

General Circular: 02-85/2014
Revised 2014

My number: DGHS /D/FHB/2010
Office of Director General of Health Services,
Ministry of Health,
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22/05/2014

To:

All Provincial Directors of Health Services,
All Regional Directors of Health Services,
Director- National Institute of Health Sciences,
Chief Medical Officer of Health (Municipal Council – Colombo, Kandy, Galle),
All Medical Officers of Health,
All Heads of Institutions.

The previous Antenatal Care circular No. 01-25/2004 and dated 2004/10/14 is cancelled by this circular.

Antenatal Care

The existing maternal care model and the package was revised extensively according to the recommendations of the external review of Maternal and Newborn Care programme done in 2007, to improve the quality of maternal care and to prevent the wastage of resources.

Furthermore, the National Maternal Mortality reviews and Maternal and Child Health reviews held in last few years had suggested the recommendations to improve maternal care in Sri Lanka.

The previous circular was revised considering all these recommendations.

1. Antenatal Clinics

1.1

In a MOH area, there should be one MCH clinic per approximately 10,000 population. This ratio could be varied according to the population density and the demographic features. This decision has to be taken by the MOH with concurrence of MOMCH and approval of RDHS. Furthermore, Antenatal clinic should be a part of a poly or combined clinic. Conducting one clinic for each PHM area is not recommended. When deciding on field clinic centers, the antenatal clinics which are been conducted at non specialized hospitals in the area should also be taken into consideration. All MOH offices should conduct central clinics on every Saturday and antenatal services should be a part of this central clinic.

1.2 Antenatal Clinics in non-specialized institutions

All divisional hospitals and primary health care units must conduct antenatal clinics for pregnant mothers of their area. Mothers who come within the draining area of the hospital should be referred to these clinics. The MOH should decide on the PHM areas which should receive services from the hospital. The Public Health Midwives of these areas should actively participate in the hospital clinics and should bring H 512 B portions to the clinic.

- The head of the institution is responsible for conducting antenatal clinics in the hospital.
- Hospital staff, i.e. Medical officers/ Registered or Assistant Medical Officers, Nursing Officers and Public Health Midwives must participate in these clinics.

- Public Health Nursing Sister (PHNS) / Supervising Public Health Mid wife (SPHM) need not attend all the clinics on a regular basis to provide routine services.
- The hospital staff should be responsible for the equipments (including surgical items) of the clinic.
- When a single medical officer is in charge of a particular medical institution, according to the general circular no. 1353 dated 1984.12.03, the Medical officer in charge or Assistant Medical Officer working in that particular hospital should conduct maternal and child health clinic / family planning clinic on that day without conducting the outpatient clinic.
- If there is more than one Medical Officer, it is the responsibility of the MOIC to delegate medical officers to conduct the clinic.

1.3 Antenatal clinics in specialized institutions

When there are several hospitals in the district with Consultant Obstetricians, the MOH areas should be assigned for each specialized hospital for referrals to minimize overcrowding of these hospitals. This should be done by the Medical Officer – Maternal and Child Health with the approval of Regional Director of Health Services and the concurrence of the relevant consultants. This will improve the communication between the MOH and consultants and thereby will help to provide a quality service.

A specialized clinic should be conducted giving priority to high risk pregnant mothers whenever possible. It is recommended to conduct a separate clinic for high risk pregnant mothers, if facilities are available. Giving special care to these high risk mothers is intended by this.

In hospitals where consultant Obstetricians working, the clinics should be conducted as referral clinics and necessary referrals should be done by the field clinics. A referral letter, clearly mentioning the reason for referral should be written in the pregnancy record by the referring medical officer.

The specialized hospital should inform the referring officer, the plan of management for the pregnant women referred by the field clinics (MOH/ hospital).

1.4 Outreach clinics

The MOMCH should discuss with the relevant hospital authorities and the consultants to organize outreach clinics. The travelling distance to a hospital with specialized facilities for pregnant women, transport facilities etc. should be taken into consideration when organizing these clinics. The equipments needed and the transport facilities for the consultants should be provided through the RDHS office.

1.5 Other

When a divisional hospital is upgraded to a base hospital with a consultant Obstetrician, it should serve as a referral hospital for high risk mothers and then the MOH should organize a new antenatal clinic at a new place for the mothers of that area.

When the MOH office is situated within the same premises or close to a hospital without an Obstetrician (non specialized unit), the hospital should conduct the antenatal clinic for the mothers of those PHM areas for which the hospital provides services.

02. How to conduct clinics

The Field/ Institutional antenatal clinic sessions should be conducted once in every two weeks. The clinic schedule should be displayed in the clinic.

2.1 Human resources for the clinic

A medical officer must always attend all antenatal clinics except under special circumstances. The number of PHMs to be participating at each antenatal clinic should be decided according to the estimated number of service recipients.

The Public Health Nursing Sister or Supervising Public Health Mid wife can participate only for management or supervisory functions or to provide essential clinic services.

A duty roster should be prepared at the beginning of the year and displayed in all clinics. This should be prepared by the PHM in charge of the antenatal clinic. The clinic should be compulsorily prepared on the day prior to the clinic session. It should be done by the PHM in charge of the clinic or a person assigned by her, according to the duty roster prepared at the beginning of the year.

2.2 Clinic visit schedule for pregnant mothers

The low risk mothers should attend the clinic as follows.

1st clinic visit - between 6-8 weeks

2nd clinic visit - between 12-14 weeks

3rd clinic visit - between 18-20 weeks

4th clinic visit - between 22-24 weeks

5th clinic visit - between 26-28 weeks

6th clinic visit - between 32-34 weeks

7th clinic visit – around 36 weeks

8th clinic visit – around 38 weeks

9th clinic visit – around 40 weeks

When giving clinic dates, other government clinics that a mother is attending should also be taken into consideration. High risk mothers should be referred to relevant specialized clinics. The consultant should inform MOH/MO regarding the management plan and the frequency of clinic visits. If not, MOH/MO/AMO/RMO should decide on the frequency of clinic visits. For the services that can be provided in these clinics and for the special clinic schedule for high risk mothers, refer and follow the 'Maternal Care Package – A guide to field health staff'.

2.3 Commencing the clinic

The clinic should start by 7.30a.m. If it is a polyclinic, appointments should be given to the different client categories.

2.4 Duties to be carried out at the clinic

2.4.1 Registration

- The mothers who were not registered in the field should be registered at the clinic and given antenatal care.
- All mothers should be welcomed and should be referred to relevant places. The services must be provided for all mothers who attend the clinic. Form 512 A should be issued to mothers who are not issued with 512 A, if necessary.

2.4.2 Examination of the nutritional status

Height and weight should be measured in all mothers coming to the clinic for the first visit and it should be marked in the pregnancy record (both in 512 A and B). The BMI should be calculated in all mothers at the booking visit paid before 12 weeks of POA. Use the BMI chart issued by the FHB to calculate the BMI. BMI and the weight gain should be marked in the weight gain chart.

2.4.3 Measuring Blood pressure

It is compulsory to measure blood pressure in all mothers attending the clinic. The blood pressure should be measured by a Medical Officer or Assistant /Registered Medical Officer, whenever possible.

In an unavoidable circumstance where a medical officer is unable to attend the clinic, blood pressure can be measured by other officers.

2.5 Basic investigations during pregnancy

2.5.1 Testing Urine

The test for urinary glucose should be performed at the first visit and at 24-28 weeks of POA. The test for urine proteins should be performed at every clinic visit. For this, urine strips or Benedict's test and heat test can be used.

The amount of chemicals needed to prepare Benedict's solution and acetic acid need to be estimated and brought to the regional drug stores. This solution can be prepared at the laboratory of the nearest Base or General Hospital.

If urine strips are used, it should be estimated, purchased locally or obtained from central drug stores.

2.5.2 Haemoglobin testing

The blood haemoglobin level should be checked in all pregnant women at the first visit and 28 weeks of POA. Anaemic women should be treated according to the general circular 1945 (revised). Hb testing should be repeated in anaemic women to monitor the response to treatment.

2.5.3 Blood sugar testing

For all mothers who are non diabetic, a suitable test to check blood sugar levels (in accordance with the guideline for screening, diagnosis and management of diabetes in pregnant women) should be performed at the first visit and around 24-28 weeks.

2.5.4 VDRL test for Syphilis & HIV Test

If possible, a blood sample should be taken at the first visit for VDRL & HIV testing. These samples should be sent to a government STI clinic. The Medical Officer Maternal and Child Health should coordinate this process. (Preferably this test should be performed before 12 weeks of pregnancy).

2.5.5 Blood grouping and Rh test

The necessary coordination should be done with the nearest hospital's blood bank. It is not necessary to perform this test in each pregnancy and the previous details can be used if acceptable information is available. The relevant guidelines should be used for managing Rh negative mothers.

After performing VDRL, HIV and Blood grouping and Rh tests, the relevant notes should be made in the cages provided in 512 A and B.

2.6 Examination of the mother

A Medical Officer should examine all mothers attending the clinic. It is compulsory to examine the precordium by a MOH/AMO/RMO three times during the pregnancy (once in each trimester). The PHM should perform breast examination during the home visits. If any abnormalities are detected, those mothers should be referred to the Medical Officer at the clinic.

The Symphysis Fundal Height should be measured in all pregnant mothers and it should be marked in the SFH chart.

After examining the mother, notes should be made in the relevant spaces given in 512 A and B.

All mothers should receive foetal movement chart at 36 weeks of POA and the mother should be clearly instructed to mark it correctly.

2.7 Tetanus toxoid immunization

Refer the general circular 01-22/2010 dated 2010.06.09 on tetanus toxoid immunization. The relevant notes should be made in the pregnancy record, after giving the tetanus toxoid.

2.8 Issuing drugs

- Folic acid 1 mg daily should be given to all mothers until 12 weeks of POA
- The following drugs should be given to all mothers after 12 weeks of POA
 - ✓ Worm treatment (Mebendazole one 500mg tablet or six 100mg tablets)
 - ✓ Folic acid 1mg tablet daily
 - ✓ Iron 200mg tablet daily
 - ✓ Vitamin C tablets -one 100mg or two 50mg tablets
 - ✓ Calcium Lactate two 300mg tablets (600mg daily)
 - ✓ Malaria prophylaxis (should be started as soon as the mother gets pregnant)
- Iron tablets, folic acid and vitamin C tablets are to be taken 1-2 hours before a meal. Instruct mothers to take the calcium tablet separately.

The instructions on micronutrient supplementation are given in the general circular number 1945 by Director General of Health Services. When issuing drugs to the mother, the next clinic date and whether she gets these from another clinic also should be taken into consideration. When issuing these drugs, it is compulsory to give necessary information on the mode of administration.

Total drug requirement should be estimated according to the general circular 01-23/2010 dated 25.08.2010.

2.9 Health Education activities

Both formal and informal health education programmes should be conducted in all clinics. The health education schedule should be prepared initially and health education topics should be displayed in the clinic. The officer who should conduct the Health Education session on the clinic date should be assigned prior to the clinic date.

- Use relevant health education materials
- Use different methods of health education
- It should be simple as possible to suit the participants

The details of health education should be entered in 512 A & 512 B.

Antenatal Classes

All pregnant women should participate in three antenatal classes, one in each trimester and along with their husbands. The Antenatal classes should be conducted monthly for each PHI area or in groups of three or four PHM areas together. The guide on antenatal classes for field health workers' should be used to plan and conduct the classes. The MOH, Public Health Nursing Sister and Supervising Public Health Midwives are responsible for supervising antenatal classes.

2.10 Special Situations

Antenatal care for mothers leaving the area and coming to reside in the area

If a pregnant woman leaves the area before the delivery, it should be recorded in the pregnant mothers' register and the pregnancy record (512 A and 512 B) along with the new address. The new address should be informed to the public health midwife of the new area for continuation of antenatal and post natal care. For this, the following method should be followed.

If the new address is in the same MOH area, the relevant PHM should be informed. It should be informed to the MOH as well. If the new address is in a different MOH area, a letter should be sent to that MOH by the present MOH. A register should be maintained at the MOH office for details of the mothers leaving the area and temporarily coming to reside in the area. New 512 B cards must be issued to all mothers coming to the field from another MOH area and the necessary information can be obtained from the 512 A cards.

Antenatal care for working mothers

These mothers can be referred to a field clinic closer to the working place of the mother if necessary.

2.1.1 Antenatal home visits

The Public Health Mid wife should pay home visits for all antenatal mothers in her area. It is compulsory to pay three home visits, one in each trimester for low risk mothers. More frequent home visits should be paid for high risk mothers as stated in the 'Maternal Care Package – A guide for field health workers'.

The MOMCH should monitor whether this circular is been implemented properly in the district. Please communicate the contents of this circular to all MOHs, Institution Heads, RMOs and other field health staff and give necessary instructions to implement the circular.

For further clarifications please use the following guidelines;

- Maternal care package – A guide to field health workers (Sinhala , Tamil and English)
- A guide for antenatal classes (Sinhala , Tamil and English)



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