National Policy on Maternal and Child Health

Certification of Authorisation

The National Policy on Maternal and Child Health had been published in the extra ordinary gazette No 1760/32 dated 31st May 2012, by Ministry of Health, according to the approval granted by the Cabinet Ministers of Democratic Socialist Republic of Sri Lanka

1. PREAMBLE

SRI Lanka, being promoted as a middle-income country with a per capita GNP of 2,804 US dollars[1], has achieved significant gains in the area of human development. Over the past few decades the country is undergoing a rapid demographic change. The rate of population growth has declined from 5.0 in 1962-64 to 2.3 during the period of 2001-2006[3]. The infant mortality maternal mortality ratio has decreased from 405 per 100,000 live births in 1955 to 31.1 per 100,000 live births in 2010[5]. A well-established health service, free of cost to the consumer, together with universal free education has contributed to bring about this situation.

The demographic change over the year has brought about several important policy concerns in terms of Maternal and child health. For instance, women in the reproductive age group (15-49 year) comprise 5.6 million (27.8 percent) of the population, creating a considerable demand for the provision of quality reproductive health services. The population under 15 years of age continued to remain high at 26.3 persent[6] while further 26 percent comprised adolescents and youth. Paradoxically the country has one of the fastest ageing populations among the development countries, with around 9 percent of the population over the age of 60 years.

A dominant feature of the health policy in Sri Lanka has been the diffusion of health services throughout the country, which provides institutional and domiciliary care to women and children. It is significant that the system of Maternal and children health (MCH) services has evolved as a part of the general health services, which has helped the development of a comprehensive, network for maternal and child health service throughout the country.

Though much has been achieved in the past, changing scenarios in MCH arena call for new policies to address the broader health need of women, children and adolescents including those directed at the new challenges faced by them. Such policies would help to guide successful implementation of the MCH programmer in the present context.

[1]Central Bank report – provisional Data- 2012
[2]Census Report-2012
[3]Department of census and statistics-DHS survey 2006/7
[4]Registrar General's Department, provisional Data-2009
[5]family health bureau, annual Report on family health Sri Lanka, 2010
[6]Department of census and statistics-2008

2. BACKGROUND

Maternal and child health (MCH) in Sri Lanka has a very long history, which dates back to the early 20th century. An organized effort to provide maternal and child health services commenced with the introduction of the health unit system in the mid 1920's, which was thereafter extended to cover the entire country. In 1965, family planning (FP) was accepted as a part of national health policy and its service components were integrated with the MCH services of the ministry of health. In 1968, the MCH bureau was established within the ministry of health, to oversee the MCH/FP service island wide. In 1972/73 population and family planning received considerable support from United Nations (UN) agencies and other international agencies, with family planning being implemented as an integral component of the MCH services. The MCH bureau was re-designated the family health Bureau (FHB) to highlight the integrated nature of the MCH/FP services. The FHB then became the central organization of the Ministry of health responsible for planning, coordination, monitoring and evaluation of the MCH/FP services, also referred to the family health programmer.

The evolution of the MCH services in Sri Lanka has been nurtured by a number of international health initiatives which include the safe Motherhood initiative launched in Nairobi in 1978, and the Reproductive health initiative following the international conference on population and Development (ICPD) in Cairo in 1994. In par with these international initiatives, Sri Lanka also produced several policy documents relevant to MCH. The first of which was the national health policy of 1992 followed by that of 1996, both of which identified maternal and child health as a priority concern. In 1998, a populations and reproductive health policy with eight goals was developed, out of which six, fall within the direct ambit of the MCH/FP services or the family health programmer. In September 2000 Sri Lanka became a signatory to achieve Millennium Development Goals (NDGs) in 2015 with three goals having a significant focus on health status of mother and child (MDG 1, MDG 4 and 5). The country plan "Mahinda Chinthana Idiri Dakma" has given high priority to Maternal and child health showing the importance attached to it by the present government.

MCH has been a long standing priority in the country and this has been reflected in the national health policy (1992). The need for formulation a separate MCH policy has arisen due to the evolving changes in priority and the new challenges on the maternal, child and the adolescent health. The evolving health care delivery system

and new policy climate have provided opportunities for reviewing the past policies and for developing new policies and innovations in MCH care with a broader view.

In this context it has to be emphasized that policies relating to upliftment of household socioeconomic status and safe environment among the less privileged have also a major part to play in the wellbeing of mother and child and the family at large. When we focus on the health of the mother and child it is imperative that we consider certain factors which affect the health of the whole family. The availability of safe water supply, adequate sanitation and proper nutrition are basic needs for maintaining health of the family as a unit. These are often cited as the single set of highest priority social services for poor households that would help to promote good health. In addition protection of family members from vector borne diseases such as Malaria in affected districts should be high in the policy agenda of such disease prevention programs. Emerging health concerns such as non-communicable Diseases (NCD), prevention of parent to child Transmission of HIV/AIDS (PPTCT) and eradication of congenital syphilis (ECS) which have their preventive measures linked to MCH services need to be addressed within the MCH policy frame work.

The central role that is continued to be played by the Ministry of health and FHB in policy making and planning of the services, and their collaborative links with the other health and health related services/programmers emphasizes the need for a well-documented Maternal and child health policy to work towards national goals. Further the change in manage in managerial processes as a result of devolution of MCH functions to the provinces for them to function effectively. Considering the challenges to MCH, arising from the rapid demographic transition that has resulting in new demands for services, rising people's expectations, and reported trends in unhealthy lifestyles and behavioral changes of adolescents, it calls for the need to have a separate Maternal and child health policy. Such a documented policy will provide the much-needed direction to strategic planning, implementation, monitoring and evaluation of MCH programmer to address such issues effectively.

3. SCOPE

The Maternal and child health (MCH) programmer was primarily directed at women during pregnancy, delivery and postpartum period, and at newborns, infants, and children up to 18 years (including school children). Most efforts to improve pregnancy outcomes during the past several years have focused on promoting antenatal care, delivery care and care for postpartum mothers. In order to be most effective, appropriate interventions must be introduced before pregnancy and continued after delivery to prevent oo detect early and manage appropriately any health conditions and risk factors that contribute to adverse maternal and infant outcomes. Addressing behavior patterns related to pregnancy, delivery and postpartum periods of women themselves, their families and the community is also equally important to achieve positive maternal and infant outcomes.

Thus, the improvement in the health status of women and children will be better achieved if a border approach to MCH is adopted. In the formulation of this policy, such a broader perspective is pursued that would not only emphasize broad policies relating to maternal, newborn, infant and child care but also include those relating to pre pregnancy care, care of older children including adolescents. Family planning has been identified as an integral component of the MCH services while certain MCH related health concerns such as prevention of NCDs and STD/HIV/AIDS, gender and women's health also have been incorporated as appropriate in the policy document.

The MCH policy however does not cover all aspects of aspects of reproductive health which is a much broader concept that extends beyond the childbearing years and covers all aspects relating to the reproductive system, its functions and processes. Therefore MCH programmer linkages with other relevant health and non-health programmers should be strengthened to facilitate coordination as required.

This document provides policy and strategic directions to continuing and emerging concerns and challenges in Maternal and child health. It also includes appropriate strategies which focus on strengthening of the already-established family health service.

4. VISION

A Sri Lankan nation that has optimized the quality of life and health potential of all women, children and their families.

5. MISSSION

To contribute to the attainment of highest possible levels of health of all women, children and families through provision of comprehensive, culturally acceptable and family friendly settings.

06. POLICY GOALS

MCH policy consists of twelve goals.

Goal 1

Promote health of women and their partners to enter pregnancy in optimal health, and to maintain it throughout the life course

Goal 2

Ensure a safe outcome for both mother and newborn through provision pf quality care during pregnancy, delivery and postpartum period

Goal 3

Ensure reduction of perinatal and neonatal morbidity and mortality through provision of quality care

Goal 4

Enable all children under five years of age to survive and reach their full potential for growth and development through provision of optimal care

Goal 5

Ensure that children aged 5 to 9 years and adolescents realize their full potential in growth and development in a conducive and resourceful physical and psychosocial environment

Goal 6

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

Goal 7

Enable all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies

Goal 8

To promote reproductive health of men and women assuring gender equity and equality

Goal 9

Ensure that national, provincial, district and divisional level health managers are responsive and accountable for provision of high quality Maternal and child health services

Goal 10

Ensure effective monitoring and evaluation of Maternal and child health programmer that would generate quality information to support decision marking

Goal 11

Promote research for policy and practice in Maternal and child health

Goal 12

Ensure sustainable conducive behaviors among individuals, families and communities to promote Maternal and child health.

6.1 POLICY GOAL 1

Promote health of women and their partners to enter pregnancy in optimal health, and to maintain it throughout the life course

Rationale

Promotion of health of women of reproductive age before conception improves pregnancy related outcomes and is helpful in reeducate of maternal and neonatal morbidity and mortality.

The maternal mortality ration in 1935 was 2700 per 100,000 live births and by 2010, the Maternal Mortality Ratio had been reduced to 31.1 maternal deaths per 100,000 live births.[1] it is reported that 72-75 percent of these maternal deaths are preventable, and in most cases correctable conditions were not detected until the woman became pregnant, while some conditions were detected only during delivery.

Early detection and treatment of several medical conditions such as heart disease, Anemia, Micronutrient and other nutritional deficiencies, diabetes, Liver disease and STD/HIV/AIDS will help to improve the health of the women at pre-pregnant stage, and prevent complications of pregnancy.

Certain personal behaviors, psychosocial risks, and environmental exposures associated with negative pregnancy outcomes can also be detected and modified before conception. Changes in the knowledge, attitudes and behaviors related to reproductive health among both men and women are useful to improve health during the preconception period, and also during the life course.

Increasing incidence of STD/HIV/AIDS requires close monitoring of those conditions. In order to reduce the prevalence of these diseases and protect the women from their adverse effects, some activities of those programmers have to be integrated into MCH programmer for example by providing all child bearing age women attending MCH/FP clinics access to STD/HIV/AIDS services.

Infant Mortality Rate in Sri Lanka has come down rapidly over the years, and has remained stagnant for the last decade or so. Eighty percent of the infant die during the neonatal period. Nearly 17 percent of newborns are of low birth weight. New strategies have to be implemented to further reduce the infant Mortality Rate, of which some intervention for reduction of infant mortality and low birth weight should be started from the preconception stage.

Women who suffer from various chronic disease conditions such as Diabetes can have adverse effects on pregnancy outcomes, leading to still births, neonatal deaths, and births, neonatal deaths, and birth defects. These can be prevented by proper care during preconception and antenatal period.

Considering the above, a new package for "pre-conception care" has been introduced to the maternal and child health programmer. The main objective of provision of this package is to create awareness, provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies.

Attention is also paid towards maintaining reproductive health of women and their partners throughout the life course. The government of Sri Lanka was a signatory to the program of action adopted at the international conference on population and development (ICPD) in Carlo in 1994. Since then, the concept of reproductive health has been introduced addressing reproductive health issues of the adolescent, the post-adolescent before they become mothers and extending to women in the elderly age group thus encompassing a life cycle approach to Maternal and child health. Women's health concerns in MCH include continuity of care and access to services before, during, after and independent of childbearing. In keeping with the government's commitment to provide comprehensive MCH services based on the life cycle approach, "well woman clinic" (WWC) program was initiated in 1996, focusing on women at and over 35 years of age with selected services including those related to non-communicable diseases such as diabetes Mellitus, hypertension, cancer prevention and management. The concept of screening health well women at community level is an approach that is relatively new, requiring public awareness.

Many of the programmers and services including the health services that are aimed at women mainly focus on the women who have access to services. However, there is an important group of women with special needs requiring special attention and care who do not have access to the routine reproductive health services. This group includes institutionalized women, migrant women, displaced and marginalized women etc.

Strategies

a) Ensure that women of childbearing age and their partners receive a comprehensive package of pre-conception care

b) Address specific reproductive health issues of women and their partners throughout the life course

c) Address the reproductive health issues of women with special needs

d) Integrate relevant STD and HIV/AIDS services to MCH program

e) Strengthen partnership with other stakeholders who provide care for woma

6.2 POLICY GOAL 2

Ensure a safe outcome for both mother and newborn through provision of quality care during pregnancy, delivery and postpartum period

Rationale

The steady development of services for the mother and newborn, that encompass both domiciliary and institutional care, has made a significant impact on the decline of maternal and infant mortality. It is reported that 99 percent of pregnant women received antenatal care and that 98 percent received trained assistance at delivery[1]. These levels of service coverage need to be maintain and improved upon to reach all women in the country. In particular the Maternal Radio can be further reducer with concerted systemic health and other appropriate interventions.

Certain quality aspects of the services provided specially in smaller hospitals and failure to meet the aspiration of the people with regard to the place of delivery remain as outstanding issues that need to be addressed. In this context, of the 94 percent of deliveries that take place in government hospitals, almost 75 percent occur in the larger hospitals that provide comprehensive emergency obstetric care at (CEmOC). This is a consequence of mothers wishing to have, “the best available care at hand’ during delivery, even if such specialized care was needed or not. This has led to overcrowding of the maternity unity in the larger hospitals and underutilization of maternity unity of the smaller hospitals. Hemorrhage, Eclampsia /pregnancy induced hypertension (PIH), septic abortion and heart disease complicating pregnancy are main causes of maternal deaths. The nutritional deficiencies such as anemia during the pregnancy and postpartum period, may contribute to also a serious issue that is yet to be addressed.

The shortfall in coverage and quality of care in the postpartum period also contributes in no small measure to maternal morbidity and morbidity and mortality and needs to be addressed. So also is the accessibility to maternal and newborn services by population groups such as those displaced by natural disasters or civil strife, remote rural populations and all other vulnerable families.

Strategies

a) Ensure quality maternal care (antenatal, intra-natal and postpartum) through appropriate systems and mechanisms in field and institutional settings

b) Maintain optimal nutritional status of pregnant and post-partum women

c) Ensure availability and accessibility of emergency obstetric care facilities and an appropriate referral system

d) Enhance maternal and newborn services for vulnerable families and in emergency situation

e) Strengthen the surveillance system for maternal morbidity and mortality

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[1]Department of Census and Statistics-DHS survey 2006/7

6.3 POLICY GOAL 3

Ensure reduction of perinatal and neonatal morbidity and mortality through provision of quality care

Rational

Infant mortality and neonatal mortality in Sri Lanka declined dramatically in the last century. The malaria control programmer, the expanded programmer of immunization, the safe motherhood programmer and promotion of breastfeeding are some of the key interventions responsible for this spectacular reeducation in infant and neonatal mortality. However the infant and neonatal mortality has been stagnant for over a decade now. Just as in other countries that have reduced the infant mortality, neonatal mortality contributes to nearly 80 percent of infant mortality in Sri Lanka. A neonatal death rate of 6.2 per 1000 live births has been reported in 2009. [1]most of these deaths occur as a result of pregnancy more than two thirds of the neonatal deaths are early neonatal deaths occurring within the first week of life.

The other prominent feature is the geographical variation in neonatal and infant mortality in Sri Lanka. There are district and institutional variations in neonatal mortality in the country according to the published mortality data through vital registration system and the hospital based management information system.

Further reduction of neonatal mortality in Sri Lanka needs well focused interventions. Promotion of nutrition of pregnant women to improve birth outcomes and reduce low birth weight, identifying and treating medical condition such as diabetes and hypertension are among some measure that could be taken prior to childbirth. At the time of delivery obstetric care of good quality including timely referrals would also help to reduce perinatal and neonatal mortality.

To produce favorable outcomes in early weeks of life, essential and emergency newborn care practices have to be strengthened and standardized in the health care facilities for management of newborns. Breastfeeding has to be initiated and established and exclusive breastfeeding for six months has to be supported by all health care professionals.A perinatal and neonatal morbidity and mortality surveillance system is essential for monitoring and evaluation of the perinatal and neonatal care services in the country. Perinatal audit has to be establish as a managerial tool to enhance the quality of perinatal care in the institutions.

Strategies

a) Institute evidence-based practices in newborn care in field and institutional settings
b) Ensure availability to basic and accessibility to basic and advanced newborn care facilities
c) Protect, promote and support breastfeeding practices with special emphasis in delivery settings
d) Strengthen the surveillance for perinatal and neonatal morbidity and mortality

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1. Registrar General's Department, provisional Data-2009

6.4 POLICY GOAL 4

Enable all children less than five years of age to survive and reach their full potential for growth and development through provision of optimal care

Rationale

Though in South East Asia Region, Sri Lanka's infant and child mortality rates are considered low in comparison with international norms, they still rate high, especially when compared to some of the other social and health indicators in Sri Lanka. Hence, determinants need to be selectively identified and effectively addressed. The well-developed MCH infrastructure and the educational levels of the population provide the means to realistically target the main causes of death and morbidities in childhood.

Though much headway has been made in reducing the disease load with regard to the main communicable diseases of childhood, much remains to be done. Given the country's relatively low infant mortality, the reduction of child malnutrition is yet to be achieved, with one out of five children aged five years and below being underweight (DHS 2006/07 underweight prevalence 21.1%), with social and cultural practices being implicated as possible causes. There is a need to actively promote nutrition education and counseling to mothers and caregivers of children. Growth monitoring and promotion have been in progress for many years, but the achievement of the desired impact is still slow.

There is also a need to strengthen psychosocial development of children with specific inputs in the age groups 0-3 years and 3-5 years. Among the other challenges are those to keep age appropriate immunization of infants and children at optimum levels all the time and to promote good oral health.

Strategies

a) Ensure the provision of quality child care services at both field and institutional settings

b) Maintain optimal nutritional status by implementing evidence based interventions; specifically ensuring exclusive breastfeeding for 6 completed months, followed by appropriate complementary feeding together with continuation of breastfeeding for two years and beyond, regular growth monitoring and promotion

c) Ensure evidence-based practices in the management of childhood illnesses

d) Strengthen the surveillance system on childhood morbidity and mortality

e) Optimize psychosocial development

f) Ensure age appropriate immunization

g) Ensure optimal oral health

h) Ensure adequate childcare services including nutrition during emergency situations

6.5 POLICY GOAL 5

Ensure that children aged 5 to 9 years and adolescents realize their full potential in growth and development in a conducive and resourceful physical and psychosocial environment

Rationale

In 2008, the school census revealed that there are 9662 school in Sri Lanka with a school population of approximately 3.9 million. More than 60 percent of school children belong to the adolescent age group of 10-19 years.[1] The school health programmer which commenced in 1918 has continued to address the health issues of school children and adolescents and this programmer need to be improved upon with a collaborative and multidisciplinary approach involving many stakeholders.

The implementation of school health programmer is the responsibility of both health and education ministries. The family health bureau is the focal point for the school and adolescent health programmer in the Ministry of health and the services are delivered through primary are responsible for implementation of the programmer in the decentralized system.

The major components of the school health programmer are school medical services including counseling services, maintenance of health school environment, life skills based health education, school community participation and implementation of health school policies. Many attempts have been taken to improve the coverage of school medical inspection in the recent past and as a result the coverage has increased to 89% in 2010,[2] however, the quality aspects of the programmer still need improvement.In order to achieve the full education potential of children and adolescents, they should also be provided with quality care that includes not only general health, but also oral health, mental health and prevention of substance abuse, promote life skills and positive behaviors that would form integral part of school Health programmer.

Considering the various challenges faced by a child during transition from childhood to adulthood, where adolescents start to make lifestyle choices that affect their health, provision of a safe and nurturing environment and appropriate care for adolescents remain crucial. In an attempt to elevate the focus on health and wellbeing

of school children and adolescents by all the stakeholders, the health promoting concept was introduced to schools in 2007. This initiative has helped to strengthen the important partnerships between the central ministries of health and education, provincial health and education approach to improve school and adolescent health.

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1. School census, Ministry of Education 2008
2. Family health bureau, Annual Report on Family Health Sri Lanka 2010

Strategies

a) Strengthen partnerships between Ministries of health and education, other relevant stakeholders and communities for the implementation of a comprehensive child and adolescent health programmer in school and community settings.

b) Implement need based health education focusing on skill development

c) Promote nutrition and health lifestyles among children and adolescents

d) Ensure access to child and adolescent friendly health services, including oral health services and counseling

e) Empower children and adolescents to make informed choices regarding their sexual and reproductive health issues

f) Empower parents, guardians and teachers in caring for children and adolescents

6.6 POLICY GOAL 6

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

Rationale

It is necessary that every child should be supported in such a way that enable them to optimally develop their mental, physical and social capacities to be independent and function as productive members of the society.

Many of the programmers that are aimed at promoting child health, the focus have generally been on the children who are accessed through the health services as at present and who require special attention. This group includes children who are physically, mentally and socially disabled, children subjected to abuse of all forms, street

children, displaced and marginalized children including children in probation schools, orphanages and prisons and children left behind by migrant workers.

The reasons as to why such children exist in today's are multifaceted. Hence the approaches to be used to improve the status of these children also need to be multifaceted. Even though limited reports are available on such children, there is no reliable data on the magnitude and the nature of the problem, and their needs, especially from a health perspective.

The role of the health sector in promoting this group to optimally develop their mental, physical and social capacities to be independent and function as productive members of the society has to be identified. There is also a need for the health sector to liaise with the other sectors that contribute towards the expected outcome.

Strategies

a) Integrate an appropriate program to address the health needs of children with special needs into the existing child health program
b) Strengthen the inter-sect oral collaboration among key stakeholders providing care for children with special needs

6.7 POLICY GOAL 7

Enable all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies

Rationale

Family planning (FP) services provided by the government are integrated with maternal and child health services and offers a wide range of modern contraceptive methods and services for regulating the number and spacing of children. FP services also include services for sub fertile planning clinics. In addition, primary healthcare staff such as public health midwives (PHMS) and public health inspector (PHIs) distribute oral contraceptive pills and condoms in the community. Also, more than 100 medical institutions provide permanent family planning methods (sterilization). In addition to the government health sector, FP is also supported by three well-established non-Government health organization (NGOs), who also provide mobile outreach services[1].

With a history of almost five decades of FP services in Sri Lanka, acceptance for modern contraceptive methods has steadily increased. However, recent studies have shown that unintended pregnancies due to unmet need for contraception (i. e. percentage of married, fertile women who do not desire to have children and not using a FP method), leading to induced abortion is a phenomenon that is increasingly seen within marriage, indicating that it is being used for spacing of births or for limiting family size[2].

The main reasons for unintended pregnancies is the inadequate services for permanent family planning methods (male and female sterilizations) and a significant percentage of women using natural and traditional methods for family planning, resulting in a greater chance of method failure. Therefore, it is imperative to address the unmet need for contraception by meeting the demand for permanent methods and motivating clients using natural and traditional methods to use modern contraceptive methods.

Today the government takes full responsibility for contraceptive supplies. Since the government is the major source of contraceptives for clients, there is a need to focus on contraceptive logistics including procurement, storage, distribution, monitoring, supervision and evaluation. A Reproductive health commodity security system has been developed for this purpose. Contraceptive services by the government are provided free of cost to the client. The NGs provide contraceptives (mainly condoms and pills) through a social marketing program at a nominal cost. The Emergency contraceptive pill (ECP) is also marketed as a branded product by NGOs at retail outlets (pharmacies) and seems to gain popularity.

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[1]family Health Bureau, Annual Report on Family Health Sri Lanka, 2006-2007

[2]Rajapakse, L., (2000) Estimates of induced abortion in urban and Rural Sri Lanka.

Strategies

a) Ensure the availability and accessibility to quality modern family planning services
b) Address the unmet need for contraception
c) Ensure availability of sterilization services in institutions
d) Establish an appropriate system for post-abortion care
e) Ensure the uninterrupted availability of contraceptive commodities [reproductive health commodity security (RHCS)]
f) Strengthen, rationalize and streamline services for sub-fertile couples

6.8 POLICY GOAL 8

To promote reproductive health of men and women assuring gender equity and equality

Rationale

Even though gender equity and equity in Sri Lanka are considered as being satisfactory compared to other countries of the region, there are still several health related areas that have a direct effect on reproductive health and need attention. These areas include specific issues related to gender such as gender based violence, including

domestic violence, lack of choice for women to control the number of pregnancies, difficulties in accessing healthcare and good nutrition, gender differences in health related behaviors and higher vulnerability of women to STI and HIV/AIDs due to their inability to negotiate safe sex.

Inadequate information of women's status especially lack of reliable data on gender issues has jeopardized work towards addressing the problems. Efforts must be made to develop gender disaggregated and gender sensitive health and social indicators to enable more objective analysis of the impact of the gender issues affecting reproductive health.

The multi factorial nature of the reasons for limitations and differences in gender equity and equality warrants the need to take a holistic view of the issues, and critically review the currently available policies and programmers of different sectors.

Advocacy can play a significant role in improving women's health status through creating an environment that is conducive to the achievement of gender equality and equality starting with sensitizing of policy makers and programmer planners at all levels. Community mobilization towards of policy makers and programmer planners at all levels. Community mobilization towards gender equity and equality is also very, so as to achieve long term results.

The traditional norm among Sri Lankan families is for the mother to be the care giver for children and father to be the sole income owner. The involvement of men in children and household chores has not been an accepted practice. Over the years with the increasing female literacy, more and more women are employed and a substantial contribution is made to the family economy. In today's context men need to be encouraged to be more concerned about their own health and the health of the family while playing an active role in child care as well as sharing household work. There is a gap in the current healthcare delivery system to actively involve the males in MCH/FP activities. The recent policy of allowing the husband to be with his wife at time of delivery is a positive step towards a father friendly MCH service that encourages strong relationships and a spirit of sharing.

Migrant workers both men and women constitute an important sector of the population with special health needs. By national Migration policy the country promotes overseas job opportunities for men and women. Addressing their health needs (prior to departure, while working overseas and after returning) is of utmost importance to secure their health. Therefore the MCH programmer should address reproductive health needs of migrant workers and their family members by providing services and also by developing linkages with relevant stakeholders.

Strategies

a) Address gender issues related to reproductive health

b) Ensure an effective response from preventive and curative health sector for prevention and management of gender based violence issues
c) Incorporate sex disaggregated data into the health management information system, so as to ensure gender equity and equality in reproductive health services
d) Promote compilation and appropriate management of data related to gender based violence within the health sector
e) Strengthen partnership within the resource network of organization and persons actively involved in the prevention and management of gender based violence
f) Promote and enhance male participation in reproductive health care
g) Empower men and women to promote community mobilization towards prevention and management of gender based violence
h) Address reproductive health needs of migrant workers

6.9 POLICY GOAL 9

Ensure that national, provincial, district and divisional level managers are responsive and accountable for provision of high quality Maternal and child Health Service

Rationale

Maternal and child health services continue to face many challenges from country's health sector reforms. One such major reform has been in devolution of powers and functions to the provinces through the 13th Amendment to the constitution of Sri Lanka, in 1978. This has caused changes in implementation of MCH services at sub national levels. Thus functions related to MCH at provincial levels need to be reviewed, redefined and realigned to produce more effective services.

The success of any health program depends on the committee of the managers running the programmer. In the case of MCH service the responsibility of implementing a quality MCH programmer falls on the provincial Director, regional Directors of health services, Hospital Director, Medical officers of Maternal and child Health and Medical Officer of health. An appropriate mechanism has to be instituted to make the managers at different levels be more accountable for MCH service provision. In addition, steps need to be taken to build commitment and improve advocacy skills among MCH programmer managers.

The managers at various levels should also be committed to strengthening of institutional capacity for delivery of quality MCH care that includes improving capacities of its human resources. The health teams who undertake the varied programmers in MCH should be of appropriate numbers and with the correct skill mix. The diversity of the activities related to the MCH programmers and the technical advances that have been made in recent

times, demand greater specialization amongst the health teams and therefore, education, training and the development of the correct skill mix is of crucial importance.

It is imperative that the health personnel involved in MCH programmer are constantly provided with the opportunities needed to update their knowledge and skills through continuing education and other methods. The continuing education and professional development, as appropriate, has to be linked to career advancement opportunities for the staff.

The ongoing collaboration with professional bodies, development partners such as WHO, UNICEF, UNFPA, world Bank and NGOs and other sectors such as education, social services, child probation has to be strengthened to take advantage of their underused resources as well as to mobilize additional resources for the programmer.

Family health bureau with its team of experts would enhance its leadership role in improving MCH knowledge and practice. This should be supported by effective use of data and field training that need to be continuously monitored and improved upon.

Strategies

a) Ensure accountability and committed leadership to provide quality MCH services
b) Strengthen institutional capacity at national, provincial, district and divisional levels to deliver quality MCH services
c) Ensure the availability of adequate resources and equitable distribution for quality MCH services
d) Ensure adherence to national policies, guidelines and practices to improve systems and services at all levels
e) Strengthen the FHB as the Centre for excellence to provide national leadership in Maternal and Child Health
f) Ensure collaboration and partnership with professional bodies and relevant stakeholders

6.10 POLICY GOAL 10

Ensure effective monitoring and evaluation of Maternal and child health programmer that would generate quality information to support decision making

Rationale

The maintenance of Heath Management information system (HMIS) in MCH/FP is a responsibility of the family health Bureau and is managed by its Monitoring and evaluation unit. Its aim is to generate quality MCH information and also to help staff responsible for MCH at national, provincial, district and divisional levels to improve their capacity to collect, analyze, and use data for planning and evidence based decision making.

The data gathered and the information generated has grown both in capacity and content. Commencing with data pertaining to family planning of government and NGO sectors, the system has expanded to collect data in the fields of MCH, Maternal Mortality, school health and well women clinic services etc.

The bulk of MCH/FP data received is generated at primary health care level, through the public health midwives (PHM), supervising public health inspector (SPHI), public health nursing sister (PHNS) and the Medical officers of health (MOH). The data collected through this system is analyzed and used at all levels, namely divisional (MOH), regional (RDHS, MOMCH), provincial (PDHS) and national (FHB) levels. Both quantitative and qualitative indicators are available and health staff at all levels has been trained in the analysis and interpretation of data. A feedback is provided by the FHB to all concerned, with analyzed data and relevant information for use by service providers and programmer managers.

However, the health Management information system of MCH programmer needs to be reviewed and improved to capture information on the current needs. Among the challenges are the irregularities in quality of data, issues on standardization of criteria and delays in submission of returns, inadequate feedback and inadequate use of information by health staff at various levels.

Reporting of data from the medical care/curative services, obtained through the hospital network is reported directly to the Medical statistical unit of the Ministry of health. The quality and completeness of the data reported from hospitals is however a matter for concert and warrants early attention. The current system of hospital based maternal and perinatal statistics need a major revision in order to obtain more informative indicators for further reduction of perinatal and newborn mortality.

The data published by other relevant departments such as Register General's, census and statistics, central Bank etc. are also important for MCH programmer management. However, a regular mechanism is not available among these departments for sharing of relevant important information. As such, establishing a network between the different organizations within the Ministry of health and also with other relevant departments should also be of concern.

Strategies

a) Strengthen the health Management information system on MCH/FP
b) Reinforce planning, monitoring and evaluation of MCH program
c) Establish network for MCH information sharing among relevant stakeholders

6.11 POLICY GOAL 11

Promote research for policy and practice in Maternal and child Health

Rationale

Research should function as the "brain" of the MCH services, to enable it to respond effectively to identify the problems, respond to them and evaluate the quality of service delivery. MCH being an area of work with considerable behavioral and socio-economic implications, the knowledge needed for successful program implementation has necessarily to be deliver by undertaking national and local level investigations and studies. The decision-marking in policy area as well as in program areas also should be as best as possible evidence-based.

Among the strategic area for research that could be considered are those directed at MCH services to underserved populations, changing roles and function of MCH staff in keeping with the demographic and epidemiological transitions, quality of MCH care both at hospital and in the community and on promotion of health of mother and healthy development of the child.

Some of the essential functions that from the core of a research system for MCH include, capacity development, for both the demand and supply sides of research, knowledge generation which helps to improve the knowledge base to act and to improve management, the actual utilization and management of knowledge for MCH service improvement and the mobilization of resources for MCH research.

Strengthening the linkages and functioning of existing and potential networks of institutions and individuals, both in-country and outside, is another way of promoting MCH research through such networks. Building partnerships with other research communities will help to get new insights and resources to support innovative research. There is also a need to establish a continuous process for the promotion and clarification of strategic issues for MCH research and health policies related to MCH.

Strategies

a) Generate and disseminate the evidence needed for policy formulation and practices in relation to MCH
b) Establish collaborative mechanism for MCH research development

6.12 POLICY GOAL 12

Ensure sustainable conducive behaviors among individuals, families and communities to promote Maternal and child health

Rationale

Improvement of Maternal and child Health (MCH) of the communities requires that healthy attitudes and behaviors are sustained and nurtured continuously. Maintaining current good behaviors conducive to MCH and cultivating desirable behaviors are required. Good behavior change communication (BCC) strategies are needed to accomplish this. BCC strategies need to be strengthened with the participation of relevant experts in

behavioral sciences in collaboration with MCH experts. Communities themselves need to be empowered and mobilized to sustain health behaviors.

The support of other sectors including civil societies is also essential to meet this goal, as health cannot be compartmentalized and separated from other sectors working towards the development and well-being of women and children. The Ministry of education has to play a key role in developing and maintaining conducive health behavior from childhood. Mass media support is also of utmost importance in achieving this goal as it has been see that the media plays a significant role in influencing health knowledge and practices among the general public. Medical officer of health (MOH), programmer managers and service providers should ensure close collaboration with all sectors involved in BCC.

Strategies

a) Strengthen BCC interventions to improve the MCH programmer
b) Promote mass media support for Maternal and child Health
c) Foster community empowerment and mobilization to sustain conducive behaviors in support of MCH
d) Develop appropriate mechanisms for inter-sectorial co-ordination at all levels to strengthen BCC interventions in MCH

7. POLICY IMPLEMENTATION

The National Maternal and child health policy upon adoption will serve as the base for development of strategic and action plans at national, provincial and district levels leading to implementation.

The existing public health and curative care infrastructure with the primary health care staff under the provincial health administration will serve as the implementing partners of the National MCH policy. In addition, curative health staff based at different levels of institutions will also be responsible for implementation of respective components. The overall responsibility of programmer management at district and provincial levels is vested with the provincial and Regional directors of health service with the technical guidance of the Medical officers of Maternal and child health and consultant community physicians. Implementation of Maternal and child Health program at field level is done by the Medical officer of Health with the team of health staff comprising of PHNS, SPHM, SPHI, PHI and PHM. PHM is the grass root level worker responsible for delivering Maternal and child Health services at the door step to the community. Family Health Bureau will provide the policy directives and technical guidance at national level and will monitor the progress of its implementation. The professional bodies such as Sri Lanka college of obstetricians and Gynecologists, college of pediatricians,

college of pathologists, college of community physicians and perinatal society of Sri Lanka will support the policy implementation through technical guidance and service provision to the national, provincial and district levels.

At national level, several technical committees are formed to support the policy implementation. They are:

1. National committee on family Health-under the chairmanship of the secretary health, with the participation of health Ministry officials, professional bodies, Development partners, representation from provincial Health staff and other relevant Ministry officials.
2. Advisory committee on Maternal Health and family planning-chaired by the Deputy Director General public Health services with participation of Health Ministry officials, professional bodies, representation from provincial Health authorities.
3. Advisory committee on Newborn and child Health-chaired by the deputy director General public Health services with participation of health Ministry officials, professional bodies, representation from provincial Health authorities.
4. National coordinating committee on school Health-chaired by the director General of Health services with participation of health Ministry officials, education Ministry officials, representation from provincial Health authorities,.
5. Advisory committee on well woman clinic programmer/ cervical cancer screening programmer-chaired by director General of Health services with participation of Health Ministry officials, professional bodies and representation from provincial Health authorities.
6. Subcommittee on Maternal and child Nutrition-chaired by the deputy director general public Health services with participation of Health Ministry officials, professional bodies and Development partners.
7. Nutrition steering committee-chaired by secretary Health with participation of Health Ministry officials, other relevant Ministry officials and development partners.
8. Monitoring committee of Sri Lanka code for the promotion, protection and support of Breast Feeding and Marketing of Designated products-chaired by the secretary Health with the participation of Health Ministry officials, other relevant Ministry officials, professional bodies and Development partners.

These committees meet regularly to discuss policy and technical matters and current issues faced in programmer implementation and decisions are taken by the committee members to support policy implementation.