES

The planning horizon of this programme is five years and the current plan period is 1985 – 1989.

The *impact objectives* of the Maternal and Child Health Programme are;

(i) To reduce maternal mortality from the current level* of 0.8 per 1000 live births to 0.6 per 1000 live births by the end of 1989;

(ii) To reduce infant mortality from the current level* of 37.7 per 1000 live births to 30 by the end of 1989;

(iii) To reduce neonatal mortality from current level* of 24.2 per 1000 live births to 21.5 per 1000 by end of 1989;

(iv) To reduce child mortality (1–4 years) from the current level* of 3.15 per 1000 children to 2.0 per 1000 by end of 1989;

(v) To increase the percentage of new borns having birth weight of at least 2500 gms from the current level† of 75 percent to 78 percent by the end of 1989;

(vi) To reduce crude birth rate from the current level† of 28.4 per 1000 population to 24 by the end of 1989;

The *coverage objectives* of the programme are:

(i) To increase the percentage of pregnant women receiving antenatal care at Government Clinics from the current level‡ of 68.5 to 80 by the end of 1989;

(ii) To increase the percentage of pregnant women receiving domiciliary care through Public Health Midwives from current level‡ of 53.8 to 75 by the end of 1989;

(iii) To increase the percentage of deliveries conducted under the supervision of trained Government Health Workers from the current level ‡ of 80 to 88 by the end of 1989;

(iv) To increase the percentage of infants covered by child care services from the current level‡ of 62 to 80 by the end of 1989;

(v) To increase immunization coverage of infants with BCG from 63.8% in 1982 to 88% by 1989; 3 doses of DPT and OPV from 56.0% and

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* Current level' refers to 1979
† Current level' refers to 1980
‡ Current level' refers to 1982

Percent based on total births in the population. However it must be noted that the coverage provided directly by the Ministry of Health does not extend to the 5 major Municipalities & the Estate Sector which have their own health personnel.

55.5% respectively in 1982 to 78% by 1989. To introduce immunization against measles as part of routine immunizations from 1984. To increase the coverage of tetanus toxoid to pregnant women (for protection against neonatal tenanus) from current level‡ of 47.1% in 1982 to 78% by 1989;

(vi) To increase the use of modern contraceptive methods from the current level‡ of 33.7 percent to 40 percent by end of 1989.

(vii) To increase coverage of school health services from the current level‡ of 8 percent to 50 percent by 1989.

Though childhood immunization is an integral component of the routine MCH services, special emphasis has been directed towards this activity as part of an Expanded Programme on Immunization, currently under operation which is directed towards accomplishing immunization coverage objectives.

6. STRATEGIC INTERVENTIONS

6.1. Service Strategies

The broad service strategies to be employed for accomplishing the objectives are listed below. Improved ante-natal care, delivery practices, post-natal care and child-care will form the corner-stone of these strategies.

(a) Active surveillance of pregnant women with special emphasis on high risk groups:
- — Early detection of all pregnant women
- — Provision of basic antenatal care to all pregnant women
- — Early diagnosis of high risk pregnant women

(b) Management of delivery and complications during delivery:
- — Provide for a safe delivery as planned during the antenatal period

(c) Management of the new born and care of the mother during the postnatal period:
- — Provide trained assistance to the mother and the new born during the postnatal period.

(d) Provide basic infant and child care services including specific measures aimed at reducing childhood morbidity and mortality:
- — Provide basic infant and child care services at home and at clinics
- — Maintain and expand specific programmes/preventive measures in respect of the immunizable diseases in childhood, diarrhoeal diseases, malnutrition, child mental health and home accidents.

(e) Provide Family Planning Services:
- — Provide specific information about family planning methods in order to reduce the gap that exists between awareness and use of modern methods of contraception (Family Health Impact Survey)
- — Improve service availability by expanding the service outlets and making possible a wider choice of methods.

(f) Improve School Health Services:
- — Train paramedical staff to undertake screening of school children with a view to detection of defects and their early correction

STRATEGIES AND ACTIVITIES – FAMILY HEALTH PROGRAMME 1985 – 1989

Specific Strategy	*Activities*
1. Early detection of all pregnant women	— Early diagnosis of pregnancy — Systematic home visiting within the community — Establish reliable information sources at village levels for obtaining information regarding target groups — Create awareness within the community regarding the service facilities available for pregnant women
2. Provide basic antenatal care to all pregnant women	— Motivate all pregnant women to seek adequate antenatal care through the domiciliary services and at clinics. — Create awareness in the community regarding the importance of adequate antenatal care — Active follow-up of all pregnant women. Plan and implement a programme of systematic home visiting and clinic services to ensure complete coverage of all pregnant women. — Ensure that service coverage is sustained both in terms of quality and quantity (a) Monitor home visits and clinic attendance. (b) Monitor basic service elements provided during home visits and at clinics (clinical examination, basic investigations, VDRL, administration of tetanus toxoid) (c) Monitor appropriate management of high risk mother and referral when needed. — Use of Home Based Mother's Card, to create an awareness and a means to self-monitoring of progress during pregnancy. — Provide adequate information to pregnant women on normal pregnancy, antenatal care, nutrition, preparation for delivery, post-partum period, breast feeding including preparation for breast feeding, care of the new born, neonatal tetanus, personal hygiene and family planning. — Provide training/refresher training to staff. — Organize health education programmes in the community. — Train community leaders/health volunteers — Utilization of mass media.
3. Early diagnosis of high risk pregnant women	— Create awareness in the community that high risk pregnant women require special care. — Specific training for detection of high risk pregnant women and appropriate interventions that would be necessary. — Detection of cases with high risk factors: (a) Those with complications during previous pregnancy. (b) Those found to have complications during the present pregnancy. — Regular physical examination and adequate support services through domiciliary visits and at clinics. — Referral to higher levels of care whenever necessary. — Planning with mothers the place of confinement in order to ensure a safe delivery.

4. Provide for a safe delivery as planned during the ante-natal period
   - — For institutional delivery – educate and encourage mothers to seek admission at the appropriate time. Special emphasis to be given to those with high risk.
   - — Teach mothers/relative how to recognize symptoms and signs of early labour.
   - — For a home delivery, inform mother/relative where trained assistance could be sought.
   - — Train mother/relative on basic preparation/requirements needed for a home delivery.
   - — Train health staff in the management of delivery and its complications.

5. Provide trained assistance to the new-born and mother during the post-natal period
   - — Train health staff (inservice/refresher) on care of the mother and infant during the post-partum period.
   - — Train mother/relative in basic care of new-born and mother after delivery.
   - — Referral from institutions with relevant information about the delivery and the new-born to PHM.
   - — Provide *early* domiciliary care to mother and new-born and follow-up during post-natal period.
   - — For delivery at home *with* trained assistance, provide adequate post-natal care to mother and new-born through regular follow-up visits.
   - — For delivery at home *without* trained assistance, provide trained assistance as early as possible and further care through follow-up visits.

6. Provide basic infant and child care services at home and at clinics including specific measures aimed at reducing childhood morbidity and mortality
   - — Provide follow-up and necessary advice through regular home visiting.
   - — Identify those in need of special care and provide referral.
   - — Provide clinic services to all infants and pre-school children which would include:
     - (a) Immunization with BCG, 3 Doses of DPT and 3 Doses of OPV and measles vaccine at recommended ages. Immunization Schedule – Annexe V
     - (b) Regular weighing and use of growth chart.
     - (c) Periodic screening of infant.
   - — Proper record keeping at clinic and by PHM
   - — Reinforce education on breast feeding, infant feeding, weaning, immunization, personal hygiene, family planning.

7. Maintain and expand specific measures in respect of immunizable diseases in childhood, diarrhoeal diseases, malnutrition, child mental health and home accidents.
   - — To increase immunization coverage and promote the adoption of proper cold chain practices.
     - — Identify target group through systematic home visiting and provide immunization to the target population in accordance with the approved immunization schedule. Age appropriate immunization will be stressed
   - — To actively implement the National Diarrhoeal Diseases Control Programme.
     - — Introduction of ORT into the community as well as hospital practice, through training of health staff and volunteers.
   - — To introduce nutritional surveillance through the use of a Child Health Development Card.
     - — Training of health staff to educate mothers in the proper use of the Child Health Card.

	— Training of staff in: (a) Proper weighing of children (b) Correct recording of weight and other information (c) Identification of children requiring special care (d) Education of mothers in the significance of and proper use of the growth chart. — To introduce a scheme for the promotion of child mental health: — Training of health staff in the relevant aspects of prevention & early detection of child mental health problems and promotion of healthy psychosocial development. — Develop an awareness among health staff on their role in the prevention of home accidents. — Training of health staff to educate mothers in the care and prevention of home accidents at clinics and during home visits.
8. Provide specific information about Family Planning Methods	— Provide refresher training to health staff about FP methods currently in use. — Train staff in specific skills that would assist them to provide better counselling services. — Train staff to provide specific information about FP methods and assist couples in the selection of an appropriate method — Training in development of necessary skills for improving communication.
9. Improve service availability for Family Planning	— Maximize the utilization of existing service outlets by training existing categories of staff eg. RMP/AMP, PHN, in new service functions. — Increase the number of service outlets in underserved areas. — Expand the service coverage of DMPA where availability has hither to been restricted.
10. Improve the coverage of School Health Services	— Develop a comprehensive plan directed at improving coverage of schools,by individual MOH areas. — Maximize the utilization of all available medical personnel in the area. MOH, Hospital Medical Officer, RMP and AMP. — Train para medical health staff (PHNS and PHI) to undertake screening of children. — Identify children with abnormalities/deficiencies and correct defects whereever possible. — Provide referral to children requiring correction of defects at a higher level of service provision. — Maintain proper records at schools. — Monitor activities to assess progress and performance.

6.2. Support Strategies

Certain support strategies are proposed which would not only enhance the capability of the health system to deliver the services effectively, but also ensure support from communities and health related sectors. They are:

(i) Design and establish systems for progress review and corrective actions at all levels of the system

(ii) Plan and organize on-the-job, need based in-service training for all categories of staff at local level with emphasis on front line workers such as Public Health Midwives and hospital staff engaged in maternal care.

(iii) Prepare and make available work manuals for all health workers

(iv) Strengthen and improve the referral system.

(v) Train and utilize the services of volunteers in the community and collaborate with other relevant health related sectors and non-governmental agencies.

(vi) Promote and undertake problem-oriented field operations research to provide answers to some of the more important service delivery problems

(vii) Recruit and train additional staff to fill the existing gaps in the supply of manpower, viz. PHM, SPHM, PHN, MOH.

(viii) Strengthen Logistics and Supply Systems at divisional level such that essential supplies are available to the front line workers in adequate quantities at the right time.

(ix) Re-design systems and procedures for management of personnel with emphasis on building incentive and disincentive systems linked to organizational productivity.

7. MONITORING AND EVALUATION

Many aspects of the Family Health Programme can be monitored and evaluated through routine statistics while certain aspects need to be assessed through special studies. The Family Health Bureau has used both techniques for monitoring and evaluating certain areas of activity. It is intended during the plan-period to widen the scope of the subjects to be evaluated.

The following activities to strengthen monitoring and evaluation of family health services are proposed during the period.

Introduction of a revised system of record keeping and reporting in respect of Maternal Health, Child Health, and Family Planning that would provide for better monitoring and evaluation of performance at all levels.

Activities would consist of training of health personnel at Health Unit level in data collection, record keeping procedures and utilization of date for assessment of work performance. Training would also include interpretation and utilization of data at other levels of the health system, which would be linked to the efforts currently being directed towards strengthening District Level Health Planning and Management.

A scheme would be developed whereby relevant information on Maternal and Child Health, collected at Health Unit level, would be received routinely by the Family Health Bureau. This would provide for better monitoring of MCH activities and establish a system of feedback reporting.

New indicators:

The indicators in respect of MCH used in the past were mainly for monitoring service delivery. It is necessary to develop indicators which would help to monitor the quality of care provided through Maternal and Child Health Services. New indicators are presently being developed and the practicability of data collection would be field tested prior to its introduction into the routine health information system.

The new Child Health Development Card which will be tested and used island-wide, would provide vital information on infant feeding practices, achievements in respect of developmental milestones and psychosocial development of the child, in addition to information on physical growth.

— Indicators will be developed to monitor nutritional status of infants and pre-school children. The proportion of children whose weights for age are below the 3rd percentile (NCHS Reference population) will be used as an index of the prevalence of Protein Energy Under-nutrition in the community.

— Indicators will be developed to monitor trends in infant feeding practices at 3, 6 and 9 months of age respectively, in regard to breast feeding and introduction of supplementary foods.

— Indicators of child mental development which can be readily elicited (milestones) will be introduced and other indicators which focus on psychosocial development, will be tested.

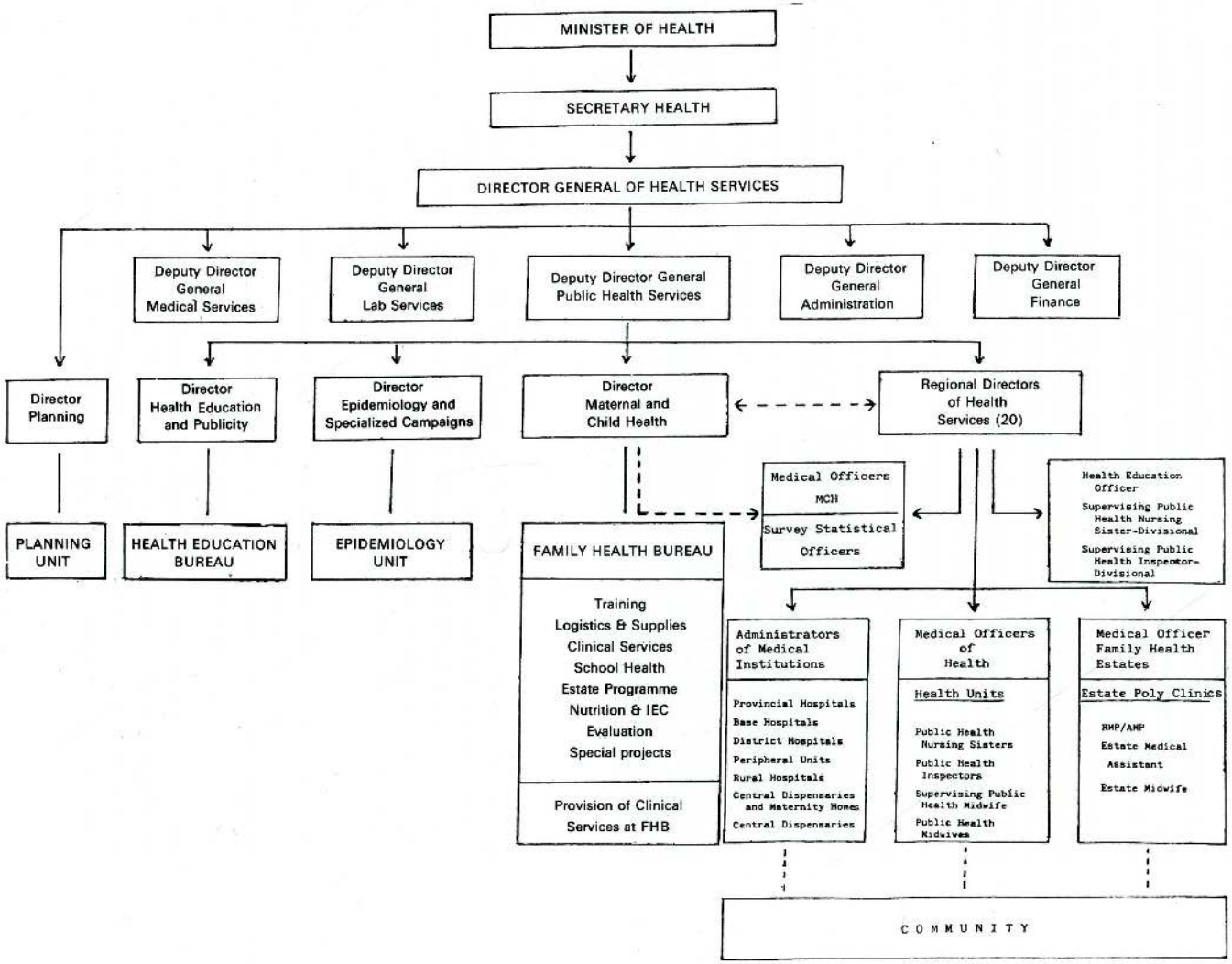
A scheme would be developed within the routine health information system that would enable periodic assessments to be made regarding the quality of maternal and neonatal care provided in the Government Health Care System. Indicators developed to assess quality of maternal and neonatal care would include –

Trained assistance at delivery
Pregnancy outcome
Complications at delivery
Maternal Morbidity and Mortality
Birth weight and survival rate of low birth weight infants upto the end of the neonatal period
Neonatal morbidity and mortality

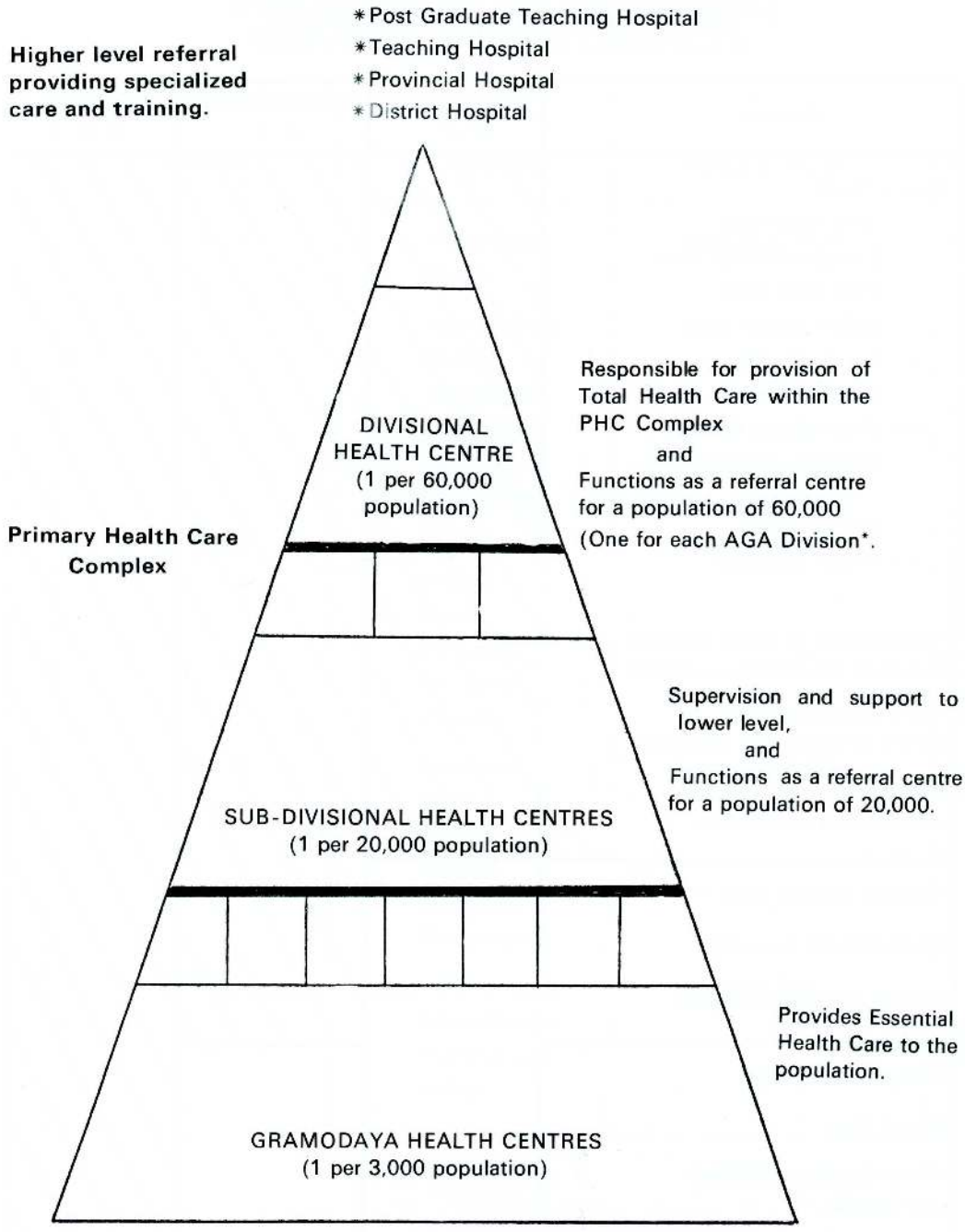
These indicators that are being developed and field tested for routine use through the Health Information System, if found to be operationally feasible, would provide very valuable information for improving the Maternal and Child Health Services in Sri Lanka.

ANNEXE I

ORGANIZATIONAL STRUCTURE OF THE FAMILY HEALTH SERVICES



PRIMARY HEALTH CARE COMPLEX



*AGA Division – Assistant Government Agent Division which is an intermediate administrative area.

ANNEXE III

SERVICES PROVIDED AT EACH LEVEL OF THE PHC COMPLEX

Services	*Gramodaya H. C.*	*Sub-divisional H. C.*	*Divisional H. C.*
Family Health — Ante-Natal Care — Emergency Natal Care — Post-Natal Care — Child Care — Family Planning — Immunization — Child Mental Health — Nutrition education and surveillance — School Health — Health Education			
Management of Minor ailments including the promotion of ORT Basic Laboratory Tests (Urine for Sugar and Albumen) Blood Filming for malaria parasite (where relevant)			
Outdoor Medical Care Environmental Sanitation Control of Comm. Diseases			
Indoor Medical Care Dental Care Minor Surgery, including sterilization Medico-Legal work			

TIME FRAME OF THE NUTRITIONAL SURVEYS OF THE 24 DISTRICTS

Cluster	*Districts*	*Period of Survey*
No. 1	Hambantota Matara	September 1979
No. 2	Nuwara Eliya Matale Moneragala Puttalam Vavuniya Kurunegala	June 1980
No. 3	Ratnapura Kegalle Kandy Ampara Mullativu Badulla	February 1981
No. 4	Gampaha Galle Kalutara Mannar Batticaloa Trincomalee	September 1981
No. 5	Colombo Anuradhapura Polonnaruwa Jaffna	January 1982

IMMUNIZATION SCHEDULE

Age	*Type of Vaccine*	*Minimum Interval for maximum response*
0–4 weeks	BCG (1st Vaccination)	
3 months	DPT and OPV (1st dose)	
5 months	DPT and OPV (2nd dose)	— Preferably 6–8 weeks after 1st dose.
7 months	DPT and OPV (3rd dose)	— Preferably 6–8 weeks after 2nd dose
9–11 months	Measles Vaccine	
In 2nd year (at 18 months)	OPV (4th dose) DPT (4th dose)	
School: Grade I (at 5 years)	*DT (Double Vaccine) BCG (for those not vaccinated earlier	
Grade V	BCG (2nd Vaccination)	
Pregnant Women	Tetanus Toxoid (1st Dose) Tetanus Toxoid (2nd Dose)	Interval of 6 weeks between doses

PROJECT ACTIVITIES IMPLEMENTED BY THE FAMILY HEALTH BUREAU DURING THE PERIOD 1985 to 1989

TITLE OF PROJECT	SUMMARY OF ACTIVITIES
1. Strengthening of Family Health Services. SRL/81/P05 – MCH 007 Project Period: 1982–1985 Funding Agency: UNFPA Executing Agency: WHO	This project has two broad components: Developing and upgrading of sterilization services in district hospitals and peripheral units, with a view to expanding service coverage. This would include physical upgrading –viz: civil works, equipment, supplies and the development of appropriate man-power through training of non-specialist medical officers in the techniques of sterilization. Training of health personnel and other support staff in selected aspects of MCH/FP, through programme reviews, workshops and inservice training courses. Provision has been made to include personnel at all levels of the system, from health administrators and supervisory staff to nursing staff and para medical personnel. Training in logistics for staff at central and regional levels is also included under this project.
2. Strengthening of Evaluation and Research, at the Evaluation Unit, FH Bureau. SRL/81/P07 – MCH 008 Project Period: 1982–1985 Funding Agency: UNFPA Executing Agency: WHO	Activities would be directed towards strengthening the capabilities of the Evaluation Unit, FH Bureau through inservice training/recruitment of personnel, strengthening or computer facilities and the provision of supplies and equipment. Training would include central level staff as well as statistical officers attached to the Regional Health Offices. This project also supports a study on the Continuation and Retention Rate of the oral pill and IUCD respectively.
3. MCH/FP Services for Estate Workers. SRL/81/P09 Project Period: 1982–1985 Funding Agency: UNFPA Executing Agency: UNICEF	Implemented in collaboration with the two Government Estate Agencies – Sri Lanka State Plantations Corporation & Janatha Estates Development Board. Activities cover two project periods. The project aims to establish 400 MCH/FP clinics (Polyclinics) on estates. This activity will be supported by the provision of basic clinic equipment and drugs and the training of health personnel namely – — Basic Training of AMP's and midwives — Inservice training of existing health staff In addition the project would undertake: Development of sterilization services in selected estate medical institutions. F.P. Surveys in selected regions utilising estate health staff, which would lead to the development of a system whereby estate health staff would utilize the survey findings to meet the family planning needs of individual families residing on the plantations.

4. Supply of Contraceptives SRL/81/P06 Project Period: 1983–1985 Funding Agency: UNFPA

The entire contraceptive requirements of the government family planning programme will be met through this project for a three year period. Training in logistics needed to support this project is provided for under Project SRL/81/P05 – MCH 007.

5. Training of Registered Medical Practitioners (RMP) & Assistant Medical Practitioners (AMP) in MCH/FP.
Funding Agency: SIDA

Inservice training of RMP's and AMP's in community health and primary health care with special emphasis on maternal health, child health and family planning. Training would be of 12 weeks duration, with 9 weeks of training in selected obstetric and paediatric units. This project will also orientate office staff attached to Health Units on important aspects of MCH/FP with specific reference to the Family Health Information System and logistics related to F.H supplies and services.

6. Integrated parasite control nutrition and family planning. Second Project Period: 1984 – 1986 Funding Agency: JOICFP

The Project aims at impoving the health status of the community in three project areas through the control of intestinal parasitic (helminthic) infestations, improved sanitation, applied nutrition programmes and strengthening of MCH/FP services. The project would place considerable emphasis on community involment and schemes for income generation.

7. Expanded Programme on Immunization. Second Project Period: 1984 – 1988 Funding Agencies: WHO and UNICEF

Implemented jointly with the Epidemiology Unit, Ministry of Health. Activities will be directed towards consolidating the inputs made during the first project period. While expanding immunization coverage specific attention will be given to age appropriate immunization and maintenance of the cold-chain. Measles vaccine will also be introduced for the first time and its implementation will be phased out over a two to three year period to cover the whole country.

8. Maternal & Neonatal Care Monitoring SRL/MCH/009 (Programme classification 3.9.1)
Project Period: 1984–1985
Funding Agency: WHO

The pregnant mothers record presently in use at clinics & by the Public Health Midwives would be modified and structured to collect relevant information on Maternal and Neonatal care. After pretesting, the modified mothers record will be introduced into the existing information system and will be maintained for all pregnant women that come under the care of Public Health Midwives. At the end of each year a cross-section of these cards would be collected and the data processed and analysed by the F.H.Bureau, using computer facilities, to determine the quantitative and qualitative aspects of Maternal and neo-natal care.

9. Maternal Health Project
Period: 1984–1988
Funding Agency: UNICEF

The project aims at:

Establishing a MCH programme which provides selective services to mothers identified as 'high risk' in order that perinatal, neonatal and maternal mortality are reduced. Project activities include training of Public Health Staff and relevant institutional staff in project areas to adopt a selective approach to the 'high risk' mother and provide improved antenatal and natal care. A Home Based Mothers Card (HBMC) will be issued to all pregnant women by PHMM in selected MOH areas during the inital project period. Based on project experience, the HBMC will be introduced on a national scale. HBMC will serve as an educational tool for the mother to be aware of risk

factors in pregnancy, as well as provide a continuous record of progress during two pregnancies. The provision of a HBMC would also strengthen domiciliary care by the PHM.

Developing a system of birth weight surveillance in a phased manner in representative institutions in 9 selected districts. The districts have been selected on a 'nutritional grading' based on past nutrition surveys. Activities include training of relevant institutional staff, supply of appropriate weighing scales for accurate weighing of new borns, and development of teaching aids and instructional materials. The collection and analysis of birth weight data will be used to monitor trends in maternal nutritional status.

10. Community Nutrition for Children/ Growth Monitoring and development.
Project Period: 1984–1988
Funding Agency: UNICEF WHO

The Project encompasses 3 sub-components. They are:

A monitoring system, of child growth and development will be established by the introduction of a newly developed growth chart. The New Child Health Development Card will incorporate physical growth indices as well as developmental milestones, immunization and risk factors relevant to the 0–5 year age group. Child Health Cards will be issued to all infants initially in selected MOH areas and will be extended to all MOH areas in a phased manner. Other project activities include preparation of instructional material for PHMM, development of teaching aids for use in educating mothers and supply of appropriate weighing scales to MOH clinics. "Training of trainers" comprising MOH and PHN of each MOH area who in turn would train PHMM and other relevant staff in the use of the card, is a major activity prior to implementation of project in the field.

A Baseline Survey on the prevalence of anaemia will be conducted in addition to a feasibility study on iron fortification of common salt.

Nutrition Department of MRI will be provided with supplies and equipment to meet the new demands in establishing a nutrition surveillance system particularly in the area of training and nutrition research.

11. Child Mental Health.
Project Period: 1984–1988
Funding Agency: UNICEF

The project aims at establishing a system for the promotion and management of child mental health services – at the home/school/community level, in selected areas – Anuradhapura RDHS Division including Mahaweli H – Area and Urban slums. Major project activities include preparation of training materials and training of Health Workers, Teachers and Probation Officers in relevant aspects of prevention, and early detection of child mental health problems and the promotion of healthy psychosocial development. Other activities include establishment of Day Care Centres for development stimulation of the "Slow Child" and the involvement of parents and the community in promotion of child mental health. Operational research and evaluation of training and service delivery using identified indicators are built into the project.

COLLABORATION WITH OTHER SPECIFIC PROGRAMMES/PROJECTS

TITLE OF PROJECT	*SUMMARY OF ACTIVITIES*
1. MCH Services to Children in the Estate Sector Second Project Period: 1984–1988 Funding Agency: UNICEF	This project is executed by the two Government Estate Agencies (SLSPC & JEDB) with FH Bureau collaboration and technical assistance. Activities would include: Consolidation of the Expanded Programme on Immunization introduced into the plantation sector during the first project period and the introduction of measles vaccine. Introducing the Diarrhoeal Diseases Control Programme in the Estate Sector with emphasis on oral rehydration therapy. Improving the Disease Notification System on estates. Introducing the 'risk-approach' to maternal care through appropriate training of estate health staff. Introducing a monitoring system for child growth and development through the introduction of a newly developed Child Health Development Card with appropriate training of estate health staff and education of mothers.
2. Programme for the Control of Diarrhoeal Disease. Second Project Period: 1984–1988 Funding Agency: WHO/UNICEF	This is a national programme managed by the Epidemiological Unit in collaboration with the Family Health Bureau and Health Education Bureau of the Ministry of Health.
3. National Health Information System. Project Period: 1984–1986 Funding Agency: UNDP	This project is being managed by the Planning Unit of the Ministry of Health. The MCH/FP components of the programme will be designed and implemented by the Family Health Bureau.
4. Child Survival & Development Monitoring Project. Project Period: 1984–1988 Funding Agency: UNICEF	This is a special project funded and executed by UNICEF in collaboration with the Department of Census & Statistics and the Family Health Bureau. This is a prospective study which would assist in identifying some critical issues in respect of child survival.

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