Operational Guidelines on FDS (Fixed Day Static) approach for Sterilization Services under the Family Welfare Programme

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

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सत्यमेव जयते

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
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FOREWORD

Dated, the 18th November, 2008

The National Population Policy advocated a holistic multisectoral approach towards population stabilization, with no targets for specific contraceptive methods except for achieving a national average total fertility rate (TFR) of 2.1 by the year 2010. The NRHM program of the Government of India introduced in 2005, which subsumes RCH II, places population stabilization as one of its goal to achieve quality life and has set the goal of TFR 2.1 by 2012. However, as per the population projections by the Registrar General of India, the TFR would reach replacement level i.e. 2.1 only by 2021. Under the current trends, the high focus states like Bihar, MP, Rajasthan, UP, Jharkhand, Chattisgarh etc. would take at least 25 years to attain replacement level fertility rates. There is very high unmet demand for terminal methods in these states, which they are not able to meet as per the service mode adopted presently.

There is, therefore, a need to adopt a strategy, which would provide assured, accessible, quality sterilization services, throughout the year, nearest to the doorsteps of the needy couples, so as to meet their unmet need.

Recognizing the need the ministry has developed a fixed day static (FDS) approach in sterilization services which will ensure provision of assured services throughout the year, on a regular and routine basis, provided by trained service providers posted in the facility, thereby achieving the twin objectives of achieving population stabilization as well as quality sterilization services.

The document elaborates the FDS strategy formulated by the ministry in provision of routine and round the year sterilization services to the community and I hope it will go a long way in achieving population stabilization sooner than projected.

(G.C. Chaturvedi)

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ACKNOWLEDGEMENT

Dated, the 18th November, 2008

The document entitled 'The Operational Guidelines On FDS (Fixed Day Static) Approach For Sterilization Services' has been developed with the objectives of empowering programme managers as well as service providers in the states with the wherewithal to formulate and implement state action plans for provision of regular, routine, round the year services in sterilization to meet the prevailing huge unmet demand and also enable them to make a smooth transition from the seasonal camp approach presently in vogue to the more desirable regular approach.

We gratefully acknowledge the constant support of our Additional Secretory & Mission Director (NRHM), Shri G. C. Chaturvedi and Joint Secretory, Shri Amarjeet Sinha in promoting the FDS strategy for provision of sterilization services, with all the states during the NPCC and state meetings with them.

We also wish to acknowledge the initiatives of our previous Deputy Commissioner Dr. M. S. Jayalakhsmi and the support of our present Deputy Commissioner Dr. Kiran Ambwani, as also the contributions of Dr. Jaya Lalmohan, consultant, Family Planning division, Dr. Loveleen Johri, USAID Dr. Dinesh Aggarwal UNFPA, who have rendered continuous technical and programmatic inputs for the document to evolve.

We also heartily acknowledge the printing support provided by FHI.

(Dr. S. K. Sikdar)

Contents

Abbreviations

ANM	–	Auxiliary Nurse Midwife
APL	–	Above Poverty Line
ASHA	–	Accredited Social Health Activist
AVSC	–	Association of Voluntary Surgeons for Contraception (now known as EnGender Health)
AWW	–	Anganwadi Worker
BPHC	–	Block Primary Health Centre
BPL	–	Below Poverty Line
CC	–	Conventional Contraceptive
CHC	–	Community Health Centre
CMHO	–	Chief Medical and Health Officer
CMO	–	Chief Medical Officer
CPR	–	Contraceptive Prevalence Rate
CS	–	Civil Surgeon
CTI	–	Collaborating Training Institute
DH	–	District Hospital
DHO	–	District Health Officer
DLHS	–	District Level Household Survey
ECP	–	Emergency Contraception Pill
ELA	–	Expected Level of Achievement
FDS	–	Fixed Day Static
GOI	–	Government of India
IEC	–	Information and Education Campaign
IUCD	–	Intrauterine Contraceptive Device
JD	–	Joint Director
LHV	–	Lady Health Visitor
MOHFW	–	Ministry of Health and Family Welfare
NFHS	–	National Family Health Survey
NGO	–	Non Governmental Organization
NIHFW	–	National Institute of Health and Family Welfare
NRHM	–	National Rural Health Mission
NSV	–	No Scalpel Vasectomy

OCP	–	Oral Contraception Pill
OT	–	Operation Theatre
PHC	–	Primary Health Centre
PIP	–	Project Implementation Plan
POL	–	Petrol, Oil and Lubricant
QAC	–	Quality Assurance Committee
RCH II	–	Reproductive and Child Health Program II
SC	–	Scheduled Caste
SC	–	Subcentre
SDH	–	Sub District Hospital
SIHFW	–	State Institute of Health and Family Welfare
ST	–	Scheduled Tribe
TFR	–	Total Fertility Rate

Introduction

Currently, India is the second most populous country in the world with a population growth rate of 1.74%, contributing to 20% of births worldwide. This rapid increase in population is one of the major factors contributing towards low quality of life in spite of rapid strides being made on the economic front.

The "National Population Policy 2000" advocated a holistic, multisectoral approach towards population stabilization, with no targets for specific contraceptive methods except for achieving a national average TFR of 2.1 by the year 2010. The NRHM program of the Government of India introduced in 2005, which subsumes RCH II, places population stabilization as one of its goal to achieve quality life and has set the goal of TFR 2.1 by 2012. However, as per the population projections by the Registrar General of India, the TFR would reach replacement level i.e. 2.1 only by 2021. Under the current trends, the states like Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chattisgarh would take at least another 25 years to attain replacement level fertility rates. There is a very high unmet demand for terminal methods in these states, which they are not able to meet as per the service mode adopted presently. Addressing these unmet needs would enable the country to achieve the replacement level fertility, much before the current projected period. There is a therefore a need to adopt a strategy, which would provide assured, accessible, available and good quality sterilization services, through out the year, nearest to the doorsteps of the needy couples, so as to meet their unmet needs.

Situation Analysis (Need for FDS)

States performing well in family planning programmes have demonstrated that the optimum level of sterilization is over 2,000 sterilization per 10,000 unsterilized couples exposed to higher order of births of 3 and 3+ . In states like Uttar Pradesh and Bihar it is less than 350. There is an urgent need to rectify the situation. The performance of the states with high TFR and high levels of unmet needs in terminal methods compared to some States which have achieved the replacement level fertility has been tabulated in Annexure A. An overview of the sterilization services provided in these states shows the following:

1. The provision of services in states with high TFR and unmet needs reveals that majority of sterilizations services are provided in the latter half of the year (October to March - winter months) where as performance of Andhra Pradesh which has achieved the replacement level fertility shows an uniform performance throughout the year. The seasonal variation in the performance is more due to lack of service provision rather than acceptors' preference (Study on Rajasthan, UNFPA) .
2. Andhra Pradesh has been doing around 4,485 sterilizations per 10,000 unsterilized couples exposed to higher order of births of 3 and 3+ as compared to less than or around 1,000 in the states with high TFR.
3. A major proportion of sterilizations in the states with high unmet need continue to be performed through camps due to paucity of trained service providers in sterilization at the CHCs and PHCs, leading to deputation of gynaecologists/surgeons from higher centers like district hospital. In contrast to this, the States which have achieved the replacement level fertility have been providing assured, weekly or fortnightly sterilization services at CHC and PHCs through trained providers posted in the facility itself.
4. The data available with the GOI shows that the southern states where the replacement level fertility has been reached shows a high proportion of minilap sterilizations (85 to 90%) compared to laparoscopic sterilizations (10 to15%), whereas laparoscopic sterilizations forms 70-90% of female sterilization in most of the high TFR states like Uttar Pradesh, Rajasthan, Madhya Pradesh, Chattisgarh, Assam and Uttaranchal. As laparoscopic sterilizations are to be performed by trained gynaecologists/surgeons only, promoting it would limit service provision in these states where the availability of specialists is low. Promoting Minilap would be a better proposition for increasing the provider base as it can be conducted by a trained MBBS doctor.
5. A number of states with high unmet need like Jharkhand, Madhya Pradesh, Gujarat, West Bengal, Chattisgarh and Punjab have increased their NSV performance substantially in the past 2 years, which not only promotes male participation in family planning but is also a substantially easier approach in terms of logistics for meeting the high unmet need in terminal methods.
6. The Expected Level of Achievement (ELA) in sterilization formulated by the Ministry for the various states based on unmet need, TFR, present performance etc. shows that a number of high TFR states can achieve replacement level fertility by giving focused attention to sterilization services and increasing the sterilization performance.

Based on the situational analysis enumerated above, there is a need to shift from camp approach to FDS (fixed day static) approach.

Definition

FDS (Fixed Day Static) approach in Sterilization Services is defined as "providing sterilization services in a health facility by trained providers posted in the same facility, on fixed days, throughout the year on a regular and routine manner".

Objectives

- To consciously move from a camp approach to a regular routine service.
- To make the facility self sufficient in provision of sterilization services.
- To enable clients to have assured service on any given day at their designated facility without depending on a traveling team of providers from elsewhere.
- To ensure the availability of at least one Minilap/NSV trained MBBS medical officer in the CHCs , Block PHCs, 24x7 PHCs and PHCs for providing regular services in sterilization.
- To ensure quality of care in sterilization services through adherence to laid down. standards of the GOI.

Advantages

- Ensures uninterrupted service provision throughout the year, following demand generation.
- Quality of care is ensured with a lower client load per session and proper follow up care.
- Shifts from the seasonal, camp approach to assured routine sterilization services, provided by trained service providers posted in the facility on a regular basis.
- Enables the clients to get the facility at their doorstep.
- Sterilization performance can be scaled up easily and rapidly.

Target Audience

These guidelines have been developed keeping in mind the specific information needs of the following stakeholders for planning for FDS:

- State and Districts Family Welfare Officers;
- CMHOs/CMOs/DHOs/JDs/CSs;
- State and Districts Programme Managers;
- I/C of training institutes such as NIHFW, SIHFW, CTIs, and I/C of identified training institutes for conducting NSV/ Minilap/ Laparoscopic training; and
- Master and District Trainers of NSV/ Minilap/ Laparoscopic training.

Guiding Principles (for Meeting the Unmet need in Terminal Methods)

- Supportive policy environment.
- Human Resource Development.
- Maintaining demand-supply balance.
- Quality Assurance.
- Monitoring and Evaluation.

Strategies to Address the Guiding Principles

1. Advocacy at State/District/Facility level.
2. Estimating state/district/facility level of achievement based on the local unmet need (ELA).
3. Assessment of facilities (Facilities mapping).
4. Assessment of capacity (Sterilization services possible).
5. Building capacity (Human resource development) for providing FDS services: both male and female sterilizations as per ELA requirement.
6. Strengthening physical infrastructure of identified facilities.
7. Publicizing FDS availability to the community.
8. Monitoring FDS services output.
9. Monitoring performance standards of trained service providers.
10. Providing clear financial guidelines.
11. Ensuring prompt payment of compensation money to acceptors and providers.

1. Advocacy at State/District level

The latest NFHS survey shows that the desire for a small family is universally high in the country with nearly 85 % of women in the reproductive age group desiring for 2 children. However nearly 40% couples are with 3 or 3+ children in the states with high TFR and unmet need. The policy makers in these states therefore need to give high priority for operationalizing the FDS service approach for meeting the demand.

2. Estimating state/district/facility level of achievement based on the local unmet need (ELA)

The M and E Division of the ministry in coordination with the Family Planning Division has formulated the Expected Level of Achievement (ELA) in sterilization (2008) for the various states based on their unmet need, TFR and present performance. The states can now formulate their district wise ELA by extrapolating the state ELA, based on the district unmet need emerging from the DLHS III.

3. Assessment of Resources (Facility mapping)

i) Identification of centers for providing sterilization services

(Under the Supreme Court Directives on sterilization services only those facilities which are designated health facilities by the state can provide sterilization services whether in the camp mode or regular mode).

The following health facilities in a district should provide female and male sterilization as regular, routine services throughout the year.

- District Hospitals.
- Sub District Hospitals.
- CHCs and Block PHCs with availability of functioning operation theatre.
- 24 x 7 PHCs, with availability of functioning operation theatre.
- Other Government facilities with availability of functioning operation theatre.

ii) Range of services

1. NSV/Conventional Vasectomy.
2. Minilap Sterilization.
3. Laproscopic Sterilizations wherever gynecologists/surgeons are available.

iii) Periodicity of services

- District /Hospital - weekly
- Sub District/ Hospital - weekly
- CHC / Block PHC - fortnightly
- 24×7 PHC / PHC - monthly

However those facilities which are already providing the services in a frequency more than what is suggested above may rationalize the distribution of the providers among the various facilities in the district and strive to augment the services even further to address the prevailing huge unmet need.

4. Assessment of capacity (sterilization services possible)

Please refer to the state/ district monitoring checklist for Family Planning explaining the manpower development plan based on the sterilization service possible in a district (**Annexure B**).

Number of facilities to be providing FDS services in a district of 20 and 10 lakhs population respectively are approximately as follows:

Sl. No.	Facility	District with 20 lac population	District with 10 lac population
1	DH	1	1
2	SDH	1	1
3	CHC/BLOCK PHC	10	5
4	24/7 PHC	10	5
	Total	**22**	**12**

Illustration: 1

Sterilization services possible in a district of an average population of 20 lakhs are around 16,080 as illustrated below:

STERILIZATION SERVICES POSSIBLE			
Sl.No.			**TOTAL**
1.	DH @ 1 per week = (52 weeks x 30 cases/ provider x 2 provider x 1 facility)	**3120**	**16,080**
2.	SDH @ 1 per week = (52 weeks x 30 cases/ provider x 1 provider x 1 facility)	**1560**	
3.	CHC/BPHC @ 1 per 2wks = (26 weeks x 30 cases/ provider x 10 facilities with 1 provider per facility	**7800**	
4.	24/7 PHC @ 1 per month = (12 month x 30 cases/ provider x 10 facilities with 1 provider per facility	**3600**	

Illustration: 2

Sterilization services possible in a district of an average population of 10 lakhs is around 10,380 cases as illustrated below:

(This illustration is also applicable for a district with a population of 20 lacs approximately but in a high focus state with weak infrastructure and low density and penetration of primary health care structures)

STERILIZATION SERVICES POSSIBLE			
Sl.No.			TOTAL
1.	DH @ 1 per week = (52 weeks x 30 cases/ provider x 2 provider x 1 facility)	3120	10,380
2.	SDH @ 1 per week = (52 weeks x 30 cases/ provider x 1 provider x 1 facility)	1560	
3.	CHC/BPHC @ 1 per 2wks = (26 weeks x 30 cases/ provider x 5 facilities with 1 provider per facility	3900	
4.	24/7 PHC @ 1 per month = (12 month x 30 cases/ provider x 5 facilities with 1 provider per facility	1800	

5. Capacity building (Human resource development) for FDS male and female sterilizations

A. Qualification Norms Of Providers: (As Laid Down In The GOI Manuals On Standards In Sterilization Services)

Sl.No.	PROCEDURE	QUALIFICATION
1	NSV / Conventional Vasectomy	Medical officer (with MBBS qualification) trained in NSV/ Conventional Vasectomy
2	Minilap	Medical officer (with MBBS qualification) trained in Minilap
3	Laparoscopic sterilization	DGO/MD (Gynecology)/ MS(Surgery) trained in laparoscopic sterilization

Justification for promoting minilap over laparoscopic sterilizations

As outlined in the situation analysis, there is a need to shift the emphasis from laproscopic sterilization to minilap, especially in the states with high unmet need for the following reasons:

- Can be offered more widely than laparoscopy because even an MBBS doctor trained in the procedure can provide it.
- Can be employed for post partum sterilization, while laparoscopy cannot.
- Requires simple, inexpensive and easily maintainable surgical equipments in comparison to expensive laparoscopes which needs intensive and costly maintenance.
- Involves low start up and continuing costs.
- Causes less post operative distress.
- Can be easily performed under local anesthesia.

Justification for promoting NSV as a major strategy in addition to the tubectomy services

There is a need to give focused attention to promote NSV services because of the following reasons:

- A trained MBBS doctor with minimal infrastructural requirements available even at the PHC level can easily provide NSV.
- It is a simple walk away procedure requiring only local anesthesia and low cost instruments.
- It is a stitch less and scalpel less procedure.
- Post operative complications are almost nonexistent.
- Ideal for low cost settings and low infrastructure facilities which is still prevalent in most parts of the country.
- Shifts the responsibility of family planning from the women to men.

The capacity building for sterilization services requires a well defined strategy for training MBBS doctors in minilap and NSV for regular services. However, in case of non availability of a trained service provider in the facility at any time, services of trained provider from outside the facility or from private sector could be utilized till the time at least one doctor is trained from the same facility. This is to ensure continuity of services to the community.

B. Road Map For Training in Female and Male Sterilization Methods

STEP I: STATE LEVEL orientation training for District level Trainers

Responsible Agency	State Family Welfare Nodal officer and SIHFW
Target Participants	• District RCH/Family welfare officer. • Gynaecologist from District./ Sub District./ CHC. • MBBS doctor with specified criteria.
Training Team	• Trainers from SIHFW and Medical college
Venue and Duration	• Venue-SIHFW • Duration-2 days
Training Objectives	• Standardize Knowledge Skills and Attitudes in accordance with GOI 'Standards for female and male Sterilization guidelines' • Standardize training competencies needed to lead district level training activities. • Introduce GOI Operational Guidelines in order to support implementation of the FDS sterilization services within the district.

STEP II: District level Training of Service Providers

Responsible Agency	• District FW Nodal Officer and District Training centers
Target Participants	• Medical Officers for Minilap • Gynecologists/Surgeons for Laproscopy • MBBS doctors/Gynecologists/Surgeons for NSV
Training Team	• Trainers from District Training center/District Hospital
Venue and Duration	• Venue - District Training center/District Hospital • Duration- 12 days for minilap and Laparoscopic/5 days for NSV
Training Objectives	• Standardize Knowledge Skills and Attitudes in accordance with GOI 'Standards for female and male Sterilization guidelines' • Introduce GOI Operational Guidelines in order to support implementation of the FDS sterilization services within the district. • Develop technical skills in conducting NSV/minilap/ Laparoscopic sterilization procedures

C. Training Need Assessment And Planning Trainings in Terminal Methods

The monitoring state/ district checklist given in annexure B will show the gap analysis in terms of providers required to be trained.

The District CMO needs to identify the gap in the number of requisite service providers for conducting minilap/laparoscopic/NSV sterilizations and plan for training in a time bound manner.

		DH/ SDH			CHC/ BPHC			24/7 PHC		
MANPOWER DEVELOPMENT PLAN		**R**	**A**	**G**	**R**	**A**	**G**	**R**	**A**	**G**
1	Tubectomy (a) Minilap surgeons									
	(b) Laparoscopic surgeons									
2	NSV surgeons									
3	Training (Batches of 4 or less)									
	i. NSV									
	ii. Minilap									
	iii. Laparoscopic sterilization									

	**To be assessed*				
	Facility	**DH**	**SDH**	**CHC/ BPHC**	**24/7 PHC**
4	Manpower required for above services.				
5	Manpower available for the same				
6	Gap to be addressed				

Legends: **R**: Required; **A**: Available; **G**: Gap to be filled (Training load)

*(*Maximum of 30 cases of NSV/ Minilap/ Laparoscopic sterilization can be provided by a trained provider in one day)*

D. Calculation Of Manpower Requirement

Illustration: 1.

Approximate number of providers required for the following procedures in a district with 20 lac population is around 30

Sl.No.	PROCEDURES	DH	SDH	CHC/ BPHC	24/7 PHC	TOTAL
1	NSV	1	1	4	4	**10**
2	Minilap	2	1	10	5	**18**
3	Laparoscopic sterilization	1	1	0	0	**2**
	For all procedures	**4**	**3**	**14**	**9**	**30**

Illustration 2

Approximate number of providers required for the following procedures in a district with 10 lac population is around 18

Sl.No.	PROCEDURE	DH	SDH	CHC/ BPHC	24/7 PHC	TOTAL
1	NSV	1	1	2	2	**6**
2	Minilap	2	1	5	2	**10**
3	Laparoscopic sterilization	1	1	0	0	**2**
	For all procedures	**4**	**3**	**14**	**9**	**18**

(This illustration No. 2 is also applicable for a population of 20 lacs approximately in a district of a high focus state with weak infrastructure and low penetration of primary health care services)

However those districts which are already having service providers in the various procedures in excess of what has been suggested above, may rationalize their distribution among the various facilities in the district and strive to improve the manpower position even further to service the prevailing huge unmet need.

E. Training Plan Based On Gap Analysis

Illustration: The following is a hypothetical case of availability of service providers as against the requirement of 30 providers in a district with 20 lac population, which may be analyzed to develop the micro plan for the training need of the district:

MANPOWER DEVELOPMENT PLAN		DH/ SDH			CHC/ BPHC			24/7 PHC			TOTAL		
		R	A	G	R	A	G	R	A	G	R	A	G
1	Tubectomy (a) Minilap surgeons	3	1	2	10	4	6	5	1	4	**18**	6	**12**
	(b) Laparoscopic surgeons	2	1	1	0	0	0	0	0	0	**2**	1	**1**
2	NSV surgeons	2	1	1	4	1	3	4	0	4	**10**	2	**8**
TOTAL		7	3	4	14	5	9	9	1	8	**30**	9	**21**
3	**Training (Batches of 4 or less- suggestive plan)**												
	i) NSV	2 batches of 4 trainees each at the District Hospital or other state/ district designated centre to **fill the gap of 8 providers**											
	ii) Minilap	3 batches of 4 trainees each at the District Hospital or other state/ district designated centre to **fill the gap of 12 providers**											
	iii) Laparoscopic sterilization	To be conducted at the state medical colleges or other state designated training centre in conjunction with trainees from other districts to **fill the gap of 1 provider**											

F. Training In Permanent Family Planning Methods

Training in permanent family planning methods like minilap, laparoscopic sterilization and NSV has to be carried out as per the guidelines given below:

Details	NSV	MINILAP	LAPAROSCOPIC TRAINING
Nature of Trainees	Medical Officers	Medical Officers Nurses and OT Technician (if needed)	Team comprising of Gynecologist/Surgeon (of 3 years standing) who are already performing or trained in Minilap and OT Nurse and OT Technician
Duration	5 Working Days	12 Working Days	12 Working Days
Content of Training	• Conducting the NSV procedures • Pre and post procedure counseling • Clinical procedure • Recognition and management of complications	• Pre and post sterilization counseling • Selection of cases • Clinical procedure including post operative management • Recognition and management of complications • Infection prevention measures • Management/Maintenance of Equipment	• Pre and post sterilization counseling • Selection of cases • Clinical procedure including post operative management • Recognition and management of complications • Infection prevention measures • Management/Maintenance of Equipment
Reference Material for Training	"NSV Surgeons Manual" published by AVSC. In addition trainers may recommend other standard text for reference.	"Standards for Female and Male Sterilization" published by MOHFW, GOI. In addition trainers may recommend other texts.	"Standards for Female and Male Sterilization" published by MOHFW, GOI. In addition trainers may recommend other texts.
Training Centres	State/District identified centres	State/District identified centres	State identified centres
Number Trained per Course	2-4	2-3	One team consisting of 1 Surgeon, 1 Staff Nurse, 1 OT Technician
Number of Cases to be done	Assist 5 Perform 5 independently	Assist at least 10 Perform at least 10 under supervision Perform at least 5 independently	Assist at least 10 Perform at least 10 under supervision Perform at least 5 independently
Evaluation and Certification	Trainer must evaluate the trainees using a checklist and inspecting the diary maintained by trainee. Proficiency Certificate to be awarded by the State/District/Faculty Trainer after assessing trainee.	Trainer must evaluate the trainees using a checklist and inspecting the diary maintained by trainee. Proficiency Certificate to be awarded by the Training Institute after assessing trainee.	Trainer must evaluate the trainees using a checklist and inspecting the diary maintained by trainee. Proficiency Certificate to be awarded by the Training Institute after assessing trainee.

G. Qualification Of Trainers

SN	PROCEDURE	Trainer's qualification
1	NSV	• An NSV provider certified as State / District trainer/ Faculty trainer.
2	Minilap	• All gynaecologists (MD, DGO) who conduct minilap. • MBBS doctors who have undergone minilap training and done at least 50 minilaps independently in the last one year.
3	Laparoscopic sterilization	• All gynaecologists (MD, DGO)/ Surgeons (M.S.) who conduct laparoscopic sterilisation.

6. Strengthening physical infrastructure of identified facilities

The facility identified for providing female / male sterilization services should have the infrastructure requirement as per the guidelines provided in 'Quality Assurance Manual for Sterilization Services' as given in **Annexure C** and accordingly efforts should be made to upgrade to those levels.

7. Publicising information on FDS service in sterilization in designated centres

For service to be delivered in a cost effective manner adequate case load is necessary. Even though the unmet need in terminal methods is quite high, the information about the provision of services is too inadequate to generate enough client load. Therefore regular and systematic demand generation activity in the form of posters, pamphlets and audio and video materials are absolutely necessary to make the community aware of the sterilization service availability in the various health facilities

The district should take action for displaying this information widely in the premises of these facilities and by other mass media channels through the IEC budget provided under RCH II.

The ANMs, AWW, ASHAs should also disseminate this information during the Village Health and Nutrition Days.

8. Monitoring FDS service output

For ensuring fixed day service in sterilization the District Family Welfare officer has to monitor

- Regularity of services
- Performance in terms of numbers achieved

as per proforma given in **Annexure E**

9. Monitoring performance standards of trained service providers

Quality of service as per **Annexure D** (to be conducted by the District Quality Assurance Committee).

Adherence to the guidelines of GOI on norms and quality of services provided is essential for achieving the goal and objectives set out for FDS services

10. Providing clear financial guidelines for FDS

Based on the guidelines presented here the states need to incorporate their strategy, action plan and budget requirement for FDS services in their annual RCH II PIPs

11. Ensuring prompt payment of compensation money to acceptors and providers

The compensation money to acceptors should be paid immediately after the surgery as this is a compensation for loss of wages. The amount due for service providers also needs to be paid promptly as these are performance based compensations and act as motivating factor for providing services, especially in low setting facilities. The details of the 'Revised Compensation for Sterilization' are placed at **Annexure F.**

ANNEXURES

Sterilization Performance in High TFR states with TFR > 2.5(SRS 07)

SN	Parameters	Bihar	UP	Raj.	MP	Jharkhand	Uttarakhand	Chattis-garh	Orissa	Haryana	Assam	Gujarat	$AP	$Tamil Nadu	$Kerala
1	Eligible couples (in 000's)	16,376	31,405	11,286	12,022	5,279	1,570	3,932	6,507	4,014	4,396	9,737	15,135	11,302	5,414
2	*TFR	4.2	4.2	3.5	3.5	3.4	2.8	3.3	2.5	2.7	2.7	2.7	2.0	1.7	1.7
3	No. of sterilizations per 1000 population 2007-08	3.5	2.8	5.8	7.46	4.08	4.08	7.35	3.3	3.8	0.7	6.1	9.5	5.65	6.7
4	**sterilization per 10000 unsterilised couples exposed to higher order births of 3 & 3+	320	319	867	1331	500	733	1479	664	807	113	1392	4485	3039	2212
5	***Ratio of Minilap to Lapro.	99: .05	14: 86	20: 80	19: 81	79: 21	30:70	30:70	71:21	73:27	1:99	48:52	91: 9	87:13	86:14
6	Proportion of NSV to total sterilization (2007-08)	2.9%	1.3%	3.8%	6.8%	16.2%	6.1%	6.4%	2.2%	12.1%	0.4%	6.7%	3.9%	0.4%	0.9%
7	Present Performance (2007-08) in lacs	3.01	4.7	3.3	4.5	1.1 1	0.35	1.5	1.2	0.81	0.18	3.1	7.2	3.5	3.5
8	#ELA for 2008-09 In lacs	4.7	8.1	4.7	4.8	1.6	0.45	1.5	1.6	1.1	0.63	3.1			
9	Expected TFR in 2012 as per ELA set.	3.42	3.47	2.4	2.4	2.67	2.1	2.3	2.18	2.14	2.2	2.1			

Source- *SRS 2007, **MIES data GOI, **NFHS 3, ***Rural Health Survey report

as per ELA developed by GOI in 2008

($ The performance of low TFR states like Andhra Pradesh, Tamil Nadu, and Kerala are provided for comparison)

Annexure-B

FAMILY PLANNING DIVISION - GOVT. OF INDIA

Monitoring for the State / District of _____

Survey officer:_____ Responder:_____

1	**BASELINE SURVEY**				
	1.	Nodal person for FP			
	2.	State/District population (average)			
	3.	Unmet need state/district N3/ D 04			
	4.	% of girls getting married below 18 yrs			
	5.	Women with Birth order of 3+			
	6.	% contraceptive use / CPR			
	7.	Total sterilization (06-07)/ (07-08)			
	8.	Vasectomy: numbers/ (% of total sterilization)-			
	9.	IUD (06-07) / (07-08)			
2	**STATE/DISTRICT ELA calculated or not (if yes)**				
	1.	Limiting methods per year estimated			
	2.	Spacing methods per year estimated			
	3.	Addressing unmet need by what % by 2012			
	4	ELA			
3	**STATE/ DISTRICT HEALTH FACILITIES**		**No.**	**No/ distr**	**Pop. covered**
	1	DH			
	2	SDH			
	3	CHC/BPHC			
	4	PHC			
	5	SC			
4	**SERVICE PROVISION**				
	A	**Camps** (Calendar in place or not)- (if yes)			
			DH	**SDH/ AH**	**CHC/ BPHC**
	1	Female sterilization camps (numbers.)			
	2	Male sterilization camp (numbers.)			
	B	**Regular services**			
	1	Regular Tubectomy services (frequency)			
	2	Regular Vasectomy services (frequency)			
	C	**No. of centres providing service**			
	1	Tubectomy			
		a) Laparoscopic			
		b) Minilap			
	2	Vasectomy			
	3	IUD			
	4	ECP/ OCP/ CC			
5	**STERILIZATION SERVICES POSSIBLE**				
		ELA per district			**TOTAL**
	1	DH @ 1 per week x (52 weeks x 30) cases per provider			
	2	SDH @ 1 per 2wks (26 x 30) cases per provider			
	3	CHC/BPHC @ 1 per 2wks x (26 x 30) cases / provider/ CHC x			
		Shortfall to be addressed			
			DH	**SDH**	**CHC**
	1	Manpower required for above services.			
	2	Manpower available for the same			
	3	Gap to be addressed			
		Achievable or not			

			DH			SDH/ AH			CHC/ BPHC		
6	**MANPOWER DEVELOPMENT PLAN**		**R**	**A**	**G**	**R**	**A**	**G**	**R**	**A**	**G**
	1	Tubectomy (a) Minilap surgeons									
		(b) Laparoscopic surgeons									
	2	NSV surgeons									
	3	Doctors (IUCD)									
	4	Nursing Personnel (IUCD)									
	5	Training (Batches of 4 or less- please specify)									
		i. Minilap									
		ii. Laparoscopic sterilization									
		iii. NSV									
		iv. IUD - i) MOs									
		- ii) SN/ LHV/ANM									
7	**CONTRACEPTIVE UPDATES**		YES			NO					
	1.	Orientation of districts in contraceptive updates									
	2.	Schedule of updates (please furnish)									
8	**QUALITY ASSURANCE COMMITTEES**		YES			NO					
	1	Revised State/Dist QAC in place (10/9members)									
	2	Meetings of State/ District QAC (6 mth /3 mth)									
	3	Reporting as per new format									
	4	Orientation and dissemination of manuals on Standards/QA of districts and MOs									
	5	If not, what is the schedule									
9	**ACCREDITATION/ EMPANELMENT**		YES			NO					
	1	Accreditation of facilities (Govt./private/ NGO)									
	2	If yes, number accredited (If not why not)									
	3	Empanelment of doctors (Govt./private/ NGO)									
	4	If yes, no. empanelled (If not why not)									
10	**REVISED COMPENSATION SCHEME**										
	1.	No. of female beneficiaries in the scheme									
	2.	No. of male beneficiaries in the scheme									
	3.	Time lag (prompt payment or not)									
	4.	Fund allocated /Fund utilized till date (this year)									
11	**FAMILY PLANNING INSURANCE SCHEME**		YES			NO					
	1	Disseminated in the state/ districts									
	2	No. of deaths /complications /failures (07-08)									
	3	No. of death audits conducted									
	4	No. of claims submitted/ settled/ pending									
12	**PLAN FOR ADVOCACY FOR PROMOTION OF FP/ COMPENSATION/ INSURANCE**		YES			NO					
	1	Display on all facilities (posters/ wall paintings)									
	2	Print materials (handouts/ flipcharts)									
	3	Audio materials (CDs) for local broadcast									
	4	Video materials (CDs) for projections									
13	**AVAILABILITY OF COUNSELOR FOR FAMILY PLANNING**										

Legends: **R**: Required; **A**: Available; **G**: Gap to be addressed (Training load)

Annexure-C

FACILITY AUDIT

		Yes/ No	Comments	Suggestions /Recommendations
Infrastructural Facilities				
1	Is the building in good condition (walls, doors, windows, roof and floor)			
2	Is the facility clean?			
3	Is running water available at service points?			
4	Clean and functional toilet facility available for staff and clients?			
5	Is electricity available?			
6	If there is no running water or electricity are alternatives available which permit providers to hygienically deliver available services?			
7	Is there a functional generator available?			
8	Is POL available for generator?			
9	Is there an earmarked space for examination and counseling to assure privacy?			
10	Availability of a waiting area with adequate seating facility			
Facilities available at OT				
11	Is there a proper OT facility available?			
12	Does the OT have running water available?			
13	Operation Table with Trendelenburg facility (***for female sterilization)?***			
14	Functional shadow-less lamp?			
15	Functional suction apparatus?			
16	Functional Emergency light (through functional inverter)			
17	Oxygen cylinder with gas and accessories?			
18	Availability of – Minilap instrument : Laparoscopic set : NSV Sets :			
19	Instruments for Laparotomy available?			
20	Availability of Emergency Resucitation Equipments like Ambu Bag, Face Mask, Airways etc			
21	Emergency medicine tray?			
22	Sterilized consumables in dressing drum?			
23	Sterilized surgical attire such as apron, gloves, mask and cap			
24	Other essential requirements			
Contraceptive stock position				
25	Buffer stock available for one month – Oral Pills : Condoms : Copper T : EC Pills:			
26	Does the facility have adequate storage facility for contraceptives (away from water, heat,			

	direct sunlight etc) on premises?			
27	Do stockouts occur?			
28	Is there an effective logistic system that tracks stock levels and notifies staff when supplies need reordering?			
29	Are supplies in good condition (not expired, not damaged etc)?			
30	Are expired contraceptives destroyed to prevent re-sale or other inappropriate use			
Availability of Vehicle				
31	Does the facility have a vehicle/ambulance in running condition?			
32	Availability of POL for vehicle			
IEC Materials				
33	Clients Rights displayed at a prominent place at the facility			
34	Board displaying service timings			
35	Availability of free and paid services displayed on wall painting			
36	Sign board indicating the direction for each service point displayed			
37	Flip charts, models, specimens and samples of contraceptives available in counseling room			
38	IEC materials such as posters, banners, hand bills available at the site and displayed			
39	Is there a suggestion and complaint system for clients (complaint box and/ or a book)			
Management Information System				
40	Client registration record maintained			
41	Records on FP (including the number of clients counseled and number of acceptors)			
42	Sterilization Records			
43	Follow-up records for FP clients			
44	Regular furnishing of Monthly Progress Reports (MPR)			
45	Does staff complete client records with information essential for continued care of clients?			
46	When clients return for follow up services can staff easily retrieve their records?			
	Manpower			
47	Availability of all staff as per sanctioned posts			
48	Are the various categories of staff adequate for the activities of the centre			
50	Are the doctors empanelled in the State			
	Infection Prevention			
51	Autoclave and Instrument boiler functional?			
52	Are needle destroyers available?			
53	Container for disposal of sharp instruments available at dispensing room?			
54	Mopping of floor by liquid bleach			
55	Utility gloves in use for cleaning floor, instrument and linen			
56	Availability of proper waste disposal mechanisms (incinerator/Others)			

Annexure-D

OBSERVATION OF QUALITY, ASEPSIS AND SURGICAL PROCEDURE

	General Information	
i)	Date (DD/MM/YY)	……/……../……..
ii)	Clinic Venue: PHC/CHC/DH/Any Other(Specify)	……
iii)	Name of the Block, District and State	……
iv)	Name and Designation of observer	……
ASEPSIS ISSUES (OBSERVE FOR 60 MINUTES IN ONE SESSION INSIDE OPERATION ROOM)		
1	Was 0.5 % Chlorine solution prepared and used correctly?	Yes…… No……...2
2	Did the theatre personnel (those involved directly or indirectly in the procedures) **change into** the following theatre attire?	Gown Yes…… No..... . Caps…….. Yes…… No..... Masks……. Yes…… No..... . Theatre shoes……. Yes…… No.....
3	Did the surgeon and assistant scrub before starting?	Yes…… ……. No……
4	Approximately how much minutes did the surgeon scrub using soap?	<5 Minutes……. 3-5 Minutes…… >5 Minutes……..
5	Was the scrubbing procedure proper	Yes……. No……
6	Was the mask kept over the bridge of the nose at all times by the surgeon (s) and assistant (s)?	Yes…….. No……
7	Were the gloves changed after operating each case?	Yes…….. No……

8	After how many cases did the surgeon scrub again?	After 1-5 cases…….. After 6-10 cases……. After>10 cases…… Did not scrub again……
9	Did the surgeon/assistant leave the OT any time between cases?	Yes…….. No……
10 a	If Yes, Did they change their shoes while going out?	Yes…….. No……
b	Did they change their gowns on return?	Yes…….. No……
c	Did they scrub on return?	Yes…….. No……

SURGERY & ANAESTHESIA (OBSERVE AT LEAST THREE PROCEDURES, BUT MORE IF POSSIBLE)

	Client Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1	Name of procedure: Tubectomy/Laparoscopy/Vasectomy/NSV							
2	Type of anesthesia used: Local/Spinal/General: If Local Anesthesia (LA) was used, what was the approximate interval between injecting LA and starting surgery **(in minutes)**							
3	Was the skin adequately scrubbed before surgery? **(Yes/No)**							
4	Were sterile drapes used **(Yes/No)**							
5	Did the client wince at any time during the operation? **(Yes/No)**							
6	What was the total duration of surgery (from skin incision to skin closure): **In minutes**							
7	If **Laparoscopy was performed**:							
a	Which gas was used for creating pneumoperitoneum?	CO2…… N2O…… Air……						
b	How was it insufflated?	Insufflation Apparatus…….. Bicycle pump……. Any Other (Specify)……..						
c	How was the laparoscope cleaned in between procedures?	Immersed in cidex ≥20 minutes…… Immersed in cidex <20 minutes… ….. (Specifyminutes)…… Cleaned with antiseptic Solution…… ….. Cleaned with water…… Any other (specify)…….						

8	**Are the following surgical instruments used for sterilization in working condition?**	
i)	Light source for Laparoscope	Yes…….. No……
ii)	Operating Laparoscope/laparocator	Yes…….. No……
iii)	Pneumoperitoneum insufflation apparatus?	Yes…….. No……
	Gas Cylinders: CO2	Yes…….. No……
	N2O	Yes…….. No……
	Any Other/Air	Yes…….. No……
iv)	Veres Needle	Yes…….. No……
v)	Trocar with cannula	Yes…….. No……
vi)	Minilap Kit	Yes…….. No……
vii)	Conventional vasectomy kit	Yes…….. No……
viii)	NSV Kit	Yes…….. No……

Annexure-E

Report on male and female sterilization as FDS services

Name of the State -
Name of the District -

Facility		Number of acceptors				
		Ist week of month	IInd week of month	IIIrd week of month	IVth week of month	Total in a month
District Hospital @ 1 FDS/week						
Sub District Hospopital @ 1 FDS/week						
CHC/BPHC @ 1 or more FDS service per 15 days						
1	CHC/BPHC					
2	CHC/BPHC					
3	CHC/BPHC					
4	CHC/BPHC					
5	CHC/BPHC					
6	CHC/BPHC					
7	CHC/BPHC					
8	CHC/BPHC					
9	CHC/BPHC					
10	CHC/BPHC					
24/7 PHC @ 1 or more FDS service per month						
1	24/7 PHC					
2	24/7 PHC					
3	24/7 PHC					
4	24/7 PHC					
5	24/7 PHC					
6	24/7 PHC					
7	24/7 PHC					
8	24/7 PHC					
9	24/7 PHC					
10	24/7 PHC					
TOTAL per month in the district under FDS service						

Annexure-F

OVERVIEW OF THE REVISED COMPENSATION SCHEME

A. HIGH FOCUS STATES

Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chattisgarh, Uttrakhand, Orissa, Jammu & Kashmir, Himachal Pradesh, Assam, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland, Tripura, Sikkim.

1. PUBLIC FACILITIES

Procedure	Acceptor	Motivator	Drugs & dressings	Surgeons' charges	Anesthetist charges	Staff nurse	OT technician	Refreshments	Camp management	Total (in Rs.)
Vasectomy (ALL)	1100	200	50	100	-	15	15	10	10	1500
Tubectomy (ALL)	600	150	100	75	25	15	15	10	10	1000

2. ACCREDITED PRIVATE/ NGO FACILITIES

Procedure	Facility	Motivator	Total(in Rs.)
Vasectomy (ALL)	1300	200	1500
Tubectomy (ALL)	1350	150	1500

B. NON HIGH FOCUS STATE

Karnataka, Kerala, Tamil Nadu, Andhra Pradesh, Maharashtra, Goa, Gujarat, Punjab, Haryana, West Bengal, Delhi, Chandigarh, Puducherry, Andaman and Nicobar Islands, Lakshadweep and Minicoy Islands, Dadra and Nagar Haveli, Daman and Diu.

1. PUBLIC FACILITIES

Procedure	Acceptor	Motivator	Drugs & dressings	Surgeons' charges	Anesthetist charges	Staff nurse	OT technician	Refreshments	Camp management	Total (in Rs.)
Vasectomy (ALL)	1100	200	50	100	-	15	15	10	10	1500
Tubectomy (BPL/SC/ ST only)	600	150	100	75	25	15	15	10	10	1000
Tubectomy (APL only)	250	150	100	75	25	15	15	10	10	650

2. ACCREDITED PRIVATE/ NGO FACILITIES

Procedure	Facility	Motivator	Total(in Rs.)
Vasectomy (ALL)	1300	200	**1500**
Tubectomy (BPL/ SC/ ST)	1350	150	**1500**

The general guidelines and salient features of the new revised scheme are as follows:

1. Extension of the increased package for vasectomy to all categories in all states including APL of Non-High Focus states both for the public and accredited private/ NGO facilities.

2. Extension of the increased package for tubectomy to all categories in the High Focus states and BPL/SC/ST only in Non High Focus states in the public sector.

3. Enhancement of the existing scheme for APL clients of tubectomy of Non High Focus States from Rs 300 to Rs 650 in the public facilities in line with the increase to the motivators and service providers for BPL/SC/ST categories to ensure that they don't discriminate between different categories of clients and provide the best possible service to all clients.

4. Extension of the increased package for tubectomy to all categories in the High Focus states and BPL/SC/ST only in the Non High Focus States in the accredited private/NGO sector.

5. No compensation scheme is admissible to APL clients for tubectomy in the Non High Focus states in the accredited private/NGO facilities.

6. Increasing the Compensation Package from the existing Rs.800 to Rs.1500 for vasectomy in public facilities.

7. Increasing the Compensation Package from the existing Rs.800 to Rs.1000 for tubectomy in public facilities.

8. Out of the compensation package of Rs.1500 for vasectomy, an amount of Rs.1100, and out of the package of Rs.1000 for tubectomy, an amount of Rs.600 is to be paid to an acceptor as compensation for loss of wages.

9. No compensation is payable to the acceptor if he or she opts to avail of sterilization services in the accredited private/ NGO sector. However the accredited private/NGO facility is bound to provide the services free to such an acceptor.

10. As against the existing scheme of paying only to the ASHA/AWWs, it has been approved that whoever, whether from the government sector or from the community, motivates or brings a case for sterilization, would be paid the component earmarked for the motivator both in the public and accredited private/ NGO sector.

11. A self motivated client is also entitled to the compensation earmarked for the motivator both in the public and accredited private/ NGO sector.

12. In states where LHVs and ANMs are manning the services in the camps in place of the regular staff nurses, the component earmarked for Staff Nurse may be paid to the LHV/ ANMs.

13. In the camp situations where the tubectomy cases are being conducted under local anesthesia administered by the operating surgeon himself in the absence of an anesthetist, the component earmarked for the anesthetist may be paid to the operating surgeon.

For details of the compensation scheme as well as all other technical manuals and various guidelines pertaining to the family planning programme, issued from time to time please refer to the website of the ministry at mohfw.nic.in

References

1. *Standards for Female and Male Sterilization Services* (2006), Ministry of Health and Family Welfare, Government of India, New Delhi. Retrieved November 20, 2008, from: http://mohfw.nic.in/NRHM/FP/Standard%20for%20female%20and%20male%20sterilization%20services.pdf
2. *Quality Assurance Manual for Sterilization Services* (2006), Ministry of Health and Family Welfare, Government of India, New Delhi. Retrieved November 20, 2008, from: http://mohfw.nic.in/NRHM/FP/Quality_Assurance.pdf