1. **Introduction:**

In 1952, India launched the world's first national programme emphasizing family planning to 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.[7] 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 honor the commitments of the Government of India (including ICPD: International Conference on Population and Development, MDG: Millennium Development Goals and others) (see table 1)[7]

Program/Policy	**X Five Year Plan**	**NPP**	**NRHM**	**MDG**	**Current Status**
Infant Mortality Rate	45	<300	30	27	55 (2006)
Maternal Mortality Ratio	200	< 100	100	100	254 (2005)
Total Fertility Rate	NA	2.1	2.1	NA	2.7 (2007)

*Source annual report 2008-09

Current Scenario of Population and Family Planning in India:

Demographic Scenario:

India's population as per 2001 census was 1.028 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 billion, second only to China in the world.[7]

Similarly, Total Fertility Rate (TFR) in the country has recorded a steady decline to the current levels of 2.6 (2008), a 42% decline from mid-1960s. The National Commission on Population has observed that "*the changes in the population growth rates in India have been relatively slow, but the change has been steady and sustained. The short and long term adverse consequences of too rapid decline in birth rates and change in age structure on the social and economic development were avoided and the country was able to adapt to these changes without massive disruption in development efforts*".[7]

Family Planning Scenario:

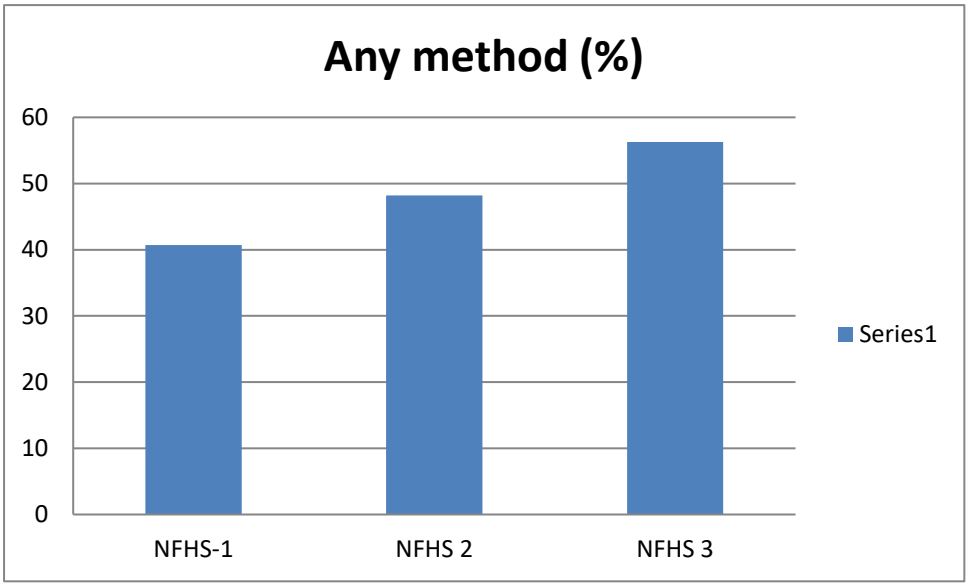
Nationwide, the small family norm is widely accepted (the wanted Fertility rate for India as a whole is 1.9: NFHS-3) and the general awareness of contraception is almost universal (98% among women and 98.6% among men: NFHS-3).

Contraceptive use is generally rising as shown in the table 1 to 4 below. In 2005-06, the contraceptive use among married women (aged 15-49 years) was 56.3%, up by 17%

from 48.2% in 1998-99. The proximate determinants of fertility like age at first marriage and age at first childbirth (which are societal preferences) are also showing good improvements at the national level.

Despite the above mentioned improvements, there are still many issues of concern regarding family planning and population stabilization.

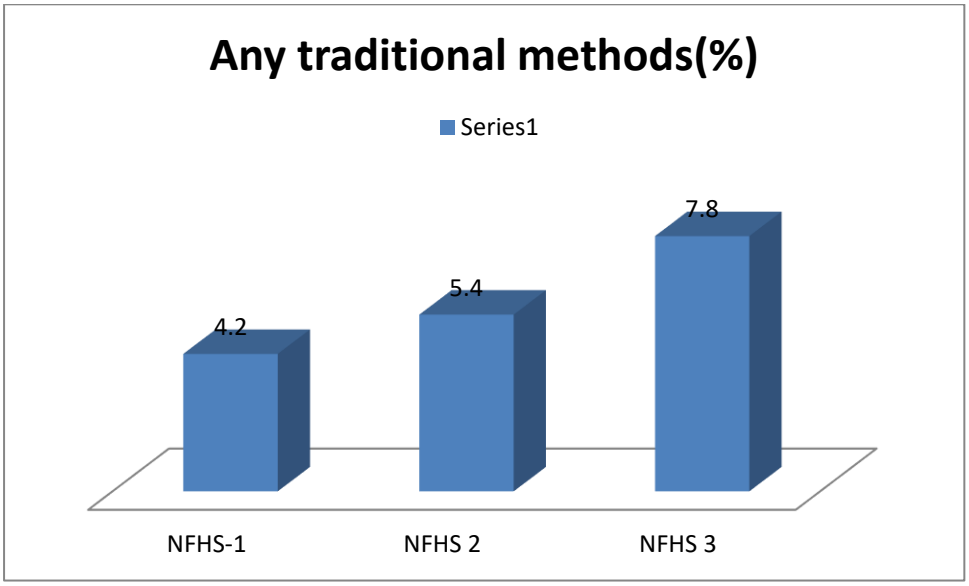
Figure 1



Source annual report 2009-10

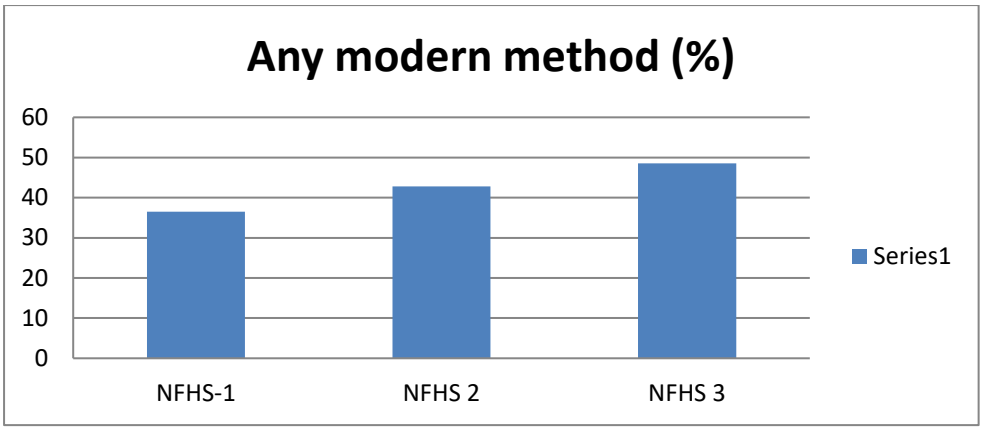
The overall status of country as far as contraceptives using by any methods has increased over the period of time from NFHS1 to NFHS 3

Fig 2



Source annual report 2009-10

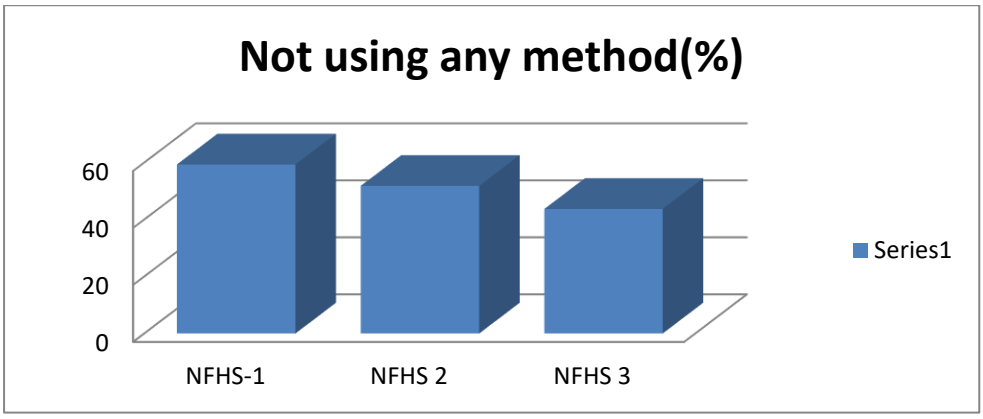
Fig 3



Source annual report 2009-10

The contraceptive use has increased over the period of time even by traditional or modern methods. The traditional methods are usually practiced in parts of Uttar Pradesh.[7]

Fig 4



Source annual report 2009-10

The unmet need for contraception in the country is still high (total unmet need of 21.5% for the country as a whole and 23% in rural areas and 18.2% in urban areas in 2007-08: DLHS-3).

The gains achieved in the areas of health and fertility is not uniform across the country, with interstate variations in TFR, CPR and unmet needs for family planning.

GoI strategies for Family Planning:

Current Family Planning Efforts:

The Family Planning (FP) division is involved in the development; implementation and monitoring of strategic interventions for fulfilling twin objectives of *population stabilization* and *promoting reproductive health* within the wider context of sustainable

development.[7] The interventions, activities and performance in the arena of family planning over the year 2009-10 are as follows:

1. Contraceptive Services under the National Family Welfare Programme:

The public sector provides a wide range of contraceptive services for limiting and spacing of births at various levels of health system as described in Table 2.

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

- Counseling, access to and provision of good quality services and follow-up care are emphasized in all services.
- GOI is promoting 'Fixed Day Static Services' (FDS) approach in sterilization services within the public health system with the aim of increasing access to sterilization services.

2. 'Quality Assurance Committees' (QACs) have been constituted in all the states and districts.

- The division is repositioning IUD as short and long term spacing method.
- Regular contraceptive updates for service providers in all states, with special focus on High Focus States (HFS).
- Emergency Contraception Pills (ECPs) are effective for preventing conception due to unplanned/ unprotected sex. Guidelines have been developed and disseminated regarding its use.
- **Family Planning Services in Public Health Sector**

Family Planning Service	**Provider Service**	**Service Location**	**Strategy & Method Promotional Schemes**
Limiting Methods :			
Minilap	Trained & certified MBBS Doctors & Specialist	PHC & higher levels	1.FDS: Fixed Day Static Approach 2.Camp Approach 3.Revised Compensation Scheme 4.National Family Planning Insurance Scheme
Laparoscopic sterilization	Trained & certified Specialist Doctors (OBG & General Surgeons)	Usually CHC & higher levels	
NSV: No Scalpel Vasectomy doctors	Trained & certified MBBS & Specialist Doctors	PHC & higher levels	

Spacing Methods			
IUD 380 A	Trained & certified ANMs, LHVs, SNs and doctors	Sub centre &higher levels	On demand Camp Approach
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Subcentre & higher levels	On demand VHNDs: Village Health Nutrition Days
Condoms	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Subcentre & higher levels	On demand VHNDs
Emergency Contraception			
Emergency Contraceptive Pills (ECPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Subcentre & higher levels	On demand VHNDs

Source annual report 2009-10

3. States are being provided technical and financial support for the development of human resources and up- gradation of health facilities for operationalisation of FDS.

- Revised compensation scheme for sterilization acceptors to compensate the wage loss is continued in all the states
- 'National Family Planning Insurance Scheme' (NFPIS) covers service providers in both public and accredited private facilities.

Details of the strategies of GoI:

1. Increasing Male Participation in Planned Parenthood, including 'NO Scalpel Vasectomy' (NSV):

Increasing male participation in 'Planned Parenthood' is one of the major strategic themes of NPP-2000. Promotion of NSV acceptance is one of the most important & visible component of increasing male participation in RCH towards addressing the gender equity issues.

With the aim to bring men to the forefront in population and reproductive health programmes, special budgetary provisions have been made in the tenth plan under Male Participation.

The No Scalpel Vasectomy (NSV), a modified male sterilization technique, was introduced in 1997 in the National Family Welfare Programme as a simple and safe technique with very little chance of complications compared to female sterilization.

Camp approach for male sterilization was adopted initially to re-popularize male sterilization method. Based on the experiential lessons from male sterilization camps in states like Madhya Pradesh, Andhra Pradesh, Punjab and Uttar Pradesh, a strategy on advocacy and community mobilization for increasing NSV acceptance through camps was introduced in the family welfare programme in 2005 and guidelines were disseminated to all the state/ UT Governments.

Simultaneously, **human resource development** in NSV was operationalized with a three pronged strategy for training surgical faculty from Medical colleges, district NSV trainers and service providers to increase the pool of NSV service providers and operationalize FDS in male sterilization services.

Addressing the Unmet Need in Contraception through assured delivery of Family Planning Services:

2. Fixed Day Static Services in Sterilization at facility level:

There is a concerted effort to operationalize the FDS approach in sterilization services all over the country with the following objectives to consciously move sterilization services from a camp approach to a regular routine service.

- To make health facilities self sufficient in provision of sterilization services.
- To enable clients to have assured sterilization services on any given day at their designated health facility without depending on a travelling team of providers from elsewhere.
- To consciously move sterilization services from a camp approach to a regular routine service.
- To make health facilities self sufficient in provision of sterilization services.
- To enable clients to have assured sterilization services on any given day at their designated health facility without depending on a travelling team of providers from elsewhere.

FDS Guidelines for sterilization services

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

3. Quality Assurance in Family Planning:

Quality assurance in family planning services is the decisive factor in acceptance and continuation of contraceptive methods and services.

The guidelines for ‘Quality Assurance and Standards’ in various Family Planning services have been developed and revised regularly by the division.

The Quality Assurance Committees (QACs) set up at the State and District level, following the Supreme Court directives, to monitor the quality of sterilization services in their respective areas; to conduct medical audits and accredit facilities and empanel service providers for sterilization services. At the central level, these activities are monitored through reports and field visits.

1. A) Review of Literature:-

- *Compulsory Sterilization: The Change in India's Population Policy Author(s): Kaval Gulhati (*march 1977*)*:

  The author talks about the changes in the policy at different stages keeping the people's need and respond in consideration from the lauch of family planning services in India.

  India was the first country in which the compulsory sterilization was advocated officially. Many professionals were dismayed at this new direction in India's population policy. At one point of time, it was suggested to integrate the family planning services with the other health programmes. The new change in India's policy failed to meet its objectives(an admission that the population factor is paramount in the development effort and that the voluntary family planning program). On 16 April 1976, Dr. Singh made a major statement on national population policy. He said, "To wait for education and economic development to bring about a drop in fertility is not a practical solution" and "considerable work has been done in our country in the field of family planning, but clearly only the fringe of the problem has so far been touched. He outlined several recommendations, such as rising the minimum age of marriage for girls to 18 years and increasing incentives for acceptance of sterilization, which would enhance the efforts of the voluntary family planning program. He then stated that the country was not ready administratively for implementing a national program of compulsory sterilization. Prior to the emergency it would have been impossible to endorse compulsory sterilization From l1952 until 1965 no leader of consequence supported the national family planning program openly and vigorously. . It was in that a separate department of family planning was formed, in the renamed Ministry of Health, Family Planning, and Urban Development. The allocation for family planning for the single year 1967-68 almost equaled the entire allocation for the 15 years from 1951 to 1966. Sterilization and condoms became the leading methods in the program. The year 1971-72 was the first year in the entire history of the program that expenditure exceeded budgetary allocation. Sterilizations increased by 70 percent. The following year, 1972-73, reached a peak both in expenditure and in the number of sterilizations performed- a record 3.1 million. At this critical point, the 1973-74 budgets were cut. Sterilization was de-emphasized and the maternal and child health care components reemphasized. The author also talks about new legislation emphasized by state Government to impose family planning services and the impact of development on the family planning. Indian policy-makers view the use of coercive laws to reduce fertility as a necessary intervention. Even for coercion program to work will require a hugely expanded commitment of administrative and financial resources.

- *The Dilemma of Past Success: Insiders' Views on the Future of the I " international Family Planning Movement written by Ann K. Blanc and Amy O. Tsui,* in which the authors examine current perspectives on the status and future of the family planning movement, factors contributing to its declining international visibility, and possible responses from the family planning field by conducting interviews and focus-group discussions with insiders in the field of population studies. Informants cited four possible courses of action for the movement: (1) forming strategic alliances with other movements, specifically HIV/AIDS prevention; (2) redefining the family planning message to mobilize and strengthen support; (3) improving service delivery

to broaden public acceptance and contraceptive method use; and (4) nurturing new leadership.

- *Reproductive Health: A Public Health Perspective Author(s): Imrana Qader : that* examines the concept of reproductive health as it emerged in the 1980s, its consequences for health research and family planning programmes in India, its advocacy for the third world agenda and the reasons behind it, its epidemiological basis, and offers an alternative public health perspective for understanding reproductive health. The author talks about the two things needed in public health perspective i.e. firstly the priories in reproductive health should be clear and should be reflected in the budgetary allocations. Secondly maternal and child health, nutrition, contraceptive services and communicable disease control must be integrated. Within the sphere of health service system this will find the solid foundation for women's health including their reproductive health. To achieve the best results the health service system needs supportive, social, economic and legislative actions favoring women. The issue of women health thus goes beyond the domain of public sector in health.

- **Demographic Trends and Population Policy in China,** Pravin Visaria

CHINA, WITH a population of over 1,060 million perons at the end of 1986, accounts for 21.4 per cent of the total population of the world (4.96 billion) and for 28.1 per cent of the total population of developing countries (3.77 billion).' China's land area of 9.6 million square kilometres makes it the third largest country in the world (after the USSR and Canada), with a population density of 109 persons per sq. km. (less than half that of India's 231). However, since only 11 per cent of China's land is considered arable, the difference between China and India with respect to density per square kilometre of arable land is much smaller.

The censuses were conducted in 1953, 1964 and 1982

The annual increment in population has been higher in India than in China for almost a decade now. Underlying this is China's unique success since about 1971 in sharply lowering its birth rate. To understand this development in the comprehensive perspective of demographic trends in China since it's 'liberation in 1949 is the objective of this paper

The post-liberation period witnessed a significant rise in the growth rate, which was much higher than the estimated average rate of 0.5 per cent during 1900-50(and zero during 1850-1990)2. Besides, the average rate of growth during the 18 years between 1964 and 1982 was higher than during 1953-64; but the vital rates for the intervening years need to be examined to understand some of the momentous changes.

Within the first inter-censal decade, the birth rate was between 40 and 44 per 1,000 population up to 1957 and the death rate was on the decline from a peak of about 29 in 1954.3During 1958-61,the years of the Great Leap Forward and the ensuing crisis, the birth rate declined and the death rate rose sharply so that during 1959-61, the population actually declined.

The birth rate reached a low of 22 during 1961 but recovered to 41 during 1962,47 during 1963 and 41 again during 1964. The death rate declined sharply during 1964-66 and has continued to show a downward trend since then. The result was an acceleration of the rate of population growth to an unprecedented2 .7 per cent during 1964-66

It is shown that the both 1953-64and 1964- show higher death rates for females than for males up to age 10. Likewise, the estimates of life expectancy at birth among women in urban Beijing in 1950 and 1953 were lower than for men.6 while the situation has certainly improved since then; the Chinese scholars confirm that the tradition of placing a higher value on sons than on daughters has not altogether disappeared from the country. However, the 1 per 1,000 sample fertility survey indicated a markedly lower sex ratio (1,028) than the 1982 census

According to the Seventh Five-Year Plan, China expects to have by 1990 'at least' 400 cities and 10,000 towns. Also, it promises to continue to adhere to the 'principle of controlling the size of large cities, developing medium-sized ones moderately and small ones actively.'"

Infant mortality was around 300 per 1.000 live births. Around 1948-49. the crude death rate was estimated at 28, although some estimates place it as high as 35-45. The first estimate was very similar to the crude death rate of 27 during the inter-censal decade 1941-51 in India,with some estimates suggesting a value of 30. The estimates of life expectancy during the inter-censal period 1953-64 are affected by the severe famine and dislocation of the economy during 1959-61. However, beginning with 1962, the Chinese death rate (roughly adjusted for understatement) has not exceeded 14 and it has been below 10 since 1969. The expectation of life at birth during the inter-censal period 1964-82 has been estimated at around 62 years. By 1981 it had risen to 68 years. The latter value was 13years above India's (55years) in 1981.In fact even in 1985 the estimated crude death rate in India was almost 12, higher than the rate estimated for China since 1965 (11 or lower). The infant mortality rate (IMR) in China during 1983-84 is estimated at no higher than 34-36, while in India the Sample Registration System has provisionally reported an IMR of 95 in 1985 and 104-105 for 1983-84. The basis of this sharp decline in mortality in China is an emphasis on public preventive services rather than curative health services. Stress has been laid on the improvement of environmental sanitation, control of infections and the elimination of malaria and schistosomaisis (bilharzia).

The National Patriotic Health Campaigns were launched to mobilize the people for preventive and health promotion activities. The first campaign was launched in 1951 and over the next 30 years, there were, on an average, four or five campaigns each year. With their effective organizational network, campaign committees with a small full-time staff were set up at each level, from the national level down to the province, prefecture, county, commune and brigade. The campaigns have inspired the people to work hard to clean the filth and wipe out the four disease-carrying pests, mosquitoes, flies, rats and bedbugs. At one time sparrows were also on the hit list as a pest. However, when the elimination of

sparrows threatened to produce serious ecological problems, bedbugs (and in some cases lice and cockroaches) were substituted as the fourth pest

A large number of 'sanitation and epidemic stations' and 'maternal and child health institutes' were set up; by 1957 they numbered 1,626 and 4,599, respectively. After the formation of communes and brigades, a sort of cooperative health insurance system has been in operation although the quality of rural medical services has been uneven. China's celebrated part-time 'barefoot doctor' system, which was greatly expanded during the Cultural Revolution, has worked well in the delivery of health services at the grassroots level. In recent years these doctors have been criticised as not adequate of or the task expected of them.2A1 s a means to upgrade their status, since 1981, barefoot doctors with five years' experience, who pass the appropriate prefectural examination (i.e., an examination conducted at the level of the prefecture - roughly equivalent to an Indian district) are awarded a certificate as a 'rural doctor'. Their professional status is thereby raised to the equivalent of that of middle-level health workers, although they continue to work at the local level.

The re-training of traditional midwives and the creation of a corpus of social workers skilled in child care have also contributed to the lowering of infant mortality rate.

The efforts to control disease and death seem to have been assisted by the State control of the production and distribution of pharmaceuticals and medical equipment. The National Drug Corporation, with 310,000 employees, distributes the pharmaceutical products throughout the country.

In the early 1950s and the early 1960s, the Chinese birth rate was in the low 40s, not much different from India's. Since then, however, it has steadily declined and during the 1980s it has been between 18 and 21, significantly below India's (33 or higher). These changes in fertility behaviour have been a result of a consious 'planned birth' policy advocating control of family size through both late marriage as well as limitation of births after marriage.

After 1971, the rise in age at marriage has been particularly sharp. The prescribed norm has been 5 to 6 years later than the legal minimum, 23 years for girls in rural areas and 24 for their urban sisters. It was implemented through a rule requiring permission to marry to be obtained from the administrative head of the work units of the bride and groom.

Contraceptive Practice The sharp decline in fertility has been achieved through increasing practice of contraception by married couples. The percentage of married women in reproductive ages 15-49 practicing contraception was 69.5.

The health departments were directed to help the public with contraceptive measures and restrictions on induced abortion were relaxed.

The third family planning campaign was launched in 1971, with an emphasis on late marriage (later than the legally prescribed minimum age), longer intervals between children, and fewer children in all. They launched a campaign for a one-child family to ensure that China's population would not exceed 1,200 million in AD. 2000. China's Marriage Law of 1980 prescribed that husband and wife are duty bound to practise family planning' (Article 12), and that 'late marriage and late

childbirth should be encouraged' (Article 5).Article 15 of the law affirmed that 'parents have the duty to rear and educate their children 'and that 'children have the duty to support and assist their parents The one-child policy has been promoted through economic incentives and disincentives. While the details seem to vary according to local regulations, the benefits offered include monetary bonuses

- **Population Policy: From bad to worse, Mohan Rao:**

National Population Policy is certainly not without problems. It has population stabilization rather than the health and well-being of the people as a goal, it is not integrated with health or indeed with the myriad other sectors that contour population dynamics. Committing itself to respect for human rights and the freedom and dignity of women, these were translate into a non-target oriented family welfare programme which rightly abjured Incentive and disincentive. Andhra Pradesh, for instance, lists an astonishing series of incentives and disincentives. At the community level, performance in RCH and rates of couple protection will determine the construction of school buildings, public works and funding for rural development programme.

Institution the U ttar Pradesh population policy, for instance, disqualifies persons married before the legal age of marriage from government jobs, as if children are

Responsible for child marriage. It has been pointed out that these disincentives and incentives are anti-women anti-adivasisa, anti-dalita, anti-child and antipoor in general. They also are profoundly violative of human and democratic rights.

The disincentives proposed, such as denying ration cards and education in government schools for the third child, withdrawal of welfare programme for the scheduled castes and scheduled tribes with more than two children, debarring such people from government jobs, etc,are questionable on various ground. The National Family Health Survey for 1998-99, notes that the infant mortality rate among the SCs, STs and the backward castes is 83, 84 and76 respectively, compared to 62 for others. Similarly the under five mortality rate is 119 among the SCs, 126 among the STs 103 among the OBCs compared to 82 among the others. Clearly, to impose a two-child norm under such circumstances is to widen the inequality gap among our people.

2. Objectives:

General objectives:

- To study the role of Government of India (under NRHM) strategies in improving the Family Planning services from 2008-09 to 2010-11 in the 6 EAG states with the high Total Fertility Rates.

Specific objectives:

1. To assess the operationalization of ‘fixed day strategy’ in these 6 EAG states.
2. To review the efforts to promote spacing methods i.e. (IUD insertion)
3. To study the proliferation of Post Partum Sterilization
4. To assess the activities in these 6 EAG states for promotion of the male participation in Family Planning
5. To assess the initiative of states in promoting HRD (Human Resource Development and deployment) for family Planning

Rationale of study:

India which accounts for 2.4% of the land area is already supporting around 17% of the world population a huge strain on the limited natural & national resources & a great challenge for sustainable and equitable development. India has been showing a slow but steady decline in population growth. India’s annual population growth rate during 1991-2001 decade was 1.93%, a decrease of over 15% from the previous decade.

So the population stabilization is one of the major concerns of India, which cannot be done without the proper Family Planning services. Also if we talk about these 6 EAG states, than they contribute maximum (almost 45%) percentage of the total population of the country. And to keep a check on that, the states need to put their family planning services and the strategies in place. Therefore, the study was conducted to know the family planning status in the states and the various interventions taken by the Government of India.

3. Data and Methods:

The study done was completely secondary review and analysis of data taken from various sources.

Tools:

1. Secondary data collection includes:

a) State Programme Implementation plans for 2008-09 to 2011-12

b) Publications, publicity material, guidebooks in use and websites

c) DLHS and NFHS data

d) Review of annual reports

e) Review of literature

2. Informal In-depth interviews or discussions with various stakeholders at different levels of the study.

4. Findings and Analysis :

4.1 To assess the operationalization of 'fixed day strategy' in these 6 EAG states.

The operationalisation of fixed day strategy and its status according to the State PIP is as follows:

4.1.1 UTTAR PRADESH:

Provide female sterilization services on fixed days at health facilities in districts

Provision of Fixed day sterilization services (ligation/abdominal tubectomy) would be continued at all district women hospitals (DWH)/ combined hospital/ PPCs and CHCs. Thus it would be available at 180 functional FRUs. At present all the DWH & combined hospitals (73) are providing female sterilization services for six days per week and fixed day sterilization services (ligation/abdominal tubectomy) on two fixed days will be continued to be provided at CHCs (107) having either a surgeon or gynecologist or an LMO. Preferably, Tuesdays and Fridays would be fixed for such services.

4.1.2 BIHAR:

STATIC SERVICES

- Ensure that district level facilities are fully equipped with manpower and equipments
- Availability of Sterilization services everyday at district hospitals, separately for, Males and Females
- Availability of Sterilization services at PHC level on at-least 3 fixed-days a week (these days could be fixed for the entire state, like the Immunization Days, which are Wednesday and Saturdays)
- Demand generation activities: wide dissemination of information on the regular (daily and on fixed days) availability of the services
    1. prominent display
    2. workshop of key department functionaries, who in turn would disseminate the same to their line staff, who in turn will directly inform the public about the availability of services

4.1.3 CHATTISGARH:

To enhance family planning services on fixed days particularly for first month of financial year performance based incentives are proposed @ Rs 50 per case/ ANM, Rs.50/ case / Mitanin and Rs 100/case/ surgeon for both Male and female sterilization.

Fixed day male and female sterilization taking place in 70 out of 140 CHCs

4.1.4 MADHYA PRADESH:

Fixed day camp strategy is there at all district hospitals. One day in a week will be fixed for camps in all CEmONC hospitals. Surgeons will be identified for each CEmONC centre for camp duty on these fixed days.

Incentive to Surgeons:

The surgeons & the team performing more than 1000 sterilization operations in a year will be given an incentive @ Rs. 50/- per case for the number of operations performed after achieving the benchmark of 1000 cases.

4.1.5 JHARKHAND:

Apart from the Camp approach fixed day services for FP also envisaged as a strategy. Fixed day FP services provide beneficiaries to take up the FP methods as per their requirement with greater flexibility to choose appropriate method for them.

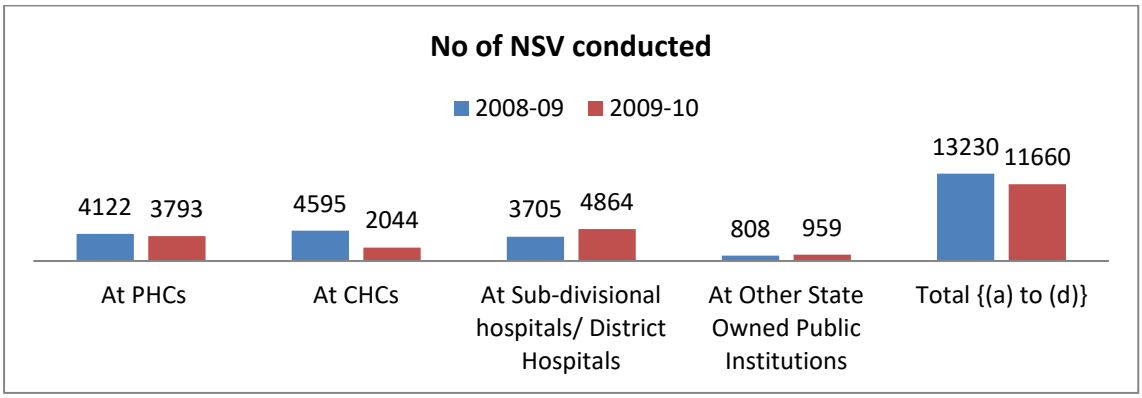
4.1.6 RAJASTHAN:

First one is to increase numbers of static centers providing services on fixed day basis. For this 150 institutions were strengthened through provision of skills enhancement of services providers for laparoscopic tubectomy.

Fixed day strategy:

UTTAR PRADESH:

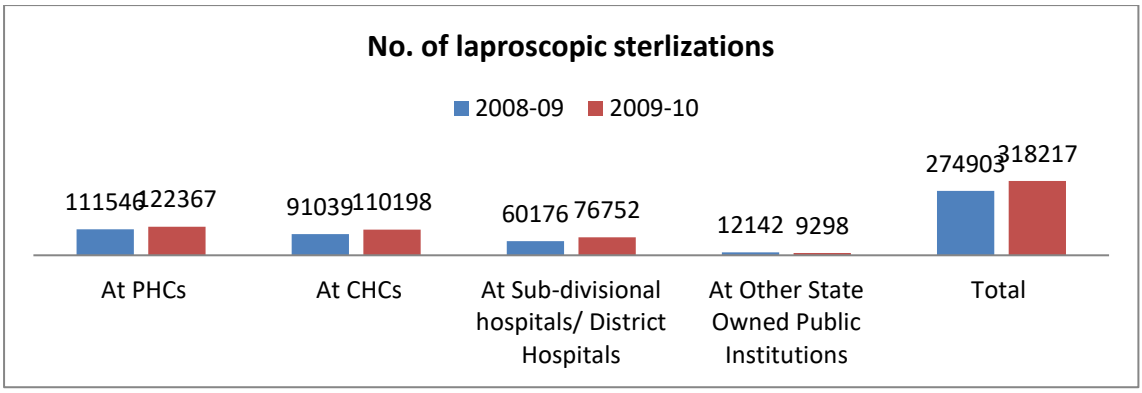
Fig 4



Source-MIS data

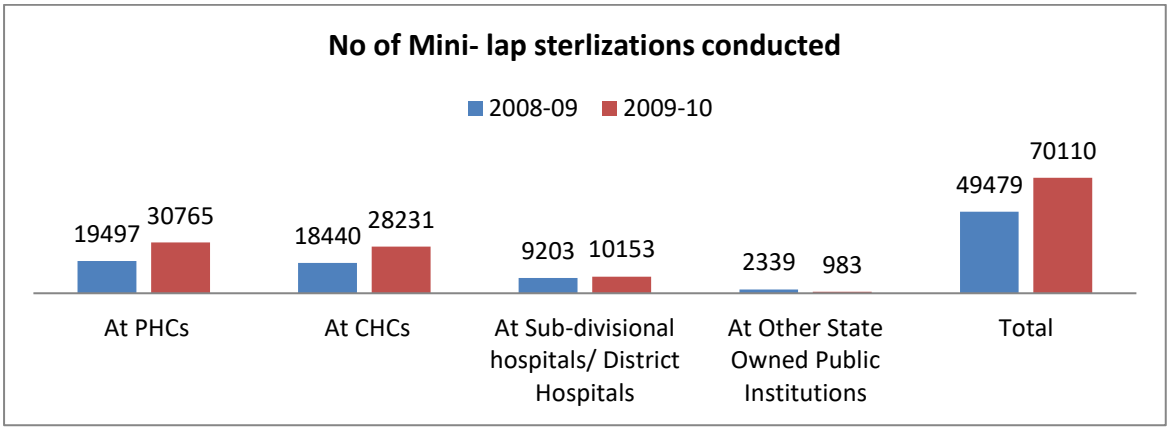
If we compare the intra state data of the NSV conducted, In **Uttar Pradesh**; the number of NSV has increased from the 2008-09 to 2009-10 at all the health facilities, except at PHCs CHCs which is reflected in the total number of NSV taking place i.e. the total no of NSV conducted has decreased as reflected in Fig 5.

Fig 5



Source-MIS data

Fig 6

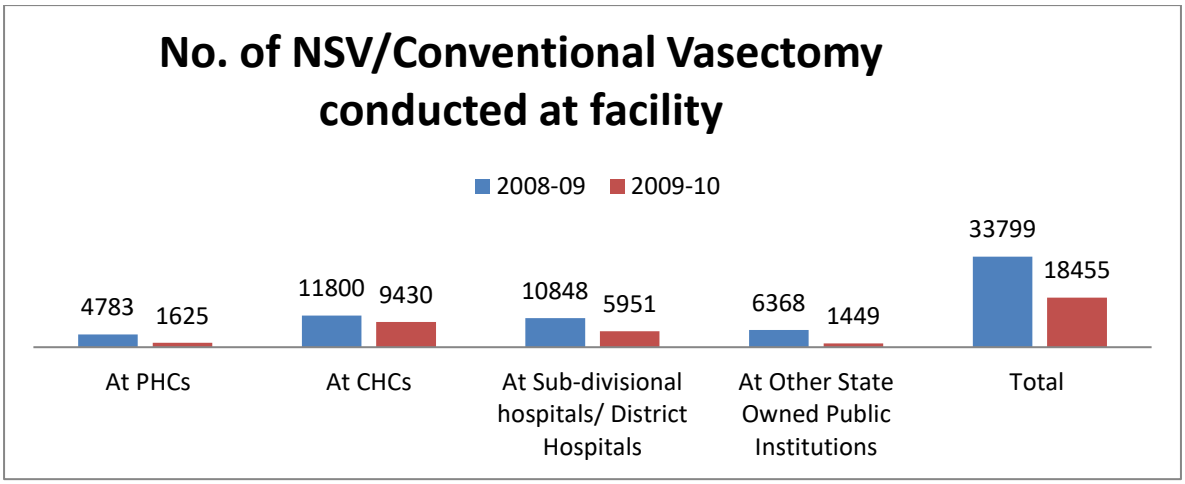


*source-MIS data

The no. of Laparoscopic sterilizations and Mini lap services has increased over the period of time at all the health facilities as seen in fig 5 and 6.

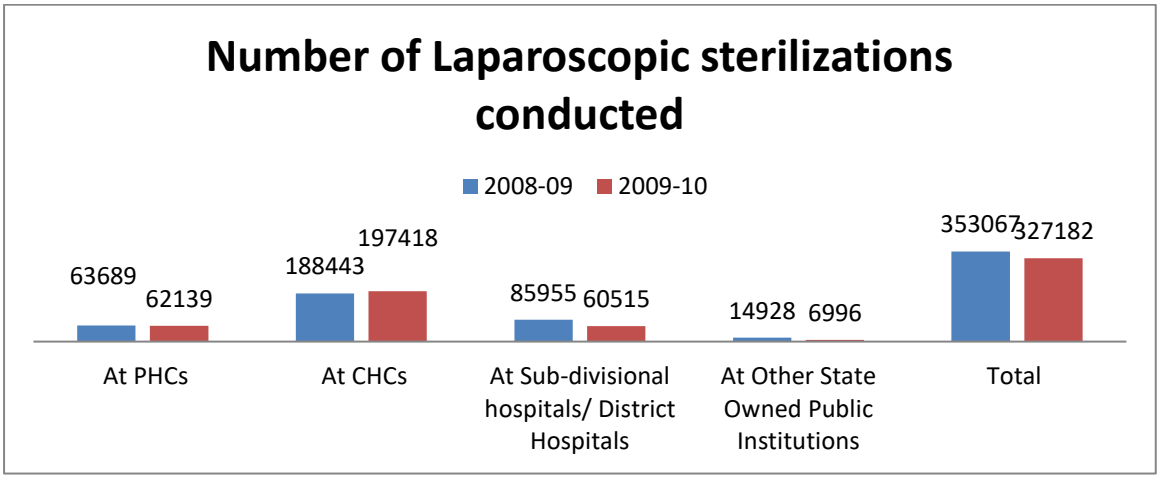
MADHYA PRADESH:

Fig 7



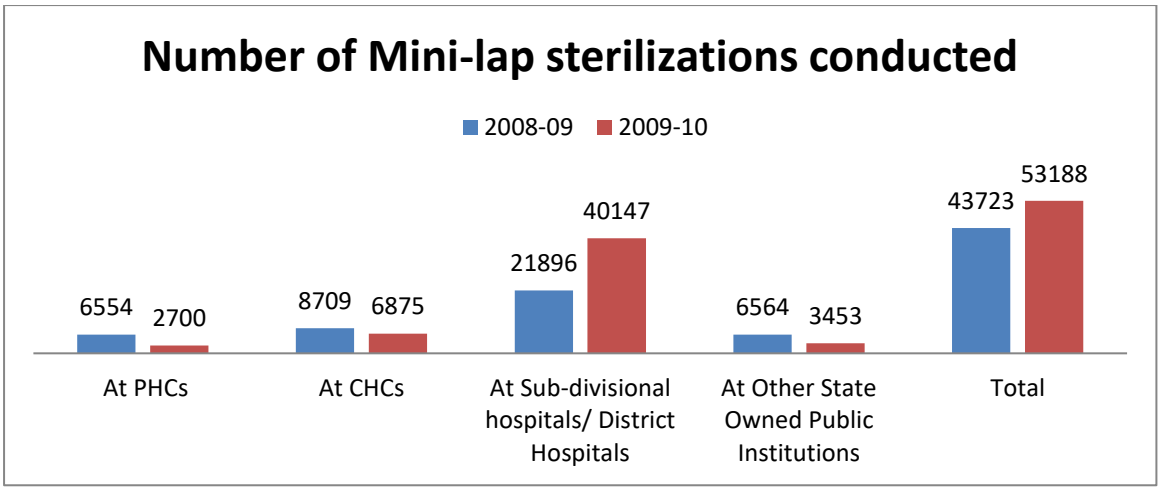
In **Madhya Pradesh,** the NSV has decreased at all the health facilities over the period of time and almost at all the health facilities.

Fig 8



*source-MIS data

Fig 9

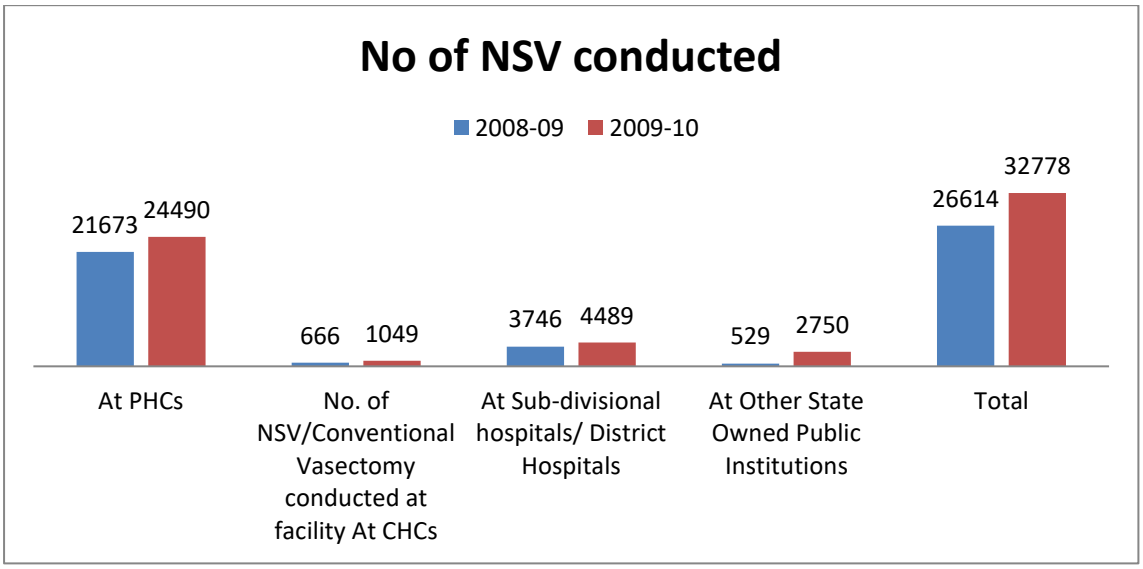


Source-MIS data

The overall status of the laparoscopic sterilizations has decreased over the period of time whereas the Mini-lap sterilizations have increased over the period of time.

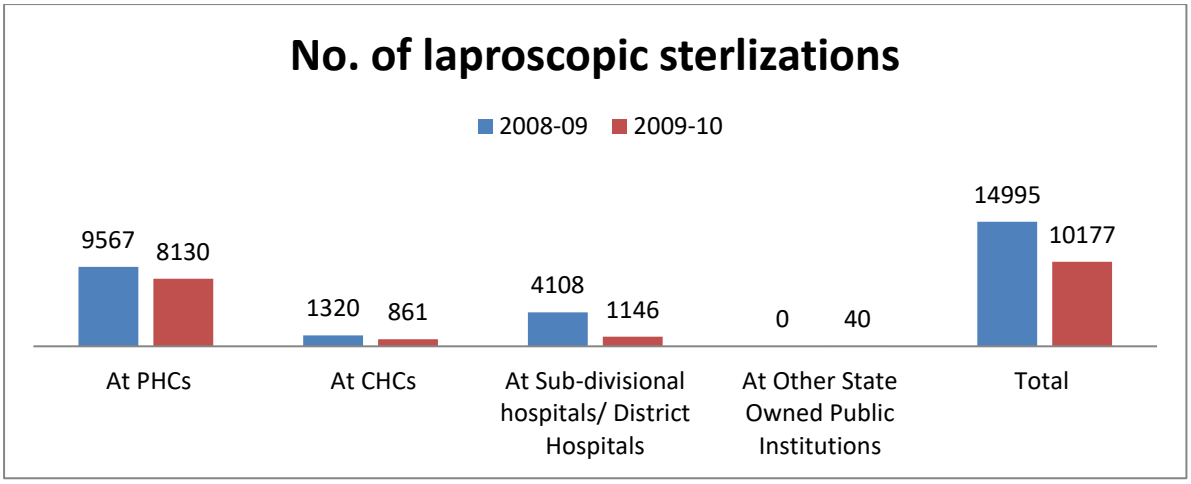
BIHAR:

Fig 10



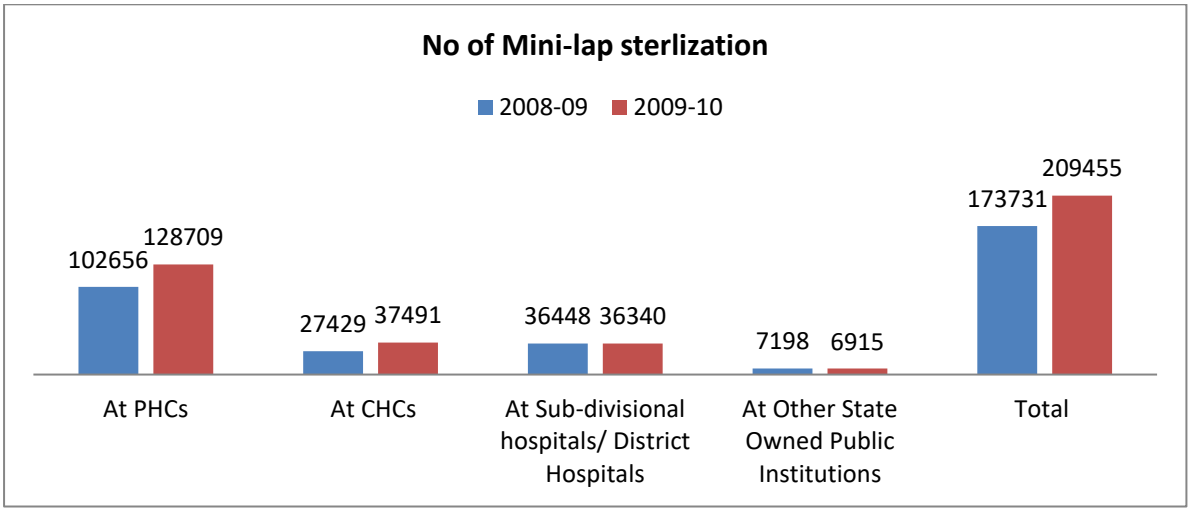
Source-MIS data

Fig 11



Source-MIS data

Fig 12

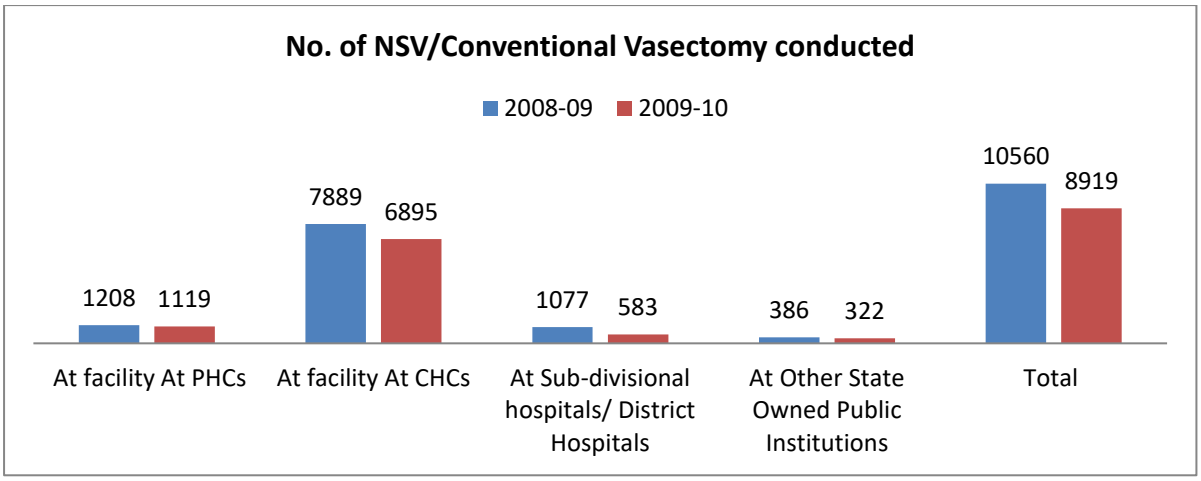


Source-MIS data

In **Bihar**, the NSV and the mini lap sterilizations have increased over the period of time and at almost all the health facilities whereas the laparoscopic sterilizations have decreased at PHCs and SDH level.

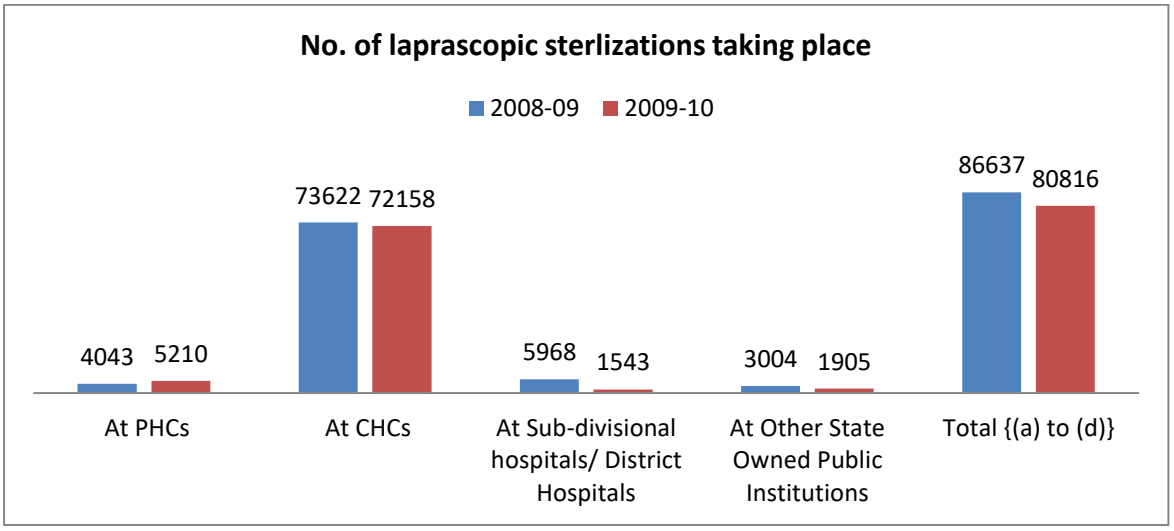
Chhattisgarh:

Fig 13



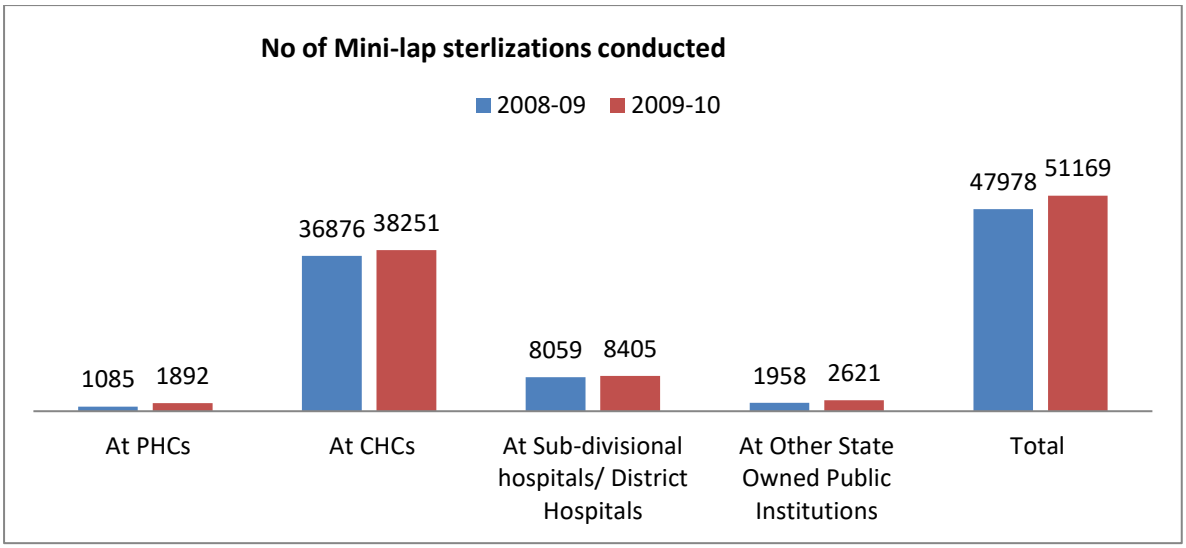
Source-MIS data

Fig 14



Source-MIS data

Fig 15

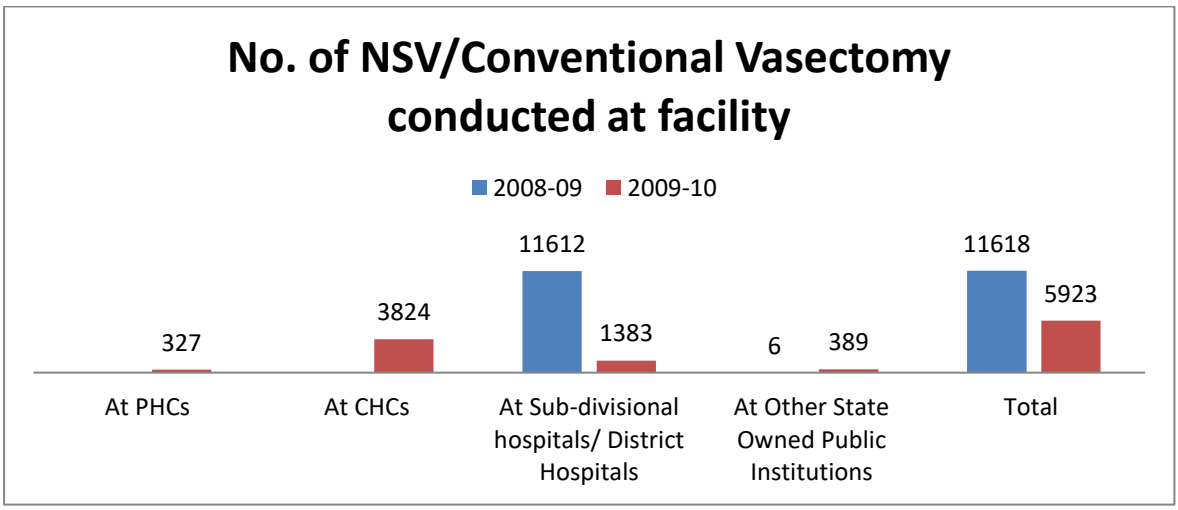


Source-MIS data

In **Chhattisgarh,** the number of Laparoscopic sterilizations and the NSV have decreased almost at all the health facilities and thus decreasing the total number whereas there is an increase in the number of the mini lap sterilizations taking place over the period of time.

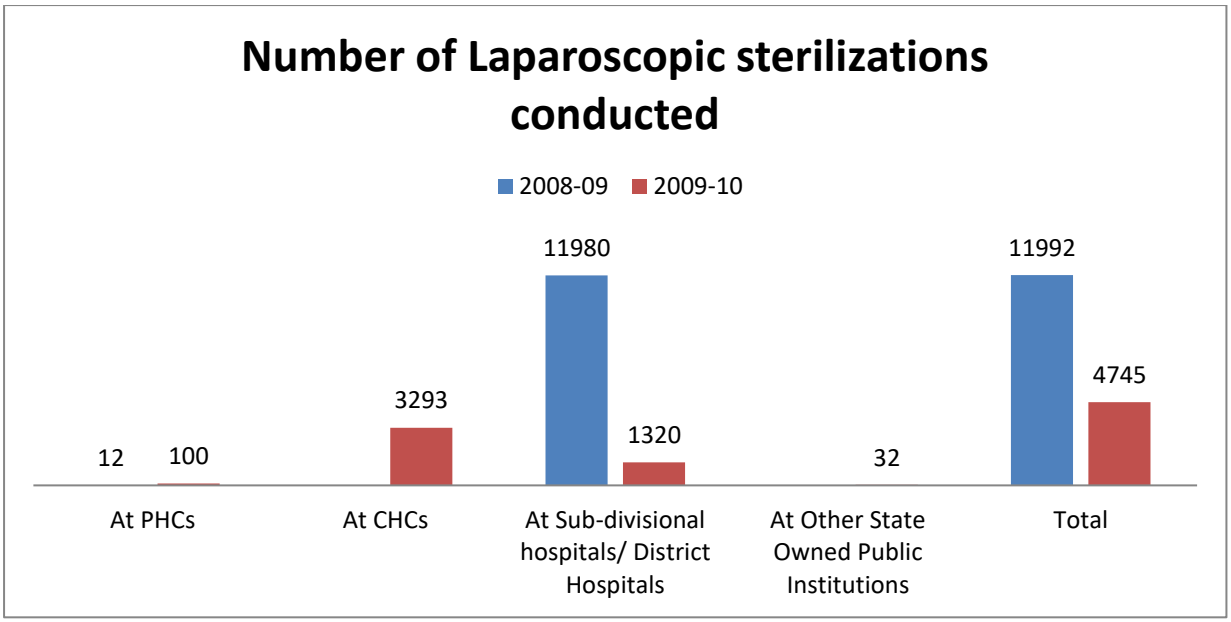
JHARKHAND

Fig 16



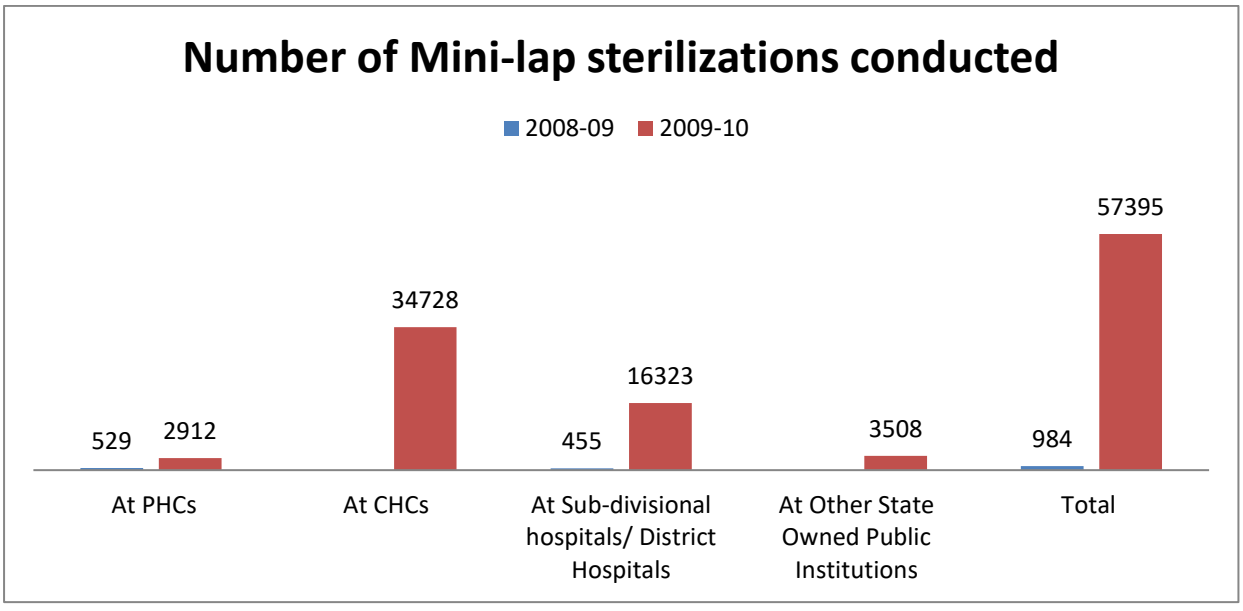
Source-MIS data

Fig 17



Source-MIS data

Fig 18

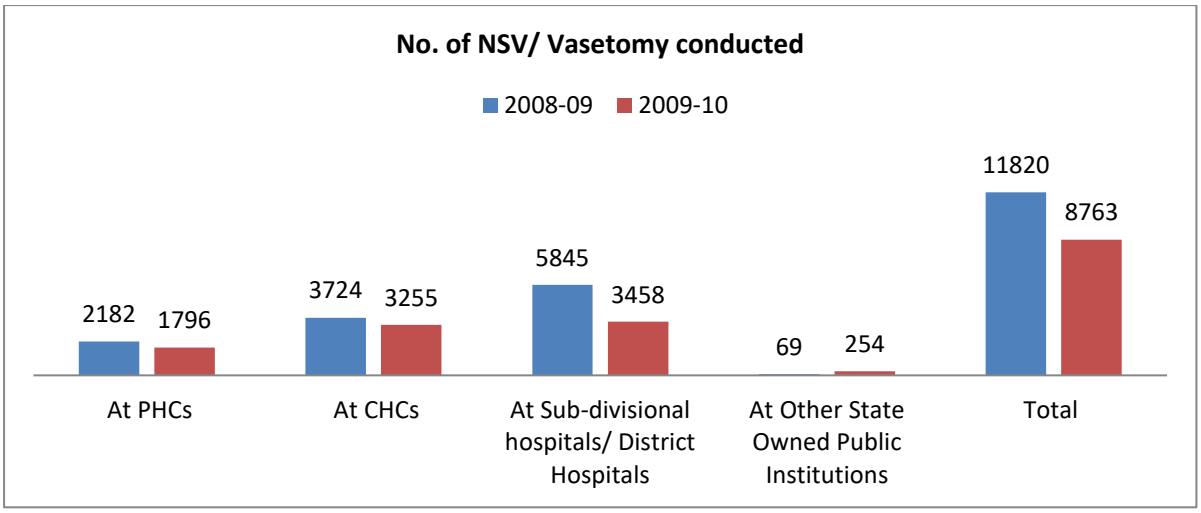


Source-MIS data

In **Jharkhand**, there is a decrease in the number of NSV and laparoscopic sterilizations but a marked increase in mini lap sterilizations

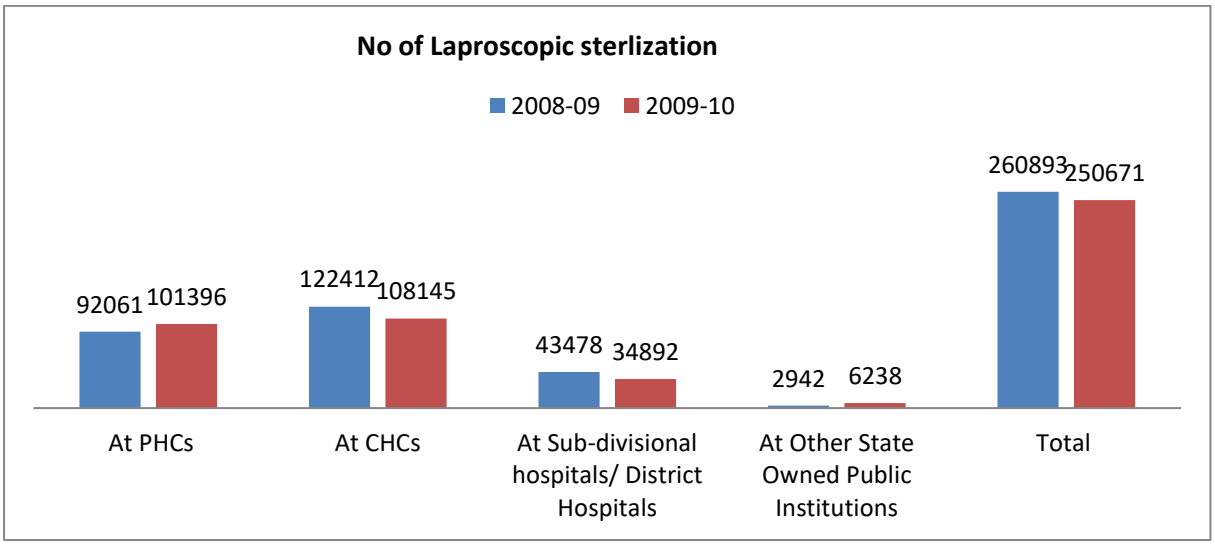
Rajasthan

Fig 19



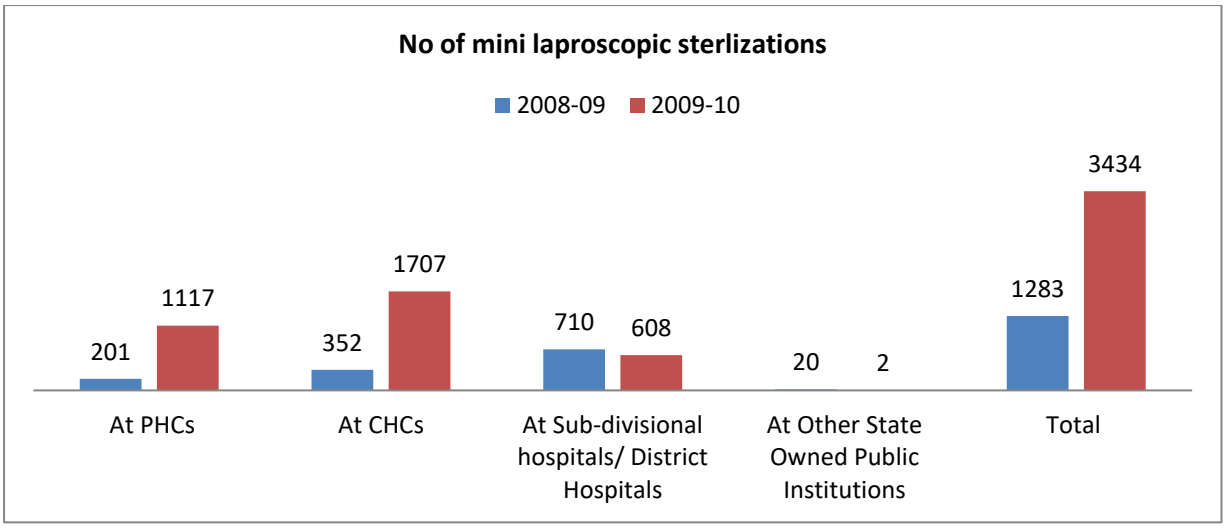
Source-MIS data

Fig 20



Source-MIS data

Fig 21



Source-MIS data

In **Rajasthan**, there is a decrease in the number of NSV and laparoscopic sterilizations but a substantial increase in mini lap sterilizations.

4.2. To review the efforts to promote spacing methods i.e. (IUD insertion)

4.2.1 UTTAR PRADESH:

Provision of IUD services at District Hospitals/CHCs/Block PHCs

Daily IUD 380-A insertion services are being provided in 73 District Hospitals (Women, Combined & PPCs), 438 CHCs and 470 block PHCs at present. It is proposed to ensure provision of fixed day services at each of these facilities and expand to remaining CHCs and Block PHCs. IUD services at the Sub Centres would be continued to be provided at 2300 accredited sub centers on fixed days. Preferably, Mondays (ANC clinic days) would be the day for IUD services also.

However, funds would be required for: (i) client cards, IEC activity - This component is budgeted under BCC section; and (ii) infection prevention services from the RCH flexi pool. The funds required under a;; three heads are given below:

Table 22

Sl.	Head Name	At District Hospital/PPC	At CHCs	At BPHCs
1	Client Card	Rs. 2500/-	Rs. 1000/-	Rs. 500/-
2	IEC Activity	Rs. 5000/-	Rs. 2000/-	Rs. 1000/-
3	Infection prevention & other consumables*	Rs. 7500/-	Rs. 3000/-	Rs. 1500/-
Total		**Rs. 15,000/-**	**Rs. 6,000/-**	**Rs. 3,000/-**

- *Includes chlorhexadine, solution for chemical sterilisation and surgical handscrub

IUD services at Sub Centres

IUD services at the Sub Centres would be continued to be provided on fixed days. Preferably, Mondays (ANC clinic days) would be the day for IUD services also.

Post Partum IUD Experiences

SIFPSA has piloted the PPIUCD training in technical assistance with USAID support at three sites in UP namely, Lucknow, Allahabad and Jhansi. The Obs. & Gynae Department of CSMMU has been strengthened as a training site for PPIUCD. The training materials are presently being finalized to suit the needs of the State. In addition, standardization of follow up systems, demand generation and reporting systems are being strengthened to ensure complete care and counseling for a beneficiary

4.2.2MADHYA PRADESH:

ASHA's would be encouraged to motivate clients for IUD insertion within 6 weeks to 3 months of delivery and based on the performance of this year provision of incentives will be considered next year.

Considering number of ASHAs functioning in the state, active mobilization of this manpower and involving them as depot holders and for motivating clients not only for IUD but also for accepting permanent methods would certainly contribute to reduction of unmet needs for family planning. Similarly for addressing unmet needs for urban areas, wherever, USHA's are functioning, they will also be engaged on the similar lines

4.2.3 BIHAR:

Availability of FP services: IUCDs, OCPs, Emergency Pills, Condoms

- Each SDH/CHC/PHC should have static FP cell / corner, with earmarked ANM / LHV responsible, for providing these services daily as OPD services to clients

4.2.4 CHATTISGARH:

- Promotion of IUD services through BCC and social marketing.
- IUD promotion through public health system as well private facilities and training of CHC/PHC doctors on 380 A manikin IUD insertion.

4.2.5 JHARKHAND:

The state PIP does not reflect much about IUD insertion services taken place in the state.

4.2.6 RAJASTHAN:

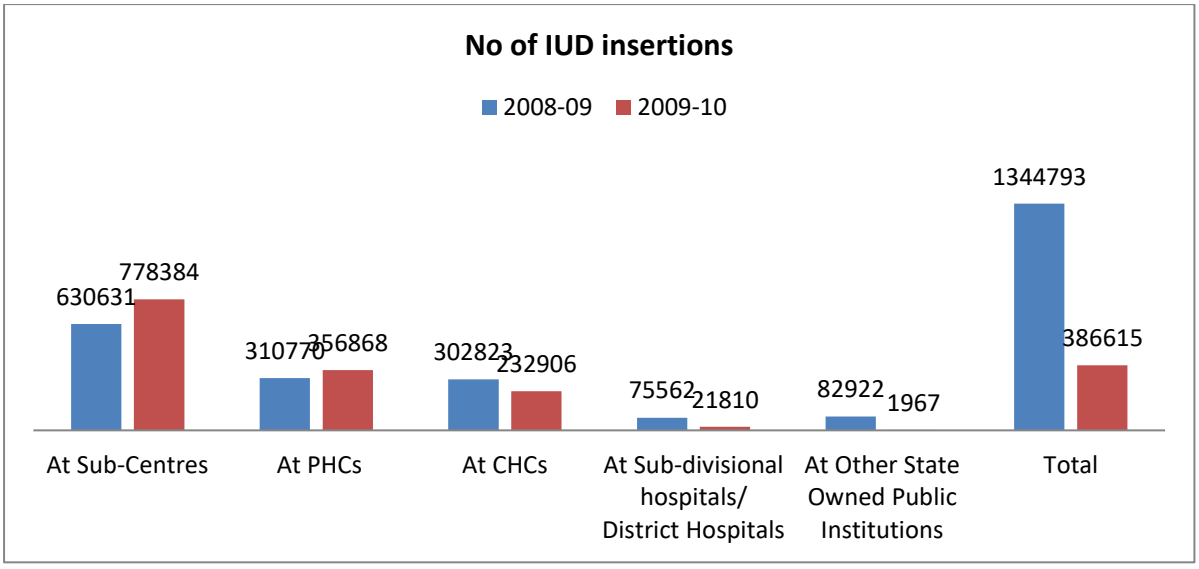
Improving quality of IUD insertion by enhancing skills of the service providers

Training Programmes for MOs, ANM/LHV will be organized at District Hospital and selected CHCs for improving their knowledge and skills for IUD insertion. This training has now been clubbed with the SBA training.

IUD insertion

UTTAR PRADESH

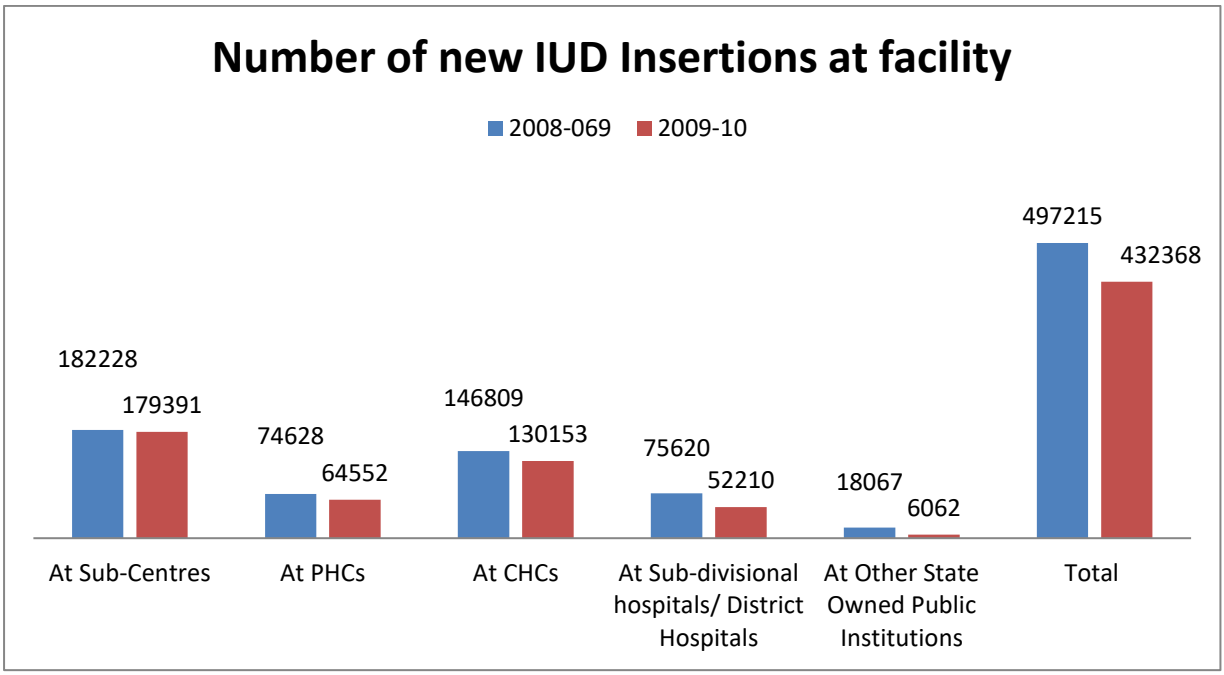
Fig 23



Source-MIS data

MADHYA PRADESH:

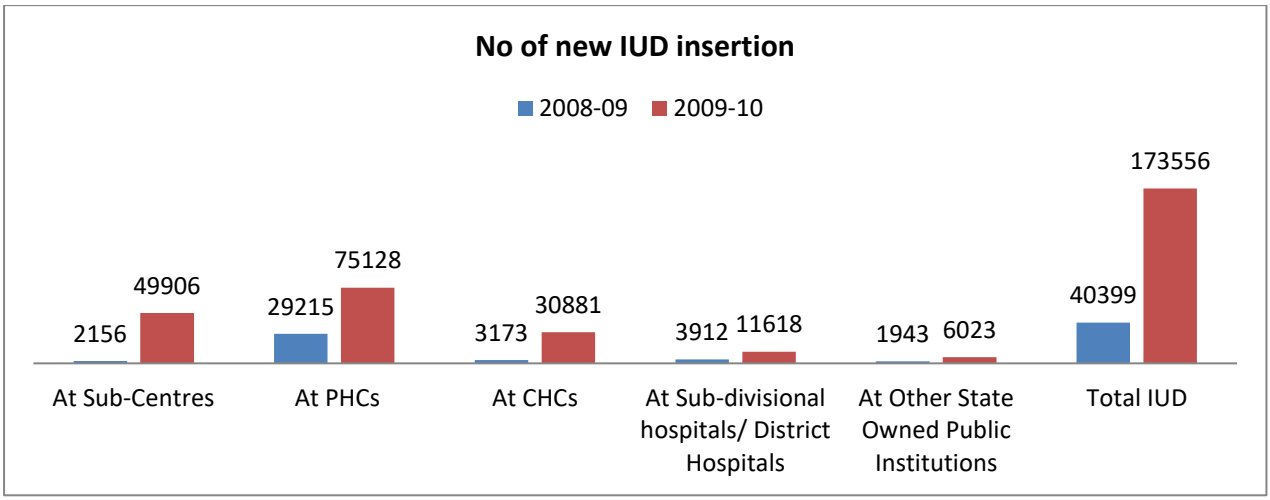
Fig 24



Source-MIS data

BIHAR:

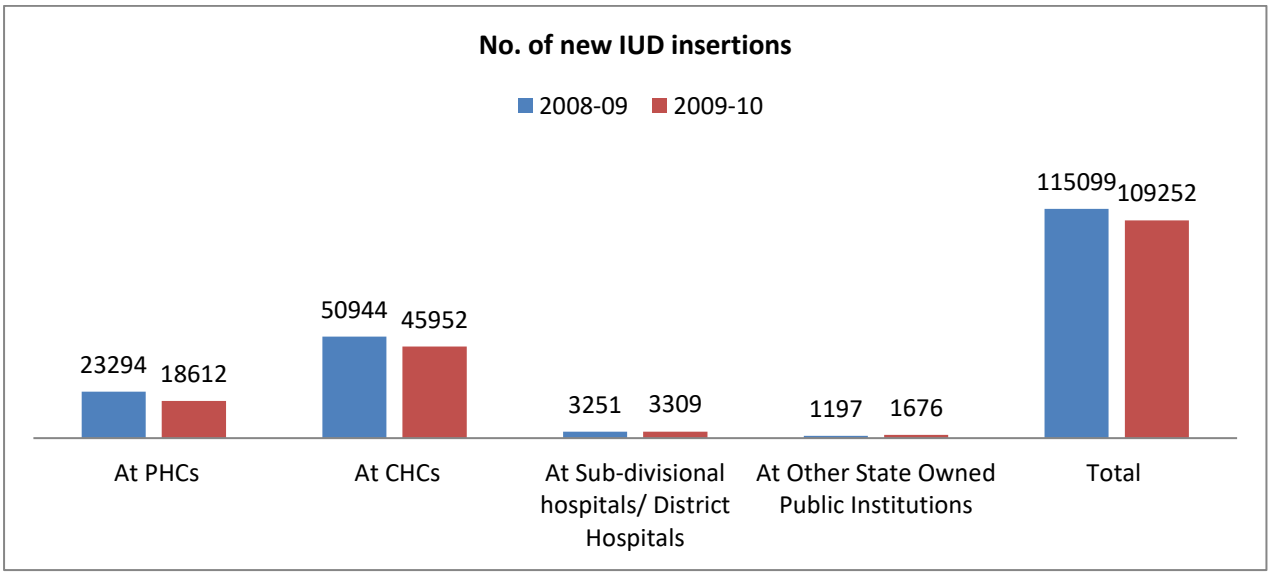
Fig 25



Source-MIS data

CHATISGARH:

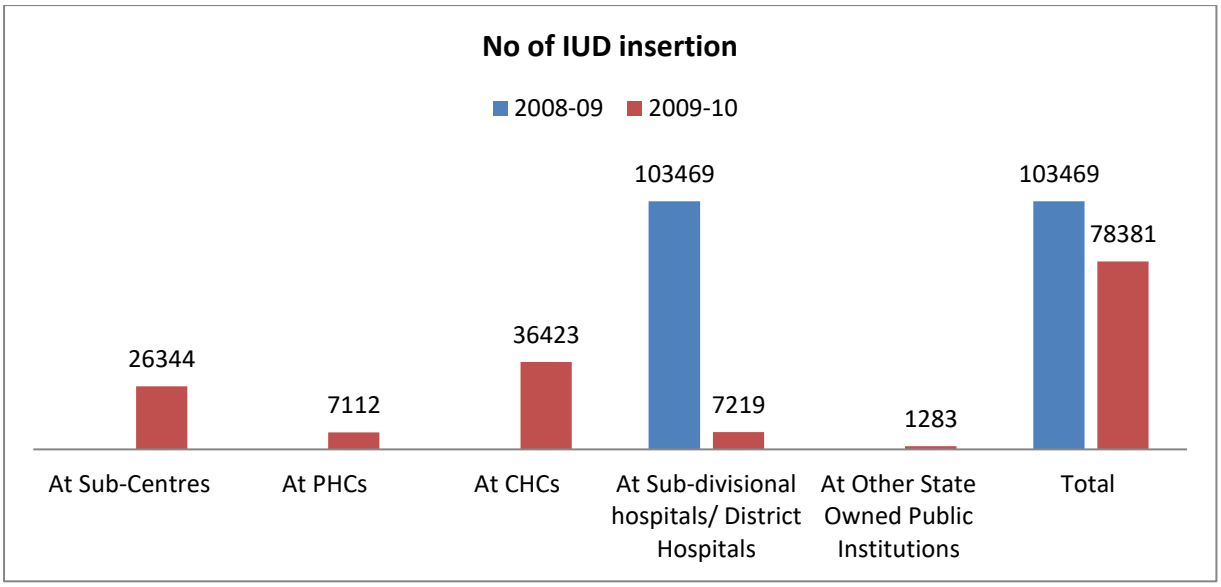
Fig 26



Source-MIS data

JHARKHAND:

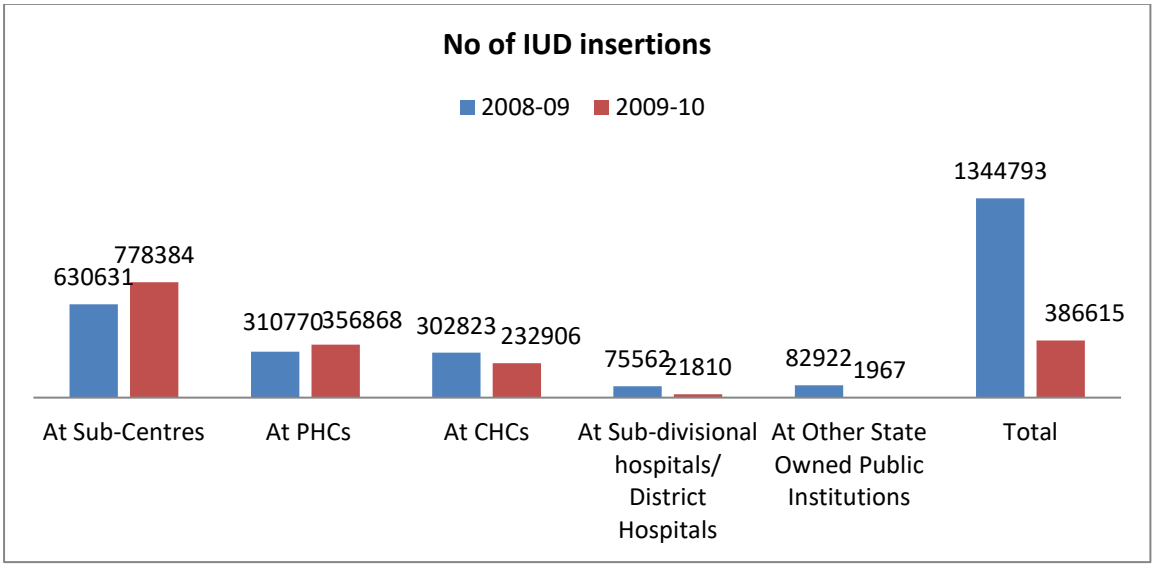
Fig 27



Source-MIS data

RAJASTHAN:

Fig 28



Source-MIS data

As seen in the Fig 23 to 28, IUD insertions have decreased in all the states except in Bihar.

IUD insertions:

Fig 29

	2006-07*	2007-08*	2008-09	2009-10	% Change 08-09- 09-10
Bihar	1,17,371	1,18,616	41,606	1,77,610	302.7
Chattisgarh	1,17,371	1,18,616	1,57,257	1,11,467	-38.6
Jharkhand	73,673	85,376	1,03,469	88,695	-17.3
Madhya Pradesh	4,62,481	5,01,433	4,95,247	4,41,536	-10.7
Rajasthan	3,03,358	3,37,979	3,53,252	4,09,560	16.7
Uttar Pradesh	18,55,173	19,43,474	21,05,501	15,35,583	-29.3

Source-MIS data

4.3. To study the proliferation of Post Partum Sterilization

4.31UTTAR PRADESH:

4.3.2BIHAR:

Motivate couple after second child in Post Partum period to go in for tubectomy / NSV

After the second child is born, the couple will be motivated to adopt a permanent method of family planning preferably NSV. For this communication materials will be prepared and distributed.

Follow up after tubectomy /NSV for side effects and treatment

Each tubectomy / NSV will be followed up for side effects and their treatment. This will provide positive reinforcement and motivate others to adopt family planning.

4.3.3 CHATTISGARH:

- Female sterilization camps in all Districts and Blocks organized regularly.
- Female sterilization services on fixed day basiswill be organized in all district hospitals and selected blocks.

4.3.4 MADHYA PRADESH:

Post Partum sterilization was one of the important strategies of earstwhile Post Partum Program implemented in district hospitals and medical colleges. Women who have gone through the stress and stain of pregnancy and delivery are highly motivated to accept sterilization immediately after delivery. If these services are not available, many of them even if do not want next child, do not return for sterilization after six weeks and unfortunately land in to a state of unwanted pregnancy. JSY has contributed effectively for enhancing institutional deliveries and around 70% of the deliveries in the state are institutional deliveries. However, because of increased load on the system in terms of non availability of beds and skilled manpower, post partum sterilization has taken a back seat.

This strategy would be propagated consciously during 2010-11, as even if 10% of women coming for institutional deliveries accept sterilization services following delivery, it will have a substantial impact on reduction of unmet needs for spacing methods.

During 2010-11, all district hospitals and medical colleges will be encouraged to restart post partum sterilization services. To Promote the Post Partum Sterlization after Institutional deliveries Additional Compensation of Rs 400 given to the Beneficiary and Rs 100 additional to Surgeon performing post Partum sterlization will be given.

4.3.5 JHARKHAND:

Post Portam Family Planning Services strategy provides scope for utilizing the opportunity of Increased institutional deliveries and subsequent hospital stay of 48 hours. After the delivery as per choice of the beneficiary FP service can be provided to her. This strategy also explores the comprehensive package of Institutional Delivery and subsequent FP services.

It has been planned to initiate the Post Partum Family Planning Services in 5 districts (District hospital and one CHC) Deoghar, Dhanbad, Palamu, Ranchi, and East Singhbhum In the pilot phase.

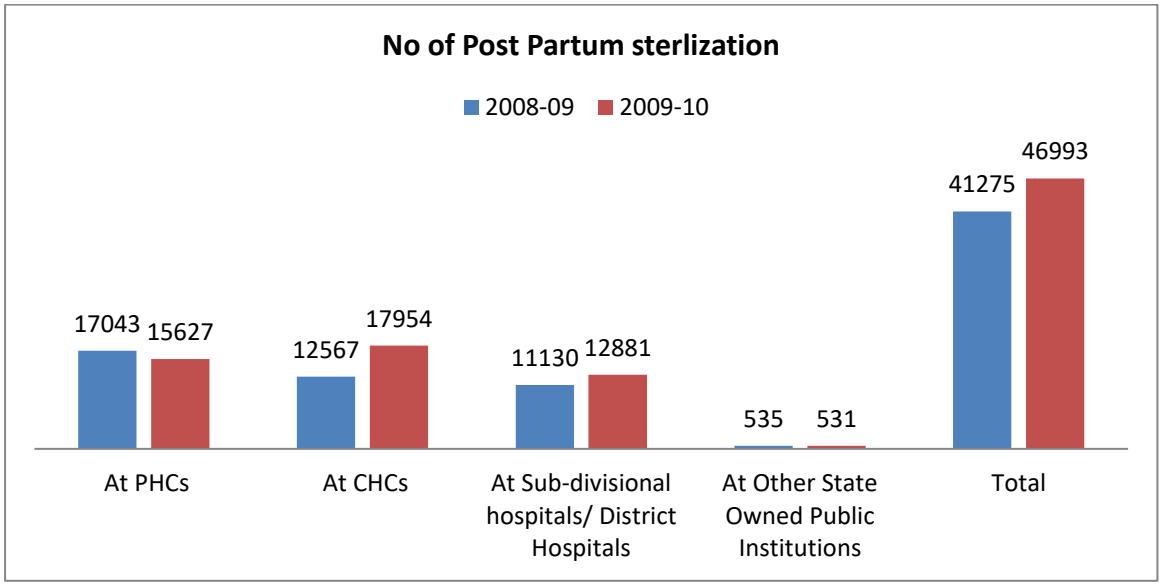
4.3.6 RAJASTHAN:

- The Post Partum FP services will be strengthened by utilizating the stay of women for 48 hrs after the institutional delivery. The women will be counselled for post partum sterlization or IUD during her stay period. For this, community based workers ASHA and Janmangal couple effective involvement will be ensured.

Post partum sterilization:

UTTAR PRADESH:

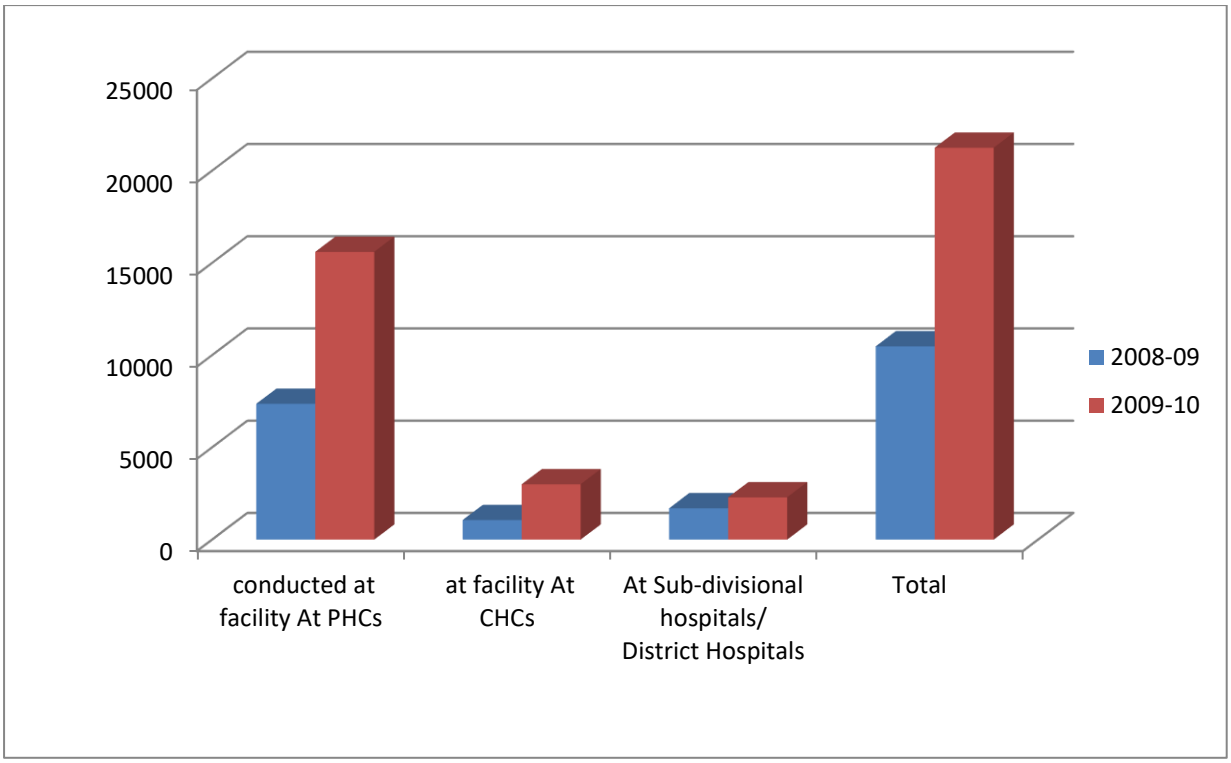
Fig 30



Source-MIS data

BIHAR:

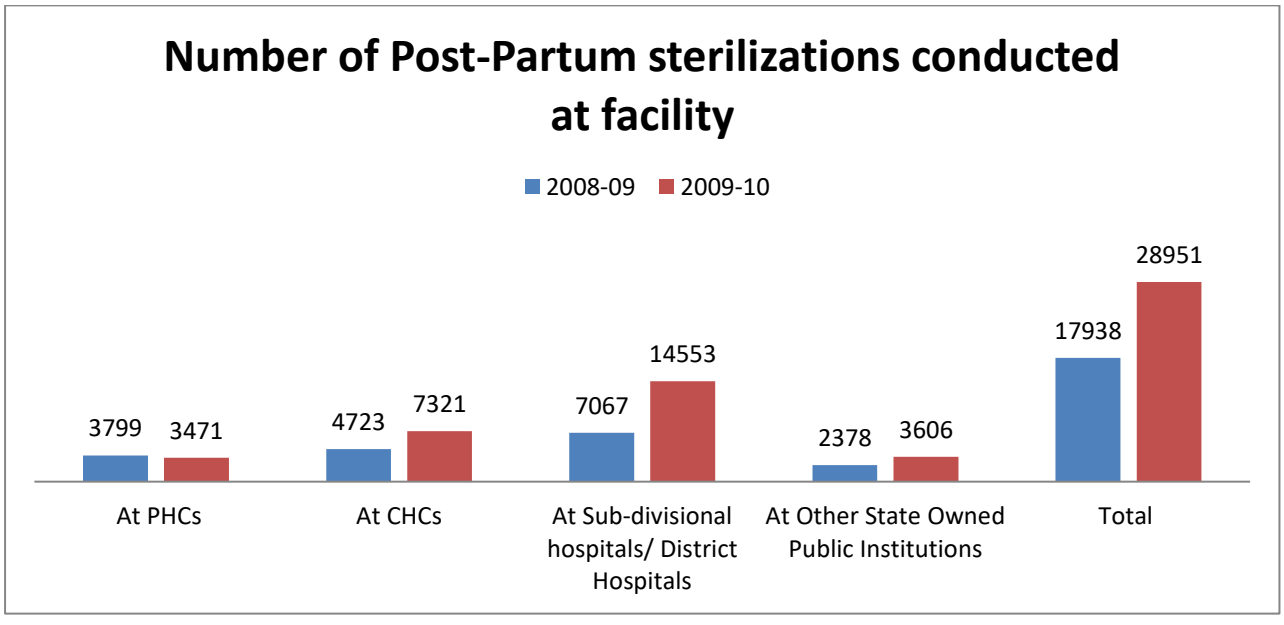
Fig 31



Source-MIS data

MADHYA PRADESH:

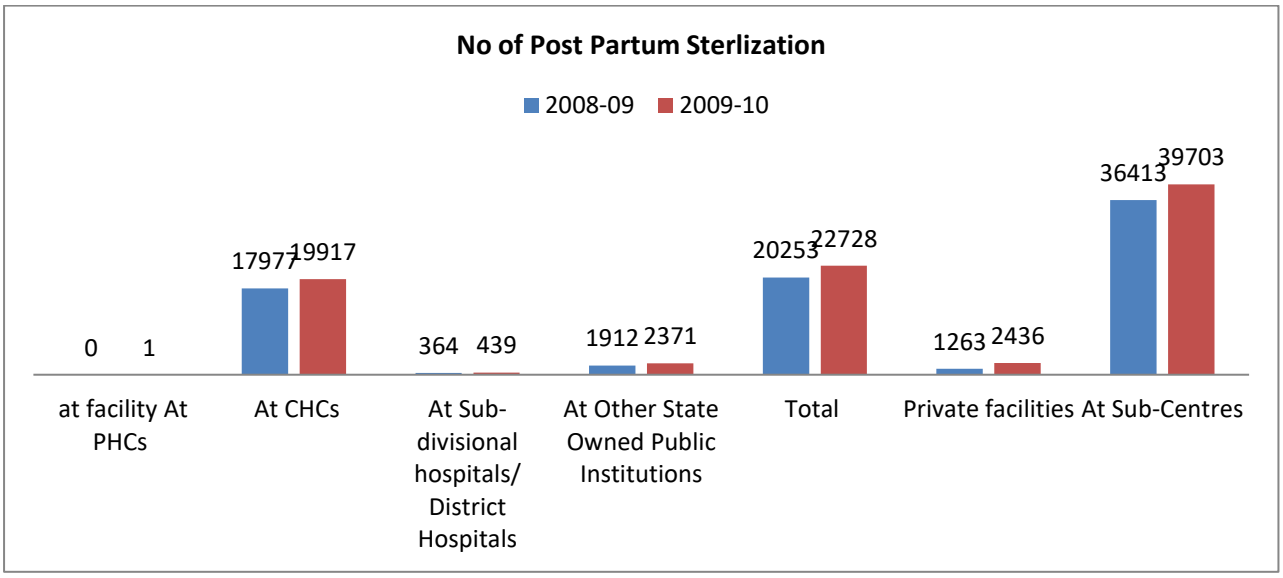
Fig 32



*source-MIS data

CHATTISGARH:

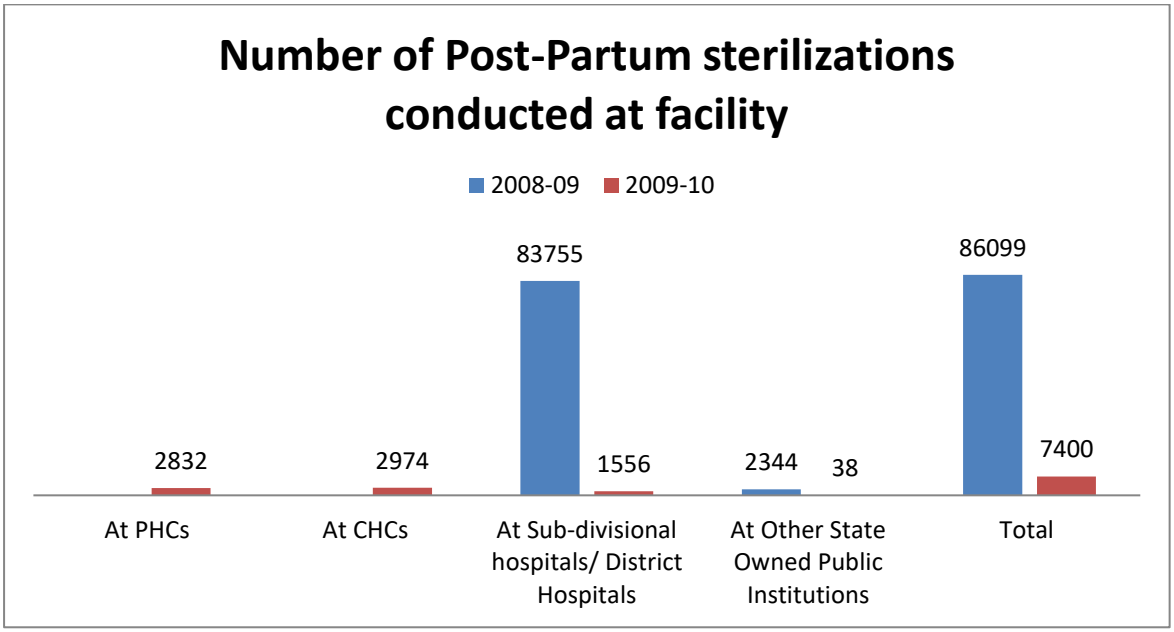
Fig 33



Source-MIS data

JHARKHAND:

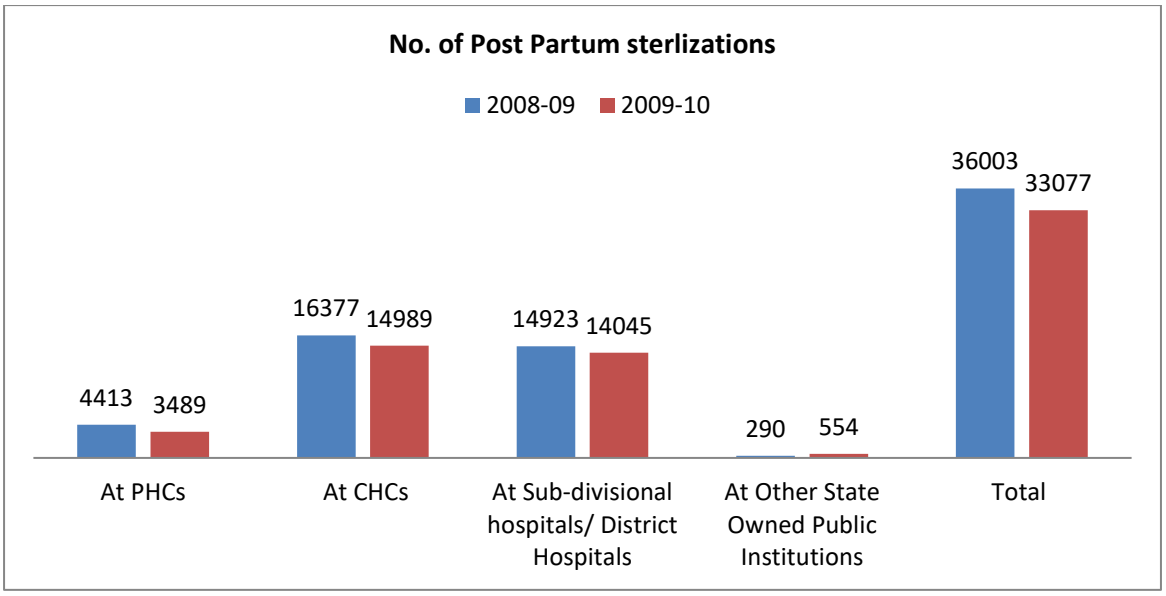
Fig 34



Source-MIS data

RAJASTHAN

Fig 35



Source-MIS data

The status of Post Partum sterilizations have increased over the period of time in all states except Jharkhand (a marked decrease in the sterilization) and Rajasthan.

4.4. To assess the activities in these 6 EAG states to promote the male participation in Family Planning

4.4.1 UTTAR PRADESH:

Provide NSV services on fixed days at health facilities in districts

Organize NSV camps in districts

Male participation is critical to success of population stabilization efforts. With the availability of NSV services, a new opportunity can be explored for improving male participation in population stabilisation. Govt. of India has developed a scheme to promote NSV services in the community. A detailed guideline for camp planning, human resources, IEC, service delivery and training service provider is available for implementation.

However, it has been observed that sufficient caseload is not available when these camps are organised at such large scale. Hence; such camps do not remain cost effective. It was therefore proposed to hold smaller NSV camps at the district level..

Plan to scale up NSV services:

Although tubectomy gained popularity in the state, NSV acceptance is not up to the desired level and constitutes about 2.3 percent of total sterilizations in Uttar Pradesh. Therefore, increasing awareness, acceptance of and access to NSV services are important components of the UP State's Family Welfare Programme. The aim of the NSV programme is to increase the contribution of NSV to total sterilizations to 7.5 percent by 2012.

A Centre of Excellence for Male Contraception (NSV) has been strengthened in the Department of Urology, CSMMU, Lucknow in the year 2005-06 with support from SIFPSA. This Centre was established with the objective of providing quality NSV training and providing NSV services at static sites. The COE also conducts camps, imparts training, generates training material and IEC material together with conducting promotional activities, including research and studies for improving quality of service delivery, developing and maintaining data base, etc. The project has been very successful and has been providing NSV services and training to doctors on regular basis.

In addition, it is proposed to scale up NSV services with USAID supported technical assistance agency for ensuring male participation. The following activities are planned:

A. Follow up of NSV providers who are trained in the Centers of Excellence

The Centers of Excellence at Allahabad, Kanpur, Meerut and Lucknow will train selected medical officers from their divisions as NSV service providers, as per GOI norms. After completion of the training, the trained medical officers are expected to provide NSV services in their facilities. In the absence of backstopping by a NSV expert, some of the medical officers may not develop the confidence and comfort level to carry out NSV surgery independently in their respective facilities.

B. Organize training of doctors on NSV

Till Centers of Excellence start rolling out clinical training of doctors on NSV, it is proposed that young male doctors especially newly recruited MBBS doctors be trained on NSV skills during existing NSV camps. Wherever sufficient client load and NSV trainer are available the NSV clinical trainings may be organized.

Where qualified NSV trainers are not available, the services of national level trainers through external technical support agencies may be availed.

The doctors from the technical assistance agency will support the NSV camps being organised in each district and provide trained service providers and trainers.

C. Orientation of facility staffs and outreach workers on NSV

The paramedical and support staff in the health facilities, and outreach workers are generally not aware of the advantages of NSV. Many of them have misconceptions about the procedure and they are not confident in giving appropriate messages to eligible couples. They lack counseling skills.

It is proposed to orient staff of those facilities where NSV services are provided (through camps, VHNDS, monthly meetings at facilities or on fixed days).

The orientation would focus on explaining the simplicity of the procedure, dispelling myths and misconception on NSV and the messages to be given to target couples. Counseling skills of the staffs would be strengthened. To minimize disruption to routine functioning of these facilities, the orientations would be organized onsite and whole-site for few hours duration on the days of monthly meetings. The facilitators would visit the health facilities and conduct the trainings onsite.

D. Increase demand for NSV by strengthening IEC/ BCC activities

The States BCC Strategy calls for a multimedia approach to include 1) interpersonal communication, 2) community engagement, and 3) mass media.

E. Conduct formative research

A systematically designed formative research will help to better understand what motivates the clients to undergoing NSV and their long term satisfaction; what are the barriers in availing NSV services. The effectiveness of different communication models and materials can be compared. It is proposed to conduct a formative research to assess the existing status regarding NSV and how it can be promoted.

4.4.2 BIHAR:

Promote the use of condoms

- Counseling men in villages to demonstrate ease of use of condoms and for prevention of STDs
- Regular supply of condoms and setting up depots which are socially accessible to all men

Promote adopting NSV: as simple and convenient method of hassle free FP methods (however, it must be told that it doesn't protect from STI/RTI of HIV / AIDS)

Increase demand for NSVs (develop a cadre of satisfied NSV Client, who could be the advocates for NSV in their designated geographical areas. Orient and train them and give them specific geographical responsibility to give roster based talks etc to identified groups of probable clients. During these talks the probable clients can be registered and they could be escorted to the nearest static facility or the camp on designated days for NSV. Once completed the procedures, then these new clients can become advocates for the same. This entire process must be fully facilitated by respective PHCs and be provided with all logistics support along with some incentives for the work or activities undertaken by them)

- Village level meetings in which men who already underwent NSV share experiences to motivate men to undergo NSV

All the GP/ADC Villages will be chosen in the district to hold meetings in which men who have undergone NSV will tell male members of the community about their experience and the benefits of NSV. These meetings will be repeated each month in the same batch of Gram Panchayat or ADC Villages. NSV will be conducted on the motivated men. The same men will then be requested to share their experiences in the next batch of five villages for the next three months.

4.4.3 CHATTISGARH:

4.4.4 MADHYA PRADESH:

Considering mid-term estimated population of MP (6.5 Crores), 9750000 estimated eligible couples are available. Considering 10.7% as unmet need for permanent methods, around 10.43 Lakhs couples have unmet needs for permanent methods. Thus there is lot of scope in MP for further improving performance in sterilization to address unmet needs.

Continuation of NSV resource cell at Gwalior: Out of Total 440531 Sterilization during 08-09 male sterilization are 29891.

The State is committed to make all out efforts to address unmet needs for family planning as an important step towards population stabilization by bringing down TFR to 2.1 by 2011. In view of encouraging response to NSV during last two years, the state has initiated systematic efforts operationalise fixed day camp approach. Trained doctors are performing NSV operations during these fixed camps. During 2006-07 more than 30000 NSV operations were performed in the state, and Madhya Pradesh was the first state in the country for performing maximum NSV operations.

Although, the state is making simultaneous efforts to institutionalize cafeteria approach with informed decisions of the clients and to provide needs based services to the clients, considering encouraging response to NSV, the state desires to further upscale service delivery component and to monitor quality of performance to expect continued positive response from the clients.

Establishment of Comprehensive Sterilization (NSV, LTT & Minilap) resource center at Indore:

The department is in the process of creating this center at Indore (commercial capital of state) under its sectoral reform scheme. From RCH/NRHM funds it is proposed to provide technical and financial support as an integral component of its State Plan of Action till the time the cell starts functioning fully out of state government funds.

4.4.5JHARKHAND:

4.4.6RAJASTHAN:

Presently the male participation in sterilization is very low. To promote male sterilization NSV mega camps will be organized. From April to September bi-monthly and October to March monthly one NSV mega camps will be organized in all districts. The minimum 100 NSV cases will be ensured in each camp.

Fig a

NSV TRENDS:

	2006-07*	**2007-08***	**2008-09**	**2009-10**
Bihar	1,134	6,238	1,427	35,170
Chattisgarh	6,322	9,920	10,562	9,985
Jharkhand	6,461	17,281	12,123	7,144
Madhya Pradesh	10,972	30,816	29,408	19,718
Rajasthan	6,366	12,555	12,219	9,309
Uttar Pradesh	2,669	5,940	11,132	17,013

*source-MIS data

4.5 To assess the initiative of states in promoting HRD (Human Resource Development) for family Planning

4.5.1 UTTAR PRADESH:

- **Post Partum Abdominal Tubectomy Training**

Post partum abdominal tubectomy training will be provided along with the short term Comprehensive Emergency Obstetrics Care (CEmOC) refresher training. It is observed that although post partum abdominal tubectomy is a simple procedure which can be performed soon after delivery (within 48 hours), service providers are reluctant to offer these services to beneficiaries in absence of current practice. During the course of this training, there will be an opportunity to refresh their skills on post partum clients who opt for abdominal tubectomy. This training will be coordinated by SIHFW.

- **Post Partum Abdominal Tubectomy (PPAT) Refresher Training for MBBS LMOs**

Presently, MBBS LMOs are providing all the obstetric services at DWH/ CHs. In service they have gained skills in all obstetrical procedures (major and minor surgeries, including LSCS) but currently they are not providing post partum abdominal tubectomy services due to lack of emphasis on post partum family planning services. Therefore, to refresh their skills for provision of PPAT it is proposed to give them a refresher training of three days at 17 divisional training centres. It is proposed to train 85 doctors (LMOs) in the year 2010-11. The services of master trainers of abdominal tubectomy will be used to impart this training. The training will be coordinated by SIHFW.

In addition to the above, NSV training in Centres of Excellence, laparoscopic sterilisation training and abdominal tubectomy training will be conducted. Details of these are available in the training section.

- **IUD training**

For staff nurses/ LHVs/ PHN is doctors and ANMs.

- **Contraceptive Technology Update**

It is proposed that the contraceptive technology update training is included in the ANM and LHV skill training so that service providers are well aware of latest options available for family planning.

4.5.2 BIHAR:

Increase capacity for NSV services

- Training of doctors for NSV

While demand is being generated, a team of doctors should be trained at all the FRU level to conduct NSVs.

- Organize NSV camps at the Sub District Level

4.5.3 CHATTISGARH:

Training of ANMs in alternative methodology of CuT insertion

4.5.4 MADHYA PRADESH:

4.5.5 JHARKHAND:

Skill based training for clinical methods of family planning

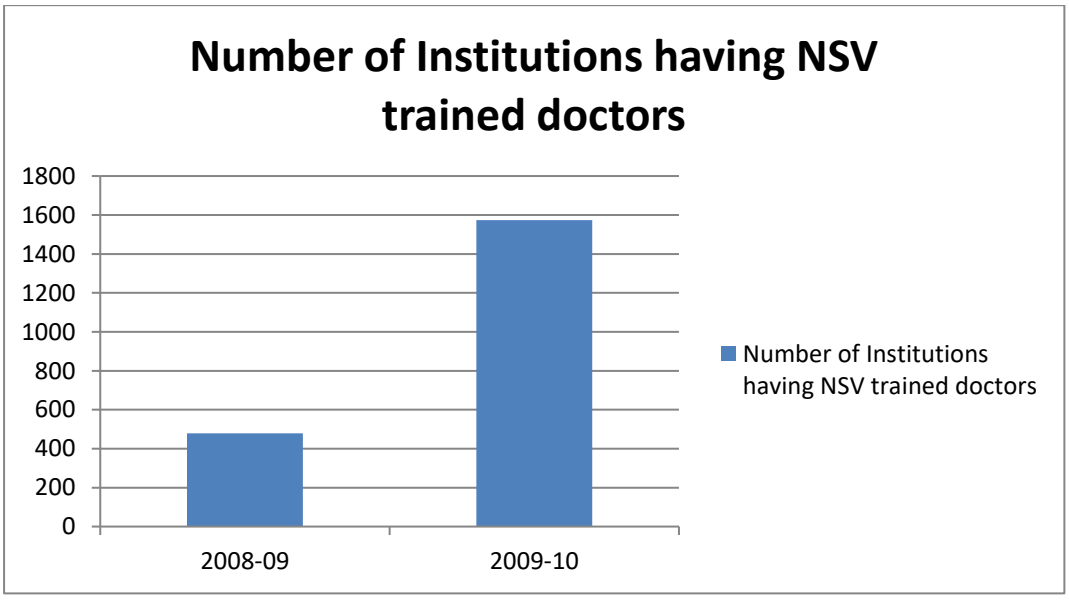
The key training programs planned can be summed up as follows:

- Training for laparoscopic sterilizations
- Training on IUD insertions
- NSV training
- Minilap training
- CTU training Emergency Contraceptives, LAM, SDM FOR ANM, AWW and Sahiyyas at Health Sub Centre Level.

4.5.6 RAJASTHAN:

Uttar Pradesh:

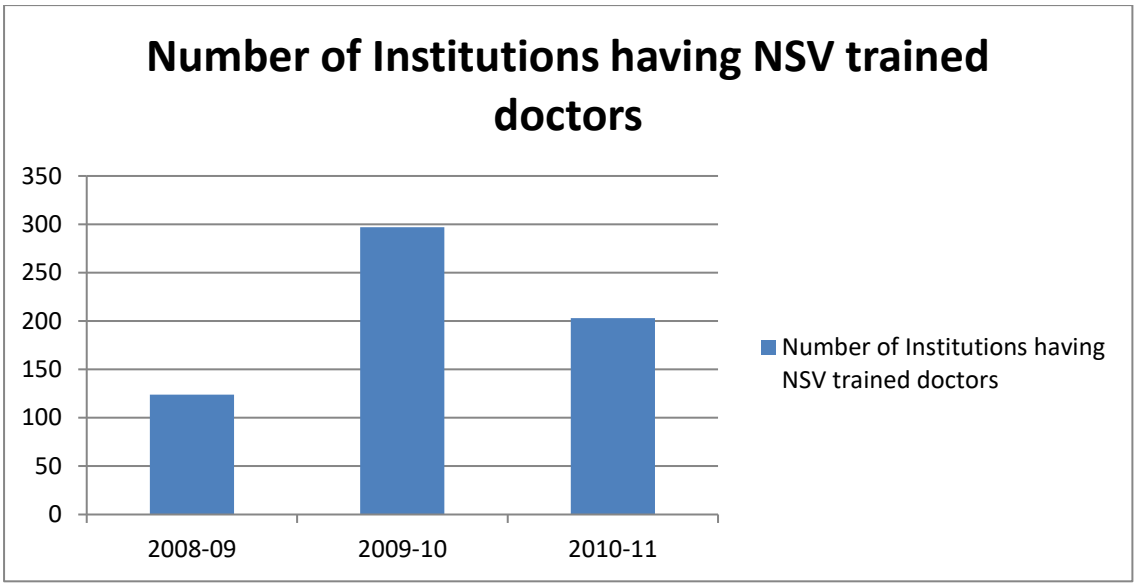
Fig 36



Source-MIS data

BIHAR:

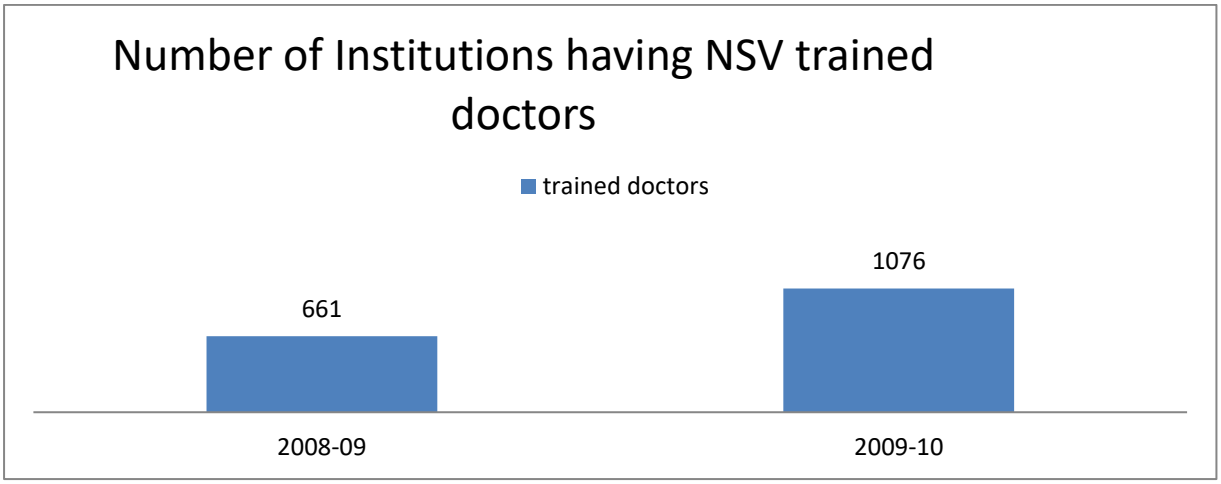
Fig 37



Source-MIS data

MADHYA PRADESH:

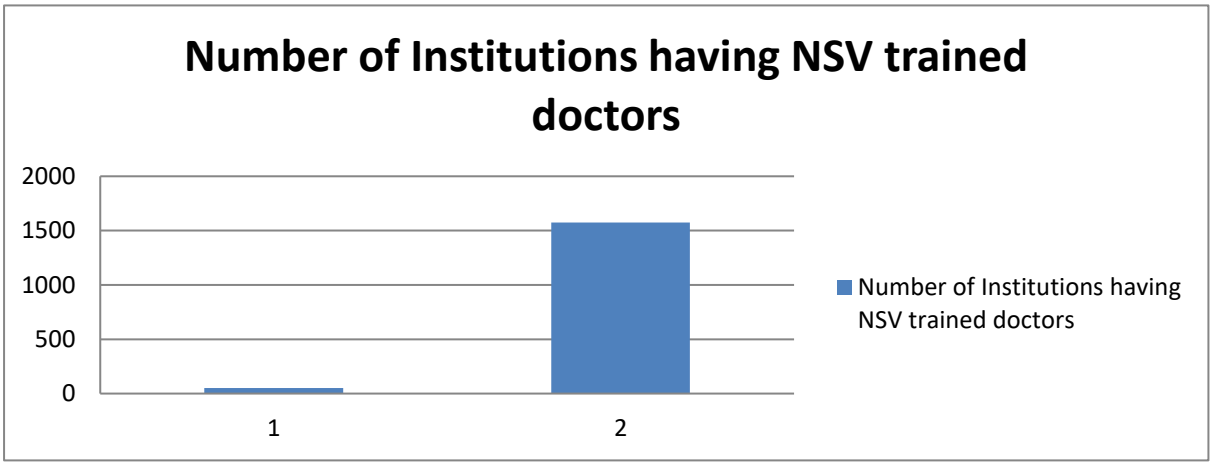
Fig 38



Source-MIS data

RAJASTHAN

Fig 39



Source-MIS data

The status of number of institutions having trained doctors has increased in the 2008-09 to 2009-10 in all the 6 EAG states

TREND OF STERILISATIONS:

	2006-07*	**2007-08***	**2008-09**	**2009-10**	**% Change 08-09- 09-10**
Bihar	1,19,977	3,00,918	2,50,550	3,12,074	20.4
Chattisgarh	1,33,094	1,53,836	1,71,306	1,72,003	0.5
Jharkhand	1,01,297	1,06,383	1,10,693	1,13,296	2.4
Madhya Pradesh	3,67,510	4,51,896	4,40,531	4,18,353	-4.9
Rajasthan	2,88,089	3,35,029	3,55,202	3,45,900	-2.8
Uttar Pradesh	4,29,484	4,29,484	4,79,513	4,73,802	-1.3

*source-MIS data

Discussion:

Fixed Day strategy and others:

1. Uttar Pradesh

The total no of NSV is decreased over the period of time as the number is decreasing in PHCs and CHCs. The PIP does not reflect the reasons but the probable reasons, as discussed with the various stakeholders in the Family Planning division, can be

- Lack of HR
- Very few facilities provide fixed day Strategy
- As more case load is there in SDHs so the relocation of the providers from PHCs and CHCs were done to SDHs.
- Also the training of health care providers in state is not up to the mark.

It was observed during various reviews e.g. CRM that the family planning surgeries were provided largely though camps for laparoscopic tubal ligation and No scalpel vasectomy. In certain districts, the officials reported that there were few qualified laparoscopic surgeon in the whole district.

However, camps reporting more than 200 women undergoing laparoscopic tubal ligation in a day were not uncommon which reflects the quality of services being so poor.

It was also seen that minilap tubectomies were not being performed regularly. Male sterilizations were found to be very few comparatively. The use of IUD needs to be promoted. Emergency contraceptive pills supply was also not available.[8]

2. Madhya Pradesh:

The NSV and laprascopic sterilizations are decreasing in the state, but at the same time the mini lap sterilizations are increasing. As the laparoscopic sterilizations are tedious processes so the trend of mini lap is increasing which is reflected in the total no of minilap sterilizations taking place.

Also, since last one and half to two years the enormous work is done in the states. Latest MIS data, 2010-11 shows approximate 6.5 lakhs sterilizations which used to be around 4 lacs earlier and out of these 6.5 lacs more than 95% is Female sterilization.

One of the challenges being faced by the state is the limited number of health institutions providing sterilization because of the acute shortage of staff. Also the lack of skilled paramedical staff for

IUD insertion has led to a few numbers of cases of IUD insertion. Also to promote the use of spacing methods Contraceptive Corners are being established at the District Hospitals.

3. Bihar:

Both the NSV and mini lap sterilizations have increased over the period of time in the state. The probable reasons, as discussed with the Government officials are:

Good PPP model is available in the state. Janani, an NGO has collaborated with the state government and helps in conducting sterilizations.

Minilap remains the focus of family planning with NSV making a beginning in some facilities. The post operative care observed in two camps in the PHCs, require more attention to patient comfort (all women lying on the floor) and hygiene as in CRM. Minilap services continue to be available through a camp approach in the Block PHCs. In two camps, it was observed that women with two and three children made up more than 60% of the cases. NSV as a FP limiting method for males has just been initiated in some block PHCs (the first one percent!). Unmet need continues to be likely because of the lack of any consistent strategy to increase the coverage for spacing. (Source CRM 2009)

4. Chhattisgarh:

Both the NSV and laparoscopic sterilizations are decreasing and at the same time there is not a substantial increase in the mini lap sterilizations. Even the PIP write up does not reflect many strategies and the activities on Family Planning.

The state is still lagging behind in Family planning. Due to paucity of trained service providers in sterilization at the CHCs and PHCs, Laparoscopic tubectomy at CHCs through camp mode is the main approach for family planning. Male sterilization accounts for only 7.4% of total cases of sterilization. In 2009-10, 10,078 male sterilizations have been performed compared to the 1, 36,761 female sterilizations done during the same period. Spacing methods are not being practiced sufficiently. Staffs trained in IUD insertion are found to be in-confident and hence, patients are being referred to CHCs and DH for the same. The CRM team could not find any record of Family Planning in the PHCs and SHCs, and even in CHCs (other than for Laparoscopic Tubectomy records).- CRM 2010

5. Jharkhand:

There is decrease in both the laparoscopic sterilizations and the NSV but a marked increase in the mini lap sterilizations.

Acceptance and use of IUD is very low, even after the introduction of new IUD with 10-years life. Also it is understood that below DH level services are not available adequately.

6. Rajasthan:

There is decrease in both the laparoscopic sterilizations and the NSV but a marked increase in the mini lap sterilizations.

The reduction of a relatively still high TFR of 2.6 is being done through strengthening of the Jan Mangal Program, the establishing of an NSV Resource Centre and through the Rajiv Gandhi Population Stabilization Mission. The determinants of the high TFR continues to be early age of marriage (40 per cent, DLHS III), high adolescent fertility rate (16 per cent), the unmet need, and programmatic issues like non-availability of trained manpower for a fixed day approach, and the predominant emphasis on limiting methods and minimal spacing method promotion. The State has started to improve access and availability of NSV services for increasing share of male sterilization in the method mix. In line with the GOI guidelines, State has increased the monetary incentive for all sterilisations. There is a huge potential untapped for increasing postpartum FP interventions by capitalising on the increase in institutional deliveries. A well thought out multiple-level FP strategy to reach different segments of eligible couples with a basket of options was absent in both the districts. This is a gap that the State and districts require to address.

Challenges identified in reducing total fertility rate (TFR) in the State include, early age of marriage (40 per cent, DLHS III) and high adolescent fertility rate (16 per cent); lack of motivation of the couples to adopt limiting methods after having two children and son

preference; not meeting the unmet need of family planning through regular provision of FP services, and lack of service providers for fixed day approach with 50 per cent vacancy of gynecologists and 53 percent vacancy of surgeons at CHCs. There is also a need to focus on promoting spacing methods.
Progress in Family Planning (Expected vs. Achieved) in Rajasthan in 2010-2011

7. IUD insertion:

The IUD insertion has decreased over the period of time (as reflected by HMIS data) in almost all the states except Bihar, the possible reasons for which can be (as told by the various concerned officials) the problem in data reporting in HMIS in 2008-09. More numbers were reported in the starting years. Though from the last financial year, the system is improving and data reporting is up to the mark now.

8. Post partum sterilization:

Focus on PPS under family planning services. The states are working on the activity with intense focus. It is increasing in all the states with exceptions like Jharkhand and Rajasthan.

9. **NSV:**

It is decreasing with exception in Bihar (there is marked increase in the NSV sterilizations) and UP (not much increase is there).

10. In spite FDS is a focus, the camp approach is still there which is reflected in state PIPs as well.

Recommendations:

1. Forming a National Advocacy group for promotion of family Planning
   A national Advocacy Group consisting of members of various Health organizations from different National and international level should be involved. The state representatives from high TFRs states
2. Acting as a catalyst for promotion of Family Planning:
   The members of National Advocacy Group should be involved in this and should take following actions:
   - Holding frequent meetings at state and national level with other stake holders and acting as a monitoring agent.
   - The NAG could closely liaison with the centre and assist the centre in supporting the states for filling the gaps in the implementation of the major strategies introduced in the programme.
3. Lead a campaign for family Planning:
   A strong leadership is required for initiating the process of repositioning family planning in the country, in the present context of assumption that providing the safe maternal and child care would bring in population stabilization, without taking corrective measures in filling the gaps under the contraceptive services.
4. Assist states in FP implementation
   - Identifying the gaps in their present FP program implementation
   - Support the states in their state RCH PIP planning in the FP for filling the gaps.
   - Support the state in implementing the FP program such as in contraceptive service provision, trainings, IEC/BCC, supportive monitoring in program implementation at district level.
5. Influencing the planning process during state PIP preparation
6. Intense review with supervision of states for family planning should be done.
7. Training program should be expanded with proper placement of HR accordingly and post training follow up should also be done.
8. Communication with proper IEC strategy should be incorporated.
9. HMIS data quality should be enhanced and proper reporting
10. An expanded reproductive health programme must address men both in terms of their own health needs and in terms of their shared responsibility as partners, husbands and fathers, and should not be limited to promoting the use of male contraceptive methods. The role of male health workers who could play an active role in promoting male involvement also needs to be clearly defined.[4]
11. IEC efforts to enable clients to exercise informed contraceptive choice have been increased, but inadequate collaboration between the health sector, IEC units and other stakeholders is reportedly rendering these efforts ineffective. Hence, inter-sectoral coordination needs to be vigorously promoted.[4]

The DPMs should have training for district PIP and reviewing of ongoing program. Implementation of the mechanism of regular monitoring of programme activities and supervision by District CMOs was a felt need of the CRM team.[8]

A dedicated effort is needed from the district program management level to regularly supervise the functioning of the facilities, the quality aspects in clinical care, observance of clinical protocols, proper utilization of the available resources including drugs, equipments, disinfectants, linens, dressing materials, furniture, registers, charts.[8]

With respect to improving access to and utilisation of family planning services in the State, differential strategies for young couples focusing on delaying their first birth and spacing their second baby required state-wide implementation.[8]

There is need to develop BCC strategy focusing as much on provider behavior as on client health seeking behavior. A two way communication strategy needs to be focused on developing ways in which the voices of the poorest and voiceless could be communicated effectively to influence policies and inform about the provisions of existing health service schemes.[8]

Limitations of study:

There were data quality issues. Percentage of data reported in HMIS was not hundred percent. So the authenticity of the data is doubtful

Due to time constraints the study could not be developed into multi centric study. The interviews of other important stakeholders i.e. the state officials and the beneficiaries which with the help of my mentors, I would try to take it forward.

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