

Fertility Transition in Sri Lanka: Programme and Non-programme Factors

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During the past four decades, Sri Lanka has experienced significant changes in the level and pattern of fertility. The total fertility rate has declined from about 5 children per woman in the early 1960s to near the replacement level of 2.1 by the end of the 1990s despite the fact that the number of women in the reproductive age group more than doubled during this period.

The changes in the total fertility rate and the crude birth rate are given in [table 1](#). It is evident that both rates have shown a steady decline and, within the short period of nearly four decades, the rates have been cut in half

The age specific fertility rates show that there have been continuous declines in fertility in all age groups between 1962 and 2000 ([table 2](#)). While in the 1960s and 1970s a greater decline in fertility took place in the age group over 30 years, resulting in a decline in high parity births, in the subsequent decades, much of the fertility decline has occurred among women below 30 years of age as a result of the deliberate desire of younger women to limit the number of children to around two. In the peak fertility age group 20-24 and 25-29 years, which together account for about 56 per cent of annual births, fertility rates have dropped by 42.2 per cent and 31.0 per cent respectively in the period between 1980 and 2000.

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Table 1. Crude birth rate and total fertility rate, Sri Lanka, 1962-2000

Period	Crude birth rate (per 1,000)	Total fertility rate (per woman)
1962-1964	34.3	5.0
1970-1972	29.7	4.1
1980-1982	27.8	3.4
1985-1987	22.9	2.6 ^a
1988-1993	20.6	2.3 ^a
1995-2000 ^b	17.5	2.1

Sources: Department of Census and Statistics, Registrar General's Department.

^a Excludes the Northern and Eastern provinces.

^b Estimated.

Undoubtedly, there have been in operation in Sri Lanka a host of programme and non-programme factors which have facilitated the development of the social environment in which reduced fertility has emerged as an important demographic trend.

Programme factors

The programme factors can be examined under the following areas: policy environment and strategies, institutional development, managerial processes and contraceptive services.

Policy environment and strategies

In 1965, the government made a policy decision to include family planning as part of the maternal and child health programme of the Ministry of Health.

Table 2. Age-specific fertility rates, Sri Lanka, 1962-2000

Age group	1962-1964	1970-1972	1980-1982	1985-1987 ^a	1988-1993 ^a	1995-2000 ^b
15-19	52	40	38	35	35	30
20-24	229	179	173	137	109	102
25-29	280	227	197	150	134	135
30-34	239	200	149	113	104	92
35-39	156	131	89	66	54	45
40-44	46	41	26	21	14	12
45-45	07	06	04	03	02	4
Total fertility rate	5.0	4.1	3.4	2.6	2.3	2.1

Sources: ESCAP (1988). *Levels and Trends of Fertility in Sri Lanka: A District-Level Analysis*, 1986; and Demographic and Health Surveys, 1987 and 1993.

^a Excluding the Northern and Eastern provinces.

^b Estimated.

In 1966, the Minister of Health appointed an advisory committee to give advice on the establishment and execution of the national family planning programme. The main recommendations of the committee were accepted. The government then took action to renew an agreement with the government of Sweden to provide the necessary financial support for the programmes.

In 1971, the five-year economic development plan of the government emphasized the importance of reducing the rate of population growth through fertility limitation and gave very high priority to the diffusion of family planning facilities among the mass of the adult population.

In 1973, a project agreement was signed by the government with the United Nations Population Fund (UNFPA) to provide assistance in a wide array of projects with a view to broaden the base of the national population programme.

In 1977, the government made a policy statement to strengthen clinical family planning services and to provide financial inducements to those who would accept sterilization voluntarily as a method of family planning. The medical teams that performed sterilizations were also given financial incentives. In addition, those medical officers who performed a higher number of sterilizations than their quota were awarded certificates in recognition of their service, and were sent on overseas study tours to further observe family planning activities in countries of the region. With these inducements, an increasing number of couples resorted to sterilization as a method of family planning. By 1987, almost half (48 per cent) of the total contraceptive prevalence rate was due to sterilization. Towards the latter part of the 1980s, the government gave equal emphasis to modern spacing methods of contraception; injectable contraceptives, Norplant and a more cost-effective IUD, namely the TCu 380A, were introduced in the programme (Abeykoon, 1996).

In 1991, the government issued a policy statement on population, emphasizing the need to achieve replacement level fertility at least by the year 2000. In 1998, the government formulated the National Population and Reproductive Health Policy in recognition of the broadly based concept of reproductive health adopted at the International Conference on Population and Development (ICPD) in Cairo. The policy document contains the following eight goals: (a) maintain current declining trends in fertility so as to achieve a stable population size at least by the middle of the twenty-first century, (b) ensure safe motherhood and reduce the levels of morbidity and mortality related to the reproductive system, (c) achieve gender equality, (d) promote responsible adolescent and youth behaviour, (e) provide adequate

health care and welfare services for the elderly, (f) promote the economic benefits of migration and urbanization while controlling their adverse social and health effects, (g) increase public awareness of population and reproductive health issues, and (h) improve population planning and the collection of quality population and reproductive health statistics at the national and sub-national levels.

Institutional development

In 1968, the Family Health Bureau was established in the Ministry of Health with responsibility for the implementation of the national maternal, child health and family planning programme. The Bureau also undertakes in-service training in family health for various categories of health workers. In addition, it also provides the necessary technical support to programme managers at the sub-national level and provides supplies, equipment, contraceptives and other material needed for the implementation of maternal and child health and family planning activities.

In 1974, a steering committee was established to coordinate and monitor the UNFPA-funded projects that began to be implemented by the Ministry of Health and other line Ministries. The Secretary of the Ministry of Plan Implementation functioned as the chairperson of this committee.

In 1977, population policy formulation and implementation was vested with the Ministry of Plan Implementation, which functioned under the President of the country. The Population Division was created under this Ministry in 1979 to coordinate and monitor the national population programme. In addition, it is vested with the responsibility to review population policies and formulate new policies. It also provided the necessary technical support to other agencies engaged in population activities and coordinated donor-funded projects. The Division is also responsible for the coordination of IEC (information, education and communication) and research activities and the dissemination of population data and information.

With the national population programme gradually reaching the stage of maturity, and the demand for family planning services rising, in 1989, the subject of population policy formulation and implementation was assigned to the Ministry of Health. Therefore, the Population Division and the Population Information Centre were transferred to the Ministry of Health with the same functions and responsibilities. Thus, population policy planning, IEC strategy implementation and family planning service delivery were brought under the purview of one ministry.

The Population Division also coordinates donor-aided projects in other government agencies and provides technical support to them. Thus, the Population Division performs a dual function of population policy planning and technical support as well as coordination and monitoring of operational activities.

Managerial processes

In the early 1990s, the government established central policy and monitoring authorities to achieve the objectives of the national population policy. The National Co-ordinating Council on Population (NCCP) chaired by the Secretary, Ministry of Health, coordinates and monitors the national population programme. The Population Division functions as the secretariat to the NCCP.

The National Health Council, chaired by the Prime Minister, is the highest decision-making body on health and health-related subjects. Population and family planning issues are discussed and policy decisions taken at these council meetings.

The management of the service delivery programme at the sub-national district level is the responsibility of the Medical Officer, Maternal and Child Health. The district is further sub-divided into divisional health areas. A divisional health area services a population ranging from 75,000 to 100,000 persons. At the grassroots level, the Public Health Midwife services a population of between 3,000 and 5,000 women. At the district level, population activities are coordinated by the Director of Planning, who functions directly under the administrative head of the district.

A unique feature of the managerial process of Sri Lanka's population programme is that both health professionals and population planners have worked in close collaboration to face challenges and find solutions to the emerging population issues that confronted Sri Lanka during the latter half of the past century.

Contraceptive services

Since the inception of family planning activities as part of the maternal and child health programme, the "cafeteria" approach of providing a variety of services has been followed. Since the mid-1980s, injectable contraceptives and Norplant have been added to the programme. These services are provided through a network of family planning clinics throughout the country. In addition, pills and condoms are distributed by midwives during their home visits.

The training of health personnel in the delivery of family planning services commenced in 1965 when a policy decision was taken to include family planning in the maternal and child health programme of the Health Ministry. The traditional midwives were replaced by institutionally trained midwives. Currently, all midwives are institutionally trained. One of the important programme factors contributing to the rise in contraceptive prevalence has been the training and the commitment of midwives working in the field. The contraceptive prevalence rate has increased from 34.4 per cent in 1975 to 66.1 per cent in 1993. The availability and accessibility of contraceptive services is widespread and cuts across all social strata. This is evident from the fact that the geographic range in contraceptive prevalence was 8.4 per cent in 1993. The variation between those with no schooling and those in the highest educated categories was only 5.8 per cent.

Non-programme factors

Participation of NGOs

Non-governmental organizations (NGOs) have made an important contribution to fertility decline in Sri Lanka. Pioneering work in the field of family planning was done by the Family Planning Association of Sri Lanka, which was founded in 1953, long before the commencement of the government programme. The work of the Association was recognized by the government. The Association developed a wide range of activities from providing information and education to clients, organizing training for medical and public health personnel, and providing services through clinics in government facilities. After the commencement of the national family planning programme, the association has played a supporting role and has focused its activities on the social marketing of contraceptives and on information, education and training activities. In addition to the Family Planning Association, three other NGOs emerged in the 1970s to supplement the government programme in IEC and service delivery activities. In 1993, about 40 per cent of the demand for supply methods and 17 per cent of the demand for clinical methods of contraception were met by NGOs. In view of the importance of this role, the government has been supporting NGOs through financial grants, equipment and supplies. In addition, NGOs are represented in the National Coordinating Council on Population, and they have also been represented in the formulation of national population and reproductive health policies.

Socio-economic development

The introduction of free education in Sri Lanka in 1944 from grade 1 to the university level was a landmark achievement in social development for a small developing country. This has resulted in the rise in literacy and

educational level of the population. The literacy rate increased from 70.1 per cent for males and 43.8 per cent for females in 1946 to 94.9 per cent and 89.4 per cent respectively in 1996/97. By 1981, the proportion of the population 10 years and over with no schooling was only 7.3 per cent (Abeykoon, 2000).

The rising educational level of the population has significantly contributed to the reduction in fertility in Sri Lanka. Survey data show a clear inverse relationship between the educational level of women and fertility. In 1993, the mean number of children ever born to currently married women with no schooling was 3.4 children, whereas the mean number for those with an education beyond the secondary level was 2.0. Thus, the rising educational level of females has increased their awareness of the social and economic costs and benefits of excessive childbearing.

While the initial impetus for fertility decline has come about through rising aspirations of females resulting from the expansion of educational opportunities and attainment, in the more recent decades, upward social mobility of females brought about by the wider availability of economic opportunities in the modern economic sectors has further contributed to the decline in fertility. For instance, between 1946 and 1990, the labour force participation rates of females in the peak ages of fertility 20-24 and 25-29 years has increased from 23.8 and 26.3 per cent respectively to 64.0 and 58.3 per cent.

Rise in age at marriage

Another important factor contributing to fertility decline in Sri Lanka has been the rise in the age at marriage of females. The singulate mean age at marriage for females has increased from 20.9 years in 1953 to 25.5 years in 1993. In 1971, the singulate age at marriage of females who have had 12 or more years of schooling was 28.0 years. Thus, the rising educational attainment of females has no doubt contributed to the rise in age at marriage. Analysis of data on the contribution of nuptiality and marital fertility to the decline of the total fertility rate during 1953 and 1981 show that between 1963 and 1971, 53.3 per cent of the decline in the total fertility rate was due to nuptiality and the corresponding percentage for the period 1971 to 1981 was 21.4 per cent.

Induced abortion

Since induced abortion is illegal in Sri Lanka except to save the life of the mother, reliable data are not available. The Demographic and Health Survey conducted in 1993, however, indicated that the rate was 23 per cent. Anecdotal evidence suggests that induced abortions are on the increase with the availability of services. The 1993 Survey also showed an inconsistency

between the total fertility rate of 2.3 and a contraceptive prevalence rate of 66.1 per cent. However, preliminary findings of a recent study indicate that a significant proportion of abortion seekers had been using a method of contraception; however, the influence of induced abortions on fertility decline in Sri Lanka cannot be totally discounted.

Breastfeeding

The duration of breastfeeding is one of the important proximate determinants of fertility (Bongaarts, 1982). In Sri Lanka, the mean duration of breastfeeding has not shown a decline with the increasing educational level of females in the reproductive ages. The mean duration has increased slightly from 21 months in 1975 to 23 months in 1993. The fertility-inhibiting effect of breastfeeding and postpartum abstinence measured as an index of postpartum infecundability has increased from 0.608 to 0.610 between 1975 and 1993.

Decline in infant mortality

The decline in infant mortality from 82 per thousand live births in 1950 to about 17 in 1996 has been another strong motivating factor in the reduction of fertility. Since the early 1960s, it has become evident to married couples that the survival chances of their new-born infants are much higher than they would have been two decades previously and that they are able to attain their desired family size through contraceptive use.

Conclusion

From the foregoing discussion, it is evident that a host of programme and non-programme factors have contributed to fertility decline in Sri Lanka during the past four decades. What has been unique in the Sri Lankan experience is that enlightened social development policies and programmes have been accompanied by the commitment and dedication of health personnel and population planners who made the right choices at the right time to bring about the desired changes in fertility.

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