International Journal of Multidisciplinary Research and Publications
ISSN (Online): 2581-6187

Review of the Activities and Progress of Maternal and Child Health Services at the Kalutara District of Sri Lanka

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Abstract— *Maternal and Child Health programme is one of the vital component of Sri Lankan health sector, which has achieved remarkable progress during past few decades. Objective of this case study was to review the current situation of MCH services in Kalutara RDHS area and it was done by mixed methodologies including key informant interviews, focused Group Discussions and participate to the review meetings etc. Several problems were identified by above techniques and Nominal group technique was used to prioritize the identified problems. "Low coverage of preconception clinics" was identified as the prioritized problem and fish bone analysis was performed. It was recommended to collaboration with marriage registrars and public health staff on conducting pre-conceptional clinics. Awareness programmes and health promotion campaigns would be useful and delivering of health messages on pre-conceptual care through multimedia is recommended.*

Keywords— *Maternal and Child Health, Regional Directorate of Health Services, Kalutara.*

I. INTRODUCTION

The evolution of the MCH services in Sri Lanka has been fostered 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 Sri Lanka maternal and child health has a very long history, which dates back to the early 20th century. Presently MCH services are carried out by a central government agency called the Family Health Bureau (FHB) which is responsible for planning, coordination, monitoring and evaluation of the MCH & Family Planning services.

Vision of Maternal and Child health services in Sri Lanka is "A Sri Lankan nation that has optimized the quality of life and health potential of all women, children and their families" and the mission of the MCH services is "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 supportive, culturally acceptable and family friendly settings".

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

MCH services have several components as follows,

a) Maternal care
   - Antenatal care
   - Intra natal care
   - Postnatal care
b) Infant & Child care
   - Newborn care
   - Infant care
   - Preschool child care
c) School health
d) Family planning
e) Women's reproductive health

II. BACKGROUND OF THE KALUTARA RDHS

Since 1989, the country's administration has been decentralized with devolution of administrative powers to nine Provincial Councils. Each province has a Provincial Director of Health Services (PDHS) who is responsible for provision of health care within the province and is supported by Regional Directors of Health Services (RDHS) who are in charge of each of the Health Districts within the provinces. The RDHS is supported by a MO Planning, Medical Officer on Maternal and Child Health

Jayasiri Wijayasiriwardhana, "Review of the Activities and Progress of Maternal and Child Health Services at the Kalutara District of Sri Lanka," *International Journal of Multidisciplinary Research and Publications (IJMRAP)*, Volume 3, Issue 7, pp. 38-42, 2021.

(MOMCH), Regional Epidemiologist (RE) Regional Supervising Public Health Nursing Officer (RSPHNO), MO Non Communicable Disease NCD, Health Education Officers (HEO) and other technical staff.

Kalutara is one of the three districts in western province of Sri Lanka1, 271,325 distributed in land area of 1,607.5 sq.km. The population density is 791 per sq. km. Kalutara district is bounded by Colombo district from North, Galle district from South and Ratnapura district from eastern. Western boundary of Kalutara district lies on the west coast of Sri Lanka.

District is further sub-divided into Health Units/ Divisions, each division being managed by a Medical Officer of Health (MOH) supported by a team of public health personnel comprising Public Health Nursing Sisters (PHNS), Public Health Inspectors (PHI), Supervising Public Health Midwives (SPHM) and Public Health Midwives (PHMs).

MOH Clinic Centers in the District

Type of clinics	No. of functioning Clinics
Total Clinic Centers in the District	161
WWC Centers in the District	60
Family Planning Clinic Centers in the District	87
Weighing Centers in the District	1056

III. Objective of the Study

To review the current situation of MCH services in RDHS area of Kalutara.

IV. Methodology

- Key informant interview
  Done with RDHS, D/RDHS, MO-MCH, Public Health Nursing sister
- Reviewing the secondary data and past literature.
  Reviewed literature of MCH activities of the district, studied notes and documents
- Participate to the review meetings.
  Participated Maternal review meetings at the regional level, provincial level and national level.

V. Results

a) District Summary of MCH clinic services 2018

I. Ante natal care (ANC) coverage (at least 1 visit) - 95.7 %
II. Coverage of HIV screening
  2.1 Tested in the clinic- 97.4%
  2.2 At the time of delivery- 99%
III. Coverage of VDRL testing
  3.1 In the clinic - 98.3%
  3.2 At the time of delivery - 99.2%

Coverage of the Ante natal care (ANC), Coverage of HIV screening, Coverage of VDRL testing at 95.7 %, 97.4%, 98.3% respectively.

Statistics of Pre-conception Care compared to other clinics

Compared to other clinics Percentage of Newly married couples registered is law

	Percentage of Newly married couples registered (H524)	Percentage of Newly married couple attend at MOH Clinic(H527)
2016	39	12.8
2017	38.7	12.4
2018	37.9	12.5

Statistics of Pregnant mothers registered at ANC

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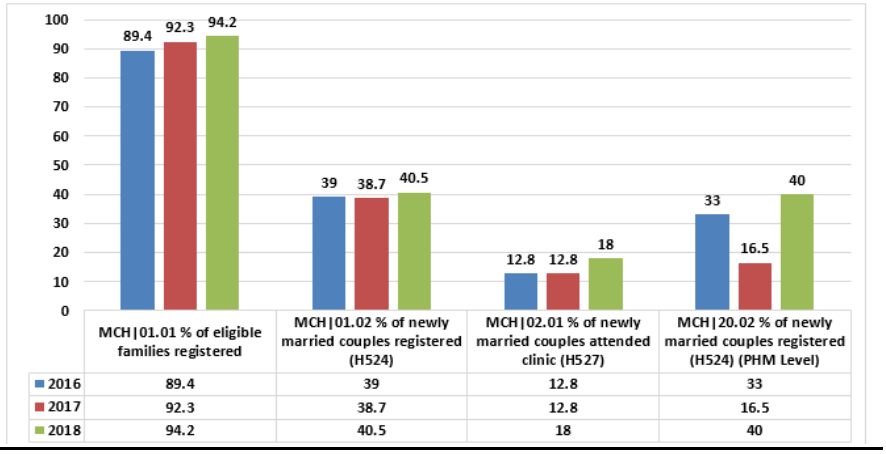


Maternal death reporting

	2016	2017	2018
No. of Maternal Death reported	5	5	8

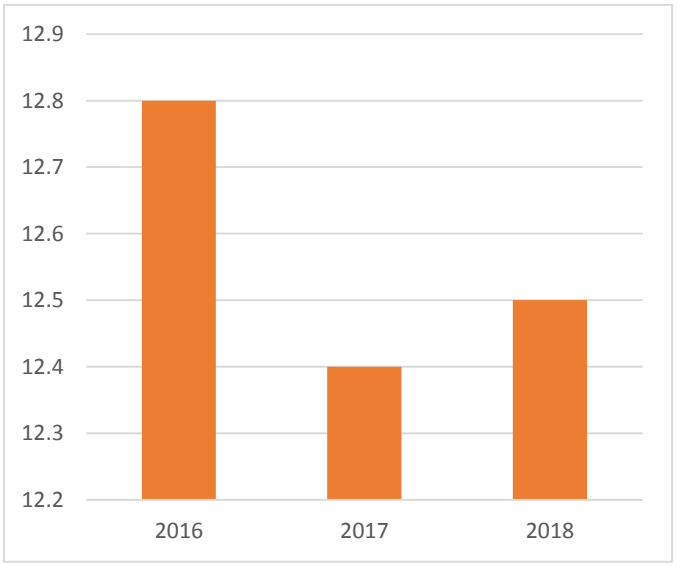
Perinatal death reporting

Indicator	2016		2017		2018	
	Hospital	Field	Hospital	Field	Hospital	Field
No. of Still births > 22 wks – 28 wks	2	70	02	93	1	76
No .of Still births > 28 wks	37		39		43	
No .of early neonatal deaths	40		53	77	42	91
Total No. of Perinatal deaths	79		92		85	
Perinatal Death Rate (1000 total births reported)	**10.7**		**13.8**		**12.8**	

Infant and Child Mortality Indicators

Indicator	2016		2017		2018		2018 National
	No.	Rate %	No.	Rate %	No.	Rate %	Rate %
Early Neonatal mortality Rate(1-7days)	62	5.05	77	6.3	91	7.5	7.1
Neonatal mortality Rate	84	6.8	96	7.9	111	9.1	8.6
Infant deaths reported	109	131	138	203	136	93%	
Infant mortality Rate		8.8		11.3		11.2	10.6
Child deaths reported (1 – 5 years)	8	80	27		19		
Under five mortality Rate (0 – 5 years)	117	9.5	165	13.5	155	12.8	12.1

Percentage of newly married couple attended at clinics



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VI. Problem Identification

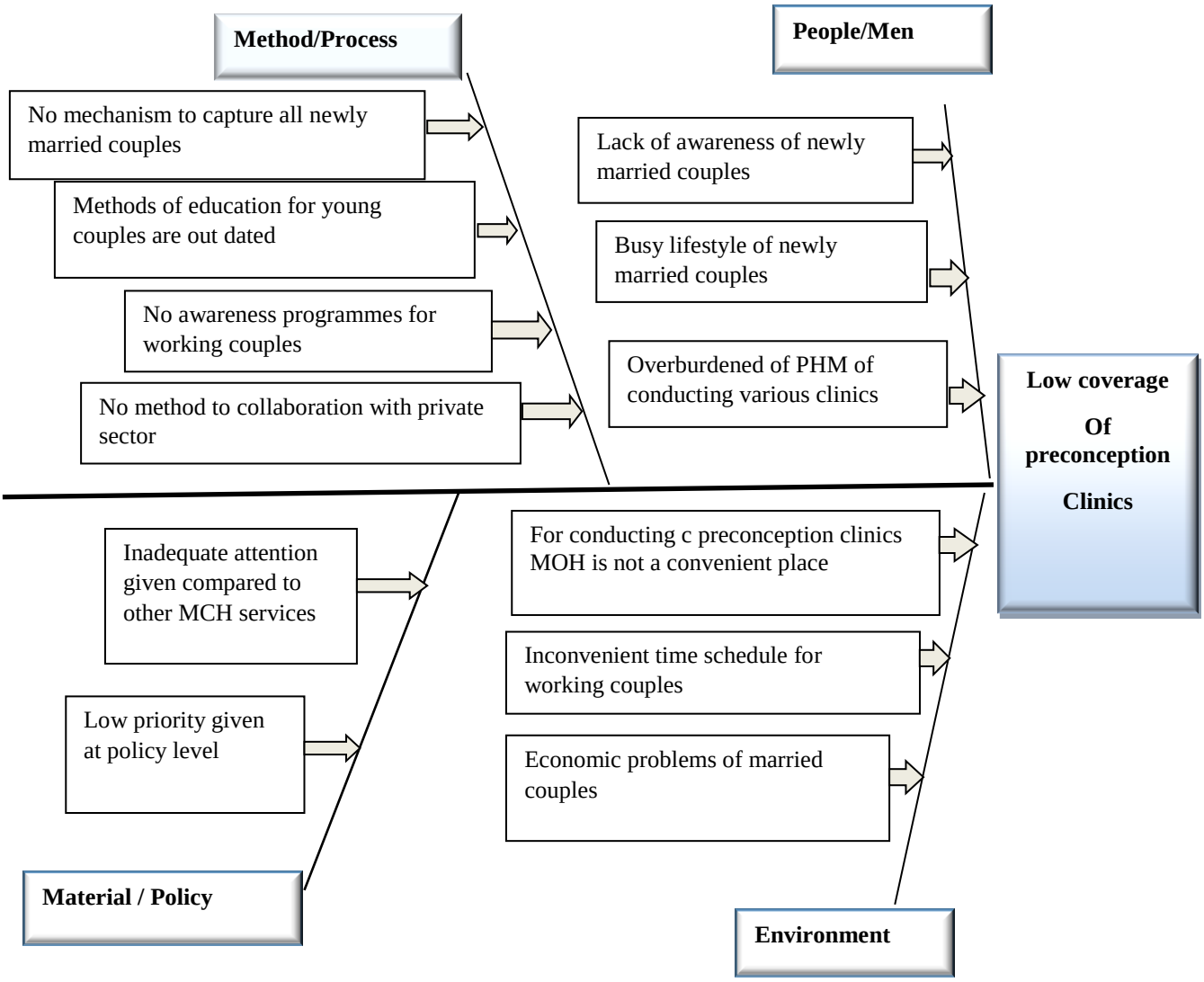
From the qualitative and quantitative methods discussed under methodology, following problems were identified

1. Low coverage of preconception clinic coverage -Participation of newly married couples for MCH programmes was fairly low when compared to other clinics.
2. Nutritional problems like child malnutrition, low BMI of pregnant mothers, Anemia during pregnancy have to be addressed further.
3. Lack of coordination on school health promotion activities, need more supervision.
4. Well woman clinic coverage is low.
5. Adolescent health problems and teenage pregnancies need to be addressed further.

VII. Problem Prioritization

Among these five problems that were identified, we had to prioritize one for the root cause analysis. The Nominal Group Technique was used here. The 4 Medical administration Registrars were engaged in this each Medical Admin registrar was given a chart and the total marks given for each problem was calculated. The Total marks given for each problem is recorded and then the prioritized problem was identified by the highest marks obtained

From the above issues, low coverage of preconception clinics received highest points and was identified as the problem statement and fish bone analysis was carried out as mentioned below.



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Prioritization of root causes

Nominal group technique used for prioritized the arm which is going to be addressed with other co- registrars. Following table was used and according to nominal group technique the' Method' arm received highest score. So recommendations were based on causes pertaining to the 'Method' arm.

	Aspects of causes (Marks Given out of 10)							
Causes Identified in each section	**I-**Technical Feasibility for intervention.	**II -** Administrative Feasibility.	**III -** Financial Feasibility.	**IV-** Practical possibility.	**V-** Impact.	**VI-** Time factor.	**VII-** Acceptance	**Total**
'Man' Arm								
'Method' Arm								
'Environment' Arm								
'Method/Policy' Arm								

VIII. Conclusion

1. *No proper mechanism to cover all newly married couples*

Four out of 10 women, reports that their pregnancies are unplanned (WHO, 2013). But in the district there is no mechanism available to reach all newly married couples. Need to incorporate with all the stakeholders and close monitoring and supervision to enhance and uplift the service delivery system.

2. *Inconvenient time schedule for working couples*

Most MCH services are delivered during day time on weekdays which invariably discourage young working healthy couples to seek preconception services at MOH. Hence their -participation decreases considerably thereby exposing them for preventable health hazards.

3. *No awareness programmes conducted about the services*

Despite popular MCH services, preconception clinic services are alien to general public. Most MCH services are sought, following conception. There need to be attractive propaganda in order to attract target groups

IX. Recommendations

1. In order to cover target group the best possible entry point would be at marriage registration. It is recommended to make it compulsory to register to preconception clinic during marriage registration process.
2. Get the assistance of marriage registrars to explain the importance of using the services. Distribute leaflet on importance of pre-conception clinic.
3. Arrange training programmes for marriage registrars and public health staff on same platform in lieu of above
4. Workplace awareness programmes to be conducted along with other health promotion activities at workplaces
5. Utilize mass media to deliver health messages to the target groups regarding the importance of MCH services at preconception clinics.

Acknowledgements

RDHS, Deputy RDHS, MO-MCH ,PHNS and all the staff at the RDHS office specially at the MCH unit. Also my gratitude goes to all the MOH officers and staff for their support.

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