

National Maternal and Child Health Policy

PREAMBLE

Sri Lanka, though a low income country with a per capita GNP of 1599 US dollars (2007¹), 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 2.8 in 1953 to 1.1 percent in 2007 and the total fertility rate has dropped from 5.0 in 1962-64 to 2.3 during the period of 2001-2006. The infant mortality rate has also declined from 72.4 in 1955 to 10.1 per 1000 live births in 2006 (RG, 2006²). Similarly maternal mortality ratio has decreased from 405 per 100,000 live births in 1955 to 39.3 per 100,000 live births in 2006 (FHB, 2007³). A well established health service, free of cost to the consumer, together with universal free education has done much to bring about this situation.

The demographic change has brought about several important policy concerns in terms of maternal and child health. For instance, women in the reproductive age group (15 – 49 years) 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 percent (in the year 2008) while further 26% comprised of adolescents and youth. Paradoxically the country is also one of the fastest ageing populations among the developing countries, with around 9 percent of the population over the age of 60 years.

A dominant feature of 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 Child Health (MCH) services has developed as a part of the general health services which has helped the development of a comprehensive network for maternal and child health throughout the country.

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

BACKGROUND

Maternal and child health has a very long history, which dates back to the early 20th century. An organised 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 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 services island wide. In 1972/73 population and family planning received considerable support from

¹ Central Bank Report 2007

² Registrar General's Report 2002

³FHB - Annual Report on Family Health – 2006/7

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, and became the central organization responsible for planning, coordination, monitoring and evaluation of the MCH/FP services, also referred to the Family Health Programme.

The evolution of the MCH services in Sri Lanka has been nurtured by a number of international health initiatives which includes the safe motherhood initiative launched in Nairobi in 1987, and 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, of both which identified maternal and child health as a priority concern. In 1998 a Population 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 programme. In September 2000 Sri Lanka became a signatory to achieve Millennium Development Goals (MDGs) in 2015 that have a significant focus on health status of mother and child (MDG 4 and 5).

MCH has been a long standing priority in the National Health policy. The need for formulating a new MCH policy has arisen due to the evolving changes in priority and the new challenges on the mother, 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.

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. The availability of safe water supply, adequate sanitation and proper nutrition are basic needs for maintaining health of mother and child. These are often cited as the single set of highest priority social service for poor households that would help to promote good health. In addition protection of mother and child from vector borne diseases such as Malaria in affected districts for example by encouraging use of impregnated bed nets, should be high in the policy agenda of such disease programs.

The central role that is continued to be played by the Ministry of Health and FHB in policymaking and planning of the services, and their collaborative links with the other health and health related services/programmes emphasizes the need for a well documented MCH policy. Further the change in managerial processes as a result of devolution of MCH functions to the provinces calls for clear national policies to enable policy guidance and directions to the provinces for them to function effectively. Considering the challenges to MCH arising from the rapid demographic transition that has resulted in new demands for services, rising peoples expectations, and reported trends in unhealthy lifestyles and behavioral changes of young adults, it has made it necessary to have a Maternal and Child Health Policy. Such a documented policy will provide the much needed direction to strategic planning, implementation, monitoring and evaluation of MCH programme to effectively address such issues.

SCOPE

The Maternal and Child Health (MCH) programme was primarily directed at women during pregnancy, delivery and postpartum period, and at the newborn, infants, and children including school children. Most efforts to improve pregnancy outcomes during the past several years have focused on promoting antenatal care and caring for post partum mothers. In order to be effective, many interventions must be delivered before pregnancy and continued after delivery to detect, manage, modify, and control maternal behaviors, health conditions, and risk factors that contribute to adverse maternal and infant outcomes.

Thus the improvement in the health status of women and children will be better achieved if a broader view of 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 and adolescents, and family planning integrated with other related health issues such as STD/HIV/AIDS, gender and women's health.

The MCH policy however does not cover all aspects of reproductive health which is a much broader concept and that extends beyond the childbearing years and covers all matters relating to the reproductive system and to its functions and processes.

This document provides policy and strategic directions to continuing and emerging policy challenges in Maternal and Child Health. This policy will be backed by appropriate strategies of MCH that will among others focus on maintenance and strengthening of the already-established effective mechanisms of MCH services.

DEFINITIONS/ABBREVIATIONS

Total fertility rate	- Total no. of children a woman would have by end of her reproductive period if she experienced the current age specific fertility rates throughout her child bearing years.
Maternal Mortality rate	- An impact indicator to evaluate maternal care services. Expresses as the number of Maternal deaths per 100,000 live births
Infant	- Child less than 1 year old
Neonate	- Infant aged up to 28 days
Infant Mortality rate	- An impact indicator to evaluate perinatal and child care services. Expresses as the number of infant deaths per 1000 live births
Neonatal Mortality rate	- An impact indicator to evaluate perinatal and child care services. Number of neonatal deaths per 1000 live births
MCH/FP	- Maternal and Child Health and Family planning
GNP	- Gross National Product
ICPD	- International Conference on Population and Development
MDG	- Millennium Development Goals
DHS	- Demographic Health Survey, a national survey conducted every 5 years by the Dept of Census and Statistics in collaboration with Ministry of Health
RHCS	- Reproductive Health Commodity Security
NGOs	- Non Governmental Organizations
WHO	- World Health Organization
UNICEF	- United Nations Children's Fund
UNFPA	- United Nations Fund for Population Activities
HMIS	- Health Management Information System
PDHS	- Provincial Director of Health Services
RDHS	- Director of Health Services
MOH	- Medical Officer of Health

PHNS	- Public Health Nursing Sister
PHM	- Public Health Midwife
PHI	- Public Health Inspector
BCC	- Behaviour Change Communication
WWC	- Well Woman Clinic

Women in the reproductive age group - Women in the age group of 15 – 49 years

Comprehensive Emergency Obstetric Care facilities – Maternity care facilities with provision of comprehensive care (Facilities for caesarean sections,

Unmet need for Contraception - Married, fertile couples who do not desire to have children but are not using FP methods

VISION

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

MISSION

To contribute to the attainment of highest possible levels of health of all women, children and families through provision of comprehensive, sustainable, equitable and quality Maternal and Child Health services in a supportive, culturally acceptable and family friendly settings.

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 of quality care during pregnancy, delivery and post partum period.

Goal 3

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

Goal 4

Enable all infants and preschool children to survive and reach their full potential for growth and development through provision of optimal care.

Goal 5

Ensure that children (5 to 9 years) and adolescents(10 – 19 years) realize their full potential in growth and development in a conducive and resourceful physical and psychosocial environment.

Goal 6

Enable marginalized children and those 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 managers are responsive and accountable for provision of high quality MCH services.

Goal 10

Ensure effective monitoring and evaluation for MCH programmes that would generate quality information to support decision making.

Goal 11

Promote research to increase evidence base and its use in policy formulation and in interventions to improve MCH care.

Goal 12

Ensure sustainable conducive behaviors among individuals, families and communities in support of Maternal & Child Health.

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 reduction of maternal and neonatal mortality and morbidity.

The maternal mortality ratio in 1935 was 2700 per 100,000 live births and by 2006, the maternal mortality ratio had been reduced to 39.3 maternal deaths per 100,000 live births. It is reported that 72-75% of these maternal deaths are preventable, and in most cases correctable conditions were not detected until the woman has become 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 pre-pregnant mother, and prevent complications of pregnancy.

Certain personal behaviours, psychosocial risks, and environmental exposures associated with negative pregnancy outcomes can also be detected and modified before conception. Changes in the knowledge, attitudes and behaviours 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 STI /HIV /AIDS requires close monitoring of this condition. In order to reduce the prevalence of these diseases and protect the women from their adverse effects, some activities of those programmes have been integrated to MCH program, 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 infants die during the neonatal period. Nearly 17% of newborns are of low birth weight. New strategies have to be implemented to further reduce the infant mortality rate. One priority strategy is for the interventions for reduction of infant mortality rate and low birth weight to start from pre-conception stage.

Women who suffer from various chronic disease conditions such as diabetes that is on the rise can have an adverse effect on pregnancy outcomes, leading to still births, neonatal deaths, and birth defects. These can be prevented by proper care during preconception period.

Considering the above, a new package for “pre-conception care” has been introduced to the maternal and child health programme. 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 of Population and Development (ICPD) in Cairo 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, a "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 cancer prevention and treatment. The concept of screening healthy well women at community level is something that is relatively new, requiring public awareness.

Many of the programmes 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 who require special attention and care who are not accessible to the routine reproductive health services. This group includes women such as 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 women.

GOAL 2

Ensure a safe outcome for both mother and newborn through provision of quality care during pregnancy, delivery and post partum 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 (DHS 2007). These levels of service coverage need to be maintained and improved upon to reach all women in the country. In particular the maternal mortality ratio can be further reduced with concerted systemic and other health interventions.

Certain quality aspects of the services provided especially in smaller hospitals and failure to meeting the aspirations 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 (EmOC). 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 units in the larger hospitals and underutilization of maternity units of the smaller hospitals. Haemorrhage, eclampsia / PIH and Heart disease complicating pregnancy are main causes of maternal deaths. The nutritional deficiencies such as anaemia during the pregnancy and postpartum period, contributes heavily on maternal and newborn morbidity and mortality. The variation in district differential MMR is also a serious issue that is yet to be addressed.

The shortfall in coverage and quality of care in the post partum period also contributes in no small measure to maternal morbidity and mortality and needs to be improved. So also is the accessibility to maternal and newborn services by groups such as populations 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.
- e) Strengthen the surveillance system for maternal morbidity and mortality.

GOAL 3

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

Rationale

Infant mortality and neonatal mortality in Sri Lanka declined dramatically in the last century. The Malaria Control Programme, the Expanded Programme of Immunization, the Safe Motherhood Concept and Promotion of Breastfeeding are some of the key interventions responsible for this spectacular reduction in Infant and Neonatal mortality. However, the infant and neonatal mortality has been stagnant for the over a decade now. Just as in other countries that have reduced the infant mortality, neonatal mortality contributes to nearly 80% of infant mortality in Sri Lanka. It reports a neonatal death rate of 7.4 per 1000 live births (2006). Most of these deaths are a result of pregnancy related or delivery related complications. Analysis of neonatal mortality data shows that more than two thirds of the neonatal deaths are early neonatal deaths occurring within the first week of life.

In addition, 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. Though the vital registration system of the Registrar General and the information system from the Medical Institutions do not provide very accurate information on neonatal mortality, it provides a proxy figure on which we can make inferences.

Further reduction of neonatal mortality in Sri Lanka needs well focused interventions. As indicated under other policy goals, improving the nutrition of pregnant women to improve birth outcomes and reduce low birth-weight, identifying and treating medical conditions such as diabetes and hypertension are among some measures that could be taken prior to birth. At the time of delivery obstetric care of good quality including timely referrals would also help to reduce perinatal and neonatal mortality.

To produce favourable 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.

The perinatal and neonatal morbidity and mortality surveillance system is essential for monitoring and evaluation of the neonatal care services in the country. Perinatal Audit has to be established 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 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.

GOAL 4

Enable all children under five years 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 to be low in comparison with international norms, they still rate high, and the 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 disease 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 poor performance on child malnutrition is disturbing, with one out of three children aged five and below being underweight, with social and cultural practices being implicated as possible causes. There is a need to actively promote nutrition education and counseling to mothers and adolescent

girls. Growth monitoring and promotion have been in progress for many years, but the desired impact is still not visible.

There is also a need to strengthen psychosocial development of child 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 lower the high prevalence of dental caries among school children.

Strategies

- a) Ensure the provision of quality child care services at both field and institutional settings.
- b) Maintain optimal nutritional status.
- 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.

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

The school population in Sri Lanka is approximately 3.9 million in 2008, studying in 9662 schools in the country (school census, 2008). More than 60 percent of school children belongs to the adolescent age group of 10 – 19 years.

The School Health Programme which commenced in 1918 has continued to address the health issues of school children and adolescents and this programme needs to be improved upon with a collaborative and multidisciplinary approach involving many stakeholders.

The implementation of school health programme is the responsibility of both Health and Education Ministries. The Family Health Bureau is the focal point for the school and adolescent health programmes in the Ministry of Health and the services are delivered through Primary Health Care infrastructure while the provincial education and health authorities are responsible for implementation of the programme in the decentralized system.

The major components of the school health programme are school medical services including counseling services, maintenance of healthy school environment, life skills based Health Education, school community participation and healthy 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 2008, however, the quality of the programme still needs improvements.

In order to achieve the full 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 that would form an integral part of School Health Programme.

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 Ministries of Health and Education, Provincial health and education authorities and also with other stakeholders by working together on a comprehensive approach to improve school and adolescent health.

Strategies

- a) Strengthen partnerships with Ministry of Education, other relevant stakeholders and communities for the implementation of a comprehensive child and adolescent health programme in school and community settings.
- b) Implement need based health education focusing on skill development
- c) Promote nutrition and healthy lifestyles among children and adolescents.
- d) Ensure access to child and adolescent friendly health services, including dental services and counseling.
- e) Empower children and adolescents to make informed choices regarding their sexual and reproductive health issues.
- f) Empower parents and guardians in caring for their children and adolescents.

GOAL 6

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

Rationale

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

Many of the programmes that are aimed at promoting child health, the focus has generally been on the children who are accessed through the available services. However, there is an important group of children, who are not 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.

The reasons as to why such children exist in today's society are multifaceted. Hence the approaches to be used to improve the status of these children also need to be multi-faceted. Even though limited reports are available on such children, there is no reliable data on the size and 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 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-sectoral collaboration among key stakeholders providing care for children with special needs.

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 & child health (MCH) services and offer 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 couples. Temporary modern methods are provided by a network of more than 1800 family planning clinics. In addition, primary healthcare staff such as Public Health Midwives (PHMs) and Public Health Inspectors (PHIs) distribute oral contraceptive pills and condoms in the community. Also, more than 100 medical institutions provide permanent family planning methods (sterilizations). In addition to the government health sector, FP is also supported by three well established Non Governmental Organizations (NGOs), who also provide mobile outreach services¹.

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 size².

The main reasons for unintended pregnancies is the inadequate services for permanent family planning methods (male & 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 NGOs 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 be well received.

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 & streamline services for sub-fertile couples.

Source:

1. Family Health Bureau, January 2009, *Annual Report on Family Health Sri Lanka, 2006-2007*.
2. Rajapakse, L., (2000). *Estimates of induced abortions in Urban and Rural Sri Lanka*.
3. Dept of census & Statistics, April 2009, *Sri Lanka Demographic and Health Survey, 2006/2007*.

GOAL 8

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

Rationale

Even though gender equity and equality 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 behaviours and vulnerability of women to 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 programmes of different sectors.

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

The traditional family set up in which mothers are the caregivers and fathers remain the income earners need to change and fathers being encouraged to play a greater role in childcare. 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.

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 in to the data management 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 who is actively involved towards the prevention and management of gender based violence.
 - (f) Promote and enhance male participation in reproductive health care.
- a) Empower men and women to promote community mobilization towards prevention and management of gender based violence.

GOAL 9

Ensure that National, Provincial, District and Divisional level managers are responsive and accountable for provision of high quality MCH services.

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 Sri Lanka Constitution, in 1987. This has caused changes in implementation of MCH services at sub national levels. Thus functions related to MCH at provincial levels needed to be reviewed, re defined and realigned to produce more effective services.

The success of any health program depends on the commitment of the managers running the programme. In the case of MCH services the responsibility of implementing a quality MCH programme falls on the Provincial Directors, Regional Directors of Health services, Hospital Directors, Medical officers MCH and Medical officers of Health. An appropriate mechanism to make these managers at different levels to be more accountable for MCH service provision has to be instituted. Steps need also to be taken to build commitment and advocacy skills among MCH programme 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 programmes in MCH should be of appropriate numbers, with the correct skill mix. The diversity of the activities related to the MCH programmes 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 programme 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 and when appropriate, has to be linked to career advancement opportunities for the staff.

The on going collaboration with professional bodies, development partners such as WHO, UNICEF, UNFPA 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 programme.

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) Ensure collaboration and partnership with professional bodies and relevant stakeholders.
- f) Strengthen the FHB as the Centre for Excellence to provide national leadership in Maternal and Child Health.

GOAL 10

Ensure effective monitoring and evaluation of MCH programme that would generate quality information to support decision making.

Rationale

The Health Management Information System (HMIS) for MCH/FP is the responsibility of the Family Health Bureau and is managed by its Research and Evaluation Unit. Its aim is to generate quality MCH information and to also help MCH personnel at the National, Provincial and local levels to improve their capacity to collect, analyze, and use data for planning and for 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 both Government and NGO sectors, the system has expanded to take in MCH data, maternal mortality data, school health and WWC services.

However the HMIS of MCH programme needs to be reviewed to capture information on the critical needs inhibiting the progress. Among the challenges are the irregularities in quality and flow of data, issues on standardization of criteria and

delays in collection of data, inadequate feedback and use of information at various levels.

The bulk of the data received is generated at PHC level, through the public health midwives (PHM) and the Medical Officers of Health (MOH). The data collated through this system is analyzed and used at all levels, namely Divisional (MOH), Regional (RDHS), Provincial (PDHS) and National (FHB).

Both quantitative and qualitative indicators are available and health staff at all levels has been trained in the analysis and interpretation of data. The information is used for improving program performance and management. However, the utilization of data is poor and needs to be strengthened at each level. A feedback is provided by the FHB to all concerned, with data analyzed and relevant information/ observations, for use by service providers and managers. The FHB also closely monitors the development of the EOC and newborn care facilities which have a major bearing on efforts to reduce morbidity and mortality.

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 concern and warrants early attention.

Strategies

- a) Strengthen the Health Management Information System on MCH
- b) Reinforce planning, monitoring and evaluation of MCH program
- c) Establish a network for MCH information sharing among relevant stakeholders.

GOAL 11

Promote research for policy and practice in MCH.

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/program delivery. MCH being an area of work with considerable behavioral and socio-economic implications, the local knowledge needed for successful program implementation has necessarily to be derived by undertaking national and local level investigations and studies. The decision-making in policy areas as well as in program areas also has to be as best as possible evidence-based.

Among the strategic areas for research that could be considered are those directed at MCH systems of care and services to underserved populations, changing roles and functions of MCH staff from the demographic and epidemiological transitions, on 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 form the core of a research system for MCH include capacity development, for both the demand and supply sides of research,

knowledge generation which helps in improving the knowledge base to act as well as 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 the evidence base needed for policy formulation and practices in relation to MCH.
- b) Establish a collaborative mechanism for MCH research development

GOAL 12

Ensure sustainable conducive behaviours among individuals, families and communities to promote Maternal and Child Health.

Rationale

Improvement of Maternal and Child Health of the communities requires that healthy attitudes and behaviours are sustained and nurtured continuously. Maintaining current good behaviours conducive to Maternal and Child Health, cultivating desirable behaviour practices that are weak and improving practices that need strengthening are required. Good Behaviour Change Communication (BCC) strategies are needed to accomplish this. BCC strategies need to be strengthened with the participation of relevant health personnel and experts in behavioural sciences, with the guidance of MCH experts. Communities themselves need to be empowered and mobilized to sustain healthy behaviours among themselves and by themselves.

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 required for the development and well-being of women and children. The support of the sectors of education (to improve and reinforce health conducive behaviour) and agriculture (for food security and economic development) is essential. Thus, BCC programmes and interventions need to be conducted in co-ordination with these and other sectors. Mass media support is also a great boon to sustaining and improving desired behaviours at grass root level. It has been seen that mass media plays a significant role in influencing the knowledge and practices of the general public. Thus, BCC programmes in support of MCH would be greatly enhanced by working together with the mass media and providing regular updates on health promoting behaviors and practices to the media.

Strategies

- a) Strengthen BCC interventions to improve the MCH programme

- b) Promote mass media support for Maternal and Child Health
- c) Foster community empowerment and mobilization to sustain conducive behaviours in support of MCH
- d) Develop appropriate mechanisms for inter-sectoral co-ordination both at all levels to strengthen BCC interventions in MCH.