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Knowledge Brief

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SRI LANKA: MATERNAL AND REPRODUCTIVE HEALTH AT A GLANCE

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KEY MESSAGES:

- Sri Lanka has met the MDG targets of poverty, primary education and gender and is on track to meet other MDGs, including for maternal health and HIV/AIDS.
- Sri Lanka's maternal mortality has historically been low. Utilization of maternal health care such as antenatal care and skilled birth attendance is nearly universal.
- Access to maternal health services is fairly equitable by residence and wealth quintile, while there are some areas with worse-off outcomes, including the conflict-affected provinces and the estates sector.
- The total fertility rate has declined to 2.3 in 2012. More than a half of currently married women are using a modern contraceptive method.
- Sri Lanka has initiated a number of key interventions to increase adolescents' access for sexual and reproductive health services; improve quality of RMNCH services through establishing guidelines and conducting maternal death audits; and improving maternal BMI.

Country Context

Sri Lanka is an island nation with a population of 20 million. In 2012, per capita income was US $2,923. From 2003 to 2012, the economy grew at 6.4 percent annually. Post-conflict, growth increased to 8 percent in May 2009. The private sector drove growth together with public reconstruction in the North and Eastern Provinces. Nearly two million Sri Lankans sent remittances in 2013, about 10 percent of GDP. [1, 2]

Twenty-five percent of Sri Lanka's population is under 15. Declining fertility and increased longevity has resulted in rapid population aging. By 2036, more than 22 percent of the population will be over 60 with 61 dependents per 100 adults. [1, 2]

From 2002 to 2009, the population living below the poverty line declined from 23 to 9 percent. The poverty head count ratio at $1.25 and $2 a day is respectively 4.1 and 23.8 percent. Inequality in per capita consumption expenditure fell during this period: the Gini coefficient declined from 0.41 to 0.36. Pockets of poverty exist in the Provinces of Eastern, Northern, Uva, and the estate sector. [1, 2]

Achievements in health and education are notable. Sri Lanka achieved the MDG target of halving extreme poverty and is on track for most MDGs, including maternal health and HIV/AIDS. It achieved universal primary education and gender equality early. Adult literacy is nearly universal. Progress on malnutrition and child mortality targets is slower: U5MR and IMR are 9.6 and 8.3 per 1,000 live births. Sri Lanka ranks 75 of 148 countries in the Gender Inequality Index (2012). [3]

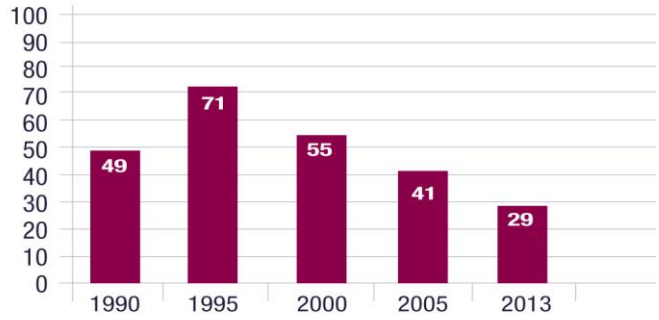
SRI LANKA: MDG 5 STATUS	
MDG 5A indicators	
Maternal mortality ratio (MMR; maternal deaths per 100,000 live births) – *UN estimate*	**29**
Births attended by skilled health personnel (percent)	**98.6**
MDG 5B indicators	
Contraceptive prevalence rate, any method (percent)	**68.4**
Adolescent fertility rate (births per 1,000 women ages 15–19)	**16.9**
Antenatal care with health personnel (percent)	**99.4**
Unmet need for family planning (percent)	**7.3**

Sources: 2014 WHO/UNICEF/UNFPA/World Bank MMR report, 2006-07 Sri Lanka DHS, 2013 World Development Indicators (WDI)

MDG Target 5a: Reduce the MMR by three-quarters, between 1990 and 2015

Sri Lanka's maternal mortality ratio (MMR) has historically been low compared to other countries in the region. MMR declined from 49 deaths per 100,000 live births in 1990 to 29 in 2013 (figure 1). Maternal mortality declined 40 percent with an average annual decline of 2.2 percent between 1990 and 2013. [4]

FIGURE 1: MATERNAL MORTALITY RATIO 1990-2013

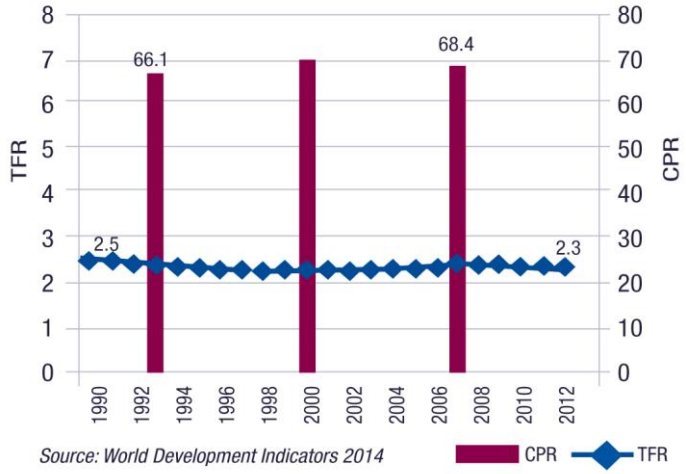


Source: 2014 WHO/UNICEF/UNFPA/World Bank MMR report

Fertility

CPR (any method) has increased from about 66.1 percent in 1993 to 68.4 percent in 2007. Modern methods are the main choice of contraceptives and are used by 52.5 percent of currently married women. Female sterilization (16.3 percent), injectables (14.8 percent) and the pill (8.1percent) are the most commonly used form of modern methods. Traditional methods are used by 15.9 percent of currently married women. While contraceptive prevalence has increased, there is still an unmet need of 7.3 percent.[5] While fertility was already low, the total fertility rate has declined from 2.5 to 2.3 between 1990 and 2012 (figure 2). [1]

FIGURE 2: TRENDS IN CONTRACEPTIVE PREVALENCE RATE (CPR) AND TOTAL FERTILITY RATE (TFR)



Source: World Development Indicators 2014

Birth intervals of less than 24 months are considered too short. Some 10.1 percent of children are born within 24 months of the previous birth in Sri Lanka. The median number of months since the preceding birth is 50.2 months. [5]

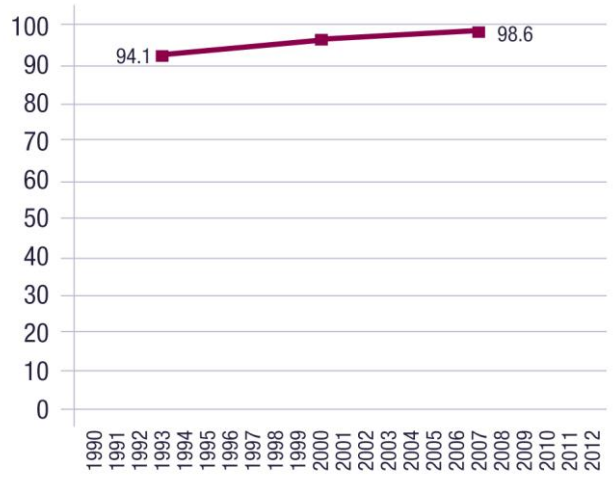
Early childbearing affects maternal health outcomes. In Sri Lanka, however, this does not appear to be an issue. The median age at first marriage among women aged 25-49 is 23.3 years and the median age at first birth among the same cohort is 25.1 years. The percentage of women age 15-19 that have begun childbearing is only 6.4 percent. [5] The adolescent fertility rate is 16.9 births per 1,000 women ages 15–19.[1]

Pregnancy Outcomes

Complete and timely antenatal care (ANC) is a necessary component for positive pregnancy outcomes. As of 2007, 99.4 percent of women sought ANC from a skilled provider. Further, 92.5 percent of women received the recommended four or more ANC visits. Nearly all women (99.7 percent) had their blood pressure measured which is one of the components in a package of ANC services. [5]

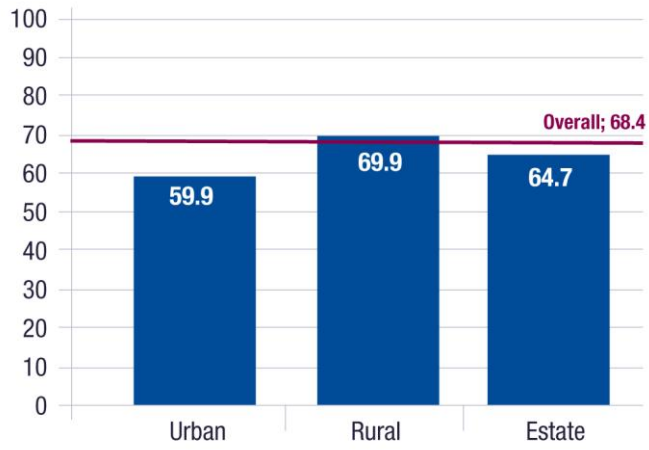
Skilled birth attendance (SBA) is critical in reducing maternal deaths. In the Maldives, skilled birth attendance by a skilled provider has historically been high. It has increased from 94.1 percent in 1993 to 98.6 percent in 2007 (figure 3). [1] Over 98 percent of births are delivered in a health facility (94 percent in a public sector facility and 4.2 percent in a private sector facility). [5]

FIGURE 3: TRENDS IN SKILLED BIRTH ATTENDANCE



Source: World Development Indicators 2014

FIGURE 4: CPR (ANY METHOD) BY RESIDENCE



Source: 2006-07 Sri Lanka DHS

Postnatal care is another important component for maternal health especially for the management of post delivery complications. It is recommended that postnatal care for mothers occur within the first two days of delivery. Over 90 percent of women sought this type of care from a skilled provider within the first two days of delivery. [5]

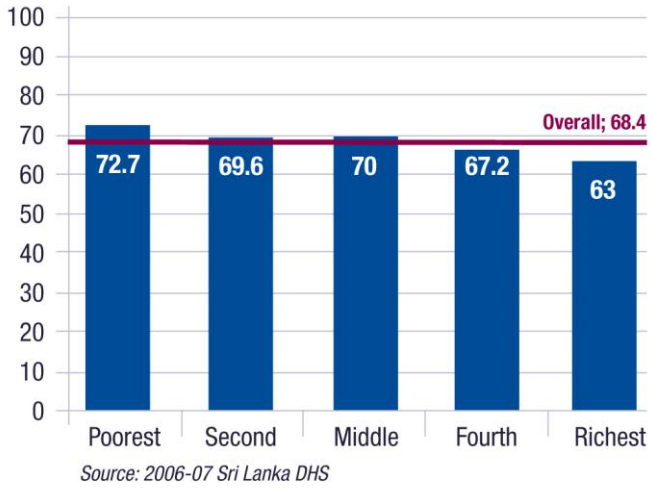
While maternal health care utilization is high in Sri Lanka, problems are still encountered in accessing health services. Overall, 47.3 percent of women aged 15-49 encountered at least one problem in accessing health care when sick. The biggest problem identified was getting money for treatment (22.3 percent). Other reasons included: not wanting to go alone (21.6 percent), distance to a facility (19.5 percent), having to take transport (19.3 percent). [5]

Equity in Access to Maternal Health Services

Access to maternal health services is fairly equitable in Sri Lanka. Little variation is observed across residences and wealth quintiles. CPR is highest in rural (69.9 percent) and estate (64.7 percent) areas. In urban areas, CPR is 59.9 percent (figure 4). [5]

CPR across wealth quintiles is interesting in Sri Lanka. CPR is highest among the poorest two wealth quintiles than the richest quintile. There is almost a 10 percentage point difference between the poorest quintile (72.7 percent) and the richest quintile (63 percent) (figure 5). [5]

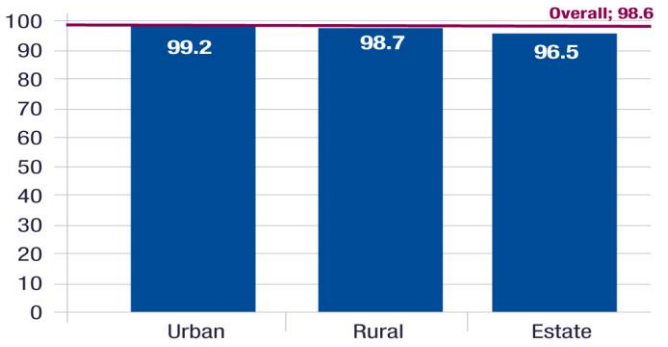
FIGURE 5: CPR (ANY METHOD) BY WEALTH QUINTILE



Source: 2006-07 Sri Lanka DHS

Skilled birth attendance is high and there is little variation across residences. In urban areas, skilled birth attendance is 99.2 percent, in rural areas it is 98.7 percent and in estate areas it is 96.5 percent (figure 6). [5]

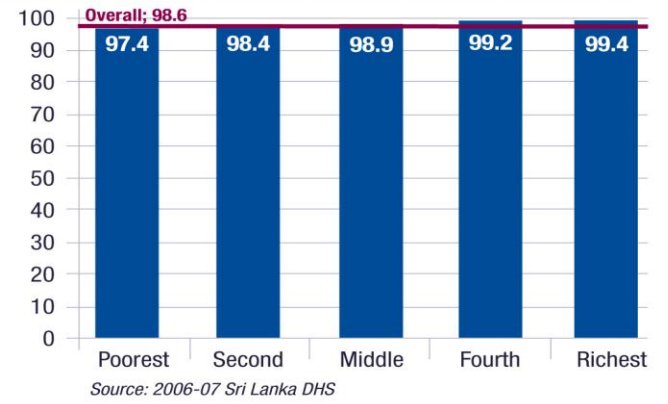
FIGURE 6: SKILLED BIRTH ATTENDANCE BY RESIDENCE



Source: 2006-07 Sri Lanka DHS

Across wealth quintiles, skilled birth attendance remains high. There is only a two point difference between the richest quintile (99.4 percent) and the poorest quintile (97.4 percent) (figure 7). [5]

FIGURE 7: SKILLED BIRTH ATTENDANCE BY WEALTH QUINTILE



Source: 2006-07 Sri Lanka DHS

References:

1. World Bank. World Development Indicators 2014: Accessed 19 May 2014
2. Sri Lanka:Country Program Snapshot. March 2014, the World Bank
3. UNDP. 2013 Human Development Report Gender Inequality Index
4. WHO, UNICEF, UNFPA and The World Bank. 2014. Trends in Maternal Mortality: 1990 to 2013: World Health Organization
5. Department of Census and Statistics (DCS) and Ministry of Healthcare and Nutrition (MOH). 2009. Sri Lanka Demographic and Health Survey 2006-07. Colombo, Sri Lanka: DCS and MOH

Key Strategies to Improve Maternal and Reproductive Health Outcomes

Addressing increasing demands from youth and adolescents: Sri Lanka has initiated a number of key interventions that include: strengthening the legal framework, including SRH into the curriculum of vocational training centers and universities, strengthening FP services for sexually active youth and adolescents, developing a minimum health care package to non-school going adolescents, and strengthening nutritional interventions for adolescents.

Improving quality of RMNCH services: The government is implementing Quality Assurance measures in maternal and newborn care, including setting standards, establishing guidelines, instituting assessment tools and accreditation processes, and conducting maternal death audits, including near-miss inquiry. Given the concern over maternal nutrition, the government is also implementing programs to improve maternal BMI. The government has initiated several interventions to improve FP, including advocacy for politicians and religious leaders, implementing the behavior change communication strategy, strengthening male participation in FP, and building the counseling capacity of health workers. Recognizing the importance of preventing cancer, cancer screening services have been scaled up, along with introducing alternative screening strategies to prevent cervical cancer.

Key Challenges

The national-level impressive achievements in maternal and child health mask inequalities between regions and much worse outcomes among the poor, the conflict-affected populations and workers in the estates sector. Over-utilization of tertiary care hospitals with regard to the place of delivery needs special attention, largely due to high educational achievement and relatively easy geographical access. Nearly all deliveries take place in government hospitals in Sri Lanka, of those, 75 percent occurs in larger hospitals that provide CEmOC. This has led to overcrowding larger hospitals and underutilization of smaller facilities. Lastly, similar to other SAR countries, malnutrition among mothers and children continues to be a challenge. Over a fifth (21 percent) of children under-five years of age are underweight and over 40 percent of pregnant and lactating mothers have been found to have anemia.