

# COUNTRY PROFILE

## COUNTRY PROFILE ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH: SRI LANKA



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## 1. Introduction

Sri Lanka's Human Development Index (HDI) value for 2013 was 0.750, positioning it at 73 out of 187 countries. This rate is above the average of 0.735 for countries in the high human development group and above the average of 0.588 for countries in South Asia (UNDP, 2014). Sri Lanka further shows impressive national health indicators, especially for maternal and child health (MCH) and HIV/AIDS. Sri Lanka has a well-networked health system in place from village to national level and has broad policies in place that cover most family health and reproductive health concerns, maternal and child health and family planning. These are provided through a health infrastructure consisting of a referral network of dispensaries, maternity homes and graded hospitals servicing defined geographical areas.

Table 1: In 2013

	Male	Female
Population ('000)	9,939 (48.5%)	10,544 (51.5%)
Life expectancy at birth	70.3 years	77.9 years
Literacy Rate	96.8	94.6
Employment Rate	65.3%	34.7%
Unemployment Rate	3.2%	6.6%
Migration for Employment	50.9%	49.1%
Parliamentary representation	94.2%	5.8%

Source: Statistical Handbook 2014, Department of Census and Statistics

A closer examination of national data shows that regional disparities in data exist, especially among conflict-affected areas in the North and East, districts that are also economically underperforming, and the estate sector<sup>1</sup>. Out-dated legislation needs to be revised and policies need to be reviewed from rights-based perspective. There is still much to be done especially in terms of rights and services for vulnerable sub-populations of women (such as young girls from rural backgrounds, widows, sex workers, female headed

households and single unmarried women who are vulnerable due to cultural and social norms that stigmatise them) and those from sexual minorities (lesbian, gay, bi-sexual and transgender persons).

## Government Expenditure on Health

Health care in Sri Lanka is financed mainly by the government, with some private sector participation and limited donor financing. Public sector financing comes from the General Treasury, generated through taxation. Public sector services are free at the point of delivery for all citizens through the public health institutions distributed island-wide, while private sector services are mainly through out-of-pocket expenditure, private insurance and non-profit contribution (IPS, 2014). In reality however, persons seeking care in public sector hospitals do incur out of pocket expenses due to shortages of drugs and costs of investigations done at private hospitals.

The total Government health expenditure for 2012 was LKR 89,291 Million, which is an increase of 8.65% since the previous year. In the same year, the proportion of public expenditure on health services was 1.2% of the Gross National Product (GNP) and 4.07% of the national expenditure. The per capita health expenditure was LKR 4,392. Total expenditure on health (including all expenditure on personal and community health services and gross capital formation in health care providers) was estimated to be LKR 238,613 Million in 2012 and was 3.1% of the Gross Domestic Product (GDP) (MSU/MOH, 2012).

Other sources reveal that the total public investment in health, covering health and indigenous medicine both at national and provincial level in 2012 was LKR 99 billion. However, public expenditure as a percentage of the GDP on health in 2010 was noted to be only 1.3% (MOFP, 2012). The current budget however, proposes to increase healthcare expenditure to 3% of GDP (MOFP, 2015). Expenditure on sexual and reproductive health related services are however, not known.

This profile discusses some key indicators when addressing sexual and reproductive health services in order to determine if these services are universally available, accessible without restriction, of acceptable quality and affordable to the population of Sri Lanka.

1. The estate/plantation sector of Sri Lanka refers to areas where plantation crops such as tea, rubber and coconut are cultivated. These areas usually have poor socio-economic conditions. National statistical data also differentiate these areas due to their distinct features.

## 2. The status of sexual and reproductive health in Sri Lanka

Sri Lanka prides itself in recognising the importance of family planning along with other reproductive services decades before the International Conference on Population and Development (ICPD) of 1994. Family planning was pioneered by the Family Planning Association (FPA, a member association of the International Planned Parenthood Federation) in 1953- a time when family planning was considered too sensitive and controversial to be introduced as a Government programme. The success of the programme however led to its uptake by the Government and its subsequent successes resulted in the country achieving its desired Total Fertility Rate of 2 (achievement was actually 1.9) in 1995, 5 years ahead of the target year of 2000.

The gradual expansion of primary health care facilities after the 1940s (through the expansion of the cadre of the medical and paramedical personnel, replacement of traditional birth attendants by trained Public Health Midwives (PHM) and the introduction of medical technology) made major contributions to improving the health system in Sri Lanka (Rannan-Eliya et al, 2000). Other factors for improvement could be attributed to high female literacy; provision of family planning services at the doorstep by the PHM free of cost; the cafeteria approach to the provision of family planning services; a strong population policy; the population education programme in schools; links between the community and institutional health services; and free healthcare and food subsidies.

Most of the current trends and health indicators can therefore be attributed to the investments made decades ago. One could see that Sri Lanka was a more liberal country in the 20th century compared to the recent past, where family planning and reproductive health has assumed serious political and religious overtones that run counter to rights of women, and pose danger to the health of the woman and family. This section explores data on contraception, maternal health, adolescent sexual and reproductive health and HIV/AIDS in order to understand the current status and future trends of sexual and reproductive health.

### Contraception

The ICPD Programme of Action paragraph 7.2 urges governments to ensure that their people are able to have a satisfying and safe sex life and

that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It further notes the rights of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice (UNFPA, 1994). In this section we look at key indicators related to contraception, namely a) Total Fertility Rate, b) Contraceptive Prevalence Rate, and c) the unmet need for contraception.

#### a) Total Fertility Rate

The Total Fertility Rate (TFR) is defined as the number of children a woman would have at the end of her reproductive life, from age 15 to 49 years, if she experienced the currently prevailing age-specific fertility rates. It is seen as an indirect indicator of good or poor reproductive health. A high TFR (over five births) represents a high risk of ill reproductive health and also indicates the lack of access to contraception services for individuals and couples (ARROW, 2013).

The TFR according to the most recent Sri Lanka Demographic and Health Survey (SLDHS) is 2.3 (DCS, 2009). That is, a woman in Sri Lanka would have an average of 2.3 children by the end of her childbearing period, if current age specific fertility rates remain unchanged. A closer look at trends in fertility rates noted that there has been a slight increase in the TFR from 1.9 in 2000. While there is no significant difference in urban (2.2) and rural (2.3) fertility rates, those in the estate sector are relatively higher, at 2.5. There was also no significant difference when comparing education levels and wealth quintiles. Data further noted that only one in 10 children are born less than 24 months after a previous birth and the median interval between births is more than 4 years (DCS, 2009).

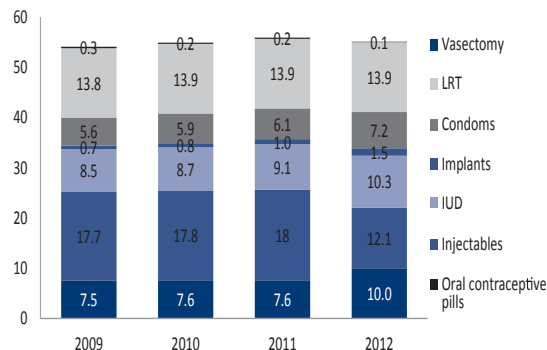
TFR is important as it summarises the reproductive experience of a woman's life and indicates the target to be reached by a country towards stabilising population growth. As noted, Sri Lanka achieved beyond the targeted TFR of two in year 2000 when it achieved a TFR of 1.9 in 1995 (DCS, 2009). This was due to satisfactory levels of uptake of modern contraceptive methods by Sri Lankan women. The increase in TFR to 2.3 during the recent past may be related to the decline in an uptake of modern contraceptive methods. It must also be noted that grand multiparity has declined steadily in Sri Lanka. The percentage of registered pregnant mothers in the fifth pregnancy and above has steadily declined from 3.9 in 2007 to 2.8 in 2012 (FHB, 2012).

## b) Contraceptive Prevalence Rate

The Contraceptive Prevalence Rate (CPR) indicates the access to reproductive health services (assuming that there is no coercion for acceptance of birth control through government policy) and the distribution of contraceptive use by methods (ARROW, 2013). In Sri Lanka, family planning was recognised as a responsibility of the Government in 1965, and the current goal of the National Family Planning Programme is to enable all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies. It therefore, facilitates families to make informed decisions and offers contraceptives through a cafeteria approach (FHB, 2012).

According to the Family Health Bureau, 64.6% of the eligible families registered under care of the PHM had been using any method of contraception at the end of 2012. The proportion using modern and traditional methods were 55.1% and 9.2% respectively. While 35.4% did not use any form of contraception, the following figure presents a breakdown of the methods of contraception used in 2012 in comparison to previous years (FHB, 2012).

Figure 1: Methods of Contraception used in Recent Years



Source: Family Health Bureau, 2012

As seen through the above chart, a greater burden in the use of contraception lies with the female. While this could be explained through the fact that PHMs are women and therefore, target women in their family planning services, it also needs to be looked at through a context where strong cultural factors influence the uptake and use of male methods. The use of condoms within marriage is linked to perceptions of infidelity, while vasectomy is believed erroneously to result in impotence. However, condom usage for prevention of STI/HIV has had greater success. At present, public health staff promote condoms for the dual benefit of prevention of STI/HIV and pregnancy.

**Sometimes the husband stops his wife from using contraception, thinking that if she uses contraceptives women will have extramarital relationships. Then women have to use contraceptives secretly. However, if the husband finds out she is doing this he punishes her with violence accusing her of infidelity. This is a widespread situation among displaced communities.**

*Woman from Mannar (Kottegoda, Samuel, and Emmanuel, 2008)*

## c) Unmet Need for Contraception

The unmet need for contraception gives the gap between women's reproductive intentions and actual contraceptive behaviour. It is usually disaggregated into two components, namely, the unmet need for family planning to limit family size and for birth spacing (ARROW, 2013).

In Sri Lanka, the unmet need for family planning is considered as the presence of sexually active couples who are not expecting a child in the next two years and yet are not practicing any family planning method. 7.3% of eligible couples had an unmet need for family planning in 2012 showing a decrease from 9.2% in 2007. However, when exploring district-wise data, the unmet need for family planning ranges from 4.7% to 12.4% showing a wide disparity among districts as illustrated in the map below (FHB, 2012).

While it is important to look into the unmet need for family planning disaggregated by socio-economic factors, such data is only available from the SLDHS 2006/07 and is presented in Table 2. In a context where unmet need for family planning is recognised as an attributing factor of maternal mortality (see below), it is noted that the stagnation in the unmet need becomes a priority policy concern (FHB, 2012).

**Table 2: Unmet Need for Family Planning by Socio-economic Characteristics**

Background Characteristics		For Spacing	For Limiting	Total
Residence	Urban	4.5	5.0	9.5
	Rural	3.2	3.6	6.8
	Estate	6.3	4.9	11.1
Education	No education	2.1	5.3	7.4
	Primary	2.6	4.4	7.1
	Secondary	3.8	3.8	7.6
	Passed G.C.E. (O/L)	4.2	4.4	8.6
	Higher	3.3	2.9	6.2
Wealth quintile	Lowest	3.6	3.7	7.2
	Second	3.9	3.7	7.6
	Middle	3.5	3.5	7.0
	Fourth	3.1	3.6	6.7
	Highest	3.7	4.4	8.1
<b>Total</b>		<b>3.5</b>	<b>3.8</b>	<b>7.3</b>

Source: SLDHS 2006/07, Department of Census and Statistics (2009)

## Maternal Health

Paragraph 8.20 of the ICPD Programme of Action called for the promotion of women’s health and safe motherhood through achieving a rapid and substantial reduction in maternal morbidity and mortality; and a reduction in the number of deaths and morbidity from unsafe abortion (UNFPA, 1994). In this section we look at key indicators pertaining to women’s health, namely, a) maternal mortality ratio, which is a reflection of how safe child delivery is for the woman; b) perinatal mortality rate, which is a good indicator of status of maternal health and nutrition and quality of obstetric care; c) infant mortality rate which is a reflection of optimal maternal health, nutrition and care during delivery; d) proportion of births attended by skilled birth attendants, which helps understand the extent to which governments have invested in developing human resources necessary for ensuring safe delivery and prevention of maternal deaths; e) availability of basic emergency obstetric care and comprehensive emergency obstetric care to ensure safe delivery and prevention of maternal deaths; f) coverage of post-partum/post-natal care within 48 hours of delivery by a skilled health provider to ensure post-delivery care immediately after child birth; and g) antenatal care coverage, which is an indicator of women’s access to health care services.

The National Policy on Maternal and Child Health (2012) and the National Strategic Plan on Maternal and New-born Health (2012-2016) are key documents that have been developed in recent years that address and present an overview of the context of maternal health in Sri Lanka. The National Policy notes that the demographic changes that have taken place over the years have brought about several important policy concerns in terms of maternal and child health. It further notes that women in the reproductive age group (15 – 49 years) comprise 5.6 million (27.8%) of the population, making the provision of quality reproductive health services a critical factor in designing health care systems (MOH, 2012).

When exploring the data below, it is apparent that Sri Lanka’s investment in maternal and child health since the 1940’s have led to considerable success in achieving good maternal health indicators. A closer look at the following data will however, help identify areas that still need improvement.

### a) Maternal Mortality Ratio (MMR)

Maternal Mortality Ratio (MMR) is a reflection of how safe child delivery is for the woman and is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period. A ‘maternal death’ is the death of a woman while pregnant or within 42 days of termination of the pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (ARROW, 2013).

Sri Lanka’s MMR stands at 37.7 maternal deaths per 100,000 live births (FHB, 2012). When considering the past two decades, the highest and lowest MMR recorded was 63.0 (in 1996) and 31.1 (in 2010) respectively. However, it must be noted that the favourable national maternal mortality statistics hide regional and sectoral differences as illustrated in the map. Sri Lanka is currently targeting zero maternal mortality.

Every maternal death in Sri Lanka is investigated through the Maternal Death Surveillance and Response (MDSR) system that includes a Maternal Death Audit. The Audit is a review process engaging the Family Health Bureau (FHB), local health authorities and obstetricians and is aimed at identifying and rectifying gaps and initiating best practices.. Data shows that, 63% of maternal deaths were due to direct causes and 37% due to indirect causes in 2012 (FHB, 2012). Table 3 presents a snapshot of maternal mortality ratios by type of cause, pregnancy period, parity and maternal age.

Table 3: Maternal Mortality Ratios by Type, Period, Parity and Maternal Age in 2012

Maternal Mortality Ratio by		2012
Type of cause	Direct	23.6
	Indirect	14.0
Pregnancy Period	Antenatal	10.4
	Intra-partum	1.4
	Postpartum	25.8
Parity	P1	10.7
	P2 - 4	20.8
	>P5	3.9
Maternal age	Less than 19 years	1.4
	20 to 35 years	27.0
	Over 35 years	9.3

Source: Annual Report on Family Health 2012, Family Health Bureau

It was also noted that while 56% of maternal deaths were preventable, 67% of maternal deaths were due to delays in service provision. The highest delay was in seeking services (39%), while 27% were due to delays in treatment and 32% due to a combined delay in seeking and the treatment provision. However, in Sri Lanka, high risk pregnancies are identified early, flagged for more rigorous and frequent monitoring during the antenatal period, and are referred to Visiting Obstetrics and Gynaecologists and delivery in a tertiary care hospital is mandatory for such cases.

Maternal death due to septic abortion is the third highest cause for maternal death, at 13% (FHB, 2012). Abortion is criminalised in Sri Lanka, unless to save the pregnant woman's life. However, considering the above data, its legal status does not prevent women from seeking abortions, but does prevent women from seeking immediate medical assistance when complications occur. Therefore, patients are brought in when the conditions are severe and are also at risk of being charged for procuring illegal abortions.

**“In the context of persisting social inequalities, to consider abortion from the moral point of view only seems unwarranted. Those who do so fail to consider the real social and economic**

**factors involved. There is a need to formulate a strategy which will safeguard the dominant values of Sri Lanka society, while giving the woman the choice to decide when she wants a child. Abortion is a social problem to be acted upon rather than a condition which must be confronted with legal restrictions.”**

*Ministry of Plan Implementation (as quoted in ASAP, 2009)*

#### b) Perinatal Mortality Rate (PMR)

Perinatal mortality rate (PMR) is a good indicator of both the status of maternal health and nutrition, and of the quality of obstetric care. The 'perinatal period' refers to the period between 22 completed weeks (154 days) of pregnancy to seven completed days after birth. Perinatal death thus includes both late foetal death (stillbirth) and early neonatal death (within the first seven days of birth) (ARROW, 2013).

The PMR in Sri Lanka was 12.0 deaths per 1,000 births in 2012 (FHB, 2012). Table 4 shows the decreasing trends in indicators of infant mortality in recent years. When considering these trends, the SLDHS 2006/07 notes PMR to be higher among mothers below 20 years of age and between 40 to 49 years, among the estate and rural women, and among those with only primary or secondary education (DCS, 2009).

#### c) Infant Mortality Rate (IMR)

Infant mortality rate (IMR) is defined as death of an infant from birth to one year of age. One of the factors contributing to infant mortality is low birth weight, which results from less than optimal maternal health, nutrition and care during delivery (ARROW, 2013).

The IMR for Sri Lanka in 2012 was 9.2 deaths per 1,000 live births showing a drop from 13.1 in 2002 (FHB, 2012). The gradual decrease can be seen in Table 4. However, it must be pointed out that such rates cannot be generalized to the whole country. The SLDHS 2006/07 notes that these

rates differ when considering sector, district (as shown in the map), educational level of the mother, and household wealth. For example, IMRs were higher in the estate sector, where the mother had low educational attainment and among the poorer households (DCS, 2009). An interesting feature to note is that a high percentage of infant deaths were investigated by the Public Health Nursing Sisters enabling a reasonably accurate cause of death to be ascertained.

**Table 4: Indicators of Infant Mortality in Recent Years**

Indicator	2009	2010	2011	2012
Neonatal Mortality Rate (1,000 live births)	7.3	8.0	7.6	6.8
Post Neonatal Mortality Rate (1,000 live births)	3.1	2.6	2.7	2.4
Perinatal Mortality Rate (1,000 live births)	13.0	13.7	12.6	12.0
Stillbirth rate (1,000 births)	7.5	7.7	7.1	6.9
Infant Mortality Rate (1,000 live births)	10.4	10.6	10.2	9.2
Number of infant deaths reported	3,263	3,293	3,269	2,938
Percentage of reported infant deaths investigated	93%	89%	92%	96%

*Annual Report on Family Health 2012, Family Health Bureau*

#### d) Proportion of births attended by skilled birth attendants

A skilled birth attendant (sometimes referred to as skilled attendant) is defined as “an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and new-borns.” This definition excludes traditional birth attendants whether trained or not, from the category of skilled health workers (ARROW, 2013).

In Sri Lanka, skilled providers (doctors, PHMs and nurses) assisted almost all births (99.4%) in 2007, which was an improvement from 96% in 2000. This demonstrates that Sri Lankan health facilities continued to improve over the seven-year period and have essentially achieved universal safe delivery (DCS, 2009). Data from 2012 indicates

that 99.9% of all deliveries were institutional and only 0.07% of all deliveries were conducted by untrained personnel (FHB, 2012).

The overwhelming majority of women (93.1%), who deliver in government institutions, do so in an institution where specialist services are available. It was also noted that their preference was for larger institutions with more than one obstetric unit, in districts where such facilities are available. This means that nearly 77% births occur in institutions with more than one specialist. Of the total births in government institutions, only 6.9% of births occur in hospitals without specialist services. Although this percentage is low, it amounts to 23,873 deliveries annually and has the potential to generate 3,581 complications per year (FHB, 2014).

#### e) Availability of basic emergency obstetric care and comprehensive emergency obstetric care

A package of interventions required to treat the seven major direct obstetric complications is collectively known as Emergency Obstetric Care (EmOC) (FHB, 2014). A list of life saving services or signal functions which defines a health facility in respect to its ability to treat obstetric and new-born emergencies is as follows:

1. Administer parenteral antibiotics
2. Administer uterotonic drugs
3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia
4. Manually remove the placenta
5. Remove retained products
6. Perform assisted vaginal delivery
7. Perform basic neonatal resuscitation
8. Perform surgery
9. Perform blood transfusion

A comprehensive study on EmOC services across Sri Lanka was carried out recently. The *National Emergency Obstetric and Neonatal Care (EmONC) Needs Assessment* (FHB, 2014) thus examines the ability of the different grades of health institutions to provide necessary life-saving care to pregnant women and their new-borns at regional and national level. While analysed findings from this study explores the current situation of basic (BEmONC) and comprehensive (CEmONC) services and presents recommendations, Table 5 presents some key data and indicators showing that Sri Lanka has a relatively good network of EmONC services and facilities. However, as the study itself noted, most of the institutions have gaps in infrastructure and equipment availability. There is also a wide variation in the availability of infrastructure resources between institutions of the same type as well as between and within districts.

Table 5: Selected EmONC Indicators and Data for Sri Lanka

Indicator / Category	Current Rate	Standard Rate
Availability of BEmONC services per 500,000 population	1.23	5 facilities per 500,000 (WHO)
Availability of CEmONC services per 500,000 population	1.65	At least 1 per 500,000 (WHO)
Availability of 24/7 CEmONC services per 500,000 population	0.79	
Percentage of deliveries in CEmONC capable facilities	88%	
Percentage of deliveries in 24/7 CEmONC capable facilities	62%	
Met need of EmONC care (women with a major direct obstetric complication seen in a hospital with CEmONC services)	80%	
Percentage of Caesarean sections	27.7	5-15% (WHO)
Direct obstetric case fatality rate	0.151	Less than 1%
Total still birth rate	6%	
Proportion of deaths due to indirect causes - 2010	31.6%	
Percentage falling outside the 30km buffer zone round CEmONC facilities	3%	
Specialists per 500,000 population	3.4	
Specialist maternity units per 500 000 population	2.6 (117 units)	
Average number of births per unit	245 per month	300 deliveries (World Health Report 2005)
Average number of births per specialist obstetrician	207 per month	

Source: Compiled through data from the Family Health Bureau, 2012

#### f) Coverage of post-partum/post-natal care within 48 hours of delivery by a skilled health provider

Postpartum care is crucial because a significant proportion of maternal and new-born deaths occur during delivery or in the postpartum period. The postpartum period begins immediately after the birth of the baby and extends up to 6 weeks (42 days) after birth. Recent World Health

Organisation guidelines recommend that the first post-partum visit take place within the first week, preferably within the first two to three days. The purpose of this visit is early detection and treatment of complications and preventive care for both mother and baby (ARROW, 2013).

The Family Health Programme in Sri Lanka requires a PHM to pay at least 4 postpartum visits to a mother who had an institutional delivery. Of these visits, at least two have to be made during the first 10 days following delivery (91.6% reported that at least one visit occurred during this period in 2011) and the other two during 11 to 28 days and 38 to 46 days respectively following the delivery. During these visits, the PHM examines the mothers and babies for any postpartum and new-born complications, supports breast-feeding the new-born, counsels for family planning, advises on health matters and registers the new-born for future care (FHB, 2012).

Data from the SLDHS 2006/07 indicate that 90.8% of women seek postnatal care within 48 hours of delivery (69.1% at less than 4 hours, 14.6% between 4 to 23 hours and 7.1% in less than 48 hours). Since most births take place in health facilities, a skilled provider performs a women's first postnatal check over 90% of the time. Another 5% of women have their first postnatal check-up at home when the PHM visits. Under the National Strategic Plan on Maternal and New-born Health (2012-2016), the aim is to increase the proportion of post natal domiciliary visits (at least 2 visits by the midwife within the first 10 postpartum days) to 80% by 2016. Postnatal checks by a skilled provider increase with an increase in wealth quintile and level of education. Women with primary or no education lack a check-up after the birth slightly more often than women with at least secondary education. However, as much as 7.9% of the Estate sector reported no postnatal check-up while this was 4.7% for the urban sector and 3.3% for the rural sector (DCS, 2009).

#### g) Antenatal care coverage

Measuring the antenatal care women receive is an important indicator of the woman's access to health care services. Four visits are considered necessary for antenatal care to achieve its potential for saving lives. A range of essential interventions is provided during these visits (ARROW, 2013).

The antenatal care model currently used in Sri Lanka (which starts with the PHM enrolling potential couples for family planning and maternal and child health services into the Eligible Couples Register) is the traditional multi-visit model; once a month up to 28 weeks, fortnightly during 28-



36 weeks and weekly thereafter. Antenatal care is provided at Maternal and Child Health Clinics conducted in health centres both in the field and in medical institutions. In addition, PHM provides domiciliary care through routine home visits. Pregnant women are registered for antenatal care early and a 'Pregnancy Record' is maintained to facilitate proper follow up. Since the early 1990's, a home based 'Pregnancy Record' was introduced which is kept and carried by the mother so that vital information regarding the pregnancy is made available to the attending doctors and the health staff at any facility she visits (FHB, 2011). The percentage of pregnant mothers enrolled before 8 weeks of pregnancy increased from 54.8% in 2007 to 75.2% in 2012 (FHB, 2011 and 2012).

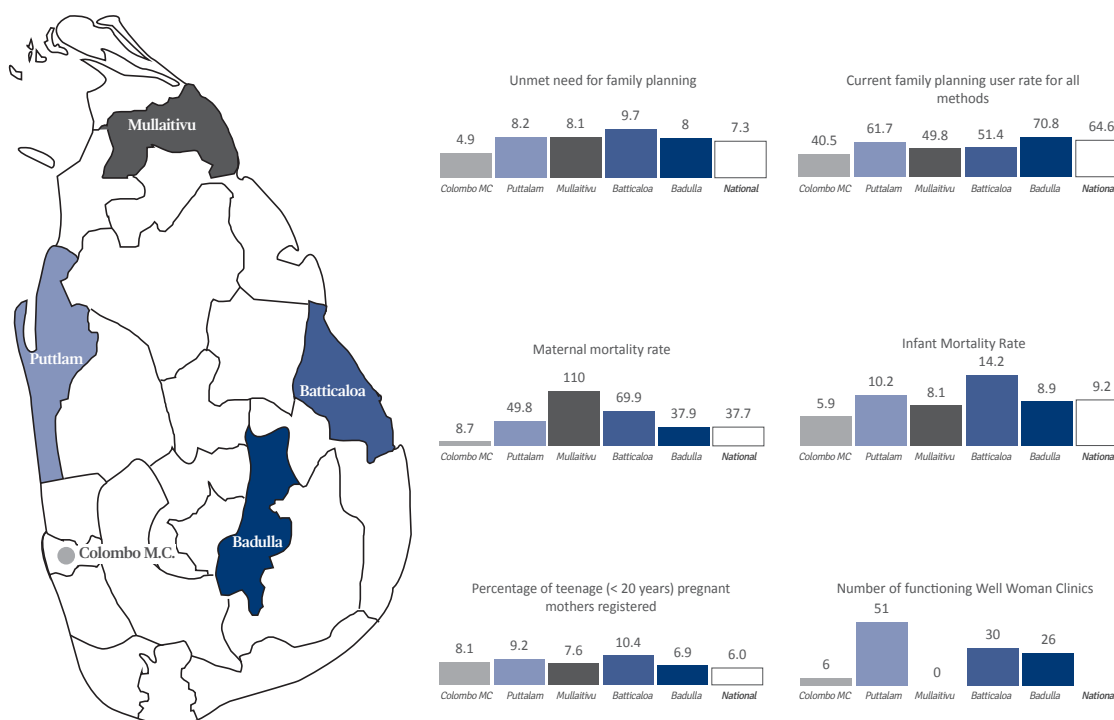
Due to these favourable conditions, virtually all mothers in Sri Lanka receive antenatal care from a health professional (specialist doctor, doctor, or PHM). The proportion receiving care from a skilled provider is remarkably uniform across all categories for age, residence, district, woman's education, and household wealth quintile. It was further noted that women in Sri Lanka receive antenatal care services early during pregnancy where 92% had their first visit within the first three months of pregnancy (DCS, 2009). Table 6 provides a look at some indicators on antenatal care in recent years. In addition to this data, it is noted that high risk pregnancies have greater frequency of attendance.

Table 6: Antenatal Coverage in Recent Years

Indicator	2009	2010	2011	2012
Percentage of pregnant women registered out of estimated pregnancies	90.0	85.9	94.3	94.0
Percentage of pregnant women making at least one field clinic visit out of registered pregnancies	95.6	94.7	95.9	95.2
Average number of clinic visits per mother	7.1	7.0	7.2	6.8
Percentage of registered pregnant women visited at least once at home by a PHM	94.4	92.9	91.7	90.2
Average number of PHM field visits per mother	5.0	4.9	5.2	5.0

Source: Annual Report on Family Health 2012, Family Health Bureau

Figure 2: Selected Districts and Indicators Showing Regional Disparities



Source: Annual Report 2013, Family Health Bureau

## Adolescent and young people's sexual and reproductive health

Paragraph 7.44 of the ICPD Programme of Action urged governments to address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, and sexually transmitted infection including HIV/AIDS. It also called for the reduction in adolescent pregnancies (UNFPA, 1994). Adolescent fertility and teenage pregnancy has major social and health repercussions. Adolescent pregnancies may have detrimental health effects on the mother and child as it is noted that adolescent mothers are more likely to suffer from severe complications during pregnancy and childbirth. In addition, young women may not be sufficiently emotionally mature to bear the burden of caring for a child. Social consequences include effects on female educational attainment, since women who become mothers in their teens are more likely to curtail education.

In this section we look at indicators of adolescent birth rate and the availability of range of adolescent sexual and reproductive health services irrespective of marital status in Sri Lanka. These indicators are reflective of the status of adolescent SRHR in the country.

### a) Adolescent birth rate

Adolescent birth rate is defined as the number of live births to women in the 15 to 19 age group out of the total number of women in that age group (ARROW, 2013). During the period of 2000 and 2006/07, the increase of adolescent fertility rate in Sri Lanka was reported as 3.7%. Despite this report, the latest census data indicate a significant leap of adolescent fertility to 12% over the period of 2006/07 and 2012 census date. Thus, even though adolescent fertility has declined in most developing countries, Sri Lanka's fertility transition with respect to adolescents seems to be going in the opposite direction (DCS, 2014).

### b) Availability and range of adolescent sexual and reproductive health services

Health services for adolescents are not a discrete entity in Sri Lanka. A person below 12 years of age is entitled to outpatient and in-ward care in paediatric services while those above 12 years have to seek these services as for adults. This may be due to the common perception that adolescents are healthy as well as the overwhelming focus on the mother and child in the orientation and establishment of sexual and reproductive health services. Sri Lanka does however have a School Health Promotion Policy and Programme and the

Family Health Bureau has incorporated adolescent health into the existing School Health Unit. This unit conducts school health inspections at Years 1, 4 and 7 and collaborates closely with the Health Unit of the Ministry of Education in the delivery of the Life Skills Program. The Life skills Programme in Government secondary schools is the vehicle through which inputs on sexual health are expected to be provided to students.

While there is no formal mechanism to restrict adolescents from accessing the desired sexual and reproductive health services, many barriers exist, including the behaviour and attitudes of the adolescents themselves and that of the service providers. The situation of unmarried and married adolescents differs significantly, yet both groups are neglected when it comes to reproductive health services (de Silva, 1998).

The recently released National Youth Policy of Sri Lanka 2014 by the Ministry of Youth Affairs and Skills Development is heavily orientated to the role of youth in development and its focus on the health of youth is relatively low. It notes the importance of integrating comprehensive sexuality education (CSE) into school curricula. In reality, however, teachers are reluctant to discuss these topics in the classroom due to cultural inhibitions (MOH, Undated).

The insufficiency of knowledge shows the inadequacy of the sexuality education programme in schools and this is further confirmed by the findings of a national survey conducted by UNICEF. Knowledge of 14-19 year olds on matters related to reproduction (such as production of sperm, ova, conception, sex hormones, secondary sexual characteristics, nocturnal emissions, and fertility) was very limited, with less than 50% answering correctly (UNICEF, 2004). The Health Master Plan (2007 - 2016) of Sri Lanka further identifies unwanted pregnancies and abortions as issues that pose a significant challenge to the well-being of adolescents. It proposes developing their knowledge attitudes, values, skills and behaviours with respect to biological, psychological, socio cultural and reproductive dimensions of adolescence (MOH, 2007).

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**...another contentious issue is the teaching of reproductive health. Attempts to introduce concepts on this subject**

**have been resisted by certain school principals, teachers, administrators and parents. Objections are on grounds of cultural sensitivity. Protagonists of introducing reproductive health to the school curriculum argue that the incidence of sexual relations among adolescents is growing and though the prevalence of HIV/AIDS is low, Sri Lanka is vulnerable due to the high prevalence rate in the neighbouring countries. Opponents contend that the magnitude of the problem is not that high and in any case discussion of issues on sexuality may exacerbate promiscuous behaviour...**

*School Health Promotion Programme in Sri Lanka, 2008, WHO Country Office Sri Lanka*

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## HIV and AIDS

Paragraph 8.29 of the ICPD Programme of Action urged governments to prevent, reduce the spread of and minimise the impact of HIV infection; and ensure that HIV infected individuals have adequate medical care and are not discriminated against (UNFPA, 1994). In this section we look at indicators of HIV prevalence and burden as well as availability of services for HIV and AIDS in Sri Lanka. The prevalence of HIV among different population subgroups and the number of persons

in the population living with HIV or AIDS are pointers to the status of sexual health of the population.

### a) Prevalence and burden

Sri Lanka is classified as a country with a low prevalence level of the HIV/AIDS epidemic in the South Asia region with an estimate of 3,000 (2000 - 5000) people living with HIV and an estimated prevalence rate of less than 0.1% as at 2014 (NSACP, 2014). The HIV prevalence is observed to be below 1% even among individuals considered at higher risk of infection based on their occupation, behaviours and practices. The National STD/AIDS Control Programme (NSACP) of the Ministry of Health spearheads the national response to HIV/AIDS in Sri Lanka. As at December 2014, a cumulative 2,074 HIV infections had been reported (NSACP, 2014). The probable modes of transmission were due to unprotected heterosexual sex (58.10%). Homosexual/bisexual conduct accounted for 12.09% of transmission and mother to child transmissions were 3.79%. Transmission through blood transfusion was 0.22% and injecting drug use, at 0.49%, was not considered a common phenomenon (NSACP, 2013).

When considering most-at-risk-populations (MARP) in Sri Lanka, it is estimated that there are about 14,132 (range from 12,329 to 15,935) female sex workers. Female sex work in Sri Lanka is extremely diverse, highly secretive and risky. While a large proportion of female sex workers are located in the Colombo district, the operations are mostly street/public place based, hotel/lodge based or home/shanty based (FPA and NSACP, 2013). Estimates from 2011 suggest that 0.2% to 0.9% of female sex workers are living with HIV (NSACP, 2012).

Another MARP are men who have sex with men. Estimates for this category were 7,551 (range from 6,547 to 8,554) (FPA and NSACP, 2013). Official figures on men who have sex with men shows an increase from 0% in 2008 to 0.5% in 2009, and to 0.9% in 2011 (UNAIDS, 2012). The National Policy on HIV/AIDS in the World of Work 2010 in Sri Lanka also noted that some of these men are married or have regular female partners and these women are also exposed to the risks of the virus. Further, women and girls bear the brunt of caregiving responsibilities for family members and dependents who may be suffering from AIDS related illnesses.

As shown in Table 7, the male: female ratio through time has changed, indicating the increasing vulnerability to HIV among women.

Table 7: Number of HIV cases reported up to end of 2013

Period	Male	Female	Total
1987-1989	13	3	16
1990-1994	76	31	107
1995-1999	101	80	181
2000-2004	173	137	310
2005-2009	344	238	582
2010-2013	408	241	649
Total	1,115	730	1,845

Source: National STD / AIDS Control Programme

Sri Lanka has identified several groups vulnerable to contract HIV. These include migrant populations, prisoners, armed forces and police personnel as well as tourist industry workers (MOH and NSACP, 2013). Most likely factors identified to influence the prevalence of HIV in the future in Sri Lanka include the emerging trend of a large youth population, internal and external migration, an underground but thriving sex industry, low levels of condom use and concurrent sexual relationships among most MARPs. On the other hand, factors that may be considered to constrain the spread of HIV include the low levels of sexually transmitted infections, availability and accessibility to free of cost state health services, a high literacy rate and the presently low number of drug injectors (FPA and NSACP, 2013).

**.STD clinic attendees include various categories of people, which include the most at risk populations such as sex workers, men who have**

**sex with men, drug users, clients of sex workers and also the general population, including youth who seek services from STD clinics. There are also referrals by clinicians in other specialities (neurology, gynaecology and obstetrics, dermatology etc). Preventive and curative services are provided free of charge by trained staff while maintaining confidentiality of information.**

*Annual Report 2013, National STD/AIDS Control Programme*

#### b) Availability of services for HIV and AIDS

According to the National STD/AIDS control programme any citizen can access state run services which are free of charge and offered by trained clinical staff. The package of services for STD and HIV management include antiretroviral therapy (ART), testing facilities, drugs for management, health education, counselling, condom promotion, partner management and follow up services. For people living with HIV there is a monthly nutrition package and family planning service. These services are provided by the NSACP and the network of 31 STD clinics linked to the NSACP. As at 2013, there were twelve ART centres in the country. The Colombo ART centre situated in the NSACP functions as the main centre providing pre ART/ART care in the country. Currently, ART is available in Sri Lanka only through public sector healthcare institutions. This gives the advantage of maintaining the standards of care and proper monitoring and evaluation of the HIV treatment and care provision (NSACP, 2014). As such, these services are not provided through the outpatient departments of general hospitals that deal with routine medical problems.

HIV/AIDS related services are also provided through private hospitals and clinics and non-governmental organisations. Several key policy documents, guidelines for service providers and strategic plans have been developed in recent years that target the prevention and treatment of HIV/AIDS and other sexually transmitted infections.

## Availability of sexual and reproductive health services at different levels of care

The Ministry of Health is responsible for almost all public service provision through its extensive network of facilities throughout the island, which are officially organized into a multi-tiered referral system. While from the 1850s to the 1980s, administration was centralized in the Ministry of Health, following the Thirteenth Amendment to the Sri Lankan constitution, responsibility for lower-level health services was devolved to eight Provincial Councils, each of which established its own Provincial Health Ministry. The Provincial Councils are responsible for management of provincial health facilities and programs, while the central Ministry is responsible for management of national facilities, medical education, formulation

of health policy and bulk purchase of drugs and medical supplies. (Rannan-Eliya et al, 2000).

Institutional services for pregnant women are provided through a graded network of 603 hospitals spread throughout the country, which have specially identified maternity wards. This comprises of 12 Teaching Hospitals, 3 Provincial General Hospitals at the tertiary level; and 18 District General Hospitals, 64 Base Hospitals and 506 Divisional Hospitals at the secondary level (FHB, 2014).

At District or primary level, services are provided through a network of medical institutions and Health Units. Medical Officer of Health area is the smallest Health unit which is managed by Medical Officer of Health (MOH) and each district comprises of seven to twenty Health Divisions. The MOH is supported by a team of public health personnel comprising of Public Health Nursing Sisters, Public Health Inspectors, Supervising Public Health Midwives and Public Health Midwives (MOH, 2014).

Table 8 presents an overview of the SRH services available at different levels of care through the health system of Sri Lanka.

Table 8: Overview of SRH Services Provided through the Health System in Sri Lanka

	Gynaecological Services	Contraception and Family planning	Maternal Health care	Emergency Obstetric Care	HIV/STI prevention and Treatment	Screening: Cervical and Breast Cancer	Safe Abortion Services*
Primary	✓	✓	✓				
Secondary	✓	✓	✓	✓			
Tertiary	✓	✓	✓	✓	✓	✓	✓
Private	✓	✓	✓	✓	✓	✓	
Other		NGO			NSACP	Well Woman Clinics	

Source: Compiled through various sources of the Ministry of Health

\*as permitted by law

### 3. Recommendations

Sri Lanka has made considerable advancements in health service provision as evidenced through the many positive indicators discussed in this Profile. The following recommendations are made to State actors and other stakeholders to enable them to address existing disparities and ensure universal access to Sexual and Reproductive Health (SRH) services.

- The health policies currently in place, need to be strengthened through the development of inclusive **SRH policies** that ensure availability of services without discrimination on the grounds of sex, gender, age, religion, race, marital status, sexual orientation, and other factors.
- Policies also need to underwrite the allocation of sufficient **human and financial resources** to implement and monitor current health policies and national strategic plans.
- Ensuring that SRH services are **universally accessible** to the whole population and in particular to those living in district with poor health indicators such as the post conflict areas, estate sector and economically underperforming districts is pivotal for equal development within the country.
- Concepts and definitions of **terminology** pertaining to SRH need to be revised. SRH services need to move beyond addressing SRH through maternal health and its approach to women's health solely in their role as a mother. This approach also leaves out men's sexual health and the mutual impact of health of partners within a couple relationship.
- More efforts should be made to improve communication between men and women on issues of sexuality and reproductive health, including enhancing understanding of **male responsibility on contraception** through sensitization and education.
- There is a need to explore the **concept of 'family'** and the services available owing to this concept, in order to cater to the changing dynamics of the 'family'. This is because segments such as female headed households (for example, post tsunami and post conflict widows), gender diverse groups, and other groups do not fall within the traditional societal definition of a family.
- The promotion of **comprehensive sexuality education** through formal and informal approaches to reach in and out-of-school adolescents from a gender and rights-based perspective is necessary.

In order to make this process more meaningful, there is also a need to develop and implement strategies to bring about attitudinal change among teachers, principals and parents to enable effective and comprehensive SRH education in schools.

- Recognising **adolescents and youth** as a distinct category entitled to services and investments in health needs to be prioritised. This can be done through the establishment /provision of a distinct budget allocation at national and provincial levels, evidence based determination of priorities, separate healthcare centres/specialized departments in public health facilities in which youth-friendly reproductive health services are available for all young people.
- In order to support evidence based policy and programming, formal **data gathering systems** are required to collect, organise and analyse SRH related data. Such systems need to target areas where there are considerable data gaps related to gender-based violence, SRH of men, sexual dysfunctions and SRH of those beyond the reproductive age group.
- There is a need to conduct programmes for attitudinal change **among health service providers**, especially in identifying and treating victims of gender based violence and those who have undergone induced abortions, and those of sexual and gender diversity, in order to provide timely and non-judgemental treatment.
- A **systematic public education** programme on induced abortions, gender based violence and sexually transmitted infections are needed. The packaging of messages for such an initiative will need to be simple and digestible to all groups of society and delivered with cultural sensitivity.

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## About Women and Media Collective

The Women and Media Collective (WMC) was formed in 1984 by a group of Sri Lankan feminists interested in exploring ideological and practical issues of concern to women in Sri Lanka. Since then WMC has been actively engaged in bringing about change based on feminist principles in creating a just society that does not discriminate based on gender. WMC has contributed at different moments in time to social and political change, the inclusion of women and gender concerns in the peace process, increased state recognition of women's rights, the enactment of new legislation or legislative and policy reform promoting and protecting women's rights, and recognition for the need to increase women's representation in politics. WMC has contributed to the formulation of the National Women's Charter, the National Action Plans for Women and the Migrant Rights Policy and co-ordinated the civil society organisations campaign which resulted in the enactment of the Domestic Violence Act of 2005. WMC has also engaged in policy discussions related to women's land rights, single women and female heads of households, peace-making and peace-building, and media reforms among others. WMC has also helped initiate women's networks and continue to work with a range of organizations from grassroots level local women's organizations to national level institutions, which have a direct voice in policy formulation and implementation.

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