National Family Planning Programme Review 2016 SRI LANKA

NATIONAL FAMILY PLANNING PROGRAMME REVIEW

SRI LANKA 2016

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Message from the Director General of Health Services

Sri Lanka has a unique and long history with regard to family planning and maternal care. Since the introduction of the National Family Planning Programme (NFPP) in 1965, there has been considerable progress in providing a wide array of family planning services.

This review provides a comprehensive analysis of the nature of Family Planning practices over the years. The objectives of the review are to conduct an assessment of existing services, identify current needs, determine the gaps in existing services, and provide recommendations to address these gaps.

The review process has been guided by an expert group of high-level experts from the government, developmental partners, and Non-Governmental Organizations.

The commitment of the relevant national stakeholders and the support given by the United Nations Population Fund is greatly appreciated.

I take this opportunity to thank the Ministry of Health officers and the Family Health Bureau for their commendable guidance and support. The commitment of the relevant national stakeholders of both private and public sectors, and the support given by the United Nations Population Fund, is greatly appreciated.

As this review showcases important recommendations and solutions related to advancing family planning services, it will serve as essential reading material for all medical health officers and professionals in Sri Lanka.

Dr. J.M.W Jayasundara Bandara
Director General of Health Services
Ministry of Health, Nutrition & Indigenous Medicine

Message from Director, Maternal and Child Health

Sri Lanka has a unique and long history with regard to family planning and maternal care. Since the introduction of the National Family Planning Programme (NFPP) in 1965, there has been considerable progress in providing a wide array of family planning services.

The NFFP provides a comprehensive analysis of the nature of family planning practices over the years. The objectives of the review is to conduct an assessment of existing services, identify current needs, determine the gaps in existing services, and provide recommendations to address these gaps.

The review process has been guided by a group of high-level experts from the government, developmental partners, and Non-Governmental Organizations. This initiative was made a success by the commitment of the stakeholders at different levels, ranging from national level to grassroots level

I take this opportunity to thank officers from health and non-health sectors, and all others who contributed, for their commendable guidance and support. The commitment of the relevant national stakeholders of both private and public sectors, and the assistance given by the United Nations Population Fund, is greatly appreciated.

As this review showcases important recommendations and solutions related to advancing family planning services, it will serve as essential reading material for all healthcare officers, professionals and other stakeholders of family planning services in Sri Lanka.

Dr. Priyanee Senadheera
Director. Maternal and Child Health
Family Health Bureau
Ministry of Health, Nutrition & Indigenous Medicine

Message from UNFPA Representative, Ms. Ritsu Nacken

We are pleased to have supported the Ministry of Health, Nutrition and Indigenous Medicine and the Family Health Bureau in carrying out the first comprehensive review of the National Family Planning Programme (NFPP) in Sri Lanka.

Access to safe, voluntary family planning services is a human right. Family planning also fosters gender equality and women's empowerment, which lead to more peaceful and inclusive societies. When in many parts of the world raising extremisms and conservative social norms are affecting fulfilment of human rights of women and girls, ensuring universal access to family planning services has become more important than ever.

In Sri Lanka the NFPP has been largely successful in meeting the family planning needs of people. However, in the last decade, a number of issues including the quality of family planning services and negative perceptions about the objective of the NFPP have posed challenges to the programme. Several critical gaps, such as limited men's engagement in family planning, lack of integration of FP in other health services, and limited private sector partnership have been also identified.

For this reason, it was proposed that the NFPP be reviewed and modified to better address the societal changes observed, as well as target high-risk and vulnerable groups. In this context, UNFPA supported the Family Health Bureau of the Ministry of Health in developing this significant and timely review.

UNFPA works to support universal access to family planning by strengthening the national healthcare systems, advocating for polices supportive of family planning and gathering data for evidence-based policy making. UNFPA also provides leadership in increasing access to family planning services by convening partners to facilitate a multi-sectoral and holistic approach to sexual and reproductive health issues.

I sincerely hope that the Family Planning Review will serve as a useful tool in guiding medical health professionals and practitioners in advancing the rights of people in all segments of society to lead fulfilled lives. This will be part of our joint efforts towards the 2030 Agenda for Sustainable Development to ensure no one is left behind in Sri Lanka.

Ms. Ritsu Nacken
UNFPA Representative Sri Lanka

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List of Acronyms

AMOH	Assistant Medical Officer of Health
ANC	Antenatal Clinics
ART	Assisted Reproductive Technologies
BCC	Behaviour Change Communication
CBG	Criteria Based Grants
CCP	Consultant Community Physician
CMC	Colombo Municipal Council
CPR	Contraceptive prevalence rate
CPS	Contraceptive prevalence survey
CRHE	Comprehensive Reproductive health Education
CS	Contraceptive security
DDGPHS II	Deputy Director General Public Health Services II
DDHS	Divisional Director of Health Services
DESC	Drug Evaluation Sub Committee
DGHS	Director General of Health Services
DHS	Demographic and Health Survey
DMPA	DepoMedroxyProgestone Acetate
DPDHS	Deputy Provincial Director of Health Services
EC	European Commission
ECP	Emergency Contraceptive Pill
EML	Essential Medical List
ET&R	Evaluation Training & Research
FEFO	First Expiry First Out
FGD	Focus Group Discussions
FHB	Family Health Bureau
FP	Family Planning
FPASL	Family Planning Association of Sri Lanka
GMP	Good Manufacturing Practices
HEB	Health Education Bureau
HMIS	Health Management Information System
HR	Human resources
HURGA	Human Reproduction and Genetics Act
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IMR	Infant Mortality Rate
IUD	Intra-uterine Contraceptive Device

HR	Human resources
HDI	Human Development Index
HEB	Health Education Bureau
HUGRA	Human Reproduction and Genetics Act
IST	In-Service Training
LMIS	Logistics Management Information System
LRT	Loop resection of the tube (female sterilization)
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MO	Medical Officer
MoH	Ministry of Health, Nutrition and Indigenous Medicine
MOH	Medical Officer of Health
MO MCH	Medical Officer Maternal and Child Health
MSD	Medical Supplies Division
MSG	Mothers Support Groups
NASTEC	National Science and Technology Commission
NCFH	National Committee on Family Health
NFPP	National Family Planning Programme
NGO	Non-Governmental Organization
NIHS	National Institute of Health Sciences
NMRA	National Medicines Regulatory Authority
NO	Nursing Officer
NTS	Nurses Training Schools
NSACP	National Sexually Transmitted Infections and AIDS Control Programme
NSV	No Scalpel Vasectomy
OCP	Oral contraceptive pills
OOP	Out of pocket
PDHS	Provincial Director of Health Services
PHI	Public Health Inspector
PHNS	Public Health Nursing Sister
PHM	Public Health Midwife
PHSRC	Private Health Sector Regulatory Council
PITC	Provider Initiated testing and counselling
PLHIV	People Living with HIV
PPP	Public Private Partnership
PSDG	Province Specific Development Grants
PSL	Population Services Lanka

QI	Quality improvement
RBM	Results based management
RDHS	Regional Director of Health Services
RH	Reproductive Health
RHMIS	Reproductive Health Management Information System
RMO	Registered Medical Officer
RMSD	Regional Medical Supplies Division
RTC	Regional Training Centres
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goals
SLCOG	Sri Lanka College of Obstetricians and Gynaecologists
SLDHS	Sri Lanka Demographic and Health Survey
SLR	Sri Lanka Rupee
SLMC	Sri Lanka Medical Council
SLVSC	Sri Lanka Voluntary Surgical Contraception
SPHM	Supervising Public Health Midwife
SRH	Sexual reproductive health
TACMH/FP	Technical Advisory Committee on Maternal Health and Family Planning
TFR	Total Fertility Rate
TOR	Terms of Reference
VMG	Vulnerable and Marginalized Groups
VTC	Vocational Training Centre
WFS	World Fertility Survey
WHO	World Health Organization
UNFPA	United Nations Population Fund

Executive Summary

Introduction

Since the introduction of family planning (FP) to Sri Lanka in 1953 and the establishment of the National Family Planning Programme (NFPP) the country has made considerable progress in providing a wide array of FP services. In the mid-1970s one in three married women aged 15–49 were using a contraceptive method. By the mid-1980s, use of contraception increased to almost two in three women. During the period 1993–2000 the overall prevalence increased from 66 percent to 70 percent. [1]This was due to a greater increase in the use of modern methods compared with the increase in the use of traditional methods. The Contraceptive Prevalence Rate (CPR) did not change much between 2000 and 2006/7. It is important to note that national figures mask district variation. The 2006/7 SLDHS indicates that 7.3 percent of currently married women had an unmet need for FP. The primary objective of the NFPP at its inception was to control the population growth while a secondary objective was to facilitate families to make informed decisions on their desired number of children. The Government affirmed the importance of FP in reducing infant and maternal mortality by integrating Maternal and Child Health (MCH) and FP from the inception of the NFPP. Following the International Conference on Population and Development (ICPD) the NFPP shifted from a demographically driven approach to FP to one that is based on human rights and the needs, aspirations, and circumstances of each woman and couples. The Population and Reproductive Health Policy was formulated in 1998.

The Ministry of Health Nutrition and Indigenous Medicine (MoH) has reaffirmed the importance of FP in the National Health Strategic Master Plan 2016-2025. In recent years the NFPP is facing considerable challenges both programmatic and from the external environment. Hence the need for a review of the NFPP was thought to be timely. The objectives of the review are to: (1) conduct an objective assessment of the existing services in relation to FP; (2) identify the current needs related to FP; (3) review the extent to which the FP services meet the needs of the population; (4) determine the gaps in existing FP services; (5) suggest strategies and services in order to address the gaps identified.The review process was guided throughout by the Expert Group of high-level experts drawn from the government, development partners, and Non-Governmental Organization (NGO)s and chaired by the Deputy Director General Public Health Services II (DDGPHS II.)

Methodology

The review organized technical issues conceptually in terms of enabling environment, supply issues, and demand generation as constituent components of a health service delivery system for FP. [2]These three programme areas are linked together; investments in one component will have an impact in another area, including quality client-provider interaction, capacity and systems building at all levels, and transformation of social norms for the acceptance and use of FP.

In consultation with the Expert Committee seven districts were selected based on the following criteria: 1) a high or low CPR; 2) high or low unmet need; 3) predominantly urban, rural and estate sectors.

[1] The 1993 and 2000 SLDHS excluded the North and Eastern Provinces.

[2]The conceptual framework for the review was based on EngenderHealth's Supply-Enabling Environment-Demand (SEED) Programming Model for FP.

For a relatively well performing district Moneragala was selected while Galle was selected for a district with average performance. Kalmunai, Trincomalee, and Jaffna were selected due to their relatively poor performance.

The following approaches were used to collect information related to the objectives of the review and consisted of the following: desk review of available documentation; a stakeholder consultative workshop; key informant interviews (KII); focus groups discussions (FGD), and; site visits, to health institutions and training institutions. Discussion guides were prepared for the KII and FGD and a checklist for health institutions was also developed. The transcripts of the KII and FGD enabled a set of codes to be developed to describe groups of words, or categories, with similar meanings. The codes made it possible to search the transcripts using the "find and select" feature in Microsoft Excel to easily read all the quotes of participants related to a particular topic or theme. Direct quotations from participants are presented in italics in the report to highlight key findings.

The Key Findings

Enabling environment

The National Committee on Family Health (NC/FH) chaired by the Secretary of Health provides leadership for the NFPP while the Technical Advisory Committee on Maternal Health and FP provides technical advice. Day to day management of the NFPP is the responsibility of the FP Unit. The capacity of the FP Unit to carry out its functions is inadequate in terms of human resources and access to reliable and timely information. The NFPP has not paid sufficient attention to prevention and treatment of subfertility, post-abortion care, services for vulnerable and marginalized groups (VMG) and changing gender and social norms in favour of FP.

Though the appointment of Consultant Community Physician (CCPs) to the provinces has strengthened the capacity of the provinces, district capacity in planning, implementation and monitoring of the NFPP is weak. Planning of FP activities at national and district level is fragmented since there is no costed multi-year national action plan for FP. There are several policies, strategies and guidelines that support FP but do not have costed implementation plans. The Population and RH Policy of 1998 needs revision. The National Strategic Plan on Maternal and Newborn Health (2012-2016) is currently under revision.

The training and supply of health workers has not kept pace with health sector needs, either quantitatively or qualitatively. Inadequate numbers of all categories of trained staff, including from ethnic minorities and the uneven geographic distribution of human resource severely constrains the delivery of rights based FP services. Recruitment of certain categories of mid-level staff is becoming increasingly difficult. For instance being a PHM is no longer attractive. The career path for some categories of staff is limited which also makes recruitment problematic. "Difficult" districts are at a disadvantage in attracting and retaining staff. Despite the maximum population to be covered by each category of public health staff having been determined by the NC/FH in many instances the population exceeds these norms. There is a pressing need for supervisory staff at district level without whom the quality of services cannot be ensured. Though the Public Health Inspector's (PHI) duty list includes male involvement and reproductive health they are the most underutilize category of health staff in delivering information and services on FP. Performance appraisal is viewed more as a routine activity than a tool for performance improvement and career development.

The main revenue source for the NFPP are Government domestic resources, followed by households, corporations, non-profit institutions and donors. Very little funds are allocated for FP from the district health budgets. It is difficult to track the allocation of funds for FP in the public sector. World Health Organization (WHO) and United Nations Population Fund (UNFPA) are currently the only donors for the NFPP. Family Planning Association of Sri Lanka (FPASL) and Population Services Lanka (PSL) the main NGOs involved in FP generate their own funds and also receive funding from their international partners.

Data sources for the NFPP are the Reproductive Health Information System (RHMIS) of the Family Health Bureau (FHB) and the non-routine sources are population-based surveys, such as the population census and the Demographic and Health Surveys. The last Sri Lanka Demographic and Health Survey (SLDHS) was in 2006/7 and data collection is underway for the next one. The quality and timeliness of RHMIS data is a matter of concern. There are lapses in reporting from curative institutions. Furthermore, the current indicators that are being used by the NFPP do not provide sufficient information on access, quality, choice, equity, and utilization for effective management of the NFPP. Data gathered at the district level is used to some extent for decision making. The FP Unit does not have direct and timely access to relevant data collected by the RHMIS in relation to FP from the districts. This is a serious drawback for decision making at central level. The NFPP does not collect data from the private sector.

It is a matter of pride that since the early 2000 all contraceptives for the public sector programme are procured using government domestic funds and that the NFPP is no longer donor dependant. Contraceptives are procured for the public sector programme from WHO prequalified suppliers so as to ensure the quality of the products. The Essential Drug List includes contraceptives and indicates government commitment to FP. Quantification of contraceptive requirements in the public sector is based on historical data which leads to inaccuracies since deficiencies and delays in reporting the H 1158 monthly stock returns was observed. The social marketing and private sector are not involved in forecasting contraceptive requirements together with the public sector. Inventory control of stocks and warehouse practices in the public sector was poor.

In recent years there are negative perception and suspicions about the objectives of the NFPP among ethnic and religious groups. Fostering positive social norms and transforming gender roles in support of FP has not received sufficient attention from the NFPP. Male involvement in family planning is very low.

Supply

A wide network of public, private and NGO sector facilities provide FP services. Though the Director General of Health Services (DGHS) has issued numerous circulars on the desired frequency of FP clinics in curative institutions in practice, however, very few institutions comply with these directives due to lack of space and personnel. In addition to the static clinics, Public Health Midwives (PHM) are expected to conduct domiciliary visits during which oral contraceptives and condoms are distributed. Levels of care for subfertility services in the public sector has not been established. There are only two institutions in the island with subspecialists in subfertility. Treatment of subfertility is only possible in institutions with gynaecologists while advanced fertility treatment is only available in the private sector.

Infrastructure and amenities vary from clinic to clinic in the public sector. Basic equipment and supplies

were available in most facilities. Lack of resuscitation equipment was cited as a reason for not providing injectables in many field clinics. Printed Information, education and communication (IEC) material both in Sinhala and Tamil was in short supply. Guidelines on delivery of FP methods have been developed but were not readily available for reference at service delivery points. Flash cards, flip charts and samples of various FP methods to use during counselling were available but need to be updated. The lack of laboratory facilities to conduct even basic subfertility investigations in the public sector at district level is a major drawback to providing services for subfertility treatment.

Vacancies exist for all categories of staff providing FP services as well as supervisors. In many districts PHMs had to cover additional areas when there were vacancies. In the absence of a closed transfer system for RH diplomates and appointment of untrained staff through the annual transfers to posts leads to breakdown of services for implants and IUD. Some Medical Officer Maternal and Child Health (MOMCH) and Medical Officer of Health (MOH) have not undergone the required training for these posts. Language differences between service provider and client also serves as a barriers to service delivery for ethnic minorities. Female service providers are preferred, especially for Intra-uterine Contraceptive Device(IUD) insertion.

The preservice training curricula of all categories of staff providing FP services reflects the theoretical aspects adequately. The infrastructure and equipment of some of the preservice training sites for nurses and midwives needs improvement. The FP Unit provides in service training for staff including Training of Trainers from the districts. There is no formal curriculum with objectives and the competencies and skills to be acquired are not clear. Trainings are not evaluated for impact. Systematic training needs assessments are not carried out. There is no mechanism for refresher training. Many trainees who are selected do not attend the training programmes. Though every MOH area has a designated in-service training day, different topics related to the work of the MOH and not necessarily FP are selected for discussion. The current format of the in-service training day needs to be changed so as to make it an interactive process.

Supervision of the NFPP is carried out at all levels of the health system. Though supervision plans are prepared in advance supervisors find it difficult to carry out all the visits. Supportive supervision is weak for the following reasons: inadequate number of supervisory staff; limited capacity of supervisory staff; lack of authority of MOMCH / CCP; breakdown in reporting lines, and; insufficient transport for supervisory staff. The Planning Monitoring and Evaluation Unit and FP Unit have developed supervision checklists. There is very little community participation encouraged for providing feedback on services. Regular reviews of the NFPP are carried out such as the monthly conference conducted by the MO, the National MCH Review at district level and bi-annual MOMCH workshops. According to key informants these reviews concentrate more on coverage but should also seek to improve the quality of services. A mechanism to supervise the quality of services provided by the private sector is lacking.

From its inception the NFPP adopted a cafeteria approach to provision of contraceptives. Oral pills, male condoms, injectable IUD, implants and female sterilization are available through the public sector. There is virtually no demand for male sterilization at present. The payment of out of pocket expenditure to clients undergoing sterilization has been terminated as well as the incentive payment to medical personnel carrying out the procedures. Informed consent for sterilization is obtained but not for other clinical methods. Emergency contraceptive pills (ECP) are currently only available through the private and NGO

sector. Administrative and medical restrictions on the use and /or provision of contraceptives based on KII and FGD were also identified during the review. Medical Eligibility Criteria needs to be updated In line with the latest WHO directives.

While FP has been integrated from the inception of the NFPP with MCH there are still ample opportunities for integration such as during the post-partum and post-abortion period prior to discharge from hospital. The expansion of the Programme for Elimination of Mother to Child Transmission of Syphilis and HIV is another entry point. The integration of FP with Well Women's Clinics (WWC) and Non-Communicable Disease (NCD) clinics will make contraception methods available for older women in the reproductive age group who are reluctant to visit FP clinics.

A functioning communication/feedback system between the referring facility and the site accepting the referral to support timely information-sharing and continuity of care is lacking. For instance there is no back referral for refused or postponed female sterilization. A proper referral system for subfertility based on levels of care has not been established.

The share of FP services provided by the private sector is increasing. The NFPP has not actively engaged with the private sector in the quantification and forecasting process of contraceptives, yet the private sector plays a significant role in increasing access, as about 63 percent of condoms and 40 percent of pills are provided the private sector. The private sector is not represented on the National Committee on Family Health while the FHB is not represented in the Private Health Services Regulatory Council.

Men, youth, vulnerable and marginalize groups such as single, separated, divorced and widowed women and older women in the reproductive age group have not been reached sufficiently by the NFPP.

Knowledge of contraception among young people is poor. Contraceptive services are available for married youth or those identified as living together but other sexually active young people found accessing contraceptive services a challenge. During Focus Group Discussions (FGD) sexually active single, separated, divorced, widowed women and women living with HIV expressed their lack of confidence in the field staff in the public sector to maintain confidentiality.

Many KI ranging from policy makers, manager, trainers and FGD with clients showed that communication and counselling skills of service providers was weak and needs improvement. Though couple counselling was ideal and would encourage joint decision making it was not feasible in most instance due to infrastructure constraints in clinics. In addition, the clinic times were not suitable for working men. Maintaining visual and auditory privacy was also an issue in some clinics which also affected the quality of counselling.

Demand

Though FP services are free in the public sector, poor women incur out of pocket expenditure for transport costs to obtain the method of their choice when it is not available close to home or to pay private sector providers when the method of their choice is not available in the public sector. Seeking FP services during working hours represents an indirect opportunity cost for many poor clients who may forfeit wages to receive care. In addition, some investigations and advanced treatments for subfertility are only available in the private sector.

Though the majority of Sri Lankans know at least one method of contraception there is a wide gap between knowledge about contraceptives and utilisation in Sri Lanka. Modern contraception uptake is hampered by misconceptions or misinformation about side effects and cultural and religious beliefs also serve as barriers in some communities. Other barriers to use of modern contraception use include personal or partner opposition to contraceptive use and reliance on traditional methods. The HEB has developed five Behaviour Change Communication Strategy Guides for Reproductive Health Programmes including a booklet on FP. Unfortunately this does not include subfertility. There is no organized, systematic approach to SBCC activities in the districts for promotion of contraception and awareness of subfertility.

Insufficient contact with health providers contribute to the non-use of modern contraception. Older women in the reproductive age group are less likely to come into contact with health workers. Very little use of the mass media has been made in recent times by the public sector to disseminate messages on FP.

The main social marketing organizations for contraceptives in Sri Lanka are FPASL and PSL. There is no formal coordination mechanism between the FHB which is responsible for the NFPP and social marketing organizations and on the messages that are disseminated.

The NFPP has not engaged sufficiently with communities to increase demand for FP though there are several potential entry points such as the Mothers Support Groups (MSG) and different women's groups and youth organizations at divisional level. Peer education is also a potential means of increasing demand but has not been utilized by the NFPP.

Recommendations

Enabling environment

Short term (2 years or less)

1. Enhance leadership and governance of the NFPP

Revise the Terms of Reference and membership of the National Committee on FH (NC/FH). The NC/FH should provide advice and guidance on issues such as inequity in service delivery, especially subfertility treatment, weak FP services in public sector curative institutions, ensuring quality of services in both the public and private sector, establish public –private partnerships, advocate with Government on addressing the human resources for health crisis and multi-sectoral issues such as the decreasing age at marriage and providing comprehensive sexuality education in schools. The composition of the TACM/FP needs to be expanded and the NSACP, Private Health Sector Development Directorate and NGO, private sector and civil society organization should be included.

2. Reposition FP as a key cross cutting intervention for national development.

An important responsibility of the NC/FH should be to reposition FP as a key cross cutting intervention for national development.

3. Develop a multi-year National Action Plan for FP

Currently FP planning is fragmented and a multi-year National Action Plan for FP which will ensure an unified plan is followed by the central government, provinces, districts, NGOs and development partner is needed. Such a plan will ensure that all FP activities are aligned with the country's needs and prevent fragmentation of efforts. The plan will be costed with an implementation roadmap with defined targets. Monitoring and evaluation will be an integral part of the plan and progress must be reviewed by the NC/FH and the TACM/FP at national level against key indicators using an executive dashboard. Costed district plans need to be developed subsequently in line with the national plan.

4. Strengthen the capacity of the FP Unit to lead, manage and coordinate the NFPP

The cadre of the FP Unit needs to be increased from two to four MOs to effectively and efficiently increase technical and monitoring capabilities of the unit for subfertility and post-abortion care - areas that the NFPP has not addressed sufficiently in the past. A logistics coordinator is necessary for the unit. The Planning Monitoring and Evaluation Unit must make data from the RHMIS directly accessible to the Head of the FP for effective and timely management of the NFPP. The NFPP must be involved in the Maternal Death Review process in determining whether there is an unmet need for FP as an underlying cause for the death.

Long term

5. Strengthen the capacity of districts to effectively plan, implement and monitor their FP programmes

Capacity assessments will be carried out in priority districts i.e. those with a high unmet need for modern contraception and those with high teenage pregnancies. The FP Unit must provide technical assistance and carry out regular supportive supervision visits. Ensure MCH district plans are submitted to FHB for comments prior to incorporation into district plans.

Make MOMCH undergone the stipulated training for the post prior to deployment mandatory. Ideally they should have prior experience as MOHs. The capacity of key district staff such as MOMCH, RSPHNO needs to be enhanced to coordinate, plan, implement and monitor the FP programme at district level by conducting annual training programmes for them. Introduce quarterly analytical reports to be submitted by the MOMCH on the performance of the NFPP in the district to both the RDHS and FP Unit.

6. Supportive laws, policies and guidelines are operational to create an enabling environment for FP

Policies

1) A Reproductive Health Policy needs to be developed to replace the Population and Reproductive Health Policy (1998). Management of subfertility needs to be addressed in detail in the revised Policy.

2) Ensure FP is well reflected in the revision of the Maternal and Newborn Health Strategic Plan 2017-2025.

3) Open communication channels with private sector providers and recognize the complementary role that the private sector can play in increasing commodities and services. Consider policy options to stimulate private sector participation such as tax rebates/exemptions on contraceptives imported

into the country.

4) Develop a policy for public private partnership (PPP) in collaboration with the Directorate of Private Health Sector Development. Some mechanisms for PPP are: social franchising; voucher schemes which involve demand side financing, and; mobile clinics. For instance PPPs will enable poor subfertile couples to access Assisted Reproductive Technology (ART) that they would not be able to receive otherwise. PPPs can also be used for expanding services for marginalized and vulnerable groups. By fostering PPPs, the government can reduce its burden on infrastructure and trained staff and help ensure FP products and services are consistently available in the long term and concentrate efforts in reaching the most marginalized and vulnerable.

5) Review and revise the contraceptives on the Essential Drugs List based on evidence guided recommendations to increase the method mix and contraceptive choice.

6) Enter into a collaborative relationship with the NMRA to fast track the registration of new contraceptive methods that are considered by the NFPP to be appropriate for use in the public sector.

7) Ensure at least one laboratory in a district is capable of performing hormonal assays, seminal fluid analysis and sperm preparation for intrauterine insemination (IUI).

Legislation

The current RHMIS does not collect FP information from the private sector. It is necessary to consider introducing legislation to obtain such information.

The legislation on ART needs to be expedited and a regulatory authority on lines of the Human Fertility and Embryology Authority of UK established.

Guidelines

Consider abolishing the circular related to criteria for sterilization; clarify for health workers the policy with regards to access for adolescents less than 18 years to FP services in clinical and community setting; guidelines on post-abortion care need to be endorsed and disseminated by the DGHS; develop service delivery levels for subfertility services in collaboration with the Sri Lanka College of Obstetricians and Gynaecologists (SLCOG).

7. Address the pressing demand for all categories of human resources

While recommendations on Human Resource for Health (HRH) in general are beyond the scope of this report, the MoH is urged to consider the follow HRH issues that impinge directly on the NFPP.

- Conduct workforce assessments for categories of staff involved in MCH FP other than PHM which has been completed.
- MoH must give priority to underperforming district sand 'difficult" districts in fulfilling their HRH needs;
- Redeploy midwives from hospitals reporting very few births as field midwives;
- Ensure adequate supervisory staff are available by re-employing retiring staff as a short term measure;

- Ensure that norms on staffing based on the population are implemented so as to provide quality services.
- In order to operationalize the two subfertility centres in Castle Street Hospital for Women and Mahamodera Hospital a cadre of embryologists and counsellors need to be created, recruited and trained.
- Retain skilled providers such as RH Diplomates in a "closed service" which will ensure that the skills are not lost during the process of annual transfers and that services do not break down in the health facility for want of trained service providers.
- Affirmative action needs to be taken to address the underrepresentation of ethnic minority groups among health staff.

8. Increase financing for FP

Develop a resource mobilization plan

Increase domestic funding for FP. Conduct evidence based advocacy with policy makers at both MoH and provincial level for allocation of additional resources for FP programming.

Mobilize additional resources from development partners.

Mobilize resources from the private sector. Encourage the private sector to: include FP as a part of the health benefits to their employee; encourage media organization to devote more time to the promotion of FP as part of their organisations' social responsibility.

Create a budget line for FP programming. This will ensure that allocations for FP are ring-fenced.

Mainstream FP in district planning and budgeting processes. The FP Unit must assist the provinces and districts in developing advocacy plans to target local leaders, including Provincial Council members for the creation of budget lines for FP at the provincial and district level. Availability of budget lines will support the prioritisation and integration of FP into provincial and district planning and budgeting processes. Technical assistance must be provided from FP Unit to help the provincial and district level make evidence-based decisions related to programming, budgeting and tracking expenditures for FP.

Track Government expenditure on FP.

Build the evidence base to increase financial support for FP. This will include commissioning studies to inform advocacy efforts so as to increase funding from government and potential development partners.

Include FP in health insurance scheme. The MoH must conduct advocacy to ensure that health insurance scheme includes coverage for all FP methods and subfertility treatment in all insurance packages.

9. Strengthen performance planning, monitoring and accountability

A culture of results based management and accountability needs to be inculcated in managers. There needs to be a paradigm shift from assessing progress of planned activities to measuring outputs, outcomes and impact against predetermined and agreed upon indicators.

Improve the collection of data from the public sector curative institutions.

Revise the indicators and data collection instruments used by the NFPP. An array of indicators for tracking NFPP performance across dimensions of access, quality, choice, equity, and utilization are necessary.

Use of an executive dashboard to monitor progress.

Conduct surveys/investigations and strategic research to collect relevant complementary data. The SLDHS is conducted too infrequently to provide the data required to monitor progress and shift priorities. Surveys to monitor performance must be carried out at least every two years. The Research Unit of the FHB can develop survey instruments to collect FP data as necessary.

10. Improve contraceptive security

Implement a comprehensive contraceptive forecasting and quantification system.

Ensure district staff are able to report contraceptive forecasting data on time and accurately. Provide training on forecasting and quantification for district level staff in both preventive and curative institution.

Improve the LMIS. An automated system is needed to capture facility level logistics data so that district and central level can make informed decisions on movement of contraceptives. The use of mobile phone technology needs to be explored to improve real time stock monitoring and resupply planning.

Proactively address selective stockouts of contraceptives at the district level.

Make improvements to infrastructure and warehouses practices.

Detection and disposal of damaged/expired FP commodities is improved.

Improve the distribution system. The Regional Director Health Services (RDHS) should procure or hire vehicles for distribution of contraceptives from Regional Medical Supplies Division (RMSD) to institutions..

Conduct supportive supervision to RMSD. Conduct joint supervision by FP Unit and MOMCH to RMSD. The checklist developed by FP Unit can be used for this purpose.

Monitor the quality of products in private sector pharmacies. Regular inspections by Drug Inspectors of NMRA must be carried out to ensure the quality of contraceptives in the private sector, especially pharmacies.

Recruit a graduate pharmacist for FP Unit as logistics coordinator. One of the important roles of the logistics coordinator is to track commodity requests and distribution closely. A cadre revision will be necessary to create the post of logistics coordinator in the FP Unit.

11. Reinvigorate advocacy to increase visibility of and support for FP

Although FP has been recognised in policy as a key element in improving national health and development, the enabling environment for FP remains weak and a lack of political will, commitment, and clear messages from leaders has hampered the momentum of the NFPP. This recommendation aims at sustaining support for FP from the highest policy levels.

Develop a FP advocacy strategy and Action Plan. The strategy seeks to create an enabling environment for FP by increasing the visibility of and support for FP. The advocacy strategy must identify objectives, primary and secondary audiences, themes and messages, tactics and have an monitoring plan with indicators. Advocacy efforts must be specific for the different groups that are identified. Some important advocacy issues the Advocacy Strategy should address are:

- Creating a separate budget line for FP programming at MoH and Ministry of Finance so as to prioritize funding for FP;
- Need based allocation of financial resource for FP by provincial authorities that prioritizes underserved and marginalized areas so as to ensure equity;
- Inclusion of FP in major national policy documents stressing the significance of FP to national development;
- Mobilizing additional resources from development partners for FP despite Sri Lanka being a LMIC in order to address marginalized and vulnerable groups;
- Stimulate private sector involvement in FP by offering attractive incentives;
- Convincing non-health sector programmes to integrate FP into their activities
- Catalyse introduction of age specific comprehensive sexuality education into the school curriculum;
- Mobilize support from religious and political leaders at national and subnational level to improve maternal and child health through proper FP practices;
- Mobilize multisectoral support to reduce early marriage and teenage pregnancies
- Strengthening subfertility services in the public sector.

12. Transform gender and social norms.

A range of interventions from service delivery, advocacy at all levels, community engagement and training of service providers in gender sensitive counselling are necessary to transform gender norms.

The NFPP should promote gender equity by placing the responsibility of contraception in the hands of both women and men. The FP Unit, the Adolescent and Youth Unit and the Gender and Women's Health Unit must work together with the Ministry of Education to transform gender and social norms at a young age.

Supply

Short term

1. Improve availability of quality contraceptive and subfertility services

Conduct a FP service availability and readiness assessment (SARA) which will provide information on the overall availability and readiness of curative and preventive institutions to provide quality FP services.

Prepare service scale up plans for areas with the greatest unmet need for modern methods and poor access. Districts should develop and implement a FP "service scale up plan" which will include training. At least one laboratory in a public sector health facility in a district must be strengthened to carry out semen

analysis and hormone assays.

Information and services for contraception and subfertility are available at times and locations that are convenient to clients.

Reduce linguistic barriers to communicating with clients. Language barriers limit access to health services including FP services and affect the quality of care.

Fully operationalize the two existing public sector subfertility centres and consider expansion to a further centre.

Long term

2. Improve infrastructure and provide equipment and supplies

The SARA will identify the facilities requiring renovation, equipment and supplies and will enable district authorities to prioritize. Explore soliciting Corporate Social Responsibility commitments from the private sector to improve the infrastructure of public sector clinics. Infrastructure improvements should include improvements to maintain auditory and visual privacy.

3. Invest in preservice and in-service training

Create an environment that is conducive to learning during the preservice training of health workers. Make improvement to the infrastructure of Nurses Training Schools (NTS). Determine and procure the package of equipment, models, commodities, and consumables required for successfully training FP workers in NTS and Regional Training Centres(RTC). Provide refresher training for preservice trainers periodically so that they improve their skills. Since RTC trainers are liable to transfer consider retaining their skills using a closed transfer system.

Recruit and train embryologists and counsellors for ART services.

Improve in-service training Significant investments are needed for in-service training so as to build the capability of health workers to competently, safely and efficiently provide quality rights based FP services.

1) Based on needs assessment develop a National in Service Training Plan. Training needs should be identified by the MOMCH for each district. As part of its annual MCH plan each district should prepare a training plan on FP and submit to the FP Unit. The district plan needs to be incorporated into the FP Units annual plan. The training plan should be monitored by the FP Unit and the MOMCH.

2) FP Unit must develop a formal curriculum for each training programme with objectives and skills that trainees are expected to be competent in.

3) FP unit should allocate sufficient resources for trainings identified by the FP unit as well as those proposed by the districts.

4) District health officials must advocate for sufficient resources for training from the district health budget.

5) Develop a core group of master trainers in the provinces / districts to conduct training within the province /district.

6) Improve the knowledge and skills of existing clinical trainers and supervisors.

7) Provide refresher training on FP and subfertility. periodically.

8) Conduct evaluations of trainings as a routine. Carry out an evaluation of the training carried out by the districts on IUD and implants.

9) Consider changing the MOH in-service training day format to one where adult learning principles are applied to the learning process. Experience sharing and exercises where health staff can use their problem-solving, reflecting and reasoning skills needs to be introduced.

10) In addition to group-based approaches to training introduce innovative techniques such as individualized and computer-assisted learning.

11) Provide training on FP to curative institution staff working on the obstetrics and gynaecology wards.

12) FHB in partnership with the Association of Pharmacists should train the 1200 strong membership, some of whom are retail pharmacists. Their practice limitations will be emphasised throughout the training to curb possible abuse. This training could be by means of a distance training programme.

13) The NFPP should consider working with the College of General Practitioners and the Independent Medical Practitioners in developing distance learning modules on FP.

14) Strengthen the existing training database into a Training Monitoring and Information System at FHB.

4. Improve the quality of FP services

Review and revise the service provision guidelines and other job aids. The service delivery guidelines, Medical Eligibility Criteria Wheel, flash cards, flip charts etc. need to be revised, updated, printed and disseminated widely. The process of revising and developing the guidelines should have wide participation including SLCOG and physicians so as to ensure ownership.

Develop National Service Standards for FP This will serve as a country-specific reference document and sets a national standard for the provision of FP services. These standards will be developed following wide consultation. The standards should take into consideration best practices globally and the latest Medical Eligibility Criteria of the WHO.

Strengthen supportive supervision of the NFPP. To improve supervision the following issues need to be addressed: 1) make up for attrition of supervisory staff due to retirement by re-employing them on contract basis as a short term measure; 2) develop duty lists for CCP and identify clear lines of responsibility for supervision carried out by CPP and MOMCH; 3) ensure newly appointed MOMCH receive training on management of RH /FP programme management prior to deployment; 4) increase the availability of transport for supervision; 5) continue to develop the capacity of PHNs and SPHMs as coaches and mentors.

Use the quality improvement (QI) teams established by the National Quality Assurance Programme in Health to improve the quality of FP services in health institutions. 1)The QI teams will check to see if the FP Standards and guidelines are being used. These FP Standards and guidelines will be made available to all facilities; 2) As part of improvement of quality of services heads of institutions including MOH and external supervisors should conduct periodic exit interviews with clients.

Reduce client waiting time.

Introduce obtaining informed consent from clients prior to insertion of IUD and implants. Currently informed consent is obtained only for sterilization. Ensuring informed choice and volunteerism will result in better and longer method use, improved client compliance and satisfied clients who will in turn encourage others to participate in FP programme.

Engage with the communities to improve the quality of services. More community participation is needed to obtain feedback on the quality of services.

Motivate health workers. Motivate staff to provide high quality rights based services. Introduce performance appraisal; provide non-monetary incentives in terms of recognition and awards e.g. study tours; MoH must open up career advancement opportunities for PHNS and PHM; agreement among provinces and the centre on standardized incentives to be provided to public health field staff; provide an allowance to PHMs to establish their office based on market rates; payment of arrears to PHMs appointed to grade 1.

5. Increase the method mix so as to further expand the choice of modern methods.

The NFPP should consider the introduction of newer cheaper implants. Train health personnel to provide no scalpel vasectomy (NSV) so as to increase the choice of contraceptive methods that are available through the NFPP.

6. Integrate to the extent possible contraceptive provision with other outpatient and inpatient services.

Capitalize on the opportunity to provide information and services on contraception during the postpartum and post abortion period:

1) Curative institutions must make available postpartum sterilization to clients who request for the service and meet the eligibility criteria;

2) Designate a staff member on obstetrics and gynaecology wards to be responsible for providing information on contraception and refer for appropriate services. This must be recorded in the discharge summary;

Older women in the reproductive age group attending WWC and NCD should be dissuaded from using traditional methods. Since the menstrual cycles become irregular with age it becomes difficult to determine the safe period. They should be offered modern methods of contraception.

Continue to provide training on contraception to NSACP staff and consider deploying a PHM in STD clinics.

7. Strengthen the referral system for FP

A monitoring system for the referral system must be put in place. When an IUD or implant is removed at a curative institution in the public or private sector at the request of a client whether or not another method is prescribed, this information should be sent to the MOH of the area. This will enable the client to be followed up in the field and the eligible couples register duly updated.

Document denial of sterilization.When a client requests or a health worker refers a client for sterilization and the procedure is not carried out, the reasons for denying the procedure must be clearly documented and the client referred back to the MOH. This will enable the field staff to make alternate arrangements.

8. Increase private sector involvement in provision of FP services

Improve access and quality of FP services in the private sector. FP Standards and guidelines must be shared with the private sector. Collaboration with the College of General Practitioners and the Independent Medical Practitioners in developing distance learning modules is needed

Scale up distribution of contraceptives through pharmacies. Pharmacies are legally permitted to sell pills, emergency contraceptive pills and condoms. Training of pharmacist is necessary on FP.

Consider public private partnerships to provide advanced infertility services. Enter into public private partnerships with private sector clinics providing ART to assist poor women until such time as public sector ART services are in place.

9. Ensure special groups receive FP services

Expand access to accurate information and FP services to youth

Partner with the Adolescent and Youth Unit of the FHB to provide rights based youth friendly health services. Build the communication, counselling and technical skills of service providers in youth focused FP services that are provided in a friendly, non-threatening, non-judgmental manner.

E***ngage with NGOs to provide services to VMGs.*** Sexually active single, widowed divorced and separated women, older married women having an unmet need are reluctant to use the local clinics so as to avoid stigmatization. The NFPP may engage with NGOs to provide services to these hard to reach groups.

Ensure FP services are accessible to people with disabilities. FP clinical service delivery guidelines will be revised and health care workers will be trained on providing FP services to people with disabilities.

10. Enhance communication and counselling skills of service providers.

Emphasize counselling skills during pre-service and in-service trainings. Provide language skills to service providers prior to deployment to predominantly Tamil speaking areas. Include PHI in training to enable them to communicate effectively with men. Supervisors should specifically observe client provider interactions during supervision visits and conduct exit interviews of clients.

Demand

Short term (within 2 years)

1. Rebrand family planning

A new look and new image is necessary for the NFPP. The objective should be to transform the perception in people's minds and dispel rumours about FP.

Long term

2. Increase demand by reducing out of pocket expenditure and opportunity costs for poor women.

Identify underserved areas and increase the availability of contraceptive services so as to increase geographic accessibility by using the findings of SARA; implement rights based outreach programmes to reach communities living in remote areas and with poor transport facilities; strengthening the contraceptive commodity supply chain in the public sector so that women can obtain their choice of method close to their homes without incurring out of pocket expenditure on transport to another clinic or obtaining services from the private sector. To the extent possible make services available during off working hours and weekends e.g. during lunch time, after 4 pm and during weekends for working women

3. Increase access to accurate information about FP.

Develop a FP Communication Plan as part of the proposed FP Action Plan (see Enabling Environment). Use mass media to provide accurate information on FP, dispel myths and misconceptions and increase demand for FP. Though expensive, the use of a professional media organization from the private sector to design the media campaign should be considered.

Move with the times - use social media and mobile technology to create demand for FP Pilot test using short text messaging (SMS) the use of social media to disseminate messages on FP. Strengthen the HEB hotline to answer questions from callers on contraception and subfertility and where services can be obtained.

Train service providers so as to improve their attitudes and communication skills to offer rights-based FP information and services.

Sensitize religious and community leaders about healthy timing and spacing of pregnancies and subfertility.

Mobilise men in support of FP.

Use the MSGs and other women's groups to increase awareness on FP.

Use satisfied clients as local champions for FP.

Pilot a peer-to-peer approach for FP targeting married women initially. The MSGs can be the entry point for peer-to peer education. Satisfied clients can also be used to develop peer groups.

Maximize encounters of health workers with women and men to discuss FP. Train and mobilize PHIs to incorporate message on FP in their encounters with men at workplaces and elsewhere. Ensure domiciliary visits by PHMs are carried out at least twice a year to women over 35 years and / or with children over 5 years of age.

Reduce factors that act as social and cultural barriers to demand for services.

4. Increase demand by expanding social marketing and the establishment of social franching networks.

Social franchising presents an untapped opportunity to engage private providers in health care delivery to increase access to high-quality FP and other services.

Chapter 1
Introduction

In 1932 the first family planning (FP) clinic was opened by Dr Mary Helen Irwin Ratnam in the premises of the Ceylon Social Service League. Unfortunately, the Second World War intervened and the clinic space was taken over by the British Military Forces. In 1953 the Family Planning Association was formed and a clinic was opened in the De Soysa Hospital for Women in 1954. A cabinet decision was made in 1965 to extend FP nationwide and the National Family Planning Programme (NFPP) commenced under the purview of the Ministry of Health (MoH). The Government affirmed the importance of FP in reducing infant and maternal morbidity and mortality by integrating maternal and child health (MCH) and FP from the inception of the NFPP. The primary objective of the NFPP at the time was to control the population growth through use of contraceptives while a secondary objective was to facilitate families to make informed decisions on their desired number of children.The NFPP incorporates both contraceptive provision and subfertility management. According to WHO "family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility."[1]

Access to FP is a fundamental dimension of sexual and reproductive health and reproductive rights. In 1994, 179 countries including Sri Lanka, came together, and adopted the Programme of Action of the International Conference on Population and Development (ICPD). The ICPD stated that the aim of family planning programmes must be "to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so."[2] This affirmation marked a paradigm shift in the way governments looked at development and population issues replacing a demographically driven approach to FP with one that is based on human rights and the needs, aspirations and circumstances of each woman and couples. Following ICPD, Sri Lanka developed a Population and Reproductive Health Policy in 1998.

Context and rationale for the NFPP Review

In recent years the NFPP is facing considerable challenges, both programmatic and from the external environment.

1. The Contraceptive Prevalence Rate (CPR) for modern methods is stagnating.
2. National figures mask district variations. In 2014, the lowest performing areas were Colombo Municipal Council and Batticaloa while Ampara health area reported the highest CPR in the country.
3. Unmet need for FP is still a major cause of preventable maternal deaths. In 2015 there were 113 maternal deaths reported throughout the country to the Family Health Bureau (FHB). Unmet need accounted for 26 deaths (23 percent).There were four maternal deaths attributed to abortion.
4. Use of traditional methods though falling is still significant.
5. Almost one-third of FP users discontinue using the method within 12 months of adoption.

[1] Fact Sheet Family Planning/ Contraception. World Health Organization http://who.int/mediacentre/factsheets/fs351/en/ (accessed 02.05.2016)

[2] ICPD Programme of Action 1994, para 7.3

6. The benefits of FP for MCH and economic well-being will remain limited unless services are better focused on the most marginalized populations who are in need of services, namely, adolescents, eligible couples with grown up children, sexually active widowed, divorced, separated and unmarried women. In 2014, 10 percent of maternal deaths were among unmarried or single mothers.
7. While services for the subfertile couple are an important component of the NFPP little attention has been paid to this aspect.
8. An emerging challenge to the FP programme is the resistance from religious and ethnic groups who fear their relative status may be threatened if their fertility is reduced.

Therefore the MoH decided that an analysis of the situation of FP was opportune as the country has developed the National Health Strategic Masterplan 2016-2025 and in order to address the Sustainable Development Goals (SDG). SDGs have been set for the next 15 years by the world leaders who gathered at United Nations in 2015.

Objectives of the NFPP Review

Though the NFPP has been in existence since 1965 a comprehensive review has not been conducted. The general objective of the review as given in the Terms of Reference for the National Family Planning Programme Review were to identify achievements, gaps and challenges faced by the programme, make recommendations and develop strategies to address the gaps and issues. (Annex 1) Addressing the issues identified would not only strengthen the programme but also enable it to respond to emerging issues.

The specific objectives of the review were:

1. To conduct an objective assessment of the existing services in relation to FP
2. To identify the current needs related to FP
3. To review the extent to which the FP services meet the needs of the population
4. To determine the gaps in existing FP services
5. To suggest strategies and services in order to address the gaps identified
6. To address any other aspect of the NFPP that needs to be reviewed, which will be communicated by the focal point of the Ministry of Health.

The expected outputs of the review are a report on the current status of the NFPP including a set of recommendations and strategies to address the gaps and emerging issues that are identified including services to vulnerable and marginalized groups (VMG).

The review was conducted in close consultation and collaboration with the MoH. An Expert Committee chaired by the Deputy Director General Public Health Services II (DDGPHS II) was appointed by the MoH in order to provide oversight and to provide technical inputs at every stage of the review process. The Terms of Reference of the Expert Committee and its members are found in Annex 2 and 3 respectively.

The intended audience and users of the NFPP Review are policy makers, programme managers, NGOs engaged in FP and development partners such as UNFPA and WHO.

How the report is organized

The report is divided into 8 chapters. Chapter 1 is the introduction and dwells with the background for the review. Chapter 2 describes the methodology for the review. Information on the country context in which the NFPP operates is found in Chapter 3. The fourth Chapter is in two parts The first part of this chapter describes the achievements made by the NFPP over the years and briefly compares these achievements with other countries in Asia. The second part discusses the current status of FP in detail.

Chapters 5,6, and 7 describe the findings from the stakeholder workshop, document review, KI, FGD and field visits on the three programme areas - enabling environment, supply and demand for FP. Each of these chapters has several components. These components are based on lessons learnt from successful FP programmes throughout the world for each of the three programme areas. The beginning of each component has a box shaded grey which gives a brief description of the importance of the component based on evidence. The findings of the NFPP review are then described for each component.

Excerpts from KI and from FGDs have been included in the report in italics. M refers to the moderator and P to the participants. If more than one participant in a FGD spoke on the topic the number they were assigned at the commencement of the FGD is given in the excerpt. The last chapter gives the recommendations for enabling environment, supply and demand.

Chapter 2
Methodology

The conceptual framework for the NFPP review was based on Engender Health's Supply-Enabling Environment-Demand (SEED) Programming Model for FP.[1] Existing literature on the characteristics of strong, comprehensive, sustainable and high-quality FP programmes address the interrelated programme areas of enabling environment, supply and demand.[2,3,4,5] These three programme areas are linked together, as investments in one programme area will have an impact on other areas, including quality client-provider interaction, capacity and systems building at all levels and transformation of gender and social norms for the acceptance and use of FP. Issues relate to the three main programme areas were examined in detail during the review.

Selection of districts for the review

In consultation with the Expert Committee seven districts were selected based on the following criteria: 1) a high or low CPR 2) high and low unmet need; 3) predominantly urban, rural and estate sectors. For relatively well performing district Moneragala was selected while Galle was selected for a district with average performance. Kalmunai, Trincomalee, Jaffna and Colombo were selected due to their relatively poor performance.

Methods of data collection for the review

Multiple methods and approaches were used to collect and analyse information related to the objectives of the review.

- desk review of available documentation,
- a stakeholder consultative workshop,
- Key Informant Interviews (KII),
- Focus Group Discussions (FGD)
- site visits to health institutions, training institutions and warehouses.

This consolidated information served as the basis for formulating recommendations.

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[1] The Supply –Enabling Environment- Demand Assessment Guide for Family Planning Programming. Engender Health 2011. https://www.engenderhealth.org/files/pubs/family-planning/seed-model/seed-assessment-guide-for-family-planning-programming-english.pdf Accessed 05.02.2016

[2] Mwaikambo L, Speizer IS, Schurmann A, Morgan G, Fikree F. What works in family planning interventions:systematic review of the evidence. 2011. Stud FamPlann.; 42: 67–82. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3761067/pdf/nihms491240.pdf. (Accessed 13.3.2016)

[3] Elements of Family Planning Success Toolkit.https://www.k4health.org/toolkits/fpsuccess. (Accessed 13.3.2016)

[4] Family Planning High Impact Practices.https://www.fphighimpactpractices.org/resources. (Accessed 13.3.2016)

[5] Elements of Success in Family Planning Programming.Johns Hopkins School of Public Health.Series J Number 57.2008. http://pdf.usaid.gov/pdf_docs/Pnadn430.pdf. (Accessed 13.3.2016)

* In the Sri Lankan context "estate sector" refers to the population who live and work in plantations called "tea estates" or "rubber estates"

Document review

A literature review of national policies, programmes, circulars issued by the FHB, technical guides, training materials and Annual Reports was carried out to assess existing mechanisms, available resources, issues, gaps and challenges in FP. In addition, the literature review looked at recent research studies (within the past 5–10 years) on FP-related issues in Sri Lanka including those by MD Community Medicine and Obstetrics and Gynaecology candidates. The document review enabled an analysis of the categories of people with whom KII and FGD would be necessary. The desk review also helped identify information gaps to be further explored during KII and FGD. Key informants (KI) also suggested documents to be included in the desk review. The documents reviewed are found in the Bibliography in Annex 4

Stakeholder Consultative Workshop

A one day workshop was conducted on 21st December 2015 as a means of obtaining stakeholder inputs from across the health system. The objectives of the workshop were to :

- share knowledge and practical experiences on securing an enabling environment for FP through renewed commitment and leadership at national and subnational levels;
- discuss strengthening the health system so as to address unmet need for FP, including vulnerable and marginalized communities;
- share knowledge and practical experiences on diminishing socio-cultural and other barriers and enhancing the demand for FP services;
- identify issues and challenges in relation to contraceptive security in the country;

The participants were mainly from the health sector and comprised of policy makers from the centre and provincial level and those from the operational level from the centre, province, district and divisional levels. In addition, the private sector, NGOs, representatives of the Sri Lanka College of Obstetricians and Gynaecologists (SLCOG), College of Community Physicians, General Practitioners and representatives from UN Agencies, WHO, UNFPA, UNICEF, World Bank and WFP were also invited. The list of participants is found in Annex 5. The findings were used in sharpening the questions for KII and the FGD that would follow.

Key Informant Interviews (KII)

The objectives of the KIIs was to obtain information that was not available from the document review and also to explore possible recommendations with the KI. Several meeting were held with FHB officials and the Expert Committee to identify KI at national, provincial and district levels. Based on the desk review and the findings of the stakeholder workshop discussion guides for the KII were developed. (Annex 6)

A total of 80 KII were conducted at national level and 119 at district level. (Annex 7) KII at national level included officials of MoH and Department of Health Services, Ministry of Women's Affairs, Ministry of Education, Ministry of Youth Affairs, private sector health institutions, development partners, professional organizations, health training institutions and NGOs. Provincial, district and divisional level officials of the Provincial Department of Health Services were also interviewed in addition to members of civil society, media personnel, educationists, private sector pharmacists, local religious and political leaders. Responses were hand-recorded by the interviewer.

Focus group discussions (FGD)

FGDs were selected as part of the methodology because it acts as a means to uncover people's subjective attitudes and experiences that are typically inaccessible through other means of data collection. A total of fifty six FGDs were conducted with the following groups:

- Married women 18-29 years;
- Married women 30-45 years;
- Married men 35-50 years;
- Unmarried women 20-30 years;
- Unmarried men 20-30 years;
- Out of school boys 16-19 years;
- Out of school girls 16-10 years;
- Widows;
- Divorced and separated women;
- Female partner from sub-fertile couples;
- Women living with HIV/AIDS;
- Public Health Midwives (PHM);
- Public Health Inspectors (PHI);
- Estate Medical Assistants;

The number of FGDs conducted with each group and the districts in which they were conducted is found in Annex 8. Although the data are not statistically representative of the total population, they provide insights into norms and rationales for what people do and think. FGDs were held between July and October 2016. The FGD guides with probes for each question were first prepared in English. These were circulated to the expert group and their comments were incorporated. The FGD guides were then translated into Sinhala and Tamil and back translated into English to ensure consistency (Annex 9).

There were two FGD teams one Tamil and one Sinhala which comprised of a moderator and a note-taker. The teams were fluent in Sinhala or Tamil as well as English. The moderators and note takers were all health personnel and familiar with issues related to FP. Prior to deployment, training was carried out using the FGD guides. The training also included aspects such as how to deal with dominant participants in the group and conversely on how to obtain the participation of quiet members. Mock FGDs were conducted to gauge the moderators and note-takers grasp of the questions. Emphasis was placed on avoiding biases and on the most appropriate way of asking the questions.

In order to maintain confidentiality and reassure the FGD participants each participant was assigned a number. FGDs were audio recorded with the participants' permission. Participants were told that they could drop out of the discussion at any time or choose not to answer any individual questions. The note-taker took notes and identified each participant by the number they were assigned. e.g. P1, P2 etc. The respondents non-verbal communications, influence by other participants and context within which the comments were made was also documented in the notes. FGD were conducted in diverse locations - in MOH offices, community centres, NGO offices, temples and even private residences.

Groups ranged in size from seven to fourteen participants and lasted from 120 to 150 minutes. In addition to tea and snacks a small stipend was paid to cover the participants travel expenses. The audio recording of the FGD was transcribed verbatim as far as possible from Tamil and Sinhala and entered in English into Microsoft Word. So as to ensure quality of the transcribed scripts and the translations from Tamil and Sinhala into English, individuals who had not been involved in the data collection and who were fluent in Tamil/English and Sinhala /English were asked to listen to the tapes, review the transcripts and the translations for any inaccuracies. A comparison of the two sets of transcriptions did not show any significant disagreement.

Site visits

Health facilities

So as to cover all types of institutions providing curative and preventive services in a district, visits to a Teaching Hospital (if present), a Provincial General Hospital, a District General Hospital, at least one Base Hospital, two Divisional Hospital and Primary Medical Care Units and at least two MOH areas were carried out. At least two PHM offices in each district were visited. Some of the facilities that were chosen were centrally located and easily accessible while others were more remote so as to ensure geographical spread. Three private hospitals that provided RH services were visited during the review. The clinics run by FPASL in Nuwera Eliya and PSL in Trincomalee were also visited. In addition private pharmacies were visited and pharmacists were interviewed. An estate hospital in the Nuwera Eliya district was also visited.

During visits to health institutions a checklist was used to observe the readiness of the institutions to provide services of an acceptable standard (see Annex 10). Readiness was assessed in terms of general service readiness and FP service specific readiness.

1. **Readiness to deliver health services in general** was determined by the following characteristics of facilities: availability of basic amenities for client services, such as external signs advertising what services were available, a sheltered waiting areas, regular electricity, improved water source, a separate latrine for female clients, communication equipment and transport for emergencies.
2. **Readiness to deliver FP** services was determined by the following domains:
    a. Availability of FP service
    b. Staff and training
    c. Equipment
    d. Stocks of FP commodities including those identified by the UN Commission on Life Saving Commodities for Women and Children.

Other institutions visited

Training institutions such as the National Institute of Health Sciences (NIHS), regional Nurses Training Schools (NTS) at Ampara, Galle, Jaffna, Trincomalee as well as the Universities of Galle, Jaffna and Sri Jayewardenepura were visited. The warehouse at FHB, the Regional Medical Supplies Divisions (RMSDs) at Galle, Jaffna, Kalmunai, Killinochchi, Moneragala, Mulleriyawa, Mullativu, Trincomalee, Nuwera Eliya, were also visited.

Information gathered from the field visits helped better understand data collected from other sources and respondents.

Analysis

The transcripts from the KII and FGDs were transferred from Microsoft Word to Microsoft Excel. Each FGD group was assigned a workbook and each district a separate worksheet in the workbook. The transcripts were read and re–read several times and a set of codes were developed to describe groups of words or categories with similar meanings. The codes made it possible to search the transcripts using the "find and select" feature in Microsoft Excel to easily read all the quotes of participants related to a particular topic or theme. The KII transcripts were examined for identification of patterns across stakeholders. The information from the sub-national levels helped to further validate findings from the central level and provide new information from the field.

Limitations

One of the limitations was that the last SLDHS was carried out about 10 years ago, hence, some of the data may now be outdated. Data collection for the new SLDHS was underway at the time of the review. The poor quality of the RHMIS data was also a constraint. Another limitation was identifying and bringing participants together for the FGDs, especially males and young people for about an hour and a half. Health providers helped to recruit participants for the discussions. Though there may have been courtesy bias in some instances because of this, in general participants were forthright as they were assured of confidentiality. The most important factor ensuring reliability of the qualitative data was that the discussions were conducted in an atmosphere of trust and sharing. It was our impression that at least some of the respondents may have reported their own experience as that of another person.

Chapter 3
Country context

Sri Lanka is ranked 73rd out of 187 countries on the Human Development Index (2015)[1] and was also on track to achieving most of the targets of the Millennium Development Goals (MDG) according to a review conducted in 2014.[2] These achievements are in large measure due to free health care provision since 1931, and free education from kindergarten to University introduced in the mid 1940s.[3] As a result, Sri Lanka has achieved human development outcomes comparable to those of high income countries.

Despite the three decades long internal armed conflict, the 2004 Tsunami and a global recession the country achieved lower middle income status in 2009 and had a per capita income of US$ 3853 in 2014.[4] The conclusion of the conflict in May 2009 has allowed the country to transition towards peace and stability. The poverty headcount index rates have fallen from 15 percent of the population in 2006/7 to 9 percent in 2009/10,and to 6.7 percent in 2012/13. However, geographic differentials in poverty rates are significant, e.g., poverty rates in Colombo District are under 1.4 percentcontrasting with Mullaitivu (28 percent), Moneragala (20.8 percent), Mannar (20.1 percent) and Batticaloa (19.4 percent).[5] Although Sri Lanka has made considerable progress in reducing poverty and improving the living conditions of its people, income inequality has remained stagnant despite sustained economic growth. The Gini coefficients for both household income and household expenditure has remained around 0.48 and 0.40, respectively from 1990-1991 to 2012. Income inequality has not changed, although many poor people managed to move out of poverty and improve their living conditions.[5]

According to the Millennium Development Goals Country Report 2014 Sri Lanka has almost achieved universal primary education, and the proportion of pupils starting grade 1 who reach grade 5 is nearly 100 percent. Net enrolment in primary schools reached 99.3 percent in 2009, for both males and females. The literacy rate of 15 to 24 year olds increased from 92.7 percent in 1996 to 97.8 percent in 2012. This increase is seen in all regions with the rate for females at 98.2 percent, exceeding the rate for males at 97.2 percent. In 2015 the literacy rate (aged 15 years and above) was 93.2 percent.[4] At present education is compulsory from 5 to 16 years.

Sri Lanka had a multi-ethnic and religiously diverse population of 20.3 million at the time of the 2012 Census of Population and Housing.The average annual population growth rate was 1.1 percent from 1981-2012 and reduced to 0.7 percent for the 2001-2012 period.[6] Recent standard population projections indicate that the population would reach 21.3 million in 2017, 22.2 million by 2022, 25 million by 2042 and 25.8 million by 2062.The population is expected to stabilize around the mid- 2060s at 25-26 million.[7]

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[1] Human Development Index 2014.UNDP Accessed 15 August 2015 http://hdr.undp.org/en/content/human-development-index-hdi-table

[2] MDG Country Report 2014. United Nations Sri Lanka 2015

[3] Education First Sri Lanka.Ministry of Education. 2013.

[4] Central Bank of Sri Lanka.Sri Lanka Socio-Economic Data 2016. June 2016

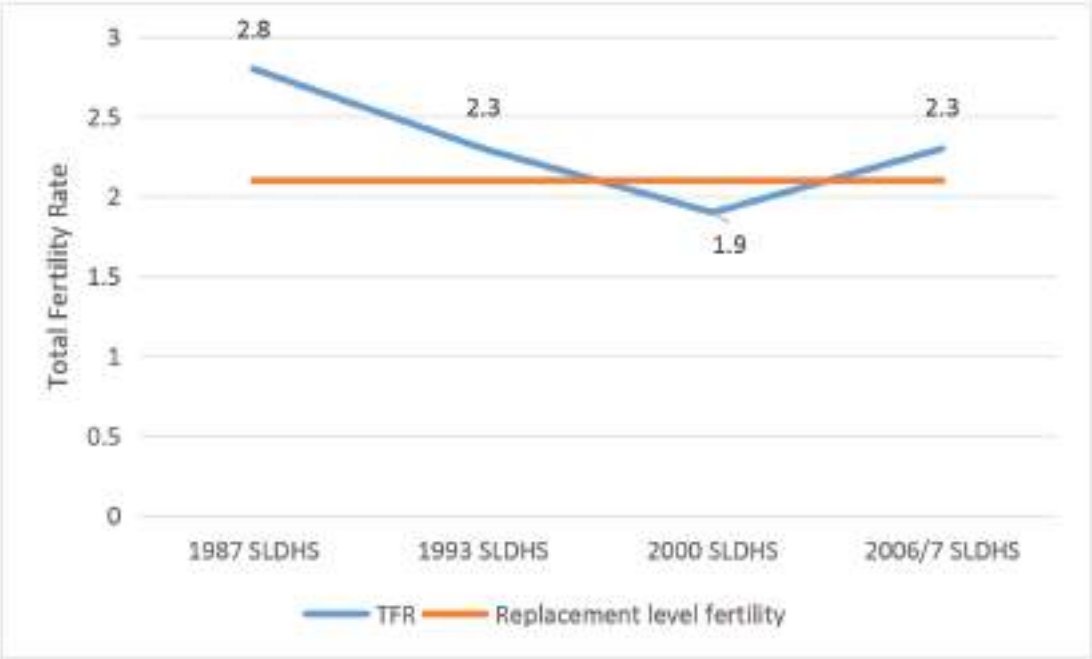
[5] Household Income and Expenditure Survey (2012/13), Department of Census and Statistics

[6] 20.4 million Sri Lanka's Population at a glance. UNFPA 2015.

[7] De Silva I, de Silva R. Sri Lanka: 25 million people and implications, Population and housing projections 2012-2062.

Fertility began declining in Sri Lanka during the 1960s. The Total Fertility Rate (TFR) fell from 5.3 in 1953 to 3.4 in 1981, by almost two live births per woman, and decreased to 2.8 children per women in 1982-1987 and further deceased to 2.3 children per women during 1988-1993 periods. The SLDHS 2000 showed that the TFR for the period 1995-2000 was 1.9 children per women, below replacement level fertility. The findings of the 2006/7 SLDHS for the period 2003-2007 showed the TFR had increased to 2.3 children per women. (See Figure 3.1)

Figure 3.1: Trends in TFR 1980-2006



Source: Sri Lanka DHS 1987, 1993, 2000 and 2006–2007

NOTE: Both the 2000 SLDHS and 2006/7 SLDHS exclude the Northern Province from enumeration while the 2000 SLDHS excluded the Eastern Province. The sample size for the 2000 SLDHS was 8,169 households. Detailed questionnaires were administered to 6,385 women. The sample size for the 2006/2007 SLDHS was much larger, 19,862 households. Detailed questionnaires were administered to 14,692 women.

Some authorities have interpreted this pattern as indicating a reversal of the fertility transition.[8] On the other hand, Wijesekera and Arunachalam[9] cast doubt on whether the TFR did go below replacement level during the five-year period 1995–2000 as the 2000 SLDHS report states. Their estimates based on vital registration data while consistent with the general fertility trends obtained from survey data showed that the fertility might not have reached replacement level.

In Sri Lanka the sex ratio of the total population based on the 2012 Population and Housing Census is estimated to be 93.8 males to 100 females. Due to son preference in some countries in Asia such as India and China the sex ratio at birth has recently emerged as an indicator of gender discrimination. However, in Sri Lanka the sex ratio is skewed in favour of females which is largely attributable to the higher life expectancy of women.

[8] De Silva, W. I., Perera, B. N. &Anuranga, K. C. (2010) Below to above replacement: dramatic increase in fertility and its determinants in Sri Lanka. Asia Pacific Population Journal 25(2), 27–52

[9] Wijesekere G and Arunachalam D, Explaining the fertility puzzle in Sri Lanka, Journal of Biosocial Science, 2015, 47(6):845–852

The population lives predominantly in rural areas, (77.4 percent) while 18.2 percent live in urban areas and 4.4 percent live in the estate sector. Life expectancy at birth for 2011-2013 was 72 years for men and 78.5 women.[10] Sri Lanka has also one of the fastest ageing populations among developing countries.

Sri Lanka defines those between the ages of 10-19 as adolescents, 15-24 years as youth and those between the ages of 10-24 as young people.[11] According to the 2012 Census, adolescents (10-19 years) comprise 16.1 percent of the total population. Youth contribute 15.6 percent of the total population. Knowledge of sexual reproductive health issues including FP is poor among this age group. The National Youth Health Survey 2012/2013 found that overall knowledge on basic sexual reproductive health knowledge was not satisfactory. For instance, only 45.6 percent of girls knew that pregnancy could take place even at the first sexual intercourse. About 14.7 percent of the sample were sexually active during the preceding year. Among unmarried 15-19 year olds 9.7 percent of boys and 2.5 percent of girls had engaged in sexual intercourse.[12]

Sri Lanka is going through a demographic and epidemiologic transition owing in part to the successes in the health sector. The remarkable success in reducing maternal and infant mortality to very low levels, i.e., 33.7 per 100,000 live births[13] and 9.9 deaths per 1,000 live births[14] respectively is partially the result of the extended availability of effective and integrated MCH services for the last half century. These indicators are better than most developing countries and many lower-middle-income countries. Almost all deliveries are attended by skilled personnel.[15] In 2015 there were 113 maternal deaths reported throughout the country to the FHB. Unmet need accounted for 26 deaths (23 percent).There were 4 maternal deaths attributed to abortion. Abortion in Sri Lanka is illegal except when a pregnancy endangers the life of the mother. Attempts have been made in the past to amend the law to allow termination of pregnancy in cases of rape and congenital abnormalities but these have failed.

Sri Lanka is classified as a HIV low prevalence country (HIV prevalence in those more than 15 years of age is less than 0.1 percent) but the number of people living with HIV AIDS has increased steadily over the years. The cumulative total of HIV cases stood at 2,436 (1,597 males and 905 females) by the third quarter of 2016.[16] The National Sexually Transmitted Infections and AIDS Control Programme (NSACP) as part of the Programme for Elimination of Mother to Child Transmission of Syphilis and HIV in Sri Lanka introduced provider initiated testing and counselling (PITC) in ANC from 2016.

Except for under-nutrition and some persisting infectious diseases, such as tuberculosis, dengue, rabies and leptospirosis, Sri Lanka has successfully dealt with most of the typical health problems of low-income countries. An increasing proportion of the population suffers from non-communicable diseases (NCDs) such as heart disease, diabetes and chronic kidney disease.

[10] Life tables for Sri Lanka 2011-2013 by district and sex. Department of Census and Statistics Sri Lanka 2016.

[11] National Strategic Plan on Adolescent Health.(2013-2017). Family Health Bureau Ministry of Health.

[12] National Youth Health Survey 2012/2013 Sri Lanka.Family Health Bureau, UNICEF and UNFPA.

[13] FHB data 2015

[14] Registrar General' Department. 2010

[15] Sri Lanka Demographic and Health Survey.2006-07. Department of Census and Statistics and Ministry of Healthcare and Nutrition. 2009

[16] NASCP http://www.aidscontrol.gov.lk/web/ (Accessed 18.11.2016)

Organization of FP service delivery

Organization of public sector health services [17,18]

The MoH is under a cabinet minister who is responsible for setting health policy in the country. From the 1850s till 1987 government health services were managed by a central health department or ministry. An unique feature of the Sri Lankan public health sector is that the organization is arranged in almost two parallel streams of community health services focusing mainly on promotive and preventive health whilst the curative services range from non-specialized care at primary level to specialized care through a range of hospitals.

The Thirteenth Amendment to the Constitution in 1987 led to devolution of some powers and functions to the Provincial Councils. The devolution functions involved administration and management of the provincial hospitals network and field health services and the Provincial Councils established their own Provincial Ministries and Departments to carry them out. This resulted in associated changes in the management structures, roles and responsibilities of the Central Ministry that had operated before 1987. The effect of devolution on FP services is discussed in Chapter 5

Central level

The MoH is responsible for stewardship functions such as policy making and provision of comprehensive health services which include services for preventive, promotive, curative and rehabilitative care. The Department of Health Services which is under the Director General of Health Services (DGHS) is responsible for providing guidance to policy makers at political level; policy making, programme planning and implementation of all health services; development of guidelines; programme monitoring and technical oversight; purchase and distribution of drugs and consumables; human resource training for provinces as well as the centre (except for Medical Officers (MO) which is the responsibility of Ministry of Higher Education),and; the operation of tertiary and a few other selected hospitals. There are several Deputy Director Generals of Health Services under the DGHS who are responsible for Public Health Services and Medical Services in addition to Planning, Education, Training and Research, Administration and Finance.

At the national level the FHB is the central organization of the MoH responsible for planning, coordinating, monitoring and evaluating the Family Health Programme within the country. The NFPP is part of the Family Health Programme. The FHB also provides the necessary direction and guidance for effective implementation of programmes at the periphery. In addition to the above role, the FHB conducts in-service training in family health for various categories of health staff, and conducts relevant health services research. It is also responsible for procurement and distribution of contraceptives and also equipment and supplies for MCH/FP. The FHB works in close collaboration with the Epidemiological Unit, Health Education Bureau (HEB) and with other related Government and Non-Governmental Organizations. In the past the FHB worked closely with the Population Division of the MoH.

Provincial level

There are nine Provincial Ministries of Health, each with a Department of Health headed by a Provincial Director of Health Services (PDHS). The PDHS are responsible for planning, implementation and monitoring of all health programmes including public health programmes, within the province. Thus,

[17] Annual Report on Family Health, Sri Lanka 2013. Family Health Bureau

[18] Annual Health Bulletin 2012, Ministry of Health.

the different directorates and special programmes of the central government have to liaise with the provincial health authorities and the provincial health care system.

The PDHS is supported by Regional Directors of Health Services (RDHS) who are in charge of each of the health districts / areas within the province.

Health district level

There are 26 health districts/areas each led by a RDHS who is responsible for secondary and primary levels of curative care and all preventive services. The RDHS areas are similar to administrative districts except in the following areas: Ampara where the district is divided into Ampara and Kalmunai health areas; the Colombo Municipal Council (CMC) and; the NIHS Kalutara field practice area. There are several technical units under the RDHS e.g. MCH, Epidemiological Unit (RE), Health Education, NCD, Rabies control, STD, RMSD etc. The MCH unit is responsible for FP and is headed by the MOMCH. The MOMCH is assisted by a Regional Supervising Public Health Nursing Officer (RSPHNO) and support staff.

Divisional level

Within each district, there are several divisions, each in charge of a Medical Officer of Health (MOH) under the administrative supervision of the RDHS. As at February 2016 there were a total of 341 MOH areas spread throughout the 26 health districts/areas.[19] An MOH area usually covers a defined geographic area with a population of 50,000 to 100,000. The MOH unit is a preventive and primary health care team, led by a MO supported by a team of public health personnel with a network of medical institutions that provide institutional and clinic based MCH, FP, Well Woman Clinic (WWC) services in addition to non-MCH services. The cadres and workload of preventive health staff for public health services in Sri Lanka have been determined and a circular issued by the DGHS.[20]

The PHM is the "grass root level" health worker responsible for the preventive and promotive health services for a population of approximately 3000 residing in a geographically defined area, focusing on family health activities. At the community level, PHMs distribute condoms and OCP during domiciliary visits free of charge.

FP services in curative institutions

Over the years the government has built up a nationwide network of health facilities. A healthcare facility can be found on an average not further than 1.4 km from any home and free Western type government health care services are available within 4.8 km of a patient's home.[21] Based on the 2014 Annual Health Bulletin, 95 percent of the inpatient care and 50 percent of the outpatient care are provided by the state healthcare system. The remaining 5 percent of the inpatient care and 50 percent of the outpatient care are provided by the private health sector. Table 3.1 shows the hospitals with indoor beds by category and their number.

[19] FHB as at 23.2.2016

[20] Criteria for deciding cadres of health staff for public health services in Sri Lanka. General Circular FHB/DIR/GF/2012 -

[21] Annual Health Bulletin Ministry of Health 2014.

Table 3.1: Hierarchy of health facilities in the public sector in Sri Lanka

Type of institution	No of institutions
Teaching Hospitals	16
Provincial General Hospitals	3
District General Hospitals	20
Base Hospitals Type A	21
Base Hospitals Type B	48
Divisional Hospital Type A	45
Divisional Hospital Type B	134
Divisional Hospital Type C	291
Primary Care Unit & Maternity Homes	18
Other intuitions *	16

*Other hospital includes Cancer, Dental, Military, Prisonsetc

Source: Annual Health Bulletin 2014, Ministry if Health, Nutrition and Indigenous Medicine

There were 487 Primary Medical Care Unit in 2016.

Investigation and treatment of subfertility is carried out in curative institutions with Obstetrician and Gynaecologists. Castle Street Hospital for Women and Mahamodera Hospital have specialized units for subfertility.

Municipalities

Municipalities provide some health services to those living within municipal limits. The Colombo Municipal Council (CMC) health services are headed by the Chief Medical Officer of Health. He is assisted by 4 Deputy Chief Medical Officers of Health, one of whom is responsible for MCH including FP. The Municipality is divided into 47 wards. The population in each ward is approximately 35,000. There are 14 medical centres and 5 maternity rooms. There are 5 MOH areas. Doctors are sent from the MoH to CMC on transfer basis. There is an acute shortage of PHMs. While the cadre for PHMs is 160 there are only 79 PHMs in post. The average population a midwife in the CMC serves is approximately 7000. Currently the eligible family registers are being rewritten. All FP methods are provided by CMC clinics except for sterilization. Clients requesting sterilization are referred to the FHB. All contraceptives used in the CMC clinics are obtained from the FHB and are provided free of charge. The FHB also includes CMC staff in trainings that it conducts.

Armed forces

The armed forces also provide health services including FP services to service personnel and their families. The armed forces and police obtain their requirements for contraceptives from the FHB.

Estate sector

Health services in the estate sector commenced during colonial rule. In 1997 an Estate and Urban Health Directorate was established in the MoH with the objective of providing basic health services, including MCH and FP, sanitation, nutrition and curative services to estate populations. For a long time the Directorate focused its attention on the takeover of estate hospitals. Of the 61 hospitals identified for

integration into the MoH 37 have been taken over. These hospitals provide services to a cluster of 4-5 estates. The Directorate is in the process of improving the infrastructure of the hospitals, constructing staff quarters, providing equipment and staff. Most hospitals that have been taken over are manned by MOs. Currently all estates are demarcated under the MOH areas to accommodate the estates into the preventive health system of the Provincial Health Authority.

Private sector

Organization of private sector service delivery

The private sector including NGOs provides services mainly in urban areas and tends to focus on curative care rather than preventive care and on outpatient services. Services are provided though hospitals, clinics, pharmacies and individual practitioners. The majority of private sector hospitals are in the Western province. The private sector is dependent to a large extent on the public sector for human resources. Dual practice is common. There are no private medical schools at present in the country whose degree is recognized by the Sri Lanka Medical Council (SLMC). A few private nursing schools exist.

Assisted Reproductive Health Techniques (ART) for treatment of complicated subfertility is only available in the private sector and treatment of subfertility services are provided by doctors both full time in the private sector and those engaged in dual practice.

Financing of health services

Sri Lanka opted early on to prioritize universal access by eliminating user fees and making services accessible to the entire population. This has been one of the main reasons behind the impressive performance of the health sector in Sri Lanka.

Sources of financing of health is provided by the government, households, international NGOs and donors. Government funding covers salaries, operating expenses, pre- and in-service training, building and renovation of health structures. The first National Health Accounts report of the MoH for the year 2013 was published recently.[22] The report uses the System of Health Accounts 2011 (SHA 2011) of the WHO.[23] SHA 2011 uses the Current Health Expenditure (CHE) and Capital Financing (CF) as the two main components of health expenditure.

In 2013 the Current Health Expenditure (CHE) and Capital Formation (CF) taken together was 3.2 percent of the Gross Domestic Product (GDP). Per capita Current Health Expenditure from all sources was US ($) 97.2 in 2013. The public sector financed 55 percent of the CHE in 2013 followed by households (40 percent). Of the CHE in 2013 approximately 91 percent was spent on curative services and only 4.5 percent on preventive services. The largest share of CHE was on non-communicable diseases (35 percent) followed by infectious and parasitic diseases (22 percent) and only 10 percent was spent on reproductive health service.

Currently there is no health economist in the MoH. A health economics cell is in the process of being established in the MoH.

[22] FSri Lanka National Health Accounts 2013, Health Economic Cell, Ministry of Health Nutrition and Indigenous Medicine. 2016

[23] OECD, Eurostat, WHO (2011), A System of Health Accounts, OECD Publishing.doi: 10.1787/9789264116016-en

Finance commission and the provincial health system

The Finance Commission is charged with making recommendations to the President on the financial resources to be allocated to the provinces so as to achieve "balanced regional development". Government funds are allocated to the provinces by means of three types of grants; Block Grants, Criteria Based Grants (CBG) and Province Specific Development Grants (PSDG).

The Block Grant is made to meet the recurrent needs of the provinces in order to sustain and improve the service delivery system of the provinces. Expense categories such as personal emoluments (salaries and wages, overtime and other allowances), maintenance, supplies and overhead costs are financed from this grant.

The CBG finances the capital needs of the provinces. Under this grant the provinces receive money as a bulk amount and the provincial councils have the discretion in choice of capital expenditure. The PSDG are meant to finance specific development projects under different devolved subjects paying particular attention to infrastructure development. For each investment it is necessary to identify measurable results such as output, outcome and impact, in terms of pre-defined indicators. Periodic monitoring and evaluation of achievements are carried out based on these indicators. A results based monitoring and evaluation process has to be carried out by the respective provincial authorities with the assistance of the Commission.

The Finance Commission in making its recommendation to the President on apportioning funds between the provinces under PSDG and CBG takes into consideration several factors. These factors are the population in the province, the provincial GDP and per capita income, and the need to progressively reduce socio-economic disparities within and among provinces, especially taking into account the Provincial Poverty Headcount Index.

Chapter 4
The status of FP in Sri Lanka

The first part of this chapter describes the achievements made by the NFPP over the years and briefly compares these achievements with other countries in Asia. The second part discusses the current status of FP in detail.

Part 1

Achievements of the NFPP

Great progress has been made during the last six decades in meeting the contraceptive needs of women and men in Sri Lanka since the FPASL was established in 1953 and the acceptance of FP as a national policy by a cabinet decision in 1965. Table 4.1 gives a timeline of key milestones on FP over the years.

Table 4.1 A timeline of FP in Sri Lanka

Year	Key Policy and Programme Activities
1932	First FP clinic was established by Dr Mary Ratnam. It was abandoned during the 2nd World War
1946	Introduction of free education from grade 1 to university education
1953	Family Planning Association is established
1954	Government provides a grant to the Family Planning Association
1958	In 1958, an agreement was signed between the governments of Sri Lanka and Sweden on co-operation in a pilot project on FP. A survey conducted under this project revealed that there was no major religious opposition to FP and a latent demand for FP existed among married couples.
1959	The National Planning Council's 10th Development Plan (mid-1959-mid 1969) included a statement on control of fertility.
1962	Prime Minister Sirimavo Bandaranayake directs that FP should be included in the maternal and child health programme of the Government.
1964	Clinical trial on IUD commenced by Dr Siva Chinnathamby at Colombo North Hospital
1965	FP was accepted as part of the National Health Policy and its service components were integrated with the MCH services of the Ministry of Health. The government renewed the agreement with the government of Sweden to obtain equipment and contraceptive commodities to implement the NFPP

1966	The Minister of Health appointed an Advisory Committee to develop a detailed plan of operation. The committee issued its report in August 1966 and declared that the program would be a routine activity of the Department of Health Services and would be integrated with its MCH services. One of the recommendations were that IUD insertions were to be free of charge. Oral contraceptives were to cost SL Rs 0.50 per monthly packet, and condoms and foam tablets were to cost SL Rs 0.05 each. The Ford Foundation entered into an agreement with the Government that, through a grant to the Population Council, an adviser on evaluation would be placed to the Ministry of Health and the Ministry of Planning and Economic Affairs to provide support for evaluating the NFPP.
1968	In 1968, the Family Planning Bureau was established by the Ministry of Health. Most FPASL clinics were taken over by the government to commence FP activities in government institutions. Clinical trial on DMPA conducted by Dr Siva Chinnathamby
1970	The Family Planning Bureau was renamed the Maternal and Child Health Bureau
1972	The Maternal and Child Health Bureau was renamed the Family Health Bureau The Five-Year Plan (1972-1976), stated that *"a high birth rate in the context of low standards of living and malnutrition can lead to a general deterioration in the health of the population, an increase in the incidence of disease and a rise in infant mortality. It is essential therefore that facilities for family planning should be made available to all groups in the population and not confined to the privileged sections of the society"*[1] Five Year Plan stated that if action is not taken, Sri Lanka would have 27 million people by the year 2000.
1973	The United Nations Population Fund (UNFPA) begins to support the NFPP. A project agreement was signed by the government with the UNFPA for assistance to broad base the population programme.
1974	A Steering Committee was established chaired by the Secretary, Ministry of Plan Implementation to coordinate the national population programme through the provision of family planning services.
1975	World Fertility Survey was conducted which provides baseline information with regards to fertility and family planning became available to monitor the programme.
1979	Financial incentives for medical teams providing sterilization services was introduced
1980	Financial incentives introduced for sterilization acceptors. This was initially SLR 100 but increased to SLR 500
1982	Contraceptive Prevalence Survey(CPS) conducted The President appointed the Parliamentary Advisory Committee on Population (PACP) to advise the government on appropriate policies in respect of population and FP. District Population Committees were established and chaired by the Government Agent to monitor population policy which was implemented partly through the NFPP.

[1] Ministry of Planning and Employment (1971).The Five-Year Plan1972-1976, Colombo: Government Press

1983	National Coordinating Committee on Population (NCCP) was established to coordinate the national programme, with the Minister of Health serving as the chairperson
1985	Injectables were introduced into the NFPP Clinical trials on implant were commenced by FPASL
1987	13th Amendment to the Constitution leads to devolution of health to the Provincial Councils SLDHS 1987 conducted
1988	By General Circular Number 1586 the government enforced limitations on the minimum age at which a woman could get sterilized.
1990	National Health Council sets goal of achieving replacement level fertility by 2000. Population Division prepares a policy statement and prepares short term population projections and contraceptive requirements to achieve replacement level fertility.
1991	Population policy formulation was re-assigned to the Ministry of Health Government set a target of reaching replacement level fertility by 2000 in its policy statement on population which was approved by the National Health Council chaired by the Hon. Prime Minister Population Division of the Ministry of Plan Implementation was moved to the Ministry of Health . Implementing the FP service delivery activities continued to be vested under the Family Health Bureau.
1993	SLDHS 1993 conducted
1994	ICPD replaced a demographically driven approach to family planning with one that is based on human rights. It reaffirmed the basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.
1997	UNFPA and a few other donors commenced withdrawal of procuring contraceptives for the government programme in a phased manner and the government took over this function.
1998	Population and Reproductive Health Policy and Action Plan was formulated.
2000	Advocacy strategy is developed SLDHS 2000 survey conducted
2004	Government had fully taken over the procurement of contraceptive requirements for the government programme.
2007	SLDHS 2006/7 conducted
2008	National Maternal and Child Health Policy formulated
2010	Removal of the fee charged for oral contraceptive pills (cents 50) & condoms (cents 5)
2013	Circular of the Director General Health Services cancelling the out-of-pocket allowance paid to clients who voluntarily undergo sterilization and the incentive paid to service providers, with effect from 18/11/2013.

Sources: Table 4.1 draws heavily from the following works. The history of family planning in Sri Lanka. Silver Jubilee

Souvenir.Family Planning Association of Sri Lanka.1978.[2] Nicholas H Wright. Early family planning efforts in Sri Lanka.In: Warren C. Robinson and John A. Ross eds. The global family planning revolution : three decades of population policies and programs.World Bank 2007[3] and ATPL Abeykoon. Reproductive Health and Family Planning Programme in Sri Lanka: Achievements and Challenges. In: eds. Wasim Zaman, HairudinMasnin and John Loftus. Family Planning in Asia and the Pacific.Addressing the challenges.International Council on Management of Population Programmes (ICOMP) and UNFPA. January 2012. P 217-224.[4]

The Centres for Disease Control and Prevention, USA, identified FP as one of the top 10 public health advancements of the 20th century.[5] As can be seen from Table 4.2 Sri Lanka has made significant advances in increasing use of modern FP methods over the years which in turn has also contributed to reduction in maternal and infant morbidity and mortality. Knowledge of FP methods is almost universal among Sri Lankan couples. In the context of a favourable political environment, the FP programme achieved commendable success until the mid-1990s.

In the mid-1970s one in three married women aged 15–49 were using a contraceptive method. By the mid-1980s, use of contraception increased to almost two in three women. This was due to a greater increase in the use of modern methods compared with the increase in the use of traditional methods. The use of traditional methods has decreased over time.

Table 4.2: Trends in contraceptive use by method of currently married women aged 15–49, by method, Sri Lanka

Contraceptive prevalence (%)	**1975***	**1982***	**1987***	**1993****	**2000****	**2006/7****
Any method	34.4	57.8	61.7	66.1	70.0	70.2
Any modern method	20.2	31.9	40.6	43.7	49.5	53.1
(a) Modern temporary (%)	9.6	9.9	10.8	16.5	26.4	36.0
(b) Permanent methods (%)	10.6	22.0	29.8	27.2	23.1	17.1
Traditional methods (%)	14.2	26.0	21.1	22.4	20.5	17.0

Source: 1975 data are from the World Fertility Survey 1975; 1982 data are from the Contraceptive Prevalence Survey 1982; data for years 1987 to 2006/7 are from the Demographic and Health Surveys conducted in the respective years.

*National estimates; **excluding the northern and eastern provinces

Despite these achievements national figures mask disparities in relation to place of residence, education and wealth. (Figure 4.1)

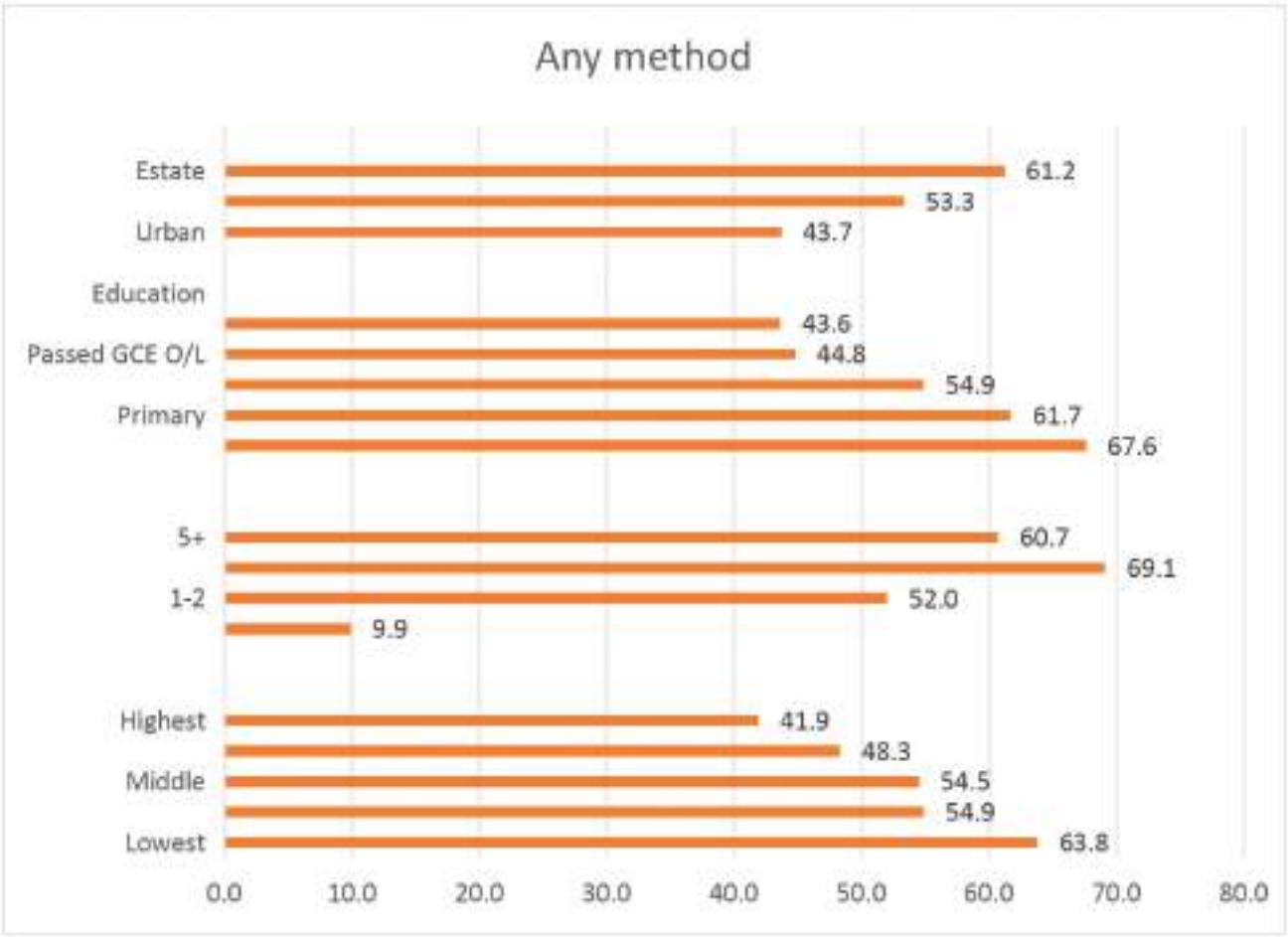
Figure 4.1: Modern contraceptive use by demographic factors SLDHS 2006/7

[2] The history of family planning in Sri Lanka. Silver Jubilee Souvenir.Family Planning Association of Sri Lanka.1978

[3] Nicholas H Wright. Early family planning efforts in Sri Lanka.In: Warren C. Robinson and John A. Ross eds. The global family planning revolution : three decades of population policies and programs. World Bank 2007

[4] ATPL Abeykoon. Reproductive Health and Family Planning Programme in Sri Lanka: Achievements and Challenges. In: eds. WasimZaman, HairudinMasnin and John Loftus. Family Planning in Asia and the Pacific.Addressing the challenges. International Council on Management of Population Programmes (ICOMP) and UNFPA. January 2012. P 217-224

[5] Achievements in Public Health 1900-1999. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4847a1.htm (Accessed 12.6.2016) The other nine include vaccines, recognition of the dangers of tobacco, motor vehicle and food safety, and fluoridation.



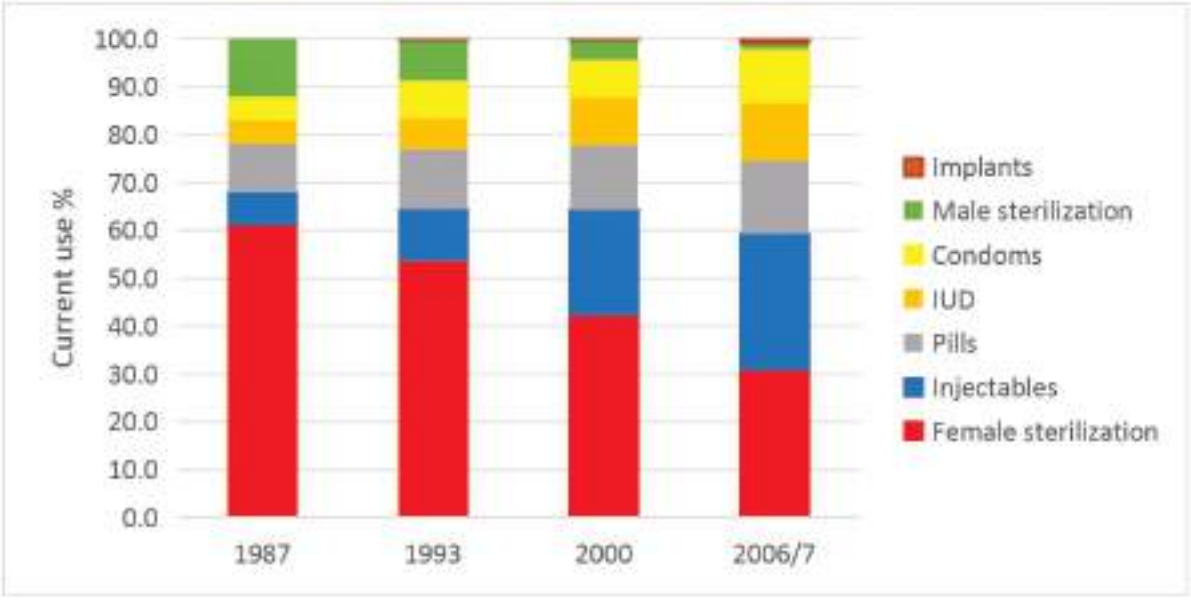
Source: 2006/7 SLDHS

The NFPP offers a wide choice of contraceptives. The modern temporary methods available are combined oral contraceptive pills (OCP), DMPA injections, intra uterine contraceptive devices (IUD), condoms and implants. Modern permanent methods include vasectomy and female sterilization. The result is a real 'cafeteria' approach with couples and providers having good access to very inexpensive methods like OCP as well as more expensive methods like implants and sterilization.

Figure 4.2 and Table 4.3 shows how modern contraceptive method mix has changed over time during the 20 year period from the 1987 SLDHS to the time of the last SLDHS in 2006/7.

In 1987 Sri Lanka had a highly skewed mix of modern contraceptive methods with the majority of currently married couples using sterilization. Since then there are striking trends in method mix, especially indicating increasing reliance on OCP, IUD, and injectables and a shift away from permanent methods. The increase in the use of modern methods can be attributed to the total increase in some modern temporary methods such as OCP, IUD, and injectables. The popularity of the IUD and implant has gradually increased.

Figure 4.2: Share of each method to total modern method use, married women 15-49 years



Source: Department of Census and Statistics SLDHS reports various years

Table 4.3: Share of each method to total modern method use, married women 15-49

	% Share				Trend	
Method ranked by 2007 % share	**1987**	**1983**	**2000**	**2006/7**	**Current users of specific method 1987-2006/7**	**Trend**
Female sterilization	61.3	53.8	42.4	30.9	24.9 -16.4	(34%) ↓
Injectables	6.7	10.5	21.8	26.9	2.7-14.3	430% ↑
Pills	10.1	12.6	13.5	15.8	4.1-8.4	105% ↑
IUD	5.2	6.9	10.3	13.0	2.1-6.9	229% ↑
Condoms	4.7	7.6	7.5	11.3	1.9-6.0	216% ↑
Male sterilization	12.1	8.5	4.2	1.3	4.9--0.7	(86%) ↓
Implants	0.0	0.2	0.2	0.8	0-0.4	40% ↑
	100.0	100.0	100.0	100.0	40.6 - 53.1	31 ↑

Source: Base data for SLDHS 1987, 1993, 2000 and 2006/7; percentage share calculated by dividing the percentage use of each method to the percentage use of any modern method.

Sri Lanka's performance compared to countries in Asia

Table 4.4 shows selected indicators from countries in Asia that conducted a DHS around the time Sri Lanka conducted its last SLDHS in 2006/7.The CPR for modern methods ranged from 57.3 (Indonesia) to 21.7 (Pakistan) percent. Sri Lanka ranked 2nd with 53.1 percent. The unmet need for modern methods was lowest in Indonesia (13.1 percent) and highest in the Philippines (39 percent).[%]

[%] Unmet need for modern methods = traditional methods +unmet need. This is based on the assumption that women using traditional methods have an unmet need for a more highly effective method.

Table 4.4: Selected indicators from countries in Asia that conducted a DHS during 2005-2008

Country	Bangladesh	India	Indonesia	Nepal	Pakistan	Philippines	Sri Lanka
Year of DHS	2007	2005/6	2007	2006	2006/7	2008	2006/7
CPR any method	55.8	56.3	61.4	48.0	29.6	50.7	68.4
CPR modern methods	47.5	48.5	57.4	44.2	21.7	34.0	52.3
Traditional methods	8.3	7.8	4.0	3.7	7.9	16.7	15.9
Unmet need	17.1	12.8	9.1	26.6	24.9	22.3	7.3
Median age at first marriage for women aged 25-49	15.0	17.4	19.2	17.5	19.5	22.2	23.3

Source: Demographic and Health Surveys Bangladesh 2007; India 2005/6; Indonesia 2007: Nepal 2006; Pakistan 2006/7; Philippines 2008[6] and Sri Lanka 2006/7

Part II

Trends and issues affecting the NFPP

Information in this report draws heavily from the SLDHS conducted over the years, the Population and Housing Census of 2012 and RHMIS statistics collected by the FHB. It should be noted that data collection for the next SLDHS is underway. We do not have historical data for unmarried sexually active women as the SLDHS collects data only from ever married women. The RHMIS of the FHB collects data from eligible families which does not make a distinction between married and unmarried women.

1. Slowing down in the rate of increase of the CPR

A wide range of social data shows that Sri Lanka has experienced substantial development in the last two decades. Education levels have been rising steadily, particularly among women. The age at marriage had continued to increase until recently. Women have entered the formal workforce in unprecedented numbers and a growing number of married women are in salaried employment that takes them away from their homes. All these social changes point to the growth of demand for contraceptives among women who increasingly want to space or limit births. But contrary to these trends the modern CPR measured by the 2006/7 SLDHS survey and last eight FHB Annual Reports remained stuck at just over half of married women of reproductive ages. This picture is indicative of a stagnation in FP programme effort in the last decade.

[6] DHS Programme. USAID http://www.dhsprogram.com/Where-We-Work/Country-List.cfm ((Accessed 12.6.2016)

Table 4.5: Compound average annual growth rate of modern contraceptive use 1975-2006/7

	WFS 1975	CPS 1982	SLDHS 1987	SLDHS 1993	SLDHS 2000	SLDHS 2006/7
Current use of any modern method	20.2	31.9	40.6	43.7	49.5	53.1
Compound average annual percentage growth rate* in modern method use		6.7	4.9	1.2	1.8	1.2

(All the growth rates in this table were calculated from the published data. Data for the Eastern Province have been excluded from the 2006/7 SLDHS in order to be comparable with the geographic areas covered by the 1993 and 2000 SLDHS surveys. World Fertility Survey (WFS); Contraceptive Prevalence Survey)

Based on WFS, CPS and SLDHS data the fastest growth rate in use of modern methods in the last 40 years was 6.7 percent from 1975 to 1983. (Table 4.5) The compound annual growth rate since then dropped steadily to 1.2 percent in 1993 and increased to 1.8 percent in 2000 but decreased between 2000 and 2007 to 1.2 percent.

RHMIS data shows there has been a five percentage point increase in use of modern methods between 2007 and 2014. The average annual percentage growth rate in the CPR for modern methods has gradually decreased from 2.5 percent in 2008 to 1.5 percent in 2014. (Table 4.6)

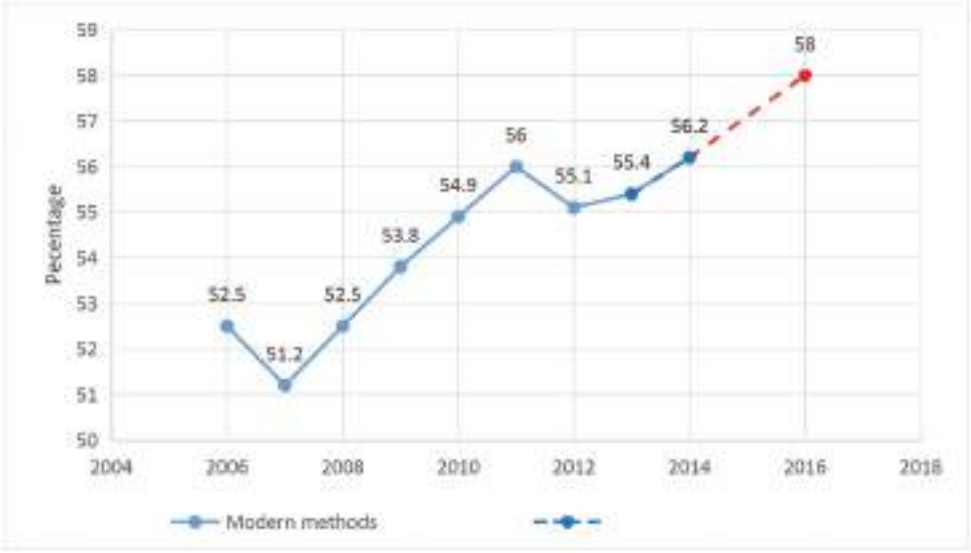
Table 4.6:Annual percentage growth rate of modern contraceptive use 2007-2014

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
Modern methods	51.2	52.5	54.2	54.7	56	55.1	55.4	56.2
Annual percentage growth rate#		2.5	3.2	0.9	2.4	-1.6	0.5	1.44

Source: Family Health Bureau RHMIS

Figure 4.3 Trends in current use of modern methods and National Strategic Plan on Maternal and Newborn Health Goal

* Compound average annual growth rate (CAGR) is the average growth rate over several years.
\# The average annual growth rate (AAGR) is the arithmetic mean of a series of growth rates.



Source: Family Health Bureau Annual Reports 2007-2014

One of the goals of the National Strategic Plan on Maternal and Newborn Health (2012-2016) is to increase the CPR for modern methods from 52.5 percent in 2006 to 58 percent by 2016. This goal is likely to be met given the current trajectory. (Figure 4.3)

2. Use of traditional methods is still high though declining

Use of traditional methods in Sri Lanka in 1974 was 14.2 percent and peaked at 26 percent in 1983. Since then there has been a gradual decrease in the use of traditional methods but it is still a major contributor to the CPR. (Tables 4.7)

Table 4.7: Traditional method use

	WFS 1975	CPS 1982	SLDHS 1987	SLDHS 1993	SLDHS 2000	SLDHS 2006/7
Current use of any traditional method	14.2	26	21.1	22.4	20.5	17
Compound average annual percentage growth rate in traditional method use		9	-4.1	1.0	-1.3	- 3.1

Source: Data for the Eastern Province have been excluded from the 2006/7 SLDHS in order to be comparable with the geographic areas covered by the 1993 and 2000 SLDHS surveys. World Fertility Survey (WFS); Contraceptive Prevalence Survey)

Modern methods are more effective than traditional methods in preventing pregnancy.[7] The decrease in traditional methods is an encouraging trend since greater reliance on modern contraceptives carries well-known benefits for women, their families and society such as lower levels of unintended pregnancy, unsafe abortion, and maternal and child morbidity and mortality.

[7] Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011.

Table 4.8: Percentage distribution of currently married women by contraceptive method currently used, according to the level of education and wealth quintile, Sri Lanka 2006-07

Background characteristics	Any method	Any modern method	Any traditional method	Not currently using	Total	Number of women
Education						
No education	72.7	67.6	5.1	27.3	100.0	448
Primary	71.5	61.7	9.7	28.5	100.0	1,843
Secondary	69.0	54.9	14.2	31.0	100.0	6,754
Passed GCE O/L	64.6	44.8	19.8	35.4	100.0	1,601
Higher	66.6	43.6	22.9	33.4	100.0	3,102
Wealth quintile						
Lowest	72.7	63.8	8.9	27.3	100.0	2,605
Second	69.6	54.9	14.6	30.4	100.0	2,724
Middle	70.0	54.5	15.5	30.0	100.0	2,746
Fourth	67.2	48.3	18.9	32.8	100.0	2,868
Highest	63.0	41.9	21.1	37.0	100.0	2,805

Source: 2006/7 SLDHS

Women's education is widely acknowledged as being one of the most important determinants of contraceptive use.[8,9,10,11] However, Sri Lanka shows a different pattern. There is a negative association between education and use of modern contraceptive method. More than 40 percent of women who have passed the GCE O/L or above are using traditional methods. Conversely, women with no or very little education are more reliant on modern methods. Only 5 percent of women with no education use traditional methods. (Table 4.8) Studies worldwide show that modern contraceptive use is lower among poor women.[12,13,14] However, in Sri Lanka poor women tend to use modern methods more than women in the higher wealth quintiles. Women in the richest wealth quintile use traditional methods more than their counterparts in the poorer quintiles. (Table 4.8)

[8] Caldwell, J. 1980. "Mass education as a determinant of the timing of fertility decline."Population and Development Review. Vol. 6, No. 2: 225-255.

[9] Cleland, J. and Rodriguez, G. 1988. "The effect of parental education on marital fertility in developing countries."Population Studies. Vol. 42, No. 3: 419-442.

[10] Martin, T. C. 1995. "Women's education and fertility: Results from 26 Demographic and Health Surveys. Studies in Family Planning. Vol. 26, No. 4: 187-202.

[11] Larsson C, Stanfors M. Women's Education, Empowerment, and Contraceptive Use in subSaharan Africa: Findings from Recent Demographic and Health Surveys. African Population Studies Vol 28 no 2 Supplement July 2014. (http://www.bioline.org.br/pdf?ep14047 Accessed 12.06.2016)

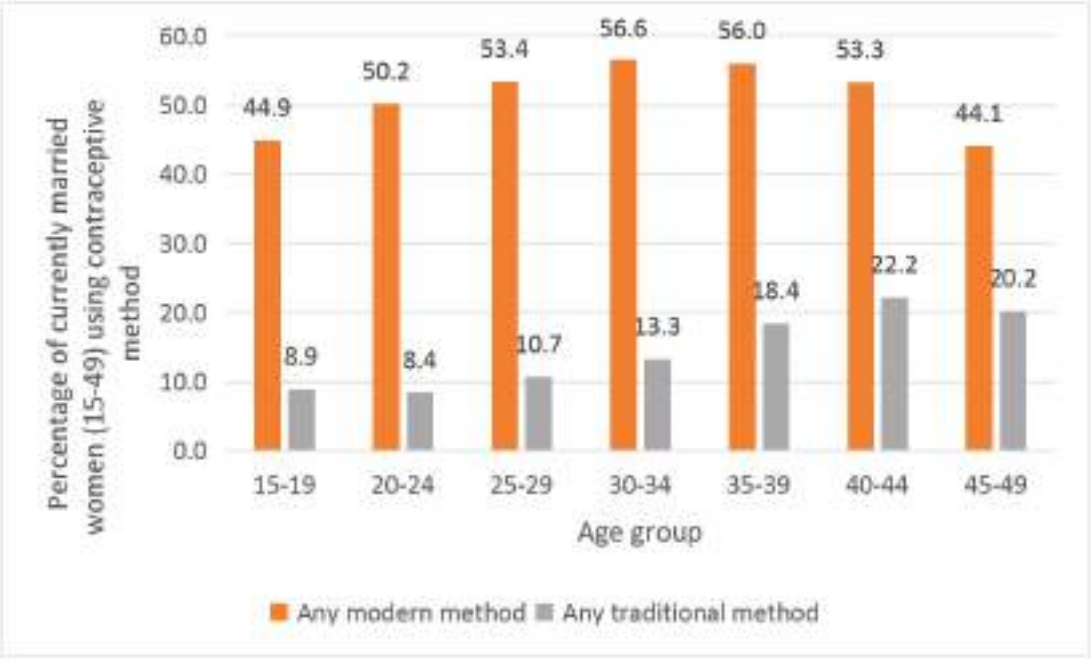
[12] Clements S, Madise N (2004) Who is being served least by family planning providers? A study of modern contraceptive use in Ghana, Tanzania and Zimbabwe.Afr J Reprod Health 8: 124–136.

[13] Schoemaker J (2005) Contraceptive use among the poor in Indonesia.IntFam Plan Perspect 31: 106–

[14] Gakidou, E., Vayena, E. (2007). Use of modern contraception by the poor is falling behind. PLoS Med. 4(2), e31 (http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.0040031#pmed-0040031-b021 (Accessed 23.11.2016)

Use of traditional methods also increases with the age of the woman. (Figure 4.4) Success of traditional family planning methods depends on the couples knowledge of reproductive physiology. According to the 2006/7 SLDHS among the ever-married women aged 15- 49 years in Sri Lanka, about 45 per cent do not know the fertile period.

Figure 4.4: Contraceptive use by age group, 2006/7 SLDHS



Source: SLDHS 2006/7

A study by Hettiarachchi and Gunawardena[15] on the use of traditional methods in Sri Lanka found that the practice was more common among women who were Muslims, in the older reproductive age groups, lived in an extended family, the last child was over 6 years of age and the distance from the clinic was more than one kilometre. Not being visited at home by the PHM was significantly associated with the use of traditional methods in the study.

RHMIS data for the period 2007-2014 shows the use of traditional methods has increased slightly from 8.9 percent in 2007 to 9.6 percent in 2014. (Table 4.9 The RHMIS does not collect the use of traditional methods by age group.

Table 4.9 Traditional method use between 2007 -2014

Indicator	2007	2008	2009	2010	2011	2012	2013	2014
Traditional methods	8.9	9.3	9.5	9.5	9.3	9.5	9.5	9.6
Annual percentage growth rate		4.44	2.15	0.00	-2.10	2.15	0.00	1.05

Source: FHB data

[15] HettiarachchiJ ,Gunawardena NS. Factors related to choice of modern vs traditional contraceptives among women in rural Sri Lanka. Sri Lanka Journal of Obstetrics and Gynaecology 2011; 33: 20-25

Findings from FGD's

Fear of side effects of modern methods was cited as the reason for using traditional methods.

> *I have heard about the side effects of modern methods and am scared even though I know they (traditional methods) are not very effective.*
>
> ***FGD married women 30-45 years, Galle***

> *Teachers and educated people usually they don't come for modern FP methods. For example there's a teacher with a 1 year old baby and now she's 4 months pregnant. We really don't know how to counsel them since most of them are bankers and teachers. These educated people think that FP is not needed to postpone births….and they think they can rely on self-control and natural methods. But when it becomes a failure only they realize and think about it.*
>
> ***FGD PHM, Nuwera Eliya***

It was recognized that use of traditional methods by men required self-control and was difficult to achieve.

> *When they are asked to avoid the fertility period they will have to restrain for a long time. Abstaining is something that couldn't be done. Now ejaculation of the sperms to the outside is a method which cannot be done easily. Therefore the methods that are available for men are difficult to use.*
>
> ***FGD PHI, Colombo***

Figure 4.5 Use of traditional methods in selected countries in Asia

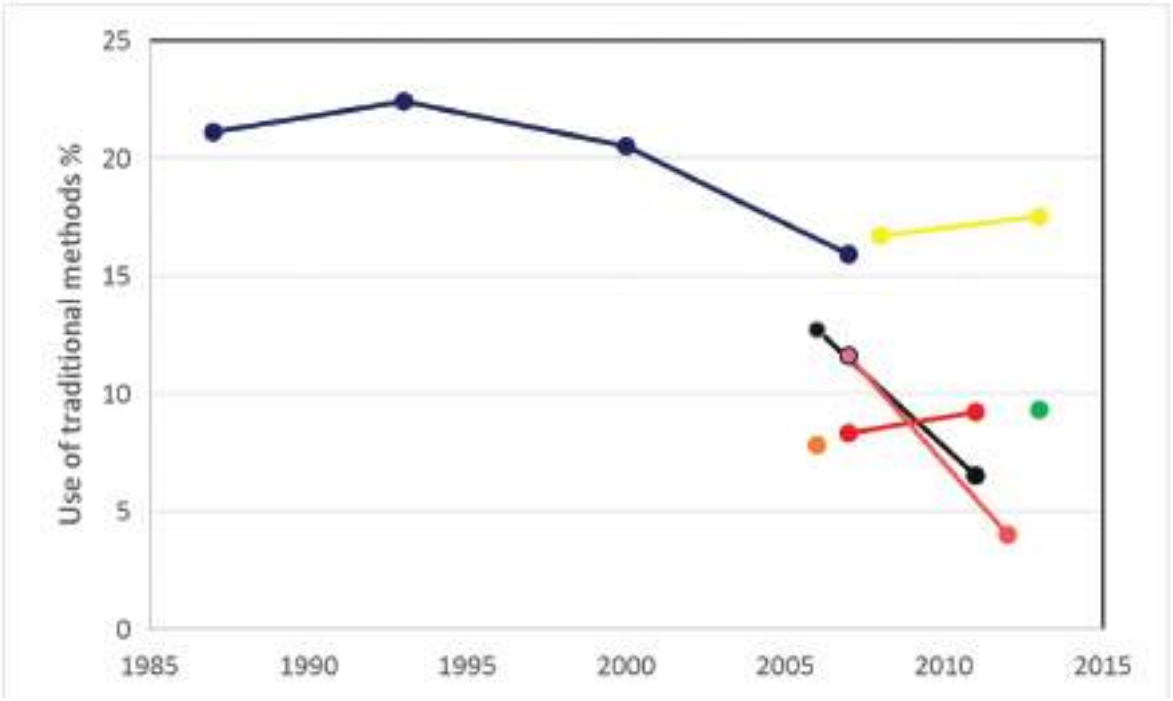


Figure 4.5 shows the use of traditional methods using data from Demographic Health Surveys from selected Asian countries.[16] It shows that Sri Lanka and the Philippines have the highest use of traditional methods.

[16] DHS Programme. USAID http://DHS program.com/publications/index.cfm (Accessed 30.09.2016)

3. No room for complacency: Unmet need for FP and unmet need for modern methods is still high

Unmet need measures the proportion of women who are fecund, want to space the next pregnancy by two years or more, or stop childbearing altogether, but are not using any method of contraception. By this definition, users of traditional methods are classified as having 'met' their need for preventing pregnancy.[17] An estimate of the size and composition of the population of women who have an unmet need for FP services is useful for planning purposes in RH programmes. An unmet need for contraception inevitably results in unintended pregnancies. These unintended pregnancies lead to three outcomes (ignoring a small number of miscarriages): mistimed births among women who have not yet reached their desired family size, unwanted births among women who want no more children and induced abortion.

According to the 2006/7 SLDHS the total unmet need for FP is 7.3 percent with 3.5 percent unmet need for spacing and 3.8 percent unmet need for limiting. It is not possible to calculate trends of unmet need with previous surveys because the definition of unmet need has differed over time in Sri Lanka.[18] Since the respondents of the 2006/7 SLDHS are married women there is a strong potential bias toward underestimating the true burden of unmet need since it excludes sexually active unmarried women. This is a key limitation of the indicator. Contraceptive needs can fluctuate due to shifts in fertility desires that occur in response to changing life circumstances or changes in household finances. Hence, women may pass in and out of unmet need rather than experiencing it as a one-time event.

Some of the characteristics of women with unmet need in Sri Lanka are as follows.

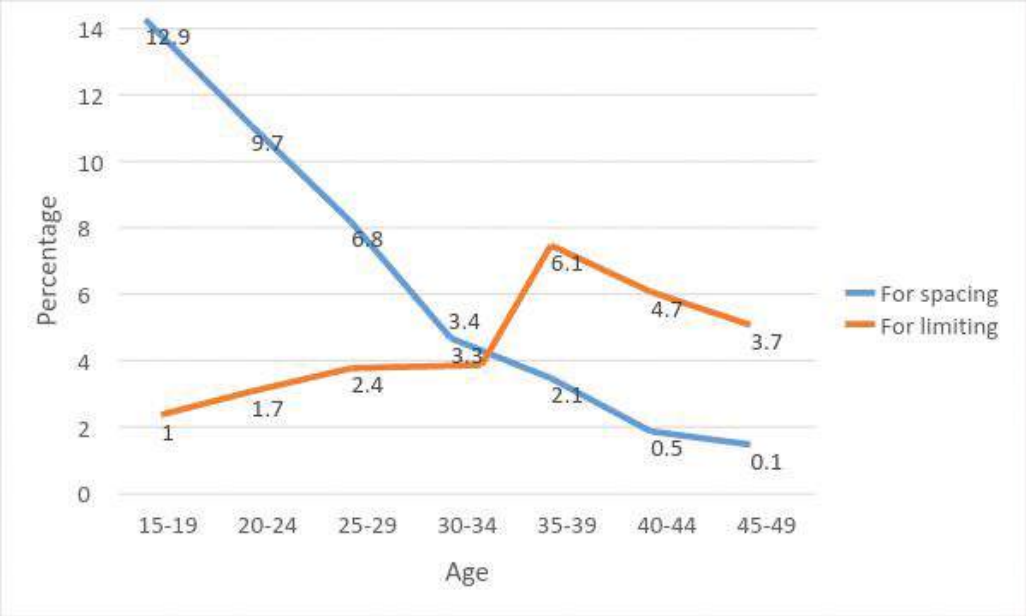
Age

As shown in Figure 4.6, among the younger age groups, unmet need is mainly for spacing, whereas among women from age 35 and above, it is mainly for limiting. This means that their desired family size has been reached, but they are not practicing contraception. The fact that unmet need for spacing is dominated by young couples below 30-34 years may reflect the effect of early marriage and lack of awareness about the importance of FP. Though demand for limiting is often associated with older women there is still a demand to limit among younger women.

[17] United Nations, Department of Economic and Social Affairs, Population Division (2014).World Contraceptive Use 2014 (POP/DB/CP/Rev2014)

[18] DHS-SL 2006/7 Department of Census and Statistics (DCS) and Ministry of Healthcare and Nutrition (MOH). 2009. Sri Lanka Demographic and Health Survey 2006-07. Colombo, Sri Lanka: DCS and MOH.

Figure 4.6: Unmet need for birth spacing and limiting by age groups



Source: 2006/7 SLDHS

Unmet need for modern methods

Unmet need for modern contraceptive methods is the proportion of fecund, sexually active women who want to limit or delay childbearing beyond two years, but who are not using a modern contraceptive method plus women who are currently using a traditional method of FP. Women using a traditional method are assumed to have an unmet need for moderncontraception.The percentage of women with an unmet need for modern methods is now used by the FP2020 Initiative as a core indicator.

Measuring unmet need for modern contraception specifically may be a better estimate of demand for services and the efficiency of FP programmes since modern contraceptive methods are more effective than traditional methods and because modern methods are delivered mainly through FP services.[19, 20] The unmet need for modern methods is especially useful for countries with high levels of traditional method use such as Sri Lanka.

Table 4.10 presents an estimate of the number of married women who do not want a pregnancy now or ever but are not using any modern method of contraception. Based on FHB service statistics the percentage of eligible families in 2014 using modern contraceptive methods and traditional methods was 56.2 percent and 9.6 percent respectively. The unmet need was 6.8 percent. Hence, the unmet need for modern methods in 2014 was 16.4 percent.

[19] Sedge G, Hussain R, Bankole A, Singh S. Women with an Unmet Need for Contraception in Developing Countries and their Reasons for Not Using a Method. Occasional Report, New York: Guttmacher Institute, 2007, No. 37.

[20] Westoff Charles F. (December 2006). "New Estimates of Unmet Need and the Demand for Family Planning", p. 19.DHS-SL Comparative Reports No. 14. Calverton, Maryland, USA. Macro International Inc.

Table 4.10: Estimated number of married women with unmet need for modern methods 2014

A	B		C		D=B-C		E		F= D+E	
Estimated eligible families (PHM)	Current users all methods		Current users modern methods		Traditional methods		Unmet need		Unmet need modern methods	
	%	Number	%	Number	%	Number	%	Number	%	Number
3,668,979	65.8	2,414,188	56.2	2,061,966	9.6	352,222	6.8	249,491	16.4	601,713

Source: RHMIS

The estimates show there are around 249, 491 couples of reproductive age with an unmet need in 2014, and approximately 352,222 using traditional methods. Overall, in order to address the unmet need for modern methods the NFPP should have reached as many as 600,000 additional couples in 2014 to help them access modern methods of contraception in addition to the 2,061,966 it did reach.

4. District variations in modern contraceptive use and unmet need for modern methods

Another area of concern for programme managers in Sri Lanka is that considerable district differences exist in the current users of modern methods and unmet need. In 2014 the best performing areas were Ampara, Nuwera Eliya, Killinochchi, Badulla and Pollonnaruwa in terms of current use of modern contraceptives. The lowest performing RDHS /Health areas were the Colombo Municipality followed by Batticaloa, Kalmunai, Vavuniya, Mullaitivu, Trincomalee and Mannar. Observing the trends between 2010 and 2014, Killinochchi and Mannar has increased the users of current methods by 94 percent and 42 percent respectively. (Table 4.11) These areas were severely affected by the war, subsequently resettlement was taking place and the quality of the data in 2010 was poor. Hence, this data needs to be interpreted with caution and is therefore difficult to compare with other districts.

The unmet need has decreased throughout the country to varying extents between 2010 and 2014 except in Mullaitivu, Mannar, Vavuniya, Nuwera Eliya and Kandy which shows an increase in unmet need. There has been a marked drop in the unmet need in Killinochchi during the same period.

The variations in contraceptive use and unmet need by district may indicate limited availability of FP services and socio-cultural differences across different regions of the country. These variations may also reflect a lack of adequate and effective BCC campaigns in the under-served areas of the country.

Table 4.11: Percentage change of current users of modern methods and unmet need by districts 2010 - 2014

District / Health area	Current users of modern methods			Unmet need		
	2010	2014	% change in current users	2010	2014	% change in unmet need
Colombo	53.7	56.3	5%	8.8	7.0	-20%
Colombo MC	39.9	41.4	4%	8.3	8.0	-3%
Gampaha	52.1	52.5	1%	9.0	7.1	-21%
Kalutara	54.4	55.2	1%	8.0	6.8	-15%
NIHS	51.3	52.4	2%	6.0	4.2	-30%
Kandy	55.0	54.8	0%	7.3	7.5	2%
Matale	58.7	59.0	1%	6.8	5.3	-22%

NuwaraEliya	65.9	66.3	1%	5.9	6.1	4%
Galle	56.9	56.8	0%	6.7	6.6	-1%
Matara	57.6	58.2	1%	8.3	6.9	-17%
Hambantota	54.9	57.2	4%	8.8	7.6	-13%
Jaffna	49.3	52.6	7%	8.8	5.7	-35%
Killinochchi	33.7	65.5	94%	18.6	2.7	-86%
Mannar	36.2	51.5	42%	5.5	8.6	56%
Vavuniya	41.5	49.0	18%	10.1	11.8	17%
Mullaitivu	38.8	49.7	28%	2.6	7.3	181%
Batticaloa	39.4	44.1	12%	9.6	8.0	-16%
Ampara	65.7	69.7	6%	6.4	4.1	-36%
Kalmunai	38.1	45.4	19%	10.6	7.4	-30%
Trincomallee	49.4	50.0	1%	9.8	7.6	-23%
Kurunegala	56.3	56.2	0%	6.9	6.3	-9%
Puttalam	53.3	55.9	5%	8.9	8.3	-7%
Anuradhapura	59.3	60.4	2%	6.6	5.3	-20%
Polonnaruwa	63.1	61.6	-2%	5.6	4.5	-19%
Badulla	66.1	65.2	-1%	8.4	7.2	-14%
Monaragala	62.7	59.2	-6%	6.2	5.6	-9%
Ratnapura	54.4	57.7	6%	9.7	7.4	-23%
Kegalle	54.5	54.9	1%	7.8	7.4	-6%
Sri Lanka	54.7	56.2	3%	8.0	6.8	-15%

Source: FHB RHMIS

Table 4.12 shows the unmet need, traditional methods and computed unmet need for modern methods. The unmet need for modern methods varies from 6.1 percent in Killinochchi to 29 percent in Vavuniya. The unmet need for modern methods was over 20 percent in Vavuniya and Mannar. There were 17 districts where the unmet need for modern methods was between 15-20 percentage points. Hence, the task ahead of reducing unmet need for modern methods is formidable.

Table 4.12: Unmet need, traditional methods and unmet need for modern methods 2014 by the RDHS areas

RSLDHS/Health area	Unmet need	Traditional methods	Unmet need for modern methods
Colombo	7.0	11.6	18.7
Colombo MC	8.0	6.2	14.2
Gampaha	7.1	12.7	19.8
Kalutara	6.8	9.9	16.7
NIHS	4.2	13.8	18.1
Kandy	7.5	8.8	16.3
Matale	5.3	7.2	12.5
NuwaraEliya	6.1	4.1	10.3
Galle	6.6	10.6	17.2

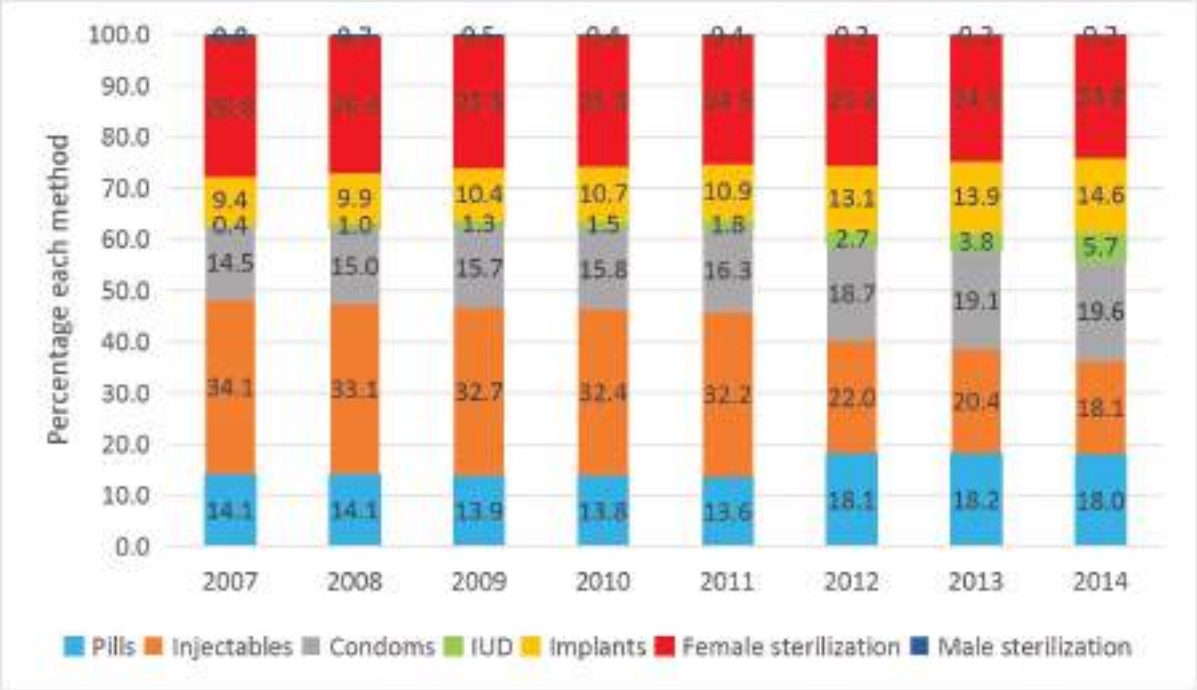
Matara	6.9	10.1	17.0
Hambantota	7.6	8.7	16.3
Jaffna	5.7	9.2	14.9
Killinochchi	2.7	3.4	6.1
Mannar	8.6	19.3	27.9
Vavuniya	11.8	17.2	29.0
Mullaitivu	7.3	2.2	9.5
Batticaloa	8.0	8.6	16.7
Ampara	4.1	4.9	9.0
Kalmunai	7.4	12.0	19.3
Trincomallee	7.6	9.9	17.5
Kurunegala	6.3	10.8	17.1
Puttalam	8.3	10.7	19.0
Anuradhapura	5.3	7.2	12.5
Polonnaruwa	4.5	5.3	9.8
Badulla	7.2	5.1	12.3
Monaragala	5.6	10.1	15.8
Ratnapura	7.4	10.2	17.7
Kegalle	7.4	10.5	17.9
Sri Lanka	6.8	9.6	16.4

5. Issues with the contraceptive method mix

The modern contraceptive method mix in the public sector FP programme 2007-2014

The use of modern contraceptive methods during the period 2007-2014 is shown in Figure 4:7.

Figure 4.7: Percentage of new acceptors by method



Source: FHB HMIS

Table 4.13 shows the compound annual growth rate for modern methods during the period 2007-20014 for each of the methods from FHB service statistics.

Table 4.13: Compound growth rate for modern methods 2007-2014

	2007	2008	2009	2010	2011	2012	2013	2014	Compound annual growth rate
Pills	7.2	7.4	7.5	7.6	7.6	10.0	10.1	10.1	4.95%
Injectable	17.4	17.4	17.7	17.8	18.0	12.1	11.3	10.2	-7.35%
IUD	7.4	7.9	8.5	8.7	9.1	10.3	10.6	11.0	5.83%
Implants	0.2	0.5	0.7	0.8	1.0	1.5	2.1	3.2	48.60%
Condoms	4.8	5.2	5.6	5.9	6.1	7.2	7.7	8.2	7.95%
Female sterilization	13.7	13.8	13.8	13.9	13.9	13.9	13.6	13.4	-0.32%
Male sterilization	0.4	0.4	0.3	0.2	0.2	0.1	0.1	0.1	-17.97%

The compound annual growth rate was calculated using RH MIS data

During the period 2007-2014 the highest compound annual growth rate has been for implants (48.6 percent) followed by condoms (7.95 percent), IUD (5.83 percent) and OCP (4.95 percent). Female and male sterilization and injectable shows a negative growth rate.

From 2007 to 2011 injectables were the most popular methods. In 2012 there was a sharp decrease in the use of injectables due to adverse reactions reported for certain brands and temporary withdrawal of the method from field clinics. Table 4.13 shows that in 2014 use of DMPA had still not reached 2009 levels. It is encouraging to note that the highest compound annual growth rate has been for implants (49 percent) which reflects the increased availability of implants through the public sector and investments in staff training paying off. Pills, condoms and IUDs have also shown an increase between 2007 and 2014.

The compound annual growth rate of short acting, long acting reversible, permanent and long acting permanent methods derived from the RHMIS data from 2007-2014 is shown in Table 4:14.

Table 4:14: Compound annual growth rate of short acting, long acting reversible, permanent and long acting permanent methods 2007-2014

Method	2007	2008	2009	2010	2011	2012	2013	2014	Compound annual percentage growth rate
Short acting methods	29.4	30	30.8	31.3	31.7	29.3	29.1	28.5	-0.44%
Long acting reversible methods	7.6	8.4	9.2	9.5	10.1	11.8	12.7	14.2	9.34%
Permanent methods	14.1	14.2	14.1	14.1	14.1	14	13.7	13.5	-0.62%
LAPM methods	21.7	22.6	23.3	23.6	24.2	25.8	26.4	27.7	3.55%

Source: FHB HMIS

Note: 1. Short acting methods = pills, injectables and condoms;
2. Long acting methods = IUD and implants
3. Permanent methods = male and female sterilization;
4. LAPM= long acting and permanent methods

The following trends are evident from Table 4:14.

1. A decline in the use of permanent methods
2. A steady increase in the use of long acting reversible methods
3. A decline in the use of short acting methods

1) Decline of female and male sterilization

Both female and male sterilization has decreased in recent years. Female sterilization has declined from 1 in 4 users in 1987 to just over 16 percent in 2006/7. Nevertheless, it is still the most frequently used method of FP among women. The use of male sterilization was at its height in 1987 (4.9 percent of couples using a contraceptive method used vasectomy) but continues to decline. Between 1987 and 2007, while there had been an increase in male participation in the use of condom, their participation in the use of permanent methods has declined. (Table 4.3 and Table 4:14) Currently there are no providers of male sterilization in the country.

2) Increase in the use of long acting reversible methods.

The compound average annual growth rate in the use of long acting reversible methods was 9.3 percent mainly due to the popularity of implants. Use of IUD has also increased during this period. (Table 4:14) These methods have higher initiation costs than short-acting methods, but because they can be used without resupply for several years, they are often less expensive per year of use. Initiation costs for these methods are higher because the costs of the commodities themselves are higher. In addition, they require providers to have special training and skills for insertion and removal as well as good counselling skills to ensure that clients can make informed choices about these long-acting methods. Unlike short-acting methods, which can be discontinued simply by the user stopping the method, discontinuation of IUDs and implants requires removal by a trained provider.

3) Stagnation in the use of short acting methods

Since 2011 the method mix among new acceptors of modern methods shows a decline in the use of short acting methods. This is probably due to the drastic reduction in the use of injectable among all age groups. Short acting methods require regular resupply, hence successful use must include access to a consistent supply of the product. Each 'resupply' visit to a service delivery point entails additional costs. Pills and condoms also require high levels of user adherence and motivation, with inconsistent and incorrect use leading to method failures and high rates of discontinuation.

Some methods are more popular than others in a district

In 12 districts LRT was the most popular method. (Table 4.15) Injectables were the next most popular method (7 districts) followed by IUD in 6 districts. Condoms were the most popular method in Gampaha and Colombo MC. The only district where the pill was the most popular was Kegalle. In none of the districts was the implant the most popular method.

Table 4.15 Most popular modern method by district

Pills	Condoms	Injectables	IUD	LRT
Kegalle	Gampaha	Trincomalee	Hambantota	Nuwera Eliya
	Colombo MC	Ampara	Moneragala	Jaffna
		Pollonnaruwa	Kurunegala	Badulla
		Anuradhapura	Matale	Killinochchi
		Batticaloa	Matara	Vavuniya
		Puttalam	Colombo	Mannar
		Galle		NIHS
				Ratnapura
				Kandy
				Mullaitivu
				Matale
				Kalutara
1	2	7	6	12

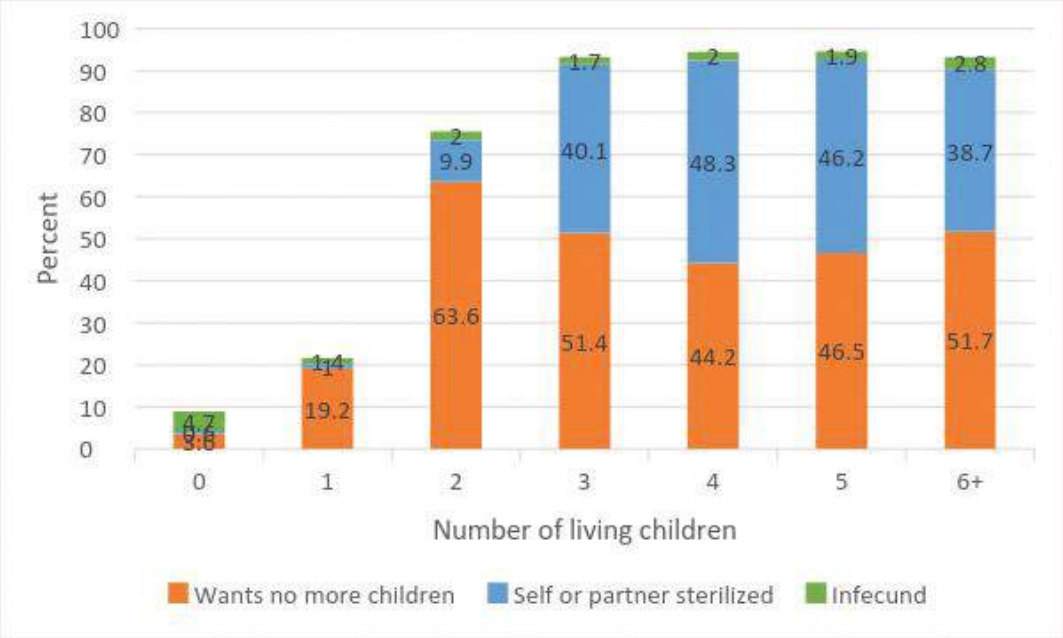
Source: RHMIS 2014

6. Disconnect between fertility preferences and method choice

The contraceptive method used by a couple tends to depend on the stage of the reproductive life cycle they are in. A hospital based study on abortions in Sri Lanka by Arambepola and Rajapakse showed that women who had completed their family needed protection from pregnancy for nearly 15 years.[21] When women decide to stop childbearing it is a reasonable assumption that most will choose a permanent method like sterilization or long acting methods such as IUDs or implants if these methods are readily available. The alternative is using short acting methods such as DMPA every three months or OCP daily for ten years or more until menopause. This latter option is inconvenient for most women and is costly for the NFPP as the contraceptives and services are provided free of cost in Sri Lanka and puts a strain on the logistics system to provide a regular supply of short acting methods. Moreover, these short acting methods have a higher likelihood of failure compared with the long term methods. The fertility preferences of women by the number of living children were compared to the current use of contraception by parity. (Figures 4.10, 4.11 and 4.12)

[21] Arambepola C &Rajapaksa LC (2014). Hospital Based Study on Unintended Pregnancies in Sri Lanka, UNFPA, Sri Lanka.

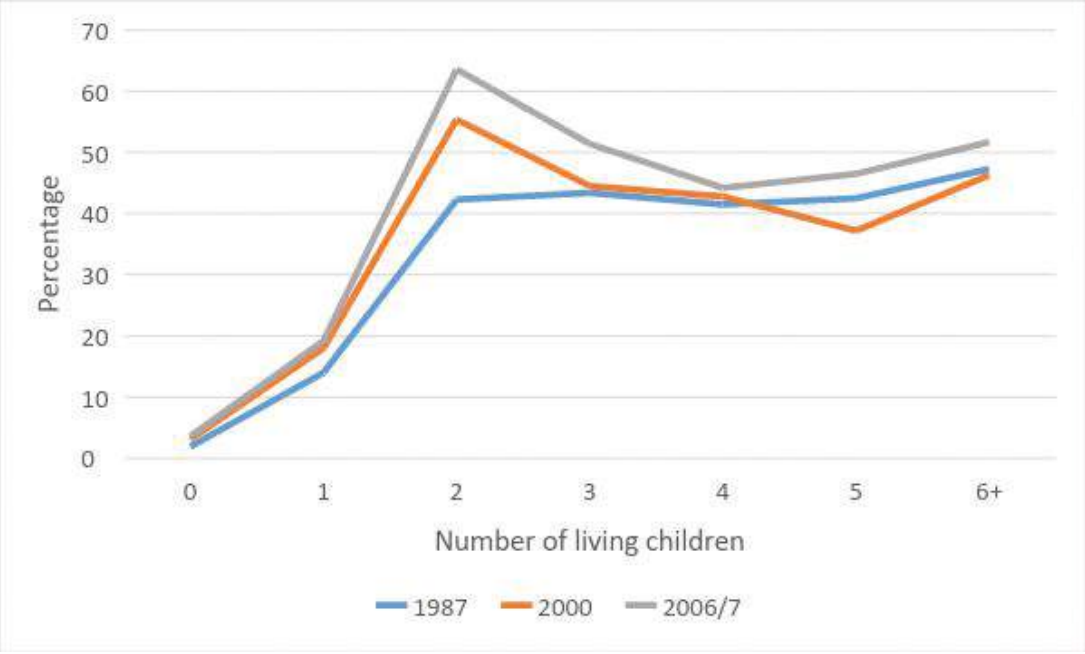
Figure 4.8: Percentage of currently married women wanting no more children by number of living children



Source: 2006/7 SLDHS

Figure 4.8 shows the desire to limit childbearing increases as the number of living children increases. Around three fourths of women with two children and over 90 percent of women with three or more children want to stop childbearing or are already sterilized. Very few women are infecund. Hence, this indicates a considerable demand for ongoing contraceptive services among women and their partners who have not been sterilized.

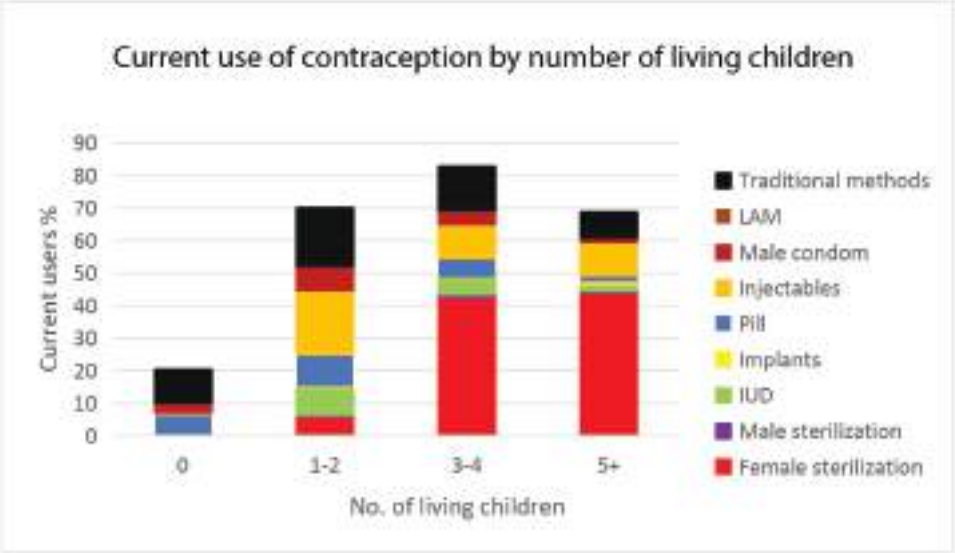
Figure 4.9: Percentages of women who do not want any more children, according to the number of children they currently have



Source: 2006/2007 SLDHS

Figure 4.9 shows, that in 2000 and 2006/7 the percentage of women with two or more children who say they want no more pregnancies are a majority, and over the years the line has pushed higher. This signifies a two child family norm. A major change is observed for women with two living children with thirty three percent of mothers saying they wanted to stop childbearing in 1987. In 2006/7 this had increased to approximately 64 percent or fifty percent more mothers with two living children saying they wanted to stop childbearing. (Data is not shown in the graph)

Figure 4:10: Contraceptive method used by currently married women, 15-49 by number of children still living



Source: 2006/2007 SLDHS

The data on contraceptive use by family size in Figure 4:10 shows over 70 percent of women with 1 to 2 children are using contraception, with the vast majority using injectables, pills and IUD. A little over 80 percent of women with 3 to 4 children, use a contraceptive method but the method mix has changed – with sterilization being the commonest method. However, other methods used are injectables, pills and condoms together with traditional methods, all of which have high discontinuation and failure rates. Figure 4:10 also shows that a large number of women with three or 4 children or more are using traditional methods.

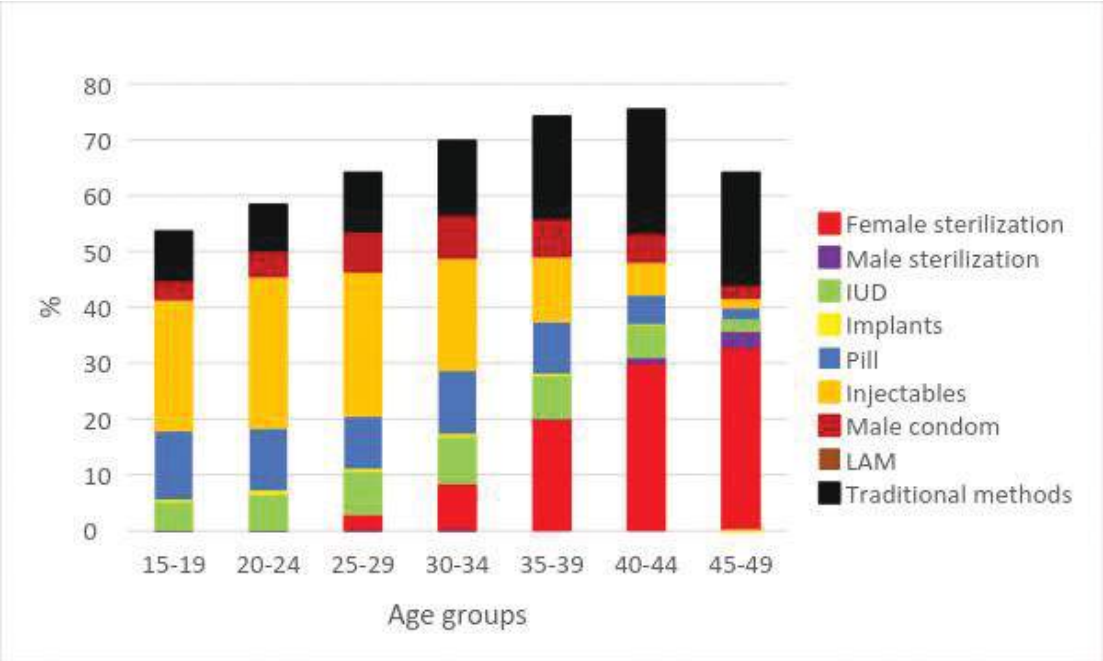
7. Women at the end of reproduction

The decrease in fertility with age is not sufficient to protect couples wishing to prevent pregnancy. Women of older reproductive age who no longer desire children still need to use effective contraception until menopause has occurred. Women more than 40 years of age may consider all methods of contraception as no method is contraindicated by older age alone. They should be advised of the risks and non-contraceptive benefits of all contraceptive methods.[22] Although the possibility of pregnancy is less likely after the age of 40 years, the clinical and social consequences of an unexpected pregnancy can be serious.

[22] Faculty of Family Planning and Reproductive Health Care. FFPRHC Guidance (January 2005) contraception for women aged over 40 years. J Fam Plann Reprod Health Care 2005;31:51–63.

The risk of spontaneous abortion and chromosomal abnormalities increases markedly over age 40.[23] Older age is also associated with an increased risk of obstetric complications, including gestational diabetes, hypertension, placenta praevia, caesarean delivery, perinatal death and maternal death.[24]

Figure 4.11:Contraceptive method used by currently married women, 15-49 by age



Source: 2006/7 SLDHS

The 2006/7 SLDHS indicates that 75.5 percent of women age 40–44 and 64.3 percent of women age 45–49 were using a method of contraception. (Figure 4.11) Among couples where the woman is aged 40–49 years, the most frequently used method of family planning is sterilization. Among the other methods used, there is special concern about the use of traditional / natural method because their efficacy depends on the presence of regular cycles, of which the incidence decreases with increasing age. Unfortunately 15.4 percent in the 40-44 age group and 13.3 percent in the 45-49 age group rely on the rhythm method. Hormonal methods were used by 11.1 percent in the 40-44 age group and 3.8 percent in the 45-49 age group. Figures 4.8 and 4.9 also show the increase in the use of LAPM with age and the reduction in the use of short acting methods.

8. High Discontinuation Rates

Many contraceptive users discontinue methods because of dissatisfaction with the method or with services. This leads to disappointment for clients, is wasteful for the NFPP and detrimental to contraceptive prevalence. Contraceptive discontinuations contribute substantially to unwanted pregnancies and induced abortions.

[23] Cleary-Goldman J, Malone FD, Vidaver J, et al. Impact of maternal age on obstetric outcome. Obstet Gynecol 2005; 105:983-90.

[24] Joseph KS, Allen AC, Dodds L, et al. The perinatal effects of delayed childbearing. Obstet Gynecol 2005;105:1410- 18 41 in the 45-49 age group. Figures 4.8 and 4.9 also show the increase in the use of LAPM with age and the reduction in the use of short acting methods.

Table 4.16: 12-month discontinuation rates by reason for discontinuation and method among most common methods used, married women 15-49, 2006/7 SLDHS survey

Method	Method failure	Desire to become pregnant	Other fertility reasons	Side effects and health concerns	Other method related	Other	Total
Pill	3.0	15.1	2.9	12.3	4.6	5.6	43.4
IUD	1.0	1.2	0.1	4.0	1.1	2.1	9.7
Injectables	0.6	3.7	2.0	13.9	2.6	4.3	27.0
Male condom	2.6	11.4	2.8	1.7	10.0	6.9	35.4
Periodic abstinence	4.5	9.4	0.6	0.2	8.0	7.9	30.5
Withdrawal	7.9	11.6	1.3	0.1	12.9	5.8	39.5
All methods	2.8	8.1	1.9	7.4	5.9	6.3	32.3

Source: 2006/7 SLDHS

Table 4.16 shows 12-month discontinuation rates for all common methods at the time of the 2006/7 SLDHS excluding implants and female and male sterilization. One third (32.2 percent) of the users stopped using a method within 12 months of starting its use. The highest rates were for short-acting methods, pills accounting for 43 percent of the total discontinuation rate, male condoms account for 35.4 percent followed by injectables (27 percent). The discontinuation rate was lowest for IUD (9.7 percent). Traditional methods also have high rates of discontinuation; one in three users of periodic abstinence and two fifths of withdrawal users stopped using within 12 months of starting use. About 15 percent of women discontinued due to method failure, side effects and health and other method related reasons. Dropping out on account of side effects and method failure may indicate low quality of FP services. Such high drop-out rates indicate huge system loss for the programme. Discontinuation rates from the RHMIS are considered to be unreliable by KI in the FHB.

Reasons for discontinuation based on FGD

Reasons for discontinuation can be divided into two categories:

1. not in need of contraception, and;
2. in need of contraception.

1. Reasons for not being in need of contraception are:

a. Infrequent sex or the husband is away

A person who uses pills and if her husband goes abroad, they will stop using it.

FGD PHMs, Kalmunai

If the husband goes aboard they don't have the need, so they say that they don't need it.

FGD PHMs, Jaffna

When the husband and wife lose interest in sex they will think that it's (contraception) not needed. So they stop.

FGD married women 30-45 years, Nuwera Eliya

b. The woman wanted to become pregnant

If an IUD is inserted for 10 years and if a lady needs another child, she will remove it.

FGD PHM, Kalmunai

c. Marital dissolution/separation

If the husband divorces the wife then she stops using contraception.

FGD PHM, Kalmunai

2. Discontinuation while in need of contraception

a. Became pregnant while using a method (method failure)

Because of the loop, very rarely they become pregnant.

FGD PHM, Kalmunai

Failure when using OCP was also mentioned by several FGD participants as a reason for discontinuation.

b. Health concerns or side effects

Periods usually come every month, but because of these tablets, it reduces or don't come. Because of that can't they become lumps inside the abdomen? That's why some are afraid. Thinking that it would affect them.

FGD married women 30-45 years, Trincomalee

For some there are these effects, some tend to have more bleeding due to injections. I used injections before and had more bleeding, so I stopped it and got changed to pills, but it didn't help. I had ulcers in the mouth also, so I stopped it too. For some there are these effects, I have these.

FGD married women 18-29 years, Jaffna

There is continuous menstruation with the injection for some people. Some people don't get menstruation and their bodies get fat. For injections some get back pain. So they stop.

FGD married women 30-45 years, Trincomalee

Symptoms of other conditions are often attributed to the contraceptive method leading to discontinuation.

When few people start FP methods, they will take symptoms of other diseases as the side effect of the methods. So if we update them with what are the true side effects then we can reduce these incidents.

FGD PHM, Kalmunai

c. Method-related reasons

Sometimes the chosen method is inconvenient e.g.some males experience discomfort during sexual intercourse when the wife had anIUD inserted.

P2 For loop….they say that while being together it is disturbing them. The string…
P8 Yes the same reason they tell us too.

FGD PHM, Jaffna

My husband had discomfort during intercourse after I had an IUD fitted. I had to take it out.

FGD married women 18-30, Galle

d) Method shifting

Sometimes women discontinues a method due to side effects and shift to another one.

If there is a side effect in one method, she will leave that and go for another method.

FGD PHM, Kalmunai

Sometimes when had the injections, some don't get the periods. So if periods don't come, it may become a problem later on, so they are changing over.
Some people forget to take the tablets every day, so they are getting injections.

FGD Married women 30-45 years, Trincomalee

I had inserted a loop for 5 years. Eight months ago I had continuous bleeding for 3 months. I came to the clinic and they checked and gave me drugs. But it didn't get better. I fainted and got chest pain. When I was taken to the hospital they removed the loop. After that, bleeding stopped. I got the side effect after 5 years. They told me that is not good for my body and they removed it. It's been 1month now. Today I came to get another method.

FGD Married women 30-45 years, Colombo

More disturbingly, some women discontinue a method due to inconvenient clinic times.

P4 Some ladies due to heavy work load, they forget it. They don't get leave to go to the clinic for this.

P5 In clinic also we have to wait for long hours, they give tokens and take us in. so we have to go and get the numbers. So because of these also they don't find time for this.

FGD Married women 30-45 years, Trincomalee

e. Opposition from husbands

Some husbands don't like their wives using contraceptive pills. So because of that there will be problems.

FGD Married women 18-29 years, Jaffna

f. Ashamed to use contraception

Older women in the reproductive age group often discontinue using a method. The contact with the PHMs is low. They are ashamed to come to the clinics and seek contraception.

There's a problem in this age group (above 40).We are unable to do anything for them. And we're unable to advise them also. We don't have time to explain them since they have well grown children and they do not have good contact with us. They have 15-20 year old children. So their contacts are less with us. So on these occasions we're missing them.

FGD PHM, Nuwera Eliya

When the children are grown up they say it is not needed. And they stop it. They say it is culturally not acceptable.

FGD PHM, Nuwera Eliya

9. Contraceptive failure

Table 4.17 shows the contraceptive failure in 2012 and 2013 based on FHB service statistics. The failure rate was highest among IUD users. Condom failure rate is lower than the failure rate of other methods. This raises questions about underreporting and the quality of the RHMIS data.

Table 4.17: Contraceptive failure in 2012 and 2013 based on FHB service statistics.

Contraceptive methods	2012		2013	
	No of failures	Failure rate per 10,000 users	No of failures	Failure rate per 10,000 users
Injectables	307	8.5	201	4.9
Oral pills	309	8.6	386	10.5
IUD	471	13.1	580	15
Condoms	51	1.4	78	2.8
Implants	3	0.1	4	0.5
LRT	82	2.3	72	1.5
Vasectomy	0	0	0	0
Total	1223		1321	

Source: Annual Report 2012, 2013 FHB

10. Unintended pregnancies leading to unintended births and abortions

The number of unintended pregnancies leading to unintended births and abortions is the most obvious evidence of unmet need for FP among women of reproductive age. While there are significant problems in measuring both of these events, there are some estimates of the magnitude of these problems. In the 2006/7 SLDHS, married women of reproductive age reported that 17.2 percent of their births were unwanted or mistimed. If a woman has an unwanted mistimed pregnancy she may respond in a number of different ways, depending on her situation. Many women will accept the pregnancy though for some it may have implications for her life prospects. Some will reject the birth, opting to terminate the pregnancy through the use of a variety of unsafe measures or by resorting to safe professional medical interventions. In making decisions among these options each woman will be heavily influenced by the cultural, legal, religious and personal circumstances and background.

Abortion is illegal in Sri Lanka except to save the women's life under Article 303 of the penal code of 1883. WHO defines an unsafe abortion as 'a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards or both.[25] The National Strategic Plan on Maternal and Newborn Health (2012-2016) includes the reduction of abortion-specific mortality from 4.5 to 3 deaths per 100 000 live births as an objective of the National Maternal and Newborn Health Programme.

It is very difficult to estimate the number of women who opt to terminate their pregnancies by induced abortion in Sri Lanka. A study conducted in 1998 reported an abortion rate of 45 per 1000 women in the reproductive age (95% CI: 38-52) which translated to an annual incidence of 240,055, approximately 650 abortions per day.[26] De Silva et al estimated that about 150,000-175,000 abortions took place annually in Sri Lanka compared to about 325,000 live births per annum.[27] These latter figures were obtained by using daily average attendance in known abortion clinics and making some allowance for those performed by private hospitals and practitioners. The same study showed that of 306 clients seeking abortion 74 percent

[25] AWorld Health Organization: The prevention and management of unsafe abortion. Report of a Technical Working Group. Geneva: 1992.

[26] Rajapakse L: Estimates of induced abortions in urban and rural Sri Lanka. Sri Lanka: Report of the Faculty of Medicine, University of Colombo; 2000

[27] de Silva WI, Dayananda RA, Perera N. Contraceptive behaviour of abortion seekers in Sri Lanka. Asian Popul Stud. 2006;2:3---18.

were using contraception. Even though three-quarters of the clients were using a contraceptive method at the time of conception, 74 percent of them were relying on safe period and/or withdrawal. Only half of the users of traditional methods possessed correct knowledge of a woman's fertile period.Worryingly, one-third of the women undergoing abortion had one or more previous induced abortions.

Studies of Sri Lankan women seeking abortion have found that most women have an abortion either because they have already completed their families or because they get pregnant too soon after the birth of their youngest child.[28,29,30,31] These studies suggest that induced abortion is commonly practiced as a method of fertility control in Sri Lanka. Despite the fact that almost 99 per cent of women know at least one method of contraception and modern contraceptives are available throughout the country, induced abortion takes place in Sri Lanka. This behaviour is probably encouraged by the low level of complications when performed by trained personnel.

The FHB together with the Sri Lanka College of Obstetricians and Gynaecologists (SLCOG) has developed Post Abortion Care Guidelines. These need to be disseminated widely and implemented.

11. Subfertility

Very few lay people including some medical personnel associate subfertility as a component of FP. The ICPD in 1994 focussed attention on womens' reproductive health including subfertility. By addressing the problem of subfertility, the NFPP demonstrate its commitment to helping people achieve their personal reproductive goals, whether that goal is to postpone a birth, to end childbearing or to conceive as soon as possible.

There is no universal definition of subfertility. The clinical definition of subfertility used by the WHO is "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse"[32], while the WHO's epidemiologic definition is "women of reproductive age at risk of becoming pregnant who report unsuccessfully trying for a pregnancy for more than two years".[33]

Estimates on the prevalence of subfertility from 25 population surveys sampling 172, 413 women found the 12-month prevalence rate ranged from 3.5 percent to 16.7 percent in more developed nations and from 6.9 percent to 9.3 percent in less-developed nations with an estimated overall median prevalence of 9 percent. [34]

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[28] Thalagala N. Process, Determinants and Impact of Unsafe Abortions in Sri Lanka. Colombo, Sri Lanka: Family Planning Association of Sri Lanka; 2010.

[29] Ban DJ, Kim J, de Silva WI. Induced abortion in Sri Lanka: who goes to providers for pregnancy termination? J Biosoc Sci. 2002;34(3):303---315.

[30] Perera J, de Silva T, Gange H. Knowledge, behaviour and attitudes on induced abortion and family planning among Sri Lankan women seeking termination of pregnancy. Ceylon Med J. 2004;49(1):14---17.

[31] de Silva WI, Dayananda RA, Perera N. Contraceptive behaviour of abortion seekers in Sri Lanka. Asian Popul Stud. 2006;2:3---18.

[32] Zegers-Hochschild F, Adamson GD, de Mouzon J, Ishihara O, Mansour R, et al. (2009) The International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) revised glossary on ART terminology, 2009. Hum Reprod 24: 2683–2687 doi:10.1093/humrep/dep343.

[33] World Health Organization (2006) Reproductive health indicators for global monitoring: guidelines for their generation, interpretation and analysis for global monitoring. Geneva: World Health Organization. 63 p

[34] Bivin J, Bunting L, Collins JA, Nygren KG, International estimates of subfertility prevalence and treatment seeking: potential need and demand for subfertility medical care. Hum. Reprod. 2007; 22:1506-1512.

Since voluntary childlessness is rare in Sri Lanka, currently married women in their late forties with no births are likely to be those who have primary subfertility. The level of childlessness among married women age 45-49 has been used as an indicator of the level of primary subfertility. The 2006/7 SLDHS indicates that primary subfertility among currently married women age 45-49 is about 5 percent. The corresponding values from the 1993 and 2000 SLDHS surveys are 3 percent each.

Based on the RHMIS data for 2014, subfertile couples as a percentage of eligible couples was 2.6 percent. (Table 4:18) In none of the districts does subfertility exceed 4.5 percent of eligible couples. Nevertheless, a significant number of couples – 97,063 - are reported as subfertile. The RHMIS does not differentiate between those with primary and secondary subfertility.

Table 4.18: Eligible couples and subfertile couples as a percentage of eligible couples by district 2014

District/ health area	Eligible Families Under Care by PHM	No of subfertile couples	%
Colombo	281341	7456	2.7
Colombo M.C	93303	1114	1.2
Gampaha	398965	14376	3.6
Kalutara	164442	5695	3.5
N.I.H.S	52153	2313	4.4
Kandy	245063	4685	1.9
Matale	93156	1861	2.0
NuwaraEliy	130732	2100	1.6
Galle	176234	5080	2.9
Matara	137780	4313	3.1
Hambantota	112231	2751	2.5
Jaffna	91552	3487	3.8
Kilinochchi	20002	526	2.6
Manner	18531	440	2.4
Vavuniya	27890	511	1.8
Mullaitivu	19098	191	1.0
Batticaloa	95570	2055	2.2
Ampara	51130	1458	2.9
Kalmunai	74228	3352	4.5
Trincomalee	70729	1393	2.0
Kurunegala	300730	9297	3.1
Puttalam	149092	3259	2.2
Anuradhapura	180864	3200	1.8
Polonnaruwa	94525	2090	2.2
Badulla	151690	2810	1.9
Monaragala	92508	2433	2.6
Ratnapura	196647	4826	2.5
Kegalle	148793	3991	2.7
National	3668979	97063	2.6

Source: FHB Annual report 2014

A study done in Colombo district among currently married women in the reproductive age group showed the point prevalence of primary subfertility to be 5.52 percent.[35] The point prevalence for secondary subfertility was found to be 10.07 percent. Both primary and secondary subfertility were lower at the extremes of age. The same study found that only 53 percent of both primary and secondary subfertile couples had sought treatment. On average there was a 24.68 month average waiting time before seeking treatment.

A study on the causes of subfertility among 518 couples attending a subfertility clinic at the Teaching Hospital Colombo North found that over half the women had ovulatory dysfunction.[36] Polycystic ovary syndrome was found in 60 percent of women with ovulatory dysfunction. Tubal factor subfertility was rare. Unilateral tubal occlusion was seen in 9.1 percent while it was bilateral in 1 percent. Uterine and pelvic pathologies were uncommon.

Subfertility generates disability (an impairment of function) in women and was ranked the 5th highest serious global disability among populations under the age of 60 by the WHO and World Bank.[37] Thus access to health care and in this case, access to treatment for subfertility falls under the Convention on the Rights of Persons with Disability.[38] Sri Lanka ratified the Convention on the Rights of Persons with Disabilities on 8th February 2016 and became the 162nd State to ratify this Convention and as such gives subfertile individuals a right to treatment.[39]

On 10th November 1999 the first baby conceived by IVF /ET was born in a Colombo private hospital. Since then several centres providing Assisted Reproductive Techniques (ART) services have been established. The expansion of ART services and the potential health risks to patients and offspring and the many ethical issues involved make it necessary to monitor and regulate the services provided. The National Science and Technology Commission (NASTEC), a body established by the Ministry of Science and Technology in 1998 to advise the Government of Sri Lanka on scientific policy appointed an expert committee which was charged with developing a national policy on biomedical ethics. The committee report *New genetics and assisted reproductive technologies in Sri Lanka: A draft national policy on biomedical ethics*" was published in 2003. The report had two major sections: 'Ethical Principles Relating to New Genetics' and 'Ethical Principles Relating to Assisted Reproductive Technologies'.[40] The section on ART recommended the establishment of a Reproductive Technologies Commission by an Act of Parliament on the lines of the Human Fertilization and Embryology Authority of the UK. Following the NASTEC report the SLMC drew up a Provisional Code of Practice for ART in 2005.[41] The SLMC was to serve as the interim Authority until the establishment of a formal Authority by an

[35] L. H. M. N. Lansakara. Project titled "Psychosocial aspect of infertility and service needs of infertile couples". Submitted as part fulfilment for the MD in Community Medicine. PGIM 2005-2008. D1269

[36] Palihawadana TS; Wijesinghe PS, Seneviratne HR.Aetiology of infertility among females seeking treatment at a tertiary care hospital in Sri Lanka.CMJ 2012; 57: 79-83

[37] WHO & World Bank.World Report on Disability. Geneva: WHO.2011

[38] Infertility WHO.http://www.who.int/reproductivehealth/topics/infertility/definitions/en/ (Accessed 15.6.2016)

[39] Press release, Permanent Mission of Sri Lanka to the United Nations in New York http://www.slmission.com/index.php/news/91-latest/832-sri-lanka-ratifies-the-convention-on-the-rights-of-persons-with-disabilities. (Accessed 15.6.2016)

[40] National Science and Technology Commission, Colombo (2003).New genetics and assisted reproductive technologies in Sri Lanka: A draft national policy on biomedical ethics

[41] Sri Lanka Medical Council.Assisted Reproductive Technologies.A Provisional Code of Practice. June 2005 http://www.srilankamedicalcouncil.org/download/download/6/66db9284166164d13be1684c657835bc.pdf (Accessed 15.6.2016)

Act of Parliament. The objective of the Authority would be the licensing and monitoring of centres carrying out in vitro fertilization and donor insemination.[42] According to KI drafting of the legislation when completed has to go through the lengthy process of MoH approval followed by review by the legal draftsman before it can be presented to Parliament for final approval.

12. Early marriage and teenage pregnancy

Age at first marriage

Even with substantial investments in female primary and secondary schooling over the years, UNICEF's Child Marriage Baseline Estimates show there are more than 20,780 girl children between the ages of 12 and 17 in Sri Lanka who are married or in cohabiting relationships and often have children before they reach 18 years of age.[43] The Census of Population and Housing 2012 indicates that 10.4 percent of girls between the ages of 15-19 years are married.

While the minimum age of marriage for both males and females is 18 years in terms of General Marriages Ordinance and Kandyan Law, the Muslim Law of Sri Lanka does not specify any minimum age of marriage. This provision contradicts section 363 of the Penal Code of Sri Lanka, which states that sexual intercourse with a girl below the age of 16 (with or without her consent) amounts to statutory rape. As one KI said Muslims leaders are taking steps to address this issue at local level;

> *We are conscious of this and that it (early marriage) affects the girls' wellbeing. The Ulama Council in Kuchavelihas decided not to recognize any marriages if the girl is less than 16 years. We intend to gradually increase the permissible age of marriage to 18 years.*
>
> ***KI local community leader, Trincomalee***

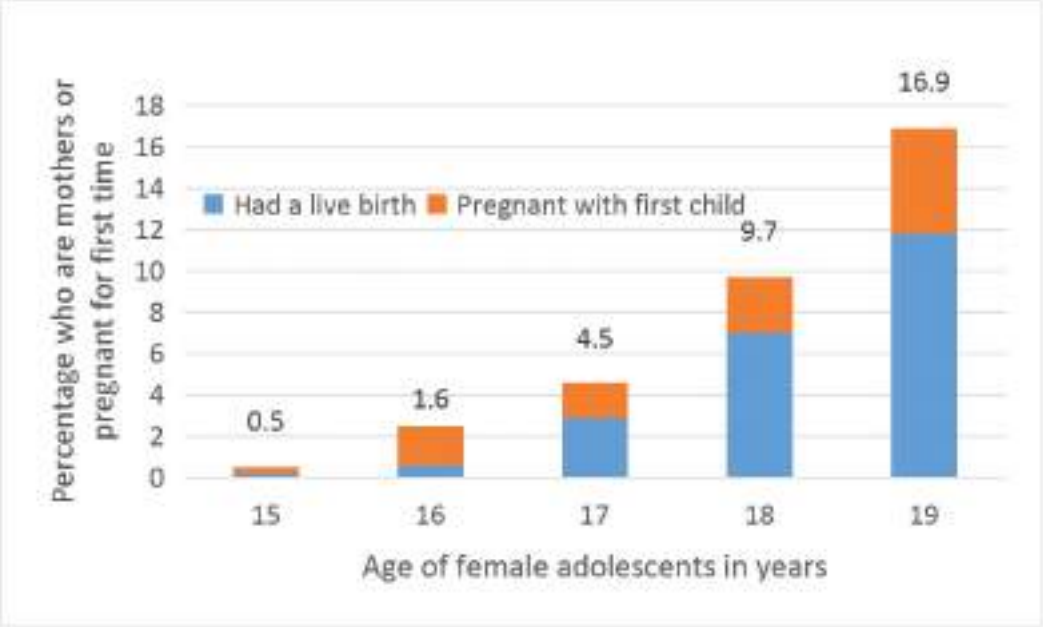
Teenage pregnancy

Teenage pregnancy in Sri Lanka is relatively low. According to 2006/7 SLDHS, overall only 6 percent of women age 15-19 are already mothers or are pregnant with their first child. About 17 percent of 19 year-olds were already mothers or pregnant for the first time. (Figure 4.12)

[42] Simpson B. IVF in Sri Lanka: A concise history of regulatory impasse. Reproductive BioMedicine and Society Online.2016: 2: 8–15. http://www.sciencedirect.com/science/article/pii/S2405661816000046 (Accessed 15.6.2016)

[43] Goonesekere S, Amarasuriya H. Emerging concerns and case studies on child marriage in Sri Lanka. UNICEF.2013

Figure 4.12: Teenage pregnancy and motherhood



Source: 2006/7 SLDHS

Table 4.19 : Percentage of all women 15-19 who have had a live birth or who are pregnant with their child and percentage who have begun childbearing by residence.

Residence	Have had a live birth	Are pregnant with first child	Percentage who have begun childbearing
Urban	4.6	1.7	6.4
Rural	4.1	2.1	6.2
Estate	7.0	2.6	9.6

Source: SLDHS 2006/7

Approximately 10 percent of adolescents from the estate sector have begun childbearing compared with 6 percent of rural and urban adolescents (Table 4.19. Early marriage in the estate community is not as common as it was in the past according to FGD participants.

P4 *Earlier what our parents say is they were married at 13 or 14 years.*

M *Is this happening now?*

P4 *If they wish only they are marrying at that age.*

M *You mean the couples who are marrying are deciding it?*

P4 *agreeing*

P5 *Otherwise parents are not marrying their children at that age.*

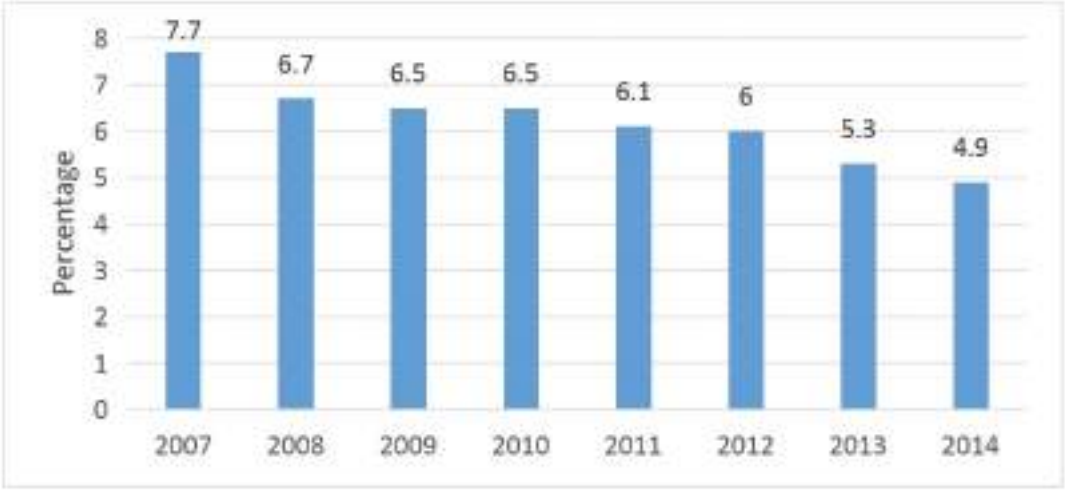
M *So at what age the parents are organizing marriages?*

P5 *By 18, 19, 20*

FGD out of school boys 16 -19, Nuwera Eliya

Based on FHB RHMIS data there has been a slow but steady decline in teenage pregnancies that are registered and in 2014 this percentage was 4.9 percent. Figure 4.13 shows the trends in teenage pregnancies over the last 8 years. It should be noted that since 2007 the FHB changed the definition of teenage pregnancy used in the RHMIS from under 19 years to under 20 years.

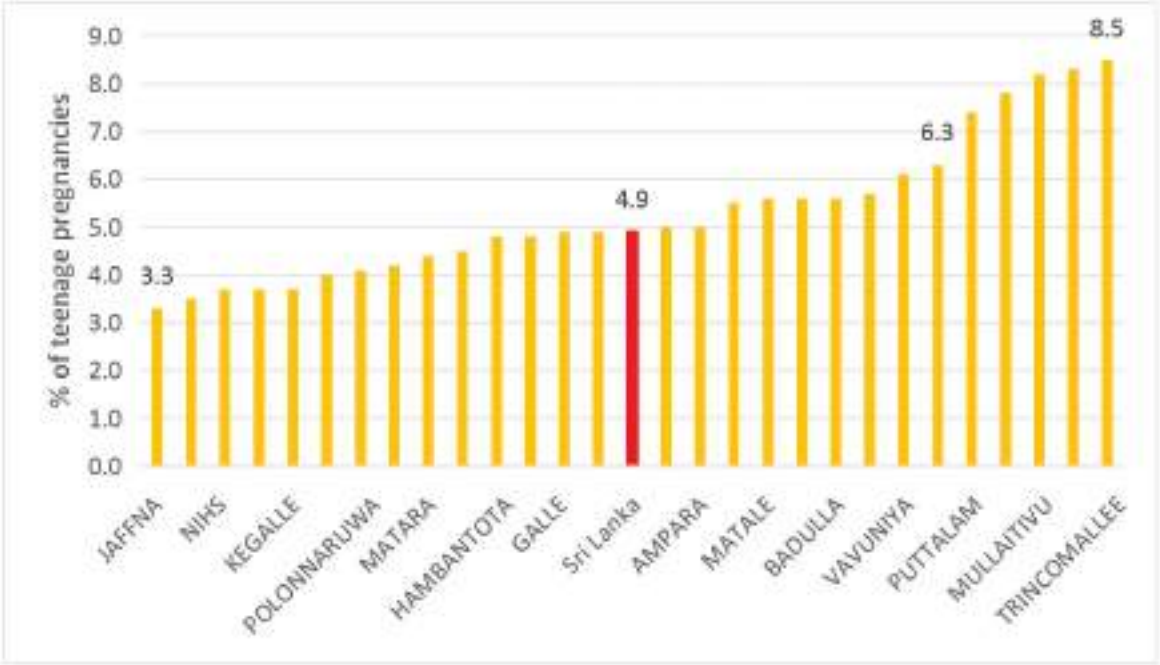
Figure 4.13: Trends in teenage pregnancy 2007-2014



Source: RHMIS

There are considerable district variations in the percentage of teenage pregnancies registered. (Figure 4.14) The RDHS areas with the highest number of teenage pregnancies were in the North and East and Colombo MC also reported that 6.3 percent of pregnancies registered were to women less than 20 years. In 2014 the number of births that took place were 349,715 which means there were 17,136 births among women less than 20 years - not an insignificant number.

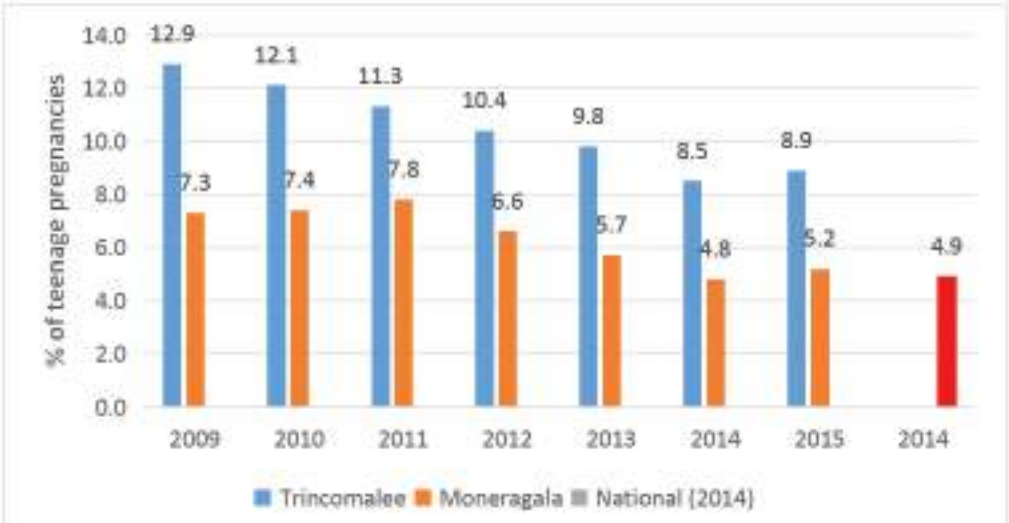
Figure 4.14: Percentage of teenage pregnancies by health areas 2014



Source: RHMIS

In Tricomalee and Moneragala, the decline in the percentage of teenage pregnancies has arrested in 2014 and increased in 2015. (Figure 4.15) This needs to be followed up closely to see if the trend persists.

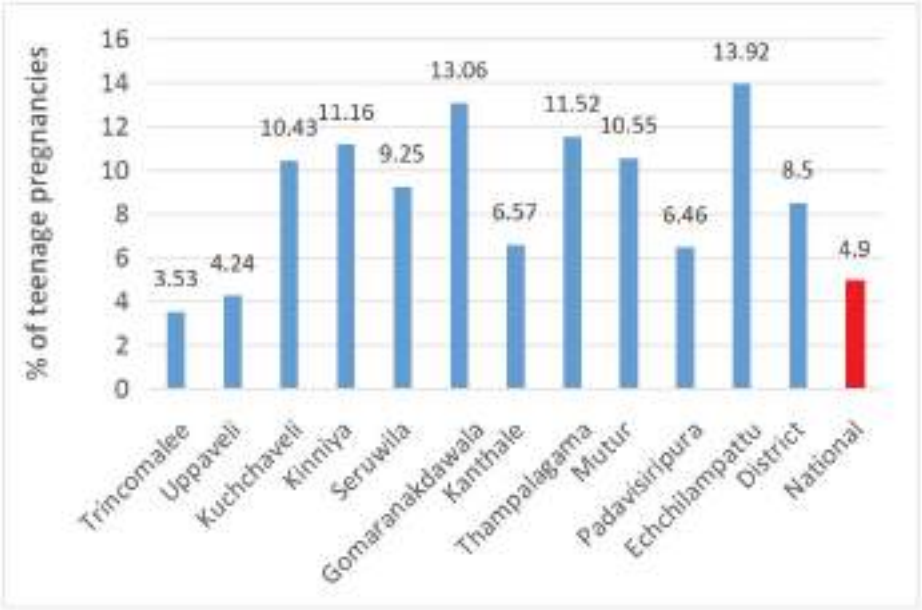
Figure 4.15: Percentage of teenage pregnancies in Trincomalee and Moneragala districts during the period 2009 -2014.



Source: RH MIS (NB: The national figure for 2015 was not available at the time of writing the report)

Trincomalee district has the highest percentage of teenage pregnancies in the country. Nevertheless, it is only in some MOH areas such as Echchilampattu, Gomaranakdawala, Kinniya, Thampalagama and Mutur that the percentage of teenage pregnancies is very high. (Figure 4.16)

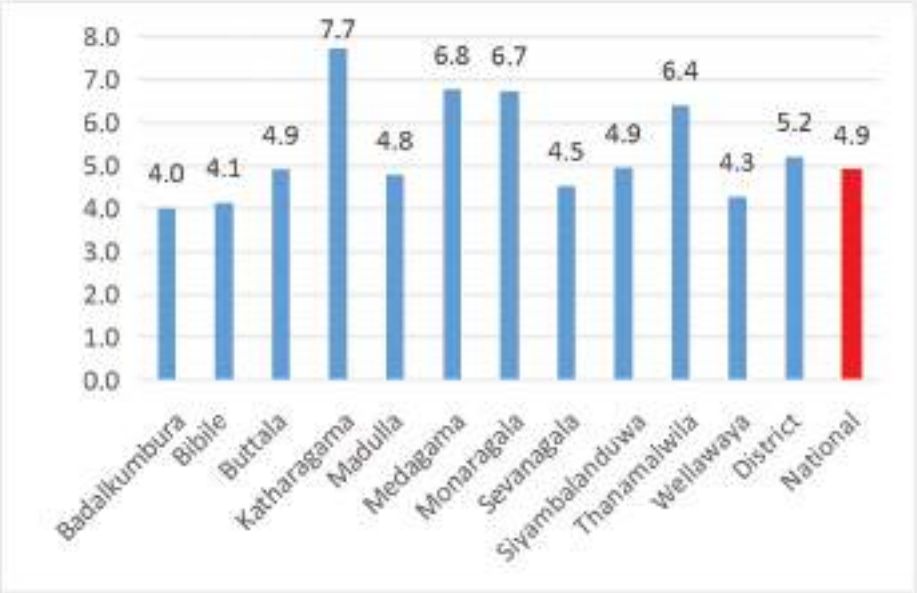
Figure 4.16: Trincomalee - Teenage pregnancy by MOH area 2015



Source: RDHS Trincomalee (NB: The National figure shown is for 2014. The National figure for 2015 was not available at the time of writing the report)

Similarly in Moneragala it is only in some MOH area that teenage pregnancy is higher than the district and national average. (Figure 4.17)

Figure 4.17: Moneragala- Teenage pregnancy by MOH area 2015



Source: RDHS Moneragala(NB: The National figure shown is for 2014. The National figure for 2015 was not available at the time of writing the report)

Risk factors for teenage pregnancy and early marriage based on FGD and KI

Lack of aware on RH / FP issues and parental guidance was identified as a reason for early marriage and teenage pregnancy.

> *Some girls after the O/L get involved with boys and become pregnant because of lack of knowledge. We should receive this information before O/L when we are in grade 10.*
>
> ***FGD out of school girls 16 -19, Moneragala***

> *Ignorance, it is because the parents have not given the relevant advice on this.*
>
> ***FGD married women 30-45. Trincomalee***

The media was a powerful influence in shaping the thinking of young people. The content of some TV programmes glamorizes being sexually active but may not include any type of information about preventing unwanted pregnancies by using contraceptives.

> *Some watch what's there (on media) and some think in a wrong way. Some don't understand. Then there's a huge tendency for them to go the wrong way. They are the ones who elope. Then they get pregnant.*
>
> ***FGD out of school girls 16 -19, Colombo***

Poverty was associated with lack of awareness but was also identified as a reason young girls engaged in sex or are forced to have sex.

> *Yes, poverty gives rise to illiteracy. Because of that problem… unawareness… because of unawareness the children get caught to these activities. Mostly in the estate. Lately there was a story in newspaper that the mother goes to pluck tea and the kid had been at home alone, after school. There is a stone quarry nearby and 20 men had abused that child within a few years.*
>
> ***FGD married women 30-45. Nuwera Eliya***

When they couldn't find money they go for prostitution.

FGD out of school boys 16 -19, Colombo

On the other hand girls from affluent families were able to obtain contraceptives and prevent unwanted pregnancies.

Yes… to an extent girls who can go to the pharmacy secretly and give money and get pills. The ones that don't have money are the ones who go and carry an unwanted pregnancy.

FGD married women 30-45. Trincomalee

Our sales of ECP are highest during Valentine's day. Its children going to international schools who come and buy them.

KI Female pharmacist. Colombo

In some communities' e.g Muslims, early marriages is common.

Some fix the proposal in the childhood periods.

FGD out of school boys 16 -19, Kalmunai

In the case of early marriage even though the girl wanted to delay getting pregnant the mother and mothers-in-law were keen that the girl got pregnant as soon as possible.

M *Do husbands and mother in laws pressure saying that they need a baby soon, is that a reason?*

P *Yes (Many agreeing at once)*

P9 *Yes some said to us, even if they don't want to have a baby, they are forced to face that situation.*

FGD out of school girls 16 -19, Kalmunai

Sexual abuse and blackmail were identified as reasons for teenage pregnancy.

Let's say one man has sexually abused a girl who was going on the road; he will know that if he gives this tablet the pregnancy won't happen. He won't do this work (sexual abuse) without knowing this (giving pills).

FGD out of school boys 16 -19, Nuwera Eliya

Make her feel scared. Men make videos and threaten to spread them.

FGD out of school boys 16 -19, Colombo

Parental neglect and lack of affection and frequent parental strife were identified by FGD participants as underlying factors for teenage pregnancy.

Being neglected by the family. If a girl is not taken care by the family she may fall into this problem.

FGD out of school boys 16 -19, Nuwera Eliya

And sometimes the mother and father may go to work, and the child may be alone in home, with no security…. There might be these kinds of reasons.

FGD married women 30-45. Trincomalee

Problems between parents… If parents are with the children this won't happen.

FGD out of school girls 16 -19, Colombo

Whatever it is a mother needs to teach her child is all that matters. They should teach the changes that take place in the body. If parents care is there mainly there won't be any problems.

FGD married women 30-45. Trincomalee

The father drinks and the mother goes abroad to earn so the daughters go astray.

KI Lead mother, Mothers Support Group, Gomarankadawala,

Insufficient employment and education obborturn her was a reason young girls entered into relationships in remote parts of the country.

If a girl fails the GCE O level there are no opportunities here like vocational training centers, only agriculture.

KI Lead mother, Mothers support Group, Gomarankadawala,

When people don't have jobs for their education they get into these relationships

FGD out of school boys 16 -19, Colombo

These findings are similar to studies carried out in other parts of the country on teenage pregnancy. Disruption to family structure during childhood and a deprived socioeconomic background were associated with teenage pregnancy in a study done in Teaching Hospital, Kandy.[44] Another study done in three districts identified the following risk factors for teenage pregnancy: families with low socio-economic background, lower educational level of parents, less parental supervision, mother working abroad and other unsatisfactory family environments such as heavy alcohol usage of the father leading to domestic violence, severe economic difficulties at home and teenagers living with relatives other than their own parents.[45]

Domestic violence was noted as a consequence in the case of early marriage and teenage pregnancy by FGD participants.

In Merayaa estate side, one girl, 18 years…. ran away with a boy and lived there. But when they mistreated her there, she called her parents, and they brought her back.

FGD Unmarried girls 16-19 years, Nuwera Eliya

Maternal deaths among adolescents

Maternal deaths among adolescents are not uncommon. These deaths are less than among other age groups. Of the 113 maternal deaths that took place in 2015, 2 deaths were among women less than 20 years of age. (Table 4.20)

[44] Ekanayake CD, Tennekoon SUB, Hemapriya S. Teenage pregnancies: Obstetric outcome and their socioeconomic determinants, a descriptive study at Teaching Hospital Kandy. 2015;37:47-53.

[45] UNFPA 2011.Extent trends and determinants of teenage pregnancy in three districts of Sri Lanka.

Table 4.20: Maternal deaths by age group of the mother

Age	2011	%	2012	%	2013	%	2014	%	2015	%
<20	10	4	5	4	8	6.7	4	3.6	2	1.8
21-25	14	11	15	11	25	21	11	9.8	14	12.4
26-30	25	30	40	30	41	34.45	25	22.3	27	23.9
31-35	25	30	41	31	24	20.16	47	42	41	36.3
36-40	19	18	24	18	14	11.76	17	15.2	24	21.2
>40	7	7	9	7	7	5.8	8	7.1	5	4.4
Total	100	100	134	100	119	100	112	100	113	100

Source: FHB RHMIS

13. Contraceptive use and subfertility in the context of social, religious and ethnic issues

Both contraception and subfertility are associated with social and religious issues. In the case of contraception various religious, ethnic and political sensitivities in recent years has adversely affected the freedom with which the NFPP operates.

Based on the 2006/7 SLDHS eight percent of respondents are not using a FP method and not intending to use a method in the future because they themselves are against FP (1.7 percent) or face opposition from the husband (3.7 percent) or due to religious proscriptions (2.6 percent).

Findings from FGD and KI

The use of the terminology "family planning" has created a barrier to FP use as people felt that it was against their societal values associating FP with population control.

Use of contraception and religious beliefs

The belief that using FP is disobedience against God and is a sin was one of the reasons that both Muslims and Catholics did not use modern methods.

P1 *The husband doesn't like to do LRT. They say that is sinful.*

M *Are they Muslims?*

P1 *Burger*

M *Are they Catholics?*

P1 *Yes*

P2 *In Muslim families those mothers take pills from me, hiding it from their mother-in-laws. Mother-in-laws don't like them taking pills.*

M *Mother-in-law in the sense who's mother?*

P2 *Husband's mother. In this house there are 3 families living. The son's wife takes pills. She says to give them secretly hiding it from her mother-in-law. That mother's daughter was pregnant and she had her baby. She does not let her do any method of FP. Since she is listening to her mother she does not go for a method of FP.*

FGD PHM, Colombo

Its very difficult to talk about FP to Muslim women. The husbands object and they say the religion teaches that FP is a sin.

FGD PHM, Galle

P5 There are some religious beliefs. For example, if they use it they think it is a sin.

M What they are thinking, is it true or false?

P5 & P2 It is a wrong opinion.

P5 But they will think it that way.

P2 In Islam, it is said to breast feed for 2 years. It is also encouraging FP. So we can use any methods. But killing a baby is a bad sin, but preventing it beforehand is not a sin. But they are thinking that using FP is also a sin.

FGD PHM Kalmunai

A participant in a FGD in Nuwera Eliya said that despite religious prohibitions due to her economic circumstances she was forced to use modern contraception.

I am a Roman Catholic. In my religion they say you should not do it (use contraception). But when we consider the financial situation, we have no choice. I'm telling you what I've been taught. And I have read it also. But to tell you the truth, I have done LRT. I had to do it because of my family situation. So every time I ask for forgiveness.

FGD Married women 30—45, Nuwera Eliya

The clergy of the main religions were consulted as KI. The Catholic Church permits the use of traditional methods, but withdrawal is a grave sin as it goes against the plan of creation. Currently there is debate in the Church according to a KI about the use of modern methods of contraception. In Buddhism there are no barriers to the use of traditional or modern methods of contraception and the choice is that of the individuals. Hinduism also does not have objections to the use of contraception. In Islam there are no prohibitions against the use of contraception except sterilization. It is recommended to have a gap of around 2 years between children to ensure that the children are healthy. Both Buddhism, Christianity and Islam prohibits abortion. The findings of the FGD show that the NFPP needs to partner with faith based organizations and clergy in order to allay fears and misconceptions.

According to PHIs in Kalmunai meetings with religious leaders has helped to bring about a positive change in their attitudes towards FP.

In the Islamic community, there is a belief that contraception should not be done. But only some. In our area there is a person, with him we can't talk about contraception. He will say children are given by God, and he is avoiding contraception.But still it(contraception) is being used

FGD Married males 35-50 years, Kalmunai

The reason for the change is that we organize programmes for the religious leaders, when we do that we tell them. They had a misbelief saying that this is wrong, and is not accepted in religion.

We have spoken with the Moulavis'. We have told them what the consequences are if couples do not use it (FP), and the benefits to them.

FGD PHI Kalmunai

Fears of ethnic imbalance due to use of contraception

FGD participants both men and women were apprehensive that FP led to ethnic imbalance.

I*n the town area the Tamils are the ones who control their family number. When compared to the Muslims, the number of Tamils is reducing.*

FGD Married women 30—45, Trincomalee

In the past our families had 10-14 children. They were looked after. The Sinhalese are only using family planning. The poor Muslim families get help from the mosque. Very soon there won't be boys to be ordained as Buddhist monks.

FGD Unmarried men, 20 - 29, Moneragala

In some Sinhala areas it is there that the votes will reduce, and their majority will be lost.

FGD Married males 35-50 years, Kalmunai

Some who are so deeply religious may speak like that. But commonly the community doesn't think that way. In our area, the Tamil Muslim difference can be identified if you ask only. Otherwise there are no differences like that. In some areas there is.

FGD Married males 35-50 years, Kalmunai

We need a strategy to convince Muslims to accept FP. The mosques can be the means to change their thinking rather than our telling them.

FGD PHM, Galle

There was also a feeling that FP was a covert means of population control.

On estates, they are limiting the babies to 2-3 children. They have economic problems and they can't maintain them. To tell you the truth, they are pushing us to control the children. We see it as a planned event to reduce our population. If this goes on there will be none of us.

FGD Married Men 30-50 years, Nuwera Eliya

Estate people can't maintain 2-3 children. It is difficult. In that way FP is good. When thinking about the society it is bad. We are afraid that it is reducing our numbers.

FGD PHI, Nuwera Eliya

The word FP is not good. Those days these people were forcibly made to do FP. May be 10-20 years ago. So when we say FP they are allergic to that. If you change that name, it will be okay.

FGD Estate Medical Assistants, Nuwera Eliya

KIs said that a religious extremist group had demand NGOs providing FP services to close its clinics and even stop sterilization. KI in some of the districts that were visited during the review said there were public sector health workers who overtly or overtly discouraged FP.

Client provider gender concordant care

The majority of FGD participants did not have a preference for the gender of the healthcare provider. However, KII and FGD indicate that certain population groups and individuals do not find the FP services acceptable because of the gender of the service provider.

The gender of the service provider was a reason why men and women did not avail themselves of modern methods, especially IUD.

M Is service providers sex a problem?

P2 Males are reluctant to get condoms from us. Females have no issues.

M So no problems with females, But it is only with the males you have this small problem.

P2 When we issue females the condom, we tell them thoroughly about it. But we don't know whether they

will tell them all to their husband.

M Do you have any issues in explaining these to the males?

P2 We don't have any issues. But they are reluctant to come to us.

FGD PHM, Nuwera Eliya

P6 Since madam (female doctor) is here, there is no problem. But if IUCD is inserted by a male, they won't like it. (Many agreeing)

P1 Most people won't like, but since madam is here, it is not a problem.

FGD PHM, Kalmunai

For putting the loop if it is a lady doctor, we will go with 100% satisfaction. But when it is a male doctor we feel a little uncomfortable.

FGD married women 30-45 years, Trincomalee

Gender concordant care may lessen the embarrassment, discomfort, or sociocultural taboo that may occur during intimate physical examination. For Muslims, the preference for gender-concordant care stems from Islamic conceptions of modesty and influence healthcare seeking patterns.

Subfertility

The way people experience, explain and deal with subfertility is strongly related with their socio-cultural and economic circumstances as well with the availability and unavailability of health care options.

In Sri Lanka subfertility and childlessness have both social and religious ramification. One KI said that religious texts such as the "Vedas" and "Upanishads" and epic poems like the "Ramayana" and "Mahabharata" signify childlessness is a curse. Among Hindus' only a male child can perform rituals related to death.

Childless women are frequently stigmatized, resulting in isolation, neglect and domestic violence.[46] FGDs with subfertile women and service providers show that childless women are frequently stigmatized resulting in isolation, neglect, domestic violence and marital disruption among all communities in Sri Lanka.

I am called vandagaeni (sterile woman) and muusala (unlucky, unfortunate) by my neighbours

FGD Subfertile women, Moneragala

Subfertility has considerable psychological impact on couples.

They get mentally completely upset. They live in line rooms. There are so many families; they will try to curse her. They won't face her. There are 24 families. So not having children becomes a problem. There are Mother-in-laws' torture, husbands' torture and the society's torture.

FGD Estate Medical Assistants, Nuwera Eliya

During FGD we found that some women had supportive families. In some instances the couple grew closer together. Those who were living away from close relatives were the most affected. One woman said:

When I am alone I feel I am going mad. I feel there is no point to living anymore.

FGD subfertile women, Moneragala.

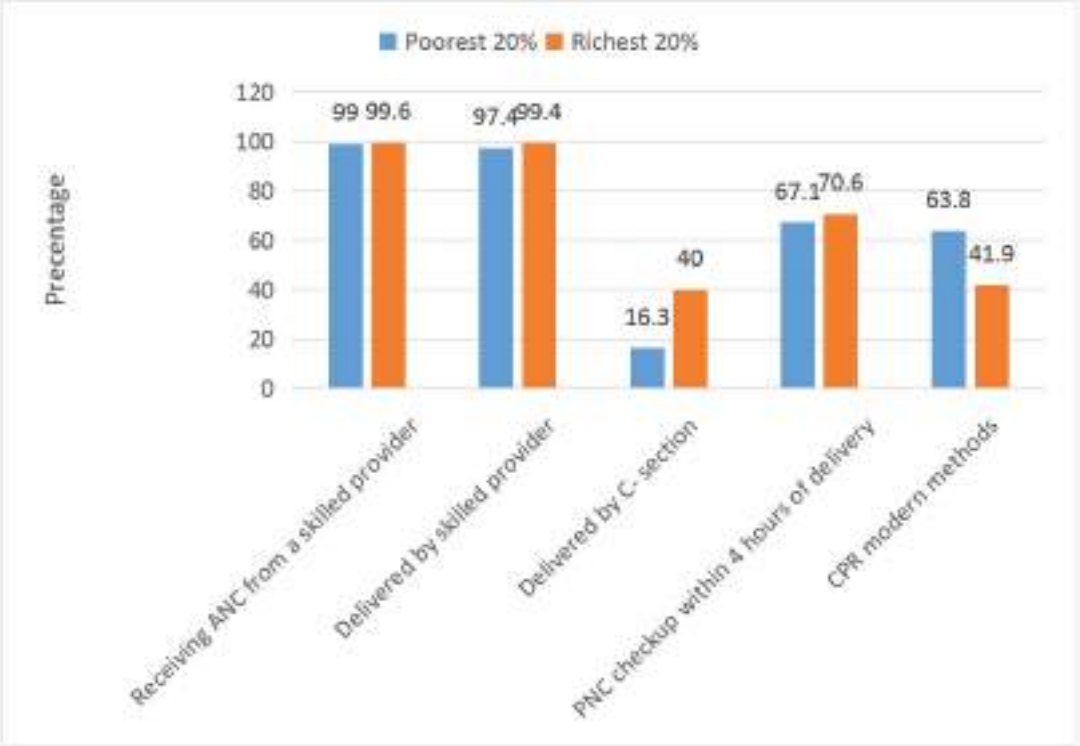
[46] Abrahams N,Mokoena NE, van der Spuy ZM. "You are a man because you have children": experiences, reproductive health knowledge and treatment-seeking behaviour among men suffering from couple subfertility in South Africa. Hum Reprod 2004;19:960–967.

Establishing support groups where subfertile women could meet and discuss their issues was suggested during the FGDs.

14. Inequity

In contrast to many low and middle income countries, in Sri Lanka the CPR for modern methods is lowest among the richest quintile. (Figure 4.18) We looked for inequities in other RH activities such as ANC by a skilled attendant, delivery by a skilled attendant, caesarean section delivery and PNC check-up within 4 hours of delivery. There is very little disparity between the richest and poorest quintiles of the population when it comes to ANC and deliveries by skilled providers. Similarly there is very little disparity with regard to PNC check-up within 4 hours of delivery. However there are wide disparities in terms of caesarean section between the richest and poorest quintiles.

Figure 4.18: Disparities in coverage between the wealthy and the poor for ANC, delivery by skilled provide, delivery by C-section, PNC within 4 hours of delivery and CPR for modern methods



Source: 2006/7 SLDHS

Table 4.21 shows the percentage of married women using different contraceptive methods by wealth quintiles. Overall, the use of female sterilization by the lowest wealth quintile (24.8 percent) is more than double that by the highest wealth quintile (10.2 percent). Use of injectables is higher among the lowest wealth quintile in comparison to the highest wealth quintile while use of condoms increases from the lowest to the highest wealth quintile.

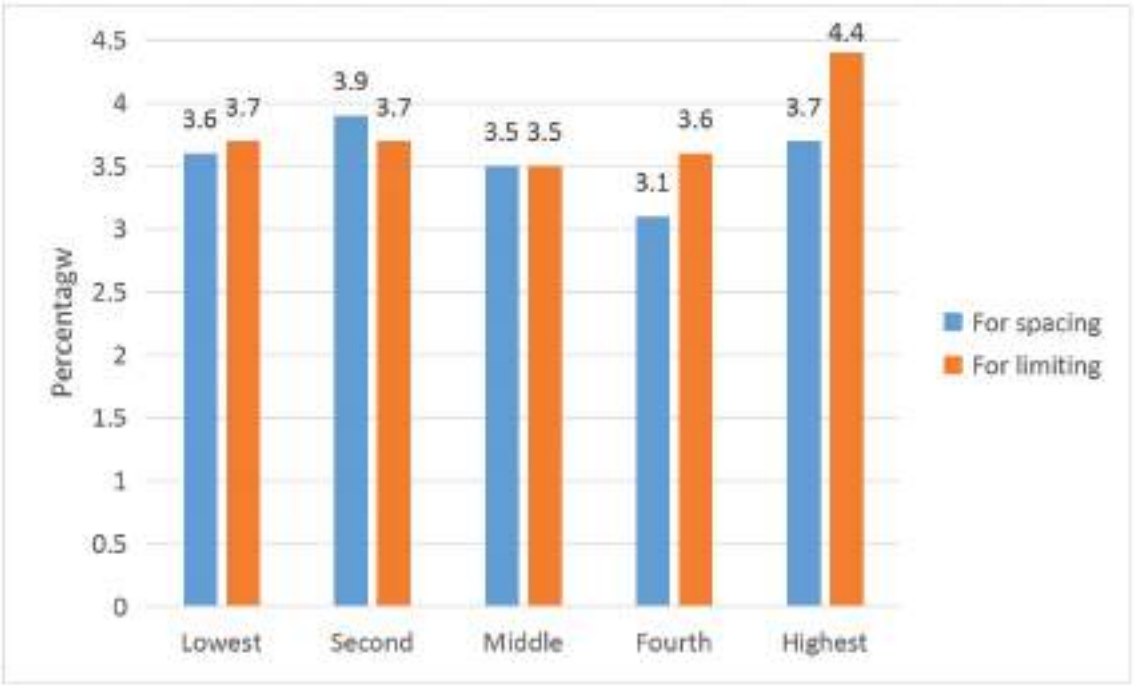
Table 4.21 Percentage of married women using contraceptives by method and wealth quintile

Wealth quintile	Female sterilization	Male Sterilization	Pill	IUD	Injectables	Implants	Condom
Lowest	24.8	0.8	8.1	7.1	20.3	0.6	2.1
Second	18.1	0.9	8.7	6.1	17.6	0.2	3.1
Middle	17.6	0.5	8.0	6.7	16.0	0.2	5.4
Fourth	11.7	0.7	9.2	6.1	12.9	0.2	7.4
Highest	10.2	0.4	6.6	6.3	8.0	0.4	10.1

Source: 2006/7 SLDHS

Figure 2.19 show that the second wealth quintile has the highest unmet need for spacing while the richest wealth quintile have a much higher unmet need for limiting than the other wealth quintiles.

Figure 4.19 Percentage of married women who want to space or limit childbearing but are not using contraceptives by wealth quintiles.



Source: 2006/7 SLDHS

Resources and capacity for investigation and treatment of infertility in the public sector is very limited. Subfertile couples with limited financial resources are confronted with a major challenge – that of gaining access to advanced subfertility treatment. Though there are private centres providing ART the cost is beyond the reach of most poor couples.

15. Quality of care

> *"Improvements in the quality of services will result in a larger, more committed clientele of satisfied contraceptive users. Over the long term, this expanded base of well-served individuals will translate into higher contraceptive prevalence and, ultimately, reductions in fertility."*
>
> ***Judith Bruce***[47]

Barriers such as availability and accessibility, the cost (direct and indirect) of accessing services and social barriers such as opposition from spouses discourages women from seeking contraception. Increasing use of modern contraception not only requires increasing availability of and access to commodities of course but ensuring the quality of care is also key. There is evidence from Bangladesh, Philippines, Peru and Kenya that demonstrates a link between quality and contraception uptake, continued use, and the decision to recommend contraception to others.[48,49,50,51] The importance of ensuring quality of contraceptive services is re-emphasized by the WHO rights-based approach to FP. [52]

The best known evidence based framework to determine quality of care in FP is the Bruce-Jain Framework[53,54] and comprises of the following: choice of methods, information given to users, technical competence, interpersonal relations, follow-up or continuity mechanisms and appropriate constellation of services. It must be noted that the Bruce-Jain framework makes the distinction between quality of care and availability of services. Another issue with the Bruce-Jain framework is that very few clients will be able to access the competency of the service provider. We assessed quality of care by the Bruce-Jain framework from KII, FGDs and field visits. (Table 4.23)

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[47] Bruce J. Fundamenta elements of the quality of care: a simple framework.StudFam Plan. 1990;21:61–9

[48] Koenig, MA, MB Hossain, M Whittaker. 1997. The influence of quality of care upon contraceptive use in rural Bangladesh. Stud FamPlann; 28 (4): 278–289.

[49] RamaRao, S, M Lacuesta, M Costello, B Pangolibay, and H Jones. 2003. The link between quality of care and contraceptive use. IntFamPlannPerspect29 (2): 76–83

[50] Mensch B, Arends-Kuenning M, Jain A. 1996The Impact of the Quality of Family Planning Services on Contraceptive Use in Peru. Stud Fam Plan.;27:59–75

[51] Tumlinson K, Pence BW, Curtis SL, Marshall SW, Speizer IS.Quality of Care and Contraceptive Use in Urban Kenya. IntPerspect Sex Reprod Health. 2015;41:69–79.

[52] World Health Organization.Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations.Geneva: World Health Organization; 2014

[53] Bruce, Judith. 1990. "Fundamental elements of the quality of care: A simple framework," Stud FamPlann 21(2): 61–91.

[54] Jain, Anrudh K. 1989. "Fertility reduction and the quality of family planning services," Stud FamPlann 20(1): 1–16.

Table 4.22: Elements of Quality of Care – Bruce-Jain framework

Element	Definition	Findings
Choice of contraceptive method	Number of available contraceptive methods	Sri Lanka adopts the cafeteria approach. A wide choice of methods is available in most clinics. If the method of choice is unavailable, e.g. DMPA, the client is referred to a facility where it is available. The methods available in most clinics included both short acting and long acting reversible methods. Therefore in the event of wanting to switch methods an alternate method was available. Clients who requested sterilization could access services in hospitals with a gynaecologist. Clients were provided information on all methods and asked their choice even if the method was not available on site. In most instances clients received the method of their choice. Specific counselling was provided about the chosen method. In a few instances, we identified provider bias to a particular method.
Interpersonal relationships	Clients are treated with sympathy and understanding	Interpersonal relations were in general satisfactory thorough there may have been courtesy bias during FGD. However, there were instances of verbal abuse by all categories of staff which was mentioned during FGD with clients. Some client's e.g. unmarried young people, widows, divorced sexually active women and PLHIV did not trust health workers to maintain confidentiality.
Information given to clients	Information provided about available contraceptive methods including how to use, benefits and risks, and potential side effects	We found from FGD that information was provided in most instances on possible side effects and complications, how to use the method, where to obtain the method, and what to expect during the procedure, if a procedure was involved and when to return for follow up services. Clients were not informed adequately about the relative effectiveness of each FP method for pregnancy prevention and each method's degree of protection against HIV and STIs. This latter aspect is particularly important during ANC as the Programme for Elimination of Mother to Child Transmission of Syphilis and HIV is rolled out throughout the country. There was a lack of printed material for clients
Technical competence	Treating clients with correct and consistent application of medical eligibility criteria and routinely completing procedures to a defined standard	Very few clinics had the WHO Medical Eligibility Criteria wheel. There was lack of familiarity with Medical Eligibility Criteria. Infection prevention precaution were in place for IUD, DMPA and implants. Precautions were taken when DMPA was provided. The emergency tray was available including adrenaline though is some field clinics oxygen cylinders were not available. Technical competence was difficult to assess as the number of observations were limited. Guidelines were not available in all clinics

Mechanisms to ensure continuity	Establishing when and how clients will return to clinic	Clients were informed when to return for follow up. In some locations due to the limited stocks of DMPA clients were referred to the private sector.
Appropriate constellation of services	Making contraception readily available to clients regardless of where they access care	To some extent contraception is integrated with other services such as the postnatal care, WWC. More needs to be done in relation to integration with post-abortion care, RTI, NCDs.

16. The NFPP and Human Rights Based Approach to FP

As a signatory to many international conventions Sri Lanka strives to ensure a human rights based approach in provision of information and FP services. Based on internationally recognized rights and principles as applied to contraceptive information and services nine health and human rights principles and standards have been identified by the international community.[55] These are:

1. Non-discrimination in provision of contraceptive information and services
2. Availability of contraceptive information and services
3. Accessibility of contraceptive information and services
4. Acceptability of contraceptive information and services
5. Quality of contraceptive information and services
6. Informed decision-making
7. Privacy and confidentiality
8. Participation
9. Accountability

We scrutinized the NFPP using the above parameters. (Table 4.23)

Table 4.23: Status of the human rights principles and standards and FP

Non-discrimination in provision of contraceptive information and services
The NFPP has taken steps to eliminate discrimination in the provision of FP services. Discrimination that prevailed in relation to minors accessing FP services through the public health sector has been removed following discussions the FHB had with the Attorney General and a circular has been issued to health staff clarifying the situation. We found that some private pharmacies did not provide FP commodities to young people. A financial incentive that was given by the government to those who underwent sterilization has been withdrawn since 2013.

[55] Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators. WHO 2014

Availability of contraceptive information and services
The NFPP makes available a wide mix of contraceptive methods. The commodities that are available through the Essential Drug List are in line with the WHO Model List of Essential Medicines. Though ECP is not available through the public sector they are available in the private sector.
Availability of contraceptive information and services
FP services are accessible through a wide network of service delivery points both in the public and private sector thus providing physical access. Financial access is assured as FP services are provided free of cost in the public sector. There is no requirement for preliminary authorization by the spouse except in the case of sterilization. Third-party authorization denies women autonomy in their decision-making. Service providers in the public sector are encouraged to inform the parents of a minor, however, "in the best interest of the child" the service provider is not obliged in all instances to inform the parents. FP has always been integrated with MCH in Sri Lanka. To some extent post-abortion care and FP are integrated and comprehensive contraceptive information, counselling and services, to help increase effective use of contraceptive methods and reduce the rate of repeat abortions is provided. Integrating HIV in the NFPP is becoming increasingly necessary. A significant challenge is the provision of comprehensive sexuality education in schools that hinder individuals' ability to make informed decisions. The NFPP is working to increase access for marginalized and vulnerable groups such as widows, separated and divorced women.
Accessibility of contraceptive information and services
In some areas the gender of the service provider acts as a barrier to accessing FP services. Language dichotomy between service provider and client is another barrier. Better counselling on possible side effects of methods is necessary to prevent discontinuation or switching to a less effective method.
Quality of contraceptive information and services
Elements of quality of care include: choice among a wide range of contraceptive methods; evidence-based information on the effectiveness, risks and benefits of different methods; technically competent trained health workers; provider–user relationships based on respect for informed choice, privacy and confidentiality; and the appropriate constellation of services (including follow-up) that are available in the same locality. KI, FGD and visits to health facilities identified areas for quality improvement e.g. instances of breaches of privacy and confidentiality; lack of respect for clients; and poor interpersonal communication skills including inadequate counselling on side effects etc.

Informed decision making
Health-care providers have the responsibility to convey accurate, clear information, using language and methods that can be readily understood by the client, together with proper, non-coercive counselling, in order to facilitate full, free and informed decision-making. In most instances clients were able to make informed decisions, however, in a few rare instances, the service provider decided on the method.
Privacy and confidentiality
Though privacy and confidentiality is maintained in most clinics, the infrastructure in some does not ensure auditory and visual privacy. During KII and FGDs we were informed of breach of confidentiality by service providers. Marginalized and vulnerable groups such as youth, widows, divorced and separated women, women living with HIV during FGDs felt that confidentiality and privacy are not guaranteed in the public sector and are therefore reluctant to seek services
Participation
Participation includes the active involvement of individuals, communities or community-based organizations in the design, implementation, management or evaluation of their community health services or systems, including in matters relating to their sexual and reproductive health. Participation is lacking in Sri Lanka.
Accountability
To ensure accountability a monitoring and evaluation system is necessary. RHMISand civil registrations systems are in place to collect data on the performance of the NFPP and thereby ensure accountability. The NFPP performance is reviewed periodically at district and national levels. Wherever possible, the disaggregation of information on the basis of sex, age, urban/rural/ estate residence, ethnicity, level of education, wealth quintile and geographic region is carried out for ensuring non-discrimination and equity, and as a basis for affording due protection to vulnerable and marginalized groups.

Chapter 5
Findings - Enabling environment

An enabling environment is a prerequisite for the success of FP programmes. Formulation and implementation of sound policy and laws and regulations that do not supress the demand for services are necessary. Strong leadership is essential to support evidence based policies and allocate human and financial resources so that FP programmes can function smoothly. National health policies should drive health system performance by improved health care access, equity, and quality. In addition, national policies affect the health system's ability to deliver efficiently, thereby affecting the overall sustainability of the system and its ability to function in the future from a financial and institutional perspective. Since health is devolved to the provinces coordination and collaboration among national, provincial and district levels is necessary so as to create an enabling environment to promote efficient and effective use of resources for FP. Although the elements of an enabling environment are often directly associated with institutions and systems, they also apply to sustainability of demand issues. Increased community involvement fosters greater community support for family planning and health services and healthy behaviours.

1.Governance, leadership and management of the NFPP

Context - Leadership and management are both essential elements to developing successful FP programmes and can help ensure resources are used effectively to achieve results.[1,2] An FP programme with effective leadership and management has a vision and a clearly laid-out and effective strategy for achieving it. Although the programme environment is likely to change from year-to year, long term strategic planning helps a programme to manage and adapt to change. Leadership and management is particularly important in Sri Lanka because health is devolved to the provinces. Provincial health authorities are responsible for delivering and managing public health services, and thus need good leadership and management skills. Political leadership can help facilitate availability of resources and commitment, but leadership and management at the implementation level through the providers or the health system is equally critical.

Findings

The MoH's commitment and leadership to FP are demonstrated in the National Health Strategic Master Plan 2016-2025 goal "to enable all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies".[3]

The Maternal and Child Health Policy (2011) with the following strategies in relation to FP provided direction to the NFPP.

- Ensure the availability and accessibility to quality modern FP services;
- Address the unmet need for contraception to reduce abortions and teenage pregnancies;
- Ensure availability of male and female sterilization services in hospitals;

[1] Dieleman M, Harnmeijer H W. Improving health worker performance: in search of promising practices. Report Prepared by KIT – Royal Tropical Institute of The Netherlands. WHO 2008.

[2] Richey, C. and Salem, R.M. "Elements of Success in Family Planning Programming," Population Reports, Series J, No. 57. Baltimore, INFO Project, Johns Hopkins Bloomberg School of Public Health, September 2008

[3] National Health Strategic Masterplan 2016-2025.Vol II Preventive Health.

- Establish an appropriate system for post-abortion care;
- Ensure the uninterrupted availability of contraceptive commodities [Reproductive Health Commodity Security (RHCS)];
- Strengthen, rationalize & streamline services for subfertile couples.

Both the National Health Strategic Master Plan 2016-2025 and the Maternal and Child Health Policy (2011) articulate the intentions of the government to provide contraception and treatment for subfertile couples.

Governance of the NFPP

National Committee on Family Health (NC/FH)

This committee is the highest level policy making and decision making body for the Family Health Programme in Sri Lanka which also encompasses the NFPP. The NC/FH is chaired by the Secretary of Health and functions as the intra and inter- ministerial coordinating body of the MoH on Family Health. It is the forum at which problems and issues arising at different levels related to the Family Health Programme are discussed. Meeting are held quarterly. Policy, technical and other related matters discussed at the technical advisory committees and working groups are forwarded to the NC/FH for decisions and approval.The Consultant Community Physician (CCP) FP Unit is co-opted as and when necessary to provide an expert opinion.

The establishment of the NC/ FH was one of the recommendations of the External Programme Review on Maternal and Newborn Health conducted in 2007. Several KI at policy level were of the opinion that the TOR of the Committee should be reviewed and revised in order to addresses issues that have not been sufficiently addressed by the NFPP such as subfertility, male involvement and emerging issues such as the decreasing age of marriage.

Technical Advisory Committee on Maternal Health and Family Planning (TACMH/FP)

The Secretary MoH appoints the TACMH/FP which is chaired by the DDG PHS II with the objective of providing technical expertise to the NC/FH on matters related to maternal health and FP. The TACMH/FP comprises of experts in all the relevant fields and meets every 2 months.

Despite the private sector providing a significant amount of FP services the TACMH/FP permanent membership does not include the Private Health Sector Development Directorate and /or representation from the NGO/private sector. Two of the strategies identified in the Strategy for Elimination of New Paediatric and HIV infections and Congenital Syphilis in Sri Lanka 2014 are:

1. primary prevention of HIV transmission among women in childbearing age, and;
2. prevention of unintended pregnancies among women living with HIV through enabling them to make informed choices.

Both these strategies are related to FP. Moreover, the NSACP is to commence provider initiated testing and counselling (PITC) in all ANC in 2016. Yet, NSACP is not represented on the TACMH/FP.

Management of the NFPP

Strong functional MoH structures and senior-level leadership on health sector issues exists in the country. Within the MoH the FHB, which is headed by the Director MCH is responsible to the DDGPHS II for the overall management of the National Family Health Programme which has several components such as:

1. Family planning
2. Maternal and newborn health
3. Infant and child health including child nutrition, development and children with special needs
4. School and adolescent health
5. Women's health incorporating premenopausal care and gender concerns

The day to day management of the NFPP at national level is by the CCP in charge of the FP Unit. The FP Unit in the FHB is responsible for the following activities:

- Provide technical guidelines to service providers on contraceptive use and counselling materials;
- Train master trainers in districts on contraceptive technology and counselling;
- Identify contraceptive needs and provide equipment to family planning clinics;
- Make recommendations on registration of contraceptives marketed in Sri Lanka;
- Monitor and evaluate FP services and contraceptive availability in districts;
- Monitor contraceptive failures, complications and poor quality products and take appropriate action;
- Post abortion care;
- Strengthening subfertility services

The NFPP has not paid sufficient attention to the following areas: meeting the unmet need for contraception of vulnerable and marginalized groups (e.g. sexually active adolescents, single, widowed divorced, separated women and older women in the reproductive age group); subfertility; post abortion care, and; male involvement.

Currently the FP Unit in addition to the CCP has two MOs, one clerical staff and an office assistant. The Unit is recognized by the Postgraduate Institute of Medicine for postgraduate trainees in Community Medicine. Considering the FP Units functions there is limited staff and system capacity for providing leadership, overseeing FP activities and coordinating with partners at present.

Planning

The FP Unit has taken the initiative to develop a multiyear plan from 2013 till 2017. The plan has a baseline and targets together with indicators. Based on this five year plan detailed annual plans are prepared for the FP Unit. These plans, however,are for activities at the national level only and does not include activities at district level. This plan has not been costed.

Planning capacity at provincial level has been enhanced by appointing CCPs to the provinces by the MoH. The CCP who were consulted as KI during the course of the review said they did not have a job description. Each year the MOMCH prepares MCH district plans in consultation with the MOHs and heads of institutions using the district RHMIS data and information gathered during supervision visits. According to KI at district level these district plans are shared with the FHB for review prior to submission to the province but no feedback is received in many instances. On the other hand, KI in FHB said that the districts provide their MCH plans "very rarely" for review.

The MCH plans are included in the composite district plans and submitted to the province where they are reviewed. At the district level the planning capacity needs to be strengthened. For example, only in one MCH district plan that was reviewed was there a link to a national policy (Nutrition Policy). Another MCH district plan had as one of its objective "to increase the percentage of eligible couples using FP

and to increase the identification of infertile women". However, there were no activities to support this objective in the MCH plan.

Implementation of the NFPP

Implementation of the NFPP is carried out by the provincial and district health authorities at the MOH level through a wide network of health facilities.

Monitoring and evaluation of the NFPP

The performance of the NFPP is monitored at several levels. At the MOH level, the monthly conference reviews all public health activities conducted in the area including FP. The FP activities are also reviewed at the biannual MCH district review meetings, the pre-review for the National MCH review conducted by the district the month prior to the National MCH Review at district level. In addition the biannual MOMCH workshops are also fora where the district performance is reviewed. The Hospital Directors Meeting and monthly FHB Review Meeting with DGHS are also fora where issues related to the NFPP are discussed when necessary.

KI in the MoH and a former Director FHB said that the concept of results based management (RBM) was lacking in the public health sector and that there was resistance to change. Many KI said that there was a lack of accountability on the part of managers and that a results oriented culture needs to be inculcated among managers at all levels. There are nascent efforts for introducing accountability and a culture of measuring results in the MoH.

Devolution and decision space

Devolution offers an opportunity for provincial and district leaders to translate national commitments into policy and programme changes at the subnational level in ways that meet the needs of their particular province. KI from national, provincial and district levels were of the opinion that devolution had its merits and that it had contributed to reducing inequities that had existed between districts to some extent. However, the consensus was that the centre did not devolve power to the provinces sufficiently. At the provincial level the Provincial Ministry of Health places less emphasis on strategy formulation and policy development and more on administration, planning and budgeting. At the district level the focus is on programme implementation. KI interviewed for this review confirmed that many districts are not able to do so effectively due to resource constraints, both financial and human.

As the lowest levels of the health system increasingly manage services, the need for leadership and management at all levels of the health system is even more crucial. While leadership and management skills are available at the national Mo Hand FHB, it is at the district level where one finds serious leadership and management gaps of the NFPP. To some extent the capacity at the provincial level has been strengthened by the appointment of CCPs. The administrative supervision is the responsibility of the RDHS in the districts. Some of the staff leading the NFPP in districts may not have had any formal training in leadership and management such as the MOMCH. They often lack skills around resource allocation, logistics management of RH commodities and supervision. These individuals are often tasked with stretching scarce resources for programming. According to a KI at the FHB many MOMCH had not undergone the FP Training of Trainers course and therefore are unable to provide technical inputs to the NFPP. Decentralization impacts on the operational strategies of the FHB to revitalize the FP programme as it no longer has line authority, staff or budgets to direct field operations.

Financial resources Article 154 R (3), of the 13th Amendment to the Constitution states "the government shall, on the recommendation of and in consultation with the Finance Commission, allocate from the annual budget such funds as are adequate for the purpose of meeting the needs of the provinces".Although devolution was to provide wide powers and decision space for provincial authorities to deliver essential public health services, commensurate financial resources did not materialize. The funds generated at district and provincial level are insufficient to finance the health services. The Finance Commission provides funds to the Provincial Councils each year. These funds are used for capital and recurrent expenditure. Stable financing and resource allocation systems are not in place. The Provincial Councils distribute the funds to the districts. Money is distributed on the basis of what is available on the district budget allocation, not according to need. KI at provincial and district level felt that some districts received a disproportionate allocation. KI pointed out that allocation of funding for programmes was inadequate. This brings us back to the point that meticulous planning is necessary to make do with the limited resources available.

Human resources The provinces inform the MoH of staff requirements. MoH is solely responsible for the recruitment, deployment / transfer of MOs. The current centralized recruitment and deployment system does not adequately address the pressing demands for MOs in some districts. Recruitment of cadres such as NO, PHI and PHM is done by the MoH by calling for applications. Following training and their position on the merit list and requests, they are posted to the provinces which decides on their deployment.

One of the most important features of decentralization is its potential for increasing programme sustainability and introducing innovation. For example, Jaffna has a shortage of PHM. At the same time there are many small institutions in which deliveries take place very rarely. The midwives in these institutions have been deployed in the field by the Provincial Directorate of Health Services to fill the vacuum for PHM. A KI in the Southern Province said managers were considering a similar course of action to address the pressing HR shortage. Contracts can be issued in special circumstances by the Provincial Public Service Commission when it is difficult to fill vacancies e.g. retired PHM, SPHMs, MO etc.

Monitoring and oversight. Mechanisms are in place for monitoring and supervision of the NFPP at district level. Joint supervision and regular reviews of the programme are conducted from divisional level to district level. However, the limitations in recruiting and retaining staff has led to some districts having insufficient supervisory cadres. Issues in relation to supervision will be discussed in detail in Chapter 6.

Accountability of local governments to the citizens has in many cases not been achieved because citizen influence at the local level is constrained by limited involvement and information. Despite this, it is clear that there is a wide variation in performance of districts.

Table 5.1 provides a summary of the findings in relation to decentralization and decision space for health system functions for FP based on KII with central, provincial and district level policy makers.The decision space approach has been used by the Harvard T.H. Chan School of Public Health researchers to study decentralization in a number of countries including Colombia, Chile, Nicaragua, Morocco, India, Pakistan, Mongolia, Liberia, and South Africa.[4,5] It has proven to be a useful framework to several other researchers, including most recently in Karnataka, India and Fiji.[6,7]

[4] Bossert T. Analysing the decentralization of health systems in developing countries: decision space, innovation and performance. 1998. Soc. Sci. Med: 47: 1513-1527

[5] Bossert TJ. Empirical studies of an approach to decentralization: "decision space" in decentralized health systems. In: Faguet JP, Pöschl C, eds. Is Decentralization Good for Development: Perspectives from Academics and Policy Makers. London: Oxford University Press; 2015:277-298.

[6] Seshadri SR, Parab S, Kotte S, Latha N, Subbiah K. Decentralization and decision space in the health sector: a case study from Karnataka. Health Policy Plan. 2016;31(2):171-181. doi:10.1093/heapol/czv034

[7] Mohammed J, North N, Ashton T. Decentralisation of health services in Fiji: a decision space analysis. Int J Health Policy Manag. 2016;5(3):173-181. doi:10.15171/ijhpm.2015.199

Table 5.1: Devolution and decision space in the context of FP in Sri Lanka

Functions	Level of Government	
	National	Provincial / District
Finance		
Revenue generation and sources	A limited amount of income generation takes place from fees for issuance of Medical Certificates and rental of canteen premises etc. This revenue cannot be used by the institution but has to be returned to the Treasury.	The limited revenue generated from fees for issuance of Medical Certificates, rental of canteen premises etc. cannot be used by the Province / district but has to be returned to the Treasury. The district can mobilize resources from donors/ NGO after submission of proposal to PDHS for approval. The proposal should be in line with the district health plan.
Budgeting, revenue allocation	The Budget allocates financial resources to the MoH.	Sources of funds are Criteria Based Grants (CBG),Province Specific Development Grants (PSDG), Health Sector Development Programme (HSDP), Line Ministry and donors and allocated by the Finance Commission. Allocations made to districts are based on population and number of institutions. Delays take place in the disbursement of the grants due to liquidity problems at the centre. This has led to cash flow problems at provincial levels
Expenditure management and accounting	MoH has extensive responsibility for expenditure management and accounting	PDHS and RDHS also are responsible for expenditure management and accounting. The spending limit for the PDHS is SLR 5 million and SLR 2 million for the RDHS which is approved by the Provincial Health Secretary
Financial audit	Extensive responsibility.	In addition to the general audit the Provincial government audit is carried out by the Provincial Auditor General's Dept. Donors conduct their own audit of their programme conducted by the PDHS / RDHS

Human resources		
Staffing (planning, hiring, firing, evaluation)	The provinces inform the MoH of staff requirements. The MoH is solely responsible for the recruitment, deployment / transfer of MOs. Recruitment for training of NO, PHM and PHI is done centrally. They are deployed to the provinces based on the order of merit and their request.	The current centralized recruitment and deployment system of MOs does not adequately address the pressing demands for human resources in some districts. Deployment of MO to health institutions in provinces by the MoH is difficult, as officers must get approval to be released for the next person to come in. This requires a chain of activities for any deployment plan to be implemented. This is one of the disadvantages of the decentralized system where deployment is centrally planned. NO, PHM and PHI are deployed within the province based on HR needs. The Provincial Public Service Commission gives appointment to staff. In many instances the allocation of human resources from the centre do not match the needs of the provinces. In the Jaffna District due to the acute shortage of PHMs since the number of deliveries are very few in some of the smaller institutions, the district health administration has taken the step to deploy hospital midwives in the field as PHMs.
Contracts	Contracts can be issued	Contracts can be issued in special circumstances, by the Provincial Public Service Commission when it is difficult to fill vacancies. e.g. retired PHM, SPHMs, MO etc
Salaries and benefits	Salary scales are set at the national level	Provincial recurrent funds are used for payment of salaries. Discussions are ongoing in some districts with PD and DGHS on standardizing the overtime rates to be paid to public health staff.
Training	Basic and in service training of NO, PHI and PHMs are a central function.	PDHS has some funds for training or receive funds from FHB. The Provincial Training Centres conduct the 2nd phase of training of PHM and PHIs. In most instances they have limited capacity to train. Districts prepare training plans which are included in the district MCH plans which are shared with FHB. FHB sometimes sends its training plans late in the year and they may not be included in the district training plans

Service delivery		
Hospital and facility management	Extensive Includes hospitals taken over by the line ministry	Extensive Institutions under the PDHS are improved in a phased manner
Defining service packages	Service package is determined by the FHB	Based on the service package determined by the centre opportunities are greater for developing new or innovative services delivery mechanisms. Capacity in the districts to implement may be limited.
Targeting service delivery to specific populations		Targeting service delivery to specific populations is a benefit of devolution. The target population varies from district to district based on need e.g. prevention of teenage pregnancy
Setting norms, standards, regulation	Norms and guidelines are set by the FHB.	Sometimes guidelines may not be implementable at the local level e.g. requirement that all curative institutions with a Consultant Obstetrician and Gynaecologist should have a dedicated FP clinic functioning for 6 days of the week. This is mainly due to inadequate staff and clinic space especially in the smaller hospitals.
Monitoring and supervision	FHB has extensive responsibility. FHB conducts the national MCH Review and provides funds for this purpose to the districts	In most provinces a monitoring unit has been established. Team supervision is conducted from the districts Lack of supervisory staff such as PHNS SPHM is an issue in many districts. The following Review meeting are conducted: 2 biannual MCH review meetings at district level A review is conducted the month prior to the National Review at district level National Review at district level facilitated by FHB Biannual Review Meetings of MOMCH
User participation		Hospital management committees Client satisfaction surveys are conducted by institutions Mothers support groups

Intersectoral and intrasectoral convergence	National Committee on Family Health and Technical Advisory Committee on Maternal Health and Family Planning are fora where intersectoral and intrasectoral issues related to the NFPP can be discussed.	The District Coordination Committees and the Divisional Coordination Committees are fora where multisectoral issues can be discussed.
Operation maintenance		
Medicines and supplies (ordering, payment, inventory)	Central procurement of FP commodities and supplies ensures quality of products and economies of scale are maintained	Other than contraceptives, devices and equipment can be purchased upto a limit. RMSD collects contraceptives from the FHB. Priority is given to collecting supplies from the MSD by RMSDs rather than for collection of contraceptives from FHB. In some instances the FHB delivers to the RMSD. Contraceptives are distributed from the RMSD to institutions and MOH on a schedule.
Vehicles and equipment	Central procurement	In the past vehicles were purchased from the provincial grant. Purchase of vehicles has been stopped. Leasing of vehicles is to be operationalized in the near future. RDHScarries out maintenance of vehicle and equipment There are insufficient vehicles which hampers supervision.
Facilities and infrastructure	Extensive responsibility for line ministry institutions	Extensive responsibility for provincial level institutions including building new clinics etc. The provincial and district health administration cannot undertake renovations to clinics housed in Municipal / Provincial Council buildings.
Information management		
Health information systems design	Responsibility of the Planning Monitoring and Evaluation Unit of the FHB. The electronic platform for RHMIS data collection is being piloted in Kalutara, Puttalam and Kurunegala	Northern Province PDHS has developed an electronic HIS and asked FHB permission to pilot it. This needs to be combined with the system developed by the centre.

Data collection, processing, and analysis	Responsibility of the Planning Monitoring and Evaluation Unit of the FHB	In some instances information collected by the RDHS is sent to the FHB bypassing the PD. RDHS will only receive health information pertaining to the institutions under the provincial ministry (curative and preventive), whereas the institutions governed centrally (Line Ministry Institutions) though located within the RDHS area, will directly report to Line Ministry on OPD and inward patients on line to the central HMIS. It was observed that many curative institutions did not report to the MOH on FP services delivered using H1200 RH MIS 527.
Dissemination of information to various stakeholders	Extensive FHB Annual Report Quarterly MCH Bulletin	Provinces publish their own Annual Health Bulletins and also maintain websites

Technical assistance

Technical assistance to the NFPP is provided by the FP Unit of the FHB. CCPs at the FHB are allocated to provide technical assistance to a cluster of districts. Many CCPs said they were unable to devote sufficient time for this task due to the heavy workload at central level. At the provincial level, the CCP and at district level the MOMCH are responsible for providing TA for the NFPP. Technical assistance has been provide to the NFPP by the SLCOG for example in the preparation of the Post Abortion Care Guideline 2nd Edition, SubfertilityManual for the Primary Health Care Provider to name a few.

Government and health development partner relationships

There is a general agreement from stakeholders that the existing mechanisms for donor coordination are good but that their functioning requires improvement. Currently the World Bank, WHO and UNFPA provide financial and technical assistance to the NFPP. The FP unit has meetings quarterly to review its work in relation to funds provided by UNFPA. There is an annual review of the programme. The very success of the programme in the past and the classification of the country as a middle income country are drawback to attracting donor support.

2.Supportive laws, policies and guidelines

Context - Policy support for FP is key to ensuring political commitment, adequate resources, and, ultimately rights based quality of FP services.[8,9] Supportive laws and policies alone, however, will not guarantee adequate or appropriate implementation unless operational guidelines, such as national strategies and service delivery standards are also available.

[8] The Global Family Planning Revolution. Three decades of population policies and programs. Ed. W C Robinson, J A Ross. World Bank 2007

[9] Three Successful Sub-Saharan Africa Family Planning Programs: Lessons for Meeting the MDGs. USAID, Ethiopian Federal Ministry of Health, Malawi Ministry of Health, Rwanda ministry of Health. 2012.

Findings

MoH plays a key role in developing health sector policy, with the aims of improving health system performance and promoting the health of the people. Several laws, policies, strategies and guidelines exists that relates to FP.

Legislation

- The Private Medical Institutions (Registration) Act 2006 has four main objectives: ensure efficiency and effectiveness of the private sector health care services; improve the health of the population; ensure equity, and; ensure the quality of the services provided by the private sector health providers. Under the Act the Private Health Sector Regulatory Council (PHSRC) has been established to develop and monitor standards to be maintained by the registered Private Medical Institutions. It acts as a method of evaluation of standards maintained by such Private Medical Institutions. Another objective of the PHSRC is to ensure the minimum qualifications for recruitment and minimum standards of training of personnel are adopted by all private medical Institutions and to ensure the quality of patient care services. The FHB is not represented on the Private Health Sector Regulatory Council.
- The National Medicine Regulatory Authority Bill was passed in parliament on 6th March 2015 followed by the establishment of a regulatory authority known as the National Medicines Regulatory Authority (NMRA) in July 2015.[10] The NMRA is responsible for the regulation and control of, registration, licensing, manufacture, importation and all other aspects relating to medicines and medical devices. The NMRA is also responsible for conducting clinical trials in a manner compatible with the National Medicines Policy.

The NFPP does not receive FP related data from the private sector. Hence there are data gaps in relation to FP. There is no legislation at present that requires the private sector to provide this information. ART has introduced a myriad of new social, religious, ethical, and legal challenges. Many countries have taken steps to regulate certain aspects of ART. Several ethical issues in relation to ART in Sri Lanka have been identified.[11] A regulatory authority on the lines of the Human Fertility and Embryology Authority of UK does not exist at present. Meanwhile, the SLMC has developed a document - Assisted Reproductive Technologies. A Code of Practice. 2005.[12] Legislation is currently under preparation.

Many women with mistimed or unwanted pregnancies put their lives at risk by terminating the pregnancy under unsafe conditions. It should be noted that Section 303 of the Penal Code prohibits abortion with the only exception being to save the life of the mother. Attempts to amend the law to a limited extent to permit abortion in the case of congenital abnormalities of the foetus, rape and incest have not been successful.

Policies and strategies

Free health services has been the policy of successive governments which has been a major contribution to improving the lives of Sri Lankans. The following policies and strategies have been adopted by the government which are relevant to FP (Table 5.2)

[10] http://www.cdda.gov.lk/images/stories/new/pdf/legislations/5e_nmdra.pdf (Accessed 17 November 2016)

[11] Seneviratne H R. Ethical issues in the provision of assisted reproduction. Sri Lanka Journal of Obstetrics and Gynaecology 2011; 33: 77-83.

[12] Sri Lanka Medical Council. Assisted Reproductive Technologies. A Code of Practice. 2005. http://www.srilankamedicalcouncil.org/download/download/6/66db9284166164d13be1684c657835bc.pdf (Accessed 15.06.2016)

Table 5.2: Recent FP related policies and strategies and a brief description

Policy / strategy	Description
National Strategic Framework for Development of Health Services 2016 - 2025 - Colombo ; Policy Analysis and Development Unit. Ministry of Health. 2016[13] Health strategic master plan 2016 - 2025 ; Volume II Preventive health services - Colombo ; Policy Analysis and Development Unit Ministry of Health . 2016[14]	These two documents set out the strategies and outputs to achieve the goals of the strategic plan including FP. The FHB has submitted its observations on the document to the MoH and recommended certain amendments.
National Youth Policy (2014) [15]	The vision of the National Youth Policy is "To develop the full potential of young people to enable their active participation in national development for a just and equitable society." The National Youth Policy has identified 7 goals – one of which is "Promote health and wellbeing among young people". Under this goal the following objectives have been articulated: provide access to youth friendly services and ensure access to information on health and wellbeing including reproductive and sexual health. In chapter 4 of the policy under the section health and wellbeing it is clearly stated that "Young people find it difficult to access information with regard to sexual and reproductive health." The policy recognizes that youth are not homogenous and that their backgrounds differ for various socio-economic and cultural reasons. The policy has identified specify groups that require targeted attention: unemployed youth; youth from war affected communities; excluded discriminated and exploited groups; youth at different education levels; young women; rural youth; urban low income youth; youth in conflict with the law; estate sector youth, and; differently-abled youth.

[13] National Strategic Framework for Development of Health Services 2016 - 2025 - Colombo ; Policy Analysis and Development Unit. Ministry of Health. 2016

[14] Health strategic master plan 2016 - 2025 ; Volume II Preventive health services - Colombo ; Policy Analysis and Development Unit Ministry of Health . 2016

[15] National Youth Policy 2014

Strategy for Elimination of New Paediatric and HIV infections and Congenital Syphilis in Sri Lanka (2014) [16]	Two of the six strategies identified in the strategy are either directly or indirectly related to FP. Strategy 1: Primary prevention of HIV transmission among women in childbearing age; Strategy 2:Prevention of unintended pregnancies among women living with HIV through enabling them to make informed choices; The strategy does not have indicators related to use of FP and prevention of HIV transmission to infants.
National Strategic Plan on Adolescent Health: Health Sector Response (2013) [17]	The basis of the National Strategic Plan on Adolescent Health is Goal 5 of the MCH Policy which states "Ensure that children (5 to 9 years) and adolescents (10 – 19 years) realize their full potential in growth and development in a conducive and resourceful physical and psychosocial environment". It is also in line with the School Health Policy, Reproductive Health Policy, National Policy of Health of Young persons and the National Nutrition Policy.
Strategies to promote optimal fetal growth and minimize the prevalence of low birth weight in Sri Lanka (2013) [18]	The National Nutrition Policy (NNP) 2010 has identified the prevention of low birth weight (LBW) as a major area of concern. Short, inter pregnancy intervals, adolescent pregnancy and pregnancy among unmarried women have been identified as modifiable causes. Of the 18 strategic objectives two are directly related to FP. Strategic objective 8 To ensure proper spacing among pregnancies and Strategic Objective 10 To prevent adolescent pregnancies by providing health services for adolescents including contraceptives/ family planning for sexually active adolescents
The National Strategic Plan on Maternal and Newborn Health (2012-2016) [19]	The National Strategic Plan on Maternal and Newborn Health (2012-2016) has been developed to implement the MNH Policy. There are a few indicators related to FP in the National Strategic Plan on Maternal and Newborn Health (2012-2016) but FP is not covered adequately. This strategic plan is not costed. Hence, allocation of resources does not take place in line with programme goals and objectives.

[16] Strategy for Elimination of New Paediatric and HIV infections and Congenital Syphilis in Sri Lanka (2014)

[17] National Strategic Plan on Adolescent Health: Health Sector Response (2013)

[18] Strategies to promote optimal fetal growth and minimize the prevalence of low birth weight in Sri Lanka (2013)

[19] The National Strategic Plan on Maternal and Newborn Health (2012-2016)

National Policy on Maternal and Child Health (2012)	MCH has been a priority in Sri Lanka from colonial times. The commencement of the Health Unit System in the mid 1920's, laid the foundation for an organized effort to provide maternal and child health services which was thereafter extended to cover the entire country. The FHB formulated the National Maternal and Child Health Policy to provide policy and strategic directions to meet the emerging challenges in MCH and adolescent health. Most efforts to improve pregnancy outcomes during the past several years have focused on promoting antenatal care and caring for post-partum mothers. In order to be effective, many interventions must be delivered before pregnancy and continued after delivery to detect, manage, modify, and control maternal behaviours, health conditions, and risk factors that contribute to adverse maternal and infant outcomes. The vision of the policy is " A Sri Lankan nation that has optimized the quality of life and health potential of all women, children and their families". The policy focuses on 12 Goals. Goal 7 of the policy is "enable all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies". The following strategies have been identified to deliver this goal: a) ensure the availability and accessibility to quality modern family planning services. b) address the unmet need for contraception. c) ensure availability of sterilization services in institutions. d) establish an appropriate system for post-abortion care. e) ensure the uninterrupted availability of contraceptive commodities [Reproductive Health Commodity Security (RHCS)]. f) Strengthen, rationalize and streamline services for sub-fertile couples.
National HIV /AIDS Policy (2011) [20]	The objectives of the policy are, to prevent HIV and other sexually transmitted infections in Sri Lanka through effective strategies aimed at reducing sexual transmission, transmission through blood and blood products and mother to child transmission, and to improve the quality of life of people infected and or affected by HIV /AIDS through minimizing stigma and discrimination, and providing quality care and support. The policy has identified 12 priority areas and strategies to achieve the objectives. Two of the strategies, Prevention of unplanned pregnancies among HIV infected women and use of condoms as dual protection against unwanted pregnancy and HIV and STIs are cross cutting for both the NSACP and FHB.

National Policy on Health of Young Persons	This policy was drafted by the Directorate/Youth, Elderly, Disabled and Displaced (YEDD) by a team of experts including youth representatives.. Furthermore this document has linkages with National Strategic Plan on Maternal and Newborn Health and Strategic Plan on National Program for the children with Special Needs. The process was supported by UNFPA and WHO.
The Population and Reproductive Health Policy (1998) [21]	Following the International Conference on Population and Development (ICPD) in 1994, Sri Lanka took several initiatives to implement the ICPD Programme of Action. One important initiative was to formulate the Population and Reproductive Health Policy which was approved by the Cabinet of Ministers in 1998. Eight goals were articulated in the policy to be achieved in 10 years. They are as follows: maintain current declining trends in fertility so as to achieve a stable population size by the middle of the 21st century, at least; ensure safe motherhood and reduce reproductive health system-related morbidity and mortality, including subfertility; achieve gender equality; promote responsible adolescent behaviour; provide adequate health care and welfare services for the elderly; promote the economic benefits of migration and urbanization while controlling their adverse social and health effects; increase public awareness of population and reproductive health issues; improve population planning and the collection of quality population and reproductive health statistics at the national and subnational levels. Six of the goals are related to the NFPP.

All of the above policies and strategies in some way mention or support RH, but not necessarily FP. While the number of these policies indicates some political will, many policies, strategies, and guidelines that could be used to support FP are not specific enough. Implementation plans are weak and do not mention how the policies/ strategies are to be implemented and monitored at national, provincial and district level. The resource requirements for implementation plans have not been costed. The data for some of the indicators identified in the strategy documents is not collected, e.g. the National Strategic Plan on Maternal and Newborn Health (2012-2016) indicator " Percent of women using a contraceptive method by 6 weeks postpartum". Some of the policies such as the Reproductive Health and Population Policy (1998) are in urgent need of revision. Despite these policy documents, there is still insufficient allocation of human and financial resources to achieve the goals set out in these documents.

[20] National HIV /AIDS Policy (2011)

[21] The Population and Reproductive Health Policy (1998)

International conventions

Sri Lanka has signed and ratified many international conventions including the following which are relevant to FP:

- International Conference on Population and Development (ICPD) ;
- Convention on the Rights of the Child;
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and;
- Convention on the Rights of Persons with Disabilities. Subfertility is considered a disability was ranked the 5th highest serious global disability (among populations under the age of 60). [22] Sri Lanka ratified the Convention on the Rights of Persons with Disabilities on 08th February 2016. [23]

Family planning guidelines:

The MoH has issued several circulars in relation to provision of FP services. At the operational level the country has developed guidelines for service providers for contraception and will be discussed in Chapter 6.

3. Human and financial resources for FP

Context- To operationalize existing policies, strategies and plans requires human, financial and other resources allocated in a timely and appropriate manner. To deliver rights based quality FP services requires an adequate supply of appropriately trained, motivated and supervised staff equipped and empowered to meet the needs of their clients. Financing of FP services is critical, to ensure availability and equitable access.

Findings
Human resources for FP

Human resource statistics

Accurate information about the number, location, and skills of healthcare workers in Sri Lanka is fragmented and frequently of suspect quality.

Availability and distribution of field health workers

The maximum population to be covered by each category of public health staff has been determined by the NC/FH and a general circular has been issued in 2011.[24]

Table 5.3 shows the status of public sector field health staff as at 23.2.2016 based on FHB data. As can be seen there are vacancies for all categories of field staff. The most acute shortage is for supervisory staff (PHNS, SPHI and SPHM).

[22] WHO & World Bank. (2011). World Report on Disability. Geneva: WHO.

[23] Press release, Permanent Mission of Sri Lanka to the United Nations in New York http://www.slmission.com/index.php/news/91-latest/832-sri-lanka-ratifies-the-convention-on-the-rights-of-persons-with-disabilities. (Accessed 15.6.2016)

[24] General Circular FHB/DER/GF/2012

Table 5.3 : Status of Public Sector Field Health Staff

Cadre	Approved cadre	Available	Vacant	% Vacant
MOH	355	317	38	10.7
AMOH	362	317	45	12.4
PHNS	418	293	125	29.9
SPHI	324	237	87	26.9
SPHM	404	354	50	12.4
PHI	1472	1256	216	14.7
PHM	6481	5814	667	10.3

Source: FHB Updated 23.2.2016.
Note: This table does not show the Regional Supervising Public Health Nursing Officers

The problem of poor distribution of the available workforce is a serious impediment to delivery of FP services. In an ideal case, the health system will distribute health care workers to match geographic, population and disease burden distributions. The distribution of health care workers in Sri Lanka does not follow this logic. Table 5.4 gives information about the number and distribution of PHMs, the frontline worker in relation to MCH/FP throughout the county. Districts with the highest deficit for PHMs are Kandy, Colombo MC, Mullaitivu, Jaffna, Killinochchi, Kegalle and Anuradhapura. Some Health areas such as NIHS, Trincomalee, Ratnapura, Nuwera Eliya, Puttalam had a surplus of PHM. Except for a few districts the population per PHM norm of 3000 was exceeded. Colombo MC, Kandy, Colombo, Killinochchi, Kurunegala, Puttalam, Ampara, Batticaloa were among the districts/ health areas with the highest population per PHM ratio.

Table 5.4: Distribution of PHMs by districts and population per PHM

Health Area	Total population	Approved cadre	Available	Vacant	% Vacant	Population per PHM
Colombo	1,740,600	404	348	56	13.9	5002
Colombo MC	553,239	160	88	72	45.0	6287
Gampaha	2,403,450	564	460	104	18.4	5225
Kalutara	993,656	307	294	13	4.2	3380
NIHS	309,975	34	76	-42	-123.5	4079
Kandy	1,527,251	457	249	208	45.5	6134
Matale	517,997	171	161	10	5.8	3217
NuwaraEliya	796,011	306	321	-15	-4.9	2480
Galle	1,117,025	350	311	39	11.1	3592
Matara	843,065	276	272	4	1.4	3100
Hambantota	670,600	237	199	38	16.0	3370
Jaffna	578,902	241	158	83	34.4	3664
Killinochchi	119,092	34	26	8	23.5	4580
Mannar	137,780	58	54	4	6.9	2551
Vavuniya	177,172	67	61	6	9.0	2904

Mullaitivu	112,135	65	40	25	38.5	2803
Batticaloa	564,842	141	134	7	5.0	4215
Ampara	277,337	74	61	13	17.6	4547
Kalmunai	444,284	182	150	32	17.6	2962
Trincomalee	394,333	128	144	-16	-12.5	2738
Kurunegala	1,749,299	456	414	42	9.2	4225
Puttalam	838,198	182	187	-5	-2.7	4482
Anuradhapura	970,289	296	238	58	19.6	4077
Polonnaruwa	464,398	137	125	12	8.8	3715
Badulla	909,407	320	306	14	4.4	2972
Monaragala	516,793	191	181	10	5.2	2855
Ratnapura	1,190,172	318	339	-21	-6.6	3511
Kegalle	836,432	305	237	68	22.3	3529
SRI LANKA	21,753,734	6481	5814	667	10.3	3742

Source: FHB (Updated 23.2.2016)

The less populated districts, war affected, remote areas and those with poor performance indicators are especially disadvantaged. According to KI part of the reason for the shortage of PHMs was because there has not been a regular intake for training and lack of career prospects.

Table 5.5 shows the vacancies for field staff in Nuwera Eliya district. It should be noted that the number of midwives in Nuwera Eliya in Tables 5.5 and 5.6 differ. The large percentage of vacancies for supervisory staff is conspicuous.

Table 5.5: Vacancies for field staff Nuwera Eliya district

Cadre	Approved cadre	Available	Vacant	% Vacant
MOH	13	9	4	30.8
AMOH	13	7	6	46.2
PHNS	13	3	10	76.9
SPHI	13	2	11	84.6
SPHM	13	6	7	53.8
PHI	40	38	2	5.0
PHM	321	289	32	10.0

Source: Courtesy RDHSNuwera Eliya July 2016

The health area / district averages conceal the fact that intra-district distribution of human resources is also uneven. For instance in the Colombo district the average population per PHM varies from 3169 in Padukka to 6501 in Kollonnawa. (See Table 5.6)

Table 5.6: Average population per PHM, Colombo district

MOH area	No of PHM areas	Average population per PHM area
Battaramulla	13	6455
Boralesgamuwa	11	5526
Dehiwela	16	5603
Hanwella	34	3411
Homagama	25	5162
Kaduwela	31	5603
Kahatuduwa	24	4680
Kollonnawa	30	5205
Maharagama	30	5205
Moratuwa	39	4382
Nugegoda	16	5431
Padukka	21	3169
Piliyandala	30	6279
Pitakotte	13	5072
Ratmalana	23	4221
TOTAL	**356**	**5035**

Source: Courtesy RDHS Colombo

When there are vacant PHM areas or a PHM is on maternity leave, other PHMs in adjacent areas have to deputize. This places an additional workload on the staff. The following statements are taken from the FGD with PHM.

> *P7 Because of acting areas, it's hard to cover the whole population. Most of us are having two areas. Some have 3 areas. This is the situation from the time we received our appointments.*
>
> *P6 Most of us are having two areas. Some have 3 areas.*
>
> ***FGD PHM, Jaffna***

> *It is difficult to promote FP. I am covering two PHM areas. It's difficult to talk to all of them (clients). Next thing you know they are pregnant.*
>
> ***FGD PHM, Galle,***

The lack of compensation for the extra work entailed in covering up was also mentioned as a demotivating factor.

> *P4 Since I had to do two areas, and now I'm on leave she has to do 3 areas. And there are no payments for the extra work also. If they want us to work more, they should give some incentives. Then only we will happily work. Even that we don't receive. Now for the Grama Sevaka Niladhari they are paying additional amount for acting areas. But we have nothing like that. We have to work only with our salary.*
>
> *P6 There is no payments but they expect the services to be upto standard.*
>
> ***FGD PHM, Jaffna***

Some provinces/ districts do not have approved cadre to absorb further staff. 'Cadre full' status does not imply there is adequate HRH. Approved cadres are considered as fixed and the system is not reviewed on a regular basis to allow cadre revision upwards or downwards[25], A workable package has not been developed that incentivizes staff especially the PHM and PHNs to join the service and to serve in less popular districts and villages in order to redress the HRH imbalance.

HR Management

Most of the issues related to HRH for FP are beyond the ambit of the FHB. Nevertheless, HR issues does adversely affect the performance of the NFPP.

According to KI there is no HR division in the MoH. An encouraging development is the recognition of the need for human resource management (HRM) skills in general, and specifically in the MoH. The recognition of the need for HRM ranges from high-level human resource (HR) planning skills to day-to-day performance supervision. The Health Strategic Master Plan 2016 – 2025 is attempting to address HRH issues.[26] While these efforts are nascent, the recognition of the need for specialized HRM skills and departments within the MoH is an encouraging sign. Overall, HR policies and the conditions of service for all public servants follow a well-documented process involving the MoH, Ministry of Public Administration, the Public Service Commission and the Ministry of Finance. Recruitment is carried out centrally, and advertised positions do not specify the posting location. While posting location is a primary driver of job satisfaction and retention, employees are posted wherever deemed necessary and based on the position in the merit list. Thus, a PHM who preferred to be posted near her family in Ampara may be posted to Nuwera Eliya.

HR Planning and policy development

Health sector strategy documents clearly demonstrate an understanding that HRH is an important limiting factor in achieving sector objectives.

Strategic Plan for HRH 2009 – 2018.

The Health Master Plan 2007-2016 identified improvement of the management of HRH as one of its key strategic objectives. It recommended development of a HR strategy to ensure the right people are available with right skills in the right locations at the right time. Following a situational analysis with the assistance of WHO the MoH developed the Strategic Plan for HRH 2009 – 2018.

Human resource information system

In Sri Lanka HRH data systems are fragmented and disconnected. The Health Information Unit at the MoH has a database of the current human resources available by province and district. The cadre requirement for the districts is available in the Directorate of Planning, MoH. The Education, Training and Research Unit (ET&R) is responsible for policy formulation, providing technical guidance to training and also coordinating of basic training programmes for all staff categories except for basic degree programmes for MOs and dental surgeons. The FHB has information on the availability of field staff by districts which has been referred to earlier.

[25] Health Strategic Master Plan 2016 - 2025 ; Volume IV Health Administration and HRH. Preventive health services - Colombo ; Policy Analysis and Development Unit . Ministry of Health ,

[26] Ibid

Workforce projections

There are no scientific cadre projections carried out other than for PHMs which has been conducted by Dr Dileep de Silva, Consultant, Community Dentistry, FHB.[27] At present there are approximately 6000 PHMs engaged in field work as against the approved cadre of 6,637. The PHM population ratio is therefore 1:3300 population which is below the accepted norm of 1:3000. The prospects for the future are gloomy as PHMs are not recruited in sufficient numbers and on a regular basis. It is estimated that approximately 1800 will retire from service within the next 4 years. Simulation models based on different plausible scenarios have been developed. Two options are suggested; (i) to increase the intake of trainees; (ii) increase the retirement age to 63 years. The constraint in relation to increasing the intake of trainees is limitations in training capacity. Currently Dr de Silva has been tasked by the Hon. Minister of Health, Nutrition and Indigenous Medicine to carry out projections for medical specialists.[28]

Performance management

With a shortage of healthcare workers, especially in rural areas, helping the existing providers to be as productive as possible and to perform up to standard becomes especially important. The only reliable productivity assessment in Sri Lanka is in relation to PHM. The Assessment of Workload of Public Health Midwives in Sri Lanka[29] conducted in 2008 showed that of the total working hours, one third was spent on home visits, 27 percent on clinic activities and 13 percent on record keeping. The same study found that two- thirds of the PHM divisions had populations higher than 3000 with 12.5 percent being above 5000. Only 40 percent lived within their service area. Thirty one percent of PHMs perceived their workload to be unbearably heavy mainly due to the large number of records and returns to be maintained (27 percent), programmes and activities not related to health (25 percent) and the large population size to be covered (24 percent).

Increasing the productivity of existing workers is almost always more cost-effective than hiring more workers, and in some cases hiring more providers may be impossible. We have already mentioned in Chapter 5 section 1 Governance, leadership and management of the NFPP about the initiative taken by the Director, Northern Provincial Health Department to utilize the midwives from smaller institutions where deliveries are uncommon as field midwives during the daytime to address the acute shortage of PHMs in the district.

In considering the factors that help providers to be optimally productive, clear performance expectations set out in an accurate and up-to-date job description is an important starting point. Duty lists are available for the different categories of staff involved in providing FP in the field. The duty lists for the PHMs is under revision. The duties of staff in obstetrics and gynaecology wards in relation to provision of FP services needs to be clarified. The current system does not have a clear functioning mechanism that recognizes performance, at individual level which can contribute to productivity. The performance appraisal system is currently used on an individual basis to formalize increments but does not objectively appraise the individual let alone improve any productivity in the system. Thus there is a lack of a formalized reward system that recognizes good performance.[30]

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[27] Cadre projections for Public Health Midwives in Sri Lanka.

[28] Personal communication. Dr D de Silva CCP FHB

[29] Health Systems Research Unit, University of Colombo and Family Health Bureau, Ministry of Health, 2008. The Assessment of Workload of Public Health Midwives in Sri Lanka

[30] Human Resources for Health Strategic Plan 2009-2018. p 23. Ministry of Healthcare and Nutrition. July 2009.

The lack of promotional avenues and incentives for lower level cadres such as PHM may explain in part why performance appraisal is viewed more as a ritual than a tool for performance improvement and career development.

Education and training and workforce licensing

Another serious HRH challenge is the existing low production capacity both quantitatively and qualitatively. The training and supply of health workers has not kept pace with health sector needs.There are knowledge and skills gaps among health workers due to the fast technological advancements in health such as treatment of subfertility and contraceptive technology.

Production of health professionals are not based on the service needs of the country. In an ideal situation, the health production system would respond to current and projected needs in the workforce. There is a clear disconnect in the health system between institutions producing MO, and the receiving systems for this category (MoH and private sector). While not unique to Sri Lanka, responsibility for training of doctors and their deployment lies with different ministries (Ministry of Higher Education and MoH respectively) which leads to differences in political and financial priorities. Since there has been no workforce projection plan for supply, admissions to medical schools are not according to any projected demand. The Human Resources for Health Strategic Masterplan states there is a lack of effective coordination between the MoH and Ministry of Higher Education, University Grants Commission and Postgraduate Institute of Medicine in planning and establishing training programmes for different categories of health professionals.[31]

Recruitment of certain categories of staff is becoming increasingly difficult. Being a PHM is no longer attractive..

> *I became a midwife because I loved the work but now I won't advice my daughter or anyone else to become a midwife.*
>
> ***FGD PHM, Galle***

So acute has the shortage become for midwives that the requirement for passes in science subjects was discontinued and recently students from commerce and arts streams were recruited. The capacity of the 17 NTS to train students is another factor that limits the production of mid-level health workers.

Workforce Licensing and Regulation

In order to practice in Sri Lanka MO, AMO, nurses, midwives, estate medical assistants and pharmacists have to be registered with the Sri Lanka Medical Council (SLMC). The register of nurses has several parts, Part A for registration of Female General Nurses, Part B for Male General Nurses, Part C for Public Health Nurses, who should be registered as General Nurses and Midwives. Eligibility for registration as midwives has been restricted to women.

HRH and decentralization (please see Table 5.1)

Currently there are only two gynaecologists who are Board Certified as sub-specialists in subfertility who have had theoretical and practical training in medical and surgical management of infertility and reproductive endocrinology. However general gynaecologists are also trained to carry out the following procedures; follicular tracking, assessment of tubal patency using the multiple methods available, laparoscopic ovarian diathermy, in utero insemination etc.

[31] Human Resources for Health Strategic Plan 2009-2018. p 47. Ministry of Healthcare and Nutrition. July 2009.

Crucial members of the ART team are the embryologists and counsellors. There are no such cadres in the public sector at present. The SLCOG and the SLMC have identified the infrastructure and human resource requirements for ART.

Financial resources for FP

(See also Chapter 3 Financing of the Health Services)

The main sources of revenue for health is from Government domestic resources, followed by households, corporations, non-profit institutions and donors. The Ministry of Finance provides funds to the MoH, which are then allocated according to its priorities. The MoH has a budget line for FHB of approximately SLR 100 million each year for capital and recurrent expenditure. This is for consumables, drugs, printing and capacity building. FP related trainingis embedded in the FHB budget and goes across several budget lines. Funds for procurement of contraceptives is under the budget of the MSD. According to FHB sources it is not possible to determine how much of the FHB budget is allocated to FP per se. FP and broader RH programme needs are thus competing with other health priorities for MoH resources. Tables 5.7 and 5.8 show the allocation of financial resources from all sources to the FHB from 2012 upto October 2016. It should be noted that the allocation is for the FHB and not for the FP Unit. None of this financial information includes information on expenditure on subfertility.

Table 5.7: Allocation for the FHB 2012-2016

	2012	2013	2014	2015	2016
Recurrent	763,915,000.00	868,315,091.00	897,593,446.00	853,050,000.00	922,309,500.00
Capital	43,015,000.00	49,400,000.00	76,200,000.00	130,500,000.00	142,212,000.00
UNICEF	23,800,000.00	8,795,000.00	6,282,307.00	12,550,000.00	1,445,648.00
UNFPA	20,020,000.00	24,760,000.00	26,060,000.00	23,800,000.00	5,000,000.00
WHO	27,049,000.00	14,180,000.00	12,874,944.00	16,000,000.00	11,000,000.00
SAARC	50,000,000.00	50,000,000.00	16,500,000.00	10,000,000.00	14,550,558.00
World Bank				40,000,000.00	43,000,000.00

Source: FHB

Table 5.8: Expenditure of the Family Planning Unit 2012-2016

Expenditure - Family Planning Unit						
		2012	**2013**	**2014**	**2015**	**2016**
GoSL	Programmes	0.00	10,145.00	861,613.74	1,358,586.00	376,985.00
	Equipment	0.00	94,162.50	936,320.00	3,100,700.00	0.00
	Commodities	247,340,475.00	180,730,000.00	168,875,000.00	134,625,000.00	837,930,000.00
UNFPA	Programmes	544,591.43	823,516.50	835,170.50	27,334.00	993,296.00
	Equipment	2,312,786.00	4,116,902.88	4,349,522.90	0.00	0.00
	Commodities	0.00	0.00	0.00	0.00	0.00
WHO	Programmes	0.00	0.00	0.00	0.00	1,002,527.25
	Equipment	0.00	288,500.00	0.00	0.00	0.00
	Commodities	0.00	0.00	0.00	0.00	0.00
World Bank	Programmes	0.00	0.00	0.00	0.00	0.00
	Equipment	0.00	0.00	0.00	0.00	0.00
	Commodities	0.00	0.00	0.00	0.00	0.00
Total		**250,197,852.43**	**186,063,226.88**	**175,857,627.14**	**139,111,620.00**	**840,302,808.25**

Source: FHB

Based on the 2014 UNFPA Netherlands Interdisciplinary Demographic Institute (NIDI) study on Resource Flows 97 percent of resources (SLR 225,423,973) for FP was from the government budget and only 3 percent from international resources. According to this study in 2014 the FHB spent SLR 128,250,000 on FP. There is a considerable discrepancy between the expenditure figure provided by the FHB and the NIDI study findings. Since HEB also carries out BCC on FP this information should also be included in any expenditure on FP.

At the provincial and district level very little funds are allocated for FP activities such as training. The FHB procures equipment for the provinces so as to ensure quality even though it is a function of the provincial heath authorities. KI policy makers at provincial and district level said that the funds they received from the provincial budgets were inadequate for programming. A stable financing and resource allocation system does not exist. KI also said that funds were received sometimes in the month of May which led to delays in implementing programmes.

All contraceptives for the public sector programme are procured by the government using domestic funds. (Table 5.9)The FPASL and PSL the main NGOs involved in FP generate their own funds and also receive funding from the International Planned Parenthood Federation in the case of FPASL and Marie Stopes International in the case of PSL.

Table 5.9: Amount and cost of contraceptives procured by the Government 2012 -2015.

		2012		2013		2014		2015	
Contraceptive		Quantity	Cost (Rs)	Quantity	Cost (Rs)	Quantity	Cost (Rs)	Quantity	Cost (Rs)
Male Condoms		7500000	28375000	6000000	18000000	4500000		7500000	27900000
OCP		Cycles	53,450,000	2,000,000	40,000,000	4,500,000	85,000,000		
DMPA	Depoprovera	299,400	38,622,600			30,000	4,800,000	300,000	51,000,000
	Depogestine	600,000	48,930,000	600,000	51,600,000				
Intra uterine Device		80,000	2,800,000	110,000	5,005,000	100,000	4,800,000	130,000	6,305,000
AD Syringes		1,200,000	7,440,000	1,200,000	14,400,000				
Single rod Implant						13,000	17,426,000	10,000	13,900,000
Two rod Implant		2000	5530000	7,000	16,800,000			40,000	50,400,000
TOTAL COST			**185,147,600**		**145,805,000**		**112,525,000**		**149,505,00**

Source: FP Unit FHB

The FHB currently does not track resource flows for contraceptive services and infertility services.

4. Evidence based decision making

Context - Managers and service providers of rights based FP programmes need access to reliable, timely information for use in programme strategy development, implementation, resource allocation, evaluation, course correction, advocacy, and policymaking. Taking an evidence-based approach allows programmes to target priority needs and use resources efficiently. Sound FP programming requires a health management information system (HMIS). A HMIS is defined as a "set of components and procedures organized with the objective of generating information that will improve health care management decisions at all levels of the health system".[32] HMIS has four functions: (1) data generation, (2) data compilation, (3) data analysis and synthesis, and (4) data communication and use.[33]

Findings

The MoH has a comprehensive Health Information System. The FHB has its own HMIS called the RHMIS related to RH and child health.

Resources for the RH HMIS

The Planning, Monitoring and Evaluation Unit of the FHB is responsible for the design, development and support of RH information collection, management, analysis and dissemination of information. This is a comprehensive paper based system. There are two CCPs one for Planning and the other for Monitoring and Evaluation. In addition there are several MOs and a statistician. At the divisional and district level the responsibility for the accuracy and timely collection of information and transmission to the FHB is the responsibility of the MOH and RDHS respectively. The review found that different categories of staff e.g. Management Assistant, PHNS, NO,SPHM, collates the information from PHM, clinics and institutions.

[32] Lippeveld T, Sauerborn R, Bodart C. Design and implementation of health information system. WHO 2000. Accessed 4.2. 2016 http://apps.who.int/iris/handle/10665/42289

[33] World Health Organization (WHO). 2008. World Health Statistics. Geneva. Available at http://www.who.int/whosis/whostat/2008/en/index.html.

Indicators

The RH MIS uses the following to assess the performance of the FP programme indicators:

1. Current user rate - Current user is a woman/man (eligible family) who is using any method of contraception at a given point of time. Data reported in H 509 is used for calculation of this indicator. Current users for all methods and modern methods is available by district.
2. New acceptor rate - A new acceptor is defined as a woman/man using a particular modern contraceptive method for the first time from any service provider belonging to the national programme. Its limitation is the possibility of counting the same person more than once with change in the method. Data on all modern methods except condoms are considered for this indicator and H 1200 provides data for this. The new acceptors can be disaggregated by age.
3. Contraceptive failure rates and complications – these are reported through the RHMIS
4. Unmet need for FP – PHMs collect the information on unmet need from the eligible couples in their care. The information on unmet need is not disaggregated into unmet need for limiting or spacing.
5. Percentage of teenage pregnancies
6. Number of subfertile couples

Need for inclusion of new indicators to assess NFPP performance

Over the past 20 years, two main metrics have been used to measure FP success — contraceptive prevalence and unmet need. Both have demonstrated improving trends in Sri Lanka. NFPP does not collect data for tracking family planning programme performance across dimensions of access, quality, choice, equity, and utilization. This will require that consultations be held with stakeholders to review the current indicators and identify specific measureable indicators.

Data sources for the NFPP

Data are gathered from different sources on both periodic and routine basis for the NFPP. The non-routine systems are typically comprised of population-based surveys, such as the population census and the SLDHS. The SLDHS is conducted too infrequently to provide the data required to monitor progress and shift priorities. The national population estimates and fertility and mortality rates published by the Registrar General are used in some of the denominators of indicators used in the Annual Report of the FHB. Medical Statistics Unit of the MoH prepares the population estimates for all MOH areas.

The RHMIS obtains its data from service statistics from public sector curative and preventive health facilities.The RHMIS, captures data on a daily, monthly, quarterly, and annual basis depending on the different aspects of data being captured. A revision of the formats has been carried out in 2015 and training for health staff has been carried out.

In the 2nd quarter of 2016 FHB commenced piloting the use of tablets to collect RHMIS data from the field in Kalutara, Kurunegala and Puttalam. The Northern Province has experience in PHMs collecting data using hand held devices as they were used during the disability survey.

A standard operating procedure for health information reporting has been developed, which provides clear step-by-step guidelines on RHMIS data collection and its reporting. One of the major challenges for the NFPP is that data from the private sector on FP is not collected through the RHMIS. Though PHMs are expected to collect this information during home visits, not all the services provide by the private sector is captured, especially in urban areas. FPASL and PSL provide their data directly to FHB. The lack of mandatory

reporting for private for-profit providers implies that service statistics from this sector are missed in planning and monitoring FP services by the NFPP.

Data management systems

Currently there are two data management systems in the FHB related to FP.

Logistics Management Information System: This is the information system for management of medicines and related medical supplies. It includes data from stock cards at RMSD. UNFPA introduced CHANNEL which is a computer software program for managing health supplies. The system allows individual warehouses to track their stock as soon as commodities enter or leave storage, and to generate simple reports and requests. The software is meant to automate the data collection and reporting requirements of the facilities at which it is used, while assisting and encouraging good practices in logistics and supply management. CHANNEL is used by the FP unit to track contraceptive supplies. Several trainings have been conducted for storekeepers in the RMSDs on channel and the software has been distributed. Nevertheless, none of the RMSDs visited during the review were using CHANNEL. The MSD and RMSDs use a LMIS known as PRONTO for management of other drugs and supplies. Currently, the logistics management is by means of RHMIS form H1158 from PHM, MOH, hospitals providing contraceptive services and the RMSDs.

RHMIS: This system collects data from MCH FP service delivery, including the data collected by the PHM, which is reported to the MOH.

Data quality and availability

The last SLDHS was conducted in 2006/7. Data for the next DHS was being collected at the time of the NFPP review.

RHMIS is regularly assessed for data quality using timeliness and completeness as indicators. Timeliness in reporting at the FHB is defined as receipt of the monthly report by the 28th day of the following month, while completeness is defined as the proportion of district reports received at the FHB.The quarterly returns are expected to be received at FHB before the 25th of the month following each quarter. Monthly returns should be available before the 20th of following month. Each return is scrutinized at FHB for completeness and accuracy of data. Discrepancies are verified by telephone and in some cases the respective MOHs are requested to revise and resubmit the data. Data are submitted from the field by surface mail.

The quality of data within the RHMIS is largely dependent on the quality of data received, aggregated, and submitted at the divisional level. Participants at the stakeholder workshop and KII affirmed that lapses were common during manual data transfer between various forms. Data quality is likely to be affected by the shortage of health workers, particularly PHMs and the workload that they handle. The Assessment of Workload of Public Health Midwives in Sri Lanka in 2008 found that PHMs spent 13 percent of the total working time on maintaining records. Human resources are mainly strained by the multiplicity of data collection demands from various stakeholders. There were many data collection forms, service registers, and indicators that health workers had to generate and submit in addition to the Family Health Programme but also to NCD, dengue programme etc. Supportive supervision visits aim to improve and sustain timely reporting of complete and accurate data. The unfilled vacancies for supervisory staff at divisional and district level also contributes to issues related to data quality.

Other issues in relation to data on contraception and subfertility:

1. Some curative institutions providing FP services was not sending the information related to FP using forms RHMIS 1200A and RHMIS 527 to the MOH;

2. In some institutions only the RHMIS 1200 form from the clinics was sent but not from the operating theatre or wards on PPIUD and sterilizations carried out;

3. Some clinics did not send the Monthly Hospital Return on MCH /FP return;

4. When a client had an IUD or implant removed in a public sector hospital or private clinic switching to another method was not promoted and these women were liable to have an unwanted or mistimed pregnancy. In most cases the PHM was not aware of the removal of the IUD or implant and therefore was not able to offer alternate methods. A system needs to be put in place for the hospitals to inform the relevant MOH.

5. Data on abortion is collected though the MCH Return RHMIS 509. There is no information on post abortion contraception collected by the NFPP.

6. Currently only information on number of subfertile couples identified is entered in the Eligible Couples Register. Couples are classified as cases of primary and secondary subfertility. The MCH Return RHMIS 509 provides information on the number of subfertile couples and the number referred. Neither the Monthly Hospital Return on MCH/FP, the Quarterly MCH Clinic Return (RHMIS 527) nor the Annual Data Sheet on Resource Availability and Performance collect information on subfertility. Many couples go directly to the private sector for investigation and services. The data on subfertility from the private sector is missing and a mechanism to collect this data is needed.

Though the Planning Monitoring and Evaluation Unit has developed guidelines on procedures related to the RHMIS it was apparent that many curative institutions did not follow them

Data processing

The returns are entered into epi data based data entry format. The analysis is carried out using SPSS software. Data entry validation is done by re-entering 5% of the returns.As can be seen these processes are a mixture if paperbound manual processes and computer based electronic processes.

Dissemination and use of data

A range of experiences was reported in relation to feedback of information from higher levels to lower levels, and use of information for planning, management, resource allocation, and monitoring and evaluation. Review and use of information was reported to take place during regular MOH monthly conference meetings. During district review meeting and MOMCH biannual workshops data are reviewed and shared, challenges and gaps are identified, and strengthening interventions and follow-up actions are discussed. No such meeting take place in health facilities.

Dissemination of RHMIS data is mainly through the Annual Report of the FHB. However, there is a considerable delay in the publication of the report. For instance the Annual Report for 2014 is yet to be published at the time of writing this report. The Planning, Monitoring and Evaluation Unit also publishes the MCH quarterly Newsletter.

Insufficient access to data for NFPP management

The only data that comes directly to the FP Unit is the H 1158 monthly stock return. This is used to monitor

the status of stock in the FHB and RMSDs. Currently the FP Unit does not have direct access to relevant data collected by the RHMIS in relation to FP. This is a serious drawback for decision making at central level.

5. Contraceptive security

Context – "Contraceptive security" exists when individuals are able to choose, obtain, and use contraceptives whenever they need them. Contraceptive shortages and inconsistent access discourage use and pose an increased health risk. An adequate and reliable supply of contraceptives, FP is a prerequisite for a rights based approach to FP.Programmes must guarantee access to services, so that providers can do their jobs, and clients obtain their preferred method. Having a diverse mix of affordable, quality-assured contraceptives available also ensures that FP clients can have their choice of methods and thus supports continuing increases in contraceptive prevalence.[34]

Finding - The FP commodity supply chain is independent of the larger public health sector supply chain in Sri Lanka. The goal of the NFPP is to provide the desired mix of FP commodities at all service delivery points in the country. The public contraceptive supply chain consists of a central warehouses located at the FHB and another in the FPASL premises in Nainamadama and 28 Regional Medical Supply Divisions (RMSD).

Pharmaceutical policy

The National Medicines Regulatory Authority Act 2015 provides for the establishment of the National Medicines Regulatory Authority (NMRA). The NMRA is responsible for the registration, licensing, manufacture, importation and all other aspects relating to medicines, medical devices and for the conduct of clinical trials.

Pharmaceutical registration

A system exists for drug registration to authorize the marketing of pharmaceuticals including contraceptives. New chemical entities are vetted by the Drug Evaluation Sub Committee (DESC) of the NMRA. The DESC comprises consultants from various specialties and a decision is taken at the DESC meeting accordingly. If the committee decides that a drug should be registered in this country, then it is taken up for thorough pharmaceutical evaluation. Pharmaceutical quality of products is assessed based on factors determining quality (starting materials/ formulation, manufacturing process, intermediate & finished product controls, packaging, stability, bioequivalence data). NMRA at time of registration of drugs looks at the pre-sale certificate whether it has been accepted by countries such as US, USA France etc, and whether the drug has been subjected to the Good Manufacturing Practices (GMP) inspection. If registration is recommended, DESC decides on the Schedule under which it should be registered (i.e. I, IIA, 11B, or 111). The local agent will be informed of the decision (whether rejected or approved).

Once approved, the Certificate of Registration will be issued by the NMRA. Registration is usually valid for 5 years. Under special circumstances (e.g. when the drug is a new chemical entity or the manufacturer is new to this country) a provisional registration will be issued for one year. Every importer should employ a registered pharmacist and should possess a wholesale license from NMRA in order to carry out the business.

KI in the NGO sector complained of the long delays they experience in registering new products.

[34] Path and United Nations Population Fund. Meeting the Need. Strengthening Family Planning Programs. Seattle. Path and UNFPA 2006

Licensing, inspection, and control

Mechanisms exist for enforcing regulations aimed at ensuring the quality of pharmaceuticals on the market. Key components of this mechanism include: systems for licensing pharmaceutical personnel;

and the licensing, inspection and control of manufacturers, distributors/importers and pharmacies/drug retail outlets. Condoms requiring inspection are tested at the Industrial Technology Institute. The Drug Inspectors attached to the NMRA carry out periodic checks of pharmacies. According to KI this is an area that requires strengthening in order to ensure the quality of products.

Product selection

Availability of an Essential Medicine List (EML) - The Formulary Revision Committee meets every 3 years to review specifications and to make additions or revisions. Sri Lanka has developed and printed five EML, the last in 2014.[35] The following contraceptives are included in the EML. (Table 5.10) Detailed specifications for contraceptives were prepared in 2010 and revised in 2014.

Table 5:10 Contraceptives on the EML

Oral hormonal contraceptives	
Ethinylestradiol + Levonorgestrel	Tablet: 0.03mg + 0.15mg
Complementary List	
Levonorgestrel	Tablet: 750 micrograms (pack of two); 1.5 mg.
* Used as Emergency Contraceptive Pills.	
Injectable hormonal contraceptives	
Medroxyprogesterone	Depot injection: 150 mg/ml in 1-ml
vial.(as acetate)	
Intrauterine devices	
Levonorgestrel IUD	20mg/24 Hours (Slow releasing)
Copper containing device	CuT 380A
Barrier methods	
Condoms	
Implantable contraceptives	
Etonogestrel	One-rod etonogestrel-releasing implant 68 mg of etonogestrel (150mg total).
Levonorgestrel	Two rod levonorgestrel (each rod 75 mg LNG)

Source: National List of Essential Medicines Sri Lanka 2013-2014

Quantification

The last contraceptive forecast was done in 2011 for the period 2011-2017 based on previous consumption not on population forecasts. When the crisis with regards to DMPA occurred in 2012 a fresh assessment of the contraceptive requirements should have been carried out as clients were switching methods. Many clients switched to implants and the demand for implants increased. KI reported during the review that there have been stock outs of implants and DMPA in 2016. There were instances because of the stock outs

[35] http://www.cdda.gov.lk/images/pdf/final-book.pdf http://www.cdda.gov.lk/images/pdf/final-book.pdf

where clients were referred to the private sector. However, a KI in FHB said there is currently a large stock of DMPA. These supply shortages reported by health facilities may be "artificial" due to misdistribution while the FHB and RMSs have adequate stock available.

FHB requests the PDHS/RDHS to estimate the type and quantity of contraceptives required. Based on the requests the FHB develops the national annual estimate based on historical consumption data, issues and forecasts of the national demand for the following year while considering the stock availability and balance due on order from suppliers. During the review it was observed that data generated at district and facility levels on consumption of FP commodities are less than satisfactory.

- The monthly contraceptive stock return RH MIS 1158 are not sent in a timely manner or not at all to the RMSD;
- The form is incompletely or incorrectly filled. In most instances this task is delegated to the DO or SPHM in a MOH;
- Some hospitals do not take into consideration the stock of contraceptives it has in stores but reports only on the contraceptives issued from the clinics;
- Some hospitals send the 1158 from the clinics only but do not take into consideration the issues of IUD made on the wards.

The flow of contraceptive information and data from downstream using the RHMIS 1158 Monthly Contraceptive Stock Return /Request Form through the system is weak. The level of engagement by MOMCH during the quantification and forecasting process is also inadequate. Data coming from lower levels to support quantification and forecasting are also limited in completeness and timeliness. MOH are not sufficiently engaged in the forecasting, delegating this function to the SPHM or PHN in most instances.

The NSACP, private and NGO sectors are not involved in the quantification of FP commodities. By including these sectors in the quantification process will result in significant savings to the NFPP.

Procurement

FHB informs the Medical Supplies Division (MSD) of the MoH of the specifications of contraceptives and the quantities required in June or August of each year preceding the actual procurement of contraceptives. MSD has an island wide logistics system known as " PRONTO" which is used to identify the demand for pharmaceuticals and supplies for the public sector. The system allows the MSD to determine the available stock in RMSD and institutions. In the case of contraceptives, FHB determines the quantity of contraceptives it requires for the NFPP and enters into PRONTO. The MSD debits the FHB facility account and places orders with the State Pharmaceutical Corporation (SPC) which is the procuring entity for MOH. The MSD plays an intermediary role in providing the specifications, quantity to be procured, delivery schedule and special conditions such as labelling, bar codes etc. The SPC publishes the tenders which are grouped according to the value. Procurement is governed by the Procurement Manual 2006. (Procurement Guidelines 2006 Goods & Works Guidelines for Procurement of Pharmaceuticals and Medical Devices).

Competitive bidding

The SPC call for global competitive bidding resulting in comparatively better prices. If the value of the tender is less than SR 100 million the FHB is authorized to evaluate the tender. If the values of the bid is more than 100 million the tender board is called by the MoH. The procurement is usually done once a year. Procurement is not done by the MSD except in very urgent instances where the SPC has failed to supply the items on time.

Supplier pre-qualification

WHO prequalified suppliers was made mandatory for all contraceptives following the spate of adverse reactions that were reported after DMPA use in 2012. The FP Unit has changed the specifications to have prequalified suppliers for all contraceptives as well. The suppliers have to be registered with the NMRA. The specifications stipulate that the items are tested at the supplier's expense.

After the evaluation process by the Technical Evaluation Committee (TEC) orders are placed by SPC with the suppliers but delivery is staggered based on stock levels. The average lead time for SPC procurements is one year. This means that the FHB has to carry one year's stock. Carrying costs can be reduced if lead time is reduced. One reason for the long lead time is that sometimes the TEC takes a long time to evaluate the bids.

The only recent emergency procurement was following the DMPA crisis in 2012 when depo provera was procured.

Warehousing and inventory management

Public sector

Storage

Once the contraceptives arrive in the country they are cleared from the port by SPC and are delivered by MSD to the FHB. The FP Unit uses the supply chain management software developed by UNFPA -CHANNEL- to track stocks and distribution using batch numbers. The FHB CHANNEL system is not used by the RMSD. There are two warehouses in FHB for contraceptives, one for hormonal contraceptives and the other is used for storing condoms and IUD. The temperature in the warehouse which contains the hormonal contraceptive is maintained at around 26° C. Additional storage space is available if necessary at the FPASL warehouse in Nainamadama. The FHB warehouse was found to be functioning in accordance with good storage practices, where stocks are secure, protected from sunlight, properly ventilated, well organized and clean. However, the space is inadequate at present. Sometimes the contraceptive warehouses have to accommodate other items required for the Family Health Programme as well. Periodic physical verification, ledger inventory and the balance based on Channel software is carried out.

Training programmes are conducted on storage and distribution procedures for RMSD staff. This is included in the training plan of the FP Unit.

There are 28 RMSDs throughout the country. The minimum stock level in the RMSD is 3 months at which level reordering must take place. The maximum stock level the RMSD can hold is for 6 months. However, this varies with the RMSD as some RMSDs are unable to maintain a climate controlled environment e.g Kalmunai. The MOH stores maintain a minimum stock of 2 months and a maximum stock of 3 months. The maximum stock a PHM can hold is one month and the minimum is 2 weeks. We observed during the review that RMSDs did not maintain the minimum stock. For instance in Kalmunai RMSD both DMPA and condoms were out of stock at the time of the visit.

The FP Unit has developed a comprehensive Warehouse Assessment Form which is used during inspection visits to RMSDs. The assessment takes into consideration the external environment of the store, storage space, stacking, racks, maintenance of stock bin cards, warehouse operations including record keeping. In general the RMSDs observe good storage practices such as storing contraceptive on racks; temperature control; avoiding direct sunlight. However, there were some issues in relation to storage at the RMSDs that were visited during the review.

1. Space was an issue in all the RMSDs that were visited;
2. Some of the RMSDs did not maintain bin cards;
3. Packages were stored almost to the level of the ceiling;
4. Boxes were stored on the ground and not on racks;
5. Lack of air conditioners especially for condomstores;
6. There were no fire extinguishers in some RMSD;
7. The roof leaked in some stores;
8. Termites were a problem at the RMSD in Monaragala

Distribution

Distributions of contraceptives in Sri Lanka are largely managed through a "pull system".[36] PHM make requests for pills and condoms to MOH of the area using the Monthly Stock return/Request Form RHMIS 1158. MOH and hospitals in turn make their request to RMSD with copies to MOMCH using the RHMIS 1158. Monthly stock returns from institutions to RMSD was not timely. We observed that many were filled incorrectly. This task is delegated to SPHM or PHNSin most instances. Since 2006 in Moneragala the RHMIS 1158 is sent to the MOMCH who compiles the information and sends the request to the RMSD. The RMSD compiles the information and sends the RHMIS 1158 to the FHB with a copy to the MOMCH. In one district we found instead of the RMSD passing the RHMIS 1158 to FHB that the MOMCH sent the RHMIS 1158 with a cover letter directly to FHB.

FHB releases stocks to RMSDs every two to three months. When request are received by the FHB from the RMSD the required quantities are issued and recoded in the ledgers which are maintained by type of contraceptive. Issues are made on a first expiry first out (FEFO) basis and by lot number. The invoice book is maintained in quadruplicate. One copy is sent to the FP unit, two copies are sent to the RMSD and the fourth copy is kept in the warehouse. The RMSD sends the receipt copy back to the FHB. The RMSDs send their own vehicles to collect contraceptives from the FHB and in some cases FHB makes deliveries to RMSD. KIs said that some RMSDs gave more importance to collecting their requirements for drugs and other medical supplies from the MSD rather than contraceptives from FHB.

Based on the requests received from MOH and institutions the RMSD issues commodities to institutions. The same procedure is followed when issues are made as described for distribution from FHB to RMSD. Information from the invoice book are entered into the ledger. The invoice number, quantity institution and balance are recorded in the ledger. Since the lot number has to be recorded the bin card is updated at the same time. The ledger balance and the physical balance are verified daily.

Distribution from RMSDs is based on a monthly schedule.KI also noted that delays in delivery from RMSD to MOH were common. The RMSDs and FHB faced difficulties in relation to transport. One RMSD (Killinochchi) did not have its own vehicle and was dependent on the RDHS vehicles to transport drugs. KI pointed out that most vehicles with the RMSDs were old and unreliable.

There are many potential points in the system where supply chain breakdowns could occur – at the top of the chain is forecasting by FHB. Forecasting is based on historical consumption data, which reflects the historical contraceptive commodity supply constraints. At the national level, stock monitoring is consistent, but information coming from lower levels on stock status is incomplete, unreliable, and delayed.There are also problems in the distribution chain:

[36] The "pull system" is a demand-based approach for ensuring the reliable availability of health commodities at all service delivery points within a health system.

- facilities do not place orders when they are supposed to or miscalculate their orders,
- institutions do not forward orders to the RMSD on a timely basis;
- RMSDs do not give sufficient priority to collecting contraceptives from FHB, and;
- RMSDs do not deliver goods to institutions in a timely manner.

The PDHS conducts annual stock verifications. We noted that there were delays in issuance of no claims certificates. For instance in Moneragala. the last no claims certificate was issued in 2013.

Clinics

Clinics providing FP services in the public sector are assigned a registration number. At least 4 methods have to be provided for a clinic to be registered. Information as to whether the clinic continued to provide 4 FP methods after registration was not collected. This was rectified in 2015 and the information is collected through the Annual Data Sheet on Resource Availability and Performance.

The ability to link divisional and district consumption data and report this information up to the centre is necessary to improve the reliability of commodity logistics reporting and efficient provision of FP commodities.

Most health facility managers who were interviewed as KI said that facilities had adequate amounts of contraceptives However, shortage of implants and DMPA were reported in some public sector facilities during the review. One teaching hospital was referring clients to FPASL for these methods.

The optimum temperature for storage of contraceptives is 15-30° C. Contraceptives are stored in steel cupboards in some health facilities. In some instances the external temperature rises to as much as 32° C and the temperature inside the steel cupboard may exceed the recommended temperature, particularly in clinics in the dry zone.

Stockouts of contraceptives

At present the RHMIS does not collect information on contraceptive stockouts. Our impression was that supply shortages reported by health facilities was often due to misdistribution as there were adequate stocks in the RMSD and FHB for certain methods.

Inventory losses

KI said there were no inventory loss resulting from expiries, damage, quality issues, except in the case of DMPA. ECP stocks had also expired in some RMSDs and no instructions have been issued about their disposal.

Financing for contraceptives

Until about 1997 international agencies such as UNFPA and other donors had procured the contraceptive requirement for the NFPP. They entered into negotiations with the government to gradually withdraw their support and for the government to take over procurement using its own funds. Since 2004, the government using its domestic resource has fully taken over the procurement of contraceptive requirements for the NFPP

Table 5.11 gives a summary of the issue related to contraceptive security in Sri Lanka.

Table 5: 11 Summary of issues related to the contraceptive commodity security system in the public sector

Logistics cycle	Barrier
Organization and staffing	Managers have no formal training or very little informal supply chain management
	DOs handling contraceptives in RMSDs and institutions have not had formal training on supply chain management
	Consistent training and supportive supervision of RMSD and institution stores
	Staff is not sufficient to manage commodities at all levels e.g pharmacists / storekeepers
Quantification	Poor and inadequate consumption data is used for quantification. The RHMIS 1158 is not sent in by institutions in a timely manner.
	There is no involvement of the NGO private sector in the quantification process
Procurement / product quality	Procurement process is lengthy with a lead time of about one year.
LMIS / inventory control	No written guidelines exist for inventory control for FP commodities
	Weak inventory control systems in place at RMSDs and institutions leading to stock out of condoms and OCP in one RMSD
	In some MOH the stock that was held was much more than the maximum they were expected to hold.
	Inventory ledger does not capture all information
	Bin cards are not maintained
Storage and distribution	Recording the receipt and dispatch of contraceptives is paper based at RMSD and lower levels. This limits the visibility of data at other levels of the supply chain
	Storage space and infrastructure for FP commodities are not sufficient at all levels
	No collection schedule exists for collecting FP commodities from FHB.
	No proper layout in some RMSD
	Formal guidelines or written procedure are not available for disposing of or destroying expired products e.g ECP. As a result expired commodities are still in storage
Distribution	Poor condition of most vehicles attached to RMSD
	Long distances from RMSD to FHB.
	RMSDs have schedules to deliver contraceptive to institutions
	Poor distribution planning. Lack of priority given by RMSD to collecting contraceptives from FHB

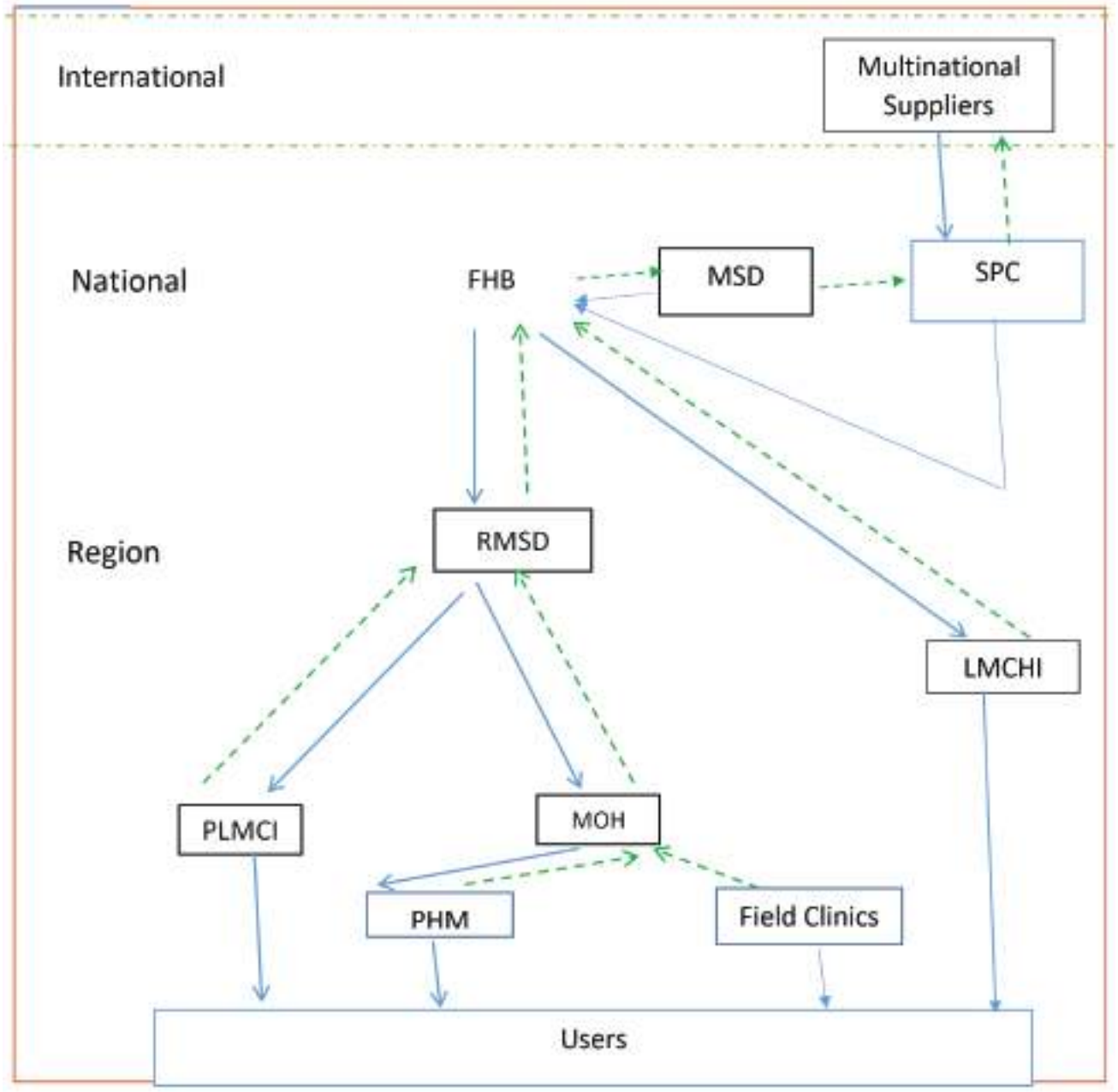
Poor inventory management leading to delayed collection of commodities from FHB leading to stock outs in RMSD and SDPs

Private and NGO sector

The NRMA has set down standards for the storage and distributions of pharmaceuticals in the private sector. Transport of pharmaceuticals can only be done in vehicles which have been approved by the NMRA. The NMRA Bill has proposed measures for making medicines more affordable. On 21st October 2016 by Gazette notification the price of 48 essential drugs was subject to price control. No contraceptives were included. There is little engagement with private sector even though often they are one of the first source for health care. The 2006/7 SLDHS documents that the pharmacies are increasing its provision of OCP, emergency contraception and condoms.

FPASL and PSL procure contraceptives using their own resources both from funds they generate and from the International Planned Parenthood Federation in the case of FPASL and Marie Stopes International in the case of PSL.

Figure 5.1: Procurement and distribution of contraceptives in the public sector in Sri Lanka



Key: FHB- Family Health Bureau, MSD- Medical Supplies Division, SPC- State Pharmaceutical Corporation, PMCHI- Provincial Ministry Curative Institutions, LMCHI- Line Ministry Curative Health Institutions RMSD- Regional Medical Supplies Division, MOH- Medical Officer of Health, PHM- Public Health Midwife

Distribution ----------> Information

6. Advocacy efforts

Context - Advocacy is defined as a set of actions undertaken by a group of committed individuals or organizations to introduce change or obtain support for specific policies, programmes, legislation, issues or causes. Advocacy differs from general information, education and communication (IEC) efforts or behaviour-change communication (BCC) programmes.[37] Advocacy objectives are different from programme objectives in that they reflect what can be achieved by communicating research and information to decision-makers and those that influence them. Strong political support for FP at all levels of government strengthens FP programmes, contributes to positive social norms and is crucial for programme success. Political commitment for FP is not only critical to ensuring that supportive policies are implemented but also that resources are adequate and allocated appropriately. Advocacy can also reinforce and support BCC activities particular those that address social norms.

Findings

The NFPP enjoyed considerable political support in the past. This support has waned in recent years.[38] Negative perceptions and lack of support for FP are some of the causes for the loss of momentum of the NFPP.

Following the intense attacks against FP by religious extremists and ethnic groups the NFPP was seriously affected. Several KI at policy making level pointed out the need for an advocacy strategy in order to revitalize the NFPP. According to KI several requests were made by the Technical Advisory Committee to the HEB to take necessary steps to commence an advocacy programme. The HEB has commenced a sensitization programme for marriage registrars. The stake holder workshop and KI at central and provincial level strongly recommended that advocacy be carried out with provincial and district politicians and administrators to allocate sufficient resources from provincial and district budget for FP activities since they might not consider FP a priority.

The stakeholder workshop and KI identified the following issues necessitating advocacy.

- Need to make policy makers and decision makers aware that in order to achieve the SDGs, especially, SDG 3 ("Ensure healthy lives and promote well-being for all at all ages") and SDG 5 ("Achieve gender equality) requires advancing FP which contributes to achievement of the other SDG goals as well;
- Support from religious and political leaders at national and subnational level to improve maternal and child health by birth spacing;
- Need based allocation of financial resource for FP by provincial authorities prioritizing underserved and marginalized areas;
- To introduce age specific comprehensive sexuality education into the school curriculum requires intense advocacy with the Ministry of Education;
- Convince decision makers to make sufficient resources allocations to improve access to investigation and treatment of subfertility in the public sector and to fully operationalize the two subfertility centres in Castle Street Hospital and Mahamodera to provide ART services.

[37] Repositioning Family planning: Guidelines for advocacy action. WHO and USAID.2008. p1.Accessed 15.7.2016. http://www.who.int/reproductivehealth/topics/family_planning/fp_advocacytool_kit.pdf

[38] http://www.dailymirror.lk/25118/small-family-concept-not-relevant-today-mahipala

As part of the review KII were held with religious and political leaders at local level. Both Catholic and Muslim religious leaders approved the use of traditional methods but opposed the use of modern methods. The local politicians while expressing concern about the changes in the ethnic composition also understood the benefits of FP to mothers, children and families. Some were unaware of the resource constraints the programmes faced and the positive role they could play in increasing the financial allocations for health at the Provincial Council level.

A KI from a mother support group in Gomarankadawala in the Trincomalee district said that if a girl fails the GCE O/L there are no other opportunities such as vocational training centres (VTC). Some leave the village in search of work. Many who stay behind enter into a relationship and live together as they are less than the minimum age of marriage. Hence, the advocacy should not just be restricted to increasing support for FP but for broader social issues such as girl's education and job opportunities in remote areas of the country.

7. Efforts to foster positive social norms and transform gender roles

Context - Social norms are understood broadly as 'widely shared beliefs and common practices within a particular group'. Patriarchal gender norms influence many aspects of FPand contraception use including, timing of marriage and childbearing, family size, sex preference and number of children, age of marriage and contraception use.[39] Gender norms can have a positive influence on FP as well. For example, programmes have emphasized the norm of men as providers for their families, encouraging them to consider the economic costs of children in the context of rising aspirations for education and consumer goods. Operations research studies have shown success in involving men in increasing spousal communication about family size and FP.[40]

The ICPD places the responsibility for FP equally on men and women instead of solely on women, thereby emphasizing the importance of educating men as a means of achieving gender equity, especially with respect to FP decisions and participation in method use. Implementing this goal, however, remains a challenge to many programmes that struggle to find ways to increase male participation.

Findings

The National Strategic Plan on Maternal and Newborn Health (2012-2016) has identified the need to enhance male participation and address gender equity and equality as one of its strategic objectives. The preconception programme and the three education sessions during pregnancy is a step in the right direction to bring to the attention of males some of the issues related to pregnancy and FP.

Women's empowerment status and current use of contraception and unmet need

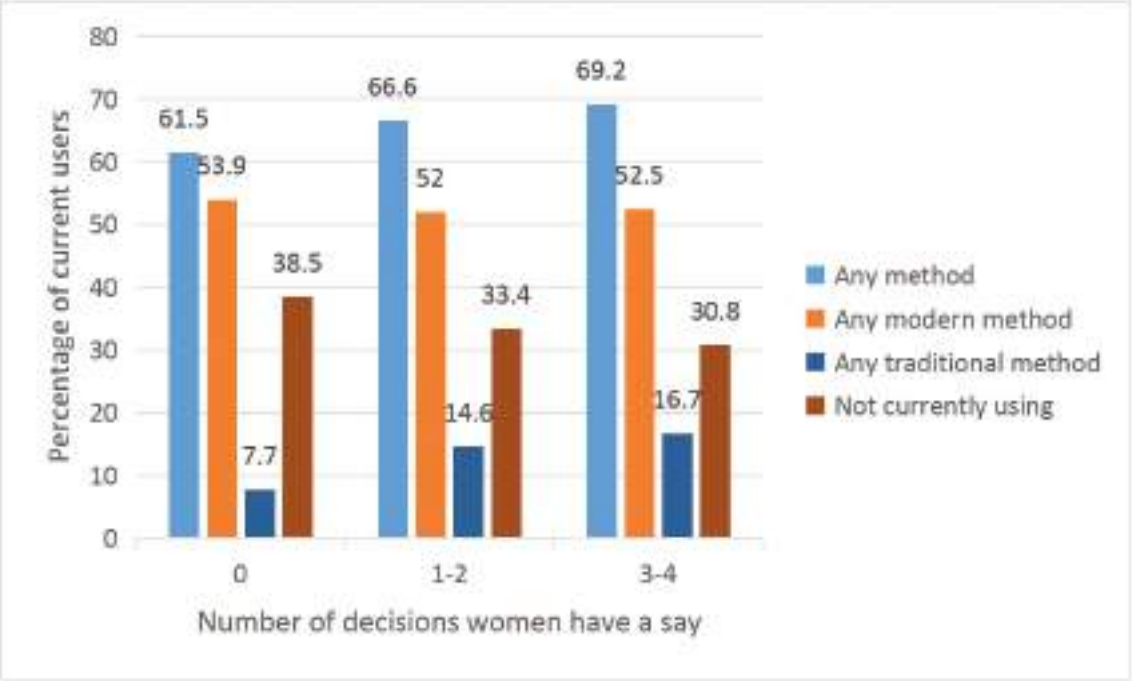
The 2006/7 SLDHS assessed women's decision making autonomy, based on women's participation in four different types of household decisions: the respondent's own health care, major household purchases, household purchases for daily needs, and visits to her family or relatives. (Figure 5.2) The use of any contraceptive method was slightly higher among women who participate in all four decisions (69.2 percent), than among women who participate in none (61.5 percent). However, the percentage currently using modern contraceptive methods among women who did not participate in decisions for which the SLDHS obtained information is almost the same as the percentage using contraception among women participating

[39] RHerbert S. 2015. Social norms, contraception and family planning.

[40] Lundgren, R.; Gribble, J.; Greene, M.; Emrick, G.; Monroy, M. (2005). Cultivating men's interest in family planning in rural El Salvador. Studies in Family Planning 36(3):173-188.

in three to four decisions (53.9 percent and 52.5 percent, respectively). There is a modest association between non-use of any FP method (38.5 percent) with no decision making power. In contrast only 30.8 percent of women who were empowered to make three to four decisions did not use contraception. Women's use of a traditional method doubles with high decision participation, from 7.7 percent among women with no decision making power to 16.7 percent for women who make 3-4 decisions.The SLDHS surmises that these results implies that when women have more self-esteem, sense of control; respect from their husbands and good communication with him, they tend to choose traditional methods which requires strong degree of self-discipline and the husband's cooperation to use them effectively.[41]

Figure 5.2 Current use of contraception by women's empowerment status

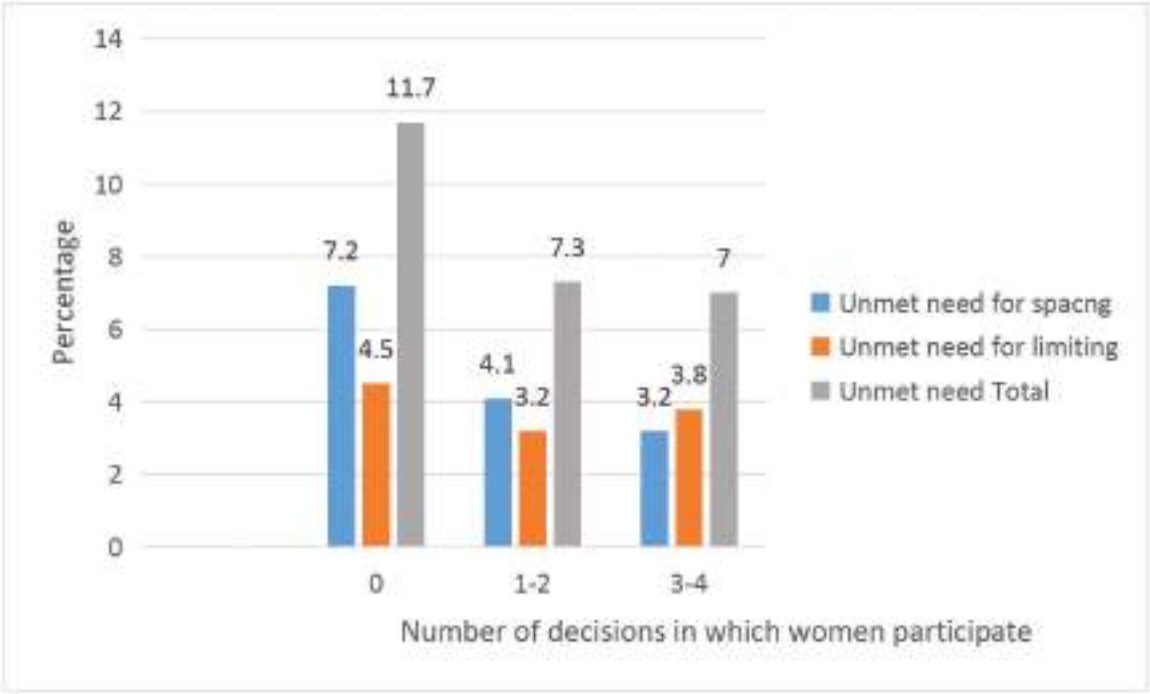


Source: 2006/7 SLDHS

The 2006/7 SLDHS found that women who do not participate in any decisions are more likely (12 percent) to have unmet need for FP than more active decision participants.(Figure 5.3) Because of these women's relative lack of decision-making power, it makes sense to provide methods that are female-controlled and can be used covertly such as DMPA. Unfortunately, the adverse reactions reported to DMPA in 2012 has decreased the popularity of this method due to fear of side effects.

[41] 2006/7 SLDHS

Figure 5.3 Women's empowerment and unmet need for FP



Source: 2006/7 SLDHS

Male involvement

Two areas in relation to male involvement are: (i) spousal communication on use of contraceptive decision-making, as a result of men's increased knowledge of and discussion about contraception with their partners; (ii) men's support for use of contraceptive methods through emotional support or allocation of resources (time, money, transportation) and increased willingness to use male-contraceptive methods when available.

Spousal communication about FP decision making

Male involvement helps not only in a woman accepting a contraceptive but also in its effective use and continuation. Spousal communication on contraception and reproductive goals suggests that the couple has an egalitarian relationship.

Married men in communities where FGDs were conducted felt that the couple were jointly responsible for FP and expressed the importance of collective decision-making around contraceptive use.

Husband and wife should jointly make the decision to use family planning. (Others agreeing)

FGD Married males 30-50 years, Trincomalee

Most female participants said that the decision on the number and timing of children are made jointly by the couple. In Nuwera Eliya district however, the majority of women said they entirely rely on the male partner's decision on issues that affect their contraception usage. Spousal agreement on use of FP can avert marital disharmony as the following statement illustrates.

I think husband and wife both should take the decision together. When it comes as a family……. my husband goes to work in the morning and comes back at 10 pm. If I start doing things on my own, he may think there is something wrong. He may start thinking why is she using it. And then he might suspect me. So these decisions should be discussed and taken by both.

FGD participant, married women 30 - 45 years Nuwera Eliya

Men's use of modern contraception

Table 5.12: Current users of modern methods

Method	2007	2008	2009	2010	2011	2012	2013	2014
Pills	7.2	7.4	7.5	7.6	7.6	10.0	10.1	10.1
Injectables	17.4	17.4	17.7	17.8	18.0	12.1	11.3	10.2
IUD	7.4	7.9	8.5	8.7	9.1	10.3	10.6	11.0
Implants	0.2	0.5	0.7	0.8	1.0	1.5	2.1	3.2
Condoms	4.8	5.2	5.6	5.9	6.1	7.2	7.7	8.2
Female sterilization	13.7	13.8	13.8	13.9	13.9	13.9	13.6	13.4
Male sterilization	0.4	0.4	0.3	0.2	0.2	0.1	0.1	0.1
Modern methods	51.2	52.5	54.2	54.7	56	55.1	55.4	56.2

Source: Family Health Bureau

The NFPPs does not engage sufficiently with men. The NFPP relies mainly on women as clients. Table 5.12 shows that use of condoms has increased during the period 2007-2014 which is encouraging. However, male sterilization is almost non-existent. Fewer than 9 percent of married couples were using a modern method for men and 48 percent using modern methods for women in 2014.

Clearly the NFPP has paid insufficient attention to enhancing male involvement in FP. Currently there are no service providers for vasectomy. Several KI from the MoH said that there has not been any organized effort to engage with the arbiters of social norms including opinion leaders especially religious leaders in relation to FP. Policy makers and managers at provincial and district level were of the opinion that PHIs could do more to promote male involvement. Weak supervision by MOH of PHIs was cited as a reason.

Opposition to use of FP

The 2006/7 SLDHS reported that 1 percent of women discontinued use of contraceptives due to disapproval of the husband. Of women who were not using a contraceptive method and said they would not use a method in the future 3.7 percent cited husband disapproved and 2.6 percent indicated religious prohibition as reasons.

Changing social norms

Changing deep seated social norms take time. It is more sustainable when such changes comes from within the community. For instance, teenage pregnancy is very high in Trincomalee. In Kuchaveli, the teenage pregnancy rate is 10.4 percent. This is a predominantly Muslim area. According to a Muslim community leader, though the age of marriage for Muslims is 14 years the local ulema (religious leaders) had decided unofficially they would register marriages only if the girl was over 16 years of age. They would gradually increase the age of marriage to 18 years in conformity with the rest of the country.

According to the KI the local girls schools do not have teachers after grade 8. This is one of the reasons for early marriage in this community.

A surprising finding during the FGD's with married women was that son preference was not uncommon.

Subfertility

As mentioned in Chapter 4 subfertile women face social isolation and stigma. Most men assume there is nothing wrong with them. Subfertile men are often in denial and do not wish to acknowledge they have a problem.

> *Some husbands don't like to accept that it is their problem even if it is their problem. They put the blame on the female.*
>
> ***FGD female partner of a subfertilecouple, Colombo***

Gendered socialization of boys and men is lacking which would enable men to understand their roles in marital relationships so that they see subfertility as a problem of couples rather than of women only.

Chapter 6
Findings - Supply side

Introduction

The World Health Organization (WHO) defines service delivery as the way inputs are combined to allow the delivery of a series of interventions or health actions through multiple actors in the public and private sectors.[1] Contraceptive services in Sri Lanka has evolved significantly since their introduction in the 1950s, when the choice of contraceptive products was limited. Services have been broadened to offer a wider array of methods and to include education and counselling.

Administrative, financial and management systems also need to be in place, with administrators focused on evidence-based medicine and the use of data for decision making to improve service quality and plan and manage programs. This aspect is discussed in detail in Chapter 5.

The following elements of supply were used during the assessment.

8. FP is offered through a variety of service delivery modalities

Context – FP require a variety of service delivery modalities. Different service delivery modalities are needed to ensure access to a range of contraceptive methods. Service delivery modalities can be stationary, mobile, or community-based. Contraceptive methods vary in how they function and in their effectiveness, side effects and mode of use. The acceptability and desirability of contraceptive methods also changes among users. To meet varying needs and demands for contraception, a variety of methods that meet common needs should be easily obtainable. Thus, a facility that offers a wide variety of contraceptive methods is best able to meet clients' needs. However, some variation is expected in the methods offered because of differences in provider qualifications and training as well as the infrastructure required to provide certain methods safely.

Categories of subfertility centres have been defined by countries as diverse as India[2] and Scotland.[3] Sallam suggested infertility services in resource poor settings should be provided at three levels - basic (level 1), advanced (level 2) or tertiary referral infertility services (level 3 based on the complexity of investigations and treatment.[4]

Findings

Public sector sources of FP

Contraception and subfertility are provided through a wide network of curative and preventive health facilities in the public sector. A health facility is on average to be found within 4 km of households.

Methods that can be provided safely with minimal training are pills, injectables, and condoms as well as counselling on natural family planning methods. To provide implants, IUDs, female and male sterilization safely requires a higher level of skill and more infrastructure. Technically, emergency contraception is not

[1] 2Report of the Scientific Peer Group on Health Systems Performance Assessment. Geneva: WHO. <http://www.who.int/health-systemsperformance/sprg/report _of_sprg_on_hspa.htm> (accessed Sept. 26, 2006).

[2] Indian Council of Medical Research Guidelines. National Guidelines for accreditation, supervision and Regulation of ART clinics in India. http://icmr.nic.in/art/Chapter%20_2.pdf (Accessed 23.06.2016)

[3] National Infertility Group Report 2016. Scottish Government 2016.

[4] Sallam HN. Infertility in developing countries: funding the project. Hum Reprod ESHRE Monographs. 2008;1:97–101.

considered a regular contraceptive method but rather a backup method. Table 6.1 shows the hierarchy of medical institutions in the public sector and the type of contraceptive methods they are expected to provide.

Table 6.1: Modern contraception methods used by the public sector by service provider and location

Contraceptive method	Service provider	Point of service delivery
Temporary methods		
Condoms	Trained PHM, PHI	Community and above
OCP	Trained PHM, MO, RMO/AMO, pharmacist	Community and above
DMPA	Trained MO should be present.	Clinic with MO and emergency tray
IUD	Trained MO, RMO/AMO, PHNS	Field clinics PMCU and above
Implants	Trained MO	Field clinic PMCU and above
Emergency contraception		
Emergency contraceptive pills (ECP)	Trained PHM, MO, pharmacist	Community and above
Permanent methods		
Mini-laparotomy	Consultant Obstetrician and Gynaecologists Trained MO,	Base hospital and above FHB
Laparoscopic sterilization	Consultant Obstetrician and Gynaecologists	Base hospital and above FHB
Vasectomy	Genito-urinary Surgeon,Trained MO,	Base hospital and above FHB

Since 2012 only clinics with a MO and having drugs and equipment to deal with an anaphylactic reaction can provide DMPA. Many field clinics do not have the necessary emergency equipment such as oxygen cylinders to deal with an anaphylactic reaction. Hence clients requesting DMPA and LRT have to be referred to institutions where they are carried out. In the estate sector field clinic are conducted by MOH. In addition in the mid 1980's, sterilization facilities were also available in several smaller institutions such as divisional hospital and estate hospitals. However, sterilization services are no longer provided in the smaller institutions.

The current recommendation is to have one field clinic per 10,000 population (the number of clinics may vary depending on the population density). To be registered as a FP clinic a minimum of four modern contraceptive methods must be provided. Every clinic providing FP services is assigned a registration number and a minimum of two clinic sessions should be conducted per month. Until recently the RHMIS does not provide information on the number of registered FP clinics that are functional. The new annual data sheet collects this information.

MOH conducts field clinics in addition to the clinics conducted at the MOH office itself. Some MOH clinics and outreach clinics were located in facilities that did not belong to the health sector. Many MOH and DH are in close proximity to each other, sometime in the same premises, e.g Kondavil, Lahugala, Madulla and Suwawila but it must be noted that services are organized differently. These DH in some cases did not provide all methods of contraception. Almost all the PMCU that were visited did not provide FP.

Figure 6.1: Madulla MOH and Divisional Hospital Moneragala District

The PHMs distribute condoms and OCP during home visits and at weighing centres. PHM's provided only 11 percent of the contraceptives at the time of the 2006/7 SLDHS. Between the 2000 SLDHS and the 2006/7 SLDHS contraceptives distributed by the PHMs have decreased by 57 percent. KI and FGD indicate that there has been a decline in home visits by PHM.

The population in some PHM areas exceeded the norm of 3000 population. This made it difficult for PHMs to provide services.

P10 The population in some PHM areas is too much.
P11 Limit the population in a PHM area to 3000.

FGD PHM, Galle

As mentioned in Chapter 5 PHMs find deputizing for vacant midwife areas a major obstacle to providing information and services. While PHMs in many areas have been provided with motor scooters to increase their mobility, they have not been distributed in some areas such as Kalmunai and Jaffna.

PHMs are expected to have an office in their area. Many had difficulty hiring office space with the allowance that was paid for this purpose. Some of these offices were rooms or part of rooms in private residences with no separate entrance.

It's not a whole room, they (owner) give part of a room they are using. They don't give the whole room, do they? They give part of it where you can keep desks and use.

FGD PHM, Colombo

P6 We have rented out our offices in some homes. So when they ask us to leave we have to move to another place. When we move frequently, the mothers have to search for our location every time… (Smiling). If it is a center it will always be in one place no. but here we have to frequently move places.

P4 And the office rent given to us is only 250/=, now we can't get a room for rent for 250/= anywhere in Jaffna. Its very difficult. Its 1000-1500/= range.

P2 In this area it becomes 3000/=, if two medical students are staying they pay 6000/=, so they expect at least 3000/= from us.

P8 When the office is inside a home, they don't allow outsiders into the office. So everything needs to be discussed outside. But everyone won't feel comfortable to speak outside. They will ask to come into the office. But the house owner will not allow to come inside. That is a problem.

FGD PHM, Jaffna

Despite the wide network of health facilities in the public sector women faced difficulties in accessing services.

P2 If want to get the injections, they ask the clients to wait for 2 hours in the hospital and after that only they let them go. And the Teaching hospital and the Thellipalai hospital are far for them. So because of that also some people don't go, saying they have to leave their babies at home. So they don't go because of this delay.

P6 Earlier we were giving injections in PMCU. At that time the contraceptive usage was also high. But now when we ask them to get the injections they agree with us but do not go for it. Earlier the injection users were in high numbers but now it is only 5-6 clients who use it.

M So now you are not providing injections in PMCU?

P6 No, we have stopped it.

P4 But most of the mothers like injection. They find it comfortable, since it is once in 3 months. But because of these problems….

FGD PHM, Jaffna

An assessment of spatial patterns, distribution, and provision of public sector FP services has not been conducted to ascertain the accessibility of services.

Frequency of services

Facilities must offer contraceptive services regularly in order to meet clients' needs. According to General Circular FHB/FB/01/2015 issued by the DGHS all specialist hospitals up to the level of Base Hospital should have a dedicated FP clinic functioning for 6 days of the week. Non- specialist hospitals upto the level of PMCU should provide FP services 6 days of the week. Institutions with Consultant Obstetricians and Gynaecologists are expected to provide female sterilizations services for at least 4 hours per week.[49] In practice, however, very few institutions are able to comply with these directives. Some of the Teaching Hospitals and larger hospitals such as DGH Trincomalee, BH Homagama have dedicate FP clinics which are held from Monday to Saturday. Some DGH and BH have FP clinics on a designated day. In other hospitals with obstetricians and gynaecologists FP services are provided at the gynaecology clinic. In some hospitals, IUD and implants are inserted in the wards on any day of the week if there are clients.

MOH clinics provide FP services on fixed days, either as part of polyclinic (ANC, CWC and FPC), combined clinics (ANC /FPC or CWC/FPC) or a standalone FP clinic. WWC clinics and NCD clinics are also opportunities to provide FP to older women.

NGO and private sector sources of FP

At present the NGOs, PSL and FPASL provide FP services, except sterilization, at their static clinics throughout the country. NGOs and private facilities offer FP services for five or more days per week. Mobile outreach services was an important means for expanding access to long acting and permanent methods of contraception, particularly in areas where the static health clinics are some distance away from settlement.

Both PSL and FPASL were providing such services. However, by circular FHB/FB/011/201 dated 11.2.2013 the mobile family planning clinics conducted by NGOs were suspended. There was a perception that the mobile clinic used coercion to perform sterilization on the estates.

Earlier there were mobile services and there was a problem saying that they are doing unnecessary LRT.

FGD Estate Medical Assistants, Nuwera Eliya

KI in the public sector said they had seen many complications such as wound infection from LRTs done by these mobile clinics in the past.

According to the President, Pharmaceutical Society there are approximately 4000 registered private sector pharmacies in the country. Many of them sell condoms, OCP and EOC. A registered pharmacy is expected to employ a qualified pharmacist who is registered with the SLMC. Currently there are about 1200 members belonging to the Pharmaceutical Society of Sri Lanka. In addition to the private sector pharmacies the State Pharmaceutical Corporation (SPC) has 39 outlets, 189 franchise outlets, 12 authorized retailers and 52 distributors. General practitioners (GP) provide contraception based on their training. In most areas, e.g GPs and government MO engaged in dual practice are an important source of DMPA. Whether all these private sector service providers had equipment to deal with an anaphylactic reaction is doubtful. The private hospitals also provide FP services on request. In addition condoms are provided though groceries as part of the social marketing programme of FPASL and PSL.

Many couples having difficulty conceiving consult a specialist in the private sector directly bypassing the PHM and MOH. Ideally, couples having difficulty in conceiving are expected to be identified by PHM and entered in the eligible couples register. At the MOH they are examined and in most instances referred to the closest hospital with an obstetrician and gynaecologist for evaluation. During FGD we found that in a few instances couples also consult traditional healers.

In government hospitals subfertility services are provided through the gynaecology clinics. The FHB Clinic carries out basic investigations and treatment of couples such as ovulation induction and IUI. The Castle Street Hospital for Women and TH Mahamodera have dedicated units for subfertility and FP. They do not have dedicated wards for admissions and conduct of investigations such as laparoscopy. Most public sector obstetricians and gynaecologists interviewed as KI mentioned lack of equipment and availability of laboratory services as barriers to providing subfertility services. The number of private centres providing subfertility and ART according to KIs is around 7 in Colombo with 2 in Kandy.

FPASL provides the following services for subfertile couples - providing awareness on fertile days, fertility scan including follicular tracking, ovarian stimulation by medication, Seminal Fluid Analysis (SFA), tubal patency tests and Intra Uterine Insemination (IUI).

Approximately 10 percent of subfertile couples who undergo fertility treatment will require advanced fertility treatments. The opinion of KI on the number of ART centres the country should establish in the public sector differed from three throughout the whole country to one in each province. According to a KI subfertility services should be provided at different incremental levels for investigation and treatment.

9. Equipment and staff to provide quality rights based FP services

Context – Minimum infrastructure (e.g a clean water source, waiting area, etc), equipment (e.g. sterilizing equipment, IUD and implant insertion kits) and supplies such as contraceptives, gloves and linen are necessary to provide quality FP services to clients. In order to provide rights based FP services facilities should be able to ensure some level of privacy for consultations and have FP guidelines and appropriately trained providers. Lastly, when a facility is adequately staffed by well-qualified personnel, FP providers can serve a greater number of clients more effectively and efficiently, thus improving the quality of services.

A number of studies have found that high quality of care in FP is associated with an increased uptake and continuation of FP use.[6,7,8] In a study conducted in the Colombo RDHS area De Silva and Fonseka found that many clients were dissatisfied with the physical conditions of the clinics (> 20 percent), information received (12.5 percent), opportunity given to discuss their problems with the service providers (18.8 percent) and waiting times (26.6 percent). On the other hand, the majority of clients were satisfied with many aspects of the service such as the FP method received (94.5 percent), confidentiality of information shared with the provider (96.1 percent), competency of provider (97.5 percent), and physical access to clinics (92.3 percent).

Staff with special skills and facilities with laboratories and special equipment are needed for provision of quality subfertility services.[9]

Findings

Basic Amenities in hospital and MOH clinics

The availability of basic amenities such as external signs advertising FP services, a sheltered waiting area, regular electricity, clean water, visual and auditory privacy during consultation and a functioning latrine for female clients were looked for during visits to health facilities.

Most sites had external signs advertising what services were provided and when FP services were available. In general, the clinics were clean. The spaciousness of waiting areas varied. In curative institutions especially, the waiting areas were generally crowded and seating arrangements were inadequate. Most clinics that were visited had electricity, acceptable toilet facilities and water on tap. Even in the Colombo district there were MOH clinics that faced interruptions to water and electricity.

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[6] Arends-Kuenning, M., and F.L. Kessy.. The Impact of Demand Factors, Quality of Care and Access to Facilities on Contraceptive Use in Tanzania.2007Journal of Biosocial Science 39:1-26.

[7] Blanc, A. K., S. L. Curtis, and T. N. Croft. 2002. Monitoring Contraceptive Continuation: Links to fertility Outcomes and Quality of Care. Studies in Family Planning 33(2):127-40.

[8] Mariko, M. 2003. Quality of Care and the Demand for Health Services in Bamako, Mali: The Specific Roles of Structural, Process, and Outcome Components. Social Science & Medicine 56(6):1183- 1196

[9] De Silva U, Fonseka P. Quality of care in Government family planning clinic services in Colombo District. 2008. Ceylon Medical Journal;53: 121-127

During FGD clients were critical of the amenities in some clinics.

P4 We are going to another clinic for loop insertion. Here they do not insert since here there are no facilities. Space is also less. We have to go to Park estate. There people from Park Estate and other places will come. Because here the space is less.

M Then is transport difficult.

P14 Yes. Difficult. We have to go to another area and it is far.

P4 Sometimes there are no toilet facilities.

P1 Yes, toilet space is a problem.

P4 There's even no water. In Park Estate we have to carry our own water. Here we have water but not there.

FGD Married women 18 -29, Nuwera Eliya

Service providers also pointed out lack of infrastructure.

> *We don't even have a MOH office. We are in DH Kondavil. We are providing the services from there. So for the mother to come and wait, and to sit there is no space. If a mother comes she has to go through some difficulties.*

FGD PHM, Jaffna

Some clinics that were located in facilities that did not belong to the MoH or Provincial Ministry of Health were not ideal as the building was not constructed initially with a clinic setting in mind, even though these clinics increase access to service. For instance, the female toilet was not situated in the clinic premises itself but was located in another part of the building.

> *We have no place. We have the clinic in Pradeshiya Sabha. The clinic is held at the place where meetings are held because these days there are no meetings. There's no room. So there is no place to put a loop even.*

FGD PHM, Galle

An important aspect of quality of care is auditory and visual privacy, particularly during counselling and medical examinations. A lack of privacy makes it difficult for clients to speak freely with health care providers. Counselling and examination settings are often cramped. In the absence of such spaces, clients' consultation with health providers were quick and often cursory and further compounded by both a high client load and limited waiting space. All the private sector institutions and NGO clinics that were visited during the review had good facilities including comfortable waiting areas and examination rooms that ensured visual and auditory privacy.

Waiting time

During FGD clients complained about the long waiting time in public sector institution.

> *I am a seamstress. I find it difficult to go to a government institution because of the long waiting time. I would be best if we are given appointments.*

FGD Married women 18-29 years, Galle

Where polyclinics are conducted most MOH tried to reduce waiting time for clients by giving appointments for FP clients late in the morning so as to manage client flow. Clients resented the fact that the waiting time could be reduced in government institution only if there was a person known to them on the staff.

> *If you know someone in a government hospital you can be seen quickly. Otherwise you have to wait in the queue for a long time.*

FGD Married women 18-29, Galle

Equipment and supplies

Most clinics that were visited had basic equipment to ensure quality of care such as a functioning blood pressure apparatus and stethoscopes.

Basic requirements for pelvic examination

Pelvic examination is usually necessary to assess medical suitability to insert a IUD or to evaluate problems with method use. Infrastructure for infection control and pelvic examination are therefore essential. The IUD is unique among temporary FP methods as it requires a pelvic examination before insertion. In order to conduct a quality pelvic examination for FP clients a private room to provide visual and auditory privacy, an examination bed or couch, an examination light, and a vaginal speculum are prerequisites. Most clinics had examination beds and lights.

Figure 6.2: Storage of DMPA at a clinic

Availability of equipment and supplies for specific contraceptive methods

A variety of equipment and supplies is necessary in order for facilities to effectively provide different contraceptive methods safely and to monitor clients. Some clinics that were visited did not have stocks of condoms, implants and DMPA. Contraceptives were stored in steel or wooden cupboards in clinics and wards. DMPA vials were not stored vertically.

Combined oral contraceptives

Women receiving COC should have their blood pressure monitoring. All facilities offering OCP had a functioning blood pressure apparatus and stethoscopes.

Injectable contraceptives

All facilities had sterile needles and syringes. In addition, the availability of an emergency tray to counter anaphylaxis was available in most institutions providing DMPA. However, some clinics did not provide DMPA because of lack of equipment to treat anaphylaxis. Many field clinics do not have oxygen

cylinders and are reluctant to provide DMPA. Uduvil MOH clinic provided all temporary methods except for DMPA. They do not have oxygen, ambu bags or an ambulance in case of anaphylaxis. Another aspect we looked at during the visits to clinics was the expiry date of the adrenaline in the emergency tray. An important observation was that in some clinics the adrenaline vials were close to the expiry date but until questioned the nurse in charge was not aware of it.

Implants

All items for implant insertion - sterile gloves, antiseptic solution, sponge-holding forceps, local anaesthetic (lignocaine), sterile syringe and needle, scalpel with blade and the implant with inserter – were available in the facilities where the method was provided.

Intrauterine contraceptive devices

The items required for IUD insertion such as disposable latex gloves, antiseptic solution, sponge-holding forceps, Cusco's speculum, vulsellum forceps, uterine sound, and examination table and examination lamp were available on the day of the visit in most institutions providing this service. Nuwera Eliya DGH clinic lacked a lithotomy bed and had to send patients to the ward for IUD insertion. Some institutions lacked sufficient IUD sets to do more than two cases a session. Some facilities did not have adequate number of speculum.

Female sterilization

Both laparoscopic sterilization and mini-laparotomy are carried out. Some hospitals even in the same district do not have similar facilities. For instance, TH Jaffna carries out laparoscopic sterilization while BH Manthilai does not have a laparoscope and mini-laparotomy is the method used. Moneragala DGH reported they were short of fallope rings. Female sterilizations are carried out under general or regional anaesthesia.

Availability of FP services

We observed during field visits that some facilities though registered as providing FP services did not provide 4 methods of contraception. The reasons for this varied:

- Some facilities reported unavailability of a particular method, e.g implant, injectable;
- Unavailability of trained staff;
- The availability of another facility in the vicinity which provided all methods. (There were some institutions such as DH which provided only two or three FP methods. This was because the MOH was close by or there were no trained staff).

Standard Precautions for Infection Control

Strict compliance with infection control guidelines and constant vigilance are necessary to prevent nosocomial infections. During our visits to institutions we assessed the presence of items for infection control in areas where FP procedures such DMPA injection, IUD and implant insertion took place. The presence of the following items for infection control were noted - washing supplies (running water and soap or else hand disinfectant), latex gloves, disinfecting solution and a sharps box. We found during our field visits that some facilities did not have autoclave drums.

We don't have enough autoclave drums.

FGD PHM, Colombo

Hence, clients requesting IUD were referred to other institutions. Some clinics had issues with sterilizing implant packs as the capacity of the sterilizer was inadequate. Many MOH clinics faced the problem of laundering linen. In some clinics the minor staff or the PHMs washed the linen.

Maintenance and Repair of Equipment

To provide rights based quality services a facility must have the means to ensure that equipment and infrastructure are in satisfactory condition. Some equipment requires routine preventive maintenance, while other equipment may require minor repairs or replacement. Long term maintenance agreements have been entered into with the suppliers for equipment such as laparoscopes. Replacement of small items of equipment such as speculum, forceps etc. are requested from the RMSD. They are supplied if available. The MOMCH collects information on functional equipment and those needing replacement annually.

The FP Unit has attempted to collected information on the status of equipment in the FP clinics through a survey in 2015. According to the FP Unit the data is incomplete. There is no routine system for FHB to collect information from clinics on the requirements of equipment and supplies. Under devolution these equipment should be procured by the provinces themselves but in order to maintain quality and gain from economies of scale the FHB procures equipment for the provinces. In 2016 due to a shortage of funds the FHB had requested the provincial health authorities to procure the necessary equipment using World Bank funds from the Health Sector Development Project.

Buildings and infrastructure also require routine maintenance and periodic repair. Some of the clinics in the north and east have been rebuilt after the conflict and tsunami and are in good condition. The infrastructure in some of the clinics visited in other parts of the country needed improvement. We also saw examples where the private sector had renovated and built public sector clinics e.g. the Antler Group of Companies had renovated the Jambureliya Clinic in Piliyandala. When buildings belong to the local government authorities need renovations or repairs it is not easy for the provincial health authorities to carry out modifications to them.

Equipment and laboratory services for investigation and treatment of subfertilty

The lack of laboratory facilities to carry out basic investigations such as seminal fluid analysis (SFA) is a serious problem in many districts. It was only in DGH and TH that laboratory facilities to carry out SFA were available. Some TH with University units carried out the hormonal assays, some others sent blood samples to MRI. Hormonal assays have to be carried out in the private sector in most instances. Some base hospitals did not have laparoscopes and were unable to perform diagnostic laparoscopy e.g. BH Manthilai. Very few public sector hospitals could carry out sperm preparation for IUI.

Sophisticated laboratories and equipment are needed for centres providing ART and for such centres team work is of the essence. The team should comprise of a Gynaecologist, andrologist, embryologist and a counsellors. The SLCOG has drawn up the minimum requirements including equipment for such a centre.

Visual aids for FP clients

The FHB and HEB has developed the following IEC material.

1) Leaflets- Common
   - IUD
   - OCP
   - Implants
   - Condoms
   - DMPA
   - LRT
   - ECP
2) Docu-drama on all methods
3) Dildo for demonstrating condom use
4) Flash cards of the different methods

In addition to the HEB / FHB material, some public sector hospitals and NGOs printed their own IEC materials. The efforts of these organizations is commendable. However the messages should be uniform and should not conflict with the messages of the national programme. In some facilities service providers had shown initiative by devising their own IEC material by pasting the different methods on a cardboard sheet.

The availability of FP communication materials in health facilities shed some light on one source of FP knowledge within communities. FGDs and visits to facilities showed there are very few printed IEC material on FP available on display (e.g. wall charts, flipcharts, and pamphlets) in public sector clinics both in the preventive and curative side. We did not observe any IEC material on subfertility in the public sector clinics. In some instances the IEC material was not displayed but locked up in a cupboard. In some clinics the IEC material was given to the clients to read and after which they had to return them.

P4 *Can't say that it is available freely. But we don't have in amounts to issue it for them to take. We can't give it to them, even if they ask to take it. We ask them to read it then and there and get it back.*

M Oh… So you don't have that much… so you can't allow them to take it home.

P2 No…

P4 We don't have that much…

FGD PHMs, Jaffna

In addition, not all material were up to date, messages were not targeted to specific audiences, such as youth or men, and could better reflect local languages, customs and literacy levels. In areas that catered to both Tamil and Sinhala speaking areas there was a paucity of material in Tamil e.g. Nuwera Eliya and Trincomalee.

FGDs with both service providers and clients suggested a number of ways to strengthen communication on FP such as:

- that FP communication materials are culturally appropriate and target those who influence decisions around FP use;
- materials are more user friendly to clients with low literacy rates by incorporating more graphics and artwork;
- the potential of videos as a means of disseminating FP messages.

Only some of the health facilities that were visited in the course of the review had videos on FP and media equipment.

The SuwaSeva clinic run by FPASL in Nuwera Eliya uses videos produced by FPASL and HEB and has found this modality to be very effective.

Visual aids for staff

Visual aids are important elements in good FP counselling. Clinics are provided with job aids such as flash cards, flip charts and samples of various FP methods to use during counselling. These materials were developed many years ago and need to be updated. For instance they do not include the newer implants that are in use.

Guidelines on FP in Sri Lanka

The FHB has produced the following guidelines on contraception:

- Guidelines for service providers on combined oral contraceptive pill (OCP) and DMPA injectable contraceptive 2010
- Guidelines for service providers on IUD insertion and removal 2010.
- Guidelines for service providers on mini-laparotomy for female sterilization. 2012

Most of the clinics visited during the review did not have the clinical guidelines available. Only a few clinics had them in Sinhala. These guidelines were not available in the service delivery areas for quick reference. Some MOHs had shown initiative and downloaded the guidelines from the FHB website. The guidelines need to be updated and a guideline on implants needs to be developed.

The FP unit has adapted the 3rd edition of the WHO Medical Eligibility Criteria Wheel and printed it in 2013. It has been distributed to MOHs and hospitals. Not all the MOH we met during the review had received the Medical Eligibility Criteria Wheel. Other members of the MOH team were unaware of the WHO Medical Eligibility Criteria Wheel. During the review we found that many service providers were not familiar with the MEC for common conditions.

In addition to the guidelines on contraception the FHB in collaboration with the SLCOG has produced the National Guidelines on Post Abortion Care now in its second edition (2015) and the Manual for the Primary Health Care Provider on Subfertility (2004).

Human resource

The Macro issues related to HR has been dealt with in Chapter 5. In this section we deal with some issues related to human resources and service delivery that were observed during the review. Many KI at policy level at central, provincial and district level as well as facility managers identified inadequate staff of all categories as one of the major constraints in providing FP services both in curative institutions and in the field. We have already alluded to the difficulties PHM face in deputizing in vacant PHM areas. Many facilities do not have an adequate number of appropriately trained staff to meet the FP needs of clients. This also contributes to long waiting time for clients. DGH Nuwera Eliya Hospital did not provide implants because until recently it did not have an MO trained in inserting and removing implants. BH Chavakacheri does not have a consultant obstetrician and gynaecologist and therefore does not carry out sterilization. Inadequate human resources e.g. PHM, to deal with the average daily client flow leads to long waiting time for clients. The position of AMOH is vacant in some areas and limits the number of FP clinics that can be conducted.

Another issue is the high turnover of trained staff, especially MOs which leads to breakdown of services. KI said there are instances where MOH are appointed through the annual transfers who have not been trained in FP. Since it is the MO who provide implants and IUD these services breakdown until such time as the replacement officer receives training. In the absence of a MO the PHNS inserts an IUD.

Though the duty list of the PHI includes RH and specifically promotion on male participation in RH we found very little evidence of this. The PHI is an underutilized human resource for FP.

There are 230 Estate Medical Assistants (EMA) on the estates providing health services. The EMA cadre will be phased out eventually. The EMAs are paid by the Plantation Human Development Trust (PHDT). On the estates the EMAs assist the MOH to conduct monthly clinics on the estates. During the field visits KI said there was friction between the EMAs and the government PHMs posted to the estates. The EMAs reside on the estates and have long years of service and are trusted by the people. One reason for this is because they are fluent Tamil speakers. Several KI in the public sector said that EMA exceed their competencies. Some even remove implants. Government PHMs are appointed to most estates with the support of FHB. Most PHMs do not reside on the estates and are not available after working hours and during weekends when the workers are free. Many of them do not speak Tamil. In the past EMA provided pills condoms and DMPA. Currently 70-80 percent of PHM on the estates are appointed by the government while the rest of the PHMs are paid by the PHDT.

Inability of health workers to communicate effectively in the language of the people they serve are barriers to service delivery for some groups such as clients in the estate sector. This was also observed in Trincomalee. KII and FGD with clients indicated that the lack of gender concordant care played a part in the acceptability of FP services. Some clients preferred a female service provider, especially for IUD insertion.

10. Provider training and skills

Context - Pre-service education, induction training/ orientation, in-service training, post-graduate training and continuous professional development are the educational building blocks of health workforce development. It is essential that FP providers have the skills to provide rights based quality services. Service providers should be adequately trained to offer comprehensive FP counselling so as to ensure that clients make an informed and voluntary contraceptive choice and for maximizing their correct and consistent use of the method.[10] Strengthening family planning providers' technical and interpersonal skills through training can enhance the quality of care and thus increase clients' satisfaction with services. Their training should also include preparing them to reach those couples and individuals with an unmet need for contraception.

In-service training of service providers is necessary to improve and sustain the quality of counselling, management of complications of side effects and provider's skills. In-service training in this section refers to structured sessions and does not include individual instructions that a provider might have received under routine supervision.Not all providers need to be skilled in providing every method. The level of skill needed depends upon the division of labour within a facility and the level of the facility itself. Training is also important for staff, as it empowers them, improves their morale and interpersonal skills, and exposes them to new ideas. FP providers should be knowledgeable to provide basic information on subfertility to couples having difficulty in conceiving. Rigorous postgraduate training is necessary for those providing advanced subfertility treatment.

[10] Hock-Long, L., Whittaker, P. G., and Herceg-Baron, R. Family planning service delivery research: A call to focus on the dynamics of contraceptive use. Perspectives on Sexual and Reproductive Health 2010. 42(1):10–11.

Findings

Different components of training in relation to FP are carried out in Sri Lanka

1. Pre-service training
2. Induction training / orientation
3. In-service training
4. Post-graduate training
5. Continuing Professional training

Pre-service training

PHM and institutional midwives

Due to difficulties in recruiting PHM with passes in science subjects at the GCE AL this requirement was done away with recently and opened up to all streams. Currently midwives receive an 18 month pre-service training. The phase one training is conducted in an NTS located in a provincial centre for 12 months followed by 6 months field training which is coordinated by NIHS. During this 6 month period they are 'attached' to a senior PHM.

The curriculum revision of PHMs commenced in 2010 based on an assessment of their workload and following a policy dialogue on the relevance of the tasks of PHMs. The curriculum revision was undertaken through a series of consultative meetings with stakeholders and was supported by UNFPA. Competency based training is provided in relation to the tasks they are expected to perform. Case scenario based learning has been introduced in addition to lecture discussions. Role play is used to train PHMs on FP counselling. KI said that the recent batches of students without a science background found anatomy difficult in the initial stages but gradually picked up. KI also said that the role of the Tutors was limited under the new curriculum and most of the didactic teaching was conducted by doctors.

The career prospects for PHMs is limited. After 12-15 years' service they can aspire to be SPHMs.

Nurses training

Nurses are trained at Nurses Training Schools throughout the country. They follow a 3 year course which also includes FP as part of obstetrics and gynaecology.

Training of PHI

PHIs undergo a training of 18 months prior to deployment.

Medical officers (MO)

FP is taught in the undergraduate curriculum of the Sri Lankan medical schools by the Departments of Obstetrics and Gynaecology and Community Medicine. In addition the Departments of Pharmacology teach about the hormonal contraceptives. Universities with Family Medicine Departments also teach family planning as part of opportunistic teaching. KI from the Departments of Obstetrics and Gynaecology and Community Medicine were unaware of circulars related to their fields that are issued periodically by the MoH.

Pre-service training institutions

Sri Lanka has preservice training institutions for health workers both in the public and private sector. There are eight Universities in the country that produce medical graduates. There are no private medical schools in Sri Lanka that are recognized by the SLMC at present. As a consequence many young Sri Lankans travel abroad to study medicine. On their return in order to practice medicine in Sri Lanka they have to be successful at the Examination to Practice Medicine (ERPM) conducted by the SLMC. Passing this examination enables them to apply for Provisional or Full Registration with the SLMC.

There are Nurses Training Schools throughout the country which conduct training for nurses and the PHM training part 1. These NTS are under the administrative control of the Director of the Hospital which provides clinical training. In addition, there are nursing schools in the private sector as well.

The National Institute of Health Sciences

The National Institute of Health Sciences (NIHS) is responsible for development of human resources for public health in the country. The NIHS has recently revised the PHM Part II curriculum. The Part I of the PHM curriculum was revised by the ET&R Unit of the MoH. The NIHS has also reviewed and revised the MOH curriculum, and the SPHM curriculum. The NIHS conducts the following basic training programmes relevant to FP.

- PHM field training (part II)
- PHI diploma
- Certificate of proficiency as pharmacists

The NIHS conducts post basic training courses relevant to FP:

- Public Health Nursing Diploma Course
- Nursing Tutor (Public Health) diploma course

The following in-service training courses are conducted by NIHS which are relevant to FP.

- Orientation on Management of Community Health for MOH / MOMCH) / MO (PH)
- Pre placement Training for Post Intern Medical Officers (AMOH)
- Supervising Public Health Inspectors' Training
- Supervising Public Health Midwifes' Training

Regional Training Centres (RTC)

The Regional Training Centres conduct the Part 2 (field) training for PHMs. In addition these RTCs also conduct courses for the PHIs.

Challenges to the basic training programmes for field staff

During our visits to the NTS and RTC we found that these training programmes face several challenges:

- Infrastructure of the schools varied. The conditions of recently built NTS such as the Ampara school were in good condition while some of the older schools such as the NTS in Jaffna and Galle require considerable repairs and renovations;
- While there were multimedia etc for teaching, the skills labs were poorly equipped. For instance there were very few models the students could practice on;

- Inadequate numbers of teaching staff;
- Lecture discussions were conducted mainly by visiting doctors. Sometimes lectures had to be postponed as they were not available due to service commitments.
- The doctors in the RTC were transferrable. Thus, the skills of these trainers is lost;
- Many KI expressed the opinion that counselling skills need to be strengthened in basic training programmes;
- Regular refresher training of trainers in the NTC and RTC was needed;
- There is no involvement of the institutions providing pre-service training and subsequent practice.

Induction training / orientation

MOH / AMOH

The MOH receives 8 weeks training in public health management. The MOH is responsible for supervising the AMOH, PHNS, SPHM and PHMs in the area.

MOMCH

The MOMCH is a doctor who is responsible for all MCH activities in a district. The MOMCH receives 2 weeks training at FHB. Some of the MOMCH are post-interns while others may come from the curative sector or have served as an MOH previously.

The MOH and MOMCH are expected to undergo induction training at the NIHS and FHB. These trainings do not always take place prior to assumption of duties but is conducted as soon as possible. During the review we came across some MOMCH and MOH who had not attended the trainings. They cited the absence of a AMOH to relieve them or exigencies of service as reasons for not attending the trainings.

Post-basic training

SPHM

PHMs with 12-15 years' experience are selected as SPHM. They undergo a three month training at NIHS on management and supervision aspects. SPHMs should ideally supervise 10-12 PHMs depending on the area.

PHNS

PHNS are nurses with five years of experience who have had an additional 18 months training. Of this, 6 months is spent in post basic midwifery training doing deliveries and 12 months training in public health at the NIHS. PHNS supervise SPHMs and PHMs in an MOH area. The career prospects for PHNS are Regional Supervising Public Health Nursing Officers (RSPHNO) or matron.

Post-graduate training

MO-RH

The Postgraduate Institute of Medicine (PGIM) awards a Diploma in Reproductive Health. The course duration is one year. There is a module on FP in the course. Some of these diplomates are engaged as full time MOs in hospitals that have established dedicated FP clinics e.g Castle Street Hospital for Women. Others may not be working in RH related fields. Even those who are currently working as MO-RH are liable to transfer and may not engage in RH thereafter. A mechanism has not been established to retain the services of these diplomates. A senior policy maker at the MoH said that there were plans to make a "closed

service" so as not to lose the expertise of this category of staff. By having a closed service even if a diplomate is transferred the new post the staff member is transferred to will also be a RH related one, thus retaining their skills.

Obstetricians and Gynaecologists

Obstetricians and Gynaecologists undergo a 5 year training including one year of training abroad. They are then Board Certified by the PGIM. Subspecialty training in infertility is for 3 years. Currently there are only two gynaecologists who are Board Certified as sub-specialists in subfertility. Crucial member of the team when providing advanced treatment such as IVF and ET in addition to the gynaecologist are the embryologist, andrologist.

In-service training (IST)

In-service training organized by FHB

Currently the main thrust of IST organized by the FP unit is to increase the number of service providers so as to provide all temporary methods. Both theoretical and practical training on FP for MO/MOH, RMO, AMO and PHNS is carried out at FHB. Two types of training were conducted in the past – one day training for MO, MOH, RMO, AMO and PHNS on IUD insertions and a one day training on implant insertion for MO. No evaluation of trainings has been carried out recently.

The FP unit has changed its strategy since 2015 and is currently conducting the following trainings:

(a) A three day Training of Trainers on FP and emergency management for MOMCH, MOs, MOH, CCPs and consultants and MOs from the NSACPat FHB. The training has theoretical sessions as well as practical sessions on models followed by lecture demonstrations on clients. Comprehensive training on implants and IUD is chronically challenged by the limited number of clients available so trainees could practice several procedures under close supervision. Trainees observe the insertion of implants and IUD carry out a few procedures under supervision. They are expected on their return to their duty stations to carry out a minimum of five IUD insertions, three implant insertions and removal of two implants under the supervision of a previously trained MO before they are certified by the FHB. They are expected to function as district level Master Trainers of MOs and other categories of staff. Although 262 MO have been trained by December 2016 under this programme to date only 33 have so far have applied to FHB for certification. The cost of a programme for 25 participants is on average SLR 83,544. The FP unit has a training plan which indicates the number of trained service providers by category and the numbers to be trained. Many MOs and MOH who attended the training said the training they received was comprehensive. Some of them were already carrying out procedure at the time they attended the training. According to a KI poor attendance of MO for training programmes is a major issue. Very few MOMCH have undergone this training, though they are considered as district level technical leads.

(b) The district Master Trainers in turn conduct a two day training at district level which includes a session on subfertility. A total of 16 district level training have been carried out by December 2016. An evaluation of these trainings is necessary. This is because of the high failure rates and discontinuation rates of IUD and implants.

(c) The FHB also conducted a 2 day course on subfertility for Medical Laboratory Technicians. (MLT).

(d) A one day training on supply chain management targeting OIC/RMSD is also conducted by the FHB.

(e) A one day orientation on FP for hospital staff has been commenced recently. The number of participants is around 40.

In the past PHNs underwent a 5 day training on FP and IUD insertion following which they too receive a certificate. This IST was greatly appreciated by many who had undergone this training. Currently PHNs receive a 2 day training on FP and a one day training on IUD.

In addition to the FHB initiated trainings we found that the Jaffna MOMCH took the initiative to arrange training at district level with the obstetricians and gynaecologists at the Teaching Hospital.

In-service training at MOH level

One of the duties of the MOMCH is capacity building. An assessment of training needs in the district is conducted based on supervision findings and performance data by the MOMCH and included in the district plan at the beginning of the year.

Every MOH area has a designated in-service training day. Different topics related to the work of the MOH and not necessarily FP are selected. The training takes the form of lectures and discussion. In-service training day at the MOH addresses some of the issues identified in the field. Many PHMs and PHI said they had received in-service training on aspects related to their work including FP during the monthly conference and in-service training day. FGD participants at monthly in-service training programmes were critical of the manner in which the trainings were conducted.

P3 Although we have in-service that is also boring type. There is only one way communication. That means you take what is given from here. There is no discussion. No discussion anywhere. You just take what is given.

P7 Everything is packed. This person does within this period and the other next. Like that… the person who comes is trying to finish it off soon.

P3 They give us the chance too. They'd say we are doing a lesson and if you need you can speak as well. Though they say, through that one way communication is going.

FGD PHI, Colombo

*In-serv*ice training and service delivery

There appears to be a gap in service delivery functions and knowledge of service providers. Some examples from FGD with PHMs are given below.

Even though the PHM does not insert the IUD or implants, as the first contact with clients they need to know the side effects of these methods.

We felt that we need trainingon IUD and Jadelle. There are issues about them and side effects. So we asked the matron and she did it for us.

FGD PHM, Nuwera Eliya

PHMs also requested for familiarization with the medical eligibility criteria.

We need training on all the methods. And side effects and to whom to be given. And for which disease what method can be given?

FGD PHM, Jaffna

Nurses and midwives serving in obstetrics and gynaecology wards do not receive additional training on FP. Since the majority of deliveries in Sri Lanka take place in hospitals the knowledge and skills of this category of staff needs to be enhanced so they can promote FP prior to a mother being discharged from hospital and also to promote post abortion FP.

Almost all pharmacy providers reported interviewed said they had never received any training on FP, so even though they may not frequently restrict access to methods based on eligibility barriers, they may not have the knowledge and training to appropriately counsel and provide the methods. FPASL has provided training to this category of service provider.

MOs in curative institutions receive on the job training on FP if attached to an Obstetrician and Gynaecologist. MOs learn to carry out female sterilizations their attachment to obstetrics and gynaecology units. There is a certification mechanism for them.

All public sector staff had received some information on subfertility during their preservice training. Lansakara[11] found that the knowledge of the PHM on definition of subfertility which is critical in identifying couples who need help was poor. Their knowledge of risk factors, when to refer and fertile period was also poor. During the FGD with PHM and PHI many expressed the need for an update on subfertility.

> *We need training regarding subfertility and the treatment options for them.*
>
> ***FGD PHM, Jaffna***

> *And we need more knowledge on that regard as what to be said and how to identify their problem. We don't have that knowledge that much.*
>
> ***FGD PHM, Nuwera Eliya***

> *How can we help subfertile women to get babies? We need that knowledge.*
>
> ***FGD PHM, Kalmunai***

Issues with the current IST

Policy and planning There is no national in-service training plan for FP. The FP Unit has its own plan for the trainings it conducts. Training needs assessments may or may not be carried out at the district level . The MOMCH may include training in FP into the district MCH plan. The topics selected will depend on the training needs assessment if one is carried out. Training planned at district level are dependent on the availability of funds and resource persons.

Financial resources Financial resources for trainings initiated by the FHB are available and provided by the centre to the districts for ear marked training. According to KI very little funds are allocated from the district budgets for training purposes.

Faculty and trainers Faculty and trainers are not an issue for training organised by the FHB. However, ensuring standardization of trainings carried out in the districts is a challenge. There is no core group of designated trainers in the district. KI said that in some instance visiting faculty were not familiar with the NFPP objectives.

Trainees Most of the training conducted by the FHB are in Colombo. Several Ki said that the trainees that are identified do not attend the trainings. Nurses and midwives serving in obstetrics and gynaecology wards do not receive additional training on FP. Since the majority of deliveries in Sri Lanka take place in hospitals the knowledge and skills of this category of staff needs to be enhanced so they can promote FP prior to a mother being discharged from hospital and also to promote post abortion FP.

The FHB has tried to provide refresher training courses on FP to full time private sector practitioners and MOs engaged in dual practice but participation has been poor.

Curriculum For each training programme the FP unit has a set of topic. For instance the three day Training of Trainers Programme on FP has on Day 1 topics such as Introduction to NFPP, anaphylaxis workshop,

[6] Dr. L. H. M. N. Lansakaraof infertile couples". 2008 PGIM D1769.

contraceptive technology, management of subfertility.; Day 2 counselling skills; GATHER approach to FP; MIS in FP; handling of logistics in FP quality of care in FP; IUCD and practice session on model; implant insertion – video. Day 3- Implant insertion – practice session on model; lecture demonstration on client (implant); lecture demonstration on client (IUD); issues related to special groups in FP; counselling clients; How to conduct a ToT; management of complications of complications and side effects of FP. Some of the session were didactic lectures with handouts while other were of a more practical hands on nature such as the counselling sessions.

There is no formal training curriculum with learning objectives. For clinical trainings the major skills that trainees are required to gain are not clearly articulated and documented. There was a skew towards theoretical rather than practical aspects . MOMCH and MOH lack sufficient training on planning, implementing, logistics management and monitoring of FP programmes.

Training methods Training is mainlygroup-based. Individualized and computer-assisted learning is not available.

Evaluation and supportive supervision after training. Pre- and post-test evaluations are conducted for training conducted by the FP unit. Training of master trainers is evaluated in terms of numbers trained at district level but the impact of the training is still to be evaluated. There is no mechanism at present to follow up trainees at district level and provide supportive supervision until such time as they are sufficiently competent, especially in clinical methods. Since trained staff mainly provide services at facility level, their performance is closely associated with capacity of district and facility supervisory staff to provide supportive supervision. We have mentioned that some MOH and MOMCH have not undergone the stipulated training.

Lack of refresher training. There is no plan at present to provide refresher training to those who have undergone training on a regular basis.

Training database The FHB has a database of trainees who have attended the training programmes. This needs to be updated to a Training Monitoring and Information System at the FP Unit.

Continuing professional development.

Continuing professional development activities are conducted by the professional colleges for their members. They also provide training based on available funding on particular aspects e.g. PPIUD to other categories of health personnel as well.

11. Management, supervision and quality assurance (QA) and quality improvement (QI) systems

Context - Essential management and administrative systems need to be in place to support the provision of quality services, including quality assurance, monitoring and supportive management practices. This information is used by policy makers and providers to improve quality. Quality is also impacted by the motivation of providers to implement standards of care. Despite its importance, supervision is frequently one of the weakest elements of family planning and reproductive health programmes[12]. Supervisors can offer workers feedback on strengths and weaknesses, motivate them to improve their performance and improve their skills, provide needed coaching, assist with prioritizing a heavy workload, and help solve problems.[13] Rigorous QA mechanisms need to be in place for ART.

Supervision by external managers helps ensure that system-wide standards and protocols are followed at the facility level and promote an organizational culture that expects standards and protocols to be followed. External supervision provides an opportunity to expose staff members to a wider scope of ideas and relevant experiences, and it can also motivate service providers, especially if the supervisor is supportive.

Findings

Management meetings with documentation

It is necessary to have a system in place for identifying and addressing management and administrative issues related to FP. The present system of monitoring the provision of FP services includes the monthly conference conducted by the MOH; the two biannual MCH reviews at district level, a review of the MCH programme programme prior to the National MCH Review at district level, the National MCH Review at district level and bi-annual MOMCH workshops. The RDHS has Monthly Conferences with the MOH. The hospital directors meeting with the DG is another forum where FP related issues in institutions are discussed. These reviews are based on the information collected through the RHMIS from the PHM level upwards. According to KI these reviews concentrate more on coverage but should also seek to improve the quality of services.

Supportive supervision of service providers

Supervision of the NFPP is carried out at all levels of the health system. Joint supervision is encouraged. From the FHB periodic supervision visits are carried out to the districts by the FP unit staff. The FP Unit has developed a checklist for this purpose. At the provincial level the provincial director and provincial CCP conducts periodic supervision visits. According to KI at provincial and district policy making level supervision by MOH, AMOH and MOMCH is weak. In the district/health area, the RDHS is the administrative supervisor while the MOMCH, RSPHNO and SPHM provides technical supervision to the MCH/FP programme at district level.

The MOH, PHNS and SPHM are the officers responsible for MCH/FP Programme supervision in an MOH area. Policy makers at all levels who were consulted as KI were of the opinion that poor

[12] PATH and United Nations Population Fund. Meeting the Need: Strengthening Family Planning Programs. Seattle: PATH/UNFPA; 2006.

[13] Marquez L, Kean L. Making Supervision Supportive andSustainable: New Approaches to Old Problems. Washington, DC: Maximimizing Access and Quality Initiative (MAQ); 2002. MAQ Papers, Vol. 1, No. 4. https://www.k4health.org/sites/default/files/maqpaperonsupervision.pdf (Accessed:12.3.2016)

supervision was a major reason for the stagnation of the NFPP. Tools for supervision of PHNS and SPHMs were developed by the FHB in 2013. Each SPHM is expected to carry out 10 supervision visits a month while the MOH and PHNS are expected to conduct 6 visits per month. Advanced supervision plans are prepared by supervisory staff. During KII many supervisors admitted they were unable to keep to the plans.

Several district level policymakers said they had observed during supervision visits that eligible couples have not been registered by PHMs and that the eligible couples register has not been updated. The reduction of home visits is attributed by PHMs to the increased workload. However, some national, provincial and district level KI were of the opinion that poor supervision was a major reason for the reduction of home visits. Prospective clients who have fears about FP therefore do not have direct contact of the PHM to obtain reassurance. Discontinuation of contraceptive methods by clients is also attributed by KI to poor follow-up and management of side effects by PHMs.

There are good examples where the district leadership leads joint supervision teams to MOH areas and institutions on a regular basis.

Reasons for deficiencies in supervision

a) Inadequate number of supervisory staff

Many RDHS areas have vacancies for supervisory staff. This leads to infrequent supervision. For instance, Jaffna RDHS area has no PHNS. On average PHMs said they were paid a supervisor visit one in three months. The following dialogue is from the FGD with PHMs in Nuwera Eliya conducted in July 2016 on supervision of their work.

M When did they last supervise you?
P3 Sir for us there're no supervising officers. It is our miss (RSPHNO) who does the acting job supervision.
M So when did they conduct the last supervision?
P3 before 2 years.
P4 2014
P5 2012
P7 In 2013 sir that was there.
P8 In 2015 SPHM miss did it.
P1 I can't remember. SPHM comes to the clinic and usually supervises.

FGD PHMs Nuwera Eliya

b) Limited capacity of supervisory staff

Based on the Duty List for this position, the MOMCH is responsible for planning, coordination, monitoring and evaluation, logistics management and human resource development. A senior policymaker at MOHNIM said that "*the district MCH /FP programme depends on the MOMCH who is only a MO and has had 2 weeks training from the FHB. They don't even get a certificate. Formerly MOMCH were directly under the FHB. Now with devolution they are isolated from a technical point of view.*"

Some MOMCH's had experience as MOHs and were therefore able to handle the responsibilities. However, some had not had any public health exposure in the past. The criteria or experience required for the position of MOMCH is not set down. For instance, a post-intern can be appointed to this post. They can be appointed directly from the curative sector. One MOMCH who had come from the curative sector was interviewed as a KI. He said, "*There is a duty list but how to do what I am expected to*

do is not set down." Though logistics management is part of the duties several MOMCH said they had not received training. One said it was the nurse who did the estimations for commodities.

Several MOH's had not received the MOH training at NIHS. In many instances they claimed this was due to the unavailability of replacements to cover up duties while they attended training. They were forced to learn on the job.

SPHMs mainly concentrated on coverage and data completeness. Insufficient attention was paid to quality of services.

c) Lack of authority of MOMCH / CCP

The role of the MOMCH is providing technical assistance to MCH activities in the district. The KI at provincial and district levels said that sometimes there is friction when the MOHs are senior to the MOMCH in service. MOMCH are expected to provide technical supervision to institutions with the permission of the head of the institution. KI also pointed out that institutional supervision by some MOMCH was weak especially of units with consultant obstetricians and gynaecologists. One MOMCH said " We have no authority over PHMs. We are helpless in the field. The PHMs are under the MOH. We only provide technical inputs."

Provincial CCPs who were interviewed also expressed their inability to directly address issues they identified during supervision visits. Their role needs to be defined in the duty list which is yet to be finalized.

d) Breakdown in reporting lines

The dispute which arose in 2014 between midwives and nurse about training nurses in midwifery. This led to PHMs not providing their advanced programme of work to PHNS. The system has still to recover from this debacle in some parts of the country.

e) Insufficient transport for supervisory staff

Many MOH areas do not have serviceable vehicles to conduct supervision.

KI said the "Tool for Supervision of the PHM" developed by the Planning, Monitoring and Evaluation Unit of the FHB is very detailed. It was too long to be used completely during a visit. In practice, only certain components are used during supervision visits. For instance, the PHMs office would be inspected during one visit and the field would be evaluated in a subsequent visit.

Another drawback of the current supervision system is that it revolves mainly around coverage of services and not sufficiently on quality aspects.

P4 They will look at the percentage, if something is lacking they will ask us for the reason? If the rates are lower than the national rates they will ask us why? And will tell us how to improve it.

P5 If the rates are too poor, they will go on field visits…. Our Doctor, SPHM, will meet them (women) and talk to them.

FGD PHM, Kalmunai

Currently there is no mechanism in place to supervise the quality of services provided by the private sector.

Staff Motivation

Non-monetary incentives are in place for staff to ensure job satisfaction. These staff reward mechanisms do not contravene volunteerism and informed choice in FP. The best performing PHMs for instance are given awards in appreciation of their services. In some MOH areas well performing PHMs are requested to share their experiences at the monthly conferences. The RDHS Killinochchi in order to motivate PHMs arranged observation tours to Jaffna, Trincomalee and Kurunegala for PHM who performed well.

Management practices supporting community participation

Community participation is of vital importance to service delivery. Encouraging community input into a facilities' management makes the facility more accountable to the community it serves. It also help the facility to better understand the community's needs. This increases the probability of better health seeking behavior, which in turn may improve the health of the community. Government policy recommends an interface with the community.

Community representation

Structures are in place to promote community participation and oversight such as Hospital Development Committees. These committees could be an instrument for quality improvement. However, KI both policy makers and facility managers said that community members of hospital management committees were in most cases political appointees and not involved in defining, appraising and improving service quality. According to KI these committees do very little for FP.

Client feedback

Some of the facilities visited during the review had developed a mechanism for obtaining community inputs on services. This was by installing suggestion boxes. However, KI said that there were very little inputs from the community. Some large hospitals have commenced consumer satisfaction surveys.

Figure 6.3 Suggestion box at a clinic.

Lack of standards for FP services

FHB has standards for the equipment for FP clinics. Standards for other aspects of FP service delivery need to be defined taking into consideration the local context. Quality will continue to be hampered by inequalities in resource distribution (discussed above), inability to collect accurate performance data in a timely manner through the RHMIS, and unreliable supply of medical products.

Quality assurance (QA)

Quality assurance is an important component of service delivery. QA refers to that set of activities that are carried out to set standards and to monitor and improve performance so that the care provided is as effective and as safe as possible.

a) Formats for supervision of FP clinics has been prepared by the FP unit. These are used by FP Unit staff on their supervision visits. However, these formats are rather cumbersome to use and need to be made more user friendly. These formats are not aligned with the guidelines developed for supervision of PHM and SPHM by the Planning Monitoring and Evaluation Unit.

b) The FHB has developed supervision checklists for PHNS, SPHMs and PHMs.

c) One of the functions of the MoH is to set standards and ensure quality for the entire health sector. The MoH has established the National Quality Assurance Programme in Health. General Circular No.01-29/2009 dated 22 September 2009 spells out the organizational structure and mechanisms for the National Quality Assurance Programme. A Quality Secretariat has been established. National guidelines for improvement of quality and safety of healthcare institutions has been developed for Line Ministry and Provincial Hospitals, primary medical care units, offices of MOH, specialized public health units and campaigns, health management units and training institutions.

Every health institution is expected to establish a Quality Management Unit (QMU) within each institution. The Quality Management Unit (QMU) serves as the secretariat for organizing training activities on quality and safety improvements as well as implementation monitoring and evaluation of the programme in the hospitals. In addition, at the ward/unit level, Work Improvement Teams (WITs) are to be formed to implement the programme. The Quality Management Team, consisting of the Hospital Director, QMU staff and the leaders of the WITs will serve as the decision making body. A set of 20 indicators have been developed to be used in monitoring the quality of care. All MOH are expected to plan and implement the Quality Management Programme, under the guidance of the Quality Management Unit of RSLDHS.

The National Quality Assurance Programme is being implemented in a phased manner addressing systems and management issues first followed by functionality and technical aspects in that order. Client and employee satisfaction surveys are conducted regularly as a system feedback mechanism. Instead of duplicating the work of the FHB the Quality Secretariat believes in working together with the FHB to improve quality. Currently the private sector is not included in this programme.

Quality improvement

Quality improvement focuses on measuring and improving performance. In most hospital and clinics we visited suggestion boxes were available. Hospital managers said that client satisfaction surveys were carried out as part of the National Quality Assurance Programme. On the other hand the FPASL encourages clients to provide feedback via SMS. They also maintain a question box. In addition FPASL staff conduct exit interviews with a few clients each day. The process lasts only about 10 minutes per client.

FP Unit efforts to improve technical quality

The FHBs role is to ensure that technical quality is maintained and has taken several initiatives in this regard.

1. Guidelines for establishing a FP clinic. Prior to registration of a new FP clinic and assigning a registration number the FP Unit ascertains the following:
    a. designation and number of staff available
    b. whether the officer conducting the clinic has received training in insertion of IUD
    c. the availability of space to provide services to clients with privacy and confidentiality
    d. availability of clinic furniture
    e. availability of water and electricity

A list of minimum equipment required for a new clinic providing IUD facilities has been developed and the Office in Charge of the clinic can request for equipment from the FHB.

2. Development of clinical service delivery guidelines for service providers -

a. Guidelines for service providers on combined oral contraceptive pill (OCP) and DMPA injectable contraceptive 2010. This document needs revision. For instance it does not mention the possibility of anaphylaxis as a side effect.

b. Guidelines for service providers on IUD insertion and removal 2010.

c. Guidelines for service providers on mini-laparotomy for female sterilization. 2012

d. Medical Eligibility Criteria Wheel for Contraceptive use (adapted for Sri Lanka)-2012

e. Guideline regarding the use of DMPA in the NFPP. Circular Letter No. 02-35/2012

These guidelines need to be updated to be in line with current policy developments and latest edition of the WHO Medical Eligibility Criteria. Since the implant is gaining in popularity among clients a guideline on implant insertion and removal needs to be developed.

3. A flip chart on contraceptive methods has been developed for service providers in 2005 to help when counselling clients. This document also needs to be revised. According to FHB these flipcharts have been distributed to all relevant health staff. On visits to clinics during the review these guidelines and flipcharts were available for reference by service providers in only a few clinics. It should be noted that presence of clinical guidelines does not mean that they are adhered to. Some service providers had downloaded them from the FHB website.

4. Reference has been made to the formats for supervision of FP clinics has been prepared by the FP unit under the QA section.

5 The FP unit has a surveillance system reporting and investigating adverse reactions following contraceptive usage.

Studies and surveys

- In 2004 the FHB conducted a Thematic Review of the Quality of RH Services.
- The FP unit is conducting two surveys at present: (i) to assess the availability of equipment in family planning clinics; (ii) number of registered family planning clinics that are functional and providing four methods of contraception.

Indicators related to quality of care for subfertility services need to be developed and adopted. The expansion of ART and the potential health risks to patients and offspring make it necessary to monitor and regulate the services provided. The SLMC has drawn up a Provisional Code of Practice for ART that requires assisted reproductive treatment practitioners to register with the Council. Private centres providing ART services are expected to have internal quality mechanisms in place.

12. A mix of contraceptive methods is available

Context – The technical term "method mix" refers to the percent distribution of contraceptive users (or alternatively, of acceptors) by method. [14] There is no optimal method mix that could fit all needs in a country. In general, the availability of a diverse method mix is in line with a rights based approach to FP. The method is an indication that women and couples have a choice and increases contraceptive use. It is recognized that the availability of only 1 or 2 contraceptive methods in a country constrains total contraceptive use and limits the options that women and couples have to manage their fertility. Contraceptive method mix is used as a proxy for method availability and client choice.[15] It may reflect preferences of women or couples or it may reflect limits regarding supply or provider bias.[16] In general, total use increases with the number of methods made available to the population at large.

Findings

(A detailed account on the trends and issues related to the contraceptive method mix are found in chapter 4 based on the desk review.)

The National List of Essential Medicines[17] includes the contraceptives found in the WHO's Model List of Essential Medicines. National policies and guidelines authorize the provision of FP methods and services at the lowest levels of the system that can safely provide them. (See Table 6.1) FP screening, counselling and service provision are based on the WHO Medical Eligibility Criteria for Contraceptive Use.

FGD, KII and observations during field visits showed that in most instances clients are counselled by service providers on the full range of FP methods that are accessible, even if they are not available on-site to facilitate decision making. When a particular method is not available at a clinic there is a referral system, albeit weak, to help clients obtain their preferred FP method. For instance, if a woman requests an implant she is referred to a clinic which provides the service. (see Chapter 6.14 Referral system) Service providers in general did not show bias for a particular method. However, FGDs with clients indicates that in some areas some service providers influenced the type of contraceptive that was used.

Temporary methods

OCP and condoms

OCP and condoms are made available through PHM in the field and through FP clinics. A highly subsidized price was charged for oral pills (Sri Lanka cents 50 per cycle) and condoms (Sri Lanka cents 05 per piece) in the past. This practice has now been discontinued and OCP and condoms are provided free of charge. PHM are the main distributors in the government programme. Between 2007 and 2014 the use of OCPs has increased from 7.2 percent to 10.1 percent respectively. Use of male condoms has increased among eligible couples from 4.8 percent in 2007 to 8.2 percent in 2014, (Table 4.13)

[14] http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/method-mix (Accessed (23.7.2016)

[15] Seiber EE, Bertrand JT, Sullivan TM. Changes in contraceptive method mix in developing countries. Int Fam Plan Perspect. 2007;33(3):117–123.

[16] Sullivan TM, Bertrand JT, Rice J, et al. Skewed contraceptive method mix: why it happens, why it matters. J Biosoc Sci. 2006;38(4):501–521.

[17] National List of Essential Medicines 5th Revision 2013-2014.

Injectable

Injectables offers several benefits, including the reduced likelihood of unplanned pregnancy, unsafe abortion and maternal mortality. The popularity of injectable use in the past was largely attributable to its widespread accessibility. Furthermore, women who feel they must conceal contraception from their husbands, families or communities can covertly use this method. Injectables are administered once every three months and there are no supplies to keep on hand at home.

Following the anaphylactic reaction to DMPA that were encountered in 2012, though there is still a demand for injectables it is provided only in clinics which have a MO and where resuscitation facilities are available. KII and visits to facilities showed that the supply of DMPA in some areas was insufficient to meet the demand. Moreover, the lack of oxygen cylinders and emergency equipment especially in field clinics does not make injectables easily accessible for women.

These short term methods (OCP, condom and injectables) have higher failure rates than long acting reversible methods and are more demanding of users in terms of adherence and the frequency of visits needed for resupply, thus posing higher time and travel costs for women.

Implants

Implants were introduced into the NFPP in 1988. Though it was not popular at first there has been a gradual increase in its popularity. Currently the 2 rod implant and the one rod implant are available. In the public sector. The one rod implant (Implanon) is being gradually phased out of production by the manufacturer. KI from all the districts visited during the review reported that implants are in high demand among women who have been informed about their availability.

The major drawback of implants is their cost. Since implants are increasing in popularity the NFPP should consider introduction of a much cheaper implant that is being used in many countries throughout the world. Sino-implant II manufactured in China is a highly effective, low-cost, subdermal contraceptive implant composed of two rods. Each rod contains 75 mg of levonorgestrel. Annual pregnancy rates are below 1 percent, and the product is currently labelled for four years of use. Another new implant the NFPP should consider introducing is the 68 mg etonorgestel implant, Nexplanon, which is radiopaque. This is because the production of Implanon is being phased out, the insertion procedure of Nexplanon is simpler and avoids placing the implant too deep under the skin. Also, the Nexplanon rod was designed to be located using X-rays.

To meet the demand for implants the FHB and MOMCH in the districts needs to ensure that under the Training of Trainers Programme commenced in 2015 by the FHB those trained as trainers in turn train additional service providers in insertion and removal techniques.

IUD

From a programmatic aspect providing IUD services is more demanding in terms of infrastructure, equipment and supplies than for other reversible methods. Trained providers in IUD insertion and PPID insertion are a prerequisite.

Two types of IUD are available in Sri Lanka – the Cu T 380A and the levonorgestrel-releasing IUCD (LNG –IUS). In the Government sector the Cu T 380A is the device that is most commonly used IUD which can be used for 10 years. A woman can commence using Cu IUD anytime when it is reasonably certain that she is not pregnant. The Copper T-380A is an extremely effective, safe, long lasting, rapidly reversible method of contraception that does not interfere with intercourse, is not subject to forgetfulness, and once inserted, is

not subject to changes in medical supply or access to health care. It is also non-hormonal, so it does not have any hormone-related side effects or contraindications and does not affect breastfeeding. The acceptance of the method has been slow in Sri Lanka.

The desk review, KII and FGD suggest there are many reasons for the slow expansion of IUD services. Factors related to the method, client, service provider and health system policies and procedures are responsible. The IUD is a clinical method which must be provided in a clinical environment by a trained service provider after a pelvic examination. A follow up visit is required monthly for the first three months and thereafter every 6 months and further visits are necessary if there are any side effects such as irregular bleeding. Moreover, the unfounded myths and rumours such as "it travels in the body" not only results in discontinuation but also leads to poor demand by women seeking a contraceptive method. For the individual service provider there is no advantage in taking the time for counselling and IUD insertion, especially when other options such as the injectable or pill could be easily prescribed without making much demands on the service provider.

IUD services are provided at the FP clinics in curative institutions and in the field by trained MO and PHNS. Some service providers, especially those in institutions, carry out ultrasound scans immediately after insertion. While there is no evidence for this practice, service providers are of the opinion this reassures clients that the IUD is indeed within the uterine cavity. Other clinicians do not perform routine ultrasound scans after IUD insertion but do so if there as signs of infection, to confirm pregnancy or if the treads are missing .

During FGD with KI and service providers many observed that the threads of the IUD after insertion had detached. This was reported from several districts that were visited during the review.

> *Mothers come and say they can't feel the threads of the IUD. When we examine we find that the threads of the IUD are not there.*
>
> ***FGD PHM, Galle***

Post-partum IUD insertion (PPIUD)

PPIUD can be inserted immediately after vaginal delivery, during caesarean section and up to 48 hours after birth, before women are discharged from the health facilities. Virtually all deliveries take place in institutions in Sri Lanka. Immediate postpartum insertion (within 10 minutes of delivery of the placenta) of copper-bearing IUD is generally safe and effective, although compared with interval insertion it carries a higher risk of expulsion.[18] Expulsion rates have been reported ranging from 9.5 percent to 12.5 percent for immediate post-partum insertion of IUDs and 25 percent to 37 percent for early postpartum (10 minutes to 48 hours post-delivery) insertion of IUDs. [19]

PPIUD insertion provides an opportunity to offer a safe, highly effective and reversible FP method to women before discharge from hospital following delivery. Insertion of the IUD immediately after delivery has the advantage of knowing for certain that the woman is not pregnant. Moreover, immediately after delivery, the woman is also likely to have a high motivation for accepting contraception, and the hospital provides a convenient setting for inserting the IUD. In 2013, PPIUD was introduced in selected hospitals as a project funded by FIGO. Postpartum women who breastfeed their infants can also use Cu IUD safely, as it does not interfere with breastfeeding. This project needs to be evaluated carefully before it is scaled up throughout the country.

[18] MuthalRathore A. Immediate postpartum insertion for intrauterine devices: RHL commentary (last revised: 1 September 2010). The WHO Reproductive Health Library; Geneva: World Health Organization.

[19] McKaig, Catherine and Blanchard, Holly. The IUD: A contraceptive option forpostpartum and postabortion women. Access/USAID.https://www.k4health.org/sites/default/files/postpartumabortion_English.pdf (Accessed 11.11.2016)

Permanent methods

Female sterilization

In the mid 1980's, female sterilization facilities were made available in hospitals with consultant obstetricians and gynaecologist and in several smaller institutions (district hospitals). Sterilizations are not being carried out in the smaller institutions at present. In addition to government institutions, the NGOs provided surgical contraception in their own centres and also conducted mobile "outreach" programmes in areas where sterilization services were needed. NGOs are no longer permitted to provide outreach FP services.

Criteria for sterilization

In 1988, the Sri Lankan government enforced limitations on the minimum age and parity at which a woman can be sterilized. Before 1988, a significant proportion of women who had the sterilization operation were either under 25 years of age or had two children with the second child being very young. The criteria for a sterilization are –

(i) The clients should be over 26 years of age and should have at least 2 living children; the younger being over 2 years of age.

(ii) Clients who are over 26 years of age and having 3 or more living children could be sterilized at any time

(iii) A client under 26 years of age, and his /her spouse insist on a sterilization, the Medical Officer concerned could use his/her discretion, and perform the sterilization provided the couple has a minimum of 3 living children.

(iv) In the event of any medical indication, which warrants sterilization, the client should be referred to a specialist in the relevant field who should make the final decision.

Incentive and "out of pocket payments" withdrawal

In 1980s the government introduced an"out of pocket allowance" (Rs.500) which was given to the client to meet the cost of travel and any incidental expenses incurred in obtaining the services. An incentive payment was also made to the service providers. These incentive payments were withdrawn by a circular issued by the Director General of Health Services on 10th October 2013. The removal of the incentive payment paid to service providers for conducting sterilization procedures did not appear to be a reason for the decline in the number of procedures carried out.

Challenges in providing female sterilization services in the public sector

Based on a circular from the DGHS, Institutions with Consultant Obstetricians and Gynaecologists are expected to provide female sterilization service at least 4 hours per week to eligible client. KI obstetrician and gynaecologists said that female sterilization were carried out on routine lists and even post-casualty lists. KI service providers from the field expressed frustration that often women who are referred for interval sterilization are admitted to the ward, prepared for surgery and the procedure is postponed due to lack of time. KI provided anecdotes of high parity women and women with medical complications being referred to institutions for LRT and having the procedure postponed and subsequently becoming pregnant and dying from pregnancy complications. The following are some of the issues with regard to provision of female sterilization services based on KI, FGD with service providers, clients and visits to institutions.

1) Insufficient operating theatre time. For instance, the Dickyoya Base Hospital Type A has two VOGs who has to share the onlyoperating theatre with the surgeon and eye surgeon;

2) Absence of a trained service provider e.g. Chavakachcheri BH does not have a VOG.

3) Individual service providers have established criteria surrounding age and parity that are in variance with the eligibility criteria in the departmental circular issued in 1988 referred to earlier.

P6 *With my twin babies, they refused to do it for me (LRT)…. Saying age… if not 31, they won't do it they said. Bit later on I spoke to the doctor and said that I have 4 children, and got it done.*

M They refused to do it initially?

P6 Yes.

M Saying that you are not 31 years?

P6 Yes.

M Then you insisted that it is difficult for you with 4 children already?

P6 Yes, I told that I have 4 children already, and it is difficult to look after them, and also I don't have any support at home… saying these I signed it in several places and got it done with great difficulty..

FGD Married women 30-45 years, Trincomalee

4) The personal opinions of some service providers both in the field and in the institutions come into play in provision of female sterilization services. Experience of health workers who encountered regret among sterilized women who lost children following the tsunami, other natural disasters, accidents, marriage dissolution, as well as the recently concluded ethnic conflict are some of these reasons.

5) NGOs are no longer permitted to provide female sterilization services. For instance in the Nuwera Eliya district the Magastota Estate hospital and the divisional hospital at Lahugala have fully equipped operating theatres that provided female sterilization services in the past. Consultant obstetricians and gynaecologists who had contact with clients who had undergone sterilization by these NGOs were critical of the quality of services that had been provided.

6) Threats from extremist religious and political parties to curtail FP activities especially those providing sterilization services.

The SLCOG had written to the MoH on 13th June 2011 regarding operating theatre time for female sterilization. The SLCOG suggested that the hospital administration;

1) identify and designate an operating theatre;
2) provide designated theatre staff;
3) provide necessary equipment, and;
4) provide designated agreed fixed theatre time.

During the review KI policy makers and service providers said that the hospital director should be held accountable for providing space, staff and operating theatre time in institutions for the conduct of female sterilization. Another option that was suggested by KI to overcome the problem of lack of theatre time was to conduct sterilizations on Sundays by the "on call" team.

Day surgery for sterilization

At the stakeholder workshop it was suggested that female sterilization be carried out as a day patient procedure. The FHB had requested for funds to establish three mini-operating theatres in selected institutions

but the request had so far not been considered by the Treasury. During the review the possibility of carrying out sterilizations as a day surgery procedure with service providers and managers was discussed. Though not comprehensive, according to KI the following are only some of the requirement that would have to be available for day surgery:

1) The client would need to have pre-operative evaluation and investigations carried out e.g haemoglobin. This would entail the client visiting the hospital to carry out the investigations before the procedure is carried out;
2) Be seen and evaluated by an anaesthetist and premedication administered;
3) Adequate staff for admission, operating theatre, post-operative care with a coordinator / manager who prepares the Operating Lists, sends to the Director and manages the unit;
4) A dedicated operating theatre;
5) A rotation of surgery days between the different consultant units;
6) Issues of responsibility needs to be resolved as the Consultant Obstetrician and Gynaecologist may not be able to be physically present in the operating theatre at all times.

IUD versus sterilization for couples who wish to limit their family

Female sterilization has many advantages such as its effectiveness in preventing pregnancy; does not affect the spontaneity of sexual intercourse or interfere with sex, and; does not affect hormone levels. Its main disadvantages are that it requires a surgical procedure with anaesthesia and reversal is very difficult. Because of the IUD's characteristics the method lends itself to addressing unmet need for both limiting and spacing. Effective use of Cu IUDs can be up to 10 years and LNG-IUS upto 5 years. Since IUDs last for a long time and perhaps long enough to allow women to become menopausal.

Some authors have suggested that the IUD may be used as substitute for female sterilization, given the method's comparable efficacy and lower cost.[20,21] The percentage of women experiencing an unintended pregnancy within the first year of typical use for the Cu IUCD, the levonorgestrel-releasing IUCD and female sterilization were 0.8 percent, 0.6 percent and 0.5 percent respectively.[22] important drawback to sterilization is that between 2 and 20 percent of women regret their decision to undergo sterilization.[23,24,25] A study by Hapugalle et al[26] of 817 women who underwent sterilization between 1980 and 1983 showed that 14 percent subsequently regretted undergoing sterilization. The most important determinants of regret were not having a child of each sex at the time of the operation, being married fewer than five years, being under age 25, having two children or fewer, not having control over the sterilization decision,

[20] Trussell J, Lalla AM, Doan QV, Reyes E, Pinto L, Gricar J. Cost effectiveness of contraceptives in the United States. Contraception. 2009; 79:5–14.

[21] Grimes, D.A., Mishell, D.R. Jr. Intrauterine contraception as an alternative to interval tubal sterilization. Contraception. 2008;77:6–9.

[22] World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. Family Planning: A Global Handbook for Providers (2011 update). Baltimore and Geneva: CCP and WHO, 2011.p.319.

[23] Grubb GS, Peterson HB, Layde PM, Rubin GL. Regret after decision to have a tubal sterilization. FertilSteril 1985; 44:248.

[24] Wilcox LS, Chu SY, Eaker ED, et al. Risk factors for regret after tubal sterilization: 5 years of follow-up in a prospective study. FertilSteril 1991; 55:927.

[25] Hillis SD, Marchbanks PA, Tylor LR, Peterson HB. Poststerilization regret: findings from the United States Collaborative Review of Sterilization. ObstetGynecol 1999; 93:889.

[26] Hapugalle D, Janowitz B, Weir S, Covington DL, Wilkens L, Aluvihare C. Sterilization regret in Sri Lanka: a retrospective study. Int Fam Plan Perspect 1989; 15:22-8.

having a husband who opposed the sterilization and having a child die subsequent to the procedure. IUD use among women who wish to end childbearing may reduce the post-sterilization regret especially in younger women who are more likely to experience remorse.[27,28] Including this option in contraceptive services can help to meet a portion of the unmet need for contraception among women not willing to choose sterilisation or hormonal methods, while reducing dependence on doctors and expensive equipment. [26] Nevertheless, the NFPP which adopts a cafeteria approach must continue to offer female sterilization for women who would prefer a one-time option and who do not want hormonal methods or an IUD.

The Curriculum of the PGIM for the MD Obstetrics and Gynaecology under family planning has "promotion of IUCD as an alternative to sterilization" as a learning outcome (page 19).[27]

PHMs were asked what methods a couple could use to limit births. The following dialogues with PHM in Colombo and Jaffna shows that they are aware that long term reversible methods could be used for limiting births instead of permanent methods.

P6 You can go for a permanent method or a non-permanent method. Loop.

M Why Loop

P6 Can put for 10 years. If it's Jadelle, it's for 5 years. That is also a long term method. For the loop the cost for the government is less.

FGD PHM, Colombo

P3 IUD, Implant, LRT and Vasectomy.

P2 Vasectomy or IUD, LRT, and IUD. IUD can be kept for long time like 15 years….if the mother is 40 years, she can keep it till she gets her menopause.

P4 (Clears throat) IUD 10 years.

P2 The implant must be removed in 5 years, and must go for another method. So having an implant is difficult. So if she doesn't want to have children she can go for LRT, and if the husband wishes, he can do vasectomy.

FGD PHM, Jaffna

Use of female sterilization by sector

Use of sterilization in the estate sector is higher than in the urban and rural sectors. (Table 6.2) Sixty five percent of modern contraceptive use in the estate sector is accounted for by female sterilization.

Table 6.2: Use of female sterilization by sector

	Sector		
	Urban %	**Rural %**	**Estate %**
Modern methods	43.7	53.3	61.2
Female sterilization	13	15.5	39.9
Female sterilization as a percentage of modern methods	29.7	29.1	65.2

Source: 2006/7 SLDHS

[27] Crosignani P G.Intrauterine devices and intrauterine systems. Human Reproduction Update.2008:14; 197–208

[28] Allen RH, Goldberg AB, Grimes DA. Expanding access to intrauterine contraception. American Journal of Obstetrics and Gynecology. 2009; 201: 456.e1–5.

[29] Iyengar K, Iyengar SD. The Copper-T 380A IUD: a ten-year alternative to female sterilisation in India. Reprod Health Matters. 2000:16; 125-33

[30] Post Graduate Institute of Medicine. Prospectus- Doctor of Medicine and Board Certification Obstetrics and Gynaecology. Board of Study in Obstetrics and Gynaecology 2012. Page 19.

Vasectomy

Vasectomy was never very popular in Sri Lanka. According to a KI even though there are trained service providers on non-scalpel vasectomy the procedure is not been carried out. That female sterilization has become the norm, while male sterilization remains rare, which is a glaring example of gender inequality. The lack of access to and failure to promote vasectomy compromises both men's and women's rights.

Emergency contraceptive pill (ECP)

The emergency contraceptive pill (ECP) is currently marketed by pharmacies and NGOs (FPASL and PSL) and can also be obtained from their clinics. Though the government also introduced the ECP into the national programme there was no demand from clients and ECP is no longer available through the NFPP. During the review we found that knowledge about ECP was poor, especially among unmarried women.

Pharmacies that were visited during the review throughout the country reported brisk sales of ECP

UN Commission on Life Saving Commodities

Of the three contraceptives identified by the UN Commission on Life Saving Commodities, i.e. implants, emergency contraception and female condoms, both implants and emergency contraception are available in the country. The demand for female condoms has not been assessed.

Administrative and medical restrictions on the use and /or provision of contraceptives based on KI and FGD

Administrative restrictions

1) Public sector hospital clinics are open from Monday to Friday from 8am – 12 pm and from 2 pm – 4 pm. They are closed on public holidays and on Sunday. These hours greatly inconvenience working women, especially daily paid workers such as women from the estate sector. Some teaching hospital clinics such as the dedicated FP clinics at De Soysa Hospital for Woman and Castle Street Hospital for Women are open from 12-2 pm.

2) Many service providers are concerned about the legal implications of providing FP services to minors.

I was told by the PHNS to get the mother's signature that she had no objection to the daughter receiving FP.

FGD PHM, Moneragala

This was due to PHMs and other staff not being aware of the current status. To provide ASRH services to a person less than 18 years of age "the MO must take all reasonable measures to obtain parental /guardian consent prior to providing such services. " However, circular FHB/AH/TP/2014 clarifies and states when providing RH services to adolescents the best interests of the child should be taken into consideration. Where the MO is unable to obtain parental/guardian consent, RH services should be provided even in the absence of parental consent, in the best interest of the child.

3) Sometimes the PHM issues only one packet of OCP at a time. This is an inconvenience for many working women since they have to meet the PHM monthly to obtain supplies, which is further compounded if the PHM does not reside in the area.

4) Due to lack of clinic space and human resources it was not possible to conduct FP clinics daily in some DGH and BH with Obstetricians and Gynaecologists. Some MOH areas do not have an AMOH which restricts the number of clinics that can be conducted and also increases the waiting time for clients.

5) Lack of sufficient operating theatre time to carry out sterilization as an elective procedure was the reason for postponement of sterilization procedure. Many women do not return if the procedure is postponed. This poses a serious, but under-recognized, barrier to FP.

6) Since there is no closed transfer system in operation grade MO, even RH Diplomates, may be transferred to a non- RH post which can result in a breakdown in service.

7) Following anaphylactic reactions to DMPA the method is provided in clinics when a MO is present and resuscitation equipment is available including oxygen, adrenaline etc. DMPA is a popular method but its use is now restricted and women have to travel to public sector clinics that provide the method or obtain it from the private sector. DMPA is covertly used by women who feel they must conceal contraception from their husbands, families or communities.

8) The National Guidelines on Post Abortion Care 2nd Edition suggests integrating emergency treatment and family planning and providing both at the same place. Due to contraceptives not being available on gynaecology wards women wanting to use contraception after counselling had to be referred to FP clinics. According to KI many do not seek FP services once discharged from the ward. Only in a few Obstetrics and Gynaecology units was an IUD or other method provided prior to discharge.

Unnecessary outdated medical restrictions

1) Eligibility criteria based on age and parity.

In some locations implants are given only to the very young and those over 35 years \

Criteria for female sterilization varies depending on the obstetrician and gynaecologist e.g.

a) Age of the woman should be over 35 with three living children and the last child should be 5 years.

b) Sterilization is done on a case by case basis

c) Age of woman should be over 30 years with 3 living children.

d) Age of woman should be over 35 years, minimum 3 children and the last child should be at least 2 years.

e) Age of mother minimum 30 years with 3 children and the last child 3 years.

2) Outdated medical eligibility criteria –

a) The IUD is considered to be contraindicated for nullipara.

b) The ECP can be used only within 72 hours

c) When I went to the hospital clinic I was told my weight was 60 kg and should not have an implant.

FGD Married women 18-29 years, Galle

3) Process or scheduling bias

Non-menstruating women are commonly told they must return when they are menstruating in order to be given a hormonal contraceptive method or to have an IUD or implant inserted. The rationale offered to justify this requirement is to ensure the client is not pregnant.

4) Provider bias

Provider bias was reported during FGD.

I was told by the PHM not to use the implant as it caused heavy bleeding and cased problems with breast feeding.

FGD Married women 18-30, Galle

We learnt during FGD with women that in some areas of the country the public sector did not provide clients with contraceptives after they had received services for a certain time period. For instance, in Moneragala after DMPA is given in the MOH clinic for one year women have to obtain subsequent injections from the private sector. In Jaffna PHMs provide OCP upto five years and stop providing contraceptives and tell the woman to have a baby. KI in many parts of the country said that there were service providers who were opposed to FP.

13. Integration of services

Context- WHO defines integration as "The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system."[31] Where appropriate and feasible, the integration of FP with other health care serves clients better and can be more cost-efficient for both the client and the health system. By treating multiple health needs, integrated services can give clients greater continuity of care and can bring services to new clients. Nonetheless, integration may not be appropriate in all settings and for all services.

Findings

Policy makers from the leadership of the MoH who were consulted as KI, attributed the success of the NFPP to its integration with MCH from the inception of the programme. Over the years the Family Health Programme has expanded from its initial focus on MCH/FP. KI from the FHB state that components of the Family Health Programme – adolescent health, preconception care, antenatal, postnatal periods to the reproductive health of older women through the Well Women Clinic programme – can be used as the entry points for FP information and services. For instance, the recently commenced programme for newly married couples has also included FP as a component.

Almost all deliveries take place in institutions in Sri Lanka. The immediate postpartum period in hospital is an opportunity to promote the use of FP. KI said that the postpartum period stay in hospital is used for this purpose but not consistently. There is no designated individual on the postnatal ward for this purpose. PPIUD project funded by FIGO, recruits women who consent for IUD insertion prior to discharge from hospital. The 6 week postnatal visit is another opportunity to promote contraception.

An area that needs strengthening is post-abortion contraception. According to WHO after a miscarriage or induced abortion, the recommended minimum interval to next pregnancy is at least six months in order to reduce risks of adverse maternal and perinatal outcomes.[32] Post abortion care and FP are provided in different settings and sometimes by different providers. As mentioned in the previous section FP is not provided in most instances prior to discharge from hospital for those women who wish to use contraception. Some KI felt that the Post-Abortion Care Guidelines were too long and that a concise version was needed. A circular from the DG on implementation of the recommendations of the guidelines is also needed.

As part of the Programme for Elimination of Mother to Child Transmission of Syphilis and HIV in Sri Lanka PITC will be conducted in ANC from 2016 throughout the country. The differences in future childbearing intentions between HIV-positive and HIV-negative women highlight the necessity of tailoring FP

[31] WHO. Technical Brief No1. 2008. Integrated health services – what and why? . http://www.who.int/healthsystems/service_delivery_techbrief1.pdf (Accessed 13.01.2016)

[32] WHO (World Health Organization) (2005) Report of a WHO Technical Consultation on Birth Spacing. WHO, Geneva.

counselling to their specific needs. As a part of Prong 2 interventions of PMTCT, FP services are provided at STD HIV clinics to HIV positive women. MO working in STI/HIV clinics have been trained by the FHB on providing FP services. HIV+ clients requesting LRT are referred to FHB or to clinics in institutions.

FP services are also integrated with the Well Women's Clinics which are conducted for women over 35 years.

P1 There are people who do FP when WWC is done.

P7 If a Loop is put they'd check that. And change…

P1 Injections even… or else for Jadelle insertion they get the dates.

P6 People who were scared of the Loop also get it at WWC.

FGD PHM, Colombo

We were informed about FP by the PHM at the Well Women Clinic.

FGD Married women, 30-45 years, Moneragala

Currently the leading causes of maternal deaths are due to medical disorders. Several consultant obstetricians and gynaecologists who were KI said that there were instances where women with known medical disorders were not referred for contraception by physicians and field staff which led to pregnancy complications and in some instances to unnecessary maternal deaths. This indicates that FP need to be better integrated with NCD services. While FP is integrated with other health services for women to some extent, integration of FP services for men into other health services leaves much to be desired. Protocols for counselling and referral forFP services from NCD health services are currently not available.

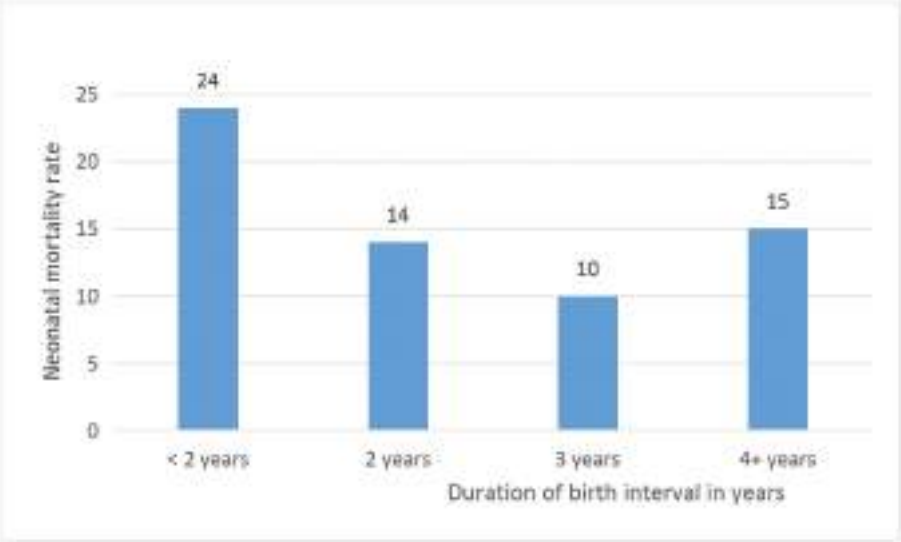
Birth spacing benefits not only the mother but also herchildren. The scientific literature is replete with evidence of close association between birth spacing and child mortality.[77,78] Following a Technical Consultation and Scientific Review of Birth Spacing in 2005[79], WHO indorsed the following two recommendations on birth spacing:

1. After a live birth, the recommended interval before attempting the next pregnancy (i.e. birth-to-pregnancy interval) is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes. (This implies that the minimum birth to-birth is at least or minimum of 33 months (33 months = 24 months for not conceiving + 9 months period of pregnancy) in order to reduce the adverse risks.)

2. After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy is at least six months in order to reduce risks of adverse maternal and perinatal outcomes.

The 2006/7SLDHS shows that when the birth to birth interval is less than 24 months the neonatal mortality is high. (Figure 6.4)

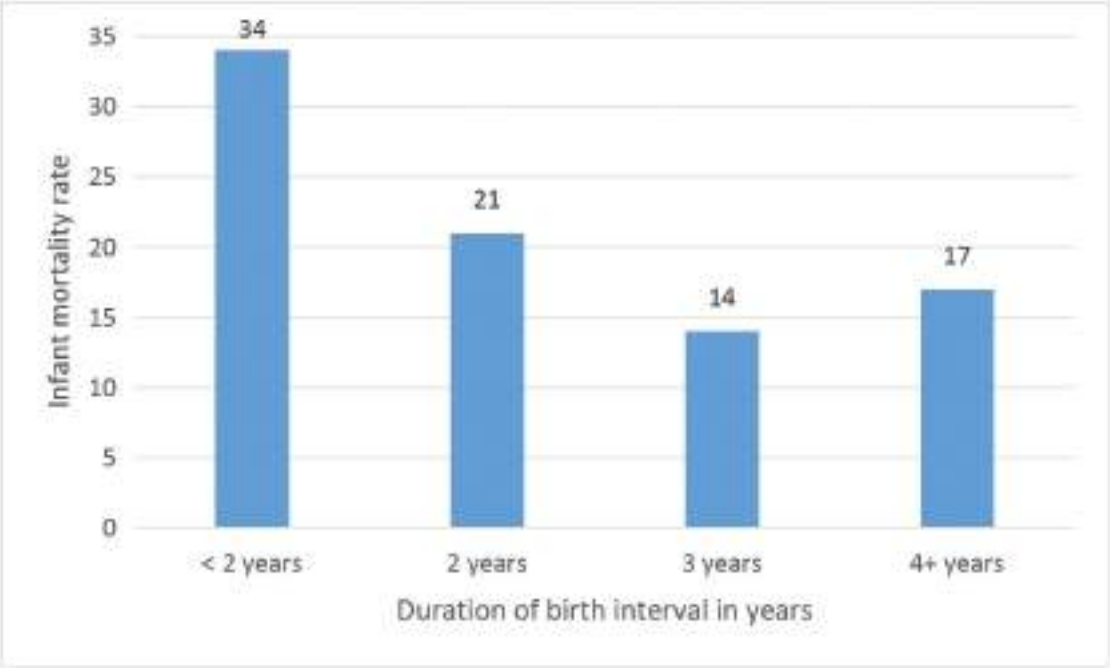
Figure 6.4: Neonatal mortality rate by birth interval



Source: 2006/7 SLDHS

The IMR is reduced by 50 percent when the birth to birth interval is 4 years compared to when the birth interval is less than 24 months. (Figure 6.5)

Figure 6.5: Infant mortality rate by birth interval



Source: 2006/7 SLDHS

The child mortality rate also decreases as the birth interval increases. (Figure 6.6)

The 2006/7 SLDHS, indicates closely spaced births continue to be fairly common in Sri Lanka. Of all non-first births, 3.9 percent were born at an interval of less than 17 months between one birth and another, and 6.2 percent at an interval of less than 24 months. A further 16.1 percent were born at an interval between 24-

35 month. This means that, 26.1 percent of women became pregnant below the recommended minimum inter-birth interval length (≥ 3 years) during the time when women and infants have the maximum amount of contacts with the health system for vaccination and growth monitoring. This missed opportunity for FP, if used would further contribute to reduce child mortality and improve maternal and child health.

14. Referral systems

Context - An operational referral system can help health care providers increase client' access to subfertility services or specific contraceptive methods that are not available on-site. Referral systems are critical to ensuring informed choice, especially since some small institutions and PHM may offer some, but not all, FP methods. Referral also supports integration of services within a site e.g. post abortion care and contraceptive service. For a referral system to be operational, providers must listen to clients' preferences, provide them with adequate information to seek services at the referral facility, provide the referral facility with adequate client information and participate in monitoring the referral system. Also, the provider at the referral facility should give feedback to the referring provider to facilitate continuity of care. A weak referral system reduces access to and quality of care. It also makes clients lose confidence in the efficiency of the health system.

Findings

In the event that a client's preferred contraceptive method is not available at a particular clinic they are referred to the nearest institution providing the method. PHMs refer clients requesting DMPA, IUD and implants to MOH clinics. Clients requesting sterilization are referred to hospitals with Consultant Obstetricians and Gynaecologists by PHMs, MOH clinics and other small institutions. There are deficiencies in the referral system for FP.

- A functioning communication/feedback system between the referring facility and the site accepting the referral to support timely information-sharing and continuity of care is lacking. For instance when a client is referred for sterilization to an institution and the procedure is not carried out because the procedure is unsuitable for her either on medical or non-medical reasons or lack of time on the operating list the site accepting the referral does not provide this information to the referring facility in most instances.
- Mechanism for client follow-up is lacking (including assessment of how well the follow-up mechanism is functioning) e.g. women who want implants or IUDs removed may go directly to the hospital bypassing the MOH. KI from the field said that the hospitals in most instances do not adequately motivate the women to adopt another method nor do they inform the relevant MOH that the implant or IUD has been removed. The onus falls on the client to inform the local PHM. If the PHM does not update the eligible couples register by doing domiciliary visits diligently the woman may not adopt a contraceptive method which may lead to unwanted and mistimed pregnancies as method switching may not take place.

Couples finding difficulty in conceiving are referred following basic investigation or directly by the PHM or MOH to the nearest gynaecologist. As mentioned before different levels of care for subfertility need to be established based on the complexity of the investigations and treatment and the available expertise. A proper referral system to advanced centres needs to be established. For this to happen the designated subfertility centres at CSTHW and Mahamodera need to be fully functional.

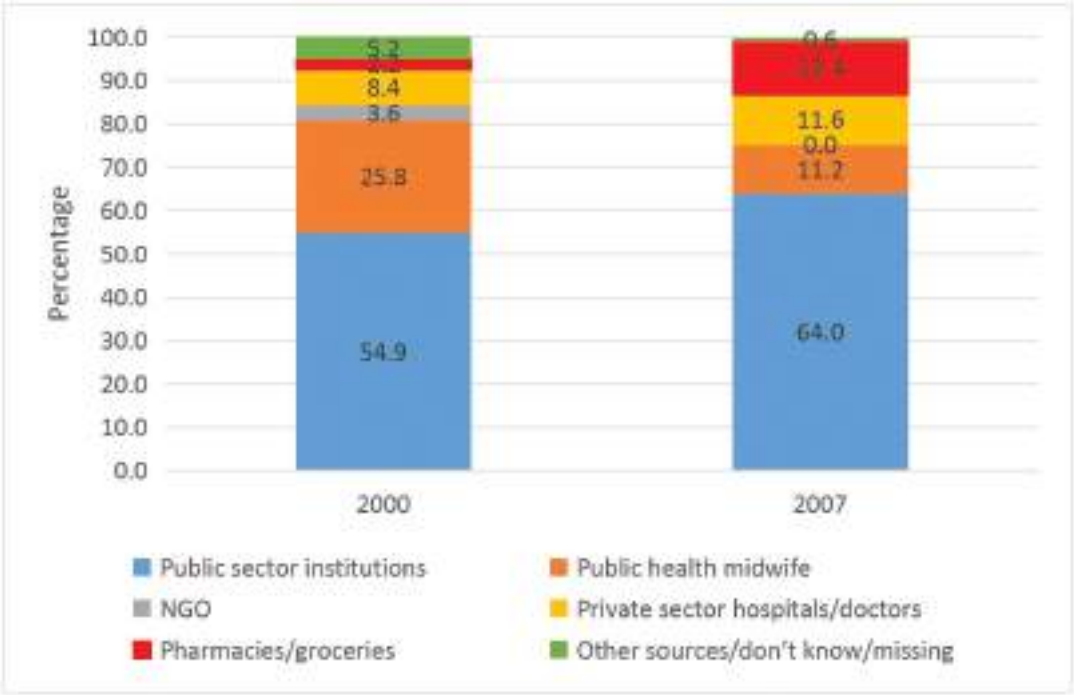
15. Private sector involvement

Context – Private-sector services often offer clients better locations, more convenient hours, shorter waiting times, and greater anonymity but have been shown to be of varying quality, often due to the inability of government regulatory bodies to adequately monitor and enforce standards than the public sector.[36,37,38] For-profit facilities have greater incentives to be efficient providers of health care, fulfilling important gaps in the supply of high-quality FP services.[39,40] In addition, as a private enterprise, pharmacies are less likely than public-sector health facilities to face commodity stock-outs and therefore are potentially a sustainable source of contraceptive methods. The not-for-profit private sector can contribute to FP through approaches like social marketing and social franchising, which use commercial marketing and franchising techniques to sell subsidized FP products and services.

Public sector funding of infertility-related health care is inadequate in developing countries. There is competition for scarce resources and not much priority is given to subfertility as it is not a life threatening condition.

Findings

Figure 6.6 Trends in source of contraceptives 2000 and 2006/7



Source: 2006/7 SLDHS

[36] Brugha, R. and A. Zwi. 1998. "Improving the quality of privately provided public health care in low and middle income countries: challenges and strategies." Health Policy and Planning 13: 107-120.

[37] Zwi, A.B., R. Brugha and E. Smith. 2001. "Private health care in developing countries." British MedicalJournal323(7311):463-464.

[38] BBhat, R. 1996. "Regulating the Private Sector: the case of the Indian Consumer Protection Act." Health Policy and Planning 11(3): 265-279.

[39] World Health Organization. 2000. The World Health Report 2000 – Health Systems: Improving Performance.Geneva.

[40] Bennett, S. 1992. "Promoting the Private Sector: a Review of Developing Country Trends." Health Policyand Planning 7: 97-110.

According to the SLDHS 2006/7, the main source of contraceptives was the public sector (75.2 percent).) NGOs as a source of contraceptives has decreased over the years. The private sector accounted for just under one-fourth of contraceptive provision. (Figure 6.6) Private sector institutions, full time and part time private medical practitioners, private pharmacies and grocery stores provide contraceptives and services in Sri Lanka.The 2006/7 SLDHS indicates that pharmacies were the source for 37.3 percent of pills and 59 percent of condoms. Pharmacies as a source of contraceptives has increased by 464 percent between the 2000 SLDHS and 2006/7 SLDHS. By their nature these providers are likely to offer the narrowest choice of methods, mainly condoms and OCP. Women using short acting methods also tend to use the private sector. Two fifths of women using OCP and one third of women using DMPA obtained them from the private sector.

Pharmacist in the private sector can provide condoms, OCPS and emergency contraception without prescriptions. Since many men and women especially in urban areas obtain their requirements of condoms and pills from pharmacies access to FP may be less of a problem for these temporary methods than the long acting methods that must be obtained from a health facility.

The NFPP has not actively engaged with the private sector in the quantification and forecasting process of contraceptives, yet the private sector plays a significant role in increasing access.The SLDHS 2006/7 found that about 63 percent of condoms and 40 percent of pills are obtained from the private sector.

FGD identified convenience as a reason why women and men, especially those employed outside the home, used private sector services.

> *I don't go to government clinic, I do it private. I can get it soon, and come back.*
>
> ***FGD Married women 18-29, Kalmunai***

> *Even if there is a place where you can get condoms for free people won't go there spending time for this. They will give some money and buy it from a pharmacy on their way. Perhaps that's why. Not that this is of low quality or so. Let's say that they get them from MOH, we live about 5 km away from there.*
>
> ***FGD Married men 30-50, Colombo***

> *And it can be obtained at any time, even in the nights. But with us it is not like that no? In our area the people who go far for works feels that getting this at night is easier for them. And they allow them to go home soon after the injection.*
>
> ***FGD PHM, Jaffna***

On average a packet of OCPs costs between SLR 100 and SLR 1648. The price of condoms varies from SLR 40 for a pack of 3 to SLR 190. A pack of flavoured condom is also sold at SLR 190. The cost of ECP is SLR 100. DMPA is provided in the private sector for between SLR 350 -500.

The Director Private Health Sector Development has issued circulars at the request of the Director MCH to the private sector hospitals requesting weekly FP clinics be conducted and that at least 4 methods be provided. In addition, institutions that have services of obstetricians and gynaecologists and operating theatre facilities should provide female sterilization services. However, no instructions were provided to the hospitals on what data on FP should be collected and to whom the information should be sent. A challenge remains in obtaining data on services and commodities supplied and used through the private sector. Currently the FHB is not represented on the Private Health Services Regulatory Council.

The burgeoning private for-profit sector presents an opportunity to increase access for FP services as well as ever-increasing oversight challenge as a result of the lack of capacity to regulate and ensure quality of services provided. Currently FP and subfertility is not included in insurance schemes and advocacy needs to be carried out for its inclusion. The Independent Medical Practitioners Association and the Sri Lanka

College of General Practitioners has not been properly engaged as a group though they can play a usefuland complementary role in providing quality FP services.

The services for infertility in the private sector are more advanced than in the public sector. However most couples cannot afford the services. According to a KI the cost of a standard treatment cycle costs approximately SLR 650,000 which is beyond many couples. This raises the issue of equity in availability of services. Quality control, regular audit and systems of accreditation and registration are not available in order to maintain appropriate standards of care.

16. Contraceptive services for special groups

Context – The NFPP faces difficulties in reaching a number of important marginalized and vulnerable population groups: young people; unmarried, divorced, separated and widowed women; women in the later reproductive years; working women; partners who have been left behind by migrant workers; people living with HIV/AIDS; people with disabilities and; males. As a result unmet need remains relatively high among such groups. The current system has not been responsive to their needs.

Contraceptive services in Sri Lanka currently focuses on the needs of younger married women, generally the most fertile. The Eligible Family Register (H526) is maintained by the PHM. The NFPP defines an eligible family as a family either legally married or living together where the woman is between 15-49 years and/or having a child under 5 years. A family with a pregnant or cohabiting woman irrespective of marital status and age and widows, divorced, separated) are also considered as an eligible family. This definition of eligible family recognizes the needs of these groups. The current service delivery modalities need to be modified to accommodate their needs.

Findings

a) High contraceptive need among young persons

Unmarried young persons in Sri Lanka are sexually active

Since the SLDHS collects information on ever married women only there is very little national data on the use of FP by unmarried women. The National Youth Health Survey 2012/2013 found that around 15 percent of the respondents declared they had sexual intercourse during the preceding year. Of them 5.3 percent were unmarried, 34.7 percent were divorced and 17.2 percent of widowed youth acknowledged they had engaged in intercourse during the last 12 month. A Needs Assessment Survey on Sexual and Reproductive Health for youth in Technical and Vocational Education and Training Sector in Sri Lanka in 2015 showed that one third of the respondents aged 15-29 had engaged in sexual intercourse.[41]

According to the National Youth Health Survey 2012/2013, 9 percent of sexually active youth or their partners had used ECP during the preceding month. Another finding was that 40.7 percent of married and sexually active youth used contraceptives. Popular methods of contraceptives were oral contraceptives followed by DMPA. It is worrying that only 4.2 percent of sexually active unmarried youth used a contraceptive method.

[41] A Needs Assessment Survey on Sexual and Reproductive Health for youth in Technical and Vocational Education and Training Sector in Sri Lanka. State Ministry of Youth and UNFPA 2015

CPR and unmet need among married adolescents

Table 6.3: CPR, unmet need and planning status of births for adolescents and young women

Age group	CPR (%)			Unmet need (%)			Planning status of births	
	Any method	Modern method	Traditional methods	Spacing	Limiting	Total	Wanted later	Wanted no more
15-19	53.7	44.9	8.8	12.9	1	13.9	15.2	3.9
20-24	58.6	50.2	8.4	9.7	1.7	11.4	11.9	4.3

Source: SLDHS 2006/7

The use of modern contraception by adolescents is 44.9 percent and unmet need for spacing is highest (12.9 percent) in this age group. They have the highest rate of unmet need at 13.9 percent compared to other age groups (Table 6.3). However these numbers only refer to married adolescents. If the NFPP were to address the RH needs of sexually active single adolescents the total number of potential adolescent clients would grow enormously.

Attempts of PHMs to delay pregnancy among teenagers by promoting FP meets with resistance from girls as well as from older family members who fear future fertility would be affected.

> *Now in early marriages, when the 16 year old gets married, and when we go to tell them to use FP for a while, they are having a belief or fear saying that because of using this, (contraception)they won't be able to get pregnant later on.*
>
> ***PHM FGD, Kalmunai***

P6 If less than 18 years, the family members won't allow them to use FP, saying that they won't have children later, and become sub-fertile. Saying us that "They are growing children, so because of FP there may be any diseases later" so giving this to below 18 is hard.

P4 We go and meet the married couples who are below 18, and when we ask them to use OCP, the mother (girls) won't allow it. "Iyoo… Miss, if she use this there won't be children" they say.

PHM FGD, Jaffna

Obstacles experienced by unmarried young people in accessing FP services

The perception of some public sector staff was that permission from the parents or guardian must be obtained prior to providing services to a minor.

> *We must always obtain the consent of the parent or guardian before providing contraception to very young girls.*
>
> ***FGD PHM, Colombo***

However, the General Circular Providing Sexual and Reproductive Health (SRH) Services to Adolescent indicates that the best interest of the child should be the foremost consideration.[86]

Unmarried young people face difficulty in obtaining contraceptives even from private pharmacies.

When young people go and ask, some pharmacies will inquire, "Are you married? Where are you from? Which place" so when they get tensed, pharmacy won't give it. So through older friends this can be obtained. Because young people can't get it. That is why they use the other method.

FGD Unmarried men 20-30 years, Kalmunai

Many single women were unaware of emergency contraception. Others faced the hurdle of private pharmacies demanding a prescription to dispense Postinor.

The pharmacy asks for a prescription to give Postinor.

Unmarried women 20-30 years, Moneragala

Some pharmacists have personal opinions or make moral judgements regarding sexual activity among youth and unmarried young people and therefore inappropriately limit these young people's access to contraception.

If I feel that they are too young I don't sell them contraception.

Male pharmacist, private pharmacy Kalmunai

I don't sell to children if they look as if they go to school or I suspect they are unmarried.

Female pharmacist, private pharmacy Nuwera Eliya

Shyness and intimidation creates another barrier to access. Not only do many adolescents and young people lack the confidence to inquire about FP, they feel nervous about the prospect of having to answer a health worker's many questions about their personal circumstances and motives for wanting to use FP.

Talking to the PHI about these things is as bad as talking to my father about sex.

Out of school Boys 16-19 FGD, Colombo

Young people are ashamed to seek access to contraception, particularly due to the issue of perceived lack of confidentiality, which came up repeatedly among FGD participants. Young people don't trust health workers not to share their secrets, and, in particular in relation to contraception. They are worried their parents will find out that they are sexually active.

M Don't you think this can be obtained from the PHI?

P Sometimes when asking from them some fear that this may be told to others due to our young age. But if there is anyone we knew, we can get it through them.

FGD Unmarried men 20-30 years, Kalmunai

Youth Friendly Clinics

Figure 6.7: Youth Friendly Clinics – Colombo South Teaching Hospital

The Youth, Elderly, Displaced and Disabled Directorate (YEDD) was created by the MoH to have oversight on

the health of youth in addition to the other subjects in its title. In 2014 a circular from the DGHS, designated the FHB as the organization responsible for youth health.

According to KI around 50 Youth Friendly Health Service Centres were established by the YEDD. However, currently only about 10 of these centres are functional. KI at the Adolescent Friendly Clinics at Colombo North Teaching Hospital and Colombo South Teaching Hospital said that very few clients came for RH issues and there were none who came for contraception. The Adolescent and Youth Health Unit of the FHB is doing its best to put systems in place. A format for reporting from the clinics on a quarterly basis has been developed.A MO and a nurse from the institutions where Youth Friendly Clinics are established were provided training by the Adolescent Health Unit recently.The Adolescent Health Unit in the FHB is in the process of revamping these clinics including the reporting system

Figure 6.8 Leaflets on adolescent health

A limited number of youth specific SBCC material was available in these clinics. (Figure 6.8) However, their layout was not attractive to youth, though their messages were relevant and encouraged youth to prevent unintended pregnancy and STI/HIV and addressed common questions and concerns of youth. None of the youth community members are involved in the design and implementation of services.

The head of the FP Unit at the FHB said that the Adolescent Health Unit of the FHB was in the process of preparing a package of services and that the FP unit will incorporate FP into it.

Lack of comprehensive sexuality education in schools

Introduction of comprehensive sexual reproductive health education into the school curriculum in Sri Lanka is a sensitive matter. The subjects on life skills, health and physical education have been incorporated in the school curriculum from grade 6 onwards. However, KIs in the health sector said there are significant barriers to introduction of comprehensive sexuality education into the curriculum due to sociocultural conservatism. In 2015, the Ministry of Education and Ministry of Health developed an action plan for school Comprehensive Reproductive Health Education (CRHE) for the next two years with the support of UNFPA. The main aim of this program is to enhance national capacity to design and implement community and school based CRHE programmes that promotes human rights and gender equality.

Meanwhile, the Policy Framework and National Action Plan to address Sexual Gender Based Violence 2016-2020 has been approved by the Cabinet of Ministers and includes the introduction of an interactive module to teach reproductive health and sex education as part of health and physical education curriculum. This module must be reviewed as to its content on FP and strengthened if necessary in partnership with the

Adolescent and Youth Health Unit of the FHB.

b) Unmarried, separated, divorced and widowed women – a growing need for contraception

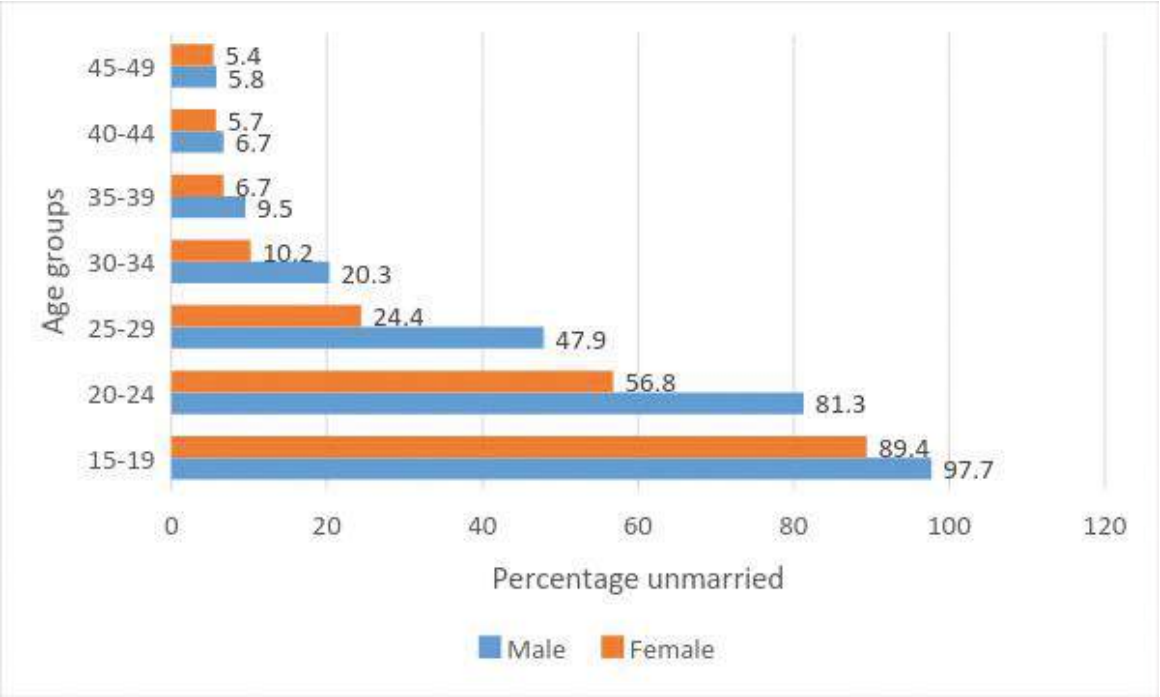
A significant trend the FP programme must respond to concerns changing patterns in family formation. At the time of the 2012 Population and Housing Census there were 1.6 million women (almost 30 percent) aged 15-49 who were unmarried. (Table 6.4) One third of women in the reproductive age group were unmarried, widowed, divorced or separated. There were approximately 87,000 women aged 15-19 who were, married, widowed, divorced or separated.

Table 6.4 Marital status of women 15-49 by age

Age group	Never married	%	Married	%	Widowed	%	Divorced	%	Separated	%	Total
15-19	737,323	46.3%	85,392	2.4%	493	0.53%	167	1.02%	947	1.60%	824,322
20-24	448,883	28.2%	335,158	9.3%	1,708	1.82%	827	5.07%	3,991	6.76%	790,567
25-29	197,364	12.4%	598,450	16.7%	4,068	4.34%	1,963	12.04%	7,493	12.68%	809,338
30-34	85,836	5.4%	734,555	20.4%	8,264	8.82%	3,001	18.41%	10,893	18.44%	842,549
35-39	48,126	3.0%	646,905	18.0%	13,405	14.30%	3,306	20.28%	11,298	19.12%	723,040
40-44	39,939	2.5%	617,503	17.2%	24,376	26.01%	3,589	22.02%	12,179	20.62%	697,586
45-49	36,385	2.3%	574,175	16.0%	41,405	44.18%	3,448	21.15%	12,277	20.78%	667,690
Total	**1,593,856**		**3,592,138**		**93,719**		**16,301**		**59,078**		**5,355,092**

Source: Census of Population and Housing of Sri Lanka 2012.

Figure 6.9 Percentage of never married population by age and sex



Source: Census of Population and Housing of Sri Lanka 2012.

Based on the 2012 Population and Housing Census, Figure 6.9 shows the never married population by age

and sex. In each age group, generally the percentage of never married is higher among males, than among females. Never married percentage in the 15-19 age group is 98 percent for males, while the corresponding figure for females is 89.4 percent. Within the broad age group of 20-34, the never married percentage of males is much higher than females; for instance in 30-34 age group, 20 percent of males never married while the figure is only 10 percent for females. At the end of reproductive age (45-49 years of age) 6 percent and 5 percent of males and females respectively are never married.

The SLDHS 2006/7 collected information from only ever married women. Even in the absence of any survey, it is safe to assume that essentially 100 percent of these young women (and men) want to delay pregnancy until marriage. Many may be practicing abstinence. Others as they leave school gain employment and mature both physically and socially may be sexually active, thus running the risk of an unintended pregnancy. Based on the National Youth Health Survey 2012/2013 of the 15 percent of respondents who declared they had sexual intercourse during the preceding year 5.3 percent were unmarried, 34.7 percent were divorced and 17.2 percent were widowed.

Every year there have been maternal deaths among women who were unmarried, divorced or separated. It may have been possible to avoid these deaths if the women had been using a contraceptive method. (Table 6.5)

Table 6.5 Maternal deaths by marital status 2011-2015

Marital Status	**2011**	**%**	**2012**	**%**	**2013**	**%**	**2014**	**%**	**2015**	**%**
Married	110	92	127	95	110	92	101	90	107	94.69
Unmarried	5	4	6	4	8	7	9	8	3	2.65
Widowed	2	3	1	1			1	1	1	0.88
Divorced	1	1					1	1	1	0.88
Living together					1	1			1	0.88
Total	**118**	**100**	**134**	**100**	**119**	**100**	**112**	**100**	**113**	**100**

Source: Courtesy Dr KapilaJayaratne, CCP, FHB

The changing demographics of Sri Lanka as it completes its demographic transition are placing growing pressure on the FP programme to provide additional services for the growing proportion of population that is currently unmarried, divorced, separated and widowed. Sri Lanka has been changing quickly, but services and social responses to these changes are slower.

There are no clear guidelines about the right of access to contraception for single women and provision of services is left to the discretion of the service provider. Data on the use of contraceptives among unmarried though sexually active women is not available. FHB is trying to reach unmarried young women upto 24 years through the Youth Health Programme. There is no strategy at present to reach older unmarried women at present. A FP programme that continues to restrict itself to providing services almost exclusively to married couples will necessarily miss a vital, and increasingly large, segment of the population. Traditional socio-cultural taboos and fear of stigmatization regarding premarital sex and pregnancy may impede access to contraception.

Unmarried women

Unmarried women who are sexually active are reluctant to obtain FP commodities from the PHMs or public sector facilities. Single women feared that if they requested for contraception from a government facility they would be stigmatized.

> *When unmarried person goes to a place like that the society… when a person like me go there and ask they will think why has a young person come here… they think like that. Even when we want to know we don't go because we have the fear & shame.*
>
> ***Unmarried women 20-30 years, Colombo***

These women felt more certain that confidentiality will be maintained in the private sector.

> *They don't like to go a government place and give their privacy to the outside. When they go to a private place and take a tablet their privacy is secured. It does not go to the outside. Only she or only one other person knows. When you take from friends, they don't spread it to the outside.*
>
> ***Unmarried women 20-30 years, Colombo***

Partly due to being shy and partly for anonymity some of these women used an intermediary to obtain contraceptives.

> *They buy it from way of a friend. They feel shy. They may be going there and saying it is for a friend and buying for them… may be… (Giggling) I don't think unmarried people are going to government places.*
>
> ***Unmarried women 20-30 years, Colombo***

Innovative ways are necessary to reach out to this group given the cultural sensitivity.

Information can be disseminated at workplaces but all the employees should be there including the executives.

Unmarried woman 20- 20 years, Moneragala

Separated and divorced women

Separated and divorced women often entered into a sexual relationship with the hope of getting married. In some instance these women were involved with multiple partners.

> *Most of the time with the idea of getting married they will have a relationship with someone. They may or may not become successful.*
>
> ***FGD separated, divorced women, Colombo***

There is not one person necessarily. There can be women who have 4, 5 affairs.

FGD separated, divorced women, Colombo

PHMs said when they recognized divorced and separated women a high risk group for unwanted pregnancy but experienced difficulty in promoting these women to accept a FP method.

P12 They say they don't need

P2 They are high risk. I keep a watchful eye. I know some have involvements. Its difficult to promote FP to them.

FGD PHM, Galle

Separated and divorced were reluctant to obtain contraceptive information and services from the village clinic for fear of being stigmatized.

[86] General CircularProviding Sexual and Reproductive Health (SRH) services to Adolescent FHB/AH/TP/2014 dated 08.07.2015

If you are divorced, and asking about contraception….. either you should marry someone first, or… if going and asking this will be like insulting ourselves. If we go and speak about it, it's a shame for us as well as for our next generation. If that kind of life, we can marry another male and getting this is ok. But we being separated and widowed, is unacceptable.

FGD separated, divorced women, Trincomalee

No there's no such possibility. The PHMs know that she is separated from her husband.

FGD separated, divorced women, Colombo

Even if the PHM were to visit the house they feared the neighbours would get suspicious

Now this is the problem, I live alone in my house, and there are two others who have their husbands near my home, and when miss comes to my house and speaks to me particularly…. What will the other two think of me? They will think wrongly about me. Soon as they see it, the next door ladies will talk " Why is miss going to her house and talking?" but sometimes if miss comes and talk regarding the children even, without knowing the matter they will start talking wrong about us. "why miss is suddenly going to her house and talking? she must be a bad person" now because of this there are many issues in the society. And when we have grown up children, and when they say "miss met your mother" that affects our children mentally, and we have a bad name in the society. But when speaking in a common meeting it is not a problem.

FGD separated, divorced women, Trincomalee

These women preferred information to be provided at common fora rather than being singled out e.g. PHMs visited preschools for vaccination, meetings related microcredit, workplace etc.

I think it's not good to separate them. They may get the feeling that "why did they separated us and selected us." If the executive officers are not present and the minor staff is selected for this they may get the feeling that they are being treated as inferiors.

FGD separated, divorced women, Colombo

Even for the loan meeting everyone comes, there is a NGO called FAMINA, which has the meeting only once a month. Every month in their meetings they give us presentations on different topics. Last time it was about the plastic bottle usage and their awareness. Like that there are many. Also on FP, and on talking so much loans what are the consequences. There are many awareness events.so for these meetings. In every area there will be 3. So from all 20 areas there will be 60 people. In that 60 people…. At least 5 separated women will be there. Even if there is one person they will get to know the good things from that meeting.

FGD separated, divorced women, Trincomalee

They recognized the need to use ECP in the event of a casual encounter. Sources of contraceptives for separated and divorced womenwere pharmacies and private doctors.

The easiest contraceptive method separated and divorced women could obtain was the pill.

There are other things like these, loops, Jadelles…. But these are mainly provided through the MOH clinic centres, so they go for the pill methods only.

FGD separated, divorced women, Trincomalee

In some instances even obtaining contraception from pharmacies was a challenge for many women.

Personality problems in asking for that (FP) from a pharmacy. Feeling shy to ask from a pharmacy.

FGD separated, divorced women, Colombo

In pharmacy they don't give it normally, if a doctor prescribes only they will give it.

FGD separated, divorced women, Trincomalee

FGD separated, divorced women, Trincomalee

In some instance the partner obtained a FP method for the woman.

When there are extramarital affairs they will give

FGD separated, divorced women, Colombo

Participants in the FGD in Colombo for separated and divorced women said they did not attend the village clinics. They preferred the anonymity of a hospital clinic.

c) Older women in the reproductive age group

Older women who are not using contraception are at risk of unwanted and mistimed pregnancies. There are preventable maternal deaths in this group. Many FGD participants had the mistaken belief that ovulation ceased with the last menstruation and were not aware that a contraceptive method should be used for about a year after the last menstruation.

Infrequent intercourse is cited as a reason for not using modern methods especially those women with grown up children.

P7 Sometimes when telling about family planning the mothers will start to say…." No miss the children are grown up, so using these are odd to us"… in my area these difficulties are there. The mothers' age is less, but when they have children in 10 years they tend to refuse. This idea is there in my area.

M So these kind of people, are they becoming pregnant later on?

P7 They will talk on only how they are in nights. They say that children will be with their father and we will be alone. They think that if their children are grown up they need not to be in a sexual relationship. So they think that FP is not needed.

FGD PHM, Nuwera Eliya

According to FGD participants women in this age group had little contact with the PHM, especially if the last child was more than 5 years. KI and FGDs said inviting older women to the WWC and NCD clinics presented an opportunity to discuss FP.

d) Women living with HIV AIDS

In addition to increasing access to more effective antiretroviral drugs during pregnancy and delivery, eliminating MTCT requires limiting the duration of breastfeeding to 12 months and eliminating the current unmet need for FP.[43,44] There is growing recognized that elimination of PMTCT will not be possible without further expanding access to contraception among women living with HIV infection.[45] However, eliminating unmet need for contraception of individuals living with HIV/AIDS to prevent unintended pregnancies is an often neglected approach to preventing HIV transmission to infants. Women with HIV infection, like other women, may wish to plan pregnancy, limit their family, or avoid pregnancy. Access to a variety of contraceptive options is therefore critical for HIV-infected women who many change their childbearing plans in response to learning their HIV-positive status.[46]

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[43] Hladik W, Stover J, Esiru G, Harper M, Tappero J. The contribution of family planning towards the prevention of vertical HIV transmission in Uganda. PLoS One. 2009 Nov 2; 4(11):e7691.

[44] Reynolds HW, Steiner MJ, Cates W Jr. Contraception's proved potential to fight HIV.SexTransm Infect. 2005 Apr; 81(2):184-5.

[45] Mahy M, Stover J, Kiragu K, Hayashi C, Akwara P, Luo C, Stanecki K, Ekpini R, Shaffer NSexTransm Infect. What will it take to achieve virtual elimination of mother-to-child transmission of HIV? An assessment of current progress and future needs.2010 Dec; 86 Suppl 2():ii48-55

[46] Hayford SR, Agadjanian V, Luz L. Now or never: perceived HIV status and fertility intentions in rural Mozambique.Stud Fam Plann. 2012 Sep; 43(3):191-9.

This was the observation of a FGD participant with HIV.\

> *The doctor was telling that having a child… that is a way of spreading infection… so no babies. They are telling it for my good. They have told me, no baby for me. Lot of people who are not having HIV have only one child. They have told me clearly and made me understood that I can't have another child. I'm sad. My child does not understand about HIV. He has it. I breast fed him for 4 years. He's got it because of that. He is asking me why he's getting the problems. I'm thinking whether I can get a baby from somehow or other method.*
>
> ***FGD PLHIV***

FGDs with this group indicate there is stigma attached to revealing their HIV status in health facilities and also in society. They were very satisfied with the services that are provide at the NASCP clinics. These women suggested that NSACP clinics should be staffed with a PHM with whom they could discuss issues related to contraception.

We found during FGD with PHM that their knowledge on suitable choices of contraceptive methods for counselling HIV positive women was suboptimal. Another issue was that PLHIV did not have trust in health personnel other than the NSACP staff to maintain confidentiality.

> *I could not go to the MOH to get information. It was the midwife who got to know and spread that everywhere in the village. I haven't gone there to get any service. But it was her who said that I have HIV.*

Another woman said-

> *The village clinics are not good places. If I was asked to come to a nurse, to a doctor or a dispensary, I don't want to go to face them. If they get to know, even the doctors will think badly of us. The nurses PHM also… I'll talk more when I go to IDH. My doctors are there, my nurses are there.*
>
> ***FGD PLHIV***

a) Contraceptive services for males

Partly because of HIV prevention efforts, young men have become increasingly aware of condoms, while vasectomy remains relatively unknown to them. According to the 2006/7 SLDHS since 1993, knowledge about male sterilization has dropped by 14 percentage points.

Service providers recognize that couple counselling would be more effective and bring about joint decision making in regard to use of contraception. However there are practical difficulties to joint couple counselling such as the limited space in many clinics and inconvenient clinic times for working men. Moreover, service providers are not trained on gender sensitive counselling. The parent craft classes are an opportunity to reach men with messages on contraception. Information and services on contraception need to be integrated into health programmes for older males e.g. NCD. KI said that the PHIs could contribute more to male involvement. (Chapter 5 Enabling Environment)

If the NFPP is to revitalize vasectomy it will have to counter several negative perceptions men have about the method. The following are perceptions of men about vasectomy from FGD conducted with men during the review. Men were aware that vasectomy is a method for limiting births and that it was carried out many years ago in Sri Lanka.

P2 For men also they have done surgery

P1 Long time back.

P2 In Kalmunai Base Hospital, for 500 rupees, many did this surgery.

P1 This was long time back

FGD married males 35-50 years, Kalmunai

There was a perception among FGD participants that there had been inadequate information provided on the procedure in the past which has led to its unpopularity. One participant from Gomarankadawala, in Trincomalee said the following.

> *There are two uncles in the village who don't have children. They say that about 20 years ago people came and gave Rs 250 and a "buth packet' (packet of rice) if they had the operation, but they were not told what it was. Now they don't have children.*

FGD married males 35-50 years, Trincomalee

Male participants were asked for their thoughts on why female sterilization was more common than vasectomy. They offered the following explanations. Men were worried that vasectomy would reduce libido.

P6 Mostly the men don't do it because they are scared. They are scared of side effects. There can be effects.

P3 Sexually… the strength will reduce

FGD married males 35-50 years, Colombo

Another concern men had was that following vasectomy they would not be able to work as hard as they did prior to the procedure.

P1 Since the man is working hard… may not be able to do heavy work

P8 Yes may not be able to exhaust himself.

FGD married males 30-50 years, Colombo

P6 when men do it they can't do heavy work. Their strength is reduced.

P8 Yes, can't do work.

FGD married males 30-50 years, Kalmunai

Fear of cancer following vasectomy was also expressed as a reason men did not ask for vasectomy.

I have heard that vasectomy causes cancer.

FGD married males 30-50 years, Trincomalee

17. Client receive high quality counselling

Context- Counselling is an essential element in the provision of high quality FP services to ensure that clients make informed and voluntary choices about their choices of contraceptive methods and investigation and treatment of subfertility. People should have the opportunity to make informed decisions regarding the type of contraceptive method to be used and couples with difficulty conceiving about the options for care and treatment based on access to evidence-based information. These choices should be recognised as an integral part of the decision-making process.

Clients seeking contraception may not have adequate information about a particular method and its effects which is further compounded by misconceptions and rumours. Research shows that when clients are counselled on contraceptive side effects in advance, they are more likely to use their chosen method correctly and longer.[47] Good counselling leads to improved client satisfaction, which in turn decreases rates of discontinuation. When counsellors treat clients with respect, listen to their concerns, and support them in identifying and meeting their reproductive needs, clients report greater satisfaction with the service they received.[48] Further, well-counselled, satisfied clients are more likely to champion contraception and recommend contraception to others, generating demand for services.[49]

Subfertility counselling is considered a specialist field and an important adjunct to treatment. In the case of subfertility, counselling should be offered before, during and after investigation and treatment, irrespective of the outcome of these procedures.[50]

To provide quality counselling to clients, facilities should be able to ensure some level of privacy. Guidelines and verbal information should be supplemented with written information or audio-visual media. Finally, service providers require supportive supervision, training and supplies, equipment and infrastructure to provide quality counselling services.

Findings

Many KI ranging from policy makers, manager, trainers and clients felt that communication and counselling skills of service providers was weak and needs improvement. They suggested that both during pre-service and in-service training emphasis should be placed on counselling skills. The new curriculum for PHMs is a step in the right direction as it stresses effective communication and interpersonal skills.

During FGD with service providers and clients we found that the following information was provided to clients choosing a method:

a. side effects and complications;

b. how to use the method, where to obtain the method, and what to expect during the procedure, and;

c. when to return for follow up services.

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[47] Informed choice in family planning: Helping people decide. Population reports Series J No 50. Baltimore: Johns Hopkins University Bloomberg School of Public Health, Population Information Program. https://www.k4health.org/sites/default/files/j50.pdf (Accessed 14.1.2016)

[48] Developing a continuing-client strategy. Population Reports series J, No. 55. Baltimore: Johns Hopkins Bloomberg School of Public Health. http://info.k4health.org/pr/j55/j55eng.pdf (Accessed 24.1.2016)

[49] Williams, T., Schutt-Aine, J., and Cuca, Y. 2000. Measuring family planning service quality through clientsatisfaction exit interviews. International Family Planning Perspectives, 26(2):63–71.

[50] NICE Guidelines Infertility 2013. https://www.nice.org.uk/guidance/cg156?unlid=729109367201612516391O (Accessed 14.1.2016)

Clients were not informed adequately about (a) the relative effectiveness of each FP method for pregnancy prevention and (b) each method's degree of protection against HIV and STIs. This latter aspect is particularly important as the Programme for Elimination of Mother to Child Transmission of Syphilis and HIV is rolled out throughout the country.

Service providers are expected to counsel clients on the full range of contraceptive methods available on site or on referral. During FGD with women many said they were informed by the PHM of all available methods and asked to choose an appropriate method. However, we also found women had been categorically told by the PHM to use or not use a particular method.

Within the time frame, it was difficult to assess the client-provider interactions and counselling with fairness. MO, PHN and PHM were able to demonstrate how they use tools for counselling, such as flipcharts and/ or samples of various contraceptive methods to counsel clients sensitively while respecting their right for privacy.

Though service providers acknowledged that couple counselling was ideal and would encourage joint decision making it was not feasible in most instance due to infrastructure constraints in clinics. In addition, the clinic times were not suitable for working men. KI expressed concerns about the insufficient amount of time that is available for counselling given provider workloads. It is possible, though we have no solid evidence, that one of the reasons for discontinuation of implants and IUD soon after insertion is the inadequate counselling skills of MO.

Empathy, counselling and psychological support for subfertile couples is as important as advanced treatment techniques. Counselling for subfertile couples requires special expertise. PHMs who are the frontline workers recognized that they needed to have their knowledge updated on subfertility and that counselling for subfertility required special skills.

> *I think it would be good to have counselling services for sub fertile couples by bringing someone who is special for that field.*
>
> ***FGD PHM, Colombo***

Chapter 7
Findings - Demand

Introduction

By demand is meant the sense of need or motivation to act. Demand creation refers to organized activities intended to stimulate interest in using FP services for birth spacing and limiting and also for treatment of subfertility. For those who argue that FP is a sensitive issue, most also agree that treating subfertility and talking about the benefits of contraception in the context of healthy timing and spacing of pregnancy is acceptable.

There are many barriers, real and perceived that hinder couples and individuals ability to utilize FP services. Demand-side barriers are as important as supply factors in deterring clients from obtaining FP services. These barriers are likely to be more important for the poor and other vulnerable groups, where the costs of access, lack of information and cultural barriers impede them from benefiting from public sector services.[1] Individuals, families, and communities need the knowledge, capacity, and motivation to seek, choose and use contraception and subfertility treatment.

18. The NFPP reduces out of pocket expenditure to increase demand

Context – Utilizing FP services can be time intensive because both clients and relatives may have to give up working so as to receive services. Similarly, the time spent traveling to facilities and waiting to receive care represents an indirect opportunity cost for many clients, who may have to forego earned income to receive care. Distance to facilities imposes a considerable cost on individuals and this may often impede their ability to access services and also reduce demand.[2]

Findings

Until 2010 the NFPP charged cents 50 for a packet of OCP and cents 5 for condoms.[3] All other contraceptive methods were provided free of charge. As mentioned in Chapter 4 there is very little inequity between the richest and poorest wealth quintiles in relation to the CPR.

However, we found there were instances where poor women had to incur out of pocket (OOP) expenditure or incurred opportunity costs if they were to obtain contraceptive services which in turn may affect demand for contraception.

Women referred for sterilization have to stay overnight in hospitals and often surgery is postponed. This leads invariably to OOP expenditure that some poor clients can ill afford for transport, meals and lodging for relatives accompanying the woman. The payment for client's undergoing sterilizations was done away with in 2013.[4] KI were of the opinion that doing away with the payment has not had an impact on the demand for female sterilization.

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[1] Ensor, T., and Cooper, S. 2004. Overcoming barriers to health service access: Influencing the demand side. Health Policy and Planning 19(2):69–79.

[2] Ibid

[3] General Circular No01-39/2010 Removal of fee for oral contraceptives pills (OCP) and condoms.

[4] General Circular FHB/FB/21/2013 Cancellation of the 'out of pocket allowance' paid to clients who voluntarily undergo sterilization

[5] Annual Health Bulletin 2013. Medical Statistics Unit, Ministry of Health, Sri Lanka

In some clinics in the public sector the client's method of choice may not be available. They are then referred to a health facility in the public sector or private or NGO sector that provides the method. Some poor women forego using the method because they have to incur expenses for transport or to pay a private provider.

M So if loop is given here they will accept it?

P8 If given free of charge they will put it. They don't want to spend money, and thinking that they need to travel far, they stay behind thinking let's get it if they give it, otherwise let's forget about it.

FGD Married women 18-29 years, Jaffna

Because many field clinics do not have the necessary equipment and supplies such as oxygen cylinders in the event of an anaphylactic reactions, women requesting DMPA are referred to clinics that provide the service. Alternately, they have to obtain supplies from the private sector where resuscitation facilities in case of anaphylaxis may or may not be available.

P2 In Kotagala, and many areas Depo is not available

M So for people in these areas, even if they prefer Depo, they do not have this option.

(Most participants agreeing)

P2 It is only in the private sectors only Sir…

M So that is they are paying for Depo…

P2 Yes

P3 In our area most people like Depo…. So they get it in nearby private clinics by EMAs. However they will charge at least Rs 500/= for a Depo

FGD PHM, Nuwera Eliya

On average Western type government health care services are available within 4.8 km of a client's home[5] and indicates geographic accessibility which reduces the cost of transport. In general, distance to the clinic was not an issue, especially in urban areas.

P3 In Colombo district clinics are not far. In Colombo mostly the clinic……

P1 Can reach from 2, 3Kms.

FGD PHI, Colombo

Some women stop using the method as they have to travel some distance to obtain contraception.

When it is far, some people won't go. If the injection is given here they will come here and get the injections. But if she had to go far to the MOH to get these, it would be difficult.

FGD Married women 30-45 years, Trincomalee

Earlier we were giving injections in the PMCU. At that time the FP usage was also high. But now when *we ask them to get the injections they agree with us but do not go for it.*

FGD PHM, Jaffna

The Teaching hospital and the Thellipalai hospital are far for them. So because of that also some people don't go, saying they have to leave their babies at home. So they don't go because of this.

FGD PHM, Jaffna

M Are far away, distant clinics a problem?

P2 Yes if they have to travel far, they will postpone the visit. And like that they will never put it (IUD). ….

FGD Married women 30-45 years, Nuwera Eliya

Earlier we gave depo. But now there's no depo. So they have to go to NuwaraEliya town for depo. And they are not going for it. There is a mother, whose baby is not yet 1 year old. But she's not using anything.

FGD PHM, Nuwera Eliya

We also found that clients seeking services in the public sector are sometimes turned away and have to seek services from the private sector.

We are given injections for only one year from the clinic. After that we are told to go and get it privately.

FGD married women 18-29 years, Moneragala

When we ask for injection…. Miss tells us that now you don't have to postpone your pregnancy, so we won't give you pills hereafter, and ask them to have a baby… what they do is, they go privately and get this injection and tablets.

FGD married women 18-29 years, Jaffna

PHMs are expected to visit women in their homes, providing information on contraception and condoms and OCP supplies and refers those who opt for DMPA and long-acting and permanent methods to health facilities.

It's not necessary for us to come to the MOH office, the midwife comes to our home and gives it to us. No need for us to pay the three wheeler and come to MOH office. For loop and Jadelle we come here, but for the tablets, they provide it at home. Once in a month she visits home.

FGD married women 18-29 years, Kalmunai

However, KI point out and even PHMs admit that they do not visit homes as frequently as they did in the past due to the heavy workload.

P7 One problem is that we have limited time to meet the mothers and discuss.

P4 We get 6 or 7 days to go in the field. Within that period we have no time to meet every mother. That's the biggest constraint we have.

FGD, PHM Galle

As more and more women join the workforce one drawback of the current public sector FP services is that they are not available at times that are convenient for clients. Seeking services during working hours represents an indirect opportunity cost for many clients who may forfeit wages to receive care.

For people who are working in the government sector it won't matter. They will get the salary anyway. People who are working in the private sector will face the problem. Their salary will be deducted.

FGD Married women 18-29 years, Colombo

Some institutions such as Castle Street Hospital for Women and De Soysa Hospital for Women are open from 12-2 pm for working women in the city to avail themselves of services.

M I want to know whether the time of these clinics is convenient or not? Do you have to take leave and come?

P8 My job is sewing. I have to finish the order when they ask. When I consider the time they ask and when I have to spend 1 day at the clinic there it is difficult for me.

M So for someone who is doing a job what time is more convenient?

P8 If they give us a time… if they say 12.00-1.00 pm time is better

FGD Married women 18-29 years, Galle

Most central MOH clinics also provide FP services on Saturday which many working women make use of. For some women, a clinic on Saturday was not an option.

> *Some are working on Saturday too.*
>
> ***FGD Married women 18-29 years, Colombo***

Subfertile couples also incur out of pocket expenditure since laboratory and treatment facilities in government hospital may not be readily available.

> *I was asked to get some hormone investigations done outside (i.e. in the private sector) and was told it would cost Rupees 15,000. It took me 9 months to collect the money.*
>
> ***FGD subfertile women's group, Moneragala***

19. The FP programme's behaviour change communication strategy increases demand

Context - BCC focuses on individuals and their behaviour and aims to motivate individuals to discuss FP with their spouse or partner, visit a clinic or community worker and initiate use of a contraceptive method when pregnancy is not desired.[6] BCC is also necessary to encourage couples to seek investigation and treatment for subfertility. A vital part of the success of voluntary FP programmes is promoting the benefits of contraception to women, their partners, and communities. Consistent and sustained BCC to build community knowledge and perceptions about the true biomedical causes of subfertility and the available forms of prevention and treatment is necessary.

BCC is disseminated by means of mass media, interpersonal communication counselling, electronic media and community mobilization and provides factual information on types of contraceptive methods, safety, sources of supply, and management of side effects. BCC programmes should dispel myths and misconceptions in relation to contraception as well as subfertility in an effort to overcome barriers to use of services. Mass media has an important role in familiarizing men and women with current information about contraception and subfertility. Although the impact of mass media on any one individual may be slight its cumulative effect on an entire population may be great because it reaches many people.[7] There is evidence from a number of studies that individuals exposure to mass media messages promoting FP influences contraceptive behaviour.[8,9] For example, in Nigeria, access to mass media messages increased the likelihood of the use of contraceptives.[10] A similar study in Tanzania found that women exposed to a mix of media promoting contraception were more likely to use contraception.[11] The disadvantage of mass media is the cost.

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[6] Bongaarts J, Cleland J, Townsend JW, Bertrand JT, Das Gupta M. Family planning programs for the 21st century : Rationale and design. New York : The Population Council, 2012

[7] Islam MA, Kabir M. Factors affecting mass media FP programs on current use of contraception in Bangladesh. 1998. Bangladesh J. Agric. Econs. XXI, 1 & 2 (1998): 111-126.

[8] Piotrow, Phyllis T., Jose G. Rimon, Kim Winnard, D. Lawrence Kincaid, Dale Huntington, and Julie Convisser. 1990. "Mass media family planning promotion in three Nigerian cities." Studies in Family Planning 21(5): 265-274

[9] Kincaid, D. Lawrence. 2000. "Social networks, ideation, and contraceptive behavior in Bangladesh: A longitudinal analysis." Social Science and Medicine 50(2): 215:231.

[10] Ajaero CK, Odimegwu C, Ajaero ID, Nwachukwu CA. Access to mass media messages, and use of family planning in Nigeria: a spatio-demographic analysis from the 2013 DHS. BMC Public Health. 2016 May 24;16:427. doi: 10.1186/s12889-016-2979-z.

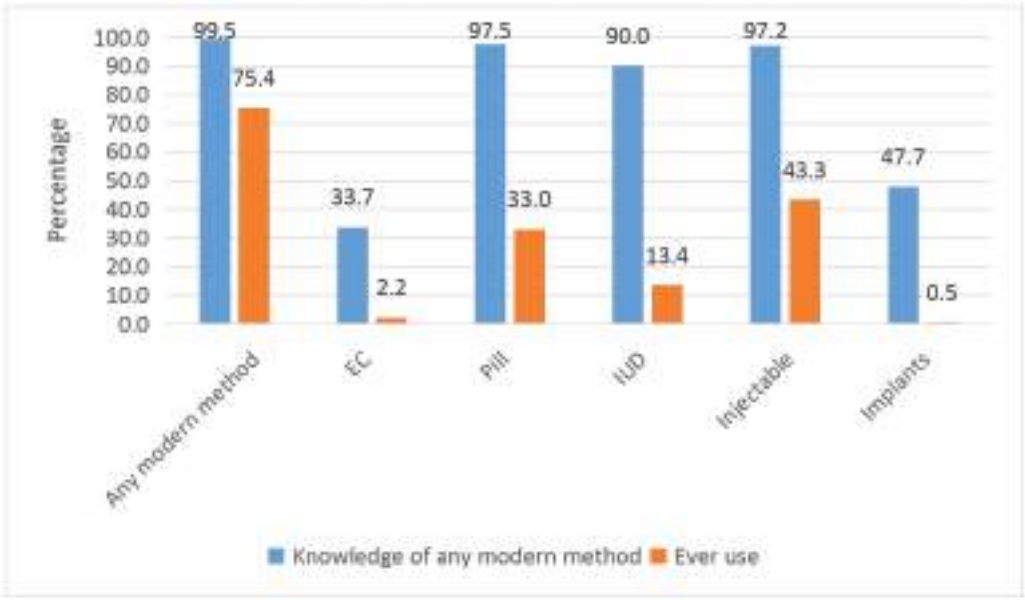
[11] Jato, Miriam N., Calista Simbakalia, Joan M. Tarasevich, David N. Awasum, Clement N.B. Kihinga, and Edith Ngirwamungu. 1999. "The impact of multimedia family planning promotion on the contraceptive behavior of women in Tanzania." International Family Planning Perspectives 25(2):60-67.

Findings

Knowledge and use of modern contraception

Despite knowledge of modern contraceptive methods being high in Sri Lanka there are wide discrepancies in their use by women. (Figure 7.1)

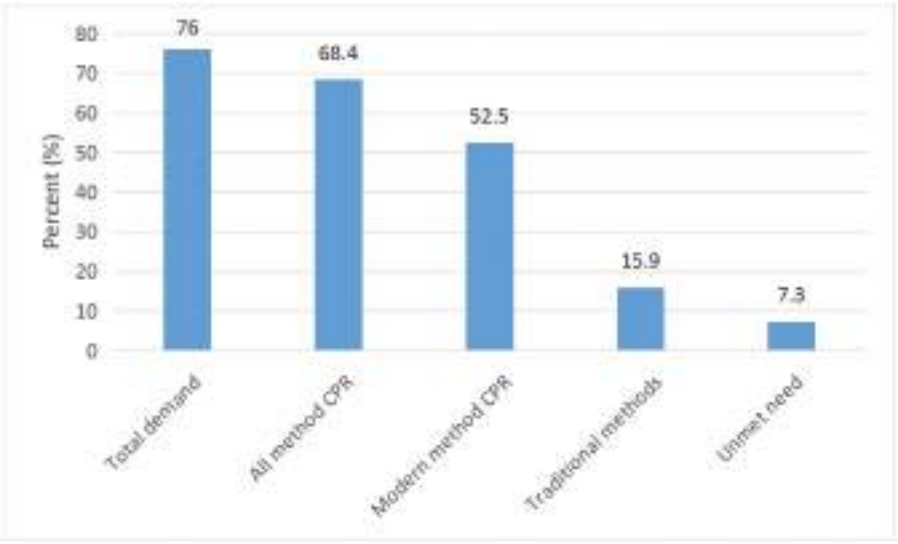
Figure 7.1: Knowledge and ever use of modern contraception and emergency contraceptive pill, OCP, IUD, injectable and implant



Source: 2006/7 SLDHS

According to the 2006/7 DHS, 76 percent of married women ages 15–49 want to avoid pregnancy and therefore need contraceptives, whereas 52.5 percent are using modern contraceptives and 15.9 per cent are using traditional family planning methods, meaning that almost 7 percent of married women want to avoid pregnancy yet are not using any method of family planning (see Figure 7.2).

Figure 7.2: Demand and Use of Family Planning, Currently Married Women



Source: 2006/7 SLDHS

The reasons DHS respondents gave for not intending to use contraception in the future are shown in Table 7.1. Two thirds of respondents cited fertility related reasons and one fifth gave method related reasons for not intending to use contraception. Opposition to use accounted for 8.1 percent of those not using contraception.

Table 7.1: Percentage distribution of currently married women 15-49 who are not using contraception and do not intend to use in the future.

Fertility related concerns	**67.8**
Infrequent sex/no sex	21
Menopausal/hysterectomy	6.6
Subfecund, infecund	30.9
Wants as many children as possible	9.3
Opposition to use	**8.1**
Respondent opposed	1.7
Spouse opposed	3.7
Religious prohibition	2.6
Others opposed	0.1
Lack of knowledge	**1.3**
Knows no method	1.2
Knows no source	0.1
Method related reasons	**21.9**
Health concerns	13.1
Fear of side effects	7.4
Lack of access	0.2
Inconvenient to use	0.8
Interferes with body's normal processes	0.4
Other	**0.3**
Missing	**0.1**
Don't know	**0.5**
Total	**100**

Source: 2006/7 SLDHS

Fertility related concerns were the most important reason for women not using contraception followed by method related reasons. Health concerns and fear of side effects were given by one fifth of respondents for not using contraception.

Rumours and misinformation about contraception

Rumours and misconception about contraception contribute to health concerns and fear of side effect.

Table 7.2 shows the rumours and misconceptions about different contraceptive methods mentioned by FGD participants

Table 7.2: Rumours and misconceptions about contraception identified by KII and FGDs with clients and service providers

Condoms	Since it's an external thing there is a high chance of germs get into the body.
OCP	Causes subfertility if used below 18 years Cause "lumps" in the uterus because of reduction in blood loss during withdrawal bleeding If used for a long time they cause congenital abnormalities in subsequent children Causes breast cancer Hair loss
ECP	Can be used upto 72 hours only
Injectable	Leads to secondary subfertility Cause "lumps" in the uterus because of reduction in blood loss during withdrawal bleeding. Noxious substances are retained in the body because of scanty withdrawal bleeding Causes breast cancer
IUCD	May migrate through the body to the liver / into the abdomen Fear of being struck by lightning was mentioned by PHMs among tea estate workers IUCD gets destroyed in the uterus and the woman gains weight May cause cancer Hair loss
Implants	into the body and causes cancer
Female sterilization	
Vasectomy	Men loose their virility Men become weak and cannot do hard work Causes cancer

Clearly any BCC campaign has to address these myths and misconceptions to allay women and men's concerns about contraception.

Sources of information on FP

During the review it was observed there was no organized, systematic approach to BCC activities in the districts for promotion of contraception and awareness of subfertility. Attention was focused on reducing teenage pregnancy in MOH areas in some districts. In many districts BCC efforts concentrated on nutrition aspects such as breast feeding, lactation etc.

The following were identified by FGD participants as sources of information on FP.

Information sources for women

The PHM was an important and respected source of information for women. PHMs were well acknowledged as sources of information for women during their antenatal, postnatal visits to the clinics as well as during domiciliary visits. This information is valuable and helpful in the women's decision to commence use of contraception.

> *We believe in our miss (PHM), we approach her for anything. We read from papers also, but we don't have any experience on them. So we come and ask our miss what is good for us. Then miss is the one who will guide us on the good path.*
>
> ***FGD Married women 18-29 years, Jaffna***

Other sources of information on FP for women were doctors,

The doctor also advices us. When we attend the last clinic during the pregnancy period, they tell us that after the baby is delivered to use a method of FP.

FGD Married women 30-45 years, Trincomalee

Radio, TV programme on health, leaflets and posters were other sources of information that were identified by FGD participants.

The internet was cited as a source of information on FP by urban women.

P1 To see a doctor also we gather information from the internet. Out of FP we select a method with lesser side effects.

M Is it reliable

P1 It is better to be aware about something and ask about it from a doctor rather than not knowing anything about it.

M So you have prior awareness on this from internet before seeing the doctor?

P1 Yes

FGD Married women 30-45 years, Colombo

Information sources for men

For males, the wife was an important source of information on FP. The information women received from PHM's was shared with their husbands. The quotations below show how men get to know about contraception through their wives.

P2 We get to know a lot of things by discussing with the midwife.

M You mean you discuss with the midwife or wife discusses with midwife and tells you?

P2 Wife discusses and tells us. She (PHM) says she wants to discuss with father as well.

P8 They come to our home and say, do this, that.

FGD Married men 35-50 years, Colombo

P4 We get to know it from our wife.

M So, your wife is able to discuss this FP with you and she is telling it to you. Is she?

P4 Yes, they will come and discuss.

FGD Married men 35-50 years, Nuwera Eliya

When things are told to the wife by the PHM, it will reach the husband automatically.

FGD Married men 35-50 years, Kalmunai

Radio, TV, posters, leaflets, and meetings organized by service providers were also sources of information for men.

P8 While conducting health meetings they use to show it (Video). In NuwaraEliya MOH they showed it to us.

M Was it organized by the PHI's ?

P8 Yes.

FGD Married men 35-50 years, Nuwera Eliya

Older men and friends were another source of information for men.

> *There are people who have got married earlier. They tell us "malli" (younger brother) do this that. There are a lot of people who say that.*
>
> *FGD Married Males 35-50 years, Colombo*
>
> *Friends, and people who are involved in it. Most of these matters cannot be talked with everyone. But friends will share it among friends.*
>
> ***FGD unmarried men 20-30 years, Kalmunai***

Service provider's perspective

Instead of having separate leaflets for each contraceptive method, PHMs suggested to have descriptions of all the methods in one leaflet.

> *P3 If leaflets contain all the methods in one that would be great. But the ones we got has everything in separate sheets. So some go missing…. So if they put all the methods in one leaflet it would be better.*
>
> ***FGD PHM, Jaffna***

Service providers felt that in addition to posters and leaflets, use of audio-visual presentations would be more appealing to clients,

> *P3&P2 New methods like CDs can help us.*
>
> *P2 If these are available, when we show the images and videos the understanding will be more… it will help us to increase awareness..*
>
> *P6 Rather than saying things, if we show them, the effectiveness is more.*
>
> *(P7&P8 Supporting; Many agreeing)*
>
> ***FGD PHM, Kalmunai***

Most MOH offices had audio-visual equipment available.

In addition, PHMs in Jaffna had found that the best advocate for FP was a woman who had successfully used a FP method.

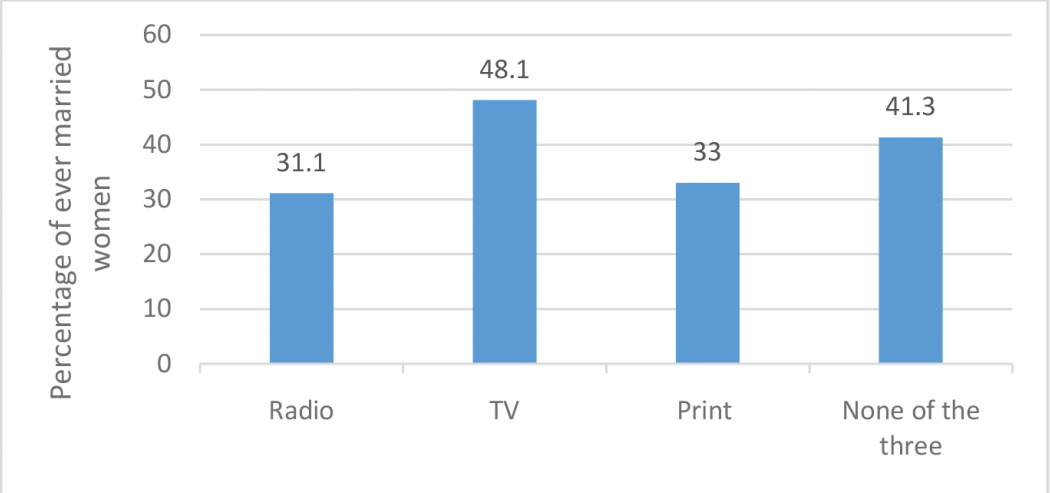
> *We organize a health talk. If someone is using loop for instance, they will tell about the benefits of it in our health talk.*
>
> ***FGD PHM, Jaffna***

Reliability of the sources of information

> *All FGD participants rely on the information provided by service providers.*
>
> *We believe what the midwife says.*
>
> ***FGD Married women 30-45 years, Trincomalee***

Mass media

Figure 7.3 Percentage of ever married women age 15-49 who heard, saw or read a message on contraception.



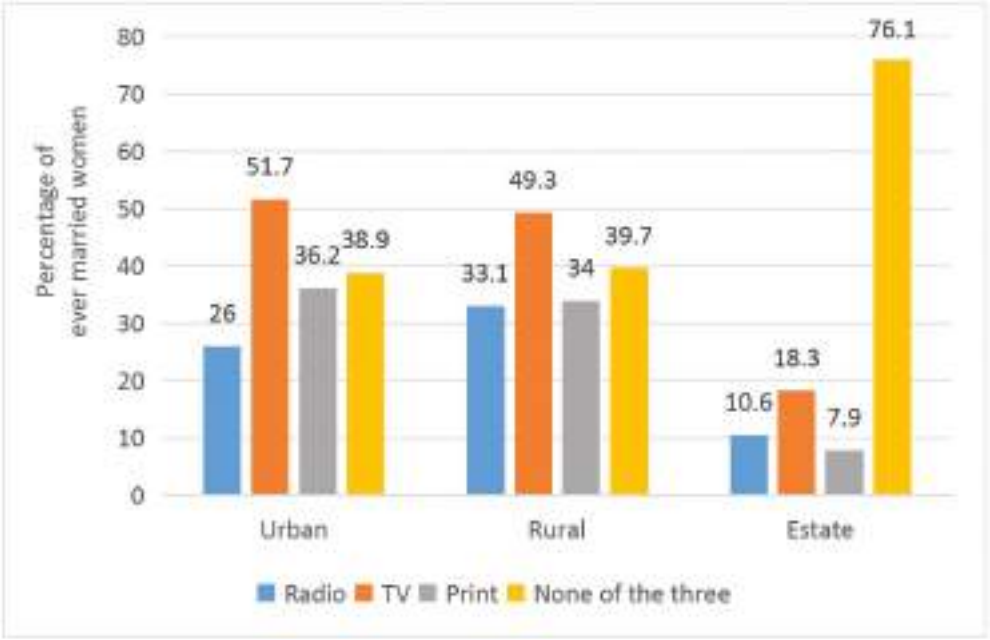
Source: 2006/7 SLDHS.

In the 1980s and 1990s messages on contraception were widely disseminated using mass media. To ascertain the effectiveness of such media on the dissemination of information, respondents in the 2006/7 SLDHS were asked whether they had heard or seen a message on the radio, television, or newspaper in the month preceding the interview (Figure 7.3). The findings were as follows:

- more than 40 percent of respondents had not seen or hear a message on any of the electronic or print media on contraception.
- television was the most frequently mentioned (48 percent) of the three types of media that carry messages about contraception.
- about 30 percent of ever-married women mentioned exposure to such information through each of the other two media—radio and newspapers/magazines.

Three-fourths of women in estate areas had no recent media exposure to messages on contraception. (Figure 7.4)

Figure 7.4: Exposure to messages on contraception on radio, TV or in print media by residence

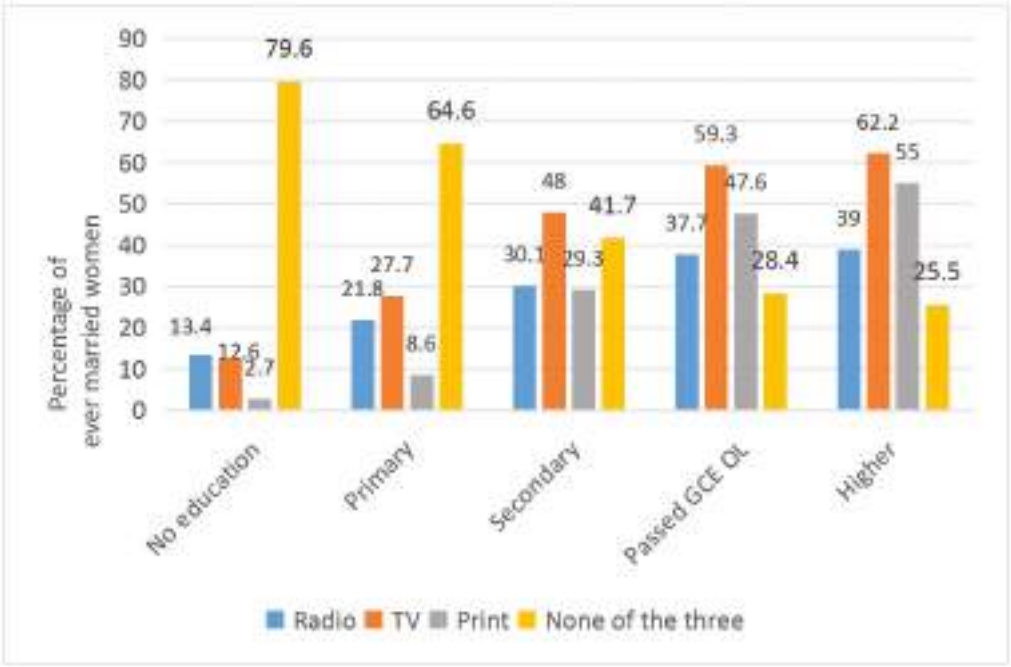


Source: 2006/7 SLDHS.

The 2006/7 SLDHS found that exposure to messages on TV is much greater for women in the two upper wealth quintiles (about 60 percent) than for those in the lowest quintile (24 percent). Women in the districts of Nuwera Eliya, Badulla, Matale and Puttalam were least exposed to contraception messages on radio, TV and newspaper magazines.

Exposure increases dramatically with increasing education levels (Figure 7.5).

Figure 7.5: Exposure to messages on contraception on radio, TV or in print media by education



Source: 2006/7 SLDHS.

There has been very little use of the mass media by the public sector to disseminate messages on contraception in recent times. This is partly due to the high costs and partly because of the religious and ethnic sensitivities regarding FP prevalent in the country. The FP Unit has conducted several seminars for the media resulting in a few feature articles on FP being published in the English and Sinhala newspapers. Journalists who were interviewed as KI suggested the use of government media outlets would lend legitimacy to the articles.

During FGD with young women they were asked how best information on contraception could be disseminated to women their age. Several participants suggested publishing articles in popular newspapers / magazines catering to young women.

Findings from FGDs indicate that TV programmes on health are an important source of information. The NFPP has not made use of social media to disseminate FP messages. During FGDs the use of hotlines maintained by the HEB or FPASL were not mentioned as a source of information by participants.

KII and focus groups provided the following information on preferred channels for each target audience and the channel mix for each audience segment. (Table 7.3)

Table 7.3 Preferred sources of information on FP

Channel	Audience
Radio programme	Women men youth
TV health programme	Women men youth
Women's newspapers /magazines	Women
Leaflets	Women men youth
Posters	Women men youth
Hotlines	Women men youth
Social media	Youth

In addition to the leaflets produced by the FHB and HEB on FP, we also found during the review that different hospitals and organizations had taken the initiative to produce leaflets on FP. It is necessary to provide consistent, uniform and accurate information to the public. There is no review process by the NFPP of such leaflets prior to dissemination.

Contact of non-users with FP providers.

Insufficient contact with health providers on contraception may contribute to the persistently high safety concerns of women and possibly other problems that may be remedied by face-to-face counselling and education. The 2006/7 SLDHS asked non-users of contraceptive methods if they had been visited by a fieldworker who talked to them about family planning in the twelve months preceding the survey. (Table 7.4)

Table 7.4: Contact of non-users with FP providers

Background characteristic	% women visited by field worker who discussed FP	Percentage of women who visited a health facility in the past 12 months and who:		Percentage of women who neither discussed FP with fieldworker nor at a health facility
		Discussed FP	Did not discuss FP	
Age				
15-19	31.7	30.4	47.2	50.4
20-24	42.1	34.6	46.3	46.9
25-29	37.4	35.4	47.6	48.8
30-34	34.7	27.5	57.2	55.1
35-39	23.4	23.3	52.1	66.6
40-44	10.8	12.2	55.6	81.7
45-49	4.1	4.6	61.4	93.0
Residence				
Urban	18.9	17.3	54.4	73.3
Rural	24.9	22.6	57.7	65.7
Estate	20.5	21.5	41.7	70.8
Education				
No education	9.8	13.0	44.1	82.4
Primary	12.9	15.9	50.4	78.6
Secondary	27.1	23.7	53.6	63.5
Passed GCE (O/L)	24.6	20.1	58.2	67.1
Higher	25.9	23.7	56.7	64.6
Wealth quintile				
Lowest	21.6	21.4	49.7	69.0
Second	26.0	22.9	51.2	65.3
Middle	25.3	24.1	51.9	65.4
Fourth	24.2	21.2	55.8	66.9
Highest	21.6	19.1	60.0	69.1
Total	**23.7**	**21.7**	**53.9**	**67.2**

Source: 2006/7 SLDHS

Table 7.4 Less than a quarter of nonusers had a field worker visit and talk about contraception. About one fifth heard about contraception when they were at a health facility. More than half of nonusers visited a health facility but reported no discussion of contraception at that time. Two-thirds of women did not hear about or discuss contraception during either a home visit or a visit to a health services outlet. The woman's age is the factor most strongly associated with having such discussions. Fieldworkers discussed contraception more often with nonusers less than 35 years of age, particularly those 20-29, than older nonusers. These younger women are prime candidates to adopt contraception, especially temporary methods for spacing births. Of

concern though is that fieldworkers discussed contraception less often with nonusers more than 35 years of age who are an extremely vulnerable group for unmet need in this country. These findings were confirmed by the FGDs that were conducted with married women.

> *After she's had 2, 3 kids the PHM comes and sees them. After the children get older, that service is not continued.. With that this kind of thing can happen. (unwanted pregnancies.)*
>
> ***FGD Married women 30 -45 years, Colombo***

Table 7.4 also shows that no discussion of contraception with a health worker either at a facility or in a home visit occurred most often for nonusers without any formal education. The proportion decreases with each succeeding level of education. There is no association with the household wealth indicator however. A study conducted by Hettiarachchi and Gunawardena on factors related to the choice of modern and traditional methods toward that not being visited at home by the PHM was significantly associated with the use of traditional methods.[12]

PHMs said that working women were a difficult group to reach.

> *P2 Working women don't have time to meet us on Monday to Friday. On Saturdays they go for their own business. So the chances we meet are less. So we wonder whether these are the reasons why they are not following FP regularly.*
>
> ***FGD PHM, NuweraEliy***

In order to develop strategies to minimise missed opportunities for discussing contraception at a health encounter we asked married women who participated in the FGD the following question. "*When you visit a health care worker to get treatment for diseases and if he/ she asks about your family planning practices, how would you feel about it?*"

The perception of most women was that asking such a question during a consultation was appropriate and justified.

> *I will think that there is a reason behind that, and it is for our good isn't it? If it is a side effect the doctor will suggest it no? Whether to stop using it or to continue with it.*
>
> ***FGD married women 18-29 years, Trincomalee***
>
> *If they ask it that is for our own good?*
>
> ***FGD married women 18-29 years, Nuwera Eliya***

Though asking about the use of FP at a consultation for an unrelated condition was good, it would be preferable if the doctor was a lady.

> *It's good to ask. I would prefer if a lady asked that question from me.*
>
> ***FGD Married women 30-45 years, Galle***

Asking about the use of FP when consulting a doctor for some other ailment was liable to generate fear and apprehension in some women.

> *We will get afraid soon. Because we will start to think whether it is the reason for the disease.*
>
> ***FGD Married women 18-29 years, Trincomalee***

There were a minority who thought that such a question was inappropriate.

[12] Hettiarachchi J , Gunawardena NS. Factors related to choice of modern vs traditional contraceptives among women in rural Sri Lanka. Sri Lanka Journal of Obstetrics and Gynaecology 2011; 33: 20-25

I think that's not good. Sometimes it won't be comfortable. We are going for another reason, but when asking like this….

FGD Married women 30-45 years, Trincomalee

Asking an unmarried woman whether she used contraception during a visit for an ailment was considered inappropriate.

If she is an unmarried woman then they should not ask about FP. If she is a married woman with children then it is necessary to ask about FP. Then it's okay to ask.

FGD married women 18-29 years , Colombo

The above excerpts from the FGD indicate that if a contraceptive history from a woman of reproductive age is taken this would open up the field for discussion about her use of contraception or if she has an unmet need for contraception and create an opportunity to dispel myths and misconceptions about contraception.

Though a small country, Sri Lanka is culturally diverse. KII suggested that BCC material should use language and pictures which were culturally appropriate and targeted to different literacy levels. KI said that there are still population pockets such as in the estate sector where the female literacy level is lower than in the rest of the country and simple messages using illustrations would be appropriate. During field visits, materials addressing FP needs of men were not available in health facilities. We found IEC material targeting young people in youth friendly clinics but not in other clinics. We also did not find printed IEC material on subfertility.

Behaviour Change Communication Strategy Guides for the Reproductive Health Programme

There has been growing realization that the IEC approach which was adopted in the past was ineffective and that it was more suitable to bring about behaviour change.[13] Hence, the HEB which is the unit in the Ministry of Health responsible for undertaking interventions related to BCC studied the present situation on knowledge, skills and attitudes covering seven districts (Colombo, Gampaha, Polonnaruwa, Batticaloa, Jaffna, NuwaraEliya and Kilinochchi) using FGD on five themes, MCH, gender based violence, family planning, adolescent reproductive health and well women clinics. The HEB has developed with financial assistance from UNFPA a comprehensive series of five Behaviour Change Communication Strategy Guides for Reproductive Health Programmes in Sri Lanka based on the above five themes. Both primary and secondary audiences have been identified in the documents. In addition, facilitating and constraining factors for each of the desired behaviours has been identified. According to KI in HEB based on the Guides a five year action plan has been developed. The Guides are to be piloted in several regions and several tools to implement the guides are to be developed. The IEC Package based on the Guides was developed with UNFPA financial assistance and launched recently.

During our meetings with KI and visits to facilities we inquired about the use of the Behaviour Change Communication Strategy Guides for Reproductive Health Programmes. Only two out of the four HEO we met during the review had a copy of the Guide. One HEO said " I was only asked by the HEB to distribute the Guide to MOH." We found a copy in the Uduvil MOH office. Service providers were not aware of how it should be used.

The NFPP has identified the target groups it wants to reach, e.g newly married women, adolescents and youth, older women in the reproductive age group etc. A Communication Plan to reach these groups has not been developed.

[13] Behavior Change Communication Strategy on Reproductive Health in Sri Lanka – Booklet 3. Family Planning. Page 3. MoH, HEb< FHB and UNFPA. September 2014

A serious shortcoming of the FP BCC Strategy Guide is that it is silent on subfertility. Raising public awareness about biomedical causes of subfertility is necessary. For example, underlining the fact that male factor subfertility is as common as female factor subfertility. Interventions to decrease stigmatization and suffering from subfertility and childlessness are needed. Effective BCC on subfertility is needed to;

1. Increase knowledge. BCC can ensure that people are given the basic facts about subfertility, for example causes of subfertility, prevention of STI etc;
2. Stimulate community dialogue. BCC can encourage community and national discussions on the basic facts of subfertility;
3. Promote essential attitude change. BCC can lead to appropriate attitudinal changes about, for example, compassionate and non-judgmental provision of services;
4. Reduce stigma and discrimination. Communication about subfertility should address stigma and discrimination;
5. Create a demand for information and services. BCC can encourage individuals and communities to demand information on subfertility and appropriate services;
6. Advocate for prevention and treatment of subfertility. BCC can lead policymakers and opinion leaders toward effective approaches to the prevention and treatment of subfertility including social and economic support.

20. Social marketing is used to create demand

Context – Social marketing is one of several "high-impact practices in family planning" (HIPs) identified by a technical advisory group of international experts.[14] Social marketing is an effective complement to the public sector by making contraceptive products accessible and affordable through private sector outlets, such as pharmacies and shops while using commercial marketing techniques. Social marketing interventions can help achieve the following:

1. increased availability of contraceptive products;
2. increased range of available products at a variety of prices resulting in increased client choice;
3. reduced burden on the public sector by shifting clients who can pay to the private sector;
4. increased FP programme sustainability;
5. increased contraception use in general and among underserved populations.

Social marketing programmes can be designed to reach the poor, if product prices are subsidized sufficiently. However, if subsidized social marketing programmes are ineffectively targeted, they can crowd out commercial brands.

[14] HIP Family Planning High Impact Practices: Social Marketing: Leveraging the private sector to improve contraceptive access, choice, and use. http://www.futuresgroup.com/files/publications/HIP_Social_Marketing_brief.pdf

Findings

The main social marketing organizations for contraceptives in Sri Lanka are FPASL and PSL. Social marketing organizations have divided the contraceptive market into different segments based on income, age, sex, social status etc. and different products are offered to suit the needs of the different segments. Product positioning, advertising and promotions are targeted at the selected segment. Social marketing organizations conduct market segmentation which subsidizes services for poor populations while gathering fees from those able to pay.

There are currently no legal barriers in the country that prohibit the marketing of contraceptives. However, prior to advertising, social marketing organizations have to obtain permission from the NMRA. Social marketing takes place through multiple communication channels. Promotion is only done for condoms through the print and electronic media by FPASL. All other products are promoted through lectures and exhibitions. Social Media is also being used in a limited manner for promotion of contraceptives.

According to KI the public response to the social marketing programme for each method offered is monitored by price and brand. Condoms, OCP and Emergency Contraceptives are popular. Customers are more brand loyal when it comes to OCP. On the other hand, except for a few brands which have unique features, the brand loyalty is less for condoms. Some customers wants to buy high price, good quality products while most are price sensitive.

According to KI, social marketing organizations face numerous challenges in Sri Lanka. These are:

1) Free supplies provided by the government and various projects.
2) Low price, low quality products entering the market in addition to smuggled products. [15]
3) Restrictions on advertising and promotion.
4) Delays in product registrations at the NMRA
5) Stigma associated with buying/selling contraceptives
6) Objections from various religious and ethnic groups
7) Cash collections from pharmacies.

There is no formal coordination mechanism between the FHB which is responsible for the NFPP and social marketing organizations and on the messages that are disseminated.

Other than the SPC's Franchise OsuSala outlets, health social franchising has not caught on in Sri Lanka. With the expanding middle class looking for quality and convenience of services there is a place for clinical social franching in Sri Lanka. For profit companies are also active in marketing brand name condoms and OCP.

21. Engaging communities and champions in BCC

Context - Champions—people who are known, respected, and trusted — have been shown to be very influential in changing attitudes and behaviours. Identifying, creating, and strengthening champions would help to increase demand for and use of contraception.[16] Community engagement has two intentions – fostering supportive social and gender norms and increasing knowledge and awareness of contraception and subfertility.

[15] http://archives.sundayobserver.lk/2013/05/05/fea08.asp

[16] Three Successful Sub-Saharan Africa Programs: Lessons for Meeting the MDGs. USAID Africa Bureau. https://www.fhi360.org/sites/default/files/media/documents/africa-bureau-case-study-report.pdf

Findings

There are volunteers who help the PHMs in conducting clinics and gathering women for meetings. According to KI they are more active in the rural rather than urban areas. However, due to the sensitivity of FP and in order to ensure they do not provide conflicting messages these volunteers have not been used to distribute contraceptives or provide messages on contraception. The FPASL has volunteers/ peers in the field but according to a KI they are not as active as they were in the past.

An important and innovative programme has been commenced by the HEB to mobilize communities to improve their health, nutrition and sanitation. Mothers' Support Groups (MSG) have been commenced with funding by UNICEF. The general objective of the MSGs are to promote good health and nutrition practices through empowering and mobilizing local communities. MSGs have 5-20 members and consist of pregnant mothers, those with infants and young children. The PHM in collaboration with the PHI is expected to facilitate these groups. It is proposed to have one MSG per PHM area or one MSG per estate division. At MSGs the groups identify their health and nutrition problems and causes, share health and nutrition related information and best practices and learn from each other under the guidance of the PHM. MSG Guidelines have been developed by HEB. Promotion of contraception is not specifically mentioned. These MSGs can also include fathers, grandparents, teenagers, community leaders and other interested persons. However, KI say that there is very little participation of males in these MSG. The FP Unit needs to be involved by HEB to improve the technical content on FP for the MSG programme. According to KI, the MSG is a forum that can be used to make contact with widows, separated and divorced women without stigmatizing them. MSG leaders could be used as local champions for FP.

> *In mother support groups, if we can explain to them about the wrong beliefs, they will go and speak with the people who are spreading the rumours, and can increase use of contraception.*
>
> ***FGD PHM, Kalmunai***

There are different women's groups and youth organizations at divisional level. The MOHs are often invited to give health education talks to these groups by the Women's Development Officers (WDO) and sports clubs at the Divisional level. There are very little or no activities by the NFPP to identify and train champions and to promote the transformation of gender norms at present.

Engaging with communities and using existing groups is an option to create awareness in communities about the causes and treatment of subfertility. Reducing stigma associated with subfertility is necessary for both men and women though for cultural reasons the woman is more affected.

22. Peer education

Context - Peer education is a process in which those of the same societal group or social standing educate each other and is used to affect changes in knowledge, attitude, beliefs and behaviours at the individual level. Research suggests that people are more likely to hear and personalize messages, and thus to change their attitudes and behaviours, if they believe the messenger is similar to them and faces the same concerns and pressures.[17,18] Satisfied contraceptive users are the most influential peer educators.

Findings

Peer education is not a new concept to Sri Lanka. The FPASL has used its field volunteers as peer educators and has developed a peer education curriculum recently. According to a KI these peer educators are not as active as they were in the past. The NFPP has not made use of this modality to increase awareness on FP.

In Jaffna,a promising approach has been used by PHMswho ask a client who is using a particular method successfully to talk about it to other women at a meeting/clinic.

> *We organize a health talk, if someone is using loop for instance, they will tell about the benefits of it in our health talk.*
>
> ***PHM FGD, Jaffna***

[17] Sloane BC, Zimmer CG. The power of peer health education. Journal of American College Health 1993; 41:241-245.

[18] Milburn K. A critical review of peer education with young people with special reference to sexual health. Health Education Research 1995; 10:407-42

Chapter 8
Recommendations

The recommendations presented in this chapter are based on the findings of the assessment. In addition, global best and high-impact practices, were identified and analysed for applicability in Sri Lanka, and included for consideration (including activities for piloting and evaluation before larger scale-up) as appropriate to the country context and according to stakeholders' expert opinions. The recommendations were presented to the Expert Committee and to a dissemination workshop.The recommendations are grouped under enabling environment, supply and demand. These recommendations are in turn grouped as short term, (less than 2 years) and long term.

Enabling environment

Short term (2 years or less)

1. Enhance leadership and governance of the NFPP

Revise the Terms of Reference and membership of the National Committee on FH (NC/FH) and TACM/FP

Building on the achievement made thus far, the most difficult challenge ahead for the NFPP is to increase performance so as to improve the quality of FP services; increase access to services, especially for marginalized and vulnerable groups; improve efficiency, and; ensure sustainability of the programme.

The NC/FH should now provide advice and guidance on issues such as inequity in service delivery, especially subfertility treatment, weak FP services in public sector curative institutions, ensuring quality of services in both the public and private sector, establish public –private partnerships and sustainability of the programme.

Another important role for the NC/FH is advocacy with Government on addressing intractable issues such as human resources for health. The NC/FH needs to also address multi-sectoral issues such as the decreasing age at marriage and providing comprehensive sexuality education in schools. The composition of the TACM/FP needs to be expanded in order to provide policy advice to the NC/FH. The NSACP, Private Health Sector Development Directorate and NGO, private sector and civil society organization should be included rather than co-opting them as and when necessary.

2. Reposition FP as a key cross cutting intervention for national development.

An important responsibility of the NC/FH should be to reposition FP as a key cross cutting intervention for national development. Because FP contributes to saving the lives of women and children and to improvements in social and economic development as well as improvements to the environment, it is important to adopt a multi-sectoral approach to address FP. Policy and decision makers need to be made aware that FP contributes to all 17 of the Sustainable Development Goals (SDGs) and contributes directly to Targets 3.1, 3.7 and Target 5.6:

> Target 3.1 *By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births;*
>
> Target 3.7: *By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.*
>
> Target 5.6: *Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.*

3. Develop a multi-year National Action Plan for FP

Using the findings of the National FP Review as the basis, develop a multi-year National Action Plan to achieve the National Health Strategic Masterplan 2016-2025 goal "to enable all couple to have a desired number of children with optimal spacing whilst preventing unintended pregnancies."

This National Action Plan for FP will ensure an unified plan for FP is followed by the central government, provinces, districts, NGOs and development partners. The Action Plan will help ensure that all FP activities are aligned with the country's needs and prevent fragmentation of efforts. The Action Plan will define key activities and an implementation roadmap with defined targets. The Action Plan will provide detailed commodity costs and programme activity costs associated with the entire NFPP programme to inform the MoH budget requests to the Ministry of Finance. This would also enable provincial health authorities to allocate resources from the provincial health budget. Monitoring and evaluation will be an integral part of the Action Plan so as to ensure the NFPP is meeting its objectives, ensuring coordination, and guiding any necessary course corrections.

The Action Plan needs to be formulated in consultation with all stakeholders and submitted for approval of the NC/FH. The plan should reflect realistic forecasts of population growth, changes in method mix, include preparations for possible scale up to address unmet need and potential increased demand as well as address both long term human resource /staffing needs and financial projections.

Costed district plans need to be developed subsequently in line with the national plan. The district plans should have the flexibility to address district specific issues and marginalized and vulnerable populations. The provincial and district health authorities should be involved in the planning process to ensure ownership of the plan. This will provide necessary responsibility and accountability for implementing activities at the district level.

The NC/FH and the TACM/FP at its meetings must review progress of the Action Plan at national level against key indicators using an executive dashboard that will be jointly managed by the Planning, Monitoring and Evaluation Unit and FP Unit of the FHB.

4. Strengthen the capacity of the FP Unit to lead, manage and coordinate the NFPP

The FP Unit must be strengthened to ensure effective management and coordination of the NFPP. It is crucial to enhance the technical and monitoring capabilities of the unit for subfertility and post-abortion care, areas that the NFPP has not addressed sufficiently. The cadre of the FP Unit needs to be increased in order to effectively and efficiently address the functions of the unit. The number of MOs in the FP Unit needs to be increased from two to four. The two additional MOs are needed to address technical issues and to carry out monitoring. A logistics coordinator is necessary for the unit. While technical capacity is very important operational capacities such as strategic planning, programme management, advocacy, monitoring and evaluation to manage the NFPP needs to be enhanced.

Data for decision making is crucial for the FP Unit. The Planning Monitoring and Evaluation Unit must make data from the RHMIS directly accessible to the Head of the FP for effective and timely management of the NFPP. Real time data on the status of contraceptives is needed by the Unit from the districts in order to manage issues of contraceptives from the FHB warehouse and ensure stock out of contraceptives are minimized in districts.

The NFPP must be closely involved in the Maternal Death Review process in determining whether there is an unmet need for FP as an underlying cause for the death.

Long term

5. Strengthen the capacity of districts to effectively plan, implement and monitor their FP programmes

Priority districts, i.e, those with a high unmet need for modern contraception and those with high teenage pregnancies will be identified and capacity assessments carried out. Based on the assessment, capacity development activities should be carried out. The FP Unit must provide technical assistance and carry out regular supportive supervision visits.

Since the MOMCH is responsible for providing technical assistance to the MCH /FP programme in the district it must be made mandatory that the individual must have undergone the stipulated training for the post prior to deployment. Ideally, they should have prior experience as MOHs.

The capacity of key staff such as MOMCH, RSPHNO needs to be enhanced to coordinate, plan, implement and monitor the FP programme at district level by conducting annual training programmes for them. These training programme will also include training on supportive supervision.

Ensure district MCH plans are submitted to FHB for comments prior to incorporation into district health plans.

Introduce quarterly analytical reports to be submitted by the MOMCH on the performance of the NFPP in the district to both the RDHS and FP Unit. The current practice of the national MCH review and district review meetings are too infrequent for timely remedial action to be taken.

In the districts, MOMCH will identify and engage partners at the district level—including other government departments and workers, traditional and faith leaders, and civil society and convene quarterly technical working groups to coordinate activities.

6. Supportive laws, policies and guidelines are operational to create an enabling environment for FP

Policies

1) A Reproductive Health Policy needs to be developed urgently to replace the Population and Reproductive Health Policy (1998). Management of subfertility needs to be addressed in detail in the revised Policy.

2) It is necessary to ensure FP is well reflected in the revision of the Maternal and Newborn Health Strategic Plan 2017-2025.

3) Open communication channels with private sector providers and recognize the complementary role that the private sector can play in increasing commodities and services. Consider policy options to stimulate private sector participation such as tax rebates/exemptions on contraceptives imported into the country.

4) Develop a policy for public private partnership (PPP) in collaboration with the Directorate of Private Health Sector Development. Some mechanisms for PPP are: social franchising; voucher schemes which involve demand side financing, and; mobile clinics. For instance PPPs will enable poor subfertile couples to access ART that they would not be able to receive otherwise. PPPs can also be used for expanding services for marginalized and vulnerable groups. By fostering PPPs, the government can reduce its burden on infrastructure and trained staff and help ensure contraceptive products and services are consistently available in the long term and concentrate efforts in reaching the most marginalized and vulnerable.

5) Review and revise the contraceptives on the Essential Drugs List based on evidence guided recommendations to increase the method mix and contraceptive choice.

6) Enter into a collaborative relationship with the NMRA to fast track the registration of new contraceptive methods that are considered by the NFPP to be appropriate for use in the public sector.

7) Ensure at least one laboratory in a district is capable of performing hormonal assays, seminal fluid analysis and sperm preparation for IUI.

Legislation

The current RHMIS does not collect FP information from the private sector. It is necessary to consider introducing legislation to obtain such information.

The proposed legislation on ART needs to be expedited. It is also necessary to establish a regulatory authority on lines of the Human Fertility and Embryology Authority of UK.

Guidelines

The Policy Framework and National Action Plan to address Sexual Gender Based Violence 2016-2020 has been approved by the Cabinet of Ministers and includes the introduction of an interactive module to teach reproductive health and sex education as part of the health and physical education curriculum. This module must be reviewed as to its content on FP and strengthened if necessary in partnership with the Adolescent and Youth Health Unit of the FHB.

Consider abolishing the circular related to criteria for sterilization.

Clarify for health workers the policy with regards to access for adolescents less than 18 years to contraceptive services in clinical and community setting.

The guidelines on post-abortion care need to be endorsed and disseminated by the Director General of Health Services.

Develop service delivery levels for subfertility services in collaboration with the SLCOG.

7. Address the pressing demand for all categories of human resources

While HRH is a complex issue the function of the NFPP requires well trained staff in adequate numbers to provide services. The training and supply of health workers has not kept pace with health sector needs, either quantitatively or qualitatively. Conduct workforce assessments for categories of staff involved in MCH FP other than PHM.

Devolving health to the districts has many benefits. However, since recruitment, transfer and deployment are central functions "difficult" district are at a disadvantage in attracting and retaining MOs. Priority needs to be given by the MoH to underperforming and understaffed districts in deployment of all categories of staff. To address the shortage of PHMs the Northern Province Health Directorate has redeployed midwives from hospitals reporting very few births as field midwives. This initiative needs to be considered for adoption by other provinces as well

The Service Availability and Readiness Assessment (SARA) which is proposed (see Supply Recommendations) will identify small hospitals with very few deliveries. Consider deploying these hospital midwives to the field.

There is a pressing need for supervisory staff at district level without whom the quality of services cannot be ensured. Short term measure such as the re-employment of retired staff on contract basis is needed.

It is also necessary to ensure that norms on staffing based on the population are implemented so as to provide

quality services.

In order to operationalize the two subfertility centres in Castle Street Hospital for Women and Mahamodera Hospital a cadre of embryologists and counsellors need to be created, recruited and trained.

Retain skilled providers such as RH Diplomates in a "closed service." A closed service will ensure that the skills are not lost during the process of annual transfers and that services do not break down in the health facility for want of trained service providers.

Reduce linguistic barriers that can have negative repercussions to accessing health services including FP for ethnic minority groups. Affirmative action needs to be taken to address the underrepresentation of ethnic minority groups among health staff.

8. Increase financing for FP

Develop a resource mobilization plan. Following the preparation of the costed action plan identify the resource gaps and develop a resource mobilization plan with a focus on identifying and financing gaps for priority activities.

Increase domestic funding for FP. The bulk of the financing of the NFPP is through domestic financing by the government. Evidence based advocacy is needed with policy makers at both MoH and provincial level for allocation of additional resources for FP programming.

Mobilize additional resources from development partners. Based on the resource mobilization plan and funding gaps that are identified prepare and submit technically sound proposals to development partners for consideration.

Mobilize resources from the private sector. The private sector must be encouraged to make corporate social responsibility investments in the NFPP, e.g. renovation of public sector clinics. Urge the private sector to include FP as a part of the health benefits to their employees. The FHB must sensitise media organization to devote more time to the promotion of FP as part of their organisations' social responsibility. Each media organisation will be encouraged to air messages cleared by the HEB promoting FP services. These measures will free up financial resources which can be targeted to marginalized and vulnerable groups.

Create a budget line for FP programming. Conduct evidence based advocacy to create a budget line for FP programming at MoH and Ministry of Finance which includes FP commodities to ensure that allocations for FP are ring-fenced.

Mainstream FP in district planning and budgeting processes. The FP Unit must assist the provinces and districts in developing advocacy plans to target local leaders, including Provincial Council members for the creation of budget lines for FP at the provincial and district level. Availability of budget lines will support the prioritisation and integration of FP into provincial and district planning and budgeting processes. Technical assistance must be provided from FP Unit to help provincial and district level make evidence-based decisions related to programming, budgeting, and tracking expenditures for FP.

Track Government expenditure on FP. The first report of the National Health Accounts has been published. In future it is necessary to introduce a system of tracking financial expenditure to determine how much the Government spends on FP from domestic resources and is reported in the National Health Accounts. The information can be used for advocacy purposes. The annual Government expenditure on FP from domestic resources should be included in the RHMIS as an indicator.

Build the evidence base to increase financial support for FP. This will include commissioning studies to inform advocacy efforts so as to increase funding from government and potential development partners.

Include FP in health insurance scheme. The MoH must conduct advocacy to ensure that health insurance scheme includes coverage for all contraceptive methods including subfertility management in all insurance packages.

9. Strengthen performance planning and monitoring

A culture of results based management and accountability needs to be inculcated in managers. There needs to be a paradigm shift from assessing progress of planned activities to measuring outputs, outcomes and impact against predetermined and agreed upon indicators.

Collect data from the public sector curative institutions. Provide training to statistical officers and ward staff in curative institutions on RHMIS and collection and recording of FP data.

Revise the indicators and data collection instruments used by the NFPP. An array of indicators for tracking NFPP performance across dimensions of access, quality, choice, equity, and utilization are necessary. This will require that consultations be held with stakeholders to review the current indicators and identify specific measureable indicators.

Existing data collection, supervision, and monitoring tools must be revised, and new tools developed to consistently and closely track a revised list of FP indicators so as to ensure the successful implementation of the National Action Plan. Relevant personnel will be trained on the revised tools.

Use of an executive dashboard to monitor progress. The data obtained will be summarised in an executive dashboard to easily track progress across the key FP indicators. The Executive dashboard will be jointly managed by the Planning, Monitoring and Evaluation Unit and FP Unit of the FHB. The dashboard will be tracked as part of regular NC/FH meetings.

Conduct surveys/investigations and strategic research to collect relevant complementary data. DHS must be carried out every 5 years or so if they are to be useful and provide the data required to monitor progress and shift priorities. If it is not possible to conduct DHS every 5 years at least surveys should be carried out every two years to assess performance. The Research Unit of the FHB can develop survey instruments to collect FP data as necessary.

10. Improve contraceptive security

Implement a comprehensive contraceptive forecasting and quantification system. Coordinate joint forecasting and quantification for contraceptive commodities together with the public, private and NGO sectors. Since the private for profit and social marketing organizations know their market share a more accurate picture of the public sector requirement for contraceptives will be arrived at. Forecasting and quantification meetings must be held biannually. Population projections also need to be taken into consideration when forecasting as the reproductive age cohort is considerable. Joint forecasting and quantification will enable reductions to be made in the quantity of OCP, condoms and DMPA that are procured for the NFPP resulting in savings. ECPs will be procured by the private sector based on the quantification plan since it is considered a life-saving commodity.

Ensure district staff are able to report contraceptive forecasting data on time and accurately. Provide training on forecasting and quantification for district level staff in both preventive and curative institution. Training should be followed up with supportive supervision to ensure facilities are stocked more efficiently.

The MOMCH need to be trained to use commodity supply data for decision making to prevent potential stock outs in the RMSD and health facilities.

Improve the LMIS. The current paper based LMIS needs to be improved to ensure commodity security. r The need for the FP Unit to have access to accurate and timely datahas been mentioned previously. An automated system is needed to capture facility level logistics data so that district and central level can make informed decisions on movement of contraceptives. The use of mobile phone technology needs to be explored to improve real time stock monitoring and resupply planning. The RHMIS should include an indicator on the percentage of SDPs that experienced a contraceptive stockout to measure efficiency of the supply chain.

Proactively address selective stockouts of contraceptives at the district level. The MOMCH and OiC RMSD must coordinate within each district to proactively manage stock within facilities.

Make improvements to infrastructure and warehouses practices. The RDHS should provide adequate resources for improvements to infrastructure of warehouses. The FHB should continue training of OiC RMSD on good warehouse practices and carry out supportive supervision. Inventory control mechanisms should be enforced.

Detection and disposal of damaged/expired FP commodities is improved. National guidelines/protocols for the detection and disposal of damaged/expired FP commodities need to be updated. During scheduled refresher trainings, health workers must be oriented on observing expiry dates of commodities before providing them to clients.

Improve the distribution system. The RDHS should procure or hire vehicles for distribution of contraceptives from RMSD to institutions. A regular distribution schedule should be prepared. RDHS, MOMCH and OiC RMSD should prioritize collection of contraceptives from the FHB.

Conduct supportive supervision to RMSD. Conduct joint supervision by FP Unit and MOMCH to RMSD. The checklist developed by FP Unit can be used for this purpose.

Monitor the quality of products in private sector pharmacies. Regular inspections by Drug Inspectors of NMRA must be carried out to ensure the quality of contraceptives in the private sector, especially pharmacies.

Recruit a graduate pharmacist for FP Unit as logistics coordinator. Currently the FP Unit is understaffed. One of the important roles of the logistics coordinator is to track commodity requests and distribution closely. The logistic coordinator will be responsible for mapping of logistics at every level of the supply chain, identifying bottlenecks in real time and following up with facilities that are not requesting or using particular commodities. A cadre revision will be necessary to create the post of logistics coordinator in the FP Unit.

11. Reinvigorate advocacy to increase visibility of and support for FP

Although FP has been recognised in policy as a key element in improving national health and development, the enabling environment for FP remains weak and a lack of political will, commitment, and clear messages from leaders has hampered the momentum of the NFPP. This recommendation aims at sustaining support for FP from the highest policy levels.

Develop a FP advocacy strategy and Action Plan. The strategy seeks to create an enabling environment for FP by increasing the visibility of and support for FP. The advocacy strategy must identify objectives, primary and secondary audiences, themes and messages, tactics and have an monitoring plan with indicators. Advocacy efforts must be specific for the different groups that are identified. Some important advocacy issues the Advocacy Strategy should address are:

- Creating a separate budget line for FP programming at MoH and Ministry of Finance so as to prioritize funding for FP;
- Need based allocation of financial resource for FP by provincial authorities that prioritizes underserved and marginalized areas so as to ensure equity;
- Inclusion of FP in major national policy documents stressing the significance of FP to national development;
- Mobilizing additional resources from development partners for FP despite Sri Lanka being a LMIC in order to address marginalized and vulnerable groups;
- Stimulate private sector involvement in FP by offering attractive incentives;
- Convincing non-health sector programmes to integrate FP into their activities
- Catalyse introduction of age specific comprehensive sexuality education into the school curriculum;
- Mobilize support from religious and political leaders at national and subnational level to improve maternal and child health through proper FP practices;
- Mobilize multisectoral support to reduce early marriage and teenage pregnancies
- Strengthening infertility services in the public sector;

External assistance may be required to develop the Advocacy strategy.

12. Transform gender and social norms.

The FP Action Plan must include a range of activities - service delivery, FP communication plan, advocacy efforts and community engagement to transform gender and social norms.

- The NFPP should promote gender equity by placing the responsibility of contraception in the hands of both women and men.
- New approaches are needed to influence men to take greater responsibility for fertility control, both by increasing the use of male contraceptive methods and by helping rather than obstructing their wives in procuring FP services.
- A range of interventions from service delivery, advocacy at all levels, community engagement and training of service providers in gender sensitive counselling are necessary to transform gender norms.
- Behaviour Change Communication messages and materials need to be male friendly and promote the transformation of gender norms.

The school system would obviously be the best entry point for fostering positive social norms and transforming gender roles. It is crucial to intervene early when adolescents are developing their understanding of social norms around sexuality and gender. The FP Unit, the Adolescent and Youth Unit and the Gender and Women's Health Unit must work together with the Ministry of Education to transform gender and social norms.

Supply

Short term (within 2 years)

1. Improve availability of quality contraceptive and subfertility services

Conduct a FP service availability and readiness assessment (SARA)

The SARA will provide information on the overall availability and readiness of curative and preventive health facilities to provide contraception and subfertility services.[1] More specifically the SARA will provide the following information: the proportion of different facility types that offer contraceptive and subfertility services including laboratory services for seminal analysis and hormone assays; to what extent facilities are prepared to provide FP services; the availability of the necessary infrastructure including electricity and water, equipment and service personnel; the extent to which the service delivery process meet standards of acceptable quality and content, and; clients and service providers satisfaction with the service delivery environment. A key element of the assessment is determining the geo-coordinates of each service delivery point which enables mapping of facility distribution and comparison with geographic and population profiles.

The SARA can be conducted by the Research Unit of the FHB. In addition to FP other components such as MCH, WWC can be added to the SARA. The Assessment can be carried out initially in poorly performing districts.

Prepare service scale up plans for areas with the greatest unmet need for modern methods and poor access. Districts with high unmet need for modern methods and areas identified by the SARA as having poor facilities requires targeted support. District managers should develop and implement a FP "service scale up plan" which will include training, deployment of staff, improve logistics and regular monitoring of progress.

At least one laboratory in a public sector health facility in a district must be strengthened to carry out semen analysis and hormone assays.

Information and services for contraception and subfertility are available at times and locations that are convenient to clients. PHM should conduct regular domiciliary visits to women in the reproductive age group and provide information on contraceptive methods to those with an unmet need, identify subfertile couples and refer them for services as an integral part of their duties. PHMs must promote adoption of a contraceptive method during the postpartum visits.

In order to be accessible in the field PHMs must be provided with an allowance at market rates to establish their offices. The PHM by having an office in her area enables women to access information and OCP and condoms with ease. Regular supervision of home visits is necessary to ensure that the PHM comes into contact with women who have little need for MCH services such as women with children over 5 years of age, women in the older reproductive age group who claim to have completed their family and use traditional methods. The number of referrals for clinical methods of contraception, subfertility services, and number of pills and condoms dispensed should be noted. The Eligible Couples Register must be inspected to verify it has been updated.

To the extent possible make FP services available during off working hours and weekends e.g. during lunch time, after 4 pm and during weekends for working women and depending on the local context e.g. "pola

[1] Service Availability and Readiness Assessment Manual. WHO 2013. http://www.who.int/healthinfo/systems/sara_reference_manual/en/ (Accessed 02.05.2016)

days" to provide expanded access to services.

Ensure mothers with young children at weighing centres and immunization clinics are provided with information on contraception and encouraged to adopt a FP method in order to optimize healthy timing and spacing of pregnancies.

Reduce linguistic barriers to communicating with clients

Language barriers limit access to health services including FP services and affect the quality of care for clients with a limited knowledge of the majority language. In order to reduce linguistic barriers it is necessary to increase the intake of linguistic minority health workers. The other option is to provide second language proficiency training to existing health workers.

Operationalize the existing subfertility centre and consider expansion to a further centre. The two subfertility centres need to be fully operationalized with laboratory facilities to carry out all types of ART. These centres should subsequently be expanded so that there is one centre in each province.

Long term

2. Improve infrastructure and provide equipment and supplies

The findings from the SARA will identify the facilities requiring renovation, equipment and supplies and will enable district authorities to prioritize. Subsequently the requirement for equipment and supplies for FP from districts should be sent annually to the FP Unit by the MOMCH for inclusion in the annual workplan so that resources are allocated and central procurement can take place. In the long term these requirements must be included in the district annual workplans together with the estimated budget.

Explore the possibility of soliciting Corporate Social Responsibility commitments to improve the infrastructure of public sector clinics. Infrastructure improvements should include improvements to maintain auditory and visual privacy.

Ensure regular inspection of life saving equipment and drugs is conducted and documented.

3. Invest in preservice and in-service training

Create an environment that is conducive to learning during the preservice training of health workers.

Make improvement to the infrastructure of NTS. This will enable to increase the number of trainees as well as create a conducive environment for learning.

Determine the package of equipment, models, commodities, and consumables required for successfully training FP workers in NTS and RTC.

Provide refresher training for preservice trainers periodically so that they improve their skills. Since RTC trainers are liable to transfer consider retaining their skills in a closed transfer system.

***Recruit and train embryologists and counsellors for ART services*.**

Improve in-service training

Significant investments are needed for in-service training so as to build the capability of health workers to competently, safely and efficiently provide quality rights based FP services. One of the objectives of the proposed multi-year FP action plan should be the establishment of a sustainable national in-service training system for FP.

4. Improve the quality of FP services

Review and revise the service provision guidelines. The service delivery guidelines, Medical Eligibility Criteria Wheel, flash cards, flip charts etc. need to be revised, updated, printed and disseminated widely. The process of revising and developing the guidelines should have wide participation including SLCOG and physicians so as to ensure ownership. The revision of the service delivery guidelines should be in line with national policy and international standards and ensure there are no unnecessary administrative or medical barriers to contraceptive use and provision.

Develop National Service Standards for FP. The National Service Standards will serve as a country-specific reference document and sets a national standard for the provision of FP services. These standards will be developed following wide consultation. The document should address:

1. Standards for counselling, client assessment, infection prevention, and medical supervision and monitoring, and FP complication management systems for provision of contraceptive services in Sri Lanka need to be developed. In addition, standards for subfertility treatment need to be established.

2. National standards for specific contraceptive methods available in Sri Lanka should include basics, pre requisites, counselling and informed consent, indications/ precautions, client assessment, method provision, client instructions/follow-up, side effects, and requirements for facilities and providers;

3. The National Service Standards should take into account clients with special needs, e.g. unmarried, widowed, separated, and adolescent and youth, older women in the reproductive age group and the disabled.

The standards should take into consideration best practices globally and the latest Medical Eligibility Criteria of the WHO.

Strengthen supportive supervision of the NFPP. To the extent possible supervisors must carry out supervision visits as planned in the advance programme. In addition, to improve supervision the following issues need to be addressed:

1) To make up for attrition of supervisory staff due to retirement consider re-employing them on contract basis as a short term measure;

2) Develop duty lists for CCP and identify clear lines of responsibility for supervision carried out by CPP and MOMCH;

3) Ensure newly appointed MOMCH receive training on management of RH /FP programme management prior to deployment;

4) Increase the availability of transport for supervision, either by procuring vehicles or by hiring transport;

5) Continue to develop the capacity of PHNs and SPHMs as coaches and mentors

Use the quality improvement (QI) teams established by the National Quality Assurance Programme in Health to improve the quality of FP services in health institutions.

1) The QI teams will check to see if the FP Standards and guidelines are being used. These FP Standards and guidelines will be made available to all facilities.

2) As part of improvement of quality of services heads of institutions including MOH and external supervisors should conduct periodic exit interviews with clients.

Reduce client waiting time

There is no easy solution to reducing client waiting time. The QI teams should address the long client waiting time as a matter of priority. Managers should ensure adequate staff are assigned to carry out the different functions in clinics. Improve the infrastructure in the waiting areas and provide adequate seating to make the waiting time bearable. To address the problem of long waiting time John Snow International has developed a Clinic Efficiency Dashboard as part of quality improvement in family planning clinics.[2] Managers need to be trained on using this new tool.

Introduce obtaining informed consent from clients prior to insertion of IUD and implants.

Introduce obtaining informed consent from clients prior to insertion of IUD and implants. Currently informed consent is obtained only for sterilization. Before signing this form, the client must have received information on the benefits and risks, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the contraceptive method chosen. Ensuring informed choice and volunteerism will result in better and longer method use, improved client compliance, and satisfied clients who will encourage others to participate in FP programme.

Engage with the communities to improve the quality of services. More community participation is needed to obtain feedback on the quality of services. Communities must be involved at divisional level in defining, appraising and improving service quality.

Motivate health workers. Motivate staff to provide high quality rights based services. Currently performance appraisal is viewed more as a routine activity than a tool for performance improvement and career development. This should not be the case. Good performance must be rewarded and penalties should be enforced for poor performance. Unfortunately the career path for some categories of staff is limited and must be addressed by the MoH.

Provide non-monetary incentives in terms of recognition and awards; field visits etc. Other issues to raise morale are:

1) MoH must open up career advancement opportunities for PHNs and PHM.
2) Agreement among provinces and the centre on standardized incentives to be provided to public health field staff;
3) Provide an allowance to PHMs to establish their office based on market rates;
4) Payment of arrears to PHMs appointed to grade 1.

[2] JSI Client Efficiency Dashboard. http://fpntc.org/training-and-resources/using-data-to-increase-clinic-efficiency-a-quality-improvement-guide (Accessed 13.11.2016)

5. Increase the method mix so as to further expand the choice of modern methods

The NFPP should consider the introduction of newer cheaper implants. Train health personnel to provide no scalpel vasectomy (NSV) so as to increase the choice of contraceptive methods that are available through the NFPP.

6. Integrate to the extent possible contraceptive provision with other outpatient and inpatient services.

Capitalize on the opportunity to provide information and services on contraception during the postpartum and post abortion period:

1) Curative institutions must make available postpartum sterilization to clients who request for the service and meet the eligibility criteria;

2) Designate a staff member on obstetrics and gynaecology wards to be responsible for providing information on contraception and refer for appropriate services. This must be recorded in the discharge summary;

3) Include the indicator Percentage of postpartum mothers at 6 weeks using a modern family planning method in the RHMIS

Older women in the reproductive age group attending WWC and NCD should be dissuaded from using traditional methods. Since the menstrual cycles become irregular with age it becomes difficult to determine the safe period. They should be offered modern methods of contraception.

Continue to provide training on contraception to NSACP staff and consider deploying a PHM in STI clinics. In collaboration with NSACP provide FP clinic staff with refresher training on HIV and prevention of paediatric infection.

7. Strengthen the referral system for FP

The referral system should be two way and link public and private health facilities and ensure clients the widest choice of FP methods. A functioning communication system must be established between the referring facility and the facility accepting the referral so that client information is shared and services are delivered in a timely and confidential manner. A monitoring system for the referral system must be put in place. In the event of removal of an IUD or implant at a curative institution at the request of a client whether or not another method is prescribed, this information should be sent to the MOH of the area. This will enable the client to be followed up in the field and the eligible couples register duly updated.

The NFPP should work with the Private Health Sector Regulatory Council and the Director Private Health Sector Development to strengthen the referral system between the public and private sector. A mechanism should be developed to inform the relevant MOH when a client discontinues a method in the private sector.

Document denial of sterilization. When a client requests for postpartum sterilization or is referred for interval sterilization and is found on evaluation to be unfit either for medical or non-medical reasons or the procedure is postponed, the reasons for denying the procedure must be clearly documented and the client referred back to the MOH. This will enable the field staff to make alternate arrangements.

8. Increase private sector involvement in provision of FP services

Improve access and quality of FP services in the private sector. FP Standards and guidelines must be shared with the private sector. Collaboration with the College of General Practitioners and the Independent Medical Practitioners in developing distance learning modules has been discussed before.

Scale up distribution of contraceptives through pharmacies.Pharmacies are legally permitted to sell pills, emergency contraceptive pills and condoms. Training of pharmacist has been discussed.

Consider public private partnerships to provide advanced infertility services. Enter into public private partnerships with private sector clinics providing ART to assist poor women until such time as public sector ART services are in place.

Ensure contraception and subfertility services are included in health insurance schemes the government proposes to introduce.

9. Ensure special groups receive FP services

Expand access to accurate information and FP services to youth. Partner with the Ministry of Education and Adolescent and Youth Unit to review the interactive module to teach reproductive health and sex education as part of health and physical education curriculum that has been proposed in the Policy Framework and National Action Plan to address Sexual Gender Based Violence 2016-2020.

The official policy on providing SRH services (including contraception) to adolescents in General Circular 01-25/2015 dated 8.7.2015 must be clarified for health workers.

Partner with the Adolescent and Youth Unit of the FHB to provide rights based youth friendly health services.

Build the communication, counselling and technical skills of service providers in youth focused FP services that are provided in a friendly, non-threatening, non-judgmental manner.

Engage with NGOs to provide services to VMGs. Sexually active single, widowed divorced and separated women, older married women are recognized as having an unmet need. The NFPP has not been able to gain the confidence of these groups. These women do not have confidence in the local clinics and PHM to maintain confidentially. The NFPP may engage with NGOs to provide services to these hard to reach groups.

Ensure FP services are accessible by people with disabilities. To increase access of people with disabilities to FP services, FP clinical service delivery guidelines will be revised to ensure the provision of FP services in accordance with human rights and quality of care standards. Health care workers will be trained on providing services to FP clients with various disabilities.

10. Enhance communication and counselling skills of service providers.

Enhance counselling and interpersonal communication skills to increase the access of couples and individuals to information on contraception and ensure clients rights to voluntary, confidential, unbiased information, counselling and services.

Emphasize counselling skills during pre-service and in-service trainings. Provide language skills to service providers prior to deployment to predominantly Tamil speaking areas. Include PHI in trainings to enable them to communicate effectively with men.

Supervisors should specifically observe client provider interactions during supervision visits and conduct exit interviews of clients.

Demand

Short term (within 2 years)

1. Rebrand family planning

A new look and new image is necessary for the NFPP is needed. The objective should be to transform the perception in many people's minds and dispel rumours about FP being a subtle means to achieve demographic objectives. It must be emphasized that the NFPP adopts a "cafeteria" approach with several contraceptive methods available, is purely voluntary and does not allow any form of coercion or discrimination to influence people's choices either for or against the use of FP services. Very few lay people including some medical personnel are aware that subfertility is a component of FP

The title of the new programme must be purposely broad so as to encompasses all target groups the FP programme currently reaches i.e. newly married couples; married couples during pregnancy and in the postpartum period; older women attending WWC, and; subfertile couples. It must also be broad enough to reach groups the NFPP has not reached as yet, e.g. men and youth, marginalized and vulnerable groups such as sexually active single women, divorced, separated , widows, those with disabilities and HIV positive women. The rebranded programme should be launched with a new logo etc.

Long term

2. Increase demand by reducing out of pocket expenditure and opportunity costs for poor women;

Identify underserved areas and increase the availability of contraceptive services so as to increase geographic accessibility by using the findings of SARA. Implement rights based outreach programmes to reach communities living in remote areas and with poor transport facilities.

Strengthening the contraceptive commodity supply chain in the public sector will ensure that women can obtain their choice of method close to their homes without incurring out of pocket expenditure on transport to another clinic or obtaining services from the private sector.

To the extent possible make services available during off working hours and weekends e.g. during lunch time, after 4 pm and during weekends for working women and depending on the local context e.g. "pola days". Consider paying extra duty to service providers working during weekends and public holidays.

3. Increase access to accurate information about FP.

Develop a FP Communication Plan as part of the proposed FP Action Plan (see Enabling Environment).

Use findings from the FP review and experience from piloting the BCC strategy guides in developing the FP Communication Plan in consultation with all stakeholders including the NGO/private sector and professional colleges. The Communication Plan seeks to address the knowledge attitude practice gap (KAP GAP) among FP clients by addressing myths and misconception about FP and fear of side effects and health concerns that impede the use of contraception. Culturally sensitive community engagement with targeted BCC is needed to reach minority groups.

Since the BCC Strategy Guide on FP does not contain subfertility it is recommended to develop a module on subfertility. The Communication Plan will target various audiences identified in the BCC Strategy Guide for FP but in addition address subfertile couples, PLHIV and people with disabilities. The desired behaviour change and targeted messages will be developed for each group. These could be an addendum to the current document. The Communication Plan will ensure that accurate, clear and consistent messaging around

contraception and subfertility are disseminated.

Multiple media outlets including mass media, IEC materials, interpersonal communication, champions and advocacy campaigns must be used to increase demand and uptake of services. The HEB has developed communication materials of various types for some of the target groups with technical support from the FP Unit. The FP Communication Plan must also include a monitoring plan with indicators to measure progress.

For the FP Communication Plan to be relevant to the needs of the people, they should be province- or even district-specific.Each district should develop its own communication plan. The Communication Plan will help RDHS, MOMCH, RSPHNO and MOH to review their FP communication programming. The communication plan must promote the transformation of gender norms. The focus will be on utilizing existing resources and networks and on creating synergy between interventions. The Communication Plan will help them to:

- analyze data in the district and community and increase understanding of FP issues ;
- segment target populations based on the FP issues unique to a community;
- identify and overcome specific barriers to FP uptake;
- ensure accurate and consistent messaging on FP;
- develop effective interventions to reach target populations

Use the expertise of the district level health workers to design material that are culturally and socially acceptable.

Use mass media to provide accurate information on FP, dispel myths and misconceptions and increase demand for FP

A major component of the FP Communication Plan is a national multimedia campaign including television, radio and print media. Key messages will include information on FP in general, choosing an FP method, method safety, dispelling rumours and myths about specific FP methods that impede its adoption and continuous use. Messages on causes of subfertility and reduction of stigma will also be incorporated. Multimedia "edutainment" must also be used to increase awareness of contraception and subfertility and dispel myths and misconceptions in a manner that engages and captures the audience's attention. FP Unit must persist in building rapport and establish a partnership with the Sinhala and Tamil mass media especially to convey messages to the public on the benefits of birth spacing and to increase awareness on prevention and treatment of subfertility.

Though expensive, the use of a professional media organization from the private sector to design the media campaign should be considered. Use of Government media outlets adds legitimacy to the campaign. The NFPP can appeal to the private sector to provide free air time as part of corporate social responsibility to disseminate messages on FP. In addition, the NFPP needs to provide well written attention catching articles on FP to be included in magazines that are popular with young people. Radio and TV discussions are popular with the public and need to be utilized by the NFPP.

HEB should produce posters and other IEC material with technical assistance from FP Unit in adequate quantities and distribute them to public sector preventive and curative institutions and the private sector.

The NFPP and HEB should ensure that all messages on FP disseminated to the public are uniform, accurate, clear and consistent. Prior to publication and dissemination of material on FP by individuals and organization they should be submitted to the TACMCH/FP for review and endorsement.

Move with the times - use social media and mobile technology to create demand for FP

Pilot test using short text messaging (SMS) as a confidential information source to answer inquiries about contraception and subfertility. Following evaluation of the pilot project mHealth technology can be scaled up.

The FGDs showed social media was an important source of information for young people and those in urban areas. The NFPP should pilot the use of social media to disseminate messages on FP. Social media is an important communications tool that can be used to provide information on FP and subfertility and to direct the users to other resources.

Strengthen the HEB hotline to answer questions from callers on contraception and subfertility and where services can be obtained.

Train service providers so as to improve their attitudes and communication skills to offer rights-based FP information and services. Provide in-service training on rights based FP demand creation so they understand FP rights and can correct myths and misconceptions and host community dialogues. All service providers in the field must be supplied with updated job aids, communication materials, and necessary supplies for community education on contraceptive methods and subfertility.

Sensitize religious and community leaders about healthy timing and spacing of pregnancies and subfertility. At the district and divisional level health staff must engage with religious and community leaders and provide them with accurate information on birth spacing so as to obtain their commitment to the health and well-being of mothers and children in their communities. These opinion makers can also play a major role in reduction of stigma in the community about subfertility.

Mobilise men in support of FP. Male involvement is crucial to a successful demand creation campaign. Lack of focus on men can lead to erroneous inferences that FP is not their concern but a "women's issue". Dispelling myths and misconceptions amongst men, and educating them on the potential benefits of FP is important to ensuring their support. Spousal communication and joint decision making about the use of contraception is necessary. There is a need to provide precise knowledge on vasectomy (which seems to be lacking among the men) and dispel misconceptions about the method. The HEB must develop appropriately targeted communications materials for men with support from the FP Unit and Gender and Women's Health Unit of the FHB.

Use the MSGs and other women's groups to increase awareness on FP. Under the guidance of the MOMCH the MOH should partner with the existing women's groups and networks to provide information on contraception and subfertility to women. The HEB should involve the FP Unit to improve the technical content on FP for the MSG meetings. The MSGs are an opportunity to increase knowledge and awareness on contraception to all mothers of reproductive age irrespective of their marital status. This is also an opportunity to create awareness on subfertility, especially on preventive aspects and to reduce stigma related to childlessness.

Use satisfied clients as local champions for FP. To improve accurate information about contraceptives, train satisfied users to address myths and misconceptions about family planning. These satisfied clients can be used as local champions who will be used in community campaigns and demand creation activities. This initiative will be piloted in some areas initially.

Pilot a peer-to-peer approach for FP. A peer –to-peer education approach on contraception must be piloted targeting married women initially. The MSGs can be the entry point for peer-to peer education. Satisfied clients can also be used to develop peer groups.

Maximize encounters of health workers with women and men to discuss FP. Train and mobilize PHIs to incorporate message on FP in their encounters with men at workplaces and elsewhere. Develop a curriculum and provide refresher training to PHII on contraception. PHIs should be mobilized to conduct community outreach events for men to provide information on contraception and distribute condoms. Job aids for PHI on contraception and subfertility must be developed.

PHIs can also provide information to men on subfertility, especially preventive aspects of subfertility. Include the number of programmes conducted for males by PHI as an indicator in the RHMIS. Such encounters should be included in the reports submitted by PHIs. Ensure domiciliary visits by PHMs are carried out at least twice a year to women over 35 years and / or with children over 5 years of age who have an unmet need to discuss FP. Sensitize and reinforce to MOs in curative institutions, especially those conducting OPD clinics to ask married women as part of the history taking process about the use and need for contraception. Conduct awareness programmes in factories and workplaces for working women.

Reduce factors that act as social and cultural barriers to demand for services. Reduce communication barriers due to language dichotomy between service providers and clients by emphasizing language proficiency in Tamil and Sinhala among health staff. In communities where early marriage is common promote delaying the first pregnancy till at least 20 years until young women are physically and mentally ready to have children. Accede to requests for gender concordant service providers recognizing that this is not always possible. In the even that a gender concordant service provider is not available the client should be involved in the decision making process so as to limit the negative effects of not adopting a FP method.

4. Increase demand by expanding social marketing and the establishment of social franching networks.

Social franchising presents an untapped opportunity to engage private providers in health care delivery to increase access to high-quality FP and other services.

Annex 1

Review of the National Family Planning Programme of Sri Lanka

Terms of Reference of the External Consultant

Background:

The National Family Planning Programme has immensely contributed to the impressive health indicators that Sri Lanka enjoys at present, but has become stagnant recently. During the last few years, there have been many challenges to the National Family Planning Programme, amongst which were issues related to quality of contraceptive commodities and negative social perceptions. In addition the programme needs to be modified to cater to the societal changes observed, as well as targeting high risk and special groups.

As such, the Ministry of Health considers a review of the National Family Planning Programme a high priority, in order to ensure its vital continuing contribution to the health and social development targeted by the Government of Sri Lanka. It needs to come up with suitable strategies, standards and guidelines necessary to address the gaps observed, at present, in the programme.

Objectives:

1) To conduct an objective assessment of the existing services in relation to family planning.
2) To identify the current needs related to family planning.
3) To review the extent to which the family planning services meet the needs of the population.
4) To determine the gaps in existing family planning services.
5) To suggest strategies and services in order to address the gaps identified.
6) To address any other aspect of the National Family Planning Programme that needs to be reviewed, which will be communicated by the focal point of the Ministry of Health.

Scope of work:

1) Desk review of the available documents, including guidelines on family planning programme of Sri Lanka.
2) Conduct initial meetings with stakeholders and a workshop to outline the current situation of the programme.
3) Conduct discussions with stakeholders to identify the current family planning needs of the population.
4) Conduct discussions with relevant stakeholders to identify the special groups that need more focus within the family planning services.
5) Draw a framework of strategies to address the identified family planning needs.

Methodology:

1) Desk review of relevant documents.
2) Meetings with stakeholders, including government officers, professional colleges, NGOs, civil organizations and clients.
3) Make field visits as necessary.
4) Conduct debriefing meetings to relevant officers.

5) Work in consultation with the international expert agency selected, and the expert committee appointed for this task.

Outputs:

1) An initial proposal outlining the methodology to be adopted and key activities to be carried out in the process of the programme review.
2) Final report to include the current status of the family planning programme.
3) Draft plan of strategies to address unmet need and emerging needs, to approach and deliver services to special groups and improve the quality of services.
4) Capacity building plan, which includes conduction of advocacy.
5) Suggestions on operational research in order to improve the coverage and quality of the family planning programme.

Annex 2

Review of the National Family Planning Programme of Sri Lanka

Terms of Reference of the Expert Committee

Purpose:

The purpose of the expert committee is to provide expert opinion on the Review of the National Family Planning Programme of Sri Lanka, which will be conducted by an external consultant.

Functions:

1) To assist in selecting an external consultant to conduct the National Family Planning Programme Review.
2) To assist in selecting other agencies and resource persons required for the National Family Planning Programme Review.
3) To identify subject areas and content that need to be covered in the programme review.
4) To assist the external consultant in identifying relevant stakeholders and resource material required to gather information relevant for the review.
5) To provide perspectives on local context related to the programme review.
6) To provide feedback to the external consultant on the initial proposal outlining the methodology and key activities.
7) To provide feedback to the external consultant on gaps identified and strategies suggested in the process of programme review.
8) To participate and contribute in the relevant meetings and workshops related to the programme review.

Frequency and venue of meetings:

These will depend on the requirements of the programme review.

Annex 3

National Family Planning Programme Review

List of the Expert Committee

1) Dr. R. R. M. L. R. Siyambalagoda - DDG.PHS II
2) Dr. Deepthi Perera - Provincial Director of Health Services/Western Province
3) Dr. B. V. S. H. Beneragama - Director.MCH
4) Dr. R. D. F. C. Kanthi - Director/HEB
5) Director.MSD or representative – Mr. Weeraratne
6) Prof Lal Jayakody, Chairman, National Medicines regulatory Authority, or representative
7) Dr. U. I Rathnayaka - RDHS/Kalutara
8) Dr. C. De Silva - Deputy Director.MCH
9) Dr. S. S. P. Godakandage - CCP/Family Planning
10) Dr. A. Basnayake - CCP/Adolescent Health
11) Dr. Ayesha Lokubalasooriya - CCP/School Health
12) Dr. NilminiHemachandra - CCP/Maternal Care
13) Dr. NiroshaLansakara - CCP/Monitoring and Evaluation
14) Dr. N. Mapitigama - CCP/Gender and Women's Health
15) Dr. ChamindaMathota - Consultant VOG/ Family Health Bureau
16) Dr. P. D. Ranasinghe - SR/HEB
17) Dr. NimalGamagedara - CCP/Uva Province
18) Dr. Kanishka Karunarathne - President/SLCOG
19) Dr. M. Achchuthan - MO.MCH/Batticaloa
20) Dr. W. S. C. De Alwis - MO/FP – De Soysa Hospital for Women
21) Dr. AnomaJayathilake/WHO
22) Mr. H. W. J. Abeywickrama /UNFPA
23) Dr. SumithraTissera, Medical Director/FPASL

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Annex 5 -
List of participants at the Workshop held on 21st December 2015

No	Name	Designation	Institution
Group 1 - Governance & leadership, finance and human resources			
1	Dr RRMLR Siyambalagoda	DDGPHS II	MOHNIM
2	Dr N Hewageegana	DDG Planning	MOHNIM
3	Dr.A.K.S.B.de Alwis	DDG/ET&R	MOHNIM
4	Dr. W. Karandagoda	Medical Director	Lanka Hospitals
5	Dr. Ayesha Lokubalasooriya	NPM/School Health	FHB
6	Dr. Nethmini Thenuwara	NPM/Planning	FHB
7	Dr.D.P.S.Kiriwandeniya	Medical Superintendent	BH Mulleriyawa
8	Dr A Rajmohan	RDHS	Trincomalee
9	Dr Mrs B Pasupathyrajah	RDHS	Vavuniya
10	Dr Priyani Senedheera	Director	TH Mahamodera
11	Dr Nimal Gamagedera	CCP	Uva Province
Group 2 - Data for decision making			
1	Dr N K J Kumara	MOH	MOH Office Padukka
2	Dr M Achchuthan	MOMCH	Batticaloa
3	Dr C P Gallage	MOH	MOH office Kurunegala
4	Dr KHJ Kumara	MOH	MOH office Padukka
5	Ms KAD Lalanie	PHNS	MOH office Kurunegala
6	Ms GDK Herath	PHNS	MOH office, Mahawewa
7	Ms EMS Eknayake	PHM	MOH office Kurunegala
8	Ms HMP Samaranayaka	PHM	MOH office Kurunegala
Group 3 - Increasing demand for FP information and services			
1	Dr R Batuwanthudawe	CCP	HEB
2	Dr Buddhika Senanayaka	Actg Deputy Director	NSACP
3	Mrs. Renuka Peiris	Director, School Health and Nutrition	Ministry of Education
4	Dr. N. Mapitigama	NPM/Gender and Women's Health	FHB
5	Dr. Chiranthika Withana	NMP/ Adolescent Health Unit	FHB
6	I Wewalwela	Principal	NTS Colombo
7	Dr. Iresha Jayawickrama –	Registrar/Com .Med.	FHB
8	Dr C J Hapudeniya	MO	FHB
9	Ms Nanditha Katugampola	Project manager	Population Services Lanka
10	TRJ Thalagal	Tutor/Special Grade	NTS Colombo
Group 4 - Contraceptive security			
1	Dr BVSH Benergama	D MCH	FHB

2	Prof Rohini Fernandopulle	Prof of Pharmacology	KDU
3	Dr Deepika Herath	MO	FHB
4	Dr Krishantha Peiris	MO	FHB
5	Dr Nimal Gamagedera	CCP	Uva Province
6	Dr Padma Balasooriya	MOMCH	Kurunegala
7	Mr ED Weeraratne	Asst Director (Pharmaceuticals)	MSD
8	MSR Junaid	Director Marketing	FPASL
9	EM Amila Ekanayaka		NMRA
Group 5 Service delivery (Institutions)			
1	Dr. C. De Silva	Deputy Director, MCH	FHB
2	Dr. U. D. P. Ratnasiri	VOG	CSHW
3	Dr. Harsha Attapattu	VOG	BH Homagama
4	Dr. Mangala Dissanayake	VOG	Kethumathi Maternity Hospital
5	Dr Chaminda Mathota	VOG	FHB
6	Dr P Amaradiwakara	VOG	TH Mahamodera
7	Dr K H D Milroy	College of General Practitioners	
8	Dr Mohomad Rishard	VOG	DGH Killinochchi
9	Dr. Sumithra Tissera,	Medical Director	FPASL
10	Dr Nimali Widanapathirana	Registrar/ Comm Med	FHB
Group 6 Service delivery (MOOH and MO)			
1	Dr. Hewapathirana	MO. MCH	Gampaha
2	Dr.Shiromi Fernando	MO/ FH	DMH
3	Dr V G Rajapakse	MOH	MOH Office Kelaniya
4	Dr Nimali Widanapathirana	Reg Comm Med	FHB
5	Dr Muraliharan	MOMCH	Killinochchi
6	Dr HJM Kumari	MOIC	DH Madampe
7	Dr Sanka Randenikumara	MOIC	DH Amugoda
8	Dr Nalin Wijesekera	MOH	Gonapinuwala
9	Dr PKN Rathnasiri	SHO Gyn Obs	BH Dambadeniya
10	Dr Amith Fernando	SHO Gyn Obs	BH Marawila
11	Dr U M Afkar	MO RH	TH Kurunegala
12	Dr RAS Kumara	DMO	DH Rambukkana
Group 7 Service delivery (Grass root level workers)			
1	Dr.Lakmini Magodaratne	DD/ Field services	NIHS
2	Dr.Chandani Denawaka	MOH	Battaramulla
3	Ms SAG Chandralatha	RSPHNO	RDHS Kurunegala
4	Ms HGTP Silva	PHNS	MOH Rambukkana
5	Ms KPD Shyamalee	NO	BH Dambadeniya
6	Ms KAP Fernando	Nursing sister	BH Marawila

7	Mr DAK Saman Raja	NO	DH Rambukkana
8	Ms H Nimali	PHM	MOH Nattandiya
9	Ms Nuwan Kumari	PHM	MOH Mahawewa
10	Ms Kalyani Rajapaksa	PHM	MOH Rambukkana
11	Ms Chitrani Piyaseeli Menike	PHM	MOH Rambukkana
12	Ms KKA Vithanage	NO	TH Mahamodera
13			

Annex 6

Key Informant Interview Guides

Discussions Guide

Government Policymakers

1 How have you seen the family planning (FP) program evolve over the past several years?

a. What factors have been behind advances or setbacks in the program (including programmatic, political, financial, social, and/or cultural)?

2) What are the most important national laws and policies related to FP and sexual and reproductive health (SRH)?

a. What are the dates of these laws and policies?

b. What national goals are related to FP use? Who are the main actors/partners involved in implementation? What is the timeframe for meeting these goals?

c. How are national goals communicated to relevant actors and stakeholders? What coordination mechanisms are used to harmonize efforts of various partners?

d. Has a long-range costed implementation plan been developed for meeting these goals/objectives? Is the plan fully funded?

e. Are there any important policy gaps related to FP and SHR? What efforts are under way to address these gaps?

f. How do current laws and policies affect the importation of and provision of contraceptive commodities?

Are there any legal barriers that need to be addressed?

g. How do current laws and policies related to advertising health products affect the promotion of FP or of certain brand-name contraceptives?

h. What laws or policies stipulate which cadres/types of health workers can provide FP services? In practice, do any of these laws or policies serve to limit the availability of certain FP methods?

i. Are there any important policy gaps or changes that are needed to support FP programming? What efforts are under way to address these policy gaps or make these changes? What else needs to be done?

3) How high is the level of political commitment to and leadership on the issue of FP?

4) **Are you aware of any FP-related advocacy efforts under way? If so, what do you seeas their main goal(s)? who are the main targets?**

5) **How is planning done in the Ministry and FHB in relation to FP?**

   a. Should there be a multi- year plan and budget for FP?

   b. What needs to be done to strengthen evidence based planning, implementation, monitoring and evaluation of FP at central, provincial and district levels?

   c. In your opinion how do you rate the capacity of the FP unit? Weak, moderate, strong

   d. What needs to be done / what further strengthening of the FP Unit is needed to carry out its functions?

   e. In the organogram of FHB on what basis are human resources allocated to the different units?

   f. How are resources allocated to the different units?

6) **What data are used for FP program planning and decision making**

   (e.g., DHS surveys; service or use statistics; formative research; pilot projects; monitoring and evaluation; best practices)?

   a. What service statistics are regularly reported from service delivery points up to the district, provincial, and national levels? What systems are in place to monitor the quality of these data? How are these data used?

7) **Budget / Funding for FP**

   a. Are MOH budgets developed based on last year's or historical totals, or are budgetsdeveloped based on estimates of resources required to meet the population's healthneeds?

   b. Is budget planning done centrally or is the budgeting process bottom-up, beginning atthe district or local level (i.e., accumulation of district or local budget planning requests)

   c. MOH budget allocation structure - What structure does the MOH use to allocate its budget? Line items? Programs? Other?

   d. Central and local government budget allocations for health in decentralized systems

   i. How does the central government allocate funds for health to lower level administrative units such as states, regions, provinces, and districts?

   ii. Do local government units have local taxing authority? If so, do they appropriate funds for health? Do they have any other method of local public funding for the health sector?

   e. In the past, has funding allocated for FP been fully disbursed?

   f. How are FP budget forecasts made, in both the short- and long-term (over 3–5 years)? What factors are taken into consideration? How are the costs of contraceptive commodities forecast?

   g. How are budget allocations tracked at the national level and at decentralized levels? Are funds allocated for FP released/made available in a timely manner? How is this process monitored?

   h. Is FP funding adequate to meet the program's stated goals? . Is funding anticipated for the long-term (3–5 yrs) and for scale-up? Have the cost of FP commodities and supplies, provider training, SBCC campaigns, and other FP resource needs been forecasted?

i. How has decentralized health planning and budgeting affected FP programming? Are districts budgeting adequately for FP? Are they receiving the funds that they request/budget in a timely manner? What additional support is needed to strengthen district planning and budgeting processes in relation to FP?

8) In your opinion how does devolution of health to the provinces impact on the FP programme?

9) How do you coordinate with donors and other partners in support of yourFP program?

a. What kind of coordination exists?

b. Who oversees coordination efforts?

c. How are coordination efforts ensured and monitored?

8) What is the nature and extent of the (for-profit and not-for-profit) private sector'srole in FP service delivery?

(e.g., nongovernmental organizations, private for-profit facilities, pharmaceutical companies, employer based services, franchising, and social marketing)

a. Does the government encourage private-sector participation? If so, how (e.g., tax breaks, incentives)?

b. Are private FP services subsidized? If so by whom?

9) In your view, are there any critical gaps related to FP commodities or supplies?

Probe for-

a. When did the Government take over funding the FP programme?

b. Are there procurement, supply,and/or distribution issues?

c. Is FP funding adequate to ensure contraceptive security?

d. Have commodity stock-outs occurred in the past 12 months? If so, of which FP methods? At which level(s)? Why?

e. Is there a contraceptive quality control system in place?

f. Is there a national-level CS working group? If so, who participates?

10) How do national health policies support and promote the engagement ofcommunities in addressing and improving health?

a. How do national policies define or envision the role of communities in improving health and meeting national health objectives?

b. What community health structures exist and what is their role in improving health? What investment has been made in building the capacity of these community health structures? How is their participation in health program planning, design, and evaluation promoted and ensured? How is the participation of women, as well as marginalized and disadvantaged groups, ensured?

c. How do national policies support and promote the involvement of community representatives in health planning and budgeting?

d. What efforts have been undertaken to build the capacity of community leaders and groups trained to promote FP and address social, cultural, and gender norms that inhibit use of FP in their communities? Are community leaders/groups active in addressing social issues that are barriers to FP use? If so, how?

11) What national guidelines or tools have been developed to support ongoing qualityimprovement (QI) at the facility level?

a. What is the focus or approach used in QI?

b. To what extent are national guidelines and tools for QI in use? Who is involved in QI at the national, regional, district, and facility levels?

c. Do national guidelines and tools define any role for communities to play in QI? If so, what specifically?

12) How do FP policies and strategies address social norms (e.g., gender roles,early marriage, son preference) that influence FP choices among individualsand couples?

a. What types of data on social norms does the program use?

13) How, if at all, does the FP program give particular emphasis to special populations,for example:

a. Youth (married and unmarried)

Are youth-friendly FP services widely available and accessible?

b. Couples (married and unmarried)

c. Men (individually and as part of a couple)

d. Low-income groups

Is FP included in national health insurance policies/plans?

e. Rural populations

Is the program working to expand the availability of FP services through various sectors/sites

(e.g., fixed facilities, mobile services, community-based health workers, employment-based services, pharmacies)?

Has data-driven market segmentation been conducted to determine where/to whom public vs. commercial vs. nongovernmental organization programs could best market their products/ services?

f. Postpartum women for counseling and contraceptive services

g. Postabortion women for counseling and contraceptive services

h. Marginalized or vulnerable population groups (e.g., people living with HIV [PLHIV],

the disabled, displaced)

14) In your opinion, what are the biggest constraints that the FP program faces?

Prompts, if needed:

Infrastructure

Gvernment support (e.g., budget, regulations, infrastructure)

Staffing at national, regional, and district levels

Staff training, motivation, oversight/supervision

Education and outreach (at all levels)

References and resources (e.g., protocols, guidelines, job aids)

Client access (e.g., costs/fees, hours; waiting times; provider availability/attitudes)

Commodity supply (e.g., logistics, budget, transport, warehousing, information system)

Sociocultural issues (e.g., myths/misconceptions, biases; spouse/family opposition; gender inequalities)

Political or religious factors/opposition

Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)

Population segments that are more difficult to reach (e.g., urban vs. rural)

15) What do you think should be done to improve the FP program?

Have national FP service delivery guidelines been developed?

a. How recently have any national FP guidelines been updated? Are there any gaps in these guidelines, in your view?

b. How are these guidelines disseminated? How is their use monitored?

b. Which other sectors and/or ministries complement national FP programming? What FP work do they do? How does the MOH collaborate with them?

Discussion Guide

Facility-Based Family Planning Providers, Managers, or other Staff

1) What services are available at this facility?

Prompts, if needed:

Family planning (FP) including subfertility

Male reproductive health (RH)

Prevention of mother-to-child transmission (PMTCT) of HIV

Maternal and child health (MCH)

Youth RH

HIV and AIDS services

Other

2) What FP methods are available at this facility?

Male condom

Female condom

Oral contraceptive

Injectable

Implant

Intrauterine device (IUD)

Male sterilization

Female sterilization

Emergency contraception

a. What method is most commonly selected for use?

b. Why is that method so commonly chosen (e.g., myths/misperceptions regarding other methods, provider bias, social norms, recommendation from friends/family, cost, availability)?

3) What kinds of (and how many) trained providers are on staff?

a. Are there enough staff to handle daily client flow and needs?

b. Have (some/most/all) providers been trained in the following areas?

FP basics

Method provision

Referral

Individual and couples counseling

Client screening

Infection prevention

Gender sensitivity1

Youth-friendly services

Integration

Logistics/commodity management

c. How frequent are refresher/in-service FP trainings? What do these trainings cover?

d. Are the quality, scope, and frequency of FP trainings adequate? If not, how could they be improved? In what areas do providers need additional training?

4) What type of job aids (e.g., screening checklists) do providers use to help identify

who should/should not use certain contraceptive methods?

a. Are job aids useful for interaction with clients? Do they address all of the clients' needs (and individual situations)?

b. If needed, do you have up-to-date national service delivery guidelines or other such reference materials on-site? (Ask to see what is available.) Do you have access to resource persons for help?

5) Do providers consistently counsel clients on a broad range of FP methods?

6) If a client requests or needs an FP service that staff here are not able to provide, canthe provider refer him/her elsewhere?

a. If so, how often do providers at this facility refer?

b. If not, why (e.g., no institutional arrangements, not in protocols/ job function)?

7) Is FP integrated with the following health services?

a. HIV and AIDS STI services(e.g., HIV counseling and testing, AIDS care and treatment, male circumcision)

b. Antenatal care

c. Postnatal care

d. WWC

e. Mituru Piyasa

d. Child immunization and well-baby visits

8) What kind of supervision do providers receive?

a. Have supervisors been trained in facilitative supervision?

b. Do providers have clear job descriptions?

c. Do providers work under a performance-based reward system? How does that work?

d. Does someone from the district or provincial level visit a) the facility, and b) community-based agents? If so, how often? Do these visits help address your issues?

e. How often do staff from this facility visit/supervise (if relevant) other facilities, community agents, and/or community activities? What happens during those visits?

9) Do providers require spousal consent before providing FP (or certain methods) tomarried clients? Do they require parental consent before providing FP (or certainmethods) to youth?

10) Are there fee(s) associated with certain methods? Are clients asked to coverother costs (e.g., medical supplies)?

a. If so, for which methods and/or supplies?

b. Do you think that fees affect clients' interest in choosing a particular method?

c. Is there a national insurance/voucher scheme for FP?

d. Is there a sliding scale or fee waiver for those who cannot afford services?

11) Are FP commodities, equipment, and supplies consistently available?

a. Do you consistently have everything you need to provide the FP services sought by your clients? What

do you lack most often (e.g., particular methods; equipment related to specific methods, such as IUDs or sterilization; bleach; gloves)?

b. Have stock-outs of certain methods (and/or equipment, supplies) occurred within the last three months? If so, why do you think this is happening?

c. Do you maintain and/or collect stock and consumption data (such as logistics management information system [LMIS]2 data)? How are they used?

d. How often is commodity forecasting done? For what period of time?

12) How is FP program performance measured, managed, and improved?

a. What service statistics are collected and reported to the district, regional, and/or national levels?

b. How often do you compile them, and where are they sent?

c. Do you receive feedback on the data? Are these data used for decision making at this health facility? If so, how?

d. Do you obtain feedback from clients (e.g., client exit interviews)? If so, how do you collect and use the feedback?

13) Does the facility engage the community in health care planningand implementation?

a. How do staff here partner with communities to address barriers to FP use?

b. What are the main community health structures or partners with whom you work at the community level? Who is involved (e.g., satisfied users, community/religious leaders, chiefs)?

c. Can you provide some examples of how the community participates in program design/ implementation/evaluation?

14) In your opinion, what are the biggest constraints to offering FP servicesat this facility?

Prompts, if needed:

Infrastructure (e.g., storage, privacy, utilities)

Lack of job descriptions; poor understanding of individual and/or team roles/responsibilities

Lack of resources for needed functions or materials (e.g., training, supervision, salaries, supplies)

Low staff satisfaction, retention, motivation, learning opportunities; absenteeism; tardiness; recognition; salary; housing

Printed materials (e.g., SBCC materials, job aids)

References and resources (e.g., protocols, guidelines)

Client access (e.g., hours, wait times)

Client load

Cost (including supplies)/fees

Sociocultural issues (e.g., myths, biases, staff gender)

15) In your opinion, what do clients see as their biggest constraints to accessing FPservices at this facility?

Prompts, if needed:

Distance and/or access (e.g., hours, waiting times, provider availability or attitude)

Infrastructure (e.g., privacy, utilities)

Lack of information, including lack of (appropriate) printed materials

Cost (including supplies)/fees

Sociocultural issues (e.g., myths, biases, sex of staff)

16) What do you think should be done to improve the FP program?

Discussion Guide

Nongovernmental organizations, for-profit organizations

1) **What is the general focus of your involvement in family planning (FP)(e.g., financial support; aspects of service delivery (supply); aspects of theenabling environment; demand)?**

   a. [If applicable] What is the name of your project? What are the project dates?

   b. What geographic areas do you target?

   c. What is the source of your funding for FP?

2) **Do you target specific demographic groups (e.g., youth, men, postpartum women,low-income groups)?**

   a. [If relevant] Are the services you offer subsidized?

3) **How do you coordinate your FP support with the government and other partners?what coordination mechanisms exist?**

   a. Are there FP-specific coordination efforts (e.g., a national FP working group) on contraceptive security

   (CS), preservice/in-service training, policies and guidelines, social and behavior change communication

   (SBCC), and/or advocacy? How effective are they? What could be done to improve them?

   b. Does the Ministry of Health (MOH) monitor or oversee your activities? If so, how?

   c. [If relevant] Does the government offer insurance/voucher schemes for lower-income people to access (for-profit or not-for-profit) private-sector FP services?

   d. [If relevant] What is the nature of MoH oversight or involvement in privately run FP facilities?

The following sections (A. Supply; B. Enabling Environment; C. Demand) seek moredetailed information on respective technical organizations' support for FP.

A. Supply

1) **Does your program support direct FP services? If yes, what type of service deliverypoints (SDPs) do you support?**

   a. What services are available at the SDPs you support (FP, infertility, male reproductive health (RH), prevention of mother-to-child transmission of HIV, maternal and child health, youth RH, HIV and AIDS services, WWC and/or other services)?

   b. Which FP methods are provided at the SDPs you support? Do you routinely experience stock-outs (of commodities or related equipment/supplies)? If so, how often and for which methods?

2) **In your view, what are the main strengths and challenges related to FPservice provision?**

   Prompts, if needed:

   Health system infrastructure and equipment

   Contraceptive security

Number and distribution of providers

Provider training and skills

Availability of protocols, guidelines, and job aids

Health service quality

Supervision and management systems

Mix of methods offered

Integration with other health services

Referral systems

Geographic/physical access (e.g., community-based distribution; clinic hours)

Financial access (e.g., fees for methods, supplies, equipment, or consultation; insurance)

Involvement of the for-profit and not-for-profit private sectors

Meeting the needs of hard-to-reach populations (e.g., married and unmarried youth, men, people living with HIV, IDP)

Engagement of communities in health service delivery issues (e.g., quality improvement, management)

3) If this is a private (for-profit or not-for-profit) organization:

a. Generally speaking, how do clients perceive private vs. public FP/RH services?

b. What is the nature of MoH oversight or involvement in privately run FP SDPs?

c. Are there any subsidies offered for private FP services, either by your organization or by the government?

d. If this is a social franchising or workplace initiative, what motivated your organization to become an active player in FP programming? What else would facilitate your efforts?

4) In your opinion what are the reason for the stagnating CPR for modern methods?

B. Enabling environment

1) In your view, what are the main strengths and weaknesses of existing nationalpolicies, strategies, and guidelines related to FP?

a. To what extent are these policies, strategies, and guidelines disseminated and in use?

How is this monitored and supported?

b. Do any policies or guidelines need updating to reflect current evidence or best practices?

c. How would you describe overall support for the FP program in terms of:

Budgeting processes

Funding allocations

Training systems (preservice and in-service)

Logistics systems

Supervision and management systems

d. What are the main programming gaps that limit or constrain progress or achievement of national policy goals and objectives?

e. How is existing health management information system data used to inform programming?

2) **How would you describe national leadership and commitment to FP? In whatspecific areas is greater leadership needed?**

3) **Thinking about the social, cultural, and gender norms that influence FP use/uptake,what are the main barriers that are being addressed by FP partners, and how arethey being addressed?**

a. What level of policy support is there for community engagement in this area? To what extent are community-level champions being involved in these efforts?

b. What do you think are the main areas in which programming in this area could be strengthened?

4) **Have FP service delivery procedures and guidelines been disseminated?**

a. Are they considered up-to-date and evidence-based?

b. How can they be improved upon?

c. How well do providers understand them?

d. Do you know if their use is monitored during site visits? Are they consistently applied throughout all levels of the health care system?

e. Are you aware of any current FP-related laws that place unnecessary medical restrictions on contraceptive use and/or provision?

5) **Are there institutional mechanisms at all levels for ongoing quality improvement(e.g., facilitative supervision, performance standards, assessment of site readiness)?**

What efforts do you support to help ensure that good working conditions arein place?

6) **Budget/funding for FP**

a. Is there a dedicated line item for FP in the national budget? In the MOH budget? How has this changed over time? In the past, has funding allocated for FP been fully disbursed?

b. Do you consider the allocated FP funding adequate for meeting stated national goals? Have the cost of FP commodities and supplies, provider training, SBCC campaigns, and other FP resource needs been forecasted?

c. Is funding anticipated for the long-term (3–5 yrs) and for scale-up?

d. What is/are the main source(s) of funding for FP (e.g., government/internal; donors/external). How diversified are they?

e. How has decentralization impacted budgeting for FP? Can/do districts budget for FP, and can they access adequate FP funds in a timely manner?

7) **Is a national contraceptive security policy and corresponding operational plan, includingbudget, in place?**

a. How do current laws and policies affect the importation of and provision of contraceptive commodities?

b. Are there any legal barriers that need to be addressed?

c. Do you participate in CS? If so, how?

d. Are you aware if the national CS strategy is supported by regulations8 that facilitate the timely importation of FP commodities? Are you aware of legal barriers that prohibit the importation of certain commodities?

e. Is there a logistics management information system (LMIS)9 in place? Are there any major logistical bottlenecks? If so, how can they be addressed?

f. Have commodity stock-outs occurred in the past three months? If so, of which FP methods?

g. Can you tell us which FP methods/supplies are included on the National Essential Drug List? If needed, are any advocacy efforts under way to expand on this list?

8) What positions have government and other leaders taken on FP?

a. Has an analysis of government and other leaders' positions on FP been conducted?

b. How broad is support for FP (or is it targeted to certain groups or focused on specific methods)? What is it informed by (e.g., evidence vs. beliefs/politics)?

c. Do heads of government and other officials speak publicly and favorably about FP at least once or twice a year? If so, what form does this take (e.g., public speeches, radio/TV broadcast)?

d. Are you aware of district/provincial, traditional, and/or religious leaders' positions and corresponding actions or statements regarding FP?

9) Has your organization reached out to supportive (government and other) officials/leaders at all levels to serve as FP champions? If so, how does your organizationengage them?

10) Is there an established national-level FP advocacy committee consisting of NGO and/or other entities working in the areas of FP and infertility)? If so, who is involved?

a. Is there a clear advocacy objective?

b. Can you provide examples of FP advocacy efforts currently under way, including the target(s) of these efforts?

C. DEMAND

1) How do current laws and policies related to advertising health products affect the promotion of FP or of certain brand-name contraceptives?

2) How would you describe the main focus of the FP program's SBCC efforts?

a. What are the main barriers that are being addressed?

b. What communication approaches (e.g., counseling, mass media, peer education) are being used?

c. How could they be strengthened or better supported? Are other issues not being effectively addressed through current SBCC efforts?

3) Are peer educator programs in place and operational?

a. Do peer educators include both men and women? Youth?

b. Are they trained in:

Interactive counseling

FP basics

Referrals

c. Are there any gaps in their training?

d. Do peer educators conduct regular sessions/events? Can you provide examples?

4) **What have been the most useful means of communication (e.g., radio, TV,newspapers, posters, billboards) for generating demand, combating FP myths/misconceptions, and educating the following populations:**

Youth

Married/unmarried couples

Men

Communities

Leaders (e.g., religious, community)

5) **How is social marketing being used to expand the distribution of FP informationand products?**

a. Are socially marketed products widely available?

b. Are they advertised within the communities served?

c. Are some areas or parts of the population difficult to reach through social marketing? If so, why, and what is being done to address this?

6) **Are you aware of or have you been involved in undertaking market segmentation or other studies/ analyses? Do you have and use information on:**

a. The extent to which sociocultural norms (e.g., gender roles, social networks, religion, local beliefs) influence FP choices among individuals and/or couples?

b. Where and to whom different sectoral programs (public vs. commercial vs. NGO) can best market their products and services?

c. Hard-to-reach and/or marginalized groups in both urban and rural areas?

7) **What efforts have been undertaken (or are under way) to help ensure that clientscan make informed and voluntary FP choices, including choosing the method thatbest meets their needs?**

a. Are providers trained in:

Interactive counseling?

Counseling specific to the needs of different FP clients (e.g., men, couples, married/single women, married/single youth, continuing FP clients, people living with HIV, postpartum women)

b. Do you support FP outreach/counseling activities within the community? If so, how often?

c. How effective are these efforts at providing services, informing/educating potential FP clients, and generating demand for FP services?

d. Are there adequate and appropriate job aids for counseling? Are there FP pamphlets available for

clients?

8) In your opinion, what are the biggest constraints that the FP program faces?

Prompts, if needed:

Education and outreach at all levels

Sociocultural issues (e.g., myths/misconceptions, biases; spousal/familial opposition; gender inequalities)

Political or religious factors/opposition

Population subsets that are more difficult to reach (e.g., urban vs. rural)

DISCUSSION GUIDE

Development Partners

1. Could you tell us a bit about the FP activities you support?

a. Which technical areas do you support?

Prompts, if needed:

- Health care planning, management, financing
- Infrastructure
- Aspects of training
- Supervision
- Quality assurance
- Logistics management information system or other information systems
- Commodities
- Community outreach
- Social and behavior change communication
- Primary health care
- Maternal and child health (MCH)
- Social marketing
- Franchising
- Workplace initiatives

b. Do you focus on specific geographic areas?

c. Are specific demographic groups targeted?

2) How do you channel your technical and/or financial support?

(direct to the Ministry of Health (MoH);through international/local nongovernmental organizations (NGOs); community-based organizations; for profit entities)

a. Which other ministries and government agencies assist with FP activities (e.g., through financial support, procurement of equipment/supplies, services, information dissemination, education)?

3) How is the support of various FP partners coordinated?

a. Is/are there point person(s)/counterpart(s) designated to work with you on FP in the MoH? In other ministries and/or agencies? Do they have enough staff for FP efforts?

b. How effective is donor coordination on FP?

What kind of coordination exists and for what purposes(e.g., MCH/FP; contraceptive security; advocacy; SBCC)

4) How would you describe national-level coordination on contraceptivesecurity (CS)? who leads these efforts, what is involved, and which organizationsparticipate? Is your organization actively involved?

a. Is/are there point person(s)/counterpart(s) designated to work with you on CS in the MoH?

In other ministries?

b. Do you see evidence of leadership on and commitment to CS as a priority? If so, what?

c. Are CS efforts backed by sufficient funding?

d. What are the major challenges to CS from your perspective?

5) What is the overall political/policy environment for FP?

a. Have government and other leaders' positions been analyzed? If so, how broad is support for FP (or is it targeted to certain groups or focused on particular methods)? What is it informed by (e.g., evidence vs. beliefs/politics)?

b. Do heads of government and other officials speak publicly and favorably about FP? If yes, how frequently (at least once or twice a year)? What form have these statements taken (e.g., public speeches, radio/TV broadcasts)?

6) How supportive of FP are MoH policies, regulations, and budget allocations?

a. Is there a dedicated line item for FP in the national/MOH budget?

b. Is funding for FP adequate? Have the cost of FP commodities and supplies, provider training, SBCC campaigns, and other FP resource needs been forecasted? Is planning long-range (i.e., over 3–5 years), and does it include scale-up?

c. How comprehensive is the national FP policy, if one exists? Has it led to evidence-based operational plans and protocols and guidelines? Are they being used?

d. Does the program target vulnerable groups? Who/what/how?

e. What is the role of the (for-profit and not-for-profit) private sector in FP?

f. Does the government encourage private-sector participation in the provision of FP? If so, who, what, and how (e.g., through tax breaks, incentives)?

g. Are you involved in supporting public-private partnerships or social marketing? If so, how (e.g., subsidizing private services)?

7) What advocacy or SBCC efforts related to FP are you aware of at the national level?

At decentralized levels? Is your organization actively involved in either or both?

a. What is the nature of your coordination with others on advocacy or SBCC efforts?

b. Do you recognize/are you aware of individuals or groups that serve as FP champions?1

c. If so, at which levels, and what do they do?

8) What are the challenges currently confronting the program and threatening past achievements to date? What should be done about them?

9) What do you think should be done to improve the FP program?

Discussions Guide

Government Policymakers Policy - 2

MSD, SPC, NMRA,

Policy / Regulation

1. Does the country have any legal barriers prohibiting the importation or marketing of contraceptives?
2. Are any family planning commodities subject to duties, import taxes or other fees?
3. If yes, for which sectors (Public, NGO, social marketing, commercial)?
4. If yes, how much are the duties, taxes or fees?
5. Are there policies that hinder the ability of the private sector (NGO, social marketing, commercial) to provide contraceptive methods (for example, proce controls, taxes/duties, advertising bans, etc)?

   Probe

   If yes, describe the policies
6. Are there policies that enable the private sector (NGO, social marketing, commercial) to provide contraceptive methods (for example, proce controls, taxes/duties, advertising bans, etc)?

   Probe

   If yes, describe the policies

System for pharmaceutical registration

1. Is periodic renewal required, and what standards are applied?
2. Is registration based on an assessment of product efficacy, safety, quality, and truth of packaging information? If so, then pharmaceutical registration is part of a comprehensive quality assurance program?
3. Is the system kept up to date?
4. Do you have any concerns about the ability of the registration system to keep up with applications?
5. What is the average turnaround time for pharmaceutical registration applications?
6. Do you have concerns about a black market, products that are circulating in the market and are not registered?

Is there a system for the collection of data regarding the efficacy, quality, and safety ofmarketed products (postmarketing surveillance)?

1. How long has the system been in place?
2. How extensively is it actually used for tracking action on substandard pharmaceutical products?
3. Are data available? What standards are used?

4. Does the country have a system by which providers and consumers can report product problems?
5. If so, is it a passive, self-reporting system or a mandatory reporting system? If it is the latter, a key component of quality assurance is in place. This indicator does not address how well follow-up on reports is conducted.

Existence of a pharmaco-vigilance system

1. How long has the system been in place?
2. Is the country a member of the WHO Programme for International Drug Monitoring?
3. Is there a national center or mechanism to collate and analyze reports and take action to prevent adverse drug events?
4. Does the country have a system by which providers and consumers can repot adverse events?

Do mechanisms exist for the licensing, inspection and control of (1) pharmaceuticalpersonnel, (2) manufacturers, (3) distributors/importers, and (4) pharmacies/drug retailstores?

1. How rigorous is the enforcement of licensing requirements? Is a report of inspections and enforcement results generated regularly?
2. Does the country have sufficient qualified staff to conduct all inspection activities?
3. Are statistics available about compliance and enforcement of pharmaceutical laws and regulations?
4. Available statistics are evidence of a functioning system for follow-up. How often are the statistics produced?

Procurement

1. Are there formal SOPs for procurement?
2. Are generic or non-proprietary names used when procuring?
3. Is there a procurement pre- or post-qualification process for suppliers and productsbased on review of objective information about product safety, efficacy, and quality?
4. Are samples requested and tested as part of the procurement process?
5. Is there capacity for testing?
6. Are quantities of contraceptives to be procured based on reliable estimates?
7. How and at what levels is quantification conducted? What data are used (historical consumption data, morbidity data, a combination of these two, or other)?
8. What is the quality of this data?

When was the last time a national quantification was conducted?

To what extent do needs exceed the available budget for procurement? How are discrepancies resolved?

9. Does the private sector plays a big role in procuring contraceptives

Supply and distribution

Is distribution of (some or all) contraceptives managed through a push or pullsystem?

1. Are storage and transportation services contracted out?
2. How is information about receipt and use of supplies communicated to the central level?

Access to Quality Products and Services

What percent of the population has access to a public or private healthfacility/pharmacy that dispenses pharmaceuticals?

Financing

Is there a price control mechanism for contraceptives in the private sector?

1. What is the legal, regulatory and policy environment for dispensing contraceptives?
2. How is the quality of medicine and services provided by these shops monitored?
3. Which contraceptives methods can shops legally sell?

Discussion Guide

Pharmacies

1. What contraceptive methods are available at this facility?

Male condom -Ask for the brand

Oral contraceptive - Ask for the brand

Emergency contraception - Ask for the brand

Injectable

Implant

Intrauterine device (IUD)

a. What method is most commonly selected for use?

b. Why is that method so commonly chosen (e.g., myths/misperceptions regarding other methods, provider bias, social norms, recommendation from friends/family, cost, availability)? " Combo"

2. What kinds of (and how many) trained providers are on staff?

a. Are there enough staff to handle daily client flow and needs?

b. Have (some/most/all) providers been trained in the following areas?

FP basics

Referral

Individual and couples counseling

Client screening

c. How frequent are refresher/in-service trainings? What do these trainings cover?

3. What government regulations are you required to follow in selling contraceptives?

How are the contraceptives you sell classified by the government?

Do you ask for prescriptions to sell contraceptives?

5. How do you advertise your contraceptive products?

6. On average how many contraceptive methods (pieces/ cycles) are sold per week?

Condoms

Pills

Emergency contraceptives

What are the price ranges for each of the products ?

7. Who are the typical customers for contraceptive products?

Male condoms –

Oral pills

Emergency contraception

Do young people buy contraceptives? Are they mainly boys or girls?

8. From where do you get your contraceptive supplies from?

FPASL,

PSL

Private suppliers

Do you encounter breakdown of supplies?

9. What is your arrangement with your supplier about payment? How often do you pay the supplier?

10. Do you use any job aids when providing contraceptive methods?

a. Are job aids useful for interaction with clients? Do they address all of the clients' needs (and individual situations)?

b. If needed, do you have up-to-date national service delivery guidelines or other such reference materials on-site? (Ask to see what is available.) Do you have access to resource persons for help?

11. In your opinion how can use of contraceptives and sale of contraceptives be increased? Probe for young people

12. Have you faced any challenges in providing contraceptives?

DISCUSSION GUIDE

Trainers of Family Planning Providers

1) What type of training do you conduct (e.g., preservice training for midwives)?

2) Is the training for family planning (FP) providers standardized across the country (for private and public training institutes)?

3) To what extent do preservice and in-service training cover the following:

- FP basics
- Client screening
- Referral
- Individual and couples counseling
- Infection prevention
- Method provision
- Gender sensitivity
- Youth-friendly services
- Integration
- Logistics/commodity management

4) How much time is devoted to practicum/hands-on practice in FP during preservice trainings? During in-service trainings?

a. On what specific methods do providers get hands-on practice in providing during these trainings?

b. What do you think the main gaps are in terms of practicum training?

5) Are the quality, scope, and frequency of FP trainings adequate? If not, how could they be improved? In what areas do providers need additional training?

a. Is class size regulated in private and public training institutes across the country?

b. Are training institutes equipped with pelvic/arm models, FP methods, job aids, and other supplies needed to demonstrate FP service provision?

c. Is the training of trainers adequate in quality, scope, and frequency?

6) Does national policy mandate the regular revision/updating/dissemination of training curricula materials?

7) What do you think should be done to improve preservice and/or in-service training of FP providers?

8) Do supervisors/managers receive training on facilitative supervision?

9) In your opinion, what are the biggest constraints that the FP program faces?

Prompts, if needed:

- Infrastructure
- Government support (e.g., budget, regulations, infrastructure)
- Staffing at national, regional, and district levels

- Staff training, motivation, oversight/supervision
- Supervision and management systems
- Education and outreach (at all levels)
- References and resources (e.g., protocols, guidelines, job aids)
- Client access (e.g., costs/fees; hours; waiting times; provider availability/attitudes)
- Commodity supply (e.g., logistics, budget, transport, warehousing, information system)
- Sociocultural issues (e.g., myths/misconception, biases; spouse/family opposition; gender inequalities)
- Political or religious factors/opposition
- Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)
- Population segments that are more difficult to reach (e.g., urban vs. rural)

10) what do you think should be done to improve the FP program?

DISCUSSION GUIDE

Professional Associations

1. What does your association do in relation to FP and infertility?

2. What is the overall family planning (FP) political/policy environment?

a. Are you aware of any current FP-related laws / circulars that place unnecessary restrictions or barriers on FP provision?

b. Which types of providers are authorized and trained to provide different FP methods? Should this distribution of responsibilities be shifted? If so, how?

3. Have FP service delivery procedures and guidelines been disseminated?

a. Are they considered up-to-date and evidence-based?

b. How can they be improved upon?

c. How well do providers understand them?

d. Do you know if their use is monitored during site visits? Are they consistently applied throughout all levels of the health care system?

4. Does preservice training for those in your profession include:

- FP basics including subfertility
- Client screening
- Referral
- Individual and couples counseling
- Infection prevention

- Method provision
- Gender sensitivity
- Youth-friendly services
- Service integration
- Logistics/commodity management
- Internships/practicums

a. How frequent are refresher/in-service FP trainings? What do these trainings cover?

b. Are the quality, scope, and frequency of FP trainings adequate? If not, how could training be improved?

In what areas do providers need additional training?

5. In your opinion, are providers well-prepared to deliver high-quality individual and couples' counseling for contraception and subfertility? Are they well-prepared to manage side effects of FP?

6. Are you aware of any systemic problems in any of the following?

a. Are the human resources allocated for FP adequate at all levels of the health care system? Is the geographic distribution of human resources adequate?

b. The supervision of FP staff: Is facilitative supervision widely used? How frequently do monitoring visits occur, and are they generally considered useful by facility staff/providers?

c. Are service delivery guidelines and protocols sufficiently disseminated and understood/applied by providers?

d. Health management information systems: Are service statistics regularly compiled? Are they checked for quality? Are they used for decision making?

e. How well-integrated is the national health care system overall? Is the referral system considered strong?

Are there any areas in which more integration/a better referral system is/are needed?

7. In your opinion, what are the biggest constraints that the FP program faces?

- Infrastructure
- Government support (e.g., budget, regulations, infrastructure including laboratory services)
- Staffing at national, regional, and district levels
- Staff training, motivation, oversight/supervision
- Education and outreach (at all levels)
- References and resources (e.g., protocols, guidelines, job aids)
- Client access (e.g., costs/fees; hours; waiting times; provider availability/attitudes)
- Commodity supply (e.g., logistics, budget, transport, warehousing, information system)
- Sociocultural issues (e.g., myths/misconception, biases; spouse/family opposition; gender inequalities)

- Political or religious factors/opposition
- Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)
- Population segments that are more difficult to reach (e.g., urban vs. rural)

8. What do you think should be done to improve the FP program?

9. What does your association do in relation to addressing infertility?

10. In your opinion, what are the biggest constraints that infertility services face?

- Infrastructure
- Government support (e.g., budget, regulations, infrastructure)
- Staffing at national, regional, and district levels
- Staff training, motivation, oversight/supervision
- Education and outreach (at all levels)
- References and resources (e.g., protocols, guidelines, job aids)
- Client access (e.g., costs/fees; hours; waiting times; provider availability/attitudes)
- Commodity supply (e.g., logistics, budget, transport, warehousing, information system)
- Sociocultural issues (e.g., myths/misconception, biases; spouse/family opposition; gender inequalities)
- Political or religious factors/opposition
- Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)
- Population segments that are more difficult to reach (e.g., urban vs. rural)

11. What do you think should be done to improve infertility services?

Discussions Guide

Community leaders

1. What is your role in this community?

How does the local population think of you?

In which situations does the local population ask for your advice? (Men? Women?)

What do you think about your influence in this community?

2. What type of community gatherings take place in this community?

Who participates in these gatherings?

What sort of topics do you discuss?

Do you discuss health and family welfare topics? Probe for topics

3. We would like to hear about your views on family planning including infertility.

Probe

FP is not important, there are many more important health issues

The time is not right - this is just after a war

Benefits to mother

Benefits to children

Benefits to family

4. **In your opinion what are the factors that decide the size of a family?**

   Probe for:

   Economic

   Health

   Social / religious

   Other

   Who influences the number of children you have?

5. **In your opinion does family planning have any advantages?**

   Probe for:

   Advantages for the mother

   Advantages for the children

   Advantages for the family

   Advantages for the family economy

   If not advantageous probe for reasons

   Question 6 is only for religious leaders

6. **What does the religion you practice recommend in terms of family planning?**

   What does it say about the spacing of children?

   What does it say about not having any more children (stopping having children)?

   Do you recommend or prohibit family planning to your constituents? Please explain.

   If you prohibit family planning, are there any particular methods you don't encourage?

7. **From your experience and what you know about your community who makes the decision to use or not to use family planning?**

   Probe for:

   - Woman's decision
   - Husbands decision
   - Both
   - In laws
   - Peers

- Health care provider
- Other

8. According to you who is / are the best persons to take this decision?

Probe for-

Wife

Husband

Joint decision

In laws

Health worker

9. In your opinion, what are the biggest constraints that members of your communityface in accessing FP?

Prompts, if needed:

Geographic/time barriers (e.g., facility hours, waiting times)

Financial barriers (e.g., transport costs, loss of wages)

Quality of services (e.g., poor management of side effects, unwelcoming provider attitudes, insufficient staff for client load)

Lack of knowledge of the benefits of FP

Sociocultural issues (e.g., myths/misconceptions, biases, sex of staff)

10. How are couples who don't have children looked upon in this community?

Annex 7 - Key Informants

Series	Contact Name	Title / Organization
1	Dr RRMLR Siyambalagoda	DDG PHS II
2	Dr B V S H Beneragama	D MCH
3	Dr Chitramalee de SIlva	Deputy Director MCH , FHB
4	Dr Sanjeeva Godakandage	CCP, National Programme Manager, Family Planning Programme FHB
5	Dr Sapumal Dhanapala	CCP Research and Development, FHB
6	Dr Kapila Jayaratne	CCP FHB National Programme Manager, Maternal Morbidity and Mortality Surveillance
7	Dr Nethanjali Mapitigama	CCP Gender and Women's Health, FHB
8	Dr Chiranthika Witharna	CCP Adolescent health, FHB
9	Dr Anoma Basnayake	CCP Maternal Health, FHB
10	Dr Neil Thalagala	CCP Child Development, FHB
11	Dr Ayesha Lokubalasuriya	CCP School health, FHB
12	Dr Dilip de Silva	CCP Oral Health, FHB
13	Dr Yamuna Ellawala	Actg Head M&E FHB
14	Dr Krishantha Peries	MO FP Unit FHB
15	Mr Stanley	Store keeper FHB
16	Dr Amal Harsha de Silva	Director HEB
17	Dr R D F C Kanthi	Deputy Director HEB
18	Dr S Mahamittawe	Director, Urban and Estate
19	Dr.Nithershini Periyasamy	CCP Estate and Urban
20	Dr Susi Perera	Policy Analysis & Development, Ministry of Health
21	Dr S R U Wimelaratne	Director Planning, Ministry of Health
22	Dr S Sridharan	Director Healthcare Quality and Safety
23	Dr Kanthi Ariyaratne	D Private Health Sector Development, Ministry of Health
24	Ms Rajapakse	Director Public Health Nursing Services, Ministry of Health
25	Dr Umanga Sooriaratchchi	CCP Evaluation, Training and Research, Ministry of Health
26	Mr A Premaratne	Asst Director MIS, Ministry of Health
27	Dr Sisira Liyanage	Director NSACP
28	Dr Lilani Rajapaksa	Coordinator EMTCT programme NSACP
29	Dr Lakmini Magodaratna	Deputy Director, NIHS
30	Dr Indrani Malwanna	CCP Training NIHS
31	Mr Isuru Wickramasuriya	Asst Director Youth Affairs Division Ministry of National Policies & Economic Affairs
32	Dr KAS Keeragala	Addl Secretary Youth Affairs Division Ministry of National Policies & Economic Affairs
33	Ms Asoka Allawatte	Add Secretary (Development) Ministry of Women and Children's' Affairs
34	Ms Renuka Peris	Director, MOE
35	Dr Gamini Seneviratne	D CSHW

36	Dr Gamini Perera	VOG CSHW and President Elect SLCOG
37	Dr Akbar	VOG CSHW
38	Dr S Lanerolle	VOG CSHW
39	Dr M Batcha	Consultant Subfertility Specialist, CSHW
40	Dr Champa Nandini	MO RH CSHW
41	Dr Lalin Chandrasekera	MO RH CSTH
42	Dr Asela Gunewardene	D CSTH
43	Dr Ramya Pathiraja	Snr Lecturer, Dept OBGYB, SJU
44	Dr Ruwanpathirana	VOG DMH
45	Dr WSC De Alwis	MO/FP DMH
46	Dr Wimal Karandagoda	Director Medical Services, Lanka Hospital
47	Dr Wimal Jayantha	Director Medical Services Durdans
48	Dr Sreeni Wilathgamuwa	Well Woman Center Durdans Hospital
49	Ms Thushara Argus	Executive Director FPASL
50	Dr Sumithra Tissera	Medical Director FPASL
51	Dr Ajit Mendis	Country Director Population Services Lanka
52	Dr Rohana Haththotuwa	Chairman Ninewells
53	Prof Kumudu Wijewardene	Prof Comm Med, SJU
54	Prof Malik Gunewardene	Prof OBGYN University of Ruhuna
55	Prof PS Wijesinghe	Prof OBGYN University of Kelaniya
56	Prof A Pathmeswaran	Prof Community Medicine, Faculty of Medicine, University of Kelaniya
57	Prof Hemantha Senanayake	Prof of Obstetrics and Gynaecology, University of Colombo
58	Dr Deepthi Liyanarachchi	Actg D Colombo Municipality
59	Dr Ravi Nanyakkara	Plantation Human Development Trust
60	Dr Kanishka Karunaratne	President SLCOG
61	Prof Antoinette Perera	President, College of General Practitioners
62	Dr Deepika Attygalle	Health and Nutrition Specialist UNICEF and President College of Community Physicians
63	Ms Chintha Abeywardene	President Pharmaceutical Society
64	Dr Nilmini Hemachandra	Consultant WHO
65	Dr S M Arnold	RDHS Colombo
66	Dr Lakshima	MOMCH Colombo
67	Dr Nandika Abeygunewardene	MOH Nugegoda
68	Dr Swarna Kariyawasam	MO FP Homagama Hospital
69	Dr Badrika Gunewardene	MOH Homagama
70	Dr M I Ellawala	MOH Ratmalana
71	Dr Mahinda Hemapriya	MO YFS Clinic NCTH
72	Dr Ratnaweera	YFS CSTH
73	Ms Kanthi Gamage	PHNS Nugegoda MOH

74	Ms R S Liyanage	SPHM Nugegoda MOH
75	Mr Dinusha Dassanayake	General Manager SPC
76	Mr E D Weeraratne	Asst Director MSD
77	Mr Sandaruwan Pathirage	NMRA Pharmacist
78	Mr Sandagiri	OiC RMSD/ IDH
79	Ms Iresha de Silva	Pharmacist, City Pharmacy, Ratmalana
80	Prof Indralal de Silva	Prof of Demography, University of Colombo
Nuwera Eliya		
1	Dr M Janani	MOIC PMCU Hatton
2.	Ms Jacintha Samuel	EMA Court Lodge Estate
3.	Dr M G Jayaweera	MOH Nuwera Eliya
4.	Dr Jagath Wijepala	VOG DGH Nuwera Eliya
5.	Dr SAAN Jayasekera	Director DGH Nuwera Eliya
7	Dr S Lovapirathan	MO PHDGH Nuwera Eliya
8.	W A Manel Perera	RSPHNO
9.	Dr PDK Adikari	RDHS, Nuwera Eliya
10	Ms Nayana Wijewickrema	HEO, RDHS Office, Nuwera Eliya
11	Dr P Sudarshan	MOMCH
12	W M Ishara Thilakshi	PHM
13	Ms Kamala Rani	Women Development Officer, Divisional Secretariat
14	Mr Deshapriya Munidasa	Member Municipal Council
15	P Sivaraja Gurukal	Hindu priest
16	Major DNCK Karunaratne	OIC National Youth Corp Camp
17	Mr Palayandi Sivakumar	Manager, FPA Suwa Sewa Center, Nuwera Eliya
18	Dr Prabath Karunanayake	MO, Divisional Hospital, Lindulla
19	Dr Lasantha Saman Kumara	VOG BH Dickoya
Kalmunai		
1	Ms Begum Bibi	SPHM
2	Mrs. V Uthayakumar	RSMHNO
3	Mr A M Rakeeb	Member Municipal Council
4	Dr MACM Fazal	MOMCH
5	Dr A l Alaavudeen	
6	Mr R M Ariyawansa	Principal NTS Ampara
7	Dr A L F Rahman	Medical Superintendent Ashraf Memorial Hospital
8	Mr U L M Iqbal	Moulavi
9	Ms A Majeena	Rural Development Society
10	Ms Thiagaragjah	HEO
11	Dr Ureka Wickramasinghe	VOG BH Kalmunai North
12	Mrs. P Rajendra Kumar	PHNS Sainamaradu

13	Dr Taslima	MOH Nintavur
14	Mr YMAP Kumara	Pharmacist Cargills Food City, Kalmunai
15	Dr M M M Shabeer	MOH Sammanthurai
Jaffna		
1	Ms R Vallipuranathan	Principal , NTS Jaffna
2	Dr. K. Sureshkumar	VOG TH Jaffna
3	Dr. Guruparan,	Senior Lecturer, Dept of OBGYN,Univ of Jaffna
4	Dr. Sathiyamoorthy,	Director, Teaching Hospital, Jaffna
5	Dr. Surenthirakumaran	Senior Lecturer and Head, Department of Community Medicine University of Jaffna
7	Ms. Rajani	Women's group leaders
8	Mr. Vasanthan,	Pharmacist, RMSD
9	Dr Sudarshani	MO, Dh Kurunagar
10	Dr. Jecitharan,	MO, MCH Clinic, Swamiyaar Veethy
11	Dr Uruththiran	DMO DH Kondavil
12	Ms Ahalya Segarajah	Asst Divisional Secretary, Uduvil
13	Dr K Nanthakumaran	RDHS Jaffna
14	Dr A Jekumaran	MOH Nalluar
15	Dr S Sheyamalan	VOG BH Manthilai
16	Dr T Thiripuvanasunthari	MOH Uduvil
17	Mr T Prakash	Chairman, Vallikamam South, Pradeshiya Sabah
18	Dr T Kumaravel	MOMCH
19	Dr A Ketheswaran	PD, Northern Province
20	Dr T Kugathasan,	MS Chavakacheri BH
21	Dr M Jeyarasa	RDHS Killinochchi
22	Dr S Muraliharan	MOMCH
Killinchchi		
23	Dr Nishadi Ranasinghe	Director District General Hospital Kilinochchi
24	Dr N Saravanabava	VOG, District General Hospital Kilinochchi
Trincomalee		
1	Dr Sameera Nanayakkara	MOH Kanthale
2	Father Alex	Roman Catholic Priest
3	Dr S Arulkumaran	CCP NE Province
4	Dr K Shanmugadas	MOMCH Trinco
5	Ms T Jeyamsabapathy	RSPHNO
6	Mr R Ratnakumar	HEO
7	Dr D G Malinton Costa	MS Kantale BH Type A
8	Mr Nicky Thomson	Local journalist
9	Dr Sathurmugam	D DGH Trincomalee
10	Dr Jeyakumar	VOG DGH Trincomalee

11	Dr KMuruganandan	PD Eastern Province
12	Mr M F M Rayees	OIC RMSD
13	Dr A M Sameem	MS BH Kinniya
14	Dr P D W Rajakaruna	VOG BH Kinniya
15	Mr Ashique	Member, Pradeshiya Saba, Kuchaveli
16	Dr A Sathyaseelan	OIC PMCU, Selvanayagampuram
17	Dr Upul	MO Gomarankadawala DH
18	Ms Nadeeka Jayatilleke	Lead mother MSG
19	Rev Father Alfred	Rector St Joseph's College, Trincomalee
20	Dr Rajmalee, Rajmoham	RDHS Trinco
21	Dr E D Gnanagunalan	MO Population Services lanka
22	MS H A Irosha Ramani	PHM, Kanthale
23	Dr V G L Weerasena	VOG Kanthale
24	Dr Sampath Karannagoda	MOIC DH Seruwila
25	Dr J W Pradeep de Silva	MOH Seruwila
26	Ms CD Jeyachandra	Pharmacist, Cargills Food City, Trincomalee
Galle		
1	Ms Piyaseeli,	Principal, NTS Galle
2	Dr G P P Sudheera	MORH, Gonapinwela
3	Dr Priyani Senadheera	Director, TH Mahamodera
4	Dr Rohan Liyanage	VOG, TH Mahamodera
5	Dr Harsha Kalansooriya	VOG TH Mahamodera
6	Dr Ashoka Dilhani	AMOH Ratgama
7	Dr Manel Devasiri	MOMCH, Galle
8	Mr K H Dayananda	Packer, RMSD
9	Ms Erin Chandrika Zoysa	Nursing Tutor
10	Dr Chandima Siritunge	RDHS Galle
11	Dr G Wijesooriya	PD Southern Province
12	Dr Harshini Obeysekera	CCP Southern Province
13	Ms Sampath Athukorale	Provincial Council , Member
14	Batuwanhena Dharmamurthi Thera	Viharadhipathi,
15	Dr L A R Sanjeeva	MOH, Elpitiya
16	Ms O K T P Karunaratne	PHNS, Elpitiya
17	Ms Malkanthie	SPHM, Elpitiya
18	Dr Nirmala Weerasekera	OiC Provincial Training Center Galle
19	Ms L A Malanie	RSPHNO, Galle
20	Ms Sujeeva Nilanthi	HEO RMSD Galle
Moneragala		
1	Dr R M C Ratnayaka	DMO DH Buttala

2	Dr Sunil Udanuwara	MOH Moneragala
3	Dr Gayan Ariyadasa	MOMCH Moneragala
4	Dr RMD Ratnayaka	Director District GH Moneragala
5	Dr S K Kariyawasam	VOG Moneragala
6	Father Praveen Perera	Parish Priest Moneragala
7	Mr A M Chandrasena	HEO
8	Mr Abeykoon	OiC RMSD
9	R M Sanath jayasekera	Principal, Royal College, Moneragala
10	Ms KDMK Dissanayaka	PHM Viharamulla
11	Dr suranga Ubayasekera	RDHS Moneragala
12	Ms M S Renuka Ratnayaka	WDO Moneragala
13	Dr Eranda Edirisinghe	MOH Madulla
14	Ms J A S N Balawardana	PHNS Siyambalanduwa

Annex 8: Participants and the locations of focus groups.

FGD	Colombo	Galle	Nuwera Eliya	Trincomalee	Moneragala	Kalmunai	Jaffna	Total
Married women 18 -29	2	1	1	1	1	1	1	8
Married women 30-45	2	1	1	1	1	1	1	8
Married men 30-50 y	1		1	1		1		4
Girls 16-19	1		1	1	1	1	1	6
Boys 16-19	1		1	1	1	1	1	6
Unmarried women 20-30	1			1	1		1	4
Unmarried men	1			1	1	1		4
Separated / divorced	1			1				2
Widows							1	1
PLWH	1							1
Subfertile women	1				1			2
PHM	1	1	1	1	1	1	1	7
PHI	1		1			1		3
EMA			1					1
Total	14	3	8	9	8	8	7	57

Annex 9

Focus Group Discussion Guides

Married women aged 18-29 years

Objective –

1. Describe knowledge attitudes and practices on contraception of married women aged 18-29 in relation to spacing, discontinuation, non-use, unwanted pregnancies
2. Identify their level of access to services, utilization, barriers and costs
3. Develop recommendations for FP programme improvement to reach married women aged 18-29

Selection of participants

1. 18 -29 year old married women
2. With at least one child
3. 7 -12 participants

Facilitator's welcome, introduction and instructions to participants

Welcome and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view is important. I realize you are busy and I appreciate your time.

Introduction: The Ministry of Health is conducting review of its National Family Planning Programme. The NFPP has greatly improved the quality of life and the health status of people in this country.The information from this focus group discussion is of national importance and will be used in providing improved health services to people like you in future. We urge you to kindly provide us with accurate information. This focus group discussion is designed to assess your current thoughts and feelings about the use of family planning. Before we start, I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. I will tape the discussion to facilitate its recollection.

The focus group discussion will take no more than two hours.

Anonymity: Despite being taped, I would like to assure you that the discussion will be anonymous. The tapes will be kept safely in a locked facility until they are transcribed word for word, then they will be destroyed. The transcribed notes of the focus group will contain no information that would allow individual subjects to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible as this information is to be used for improving health services for people like you. I and the other focus group participants would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you can refrain from doing so but do not distract others; however please try to answer and be as involved as possible. When we present results it is not individuals views that we present but that of the group.

Ground rules

- The most important rule is that only one person speaks at a time. There may be a temptation to

jump in when someone is talking but please wait until they have finished.

- There are no right or wrong answers
- You do not have to speak in any particular order
- When you do have something to say, please do so. There are many of you in the group and it is important that I obtain the views of each of you
- You do not have to agree with the views of other people in the group but respect their views
- The objective of this meeting is to obtain information from you.Warm up

First, I'd like everyone to introduce themselves. Can you tell us your names and what you do?

1. **What is your understanding on " family planning"?**
2. **In your opinion what are the factors that decide the size of a family?**

   Probe for:

   Economic

   Health

   Social / religious

   Other

   Who influences the number of children you have?
3. **What do women your age use or do to delay a pregnancy or avoid getting pregnant?**

   Probe for:

   - Not having sex due to fear of getting pregnant
   - Use of contraception
4. **Do you know of women who have had unwanted pregnancies? What did they do about the pregnancy?**

   Probe for:

   Continue with the pregnancy

   Terminate the pregnancy

   How old were the women,

   Were they unmarried or married?

   How many children did they have?

5. **What are the consequences of unwanted pregnancies?**

   Probe for:

   Woman's health suffers

   Abortions and its consequences

   Children's health suffers

Less attention to children

Economic consequences

6. **Do you know whether abortions is legal or illegal in Sri Lanka?**
7. **In your opinion does contraception have any advantages?**

   Probe for:

   Advantages for the mother

   Advantages for the children

   Advantages for the family

   If not advantageous, probe for reasons
8. **From your experience and what you know about your community who makes the decision to use or not to use contraception?**

   Probe for:

   - Woman's decision
   - Husbands decision
   - Both
   - In laws
   - Peers
   - Health care provider
   - Other

   Who is / are the best persons to take this decision?

   Probe for-

   Wife

   Husband

   Joint decision

   In laws

   Health care provider
9. **What are the sources of information for women your age on family planning?**

   Probe for:

   Print, electronic media, health worker private/ public

   If health worker is mentioned as the source of information ask

   When was the last time a health worker discussed family planning with you?

   When was the last time a PHM visited you.

   Friends

Neighbors

In-laws

What source do you think is the most reliable?

10. From your experience or from what you have heard, what are the methods women/men use when they want to space their children between pregnancies?

Probe for

- Condom
- Pill
- IUCD
- Injectable
- Implant
- Natural methods
- Breast feeding
- Abortion

Probe for why they choose a particular method

11. Where do you and women in your community go to obtain contraceptive methods??

Probe for

- Hospital clinic
- MOH office
- Municipality clinic
- NGO clinic
- Midwife
- Private doctor
- Private pharmacy
- Other

If women have paid for services, probe for the cost

Can you describe about your experience when you went to receive FP services?

Probe

Was the clinic clean?

Was the clinic time convenient?

Did you have to wait a long time to be seen?

Were you treated courteously?

Was there auditory and visual privacy and did you think that confidentiality was maintained?

Were you offered a choice of methods?

Were there communication materials?

What FP methods were available?

What needs to be done to improve services?

Would you go back again?

12. Some couples your age use a contraceptive method for some time and then discontinue. What are the reasons for stopping using the method?

Probe for

a. Want more children
b. Partner away so don't need family planning
c. Opposition from partner, religious reasons
d. Side effects
e. Fear of side effects
f. Time of clinic is inconvenient
g. Distance to clinic
h. Long waiting time
i. Health providers are rude
j. Quality of services is perceived to be poor
k. Desired method is not available
l. Gender of the service provider
m. Cost

13. From what you know or have heard what do you think are the main reasons for women your age not using a family planning method in your community?

Probe for

- Not reached the ideal family size
- Women are not aware of family planning
- Woman or partner is sterilized
- Partner away so don't need family planning
- Single, divorced widowed, separated
- Opposition from partner, religious reasons, cultural reasons, other
- Fear of side effects
- Time of clinic inconvenient
- Distance to clinic
- Long waiting time

- Health providers are rude
- Quality of services is perceived to be poor
- Desired method is not available
- Gender of the service provider
- Cost

14. Are there any special local beliefs on FP and contraceptive methods that should be addressed in your community?

Probe

IUD

DMPA

15. When was the last time you came into contact with a health worker?

Probe for:

Hospital

FP clinics

PHM

GP

Why for what reason?

Was there a chance to discuss FP?

When was the last time the PHM visited you at home?

16. When you visit a health care worker to get treatment for diseases and if he/ she asks about your family planning practices, how would you feel about it?

17. From what you know or have heard why do some men in your community not use and do not encourage the use of contraception?

Probe for

- Woman or partner is sterilized/hysterectomy
- Opposition from partner and others
- Men think the wife will not be faithful
- Fear of side effects for wife
- Time of clinic is inconvenient
- Distance to clinic
- Long waiting time
- Health providers are rude
- Quality of services is perceived to be poor
- Cost

- Loss of satisfaction during sex
- Women's domain
- Cultural / religious reasons
- Gender of the service provider

18. Lets summarize some of the key points from our discussion. Is there anything else?

Thank you for taking the time to talk to us!

Focus Group Discussion Guide

Married women aged 30 -45 years

Objective

1. Describe knowledge attitudes and practices on contraception of married women aged 30-45 years in relation to limiting, discontinuation, non-use, unwanted pregnancies
2. Identify their level of access to services, utilization, barriers and costs
3. Develop recommendations for FP programme improvement to reach married women men aged 30-45 years

Selection of participants

1. 30 – 45 year old married women
2. With two or more children
3. 7 -9 participants

Facilitator's welcome, introduction and instructions to participants

Welcome and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view is important. I realize you are busy and I appreciate your time.

Introduction: The Ministry of Health is conducting review of its National Family Planning Programme. The NFPP has greatly improved the quality of life and the health status of people in this country.The information from this focus group discussion is of national importance and will be used in providing improved health services to people like you in future. We urge you to kindly provide us with accurate information. This focus group discussion is designed to assess your current thoughts and feelings about the use of family planning. Before we start, I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. I will tape the discussion to facilitate its recollection.

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Ground rules

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- You do not have to speak in any particular order
- When you do have something to say, please do so. There are many of you in the group and it is important that I obtain the views of each of you
- You do not have to agree with the views of other people in the group but respect their views
- The objective of this meeting is to obtain information from you.

Warm up

- First, I'd like everyone to introduce themselves. Can you tell us your names and what you do?

1. What is your understanding of" family planning"?

2. In your opinion what are the factors that decide the size of a family?

Probe for:

Economic

Health

Social / religious

Other

Who influences the number of children you have?

3. What do women your age in your community use or do to delay or avoid getting pregnant?

Probe for:

- Not having sex due to fear of getting pregnant
- Use of family planning by method

4. Do you know of married women your age who have had unwanted or mistimed pregnancies? What did they do about the pregnancy?

What are the consequences of unwanted pregnancies?

Probe for:

Woman's health suffers

Abortions and its consequences

Children's health suffers

Less attention to children

Economic consequences

Do you know whether abortions is legal or illegal in Sri Lanka?

5. **In your opinion does family planning have any advantages?**

Probe for:

Advantages for the mother

Advantages for the children

Advantages for the family

Advantages for the family economy

If not advantageous probe for reasons

6. **From your experience and what you know about your community who makes the decision to use or not to use family planning?**

Probe for:

- Woman's decision
- Husbands decision
- Both
- In laws
- Peers
- Health care provider
- Other

According to you who is / are the best persons to take this decision?

7. **What are the sources of information for women your age on family planning?**

Probe for:

Print, electronic media, health worker private/ public

If health worker is mentioned as the source of information ask

When was the last time a health worker discussed family planning with you?

When was the last time a PHM visited you.

Friends

Neighbors

In-laws

What source do you think is the most reliable?

8. **When couples your age have achieved their ideal family size what do they do to prevent pregnancy?**

   Probe

   No sex

   Use contraceptives

   - Condom
   - Pill
   - IUCD
   - Injectable
   - Implant
   - Sterilization female
   - Sterilization male
   - Natural methods

   Probe for why they choose a particular method

9. **Some couples use a contraceptive method for some time and then discontinue. What are the reasons for stopping using the methods?**

   Probe for

   - Not reached the ideal family size
   - Woman or partner is sterilized
   - Partner away so don't need family planning
   - Shift to another method Probe for why? E.g to use a more effective method
   - Opposition from partner, religious reasons, social reasons
   - Fear of side effects
   - Time of clinic inconvenient
   - Distance to clinic
   - Long waiting time
   - Health providers are rude
   - Quality of services is perceived to be poor
   - Desired method is not available
   - Gender of the service provider
   - Cost

10. **From what you know or have heard what do you think are the main reasons for women your age not using a family planning method in your community?**

    Probe for

- Not reached the ideal family size
- Women are not aware of family planning
- Partner away so don't need family planning
- Infrequent sex
- Unlikely to get pregnant with age
- Single, divorced widowed, separated
- Opposition from partner,
- Religious reasons
- Fear of side effects
- Time of clinic is inconvenient
- Distance to clinic
- Long waiting time
- Cost
- Health providers are rude
- Quality of services is perceived to be poor
- Service provider is a male
- Desired method is not available

11. Where do women in your community go to obtain a FP method?

Probe for

- Hospital clinic
- Municipality clinic
- MOH
- NGO clinic
- Midwife
- Private doctor
- Private pharmacy
- Other

If women have paid for services, probe for the cost and why she opted for private sector

Can you describe about your experience when you went to receive FP services?

Probe

- Was the clinic clean?
- Was the clinic time convenient?
- Did you have to wait a long time to be seen?

- Were you treated courteously?
- Was there auditory and visual privacy and did you think that confidentiality was maintained?
- Were you offered a choice of methods?
- Were there communication materials?
- What FP methods were available?
- What needs to be done to improve services?
- Would you go back again?

12. When was the last time you came into contact with a health worker?

Probe for:

Hospital

FP clinics

PHM

Was FP discussed?

When was the last time the PHM visited you at home?

When you visit a health care worker to get treatment for diseases and if he/ she asks about your family planning practices, how would you feel about it?

13. Are there any special local, cultural, religious health beliefs on family planning and contraceptive methods that service providers need to know about to reassure women?

14. From what you know or have heard why don't some men in your community use and do not encourage the use of contraception?

Probe for

- Woman or partner is sterilized/hysterectomy
- Opposition from partner and others
- Men think the wife will not be faithful
- Fear of side effects for wife
- Time of clinic is inconvenient
- Distance to clinic
- Long waiting time
- Health providers are rude
- Quality of services is perceived to be poor
- Cost
- Loss of satisfaction during sex
- Women's domain
- Cultural / religious reasons

Gender of the service provider

15. In your opinion to what extent should adolescent boys and girls be sensitized about family planning?

Probe

Not all

Yes

What are some of the influences that lead adolescent girls in the community to become pregnant? What are some of the influences that prevent them from becoming pregnant?

Probe

Pressure from partner

Poverty

Lets summarize some of the key points from our discussion. Is there anything else?

Thank you for taking the time to talk to us!

Focus Group Discussion Guide

Married men aged 30-50 years

Objective –

1. Describe knowledge attitudes and practices on contraception of married men aged 30-50
2. Identify their level of access to services, utilization, barriers and costs
3. Develop recommendations for FP programme improvement to reach married men aged 30-50 years

Selection of participants

1. 30-50 year old married men
2. With one or more children
3. 7 -9 participants

Facilitator's welcome, introduction and instructions to participants

Welcome and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view is important. I realize you are busy and I appreciate your time.

Introduction: The Ministry of Health is conducting review of its National Family Planning Programme. The NFPP has greatly improved the quality of life and the health status of people in this country.The information from this focus group discussion is of national importance and will be used in providing improved health services to people like you in future. We urge you to kindly provide us with accurate information. This focus group discussion is designed to assess your current thoughts and feelings about the use of family planning. Before we start, I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be

frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. I will tape the discussion to facilitate its recollection.

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- You do not have to agree with the views of other people in the group but respect their views
- The objective of this meeting is to obtain information from you.

Warm up

- First, I'd like everyone to introduce themselves. Can you tell us your names and what you do ?

1. **What is your understanding of" family planning"?**
2. **What do couples in your community use or do to delay or avoid getting pregnant?**

   Probe for:

   Not having sex

   Use of contraception

   Induced abortion
3. **What are the contraceptive methods you know to space births?**

   What are the contraceptive methods you know to limit births?

   Probe

   Male sterilization

   Female sterilization
4. **From where did you get to know about family planning?**

   Probe:

   Radio

   TV

   Print media

   Friend

   PHI

   PHM

   Doctor

   Wife

   Family member

5. **In your opinion what are the factors that decide the number of children a family has?**

   Probe for:

   Economic

   Health

   Social / religious

   Other

   Who influences the number of children you have?

6. **What are some of the implications of having more than the desired number of children?**

   Probe for :

   For the mother

   For the children

   For the father

   For the family as a whole

7. **What would be the best ways to bring information on contraception to men in your community?**

   Probe for –

   Are there any special cultural beliefs or health beliefs about contraception?

8. **In your opinion why is the use of sterilization more common among women than men?**

   Probe

   Women's domain

   Makes the man weak

   No feeling

   No services for vasectomy

9. **From what you know or have heard why do some men object to their wives using FP?**

   Probe for

   a. Wants more children
   b. Fear of side effects for wife
   c. Quality of services is perceived to be poor
   d. Cost – transport, loss of wages,
   e. Loss of satisfaction during sex
   f. Cultural / religious reasons
   g. Social reasons / nationalistic
   h. Fear of infidelity

10. **From where do men in your community obtain contraceptive methods?**

Probe for

- Hospital clinic
- Municipality clinic
- NGO clinic
- Midwife
- Private doctor
- Private pharmacy

Probe for the cost and why he opted for private sector

11. What do you think are the reasons for some couples not having children?

Probe

Problem with man

Problem with woman

12. Do you know where couples seek help when they have difficulty in conceiving?

Probe

Hospital, clinics, Private doctor, other,

13. What is your opinion about adolescent boys and girls being provided with reproductive health andcontraception information and services?

Thank you for taking the time to talk to us!

Focus Group Discussion Guide

Men 20 - 30 years

Objective –

1. Identify need for FP services in this group.
2. Describe sexual practices that unmarried men engage in.
3. Describe FP services available for unmarried men.
4. Discuss whether current services are appropriate and accessible, Identify promotional strategies that might increase service uptake.

Selection of participants

1. 20-30 year unmarried working men
2. 7 -9 participants

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Introduction: The Ministry of Health is conducting review of its National Family Planning Programme. The NFPP has greatly improved the quality of life and the health status of people in this country. This information is of national importance and will be used in providing health services to people like you in future. We urge you to kindly provide us with accurate information. This focus group discussion is designed to assess your current thoughts and feelings about the use of family planning. Before we start, I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. I will tape the discussion to facilitate its recollection.

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- Do not expect answers to your questions. The main objective of this meeting is to obtain information from you.

Warm up

- First, I'd like everyone to introduce themselves. Can you tell us your name?

1. **What do you understand by "family planning"?**
2. **How do young people of your age usually find out about love affairs, sex and contraception?**

   Probe

   Which source of information do they rely on?

   Is the information adequate?

3. **What sexual activities do men your age engage in?**

   Probe

   Hold hands /Hug

   Kissing

   Touching (above/below clothes)

   MSM

   Oral sex

   Sexual intercourse

4. **With whom do men your age engage in sex with?**

   Probe

   Girl friend

   Tourists

   Sex worker

   People known to you

   Other

5. **What forms of protection against pregnancy do men your age or your friends take when intercourse takes place?**

   Probe

   What methods of protection were used?

   How was this decided – by you or your partner, or both?

   If protection was not used what was the reason?

6. **From where does men your age or your friends obtain the method?**

   Probe:

   PHI

   PHM

   Private Doctor,

   Pharmacy

   Grocery store

7. **If from private pharmacy or private doctor how much did it cost?**
8. **What do young men your age group think about using contraception?**
9. **In your opinion what are the best ways to inform men your age about contraception?**
10. **What are the best ways to provide "men friendly" contraceptive services to unmarried men?**

    Probe

Who should provide services?

Location

Timing

Sex of the provider matter

11. Optional question

12. You would have heard that some couples find it difficult to have a baby. What could be the possible causes?

Probe:

Problem with the man – surgery, hydrocele, war injury, poor sperm quality, mumps, STI

Problem with the woman – surgery, STI, ovulatory problems

Both

Do you know where couples who have such a problem can go for help?

Lets summarize some of the key points from our discussion. Is there anything else?

Thank you for taking the time to talk to us!

Focus Group Discussion Guide

Unmarried women 20 -30 years old

Objective –

1. Identify the need for FP in this group.
2. Identify sources of information on family planning
3. Describe contraceptive practices of unmarried women
4. Describe FP services available for unmarried women
5. Develop recommendations for FP programme improvement to reach young unmarried women

Selection of participants

1. 20 – 30 year unmarried women
2. Both working and non-working
3. 7 -9 participants

Facilitator's welcome, introduction and instructions to participants

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Warm up

- First, I'd like everyone to introduce themselves. Can you tell us your names and what you do?

1. From where do you obtain health services?

Probe for:

Factory clinic

Government Hospital clinic

MOH clinics

PHM

Private sector doctor

Pharmacy

Who pays for medical expenses?

If not roughly how much do you spend on health per month

2. **What do you understand by family planning? What are the methods that your friends or women your age who are not married use to prevent getting pregnant?**

   Probe for:

   a. Condoms
   b. OCP
   c. Injectable
   d. IUD
   e. Implants
   f. Emergency contraception
   g. Natural methods
   h. Combo

3. **From where do your friends or women your age obtain the method?**

   Probe for:

   Factory clinic

   Government hospital

   MOH

   PHM

   Private sector doctor

   Pharmacy

   Friend

   Colleague

4. **What are the barriers for women your age to obtain FP services?**

   Probe for:

   Not convenient

   Due to fear of side effects

   Due to experiencing side effects

   Method is expensive

   Partner opposes

   Afraid of not being able to have a child later

   Unreliable

   Used only because it was an emergency

Other

5. **What do unmarried women your age who have an unwanted pregnancy do?**

   Probe

   Carry on with the pregnancy and marry the partner

   Carry on with the pregnancy

   Abort the pregnancy

6. **Do you know whether abortions are legal or illegal in Sri Lanka?**
7. **With whome do women your age engage in sex with?**
8. **Consider a hypothetical situation where you have a boyfriend and you engage in sex. Do you think you are able to -**

   Discuss FP with your partner

   Tell your partner you wish to use FP

   Use FP even if your partner did not want to

9. **Consider a hypothetical situation where you have a boyfriend and you engage in an unplanned sexual encounter. What would you do to prevent an unwanted pregnancy?**

   Probe

   Postinor

10. **In your opinion what are the best ways to inform young working and non working women your age about preventing unwanted pregnancies?**

    (Probe seperately working and non working)

11. **In your opinion what are the best ways to provide services to prevent unwanted pregnancy to young working and non working women your age?**

    (Probe seperately working and non working)

    Lets summarize some of the key points from our discussion. Is there anything else?

    Thank you for taking the time to talk to us!

Focus Group Discussion Guide

Girls16-19 years

Objective –

1. Obtained information on main sources of information on reproductive health/family planning
2. Assessed their level of access and availability to services, utilization, barriers and costs
3. Developed recommendations for FP Programme improvement to reach them

Selection of participants

1. 16-19 year girls
2. Out of school
3. 7 -9 participants

Facilitator's welcome, introduction and instructions to participants

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Warm up

First, I'd like everyone to introduce themselves. Can you tell us your names and what you do ?

1. **How do young people of your age spend their free time?**

   Probe

   What do the teens you know do after school?

   What do the teens you know do on the weekends?

   With whom do teens spend most time?

   Where do teens spend a lot of time?

2. **What is your opinion about the adolescent period?**

   Probe

   Physical changes

   Psychological changes

   Social changes

3. **What do you think about having a love affair during this period?**
4. **How do young people your age usually find out about sex and contraception?**

   Probe

   Family member, friends, the media, school, doctors/nurses/PHM/PHI

   What did you learn from each source you mentioned?

   Given what you already know about pregnancy prevention, what would you like to know more about?

What are some things you've heard teens say about sex and pregnancy prevention that you know aren't true?

Which source of information do they rely on?

Is the information adequate?

5. **What are the methods you know to prevent pregnancy?**

   Probe for methods

6. **What sexual activities do Girls your age engage in?**

   Probe for

   Sexual intercourse

   If they are involving in sexual intercourse, with whom do they have sex?

7. **What are some of the influences that lead adolescent girls in the community to become pregnant? What are some of the influences that prevent them from becoming pregnant?**

   Probe

   Pressure from partner

   Poverty

8. **Which forms of protection against pregnancy do girls in your age group take when they have intercourse?**

   Probe

   Who decides on it? Male partner or female partner or both?

9. **In your opinion what are the best ways to inform girls your age about reproductive health includingfamily planning?**

10. **What are your general impressions of the health services provided for young people at present?**

    Probe

    Do you feel comfortable talking to health professionals?

    Where do you think young people's adolescent health services should be held (location)? Why?

    Who should provide the information and advice?

11. **If you have a reproductive health problem what factors would you consider before seeking help from a health worker?**

    Lets summarize some of the key points from our discussion. Is there anything else?

    Thank you for taking the time to talk to us!

Focus Group Discussion Guide

Boys16-19 years

Objective –

1. Obtained information on main sources of information on reproductive health/family planning
2. Assessed their level of access and availability to services, utilization, barriers and costs
3. Developed recommendations for FP programme improvement to reach them

Selection of participants

1. 16-19 year boys
2. Out of school
3. 7 -9 participants

Facilitator's welcome, introduction and instructions to participants

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Warm up

First, I'd like everyone to introduce themselves. Can you tell us your names and what you do?

1. **How do young people of your age spend their free time?**

   Probe

   What do the teens you know do after work / classes?

   What do the teens you know do on the weekends?

   With whom do teens spend most time?

   Where do teens spend a lot of time?

2. **What is your opinion about the adolescent period?**

   Probe

   Physical changes

   Psychological changes

   Social changes

3. **What do you think about having a love affair during this period?**

4. **How do young people your age usually find out about sex and contraception?**

   Probe

   Family member, friends, the media, school, doctors/nurses/PHM/PHI

   What did you learn from each source you mentioned?

   Given what you already know about pregnancy prevention, what would you like to know more about?

   What are some things you've heard teens say about sex and pregnancy prevention that you know aren't true?

   Which source of information do they rely on?

   Is the information adequate?

5. **What are the methods you know to prevent pregnancy?**

   Probe for methods

6. **What sexual activities do boys your age engage in?**

   Probe for

   Sexual intercourse

   If they are involving in sexual intercourse, with whom do they have sex?

7. **What are some of the influences that lead adolescent girls in the community to become pregnant? What are some of the influences that prevent them from becoming pregnant?**

   Probe

   Pressure from partner

   Poverty

8. **Which forms of protection against pregnancy do boys your age take when they have intercourse?**

   Probe

   Who decides on it? Male partner or female partner or both?

9. **In your opinion what are the best ways to inform boys your age about reproductive health includingfamily planning?**

10. **What are your general impressions of the health services provided for young people at present?**

    Probe

    Do you feel comfortable talking to health professionals?

    Where do you think young people's sexual health services should be held (location)? Why? Who should provide the information and advice?

11. **If you have a reproductive health problem what factors would you consider before seeking help from a health worker?**

    Lets summarize some of the key points from our discussion. Is there anything else?

    Thank you for taking the time to talk to us!

FGD

Subfertile women

Objectives

1. To understand the perceptions of subfertility causes, treatment-seeking behaviour and factors associated with seeking medical care as well as the response of healthcare providers,
2. To understand the consequences of female and/or male factor subfertility for men and women
3. To suggest policy measures to address issues related to subfertility treatment.

Selection of participants

4. 30-39 year old married women
5. With primary or secondary subfertility
6. 7 -9 participants

Facilitator's welcome, introduction and instructions to participants

Welcome and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view is important. I realize you are busy and I appreciate your time.

Introduction: The Ministry of Health is conducting review of its National Family Planning Programme. Including infertility services. The findings will be used to improve the quality of services and to make them more user friendly. Because this information is of national importance in providing health services to people like you we urge you to kindly provide us with accurate information. This focus group discussion is designed to assess your current thoughts and feelings about the health services available for subfertile women.Before we start, I would like to remind you that there are no right or wrong answers inthis discussion. We are interested in knowing what each of you think, so please feel freeto be frank and to share your point of view, regardless of whether you agree or disagreewith what you hear. It is very important that we hear all your opinions.I will tape the discussion to facilitate its recollection.

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Warm up

First, I'd like everyone to introduce themselves. Can you tell us your name?

1. **What is your understanding of "family planning"?**
2. **We would like to know about your knowledge on conception. Why do some couples find it difficult to conceive?**

   Probe

   Timing of intercourse

   Frequency of intercourse

   Lack of libido

   Husband away

   Husband had mumps

   Irregular period's ovulatory problems

   Hormone problems – e.g thyroid

   Previous infection – septic abortion, post-partum.

3. **Who encouraged you and your husband to seek treatment?**

   Probe

   Mother

   Relative

   PHM

   MOH

   Private Doctor

   Ayurveda physician

   Traditional healers

4. **From whom did you seek advice and treatment first?**

   Probe

   PHM

   MOH

   Government hospital

   Private Doctor

   Ayurveda physician

   Traditional healers

   Did you go alone or with your husband?

5. **Have you been pregnant before?**
6. **What investigations and treatment were carried out first?**

   Probe

   HSG

   Seminal analysis

   Ultrasound

   Ovulation induction

   Laparoscopy

   IUI
7. **What was your opinion of the private sector services you received?**

   Probe

   Convenient

   Courteous
8. **What was your opinion of the public sector services you received?**

9. **In your opinion what should the government health services do better to provide subfertile couples with better services?**
10. **How does this problem affect your life?**

    Probe

    Depression

    Marital disharmony

    Domestic violence

    Out of pocket expenditure on treatment – how much has been spent? Is it affordable?

    Social isolation
11. **How does this problem affect your husband?**

    Probe

    Depression

    Marital disharmony

    Alcoholism

    Extramarital relations

    Out of pocket expenditure on treatment
12. **Who is supportive of you?**

Probe

Husband

Parents

Sisters / brothers

In-laws

PHM

In your opinion what information on will be useful for subfertile couples and how should such information be disseminated?

Lets summarize some of the key points from our discussion. Is there anything else?

Thank you for taking the time to talk to us!

Focus Group Discussion

Women of Reproductive Age Living with HIV

Objective –

1. To define knowledge attitudes and practices on family planning of women with HIV AIDS
2. To identify their level of access to services, utilization, barriers and costs
3. To identify if there is integration of HIV and FP services
4. Develop recommendations for FP programme improvement to reach them

Selection of participants

7. 20 – 45 year old females living with HIV
8. 7 – 9 participants

Facilitator's welcome, introduction and instructions to participants

Welcome and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view is important. I realize you are busy and I appreciate your time.

Introduction: The Ministry of Health is conducting review of its National Family Planning Programme. (Birth spacing programme.)The findings will be used to improve the quality of services and to make them more user friendly. Because this information is of national importance in providing health services to people like you and your family we urge you to kindly provide us with accurate information. This focus group discussion is designed to assess your current thoughts and feelings about the use of family planning. Before we start, I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. I will tape the discussion to facilitate its recollection.

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Warm up

- First, I'd like everyone to introduce themselves.

1. **What is your understanding of "family planning"?**
2. **How does knowing the HIV status affect women's plans for a family?**

   Probe for:

   Don't want more children

   Want children later

3. **If a HIV + woman decides she does not want to have children what precautions should she take?**

   Probe

   Use contraception

   Abortion

   None

4. **If a HIV + woman wants to use contraception what information is necessary for her?**

   Probe

   Types of methods and effectiveness of the methods

   Effects on disease

   Prevention of transmission to partner

5. **What do you think are the contraceptive methods that can be used by a HIV + woman?**

6. **Where do you go for FP services?**

   Probe for:

   PHM

   MOH clinic

   NSACP clinic

   Private sector

   If the method you want is not available at the clinic what happens next?

7. **If not going to a NSACP clinic ask how are you treated when you go for health services?**

   Probe

   Do you know anyone who has been denied access to services or treatment at a health clinic because of their HIV status?

   Probe:

   What types of services were denied?

   How was the denial of access communicated?

8. **If your partner is HIV positive how do you negotiate with your partner to use a condom?**

9. **What is the best way to reach HIV+ women and men with family planning information and services?**

   Lets summarize some of the key points from our discussion. Is there anything else?

   Thank you for taking the time to talk to us!

Focus Group Discussion Guide

Divorced and Separated women

Objective –

1. Identify the need for FP in this group.
2. Identify sources of information on family planning
3. Describe contraceptive practices of divorced and separated women
4. Describe FP services available fordivorced and separated women
5. Develop recommendations for FP programme improvement to reach young widows

Selection of participants

1. 20 – 40 year divorced and separated women Both working and non-working
2. 7 -9 participants

Facilitator's welcome, introduction and instructions to participants

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Warm up

- First, I'd like everyone to introduce themselves. Can you tell us your names and what you do?

1. **From where do you obtain health services?**

   Probe for:

   Government Hospital clinic

   MOH clinics

   PHM

   Private sector doctor

   Pharmacy

2. **On average how much do you spend on medical expenses per month?**

   Probe

   Who pays, if working employer

3. **What do you understand by family planning?**
4. **What are the contraceptive methods that you are familiar with? Probe for:**

   a. Condoms

   b. OCP

   c. Injectable

   d. IUD

   e. Implants

   f. Emergency contraception

   g. Natural methods

   h. Combo

What are the advantages and disadvantages of these methods?

5. **Who do sexually active women who are divorced or separated trust to obtain information on contraception from?**

   Probe for:

   a. Workplace clinics
   b. Government hospital
   c. MOH
   d. PHM
   e. Private sector doctor
   f. Pharmacy
   g. Friend
   h. Colleague
   i. Partner

6. **In your opinion what contraceptive methods should sexually active women who are divorced or separated from their husbands use to prevent pregnancy?**

   Probe for:

   a. None
   b. Condoms
   c. OCP
   d. Injectable
   e. IUD
   f. Implants
   g. Emergency contraception
   h. Natural methods
   i. Combo

7. **What contraceptive methods do sexually active women who are divorced or separated from their husbands use to prevent pregnancy?**

   Probe for:

   a. None
   b. Condoms
   c. OCP
   d. Injectable
   e. IUD

f. Implants

g. Emergency contraception

h. Natural methods

i. Combo

8. What are the barriers sexually active women who are divorced or separated from their husbands face in obtaining contraceptive methods?

Probe for:

a. Not possible to get the service due to social constrains

b. Not convenient

c. Method is expensive

d. Partner opposes

e. Used only because it was an emergency

f. Other

9. From where do sexually active women who are divorced or separated from their husbandsobtain contraception?

Probe for:

a. Workplace clinics

b. Government hospital

c. MOH

d. PHM

e. Private sector doctor

f. Pharmacy

g. Friend

h. Colleague

i. Partner

10. What dosexually active women who are divorced or separated from their husbandswho have an unwanted pregnancy do?

Probe for:

Carry on with the pregnancy and marry the partner

Carry on with the pregnancy

Abort the pregnancy

11. What types of relationships dowomen who are divorced or separate from their husbands have?

Probe

Regular partner

Engage in casual sex

12. In your opinion are sexually active women who are divorced or separated from their husbandsable to -

Discuss FP with their partner

Tell the partner you wish to use FP

Use FP even if the partner did not want to

13. In your opinion if women who are divorced or separated from their husbands have an unplanned sexual encounter what should they do to prevent an unwanted pregnancy?

Probe

Postinor

14. In your opinion what are the best ways to inform sexually active women who are divorced or separated from their husband about preventing unwanted pregnancies?

(Probe separately working and non working women)

15. In your opinion what are the best ways to provide services to sexually active women who are divorced or separated from their husband?

(Probe separately working and non working women)

Lets summarize some of the key points from our discussion. Is there anything else?

Thank you for taking the time to talk to us!

Focus Group Discussion Guide

Young widows

Objective –

1. Identify the need for FP in this group.
2. Identify sources of information on family planning
3. Describe contraceptive practices of divorced and separated women
4. Describe FP services available fordivorced and separated women
5. Develop recommendations for FP programme improvement to reach young widows

Selection of participants

1. 20 – 40 year widows Both working and non-working
2. 7 -9 participants

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Warm up

- First, I'd like everyone to introduce themselves. Can you tell us your names and what you do?

1. From where do you obtain health services?

Probe for:

Government Hospital clinic

MOH clinics

PHM

Private sector doctor

Pharmacy

2.**On average how much do you spend on medical expenses per month?**

Probe

Who pays, if working employer

3. What do you understand by family planning?

4**. What are the contraceptive methods that you are familiar with?**

Probe for:

1. Condoms
2. OCP
3. Injectable
4. IUD
5. Implants
6. Emergency contraception
7. Natural methods
8. Combo

What are the advantages and disadvantages of these methods?

5. Who do sexually active women who are widowed trust to obtain information on contraception from?

Probe for:

j. Workplace clinics

k. Government hospital

l. MOH

m. PHM

n. Private sector doctor

o. Pharmacy

p. Friend

q. Colleague

r. Partner

6. In your opinion what contraceptive methods should sexually active women who are widowed use to

prevent pregnancy?

Probe for:

a. None

b. Condoms

c. OCP

d. Injectable

e. IUD

f. Implants

g. Emergency contraception

h. Natural methods

i. Combo

7. What contraceptive methods do sexually active women who are widowed use to prevent pregnancy?

Probe for:

a. None

b. Condoms

c. OCP

d. Injectable

e. IUD

f. Implants

g. Emergency contraception

h. Natural methods

i. Combo

8. What are the barriers sexually active women who are widowed face in obtaining contraceptive methods?

Probe for:

g. Not possible to get the service due to social constrains

h. Not convenient

i. Method is expensive

j. Partner opposes

k. Used only because it was an emergency

l. Other

9. From where do sexually active women who are widowed obtain contraception?

Probe for:

Workplace clinics

Government hospital

MOH

PHM

Private sector doctor

Pharmacy

Friend

Colleague

Partner

10. What dosexually active women who are widowed do when they have an unwanted pregnancy?

Probe for:

Carry on with the pregnancy and marry the partner

Carry on with the pregnancy

Abort the pregnancy

11. What types of relationships dowomen who are widowed have?

Probe

Regular partner

Engage in casual sex

12. In your opinion are sexually active widowsable to -

Discuss FP with their partner

Tell the partner you wish to use FP

Use FP even if the partner did not want to

13. In your opinion if a widow has an unplanned sexual encounter what should they do to prevent an unwanted pregnancy?

Probe

Postinor

14. In your opinion what are the best ways to inform sexually active widows about preventing unwanted pregnancies?

(Probe seperately working and non working widows)

15. In your opinion what are the best ways to provide services to sexually active widows?

(Probe seperately working and non working and widows)

Lets summarize some of the key points from our discussion. Is there anything else?

Thank you for taking the time to talk to us!

Focus Group Discussion Guide

Public Health Midwives

Objectives

1. Identify PHM perception of barriers clients face in accessing FP
2. Describe PHM perception of quality of care and barriers to quality of care at the societal and organizational level
3. Identify providers' knowledge about and bias toward particular methods.
4. Identify constraints faced in delivering services

Selection of participants

- 7-9 PHMs

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Warm up

First, I'd like everyone to introduce themselves. Can you tell us your names?

1. **What is your understanding on "family planning"?**
2. **When did you last receive in-service training on FP? On what aspects?**

   Probe for:

   a. Aspects of training e.g on infertility, Youth-friendly services, infection control, counselling

   b. Was the training adequate? If not, how could it have been improved?

   c. Could you benefit from more training? If so, in what area(s)?
3. **What do you tell a woman requesting a FP method who has the following condition?**

   Heart disease

   Obesity

   Hypertension

   HIV
4. **What do you tell a client who wants to use the combined pill?**

   Probe for

   Side effects

   Missed pill

   Protection against STI/HIV
5. **What methods do you recommend for spacing births?What methods do you recommended for stopping births?**
6. **What methods do you think should not be promoted?**
7. **When would you advice a client to use emergency contraception?**
8. **What are the issues in relation to providing girls less than 18 years with FP?**

9. What kinds of materials (e.g., pamphlets, job aids, and sample methods) do you have/use to help you work with clients?

a. Are they helpful?

b. What other kinds of materials/tools would be useful to you?

10. I would like to ask about supervision of your work:

a. when was the last time you were paid a supervisory visit? How regular or routine are these visits?

b. What takes place during the supervision visit? (Ask PHM to describe the type of feedback; reviews of work logs; assessment of commodity supply/resupply; client issues.) How useful are these visits to your work?

c. Do you know what is expected of you? If not, can you get support from your supervisor?

11. In your opinion why are women who need contraception not using FP?

Probe for:

a. Clinic times inconvenient for working women

b. The method desired is not available

c. Language barrier

d. Distance to clinic

e. Opposition from husbands/ in-laws/ community / religious leaders?

f. The gender of the provider?

12. Why do women who start a family planning method discontinue using the method?

Probe for:

What can be done to reduce it?

13. In your area who are the women you find most difficult to reach?

Probe for:

Single

Divorced/separated

Widowed

Working women

14. In your opinion, what are the biggest constraints that the FP program faces?

Prompts, if needed:

- Infrastructure
- Government support (e.g., budget, regulations, infrastructure)
- Staffing at national, regional, and district levels

- Staff training, motivation, oversight/supervision
- Supervision and management systems
- Education and outreach (at all levels)
- References and resources (e.g., protocols, guidelines, job aids)
- Client access (e.g., costs/fees; hours; waiting times; provider availability/attitudes)
- Commodity supply (e.g., logistics, budget, transport, warehousing, information system)
- Sociocultural issues (e.g., myths/misconception, biases; spouse/family opposition; gender inequalities)
- Political or religious factors/opposition
- Unnecessary medical policies or criteria/barriers to services (e.g., menstruation)
- Population segments that are more difficult to reach (e.g., urban vs. rural)

15. What do you think should be done to improve the FP program including infertility?

Prompts, if needed:

- Infrastructure
- Government support (e.g., budget, regulations, infrastructure)
- Increase staffing and distribution at national, regional, and district levels
- Staff training, motivation, oversight/supervision
- Supervision and management systems
- Education and outreach (at all levels)
- References and resources (e.g., protocols, guidelines, job aids)
- Client access (e.g., costs/fees; hours; waiting times; provider availability/attitudes)
- Commodity supply (e.g., logistics, budget, transport, warehousing, information system)
- Sociocultural issues (e.g., myths/misconception, biases; spouse/family opposition; gender inequalities)
- Address political or religious factors/opposition
- Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)
- Population segments that are more difficult to reach (e.g., urban vs. rural)

Let's summarize some of the key points from our discussion. Is there anything else?

Thank you for taking the time to talk to us!

Focus Group Discussion Guide

Public Health Inspectors

Objectives

1. To describe the perception of PHI towards improving male involvement in family planning
2. To identify the barriers men face in obtaining accurate information and service
3. To identify constraints faced by PHI in providing information and services

Selection of participants

PHIs 7 -9

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Warm up

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Warm up

First, I'd like everyone to introduce themselves. Can you tell us your names?

1. **What do you understand by Family Planning?**
2. **As a service provider we would like to hear about your views on family planning.**

   Probe

   FP is not important, there are many more important health issues

   The time is not right - this is just after a war

   Benefits to mother

   Benefits to children

   Benefits to family

3. **In this community, who makes the decisions about using contraception?**

   Probe:

   Husbands

   Mother-in-laws

   Religious or community leaders

Others

4. **In your opinion why do some men object to their wives using contraception?**

   Probe

   Lack of accurate information on contraception

   Fear of side effects on wife

   No pleasure when using condoms

   Social - ethnic feelings among men, fear of wife being unfaithful

   Cultural - religious beliefs.

   Organizational – Timing of clinics, too far, wife cannot travel alone

5. **In your opinion what do you see as the reasons males are reluctant to use contraception themselves?**

   Probe

   Lack of accurate information on contraception

   Few methods

   No pleasure when using condoms

   Vasectomy makes men weak

   Social - ethnic feelings among men

   Cultural - religious beliefs, women's domain

   Organizational – Timing of clinics, clinics are not male friendly,

6. **What opportunities do you have to talk to men about FP?**

   Probe

   Occupational health

   SHP

7. **As part of your duties how much importance do you give to male involvement?**

   Probe

   A great deal

   Very little

   Not at all

8. **How confident are you to talk to men about FP and subfertiliy?**

   Very confident,

   Confident

   Not at all

   Probe for

Inadequate training

9. In addition to other duties, ensuring male participation is mentioned as one of your duties. How do you go about promoting FP?

Probe

Organize meeting with men

10. What are the challenges you face in carrying out your duties in relation to FP?

Probe

Social - Ethnic feelings among men

Cultural - religious beliefs

Organizational - Other duties take precedence, no transport,

11. What is your opinion about providing information and services to adolescents?

How do we increase access to services for adolescent and youth?

12. When did you last receive in-service training on FP? On what aspects?

Probe :

Aspects of training e.g on infertility, Youth-friendly services, infection control, councelling

Was the training adequate? If not, how could it have been improved?

Could you benefit from more training? If so, in what area(s)?

13. What kinds of materials (e.g., pamphlets, job aids, sample methods) do you have/ use to help you work with clients?

Probe for:

Are they helpful?

What other kinds of materials/tools would be useful to you?

In what languages are they

What additional tools do you require to communicate more effectively with males?

14. I would like to ask about supervision of your work:

Probe for:

When was the last time you were paid a supervisory visit? How regular or routine are these visits?

What takes place during the supervision visit? (Ask PHI to describe the type of feedback; reviews of work logs; assessment of commodity supply/resupply; client issues.) How useful are these visits to your work?

Do you know what is expected of you? If not, can you get support from your supervisor?

Let's summarize some of the key points from our discussion. Is there anything else?

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Focus Group Discussion Guide

Estate Medical Assistants

Objectives

1. Identify EMA perception of barriers clients face in accessing FP
2. Describe EMA perception of quality of care and barriers to quality of care at the societal and organizational level
3. Identify providers' knowledge about and bias toward particular methods.
4. Discuss measures to improve services

Selection of participants

- 7-9 EMA

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Warm up

First, I'd like everyone to introduce themselves. Can you tell us your names and what you do?

1. **What is your understanding on "family planning"?**
2. **We would like to hear from you as to why women and men don't use family planning services in** the **estates?**
    a. Probe
    b. Clinics are not held daily, or not frequently
    c. Timing of clinics is inconvenient
    d. Distance to clinic average distance
    e. Long waiting time
    f. Cannot travel alone
    g. Cost of transport
    h. Loss of wages
    i. Opposition from husband and wife
    j. Opposition from community
    k. Opposition from Religious leaders
    l. Gender of the service provider
    m. Method they want is not available
    n. Contraceptive stockouts
    o. Lack of trained staff for certain methods e.g implants
3. **To provide quality services requires good infrastructure. Can you tell us about the facility you work in?**
    a. Probe
    b. Water is available on tap
    c. Electricity is available
    d. Adequate waiting area with seating

e. There are function toilets for clients

f. There are sterilizing equipment

g. Where is the clinic linen laundered?

h. Does the examination room have visual and auditory privacy?

i. Is there a notice board giving the clinic time?

4. When did you last receive in-service training on FP? On what aspects?

a. Probe for:

b. Aspects of training e.g on infertility, Youth-friendly services, infection control, councelling

c. Was the training adequate? If not, how could it have been improved?

d. Could benefit from more training? If so, in what area(s)?

5. In the estate community, who makes the decisions about the number of children in thefamily? (Probe: Husbands? Mother-in-laws? Religious or community leaders? midwives?

a. Others?)

b. Who makes decisions about the spacing of births?

c. How are these decisions made?

6. According to you, what are the socio-cultural issues associated with :

a. Early marriage in this community

b. Having a lot of children?

c. Having few children?

d. Waiting a certain amount of time between pregnancies?

e. Subfertility

7. How do people in this community feel about family planning?

a. Probe

b. Socially acceptable to have large families

c. Economic pressure limits number of children

8. What do you tell men (married or unmarried) about family planning?

a. If so, what are the challenges to providing youth with FP? What approaches work well?

9. What kinds of materials (e.g., pamphlets, job aids, sample methods) do you have/ use to help you work with clients?

Probe for:

a. Are they helpful?

b. What other kinds of materials/tools would be useful to you?

b. In what languages are they

10. How do you integrate family planning into other services provided by you?

11. What do people do when they are subfertile?

12. I would like to ask about supervision of your work:

Probe for:

a. When was the last time you were paid a supervisory visit? How regular or routine are these visits?

b. What takes place during the supervision visit? (Ask EMA to describe the type of feedback; reviews of work logs; assessment of commodity supply/resupply; client issues.) How useful are these visits to your work?

c. Do you know what is expected of you? If not, can you get support from your supervisor?

13. In your opinion, what are the biggest constraints you face in your work?

a. Prompts

b. Sociocultural issues (e.g., myths/misconception, biases; spouse/family opposition; gender inequalities)

c. Political or religious factors/opposition

d. Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)

e. Population segments that are more difficult to reach (e.g., those living far from the road

f. Contraceptive stockouts

g. Inadequate sterilization services

h. Language barrier

i. Lack of isubfertility services

j. Transport issues

Isolation on the estates

14. What are your suggestions to improve FP services on the estates?

Let's summarize some of the key points from our discussion. Is there anything else?

Thank you for taking the time to talk to us!

Annex 10

Checklist for visits to institutions providing FP services

District

Name of institution

Date of visit .

Domain	Tracer indicator	Definition	Data collection notes
GENERAL SERVICE READINESS			
Basic amenities	External signs advertising FP services		Observed availability
	Covered waiting area		Observed availability
	Adequate seating		Observed availability
	Power	Facility routinely has electricity for lights and communication (at a minimum) from any power source during normal working hours; there has not been a break in power for more than 2 hours per day during the past 7 days.	Reported avaiilability.
	Piped water source		Observed availability
	Room with auditory and visual privacy for patient consultations	Private room or screened off area available in main service area (usually the general outpatient service area), a sufficient distance from sites where providers/clients routinely may be, so that a normal conversation could be held without being overheard, and without the client being observed	Observed availability.
	Access to adequate sanitation facilities for clients	The toilet/latrine is classified using uniform criteria for improved sanitation promoted by UNICEF. These include the following: Flush/ pour flush to piped sewer system or septic tank	Reported availability accepted.
	Communication equipment	Functioning communication equipment. This will not include private cell phones	Reported availability accepted

	Facility has access to computer with email/internet access	Facility has a functioning computer and has access to email/internet with internet working on the day of the survey.	Reported availability accepted
	Emergency transportation	Facility has a functioning vehicle with fuel that is routinely available that can be used for emergency transportation or access to a vehicle in near proximity that can be used for emergency transportation	Reported availability accepted
STANDARD PRECAUTIONS FOR INFECTION PREVENTION			
	Safe final disposal of sharps	Safe final disposal of sharps includes incineration, open burning in protected area, dump without burning in protected area, or remove offsite with protected storage. If method is incineration, incinerator functioning and fuel available	Observed final disposal/holding site for sharps and verify no unprotected sharps are observed.
	Safe final disposal of infectious wastes	Safe final disposal of infectious wastes includes incineration, open burning in protected area, dump without burning in protected area, or remove offsite with protected storage. If method is incineration, incinerator functioning and fuel available	Observed final disposal/holding site for infectious wastes and verify no unprotected waste is observed.
	Appropriate storage of sharps waste	A puncture-resistant, rigid, leakresistant container designed to hold used sharps safely during collection, disposal and destruction. Sharps containers should be made of plastic, metal, or cardboard and have a lid that can be closed. Sharps containers should be fitted with a sharps aperture, capable of receiving syringes and needle assemblies of all standard sizes, together with other sharps. Boxes must be clearly marked with the international biohazard warning not less than 50mm diameter, printed in black or red on each of the front and back faces of the box. .	Observed availability in OPD and surgery area
	Disinfectant	Chlorine-based	Observed availability anywhere in the facility

	Single use —standard disposable syringes	Latex glove	Observed availability in OPD and surgery area
	Soap and running water or alcohol based hand rub		Observed availability in OPD and surgery area
DIAGNOSTIC CAPACITY			
	Haemoglobin		Able to conduct the test onsite (in the facility) and functioning equipment and reagents needed to conduct the test are observed onsite on the day of the survey. These may be in a laboratory or in the service area where the test is conducted.
	Blood glucose		
	Urine dipstick-protein		
	Urine dipstick-glucose		
	Urine test for pregnancy		
FAMILY PLANNING SERVICE AVAILABILITY			
	Condoms		
	OCP		
	DMPA		
	Implants		
	IUCD		
	ECP		
	LRT		
	Vasectomy		
SERVICE READINESS			

Staff and training	Guidelines on family planning	a. Guidelines for service providers on combined oral contraceptive pill (OCP) and DMPA injectable contraceptive 2010. b. Guidelines for service providers on IUCD insertion and removal 2010. c. Guidelines for service providers on mini-laparotomy for female sterilization. 2012 d. Medical Eligibility Criteria Wheel for Contraceptive use (adapted for Sri Lanka)-2012. e. Guideline regarding the use of DMPA in the NFPP.	Guidelines observed in service area.
	Staff trained in FP	At least one staff member providing the service trained in the last two years in some aspect of FP	Interview response from incharge of service area day of survey
	Staff providing family planning services trained in adolescent sexual and reproductive health	At least one staff member providing FP services trained in ASRH in the last two years	
Equipment	Blood pressure apparatus	Digital BP machine or manual sphygmomanometer with stethoscope	Observed availability, reported functionality, and in service area or adjacent area.
	Examination bed		Observed availability, reported functionality, and in service area or adjacent area.
	Examination light	Spotlight source that can be used for patient examinations. A functional flashlight is accepted	Observed availability, reported functionality, and in service area or adjacent area.

	Emergency tray	Adrenaline 1:1000 vials Hydrocortisone vials Chlorpheniramine vials 0.9% sodium choride iv solution Water for injection 1cc disposable syringe with 23 gauge needles Airways (small, medium and large) ET tubes Sphygmomanometer (adult and child cuffs) Stethoscope Alcohol swabs Tourniquet Tongue depressors Flashlight with extra batteries	
	Oxygen cylinder		Observed availability, reported functionality, and in service area or adjacent area.
	Ambu bag		Observed availability, reported functionality, and in service area or adjacent area.
FP commodities in stock	OCP		Observed in service area OR where routinely stored; in stock with at least one valid.
	DMPA		
	Condoms		
	Implants		
	Insertion kits		
	IUCD		
	IUCD kits		
LIFE-SAVING COMMODITIES FOR WOMEN AND CHILDREN			
	Female condoms		Observed available in pharmacy or where they are routinely stored, at least one with valid expiration date;
	Implants		
	Emergency contraception		