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Trip Report

#0-16

Travelers: James E. Veney
Evaluation Officer

Country Visited: Sri Lanka

Date of Trip: Oct. 17-23, 1987

Purpose: To provide technical assistance to the FPASL in the analysis of evaluation data derived from a series of FPASL volunteer training activities.

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LIST OF ABBREVIATIONS USED IN THIS REPORT

DAC	District Action Committee
FPASL	Family Planning Association of Sri Lanka
GRLAC	Grass Roots Level Action Committee

EXECUTIVE SUMMARY

INTRAH Evaluation Officer Dr. James E. Veney, visited Colombo, Sri Lanka to work with Family Planning Association of Sri Lanka evaluation personnel from October 17 to 23, 1987. The purpose of the trip was to advise and assist the FPASL in the analysis of evaluation data derived from a series of FPASL volunteer training activities. Dr. Veney worked primarily with Mrs. Mala Salgado, Research and Evaluation Consultant and Mr. G.A. Gunsekara, Assistant Director of Research and Evaluation of the FPASL. In addition, meetings were held with Mr. Amarananda Dissanayake, Training Director, Mr. Daya Abeywickrame, Director and Mr. Victor de Silva, Research and Evaluation Consultant, FPASL; Dr. Gnani Thenabadu, Mr. William Binns and Mr. Dennis Zviniakis USAID/Colombo; and Dr. Tissa Cooray, Director, NIH, Kalutura.

Because of the incompleteness of the evaluation data, it was not possible to carry out the analysis. Instead, trial analyses were carried out with partial data to assure that the procedure was understood by FPASL staff. A time schedule for the analysis was also established to which the FPASL should be expected to adhere.

During the meeting with Dr. Tissa Cooray, it became clear that INTRAH might be able to provide assistance in some development activities of the NIH, Kalutura, and that an effective INTRAH-UNC/SPH link might be formed to provide assistance. Such a link should be promoted.

SCHEDULE DURING VISIT

Saturday
October 17 Arrived in Colombo.

Sunday
October 18 Visited FPASL Training Center and observed training of District Action Committee members. Met with Training Center Director Mr. Fostin Mirando, Training Director Mr. Dissanyaka and Assistant Training Director Mr. Joe Livera.

Monday
October 19 Met with Dr. Gnani Thenabadu, USAID/Colombo.

Met with FPASL Staff:
-Mr. Daya Abeywickrame, Director
-Mr. Dissanayaka
-Mr. Livera
-Mr. Victor de Silva, Research and Evaluation Consultant
-Mrs. Mala Salgado, Research and Evaluation Consultant
-Mr. G.A. Gunsekara, Assistant Director of Research and Evaluation.

Worked with FPASL staff, particularly Mrs. Salgado and Mr. Gunsekara on analysis of post-post test results, performance appraisals and experimental-control group data.

Tuesday
October 20 Continued work on analysis of evaluation data at FPASL.

Met with Dr. Tissa Cooray at Oberoi Hotel.

Wednesday
October 21 Worked with FPASL staff on analysis of evaluation data.

Thursday
October 22 Continued work with FPASL staff on analysis of evaluation data.

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Reported progress to Mr.
de Silva and Mr. Abewrickema.

Debriefed with Dr. Gnani Thenabadu,
Mr. William Binns and Mr. Dennis
Zviniakis.

Friday
October 23

Departed Colombo for the U.S.

I. PURPOSE

The purpose of the trip was to advise and assist the FPASL in the analysis of evaluation data derived from a series of FPASL volunteer training activities. The objectives were:

1. To advise and assist in the analysis of a post post test (one year after training) administered to a random sample of approximately 300 active and inactive volunteers.
2. To advise and assist in the analysis of performance assessment data collected on approximately 100 active (at time of assessment) village volunteers.
3. To advise on the analysis approach for the experimental control group areas being followed by the FPASL as a test of the overall effectiveness of the volunteer program.

II. ACCOMPLISHMENTS

- A. Visited FPASL Training Center and observed a District Action Committee training activity.
- B. Met with the FPASL Research and Evaluation unit to discuss the analysis of evaluation information collected on village volunteers trained with INTRAH support. Returns from the administration of the post-post test were reviewed.
- C. Met with Dr. Tissa Cooray and Dr. Roderigo, National Institute of Health, Kalutura, to discuss possible INTRAH training assistance.
- D. Briefing and Jebriefing sessions were held with USAID/Colombo.

III. BACKGROUND

FPSAL has accepted a substantial role in evaluation of their INTRAH-sponsored training, embracing the entire basic evaluation design including Participant Reaction

and Biodata forms, post-post tests of knowledge at follow-up intervals of one and two years and performance appraisal of the volunteers' capabilities. In addition, they have agreed to an experimental-control study of the effect of the volunteer program in five experimental areas [matched to five control areas]. While FPASL has experience and capability in data collection and handling, they are not as experienced in the most effective analysis of the data. The need for technical assistance in this area was clear from the initial evaluation workshop in Chapel Hill (May/July 1985) and the May 1986 follow-up in Bangkok (INTRAH Trip Report #0-99). Also, two of the people best trained to handle the analysis, Mr. Jayasingha and Ms. Thalata, both of whom attended the Bangkok workshop, have now left FPASL permanently, and Mrs. Mala Salgado, a third person knowledgeable about the analysis, is working as a part-time consultant only. Mr. G.A. Gunsekera has recently replaced Mrs. Salgado and will assume some of the responsibility for the INTRAH analysis, but his background has been in statistical applications in agriculture and commerce, rather than in the social sciences and he needs guidance in analysis of FP data. Ms. Brown (INTRAH Trip Report #0-95) recommended a visit to the FPASL by INTRAH evaluation persons.

IV. DESCRIPTION OF ACTIVITIES

- A. A visit to a DAC training event on Sunday, October 18, at the FPASL training facility in Negumbo was a result of arriving in Colombo on Saturday the 17th.
- B. Dr. Veney met with the FPASL research and evaluation staff to discuss the analysis of evaluation information collected on village volunteers trained with INTRAH support. The analyses were used on a trial basis with

partial data to determine feasibility and to assure understanding by the FPASL research and evaluation staff including the Director of Volunteer Training, Mr. Dissanayake, Research and Evaluation Consultants Mr. Victor de Silva and Mrs. Mala Salgado, Assistant Director of Research and Evaluation Mr. G.A. Gunsekara, and Director of Computing Mr. Gamini Weerakady. Most activities were carried out with Mrs. Salgado and Mr. Gunsekara. Results of these trial runs were then discussed at the next meeting and final analysis strategy agreed upon.

- C. Returns from the administration of the post-post test were reviewed. These were virtually complete for active volunteers, but only about fifty percent complete for inactive volunteers. It was agreed that additional efforts would be mounted to complete the inactive tests during November 1987. The analysis for the post-post test is to be in two phases as follows:
- 1) A test of the significance of any difference between the post-test (administered at the end of the workshops) and the post-post test (after one year). This test will be done separately for volunteers who were active at the time of the post-test (about 200) and volunteers who were inactive at that time (about 100).
 - 2) A regression analysis will be run with the difference in scores between the post-test and the post-post test as the dependent variable, and including such volunteer characteristics as age, sex, project area, number of families assigned, pre-test scores and active or inactive status, to determine whether characteristics of volunteers who do or do not retain learned knowledge can be separated out. A sample analysis was carried out on a small data set to assure that the methodology was understood by FPASL staff. The completed analysis will be sent to INTRAH by the end of January 1988.

It was not possible to accomplish the analysis of data from the post-post test and the performance assessment because the data from the post-post test had not been

collected for all the sample volunteers nor had the data from performance assessments been completely entered into the computer. This appeared to be due largely to the fact that the FPASL staff working on the INTRAH analysis had either taken other work (Mr. Jayasingha and Ms. Thalata) or in the case of Mrs. Salyado, worked only part time as a consultant. Because of this, it was possible only to run some trial analyses on a sample of the data from these two assessments and to agree on a time when the completed analysis would be sent to INTRAH. It was possible to discuss the analysis of the experimental-control area data as was planned.

- D. Performance assessment analysis will focus on three specific variables: 1) the average proportion of families assigned to a volunteer who are motivated to accept an FP method at three quarterly periods minus the proportion accepting at the baseline; 2) the skill with which the volunteers present their activities to the GRLAC (assessed by trainers on four dimensions), and; 3) the accuracy and completeness of record keeping by volunteers. These will be examined from the basis of established FPASL norms and secondly, the dependent variables in a regression analysis designed to determine which of a set of characteristics such as age, sex, education project area and post-post-test scores account for differences in performance measures.

A trial run for this analysis was done on a sample of complete data to assure that the method is understood by FPASL staff. The final analyses will be completed and sent to INTRAH by the end of January 1988.

- E. Experimental-Control Group Analysis. The analysis of the experimental and control group areas can only be completed at the end of 1988 as it is a two-year study. Baseline data have now been analyzed and a draft of the

analysis is attached as appendix B. Mrs. Salgado was asked to add actual frequencies (in addition to percentages) to the analysis tables. It was agreed that Dr. Veney would return in October 1988 to assist in the final analysis of the experimental-control area data.

- F. At the suggestion of Dr. Gnani Thenabadu, Dr. Veney met with Dr. Tissa Cooray and Dr. Roderigo of the National Institute of Health, Kalutura, to discuss possible INTRAH training assistance. They were informed that Dr. Veney's specialty was evaluation and not program development. They had previously spoken with INTRAH Program Officer Maureen Brown about NIH training needs. From the conversation, it appears that Ms. Brown and Dr. Veney conveyed similar messages; that is, INTRAH may be able to provide assistance where training needs are clearly related to FP, but could probably not support the entire NIH projected effort in development of management capability for all health sectors. Dr. Cooray indicated that a formal request for INTRAH assistance would be sent to USAID/Colombo through the appropriate government channels.

V. FINDINGS/CONCLUSIONS AND RECOMMENDATIONS

1. Findings/Conclusions:

Logistical and administrative aspects of the visit were handled well and expeditiously. FPASL provided transport in-country and an adequate work site.

Recommendations:

None.

2. Findings/Conclusions:

Because of the incompleteness of the evaluation data, it was not possible to carry out the analysis of post-post tests data and performance assessment data. The fact that the data were not complete appeared to be in part due to the departure or part time status of key evaluation personnel. Mr. Gunsekara, who replaced Mrs. Mala Salgado as Assistant Director of Research and Evaluation had not been brought into the data analysis of INTRAH evaluation data until Dr. Veney's visit which motivated FPASL to resume collection and analysis of INTRAH evaluation data.

Recommendations:

FPASL should be expected to adhere to the completion schedule for the analysis indicated in sections I and II of this report, and should be encouraged to continue to involve Mr. Gunsekara, the only full-time FPASL staff member who is knowledgeable about the INTRAH evaluation design, in the completion of the INTRAH evaluation. To assure that the INTRAH evaluation continues to receive adequate attention, a return visit of two to three weeks to complete the data analysis for all evaluation data should be planned by Dr. Veney for October 1988.

3. Findings/Conclusions:

It appears that the Research and Evaluation Unit at FPASL has difficulty accessing the computer for data analysis. The IBM AT, purchased jointly by FPASL, FHI and INTRAH, is set up, but has no working software at this time making it difficult to complete the data analysis. The Research and Evaluation unit must rely on the FPASL computer staff who have other pressing responsibilities, and on the Texas Instrument Computer that has limited analysis capacity as compared to the AT if it had the proper software package (such as SAS) for analysis.

Recommendations:

FPASL should be urged to purchase the SAS computer package (it is apparently available in Colombo for Rps 5000) for use on the IBM AT and that computer should be made readily available to the Research and Evaluation unit for analysis of the INTRAH evaluation data.

4. Findings/Conclusions:

An examination of the experimental-control area baseline data raises the question of whether the INTRAH sponsored training of village volunteers is likely to have any useful impact on the level of contraceptive prevalence, or, even if it does, whether it is justified. These data show that over half of the couples from both the experimental and control areas were using contraceptives at the time of the baseline survey and that over seventy percent of couples that were considered to be eligible users (that is, those in which the woman is not currently pregnant or those which are not currently trying to have a child) are actually using contraceptives. This suggests that the village volunteer cannot be expected to make a very large impact on the community in which s/he is working because there are so few couples who are legitimate targets for motivation.

Recommendations:

INTRAH will cease to work with FPASL at the conclusion of the current contract as a result of a change in direction by USAID/Colombo for Sri Lanka. If this were not the case, it would be worthwhile to await the results of the analysis of the experimental-control area data before deciding on continued support of the volunteer training effort as it is now carried out. These results would be expected to show not only a statistically significant difference in acceptance between the experimental and control areas, but also a conceptually important addition to the number of couples already accepting in the experimental areas before any continuation of the program was agreed to.

5. Findings/Conclusions:

The DAC workshop was impressive. The workshop was the focus of about 20 community leaders from the north-central part of Sri Lanka discussing the practical aspects of the implementation of FP programs. One suspects that if a similar group of community leaders was convened in a place such as Benue State, Nigeria, for example, the discussion would be much more likely to concentrate on whether FP was a desirable activity at all, or whether it might not lead to sterility and/or promiscuity among women. The fact that Sri Lanka has progressed to the stage of practical implementation issues may suggest that the country

has also progressed beyond the need for additional INTRAH support for training, at least in view of the present position of USAID/Colombo.

Recommendations:

Even if the volunteer program is successful as indicated in (4) above, and in the presence of USAID/Colombo agreement, INTRAH should question whether Sri Lanka is in need of resources, even though it is quite clear that such resources are being and will be used well.

6. Findings/Conclusions:

Dr. Tissa Cooray indicated a primary desire to upgrade the management training capability of the NIH. His concern is with all aspects of the management of primary health services, and not only with family planning. Further, he indicates the desire to establish a relationship with a university outside Sri Lanka that would provide support in this endeavor, and mentioned specifically UNC, from which they have received some support in the person of Dr. Charles Harper, former faculty member from UNC/SPH/HPAA through a WHO short term assignment, and the University of Birmingham in England.

INTRAH, because of its specific FP mandate, can probably not provide support for all NIHS needs, nor provide NIH with a strong link to UNC. However, INTRAH, working together with the UNC/SPH through the International Program Office, might be able to assist in upgrading NIH capabilities in those areas where it is appropriate to do so and to help Dr. Cooray establish links with a university.

Recommendations:

Dr. Cooray should be encouraged to communicate with INTRAH in regard to his expectations. INTRAH should communicate with IPHP/SPH on possible ways in which collaboration between the two units could be carried out to meet Dr. Cooray's goals (and with an appropriate distribution of financial responsibility between the two units).

APPENDIX A
PERSONS CONTACTED/MET

APPENDIX A

PERSONS CONTACTED/MET

USAID/Colombo

Dr. Gnani Thenabadu

Mr. William Binns

Mr. Dennis Zviniakis

Family Planning Association of Sri Lanka

Mr. D. Abeywickrame, Director

Mr. Victor de Silva, Consultant, Research and Evaluation

Mrs. Mala Salgado Consultant, Research and Evaluation

Mr. G.A. Gunsekara, Assistant Director, Research and Evaluation

Mr. A. Dissanayaka, Director of Training

FPASL Training Center

Mr. Fostin Miranda, Director, FPASL Training Center

Mr. Joe Livera, Assistant Director, Training

Mr. Gamini Weerakody, Computer Manager

National Institutes Of Health

Dr. Tissa Cooray, Director, Kalutura

Dr. Roderigo, Assistant Director, Kalutura

APPENDIX B

AN EVALUATION OF THE CMIRFHP THROUGH AN EXPERIMENTAL CONTROL
STUDY: RESULTS OF THE BASELINE SURVEYS 1986

AN EVALUATION OF THE OMIEFHP THROUGH AN EXPERIMENTAL
CONTROL STUDY : RESULTS OF THE BASELINE SURVEYS 1986

1. INTRODUCTION :

The OMIEFHP has been in existence since 1980 and has been subject to a number of evaluation surveys. The main limitations of these past studies has been ;

- (i) that there has been no control groups, so that the volunteers contribution to changes in contraceptive use levels, have been difficult to measure.
- (ii) the base line and evaluation surveys have been carried out by two different types of investigators - the former by volunteers who receive hardly any training and the latter by specially trained female investigators all of whom are graduates. This led to the quality of the data obtained from the two surveys being not the same.

The limitations of previous evaluations surveys were taken into account in designing this evaluation study. An experimental control group study was drawn up and trained female graduates were employed to conducting the base line surveys.

This report presents the findings of the first stage of the evaluation i.e. results of the base line surveys conducted in 5 experimental communities (project areas) and 5 control communities.

This evaluation will only be complete when a second round of surveys ^{are} ~~will~~ be carried in about 2 years time (mid 1988) in these same communities. This will enable us to find out the changes that have taken place in these communities over a period of time, and also judge the effectiveness of the volunteers work in the project areas by comparing the results of the experimental and control areas.

1.1 Objectives of the Study :

This study has been designed to evaluate some of the general and operational objectives spelt out in the project proposal submitted to INTRAH. These objectives are:

General Objectives :

1. To increase acceptance of temporary and permanent FP methods by rural eligible couples (EC)

2. To increase continuation of use of temporary family planning methods by rural eligible couples.
3. To achieve contraceptive prevalence of 80% at the end of two years in the villages served by village volunteers.

Operational Objectives :

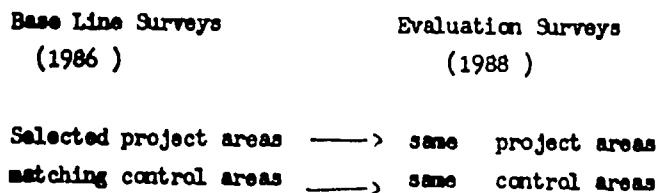
4. To increase the acceptance by rural couples of village volunteers as recruitment sources for FP to the extent that 40% of couples interviewed will identify village volunteers as their recruitment source.

1.2 Methodology :

The two main components of the research design employed in this study are :

1. Conducting an initial base line survey followed by an evaluation survey two years later in order to find out the changes that have taken place in these communities over a period of time.
2. The selection of project areas (experimental areas) and control areas so that the changes due to the CMIRFHP can be inferred by comparing the changes that have taken place in the project areas and control areas respectively.

In diagrammatic form the research design looks like ;



The effectiveness of the CMIRFHP will be judged as follows :

changes in FP use in project areas between 1986-1988 = A
changes in FP use in control areas between 1986-1988 = B
changes due to the work of volunteers = A - B

The above formula will present a true picture of the changes that have taken place due to the GMEFHP to the extent that;

- (1) the experimental and control areas are well matched with regard to socio-economic conditions and access to health facilities.
- (11) that similar influences take place in both the experimental and control areas.

1.2.1 : Selection of experimental and control areas :

The different socio-economic and cultural characteristics of the country were taken into account when selecting the study areas. This was done by dividing the 25 administrative districts of Sri Lanka into 7 strata on the basis of homogeneity in socio-cultural characteristics. (see annexure 1)
A decision to limit this study to only Sinhalese areas, taken, due to the ethnic disturbances that prevailed in the country in 1986. Therefore the number of strata that were considered for this study was only five.

In selecting the projects for this study all the 1986 Sinhalese projects (excluding those in the Eastern Strata) were regrouped into the 5 strata and one project was selected randomly from each strata.

The 5 control areas were selected only after the baseline survey had been conducted in the project areas. These control areas were chosen with the help of the District Project Officers (D.P.OO) of the districts in which the project areas were selected . From the baseline surveys conducted in the project areas, certain selected indicators (number of families, type of community, main occupation of residents, facilities available within project areas such as school, clinic) was obtained and sent to the D.P.OO. The D.P.OO were asked to select with the help of local officials (eg: Assistant Government Agents, Grama Sevaka, Midwives, & GRLAC members) communities within their districts with similar characteristics. From the 3 communities selected by the D.P.OO, the evaluation division selected one area as the control group. This decision was sometimes made after consultation with other officials both within and outside the FPA who were familiar with these areas.

Visits were also made to these control areas by the Director, Evaluation to see that the socio-economic conditions of these control areas was similar to that of the project areas.

The experimental and control areas that were selected are :

<u>Region</u>	<u>Experimental</u>	<u>Control</u>	<u>District</u>
Wet Zone	Koggala	T-elwatte	Galle
North Central	Akkara 500	Ragangana	Anuradhapura
Dry Zone			
South East	Muthukandiya	Muthukandiya	Moneragala
Dry Zone	iv	vi	
Central Midlands (Intermediate Zone)	Magala	Uduwa	Kegalle
Central High lands (Hilly Region)	Hingurukaduwa	Mandanunuwara	Nuwara Eliya

1.2.2 Data Collection and Data Analysis :

As mentioned above (see section 1.2.1) , these base line surveys were first carried out in the project areas by specially trained female investigators, (all of whom were graduates)^{and} were done before the volunteers started working in the project areas i.e. after the volunteers had received their 3 day training but before they conducted their own baseline surveys. Volunteers from each project area pointed out to survey investigators the houses that belonged to their respective projects. After the volunteers did their own HLS , it was found that the volunteers had sometimes interviewed more couples than that done by the survey investigators.⁽²⁾

In these instances, the survey investigators were sent back to the project areas to interview these "new" couples. Questions such as pregnancy status, contraceptive use was ascertained from these couples as that practised during the period the survey was first conducted in their communities.

Field work in the 5 project areas was carried out during the period April - May 1986. The surveys in the control areas took place ^{12 w} a months later ~~took place~~ during the period July to August 1986, as selection of these areas was dependent on the preliminary tabulations of the project areas. Every community was also visited ^{and} field work supervised ^{by} the permanent staff of the evaluation division.

All houses pointed out by the volunteers were visited during the survey. The first three or four questions in the questionnaire ~~was~~ enabled the investigators to ascertain whether the ^{couple} concerned fell into the "eligible couple" category, or not. If the ~~couple~~ was an eligible couple the rest of the questionnaire was also filled.

This questionnaire that was filled for all married persons in the community was drawn up with the help of an INTRAH evaluation staff member and consisted of 3 sections, namely;

- Part 1 - Basic information and demographic data and contraceptive use status.
- Part 11 - For those using a contraceptive method.
- Part 111 - Knowledge and Behaviour on health related issues.

(2) Matching of couples interviewed at both surveys was done at head office.

So as to make certain that the special ELS conducted covered the population the volunteers were to work with.

In addition to visiting homes, the survey investigators were also asked to interview a few of the local GRLAC leaders and government field level officers in the area (eg: Grama Sevaka, Midwife) and fill up a short questionnaire that gave information about the community - ie. the population of the area, and availability and access to educational, health and communication facilities etc.

The survey investigators also drew a map of the communities they visited . This will help the next group of investigators, who will visit these same communities in two years time for the evaluation survey(ie. in 1988) to know the areas covered during the baseline survey.

All questionnaires were edited and coded at the head office & entered into the computer. The necessary tabulations were obtained and the data stored on a diskette for further analysis as and when required.

BACKGROUND INFORMATION ABOUT THE EXPERIMENTAL & CONTROL

AREAS

Background information about the community was collected at the village level as well as from the respondents. The village data ^{from gathered} ~~from collected~~ information such as the total population of the village, access to school and health facilities, availability of facilities like electricity within the village and access to transport facilities. Education level and occupational pattern of both males and females was obtained from the individual level questionnaire .

Kogalla and Telwatte were the two communities chosen to represent the Wet Zone of the country. This particular zone is well known to be relatively more urbanized and than the other parts of the country since these areas were developed during the colonial era. Hence communities in this zone are relatively more densely populated and have had access to educational, health and communication facilities for a longer period than communities else where. This is reflected when the 10 study areas are compared. (see tables 2.1 and 2.2.) The educational and occupational distribution show that the percentage of husbands engaging in Agriculture is lowest for these two communities (less than 20%) while the % of both husbands and wives who have studied for 10 years is comparatively high. Further electricity is available only to these two communities.

These 2 communities are located in the District of Galle along the coastal belt. Hence those working in the agricultural sector are fisherman, of the other's about 15% are service providers, 10% traders and over 40% work in skilled and unskilled jobs. Educationally more Telwatte residents have studied for 10 years or more than Kogalla folk.

Being in the Wet Zone & located in close proximity to the main road running from Colombo to Matara (ie. Galle Road), the residents in these communities do not have access to health facilities within the village itself. ^{have access to a very good transport network. Therefore, though the} accessibility to facilities outside is relatively easy. Even with regard to other facilities , the question on distances to closest facility available is not very meaningful.

TABLE 2.1

EDUCATION LEVELS OF HUSBANDS AND WIVES

% who have studied upto at least Grade 10	EXPERIMENTAL						CONTROL					
	Koggala	Akkara 500	Muthukandi ya iv	Magala	Hingurukaduwa	A L L	Telwatta	Rajangana	Muthu. vi	Uduwa	Madannuwa	A L L
Husbands	25	21	20	19	13	20	45	23	29	37	23	32
Wives	32	29	20	24	19	26	44	32	22	44	14	33

TABLE 2.2

OCCUPATION DISTRIBUTION OF HUSBANDS

Occupation Category	EXPERIMENTAL						CONTROL					
	Koggala	Akkara 500	Muthukandi ya iv	Magala	Hingurukaduwa	A L L	Telwatta	Rajangana	Muthukandiya vi	Uduwa	Mandaran nuwara	A L L
Agriculture related	17	75	84	50	83	47	19	69	68	29	84	51
Service sector	16	10	5	10	4	10	16	7	6	18	4	11
Skilled	20	7	6	10	7	12	26	3	12	12	3	12
Unskilled	28	4	2	19	2	15	21	17	8	24	7	19

TABLE 2.3

OF

ACCESSIBILITY OF CERTAIN FACILITIES TO THE EXPERIMENTAL & CONTROLAREAS

Accessibility of facilities (distance given in miles)	EXPERIMENTAL					CONTROL					
	Koggala	Akkara 500	Muthu-iv	Magala	H°kaduwa	Telwatta	R°gana	Muthu-vi	Uduwa	M°nuwara	
Accessibility of health services.	Closest rural Hospital	2 1/2	4	2	5	4 1/2	3	3	*	9 1/2	12
	Closest family health clinic	3/4	2 1/2	2	10	4 1/2	1/2	3	*	9 1/2	*
	Closest Hospital with sterilization facilities	10	28	22	24	11	14	25	21	12	15
	Availability of public health midwife	3	1 1/2	*	*	*	1/2	*	2	*	*
Accessibility of closest town & other facilities.	Closest town	10	2 1/2	22	10	11	2	8	21	9 1/2	9
	Closest weekly fair	3 1/2	2 1/2	2	10	12	2 1/2	3	*	9 1/2	20
	Closest post Office	*	1 1/2	2	3	3	1/4	6	1/2	*	*
	Closest school with classes upto Gr.10	*	1 1/2	*	5	3	1/4	*	2	*	*

* - facilities available within village

Akkara 500 and Rajangana are the two communities that were selected from the Northern Dry Zone . This area was malaria infested and ^{S. PARASU 17} sparsely populated during the colonial era, but with the opening up of colonization schemes after independence a large number of persons ~~are~~ have migrated to these areas from the densely populated Wet Zone . Both Akkara 500 and Rajangana are typical of the large settlement schemes in the Dry Zone. As could be expected the majority of the husbands engage in cultivation.

Being settlement schemes, the government provided educational and health facilities to the migrants at fairly accessible distances. In this regard table 2.3 shows that both Akkara 500 and Rajangana residents have access to a health clinic at a fair distance but they have to travel a long distance to obtain sterilization facilities. A midwife is resident in Rajangana though not in Akkara 500. Of the two colonies, Akkara 500 is situated closer to a town.

Muthukandiya iv and Muthukandiya vi are two " yayas " (tracts) that belong to the Muthukandiya Irrigation scheme. This settlement scheme is located in the Moneragala District. This district is one of the least developed districts in Sri Lanka and is a part of the Southern East Dry Zone. The colonization schemes in this district were started later in comparison to the schemes in the Northern Dry Zone. Further the large scale migration seen to the Northern Dry Zone, was not ^{experienced in this part.} settlers chosen for Muthukandiya iv were not original migrants to the Moneragala district but were from migrant families who had settled down in Moneragala in the ^{past} in another colonization scheme (ie.) Hence a phenomenon seen when the survey was carried out in Muthukandiya iv was that some of the eligible couples resided in the project area only during the cultivation season.

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Though these 2 communities are a part of the same settlement scheme, they are not adjoining tracts. Hence it is felt that the effects of the CMIRFHP will not spill over to the control area.

Educational and Health facilities have been generally made available to colonists of the Muthukandiya settlement scheme within the scheme itself. Since the two chosen communities are two tracts of the large scheme, the facilities available in one tract serve not only its residents but other colonists as well. Thus table 2.3 reveals that a rural hospital and ^{poly}poly clinic are located in Muthukandiya vi while a school is situated in Muthukanidya iv. The closest town to this scheme is Moneragala which is 20-22 miles away. This is the district capital. Further, ^{the}district hospital in which sterilization facilities are available is located in this town.

Magala and Uduwa were the two selected communities chosen to represent the Intermediate Zone. These two communities are located in Kegalle District, Compared to most of the communities (excluding the two in the Wet Zone). ~~The~~ % engaging in cultivation is relatively lower (about 30%) in both these communities, In Magala another 1/3rd of the males are engaged in agriculture related jobs, such as ~~to~~ ^{today} tapping and jaggery making while in Uduwa, 34% of the husbands are engaged in unskilled jobs such as ^a ~~a~~ ^{a equivalent percentage of} ~~a~~ In terms of education level, both Uduwa males and females have studied for 10 years and more than their counterparts in Magala.

Table 2.3 ^{also} shows that both these communities are fairly isolated in that the closest town is 9-10 miles away, the closest weekly fair is least 10 miles away and the closest poly clinic is also about 10 miles away. Sterilization facilities are even further away.

Hingurukaduwa and Mandaramnuwara are the two communities representing the upcountry region or central Highlands of Sri Lanka . This region is well known for its large scale tea plantations. Since the CMIRFHP projects are selected from the rural sector, the 2 communities selected for this study are typical villages. The main occupation of the majority of husbands in these communities is agriculture. Upcountry vegetables are grown by the farmers in these communities. In addition paddy is cultivated in Mandaramnuwara.

Being nestled among the plantations these communities have not had the same access to education and health facilities as those in other regions of Sri Lanka. This is reflected in the % of husbands and wives who have had a secondary education (see table 2.1) In fact comparatively residents in these 2 communities have not gone in for higher education as seen by the % who have studied for 10 years or more.

The isolation of these communities is also seen from the fact that the closest town is about 10 miles away, as is the weekly fair. In contrast health facilities are more accessible with midwives being resident in both these communities and a family health clinic functioning in the control village and being within 5 miles of the experimental village.

Sum up the two communities in the wet zone are the most urbanized, the communities on the dry zone are settlement scheme with colonists in the Northern Dry Zone having more access to education and health facilities than their southern counterparts and the communities in the intermediate zone and the hilly regions are comparatively isolated villages. In fact these latter communities are typical of the villages in which the FPASL tries to work in-remote rural communities .

Demographic characteristics:

Age, number of living children, number of live births, desire for additional children, pregnancy, desired family size are among the demographic variables considered in this study.

The mean ages of the respondents and their husbands is given in the table below while the age distribution can be seen in the appendix.

Table 3.1 Mean Age of husbands & wives

Age	EXPERIMENTAL						CONTROL					
	Koggala	Ak.500	Muthukandiya iv	Koggala	Muthukandiya vi	II	T'ratte	R'Gama	Muthukandiya vi	Idawa	M'Uwara	III
Mean age of wife	31.0	27.3	29.2	32.1	30.7	30.8	31.6	32.5	31.7	31.7	29.7	31.1
Mean age of husband	35.8	32.0	34.6	37.1	34.3	34.4	34.9	37.7	37.4	37.4	34.4	34.7

It is seen that both the respondents in the Control areas and their husbands are on the average one year older than the respective counterparts in the experimental area. It is also interesting to note that the age difference between the husbands and wife's is on a relatively five years which is the average age gap that generally prevails between spouses in Sri Lanka.

When individual communities are considered it is seen that wife's mean age differs fairly markedly between the **Experimental** and **Control** villages situated in the Northern dry zone area (ie. 27.3 for Akkara 500 and 32.5 for M'Uwara). A slight difference is also noted for the 2 communities located in the Southern dry zone area (29.2 in Muthukandiya iv and 31.3 in Muthukandiya vi). In the other 3 communities the average age of wives is very similar.

When husbands age is considered a similar trend to that observed for wife's age is seen, with differences noted between the Experimental and Control areas in the two dry zone strata.

Indicies relating to fertility are depicted in the following tables.

Table 3.2
Fertility Indices

VARIABLES	EXPERIMENTAL						CONTROL					
Mean No. of living children	2.79	2.46	3.33	2.93	2.51	2.57	2.76	2.96	3.33	2.43	3.32	2.92
Mean No. of live births	3.97	2.54	3.52	3.09	3.11	3.05	2.95	3.09	3.56	2.51	3.56	3.09
% of wives whose youngest child is \leq 1 year	23	23	26	19	22	23	21	16	21	20	20	20
% of wives who are pregnant	12	15	13	5	10	11	11	9	8	9	16	10
% of wives who want additional children.	32	48	31	29	43	35	32	28	32	35	35	32
Mean number of additional children wanted.	1.46	1.54	1.56	1.42	1.67	1.52	1.62	1.29	1.78	1.14	1.57	1.46
Mean No. of children desired.	3.38	2.36	3.95	3.40	3.66	3.51	3.37	3.42	3.98	2.91	4.03	3.49

Comparison of the Experimental & Control groups (irrespective of Projects) on each of these variables (ie. columns 7 & 13) reveal that the indices are very similar for mean number of living children (2.76 vs 2.92) mean number of live births (3.05 vs 3.09) % of respondents who are pregnant (11% vs 10%) and mean number of children desired (3.51 vs 3.49) and vary slightly for respondents whose youngest child is less than one year (22% vs 20%) and % of respondents who want additional children (35% vs 32%). Furthermore for each of these 7 variables no significant differences were found between the Experimental & Control areas.

When the pairs of projects are considered (ie. the Experimental & Control areas of the same strata) the following similarities and differences were noted.

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(1) Wet zone - Koggala & Thelwotte for all the indicies these 2 communities showed very similar results.

(2) Akkara 500 & Rajangama - Differences are observed for all the variables, with the exception of the mean desired number of children. These results are due to the fact that the Akkara 500 respondents are on the average younger, have had ^{fewer} less children but want more additional children than those in Rajangama. When these differences are taken into account as in the case of the desired family size (see footnote 1) the results are very similar.

(3) Muthukandiya iv and Muthukandiya vi - the mean number of living children, the mean number of desired children and the % wanting additional children are seen to be very similar between these 2 communities. On the other hand, the two indicators of recent fertility ie. the % of respondents ^{who are pregnant & those} whose youngest child is less than one year is higher for the experimental community. (ie. Muthukandiya iv) It is interesting to note that though recent fertility is higher in Muthukandiya iv, the % wanting more than one additional child (that is future desires) is higher in Muthukandiya vi (see appendix)

(4) Magala & Uduwa - The only indicator on which these 2 communities show a similarity is the % of respondents whose youngest child is less than one year. Table 3.7 reveals that the mean number of living children (ie. present fertility level) in Magala is higher than in Uduwa. Even after taking into account future aspirations for children, the mean number of children desired by women in Magala is higher than in Uduwa.

Furthermore the mean number of additional children desired by Magala women is higher than that desired by Uduwa women, though a larger percentage of Uduwa respondents () want additional children than those in Magala. It may be interesting to note that of all the 10 communities Uduwa has the lowest current fertility (2.43) as well desired fertility (2.91)

* Computed as follows
total number desired = number living + no. wanted additionally + 1 (if pregnant)

(5) Hingurukaduwa & Mandaramuwara - The percentage of respondents whose youngest child is below 1 year is the only indicator on which these 2 communities are similar. The fertility of the control village is higher than that of the Experimental village with a higher mean number of living children, a larger % pregnant and a higher mean number of additional children desired. In fact Mandaramuwara shows the highest current fertility and highest desired fertility of all the communities studied.

Therefore, except for Thalwatta & Koggala variation in fertility level between the individual Experimental & Control communities is observed. These differences will need to be noted and taken account of when these subjects are evaluated in 2-3 years time.

ASSOCIATION BETWEEN THE VARIABLES:

When overall trends or the relationship between variables in Table 2 is considered a number of interesting points emerge. These points need to be noted for future evaluation purposes. Hardly any difference is observed between the mean number of live births and mean number of living children. This reflects the low mortality levels prevailing in the country.

As could be expected a direct relationship is seen for the two recent indicators of fertility, that of % of respondent currently pregnant and % of respondents whose youngest child is less than one year.

Mean number of living children and mean number desired are two other variables which shows a direct relationship.

Though these 2 variable show a direct relationship, No clear relationship is observed between the current number of living children and future desires (ie. % of respondents wanting additional children and the mean number of additional children wanted). For example compare Kithukandiya vi and Mandaramuwara, 2 communities where a similar fertility level prevails or Akkara 500 and Uluwa.

A further examination of the variable, % of respondents wanting additional children was carried out for the Experimental and Control areas as a whole.

Table 3.3
% Distribution of respondents who want additional children

No. of living children	EXPERIMENTAL						CONTROL					
	% wanting addl. children	No. wanted additionally				Mean add. No. wanted	% wanting addl. children	No. wanted additionally				Mean addl. No. wanted
		1	2	3	4			1	2	3	4	
0	95	26	43	23	8	2.1	98	21	64	13	2	2.0
1	77	56	39	5	0	1.5	84	60	31	8	0	1.5
2	41	85	17	1	0	1.2	79	89	10	0	2	1.1
3	13	87	13	0	0	1.1	7	89	11	0	0	1.1
4	3	100	0	0	0	1.0	1	100	0	0	0	1.0
ALL	35	59	31	8	2	1.5	82	61	32	7	0	1.5

The above table reveals that one third of the respondents in both the Experimental and Control areas want ^{additional children & that there is a} direct relationship between the number of children living and % wanting additional children, i.e. a large majority of those with either no children or one child want another ^{child} (over 75%) while ~~only~~ only one in 4 respondents who have two children want more. The fact that only about 10% of those with three children want another child indicates that the small family norm is ~~is~~ will established in these 10 communities. This is further seen by the fact the mean number of additional children wanted by those with no children is approximately 2.0 in both the Experimental & Control areas.

Of those wanting children, a question was also asked, when they wanted the next child. Table 2.4 shows that about 70% of those whose youngest child is below 2 years want another child in 2 years time. In contrast 30% - 50% of respondents whose youngest child is over 2 years, wish to have their next child "as soon as possible", thus indicating that the concept of spacing of children is prevalent among a fairly large proportion of mothers.

of those respondents who want additional children, the time period when the next child is wanted by age of youngest child.

Age of youngest child (in months)	EXPERIMENTAL					CONTROL				
	soon	within 1-2 years	2 years or more	other	All	soon	within 1-2 years	2 years or more	other	All
1-12	23	7	67	3	100	74	5	68	3	100
13-24	6	6	84	4	100	10	3	76	5	100
25 & more	31	14	44	12	100	52	5	31	12	100
ALL	24	7	63	6	100	29	6	60	5	100

CONTRACEPTIVE USE :

One of the main objectives of the CMIRFHP programme is;

" To increase acceptance of temporary / permanent family planning methods by rural eligible couples "

In order to assess the effectiveness of the motivation programme it thus becomes necessary to collect information on the contraceptive use status of the families of the project before the motivation programme is started. Table 4.1 presents this information in the form of 2 indicators. The first indicator is that which is often usedi.e. % of eligible couples who are using a method. Indicator is different from the first in that pregnant women are excluded from the denominator.

TABLE : 4.1
CONTRACEPTIVE PREVALENCE RATES

Indicator of Contraceptive Use	EXPERIMENTAL						CONTROL					
	Kegalle	Akkara 500	Muthukandiye IV	Kagala	Hinjurukadu VA	A L L	Thelwatte	Rajanrana	Muthukandiya VI	Kuduwa	Mandaram	ALL
As a percent of eligible couples.	46.1	55.5	59.8	61.2	58.3	54.6	58.0	58.7	51.0	49.5	50.0	54.1
As a percent of eligible couples excluding pregnant.	52.5	65.0	68.5	64.4	65.0	61.2	65.0	64.6	55.7	56.5	59.2	60.4

Comparison of the Experimental and Control groups (irrespective of projects)

The above table on each of these 2 indicators reveals that the % using contraceptives is very similar. A Chi-square test further revealed that there were no significant differences between these 2 areas.

When the pairs of projects are considered (i.e. Experimental and Control areas of the same strata) it is seen that for both indicators, fairly marked differences are seen in 4 of the 5 communities (exception being Akkara 500/Rajangana)

In 1982, the results of the contraceptive prevalence survey showed that the % of rural women currently using contraceptives was 54.3. In this survey in 9 of the 10 communities about half the eligible couples were using a family planning method. Thus it is seen that the contraceptive usage pattern in the FPA projects is relatively similar to the situation that prevailed in rural Sri Lanka 4-5 years ago.

Thus the pictures that emerges/^{is} that a significant proportion of those couples that need protectionⁱⁿ these communities are currently using some method of family planning. In this context what needs to^{be} investigated is;

- (1) to see, from those not using a method, the reason why they are not doing so, and if they can be motivated in the future,
- (2) to see if the couples presently using a method (at the time of the baseline) are using the most effective or appropriate method and if they are practising it correctly,
- (3) to see what type of couples are currently using a method.

5.1 Those currently using a contraceptives method : Table 4.1 showed that 40% of the couples (including those pregnant) were not using a method. The reasons as to why these couples are not using a method are presented in the following table.

TABLE - 4.2

REASONS FOR NOT USING A CONTRACEPTIVE METHODS

	EXPERIMENTAL						CONTROL					
	Kegalle	Atkara 500	M'kandi ya	Kagala	H'kadurwa	ALL	Thei watte	Pajar Sans	M'kandi ya-vi	Uduwa	M'nuwara	ALL
Want a child	18	27	24	22	24	21	28	35	29	28	19	26
Breast feeding	8	5	11	8	7	8	5	18	7	24	6	13
Youngest child was born fairly recently	23	44	29	24	21	106 25	30	14	29	17	36	24 ⁷⁷
Believe can't conceive	20	7	13	17	22	76 18	20	29	29	27	28	26 ⁸³
Fear of side effects	10	12	4	4	4	38 7	5	0	0	0	8	2 ⁷
Husband opposed	3	2	2	2	3	13 3	0	0	2	3	2	1 ⁷
Lack of services	2	0	9	2	3	2	0	0	0	0	0	0
Other *	16	3	3	21	16	16	12	4	4	1	1	6

* includes those whose haven't heard about family planning, those who are shy do ask, those whose spouses are abroad etc. (see Appendix table... for details)

Want a child, youngest child born fairly recently, believe can't conceive are the three main reasons mentioned by at least 60% of the couples who are not using a method in 8 of the 10 communities. In the other two communities (Rajangana and Uduwa) the % stating youngest child born fairly recently was relatively lower but the % mentioning currently breast feeding was comparatively high, both being somewhat similar reasons. The validity of these reasons given by the respondents can be seen by the following:

- (1) Of those who mentioned that " their youngest child was born fairly recently " 94% have an infant less than or equal to one year in the experimental as well as the control areas.
- (2) Of those who state they are not practising a method because they want a child, 94% and 95% in the experimental and control areas want their next child within a year. The other 4.5% stated the period as " God's wish " or " when it happens "
- (3) Of those who believe they cannot conceive, 59% in the Experimental and 77% in the control areas belong to the age group (40-44) and approximately have a youngest child over 5 years 75% in both these areas.

In examining the reasons given by those not using a method, it is seen that apart from those who believe they can't conceive (especially those over 40 years old) practically all the others can be motivated to use a method. In this respect it is important that those whose youngest child was born fairly recently or who are currently breast feeding are motivated to use a method at the correct time, so that accidental births are avoided and spacing of children is practised.

4.2

Those currently using contraceptives : The type of method used by those practising a family planning is given in the table presented below:

Table 4.3

Percentage of eligible couples using contraceptives by method

	EXPERIMENTAL						CONTROL					
	Koskalla	AK. Suro	M'landiya	Magala	H'haduna	ALC	T'walle	R'gana	M'landiya	Udunna	M'N'wara	ALC
Pills	09	04	05	06	07	06	04	05	03	03	07	04
Condom	02	03	00	03	01	02	04	02	00	00	00	01
IUD	12	05	04	06	07	00	09	01	00	04	01	04
Depo Provera	00	01	14	00	05	03	02	00	13	03	00	03
Safe Period	29	24	15	41	06	25	27	34	26	39	16	29
With drawal	01	04	04	06	07	04	03	00	00	02	04	02
LRT	39	49	46	19	39	36	42	57	51	35	54	48
VASECTOMY	07	06	05	06	24	10	06	01	01	04	13	05
Other	00	00	01	02	01	01	01	00	00	00	00	00
2 or more traditional methods	01	03	05	09	02	04	02	00	06	10	05	04
2 or more other methods	-	01	00	02	01	01	00	00	00	00	00	00

From the above it is seen that except for 2 communities in all the other the most popular method practised is female sterilization with the % using this method varying from 35-50%. In the other 2 communities (those chosen to represent the central middle strata) safe period is the most popular method, followed by LRT. The next most popular method in the other 8 communities is ^{the} safe period with the exception of couples in Hingurukaduwa where ^{have been done.} vasectomys ~~used~~. This method mix is similar to that found at the CPS. Of the temporary scientific methods either the loop or the pill was the most popular with the exception of the 2 communities in the Southern dry zone. In these 2 communities situated in Moneragala § 13 - 14 ; pf the couples were using depo-provera (DP) .

available

It is interesting to note that DP was first made/by the Govt. in the early 1980s. on a pilot basis to backward areas (Moneragla being considered one of these areas) where other methods were generally not available. (*)

The question that arises from these results is whether the fair^{ly} large percentage practising traditional methods in these project areas are using the most effective method. In other words are they practising these methods correctly and whether accidental pregnancies are fairly frequent or not . Data on this latter aspect was not collected.

On the other hand those who were using the pills, were asked a few open ended questions on the manner in which they were taking the pill. Since only 41 women in the experimental areas and 21 women in the control areas were using this method the data is presented in terms of the experimental and control areas.

The first question the pill users were asked was " How many days after menstruation begins should the first course of pills be taken ? " It is seen that 4-70% of the respondents in the experimental and control areas knew that the first course of pills should be taken either on the 1st. day or within 5 ^{days} ~~days~~ of the beginning of menstruation. Further another 17% in the experimental areas and 6% in the control mentioned that it should be begun on the last day of the menstrual period. This is generally not the answer expected since the correctness of this answer would depend on the individual respondent, (the last day could fall within the 1st. 5 days , if the respondents period was for 3-5 days) . Thus those who really did not know the correct answer were, those who didn't know, those who started it should be started before menses starts etc. This group constituted 30% in the experimental areas and 25% in the control areas.

Knowledge regarding what should be done if you forgot to take the pill for one day was also ascertained from pill users. In this context over 85% of the respondents knew that two pills should be taken on the second day, ^{thus} revealing that those using the pill had a good knowledge regarding this aspect.

DP was introduced islandwide by the govt. only

As to the question, as to whether they take the pills on the days they have their menstrual period, ~~at~~ less than half the respondents stated that they did so - thus revealing that regarding this aspect pill users were not practising the method as generally recommended, though they would not be at ^{risk} ~~visits~~ for not taking the pills during this period.

TABLE - 4/4

OF THOSE USING THE PILLS - THEIR KNOWLEDGE LEVELS AND METHOD
OF USING

		EXPERIMENTAL	CONTROL
When to Start	On the first days of menstrual period	15	33
	Within 5 days of beginning of menstrual period	39	39
	On the days menstrual period stops	17	6
	Before the beginning of the menstrual period	2	6
	Don't know	7	11
	Other	20	5
Forgot to take the pill	Take 2 days on the next days	88	86
	Skip Sleep the forgotten pill	3	5
	Other	9	9
% taking pill during menses		46	48

Thus the picture that emerges is that the majority of pill users have a knowledge of when to start using the pills, and what to do if they forget to take the pill on one day. On the other hand less than half the pill users take the pills on the days they have their menstrual period.

The next question that needs investigation is whether the most appropriate method is used by those practising family planning. In this regard the contraceptive use pattern of those not desiring any more children is examined.

TABLE 4.5

CONTRACEPTIVE USE PATTERN OF THOSE COUPLES NOT WANTING ADDITIONAL CHILDREN

	EXPERIMENTAL						CONTROL						
	Kogalla	Ak. 500	M'kandya IV	Mayala	H'kaduna	ALL	T'walle	R'gana	M'kandya VI	Uduwa	M'Wunas	ALL	
% of couples not wanting additional children.	61	51	65	67	57	61	64	72	66	65	64	66	
% Using perm. method.	35	60	47	47	65	42	43	48	42	31	53	43	
of those not wanting additional children	% using scientific temp.	09	03	12	12	07	09	10	05	07	04	03	06
	% using trad.	15	07	15	15	03	16	17	17	16	31	09	19
	% not using	41	30	26	26	25	33	30	30	35	34	35	32
	Total	100	100	100	100	100	100	100	100	100	100	100	100

The above table indicates that 40% of the couples who do not desire additional children in both experimental and control areas are protected by a permanent method. On the other hand, one third of the couples are not using a method, while over 15% are practising a traditional methods.

When individual communities are considered, it is seen that only about one third of the couples not desiring children in Kogalla and Uduwa are practising a permanent method while over 40% are doing so in Akkara 500 and H'kaduna. Though only 31% are practising a permanent method in Uduwa it is seen that since another one third are practising traditional methods, it is only one third of the couples who are not protected at all.

Examination of the reasons given by those not practising a method though desiring no more children reveals that over 50% of the couples in the control areas and almost 40% in the experimental areas do not do so, because it is not essential or they believe they cannot conceive. Further another 30% do not do so because the wife has given birth to their youngest child fairly recently or because they

are breast feeding. Whether this latter groups intends to get a sterilization done in the future is not known. Reasons such as don't know how to obtain services, shy to ask are given by very few of the respondents. Even fear of side effects has been mentioned by less than 10% of the couples in both these areas, though about 30% of the couples have given this reason in Akkara 500.

TABLE - 66

REASONS FOR NOT USING A METHOD GIVEN BY THOSE NOT WANTING CHILDREN BUT NOT PRACTISING A METHOD

	EXPERIMENTAL						CONTROL					
	Kizalla	Akkara 500	M'landy 14	Mayala	M'landan	Akk	T'walle	R'gana	M'landy VI	Madawa	M'landan	Akk
1. Don't know any method.	0	0	5	6	-	-	-	-	-	-	-	-
2. Breast feeding	4	15	5	10	4	7	4	13	7	22	8	12
3. Child is young	19	23	35	25	14	22	30	19	29	11	32	23
4. Believe can't conceive	39	23	40	31	54	38	41	58	54	56	44	51
5. Fear of side effects	11	31	5	2	4	8	4	-	-	-	8	2
6. Spouse against	4	8	5	2	7	4	-	-	4	6	4	3
7. Don't know how to obtain services	-	-	5	4	-	2	-	-	-	-	-	-
8. Shy to ask	1	-	-	-	-	1	-	-	3	-	-	1
9. Husband gone abroad	5	-	-	-	-	2	11	-	-	-	-	2
10. Other	13	-	-	16	17	11	11	10	3	5	-	6
11. No special reason	3	-	-	4	-	2	-	-	-	-	4	1

Of those couples not desiring any more ~~more~~ children/presently practising a temporary method. Table 67 reveals that the reasons for not getting sterilized are many with no one reason predominating. Fear of getting the operation done, fear of the resultant side effects, satisfied with present method, husbands

disapproval, not being eligible for the operation due to ill health, a decision not being made as yet are among the reasons given by more than 10% of these respondents. On the other hand it is interesting to note that lack of facilities has been mentioned by less than 5% of the respondents in 6 of the 10 communities, with this % exceeding 10% only in Akkara 500. Examination of these many reasons given by the respondents indicates that it may be possible to motivate some of these couples currently using a temporary methods to switch to a permanent method.

TABLE - 5.7
PERCENTAGE DISTRIBUTION OF COUPLES WHO ARE CURRENTLY PRACTISING
A TEMPORARY METHOD AND DO NOT WANT ADDITIONAL CHILDREN BY
REASONS FOR NOT GETTING STERILIZED

TABLE - 5.7

Reasons given	EXPERIMENTAL						Control					
	Koggala	Akkara 500	Muthu- iv	Magala	Hingu- rukadawa	Total	Thelwa tta	Rajanga na	Muth- vi	Uduwa	M'nuwara	Total
Fear of facing an operation	32.8	-	21.4	10.5	23.1	20.1	11.8	3.2	-	11.9	18.2	9.7
Fear of resultant side effects	9.8	16.7	28.6	23.7	7.7	18.5	29.4	22.6	30	7.1	18.2	20.3
Don't know where and how to get operation done	-	-	-	9.2	7.7	4.3	-	-	-	-	9.1	0.7
Not Eligible for sterilization	9.8	16.7	10.7	5.3	38.5	10.3	2.9	-	10	9.5	18.2	6.5
Difficult in obtaining services	1.6	16.7	3.6	1.3	7.7	2.7	-	3.2	-	7.1	9.1	3.6
No decision made as yet	9.8	16.7	14.3	10.5	-	10.3	14.7	25.8	40	11.9	-	18.7
Satisfied with present method	6.6	16.7	10.7	9.2	7.7	8.7	17.6	35.5	5	11.9	-	16.7
Husband disapproves	14.8	-	7.1	19.7	-	11.1	11.8	6.5	15	38.1	18.2	19.6
Other personal reasons (lack of time etc.)	11.5	16.7	-	5.3	7.7	7.1	11.8	3.2	-	2.4	9.1	5.1
Other	3.3	-	3.6	5.3	-	3.8	-	-	-	-	-	-
Total	100	100	100	100	100	100	100	100	100	100	100	100

CHAPTER 2
KNOWLEDGE AND PRACTISE REGARDING SOME FAMILY HEALTH
ISSUES

The main task of the volunteers is to motivate couples to use contraceptives. In addition volunteers are expected to impart knowledge on certain family health issues, especially such as telling mothers of the advantages of breast feeding and informing pregnant mothers of the venue and dates of the ante-natal clinics and what time ^{during} ~~in~~ their pregnancy they should attend these clinics, making sure that mothers take their infants for the full course of immunizations, persuading families to build their own toilets etc.

In order to find out the manner in which volunteers are carrying out these additional tasks, baseline data was collected on the knowledge of mothers regarding spacing of births and breast feeding duration and their practises regarding attending of clinics by pregnant mothers, the immunization of children under 5, giving of ORT to children who have had diarrhoea and giving kola kanda to their families.

5.1 Knowledge levels :

Knowledge levels regarding spacing of children and breast feeding of infants was obtained from the respondents in terms of ideal interval between two births and ideal breast feeding duration . The results are presented in the following table.

TABEL 5.1

M E A N	EXPERIMENTAL						CONTROL					
	Kogala	Akkara 500	Muthu- iy	Megala	H'kaduwa	A L L	Telwatta	R'gana	Mut.vi	Uduwa	M'nuwara	A L L
Mean ideal birth interval	47.4	45.4	49.6	52.8	42.6	47.6	45.0	48.5	48.1	50.4	41.1	46.8
Mean Ideal breast feeding duration	20.1	21.9	20.9	27.5	22.2	25.2	24.2	21.0	21.2	27.0	27.0	25.7

It is seen from the above that the mean ideal birth interval between 2 births is considered to be approximately 4 years in all the 10 communities with the lowest ideal interval being about 3 1/2 years in the Hill region and highest being 4 1/4 years in the intermediate zone. It must be remembered that this is the ideal birth interval. In practise most respondents wanting another child, wanted to have the child in about 2 years time (see table 3.4).

The mean ideal breast feeding duration is seen to be approximately 2 years in most of the communities with it being lowest in the relatively urbanized community Koggala and highest in the dry zone colony - Muthukandiya iv.

5.2 Practises :

In recent years there has been a concerted effort by the government to achieve a complete coverage of all infants in their immunisation programme and to educate mothers to give ORT to children when they have diarrhoea. Present practise levels regarding these are seen in the following tables 5.2 and 5.3.

Of children under 5, the percentage who have been given the full course of triple (also polio)^{*} is seen to vary between 55% and 75% . In this regard ^{fairly} family wide variations are seen between the experimental and control communities in the Northern Dry Zone and intermediate zone. On the other hand those who have not been given or who stopped before completing the course is round about 8% in the experimental areas and 2% in the control areas. While about 25% of the children are in the process of obtaining their immunizations.

* Though information was obtained separately regarding polio and triple , the results are similar in that both these are given together.

TABLE 5.2

% OF CHILDREN LESS THAN 5 YEARS WHO HAVE RECEIVED
THEIR IMMUNIZATIONS

	% of children who have been given	EXPERIMENTAL						CONTROL					
		Koggala	Akkara 500	Muthu.iv	Megala	H'kaduwa	A L L	T'watte	R'gana	Muthu'vi	Uduwa	M'nuwara	A L L
TRIPLE	Given fully	71	64	69	55	75	67	66	75	74	74	72	72
	Given partly and stopped	3	12	3	3	4	4	1	1	2	-	3	1
	Not given at all	3	6	3	6	2	4	1	-	1	1	-	1
	In the process of giving	23	18	25	36	19	25	32	24	23	25	25	26
	Total	100	100	100	100	100	100	100	100	100	100	100	100
	Given fully	71	64	69	64	75	69	66	74	74	74	72	72
P.G.I.C	Given partly and stopped	3	12	3	1	4	4	1	3	2	-	3	2
	Not given at all	3	6	3	6	2	4	1	-	1	-	-	-
	In the process of giving	23	18	25	29	19	23	32	24	23	26	25	26
	Total	100	100	100	100	100	100	100	100	100	100	100	100
BOG	Given	99	95	99	91	94	95	100	100	96	99	98	99

The position regard the BCG^{vaccination} is seen to be extremely good with over 95% of the children under 5 in 9 communities having had the injection. This is a result of the practise of giving this injection in hospital within the first two or three days^{at} a baby's birth.

Current practises regarding the use of ORT when their children have diaorrhoea was obtained from the respondents and is presented below :

TABLE 5.3

DISTRIBUTION OF MOTHERS WHO HAVE GIVEN ORT TO CHILDREN

Mothers	EXPERIMENTAL						CONTROL					
	Koggala	Alkara	Muth. I	Magala	N'kaduwa	A L L	T'watta	R'gana	Mu'vi	Uduwa	M'nuwara	A L L
Of mothers whose children have had diaorrhoea	20 (54)	25 (23)	19 (19)	22 (37)	20 (24)	21 (157)	15 (19)	8 (8)	18 (17)	2 (2)	20 (22)	13 (68)
Frequently	54	30	47	32	8	38	21	100	29	50	18	32
Occassion-ally	2	-	6	11	8	5	10	-	-	-	-	3
Not given at all	44	70	47	57	84	57	69	-	71	50	82	65

It is seen that wide variations are prevalent among mothers in the 10 communities regarding the giving of ORT to children. In this regard it must be noted firstly that many more mothers in the experimental areas stated that their children have had diaorrhoea and secondly that the giving of ORT to children is a practise that the government started to popularize within the last 2 - 3 years.

Another relatively new practise that the government health workers are trying to persuade mothers to give their children is the giving of kola kanda . Kola Kanda has been found to be cheap and very nutritious. The following table shows that apart from mothers in the two upcountry communities and in Akkara NO, more than 75% of the mothers have given their children kola Kande at least occasionally, if not frequently. This practise is seen to be fairly similar between the experimental and control communities, with the exception of the communities in the Hill Region and Northern Dry Zone.

TABLE 5.4

DISTRIBUTION OF MOTHERS WHO GIVE KILA KANDE TO THEIR CHILDREN

% giving Kola Kande	EXPERIMENTAL						CONTROL					
Frequently	39	15	49	56	23	38	32	24	37	55	3	31
Occasionally	45	39	36	29	30	37	46	65	42	28	26	42
Not at all	16	46	15	14	47	25	22	11	21	17	71	27
Total	100	100	100	100	100	100	100	100	100	100	100	100

Use ~~and~~ of toilets ~~at~~ is yet another practice that health workers are trying to promote. A question was asked from the respondents regarding the type of toilet the family used.

TABLE 5.5

Type of Toilet	EXPERIMENTAL						CONTROL					
Pit	24	64	82	56	85	55	9	78	70	62	60	55
Ducket	-	2	1	-	-	-	1	-	1	5	-	1
Water Seal	44	7	4	12	4	20	48	15	8	25	15	24

The above table shows that the % of families not using a latrine varies from 6% in Akkara 500 to 42% in Thelwette. Wide differences are noted between the experimental and control areas. This percentage is highest in the two relatively urbanized wet zone communities where as could be expected the % using waterseal toilets is the highest (over 30% in both communities).

In addition to promoting ^{the health} of infants and children, family health workers also focus on the health of pregnant women. One of the most important aspects in this regard is to see that pregnant women attend the ante-natal clinics regularly. Data regarding this aspect was collected during this survey and is presented in table 5.6. Which shows that the % of pregnant women attending clinics is highest in the inter-mediate zone, (over 60%) and is lowest in Muthukandiya iv. (37%)

TABLE 5.6

% of Pregnant women attending ante-natal clinics

	EXPERIMENTAL						CONTROL					
	Koggala	Akk.500	Mu.iv	Magala	H.kadu	ALL	T'watte	R'gana	M'vi	Uduwa	M'nuwara	ALL
Regularly	45	56	37	69	42	47	50	41	42	78	50	54
Occasion-ally	-	8	21	8	12	8	18	6	8	-	4	7
Not atten-ded	4	18	16	-	21	11	14	12	8	-	21	12
Less than 3 months	5	18	26	23	25	34	18	41	42	22	21	27

Visits by health workers :

Health workers, primarily governmental (such as the midwife and PHI) and sometimes in addition nongovernmental (eg: Sarvodaya workers, FPA volunteers) visit rural homes and educate mothers on various aspects of health care such as family planning , nutrition, sanitation etc.

Base Line data was collected on whether governmental or non-governmental workers have visited the respondents homes within the last 3 months.

TABLE 5.7

OF
% FAMILIE VISITED BY GOVERNMENTAL AND NON-GOVERNMENTAL HEALTH WORKERS

% visited by	EXPERIMENTAL						CONTROL					
	Koggala	A.500	Mu'iv	Magala	H'kadu	ALL	T'watte	R'gana	Mu'vi	Uduwa	M'muwara	ALL
Governmental health workers	-	22	28	28	8	14	-	31	8	36	64	37
Non-governmental workers	-	1	-	-	-	-	-	-	15	-	-	2

Above table shows that government field level officers have visited at least some homes in 8 of the 10 communities (exception being the two wet zone communities) . Both these communities do not have a midwife living within the village. The two other communities which also experience a similar situation are Akkara 500 and Muthukandiya vi. (see table 2.3) In the latter community only 8% of the homes have been visited by a government officer, while more than 20% of the homes have been visited in Akkara 500 inspite of having no resident midwife. On the other hand though there is a resident midwife, in Hingurukaduwa only 8% of the homes have been visited.

As far non-governmental workers , only 15% of residents in Muthukandiya vi have had visits from such workers.