PD-AAP-202

INTERNATIONAL HEALTH PROGRAMS

POPULATION SECTOR REVIEW
SRI LANKA

AMERICAN PUBLIC HEALTH ASSOCIATION
International Health Programs
1015 Fifteenth Street, NW
Washington, DC 20005

POPULATION SECTOR REVIEW
SRI LANKA

A Report Prepared By:
STEVEN W. SINDING
JOHN J. DUMM
JOSEPH S. TONER

During The Period:

OCTOBER 31 - NOVEMBER 23, 1983

Supported By The:
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
(ADSS) AID/DSPE-C-0053

AUTHORIZATION:
Ltr. AID/DS/POP: 4/4/84
Assgn. No. 582212

CONTENTS

	Page
INTRODUCTION	i
I. POPULATION GROWTH IN SRI LANKA	1
II. FAMILY PLANNING SERVICE PROGRAMS	3
Ministry of Health: Family Health Bureau	3
Family Planning Association of Sri Lanka	5
Community Development Services	6
Sri Lanka Association for Voluntary Surgical Contraception	6
Population Services International	7
Natural Family Planning	7
III. FUTURE PROGRAM DIRECTIONS	9
What Kind of Bilateral Support?	10
Components of Public Sector Support	11
Coordination, the Private Sector and NOGs	12
Coordination	13
Policy Coordination	13
Role of NGOs	14
APPENDIX A - Itinerary for Population Review Team	

INTRODUCTION

This report is presented in response to a USAID/Sri Lanka request for a review of the population and family planning program in the country and for recommendations on the future rule of AID in support of the Sri Lanka program. It is intended to help the AID Mission to make decisions regarding both the substance of population program assistance and the manner in which it is provided. Our central recommendation is that the Mission undertake bilateral support of both public and private sector programs as soon as possible.

The report is organized in three parts following this introduction: a brief overview of the demographic situation; a review of the present national program, both public and private; and our recommendations for future program directions. We have not annotated the volumes of documentary material we reviewed in the course of preparing our findings. However, the documents are all available for review in the Health, Population, and Human Resources Division of USAID/Sri Lanka.

The report was prepared during a three-week visit to Sri Lanka, following several weeks of preparatory literature review in Washington (Sinding and Toner) and Manila (Dumm). We were able to meet and talk in some depth with every key figure on the Sri Lanka population scene. A copy of our schedule is listed in Annex A.

While we cannot list here everyone whose hospitality we enjoyed, we would like to express our special thanks to Bill Johnson of USAID/Sri Lanka, our host, advisor, and confessor during our stay in Colombo, and to his assistant, Dr. Gnani Thenabadu; Mr. Daya Abeywickrema, FPASL; Brig. Dennis Hapugalle, CDS; Mr. Terry Louis, PSI; Mr. P.K. Dissanayake, SLAVSC, who made our travels to see their field activities a particular delight; Dr. Wickrema Weerasooria, Secretary, MOPI, for his kind hospitality and attentiveness; and Drs. N. Vidyasagara and K. Wickremasuriya of the Family Health Bureau for making our review of the Government's MCH program most rewarding.

POPULATION GROWTH IN SRI LANKA

The demographic situation in Sri Lanka is well documented. Thorough analyses of fertility and mortality differentials among ethnic, religious, social, and economic groups are current and reliable. The purpose of this section of the report is not to repeat what already has been reviewed by the AID Mission, but rather to highlight those demographic features that we found to be most important and relevant to our scope of work. For this reason, most of the comments in this section relate to fertility and to the implications of population growth.

The population of Sr Lanka has more than doubled in the post-war era from 6.6 million in 1946 to over 15 million today. If the present fertility rate remains constant, the population will rise to 23 million in 17 years, a increase of 53 percent, and to 36 million by the year 2025, an increase of 140 percent over today's level. While Sri Lanka's average annual rate of growth declined from 2.2 percent per annum in 1970 to 1.79 percent in 1981, its rate of natural growth (births minus deaths) has actually increased slightly during the past few years due to an increase in the Crude Birth Rate (CBR) and a decrease in the Crude Death Rate (CDR). The natural rate of increase now stands at 2.15 percent, only 0.14 of a point lower than the rate measured in 1970. This rate of natural increase is higher than India's (2.0), and Indonesia's (1.7), and is equal to Thailand's. Almost all of the decrease in the rate of population growth since 1970 has been the result of outmigration. This migration is likely to taper off or even to reverse itself in the coming years. Therefore, unless there is a significant decrease in fertility, the population growth rate in Sri Lanka will likely increase.

Since 1960, age specific and marital fertility rates have declined for all age groups and for all social strata. However, while the Total Fertility Rate (TFR) in Sri Lanka declined from 4.22 in 1970 to 3.66 in 1981, the CBR only declined 1.8 points, from 29.4/1000 to 27.6/1000. The very modest decrease in the CBR is attributable to the large increase in the number of women in the reproductive age group. The number of women of reproductive age increased by 33 percent from 1971 to 1981. It is expected to increase again by 16 percent between 1981 and 1991. Unless there are significant decreases in fertility rates or increased outmigration to offset this growth in the number of child bearing-aged women, the CBR will increase and so will the rate of population growth.

It seems very apparent to the team that the relatively high rate of population growth will become an even greater factor in Sri Lanka's development equation than it has been

in the past and that unless there is a significant and rapid decrease in fertility, population growth will diminish development prospects for the remainder of this century and perhaps beyond.

FAMILY PLANNING SERVICE PROGRAMS

A major part of the scope of work is to evaluate the impact of the existing family planning service programs of the Government and the four major NGOs and to evaluate the impact of AID central population assistance. Time did not allow us to measure the impact of the programs we reviewed. However, because we were able to discuss these programs with a wide variety of professionals and to visit the service programs of these organizations, we believe that the comments that follow are accurate and reflect what we were told and what we saw. Since we were not able to discuss program activities with representatives of the centrally-funded intermediaries, our comments in regard to the impact they are having on the program are implicit in our review of the projects they support.

In general, the team was impressed with the dedication and high level of competence and professionalism of the staff of the Family Health Bureau and the four NGOs. It seems clear that the successes of the Sri Lanka family planning program are due in large part to this factor. It also seems clear that in general the resources that the AID centrally-funded intermediaries are providing are solid investments. How cost effective they are and how much impact they are having are questions that we can only speculate on, given our time limitations.

AID currently provides about 0.5 to 0.7 million dollars of annual support through nine intermediaries. This level of support does not include the annual assistance provided by UNFPA and IPPF which totals approximately 1.5 million dollars.

Ministry of Health: Family Health Bureau

The Family Health Bureau of the Ministry of Health is responsible for managing the Government's family planning program. In the field, the Medical Officer of Health (MOH) is primarily responsible for the supervision of the program and provides sterilization and IUD services as well. Voluntary sterilization services are currently provided at 107 institutions. The MOH is responsible for certifying that physicians at these centers are capable of providing sterilization services. Of the 668 service centers that theoretically could provide IUD services, only 450 are currently providing them. Pills and condoms are available at almost all levels of the Ministry's service structure.

During our visit we had the opportunity to review the Ministry's program at all levels of service delivery. However, we concentrated our review on the role of the Family Health

Worker (FHW) since the Government has made the FHW the focal point of its primary health care program, including family planning. With 18 months of training, the FHW is one of the better trained peripheral workers in any primary health care program in the world. The goal of the Government is to have one FHW for ever 3,000 people. Roughly 75 percent of the required number of FHWs have been trained and posted. The Government expects to have all posts filled by the end of 1984. Most recently, many of those chosen to be trained as FHWs have been selected from the Job Bank. There was concern expressed to us that these workers might be less motivated and hard working than the earlier batches of trained FHWs.

While the operational details of the Government's primary health care programs have not yet been fully worked out, we were impressed with the soundness of the design of the delivery system for family planning and the implementation aspects of the program we reviewed during a field trip. Unlike the case in most countries where governments have provided inadequate training to volunteers or semi-volunteers, Sri Lanka is in the process of training and fielding a professional cadre of qualified paramedics who receive a full-time salary. We were equally impressed with the plans to delineate the job functions of these workers so that they are responsible for six basic functions centered around MCH and family planning services, with a number of other supporting functions. This emphasis on selective care should help to insure that family planning services are not forgotten in the rush to provide curative services.

Another area that will help to insure the effectiveness of the FHW is, of course, supervision. Since there are many vacancies among the ranks of the MOHs, the principal supervisors of the FHWs, and since those who are posted find it difficult to travel because of fiscal restrictions, there is concern that the FHWs will not receive adequate supervision. Close supervision will be required, especially for the new FHWs, because of their lack of experience and need to instill strong motivation.

Another area that we think will need strengthening is the training of the FHWs. While we had the opportunity to visit a training session and interview FHWs who did seem to know contraceptive technology and other related family planning issues, a review of their curriculum revealed very little family planning content.

During our review of the Family Health Bureau's family planning program we concentrated our assessment on the service delivery aspects of the Ministry's program, as we were requested to do in the scope of work. However, we feel it appropriate to add here that we were impressed with the Family Health Bureau's

Research and Evaluation Division. Unlike many other Ministries of Health, the Family Health Bureau has an accurate and up-to-date assessment of its program and has undertaken a number of useful research projects to help examine issues which surface in the review of service statistics.

The Family Planning Association of Sri Lanka (FPASL)

The FPASL currently manages two large family planning service projects. Its principal program is its rural community outreach program with a national network of volunteers who assist the people in a selected number of villages to undertake a variety of development and income generating activities. Family planning motivational activities and linkages to government primary health care and family planning services are integral components of this program. The second large service project managed by FPASL is the social marketing project which is national in scope. The FPASL also maintains a large, full-service clinic in Colombo and uses this facility to train medical and paramedical personnel in contraceptive technology.

The FPASL's rural community program is now operating in 1,000 villages and can increase its coverage only at the rate of 240 villages a year. We were impressed by the enthusiasm and commitment displayed by the volunteers and by what seems to be effective ways of working with the community and with government midwives. It seems likely that the approach that FPASL is using to gain community acceptance and involvement in family planning can have an impact if the FPASL could cover a larger number of villages. Before this program is expanded, however, an evaluation is needed to determine whether or not expansion is warranted on cost effectiveness grounds.

FPASL's social marketing project provided 108,003 couple years of protection during 1982. This was a slight reduction in coverage from the level of protection that was provided during each of the last three years. However, FPASL recovered 99 percent of its operational costs in 1982 versus an average of 74 percent for each of the past three years. The level of advertising and promotion has fallen in recent years and data indicate that sales are stagnating.

We received a wide variety of advice on what was needed to increase the effectiveness of the social marketing project. However, everyone with whom we discussed this project agrees that social marketing in Sri Lanka can play a much more important role than it currently is playing in increasing the use of spacing methods.

Community Development Services (CDS)

The principal service project under the management of CDS is its Integrated Community Development and Family Planning Services Project which is financed by FPIA. Under this project, CDS trains and supervises a cadre of Community Health Workers who refer women to government centers for primary health care services including family planning. In addition, assistance is provided to communities in the design and implementation of community development projects. This project is currently active in seven Districts with plans to expand into three additional ones. CDS also supports a large and well-managed full-service family planning clinic in Colombo that emphasizes vasectomy services.

In some respects, CDS's approach in working with the community to gain acceptance and use of family planning is similar to the approach used by the FPASL. Both approaches are community development as an entry into the community; both approaches emphasize comprehensive family well-being; and both approaches work closely with government widwives as the link to the provision of services. A principal difference, however is that FPASL uses volunteers in its program while CDS uses paid workers. We believe that the cost-effectiveness study we suggested for the FPASL program could also look at CDS to determine exactly how effective this type of community approach is in gaining acceptance and use of family planning services. An important issue here is to determine the extent to which the inputs for community development projects actually contribute to community acceptance of family planning. In Sri Lanka, where everyone we met indicated that increased services were the top priority, the team feels that in the current period of severe budget constraints for population programs, it is essential to take a close look at the advisability of devoting population funds to community development projects.

Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC)

SLAVSC has been receiving support from IPAVS since 1978 and currently receives four special project grants and one general program grant. The role of SLAVSC in the program is to provide IEC and motivation support for sterilization services and to develop and maintain medical standards for sterilization services. Recently, SLAVSC has begun to emphasize counselling as part of its leadership role in sterilization.

SLAVSC has not undertaken a large service provider role and, in view of the emphasis the Government has placed on providing sterilization services, we believe that this is appropriate. It also seems highly appropriate to us that

SLAVSC has assumed the leadership role in communications, establishing minimal medical standards, and counselling. We feel that SLAVS should continue to play this role and that IPAVS should continue to provide the resources to enable it to do so.

Population Services International (PSI)

PSI's principal role in the program has been to initiate and implement FPASL's social marketing project in its first two years. Currently, it is managing programs in the promotion of breast-feeding and oral contraceptives, and has sponsored an innovative project with ayurvedic practitioners. PSI has trained over 2,000 ayurvedics in family planning and now mails them pills, condoms, and information material. Over 70 percent of the ayurvedics who were originally trained have stayed in the program.

This approach to resupplying a large number of medical personnel is an innovative and probably cost effective way of supplying a large cadre of workers. It is the nucleus of what might become a larger social marketing project to sell contraceptives to segments of society not normally included in family planning programs. This type of innovation and experimentation with new ways to increase spacing methods should be supported by the intermediary organizations working in Sri Lanka. PSI also manages a full service family planning clinic in Colombo.

Natural Family Planning

As part of the Scope of work, the Mission asked us to suggest ideas for improving the use of natural (also called "traditional") family planning methods. We defer on this request because a) the data are contradictory and confusing, and b) Family Health International (FHI) will be assisting the Government in a major effort to clarify this issue in early 1984.

III. FUTURE PROGRAM DIRECTIONS

FUTURE PROGRAM DIRECTIONS

The central recommendation of our report is that USAID begin high level discussions in earnest with the Government of Sri Lanka, leading toward bilateral population program support in FY 1985. Our reasons for this conclusion are several. First, among the various health and population variables of interest and concern to AID and the Government, fertility is clearly the one in greatest need of attention. Mortality, including infant and young child mortality, has fallen to low levels by any standard and is unlikely to fall much further in the near future. Likewise, morbidity has declined significantly since 1970. While there are several actions AID can take to further improve the health situation in Sri Lanka, none would appear more important than family planning service support. With a crude birth rate that has hardly declined since 1975 and a rate of natural population increase of over two percent per year, Sri Lanka's principal health sector problem is excessive population growth. Indeed, one of Sri Lanka's primary development problems remains rapid population growth, the publicity about the country's population "success story" notwithstanding.

A second reason for our recommendation that the Mission undertake bilateral population support is a strong sentiment on the part of public and private sector Sri Lankans with whom we spoke that such support would be timely. With Swedish population aid very probably ending, with no other source of increased international assistance apparent, with recently increased GSL resource constraints, and with a strong public program likely to continue for several more years, there are very good reasons for the United States to seriously consider direct program support at this time.

Third, central AID funds which have heretofore been in relatively abundant supply are becoming scarce. Many of the NGO activities in Sri Lanka which have been supported through centrally funded AID intermediaries will have to find alternative sources of funds if they are to continue at their present pace. A bilateral project would be one potential alternative to central AID population support for these programs. It would help to assure that there would be adequate future support for vital NGO activities in the population sector.

We recognize that in years past both the Government of Sri Lanka and the United States Government have from time to time considered bilateral population program support politically sensitive. Those with whom we spoke on this visit felt that population assistance per se was not sensitive but acknowledged that a bilateral project might run the risk of being used for political purposes. However, the majority opinion was that with

proper design and coordination, the risk of that happening is not high. Everyone we spoke with who advocated a bilateral project did so after taking into consideration the political issues involved.

What Kind of Bilateral Support?

We think that bilateral support should be provided both to the Government's Family Health Bureau and to private organizations through the Population Division of the Ministry of Plan Implementation. However, this general objective could be accomplished in several different ways. AID could provide support to the Family Health Bureau through the proposed new Preventive Health and Family Planning (PH & FP) project and to MOPI and the private sector by means of a separate project. Alternatively, there could be a single new population project, separate from the health project, that would provide support for both the public and the private sectors. A third approach would be to provide all support through the proposed new PH & FP project. We suggest that, because of the political sensitivities alluded to above, support for public sector services should be in the context of a maternal and child health care package of the sort envisioned in the PH & FP project.

Whatever implementation approach is selected, we feel that it should include support for both publicly and privately provided family planning and associated services. There is ample room for both sectors to expand and improve their performance in Sri Lanka; we can see no reason why AID should not support the efforts of both. Furthermore, we can see no reason not to begin family planning program support at once, given the high priority of this particular service.

No matter which approach the Mission selects, we deem it essential that a full-time American population officer be assigned at the earliest possible date to assist in program design and implementation. Because of the complexities in the organization of population services in Sri Lanka, a full-time officer will be required to design and manage AID inputs. The function, however, could be handled either by a personal services contractor or by a direct hire. In addition to designing and monitoring direct bilateral inputs, such an officer is essential to coordinating and monitoring the activities of the centrally-funded intermediaries to the extent they remain actively involved in Sri Lanka. In view of the absence of bilateral support, we believe that the Mission has not given enough attention to centrally-funded intermediary programs in the past.

Components of Public Sector Support

The population program in Sri Lanka has been overwhelmingly biased toward sterilization for many years To many Sri Lankans the term "family planning" is synonymous with sterilization. While sterilzation must remain an important component of the program, we believe the time has come to give substantially greater attention to temporary family planning methods, most notably injectables, the IDU, the oral pill, and the condom. Depending on the outcome of the FHI-assisted research project discussed above, natural family planning could be included in this list.

Most Sri Lankan officials with whom we spoke agreed that more emphasis should be given to what here are termed "spacing methods." They said that these temporary methods are needed to increase the demographic impact of the program by lowering fertility among the younger age groups. At present, Sri Lankans tend to delay marriage until comparatively high ages, then to bear children in rapid succession before terminating childbrearing by means of sterilization. Greater spacing of births would have the dual benefit of lowering fertility and at the same time improving the health of both mothers and infants.

AID is, of course, precluded from supplying Depoprovera, the only injectable manufactured in the United States, because it has not been approved for contraceptive use by the U.S Food and Drug Administration. However, there is universal agreement among those with whom we spoke in Colombo (including the UNFPA Deputy Representative and Coordinator, Dr. Vanderportaele) that it would be desirable for USAID to assume responsibility for the provision of IUDs, pills, and condoms, thus freeing up UNFPA resources to import Depoprovera. (At present UNFPA provides all contraceptives to the Government program, while AID, through IPPF and FPIA, provides orals and condoms to FPASL and CDS.)

Regarding Depoprovera, the Government is somewhat reluctant to actively promote its use because of its expense (approxiamately $1.00 or Rs. 24.00 per dose). The Family Planning Association has similar concerns, yet both agree that it is in very strong demand and that, cost considerations aside, it should be actively promoted because it is probably the most effective spacing method for most women.

As we said, AID is precluded from providing Depoprovera for the time being. However, it would be possible for AID to support a study of the price elasticity of demand for Depoprovera. Such a study could provide guidance to both public and private providers regarding the price at which Depo should be offered,

thus transferring at least a portion of the cost to the user and making its wider availability more feasible. Since all users of pills and condoms are charged a nominal price for these commodities, it would be consistent with existing policy to charge for Depoprovera as well. The question is: at what price?

In addition to providing contraceptives, AID could contribute to an improved understanding of spacing methodologies and approaches in Sri Lanka by sponsoring a national conference on the subject. A particular focus of such a conference should be the Family Health Bureau which represents the single most important source of information and contraceptives nationwide, although at present it is falling far short of its potential.

It is equally important for the Government to improve the training and supervision of trained midwives (Family Health Workers) in family planning. A brief review of the current curriculum for FHW training suggests that insufficient attention is given to family planning techniques. Furthermore, it appears that the Family Health Bureau could give considerably greater priority to population and family planning among the tasks of the peripheral workers in the system. A bilateral project could assist the Family Health Bureau to strengthen its capabilities in both training and supervision to increase the effectiveness of its family planning service delivery program. It is our strong impression that, unlike many developing countries where rural services simply do not exist, in Sri Lanka the essential system is in place. Relatively well-trained full-time workers are in place. The system of referrals is sound. A modest strengthening of the system could produce significant gains in terms of fertility control and the management of diseases affecting mothers and children

The Mission will have to determine what the components of a public sector project should be. We suggest that the following be considered:

- Contraceptives
- Improved curriculum training, and supervision of FHWs
- Study trips to other Asian countries as incentives for workers and supervisors
- A national conference on spacing methods
- Research and evaluation studies

Coordination, the Private Sector, and NGOs

The biggest single problem in the Sri Lanka population program is the lack of adequate coordination between the public

and the private sectors, and among private sector institutions. Examples of the consequences of this lack of coordination abound: different contraceptives sold at different prices through different delivery systems but all in the same geographic area; paid workers competing with volunteers; different organizations claiming credit for sterilization referrals, and duplicative national family planning surveys, to name just a few.

Coordination

Like the problem of improving the effectiveness of the Family Health Worker program, a small investment in coordination could yield major improvements. The situation, far from being hopeless, is really only in need of some marginal improvements to become truly effective. The core of the problem seems to be the inadequate level of authority and understaffing (or lack of a permanent cadre) of the Population Division of the Ministry of Plan Implementation. Since 1977, the MOPI has had primary responsibility for the formulation of population policy and for coordination of population activities in the country. Unfortunately, it appears to us that, while population policy is generally clear and sound, coordination of planning, evaluation, and implementation has been deficient with respect to NGOS, with respect to lower units of government, and between MOPI and the Ministry of Health.

Of these three areas, the most serious is lack of coordination among the NGOs. Because of the relatively high degree of competitiveness among the NGOs, only government is in a position to adjudicate and resolve some of the differences. Yet the Population Division of MOPI has been reluctant or unable to resolve some fairly important disputes. The Population Division is severely understaffed at the present time. Before it could begin to play an effective coordinating role, it would have to be substantially strengthened in terms of manpower. We suggest to USAID/Sri Lanka that such a strengthening of the Population Division be made a Condition Precedent to disbursement of Funds under a bilateral population project. Furthermore, we suggest that before entering into an Agreement, the Mission assure itself that MOPI is prepared to play a far more active role than heretofore in assuring that the activities of the NGOs are fully complementary to those of the FHB.

Policy Coordination

The population Division of MOPI could play a significantly larger part in strengthening the role of the Government Agent in population work as well. From our limited exposure, it appeared to us that the Government Agents are not nearly as

active in coordinating District-level population activities as was originally envisioned. The District Population Committees appear to meet only sporadically these days. Furthermore, from what we were told these committees do not perform the intended functions of coordinating agency activities and encouraging enhanced performance. A strengthened MOPI Population Division, with staff specifically assigned to support and coordinate the work of the District Population Committees, could give new life to these units and make them truly effective local stimuli of population program momentum. One step toward revitalizing the District Population Committees might be a USAID-supported national workshop on the role of district and local governments in population program implementation.

Role of NGOs

As regards the private sector role in the provision of contraceptives, there is much that can be done. Spacing methods have long been the province of the private sector, most particularly the contraceptive social marketing activities of the Family Planning Association and Population Services International. The data we have seen suggest to us that contraceptive retail sales (CRS) of 'Preethi' and'Mithuri' could be substantially higher. Because the sales of these brands have to some extent stagnated in recent years, certainly in comparison with earlier rates of growth, we sugges that USAID consider supplying contraceptives to the CRS program, and also providing funds that would permit a major increase in advertising and promotion, the development of detailed marketing plans, and perhaps, continued subsidization of prices.

Along similar lines, it appears that the role of ayurvedic practitioners as providers of pills and, perhaps, condoms could be enhanced. PSI, FPASL, CDS and the Family Health Bureau have all had encouraging (albeit different types of) experiences with ayurvedic practitioners. Here, as in other areas, coordination has been less than optimal. We suggest that USAID, following the lead of the Population Division, support a unified program of training and assistance to ayurvedic practitioners for the distribution of consumable contraceptives.

Still another area for potential improvement is in collaboration between NGO field staff and the Family Health Bureau's Family Health Workers. USAID should consider working with the FHB and the NGOs, especially FPASL, to develop a plan under with NGO fieldworkers could be trained in conjunction with the midwives so that they could more effectively complement one another at the village level. At the present time it appears that, while there are some efforts to coordinate the work of Health Ministry employees and NGO field volunteers and workers, this coordination is not systematic and universal.

One way of overcoming this problem would be for the FHB to set aside a couple of days in the training of FHWs when FPASL volunteers or CDS Community Health Workers could join them for joint training on cooperative field activities.

Several people mentioned to us, and we were ourselves struck by, the comparative absence of promotional materials and other publicity for the population program, especially in the press and on radio and television. Particularly conspicuous by its absence in method-specific publicity and public promotion. It would seem that here, too, there might be a need for AID assistance to a coordinated public and private enhancement of information, education, and communication activities, especially those supporting birth-spacing. As a first step, we suggest that the centrally-funded Population Communication Services project be tapped to do a general needs assessment and to prepare a prototype I & E strategy for the country. The program of bilateral population support that we are proposing could then help to fund the implementation of the strategy.

As a final note and sort of postscript to this report, we feel strongly that the Mission should undertake a detailed review of the implications of population growth for Sri Lankan development in the years ahead. This review should be done in conjunction with the next updating of the CDSS. We feel that it would provide a much stronger basis than the Mission currently has for mapping out the AID development program in Sri Lanka.

APPENDICES

Provisional*

Itinerary for Population Review Team

(October 31-November 18, 1983)

nday, October 30, 1983

6:00	p.m.	-	Informal USAID reception.

nday, October 31, 1983

8:00	a.m.	-	Meet with W.H. Johnson, R.L. Chamberlain & G. Thenabadu in HPHR office (USAID Annex).
10:00	a.m.	-	Meet with S.J. Littlefield (Director, USAID) and W.P. Schoux (Deputy Director, USAID) in Director's office.
11:15	a.m.	-	Meet J.M. Miller, N. Mahesan & L.A. Ross (Program office) and R. Singleton, C. Schoux (PDSP) in USAID conference room.
12:30	p.m.	-	Informal luncheon hosted by Dr. W. Weerasooria (Secretary, MOPI) at his residence (5th Lane, #16).
3:00	p.m.	-	Meet Mr. D.P. Wijegoonasekera (Director, Population Division, MOPI), Representatives of FPASL, CDS, PSI, SLAVSC and GSL at Population Division, MOPI, 220/4, Havelock Road, Colombo 5.

ıesday, November 1, 1983

8:00	a.m.	-	Meet Dr. D. Vandeportaele (UNFPA Coordinator for Sri Lanka) at 202-204, Bauddhaloka Mawatha, Colombo 7.
10:00	a.m.	-	Meet Mr. L. Athulathmudali (Minister of Trade & Shipping & Chairman of the Parliamentary Committee on Population) at 7th Floor, Rakshana Mandiraya, 21, Vauxhall St., Colombo 2.
11:30	a.m.	-	Mr. Bradman Weerakoon (Secretary to the Prime Minister, Commissioner of Essential Services, & former Director, Indian Ocean Region, IPPF) at office of Commissioner of Essential Services, York Street, Fort.
2:00	p.m.	-	Meet Mr. D. Abeywickrema (Director, FPASL) at 37/27, Buller's Lane, Colombo 7.

To be confirmed with team members at meeting 3:00 p.m. October 31, 1983.

BEST AVAILABLE COPY

Wednesday, November 2, 1983

7:30	a.m.	-	Meet Dr. M. Fernando (Director of Health Services) at 5th Floor. Inland Revenue Building, Sir Chittampalam A. Gardiner Mawatha, Colombo 2.
9:00 ~~9:00~~	a.m.	-	MOPI Pop Division Meet Dr. N. Vidyasagara (Assistant Director, MCH) at Ministry of Women's Affairs & Teaching Hospitals (WATH), 231, De Saram Place, Colombo 10.
10:30 11:00	a.m.	-	Pop Info Center Meet Mrs. S. Ranasinghe (Minister, Ministry of Women's Affairs & Teaching Hospitals) and Dr. D. Samarasinghe (Secretary, WATH) at 231, De Saram Place, Colombo 10.
2:30	p.m.	-	Meet Dr. R. Atapattu (Minister of Health) and Mr. L. Panambalana (Secretary, MOH) at 5th Floor, Inland Revenue Building, Sir Chittampalam A. Gardiner Mawatha, Colombo 2.
3:30	p.m.	-	Meet Mr. A. Mohammed (Director, External Resources Dept.) and Mrs. S.L. Kuruppu (Deputy Director, ERD) at 15th Floor, Inland Revenue Building, Sir Chittampalam A. Gardiner Mawatha, Colombo 2.

Thursday, November 3, 1983

6:00	a.m.	-	Leave Colombo for Kandy. (Should arrive Kandy by 8:45 a.m.)
8:~~30~~ 45	a.m.	-	Meet Mr. P.K. Dissanayake (Director, SLAVSC) at No.2, Primrose Road, Kandy.
9:00	a.m.	-	Visit Kandy General Hospital.
9:30	a.m.	-	Visit Kandy Municipal MCH Clinic at Siyabalagastenne.
10:30	a.m.	-	Meet District Population Committee at Kandy Kachcheri (MOPI).
12:00-2:00	p.m.	-	Lunch.
2:00	p.m.	-	Kandy Hospital Meet Governing Board of SLAVSC.
~~3~~ 4:30	p.m.	-	Leave for Colombo.

BEST AVAILABLE COPY

18

Friday, November 4, 1983 (This is a GSL holiday)

9:30	a.m.	-	Meet Mr. T. Louis (Director, PSI) at Hotel Oberoi and proceed to 122/12, Arnolda Place, Kirillapone Avenue, Colombo 5.
10:30	a.m.	-	Field visit to PSI Clinic.
	noon	-	Lunch hosted by Mr. T. Louis.
7:00	p.m.	-	Reception hosted by Brigadier Hapugalle to meet Board Members of CDS.

Saturday & Sunday (November 5th & 6th), 1983 - Bell/Shoup lunch Hotel Saturday 12:30 Sunday dinner Daya

- Open.

Monday, November 7-Saturday, November 12, 1983 (Field Trip)

Monday, November 7, 1983

8:15	a.m.	-	Arrive Family Health Bureau, Ministry of Health at 231, De Saram Place, Colombo 10.
		-	Meet with Dr. N. Vidyasagara (Assistant Director, Maternal & Child Health) and staff.
9:00-12:00	a.m.	-	Observe family planning and maternal & child health activities at Family Health Bureau.
11			Natl. Plng. Mr Fernando
1:00	p.m.	-	Leave for Kottawa (45 minutes from Colombo).
1:45	p.m.	-	Arrive at Kottawa field midwives office . Observe midwives activities.
		-	Meet with Medical Officer of Health (M.O.H.).
5:00	p.m.	-	Leave for Colombo.
7			Drink w/ Terry Lowe at Hotel

Tuesday, November 8, 1983

6:00	a.m.	-	Leave for Kurunegala (accompanied by Dr. N. Vidyasagara).
8:30	a.m.	-	Arrive Kurunegala.
8:45	a.m.	-	Meet with Superintendent of Health Services, Kurunegala.
		-	Meet with Medical Officer of Health, Kurunegala.
		-	Visits to Divisional Drug Store, Peripheral Unit, Central Dispensary & Field Clinic.
		-	Overnight stay at Kurunegala or Kandy.

10 AM - Sat Malone - Pentecost Hotel

BEST AVAILABLE COPY

19

dnesday, November 9, 1983 10= USIS - Offer

8:00	a.m.	-	Meet with CDS staff (Dr. Wijetunga, Project Director & Mr. Evans Silva, District Organizer) at Kurunegala (new rest house by lake.
		-	Visit CDS District Office at Saragama.
9:30	a.m.	-	Meet Brigadier Hapugalle at Kobeiganne CDS Mothers Club.
	noon	-	Lunch.
1:45	p.m.	-	Visit Gam Udawa Model Village & Aswedduma Village.
12=		-	Overnight at Ranweli Resort, Waikkal.

Meet Sandy Jones for lunch

ursday, November 10, 1983

8:00	a.m.	-	Visit Integrated R.D. Project at Munakkara
11:00	a.m.	-	Leave for Colombo.
2:00	p.m.	-	Meet Mr. W.A.A.S. Peiris (Director, Department of Census & Statistics).
3=			UNICEF ??
3:15	p.m.	-	Visit CDS Suva Sevana Clinic, Cotta Road, Colombo 8, CDS headquarters (briefing, discussions).
6=	Drinks at SCJ's		

iday, November 11, 1983 7:30 Dinner at Bob Chamberlains

ASL Director, Mr. D. Abeywickrema will provide transportation.

~~8:00~~ 7:30	a.m.	-	Leave Colombo.
9:30	a.m.	-	Arrive Kalutara.
		-	Visit village in Kalutara District to observe FPASL program.
		-	Lunch at Bentota.
Afternoon		-	To observe village level family planning program (FPASL).
6:30		-	Return to Colombo. ESTATE PLNG

turday, November 12, 1983

~~8~~ 7:30	a.m.	-	Leave Colombo.
10:00	a.m.	-	Arrive Marawila. Cancel
		-	Observe the volunteer convention at the Marawila school.
		-	Lunch at Negombo.
2:00	p.m.	-	Leave for Colombo. (5:30)

BEST AVAILABLE COPY

20

6:00 Dinner with Secret

Sunday, November 13, 1983 - Open.

Monday, November 14, 1983 - Open. 9:00 Mtg MOPI w IPPF

Tuesday, November 15, 1983 - Open. Dinner w/ Bill Johnson

Wednesday, November 16, 1983- Open.

Thursday, November 17, 1983 - Open. 9:00 AM

Friday, November 18, 1983

9:00 a.m. - Discuss recommendations and report with MOPI, FPASL, CDS PSI. SLAVSC, MOH, WATH, USAID at meeting.

~~2:00 p.m. - Debrief Mission.~~

~~Saturday~~, November 19, 1983 - Departure.

Thursday " 17 10:00 P.M. "

BEST AVAILABLE COPY