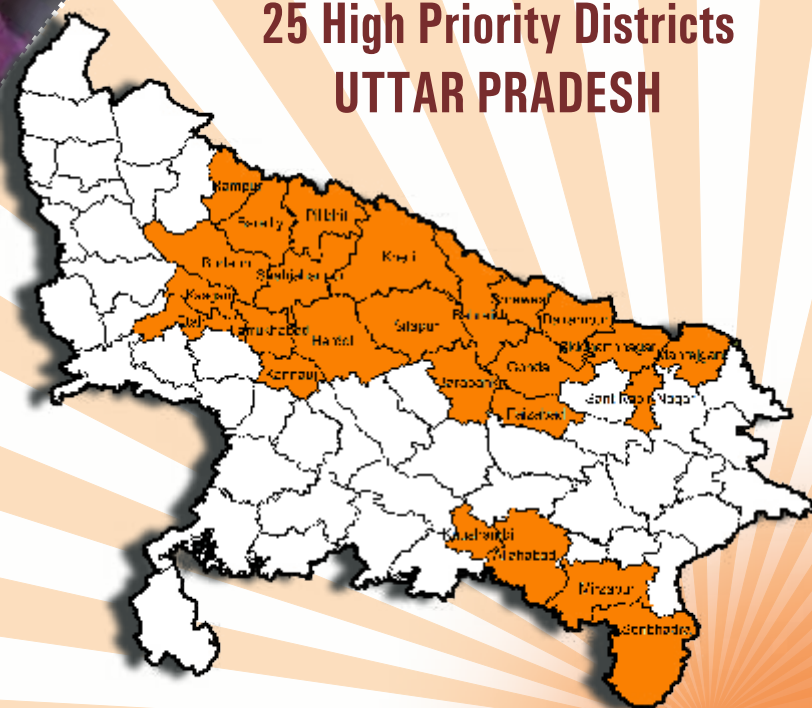




# The Uttar Pradesh Technical Support Unit COMMUNITY BEHAVIOUR TRACKING SURVEY (CBTS-3) 2016



## 25 High Priority Districts UTTAR PRADESH



# **COMMUNITY BEHAVIOUR TRACKING SURVEY (CBTS-3) 2016**



**25 High Priority Districts  
UTTAR PRADESH**

**February 2017**

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## MESSAGE

The Uttar Pradesh Technical Support Unit (UP-TSU) provides an integrated and embedded techno-managerial support to the Government of Uttar Pradesh (GoUP) in order to improve planning, implementation and monitoring of health programmes in the 25 High Priority Districts (HPDs) of the state. In order to boost the GoUP's initiatives in upscaling coverage and quality of reproductive, maternal and child health services, the TSU helps in mobilizing the community demand through its structured grass-root level linkages, supported by a cadre of resource persons at different administrative levels, as well as in improving quality of health services provided by public health facilities through onsite Nurse Mentors. In addition, the TSU also strengthens the state monitoring systems by improving the quality and use of HMIS/MCTS data.

The Community Behaviour Tracking Survey (CBTS) is an integral part of a standard monitoring system established for tracking the progress of the TSU's community intervention programme. The CBTS is implemented biannually, focusing on the estimates required for different geographies (i.e., block and district level estimates) in its different waves of survey, and each wave is supposed to repeat itself in a span of roughly one year. This is the first time, when the CBTS (in its third wave of survey) is providing the district level estimates on key reproductive, maternal, newborn and child health (RMNCH) indicators.

This report brings forth considerable district level variation in most of the RMNCH indicators, highlighting selected poor-performing districts across the 25 HPDs. In addition, a comparative status of a few selected indicators are also shown, depicting the changes took place during 2015-16 in comparable geographies. The graphic representation of the indicators and their associations with programme indicators are informative and clearly understood.

We expect that the estimates and analyses provided in this report will be used by district and block health officials to review, develop, implement and prioritize specific plans for the improvement of RMNCH indicators in their respective areas.

**(Arun Kumar Sinha)**

**Alok Kumar**  
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### **MESSAGE**

The Uttar Pradesh Technical Support Unit (UP-TSU) has established a concurrent monitoring system to provide periodic community-based reliable estimates on key reproductive, maternal newborn, and child healthcare (RMNCH) indicators in the 25 High Priority Districts (HPDs) of Uttar Pradesh, in the form of Community Behaviour Tracking Survey (CBTS). Unlike the previous two rounds of the CBTS, which provided the estimates on key RMNCH indicators for 100 TSU blocks and 20 poor-performing blocks respectively, the third round of the CBTS was designed to provide district-level estimates.

I am impressed with the quality estimates, the CBTS has been providing in its previous multiple rounds and reports, and glad to see this third report in a row. However, I am equally concerned about the subtle variations in maternal health care indicators across 25 HPDs. The low level of full antenatal care (ANC) and postnatal care (PNC) services are major concern for majority of the districts. The findings suggest that the low level of full ANC is attributed to the fact that the women are not extensively receiving recommended dose of IFA tablets and at least three antenatal check-ups. Similarly, the higher acceptance of PNC services are associated with the institutional delivery.

Increasing the level of institutional delivery continues to be a priority in the state, and particularly in the HPDs. This report highlights the importance of birth preparedness plan and early registration of women for ANC in upscaling the level of institutional delivery. The intensive efforts are required to increase the coverage and strength of Front Line Workers' (ASHAs, AWWs, ANMs) continued interactions with the women, and helping them to be informed and educated about the importance of institutional delivery, PNC services, exclusive breastfeeding and full immunization.

Further, from an equity perspective, it is required to target specific sub-groups of population and geography that are in need and may be the most vulnerable to poor outcomes due to various circumstances.

**(Alok Kumar)**



**Dr. Neena Gupta**  
Director General



**Directorate of Family Welfare**  
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### **MESSAGE**

This is the first time, the Community Behaviour Tracking Survey (CBTS), designed and implemented by the Uttar Pradesh Technical Support Unit (UP-TSU), is providing district-level estimates on important RMNCH indicators for the 25 High Priority Districts (HPDs) of the state.

This report, which is based on the information collected during the third round of the CBTS, is quite informative and useful for the Department of Family Welfare. This provides an updated, brief and important information on key RMNCH indicators, their distribution across 25 HPDs, and their associations with programme interventions in the state. The findings suggest that there are certain districts and sub-population groups that need more focused intervention in maternal, newborn and child health care as well as family planning services.

I encourage the district and block health officials in the 25 HPDs to use these information for improving health outcomes in their respective areas, focusing equally on community health workers, facility improvements, and data supply systems.

My sincere thanks to the UP-TSU for making this data available for further planning and implementation of key RMNCH+A strategies.

A handwritten signature in black ink, appearing to be 'Dr. Neena Gupta'.

**(Dr. Neena Gupta)**



**Vikas Gothwal**  
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## MESSAGE

The Uttar Pradesh Technical Support Unit (UP-TSU) has setup a concurrent monitoring system in the 25 High Priority Districts (HPDs) of the state. The objective is to provide a critical RMNCH+A outcome and output (coverage) level indicators for community and facility level interventions.

The concurrent monitoring system is intended to complement the existing administrative data systems (e.g., HMIS & MCTS). This system also provides an opportunity to validate the existing data systems. The TSU data provides indicators relating to practices and behaviours of providers and beneficiaries; and helps in reviewing and planning to become more result-oriented rather than process-driven.

The TSU conducts the Community Behaviour Tracking Survey (CBTS) at community level and the Rolling Facility Survey (RFS) at facility level. The CBTS is designed to track critical RMNCH+A behaviours and coverage of health programs at the community level. The RFS helps in tracking the knowledge, skills, and practices of healthcare providers and enable them to deliver critical RMNCH+A services at Community Health Centres (CHCs), Primary Health Centres (PHCs), and Sub Centres (SCs).

This is the third CBTS report, which is, first time, providing the district-level estimates on key RMNCH indicators across 25 HPDs. The major highlights of this report lie in the subtle differences in the level of RMNCH indicators across districts, profound linkages in the programme intervention indicators and the health indicators, changes in the selected indicators in a certain area (i.e., 64 TSU blocks, which were surveyed in CBTS-1 as well as CBTS-3), and inclusion of a few additional dimensions of RMNCH, which were not included in previous CBTS reports.

This report puts forward some priority areas, such as full antenatal care, postnatal care, exclusive breastfeeding, skin-to-skin care, full immunization, and unmet need for family planning, which need to be prioritized for certain population groups and districts in order to minimize the risk of neonatal deaths and maternal mortality in the state.

I believe that this report will help various departments and officials of the Government of Uttar Pradesh and non-Governmental organizations and agencies involved in making a positive change in the RMNCH indicators and issues in the HPDs and other districts of the state.

  
(Vikas Gothwal)

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The third round of the Community Behaviour Tracking Survey (CBTS) was successfully completed due to the efforts, support and involvement of a number of institutions and individuals at different stages of the survey. The UP-TSU acknowledges everyone who was involved in the survey and made it a success.

At the outset, the UP-TSU is grateful to the Bill & Melinda Gates Foundation (BMGF) for providing financial support to the programme monitoring activities and conducting the CBTS in 25 High Priority Districts (HPDs) of Uttar Pradesh. The TSU also extends its sincere gratitude to the Department of Medical, Health and Family Welfare, Government of Uttar Pradesh (GoUP) and National Health Mission (NHM), Uttar Pradesh for extending their support for the successful implementation of the CBTS. However, the BMGF and GoUP do not fully endorse all of the contents of this report, nor does the report necessarily represent their views or opinions. The estimates, statements and recommendations contained within this report are primarily of the contributors of this report from the UP-TSU.

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The CBTS schedules underwent an ethical review by an Institutional Review Board (IRB) established by the **Sigma Research and Consulting Pvt. Ltd.**, New Delhi, India. The TSU appreciates the comments and suggestions provided by the members of the IRB for further improving the schedules.

The UP-TSU acknowledges the guidance and support provided by a dedicated team of resource persons including **Dr. Abhishek Kumar**, **Mr. Naveen Roy**, **Mr. Sher Bahadur Singh**, **Mr. Rakesh Kumar Singh**, **Mr. Ashesh Srivastava**, **Mr. Raushan Jha**, **Mrs. Mansi Shekhar**, **Mr. Gundurao Arun Desai** and **Mr. Vishal Mhadeshwar** from the UP-TSU, and **Mr. Arnab Dey** and **Mr. Amit Chakraborty** from SAMBODHI, to the Research Investigators (RIs), Team Coordinators (TCs) and Quality Supervisors (QS) of the CBTS.

Thanks are also due to the Community team (Programme Intervention) of the UP-TSU including the Community Resource Persons (CRPs), Block, District and Zonal Community Specialists (BCS, DCS and ZCS) for their cooperation and support provided during the

survey. The UP-TSU also acknowledges the support provided by the district/block-level administrative officials and ASHAs in respective survey areas.

The data collection of the CBTS was performed using handhelds (mobile) with ODK (Open Data Kit) based application, which was efficiently designed and developed by the ICT team of the UP-TSU led by **Mr. Kartikeyan L.** The UP-TSU highly appreciates Mr. Kartikeyan L. and **Ms. Ayushi Srivastava** for their technical support during the entire period of the survey.

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## ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Check-up
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	<i>Anganwadi</i> Centre
AWW	<i>Anganwadi</i> Worker
BCG	Bacillus Calmette–Guérin
CEmOC	Comprehensive Emergency Obstetric Care
DPT	Diphtheria, Pertussis and Tetanus
ENC	Essential Newborn Care
FLW	Front Line Worker
FP	Family Planning
GoI	Government of India
GoUP	Government of Uttar Pradesh
HBNC	Home Based Newborn Care
HPD	High Priority District
ICDS	Integrated Child Development Scheme
IFA	Iron Folic Acid
IUCD	Intra-Uterine Contraceptive Device
LBW	Low Birth Weight
LHV	Lady Health Worker
mCPR	Modern Contraceptive Prevalence Rate
MUAC	Mid Upper Arm Circumference
NMR	Neonatal Mortality Rate
OBC	Other Backward Castes
ORS	Oral Rehydration Solution
PNC	Postnatal Check-up
PRI	<i>Panchayati Raj</i> Institution
SAM	Severely Acute Malnourished
SC/ST	Scheduled Castes/Scheduled Tribes
SN	Staff Nurse
SSC	Skin-to-Skin Care
SUW	Severely Underweight
THR	Take Home Ration
TL	Tubal Ligation
TSU	Technical Support Unit
UNICEF	United Nations Children’s Fund
VHND	Village Health Nutrition Day



# INTRODUCTION

The Uttar Pradesh Technical Support Unit (UP-TSU) has established a concurrent monitoring system, responsible for periodically tracking the progress of its community intervention programme, named as the Community Behaviour Tracking Survey (CBTS). The CBTS aims to support the Government of Uttar Pradesh (GoUP) by providing concurrent data on relevant indicators of reproductive, maternal, newborn, child and adolescent health (RMNCH+A), which can complement the GoUP data system in evidence-based review and planning mechanism. The CBTS is designed to meet the data requirements for an evidence-based programme planning and review at state, district and sub-district levels, which the national surveys often lack to provide. These periodic surveys are meant to be short, focused, and semi-annual.

In order to obtain more recent information as well as to avoid recall bias, the CBTS includes five demographic groups, relevant for the measurement of RMNCH+A indicators:

Group 1: Women who ended their pregnancy in the past 60 days<sup>1</sup>

Group 2: Mothers with children age 3-5 months (61-180 days)

Group 3: Mothers with children age 6-11 months (181-364 days)

Group 4: Mothers with children age 12-23 months (365-729 days)

Group 5: Girls age 13-19 years

The first round of the CBTS (CBTS-1) was implemented in the 100 TSU Blocks<sup>2</sup> of 25 High Priority Districts (HPDs)<sup>3</sup> during May 2014 to February 2015. The follow-up survey (CBTS-2) was implemented in the 20 lowest-performing Blocks during February-March 2016. These 20 lowest-performing blocks were identified based on the relative performance of a set of 10 RMNCH+A indicators estimated from the CBTS-1. The latest round (CBTS-3) was conducted in 125 Blocks (64 TSU & 61 non-TSU Blocks) of the HPDs during April-July 2016 to provide district level estimates. Considering the present focus of the program, the fifth survey group (i.e., Girls age 13-19 years: adolescents) were not included in recent two rounds of the CBTS (i.e., CBTS-2 and CBTS-3).

---

<sup>1</sup>The Group-1 respondents not only include the women who delivered a livebirth in the last 60 days preceding the date of survey, but also those women who had a stillbirth and who experienced an abortion.

<sup>2</sup>The UP-TSU and TSU are used interchangeably throughout this report. The TSU Blocks represent those blocks in 25 HPDs, where the UP-TSU implements the RMNCH+A Intervention Programme.

<sup>3</sup>The High Priority Districts (HPDs) comprise of 25 districts (out of all 75 districts) of Uttar Pradesh. These 25 districts (which are further mentioned in this report) are identified on the basis of their poor health indicators and the recommendation of the GoUP. The term “HPDs” throughout this report refers to 25 districts of Uttar Pradesh, whether specified or not in the following text.

## Methodology

The CBTS-3 adopted three-stage cluster sampling design. Required number of samples for each HPD was estimated based on District-specific prevalence of key RMNCH indicators from the Annual Health Survey (AHS), 2012-13. In the first stage, 5 Blocks from each HPD were selected using Probability Proportional to Size (PPS) method. Required number of samples estimated for each HPD was proportionately divided into 5 Blocks (based on their population size). Within each block, the number of primary sampling unit (PSU) was estimated considering the required sample size of the particular block, and these PSUs were selected using simple random sampling approach. In the CBTS, an ASHA (Accredited Social Health Activist) catchment area, which represents nearly 1000 population, is considered as a PSU. As per the CBTS design, in each selected ASHA area, all households are screened and all eligible women, who satisfy the criteria of the four survey groups, are interviewed. The CBTS-3 also followed the same design for selection of eligible women for interview, as was followed in last two rounds of the survey.

Sample Coverage, CBTS-1 & 3								
	CBTS-1				CBTS-3			
	Women who ended their pregnancy in the past 2 months	Women who delivered in the past 3-5 months	Mother with children age 6-11 months	Mother with children age 12-23 months	Women who ended their pregnancy in the past 2 months	Women who delivered in the past 3-5 months	Mother with children age 6-11 months	Mother with children age 12-23 months
Total number of ASHA area in the block	19,071	—	—	—	24,486	—	—	—
Number of ASHA areas selected	11,664	7,791	4,933	2,829	2,697	1,762	1,450	1,011
Sample size required	52,276	40,764	52,164	51,444	12,938	9,751	13,086	13,477
Number of eligible women identified	72,054	58,411	64,952	67,888	14,356	13,977	19,731	21,127
Number of eligible women interviewed	57,788	44,196	49,722	52,110	12,474	11,832	16,593	17,699
Response rate (%)	80	76	77	77	87	85	84	84

The CBTS-1 was designed to provide block-level estimates for all 100 TSU blocks, while the CBTS-3 was specifically designed to provide district-level estimates for the HPDs. In order to provide district-level estimates, 125 blocks were selected following the specific sampling design discussed above, out of which 64 blocks were the TSU blocks. The present report provides a summary of recent estimates on key RMNCH indicators. The trends of key indicators are presented comparing the estimates based on common areas (i.e., 64 TSU blocks) surveyed in both CBTS-1 and CBTS-3, wherever applicable. Although,

the key findings on selected RMNCH indicators are discussed in the report, estimates on pertinent indicators across relevant background characteristics of women and children as well as across the HPDs are presented in separate tables. In both the rounds of the CBTS, the response rates ranged 76-87% for all the groups of respondents. The reason behind the non-response in all survey groups primarily included the unavailability of women identified for interview. Another reason for non-response among Group 1 respondents was the death of mother after delivery. District wise sample coverage is included in the Annexure.

### **Data Quality Assurance Measures**

The CBTS maintains a good quality of community data by undertaking a number of quality assurance measures. First, the CBTS schedules undergo an ethical review by an Institutional Review Board established by the Sigma Research and Consulting Pvt. Ltd., New Delhi, India. Second, an adequate number of female interviewers are rigorously trained on each of the domains of the schedules including mock interviews and a pilot survey for more than a week, depending upon the size and coverage of the particular round of the survey. Third, the handhelds (mobile) with ODK (Open Data Kit)<sup>4</sup> based application are used for interview which are adjusted for automatic skipping and outliers in the questions wherever applicable. This also provides additional information such as time spent per interview with date, which helps supervisors to track/back-check the interviews of particular investigator. Daily transfer of the digital data from the field helps the State team to quickly analyse the pattern of a few important indicators and to provide feedback to the field supervisors. Fourth, the female quality supervisors are also appointed to back-check the interviews within 1-2 days and compare/rectify the interviews accordingly. In addition, State level Survey Specialists visit the field weekly and observe/back-check the interviews. Lastly, a specific proportion of total interviews conducted are also monitored by an MLE (Monitoring, Learning and Evaluation) Partner of the UP-TSU in order to ensure coverage, eligibility of the respondent, ways of enquiry on specific questions, etc.

## **MATERNAL HEALTH**

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death.<sup>5</sup> Most of these

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<sup>4</sup>Open Data Kit (ODK) is a free and open-source set of tools which help in preparing a data collection form for survey, in collecting the data on a mobile device and sending it to a server, and in aggregating the collected data on a server and extract it in useful formats.

<sup>5</sup>[http://www.who.int/topics/maternal\\_health/en/](http://www.who.int/topics/maternal_health/en/)

deaths can be avoided as the necessary medical interventions exist and are well known. The key obstacle is pregnant women's lack of access to quality care before, during and after childbirth. Thus, the state of progress and issues in maternal health across the HPDs are discussed here under separate sub-sections, namely antenatal care (before childbirth/during pregnancy), delivery care (during childbirth), and postnatal care (after childbirth). In addition, considering the importance of nutritional status of women during pregnancy and after childbirth on the overall health of mothers and their children, the state of maternal nutrition is also discussed in separate sub-section.

## Antenatal Care

Antenatal care, also known as prenatal care, is a type of preventive healthcare with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child.<sup>6</sup> During check-ups, pregnant women are supposed to receive medical information over maternal physiological changes in pregnancy, biological changes, and prenatal nutrition including prenatal vitamins. Recommendations on management and healthy lifestyle changes are also made during regular check-ups. The availability of routine prenatal care, including prenatal screening and diagnosis, has played a part in reducing maternal death rates and miscarriages as well as birth defects, low birth weight, neonatal infections and other preventable health problems.

As per the Government of India (GoI) guidelines, each pregnant woman should receive at least four antenatal check-ups<sup>7</sup> (including the first visit for registration), administering two doses of TT injection<sup>8</sup>, and providing at least 100 tablets of Iron Folic Acid (IFA)<sup>9</sup>.

The CBTS-3 estimates that nearly 64% women received at least one antenatal check-up (ANC) in the intervention area, which shows a considerable improvement from the estimates of CBTS-1 (46%).

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<sup>6</sup><https://medlineplus.gov/prenatalcare.html>

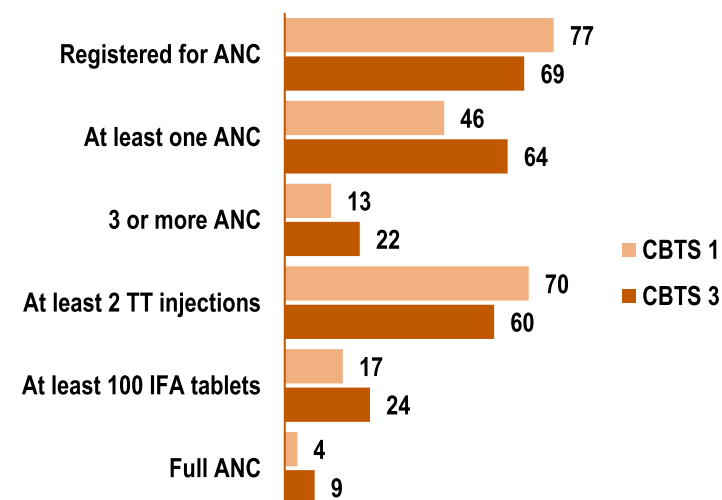
<sup>7</sup>Essential components of every antenatal check-up (ANC) includes: taking the pregnant woman's history; conducting a physical examination-measure the weight, blood pressure and respiratory rate and check for pallor and oedema; conducting abdominal palpation for foetal growth, foetal lie and auscultation of Foetal Heart Sound (FHS) according to the stage of pregnancy; carrying out laboratory investigations, such as haemoglobin estimation and urine tests for sugar and proteins.

<sup>8</sup>Pregnant women with an inadequate or unknown immunization history should always receive 2 doses of tetanus toxoid-containing vaccine: the first dose as early as possible during pregnancy and the second dose at least 4 weeks later.

<sup>9</sup>Daily oral iron and folic acid supplementation is recommended as part of ANC to reduce the risk of low birth weight, maternal anaemia and iron deficiency.

## Trends in Antenatal Check-up

% women receiving antenatal check-up



Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

However, despite a slight improvement in the proportion of women receiving full ANC (4% in CBTS-1 to 9% in CBTS-3), which comprises 3 or more ANC visits, receiving 100 IFA tablets and uptake of at least 2 TT injections, the level of women receiving full ANC remained low, and thus a prime concern for the maternal health in the state.

There was an improvement in all the components of ANC except the uptake of 2 doses of TT injection between CBTS-1

and CBTS-3. However, excluding the abortion cases<sup>10</sup>, which highly affect the overall estimate, the proportion of women receiving 2 TT injections remained same over period.

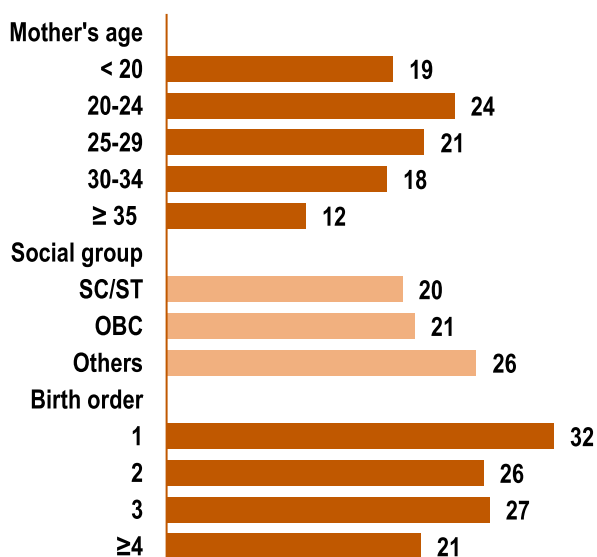
In addition, the

consumption of IFA tablets becomes another concern to be focused on, as the CBTS-3 estimates that out of 24% women who received at least 100 IFA tablets, only 5% women consumed the recommended number of IFA tablets. Overall, only around 1% women reported consuming at least 100 IFA tablets.

Assessment of women's haemoglobin (Hb) and blood pressure (BP) during the third trimester becomes important ANC component

## Antenatal Check-up varies by mother's age, social group and child's birth order

% women receiving  $\geq 3$  antenatal check-up, CBTS-3



<sup>10</sup> In the CBTS-3, about 22% women, who delivered in past 2 months before the date of survey, reported experiencing abortion.

in order to identify High Risk Pregnancies (HRP). Nearly 47% women reported to be assessed for haemoglobin and blood pressure during the CBTS-3, which indicates considerable improvement over the CBTS-1 (25% and 24% women assessed for Hb and BP, respectively) estimates.

Younger women (except the adolescent women age below 20<sup>11</sup>) were found more likely to receive ANC compared to the older (age  $\geq 35$ ) women. Less than 5% of women age 35 and above reported receiving full ANC during the CBTS-3. The women belonging to scheduled castes (SC)/scheduled tribes (ST) and other backward castes (OBC) registered slightly lower proportion compared to the women of other castes in receiving 3 or more ANC and the full ANC. In addition, women with higher order births were less likely to receive ANC. The CBTS-3 estimate shows that only 7% women with 4 or more birth-order received full ANC, while 15% women who recently delivered their first birth reported receiving the same.

On the other hand, the state's initiative to strengthening VHND<sup>12</sup> has now started reflecting positively, as more than half of the women who reported receiving ANC visited VHND for at least one of their ANC. Nearly 12% and 19% women visited District Hospitals and Community Health Centres for at least one of their ANC respectively, while 10% women visited Sub-Centres and less than 5% women visited Primary Health Centres. This suggests that there is a great opportunity for VHND to mobilize the women for receiving at least three ANC and consuming at least 100 IFA tablets, who come in its contact.

Women who were contacted by ASHA during their pregnancy were more likely to receive 3 or more ANC and the full ANC. However, the proportion of women being contacted by

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<sup>11</sup>Age is to be considered in years throughout this report, if the unit is not specified.

<sup>12</sup>The basic objective of organizing Village Health and Nutrition Day (VHND) in *Anganwadi* Centres (AWCs) is to provide momentum to the efforts towards increasing early registration, ANC, counselling on institutional delivery, counselling on breastfeeding, family planning, immunization, menstrual hygiene etc. leading to better maternal and child health. The VHND is proposed to be organized once in a month at each AWC. ANM, AWW (*Anganwadi* Worker) and ASHA are supposed to ensure their presence on Saturday (as per Schedule) and coordinate to make this activity at village level an effective intervention. During the VHND, CHC/PHC wise supervisor/ HV (Health Visitor)/BPMU (Block Programme Management Unit) are responsible for Supervision/monitoring of VHND in their respective area.

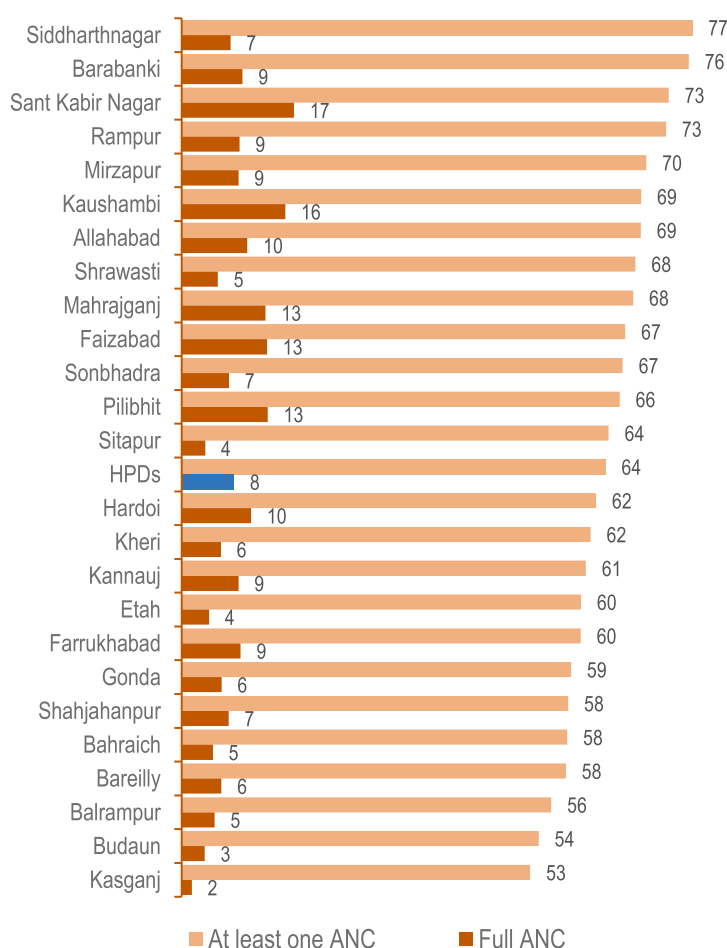
VHND is also seen as a platform for interfacing between the community and the health system. The AWWs/ASHAs/ANMs/PRI representatives are supposed to discuss the following issues with the community : Danger signs during pregnancy; Importance of institutional delivery and where to go for delivery; Importance of seeking postnatal care, Counselling on Essential Newborn Care, Registration for the *Janani Suraksha Yojana*, Counselling for better nutrition, Exclusive Breastfeeding, Weaning and complementary feeding, Care during diarrhoea and home management, Care during acute respiratory infections, Prevention of malaria, TB, and other communicable diseases, Prevention of HIV/AIDS, Prevention of STIs, Importance of safe drinking water, Personal hygiene, Household sanitation, Education of children, Dangers of sex selection, Age at marriage, Information on RTIs, STIs, HIV and AIDs, Disease outbreak, and Disaster management.

ASHA during their pregnancy declined by 14% points between the CBTS-1 (55%) and CBTS-3 (41%). The proportion of women contacted by ASHA during their pregnancy (at least once) was also found considerably varying across the HPDs, where Kasganj, Etah and Sitapur recorded less than 30% of such women.

There was marked variation in the proportion of women receiving at least one ANC and full ANC across the HPDs. The coverage of full ANC was found poor in most of the HPDs. The percentage of women receiving full ANC was recorded the lowest in Kasganj (2%) followed by Budaun (3%) and Etah (4%). Sant Kabir Nagar (17%) and Kaushambi (16%) recorded relatively higher proportion of women receiving full ANC among all 25 HPDs.

### Antenatal Check-up across the HPDs

% women receiving antenatal check-up



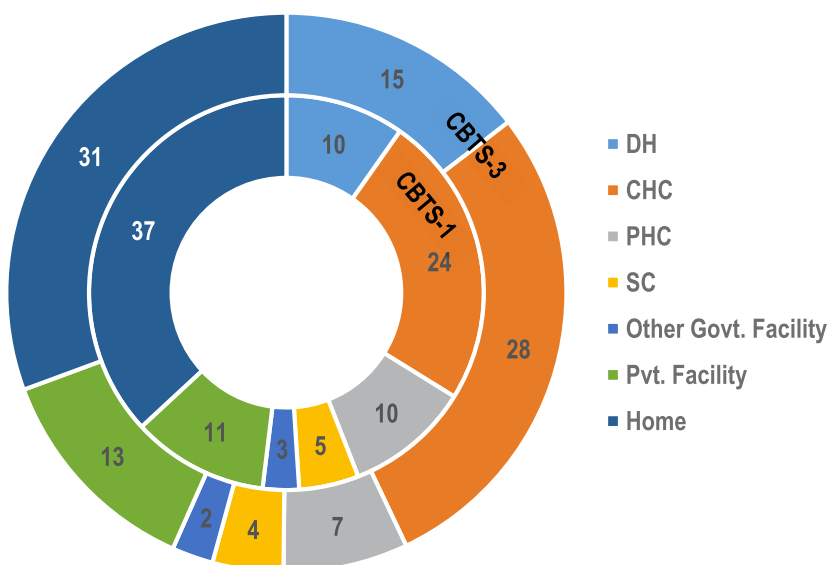
*Half of the HPDs were recorded with lower level of women receiving at least one ANC and full ANC than average (64%/8%) and about one third of the HPDs recorded < 60% of women receiving at least one ANC*

## Delivery Care

Most maternal deaths occur during labour, delivery, or the first 24 hours post-partum, and most complications cannot be predicted or prevented. This makes effective intra-partum care essential to avert deaths and reduce morbidity. Skilled attendance at birth has been shown to reduce maternal mortality, but not necessarily at home. Considering a moderate to good coverage of villages in India by Primary Health Centres (PHC) and Sub-Centres (SC), an institutional model is adopted as the most sensible option for delivery care, with referral to tertiary care hospitals when needed. Several studies suggest that more than 80% of maternal deaths could be prevented or avoided through either increasing the institutional deliveries or by improving the quality of care provided to women.<sup>13,14</sup> Therefore, the GoI gives high priority to promote institutional deliveries to improve maternal survival.<sup>15</sup>

### Place of Delivery — whether improved or not?

% women who delivered in past 2 months preceding the date of survey



Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

The level of institutional delivery in the intervention area has improved by 6% points between the CBTS-1 (63%) and CBTS-3 (69%). The CBTS-3 estimates that about 56% of the births took place in public health facilities, suggesting an improvement of 4% points over the CBTS-1 estimate (52%). The increased proportion of births which took place in public health facilities between the

two survey periods were primarily delivered in higher level facilities such as District

<sup>13</sup>World Health Organization (WHO). 2010. Trends in maternal mortality: 1990 to 2008. Geneva: WHO.

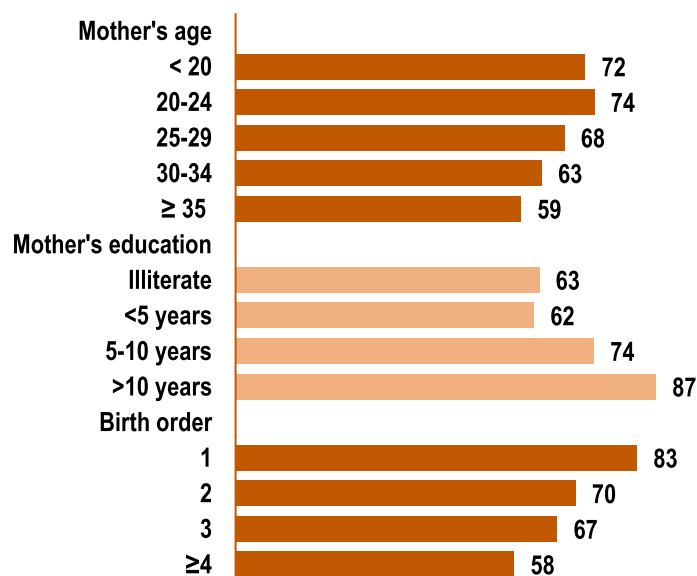
<sup>14</sup>Hogan MC, Foreman KJ, Naghavi M, Ahn SY, Wang M, Makela SM, et al. 2010. Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. *Lancet*, 375: 1609-1623.

<sup>15</sup>A well-known scheme *Janani Suraksha Yojana* or JSY was launched in April 2005 under the umbrella of National Rural Health Mission (NRHM) of India to promote institutional deliveries with an aim to reduce maternal mortality ratio (MMR).

Hospitals (DHs) and Community Health Centres (CHCs). Accordingly, the share of PHCs and SCs in overall institutional delivery reduced between the CBTS-1 and CBTS-3.

### **Institutional delivery varies by mother's age, mother's education and child's birth order**

*% women who delivered in a health facility, CBTS-3*



Younger women (except the adolescent women age below 20) were more likely to have institutional delivery. The level of institutional delivery was found the highest (74%) among women age 20-24, and the lowest (59%) among women age 35 and above. The proportion of deliveries conducted at health facilities was reported slightly less among women belonging to the SC/ST (68%) and OBC (71%) compared to the women of other castes (73%). Women with the higher order births were less likely to deliver in a health facility.

The CBTS-3 estimate shows that only 59% women, who had to deliver their fourth or higher order birth, delivered in a health facility, compared to 83% of women, who had to deliver their first birth.

The level of institutional delivery was also found considerably varying by the level of women's education. Women with more than 10 years of education were estimated to have nearly 87% institutional delivery compared to illiterate women or women with less than 5 years of education, among whom the institutional delivery was estimated nearly 64%. In addition, the women who had 3 or more ANC and who were visited by ASHA at home during their pregnancy at least 3 times were more likely to deliver in a health facility<sup>16</sup>.

Similarly, the women who had emergency birth preparedness plan (which includes intention to deliver at health facility and also planned for transportation) in advance were

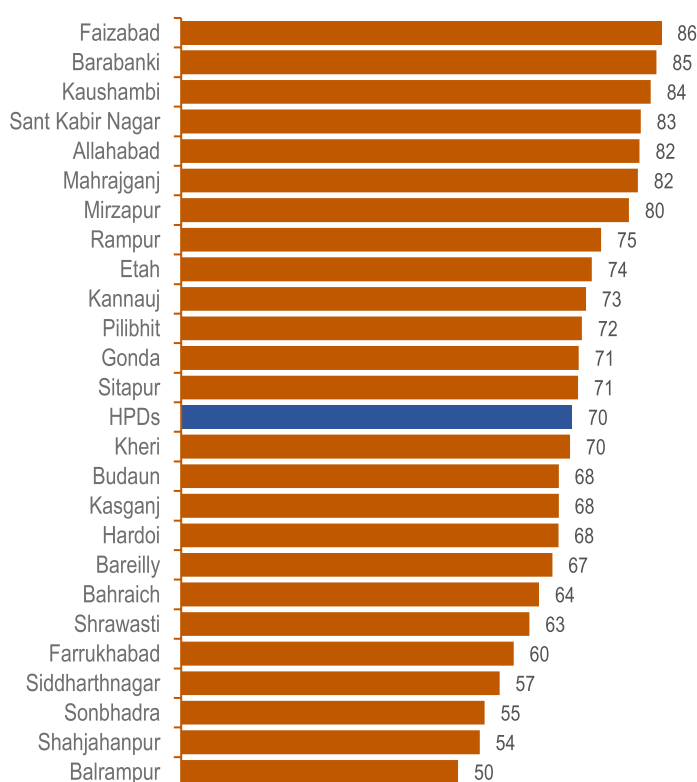
<sup>16</sup>The adjusted odds ratios (AOR) for women experiencing institutional delivery across the number of ANC received by women (compared to receiving no ANC) are: 1 ANC [AOR: 1.02 (95% CI: 0.88, 1.19)], 2 ANC [1.38 (1.19, 1.60)], and ≥3 ANC [1.78 (1.51, 2.09)]. Similarly, the AOR for women who were visited by ASHA at home during pregnancy (compared to no visit of ASHA) was estimated as: 1.41 (1.24, 1.61). The logistic regression model was adjusted for women's age, education, religion, social group, period (trimester) of pregnancy registration, child's birth order, emergency birth preparedness plan in addition to the above two predictors.

6 to 8 times more likely to deliver in a health facility compared to women who did not have any birth plan.

A considerable variation was found in the level of institutional delivery across the HPDs, aptly reflected in the state's situation where one third of all deliveries took place at home. The CBTS-3 recorded 7 HPDs with 80% or above institutional delivery, and 8 HPDs within a range of 70-79%, while 4 HPDs namely Balrampur (50%), Shahjahanpur (54%), Sonbhadra (55%) and Siddharthnagar (57%) were registered with less than 60% institutional delivery.

### Institutional Delivery across the HPDs

% women who delivered in a health facility, CBTS-3



*Nearly half of the HPDs were recorded with lower level of Institutional Delivery than average (70%) and four HPDs recorded < 60% of women delivering at any health facility*

In order to rapidly increase the level of institutional delivery in the poor-performing districts, the women during their pregnancy need to be mobilized for receiving more number of ANC and to be educated for the advantages of institutional delivery by ASHA (or at VHND, where they come for their first ANC). The women with higher order birth (3<sup>rd</sup> or more order birth) should be the prime catch for ASHA who need to be persuaded or convinced more. The higher proportion of pregnant women needs to be registered by

ASHA as early as possible, preferably in their first trimester of pregnancy. The pregnant women should also be mobilized and helped by ASHA for birth planning (identification of place of delivery & transportation well in advance).

## Postnatal Care

Early postnatal care for a mother helps safeguard her health and can reduce maternal mortality. The World Health Organization (WHO) recommends that after an uncomplicated vaginal birth in a health facility, healthy mothers and newborns should receive care in the facility for at least 24 hours after birth.<sup>17</sup> The GoI promotes at least 48 hours hospital stay post-delivery.

The CBTS-3 estimates that nearly 34% women stayed for at least 24 hours in the facility post-delivery, while only 21% women stayed for at least 48 hours.<sup>18</sup> It is envisaged that the women who stayed for at least 24 hours in the facility post-delivery must have received postnatal check-ups before being discharged. During the CBTS-3, the women, who delivered in the past 2 months preceding the date of survey, were asked whether they received postnatal check-up for themselves irrespective of the place they delivered at. Overall, nearly 21% women in the HPDs reported receiving postnatal check-up within 48 hours post-delivery.

A higher proportion (24%) of women in the age group of 20-24 years reported receiving postnatal check-up compared to the women of other age-groups. Nearly 18% women age below 20, and 17% women age 35 and above reported receiving postnatal check-up. The level of postnatal check-up was also found considerably varying by the level of women's education. Nearly 29% women with more than 10 years of education reported to have postnatal check-up compared to 16% women who were illiterate or had less than 5 years of education. However, the place of delivery appeared to play the most important role in determining whether the women receive postnatal check-up within 48 hours or not.<sup>19</sup> Nearly 27% women who delivered at facility (Govt. or Pvt.) reported receiving postnatal check-up compared to only 7% women who delivered at home. The women who were

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<sup>17</sup>The WHO Guidelines on Maternal, Newborn, Child and Adolescent Health: Recommendations on Newborn Health, approved by the WHO Guidelines Review Committee. ([http://www.who.int/maternal\\_child\\_adolescent/en/](http://www.who.int/maternal_child_adolescent/en/))

<sup>18</sup>The CBTS measures the indicator of hospital stay (within 48 hours post-delivery) for those women who had non-caesarean delivery, as it is envisaged that the women who undergo the caesarean delivery are universally insisted to stay at hospital under care at least for 48 hours.

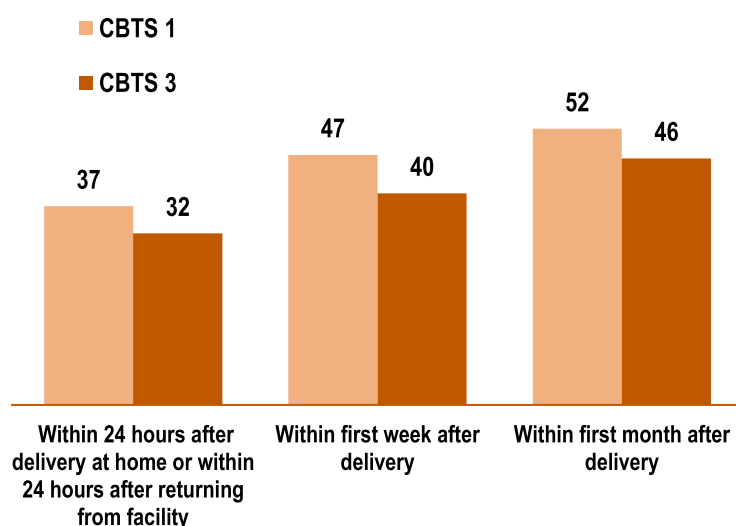
<sup>19</sup>The adjusted odds ratios (AOR) for women receiving postnatal check-up within 48 hours post-delivery in case of women delivered at a facility (compared to home delivery) was estimated as: 3.31 (95% CI: 2.52, 4.35). The logistic regression model was adjusted for women's age, education, religion, social group, period (trimester) of pregnancy registration, number of ASHA visits at home during pregnancy, number of ANC, emergency birth preparedness plan, and child's birth order.

visited by ASHA at home three or more times, who received 3 or more ANC and had planned to deliver in a facility in advance were also more likely to receive postnatal check-up within 48 hours post-delivery. These factors lead to institutional delivery (as discussed above), and the latter significantly determines the likelihood of women receiving postnatal check-up.

The WHO also strongly recommends at least three additional postnatal contacts between women (recently delivered) and health personnel, which should preferably be on day 3 (48–72 hours), between days 7–14, and after six weeks post-delivery. The GoI guidelines advocate for six visits by ASHA in the post-partum period in the case of institutional delivery, and seven visits in the case of home delivery<sup>20</sup>.

### Trends in Postnatal contacts by ASHA

% women visited by ASHA at home post-delivery



Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

across women with children of different birth orders. However, the women who delivered in a health facility were more likely to be visited by ASHA at home after delivery compared to those who delivered at home.

Only 5% of women, who delivered in past 2 months preceding the CBTS-3, reported that they were assessed for temperature by the ASHA during her postnatal visits at home. Nearly 18% and 7% women reported that the ASHA discussed on mother's feeding and enquired about vaginal bleeding post-delivery, respectively.

Comparing the estimates of common blocks surveyed in CBTS-1 and CBTS-3, it is evident that the proportion of women visited by ASHA at home during all recommended periods post-delivery has declined.

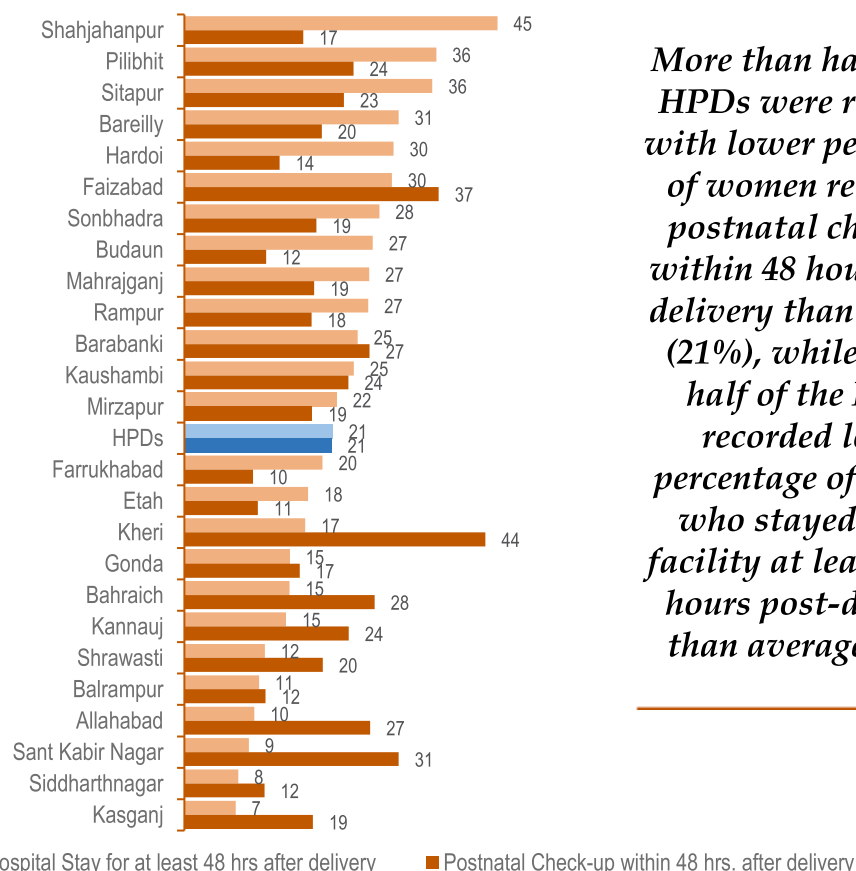
The postnatal contacts made by ASHA at home after delivery was not found considerably varying among different ages of women, across women of different social and religious groups, among women with different educational status, and

<sup>20</sup>Government of India (GoI). 2011. *Home Based Newborn Care: Operational Guidelines*. Ministry of Health and Family Welfare (MoHFW), GoI.

Of all 25 HPDs, eleven districts recorded less than 20% of women who stayed for at least 48 hours in the facility post-delivery. Kasganj (7%), Siddharthnagar (8%), and Sant Kabir Nagar (9%) were the three HPDs recorded with lower level of recommended post-delivery hospital stay.

### Postnatal Care across the HPDs

% women (recently delivered), CBTS-3



*More than half of the HPDs were recorded with lower percentage of women receiving postnatal check-up within 48 hours post-delivery than average (21%), while nearly half of the HPDs recorded lower percentage of women who stayed in the facility at least for 48 hours post-delivery than average (21%)*

Similarly, there was considerable variation across districts in the proportion of women receiving postnatal check-up within 48 hours post-delivery. Six HPDs namely Farrukhabad (10%), Etah (11%), Sidharthnagar (12%), Balrampur (12%), Budaun (12%), and Hardoi (14%) registered less than 15% of women receiving postnatal check-ups within 48 hours post-delivery. The level of overall postnatal check-up across the HPDs was considerably dependent on the proportion of women receiving postnatal check-up who delivered at home. There were ten HPDs<sup>21</sup> which recorded less than 5% of women, who

<sup>21</sup>These include Budaun (1%), Rampur (3%), Balrampur (3%), Siddharthnagar (4%), Shahjahanpur (4%), Kasganj (4%), Mahrajganj (4%), Sitapur (~5%), and Farrukhabad (~5%).

delivered at home, receiving postnatal check-up within 48 hours post-delivery. A few HPDs such as Kheri, Allahabad, Sant Kabir Nagar, Bahraich, Kannauj and Shrawasti recorded a considerable proportion of women receiving postnatal check-up within 48 hours post-delivery, even if these districts had lower proportion of women who stayed in the facility for at least 48 hours post-delivery.

## Maternal Nutrition

The role of maternal health and nutrition is emphasized by the recognition of the problem of low birth weight (LBW) which affects some 20 million newborns annually, mainly in developing countries.<sup>22,23</sup> Deficiencies of certain nutrients during pregnancy are associated with maternal complications and death, fetal and newborn death, birth defects, and decreased physical and mental potential of the child. When the pregnant woman's diet does not supply the required nutrients for her needs and for those of the fetus<sup>24</sup>, the fetal requirements are met by withdrawing these from the tissues of the pregnant mother. The tissue depletion weakens the mother and increases the probability of serious complications and the chances of delivering an LBW baby who is unlikely to feed adequately early in life.<sup>25</sup> Emerging evidences suggest that improving food intake during pregnancy might reduce LBW.<sup>26</sup>

The threat of malnutrition begins in the womb and continues throughout the life cycle. A mother who was malnourished as a fetus, young child, or adolescent is more likely to enter pregnancy stunted and malnourished. Her compromised nutritional status affects the health and nutrition of her own children. Thus, the maternal malnutrition cannot be addressed during pregnancy alone. The periods before and between pregnancies provide an opportunity for women of reproductive age to prepare for pregnancy by consuming an adequate balanced diet, including supplements and fortified foods (subject to availability), and by achieving a desirable weight.<sup>27</sup>

In this section, a few aspects of maternal nutrition (excluding those discussed as a part of antenatal care, e.g., use of IFA tablets) such as counselling on maternal nutrition, Take

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<sup>22</sup>Metcoff J. 1981. Maternal nutrition and fetal outcome. *American Journal of Clinical Nutrition*, 34: 708–21.

<sup>23</sup>United Nations Children's Fund (UNICEF) and World Health Organization (WHO). 2004. *Low Birthweight: Country, regional and global estimates*. UNICEF, New York.

<sup>24</sup>Energy needs increase in the second and particularly the third trimester of pregnancy.

<sup>25</sup>Simpouolos AP. 1991. Selected vitamins, minerals and functional consequences of maternal malnutrition. *World Review of Nutrition and Dietetics*, 61(suppl): S87–121.

<sup>26</sup>Ramakrishnan U. 2004. Nutrition and low birth weight: from research to practice. *American Journal of Clinical Nutrition*, 79(1): 17–21.

<sup>27</sup>[http://www.coregroup.org/storage/documents/Workingpapers/MaternalNutritionDietaryGuide\\_AED.pdf](http://www.coregroup.org/storage/documents/Workingpapers/MaternalNutritionDietaryGuide_AED.pdf)

Home Ration (THR)<sup>28</sup> from the *Anganwadi* Centre (AWC)/ICDS<sup>29</sup> Centre during pregnancy, Minimum Dietary Diversity for Women (MDD-W)<sup>30</sup>, and consumption of iodized salt are discussed.

During the CBTS-3, the women who ended their pregnancy in last 2 months prior to the survey were asked, whether they received any counselling/advice on maternal nutrition by ASHA/AWW during their last pregnancy. Similarly, they were also asked, whether they received THR from the AWC/ICDS Centre during their last pregnancy. Under the Supplementary Nutrition Programme (SNP) of ICDS, the pregnant women are supposed to get Amylase Rich Energy Food (AREF) fortified with essential micronutrients as per the Government specification (at the rate of 140 g/day), so that the beneficiaries could get 600 cal. and 18 g protein per day.<sup>31</sup>

The CBTS-3 estimates that nearly one-third (27%) of the women who ended their pregnancy in last 2 months prior to the survey received any counselling/advice on maternal nutrition from ASHA/AWW during their pregnancy. Women age 20-24 were more likely to receive counselling/advice compared to older women (age ≥ 25). The women belonging to the SC/ST (29%) and OBC (27%) reported receiving proportionately higher counselling/advice compared to the women of other castes (25%). The women with higher order births (i.e., 4 or more) were less likely to receive counselling/advice. The proportion of women receiving counselling/advice increased with the increasing level of women's education and the increasing numbers of visits made by ASHA at their home during pregnancy.

The proportion of women receiving counselling/advice on maternal health during pregnancy ranged from 14% in Balrampur to 42% in Kaushambi. Of all 25 HPDs, eleven districts were recorded with lower proportion of women receiving counselling/advice than average (27%).

On the other hand, almost half of the women who ended their pregnancy in last 2 months prior to the survey received THR from the AWC/ICDS centre during their pregnancy. Women age 20-24 were more likely to receive THR compared to older women (age ≥ 25). The higher proportion of women belonging to the SC/ST (51%) and OBC (48%) received THR compared to the women of other castes (41%). The women with higher order births

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<sup>28</sup>Under the Supplementary Nutrition Programme (SNP) of ICDS (Integrated Child Development Scheme), energy dense micronutrient fortified food is provided as THR to young children, pregnant women, nursing mothers and adolescent girls.

<sup>29</sup>Integrated Child Development Scheme (ICDS)

<sup>30</sup>The MDD-W is a dichotomous indicator of whether or not women age 15-49 have consumed at least four out of ten defined food groups the previous day or night prior to the date of survey.

<sup>31</sup><http://icdsupweb.org/hindi/poshankariya.html>

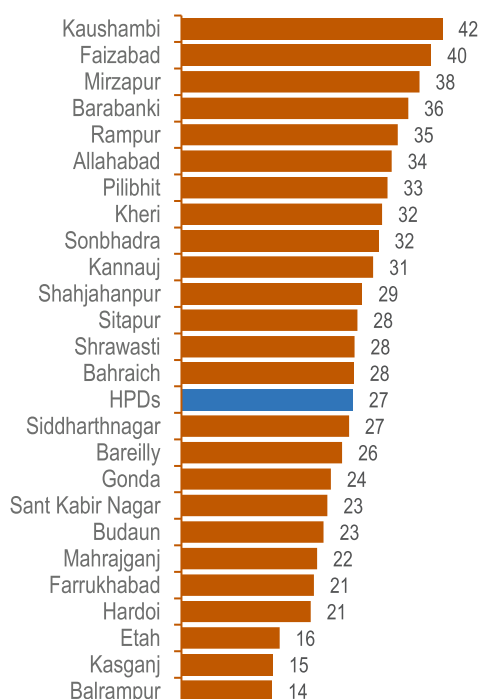
(i.e., 4 or more) were less likely to receive THR. Nearly two-third (74%) of the women, who were visited by ASHA three or more times at home during their pregnancy, received THR compared to only 35% women who were not visited by ASHA at all during their pregnancy.

The proportion of women receiving THR from the AWC/ICDS centre during pregnancy ranged from 32% in Farrukhabad to 63% in Rampur. More than half of the 25 HPDs were recorded with lower proportion of women receiving THR than average (48%).

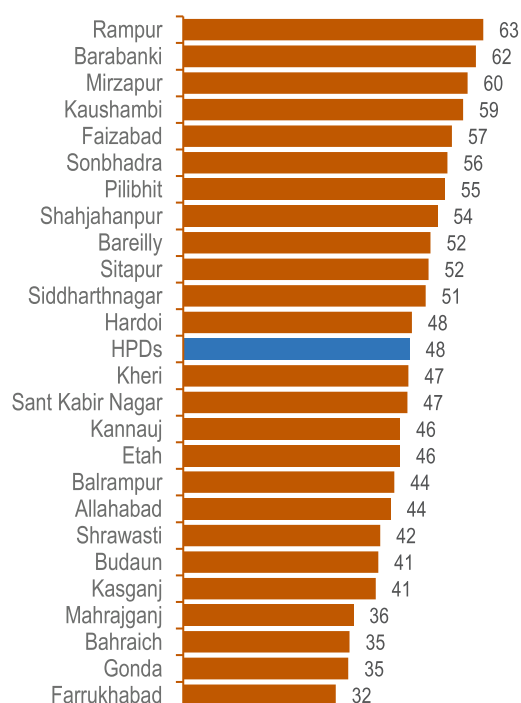
## Counselling and THR (during pregnancy) across the HPDs

% women, CBTS-3

### I. Counselling on maternal nutrition



### II. Received THR during pregnancy



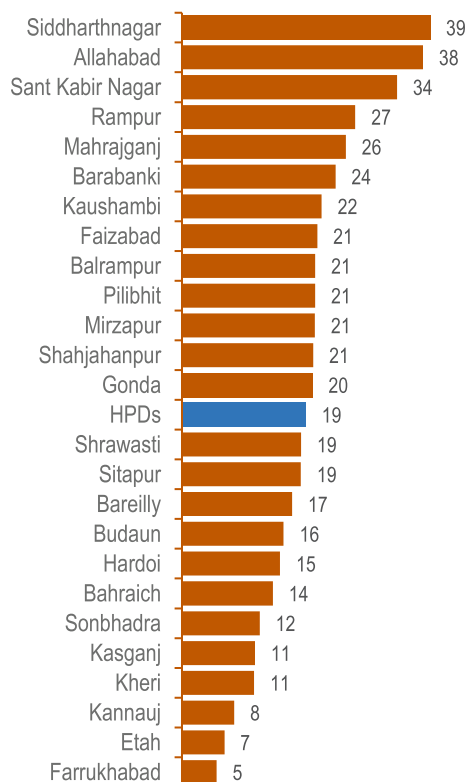
In addition, the women, who ended their pregnancy in last 2 months prior to the survey and the mothers with children age 2-5 months, were also asked about a range of food items and liquids they consumed in the previous day (24 hours from morning till night) during the CBTS-3. A set of ten food/liquid options were given to the women in the survey, which included starch staple food, beans and peas, nuts and seeds, dairy, flesh food, eggs, vitamin-A and dark green vegetables, other vitamin-A rich vegetables and fruits, other vegetables, and other fruits. These food/liquid items is harmonised with a similar Minimum Dietary Diversity (MDD) indicator for infants and young children

recommended by the WHO.<sup>32</sup> These information were used to estimate a proxy indicator, called MDD-W, to assess the level of micronutrient adequacy (one important dimension of diet quality) among the pregnant women. The MDD-W indicator, here, represents the women who consumed at least four out of ten food/liquid items.

The CBTS-3 estimates that almost one-fifth (19%) of the women who ended their pregnancy in last 2 months prior to the survey and the mothers with children age 2-5 months received MDD in the previous 24 hours prior to the survey. Women age 20-24 were more likely to receive MDD compared to older women (age  $\geq 25$ ). The lower proportion of women belonging to the SC/ST (17%) and OBC (21%) received MDD compared to the women of other castes (27%).

### Minimum dietary diversity of mothers across the HPDs

% women (lactating women), CBTS-3



*Nearly half of the HPDs were recorded with lower proportion of women receiving minimum dietary diversity during last 24 hours prior to the date of survey than average (19%)*

The women with higher order births (i.e., 4 or more) were less likely to receive MDD. The higher proportion of women, who were visited by ASHA three or more times at home during their pregnancy, received MDD compared to their counterparts. Similarly, the

<sup>32</sup>World Health Organization (WHO). 2010. *Indicators for assessing infant and young child feeding practices, Part-2: Measurement*. Geneva: WHO.

higher proportion of women with more than 10 years of schooling received MDD compared to their counterparts (illiterate or less educated women).

The proportion of MDD-W ranged from 5% in Farrukhabad to 39% in Siddharthnagar. Of all 25 HPDs, twelve districts were recorded with lower MDD-W than average (19%).

Deficiency of iodine in daily diets of the pregnant women also affects the fetus shortly after conception. During the CBTS-3, the survey investigators tested the level of iodine in the salt consumed in the surveyed household using the MBI kits.<sup>33</sup> It was found that nearly two-third (69%) of the households were consuming iodized salt in their daily diets. More than three-fourth of the households were found consuming iodized salt in Allahabad (83%), Budaun (81%), Etah (79%), Kaushambi (78%), Mirzapur (77%), and Barabanki (75%). On the other hand, there were a few HPDs, such as Shrawasti (42%), Bahraich (54%), Balrampur (57%), Sitapur (58%), and Siddharthnagar (58%), where less than 60% households were found consuming iodized salt.

Providing Calcium supplementation to all pregnant women is adopted as a preventive strategy for pregnancy induced hypertensive disorders by the Ministry of Health & Family Welfare, GoI. Various international evidences are available on the benefit of daily maternal calcium supplementation during pregnancy. These include the Lancet 2013 series in maternal and child nutrition<sup>34</sup>, several meta-analysis, WHO 2011 and WHO 2013 guidelines<sup>35</sup> and the 2014 Cochrane systematic review<sup>36</sup>. A summary of these evidences is that the daily intake of at least one gm/day of calcium in pregnancy after the first trimester reduces the risk of pre-eclampsia by at least 50%, with an additional 24% reduction in the risk of pre-term birth.<sup>37</sup> The daily Recommended Dietary Allowances (RDA) for calcium in pregnancy and lactation is 1200 mg per day. The National Nutrition Monitoring Bureau (NNMB) - 2012<sup>38</sup> data from 10 Indian states showed that most pregnant and lactating women in India had low dietary calcium intake.

During the CBTS-3, the women (who ended their pregnancy in last 2 months prior to the survey) were asked about the number of calcium tablets they received/purchased during their recent pregnancy. Similarly, the lactating mothers (women with their children age 61-180 days at the time of the survey) were asked about the number of calcium tablets they

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<sup>33</sup><http://www.mbikits.com/the-mbi-kit/>

<sup>34</sup><http://www.thelancet.com/series/maternal-and-child-nutrition>

<sup>35</sup>[http://apps.who.int/iris/bitstream/10665/85120/1/9789241505376\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/85120/1/9789241505376_eng.pdf)

<sup>36</sup>Hofmeyr GJ, Lawrie TA, Atallah ÁN, Duley L, Torloni MR. 2014. Calcium supplementation during pregnancy for preventing hypertensive disorders and related problems (Review). Cochrane Database of Systematic Reviews, Issue 6.

<sup>37</sup>[http://www.nrhmhp.gov.in/sites/default/files/files/NG\\_calcium.pdf](http://www.nrhmhp.gov.in/sites/default/files/files/NG_calcium.pdf)

<sup>38</sup>[http://nnmbindia.org/1\\_NNMB\\_Third\\_Repeat\\_Rural\\_Survey\\_Technical\\_Report\\_26.pdf](http://nnmbindia.org/1_NNMB_Third_Repeat_Rural_Survey_Technical_Report_26.pdf)

received/purchased after their recent delivery. As per the GoI guidelines, a woman during her pregnancy needs to receive 360 calcium tablets (@ 2 tablets per day from 14 weeks to 40 weeks = 26 weeks = 182 days), and a lactating mother also requires 360 calcium tablets in the first six months of the postnatal period (@ 2 tablets per day for 6 months). However, the CBTS-3 estimates that less than 1 % of women received/purchased the recommended dose of calcium supplementation during pregnancy and in the first six months after delivery across the HPDs.

## NEWBORN HEALTH

Having been nourished by the pregnant woman for nine months in the womb the most

### Essential Newborn Care

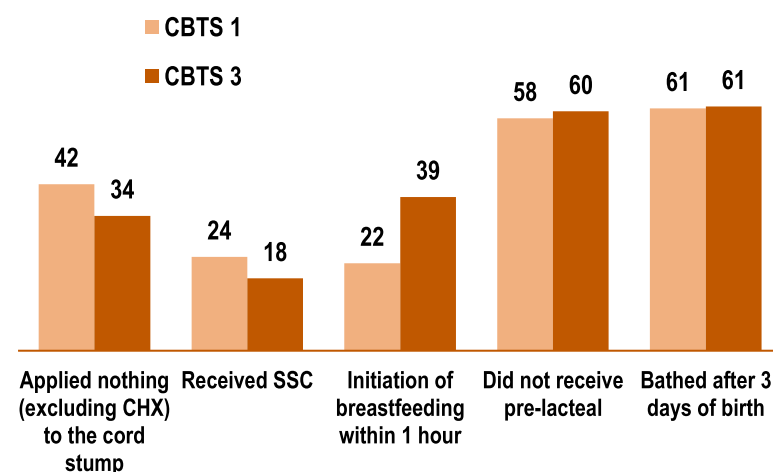
important need of a newborn for the first 24–48 hours is protection. A newborn does not have a mature system to fight infections. Thus, an immediate response and care to newborns is pertinent in order to avoid complications in

early days of life. The cord care, skin-to-skin contact (SSC), early initiation of breastfeeding (IBF), exclusive breastfeeding (pre-lacteal not to be given), keeping the newborn warm (first bathing to be delayed) as well as assessment of the newborn during each postnatal contact by the health workers are a few important practices for newborn health care.

It is recommended that nothing should be applied to the newborn's cord stump. However, the use of chlorhexidine (CHX) in case of home delivery may be considered only to replace application of a harmful traditional substance, such as cow dung, to the cord stump.<sup>17</sup>

### Trends in Essential Newborn Care

% newborns



Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

The CBTS-3 estimate shows that only 34% newborns were not applied anything on their cord stump — the practice which reduced in recent period. The WHO strongly recommends that newborns without complications should be kept in SSC with their mothers during the first hour after birth to prevent hypothermia and promote breastfeeding.

Only 18% of newborns born to the women, who delivered in the past 2 months preceding the CBTS-3, received SSC. The SSC practice also found to be declined between the CBTS-1 and CBTS-3. However, the newborn care practices such as initiation of breastfeeding within one hour after birth, and the newborn not given pre-lacteal<sup>39</sup>, improved during 2015-16.

The early initiation of breastfeeding is one of the important interventions related to newborn care that needs to be focused immediately in order to make it a universal practice, and which costs little to accomplish. There is a strong need of educating mothers about the importance of the newborn receiving first breast milk as early as possible after birth.

The breast milk secreted after the child birth for the first few days is called 'Colostrum' (yellowish in colour and sticky). It is highly nutritious and contains anti-infective substances. It is very rich in vitamin-A. Colostrum has more protein, sometimes up to 10%. It has less fat and the carbohydrate lactose compared to the mature milk. Feeding colostrum to the baby helps in building stores of nutrients and anti-infective substances (antibodies) in the baby's body. The anti-infective substances protect the baby from infectious diseases such as diarrhoea, to which the child might be exposed during the first weeks after birth. Colostrum is basically the first immunization a child receives from the mother. Some mothers consider this first milk as something dirty and indigestible. Difference in colour and consistency could be possible reasons for such beliefs. Practically, all mothers, including those with mild to moderate chronic malnutrition, can successfully breastfeed.<sup>40</sup>

The SSC practice should be considered as a preceding step for initiation of breastfeeding. For all normal newborns (including those by caesarean section), the SSC should be initiated in about 5 minutes of birth in order that baby initiates breastfeeding in an hour of birth. The method of 'Breast crawl' can be adopted for early initiation.<sup>41</sup> In case of operative birth, the mother may need extra motivation and support. The SSC between the mother and newborn should be encouraged by 'bedding in the mother and baby pair'. Mother

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<sup>39</sup>Pre-lacteal feeds are those foods given to newborns before breastfeeding is established or before breast milk "comes in," usually on the first day of life. Pre-lacteals include honey, *jaggery* (brown sugar from sugar cane), *ghee* (clarified butter), and *ghutti* (herbal paste). The choice of pre-lacteals may be specific to a caste or family. These pre-lacteals may be prepared with herbs such as cumin, cardamom, nutmeg, asafetida, caraway, cinnamon, and aniseed. The National Guidelines on Infant and Young Child Feeding (GoI) do not recommend any pre-lacteal to be given to newborn, as they may be potentially harmful or infectious.

<sup>40</sup>Government of India (GoI) 2004. *National Guidelines on Infant and Young Child Feeding*. Ministry of Human Resource Development, Department of Women and Child Development (Food and Nutrition Board), GoI.

<sup>41</sup>Ten steps to successful Breastfeeding- UNICEF/WHO Baby Friendly Hospital Initiative (BFHI). *Initiation of breastfeeding by breast crawl*. Available from: <http://www.breastcrawl.org/10steps.shtml>

should communicate, look into the eyes, touch and caress the baby while feeding. The newborn should be kept warm by promoting Kangaroo Mother Care (KMC) and promoting local practices to keep the room warm.<sup>42</sup>

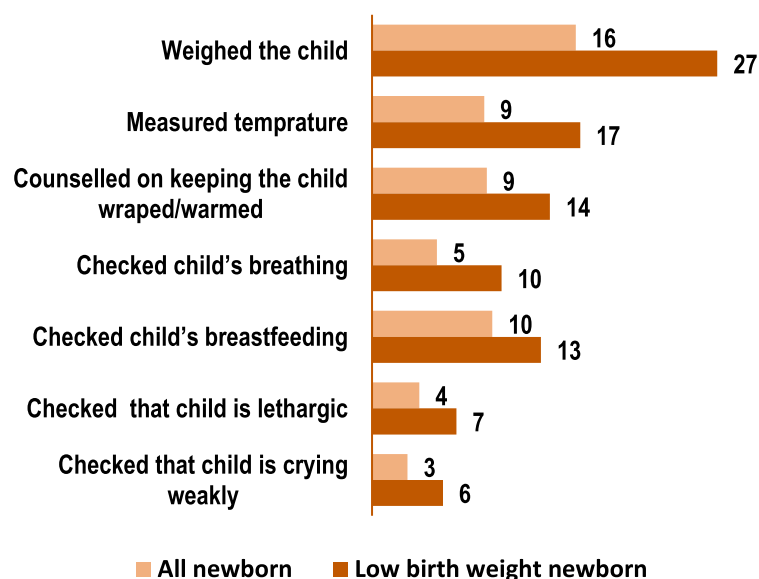
Prevalence of newborn care practices was found higher among newborns delivered in a health facility, especially in the government health facility<sup>43</sup>, compared to newborns delivered at home. In addition, the SSC practice was found lower among newborns of higher birth-order and born to older mothers.

The CBTS-3 estimates that nearly two out of every five newborns (46%) who were delivered at home received health check-up within 48 hours after birth.

The newborns should be assessed for specific danger signs during each postnatal contact by the health worker (e.g., ASHA) and they should be immediately referred to for further evaluation if any of the danger signs is present.

### Assessment or counselling on newborn care by ASHA during home visits

% newborns and LBW newborns, CBTS-3



When inquired about the services/advice given by ASHA during their post-delivery home visits in CBTS-3, it was found that only 17% newborns were weighed, 9% were assessed for body temprature, 5% were assessed for their breathing, 10% were observed for breastfeeding practice, 4% were assessed whether they were lethargic and only 3% were observed if they were crying properly. The proportions of low birth weight (LBW) newborns assessed or counsellled by ASHA on the

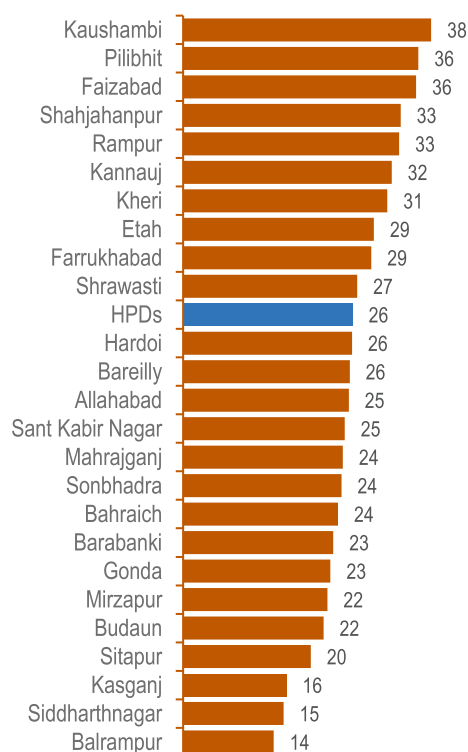
<sup>42</sup>World Health Organization (WHO). 2003. *Kangaroo Mother Care: A Practical Guide*. Geneva: Department of Reproductive Health and Research, WHO.

<sup>43</sup>The newborn care practices varied for births delivered in Govt. Health Facility (GHF) and at home (H) as follows: Initiation of breastfeeding within 1 hour (GHF: 50%; H: 20%), SSC (GHF:25%; H: 12%), Applied nothing (except CHX) to the cord stump (GHF: 35%, H: 31%), Didn't receive pre-lacteal (GHF: 73%, H: 46%), and Delayed (after 3 days of birth) bathing (GHF: 73%, H: 66%)

above-mentioned components of newborn care were relatively higher. Overall, only a quarter of newborns (25%) were assessed for any of the mentioned newborn care signs by ASHA during their postnatal home visits, while the respective proportion was relatively higher (36%) in case of LBW newborns.

### Assessment or counselling on newborn care by ASHA during home visits across the HPDs

% newborns, CBTS-3



*More than half of the HPDs were recorded with lower level of newborns assessed during postnatal visits by ASHA than average (26%) and three HPDs were recorded with < 20% newborns assessed by ASHA during postnatal visits*

Of all 25 HPDs, none was registered with at least 50% newborns assessed by ASHA during postnatal visits at home. Eleven HPDs were recorded with less than a quarter of newborns assessed by ASHA during postnatal visits. Balrampur (14%), Siddharthnagar (15%) and Kasganj (16%) were recorded with even less than 20% newborns assessed by ASHA post-delivery.

As postnatal home visit by a health worker (i.e., ASHA) has been identified as one of the key interventions by GOI & WHO to reduce maternal and neonatal mortality, more

intensified focus is required in HBNC<sup>44</sup> programme to improve the coverage and quality of newborn care.

## Neonatal Mortality

The first 28 days of life – the neonatal period – is the most vulnerable time for a child’s survival. While efforts to reduce maternal and child mortality rates over the past 20 years have had a striking impact, stillbirths and newborn deaths have over the same period missed out on the attention they need.<sup>45</sup> India accounts for more than a quarter (26%) of the world’s neo-natal deaths. More than half (56%) of under-five deaths take place in the first 28 days of life and nearly three-quarters of these newborn deaths occur in the first week of life. The states of Uttar Pradesh, Madhya Pradesh, Rajasthan and Bihar contribute to more than half of newborn deaths in India.<sup>46</sup> This sub-section further discusses the pattern and issues of neonatal mortality in the HPDs.

Based on a survival analysis<sup>47</sup> of livebirths recorded during two months prior to the CBTS-3, the Neonatal Mortality Rate (NMR)<sup>48</sup>, which represents the newborn deaths during the first 28 days after birth, was estimated to be 28 per 1,000 live births (95% CI: 25-32) in the 64 common TSU blocks.

As per the CBTS-3 estimates the NMR was higher among births which took place in a health facility (30, 95% CI: 25-36) compared to those delivered at home (22, 95% CI: 16-30). However, it was significantly lower among the deliveries conducted in government health

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<sup>44</sup>The GoI has launched a new scheme to incentivize ASHA for providing Home Based Newborn Care (HBNC). ASHA is supposed to make visits to all newborns according to specified schedule up to 42 days of life. The proposed incentive is Rs. 50 per home visit of around one hour duration, amounting to a total of Rs. 250 for five visits. This would be paid at one time after 45 days of delivery, subject to the following:

- Recording of weight of the newborn in MCP card
- Ensuring BCG, 1st dose of OPV and DPT vaccination
- Both the mother and the newborn are safe till 42 days of the delivery, and
- Registration of birth has been done

<sup>45</sup>India has achieved a reduction of 59% in under-5 mortality from 126 in 1990 to 52 in 2012, while the decline in neonatal mortality has been much slower compared with under-5 mortality.

<sup>46</sup><http://unicef.in/Whatwedo/2/Neonatal-Health->

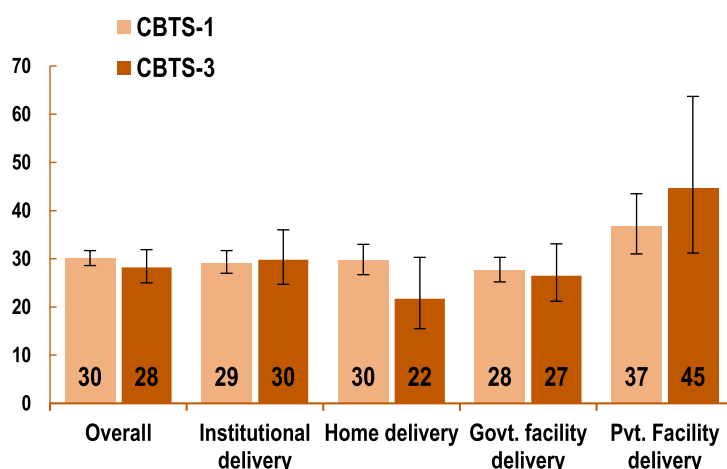
<sup>47</sup>Survival analysis is generally defined as a set of methods for analyzing data where the outcome variable is the time until the occurrence of an event of interest. The event can be death, occurrence of a disease, marriage, divorce, etc. The time to event or survival time can be measured in days, weeks, years, etc. For example, if the event of interest is neonatal death, then the survival time can be the time in days until a newborn dies between the 1<sup>st</sup> and 28<sup>th</sup> day after birth.

<sup>48</sup>The NMR represents the number of newborn deaths taking place during the first 28 days of life per 1,000 livebirths. The estimate is based on 5,212 livebirths and 162 deaths (in 64 common blocks) recorded in the 2 months preceding the CBTS-3. However, a total of 285 deaths were recorded among 9,492 livebirths in 25 HPDs.

facilities (27, 95% CI: 21-33) than those conducted in private health facilities (45, 95% CI: 31-64).

## Neonatal Mortality among births during 2 months prior to survey

Neonatal mortality rate (per 1000 livebirths)



Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

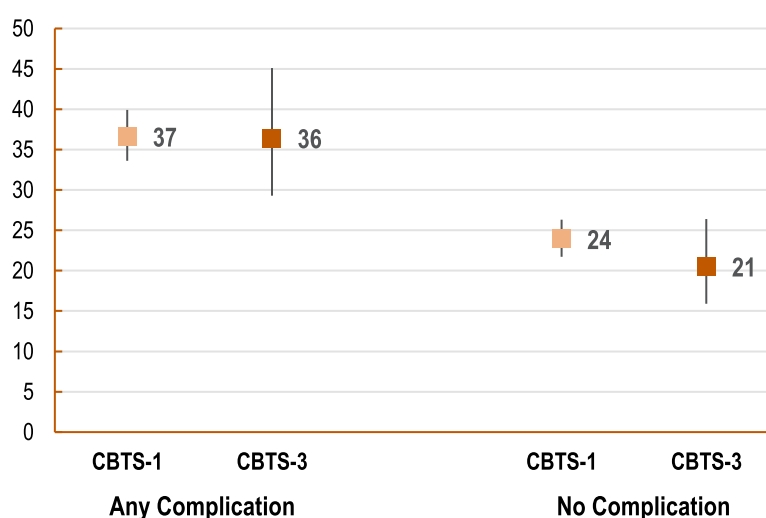
Comparing the estimates of 64 common TSU blocks surveyed in both the CBTS-1 and CBTS-3, the overall NMR appeared to decline by 2 per 1,000 livebirths between the two survey rounds, while a fall in NMR of nearly 8 per 1,000 livebirths was estimated in case of home deliveries, and of 1 per 1,000 livebirths in case of deliveries conducted in government health facilities. A considerable decline in NMR among newborns delivered at

home might be attributed to the efforts being made through HBNC programme, although it would be worth mentioning that the complicated delivery cases are managed at health facilities.

The NMR was estimated considerably higher among newborns whose mothers reported any complication during the delivery (36 per 1,000 livebirths) compared to those whose mothers did not report any delivery complication (21 per 1,000 livebirths). Between the CBTS-1 and CBTS-3, a slight decline in NMR of nearly 1 per 1,000 livebirths was estimated

## Neonatal Mortality by Delivery Complication

Neonatal mortality rate (per 1000 livebirths)



Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

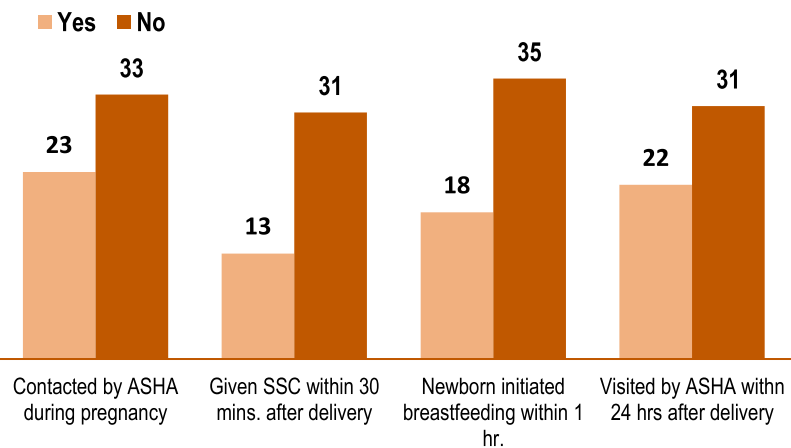
for the newborns whose mothers experienced any complication during the delivery, while in case of non-complicated deliveries, the NMR declined by about 3 per 1,000 livebirths.

The livebirths delivered by the younger age women (age below 20) were more susceptible in early days of life, as the CBTS-3 estimates an NMR of 42 per 1,000 livebirths (95% CI: 25-71) for newborns of mother age below 20. Among the newborns delivered by mother age 20-29 and ≥ 30, the NMR was estimated as 28 per 1,000 livebirths each, although the 95% CI varied for both as (24-32) and (21-37), respectively. Similarly, the neonatal mortality was estimated higher among Hindus [NMR: 30 (95% CI: 26-34)] compared to non-Hindu newborns [NMR: 21 (95% CI: 15-29)]. The NMR was also estimated higher among newborns belonging to the SC/ST (32 per 1,000 livebirths) compared to the OBC (27 per 1,000 livebirths) and other castes (26 per 1,000 livebirths).

As discussed above, the improvement in newborn care can considerably reduce the neonatal mortality, and the increasing level of ASHA outreach in the community will substantially improve the newborn care practices. While estimating the NMR by the status of ASHA contact and a few newborn care practices, it was found that the NMR was substantially higher among newborns whose mothers were not visited by ASHA at home during pregnancy (33 per 1,000 livebirths) and within 24 hours after delivery or returning from the health facility (31 per 1,000 livebirths) compared to those whose mothers were contacted by ASHA during the same period.

**Neonatal Mortality varies by status of ASHA contact and newborn care**

*Neonatal mortality rate (per 1000 livebirths), CBTS-3*



Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

Similarly, the difference in NMR was nearly 18 per 1,000 livebirths between newborns who were given SSC within 30 minutes after delivery and those who were not given. The initiation of breastfeeding during the first hour after birth was also found equally important for the survival of newborns in the early days of life. A difference of nearly 17 per 1,000 livebirths in the NMR was estimated between the newborns who

initiated the breastfeeding during the first hour after birth and who did not.

## CHILD HEALTH

Child health is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity (WHO).<sup>49</sup> The health of children is a product of complex, dynamic processes produced by the interaction of external influences, such as children's family, social, and physical environments, and their genes, biology, and behaviours. Because children are rapidly changing and developing in response to these interactions, the developmental process plays an important role in shaping and determining their health.<sup>50</sup> The key domains of the child health which are discussed here include the exclusive breastfeeding (up to 6 months of age), complementary feeding (among children age 6-23 months), immunization (among children age 12-23 months), malnutrition (among children age 6-23 months), and management of Pneumonia and Diarrhoea (among children age 0-23 months).

### Exclusive Breastfeeding

Exclusive breastfeeding means that babies are given only breast milk and nothing else – no other milk, food, drinks and not even water. The exclusive breastfeeding since birth helps ensure young children the best possible start to life. Breastfeeding is nature's way of nurturing the child, creating a strong bond between the mother and the child. It provides development and learning opportunities to the infant, stimulating all five senses of the child – sight, smell, hearing, taste, and touch. Breastfeeding fosters emotional security and affection, with a lifelong impact on psychosocial development. Special fatty acids in breast milk lead to increased intelligence quotients (IQs) and better visual activity. A breastfed baby is likely to have an IQ of around 8 points higher than a non-breastfed baby.<sup>41</sup> Studies<sup>51,52,53</sup> have also revealed that exclusive breastfeeding prevents infections, particularly the diarrhoeal infections in the child, and also helps in preventing anaemia in child, as breast milk has the best bioavailable iron.

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<sup>49</sup>[http://www.who.int/maternal\\_child\\_adolescent/documents/child/en/](http://www.who.int/maternal_child_adolescent/documents/child/en/)

<sup>50</sup>National Research Council (US); Institute of Medicine (US). 2004. Children's Health, The Nation's Wealth: Assessing and Improving Child Health. Washington (DC): National Academies Press (US). Available from: <https://www.ncbi.nlm.nih.gov/books/NBK92213/>

<sup>51</sup>Bhandari N, Bahl R, Mazumdar S, et al. 2003. Effect of community-based promotion of exclusive breastfeeding on diarrhoeal illness and growth: a cluster randomised controlled trial. *Lancet*, 361(9367): 1418-23.

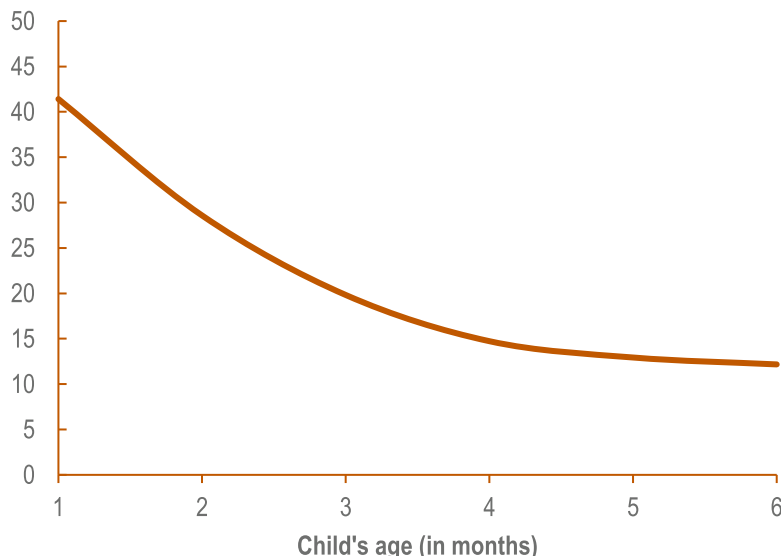
<sup>52</sup>Howie P, Forsyth J, Ogston S, Clark A, Florey CD. 1990. Protective effects of breastfeeding against infection. *British Medical Journal*, 300: 11-16.

<sup>53</sup>Oddy WH. 2001. Breastfeeding protects against illness and infection in infants and children: a review of the evidence. *Breastfeeding Review*, 9: 11-18.

The WHO strongly recommends that all babies should be exclusively breastfed from birth until 6 months of age.<sup>54</sup> Mothers should be counselled and provided support for exclusive breastfeeding at each postnatal contact.

During the CBTS-3, the mothers with children age 0-2 months and children age 3-5 months were asked whether their children were breastfed a day (during the 24 hours) before the date of survey. The enquiry followed a probing to the mothers in order to confirm whether the child was given any of the liquid/semi-solid/solid (food) items in addition to the breast milk. The list of liquid items and the measurement of the indicator representing exclusive breastfeeding of children age below 6 months followed the WHO guidelines<sup>32</sup>.

**Pattern of exclusive breastfeeding by child's age**  
% children, CBTS-3



The CBTS-3 estimates that only 24% of children age 0-5 months were currently exclusively breastfed in the HPDs. The proportion of these children was found considerably varying by their age-group. Nearly 35% children age 0-2 months were found currently breastfed, while this was observed for only 15% children age 3-5 months. The pattern of exclusive breastfeeding practice among the

children age 0-5 months at discrete age (in months) clearly manifests that the proportion of exclusively breastfed children considerably declined at each month of child's age, especially between the first month and the fourth month. In the first month after birth, nearly 41% children were found exclusively breastfed, which declined by 12% points in the second month (29%). The decline in proportion further continued as only 20% children were found exclusively breastfed in the third month, 15% in the fourth month, 13% in the

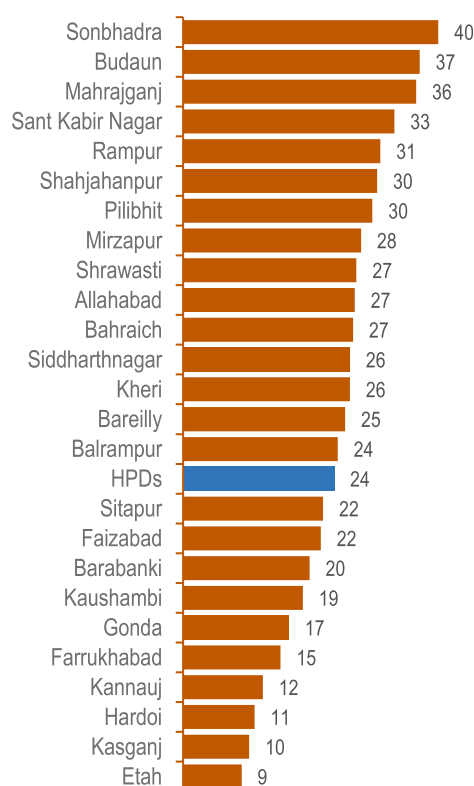
<sup>54</sup>The WHO in late 70s recognised the seriousness of the declining trend in breastfeeding and introduced an International Code for Protection and Promotion of Breastfeeding (ICPPB) in 1981. During that time, the sound practice of breastfeeding suffered a setback because of aggressive media campaign of the multinational companies producing baby milk powder and infant foods. In 1983, the GoI adopted a National Code for Protection and Promotion of Breastfeeding (NCPBP). The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, is being implemented by the Department of Women and Child Development since 1993.

fifth month, and only 12% children were found exclusively breastfed during the sixth month after birth.

The practice of exclusive breastfeeding was found slightly lower among children (age 0-5 months) of younger mothers (age below 20). The SC/ST mothers (25%) had slightly higher proportion of children practising exclusive breastfeeding compared to mothers belonging to the OBC (23%) and other castes (19%). The exclusive breastfeeding practice was not found varying across children of different birth-orders. Nearly 26% women reported to receive counselling on exclusive breastfeeding by health workers (ASHA/AWW/ANM).

### Exclusive Breastfeeding across the HPDs

% children age 0-5 months, CBTS-3



*Ten out of all 25 HPDs were recorded with lower level of children age 0-5 months who were exclusively breastfed than average (24%) and seven HPDs registered even less than 20% of such children*

Of all 25 HPDs, none was registered with at least 50% children age 0-5 months who were exclusively breastfed. Eleven HPDs were found where less than a quarter of children age 0-5 months were exclusively breastfed. Etah (9%), Kasganj (10%), Hardoi (11%), Kannauj (12%), Farrukhabad (15%), Gonda (17%), and Kaushambi (19%) were recorded with even less than 20% of such children.

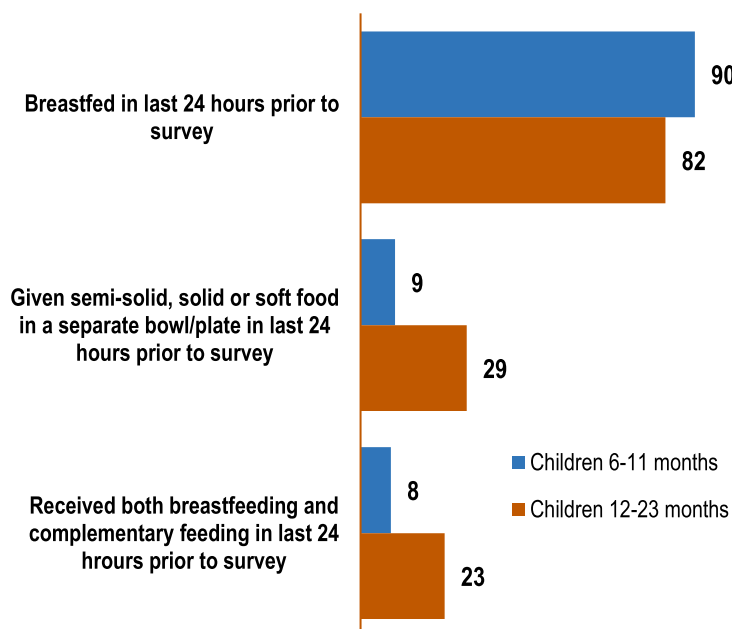
## Complementary Feeding

Mothers should practice exclusive breastfeeding to their children from birth to 6 months of age and introduce complementary foods after the completion of the 6th months (180 days) while continuing to breastfeed. The appearance of enzyme amylase in the seventh month of the infant is suggestive of desirability of introducing cereal based foods in the diet of infant.<sup>50</sup> The rate of growth at this stage is incomparable to that in later period of life. An infant weighing around 3 Kg at birth doubles its weight by six months, and by one year, the weight triples and the body length increases to one and a half times than at birth. Most of the organs of the body grow rapidly, both structurally and functionally during the early years of life and later on, the growth slows down.

Most of the growth in the nervous system and brain take place in the first two years of life. In order to achieve optimum growth and development, there is an increased demand for a regular supply of raw material in the form of better nutrition. Breast milk is an excellent food and meets all nutritional requirements of the baby for the first six months. However, after six months of age, breast milk alone is not enough to make an infant grow well, other foods are also required. Since the infant grows in size along with its activities, the nutritional needs of the infant increase significantly at this age. Thus, the complementary feeding should be projected as a bridge that the mother has to make between liquid to

### Breastfeeding and Complementary Feeding

% children age 6-11 months/12-23 months, CBTS-3



solid transition and to empower the baby to 'family pot feeding.'<sup>55</sup>

The GoI has always been promoting at the national and international fora exclusive breastfeeding for the first six months and introduction of complementary foods thereafter with continued breastfeeding upto 2 years which is consistent with the Indian tradition of prolonged breastfeeding and introduction of

<sup>55</sup>Tiwari et al. 2016. Recommendation: Infant and Young Child Feeding Guidelines, 2016. *Indian Pediatrics*, 53: 703-713. Available from: <http://www.indianpediatrics.net/aug2016/703.pdf>

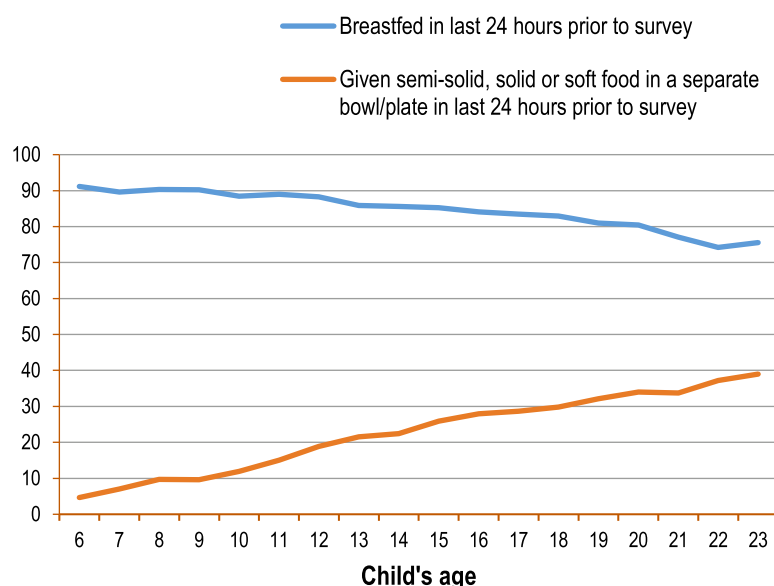
complementary foods from six months of age through an *Annaprashan*<sup>56</sup> ceremony.<sup>33</sup>

As per the response of mothers of the children age 6-23 months during the CBTS-3, it was estimated that 90% of children age 6-11 months continued being breastfed, while only 9% of children of the same age were given complementary foods (e.g., semi-solid, solid or soft food in a separate bowl/plate), and 8% of children age 6-11 months received both breastfed milk and complementary foods.

On the other hand, nearly 29% children age 11-23 months were given complementary foods, while slightly lower proportion of children age 11-23 months (82%) were found continuing breastfeeding compared to children age 6-11 months (90%).

### Breastfeeding and Complementary Feeding by age of children

% children, CBTS-3



Overall, 23% of children age 12-23 months received both breastfed milk and complementary foods. The breastfeeding practice was found gradually declining with increasing age of children and that is complemented by increasing proportion of children, who started receiving semi-solid/solid or soft foods — this pattern is very much evident among children between age 6 and 23 months.

The estimates show that complementary feeding to children age 6-23 months with adequate frequency and quantity marginally improved over the two survey rounds, while there was considerable progress in complementary feeding with adequate variety between the two survey rounds. Despite the low level of adequate frequency and quantity of

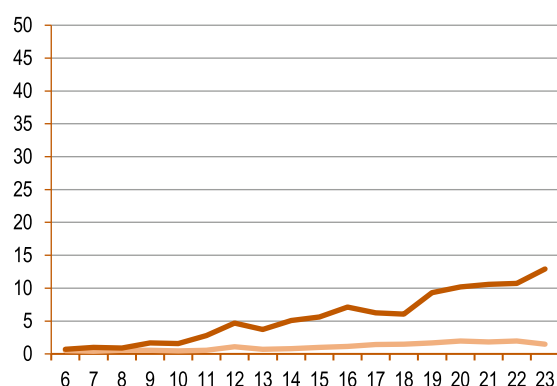
<sup>56</sup>*Annaprashan* is a Sanskrit term which means “grain initiation”. *Annaprashan* celebrates the transition of the newborn baby from liquid to solid food, and is celebrated in most parts of India. In Bengal, the ceremony is called *Mukhe Bhaat* (literal meaning – rice in your mouth), and in other regions, probably celebrated with different local names.

complementary feeding, it was found improving with increasing age of the children — where less than one percent children age 6 months received adequate frequency and quantity of complementary feeding during the CBTS-3, it was nearly 13% among children age 23 months.

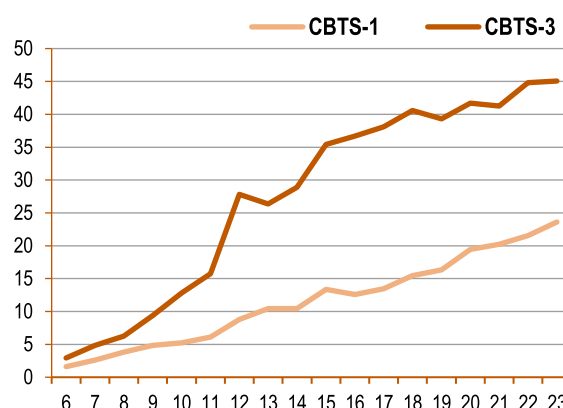
## Complementary Feeding (CF) by age of children

% children

### I. CF with adequate frequency and quantity



### II. CF with adequate variety



Age of the child (in months)

Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

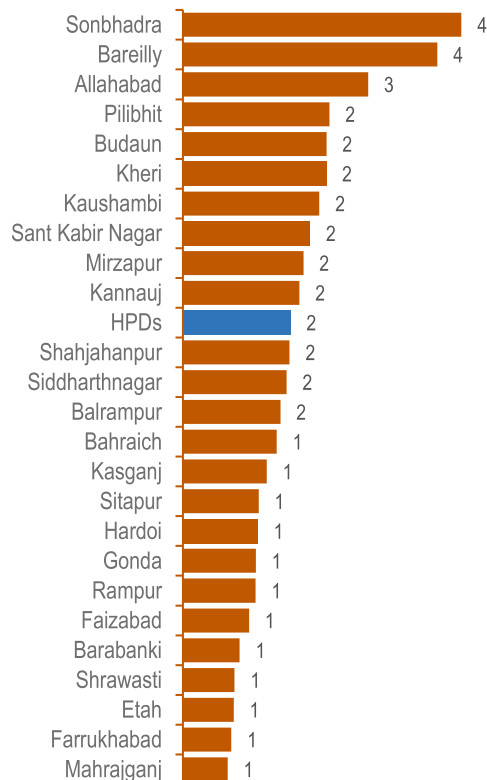
Similarly, the CBTS-3 estimates that the proportion of children who received adequate variety of food increased from 3% among children age 6 months to 45% among children age 23 months.

Three or more meals of the half or full bowl of 250 ml bowl each, was considered as the adequate frequency and quantity for children age 6-23 months. Children who received at least 4 of the 7 food items (fats and oils, pulses and legumes, green leafy/other vegetables, fruits, cereals and millets, milk and milk products, egg and animal products) were considered as receiving adequate variety.

The CBTS-3 estimates that only 2% children age 6-23 months received age-appropriate complementary feeding (including adequate frequency and quantity, variety, and breastfeeding) in the HPDs. Maharajganj, Farrukhabad, Etah, Shrawasti and Barabanki were the five HPDs, where the lowest proportion of such children was found.

## Age-appropriate Complementary Feeding across the HPDs

% children age 6-23 months, CBTS-3



*Fifteen out of all 25 HPDs were recorded with lower level of children age 6-23 months who received age-appropriate complementary feeding than average (2%)*

## Childhood Immunization

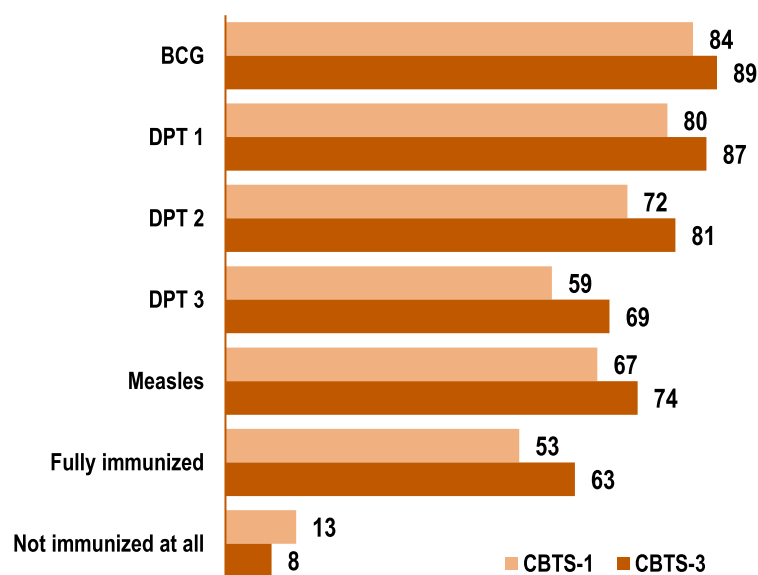
The GoI recommends one dose each of BCG (Bacillus Calmette-Guérin) and measles, and three doses each of DPT (Diphtheria, Pertussis and Tetanus) and Polio vaccine for all children of India to receive by 9 months of age. As per the WHO guidelines, all children age 12-23 months who receive the recommended doses of all the above vaccines are identified as fully immunized.

Considering the Polio vaccines universally received in the country, the CBTS focuses on other important vaccines. Thus, the estimate on full immunization in CBTS constitutes three doses of DPT/Pentavalent and one dose each of BCG and Measles. The estimates suggest that the coverage of children age 12-23 months receiving all recommended vaccines increased considerably in the HPDs during 2015-16. The proportion of children receiving BCG and measles vaccination increased by 5% points and 7% points respectively between the CBTS-1 and CBTS-3. Similarly, the coverage in three doses of DPT vaccination improved by 7% points (DPT 1), 9% points (DPT 2) and 10% points (DPT 3) respectively.

However, still 8% of children age 12-23 months were observed left out to receive any of the recommended vaccines (except Polio). Between the CBTS-1 and CBTS-3, an increase of 10% points was estimated among children age 12-23 months receiving full immunization.

### Trends in Childhood immunization

% children age 12-23 months



Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

likely to receive full vaccinations. The CBTS-3 estimates that 64% of children (age 12-23 months) of first birth-order received full vaccination compared to 53% children of four or higher birth-order. Similarly, 74% of children age 12-23 months received full vaccination whose mothers had more than 10 years of education compared to 54% children of illiterate mothers.

In order to further improve the level of full immunization, the dropout of the children, who received DPT 1 and could not receive its successive two doses, has to be addressed, although the dropout of children (from DPT 1 to DPT 3) has reduced between the CBTS-1 (21%) and CBTS-3 (18%). The dropout in DPT vaccination was relatively higher among children of younger (age below 20) and illiterate mothers, among the Muslim children and children of higher birth-order (4 or more).<sup>57</sup>

<sup>57</sup>The proportion of dropout in children from receiving DPT 1 to DPT 3 : by mother's age [15-19 years: 23%; 20-24 years/25-29 years: 17%; 30-34 years/≥35 years: 18%]; by religion [Hindu: 17%; Non-Hindu: 20%]; by social group [SC/ST: 17%; OBC: 18%; Others: 16%]; by mother's years of schooling [Illiterate: 20%; <5 years: 18%; 5-10 years: 16%; >10 years: 12%]; by child's birth order [Order 1: 16%; Order 2: 17%; Order 3: 18%; Order ≥4: 19%].

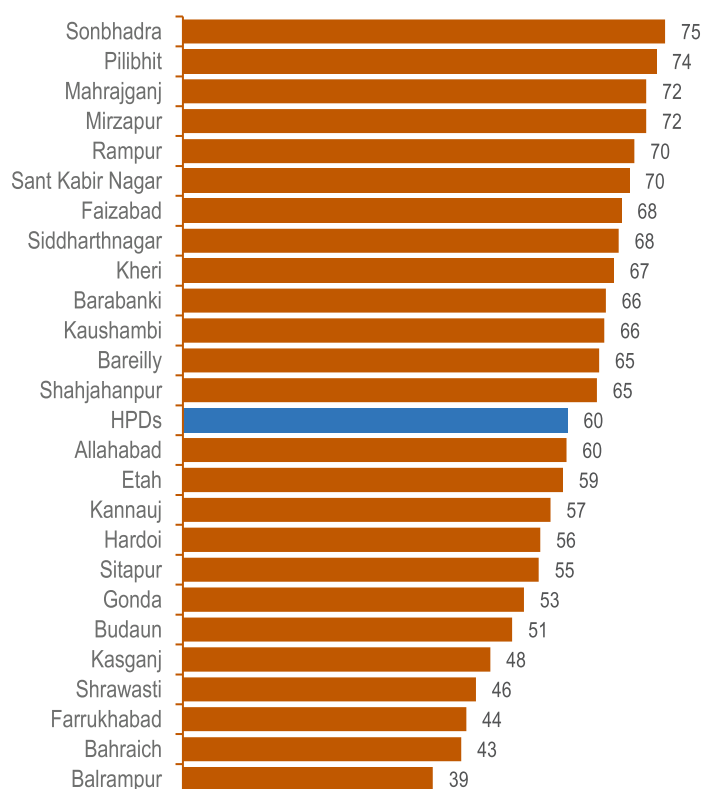
In addition, there was considerable improvement in the availability of cards for the verification of immunization details between the two survey periods. Where only in 35% of the cases during the CBTS-1 the immunization details were recorded in the cards, it was found in almost 52% of the cases during the CBTS-3.

Children of lower birth orders and of educated mothers were more

The coverage of children age 12-23 months receiving full immunization was found considerably varying across the HPDs, where it ranged from 39% children in Balrampur to 75% in Sonbhadra. Twelve of the 25 HPDs registered lower proportion of children age 12-23 months receiving full immunization than average (60%), and five HPDs namely Balrampur (39%), Bahraich (43%), Farrukhabad (44%), Shrawasti (46%) and Kasganj (48%) were recorded with even less than 50% of such children.

### Full immunization across the HPDs

% children age 12-23 months, CBTS-3



*Nearly half of all 25 HPDs were recorded with lower level of children age 12-23 months who received full immunization than average (60%), while five districts recorded even less than 50% of such children*

## Child Malnutrition

Nutrition is among the fundamental needs of a human being, and access to proper nutrition is even more imperative for a child. A nation-wide Rapid Survey on Children (RSOC), in association with UNICEF, conducted in 2014 estimated that half of the children under 5 years of age in Uttar Pradesh, the densest state of India by population, were stunted<sup>58</sup> due to malnutrition.<sup>59</sup> The RSOC (2014) also estimated that nearly one in

<sup>58</sup>Stunted children refer to those children who had reduced growth rate in terms of 'height for age'.

<sup>59</sup>Raykar N., Majumdar M., Laxminarayan R., Menon P. 2015. India Health Report: Nutrition 2015. New Delhi, India: Public Health Foundation of India.

every ten children age below 5 years in Uttar Pradesh were wasted<sup>60</sup>. The India Health Report: Nutrition (2015)<sup>59</sup> mentioned that the stunting rate for children under-five did not undergo significant change in Uttar Pradesh between 2006 and 2014.

To address the prevalence and severity of development delays in children resulting into acute and chronic malnutrition and undernutrition, the GoI and GoUP promote the regular growth monitoring of children by health workers at AWC and VHND. Growth monitoring consists of routine measurements to detect abnormal growth, combined with some action when this is detected. Both growing too slowly or too fast may indicate a nutritional or other health problem. The regular monitoring aims to improve nutrition, reduce the risk of death or inadequate nutrition, help educate carers, and lead to early referral for conditions manifest by growth disorders.<sup>61</sup> A narrative overview of 10 health intervention projects suggested that growth monitoring (used in three of them) has the potential for “a significant impact on mortality....even in the absence of nutrition supplementation or education”.<sup>62</sup>

The CBTS-3 enquired about a set of issues related with growth monitoring of children (of different age groups i.e., 3-5 months, 6-11 months, and 12-23 months) from their mothers. In addition, the survey investigator also measured the Mid Upper Arm Circumference (MUAC)<sup>63</sup> of the child in order to assess the actual physical status of the child.

It was found that nearly 8% children age 3-23 months were screened by a medical doctor for any of the four Ds<sup>64</sup> [i.e., *Birth Defects* (2%), *Development Delays* (2%), *Deficiency* (1%), and *Disease* (3%)]. Nearly 3% of children age 0-23 months were identified severely underweight (SUW) by AWW. However, only one third (37%) of the SUW children age 0-23 months were weighed at AWC/VHND in the last one month preceding the CBTS-3.

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<sup>60</sup>Wasted children refer to acute malnourished children in terms of ‘weight for height’.

<sup>61</sup>Garner P., Panpanich R., Logan S. 2000. Is routine growth monitoring effective? A systematic review of trials. *Archives of Disease in Childhood*, 82:197-201.

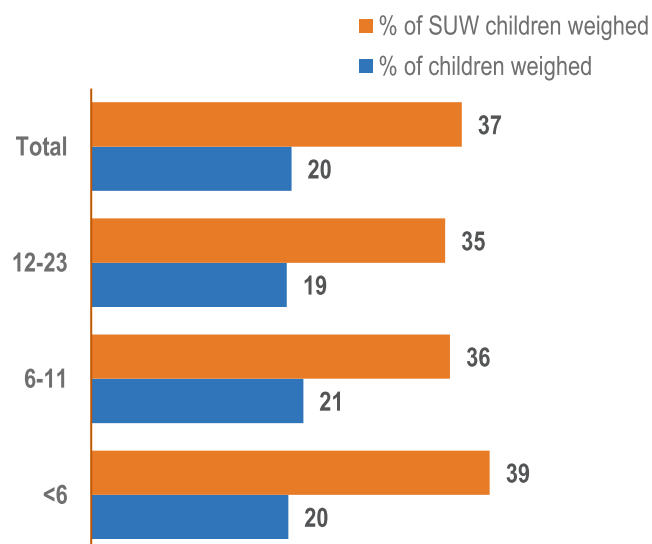
<sup>62</sup>Gwatkin DR, Wilcox JR, Wray JD. 1980. *Can health and nutrition interventions make a difference?* Washington DC: Overseas Development Council. (Monograph No. 18).

<sup>63</sup>MUAC is the circumference of the left upper arm, measured at the mid-point between the tip of the shoulder and the tip of the elbow. It is a standard anthropometric measure, which requires little equipment and is easy to perform even on the most debilitated individuals. MUAC is less affected than weight and height based indices (e.g. WHZ, WHM, BMI) by the localised accumulation of fluid (i.e. bipedal or nutritional oedema, periorbital oedema, and ascites) common in famine and is a more sensitive index of tissue atrophy than low body weight. It is also relatively independent of height and body-shape.

<sup>64</sup>*Rashtriya Bal Swasthya Karyakram* (RBSK) is a new initiative aimed at screening over 27 Crore children from 0 to 18 years for 4 Ds -Defects at birth, Diseases, Deficiencies and Development Delays including Disabilities. Children diagnosed with illnesses should receive follow up including surgeries at tertiary level, free-of-cost under the National Rural Health Mission (NRHM).

## Weighing of children at AWC/VHND in the last month before the date of Survey

% children age 0-23 months, CBTS-3



Eleven HPDs recorded higher proportion of SUW children age 0-23 months than average (3%).

Kaushambi (5%), Barabanki (5%), Allahabad (5%), Bareilly (4%) and Kannauj (4%) were the top five HPDs with higher proportion of SUW children age 0-23 months.

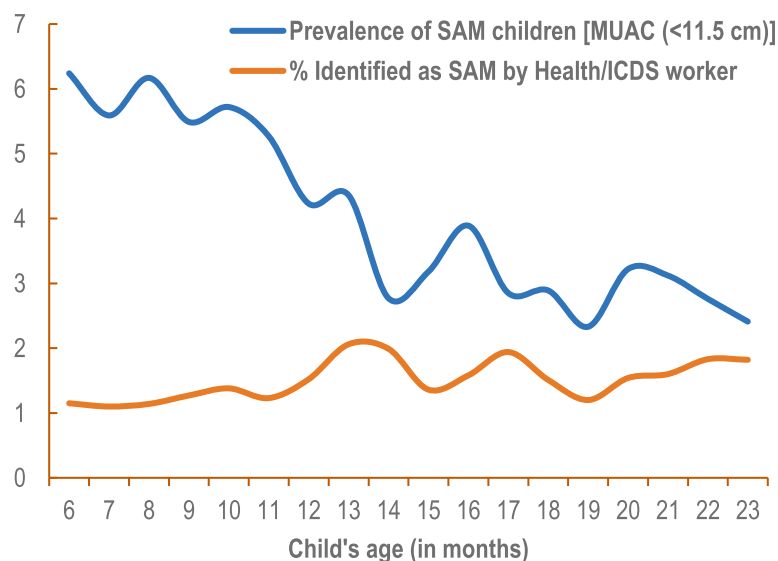
On the other hand, nearly 2% children age 6-23 months were identified as severely acute malnourished (SAM) by health/ICDS workers during the CBTS-3.

However, in actual assessment made by the survey investigators using MUAC, it was found that nearly 5% of children of the same age (6-23 months) were SAM (following the criteria of MUAC <11.5 cm). The proportion of the SAM children was higher in the age group of 6-11 months (6%), compared to 12-23 months (3%).

Malnourishment was found higher among female children, among children of illiterate mothers or mothers having less than 5 years of schooling, and among children of 4 or more birth-order.

## Severely Acute Malnourished (SAM) by child's age

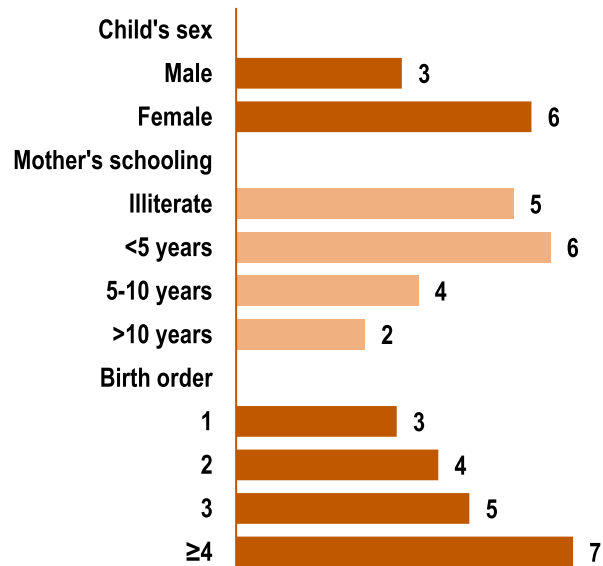
% children age 6-23 months, CBTS-3



The proportion of female children age 6-23 months, who were identified as SAM (MUAC <11.5 cm) was double of their male counterparts. Similarly, the proportion of SAM children, whose mothers had more than 10 years of schooling, was less than half that of the children whose mothers were illiterate or had less than 5 years of schooling.

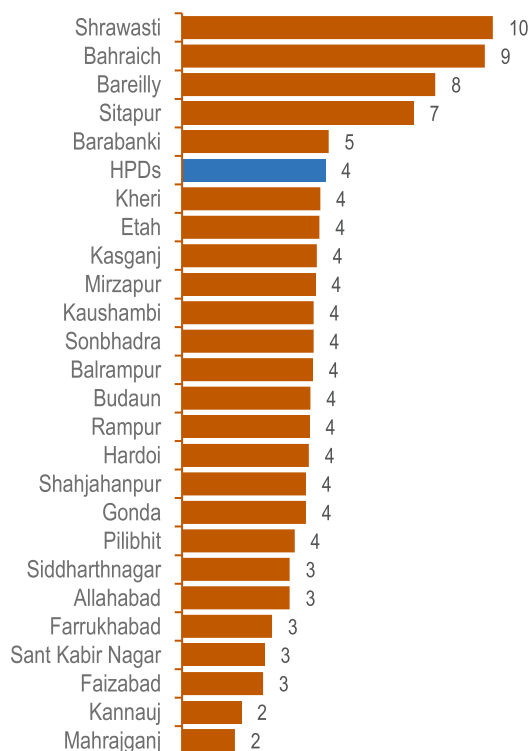
### Severely Acute Malnutrition varies by child's sex, mother's education and child's birth-order

% children age 6-23 months [MUAC <11.5 cm], CBTS-3



### Severely Acute Malnutrition across the HPDs

% children age 6-23 months, CBTS-3



*Five HPDs were recorded with higher level of children age 6-23 months who were assessed as SAM (MUAC < 11.5 cm) than average (4%)*

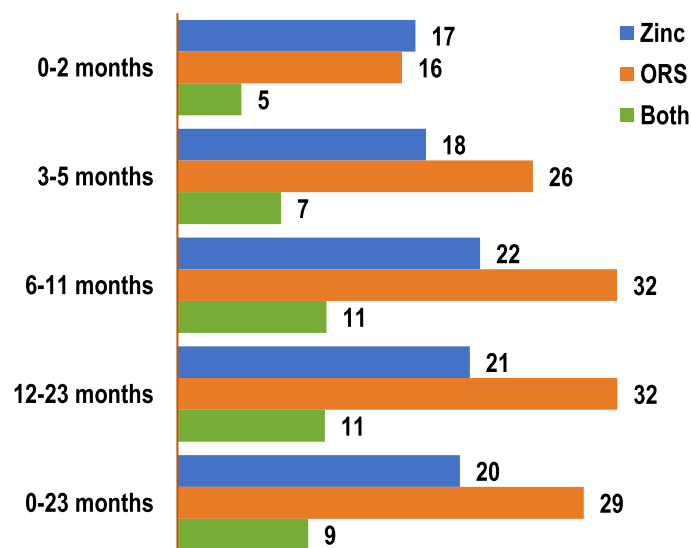
The proportion of SAM (MUAC <11.5 cm) children age 6-23 months ranged from the lowest in Maharajganj (2%) to the highest in Shrawasti (10%) across the HPDs. Five HPDs namely Shrawasti (10%), Bahraich (9%), Bareilly (8%), Sitapur (7%), and Barabanki (5%) registered higher proportion of SAM (MUAC <11.5 cm) children age 6-23 months than the average level in the HPDs (4%).

## Pneumonia and Diarrhoea Treatment

According to the Million Death Study Collaborators (2010)<sup>65</sup>, diarrhoea is the third most common cause of death among under-five children (responsible for 13% deaths), killing an estimated 300,000 children in India each year. Nearly 11% children in Uttar Pradesh were estimated to be suffering from diarrhoea as per the Annual Health Survey (2012-13)<sup>66</sup>. Similarly, two out of every five children age 0-5 years in Uttar Pradesh was estimated to be suffered from severe pneumonia in 2010, and responsible for around 94 thousand deaths of children in this age-group. Treatment practices and contact of health services among children with these important childhood illnesses help in the assessment of National and State level Health Programmes aimed at reducing the mortality impact of these illnesses.

### Diarrhoea treatment with Zinc and ORS

% children, CBTS-3



During the CBTS-3, mothers (with children age 0-2 months, 3-5 months, 6-11 months and 12-23 months) were asked if their children had suffered from any episode of diarrhoea in the past 2 weeks preceding the date of survey, and if suffered how they treated. The CBTS-3 estimates that nearly one third (29%) of children age 0-23 months were suffered from diarrhoea in the HPDs, and in 86% of the cases, the health care was sought.

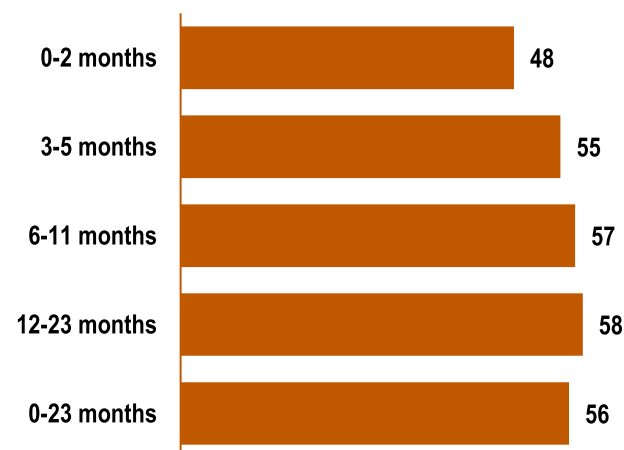
<sup>65</sup>For the Million Death Study Collaborators. 2010. Causes of neonatal and child mortality in India: nationally representative mortality survey. *Lancet*, 376(9755), 1853-1860.

<sup>66</sup>[http://www.censusindia.gov.in/vital\\_statistics/AHSBulletins/AHS\\_Factsheets\\_2012-13/FACTSHEET-UTTAR\\_PRADESH.pdf](http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Factsheets_2012-13/FACTSHEET-UTTAR_PRADESH.pdf)

However, for only 22% of the children with diarrhoea, the health care was first sought from public health providers. Nearly 29% of children age 0-23 months received ORS during the last episode of diarrhoea, 20% received zinc and 9% received both zinc and ORS.

### **Pneumonia treatment with antibiotics**

*% children, CBTS-3*



During the CBTS-3, the mothers were also asked if the child had symptoms of pneumonia in the past 2 weeks preceding the date of survey, and if the child had such symptoms how they treated.

The CBTS-3 estimates that nearly 4% children age 0-23 months were suspected with pneumonia in the HPDs. For nearly 92% of these children with suspected pneumonia,

the health care was sought, and for only 29% of these children, the health care was first sought from public health providers.

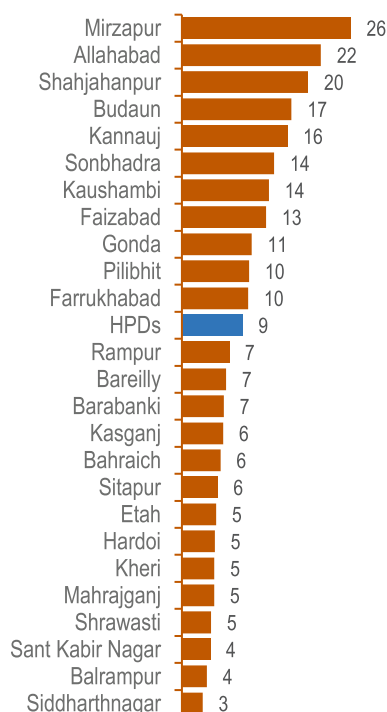
As per the CBTS-3 estimates, nearly 56% of children age 0-23 months, who were suspected with pneumonia, received antibiotics. The proportion of children, who were treated for pneumonia with antibiotics, was the lowest in the age group of 0-2 months (48%). Nearly, 55% children in the age group of 3-5 months, 57% children in the age group of 6-11 months, and 58% children in the age group of 12-23 months were treated for pneumonia with antibiotics.

The coverage of children age 0-23 months who had diarrhoea and received both zinc and ORS ranged from 3% in Siddharthnagar to 26% in Mirzapur, while fourteen of all 25 HPDs recorded lower proportion of such children than average (9%). Similarly, the proportion of children age 0-23 months, who were suffered from pneumonia and received antibiotics for its treatment, was found considerably varying across the HPDs — the proportion was recorded the lowest in Gonda (34%) and the highest in Bareilly (74%). Eight out of all 25 HPDs were recorded with less than 50% of children age 0-23 months who were treated with antibiotics when they last had symptoms of pneumonia. Six out of these eight HPDs belong to a contiguous geographical cluster in the north-eastern part of the state.

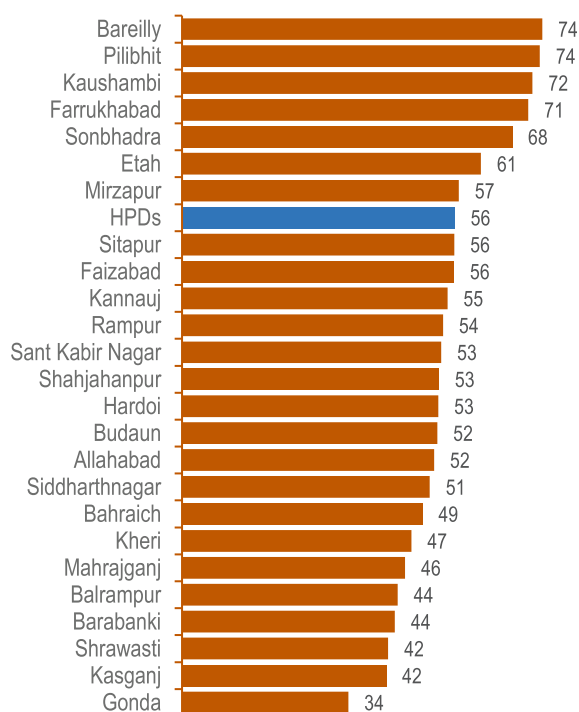
## Diarrhoea and Pneumonia treatment across the HPDs

% children age 0-23 months, CBTS-3

### I. Diarrhoea treatment with Zinc & ORS



### II. Pneumonia treatment with antibiotics



## FAMILY PLANNING

Family Planning (FP) is a key component to comprehensive sexual and reproductive health. The FP programmes provide essential and often life-saving services to women and their families. By enabling women to delay pregnancy, avoid childbearing, or space births, effective FP programmes are not only fundamental to women's health, they also allow women and families to better manage household and natural resources, secure education for all family members, and address each family member's healthcare needs.<sup>67</sup> FP services are essential for the widespread adoption of preconception care for two reasons.<sup>68</sup> First, preconception care is more likely if pregnancies are planned, and FP services encourage pregnancy planning. Second, FP services usually include counselling, and counselling provides an opportunity to discuss the advantages of preconception care. Considering the importance of FP services in the RMNCH+A intervention programme, a few important

<sup>67</sup>[http://www.genderhealth.org/the\\_issues/family\\_planning/](http://www.genderhealth.org/the_issues/family_planning/)

<sup>68</sup>Klerman LV. 2006. Family Planning Services: An Essential Component of Preconception Care. *Maternal and Child Health Journal*, 10 (Suppl 1): 157-160.

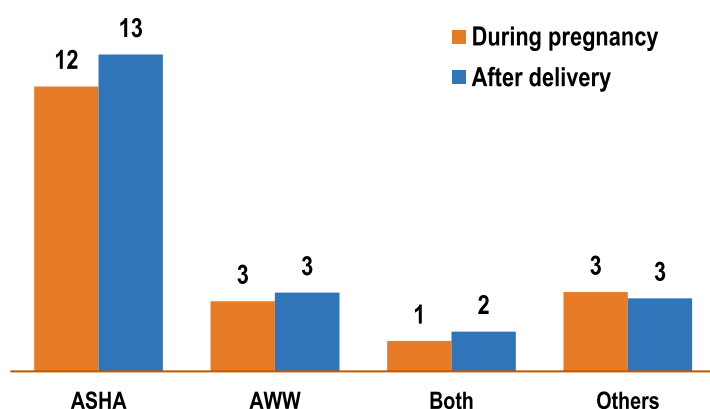
components related to FP services such as counselling, contraceptive use, unmet need for FP services, and abortion are discussed here in the context of the HPDs.

## Counselling on Family Planning

According to the National Family Health Survey (NFHS-3, 2005-06)<sup>69</sup> the knowledge of contraception is almost universal in Uttar Pradesh. However, counselling is one of the critical elements in the provision of quality family planning services. Through counselling, providers help clients make and carry out their own choices about reproductive health and family planning. Good counselling leads to improved client satisfaction. A satisfied client promotes family planning, returns when he/she needs to and continues to use a chosen method.

### Counselling on Family Planning

% women, CBTS-3



During the CBTS-3, the women were asked whether they received any counselling/advice on family planning from ASHA/AWW/ANM during their pregnancy and after the birth of the child. Nearly 18% of the recently delivered women reported that they were counselled on family planning during their pregnancy (19% women received counselling post-delivery) from any source.

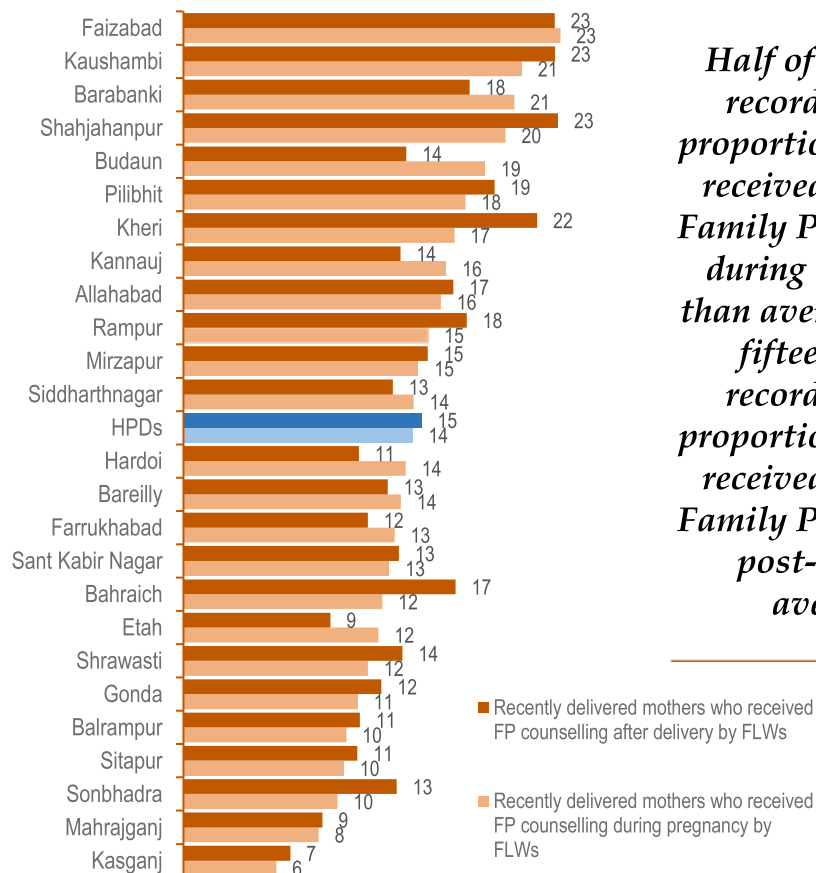
Majority of women reported that they were counselled by ASHA during pregnancy (12%) and after the birth of the child (13%).

The proportion of women who were counselled on family planning during pregnancy by front line workers (FLWs) ranged from the lowest in Kasganj (6%) to the highest in Faizabad (23%). Thirteen out of all 25 HPDs recorded the lower proportion of women receiving counselling on family planning during their pregnancy than average (14%). Similarly, there was considerable variation across the HPDs in women receiving counselling post-delivery too — the lowest recorded in Kasganj (7%) and the highest in Shahjahanpur (23%).

<sup>69</sup>IIPS & ORC Macro. 2007. National Family Health Survey India, 2005–06 NFHS-3. Mumbai: International Institute for Population Sciences.

## Counselling on Family Planning across the HPDs

% women, CBTS-3



*Half of the HPDs were recorded with lower proportion of women who received counselling on Family Planning by FLWs during their pregnancy than average (14%), while fifteen HPDs were recorded with lower proportion of women who received counselling on Family Planning by FLWs post-delivery than average (15%)*

## Contraceptive Use

Uttar Pradesh is the most populated state in India with the highest<sup>70</sup> total fertility rate (TFR)<sup>71</sup> of 3.2 (SRS, 2014)<sup>72</sup>. The contraceptive prevalence rate is one of the key determinants of TFR. In the CBTS, the women, who delivered in past 2 months preceding the date of survey, are asked if they or their husbands were currently using any modern method to delay or avoid pregnancy.

<sup>70</sup>Uttar Pradesh and Bihar share the same level of TFR.

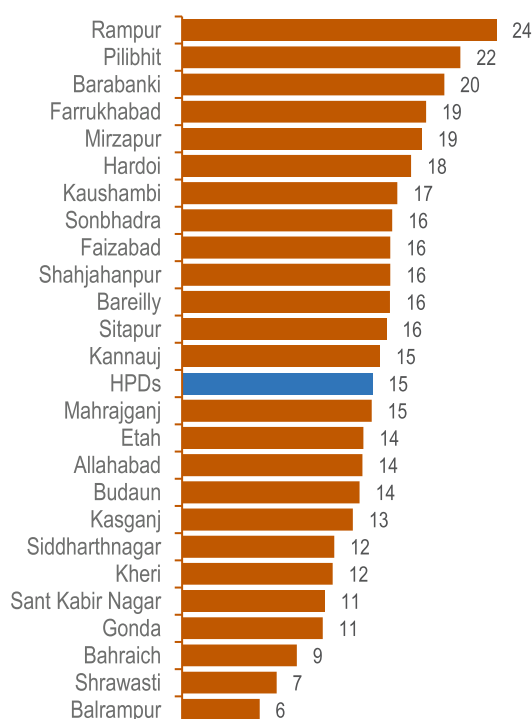
<sup>71</sup>TFR refers to the average number of live births a woman would have by the completion of her reproductive age if she were subject, throughout her life, to the age-specific fertility rates observed in a given year. Its calculation assumes that there is no mortality.

<sup>72</sup>[http://www.censusindia.gov.in/vital\\_statistics/SRS\\_Report\\_2014/7.%20Chap%203-Fertility%20Indicators-2014-U.pdf](http://www.censusindia.gov.in/vital_statistics/SRS_Report_2014/7.%20Chap%203-Fertility%20Indicators-2014-U.pdf)

The CBTS-3 estimates that nearly 15% women who had delivered in last 2 years, were currently using any modern contraceptive method. The older and educated women were more likely to use any modern method compared to younger and illiterate/less educated women. The modern contraceptive use was higher among Hindu women (15%) compared to women belonging to other religious groups (13%).

### Modern Contraceptive Prevalence Rate across the HPDs

% women who delivered in last 2 years, CBTS-3



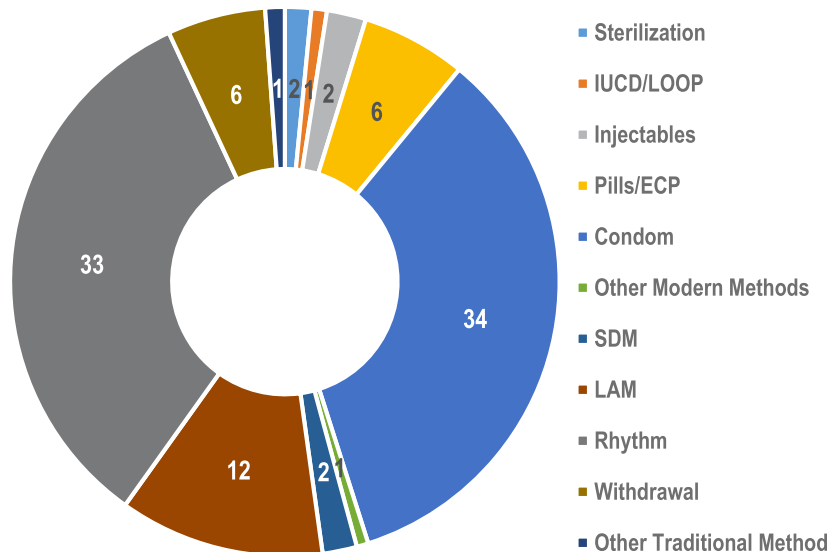
*Nearly half of all 25 HPDs were recorded with lower level of contraceptive prevalence rate than average (15%), while three HPDs recorded mCPR of even less than 10%*

The modern contraceptive prevalence rate (mCPR), which refers to the percentage of women who delivered in last two years and currently using or their husbands are currently using any modern contraceptive method, was found considerably varying across the HPDs. The mCPR was registered the lowest in Balrampur (6%) and the highest in Rampur (24%). Twelve out of all 25 HPDs were recorded with lower mCPR than average (15%), and for three of the HPDs namely Balrampur, Shrawasti and Bahraich, the mCPR was estimated even less than 10%.

Among all modern contraceptive methods, condom (34%) was observed the most prevalent/popular method in the HPDs. The other prevalent modern methods were pills

## Which contraceptive methods are prevalent?

% women who delivered in last 2 years, CBTS-3



including emergency contraceptive pills (6%), injectables (2%), sterilization (2%), and IUCD/LOOP (1%).

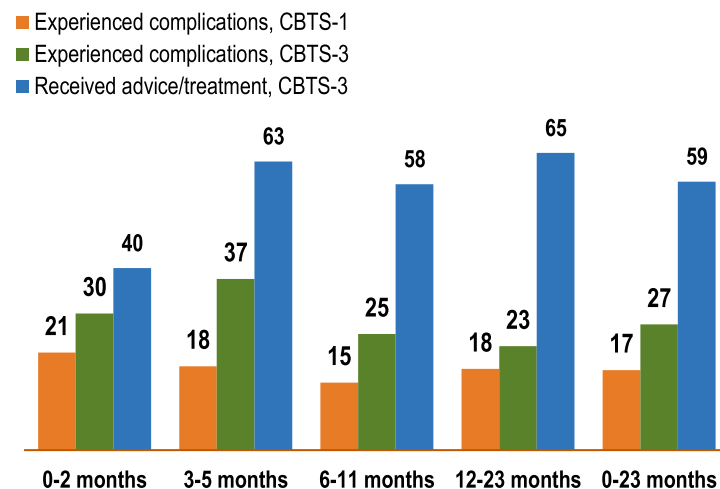
The high prevalence of condom use and the use of traditional methods suggest a huge potential for the demand of more efficacious spacing methods.

The post-partum family planning method is one of the key focus areas in the country as well as in Uttar Pradesh. The proportion of women who accepted IUCD or TL increased from 1.4% in CBTS-1 to 3.9% in CBTS-3.

In the family planning programme, one key component for the provision of quality care concentrates on the management of family planning related complications. It was found that the complication among women, who had delivered in last two years and adopted IUCD or TL post-delivery, increased from 17% in CBTS-1 to 27% in CBTS-3. Almost two-fifths of those who had complications did not receive any advice and treatment.

## Complications after adoption of IUCD/TL

% women



Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

## Unmet Need

The women who were not using any modern family planning method and who were not currently pregnant were asked if they or their partners wanted to have more children. Those who wanted to have more children were further inquired about when they would prefer having the next child. Based on the responses received from the women, they were classified into two categories: 1) unmet need for limiting (do not want additional children), and 2) unmet need for spacing (want another child after 3 years).

Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child.<sup>73</sup> Women with an unmet need for limiting are those who desire no additional children and who do not currently use a contraceptive method.

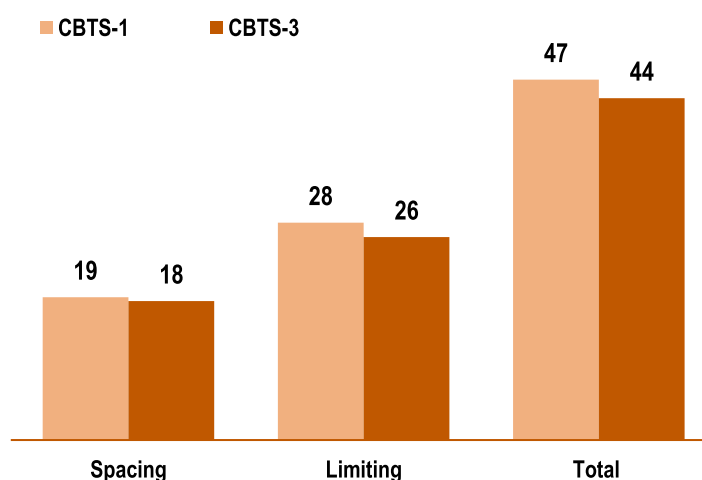
Women with an unmet need for spacing are those who desire to postpone their next birth by a specified length of time (for example, for at least two years from the date of a survey) and who do not currently use a contraceptive method.<sup>74</sup> The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behaviour.

The unmet need appeared to slightly decline in recent years in the HPDs. During the CBTS-1, the unmet need among women who had delivered in last 2 years was estimated around 47%, which declined to 44% during the CBTS-3.

The unmet need for family planning was registered the lowest in Rampur (32%) and the highest in Gonda (59%). Thirteen out of all 25 HPDs were recorded with higher unmet need among women who delivered in last 2 years than average (25%).

### Trends in Unmet need for Family Planning

% women



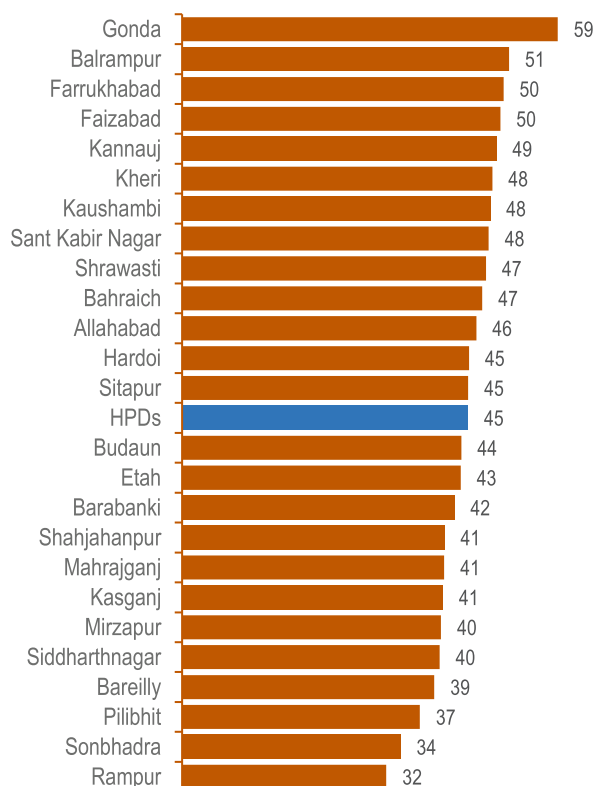
Note: Estimates represent 64 common TSU Blocks surveyed in both the rounds

<sup>73</sup>[http://www.who.int/reproductivehealth/topics/family\\_planning/unmet\\_need\\_fp/en/](http://www.who.int/reproductivehealth/topics/family_planning/unmet_need_fp/en/)

<sup>74</sup>[https://www.measureevaluation.org/prh/rh\\_indicators/specific/fp/unmet-need-for-family-planning](https://www.measureevaluation.org/prh/rh_indicators/specific/fp/unmet-need-for-family-planning)

## Unmet need for Family Planning across the HPDs

% women who delivered in last 2 years, CBTS-3



*More than half of the HPDs were recorded with higher level of unmet need than average (45%), while in four HPDs, more than half of the women who delivered in last 2 years had unmet need*

## Abortion

Abortion is the spontaneous or induced termination of pregnancy before fetal viability (i.e., the fetus is not yet able to survive independently outside the womb), although the definition varies based on the stage of viability. The fetal viability varies from 20<sup>th</sup> to 28<sup>th</sup> week of gestation depending on the biological and environmental conditions. Thus, the definition of abortion includes the termination of an embryo or fetus, prior to 20 weeks' gestation or fetal weight below 500 gm.<sup>75</sup>, or before the 24<sup>th</sup> gestational week<sup>76</sup>, or during the first 28 weeks of pregnancy<sup>77</sup>. In order to properly differentiate between the abortion/miscarriage<sup>78</sup> and stillbirth, the community level surveys worldwide consider

<sup>75</sup>Cunningham FG, Leveno KJ, Bloom SL, Hauth JC, Rouse DJ, Spong CY (eds.). 2010. "1. Overview of Obstetrics". *Williams Obstetrics* (23 ed.). McGraw-Hill Medical.

<sup>76</sup>*Cambridge Dictionary of Human Biology and Evolution*. Cambridge, New York: Cambridge University Press. 2005.

<sup>77</sup>*Dictionary of Medical Terms*. London: A & C Black. 2005.

<sup>78</sup>Popular use of the word abortion implies a deliberate pregnancy termination, whereas a miscarriage is used to refer to spontaneous fetal loss when the fetus is not viable.

abortion as the termination of pregnancy prior to the 28<sup>th</sup> week (i.e., the 7<sup>th</sup> month) of gestation.<sup>79</sup>

Abortion is an important concern in public health, which draws the attention of both the family planning as well as the maternal health programmes, based on whether the abortion is induced or spontaneous. Singh et al.<sup>80</sup> find that more than one-third of all pregnancies are unintended, and 1 in 5 ends in abortion. In developing countries, two-thirds of unintended pregnancies occur among women who were not using any method of contraception. In a recent study based on all women of reproductive age in Denmark over 25 years-period, Reardon & Coleman<sup>81</sup> found that a single induced abortion increases the risk of maternal death by 45% compared to women with no history of abortion. In addition, each additional abortion is associated with an even higher death rate. Although abortions done according to medical guidelines carry very low risk of complications,<sup>82,83,84</sup> unsafe abortions contribute substantially to maternal morbidity and death worldwide.<sup>85,86,87</sup>

In order to eradicate unsafe illegal abortions in the country, the GoI passed the Medical Termination of Pregnancy Act in the early 1970s. The act appeared to remove legal hindrances to terminating pregnancies in the underfunded (national) health care system, but women still turn to unqualified local providers for abortion<sup>88</sup> or end up aborting at home, which is crucial to the efforts of reducing maternal mortality in India.

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<sup>79</sup>For international comparison, the WHO recommends the definition of stillbirth as a baby born with no signs of life at or after 28 weeks' gestation.

<sup>80</sup>Singh S, Darroch JE, Vlassoff M, Nadeau J. 2003. *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*. New York: The Alan Guttmacher Institute and United Nations Population Fund. <http://www.guttmacher.org/pubs/addingitup.pdf>.

<sup>81</sup>Reardon DC, Coleman PK. 2012. Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980-2004. *Medical Science Monitor*, 18(9): 71 – 76.

<sup>82</sup>Bartlett LA, Berg CJ, Shulman HB, et al. 2004. Risk factors for legal induced abortion-related mortality in the United States. *Obstetrics & Gynecology*, 103: 729–37.

<sup>83</sup>Henshaw SK. 1993. How safe is therapeutic abortion? In: Teoh ES, Ratnam SS, Macnaughton M, eds. *The Current Status of Gynaecology and Obstetrics Series*, vol. 5. Carnforth, UK: Parthenon Publishing Group.

<sup>84</sup>Grimes DA. 2006. Estimation of pregnancy-related mortality risk by pregnancy outcome, United States, 1991 to 1999. *American Journal of Obstetrics & Gynecology*, 194: 92–94.

<sup>85</sup>WHO. 2011. *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*, 6th edn. Geneva: World Health Organization.

<sup>86</sup>Grimes DA, Benson J, Singh S, et al. 2006. Unsafe abortion: the preventable pandemic. *Lancet*, 368: 1908–1919.

<sup>87</sup>Singh S. 2006. Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. *Lancet*, 368: 1887–1892.

<sup>88</sup>Malhotra A, Nyblade L, Parasuraman S, et al, eds. 2003. *Realizing Reproductive Choice and Rights: Abortion and Contraception in India*. Washington, DC: International Center for Research on Women. [http://www.icrw.org/docs/RCA\\_India\\_Report\\_0303.pdf](http://www.icrw.org/docs/RCA_India_Report_0303.pdf)

However, greater contraceptive access and use alone can drastically reduce safe and unsafe abortion by reducing unintended pregnancies. It is estimated that of the 210 million pregnancies that occur each year worldwide,<sup>89</sup> some 80 million are unintended and 33 million of these are due to ineffective use of a contraceptive method (mostly traditional methods).<sup>90</sup> An increase in the use of effective contraceptive methods results in reducing unintended pregnancies and, consequently, the incidence of abortion.<sup>91</sup> Three out of four induced abortions could be eliminated if the need for family planning were fully met by expanding and improving family planning services and choices.<sup>92</sup>

Although, the pregnancy termination is perceived as a basic aspect of comprehensive reproductive health services, and as a key component of a woman's right to make her own childbearing decisions, it is difficult to obtain detailed, reliable information about the practice of unsafe abortion and to create accurate measures of its extent and harmful consequences. In countries where the procedure is legally restricted, most women who obtain abortions and most providers of the service are reluctant to respond to survey questions concerning abortion. In addition, in many parts of the world, the social and religious stigma that often surrounds pregnancy termination tends to discourage open public discussion about this important public health and human rights issue.<sup>32</sup> Researchers have also tried to develop new, indirect methods for estimating the incidence of abortion and to be innovative in finding ways to maximize the quality of data through a variety of survey and questionnaire designs. Despite these efforts, population representative information on the women who have clandestine abortions is scarce.

Acknowledging all possible limitations, the CBTS-3 estimates an unexpectedly high prevalence of abortion in the HPDs of Uttar Pradesh. In the CBTS-3, the women, who had ended their pregnancy in past two months prior to the date of survey, were asked about the outcome of their most recent pregnancies. If the woman reported that her last pregnancy ended up in any form (i.e., induced or spontaneous) of abortion, she was further asked about her antenatal care and birth preparedness plan for the reported pregnancy. During the survey, wherever the abortion cases were identified, the data-quality auditors were instructed to take additional care while following up.

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<sup>89</sup>Singh S, Wulf D, Hussain R, Bankole A, Sedgh G. 2009. *Abortion worldwide: a decade of uneven progress*. New York: Guttmacher Institute.

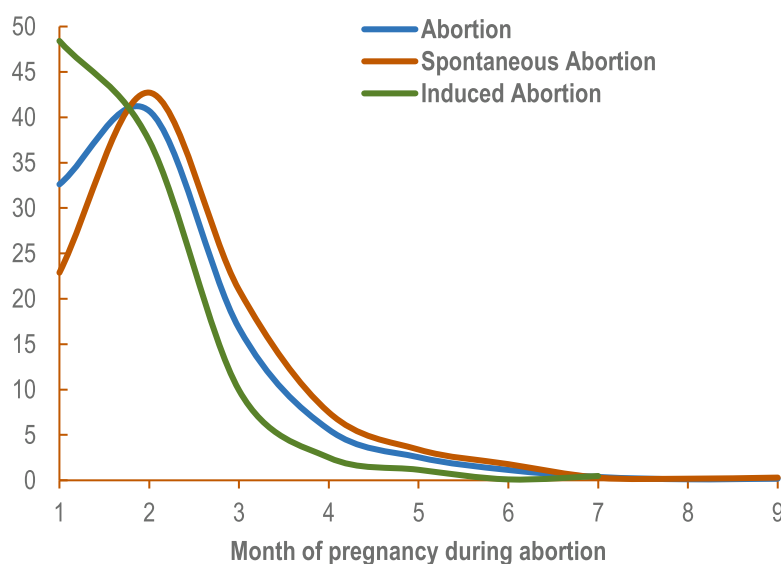
<sup>90</sup>*Safe abortion: technical and policy guidance for health systems*. World Health Organization, Geneva.

<sup>91</sup>Bongaarts J, Westoff CF. 2000. The potential role of contraception in reducing abortion. *Studies in Family Planning*, 31(3): 193-202.

<sup>92</sup>Singh S, Darroch J, Vlassoff. M. 2009. *Adding it up. The costs and benefits of investing in family planning and maternal and newborn health*. New York: Guttmacher Institute.

### Pattern of abortion by the month of pregnancy

% women who recently aborted their pregnancy, CBTS-3



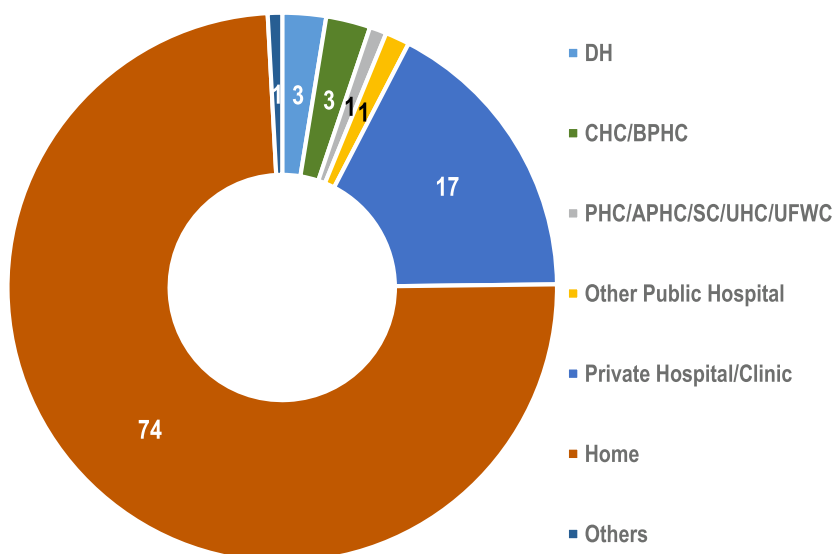
As per the estimate, nearly one in every five pregnancy (22%), which ended in two months before the CBTS-3, were aborted<sup>93</sup>. Around one fourth of these abortions (38%) were induced, while majority of them were reported as spontaneous (62%). Majority (90%) of the abortions took place in the first trimester of the pregnancy. Nearly 96% of the induced abortion and 87% of the

spontaneous abortion occurred in the first trimester of the pregnancy.

Nearly two-third of the total abortions took place at home (74%), while around 17% and 8% of the total abortions were performed at private hospital/clinic and public hospital/healthcare centre, respectively. The pattern of place of abortion clearly suggests about the concealed nature of abortion practices.

### Where do women abort their pregnancy?

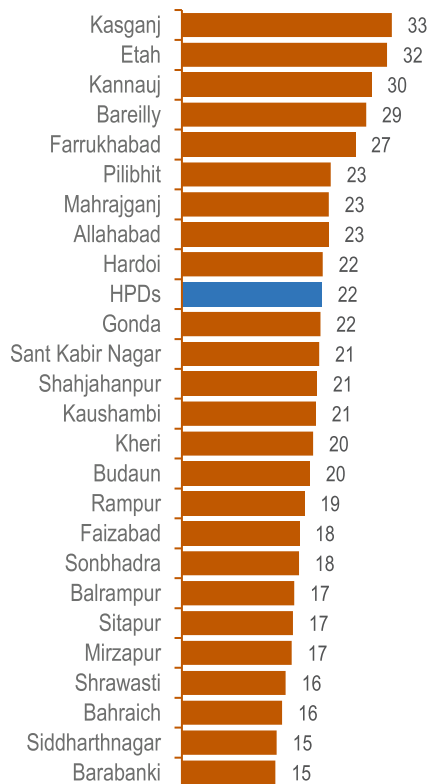
% women who recently aborted their pregnancy, CBTS-3



<sup>93</sup>Out of a total 12474 women interviewed, 2720 women reported experiencing abortion.

## Prevalence of abortion across the HPDs

% women who recently aborted their pregnancy, CBTS-3



*Nine out of all 25 HPDs were recorded with higher level of women who underwent either spontaneous or induced abortion than average (22%), while in three HPDs, nearly one third of women underwent abortion who ended their pregnancy in 2 months before the survey*

The highest proportion of abortion was reported among women age 35 and above (33%), followed by the adolescent women age below 20 (28%) and women age 30-34 (26%). The induced abortion was reported the highest (16%) among older age women (age 35 and above), while the spontaneous abortion was reported the most among the adolescent women (26%). The prevalence of abortion was reported higher among Hindus (23%) compared to women of other religious group (17%). There was little difference in women reporting abortion across different social groups, such as the SC/ST (21%), OBC (22%), and others (24%). The prevalence of abortion was found considerably varying by the level of women's education. Nearly 17% women having more than 10 years of schooling reported experiencing abortion, while 22% women who were illiterate or had less than 5 years of schooling, and 23% women with 5 to 10 years of schooling reported experiencing any form of abortion.

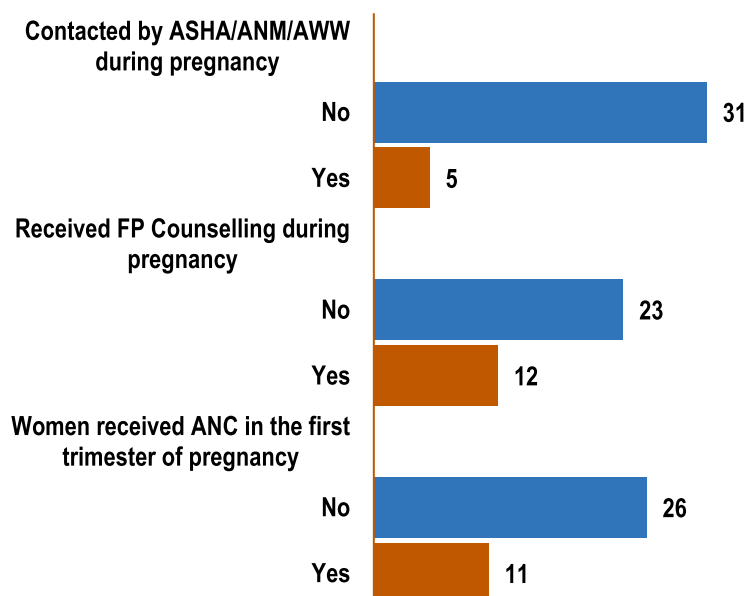
The prevalence of abortion was also found varying across the HPDs, but little. The CBTS-3 estimated relatively higher proportions of women experiencing abortion in Kasganj (33%), Etah (32%), Kannauj (30%), Bareilly (29%) and Farrukhabad (27%), where more than

quarter of women, who ended their pregnancy in last two months before the date of survey, underwent any form of abortion. The recent HMIS Bulletin<sup>94</sup> also documents the low level of sex-ratio in these districts, suggestive of sex-selective abortions. Nine out of all 25 HPDs recorded higher proportion of women who experienced any form of abortion than the average prevalence of abortion (22%) in the HPDs.

Regulating the high prevalence of abortion in the HPDs would be crucial to the state and the ongoing intervention programmes in the domain of family planning and maternal health. The CBTS-3 provides some evidences, which may be encouraging for the programme planners and implementers. The survey estimates suggest that there were substantially lower prevalence of abortion among women who were contacted by any

### Can Programme Intervention regulate abortion?

% women who recently aborted their pregnancy, CBTS-3



health worker (ASHA/ANM/AWW) during their pregnancy (5%), compared to those who were not contacted at all (31%). Similarly, if the women received counselling on family planning during their pregnancy, they shared proportionally less experience of abortion (12%), compared to women who did not receive family planning counselling from any source during their pregnancy (23%). Further, the women, who received ANC in their first trimester

of pregnancy, experienced less abortion (11%), compared to the women who did not receive the same (26%). All these programme components, e.g., contact (health workers' interactions with the women), counselling (advice on family planning methods), and utilization of health services, work in continuum and are important agents of healthcare intervention programmes. The maximum benefits of this continuum are achieved at the source point, which means if the maximum number of women, who are exposed to childbearing, could be introduced to this continuum at the earliest, there is optimum chance of success. Although regulating the incidence of abortion, as discussed earlier, is

<sup>94</sup><https://nrhm-mis.nic.in/SitePages/Home.aspx>

complex due to multiple reasons, nonetheless, by extending maximum information of reproductive choices (i.e., family planning methods) to the maximum number of women, the unintended pregnancies (which later converts into abortions) could be successfully avoided.

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PREGNANCY REGISTRATION					
District	Women registered with ASHA/ANM for their recent pregnancy (%)	Women registered with ASHA/ANM for their recent pregnancy (excluding abortion) (%)	Women registered with ASHA/ANM in the first trimester of pregnancy (%)	Women registered with ASHA/ANM in the second trimester of pregnancy (%)	Women registered with ASHA/ANM in the third trimester of pregnancy (%)
HPDs	68.0	84.0	28.4	33.6	6.0
Allahabad	66.6	83.2	36.0	26.4	4.2
Bahraich	64.7	73.4	22.2	37.6	4.9
Balrampur	64.2	75.1	18.4	37.2	8.6
Barabanki	79.0	90.7	36.5	37.7	4.8
Bareilly	66.9	86.9	26.4	29.9	10.6
Budaun	61.3	75.4	21.1	31.8	8.4
Etah	65.1	91.1	30.6	28.0	6.5
Faizabad	72.7	85.0	35.5	33.7	3.4
Farrukhabad	65.6	86.4	28.0	27.9	9.7
Gonda	55.9	69.9	18.7	30.9	6.2
Hardoi	70.8	88.3	35.6	28.4	6.8
Kannauj	63.2	87.6	30.7	27.8	4.8
Kasganj	60.4	85.0	22.5	29.9	8.0
Kaushambi	72.9	88.7	30.3	36.7	6.0
Kheri	66.2	81.3	24.3	38.0	3.9
Mahrajganj	72.3	90.6	29.2	41.0	2.1
Mirzapur	76.1	89.1	37.8	34.2	4.1
Pilibhit	66.0	83.6	36.5	27.1	2.4
Rampur	73.8	87.2	33.8	36.8	3.3
Sant Kabir Nagar	71.3	88.4	27.3	40.1	3.9
Shahjahanpur	64.4	77.8	31.1	27.4	5.9
Shrawasti	72.7	83.5	25.9	40.9	5.9
Siddharthnagar	73.8	85.4	17.3	47.7	8.9
Sitapur	74.2	86.2	26.0	40.4	7.7
Sonbhadra	71.9	85.8	36.7	30.1	5.2

PREGNANCY OUTCOME							
District	Women had livebirth in past 2 months (%)	Women had stillbirth in past 2 months (%)	Women experienced abortion in past 2 months (%)	Number of total sampled women (N)	Abortion		
					Women reported spontaneous abortion (%)	Women reported induced abortion (%)	Number of sampled women who went through abortion (N)
HPDs	76.1	2.1	21.8	12474	61.9	38.1	2720
Allahabad	75.2	2.0	22.9	455	69.2	30.8	104
Bahraich	82.3	2.1	15.6	468	68.5	31.5	73
Balrampur	79.1	3.5	17.5	463	76.5	23.5	81
Barabanki	83.1	2.3	14.6	480	68.6	31.4	70
Bareilly	69.0	2.3	28.7	568	55.2	44.8	163
Budaun	78.4	1.6	20.0	431	62.8	37.2	86
Etah	66.3	1.8	32.0	510	55.2	44.8	163
Faizabad	80.7	1.0	18.3	498	70.3	29.7	91
Farukhabad	72.3	0.7	27.0	585	58.2	41.8	158
Gonda	77.1	1.3	21.6	598	61.2	38.8	129
Hardoi	75.7	2.4	22.0	469	68.9	31.1	103
Kannauj	67.2	3.2	29.5	525	60.7	39.4	155
Kasganj	65.9	1.4	32.7	725	56.5	43.5	237
Kaushambi	77.3	1.8	20.9	436	69.2	30.8	91
Kheri	77.5	2.0	20.4	592	58.7	41.3	121
Mahrajganj	75.3	1.8	22.9	332	73.7	26.3	76
Mirzapur	81.5	1.4	17.1	444	61.8	38.2	76
Pilibhit	74.6	2.2	23.2	586	46.3	53.7	136
Rampur	78.5	2.5	19.1	367	64.3	35.7	70
Sant Kabir Nagar	77.0	1.6	21.4	561	52.5	47.5	120
Shahjahanpur	75.6	3.4	21.1	508	48.6	51.4	107
Shrawasti	81.7	2.1	16.2	513	80.7	19.3	83
Siddharthnagar	83.8	1.5	14.8	474	74.3	25.7	70
Sitapur	79.4	3.3	17.3	480	66.3	33.7	83
Sonbhadra	77.3	4.4	18.2	406	66.2	33.8	74

ANTENATAL CARE					
Background	Women registered with ASHA/ANM for their recent pregnancy (%)	Women who recently ended their pregnancy received at least one ANC services (%)	Women who recently ended their pregnancy received at least 3 ANC services (%)	Women who recently ended their pregnancy received full ANC services (%)	Number of sampled women (N)
<b>Age of the woman</b>					
15-19	64.5	60.2	18.7	6.2	530
20-24	73.5	69.7	23.8	9.5	4676
25-29	68.1	64.6	21.3	8.5	4523
30-34	62.2	56.9	18.2	5.3	1817
≥ 35	53.4	47.6	11.5	3.8	928
<b>Years of schooling</b>					
Illiterate	66.0	59.7	16.5	5.6	6906
<5	67.8	60.7	22.1	9.0	267
5-10	69.2	67.2	23.6	9.0	3617
> 10	73.9	74.5	33.7	15.4	1684
<b>BPL card status</b>					
BPL	68.6	65.0	20.4	8.1	1172
Non-BPL	69.5	66.4	23.9	9.3	5303
No Card	66.6	61.5	18.5	6.7	5999
<b>Social group</b>					
SC/ST	67.6	63.8	19.5	7.3	2396
OBC	68.9	64.1	20.5	7.9	4323
Others	65.7	63.3	25.6	9.6	1253
<b>Religion</b>					
Muslim	70.1	66.4	23.1	7.8	2235
Others	67.6	63.4	20.5	8.0	10239
<b>ASHA visit at home during pregnancy</b>					
No visit	54.0	50.1	13.8	4.4	7611
1	80.6	75.9	22.5	6.5	911
2	88.8	82.9	26.9	10.6	1308
≥ 3	93.8	90.1	38.3	17.4	2644
<b>Place of delivery</b>					
Govt. facility	87.5	81.7	29.6	11.9	5544
Private facility	84.0	84.4	36.9	12.8	1305
Home	77.3	68.1	15.7	5.5	2905
<b>Birth order</b>					
1	86.3	83.6	32.0	14.3	2643
2	84.2	79.5	26.2	10.2	2392
3	84.4	78.0	26.7	9.7	1805
≥ 4	81.3	71.0	21.0	6.6	2635
<b>HPDs</b>	<b>68.0</b>	<b>63.9</b>	<b>21.0</b>	<b>8.0</b>	<b>12474</b>

ANTENATAL CARE			
District	Women who recently ended their pregnancy received at least one ANC services (%)	Women who recently ended their pregnancy received their first ANC in the first trimester of pregnancy (%)	Women who recently ended their pregnancy had had BP measured and Hb tested during the last trimester of pregnancy (%)
HPDs	63.9	26.0	43.2
Allahabad	69.2	41.5	51.2
Bahraich	58.1	18.8	31.4
Balrampur	55.7	20.3	30.2
Barabanki	76.5	31.7	51.5
Bareilly	57.9	22.5	45.4
Budaun	53.8	14.4	40.6
Etah	60.2	26.7	38.2
Faizabad	66.9	34.1	48.6
Farrukhabad	60.2	24.1	42.6
Gonda	58.7	25.4	32.4
Hardoi	62.5	23.7	39.2
Kannauj	61.0	23.6	50.9
Kasganj	52.6	16.3	32.7
Kaushambi	69.3	31.4	53.2
Kheri	61.7	20.4	42.1
Mahrajganj	68.1	25.6	42.5
Mirzapur	70.0	37.4	47.1
Pilibhit	66.0	29.9	54.9
Rampur	73.0	27.8	57.8
Sant Kabir Nagar	73.4	34.4	44.4
Shahjahanpur	58.3	25.8	49.0
Shrawasti	68.4	22.6	36.3
Siddharthnagar	77.0	23.6	45.8
Sitapur	64.4	19.4	35.2
Sonbhadra	66.5	37.4	46.3

ANTENATAL CARE					
District	Women who recently ended their pregnancy received at least three ANC services (%)	Women who recently ended their pregnancy received at least two TT injections during pregnancy (%)	Women who recently ended their pregnancy received at least 100 IFA tablets during pregnancy (%)	Women who recently ended their pregnancy consumed at least 100 IFA tablets during pregnancy (%)	Women who recently ended their pregnancy received full ANC services (%)
HPDs	21.0	60.4	23.8	1.3	8.0
Allahabad	26.4	63.1	23.7	0.9	9.9
Bahraich	14.5	67.1	16.9	1.5	4.7
Balrampur	14.5	63.1	19.2	0.6	5.0
Barabanki	33.5	70.6	21.7	0.8	9.2
Bareilly	16.9	55.5	24.6	1.4	6.0
Budaun	10.0	49.4	26.5	0.5	3.5
Etah	11.6	42.2	18.0	0.2	4.1
Faizabad	31.9	75.7	24.7	3.2	12.9
Farrukhabad	19.3	49.4	24.4	2.6	8.9
Gonda	24.1	61.5	15.4	1.2	6.0
Hardoi	22.8	63.5	23.5	1.7	10.4
Kannauj	21.5	56.2	22.9	1.3	8.6
Kasganj	14.3	46.1	7.2	0.6	1.5
Kaushambi	31.2	53.7	39.0	2.1	15.6
Kheri	17.9	62.0	16.9	0.8	5.9
Mahrajganj	26.2	67.2	34.9	0.6	12.7
Mirzapur	25.0	67.6	26.1	2.3	8.6
Pilibhit	22.0	64.3	38.6	2.2	13.0
Rampur	21.3	61.6	27.0	1.9	8.7
Sant Kabir Nagar	34.9	68.3	34.9	0.4	16.9
Shahjahanpur	13.8	55.9	35.8	1.2	7.1
Shrawasti	20.7	64.1	17.0	2.7	5.5
Siddharthnagar	20.0	76.8	28.5	0.6	7.4
Sitapur	11.7	64.4	18.3	0.0	3.5
Sonbhadra	22.9	50.7	22.9	0.7	7.1

ANTENATAL CARE				
District	Women who recently ended their pregnancy had an emergency birth preparedness plan (%)	Women (recently delivered) who had at least 2 contacts with ASHA at home during the last trimester of pregnancy (%)	Women (recently delivered) who had at least one contact with AWW at home during the last trimester of pregnancy (%)	Women who delivered in last 2 years had at least one contact with AWW at home in last one month (%)
HPDs	36.3	28.5	6.1	4.6
Allahabad	36.5	25.1	6.0	6.4
Bahraich	26.1	27.1	5.6	3.0
Balrampur	21.0	16.8	3.4	2.9
Barabanki	41.3	33.2	8.0	4.7
Bareilly	38.6	44.7	11.4	7.0
Budaun	41.8	25.8	8.4	2.8
Etah	28.6	20.7	7.5	3.6
Faizabad	37.8	39.1	5.2	4.9
Farrukhabad	26.7	29.3	2.8	3.4
Gonda	39.8	24.3	6.4	6.0
Hardoi	38.4	23.8	2.2	2.9
Kannauj	37.3	28.4	7.0	3.8
Kasganj	24.6	17.4	5.5	2.8
Kaushambi	54.8	38.8	9.6	8.0
Kheri	34.1	27.2	4.0	2.9
Mahrajanj	47.0	30.9	3.1	4.6
Mirzapur	42.3	31.8	4.6	5.0
Pilibhit	45.4	38.9	8.4	8.3
Rampur	43.6	42.8	15.2	8.9
Sant Kabir Nagar	38.7	29.5	3.9	2.5
Shahjahanpur	36.6	37.4	13.2	7.7
Shrawasti	35.5	28.6	3.0	2.5
Siddharthnagar	36.9	18.3	5.2	3.9
Sitapur	33.8	18.4	2.0	2.5
Sonbhadra	30.8	17.2	1.8	4.3

Note: Women (recently delivered): Women who delivered in past 2 months preceding the date of survey

DELIVERY CARE		
Background	Women (recently delivered) who had the delivery in a health facility (%)	Number of sampled women (N)
<b>Age of the woman</b>		
15-19	74.1	379
20-24	75.1	3844
25-29	68.6	3568
30-34	65.0	1341
≥ 35	58.4	622
<b>Years of schooling</b>		
Illiterate	63.6	5381
<5	64.6	195
5-10	75.2	2776
> 10	86.7	1402
<b>BPL card status</b>		
BPL	70.1	937
Non-BPL	74.2	4134
No Card	66.7	4683
<b>Social group</b>		
SC/ST	68.1	2950
OBC	70.6	5293
Others	73.0	1511
<b>Religion</b>		
Muslim	66.2	1866
Others	71.2	7888
<b>ASHA visit at home during pregnancy</b>		
No visit	64.6	5103
1	71.6	798
2	75.1	1239
≥ 3	78.5	2614
<b>Birth order</b>		
1	83.0	2643
2	70.9	2392
3	66.9	1805
≥ 4	59.1	2635
<b>HPDs</b>	<b>70.2</b>	<b>9754</b>

Note: Women (recently delivered): Women who delivered in past 2 months preceding the date of survey

DELIVERY CARE				
District	Women (recently delivered) who had the delivery in a health facility (%)	Women (recently delivered) whose delivery was conducted by ANM/LHV/SN/DOCTOR (%)	Women (recently delivered) received Misoprostol after delivery at home (%)	Women received Misoprostol immediately after abortion at home (%)
HPDs	70.2	71.5	8.9	7.1
Allahabad	82.3	82.6	29.0	12.7
Bahraich	64.3	65.3	6.5	5.7
Balrampur	49.7	53.9	14.1	8.1
Barabanki	85.4	84.9	7.0	6.8
Bareilly	66.7	64.9	3.8	4.1
Budaun	67.8	69.0	5.5	3.4
Etah	73.8	75.2	5.8	3.9
Faizabad	86.2	85.7	10.9	5.7
Farrukhabad	59.7	67.2	7.2	8.2
Gonda	71.4	70.1	9.8	12.8
Hardoi	67.8	69.1	4.4	5.9
Kannauj	72.7	74.9	6.0	5.9
Kasganj	67.8	68.0	2.0	4.1
Kaushambi	84.3	84.6	35.2	13.3
Kheri	69.9	70.1	0.7	2.1
Mahrajganj	82.0	81.6	6.5	9.5
Mirzapur	80.4	81.5	27.0	12.3
Pilibhit	72.0	74.9	4.0	7.1
Rampur	75.4	79.8	5.6	2.2
Sant Kabir Nagar	82.5	81.4	11.4	9.5
Shahjahanpur	53.6	57.6	5.9	10.5
Shrawasti	62.6	65.6	14.1	0.0
Siddharthnagar	57.2	56.7	6.5	10.0
Sitapur	71.3	70.3	5.5	15.8
Sonbhadra	54.5	60.5	18.5	3.0

Note: Women (recently delivered): Women who delivered in past 2 months preceding the date of survey

DELIVERY CARE			
District	Women (recently delivered) who received at least 100 IFA tablets after delivery (%)	Women (recently delivered) who consumed at least 100 IFA tablets after delivery (%)	Women (recently delivered) with major direct obstetric complications treated at CEmOC facility (%)
HPDs	1.7	0.6	42.9
Allahabad	2.0	1.2	38.2
Bahraich	0.7	0.3	51.1
Balrampur	1.7	1.2	26.5
Barabanki	1.8	0.5	52.3
Bareilly	1.5	0.5	45.7
Budaun	1.1	0.5	39.4
Etah	0.7	0.0	27.9
Faizabad	2.8	1.5	46.9
Farrukhabad	1.8	0.6	39.2
Gonda	1.6	0.5	40.3
Hardoi	0.4	0.1	51.4
Kannauj	1.3	0.4	34.4
Kasganj	0.1	0.0	38.6
Kaushambi	6.0	2.6	47.0
Kheri	1.0	0.5	53.8
Mahraiganj	0.7	0.1	47.1
Mirzapur	1.8	1.3	43.2
Pilibhit	4.0	0.6	49.2
Rampur	0.6	0.5	33.3
Sant Kabir Nagar	2.4	0.6	43.4
Shahjahanpur	5.5	1.3	36.8
Shrawasti	1.1	0.2	50.4
Siddharthnagar	0.5	0.1	34.3
Sitapur	0.3	0.0	49.5
Sonbhadra	0.9	0.3	41.8

Note: Women (recently delivered): Women who delivered in past 2 months preceding the date of survey

POSTNATAL CARE						
Background	Women recently delivered (non-caesarean) in a health facility who stayed in the facility for at least 48 hours (%)	Women (recently delivered) who had health check-up within 48 hours after delivery (%)	Women (recently delivered) who received follow-up visit at home by ASHA within 24 hours after delivery or returning from the facility (%)	Women (recently delivered) contacted at home by ASHA at least once within the first week of delivery (%)	Women (recently delivered) contacted at home by ASHA at least once in the first month after delivery (%)	Women (recently delivered) contacted at home by ASHA at least once during the second month after delivery (%)
						Number of sampled women (N)
Age of the mother						
15-19	12.5	17.7	27.1	33.2	39.9	22.8
20-24	21.9	23.5	33.1	40.6	47.0	30.7
25-29	21.9	20.5	32.4	38.6	45.3	30.1
30-34	22.2	20.4	32.5	38.3	45.0	28.1
≥ 35	20.6	16.6	28.0	34.7	41.3	25.2
Years of schooling						
Illiterate	21.0	18.4	31.5	37.6	44.1	28.2
<5	14.8	16.3	36.8	41.2	46.5	34.8
5-10	22.0	23.3	33.4	41.1	47.6	30.8
> 10	22.9	29.0	31.9	39.2	46.2	30.9
BPL card status						
BPL	20.5	21.2	33.0	38.5	45.3	29.5
Non-BPL	20.4	22.3	32.7	39.9	46.5	29.5
No card	22.7	20.5	31.6	38.1	44.6	29.4
Social group						
SC/ST	23.9	21.0	32.8	40.4	46.3	27.6
OBC	19.8	21.0	32.4	39.5	46.1	30.5
Others	22.7	23.2	30.4	33.8	41.5	29.4
Religion						
Muslim	17.4	20.5	30.4	36.8	43.6	30.5
Others	22.4	21.5	32.6	39.4	45.9	29.2

POSTNATAL CARE						
Background	Women recently delivered (non-caesarean) in a health facility who stayed in the facility for at least 48 hours (%)	Women (recently delivered) who had health check-up within 48 hours after delivery (%)	Women (recently delivered) who received follow-up visit at home by ASHA within 24 hours after delivery or returning from the facility (%)	Women (recently delivered) contacted at home by ASHA at least once within the first week of delivery (%)	Women (recently delivered) contacted at home by ASHA at least once during the second month after delivery (%)	Number of sampled women (N)
ASHA visit at home during pregnancy						
No visit	20.4	14.2	15.1	20.3	15.5	4948
1	18.0	22.7	34.7	40.9	28.3	779
2	22.4	27.7	43.8	52.6	39.4	1209
≥ 3	23.7	31.6	59.0	68.1	52.8	2556
Place of delivery						
Govt. facility	21.9	26.6	42.4	47.8	33.9	5438
Private facility	18.9	30.1	21.6	28.7	23.5	1228
Home		7.3	17.3	26.5	23.7	2826
Birth order						
1	22.4	25.1	33.9	41.1	30.6	2643
2	20.3	21.9	32.4	39.4	32.0	2392
3	21.4	19.4	31.5	38.2	30.5	1805
≥ 4	21.0	18.2	30.8	38.0	26.7	2635
HPDs	21.5	21.3	32.2	38.9	29.5	9492

POSTNATAL CARE			
District	Women recently delivered (non-caesarean) in a health facility who stayed in the facility for at least 48 hours (%)	Women (recently delivered) who had health check-up within 48 hours after delivery (%)	Women (recently delivered) who received follow-up visit at home by ASHA within 24 hours after delivery or returning from the facility (%)
HPDs	21.5	21.3	32.0
Allahabad	10.1	26.9	29.6
Bahraich	15.2	27.5	31.9
Balrampur	10.8	11.8	17.3
Barabanki	25.1	26.8	32.7
Bareilly	31.0	19.9	41.5
Budaun	27.3	11.8	35.4
Etah	17.9	10.7	21.6
Faizabad	30.0	36.8	44.0
Farrukhabad	20.0	9.9	27.4
Gonda	15.2	16.7	29.2
Hardoi	30.3	13.8	28.7
Kannauj	14.7	23.8	33.8
Kasganj	7.4	18.6	19.9
Kaushambi	24.5	23.7	39.1
Kheri	17.5	43.6	36.1
Mahrajganj	26.7	18.8	35.5
Mirzapur	22.1	18.5	30.7
Pilibhit	36.5	24.5	41.8
Rampur	26.6	18.4	39.4
Sant Kabir Nagar	9.3	31.0	38.1
Shahjahanpur	45.3	17.2	39.2
Shrawasti	11.6	20.1	30.2
Siddharthnagar	7.8	11.6	26.2
Sitapur	35.9	23.1	26.2
Sonbhadra	28.2	19.1	25.9

Note: Women (recently delivered): Women who delivered in past 2 months preceding the date of survey

POSTNATAL CARE					
District	Women (recently delivered) contacted at home by ASHA at least three times within the first week of delivery (%)	Women (recently delivered) contacted at home by ASHA at least once in the first month after delivery (%)	Women (recently delivered) contacted at home by ASHA at least once during the second month after delivery (%)	Women (recently delivered) contacted by ASHA at home at least once in the last three months (%)	Women (recently delivered) contacted at least once between 5-8 months after delivery by ASHA/AWC/ ICDS (%)
HPDs	3.3	40.8	29.5	38.2	27.5
Allahabad	1.7	42.5	29.6	45.4	27.1
Bahraich	2.5	34.7	23.7	36.2	23.1
Balrampur	2.1	36.4	22.6	32.2	19.3
Barabanki	3.9	36.8	25.4	31.4	20.7
Bareilly	3.7	47.9	44.7	43.9	35.7
Budaun	1.7	41.4	30.3	32.2	31.9
Etah	6.6	37.8	31.9	36.1	14.4
Faizabad	7.1	46.9	28.8	35.2	27.2
Farrukhabad	5.9	40.3	27.1	36.2	14.5
Gonda	3.0	34.3	28.8	39.4	27.7
Hardoi	3.8	37.4	25.7	26.2	14.5
Kannauj	7.3	45.9	31.9	38.5	23.8
Kasganj	1.0	27.9	20.0	19.7	14.9
Kaushambi	3.8	49.3	28.5	45.9	37.5
Kheri	1.5	42.7	19.8	35.9	22.3
Mahrajganj	1.6	41.4	36.0	40.7	26.7
Mirzapur	6.5	38.6	24.1	41.9	36.4
Pilibhit	3.8	50.7	47.6	51.2	43.5
Rampur	0.3	45.8	34.3	47.5	51.9
Sant Kabir Nagar	3.6	47.8	34.4	38.6	20.9
Shahjahanpur	1.2	44.4	38.5	61.6	48.6
Shrawasti	4.4	42.8	25.1	54.7	27.8
Siddharthnagar	2.5	37.6	26.9	38.6	29.9
Sitapur	1.3	34.0	26.8	21.2	16.3
Sonbhadra	1.2	38.6	24.6	38.9	25.4

Note: Women (recently delivered): Women who delivered in past 2 months preceding the date of survey

MATERNAL HEALTH SERVICES		
District	Women (recently delivered) who received full ANC services, had institutional delivery, and received follow-up visit by ASHA at home within 24 hours after returning from the facility (%)	Women attended to VHND in the last one month (%)
HPDs	4.2	20.9
Allahabad	3.7	19.1
Bahraich	3.5	19.5
Balrampur	1.0	15.1
Barabanki	5.4	18.8
Bareilly	3.7	17.2
Budaun	2.0	20.0
Etah	1.4	13.3
Faizabad	7.6	21.8
Farrukhabad	4.4	13.0
Gonda	3.0	17.6
Hardoi	5.2	18.5
Kannauj	5.9	11.8
Kasganj	0.6	15.4
Kaushambi	9.9	33.5
Kheri	3.6	20.4
Mahrajganj	7.4	19.0
Mirzapur	3.3	19.5
Pilibhit	6.9	29.2
Rampur	4.7	31.9
Sant Kabir Nagar	8.8	16.3
Shahjahanpur	4.2	33.6
Shrawasti	3.5	21.9
Siddharthnagar	2.7	24.9
Sitapur	1.3	26.7
Sonbhadra	2.4	26.9

Note: Women (recently delivered): Women who delivered in past 2 months preceding the date of survey

MATERNAL NUTRITION				
Background	Women counselled on maternal nutrition during pregnancy (%)	Women received take home ration (THR) from the AWC/ICDS during pregnancy (%)	Women (Lactating women) received minimum dietary diversity in last 24 hours (%)	Number of sampled women (N)
<b>Age of the woman</b>				
15-19	22.5	39.4	15.8	530
20-24	30.0	51.6	22.0	4,676
25-29	28.2	48.3	21.5	4,523
30-34	24.3	44.6	19.5	1,817
≥ 35	19.6	36.4	16.6	928
<b>Years of schooling</b>				
Illiterate	25.2	46.5	16.8	6,906
< 5	24.7	49.8	22.5	267
5-10	29.1	48.4	22.4	3,617
> 10	33.4	51.0	33.5	1,684
<b>BPL card status</b>				
BPL	26.7	49.6	19.0	1,172
Non-BPL	28.9	48.8	23.5	5,303
No Card	26.2	46.4	18.7	5,999
<b>Social group</b>				
SC/ST	29.2	51.0	16.8	3,755
OBC	27.2	47.8	21.2	6,740
Others	25.0	41.2	27.1	1,979
<b>Religion</b>				
Muslim	26.7	26.0	44.9	2,235
Others	27.6	19.7	48.3	10,239
<b>Birth order</b>				
1	36.5	59.6	24.6	2,643
2	34.2	59.2	23.3	2,392
3	35.1	60.5	23.0	1,805
≥ 4	30.1	57.5	17.8	2,635
<b>HPDs</b>	<b>27.4</b>	<b>47.7</b>	<b>19.4</b>	<b>12,474</b>

*Note:* Minimum Dietary Diversity of women (who delivered in last 6 months before the date of survey) represents the percentage of women who consumed at least four types of food and liquid in last 24 hours (from morning till night) out of a set of food/liquid options they were given during survey such as Starch staple food, Beans and peas, Nuts and seeds, Dairy, Flesh food, Eggs, Vitamin A dark green vegetables, Other Vitamin A rich vegetables and fruits, Other vegetables, and Other fruits.

MATERNAL NUTRITION					
District	Women counselled on maternal nutrition during pregnancy (%)	Women counselled on maternal nutrition in last one month (%)	Women (Lactating women) received minimum dietary diversity in last 24 hours (%)	Women received take home ration (THR) from the AWC/ICDS during pregnancy (%)	Women received take home ration (THR) from the AWC/ICDS in last one month (%)
HPDs	27.4	16.8	19.4	47.7	34.2
Allahabad	33.6	20.4	37.7	43.7	32.7
Bahraich	27.6	20.9	14.2	35.0	23.6
Balrampur	14.5	8.8	20.8	44.5	20.7
Barabanki	36.3	20.8	24.0	61.7	51.8
Bareilly	25.7	14.7	17.2	52.1	37.5
Budaun	22.7	11.8	15.9	41.1	30.2
Etah	15.7	10.6	6.6	45.7	27.7
Faizabad	40.0	22.9	21.2	56.6	40.1
Farrukhabad	21.2	8.0	5.4	32.1	16.5
Gonda	23.9	16.6	20.4	34.8	21.6
Hardoi	20.7	8.3	15.4	48.2	39.9
Kannauj	30.7	15.9	8.2	45.7	29.4
Kasganj	14.6	7.6	11.4	40.6	24.9
Kaushambi	41.7	27.4	21.9	58.9	40.6
Kheri	32.1	22.4	11.3	47.5	34.7
Mahrajganj	21.7	15.7	25.6	35.8	22.2
Mirzapur	38.1	18.1	20.8	59.9	41.4
Pilibhit	32.9	27.8	20.8	55.1	52.4
Rampur	34.6	22.6	27.1	63.2	52.2
Sant Kabir Nagar	23.4	11.3	33.6	47.2	24.3
Shahjahanpur	28.9	26.6	20.5	53.5	48.5
Shrawasti	27.7	20.7	18.6	41.5	25.0
Siddharthnagar	26.8	13.2	38.8	51.1	31.6
Sitapur	28.1	10.7	18.6	51.7	41.0
Sonbhadra	31.5	14.5	12.2	55.7	41.7

*Note:* Minimum Dietary Diversity of women (who delivered in last 6 months before the date of survey) represents the percentage of women who consumed at least four types of food and liquid in last 24 hours (from morning till night) out of a set of food/liquid options they were given during survey such as Starch staple food, Beans and peas, Nuts and seeds, Dairy, Flesh food, Eggs, Vitamin A dark green vegetables, Other Vitamin A rich vegetables and fruits, Other vegetables, and Other fruits.

NEWBORN CARE							
Background	Newborns initiated breastfeeding within one hour after birth (%)	Newborns who started SSC within an hour after birth (%)	Newborns who were not applied anything (excluding CHX) at their cord stump (%)	Newborns who were not bathed within 24 hours of birth (%)	Newborns who were not bathed within 3 days of birth (%)	Newborns who were not given any pre-lacteal (%)	Newborns who had a check-up within 48 hours after birth (%)
							Number of sampled children (N)
<b>Sex of the child</b>							
Male	39.4	13.9	32.4	72.6	63.0	60.8	5023
Female	40.1	13.0	34.1	70.1	59.3	58.4	4469
<b>Age of the mother</b>							
15-19	29.8	15.8	31.8	67.1	57.2	50.3	362
20-24	38.7	14.0	32.4	74.6	64.0	59.4	3747
25-29	43.0	14.2	32.9	71.0	61.1	61.5	3483
30-34	38.9	11.2	35.5	68.5	57.7	59.8	1303
≥ 35	34.8	10.1	35.8	63.1	55.1	55.6	597
<b>Years of schooling</b>							
Illiterate	39.9	13.1	34.4	67.2	57.1	58.1	5208
<5	36.8	12.6	34.7	70.0	58.4	52.1	190
5-10	40.0	13.7	32.9	74.5	64.6	61.5	2720
> 10	38.9	14.6	29.0	81.4	70.7	62.8	1374
<b>BPL card status</b>							
BPL	41.9	12.0	35.8	71.6	62.1	63.7	914
Non-BPL	39.6	14.2	32.7	73.1	62.7	60.5	4027
No	39.4	13.1	33.1	69.9	59.8	58.0	4551
<b>Social group</b>							
SC/ST	44.1	13.7	34.6	71.7	61.1	63.5	2869
OBC	38.6	13.4	33.4	71.2	60.8	58.5	5157
Others	35.1	13.4	29.7	71.8	63.0	55.9	1466

NEWBORN CARE							
Background	Newborns initiated breastfeeding within one hour after birth (%)	Newborns who started SSC within an hour after birth (%)	Newborns who were not applied anything (excluding CHX) at their cord stump (%)	Newborns who were not bathed within 24 hours of birth (%)	Newborns who were not bathed within 3 days of birth (%)	Newborns who were not given any pre-lacteal (%)	Newborns who had a check-up within 48 hours after birth (%)
Number of sampled children (N)							
Religion							
Muslim	39.8	13.6	34.8	67.1	58.8	58.1	23.1
Others	39.7	13.5	32.8	72.5	61.8	60.0	23.2
ASHA visit at home during pregnancy							
No visit	34.8	11.8	32.9	68.3	58.8	55.1	15.7
1	43.4	12.5	31.8	72.5	60.1	61.6	24.8
2	44.2	14.9	31.1	74.2	63.9	62.3	27.9
≥ 3	46.0	16.3	35.3	75.8	65.1	66.5	34.8
Place of delivery							
Govt. facility	49.9	18.4	33.9	82.8	71.0	73.0	29.0
Private facility	21.6	8.5	29.8	79.8	69.5	43.9	31.9
Home	27.9	6.2	33.3	45.9	38.8	40.8	8.1
Birth order							
1	38.6	15.3	31.8	77.3	67.5	58.8	26.6
2	41.5	14.0	33.8	72.1	61.7	61.5	24.3
3	40.3	12.6	33.1	71.2	59.7	60.3	21.3
≥ 4	38.7	11.9	34.1	65.2	55.7	58.3	19.9
HPDs	39.7	13.5	33.2	71.4	61.2	59.6	23.2
							9492

NEWBORN CARE					
District	Newborns who were not applied anything (excluding CHX) at their cord stump (%)	Newborns who started SSC within an hour after birth (%)	Newborns who started SSC within 30 mins. after birth and kept in SSC for at least an hour (%)	Newborns initiated breastfeeding within one hour after birth (%)	Newborns who were not given any pre-lacteal (%)
HPDs	33.2	13.5	6.0	39.7	59.6
Allahabad	31.3	12.3	8.8	41.8	61.7
Bahraich	42.1	19.0	10.9	45.2	71.9
Barabanki	40.7	11.8	5.7	29.0	44.5
Barabanki	32.8	10.3	4.8	48.4	77.9
Bareilly	18.1	13.3	4.6	34.4	52.6
Budaun	31.7	12.7	6.8	34.3	58.6
Etah	18.6	11.2	4.4	16.0	40.5
Faizabad	37.8	17.4	4.2	56.2	73.6
Farrukhabad	17.7	9.7	4.0	16.8	41.1
Gonda	42.5	23.6	5.4	42.3	61.6
Hardoi	19.7	13.2	4.2	26.5	53.5
Kannauj	23.8	7.4	3.7	30.9	48.4
Kasganj	21.5	1.1	0.0	20.5	37.2
Kaushambi	22.6	14.8	6.8	56.4	70.6
Kheri	42.7	11.6	2.4	46.4	71.9
Mahrajganj	42.8	14.8	7.2	48.8	78.0
Mirzapur	35.6	9.9	6.4	44.8	72.4
Pilibhit	31.8	18.1	6.9	51.5	54.2
Rampur	31.3	14.6	9.0	39.2	52.8
Sant Kabir Nagar	46.5	13.2	9.5	42.4	65.0
Shahjahanpur	28.1	14.1	3.7	48.2	52.6
Shrawasti	51.8	20.8	11.0	38.4	58.7
Siddharthnagar	45.8	11.1	9.1	38.0	50.9
Sitapur	34.9	19.4	8.1	52.0	75.3
Sonbhadra	32.8	11.5	4.8	48.4	74.2

NEWBORN CARE				
District	Newborns received Hepatitis B 0 dose within 24 hours after birth (%)	Newborns who had a check-up within 48 hours after birth (%)	Newborns who were not given any pre-lacteal in the first three days after birth (%)	Newborns who were not bathed within 3 days of birth (%)
HPDs	43.5	23.2	57.3	61.2
Allahabad	39.5	30.7	58.8	81.6
Bahraich	42.1	29.1	71.9	57.4
Balrampur	37.7	10.1	47.8	41.3
Barabanki	38.1	35.3	70.7	65.4
Bareilly	41.3	19.9	53.1	60.2
Budaun	44.1	11.5	57.7	67.5
Etah	30.2	13.6	35.5	46.2
Faizabad	47.0	40.8	70.4	77.1
Farrukhabad	40.0	13.2	38.1	57.0
Gonda	50.1	20.0	60.3	63.3
Hardoi	51.3	17.2	46.2	55.2
Kannauj	37.1	23.8	41.6	52.7
Kasganj	47.5	19.9	29.5	41.8
Kaushambi	60.2	24.6	66.2	47.8
Kheri	48.1	46.8	70.4	59.9
Mahrajganj	47.2	18.0	80.4	72.0
Mirzapur	45.9	19.1	67.1	81.8
Pilibhit	53.8	22.4	59.7	69.8
Rampur	55.6	17.7	54.9	59.7
Sant Kabir Nagar	36.8	35.2	61.3	73.8
Shahjahanpur	48.4	18.5	55.7	62.2
Shrawasti	41.8	22.7	51.8	45.3
Siddharthnagar	34.0	15.9	53.4	59.7
Sitapur	38.3	23.9	71.1	63.0
Sonbhadra	29.3	17.5	70.7	77.1

NEWBORN CARE			
District	Weak newborns identified by ASHA or ANM (%)	Identified weak newborns treated (%)	Newborns ever suffered from fever and treated with Gentamycin for the last episode (%)
HPDs	6.1	21.6	19.7
Allahabad	5.6	31.6	31.3
Bahraich	3.4	15.4	27.3
Balrampur	5.2	15.8	10.4
Barabanki	7.3	37.9	17.5
Bareilly	11.0	30.2	10.2
Budaun	6.2	28.6	25.0
Etah	8.9	20.0	7.5
Faizabad	5.2	28.6	30.1
Farrukhabad	11.1	14.9	16.9
Gonda	5.0	4.3	16.5
Hardoi	7.6	14.8	24.7
Kannauj	7.6	14.8	23.9
Kasganj	8.6	31.7	18.2
Kaushambi	6.8	8.7	35.4
Kheri	3.5	25.0	9.0
Mahrajganj	4.8	25.0	27.9
Mirzapur	8.3	13.3	29.0
Pilibhit	6.2	18.5	12.7
Rampur	8.3	45.8	19.6
Sant Kabir Nagar	5.1	9.1	15.3
Shahjahanpur	4.7	27.8	25.0
Shrawasti	3.3	21.4	13.0
Siddharthnagar	2.0	25.0	17.6
Sitapur	4.7	11.1	27.8
Sonbhadra	3.2	10.0	26.8

NEWBORN CARE				
District	Newborns weighed after delivery (%)	Newborns identified as LBW (%)	LBW Newborns who were given SSC within 30 minutes after birth (%)	LBW newborns received SSC for 2 hours after initiation (%)
HPDs	51.7	8.8	19.1	7.0
Allahabad	64.6	7.9	18.5	7.4
Bahraich	41.8	8.3	31.3	18.8
Balrampur	34.2	4.6	5.9	5.9
Barabanki	51.9	8.8	11.4	0.0
Bareilly	39.5	8.7	14.7	2.9
Budaun	44.1	10.7	19.4	2.8
Etah	44.4	6.5	13.6	0.0
Faizabad	66.2	6.5	19.2	0.0
Farrukhabad	45.6	8.5	2.8	2.8
Gonda	49.7	5.6	15.4	3.8
Hardoi	47.6	10.1	30.6	2.8
Kannauj	64.3	11.6	24.4	12.2
Kasganj	42.1	8.4	2.5	0.0
Kaushambi	71.5	11.0	24.3	18.9
Kheri	59.5	12.9	16.9	11.9
Mahrajganj	58.0	8.0	20.0	10.0
Mirzapur	65.7	10.5	23.7	18.4
Pilibhit	48.7	11.7	27.5	3.9
Rampur	47.6	12.8	21.6	5.4
Sant Kabir Nagar	75.7	8.3	11.1	8.3
Shahjahanpur	44.3	9.1	37.1	2.9
Shrawasti	51.3	9.3	20.5	12.8
Siddharthnagar	47.1	4.3	0.0	5.9
Sitapur	43.3	9.4	27.8	5.6
Sonbhadra	46.8	6.4	15.0	0.0

NEWBORN CARE		
District	Mothers of the newborn who received support to breastfeed immediately after delivery (%)	Mothers of the newborn who received counselling on Essential Newborn Care (ENC) (%)
HPDs	34.8	26.0
Allahabad	56.4	25.4
Bahraich	32.7	23.7
Balrampur	12.0	13.9
Barabanki	55.1	23.0
Bareilly	46.9	25.5
Budaun	31.4	21.5
Etah	33.7	29.2
Faizabad	39.3	35.7
Farrukhabad	34.0	28.8
Gonda	26.2	22.6
Hardoi	29.3	25.9
Kannauj	40.2	32.0
Kasganj	25.5	15.8
Kaushambi	44.5	38.0
Kheri	31.8	31.3
Mahrajganj	41.6	24.5
Mirzapur	39.5	22.1
Pilibhit	38.4	36.0
Rampur	38.9	33.1
Sant Kabir Nagar	34.3	24.8
Shahjahanpur	34.4	33.3
Shrawasti	24.6	26.7
Siddharthnagar	18.6	15.4
Sitapur	38.6	19.6
Sonbhadra	31.5	24.3

BREASTFEEDING & SUPPLEMENTATION				
District	Children age 0-5 months who were currently exclusively breastfed (%)	Children age 12-23 months who were currently breastfed (%)	Children age 6-11 months who initiated complementary (received solid, semi-solid, or soft foods) feeding between 6-8 months (%)	Children age 6-8 months currently receiving solid, semi-solid, or soft foods in a separate bowl (%)
HPDs	23.6	81.9	36.0	6.6
Allahabad	26.9	80.0	40.0	6.9
Bahraich	26.6	84.9	41.4	3.2
Balrampur	24.2	85.8	39.7	2.1
Barabanki	19.8	80.7	33.6	7.5
Bareilly	25.3	80.2	26.2	3.4
Budaun	37.0	81.9	15.8	3.9
Etah	9.2	73.9	29.4	2.9
Faizabad	21.5	79.2	34.9	6.8
Farrukhabad	15.2	74.7	28.7	1.1
Gonda	16.5	85.3	31.9	5.5
Hardoi	11.2	82.1	39.6	4.6
Kannauj	12.5	74.9	45.7	10.0
Kasganj	10.3	73.0	33.6	7.1
Kaushambi	18.7	75.5	34.3	14.1
Kheri	26.1	84.9	44.1	8.6
Mahrajganj	36.5	90.7	49.4	6.7
Mirzapur	27.8	79.2	39.0	10.7
Pilibhit	29.6	86.0	25.0	4.4
Rampur	30.9	85.0	29.3	6.4
Sant Kabir Nagar	33.0	84.3	59.9	9.4
Shahjahanpur	30.4	89.6	16.9	5.2
Shrawasti	27.1	83.9	37.9	3.6
Siddharthnagar	26.1	86.8	40.4	4.9
Sitapur	21.9	86.8	39.4	5.4
Sonbhadra	39.9	85.7	55.2	22.5

BREASTFEEDING & SUPPLEMENTATION			
District	Children age 6-23 months currently receiving age-appropriate complementary feeding in adequate frequency and variety with continued breastfeeding (%)	Mothers of children age 0-5 months received counselling from FLW regarding exclusive breastfeeding in the past 30 days (%)	Mothers of children age 6-23 months received any counselling regarding age appropriate complementary feeding in last one month (%)
HPDs	6.8	26.1	11.7
Allahabad	10.4	41.6	16.1
Bahraich	4.0	21.9	12.3
Balrampur	8.7	14.6	5.6
Barabanki	6.6	38.2	14.7
Bareilly	11.7	30.3	9.7
Budaun	8.7	15.9	13.3
Etah	3.0	28.6	5.2
Faizabad	5.3	26.1	16.6
Farrukhabad	2.5	25.4	3.3
Gonda	7.8	25.8	7.3
Hardoi	3.4	21.7	3.7
Kannauj	6.6	32.1	6.2
Kasganj	4.1	14.0	3.1
Kaushambi	12.4	33.3	18.2
Kheri	5.9	19.5	12.5
Mahrajganj	6.9	27.2	8.7
Mirzapur	6.9	35.4	12.4
Pilibhit	8.5	35.3	21.4
Rampur	6.8	29.7	25.5
Sant Kabir Nagar	5.7	27.3	5.7
Shahjahanpur	7.3	32.1	23.8
Shrawasti	4.3	17.9	13.1
Siddharthnagar	7.7	18.3	14.9
Sitapur	5.9	11.8	12.0
Sonbhadra	10.2	30.9	10.4

VITAMIN A & IRON SUPPLEMENT				
District	Children received Micronutrient supplementation Vit.A in the past 6 months (%)	Children received Micronutrient supplementation IFA in the past 6 months (%)	Children received Micronutrient supplementation (Vit.A and IFA) in the past 6 months (%)	Children received Micronutrient supplementation IFA in the last one week (%)
HPDs	38.1	6.6	5.0	2.2
Allahabad	40.3	10.0	8.6	3.3
Bahraich	27.5	4.0	2.9	1.2
Balrampur	25.5	3.7	2.4	0.3
Barabanki	39.0	7.5	6.3	1.2
Bareilly	40.1	7.2	4.9	2.4
Budaun	34.4	8.4	5.8	3.6
Etah	36.4	2.8	1.7	0.5
Faizabad	35.6	8.2	5.8	2.8
Farrukhabad	28.9	4.7	3.0	0.6
Gonda	34.3	4.3	3.2	1.1
Hardoi	41.0	4.8	3.5	1.4
Kannauj	43.7	5.8	4.2	1.1
Kasganj	31.2	4.9	3.3	0.8
Kaushambi	48.5	19.0	15.2	11.2
Kheri	36.8	4.7	3.4	1.9
Mahrajganj	41.6	4.9	3.8	0.2
Mirzapur	43.9	7.0	5.3	1.4
Pilibhit	60.9	7.9	7.1	3.1
Rampur	51.4	12.2	10.5	6.5
Sant Kabir Nagar	35.0	2.9	2.1	0.8
Shahjahanpur	45.3	11.5	9.2	4.9
Shrawasti	27.9	3.6	1.8	0.5
Siddharthnagar	30.6	1.9	1.4	0.2
Sitapur	32.4	3.6	2.5	0.7
Sonbhadra	47.7	10.6	9.6	5.0

CHILDHOOD IMMUNIZATION				
District	Children age 6-11 months received 3 doses of DPT vaccine (%)	Children age 12-23 months received BCG vaccine (%)	Children age 12-23 months received measles vaccine (%)	Children age 12-23 months fully immunized (received BCG+DPT3/Pentavalent+Measles) (%)
HPDs	56.0	88.7	74.3	63.0
Allahabad	61.1	91.5	80.0	63.9
Bahraich	43.5	79.2	57.7	43.4
Balrampur	38.6	74.1	57.8	39.0
Barabanki	55.5	91.9	74.6	66.3
Bareilly	62.0	90.7	80.2	67.1
Budaun	51.8	89.5	72.6	54.4
Etah	52.9	90.9	72.8	59.6
Faizabad	67.4	88.4	80.3	70.2
Farrukhabad	44.5	85.0	59.6	45.9
Gonda	55.5	86.8	68.3	58.9
Hardoi	55.9	86.2	73.8	61.2
Kannauj	67.6	94.7	79.0	71.4
Kasganj	46.5	82.6	62.7	51.3
Kaushambi	60.8	91.9	82.1	71.1
Kheri	59.3	92.0	75.9	68.7
Mahrajanj	67.6	91.6	79.5	73.4
Mirzapur	65.2	90.9	86.6	74.2
Pilibhit	70.4	94.7	90.7	84.2
Rampur	60.8	89.4	81.4	73.8
Sant Kabir Nagar	64.1	93.5	80.2	69.5
Shahjahanpur	57.6	90.2	79.1	65.7
Shrawasti	41.0	85.3	63.0	48.9
Siddharthnagar	63.7	92.6	78.1	69.0
Sitapur	46.7	84.8	65.9	55.8
Sonbhadra	68.3	92.4	84.6	75.7

CHILD HEALTH & CHILDHOOD ILLNESS							
Background	Children age 6-11 months who initiated complementary feeding between 6-8 months (%)	Children age 0-23 months with diarrhoea received ORS and Zinc (%)	Children age 0-5 months who were currently exclusively breastfed (%)	Children age 12-23 months fully immunized (received BCG+DPT3/ Pentavalent+ Measles) (%)	Children age 0-23 months suspected with pneumonia received an antibiotic (%)	Children age 0-23 months identified as Severely Acute Malnourished (SAM) by health workers/FLWs (%)	Number of sampled children age 0-23 months (N)
Sex of the child							
Male	35.6	10.0	23.7	64.2	57.4	1.2	28864
Female	36.4	8.8	23.5	61.8	54.2	1.3	26467
Age of the mother							
15-19	36.8	7.1	19.6	50.8	51.4	0.6	1400
20-24	37.3	9.2	23.5	65.2	58.1	1.2	20416
25-29	35.9	10.3	24.0	65.0	56.3	1.2	21767
30-34	33.7	8.1	24.6	59.6	55.7	1.4	8048
≥ 35	33.4	9.6	22.2	53.4	45.7	1.4	3700
Years of schooling							
Illiterate	32.7	7.8	24.4	56.9	54.3	1.2	31129
<5	41.4	9.4	21.3	61.9	57.4	1.4	968
5-10	37.4	9.8	22.4	68.8	57.5	1.3	15333
> 10	45.3	15.7	23.3	78.4	60.8	1.2	7901
BPL card status							
BPL	38.4	8.3	24.5	62.0	54.2	1.0	4755
Non-BPL	37.9	10.2	23.3	65.7	54.8	1.2	23509
No Card	34.1	9.0	23.8	60.8	57.3	1.3	27067

CHILD HEALTH & CHILDHOOD ILLNESS							
Background	Children age 6-11 months who initiated complementary (received solid, semi-solid, or soft foods) feeding between 6-8 months (%)	Children age 0-23 months with diarrhoea received ORS and Zinc (%)	Children age 0-5 months who were currently exclusively breastfed (%)	Children age 12-23 months fully immunized (received BCG+DPT3/ Pentavalent+ Measles) (%)	Children age 0-23 months suspected with pneumonia received an antibiotic (%)	Children age 0-23 months identified as Severely Acute Malnourished (SAM) by health workers/FLWs (%)	Number of sampled children age 0-23 months (N)
Social group							
	SC/ST	34.3	9.2	25.3	63.7	55.3	1.5
	OBC	36.7	8.9	23.7	62.6	57.8	1.1
	Others	36.7	11.6	20.4	63.4	51.6	1.3
Religion							
	Muslim	37.1	8.9	24.4	51.4	51.2	1.3
	Others	35.7	9.6	23.5	65.8	57.2	1.2
Birth order							
	1	37.9	10.5	22.7	67.4	57.7	1.2
	2	36.2	9.4	24.1	65.5	57.7	1.1
	3	36.1	10.3	24.6	63.5	55.5	1.1
	≥ 4	33.6	7.9	23.5	56.2	53.4	1.5
HPDs		36.0	9.4	23.6	63.0	56.0	1.2
							55331

CHILD HEALTH & CHILDHOOD ILLNESS		
District	Children age 3-23 months screened for 4 D's (birth defects, development delays, deficiencies, and disease) (%)	Mothers with children age 6-23 months hand-washed with soap before feeding the child (%)
HPDs	5.6	28.6
Allahabad	4.4	33.9
Bahraich	5.7	17.1
Balrampur	3.2	17.6
Barabanki	3.7	37.6
Bareilly	8.5	43.0
Budaun	4.6	42.6
Etah	6.2	15.6
Faizabad	11.9	22.9
Farrukhabad	4.7	21.7
Gonda	4.9	28.3
Hardoi	5.2	29.0
Kannauj	4.0	30.0
Kasganj	6.1	19.0
Kaushambi	6.4	37.3
Kheri	11.1	14.2
Mahrajganj	3.9	35.1
Mirzapur	4.9	35.9
Pilibhit	5.6	48.0
Rampur	6.3	50.9
Sant Kabir Nagar	4.4	18.8
Shahjahanpur	3.7	41.9
Shrawasti	5.7	16.3
Siddharthnagar	5.4	24.4
Sitapur	3.2	28.0
Sonbhadra	5.8	25.2

CHILD HEALTH & CHILDHOOD ILLNESS				
District	Children age 0-23 months suffered from diarrhoea within 2 weeks prior to the survey (%)	Children age 0-23 months with diarrhoea for whom health care was sought (%)	Children age 0-23 months with diarrhoea for whom care was first sought from a public health provider (%)	Children age 0-23 months with diarrhoea received ORS and Zinc (%)
HPDs	29.4	86.3	22.2	9.4
Allahabad	21.8	85.0	30.5	21.7
Bahraich	29.3	80.4	13.3	6.0
Balrampur	31.4	81.7	31.7	3.9
Barabanki	32.0	82.7	27.8	6.5
Bareilly	39.6	88.4	22.2	6.9
Budaun	24.0	88.0	16.8	17.1
Etah	36.7	89.9	15.1	5.3
Faizabad	20.4	84.2	21.9	13.1
Farrukhabad	32.8	88.2	10.8	10.3
Gonda	27.3	86.7	44.3	10.9
Hardoi	30.8	90.4	17.8	5.1
Kannauj	29.6	85.9	29.1	16.4
Kasganj	37.7	88.9	20.0	6.4
Kaushambi	32.2	81.9	15.3	13.5
Kheri	29.5	87.0	21.8	5.1
Mahrajganj	22.2	80.5	21.9	5.0
Mirzapur	26.6	88.7	13.6	26.3
Pilibhit	31.4	91.1	19.4	10.5
Rampur	29.3	88.6	20.1	7.4
Sant Kabir Nagar	19.3	88.9	35.8	4.4
Shahjahanpur	26.4	88.7	15.1	19.7
Shrawasti	26.3	87.6	34.5	4.5
Siddharthnagar	20.7	85.7	33.6	3.2
Sitapur	40.4	83.7	18.8	5.5
Sonbhadra	25.2	78.7	13.1	14.4

CHILD HEALTH & CHILDHOOD ILLNESS					
District	Children age 0-23 months suspected with pneumonia within 2 weeks prior to the survey (%)	Children age 0-23 months suspected with pneumonia for whom health care was sought (%)	Children age 0-23 months suspected with pneumonia for whom care was first sought from a public health provider (%)	Children age 0-23 months suspected with pneumonia received an antibiotic (%)	Children age 0-23 months suspected with pneumonia received Amoxicillin (%)
HPDs	4.1	92.3	29.4	56.0	26.5
Allahabad	2.9	82.1	33.9	51.8	17.9
Bahraich	3.8	89.2	25.3	49.4	30.1
Balrampur	3.5	88.6	37.5	44.3	27.3
Barabanki	4.9	92.9	44.6	43.8	12.5
Bareilly	10.5	89.9	26.4	74.0	23.8
Budaun	4.8	97.6	28.0	52.4	31.7
Etah	3.2	98.6	17.1	61.4	38.6
Faizabad	1.6	91.2	29.4	55.9	47.1
Farrukhabad	4.3	94.8	13.4	71.1	44.3
Gonda	4.6	96.7	50.8	34.2	18.3
Hardoi	1.9	89.5	18.4	52.6	28.9
Kannauj	3.1	95.5	47.0	54.5	25.8
Kasganj	4.3	93.5	18.5	41.9	21.8
Kaushambi	4.1	96.0	26.0	72.0	39.0
Kheri	3.7	87.4	20.7	47.1	27.6
Mahrajganj	2.8	100.0	22.9	45.8	22.9
Mirzapur	7.3	89.2	16.2	56.9	25.7
Pilibhit	5.1	92.6	22.1	73.5	25.0
Rampur	3.9	88.4	26.1	53.6	18.8
Sant Kabir Nagar	3.4	97.4	55.8	53.2	23.4
Shahjahanpur	3.3	91.7	22.2	52.8	40.3
Shrawasti	2.6	96.6	55.9	42.4	22.0
Siddharthnagar	2.6	92.7	54.5	50.9	20.0
Sitapur	4.4	92.4	27.1	55.9	25.4
Sonbhadra	5.6	88.5	23.0	67.8	25.3

CHILD HEALTH & CHILDHOOD ILLNESS		
District	Children age 0-23 months identified as Severely Underweight (SUW) by AWW (%)	Children age 0-23 months identified as Severely Underweight (SUW) received adequate referral and care (%)
HPDs	2.6	52.6
Allahabad	4.5	55.2
Bahraich	2.0	34.1
Balrampur	1.2	38.7
Barabanki	4.8	52.7
Bareilly	4.1	44.3
Budaun	2.3	48.7
Etah	2.9	38.5
Faizabad	1.7	75.7
Farrukhabad	3.4	41.6
Gonda	2.0	64.7
Hardoi	2.9	41.7
Kannauj	3.9	45.1
Kasganj	2.5	41.1
Kaushambi	5.1	66.4
Kheri	2.3	38.9
Mahrajganj	1.7	62.1
Mirzapur	3.2	48.6
Pilibhit	2.9	44.9
Rampur	1.9	67.6
Sant Kabir Nagar	1.4	67.7
Shahjahanpur	2.1	80.0
Shrawasti	1.7	48.7
Siddharthnagar	0.5	80.0
Sitapur	1.1	73.3
Sonbhadra	3.1	73.5

CHILD HEALTH & CHILDHOOD ILLNESS				
District	Children age 0-23 months identified as Severely Acute Malnourished (SAM) by health workers/FLWs (%)	Children age 6-23 months assessed as SAM (MUAC <11.5) (%)	Severely Acute Malnourished (SAM) children (0-23 months) referred and treated (%)	Children age 6-23 months assessed as malnourished (MUAC- 11.5-12.5) (%)
HPDs	1.2	4.5	22.3	18.9
Allahabad	1.1	3.4	4.5	17.2
Bahraich	0.6	9.4	15.4	20.6
Balrampur	1.3	4.1	14.7	20.3
Barabanki	1.2	4.6	21.4	16.6
Bareilly	1.8	7.9	47.4	18.0
Budaun	1.8	4.0	41.9	15.7
Etah	0.9	4.3	25.0	16.8
Faizabad	0.5	2.5	40.0	18.0
Farrukhabad	0.8	2.8	5.3	15.7
Gonda	1.4	3.9	16.7	21.6
Hardoi	1.7	4.0	8.6	20.8
Kannauj	2.1	1.8	11.1	11.4
Kasganj	0.7	4.2	14.3	17.8
Kaushambi	2.6	4.1	9.4	18.7
Kheri	0.6	4.3	20.0	24.0
Mahrajganj	0.5	1.6	12.5	18.4
Mirzapur	1.4	4.2	18.8	20.0
Pilibhit	1.4	3.5	23.1	12.0
Rampur	1.2	4.0	59.1	15.3
Sant Kabir Nagar	1.6	2.6	5.6	23.7
Shahjahanpur	1.9	3.9	33.3	14.8
Shrawasti	1.1	9.7	52.0	29.2
Siddharthnagar	0.8	3.4	17.6	22.3
Sitapur	0.5	7.2	14.3	19.5
Sonbhadra	1.2	4.1	47.4	22.2

CHILD HEALTH & CHILDHOOD ILLNESS		
District	Children age 6-23 months received take home ration (THR) from the AWC/VHND in last one month (%)	Children age 0-23 months weighed by the AWC/ICDS centre in last one month (%)
HPDs	32.6	19.8
Allahabad	36.8	25.2
Bahraich	21.4	10.9
Balrampur	19.5	9.3
Barabanki	49.8	17.1
Bareilly	37.2	22.0
Budaun	29.1	19.4
Etah	27.6	14.5
Faizabad	39.7	21.3
Farrukhabad	17.5	13.0
Gonda	18.2	10.8
Hardoi	38.2	19.4
Kannauj	26.8	22.9
Kasganj	22.6	16.0
Kaushambi	38.5	28.0
Kheri	31.7	16.0
Mahrajganj	18.4	12.2
Mirzapur	40.0	26.3
Pilibhit	50.5	29.6
Rampur	53.1	37.6
Sant Kabir Nagar	19.5	13.6
Shahjahanpur	45.6	44.6
Shrawasti	21.9	11.1
Siddharthnagar	28.4	17.0
Sitapur	49.0	22.3
Sonbhadra	39.4	19.9

CHILD STOOL DISPOSAL	
District	Mothers of children age 0-5 months reported that the child stool was disposed hygienically (%)
HPDs	9.4
Allahabad	6.9
Bahraich	0.9
Balrampur	6.6
Barabanki	4.0
Bareilly	16.7
Budaun	17.6
Etah	8.1
Faizabad	12.5
Farrukhabad	6.9
Gonda	4.1
Hardoi	9.0
Kannauj	11.6
Kasganj	16.2
Kaushambi	10.8
Kheri	5.2
Mahrajganj	14.3
Mirzapur	14.1
Pilibhit	19.4
Rampur	20.8
Sant Kabir Nagar	4.5
Shahjahanpur	16.1
Shrawasti	2.8
Siddharthnagar	3.1
Sitapur	1.2
Sonbhadra	11.7

IODIZED SALT & SAFE DRINKING WATER		
District	Households consuming iodized salt (%)	Households having safe drinking water (%)
HPDs	68.8	4.2
Allahabad	83.0	4.5
Bahraich	53.9	3.1
Balrampur	56.6	1.6
Barabanki	75.3	2.2
Bareilly	72.1	8.9
Budaun	81.1	7.4
Etah	78.7	2.7
Faizabad	70.5	8.3
Farrukhabad	66.6	2.1
Gonda	67.5	5.0
Hardoi	63.1	1.4
Kannauj	63.8	2.4
Kasganj	69.2	3.0
Kaushambi	77.5	4.4
Kheri	68.3	2.7
Mahrajganj	67.4	2.9
Mirzapur	77.3	4.4
Pilibhit	74.5	5.1
Rampur	74.0	3.7
Sant Kabir Nagar	68.6	3.9
Shahjahanpur	72.7	8.9
Shrawasti	41.8	1.4
Siddharthnagar	58.4	4.2
Sitapur	58.2	2.6
Sonbhadra	70.8	10.1

FAMILY PLANNING					
Background	Women delivered in past 2 years currently using modern method of contraception (%)	Women delivered in past 2 years with unmet need for family planning (%)	Women delivered in past 2 years with unmet need for spacing (%)	Women delivered in past 2 years with unmet need for limiting (%)	Number of sampled women (N)
<b>Age of the woman</b>					
15-19	8.4	39.3	33.3	5.9	1582
20-24	13.4	40.6	27.4	13.2	21468
25-29	16.4	43.8	14.4	29.4	22899
30-34	15.6	51.4	7.0	44.4	8595
≥ 35	14.3	57.1	4.1	53.0	4054
<b>Years of schooling</b>					
Illiterate	12.6	45.3	14.5	30.9	32991
<5	14.6	43.5	15.7	27.7	1049
5-10	16.1	43.5	20.7	22.8	16317
> 10	21.2	43.5	25.9	17.6	8241
<b>BPL card status</b>					
BPL	13.5	46.0	19.6	26.4	5038
Non-BPL	15.5	45.1	18.3	26.8	24898
No Card	14.4	43.8	18.3	26.6	28662
<b>Social group</b>					
SC/ST	14.0	46.3	17.9	28.4	17287
OBC	14.6	43.2	17.3	25.8	32103
Others	17.0	46.0	19.6	26.5	9208
<b>Religion</b>					
Muslim	12.7	44.6	17.6	27.0	11050
Others	15.3	44.5	17.9	26.6	47548
<b>Birth order</b>					
1	12.4	39.1	34.3	4.8	15643
2	14.9	41.7	20.1	21.7	14374
3	17.5	45.6	11.6	34.1	10496
≥ 4	15.5	54.1	5.3	48.8	15069
<b>HPDs</b>	14.8	44.5	17.9	26.7	58598

FAMILY PLANNING				
District	Women delivered in past 2 years accepted IUCD or TL after delivery (%)	Women delivered in 6-11 months used IUCD or TL continuously for at least 6 months (%)	Women delivered in past 2 years received follow up care within 1 month after started using IUCD/TL (%)	Women delivered in past 2 years experienced complications due to IUCD/TL (%)
HPDs	3.7	49.2	38.0	27.5
Allahabad	6.5	30.8	55.3	17.4
Bahraich	2.0	58.3	31.1	31.1
Balrampur	0.8	22.2	36.4	27.3
Barabanki	5.5	70.0	37.4	35.9
Bareilly	2.8	57.1	38.5	26.2
Budaun	2.3	37.5	31.0	35.7
Etah	6.0	52.2	26.6	39.2
Faizabad	3.3	40.0	55.3	19.7
Farrukhabad	5.4	40.5	30.3	35.6
Gonda	2.2	66.7	40.0	25.0
Hardoi	6.5	56.7	23.6	25.7
Kannauj	4.7	58.3	40.7	21.3
Kasganj	3.0	66.7	35.1	30.9
Kaushambi	4.8	44.0	41.9	24.2
Kheri	2.6	60.0	45.3	29.7
Mahrajganj	3.3	83.3	52.5	33.9
Mirzapur	9.5	40.0	44.1	18.5
Pilibhit	3.1	69.6	40.4	32.6
Rampur	2.5	50.0	39.1	34.8
Sant Kabir Nagar	2.4	38.5	35.1	19.3
Shahjahanpur	2.2	68.8	35.3	45.1
Shrawasti	1.6	66.7	34.2	26.3
Siddharthnagar	0.9	66.7	42.1	36.8
Sitapur	4.3	38.5	25.0	30.0
Sonbhadra	6.3	24.5	39.8	14.6

FAMILY PLANNING				
District	Women delivered in past 2 years received any advice or treatment for the complication related to IUCD/TL (%)	Women delivered in past 2 months received FP counselling during pregnancy by FLWs (%)	Women delivered in past 5 months received FP counselling after delivery by FLWs (%)	Women delivered in past 2 months received FP counselling during pregnancy and after delivery (%)
HPDs	60.4	14.3	14.8	8.9
Allahabad	73.9	16.0	16.8	7.5
Bahraich	85.7	12.4	17.0	9.0
Balrampur	83.3	10.2	11.0	6.0
Barabanki	59.6	20.6	17.8	12.5
Bareilly	58.8	13.6	12.7	7.7
Budaun	53.3	18.8	13.9	13.0
Etah	46.4	12.2	9.2	6.5
Faizabad	80.0	23.5	23.1	15.1
Farrukhabad	59.6	13.2	11.5	5.5
Gonda	53.3	10.9	12.3	6.9
Hardoi	50.0	13.9	10.9	8.3
Kannauj	65.2	16.4	13.5	10.1
Kasganj	48.3	5.8	6.7	3.3
Kaushambi	66.7	21.1	23.2	14.2
Kheri	52.6	16.9	22.0	13.0
Mahrajganj	75.0	8.4	8.7	5.4
Mirzapur	59.5	14.6	15.2	8.3
Pilibhit	62.1	17.6	19.4	11.9
Rampur	56.3	15.3	17.7	12.3
Sant Kabir Nagar	81.8	12.8	13.4	7.5
Shahjahanpur	52.2	20.1	23.3	15.2
Shrawasti	60.0	11.5	13.7	6.6
Siddharthnagar	57.1	14.3	13.1	9.3
Sitapur	63.9	10.0	10.8	4.8
Sonbhadra	73.3	9.6	13.3	5.2

FAMILY PLANNING		
District	Women delivered in past 2 years currently using modern method of contraception (%)	Women delivered in past 2 years currently using IUCD/TL (%)
HPDs	14.8	1.4
Allahabad	14.0	0.6
Bahraich	8.9	1.3
Balrampur	6.0	0.2
Barabanki	20.4	2.3
Bareilly	16.2	0.9
Budaun	13.8	0.7
Etah	14.1	3.1
Faizabad	16.2	1.6
Farrukhabad	19.0	2.7
Gonda	11.0	0.7
Hardoi	17.8	3.2
Kannauj	15.4	2.8
Kasganj	13.3	1.7
Kaushambi	16.8	1.5
Kheri	11.7	1.0
Mahrajganj	14.8	0.7
Mirzapur	18.7	1.2
Pilibhit	21.7	1.7
Rampur	24.5	0.7
Sant Kabir Nagar	11.1	0.6
Shahjahanpur	16.2	0.9
Shrawasti	7.4	0.8
Siddharthnagar	11.8	0.3
Sitapur	15.9	1.4
Sonbhadra	16.4	1.2

FAMILY PLANNING			
District	Women delivered in past 2 years with unmet need for family planning (%)	Women delivered in past 2 years with unmet need for spacing (%)	Women delivered in past 2 years with unmet need for limiting (%)
HPDs	44.5	17.9	26.7
Allahabad	45.8	15.5	30.4
Bahraich	46.8	20.0	26.8
Balrampur	50.9	23.4	27.5
Barabanki	42.4	15.1	27.4
Bareilly	39.3	13.6	25.7
Budaun	43.5	16.4	27.1
Etah	43.4	14.1	29.4
Faizabad	49.6	23.7	25.9
Farrukhabad	50.1	19.0	31.0
Gonda	58.5	27.4	31.1
Hardoi	44.7	18.7	26.0
Kannauj	49.0	17.9	31.1
Kasganj	40.6	11.7	29.0
Kaushambi	48.0	17.7	30.3
Kheri	48.3	19.6	28.8
Mahrajganj	40.8	19.7	21.2
Mirzapur	40.4	16.4	23.9
Pilibhit	37.1	14.6	22.5
Rampur	31.8	10.8	21.1
Sant Kabir Nagar	47.8	16.1	31.7
Shahjahanpur	40.9	17.3	23.6
Shrawasti	47.3	22.2	25.1
Siddharthnagar	40.1	18.8	21.3
Sitapur	44.6	20.7	23.9
Sonbhadra	34.0	13.5	20.6

FAMILY PLANNING		
District	Women delivered in past 2 years intended to use any contraceptive method in next 6 months (%)	Women delivered in past 2 years preferred to use modern contraceptive method in next 6 months (%)
HPDs	26.3	22.4
Allahabad	18.3	16.6
Bahraich	22.5	20.2
Balrampur	23.6	21.6
Barabanki	20.8	19.6
Bareilly	24.1	20.6
Budaun	23.9	21.2
Etah	33.3	24.4
Faizabad	24.3	21.1
Farrukhabad	29.5	25.5
Gonda	26.4	23.1
Hardoi	28.8	22.4
Kannauj	27.0	23.1
Kasganj	27.3	21.6
Kaushambi	27.4	23.3
Kheri	25.3	22.6
Mahrajganj	31.1	26.3
Mirzapur	29.1	25.6
Pilibhit	23.7	19.2
Rampur	28.7	22.8
Sant Kabir Nagar	27.1	22.2
Shahjahanpur	26.7	23.1
Shrawasti	29.8	23.4
Siddharthnagar	29.5	24.4
Sitapur	23.4	22.0
Sonbhadra	31.9	27.1

## ANNEXURE

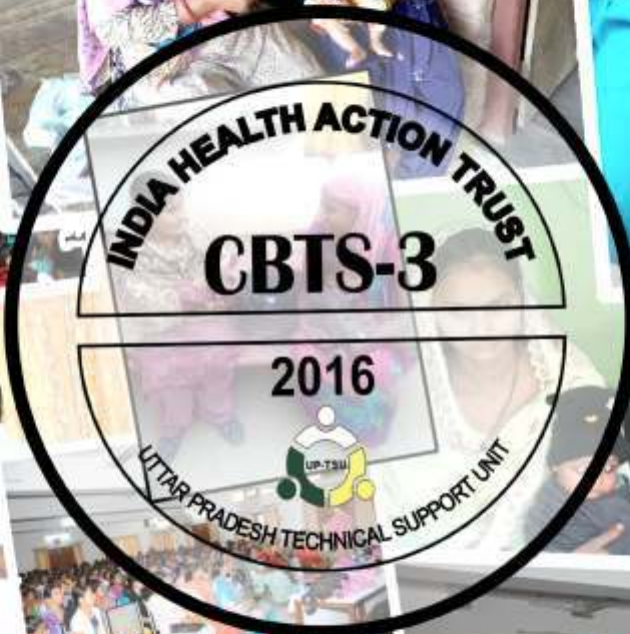
SAMPLE COVERAGE, CBTS-3 (2016)					
District	Total sampled women (N)	Women who ended their pregnancy in past 2 months (N)	Mothers with children age 3-5 months (N)	Mother with children age 6-11 months (N)	Mother with children age 12-23 months (N)
HPDs	58,598	12,474	11,832	16,593	17,699
Allahabad	2,046	455	383	512	696
Bahraich	2,305	468	475	781	581
Balrampur	2,650	463	482	804	901
Barabanki	2,387	480	669	461	777
Bareilly	2,346	568	547	565	666
Budaun	1,811	431	267	620	493
Etah	2,384	510	363	783	728
Faizabad	2,275	498	617	522	638
Farrukhabad	2,426	585	519	595	727
Gonda	2,740	598	739	605	798
Hardoi	2,152	469	573	546	564
Kannauj	2,289	525	392	595	777
Kanshiram Nagar	3,152	725	370	1,040	1,017
Kaushambi	2,564	436	488	737	903
Kheri	2,499	592	524	683	700
Maharajganj	1,797	332	464	429	572
Mirzapur	2,379	444	344	865	726
Pilibhit	2,852	586	739	636	891
Rampur	1,851	367	341	556	587
Sant Kabir Nagar	2,386	561	518	526	781
Shahjahanpur	2,316	508	310	805	693
Shrawasti	2,372	513	373	934	552
Siddharth Nagar	2,176	474	407	659	636
Sitapur	2,795	480	627	763	925
Sonbhadra	1,648	406	301	571	370

## NOTES

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**Uttar Pradesh Technical Support Unit**  
 Training Program of Investigator & Supervisor's for  
 Community Behavior Tracking Survey - (CBTS)  
 In High Priority District's of Uttar Pradesh  
 Training Duration – 13th April to 19th April 2016

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