Chapter 9

Family Planning

9.1 INTRODUCTION

In 1952, India launched the world's first national 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". Since then, the family planning programme has evolved and the programme is currently being repositioned to not only achieve population stabilization but also to promote reproductive health and reduce maternal, infant & child mortality and morbidity.

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

9.2 CURRENT SCENARIO OF POPULATION AND FAMILY PLANNING IN INDIA

Expected increase of population of 15.7% in fifteen years	• From 1210 million in 2011 to 1400 million in 2026.
Decline in Total Fertility Rate(TFR)	• Helps to stabilize India's population growth which in turn spurs the economic and social progress
Greater investments in family planning	• Helps to mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies • Reduce maternal mortality by 35% • Reduce infant mortality and abortions significantly
Govt. of India's commitment by 2015	• Maternal Mortality Ratio (MMR) to 100/100,000 • Infant Mortality Rate (IMR) to 30/1000 live births • Total Fertility Rate (TFR) to 2.1

Factors that Influence Population Growth

Unmet need of Family Planning	• 21.3% as per DLHS-III (2007-08)
Age at Marriage and first childbirth	• 22.1% of the girls get married below the age of 18 years • Out of the total deliveries 5.6% are among teenagers i.e. 15-19 years • Marriages below legal age is more alarming in few states like, Bihar (46.2%), Rajasthan (41%), Jharkhand (36%), UP (33%), and MP (29.2%)
Spacing between Births:	• spacing between two childbirths is less than the recommended period of 3 years in 61% of births (NFHS-3) • 47% of women have spacing less than 30 months
15-25 age group (women)	• 47% contribution in total fertility • 45% contribution in maternal mortality

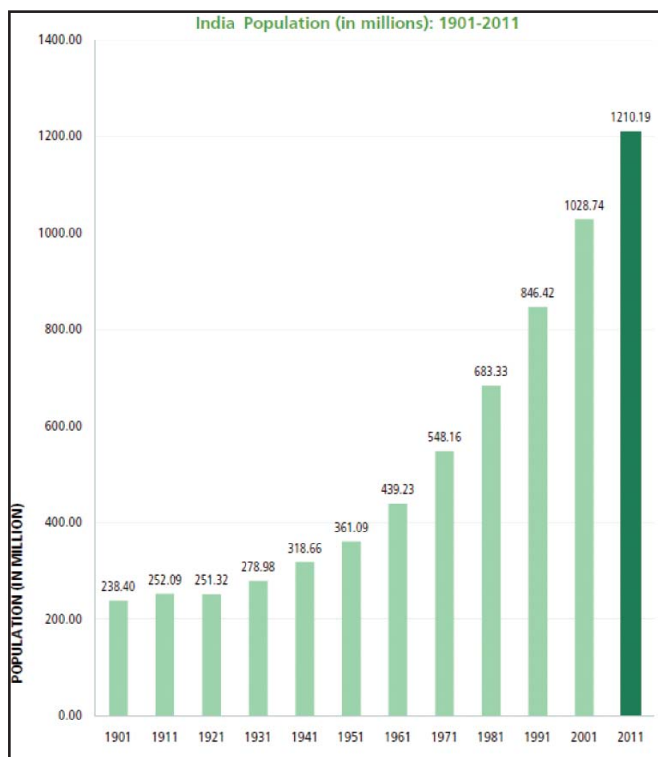
Current Demographic Scenario in the Country (CENSUS 2011)

2.4% of world's land mass	• 17.5% of the world's population
1.21 billion	• India's population as per Census-2011
	• Equal to the combined population of U.S.A., Indonesia, Brazil, Pakistan, Bangladesh and Japan put together (1214.3 million).
200 million	• **Population of Uttar Pradesh** – more than the population of Brazil

Growth of Population in India

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

Perceptible decline (in last 5 decades)	• Crude birth rate – 40.8 per 1000 in 1951 to 22.1 in 2010.
	• Infant mortality rate – from 146 in 1951-61 to 47 in 2010.
	• Total Fertility rate – from 6.0 in 1951 to 2.5 in 2010
	• Steepest decline in growth rate between 2001 and 2011 from 21.54% to 17.64%.
	• Decline in 0-6 population by 3.08% compared to 2001
Population added	• Lesser than the previous decade, 18.14 crores added during 2001-2011 compared to 18.23 crores during 1991-2011.
Significant decline	• There is a 4.1 percentage point fall from 24.99% in 2001 to 20.92% in 2011 in the growth rate of population in the EAG States (U.P, Bihar, Jharkhand, M.P, Chhattisgarh, Rajasthan, Odisha and Uttaranchal) after decades of stagnation.



Progress in TFR

TFR decline	• From 2.9 in 2005 to 2.5 in 2010. • Decline more significant in High Focus States.
TFR of 2.1 or less	• 21 States and Union Territories
TFR 2.1-3.0	• **7 States** – Odisha-2.3, Haryana-2.3, Gujarat-2.5, Assam-2.5, Uttarakhand-2.6, Arunachal Pradesh-2.7 and Chhattisgarh-2.8.
TFR above 3.0	• **7 States** - Bihar-3.7, Uttar Pradesh-3.5, Dadara & Nagar Haveli-3.3, Rajasthan-3.1, Madhya Pradesh-3.2, Meghalaya-3.1 and Jharkhand-3.

Details are given at **Appendix-I**.

Impact of High Focus Approach of the Government of India: Government of India has categorized states as per the TFR level as very high-focus (more than or equal to 3.0), high-focus (more than 2.1 and less than 3.0) and non-high focus (less than or equal to 2.1)

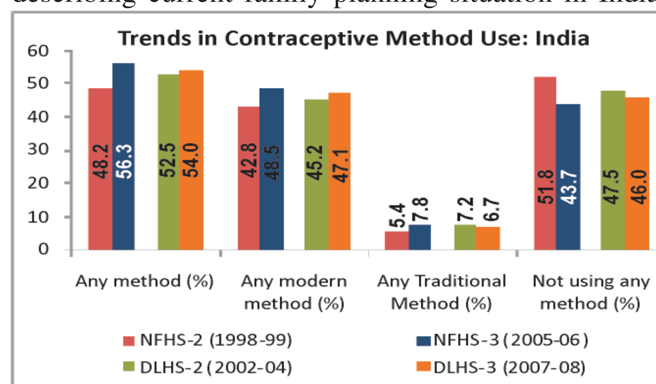
Decline in TFR

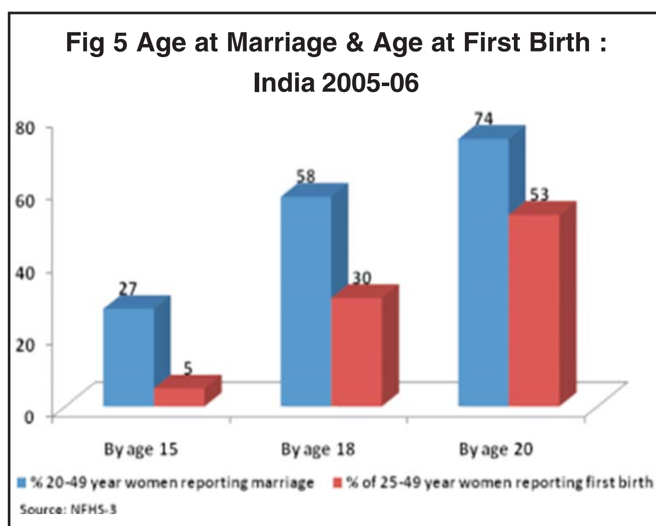
- All the 6 very high focus states except MP have shown a decline of 0.2 points
- Except Gujarat, rest of the high focus states has shown a decline of 0.1 point; Haryana has shown a decline of 0.2 points

Category	State	SRS - 2009	SRS- 2010	Point Change
Very High Focus States for FP	Bihar	3.9	3.7	-0.2
	Uttar Pradesh	3.7	3.5	-0.2
	Madhya Pradesh	3.3	3.2	-0.1
	Rajasthan	3.3	3.1	-0.2
	Jharkhand	3.2	3.0	-0.2
	Chhattisgarh	3.0	2.8	-0.2
High Focus States for FP	Assam	2.6	2.5	-0.1
	Gujarat	2.5	2.5	-0.0
	Haryana	2.5	2.3	-0.2
	Odisha	2.4	2.3	-0.1
Other Non-High Focus States for FP	Karnataka	2.0	2.0	0.0
	Andhra Pradesh	1.9	1.8	-0.1
	Kerala	1.7	1.8	+0.1
	Tamil Nadu	1.7	1.7	0.0

9.2.1 Family Planning Scenario (NHFS, DLHS and AHS)

The last survey figures available are from NFHS-3 (2005-06) and DLHS-3 (2007-08), which are being used for describing current family planning situation in India.





Nationwide, the small family norm is widely accepted (the wanted fertility rate for India as a whole is 1.9 (NFHS-3) and the general awareness of contraception is almost universal (98% among women and 98.6% among men: NFHS-3). Both NFHS and DLHS surveys showed that contraceptive use is generally rising (see adjoining figure). Contraceptive use among married women (aged 15-49 years) was 56.3% in NFHS-3 (an increase of 8.1 percentage points from NFHS-2) while corresponding increase between DLHS-2 & 3 is relatively lesser (from 52.5% to 54.0%). The proximate determinants of fertility like, age at marriage and age at first childbirth (which are societal preferences) are also showing good improvement at the national level. The adjoining figure indicates the current position of social determinants of fertility in the country.

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

- All the states except Uttarakhand has shown an increase in use of any modern contraceptive method.
- The increase has mainly been on account of increase of female sterilisation, which means there has not been much improvement in other methods of family planning.

9.3 CURRENT FAMILY PLANNING EFFORTS

National Policies recognize that lowering Total Fertility Rate would help to stabilize India's population growth, which in turn spurs the economic and social progress. Greater investments in family planning can help mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent recourse to induced abortion and eliminate most of these deaths. It has been estimated that meeting unmet needs for family planning can avert around 50 lakhs child deaths over 8 years in India. Especially in areas with poor health infrastructure, family planning is a cost-effective and feasible way to reduce maternal deaths, as it does not rely on complex technology. It is estimated that if the current unmet need for family planning could be fulfilled over the next 5 years, we can:

- Avert 35,000 maternal deaths
- Avert 1.2 million infant deaths
- Save more than Rs. 4450 crores
- Saving of Rs. 6500 crores, if safe abortion services are coupled with increased family planning services.

Considering the above, a new strategic direction has been developed for family planning programme wherein, it has been repositioned to not only achieve population stabilization but also to reduce maternal mortality as well as infant and child mortality. This strategic direction would be the guiding principle in implementation of family planning programme in future.

Government of India has redesigned its family planning programme to have more focus on spacing methods, especially, IUCD (both post-partum and interval). To strengthen the spacing services, it is envisaged that states would ensure the fixed day service delivery up to the SHC level for IUCD insertions so as to enable clients to avail the services in close vicinity of their community. Services of ASHAs would also be utilized for counseling clients to promote delay in first child birth and healthy spacing between 1st and 2nd child birth. The interventions, activities and performance in the arena of family planning are as follows:

9.3.1 Contraceptive services under the National Family Welfare Programme: The Family Planning methods available currently in India may be broadly divided into two categories, spacing methods and permanent methods. There is another method (emergency contraceptive pill) to be used in cases of emergency.

9.3.1.a Spacing Methods- These are the reversible methods of contraception to be used by couples who wish to have children in future. These include:

A. Oral contraceptive pills

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

B. Condoms

- These are the barrier methods of contraception which offer the dual protection of preventing unwanted pregnancies as well as transmission of RTI/STI including HIV. The brand "Nirodh" is available free of cost at government health facilities and supplied at doorstep by ASHAs for minimal cost[1].

C. Intrauterine contraceptive devices (IUCD)

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

[1]In 233 pilot districts of 17 states, Condoms are not available at SHC and PHC level and supplied by ASHA at doorstep.

9.3.1.b Permanent Methods: These methods may be adopted by any member of the couple and are generally considered irreversible.

A. Female Sterilisation

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

B. Male Sterilisation

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

9.3.1.c Emergency Contraceptive Pill

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

9.3.1.d Other Commodities - Pregnancy Testing Kits

- These are vital for the success of family planning programme. Very simple method which helps detect pregnancy as early as one week after the missed period, thus proving an early opportunity for medical

termination of pregnancy, thus saving lives lost to unsafe abortions.

- If a woman wants to continue the pregnancy then she may get registered for antenatal care and thus reap benefits of care throughout the pregnancy.
- These are available at the subcentre level and also carried by ASHA.

9.3.1.e Service Delivery Points

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

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

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

9.3.2 The Salient Features of the Family Planning Programme

A. On-going interventions:

- More emphasis on Spacing methods like IUCD.
- Availability of Fixed Day Static Services at all facilities.
- Emphasis on minilap tubectomy services because of its logistical simplicity and requirement of only MBBS doctors and not post graduate gynaecologists/surgeons.
- A rational human resource development plan is in place for provision of IUCD, minilap and NSV to empower the facilities (DH, CHC, PHC, SHC) with at least one provider each for each of the services and Sub Centres with ANMs trained in IUD insertion.
- Ensuring quality care in Family Planning services by establishing Quality Assurance Committees at state and district levels.
- Accreditation of more private/ NGO facilities to increase the provider base for family planning services under PPP.
- Increasing male participation and promoting Non-scalpel vasectomy.
- Compensation scheme for sterilization acceptors - under the scheme MoHFW provides compensation for loss of wages to the beneficiary and also to the service provider (& team) for conducting sterilisations.
- 'National Family Planning Insurance Scheme' (NFPIS) under which clients are insured in the eventualities of deaths, complications and failures following sterilization. The providers/ accredited institutions are indemnified against litigations in those eventualities.
- Improving contraceptives supply management up to peripheral facilities.
- Demand generation activities in the form of display of posters, billboards and other audio and video materials in the various facilities.
- Strong political will and advocacy at the highest level, especially in states with high fertility rates.

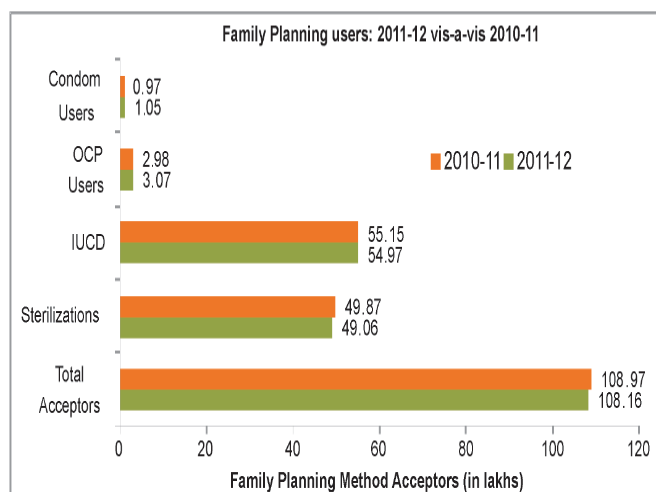
B. New interventions to improve access to contraception:

- A new scheme has been launched to utilize the services of ASHA to deliver contraceptives at the doorstep of beneficiaries. Scheme is being implemented in 233 districts of 17 states. ASHA is charging a nominal amount from beneficiaries for her effort to deliver contraceptives at doorstep i.e. Re 1 for a pack of 3 condoms, Re 1 for a cycle of OCPs and Rs 2 for a pack of one tablet of ECP.
- Under a new scheme launched by the Government of India, services of ASHAs to be utilised for counselling newly married couples to ensure spacing of 2 years after marriage and couples with 1 child to have spacing of 3 years after the birth of 1st child. The scheme is operational in 18 states (EAG, NE and Gujarat and Haryana). ASHA would be paid following incentives under the scheme:
  - Rs. 500/- to ASHA for delaying first child birth by 2 years after marriage.
  - Rs. 500/- to ASHA for ensuring spacing of 3 years after the birth of 1st child
  - Rs. 1000/- in case the couple opts for a permanent limiting method up to 2 children only
- MoHFW has introduced short term IUCD (5 years effectivity), Cu IUCD 375 under the National Family Planning programme. Training of state level trainers has already been completed and process is underway to train service providers up to the sub-center level.
- A new method of IUCD insertion (post-partum IUCD insertion) has been introduced by the Government.
- Promoting Post-partum Family Planning services at district hospitals by providing for placement of dedicated Family Planning Counsellors and training of personnel.

9.3.3 Progress Made under Family Planning Programme

Service Delivery 2011-12: The performance of family planning services during 2011-12 is provided below (source: HMIS):

- Number of IUCDs and sterilisations have remained static in spite of declining CBR and TFR. There is



a need to sustain momentum to reach the replacement level fertility.

- Considering the current efforts to focus on spacing, it is expected that IUCD performance would increase in near future.

- State wise sterilisation and IUCD achievements is provided at **Appendix-II.**

9.3.4 Promotion of IUCDs as a short & long term spacing method

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

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

Actions taken and achievements

- Approval of around Rs. 44 crores in 2012-13 PIP for IUCD training.

- HLFPPT has been engaged to support states to conduct interval IUCD training and also post training follow-up of trained personnel. HLFPPT would also follow-up sample cases of IUCD insertion to ensure retention.

- Directive has been issued to the states to notify fixed days/ per week at SHC and PHC level for conducting IUCD insertions.

- IUCD training has been proposed for around 32000 personnel in current year.

- Introduction of **Cu IUCD-375** (5 years effectivity) under the Family Planning Programme:

  - o Training of state master trainers completed in December 2011.

  - o Sample Cu IUCD 375 dispatched to states for conducting district level training

  - o Funds approved under PIP for conducting training and orientation of other staff

9.3.5 Emphasis on Postpartum Family Planning (PPFP) services

- In order to capitalize on the opportunity provided by increased institutional deliveries, the Government of India is focusing on strengthening post-partum FP services.

- PPFP services are not being offered uniformly at all levels of health system across different states of India resulting in missed opportunities.

- Insertion of IUCD (CuT 380 A) during the post partum period, known as Postpartum Intrauterine Contraceptive Device (PPIUCD), is being focused to address the high unmet need of spacing during postpartum period.

Actions taken and achievements

- **Strengthening Post-Partum IUCD (PPIUCD) services at high case load facilities**

  - o Currently the focus is on placement of trained providers for PPIUCD insertion at district and sub-

district hospital level only, considering the high institutional delivery load at these facilities.

- o Jhpiego is providing technical support to 6 high focus states (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan and Uttar Pradesh) to train service providers at DH and SDH level.
- o Other than these 6 states, other states have also proposed for PPIUCD training and budgeted under 2012-13 PIP. Around Rs. 2.97 crores has been approved for training of 6000 personnel in PPIUCD.

- **Training of MOs in Minilap:** Minilap training is important in the high case load facilities for provision of Post-Partum Sterilisation (PPS). Considering that there is no need for a gynaecologist/ surgeon to provide Minilap sterilisation, a trained MBBS doctor can provide this service:

- o As per the PIP around 5000 personnel have already been trained in Minilap.
- o Training of over 3000 doctors has been proposed in the PIP for 2012-13 at a cost of Rs. 4.35 crores.

- **Appointing dedicated counsellors at high case load facilities**

- o MoHFW has decided to appoint counsellors at all high case load facilities to provide counselling services in following areas:

- ▪ Post-partum Family Planning (IUCD and Sterilisation)
- ▪ Other family planning methods such as condoms, pills etc.
- ▪ Ensuring healthy timing and spacing of pregnancy
- ▪ Mother & baby care
- ▪ Early initiation of breast feeding
- ▪ Immunization
- ▪ Child nutrition.

- o Government of India has approved around Rs. 12.60 crores for appointment of 1275 counsellors

9.3.6 Assured delivery of family planning services

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

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

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

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

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

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

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

Actions taken and achievements

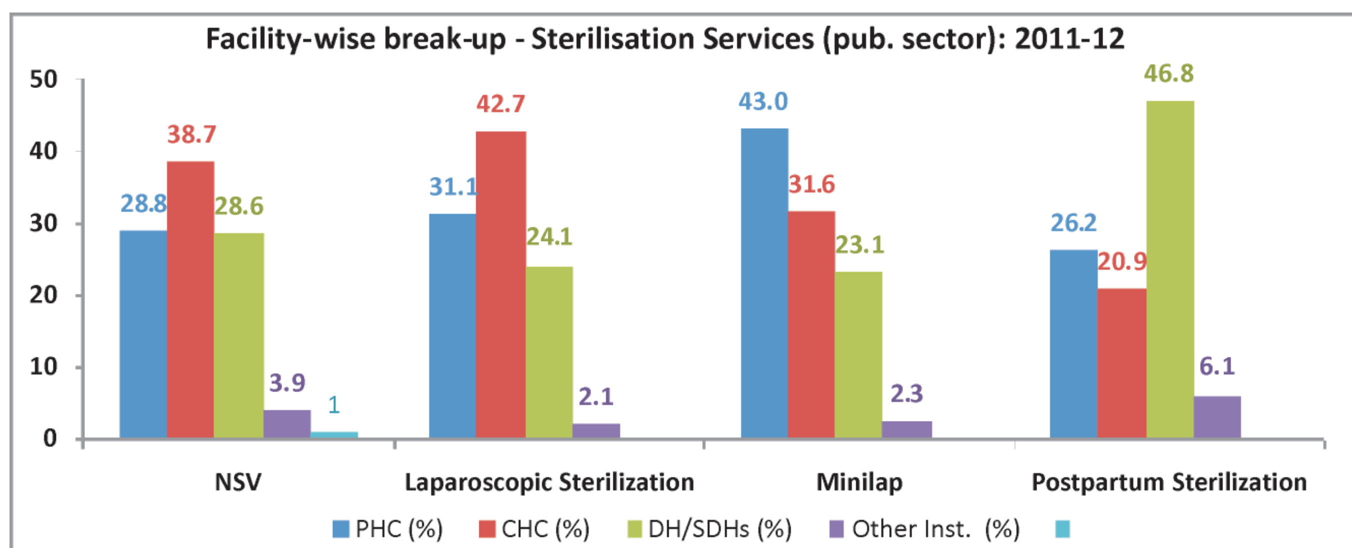
- In year 2012-13 all the states have shown their commitment to strengthen fixed day family planning services for both IUCD and sterilisation and it has been included under quarterly review mechanism to assess progress made by the states:

S.No.	State	Fixed Day Services for IUCD	Fixed Day Services for Sterilisation
High Focus State			
1	Bihar	534 PHCs + all DH and SDH	PHC - 534, DH-36 & SDH-46
2	Chhattisgarh	2 days/ week at PHCs and SHCs. At DH, FRU and CHCs on daily basis	15 DH and 75 FRU
3	Himachal Pradesh	Weekly except Shimla (twice/ week) and L & Spiti (no FDS)	All DH
4	Jammu & Kashmir	Sub-Centre level 2 -Tuesdays and Fridays	52 Facilities
5	Jharkhand	DH, CHC and PHC	170 facilities both for Male & female Sterilization
6	Madhya Pradesh	3 days/ week - DH - 50 & SH-56 2 days/ week - CHC - 333 SHC-1 day/ week	DH - 50 - Daily CH - 56 - Daily CHC - 333 - 2 days/ weekPHC - 2 days/ week
7	Odisha	793 DPs of L3- FRU, L2 -24x7 & L1 and V4 SCs	FS - (FRU - 145, 24x7 PHC - 319)MS - (FRU & 24x7 PHC - 136, others - 3)
8	Rajasthan	12, SH-6, CHC-380, PHC-1528, SC-11487(13447)	212 facilities
9	Uttar Pradesh	Existing: 992 facilities Proposed: 500 NPHCs + 1500 SHCs	FS - (51 - DWH, 15 DCHs and 66 FRUs) MS - (45 DMHs + 15 proposed)
10	Uttarakhand	SHC - 1765 PHC - 239	40 (CHCs + DH)
NE States			
1	Arunachal Pradesh	1) Once weekly SCs-301 2) Twice weekly in PHCs-2 & CHCs-25	1) Twice weekly in 13 FRUs 2) Once weekly (24x 7) in 29 PHCs
2	Assam	CH and CHC/ FRU/ BPHC/ PHC and SHC	FS (DH-21 & FRU-39)MS (BPHC-149)
3	Manipur	SHC – 30 & PHC – 40	FS (RIMS & JNIMS) MS (16 DH/ CHC/ PHC)
4	Meghalaya	39 Health Facilities (SCs, PHCs and CHCs)	DH- dailySDH-bi-weekly Fixed Days at 28 CHCs & all FRUs
5	Mizoram	Twice a week CHCs-9, SDH-2, PHCs -40	FS Monthly once at CHCs -9, PHCs -41
6	Nagaland	SC 397; PHC 125; CHC 21; DH 11	1. F.S in 11 DHs weekly 2. M.S Monthly at 3 DHs

S.No.	State	Fixed Day Services for IUCD	Fixed Day Services for Sterilisation
7	Sikkim	**Not provided**	**Not provided**
8	Tripura	91 Facilities (Weekly at PHC & CHC)	Both F.S & M.S Weekly once on fixed day at 2 DHs & 2 SHs
Other States			
1	Andhra Pradesh	SHC - 301; PHC - 29; CHC - 25	FRU - 13 (MS & FS); 24x7 - 29 (FS)
2	Goa	All DHs/ CHCs/ PHCs	FS - 6 facilities MS - 4 facilities
3	Gujarat	PHC - 104 SHC - 688	FS (104-PHCs & 136-DH/ FRUs) MS (45-DH / SDH)
4	Haryana	Daily - 22 DH, 29 SHD and 50 CHCs. Twice/ week - 330 PHC and 1300 SHC	DH-21; SDH-25; CHCs-93; PHCs-140
5	Karnataka	PHC and SHC - Tuesday & Friday	AT all DH & SDH
6	Kerala	1061 facilities	FS – (SDH – 80, DH – 26, W&C – 7) MS – (SDH – 80, DH – 26)
7	Maharashtra	23 DH; 9 WH; 4 GH; 24 SDH (100 bed); 56 SDH (50 bed); 386 RH and 1816 PHCs	23 - DHs; 9 - WHs; 4 GHs (200 bed); 24 - SDHs (100 bed); 56 - SDHs (50 bed); 386 - RHs; 1577 - PHCs
8	Punjab	170 facilities	170 facilities
9	Tamil Nadu	Wkly once - HSC, PHC, UFWC, HPC. Daily - PPCs	F.S: 639 facilities M.S: 97 facilities
10	West Bengal	PP Units - daily8000 SHC - Thursday	FS (DH-15, SDH-56 & CHC - 349) MS (DH-15, SDH-45 & CHC - 296)
Union Territories			
1	A&N Islands	**Not provided**	**Not provided**
2	Chandigarh	**Not provided**	**Not provided**
3	D&N Haveli	All DHs/ CHCs/ PHCs	FS - 6 facilities MS - 4 facilities
4	Daman & Diu	**Not provided**	**Not provided**
5	Delhi	FRU/DH:25; SDH:17; CHC/MH :30; DGD : 210; MCWs : 110; ESI disp :18; Seed PUHC: 57; CGHS disp. :50; IPP VIII : 15	23 DH,02 - maternity homes & 01 IPP VIII centre
6	Lakshadweep	**Not provided**	**Not provided**
7	Puducherry	**Not provided**	5 facilities for female sterilisation

- FDS guidelines have been disseminated to all the states; recent filed visits and review missions to the states reveal that most of the facilities at the level of CHC and above have been operationalised for providing FP services on fixed day basis.
- Guidelines for "Standard Operating Procedures for sterilization services in camps" were developed, printed and disseminated to all the states.
- "Guidelines for Clinical Skill Building Trainings in Male and Female Sterilization Services" were developed and disseminated to all states.
- Analysis of the data available from HMIS for 2011-12 reveals that:

o Around 68% of NSVs are conducted at PHC and CHC level



Above chart reflects that FDS approach for sterilisation is taking slow but steady root.

o Majority of minilap sterilisations (43%) are conducted at PHC level followed by 31.6% at CHC level

o Although data shows that 31% laparoscopic sterilisation is conducted at PHCs, this may not be correct considering laparoscopic sterilization requires services of specialists. However, it is important to note that majority of laparoscopic sterilisation (43%) is conducted at CHC level.

o As anticipated around 47% of the PPS is reported at DH/ SDH level since majority of institutional deliveries are conducted at these facilities; however, this needs to increase at PHC and CHC level as well:

9.3.7 Quality assurance in family planning

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

- Creation of panel of Doctors/health facilities for conducting sterilization procedures and laying down of criteria for empanelment of doctors for conducting sterilization procedures.
- Laying down of checklist to be followed by every doctor before carrying out sterilization procedure.
- Laying down of uniform proforma for obtaining of consent of person under Government of Indiang sterilization.
- Setting up of Quality Assurance Committee for ensuring enforcement of pre and postoperative guidelines regarding sterilization procedures.

- Bringing into effect an insurance policy uniformly in all States for acceptors of sterilizations etc.

Actions taken and achievements

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

- **Standards for Female and Male Sterilisation Services (2006)**

o It sets out the criteria for eligibility, physical requirements, counselling, informed consent, preoperative, postoperative, and follow-up procedures and procedures for management of complications and side effects.

- **Quality Assurance Manual for Sterilization Services (2006)**

o It sets out modalities for formation of Quality Assurance Committees (QACs) at state and district whose main functions include:

▪ Empanelment of doctors for sterilization procedures

▪ Accreditation of private/NGO facilities

▪ Review/report post sterilization deaths/ complications /failures

- **Standard Operating Procedure (SOP) for Sterilisation Services in camps (2008)**

o It mandated that all Sterilization Camps must be organized only at established health care facilities as laid down in the Standards by GOVERNMENT OF INDIA.

- **Fixed Day Static approach for Sterilization Services (2008)**

o To consciously move from a camp approach to a regular routine service, to make the facility self-sufficient in provision of sterilization services.

- **Family Planning Insurance Scheme**

o For the acceptors of Sterilization for treatment of post-operative complications, failure or death attributable to the procedure of sterilization.

- MoHFW, Family Planning Division has recruited technical experts to support states in improving delivery of quality services

9.3.8 Other promotional schemes

9.3.8.a Revised compensation scheme for acceptors of sterilization:

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

For Public (Govt.) facilities

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

Category	Type of operation	Facility	Motivator	Total
High focus states	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**

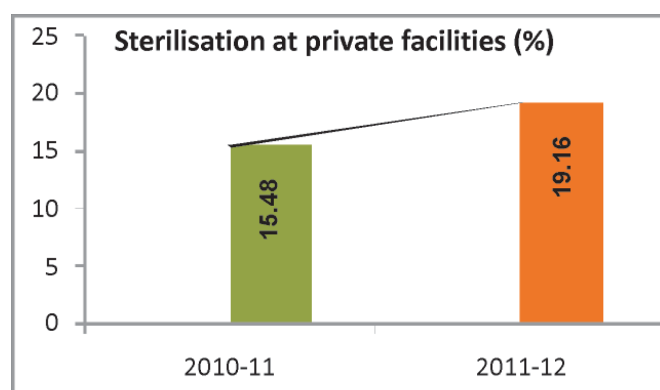
9.3.8.b National Family Planning Insurance Scheme (NFPIS)

With a view to do away with the complicated process of payment of ex-gratia to the acceptors of Sterilization for treatment of post-operative complications, failure or death attributable to the procedure of sterilization, the Family Planning Insurance Scheme was introduced w.e.f. 29th November, 2005. It also provides indemnity cover to the doctor / health facility performing Sterilization procedure.

- The scheme is currently in implementation with ICIC I Lombard.
- Payment to 438 complicated cases, 18887 failure cases and 675 death cases has been done between 2008 and March 2012.

9.3.8.c Public Private Partnerships (PPPs)

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



- Accreditation and empanelment of private health facilities /healthcare providers is decentralized to District Quality Assurance Committees (DQAC).
- Sterilisation services at private facilities have improved in 2011-12 compared to 2010-11.
- Top five and bottom five states in terms of sterilisation services at private facilities:

SN.	State	Sterilisation at private facilities (%) 2010-11	2011-12	Change (% point)
Top five states				
1	**Kerala**	46.90	49.23	2.33
2	**Andhra Pradesh**	40.57	39.77	-0.81
3	**Daman & Diu**	34.78	33.99	-0.80
4	**Tamil Nadu**	34.99	33.89	-1.10
5	**Bihar**	15.92	31.01	15.09
Bottom five states				
1	**Uttarakhand**	0.41	0.00	-0.41
2	**Arunachal Pradesh**	2.23	0.00	-2.23
3	**Sikkim**	2.51	0.00	-2.51
4	**A &N Islands**	0.00	0.00	0.00
5	**Lakshadweep**	0.00	0.00	0.00
	INDIA	**15.48**	**19.16**	**3.68**

9.3.8.d Scheme of Home delivery of contraceptives by ASHAs at doorstep of beneficiaries

- Community based distribution of contraceptives by involving ASHAs and focused IEC/BCC efforts are undertaken for enhancing demand and creating

awareness on family planning. To improve access to contraceptives by the eligible couples, services of ASHA are utilised to deliver contraceptives at the doorstep of beneficiaries. The initiative is currently implemented in 233 districts in 17 States on a pilot basis (**as per list at Appendix-III**). The scheme is expected to be rolled out in all the districts of the country.

- 3 independent agencies evaluated the scheme and following points emerged out of it:

o Majority (62 %) respondents have heard of the scheme from ASHA. In other words, ASHA has been communicating on the scheme to the community;

o Nearly, 78 % of those she visited, said that ASHA was able to explain and counsel on the use of contraceptives

o 95% of the women beneficiaries (interviewed) were completely satisfied with the Scheme;

o 65 % of those who procured from ASHA cited easy access as the reason. In other words, ASHA is emerging as an important source on account of her easy access.

o Of the respondents who were provided contraceptives by ASHA, 53 % were willing to pay.

o 86% ASHAs believed that the Scheme including payments will be successful in the longer term.

o 50% of the ASHAs indicated positive community response.

o ASHAs feel empowered and have expressed confidence in distributing contraceptives to beneficiaries, irrespective of receiving any payment by beneficiaries.

9.3.8.e Scheme for ASHAs to ensure spacing in births

- Under the scheme, services of ASHAs to be utilised for counselling newly married couples to ensure spacing of 2 years after marriage and couples with 1 child to have spacing of 3 years after the birth of 1st child.

- The scheme is being implemented in 18 states of the country (8 EAG, 8 NE, Gujarat and Haryana)

- ASHA would be paid following incentives under the scheme:

o Rs. 500/- to ASHA for ensuring spacing of 2 years after marriage.

o Rs. 500/- to ASHA for ensuring spacing of 3 years after the birth of 1st child

o Rs. 1000/- in case the couple opts for a permanent limiting method up to 2 children only

- The scheme is operational from 16th May 2012.

9.3.9 Celebration of World Population Day & fortnight (July 11 – 24, 2012)

- The World Population Day was celebrated in the country in all states (except Assam) in **5530 blocks of 621 districts** in all the states.

- The event was observed over a month long period, split into an initial fortnight of mobilization/sensitization followed by a fortnight of assured family planning service delivery.

o **June 27 to July 10, 2012: "Dampati Sampark Pakhwada"** or "Mobilisation Fortnight" was organised.

o **July 11 to July 24, 2012 "Jansankhya Sthirtha Pakhwada"** or "Population Stabilisation Fortnight" was organised.

- For the first time in the last three years, the states projected funds for WPD in their annual PIP which was duly approved so that they did not face any fund crunch and could accomplish their plans well.

- 1 Chief Minister, 1 Dy Chief Minister and 10 Health Ministers inaugurated the function in different states. In other states/ UTs functions were inaugurated by film celebrities, senior government officials, elected representatives etc.

- In addition to the district hospitals, facilities at the block level like FRUs and Block PHCs were also activated as Post-Partum Centres with a team of doctors and nurses, assigned to the centre for the whole week to provide tubectomy, vasectomy and IUD services in addition to the OCPs and CCs.

- NGOs were also involved in the states to provide services during the fortnight.

Key findings

- Overall performance during the fortnight is placed below:

S. No.	Method	2011	2012	% change
1	IUD Insertion	322164	435986	**35.33**
2	Sterilisation			
•	Female	150540	201715	33.99
•	Male	16376	16873	3.03
	Total Sterilisation	**166916**	**218588**	**30.96**

- Above Table reflects that there is a significant increase reported in total number of IUCDs and sterilisations during the "Population Stabilisation Fortnight".

- While most of the states reported improvement in performance over previous year, there are some states which showed decline and this could be due to lack of monitoring from the state level:

  - IUCD – Odisha, Uttar Pradesh, Meghalaya, Tripura, Andhra Pradesh and Himachal Pradesh

  - Sterilisation – Jharkhand, Madhya Pradesh, Uttarakhand, Arunachal Pradesh, Meghalaya, Andhra Pradesh, Gujarat, Himachal Pradesh.

- In the past 3 years, with intensive advocacy/ awareness campaign during the WPD and linked with assured service delivery has resulted in breaking the seasonal phenomenon of conducting sterilisations only in the winter months, in the country.

- The awareness campaigns have highlighted the positive impact of Family Planning on maternal and child health in addition to population stabilisation.

- Many of the states were organising this event for the first time and showed keen interest and enthusiasm.

- In various states, government functionaries beyond departmental boundaries were involved in the event.

- Performance during the WPD campaign also shows that states can provide FP services and information throughout the year with same intensity through meticulous planning for HR, logistics and commodities. This would help in meeting the unmet need for family planning.

- Performance has been better in those states where the district collectors were enlisted through government orders from the level of Chief Secretary/ Principal Secretaries of Health.

9.4 KEY CHALLENGES & OPPORTUNITIES

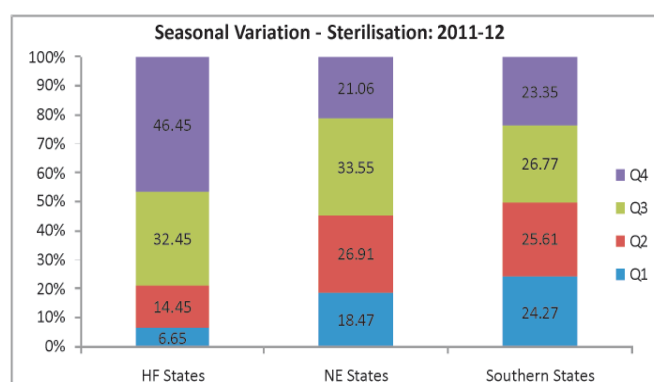
9.4.1 Unavailability of regular sterilization services

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

  - lack of trained service providers specially in minilap & NSV at the CHCs and PHCs

  - Lack of willingness to plan for provision of services across the year

  - poor facility readiness

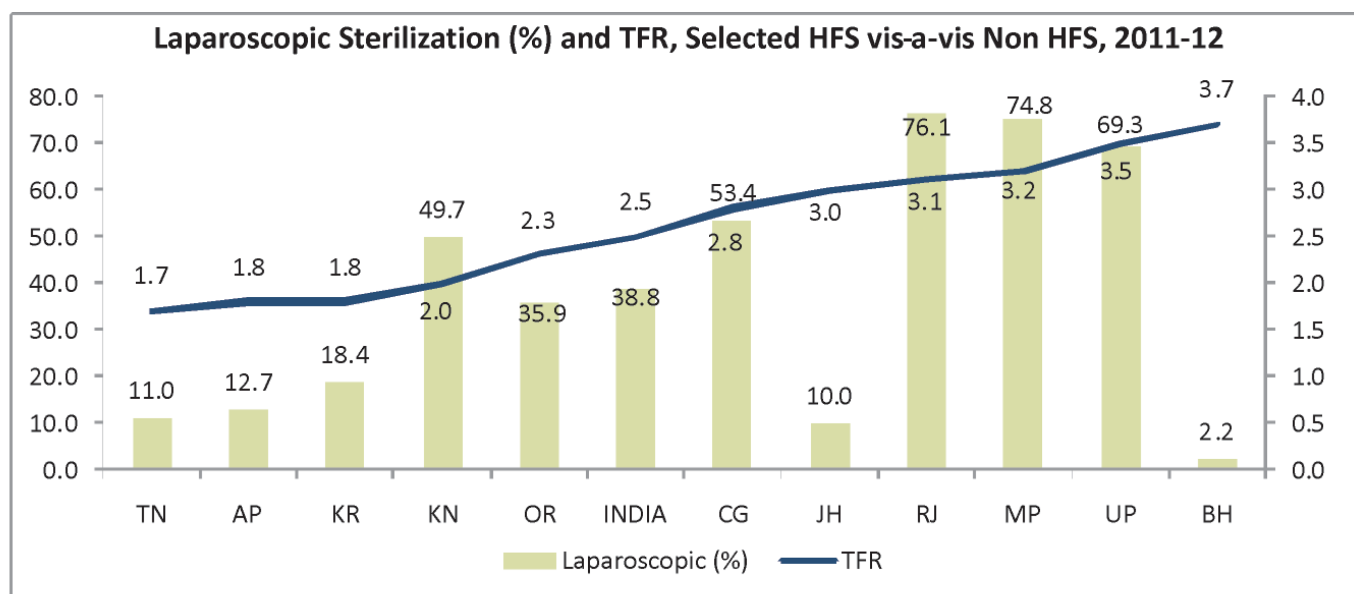


- Above chart clearly reflects that majority of sterilisations in high focus states (79%) are conducted in last 2 quarters.
- NE states are relatively better; however, sterilisation services are not equally distributed across year.
- Southern states provide uniform services arcos the year which also reflects on their outcomes.
- Effort has been made through 15 days long "Population Stabilisation Fortnight" during the celebration of Word Population Day 2012; it has been observed that with concerted efforts and detailed micro-planning, services can be delivered during any time of the year.
- Data from 2011-12 shows that as compared to 2010-11 there has been some improvement in the sterilisation service delivery in 1st 2 quarter in high focus states:

Category of State	Q1			Q2			Q3			Q4		
	2011	2012	% Change	2011	2012	% Change	2011	2012	% Change	2011	2012	% Change
High Focus states	5.41	6.65	**1.24**	13.42	14.45	**1.04**	32.92	32.45	**-0.47**	48.25	46.45	**-1.81**
NE States	19.83	18.47	**-1.36**	23.56	26.91	**3.35**	21.00	33.55	**12.55**	35.61	21.06	**-14.55**
Southern States	26.28	24.27	**-2.00**	25.59	25.61	**0.02**	26.86	26.77	**-0.09**	21.28	23.35	**2.08**

9.4.2 Heavy reliance on expensive, technically and logistically high-demanding laparoscopic sterilizations:

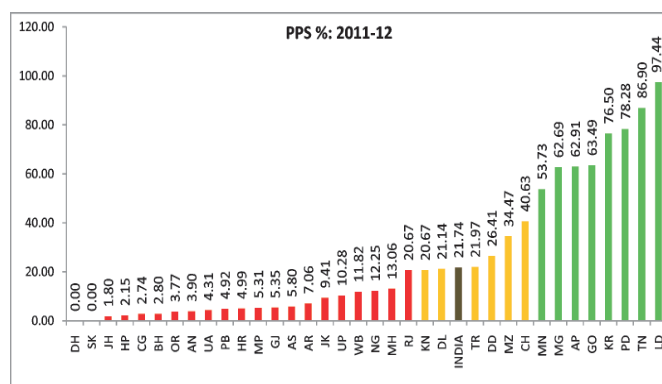
- As evidenced in figure below, the southern states, except Karnataka, show a very low proportion of laparoscopic sterilizations; only Bihar and Jharkhand out of high focus states show low proportion of laparoscopic sterilisation; however, these states do not follow minilap technique and primarily conventional tubectomy is conducted.
- In most of the high focus states, with the exception of Bihar and Jharkhand, laparoscopic female sterilization remains the predominant procedure:



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

9.4.3 Increased institutional delivery vs. PPFP

- The huge potential for postpartum contraception offered by the increasing number of institutional deliveries has not been tapped adequately due to lack of planning, lack of trained postpartum family planning service providers and lack of infrastructure in most of the high focus states.

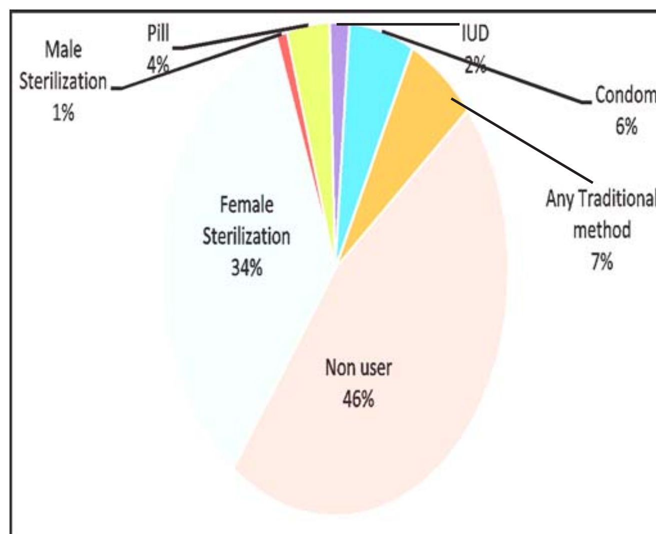


This is evident from following figure, which shows that in high focus states postpartum sterilization is very low (2-20%) as compared to 70-80% in non-high focus states like Kerala and Tamil Nadu

9.4.4 Inadequate attention to spacing methods

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

- Latest survey data of AHS 2010 reflects that the districts/ states with very good CPR for modern



methods have not focused on IUCD and it is highly skewed towards female sterilization. The highest IUCD usage has been reported by Kokrajhar district of Assam; however, it is still very low (5.7%). Almost all the districts have reported IUCD usage less than 2% (267 out of 284 districts surveyed), which is a matter of concern.

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

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

9.5 FUTURE STRATEGIES

- Greater emphasis on spacing methods:
  - Interval and Post-partum IUCD training
  - Strengthening fixed day IUCD services
- Focus on revitalising Post-partum FP delivery system through strengthening district hospitals in focused states to provide PPFP services along with good counselling.

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

- Strengthening management systems at national, state, district and block levels by infusing public health management professionals at these levels.
- Addressing social determinants such as education, delay age at marriage etc. through communication.
- Strengthening contraceptive supply and availability at every level.

9.6 CONTRACEPTIVES IN THE NATIONAL FAMILY WELFARE PROGRAMME

The Department of Health and Family Welfare is responsible for implementation of the National Family Welfare Programme by interalia, encouraging the utilization of contraceptives and distribution of the same to the States/UTs through Free Supply Scheme and Public-Private Partnership (PPP) under Social Marketing Scheme. Under Free Supply Scheme, contraceptives, namely, Condoms, Oral Contraceptive Pills, Intra Uterine Device (Cu-T), Emergency Contraceptive Pills and Tubal Rings are procured and supplied free to the States/UTs.

The channel for supply of these contraceptives under Free Supply Scheme is Government network comprising Sub-Centers, Primary Health Centers, Community Health Centers and Govt. Hospitals, State AIDS Control Societies throughout the country.

Procurement Procedures: Orders are placed on HLL Life Care Ltd. (a PSU under the Ministry) for procurement of contraceptives being manufactured by them as per Govt. instructions. For the remaining quantities, tenders are solicited from the firms through Advertised Tender Enquiries for concluding Rate Contracts. Rate Contracts are concluded with the manufacturers and Supply Orders are placed upon them as per their competitive rates and the capacity to manufacture the items.

Quality Assurance: Manufacturers do in-house testing of stores before offering them for inspection. At the time of acceptance of stores, all the batches are tested and thereafter stores are supplied to the consignees.
The quantities given to the States under Free Supply Scheme during the last two years and the current year (upto November, 2012) along with the budget utilized are given in the following tables:

Quantities supplied to States/UTs

Contraceptives	2010-11	2011-12	2012-13 (upto Nov. 12)
Condoms (in million pieces)	290.137	295.000	327.313
Oral Pills (in lakh cycles)	237.998	298.135	220.210
IUDs (in lakh pieces)	90.000	73.500	64.170
Tubal Rings (in lakh pairs)	34.534	30.359	31.22
ECP(in lakh packs)	21.540	18.300	39.29
Pregnancy Test Kits(in lakhs)	211.74	211.74	0.000

Budget Utilization

(Rs. in crore)

Contraceptives	2010-11	2011-12	2012-13 (up to Nov.,12)
Condoms	44.420	53.327	59.168
Oral Pills	7.973	9.697	7.162
IUDs	17.721	15.986	13.957
Tubal Rings	4.403	4.372	4.496
ECP	1.723	0.485	1.041
Pregnancy Test Kits	22.89	22.89	0.000

9.6.1 Social Marketing Scheme

The National Family Welfare Programme initiated the Social Marketing Programme of Condoms in 1968 and that of Oral Pills in 1987. Under the Social Marketing Programme, both Condoms and Oral Pills are made available to the people at highly subsidized rates, through diverse outlets. The extent of subsidy ranges from 70% to 85% depending upon the procurement price in a given year. Both these contraceptives are distributed through Social Marketing Organizations (SMOs).

The SMOs are given Deluxe Nirodh condom at Rs.2.00 per packet of 5 pieces and this is sold @ Rs.3/- per packet of 5 pieces to the consumer. One cycle of Oral Pills, which is required for one month, is given to the SMOs @ Re.1.60/- and it is sold to the consumer @ Rs.3/- per strip (cycle) under the brand name-"Mala –D". Under the Social Marketing programme, currently three Government brands and fourteen different SMOs brands of condoms are sold in the market. Similarly for Oral Pills, one Government brand and seven SMOs brands of Pills are sold. Based on the recommendation of the Working Group on Social Marketing of Contraceptives, SMOs have the flexibility to fix the price of branded condoms and OCPs within the range fixed by the Government.

9.6.1.a Sale of Condoms (Quantity in Mcps)

S. No.	Social Marketing Organisation	2010-11	2011-12	2012-13 (Upto Nov. 12)*
1	HLL Lifecare Ltd., Thiruvananthapuram	253.81	225.03	140.34
2	Population Services International,Delhi	154.02	164.65	81.41
3	Parivar Seva Sanstha, Delhi	40.46	67.56	33.72
4	World Pharma,Indore	0.00	0.00	0.00
5	DKT, India, Mumbai	71.36	89.84	49.31
6	Eskag Pharma(Pvt.) Ltd., Kolkatta	0.00	0.00	0.00
7	Janani, Patna	11.24	46.81	10.56
8	Population Health services, Hyderabad	50.51	69.20	24.09
9	Sanskar Shiksha Samiti, Bhopal	0.04	0.04	0.00
10	PCPL, Kolkata	0.00	14.51	6.90
11	World Health Partner, New Delhi	0.00	0.27	0.88
	Total	**581.44**	**677.91**	**347.21**

**Figures are provisional.*

9.6.1.b Sale of Oral Contraceptive Pills (Quantity in Lakh Cycles)

S.No.	Social Marketing Organisation	2010-11	2011-12	2012-13 (Upto sep. 12)
1	HLL Lifecare Ltd.,Thiruvananthapuram	77.20	139.52	53.08
2	Population Services International,Delhi	110.55	69.37	54.94
3	Parivar Seva Sanstha,Delhi	0.00	19.355	0.357
4	World Pharma,Indore	0.00	0.00	0.00
5	DKT, India, Mumbai	107.89	184.33	70.389
6	Eskag Pharma(Pvt.) Ltd. , Kolkata	0.00	0.00	0.00
7	Janani, Patna	17.54	24.87	4.12
8	Population Health services, Hyderabad	41.90	34.53	3.722
9	Sanskar Shiksha Samiti, Bhopal	0.00	0.00	0.00
10	PCPL, Kolkata	3.00	0.00	0.00
11	World Health Partner, New Delhi	0.00	0.00	0.38
	Total	**358.08**	**471.975**	**186.988**

9.6.1.c Centchroman (Oral pills)

Since December 1995, a non-steroidal weekly Oral Contraceptive Pill, Centchroman (Popularly known as Saheli), to prevent pregnancy is also being subsidized by the Government. The weekly Oral pill is the result of indigenous research of CDRL, Lucknow. The pill is now available in the market at Rs.2.00 per tablet. The Government of India provides a subsidy of Rs.2.59 per tablet towards product and promotional subsidy.

9.6.2 Performance of Social Marketing Programme in the sale of contraceptives

Contraceptives	2010-11	2011-12	2012-13 (Upto Nov. 2012)
Condoms (Million pieces)	581.44	677.91	347.21
Oral Pills(Social Marketing) (lakh cycles)	358.08	471.975	186.988
SAHELI (Tablets)	234.31904	244.56	37.178

9.6.3 Emergency Contraceptive Pills [ECP]

Department of Health &Family Welfare introduced 'Emergency Contraceptive Pills' (E- pills) in the National Family Welfare Programme during the year 2002-03. This contraceptive is used within 72 hours of un-protected sex. The following quantities of E-pills were procured during the years 2010-11, 2011-12 & 2012-13 (upto Nov.2012).

(in lakh packs)

Quantity procured			
Item	2010-11	2011-12	2012-13 (Nov.2012)
ECP	21.54	18.30	39.29

9.6.4 Pregnancy Test Kits

Orders have been placed on HLL Lifecare Ltd, (a PSU under the Ministry), for procurement of 2,17,48,200 Pregnancy Test kits each during the year 2010-11, 2011-12 and procurement were made i.e. 2,22,18,600 Kits during the year 2012-13 for free-of-cost supply for timely and early detection of pregnancy. The kits are home-based and easy to use.

9.6.5 Copper-T

Under the National Family Welfare Programme, Cu-T-200B was being supplied to the States/UTs. From 2003-04, advanced version of Intra Uterine Device i.e. Cu-T-380-A has been introduced in the Programme. This Cu.-T has longer life of placement in the body and thus provides protection from pregnancy for a period of about 10 years. Now the advanced version of IUDs i.e.Cu-T-380-A is being procured and supplied to the States/UTs. Orders have been placed for a quantity of 90 lakh Copper – T-380-A, out of which nearly 53 lakhs Copper-T -380-A have been supplied. In the current year 2012-13 another advanced version of IUD-375 has been introduced in the programme which is also being procured by the Government for supplying to the states.

Appendix-I

States/UTs-wise TFR

Sl.No.	States	2007	2008	2009	2010
	ALL INDIA	**2.7**	**2.6**	**2.6**	**2.5**
1	Andhra Pradesh	1.9	1.8	1.9	1.8
2	Assam	2.7	2.6	2.6	2.5
3	Bihar	3.9	3.9	3.9	3.7
4	Chhattisgarh	3.1	3.0	3.0	2.8
5	Gujarat	2.6	2.5	2.5	2.5
6	Haryana	2.6	2.5	2.5	2.3
7	Jharkhand	3.2	3.2	3.2	3.0
8	Karnataka	2.1	2.0	2.0	2.0
9	Kerala	1.7	1.7	1.7	1.8
10	Madhya Pradesh	3.4	3.3	3.3	3.2
11	Maharashtra	2.0	2.0	1.9	1.9
12	Odisha	2.4	2.4	2.4	2.3
13	Punjab	2.0	1.9	1.9	1.8
14	Rajasthan	3.4	3.3	3.3	3.1
15	Tamil Nadu	1.6	1.7	1.7	1.7
16	Uttar Pradesh	3.9	3.8	3.7	3.5
17	W. Bengal	1.9	1.9	1.9	1.8
18	Arunachal Pradesh	2.7	..	..	..
19	Delhi	2.0	2.0	1.9	1.9
20	Goa	1.6	..	..	..
21	Himachal Pradesh	1.9	1.9	1.9	1.8
22	J & K	2.3	2.2	2.2	2.0
23	Manipur	1.6	..	..	..
24	Meghalaya	3.1	..	..	..
25	Mizoram	2.0	..	..	..
26	Nagaland	2.0	..	..	..
27	Sikkim	2.0	..	..	..
28	Tripura	1.7	..	..	..
29	Uttarakhand	..	..	..	..
30	A&N Islands	1.5	..	..	..
31	Chandigarh	1.8	..	..	..
32	D&N Haveli	3.3	..	..	..
33	Daman & Diu	1.9	..	..	..
34	Lakshadweep	2.1	..	..	..
35	Puducherry	1.6	..	..	..

Note: TFR for Smaller States/UTs are based on three years average

Appendix-II

Number Sterilisations and IUCDs, by states: 2011-12

S.No.	State/ UT	Sterilisation			IUCD
		Male Sterilisation	Female Sterilisation	Total	Insertion
1	Bihar	7,146	544,701	551,847	346,525
2	Chhattisgarh	6,666	125,620	132,286	118,272
3	Jharkhand	12,698	122,305	135,003	103,131
4	Madhya Pradesh	43,077	551,966	595,043	296,140
5	Odisha	3,070	139,506	142,576	142,063
6	Rajasthan	5,461	306,777	312,238	389,535
7	Uttar Pradesh	11,048	320,168	331,216	1,351,963
8	Uttarakhand	2,587	29,552	32,139	146,885
9	Arunachal Pradesh	4	669	673	2,057
10	Assam	7,003	68,655	75,658	68,698
11	Manipur	109	1,685	1,794	5,429
12	Meghalaya	63	2,762	2,825	4,659
13	Mizoram	3	4,502	4,505	6,753
14	Nagaland	3	2,202	2,205	2,248
15	Sikkim	98	193	291	1,479
16	Tripura	206	5,949	6,155	1,267
17	Andhra Pradesh	13,587	527,334	540,921	320,493
18	Delhi	2,705	17,730	20,435	43,975
19	Goa	55	4,081	4,136	2,426
20	Gujarat	3,478	321,822	325,300	613,608
21	Haryana	6,873	70,435	77,308	192,796
22	Himachal Pradesh	2,344	20,514	22,858	19,697
23	Jammu & Kashmir	1,054	15,713	16,767	19,132
24	Karnataka	2,924	327,494	330,418	207,125
25	Kerala	1,819	95,319	97,138	57,100
26	Maharashtra	21,852	486,269	508,121	364,471
27	Punjab	8,192	61,970	70,162	224,866
28	Tamil Nadu	1,901	337,944	339,845	340,442
29	West Bengal	9,574	201,813	211,387	97,238
30	A&N Islands	27	1,305	1,332	786
31	Chandigarh	96	1,779	1,875	3,171
32	D&N Haveli	2	1,239	1,241	198
33	Daman & Diu	4	405	409	233
34	Lakshadweep	0	39	39	43
35	Puducherry	11	10,273	10,284	2,348
	All India	**175,740**	**4,730,690**	**4,906,430**	**5,497,252**

Appendix-III

State-wise number of Districts under the scheme of delivery of contraceptives by ASHAs at doorstep

Sl. No.	State	Number of Districts
1	Arunachal Pradesh	03
2	Assam	14
3	Bihar	36
4	Chhattisgarh	16
5	Gujarat	06
6	Haryana	01
7	Himachal Pradesh	03
8	Jammu & Kashmir	04
9	Jharkhand	19
10	Madhya Pradesh	34
11	Manipur	04
12	Meghalaya	05
13	Odisha	18
14	Rajasthan	19
15	Tripura	02
16	Uttar Pradesh	45
17	Uttarakhand	04
	Total	**233**