Reproductive Health and Family Planning Programme in Sri Lanka: Achievements and Challenges

by

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Historical Overview

- Sri Lanka, in the Asian context is unique in that it has a long history with regard to maternal care and data collection.
- The first organized effort towards providing care to childbearing women commenced in 1879.
- Registration of births and deaths commenced in 1867.
- The registration of traditional midwives began in 1887 and from 1902 maternal mortality statistics were reported in the Annual Report of the Registrar General.
- The first antenatal clinic was held in 1921 and the first health unit was established in 1926.
- By 1950, 91 health units were established.

- The expansion of maternal and child health services contributed significantly to lowering maternal and infant mortality rates.
- The maternal mortality ratio declined from 2650 in 1935 to 560 in 1950. Similarly, the infant mortality rate declined from 263 to 82.
- The family planning activities in Sri Lanka commenced in 1953 with the establishment of the Family Planning Association.
- The government recognized the work of the Association in 1954 by providing an annual grant.
- In 1958, an agreement was signed between the governments of Sri Lanka and Sweden for co-operation in a pilot project on family planning
- A survey conducted under this project revealed that there was no major religious opposition to family planning and a latent demand for family planning existed among married couples.

- During the period 1958 to 1965, family planning activities continued to gather momentum.
- When the ten year economic development plan was presented in 1959, it highlighted the implications of the rapid increase of population and its effects in slanting investment away from directly productive economic activities
- In 1960, a labour force survey showed that the unemployment rate had increased to over 10 percent.
- Therefore, in view of the above, it became evident to policy makers that the population growth rate in the country needs to be brought under control.
- Thus in 1965, family planning became a national programme and was integrated with the maternal and child health programme of the Ministry of Health.
- Thus it was three decades before the ICPD that Sri Lanka recognized the importance of integrating family planning with other reproductive services such as maternal and child health.

- The social environment in the country was conducive. The primary health care system was well developed and about 70 percent of women in the reproductive age group were literate.

Launching Phase, 1965-1975

- In 1965, the government renewed the agreement with the government of Sweden to obtain equipment and contraceptive commodities to implement the national family planning programme.
- In 1968, the Family Health Bureau (FHB) was established in the Ministry of Health to coordinate and implement the maternal and child health and family planning activities.
- By 1971 as a result of the rapid growth of youth population, the unemployment rate increased to more than 20 percent of the labour force which resulted in a youth uprising in April 1971

- Therefore, in 1972, when the Five Year Plan was presented by the government it emphasized the need to slow down the rate of population growth and stated that if action is not taken, Sri Lanka would have 27 million people by the year 2000.
- In 1973, a project agreement was signed by the government with the UNFPA for assistance to broad base the population programme.
- As many population information, education and communication activities were implemented by other government agencies outside the Ministry of Health, in 1974 a Steering Committee was established chaired by the Secretary, Ministry of Plan Implementation to coordinate the national population programme.
- Thus in 1975 when the first fertility survey was conducted, baseline information with regard to fertility and family planning became available to monitor the programme.

Table 1

Reproductive Health Indicators, 1975

Indicator	Rate/Ratio
Total Fertility Rate	3.4 (1974)
Adolescent Fertility Rate (15-19)	31 (1974)
Contraceptive Prevalence (%)	34.4
(a) Modern Temporary (%)	9.6
(b) Permanent Methods (%)	10.6
(c) Temporary Methods (%)	14.2
Infant Mortality Rate (per 1000 live births)	45.1
Maternal Mortality Ratio (per 100,000 live births)	100.0

Sources: Fertility Survey 1975; Registrar General's Department

Progressive Phase 1975-1985

- In 1977, the government policy on population was clearly stated in the Throne Speech of the government in the Parliament. It noted the need to strengthen clinical contraceptive services and provide financial inducements to those who voluntarily accept sterilization as a method of contraception.
- In May 1979, the government introduced for the first time financial incentives to medical teams that carry out sterilizations. This scheme was extended to new acceptors of sterilizations from January 1980.
- The programme received greater visibility through information education and communication activities organized by the government and the NGOs. The government also recognized the role that the NGOs could play in supplementing the national programme and gave them all the encouragement.
- In 1979, a Population Division was created in the Ministry of Plan Implementation to coordinate the population programme.

- In 1982, the President of Sri Lanka appointed a Parliamentary Advisory Committee on Population (PACP) to advice the government on appropriate policies on population and family planning.
- In 1983, the National Coordinating Committee on Population (NCCP) was established to monitor and coordinate the national programme with the Minister of Health as the Chairperson and the Secretary, Ministry of Plan Implementation as its secretary. The Population Division functioned as the secretariat to both the PACP and the NCCP.
- With the strong commitment shown by a key Ministry placed directly under the President of the country, the programme gathered momentum and many indicators of family planning and reproductive health further improved.

Table 2

Reproductive Health Indicators, 1982

Indicator	Rate/Ratio
Total Fertility Rate	3.7 (1981)
Adolescent Fertility Rate (15-19)	34 (1981)
Contraceptive Prevalence (%)	57.8
(a) Modern Temporary (%)	9.9
(b) Permanent Methods (%)	22.0
(c) Temporary Methods (%)	26
Infant Mortality Rate (per 1000 live births)	30.5
Maternal Mortality Ratio (per 100,000 live births)	60.0

Sources: Fertility Survey 1982; Registrar General's Department

Maturity Phase 1985-1994

- During this decade, the population programme transformed from a demand creation phase to a supply oriented one where family planning service delivery became the focus of attention.
- Thus in August 1989, the function of population policy formulation and implementation was re-assigned to the Ministry of Health.
- As a result, the Population Division of the Ministry of Plan Implementation was moved to the Ministry of Health with the same functions and responsibilities.
- Thus the Ministry of Health took over the overall coordination and management of the national population programme. The Population Division being placed directly under the Secretary, Ministry of Health, assumed greater responsibility in population policy planning and coordination of the national programme.

- The responsibility of implementing the family planning service delivery activities continued to be vested under the Family Health Bureau.
- The unmet need for family planning in 1987 was 12 percent. Thus meeting the demand for family planning became a key service delivery issue which was addressed by improving field supervision and strengthening the information, education and communication activities.
- In 1991, for the first time the government set a target of achieving replacement level fertility by the year 2000 in its policy statement on population which was approved by the National Health Council chaired by the Hon. Prime Minister.
- Thus by 1993, the family planning and reproductive indicators showed further improvement.

Table 3
Reproductive Health Indicators, 1987 and 1993

Indicator	Rate/Ratio	
	1987	1993
Total Fertility Rate	2.8 (1982-87)	2.3 (1986-93)
Adolescent Fertility Rate (15-19)	38 (1982-87)	35 (1986-93)
Contraceptive Prevalence (%)	61.7	66.1
(a) Modern Temporary (%)	10.8	16.1
(b) Permanent Methods (%)	29.6	27.2
(c) Temporary Methods (%)	21.1	22.4
Unmet need for contraception (%)	12.3	10.8
Trained assistance at delivery (%)	93.1	97.7
% of childern aged 3-36 months		
(a)Stunted	27.5	23.8
(b) Wasted	12.9	15.5
Infant Mortality Rate (per 1000 live births)	22.6	16.3
Maternal Mortality Ratio (per 100,000 live births)	40.0	30.3

Sources: Fertility Surveys 1987 and 1993; Registrar General's Department

The Post ICPD Period

- In 1994 Sri Lanka became a signatory to the adoption of the Programme of Action on Population and Development at ICPD.
- Sri Lanka adopted number of initiatives reponding to the ICPD PoA.
- In 1998, the Population and Reproductive Health policy and Action Plan was formulated.
- In 2000, an Advocacy Strategy was developed.
- The paradigm shift from family planning to the holistic approach of reproductive health took place.
- The maternal and child health and family planning services were broad based to include other elements of reproductive health through the network of existing primary health care facilities. A life-cycle approach to women's reproductive health was adopted.

- In 1996, the Family health Bureau established Well Women's Clinics (WWC) in the sub-divisional health areas for screening of breast and cervical cancer and detection of hypertension and diabetes among women over 35 years of age.
- The government also took action to further strengthen the National STD/AIDS and Cancer Control programmes. These initiatives have resulted in the increase in screening, diagnosis and treatment.
- In 2008, the Family Health Bureau formulated the National Maternal and Child Health Policy providing strategic directions to meet some of the important challenges in the national reproductive health programme.
- Thus by 2007, Sri Lanka was able to demonstrate the impact of its reproductive health programme by the impressive indictors it had achieved during the past three decades.

Table 4

Reproductive Health Indicators, 2000 and 2006/07

Indicator	Rate/Ratio	
	2000	2006/07
Total Fertility Rate	1.9 (1995-00)	2.3 (2003-06)
Adolescent Fertility Rate (15-19)	27 (1995-00)	28 (2003-06)
Contraceptive Prevalence (%)	70.0	70.2
(a) Modern Temporary (%)	26.4	36.0
(b) Permanent Methods (%)	23.1	17.1
(c) Temporary Methods (%)	20.5	17.0
Unmet need for contraception (%	9.1	7.3
Trained assistance at delivery (%)	96	98.6
Low birth weight (%)	16.7	16.6
Delivery of births at health facility (%)	97.1	98.2
Infant Mortality Rate (per 1000 live births)	13.3	10.0
Maternal Mortality Ratio (per 100,000 live births)	21.0	14.2

Sources: Fertility Surveys 2000 and 2006/07; Registrar General's Department

Future Challenges

- Identify vulnerable groups in geographic pockets for focused attention in reproductive health activities.
- Give priority to the improvement of logistic management and commodity security of contraceptives and drugs and the availability of equipment.
- Reduce septic abortions which account for about 12 percent of maternal deaths.
- Provide information and education of the need for adequate nutrition during pregnancy and lactation and the importance of birth spacing.
- Develop age appropriate behavior change communication approaches to influence the behavior patterns of adolescents.
- Promote equal participation of men and women in parenting and family care.

- Strengthen the administration of justice and effective law enforcement for progress on gender equality and zero tolerance for violence against women in the family and the community.
- Strengthen the database used for population and reproductive health planning at national and sub-national levels by improving quality and timely reporting of data.
- Advocate the importance of informed choice in the use of family planning services.
- Advocate through government agencies and women's organizations higher representation of women in governance and decision making positions.
- Undertake research to ascertain the causes of the widening gap between male and female life expectancy at birth.
- Incorporate population and development concerns into national development planning with focus on poverty alleviation.

Thank you for your Attention