

Introduction

In 1952, India launched the world's first national program emphasizing family planning to the extent necessary for reducing birth rates *"to stabilize the population at a level consistent with the requirement of national economy"*. Since then, the family planning program has evolved and the program is currently being repositioned to not only achieve **population stabilization** but also to promote **reproductive health** and reduce **maternal, infant & child mortality and morbidity**.

Table.1. Stated goals in recent National Population and Health Policies related to Family

Welfare and their current status						
Program/ Policy	X Five Year Plan (by 2007)	NPP (by 2010)	NRHM (by 2012)	MDG (by 2015)	Current Status (Reference Year)	
Goals						
Infant Mortality Rate	45	<30	30	27	50 (2009)	
Maternal Mortality Ratio	200	<100	100	100	212 (2009)	
Total Fertility Rate	NA	2.1	2.1	2.1	2.6 (2009)	

The objectives, strategies and activities of the Family Planning division are designed and operated towards achieving the family welfare goals and objectives stated in various policy documents (NPP: National Population Policy 2000, NHP: National Health Policy 2002, and NRHM: National Rural Health Mission) and to honour the commitments of the Government of India (including ICPD: International Conference on Population and Development, MDG: Millennium Development Goals and others) (see Table 1 above).

1. CURRENT SCENARIO OF POPULATION AND FAMILY PLANNING IN INDIA

1.1. Demographic Scenario:

India's population as per 2011 census is 1.21 billion, second only to China in the world. 6 most populous states (viz. Uttar Pradesh, Maharashtra, Bihar, West Bengal, Andhra Pradesh and Madhya Pradesh) together have 54.9% of India's Population. Uttar Pradesh and Bihar together share 25.1% of country's population with the highest fertility rates in the country. India which accounts for 2.4% of the land area is already supporting around 17% of the world population

Nevertheless, there are some positive signs as well:

- India has been showing a slow but steady decline in population growth. India's annual population growth rate during 2001-2011 decade is 1.64%, which is the lowest since independence.
- During the decade 2001-2011, India added the least population (181.46 million) compared to the previous decade

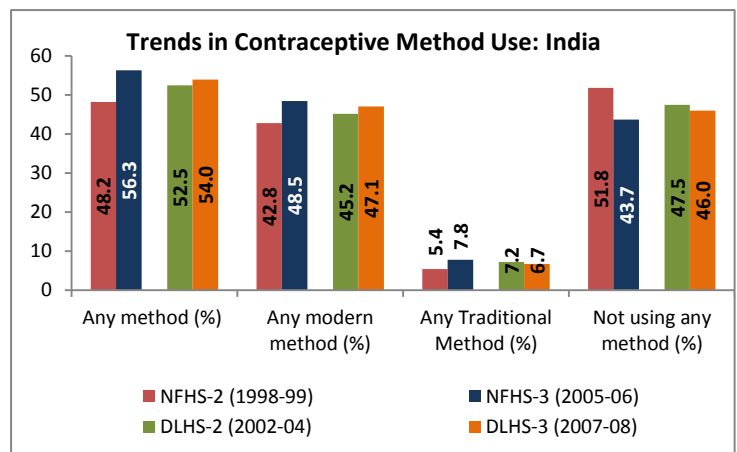
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- Census 2011 marks a milestone in the demographic history of the country, as it is perhaps for the first time, there is a significant fall in growth rate of population in the EAG States after decades of stagnation
- 0-6 population has declined in the country by 3.08%
- Similarly, Total Fertility Rate (TFR) in the country has recorded a steady decline to the current levels of 2.6 (SRS 2009), a 42% decline from mid-1960s.
- Total Fertility Rate (TFR): 20 states/ UTs have already reached the replacement level of fertility i.e. TFR of 2.1: Andaman & Nicobar Islands, Goa, Puducherry, Manipur, Tamil Nadu, Kerala, Tripura, Chandigarh, Andhra Pradesh, Himachal Pradesh, West Bengal, Punjab, Delhi Maharashtra, Daman & Diu, Karnataka, Mizoram, Nagaland, Sikkim and Lakshadweep
- Recent Annual Health Survey (AHS-2010) data (available for 9 states) shows that there is a significant decline (average 2 points decline for each state) in Crude Birth Rate (CBR)

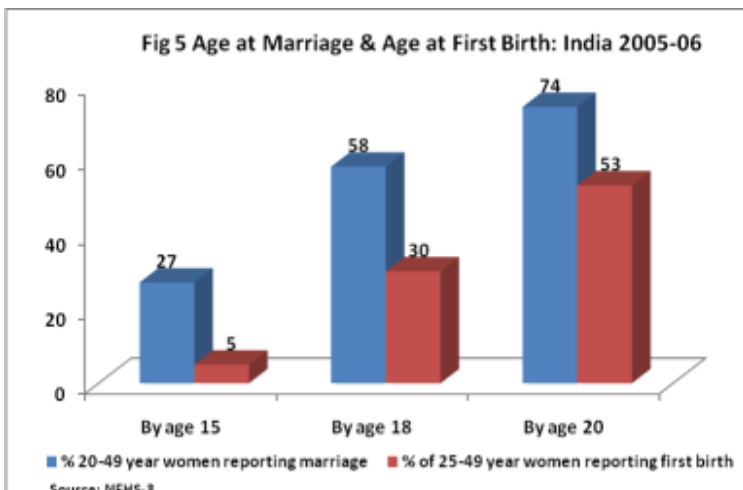
1.2. Family Planning Scenario:

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 first marriage and age at first childbirth (which are societal preferences) are also showing good improvements at the



national level and adjoining figure indicates the current position of social determinants of fertility in the country.

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2. CURRENT FAMILY PLANNING EFFORTS:

The Family Planning (FP) division is involved in the development, implementation and monitoring of strategic interventions for fulfilling the twin objectives of promoting reproductive health and population stabilization within the wider context of sustainable development. The interventions, activities and performance in the arena of family planning over the year 2010-11 are as follows:

2.1. Contraceptive services under the national family welfare program:

The public sector provides a wide range of contraceptive services for limiting and spacing of births at various levels of health system as described in the following table:

Family Planning Method	Service Provider	Service Location	Service Strategy* & Promotional Schemes
SPACING METHODS			
IUCD 380 A	Trained & certified ANMs, LHVs, SNs and doctors	Subcentre & higher levels	<ul style="list-style-type: none"> On demand Camp Approach Revised Compensation Scheme
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	At door step (in pilot districts) Village level Subcentre & higher levels	<ul style="list-style-type: none"> On demand VHNDs: Village Health Nutrition Days
Condoms	Trained ASHAs, ANMs, LHVs, SNs and doctors	At door step (in pilot districts) Village level Subcentre & higher levels	<ul style="list-style-type: none"> On demand VHNDs
LIMITING METHODS			
Minilap	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels	<ul style="list-style-type: none"> FDS: Fixed Day Static Approach Camp Approach
Laparoscopic Sterilization	Trained & certified Specialist Doctors (OBG & General Surgeons)	Usually CHC & higher levels	<ul style="list-style-type: none"> Revised Compensation Scheme National Family Planning Insurance Scheme
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	At door step (in pilot districts) Village level Subcentre & higher levels	<ul style="list-style-type: none"> On demand VHNDs

Legends: ANM: Auxiliary Nurse Midwife; LHV: Lady Health Visitor; SN: Staff Nurse; ASHA: Accredited Social Health Activist

Note: * extensive IEC is key component of all the strategies of Family Planning Programme

The salient features of the family planning programme are as follows:

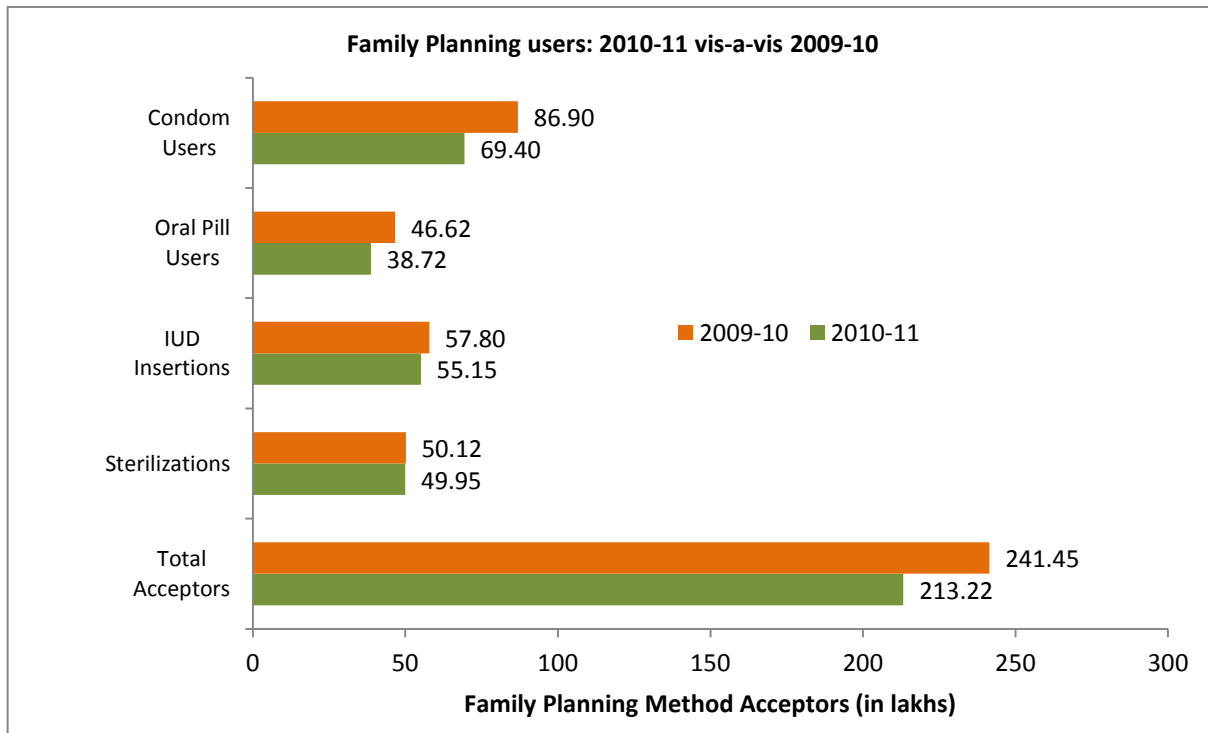
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- New Initiative: To improve access to contraceptives by the eligible couples, it has been decided to utilize the services of ASHA to deliver contraceptives at the doorstep and incentivise her for the effort. To begin with, the initiative is being implemented on a pilot basis in 233 districts in 17 States. Under the schemes contraceptives are being directly supplied to the districts.
- Strong Political Will and Advocacy at the highest level, especially in states with high fertility.
- In the past 2 years World Population Day celebration involving all the elected representatives has been a great platform for advocating masses about Family Planning programme and services.
- Emphasis on Spacing methods like IUCD: IUD 380-A with 10 years effectiveness was introduced earlier for which more than 50000 personnel have already been trained in different states to provide quality services under Alternate Training Methodology (ATM). A new Cu IUCD-375 with effectiveness of 5 years as a short term spacing method is also being considered for introduction.
- Revitalizing Postpartum Family Planning including PPIUCD in order to capitalise on the opportunity provided by increased institutional deliveries. MoHFW has already identified and designated institutions with high institutional deliveries (above bench mark) as 'delivery points'; focus is being given to ensure availability of PFP services at least at these facilities to start with.
- Availability of Fixed Day Static Services at all facilities: attempts have been made to operationalise facilities to provide fixed day static family planning services at different levels. Supports such as HR, infrastructure, equipments etc. have been provided through state PIPs.
- Continuation of sterilization camps in the states with high fertility till the time FDS is implemented effectively.
- Ensuring quality care in Family Planning services by establishing Quality Assurance Committees at state and district levels
- Accreditation of private providers; states have been encouraged to indentify and accredit private / NGO facilities to provide FP services such as sterilisation, IUCD insertion etc.
- Increasing male participation and promoting Non scalpel vasectomy.
- Improving contraceptives supply management upto peripheral facilities.
- Counselling, access to and provision of good quality services and follow-up care.
- Revised compensation scheme for sterilization acceptors.
- 'National Family Planning Insurance Scheme' (NFPIS) under which clients are insured in the eventualities of deaths, complications and failures following sterilization and the providers/ accredited institutions are indemnified against litigations in those eventualities.

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Actions taken and achievements in 2011-12:

The performances of family planning services are showing a marginal decline in all methods (refer Annex-1 for details) for the year 2010-11 compared to 2009-10 (source: HMIS):



- There is no improvement in number of sterilisations and it remains static; one reason could be improvement in data quality.
- There is a decline in number of IUCD insertions; several efforts are being made to improve the scenario such as widening ANM training network, fixed day service delivery for IUCD insertion (at SHC and PHC) and also new BCC/IEC campaigns.
- Detailed report for all the methods for first two quarters is not available; however, male & female sterilisation and IUD insertion is showing encouraging trend:
 - 13.89 lakhs female sterilisations and 0.61 lakhs male sterilisations reported till September 2011, which is reported which is 29% of last year's performance and considering the seasonality in sterilisation, it is expected that performance would improve in current year.
 - 27 lakhs IUD insertions reported till September 2011, which 49% is of last year's performance.

2.3. Promotion of IUDs as a short & long term spacing method:

In 2006, GOI launched "Repositioning IUCD in National Family Welfare Program" (http://mohfw.nic.in/NRHM/FP/Repositioning_IUCD.pdf) 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 in 2011-12:

- **As on October 2011:**
 - GOI has trained state trainers from all the states at the National level
 - Anatomical simulator pelvic models have been distributed to all the districts
 - All the states have started district trainers’ and service providers’ trainings.
 - Approximately 50,000 service providers (MOs, SNs, LHVs, & ANMs) have been trained till date.
- **Rapid Assessment** of IUCD training has been completed which highlights the significance of training as it focuses on the aseptic insertion technique, counselling skills and follow-up care as essential features of long term capacity building measure of ANMs/LHVs, staff nurses. The Report also highlights that the general trend observed in all the study areas shows high satisfaction among beneficiaries regarding the service quality provided at health facility and in using IUCD.
- In order to increase basket of contraceptives in spacing methods, decision to introduce **Cu IUCD-375** has been taken, modalities are being worked out to roll-out the new IUCD in the country.

2.2. Increasing male participation in Planned Parenthood, including ‘No Scalpel Vasectomy’ (NSV):

- Increasing male participation in ‘Planned Parenthood’ is one of the major strategic themes of NPP-2000.
- Promotion of NSV acceptance is one of the most important & visible component of increasing male participation in RCH towards addressing the gender equity issues.
- The No Scalpel Vasectomy (NSV), a modified male sterilization technique, was introduced in 1997.
- Human resource development with a three pronged strategy for training surgical faculty from Medical colleges, district NSV trainers and service providers is in place.

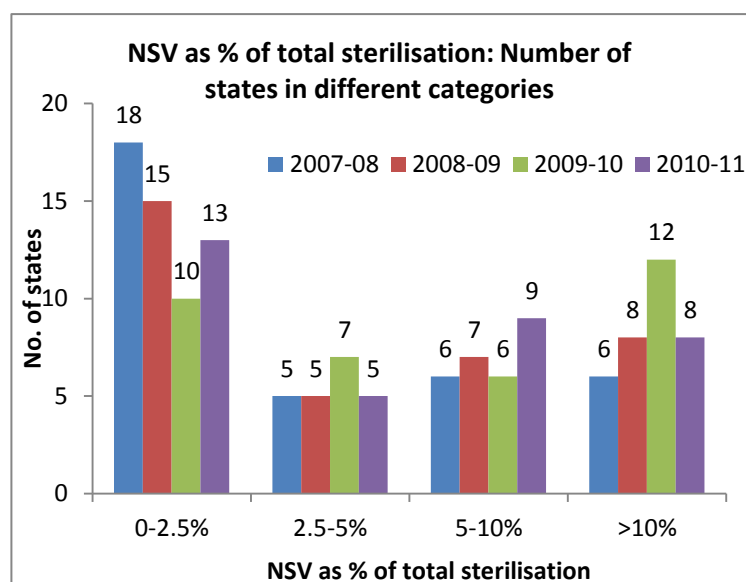
Actions taken and achievements in 2011-12:

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- The camp approach was continued in most states across India (http://mohfw.nic.in/NRHM/FP/Revised_Budget_Guidelines_CSS.pdf)
- Training in NSV, was continued on a priority basis. As on September 2010:
 - As per the latest reports available (NIHFW and State data) there are around 8000 NSV providers in the country.
 - NSV trainers are widely available across the states.
 - Surgical faculty training is being continued across two regional training centres and funds for the same are being disbursed.
- NSV performance had earlier shown positive trend; however, it has reported a decline in 2010-11 and has shown an increase in 2009-10:

Contraception	Period	April – March		April-September
	2009-10	2010-11	Annual Change (%)	2011-12 (lakhs)
Male Sterilizations	2.74	2.17	-21.04	0.61
Male Sterilization as % of Total Sterilization	5.6	4.4		4.2

- Male sterilization as a percentage of total sterilization had reached a low of 1.89% in 1999 and was hovering around 2.5% until 2006 without much improvement. As a result of intensive efforts to increase male participation, the proportion of male sterilization rose to 4.3% in 2007-08 and 5.5% in the year 2008-09 and it has further improved to 5.6% in 2009-10. Reported number of NSVs is 4.2% for the period ending September 2010-11.



- From the chart, it is evident that NSV as a percentage of total sterilization is increasing across the country and more and more states are moving in the positive direction:

2.3. Addressing the unmet need in contraception through assured delivery of family planning services:

2.4.a. *Fixed Day Static Services for IUCD Insertion at facility level:* 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).

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

- Operationalization of FDS has following objectives (http://mohfw.nic.in/NRHM/FP/Fixed_Day_Static_Guidelines.pdf):
 - 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.

Health Facility	Minimum frequency of sterilization services
District Hospital	Weekly
Sub District Hospital	Weekly
CHC / Block PHC	Fortnightly
24x7 PHC / PHC	Monthly

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

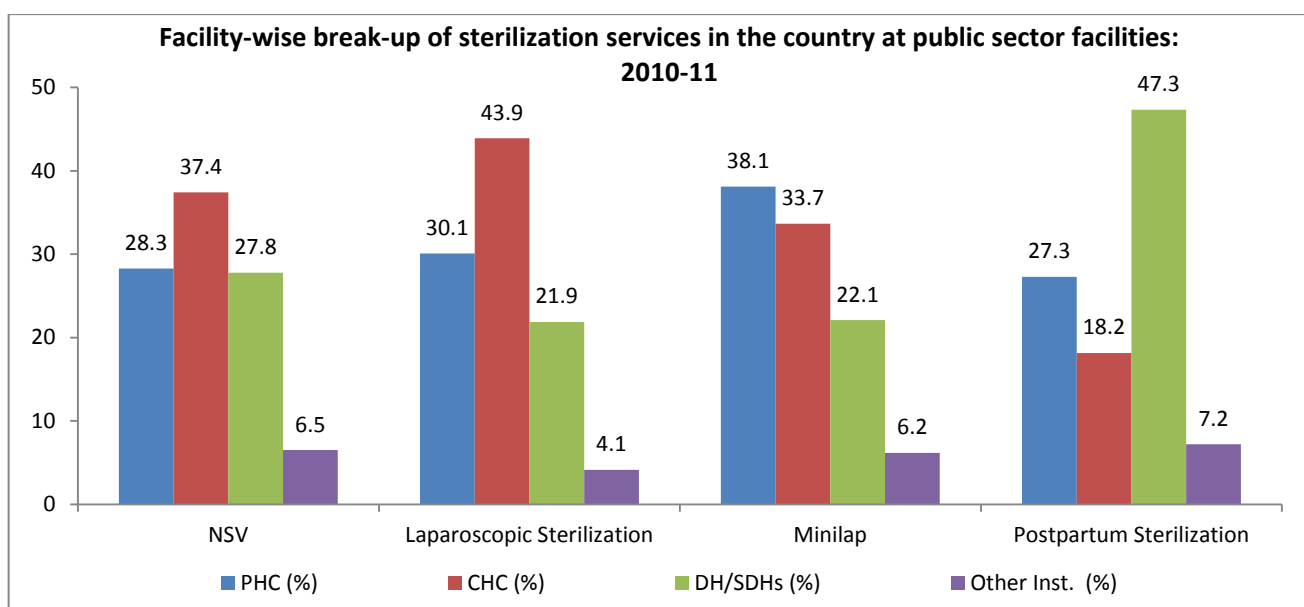
2.4.c. *Camp approach for sterilization services* is continued in those states where operation of regular fixed day static services in sterilization takes longer time duration.

2.4.d. *Training of service providers* for full operationalization of FDS is continued across all the states for all sterilization services (NSV, minilap abdominal tubectomy and laparoscopic tubectomy) and IUCD services.

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

Actions taken and achievements in 2011-12:

- FDS guidelines have been disseminated to all the states; recent review missions and field visits 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
- Guidelines for “Standard Operating Procedures for sterilization services in camps” were developed, printed and disseminated to all the states.
- “Guidelines for Clinical Skill Building Trainings in Male and Female Sterilization Services” was (http://mohfw.nic.in/NRHM/FP/Scan_Clinical_Skill_Building.pdf) developed and disseminated to all states.
- Analysis of the data available from HMIS for 2010-11 reveals that around 70% of NSV, Minilap and even laparoscopic sterilization (which requires specialist training and expensive instruments) procedures and approximately 45% of postpartum sterilizations are being conducted at PHC and CHC level, indicating that FDS approach in sterilization is taking root in the country:



Note: Facility wise data is not available for 2011-12 is not complete and hence 2010-11 data is used; it is assumed that trend would not change much.

2.4. 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 guidelines for 'Quality Assurance Manual for Sterilization Services' in place. The Quality Assurance Committees (QACs) set up at the State and District level, following the Supreme Court directives. At the central level, these activities are monitored through reports and field visits.

Up-to-date guidelines on quality of services are now available for

- Male and female sterilization services:
(http://mohfw.nic.in/NRHM/FP/Quality_Assurance.pdf)
- Sterilization services in camps (http://mohfw.nic.in/NRHM/FP/SOP_Book.pdf)
- IUCD services(http://mohfw.nic.in/NRHM/FP/medical_officer.pdf &
<http://mohfw.nic.in/NRHM/FP/nursing.pdf>)
- ECP administration (http://mohfw.nic.in/NRHM/FP/ECP_Book_Final.pdf) The division has developed reference manuals on:
 - Minilap tubectomy
 - Post partum family planning
 - Immediate post partum insertion of IUCD
 - Guidelines for training in female sterilisation

Actions taken and achievements in 2011-12:

- A 2 days national workshop for review of Family Planning programme was held in August 2011 and a full session was dedicated on quality issues under Family Planning. State programme officers were updated about recent guidelines/ manuals developed in regards to quality improvement.
- Almost all states have reported the constitution of the “SQACs” and of ‘DQACs”.

2.5. Postpartum Family Planning (PPFP) services:

- There is a thrust on Postpartum Family Planning services including PPIUCD at facilities with high institutional deliveries
- PPFP services are not being offered uniformly at all levels of health system across different states of India resulting in missed opportunities.
- Immediate Postpartum Intrauterine Contraceptive Device (PPIUCD) insertion of IUCD (CuT 380 A) is a new intervention introduced in the country to address the high unmet need of spacing during postpartum period.

Actions taken and achievements in 2011-12:

- Strengthening PPFP services at facilities has been supported through state PIPs and all the high-focus states were encouraged to propose activities for the same in 2011-12 PIP.
- Training for PPIUCD had been initiated in February 2010. 19 states were covered (with special focus on 6 EAG states). More than 12000 insertions have been done by 350 providers. Counsellors have also been trained and posted at District Hospital after 2-day training with technical assistance from JHPIEGO based on their expertise in this technique. A strategy has been developed to increase the follow-up of beneficiaries
- PPS is showing increasing trends at the National level. The proportion of PPS out of total female sterilization reached to 24% in 2009-10 and showed minor decline in 2010-11 to 23.23% (*bifurcated data for 2011-12 is not available*).

2.6. Promotion of Emergency Contraceptive Pills (ECPs):

ECPs are effective for preventing conception due to unplanned/ unprotected sex. This helps to reduce unwanted pregnancy and associated abortions, maternal mortality and morbidity.

- ECPs have been included in National Family Welfare Program and efforts are being made to utilize them at all levels of public health system.
- ECP had been included in the ASHA kits to address the issue of unwanted pregnancy at the community level.
- In 233 pilot districts (under a new scheme) ASHA has been provided ECP to sell to clients at the doorstep on a nominal price.

2.7. Introduction of newer contraceptive methods and contraceptive services:

It has been documented worldwide that introduction of a new contraceptive method increases the CPR by approximately 3%. The division is taking proactive approach to introduce new contraceptive methods and services in family welfare program.

Actions taken and achievements in 2010-11:

- Post Partum IUCD (PPIUCD) has been introduced as a contraceptive technique in the programme. Training of service providers and trainers has been done in 18 states – 32 Gynaecologists and 30 (as state trainers) have trained more than 100 Gynaecologists and nurses at the district level who will be further train medical officers from FRUs. 2000 anatomical pelvic models with postpartum uterus procured with the support of UNFPA and distributed to the states.
- Cu IUCD-375 is being considered for introduction in the programme. A detailed roll-out plan is underway.
- RISUG is an indigenously developed intra-vasal male contraceptive. It is under Phase 3 clinical trial which is funded by the ministry. Currently the reversibility is being tested on human being by Department of Health Research under a project funded by ministry.

2.8. Other promotional schemes:

2.9.a. Revised compensation scheme for acceptors of sterilization:

1.1 GOI has been providing compensation to the acceptors of sterilization for their loss of wages for availing the services as per the revised rates since September 2007 and all the states are covered under this scheme. Funds in the scheme have also been earmarked for the compensation for sterilization in accredited private health facilities and empanelled private healthcare providers.

1.2 The detailed scheme is available on the ministry's website at

http://mohfw.nic.in/NRHM/FP/Revised_compensation.pdf .

2.9.b. National Family Planning Insurance Scheme (NFPIS):

GOI launched the NFPIS Scheme in November 2005 to compensate the acceptors of sterilization or his/her nominee in the unlikely event of failure, complications, death, following a sterilization operation. The scheme also provides for indemnity cover to the medical officers and the health facilities for up to four cases of litigations per year that the healthcare provider or the facility may face as a consequence of performing sterilization operations.

- The Insurance scheme has been renewed with the ICICI Lombard in 2010 and is valid till 2012.
- Payment to 354 complicated cases, 14442 failure cases and 560 death cases has been done between 2008 and June-2011.
- 2.2 The manual for NFPIS is available on the ministry's website at

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<http://mohfw.nic.in/index1.php?lang=1&level=0&linkid=61&lid=694>

2.9.c. *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 districts.

2.9.d. *Scheme of Home delivery of contraceptives by ASHAs at doorstep of beneficiaries:*

- In order to improve access to contraceptives by the eligible couples, it has been decided to utilize the services of ASHA to deliver contraceptives at the doorstep of households and incentivise her for the effort.
- The initiative has been implemented on a pilot basis in 233 districts in 17 States
- Packs of contraceptives to be used under the scheme have been marked as:

“Government of India supply,” “for home delivery by ASHA,”

“Re 1 for a pack of 3 condoms/ Re 1 for a cycle of OCPs/ Rs 2 for a pack of one tablet of ECP”.

- Contraceptive supplies are directly being sent to all pilot districts to reduce the time gap of supplies reaching to ASHAs. As per the latest information (as on November 23, 2011) supply of condom has reached to 209 districts, OCP 180 districts and ECP to 152 districts. Discussions have been made with the districts and 70 districts have already started the scheme:

Sn.	State	No of dist.	Condom	OCP	ECP
1	Arunachal	3	1	2	1
2	Assam	14	14	5	6
3	Bihar	36	26	20	11
4	Chhattisgarh	16	15	11	5
5	Gujarat	6	6	5	4
6	Haryana	1	1	1	0
7	Himachal Pradesh	3	3	2	1
8	Jammu	4	4	4	4
9	Jharkhand	19	14	12	10
10	Madhya Pradesh	34	34	34	34
11	Manipur	4	2	2	0
12	Meghalaya	5	5	4	4
13	Orissa	18	15	15	11
14	Rajasthan	19	19	15	15
15	Tripura	2	2	1	2
16	Uttar Pradesh	45	44	44	41
17	Uttarakhand	4	4	3	3
	TOTAL	233	209	180	152

2.9. Some major activities during the year:

2.10.a. Celebration of World Population Day & fortnight (July 11 – 24, 2011):

- World Population Day was celebrated for the first time in all districts of the high focus states (304 districts) to generate awareness about population issues in 2010.
- Buoyed by the overwhelming response last year, the ministry celebrated the World Population Day 2011 in over 3800 blocks of 401 districts of 22 states of the country
- 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. “Mobilisation Fortnight” or “Dampati Sampark Pakhwada” was organised between June 27 to July 10, 2011; while “Population Stabilisation Fortnight” or “Jansankhya Sthirtha Pakhwada” was organised between July 11 & July 24, 2011.
- At New Delhi, the Minister of States for Youth Affairs Shri Ajay Maken inaugurated a national level workshop of Nehru Yuva Kendras on the occasion of World Population Day at Vigyan Bhavan.
- Similar functions were held in other states as well; Hon’ble Chief Ministers of 3 states viz. Rajasthan, Odisha and Delhi and health ministers of 5 states attended the functions in their respective states.

Key findings:

- In spite of heavy monsoon in Bihar, Jharkhand and Chhattisgarh and parts of Rajasthan, and widespread flooding in Assam, the population fortnight was by and large conducted successfully in all the states. Overall performance during the fortnight is placed below:

Sn.	Method	Progress Reported
1	Female Sterilisation	150540
2	Male Sterilisation	16376
	Total Sterilisation	166916
3	IUCD Insertion	322164
4	OCPs Distributed	1267197

- The above data reflects that the ‘World Population Fortnight’ initiative has helped in terms of breaking the seasonal phenomenon of conducting sterilisations only in the winter months, in the country.
- Anecdotal evidences suggest that this month long event has worked as a catalyst in terms of generating demand, developing systems for local level innovations to increase demand, ensure quality services etc.
- In various states, government functionaries beyond departmental boundaries were involved in the event.

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- With meticulous micro planning the available service providers can be judiciously distributed to make more facilities functional and thereby provide service to the clients nearer their place of residence
- Performance has been better in those states where the district collectors were enlisted through government orders from the level of Chief Secretary/ Principal Secretaries of Health.

2.10.b. National Review of Family Planning Programme (August 18-19, 2011):

- A National Review Meeting on Family Planning, titled, "Family Planning for Improving Maternal Health, Child Health and Stabilising Population" was organised by the Family Planning Division in the Ministry of Health & Family Welfare (MoHFW), on 18-19 August 2011, with following objectives:
 - To deliberate on programmatic aspects, thrusts, interventions and implementation processes of the family planning programmes
 - To provide inputs that can feed into the next Programme Implementation Plan (PIP)
 - To develop a pool of service providers; ensure quality of services; and reposition family planning in the overall framework of reproductive and child health (RCH)
 - To update knowledge levels of new entrants in field work
- Over 100 participants from state govts, NGOs, development partners etc. participated in this two days workshop.

2.10.c. Desk review with high focus states: 11 high focus states have been reviewed in November 2011 on following components under family planning:

- Progress in service delivery in past 3 years and in current year
- Availability of HR for various technical methods as well as their placement at the identified facilities
- Awareness of various schemes, guidelines, standards etc.
- Planning for 2012-13

3. Key challenges & opportunities:

3.1. Demographic challenges:

- It has been estimated that with current trends, the population in India will increase from 1.21 billion to 1.4 billion during the period 2001-2026, an increase of 36% in twenty-five years at the rate of 1.2% annually.
- There are substantial differences in TFR between and within states and the national progress must be seen in the context of these striking differences e.g. Kerala, Tamil Nadu, Andhra Pradesh & Karnataka with TFR at or below replacement levels and states like Uttar Pradesh, Bihar, Madhya Pradesh, Chhattisgarh, Uttarakhand, Rajasthan, Jharkhand and Orissa, with an estimated combined TFR of 4.2 in 2000. Table 5 gives the estimated year

by which some selected HFS will reach replacement level fertility if the current trends continue and it will delay the attainment of replacement level fertility in India until 2021:

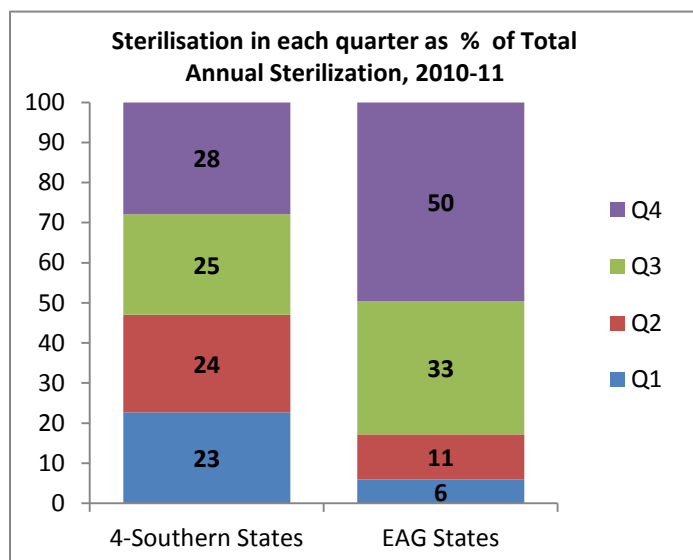
Table 5 Projected Year to reach Replacement-level Fertility

SI No.	Name of the State	Year
1	Uttar Pradesh	2027
2	Madhya Pradesh	2025
3	Chhattisgarh	2022
4	Uttarakhand	2022
5	Bihar	2021
6	Rajasthan	2021
7	Jharkhand	2018
	INDIA	2021

Source: Report of the technical group on population projections commissioned by the National Commission on Population, May 2006

3.2. Programmatic and service delivery challenges in family planning:

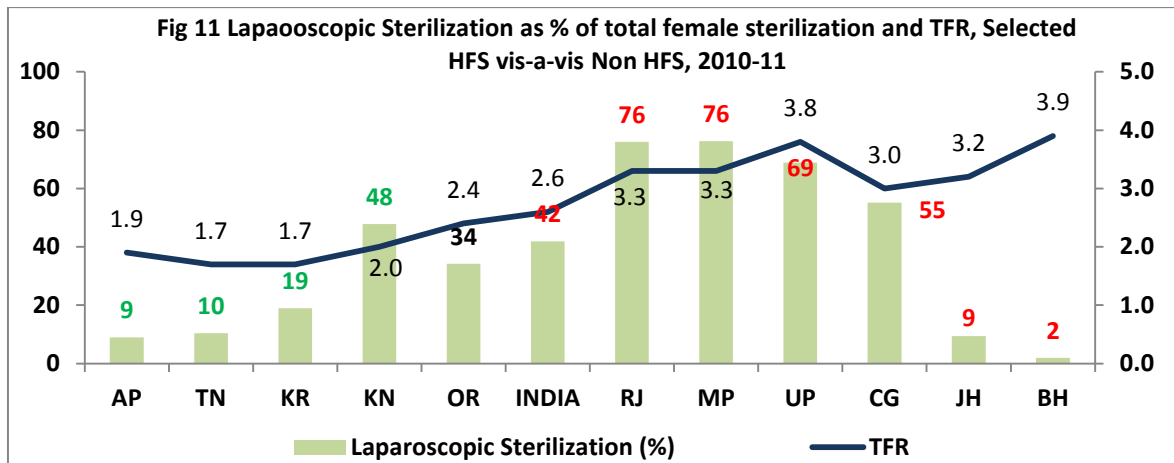
- **Unavailability of regular sterilization services:** The access to sterilization services at sub-district levels is restricted due to poor implementation of FDS approach, especially so in high focus states with high TFR and high unmet need due to:
 - lack of trained service providers specially in minilap & NSV at the CHCs and PHCs
 - Lack of willingness to plan for provision of services across the year
 - poor facility readiness



Effort has been made through 15 days long “Population Stabilisation Fortnight” during the celebration of World Population Day 2011; it has been observed that with concerted efforts and detailed micro-planning, services could be delivered during any time of the year. However, there is still a long way to go; data from HMIS shows **High seasonal variation** in sterilisation services in high focus states (83% sterilization in last 6

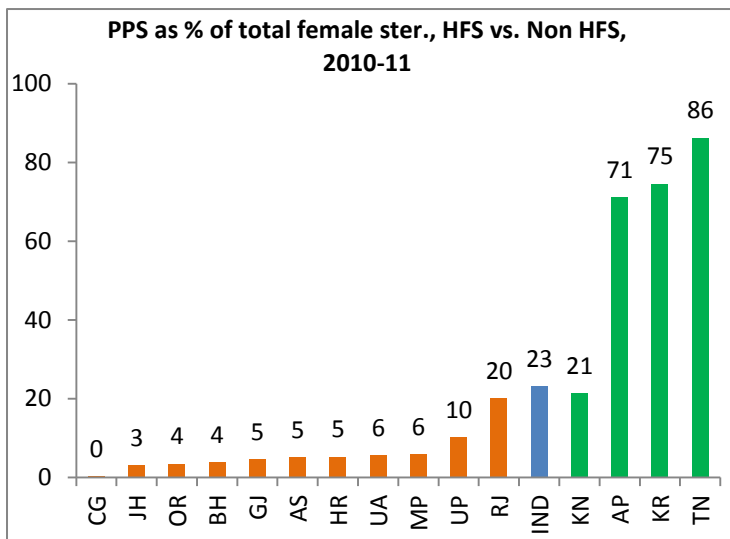
months and 50% in last three months) compared to a more uniform performance throughout the year in southern states (see adjoining figure). There is a need for more efforts from state/ district / block levels to make services available at every level across the year.

- **Heavy reliance on expensive, technically and logistically high-demanding laparoscopic sterilizations:** As evidenced by adjoining figure, the southern states, except Karnataka, show a high proportion of minilap sterilizations (75 to 89% out of total female sterilization). However, in most of the high focus states, with the exception of Bihar and Jharkhand, laparoscopic female sterilization remains the predominant procedure.



Laparoscopic sterilization services can be provided by trained gynaecologists/surgeons only; the procedure requires expensive instruments with high maintenance and sophisticated infrastructure including basic OT. Hence, heavy reliance on it would limit service provision in these states where the availability of specialists and facility readiness is still low. Promoting the simpler, safer and easy-to-provide minilap would be a better proposition for increasing the access to sterilization services and reduce the unmet need in limiting methods in high focus states.

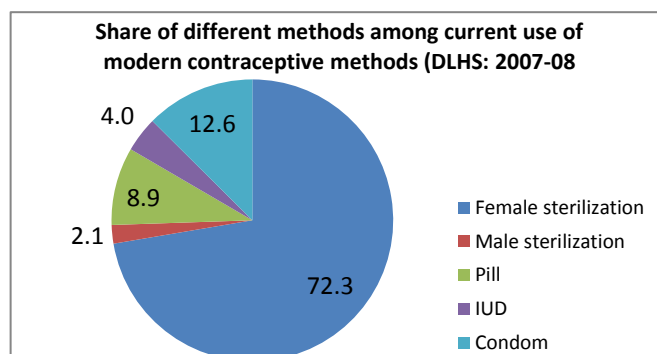
- The huge potential for **postpartum contraception** offered by the increasing number of



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 above figure which shows that in high focus states like Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh, Uttarakhand, Orissa, Assam, Gujarat and Haryana

postpartum sterilization accounts for a very lowly 0.35-20% of total female sterilization as compared to 71-86% in non-high focus states like Kerala and Tamil Nadu.

- **Inadequate attention to spacing methods** is evident by consistently low use of spacing methods across 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.

- **Human resource development** for minilap, laparoscopic sterilization & NSV to operationalize FDS in sterilization is picking up. However, the quality of training, post-training follow-up and support for adherence to standard service delivery protocols are poor. More importantly, there is a lack of rational human resource development plan in the states where selection of trainees, post-training placement and post-training infrastructure & logistic support are not given adequate importance leading to loss of trained service providers to the system and wasted resources.
- **Lack of regular contraceptive updates** at state/district level for all categories of service providers is limiting the service providers' knowledge level and skills to provide quality contraceptive services according to the latest service delivery protocols.
- 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.
- **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.
- **Community based family planning services** (including counselling, contraceptive distribution, referral services) utilizing ASHAs, VHNDs and VHSCs have not yet been operationalized effectively.

4. Future strategies:

All the strategies (described in the beginning of the document) focuses on improving utilisation of FP services along with encouraging method mix; however, to give more thrust in next 1-2 years, following approach would be adopted:

- State specific focused dialogue to identify local issues and bring out strategies/activities to solve them
- Focus on revitalising Post-partum FP delivery system through strengthening district hospitals in focused states to provide PP FP services along with good counselling.
- Strengthening management systems at national, state, district and block levels by infusing public health management professionals at these levels.
- Finding out ways to make procurement decentralised (to states) to ensure no situation of stock out at facilities

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ANNEXURE 1: Number and percentage of family planning users, by states: 2010-11

State/UT/Agency	Total Sterilization acceptors		IUCD Insertions		OCP Users		Condom Users	
	2010-11	% Change from 2009-10	2010-11	% Change from 2009-10	2010-11	% Change from 2009-10	2010-11	% Change from 2009-10
I. High Focus North-East								
Arunachal Pradesh	1,657	19	2,386	12.65	1408	21	664	35
Assam	81,136	0.03	45,046	25.55	75837	21	58913	31
Manipur	1,468	49	2,386	12.65	2914	26	2319	-21
Meghalaya	2,030	11	5,097	-1.66	5727	18	4170	17
Mizoram	2,373	-6	4,021	55.19	6583	-1	4161	-8
Nagaland	1,646	36	3,067	17.02	672	0	978	114
Sikkim	239	-56	1857	-16.69	4561	1	2343	-38
Tripura	4,043	8	1822	14.02	5521	-58	7877	1
II. High Focus Non North-East								
Bihar	557,434	-16	207,545	16.93	46558	2	88619	33
Chhattisgarh	150,031	-14	105,100	-5.41	91021	-18	145165	-10
Himachal Pradesh	23,638	-14	21,220	-12.29	26308	-10	81549	-20
Jammu & Kashmir	20,964	4	21,044	-6.76	17963	15	28632	6
Jharkhand	127,523	12	106,863	20.12	83726	-3	118158	-29
Madhya Pradesh	259,609	-34	364,553	-17.41	391003	-19	608509	-39
Orissa	107,572	6	135,206	-1.47	168995	-5	190687	-24
Rajasthan	644,000	48	395,603	-5.61	717744	-18	1337031	-20
Uttar Pradesh	503,483	-5	1,570,880	1.27	389344	-40	786134	-8
Uttarakhand	137,366	16	96,535	-1.80	37716	-20	59277	-25
III. Non-High Focus Large								
Andhra Pradesh	5,57,434	-16	358,215	-11.16	289977	-21	680932	-18
Goa	3,776	-10	36,238	10.61	3622	9	1536	7
Gujarat	325,748	4	2,171	0.74	231831	-16	712489	-16
Haryana	80,203	-7	599,778	3.28	66879	-23	205479	-30
Karnataka	127,523	12	179,369	-4.28	110433	-35	204785	-18
Kerala	259,609	-34	21,220	-12.29	8915	-62	69335	-43
Maharashtra	107,572	6	21,044	-6.76	189306	-32	295879	-37
Punjab	644,000	48	218,733	-18.15	100902	6	412111	0
Tamil Nadu	503,483	-5	49,831	-19.32	119603	32	165108	-2
West Bengal	137,366	16	331,108	-19.45	657330	2	591382	6
IV. Non-High Focus Small & UTs								
A & N Islands	711	-14	400	-49.17	752	-54	514	-67
Chandigarh	2,016	-3	3,190	-8.91	748	-4	13358	-4
Dadra & Nagar Haveli	1,045	-10	108	30.12	237	-9	1321	13
Daman & Diu	391		226		482		2344	
Delhi	18,695	-14	36,238	-17.27	14577	-5	102875	-10
Lakshadweep	32	300	22	-21.43	2	-98	67	-22
Puducherry	11,218	23	2,180	-37.36	2334	2	9294	99269
V. Other Agencies								
M/O Defence	7,160	-24	NA	NA	NA	NA	NA	NA
M/O Railways	1,705	-58	NA	NA	NA	NA	NA	NA
All India	4,995,445	-0.3	5,515,110	-6.74	3871531	-17	6993995	-18