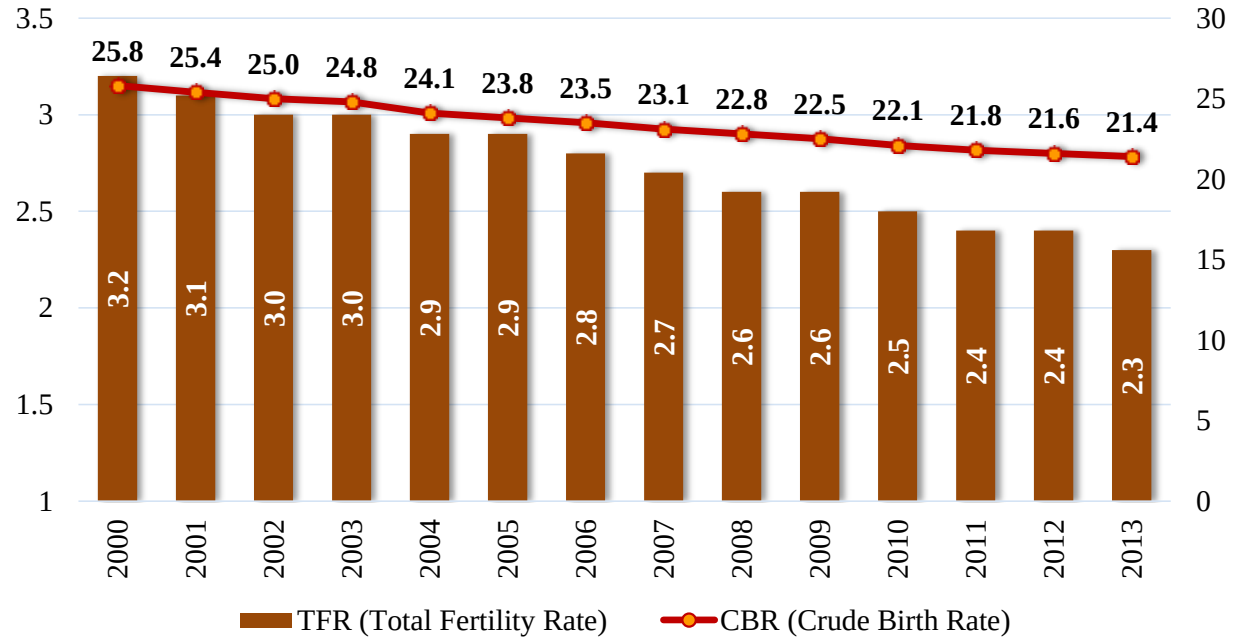
1. INTRODUCTION:

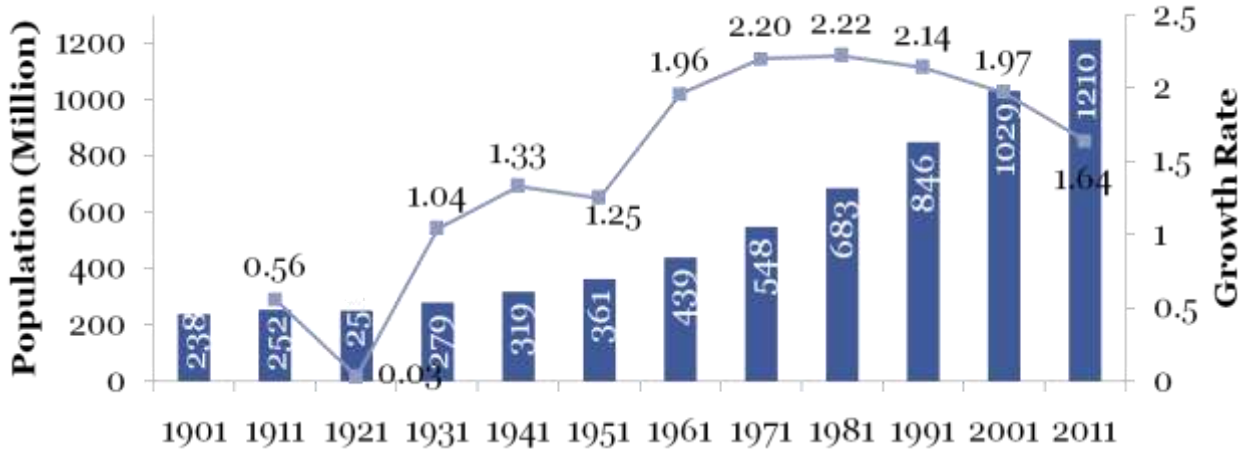
India was the first country in the world to have launched a National Programme for Family Planning in 1952. With its historic initiation in 1952, the family planning program has undergone transformation in terms of policy and actual program implementation. There occurred a gradual shift from clinical 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.

Post ICPD 1994 held in Cairo, there was a de-emphasis on Family Planning globally and the donors withdrew funding for FP programmes substantially. However subsequently it was realized that without increasing use and access to contraceptives, it would be difficult to impact the high maternal, infant and child mortality.

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), total fertility rate and growth rate ***(2011Census showed the steepest decline in the decadal growth rate.)***



Trend of TFR and CBR



Population increase and 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, Sustainable Development Goals-SDG, FP2020 Summit and others).

2. Some facts on Family Planning and related matters

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 2017	• 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 59.3% of births (SRS 2013)
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 21.4 in 2013.
- Infant mortality rate – from 146 in 1951-61 to 40 in 2013.
- Total Fertility rate – from 6.0 in 1951 to 2.3 in 2013 (**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 2.3 in 2013.
- Decline more significant in High Focus States.

TFR of 2.1 or less
- **24 States and Union Territories**

TFR 2.1-3.0
- **10 states** –Haryana-2.2, Gujarat-2.3, Arunachal Pradesh-2.3, Assam-2.3, Chhattisgarh-2.7, Jharkhand-2.6, Rajasthan-2.8, Madhya Pradesh-2.9, Meghalaya-2.9 and Dadara & Nagar Haveli-2.9

TFR above 3.0
- **2 states** - Bihar-3.4, Uttar Pradesh-3.1

Note: refer Annexure – I for details.

Impact of High Focus Approach of the GoI:

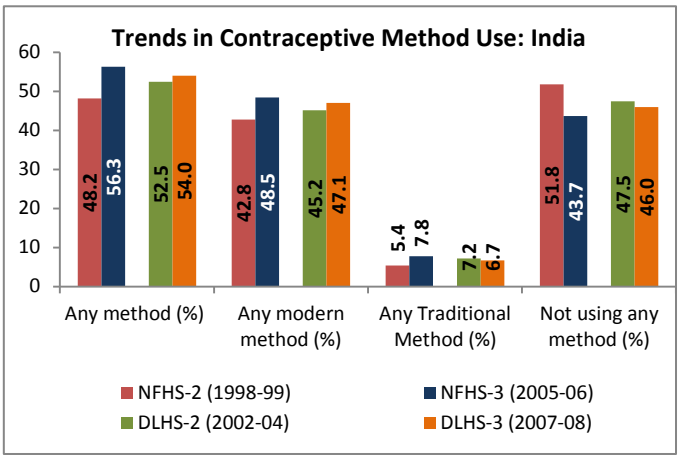
Govt of India has categorized states as per the TFR level in very high-focus (more than or equal to 3.0), high-focus (more than 2.1 and less than 3.0) and non-high focus (less than or equal to 2.1)

In 6 very high focus states, U.P has shown a decline of 0.2 points (between 2012 & 2013). Among high focus states Jharkhand has shown a decline of 0.2 points. MP, Chhattisgarh and Gujarat have not shown any decline whereas Rajasthan, Assam and Haryana has shown a decline of 0.1 points.

Category	State	SRS-2011	SRS-2012	SRS-2013	Point Change
Very High Focus states for FP	**Bihar**	3.6	3.5	3.4	-0.1
	Uttar Pradesh	3.4	3.3	3.1	-0.2
High Focus States for FP	**Madhya Pradesh**	3.1	2.9	2.9	0.0
	Rajasthan	3.0	2.9	2.8	-0.1
	Jharkhand	2.9	2.8	2.6	-0.2
	Chhattisgarh	2.7	2.7	2.7	0.0
	Assam	2.4	2.4	2.3	-0.1
	Gujarat	2.4	2.3	2.3	0.0
	Haryana	2.3	2.3	2.2	-0.1
	Odisha	2.2	2.1	2.1	0.0

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. Rajasthan and Chhattisgarh have shown a substantial increase in modern contraceptive usage.

State wise TFR, Modern Contraceptive Prevalence Rate & Unmet Need for High Focus States

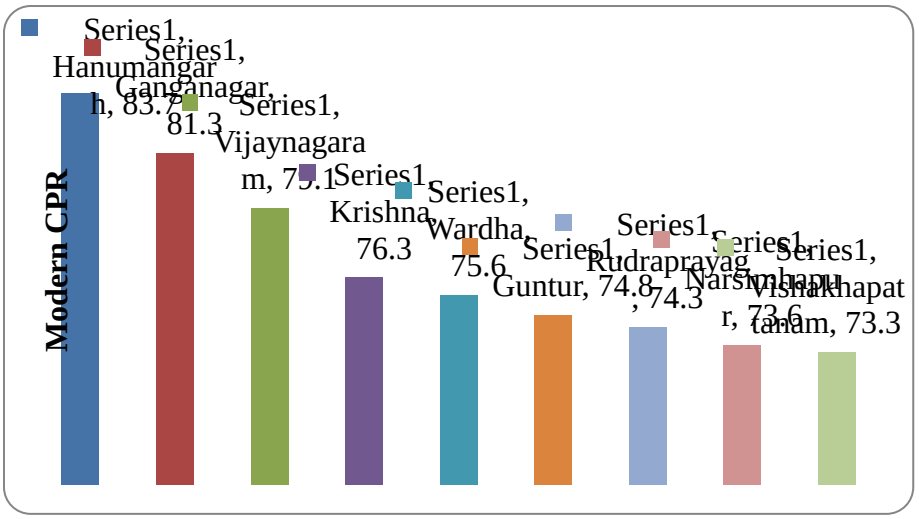
Sl. No	States	TFR			mCPR			Unmet Need		
		2010	**2011**	**2012**	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**
1	Uttarakhand	2.3	2.1	2.1	55.4	54.1	54.3	23.2	18.1	15.3
2	Odisha	2.3	2.3	2.2	44	46.8	46.3	23.2	19.1	18.9

3	Assam	2.6	2.4	2.4	35.7	37.9	38.1	24	15.9	13.1
4	Chhattisgarh	2.9	2.8	2.7	49.5	55.4	57.2	26.4	24.8	24.4
5	Jharkhand	3.1	2.9	2.7	38.0	43.9	43.7	30.5	22.6	22.3
6	Rajasthan	3.2	3.1	2.9	58.8	59.4	62.4	19.6	12.6	13.0
7	Madhya Pradesh	3.1	3.1	3.0	57.0	59.3	59.4	22.4	21.6	21.6
8	UP	3.6	3.4	3.3	31.8	37.3	37.6	29.7	24.1	20.7
9	Bihar	3.7	3.6	3.5	33.9	38.2	36.5	39.2	33.5	31.5

- The unmet need has declined in all states except Madhya Pradesh where it has remained static.

6.3 District wise contraceptive prevalence:

- The graph shows the districts with the highest contraceptive prevalence



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. Intrauterine 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 MBBS doctor or specialist.

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:

- 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 MBBS doctors & Specialist Doctors	Usually CHC & higher levels
NSV: No Scalpel Vasectomy	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels
EMERGENCY CONTRACEPTION:		
Emergency	Trained ASHAs, ANMs, LHVs, SNs	Village level, Subcentre &

Family Planning Method	Service Provider	Service Location
Contraceptive Pills (ECPs)	and doctors	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 associated with less failure and complication rates.
- 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 sterilizations. 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.
- 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.
- ***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.

- ***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
- ***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 on **24th January, 2012.**
    - 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.
- 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.

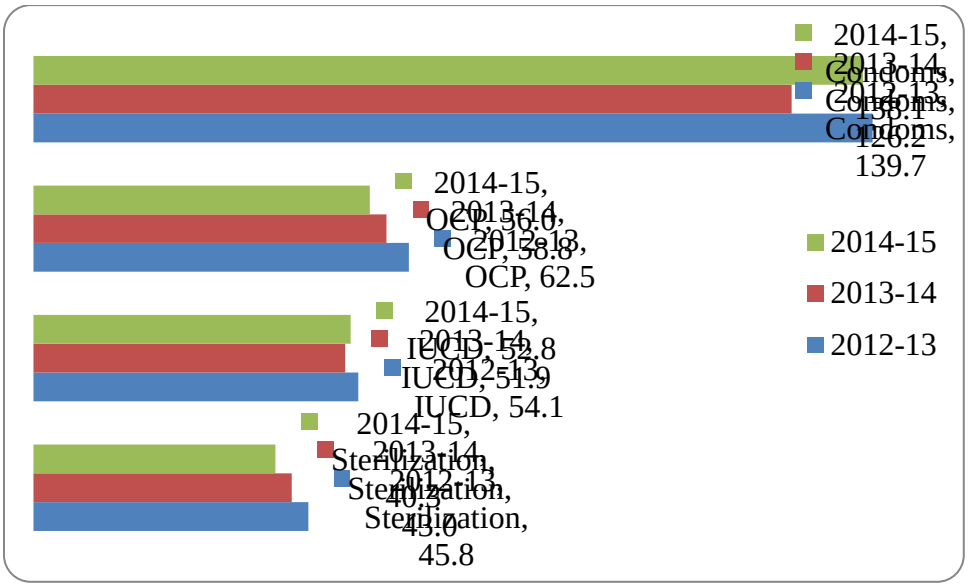
B. New interventions to improve access to contraception:

- **Expansion of Basket of Choice:**
    - **Injectable DMPA**: The Drugs Technical Advisory Board (DTAB) agreed to the introduction of the injectable contraceptive DMPA in the public health system under the National Family Planning Programme. Programming is completed and planning for development of technical manual is under way.
    - **POP**: under piloting process
    - **Centchroman**: under programming
- **Improved Contraceptive Packaging**: The packaging for Condoms, OCP and ECP has now being improved so as to influence the demand for these commodities. Is under procurement and subsequent distribution.
- Planning for improved service delivery through promotion of post partum family planning (esp through Minilap) and NSV- The detailed programming was shared with states in August 2015-16. Handholding of the states is being done for improving the static centers for post partum family planning and NSV.

8. PROGRESS MADE UNDER FAMILY PLANNING PROGRAMME:

8.1.Service Delivery:

The performance of family planning services (in lakhs) during 2014-15 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:

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:

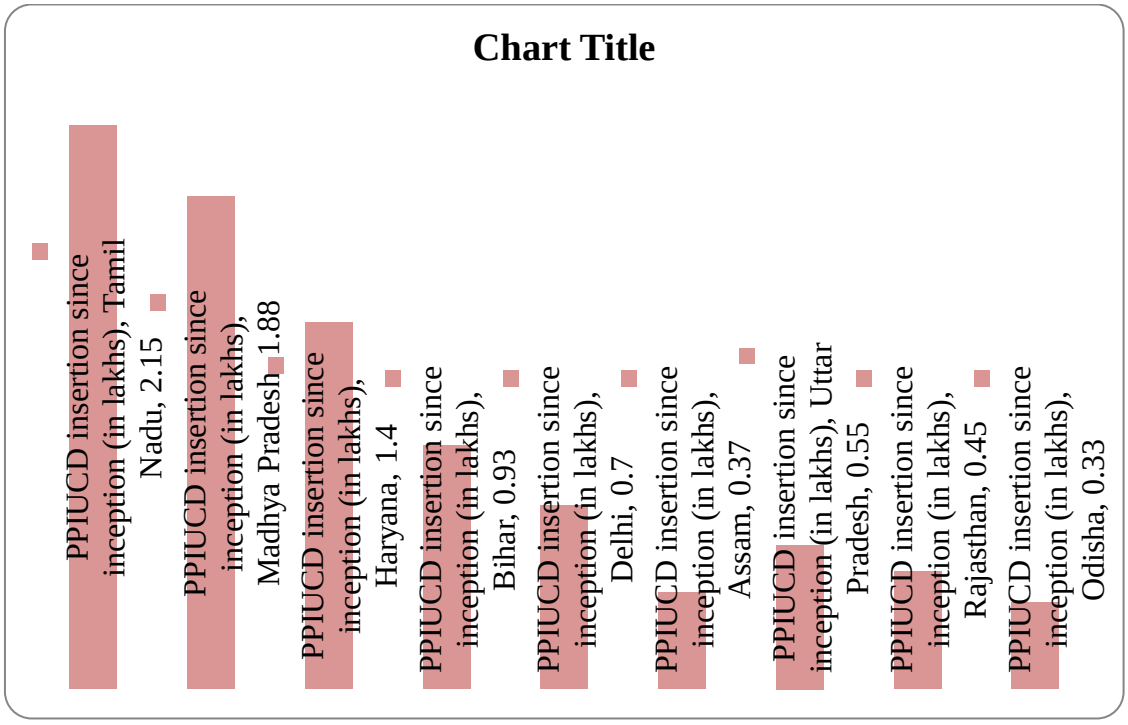
- Jhpiego, Engender Health and IPAS have been engaged for onsite training for IUCD services.
- To track the progress of training and for better post training follow up an IUCD tracking software has been designed and is operational now.

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

- Total **10,34,894** PPIUCDs have been inserted all across the country since the initiation of the PPIUCD programme. Approximately **5,90,217** PPIUCD insertions have taken place in 2014-15 as against around **3,24,487** in 2013-14.
- **Appointing dedicated counsellors at high case load facilities:**

- RMNCH+A counsellors are being appointed 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
- The posts of 1633 RMNCH+A counselors have been approved across the country (as per the state projections) in financial year 2014-15. Of these 959 positions are filled and counselors are in place

8.4.Assured delivery of family planning services:

8.4.1. *Fixed Day Services (FDS) for IUCD Insertion***:** States are facilitated 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.

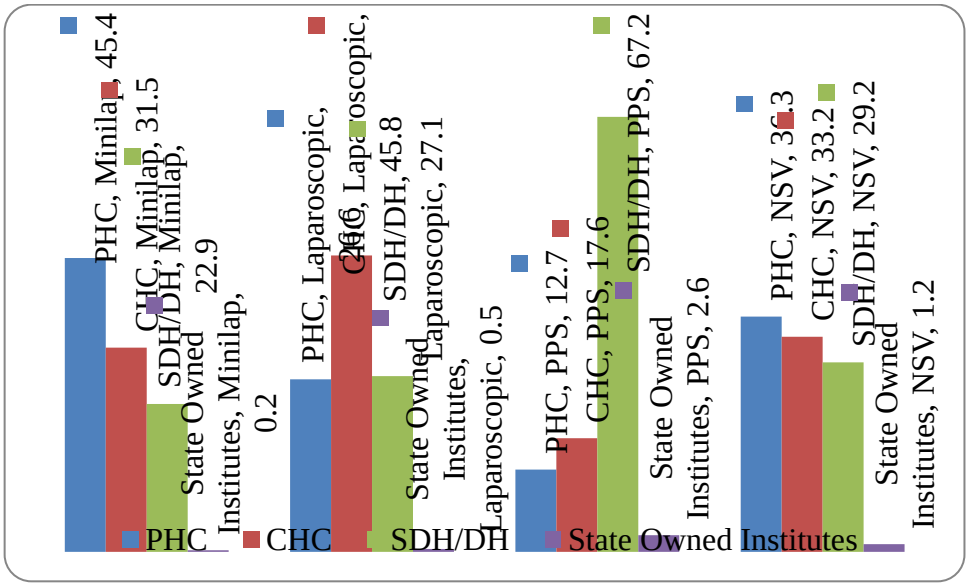
8.4.4. ***Rational placement of trained providers*** at the peripheral facilities for provision of regular family planning services.

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 2014-15 reveals that:

- Around 36.3% of NSVs are conducted at PHC and 33.2% at CHC level 29.2% at SDH/DH level and 1.2% at State owned institutes.
- Majority of minilap sterilisations (45.4%) are conducted at PHC level followed by 31.5% at CHC level. 22.9% of the minilap were conducted at SDH/DH level and 0.2% at state owned institutes.
- 26.6% laparoscopic sterilisation is conducted at PHCs via camp mode. However, it is important to note that majority of laparoscopic sterilisation (45.8%) is conducted at CHC level. 27.1% of cases were operated at SDH/DH level and 0.5% at state owned institutes.
- As anticipated around 67.2% 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 (12.7%) and CHC (17.6%) level as well:

- **Facility wise number of sterilizations in India**



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.

8.5.1 Actions taken and achievements:

8.5.1.1 Revision of FP manuals and Guidelines:

The MoHFW developed has revised and updated the standards/ manuals/ guidelines and directed the states to adhere to the same to ensure quality of service provision.

FP manuals and guidelines have been widely disseminated and can be freely accessed at the NHM website.

- ***Standards and Quality assurance in Sterilization Services:***
  A comprehensive manual on 'Standards and Quality Assurance in Sterilization Services' which is an amalgamation of four existing manuals (i.e. Standards for Female and Male sterilization- 2006; Quality Assurance manual for Sterilization Manual- 2006; Standard operating procedure for sterilization services in camps- 2008; Operational Guidelines for FDS approach for Sterilization services -2008) was released in November 2014. The manual not only includes the contents of the four manuals but also newer inclusions based on field experiences were made.
- The ***'Reference Manual for Female Sterilization'*** has been prepared and released in November 2014 which is a combination of two existing manuals, i.e. Reference manual for Minilap Tubectomy- 2009; Guidelines for Training in Female Sterilization for Programme Officers, Training Coordinators and Trainers- 2010.
- ***IUCD Reference Manual for Medical officers and Nursing personnel:*** Comprehensive manual for the interval IUCD and PPIUCD insertion
- ***IUCD reference manual for AYUSH***
- ***Reference manual on male sterilization***
- ***Manual on Family Planning Indemnity Scheme:***
- ***Manual for RMNCH+A Counsellors***
- The division came up with the ***'India's Vision FP 2020'*** document which manifests the efforts taken by our country in turning the global FP 2020 commitment into reality.
- Ministry of Health and Family Welfare, Family Planning Division has recruited technical experts to support states in improving delivery of quality services

8.5.1.2 State Quality Workshops:

To orient the states and services providers on technical standards, orientation workshop for updated guidelines has been conducted in all the states by FP division technical experts and core group members.

8.6.Other promotional schemes:

8.6.1. 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.
- 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 (UP), Bihar (BH), Madhya Pradesh (MP), Rajasthan (RJ), Chhattisgarh (CG), Jharkhand (JH), Odisha (OD), Uttarakhand (UK), Assam (AS), Haryana (HR) and Gujarat (GJ).

Compensation scheme in Public Facilities

States	Type of Operation	Acceptor	ASHA/ Health Worker	Others	Total
11 High focus states (UP, BH, MP, RJ, CG, JH, OD, UK, AS, HR, GJ)	VASECTOMY	**2000**	300	400	**2700**
	TUBECTOMY	**1400**	200	400	**2000**
Other High focus states (NE states, J&K, HP)	VASECTOMY	**1100**	200	200	**1500**
	TUBECTOMY	**600**	150	250	**1000**
Non High focus states	VASECTOMY	**1100**	200	200	**1500**
	TUBECTOMY (BPL + SC/ ST only)	**600**	150	250	**1000**
	TUBECTOMY(APL)	**250**	150	250	**650**

Compensation scheme in Private Accredited Facilities

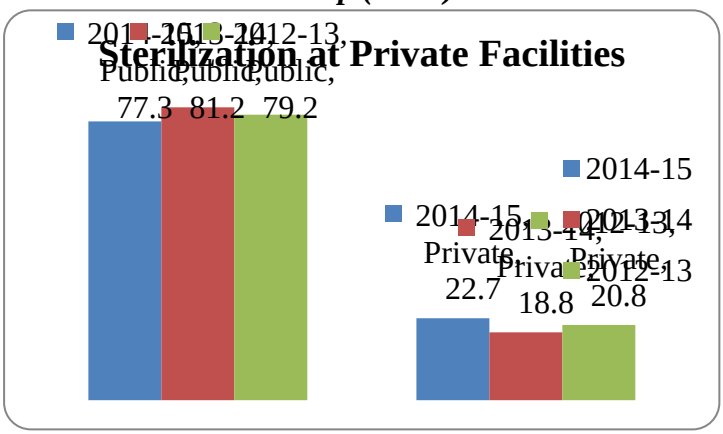
States	Type of Operation	Facility	Others/ Acceptor	Total
11 High focus states (UP, BH, MP, RJ, CG, JH, OD, UK, AS, HR, GJ)	VASECTOMY (ALL)	**2000**	1000	**3000**
	TUBECTOMY (ALL)	**2000**	1000	**3000**
Other High focus states (NE states, J&K, HP)	VASECTOMY (ALL)	**1300**	200	**1500**
	TUBECTOMY (ALL)	**1350**	150	**1500**
Non High focus states	VASECTOMY (ALL)	**1300**	200	**1500**
	TUBECTOMY (ALL)	**1350**	150	**1500**

8.6.2. 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".

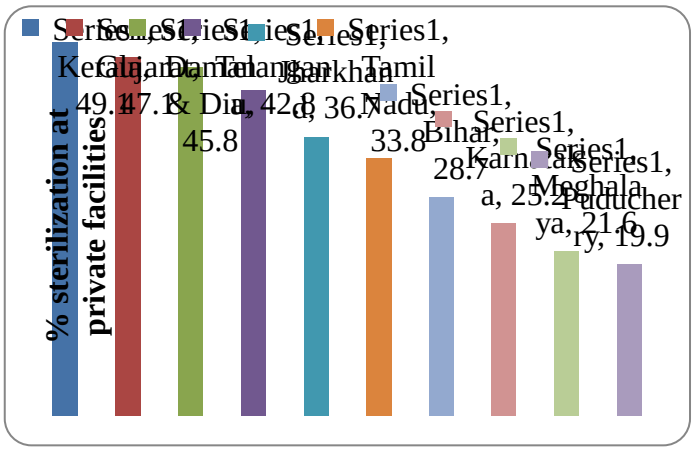
Claims arising out of Sterilization Operation		Amount (Rs.)
A	Death at hospital/ within seven days of discharge	2,00,000
B	Death following Sterilization (8^{th} – 30^{th} day from discharge)	50,000
C	Expenses for treatment of Medical Complications	25,000
D	Failure of Sterilization	30,000
E	Doctors/facilities covered for litigations up to 4 cases per year including defense cost	2,00,000 (per case)

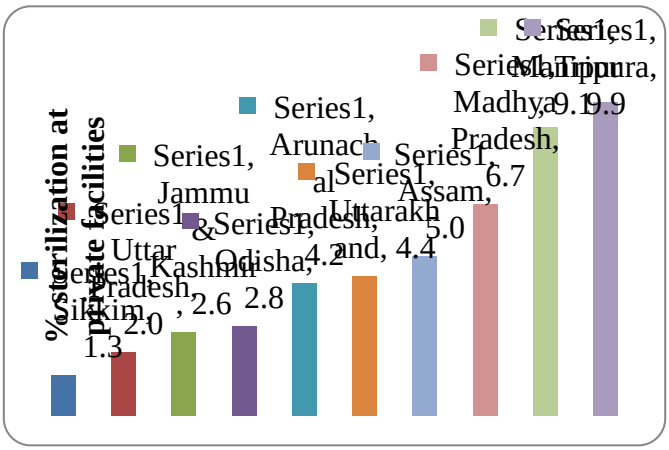
8.6.3. Public Private Partnership (PPPs):



- 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 increased in 2014-15 compared to 2012-13.
- Top ten and bottom ten states in terms of sterilisation services at private facilities:





8.6.4. 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.

- Under HDC schemes ASHAs are distributing condoms, OCPs and ECPs in all states of India except Tamil Nadu, Puducherry and Himachal Pradesh where ASHA structure is non-existent. Contraceptive distribution in these three states is being done by Anganwadi Workers and ANMs.
- 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.

8.6.5. Scheme for Ensuring Spacing at 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 was initially conceived for 18 states, but in later years the spacing component of the scheme was rolled out in few other states like West Bengal, Maharashtra, Andhra Pradesh, Telangana and Daman Diu. Dadar and Nagar Haveli have also initiated the implementation of the scheme (both spacing and limiting components).

8.7.Celebration of World Population Day & fortnight (July 11 – 24, 2015):

- 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, 2015: “Dampati Sampark Pakhwada” or “Mobilisation Fortnight” was organised.
    - July 11 to July 24, 2015 “Jansankhya Sthirtha Pakhwada” or “Population Stabilisation Fortnight” was organised.
- A workshop was organized at Vigyan Bhavan on “***Vulnerable Populations in Emergencies***” chaired by AS & MD NHM, Ministry of Health & Family Welfare. The aim was to motivate and mobilize the nation towards population related issues, especially during emergencies.

The inaugural session of the workshop also witnessed prize distribution by the Hon'ble Union Minister of Health & Family Welfare, Shri J.P .Nadda and Union Minister of State, Shri Sripad Yesso Naik to school children who had brought laurels to the schools by winning prizes in the painting competition organized by Jansankhya Sthirata Kosh. The inaugural session was followed by a panel discussion which was moderated by AS & MD, Shri C. K. Mishra. In this forum Dr. Rakesh Kumar, JS (RCH) & Executive Director- Jansankhya Sthirata Kosh (JSK), Dr. Jagdish Prasad, DGHS and other prominent dignitaries presented their views on the subject.

Overall Performance:

- Overall performance during the fortnight (11th to 24th July 2015) is placed below:

S.N.	Method	2013	2014	2015
1	Female Sterilisation	1,57,431	1,49,262	1,42,372
2	Male Sterilisation	8130	5085	6035
	Total Sterilisation	**1,65,561**	**1,54,347**	**1,48,407**
3	**Total IUCD Insertion**	**3,50,642**	**3,93,276**	**3,51,444**
	PPIUCD Insertion	-	-	43,829

Some states such as Bihar, M.P, Jharkhand, J&K have extended their fortnights. Bihar has extended their fortnight till 31st July whereas J& K has extended another fortnight. M.P and Jharkhand has extended the celebrations till 11th Aug.

The total sterilizations which took place during the 2015-16 fortnight were **1.48 lakhs** (1.42 lakhs female sterilizations and 6035 Male Sterilizations). In 2015-16 male sterilization has shown an increased trend. **Despite the backlash, Chhattisgarh reported highest male sterilizations (1097)**. **In female sterilization Bihar reported the highest performance** with total female sterilizations at 25,906 followed by Madhya Pradesh (21,322) and Odisha (17,751).

The total **IUCDs (Interval & PPIUCD) inserted were 3.51 lakhs**, comprising of 88% of interval IUCD and 12% PPIUCD. The **highest interval IUCD insertions were in Uttar Pradesh** (43,370) followed by Odisha (41,138) and West Bengal (38,293) whereas for PPIUCD insertions Madhya Pradesh was the highest (14,313).

9. KEY CHALLENGES & OPPORTUNITIES:

9.1.Unavailability of regular sterilization services:

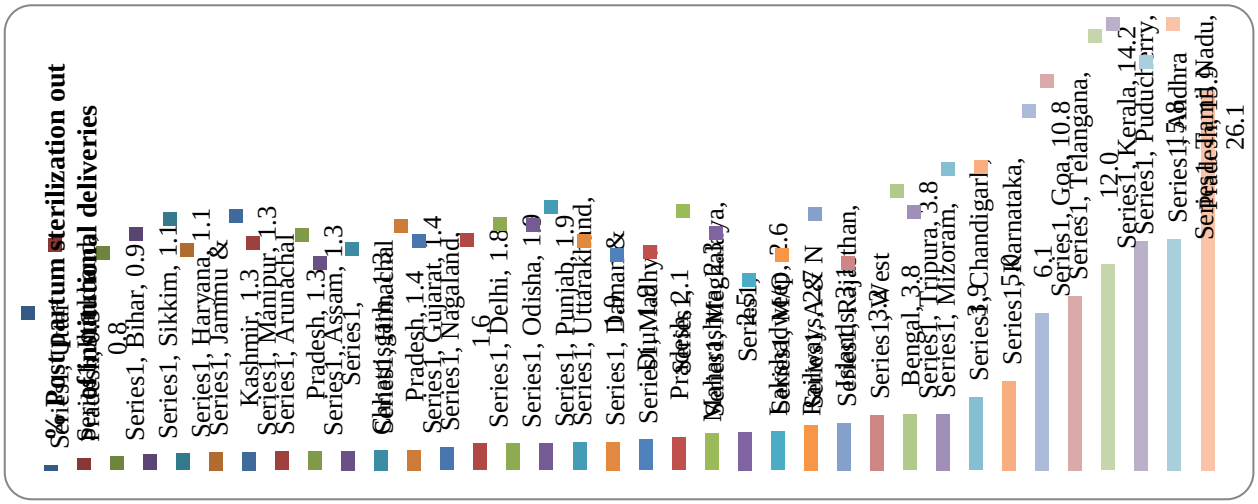
- The access to sterilization services at sub-district level is restricted due to poor implementation of FDS approach, especially so in high focus states with high TFR and high unmet need due to:

- 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

- Seasonal Trend of Sterilization: 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 across the year which also reflects on their outcomes.

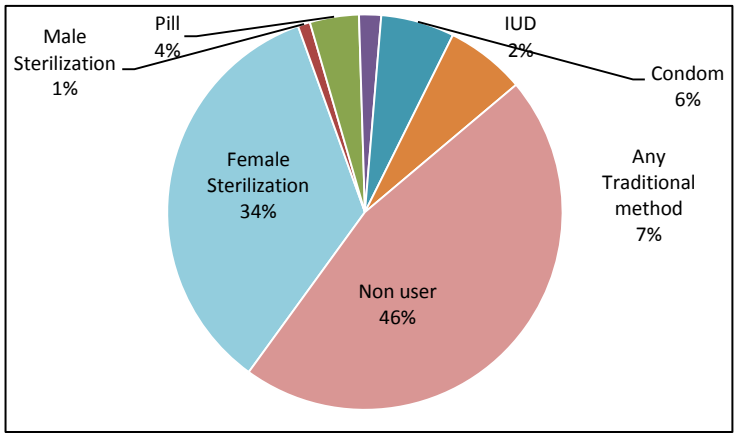
9.2.Increased institutional delivery vs. PPFP:

- 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.
- As evident from the graph above almost 26.1% of the delivered women underwent post partum sterilization in Tamil Nadu in 2014-15
- There is huge potential for post partum sterilization in High focus states where less than 1 to 2 percent of women undergo post partum sterilization.



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 of AHS 2012, DLHS III and DLHS IV reflects that the Leh and Kargil districts of J&K and Pathanamthitta district in Kerala

has highest prevalence for IUCD (35.5%, 20.9% and 17.7% respectively. All the distrcist of high focus states have very low usage of IUCDs.

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.

9.4.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.
- Expanding Basket of choices in Family Planning
- 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

State	Total Fertility Rate			Crude Birth Rate			Girls married below age 18 (%)		Births to women during age 15-19 (%)		Spacing Between Births 2013		Birth Order		% of currently married women (15 – 49) using contraception			Total Unmet Need for Family Planning (%)		
	2012	2013	AHS 2012	2012	2013	2012	DLHS III	DLHS 4	DLHS III	DLHS 4	36+ months	36+ months	3 & above	3& above	Modern Method (%)			2007-08 (DLHS III)	AHS 2011	AHS/ DLHS 2012
	SRS	SRS		SRS	SRS	AHS					AHS 2012	SRS	DLHS 4/ AHS 2012	SRS 2013	DLHS III	AHS 2011	AHS/ DLHS 2012			2012
India	**2.4**	**2.3**		**22**	**21**		**24.6**		**5.6**			**40.7**		**24**	**47.1**			**21.3**		
Andaman	1.6*	1.6*		15	15		6		2.9						..			..		
AP	1.8	1.8		18	17		28.7	14.2	10.4	5.5		34.8	14.3	8.9	65.1		66.2	8.5		19.1
Arunachal P	2.3*	2.3*		19	19		8.2	12.9	2.5	4.3			42.6		49		43.9	14.3		32.3
Assam	2.4	2.3	2.4	23	22	21	21.8		5.2		52.3	57.8	32.3	23	31.2	37.9	38.1	24.3	15.9	13.1
Bihar	3.5	3.4	3.5	28	28	26	46.2		8.2		45.2	35.2	44.9	37	28.4	38.2	36.5	37.2	33.5	31.5
Chandigarh	1.7*	1.7*		15	15		3.3	2.8	1.1	0.0			16.6		70.7		65.9	8.3		12.1
Chhattisgarh	2.7	2.6	2.7	25	24	23	21.3		7.3		46.4	37.7	28.0	25.9	47.1	55.4	57.2	20.9	24.8	24.4
DNH	2.9*	2.9*		26	26		28.7		4.3						..			..		
Daman Diu	2.0*	2.0*		18	18		5.4		1.4						..			..		
Delhi	1.8	1.7		18	17		6		2.1			53.7		20	55.5			13.9		
Goa	1.4*	1.4*		13	13		3.3	1.5	2.3	2.2			14.3		35.9		24.0	28.8		33.5
Gujarat	2.3	2.3		21	21		18.9		3.4			41.2			54.3			16.5		
Haryana	2.3	2.3		22	21		15.9	5.9	4.3	2.9		37.4	24.1	20	54.5		48.6	16		30.4
Himachal P	1.8	1.7		16	16		1.6	3.4	0.8	1.1		39.9	11.4	13	68.1		56.1	14.9		20.6
JK	1.9	1.9		18	18		7.4		1.2			49.4		25.1	41.2			21.6		
Jharkhand	2.8	2.8	2.7	25	25	23.0	36		5.9		51.1	44	36.2	32	30.8	43.9	43.7	34.7	22.6	22.3
Karnataka	1.9	1.9		19	18		22.8	14.1	10.7	6.6		34.3	23.1	17	60.8		61.6	15.8	16.1	
Kerala	1.8	1.8		15	15		6.7	2.8	2.6	0.0		65.9	10.8	13	53.1		53.9	16.8		19
Lakshadweep	1.6*	1.6*		15	15		2.6		0.8						..			..		
MP	2.9	2.9	3.0	27	26	25	29.2		5.2		39.7	31	33.7	26	53.1	59.3	59.4	19.3	21.6	21.6
Maharashtra	1.8	1.8		17	17		17.7	12.0	9.7	4.8		40	19.6	16	62.6		65.3	14.2		19
Manipur	1.5*	1.5*		15	15		6.3	7.2	1	2.2			31.2		..		11.1	..		54.5
Meghalaya	2.9*	2.9*		24	24		15.1	5.7	3.6	3.5			49.8		16.8		14.3	32.7		55.5

Mizoram	1.7*	1.7*		16	16		9.9	6.0	2.8	2.9			42.1		53.5		59	16.7		21.4
Nagaland	1.8*	1.8*		16	15										..			..		
Odisha	2.1	2.1	2.2	20	20	20	19.1		4.6		56.2	55.7	25.7	21	37.8	46.8	46.3	24	19.1	18.9
Puducherry	1.8*	1.8*		16	16		3.6	4.9	2	2.7			10.6		57.5		52.3	19.8		27.1
Punjab	1.7	1.7		16	16		5.9	4.9	1.7	2.0		42.9	19.5	12	62.9		59.8	11.9		15.3
Rajasthan	2.9	2.9	2.9	26	26	24	41		4.7		41.5	35.5	35.1	31	54	59.4	62.4	17.9	12.6	13
Sikkim	1.7*	1.7*		17	17		16	8.3	5.4	6.8			18.2		61.1		53.8	16.1		20.2
Tamil Nadu	1.7	1.7		16	16		9.4	5.3	3.2	4.2		42.2	12.6	8.6	57.8		52.4	19.4		27.1
Tripura	1.4*	1.4*		14	14		21.5	19.8	9	12			19.0		40.8		40.6	12.8		26.7
UP	3.3	3.3	3.3	27	27	25	33.1		6.3		43.7	40.4	45.1	30	26.7	37.3	37.6	33.8	24.1	20.7
Uttarakhand	2.1	2.1	2.1	19	18	18.0	5.8		1.7		44.3		28.9		53.3	54.1	54.3	11.6	18.1	15.3
West Bengal	1.7	1.7		16	16		41.3	32.1	10.6	11		56.5	19.8	13	53.3		59.0	11.6		12.1

Source: **SRS 2010 estimates*

ANNEXURE 2: Number Sterilisations and IUCDs, by states: 2014-15

	Female Sterilization	Male Sterilization	IUCD
All India	3951972	78362	5277460
A & N Islands	1148	4	940
Andhra Pradesh	182415	2231	121579
Arunachal Pradesh	982	2	3292
Assam	40537	4276	98249
Bihar	513816	3498	374147
Chandigarh	2209	73	4587
Chhattisgarh	46265	1888	97355
Dadra & Nagar Haveli	1028	3	654
Daman & Diu	275	0	168
Delhi	17121	811	72027
Goa	2792	15	1360
Gujarat	318490	2268	605908
Haryana	65651	4214	271576
Himachal Pradesh	16344	1362	23682
Jammu & Kashmir	12573	442	18160
Jharkhand	110498	3815	92708
Karnataka	321007	1006	188756
Kerala	91412	1281	51273
Lakshadweep	21	1	32
M/O Defence	1578	260	1327
M/O Railways	1944	132	1515
Madhya Pradesh	367604	5980	403311
Maharashtra	456770	13912	390163
Manipur	712	91	5285
Meghalaya	2116	22	4723
Mizoram	1545	0	2515
Nagaland	1431	9	3865
Odisha	103320	2065	175035
Puducherry	8628	23	7224
Punjab	55097	3302	211067
Rajasthan	299134	4302	388609
Sikkim	128	28	1530
Tamil Nadu	310554	1187	393894
Telangana	151437	5292	55472
Tripura	4242	18	1102
Uttar Pradesh	228344	9798	970731
Uttarakhand	19475	979	86810
West Bengal	193329	3772	146829