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PART I : SECTION (I) — GENERAL

Government Notifications

NATIONAL MATERNAL AND CHILD HEALTH POLICY OF SRI LANKA

THE National Maternal and Child Health Policy and the Revised Maternal and Child Health Action Plan and are approved by the Cabinet Ministers, to enable effective implementation from today onwards. They were long felt needs of the country and will enable policy guidance and directions to relevant stakeholders and provincial authorities for effective implementation of the Maternal and Child Health Programme.

DR. T. R. C. RUBERU,
Secretary,
Ministry of Health.

Ministry of Health,
No. 385,
Re. Baddegama Wimalawansa Thero Mawatha,
Colombo 10,
31st May, 2012.

1. PREAMBLE

Sri Lanka, being promoted as a middle income country with a per capita GNP of 2804 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 2.8 in 1953 to 0.7[2] percent and the total fertility rate has dropped from 5.0 in 1962-64 to 2.3 during the period of 2001-2006 [3]. The infant mortality rate has also declined from 72.4 in 1955 to 9.0 per 1000 live births in 2009 [4]. Similarly 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 years 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[6] while further 26 percent comprised adolescents and youth.

[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

Paradoxically the country has 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 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 Child 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 services 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 needs 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 programme in the present context.

2. BACKGROUND

Maternal and child health in Sri Lanka 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 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 services 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 Programme.

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 1987, 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 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 with two goals having a significant focus on health status of mother and child (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 formulating 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/programmes emphasizes the need for a well documented Maternal and Child Health Policy to work towards national goals. 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 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 programme to address such issues effectively.

3. SCOPE

The Maternal and Child Health (MCH) programme 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 post partum mothers. In order to be most effective, appropriate interventions must be introduced before pregnancy and continued after delivery to prevent or 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 post partum 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 broader 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 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 programme linkages with other relevant health and non health programmes 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 Maternal and Child Health services.

4. VISION

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

5. 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.

6. 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 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 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 MCH services.

Goal 10

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

Goal 11

Promote research for policy and practice in MCH. (Maternal and Child health)

Goal 12

Ensure sustainable conducive behaviours 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 reduction of maternal and neonatal morbidity and mortality.

The maternal mortality ratio 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 woman at pre-pregnant stage, 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 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 programmes have to be integrated into MCH programme, 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 percent of newborns are of low birth weight. New strategies have to be implemented to further reduce the infant mortality rate, of which some interventions for reduction of infant mortality and low birth weight should be started from the pre-conception 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 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 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.

[1] Register General's Department –Provincial Data - 2009

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 Diabetes Mellitus, Hypertension, Cancer prevention and management. The concept of screening healthy well women at community level is an approach 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 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 programm.
(*e*) Strengthen partnership with other stakeholders who provide care for women.

6.2 POLICY 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 (Census, 2007[1]). 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 health and other appropriate interventions.

Certain quality aspects of the services provided specially in smaller hospitals and failure to meet 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 (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 units in the larger hospitals and underutilization of maternity units of the smaller hospitals. Haemorrhage, Eclampsia[2] Pregnancy Induced Hypertension, Septic Abortion and Heart disease complicating pregnancy are main causes of maternal deaths. The nutritional deficiencies such as anaemia during the pregnancy and postpartum period, may contribute to 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 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 postpartum women.

[1] Dept. of Census & Statistics –DHS survey 2006/7

(*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.

6.3 POLICY 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 Programme 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 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 neontal death rate of 6.2 per 1000 live births has been reported in 2009. Most of these deaths occur as 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.

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 conditions such as diabetes and hypertension are among some measures 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 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.

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 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.

6.4 POLICY 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.

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

[1] Register General's Department –Provincial Data - 2009

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 schools 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 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 implementation of 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 2010[2], however, the quality aspects of the programme still need improvement.

[1] School Census, Ministry of Education 2008
[2] Family Health Bureau, Annual Report on Family Health Sri Lanka 2010

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 behaviours 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 Central 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 between Ministries of Health and 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 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 enables them to optimally develop their mental, physical and social capacities to be independent and 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 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 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 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-sectoral 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 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 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 & 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 gain popularity.

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.

6.8 POLICY 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

[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.

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 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 programmes 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 equity starting with sensitizing of policy makers and programme planners at all levels. Community mobilization towards gender equity and equality is also very vital, 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 a 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 programme should address reproductive health needs of migrant workers 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 in to 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 organizations 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 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 need to be reviewed, redefined 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 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 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 and 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 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*) 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 MCH programme that would generate quality information to support decision making.

Rationale

The maintenance of Health 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 both Government and NGO sectors, the system has expanded to collect data in the fields of MCH, maternal mortality, school health and Well Woman 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 Midwife (SPHM), Public Health Inspector (PHI), 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 programme managers.

However, the Health Management Information System of MCH programme 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 concern 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 Registrar General's, Census and Statistics, Central Bank etc. are also important for MCH programme 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 a 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 derived by undertaking national and local level investigations and studies. The decision-making in policy areas as well as in program areas also should be as best as possible evidence–based.

Among the strategic areas for research that could be considered are those directed at MCH services to underserved populations, changing roles and functions 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 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 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 a collaborative mechanism for MCH research development.

6.12 POLICY GOAL 12

Ensure sustainable conducive behaviours 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 behaviours are sustained and nurtured continuously. Maintaining current good behaviours conducive to MCH and cultivating desirable behaviours are required.Good Behaviour Change Communication (BCC) strategies are needed to accomplish this. BCC strategies need to be strengthened with the participation of relevant experts in behavioural sciences in collaboration with MCH experts. Communities themselves need to be empowered and mobilized to sustain healthy behaviours.

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 seen that the media plays a significant role in influencing health knowledge and practices among the general public. Medical Officer of Health (MOH) programme managers and service providers should ensure close collaboration with all sectors involved in BCC.

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 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 programme management at district and provincial levels is vested with the Provincial and Regional Directors of Health Services with the technical guidance of the Medical Officers 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 and national level and will monitor the progress of its implementation. The Professional bodies such as Sri Lanka College of Obstetricians and Gynaecologists, College of Paediatricians, 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 Programme / Cervical Cancer Screening Programme – chaired by Director General of Health Services with participation of Health Ministry officials, Professional bodies and representation from Provincial Health authorities.
6. Sub Committee 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 programme implementation and decisions will be taken by the committee members to support policy implementation.

According to the Section 5 of the Health Services Act (Act, No. 12 of 1952) the Honorable Minister of Health shall make regulations in addition to the provision published under the National Policy on Maternal and Child Health of Sri Lanka based on the future demand and necessities of the concerned sector.

Maternal and Child Health Policy – Action Plan

Component	*Maternal Health*
Objective:	Ensure a safe outcome for both mother and newborn through provision of quality care during pregnancy, delivery and post partum period

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
1. Maternal care strategic plan available and used for planning purposes	1. Develop national strategic plan, annual operational plan on maternal care	Availability of National Strategic plan	Zero	Available by end 2012	MoH, Family Health Bureau	WHO, SLCOG
	2. Provinces and districts to develop their operational plans based on the national strategic plan	Availability of district operational plans	Adhoc	Availability by 2013	FHB & Provincial Health authorities	SLCOG
	3. Establish a technical Advisory committee on Maternal health and function regularly	No. of meeting of Technical Advisory Committee on Maternal Health in year	Zero	Meetings held once in two months	MoH, FHB	SLCOG WHO, UNICEF, UNFPA, Provincial authorities
2. Availability of uniform, updated evidence based technical guidance and direction to improve Maternal Care	1. Develop protocols and guidelines on maternal care based on internationally accepted current evidences	Availability of a pilot tested evidence based maternal care service delivery package	Adhoc	Available and implement in all districts by 2013	FHB, SLCOG	WHO, UNFPA, UNICEF
	2. Develop and disseminate Management protocols and guidelines on ten leading maternal morbidities	Availability of protocols'	Few	Availability of 10 protocols by 2013	FHB, SLCOG	WHO, UNFPA, UNICEF
3. Availability and adherence to uniform, updated, evidence based technical guidance on EOC and EmOC	1. EOC, and EmOC guidelines and protocols developed and disseminated	Availability of EOC and EmOC guidelines and protocols	Few, adhoc	Guidelines and protocols available by 2013	FHB, SLCOG	WHO, UNFPA
	2. Establish women friendly intra natal care including pain relief and positive birth care practices	% of women received pain relief during delivery % of women who had birth companion at delivery	Data not available	50% women delivered by 2013 75% of women delivered by 2013	FHB, SLCOG	Provincial Health authorities/ WHO/UNICEF/ UNFPA

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
	3. Practice universal precautions for BOC, EOC and EmOC	% of institutions practiced standard universal precautions	Data not available	100% of institutions by 2013	FHB, SLCOG	Provincial Health authorities/ WHO/ UNICEF/ UNFPA
	4. Develop a model system for effective management of medical diseases complicating pregnancy	No. of management protocols for effective management of medical diseases complicating pregnancies available	Zero	Protocols available by 2013	FHB, SLCOG SL College of Physicians	Provincial Health authorities/ WHO/ UNICEF/ UNFPA
	5. Establish high dependency units (HDU) in obstetric units	% of hospitals with specialised care having HDU	DNA	100% CEmOC facilities to have HDUs	FHB, SLCOG Heads of institutions	UNFPA, WHO
	6. 24 hour functioning EmNOC facilities established as per norm	% of hospitals with specialised care having 24/7 blood transfusion services % of hospitals with specialised care having 24/7 laboratory services	DNA	100% in CEmOC institutions by 2013	MoH, FHB	SLCOG/ UNFPA, UNICEF, WHO
4. Strengthen supportive services (laboratory, radiology, blood transfusion, high dependency and intensive care) to improve maternal care	1. Develop norms for supportive care services	Availability of norms for supportive services	Zero	Available by 2013	MoH, FHB Professional bodies	Provincial health authorities/ WHO/ UNICEF/ UNFPA
	2. Establish supportive services to provide basic, essential and emergency maternal care services	% of institutions equipped with supportive services according to norms	DNA	25% by 2013	MoH, FHBProvincial Health authorities	WHO/ UNICEF/ UNFPA/ Professional bodies
5. Logistics Management System (LMIS) for maternal care and supportive services established	1. Establish LMIS for maternal care and function on annual basis	Availability of the system % of institutions with stock outs of essential items	Zero	System established by 2013 75% of institutions with adequate stocks	MoH, FHB,Provincial Health authorities	WHO/ UNICEF/ UNFPA/ Professional bodies

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
6. A functioning quality assurance system for maternal care established	1. Standards developed on quality of maternal care	Availability of standards on maternal care	Adhoc	Availability of the standards by 2013	MoH, FHB, Professional bodies	WHO/ UNICEF/ UNFPA
	2. Establish an effective quality assurance system for Maternal Care	Availability of Accreditation system for maternal care service delivery points	Zero	50% of institutions to be accredited by 2013	MoH, FHB Professional bodies	Provincial Health authorities/ WHO/ UNICEF/ UNFPA/
	3. Build capacity of all maternal care service providers through pre service and in-service training programmes	% of health staff trained in quality assurance	DNA	50% coverage by 2013	MoH, FHB Professional bodies, Provincial Health authorities	WHO/ UNICEF/ UNFPA
	4. Maternal care quality indicators introduced into routine MIS for monitoring	Availability of quality indicators in the RH MIS	A few	100% coverage by 2013	FHB/ Hospitals	WHO/ UNICEF/ UNFPA
7. Nutritional status of pregnant and lactating women improved	1. Implement appropriate interventions to improve nutritional status of all pre-pregnant, pregnant and lactating women	% of mothers BMI less than 18.5 % of mothers gained adequate weight during pregnancy according to BMI % of pregnant women with Hb < 11g/dl	24% in 2009	20% by 2013 50% mothers to gain adequate weight by 2013 15% by 2013	FHB and Provincial Health authorities	WHO/ UNICEF/ UNFPA
8. Improved Behaviour Change Communication (BCC) interventions in maternal care	1. Implement awareness programs for expecting couples	% of pregnant women attended to 3 parent crafting classes during pregnancy	Adhoc	80% by 2013	HEB, FHB and Provincial Health authorities	Community groups
9. An effective referral system for maternal care established and implemented	1. Develop specific criteria and guidelines for emergency transfers and established the system	Availability of guidelines on emergency obstetric transfers	Adhoc	Availability of the guidelines by 2013 andImplement in 50% of districts by 2013	FHB and Provincial Health authorities	
	2. Create public awareness to minimize delays in seeking appropriate maternal care	Proportion of maternal deaths due to 1st delay		Reduce proportion of 1st delay by 25% by 2013	FHB and Provincial Health authorities,	Community groups

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
10. Improved availability and accessibility of quality maternal care services to special target groups	1. Strengthen MCH service delivery in the estate sector and resettlements	% of skilled birth attendance in the estate sector and resettled areas No. of BEmOC facilities in resettlement areas	80%	95% by 2013	SLCOG FHB, Plantation Trust, Provincial staff	UNICEF, UNFPA, SLCOG
11. Maternal Mortality and Morbidity Surveillance System is re-oriented and implemented successfully	1. Conduct national Maternal mortality reviews timely	% of health regions conducted NMMRs	75%	100% by 2011 - 2013	FHB/ MoH, Provincial Staff, SLCOG,	UNICEF
	2. Strengthen linkages with Registrar General's Dept./ Medical Statistics unit on Maternal Mortality data base	Availability of a mechanism to link data	Zero	No. of maternal deaths reported from other sectors	RGs Dept, MoH, FHB	SLCOG
	3. Develop and implement a comprehensive Maternal Mortality Database and published data annually	Availability of database Annual report published	50% Zero	Available by 2013	FHB	UNICEF/ WHO
	4. Establish a confidential enquiry into maternal deaths surveillance system (CEMD)	Availability of CEMD	Zero	No, of cases reviewed through CEMD	FHB, SLCOG	WHO/ UNICEF
	5. Establish an Institution-based Maternal Morbidity Surveillance system	Availability of survelliance system on severe Maternal Morbidity (near-miss inquiry)	Zero	Pilot tested in 10 Health care institutes	FHB/SLCOG	WHO
	6. Strengthen existing field surveillance system on maternal morbidity	% of MOH areas with accepted levels of reporting	30%	60% MOH areas with accepted levels of reporting	FHB/Provincial Health staff	

Component	*Newborn Health*
Objective:	Ensure reduction of perinatal and neonatal morbidity and mortality through provision of quality care

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
1. Policy guidance and direction to the Newborn Care programme in place	1. Develop and make available a National MCH/FP policy encompassing all components of the newborn care programme	National Policy on MCH/FP including all the components of the newborn health available	Draft	Available by 2012	FHB	Professonal bodies MoH
	2. Advocate and create awareness on the newborn care program to parliamentarians, policy makers, central and provincial administrators, service providers, development partners, all other stakeholders and public	No. of awareness programs conducted	NA	Ongoing programme 2012-2016	FHB, MoH	Development partners
	3. Develop, implement and monitor a five year strategic plan, annual operational plan on newborn care based on the policy	National Strategic plan on Maternal and Newborn Health Operational plans in par with the National MNH strategy	NA	Available by 2012 Available from 2012-2016	FHB	WHO, MOH Professional Bodies
	4. Facilitate, coordinate and guide the provinces and districts to develop their operational plans based on the MCH/FP policy	Availability of operational plans in par with the National Policy and MNH strategic plan at Provincial, district and divisional levels	Adhoc	Annually from 2012-2016	FHB	Provincial staff
	5. Establish and regular functioning of Technical Advisory Committee (TAC) on Newborn care	Availability of a effectively functioning Technical Advisory Committee on Newborn Health	On-going	Conduct regular meetings (6 annually 2012-2016)	FHB DDG(PHS)	Professional bodies, Committee members

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
2.Uniform, updated evidence based technical guidance and direction available to improve neonatal care	1. Incorporate current evidences in to the Newborn Heath Programme on a regular basis	No. of evidences incorporated	A few	Available and implement in all districts by 2013	FHB	SLCCP, WHO UNICEF
	2. Update existing circulars, guidelines and protocols and develop new ones based on current evidence, to disseminate them	Circulars, guidelines and protocols updated once in two years	A few	Update once in two years 2012-2016	FHB, SLCCP	Provincial Staff
	3. Develop and introduce evidence based essential and advanced newborn care service delivery packages	Availability of a evidence based newborn care service delivery package	Adhoc	Available by 2012 Implement in all districts by 2013	FHB	WHO, Provincial Staff
3. A comprehensive quality assurance system for newborn care in place	1. Establish an inbuilt system for regular monitoring of the quality of care	Availability of Newborn Care standards	Draft stage	Regular monitoring established by 2013	FHB, SLCCP	WHO, UNFPA
	2. Train all neonatal care providers through pre service and in service training programmes to ensure quality service provision	% of staff trained	DNA	90% by2013	FHB, SLCCP	WHO, Proviincial Staff
	3. Newborn care quality indicators introduced into the MIS and monitor them	No. of indicators in use	NA	Completed by 2015	FHB, SLCCP	WHO, UNICEF
4. Quality essential care available to all newborns at institutional and field levels	1. Develop Essential Newborn Care package	Availability of ENC package	Draft	Develop ENC package by 2012	FHB, SLCCP	WHO, UNICEF
	2. Introduce Essential Newborn Care package	% of institutions introduced with ENC package % of MOH areas introduced with the community ENC package	Draft	90% of institutions by 2013 90% by 2015	FHB, SLCCP	WHO, UNICEF

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
	3. Develop standards for Essential Newborn Care	Availability of Newborn Standards	Draft	Complete by 2012	FHB, SLCCP	WHO, UNICEF
	4. Implement standards for Essential Newborn Care	% of institutions following newborn standards	Nil	90% institutions following newborn standards by 2015	FHB, SLCCP	WHO, UNICEF
5. Improved quality services for high risk newborn	1. Develop and implement standards for high risk newboran care	% of institutions following high risk newborn care standards	Nil	90% institutions following standards for high risk new born by 2015	FHB, SLCCP	WHO, UNICEF
	2. Develop guidelines and protocols to manage high risk (premature, LBW, IUGR, congenital abnormalities etc.) and sick newborns (septicaemia, jaundice etc.)	Availability of guidelines and protocols to manage high risk and sick newborn	Adhoc	Available by 2012	FHB, SLCCP	WHO, UNICEF
	3. Implement guidelines and protocols to manage the above high risk and sick newborns	% of institutions using guidelines and protocols to manage high risk and sick newborns % of deaths due to high risk conditions like asphyxia, septicaemia	Nil	90% of the institutions using guidelines and protocols to manage high risk and sick newborns by 2015	FHB, SLCCP	WHO UNICEF UNFPA
	4. Develop management guidelines and protocols for resuscitation, ventilation newborns	Availability of management guidelines and protocols for resuscitation, ventilation newborns	NA	Available by 2013	FHB, SLCCP	WHO UNICEF UNFPA
	5. Implement management guidelines and protocols for resuscitation and ventilation	% of institutions using management guidelines and protocols for resuscitation and ventilation	NA	90% of the institutions using guidelines and protocols for resuscitation and ventilation	FHB, SLCCP	WHO UNICEF UNFPA

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
		% of newborns successfully resuscitated % of SCBU admissions due to asphyxia				
	6. Establish Kangaroo Mother Care at the centres providing specialised care and in the domiciliary setting	% of institutions practicing KMC % of LBW babies discharged on KMC	A few	100% by 2012	FHB, SLCCP	WHO UNICEF UNFPA
6. Improved care for newborns through capacity building on knowledge, skills and competencies of health staff on essential and advanced newborn care	1. Train institutional staff on Essential Newborn Care based on the adapted WHO training module to all institutions providing maternity care	% of staff trained in institutions providing maternity care with ENCC % of staff in the institutions practicing proper hand washing % of institutions practicing the new concepts of ENC	DNA	100% by 2013 100% by 2013 100% by 2013	FHB, SLCCP	WHO UNICEF/ UNFPA Institutional staff
	2. Train field staff to provide essential/ routine newborn care in the domiciliary setting.	% of field staff trained in essential/ routine newborn care in the domiciliary setting	DNA	100% by 2015	FHB, SLCCP	WHO UNICEF UNFPA Provincial staff
	3. Train field staff to support the mothers in domiciliary care of the newborns who are discharged following special/ intensive care	% of field staff trained in domiciliary care of the newborns who are discharged following special/ intensive care	DNA	100% by 2015	FHB	WHO UNICEF UNFPA Provincial staff
	4. Train staff in Neonatal Intensive Care Units (NICU) and Special Care Baby Units (SCBU) regularly in-service on advanced newborn care	% of staff in NICU and SCBU trained regularly on NALS % Neonatal deaths due to asphyxia % Neonatal admissions to NICU and SCBU due to asphyxia	30% DNA	100% by 2015 5% by 2015 10% by 2015	FHB	WHO UNICEF UNFPA Institutional staff

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
	5.Assessment of in service skills of the health personnel working in newborn care and improve skills	% of health staff has skills to resuscitate newborns % of institutions that conduct regular drills on NALS	Few	90% by 2015 90% by 2015	FHB, Heads of Institutions	
	6. Incorporate new concepts of newborn care provision into the basic midwifery, nursing, post basic nursing, undergraduate medical and postgraduate medical curricula	No. of basic medical and related course incorporated with new concepts of newborn care	A few	100% by 2015	DDG (ETR), Deans of Medical Faculties, PGIM FHB	WHO, UNICEF
	7. Provide standard facilities at newborn corners (in Labour Room and Operating Theatre) in institutions providing maternity care	% of institutions with standard facilities in the newborn corners	DNA	100% by 2012	DDG (MSD)	PDHS, Heads of Institutions UNFPA/ UNICEF
	8. Provide standard facilities at neonatal stabilization units in institutions providing maternity care	% of institutions with standard facilities in neonatal stabilization units	DNA	100% by 2012	DDG (MSD)	PDHS, Heads of Institutions UNFPA/ UNICEF
	9. Provide standard care at Special Care Baby Units/ Neonatal Intensive Care Units in all the institutions	% of specialised institutions with standard facilities in the SCBU/NICU	DNA	100% by 2015	DDG (MSD), PDHS, Heads of Institutions	Government/ UNFPA/SDF/ UNICEF
	10. Establish at least one functioning Neonatal Intensive Care Unit in each district with all facilities	No. of districts that have at least one Neonatal Intensive Care Unit	90%	100% by 2015	DDG (BME), D(MSD),	PDHS, Heads of Institutions UNICEF

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
	11. Establish Mother baby centres with standard facilities in all institutions providing specialised care	% of specialised institutions with standard facilities in the Mother Baby Centers	50%	100% by 2013	DDG (BME), D(MSD),	PDHS, Head of Institutions UNICEF
	12. Establish lactation management centres with standard facilities in all institutions providing specialised care	% of specialised institutions with standard facilities in the Lactation Management Centers	50%	100% by 2013	DDG (BME), D(MSD),	PDHS, Heads of Institutions UNICEF/ UNFPA
	13. Implement a functional referral system for specialized care with clear catchments areas	No. of provinces with a functioning referral system	None	All provinces by 2013	PDHS, FHB	SLCCP
	14. Conduct regular needs assessment for essential and advanced newborn care facilities in institutions	% of institutions in which needs assessment is conducted annually	None	100% by 2012	FHB	PDHS, Heads of Institutions
7. Effective Implementation of the Baby Friendly Hospital Initiative	1. Implement the Baby Friendly Hospital Initiative	BFHI strategy developed	Draft	Completed by 2011	DDG(PHS), FHB	Heads of Institutions WHO/ UNICEF
	2. Train all staff in maternity and newborn care units in the institutions in the 20 hour WHO/ UNICEF Baby Friendly Hospital Initiative training course	% of staff trained in the 20hr revised course on BFHI	5%	90% by 2013	FHB	RDHS, Heads of Institutions WHO/ UNICEF
	3. Establish a system for internal and external assessment and accreditation	No. of institutions accredited as BFHI	None	60% by 2013	FHB	RDHS, Heads of Institutions WHO/ UNICEF
	4. Ensure regular functioning of the formal BFHI implementation and monitoring committee	Regular meetings of the BFHI implementing committee held	Regular	100% by 2012- 2016	Secretary Health, DGHS,DDG (PHS)	Committe Members

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
	5. Monitor the Sri Lanka code for promotion, protection and support of breastfeeding and marketing of designated products in collaboration with Infant and Young Child Feeding (IYCF) Programme	Regular conduction of monitoring committee meetings (once in two month) No. of violations reported % of reported violations to which action is taken	Regular	2012-2016 All meetings are conduced regularly	Secretary Health, DGHS, DDG(PHS), FHB	Attorney Generals Dept., Ministry of Consumer Affairs
8. Well implemented neonatal information system	1. Introduce and ensure utilization of newborn formats in all institutions providing care for the newborns	% of institutions using newborn formats	60%	100% by 2012 2012 -2016	FHB , SLCCP	RDHS, Head of Institutions
	2. Improve coverage , quality and timeliness of Hospital Maternity and Newborn statistics return (H 830)	% of institutions sending H 830 return		100% by 2013 2012 -2016	FHB, MSU, SLCCP	PDHS, RDHS, Head of Institutions
	3. Establish a linkage with the vital registration system to share information	Availability of the system	NA	By 2013	FHB RGs Dept.	Director/ Information
	4. Use GIS package to monitor newborn care facilities and outcomes up to institutional level	% of institutions covered by the GIS mapping	None	100% by 2015	FHB, MSU	Government/ WHO/ UNICEF
	5. Periodically publish a report on neonatal morbidity and mortality.	No. of periodicals published	None	Annually one report 2012 -2016	FHB	UNICEF

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
9. Evidence based information on newborn care established	1. Conduct newborn care research with other relevant partners.	Areas researched	Few	2012-2016	FHB	WHO, UNICEF/ UNFPA
	2. Pilot test interventions on newborn care and analyse the cost effectiveness and sustainability	% of interventions costed	None	90% by 2015	FHB, Director/ Finance	Government
	3. Work with government, non governmental and private sector authorities for development of Newborn Care Services (eg: Labour Department, Ministry of Women and Child Development, Social services etc.).	No. of meetings held	Few	75% by 2015	FHB	Other relevant Ministries
10. Newborn Care Unit of the Family Health Bureau strengthened for effective implementation and monitoring of the newborn care programme	1. Upgrade intranasal and newborn care unit of the FHB	Facilities for provision of quality services available at the unit	60%	Up graded by 2013	FHB	
	2. Strengthen technical and managerial capacity of the NBH programme managers	No. of programmes attended by the programme manager		2012- 2016	FHB, DDG/ (PHS II)	WHO/ UNICEF
	3. Establish a NBH Programme monitoring and coordination mechanism with the central ,provincial, district health authorities, plantation sector, local government, private sector authorities etc.	Monitoring and coordinating mechanism established	Initiated	2014	FHB /MoH SLCCP	UNICEF/ UNFPA

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
	4. Develop annual operational plans (with costing) in collaboration with provincial and district authorities	No. of districts supported to develop the district plans	5%	2012- 2016	FHB /MoH SLCCP	PDHS/RDHS
	5. Develop web based system to share information to provide guidance and directions to newborn care stakeholders	Development of the website	Under develop-ment	2012- 2016	FHB	GAVI-HSS, UNICEF

Component	*Child Health*
Objective:	Enable all children under five years of age to survive and reach their full potential for growth and development through provision of optimal care

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
1. High quality infant and child care services made available both at field and institutional settings	1. Develop policy and strategic plan on child health	Availability of policy and strategic plan on child health	National MCH policy	Policy and strategic plan available by 2013	FHB	UNICEF/ WHO/College of Paediatricians
	2. Develop relevant protocols and guidelines in Child Health	No. of protocols and guidelines available	IYCFguideline, Managing malnutrition in community, Vit. A supplementation, feeding during emergency, MMN supplementation	All available by 2013	FHB	College of Paediatricians UNICEF/ WHO
	3. Supply necessary equipment and other supplies to all institutions (including field)	% of MOH areas with standard set of equipment	DNA	80% by 2013	FHB	Provincial authorities, UNICEF

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
2. Optimal nutritional status achieved by all children	1. Development of a national strategic plan on Infant and Young Child Feeding	Availability of the strategic plan	NA	Strategic plan available by 2013	FHB	Other relevant Directorates, UNICEF, WHO
	2. Regular monitoring of growth of all under five children	% of children <5 yrs whose growth is monitored regularly	80%	100% by 2012	FHB	Provincial staff
	3. Improve nutritional status of children under five years by promoting appropriate IYCF practices	Prevalence of underweight among under 5 children Prevalence of wasting among under 5 children Prevalence of stunting among under 5 children Prevalence of Iron deficiency anaemia among under 5 children Prevalence of vitamin A deficiency among under 5 children	21.1% 14.7% 17.3% (DHS 2006/7) 25. 2% NFSA 2009 29.3% MRI 2006	19.0 % by 2013 13.5% by 2013 16.5 % by 2013 20.0% by 2013 20.0% by 2013	FHB	UNICEF/ WHO GOSL
	4. Capacity building of health staff on child health -Infant and Young Child Feeding - Growth Monitoring	% of districts with trained trainers - Infant and Young Child Feeding - Growth Monitoring	End 2011 77% 15%	100 % by 2013 50% by 2013	FHB	Provincial Health staff UNICEF/ WHO
	5. Supplement all children under five years with age appropriate Vit A.	% of target population covered % of children<5 yrs. with Vit A deficiency	66% MRI 2006 29.3% MRI 2006	80% by 2013 Vit A deficiency reduced to 20% by 2015	FHB	Provincial Health staff UNICEF
3. Evidencebased practices in place for management of common childhood illnesses	1. Develop management protocols for common childhood illnesses	Availability of protocols	Adhoc	Protocols on 10 disease entities developed by 2013	FHB, SLCP	WHO

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
	2. Integrate management protocols into different levels of medical curricula	No. of institutes with relevant curricula		80% of institutes with revised curricula		WHO
	3. Capacity building of primary care physicians	No. of staff trained	DNA	100 physicians trained	FHB, SLCP	WHO
4. Surveillance system on childhood morbidity and mortality developed	1. Establish a reporting system on child mortality	% of deaths reported through the system	NA	50% by 2013	FHB, Medical Statistics Unit	UNICEF/ WHO, SLCCP
	2. Develop a child mortality database	Availability of data base	NA	Available by 2012	FHB, RG's Dept.	UNICEF/ WHO, SLCCP
	3. Conduct a Birth cohort study	Report available	NA	By 2013	FHB	
5. Optimized psychosocial development	1. Adopt Early Childhood Care and Development manual	Manual is developed in both Sinhala and Tamil languages.	NA	By 2012	FHB, College of Psychiatrists& Paediatricians, Child Secretariat	UNICEF WHO, NGO, CBOs
	2. Develop ECD standards	Report available	NA	By Q1 2012	FHB, College of Psychiatrists& Paediatricians, Child Secretariat	UNICEF
	3. Audit and revamp the ECD programme	Proportion of mothers who has awareness on ECD	Adhoc	75% by 2013	FHB, Child Secretariat, Ministry of Health, Ministry of Child Development& Women's Empowerment	Provincial Health & ECCD officers, UNICEF
	4. Train local programme implementers in all districts on ECD	Proportion of PHC workers trained on ECD	DNA	100% by 2015	FHB, College of Psychiatrists& Paediatricians, Child Secretariat	Provincial Health staff, UNICEF
	5. Incorporate ECD training in to the pre-service training programmes	No. of curricula with ECD component incorporated (PHMS, PHNS, MOs)	Adhoc	All main curricula included ECD By 2015	FHB, College of Psychiatrists& Paediatricians, Child Secretariat	DDG/ET &R, NIHS

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
6. Optimal oral health ensured in all children	1. Develop guidelines & strategic plan to introduce essential preventive, curative & rehabilitative oral health care components to existing infant & child care services	Strategic plan & guidelines available		Guidelines available by 2012	FHB, DDG/ Dental services	
	2. Print guidelines (2 Booklet Dental Professionals & PHC staff)	Strategic plan & guidelines printed		Guidelines available in printed format by 2012	FHB, DDG/ Dental services	
	3. Improve capacity of PHC staff to identify and provide basic preventive oral health care	No. of PHC staff trained	Adhoc	100% by 2013	FHB,	Provincial Health Staff
	4. Improve capacity of dental workforce to identify and provide basic preventive curative & rehabilitative oral health care on developed guidelines	No. of staff DS & SDTT trained	Adhoc	25% trained by the end of 2012, 100% by 2013	FHB	Provincial Health Staff
	5. Strengthen monitoring & evaluation system	% of infants with good oral health practices % of infants with caries % preschoolers with caries		Increase by 75% from the present level by 2013 100% by 2015 Reduction 50% from the present level (23% to 12 %) by 2015 Reduced by 50% (from 68% to 34%) by 2015	FHB, DDG/ Dental services	Provincial Health Staff

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

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
1. Address the health needs of children with special needs by incorporating a package of intervention to existing child health program	1. Pilot project on special need is completed	Presence of pilot programme in the MOH areas of Puttalam Districts	Nil	By 2012	FHB	WHO
	2. Special need programme is expanded in 5 districts	Available of special need programme in 5 districts	Nil	In 5/25 districts by 2015	FHB	WHO

Component	*School and Adolescent Health*
Objective:	Ensure that children aged 5 to 9 years and adolescents realize their full potential in growth and development in a conductive and resourceful physical and psychosocial environment

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
1. Partnerships between Ministries of Health and Education, other relevant stakeholders and communities are strengthened for the implementation of a comprehensive child and adolescent health programme in school and community settings	1. Establishment of Provincial and Zonal Steering Committees	Number of provinces and having committees	No data	By the year 2015 all the provinces conducting one steering committee meeting per school term	Ministry of Health, Ministry of Education, FHB	Coordination committee members Development partners
	2. Performed regular meetings with all the stakeholders at National level coordinating committee	Number of meetings held committees	5 meetings per year	5 meetings per year	FHB D/Health & Nutrition in Ministry of Education	Coordination committee members Development partners

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
2. Need based health education, focusing on skill development is implemented	1. Conduct training programs for health & education officials on teaching life skills	% of Health & Education officers trained in life skill development	All the district teams have been formulated	By the year 2015, 75% of field health workers and 50% of secondary school teachers trained in life skill development	FHB, Provincial Health and Educational Authorities	Health Education Bureau Development partners
	2. Programs for school children on life skills development	% of school children with adequate life skills	65% of school children have adequate life skills (UNICEF, 2004)	By the year 2015 the % of children with adequate life skills increased to 75%	Provincial Health and Educational authorities	Health Education Bureau Development partners
3. Nutrition is improved and healthy lifestyles are in practice among school children and adolescents	1. Encourage school children to engage in routine exercise/ physical activity	% of school children doing exercise>1 hr	11% (GSHS,2008)	By the year of 2015 the children do exercise increases to 25%	Ministry of Health, Ministry of Education, FHB	Health Education Bureau
	2. Establishing Health promoting school program	% of schools identified as Health Promoting Schools	20%	% of Health Promoting school increased from 20% to 60% by 2015	Ministry of Health, Ministry of Education, FHB	Health Education Bureau Development partners
	3. Growth monitoring & nutrition education for school children	% of adolescent school children having optimal BMI	65% of male & 75% of female school children have optimum BMI (2010)	68% of male & 77% of female school children have optimum BMI in 2015	Ministry of Health, Ministry of Education, FHB	Health Education Bureau D/Nutrition
4. Increased access to child and adolescent friendly health services, including dental services and counselling	1. Establishment of adolescent friendly Services in all MOH areas	Number of adolescent friendly centres per MOH area	No data	By the year 2015 at least one referral centre at MOH office	Ministry of Health, Ministry of Education, FHB	D/YEDD
	2. School Medical Inspection	SMI coverage	85% in 2009	90% in 2015	Provincial Health & Education authorities	Health Education Bureau Epidemiology Unit
	3. Establishment of counselling services for adolescents	% of schools having counselling services	No data	75% in 2015	Provincial Health & Education authorities	

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
5. Children and adolescents are empowered to make informed choices regarding their sexual and reproductive health issues.	1. Conduct training programs for health & education officials on SRH education	% field health officials and secondary school teachers trained in SRH education	All the district teams have been formulated	By the year 2015, 75% of field health workers and 50% of secondary school teachers trained	FHB Provincial Health and Educational authorities	D/YEDD Health Education Bureau Development partners
	2. Programs for school & out of school adolescent children on SRH education	% of children with adequate knowledge on RH	50% school children have adequate knowledge (UNICEF, 2004)	By the year 2015, % of school children with adequate RH knowledge will be increased to 60%	Ministry of Health, Ministry of Education, FHB	Health Education Bureau Development partners
6. Parents, guardians and teachers are empowered in caring for children and adolescents.	1. Conduct parental programs to improve parent adolescent connectedness	% of MOH conducting parenting programs	No data	By the year 2015 50% of MOH are conducting parenting programs	Ministry of Health, Ministry of Education, FHB	D/YEDD Health Education Bureau Development partners
	2. Conduct training programs for health & education officials on parenting and caring for adolescents	% field health officials and secondary school teachers trained on Parenting	No data	By the year 2015, 60% of field health workers and 40% of secondary school teachers trained	Ministry of Health, Ministry of Education, FHB	Health Education Bureau Development partners

Component	*Family Planning*
Objective:	Enable all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
1. Increased Contraceptive prevalence for modern temporary methods	1. Develop and print guidelines on DMPA, OCP, IUD and sterilization	No. of printed guidelines available	Guidelines on DMPA, OCP, IUD available	Sterilization guideline will be available by 2012	FHB,SLCOG	UNFPA
	2. Build capacity of Health staff on Family planning	No. of training programmes conducted	16 programs annually	16 programs annually	FHB	Provincial Health staff, UNFPA

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
	3. Increase accessibility to FP services by establishing new FP clinics (registered & equipment provided)	No. of new clinics registered annually No. of clinics provided with equipment	12	50 per year	FHB	Provincial Health staff, UNFPA
		No. of FP clinics functioning	1888	2000 by 2013	FHB	Provincial Health staff UNFPA
		% of FP clinics providing method mix	70%	100%	FHB/ SLCOG	Provincial Health staff UNFPA
		% Contraceptive prevalence (modern methods)	52%	58% by 2013	FHB/ SLCOG	Provincial Health staff UNFPA, NGOs
	4. Improve FP services provision in the field by PHMM and PHII	% of OCP & Condoms distributed by PHMM/ PHII	45%	50%	FHB	Provincial Health staff
2. Decreased unmet need for contraception	1. Identify and provide services for couples with unmet need for Family Planning 2. Strengthen FP services for newly married couples who need postponement	% Unmet need for contraception	7.3 %	<8% by 2013	FHB/ SLCOG	Ministry of Education and Youth affairs UNFPA
		% Teenage pregnanciesc	7%	<7% by 2013	FHB	
		% Pregnancies among ⩾P5	2%	<1% by 2013	FHB	
		No. of maternal deaths due to septic abortions	10	0	FHB	
3. Increased prevalence of permanent methods	1. Provide sterilization services in all specialized hospitals	% of ⩾P5 mothers who underwent sterilization by Medical Officer of Health area	Data not available	>90%	FHB, SLCOG,	Provincial Health staff All curative institutions World Bank UNFPA
		% prevalence of permanent methods	17%	20%	Ministry of Health	

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
4. Improved logistics management of contraceptives at all levels	2. Increase allocation for procurement of contraceptives from the national budget	% of contraceptives procured from annual requirement	90%	100	FHB, Treasury	
	2. Build capacity of staff involved in Logistics Management	No. of training programmes for store Keepers of Regional Medical Supplies Divisions (RMSD)	3 per year	3 per year	FHB	UNFPA
	3. Prepare RHCS plan for Sri Lanka	Availability of a RHCS plan	Draft	By end 2012	FHB/UNFPA	UNFPA

Component	*Women's Health*
Objective:	Promote health of women and their partners to enter pregnancy in optimal health, and to maintain in throughout the life course

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
1. Women of childbearing age and their partners receive a comprehensive package of pre-conception care.	1. Capacity building of staff on pre - pregnancy care	% of staff trained	Zero	50% of staff by 2012 75% by 2013	FHB, NIHS	WHO/ UNFPA
	2. Implement Pre-conception care package for newly married couples	% of MOH areas implemented	Zero	75% of MOH areas by 2013	FHB, Provincial Health authorities, Women's Bureau	WHO/ UNFPA, National Committee on Women's Health
2. Most reproductive health issues of women and their partners are attended throughout the life course	1. Establish Well Woman Clinics in all MOH areas per 15,000 population	Average population served by a WWC in a district	30%	75% WWCs Established in the country according to the norm by 2013	FHB, Provincial Health authorities	UNFPA/ SLCOG/SL College of Pathologists
	2. Increase the coverage of women at 35 yrs. undergone Cervical Cancer screening	% of the target population screened by district	10%	80% coverage by 2013	FHB, Provincial Health authorities	UNFPA/ SLCOG/SL College of Pathologists, NGOs

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
3. Reproductive Health issues of migrant women and their families are addressed	1. Preparation and printing of Package for migrant women	Availability of the package	NA	Printed copies available by 2012	FHB, Provincial Health authorities,National Committee on Women's Health	WHO/ UNFPA, Women's Bureau
	2. Capacity building of staff on new package	% of staff trained	Zero	30% of staff by 2012 60% by 2013	FHB, NIHS	WHO/UNFPA Women's Bureau
	3. Implement the package for Migrant women & their families island wide	% of MOH areas implemented	Zero	50% of MOH areas by 2013	FHB, Provincial Health authorities, Women's Bureau	WHO/ UNFPA
4. STD and HIV/ AIDS services are integrated to MCH program	1. Integrate relevant STD & HIV/AIDS services to pre-conception care package & package for migrant workers & WWC programme	Availability of the integrated package	Adhoc	Integrated by 2013	FHB, NSACP	WHO/UNFPA Women's Bureau

Component	*Gender and Reproductive Health*
Objective:	Promote reproductive health of men and women assuring gender equity and equality

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
1. Capacity of health staff built on gender issues related to reproductive health	1. Conduct training programs for trainers at district level on Gender and prevention of GBV	No. of districts where master trainers are trained		Trainers available in all districts by 2012	FHB and Provincial/ District staff. National Committee on Women's Health	WHO/ UNFPA Women's Bureau
	2. Train all Primary Health Care staff in the Country	% of health staff trained (preventive/ curative)		By 2013, all PHC staff trained in the country	FHB, Provincial/ District staff.	WHO/ UNFPA Women's Bureau
	1. Preparation and printing of Package	Availability of a printed package	NA	2012	FHB National Committee on Women's Health,Women's Bureau	WHO/ UNFPA

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
2. Services for prevention and management of gender based violence established in the preventive and curative health sector	2. Conduct sensitization & Training programmes in hospital in the country	No. of hospitals in covered per district	Nil	20% of districts by 2013	FHB and Provincial/ District staff	WHO/ UNFPA
	3. Establish hospital centres providing befriending services	No. of districts where hospital centres established	02	20% of districts by 2013	FHB, Provincial/ District and hospital staff	WHO/ UNFPA
	4. Implement a package for hospital staff	No. of hospitals where the package is implemented	Nil	20% of districts by 2013	FHB, Provincial/ District and institutional staff	WHO/ UNFPA
3. Sex disaggregated data is incorporated into the health management information system, so as to ensure gender equity and equality in reproductive health services.	1. Incorporate data regarding prevention & management of GBV into MIS of Public Health System	No. of data elements incorporated	Very few	Data incorporated to MIS by 2012	FHB, Police Women's and children's Bureau	WHO/UNFPA GBV Forum
	2. Incorporate data regarding management of GBV into the hospital MIS system in hospitals providing befriended services	No. of hospitals sending timely returns	Nil	Data incorporated into hospital MIS 2013	FHB, Heads of institutions and hospital staff	WHO/ UNFPA
	3. Incorporate sex disaggregated data into the MIS in Public Health System	No. of data elements incorporated and No. of MOHs reported correctly	Nil	Data incorporated by 2012	FHB and Public Health staff	WHO/ UNFPA
4. Data related to gender based violence within the health sector are compiled and published	1. Promote compilation and appropriate management of data related to gender based violence within the health sector	No. of reported compiled and published	Nil	Compilation of all the data 2013 and publishing of reports	FHB	WHO/ UNFPA

Component	*Monitoring and Evaluation of Maternal and Child Health*
Objective:	Ensure effective monitoring and evaluation of MCH Programme that would generate quality information to support decision making

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
1. Health Management Information System on MCH/FP is updated, strengthened and implemented well at all levels	1. Review and revise the current Management Information system on MCH/FP	No. of records revised % of districts implementing revised MIS	Nil	All records reviewed and revised by 2013	FHB	Provincial Health staff UN agencies
	2. Build the capacity of health staff managing and implementing MIS	% of staff trained by district	25%	75% by 2013 100% by 2014	FHB, Provincial Health staff	UN agencies
	3. Improve timeliness of returns and quality of information submitted in returns	% of MOHs sent returns timely	65%	100% by 2013	FHB, Provincial Health staff	
	4. Logistic system of printed forms improved at all levels	% of records available No. of records where stock outs reported	Nil	90% by 2012 10% by 2012 0% by 2013	FHB, Ministry of Health	UNFPA
	5. Maternal and perinatal information system in maternity care institutions developed and implemented	No. of institutions implemented	Nil	50% by 2013 100% by 2014	FHB, Medical Statistics unit	WHO Hospitals SLCOG, SLCCP
2. Reinforce planning, monitoring and evaluation of MCH program	1. Strategic plan on MCH is developed and used by provincial health staff	Availability of Strategic plan	Nil	Available by 2012	FHB	WHO
	2. New supervision tools and self evaluatory tools in place	Availability of new tools Improved supervision	Nil	Available by 2012 75% of the target by 2012	FHB	GAVI-HSS Provincial Health staff

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
	3. Regular meetings conducted to review the progress of programme implementation at different levels	% of Review meetings	60%	75% by 2012 100% by 2013	FHB	Provincial Health staff
	4. Performance evaluation of health staff in place	No. of staff evaluated and rewarded	Nil	60% by 2012 80% by 2013	FHB, Ministry of Health	Provincial Health staff
	5. Monitoring system to track the achievement of MDGs developed and implemented	Availability of monitoring indicators	Nil	Available by 2013	FHB	WHO
	6. Introduce GIS into the existing MIS	Availability of GIS system for Monitoring	Nil	Available by 2014	FHB	WHO Provincial Health staff
3. Establish a network for MCH information sharing among relevant stakeholders	1. MIS of MCH/FP computerized from divisional up to national level with electronically linked transfer	Electronic data management and transfer from divisional to central level available	Nil	Available by 2014	FHB	Development Partners Provincial Health staff
	2. Network established among all relevant data bases and data shared among stake holders	No. of institutions linked through the network	50%	All by 2013	FHB, MSU, RG	Development Partners Provincial Health staff
	3. Timely reporting of feed back reports & national statistics	No. of feedback reports published timely	75%	100% by 2013	FHB	Development Partners

Component	*Reproductive Health Research*
Objective:	Promote research for policy and practice in MCH

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
1. Evidence base generated in relation to MCH services	1. Establishment of RH data base	Availability of RH data base	A few	Available by the end of year 2013	FHB	WHO, RHR committee
	2. Provide grants for outstanding research proposals in the MCH field	No. of grant offered	A few	At least one per year	FHB, RHR, DDG/ET&R	WHO, UNFPA
	3. conduct research on priority areas	Conduct at least one research annually	Once in two years	Three research studies at the end of 2013	FHB	WHO
2. Research findings/ evidence base disseminated for policy formulation and practices in relation to MCH	1. Conduct meetings for knowledge transfer/ dissemination	No. of dissemination sessions conducted	Occasional	At least one per quarter	FHB, RHR committee PGIM DDG/ET &R	WHO,UNFPA
		No. of presentations done at conferences	A few	At least one for a research		
		No. of papers/ publications done on reproductive health research	DNA	At least one for a research		
		No. of policy decisions taken based on research findings	Occasional	At least one per research		
	2. Formulation of agreed upon policy for research ownership and publications	Availability of a policy	NA	Available by 2013	FHB, DDG ET&R	WHO
3. A collaborative mechanism is established for MCH research development and conduct	1. Establish a network between research focal points	No. of linkages established	No linkage	Available by 2013	FHB, DDG/ET&R RHR committee	
		No. of collaborative work done		At least three per year		

Expected outcome	*Major activities*	*Outcome indicators*	*Baseline*	*Target and timeframe*	*Responsible National organization*	*Partners*
4. Human resource and infrastructure development strengthened at Research unit	1. Infrastructure and human resource development	Availability of adequate skilled personnel Availability of infrastructure	NA	Made available by 2012	FHB, MoH	Development partners

DEFINITIONS/ABBREVIATIONS

TFR (Total fertility rate)	-	Total number 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.
MMR (Maternal Mortality Ratio)	-	An impact indicator to evaluate maternal care services. Expressed 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
IMR (Infant Mortality rate)	-	An impact indicator to evaluate perinatal and child health services. Expressed as the number of infant deaths per 1000 live births
NNMR (Neonatal Mortality rate)	-	An impact indicator to evaluate perinatal and neonatal services. Number of neonatal deaths per 1000 live births
Perinatal death	-	Still birth occurring after 28 weeks of POA or Neonatal death occurring within seven days of birth.
Child	-	Individual below 18 years of age
Adolescent	-	Individual between the age of 10 – 19 years
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 Population Fund
HMIS	-	Health Management Information System
PDHS	-	Provincial Director of Health Services
RDHS	-	Regional Director of Health Services
MOMCH	-	Medical Officer, Maternal and Child Health
RE	-	Regional Epidemiologist
MOH	-	Medical Officer of Health
RSPHNO	-	Regional Supervising Public Health Nursing Officer
PHNS	-	Public Health Nursing Sister
SPHM	-	Supervising Public Health Midwife
PHM	-	Public Health Midwife
SPHID	-	Supervising Public Health Inspector District
SPHI	-	Supervising Public Health Inspector
PHI	-	Public Health Inspector
BCC	-	Behaviour Change Communication
WWC	-	Well Woman Clinic – clinics mainly based at Primary health care settings, providing screening services for common Non-communicable diseases such as diabetes, hypertension, breast and cervical cancers
Women in the reproductive age group	-	Women in the age group of 15 – 49 years
CEmOC (Comprehensive Emergency Obstetric Care facilities)	-	Maternity care facilities with provision of comprehensive care (Administration of parenteral antibiotics, Administration of parenteral oxytocic drugs, Administration of parenteral anticonvulsants, Manual removal of placenta and retained products, assisted vaginal delivery, Caesarean section, administration of blood transfusion.)
UMN(Unmet need for Contraception)	-	Married, fertile couples who do not desire to have children but are not currently using any contraception.

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