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சுகாதார வைத்திய அமைச்சு
Ministry of Health

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திகதி)
Date) 23/05/2022

All Provincial Directors of Health Services

All Regional Directors of Health Services

All Heads of Institutions

Interim guideline to maintain essential Family Health Services during the current economic downturn

This interim guideline on Family Health Services is prepared based on the prevailing situation to prevent excess maternal, infant and child mortality and morbidity. This guidance is on prioritizing essential care for most vulnerable groups in the community and it is a proactive measure to prevent occurrence of public health emergencies as a result of the economic downturn experienced in the country.

1. **General measures:**
   1.1. MOH team should be able to contactable at any given time for the clients.
   1.2. There should be an effective communication network within the MOH team and with the RDHS team. Any adversity (staff not reporting to duty, service disruption due to lack of supplies etc) needs to be communicated to the RDHS team.
   1.3. Clinic services and home visits need to be maintained and prioritized as critical services.
   1.4. Need to prioritize the care for vulnerable groups and socio-economically deprived communities in providing routine care. Home risk factors - Z code in Child Health Development Record given for children less than 5 years can be used to identify vulnerable households with food insecurity and poverty.
   1.5. Educate the community that preventive health services are maintained as a routine and to obtain services.

2. **Maternity care:**
   2.1. Antenatal clinics should be continued and should be conducted at a regular frequency.
   2.2. If a mother fails to be present at a clinic, explore the reasons and provide required care as early as possible at the first contact point.
   2.3. Maintain a list of high-risk mothers in the PHM area at the MOH office. If a PHM is likely to fail to attend the duties, a cover-up arrangement should be maintained. Postpartum home visits and home visits for antenatal mothers with complications should be continued as a priority service.
   2.4. In an emergency (due to emergence of danger signals), pregnant mothers should be advised to get admitted to the nearest hospital. The hospital team should stabilize the mother before

transferring to appropriate specialist hospital, with the concurrence of the respective consultant. If they have difficulty in reaching even the nearest hospital, Suwaseriya 1990 ambulance should be contacted.

2.5. Home deliveries are not recommended at all. Mothers should be advised to get admitted to the nearest hospital if they are unable to access the specialist hospital that they have planned for the delivery in an emergency. The hospital team should transfer the woman if she is stable to the previously planned specialized hospital. Divisional Hospitals to be alerted about the increased possibility of pregnant mothers turning up at their institutions for delivery, and be prepared to manage such situations.

2.6. MOH team should assess every pregnant mother, with special focus on vulnerable communities for the risk of home delivery. According to the risk assessment, they can admit the mother early to the hospital at 39 weeks to avoid home delivery in consultation with the VOG allocated for the respective division (see 2.8).

2.7. Each MOH area/PMCI is assigned to a Consultant Obstetrican and Gynaecologist working in the specialized hospital in the draining area. MOH/AMOH/MO PMCI can contact the VOG for clarifications of clinical scenarios and obtain further guidance in difficult situations. Aim of the assignment is to reduce non-essential referrals to specialized care hospital and to manage mothers who failed to comply with the specialist referral due to difficult economic circumstances.

2.8. If antenatal or postnatal mothers find it difficult to comply with referrals due to transport issues, the divisional teams can discuss with the allocated VOG and offer one of the following options:

- groups of referred mothers to be sent to a specialized facility by ambulance
- arranging mobile clinics at divisional level with specialist care.

2.9. Remind all mothers on danger signals during the antenatal, postnatal and neonatal periods and request to seek care early.

3. Laboratory investigations in maternity care:

3.1 Full Blood Count – Conduction of FBCs on all pregnant women at 16-20 weeks of POG
Priority should be given for testing of pregnant women. If the facilities are still not available, following options need to be explored:

- Not to repeat the test if a test report done in the preceding few months is available, unless it is essential for management.

If a spectrometer is available, conduction of Hb tests manually
If haemocue machines are available, checking of Hb at the community level
If all the options are limited, at least mothers with pallor or having a history of anaemia should be investigated.

3.2 Platelet count – Give priority to pregnant women. If the facilities are still not available, manual testing should be conducted.

3.3 Blood group and Rh – Should not be repeated if a reliable previous test report is available, unless the pregnant woman is Rh (-).

3.4 Blood sugar tests – Give priority to pregnant women.

3.5 In order to minimize the negative consequences of current issues in supply chain of reagents of VDRL and HIV tests, it is recommended to limit testing to the 2nd/3rd trimesters only, on previously untested pregnant women. This should be effective till the supply of test kits is normalized.

4 Child care:

4.1 Growth monitoring and promotion, immunization, micronutrient supplementation, provision of supplementary food, child development screening should be encouraged and be continued

in the regular manner. Referrals for management of severe acute malnutrition (severe wasting/SAM) of children under the age of 5 years to be ensured.

4.2 Special attention should be paid to children from vulnerable households (Home risk factors denoted by Z Codes in CHDR B portion and Reasons for special care in CHDR A portion).

5 **Family Planning and well women clinic services**:

5.1 Services should be provided in polyclinics and specific FP & Well woman clinics as usual.

5.2 In a situation where there is a shortage of contraceptive supplies, prioritize services for poor and marginalized women.

5.3 Promote long-acting reversible methods of contraception (preferably the IUD) to women who intend to postpone their pregnancy for two or more years.

5.4 Women who were detected as having precancerous lesions and cancers should be followed up without missing even a single woman.

6 **Mithuru Piyasa centers**:

6.1 Due to increased vulnerability of women during a crisis situation, the services and the hotline facility need to be continued to needy women/families.

6.2 Measures to be taken to increase community awareness on these services that are available to those in need.

6.3 PHMM and field health team should refer needy clients for services.

7 **School and adolescent health services:**

7.1 School health programme consist of a package of cost effective interventions for school going children. It should be delivered whenever possible.

7.2 Continue Yowun Piyasa service provision for adolescents and youth.

7.3 Measures to be taken to increase community awareness and demand creation on Yowun Piyasa services. Encourage working with youth for youth health promotion using multiple platforms including virtual platforms

8 **Antenatal sessions, Complimentary feeding sessions, pre-pregnancy care and any other health education activities:**

8.1 Priority should be given to problem-based preventive type of education programmes (eg: effective management of cash, cost effective living) which would be helpful for the community.

8.2 All opportunities (health education sessions, clinic sessions) to raise awareness on danger signs of pregnant, postpartum mothers and newborns and advise them to reach hospitals at the earliest opportunity.

8.3 Low cost, practical nutrition advice on home gardening and recipes for meals should be given.

9 **Information and surveillance:**

9.1 All maternal, perinatal and under 5 years child deaths should be notified and investigated promptly.

9.2 Home deliveries need to be notified and investigated early. Occurrence of home delivery or a maternal death due to any delay due to present crisis situation should be considered as an early warning sign and preventive measures should be taken to prevent similar events in the community.

9.3 All routine registers, forms and returns of RHMIS to be maintained and should enter all relevant data to the eRHMIS on time

10 Care for vulnerable households:

10.1 Identify vulnerable families (socially & economically) in the community and establish a linkage with non-health stakeholders who could provide assistance.

11 Mental health promotion in the community:

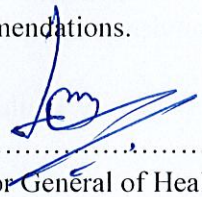
11.1 Community should be informed about the services available for mental health (stress, depression fear etc).

11.2 Primary health care teams should be vigilant of families with risk of violence/abuse and self-harm and refer them for appropriate services

12 **Elderly care**:

12.1 Families can be informed to support their elders to protect their health and visit the closest PMCI for services (simple measures for self help and health protection will be made available as an awareness package).

You are advised to communicate the contents of this guideline with the staff and implement the above recommendations.



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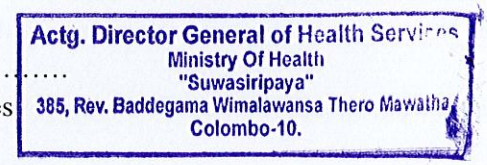
Director General of Health Services



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MOMCH – to monitor implementation of the guidelines
Regional Epidemiologist – to monitor implementation of the guidelines
President, Sri Lanka College of Obstetricians and Gynaecologists
President, Sri Lanka College of Paediatricians
President, Sri Lanka College of Community Physicians
President Perinatal Society of Sri Lanka