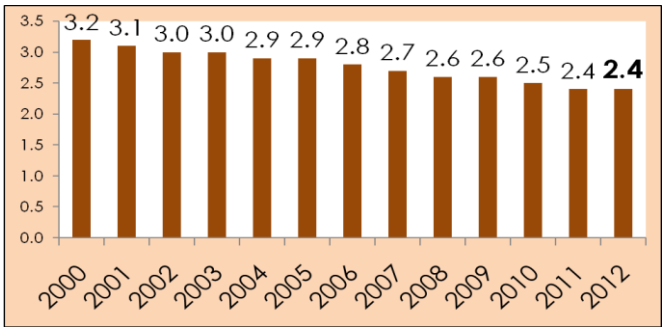
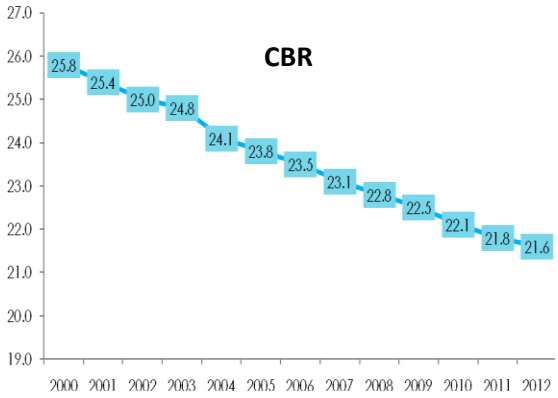
1. INTRODUCTION:

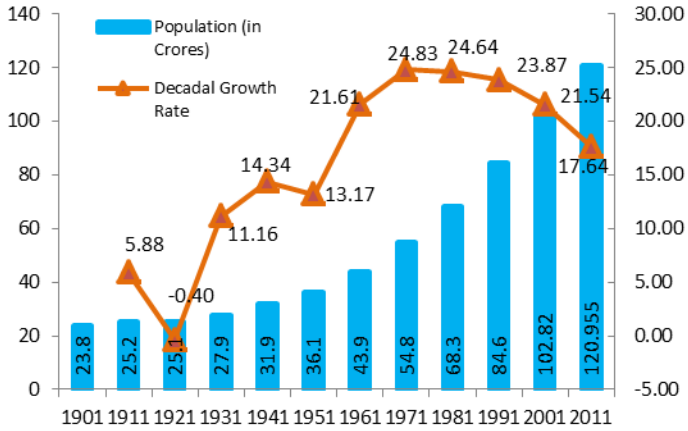
With its historic initiation in 1952, the family planning program has undergone transformation in terms of policy and actual program implementation. There occurred a gradual shift from clinical approach to the reproductive child health approach and further the national population policy (NPP) in 2000 brought a holistic and a target free approach which helped in reduction of fertility.



The target free approach is now reflected in the state project implementation plans based on community needs assessment. Presently the expected level of achievement is estimated for each state by the indicators reflecting the community needs like contraceptive usage, parity, unmet need and existing fertility.

Over the years, the program has been expanded to reach every nook and corner of the country and has penetrated into PHCs and SCs in rural areas, Urban Family Welfare Centers and Postpartum Centers in the urban areas. Technological advances, improved quality and coverage for health care have resulted in a rapid fall in the crude birth rate (CBR) and growth rate ***(2011Census showed the steepest decline in the decadal growth rate.)***





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, FP2020 Summit and others).

2. Current Scenario of Population and Family Planning in India

Expected increase of population of 15.7% in fifteen years	• From 1210 million in 2011 to 1400 million in 2026.
Decline in TFR	• Helps to stabilize India's population growth which in turn spurs the economic and social progress
Greater investments in family planning	• Helps to mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies • Reduce maternal mortality by 35% • Reduce infant mortality and abortions significantly
Govt. of India's commitment by 2015	• Maternal Mortality Ratio (MMR) to 100/100,000

- Infant Mortality Rate (IMR) to 30/1000 live births
- Total Fertility Rate (TFR) to 2.1

3. FACTORS THAT INFLUENCE POPULATION GROWTH:

Unmet need of Family Planning	• 21.3% as per DLHS-III (2007-08)
Age at Marriage and first childbirth	• 22.1% of the girls get married below the age of 18 years • Out of the total deliveries 5.6% are among teenagers i.e. 15-19 years
Spacing between Births:	• Spacing between two childbirths is less than the recommended period of 3 years in 57.4% of births (SRS 2012)
15-25 age group (women)	• 52.5% contribution in total fertility • 46% contribution in maternal mortality

4. CURRENT DEMOGRAPHIC SCENARIO IN THE COUNTRY (CENSUS 2011):

2.4% of world's land mass	• 17.5% of the world's population
1.21 billion	• India's population as per Census-2011
200 million	• Population of Uttar Pradesh – more than the population of Brazil

Growth of Population in India:

Census Year	Population (In Crores)	Decadal Growth (%)	Average Annual Exponential Growth (%)
1971	54.82	24.80	2.20
1981	68.33	24.66	2.22
1991	84.64	23.87	2.16
2001	102.87	21.54	1.97
2011	121.02	17.64	1.64

Perceptible decline (in last 5 decades)	• Crude birth rate – 40.8 per 1000 in 1951 to 21.6 in 2012. • Infant mortality rate – from 146 in 1951-61 to 42 in 2012. • Total Fertility rate – from 6.0 in 1951 to 2.4 in 2012 (**Ref: Annexure –I**). • Steepest decline in growth rate between 2001 and 2011 from 21.54% to 17.64%. • Decline in 0-6 population by 3.08% compared to 2001
Population added	• Lesser than the previous decade, 18.14 crores added during 2001-2011 compared to 18.23 crores during 1991-2011.
Significant decline	• There is a 4.1 percentage point fall from 24.99% in 2001 to 20.92% in 2011 in the growth rate of population in the EAG States (U.P, Bihar, Jharkhand, M.P, Chhattisgarh, Rajasthan, Orissa and Uttaranchal) after

decades of stagnation.

5. PROGRESS IN TFR:

TFR decline	• From 2.9 in 2005 to 2.4 in 2012. • Decline more significant in High Focus States.
TFR of 2.1 or less	• **23 States and Union Territories**
TFR 2.1-3.0	• **10 states –**Haryana-2.3, Gujarat-2.3, Arunachal Pradesh-2.3, Assam-2.4, Chhattisgarh-2.7, Jharkhand-2.8, Rajasthan-2.9, Madhya Pradesh-2.9, Meghalaya-2.9 and Dadara & Nagar Haveli-2.9
TFR above 3.0	• **2 states** - Bihar-3.5, Uttar Pradesh-3.3

Note: refer Annexure – I for details.

Impact of High Focus Approach of the Government of India (GoI)

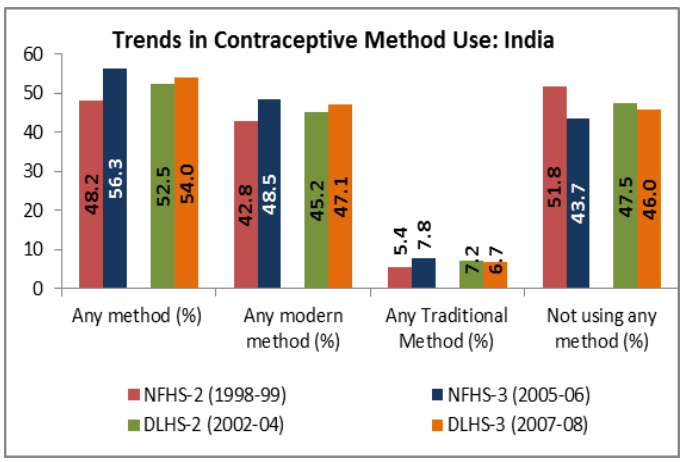
Govt of India has categorized states as per the TFR level in very high-focus (more than or equal to 3.0), high-focus (more than 2.1 and less than 3.0) and non-high focus (less than or equal to 2.1)

In 6 very high focus states, M.P has shown a decline of 0.2 points (between 2011 & 2012) and all others except Chhattisgarh have shown 0.1 point decline. Chhattisgarh has shown no decline.

Category	State	SRS 2010	SRS2011	SRS-2012	Point Change
Very High Focus states for FP	Bihar	3.7	3.6	3.5	-0.1
	Uttar Pradesh	3.5	3.4	3.3	-0.1
High Focus States for FP	Madhya Pradesh	3.2	3.1	2.9	-0.1
	Rajasthan	3.1	3.0	2.9	-0.1
	Jharkhand	3.0	2.9	2.8	-0.1
	Chhattisgarh	2.8	2.7	2.7	0.0
	Assam	2.5	2.4	2.4	0.0
	Gujarat	2.5	2.4	2.3	-0.1
	Haryana	2.3	2.3	2.3	-0.1
	Odisha	2.3	2.2	2.1	-0.1

6. FAMILY PLANNING SCENARIO (NHFS, DLHS and AHS):

6.1 The last survey figures available are from NFHS-3 (2005-06) and DLHS-3 (2007-08), which are being used for describing current family planning situation in India. 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 (see adjoining figure). 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%). The proximate determinants of fertility like, age at marriage and age at first childbirth (which are societal preferences) are also showing good improvement at the national level.

6.2 AHS survey has been conducted in 9 states (8 EAG states + Assam) which indicates that:

- Contraceptive use has been static in almost all AHS states except Bihar which has shown a decrease in use of modern contraceptives.

7. CURRENT FAMILY PLANNING EFFORTS:

Family planning have undergone a paradigm shift and emerged as one of the interventions to reduce maternal and infant mortalities and morbidities. It is well-established that the states with high contraceptive prevalence rate have lower maternal and infant mortalities.

Greater investments in family planning can thus help mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent recourse to induced abortion and eliminate most of these deaths. Studies show that if the current unmet need for family planning could be fulfilled over the next 5 years, we can avert 35,000 maternal deaths, 1.2 million infant death, save more than Rs. 4450 crores and save Rs. 6500 crores, if safe abortion services are coupled with increased family planning services. This strategic direction is the guiding principle in implementation of family planning programme in future.

7.1. Contraceptive services under the national family welfare program:

The methods available currently in India may be broadly divided into two categories, spacing methods and permanent methods. There is another method (emergency contraceptive pill) to be used in cases of emergency.

7.1.1. SPACING METHODs- these are the reversible methods of contraception to be used by couples who wish to have children in future. These include:

A. Oral contraceptive pills-

- These are hormonal pills which have to be taken by a woman, preferably at a fixed time, daily. The strip also contains additional placebo/iron pills to be consumed during the hormonal pill free days. The method may be used by majority of women after screening by a trained provider.
- At present, there is a scheme for delivery of OCPs at the doorstep of beneficiaries by ASHA with a minimal charge. The brand “MALA-N” is available free of cost at all public healthcare facilities.

B. Condoms-

- These are the barrier methods of contraception which offer the dual protection of preventing unwanted pregnancies as well as transmission of RTI/STI including HIV. The brand “Nirodh” is available free of cost at government health facilities and supplied at doorstep by ASHAs for minimal cost.

C. Intra-Uterine Contraceptive Devices (IUCD) -

- Copper containing IUCDs are a highly effective method for long term birth spacing.
- Should not be used by women with uterine anomalies or women with active PID or those who are at increased risk of STI/RTI (women with multiple partners).
- The acceptor needs to return for follow up visit after 1, 3 and 6 months of IUCD insertion as the expulsion rate is highest in this duration.
- Two types:
    - Cu IUCD 380A (10 yrs)
    - Cu IUCD 375 (5 yrs)

- New approach of method delivery- postpartum IUCD insertion by specially trained providers to tap the opportunities offered by institutional deliveries.

7.1.2. PERMANENT METHODS- these methods may be adopted by any member of the couple and are generally considered irreversible.

A. Female Sterilisation-

- Two techniques:
  - ***Minilap*** - Minilaparotomy involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked. Can be performed by a trained MBBS doctor.
  - ***Laparoscopic*** - Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen. Can be done only by trained and certified gynaecologist/surgeon.

B. Male Sterilisation:

- Through a puncture or small incision in the scrotum, the provider locates each of the 2 tubes that carries sperm to the penis (vas deferens) and cuts or blocks it by cutting and tying it closed or by applying heat or electricity (cautery). The procedure is performed by MBBS doctors trained in these. However, the couple needs to use an alternative method of contraception for first three months after sterilization till no sperms are detected in semen.
- Two techniques being used in India:
  - Conventional
  - Non- scalpel vasectomy – no incision, only puncture and hence no stiches.

7.1.3. EMERGENCY CONTRACEPTIVE PILL-

- To be consumed in cases of emergency arising out of unplanned/unprotected intercourse.
- The pill should be consumed within 72 hours of the sexual act and should never be considered a replacement for a regular contraceptive.

7.1.4. OTHER COMMODITIES - Pregnancy Testing Kits (PTK)

- Helps to detect pregnancy as early as one week after the missed period, thus proving an early opportunity for medical termination of pregnancy, thus saving lives lost to unsafe abortions.
- These are available at the subcentre level and also carried by ASHA.

7.1.5. Service Delivery Points:

- All the spacing methods, viz. IUCDs, OCPs and condoms are available at the public health facilities beginning from the sub-centre level. Additionally, OCPs condoms, and emergency contraceptive pills (since are not skill based services) are available at the village level also through trained ASHAs.
- Permanent methods are generally available at primary health centre level or above. They are provided by MBBS doctors who have been trained to provide these services. Laparoscopic sterilization is being offered at CHCs and above level by a specialist gynaecologist/surgeon only.
- These services are provided to around 20 crores eligible couples; Details of services provided at different level of:

Family Planning Method	Service Provider	Service Location
SPACING METHODS:		
IUD 380 A/IUCD 375	Trained & certified ANMs, LHVs, SNs and doctors	Subcentre & higher levels
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Subcentre & higher levels
Condoms	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Subcentre & higher levels
LIMITING METHODS:		
Minilap	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels
Laparoscopic Sterilization	Trained & certified Specialist Doctors (OBG & General Surgeons)	Usually CHC & higher levels
NSV: No Scalpel Vasectomy	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels
EMERGENCY CONTRACEPTION:		
Emergency Contraceptive Pills (ECPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level, Subcentre & higher levels

Note: Contraceptives like OCPs, Condoms are also provided through Social Marketing Organizations

7.2. THE SALIENT FEATURES OF THE FAMILY PLANNING PROGRAMME:

A. On-going interventions:

- More emphasis on Spacing methods like IUCD.
- Availability of Fixed Day Static Services at all facilities.
- Emphasis on minilap tubectomy services because of its logistical simplicity and requirement of only MBBS doctors and not post graduate gynaecologists/ surgeons.
- A rational human resource development plan is in place for provision of IUCD, minilap and NSV to empower the facilities (DH, CHC, PHC, SHC) with at least one provider each for each of the services and Sub Centres with ANMs trained in IUD insertion.
- Ensuring quality care in Family Planning services by establishing Quality Assurance Committees at state and district levels.
- Accreditation of more private/ NGO facilities to increase the provider base for family planning services under PPP.
- Increasing male participation and promoting Non- scalpel vasectomy.
- Compensation scheme for sterilization acceptors - under the scheme MoHFW provides compensation for loss of wages to the beneficiary and also to the service provider (& team) for conducting sterilisations. The compensation scheme has been enhanced in 11 high focus states from the year 2014.
- 'National Family Planning Indemnity Scheme' under which clients are indemnified in the eventualities of deaths, complications and failures following sterilization. The providers/ accredited institutions are indemnified against litigations in those eventualities.
- PPIUCD Incentive for service providers and ASHAs.
- Improving contraceptives supply management up to peripheral facilities.

- Demand generation activities in the form of display of posters, billboards and other audio and video materials in the various facilities.
- Strong political will and advocacy at the highest level, especially in states with high fertility rates.

B. New interventions to improve access to contraception:

Home Delivery of Contraceptives (HDC):

- A new scheme has been launched to utilize the services of ASHA to deliver contraceptives at the doorstep of beneficiaries. The scheme was launched in 233 pilot districts of 17 states on 11 July 2011 and is now expanded to the entire country from 17th Dec 2012.
- ASHA is charging a nominal amount from beneficiaries for her effort to deliver contraceptives at doorstep i.e. Re 1 for a pack of 3 condoms, Re 1 for a cycle of OCPs and Rs 2 for a pack of one tablet of ECP.

C. Ensuring Spacing at Birth (ESB):

- Under a new scheme launched by the GOI, services of ASHAs to be utilised for counselling newly married couples to ensure spacing of 2 years after marriage and couples with 1 child to have spacing of 3 years after the birth of 1st child. The scheme is operational in 18 states (EAG, North Eastern and Gujarat and Haryana). ASHA would be paid following incentives under the scheme:
    - Rs. 500/- to ASHA for delaying first child birth by 2 years after marriage.
    - Rs. 500/- to ASHA for ensuring spacing of 3 years after the birth of 1st child
    - Rs. 1000/- in case the couple opts for a permanent limiting method up to 2 children only
- MoHFW has introduced short term IUCD (5 years effectivity), Cu IUCD 375 under the National Family Planning programme. Training of state level trainers has already been completed and process is underway to train service providers up to the sub-center level.
- A new method of IUCD insertion (post-partum IUCD insertion) has been introduced by the Government.
- Promoting Post-partum Family Planning services at district hospitals by providing for placement of dedicated Family Planning Counsellors and training of personnel.

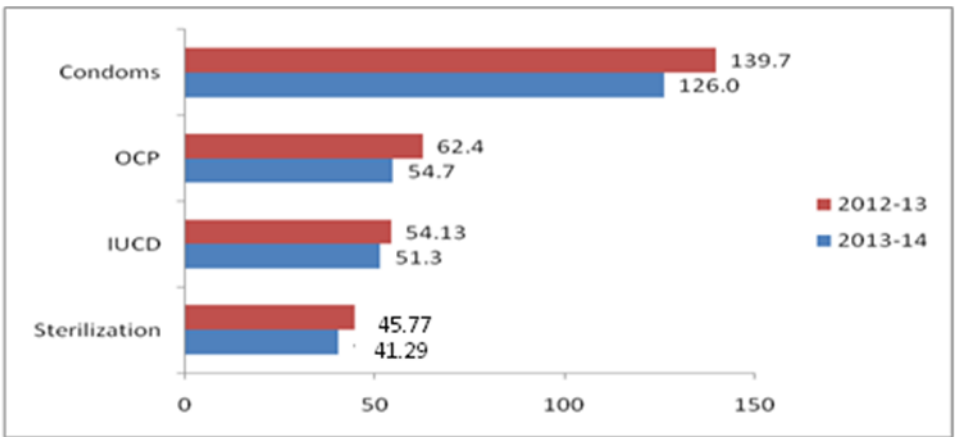
D. Pregnancy Testing Kits:

- Nishchay-Home based pregnancy test kits (PTKs) was launched under NRHM in 2008 across the country and was anchored with the Family Planning Division**.**
- The PTKs are being made available at subcenters and to the ASHAs.
- The PTKs facilitate the early detection and decision making for the outcomes of pregnancy.

8. PROGRESS MADE UNDER FAMILY PLANNING PROGRAMME:

8.1. Service Delivery 2013-14:

The performance of family planning services (in lakhs) during 2013-14 is provided below (source: HMIS):



- Number of IUCDs and sterilisations has remained static in spite of declining CBR and TFR. There is a need to sustain momentum to reach the replacement level fertility.
- Considering the current efforts to focus on spacing, it is expected that IUCD performance would increase in near future.
- State wise sterilisation and IUCD achievements is provided at **ANNEX-2**

8.2. Promotion of IUCDs as a short & long term spacing method:

In 2006, GOI launched "Repositioning IUCD in National Family Welfare Program" with an objective to improve the method mix in contraceptive services and has adopted diverse strategies including advocacy of IUCD at various levels; community mobilization for IUCD; capacity building of public health system staff starting from ANMs to provide quality IUCD services and intensive IEC activities to dispel myths about IUCD. Currently, increased emphasis is given to promotion of IUCD insertion as a key spacing method under Family Planning programme.

"Alternative Training Methodology in IUCD" using anatomical, simulator pelvic models incorporating adult learning principles and humanistic training technique was started in September 2007 to train service providers in provision of quality IUCD services.

Actions taken and achievements:

- HLFPPT has been engaged to support states to conduct interval IUCD training and also post training follow-up of trained personnel. HLFPPT would also follow-up sample cases of IUCD insertion to ensure retention.
- Directive has been issued to the states to notify fixed days/ per week at SHC and PHC level for conducting IUCD insertions.
- Introduction of **Cu IUCD-375** (5 years effectivity) under the Family Planning Programme:
  - Training of state master trainers completed in December 2011.
  - Sample Cu IUCD 375 despatched to States for conducting district level training.
  - Funds approve under PIP for conduct of training and orientation of other staff.

Increasing provider base for IUCD (Through AYUSH Practitioners)

- It has been approved to train ASU doctors in IUCD after a short refresher course/training and AYUSH doctors except Yoga and Naturopathy practitioners are allowed to perform IUCD insertions at public health facilities after undergoing stipulated training.

Onsite training for IUCD services:

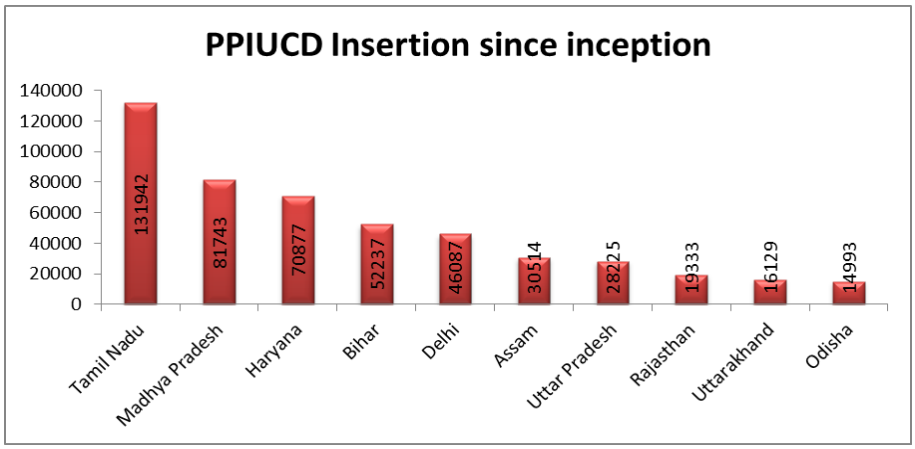
- Jhpiego, Engender Health and IPAS have been engaged for onsite training for IUCD services.

8.3. Emphasis on Postpartum Family Planning (PPFP) services:

- In order to capitalize on the opportunity provided by increased institutional deliveries, the GoI is focusing on strengthening post-partum FP services.
- PPFP services are not being offered uniformly at all levels of health system across different states of India resulting in missed opportunities.
- Insertion of IUCD during the post partum period, known as Postpartum Intrauterine Contraceptive Device (PPIUCD), is being focused to address the high unmet need of spacing during postpartum period.

Actions taken and achievements:

- **Strengthening Post-Partum IUCD (PPIUCD)** services at high case load facilities:
  - Currently the focus is on placement of trained providers for PPIUCD insertion at district and sub-district hospital level only, considering the high institutional delivery load at these facilities.



Graph 6: Top 10 performing states as per total PPIUCD insertions

- From the inception till September **5,65,435** insertions has been done
- **Appointing dedicated counsellors at high case load facilities:**
  - MoHFW has decided to appoint counsellors at all high case load facilities to provide counselling services in following areas:
    - Post-partum Family Planning (IUCD and Sterilisation)
    - Other family planning methods such as condoms, pills etc.
    - Ensuring healthy timing and spacing of pregnancy
    - Mother & baby care
    - Early initiation of breast feeding
    - Immunization
    - Child nutrition.

8.4. Assured delivery of family planning services:

8.4.1. ***Fixed Day Services (FDS) for IUCD Insertion*:** decision has been taken to ensure fixed days IUCD insertion services at the level of SC and PHC (at least 2 days in a week).

8.4.2. ***Fixed Day Static Services in Sterilisation at facility level*:**

- Operationalization of FDS has following objectives:

- To make a conscious shift from camp approach to a regular routine services.
- To make health facilities self sufficient in provision of sterilization services.
- To enable clients to avail sterilization services on any given day at their designated health facility.

FDS Guidelines for sterilization services	
Health Facility	**Minimum frequency**
District Hospital	Twice a week
Sub District Hospital	Weekly
CHC / Block PHC	Fortnightly
24×7 PHC / PHC	Monthly

Note: Those facilities providing more frequent services already must continue to do so

8.4.3. ***Camp approach for sterilization services*** is continued in those states where operation of regular fixed day static services in sterilization takes longer time duration.

8.4.4. ***Rational placement of trained providers*** at the peripheral facilities for provision of regular family planning services.

Actions taken and achievements:

- In year 2014-15 all the states have shown their commitment to strengthen fixed day family planning services for both IUCD and sterilisation and it has been included under quarterly review mechanism to assess progress made by the states.
- Recent field visits and review missions to the states reveal that most of the facilities at the level of CHC and above have been operationalised for providing FP services on fixed day basis.
- Analysis of the data available from HMIS for 2013-14 reveals that:
    - Around 34.9% of NSVs are conducted at PHC and 33.2% at CHC level and 29.7% at SDH/DH level.
    - Majority of minilap sterilisations (41.6%) are conducted at PHC level followed by 33.9% at CHC level. 24.1% of the minilap were conducted at SDH/DH level.
    - Although data shows that 27.9% laparoscopic sterilisation is conducted at PHCs, this may not be correct considering laparoscopic sterilization requires services of specialists. However, it is important to note that majority of laparoscopic sterilisation (45.7%) is conducted at CHC level. 25.8% of cases were operated at SDH/DH level.
    - As anticipated around 58.1% of the PPS is reported at DH/ SDH level since majority of institutional deliveries are conducted at these facilities; however, this needs to increase at PHC (22.9%) and CHC (15.5%) level as well.

8.5. Quality assurance in family planning:

Quality assurance in family planning services is the decisive factor in acceptance and continuation of contraceptive methods and services. The Hon'ble Supreme Court of India in its Order dated 1.3.2005 in Civil Writ Petition No. 209/2003 (Ramakant Rai V/s Union of India) has, inter alia, directed the Union of India and States/UTs for ensuring enforcement of Union Government's Guidelines for conducting sterilization procedures and norms for bringing out uniformity with regard to sterilization procedures by:

- Creation of panel of Doctors/health facilities for conducting sterilization procedures and laying down of criteria for empanelment of doctors for conducting sterilization procedures.
- Laying down of checklist to be followed by every doctor before carrying out sterilization procedure.

- Laying down of uniform proforma for obtaining of consent of person undergoing sterilization.
- Setting up of Quality Assurance Committee for ensuring enforcement of pre and postoperative guidelines regarding sterilization procedures.
- Bringing into effect an insurance policy uniformly in all States for acceptors of sterilizations etc.

Actions taken and achievements:

The MoHFW developed various standards/ manuals/ guidelines and directed the states to adhere to the same to ensure quality of service provision, which are as follows:

- **Standards for Female and Male Sterilisation Services (2006):**
    - It sets out the criteria for eligibility, physical requirements, counselling, informed consent, preoperative, postoperative, and follow-up procedures and procedures for management of complications and side effects.
- **Quality Assurance Manual for Sterilization Services (2006):**
    - It sets out modalities for formation of Quality Assurance Committees (QACs) at state and district whose main functions include:
        - Empanelment of doctors for sterilization procedures
        - Accreditation of private/NGO facilities
        - Review/report post sterilization deaths/ complications /failures
- Standard Operating Procedure (SOP) for Sterilisation Services in camps (2008)
- Fixed Day Static approach for Sterilization Services (2008)
- IUCD Reference Manual: Comprehensive manual for the interval IUCD and PPIUCD insertion
- Comprehensive manual on female sterilization
- Comprehensive manual on male sterilization
- Family Planning Indemnity Scheme:
    - For the acceptors of Sterilization for treatment of post-operative complications, failure or death attributable to the procedure of sterilization. The manual has been revised in 2013.
- Ministry of Health and Family Welfare, Family Planning Division has recruited technical experts to support states in improving delivery of quality services

8.6. Other promotional schemes:

8.6.1. Revised compensation scheme for acceptors of sterilization:

- Government has been implementing a Centrally Sponsored Scheme since 1981 to compensate the acceptors of sterilization for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilization. This compensation scheme for acceptors of sterilization services was revised with effect from 31.10.2006 and has been further improved with effect from 07.09.2007. Breakup of compensation scheme provided below:

For Public (Govt.) facilities:

	Breakup of the Compensation package	**Acceptor**	Motivator	Drugs and dressing	Surgeon charges	Anaesthetist	Staff nurse	OT technician/ helper	Refreshment	Camp management	**Total**
High focus states	**VAS - ALL** **TUB - ALL**	**1100** **600**	200 150	50 100	100 75	- 25	15 15	15 15	10 10	10 10	**1500** **1000**
Non High focus states	**VAS.-ALL** **TUB (BPL + SC/ ST only)**	**1100** **600**	200 150	50 100	100 75	-- 25	15 15	15 15	10 10	10 10	**1500** **1000**
	TUB (APL)	**250**	150	100	75	25	15	15	10	10	**650**

For Private Facilities:

Category	Type of operation	Facility	Motivator	Total
High focus states	Vasectomy (ALL) Tubectomy (ALL)	1300 1350	200 150	**1500** **1500**
Non High focus states	Vasectomy (ALL) Tubectomy (BPL + SC/ST)	1300 1350	200 150	**1500** **1500**

8.6.2. Enhanced Compensation Scheme for 11 states:

In the light of the rise in cost of living, the ever increasing transport cost which enables a client to travel from his residence/village to the nearest service centre, the prevalent high wage compensation for the days requiring recuperation as well as other incidental cost GoI has approved an enhancement in the current compensation package for the 11 high focus states- Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana and Gujarat.

Public (Government) Facilities: *(all amounts in Rupees)*

SN	Procedure	Tubectomy		Vasectomy
	Details of the package	**Interval**	**PPS**	
1	Acceptor	1400	2200	2000
2	Motivator/ASHA	200	300	300
3	Drugs and dressings	100	100	50
4	Surgeons' compensation	150	250	250
5	Anaesthetist/ Assisting MO (if any)	50	50	-
6	Nurse/ANM	30	50	30
7	OT technician/helper	30	50	30
8	Clerks/ documentation	20		20
9	Refreshment	10	-	10
10	Miscellaneous	10	-	10
	TOTAL	**2000**	**3000**	**2700**

**PPS: (Post Partum Sterilisation)*

Accredited Private/NGO Facilities: (all amounts in Rupees)

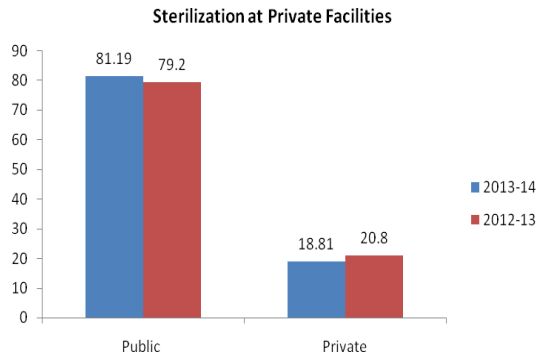
S.N	*Procedure*	*Tubectomy*	*Vasectomy*
1	Facility	2000	2000
2	Acceptor	1000	1000
	TOTAL	**3000**	**3000**

8.6.3. National Family Planning Indemnity Scheme (NFPIS):

With effect from, 01.04.2013, it has been decided that States/UTs would process and make payment of claims to accepters of sterilization in the event of death/failures/complications /Indemnity cover to doctors/health facilities. The States/UTs would make suitable budget provisions for implementation of the scheme through their respective State/UT Program Implementation Plans (PIPs) under the National Rural Health Mission (NRHM)and the scheme is renamed as "Family Planning Indemnity Scheme".

8.6.4. Public Private Partnership (PPPs):

- PPP in family planning services are intended to utilize the reach of private sector in increasing the access to family planning services. In order to promote PPP in family planning services, accredited private facilities and empanelled private healthcare providers are covered under revised compensation scheme for sterilization and NFPIS.



- Accreditation and empanelment of private health facilities /healthcare providers is decentralized to District Quality Assurance Committees (DQAC).
- Sterilisation services at private facilities have declined in 2013-14 compared to 2012-13.
- Top five and bottom five states in terms of sterilisation services at private facilities:

SN.	State	Sterilisation at private facilities (%)		
		2012-13	2013-14	Change (% point)
Top five states				
1	Kerala	48.4	48.0	-0.4
2	Gujarat	20.8	37.9	17.1
3	Tamil Nadu	36.9	36.7	-0.2
4	Daman & Diu	32.4	34.5	2.2
5	Dadra & Nagar Haveli	13.9	29.1	15.3
Bottom five states				
1	Orissa	0.3	0.9	0.6
2	Uttar Pradesh	9.4	1.3	-8.1
3	Jammu & Kashmir	0.2	2.1	1.9
4	Madhya Pradesh	8.2	3.6	-4.7
5	Assam	5.9	4.9	-1.0
	INDIA	**20.8**	**18.8**	**-2.0**

8.6.5. Scheme of Home delivery of contraceptives by ASHAs at doorstep of beneficiaries:

- Community based distribution of contraceptives by involving ASHAs and focused IEC/BCC efforts are undertaken for enhancing demand and creating awareness on family planning. To improve access to contraceptives by the eligible couples, services of ASHA are utilised to deliver contraceptives at the doorstep of beneficiaries. The scheme has been rolled out in all the districts of the country.
- 3 independent agencies evaluated the scheme and following points emerged out of it:
    - Majority (62 %) respondents have heard of the scheme from ASHA. In other words, ASHA has been communicating on the scheme to the community;
    - Nearly, 78 % of those she visited, said that ASHA was able to explain and counsel on the use of contraceptives
    - 95% of the women beneficiaries (interviewed) were completely satisfied with the Scheme;

- 65 % of those who procured from ASHA cited easy access as the reason. In other words, ASHA is emerging as an important source on account of her easy access.
- Of the respondents who were provided contraceptives by ASHA, 53 % were willing to pay.
- 86% ASHAs believed that the Scheme including payments will be successful in the longer term.
- 50% of the ASHAs indicated positive community response.
- ASHAs feel empowered and have expressed confidence in distributing contraceptives to beneficiaries, irrespective of receiving any payment by beneficiaries.

8.6.6. Scheme for ASHAs to ensure spacing in births:

- As discussed above under the scheme, services of ASHAs to be utilised for counselling newly married couples to ensure spacing of 2 years after marriage and couples with 1 child to have spacing of 3 years after the birth of 1st child.
- The scheme is being implemented in 18 States of the country (8 EAG, 8 NE, Gujarat and Haryana)
- ASHA would be paid following incentives under the scheme:
  - Rs 500/- to ASHA for ensuring spacing of 2 years after marriage.
  - Rs 500/- to ASHA for ensuring spacing of 3 years after the birth of 1st child.
  - Rs 1000/- in case the couple opts for a permanent limiting method up to 2 children only.

The scheme is operational from 16th May 2012.

8.7. Celebration of World Population Day (WPD) 2014

- For the first time, the World Population Day was celebrated in the country in all states.
- The event was observed over a month long period, split into an initial fortnight of mobilization/ sensitization followed by a fortnight of assured family planning service delivery.
  - June 27 to July 10, 2014: "Dampati Sampark Pakhwada**"** or "Mobilisation Fortnight" was organised.
  - July 11 to July 24, 2014 "Jansankhya Sthirtha Pakhwada" or "Population Stabilisation Fortnight" was organised.

Key Findings:

- Overall performance during the fortnight (11th to 24th July 2014) is placed below:

S N.	Method	2013	2014
1	Female Sterilisation	1,57,431	1,48,251
2	Male Sterilisation	8130	5004
	Total Sterilisation	**1,65,561**	**1,53,255**
3	IUCD Insertion	3,50,642	3,88,535

Bihar extended the activity till 31st July 2014. Assam extended the activity till 30th August 2014 in 4 districts, where the activities were not conducted due to Ramzan.

The total sterilization which took place during the WPD was **1.53 lakhs** (1.48 lakhs female sterilizations and 5004 Male Sterilizations). **Bihar was the highest performing state in sterilization** with total female sterilizations at 27,248 followed by Rajasthan (17,167) and Odisha (16,709). The total Male sterilizations were highest in Uttar Pradesh at 870.

The total **IUCDs inserted were 3.88 lakhs** and was approximately 8% higher than the performance of the previous year. The **highest IUCD insertions were in Rajasthan** (70,255), followed by Uttar Pradesh (56,941) and Bihar (42,325).

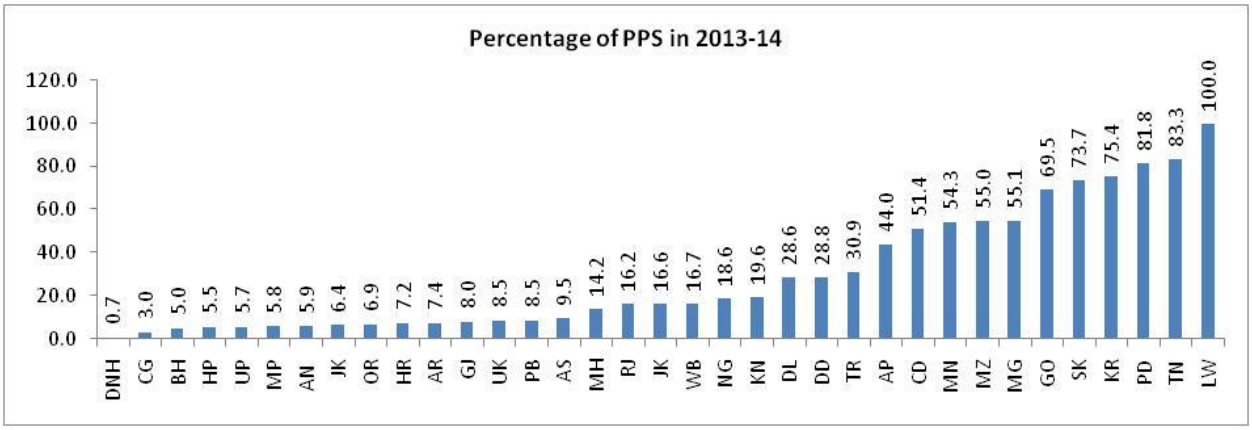
9. KEY CHALLENGES & OPPORTUNITIES:

9.1. Unavailability of regular sterilization services:

- The access to sterilization services at sub-district level is restricted due to poor implementation of FDS approach, especially so in high focus states with high TFR and high unmet need due to:
  - lack of trained service providers specially in minilap & NSV at the CHCs and PHCs
  - Lack of willingness to plan for provision of services across the year
  - poor facility readiness
- Majority of sterilizations in high focus states (70-75%) are conducted in last 2 quarters.
- NE states are relatively better; however, sterilisation services are not equally distributed across year.
- Southern states provide uniform services arcos the year which also reflects on their outcomes.

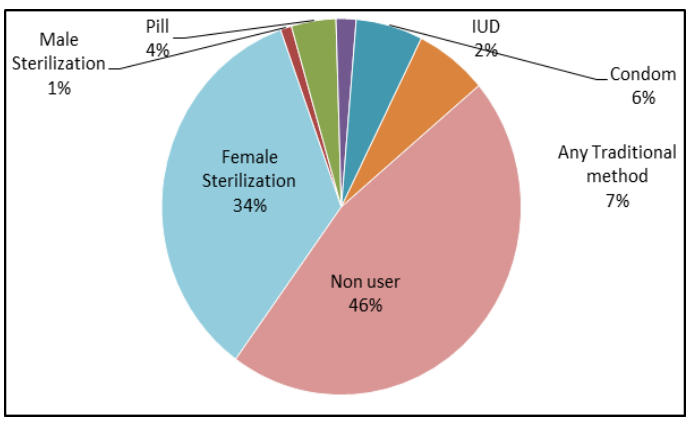
9.2. Increased institutional delivery vs. PPFP:

- The huge potential for postpartum contraception offered by the increasing number of institutional deliveries has not been tapped adequately due to lack of planning, lack of trained postpartum family planning service providers and lack of infrastructure in most of the high focus states.
- This is evident from following figure, which shows that in high focus states postpartum sterilization is very low as compared to 70-80% in non-high focus states like Kerala and Tamil Nadu:



9.3. Inadequate attention to spacing methods

- Low use of spacing methods is evident by most states of India, despite high unmet need in spacing. According to DLHS 3, all the spacing methods together account for just around 25.5% of the current contraceptive use compared to 74.5% by female & male sterilizations put together as evidenced in adjoining pie chart.



- The survey data (AHS/DLHS) shows that the uses of modern contraceptive is highly skewed towards female sterilization. The CPR for IUCD has almost remained static from DLHS-I to DLHS-III.

9.4. The demand from the states for contraceptives and survey findings on contraceptive use are in variance. To address this issue, the logistics of procurement and supply of contraceptives has to be rationalized to reflect the actual requirement and usage.

9.5. Public Private Partnership (PPP) in family planning has not been adequately promoted across most states in India and there is a reluctance to accredit private providers at state/district level, which is adversely affecting the widest possible access of family planning services to clients.

10. FUTURE STRATEGIES:

- Greater emphasis on spacing methods:
    - Interval and Post-partum IUCD training
    - Strengthening fixed day IUCD services
- Focus on revitalising Post-partum FP delivery system through strengthening district hospitals in focused states to provide PPFP services along with good counselling.
- Strengthening management systems at national, state, district and block levels by infusing public health management professionals at these levels.
- Addressing social determinants such as education, delay age at marriage etc. through communication.
- Strengthening contraceptive supply and availability at every level.

NOTE: All the guidelines related to Family Planning programme are available at following link:
http://www.mohfw.nic.in/NRHM/FP.htm

Annexure 1: State wise survey data

SNo.	State	Total Fertility Rate		Infant Mortality Rate		Maternal Mortality Ratio		Crude Birth Rate		Spacing Between Births		% of currently married women (15 – 49) using contraception		Total Unmet Need for Family Planning (%)	
		2012	AHS 2012	2012	2012	2010-12	2012	2012	2012	36+ months	36+ months	Modern Method (%)		2007-08 (DLHS III)	AHS/ DLHS 2012
		SRS		SRS	AHS	SRS	AHS	SRS	AHS	SRS	AHS 2012	DLHS III	AHS/DLHS 2012		
	INDIA	**2.4**		**42**		**178**		**21.6**		**42.6**		**47.1**		**21.3**	
1	AN	1.6*		24		..		15		..		..		..	
2	AP	1.8		41		110		17.5		36.9		65.1	66.2	8.5	19.1
3	Ar P	2.3*		33		..		19.4		..		49	43.9	14.3	32.3
4	AS	2.4	2.4	55	55	328	301	22.5	21.2	57.6	52.3	31.2	38.1	24.3	13.1
5	BH	3.5	3.5	43	48	219	274	27.7	26.1	37.7	45.2	28.4	36.5	37.2	31.5
6	CD	1.7*		20		..		14.8		..		70.7	65.9	8.3	12.1
7	CG	2.7	2.7	47	46	230	244	24.5	23.2	36.3	46.4	47.1	57.2	20.9	24.4
8	DNH	2.9*		33		..		25.6		..		..		..	
9	DD	2.0*		22		..		18.1		..		..		..	
10	DL	1.8		25		..		17.5		54		55.5		13.9	
11	GO	1.4*		10		..		13.1				35.9	24.0	28.8	33.5
12	GJ	2.3		38		122		21.1		41		54.3		16.5	
13	HR	2.3		42		146		21.6		39.8		54.5	48.6	16	30.4
14	HP	1.8		36		..		16.2		37.9		68.1	56.1	14.9	20.6
15	J & K	1.9		39		..		17.6		49.6		41.2		21.6	
16	JH	2.8	2.7	38	36	219	245	24.7	23.0	45.9	51.1	30.8	43.7	34.7	22.3
17	KN	1.9		32		144		18.5		35.6		60.8	61.6	15.8	
18	KR	1.8		12		66		14.9		66.1		53.1	53.9	16.8	19.0
19	LW	1.6*		24		..		14.8		..		..		..	
20	MP	2.9	3.0	56	62	230	227	26.6	24.5	35.4	39.7	53.1	59.4	19.3	21.6
21	MH	1.8		25		87		16.6		41.7		62.6	65.3	14.2	19.0
22	MN	1.5*		10		..		14.6		..		..	11.1	..	54.5
23	MG	2.9*		49		..		24.1		..		16.8	14.3	32.7	55.5
24	MZ	1.7*		35		..		16.3		..		53.5	59	16.7	21.4
25	NG	1.8*		18		..		15.6		..		..		..	
26	OD	2.1	2.2	53	56	235	230	19.9	19.5	56.8	56.2	37.8	46.3	24	18.9
27	PD	1.8*		17		..		15.8		..		57.5	52.3	19.8	27.1
28	PB	1.7		28		155		15.9		45.5		62.9	59.8	11.9	15.3
29	RJ	2.9	2.9	49	55	255	208	25.9	24.1	37.2	41.5	54	62.4	17.9	13.0
30	SK	1.7*		24		..		17.2		..		61.1	53.8	16.1	20.2
31	TN	1.7		21		90		15.7		43.5		57.8	52.4	19.4	27.1
32	TR	1.4*		28		..		13.9		..		40.8	40.6	12.8	26.7
33	UP	3.3	3.3	53	68	292	258	27.4	24.8	42.2	43.7	26.7	37.6	33.8	20.7
34	UK		2.1	34	40	292	165	18.5	18.0	..	44.3	53.3	54.3	11.6	15.3
35	WB	1.7		32		117		16.1		59		53.3	59.0	11.6	12.1

Source: **SRS 2010 estimates*

ANNEXURE 2: Number Sterilisations and IUCDs, by states: 2013-14

States	Female Sterilisation	Male Sterilisation	Total Sterilisation	IUD insertions
Bihar	497124	3202	500326	383113
Chhattisgarh	122634	4030	126664	89613
Himachal Pradesh	19626	2119	21745	21003
Jammu & Kashmir	15476	638	16114	18571
Jharkhand	105496	5471	110967	92537
Madhya Pradesh	354987	6432	361419	383872
Orissa	134470	1879	136349	138696
Rajasthan	299868	3770	303638	374948
Uttar Pradesh	261467	9323	270790	1094963
Uttarakhand	23088	1212	24300	91660
Arunachal Pradesh	1249	2	1251	2982
Assam	49375	4122	53497	84813
Manipur	682	129	811	4767
Meghalaya	2493	14	2507	4439
Mizoram	1781	0	1781	2887
Nagaland	1775	15	1790	3810
Sikkim	167	49	216	1434
Tripura	5407	23	5430	987
Andhra Pradesh	308205	9075	317280	195333
Goa	2784	18	2802	1399
Gujarat	265030	1867	266897	556427
Haryana	68847	4068	72915	216618
Karnataka	310025	1390	311415	179539
Kerala	96337	1805	98142	56675
Maharashtra	532828	17601	550429	398759
Punjab	59871	3986	63857	215360
Tamil Nadu	258460	1206	259666	334081
West Bengal	205557	5873	211430	110752
A &N Islands	1050	1	1051	623
Chandigarh	2086	74	2160	3899
Dadra & Nagar Haveli	1494	2	1496	504
Daman & Diu	382	3	385	252
Delhi	17780	1401	19181	57957
Lakshadweep	40	0	40	51
Puducherry	8742	2	8744	5569
MO Railways	1891	143	2034	1447
TOTAL	**4036683**	**90802**	**4127485**	**5128893**