Chapter VIII

# CONCLUSION

The foregoing chapters presented the findings on fertility and contraceptive knowledge, use, and availability from the Sri Lanka Contraceptive Prevalence Survey of 1982. In this concluding chapter we review the major findings in an attempt to integrate them, to derive possible policy implications and to identify areas of further research.

## SUMMARY

The main findings on fertility were:

1. There were considerable differentials in observed completed fertility regionally, culturally, and socio-economically: Colombo and the adjoining coastal districts to its south and urban centres were decidedly low fertility areas while the hill country and the adjoining eastern and north central plains had high fertility. Indian Tamils and Moors had decidedly higher than average fertility levels while the multi-ethnic Roman Catholics had below average completed parity. Completed parity varied inversely with education. Surprisingly, non-working women had lower fertility than working women.

2. Differentials in completed fertility remained to a considerable extent unlike in the WFS where such differentials largely disappeared when controlled for age at marriage suggesting that factors other than age at marriage were working to produce differentials.

3. Overall fertility in terms of total fertility rate, had risen since 1974. This rise resulted from an increase in the age specific general fertility rates of the middle ages of 20-34 years. It was considered that the apparent rise in age specific general rates was a temporary phenomenon resulting from a higher frequency of marriages and first order births in recent times. Within marriage, fertility continued to decline as reflected in the decreases in age specific marital fertility rates for almost all age groups.

4. There was a definite preference for small families and a desire to stop child bearing early. Fifty per cent of mothers desired to have no more children at age 27 and family size 1.7 children, showing a downward trend since the WFS when the corresponding age was 28 years and the family size 2 children. On the average, a woman wanted 3.2 children and the number of children considered best was 2.8.

5. In general, the desire to stop child bearing and preferences for family size were consistent with fertility levels among sub-groups of the population. The major exception was the Hindus, a lower proportion of whom stated a desire to have no more children relative to their levels of fertility.

The main findings on contraceptive knowledge were:

1. Contraceptive knowledge, in the sense of having heard of at least one method, was universal. Knowledge increased to 99 per cent from the already high level of 91 per cent in the WFS. The methods that became increasingly known between the two surveys were male sterilization and injections, and to a lesser extent, the pill and the condom.

2. The overall knowledge was uniformly high over all ages across all sub-groups considered, whereas at the time of the WFS differentials existed by background variables.

3. Specific methods, however, were not equally widely known. Of the modern methods female sterilization (96 per cent) was the best known; injection (72 per cent), and condom (73 per cent) the least known. Of the traditional methods rhythm (64 per cent) was the best known.



4. Knowledge of specific methods varied to a small extent among sub-groups, but the variation was confined to methods other than female sterilization which was almost universally known among all sub-groups. Some of the more important differentials in knowledge of other methods were that knowledge was lowest for the Indian Tamils and relatively low for Moors but the other two ethnic groups had similar levels; knowledge was lower for urban than rural women and for non-working women than for working women; and knowledge of specific methods other than sterilization was strongly positively related to education.

The main findings on contraceptive use were:

1. The impressive increase in contraceptive use between 1975 and 1982 was brought about more as a result of increased use of traditional rather than modern methods. Ever-use of the two most popular modern methods, female sterilization and the pill, increased from 8 to 16 per cent and from 8 to 12 per cent. Of the traditional methods, rhythm found increased use from a level of 22 per cent to 34 per cent and withdrawal from 6 to 15 per cent. Overall, the use of traditional methods increased more than two fold from 18.5 to 43.5 per cent but modern methods increased much less from 24.7 to 39.4 per cent.

2. The single most currently practiced contraceptive method was female sterilization. Of all women who used any method 31 per cent used female sterilization. The second major contraceptive method was rhythm used by 24 per cent of current users. Withdrawal and male sterilization were adopted to a much less extent - 8.5 and 6.6 per cent respectively. Pill, condom, and IUD each had a low use level of about 5 per cent.

3. Contraceptive use showed considerable variation across sub-classes of the population. The current use of modern methods was higher for the Sinhalese and Indian Tamils than Moors and Sri Lanka Tamils, for Buddhists and Roman Catholics than the other religious groups. It was marginally higher for the urban than rural and for working than non-working and showed a positive relation to education. However, this education-use positive relation stemmed entirely from rapid increase of traditional methods with increasing education, and the use of modern methods was conspicuously unrelated to education. The highest educated women used modern and traditional methods almost equally while the less educated women used modern methods to a far greater extent.

As for the other sub-groups of population, the groups more likely to use modern methods were also more likely to use traditional methods with a few exceptions. Indian Tamils had the highest use of modern methods - mainly because of the high use of female sterilization - but they ranked lowest in the use of traditional methods. The other exception is that non-working women used traditional methods more than working women but this differential was reversed for modern methods.

4. Change of methods was found to be fairly frequent with more women changing from traditional to modern methods than from modern to traditional methods. Very significantly more than one half of sterilized women had not used another method previously.

5. There were indications of emerging interest in spacing births. For instance 57 per cent of women who wanted more children preferred to have the next birth after 2 years. There was, however, hardly any effort to achieve that spacing through modern contraception; only twelve per cent were using a modern method.

6. The stated high desire to have no more children was also not accompanied by adequate contraception. Although 67 per cent of currently married women wanted no more children only 24 per cent of these women used a modern method, and 40 per cent relied on traditional methods.

The main findings on contraceptive availability were:

1. In general almost all non-users of contraceptives knew of a source of at least one modern method. Awareness of a source for specific

methods was greater for the better educated, urban, and non-working women.

2. In terms of sources of specific methods the less well known the method, the less well known was its source. Knowledge of condom supplies was notably low among women who knew of it as a method, probably because the supplies were obtained by males.

3. By far the largest source of supply was the government: 4 out of every 5 women who were currently using a method obtained it from a Government source. Private (mostly FPA) and non-program (commercial outlets and work places) each served about one out of every ten current users. Female sterilization and IUD were supplied exclusively by the government. A significant proportion of 24 per cent of all male sterilizations and 50 per cent of injectables were supplied by the private sources. The largest supplier of condoms (85 per cent) was the non-program sources. Such sources also supplied about 36 per cent of orals.

4. The more frequent users of non-government sources were the urban, the better educated and women in employment outside their homes.

5. Convenience of obtaining contraceptive material and services was method specific. Condoms, and to a lesser extent, the pill, were the most easily obtainable methods. Over fifty per cent of users could obtain them from a nearby supply source within walking distance or within 30 minutes of travel time. Female sterilization was the least convenient to obtain; one out of every 3 of its users stated that it was inconvenient to obtain it and a majority of users required over 60 minutes of travel time to reach a service point. Male sterilization and IUD also required over 60 minutes of travel time.

## POLICY IMPLICATIONS AND FURTHER RESEARCH

Fertility levels are still relatively high in the backward areas of the country, the north central plains and the eastern coastal belt. Population programs should pay particular attention to these areas.

The increase in the awareness of contraceptives has cut across all sub-groups of the population eliminating differences in overall knowledge. Yet, examination of knowledge levels of specific methods indicated that it was the terminal method of sterilization that had become increasingly known. Other modern methods - condom, pill, injection, and IUD - were known to fractions of 70 to 80 per cent of the married women. The awareness of such methods was lower among Indian Tamils, working women, rural women, and the less educated. Thus the educational and information services of family planning programs should strengthen and target message about temporary modern methods.

The increase in the contraceptive use compliments the family planning services in the country, particularly the sterilization programs. It is a concern, however, that traditional methods have increased more in use and that their level of current use was very close to that of modern methods. The particularly high use of traditional methods among younger and low parity women suggests that first and early attempts at contraception begin with traditional methods. The reasons for this high level of acceptance of traditional methods in preference to modern methods need to be understood for a more efficient family planning drive. Family planning programs might also consider developing strategies to increase the use of temporary modern methods among women who want to postpone births and to encourage use of modern methods - both temporary and permanent - by women who do not want more children.

The most prevalent modern contraceptive was female sterilization; the other methods, IUD, pill, condom, and injection were a small fraction of the overall use. This brings home the point that modern contraception is largely limited to the acceptance of this terminal method which is offered with incentives by government hospitals by women already having large families at the time of the last birth. Modern contraception for planning families in the sense of spacing between births is very limited. One reason for this could be the lack of services for these methods and another could be their unacceptability because of the regularity demanded by the pill, the discomfort of IUD and constant re-supplies required in all other cases. Identification of exact reasons and adoption of requisite corrective measures is then a priority need for systematising the contraceptive use in Sri Lanka.

It was conspicuous that education and work status were not cirteria in promoting current use of contraceptives. Cultural factors on the other hand, were differentiators of use levels. In general, the sub-groups that used contraception relatively more had relatively lower fertility.

In general, the reported availability of contraceptives was satisfactory. The high level of reported inconvenience in getting a female sterilization may be because it required time and hospitalisation. Private organizations have significantly helped the major supplier, the government, by supplying condoms and performing male sterilizations. Both government and non-government sources should pay more attention to providing better services with respect to orals, condoms, IUD and injections in rural areas, where the reported availability was less than in urban areas.

In conclusion then, women in Sri Lanka are sufficiently motivated to desire small families and to adopt contraception. The knowledge of methods, awareness of sources and actual use, however, are largely confined to the terminal method of female sterilization. Other modern methods are much less known and little used and traditional methods are resorted to in order to achieve the fertility intentions. The direction of further improvement in family planning services seem to be towards increasing the services and acceptability of efficient non-terminal modern methods while maintaining the sterilization programs.