

**Summer Training at
UNFPA, Rajasthan
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**AN ANALYSIS OF FAMILY PLANNING SERVICES IN
RAJASTHAN STATE AT UNFPA, JAIPUR**

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**Under the guidance of
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**Post Graduate Diploma in Hospital and Health Management
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CERTIFICATE

This is to certify that the work on the summer training entitled "An Analysis of Family Planning services in Rajasthan state at UNFPA (United Nations Population Fund) Jaipur, has been done by Dr. Preeti Pareek under my personal guidance and supervision.

All the investigations related to the study were carried out by the candidate herself. Her approach to the subject was sincere and analytical.

This work is submitted in partial fulfilment of the requirement for the award of the Post Graduate Diploma in Health Management.



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August 29, 2013

TO WHOM IT MAY CONCERN

This is to certify that Dr. Preeti Pareek has undertaken her internship in UNFPA Rajasthan State office in India from 28th March to 15th June 2013. During her internship with UNFPA, Dr. Pareek has undertaken very competently the responsibilities given to her during the internship. She has shown keen interest in understanding UNFPA's programmes in the country, particularly about the programmes in Rajasthan. She took keen efforts in gaining updates on the Population stabilization and Reproductive health programmes that are being implemented in the State.

Dr. Pareek during her internship worked on the analysis of the Family Planning services with reference to the static centers and Camps, Analysis of the IUD services, analysis of the high loaded institutions with respect to the deliveries and adoption of the FP methods in these institutions and an analysis of trends in NSV in the State. During her internship, she has developed presentations and posters on the topics related to the internship and has presented the same before her faculty and UNFPA state officials.

Dr. Pareek is a hard working professional and has got good analytical skills. She has taken initiative in meeting the different stakeholders as part of her internship to complete her work.

We hope Dr. Pareek has benefitted from this internship and we wish her success in her career and future endeavour.

A handwritten signature in black ink, appearing to read "ATL", is positioned above the name of the Deputy Representative.

Anders Thomsen
Deputy Representative

Acknowledgement

This is a 2.5 months summer training report from 28th March 2013 to 15th June 2013 in UNFPA Rajasthan. This training wouldn't have been completed without a substantial support of great number of people. Although it is not possible to acknowledge each and every person individually, I would like to thank all those who contributed their time and efforts. At the onset of the report I would like to acknowledge my sincere thanks to our institute, Institute of Health Management and Research Jaipur for providing me a platform to gain knowledge and skills in different aspects of health management. With profound gratitude and gratefulness, I express my deep indebtedness to Colonel Ashok Kaushik, Dean Academics IIHMR, Placement coordinator Mr. Dalbir for arranging our internship at UNFPA Rajasthan and their guidance and support during this training.

I would like to thank the officials at the UNFPA Rajasthan, for giving me this opportunity of endless learning there for 2.5 months. I would like to acknowledge the immense support given to me Mr Sunil Thomas Jacob (UNFPA), Mr. Rajnish and Mr. Pankaj Saxena. I would like to thank all other staff members at UNFPA Rajasthan for being so helpful all the time and making this summer training project an unforgettable experience who despite their pre-occupations and busy schedule were there to guide me on my project.

I would like to give my sincere gratitude to Mrs Monika Choudhary for their rational criticism, keen interest and valuable expert suggestion. Finally I also extend our heartfelt gratitude to The Director of IIHMR, Dr S D Gupta for giving us a platform and opportunities in health care sector. Last but not the least, I wish to thank the people whose insights and experience have shaped the content of this study.

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Acronyms / Abbreviations

ANM – Auxiliary Nurse Midwife
APL – Above Poverty Line
ASHA – Accredited Social Health Activist
AVSC – Association of Voluntary Surgeons for Contraception
AWW – Anganwadi Worker
BPHC – Block Primary Health Centre
BPL – Below Poverty Line
CC – Conventional Contraceptive
CHC – Community Health Centre
CMHO – Chief Medical and Health Officer
CMO – Chief Medical Officer
CPR – Contraceptive Prevalence Rate
CS – Civil Surgeon
CTI – Collaborating Training Institute
DH – District Hospital
DHO – District Health Officer
DLHS – District Level Household Survey
ECP – Emergency Contraception Pill
ELA – Expected Level of Achievement
FDS – Fixed Day Static
GOI – Government of India
IEC – Information and Education Campaign
IUCD – Intrauterine Contraceptive Device
JD – Joint Director
LHV – Lady Health Visitor
MOHFW – Ministry of Health and Family Welfare
NFHS – National Family Health Survey
NGO – Non Governmental Organization
NIHFW – National Institute of Health and Family Welfare
NRHM – National Rural Health Mission
NSV – No Scalpel Vasectomy
OCP – Oral Contraception Pill
OT – Operation Theatre
PHC – Primary Health Centre
PIP – Project Implementation Plan
POL – Petrol, Oil and Lubricant
QAC – Quality Assurance Committee
RCH II – Reproductive and Child Health Program II
SC – Scheduled Caste
SC – Subcentre
SDH – Sub District Hospital
SIHFW – State Institute of Health and Family Welfare
ST – Scheduled Tribe
TFR – Total Fertility Rate

Introduction of UNFPA

Introduction

The United Nations Population Fund-UNFPA is an international development agency that works on population and development, sexual and reproductive health, and gender. In the area of ageing populations, UNFPA supports public policy and promotes policy dialogue to respond to the challenges posed by the social, health, and economic consequences of ageing populations – and to meet the needs of older persons, with particular emphasis on the poor, especially women.

The work of the UNFPA involves promotion of the right of every woman, man and child to enjoy a life of health and equal opportunity. This is done through major national and demographic surveys and with population censuses. The data generated are used to create programmes to reduce poverty and address issues concerning the rights of particular minority population groups. The UNFPA supports programs in more than 150 countries, territories and areas spread across four geographic regions: Arab States and Europe, Asia and the Pacific, Latin America and the Caribbean, and sub-Saharan Africa. Around three quarters of the staff work in the field. It is a member of the United Nations Development Group and part of its Executive Committee.

Mission

UNFPA, the United Nations Population Fund, delivers a world where every pregnancy is wanted, every birth is safe, every young person's potential is fulfilled.

Meeting developmental goals-

UNFPA partners with governments, other agencies and civil society to advance UNFPA's mission. Two frameworks guide its efforts: the Programme of Action adopted at the 1994 International Conference on Population and Development and the Millennium Development Goals, eight targets to reduce extreme poverty by 2015. Since the date for achieving these goals and targets is fast approaching, work is being accelerated to analyze successes, to galvanize support and to redouble efforts.

The goals of UNFPA - achieving universal access to sexual and reproductive health (including family planning), promoting reproductive rights, reducing maternal mortality and accelerating progress on the ICPD agenda and MDG 5 - are inextricably linked. UNFPA also focuses on improving the lives of youths and women by advocating for human rights and gender equality and by promoting the understanding of population dynamics. Population dynamics, including growth rates, age structure, fertility and mortality and migration have an effect on every aspect of human, social and economic progress. And sexual and reproductive health and women's empowerment all powerfully affect and are influenced by population trends.

Population and development strategies

As the world population edged to 7 billion people in 2011 (up from 2.5 billion in 1950), it has had profound implications for development. Governments need to gather adequate information about population dynamics and trends to create and manage sound policies and generate the political will to address both current and future human needs. UNFPA supports governments in these tasks, including censuses, surveys and population and development-related research and analysis. Key areas of focus include migration, ageing, climate change and urbanization. The 7 Billion Actions campaign, led by UNFPA and partners, engages people from all walks of life in these issues.

Sexual and reproductive health

Working with a range of partners, UNFPA assists governments in delivering sexual and reproductive health care throughout the life cycle of women and youths. These areas include:

- Voluntary family planning
- Antenatal, safe delivery and post-natal care
- Prevention of abortion and management of its consequences
- Treatment of reproductive-tract infections
- Prevention, care and treatment of sexually transmitted infections, including HIV
- Information, education and counselling, as appropriate, on human sexuality and reproductive health
- Prevention of violence against women, care for survivors of violence and other actions to eliminate traditional harmful practices
- Appropriate referrals for further diagnosis and management of the above.

Improving maternal health, MDG5, is a key UNFPA priority and the MDG target lagging the most. Important UNFPA initiatives include the Maternal Health Thematic Fund, the Campaign to End Fistula and numerous partnerships. The importance of universal access to reproductive health is underscored by the fact that it was added as an MDG target by the international community in 2005.

Access to reproductive health care also demands what UNFPA calls reproductive health commodity security, the ability for all individuals to obtain and use quality reproductive health supplies of their choice whenever they need them. This is the aim of the UNFPA-led Global Programme on Reproductive Health Commodity Security. Expanding access to reproductive health care also relies on skilled midwives and other health-care workers.

Family Planning

Some 215 million women worldwide who would like to avoid or delay a pregnancy lack access to effective contraception. Fulfilling this unmet need for modern family planning in the developing world would reduce unintended pregnancies to 22 million from 75 million. UNFPA advocates for the right of all people to voluntarily decide the number and timing of their children. It supports programmes that improve access to and affordability of family planning services, offer a

broad selection of choices, reflect high standards of care, are sensitive to cultural conditions, provide sufficient information about their use and address other reproductive health needs of women.

Gender equality and women's empowerment

The importance of gender equality and women's empowerment to development progress is underscored by its inclusion as one of the Millennium Development Goals. In fact, gender equality drives all the MDGs and is intimately linked and connected to goals to improve maternal and newborn health and reduce the spread of HIV.

UNFPA's gender framework incorporates four strategies that address critical factors behind inequalities and rights violations: girls' education, women's economic empowerment, women's political participation and balancing reproductive and productive roles.

UNFPA also brings gender issues to wider attention and promotes legal and policy reforms and gender-sensitive collection. It works to end gender-based violence, including traditional practices that harm women, such as child marriage and female genital mutilation/cutting as well as pre-natal sex selection. UNFPA also raises awareness of women's strengths, vulnerabilities and needs in a variety of situations and issues, such as humanitarian emergencies, climate change and migration. It recognizes the rights, perspectives and influences of men and boys and seeks to involve them in promoting gender equality and improving reproductive health.

Promoting and protecting fundamental human rights, including reproductive rights, lie at the core of UNFPA activities. That is why the Fund places priority on reaching those with the greatest needs, whether it be related to poverty, marginalization, emergencies, age, sex, ethnicity or health.

Culturally sensitive human rights-based approaches

A strong emphasis on the human rights, including reproductive rights, of individual women and men underpins all of UNFPA's work. Promoting and protecting human rights, including reproductive rights, of women and men requires considerable cultural fluency as UNFPA works in some of the most sensitive and intimate spheres of human existence, including sexuality, gender relations and population issues. Since 2002, UNFPA has emphasized the integration of culturally sensitive approaches into its programmes. In doing so, it has worked closely with communities and with local agents of change, including religious leaders and faith-based organizations.

Supporting adolescents and youth

About one-quarter of the world's people is between 10 to 24 years old. UNFPA promotes and protects the rights of this important generation, particularly adolescent girls, and strives to achieve a world in which girls and boys have the best opportunities to develop their full potential, to express themselves freely, to have their views respected and to live free of HIV, poverty, discrimination and violence.

UNFPA's four keys to ensuring opportunities for young people include incorporating youth issues into national development and poverty-reduction strategies; expanding access to gender-sensitive sexual and reproductive health education that encourages the development of life skills; promoting a core package of health services and commodities for young people; and encouraging youth leadership and participation.

Responding to the AIDS epidemic

UNFPA's contribution to the global response to AIDS reflects its mandate to reduce poverty, eliminate gender inequality and ensure universal access to sexual and reproductive health. As a co-sponsor of UNAIDS and under the UNAIDS division of labour, UNFPA focuses its response on HIV prevention among young people, women and marginalized groups, including within the context of sex work. It supports comprehensive programming for male and female condoms and advocates the linking and integration of sexual and reproductive health and HIV policies, programmes and services. UNFPA ensures that family planning and maternal health services meet the needs of women living with HIV. This includes interventions to prevent mother-to-child transmission and support for confidential voluntary HIV testing and counselling.

UNFPA also works in many contexts, including humanitarian and post-conflict situations, toward the elimination of gender-based violence and prevention of HIV.

Assisting in emergencies

In times of upheaval and conflicts, pregnancy-related deaths and sexual violence soar. Reproductive health and obstetric services often become unavailable. Young people become more vulnerable to HIV infection and sexual exploitation. Too often, the special needs of women and young people are overlooked in humanitarian emergencies.

Within the coordinated interagency response to disasters, UNFPA takes the lead in providing supplies and services to protect reproductive health, emphasizing the special needs and vulnerabilities of women and young people. Both groups can figure prominently in rebuilding peace or communities.

UNFPA supports various data collection activities, including censuses to provide detailed information for planning and rapid health assessments to allow for appropriate, effective and efficient relief. It also assists stricken communities as they move beyond the acute crisis stage and enter the reconstruction phase.

Data Collection Process

Data collection process

Once the evaluation purposes, objectives, questions and standards for assessing the programme have been selected the adequacy of existing information to provide answers to the evaluation questions which meet the selected measurement standards should be reviewed. Up to date programme results statements (outputs, outcomes and impact) and corresponding indicators as stated in the programme results and resources frameworks (RRFs) are some of the readily available information on standards established for UNFPA's programmes and their components. It is important to ensure that indicators and means of verification are regularly reviewed and updated to enable effective assessment of programme progress and performance.

Additional information to be used by the evaluation, including analysis of implementation processes to achieve planned results, can be obtained from programme work plans; progress and evaluation reports; field monitoring visit reports; technical assessments and survey reports; clinic statistics; research reports; government policy documents and the like. Analysis of existing data can be helpful to refine evaluation questions, identify informants for subsequent interviewing, develop interview protocols, and determine what data important to the evaluation is missing and should be collected by the evaluator, below following highlights some useful criteria for determining the need for additional data.

Useful questions to help determine the need for additional data.

- What level of detail is required? What difference would it make if additional information is or is not obtained?
- How will the additional information be used? It is important to collect only the information, which will be used and to use all the information collected.
- How credible are different types of data to the intended users of evaluation results? The level of credibility of data sources and data collection methods determines the acceptance and use of evaluation conclusions and recommendations by the intended users.
- When is the information needed? Time constraints may determine the length and nature of additional data collection exercises.
- What resources are available for the evaluation? The availability of expertise and financial resources determines the sophistication of additional data collection.

Introduction of Family Planning

Introduction

India launched a nationwide Family Planning Programme in 1952, which was later, expanded to cover maternal and child health, family welfare and nutrition. As per available data from SRS, there has been a gradual decline in the share of population in the age group 0-14 from 41.2 to 38.1 per cent during 1971 to 1981 and 36.3 to 29.5 percent during 1991 to 2011, whereas, the proportion of economically active population (15-59 years) has increased from 53.4 to 56.3 percent during 1971 to 1981 and 57.7 to 62.5 per cent during 1991 to 2011. India higher proportion of population is between 15-59 years and it constitutes 62.5 % of total population.

Unmet need of Family Planning: This includes the currently married women, who wish to stop child bearing or wait for next two or more years for the next child birth, but not using any contraceptive method. Total unmet need of Family Planning is 21.3% (DLHS-III) in our country.

Age at Marriage and first childbirth: In India 22.1% of the girls get married below the age of 18 years and out of the total deliveries 5.6% are among teenagers i.e. 15-19 years. The situation regarding age of girls at marriage is more alarming in few states like, Bihar (46.2%), Rajasthan (41%), Jharkhand (36%), UP (33%), and MP (29.2%). Delaying the age at marriage and first child birth could reduce the impact of Population Momentum on population growth.

Spacing between Births: Healthy spacing of 3 years improves the chances of survival of infants and also helps in reducing the impact of population momentum on population growth. NFHS III data shows that In India, spacing between two childbirths is less than the recommended period of 3 years in 61% of births. Nationwide, the small family norm is widely accepted (the wanted fertility rate for India as a whole is 1.9: NFHS-3) and the general awareness of contraception is almost universal (98% among women and 98.6% among men: NFHS-3).

Both NFHS and DLHS surveys showed that contraceptive use is generally rising. Contraceptive use among married women (aged 15-49 years) was 56.3% in NFHS-3 (an increase of 8.1 percentage points from NFHS-2) while corresponding increase between DLHS-2 & 3 is relatively less (from 52.5% to 54.0%).

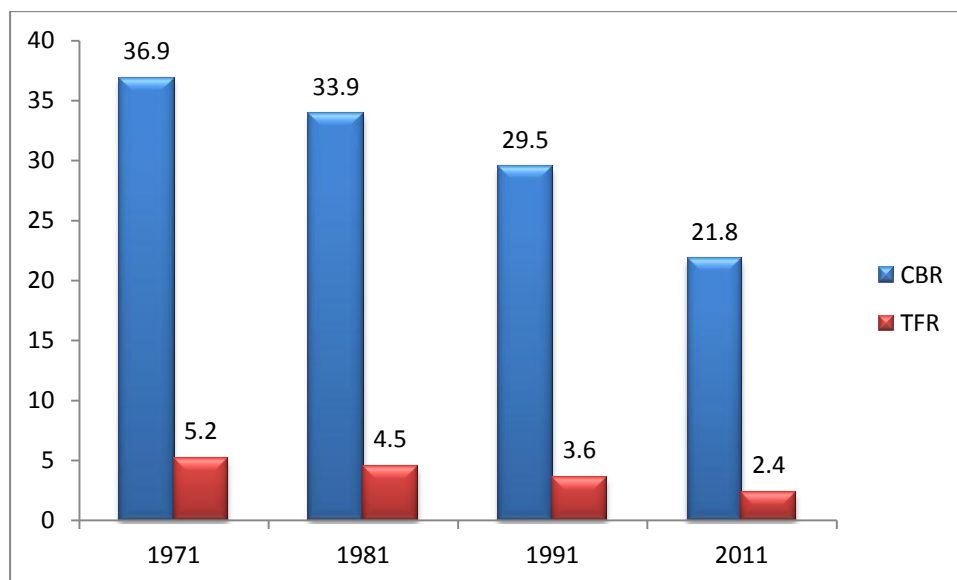
In 1996 the Government of India initiated the Target-Free Approach (TFA) in family planning as a result of dissatisfaction with over-emphasis on demographic targets, leading to a numbers game, insensitivity to client needs, low demographic impact, violation of reproductive rights, neglect of the quality aspect, and stagnation of the programme. The process and the results of implementation, as documented in various reports, have been analysed to learn lessons from the pilot and the expanded programmes.

There were periodical reverses, and the implementation has been uneven. The following factors are critical for the success of the TFA: Commitment of the top bureaucratic leadership; political, administrative and academic support, local adaptation of the approach; effective communication and training; thorough assessment of the clients' needs; effective monitoring and evaluation systems; and mobilisation of community support.

Demographic status

India has the distinction of being the first country in the developing world to initiate a family planning programme-it later came to be called the Family Welfare Programme (FWP)-with a view to bring down the country's fertility level and contain population growth. Fertility levels have come down throughout the country, albeit at varying paces in different regions.

The crude birth rate (CBR) at all India level had declined from 36.9 in 1971 to 33.9 in 1981, registering a fall of about 8 per cent, During 1991-2011, the decline has been about 26.1 per cent from 29.5 to 21.8. The rural-urban differential has also narrowed over these years. However, the CBR has continued to be higher in rural areas compared to urban areas in the last three decades.



The total fertility rate (TFR) of country has declined from 5.2 to 4.5 during 1971 to 1981 and from 3.6 to 2.4 during 1991 to 2011. The TFR in rural areas has declined from 5.4 to 2.7 from 1971 to 2011 whereas the corresponding decline in urban areas has been from 4.1 to 1.9 during the same period. In 2011, around 67 per cent of the deliveries were institutional which includes Government as well as private hospitals. The percentage of institutional deliveries in urban areas is 87.9 as against about 60.7 percent recorded in rural areas.

Commonly practiced Family Planning methods include birth control pills, condoms, sterilization and IUD (Intrauterine device). The efforts of the Government in implementing the Family Planning Programme have significant impact in the country.

Rajasthan

The north western Indian state of Rajasthan has 68.62 million population (census 2011). The decadal growth rate of the state is 21.44 per cent (against 17.64 per cent for the country), and the population of the state continues to grow at a rate much faster than the national rate. Rajasthan is divided into six zones covering 33 Districts, 237 blocks and 41,353 villages. The state is largely rural and 80 per cent of the population is dependent on agriculture for livelihood, water availability is very low.

More than 60 per cent of Rajasthan is desert, with 1 per cent of India's water resources to support 10 per cent of the country's land and 5 per cent of the population. Drought and scarcity conditions are common, as are food shortages and even famine. This situation is compounded by unequal land distribution, with 50 per cent of landholdings less than two hectares in size and cover only 10 per cent of the total area under cultivation. Rajasthan is a net out-migrating state and migrants from this state go to all parts of the country, especially to the big urban centres in India.

Indicators	Rajasthan	India
Population census 2011	68.62 million	1210.2 million
Decadal population growth rate, 2001-2011.	21.44	17.64
Sex Ratio	926	940
Literacy Rate Total	67.06	74.04
Literacy rate Male	80.51	82.14
Literacy rate Female	52.66	65.46
Total Fertility Rate	3.1	2.4
Infant mortality Rate	52	44
Maternal mortality Ratio	264	

Objective of FP

- Ensure optimal conditions for the couples and individuals to accomplish their reproductive function.
- Achieve the ideal – “each pregnancy has to be wanted and planned”.
- Decrease the role of abortion as a birth control method by providing modern contraceptive methods.
- Increase the level of the population's knowledge on advantages and benefits of the family planning.
- Increase the access to and affordability of qualified family planning and reproductive health services.

- Enhance the active and aware participation of women, men and youth in regarding reproductive options decision-making.
- Optimize the monitoring, evaluation and report system in family planning.

The objectives, strategies and activities of the Family Planning division are designed and operated towards achieving The family welfare goals and objectives stated in various policy documents (NPP: National Population Policy 2000, NHP: National Health Policy 2002, and NRHM: National Rural Health Mission) and to honour the commitments of the Government of India (including ICPD: International Conference on Population and Development, MDG: Millennium Development Goals and others)

The purpose of family planning is to make sure that any couple, man, or woman who has the desire to have a child has the resources that are needed in order to complete this goal. Raising a child requires significant amounts of resources: time, social, financial, and environmental. Planning can help assure that resources are available. With these resources a couple, man or women can explore the options of natural birth, surrogacy, artificial insemination or adoption. In the other case, if the person does not wish to have a child at the specific time, they can investigate the resources that are needed to prevent pregnancy, such as birth control, contraceptives, or physical protection and prevention.

Methodology

Methodology

The study is based on secondary data analysis; the data collected from the MOHFW department of Rajasthan. This comparative study of last 4 years shows the different trends in terms of Family planning service utilization in state.

There are different parameters of this study are as follows

1. Sterilization services at static centre & camps in last 4 years
2. IUD utilization in last 4 years
3. High loaded delivery institutions in last 2 years
4. NSV utilization in last 4 years

Factors that influence population growth:

Factors influencing population growth can be grouped into following 3 categories-

Unmet need of Family Planning: This includes the currently married women, who wish to stop child bearing or wait for next two or more years for the next child birth, but not using any contraceptive method. Total unmet need of Family Planning is 21.3% (DLHS-III) in our country.

Age at Marriage and first childbirth: In India 22.1% of the girls get married below the age of 18 years and out of the total deliveries 5.6% are among teenagers i.e. 15-19 years. The situation regarding age of girls at marriage is more alarming in few states like, Bihar (46.2%), Rajasthan (41%), Jharkhand (36%), UP (33%), and MP (29.2%). Delaying the age at marriage and first child birth could reduce the impact of Population Momentum on population growth.

Spacing between Births: Healthy spacing of 3 years improves the chances of survival of infants and also helps in reducing the impact of population momentum on population growth. NFHS III data shows that In India, spacing between two childbirths is less than the recommended period of 3 years in 61% of births.

Some positives:

Total Fertility Rate (TFR):

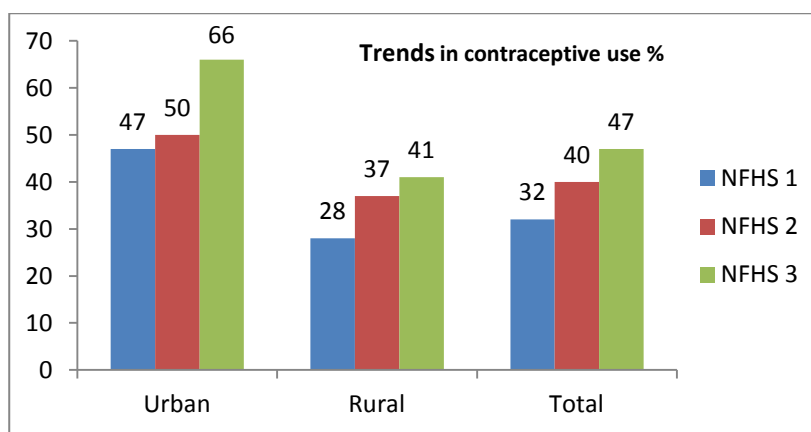
Total Fertility Rate (TFR) in the country has recorded a steady decline to the current levels of 2.5 (SRS 2010), 21 States/ UTs have already reached the replacement level of fertility i.e. TFR of 2.1:

2005	2006	2007	2008	2009	2010
2.9	2.8	2.7	2.6	2.6	2.5

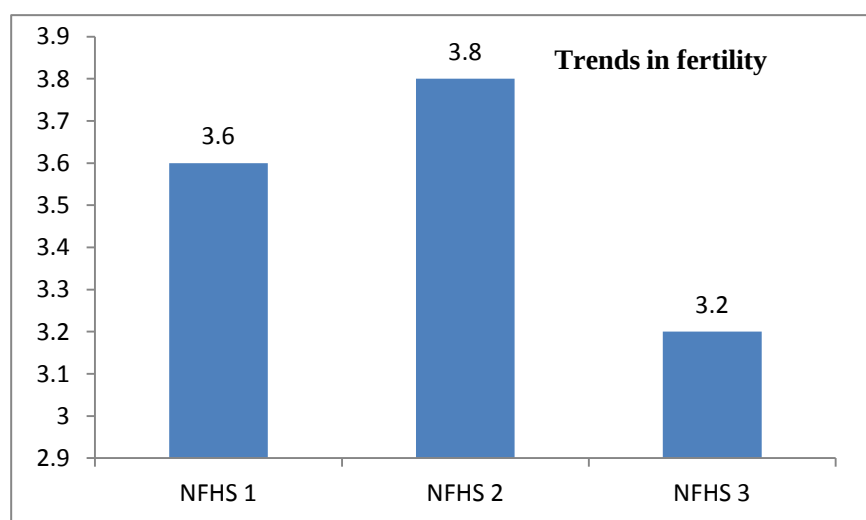
Survey Data (NFHS & DLHS):

Nationwide, the small family norm is widely accepted (the wanted fertility rate for India as a whole is 1.9: NFHS-3) and the general awareness of contraception is almost universal (98% among women and 98.6% among men: NFHS-3).

Both NFHS and DLHS surveys showed that contraceptive use is generally rising. Contraceptive use among married women (aged 15-49 years) was 56.3% in NFHS-3 (an increase of 8.1 percentage points from NFHS-2) while corresponding increase between DLHS-2 & 3 is relatively lesser (from 52.5% to 54.0%).



(Currently married women (15-49) Key findings for Rajasthan from NFHS 3)



(Total fertility rate)

Rajasthan has succeeded in reducing its total fertility rate (TFR) -- the average number of children expected to be born per woman during her reproductive years - by 0.2% from 2009 to 2010, but it is still far above the national average. NFHS1 data shows 3.8 TFR of the state followed by 3.6 & 3.2 during NFHS2 & NFHS3. The TFR of India is 2.5 but it is 3.1 for Rajasthan, which shows that Rajasthan has to improve a lot on TFR, which is one of the health indicator.

The latest Sample Registration System 2010 data prepared by the Registrar General of India states that among bigger states, after Bihar, Uttar Pradesh and Madhya Pradesh, Rajasthan registered the highest TFR in the country. A medical, health and family welfare department said that Rajasthan is targeting to bring down the level of TFR to 2.1 (replacement level fertility) by 2015, which is also its Millennium Development Goal, TFR of the rural areas more in comparison to the urban areas. In urban areas, the TFR is 2.4, but in the rural areas the TFR is 3.3, the SRS system data.

The early age of marriage (40% - DLHS III) and high adolescent fertility rate (16 %) are some of the major challenges which need to be tackled to achieve the replacement level fertility of 2.1 but it needs a lot of efforts. However, Rajasthan has improved a lot in the last one decade as it has registered a decline of 22% in TFR between 2000 -2010, which shows that the state is slowly but surely decreasing its TFR.

The Family planning methods among currently married couple can help to reduce TFR the data shows the improvement in adopting the family planning methods among people NFHS3 report of Rajasthan state shows the use of contraceptive method among currently married women age group (15-49).

Family Planning (currently married women, age 15–49)	Residence			Education				NFHS-2(1998-1999)	NFHS-1(1992-93)
	NFHS - 3 (2005-06)	Urban	Rural	No education	< 8 years complete	8-9 years complete	10 years complete & above		
Current use									
Any method (%)	47.2	65.7	40.5	44.1	47.9	56.9	62.5	40.3	31.9
Any modern method (%)	44.4	62	38	41.6	46.1	51	57.7	38.1	31
a. Female sterilization (%)	34.2	39.6	32.2	36	33.1	31.3	24.1	30.8	25.4
b. Male sterilization (%)	0.8	1.7	0.5	0.9	0.4	1.6	0.6	1.5	2.4
c. IUD (%)	1.6	2.4	1.3	1.2	1.4	1.8	4.9	1.2	1.2
d. Pill (%)	2	4.9	1	0.8	3.8	5	5.5	1.5	0.5
e. Condom (%)	5.8	13.3	3.1	2.7	7.7	11	22.2	3.1	1.5
Unmet need for family planning									
Total un-	14.7	9.8	16.5	14.3	16	16.2	14	17.6	19.8

met need (%)									
a. For spacing (%)	7.3	5.2	8.1	5.9	10.7	12.5	8.1	8.7	10.8
b. For limiting (%)	7.4	4.6	8.4	8.4	5.3	3.7	5.9	8.9	9

Knowledge of contraception is nearly universal: 98 percent of women and 99 percent of men age 15-49 know one or more methods of contraception in India, whereas in Rajasthan state only 47.2 % currently married women using any contraceptive method, during NFHS3 among those 65.7% were resident of urban area and 40.5 % were from rural area. The use of any contraceptive method during NFHS2, NFHS1 were 40.3%, 31.9% in state.

The highest adoption of contraception varies according to the education, residence, religion, cast and wealth. In state education and residence were found the two major factors in contraceptive use, during NFHS3 currently using any modern method were 44.4%, the high adoption among urban women were 62% followed by rural women only 38%. The use of method increases with the education level, illiterate women has 41.6% followed by less than 8 years education had 46, 8-9 years completed in education has 51, whereas 57.7% women who used any modern method had 10 years and above education. The overall use of any modern method during NFHS2, NFHS1 was 38.1 and 31%.

Since NFHS-2, ever use of any method among currently married women has increased by 11 percentage points. The increase is greatest for spacing methods; ever use of condoms and the rhythm method has increased by 6 percentage points each. The contraceptive prevalence rate for currently married women in India is 56 percent, up from 48 percent in NFHS-2. Female sterilization, with a prevalence of 37 percent, accounts for 66 percent of all contraceptive use, down from 71 percent of all contraceptive use at the time of NFHS-2. The use of female sterilization is higher for women with less education and women who are employed for cash than for most other groups of women.

The highest adoption rate of female sterilization, at 67 percent, is among women with three children who have two sons. The most common spacing methods are condoms and the rhythm method, each used by 5 percent of currently married women. Contraceptive use among currently married women varies markedly by education, religion, caste, and wealth. Just over half of women with no education (52 percent) use any method, compared with 62 percent of women with 12 or more years of education.

Contraceptive prevalence is highest among Jains (75 percent), followed by Buddhists/Neo-Buddhists (68 percent), and Sikhs (67 percent). Contraceptive use ranges from 46 to 58 percent among Muslims, Hindus, and Christians. By caste or tribe, contraceptive prevalence is highest among women who do not belong to any scheduled caste, scheduled tribe, or other backward class (62 percent), followed by women belonging to the scheduled castes (55 percent) and other backward classes (54 percent). Contraceptive use is lowest among women from the scheduled

tribes (48percent). Wealth has a positive effect on contraceptive prevalence, with use increasing from 42percent among currently married women in the lowest wealth quintile, to 68 percent among those in the highest wealth quintile. Current use of contraception varies greatly with parity; first increasing from 34 percent for women with one child to 74 percent for women with three children, and then declining to 63percent for women with 4 or more children. At each parity, women who have sons are much more likely than women who have no sons to be using contraception.

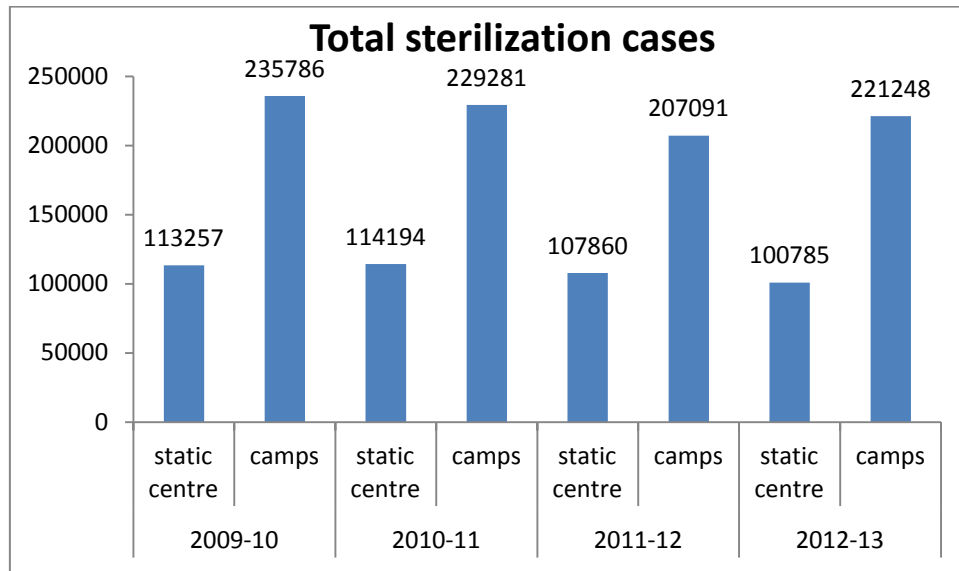
Discontinuation rates for temporary methods are fairly high: 39 percent of users discontinue use within the first year of adopting the method, and discontinuation is also high for condoms (45 percent). One-year discontinuation rates are also substantial for users of the rhythm method (32 percent) and withdrawal (35 percent), the methods with the highest failure rates.

Data Analysis & Results

Sterilization services trends

Section: 1

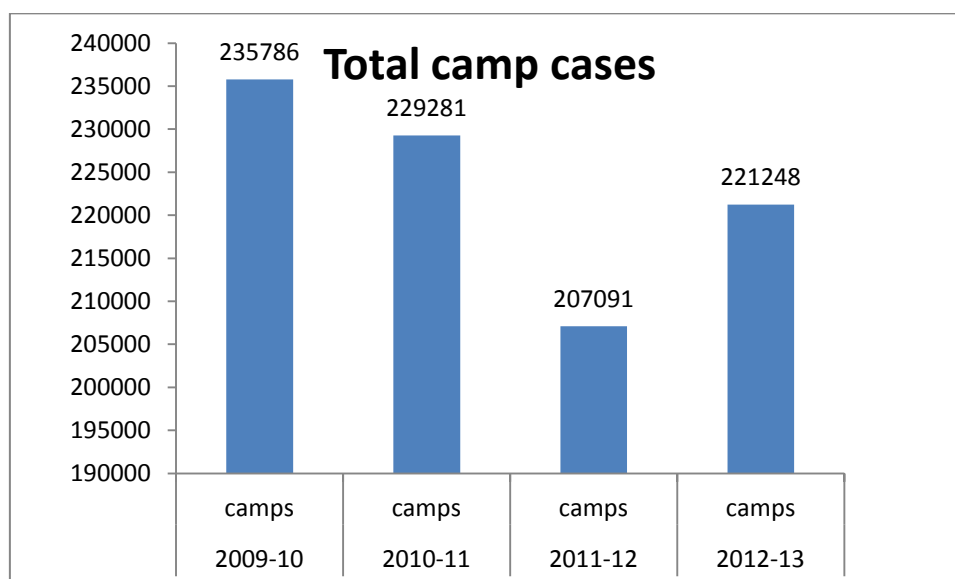
Sterilization in static centre & camps



The sterilization service trend shows that in last 4 years the total number of cases at camps were reported more compare to the static centre.

Sterilization at camps

Sterilization at camps in last 4 years shows the continuous decrease and shows the negative growth in terms of utilization, in year 2012-13 data shows the only 6.8 percent positive change.



Year 2009-10 to 2010-11 data shows the -2.75 percent change in utilization where year 2010-11 to 2011-12 data shows the -9.67 % change.

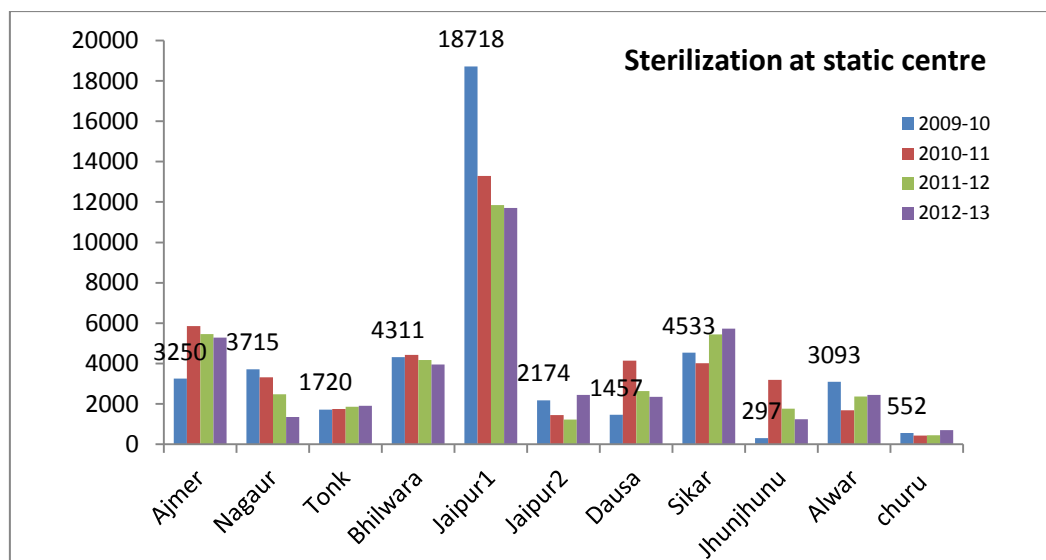
% change in sterilization service utilization at camps		
2009-10 to 2010-11	2010-11 to 2011-12	2011-12- 2012-13
-2.75	-9.67	6.8

Sterilization at static centre

Sterilization % change for positive recorded in year 2010-11 but after that tremendous decrease recorded, percent change at static centre in year 2009-10 to 2010-11 were 0.83 whereas year 2010-11 to 2011-12 were -5.5 and year 2011-12 to 2012-13 were -6.5 respectively.

% change in sterilization service utilization at static centre		
2009-10 to 2010-11	2010-11 to 2011-12	2011-12 to 2012-13
0.83	-5.5	-6.5

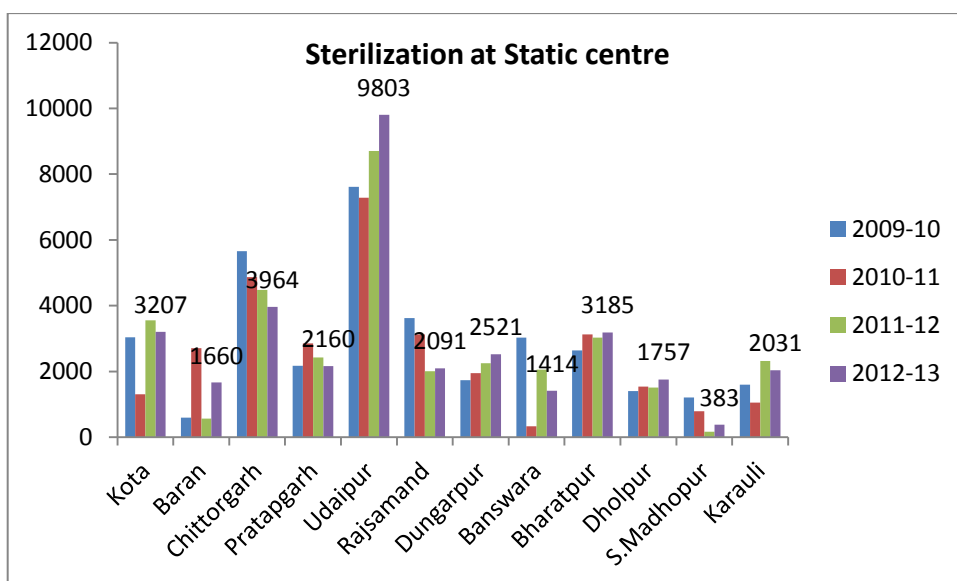
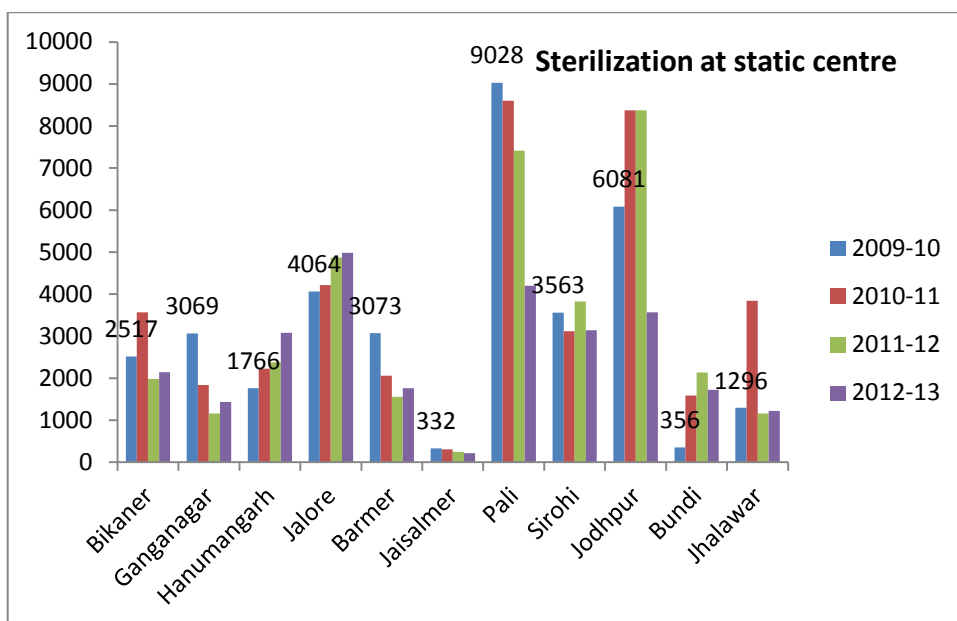
Section: 2 Sterilization trend at static centre



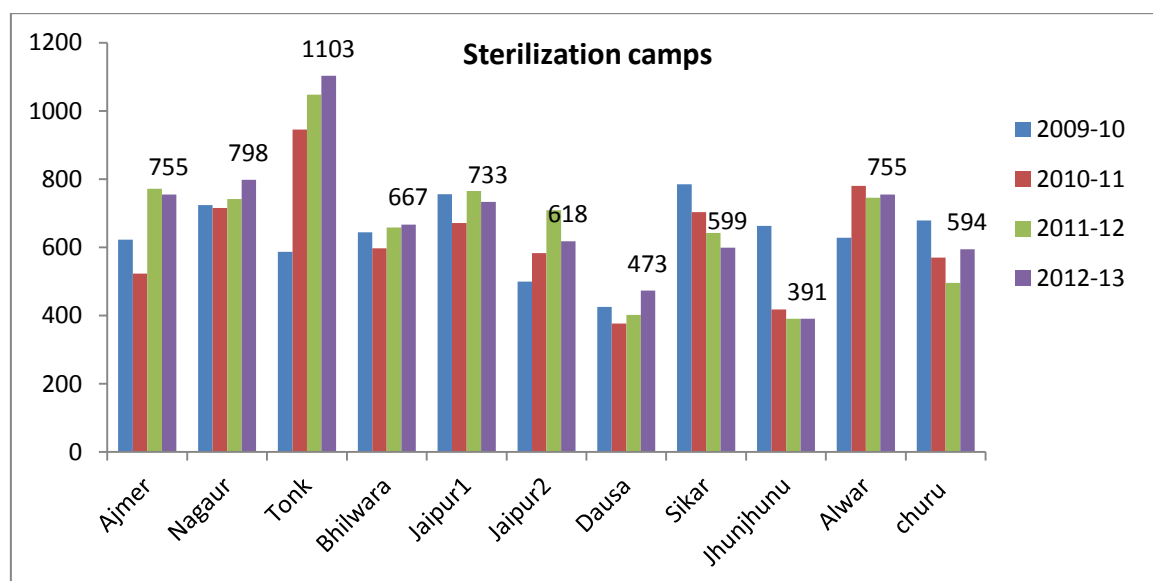
Sterilization in 34 districts of Rajasthan under static centre shows the sterilization services performed by the centres, the maximum sterilization were reported at jaipur1 district, the numbers were 18718 during year 2009-10, it was the highest among all 34 districts in last 4 year, the year 2009-10 data shows maximum sterilization at static centres compare to other three years, In pali district 9028 sterilization cases were reported followed by Udaipur 7613 and jodhpur 6081 respectively, these districts found to be the high performing among all 34 districts in year 2010-11. On the other hand the low performing districts were Jhunjhunu, churu, Tonk Baran, S.madhopur, Jaisalmer & Bundi in last 4 year year.

In last 4 year the highest sterilization cases were performed by these 3 high performance districts (Jaipur1, Jodhpur & Pali) shows the tremendous decreased where as district Udaipur showed improved performance in year 2012-13 and reported 9803 cases.

Low performance districts were reported as Jaisailmer, Churu, S. Madhopur, Baran , Dholpur and Jhunjhunu in last 4 years.

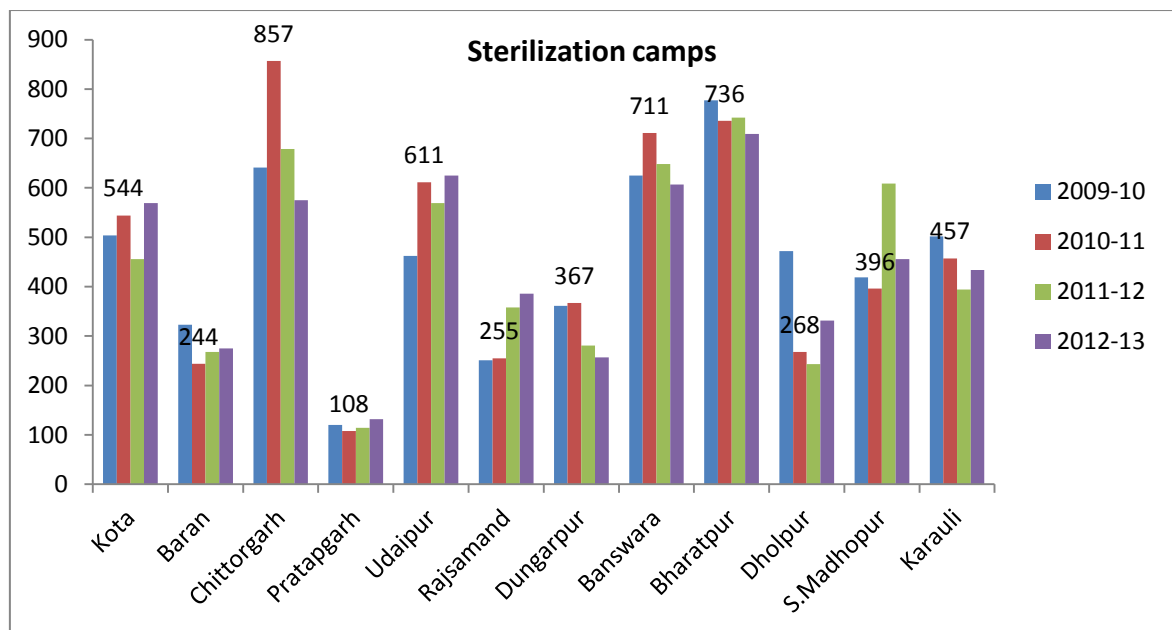
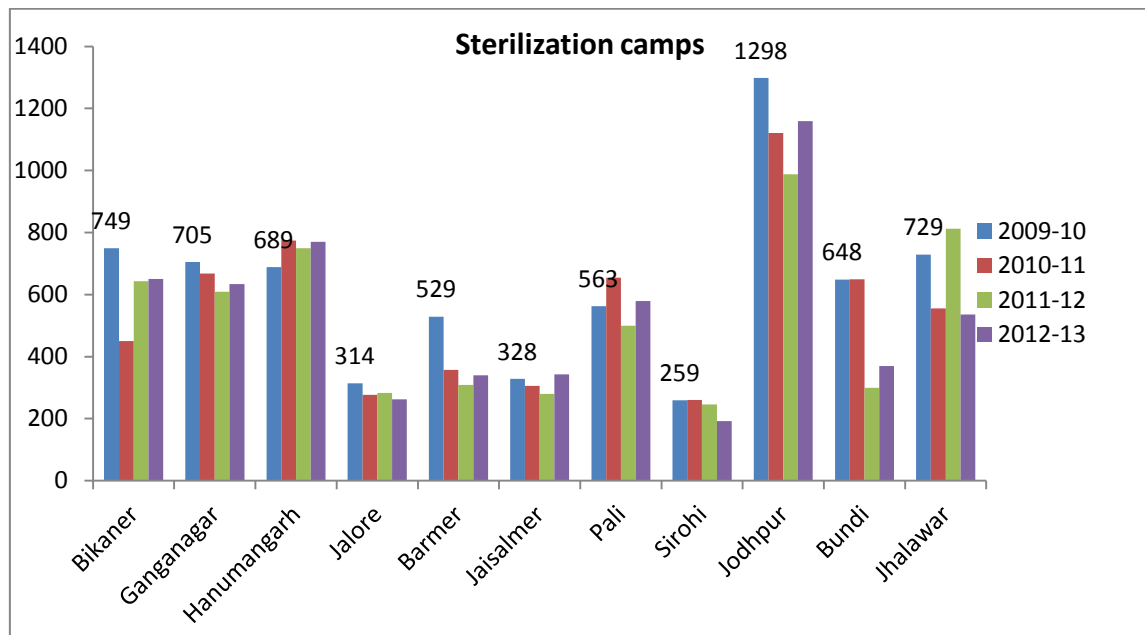


Section: 3 Sterilization camps in Rajasthan

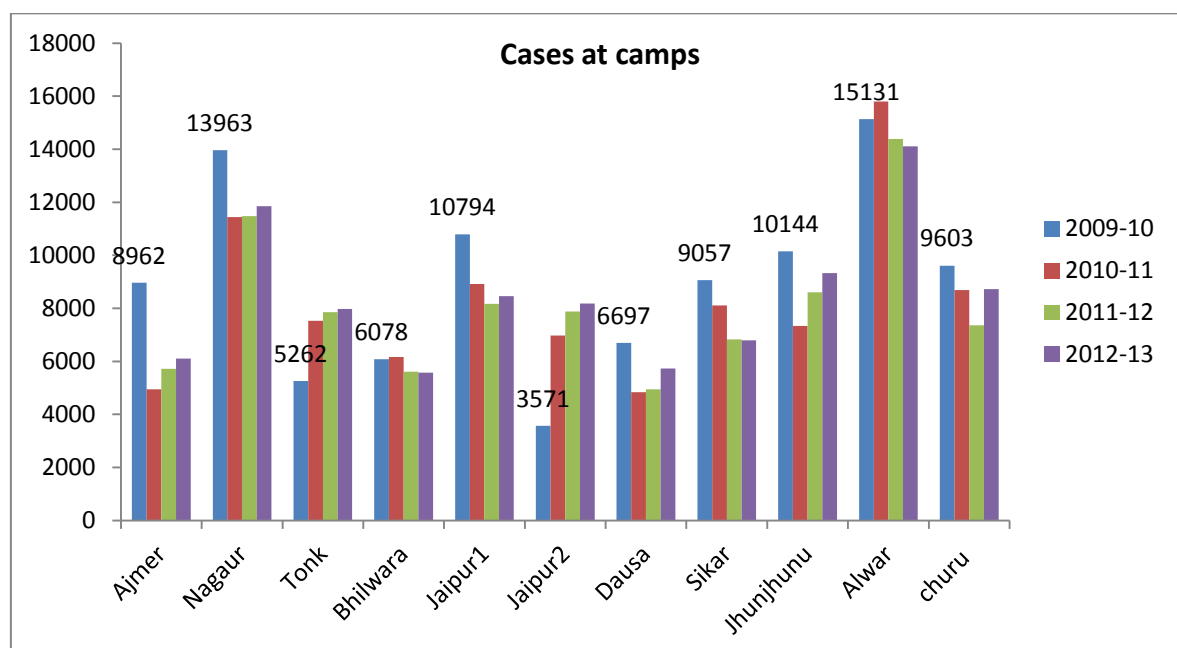


Sterilization camps held in all 34 districts shows the almost same trend district wise except some districts, the numbers of camps held at Jodhpur district were reported highest in last 4 years, the maximum number of camp held during year 2009-10 were 1298. The district also show the same trend in terms of organizing the camp but the year 2011-12 showed slight decrease in organizing camps at the district. Whereas district Tonk reported highest camps of year 2011-12 were 1048 compare to 988 at jodhpur in that year.

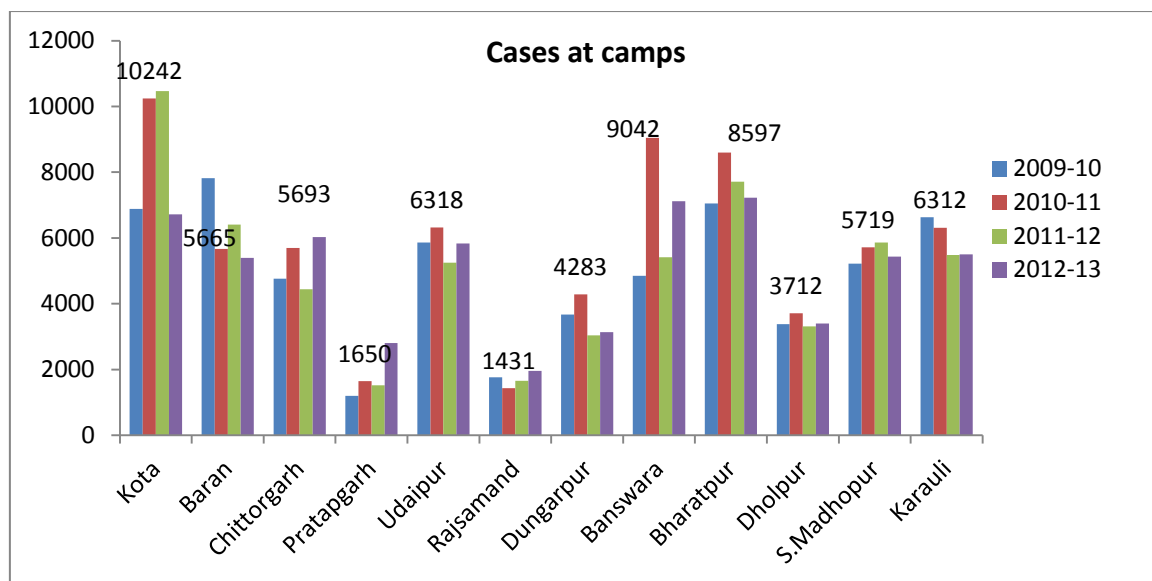
Less number of camp were reported at Pratapgarh, Sirohi, Baran, Jalore, Barmer, Jaisalmer, Rajasamand, Dungarpur and Dholpur in last 4 years.



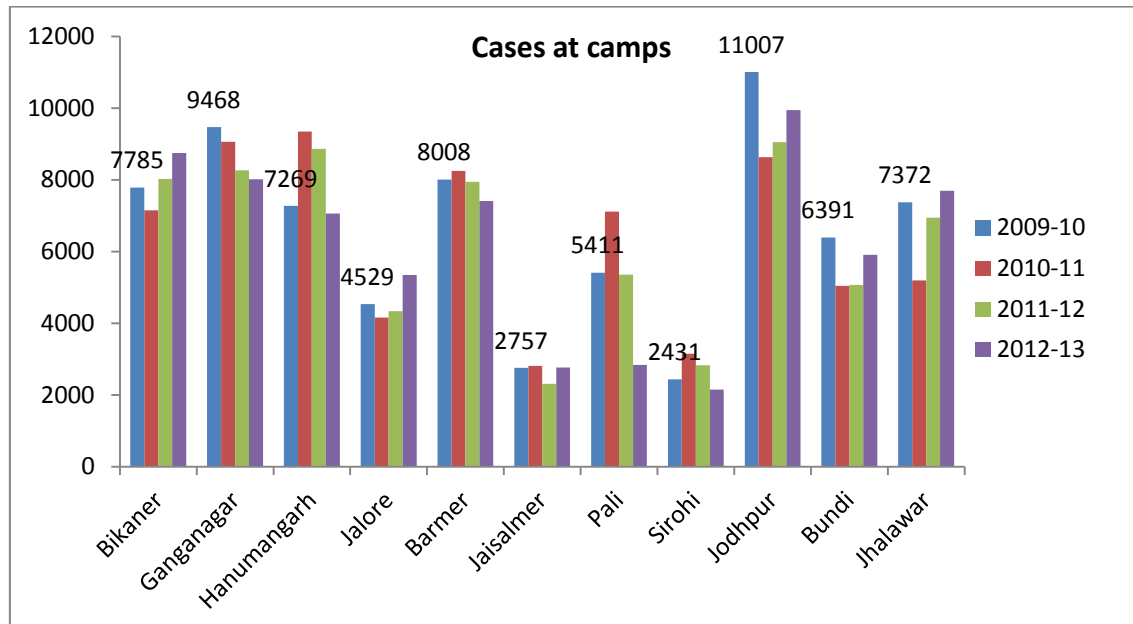
Section: 4 Sterilization cases at camps



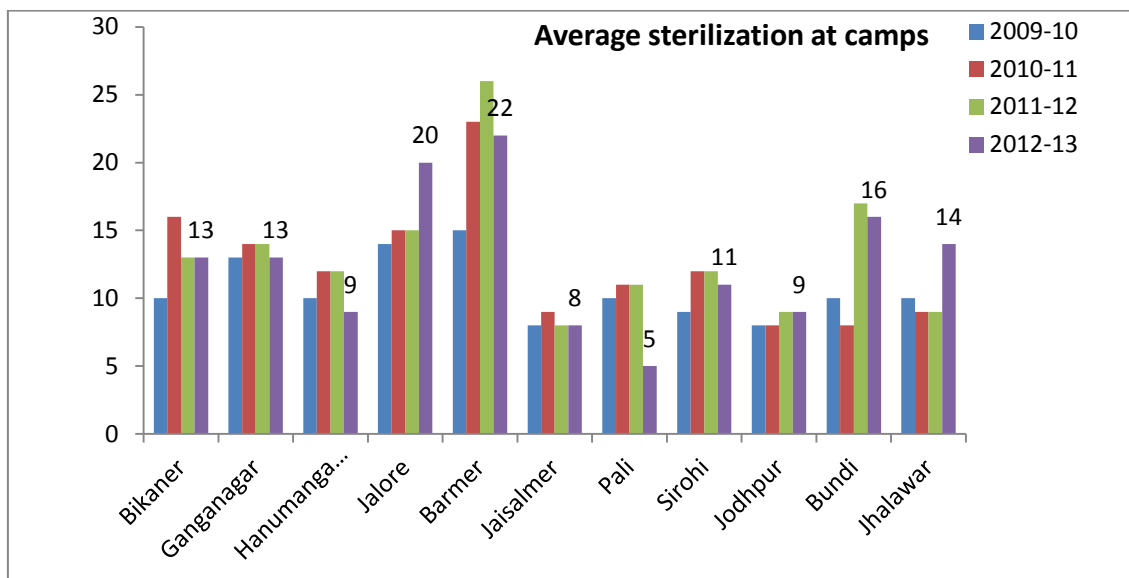
In year 2009-10 jodhpur district stand for the highest (1298) sterilization camps but only 11007 cases performed in those camps, in year 2010-11 Alwar district performed highest sterilization cases in camps were 15794 whereas only 780 camps held in that year, district Alwar reported for maximum sterilization cases held at camps in last 4 years, the number of camps organized by district were not higher as compare to other districts but this district shows the tremendous result in terms of camp sterilization.



The working conditions in camps are quite different from the static centres, The quality of services provided at camps is the main factor in performing the sterilization, the constant cases in some districts shows the stability or satisfaction of sterilization use, where as in other district sterilization cases showing the continuous decrease.

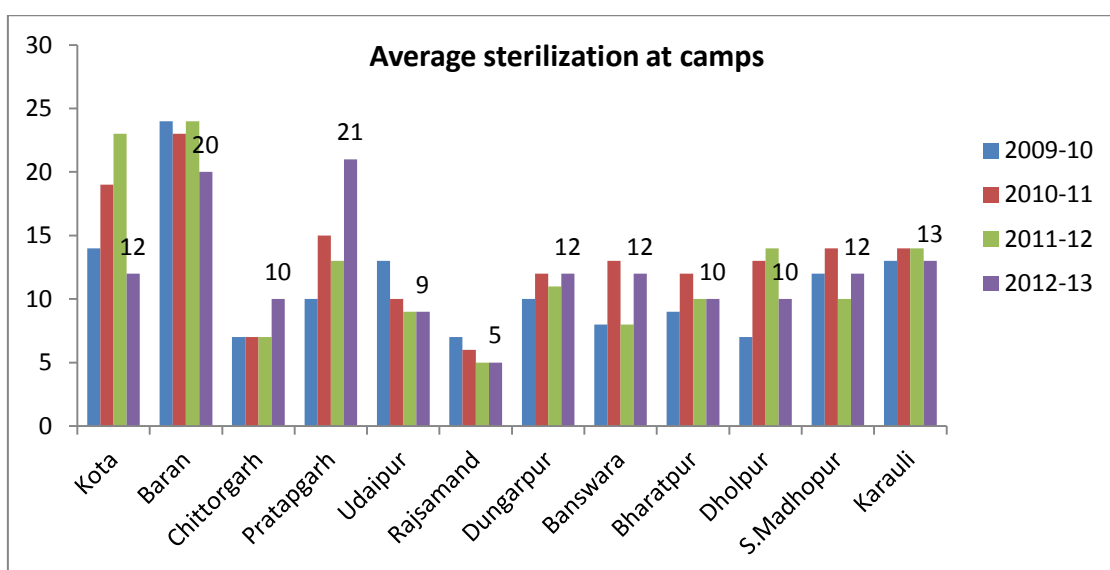


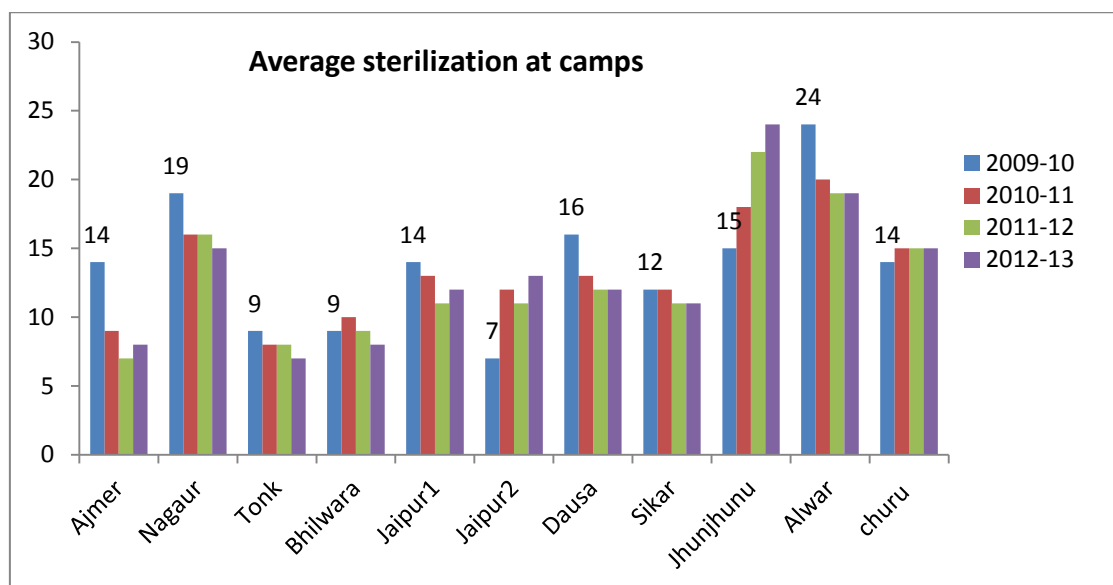
Section: 5 Average sterilization at camps



District wise average also enlighten the use of services during last 4 years, the average sterilization at camps in 34 districts shows that stirring results in Barmer district, the camps held by the district were much lesser then high performance districts, it has reported under low performance district of state but the average result shown the maximum average cases performed by Barmer district were 26.

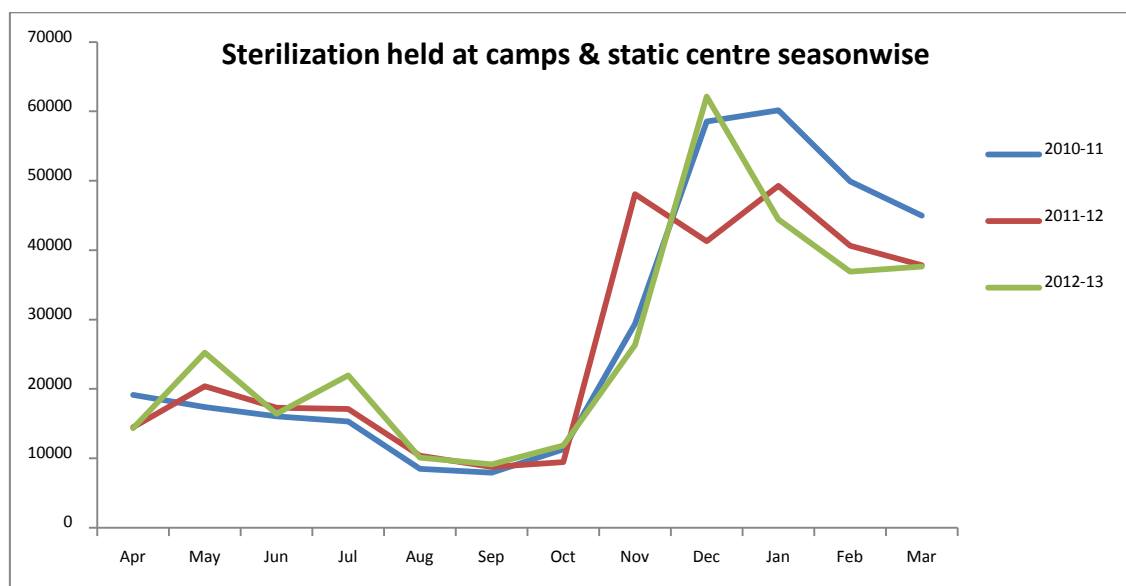
In year 2011-12 the barmer district organized only 309 sterilization camps but the sterilization cases were 7942. The highest average came from barmer only where as the other 3 high performance districts remained below 26. In year 2009-10 Jhunjhunu and in year 2012-13 Alwar district reported as a 24 average cases in camp.





Year 2012-13 showed minimum average 5 in Rajsamand and Pali district, that were the lowest average among all districts in last 4 years.

Section: 6 Season wise Sterilization in state



The seasonality trends of sterilization shows that the maximum number of sterilization performed after mid October to March month in each year, the reason might be the maximum wedding ceremony performance in these months.

IUD utilization trends

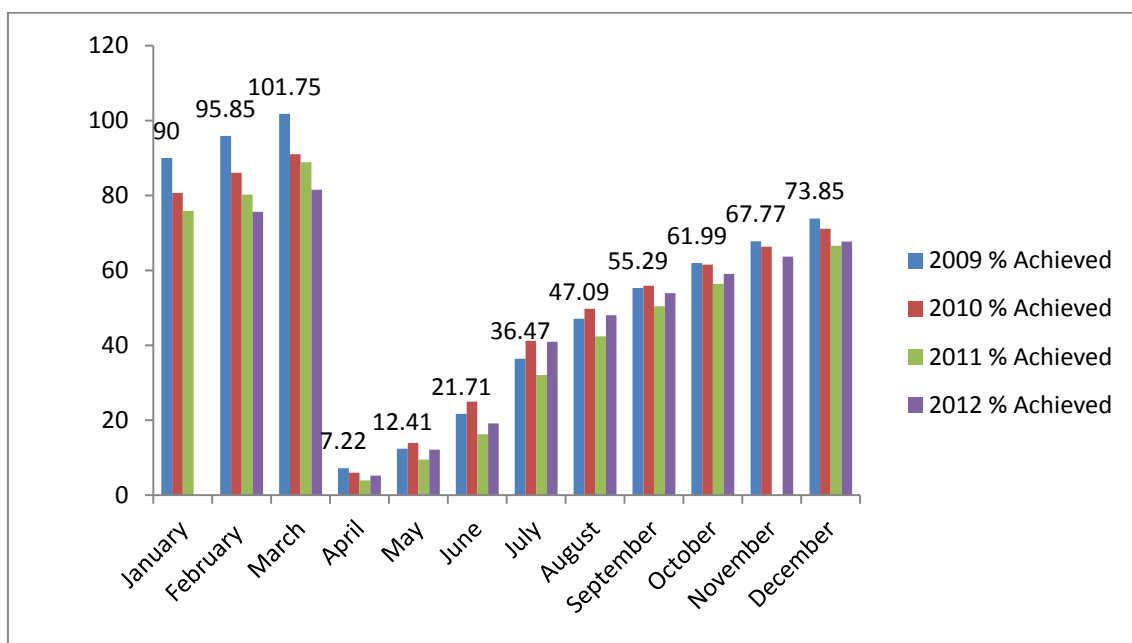
Section: 1

<u>IUD insertion more than 15000 & removal more than 2500 per year.</u>									
S.No	Districts	2009-10		2010-11		2011-12		2012-13	
		Inserted	Removal	Inserted	Removal	Inserted	Removal	Inserted	Removal
1	Jodhpur	22558	8223	23091	10510	19502	4697	-	-
2	Jaipur 1	22378	3541	20223	4763	17978	4128	16135	3629
3	Udaipur	20273	5370	18034	5729	18323	3963	16180	3768
4	Pali	17644	2824	16030	5462	-	-	-	-
5	Bhilwara	16275	8106	-	-	16809	7591	-	-
6	Alwar	16488	11547	23200	13014	22502	14228	18342	14216
7	jhunjhunu	15114	4863	-	-	-	-	-	-
8	riganganagar	-	-	16508	2733	-	-	-	-
9	Bharatpur	-	-	-	-	17329	5155	-	-
10	Nagaur	-	-	-	-	17551	3521	17532	3650
11	Barmer	-	-	-	-	15806	5467	-	-

Section: 2 Month wise IUD target & Achievement of last 4 years

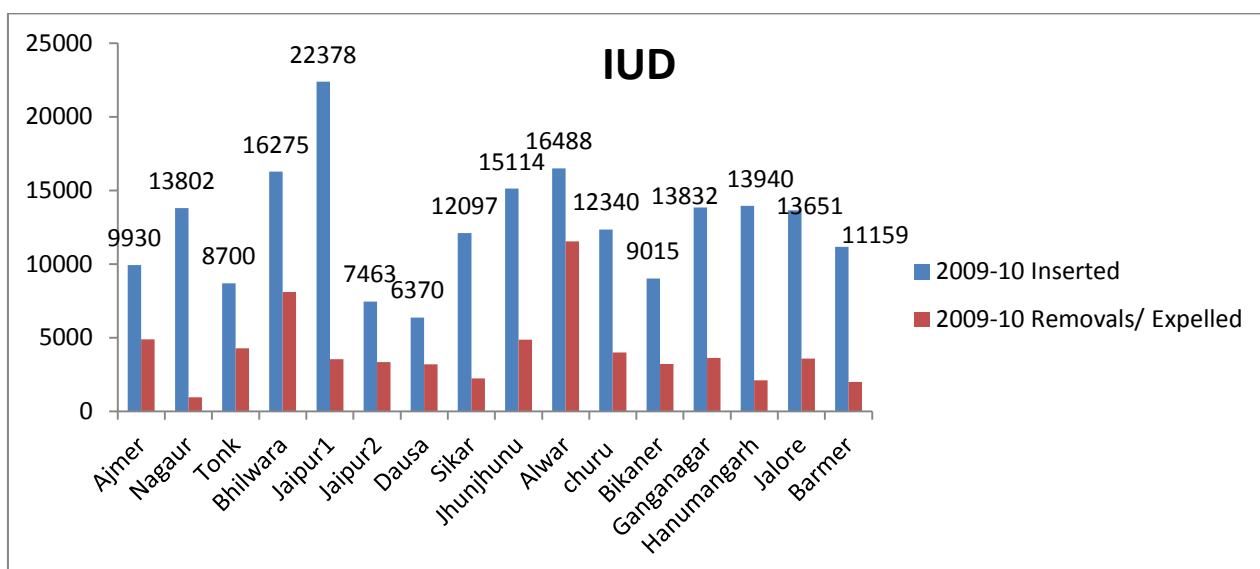
IUD Insertion								
Months	2009		2010		2011		2012	
	ELA target	Ach.	ELA target	Ach.	ELA target	Ach.	ELA target	Ach.
January	347783	312993	450000	363034	458207	347938		
February	347783	333358	450000	387445	458207	367834	485000	366858
March	347783	353877	450000	409560	458207	407122	485000	395367
April	347783	25123	450000	27012	485000	19374	485000	25421
May	450000	55824	450000	62696	485000	46108	485000	59142
June	450000	97677	450000	112280	485000	79116	493759	94782
July	450000	164103	458207	188989	485000	155567	493759	202203
August	450000	211885	458207	228067	485000	205725	493759	237127
September	450000	248822	458207	255998	485000	244619	493759	266331
October	450000	278947	458207	282188	485000	273565	493759	291459
November	450000	304981	458207	303977	485000		493759	314356
December	450000	332336	458207	325901	485000	322899	493759	334255

Percent trend of IUD insertion in last 4 years



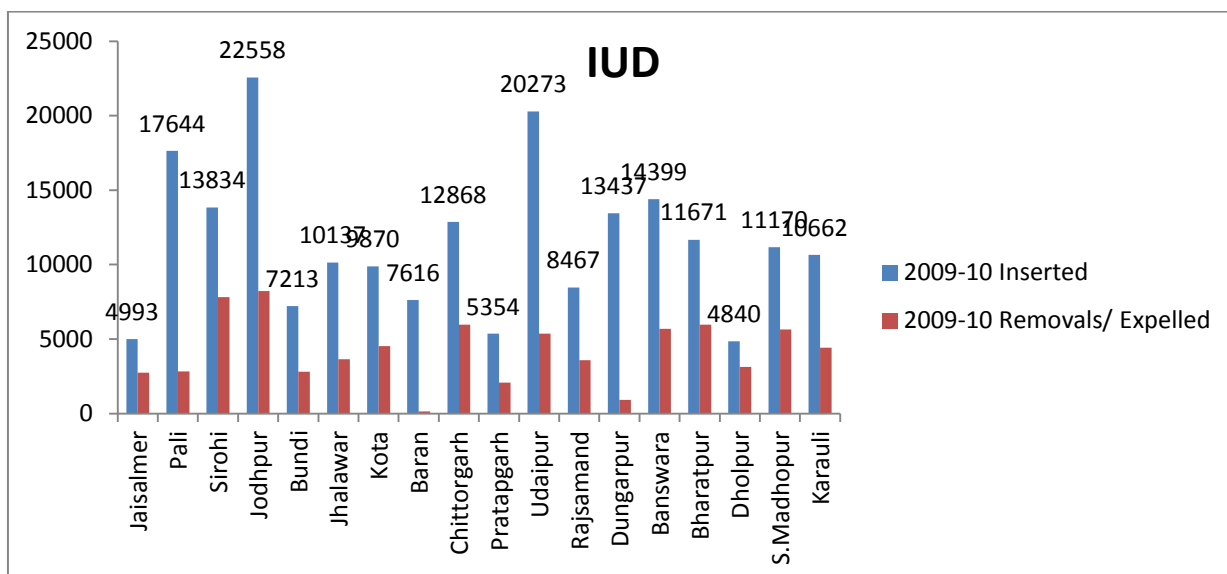
The data of last 4 years shows that in March 2009 the 100 percent target achieved of IUD insertion, the performance of IUD insertion was also above 90 percent in January and February month of 2009, whereas the low insertion were reported in last 4 years in the month of April, May & June.

Section: 3



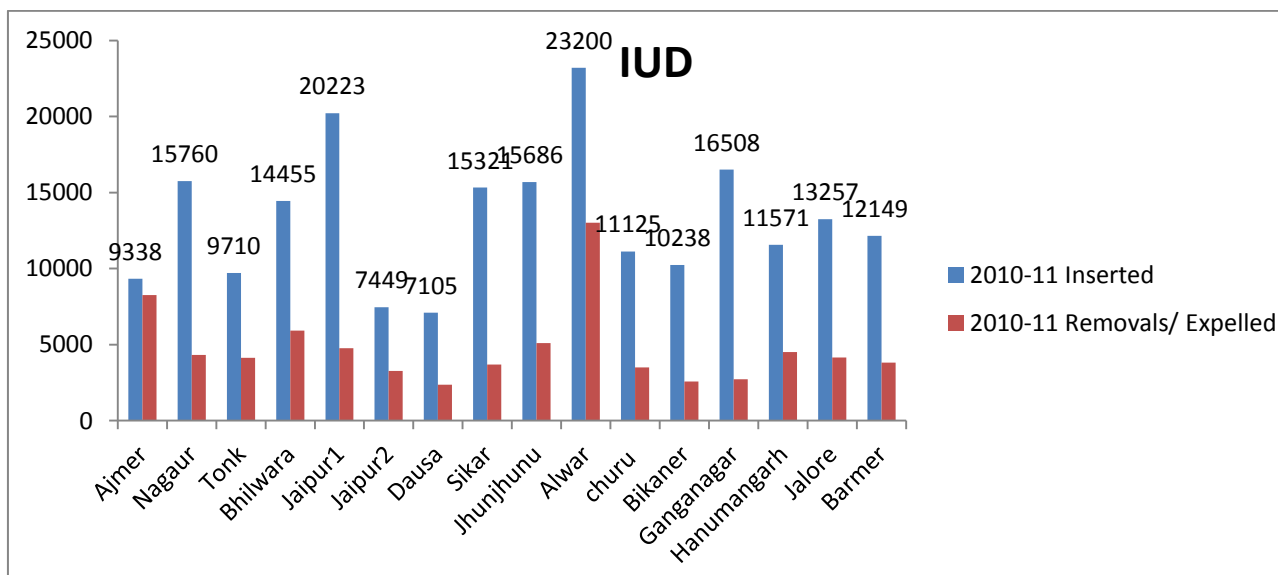
(IUD inserted & expelled in year 2009-10 In Rajasthan)

In year 2009-10 maximum insertion of IUD done in Jodhpur district were 22558 where as removal were reported 8223, but in year 2012-13 the number of IUD insertion in district remained below 15000. On the other hand districts like Jaipur1, Udaipur & Alwar performance of IUD utilization noticed above 15000 in last 4 year, they shown the constant performance in last 4 years. There some other districts also shown the IUD insertion more than 15000 but the fluctuations among use vary yearly, in Pali district year 2009-10 & 2010-11 shown the slight difference among utilization but after that in another last 2 years utilization of IUD decreased.



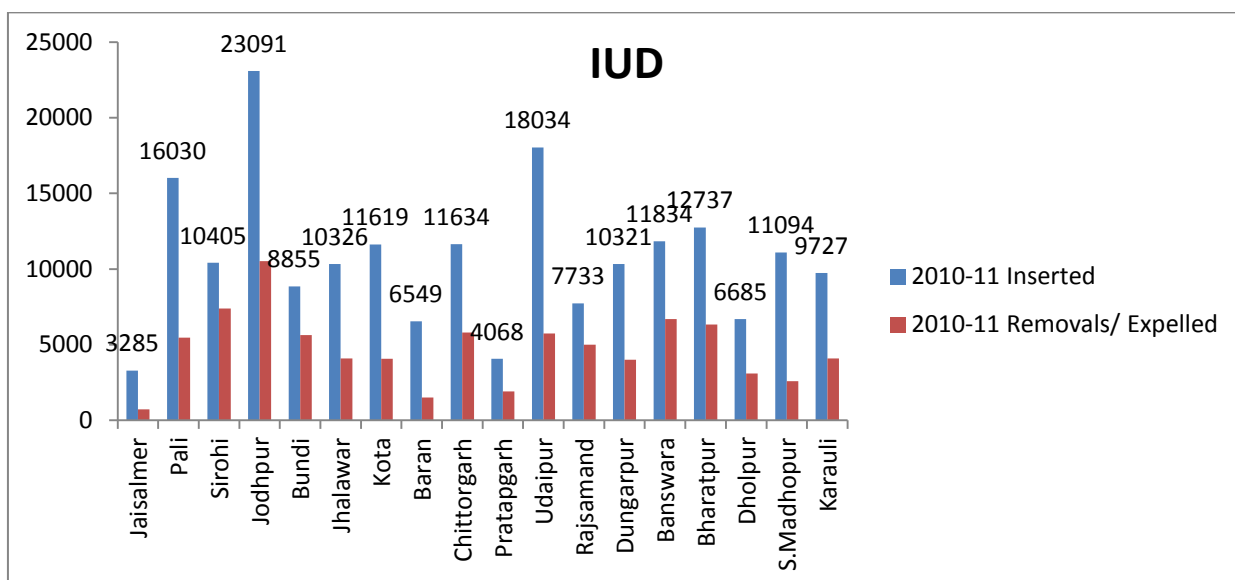
(IUD inserted & expelled in year 2009-10 In Rajasthan)

Section: 4



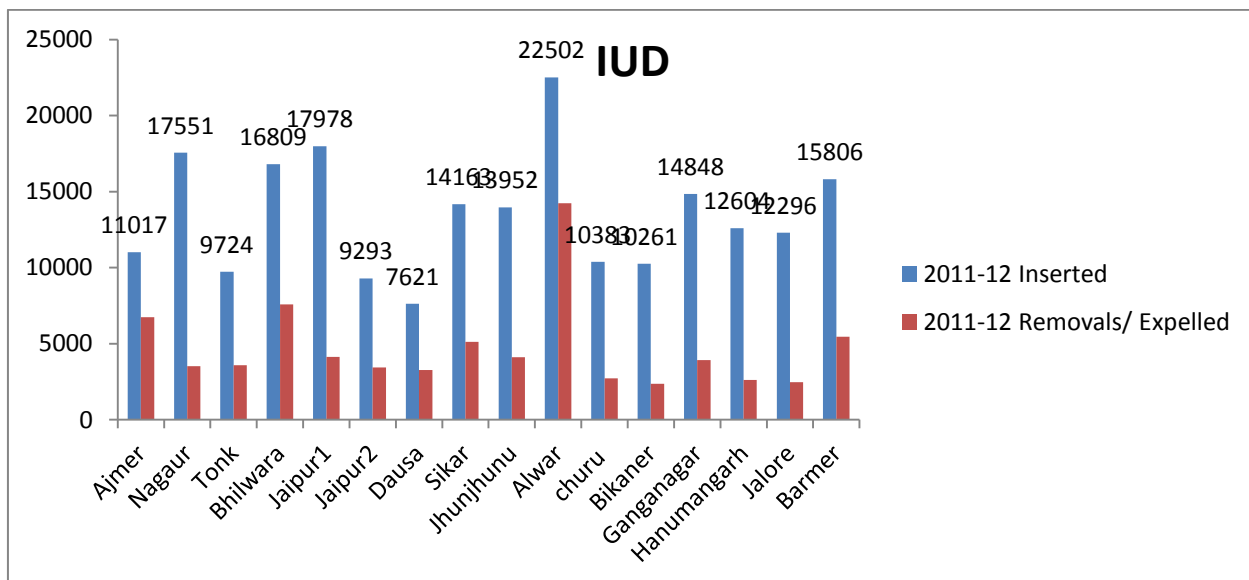
(IUD inserted & expelled in year 2010-11 In Rajasthan)

In Bhilwara district alternate year shown increased & decreased utilization of IUD from 2009-10 to 2012-13 whereas in Jhunjhunu year 2009-10 shown above 15000 IUD utilization, but after that year the another last 3 years reported decreased utilization. The other districts which shown more than 15000 IUD utilization in a year was Sriganganagar in year 2010-11 and Bharatpur, Barmer in year 2011-12, whereas Nagaur district's utilization of IUD reported above 15000 in last 2 years.

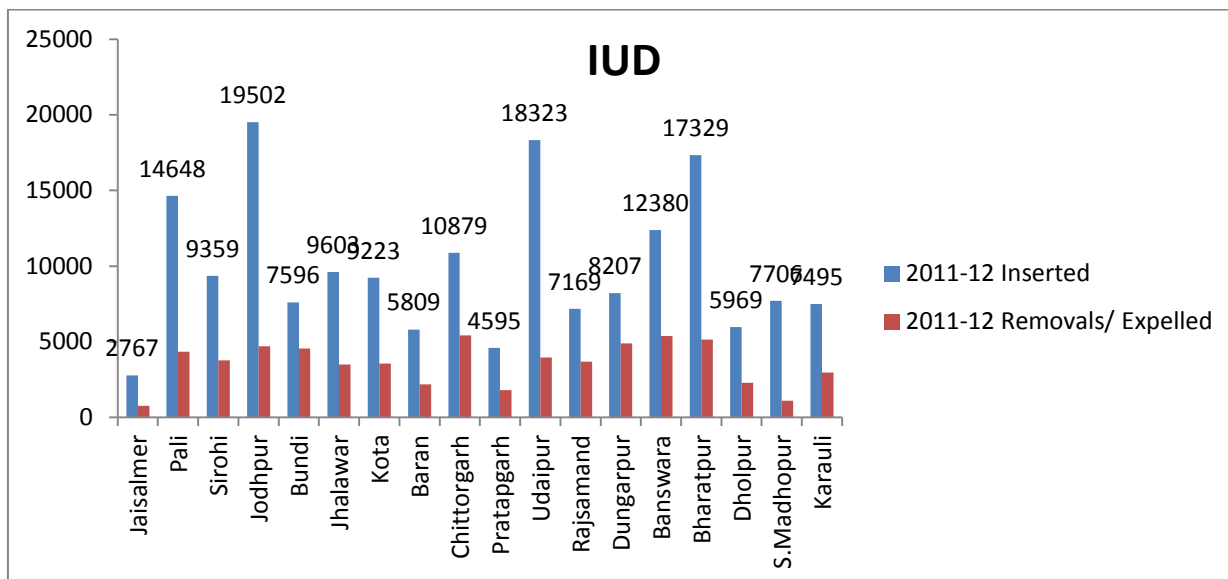


(IUD inserted & expelled in year 2010-11 In Rajasthan)

Section: 5

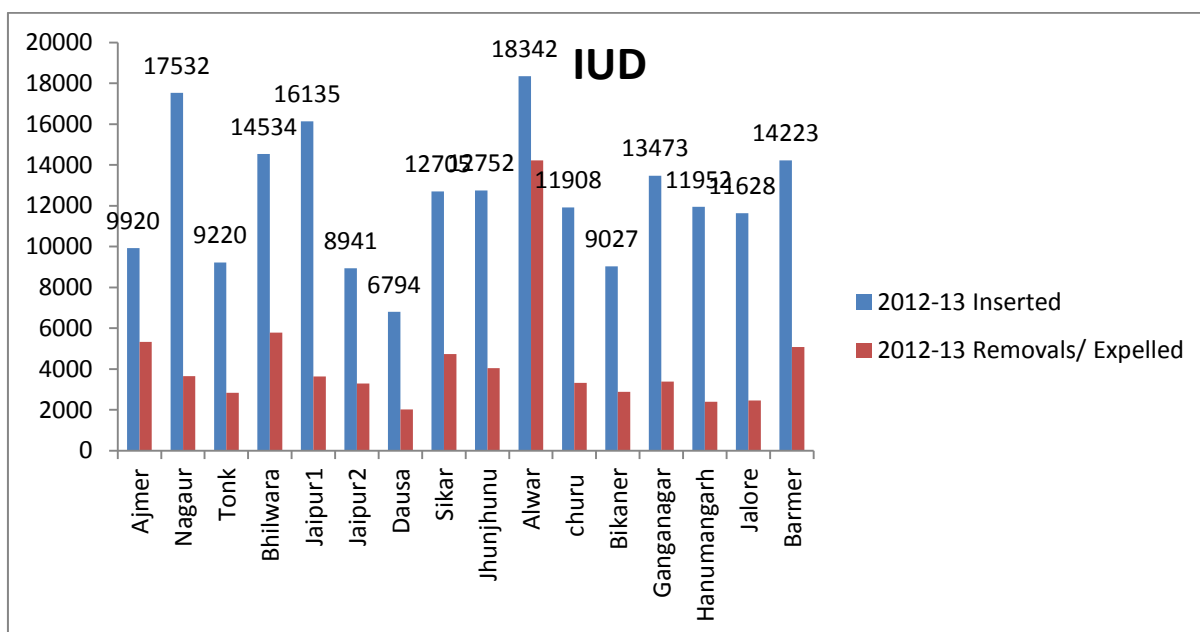


(IUD inserted & expelled in year 2011- 12 In Rajasthan)

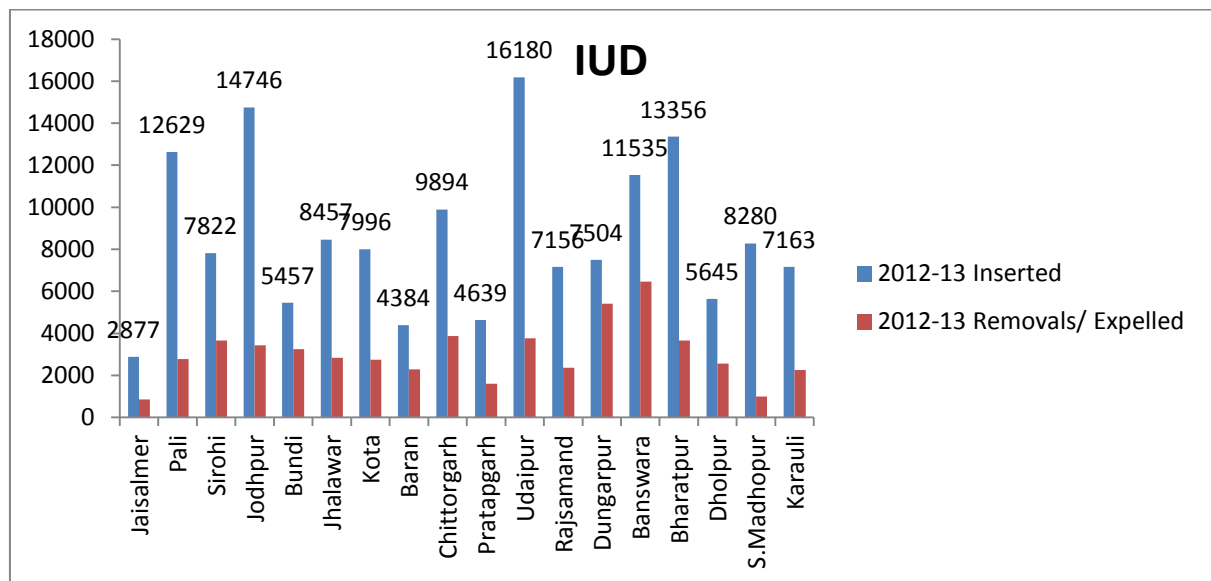


(IUD inserted & expelled in year 2011- 12 In Rajasthan)

Section: 6



(IUD inserted & expelled in year 2012-13 In Rajasthan)

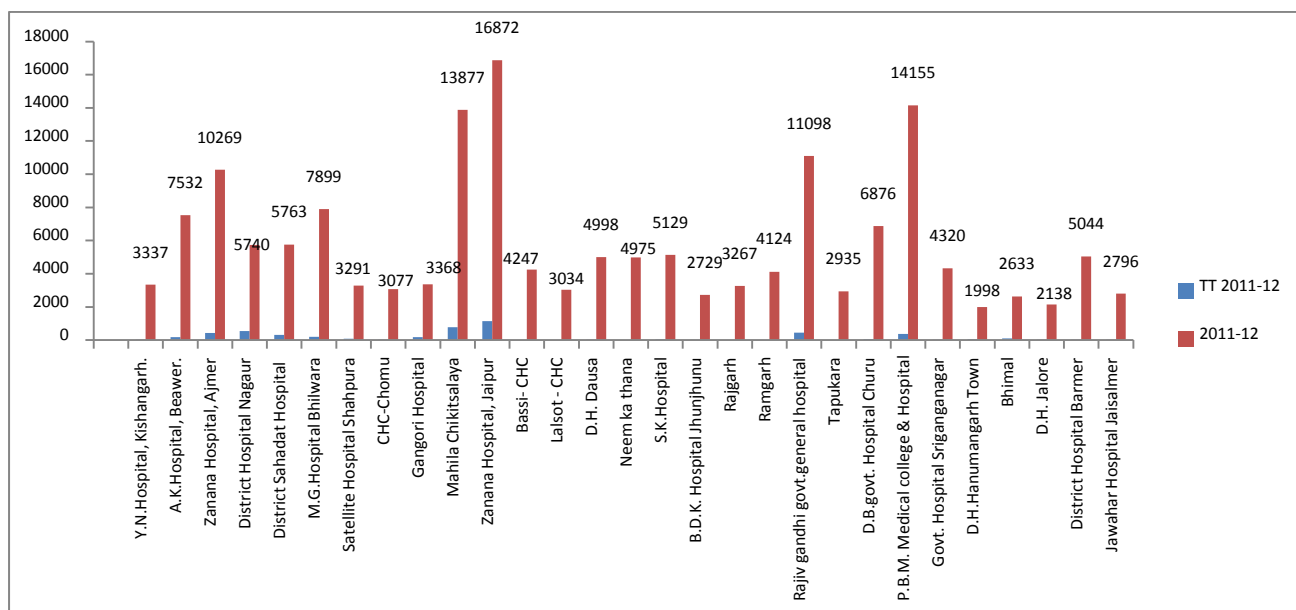


(IUD inserted & expelled in year 2012-13 In Rajasthan)

In Rajasthan state out of 34 Districts only 11 districts shows more than 15000 utilization at least once in the last 4 years, where as other districts have low utilization of IUD.

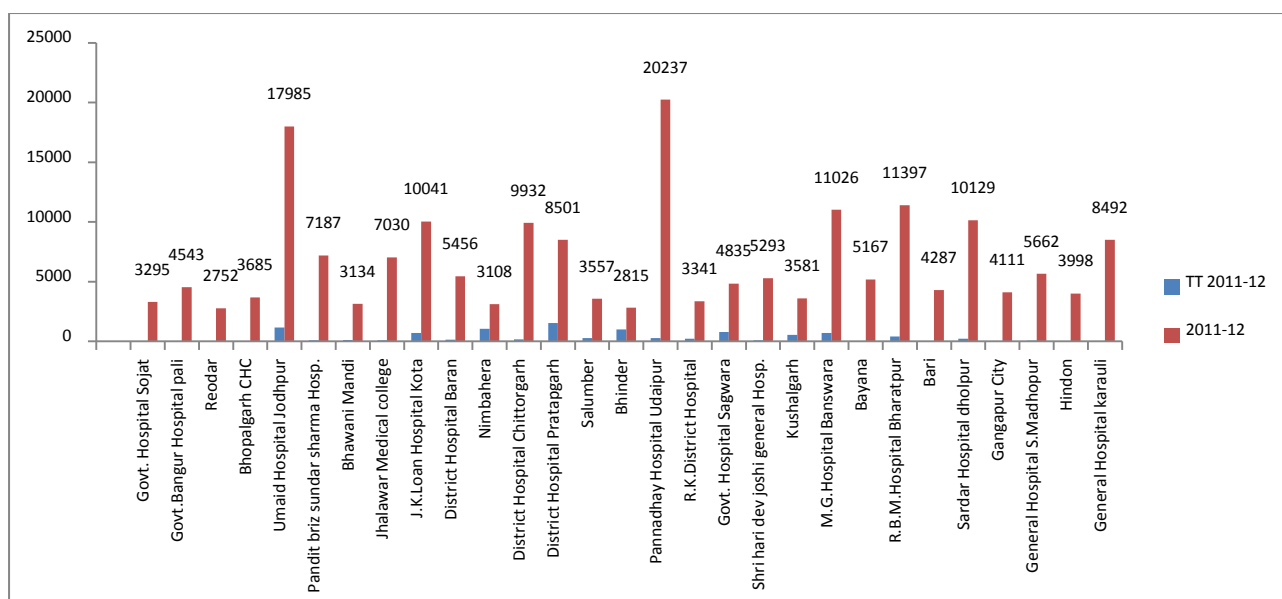
High Loaded Delivery Institution trend

Section: 1



(Total no of deliveries & total Tubectomy done at high loaded centres in year 2011-12)

In year 2011-12, Eleven institutions reported more than 10,000 deliveries and in year 2012-13, Twelve institutions reported the same, the different institution in 2012-13 was District hospital Chittorgarh, another 11 institutions remained same only the position changed because of the more or less deliveries performed at institution, in year 2011-12 Pannadhay hospital Udaipur reported with highest deliveries and remained on 1st position in high loaded institution, the hospital reported more than double i.e. 20237 deliveries in a year and only 237 T.T cases reported there, in year 2012-13 hospital came down to position 2nd with 22009 deliveries and 310 T.T cases.



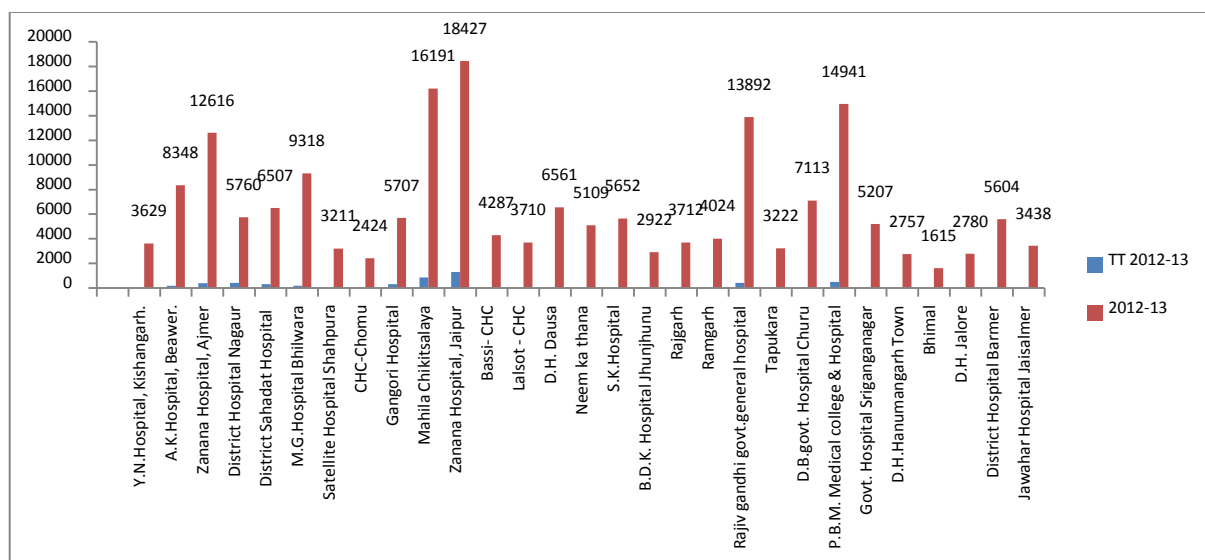
(Total no of deliveries & total Tubectomy done at high loaded centres in year 2011-12)

Whereas in year 2012-13 Umaid hospital remained on 1st position with 26193 deliveries and 999 T.T. cases, in year 2011-12 the hospital was on 2nd position with 17985 deliveries and 1161 T.T. cases, the number of T.T. were recorded as a highest in that year. Zanana hospital jaipur remained on 3rd position in last 2 years , 16872 deliveries with 1135 T.T. were performed in the year 2011-12 whereas in year 2012-13 with slight increase of numbers i.e. 18427 deliveries with 1309 T.T. cases, the institution reported as a maximum T.T. cases in year 2011-12.

More than 10,000 deliveries & T.T. in 2011-12			
S.No.	Districts	Total Deliveries	T.T.
1	Pannadhay Hosp.Udaipur	20237	257
2	Umaid Hosp. Jodhpur	17985	1161
3	Zanana Hosp. Jaipur	16872	1135
4	P.B.M. Medical Hosp.Bikaner	14155	376
5	Mahila chikitsalya Jaipur	13877	770
6	R.B.M. Hosp. Bharatpur	11397	412
7	Rajiv Gandhi govt & gen Hosp. Alwar	11098	441
8	M.G. Hosp. Banswara	11026	686
9	Zanana Hosp. Ajmer	10269	429
10	Sardar Hosp. Dholpur	10129	217
11	J. K. Loan Hosp. Kota	10041	703

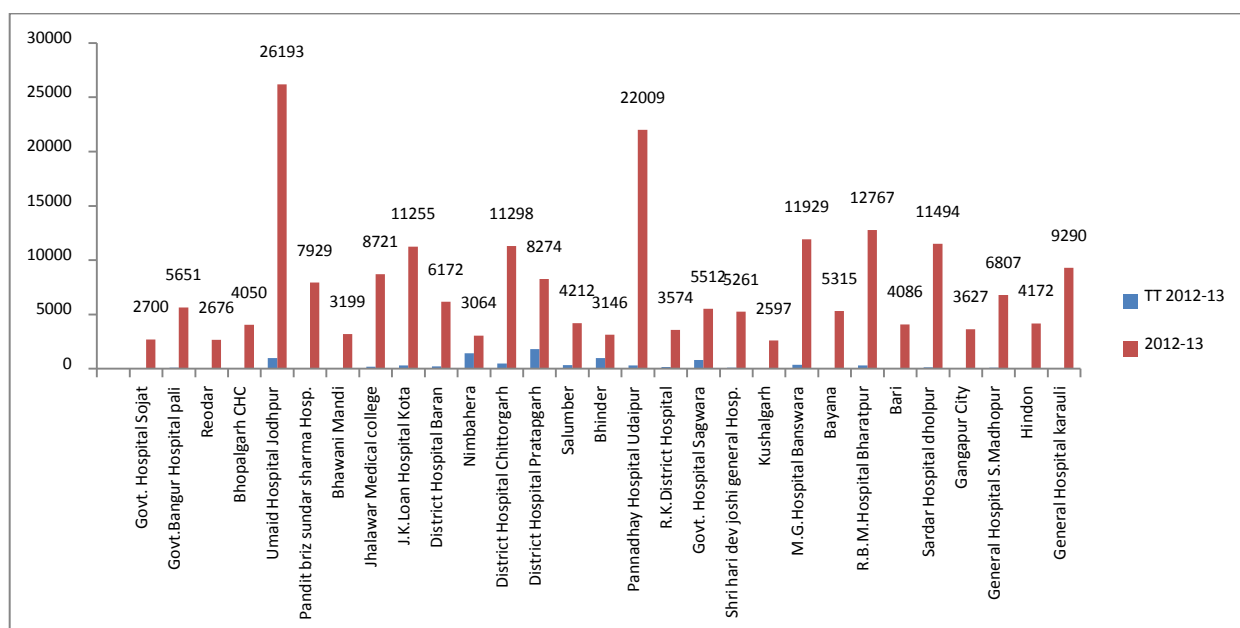
In year 2011-12 the lowest T.T. cases 217 performed by the sardar hospital dholpur whereas the hospital reported under high loaded institution and performed 10129 deliveries, other institutions who reported under the high loaded shown in table for better understandings.

Section: 2



(Total no of deliveries & total Tubectomy done at high loaded centres in year 2012-13)

In year 2012-13 Mahila chikitsalya jaipur showed 16191 deliveries & T.T. cases of 877 followed by P.B.M. hospital Bikaner 14941 deliveries and 503 T.T. cases. Rajeev Gandhi govt & gen hospital Alwar 13892 deliveries with 440 T.T. cases, R.B.M hospital Bharatpur 12767 deliveries and T.T cases were 298 .



(Total no of deliveries & total Tubectomy done at high loaded centres in year 2012-13)

The institutions showed more than 3000 deliveries reported as a high loaded institution, the all 11-12 institutions who came under this criteria showed 5-8 times higher than preset target for high loaded and they are the highly loaded delivery institutions, though the deliveries were very high but the Tubectomy cases were reported less, the lowest number of Tubectomy were reported in year 2012-13 at Sardar hospital dholpur were 137cases, this was the lowest T.T cases in last 2 years among all high loaded institutions.

More than 10,000 deliveries & T.T. in 2012-13			
S.No.	Districts	Total Deliveries	T.T.
1	Umaid Hosp. Jodhpur	26193	999
2	Pannadhay Hosp. Udaipur	22009	310
3	Zanana Hosp. Jaipur	18427	1309
4	Mahila Chikitsalya Jaipur	16191	877
5	P.B.M. Medical Hosp. Bikaner	14941	503
6	Rajiv Gandhi govt & gen Hosp. Alwar	13892	440
7	R. B. M. Hosp. Bharatpur	12767	298
8	Zanana Hosp. Ajmer	12616	390
9	M. G. Hosp. Banswara	11929	370
10	Sardar Hosp. Dholpur	11494	137
11	District Hosp. Chittorgarh	11298	486
12	J. K. Loan Hosp. Kota	11255	298

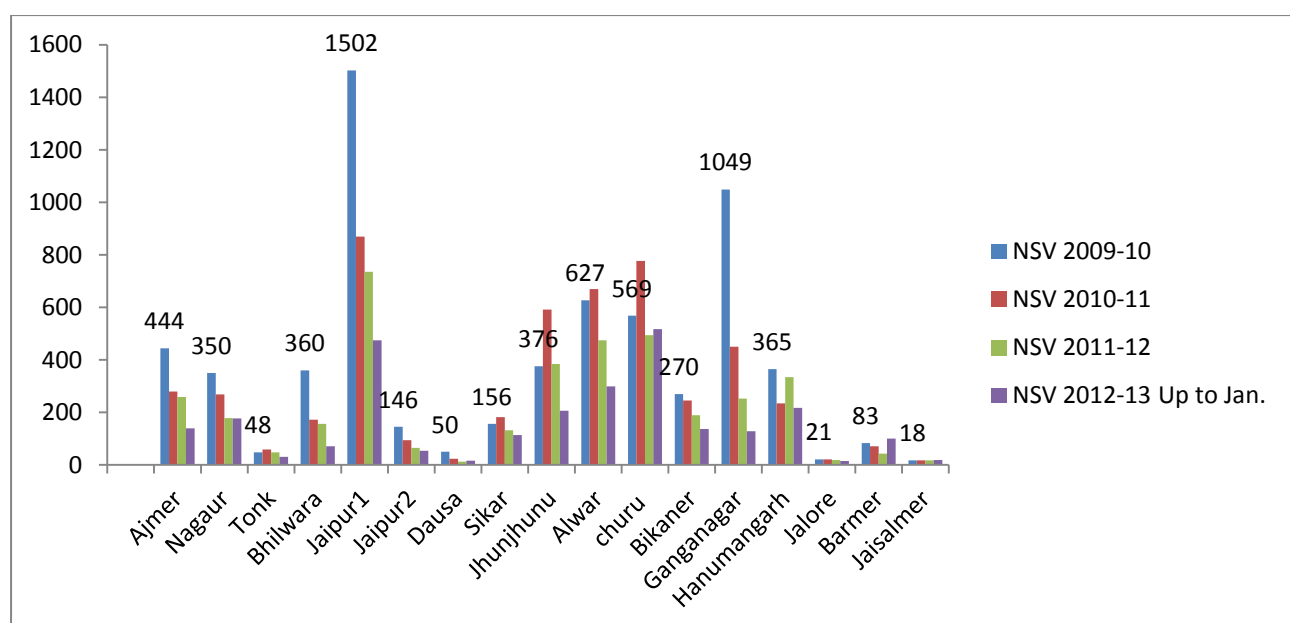
NSV Utilization trends

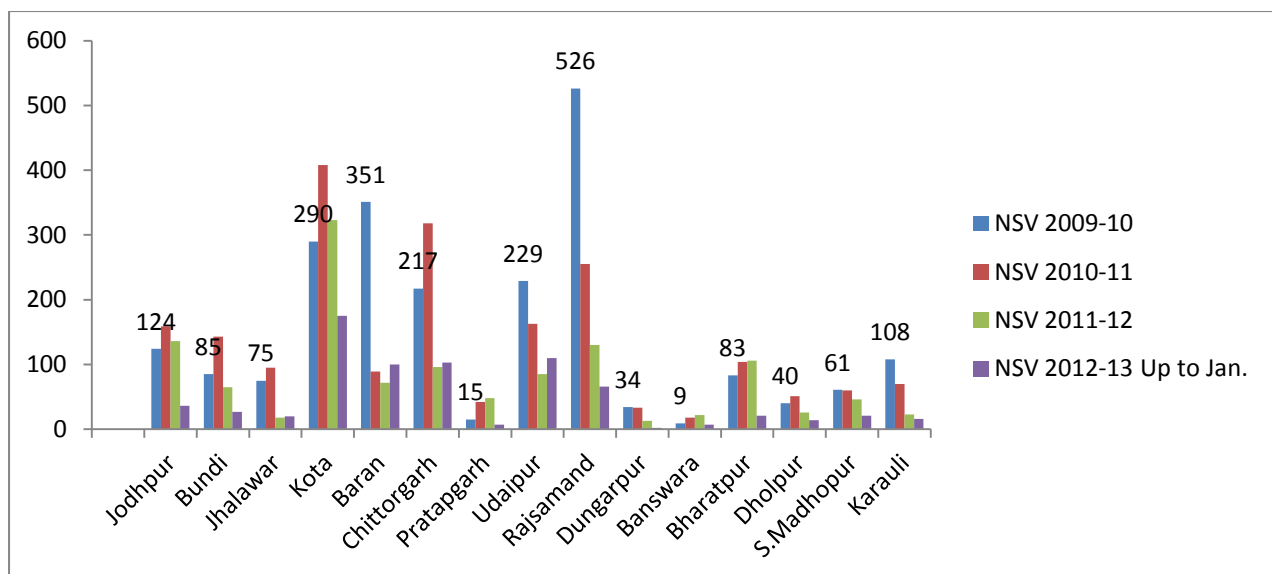
Section: 1

Districts more than 500 NSV cases in year						
S.No	District	2009-10	2010-11		2011-12	2012-13
1	Jaipur 1	1502	870		735	-
2	Sriganganagar	1049	Jhunjhunu	592	-	-
3	Alwar	627	670		-	-
4	Churu	569	777		-	517
5	Raisamand	526	Pali	610	-	-

Districts less than 30 NSV cases in a year					
S.No.	Districts	2009-10	2010-11	2011-12	2012-13
1	Banswara	9	18	22	-
2	Jalore	21	21	19	15
3	Jaisalmer	18	18	18	19
4	pratapgarh	15	-	-	7
5	Dausa	-	24	13	16
6	Sirohi	-	-	15	20
7	Dungarpur	34	33	13	2
8	Jhalawar	-	-	18	20
9				S.Madhupur	21
10				Karuli	23
11				Dholpur	26
12				Bharatpur	21
				Bundi	27

Section: 2





Conclusion & Recommendations

Conclusion

The uses of family planning are allowing women the freedom to control the number and spacing of their births, family planning helps women preserve their health and fertility and also contribute to improving the overall quality of their lives. Family planning also contributes to improving children's health and ensuring that they have access to adequate food, clothing, housing, and educational opportunities. Family planning achieves these improvements in health and quality of life very cost-effectively compared with investments in most other health and social interventions. Committing human and financial resources to improving family planning services will not only improve the health and wellbeing of women and children, but it will also support efforts to achieve a sustainable global population.

Recommendation

High-Quality Family Planning Services

All RH services should be of the highest quality possible. High-quality contraceptive care involves providing women and men with safe and appropriate methods to meet individuals' and couples' needs at every stage of their reproductive lives. Accurate and complete information should be provided, allowing women and men to select freely a method that suits their needs.

High quality means that:

- a) The needs of clients are assessed.
- b) An appropriate range of methods is provided.
- c) Complete and accurate information about all methods is offered, thus ensuring informed choice.
- d) A mix of methods matches the needs of all potential clients.
- e) Providers have the necessary technical skills to offer the methods safely (i. e., provider screen women for medical contraindications, assess STD/ HIV risks, and can medically manage side effects).
- f) Providers should trained, technically accurate and provide culturally appropriate counselling techniques effectively.
- g) Services should be convenient, accessible and acceptable to clients.
- h) Follow-up care to ensure continuity of services is provided.
- i) An adequate logistics system ensures a continuity of supplies.

Procurement of Contraceptives and Logistics of Distribution

It is not possible to provide quality services unless an uninterrupted supply of contraceptives is ensured and staffs are appropriately trained. Local supply channels should be investigated. If these are inadequate, supplies should be obtained through reliable suppliers.

Planning Outlets and Opportunities for Family Planning Services

Family planning delivery sites should be accessible and convenient. Ideally, family planning services should be available at health centres, outreach health posts and through community-based distribution channels, when appropriate. Some groups, such as adolescents, unmarried women and men, may need special consideration so they feel comfortable using the services and so they can avoid the risk of stigmatisation by the community. Contraceptives should be available at the consultation point; the client should not be referred to a central pharmacy to obtain the selected method.

Counselling and family planning methods should be systematically offered to refugees after providing services related to post-abortion care, STDs or after childbirth.

Human Resource Needs

Family planning programmes should be organised and supervised by an experienced nurse, midwife or doctor and maximum use should be made of qualified or experienced local staff. If lay workers are used for community-based distribution, they must be trained in appropriate skills and attitudes and must be supervised.

Those involved in providing family planning services must show respect for the client's opinion and for the need for confidentiality. To increase use, the provider may need to be of the same sex and cultural background as the user and have strong communication skills.

Preparation of the information, education and communication (IEC) component

Counselling should always be an integral part of family planning services. Appropriate, culturally acceptable IEC materials help individuals and couples make free contraceptive choices. Information must include the benefits and constraints of different methods, and how to use them.

Preparation of an adequate training programme for service providers

In many situations, there will be trained providers among the population. These people should be employed to the fullest extent possible. All staff involved in providing family planning services must have adequate training on contraceptive methods and counselling, as indicated in the list below. This training should be supplemented by periodic refresher courses. On-the-job training and supervised practice are essential to ensure adequate performance and must be integral components of the supervisory programme.

The elements of an adequate training programme for service providers include:

- **Technical Competence**

- description of methods (including advantages and effectiveness)
- mode of action, side-effects, complications, danger signs
- appropriate groups of users and instructions for use or administration
- contraindications and drug interactions
- technical skills relating to the provision of each method (e. g., insertion of IUD or hormonal implant)
- follow-up and re-supply requirements, including ordering supplies
- record keeping

For methods that require specific technical skills -- such as implants, IUDs, voluntary sterilisation and the diaphragm -- providers need hands-on training in method provision and close supervision.

- **Interpersonal Skills**

- communication and counselling skills
- appropriate attitudes towards users and non-users and respect for their choices
- appropriate responses to rumours and misconceptions
- respect for dignity, privacy, confidentiality
- understanding of the needs of specific groups, such as adolescents, single women and men

- **Communication Skills**

It is important for providers to be trained in culturally sensitive, unbiased communication techniques that encourage open, interactive relationships with clients. Skills necessary for this kind of communication include listening, clarifying, encouraging clients to speak, acknowledging client feelings, and summarising what has been said. In addition, providers should be taught strategies for effective counselling of clients about method choices in a limited time period. Providers should also be trained to use visual and other support materials and to identify clients with special needs, such as those with a high risk of STDs, post-abortion clients, breast-feeding women, adolescents, etc.

- **Administrative Skills**

Many family planning providers must also perform routine administrative and managerial tasks, such as record keeping, referrals and inventory control, and should therefore be trained in these activities. Training should emphasise not only the specific skills necessary to carry out these functions, but also why they are important.

Plan protocols to be used during the family planning consultation

First contact involves:

- registration and taking an individual RH history;

- physical, gynaecological and pelvic examination when indicated (for example, to ascertain whether a woman is pregnant, to investigate unexplained vaginal bleeding, to determine the presence of an STD);
- counselling regarding available methods and the user's preferred choice according to her/ his STD/ HIV risk;
- provision of the contraceptive method supply, as indicated;
- counselling on when and how to use the contraceptives;
- counselling on possible side effects and reassurance that she/ he can return to the health facility at any time and change methods;
- Scheduling a follow-up visit.

The support of community, social and religious leaders should be sought before setting up family planning services. Without this support, only those willing to risk community censure may use the services. For example, in some traditional cultures, talk of women's reproductive rights may provoke opposition. But support may be given for an information, education and communication (IEC) campaign emphasising child spacing, safe motherhood and the health of women.

Discussions should be held with individual women (including leaders and traditional birth attendants [TBAs]) and women's organisations to obtain their advice on the location of service points, the timing of services at the health facilities and the level of privacy and confidentiality that will ensure maximum use.