

Table 2.3: New Entrants to Grade 1 with ECCE Experience (2001-2005)

Year	New entrants		Total	New entrants with ECCE		Total	% with ECCE		% Total
	M	F		M	F		M	F	
2000	170,531	163,361	333,892	129,837	128,368	258,205	76	79	77
2001	167,734	160,264	327,998	134,169	132,532	266,701	80	83	81
2002	165,513	160,250	325,763	138,736	136,305	275,041	84	85	84
2003	167,196	162,504	329,700	136,964	133,403	270,367	82	82	82
2004	154,101	149,170	303,271	135,913	132,842	268,755	88	89	89
2005	162,302	156,776	319,078	145,036	141,113	286,149	89	90	90

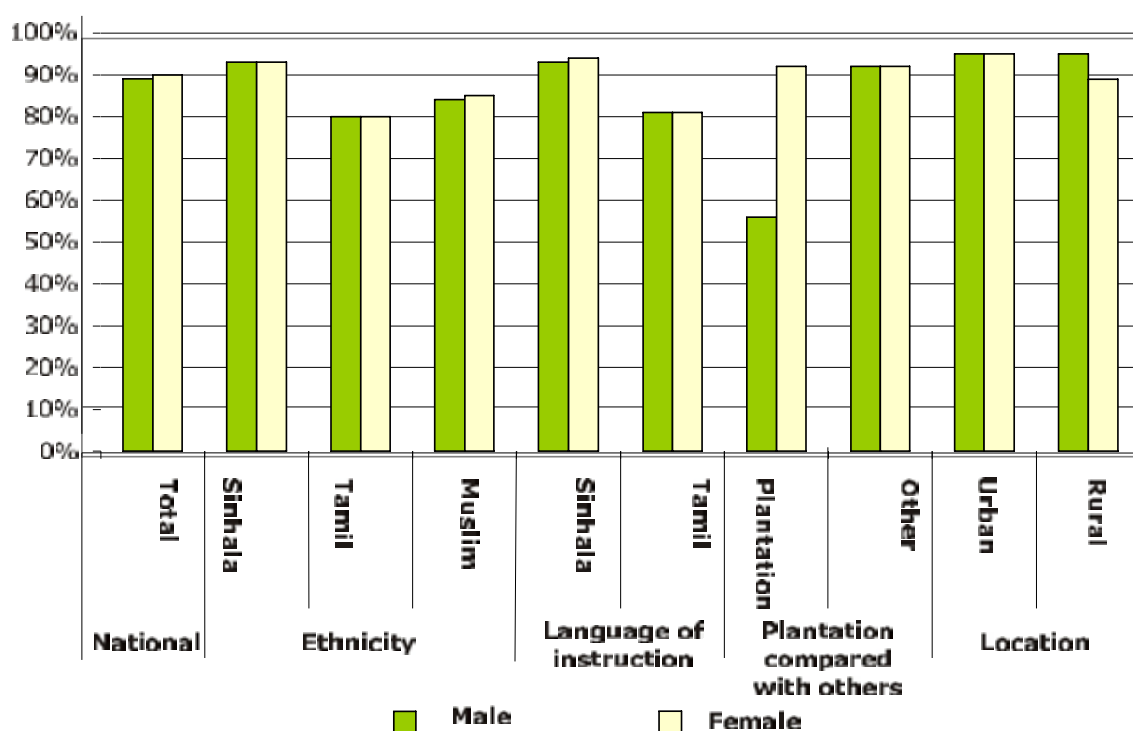
Source: School Census (MOE, 2005)

The ECCE programmes, the new entrants have experienced are likely to vary in many characteristics. However, the situation seems to be satisfactory and hopeful. Data depict the total percentages of new entrants to primary grades have increased every year.

The data also reveal that gender differences are not very significant in primary school enrolment and ECCE experiences. Sri Lanka seems to be on the right track of achieving the target expected in expanding and improving ECCE.

Percentages of New Entrants to Primary School with ECCE Experiences According to Country Specific Characteristics

Data gathered on new entrants to grade 1 could only be disaggregated by gender, ethnicity, medium of instruction, and geographical location. Plantation sector is also considered in Sri Lanka as a specific subdivision since it differs socially, culturally and economically from the other sections in the society. From the total percentage of children admitted to grade 1 with ECCE experience 89% were Males and 90% were females. Although there is no significant

Figure 2.3: Grade 1 Entrants with ECCE Experience

Source: (MoE 2005)

gender difference, 10% children not gaining any experience in ECCE should not be overlooked.

Tamils and Muslims are the main minority ethnic groups living in Sri Lanka. The percentage of Tamil children (80%) with ECCE experiences is less than the Sinhala (93%) and even Muslim children (85%). These two groups as a whole have gained less benefit from ECCE programmes than Sinhalese. Percentages of males and females exposed to ECCE are equal in relation to Tamils (80%) and only 1% difference in relation to Muslims (M 84% & F 85%). This shows that gender disparity is not a discriminatory factor among all sections of Sri Lankan society.

Sinhala and Tamil are national languages in Sri Lanka. When considering the medium of instruction the percentage of children who have ECCE experience in Tamil medium (81%) is lower than that of Sinhala medium (93%). Medium of instruction for a majority of Muslims and Tamils is Tamil language. Data reveal that to some extent Tamil medium children are at a disadvantage in receiving ECCD benefits. When compared with the other children in the Sri Lankan society male children in the plantation sector appear to have received the least benefits from ECCE Programmes; the percentage (56%) being the lowest. This should be considered as a serious issue specific for male children since 92% of female children have received some sort of an ECCE experience. Why male children in the plantation sector do not get this opportunity should be looked into. Further, if children in this sector are neglected, achieving the EFA Goal 1 in the targeted year would perhaps be only a dream.

The Plantation Sector of Sri Lanka

The plantation sector comprising mainly of tea, rubber and coconuts for export is considered as a vital factor in economy of Sri Lanka. A majority of workers in the tea industry are Tamils brought down by the British from South India during the colonial period. Due to this reason and the nature of the industry workers in the tea industry differ significantly from those of other industries in the plantation sector as well as other sectors in the society.

2.4.3. Private Sector enrolment as percentage of Total Enrolment in ECCE Programmes

Lack of data in relation to ownership and management of ECCE programmes makes it difficult to disaggregate enrolments in ECCE according management. Available data on simple surveys reveal ownership of preschools which are historically, the responsibility of the private and religious organisations. Studies have shown (*Wijetunegge & Wickremaratne, 2004; Talagala, 1997*) that a majority of preschools in Sri Lanka are managed by private institutions. The following table presents the percentages of categories of different management sectors of a sample of 6277 preschools. This data will help to surmise private centre enrolments in ECCE programmes for preschoolers to a certain extent.

There are more privately managed preschools in the Western Province than the other provinces. Only North Western and North Central provinces have more preschools managed by the public sector.

Table 2.4 : Category of Management by Province

Province	Private %	Public	Religious body	NGO
Western	60.5	08.3	14.4	16.7
Central	57.8	26.6	05.3	10.2
Southern	33.4	29.8	15.7	21.0
Northern	12.6	16.5	20.5	50.4
Eastern	23.6	21.8	13.8	40.8
North Western	32.0	33.0	09.0	26.0
North Central	14.6	59.9	11.0	14.3
Uva	35.0	25.5	10.2	29.1
Sabaragamuwa	83.8	07.9	03.7	04.6
Total(6277)	39.2	25.4	11.5	23.6

Source: National Study on Childcare provisions in preschools, Sri Lanka 2004

There are number of private schools (e.g. such St. Bridges Convent, Museus College) in the country that have preschools attached to their schools. However, these schools are answerable to the MoE only about the matters related to general education. International schools too have preschools and these schools do not come under the MoE. Therefore specific data related to private centre enrolment are not available to identify their role in ECCE programmes.

The data above does not reveal the quality of ECCE programmes experienced by Sri Lankan children. Conversely, the number of children in the plantation sector who receive ECCE experiences and the number of private preschools in some provinces depict that inequality that prevails in ECCE programmes and the experiences children receive.

2.4.4 Adult Child Ratio

Adult child ratio is an indication of quality provided by the ECCD Centres. However, no national surveys have been conducted to find out structural features such as adult (teacher) child ratios of Sri Lankan preschools or Child Development Centres. The minimum standards for Child Development Centres prepared by the Children's Secretariat (2006) indicate adult child ratio as 1:20. Children's Secretariat hopes to implement these standards to assure the rights of children for growth development and education.

2.4.5 Percentages of Trained Teachers in ECCE Programmes

Structural features of preschool services contribute immensely to the development of children in the early years. Qualifications of the care givers and wages paid to them are included in the structural features in a preschool setting (GAO, 2002). Both educational and professional qualifications are needed for preschool teachers to work successfully with young children. Since general education is the responsibility of the Government of any country acquiring educational qualifications is not an issue for ECCE care providers. However to acquire necessary skills related to ECCE care providers (preschool teachers and crèche workers) have to be provided with necessary training. Training in the Sri Lankan context could be defined as "what has been obtained other than on the job" (*Wijetunge and Wickramaratne, 2006*). The authors state that this definition is very general and inclusive. In view of the duration of various ECCE training programmes in Sri Lanka no other definition explains the term 'training' more appropriately. Improving and expanding training opportunities for care providers has been spelt out in the National Policy on ECCD. Minimum educational and professional qualifications required for care providers are specified in the "Guide lines for Child Development Centres" by the Children's Secretariat in the year

2006. Furthermore, provincial councils also have emphasised the need for training child care providers in their statutes. The North Western Provincial Council has specified that a “child development instructor” should possess at least a one year Diploma in

Preschool Education (Schedule II of the Gazette Notification of Democratic Socialist Republic of Sri Lanka, 2005,).

The current status of the training of ECCE care providers in selected provinces is shown in the following table:

Table 2.5 Status of the Training of ECCE Care Providers

Province	Trained		Untrained		Total No.
	No.	%	No.	%	
Western	2109	48.6	2227	51.4	4336
Southern	888	22.9	2988	77.1	3876
North Central	1682	78.8	453	21.2	2135
North Western	651	62.8	1538	37.2	1752

Source: : National Study on Childcare provisions in preschools, Sri Lanka 2004

According to the table above a majority of preschool teachers serving in the Southern and Western provinces are untrained. However the data in the table does not reveal the true picture of training since the Provinces have their own definitions for teacher training. The duration of most of the short term in-service training programmes provided for preschool teachers vary from one year to few days and the author found that in one of the Provinces teachers who received two days training at workshops conducted by an INGO are also considered as trained teachers.

The OUSL conducts two certificate level training programmes i.e. Certificate in Preschool Education and Advanced Certificate in Preschool Education for those who wish to become preschool teachers. The duration of each of these programmes is one year. Training is provided in all three media (Sinhala, Tamil and English) and location is no barrier since the Open University conducts these Programmes at Regional Centres established island wide. Training is available for both urban and rural population. The University of Sabaragamuwa also conducts a teacher training programme in preschool

education from the year 2000. The duration of this programme is one and half years. The University has trained 666 preschool teachers since inception of this programme.

Among the other Government institutions the Children’s Secretariat conducts in service training programmes for ECCD service providers regularly. They get the assistance from the experts in the field of ECCD for this training. Plantation Human Development Trust provides training for plantation crèche workers and monitors their services. They get the assistance of the OUSL to assess their training. Preschool Education became popular in Sri Lanka with the visit of Madam Maria Montessori in 1944. A group of teachers weretrained by Maria Montessori and Montessori Method became very popular since then.

Currently, A.M.I. Montessori preschools are very popular among urban affluent society. Montessori teacher training institutions offer Diplomas in Montessori Method that vary from 6 months to two years. Ladies College vocational institute and North Western Preschool Teacher Institute are among the other leading private institutions that provide one year

pre service training programmes in preschool education for ECCE care providers. Further, various National and International Non Governmental Organisations conduct in-service teacher training programmes successfully in Sri Lanka. Sarvodaya Early Childhood Development Unit, Sithuvama Training Education and Development Organisation, South Asia Partnership, Young Women's Christian Association, Forut, Save the Children Fund, Plan Sri Lanka and Room to Read Sri Lanka are some of the NGOs and INGOs that conduct short term teacher training programmes for ECCE care providers working in disadvantaged communities.

Training Opportunities in the Plantation Sector

Children in the Plantation sector are at a disadvantage in receiving ECCE benefits. However, there is a growing concern about these children in the public sector resulting in many regular training and progress monitoring programmes being implemented in estates. Plantation Human Development Trust (PHDT) is one of the key institutions that is involved in ECCE in the plantation sector. Providing basic training to Child Development Officers who provide services in the child development centres (crèches and preschools) in the plantation sector is one of the responsibilities of the PHDT. The type of training Child Development Officers receive according to PHDT is fairly comprehensive. They receive:

- One year basic training with field assignments
- 21 days refresher training
- 10 days training in preschools and
- 05 days training on ECCD

Various other NGOs and INGOs also provide short-term training for care providers in the plantation sector. Save the Children Fund, Plan Sri Lanka, Sarvodaya, Room to Read Sri Lanka and Forut are some of these institutions extending support in training Care Providers. Although many institutions are involved in training preschool teachers it is not possible to calculate the percentage since a data base on trained teachers in ECCE are not available. Conversely, the programmes vary considerably in relation to the duration and many other attributes.

2.4.6 Support for Early Learning

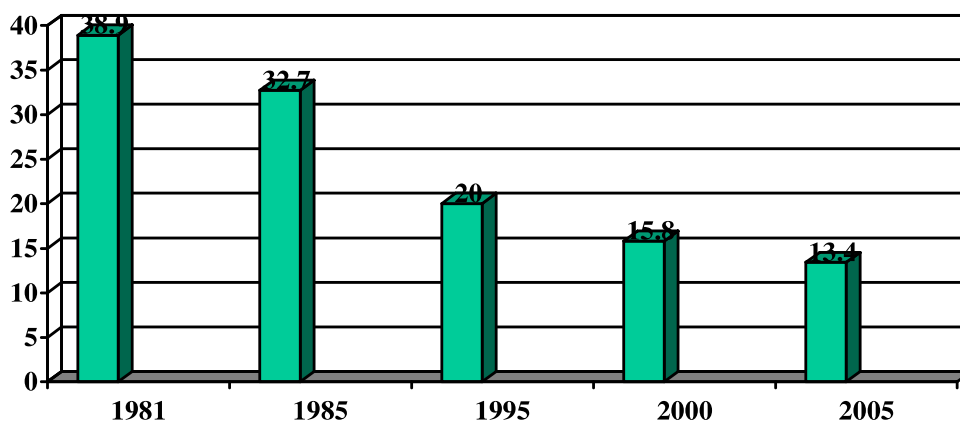
Sri Lanka has a long tradition of introducing first letter in the alphabet to the child at an auspicious hour when he becomes around three years. Even today many families observe this tradition without gender prejudices. This is an indication of parents' expectations on children's early learning. However, systematic studies have not been conducted to establish how parents or adult family members support early learning.

2.5. Health Indicators

2.5.1 Under five mortality rate

The under five-mortality rate is the probability of a child born during a specific year dying before reaching age five if subjected to current mortality rates. It is expressed as a rate per 1000 live births. This reflects the availability and accessibility of MCH care, availability and accessibility to safe water and sanitation and living standards in the country.

Figure 2.4: Trends in Under Five Mortality Rates

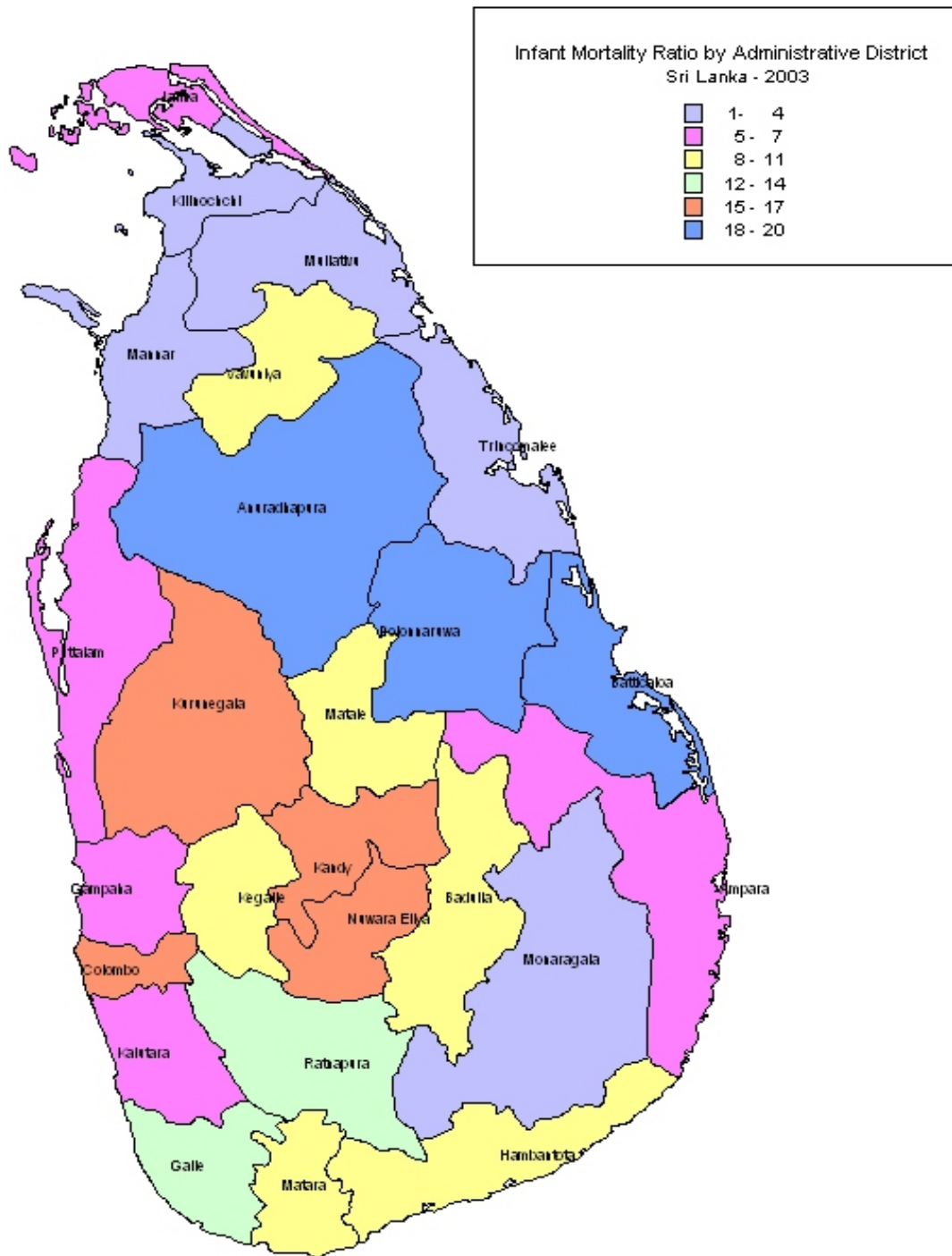


Source: Annual Health Bulletin 2005

Figure 2.4 shows declining trends in Under five Mortality Rates from 38.9 per 1000 live births in 1981 to 13.4 per 1000 live births in 2005. This declining trend observed has been attributed to improvements in the access to safe water and sanitation, better living standards, improved access to health services including public health services and maternal care. However the decline has been at a rather slower rate in recent past. Approximately 75% to 80% of deaths during infancy take place in the first 28 days in life i.e. neonatal period. Therefore further reduction in IMR and thereby under five mortality can be achieved only by

focusing on reducing Neonatal Mortality. Improved survival is a major achievement in the overall growth and development of children. Further figure 2.5 shows gross inter district disparities in the distribution of IMR the highest rates being reported from the districts of Anuradhapura, Polonnaruwa and Batticaloa (Annual Health Bulletin 2003). Therefore it is important to focus attention on minimising these disparities by improving resource allocation and human resource development in the underserved districts as survival is of prime concern in ECCD.

Figure 2.5: Distribution of IMR by District



Source: Annual Health Bulletin, 2003

Table 2.6 Distribution of IMR in different sectors between 1991 and 2002

Sector	1991		2002	
	Male	Female	Male	Female
Sri Lanka	19.9	15.4	12.9	10.2
Urban	27.1	20.3	16.9	13.1
Rural	7.9	6.6	5.2	4.6
Estate	30.5	30.1	16.4	15.7

Source: Millennium development Goals in Sri Lanka: A Statistical review – 2006

The table above indicates that IMR has been consistently higher in the males compared to females in all sectors during 1991 as well as 2002. The rates are highest in the estate sector for both sexes during 1992 and 2002 compared to other sectors except for males in 2002 where it is highest in the urban sector. The rates appear to be higher in the urban sector compared to the rural sector and this may be due to the fact that all tertiary care hospitals are located in the urban sector. Estate sector is represented by those engaged in the tea plantation industry.

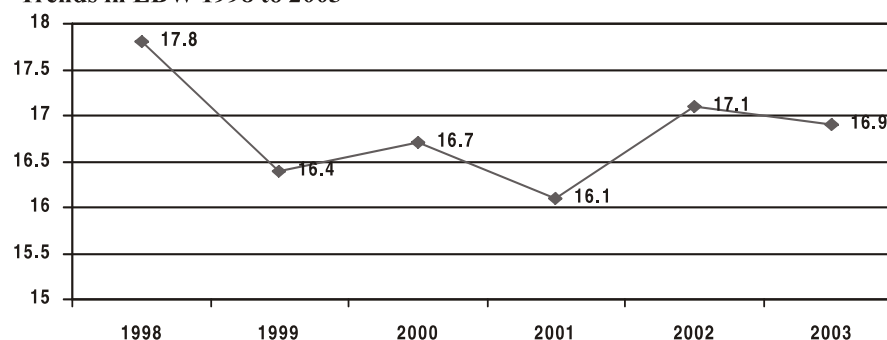
However, a decrease IMR is seen in both sexes in all sectors including the estate sector in 2002 compared to 1991. Although the difference in IMR between males and females is narrow in the Estate sector there appears to be a wide difference between the other two sectors and the estate sector. High IMR in the Estate (Plantation) sector is an issue that should be addressed.

2.5.2 Proportion of infants with low birth weight

Low Birth Weight (LBW) was defined as a baby born with a birth weight less than 2500

grams. This is associated with a higher morbidity and mortality during the neonatal period. In developing countries 2/3rds of LBW is considered to be due to Intra Uterine Growth Retardation, which contributes towards a poor mental capacity that would reduce the opportunities in a child reaching his optimal growth and developmental potential thus having a negative impact on school performance. Reporting of LBW has improved considerably over the years with 97% deliveries taking place in institutions and 98% with skilled attendance (Annual Health Bulletin, 2002). Although there has been a significant drop in the LBW percent over the years the past six years from 1998 to 2003 shows that it has remained almost static fluctuating around 17%.

Despite marked improvements in other health indicators such as Maternal Mortality Rate and Infant Mortality Rate, without a parallel increase in the per capita income the reduction in LBW has been rather slow. According to available data it is reported to be 16.9% in 2003 (Annual Health Bulletin 2003) and hence identified as a major public health problem in Sri Lanka.

Figure 2.6 : Trends in LBW 1998 to 2003

Source: Annual Health Bulletin 2005

2.5.3. Percentage of under-fives suffering from stunting

Stunting is defined as the height for age below 2 standard deviations from the median and the NCHS/WHO data base has been used as the reference. This indicator measures whether a child has achieved his/her potential for optimal growth in height and indicates chronic malnutrition or long-term deprivation of nutrition. The first three years in a child’s life are crucial for healthy growth and development and any deprivations during this period could lead to irreversible negative impacts such as reduced mental capacity which may hinder the child from benefiting optimally during the early childhood years and thereafter school years.

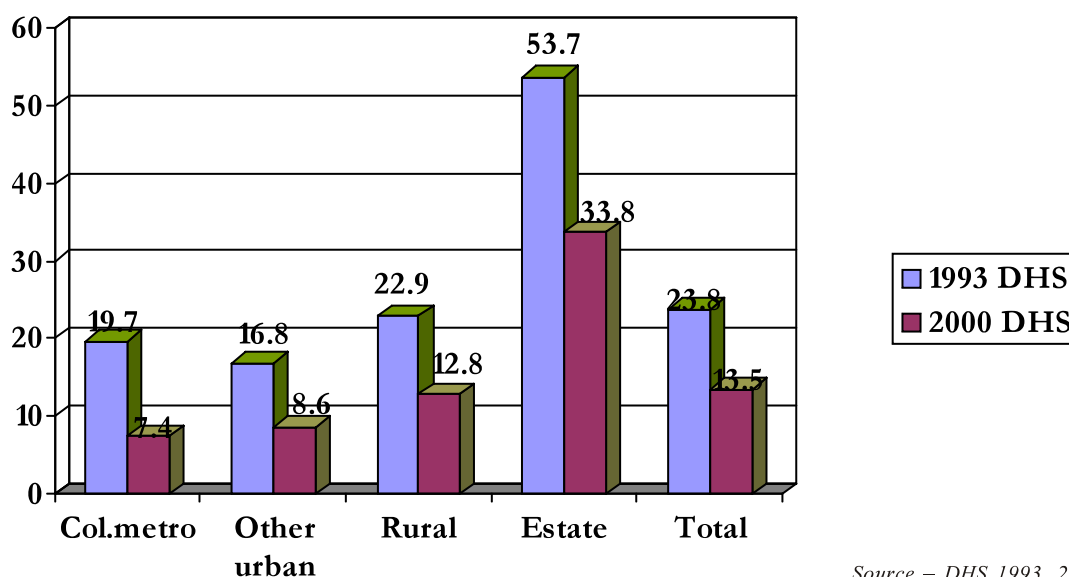
Distribution of stunting in different sectors (DHS 2000)

Overall picture of stunting in Sri Lankan children shows great achievements where there has been a significant reduction from 23.8% in 1993 to 13.5% in 2000. However analysis of the prevalence of stunting in different sectors in the country shows that it is a major problem in the Plantation sector despite improvements seen over the years.

Stunting among children less than five years in

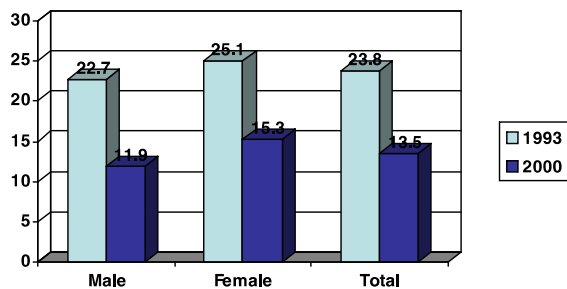
the plantation sector has reduced from 53.7% in 1993 to 33.8% in 2000. Stunting which indicates chronic malnutrition will definitely contribute to poor academic performance limiting the child’s ability to make optimal use of the opportunities provided through schools. More recent data from several districts in the North and East shows that the highest prevalence of stunting (28.8%) is reported from the district of Killinochchi followed by Batticaloa (24.7%) and Mannar (20%). Killinochchi and Mullaitivu are districts affected by the war and not under government control and therefore the routine service provision has been disrupted. (Figure1: Appendix 1) Data from a survey done in 2003 in seven districts identified as vulnerable based on poverty indicators reveals that the prevalence of stunting is highest (31.1%) in the district of Nuwara-eliya which is even higher than that reported by the districts affected by the conflict. Badulla district has reported a prevalence of 25.1%. Both these districts have a large population from the tea plantation industry who are identified as representing the estate population and the severity of the problem in this sector is well reflected. (Figure2: Appendix 1)

Figure 2.7: Prevalence of stunting among children less than five years



Source – DHS 1993, 2000

Figure 2.8: Comparison of stunting by gender between 1993 and 2000



Source: DHS 1993 and 2000

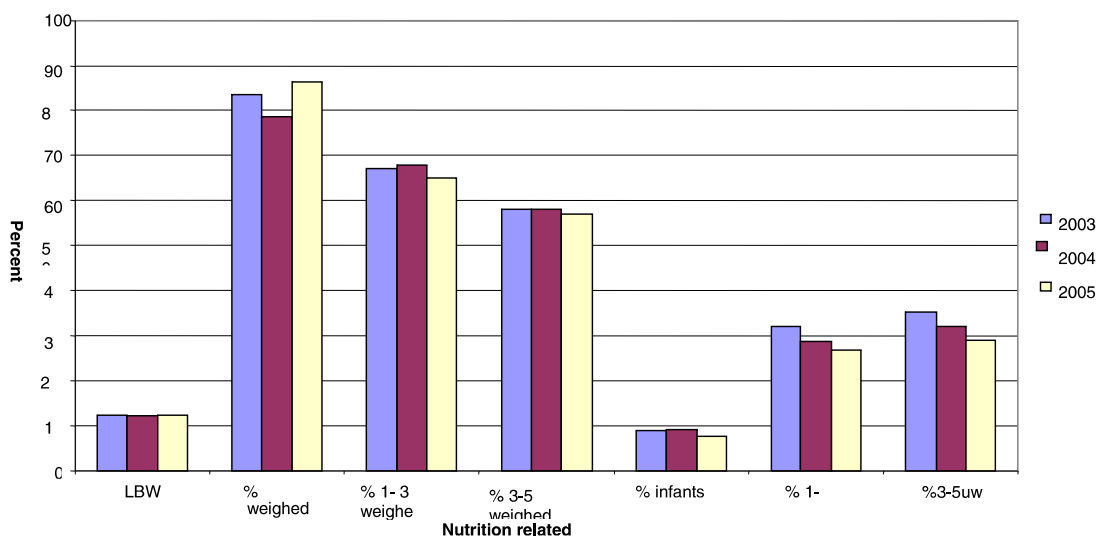
DHS 2000 data reveals that Stunting appears to be slightly higher among females (15.3%) compared to 11.9% among males.

The data presented (Figure 3: Appendix) reveals that the prevalence of stunting in all age groups has come down in 2000 compared to 1993. However, there is a sharp rise in the percent stunted between 12-23 months (16.2%) compared to the percent between 6-11 months (5.7%) in 2000. This could be attributed to poor complementary feeding practices. Stunting due to long term deprivation of nutrition during the early childhood period will have negative implications on the overall growth and development of children thus affecting their

overall performance during the school years. Conversely, it could be noted that national data on stunting is not available after the year 2000. The latest DHS survey which was concluded this year is yet to be published.

Growth Monitoring and Promotion is done routinely for all children from birth until five years of age through the infrastructure of the MoH at clinic and field level. The weighing coverage for infants has been quite high around 77% and 80% during 2004 and 2005 respectively (Annual Report on Family Health Sri Lanka, 2004-2005), however comparatively lower rates have been observed in the older age group of 1-5 year aged children where only 51% had been weighed during 2004 and 2005 (Annual Report on Family Health Sri Lanka, 2004-2005). Weight for age was the indicator used for monitoring for several decades but with the revisions to the CHDR in 2004 length/height for age also has been introduced. Growth Monitoring and Promotion is done by the PHM at clinic and village level in an organised manner to facilitate service provision to parents/ caregivers of infants and children less than five years.

Figure 2.9: Trends in LBW, growth monitoring and under weight in 34 Medical Officer of Health division implementing the ECD Programme 2003- 2005



Source: Unpublished, Monitoring and Evaluation Unit, FHB

The routine data received from 34 MoH areas implementing the ECCD programme since 2003 was analysed in 2005 and the trends observed. It showed some achievements in relation to important indicators such as LBW and percent underweight in children less than five years. As the programme focused on improving care practices at family level, implementation for three years has shown an improvement in the percent of infants weighed while the percent of infants and young children with underweight shows declining trends. LBW percent has remained more or less static and may be due to better reporting, because steps were taken by the MoH to improve the reliability and reporting of data.

2.5.4. Percentage of Households Consuming Iodized Salt

Iodine deficiency is the single most common cause of preventable mental retardation and brain damage. Children with Iodine Deficiency Disorder (IDD) grow up stunted, apathetic, mentally retarded and incapable of normal movements, speech and hearing. As such preventing IDD is of major importance to optimise child development. Iodination of salt for human consumption is the most effective method of preventing such disorders.

Table 2.7: Iodination of Salt at Household Level (tested by rapid kit method) by Provinces:

Province	% positive
Western	95.9
Central	92
Southern	82
Northern	91.1
Eastern	86.8
North western	83.3
North Central	92.3
Uva	91.7
Sabaragamuwa	87.2
Sri Lanka	89.2

Source - *Iodine Nutrition Status in Sri Lanka 2005, MRI 2006*

The survey done by Medical Research Institute tested Iodine levels of salt at household level using the rapid test kit as well as titration methods. Results of the rapid test kit method found that 89.2% of households had access to iodized salt, and the titration method revealed that 91.2% had iodine levels within the permitted range, i.e. 15 ppm which is a major achievement. However inter provincial variations are seen the lowest coverage (82%) of access to iodized salt at household level reported from the Southern Province (*Iodine Nutrition Status in Sri Lanka 2005, MRI 2006*). Further the Northern Province reported the highest coverage (27%) in respect of iodine levels less than the recommended level of 15 ppm. Same survey also found that the total goitre prevalence among primary school children has reduced from 20.1 in 2000/01 to 3.8 in 2005 which is a major achievement considering the undesirable impact of iodine deficiency on early childhood development. According to Sethi Vani, Kapil Umesh (2004) the most disturbing feature of childhood iodine deficiency is the impaired school performance and lowered I.Q. The Iodination of salt at household level depicted in the above table needs to be improved if Sri Lanka to achieve the EFA Goal 1 by the year 2015.

2.5.5 Vitamin A coverage

Vitamin A is essential for normal vision as well as to protect children from infections by enhancing immunity. Repeated infections in children will contribute to malnutrition limiting opportunities for learning and interaction thus having a negative effect on overall development. Vitamin A deficiency has been identified as a major public health problem (Vitamin A Deficiency Status of children in Sri Lanka, 1995/96, MRI, 1998) in Sri Lanka. Therefore vitamin A mega dose linked to the immunisation schedule was provided to children at nine

months and eighteen months respectively which was implemented since 2002.

Vitamin A coverage reported through the routine Medical Information System (MIS) was used to calculate the coverage. National Vitamin A coverage at 9 months has increased from 44.44% in 2003 to 62.8% and 74.2% in 2004 and 2005 respectively (MIS, Family Health Bureau). Surprisingly the coverage with Vitamin A mega dose supplementation appears relatively low compared to the measles coverage as it is linked to the immunisation schedule. Data from recent surveys are not available.

Prevalence of Vitamin A deficiency (based on serum retinal levels less than 20µg per dl) has reduced from 36% in 1996 to 28% in 2005 (unpublished; Vitamin A survey, MRI 2006.)

2.5.6 Proportion of under five children with anaemia

Proportion of children with haemoglobin less than 11 g/dl was calculated. Anaemia is associated with reduced cognitive development and implies poor feeding practices and poor maternal nutrition with inadequate iron stores. Iron deficiency anaemia has significant implications on development since iron is an important nutrient for normal development. Iron deficiency during the most critical periods of

development has irreversible impacts on the growing child. Research has found that even if it is corrected it will affect the cognitive performance of children at school entry and the negative effects continue even during adolescence. Therefore the early childhood period is of utmost importance to help children to make optimal use of the learning opportunities provided through the formal education systems.

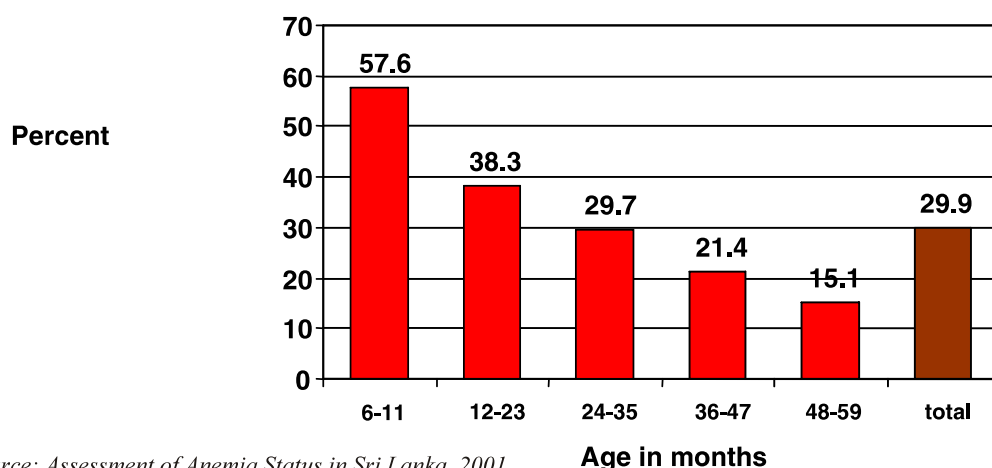
Effects of iron deficiency:

- Altered behaviour
- Lower motor and mental development
- Poor cognitive performance, behaviour and physical growth of infants, preschool and school children
- Reduced immune status and morbidity from infections of all age groups
- Reduced physical capacity and work performance of adolescents and adults of all age groups

Follow up after correction during infancy has shown the following:

- Low scores at school entry
- Low scores even during adolescence
- Arithmetic achievement
- Written expression
- Cognitive functions
- Spatial memory

Figure 2.10: Distribution of Anaemia among children less than five years by different age groups

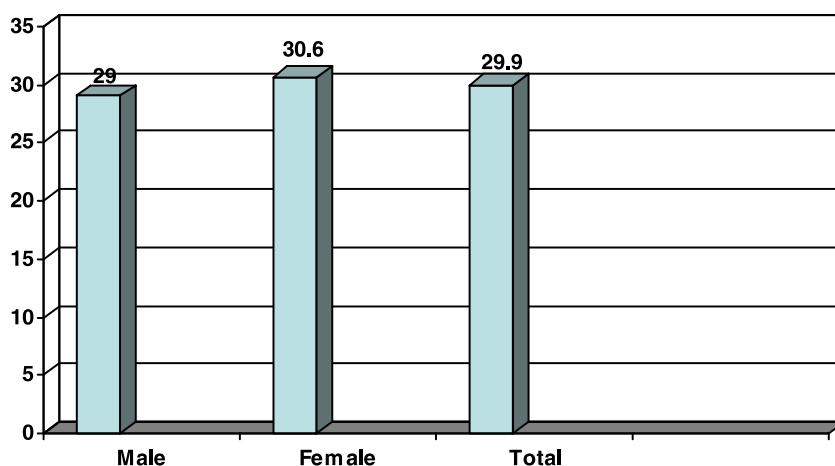


Source: Assessment of Anemia Status in Sri Lanka, 2001

Recognising the negative impacts of iron deficiency anaemia on development of children the MoH has already taken steps to prevent iron deficiency during the early childhood years by providing provide Multiple Micronutrients which contains 12.5mg of iron in addition to other vitamins and minerals to

infants and young children. This has been initiated already in four selected districts as a pilot project. Initially all infants from six months of age until two years of age would be given MMN but would be expanded to other districts on a phased out basis.

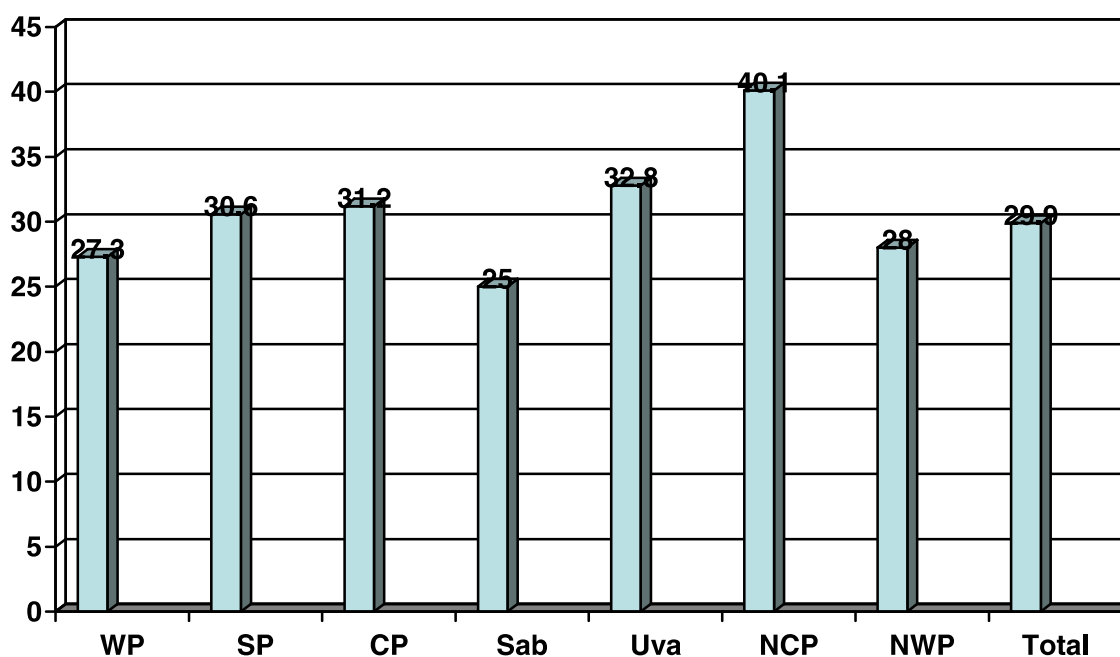
Figure 2.11: Prevalence of anaemia by gender



Source: Assessment of Anemia Status in Sri Lanka, 2001

Figure 2.11 shows that there is no marked difference in the anaemic status between the two sexes.

Figure 2.12: Distribution of Iron Deficiency anaemia among children less than five years by Province



Source: Assessment of Anemia Status in Sri Lanka, 2001

Inter-provincial variations in the prevalence of iron deficiency anaemia among children less than five years have been noted. Highest prevalence of iron deficiency anaemia (40.1%) has been reported from the North Central Province and may be due to the fact that Malaria is endemic in this province.

Uva and Central Provinces have reported the next highest levels of 32.8% and 31.2% respectively and these are the districts which have been constantly identified as having high rates of stunting and LBW rates where the largest proportion of tea plantation workers commonly defined as “estate population” reside.

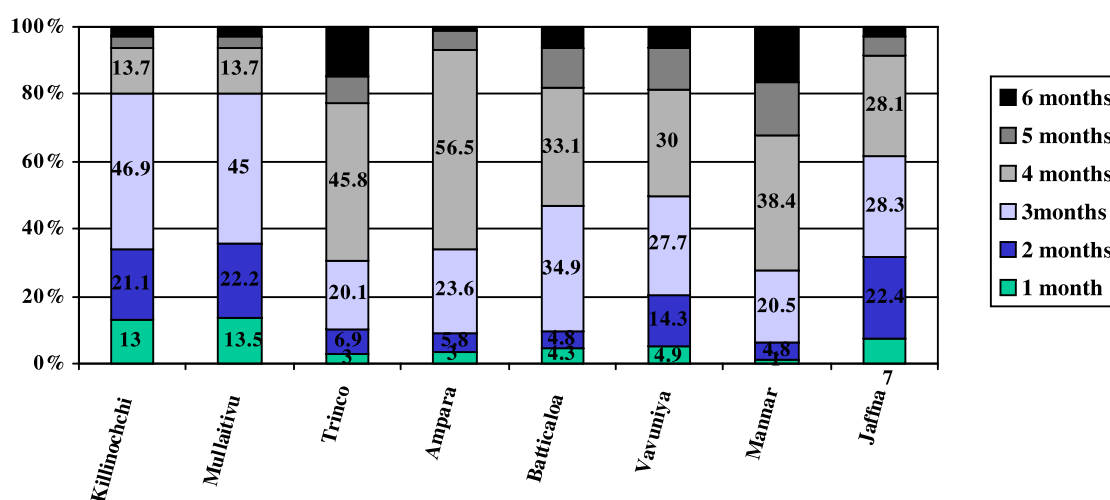
2.5.7 Exclusive Breast Feeding rates

Breast milk provides all the nutrition needed for optimal growth and development of children during the first six months and continues to

provide a proportion of good quality nutrients needed until two years of age. It also contains antibodies and live cells which protects children from infections. Further the bonding between mother and baby established and strengthened during breast feeding is essential for normal development. Exclusive

Breast Feeding (EBF) has been associated with improved morbidity and mortality and improved cognitive performance among children. Until 2002 the Sri Lankan policy was to provide EBF for a period of four months, however this was later extended to a period of 4-6 months and thereafter for six months since late 2005 to fall in line with current WHO recommendations. Nationally EBF for a period of four months has improved from 19% in 1993 to 52% in 2000 (DHS data 1993 and 2000) however gross inter-district variations have been observed following subsequent surveys.

Figure 2.13: EBF rates in the districts in North and East

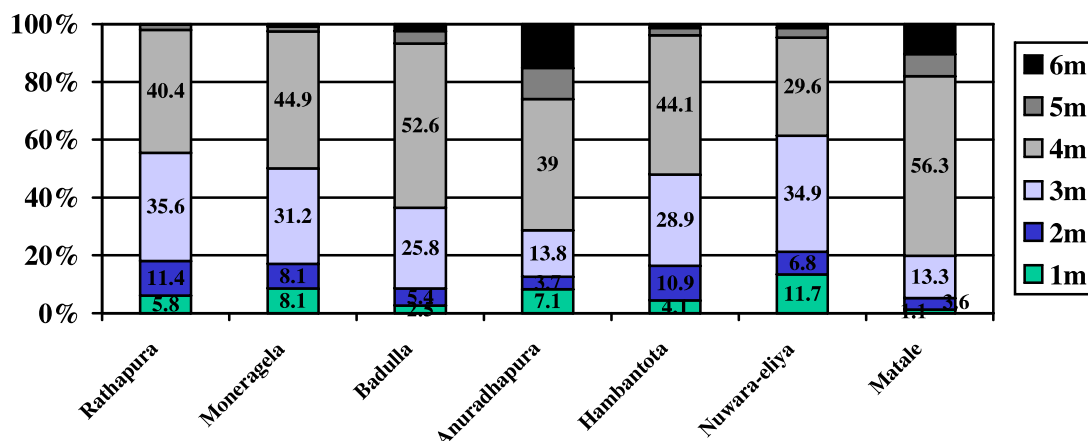


Source - Survey of Child Health and Welfare in selected Northern and Eastern Districts in Sri Lanka 2004 and Killinochchi and Mullaitivu Districts in Sri Lanka 2005/06.

According to the survey on Child Health and Welfare in Northern and Eastern districts done in 2004, 2005/06 EBF rates for 4 months is rather unsatisfactory in most districts. The highest rate of 56.5% has been reported from Ampara district. This has a negative influence

on the overall nutritional status of infants and young children. Efforts to strengthen breast feeding practices still needs priority in view of the current recommendations to provide exclusive breast feeding for a period of six months.

Figure 2.14: EBF rates in seven vulnerable districts



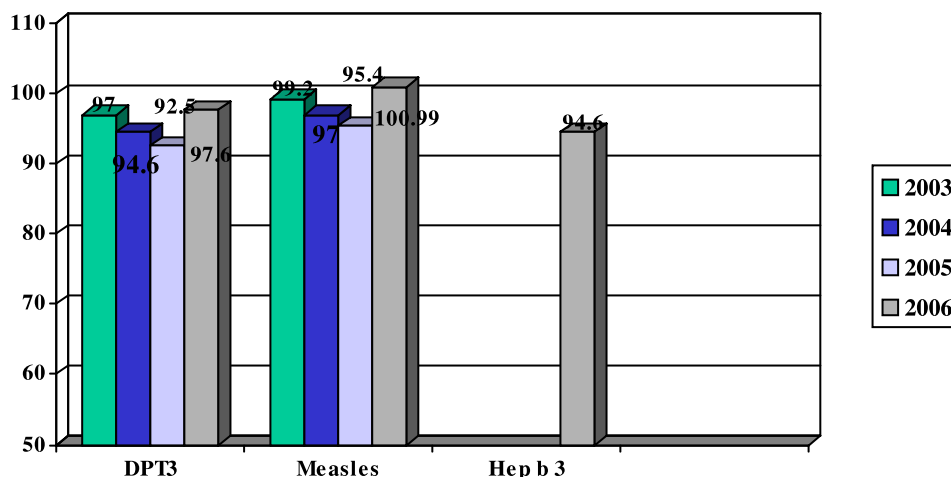
Source - Survey of Child Health and Welfare in Seven Districts in Sri Lanka 2003.

Similar picture seen in the districts in the North and East are also seen in several vulnerable districts in the southern parts of the country. Despite efforts taken by the MoH to improve breast feeding survey findings show that the EBF rate for a period of four months in these districts are rather unsatisfactory, the highest percentage of 56.3% reported from the district of Matale. Poor EBF rates will definitely contribute to under nutrition among infants and young children with a higher risk of infections. Therefore improving breast feeding practices are of prime importance in reducing under nutrition among children thus laying a good foundation for overall growth and development.

2.5.8. Proportion of one-year-old children immunised against DPT3, Polio, Measles and Hepatitis

Immunisation protects children from vaccine preventable diseases and is considered a priority preventive health service. Sri Lanka has been able to maintain high coverage against vaccine preventable diseases. Immunization coverage of infants has been maintained above 90% from 2003 to 2006. OPV3 and DPT3 coverage for 2006 has been reported as 93.7% while it is 90.8% and 101% for Hepatitis B and Measles respectively (unpublished data, Epidemic Unit, 2006).

Figure 2.15: National immunisation coverage for OPV/DPT3, Measles and Hepatitis B3 from 2003 to 2006



Source: Unpublished data, Epidemiological unit, MoH

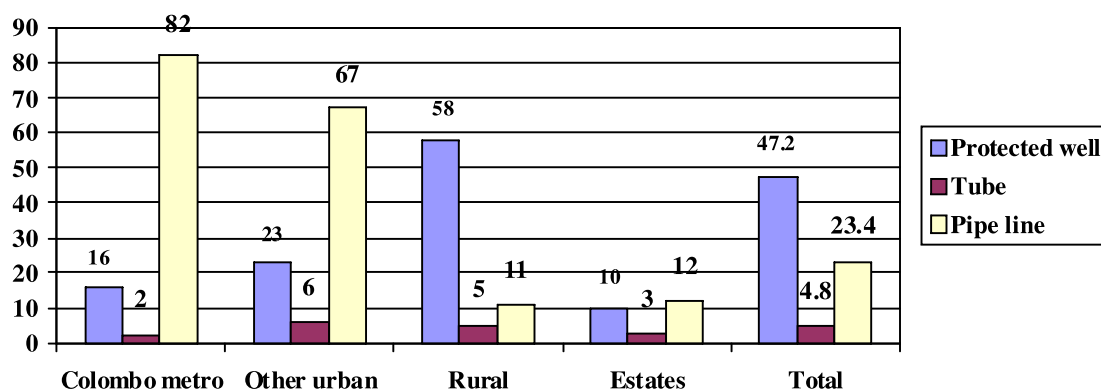
2.5.9. Proportion of population with sustainable access to safe drinking water

This is defined as the percentage of population using improved drinking water sources (including household water connection, public standpipe, borehole, protected dug well, protected spring, rain water collection and bottled water).

Access to safe water is a major strategy to prevent water borne diseases especially diarrhoea. Recurrent attacks of diarrhoea may have a negative impact on the growth and development of children.

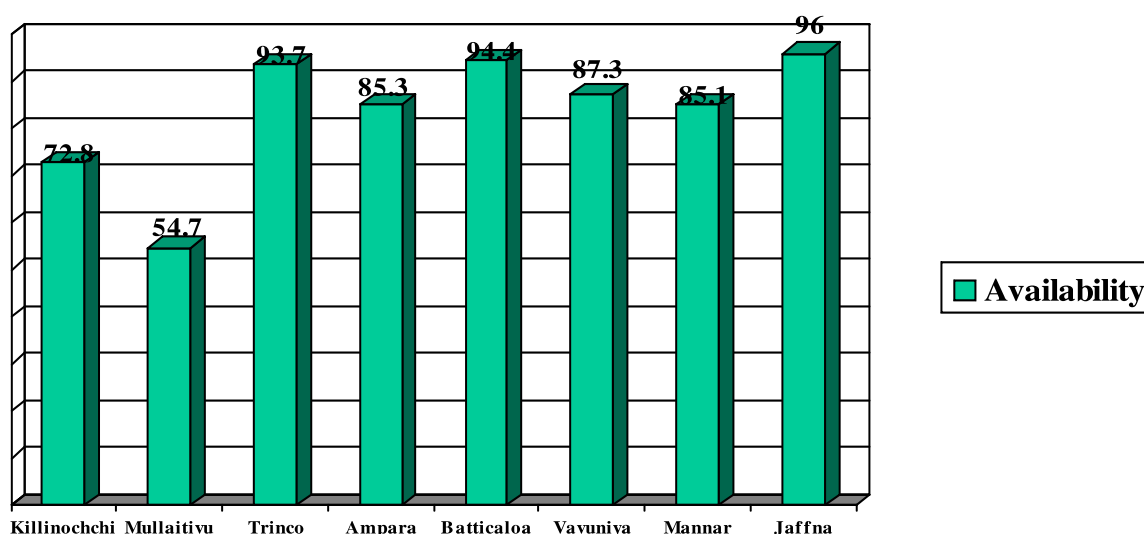
Figure 2.16 shows that 47.2% of households get water from protected wells while 4.8% and 23.4% from tube wells and main pipe lines respectively, thus a majority (75.4%) having access to a safe source of drinking water (DHS 2000). However there are gross sectoral disparities observed where only 24.8% of households in the estate sector had access to safe drinking water while it was 99.2% for those in the Colombo metro.

Figure 2.16: Distribution of households by source of safe drinking water and sector:



Source – DHS 2000

Figure 2.17: Accessibility to a source of safe water in districts in Northern and Eastern Provinces



Source - Survey of Child Health and Welfare in Selected districts in North and East (2004) and Killinochchi and Mullaitivu Districts in Sri Lanka 2005/06. Department of Census and Statistics and UNICEF, Sri Lanka

As indicated by figure 2.17 Mullaitivu district has reported the lowest percentage (54.7%) of households which had access to a safe drinking water source while it is more than 70% in all other districts. Mullaitivu and Killinochchi areas are considered un-cleared because of the ongoing war and routine government systems do not function efficiently as in other districts.

2.5.10. Proportion of population with sustainable access to basic sanitation

Proportion of the population with access to improved sanitation refers to the percentage of families those hygienically separate human excreta from human, animal and insect contact. Facilities such as sewers or septic tanks, poor flush latrines and simple pit

or ventilated improved pit latrines were considered as adequate. Lack of adequate sanitation facilities at home is a key reason for higher incidence of diarrhoea and related diseases contributing to growth failure and thereby reduced mental capacity. Such recurrent episodes of illness have a direct impact on school performance, through poor school attendance which may eventually result in repetition or dropout. There are also concerns in the early years that poor sanitation results in slow growth and poor nutrition which in turn has impacts on cognitive and social development. In addition there is concern that efforts to introduce sanitation and hygiene education activities in schools for behaviour change are seriously undermined when there are no sanitation facilities in the community or at home.

Table 2.8 : Distribution of Households by types of latrine and sector

Sector	Total%	Water seal %	Pour flush %	Pit %	Other %	Bucket %	None %
All	100	72.6	8.2	12.8	0.3	0.0	6.1
Colombo metro	100	87.3	10.2	1.8	0.3	0.1	0.2
Other urban	100	86.5	4.8	3.3	0.2	0.2	4.8
Rural	100	72.6	6.2	16	0.1	0.1	5.0
Estates	100	35.5	30	6.3	0.5	0.5	27.7

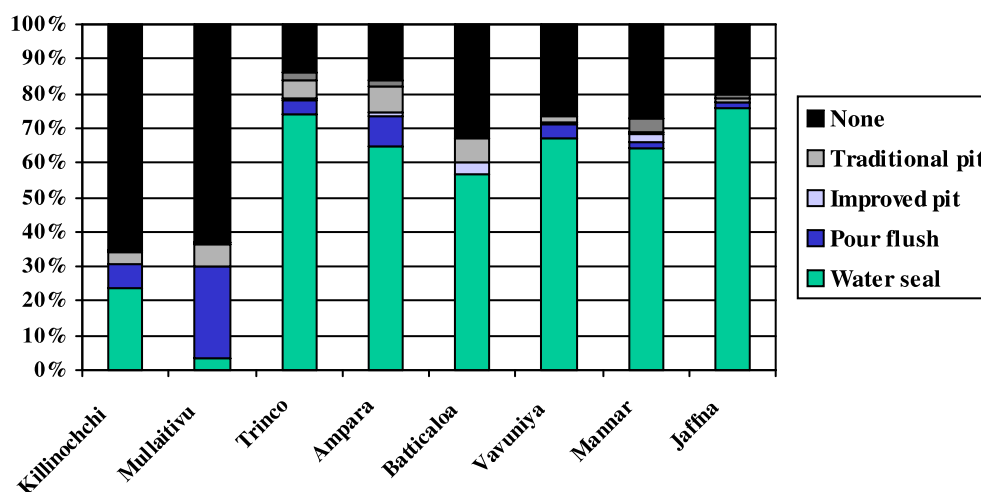
Source – DHS 2000

Data shows that 94% of houses have access to some kind of toilet. However when the different sectors are considered 28% of households living in the estates have no access to any type of toilet. This is a major concern in preventing diarrhoeal diseases and the associated consequences on the children.

Majority of households in both Killinochchi and Mullaitivu districts do not have access to

sanitary facilities while the access in other districts is more than 60%. These are the two districts which are un-cleared and not under Government control. However the situation in other districts is definitely better than the estate sector. Taking all data into consideration it is observed that minimising inter-sectoral disparities with priority to estate sector is an urgent need.

Figure 2.18: Distribution of households by types of latrines by types of latrines by districts in the Northern and Eastern provinces



Source - Survey of Child Health and Welfare in Selected districts in North and East (2004) and Killinochchi and Mullaitivu Districts 2005/06. Department of Census and Statistics and UNICEF, Sri Lanka

2.6 Additional EFA Indicators

2.6.1 Birth registration rate

According to the website of Plan International Sri Lanka has the highest number of birth registrations compared to the other countries in the region. It is estimated that approximately 94% of births are registered. Accordingly 183807 male births and 176413 female births have been registered during 2004 the total being 360220 births. The Registrar General's Department together with Plan Sri Lanka a NGO has launched a Universal Birth Registration programme targeting the vulnerable populations such as the estate population and street families registration is expected to be achieved by end of 2010.

2.6.2 Proportion of young children whose parents participate in ECCE programmes

The government institutions such as the Children's Secretariat and NGO's such as Sarvodaya, conduct parental awareness programmes on ECCE regularly. The OUSL has conducted a survey to identify parent's needs in relation to development and education

of preschool children in order to conduct awareness raising programmes on ECCE. However to present a proportion of children whose parents participate in ECCE programmes a survey should be conducted at national level.

2.6.3 Public Expenditure on ECCE Program

The government funds are allocated for ECCD through the Ministries of Health, Child Development and Women Empowerment and Social Welfare. These Ministries are also funded by various agencies.

There are several financiers such as UNICEF, Save the Children's Fund, and Plan Sri Lanka who provides support without which Sri Lanka would not be able to address many issues.

2.6.4 Public Current Expenditure on ECCE per child as a percentage

Government Expenditure for education is 2.7% from the total expenditure. There is no budgetary allocation exclusively for Early Childhood Care Education. However, the Government allocates funds for ECCE through various Ministries such as Health, Child

Development and Women empowerment and Social Welfare. Therefore, computing public current expenditure per child as a percentage is a very complex task in the Sri Lankan context.

2.7 Summary and Recommendations

The state involvement in ECCE is more prominent today than any other period in the history of Sri Lanka. Inclusion of ECCE in the 1997 Educational Reforms as well as other measures taken by Ministries such as of Child Development and Women Empowerment, Health and Nutrition, has proved that Sri Lanka is working towards achieving EFA goals by the year 2010. Collective efforts of the Government, NGOs and private sector to assure young children the benefits of ECCE programmes were evident in many spheres. The National ECCD Policy (2004) is a timely measure taken by the Government to ensure that Sri Lankan children in the early childhood get care and nurture they deserve to develop to their full potential. The vision, mission, aims, areas of action and objectives of each area have been clearly stated in the policy statement. It has identified the framework and mechanisms to ensure quality assurance in ECCD and stipulated the responsibilities and functions of the Government, private sector, NGOs and the community at various levels. The Policy also has formulated aims and strategies for children with special needs which cover the category of most vulnerable and disadvantaged mentioned in the EFA Goal 1. Professionalising people for inclusive education has been undertaken by the state through universities and training colleges. However the National Policy should be reviewed to suit the international definition of Early Childhood since it has left out children between five to eight years. These three years

are considered as the transition period from home or preschool to formal education. The early primary years are included in the international definition of early childhood since the experiences of a child during these two years are critical in sustaining what he/she learnt prior to formal school, (*Evans and Myers, 2000*).

- **Therefore, it is recommended that Sri Lankan children between 5-8 years should be included in the definition of early childhood, regardless whether they attend primary school or not. In this context it is suggested to have strong linkages between the different Ministries responsible for the provision of services to children during the Early Childhood period mainly the MoH, MCDWE and MoE.**

The aims of the National Policy do not reflect the multicultural facet of Sri Lankan society. Development of harmony among various ethnic groups living in Sri Lanka should be a major aim of ECCD/ECCE. Since preschools are important agents in reaching parents, objectives with regard to social cohesion and social integration should be included in the National Policy on ECCD.

- **It is recommended that bilingual (Sinhala and Tamil) or multilingual (Sinhala, Tamil and English) staff that view diversity as an asset should be trained to work with children that attend ECCD centres from different linguistic backgrounds.**

Conversely, specific policies should be incorporated in the National policy to combat educational disadvantage although the Policy has specifically stipulated objectives and strategies of ECCD programmes for children with special needs.

- **Reduction of educational disadvantage can be successful only if it is addressed through policy framework with setting objectives, determining priorities and monitoring and evaluation of policy. Compensatory policy within the national policy framework is necessary to reduce educational disadvantage.**

The Policy has stated that training all ECCD personnel in identifying children at risk and children with special needs as a strategy to improve and expand training opportunities for service providers. It is important to identify children at risk and provide referral services through screening programmes that could support families and children at risk.

Formalising screening programmes and developing national standards for monitoring developmental readiness are pressing needs that should be addressed through the national policy.

In spite of many progressive steps taken by the state for care and development of young children as stated in this report, it is noteworthy that no standards are laid down at national level to monitor young children's total development. Even in the health sector inadequate attention has been paid to early developmental screening. As a result some children are unable to benefit from the opportunities provided through free education. Appropriateness of instruments used, completeness and quality of developmental assessments are issues to be looked at critically and steps should be taken to improve early screening. Further, services for children identified as having developmental delays need to be strengthened since, a well-established referral system linked to ECCE programmes and well-trained personnel to assess children are lacking in Sri Lanka. This has resulted in

preschool teachers assessing children on preconceived notions. Effects of such assessments will remain as a stigma through out their primary school and may contribute to children being dropped out of school.

- **Therefore, instruments should be developed to assess Sri Lankan children's readiness for school and identify developmental delays during the early childhood. Since Sri Lanka is developing country the Government's support is essential in this regard.**

Data reveal that a majority of children have experienced ECCE prior to admission to primary school although the quality of the programmes has not been evaluated. Practices that affect how children experience child care including the responsiveness of the care giver, individualisation of care and use of language in the classroom should be assessed through the state organisations responsible for ECCE. Such studies are conducted from time to time in developed countries since children who receive high quality care are more likely to develop better cognitive skills in the areas of language in particular and are more likely to develop positive social skills than children who receive low quality care (*Facts in Action, 2000*). This review was able to identify many gaps in the provision of ECCE especially for disadvantaged communities in the society. A considerable number of children do not attend preschools for the reason that preschools are not situated within their locality (Children's Secretariat, 2006). Conversely, the plantation sector which contributes immensely to our economy is still behind the rest of the society in reaping benefits of ECCE Provisions. There are beggar children and street children who have not been reached by these programmes. It has been estimated that there are 5000 child beggars in Sri Lanka (Dharmadasa and

Wickremeratne 2004). There may be children in the early childhood among them. These issues cannot be addressed only through ECCE. It should be linked within a broader framework such as poverty alleviation. Issues of street children and displaced children should be addressed separately.

- **Therefore, compensatory programmes for such children who have not been reached so far and those in disadvantaged communities are recommended in this report.**

Although different Ministries have made efforts to implement policies targeting the expansion of ECCE to all the children from 0-5 years and assimilation of children from vulnerable and disadvantaged groups into the mainstream, lack of information is a challenge faced by the policy makers today.

- **Therefore, this report recommends creating a comprehensive data base which would be maintained and up dated systematically to enable policy makers to implement ECCE policies successfully.**

The experience children gain through ECCE could be considered as sustainable only if the care providers are qualified, motivated and their future aspirations met. Except for the programmes recently offered by the Open University of Sri Lanka, opportunities available for ECCE care providers to progress in their career are limited. For the majority, the maximum qualification is limited to one year Diploma. The highest position they can obtain with this qualification is the principal post of a care providing institution or a supervising officer attached to a local government authority. Most of the ECCD officers in Government institutions are

graduates in Sociology and other disciplines.

Lack of resource persons in the field of ECCE is one of the major issues faced by universities in offering degree programmes for care providers.

Since ECCE is very much focused on the preschool, most of the training programmes for ECCE care providers evolve around preschool education. However, there is a pressing need to re-examine these training programmes to ensure the quality. The duration of training programmes, curriculum, and also physical and human resources reflect the quality of any training programme. The study conducted by Wijetunge and Wickremeratne (2003) on childcare provisions in preschools with a sample drawn from nine provinces reveals that 45.1% respondents have followed programmes of less than a month duration and only 15.1% have followed programmes of one year duration. This clearly shows the inadequacy of training received by care providers. Experiences and qualifications of some of the trainers are also questionable. Tailor made programmes are often used disregarding the appropriateness and diversity of cultures.

- **National standards should be place regarding these training programmes, quality assurance and accreditation of ECCE programmes.**

Finally, it should be mentioned that a budgetary allocation for early childhood care and education is a necessity. Financing the ECCE programmes is the major concern the state agencies face.

- **Therefore, an equitable system of financing childcare and early education with a strong partnership among Government, Non Governmental Organisations and the private sector is strongly recommended by this report.**

