Multi-Year Costed Action Plan for the National Family Planning Programme in Sri Lanka

Prepared by Health Policy Research Associates
for the Family Health Bureau
of the Ministry of Health

February, 2019

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This report consists of the following sections a) Historical overview of the national family planning programme b) Situation analysis contraceptive use, c) Stagnation to revitalization of family planning activities: Some lessons from selected countries in the Region d) Policy framework to revive the family planning programme, e)Action plan: strategies and costs.

The report was prepared by Dr. A.T.P.L. Abeykoon, Senior Fellow, Health Policy Research Associates.

Executive Summary

- As a result of the policy decision taken by Government in 1965, family planning became a national programme and was integrated with the maternal and child health activities of the Ministry of Health. With the establishment of the Family Health Bureau in 1968and the implementation of family planning services and training with financial support from the Swedish Government (SIDA), the national family planning programme took off the ground.

- In 1973, a Project Agreement was signed by the Government with the United Nations Population Fund for assistance in making family planning facilities available to all sections of the population. As there were many government agencies outside the Ministry of Health implementing population activities, coordination become an important issue. Thus in 1974, the coordination of UNFPA funded projects was vested under the new Ministry of Plan Implementation which functioned under the Executive Prime Minister.

- In the early 1980s the programme received further impetus with emphasis on clinical contraception and by 1987 the Contraceptive Prevalence Rate (CPR) rose to 61.7 percent with prevalence of voluntary sterilizations contributing to about 50 per cent of the total prevalence. One major factor was the increase in the facilities for sterilization services and the introduction of financial inducements to acceptors of voluntary sterilizations and the medical teams who provided the services.

- The programme reached maturity towards the end of the decade of 1980s where the programme was transformed from a demand creation phase to a supply-oriented one with the provision of family planning services receiving high priority. In 1991, the Government made a policy statement to reach replacement fertility by the year 2000.The CPR increased further to 66.1 per cent in 1993.

- Sri Lanka became a signatory to the global consensus of a broad-based concept of reproductive health at the International Conference on Population and Development (ICPD) held in Cairo in 1994.

- During the period 2000 to 2016, the family planning programme experienced a setback where the decline in the use of traditional methods was not offset by the use of modern methods mainly due to the decline in the prevalence of permanent methods. It was thus evident that the promotion of temporary methods of family planning was equally important.

- Analysis of family planning data during the past decade shows that satisfied demand for modern methods of the total demand was 74.2 per cent in 2016 meaning that a shortfall of about 25 per cent due to unmet need and use of traditional methods. Therefore, rather than creating new demand, in the short run, meeting the existing demand is of paramount importance. In particular, efforts should be made to work towards zero unmet need. Sri Lanka has now reached a phase where family planning services have to be provided largely on demand to avoid unintended pregnancies which may lead to induced abortions and in turn could result in maternal morbidity and mortality.

- Analysis of family planning data shows that the current setback in terms of contraceptive prevalence is mainly due to the low performing geographic areas. For instance, the DHS 2016 shows that satisfied demand for modern family planning methods is relatively low in the districts of Batticaloa, Vauniya, Trincomalee, Ampara,

Galle, Ratnapura, Matara and in the districts of Western Province. The family planning activities in identified MOH areas in these districts need to be strengthened after ascertaining the reasons for the low performance. Thus in addition to the current activities, the future programmes should focus on identified target areas. For, limited public funds have competing demands not only in other sectors of the economy but also within the health sector itself. Thus public funds should be utilized judiciously to meet the desired goals of the programme.

- The family planning programme needs to be re-branded as an important component of the national reproductive health programme aimed at promoting desired quality children. Maternal health and nutrition should be an integral part of the programme. In addition, counseling and services to sub-fertile couples should be an important element of the family planning programme as married couples facing the problem of sub-fertility may experience anxiety, stress and depression.

- Coordination of the national family planning programme needs to be strengthened. Therefore, a high powered National Coordinating Committee on Reproductive Health (NCCRH) may be established under the chairmanship of the Director General of Health Services to coordinate, monitor and evaluate the national programme.

- Family planning is an essential component of primary health care and reproductive health. It plays a major role in reducing maternal and new born morbidity and mortality and transmission of HIV and other sexually transmitted infections. It also helps to prevent unintended pregnancies which may result in induced abortions. Thus family planning information, education and communication, and behavior change communication activities should be linked to other elements of reproductive health to avoid any misconceptions about the family planning programme.

- Elected representatives, community leaders and health professionals have an important role to play in providing the necessary support and commitment to the national family planning programme. The Family Health Bureau should work closely with the Sri Lanka Parliamentary Group on Population and Development to dispel any misconceptions on family Planning among elected representative at the national and sub-national level and promote among married couples the desired number of quality children.

- In order to strengthen the maternal and child health activities including family planning, the Ministry of Health presented the National Policy on Maternal and Child Health in 2012 with 12 Policy Goals. The Goal 7 specifically addressed family planning as follows: “Ensure all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies”. Subsequently, the National Strategic Plan on Maternal and Newborn Health in 2017 has stressed the need to “enable all couples/individual optimally time and space their pregnancies while preventing unintended conceptions”.

- The Ministry of Health has outlined the following indicators to be achieved by 2025 to assess the progress of the family planning programme: a) Increase the percentage of eligible families who have their need for family planning satisfied with modern methods to 79.0% b) Reduce unmet need for family planning to 5.7% c) Increase the contraceptive prevalence rate to 66.4% and the rate of modern methods to 57.2%.

- The health impacts as a result of achieving the target of modern contraception are aversion of more than 1.7 million abortions and about 1,100 maternal deaths during 2019 to 2025.

- The report outlines the following family planning action plan with strategies and costs for the period 2019 to 2025 to further strengthen the programme:1) Coordinate, monitor and evaluate family planning activities periodically at national and sub national level. 2) Estimate contraceptive commodity requirements for the future and their costs3) Strengthen the availability of clinical methods at service points to provide services on demand. 4) Promote family planning as an important element of the national reproductive health programme. 5) Provide family planning information and services on demand to unmarried persons, youth and other special groups. 6) Strengthen counseling and services to couples with primary and secondary sub-fertility. 7) Provide training to Medical Officers and other public health staff 8) Provide refresher training to health staff 9) Provide advocacy programmes on reproductive health including family planning to elected representatives and media personnel at national and sub-national level. 10) Ensure adequate behavior change communication materials on reproductive health including family planning (both print and electronic) are available. 11) Strengthen family planning clinics by providing the necessary equipment 12) Use smart phone apps to provide accurate and timely information on reproductive health and family planning.13) Ensure equity through focusing on low performing areas.

- The projections with regard to contraceptive commodity costs were made of on the assumptions that the contraceptive prevalence rate would increase to 67 per cent and the contraceptive prevalence of modern methods would increase to 57.3 per cent by 2025. The total costs of contraceptive commodities would increase from Rs. 353 million in 2019 to Rs. 707 million in 2025. The projections of costs made for contraceptive commodities and other activities need to be reviewed annually in the light of the costs incurred in the previous year.

- Some other key areas of costing are: The costs of training of health personnel in family planning and sub-fertility would increase from Rs. 8.1 million 2019 to Rs. 10.8 million in 2025. The costs to improve the service facilities by providing equipment to clinics would entail Rs. 8.0 million in 2019.

- In the areas of information, education and communication and behavior change communication activities, the costs would be Rs. 14.1 million in 2019. It is likely that it would increase to Rs.20.6million in2025. Media seminars and advocacy programmes for elected representatives at the national and sub-national level will increase from Rs. 3.5 million in 2019 to Rs.4.5 million in 2025.

1 Historical Overview of the National Family Planning Programme

In 1965, the government took a policy decision to include family planning as part of the maternal and child health programme. This legitimized family planning which hitherto was seen as 'ugly' by certain quarters. By that time the primary health care system in the country was well developed with a network of institutions and trained personnel which facilitated the implementation of family planning activities. The efforts of the Family Planning Association which was established in 1954 and the pilot study undertaken in 1958 under the Swedish-Ceylon Project demonstrated that family planning needs can be met by methods acceptable to married couples in the country (Abeykoon 1996).

In 1966, the Minister of Health appointed an Advisory Committee to advice on the implementation of the national family planning programme. The main recommendations of the committee were accepted by the government. The goal of the programme was to reduce the crude birth rate from 33 per thousand of the population in 1965 to 25 per thousand by the end of 1975. It was estimated that about 115,000 new acceptors per year would be necessary to achieve this goal.

An agreement was reached with the government of Sweden to provide assistance in contraceptive supplies, equipment and training to implement the programme. The implementation strategy was essentially designed to provide family planning services through the Maternal and Child Health network. The clinics operated by the Family Planning Association were handed over to the government during the period 1966-1968 in a phased programme. An agreement with the Ford Foundation in 1967 provided for evaluation of family planning activities which included improvements in reporting procedures, analysis of data and planning of follow-up surveys.

In 1968, the Family Health Bureau (FHB) was established with the Assistant Director (MCH) as its chief. At the national level, the FHB is the central organization responsible for the coordination of the maternal and child health and family planning activities. Subsequently, a Family Planning Unit was established in the FHB as the focal point for the National Family Planning Programme. In 2012, the following strategies and activities were outlined in the MCH policy.

- Ensure the availability and accessibility to quality modern family planning services.
- Address the unmet need for contraception to reduce abortions and teenage pregnancies.
- Ensure availability of male and female sterilization services in hospitals.
- Establish an appropriate system for post-abortion care.
- Ensure the uninterrupted availability of contraceptive commodities [Reproductive Health Commodity Security (RHCS)].
- Strengthen, rationalize and streamline services for sub-fertile couples.

The importance of family planning was stressed in the Five Year Plan of the government in 1971 as follows:

"The significance of family planning as a health measure has not received sufficient attention in the past, especially the effect of excessive child bearing on individual and family health and welfare. In Ceylon, as in other developing countries, the largest number of births is among mothers from low-income families. According to the Socio-economic Survey of 1969/70, it was estimated that, of the mothers who had five or more children, as many as 63 per cent were in households with income less than Rs. 200 per month. Frequent and ill spaced pregnancies undermine the health of the mother. A high birth rate in the context of low standards of living and malnutrition can lead to general deterioration in the health of the population and to an increase in the incidence of disease and to 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 be confined to the privileged sections of society"(Ministry of Planning and Employment 1971).

In 1973, a Project Agreement was signed by the Government with the United Nations Population Fund for assistance in making family planning facilities available to all sections of the population. As there were many government agencies outside the Ministry of Health implementing population activities, coordination become an important issue. Thus in 1974, the coordination of UNFPA funded projects was vested under the new Ministry of Plan Implementation which functioned under the Executive Prime Minister.

Table 1.1: Family planning and other RH indicators, 1975 and1982

Indicators	1975	1982
Contraceptive Prevalence Rate (CPR)	34.4	57.9
CPR of Modern Methods	20.2	31.9
CPR of Traditional Methods	14.2	26
Maternal Mortality Ratio	75.8	70.6
Infant Mortality Rate	45.1	30.5
Total Fertility Rate	3.4	3.7

*Source:*WFS 1975(Department of Census and Statistics 1978), CPS 1982 Reports(Department of Census and Statistics 1983) and data of Registrar General

In 1977, the subject of population policy formulation and coordination was assigned to the Ministry of Plan Implementation. Later, in the Throne Speech of the Government, the need to give high priority to the population programme with emphasis on clinical contraceptive services was clearly stated. From May 1979, the government decided to give financial incentives to medical teams who perform voluntary sterilizations.

The financial inducements were extended to clients from January 1980.The new acceptors of voluntary sterilizations increased from 4,971 in 1970 to 112,926 by the end of 1980. The numbers of new acceptors continued to remain relatively high until the high parity women moved out of the reproductive ages (Table 1.1). The Total Fertility Rate declined from 3.7 children per woman in 1982 to 2.8 in 1987 and the contraceptive prevalence rate of voluntary sterilizations was nearly 50 per cent of total contraceptive prevalence. In other words, sterilizations provided half the total protection from unwanted births.

Table 1.2: Family planning and other RH indicators, 1982 and 1987

Indicators	1982	1987
Contraceptive Prevalence Rate (CPR)	57.9	61.7*
CPR of Modern Methods	31.9	40.6
CPR of Traditional Methods	26.0	21.1
Maternal Mortality Ratio	70.6	66.9
Infant Mortality Rate	30.5	22.6
Total Fertility Rate	3.7	2.8

*Source:*CPS 1982(Department of Census and Statistics 1983) and DHS 1987Reports(Department of Census and Statistics 1988) and data of Registrar Genera
*Excludes the Northern and Eastern Provinces

In the 1980s the family planning programme received high visibility with a vigorous information, education and communication campaign. The NGOs provided the much needed supplementary support to the government programme. The National Coordinating Committee on Population (NCCP) chaired by the Minister in charge of Family Health and the Secretary, Ministry of Plan Implementation who functioned as the member secretary effectively coordinated the programme. The newly created Population Division functioned as the secretariat to the NCCP and monitored the programme at the national and district level.

At the district level, the Ministry of Plan Implementation not only received the cooperation of health personnel but also the support of District Secretaries and planning officials at the sub-national level. The family planning indicators further improved by 1987(Table 1.2). In that context it is evident that an effective coordination mechanism appropriate to the present context needs to be strengthened at the National and District level.

Towards the end of the decade of 1980s the population programme transformed from a demand creation phase to a supply-oriented one where the provision of family planning services became a high priority. Therefore, the function of population policy formulation and coordination was re-assigned to the Ministry of Health. In 1991, a population policy statement was issued by the National Health Council of achieving a total fertility rate of 2.1 by the year 2000. In 1994, Sri Lanka became a signatory to the global consensus of a broad-based concept of reproductive health detailed in the Programme of Action at the International Conference on Population and Development (ICPD) held in Cairo.

The ICPD Programme of Action outlined the basis for action on family planning as follows: "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 and to ensure informed choices and make available a full range of safe and effective methods" (UNFPA 1994).

During the decade of the 1980s, contraceptive prevalence rate further improved despite data from the Northern and Eastern provinces not being available (Table 1.3).

Table 1.3: Family planning and other RH indicators,1987and 1993

Indicators	1987	1993
Contraceptive Prevalence Rate (CPR)	61.7*	66.1*
CPR of Modern Methods	40.6	43.7
CPR of Traditional Methods	21.1	22.4
Maternal Mortality Ratio	66.9	62.5
Infant Mortality Rate	22.6	16.3
Total Fertility Rate	2.8	2.3

Source: DHS 1987 (Department of Census and Statistics 1988)and DHS 1993 Reports data of Registrar General
*Excludes the Northern and Eastern Provinces

Sri Lanka adopted a number of initiatives responding to the ICPD programme of Action. An important initiative was the formulation of the Population and Reproductive Health Policy in 1998 which was approved by the Cabinet of Ministers. The Policy had 11 Goals of whichGoal2 was: "Ensure safe motherhood and reduce reproductive health system related morbidity and mortality"(Ministry of Health and Indigenous Medicine 1998).

Two of the strategies were directly related to family planning: i) Provide affordable, accessible and acceptable family planning services to protect against unplanned pregnancy. ii) Promote family planning so that pregnancies do not take place too early in life or too late in life, are appropriately spaced and are not too many.

During 1993 to 2000 contraceptive prevalence of modern methods showed a significant increase (Table 1.4).

Table 1.4: Family planning and other RH indicators,1993 and 2000

Indicators	1993	2000
Contraceptive Prevalence Rate (CPR)	66.1*	70.0*
CPR of Modern Methods	43.7	49.5
CPR of Traditional Methods	22.4	20.5
Maternal Mortality Ratio	62.5	55.6
Infant Mortality Rate	16.3	13.3
Total Fertility Rate	2.3	1.9

Source: DHS 1993 and DHS 2000 Reports data of Registrar General
*Excludes the Northern and Eastern Provinces

During the period 2000 to 2016, the family planning programme showed sings of slowing down. The decline in the use of traditional methods did not show a corresponding increase in modern methods (Table 1.5). This may be due to the decline in the prevalence of permanent methods (not shown in Table). It was thus evident that the promotion of temporary methods was equally important.

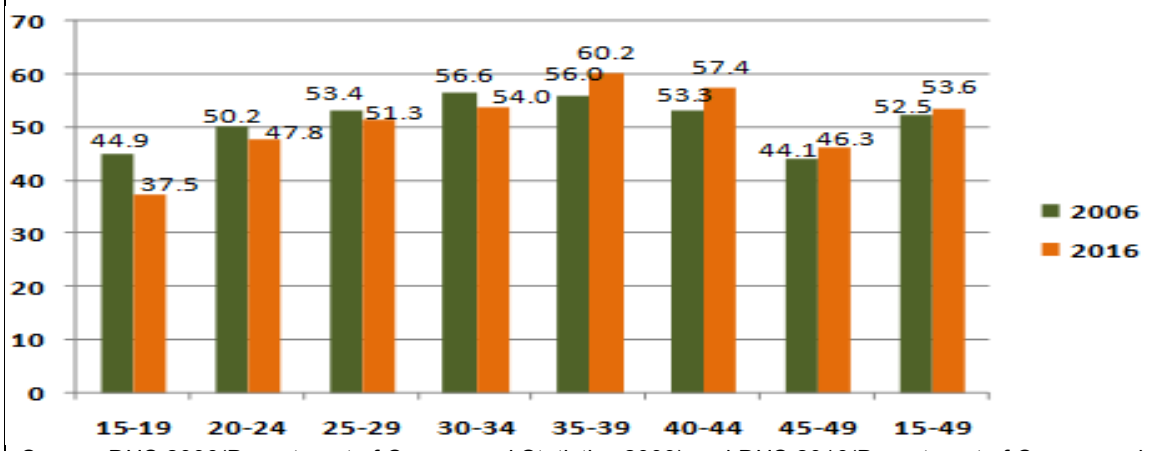
Table 1.5: Family planning and other RH indicators, 2000 to 2016

Indicators	2000	2006	2016
Contraceptive Prevalence Rate (CPR)	70.0*	68.4*	64.6
CPR of Modern Methods	49.5	52.5	53.6
CPR of Traditional Methods	20.5	15.9	11.0
Maternal Mortality Ratio	55.6	40.2	33.8
Infant Mortality Rate	13.3	10.0	9.0
Total Fertility Rate	1.9	2.3	2.2

Source: DHS 2000,2006and2016(Department of Census and Statistics 2017) and data of Registrar General Department
*Excludes the Northern Province. When the Northern Province is excluded in 2016, the contraceptive prevalence rate is 65.5%. For modern methods, it was 54.1%.

2 Situation Analysis of Contraceptive Use

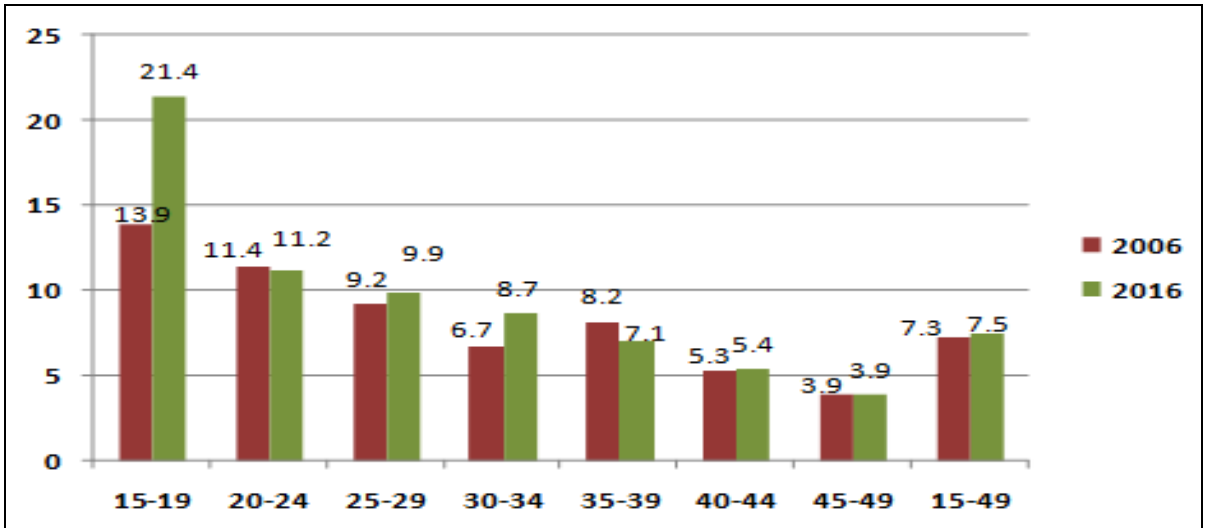
This section focuses on the period between 2006 and 2016 based on the data of Demographic and Health Surveys of2006/07 and 2016 conducted by the Department of Census and Statistics and the Reproductive Health Information System (RHMIS) of the Family Health Bureau. While considerable progress has been made by the National Family Planning Programme over the years, the contraceptive prevalence of modern methods during 2006 to 2016 showed signs of slowing down.



Source: DHS 2006(Department of Census and Statistics 2009) and DHS 2016(Department of Census and Statistics 2017) Reports. *Excludes the Northern Province

Figure 2.1: Contraceptive prevalence rate of modern methods by age, 2006* and 2016

It can be seen from Figure 2.1 that the contraceptive prevalence of modern methods has increased by only one percentage point during the ten years period. It is to be noted that the family planning use has dropped in the younger age group 15 to 34 years and a slight increase in the older ages 35-49 years.

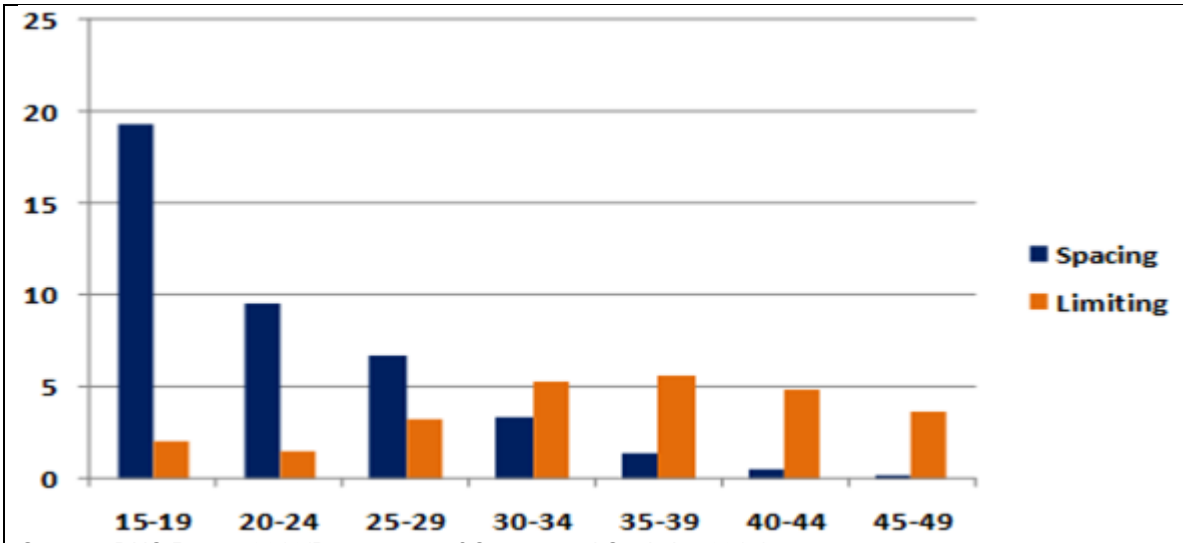


Source: DHS 2006(Department of Census and Statistics 2009) and DHS 2016 Reports(Department of Census and Statistics 2017). *Excludes the Northern Province

Figure 2.2: Percent unmet need for family planning by age, 2006* and 2016

The decline in family planning use among those under 35 years of age is the result of young people being unable to fully meet their family planning needs (Figure 2.2). It can be seen

that the unmet need for family planning has increased among those under 35 year of age. The highest unmet need is in the age group 15-19 years.



Source: DHS Report 2016(Department of Census and Statistics 2017)

Figure 2.3: Percent unmet need for family planning for spacing and limiting,2016

The Figure 2.3 shows that among those under 30 years of age, a considerable percentage were unable to meet their needs for spacing methods. The unmet need for spacing is highest among those aged 15-19 years which is about one fifth of those in that age group. It is also evident nearly 5 percent of currently married women over age 30 years have not been able to meet their needs to limit family size in 2016.

Table 2.1: Contraceptive prevalence by method and age, 2006* and 2016

Method	15-29		30-39		40-49	
	2006	2016	2006	2016	2006	2016
Sterilization	1.7	-	14.2	11.9	31.3	25.8
IUD	7.1	10.3	8.0	12.3	4.0	8.7
Injectables	26.1	12.6	15.9	9.9	3.8	4.1
Implant	0.5	8.3	0.4	5.0	0.1	1.5
Pill	10.3	9.8	10.3	10.0	3.7	5.9
Condom	5.8	7.3	7.1	7.9	3.8	5.7

Source: DHS 2006(Department of Census and Statistics 2009)and DHS 2016 Reports.(Department of Census and Statistics 2017)

*Excludes the Northern Province

It is seen from Table 2.1 that there has been a decline in prevalence for injectables among those in the age groups, 15-29 and 30-39 years. The decline in sterilizations is significant. It appears that this short fall is partly compensated by the increase in prevalence of IUDs and implants.

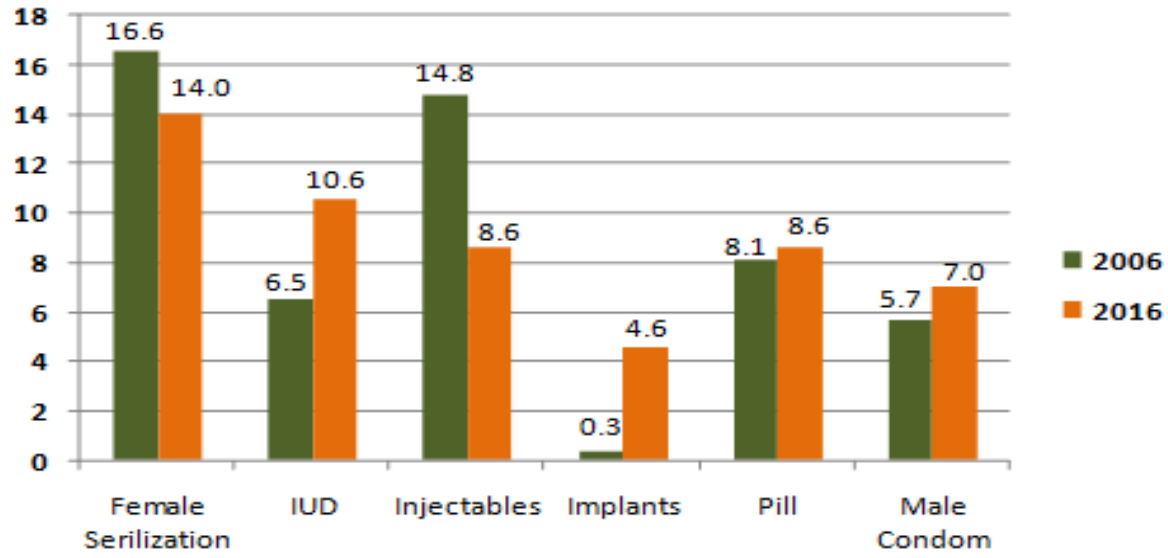
Table 2.2: Contraceptive use of modern methods and fertility, 2006* and 2016

District	2006	2016	% Change	% Demand Satisfied 2016**	Total Fertility Rate, 2016
Colombo	46.2	47.4	2.6	67.4	1.8
Gampha	46.4	52.0	12.1	69.4	1.8
Kalutara	52.1	55.4	6.3	69.5	2.2
Kandy	57.1	52.3	-8.4	75.3	2.6
Matale	60.4	61.7	2.2	81.0	1.9
NuwaraEliya	63.2	62.7	-0.8	83.9	2.2
Galle	48.9	53.8	10.0	70.3	2.1
Matara	49.0	52.9	8.0	72.1	2.3
Hambantota	47.0	54.0	14.9	74.8	1.9
Jaffna	-	42.7	-	77.8	2.1
Mannar	-	18.7	-	75.2	2.0
Vavuniya	-	30.7	-	63.4	2.0
Mulaitivu	-	63.9	-	86.9	2.0
Kilinochichi	-	56.3	-	83.1	2.1
Batticaloa	34.0	28.5	-16.2	52.5	2.4
Ampara	49.9	40.6	-18.6	72.7	2.4
Trincomalee	49.7	45.4	-8.7	72.1	2.3
Kurunegala	58.0	55.8	-3.8	74.0	2.2
Puttalam	52.5	55.6	5.9	75.4	2.1
Anuradhapura	62.6	62.5	-0.2	87.5	2.4
Polonnaruwa	68.3	67.0	-1.9	85.6	2.5
Badulla	62.0	64.7	4.4	83.4	2.3
Moneragala	57.4	63.7	11.0	81.7	2.4
Ratnapura	54.3	55.8	2.8	71.3	1.8
Kegalle	49.8	59.3	19.1	79.2	2.6
Sri Lanka	52.5	53.6	2.1	74.2	2.2

Source: DHS 2006(Department of Census and Statistics 2009) and DHS 2016 Reports.(Department of Census and Statistics 2017)
*Excludes the Northern Province
**Percentage demand satisfied for modern methods.

It can be seen from

Table 2.2 that Batticaloa district is the worst affected in terms of demand satisfied. The contraceptive prevalence of modern methods which was relatively low at 34 percent in 2006, further declined to 28.5 percent in 2016. The percentage of demand satisfied was 52.5 percent in 2016 indicating that there is considerable unmet demand for family planning. A study undertaken in 2009 using the 2006 DHS data showed that prevalence of induced abortion in the Batticaloa district is notably high followed by the districts of Trincomalee and Amparai (Abeykoon 2009).As the contraceptive use of modern methods has declined in these three districts, it appears that there has been a poor performance of family planning activities in the Eastern Province during the past decade. It is also evident that there is a positive correlation between contraceptive use and fertility in the districts in 2016 which indicates that other proximate determinants other than contraceptive use has influenced fertility. Even if one assumes a 10 percent use of traditional methods, the satisfied demand for modern methods is much lower than 90 percent in many districts. It is thus evident that the programme has not been able to fully meet the demands of married couples.



Source: DHS 2006(Department of Census and Statistics 2009)and DHS 2016 Reports.(Department of Census and Statistics 2017)
*Excluded the Northern Province

Figure 2.4: Contraceptive prevalence rate by method, 2006* and 2016

Contraceptive prevalence by method shows that the prevalence of female sterilization and injectables has declined during 2006 and 2016. Demand for IUD and implants shows a significant increase while the demand for Pills and condoms shows only a marginal increase.

Table 2.3: Family planning performance, 2010 and 2016

RDHS/Health Area	Current user rate of modern methods		% Unmet need for family planning	
	2010	2016	2010	2016
Colombo	53.7	56.8	8.8	6.3
Colombo MC	39.9	43.8	8.3	10.6
Gampha	52.1	52.5	9.0	7.8
Kalutara	54.4	56.5	8.0	6.7
NIHS	51.3	52.9	6.0	4.2
Kandy	55.0	56.8	7.3	6.5
Matale	58.7	60.2	6.8	4.5
NuwaraEliya	65.9	68.4	5.9	6.8
Galle	56.9	58.8	6.7	6.0
Matara	57.6	60.1	8.3	6.1
Hambantota	54.9	60.2	8.8	6.6
Jaffna	49.3	52.6	8.8	5.1
Kilinochichi	33.7	67.1	18.6	2.0
Mannar	36.2	52.3	5.5	6.1
Vavuniya	41.5	51.0	10.1	9.7
Mullaitivu	38.8	60.6	2.6	6.3
Batticaloa	39.4	44.9	9.6	6.5
Ampara	65.7	68.1	6.4	3.3
Kalmunai	38.1	46.8	10.6	7.0
Trincomalee	49.4	53.2	9.8	5.5
Kurunegala	56.3	59.9	6.9	5.9
Puttalam	53.3	57.6	8.9	7.1
Anuradhapura	59.3	61.1	6.6	5.1
Polonnaruwa	63.1	63.6	5.6	4.3
Badulla	66.1	64.6	8.4	6.1
Moneragala	62.7	64.3	6.2	4.5
Ratnapura	54.4	58.3	9.7	7.0
Kegalle	54.5	57.8	7.8	5.5
Sri Lanka	54.7	57.6	8.0	6.4

Source: Family Health Bureau Annual Reports, 2010 and 1016

The data from the Reproductive Health Management Information System (RHMIS) of the Family Health Bureau show a 4 percentage points higher contraceptive prevalence rate for modern methods for the year 2016 compared to the DHS rate for the same year (Table 2.3).

It is interesting to note that contraceptive prevalence in the in the Northern and Eastern areas have shown marked improvements during 2010 to 2016 indicative of the peaceful ground situation that prevailed after the end of the armed conflict in 2009. For instance, in Kilinochchi the current use rate has increased from 33.7 per cent in 2010 to 67.1 per cent in 2016 and the unmet need has declined from 18.6 percent to 2.0 percent. There is a clear negative relationship between contraceptive prevalence and unmet need.

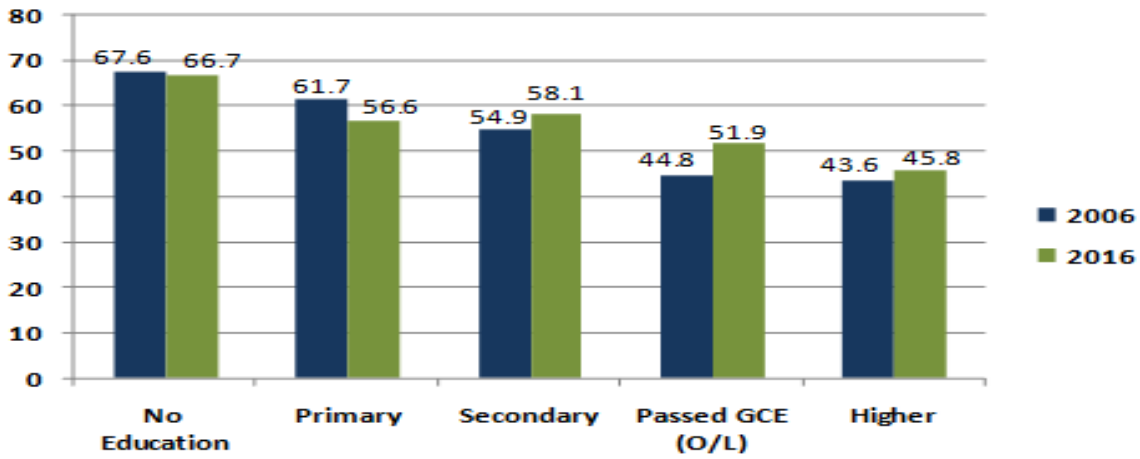
Table 2.4: Growth of female population 15-49 years

District	2017	2022	2027	%Change 2017-2027
Sri Lanka	5408	5485	5564	2.9
Colombo	593	572	552	-0.7
Gampaha	624	631	637	2.1
Kalutara	322	330	332	3.1
Kandy	359	359	361	0.6
Matale	131	135	140	6.9
NuwaraEliya	186	195	203	9.1
Galle	271	272	273	0.7
Matara	206	210	213	3.4
Hambantota	158	165	170	7.6
Jaffna	159	162	160	0.6
Mannar	29	30	30	2.1
Vavuniya	51	54	57	11.8
Mullaitivu	24	23	23	-0.3
Kilinochchi	29	30	30	2.0
Batticaloa	156	165	170	9.0
Ampara	187	196	204	9.0
Trincomalee	111	119	127	14.4
Kurunegala	418	421	431	3.1
Puttalam	206	210	211	2.4
Anuradhapur	242	251	261	7.9
Polonnaruwa	113	117	121	7.1
Badulla	213	217	217	1.9
Monaragala	125	130	138	0.4
Ratnapura	281	282	286	1.8
Kegalle	212	213	212	0.0

Source:(Abeykoon 2018)

It is evident from Table 2.4 that the female population in the reproductive age group will continue to increase during the next ten years in Sri Lanka and in many districts. Relatively

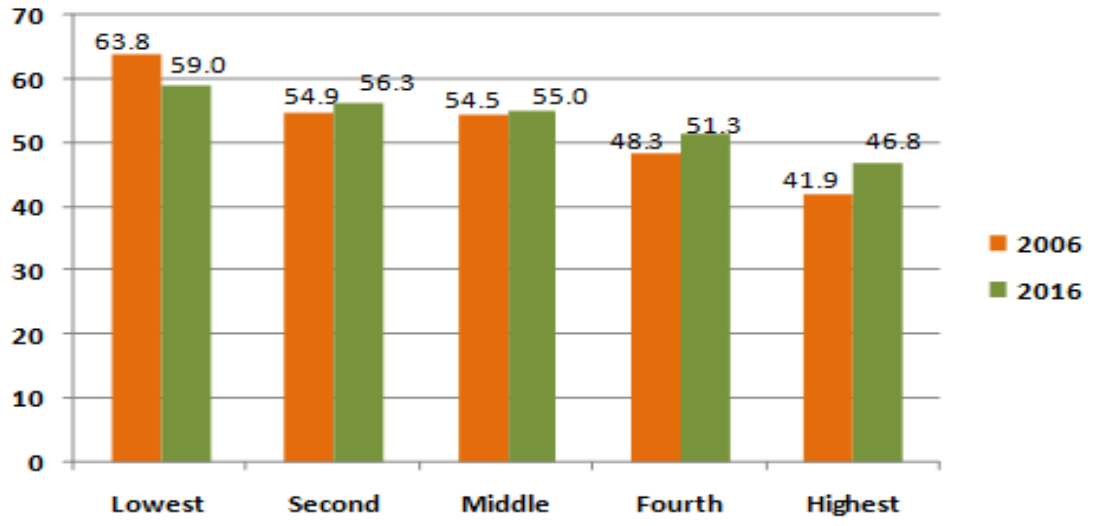
high increases are expected in the districts of Trincomalee and Vavuniya. The districts of Colombo and Mullaitivu show a slight decrease. Therefore, it is possible that the absolute number of contraceptive users will increase at least upto 2027 in many districts due to the new additions of females to the reproductive age group and the likely desire to reduce the family size among currently married women. However, one needs to note that supply side factors alone will not increase the number of users. Demand side factors are equally important.



Source: DHS 2006(Department of Census and Statistics 2009) and DHS 2016 Reports(Department of Census and Statistics 2017). *Excludes the Northern Province

Figure 2.5: Contraceptive prevalence rate of modern methods by education, 2006* and 2016

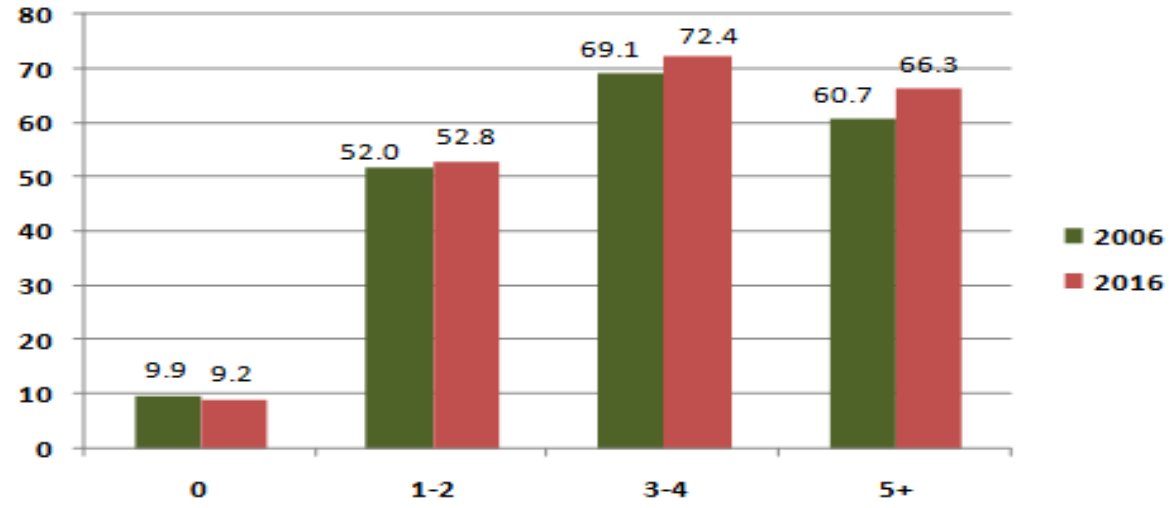
It is evident from Figure 2.5 that the highest demand for contraception is among women with no education. However, among the illiterate women the demand has more or less remained the same. While there has been a drop in the demand among those with primary education, slight improvements have been observed among those with secondary and higher educational level.



Source: DHS 2006(Department of Census and Statistics 2009)and DHS 2016 Reports(Department of Census and Statistics 2017). *Excludes the Northern Province

Figure 2.6: Contraceptive prevalence rate of modern methods by wealth quintile, 2006* and 2016

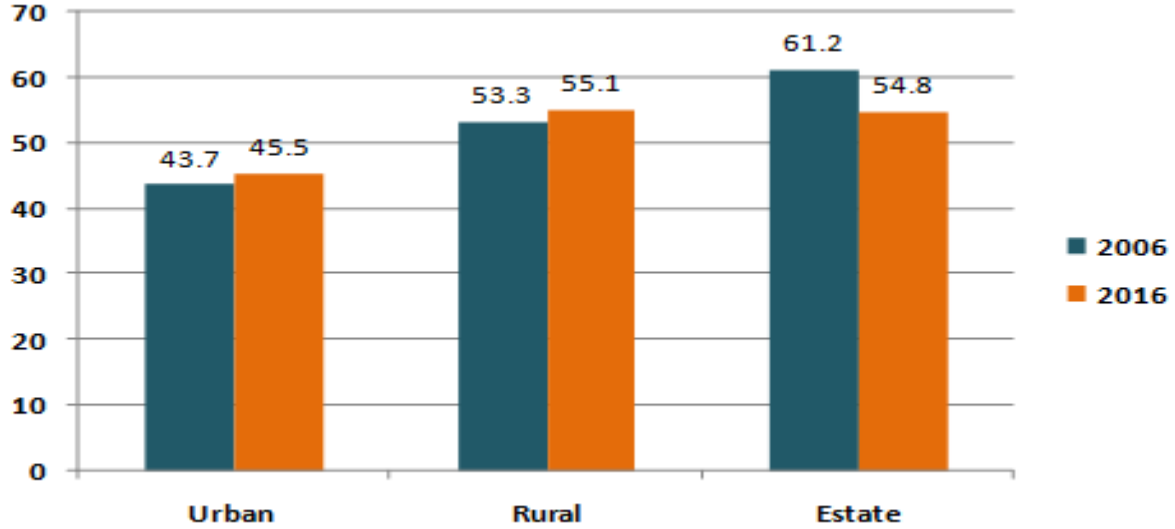
Figure 2.6 shows that among lowest wealth quintile group, contraceptive prevalence has dropped during 2006 and 2016. The highest income quintile has the lowest prevalence partly due to the fact that more educated women prefer traditional and natural methods. In 2006 and 2016, the highest prevalence levels of traditional methods were seen among the highest wealth quintile group. For instance it was 21.1 percent when the national average was 15.9 percent in 2006. The corresponding rates in 2016 were 16.2against 11.0 (data not shown in the Figure).



Source: DHS 2006(Department of Census and Statistics 2009) and DHS 2016 Reports(Department of Census and Statistics 2017). *Excludes the Northern Province

Figure 2.7: Contraceptive prevalence rate of modern methods by number of living children, 2006* and 2016

As expected, larger the number of children, higher is the prevalence of contraception. It is observed that contraceptive prevalence has increased among women with 3 or more children indicative of the conscious desire to limit family size (Figure 2.7). The lower prevalence for those with 5 or more children compared to those with 3-4 children is due to the small sample size of women with 5 or more children. In 2016, only 2.2% of currently married women had 5 or more children.

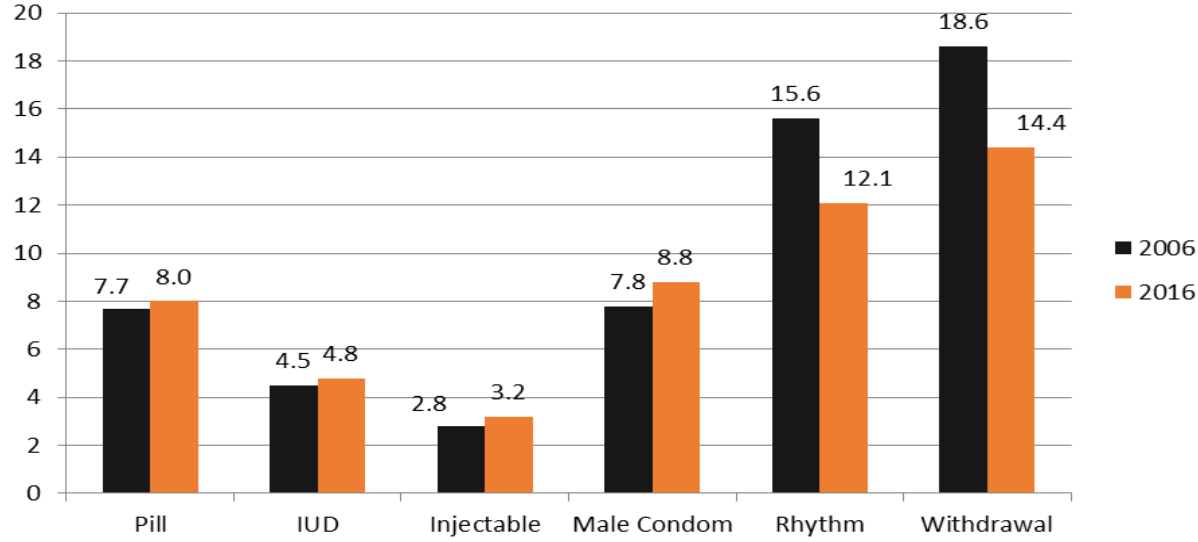


Source: DHS 2006(Department of Census and Statistics 2009) and DHS 2016(Department of Census and Statistics 2017) Reports. *Excludes the Northern Province

Figure 2.8: Contraceptive prevalence rate of modern methods by residence, 2006*

and 2016

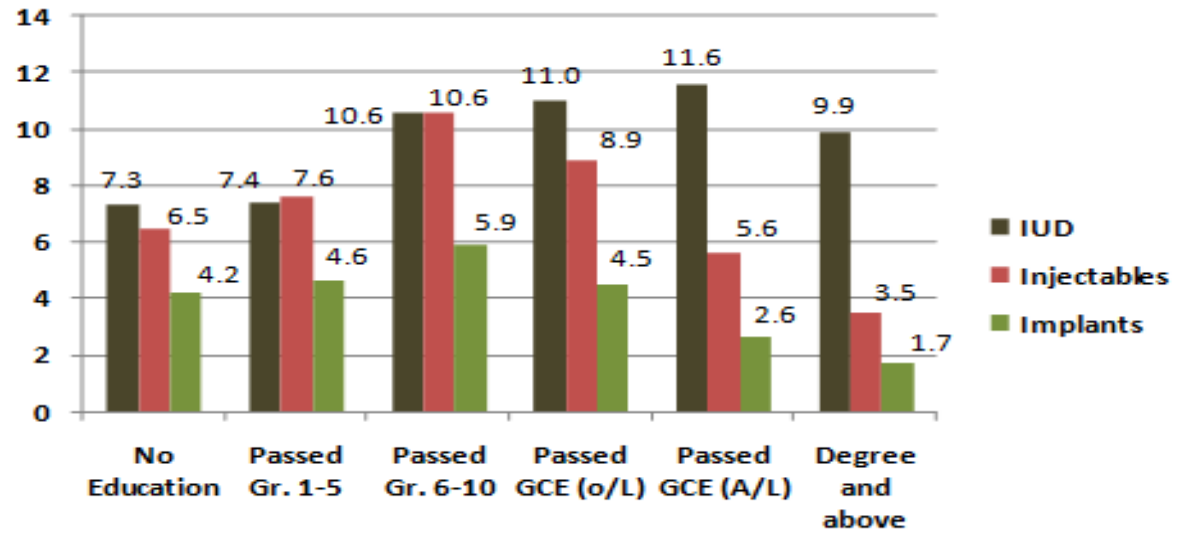
It is evident from Figure 2.8 that the prevalence of modern methods of family planning has declined in the Estate sector during the period 2006 and 2016. The decline may be attributed to the drop in sterilization services which was quite popular in the Estate sector. The prevalence of female sterilization in the estates which was 40 percent in 2006 dropped to 27 percent in 2016 (data not shown in the figure).



Source: DHS 2006(Department of Census and Statistics 2009) and DHS 2016(Department of Census and Statistics 2017) Reports. *2006 data excludes the Northern Province

Figure 2.9: Percentage becoming pregnant while using a method, 2006* and 2016

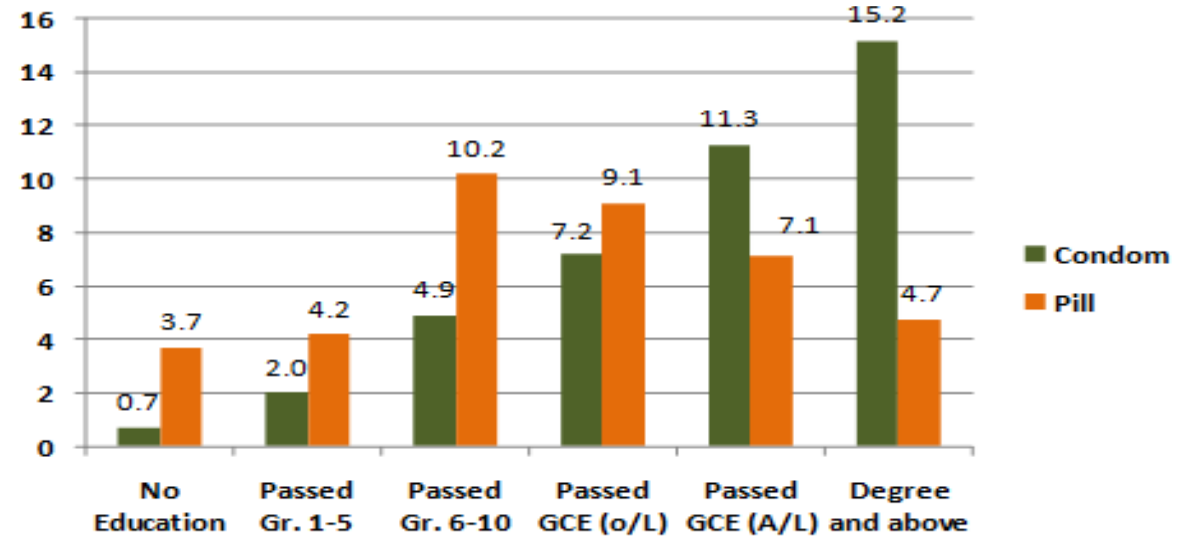
It can be seen from Figure 2.9 the percentage of women becoming pregnant while using a family planning method has shown slight increases for methods such as Pill, IUD and Condoms during the period 2006 to 2016.In the case of traditional methods, such as Rhythm and Withdrawal although the proportions have declined is still relatively high. The need for information and counseling on the proper use of family planning methods is thus evident.



Source:DHS2016 Report(Department of Census and Statistics 2017)

Figure 2.10: Percent current users of clinical methods by education, 2016

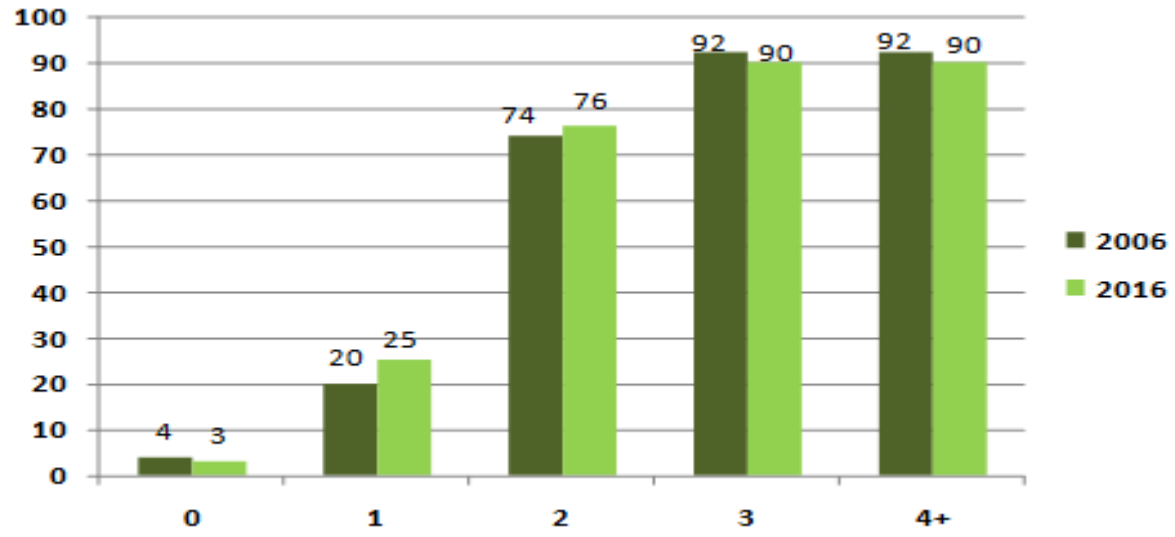
It is seen from Figure 2.10 that IUD and Injectables are more popular among those with education up to GCE(O/L). Among those with GCE (A/L) and Degree above, the single most popular method appears to be the IUD. Thus it is important to ensure the supply chain of these contraceptive commodities without any breakdowns and promote long acting reversible contraceptives.



Source:DHS 2016 Report(Department of Census and Statistics 2017)

Figure 2.11: Current users of supply methods by education, 2016

The demand for condoms appears to have a positive relationship with education. It is also seen that the demand for condoms is more than seven times between those who have passed primary level education and those who have had degree and higher education. As regards the demand for the Pill, the most popular group is those with education from Grade 6 to GCE(O/L) (Figure 2.11).



Source: DHS 2006(Department of Census and Statistics 2009) and DHS 2016(Department of Census and Statistics 2017)Reports. *Excludes the Northern Province

Figure 2.12: Percentage of currently married women who want no more children by number of children, 2006* and 2016

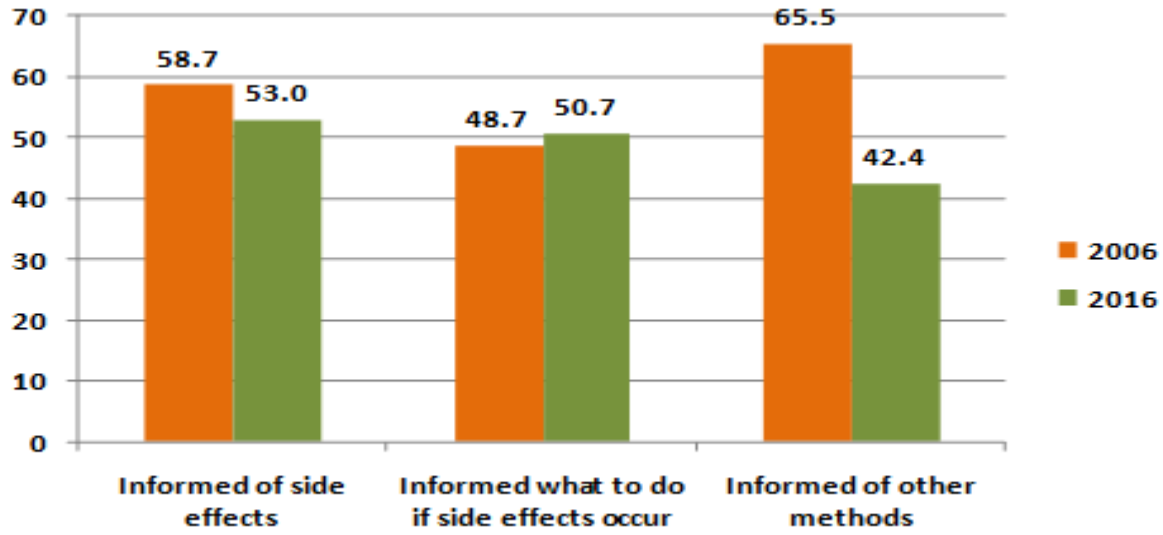
Figure 2.12 clearly demonstrates that a large percentage (90%or more) of currently married women in the reproductive age group who already have 3 or more children do not want any more children. This indicates the potential demand for family planning.

Table 2.5: Percent distribution of users by source of method, 2006* and 2016

Method	Public Sector		Private Sector		Other Sources	
	2006	2016	2006	2016	2006	2016
Female Sterilization	93.9	94.1	5.8	5.7	**	**
Male Sterilization	93.6	**	2.5	**	**	**
Pill	59.7	56.7	39.7	43.0	0.4	0.2
IUD	93.8	96.6	5.8	3.3	**	**
Injectables	68.9	31.5	30.4	68.5	0.2	0.1
Implants	92.0	99.1	8.0	0.9	**	**
Condom	36.4	36.7	59.3	61.1	4.0	2.1

Source: DHS 2006(Department of Census and Statistics 2009) and DHS 2016(Department of Census and Statistics 2017) Reports. *Excludes the Northern Province
** Negligible number

It is evident form Table 2.5 that the permanent methods are mostly provided by the Public Sector. However, it is to be noted that in 2016 the services for male sterilizations have been almost non existent. Between 2006 and 2016 the services for injectables have dropped in the public sector but has picked up in the Private Sector. However, IUD and Implants are mainly made available in the Public Sector. The demand for Condoms and Pills in the Public Sector has more or less remained the same despite the decision to provide these commodities at no cost to the client. It is seen that close to two thirds of the demand for Condoms is met by non-government sources.



Source: DHS 2006(Department of Census and Statistics 2009)and DHS 2016(Department of Census and Statistics 2017) Reports. *Excludes the Northern Province

Figure 2.13: Percentage of users provided informed choice, 2006* and 2016

An important reason for users to dropout while using a method is health concerns, 18.7% for the Pill, 20.6% for IUD and 28.7% for Injectables in 2016 (not shown in Figure 2.13). Proper counseling would certainly reduce the dropout of users. It is clear from Figure 2.13 that the percentage receiving informed choice (of other methods) has significantly declined over the past decade. This is an area that needs to be strengthened.

3 Stagnation to revitalizationof family planning activities: Some lessons from selected countries in the Region

In this section we briefly examine the family planning programmes of selected countries in the Asian region who have gone through lean periods and have overcome them with successful strategies.

Indonesia had one of the strongest and most successful national family planning initiatives in Asia a few decades back with the backing of Muslim religious leaders. With the strong leadership provided by the head of the National Family Planning Board (BKKBN),the country was able to double its contraceptive prevalence rate to 60 per cent between 1976 and 2002 and reduce the total fertility rate from 5.6 to 2.6 children per woman. This among other things helped the country to have an annual economic growth rate of 5 percent during the 1980s(Putjuk 2014).

However, Indonesia's remarkable progress in family planning stagnated in the decade of 2000. The country's contraceptive prevalence rose by only 1.5 per cent. This was due largely to the devolution process that shifted power of the national family planning programme to the district level, leading to confusion about the roles and responsibilities of the national coordinating agency and the district authorities. However, since 2012, the government has revitalized the national family planning programme with the following stategies: a) Strengthen the programme at provincial and district levels, b) Improve the training of health workers, c) improve the facilities at family planning clinics, d) Reach women in homes and in the community, e) Work with Muslim women's groups.

The outreach programmes are supplemented by mass media campaigns with the support of NGOs and the private sector. The programme also use smartphone apps to provide accurate and timely information on family planning. By working with well respected members in the community, the programme aims to show that family planning is both socially and religiously acceptable and dispel common myths and misconceptions around the use of modern contraceptive methods.

Political management

Political support for family planning was seen as one of the main success stories of the Indonesian family planning programme. The National Family Planning Coordinating Board (BKKBN), the government agency responsible for coordinating the national family planning programme was able to address three political challenges: defuse religious opposition, harness political support at the sub-national level and generate implementation support from the government bureaucracy. The BKKBN officials engaged with religious leaders and modified policy in response to their concerns. This approach yielded results. The Muhammadiyals decided to allow the use of contraceptives for the purpose of birth spacing and later trained family planning motivators in cooperation with the BKKBN. The BKKBN officials worked closely with Provincial Governors and obtained their support for the family planning programme. They in turn worked with the Governors' subordinates- district heads and sub-district heads to seek support for the programme. They also worked closely grass root level women's organizations. The agency established national network of village-level family planning groups and build alliances with national women's organizations to support family planning promotion. The BKKBN successfully lobbied with the Ministry of Home Affairs as this Ministry was very important to obtain the support of the bureaucracy. The provincial governors who came under this Ministry not only had authority in the provinces but also were the most powerful officials below the national level. Their subordinates such as district chiefs and sub-district chiefs and lurahs also had administrative authority in their respective territories.

(Shiffman 2004)

The **Thailand** family planning programme has been one of the successfully implemented programmes in Asia. The contraceptive prevalence rate has increased from about 15 per cent in the early 1970s to 75.5 per cent in 2015. The people of Thailand being 95 per cent Buddhists, there has not been any religious opposition to family planning. The Thai government has continuously supported the NGOs and the private sector in the delivery of family planning services. In order to avoid duplication of effort, the Thai national programmeis effectively coordinated. The success of the programme is also attributed to the demographic-economic approach of the programme. Along with the fertility transition, the rapid economic development that took place in Thailand has given the Thai people the message that family planning is a way of improving their quality of life.

The success of the Thai family planning programme is the result of wide availability and accessibility of family planning services at the community level. In addition, all government hospitals have a family planning clinic with trained midwives, nurses and doctors. A postpartum programme which attempted to motivate women in the use of family planning two to four days following delivery showed that with proper motivation efforts many women accept family planning services postpartum (Nepomuceno 1991).Over the past decade, the Thai family planning programme has evolved from a purely family planning commodity service programme to community development programme designed to improve the productivity of the community and improve their welfare. The status of women in the Thai society has facilitated the rapid increase in prevalence of contraceptives. The relationships between men and women in the Thai society are egalitarian than in most developing countries. Thai spouses share equally in decisions regarding children, family life and contraception.

Postpartum Family Planning

In Thailand, the changing contraceptive preference among adolescents and young mothers to the use of LARC has been the effect of immediate postpartum counseling. Young mothers who received immediate postpartum contraceptive counseling showed almost four times greater LARC use than those who only received conventional postpartum counseling. Therefore immediate postpartum counseling has been shown as an important strategy to enable effective contraceptive use, address unmet needs for contraception and optimize birth spacing in young mothers. Thus while there is clear evidence that contraceptive counseling is essential to promote contraceptive use, its benefits depend on timing of counseling.

(Kaewkiattikun 2017)

The official family planning programme in **Bangladesh** commenced in the 1960s. The programme achieved considerable success until the mid 1990s. After that there was a set back resulting in slowing down in the increase in contraceptive prevalence owing to the erosion of political will and commitment to the programme. Although there was no change in official policy regarding the need to slow down the rate of growth of population, the commitment of the political leadership weakened considerably. As a result, it affected the commitment of the officials concerned with programme implementation(Khuda and Barket 2012). The decline in the rate of increase of the contraceptive prevalence has been attributed to a) Erosion in political will and commitment, b) Failure on the part of the 1994 ICPD to clearly operationalize how family planning is to be made an integral part of the reproductive health programme, c) Various organizational weaknesses of the programme, d) Variation in contraceptive use by region and place of residence, e) Low contraceptive use among young married women, f) low number of field worker per population and their poor distribution, g)Declining trend in the relative share of long acting contraceptives and permanent methods, h) High discontinuation rates and i) rising unmet need for contraception.

The unmet need increased to 25 per cent in 2007 across all age groups as well as educational levels. It reflected the problem of breakdown of regular home visits of field workers, shortages in the supply chain of contraceptives and the actual increase in the demand for family planning.

The contraceptive prevalence rate increased from 7.7 per cent in 1975 to 30.8 per cent in 1989 and to 55.8 per cent in 2007. Since then a revival of the programme is seen where the contraceptive prevalence rate has increased to 62.3 per cent in 2014.

The political leadership showed renewed commitment in the mid 1990s. Thus the family planning programme established the following strategies: a) promote family planning before the first birth, b) provide better counseling on side effects, c) hire additional field workers in low performing regions, d) hire, train and update programme personnel, e)improve delivery of family planning as part of post-abortion care, f)use different service delivery approaches for different geographic regions, g) segment the target population by specific characteristics, h) promote the use of longer acting contraceptives and permanent methods, i) strengthen behavioral change communications and j) improve commodity security (Khuda et al. 2012).
Some other strategies envisaged are:work with marriage registrars to reach newlywed couples with family planning messages and organize family planning client fairs in hard to reach areas.

Field Worker Supervision

Despite an intense programmatic input in family planning in Bangladesh, the level of success in terms of contraceptive prevalence has not been uniform across the administrative units of the country. The Chittagong Division, one of the six administrative divisions has been consistently identified as the lowest performing division. Research has shown that lack of effective supervision was a contributory factor for the poor performance of the family planning programme in the Division. Periodic absence of family planning staff from the work place was also a common factor.
(Hanifi and Bhuiya 2001)

In **Malaysia**, the National Family Planning Programme which was launched in 1966 aimed at improving maternal and child health and reducing the rate of population growth from 3 per cent in 1966 to 2 percent by 1985. The National Family Planning and Family Development Board was established in order to plan, execute and coordinate all family planning activities in the country. The programme commenced with the provision of clinical contraceptive services mainly in urban areas. Subsequently, the programme activities were expanded to the rural areas with the integration of family planning with primary health care services of the Ministry of Health in the 1970s.

The contraceptive prevalence rate (CPR) increased from 8 per cent in 1966 to 36 per cent in 1974 and further increased to 52 per cent in 1984. However, since then the CPR has remained more or less stagnant. In 2014, the CPR was 52.2 per cent but the fertility rate has continued to decline to 1.9 in 2016. Rising age at marriage has also been a factor for the continuous decline in fertility.

In the Ministry of Health, family planning services are integrated with other services namely maternal and child care services, and outpatient care including for HIV and sexually transmitted infections. Women who are being followed up for medical reasons in outpatient care are also counseled in family planning. HIV and STI education and counseling are provided during family planning visits.

Logistics management of the family planning programme is decentralized to all the State health departments. The Ministry of Health allocates specific budgets to the State Health Departments for purchasing contraceptive supplies. The funds allocated depend on the State's requirements of contraceptive commodities. In each State programme, the manager

is responsible for purchasing and delivering supplies to the health clinics, which are the service delivery points.

Unmet need for modern contraception for the purpose of limiting births increased from 25 per cent in 1988 to 36 per cent in 2004. Unmet need is more pronounced among those with no education or with only primary level education and also among older and high parity women.

The stagnation in contraceptive prevalence rate and the increase in unmet need showed that there is a need to revitalize family planning. Therefore to improve reproductive health and bring the benefits of family planning to a wider segment of the population, the attention was paid to the following target groups: a) those with unmet need for contraception in order to space births, and prevent unwanted or mistimed births, b) husbands who are apathetic to the benefits of family planning, c) marginalized groups who may lack knowledge of and access to family planning and d) users of traditional methods (Ahmad et al. 2012).

Female Employment and Family Planning

The rising female labour force participation in Malaysia is attributed to economic incentives in employment and policies favouring employment of women. In addition, the combined effects of increase years of schooling, access to family planning services, improved maternal and child care, have allowed women to take advantage of the growing employment opportunities in Malaysia.

(Abu, Nor, and Norehan 2010)

Nepal has a long history of over 50 years in family planning. In 2004, the Ministry of Health and Population was a partner to the Nepal Sector Programme Implementation Plan in Phase I and II with focus on reproductive, maternal and child health. The national family planning programme in Nepal is an integral part of the Health Sector Programme.

Due to inadequate funding and loss of focus on family planning, the targets set for contraceptive prevalence rate was not met. Thus the Ministry of Health expanded the outreach programme through mobile clinics and mobile surgical contraceptive camps. The community health volunteers were recruited to provide family planning counseling and act as depot holders of family planning commodities. The NGOs and INGOs were encouraged to supplement the government programme. In addition, the postpartum IUD programme was launched in 2011 and was expanded through private sector facilities.

Despite the universal knowledge about family planning, there is a high unmet need for family planning. About 25 per cent of women have an unmet need and it is much higher for adolescent girls with 42 per cent (WHO 2016).The utilization of community health volunteers as distributors of family planning products and the involvement of NGOs enabled to revive the programme. The contraceptive prevalence rate in 2016 was 52.6 per cent compared to 37.9 per cent in the year 2000. Female sterilization is the most popular method with a prevalence of 14.7 percent followed by injectable contraceptives with 8.9 per cent. The traditional methods provide about 10 per cent of the protection. These data suggest that Nepal has begun its fertility transition and show an accelerated increase in contraceptive use. Nepal's family planning program is now challenged to expand and strengthen quality services to meet the increased demand for contraceptives.

Emerging Challenges in Family Planning

The Nepal Demographic and Health survey 2011 showed unexpected results of declining contraceptive prevalence rate during 2006 to 2011. A research study identified in 2012 the possible reasons for the decline as high spousal separation, increased use of traditional methods, abortion, emergency contraception and lack of innovative approaches to cater to difficult-to-reach and special sub-groups. The paper notes that to improve contraceptive prevalence, the family planning programme should be implemented more strategically.

(D. R. Shrestha et.al. 2012)

What comes out clearly from the above discussion as important factors contributing to the successful revival of family planning programmes are:(a) political support(b) commitment of officials coordinating, managing and implementing programme activities (c) mass media campaigns with the support of NGOs and the private sector (d) use of smart phone apps to provide accurate and timely information (e) provide family planning knowledge and services to postpartum mothers (f) integrate family planning services with such services as HIV and other sexually transmitted infections (g) use of community health volunteers as distributers of family planning products (h) use different service delivery approaches for different geographic areas (particularly low performing areas), (i) work with marriage registrars to reach newlywed couples with family planning messages and organize family planning client fairs in hard to reach areas,(j) mobilize the support of family planning NGOs and community organizations and (j)effective supervision of field workers.

4 Policy Framework to Revive the Family Planning Programme

4.1 Possible reasons for the recent setback

Over the past decade, family planning activities in Sri Lanka have slowed down where the contraceptive prevalence rate has dropped from 68.4 per cent in 2006 to 64.6 per cent in 2016.However, the Northern Province was not included in the 2006 survey. When the Northern Province is excluded from the data in 2016, the rate is 65.5 per cent still lower than that of 2006. The prevalence of modern methods show only a modest increase from 52.5 per cent to 53.6 percent (54.1% when the northern districts are excluded in 2016). The increase in the prevalence of modern methods is not matched by the decrease in the prevalence of traditional methods which had declined from 15.9 per cent to 11.0 per cent during that period. If one were to use the past relationship between fertility and contraceptive use in Sri Lanka (TFR=9.193 -0.1021CPR), at a contraceptive prevalence rate of 64.6 per cent in 2016, it would give a total fertility rate of 2.6 instead of the reported rate of 2.2.Thus it is evident that factors other than contraception have kept the fertility rate relatively low.

Evidence shows that proximate determinants of fertility such as age at marriage or duration of breast feeding (lactational in fecundability) nor the number of females in the reproductive age group have significantly contributed to this discrepancy.

Thus the possible reasons other than the reported contraceptive use could be induced abortion, use of emergency contraceptive pill to control fertility not being reported (emergency contraception is available in pharmacies and with NGOs. In 2016, the Family Planning Association alone sold 2 million units. However, the DHS 2016 reported a prevalence of only 0.1%). Another reason could be under-reporting of contraceptive use due to religious and political reasons. Also, it is possible that the commitment of field staff in providing family planning services is weak in some geographic areas.

Although the prevalence of induced abortions has declined over the years (Abeykoon 2009), the possibility of using abortion as a family planning method in the context of relatively low fertility may not be ruled out altogether. It is also to be noted that medical abortion pill is available in the private sector though illegal. The Family Health Bureau in its policy statement has noted that “the proportions of maternal deaths due to septic abortions remain unchanged, and available evidence suggests a high number of induced abortions taking place in the country” (Family Planning 2020 Sri Lanka).

In a situation where the contraceptive prevalence is relatively high and shows a decline, it is mainly due to a problem in certain geographic areas. For instance, the DHS 2016 shows that satisfied demand for modern methods of family planning is relatively low in the districts of Batticaloa, Vauniya, Trincomalee, Ampara, Galle, Ratnapura, Matara and in the districts of Western Province. The family planning activities in identified MOH areas in these districts need to be strengthened after identifying the reasons for the decline. Thus in addition to the current activities, the future programmes should focus on identified target areas. For, limited public funds have competing demands not only in other sectors of the economy but also within the health sector itself. Thus public funds should be utilized judiciously to meet the desired goals of the programme.

4.2 The global evidence

Worldwide, there is a large empirically verified demand for family planning to space or limit childbearing. It is estimated that more than 200 million women have an unmet need for modern contraception(United Nations 2017). That is, they are sexually active, they want to delay or stop childbearing, and are not able to use a modern method of contraception. Notably, more than 80 million mistimed or unintended pregnancies occur each year worldwide, contributing to high rates of induced abortions, maternal morbidity and mortality, and infant mortality.

Furthermore, family planning has been found to be an essential approach for countries to achieve their sustainable development goals. Few public health interventions are as effective as family planning programmes at reducing the mortality and morbidity of mothers and infants (Cleland et al. 2006).

In many developing countries in the Asian region, family planning programmes have had different emphasis on demand generation and supply side activities in increasing contraceptive method choice using varying service delivery approaches. Having studied these approaches, Bongaarts and others (Bongaarts, Mauldin, and Phillips 1990)have outlined the key issues that are relevant for strengthening programme performance in a variety of settings as follows:

1) Passive clinical approaches are less successful than that make services available to couples in their villages or home.
2) The quality of services is a crucial but often neglected element of programmes; this entails choice among a number of methods, to be well informed about alternative methods, to have competent and caring providers of services, to have follow-up exchanges with knowledgeable programme staff.
3) No single formula for programme design meets all needs. It is imperative to develop culturally appropriate, sensitive approaches and monitor and adjust programs as a result of lessons learned.
4) Political support for family planning is often critical to establishing strong programme effort.

The above list certainly is very relevant to Sri Lanka in the present context.

4.3 Policy framework on family planning

Several policies with regard to family Planning have been included under the broad framework of health of the mother and child. As stated in Section 1, the first comprehensive policy on family planning was included in the Population and Reproductive Health Policy of 1998. Under Goal 2 of the policy, two Strategies clearly spelled out the importance of family planning as follows:

> "Provide affordable, accessible and acceptable family planning services to protect against unplanned pregnancy."
>
> "Promote family planning so that pregnancies do not take place too early in life or too late in life, are appropriately spaced and are not too many." (Ministry of Health and Indigenous Medicine 1998).

Subsequently, in 2012 the Ministry of Health formulated the National Policy on Maternal and Child Health with 12 Policy Goals. The Policy Goal 7 specifically refers to family planning as follows:

> "Enable all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies" (Ministry of Health 2012).

The Goal 7 had the following strategies:

i. Ensuring availability of, and accessibility to, quality modern family planning services.
ii. Addressing the unmet need for contraception.
iii. Ensuring availability of sterilization services in institutions.
iv. Establishing an appropriate system for post-abortion care.
v. Ensuring the uninterrupted availability of contraceptive commodities
vi. Strengthening, rationalizing and streamlining services for sub-fertile couples

The National Health Strategic Master Plan 2016-2025 (Ministry of Health 2017)in making reference to family planning has stated as follows:

“The need to focus on Family Planning services has become more important than never before. The demographic transition shows that there are a growing (number) proportion of females in the reproductively active age group. Further, some studies show that there are over 650 abortions taking place each day and also according to hospital statistics a significant number of women seek care following septic abortions. Of these septic abortions a significant proportion leads to maternal deaths” (Ministry of Health Nutrition and indigenous medicenes 2017).

The National Strategic Plan on Maternal and Newborn Health in 2017 has stressed under Strategic Objective 2 to “address all causes of maternal, perinatal and neonatel mortality and morbidity” and further promotes the need to “enable all couples/individual optimally time and space their pregnancies while preventing unintended conceptions”.(Family Health Bureau 2017)

The Ministry of Health has outlined the following indicators to assess the progress of the family planning programme:

1) Increase the percentage of eligible families who have their need for family planning satisfied with modern methods, from 74.2% in 2016 to 79.0% by 2025.
2) Reduce unmet need for family planning from 7.5% in 2016 to 5.7% by 2025.
3) Increase the contraceptive prevalence rate from 64.6% in 2016 to 66.4% by 2025
4) Increase the contraceptive prevalence rate of modern methods from 53.6% in 2016 to57.2%by2025.

As part of its policy, the Ministry of Health has stated that wider access to family planning services will be achieved through the engagement of the private sector in a public private partnership (Family Planning 2020 Sri Lanka)

5 Intervention Strategies and Costs

It is evident from the analysis on recent trends in contraceptive use in Section 2 of this report, that the satisfied demand for modern methods is 74.2 per cent meaning that the shortfall of about 25 per cent is due to unmet need and use of traditional methods. Therefore, rather than creating new demand, in the short run, meeting the existing demand is of paramount importance. In particular, efforts should be made to work towards zero unmet need. Sri Lanka has now reached a phase where family planning services have to be provided largely on demand to avoid unintended pregnancies which may lead to induced abortions and in turn could result in maternal morbidity and mortality. In addition, the family planning programme needs to address periodic bottlenecks in service delivery including issues related to provider bias, inadequate guidelines and inconsistent supportive supervision and mentoring.

To provide family planning services on demand, the Rights Based Approach is of paramount importance which will also facilitate the objective of reaching near zero unmet in the future. The Ministry of Health has made the following financial commitment to the family planning programme: 1) The Ministry will commit to make available adequate financial allocations for existing as well as new family planning interventions in order to cater to increasing demands. 2) Inclusion of a budget line on Reproductive Health in the Government Budget in 2019 and 3) The Ministry will commit to procure the required amounts of contraceptives commodities through allocations of maternal and child health commodities(Family Planning 2020 Sri Lanka).

Strategic Action Areas 2019-2025

The following strategic action areas need to be further strengthened to provide better services to family planning clients.

1) Coordinate, monitor and evaluate family planning activities periodically at national and sub national level.
2) Estimate contraceptive requirements for the future and their costs to ensure the commodity chain functions uninterrupted.
3) Strengthen the availability of clinical methods at service points to provide services on demand.
4) Promote family planning as an important element of the national reproductive health programme.
5) Provide family planning information and services on demand to unmarried persons, youth and other special groups.
6) Stregthen counseling and services to couples with primary and secondary sub-fertility.
7) Provide training to Medical Officers and other public health staff.
8) Provide refresher training to health staff
9) Provide advocacy programmes on reproductive health including family planning to elected representatives and media personnel at national and sub-national level.
10) Ensure adequate behavior change communication materials on reproductive health including family planning (both print and electronic) are available at service points and other health facilities as well as with field staff.
11) Strengthen family planning clinics by providing the necessary equipment.
12) Use smart phone apps to provide accurate and timely information on reproductive health and family planning.
13) Ensure equity through focusing on low performing areas

Strategy 1: Coordinate, monitor and evaluate family planning activities

Coordination of the national family planning programme needs to be strengthened. Therefore, a high powered National Coordinating Committee on Reproductive Health (NCCRH) may be established under the Director General of Health Services. The members may include Additional Secretary (Public Health), Deputy Director General (Public Health), Director Maternal and Child Health, Director Health Promotion Bureau, Director Nutrition, Director STD and AIDS, Provincial Directors of Health Services and the Executive Directors of the Family Planning Association of Sri Lanka and the Population Services Lanka. The representatives of the General Practitioners Association, Pharmaceutical Society of Sri Lanka may be opted to the meetings as and when necessary. Leadership and commitment are vital to the success of the family planning/reproductive health programme.

It would useful if the NCCRH could meet periodically at least every quarter of the year to effectively coordinate and monitor the programme at the national and sub-national level. The Director of Family Health Bureau may function as the member secretary of the NCCRH and provide the necessary feedback to the Committee in the form of latest data and briefs on performance including observations during field visits. The Family Planning Unit of the Family Health Bureau should provide the necessary information and data on family planning to the NCCRH. The family planning unit thus needs to be strengthened with additional trained staff and have timely access to family planning data from the RHMIS of the Family Health Bureau.

The monitoring process should include the following: a) identify the expected outcomes of the prioritized strategies b) set performance targets c) develop indicators and d) periodically undertake field supervision to identify bottlenecks.

Every two years it would be necessary to conduct rapid assessment evaluations to ascertain the issues in critical areas of the programme and take corrective actions.

1.1 Rapid Assessment Evaluations

Rapid Assessments	**Year**	**Cost**
Rapid Assessment 1	2021	Rs. 5 Mil
Rapid Assessment 2	2024	Rs 7 Mil

1.2 Field supervision (cost per visit)

Number of visits per year	6
Accommodation for two Medical Officers from FHB	Rs. 8000
Transport costs	Rs. 10,000
Total costs per visit	**Rs. 18,000**

Strategy 2: Estimate contraceptive commodity requirements and costs

2.1Contraceptive logistics

In family planning programmes, logistics management refers to the selection, financing, delivery and distribution of contraceptives and related supplies. Successful family planning programmes deliver the right commodity according to clients' needs. As supply chains often

involve many different procedures, managing family planning logistics is an important factor in successful programmes in meeting the needs of clients. Thus contraceptive supplies depend on well organized activities such as estimation of commodity needs, efficient procurement procedures and timely delivery to the end point of the supply chain. Contraceptive security ensures that individuals are able to choose, obtain and use quality contraceptives whenever they need them. Thus the availability of reliable and quality contraceptives is necessary to ensure that family planning demand is met at all levels of the health care delivery system. Commodity security requires among other things, sufficient and adequate financing, strong supply chain, supportive policies and regulations and effective coordination. It appears that the Family Health Bureau lacks adequate technical capacity to effectively conduct a contraceptive forecasting and quantification exercise. This needs to be rectified soon.

The NFPPR of 2016 has made the flowing important recommendations with regard to contraceptive security.

i. Implement a comprehensive contraceptive forecasting and quantification system
ii. Improve the Logistics Management Information System
iii. Proactively address selective stockouts of contraceptives at the district level
iv. Make improvements to infrastructure and warehouse practices
v. Improve the distribution system
vi. Conduct supportive supervision to Regional Medical Supplies Division
vii. Monitor the quality of products in private sector pharmacies
viii. Recruit a graduate pharmacist for Family Planning Unit as logistics coordinator

2.2 Forecasting contraceptive requirements and costs

In this Report we focus on one aspect of the logistics system, namely, the forecasting and costing of contraceptive needs for the next 7 years (2019-2025). Other aspects have been addressed in the NFPPR report after examining the logistics system. Apart from costing of contraceptive needs, other aspects are management issues that need to be addressed by the Family Health Bureau.

In forecasting the future contraceptive needs and costs, we have employed the Spectrum FamPlan Model v.5.71 using the Proximate Determinants Method(Health Policy project 2018). The following assumptions were made:

The method mix for the base year is based on the DHS data for the year 2016.It is assumed that the method mix will gradually change with further decline in the use of traditional methods as shown in Table 5.The projections of contraceptive needs are based on the following assumptions: The contraceptive prevalence rate would increase from an estimated rate of 65.3% in 2019 to 67.0% in 2025 and the demand for modern methods will increasefrom55.2 % to 57.3 % during the same period (Table 5.2) As a result, the unmet need would decline further to 5.5 % in 2025. These assumptions are consistent with the targets set by the Family Health Bureau (Family Planning 2020 Sri Lanka).The assumed costs per user for Condoms, Injectables and Oral Pills, and for IUDs and Implants costs per acceptor are presented in Table 5.3. The costs per user and acceptor were increased to take into account the price inflation of 10 per cent per year during the projection period in view of the continues depreciation of the Rupee to the US Dollar. The data on contraceptive users for Condoms, Pills and injectables are based on DHS 2016whilethe new acceptor data for IUDs and Implants as well as costs of contraceptives for the base year are based on data available at the Family Health Bureau. The costs of contraceptives are presented in Table 5.4 for the period 2019 to 2025. It is seen that the total budget for contraceptives would increase from Rs. 353.0 million in 2019 to Rs. 707.1 million in 2025. Other outputs such as contraceptive users, new acceptors and unmet need etc are given in Table 5.5.

Inputs:

Table 5.1: Assumptions of method mix, 2019 to 2025

Method	2019	2020	2021	2022	2023	2024	2025
Condom	11.1	11.1	11.2	11.3	11.4	11.4	11.5
Female Sterilization	20.6	20.2	19.7	19.3	18.9	18.4	18.0
Male Sterilization	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Injectables	14.1	14.2	14.4	14.5	14.7	14.8	15.0
Implants	7.6	7.7	7.9	8.0	8.2	8.4	8.5
IUD	16.7	16.9	17.0	17.1	17.2	17.4	17.5
Pill	13.6	13.6	13.7	13.8	13.9	13.9	14.0
Traditional/natural methods	15.3	15.3	15.1	15.0	14.7	14.7	14.5
Total	100	100	100	100	100	100	100

*Source:*IHP assumptions

Table 5.2: Assumptions of proximate determinants, 2019-2025

Indicators	2019	2020	2021	2022	2023	2024	2025
Contraceptive prevalence rate (CPR)	65.3	65.6	65.9	66.1	66.4	66.7	67.0
CPR of Modern Methods	55.2	55.6	55.9	56.3	56.6	57.0	57.3
Total fertility rate	2.19	2.18	2.17	2.16	2.16	2.15	2.14
Percent women in union	68.3	68.6	68.9	69.1	69.4	69.7	70.0
Postpartum insusceptibility (months)	9.0	9.0	9.0	9.0	9.0	9.0	9.0
Sterility (%)	6.8	6.8	6.8	6.8	6.8	6.8	6.8

Source: IHP assumptions and FamPlan model estimates

Table 5.3: Costs per user/acceptor (Rs.)

Method	2019	2020	2021	2022	2023	2024	2025
Condom	443	488	536	590	649	714	785
Injectable	791	870	957	1052	1158	1273	1401
Implants	2,759	3,035	3,339	3,672	4,040	4,444	4,888
Pill	367	404	445	489	538	592	651
IUD	144	158	174	191	210	232	255

Source: IHP assumptions for the government programme

Outputs:

Table 5.4: Costs of Contraceptives, 2019-2025 (Rs. Million)

Contraceptive	2019	2020	2021	2022	2023	2024	2025
Condom	43.2	48.3	53.9	60.4	67.4	75.2	83.9
Injectable	83.9	94.2	105.8	119.0	133.5	149.6	167.2
Implants	144.9	165.4	185.3	211.1	236.2	268.6	300.3
Pill	67.9	75.6	84.4	94.3	105.2	117.4	130.6
IUD	13.1	14.7	16.5	18.3	20.3	22.6	25.1
Total	**353.0**	**398.2**	**445.9**	**503.1**	**562.6**	**633.4**	**707.1**

Source: IHP estimates for the government programme

Table 5.5: Contraceptive users, Acceptors and CYP, 2019-2025

Indicators	2019	2020	2021	2022	2023	2024	2025
Contraceptive Users (Mil)	2.40	2.42	2.45	2.47	2.49	2.51	2.53
New Accptors (000)	188	192	194	196	197	198	201
CYP (Mil.)	1.97	2.00	2.03	2.05	2.06	2.07	2.09
Unmet Need (%)	7.2	6.9	6.6	6.4	6.1	5.8	5.5
Number of unsafe abortions averted due to modern contraception (000)	244	246	249	252	255	257	259
Maternal deaths averted due to modern contraception	157	159	161	163	165	166	168

Source: IHP estimates

The health impacts as a result of increase in the prevalence of modern contraception from an estimated rate of 55.2 per cent to 57.3 per cent would be the aversion of more than 1.7 million abortions. In addition, it would avert about 1,100 maternal deaths (Table 5.5).

Strategy 3: Strengthen the availability of clinical methods at service points to provide services on demand

It has been established that when demand for family planning methods increases, the supply rises to meet the demand and family planning becomes an activity as part of family life. Contraceptive security is usually achieved when individuals can choose, obtain and use quality services whenever they are needed. Demand is created when awareness of modern family planning methods show how to use them and their contribution to improved health and welfare outcomes. Family planning programme managers and service providers need to understand the linkages between family planning and economic welfare goals, gender equality, HIV/AIDS prevention and maternal and child health all of which would support long-term family planning programme impact and sustainability. As the cafeteria approach is followed, it is necessary that at least five modern methods are available at service points. As the acceptance of vasectomy is relatively low due to non availability of services at many service points it is envisaged the initially a medical officer is trained abroad so that he could in turn train other medical officers.

3.1 Training abroad on Vasectomy for one Medical Officer of FHB

Duration: 7 days

Country: Nepal

Costs: International Travel =Rs. 75,000

Daily living allowance; (Rs.16,000 x 7) = Rs. 112,000

Total costs: Rs. 187,000

Strategy 4: Promote Family Planning as an important element of the National RH programme

The family planning programme needs to be re-branded as an important component of the national reproductive health programme aimed at promoting desired quality children. Maternal health and nutrition should be an integral part of the programme. In addition, counseling and services to sub-fertile couples should be an important element of the family planning programme as married couples facing the problem of sub-fertility may experience anxiety, stress and depression.

Family planning is an essential component of primary health care and reproductive health. It plays a major role in reducing maternal and new born morbidity and mortality and transmission of HIV and other sexually transmitted infections. It also helps to prevent unintended pregnancies which may result in induced abortions. Thus family planning information, education and communication (IEC), and behavior change communication (BCC) activities should be linked to other elements of reproductive health to avoid any misconceptions about the family planning programme.

IEC and BCC activities in 2019	Rs. 14.9 Mil

Strategy 5: Provide family planning information and services on demand to unmarried persons, youth and other special groups

Studies show that many unmarried persons are sexually active and need family planning information and services. In addition, women of higher reproductive ages and marginalized groups also need such services.

Family planning services to effectively meet the needs of unmarried and youth, providers must be trained to understand the behavior of young people's sex life and deliver both counseling and appropriate methods to meet their reproductive desires. A comprehensive method mix should be available. The providers should be able to explain how different methods work. The services should be private, confidential and linked to other health services. The services should be available at convenient hours with reasonable waiting time. Evidence suggests that family planning programmes delivering all these components increase the general quality of youth friendly services. A policy decision needs to be made to include unmarried women in future DHS surveys to know about their needs, desires and practice of family planning.

It is necessary to provide young women information and services of Long-acting reversible contraception (LARC). The LARCs provide effective contraception for an extended period without requiring user action. Their failure rate is equal to, or lower than that of female sterilization and is significantly lower than that of Oral contraceptives. Not only are LARC devices very effective, they have higher rate of satisfaction than any other reversible contraceptive (Kolman, Hadley, and Jordahl-Iafrato 2015)

It is necessary to ensure that policies are in place and enforced to facilitate access to services and information to all young people irrespective of marital status and age. It important to conduct outreach programmes to work with community leaders, school teachers and parents to promote supportive attitudes about sexual and reproductive healthcare among adolescents.

Different government agencies address youth issues including the Ministries of Health, Youth Affairs, Women and Child Affairs etc. However, there is a lack of a harmonized policy especially around sexual and reproductive health of young persons. Currently about 17,000 births occur annually to mothers under 20 years of age. Therefore a "teen pregnancy reduction strategy' using a multisectoral approach led by the Family Health Bureau would be useful not only to improve the health of young mothers and children but also to emancipate young women to join the labour force.

Parents, guardians including teachers and the community leaders are key influencers for use of family planning services by youth. Hence, it is important to reach and sensitize them to support a conducive environment for youth to use family planning information and services. With the support of family planning NGOs and the private sector it would be useful to organize and hold youth-led intergenerational public dialogues on radio and TV and community platforms on adolescent/youth sexuality and teenage pregnancies with parents, young people, religious and traditional leaders, and ASRH experts.

Family planning services to marginalized groups are often limited given their locality of residence. Thus it is necessary to have outreach programmes to meet their family planning needs. In this regard, NGOs and community organizations may be supported by government to be partners of this endeavour. It is also necessary to ensure that family planning services are made available in a non-coercive manner. By integrating family planning with other SRH services, there is a greater possibility of addressing the unmet needs of these groups.In providing services to these special groups, the service points should be made friendly and all temporary methods available to them.

5.1 Costs of outreach Programmes

Outreach programmes for targeted audiences	Rs. 1.5 million per year from Government funds

Strategy 6: Strengthen counseling and services to couples with primary and secondary sub-fertility

In Sri Lanka, it is estimated that about 15 per cent of married couples suffer from sub-fertility, with a prevalence of 5 per cent for primary sub-fertility and 10 per cent due to secondary sub-fertility. Due to the past emphasis on fertility control as a means to reduce the rate of population growth, the family planning programme is still seen essentially as a population control programme in certain quarters, rather than as a programme that assist married couples to have desired healthy children. Counseling and treatment of sub-fertility should therefore, be an essential component of the national family planning programme.

Many couples facing the problem of sub-fertility experience anxiety, stress, and depression. Demands and pressures are placed on sub-fertile couples in different cultures. On the other hand, one or both partners may feel guilty or have a sense of failure and as a result cause misunderstanding which may result in breakdown of relationship. Therefore, counseling and treatment of sub-fertility should be an essential component of the national family planning programme. However, currently such facilities are not widely available. The NFPPR (2016) has made several references in this regard as follows: "Management of sub-fertility needs to be addressed in detail in the revised policy" (p15). "Provide refresher training on FP and sub-fertility periodically" (p.21). 'Investigations and advanced treatment for sub-fertility are only available in the private sector" (p.13).

Therefore, it is necessary to have sub-fertility investigations and IUI facilities where there are gynecologists in government facilities up to base hospitals. The costs of equipment if needed should be estimated after undertaking a needs assessment survey. There is a need for a directive to be sent by the Ministry of Health to provide such services where facilities are available at present. The facilities at the sub-fertility clinic of the Family Health Bureau need to be expanded to accommodate more clients. In addition, it is necessary to establish IVF centres in each province starting from Colombo in the Western Province.

Given that only about 10 per cent of married women suffer from secondary sub-fertility, IVF centres need to be established depending on the demand for such services. It is also important to have the necessary trained medical personnel to provide counseling and services.

6.1Sub-fertility training of Medical Officers(National)

Number of programmes per year	2
Number of participants	15
Resource persons	3
Duration of training	2 days
Skill lab	Rs. 25,000
Accommodation	Rs. 4000
Refreshments per participant	Rs. 500
Training material costs	Rs. 15,000
Resource persons per day	Rs. 900

Costs per programme

Accommodation room days (Rs. 4,000 x 24)	Rs. 96,000
Rent of skill Lab (Rs.25,000 x 2)	Rs. 50,000
Refreshments: (22* x Rs. 500 x 2)	Rs. 22,000
Resource persons; (3 x Rs. 900 x2)	Rs. 5,400
Training material costs	Rs. 15,000
Total costs per programme	**Rs. 188,400**

6.2 Sub-fertility training (District)

Number of programmes per year	12
Number of participants	20
Resource persons	3

Duration of training	1 day
Skill lab	Rs. 25,000
Accommodation	Rs. 4000
Refreshments per participant	Rs. 500
Training material costs	Rs. 15,000
Resource persons per day	Rs. 900

Costs per programme

Accommodation room days (24 x Rs. 4,000)	Rs. 96,000
Rent of skill Lab (Rs.25,000)	Rs. 25,000
Refreshments: (27* x Rs. 500)	Rs. 13,500
Resource persons; (3 x Rs. 900)	Rs. 2,700
Training material costs	Rs. 15,000
Total costs per programme	**Rs. 152,200**

Strategy 7: Training of health personnel

7.1Trainingof health personnel in family planning

The use of modern family planning methods usually require an interaction with health workers. Evidence suggests that clients are more likely to trust health information provided by health workers than any other source. Thus it is necessary to have well trained, qualified and motivated health personnel to provide family planning counseling and services. Strengthening the family planning workforce through training to meet contraceptive needs is of paramount importance. The family planning workforce includes doctors, nurses and midwives. Some of the challenges faced by the family planning managers are: i) shortage of health workers ii) uneven distribution of health workers iii) imbalances in the level of skills iv) training not kept in keeping client needs vi) poor supervision and management and vii) negative attitudes of health workers.

Therefore, during the next five years, continuous training of medical officers, nurses and midwives need to be undertaken to meet the client needs of family planning information and services. The costs of such training are outlined below. These costs are based on the discussions with the Staff of the Family Planning Unit of the Family Health Bureau. A price inflation of 5 per cent per year was assumed in the projections of all training programmes up to 2025.

7.1.1Trainingprogrammes for Medical Officers (ToT)

Number of programmes per year	5

Number of participants	25
Resource persons	9
Duration of programme	3 days
Refreshments per participant per day	Rs. 500
Training material costs	Rs. 20,000
Resource person per day	Rs. 900

Costs per programme:

Refreshments: (38* x Rs. 500 x 3)	Rs. 57,000
Resource persons: (9 xRs.900 x 3)	Rs. 24,300
Training material costs	Rs. 20,000
Total cost per programme	**Rs. 101,300**

*four supporting staff

7.1.2Trainingprogrammes for PHNs and PHMs (ToT)

Number of programmes per year	5
Number of participants	25
Resource persons	9
Duration of programme	2 days
Refreshments per participant per day	Rs. 500
Training material costs	Rs. 20,000
Resource person per day	Rs. 900

Costs per programme:

Refreshments: (38* x Rs. 500 x 2)	Rs. 38,000
Resource persons: (9 x Rs.900 x 2)	Rs. 16,200
Training material costs	Rs. 20,000
Total cost per programme	**Rs. 74,200**

*four supporting staff

7.1.3 District level training of health personnel (ToT)

Number of programmes per year	25
Number of participants	25
Resource persons	9
Duration of programme	2 days
Refreshments per participant per day	Rs. 500
Training material costs	Rs. 20,000
Resource person per day	Rs. 900

Costs per programme:

Refreshments: (38* x Rs. 500 x 2)	Rs. 38,000
Resource persons: (9 x Rs.900 x 2)	Rs. 16,200
Training material costs	Rs. 20,000
Total cost per programme	**Rs.74,200**

*four supporting staff

7.1.4Training in PPFP counseling (ToT)

Number of programmes per year	1
Number of participants	10
Resource persons	3
Duration of programme	1 day
Rent for Skills Lab	Rs. 25,000
Refreshments per participant per day	Rs. 500
Training material costs	Rs. 20,000
Resource person per day	Rs. 900

Costs per programme

Rent for Skills Lab (Rs. 25,000)	Rs. 25,000
Refreshments: 17* x Rs. 500	Rs.8,500
Resource persons: Rs. 900 x 3	Rs. 2,700
Training material cost	Rs. 20,000

Total cost per programme	**Rs.56,200**

*four supporting staff

7.2 Postgraduate training

7.2.1Diploma in Reproductive Health (a)

Number of programmes per year	1
Number of participants	50
Resource persons	3
Duration of programme	one day
Refreshments per participant	Rs. 500
Training material costs	Rs.10,000
Resource person per day	Rs. 900

Costs per programme

Refreshments: (57* x Rs.500)	Rs. 28,500
Resource persons: (3 x Rs. 900)	Rs. 2,700
Training material costs:	Rs. 10,000
Total costs per programme	**Rs.41,200**

*four supporting staff

7.2.2 Diploma in family medicine (b)

Number of programmes per year	1
Number of participants	50
Resource persons	3
Duration of programme	0ne day
Refreshments per participant	Rs. 500
Training material costs	Rs. 10,000
Resource persons per day	Rs. 900

Costs per perogramme

Refreshments: (57* x Rs. 500)	Rs. 28,500
Resource persons (3 x Rs.900)	Rs. 2,700
Training material costs	Rs. 10,000
Total costs per programme	**Rs.41,200**

*four supporting staff

7.3 Hospital based training programme (Provinces)

Number of programmes per year	9
Number of participants	40
Resource persons	9
Duration of programme	One day
Refreshments per participant	Rs. 500
Training material costs	Rs. 20,000
Resource persons	Rs. 900
Accommodation for two from FHB	Rs. 8,000
Transport to and from Province	Rs. 10,000

Costs per programme

Refreshments:(53* x Rs. 500)	Rs. 23,500
Resource persons: (9 x Rs.900)	Rs. 8,100
Training material costs	Rs. 20,000
Accommodation	Rs. 8,000
Transport	Rs. 10,000
Total costs per programme	**Rs. 72,600**

*four supporting staff

Strategy 8: Refresher training of health personnel

8.1 Refresher training–National (ToT)

Short-term refresher training courses for health workers are aimed at recalling and reinforcing previously acquired knowledge and skills of health workers through training with the purpose of continuous improvement of their efficiencies on the job. Refresher training also makes it possible to introduce new methods and technologies that would result in increased productivity and reduce the monotony in workers daily routines. The importance of refresher training is highlighted in the NFPPR 2016 as follows; "There is no proper mechanism for refresher training. Many trainees who are selected do not attend the training programmes" (p.12). Thus greater attention and priority need to be given for such training.

Number of programmes per year	2
Number of participants	24
Resource persons	9
Duration of programme	1 day
Refreshments per participant	Rs. 500
Training material costs	Rs. 15,000
Resource person per day	Rs. 900

Costs per programme

Refreshments: (37* x Rs.500)	Rs. 18,500
Resource persons: (9 x Rs 900)	Rs.8,100
Training material costs	Rs. 15,000
Total costs per programme	**Rs.41,600**

*four supporting staff

8.2 Refresher training –District level (ToT)

Number of programmes per year	12
Number of participants	20
Resource persons	3
Duration of programme	1 day
Refreshments per participant	Rs. 500
Training material cost	Rs. 10,000
Resource person per day	Rs. 900

Cost per Programme

Refreshments (27*xRs. 500)	Rs. 13,500
Resource persons (Rs.900 x 3)	Rs. 2,700
Training material (Rs. 10,000)	Rs. 10,000
Total Costs per programme	**Rs. 26,200**

*four supporting staff

Strategy 9: Provide advocacy programmes to elected representatives and media personnel

Family planning is an essential component of primary health care and reproductive health. It plays a major role in reducing maternal and new born morbidity and mortality and transmission of HIV. It also helps to prevent unintended pregnancies resulting in induced abortions. Family planning contributes to the achievement of sustainable development goals. Thus the objective of the behaviour change communication advocacy programme is to reposition family planning in the government programme. Advocacy to seek the support of elected representatives to improve the health of the mother and child and promote sub-fertility treatment should be the focus of the new communication strategy on reproductive health. Access to quality family planning services can significantly reduce induced abortions. Family planning education, counseling and contraceptive services can help in spacing births at intervals recommended for the health of the mother and the baby. Family planning using condoms can provide dual protection from unintended pregnancies and reducing HIV transmission. Thus family planning information, education and communication, and behavior change communication activities should be linked to other elements of reproductive health to avoid any misconceptions about the family planning programme. At present family planning and other reproductive health issues lack sufficient media visibility to urge public attention and discourse. There have been few opportunities for engaging journalists in reporting issues in a consistent manner.

The use of evidence to justify the desired change and demonstrate the potential impact of the change is best practiced when carrying out effective advocacy. Efforts need to be made to review and strengthen the evidence base for family planning to facilitate advocacy efforts, mobilize resources, and enhance the visibility of family planning in the national agenda.

The steps in a good strategy for behavior change communication activities can include the following steps: 1) Identify the issues, ii) Define the goal, iii) Know the audience who accomplish the goal, iv) Find partners who can assist, v) Tailor messages to specific audiences, vi) Decide on methods of communication –face to face, print, e-mail, social media, apps and mail, vii) Advocate – how you will get it done and finally, viii) Follow-up on your target audience.(University of Michigan 2018).

Freedom to determine the number and spacing of one's children is recognized as a basic human right. Thus couples are entitled to accessible and reliable family planning information and services to help them to exercise their rights. Elected representatives, community leaders and media personnel have an important role to play in providing the necessary support and commitment to the national family planning programme. The Family Health Bureau and the Health Promotion Bureau should work closely with the Sri Lanka Parliamentary Group on Population and Development to dispel any misconceptions on family Planning among elected representative at the national and sub-national level and promote among married couples desired quality children.

9.1 Advocacy Seminars on RH for Media Personnel and Elected Representatives 2019-2025

Elected representatives at national and sub-national level	Rs. 23.6 Mil.
Media personnel at national and provincial level	Rs. 4.1 Mil
Total	**Rs. 27.7 Mil.**

The costs for the behavior change communication activities and advocacy seminars to elected representatives were estimated in consultation with the Health Promotion Bureau Staff. A 5 per cent price inflation was assumed in the projection of costs.

Strategy 10: Produce IEC and BCC material for clients

The provision of information, education, and communication (IEC) and behavior change communication material have long been considered as important components of family planning activities. The IEC activities need to have two major objectives: a) to inform the target population of the availability of family planning methods, and b) to educate the family planning clients on the proper use of methods and ensure correct and continued use of temporary methods. Understanding the role that IEC plays in service delivery is critical to the management of the family planning programme. Behavior change communication (BCC) aims at sustainable change in behaviours that contribute to improved reproductive health and use of family planning products and services by addressing social norms, personal attitudes and reducing barriers to reproductive health and family planning. Therefore, periodic evaluation of the effectiveness of IEC and BCC activities should be an essential component of the family planning programme.

10.1Development of IEC and BCC material 2019-2025

Development of videos on FP, 2019 and 2020 (FHB)	**Rs. 2 million**
Development of leaflets on FP, 2019 and 2020	**Rs. 1 million**
Development of posters on FP, 2019 and 2023 (FHB and HPB)	**Rs. 1.9 Million**
Development of booklets on FP, 2020 and 2023 (FHB and HPB)	**Rs. 11.5 million**
Comprehensive sexual education package for youth (HPB), 2019	**Rs. 400,000**
National Family Planning Day 2019-2025 (FHB)	**Rs. 4.1 million**

Strategy 11: Improve service facilities in Clinics

11.1Improve family planning clinics

The availability of equipment and supplies for specific methods is of paramount importance for family planning clinics. Different contraceptive methods require different equipment to ensure method safety and monitor the client. Therefore, periodic upgrading of family planning clinics is of outmost importance to provide quality services.

11.1.1 Equip Reproductive health clinics

Commencement year	2019
Number of new clinics to be equipped	30
Number of existing clinics to be equipped	30
Total estimated costs	**Rs.8 million**

Strategy 12: Use smart phone apps to provide accurate and timely information

In today's technology driven world, smart phones have become essential tools in everyday life. Women appear to be taking a lead role when it comes to smart phone use. Mobile phone apps make participation possible for women to access health care they need including family planning (Jayaseelam, Pechandry, and Rushandvamani 2015). The introduction of smart phone apps to provide correct information on reproductive health and family planning to clients is the way forward.

12.1 Costs of Developing Apps

Development of Apps on RH and FP, 2021 and 2022	**Rs. 2.0 Million**

Strategy 13: Ensure equity through focusing on low performing areas

It is imperative to make family planning more accessible in low performing geographic areas as it is in low performing areas that maternal health outcomes are also poor. Thus family planning can contribute to improve maternal and child health particularly in poor families. Thus it is exactly in those settings where family planning services are most needed to reduce inequalities in health, alleviate poverty and foster economic prosperity.

Data from the 2016 DHS show that the satisfied demand for family planning is relatively low in the districts of Batticaloa, Vavuniya, Galle Matara, Ratnapura, Ampara, Trincomalee, Colombo, Gampha and Kalutara. There could be multiple reasons for the low performance depending on the particular settings such as poor accessibility, limited knowledge, unavailability of method choice, unavailability of services on required days and times, not willing to practice family planning etc. Therefore, in the first instance, it is necessary to conduct a rapid assessment survey in selected MOH areas in these districts to ascertain the reasons for the poor performance and accordingly implement an action programme by the Family Health Bureau in collaboration with family planning NGOs and community health workers.

13.1 Cost of Rapid Assessment Surveys

Cost of Rapid Assessment Survey – 2019 and 2023	Rs. 2.5 Million and 4.0 Million

6 Institutional Arrangements for Implementation of the Action Plan

The implementation of the Action Plan over the next five years will be the responsibility of the Ministry of Health with the leadership role by the Family Health Bureau. The Plan involves all stakeholders engaged in the implementation of the national family planning programme at all levels of the healthcare delivery system. In addition, the Ministry of health will steward the execution through the engagement of a broad range of stakeholders, including key government agencies, family planning NGOs, professional associations, the private sector, community organizations and donor agencies. The coordination of this multisectoral effort has to take place at the national, district and community levels. At each level, government officials, NGO and community members need to be partners of this effort.

Roles and responsibilities of key partners

a) Family Health Bureau

The Family Health Bureau which is the focal point for the national family planning programme, will perform the following key functions: (1) manage, coordinate and monitor the implementation of the plan to ensure the attainment of annual targets; (2) mobilize and ensure efficient use of resources; and (3) set guidelines for programme and service delivery. The following health institutions/authorities will facilitate the implementation plan.

i) **Medical Supplies Division (MSD)**: As MSD is responsible for the procurement of family planning commodities and equipment to foster commodity security, MSD will ensure that procurement, distribution and warehousing systems are effective and efficient.

ii) **National Quality Assurance Laboratory (NQAL**): As it is responsible to oversee quality assurance of health commodities, it will strengthen the quality, safety and efficacy of contraceptive commodities by regulating their importation, storage and use. NQAL will ensure the quality of the commodities as per WHO standards.

iii) **Provincial Health Authorities**

Family planning being a devolved subject, the Ministry of health will work closely with the Provincial and Regional health authorities to coordinate and implement the national family planning programme

b) Other Agencies and Institutions

Since the benefits of family planning interventions cut across beyond the health sector, the interventions of other relevant sector is crucial for the implementation of the plan. Some key partners in this regard include:

i) Department of Census and Statistics (DCS): In addition to the conduct of a Demographic and Health Survey in 2024, which will provide the necessary data to evaluate the impact of the family planning programme, the DCS would assist the MOH to conduct rapid assessment surveys to evaluate the impact at the sub-national level.

ii) Department of National Budget: In accordance with its mandate, the Ministry of Health will collaborate closely with the Budget Department to ensure timely allocation of funds for family planning programme activities.

iii) Ministry of Education: The Ministry of Health will collaborate with the Ministry of Education to ensure the reproductive health curriculum for school

children is in place and facilitate the teaching of the subject to school children at appropriate levels.

iv) **Ministries of Women and Child Affairs; Labour and Youth Affairs**: The Ministry of Health with the support these Ministries will collaborate with womens' organizations; youth clubs and export processing zone establishments to provide the necessary family planning information and services to the workers of these organizations. The HIV/AIDS platform will offer a good opportunity to promote dual protection to prevent unintended pregnancy. The Family Health Bureau, Health Promotion Bureau and the STD/AIDS programme officials may jointly organize these activities.

v) **Parliamentarians and Sub-national level elected Representatives:** induced abortions, maternal mortality and morbidity and Infant child health through better birth spacing as well as female participation in the labour force are issues that will be addressed through elected representatives at the national and sub-national levels. The Health Promotion Bureau in collaboration with the Family Health bureau will jointly organize these activities.

vi) **Research and Academic Institutions and Professional organizations**: Research and academic institutions will be utilized to contribute to the national effort to increase the use of family planning services through research, technical support and training of medical professionals. Similarly professional bodies too would support family planning activities through research, curriculum development, ethics and mentoring.

vii) **Civil Society and non-governmental Organizations:** The Ministry of Health will closely collaborate with family planning NGOs and other civil society organizations and the private sector to effectively supplement the government effort through advocacy and family planning services.

viii) **Donor Agencies:** The UNFPA and the WHO are the key agencies that would provide financial resource, technical expertise and material supplies for the family planning programme. These agencies will in particular closely collaborate with the Ministry of Health in the areas of advocacy and technical expertise.

7 Coordination and Performance Monitoring

Coordination, monitoring and supervision are essential management tools to know the status of implementation of given activities of the national family planning programme. It is a basic management tool to know the activities performed have an effect on the target beneficiaries and eventually meet the programme objectives. The Monitoring process becomes effective if some objective indicators are employed so that the management would know to what extent the activities completed would produce expected effects on the people to whom the services are provided. Periodic evaluation of the effectiveness of the service delivery outcomes should be an essential component of the family planning programme.

At the national level, coordination will be done by the National Coordinating Committee on Reproductive Health (NCCRH) under the chairmanship of the Director General of Health Services. It will be the highest coordinating structure of governance within the Ministry of Health, which will develop strong linkages with non-health Ministries and other agencies to realize the objectives of the national family programme.

With the launch of the Action Plan, there will be concerted effort to establish a performance monitoring mechanism at the Family Planning Unit of the Family Health Bureau. Annual evaluation workshops would enable various stakeholders to review data on several core indicators. Timely availability of service statistics and other information is crucial to assess progress and make programmatic decision making. The Family Health Bureau and Provincial Staff will conduct regular mentoring and supervision at the national and sub-national level to monitor the implementation work plan.

The following matrix would be useful tool to evaluate the progress in terms of outputs and costs on an annual basis.

Table 7.1: Annual Monitoring Plan (example 2019)

Strategic Actions	Activities	Costed Amount	Funds Expended	Remarks
1. Coordination and Monitoring	1. Coordinating meetings (No.) 2. Field visits (No.)	– Rs. 108 Th.	–	
2. Contraceptive Procument	1. Condoms 2. Injectables 3. Implants 4. Pills 5. IUDs	Rs. 43.2 Mil. Rs. 83.9 Mil. Rs. 144.9 Mil. Rs. 67.9 Mil. Rs. 13.1 Mil.		
3. Strengthening of clinical methods	Training in Vasectomy procedure	Rs. 187 Th.		
4. Promote family planning	IEC and BCC (No. of programmes	Rs. 14.9 Mil.		
5. Provide FP information and	Outreach programs (No.)	Rs. 1.5 Mil.		

services				
Strategic Actions	**Activities**	**Costed Amount**	**Funds Expended**	**Remarks**
6. Strengthen counseling and services for sub-fertility couples	Number of training programmes	Rs. 2.2 Mil		
7. Training of health personnel in FP	Number and type of training	Rs. 3.9Mil.		
8. Refresher training in FP	Number and type of training	Rs. 397 Th.		
9. Advocacy for elected Reps. and media	Number and type of advocacy progrmmes	Rs. 3.45 Mil.		
10. Produce IEC & BCC material	Number and type of material	Rs. 14.9 Mil.		
11. Improve facilities in FP clinics	Number and type of supplies provided	Rs. Rs. 8.0 Mil.		
12. Develop smartphone apps on FP & RH	Type and number of Apps developed	(Rs. 2.0 Mil in 2012)		
13. Focus on low performing areas	Rapid assessment survey	Rs. 2.5 Mil.		

Appendix 1: Summary of Strategies

Table A. 1:Summary of Strategies: Key Actions, Costs, Indicators and Responsible Agencies

Strategies	Key Actions	Costs	Indicators	Responsible Agencies
1.Coordinate monitor and evaluate	National coordinating committee and field supervision& Survey	Rs 18,000 per year and Rs. 5Mil in 2021 and Rs. 7 Mil in 2024	No. of meetings and field supervision visits& evaluation results	Family Health Bureau (FHB)
2.Contraceptive commodity services	Estimation of contraceptive requirements	Rs. 353 Mil in 2019 to Rs. 707 Mil in 2025	Supply chain continues uninterrupted	Family Health Bureau; Provincial health authorities
3.Availability of FP services	Trained medial officer in vasectomy	Rs. 187,000 in 2019	Training completed and vasectomy services in place	Family Health Bureau
4.Family planning rebranded	FP as an important component of RH		FP integrated with other RH components	Ministry of Health
5.Provide FP services to special target groups	Outreach programmes for special groups	Rs. 1.5 Mil. per year	Increased prevalence of FP special groups	Family Health Bureau and NGOs
6.Provide training to Medical officers to provide services to sub-fertile couples	Expand services and training of health personnel	Rs. 2.2 Mil in 2019 to Rs. 2.8 Mil in 2025	No. of training programs held and No. of clients served	Family Health Bureau and Provincial health authorities
7.Training of health personnel	Timely training of health personnel	Rs. 3.9Mil in 2019 to Rs. 7.23 Mil in 2025	No. of training programs heldand number trained	Family Health Bureau and Provincial health authorities

Strategies	Key Actions	Costs	Indicators	Responsible Agencies
8.Refresher training of health personnel	Timely conduct refresher training of health personnel	Rs. 397Th in 2019 to Rs.747.2 Th in 2025	No. of training programs held and number trained	Family Health Bureau and Provincial health authorities
9.Advocacy seminars for elected representatives and media personnel	Advocacy seminars and distribution advocacy material	Rs.3.45 Mil in 2019 to Rs. 4.5 Mil in 2025	No. of seminars held, number of participants, No of advocacy material distributed.	Health promotion Bureau and Provincial health authorities
10. Produce IEC and BCC material	Design and production of material	Rs. 14.9Mil in 2019	No. and types of materials produced	FHB and HPB
11. Improve service facilities in clinics	Provide equipment and supplies	Re. 8.0 Mil in 2019	Equipment and supplies in place	Family Health Bureau
12. Develop smart phone Apps.	Make available Apps to the public	Rs. 2.0 Mil in 2021 and 2022	Number of users of Apps	Family Health Bureau
13.Focus on low performing areas	Identify areas through Rapid Assessment methods	Rs. 2.5 Mil in 2019 and 4.0 Mil in 2023	Number of Activities implemented in identified MOH areas	Family Health Bureau and Provincial health authorities

Appendix 2: Summary of Costs of the Action Plan, 2019-2025

Table A. 2: Coordinating Agency: Family Health Bureau

Activity	Year	No.*	Cost	Year	No.*	Cost	Year	No.*	Cost
1.Coordinate, monitor and evaluate	2019	6	Rs.108Th	2020	6	113.4Th	2021	6	Rs. 5.1 Mil
2.Contraceptive commodities	2019	-	Rs. 353.0 Mil.	2020	-	Rs.398.2Mil.	2021	-	Rs.445.9 Mil.
3.Training of Medical Officers	2019	5	Rs. 506.5Th.	2020	5	Rs. 531.8Th.	2021	5	Rs. 558.4Th.
4.Training of PHNs and PHMs	2019	5	Rs. 371.0Th.	2020	5	Rs. 389.5Th.	2021	5	Rs. 409.0Th.
5.District level training	2019	25	Rs. 1.9 mil.	2020	25	Rs. 2.0 Mil.	2021	25	Rs.2.1 Mil.
6. Postpartum training	2019	1	Rs. 56.2 Th.	2020	1	Rs.59.0 Th.	2021	1	Rs. 62.0 Th.
7.Postgraduate training (a)	2019	1	Rs. 41.2Th.	2020	1	Rs. 43.3 Th.	2021	1	Rs. 45.4Th
8.Postgraduate training (b)	2019	1	Rs. 41.2Th.	2020	1	Rs. 43.3 Th.	2021		Rs. 45.4Th.
9.Hospital based training (Prov)	2019	9	Rs.653.4Th.	2020	9	Rs.686.1Th.	2021	9	Rs. 720.4Th.
10.Training in Vasectomy	2019	1	Rs. 187.0 Th.	2020	-	-	2021	-	-
11.Refresher training	2019	14	Rs. 397.6 Th.	2020	14	Rs. 417.5Th.	2021	14	Rs. 438.4 Th
12.Subfertility training	2019	14	Rs. 2.2 Mil.	2020	14	Rs. 2.3 Mil	2021	14	Rs. 2.4 Mil
13.Equipment to FP clinics	2019	-	Rs. 8.0 Mil.	2020	-	-	2021	-	-
14. National FP Day	2019	-	Rs. 600.0 Th.	2020		Rs. 630 Th.	2021	-	Rs. 662 Th.
15. Low performing area (RAP)	2019	-	Rs. 2.5 Mil.	-	-	-	-	-	-
16. Outreach programme	2019		Rs. 1.5 Mil	2020		Rs. 1.5 Mil	2021		Rs. 1.5 Mil
16.IEC material									
a) Vidios on FP	2019	-	Rs.2.0 Mil	2020	-	Rs.2.0 Mil	2021	-	-
b) Develop Apps	2019	-		2020	-		2021	-	Rs.2.0 Mil
c) Dev. and Print posters	2019	-	Rs.400 Th	2020	-	-	2021	-	-
d) Dev. and print leaflets	2019	-	Rs.1.0 Mil	2020	-	Rs.1.0 Mil	2021	-	-
e) Dev. and print FP booklets	2019	-	1.0 Mil	2020	-		2021	-	
f) Sex education package	2019	-	Rs. 400Th	2020	-	-	2021	-	-
Grand Total	**2019**		**Rs.376.9 Mil**	**2020**		**Rs.409.9 Mil**	**2021**		**Rs.461.9 Mil**

Summary of Costs of the Action Plan, 2019-2025 (Appendix 2 continued)

Activity	Year	No.*	Cost	Year	No.*	Cost	Year	No.*	Cost
1. Coordinate, monitor and evaluate	2022	-	Rs. 125.0 Th	2023	-	Rs. 131.3Th	2024	-	Rs. 7.1 Mil
2. Contraceptive commodities	2022	-	Rs. 503.0 Mil	2023	-	Rs. 562.6 Mil	2024	-	Rs.633.4 Mil.
3. Training of Medical Officers	2022	5	Rs. 586.3Th.	2023	5	Rs. 615.7Th.	2024	5	Rs.646.4Th.
4. Training of PHNs and PHMs	2022	5	Rs. 429.5Th.	2023	5	Rs. 451.0Th.	2024	5	Rs.473.5Th.
5. District level training	2022	25	Rs. 2.3 Mil.	2024	25	Rs. 2.4 Mil.	2024	25	Rs. 2.5 Mil.
6. Postpartum training	2022	1	Rs. 65.0Th.	2023	1	Rs. 68.3 Th.	2024	1	Rs.71.7Th.
7. Postgraduate training (a)	2022	1	Rs. 47.7 Th.	2023	1	Rs. 50.1 Th	2024	1	Rs. 52.6 Th.
8. Postgraduate training (b)	2022	1	Rs. 47.7 Th.	2023	1	Rs. 50.1 Th	2024	1	Rs. 52.6 Th.
9. Hospital based training (Prov)	2022	9	Rs.756.4 Th.	2023	9	Rs.794.2Th.	2024	9	Rs.833.9Th.
10. Training in Vasectomy	2022	-	-	2023	-	-	2024	-	-
11. Refresher training	2022	14	Rs 460.3 Th	2023	14	Rs. 483.3 Th	2024	14	Rs. 507.4 Th.
12. Subfertility training	2022	14	Rs. 2.5 Mil.	2023	14	Rs. 2.7Mil.	2024	14	Rs.2.8 Mil
13. Equipment to FP clinics	2022	-	-	2023	-	-	-	-	-
14. National FP Day	2022	-	Rs. 695 Th.	2023	-	Rs. 729 Th.	2024	-	Rs.766 Th.
15. Low performing area (RAP)	2022	-	-	2023	-	RS. 4.0 Mil	2024	-	-
16. Outreach programme	2022		Rs. 1.5 Mil	2023		Rs. 1.5 Mil	2024		Rs. 1.5 Mil
17. IEC material									
a) Vidios on FP	2022	-	-	2023	-		-	-	-
b) Develop Apps	2022	-	Rs.2.0 Mil	2023	-		-	-	-
c) Dev. And Print posters	2022	-	-	2023	-	Rs.400 Th	2020	-	-
d) Dev. And print leaflets	2022	-	-	2023	-		2024	-	-
e) Dev. And print FP booklets	2022	-	-	2023	-	Rs. 1.0 Mil.	2024	-	-
f) Sex education package	2022	-	-	2023	-	-	2024	-	-
Grand Total	**2022**		**Rs.514.5 Mil**	**2023**		**Rs. 578.0 Mil**	**2024**		**Rs. 650.7 Mil**

*Number of programmes per year

Summary of Costs of the Action Plan, 2019-2025(Appendix 2 continued)

Activity	Year	No.*	Cost
1.Coordinate, monitor and evaluate	2025	-	Rs. 144.7Th
2.Contraceptive commodities	2025	-	Rs. 707.1 Mil
3.Training of Medical Officers	2025	5	Rs. 678.8Th
4.Training of PHNs and PHMs	2025	5	Rs. 497.2Th.
5.District level training	2025	25	Rs. 2.5 Mil.
6.Postpartum training	2025	1	Rs. 75.3 Th.
7.Postgraduate training (a)	2025	1	Rs. 55.2 Th.
8.Postgraduate training (b)	2025	1	Rs. 55.2 Th.
9.Hospital based training (Prov)	2025	9	Rs.875.6Th
10.Training in Vasectomy	2025	-	-
11.Refresher training	2025	14	Rs.532.8Th
12.Subfertility training	2025	14	Rs. 2.8 Mil.
13.Equipment to FP clinics			
14.National FP Day	2025	-	-
15. Low performing area (RAP)	2025	-	Rs. 804 Th.
16. Outreach programme	2025	-	-
17.IEC material	2025		Rs. 1.5 Mil
a) Vidios on FP			
b) Develop Apps	2025	-	-
c) Dev. and Print posters	2025	-	-
d) Dev. and print leaflets	2025	-	-
e) Dev. and print FP booklets	2025	-	-
f) Sex education package	2025	-	-
g) Grand Total	2025	-	-
Grand Total	**2025**		**Rs. 717.6 Mil**

*Number of programmes per year

Appendix 3: Summary of Costs of the Action Plan, 2019-2025

Table A. 3: Implementing Agency: Health Promotion Bureau

Activity	year	No.	Cost	Year	No.*	Cost	Year	No.*	Cost
Booklet to promote Family Planning and Happy Family	2019	100,000	Rs. 9.5 Mil	2020			2021		
Capacity building in communication Skill on RH	2019	Five programs	Rs. 1.5 Mil	2020			2021		
Comprehensive sexual education package for youth	2019	CSE Curriculum designed	Rs. 0.4 Mil (UNFPA)	2020			2021		
Posters on RH	2019	2,000	Rs. 0.7 Mil	2020			2021		
Media seminars on RH at National and provincial level	2019	10seminars	Rs. 0.5 Mil	2020	10	Rs. 0.53	2021	10	Rs. 0.56 Mn
RH Seminars for elected representatives of Prasdeshiya Sabha	2019	12 Districts	Rs. 0.9 Mil (UNFPA)	2020	13	RS. 1.0 Mn (UNFPA)	2021	12	Rs. 0.96 Mn (UNFPA)
RH Seminars for elected representatives of Provincial Councils	2019	9 Seminars	Rs. 1.8 Mil UNFPA)	2020	9	Rs. 1.89 Mn	2021	9	Rs. 1.98 Mn
RH Seminars for Parliamentarians	2019	1 seminar	Rs. 0.250 Mil (UNFPA)	2020	1	Rs. 0.263 Mn (UNFPA)	2021	1	Rs. 0275 Mn (UNFPA)
Grand Total	**2019**		**Rs.15.6 Mil**	**2020**		**Rs. 3.7 Mil**	**2021**		**Rs. 3.6 Mil**

Summary of Costs of the Action Plan, 2019-2025(Appendix 3 continued)

Activity	Year	No.	Cost	year	No.	Cost
Media seminars on RH National and Provincial level	2022	10 Seminars	Rs. 0.59 Mil	2023	10	Rs. 0.62 Mil
RH Seminars for elected representatives for Pradeshiya Sabha	2022	13 districts	Rs. 0.9 Mil (UNFPA)	2023	12	Rs. 1.0 Mil (UNFPA)
RH Seminars for elected representatives of provincial Councils	2022	9 Seminars	Rs. 2.1 Mil (UNFPA)	2023	9	Rs. 2.18 Mil (UNFPA)
RH Seminars for Parliamentarians	2022	1 Seminar	Rs. 0.289 Mil (UNFPA)	2023	1	Rs. 0.303 Mil (UNFPA)
Grand Total	**2022**		**Rs. 3.9 Mil**	**2023**		**Rs. 4.1 Mil**

Activity	Year	No.	Cost	year	No.	Cost
Media seminars on RH National and Provincial level	2024	10 Seminars	Rs. 0.65 Mil	2025	10Seminars	0.68 Mil.
RH Seminars for elected representatives for Pradeshiya Sabha	2024	13 districts	Rs 1.1 Mil (UNFPA)	2025	12 districts	Rs. 1.1 Mil (UNFPA)
RH Seminars for elected representatives of provincial Councils	2024	9 Seminars	Rs. 2.29 Mil (UNFPA)	2025	9 Seminars	Rs. 2.4 Mil (UNFPA)
RH Seminars for Parliamentarians	2024	1Seminar	Rs. 0.318 Mil	2025	1 Seminar	Rs. 0.334 Mil
Grand Total	**2024**		**Rs. 4.4 Mil**			**Rs. 4.5 Mil**

People Consulted

1. Dr. N. Mapitigama, Acting Director, Family Health Bureau, Ministry of Health
2. Dr. S.S. Godakandage, Consultant Community Physician, Head, Family Planning Unit, Family Health Bureau, Ministry of Health
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4. Dr. C de Silva, former Deputy Director, Family Health Bureau, Ministry of Health
5. Dr. Paba Palihawardana, Director, Health Promotion Bureau, Ministry of Health
6. Dr. Gamini Samarawickrama, Medical Officer, Health Promotion Bureau, Ministry of Health
7. Dr. J. Gunasekera, Medical Registrar, Health Promotion Bureau, Ministry of Health
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11. Mrs. Ritsu Nacken, UNFPA Representative in Sri Lanka
12. Mrs. Madu Dissanayake, Assistant Representative, UNFPA Sri Lanka
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