A STATUS REPORT

CHILDREN IN SRI LANKA

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FOREWORD

This study of children in Sri Lanka was commissioned by UNICEF and prepared by Mr. Godfrey Gunatilleke of the Marga Institute, in order to take stock of the situation with regard to Child Survival and Development in Sri Lanka, which has justly been acclaimed as a leader in social welfare policies in the context of poor developing countries.

Sri Lanka today has very low infant and child mortality rates which are within striking distance of rates prevailing in developed countries. However, there are yet groups in the country among whom the mortality of infants and pre-schoolers are at unacceptably high levels.

Even more disturbing are the various problems which affect Child Development. Malnutrition of various types affect more than 40% of Sri Lankan children and the indications are that Early Child Development, both physical and psycho-social, seem to have been neglected and both are emerging as areas for serious concern.

The problems affecting children in Sri Lanka to a great extent portray the attendant problems of the mortality transition where death rates decline but other problems surface — some of them old and others new — which are associated with rapid social transformation and change.

Mr. Godfrey Gunatilleke and the Marga Institute have been in the forefront of efforts to investigate these trends from a Sri Lankan perspective. UNICEF Colombo must thank them for preparing this valuable work, which it is hoped will contribute to the formulation and implementation of policies to develop an environment where all children have a better opportunity of not only survival, but also of healthy physical growth and psycho-social development.

I must thank Dr. Ananda Meegama of UNICEF for co-ordinating this study.

Farid Rahman
UNICEF Representative
1. INTRODUCTION

The success with which Sri Lanka has dealt with the problems of survival has been widely recognised as an exceptional achievement. At a very low level of income, she has been able to create the conditions which have led to a remarkable decline in infant, child and maternal mortality. The prevailing health situation, however, reflects a mix of trends and possibilities, some of which could lead again to dramatic improvements in health, while others can intensify existing problems.

Several socio-economic and demographic changes in Sri Lanka have created an unusual opportunity for a major advancement in the quality of life and well-being of children.

- With a continuing improvement in the educational level of females and the rise in the average age of marriage, the young woman of today is better equipped to assume the responsibility of motherhood and participate actively in existing family health programmes.

- Birth rates are declining and the size of the family is getting smaller.

- A wide range of low-cost health interventions is within easy reach of poor households.

- Furthermore, with fertility declining it is most likely that there would be no significant increase in absolute numbers in the age groups 0–4 and 5–9 years.

Consequently, the future demand for existing services for these age groups will stabilise and even contract, leaving room for the provision of new services and enhancing the quality of those already being delivered. The high rates of economic growth of the recent past have improved the prospects for raising household incomes and reducing absolute poverty. All these changes can converge to transform the environment of child care, in which well-designed strategies can achieve dramatic results in the second half of the eighties and nineties.

As against these positive trends, there are signs of growing economic stress in the poorest segments of the population.

- For a large number of mothers, infants and children, the health status and the level of physical well-being after survival continue to be poor.

- For a significant segment of the population as a whole, the quality of life is gravely impoverished in relation to several basic needs. Malnutrition remains a serious problem. Morbidity continues to be high and ill-health due to common diseases, such as diarrhoea and respiratory infections, is widespread.

- Nearly 10 per cent of the children have no schooling and a significant proportion drops out of school in the primary stage.

- Inequalities have been increasing and the economic reforms which have been implemented after 1977 have led to a some erosion in the social welfare base which has had adverse effects on the well-being of the poorest.

- The ethnic conflict, while endangering the country's development as a whole, has resulted in death, suffering, homelessness and loss of parental care for a significant number of children.

In the final analysis, a large part of the avoidable mortality, ill-health and malnutrition in Sri Lanka has its roots in hardcore poverty and the structures which perpetuate it. Therefore, in the situation which has emerged after the mortality decline, child health strategies would have to be linked meaningfully to integrated development efforts that reach the disadvantaged groups and enhance their capacity to improve the total environment in health. This will include nutrition, water, sanitation, housing, personal hygiene, knowledge and education for a healthy life.

The exceptional success which Sri Lanka has had in lowering mortality was itself largely due to development processes in which health improvement was part of a broader welfare-oriented effort directed at satisfying some of the basic needs of the poor. This comprehensive approach to health care has even greater validity for the emerging situation. However, the combination of interventions essential for enhancing the post-survival quality of life would have to go beyond what has been adequate for dealing with most of
the problems of survival. The distribution of effort and shifts of emphasis would have to respond to the changing profile of ill-health and mortality among infants and children. On the one hand, this would require closer identification of the disadvantaged and vulnerable groups where hardcore infant mortality and ill-health persist. On the other, it will require the promotion of well-being which goes further than the prevention of specific disease or prompt remedial action.

All these tasks have to be accomplished in Sri Lanka at a level of resources and per capita income which will continue to be relatively low and modest even with high rates of growth. Therefore, the strategies which are evolved in Sri Lanka for the improvement of children’s well-being in the next phase will have relevance for other low-income countries which will have to grapple with similar problems and enhance the quality of life within resource constraints which are inescapable.

The report which follows, begins with a historical perspective which briefly reviews the past developments which led to the remarkable transition in mortality and defines the context in which new problems are appearing. Thereafter, it goes on to examine the impact of current socio-economic policies on the well-being of children. The main part of the report presents and analyses the data on the prevailing health status of the Sri Lankan child and attempts to identify some of the critical elements in the changing health profile and the new priorities that are emerging. The concluding chapters focus on two relatively neglected aspects—the situation of the preschool child and the specially disadvantaged segments of the child population in Sri Lanka.

2. TRANSITION IN MORTALITY – HISTORICAL PERSPECTIVE
In the forty years between 1945 and 1985, the expectation of life at birth of the average Sri Lankan rose from about 45 years to about 70 years. This rapid increase in the average life span reflects, above all, a dramatic improvement in the survival of those groups in the population which were among the most vulnerable and exposed to the high risk of mortality – infants, children in the age group 1–4 years, and women during the period of child-bearing. During these four decades, the infant death rate declined from about 140 to 25 per thousand. The mortality rate for children in the age group 1–4 years dropped from approximately 25 to 2 per thousand. The number of mothers who died in child bearing fell from 15.5 to 0.8 per thousand live births.

It is now widely recognised that these improvements were the outcome of the complex interaction of social and economic processes and policies that were pursued in Sri Lanka over a period of more than fifty years. There are several distinct phases in this transition which drive home the lessons to be derived from Sri Lanka’s experience.

Lowering of mortality in the period 1945 – 1960
The first phase of the transition in health was witnessed in the rapid changes that took place in the second half of the forties. The death rate dropped from 19.8 per thousand in 1946 to 12.6 in 1950. During the same period, infant mortality was reduced from 140 to 82 and maternal mortality from 16.5 to 5.6. There are several factors which contributed to this achievement. The health services provided by the state expanded at a time when significant breakthroughs in the curative field, such as the development of antibiotics, were taking place. As a result, the benefits of the new medical technology were brought within reach of a progressively larger number of people. The application of DDT and the control of malaria made an important contribution to the reduction in mortality. At the
same time, there were similar declines in almost all leading causes of mortality. There had been a considerable increase in adult literacy, particularly among females.

**FIG. 1 (c) CHILD MORTALITY RATE**

(1 - 4 years) per 1000

![Graph showing child mortality rate from 1945 to 1981.](image)

Source: Registrar General's Department

But above all, with the end of the Second World War, the conditions in the economy, its output and supply, and the use of resources soon returned to normal. Mortality rates had risen in the first half of the forties when scarcities caused by the war were severe. The supply of goods expanded rapidly after 1945; the value of imports more than doubled by 1950 and food supply increased substantially. With these improvements in economic well-being and the increase in average levels of consumption, the social infrastructure that had been put in place before independence, began to yield positive results at a rapid pace. In the years that followed independence and in the decade of the fifties, the social welfare policies directed at the satisfaction of basic needs in health, education, food and nutrition were incorporated in a comprehensive nation-wide programme. At the beginning of the sixties, the crude death rate was 8.6, and infant mortality had dropped to around 53.

**FIG. 1 (d) MATERNAL MORTALITY RATE**

Per 1000 births

![Graph showing maternal mortality rate from 1945 to 1980.](image)

Source: Registrar General's Department

**Stagnation in the 1963 – 1975 period**

After the rapid decline in mortality during the late 'forties and 'fifties, the progress achieved during the 'sixties and the first half of the 'seventies, showed distinct signs of retardation. Crude death rates hovered around 8.5 throughout this period, and the infant mortality rate which had dropped to 52 in 1961, fluctuated around 50. It had risen to 51 in 1974 after having declined to 45 in 1971.

**The impact of development policies on health**

- The government steadily expanded state services in the field of health to provide nation-wide coverage within easy reach of poor households. Striking achievements were recorded in the prevention and control of some of the major diseases — malaria, tuberculosis, smallpox, ankylostomiasis (hook-worm). More lasting and durable improvements in the well-being of the population were gained in primary health care in which maternal and child health received high priority.

- The system of mass free education introduced in the mid-forties, resulted in a steady expansion in school enrolment, in which the most notable feature was the rapid increase in female participation. This made a major long-term contribution to improving the well-being of women, every succeeding generation of mothers reached a progressively higher educational level. This was reflected in enhanced knowledge, changes in reproductive behaviour and more informed participation in the field of health care, particularly child care.

- In the food sector, a nation-wide food distribution system provided a subsidised food ration and gave a significant measure of food security to the population as a whole. The food subsidies comprised an important part of the calorie intake of the lowest income group. The trading system based on the state trading of major food items and a widespread network of co-operative institutions maintained a fairly stable structure of prices of food and essential items over the fifties and sixties.

- At the same time, the highest priority was given to local production of the staple food — rice. This programme directly benefited the smallholding peasant community. The state land and the effective delivery and establishment of agricultural extension services, helped to improve living conditions and levels of nutrition among the rural poor.

- Government programmes also improved the rural infrastructure. These included schemes for subsidising village housing, rural roads, community wells and latrines. Model houses which were introduced into village expansion schemes, tended to improve the quality of rural housing. These initiatives altered rural life-styles, raised expectations and helped to improve the environment for health and well-being as a whole.

- Representative political institutions with universal adult franchise was introduced in the early 'thirties. The multi-party system that developed and the relations between political representatives and the electorate, helped to generate social pressure from below, articulate the needs of the common people and promote appropriate responses by the state.
The system was evidently encountering a hardcore of mortality, ill-health and malnutrition that was rooted in conditions of acute deprivation. The system which had been developed relied heavily on the top-down delivery of health services through state institutions and cadres. The involvement of family and community in health care had received far less attention. Many of the persistent problems of health required action at the household level — better nutrition, improved housing and sanitation, enhanced capacity of families for early diagnosis of ill-health, more active participation in preventive and primary health care programmes, and further improvement in knowledge, attitude, and practices related to child care, on the part of mothers.

The economy had not grown fast enough to generate adequate employment for the rapidly growing workforce, or raise incomes at an adequate pace. There were over 500,000 unemployed youth by the end of the ‘sixties. This number had increased to a million in the mid-seventies. After a spurt of growth in the latter part of the ‘sixties, a period of slow growth had followed. The average rate of growth from 1971 to 1977 was no more than 2.9%. The country faced a succession of crises during this period. A political upheaval in 1971, which setback the economy, was followed by a world food shortage, a widespread drought and failure of domestic harvests and, finally, by the drastic impact of the rise in international oil prices. While these were the immediate causes of the crisis, the problems that surfaced had their roots in deep-seated structural causes. These included the continued dependence on a few agricultural exports which were not generating adequate external resources; and the inability of the economy to absorb the growing young workforce in productive employment.

The adverse developments in the first half of the ‘seventies had grave consequences for the health of the socio-economic groups whose capacity to satisfy basic needs was on the borderline of sufficiency. This period of economic stress could be contrasted with the 1945–1950 period when the economic recovery and social improvements converged to raise the well-being of the population. In the period 1971–1974, mortality rates increased. In 1974, the crude death rate had risen to 9 and infant mortality to 51 from 7.7 and 44.8 respectively in 1971. The developments that followed in the period 1976–1985 have to be examined and evaluated against this background.

**FIG. 2 (a) TREND INCREASE IN LIFE EXPECTANCY IN SRI LANKA AND IN DEVELOPING COUNTRIES**

![Graph showing trend increase in life expectancy.](image)


Fig. 2 (a) has been adapted from Box 4 of the World Development Report 1984. It is estimated that on average it would take about 80 years to raise life expectancy from 42 years — the lowest life expectancy for a developing country at present — to 75 years, which is the average for industrial countries. In the case of Sri Lanka, the increase in life expectancy from 46 (1946) to about 70 years (1984) has been achieved in a period of about 38 years — a little more than half the average.

**FIG. 2 (b) LIFE EXPECTANCY AND PER CAPITA INCOME**

![Graph showing life expectancy and per capita income.](image)

Source: Based on data from World Development Report 1986

Fig. 2 (b) depicts the life expectancy for selected developing countries at different levels of per capita income. As the boxes show, most countries at Sri Lanka’s level of per capita income have a life expectancy between 40 and 50 years. Life expectancy comparable to that of Sri Lanka becomes the average only at per capita incomes around US dollars 2000 and above.
Income distribution, food availability, and nutrition

The effect of these changes on real incomes, particularly those of poor households, was of a mixed character. The average monthly income of spending units at current prices increased more than five-fold from Rs. 311/= in 1973 to Rs. 1,635/= in 1981/82. The median income increased more than four-fold from Rs. 250/= to Rs. 1,159=/=. However, when these money incomes are adjusted for inflation, real incomes grew at a much slower pace. The increase in real incomes between 1973 and 1982 appears to be in the region of 43 per cent for the mean and 29 per cent for the median. These figures appear to be more consistent with the national income accounting which estimates per capita real growth for the period 1973–1982 at 20 per cent, with per capita income growing much faster for the 1977–82 period.

The broad conclusion which can be derived from this analysis is that the real incomes of average households increased moderately in the period 1973–1982. In all probability, the major part of the increase occurred in the period after 1977 when the economy responded positively to the new policies.

These aggregate figures, however, do not reveal the whole story. Although the evidence is not as yet fully available to draw firm conclusions, the changes during the seven-year period do not appear to have brought significant benefits to the lowest income groups. Income distribution worsened during this period; while the gains to the upper income deciles were quite substantial, the share of income accruing to the lowest two deciles declined significantly. The increase in inequality and the worsening of distribution by itself would not increase poverty, if at the same time, it is offset by an adequate improvement in the real income of the poorest income deciles. This would have resulted in the reduction of absolute poverty where households are unable to satisfy their minimum nutrition needs.

![Figure 4: Average Monthly Income Per Spending Unit](image)

- It would appear that between 1973 and 1982, the real incomes of the lowest two deciles of spending units improved only marginally — by a meagre 10 per cent in the lowest two deciles, and 13 per cent in the next two deciles. It is more than likely that some socio-economic groups within them stagnated or even suffered a lowering of living standards.

![Figure 5: Percentage of Total Income Received by the Lowest 40% of Spending Units](image)
However, the evidence available on the
growth of real incomes has to be treated
with some caution. There has been a strong
bias for understatement of income on the
part of low-income households, particularly
after the introduction of the food stamp
scheme based on an income qualification. In
this context, the data on food consumption
and nutrition would provide a better basis
for assessing the improvements in well-being.
The national data on the availability of food
per head indicates that the situation improved
considerably after 1976. The daily supply of
-calories has been marginally above 2200
calories for most of the period 1977 to 1983,
and well above it in 1984 and 1985. This
compares favourably with the period 1970 to
1976. The average annual supply taken for
the period as a whole was below 2200 calories.
Although 1970 was an exceptionally good
year, it would appear that with rare excep-
tions, the availability during the whole of the
sixties remained also below the norm.

- During the 1977–1985 period, food
availability per head has been sustained
at a level above the norm. Domestic
food production, particularly in rice,
contributed to this situation.

The data on food consumption in the
Consumer Finance Surveys conducted by the
Central Bank in 1973 and 1981/82, indicate
that the lowest 20 per cent of the households
has had modest increases in the consumption
of some of the main food items – rice,
coconut, fish and meat, while the total
consumption of the main cereals – rice,
wheat flour, and bread, taken together
showed a marginal decline. This was offset by
a substantial increase in the consumption of
items described as ‘other starchy food’. The
data in the two surveys, however, are not
strictly comparable. Moreover, the use of
different measurements in the two surveys
could have resulted in margins of error which
can affect the final figures significantly.

Finally, the year 1973, for purposes of
comparison, is a poor year with low food
availability. The more appropriate year would
be 1970 when per capita food availability was
at a comparable level. Socio-economic surveys
of that period indicated that even then, ap-
proximately 10 per cent of households had
a calorie intake below 2200 calories. Even
when the average daily supply is around this
level, its distribution will be affected by
inequality in incomes. The calorie intake
could also be low for the income groups in
the bottom 40 per cent of households who
have household incomes well below the
average.

![FIG. 6 PER CAPITA AVAILABILITY OF CALORIES PER DAY 1962 – 1985](source: Department of Census and Statistics Food Balance Sheets)