



Safe motherhood in Sri Lanka: a 100-year march

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Abstract

The present safe motherhood status in Sri Lanka has been achieved by a series of activities for health and social development during the past century. While ancient and traditional religious, as well as cultural concepts provided a sound foundation, it was the policies that focused on human development that resulted in reducing the maternal mortality rate to 2.4 per 10 000 live births, and the infant mortality rate to 16.5 per (1000) live births. Maternal and Child Health (MCH) services were initially closely linked to improvements in the healthcare infrastructure and social development, while family planning introduced in 1953 enhanced its progress further. With MCH integrated into reproductive health, the march towards a safer motherhood in Sri Lanka will require the implementation of new policies and strategies. © 2000 International Federation of Gynecology and Obstetrics.

Keywords: Safe motherhood; MCH services

1. Introduction

Sri Lanka represents a unique demographic scenario in the Asia Pacific region. The last decennial census in 1981 recorded a population of 14.9 million and the estimated mid-year population for 1996 is 18.3 million with a growth rate of 1.1% [1]. The crude birth rate recorded for 1996 is 18.6 per thousand of the population and the crude death rate is 6.5 per thousand of the popu-

lation. For the year 1995, maternal mortality was recorded as 2.4 per 10 000 live births and infant mortality as 16.5 per thousand live births, while the neonatal mortality was recorded as 12.5 per thousand live births. One of the most clearly visible features in Sri Lanka's age composition is the increasing trend of the population in the older age groups and a concurrent reduction in the percentage of children between the ages of 0 and 9 years. The female life expectancy increased to 73 years in 1991, and the Sri Lanka Demographic and Health Survey 1993 (SLDHS, 1993) [2] recorded a literacy rate of 90%. This is the success story of Sri Lanka.

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The unique position achieved by Sri Lanka in terms of its health indicators, may be ascribed to a high degree of commitment to social welfare and an expensive social welfare package implemented continuously since independence. These measures resulted in widespread access to health-care and high levels of education of both men and women; the increasing educational attainment of the latter being associated with striking advances in the position of women in all spheres of national life.

The welfare style of development in Sri Lanka can be traced to a very early period in the country's history when free health services and free education were provided to the people under the patronage of the King [3]. The country, which has one of Asia's oldest civilizations, has a culture that adopts a Buddhist way of life in which women are held in high esteem. Royal patronage of the religion ensured that the social philosophy of Buddhism was woven into the texture of life of society and pervaded all areas of activity. The status of women in society was enhanced with the establishment of an order of Buddhist nuns in 288 BC shortly after the advent of Buddhism to the country in 307 BC. With the granting of franchise to women in 1931 their status in society was further enhanced and women have contributed in no mean measure to the social and human development of the country.

2. Education

Sri Lanka has a long history of organized education, the beginnings of which can be traced back to the 3rd and 4th centuries BC. What is more important is that, traditionally, the general population had free access to learning. In the scale of social values therefore, education was rated higher than mere wealth. Since the portals of learning were open to women from ancient times their education was always ensured. Buddhist temples served as centers of education to the general population, while the larger monasteries developed into renowned and influential centers for religious as well as secular learning.

These traditional systems of learning were disrupted during the period of occupation of the maritime provinces by the Portuguese (1505–1658) and the Dutch (1658–1795). A free state school system was started in the country by the colonial Dutch rulers. The beginnings of the modern educational system, however, can be traced to the educational reforms initiated under the British in 1830. Legislative action for compulsory education soon followed, and the Director of Public Instruction in his report of 1903 observed that '25% of the female population of this country get something in the way of education' [4]. He was no doubt referring to Western education.

When a semi-autonomous government was instituted in 1931, the 'free education scheme' came into being. It resulted in the opening of new schools and improvement of old schools. The rapid expansion of school enrolment that followed caused a greater expansion of female education (Table 1) [5]. These developments contributed much to the improvement in the quality of life as shown by the high levels reached by the health indicators.

3. Maternal and child health services

It is very significant to note that throughout the history of Sri Lanka, the health of its people has been a major concern of its governments. Services were provided to ensure the well being of vulnerable groups such as mothers, children and the aged, even during the reign of ancient kings.

Table 1
Percentage literacy by sex, 1901–1981

Census year	Male	Female	Both sexes
1901	42.0	8.5	26.4
1911	47.2	12.5	31.0
1921	56.3	21.2	39.9
1946	70.1	43.8	57.8
1953	75.9	53.6	65.4
1963	85.8	67.5	77.1
1971	85.6	70.9	78.5
1981	91.1	83.2	87.2

Western medicine was introduced to the country with the advent of colonial rule. The present health services of the country evolved from the military and estate medical services introduced by the British when a civil medical department was established in 1858.

The changes in maternal mortality closely followed the development of facilities for healthcare in the country. The establishment of the Colombo Medical School in 1870 [6] and the donation of the DeSoysa Lying-in Home by a philanthropist, the late Charles De Soysa in 1879 [7], could be said to have laid the foundation for ensuring safe motherhood in the country. Both these institutions are the second oldest of their kind in Asia and continue to play a major role in medical training and service. Training in midwifery and the registration of midwives were introduced the same year as the establishment of the maternity hospital. A maternal and child health department was established in the Colombo Municipality as early as 1906.

Significant landmarks in the development for safe motherhood in the early 20th century were the commencement of the first ante-natal clinic at DeSoysa hospital in 1921 and the establishment of the Health Unit System in 1926. One of the main activities of a health unit was the provision of maternal and child healthcare through domiciliary as well as clinic based services [7]. The Health Unit System initiated the community based MCH care in the country, and was commenced in Kalutara, a town in the western province, approximately 30 miles south of Colombo. The unit provided the template for promotive and preventive services and similar units were established throughout the country. The units provided domiciliary and outpatient ante-natal care through health centers and field clinics, trained assistance during delivery through institutions or at home, and domiciliary or clinic based post partum and infant care during the early months. It is the general organization around which the Maternal and Child Health services function even today.

When some degree of self government was established in 1931, expansion of both the curative and preventive health services of the country was implemented. The number of health units

increased from eight in 1931 to 572 in 1937. Training of midwives commenced at two centers under the supervision of the Ceylon Medical College Council based at the Medical Faculty in Colombo. Female medical officers were provided for services aimed at women and facilities for institutional deliveries increased considerably and today 94% of deliveries in the country occur in institutions [1].

The development in the institutional and community based health infrastructure commenced during the colonial period continued in the post independent phase. By the late 1950s the staff of both curative and preventive services were providing MCH services, and a subdivision for the MCH services within the Ministry of Health was considered. A special committee to investigate maternal deaths was appointed in 1960 and a full-time MCH medical officer was appointed in 1961. A separate organizational structure, the Maternal and Child Health Bureau, later named the Family Health Bureau was established in 1968. With decreasing maternal mortality, the focus of attention soon shifted to maternal morbidity.

The healthcare services were further strengthened on a three tiered basis so that a referral system was established between the primary, secondary and tertiary care units. Professional organizations in the fields of obstetrics and gynecology, pediatrics and community medicine have played an increasing role in the improvements that have occurred, particularly by establishing training and service links. With the establishment of the Family Health Bureau and the commencement of the government family planning program maternal mortality continued to decline and in 1974 its reduction to 10 per 10000 live births was achieved. The government adopted the policy of integrated reproductive healthcare in 1997, and at present maternity care is provided within this context.

Registration of births and deaths became compulsory as early as 1897, and since 1921 the administrative report of the Registrar General devoted a special section to maternal mortality. The ready availability of statistics facilitated the evaluation of MCH services and contributed to

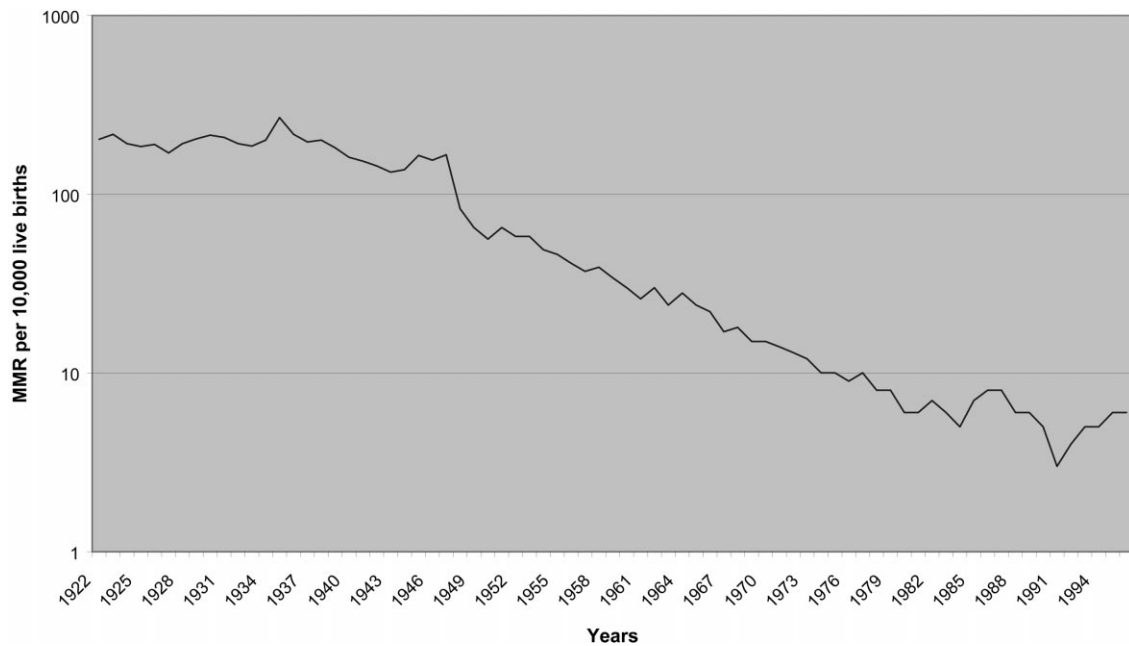


Fig. 1. Trends in maternal mortality. Sri Lanka, 1922–1996.

the development of programs and services. Another important feature was the participation of voluntary organizations in MCH activities from as early as the pre-independence era.

4. Trends in maternal mortality

The past trends in maternal mortality in Sri Lanka are shown in Fig. 1. The rate is seen to follow a downward trend from 210 per 10 000 live births in 1881 to the present level of 2.4 per 10 000 live births in 1995. Until 1947 the decline was gradual. The periodic peaks of maternal mortality seen during this period coincide with the successive epidemics of malaria which ravaged the country, the highest ever maternal mortality rate for the past 100 years being recorded during the 1934–1935 malaria epidemic.

A dramatic drop in the maternal mortality was observed from 1947 to 1948 onwards (Table 2). This decline could be attributed to malaria control activities, implementation of public health measures and the expansion of MCH services. Further developments in healthcare such as blood

transfusion services, availability of antibiotics and decline in fertility contributed to the steady decline of maternal mortality.

5. Fertility

The reduction in maternal mortality in Sri

Table 2
Maternal mortality rate — Sri Lanka (1947–1980) (maternal deaths per 10 000 live birth).

Year	M.M.R.
1947	166
1948	83
1951	65
1953	58
1955	46
1957	37
1960	30
1965	24
1967	17
1970	15
1975	10
1978	8
1980	8

Lanka is linked to its fertility decline. The fertility transition in Sri Lanka commenced in the mid-1950s. Prior to this period the fertility levels remained high as an insurance against high mortality. Community and family pressures as well as social values and institutions were geared to encourage large families [8]. The birth rates during this period, however, fluctuated considerably due to outbreaks of epidemics and poor health conditions exerting direct and indirect effects on fertility.

During the downward trend in fertility which commenced in the mid-1950s, the initial decline was mainly due to the rise in age at marriage of females [9]. The latter was 20.9 years in 1953 and increased to 22.1 years in 1963 and subsequently to 24.8 years in 1987. Since 1975 an increasing proportion of the fertility decline was due to the decline in marital fertility. During the period 1972–1982 more than 75% of the decline in fertility was by the use of contraceptives, and it increased very rapidly during the next decade [10].

With the organization of the Maternal Child Health services on a national basis it was in-

evitable that the family planning program would be linked to it. In 1965 The Maternal and Child Health Unit of the Ministry of Health commenced the government family planning program. However, initiation of family planning activities in the country preceded these events. The now much quoted speech by the late Mr S.W.R.D. Bandaranaike in 1949 to the Second World Health Assembly held in Rome refers to 'the growing need for the consideration of the problem of birth control on an international plane'. The issue was raised by him once again in 1951 at the World Health Organization meeting held in Kandy, Sri Lanka. It is regrettable that on both occasions he received no support from the world forum [11]. The political leaders of the immediate post independence era were mindful of the need to control population for future socioeconomic progress. A comprehensive analysis of the implications of rapid population growth was included in the 10-year plan prepared in 1959.

The Family Planning movement was launched in 1953 when the Family Planning Association (FPA) was started by a group of concerned social

Table 3
Milestones in family planning in Sri Lanka

Year	Activity/program
1953	Formation of the Family Planning Association.
1955	Government recognizes need for family planning and first grant of Rs.2000/= to Family Planning Association.
1958	Swedish government support FPA activities.
1961	Agreement between the Governments of Sri Lanka and Sweden for community based family planning services.
1963	Plantation Sector Family Planning Program commenced.
1965	The Government initiates family planning activities under its MCH program; approximately 200 FPA clinics handed over to MCH program.
1968	The Family Health Bureau established by MCH unit.
1973	Government signs agreement with UNFPA to support national family planning effort.
1975	The World Fertility Survey conducted.
1978	Government recognizes three more NGO for family planning activities.
1982	Contraceptive Prevalence Survey shows an increasing acceptance of family planning.
1987	The Demographic and Health Survey shows contraceptive prevalence to be 63%.
1993	The second DHS: contraceptive prevalence = 66.7%.
1997	Government adopts Reproductive Health Concept in its health policy.

workers. The Association was the only organization providing for research, organized clinical services and training in this field for the next decade. Milestones in the establishment of family planning activities in Sri Lanka are listed in Table 3. Following its early difficult stage, it gradually achieved government and public acceptance, initiated links with foreign governments and international health agencies, and then handed over the service delivery of family planning to the government health authorities. The FPASL is still a major contributor to the national family planning effort in the country.

The impact of family planning on safe motherhood in Sri Lanka should be considered within the context of other health and social changes over the years. The information available in the many surveys, though reliable, has not directly looked at this aspect. The data from these sources, however, give a reasonable insight into the relationship of family planning to safe motherhood in Sri Lanka.

5.1. Contraceptive prevalence

Four major surveys have been conducted in Sri Lanka to study the fertility and family planning situation [2,10,12,13]. Due to the inaccessibility of the areas of the northern and eastern provinces in the last two decades, the Sri Lanka Demographic and Health Surveys of 1987 (SLDHS 1987) [10] and that of 1993 (SLDHS 1993) [2] did not contain the data from these two provinces. For purpose of comparison, therefore, the data from these two provinces in the Sri Lanka World Fertility Survey (SLWFS 1975) [12] and the Sri Lanka Contraceptive Prevalence Survey (SLCPS 1982) [13] were excluded from the analysis. Starting from a low 34.4% in 1975 [12], the contraceptive prevalence rate (CPR) has increased progressively to 66.1% in 1993 [2]. The contraceptive method mix, however, is far from ideal as traditional methods are still used by 22.4%. Male and female sterilizations which reached 29.8% in 1987 [10] has declined to 27.2% in 1993 [2], while modern temporary methods seem to enjoy a steady but slow increase in popularity to reach 16.5% in 1993.

Of greater significance is the relationship of contraceptive use to the educational levels of Sri Lankan society. Non-use is highest at 41.8% amongst the non-educated. Paradoxically non-use of contraceptives is next highest at 36% in those who are educated above the secondary level and decreases with the educational status to reach a figure of 31.1% in those with only a primary education. The use of traditional methods is also highest and sterilization is lowest amongst the highest educated. It therefore creates an increasing potential for termination of pregnancy when contraception fails. An increasing trend, however, in the use of modern temporary methods amongst all levels of education is encouraging to service providers, and health program managers should develop urgent strategies to exploit this to improve the family planning status in the country.

5.2. Fertility trends and safe motherhood.

Sri Lanka occupies a unique position in south Asia in that it has the highest contraceptive prevalence and the lowest maternal mortality. When the total fertility rate (TFR) is matched against the maternal mortality rate for the different countries of south Asia, interesting features emerge. Beyond a maternal mortality of approximately 50 per 10000 live births, the TFR remains steady at a high figure of approximately 7.0. It appears that at this high rate of maternal mortality, factors other than fertility control would determine its reduction. Some of these are improvements in education, the healthcare system, transport facilities and communication infrastructure.

When the maternal mortality rate falls below 50 per 10000 live births it appears to be related in a linear manner to the reduction in TFR [14]. It is, therefore, relevant that family planning inputs be considered as an acceptable strategy for reducing maternal mortality when the latter has fallen below this critical level. The introduction of family planning in 1953 came at an appropriate time as the maternal mortality was at 50 per 10000 live births. It can be assumed that a program for fertility control, if initiated in the 1940s, would have only minimally affected the maternal mortal-

ity of that time. The available resources were better spent on improvements in the healthcare structure and educational developments.

With this background how do the family planning achievements in Sri Lanka relate to safer motherhood for its people? The World Health Organization has stated that ‘To promote safe motherhood avoid pregnancies too early, too late, too many and too close together’. It is interesting to examine whether the Sri Lankan situation coincides with this concept.

5.3. Pregnancy too early?

The surveys performed over the past two decades have helped to determine the age of the first pregnancy amongst the Sri Lankan population. The data from the SLDHS of 1987 show that the median age at first birth is later in the younger women. This was further highlighted in the SLDHS of 1993 when the mean age at first union was shown to be 24 years for women aged 25–29 years while the those aged 45–49 years reported a

figure of 21.8 years. The latter would reflect the age of marriage for women during the early 1970s. A decline in fertility was observed in the 1950s and it is thought that it occurred due to a delay in the age of marriage in the post independence period. An increase in the age of marriage would result in a corresponding delay in the age at first birth, thus shifting it to a time when the mother is more mature to withstand the rigors of pregnancy and child bearing.

The delay in the average age of marriage commenced prior to the introduction of family planning to Sri Lanka. Therefore, it cannot lay claims for this beneficial trend. Other social developments such as free education from 1947 were instrumental in bringing about this change. Family planning, when introduced in 1953 would have accelerated the decline in fertility that had already commenced.

Age-related maternal mortality figures for Sri Lanka (Fig. 2) [15] have shown that deaths in teenage pregnancies are only marginally higher than those in the early reproductive age of 20–30

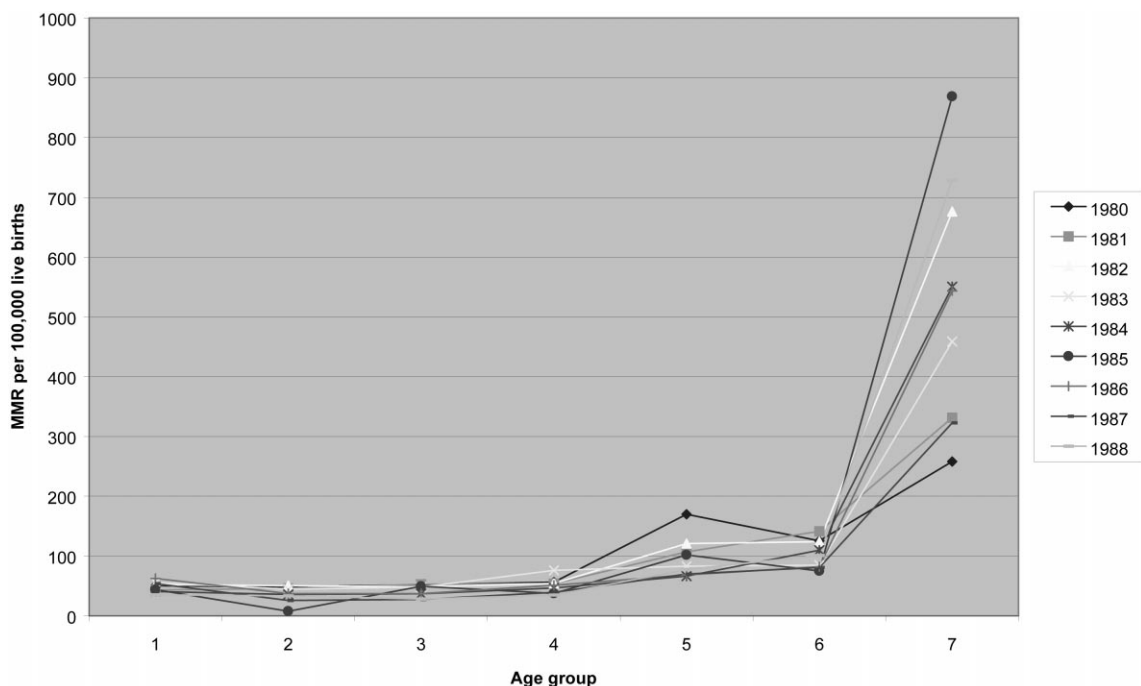


Fig. 2. Trends in age-specific maternal mortality. 1 = 15–19; 2 = 20–24; 3 = 25–29; 4 = 30–34; 5 = 35–39; 6 = 40–44; 7 = 45–49 years old.

years. It is still desirable that pregnancies occurring too early should be avoided, so as to prevent the adverse effects on the other MCH parameters such as perinatal mortality which should be used to assess the quality of teenage pregnancies.

5.4. *Pregnancy too late?*

The age-related maternal mortality figures for Sri Lanka in all surveys have shown an increase in maternal mortality from age 35 years which is further increased after 40 years (Fig. 2) [15]. The fertility rate of those over 35 years, however, has declined parallel to that of the country as a whole. This can be considered as a healthy trend, where a lesser number of women in this age group are embarking on a pregnancy.

The influence of the family planning program in establishing this change is debatable. It is, however, a consideration that since the early 1970s a very active sterilization program was in operation and which may have played its part in reducing the mean fertility rate and maternal mortality rate to what it is today. With a reduction in the sterilizations from 1987 there was a risk of increased pregnancies in the later years. Although marginal, the increasing acceptance of the modern technological methods [2] is viewed with favor. It is necessary to develop future strategies towards improving the service delivery and acceptance of these methods so as to prevent alternatives such as pregnancy terminations coming in to fill this gap.

A further consideration would be the delay in marriage and first pregnancy which may result from professional and financial considerations. The socio-economic factors and norms of Sri Lankan society have changed very rapidly so that delay in marriage to later years may be considered as a necessary component of modern living. Reproductive health awareness programs need to address this aspect when providing educational messages to the public.

5.5. *Too many pregnancies?*

While the effect of parity of five and above on maternal health is well known, the effect of its

reduction on maternal mortality is difficult to assess. The status of high parity in Sri Lanka at present can be studied in three ways.

The average number of children ever born to women aged 45–49 years has declined from 6.0 in 1975 [12] to 5.1 in 1987 [10], and then 4.0 in 1993 [2].

The data from these surveys for the same age group also showed a shift in the percentage in each parity group, away from parity six and above towards parity five and below. For all age groups the percentage of women having a parity of four and above declined from 49.9% in 1975 [12] to 30% in 1987 [10] and then finally to 25.9% in 1993 [2]. Thus, fewer women were reaching a high parity status in recent times.

The 'parity progression ratio' further highlights this trend. This is the proportion of women in each parity group who move into a higher parity status. A sharp reduction is noted for parities above four. In contrast to the surveys of 1975 [12] and 1987 [10], the DHSS of 1993 [2] showed a decline from para 1 onwards which was enhanced from para 3. This overall reduction in parity progression seen from para 1 has created concerns about the demographic effects of family planning.

Sri Lanka has, therefore, successfully moved away from the grand multi-parous status and this achievement has been a major step in the march towards safe motherhood in the country.

5.6. *Pregnancies too close together*

Information on birth spacing is available from the SLDHS 1987 and SLDHS 1993. Although the effect of birth spacing on maternal mortality cannot be assessed, for Sri Lanka its effect in general on MCH parameters is well established [2]. The status of birth spacing amongst the Sri Lankan population can be determined when the data for the previous birth interval and those for fertility preference are analyzed. In the SLDHS of 1993 [2] the previous birth was noted to have occurred within 2 years only in 13.6%, while 12.5% expressed the desire for another pregnancy within this period. Spacing of 2–3 years had occurred in 26.8%, and 4 years or more in 21.1%. Preference for another pregnancy after 2 years was indicated

by 18.6% while 37.9% did not want another pregnancy although they had not been sterilized. This information indicates that the Sri Lankan public is motivated towards spacing their pregnancies; a need which should be fulfilled if safe motherhood is to be ensured in the future.

Although Sri Lanka can boast of a high contraceptive prevalence it is still far short of ideal achievements in fertility control. Many factors contribute to this deficiency. Rapid changes in the social structure and needs have stressed the program for fertility control in recent times. Strategies to deal with these needs are of great importance, as its failure will no doubt compel couples to seek termination of pregnancy as a means of 'fertility control'.

5.7. Abortions

Maternal mortality figures over the years indicate that abortions contribute to approximately 10% of the reported maternal deaths [15]. At present the annual number of deaths known to be due to abortions would be, therefore, approximately 25 out of a total of approximately 250 annual maternal deaths. It is well established that this would not reflect the true figure, as many deaths due to abortion remain unreported.

The Demographic and Health Survey Further Analysis Series No. 2, compares the expected total fertility rate for a given increase in contraceptive prevalence with the value observed from the survey. For the contraceptive prevalence rates (CPR) noted from the surveys of 1982 [13], 1987 [10] and 1993 [2] the expected TFR were 3.6, 2.9 and 2.6, respectively. The observed rate, however, was 3.7, 2.7 and 2.2. The total fertility rate appears to have declined more than the estimated figure. This discrepancy is said to be due to increasing pregnancy terminations and is a statistical indicator of the need to strengthen family planning service delivery in Sri Lanka.

The limited number of studies performed on induced abortions in the country show some very important features. In general terms, abortions are sought by women who are married and who are parous. In the SLDHS 1993 [2], 152 previous induced abortions were reported by 6983 women

surveyed, of which 83.6% were by women over the age of 30 years. The Sri Lankan community has a strong desire for spacing. Sociocultural barriers, deficiencies in service delivery and fears of adverse effects such as cancers appear to be the reason for the non-use of contraceptives amongst these women. Although it may change in the future, terminations of pregnancy amongst teenagers are low in number. Complications following terminations of teenage pregnancy are, however, as severe and the repercussions on overall reproductive performance and health are serious. Sri Lanka, therefore, needs to have an objective review of all aspects of its family planning programs if the momentum gained on its beneficial effect for safe motherhood is to be capitalized.

6. Safe motherhood: march into the future

While it is clear that Sri Lanka has marched forward in the drive for safer motherhood, new policies and strategies are urgently needed if it is to move further still. The nucleus around which future development would operate would still be integrated social and health development with family planning providing an invaluable link between the two.

Social development programs will need to address the problem of poverty alleviation, enhanced education and improved human values. Though poverty alleviation programs have been in place for the past two decades, they have been hampered by global economic changes, local conflicts and poor management. There are indications of a widening economic gap [16,17] and it will no doubt affect the safety of child bearing.

On the educational front it is indeed fortunate that the Sri Lankan public, from all social strata, have an inherent desire to ensure a good education for the next generation. Regional and social disparities, however, remain. Almost 95% of female children receive education at the primary level, but the figure drops to 56% for secondary schooling. Mechanisms to involve these early school leavers in the reproductive health educational programs initiated by the Ministry of Edu-

cation in collaboration with the United Nations Fund for Population Activities (UNFPA) are absolutely necessary. Lethargy in this regard would be a tremendous setback as the male school leavers also would be deprived of this valuable source of health education. Worldwide it is known that it is the early school leavers who need the greatest inputs to ensure a better society for all.

Higher literacy also carries with it a better understanding of health standards and the rights of the medical client. This was shown to be the case when free education was introduced 50 years ago in Sri Lanka. At that time the services could handle the increased demand for maternal care; hence the improvements in MCH care. How well can the available resources provide for the demands and needs of the future?

In terms of developments in healthcare, recent activities such as the organization of the maternal death audit, advanced training for care providers, introduction of a two-way referral pregnancy record, have provided for a further improvement in safe motherhood. The active involvement of the Sri Lanka College of Obstetricians and Gynecologists (SLCOG) in post graduate education, in

developing policies related to medical staffing and basic requirements for maternal care have provided the path on which safe motherhood would progress in the future. The SLCOG Safe Motherhood Training program for peripheral MCH care providers commenced in 1992 with assistance from the International Planned Parenthood Federation. It continues today focusing on the use of partograms in smaller institutions and is supported by the Asia and Oceania Federation of Obstetrics and Gynaecology (AFOG) and the United Nations Children's Emergency Fund (UNICEF).

The major problem involving service delivery for safe motherhood relates to the place of delivery (Fig. 3). The safe motherhood strategy of many developing countries is to shift its deliveries from a domicilliary to an institutional setting. Sri Lanka in contrast had a healthy distribution up to 1985 where 7% were in primary care institutions, 47% occurred in district hospitals with trained doctors in attendance (intermediate level) and 43% delivered in specialist (tertiary care) hospi-

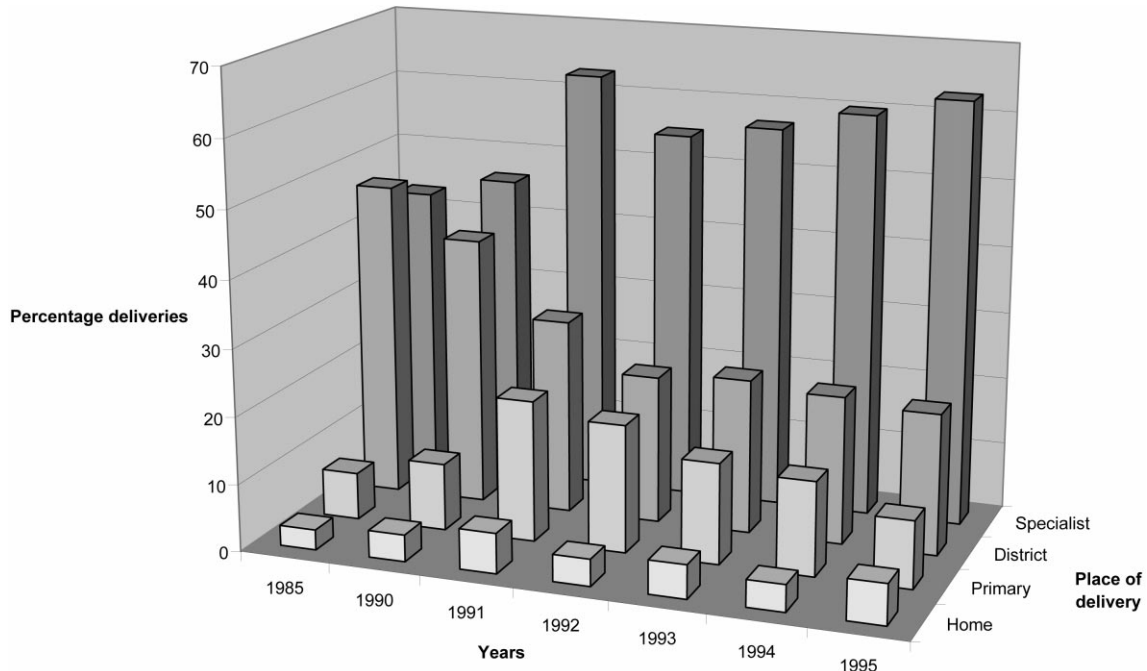


Fig. 3. Trends in distribution of deliveries by place of delivery.

tals, while home deliveries accounted for 3%. From 1990, the deliveries have shifted away from the district hospitals so that the specialist hospitals are now burdened with the task of providing for a large number of low risk deliveries in addition to all the high risk ones. The public demand for access to a higher level of care, even for very low risk situations, is linked to low fertility and high literacy within the country. How the future services should be modified to cater for this demand and also ensure that the appropriate care is provided is a task for the health policy makers and managers to explore.

Increasing deliveries at home along with a decrease of those at primary level institutions is also a cause for concern. Worsening poverty amongst the economically deprived groups in the country is said to be responsible. In the year 1995 deliveries at home accounted for 6% raising the risk of maternal mortality and morbidity. Strategies to counter this dangerous trend are urgently needed if the high status of safe motherhood in Sri Lanka is to be maintained.

The greatest threat to the national family planning effort is complacency. Since reaching its high health status, new strategies for increasing the use of contraceptives have yet to be introduced. An assumption that the momentum gained in contraceptive prevalence will continue on its own would be a serious setback for family planning activities in the country. The relocation of Sri Lanka into UNFPA category 'C' from category 'B' in 1993 had a serious effect on resource development from international donor agencies for family planning. A rise in induced abortions as a method for fertility control has been noted recently. Much needs to be done to prevent rational contraceptive practices from being replaced by induced abortions.

In all aspects Sri Lanka's march towards safer motherhood has progressed to such an extent that it is often quoted as a success story for other countries to follow. It has, however, now reached a point where the path could be towards greater success or rapid decline. While traditional strategies for MCH are strengthened, the drive for maternal safety is firmly linked to the other components of reproductive health and human devel-

opment. Adolescent reproductive health education and counseling in particular should be the main focus of the country policy. By initiating the reproductive health education program in schools the government has moved in the right direction. The experience gained so far, together with the commitment shown by policy makers and care providers, gives much hope for the march towards the highest level of safe motherhood for the people of Sri Lanka.

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