NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

सत्यमेव जयते

India's
'VISION FP 2020'

india IN SUPPORT OF FP FAMILY PLANNING 2020

November 2014

Family Planning Division
Ministry of Health and Family Welfare
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Government of India, Nirman Bhawan, New Delhi-110011

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LOV VERMA
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स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Dated : 3rd November, 2014

MESSAGE

India, home to 17.5% of the World's population, has a potential to influence the global health indicators due to its sheer population size. In the past few years it has been increasingly realized that without increasing access to quality family planning services and meeting the unmet need for contraception, it would be difficult to reduce the prevailing rate of maternal and child mortality.

The London Summit on Family Planning in 2012 provided a platform to bring family planning program back to the center stage where India made commitments to improve access to family planning services and reduce the unmet need for contraception. The FP 2020 partnership intends to support the rights of women and girls to decide, freely and for themselves, whether, when and how many children they want to have. This would help avert thousands of maternal and infant deaths due to unwanted pregnancies.

I congratulate the Family Planning Division for their efforts in preparing this vision document for FP 2020 and urge the States to accelerate their efforts towards achievement of FP 2020 goals.

(Lov Verma)

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Dated: 7th November, 2014

FOREWORD

Voluntary family planning is one of the great public health advances of the recent times. Enabling women to make informed decisions about whether and when to have children reduces unintended pregnancies as well as obviate maternal and newborn deaths. It also increases educational and economic opportunities for women and leads to healthier families and communities. However, unmet need for contraception in India remains as high as 21.3% (DLHS 3) which accounts for thousands of preventable maternal and infant deaths.

In 2012, the landmark London Summit on Family Planning mobilized governments, international agencies, civil society organizations, and the private sector to commit to dramatically expanding access to voluntary family planning; India being a major partaker of the summit. The resulting partnership, called Family Planning 2020 (FP2020), has created a national momentum on the issue of access to quality contraceptive services.

The FP 2020 Vision document focuses on the paradigm that rapid progress is possible when linking key interventions across the continuum of care, from pre-pregnancy period through the post-partum period. I appreciate the efforts of the family planning division in preparing this FP 2020 vision document that may be used by all the stakeholders as guidance for achieving India's FP 2020 commitments.

(C. K. Mishra)

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PREFACE

India is one of the principal protagonists in the global FP2020 action plan formulated in 2012, having pledged to meet the unmet contraception need for family planning for 40% of the global targets translating to an estimated 48 million additional couples by the year 2020. Placed in the context of the Government of India's RMNCH+A (Reproductive, Maternal, Newborn and Child Health and Adolescents) program, the initiative has been structured to allow for focused intensified efforts in order to achieve the FP 2020 national commitments through decentralized actions at the state and district levels.

India is already implementing measures like the institutionalization of fixed days services, placement of outreach contacts and counsellors, post-partum contraceptive services, particularly PPIUCD to improve access to and use of contraception, but there is still a significant need for spurred collaborations, innovations, and greater accountability in family planning efforts.

I am certain that this vision document will bring sharper focus to family planning efforts and will guide the efforts of the State Governments and development partners to design and implement state and district specific plans for accelerating progress in achieving FP 2020 commitment and work towards the long term goal of ending preventable maternal and child deaths.

I congratulate the Family Planning Division for their painstaking efforts in preparing this vision document for FP 2020, extend fervent support in this vital initiative and urge the states to accelerate their efforts towards achievement of FP 2020 commitment

Rahc

(Dr. Rakesh Kumar)

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ACKNOWLEDGEMENT

India's Vision FP 2020' is a conglomeration of efforts that India is and would be undertaking for fulfillment of the FP 2020 commitments that the country made at the 2012 London Summit on Family Planning. The document has been developed with the objective to make all the stakeholders aware of government strategies and the roadmap towards attaining the FP 2020 goals.

The preparation of this vision document has been made possible with guidance received from Shri Lov Verma, Secretary (H&FW) and encouragement from Shri C. K. Mishra, Additional Secretary and Mission Director. I am especially grateful to Dr. Rakesh Kumar, Joint Secretary (RMNCH+A), for his benevolent guidance and the liberty extended to the division for undertaking and completion of this path breaking task.

A special expression of appreciation for Dr. Pragati Singh of the Family Planning Division who shouldered the enormous burden of coordinating the development of the National and state roadmaps.

Appreciation is also due to other members of the Family Planning Division; Dr. Teja Ram, DC, and Ms. Renuka Patnaik, Consultant.

I am also thankful to all the members of National TSU team especially Dr. Nidhi Bhatt and Ms. Shikha Bansal for drafting and reviewing the content of this document and giving it it's final shape.

My special thanks to BMGF, USAID, DFID and UNFPA for providing logistic support in FP 2020 state vision workshops.

I am also thankful to all the State officials for providing an impetus to the family planning agenda and I am certain that the states and our partner agencies will do their utmost in translating the FP 2020 Vision into reality.

(Dr. S. K. Sikdar)

Contents

ABBREVIATIONS

AHS	Annual Health Survey
ANM	Auxiliary Nurse Midwife
ARC	Advocating Reproductive Choices
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
BCC	Behavior Change Communication
BMGF	Bill and Melinda Gates Foundation
CBR	Crude Birth Rate
CHC	Community Health Centre
DH	District Hospital
DFID	Department for International Development
DLHS	District Level Household Survey
DQAC	District Quality Assurance Committee
EC	Eligible Couples
ECP	Emergency Contraceptive Pills
ESB	Ensuring Spacing at Birth
FDS	Fixed Day Static Strategy
FHI	Family Health International
GOI	Government of India
HBNC	Home Based New Born Care
HDC	Home Delivery Of Contraceptives
HMIS	Health Management Information System
HR	Human Resource
IEC	Information, Education, Communication
IUCD	Intra Uterine Contraceptive Device
LAM	Lactational Amenorrhea Method
mCPR	Modern Contraceptive Prevalence Rate
MCTS	Mother And Child Tracking System
MoHFW	Ministry of Health and Family Welfare
MSI	Marie Stopes India
NACO	National AIDS Control Organization
NFPIS	National Family Planning Indemnity Scheme
NGO	Non-government Organization
NHM	National Health Mission
NPP	National Population policy
NRHM	National Rural Health Mission
NSV	Non Scalpel Vasectomy
OCPs	Oral Contraceptive Pills
PHC	Primary Health Centre
PIP	Project Implementation Plan
PPFP	Post-Partum Family Planning
PPIUCD	Post-Partum Intra Uterine Contraceptive Device
PPS	Post-Partum Sterilization
PSI	Population Service International
PTK	Pregnancy Testing Kit
RCH RMNCH+A	Reproductive and Child Health Reproductive Maternal Newborn Child Health + Adolescents
SC	Sub Centre
SQAC	State Quality Assurance Committee
TFR	Total Fertility Rate

Executive Summary

'Vision FP 2020' for India is not just about providing contraceptive services to an additional 48 million users but aversion of 23.9 million births, 1 million infants deaths and over 42000 maternal deaths by 2020.

Executive Summary

India has traversed a long and arduous path since launching the first ever Family Planning programme in the world in 1952. The programme has further evolved from a targeted approach to a target free approach and has now been anointed as a critical intervention to reduce maternal and child mortality and morbidity beyond a simple strategy for achieving population stabilization.

This document tries to articulate India's global commitments made at the London Summit 2012 where over 60 developing countries pledged access to family planning services for 120 million (12 crore) additional women, a sizeable 40% of which would have to be generated from India.

India also pledged to commit over 2 billion USD, provide family planning services to 48 million additional women and sustain the current coverage of over 100 million users till 2020.

For achieving the above goals, it has been envisaged not only to strengthen the existing strategies but also nurture innovations in the arena of family planning as well as other related sectors, for example, working to reduce teenage marriages and teenage births, increasing literacy of the girl child, addressing other socio cultural barriers etc. For this, India has established a national FP2020 structure with a 'National Steering Committee' and an 'India FP 2020 Country Coordination Committee'.

Achieving the goal of 48 million additional women would mean reaching mCPR of 63.7% which would necessitate contributions from all states of India. The projections charted out in this document show that the share of the much preferred female sterilization will decrease substantially and that of spacing methods will increase significantly. The current focus on post-partum family planning (PPFP) and introduction of a new method in PPIUCD as well as a new device in Cu IUCD 375, will assist in accelerating India's march towards achieving the FP2020 goals.

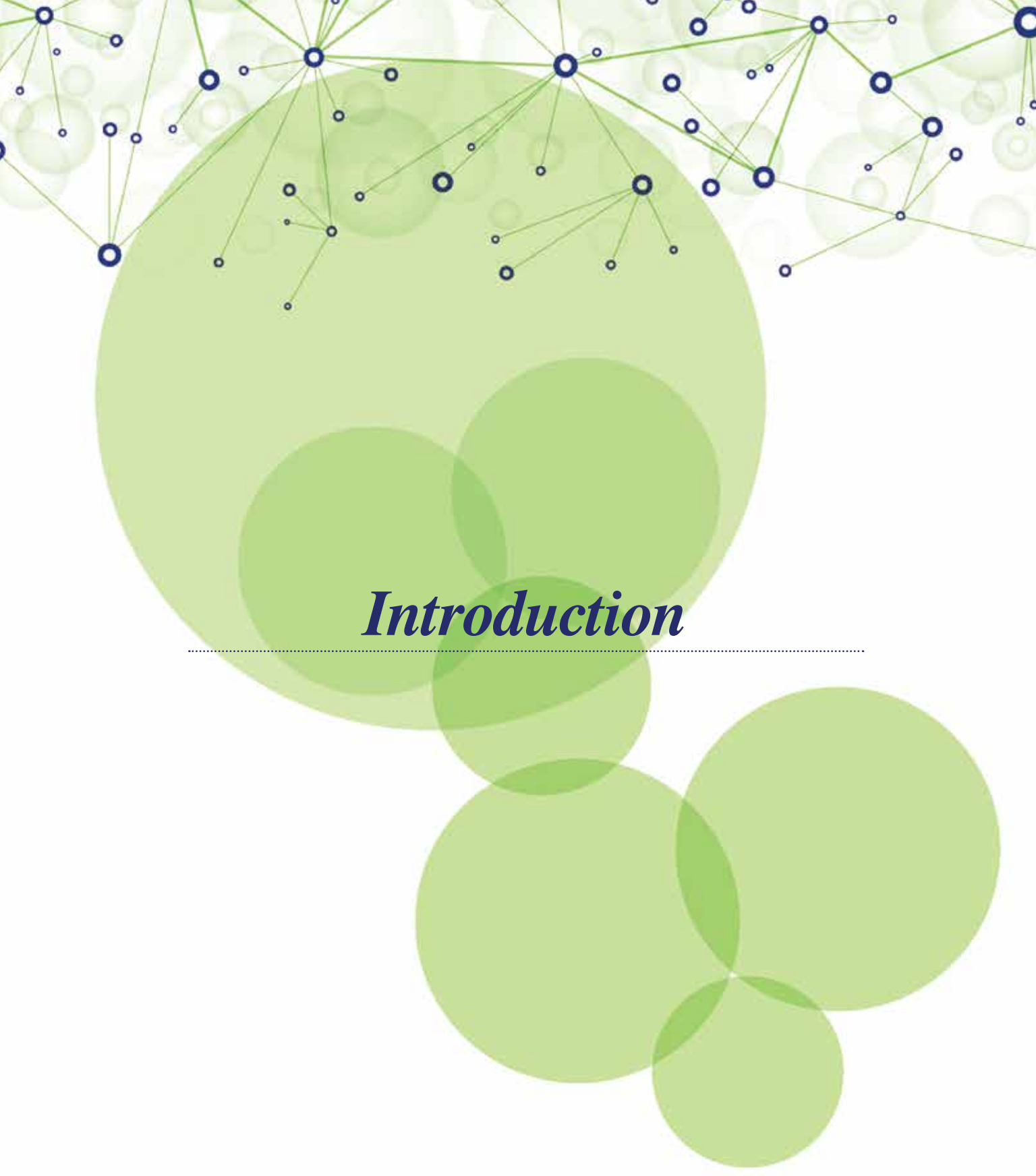
The government has drawn out comprehensive national and state roadmaps and also district action plans adopting a decentralized planning approach focusing on operationalisation of facilities and delivery of services.

The RMNCH+A strategy has provided a platform for addressing the reproductive rights while integrating the current FP services with maternal, child as well as adolescent health. Further impetus to Family Planning services would thus require more community based approach, demand generation together with provision of quality services.

The current FP interventions include: PPFP, Fixed day strategy, male participation, and community based schemes through ASHAs viz. Home Delivery of Contraceptives, Ensuring Spacing at Birth, Pregnancy Testing Kits, Family Planning Counselors, Compensation scheme, Family Planning Indemnity Scheme, Public private partnership etc. The government is also

harnessing the expertise of various partners in the field of advocacy, capacity building, IEC and BCC, programme management, quality improvement, evaluation and assessments, feasibility studies, development of resource material and E- learning modules, software development, social marketing, social franchising and provision of skilled human resource for successful implementation of the programme.

FP 2020 has energized the Family Planning programme in India and has enabled its inclusion as a central element of our efforts to achieve universal health coverage.



Introduction

Steepest decline
in the growth rate in the last decade

But still a long way to go…

India, the second most populous country of the world, harbours 17.5% of the world's population in only 2.4% of the global land mass. Coincidentally it also houses almost 17.3% of the world's protected couples and 20% of world's eligible couples with unmet need. Therefore, large population size of India not only impacts its own but also the global health indicators.

India is the first country in the world to have launched a National Family Planning Programme way back in 1952. One of the goals enunciated in its National Population Policy 2000, was to stabilize the population at a level consistent with the requirement of national economy. The National Rural Health Mission launched in 2005 had achievement of a replacement level TFR of 2.1 as one of its main objective by 2012. However this goal could not be achieved in the stipulated time. The program has since come a long way and currently it has been redesigned not only to attain population stabilization but also to considerably reduce maternal, infant and child mortality and morbidity. Post International Conference on Population and Development, 1994 held in Cairo, there was a de-emphasis on family planning globally and countries of the world and the donors alike withdrew funding from family planning programmes substantially. However, subsequently it was realized that without increasing use and access to contraceptives it would be difficult to impact the prevailing high maternal, infant and child mortality substantially.

In 2012 the 'London Summit on Family Planning' was held against this backdrop to bring back the focus on family planning globally. Over 60 of the world's developing countries represented by some Heads of states, ministers and senior government officials together with over 100 governments, donors, private sector and civil society organizations participated in the summit which was co-hosted by the British government, the Bill and Melinda Gates Foundation, UNFPA and USAID and was a watershed event in the history of family planning worldwide wherein countries and donors pledged around $2 billion (INR12000 crores) annually and all round efforts to reach 120 million (12 crores) women with lifesaving family planning information, services and supplies, a sizeable 48 million (4.8 crores) of whom are resident in India.

Needless to emphasize that the London Summit on Family Planning provided a much needed impetus to the national agenda across countries in order to revolutionize the global vision of protecting children and mothers dying due to unhealthy spacing and lack of access to family planning choices.

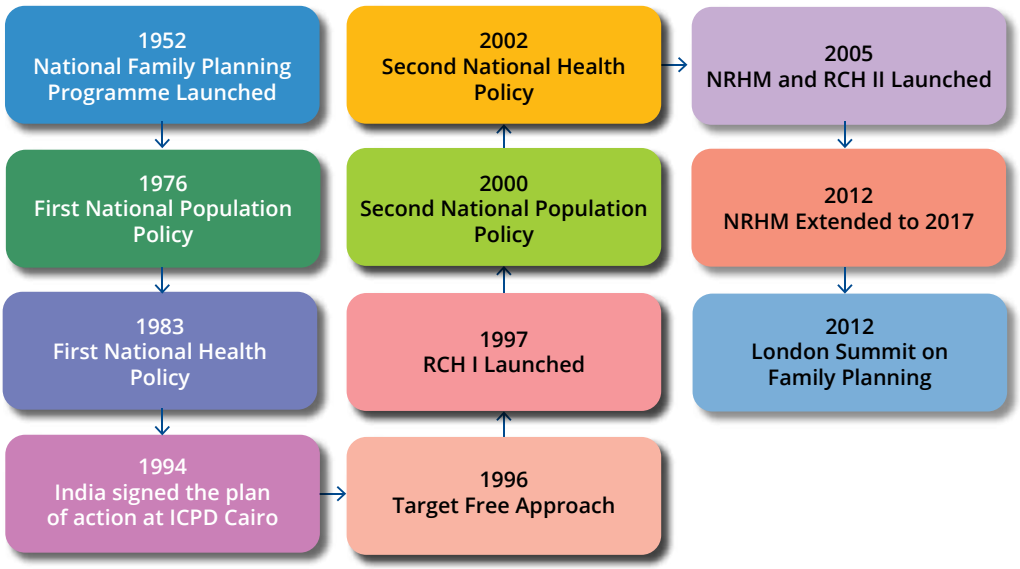


Figure 1: Milestones in Family Planning Programme in India

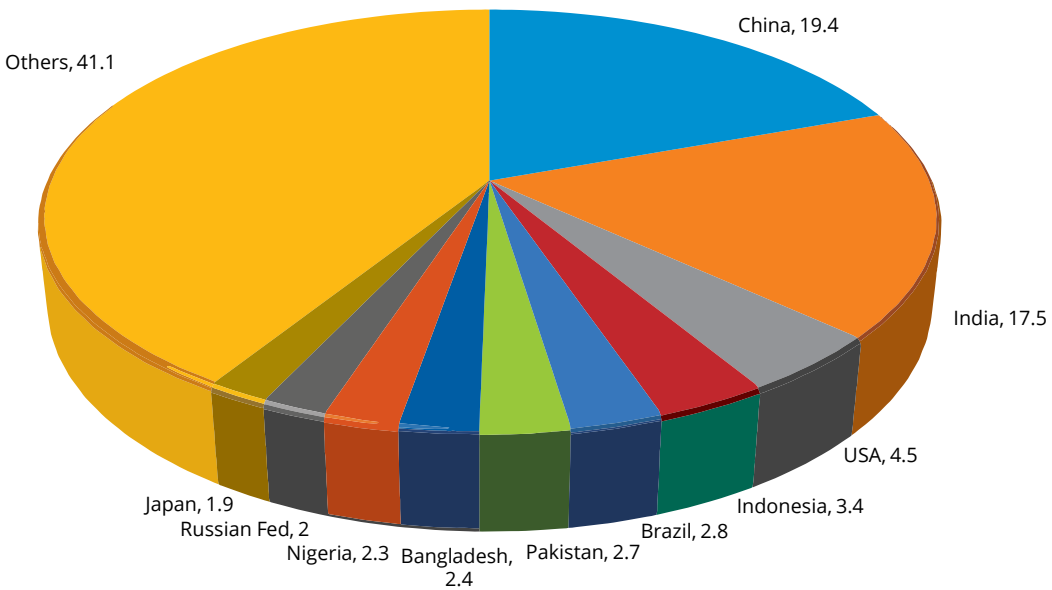


Figure 2: Population share of major countries of the world

India's Commitments

- Inclusion of family planning as a central element of our efforts to achieve Universal Health Coverage.
- Increasing financial commitment on Family Planning to more than 2 billion USD from 2012 to 2020
- Ensuring access to family planning services to 48 million (4.8 Crore) additional women by 2020 (40% of the total FP 2020 target)
- Sustaining the coverage of over 100 million (10 Crore) women currently using contraceptives
- Reducing the unmet need by an improved access to voluntary family planning services, supplies and information.
- Expanding the basket of choices and scaling up the usage of current methods available.
- Ensuring availability of free commodities, through a strengthened commodity supply system in public health facilities for all couples of reproductive age group and adolescents seeking contraceptive services
- Provision of services to all beneficiaries including adolescents through an integrated RMNCH+A approach
- Increasing access to contraceptives through distribution of contraceptives at the doorstep of beneficiary through community health workers
- Ensuring healthy birth spacing by augmenting the focus on spacing methods
- Strengthening the sterilization services through quality service delivery and demand generation
- Ensuring quality Family Planning services though updating existing and formulating new standard operating protocols leading to-
    - o Skill enhancement of providers
    - o Better counseling and monitoring.
- Addressing equity so that the poorest and most vulnerable population have more access to quality services and supplies
- Fostering partnership at the country level with the non-government sector for an improved service delivery
- Raising global awareness on the positive impact of Family Planning

India's Vision FP 2020

Reaching 48 million additional users is not a target but a benchmark of progress towards commitment... A commitment to enable users to choose and plan their healthy reproductive life.

3.1 Background

India, the largest democracy in the world is striving not only to stabilise its population but also offer a healthy and productive life to its citizens. As part of its FP2020 efforts, India is now committed to cover at least 4.8 crores (48 million) additional women and to sustain the coverage of 10 Crore (100 million) protected women, by the year 2020. Besides this, it is also committed to allocate over INR12000 crores (2 billion USD) of federal funding alone from 2012 to 2020 on family planning. These commitments are very much in tune with the current policy and programme thrusts towards improving access and availability of contraceptive services and commodities.

In a country of 125 Crore (1.25 billion), at the outset the goal seems to be unattainable considering the existing pace of the programme. Therefore, in terms of actual demand creation, convincing people to use contraceptives, provision of quality services and simultaneously protecting the reproductive rights of the people requires meticulous planning with effective implementation and monitoring system in place.

For achieving the London Summit Goals, it has been planned not only to strengthen the existing strategies but also nurture new innovations in the arena of family planning as well as the other related sectors, for example, working for improving literacy of the girl child, reducing teenage marriages and teenage births, addressing other socio cultural barriers etc. This would require empowering the rights holders through various interventions and strengthening the capacity of duty bearers.

India has had two National Population Policies which were drafted in the years 1976 and 2000. NPP 2000 focused on stabilizing the population for promoting sustainable development while affirming the commitment of government towards voluntary and informed choice and consent of citizens while availing reproductive health care services and continuation of the target free approach in administering family planning services.

Transitioning from a population control centric approach to a reproductive rights' based approach is the outcome of the experience gained in the last 50 years.

India's policy evolved with the advent of RCH II and further with NRHM, which later transformed to NHM. The latest policy shift to an integrated RMNCH+A approach has anointed family planning as a critical intervention to reduce maternal and child mortality beyond a simple strategy for achieving population stabilization.

Policy for contraceptive provision has evolved over time as per the nation's priority. India started with an approach of more emphasis on sterilization methods, moved to equal emphasis on spacing and sterilization and now the country is focusing more on spacing services. However, for the states with higher TFR, there is still an equal focus on sterilization and spacing.

Vision FP 2020 will build on the current policy of increasing focus on spacing services without disturbing the sterilization pie through voluntary adoption of family planning, based on the felt need of the community and ensuring couples have children by choice, not by chance

FP2020 has emerged as a catalyst that has catapulted the program from a vision mode to a mission mode wherein the Government of India has walked the extra mile in engraving this commitment through micro level planning. FP 2020 District Action Plans submitted by the districts and owned up by the states are testimony to the percolation of these commitments to the ground level. Despite huge commitments, quality is the prime focus. Quality Assurance Committees at state and district level have been strengthened and empowered to monitor the quality in services.

It is envisioned that for realizing these goals, India needs a definitive structure with clear roles and responsibilities.

3.1.1 India's Vision FP 2020 structure:

Figure 3: India's vision FP 2020 structure

- National Steering Committee on FP2020 has been formed under the chairmanship of Additional Secretary & Mission Director- National Health Mission, Government of India. The Committee comprises of RMNCH+A donor partners (BMGF, UNFPA,

USAID and DFID) along with the GoI representatives and representatives of NGOs working in the reproductive health arena with a mandate to meet once a year.

- India FP 2020 Country Coordination Committee has been formed under the chairmanship of Joint Secretary (RCH). This committee is comprised of the core international sponsoring partners namely BMGF, UNFPA, USAID and DFID and Government of India representatives with a mandate to meet at least twice a year.
- National Technical Support Unit (NTSU) for FP 2020: A National Technical Support Unit has been established to provide technical support to the national and state governments, with special focus in 6 high priority states in India. It is funded by the Bill and Melinda Gates Foundation.
- To strengthen the monitoring, Family Planning division is being supported by 'Track 20' mandated by FP2020 to assist pledging countries.

3.1.2 Country Snapshot for FP 2020 activities:

- India FP 2020 Country Coordination Committee meeting: was held on 26th May 2014 with a view to strengthen the planning and implementation process for achieving FP 2020 goals. At this meeting the National Roadmap was unveiled to the core partners.
- FP 2020 Dissemination workshops at State level: The state specific roadmaps were developed for each state in India and disseminated at state level workshops. The roadmaps are based on the unmet need, contraceptive use, performance levels of the states as reported in latest survey and service data.
- District roadmaps: Following the state dissemination workshops, each district was facilitated to formulate the district action plans to operationalize the facilities for services for year 2014-15.
- Country level meeting with the international Track 20 group: The Track 20 team is responsible for monitoring of FP2020 country progress worldwide. The first meeting was held on 1st July, 2014 which resulted in alignment of India's monitoring strategy with the global monitoring strategies.

3.2 Analyzing Current Scenario

As discussed in the previous chapter, India was the first country in the world to launch a national FP programme, 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". In 1996, the new approach had a very strong reproductive health

orientation and the target based approach was replaced by a decentralized community need assessment based approach.

The program has come a long way and currently family planning program has been repositioned to not only achieve population stabilization but also to reduce maternal mortality and infant and child mortality.

3.2.1 Current demographic scenario (census 2011):

India's population as per 2011 census is 121 Crore (1.21 billion), second only to that of China in the world. India accounts for 2.4% of the world's surface area yet it supports more than 17.5% of the world's population. In absolute terms, the population of India has increased by about 18.1 Crore (181 million) between 2001 and 2011.

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 large Non-NE High Focus States after decades of stagnation.

The decadal growth rate of India has declined from 21.54% in 1991-2001 to 17.64% in 2001-2011. 2001-2011 is the first decade (with the exception of 1911-1921) which has actually added lesser population compared to the previous decade.

3.2.2 Fertility Indicators:

3.2.2.1 Crude Birth Rate:

India's CBR is 21.6 as per SRS 2012. The CBR is showing a consistent decline each year recording total decline of 16% from the year 2000 to 2012. India is in latter half of the third stage of demographic transition whereby the death rate has declined substantially and the birth rate is also declining. Among the states, Bihar has the highest CBR of 27.7 followed by UP with a CBR of 27.4. Goa and Tripura have lowest CBR of 13.1 and 13.9 respectively.

3.2.2.2 Total Fertility Rate:

India's TFR is 2.4 as per the latest available data (SRS 2012). TFR has declined by 25% from the year 2000 to 2012.

Out of 36 states/UTs, 24 states/ UTs (48% of population) i.e. Goa, Manipur, Tamil Nadu, Tripura, Kerala Andhra Pradesh, Telangana, Himachal Pradesh, West Bengal, Punjab, Delhi, Maharashtra, Karnataka, Mizoram, Nagaland, Jammu & Kashmir, Sikkim, Uttrakhand, Odisha, Andaman & Nicobar Islands, Puducherry, Chandigarh, Daman & Diu and Lakshadweep have already achieved replacement level fertility (i.e. 2.1 or less).

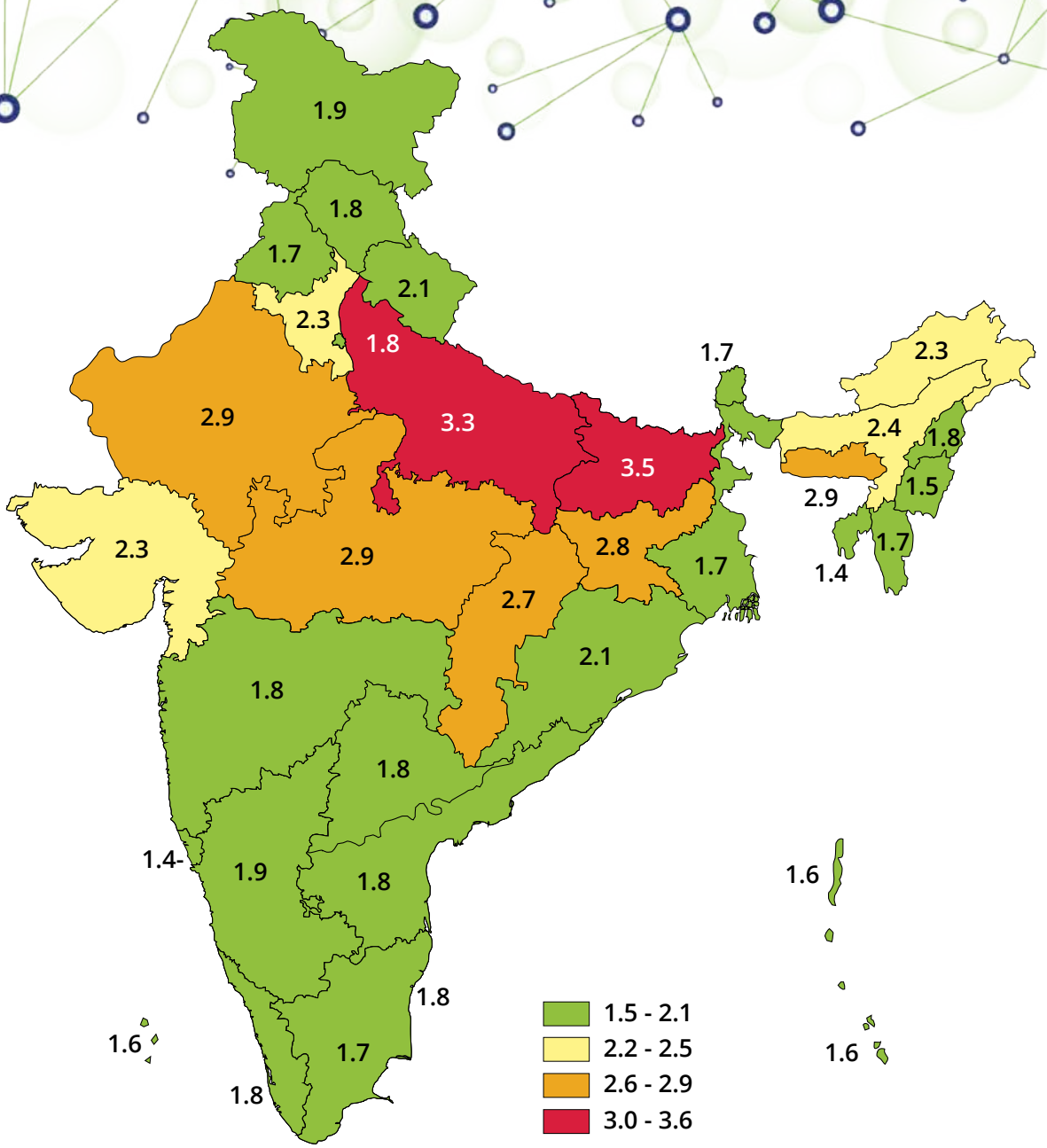


Figure 4: Total Fertility Rate of Indian States/ UT (Source: SRS 2012)

3.2.2.3 Age Specific Fertility Rate:

In India 52.5% of fertility is contributed by women in the age group of 15 - 24 years (SRS 2012). The teenage fertility stands at 31.5 in India with inter and intra state variations (SRS 2012). The Age Specific Fertility Rate (ASFR) in the younger age group 15 -19 varies from 6.2 in Jammu & Kashmir to 59.0 in West Bengal (SRS 2012).

In the age group 30 - 34, the variation in the level of ASFR is from 24.9 in Andhra Pradesh to 124.9 in Bihar (SRS 2012). Except for Jammu & Kashmir, Kerala, Punjab and Uttar Pradesh where fertility reached its peak in the age group 25 - 29, the highest fertility in all the other bigger States has been attained in the age group 20 - 24. Fertility, however, declines from age 30 onwards in all the bigger States.

3.2.3 Family Planning Indicators:

3.2.3.1 Modern Contraceptive Usage:

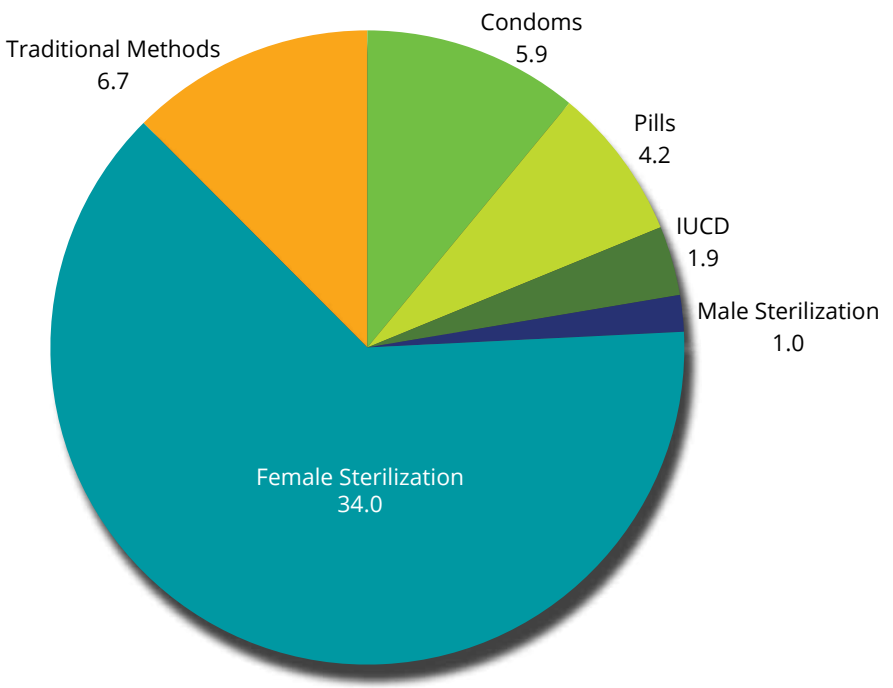


Figure 5: Contraceptive method mix in India (DLHS III)

47.1% of the eligible couples are using some modern contraceptives in India (Source: DLHS III). The highest share is of female sterilization followed by condoms, pills and IUCD.

The share of male sterilization is lowest. 6.7% of the eligible couples are resorting to traditional methods

3.2.3.2 Unmet need of Family Planning:

21.3% of eligible couples in India have unmet need for family planning (Source: DLHS-3). The unmet need is higher for the limiting methods (13.4%) as compared to the spacing methods (7.9%).

The unmet need has shown a decline from 25.4% to 21.3% in DLHS I (1998-99) to DLHS III (2007-09)

3.3 Drawing national/ state and district roadmaps

Family planning program has profound impact on maternal and child health as well as the overall development of the country. To channelize the efforts towards achieving London Summit Goals, Government of India took an initiative to work out detailed country projection with expected contributions from each state.

Considering the DLHS III figures nearly 4.4 Crore (44 million) people in India have unmet need for contraception of which 1.6 Crore (16.3 million) have unmet need for spacing and 2.6 Crore (25.5 million) have unmet need for limiting. As per the current statistics, nearly 10.3 Crore (103 million) eligible couples are using some method of modern contraception.

3.3.1 mCPR Projections for 2020:

If mCPR in India follows a linear trend, then it will rise to 53.8% by 2020.

Currently the contraceptive usage in India is skewed towards female sterilization. With the current rate the share of condoms and pills will increase while the share of other methods will decrease. With the linear increase the projected number of users by 2020 will be around 12.8 Crore (128 million), with 2.4 Crore (24.2 million) additional users.

The goal of 4.8 Crore (48 million) additional users would thus necessitate more intensive efforts and will require 35.2% increase in mCPR from current DLHS 3 estimates.

Table 1: mCPR required to achive FP2020 commitments

Number of estimated Users (2012) (As per projected CPR and population)	103,871,282
Number of projected users by 2020	128,053,042
Number of users required to achieve the goal of 48 million additional users	151,871,282
Required CPR by 2020	63.7%
% increase in CPR required	35.2%

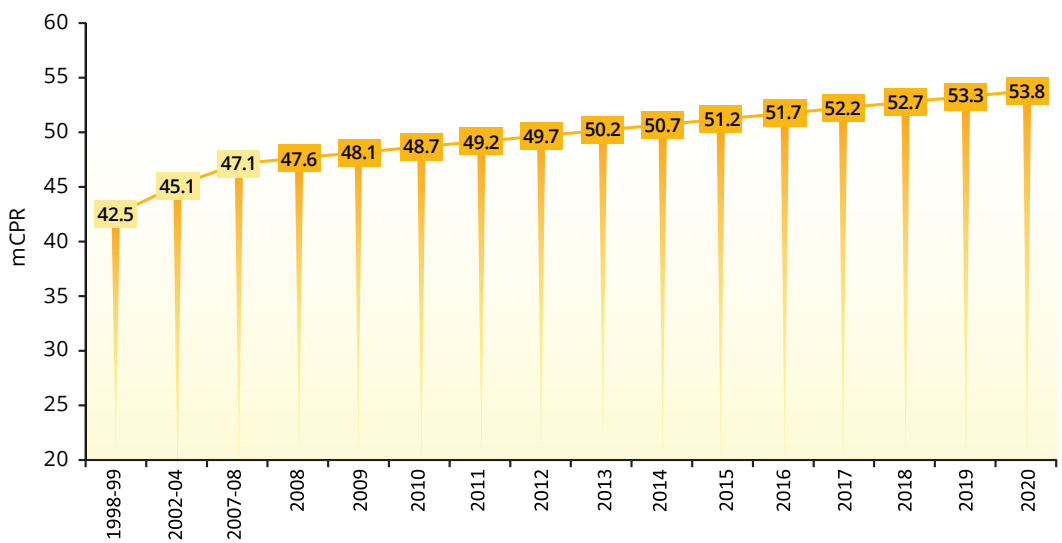
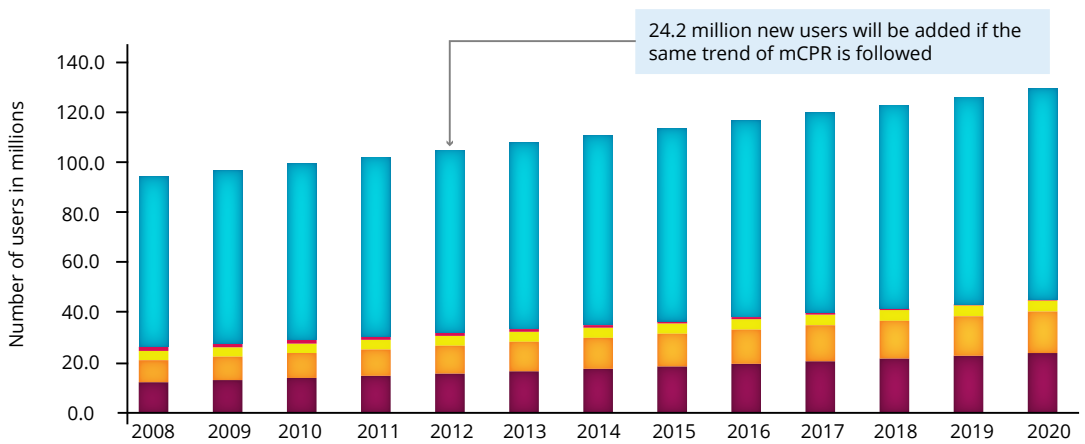


Figure 6: Year wise projection of Contraceptive Prevalence Rate (mCPR) as per linear trend (estimates from DLHS I,II and III)

Table 2: mCPR Projections

YEARS	1998-99 (DLHS I)	2002-2004 (DLHS II)	2007-2008 (DLHS III)	PROJECTED 2020
Pill	2.4	3.5	4.2	6.9
Condom	3.1	4.6	5.9	9.9
IUCD	1.9	1.8	1.9	1.9
Female Sterilization	33.5	34.3	34	35
Male Sterilization	1.5	0.9	1.0	0.1
Any modern method	42.5	45.1	47.1	53.8



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Condoms	12.1	12.9	13.8	14.7	15.5	16.5	17.4	18.4	19.4	20.4	21.4	22.5	23.6
Pills	8.7	9.2	9.8	10.4	11.0	11.6	12.2	12.8	13.5	14.2	14.9	15.6	16.3
IUCD	3.6	3.7	3.8	3.8	3.9	3.9	4.0	4.1	4.1	4.2	4.3	4.3	4.4
Male Sterilization	1.6	1.5	1.4	1.3	1.2	1.1	1.0	0.9	0.8	0.7	0.6	0.4	0.3
Female Sterilization	67.1	68.3	69.6	70.8	72.1	73.4	74.8	76.1	77.5	78.9	80.3	81.8	83.3

Figure 7: Projected users in millions from 2008 to 2020

3.3.2 Required Method mix by 2020:

Contraceptive usage is multifactorial and does not follow a linear trend. As discussed above, almost 48% of population residing in 24 states of India have achieved replacement level TFR. Healthy spacing of births, however, remains a concern in most of the states of India. As a policy, presently there is more focus on spacing services (except for the High TFR states where both spacing and limiting are emphasized upon).

Considering the program thrust and past trends, it has been assumed that the share of spacing methods (IUCDs, Condoms and Pills) will now rise with time. Although male sterilization shows a declining trend in the past surveys, in practical sense it won't zero down with time. So it is considered that male sterilization share will almost remain the same.

Most of the additional users in 2020 will be availing of female sterilizations followed by Condoms, IUCD and pills.

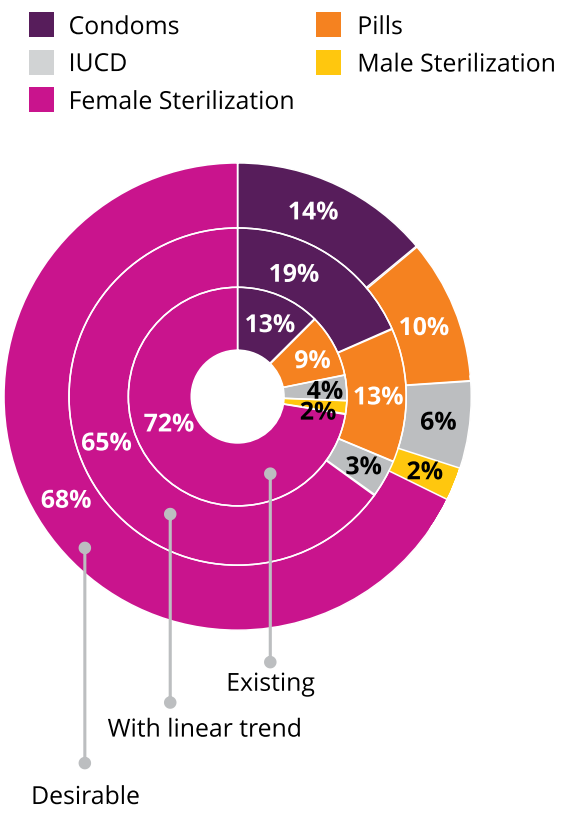
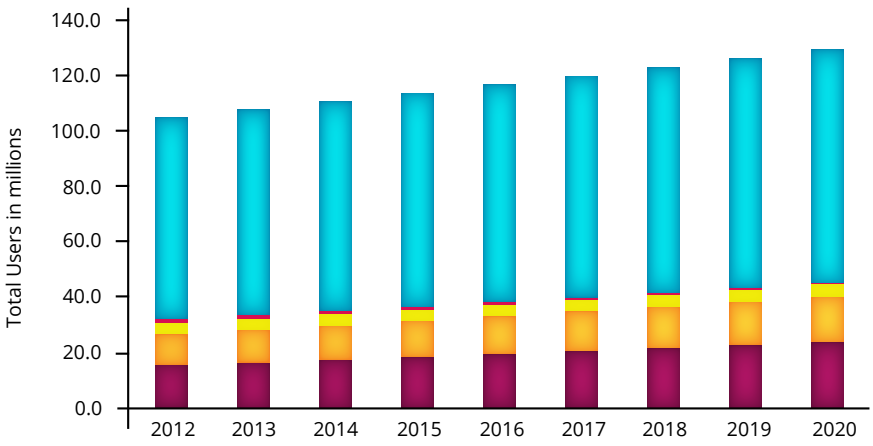


Figure 8: India's method mix in three different scenarios



	2012	2013	2014	2015	2016	2017	2018	2019	2020
Condoms	14.4	14.9	15.1	15.9	16.1	17.0	18.0	19.7	21.2
Pills	10.0	10.2	10.6	11.1	12.1	12.7	13.6	14.3	15.2
IUCD	4.4	4.7	5.0	5.4	6.0	6.8	7.6	8.4	9.1
Male Sterilization	2.3	2.4	2.5	2.6	2.6	2.7	2.8	2.9	3.0
Female Sterilization	79.0	82.2	85.5	88.9	92.2	95.3	98.0	100.5	103.1

Figure 9: Projected users for achieving 2020 goals (number in millions)

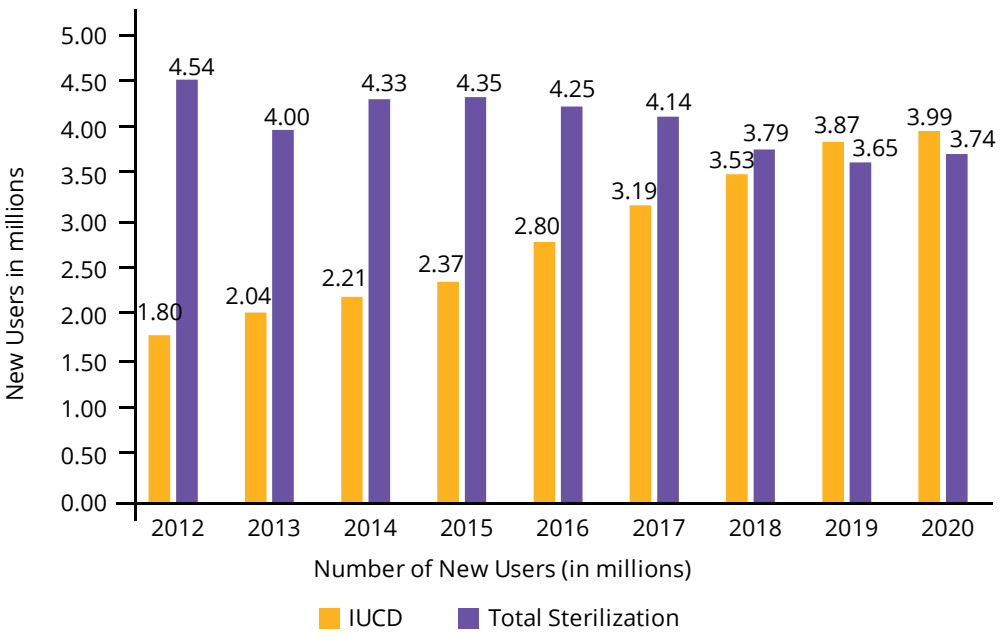


Figure 10: Projected number of additional users for achieving 2020 goals (in millions)

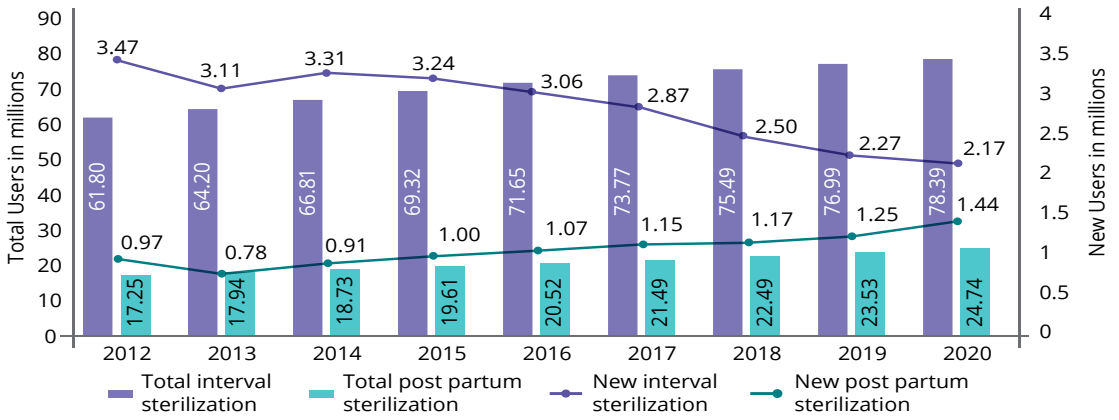


Figure 11: Projected number of total and new users of interval sterilization and post-partum sterilization (in millions)

3.3.3 Share of post-partum family planning methods:

Till few years back there was no spacing method available for women in post-partum period in public health facilities. The recent introduction of PPIUCD in India has revolutionised the basket of choice for Indian women.

In 2012-13 the acceptance for Post-partum sterilization was around 7.6% (HMIS) of the total deliveries in the country and for PPIUCD this rate was around 0.9% (HMIS). Low percentage of PPIUCD may be attributed to non-operationalization of the facilities in 2012-13. India is now extensively focusing on post-partum family planning services.

3.3.3.1 Post-partum Sterilization (PPS):

The renewed thrust on PPS is expected to increase its share in the coming years which is also reflected in the projections made. Considering the realistic scenario it is assumed that the maximum increase in PPS will be around 40% of the total new cases of female sterilization. It is estimated that by 2020 there will be around 7.8 Crore (78.4 million) users of interval female sterilization and 2.4 Crore (24.74 million) users of post-partum sterilization

3.3.3.2 Post-partum IUCD:

Enhanced focus on PPIUCD increased the uptake of PPIUCD services; with

1.2 lakh (0.1 million) insertions in 2012-13 to approximately 3 lakh (0.3 million) insertions in 2013-14. It is estimated that by 2020 there will be around 42.7 lakh (4.27 million) users of interval IUCD and 47.8 lakh (4.78 million) users of post-partum IUCD.

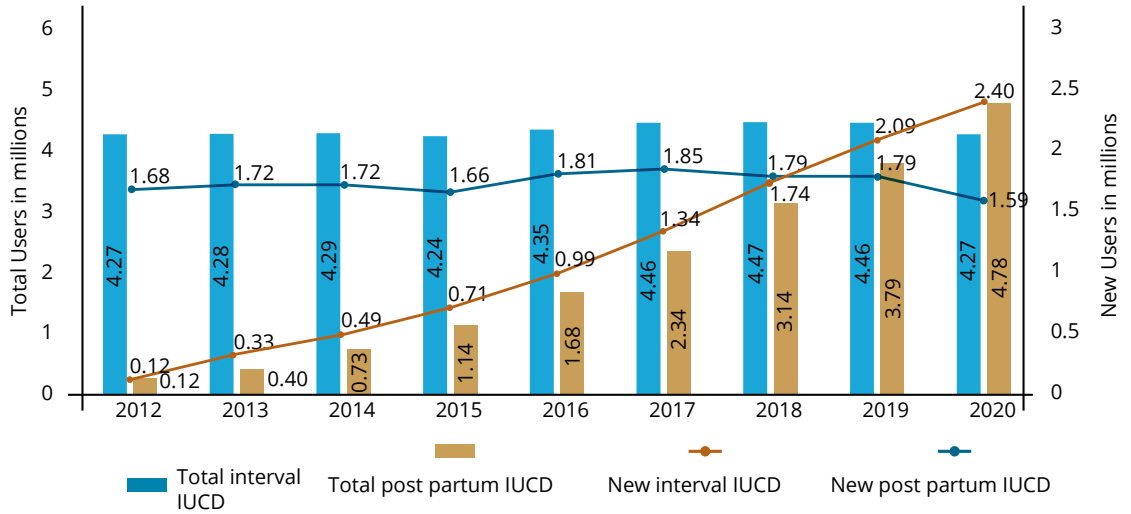


Figure 12: Projected number of total and additional users of interval IUCD and post-partum IUCD (in millions)

3.3.4 Operationalization of facilities for FP Services:

3.3.4.1 PPIUCD:

Almost 70% of the district and sub district level public health facilities of the country are conducting deliveries and it is planned to operationalize all of them for provision of PPIUCD services. That would translate into operationalization of almost 3700 more district and sub district facilities almost 5666 primary health centres and 5000 Health sub centres. For this India currently has to train a minimum of 27,000-30,000 providers; 80% of these would be from the nursing cadre and a small percentage of it would be the AYUSH practitioners.

3.3.4.2 Interval IUCD:

Since year 2005, over 1.2 lakh (0.1 million) service providers have been trained for interval IUCD. Approx. 35,000 additional manpower needs to be trained in order to saturate all district level facilities, sub district level facilities, PHCs and 50% of SCs to achieve 2020 goals.

Assuming that the training load will have at least 20% doctors and 80% nurses, nearly 27,800 nurses and 7000 doctors are required to be trained.

3.3.4.3 Sterilization:

It is assumed that for achieving 2020 goals, India needs to operationalize all district and sub district hospitals for laparoscopic sterilization services, all district, sub district hospitals and 50% of PHCs for minilap sterilization services and all district, sub district hospitals and 10% of PHCs for NSV services.

At present, a total of 11,793 minilap trained providers, 5483 laparoscopic trained providers and 3574 NSV trained providers are available at various public health facilities. An additional 7000 doctors need to be trained for minilap services, 1600 doctors for laparoscopic services and 6000 doctors to be trained for NSV services in the country.

3.3.5 Commodities Required:

Ensuring uninterrupted supply of commodities is one of the most crucial inputs in order to fulfill commitments. Hence year wise projections for commodity requirements have been arrived at. India would require approximately 164.7 Crore (1.64 billion) cycles of OCPs; 1830 Crore (18.3 billion) pieces of condoms; 3.2 Crore (32.2 million) IUCDs and 1.3 Crore (13.9 million) pairs of tubal rings to cater to the demand for services.

3.3.6 Financial allocation for FP program:

The funding for family planning program is channelised through two routes: the National Health Mission (NHM) route and the treasury route.

The table below shows India's projection on expenditure for Family Planning.

Table 3: Projected financial allocation for Family Planning Programme

Budget Head	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	Total up to 2020
Service Delivery/ Infrastructure/HR	1329.6	1255.2	1380.7	1518.8	1670.7	1837.7	2021.5	2223.7	13237.9
Commodities	400.0	440.0	484.0	532.4	585.6	644.2	708.6	779.5	4574.4
TOTAL INR (Crores)	1729.6	1695.2	1864.7	2051.2	2256.3	2481.9	2730.1	3003.2	17812.3
TOTAL (billion $) 1 USD = 60	0.29	0.28	0.31	0.34	0.38	0.41	0.46	0.50	3.0

The infrastructure and HR cost is integrated under NHM state PIP. As discussed with 'Track 20', the financial estimation is made taking into account the actual allocation to FP (service delivery cost, training cost, IEC/BCC cost, equipment costs, others). For HR and infrastructure, 10% of the total HR and infrastructure cost under NHM has been factored in to arrive at the projected allocation.

3.4 State wise goals

(Annexure 1)

FP 2020 envisions reaching 4.8 Crore (48 million) additional users by the year 2020. It is considered that the states with higher unmet need and higher population will have to contribute more for attaining the FP 2020 goals.

As far as percentage share of unmet need is considered, about a quarter (25.8%) of the country's unmet need is contributed by Uttar Pradesh, followed by Bihar which contributes to about 15%

The figure below shows approximate increase in mCPR required for the states of India to attain FP 2020 goals

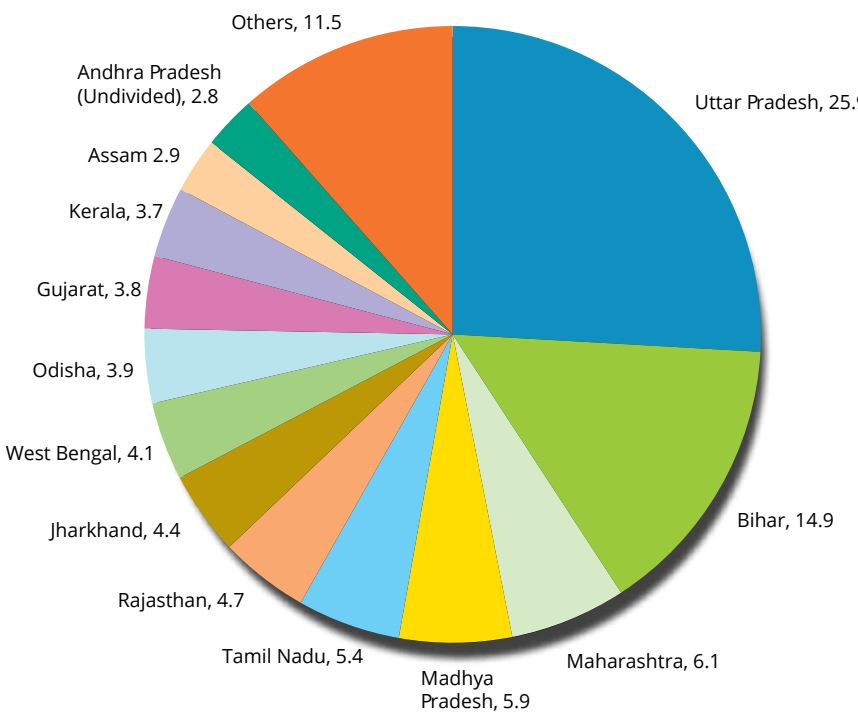


Figure 13: Percentage share of unmet need of Indian states

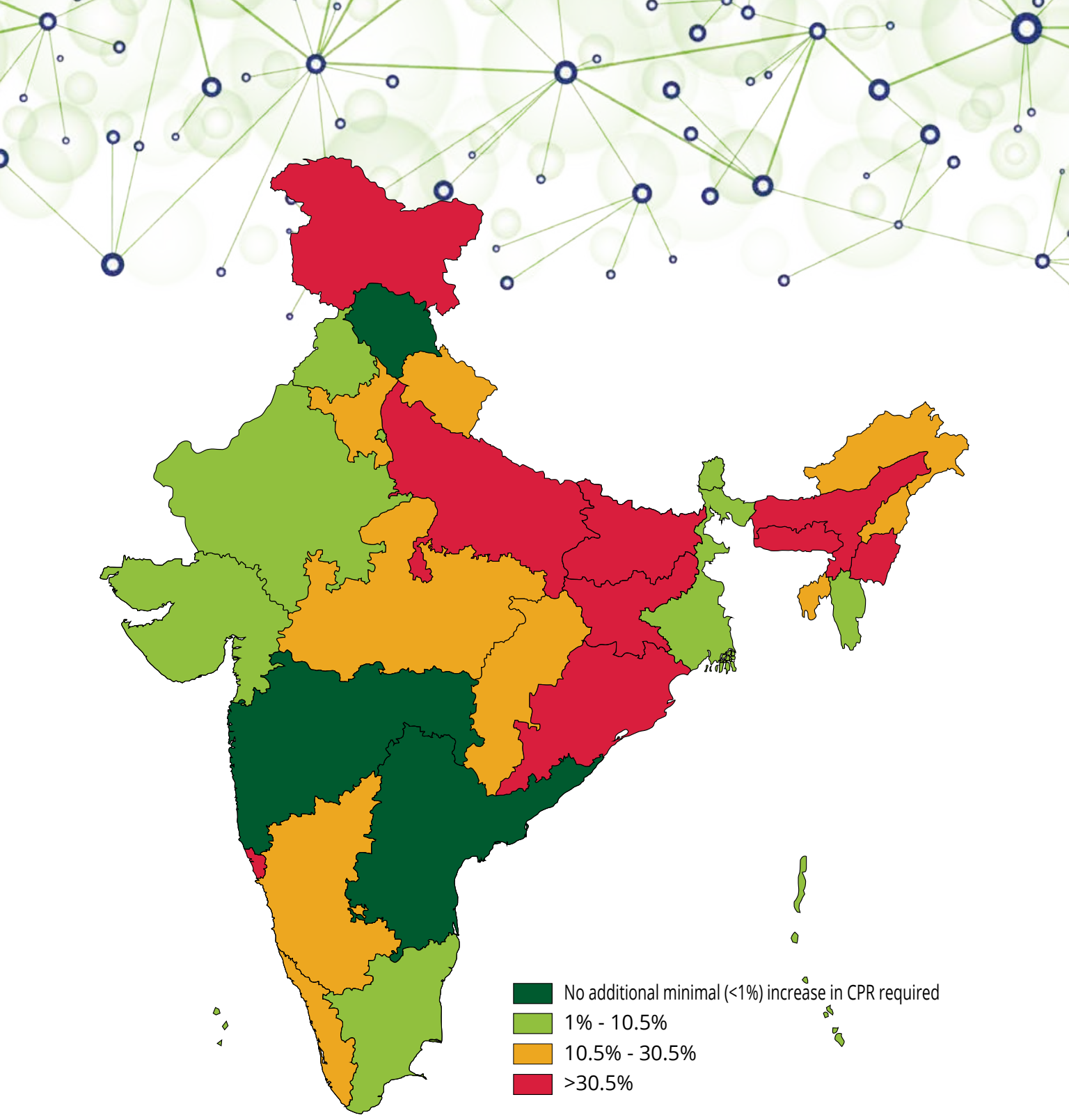
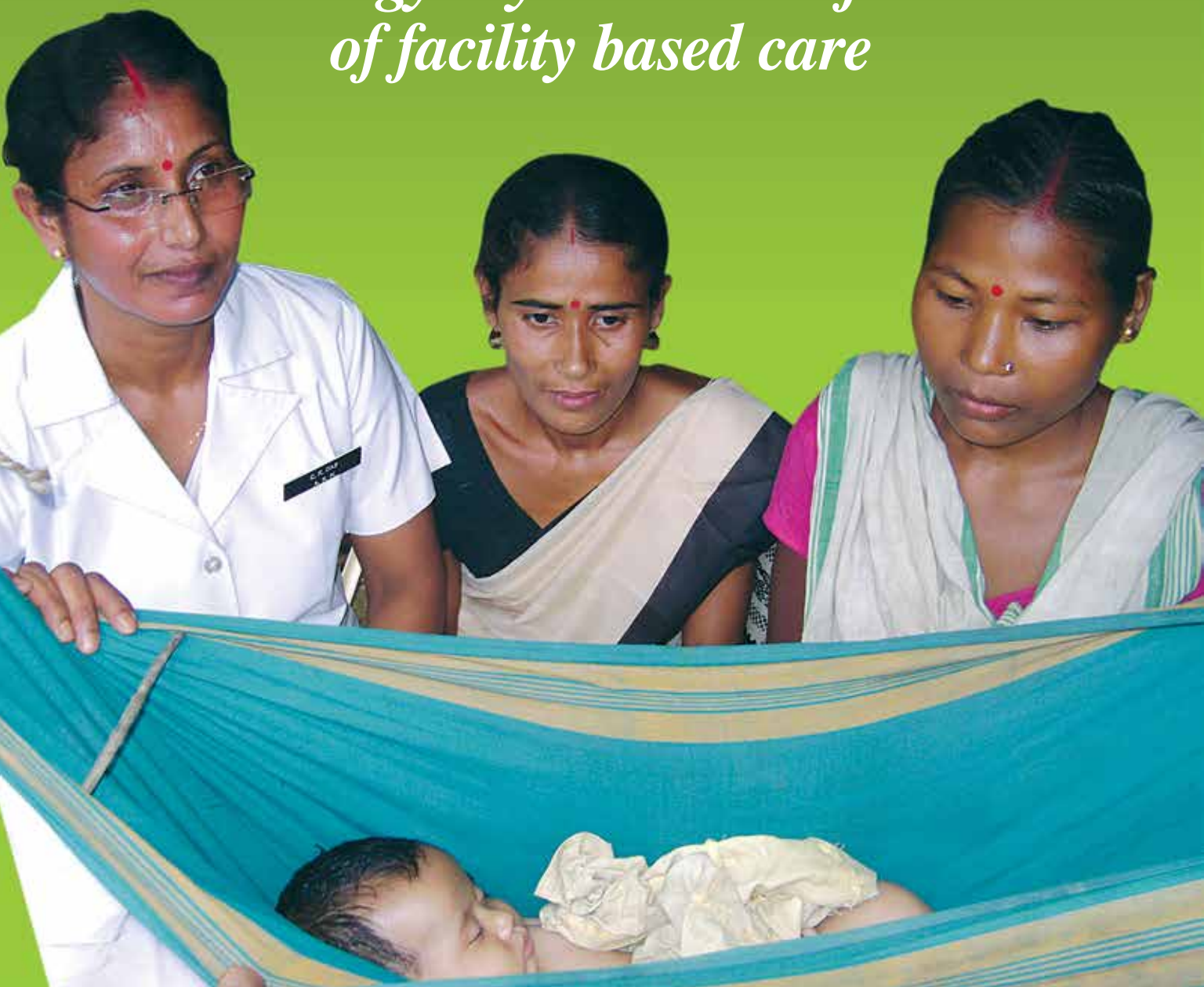


Figure 14: Additional increase in mCPR required (over and above linear increase) in Indian States

Pursuing an Integrated RMNCH+A Approach

Existing network of community health workers act as a channel for extending service delivery under the ambit of RMNCH+A strategy beyond the confines of facility based care



4.1 Background

Subsequent to the London Summit on Family Planning, India launched its call to action for child survival and development in February, 2013 and the comprehensive Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategy was thereafter unveiled in May, 2013. Family planning program gained a huge momentum in improving maternal and child health outcomes and became the first pillar of the operational RMNCH+A strategy. This was a laudatory change from the erstwhile vertical approach envisioned to address the gap between the services and demand and ultimately attain the MDG goals 4 and 5.

Vision FP 2020 builds on the integrated RMNCH+A approach.

The 'Plus' in the strategic approach denotes inclusion of adolescence as a distinct 'life stage' which forms the basis for a healthy life. This also denotes linking of maternal and child health to reproductive health components like family planning and linking of community and facility-based health care. Apart from this, due importance has been given to health system strengthening, reducing out of pocket expenditure and providing services in underserved areas.

A ' 5" X 5" matrix for RMNCH +A interventions has been developed to support the implementation of health service delivery across all life stages. A list of minimum essential commodities required for these interventions are also provided along with the matrix. This matrix notifies the minimum services to be offered to the clients which cannot be compromised under any situation (Figure 16). This matrix is now omnipresent across the country acting as a techno managerial tool for the administrators, program managers, service providers as well as clients at all levels of healthcare from the national to the state, district, block and the village level.

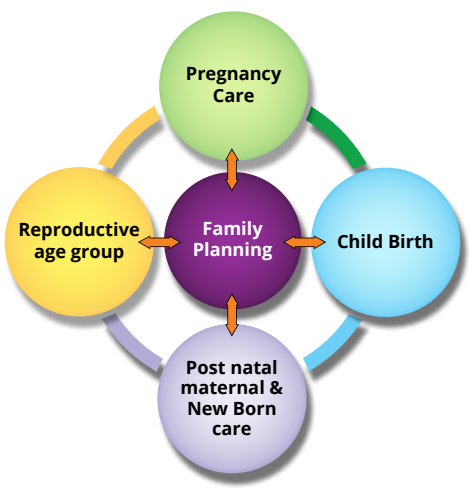
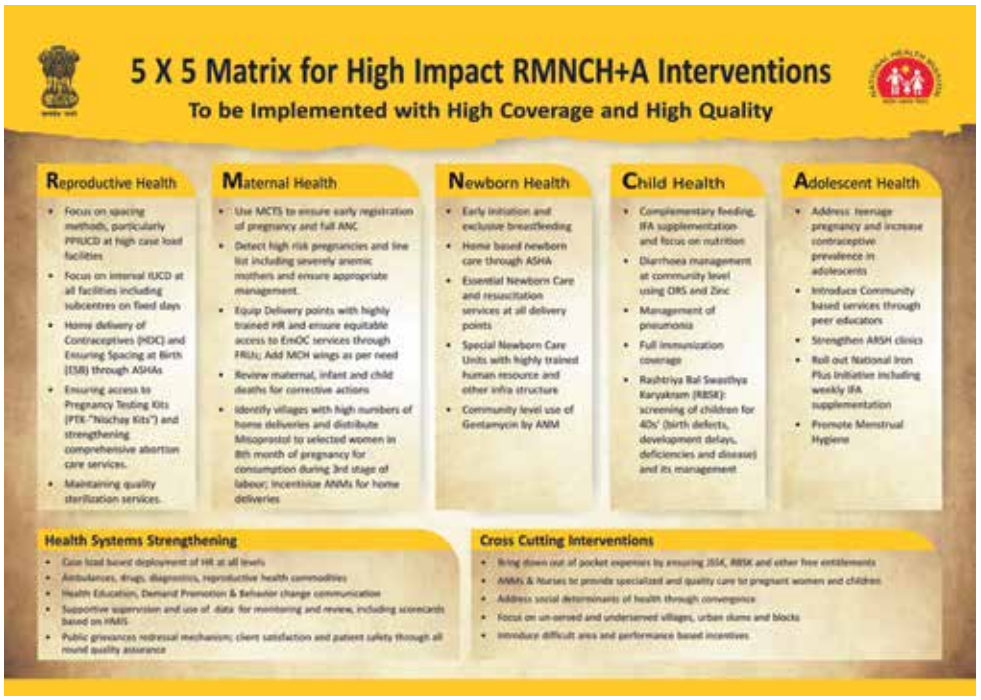


Figure 15: RMNCH +A strategy with equal focus on various life stages



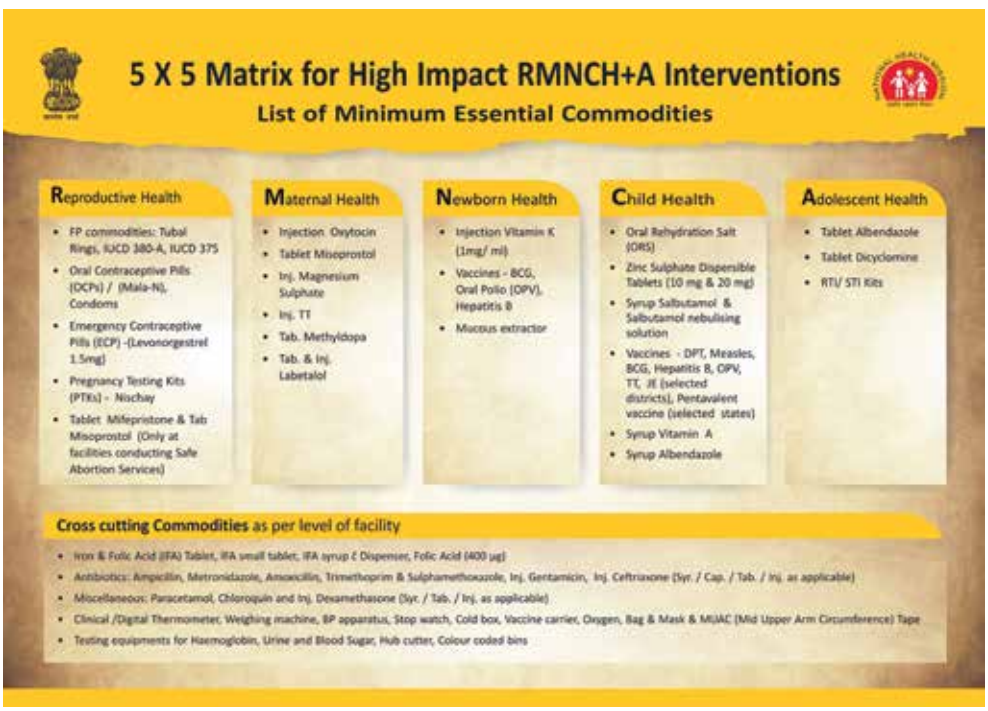


Figure 16: 5X5 Matrix for High Impact RMNCH+A Interventions

4.2 Integration of services under RMNCH+A strategy

Integration of services at all stages of life with family planning services is imperative which would not only help India achieve its national FP 2020 goals but also help ensure provision of quality reproductive health care in a holistic manner.

4.2.1 Adolescent Health:

With significant unmet need of contraception and low condom use, adolescents (especially adolescent girls) are at high risk of contracting sexually transmitted infections and unintended pregnancies. This in turn leads to lessened productivity, increased likelihood of unsafe abortions, morbidity and mortality. Thus, RMNCH+A strategy can be phenomenal in addressing the contraceptive needs of this age group through established ARSH clinics at facility level and ASHA/ Anganwadi Workers at the community level.

4.2.2 Maternal Health:

There are sufficient evidences to show early, frequent and multiple pregnancies have detrimental effects on health of mothers which predisposes them to increased chances of mortality.

India currently contributes to approximately 19% of global maternal deaths which is a huge burden for any single country to carry. Therefore, RMNCH+A strategy views family planning methods as cost effective and feasible way to reduce maternal mortality. Healthy timing of pregnancy and birth spacing are valued because it is estimated that if the current unmet need for family planning is met within the next five years, India can avert over 35 thousand maternal deaths. Contacts during antenatal period and postpartum period are the opportunities to counsel women to adopt family planning methods.

4.2.3 Neonatal, Infant and child health:

Use of contraceptives has the ability to improve perinatal outcomes and child survival as it widens the interval between successive pregnancies. Therefore, apart from other newborn and child health interventions, RMNCH+A strategy focuses on spacing between children through varied contraceptive methods. Contact during HBNC, immunization visits, other contacts can be utilized for creating awareness, counselling and providing family planning choices to tap the unmet need during the post-partum period.

4.3 Fuelling the demand

4.3.1 Community driven Family Planning Program in India:

Demand generation with respect to family planning refers to coordinated activities intended to stimulate a latent interest or generate a new interest in acccssing family planning services. Experiences and studies worldwide including India have shown the effectiveness of involving communities in success of family planning programs and integrating them with other health services.

The family planning program in India looked beyond delivering services through static facilities and utilized the huge army of community health workers namely ASHAs to make information, services and supplies available at the doorstep of beneficiaries. ASHA schemes have been instrumental in reaching the services to the community at their doorstep.

Since the ministry of health is striving to achieve universal accessibility of contraceptives so that eligible couples can make informed choices regarding their reproductive health, community based schemes like Home delivery of contraceptives, Ensuring spacing at birth and Pregnancy testing kits implemented through ASHA have been initiated. These schemes are intended to overcome multiplicity of demand side obstacles including ignorance about basket of choices of contraceptives and benefits of spacing in births, reluctance of couples to seek contraceptives from health facilities and minimizing costs incurred on seeking reproductive health care.

4.3.1.1 Home Delivery of contraceptives by ASHA (HDC):

Inspired by the success of community based schemes under NHM, the government piloted an innovative strategy of home delivery of contraceptives through ASHAs in 233 districts across the country in June 2011.

The pilot was evaluated by three independent international and national NGOs namely FHI, Pathfinder International and Population Foundation of India in different states which unanimously proclaimed the success of the program. All the evaluation reports brought out that ASHAs have emerged as an important source for accessing contraceptives in the rural areas by eligible couples in the privacy of their homes. Also it helped in reducing the gender differentials for contraceptive usage as ASHAs revealed their negotiating skills in distributing contraceptives to male beneficiaries too. Therefore, the scheme was universalized all across the country in December 2012.

Presently in India 8.7 Lakh (0.87 million) community health workers (ASHA) are acting as depot holders for contraceptives at the village level. 6.4 lakh (0.64 million) villages across 643 districts are being covered under the scheme.

ASHAs are also entitled to charge a minimal amount for the contraceptives as service charges. However it is the discretion of ASHAs to charge the money or use the transaction as an entry point for delivering other RCH services to the clients for which they would otherwise get paid decent sums. The ASHA stock of contraceptives is replenished each month from the designated health center and the same is tracked through predefined formats.

4.3.1.2 Ensuring spacing at birth through ASHA (ESB):

Healthy birth spacing has a direct linkage with maternal and newborn health as it reduces the morbidities and mortalities. The fact that India accounts for almost 19% of all global maternal deaths and more than 22% of under-five child deaths made it imperative to focus on healthy birth spacing.

Since 2012, the services of 5.9 lakh (0.59 million) ASHAs have been utilized to counsel the beneficiaries on advantages of healthy birth spacing, delaying the first birth by two years and maintaining the birth interval of at least three years between the two children across 18 states of the country (including 8 Empowered Action Group states, 8 North Eastern states and the states of Gujarat and Haryana) covering 4 lakh villages (0.4 million villages) across 410 districts of the country.

The funds for the scheme are sourced from NHM and routed through state annual program implementation plans (PIP). INR 126.8 crores (US$ 12.68 million) has been approved for the scheme in 2013-14. For the smooth implementation of the scheme, the roles and responsibilities of state, district and facility level officials has been clearly laid down. The scheme too has been a success and the money apportioned for the same in 2014-15 is substantially higher considering the demands from the states.

4.3.1.3 Pregnancy Testing Kits (PTK):

Early detection of pregnancy sets the stage for healthy fetal development and ensuring good health for the women. It is imperative that each pregnant woman gets tested in time. An army of 8.7lakh (0.87 million) ASHAs and 2 lakh (0.2 million) ANMs are now involved in early detection of pregnancy and subsequent follow up through this simple technique.

It is well evident that early detection of pregnancy is a way to reduce maternal morbidities along with unwanted births. On an average 2.2 crores (22.2 million) pregnancy testing kits are provided annually to all the states.

An amount of INR 22.2 crores (3.7 million USD) is being spent annually on this initiative. Each sub centre receives PTKs based on the projected annual requirement (not exceeding 150 PTKs/year). The sub centres ensure that 50% of the stocks received are distributed equally among ASHA and the stocks are replenished regularly based on performance of each ASHA. These PTKs are part of the ASHA drug kit and are meant to be distributed free of cost to the clients. Apart from this, ASHA/ANM is also responsible for referring the cases for appropriate care as the need may be. Considering the demand from states the Ministry is in the process of projecting requirement for DHs, CHCs and PHCs as well.

The above schemes are not limited to distribution of family planning commodities rather they provide an impetus to the Family Planning program though community engagement, influencing demand and awareness generation. MoHFW, GoI has devised a periodic monitoring mechanism to assess the progress made by each state and district in community based FP programs.

There is a multi-pronged approach to monitor the program progress that includes review of quarterly reports from each district (compiled at the state level) and supportive supervision visits which includes interaction with ASHAs. MoHFW follows a strong feedback mechanism which helps the states to assess their performance and formulate an appropriate action plan thereon.

4.3.2 Improvising existing schemes:

4.3.2.1 Compensation Scheme:

Revised compensation scheme for acceptors of sterilization:

The Government has been implementing a centrally sponsored scheme since 1981 to compensate the acceptors of sterilization for the loss of wages for the period they require for recuperation following sterilisation. This compensation scheme for acceptors of sterilization services was revised with effect from 31.10.2006 and was further improved upon with effect from 07.09.2007.

The scheme has now been enhanced for 11 high focus states where the

TFR continues to be high namely Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh, Uttarakhand, Odisha, Assam, Haryana and Gujarat. The scheme has been modified in the light of rise in cost of living and transportation cost and tapping the postpartum opportunity for family planning.

Table 4 : Compensation scheme in Public (Govt.) facilities (amounts in INR)

Category	Type of operation	Acceptor	ASHA/ Health Worker	Others	Total
11 High Focus States (Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttrakhand, Assam, Haryana, Gujarat)	**Vasectomy**	**2000**	300	400	**2700**
	Tubectomy	**1400**	200	400	**2000**
Other High Focus States (North East states except Assam, Jammu & Kashmir, Himachal Pradesh)	**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**

Table 5 : Compensation scheme in Accredited Facilities (amounts in INR)

Category	Type of operation	Facility	Others/ Acceptor	Total
11 High Focus States (Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttrakhand, Assam, Haryana, Gujarat)	Vasectomy (All)	2000	1000	**3000**
	Tubectomy (All)	2000	1000	**3000**
Other High Focus States (North East states except Assam, Jammu & Kashmir, Himachal Pradesh)	Vasectomy (All)	1300	200	**1500**
	Tubectomy (All)	1350	150	**1500**
Non High Focus States	Vasectomy (All)	1300	200	**1500**
	Tubectomy (BPL + SC/ST)	1350	150	**1500**

4.3.2.2 National Family Planning Indemnity Scheme (NFPIS):

For the sterilization services undertaken in India, compensation was provided to the beneficiary; however, no viable insurance mechanism was in place to cover for failure or incapacitation on account of undergoing the sterilization procedure and no indemnity cover was provided to doctors/ health facilities providing sterilization services. Moreover, there was a huge demand for indemnity insurance cover since many empanelled doctors were facing litigation on account of claims filed by the beneficiaries for compensation following failures/complications/ deaths.

On the directives of the hon'ble Supreme court of India, GOI launched the NFPIS in November 2005 to compensate the acceptors of sterilization or his/her nominee in an unlikely event of complication, failure or 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.

This insurance scheme underwent many revisions to best suit the ever-changing demands and protect the right of both the client and the provider.

To reduce the evitable delays and increase the state and district ownership and accountability towards the quality of services provided by the state, it has been decided to do away with the insurance companies and states have been asked to administer the scheme themselves so that they would process and make payment of claims to acceptors of sterilization in the event of death/failures/complications and provide indemnity cover to doctors/health facilities. It was envisaged that States/UTs would make suitable budget provisions for implementation of the scheme through their respective State/UT Program Implementation Plans (PIPs) under the National Health Mission (NHM) and the scheme was rechristened "Family Planning Indemnity Scheme". The scheme is uniformly applicable for all States/UTs .

The Government has developed a manual on FPIS with detailed implementation steps and monitoring mechanisms. Family Planning division closely monitors the scheme with states every quarter through review of quarterly reports and supportive supervision visits in the state.

Table 6: Available benefits under the Family Planning Indemnity Scheme

SECTION	COVERAGE	LIMITS
I A	Death attributable to sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital	Rs. 2 lakh
I B	Death attributable to sterilization within 8 - 30 days from the date of discharge from the hospital	Rs. 50,000/-
I C	Failure of sterilization	Rs 30,000/-
I D	Cost of treatment **in hospital and upto 60 days** arising out of complication attributable to sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge	Actual not exceeding Rs. 25,000/-
II	Indemnity per Doctor/Health Facilities but not more than 4 in a year	Upto Rs. 2 Lakh per claim

4.3.2.3 Engaging RMNCH+A Counselors:

Universally counselling is accepted to be instrumental in bridging the gap created by lack of awareness among the clients about the availability and advantages of services.

Hence, the government appointed dedicated RMNCH+A counselors in the

districts and some of the sub district level facilities. It was envisioned at the outset that the counselor would play a key role in increasing awareness and generating demand for the various RMNCH services provided at the facilities, of which family planning is a major component. The counselor undergoes a 4 day extensive training program to gain competency in counseling skills. Under the reproductive health component of RMNCH+A, the counselor provides family planning messages to the clients by providing up-to-date unbiased information regarding all the applicable family planning methods, including their benefits and adverse effects. Apart from this, she/he dispels myths and misconceptions of the clients regarding the various family planning methods and helps the clients to make informed decisions on accepting family planning methods.

This program started in the year 2012 with annual budget allocation of approx. INR 8.1 Crore (1.35 million USD).

States innovated differently to utilize the program optimally and help improve the coverage of family planning services. Some of these innovations were designating 'Counseling Corners' in the health facilities, providing 'Counseling Kits' to the counselors (comprising of job aids) and providing 'uniforms' to the counselors so that they can be identified easily. The performance review mechanism for the counselors is also in place where predefined formats on a quarterly basis are used by the states and shared with GOI.

Considering the success of RMNCH+A counselors' work, more RMNCH+A counselors have been approved for the states for year 2014-15.

Snapshot of Family Planning Interventions / Services

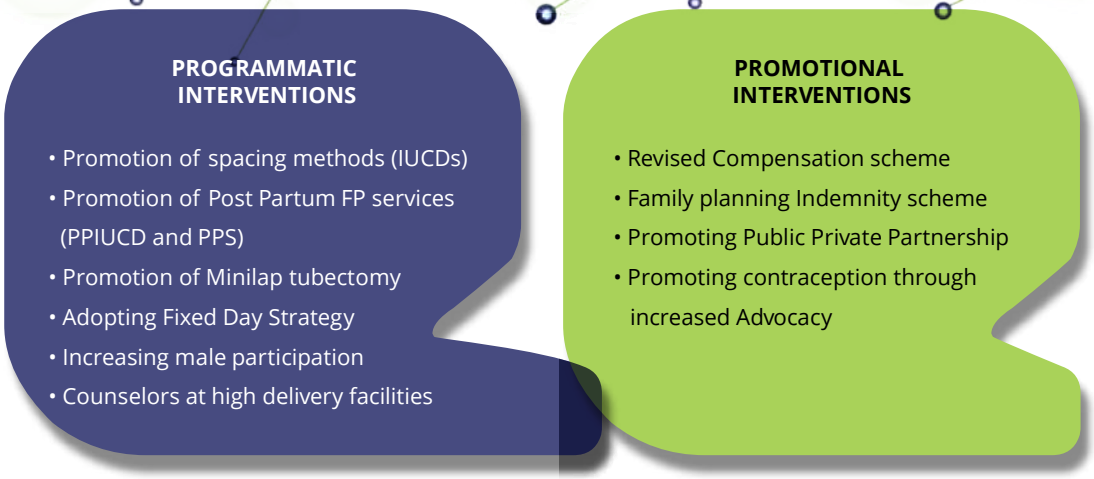


Figure 17: Ongoing Family Planning Interventions

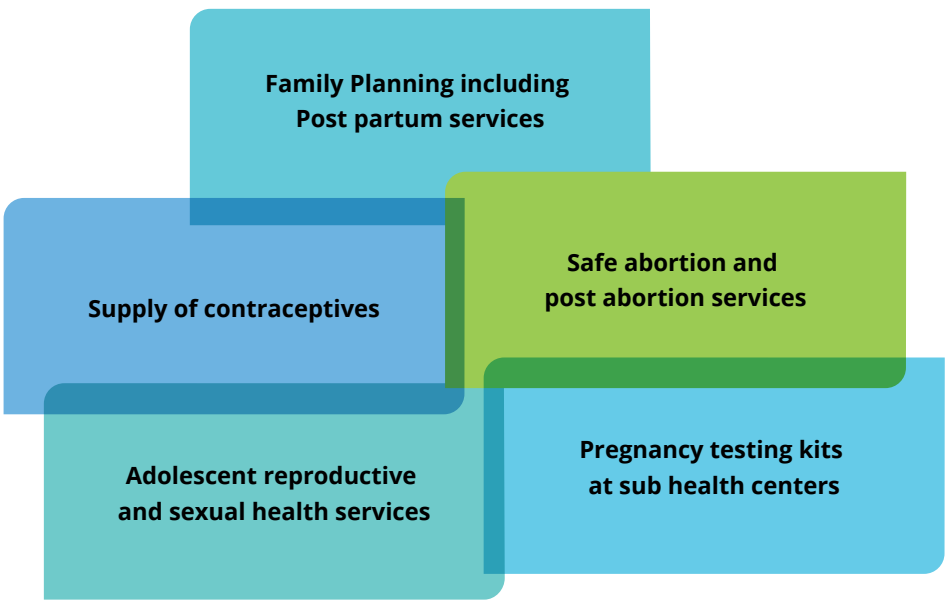


Figure 18: Bouquet of Family Planning Services

4.3.3 Refurbishing communication strategy:

India is a confluence of diverse culture, language and ethnicity; therefore, IEC activities for family planning program in India have been developed based upon needs assessments of the communities' felt need, sound educational principles and periodic evaluation. As per GOI policy, family planning program follows a target free approach and works towards realizing the right of the couple to have 'Children by Choice and not by Chance'.

The IEC strategy on family planning primarily promotes the available basket of choices of family planning methods (both limiting and spacing) and FP schemes including ASHA schemes and use of pregnancy testing kits (PTKs). Various materials have been developed in collaboration with development partners like IHBP, PSI, BBC Media and Futures.

Some of the IEC materials prepared by the ministry in association with the development partners are enlisted in the figure below:

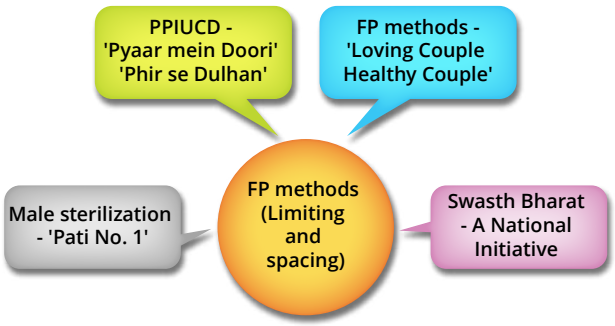


Figure 19: Examples of Family Planning IEC materials

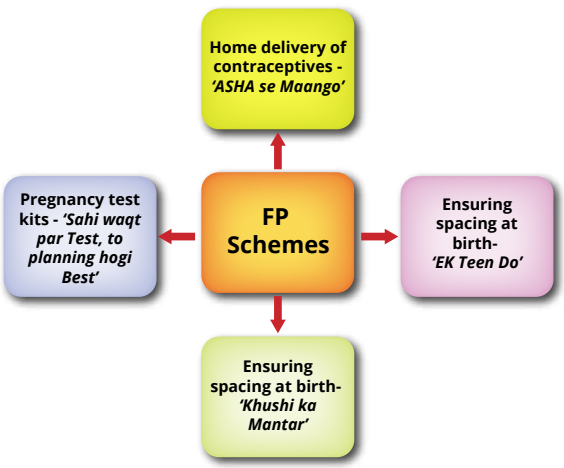
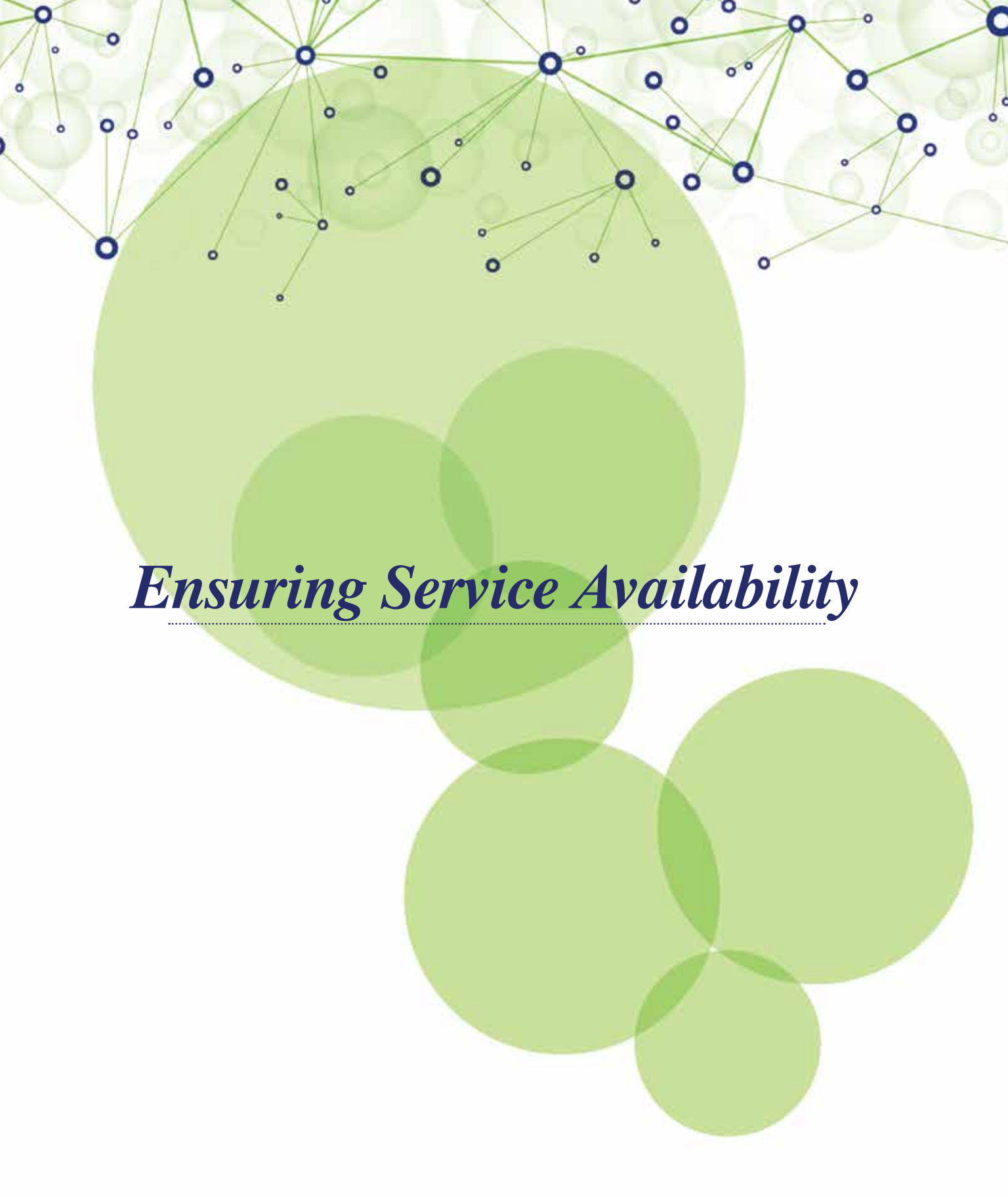


Figure 20: IEC Campaign on FP Schemes

The material has been made available on the ministry's web portal. It is free source and the states can adopt the material as it is or get it translated into local language for transmission.

Moving Ahead:

Any large scale government intervention like achievement of the FP 2020 goals requires a robust communication strategy as well as involvement of local and diverse partners. Therefore FP division has now embarked on formulating a new multimedia strategy for the country synergizing not only the existing software but also plugging in wherever gaps exist in collaboration with 'the communication hub' funded by the BMGF. The strategy would exploit the capability of all the players in the field of Family Planning. Further, the ministry is exploring the possibility of using mobile video technology for empowering the ASHAs as well as the clients in promotion of Family planning programs at the grass root level in collaboration with development partners. Additionally, a Mother and Child Tracking Facilitation Center has been set up under MCTS which assesses the knowledge of the providers and beneficiaries and bridges the knowledge gaps, if any, through inter personal communication.



Ensuring Service Availability

Family planning Services: Not a privilege, but a basic human right. No client in need should go unserved.

5.1 Expanding Basket of Choices

International evidence shows that increasing the availability of method choice increases acceptance rate and helps meet the changing needs of couples. Multiple methods make switching easier, reduce method specific discontinuation and improve user satisfaction.

The National Family Planning program added a range of methods for spacing and limiting in last 6 decades. The temporary contraceptive methods currently available for spacing are the Intra Uterine Contraceptive Devices, Oral Contraceptive Pills and Condoms.

5.1.1 Intra Uterine Contraceptive Device (IUCD):

Provision of IUCD services is one of the key interventions of the Government of India (introduced in 1965 in its endeavour to provide spacing methods of family planning to the clients). Advancement in IUCD from Lippe's Loop to Cu 375 has been a breakthrough in the duration of contraception provided to couples. The Government envisions higher acceptability of the method by encouraging insertion in post-partum period and this has been acknowledged as one of the prime strategies under FP2020 to make IUCD services available in all delivery points across the country.

Currently there are 2 types of Copper IUCDs available under the national programme–

1. Cu IUCD 380 A, which is effective up to 10 years.

2. Cu IUCD 375, which is effective up to 5 years.

In India the IUCD services are available at all levels of the health system and to combat the challenge of unavailability of trained providers, a policy of task shifting has been made wherein AYUSH practitioners are also being trained for IUCD insertions at CHCs and PHCs.

5.1.2 Oral contraceptive pills:

The inclusion of OCPs in family planning program dates back to 1952. Combined oral contraceptive pills are supplied through the government supply chain which are made available at the grass root level through ASHA (she may charge Re. 1/- for

one cycle of OCPs) under the HDC scheme. However, the OCPs are available free of cost at the public health facilities.

5.1.3 Emergency Contraceptive Pills (ECP):

Introduced in 2003 under the Family Welfare Program, Emergency contraception refers to back-up methods for contraceptive emergencies which women can use within the first few days after unprotected intercourse to prevent an unwanted pregnancy. These are distributed through ASHAs under HDC scheme to make it available within the community in the privacy of their homes. It is proposed to make it available at the higher centres like PHCs and CHCs.

5.1.4 Male Condoms (for Spacing):

The Government has adopted a conscious policy of use of condoms through the social marketing and community-based distribution system. The distribution of condoms in the health facilities is free, whereas at community level, it is distributed through ASHA who can sell it for Re. 1/- for a pack of 3 condoms.

5.1.5 Tubectomy:

Among the terminal methods, the percentage of acceptors for female sterilization is the highest. Since the inception of the family planning program in India, technique of performing tubectomy evolved with technological advancement. With the advent of laparoscope, the laparoscopic tubal occlusion method gained wider acceptability over minilap and conventional tubectomy and gradually it became one of the prime methods of performing tubectomy. As a policy, emphasis has been laid on Minilap over Laparoscopic sterilization as it can be provided by trained MBBS doctors with simple, inexpensive and easily maintainable surgical equipment which greatly addresses the issue of shortage of human resource as well as equipment.

Also, the client can receive minilap sterilization services in postpartum period under local anaesthesia with least postoperative distress. FP2020 initiatives emphasize on providing minilap sterilization services in high delivery case load facilities. This would be instrumental in exploiting the opportunity of providing services even during postpartum period. All these benefits advocate the need for promoting minilap over laparoscopic sterilization.

5.1.6 Vasectomy:

Currently two methods of vasectomy; Conventional and No Scalpel are practised. Introduction of NSV in the family welfare programme and its availability up to the peripheral level is expected to help men adopt male sterilization and thus promote male participation. NSV can be easily performed by a trained MBBS doctor even at

PHC level with minimal infrastructure and logistics.

Availability of NSV services increases the range of choices of family planning services available in low infrastructure set up and also shifts the responsibility of uptake of services from women to men. Under the 'Vision FP2020', the government has encouraged the districts to ensure the availability of NSV services in their facilities on fixed day basis. This desired increase in service provision would play a key role in generating a supply induced demand and fulfilling the same thereof.

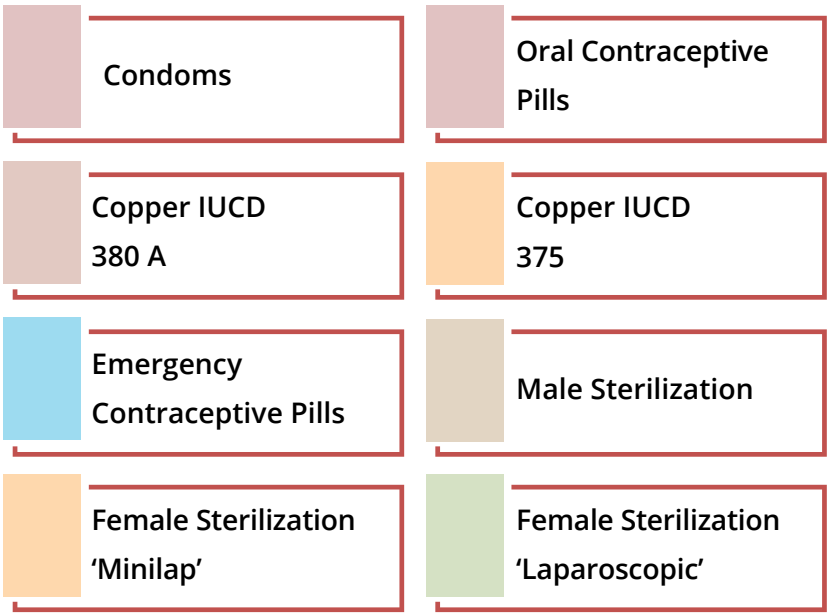


Figure 21: Basket of Choice in public health sector

5.2 Stabilizing Fixed Day Static Approach

'Fixed Day Static' approach (FDS) is envisioned as one of the long term strategies to fulfil the unmet demand for family planning, throughout the year on a regular and routine manner. Currently camp approach for sterilization services is still being followed in most parts of the country. The only improvement that has happened is that the 'fixed day camps' have replaced the 'camps' in most places so that the clients are aware that services are going to be rendered to them on a particular day and place which they can prepare for. The camp approach of providing FP services is acknowledged as a temporary solution for catering to the huge demand in the far flung areas where surgeons are not available and that raises concerns on quality.

In view of this fact, the government advocated Fixed Day Static Approach to provide assured, accessible, quality sterilization services in a health facility through trained providers posted in the same facility, on fixed days, throughout the year.

Under this strategy, health facilities designated by the state are identified to provide sterilization services, like Non Scalpel/Conventional Vasectomy, Minilap and Laparoscopic Tubectomy. The type and periodicity of services are dependent on the type of trained provider available at all levels of facilities viz. District, Sub District Hospitals, CHCs/ Block PHCs/ PHCs to provide different sterilization services on daily/weekly/ fortnightly/ monthly basis respectively.

To synchronize the efforts across country, the guidelines for FDS prepared by GoI clearly detail the strategy and suggest states to develop an action plan and budget requirement for FDS services in their annual NHM PIPs. Services can be delivered in cost effective manner only when information is percolated within the community to generate sufficient case load. Therefore, intensive IEC through all media including information dissemination points like Village Health and Nutrition Day are imperative to sensitize on need and availability of services.

Promoting the Fixed Day approach may act as a long term solution to the existing challenge of dearth of trained human resource and infrastructure for catering to the unmet need for family planning services. FP2020 strategy highlights the provision of fixed day services of Minilap sterilization from District to Block level facilities, especially where delivery case load is high, to utilize the opportunity in the postpartum period.

5.3 Ensuring Quality of services

Quality improvement is an unending process. Monitoring and constant assessment is very essential for providing quality services which is also a major thrust area under NHM. The basket of choices under family planning program has extended beyond sterilization but sterilization continues to be the preferred and widely accepted method among couples adopting family planning methods. The government has been actively pursuing improvement in quality of sterilization services provided through the states' fixed day static centres as well as camp outlets.

India's Family Planning Program tries to blend services, supplies and information which are the three components of quality.

With a view to ensure uniform standards across the country, the government developed a manual on ' Standards and Quality Assurance in sterilization services' for outlining the steps and mechanisms for measuring the quality of services provided at both static facilities and camps. The objective was to augment the capacity of programme managers, both at state and district level in monitoring the quality of care in terminal family planning methods.

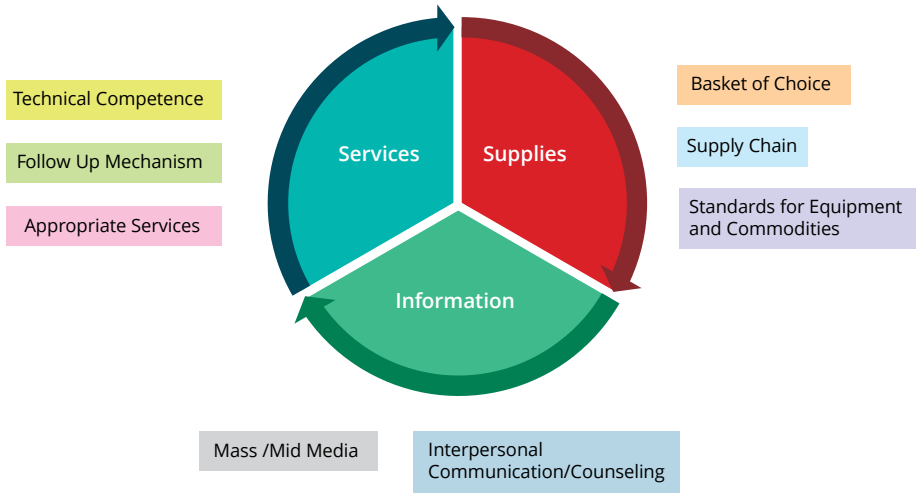


Figure 22: Comprehensive approach to ensure quality of services

At state and district level, Quality Assurance Committees (QACs) are present to ensure that the standards for female and male sterilization as laid down by the Government of India are being followed with respect to preoperative measures, operational facilities and post-operative follow-ups. Besides these, these quality assurance committees provide directions on the implementation of measures for improving the quality of sterilization services in the state. State QAC is mandated to meet once every six months whereas District QAC is supposed to meet every three months.

Figure 23: Tools for Assessment and quality improvement

To equip the team, assessment tools have been prepared to identify the gaps and implement actions for improvement. Checklists/Tools are used for assessing all the components of quality and addressing the gaps. Additionally, regular review of facility records and registers during monitoring visit is undertaken and quarterly report is prepared. To gain the clients' perspective and assess satisfaction level, client exit interviews are also included in the monitoring visits. Readiness of facilities in terms of the requisite inputs for providing sterilization services is assessed on quarterly basis by the District QAC for at least 10 per cent of the facilities through a structured facility observation checklist. Furthermore, the frequency of quality assessment visits has been outlined for DQAC which is provided below:

Table 9 : Frequency of quality assessment visits for District QAC

Service venue	Frequency	Responsibility
Camps	5 per cent camps in each quarter	1–2 members of the District QAC
Static facilities	2 each month	1–2 members of the District QAC
Accredited private/ NGO facilities	1 each month	1–2 members of the District QAC

Special emphasis is laid on assessing the impact on outcome of sterilization services. DQACs have major role in reviewing, scrutinizing and settling the claims.

SQACs are required to regularly follow up on the reports of sterilization audit on complications, failures and deaths and ensure corrective actions are taken by districts.

Another step towards ensuring quality of services is establishing direct telecommunication with ASHA through mobile phones. Through these calls, basic information on distribution of contraceptives and ASHA schemes are sought which is verified at field level during supportive supervision visits. These visits also aim to strengthen the knowledge base on schemes and remove any information barrier existing within the system. In addition to supportive supervision visits and ASHA tele-calling, quarterly reports are collected from states which reflect the implementation of schemes including PPIUCD, FPIS, HDC scheme and PTK distribution. Quarterly update is prepared, reviewed and feedback is shared with the state for appropriate interventions. For PPIUCD services, the data is collected both facility wise and provider wise and at field level, beneficiaries' interviews are conducted to assess the quality of counselling and follow-up.

Similarly the ministry has laid down standard manuals on all procedures concerning Family planning services which are enumerated below:

1. Standards and Quality Assurance in Sterilisation Services

2. Reference Manual for Female Sterilization

3. Reference Manual for Male Sterilization

4. IUCD Reference Manual for Medical Officers and Nursing Personnel

5. IUCD Reference Manual for AYUSH doctors

6. Handbook for Reproductive, Maternal, Neonatal and Child Health Counsellors

7. Manual for Family Planning Indemnity Scheme

These are all comprehensive one stop reference manuals meant to be used by policy makers and programme managers at the national and state levels, service providers, trainers and trainees at all levels as well as faculty of medical colleges and post graduate students.

5.4 Innovating service delivery models

5.4.1 Deploying FP Mobile Teams:

Government has been promoting fixed day services for sterilization through static centres. Fixed day strategy is gradually gaining ground in the states and operational plans have been developed to increase the service coverage through static centres up to PHC level with availability of trained providers

However, in order to achieve FP 2020 national goals and to cater to the high unmet need for family planning, especially for sterilization and IUCD services, government has devised an innovative strategy of Mobile teams for states with high fertility rates. This concept was proposed in December 2013 for 10 states namely Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh, Odisha, Assam, Haryana and Gujarat. Different states have proposed different structures for this innovation. However in most of the cases the mobile teams were set up at the divisional level or for a cluster of districts depending on the state dynamics. Priority was given to the districts where service providers are not available and the districts having hard to reach areas.

The mobile teams in these areas will strengthen the FP service delivery by providing a range of services including Minilap sterilization, Laparoscopic female sterilization, Male sterilization, IUCD Insertion and FP Counselling along with provision of other temporary methods.

Under this scheme, it is envisioned that vehicles with recruited staff consisting of a surgeon, nurse/ANM, OT technician and helper cum data entry operator will be utilized to provide Family Planning services for about 120 days a year.

The states have also come up with other models implemented locally through NHM funds to improve contraceptive coverage.

5.4.2 District Model of Contraceptive Service Delivery:

This aims to establish grassroot level service delivery mechanism at the doorstep for poor and vulnerable population. The objective is to provide high quality family planning services in a phased manner, ensuring access to contraceptive methods up to the last hamlet.

The important elements include establishing a District Centre for Family Planning where FP services can be provided, including sterilizations, NSVs and MTPs. This would be supported by one Satellite centre at each block of the district which would provide all FP services, except Sterilization at the outreach (mobile service delivery).

Each centre (District centre and satellite centre) is saturated with appropriate number of trained providers and support staff. In addition, field workers are appointed and ASHAs are mentored for community mobilization.

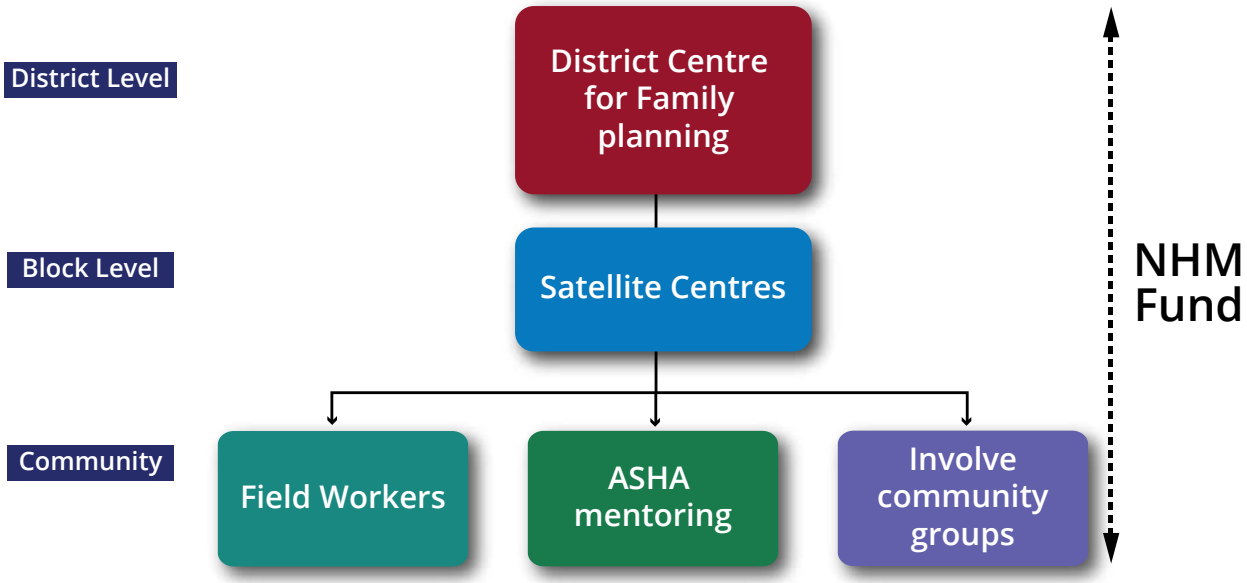


Figure 24: District Model of Contraceptive Service Delivery

The funds for the model were approved under state project implementation plan to be operationalised through NGOs.

5.4.3 Clinical Outreach Model:

Another model implemented in few states is the Clinical Outreach Model where dedicated clinical mobile teams utilize the existing health facilities to provide family planning services.

9-10 member team for tubectomy services and 3 member team for NSV accredited under PPP model of NHM utilise CHC and PHC infrastructure for providing these services.

In addition, a mini clinical outreach team comprising of 4 members is dedicated for providing IUCD services at the sub centres. The route plan for the mobile teams is predefined and community mobilization is done beforehand to ensure maximum utilisation.

5.5 Harnessing private sector (Social Franchising)

A large segment of population in India depends on the private sector for its health needs. This is a result of a dearth of health care providers in the public sector as well as perceived better quality services in the private sector. Though the contribution of private sector in providing other health services is huge, their contribution in family planning services has been very limited. Therefore, it is an opportunity to tap this pool of resources and it is assumed that effective collaboration with the private sector in the form of Public Private Partnership would address the unmet need in family planning significantly.

Government has been following a policy of accreditation of private facilities or NGOs under the compensation scheme in which private clinics and nursing homes are accredited by the state which enables them to not only get paid on a case by case basis as per the scheme but also get coverage under the Family Planning Indemnity Scheme.

Every state has a list of private accredited centres providing family planning services. Unfortunately the reach of these facilities are quite limited to the urban and semi urban areas and the difficult, hard to reach areas do not get the benefit of this scheme as the private sector in those areas is almost nonexistent.

5.5.1 Government of India Social Franchising scheme:

Against this background, the social franchising scheme has been envisioned for four high focus states namely Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan.

There would be two modes for delivery of services by private sector:

a Social Franchising Organisations would be selected through a tender who would then bring under its fold franchisees in the form of small hospitals or clinics. These franchisees would then be accredited by an independent accrediting agency selected again through tenders and having the blessings of the state/ district quality assurance committees.

b. Private Sector providers will go to the government facility (COT – clinical outreach team) and deliver the services.

A private provider is expected to perform approximately 10 sterilizations and 5 IUCD insertions in a month.

A validation agency would also be selected through tender to verify on a sample basis the cases performed by them and then be eligible for payment of compensation as per the scheme.

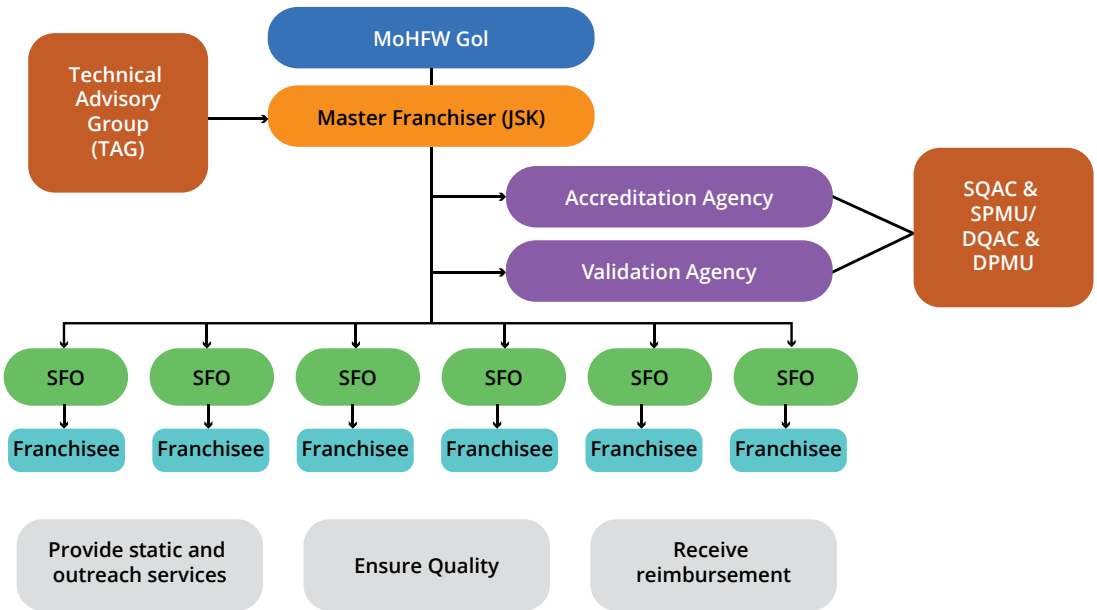


Figure 25: Social Franchising Model

5.6 Leveraging World Population Day efforts

Each year the World Population Day is celebrated globally on 11th of July to raise awareness on population issues. However for India, the largest democracy in the world, this day is the harbinger of family planning services in a campaign mode. This occasion is observed over a month long period, split into an initial fortnight of mobilization/ sensitization followed by the fortnight of assured family planning service delivery. Every year "Mobilization Fortnight" or "Dampati Sampark Pakhwada" is organized between June 27th and July 10th; while "Population Stabilization Fortnight" or "Jansankhya Sthirtha Pakhwada" is organized between July 11th and July 24th.

Mobilization fortnight unleashes an intensive awareness drive on population issues and family planning. The awareness generation is not only restricted to mass/mid media campaigns but also IPC achieved through a large workforce of ANM and community health workers.

The World Population Day (11th of July) marks the start of service fortnight. During this fortnight, 'melas' on family planning are organized at facility and community level. In addition to this, district hospitals and facilities at the block level like FRUs and Block PHCs are activated with teams of doctors and nurses. These teams are assigned to the centre for the entire fortnight to provide IUCD, female and male sterilisation services along with

OCPs and CCs distribution. Elaborative guidelines and micro plan is formulated to ensure the quality of services offered during this event. The growing concern of reproductive rights is taken care of by ensuring counseling services and an increased supply of different types of contraceptives besides IEC/BCC.

The political commitment in different states provides further impetus to this event. In each state/district, it is inaugurated by one or more political figures (chief minister/, health minister/, member of parliament and/or senior officials) , setting an example of political will and bureaucratic support to intensify the delivery of family planning services up to the grass root level.

In the year 2014-15, all States/UTs actively participated to celebrate the event where the campaign included a special focus on adolescents. Each year a campaign slogan is coined which is then passed on to the states and the states are encouraged to translate the same in their local language so that country wide, there is uniformity of the intent and solidarity.

Tapping the hidden potential- Post-Partum Family Planning

Capitalizing on the opportunity to provide quality reproductive health services to 11.34 million couples during post-partum period

6.1 Background

Capitalizing on the opportunity provided by the increasing number of women opting for deliveries in institutions, post-partum IUCD services (PPIUCD) and post-partum sterilization (PPS) have been introduced at high case load facilities to reduce the huge unmet need in the post-partum period.

Availability of family planning services in the postpartum period is imperative to increase the services. 65% women have unmet need for FP during postpartum period. As parity increases, the unmet need for limiting increases simultaneously and it is found to be 75% in case of parity more than 3. Despite the higher need of family planning services, only 26% resort to usage of any method in postpartum period. One of the reasons is poor availability of services. Therefore, opportunity in postpartum period can be tapped successfully if clients are motivated and counselled for adoption of contraceptive choices right through the antenatal period to immediate postpartum period and during the newborn visits as well as providing those services.

Post-partum period is also the best time to initiate family planning services as there is more likelihood of contraceptives uptake because of availability of sufficient time for counselling during hospital stay and improved ability of providers to make more comprehensive assessment of women's reproductive health needs.

The government has taken initiatives towards fulfilling the unmet need in the postpartum period because expanding postpartum IUCD and sterilization can pay high dividends in terms of programmatic success and impacting health of the mother and child by reducing the unwanted risk of conception.

6.2 Promoting PPIUCD

PPIUCD has been introduced in the light of the fact that with the right technique (high fundal approach) expulsion rate is minimal, there is practically no risk of perforation due to the thick uterine wall and it has no additional limitation in comparison to interval IUCD.

Efforts towards PPIUCD have been intensified since 2011, however, the real uptake of the programme has happened from 2012-13 onwards.

GOI has harnessed the strength of development partners based on their presence in various states, to support training of providers. The initiative has picked up very well in certain states like Tamil Nadu, Delhi, Haryana, Madhya Pradesh and gradually gaining ground in other states.

Moving Ahead:

In continuation to the above efforts, under the 'vision FP 2020', district wise roadmaps have been developed for the entire country where high delivery case load facilities have been identified for operationalization in the current year to tap the opportunity of providing IUCD services in postpartum period among women delivering in facilities.

In addition to this, emphasis is laid on training of more nurses to deliver the service in a 24 hour mode to the women opting for the method. The ministry's vision is to saturate all high delivery case load facilities from DH to Sub Centres wherever deliveries are being conducted in the not too distant future.

6.3 Rejuvenating Post-Partum Sterilization: Indian Experience

Minilaparotomy is the only method of sterilisation available in the postpartum period. With the advent of laparoscopes, minilap method lost its popularity especially in the northern part of India over time. On the other hand minilap is still widely popular in the southern states due to high demand for limiting family size.

Under the government's initiatives of strengthening PPFP, minilap method is being promoted in institutions conducting higher number of deliveries as increased institutional deliveries provides a large platform to address family planning needs in postpartum period.

Moving Ahead:

Considering the need for augmenting the limiting methods in the northern states and maintaining it in rest of the country, state wise FP2020 road maps have been designed in a way that the lost focus on PPS can be regained in the states where uptake is poor and further services can be strengthened in the states where uptake is better.

GOI envisions the availability of minilap trained provider from DH to PHC level in high delivery case load facilities so that in addition to spacing methods, the clients with need of limiting methods can also be served appropriately.

6.4 Exploring other options

In absence of acceptability of any of the above choices by women in the early postpartum period, other options like condoms and LAM can be offered immediately. Uptake of these options is dependent on the effective counselling of clients at various contact points within the health facilities.

Reviving Post Abortion Family Planning

Emphasizing the right of mothers to plan for their motherhood

7.1 Background

Unintended and unplanned pregnancies end up either in unwanted births or in abortion contributing to increased morbidity and mortality among mothers. After a spontaneous or induced abortion, the recommended minimum interval to next pregnancy is at least six months in order to reduce risks of adverse maternal and perinatal outcomes (World Health Organization, 2006 Report of a WHO Technical Consultation on Birth Spacing).

Studies clearly indicate that women may ovulate soon, as early as 10-11 days, after an abortion (spontaneous or induced). Therefore, post abortion period is crucial in terms of adoption of family planning methods. The objective is to avoid pregnancy particularly for those women, who do not want to be pregnant and may undergo a subsequent induced abortion if contraception is not made available immediately after abortion. Providing family planning services as a part of post-abortion care can improve contraceptive acceptance and help break the cycle of repeated unwanted pregnancies thereby preventing 90% of maternal mortality associated with unsafe abortions.

In light of the above fact, it is quintessential to counsel and motivate the women receiving management for abortion for adoption of family planning methods at the facility itself as she is not likely to come back for family planning services.

7.2 Range of Family Planning choices

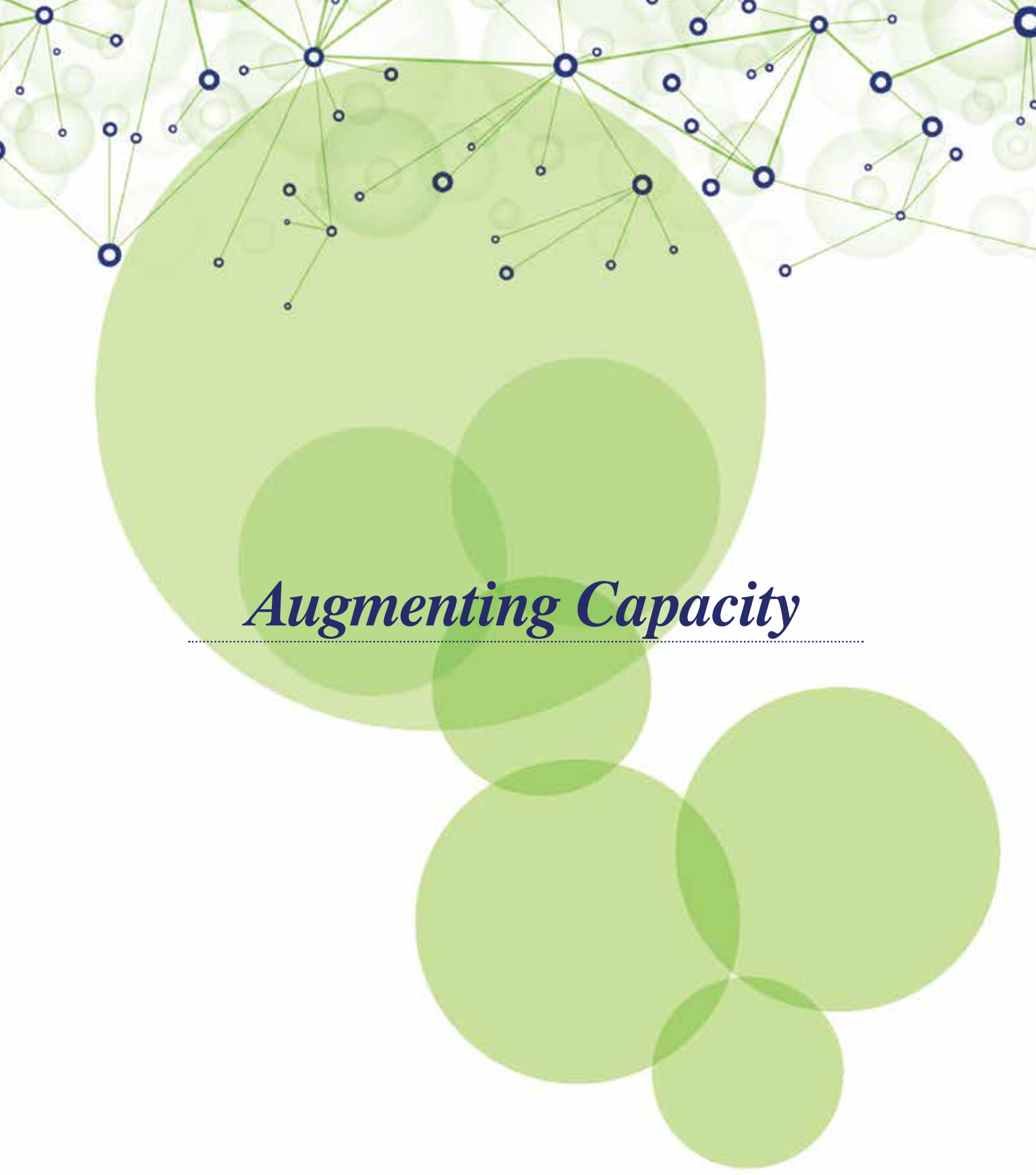
A woman undergoing an abortion should be offered family planning counseling on the range of family planning methods available, so that she can choose one or more methods to keep the recommended minimum interval of six months from abortion to next pregnancy and control her future fertility. GOI advocates the availability of entire range of family planning options in the immediate postpartum period. Similarly, the entire basket of family planning choices is available during post abortion period. Presently the following options are available in post abortion period in public health facilities of India:

1. Condoms: Can be used immediately following abortion
2. Oral Contraceptive pills: Can be adopted immediately depending on time and type of abortion and after proper medical screening
3. PAIUCD (Post abortion IUCD insertion): Can be adopted after medical screening of the client

- Immediate or
- Interval

4. PAS (Post abortion sterilisation): Can be adopted after medical screening of the client
    - Immediate or
    - Interval

Providers are encouraged to ensure the uptake of any one of the family planning options by the client after proper screening. Integrated approach under RMNCH+A provides a wider platform to address the issue in a coherent and promising way.



Augmenting Capacity

Commitment to develop a competent workforce to deliver services meeting quality standards

8.1 Background

Capacity building approaches are indispensable for success of any program. GOI closely works with the state governments and key development partners to engender trained providers and ensuring sustainable service provisions at various levels.

8.1.1 Types of Trainings:

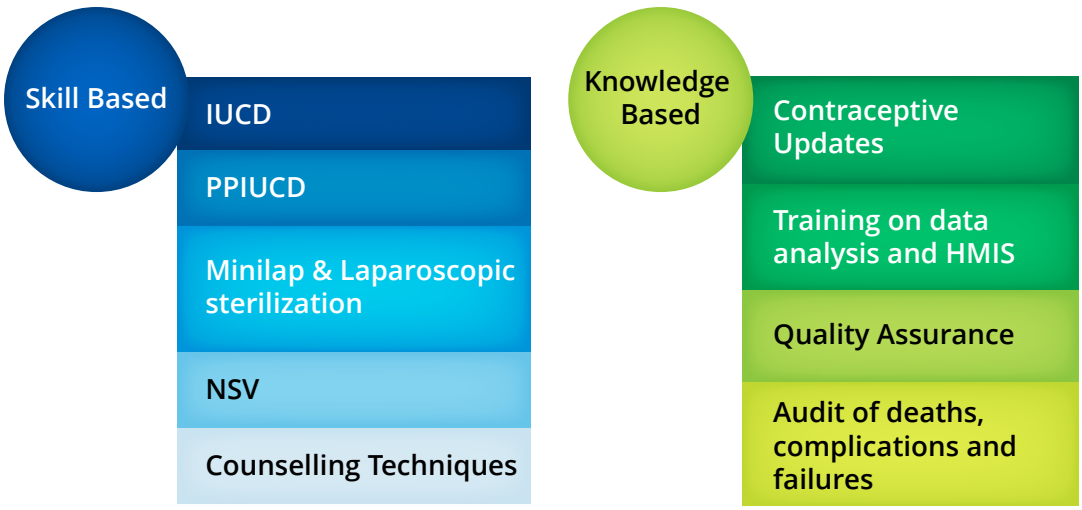


Figure 26: Types of trainings for service providers

8.1.2 Training Packages:

The government, with support from the Technical Resource Group and other key experts, has developed numerous relevant training materials and job aids for the service providers and programme managers.

These training packages and tools are designed to enhance technical knowledge and skills for clinical procedures and counselling in accordance with the established protocols and guidelines. The packages are based on technological advancements and developments made in the areana of family planning as Government of India

generates evidences and makes necessary revisions in these training packages and job aids from time to time.

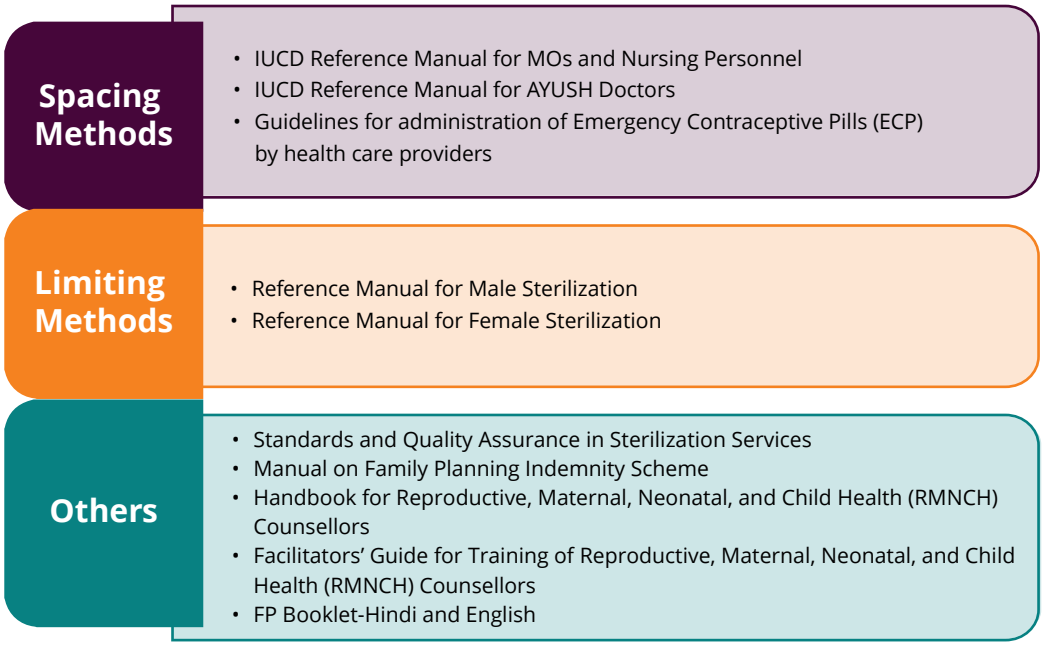


Figure 27: Available Training Packages in Family Planning Programme

8.1.3 Institutional Framework for Capacity Building:

The technical and skill based trainings in family planning are provided through two modalities; the Institution based training and Onsite training. The onsite trainings are provided through various development partners working in the field of family planning in different states. The training calendars are shared with the state and district beforehand for approval and consensus. On the other hand, Institution based trainings are carried out through the regional and district training centres which work in close collaboration with the state institutes of health and family welfare (SIHFW).

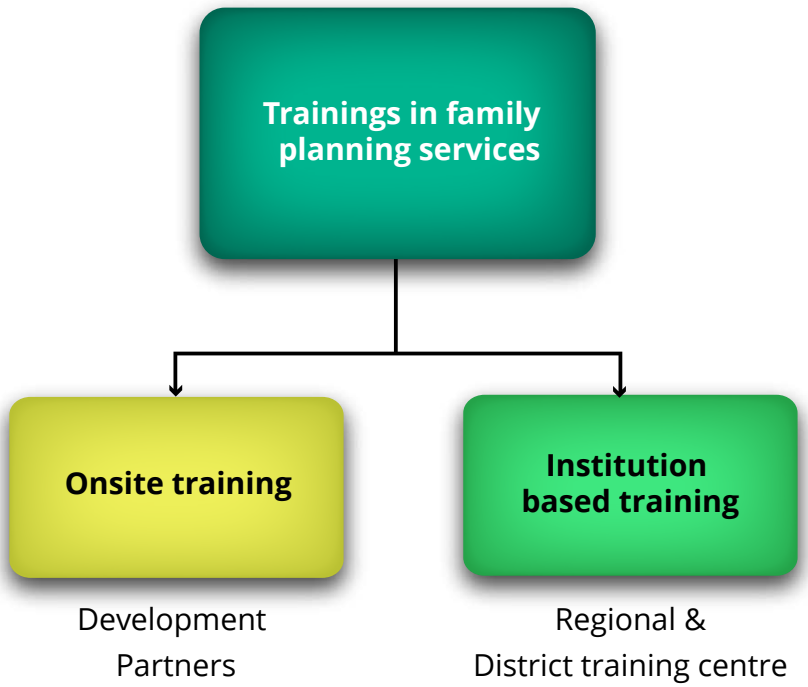


Figure 28: Institutional framework for capacity building in family planning services

8.1.4 Support of Development Partners:

Government of India's extensive focus on trainings related to family planning services is supported by several development agencies. Partners such as Jhpiego, IPAS, Engender Health and Hindustan Latex Family Planning Promotion Trust (HLFPPT) are conducting training programs for service providers on Interval IUCD and Post-Partum IUCD services. Onsite trainings, along with post-training follow-ups, are conducted to observe the performance of the trained service providers. Additionally, on- the-job hand-holding to enhance competency in skills and counselling is focused upon.

8.1.5 Task Shifting:

To overcome the shortage of trained human resource for providing IUCD services at public health facilities, Government of India took the policy decision to train AYUSH Doctors belonging to the streams of Ayurveda, Unani, Siddha and Homeopathy for IUCD insertions. Presently more number of nurses (Staff Nurse/ Midwife/ Lady Health Visitor/ ANM) are being trained to provide the Interval and Post-partum IUCD services.

8.1.6 Monitoring and follow up:

The real harvest of training is reaped when it translates into service delivery in actual field situations. Therefore, it is essential to have a mechanism of follow up for trained service providers. Since the overall responsibility of training lies with the states, they collaborate with the development agencies working in the field of capacity building and supervise the development of training calendar and ensure the implementation of same. Different approaches appropriate in state specific contexts are undertaken for monitoring the quality of trainings.

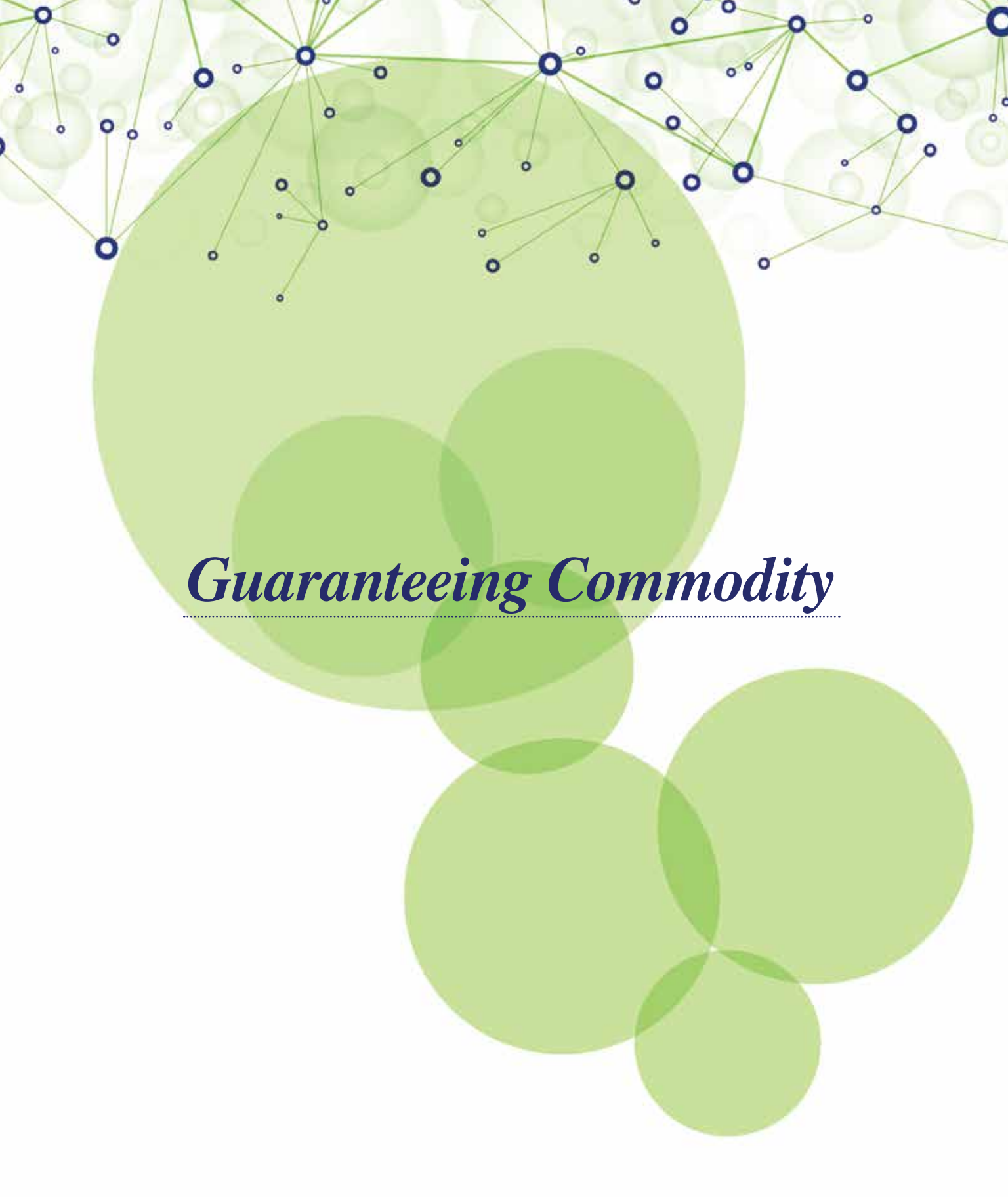
Development agencies support in imparting onsite training on the techniques within the facility settings and following up on the performance of trained providers. This is supplemented with a robust feedback mechanism where the concerned authorities are apprised of the situation and corrective actions are recommended. MoHFW teams and state teams visit the training sites during their supportive supervision visits and share the feedback of the same.

Moving Ahead

FP 2020 commitment has set a stage to streamline the initiatives of capacity building across the nation. State roadmaps developed to achieve FP 2020 vision sensitized the state government officials and development partners regarding the need for improved service delivery through static facilities.

State wise workshops conducted for development of District Action Plan for FP 2020 provided a rational outlook to the way in which providers are nominated for training in various services and health facilities taken up for operationalization of those services. Compiled district action plans thus reflect the training need of the state and facilitate the development of logical state training plans.

In addition to identifying training needs, districts are encouraged to strengthen the existing system of monitoring the quality of services under the program. District Quality Assurance Committees are directed to closely follow up on the empanelment of trained service providers and monitor the performance thereon.



Guaranteeing Commodity

Strengthening the supplies and securing access to the whole range of quality contraceptives.

9.1 Background

Ensuring the supply of commodities from manufacturers to end users in a stipulated time, while maintaining the quality, is essential for reproductive health programs. Security can be affirmed if end users (beneficiaries) have access to commodities and are able to choose and use them as per their need. Uninterrupted, regular supply of quality commodities is a determining factor in the success of the programme. The commodities required to offer family planning services comprise of contraceptives (OCP, ECP, Condoms, IUCD, Tubal rings); equipments (NSV Kits, Minilap Kits, Laparoscopic kits) and drugs (medicines and anaesthetics) which are available in public health system for use in the community.

9.2 Supplies

Family Planning Commodity Supply in India is centralized. India has already developed indigenous capacity, in public and private sector, to manufacture the entire range of family planning commodities, many of which are now being exported. The country is also committed to utilizing its own domestic resources without dependence on external aid.

9.2.1 IUCD:

Currently there are 2 types of IUCDs available under the national programme–

1. IUCD 380 A, which is effective up to 10 years

2. IUCD 375, which is effective up to 5 years

These two IUCDs are supplied in the ratio of 50:50 to the states.

9.2.2 OCP:

Mala N is available for distribution through the health facilities and ASHA, as 'Free' and 'ASHA' supply respectively. These are provided to the state in the ratio of 20:80, with an aim to strengthen the Home Delivery of Contraceptive scheme through ASHA. Contraceptives supplied under 'Free' and 'ASHA' supply can be differentiated with distinct label on the packaging.

9.2.3 Condoms:

Like OCPs, Condoms are also available in public health system as 'Free' and 'ASHA' supply, under the brand name 'Nirodh'. Both supplies can be identified with the

number of pieces of condoms packed. Free supply comprises of a pack of 10 condoms whereas ASHA supply contains 3 condoms in a pack.

9.2.4 Emergency Contraceptive Pills:

ECP has been introduced in the national programme in 2003. This is also distributed under ASHA scheme of Home Delivery of Contraceptives. Therefore, ECP too is available as 'Free' and 'ASHA' supply under the programme.

9.2.5 Tubal Rings:

These are provided to the states based on the projected requirement submitted on the basis of an average of the past 3 years' performance.

9.3 Quality Control

Central procurement system in India follows a two bid system to award contracts to the manufacturers. The supply is preceded by strict quality control check and for this sample checks are undertaken. Feedback from states and districts are received regularly to assess the quality and field verification of the same is conducted during supportive supervision visits.

9.4 Demand and supply chain framework

State submits its requirement of commodities to MoHFW after averaging out the performance of each service for the last three years and factor in the demand raised by the districts. This demand of FP division is shared with the Supply and Social Marketing division, which is entirely dedicated towards maintaining of supply chain and timely dispatch of commodities.

Supplied commodities reach the central store of state from where it is further dispatched to districts based on the requirement submitted. District central store is responsible for supplying these commodities further, in the predefined ratio, to the facilities for distribution and use. 'ASHA' supplies are subject to the demand submitted by ASHA, depending on the utilization rate in their respective areas.

FP equipments, a part of FP commodities, are procured in a decentralised manner. Government of India has laid down specifications for equipment which has been uploaded on the national website. Each state/district is empowered to procure the equipment as per the specifications and from the approved budget in PIP. States have been given flexibility to develop their own procurement channels, strictly complying with the standards laid down by GOI. On an average INR 22.74 crores (3.79 million USD) is allocated each year for Family Planning equipment purchase.

Family Planning invasive services (IUCD, Tubectomy and Vasectomy) require general

medicines and do not require any separate set of medicines. These medicines are purchased in bulk along with other medicines from the budget approved in PIP.

9.5 Monitoring of supplies

Adequate stock availability is a key component of commodity security which directly affects the performance of the service providers. Under FP2020, state wise requirement of commodities has been projected to help in achieving 2020 goals. This is essential to achieve desired performance by state and to reduce the duplication and wastage.

Supportive supervision visits are advocated to strengthen the supply chain from the centre to state and within the state at regular intervals. Quarterly review of stock position of ASHA supply and linking it with the performance reported in HMIS is an innovative mechanism of monitoring proposed to the states.

Some of the states have come up with the innovative strategies of monitoring the stocks. An example from the state of Odisha is worth mentioning where the state has developed its own software for logistic management purpose. ASHAs enter monthly stock position in their mobile phones, enabled with an application and this data directly gets uploaded in the server at the state from where compiled report is generated and submitted to the health department.

9.6 Central Medical Supplies Society (CMSS)

With a view to assure procurement and distribution of supplies in time, the government has now set up an autonomous agency by the above name whose sole responsibility would be to ensure uninterrupted supplies of commodities in the states. This agency would be able to cut the proverbial bureaucratic tape by laying down a firm procurement and distribution system in the country, thereby transforming the committed goals into a reality.

Basket of choices under Family Planning programme

Assuring Finances

Investing for healthy choice and healthy life to bring smile to millions of faces…

10

A robust financial mechanism is the basis for smooth implementation of any program. Family planning program in India initially was a state funded program covering the operational costs of family welfare centres in all the states whereas the commodity costs were incurred centrally by funding from MOHFW, which continues till date.

Launch of the National Rural Health Mission in the year 2005 revised the funding pattern wherein the states started proposing budget for the program under NRHM in the form of annual state program implementation plans (State PIP), in addition to their own state budget. Uniqueness of this approach is that the budget is prepared in a predefined format; at the same time providing flexibility to budget for state specific activities and innovations. Funds are released every year after appraisal and approval of the plan by MOHFW.

Monthly review of financial progress is undertaken based on financial management report submitted by each state. Currently, 23 line items are dedicated for family planning program, in the above mentioned predefined format. Cross cutting requirements like human resource, IEC budget, program management are dealt with separately. In the year 2013, INR 769.8 crores (128.3 million USD) was approved for family planning program (excluding the program management and commodities cost); the largest share of this amount is for the program operational cost.

Under 'Vision FP2020' India has prepared a roadmap to accelerate the efforts in family planning program and enhance the budget allocation for the same. This is evident as huge money is being pooled by the Central government under NRHM. Since the advent of NRHM, total federal funding has been INR 1.3 lakh crore (17.32 billion USD) with annual funding of INR 16,800 Crore (2.8 billion USD). The share of RMNCH+A activities is INR 94,320 Crore (15.72 billion USD). The funding is projected to increase by INR 22,200 crore (3.7 billion USD) annually, incrementing over the next few years. This means from the advent of NRHM till 2020, the federal funding will amount to INR 2.04 lakh crore (34 billion USD) (including RMNCH+A).

The total Family Planning budget amounted to INR 1864.7 Crore (282.5 million USD) in 2013-14, including INR 440 Crore (73.3 million USD) for commodities and supplies. By the year 2020, the projected funding for Family planning will increase to INR 3003.2 crore (500 million USD). This indicates that from 2012 to 2020, the total allocation for family planning will amount to over INR 17,812 crore (3 billion USD).

Institutionalizing Monitoring

Commitment to move with numbers and beyond numbers…

11

11.1 Background

Mechanism to monitor and evaluate family planning programme exists since its inception. Historically, ICPD conference changed the approach of monitoring the program. Overall development, rather than just contraceptive use, thus became an objective for the family planning program, resulting in inclusion of fertility as well as social indicators to assess the overall reproductive health of the country. However, the major breakthrough in monitoring of the program in India was the introduction of "Health Management Information System" in 2008. This web based application captures service delivery data from the facility level for the various national programmes including family planning on monthly basis. "Physical reports" are added in data collection process to capture information on data elements on quarterly basis for strategies implemented recently under the programme. Data definitions and indicators are standardized to maintain the quality and uniformity. To ensure greater accountability of results, monitoring on ground is being done through triangulation of data wherein HMIS data available on the web portal is analyzed. Key indicators for family planning monitoring is discussed in Annexure 3.

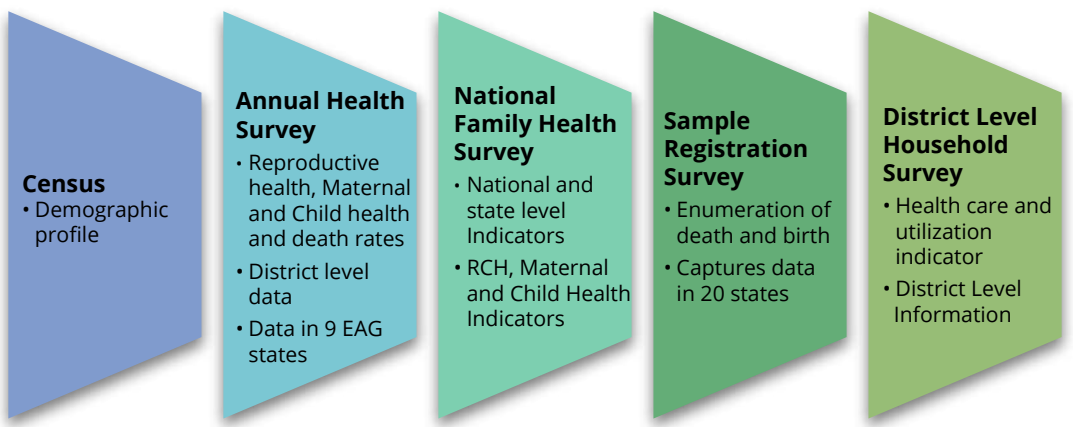


Figure 29: Various Sources of data

This generated and analyzed data are authenticated in the field through regular supportive supervision visits made to all the states by central, regional as well as state teams. Facility audits conducted by the "District Quality Assurance Committee" at the district level, Census survey, Annual Health Survey (AHS), Sample Registration Survey (SRS), District Level Household Survey (DLHS) and National Family Health Survey (NFHS) also act as an important source of input and output indicators. The schematic representation below highlights various sources and contribution in data collection.

11.2 Monitoring and Evaluation Framework

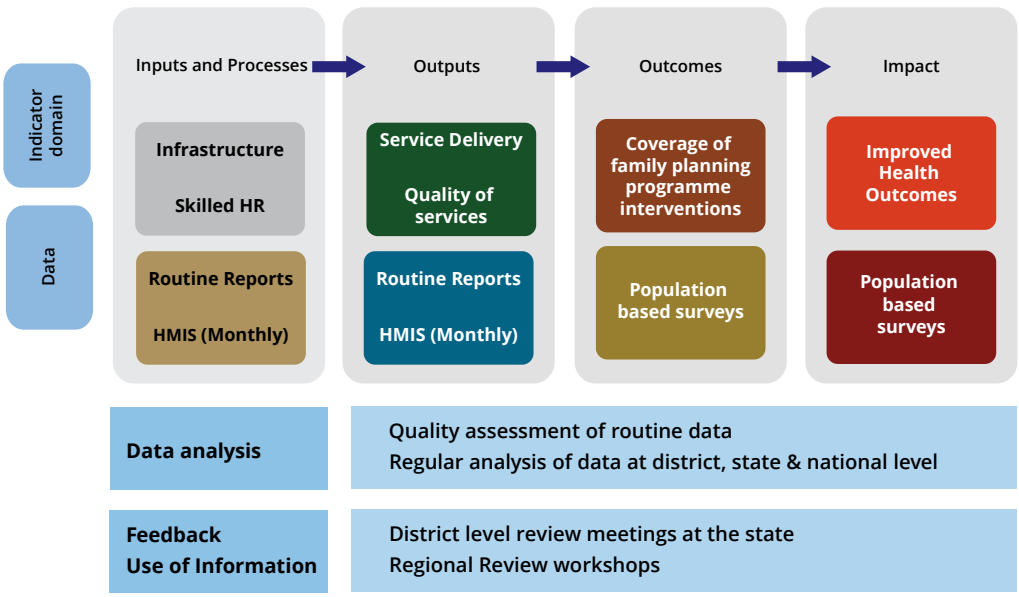


Figure 30: Monitoring and Evaluation Framework

11.2.1 Evaluation Process:

In addition to routine data collection system and surveys, evaluation is an important component to understand progress of the programme. Evaluation studies through external agencies are conducted regularly to appraise the different component of the programme. Track 2020, an international agency will also support the evaluation of family planning program and will be providing an independent, clear and concise picture of the programme achievements under FP2020.

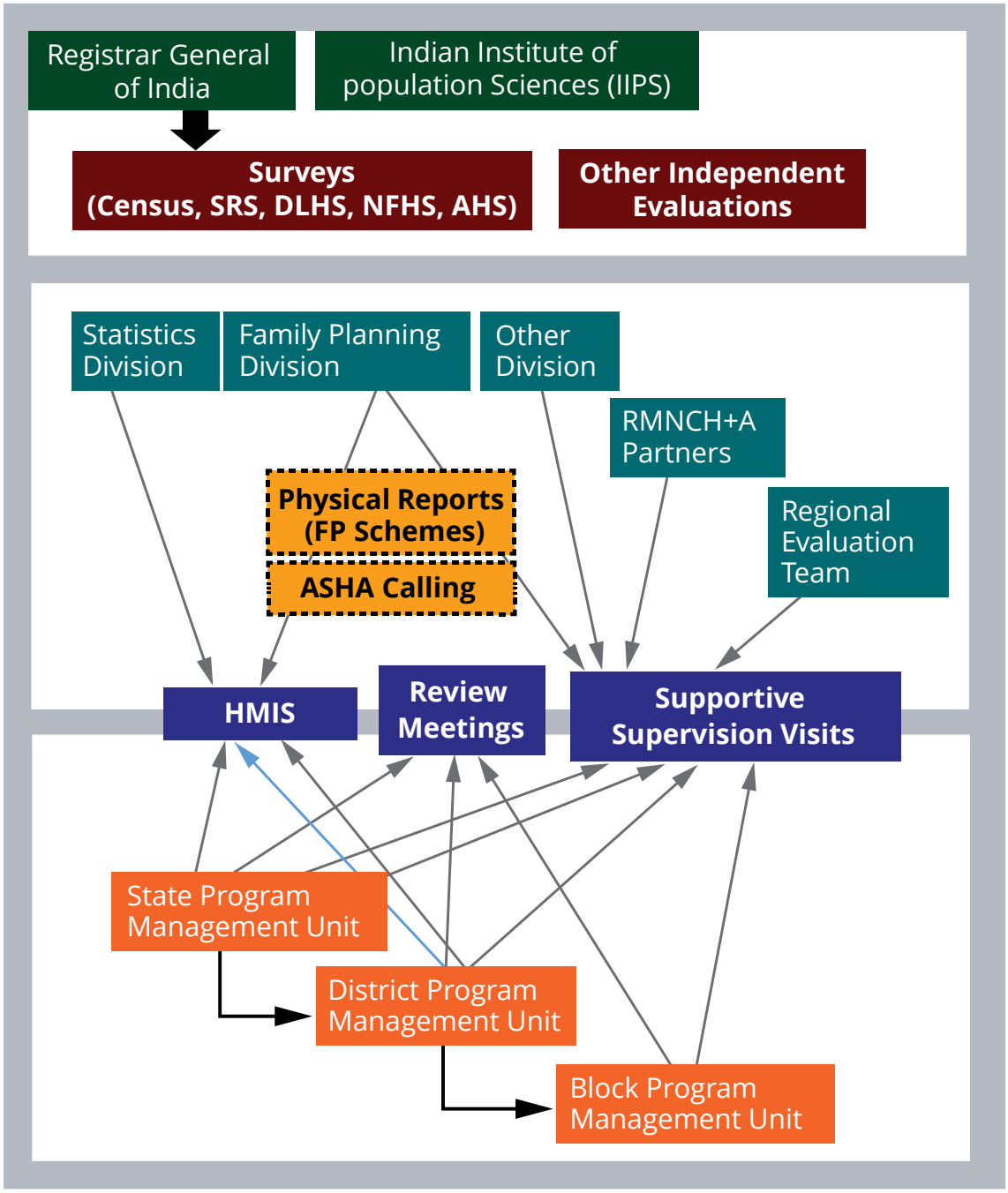


Figure 31: Existing monitoring structure

11.2.2 Feedback and Review:

Quality of services and verification on field requires involvement of stakeholders delivering and receiving services. Regional, state and district level review meetings by center and state are utilized to disseminate analyzed information on periodic basis to support evidence based planning.

Community perspective is incorporated by involving all relevant stakeholders in community based monitoring which thus increases the accountability of improving services by providing opportunities to influence the decision and share their priorities and experiences as a part of the process.

Moving Ahead:

'Vision FP2020' lays emphasis on various other aspects like capacity building, demand generation and other soft issues besides focusing only on quantitative indicators. There is a shift in the approach in the sense that state/district program managers are now being oriented more and more for appraising quality indicators and service preparedness. FP2020 state workshops were utilized as a platform to apprise the state governments regarding quality of data uploaded on web based system of HMIS and to highlight the disparities in them and how to plug those loopholes in feeding in robust data for the correct evaluation of the programme.

Forging Partnerships

Family Planning 2020 movement,
a whiff of fresh air
fresh energy
and fresh ideas
to work across sectors,
across regions and across borders
to collaborate and innovate…

12

12.1 Background

12th five year plan emphasizes on building partnerships that offer an opportunity to tap the material, human and managerial resources and technical expertise of the private sector for public good. Various existing Public Private Partnership models play vital role in addressing equity and reducing out of pocket expenditure. Implementing the models of PPP provided an opportunity to regulate services with improved accountability. These models set examples of best practices to deliver effective and efficient health care within the existing scenario.

Family Planning Division of MoHFW, works in close collaboration with various national agencies, UN organizations, international funding agencies, professional bodies, national and international NGOs and the civil society, with the objective to enhance technical expertise and provide efficient services with equity. Currently the government is harnessing the expertise of various agencies in the field of advocacy, capacity building, IEC and BCC, programme management, quality improvement, evaluation and assessments, feasibility studies, development of resource material and E-learning modules, software development, social marketing, social franchising and provision of skilled human resource for successful implementation of the program.

12.2 Advocacy

ARC (Advocating Reproductive Choices) is a consortium of substantial number of NGOs working in the arena of reproductive health and family planning who are able advocates of the programme at various fora.

Organizations like IAPPD (Indian Association of Parliamentarians on Population and Development) play a supportive role in advocacy and communication with emphasis on population stabilization through elected members of parliament, state legislative members and elected representatives of local bodies.

12.3 Capacity Building

Agencies like HLFPPT (Hindustan Latex Family Planning Promotion Trust), Jhpiego (Johns Hopkins Program for International Education in Gynecology and Obstetrics), Engender Health, IPAS, are playing a key role in generating the pool of skilled health providers.

Agencies with similar technical expertise are jointly working for the program under the guidance of Family Planning division with clear demarcated areas of work. For example, the training of IUCD, PPIUCD and Minilap sterilization procedure is funded by BMGF (Bill and Melinda Gates Foundation).

In certain high focus states (Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Uttarakhand, Jharkhand, Gujarat, Odisha and Chhattisgarh), the PPIUCD program is facilitated by Jhpiego, Engender Health and IPAS through onsite PPIUCD training model. HLFPPT is involved in imparting IUCD training in ten high focus states.

12.4 IEC and BCC

IHBP, PSI, BBC Media are extending their support for the development of IEC material to promote healthy spacing behaviour and generating demand for FP services within the community. 'The communication hub' has been vested with the responsibility to develop a holistic communication strategy to reposition family planning to achieve its potential.

PSI (Population Services International) has helped in developing a compendium of all communication materials on family planning developed in the country since 2000. ARC is contributing in the development of messages on Emergency Contraceptive pills whereas Engender Health has contributed towards the promotion of NSV through Respond Project.

12.5 Resource material

Jhpiego has helped in developing resource material for RMNCH+A Counsellors.

12.6 Public Private Partnership

Partnership with MSI has been beneficial in the development of private sector in family planning services. DFID through the Futures Group also contributed in harnessing private facilities to improve access to high-quality family planning services.

12.7 Social Marketing and Franchising

HLFPPT, Futures Group, MSI, Janani, PSS (Parivar Sewa Sansthan) are extending support to the FP programme in providing the FP commodities and services at affordable prices and at the same time linking it to a communications campaign geared toward behavioral changes.

12.8 Service Provision

Family Planning Association of India (FPAI) and PSS through their family planning clinics are involved in service provision.

12.9 Evaluation and Studies

FHI (Family Health International) conducted a pilot study to assess the feasibility of introducing IUCD 375 in six states. Based on the positive outcome of the study IUCD 375 has been rolled out in the entire country. Path Finder International, Population Foundation of India and FHI conducted the evaluation of ASHA schemes for home delivery of contraceptives. Following their declaration of the success of the pilot, the scheme was universalized in the entire country subsequently. UHI is currently conducting evaluation studies on the PPIUCD initiatives.

These partnerships are anticipated to have long term impact in addressing the reproductive healthcare needs of girls, women and underserved communities around the country by increasing support, building evidences and leading the scale-up of best practices that improve family planning services universally.

Conclusion

India has the overwhelming share of 40% of the global FP2020 commitments for providing family planning services to 48 million additional women. The government visualizes this not only as a challenge but also an opportunity to make available contraceptive services in its all-round effort to avert preventable maternal and child deaths. This has put added responsibility on the health system under the ambit of an integrated RMNCH+A approach to deliver the services in a stipulated time frame. Accepting this onerous task, the government has donned the mantle of leadership with support from committed development partners and has accelerated efforts to optimally utilize this opportunity for maximizing the coverage of quality family planning services. These efforts manifested in the development of national and state roadmaps for each state in India to achieve FP2020 goals. Additionally, districts of all the states formulated their own roadmaps; including calculation of annual training loads for various methods and facility operationalization plan for servicing the huge unmet need. This now calls for accountability and greater responsibility on the administrators, programme managers and providers alike who would now have to meet the dual challenge of universalizing service coverage while paying due importance to quality of services.

It has been progressively realized that creating demand through convincing people to use appropriate contraceptives and simultaneously protecting their reproductive rights as well as rights of providers is of utmost importance and needs sensitive nurturing. Hence the government is following a multipronged approach. This includes demand generation through counseling by ASHAs at village level; engaging RMNCH+A counselors at the facility level; BCC/IEC activities in partnership with various development partners; indemnifying the acceptor of sterilization service and the providers in the unlikely mishaps like complications, failures and death under FPIS and providing wage loss compensation to acceptors of sterilization services. Emphasis has also been given to the much needed post-partum and post - abortion family planning services. Since India is a country of diverse social and cultural practices and beliefs, the government also encourages the states to design locally implementable innovations to improve service uptake albeit within the ambit of the national guidelines. As a result, some states have already demonstrated various models, few of which are now being considered for scale up.

Besides these, quality assurance committees have been made operational at state and district level to ensure that standards laid down by the government on family planning services are strictly adhered to which are appraised through audit reports, direct procedure observation, client exit interviews and records and registers. Robust monitoring using periodic population surveys, HMIS and physical reports has now become an integral part of the program.

With these strengthened systems in place, the government is confident and steadfast in its resolve to fulfill the commitments made at the 2012 London summit by 2020.

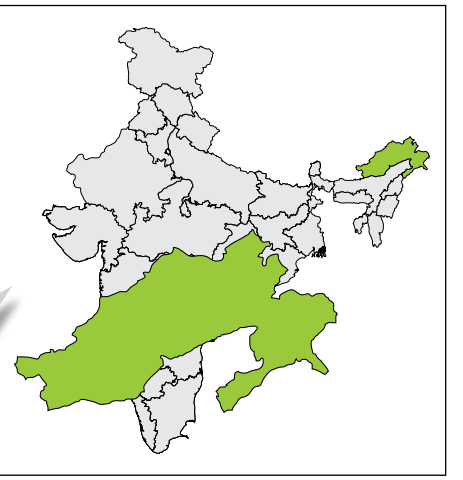
Annexures

Annexure 1: State wise fact sheets

Arunanchal Pradesh

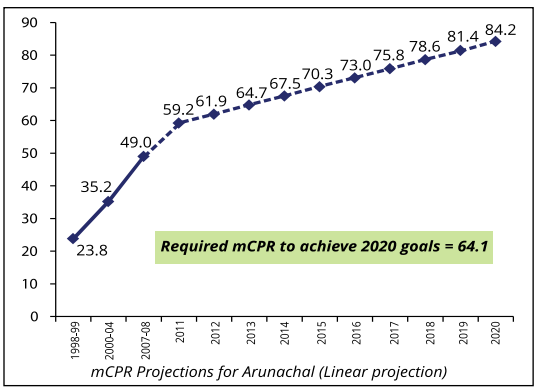
State Profile :

Indicator	Value	Source
Total Population	1,382,611	Census 2011
Unmet Need	14.3	DLHS III
CPR (Any Method)	52	DLHS III
mCPR	49	DLHS III

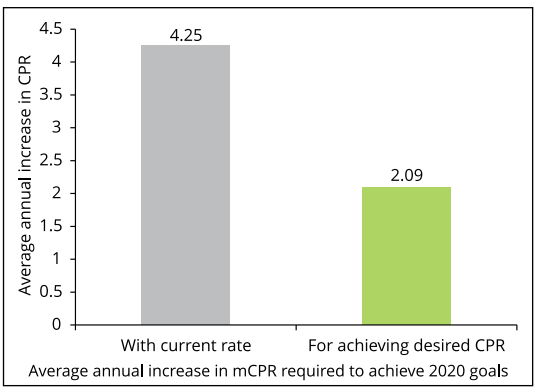


FP 2020 Goal:

- To provide family planning services to 36,498 additional women.
- To sustain the coverage of 0.15 million (1.5 lakh) women currently using contraceptives



mCPR Projections for Arunachal (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

Required Method mix for Arunachal Pradesh by 2020

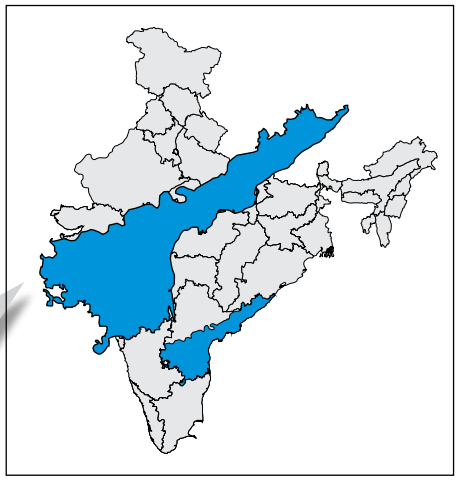
	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	64.1		0.185	0.036
Condoms	4.5	7.0	0.013	0.003
Pills	16.7	26.0	0.048	0.009
IUCD	6.4	10.0	0.019	0.007
Male Sterilization	0.4	0.7	0.001	0.000
Female Sterilization	36.1	56.3	0.104	0.017

Andhra Pradesh

State Profile :

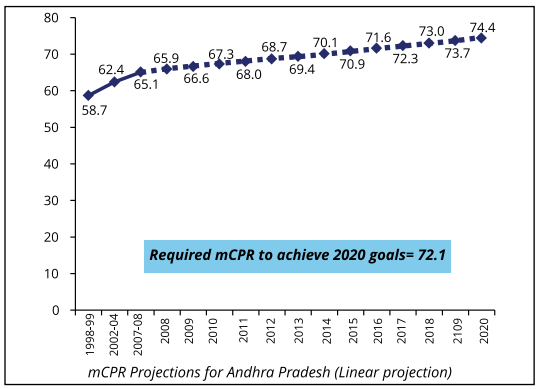
Indicator	Value	Source
Total Population	49,378,776	Census 2011
Unmet Need	7.6*	DLHS-III
CPR (Any Method)	69.5*	DLHS-III
CPR (Modern Method)	69.2*	DLHS-III

*approx. estimates calculated with the district estimates from DLHS III

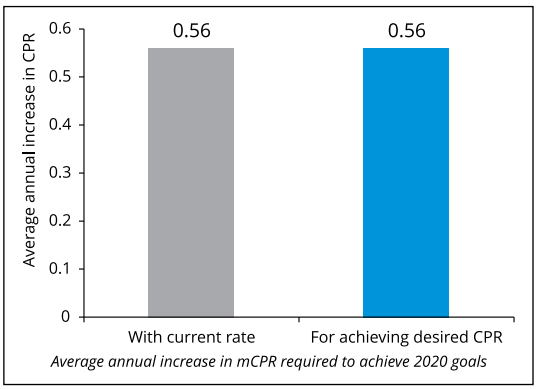


FP 2020 Goal:

- To provide family planning services to 0.99 million (9.9 lakh) additional women.
- To sustain the coverage of 6.0 million (59.9 lakh) women currently using contraceptives



mCPR Projections for Andhra Pradesh (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

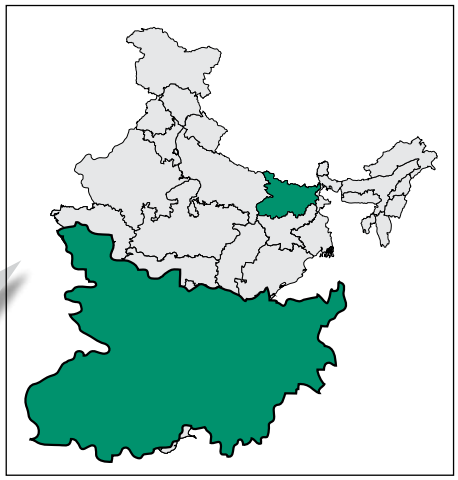
Required Method mix for Andhra Pradesh by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	72.1		6.98	0.99
Condoms	1.1	1.5	0.1	0.1
Pills	0.4	0.5	0.0	0.0
IUCD	2.2	3	0.2	0.2
Male Sterilization	1.4	2	0.1	0.0
Female Sterilization	67.1	93	6.5	0.7

Bihar

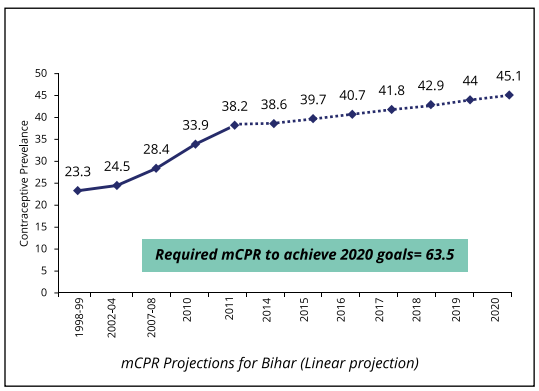
State Profile :

Indicator	Value	Source
Total Population	103,804,637	Census 2011
Unmet Need	33.5	AHS 2011
CPR (Any Method)	43.0	AHS 2011
CPR (Modern Method)	38.2	AHS 2011

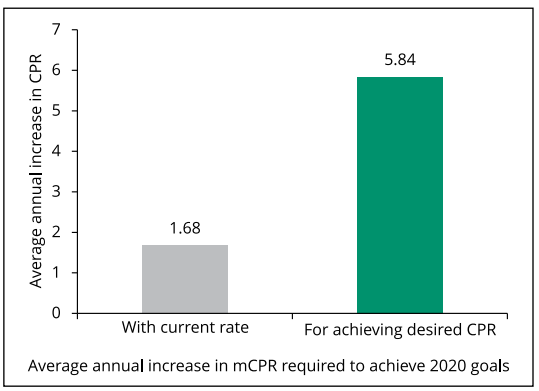


FP 2020 Goal:

- To provide family planning services to 7.13 million (71.3 lakh) additional women.
- To sustain the coverage of 6.57 million (65.7 lakh) women currently using contraceptives



mCPR Projections for Bihar (Linear projection)

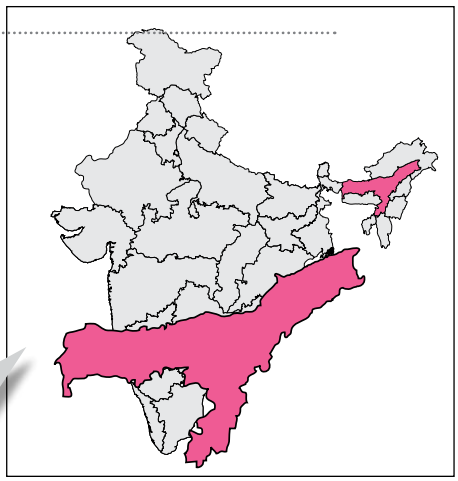


Average annual increase in mCPR required to achieve 2020 goals

Required Method mix for Bihar by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	63.5		13.70	7.13
Condoms	7.0	11	1.51	1.01
Pills	3.2	5	0.68	0.39
IUCD	3.2	5	0.68	0.57
Male Sterilization	0.6	3	0.14	0.10
Female Sterilization	49.5	78	10.68	5.06

Assam

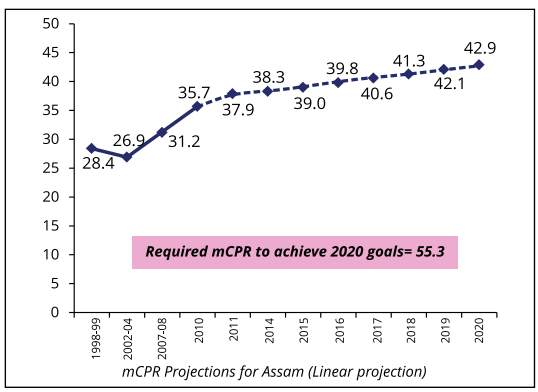


State Profile :

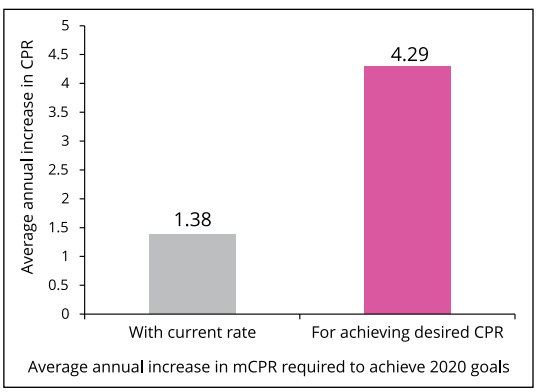
Indicator	Value	Source
Total Population	31,169,272	Census 2011
Unmet Need	15.9	AHS 2011
CPR (Any Method)	65.1	AHS 2011
CPR (Modern Method)	37.9	AHS 2011

FP 2020 Goal:

- To provide family planning services to 1.4 million (14 lakh) additional women.
- To sustain the coverage of 1.98 million (19.8 lakh) women currently using contraceptives



mCPR Projections for Assam (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

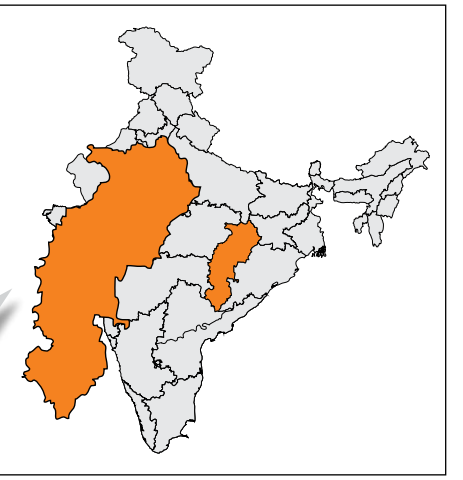
Required Method mix for Assam by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	55.3		3.38	1.40
Condoms	2.8	5	0.17	0.04
Pills	27.7	50	1.69	0.59
IUCD	4.3	7.8	0.26	0.19
Male Sterilization	0.7	1.2	0.04	0.04
Female Sterilization	19.9	36	1.22	0.54

Chhattisgarh

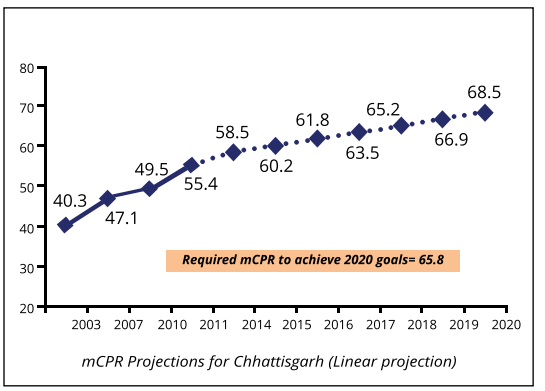
State Profile :

Indicator	Value	Source
Total Population	25,540,196	Census 2011
Unmet Need	24.8	AHS 2011
CPR (Any Method)	58.6	AHS 2011
CPR (Modern Method)	55.4	AHS 2011

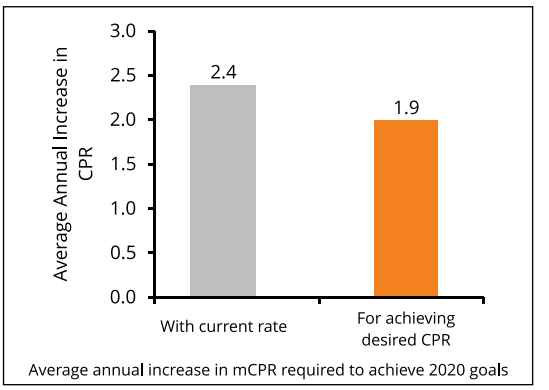


FP 2020 Goal:

- To provide family planning services to 0.99 million (9.9 lakh) additional women.
- To sustain the coverage of 2.44 million (24.4 lakh) women currently using contraceptives



mCPR Projections for Chhattisgarh (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

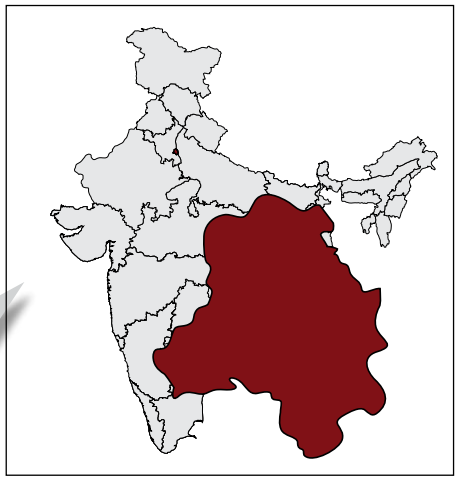
Required Method mix for Chhattisgarh by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	65.8		3.43	0.99
Condoms	2.6	4	0.137	0.033
Pills	2.6	4	0.137	0.100
IUCD	3.6	5	0.172	0.151
Male Sterilization	1.3	2	0.069	0.030
Female Sterilization	55.9	85	2.916	0.670

Delhi

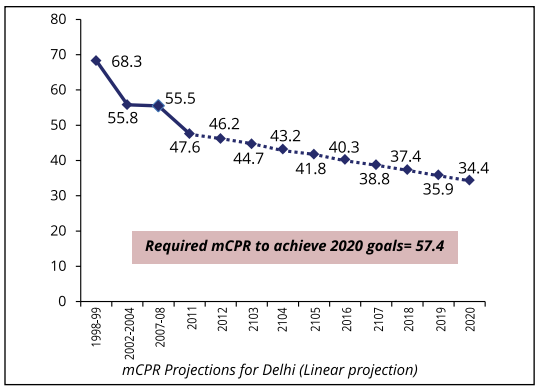
State Profile :

Indicator	Value	Source
Total Population	16,753,235	Census 2011
Unmet Need	13.9	DLHS 2011
CPR (Any Method)	66.1	DLHS 2011
mCPR	55.5	DLHS 2011

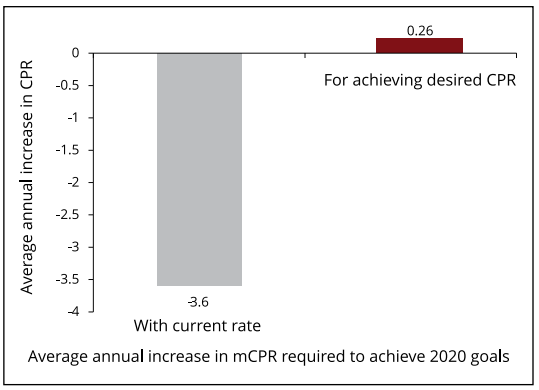


FP 2020 Goal:

- To provide family planning services to 0.43 million (4.3 lakh) additional women.
- To sustain the coverage of 1.5 million (15 lakh) women currently using contraceptives



mCPR Projections for Delhi (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

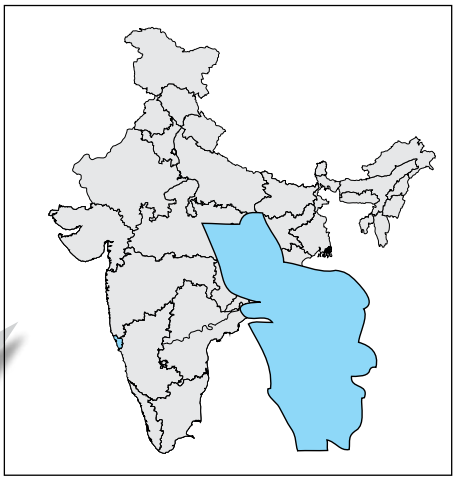
Required Method mix for Delhi by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	57.4		1.94	0.43
Condoms	21.8	38	0.74	0.17
Pills	5.2	9	0.17	0.06
IUCD	6.3	11	0.21	0.07
Male Sterilization	0.8	1.4	0.03	0.01
Female Sterilization	23.3	40.6	0.79	0.12

Goa

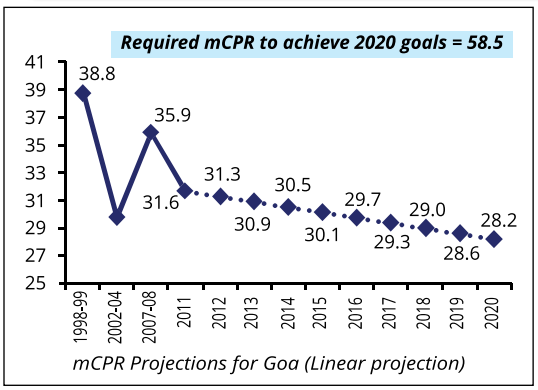
State Profile :

Indicator	Value	Source
Total Population	1,457,723	Census 2011
Unmet Need	28.8	DLHS III
CPR (Any Method)	45	DLHS III
CPR (Modern Method)	35.9	DLHS III

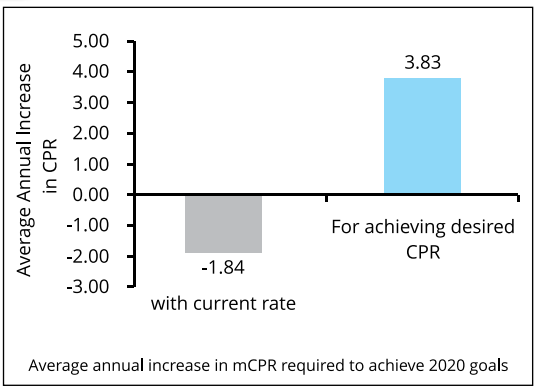


FP 2020 Goal:

- To provide family planning services to 0.078 million (0.78 lakh) additional women.
- To sustain the coverage of 0.078 million (0.78 lakh) women currently using contraceptives



mCPR Projections for Goa (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

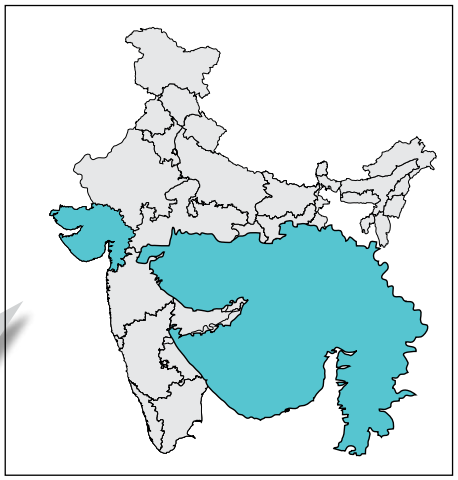
Required Method mix for Goa by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	58.5		0.156	0.078
Condoms	18.1	31	0.048	0.024
Pills	2.9	5	0.008	0.003
IUCD	4.7	8	0.012	0.008
Male Sterilization	0.5	0.8	0.001	0.001
Female Sterilization	32.3	55.2	0.086	0.042

Gujarat

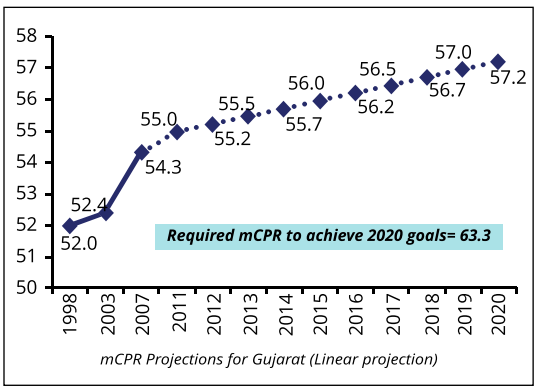
State Profile:

Indicator	Value	Source
Total Population	60,383,628	Census 2011
Unmet Need	16.5	DLHS III
CPR (Any Method)	61.6	DLHS III
CPR (Modern Method)	54.3	DLHS III

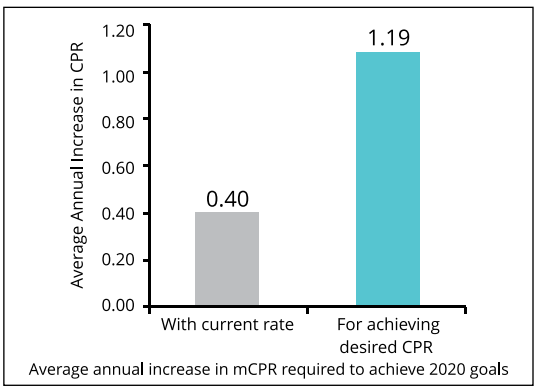


FP 2020 Goal:

- To provide family planning services to 1.84 million (18 lakh) additional women.
- To sustain the coverage of 5.8 million (58 lakh) women currently using contraceptives



mCPR Projections for Gujarat (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

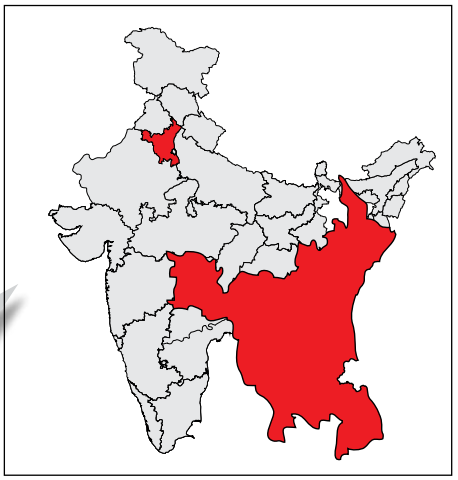
Required Method mix for Gujarat by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	63.3		7.61	1.84
Condoms	5.7	9	0.68	0.08
Pills	3.8	6	0.46	0.07
IUCD	4.4	7	0.53	0.22
Male Sterilization	1.7	2.7	0.21	0.04
Female Sterilization	47.7	75.3	5.73	1.44

Haryana

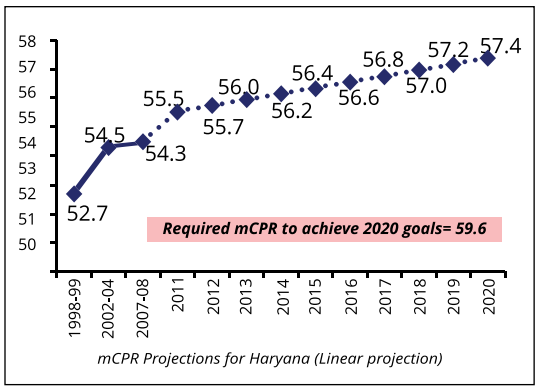
State Profile:

Indicator	Value	Source
Total Population	25,353,081	Census 2011
Unmet Need	16	DLHS III
CPR (Any Method)	62.0	DLHS III
CPR (Modern Method)	54.5	DLHS III

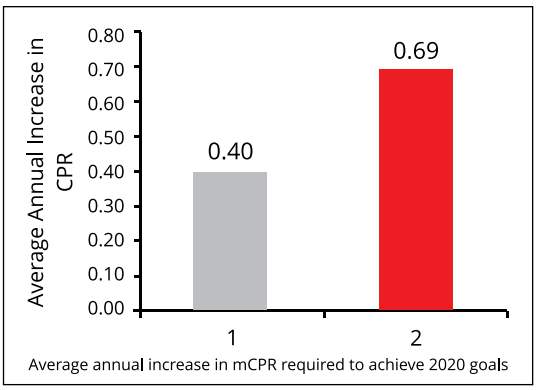


FP 2020 Goal:

- To provide family planning services to 0.75 million (7.5 lakh) additional women.
- To sustain the coverage of 2.4 million (24 lakh) women currently using contraceptives



mCPR Projections for Haryana (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

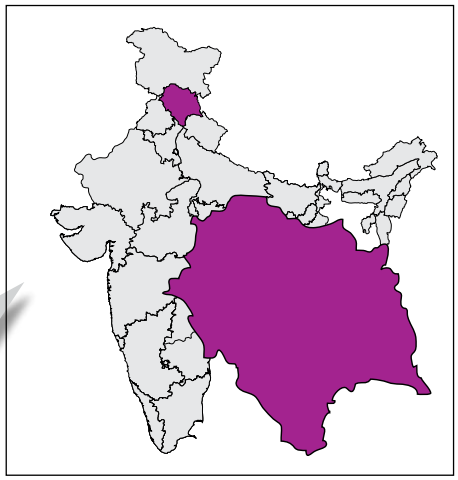
Required Method mix for Haryana by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	59.6		3.20	0.75
Condoms	11.9	20	0.64	0.10
Pills	4.8	8	0.26	0.10
IUCD	6.0	10	0.32	0.14
Male Sterilization	1.2	2	0.06	0.04
Female Sterilization	35.8	60	1.92	0.38

Himachal Pradesh

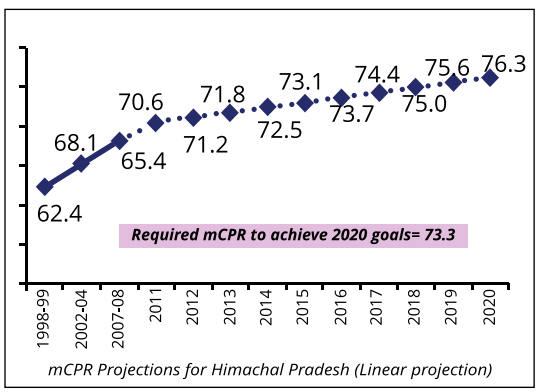
State Profile:

Indicator	Value	Source
Total Population	6,856,509	Census 2011
Unmet Need	14.9	DLHS III
CPR (Any Method)	70.2	DLHS III
CPR (Modern Method)	68.1	DLHS III

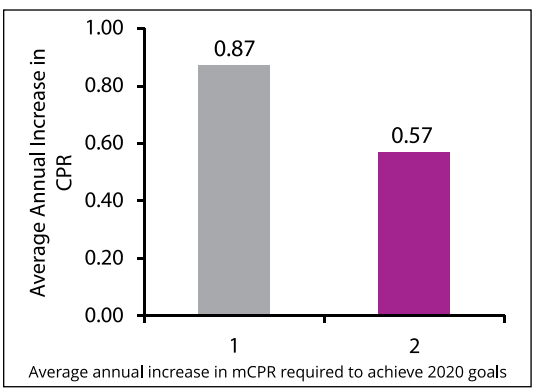


FP 2020 Goal:

- To provide family planning services to 0.1 million (1 lakh) additional women.
- To sustain the coverage of 0.8 million (8 lakh) women currently using contraceptives



mCPR Projections for Himachal Pradesh (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

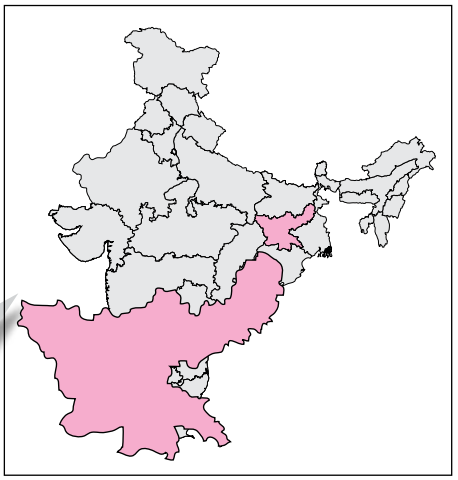
Required Method mix for Himachal Pradesh by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	73.3		0.95	0.11
Condoms	13.6	18.5	0.18	0.002
Pills	4.8	6.5	0.06	0.010
IUCD	2.2	3	0.03	0.021
Male Sterilization	6.2	8.5	0.08	0.010
Female Sterilization	46.6	63.5	0.60	0.074

Jharkhand

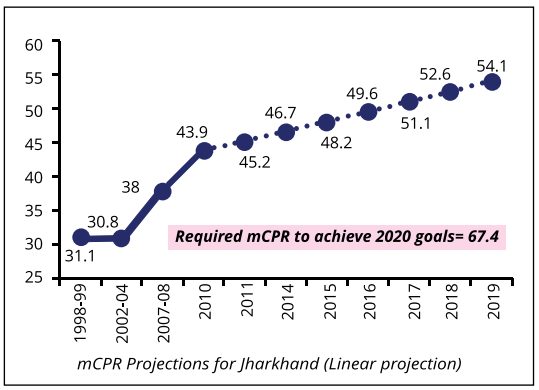
State Profile :

Indicator	Value	Source
Total Population	32,966,238	Census 2011
Unmet Need	22.6	AHS 2011
CPR (Any Method)	56.5	AHS 2011
CPR (Modern Method)	43.9	AHS 2011

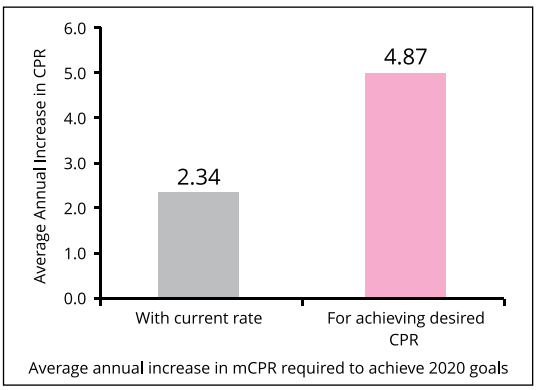


FP 2020 Goal:

- To provide family planning services to 2.11 million (21 lakh) additional women.
- To sustain the coverage of 2.4million (24lakh) women currently using contraceptives



mCPR Projections for Jharkhand (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

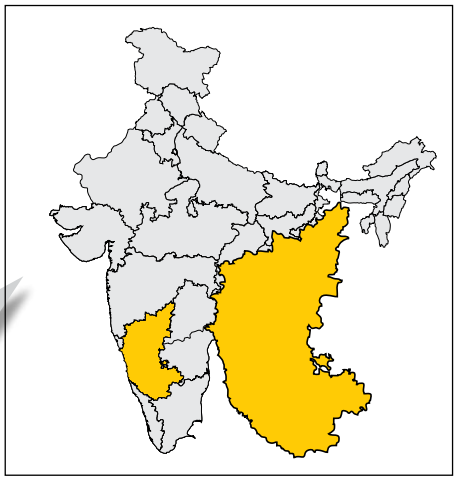
Required Method mix for Jharkhand by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	67.4		4.53	2.11
Condoms	8.1	12	0.54	0.31
Pills	8.1	12	0.54	0.29
IUCD	2.7	4	0.18	0.14
Male Sterilization	1.3	2	0.09	0.06
Female Sterilization	47.1	70	3.17	1.30

Karnataka

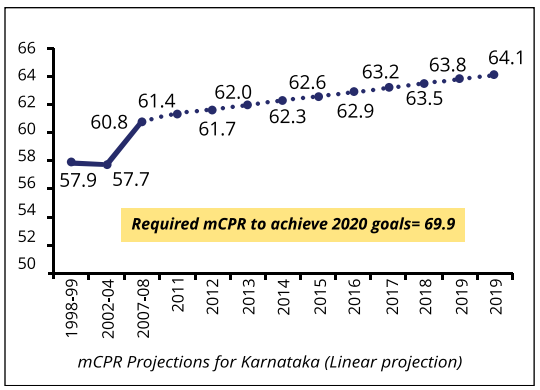
State Profile :

Indicator	Value	Source
Total Population	61,130,704	Census 2011
Unmet Need	15.8	DLHS III
CPR (Any Method)	61.8	DLHS III
CPR (Modern Method)	60.8	DLHS III

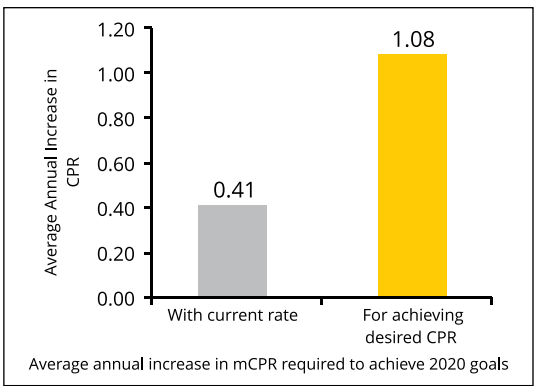


FP 2020 Goal:

- To provide family planning services to 1.8 million (18 lakh) additional women.
- To sustain the coverage of 6.5 million (65 lakh) women currently using contraceptives



mCPR Projections for Karnataka (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

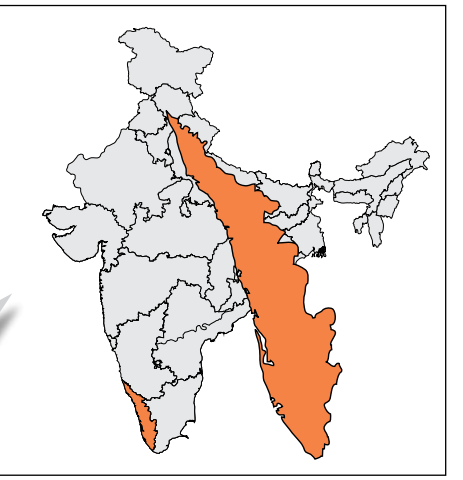
Required Method mix for Karnataka by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	69.9		8.29	1.78
Condoms	3.5	5	0.41	0.28
Pills	3.5	5	0.41	0.32
IUCD	3.5	5	0.41	0.26
Male Sterilization	0.3	0.5	0.04	0.04
Female Sterilization	59.1	84.5	7.00	0.87

Kerala

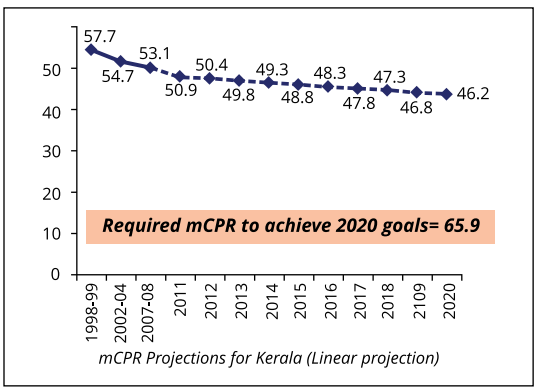
State Profile :

Indicator	Value	Source
Total Population	33,387,677	Census 2011
Unmet Need	16.8 %	DLHS III
CPR (Any Method)	62.3 %	DLHS III
CPR (Modern Method)	53.1 %	DLHS III

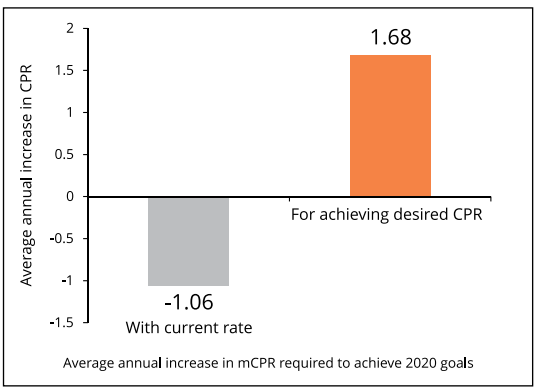


FP 2020 Goal:

- To provide family planning services to 1.04 million (10 lakh) additional women.
- To sustain the coverage of 2.9 million (29 lakh) women currently using contraceptives



mCPR Projections for Kerala (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

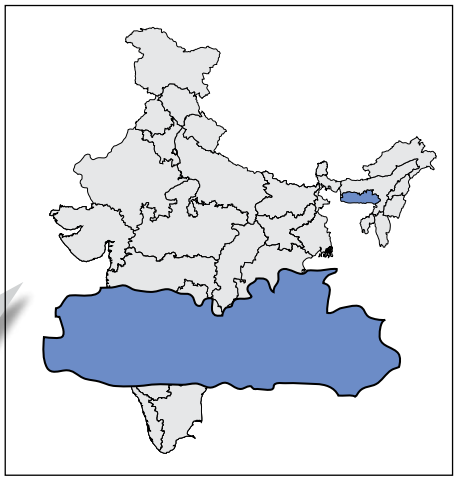
Required Method mix for Kerala by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	65.9		3.91	1.04
Condoms	7.9	12	0.47	0.21
Pills	0.7	1	0.04	0.02
IUCD	4.6	7	0.27	0.18
Male Sterilization	0.6	0.9	0.04	0.04
Female Sterilization	52.2	79.1	3.09	0.56

Meghalaya

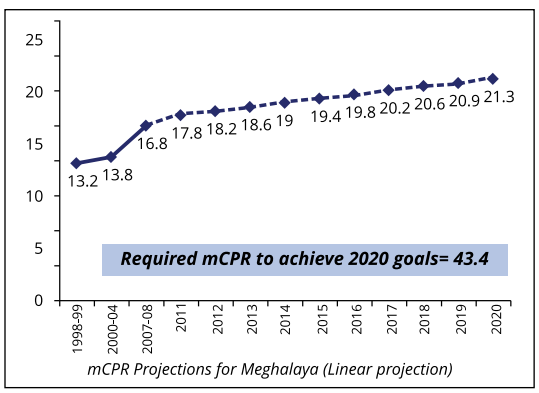
State Profile :

Indicator	Value	Source
Total Population	2964007	Census 2011
Unmet Need	32.7	DLHS III
CPR (Any Method)	22.9	DLHS III
CPR (Modern Method)	16.8	DLHS III

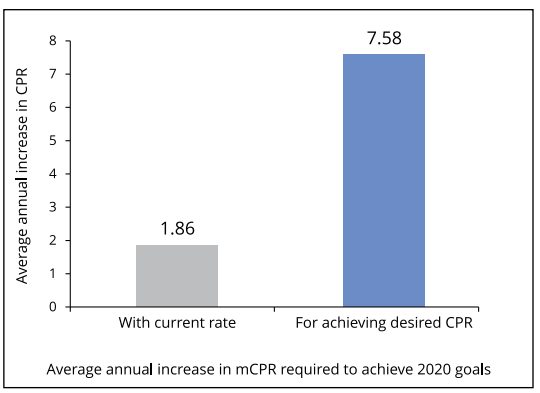


FP 2020 Goal:

- To provide family planning services to 0.18 million (18 lakhs) additional women.
- To sustain the coverage of 0.094 million (94,125) women currently using contraceptives



mCPR Projections for Meghalaya (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

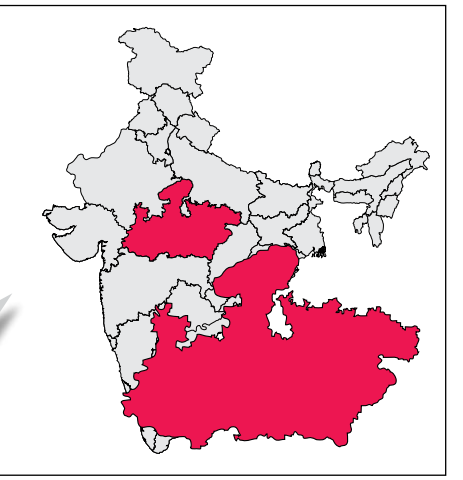
Required Method mix for Meghalaya by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	43.4		0.273	0.179
Condoms	7.6	17.4	0.048	0.033
Pills	13.5	31.1	0.085	0.056
IUCD	2.8	6.5	0.018	0.016
Male Sterilization	0.3	0.8	0.002	0.001
Female Sterilization	19.2	44.2	0.121	0.073

Madhya Pradesh

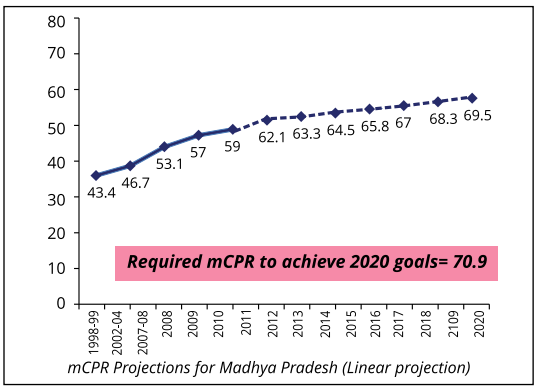
State Profile :

Indicator	Value	Source
Total Population	72,597,565	Census 2011
Unmet Need	21.2,	DLHS III
CPR (Any Method)	63.4	AHS 2011
CPR (Modern Method)	59.3	AHS 2011

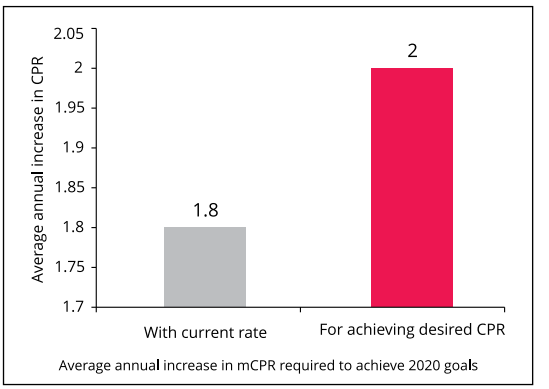


FP 2020 Goal:

- To provide family planning services to 2.8 million (28 lakh) additional women.
- To sustain the coverage of 7.5 million (75 lakh) women currently using contraceptives



mCPR Projections for Madhya Pradesh (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

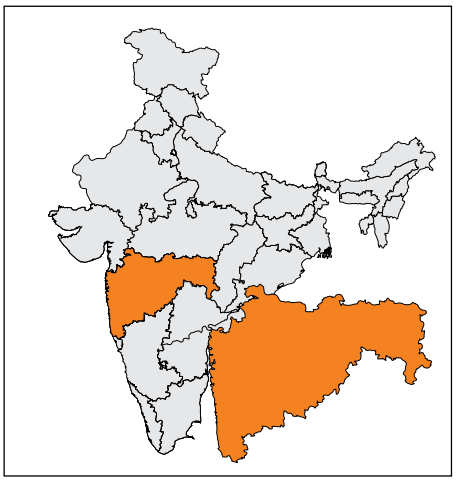
Required Method mix for Madhya Pradesh by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	70.9		10.33	2.84
Condoms	8.5	12	1.24	0.37
Pills	3.0	4.3	0.44	0.20
IUCD	3.5	5	0.52	0.44
Male Sterilization	1.2	1.7	0.18	0.09
Female Sterilization	54.6	77	7.96	1.74

Maharashtra

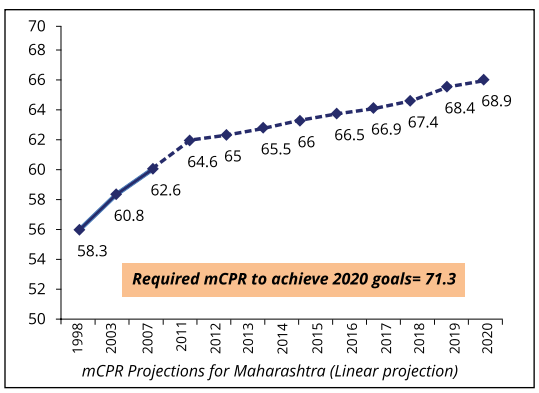
State Profile :

Indicator	Value	Source
Total Population	112,372,972	Census 2011
Unmet Need	14.2	DLHS- III
CPR (Any Method)	63.8	DLHS -III
CPR (Modern Method)	62.6	DLHS -III

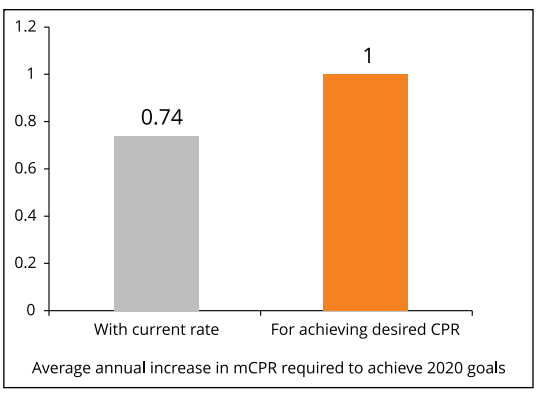


FP 2020 Goal:

- To provide family planning services to 2.95 million (30 lakh) additional women.
- To sustain the coverage of 12.6 million (1.3 crore) women currently using contraceptives



mCPR Projections for Maharashtra (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

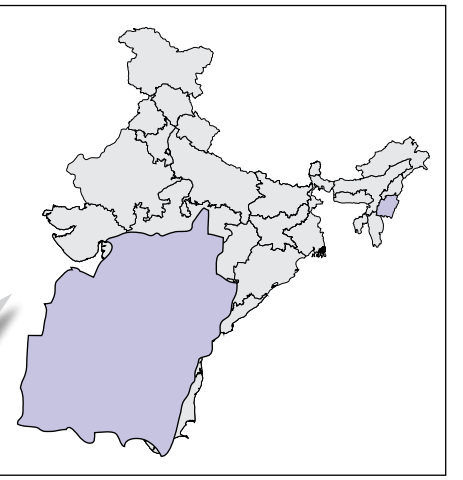
Required Method mix for Maharashtra by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	71.3		15.55	2.95
Condoms	6.4	9	1.40	0.27
Pills	2.9	4	0.62	0.07
IUCD	3.6	5	0.78	0.33
Male Sterilization	2.1	3	0.47	0.08
Female Sterilization	56.3	79	12.29	1.99

Manipur

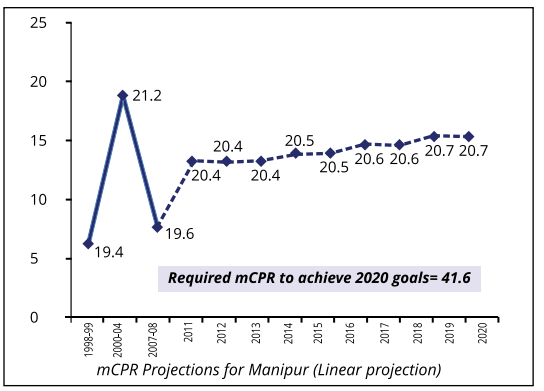
State Profile :

Indicator	Value	Source
Total Population	2,721,756	Census 2011
Unmet Need	25.6	DLHS III
CPR (Any Method)	44.8	DLHS III
CPR (Modern Method)	19.6	DLHS III

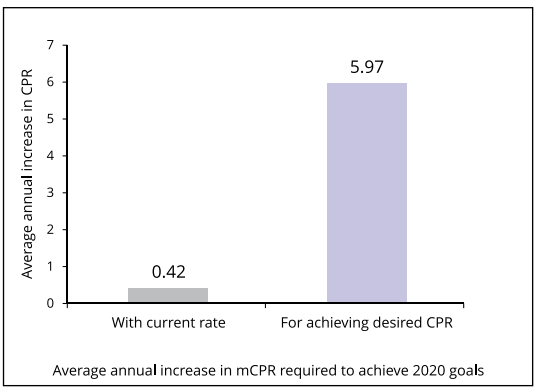


FP 2020 Goal:

- To provide family planning services to 0.13 million (1.3 lakh) additional women.
- To sustain the coverage of 96,029 women currently using contraceptives



mCPR Projections for Manipur (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

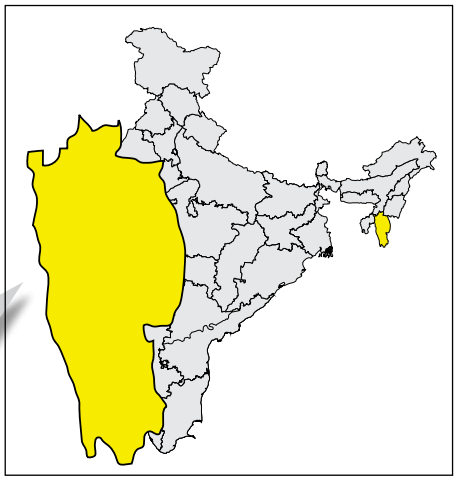
Required Method mix for Manipur by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	41.6		0.225	0.129
Condoms	10.5	25.1	0.056	0.035
Pills	11.3	27.1	0.061	0.028
IUCD	8.7	21.0	0.047	0.025
Male Sterilization	0.5	1.1	0.002	0.002
Female Sterilization	10.7	25.7	0.058	0.042

Mizoram

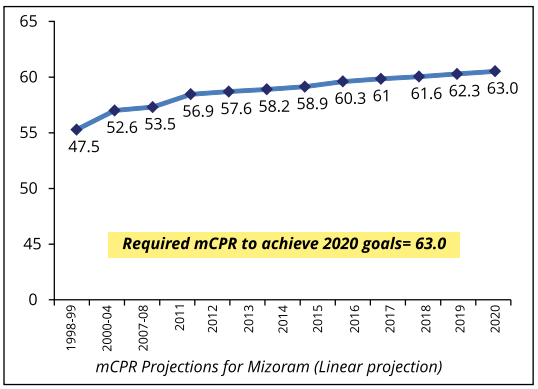
State Profile :

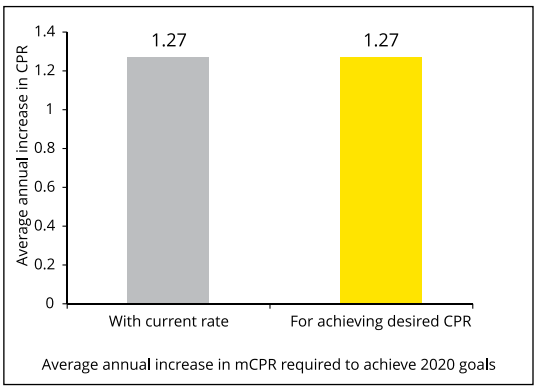
Indicator	Value	Source
Total Population	1,091,014	Census 2011
Unmet Need	16.7	DLHS III
CPR (Any Method)	53.9	DLHS III
CPR (Modern Method)	53.5	DLHS III



FP 2020 Goal:

- To provide family planning services to 0.03 million (0.32 lakh) additional women.
- To sustain the coverage of 0 .11 million (1.1 lakh) women currently using contraceptives





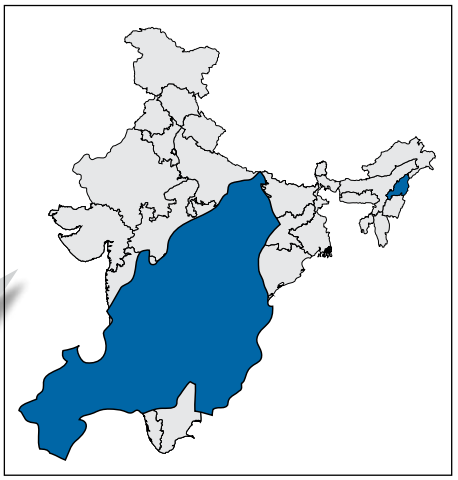
Required Method mix for Mizoram by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in thousands)	Number of Additional Users (in thousands)
mCPR	63		140.5	31.6
Condoms	2.5	4	5.6	1.8
Pills	17.1	27.1	38.1	10.9
IUCD	7.4	11.8	16.6	5.7
Male Sterilization	0.1	0.2	0.3	0.2
Female Sterilization	35.9	56.9	80	14

Nagaland

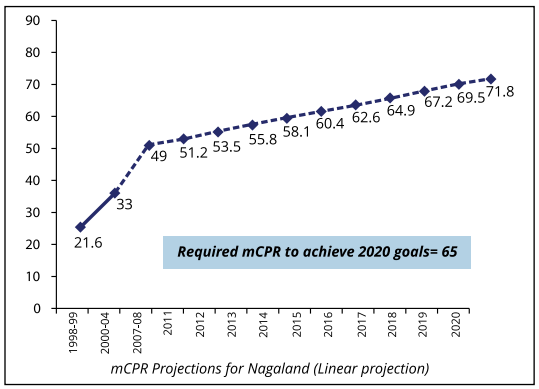
State Profile :

Indicator	Value	Source
Total Population	1,980,602	Census 2011
Unmet Need	33.8	DLHS III
CPR (Any Method)		
CPR (Modern Method)	33	DLHS III

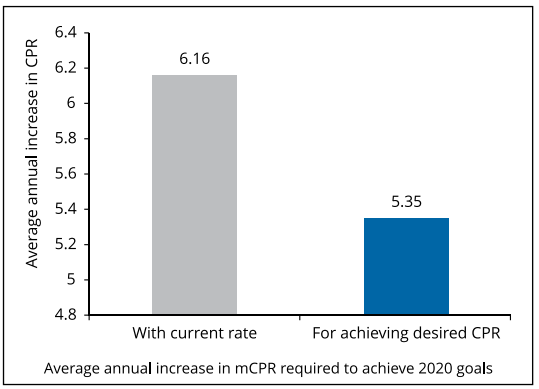


FP 2020 Goal:

- To provide family planning services to 37760 additional women.
- To sustain the coverage of 0.22 million (2.2 lakh) women currently using contraceptives



mCPR Projections for Nagaland (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

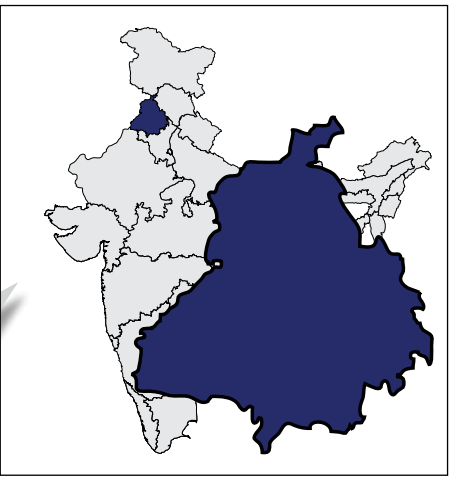
Required Method mix for Nagaland by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in thousands)	Number of Additional Users (in thousands)
mCPR	65.0		217.9	37.76
Condoms	3.1	4.8	10.46	0
Pills	19.8	30.5	66.45	43.16
IUCD	7.8	12.0	26.14	0
Male Sterilization	0.5	0.7	1.525	0
Female Sterilization	33.8	52.0	113.3	43.97

Punjab

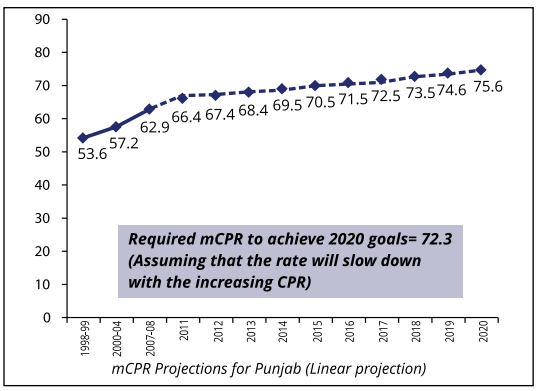
State Profile :

Indicator	Value	Source
Total Population	27,704,236	Census 2011
Unmet Need	11.9	DLHS III
CPR (Any Method)	69.3	DLHS III
CPR (Modern Method)	62.9	DLHS III

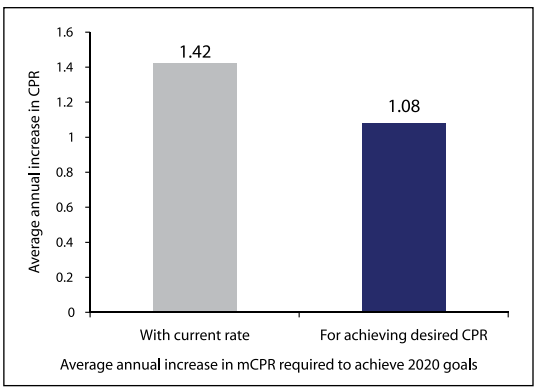


FP 2020 Goal:

- To provide family planning services to 0.6 million (6 lakh) additional women.
- To sustain the coverage of 3.2 million (32 lakh) women currently using contraceptives



mCPR Projections for Punjab (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

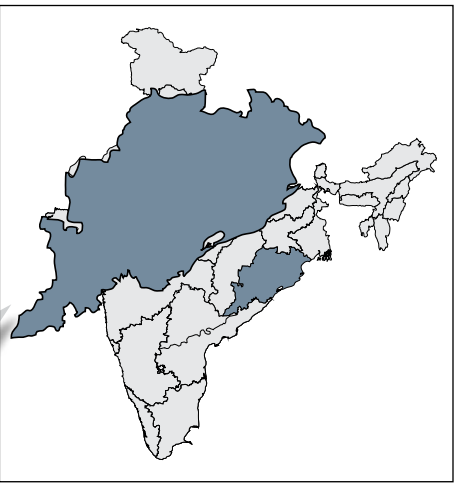
Required Method mix for Punjab by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
CPR	72.3		3.83	0.61
Condoms	22.1	30.5	1.17	0.08
Pills	5.1	7	0.27	0.04
IUCD	7.2	10	0.38	0.11
Male Sterilization	1.1	1.5	0.06	0.05
Female Sterilization	36.9	51	1.95	0.33

Odisha

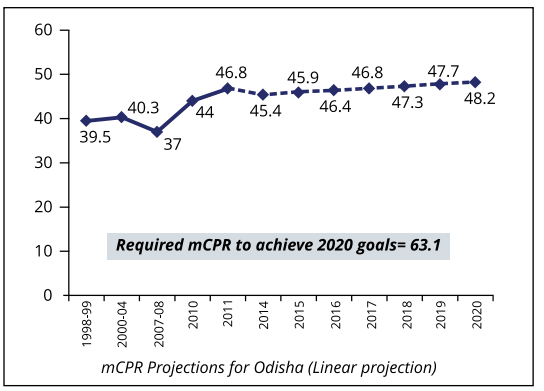
State Profile :

Indicator	Value	Source
Total Population	41,947,358	Census 2011
Unmet Need	19.1%	AHS 2011
CPR (Any Method)	59.4%	AHS 2011
CPR (Modern Method)	46.8%	AHS 2011

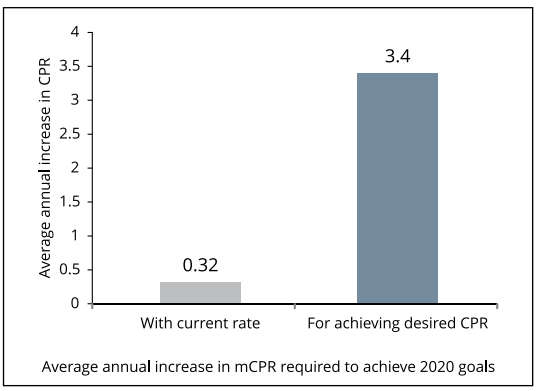


FP 2020 Goal:

- To provide family planning services to 1.86 million (19 lakh) additional women.
- To sustain the coverage of 3.22 million (32 lakh) women currently using contraceptives



mCPR Projections for Odisha (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

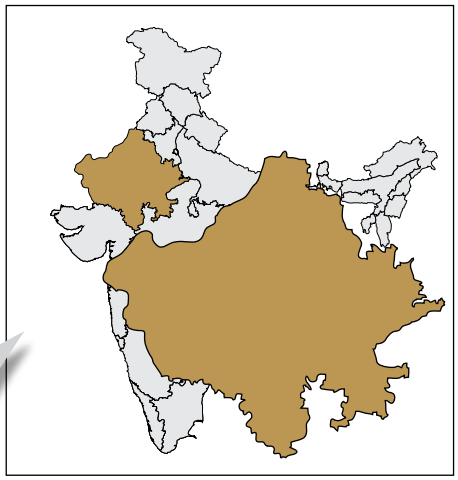
Required Method mix for Odisha by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	63.2		5.08	1.86
Condoms	3.2	5	0.25	0.11
Pills	15.8	25	1.27	0.34
IUCD	2.5	4	0.20	0.19
Male Sterilization	0.6	1	0.05	0.04
Female Sterilization	41.1	65	3.30	1.18

Rajasthan

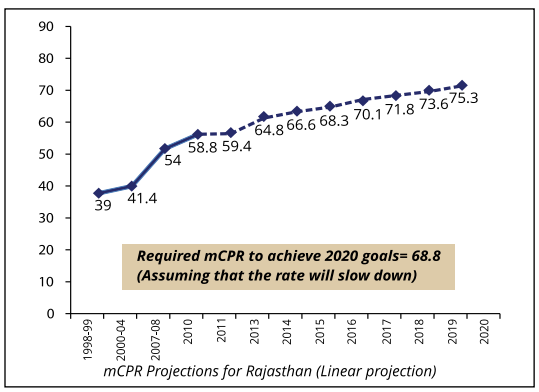
State Profile :

Indicator	Value	Source
Total Population	68,621,012	Census 2011
Unmet Need	17.9% 12.6%	DLHS III AHS 2011
CPR (Any Method)	66.4	AHS 2011
CPR (Modern Method)	59.4	AHS 2011

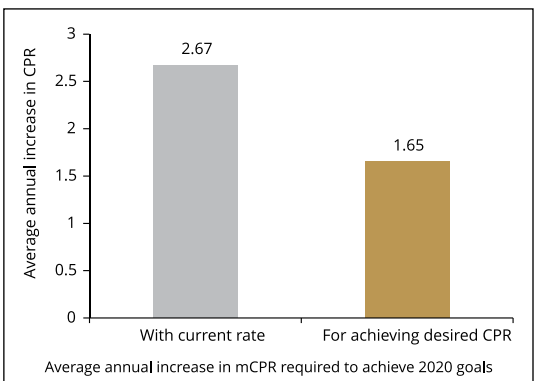


FP 2020 Goal:

- To provide family planning services to 2.3 million (23 lakh) additional women.
- To sustain the coverage of 7.3 million (73 lakh) women currently using contraceptives



mCPR Projections for Rajasthan (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

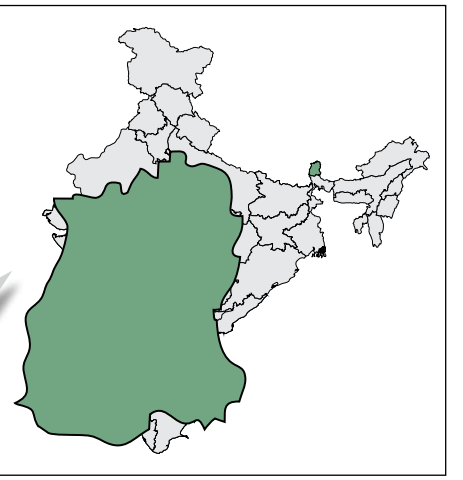
Required Method mix for Rajasthan by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
CPR	68.8		9.56	2.27
Condoms	11.7	17	1.63	0.39
Pills	3.4	5	0.48	0.12
IUCD	3.4	5	0.48	0.35
Male Sterilization	0.7	1	0.10	0.06
Female Sterilization	49.6	72	6.89	1.34

Sikkim

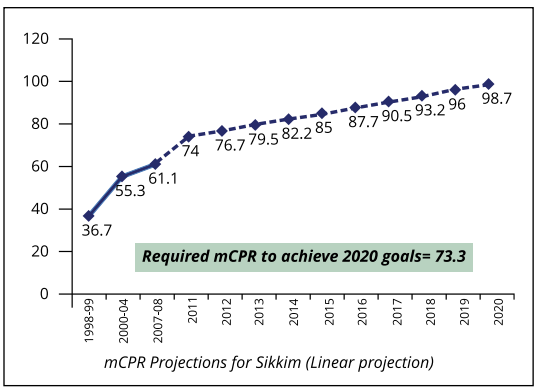
State Profile :

Indicator	Value	Source
Total Population	607,688	Census 2011
Unmet Need	16.1%	DLHS III
CPR (Any Method)	71.1%	DLHS III
CPR (Modern Method)	61.1%	DLHS III

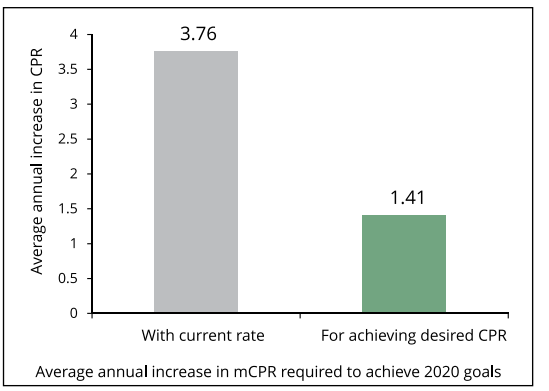


FP 2020 Goal:

- To provide family planning services to 20,393 additional women.
- To sustain the coverage of 63,688 women currently using contraceptives



mCPR Projections for Sikkim (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

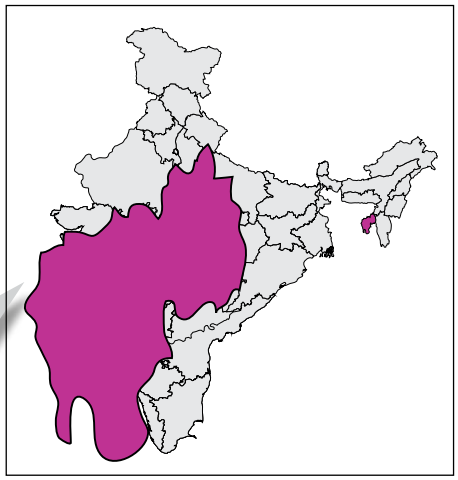
Required Method mix for Sikkim by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in thousands)	Number of Additional Users (in thousands)
mCPR	73.3		84.1	20.4
Condoms	8.8	12.0	10.1	4.2
Pills	27.5	37.5	31.5	8.7
IUCD	10.3	14.0	11.8	5.0
Male Sterilization	4.8	6.6	5.5	0.2
Female Sterilization	21.9	29.9	25.1	2.3

Tripura

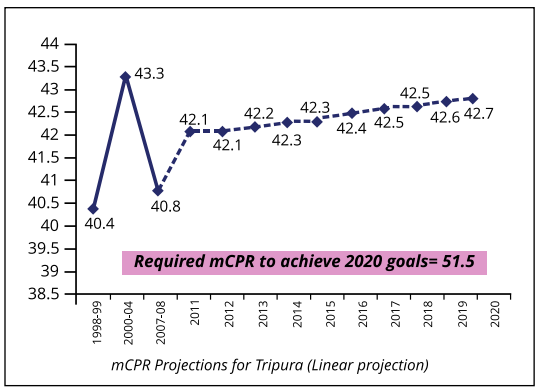
State Profile :

Indicator	Value	Source
Total Population	3,671,032	Census 2011
Unmet Need	12.8	DLHS III
CPR (Any Method)	68.5	DLHS III
CPR (Modern Method)	40.8	DLHS III

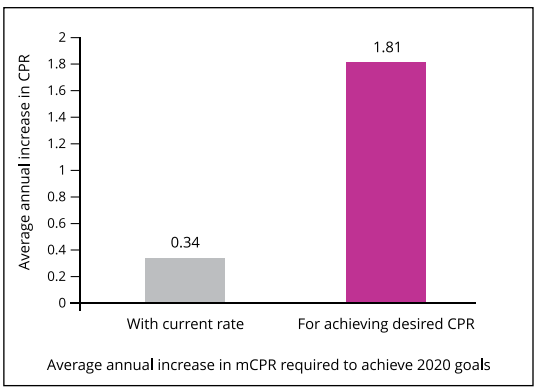


FP 2020 Goal:

- To provide family planning services to 0.098 million (0.98 lakh) additional women.
- To sustain the coverage of 0.27 million (2.7 lakh) women currently using contraceptives



mCPR Projections for Tripura (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

Required Method mix for Tripura by 2020

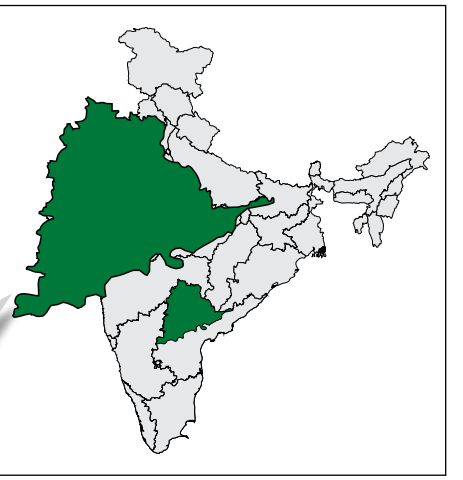
	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
CPR	51.5		0.364	0.098
Condoms	6.2	12.0	0.044	0.006
Pills	25.2	49.0	0.178	0.008
IUCD	2.1	4.0	0.015	0.010
Male Sterilization	0.3	0.5	0.002	0.002
Female Sterilization	17.8	34.5	0.126	0.077

Telangana

State Profile :

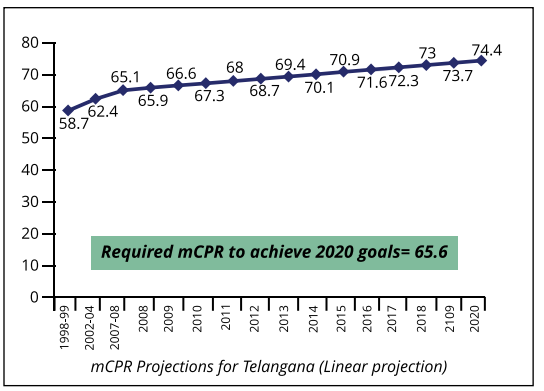
Indicator	Value	Source
Total Population	35,286.757	Census 2011
Unmet Need	8.6*	DLHS III
CPR (Any Method)	64.5	DLHS III
CPR (Modern Method)	64.4*	DLHS III

* approx estimates calculated with the district estimates from DLHS III

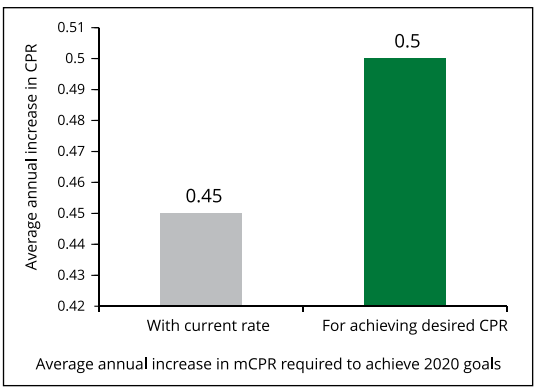


FP 2020 Goal:

- To provide family planning services to 0.79 million (7.9 lakh) additional women.
- To sustain the coverage of 3.8 million (37.5 lakh) women currently using contraceptives



mCPR Projections for Telangana (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

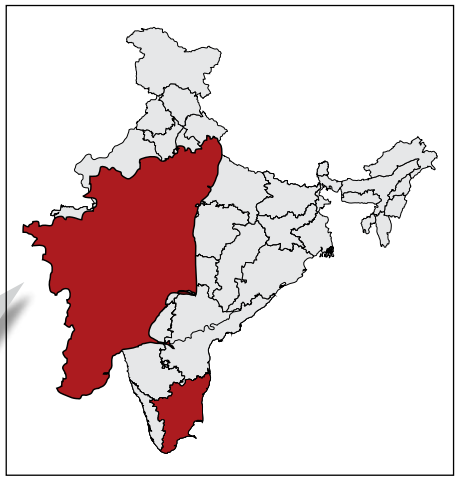
Required Method mix for Telangana by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	65.6		4.54	0.79
Condoms	1.3	2	0.09	0.04
Pills	0.7	1	0.05	0.03
IUCD	2.0	3	0.14	0.13
Male Sterilization	3.0	4.5	0.20	0.04
Female Sterilization	58.7	89.5	4.06	0.56

Tamil Nadu

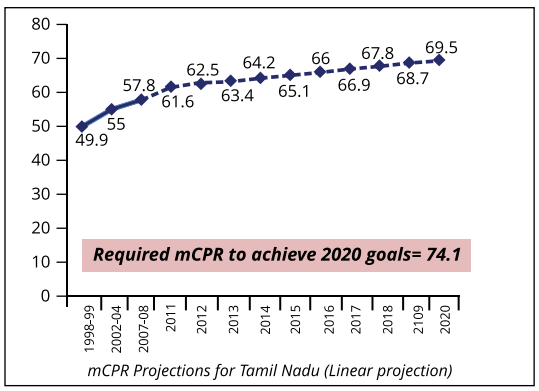
State Profile :

Indicator	Value	Source
Total Population	72,138,958	Census 2011
Unmet Need	19.4	DLHS III
CPR (Any Method)	59.9	DLHS III
CPR (Modern Method)	57.8	DLHS III

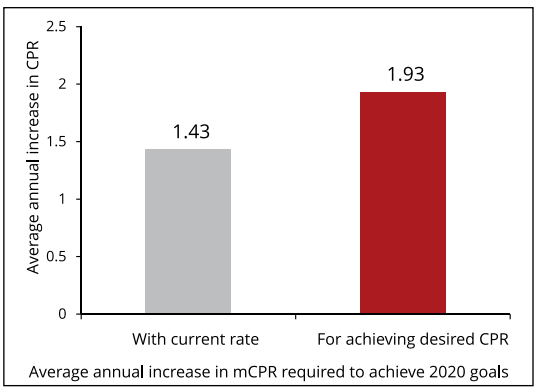


FP 2020 Goal:

- To provide family planning services to 2.58 million (26 lakh) additional women.
- To sustain the coverage of 7.77 million (78 lakh) women currently using contraceptives



mCPR Projections for Tamil Nadu (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

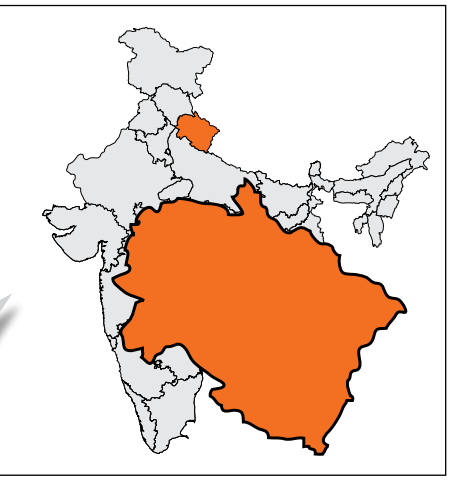
Required Method mix for Tamil Nadu by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
CPR	74.1		10.36	2.58
Condoms	3.7	5	0.52	0.26
Pills	0.7	1	0.10	0.08
IUCD	4.5	6.1	0.63	0.43
Male Sterilization	0.1	0.2	0.02	0.01
Female Sterilization	65.0	87.7	9.08	1.80

Uttrakhand

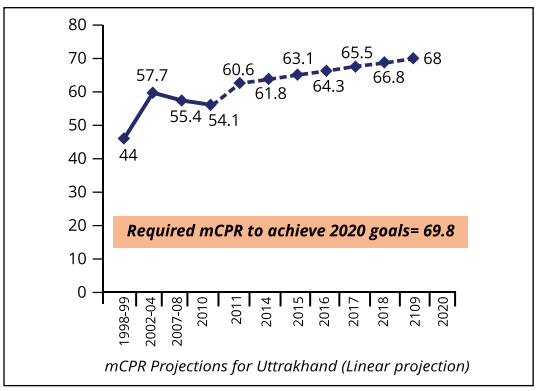
State Profile :

Indicator	Value	Source
Total Population	10,116,752	Census 2011
Unmet Need	20.8	DLHS III
CPR (Any Method)	61.7	AHS 2011
CPR (Modern Method)	54.1	AHS 2011

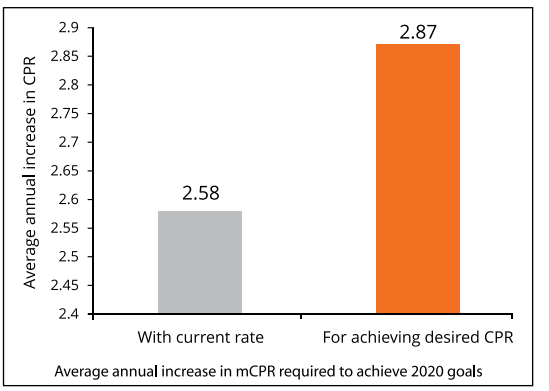


FP 2020 Goal:

- To provide family planning services to 0.39 million (3.9 lakh) additional women.
- To sustain the coverage of 1.02 million (10.2 lakh) women currently using contraceptives



mCPR Projections for Uttrakhand (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

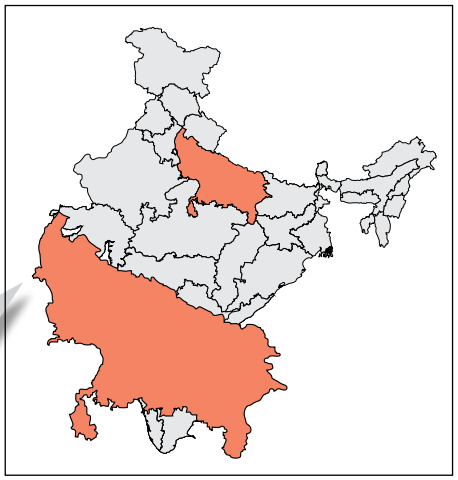
Required Method mix for Uttrakhand by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	69.8		1.41	0.39
Condoms	23.0	33	0.46	0.15
Pills	4.9	7	0.10	0.02
IUCD	3.5	5	0.07	0.06
Male Sterilization	2.1	3	0.04	0.01
Female Sterilization	36.3	52	0.73	0.15

Uttar Pradesh

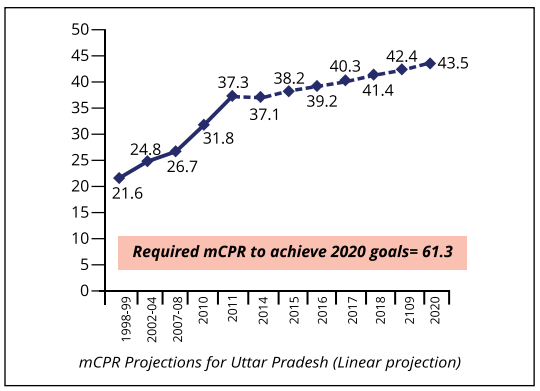
State Profile :

Indicator	Value	Source
Total Population	199,581,477	Census 2011
Unmet Need	24.1	AHS III
CPR (Any Method)	58.6	AHS III
CPR (Modern Method)	37.3	AHS III

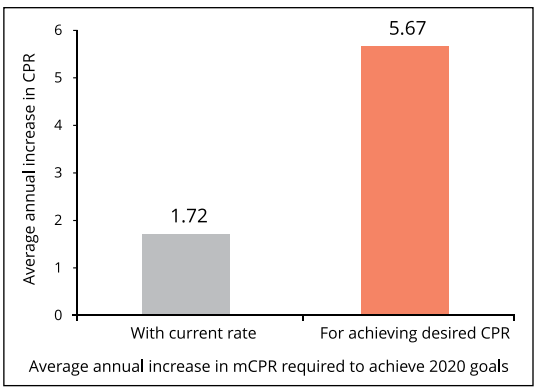


FP 2020 Goal:

- To provide family planning services to 12.4 million (1.24 crore) additional women.
- To sustain the coverage of 12.6 million (1.21 crore) women currently using contraceptives



mCPR Projections for Uttar Pradesh (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

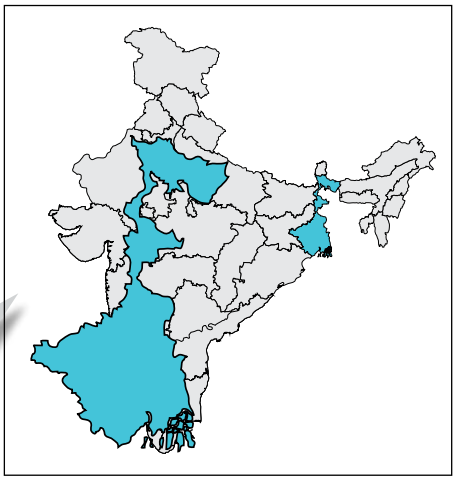
Required Method mix for Uttar Pradesh by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
CPR	61.3		24.51	12.42
Condoms	21.4	35	8.58	4.39
Pills	7.4	12	2.94	1.96
IUCD	3.2	5.3	1.30	0.95
Male Sterilization	0.4	0.7	0.17	0.13
Female Sterilization	28.8	47	11.52	5.00

West Bengal

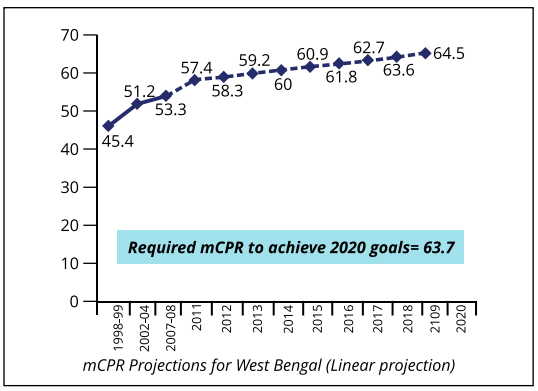
State Profile :

Indicator	Value	Source
Total Population	91,347,736	Census 2011
Unmet Need	11.6	DLHS III
CPR (Any Method)	72.7	DLHS III
CPR (Modern Method)	53.3	DLHS III

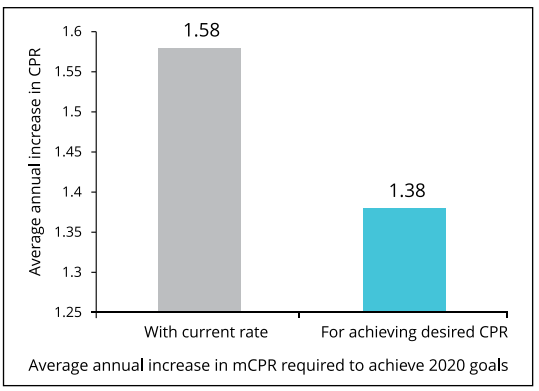


FP 2020 Goal:

- To provide family planning services to 1.96 million (20 lakh) additional women.
- To sustain the coverage of 9.2 million (92 lakh) women currently using contraceptives



mCPR Projections for West Bengal (Linear projection)



Average annual increase in mCPR required to achieve 2020 goals

Required Method mix for West Bengal by 2020

	Required mCPR by 2020 (considering a desirable method mix)	% share	Number of Users (in millions)	Number of Additional Users (in millions)
mCPR	63.7		11.12	1.96
Condoms	5.1	8	0.89	0.18
Pills	20.1	31.5	3.50	0.70
IUCD	1.9	3	0.33	0.25
Male Sterilization	0.3	0.5	0.06	0.06
Female Sterilization	36.3	57	6.34	0.80

Annexure 2: District Roadmap - Guidance Note

1. District Map

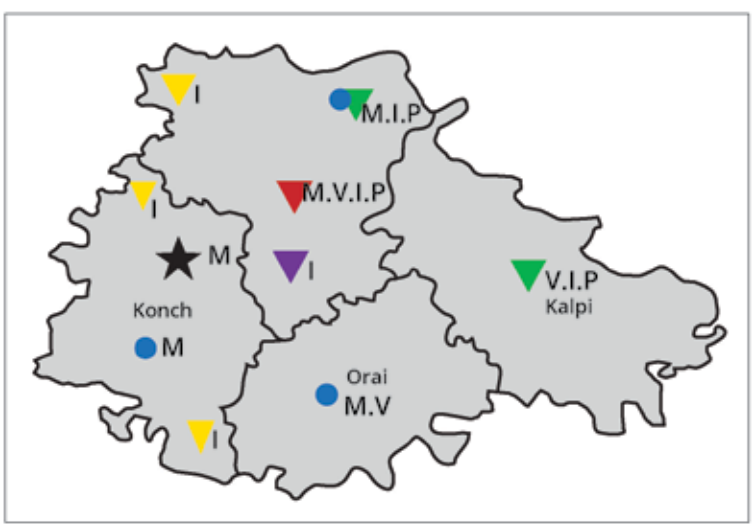
Districts need to make a map showing:

a) Block Boundaries

b) Operational Facilities: Mark all the facilities operational in family planning services (Female sterilization/Male Sterilization/Interval IUCD/PPIUCD)

Instructions for marking:

- Use the symbol (▼) to mark all the functional facilities (the facilities which have reported the services in last six months)
- (▼) Red Colour Symbol for District level Facility; (▼) Green colour symbol for Sub district and CHC; (▼) Purple colour symbol for PHC; (▼) Yellow Colour Symbol for SC
- Additionally mention: M-Minilap, L- Laparoscopic, V-Vasectomy, I-Interval IUCD and P-PPIUCD.
- Mark only the static centres (Static Centres: are the ones providing sterilization services in the health facility by the trained providers posted in the same facility throughout the year on a regular and routine manner)
- For marking other FDS/Camp use the symbol (●)
- Mark ★ for Blocks having accredited private service providers
- For e.g.:



2. District Fact Sheet

Guidance Note for Table 1:

- Mention the district data in the table below.
- Parity Wise Data- Fill in the information as per the District Eligible Couple Survey.

Table 1: Profile of District

	Information	Source
Total Population		**Census/District Survey**
Total number of blocks		
Total Eligible Couples		**District Survey**
Parity Wise Data (As per the household survey by ANM, 2014-15)	**Total Number of Couples (As per the household survey by ANM, 2014-15)**	**Number of couples using modern contraceptive including sterilization (Time of survey)**
i. No. of Eligible Couple with 1 child		
ii. No. of Eligible Couple with 2 children		
iii. No. of Eligible Couple with > 2 children		

Table 2: Training and HR

Data Element	Total number in district
No. of Divisional Training Centres (Medical College/RHFWTC)	
No. of District Training Centres (DH/Medical College etc. where the trainings for NSV/Laparoscopic Sterilization/ Minilap/PPIUCD/Interval IUCD is taking place)	
No. of ANM training centres	
No. Private Health Facilities accredited for sterilization services under NRHM	
No. Private Health Facilities accredited for IUCD services under NRHM	

Table 3: Training details for the district

Method		Total trained provider number in district
Minilap	Specialist and MBBS	
Laparoscopic	Specialist	
NSV	Specialist and MBBS	
Interval IUCD	MO	
	AYUSH	
	SN/LHV/ANM	
PPIUCD	MO	
	AYUSH	
	SN/LHV/ANM	

Write the total number of all the trained providers available in the district.

Table 4: HR Status

Total General Surgeon in the District	No's of Surgeon Providing FP Services	Total Gynecologist in the District	No's of Gynecologist Providing FP Services	Total No Of Anesthetist

Table 5: Expected Level of Achievement

Years	2013-14 ELA	2013-14 achievement	2013-14 achievement (%)	ELA for 2014-15
Female Sterilization				
Male Sterilization				
PPIUCD				
Interval IUCD				
Pills				
Condoms				

3. District Situation Analysis

3.1 Block Wise facility detail:

Guidance Note for Table 6:

- Column 2-3: Name of all the blocks with facility break up should be provided.
- Column 4: Give the total number of facilities block wise.
- Column 5-11: Give the number of Functional Facility.

  Note for Sterilization services only static centres should be enlisted.

  Static Centres are the ones providing sterilization services in the health facility by the trained providers posted in the same facility throughout the year on a regular and routine manner.

- Functional facility means the facilities which have reported services in last six months.

Table 6: Block wise facility detail

1	2	3	4	5	6	7	8	9	10	11
SNo.	Name of Block	Type of Facility	Total Number	Number of Functional Facility						
				Minilap	Laparoscopic	NSV	Interval IUCD	PPIUCD	Conventional Tubectomy	Conventional Vasectomy
1		SDH*								
		CHC								
		PHC								
		SC								
2		SDH*								
		CHC								
		PHC								
		SC								
District Total		DH								
		SDH*								
		CHC								
		PHC								
		SC								

*This includes all public health hospitals at sub district level- Civil Hospital/Taluka Hospital etc.

4. Action Plan 2014-15

4.1 Operational Plan of facilities for year 2014-15

Guidance Note for Table 7:

- Column 2: Name of all the blocks should be provide.
- Column 4: Give the number of facilities.
- Column 5: Delivery Points: Give the number as per the list shared from GoI.
- Column 6-10: Write the number of facilities to be made functional.

(Use the Criteria for selection of facilities for operationalization as mentioned below):

1) Minilap and NSV-

a) Consider the facilities (Upto PHC level) which can be immediately operationalized with the training of provider (specialist/MBBS).

b) Consider the facilities (Upto PHC level) which can be immediately operationalized with the minor repairs and provision of equipment's.

c) Prioritize the high case load facilities (Upto PHC level).

d) Prioritize the blocks where the static centres are not present. *(Static Centres are the ones providing sterilization services in the health facility by the trained providers posted in the same facility throughout the year on a regular and routine manner)*.

Note: Camp approach should not be considered.

2) Laparoscopic-

a) Consider the facilities (DH/SDH/CHC level) which can be immediately operationalized with the training of provider (specialist) or minor repairs and provision of equipment's.

b) Prioritize the blocks where the static centres are not present. *(Static Centres are the ones providing sterilization services in the health facility by the trained providers posted in the same facility throughout the year on a regular and routine manner).*

Note: Camp approach should not be considered.

3) Interval IUCD-

a) Consider the facilities (Upto SC level) which can be immediately operationalized with the training of provider (MO/AYUSH/SN/LHV/ANM).

b) Consider the facilities (Upto SC level) which can be immediately operationalized with the minor repairs and provision of equipment's.

c) Prioritize the high case load facilities (Upto SC level).

d) Prioritize the blocks where the services are not present.

4) PPIUCD-

a) Operationalize at least all delivery points (Upto SC level) in year 2014-15.

Table 7: Block wise number of facilities to be operationalised

1	2	3	4	5	6	7	8	9	10
SNo.	Name of Block	Type of Facility	Total Number to be operationalized	Delivery Point (Number)	Services to be made Functional in 2014-15 (in numbers)				
					Minilap	Laparoscopic	NSV	Interval IUCD	PPIUCD
		DH							
1		SDH							
		CHC							
		PHC							
		SC							
2		SDH							
		CHC							
		PHC							
		SC							

4.2 Details of facilities to be operationalized in 2014-15:

Guidance Note for Table 8:

- Column 2: Name of all the blocks should be provided.
- Column 4-6: Give the name of facilities planned to be operationalized in 2014-15.
- Column 5: Delivery Points: For each facility specify Y/N for delivery points as per the list shared from GoI.
- Column 6-10: Write **Y/N/E** for services to be made functional for each facility listed where **Y** stands for Yes, **N** for 'No' and **E** for already established services.
- Column 11-15: Write **Y/N** for the additional requirement to ensure the operationlization of the services.

Criteria for selection of facilities for operationalization:

1) Minilap and NSV-

a) Consider the facilities (DH/SDH/CHC/PHC level) which can be immediately operationalized with the training of provider (specialist/MBBS).

b) Consider the facilities (DH/SDH/CHC/PHC level) which can be immediately operationalized with the minor repairs and provision of equipment's.

c) Prioritize the high case load facilities (DH/SDH/CHC/PHC level).

d) Prioritize the blocks where the static centres are not present. *(Static Centres are the ones providing sterilization services in the health facility by the trained providers posted in the same facility throughout the year on a regular and routine manner).*

Note: Camp approach should not be considered.

2) Laparoscopic-

a) Consider the facilities (DH/SDH/CHC level) which can be immediately operationalized with the training of provider (specialist) or minor repairs and provision of equipment's.

b) Prioritize the blocks where the static centres are not present. *(Static Centres are the ones providing sterilization services in the health facility by the trained providers posted in the same facility throughout the year on a regular and routine manner).*

Note: Camp approach should not be considered.

3) Interval IUCD-

a) Consider the facilities (DH/SDH/CHC/PHC/SC level) which can be immediately operationalized with the training of provider (MO/AYUSH/SN/LHV/ANM).

b) Consider the facilities (DH/SDH/CHC/PHC/SC level) which can be immediately operationalized with the minor repairs and provision of equipment's.

c) Prioritize the high case load facilities (DH/SDH/CHC/PHC/SC level).

d) Prioritize the blocks where the services are not available.

4) PPIUCD-

a) Operationalize at least all delivery points (DH/SDH/CHC/PHC/SC level) for 2014-15.

Table 8: Details of facilities to be operationalized

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
					Services functional/to be made Functional in 2014-15 (Y-Yes, N-No, E-Established)					Requirements for Operationalization of Facility (Y-Yes, N-No)				
SNo.	Name of Block	Name of Facility	Type of Facility	Delivery Point (Y/N)	Minilap	Laparoscopic	NSV	Interval IUCD	PPIUCD	Infrastructure	HR	Training	Equipment's	Others (specify)

4.3 : Human Resource status of identified facility (Already Trained and To be Trained)

Guidance Note for Table 9:

- Column 2: Name of all the blocks should be provided
- Column 4-12: Give the number of trained providers currently available for each type of service at each level of facility
- Column 13-21: Fill the number of providers to be trained for each type of service at each level of facility according to following criteria:

The criteria below is a minimum training load criteria and will vary as per the case load and state norms.

1. Minilap and NSV-

a) One Provider can be trained in Minilap and NSV at DH,SDH,CHC,PHC respectively
b) MO are eligible for Minilap and NSV training and can be nominated from facilities where functional OT are available.

2. Laparoscopy-

a) One Provider can be trained in Laparoscopy at DH, SDH and CHC respectively.
b) Only Gynecologist and surgeons are eligible for Laparoscopy and should be nominated for training.

3. Interval IUCD:

a) 5 providers can be trained for DH and SDH/CHC respectively-
b) Two providers can be trained for PHC.
c) At SC one ANM can be at least trained.

4. PPIUCD-

a) 9 providers can be trained for DH. (3 MO/AYUSH and 6 SN/LHV/ANM)
b) 5 providers can be trained for SDH/CHC. (2 MO/AYUSH and 3 SN/LHV/ANM)
c) Two providers can be trained for PHC (1 MO/AYUSH and 1 SN/LHV/ANM). For 24*7 PHC the 2 SN/LHV/ANM should be considered for training apart from 1 MO/AYUSH.
d) One provider can be trained for SC

The training load is subject to change as per the HR availability in the facility.

Table 9: Human Resouce status of identified facilities (Trained and to be Trained)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
S No	Name of Block	Type of Facility to be operationalized	Trained Providers Available									Providers to be trained								
			Minilap (Specialist/ MBBS)	Laparoscopic	NSV (Specialist/ MBBS)	Interval IUCD			PPIUCD			Minilap (Specialist/ MBBS)	Laparoscopic	NSV (Specialist/ MBBS)	Interval IUCD			PPIUCD		
						MO	AYUSH	SN/ LHV/ ANM	MO	AYUSH	SN/ LHV/ ANM				MO	AYUSH	SN/ LHV/ ANM	MO	AYUSH	SN/LHV/ ANM
		DH																		
1		SDH																		
		CHC																		
		PHC																		
		SC																		
2		SDH																		
		CHC																		
		PHC																		
		SC																		

Table 9(a): In case the district wants to train additional providers from already operational facilities then it can be reflected in the table below

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
S No	Name of Block	Type of Facility to be operationalized	Trained Providers Available									Providers to be trained								
			Minilap (Specialist/ MBBS)	Laparoscopic	NSV (Specialist/ MBBS)	Interval IUCD			PPIUCD			Minilap (Specialist/ MBBS)	Laparoscopic	NSV (Specialist/ MBBS)	Interval IUCD			PPIUCD		
						MO	AYUSH	SN/ LHV/ ANM	MO	AYUSH	SN/ LHV/ ANM				MO	AYUSH	SN/ LHV/ ANM	MO	AYUSH	SN/LHV/ ANM
		DH																		
1		SDH																		
		CHC																		
		PHC																		
		SC																		
2		SDH																		
		CHC																		
		PHC																		
		SC																		

Guidance Note for Table 10:

This format is to be filled if district has any problem in operationalization of facility identified for year 2014-15

- Column 2: Write the problem identified in operationalization of facility for services.
- Column 3: What possible action is required to solve that identified problem.
- Column 4: Who will take necessary action for the problem identified?
- Column 5: Give the tentative month by when the action will be taken
- Column 6: Mention the level at which problem can be solved.
- Column 7: Mention the supportive supervision plan; clearly mention the frequency of supervision visits in the facilities prioritized and the level at which supervision will be done-for eg. Block/District.

Table 10 : Plan of action

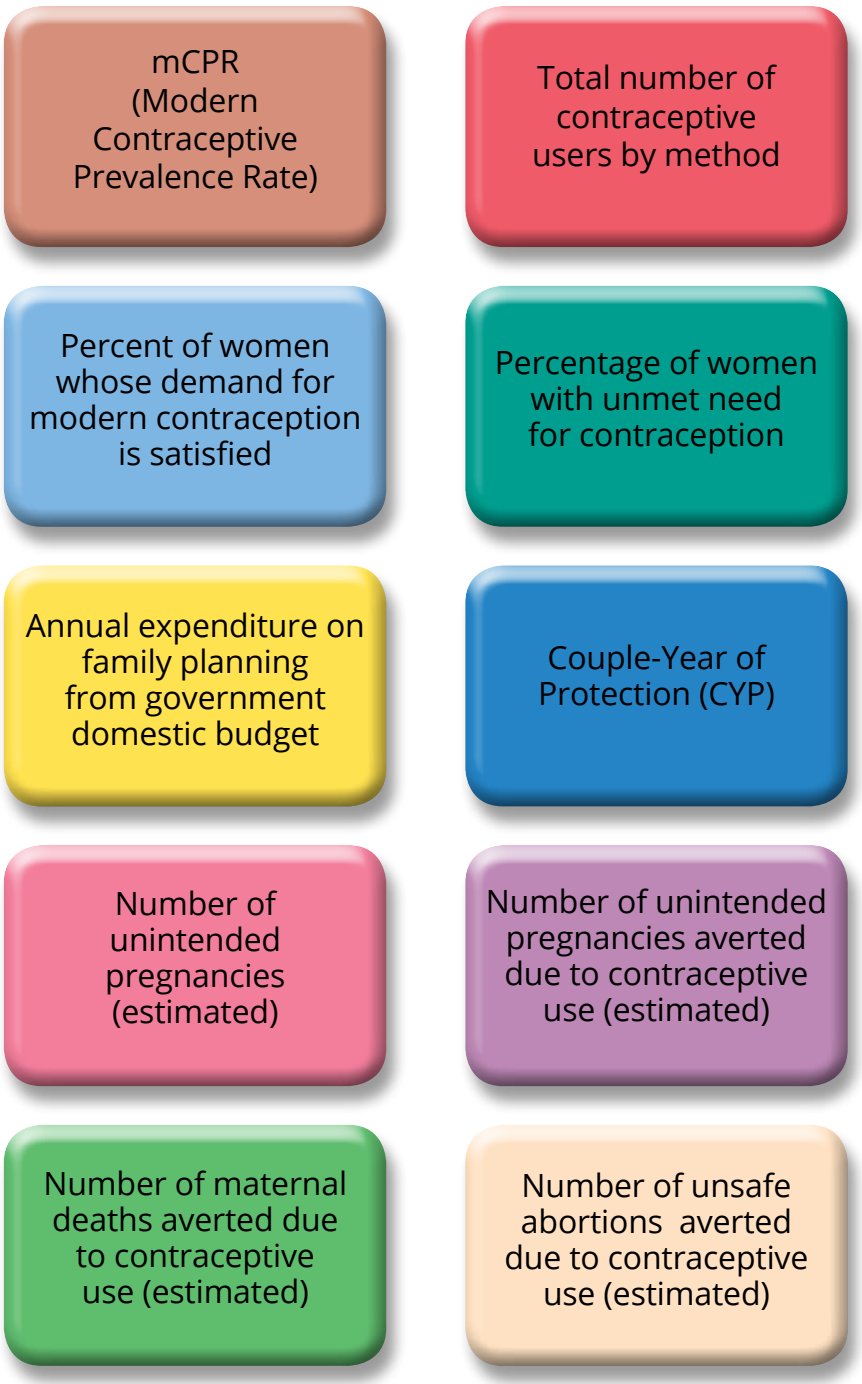
1	2	3	4	5	6	7
S.No	Problem Identified	Action required	Person Responsible	Tentative Timeline for Completion (Mention Month)	Level at which action required (Facility/ District/State/ National)	Supportive Supervision plan (Mention Frequency and the level of supervision)

Annexure 3: Key monitoring indicators

Family Planning Programme Indicators

Input and Process	Output Indicators	Outcome Indicators	Impact Indicators
% of operational facilities for male sterilization	Male Sterilization Coverage Rate	Contraceptive Prevalence Rate for any method	Crude Birth Rate
% of operational facilities for female sterilization	Female Sterilization Coverage Rate	Contraceptive Prevalence Rate for modern method	Age Specific Fertility Rate
% of operational facilities for Interval IUCD	Sterilization Coverage Rate	Contraceptive Prevalence Rate for traditional method	Total Fertility Rate
% of operational facilities for Postpartum IUCD	IUCD Coverage Rate	Contraceptive Prevalence Rate for male sterilization	Births to women during age 15-19 out of total births
% of doctors trained for NSV	PPIUCD Coverage Rate	Contraceptive Prevalence Rate for female sterilization	Women age 20-24 reporting birth of order 2 & above
% of doctors trained for minilap	OCPs Coverage Rate	Contraceptive Prevalence Rate for IUCD	Maternal Mortality Ratio
% of doctors trained for lap sterilisation	Condom Coverage Rate	Contraceptive Prevalence Rate for Condoms	Infant Mortality Rate
% of doctors trained for interval IUCD	% of complications following female sterilization	Contraceptive Prevalence Rate for OCPs	
% of SN/ LHVs trained for interval IUCD	% of complications following male sterilization	Unmet Need for limiting method	
% of doctors trained for PPIUCD	% of IUCD removals out of total IUCD insertions	Unmet Need for spacing method	
% of SN/ LHVs trained for PPIUCD	% of deaths following sterilization	Total Unmet Need	
% of stock utilised Condoms			
% of stock utilised OCPs			
% of stock utilised ECPs			

FP 2020 Core Indicators



Resources

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November 2014

Family Planning Division
Ministry of Health and Family Welfare
Government of India