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Family health programme in Sri Lanka: its origin and development

J.K.Malinie de Silva[1]

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The history

Family Health Programme in Sri Lanka originated in 1972 with the objective of improving the quality of life of the entire family. This was the continuation of the existing Maternal and Child Health (MCH) and Family Planning (FP) services, which focused attention mainly on the mother and child.

The Maternal and Child Health (MCH) Programme in Sri Lanka has a long history. The first organised effort towards care and attention of the child bearing woman was made in 1879 with the opening of the De Soysa Lying-in-home now known as De Soysa Hospital for Women.

Some of the important early landmarks of the MCH services were,

- registration of births and deaths made compulsory in 1897 ,
- registration of midwives in the same year (1897) and,
- inclusion of maternal mortality in the Registrar Generals Annual Report in 1921 .

An investigation report on the high infant mortality rate in the Colombo Municipality led to the establishment of a maternal and child health service within the Municipality. Six midwives were appointed in 1906 followed by 2 health visitors in 1913. The MCH services were thereafter gradually expanded.

In recognition of the importance of antenatal care. the first antenatal clinic was opened at the De Soysa Lying-in-home in 1921 by the government.

The report of the Director Medical and Sanitary services of 1927 states that "The gradual elimination of the ignorant midwife and her replacement by trained ones available to the people in their homes will be a far more important factor in reducing of infant mortality and maternal disability than building of Lying-in-homes".

Accordingly at that time the most appropriate strategy was to promote trained home deliveries to reduce maternal and infant morbidity and mortality. An important development of the Public Health Services, which helped in achieving this objective, was the establishment of the Health Unit system commencing in Kalutara in 1926. This system was to provide both institutional and domiciliary care for the mother and child and it helped greatly in replacing the ignorant midwife by trained ones. By 1936, eight health units were established and this was increased to 91 by 1950. Each Health Unit was in charge of a Medical Officer of Health (MOH) who was responsible for all promotional and preventive health activities within a defined area with a population ranging from 40,000 to 80,000. The MOH was supported by a team of health personnel comprising Public Health Nurses (PHNN), Public Health Inspectors (PHII) and Public Health Midwives (PHMM). Calculated on the Birth Rate at that time a population of 3500-4000 was allocated to a midwife to cover 12 births a month. The PHN was responsible for double this population.

The training of midwives commenced in 1926. The public health midwife had one year's basic training in one of the Provincial hospitals followed by one month field training in public health midwifery at Kalutara Kadugannawa or Padukka. The field training was subsequently extended to 6 months after 1938. Currently one years training for midwives is conducted in a Nurses Training School followed by field

[1] President, The College of Community Physicians of Sri Lanka ,1997-1998,
Former Director, Family Health Bureau, Ministry of Health

training of 6 months at one of the nine field training centres.

Training of PHNN commenced in 1928 and consisted of 6 months training in midwifery and 6 months in public health. Since 1980, training at the National Institute of Health Sciences (NIHS) Kalutara was extended to one year with a Diploma in Public Health Nursing being awarded at the end of the course.

A major portion of the service component of the health team even at the initial stage of the Health Unit system revolved round MCH which included maternal and child health, nutrition, health education, school health work, vaccination against small pox, collection and study of vital statistics of the area. Other service components as rural and urban sanitation and control of communicable diseases also supported maternal and child health activities.

This system brought about a scheme to provide domiciliary care commencing with case finding and registration of expectant mothers by trained PHMM through regular home visiting, bringing pregnant mothers to a health centre for examination by a medical officer.

Figure –1. The first health centre in Sri Lanka

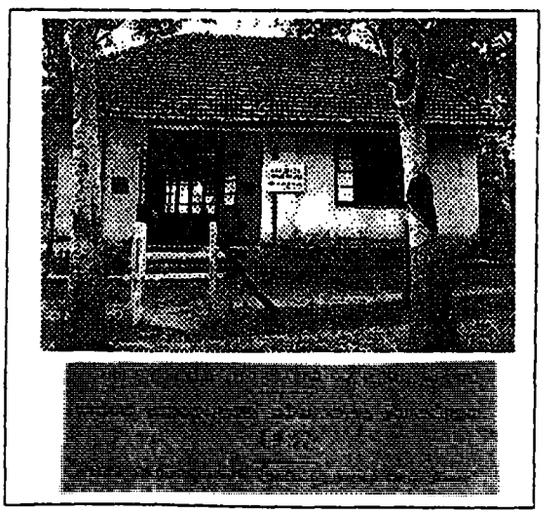
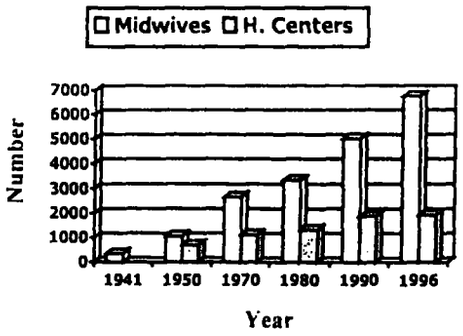


Figure-2. The number of midwives and the health centres from 1941 to 1996



The Figure -1 shows the first health centre in Sri Lanka and Figure- 2 shows the increase of the number of midwives and the health centres over the years.

The PHM was also responsible for the provision of a safe delivery and post-partum care through daily visits during the first 10 days following the delivery. Home delivery with trained assistance was encouraged for normal cases while complicated cases were referred to the nearest medical institution for specialised care.

The control measures adopted following the Malaria epidemic of .1935 led to further expansion of the Health Unit system. By 1950 such Health Units had been established in 91 areas. The number was further increased to 104 by 1982 and currently there are 237 Health Units established within the country. The above system contributed significantly to lowering of maternal and infant mortality in Sri Lanka. Maternal Mortality declined from 19.9/1000 live births in 1937 to 10.6 in 1947, and infant mortality from 170 per 1000 to 80 per 1000 live births during the same period.

The responsibility for the care of the infant after ten days following delivery and care of the pre-school child was with the Public Health Nurse unlike today where she plays more of a managerial role. The MCH clinics were conducted fortnightly by the MOOH. Dr. Cumpston in his review of health

services in 1950 recommended that maternal and child welfare work should be handed over to the curative medical officers. This recommendation was implemented in 1952 and was in effect for some time. However this was subsequently given up. Now both curative and preventive officers are responsible for MCH work.

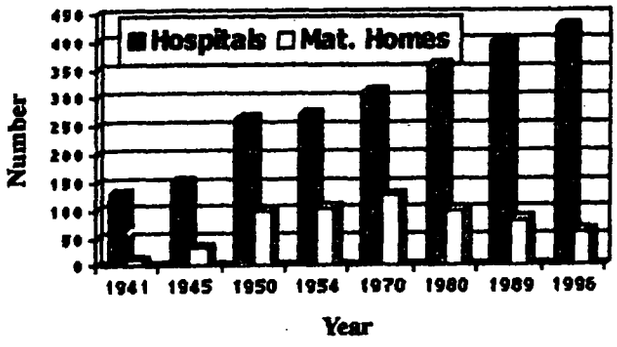
World Health Organisation in their publication commemorating 50 years of co-operation with Sri Lanka" made the following statement with reference to a request for assistance for development of MCH services in Ceylon at the First World Health Assembly in 1948. "These services were in their infancy in India and Siam. In Ceylon however it was already well organised and was said to be the most popular with local authorities as well as the public".

A characteristic feature of the Government policy was the adoption of strategies for diffusion of health services throughout the country. This was supported by political demands for health services and medical institutions in the rural areas after the granting of Universal franchise in 1931. A large number of maternity homes (first was constructed in 1939), rural hospitals and cottage hospitals were constructed and the services of these institutions were linked to the increasing number of Health Units.

Figure –3 shows the increase in the number of maternity homes and hospitals over the years. Medical and paramedical staff in the field and in the medical institutions was trained in care of the mother and child. The government ensured that services were given free. Free education system commencing in 1946 helped in increasing the level of health consciousness and health utilisation. Introduction of antibiotics, D.D.T., blood transfusion services and involvement of voluntary organisations such as social service workers and ladies leagues, improvement of transport and communication facilities and other socio-economic development activities also contributed to the improvement of MCH services. Home delivery with trained assistance became the norm by the middle of this century. Over the years however, with the availability of an increasing number of institutions Sri Lanka has adopted the strategy to promote institutional deliveries. Currently about 85% of deliveries take place in Government Hospitals and 6-7% in private hospitals

The Maternal Mortality Rate (MMR) which was 16.5/1000 LB in 1945 decreased to 5.6/1000 LB in 1950 and the IMR from 140/1000 LB to 82/1000 LB during the same period. Although a decline in maternal and infant mortality rates were observed, the absolute figures however remained high with 1737 maternal deaths 25,436 infant deaths occurring in 1950. These conditions

Figure-3 . Number of Hospitals with Maternity Homes from 1941 to 1996



led to fresh thinking on measures such as family planning to further reduce the maternal and infant mortality.

Family planning

In 1953 a non-governmental organisation, The Family Planning Association (FPA) of Ceylon was established. Its main object was to make "every child a wanted child and to protect the health of the mother and the well being of the family by limiting its size".

FPA made an organised effort to introduce family planning, first in Colombo and in areas around Colombo. Attention was focussed on family welfare with a view to reducing maternal mortality, infant mortality and malnutrition. The work done by the association was given Government recognition in 1954 and a yearly financial grant was given.

The opposition to family planning, which was much experienced at the beginning gradually, declined with time. In 1958 the Government, realising the importance of family planning signed a bilateral agreement with the Royal Government of Sweden to conduct a pilot project in community family planning. The project was designed to investigate the prospects of family planning in Sri Lanka and study the attitudes of people towards family planning. The results of this pilot project were encouraging. It demonstrated a positive attitude to family planning in the community and the successful integration of family planning into the already well established MCH services.

The ten-year plan presented in 1959 highlighted the implications of post war increase in population growth and particularly its effect in shunting investment away from directly productive activities to social sectors. In 1960 a labour force survey conducted with the assistance of International Labour Organisation (ILO) showed that unemployment rate was over 10 percent. In view of the above it became evident to policy makers that the population growth rate needs to be brought under control.

Based on the experience of the FPA and the Pilot Project in Community Family Planing, the government accepted family planning as national policy in 1965. In early 1966 the Minister of Health appointed a committee to advise on the establishment and execution of the national family planning programme. An important recommendation of the committee was to achieve a reduction in the crude birth rate from 33/1000 population in 1965 to 25 per thousand by the end of 1975.

Family Planning services were integrated with the existing maternal and child health services and were provided through the well-developed MCH infrastructure of the Ministry of Health. A separate division called the Family Planning Bureau was established in 1968 in the Ministry of Health with an Assistant Director, Maternal and Child Health (ADMCH) as the administrative head. The name of this central organisation was changed to Maternal and Child Health Bureau under the administration of the ADMCH in 1970. This post was made Director, Maternal and Child Health in 1983. The Bureau was situated in a private house at Bagatalle Road Colombo 3 with the Swedish International Development Agency (SIDA) office occupying a section of the building. The Family Health programme was implemented in the periphery by the Superintendents of Health Services (SHSS) assisted by medical officers MCH, appointed to supervise the relevant activities and to function as the link between the Bureau and the Health Divisions.

In 1965 Government renewed the agreement with the Swedish and SIDA continued to support the national family planning programme by providing contraceptives, equipment for clinics and vehicles. Supply of contraceptives through Swedish assistance continued upto early 80's. The two storey building which now houses the Family Health Bureau was donated by SIDA and it's 'soft opening' in 1977.

In 1970 the government made a positive statement towards family planning. The five-year plan presented in 1971 stated that "family planning should be made available to all groups and not be confined to the privileged section of society".

In 1972, 100 pilot projects were started, one in each MOH area to co-ordinate all MCH activities such as MCH, family planning, nutrition, immunisation, health education etc. Based on the experience gained from these pilot projects, the MCH/FP programme received a new dimension with a more comprehensive approach towards the family. The Bureau was re-designated the Family Health Bureau in 1972 and the programme was named the Family Health Programme.

From 1972, the family planning programme had the necessary political endorsement. The government sought the assistance of international organisations to financially support the expansion of services within the country. With financial assistance from the UNFPA, twelve projects were formulated, the largest being the Family Health project. Implementation of the UNFPA project commenced in 1973 with necessary support from other International Agencies like the WHO and UNICEF. The balance 11 projects funded by UNFPA and implemented by the other ministries and non-governmental organisations created a favourable and a supportive atmosphere for implementation of the Family Health programme.

A feature that deserves special mention is the support and guidance given by the then Hon. Deputy Minister of Health who later become the Hon. Minister of Health, Mrs.Siva Obeysekera now Deshamanya Siva Obeysekera. This very positive feature enabled the family health programme to receive the necessary political commitment and support of the relevant ministries.

The Family Health Bureau was made the central organisation of the Ministry of Health responsible for planning, co-ordination, direction, monitoring and evaluation of family health programme. The staff at the Family Health Bureau was strengthened to man five units, namely Training, Health Education, Plantations, Supplies & Services and Evaluation & Research initially. National seminars for University staff, medical administrators and other medical personnel, nursing personnel and midwives organised by the Ministry of Health brought about consensus of opinion on the implementation of the Family Health Programme with recommendations for improvement by representative groups of managers and service providers.

The national family health programme

The objectives of the National Family Health Programme formulated at the initial stage were,

1. To improve the health of people especially that of the mother and child by the provision of improved MCH/FP services at all levels.
2. To assist the government to effect a significant reductions of the crude birth rate with a view to lowering the socio-economic burden of the country.

The Family Health Programme after several additional components now covers a wide spectrum of services comprising:

1. Maternal care
2. Infant and Child care which provides for immunisation against six common childhood diseases, monitoring growth and development, psychosocial development of the child, control of diarrhoeal diseases and acute respiratory infections
3. Nutrition of the pregnant mothers and children
4. Care of the School child
5. Adolescent health
6. Family Planning

Government policy on population

In 1977 the government policy on population was enunciated as follows.

1. The government is concerned with the rate of population growth and its policy is to take all meaningful steps to curb unplanned growth of population.

2. Enhanced family planning services will be provided by the state and financial incentives with a view to controlling the population explosion will be given to individuals who practice family planning.

3. In the field of family planning emphasis of the government will be in the field of service created programmes to enable motivated couples and individuals to receive family planning services and undergo sterilisation voluntarily.

In 1977 the subject of population was gazetted as a function of a separate ministry and was handed over to Ministry of Plan Implementation directly under the President. Population Division was established under Ministry of Plan Implementation in 1979 for formulation of population policy, implementation, co-ordination of population activities and monitoring, of population programmes. Implementation of activities was assigned to the then Ministry of Health and Women's Affairs. In 1989, the Population Division together with the Population Information Centre came under the Ministry of Health and Women's Affairs facilitating close co-ordination between the Population division and the Family Health Bureau (FHB).

In August 1978 the first Project Ministry, the Ministry of Colombo Hospitals and Family Health was established with Dr. Ranjith Attapattu as the Hon.Minister. and the Secretary of the Ministry was Mr.Tissa Devendra who is our chief guest today. One important function of the Ministry was to improve the delivery of maternal, child care and family planning services in the country particularly in the rural periphery.

Management of family planning and population activities in the regional level was co-ordinated with other sectors from mid seventies by the District Population Committee and at peripheral level by the Divisional Action Committees. Many conferences and seminars were held at central level to strengthen implementation of the Family Planning activities.

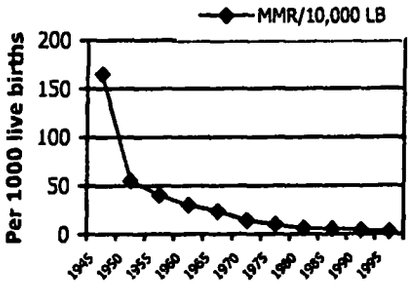
The first ever international conference for Parliamentarian was held in September 1979 organized by the Ministry of Plan implementation. This was followed by 5 national seminars. The national seminar on Population and Development in March 1980 organized by the Ministry of Plan Implementation at the Family Health Bureau Auditorium had a special feature. The chief speakers were politicians from three major political parties in Sri Lanka's parliament. All three political leaders announced openly from the same platform that they would give their wholehearted support to the Government's population policy and programme.
Thus we find that family planning which was initially solely meant to improve the health of the mother and child, came to be a means of controlling unplanned population growth as well.

The Family Health Programme continued to grow in strength both in quantity and quality delivering a very wide spectrum of services. The close linkages between the provincial health administration and the Family Health Bureau contributed toward this enhancement of the programme.

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The Family Health Bureau has been collaborating with the Epidemiological Unit, Health Education Bureau, Population Division, Medical Research Institute, related Ministries like Labour, Education, Higher Education, Universities Professional Organisations and Non Governmental Organizations like Family Planning Association of Sri Lanka, Sri Lanka Association for Voluntary Surgical

Figure-4. Maternal mortality rates from 1945 to1995



Contraception and Family Health, Population Services Lanka and Community Development Services.

Other Key Activities contributing to development of Family Health Services

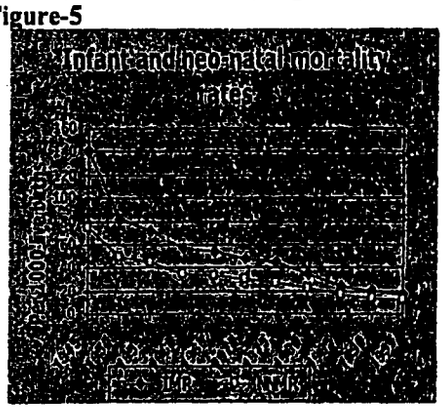
- 1973 - Estate Family Health Programme,
- 1978 - Expanded Programme on Immunisation,
- 1984 - Monitoring Growth and Development of child,
- 1986 - Revised information system on MCH/FP,
- 1987 - Safe Motherhood Programme,
- 1990 - ARI/CDD Programme,
- 1992 - Baby Friendly Hospital Initiative.

Achievements

Achievements in Family Health during the last five decades include:

- reduction of maternal mortality (Figure-4)
- reduction in neonatal and infant mortality (Figure-5)
- reduction in Peri-natal mortality
- high coverage of antenatal care (more than 98% covered by programme)
- high proportion of trained deliveries (96% receive trained assistance)
- high levels of immunisation (Universal child immunisation status in 1989) marked decrease of EPI Target diseases (Figure-6)
- reduction in fertility
- high contraceptive prevalence (34% in 1975 to 66% in 1993)(Figure-7)

Figure-5



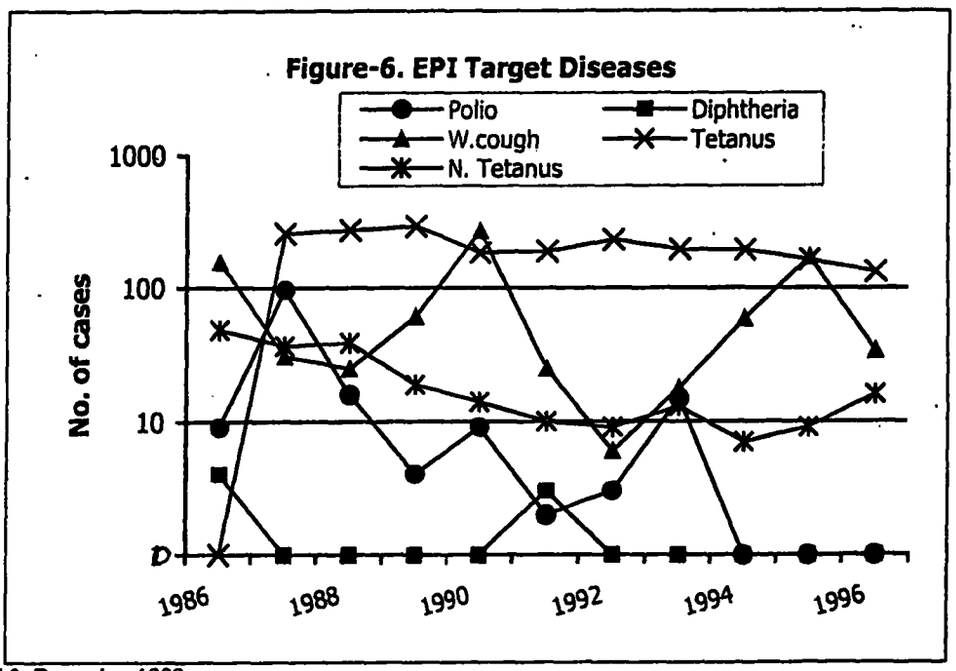
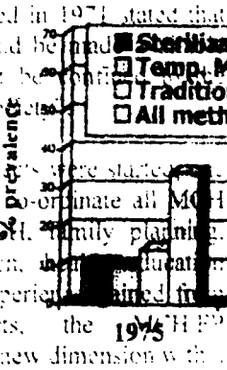


Figure-1 Contraceptive Prevalence



Main reasons for success

- Firm political commitment
- Close integration of MCH services
- Trained manpower
- Provision of quality services
- IEC support
- Multisectoral approach with active involvement of professional and non-governmental organisations
- Support from international agencies

Concept of reproductive health

Since the International Conference on Population and Development in Cairo in 1994, the concept of reproductive health is being introduced in Sri Lanka. This addresses reproductive health issues of the adolescent and post adolescent before they become parents. It also deals with women's reproductive health conditions during the childbearing period and also during peri and postmenopausal periods, thus introducing a life cycle approach to family health care.

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