INTEGRATED FAMILY PLANNING SURVEY 2021

Authors
Shivani Singh, Shreya Singhal, Ravi Prakash, Bidyadhar Dehury, Pradeep Kumar, Preeti Anand, Shajy K. Isac, Vasanthakumar Namasivayam

Editors
Prapti Bhatia, Pravara Amreliya

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For additional information about the Integrated Family Planning Survey (IFPS) 2021, please contact:

India Health Action Trust (IHAT)
Uttar Pradesh Technical Support Unit (UP-TSU)
No. 404, 4th Floor, Ratan Square
No. 20-A, Vidhan Sabha Marg
Lucknow - 226 001, Uttar Pradesh
Telephone: 0522 4922350, 4931777
E-mail: ihat.lucknow@ihat.in
Website: http://www.ihat.in

INTEGRATED FAMILY PLANNING SURVEY 2021

Shri Partha Sarthi Sen Sharma, I.A.S
Principal Secretary,
Medical, Health & Family Welfare Dept.,
Government of Uttar Pradesh

Government of Uttar Pradesh
U.P. Secretariat, Lucknow – 226001
E-mail: psecup.health@gmail.com

MESSAGE

A woman's ability to choose if and when to become pregnant directly impacts her health and well-being. Use of contraceptive methods allows women to space as well as limit pregnancies to avoid unwanted health risks and death from childbearing. Aligning with the Sustainable Development Goals (SDG 3.7) to ensure universal access to sexual and reproductive health and the National Health Policy, 2017, the Government of Uttar Pradesh (GoUP) recognizes the need for accelerated action in family planning (FP). The state's Vision 2030 document lays down the GoUP's goals to achieve a modern contraceptive prevalence rate (mCPR) of 52% among currently married women in the reproductive age (CMWRA) and satisfy 75% of contraceptive demand by modern methods to achieve a TFR of 1.9 by 2030 in the state of Uttar Pradesh.

The Uttar Pradesh Technical Support Unit (UP TSU) provides an integrated and embedded techno-managerial support to the GoUP to improve the planning, implementation and monitoring of health programs across the state. The UP TSU conducted a survey among CMWRA along with frontline workers and facility-based service providers catering to women's FP needs in study geographies across all 18 divisions of the state. The uniquely designed study provides a comprehensive overview of the service delivery coverage and quality along with the use of FP services in UP. The findings show an increase in CPR and mCPR in UP, with a noted geographical heterogeneity across divisions. Moreover, a large proportion of non-users (42%) and traditional method users (24%) provide a greater scope as potential modern method users in achieving the state's mCPR goals by 2030.

We expect that the estimates and analyses provided in this report will be used by division, district and block health officials to review, develop, implement and prioritize specific plans to improve key Family Planning services in their respective areas.

(Partha Sarthi Sen Sharma)

Dr. Pinky Jowel, I.A.S
Mission Director,
National Health Mission, UP

National Health Mission, Uttar Pradesh
Mandi Parishad Bhawan
16, A.P.Sen Road, Lucknow 226001
Ph.No.: 0522 - 2237496
Email: mdupnrhm@gmail.com

Family planning (FP) can prevent closely spaced and unplanned pregnancies and births, to contribute to reduced maternal and infant mortality. The state's Vision 2030 document highlights the FP milestones as satisfying 75% of contraceptive demand by modern methods, modern contraceptive prevalence rate of 52% and the Total Fertility Rate at 1.9 by 2030.

To strengthen the evidence based of Family Planning (FP) service provisioning and uptakes, in 2021 the Uttar Pradesh Technical Support Unit (UP TSU) conducted a uniquely designed integratedstudy on FP among Currently Married Women in Reproductive Age (CMWRA) of 15-49 years across all 18 administrative divisions of Uttar Pradesh. It also included frontline workers, assessment of the facilities, and service providers in the facilities (PHCs and above) catering to the CMWRA's needs in study geographies. This report highlights that the use of any contraceptive and modern contraceptive methods has improved while unmet need of contraceptives have significantly declined. Alongside state's achievement in FP outcomes, the findings also indicate towards strengthening the quality of services at the facilities to improve the Post-Partum Family Planning (PPFP) uptake. Various other data-based insights presented in this report highlights the opportunities for program strengthening and targeted interventions to accelerate the changes in FP-related outcomes going forward.

I wish that the program managers across all levels will use the findings from this report to develop context-specific strategies to improve the FP method uptake and the overall wellbeing of women and children in the state and further contribute to reduce MMR and NMR and also to reduce the out of pocket expenditure of the target population which will further improve the productivity and economy of the state by providing healthy citizens.

(Dr. Pinky Jowel)

Dr. Shailesh Kumar Srivastava
Director General

Directorate of Family Welfare
Uttar Pradesh, Lucknow

MESSAGE

The state of Uttar Pradesh monitors the key health outcomes through multiple data sources like Health Management Information System, e-kavach, Sample Registration System, and National Family Health Survey. In addition to these, different health partners also conduct periodic studies to support Government of Uttar Pradesh with appropriate evidence to formulate relevant policies and design interventions. In this line, the Uttar Pradesh Technical Support Unit (UP TSU) has designed and implemented a comprehensive integrated Family Planning Survey with the currently married women of reproductive age (CMWRA) from 15-49 years along with frontline workers, facility assessment, and service providers in the facilities (PHCs and above) catering to the FP needs of women, to monitor the progress in family planning (FP) indicators and persisting gaps.

This report provides a holistic overview of FP use by CMWRA along with service availability and quality of services across all the 18 divisions of UP. The findings show an increase in use of contraceptives, both modern and traditional across the state. However, geographical heterogeneities in the method wise use, unmet need for FP, and the preferences for future method underscores the need for targeted approach according to the geography and population characteristics enabling state to be able to meet the FP services needs of CMWRA.

I encourage the health officials at all levels across the state to use the volume of information generated from this study for making micro plans and implementation 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 FP strategies to improve uptake of modern contraceptives in the state and provide quality FP services to potential additional users as per their needs.

(Dr. Shailesh Kumar Srivastava)

Dr. Vasanthakumar N.
IAS
Executive Director, UP-TSU

UTTAR PRADESH TECHNICAL SUPPORT UNIT
No. 404, 4th & 505, 5th Floor, Ratan Square,
No. 20-A Vidhan Sabha Marg,
Lucknow-226001, Uttar Pradesh
Phone: 0522 - 4922351; Fax: 0522 - 49931777
Email: drvasanth@ihat.in; Website: www.ihat.in

The Uttar Pradesh Technical Support Unit (UP TSU) supports the Government of Uttar Pradesh (GoUP) by providing integrated and embedded techno-managerial inputs on planning, implementation and monitoring of health programs across the domains of reproductive, maternal, newborn, and child health. The UP TSU is supporting the GoUP in its efforts to reach family planning (FP) goals of mCPR of 52% and TFR of 1.92 as laid down in the state's Vision 2030 document by employing multi-faceted approaches such as greater community engagement, expanding the available basket of contraceptives, strengthening service delivery, and using innovative outreach tools.

As a first step towards understanding the current FP situation in Uttar Pradesh, the UP TSU designed and implemented a unique integrated Family Planning Survey to provide a 360-degree overview of FP use, service availability and quality of services, along with the currently married women of reproductive age (CMWRA) from 15-49 years, the study also included frontline workers (ASHAs and ANMs), assessment of the facilities, and service providers (doctors, staff nurses and FP counsellors) in the facilities (PHCs and above) catering to the needs of women in villages selected under the study.

This report provides the division level estimates on critical indicators of FP services, highlighting the sub-population variations and geographical heterogeneities in contraceptive use across divisions. The findings cover the major domains of FP, such as fertility behaviour, contraceptive use, current method-mix and desired method-mix, unmet need for FP, and the role of frontline workers in the use of modern contraceptive methods. One of the important findings of this study around the rising use of traditional method (TM) in the state underscored that a group of women start with the TM as a first contraceptive and continue to use the same consistently over time. On the other hand, there is also a group of sporadic TM method users. Such findings highlight that different sets of interventions will be required for these two groups of women. In addition, considering the fact that 80% of the current method users prefer to continue with the same method, ensuring the adequate availability and quality of modern methods at public health facilities will be crucial. This report identifies several other areas for program strengthening to improve the modern contraceptive uptake among the CMWRA in the state.

We believe that this report will help various departments and officials of the Government of Uttar Pradesh and non-governmental organizations and agencies involved in achieving the state FP2030 goals of mCPR.

(Dr. Vasanthakumar N.)

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ABBREVIATIONS

AAA	ASHA-AWW-ANM
ANC	Antenatal Care
ANM	Auxiliary Nurse and Midfwife
AOR	Adjusted Odds Ratio
ASHA	Accredited Social Health Activist
AWW	Anganwadi Workers
BPHC	Block Primary Health Centre
CEB	Children Ever Born
CHC	Community Health Centre
CiVHSND	Chhaya Integrated Village Health Sanitation and Nutrition Day
CMWRA	Currently Married Women of Reproductive Age
CBTS	Community Behaviour Tracking Survey
CPR	Contraceptive Prevalence Rate
D2C	Direct to Consumer
DH	District Hospital
DVDMS	Drugs and Vaccine Distribution Management System
ECP	Emergency Contraceptive Pills
FDS	Fixed Day Service
FDOS	Fixed Day Outreach Services
FLW	Front-Line Worker
FP	Family Planning
FP-LMIS	Family Planning Logistics Management Information System
FRU	First Referral Unit
GoI	Government of India
GoUP	Government of Uttar Pradesh
HBNC	Home Based Newborn Care
HDC	Home Delivery of Contraceptives
HR	Human Resources
HTSP	Healthy Timing and Spacing of Pregnancy
ICC	Intra-class Correlation Coefficient
IEC	Information, Education & Communication
IFPS	Integrated Family Planning Survey
IHAT	India Health Action Trust
IPHS	Indian Public Health Standards
IPV	Intimate Partner Violence
IUCD	Intrauterine Contraceptive Device
LAM	Lactational Amenorrhea Method
LAP	Laparoscopic
LARM	Long-Acting Reversible Methods
mCPR	modern Contraceptive Prevalence Rate
MPV	Mission Parivar Vikas
NFHS	National Family Health Survey
NHM	National Health Mission
NHP	National Health Policy
NSV	Non-Scalpel Vasectomy
OBC	Other Backward Class

OCPs	Oral Contraceptive Pills
ODK	Open Data Kit
PAIUCD	Post Abortion Intrauterine Contraceptive Device
PHC	Primary Health Centre
PNC	Postnatal Care
PPE	Personal Protective Equipment
PPFP	Postpartum Family Planning
PPIUCD	Postpartum Intrauterine Contraceptive Device
PPS	Postpartum Sterilization
PSU	Primary Sampling Unit
RMNCH	Reproductive, Maternal, Newborn and Child Health
SC	Sub Centre
SC/ST	Scheduled Castes/Scheduled Tribes
SDG	Sustainable Development Goals
SHG	Self-Help Groups
SRS	Sample Registration System
TFR	Total Fertility Rate
TM	Traditional Methods
VHSND	Village Health Sanitation and Nutrition Day
UCHC	Urban Community Health Centre
UoM	Univeristy of Manitoba
UP	Uttar Pradesh
UP TSU	Uttar Pradesh Technical Support Unit
UPHC	Urban Primary Health Centre
YLPC	Young and Low Parity Couples

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The Integrated Family Planning Survey underwent an ethical review by the Health Research Ethics Board (HREB) from the UoM and an Institutional Review Board (IRB) established by Sigma Research and Consulting Pvt. Ltd., New Delhi, India. We appreciate the comments and suggestions provided by the members of the ethics committee for improving the study design and schedules.

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EXECUTIVE SUMMARY

Population 231 Million

Uttar Pradesh (UP) is the most populous state of India, with a projected population of 231 million in 2021, with women in the reproductive age group (15-49 years) contributing to more than half of the population (54%), two-thirds of which are married. As a result, the state is and will experience population growth in the coming years. However, the state's efforts for population stabilization through a comprehensive, multi-sectoral approach have contributed to an extent in slowing down the population growth rate, as evident by the declining Total Fertility Rate (TFR) from 2.7 (NFHS-4) to 2.4 (NFHS-5), though far from the replacement level. This requires accelerated action in family planning (FP), as recognised by the state's Vision 2030 document, which advocates meeting contraceptive demand through multi-sectoral and multi-dimensional approaches. The Government of Uttar Pradesh (GoUP) has identified its FP milestones for 2030 as satisfying 75 percent of contraceptive demand by modern methods, a modern contraceptive prevalence rate (mCPR) of 52 percent and a TFR of 1.92. The state has employed approaches such as greater community engagement, expanding the available basket of contraceptives, strengthening service delivery, and using innovative outreach tools to meet its FP goals. The UP TSU helps the GoUP improve the availability, quality and utilisation of FP services by addressing infrastructure, equipment, supplies and human resources gaps.

In order to attain the FP objectives and to guide the program focus, the state requires robust periodic data on key FP indicators.

To this objective, IHAT-UP TSU conducted a state representative Integrated Family Planning survey (IFPS) in 2021 with

12200
currently married women of reproductive age (CMWRA)

419
frontline workers (FLWs)

496
health facilities

The Survey covered all 18 administrative divisions of UP, and provided reliable estimates on the progress of the FP programme at the state and division levels. IFPS uses a mixed method approach and focuses on the availability, quality, and use of FP methods.

In terms of socio-demographic traits of women, their mean age was 33 years, with almost 41 percent aged between 15-29 years. The majority of women were Hindus, the majority belonged to the Other Backward Caste group, and about 41 percent of women had no education. Nearly one-fourth of women were married before 18 years. The study further recorded the TFR of 2.3 children per woman.

The women had high awareness about certain contraceptives, viz. condoms, pills, IUCD and injectables (*Antara*), but had low awareness of centchroman (*Chhaya*) and emergency contraceptive pills. However, the correct knowledge of the methods was inadequate, except for using condoms and IUCD. Among the CMWRA, more than half reported using contraceptives, while almost one-third used a modern method. Among users, nearly one-fourth used Traditional Methods (TM), followed by sterilisation (male and female) and condoms, with a marginal share used other modern methods (pills, injections, and IUCD). The use of new methods such as injectables (Antara) and centchroman (Chhaya) was overall very low.

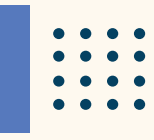
Moreover, there was more heterogeneity in the modern and method-specific use across divisions. While the majority of the divisions showed an increase in mCPR, Saharanpur, Moradabad, Meerut, Bareilly, and Aligarh registered a decline. Method-wise, southern divisions depicted relatively higher use of sterilisation, while divisions in the Tarai region had a higher inclination towards TM users. Moreover, western divisions depicted a predominance of both condom and TM users.

For both the modern method and TM users, the majority intended to continue with their current method. Almost 47 percent demand for FP was satisfied by modern methods, and the unmet need stood at 15 percent, with the unmet need for limiting (10.7%) being more than twice the unmet need for spacing (4.4%). The unmet need for spacing was found to be higher among younger and low parity women, while the unmet need for limiting was higher for older and high parity women.

Frontline workers (FLWs) play a critical role in addressing the FP needs of the community; the findings showed that the majority of ASHAs engaged in their routine FP work, viz., listing and identifying eligible couples and distributing contraceptives. However, only a small share of FLWs performed follow-up activities or referred women with complications (post-procedure complications or side effects) to health facilities. Further, the knowledge of FLWs on all seven FP methods and healthy timing and spacing of births was not universal, reflected in their discussions with couples on FP. Only a nominal share of FLWs provided complete counselling to women on appropriate contraceptive methods, their health benefits and side effects.

Additionally, most doctors and staff nurses had low knowledge of pre and post procedures such as sterilisation and injectables (Antara). Such a low level of procedural knowledge of providers impacts the quality of services and counselling proving they provide contrast, most of the health providers discussed about different methods and their benefits, but they rarely discussed side effects. Even in the case of the FP counsellors, less than half received training on all methods, and only a few provided complete counselling to the women. The majority of them did not counsel women on side effects and accessibility of methods.

The availability of essential equipment for sterilisation and IUCDs improved between 2018 and 2021 across all levels of facilities in UP. However, only 37 percent of facilities across the state had providers trained on sterilisation, while only 10 percent of facilities were ready in terms of availability of all functional equipment, infection prevention material and trained HR to provide sterilisation services in the state. Only a few facilities had the required number of doctors (18%) and staff nurses (23%) as per the IPHS norms, 2022. Among the facilities, while the majority of DHs and CHCs had availability of almost all spacing methods, a larger share of PHCs reported stock-outs for all the methods.



Based on findings from this study, there are key areas of improvement to meet the GoUP's goals of increasing the mCPR and reducing unmet need.

- To reduce the inequity in mCPR and method-specific use, there is a need to adopt geography and method-specific approaches to programming.
- Given the increasing use of traditional methods and their future preference, it will be beneficial if women are correctly informed about the appropriate modern methods according to their needs and negative aspects related to TM use, such as unwanted pregnancy.

Further, to ensure safe abortion and strengthen post-abortion family planning, public health facilities should be strengthened, and staff should be trained. Moreover, the first method of contraception significantly defines current choices and future method preference, which makes it crucial for the program to focus on young and low parity women, improving communication and outreach with them on new methods, and improving supply side availability provision of condoms. Given the higher unmet need for limiting and the

fact that the majority depends on the public sector for sterilisation, there is a need to increase the target of sterilisations to 5 lakhs per year over the next five years. There is a need to focus on FDS services in the Tarai region due to the higher unmet need for limiting and low mCPR in the area and a need to train more providers for the provisioning of sterilisation services.

The GoUP is working to strengthen the community platforms to ensure the availability of more FP services closer to the community. One such effort is strengthening and leveraging Village Health Sanitation and Nutrition Day (VHSND), recently renamed Chhaya integrated VHSND (CiVHSND). This includes mobilizing newly-weds and zero parity women to CiVHSNDs, and improving the availability of information and FP commodities for low parity women in extended post-partum and inter conception stages to minimise missed opportunities for FP. Additionally, the state is using Direct-to-Consumer (D2C) platform to reach married women of reproductive age with FP messages. For this, D2C is linked with the e-Kavach database, which helps to identify women who are non-users or have recently given birth, and the digital platform then uses this information to relay FP messages on various methods modern methods, where to access them, associated side-effects etc. as per women's need. Furthermore, the availability of FP services and commodities at the facilities is ensured via the mechanisms such as Family Planning Logistics Management Information System (FPLMIS) and Drugs and Vaccine Distribution Management System (DVDMS).

Thus, going forward, the state can focus on strengthening the quality of FP services provided at both facility and community levels.

1 BACKGROUND

1.1 Uttar Pradesh – Overview of demographic and reproductive health status

Uttar Pradesh (UP), with a projected population of 231 million in 2021[1], is the most populous state of India, and accounts for around 16 percent of India's and three percent of the world's population[2]. The Sample Registration System's (SRS) Statistical Report of 2019 shows that 65 percent of the state's population is in the working age group of 15 to 59 years.[3] UP can reap benefits from this demographic dividend to accelerate economic development, provided the state makes investments in health, education and skill development for the youth's healthy and productive life.

Moreover, the National Commission on Population projected that as of 2021, women in the reproductive (15-49 years) age group contributed to more than half of the population (54%). Further, the SRS 2019 report also shows that about two-thirds (61%) of women aged 15 years or older in UP were married. A bulge in the reproductive age-group population means the state is, and will continue to experience growth in population for some time. The population projection estimates an increase in India's population by nearly 26 percent over 25 years from 2011 to 2036, in which Uttar Pradesh would contribute the most – an estimated 19 percent.

However, the state's efforts for population stabilization through a comprehensive, multi-sectoral approach have contributed to an extent in slowing down the population growth rate.

12.4% decline in crude birth rate in the state[3]

29.1% (2007-2009) → 25.1% (2020)

As evident in National Family Health Survey (NFHS), the total fertility rate (TFR) also declined

2.7% (2015-2016[4]) → 2.4% (2019-2021[5])

However, it is still above the national average of 2.0 and far from the replacement level (2.1).

1.2 Commitment to a multi-dimensional family planning program in Uttar Pradesh

Safe and voluntary family planning (FP) is not only key to population stabilization but is critical for advancing gender equality and women's right to continue education, participate in economic activities, and lead healthy lives. The National Health Policy (NHP) of 2017 recognises that improved access, education and empowerment would be the basis of successful population stabilization. The policy lays down the goal of meeting above 90 percent of FP need at the national and sub-national levels by 2025. India's Family Planning programme also affirms the government's commitment towards improving reproductive health care services, which aligns with India's global commitments towards the Sustainable Development Goals (SDG 3.7), to substantially reduce the unmet need for contraception by 2030 by increasing the range of contraceptives and improving the quality of FP services.

[1]Population Projections for India and States, 2011-2036, National Commission on Population, Ministry of Health and Family Welfare, 2020
[2]Sustainable Development Goals Vision 2030, Uttar Pradesh
[3]Sample Registration System Statistical Report 2020, Ministry of Home Affairs, Government of India, 2022
[4]International Institute for Population Sciences (IIPS) and ICF (2017) National Family Health Survey 2015–2016
[5]IIPS and ICF (2021) National Family Health Survey (NFHS-5), India, 2019–21: Uttar Pradesh, IIPS, Mumbai.

1.3 Uttar Pradesh Technical Support Unit

The Uttar Pradesh Technical Support Unit (UP TSU) was formed in 2013 to provide techno-managerial support to the Government of Uttar Pradesh (GoUP) under a Memorandum of Cooperation with the Bill & Melinda Gates Foundation.

The University of Manitoba (UoM), in partnership with India Health Action Trust (IHAT), manages the programme to support the state government's Reproductive, Maternal, Newborn and Child Health (RMNCH) and Nutrition programmes in all 75 districts of the state.

The UP TSU helps the GoUP in improving the availability, quality and utilization of FP services by addressing gaps in infrastructure, equipment, supplies and human resources. The UP TSU has extended support to the government in expansion of the basket of contraceptive choices, and rolling out innovative community outreach mechanisms. It works with counsellors and service providers at the facility level, and with Frontline Health Workers (FLWs) at the community level to extend information and services to couples that help them make informed and voluntary decisions to plan their families. The UP TSU also engages with private sector service providers to augment the capacity of public health facilities. The programme has supported the state government in establishing review platforms that manage focused day services, FP commodity logistics, and training and monitoring of service providers.

The consistent efforts of governments have resulted in improved FP indicators, as evident from the latest round of NFHS. India's modern contraceptive prevalence rate went up from 47.8 percent in NFHS-4 to 56.5 percent in NFHS-5. The unmet need for spacing methods reduced from 5.7 percent (NFHS-4) to 4 percent (NFHS-5), while the total unmet need reduced from 12.9 percent (NFHS-4) to 9.4 percent (NFHS-5). However, since the achievements in FP are unevenly distributed across the country, in 2017 the government introduced Mission Parivar Vikas (MPV) to accelerate access to contraceptives and FP services in 145 high-fertility districts with a TFR of 3.0 or more.

The critical components of MPV include

01 Delivering assured services with the rollout of new contraceptives and making contraceptives available through multiple channels.

02 Building additional capacity through training of health service providers, ensuring commodity security by introducing a logistics management system

03 Implementing new promotional activities for better outreach to eligible couples

04 Creating an enabling environment from the highest decision-making level to program implementers on the ground.

While UP has made significant progress on maternal and child health, the state continues to have high birth rates and fertility rates above replacement levels. Recognizing the need for accelerated action in FP, the state's Vision 2030 document highlights the need to expand the basket of choice for FP methods to enable individuals to choose according to their requirements. The document advocates meeting contraceptive demand, especially of younger and lower parity couples, through multi-sectoral and multi-dimensional approaches that address geographic, social and economic barriers. The state plans to employ approaches such as greater community engagement, expanding the available basket of contraceptives, strengthening

service delivery, and using innovative outreach tools to meet its FP goals. The state has identified its FP milestones for 2030 as satisfying 75 percent of contraceptive demand by modern methods, a modern contraceptive prevalence rate (mCPR) of 52 percent and a TFR of 1.92.

1.4 About the IFPS survey

1.4.1 Objectives

In order to attain the FP objectives and to guide the program focus, the state requires robust periodic data on key FP indicators. The Integrated Family Planning Survey (IFPS) has been conceptualized as a multi-pronged study that collects data at three levels- individual, community and facility. This was one of the first studies that adopted a 360-degree approach wherein currently married women of reproductive age were the primary respondents, and other stakeholders responsible for service delivery in the same geography, including FLWs, namely ASHAs[6] and ANMs[7] and health facilities adjoining to or situated in the Primary Sampling Units (PSUs) selected for the household survey were secondary and tertiary level respondents. This methodology helped in linking the service uptake (coverage indicators) with the availability and quality of services. The survey, covering all 18 administrative divisions of UP, aims to provide reliable estimates on the progress of the FP programme at the state and division levels.

IFPS uses a mixed method approach and focuses on the availability, quality, and use of FP methods. The survey maps FP intentions, including contraceptive method use behaviours of married couples, with special attention to new contraceptive methods, and zero and low parity women. The survey also assesses opportunities and gaps in the availability and quality of services, including the central government's MPV components.

IFPS aims to meet the following key objectives at the different levels:

COMMUNITY

1. Assess modern contraceptive prevalence rate (mCPR), unmet need, intention to use, and demand satisfied for FP services at the state and divisional levels
2. Assess the quality of services received from FLWs by users of FP methods
3. Assess FLWs' knowledge levels and attitudes towards individual contraceptive methods and provision of services

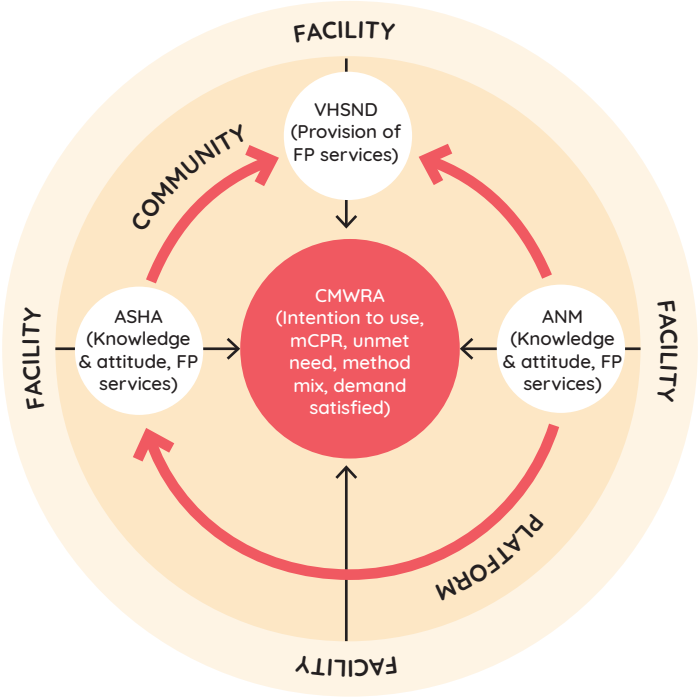
FACILITY

1. Assess the preparedness of facilities (including Village Health & Nutrition Days – VHSNDs) in providing a demand-linked basket of contraceptive choices
2. Assess the availability and quality of FP services at facilities, including the knowledge and attitudes of healthcare providers on contraceptive methods or available services at the facility survey design and methodology

[6]ASHA - Accredited Social Health Activist: One of the key components of the National Rural Health Mission of India, ASHAs are trained female community health activists from the village who work as an interface between the community and the public health system
[7]ANM - Auxiliary nurse midwife: female health workers stationed at village-level sub-centers that provide primary health care to the community

The survey was designed to provide insights on both demand- and supply-side factors, to test the hypothesis that the availability of high-quality FP services at the facility and community levels would lead to increased utilization of services, and, thereby high mCPR, high demand satisfaction and low unmet need (Figure 1).

Figure 1: Approach of the Integrated Family Planning Survey



Areas of enquiry and key indicators

The survey included a set of indicators relevant to FP2030 and the state's SDG commitments. The survey covered the following domains:

Measurements for women's agency and empowerment, spousal communication on FP, the quality of interaction with FLWs about FP, the nature of interaction on FP with other women within the household/ Self-Help Group (SHGs)/community, and exposure to media and role of social networks.

Knowledge and exposure to the government's recent FP promotion schemes such as Saas-Bahu Sammelans, distribution of Nayi Pahal kits to newly- married couples, the Saarthi awareness on wheels campaign, and the AAA forum, especially for the MPV districts.

Women's access to incentives for contraceptive use, women's knowledge and awareness about sources of availability of methods, acceptability, use, and experience with new contraceptives injectables (Antara) and centchroman (Chhaya) exposure to FP counselling through CARELINE[8] among new method (injectable) users.

[8]CARELINE is a tele-counselling platform for women users of the injectables (Antara), to reassure them about side-effects and send out reminders for their next injection dose

The key outcome indicators for the community household survey included: contraceptive use and method mix, fertility journey and intentions, demand satisfied and unmet need for FP, fertility rate, and knowledge and misinformation about contraceptive methods. Additionally, the indicators measured through facility and FLW assessments included: the availability of FP methods and services at the community and facility levels, knowledge and attitudes of FLWs and health professionals towards FP issues, performance related to working conditions, motivation and self-efficacy of FLWs, quality and availability of infrastructure at the facilities, and trainings received by health service-providers.

1.4.2 Sampling design and coverage

The survey covered households in rural and urban areas of all the 75 districts of Uttar Pradesh, with samples representative of each of the 18 administrative divisions. The sampling design of the study is similar to NFHS.

Selection of married women respondents

The required sample size in each division was proportionately allocated based on the proportion of rural and urban population as per the Census of India 2011. In each division, a two-stage sampling method was used to select the required number of currently married women of reproductive age (CMWRA).

In the first stage, the required number of PSUs (villages in rural areas and Census Enumeration Blocks in urban areas) in each of the 18 divisions were selected using the probability proportional to size (PPS) method. Villages with less than 50 households (HHs) were linked to the nearest geographically located village prior to the selection of PSUs. In the second stage, 25 households from each selected PSU were chosen using a systematic random sampling procedure. A household listing operation was carried out in all of the selected PSUs before the main survey to provide the sampling frame for the selection of households. The household questionnaire was canvassed to all the selected households to determine the availability of eligible respondents (currently married women aged 15-49 years).

Ethical Considerations: Written consent was obtained from all the currently married women aged 15 to 49 years before the interview. Written permission using assent forms was obtained from the husband or head of the household of currently married women aged 15 to 17 years. If the husband or head of the household denied assent, the interview was not conducted.

Sample size

The sample for the household survey included currently married women aged 15 to 49 years, with additional samples for younger women aged 15 to 29 years. The sample size was calculated by considering the current prevalence of modern contraceptives for each division (value for each division based on NFHS-4, 2015-16), $Z\alpha$=1.96 (two tail value), with precision of 5 percent, a design effect of 1.3 (as per NFHS-4 for mCPR) and 10 percent non-response. This yielded 7,924 CMWRA in the age group of 15 to 49 years. The sample was further inflated considering the high percentage distribution of currently married women in the age group of 15 to 29 years. This helped provide robust estimates for FP indicators at the state and divisional levels for both High Priority and non-High Priority Districts.

The study covered the ASHA of the PSU, the ANM, the Sub-centre and Primary Health Centre (PHC) within the selected PSUs, the Block Primary Health Centre (BPHC) or the Community Health Centre (CHC) in the Block, and the District Hospital (DH) in the district to which the PSU belongs. Additionally, 50 percent of the Village Health Sanitation and Nutrition Days (VHSNDs) in the selected PSUs were included in the study. The data collection methods included facility audits (VHSNDs, PHCs, BPHCs, CHCs and DHs) and interviews with the providers (ASHA, ANM, staff nurses and doctors). A detailed sample distribution is given in Table 1.

Table 1: Sample coverage at community and facility level

Assessments	Sample completed
A. Community	
Number of HH covered	12741
Currently Married Women of Reproductive Age (CMWRA)	12200
ASHA (ASHAs serving the select rural PSU)	419
ANM (ANM serving the select rural PSU)	370
VHSND observation (50% of selected ASHA area)	193
B. Facility	
Facility assessment (Nearest Facility PHC and above to the PSU)	496
Doctors (1 doctor/ facility engaged in providing FP services)	476
Nurses (1 nurse/ facility engaged in providing FP services)	451
Counsellors (all the counsellors in the state)	223

1.4.3 Data collection process

All the data collection tools, including the Household and Eligible Woman, questionnaires, facility/VHSND checklists, and the provider questionnaires were available in a mobile-based application. The interviewers uploaded all the encrypted data to a secured centralized server via the mobile-based ODK (Open Data Kit) application.

1.4.4 Quality assurance mechanism

The UP TSU's State, divisional and district quality assurance teams conducted regular back-checks and gave feedback to the agency conducting the survey. Protocols established and implemented to reduce potential non-sampling errors in the survey included standardization of the interview method, spot checks and back checks by field supervisors during data collection and regular review-cum feedback meetings with the field investigators.

1.4.5 Ethical considerations

To protect the privacy and confidentiality of participants in the survey, no personal identifiers of the respondents were included in the database. Each category of respondent was assigned identification numbers and the master lists were available only to the designated field supervisors, survey managers and the Principal Investigator (PI).

1.4.6 Ethical considerations in response to the COVID-19 pandemic

The field survey was carried out during the COVID-19 pandemic, ensuring all necessary precautions, after the state government granted permission to conduct the IFPS. A COVID-19 risk mitigation plan was put in place during the training and data collection phases. COVID safety protocols viz. following recommended hand hygiene practices, social distance, use of masks, and monitoring the health of field investigators, were maintained during training and data collection.

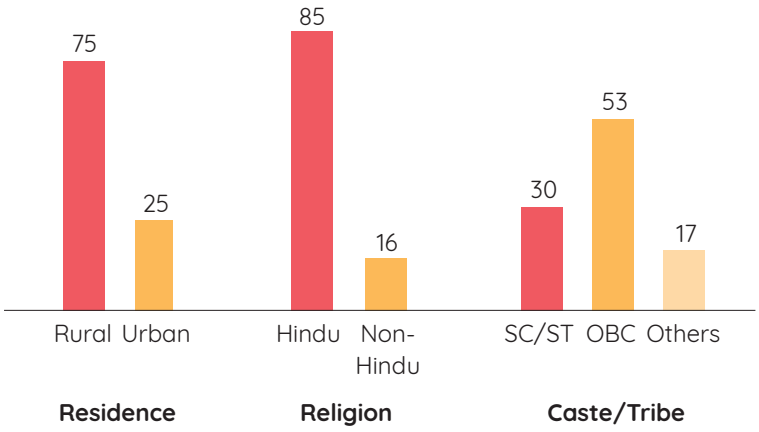
2 COMMUNITY SURVEY

2.1 Socio-demographic profile

2.1.1 Characteristics of survey households

The survey listed a total of 12,741 households, of which 2,065 did not have eligible respondents. Three-quarters were in the rural area, over four-fifth were Hindus and more than half belonged to Other Backward Caste (OBC) communities (Figure 2). Two of three households had more than five family members, and the mean household size was six members.

Figure 2: Distribution of survey households by place of residence and social characteristics, 2020-21



2.1.2 Characteristics of women respondents

A total of 12,200 currently married women of reproductive age (15 to 49 years old) from 10,676 households were interviewed in the survey. Table 2 reflects the socio-demographic traits of the respondents. The mean age of the women was about 33 years. Almost 41 percent of women were in the 15–29 age-group. Almost one-third of women had four or more children while 44 percent had two to three children. The majority of women (84%) were Hindus, and more than half (54%) belonged to Other Backward Castes (OBCs). Almost 41 percent of women had no education, while about one-third had 5-10 years of schooling.

Table 2: Distribution of CMWRA by socio-demographic characters, 2020-21

Background characteristics	Residence		Total
	Rural Percentage	Urban Percentage	Percentage
Age (in years)			
15-24	22.4	14.2	20.5
25-29	20.4	20.9	20.5
30-34	17.5	18.9	17.8
35-39	15.2	16.4	15.5
40-49	24.5	29.6	25.6
Mean age	32.3	33.9	32.7
Median age	31.0	33.0	32.0
15-29	42.9	35.0	41.1
Parity			
0	9.7	10.7	9.9
1	13.4	18.0	1.5
2-3	42.6	48.7	44.0
4+	34.2	22.7	31.6

Background characteristics	Residence		Total
	Rural Percentage	Urban Percentage	Percentage
Years of schooling			
No schooling	44.5	30.1	41.2
<5 years complete	3.4	2.4	3.2
5-10 years complete	33.5	30.5	32.8
10+ years complete	18.6	37.1	22.9
Religion			
Hindu	87.4	23.6	84.3
Non-Hindu	12.2	25.7	15.3
Missing	0.4	0.7	0.5
Caste/tribe			
SC/ST	31.4	21.5	29.1
OBC	53.0	55.6	53.6
Others	15.7	22.9	17.4
Wealth quintile			
Lowest	20.5	3.6	16.6
Second	22.4	5.9	18.6
Middle	24	9.9	20.8
Fourth	21.4	25.6	22.3
Highest	11.3	54.4	21.2
Missing	0.4	0.7	0.5
Husband staying together			
Yes	77.0	91.5	80.31
No	23.0	8.5	19.69
Number of women	**9,704**	**2,496**	**12,200**

2.1.3 Profile of women respondents' husbands

In the case of CMWRA's husbands, out of a total of 12,200 men, more than one-fourth (27%) were in the 40-49 age-group. The mean age of husbands was 36.5 years. Most men (48%) had completed five to 10 years of schooling, while almost one-third (31%) had 10 or more years of education. A majority (41% men) worked as non-agricultural labour, while about 21 percent were cultivators/agricultural labourers. Most of the men (64%) worked within their village, and over 80 percent visited home daily. A little over one in 10 men worked outside the state (Table 3).

Table 3: Socio-demographic characters of husbands of CMWRA, 2020-21

Background characteristics	Residence		Total
Age (in years)	**Rural Percentage**	**Urban Percentage**	**Percentage**
15-24	9.2	4.7	8.2
25-29	18.0	14.8	17.3
30-34	17.0	18.1	17.2
35-39	17.1	19.0	17.5
40-49	25.9	28.9	26.6
50-80	11.2	13.5	11.7
Age not specified	1.7	1.1	1.6
Mean age	36.1	37.8	36.5
Median age	35.0	37.0	35.0
Years of schooling			
No schooling	19.9	15.1	18.8
<5 years complete	2.2	1.0	1.9
5-10 years complete	50.1	39.7	47.7
10+ years complete	27.3	43.6	31.0
Do not know	0.6	0.5	0.6
Occupation			
Non-agricultural labour	43.1	33.9	41.0
Salaried	15.8	32.2	19.6
Cultivator/agricultural labour	25.6	3.5	20.6
Business	12.3	28.2	16.0
Other	3.1	2.3	2.9
Workplace			
Within village/town	63.3	64.5	63.6
Outside village/town	15.3	27.1	18.0
Outside district	8.0	4.1	7.1
Outside state	13.4	4.3	11.3
Frequency of visiting			
Visit home daily	77.0	91.5	80.3
Once in 1-3 months	8.5	4.2	7.5
Once in 4-6 months	7.4	2.2	6.2
Once in a year	4.9	1.3	4.1
Other	2.2	0.8	1.9
Total number of men	**9,704**	**2,496**	**12,200**

2.2 Marriage, fertility behaviour and preferences of women respondents

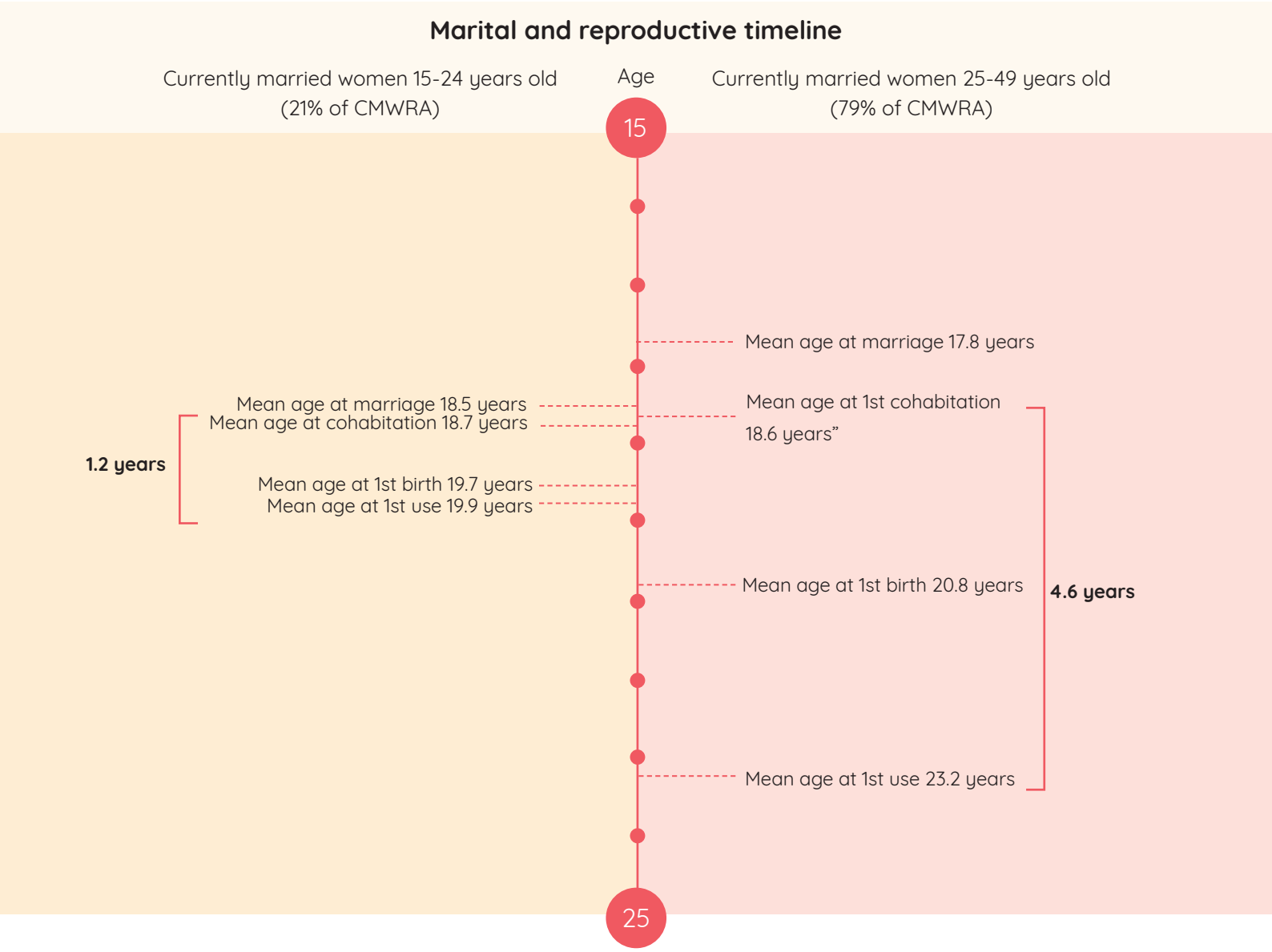
2.2.1 Initiation into marital and sexually active life

Overall, almost a quarter of women was married before 18 years, while in the 25-49 age-group, 43 percent had married by 18 years, and 70 percent by 20 years (Table A.1). The median age at first marriage, cohabitation and first sex for 25–49-year-old women was 18 years.

As seen in the marital and reproductive timeline (Figure 3), the age at marriage and age at first birth of younger (15–24-year-old) and older (25–49-year-old) women were similar. However, while both had almost the same mean age at first cohabitation, the gap between age at first cohabitation and age at first contraceptive use of older women was almost four times that of the younger age-group.

About 43 percent of those belonging to the lowest wealth quintile and 37 percent of those who were uneducated were married before 18 years. Early marriage was also closely linked to early and frequent childbirth. 85 percent of younger (18–24-year-old) women with four or more children and 43 percent with two to three children were married before the age of 18.

Figure 3: Marital and reproductive profile of CMWRA, 2020-21

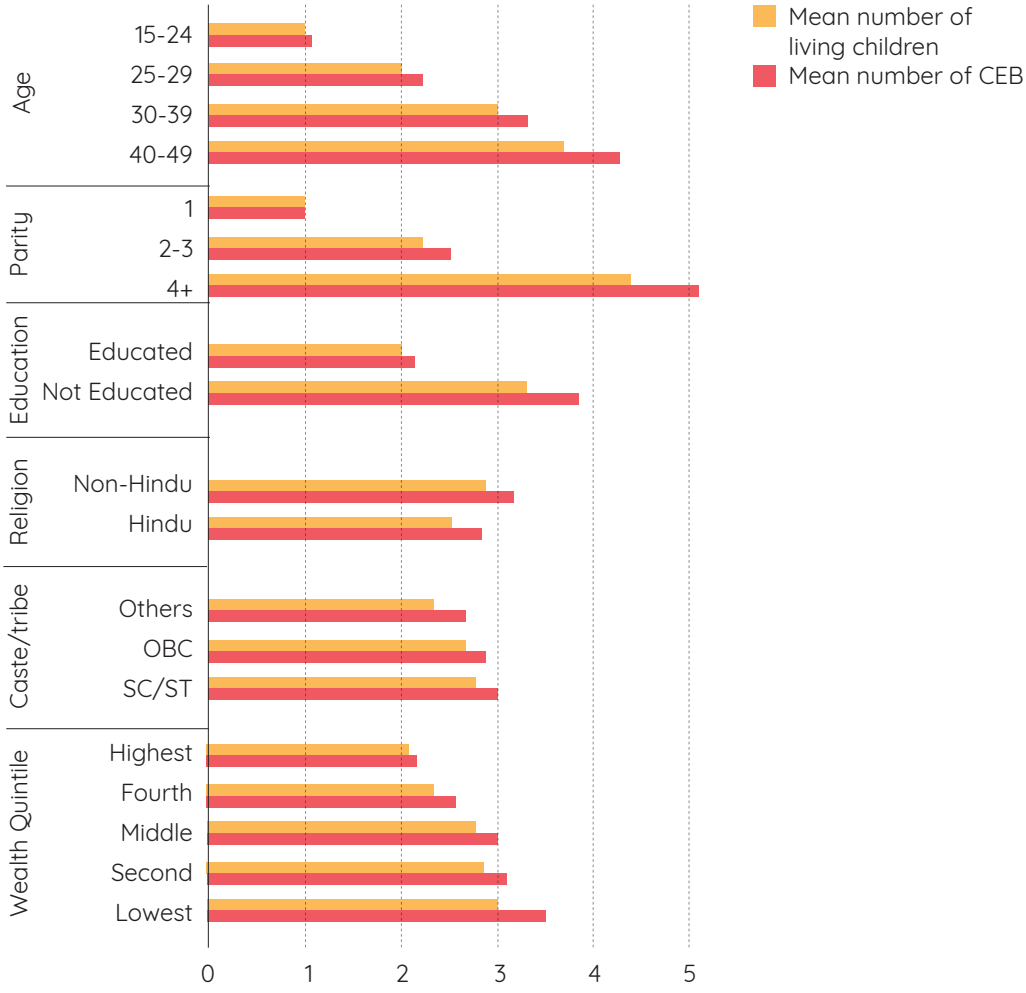


2.2.2 Fertility status and preferences of married women

The survey recorded a TFR of 2.3 children per woman among CMWRA which means a reduction of 0.4 children from the TFR of Uttar Pradesh since NFHS-4 (2015-16) and much closer to the TFR of UP recorded in NFHS-5 (2.4). However, the State TFR is higher than the replacement level fertility rate of 2.1 and the national TFR of 2 (NFHS-5). Division-wise, Ayodhya had the lowest TFR (1.9), while Gonda had the highest (2.9). The decline in TFR from NFHS-4 in 2015-16 to IFPS in 2021 was the maximum in Bareilly (3.1 to 2.2). The level of education had a strong bearing on the fertility rate – the TFR among literate women was 1.9 as against 3.3 among those who were not literate. Similarly, the TFR of those who had education up to Class 10 or more was 1.6 as compared to 2.2 for those who had studied between Classes 1 to 9 (Table A.2).

Overall, the mean number of children ever born (CEB) for women aged 15-49 years was 2.9, and the mean number of living children was 2.6. The difference between mean CEB and mean number of living children was found to be higher among older women, women with no educated, higher parity, and from the lowest wealth quintile (Figure 4).

Figure 4: Mean number of children ever born to CMWRA by background characteristics, 2020-21



Among women respondents who had more than one child, the highest share (24%) had an interval of two to three years since the preceding birth, followed by those with a three to four years birth interval. About 11 percent of women with more than one child reported a birth interval of seven to 17 months (Table A.3).

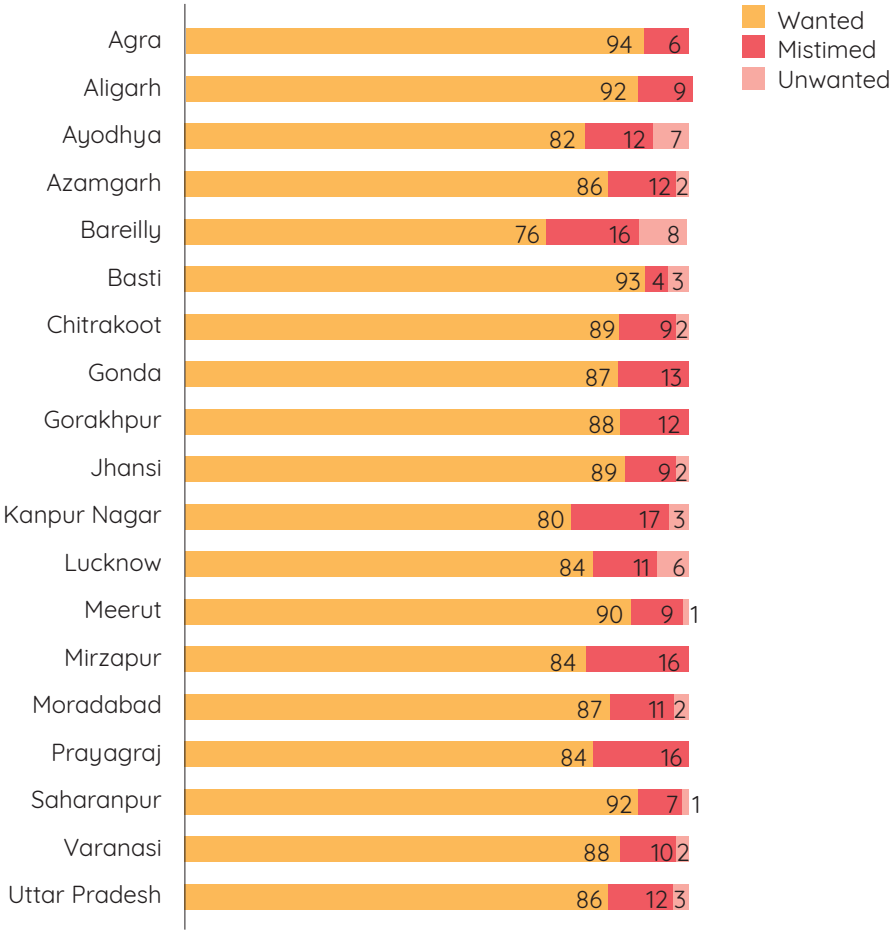
To study the reproductive preferences, the Survey recorded the ideal number of children desired by currently married women respondents. A majority of women in the age-group of 18 to 49 years reported an ideal of two children, with variations depending on the number of living children (Table 4).

Table 4: Distribution of CMWRA by ideal number of children and number of living children, 2020-21

	Ideal number of children						
Number of living children	**No child**	**1**	**2**	**3**	**4+**	**Non-numeric responses**	**Missing**
No child	2.2	6.9	59.3	14.2	4.3	1.2	11.9
1	2.2	11.4	69.9	12.7	3.0	0.7	0.1
2	2.6	3.3	74.4	15.9	3.1	0.7	0.0
3	3.0	0.7	42.0	45.0	7.7	1.5	0.1
4+	4.3	0.6	22.9	33.3	34.9	3.9	0.0
Total	**3.0**	**3.7**	**51.7**	**26.1**	**12.5**	**1.7**	**1.3**

With respect to birth planning, almost 12 percent of CMWRA stated that they would have preferred delaying birth. A similar trend was recorded across the divisions. Women respondents from Bareilly (8%), Ayodhya (7%) and Lucknow (6%) divisions reported the highest share of unwanted births (Figure 5).

Figure 5: Division-wise percent distribution of CMWRA by planning status of birth, Uttar Pradesh, 2020-21



2.3 Family planning knowledge and practices

2.3.1 Level of knowledge and misconceptions about contraceptive methods

Knowledge about contraceptive methods is a measure of women's agency in adopting family planning practices. The IFPS 2020-21 found an overall high percentage of women had heard about condoms, intra-uterine devices (IUCD – Copper-T) and pills, and about two-thirds knew of injectables (Antara). However, a much lower share of women had knowledge of emergency pills and weekly centchroman (Chhaya). The survey found a positive correlation of married women respondents' educational level and wealth quintile with their knowledge of contraceptives. Further, lower shares of younger women (15-24 years), who were zero parity, and who belonged to backward castes had heard of contraceptive methods (Table 5).

Table 5: Percentage of CMWRA who have heard about contraceptive method by type of method and socio-demographic characters, 2020-21

Background characters	Methods						Heard about at least three methods	Number of women
	IUCD/ Copper-T	Injectables /Antara	Pills	Chhaya/ Centchroman	Emergency contraception	Condom		
Age (in years)								
15-24	66.3	53.5	58.6	13.3	12.4	90.3	62.6	2,556
25-29	84.0	66.0	78.8	19.1	19.9	95.1	82.3	2,508
30-34	86.6	65.4	82.8	21.5	19.6	94.1	83.8	2,145
35-39	87.0	60.4	81.7	21.7	16.9	92.1	80.8	1,875
40-49	85.6	59.8	78.8	17.4	11.8	87.6	77.7	3,116
15-29	75.1	59.7	68.7	16.2	16.1	92.7	72.5	5,064
Parity								
0	60.5	44.9	55.4	11.8	14.8	88.9	55.6	1,200
1	78.3	59.9	73.6	18.9	23.6	94.2	76.7	1,723
2-3	86.3	66.2	80	208	18.3	93.6	82.6	5,406
4+	83.4	58.9	77.4	16.5	8.9	88.4	76.5	3,871
Years of schooling								
No schooling	77.7	53.9	70.5	12.4	6.9	85.9	69.6	5,005
<5 years	76.3	57.0	73.4	17.8	8.3	91.1	72.4	369
5-10 years	82.1	63.0	76.7	19.0	13.5	93.8	79.5	4,111
10+ years	89.0	70.8	84.5	28.0	35.8	98.6	87.9	2,715
Religion								
Hindu	82.2	61.9	76.1	18.3	15.7	91.3	77.7	10,369
Non-Hindu	79.1	55.0	74.3	18.0	15.6	92.9	73.9	1,790
Caste/tribe								
SC/ST	78.0	59.4	71.9	15.9	11.4	90.0	73.7	3,665
OBC	81.5	60.5	75.5	17.4	14.8	91.5	76.8	6,438
Others	88.8	64.2	83.7	25.3	26.2	94.4	83.9	2,041
Wealth quintile								
Lowest	72.3	53.8	65.1	11.4	6.6	85.9	65.6	2,028
Second	78.5	59.0	70.8	13.6	8.4	89.4	73.6	2,457
Middle	79.0	58.3	73.9	15.2	10.7	90.4	74.3	2,622
Fourth	86.8	63.2	80.3	21.0	17.0	93.5	82.3	2,609
Highest	90.2	68.9	87.0	29.1	34.8	97.5	87.8	2,443
Total	**81.7**	**60.9**	**75.8**	**18.3**	**15.7**	**91.6**	**77.1**	**12,200**

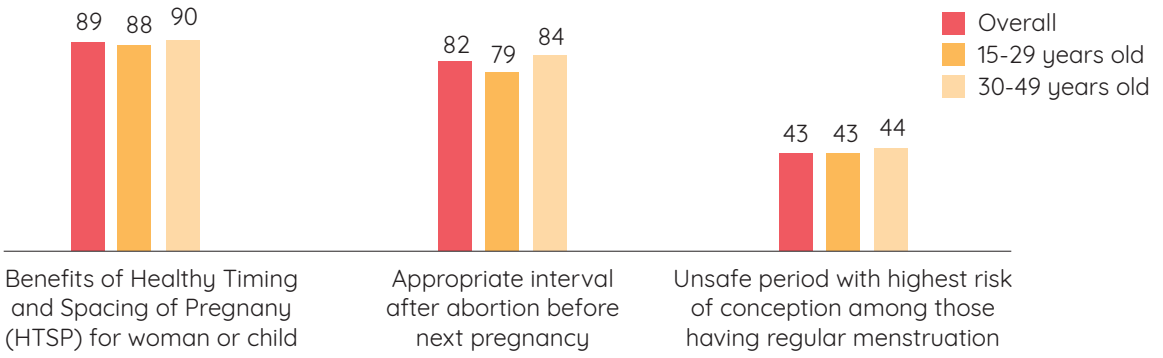
Even though overall awareness of contraceptives was high, correct knowledge on the different methods was not universally high, except for the use of condoms and protection offered by IUCDs (Table 6). The trend was similar across the 18 divisions of Uttar Pradesh, and was especially low on correct knowledge of the frequency of taking the weekly centchroman (Chhaya), and the recommended gap between unprotected intercourse and taking the emergency pill.

Table 6: Percentage of CMWRA with correct knowledge about use of contraceptive methods by divisions, Uttar Pradesh, 2020-21

Divisions	Had correct knowledge on the:					
	Duration of protection offered by IUCD	Timing of repeating Antara dose	Steps to take in case daily pills are missed	Frequency of weekly pills	Interval between unprotected intercourse & ECP	Condom use
Agra	69.8	28.2	16.7	1.3	15.9	86.3
Aligarh	74.0	26.3	13.2	2.4	13.5	87.7
Ayodhya	39.3	18.7	14.2	0.7	7.2	73.3
Azamgarh	44.5	23.3	19.1	0.3	3.8	78.3
Bareilly	36.1	12.2	8.3	0.3	7.8	72.8
Basti	45.9	23.9	24.6	2.3	5.2	77.7
Chitrakoot	54.8	18.3	13.8	1.0	7.9	82.3
Gonda	39.4	22.2	18.6	2.0	10.4	68.3
Gorakhpur	55.4	21.7	31.8	3.0	7.6	78.8
Jhansi	48.8	18.7	12.9	1.0	13.9	85.9
Kanpur Nagar	46.5	20.7	17.6	1.7	15.1	81.2
Lucknow	46.8	25.6	25.3	2.0	12.9	79.6
Meerut	64.5	20.4	17.0	0.8	18.9	85.4
Mirzapur	61.9	20.5	13.7	0.9	10.2	82.7
Moradabad	38.8	18.0	10.7	0.1	10.8	79.6
Prayagraj	58.8	16.8	15.4	1.2	13.5	86.4
Saharanpur	47.4	13.7	12.4	0.0	15.7	82.4
Varanasi	61.0	27.3	20.8	1.9	10.2	83.7
Total	**51.5**	**21.3**	**18.0**	**1.4**	**11.4**	**80.4**

The correct knowledge of family planning practices was similar among younger (15-29 years) and older women (30-49 years). A high percentage (89%) knew about the benefits of Healthy Timing and Spacing of Pregnancy (HTSP) for the woman or child and the appropriate interval after an abortion before the next pregnancy (82%). However, less than half of women (43%) had correct knowledge of the days with the highest risk of conception among those having regular menstruation (Figure 6).

Figure 6: Percentage of CMWRA with correct knowledge about family planning practices, Uttar Pradesh, 2020-21



Along with awareness and correct knowledge of contraceptives, commonly prevalent myths and misconceptions about methods influence women's decision to adopt family planning measures. The findings from IFPS show that while women had high awareness and correct knowledge about IUCD, almost half (47%) of the respondents also held myths and misconceptions about this method. This was followed by women holding myths and misconceptions about female sterilization (43%). The trends were similar across background characteristics (Table A.4) and divisions (Table 7).

Table 7: Percentage of CMWRA with myths and misconceptions about contraceptive methods by divisions, Uttar Pradesh, 2020-21

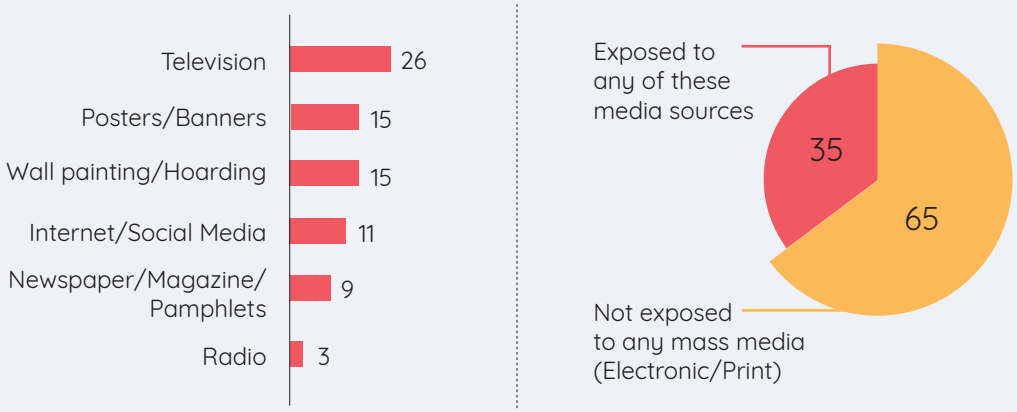
Divisions	Held myths and misconceptions about							
	Female sterilization	Male sterilization	IUCD/ PPIUCD	Injectable/ Antara	Pills	Chhaya/ Centchroman	ECP	Condom
Agra	49.2	19.7	57.5	14.3	10.1	1.4	2.5	13.3
Aligarh	45.2	21.5	61.3	16.2	12.0	2.3	2.8	15.9
Ayodhya	41.7	13.6	41.0	9.7	6.3	0.5	2.0	8.5
Azamgarh	52.9	10.4	37.3	14.3	10.3	0.6	0.5	8.2
Bareilly	42.8	10.7	39.2	13.5	11.6	3.6	2.6	17.9
Basti	29.7	7.5	36.0	10.7	10.0	1.5	1.5	9.1
Chitrakoot	42.3	25.4	44.9	10.1	6.0	0.8	0.4	8.6
Gonda	31.2	5.3	33.8	7.7	4.4	1.4	2.6	8.0
Gorakhpur	36.1	7.2	42.3	13.5	7.9	1.7	1.8	8.9
Jhansi	37.0	24.8	41.0	8.6	7.2	0.9	3.3	10.8
Kanpur Nagar	44.6	20.7	48.3	14.2	9.0	1.3	6.0	12.4
Lucknow	43.6	8.9	50.4	13.2	8.9	1.6	2.7	13.8
Meerut	43.0	17.2	55.1	13.5	10.9	3.5	3.4	16.8
Mirzapur	52.4	20.0	58.0	15.9	11.6	1.1	1.8	9.0
Moradabad	35.0	8.5	38.0	12.8	9.1	2.5	3.7	14.4
Prayagraj	50.6	20.9	55.2	18.3	7.0	0.6	3.7	12.7
Saharanpur	36.4	9.3	41.4	10.4	8.2	1.8	2.4	14.5
Varanasi	51.1	16.0	59.7	21.4	10.1	2.0	2.4	9.2
Total	**43.0**	**13.9**	**47.4**	**13.7**	**8.9**	**1.7**	**2.7**	**12.1**

Exposure to family planning programme messages through mass media

The IFPS findings showed limited exposure of the women respondents to family planning messages on mass media. Just over one-third (35%) received FP messages over any mass media (Figure 7) while messages over television received the highest exposure (26%).

Radio had the least reach and just over one in 10 women (11%) were reached via the internet or social media. A similar pattern was seen across divisions also (Table A.5), with the share of women exposed to any media being the lowest in Chitrakoot (19%) and the highest in the Varanasi division (44%).

Figure 7: Percentage CMWRA with mass media exposure on family planning in the past 12 months, 2021



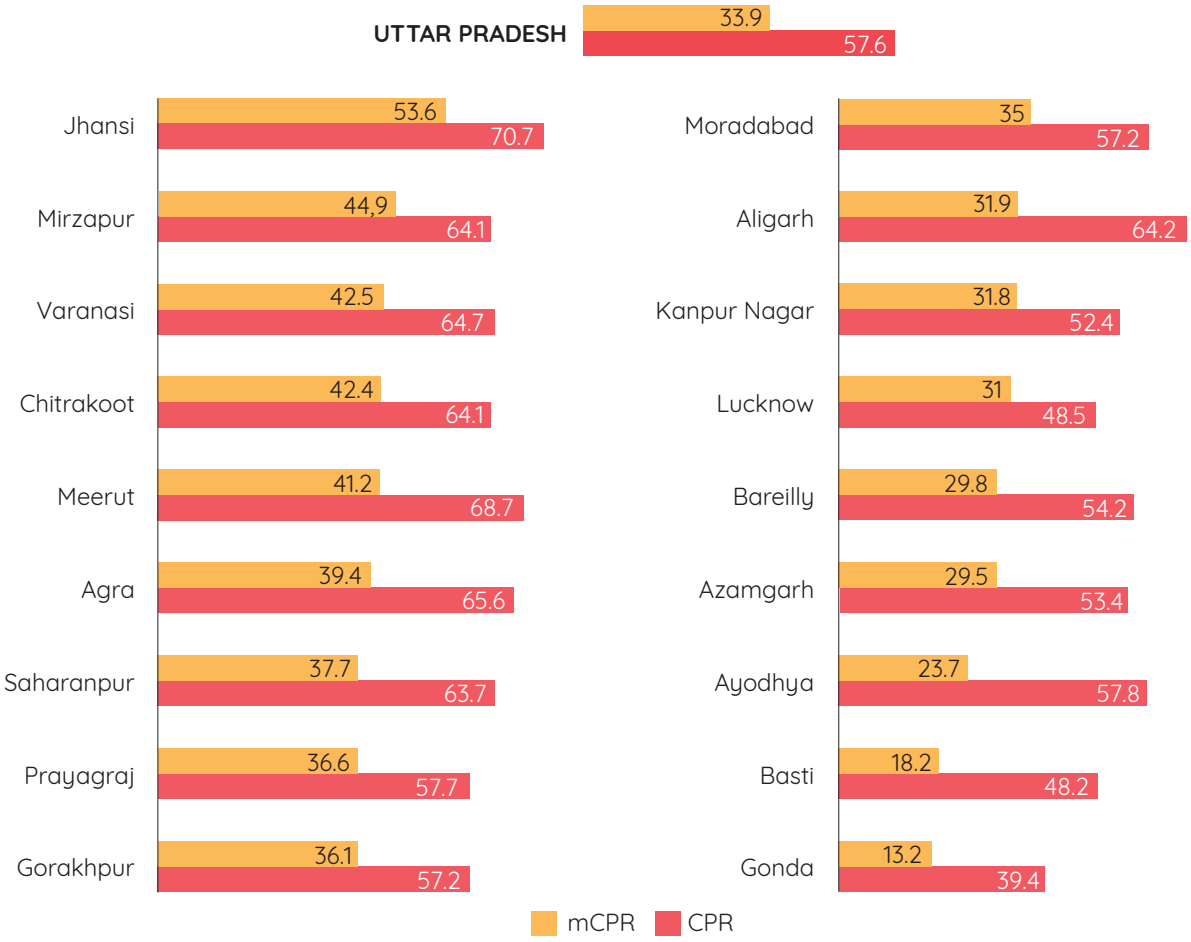
2.3.2 Level and patterns of contraceptive use

Modern Contraceptive Prevalence Rate (mCPR), use of contraception by method and its variation by background characteristics

Among currently married women respondents of the IFPS, just over half (58%) reported using any contraceptive method, while only a third (34%) used any modern contraceptive method (Figure 8), which is far below the SDG Vision 2030 of UP of mCPR at 45 percent by 2024 and 52 percent by 2030.

The division-wise data shows that Jhansi, Mirzapur, Varanasi, Chitrakoot and Meerut are the divisions with higher mCPR (over 40%) while divisions such as Bareilly, Azamgarh, Basti, Ayodhya and Gonda have the lowest mCPR (below 30%).

Figure 8: Percentage of CMWRA using any contraceptive method and any modern contraceptive method by divisions, UP, 2020-21



The level of education, caste and economic background has very little bearing on the modern contraceptive prevalence rate (Table A.6). Women respondents who had interaction with FLWs, facility-based service providers or messages on television, and those who were members of SHGs reported higher use of contraceptive methods. The number of living children determined the use of contraceptives, with a significantly lower percentage of women with one or no living child using any contraceptive method (Figures 9a, 9b).

Figure 9: CPR and mCPR among CMWRA by FLWs, mass-media, parity and SHG membership

Figure 9a: CPR and mCPR among CMWRA by FLWs and mass media exposure, 2020-21

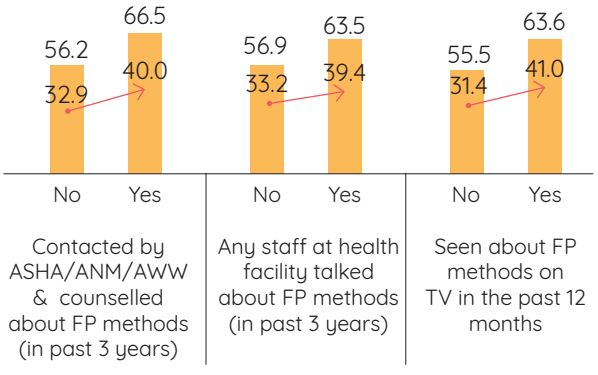
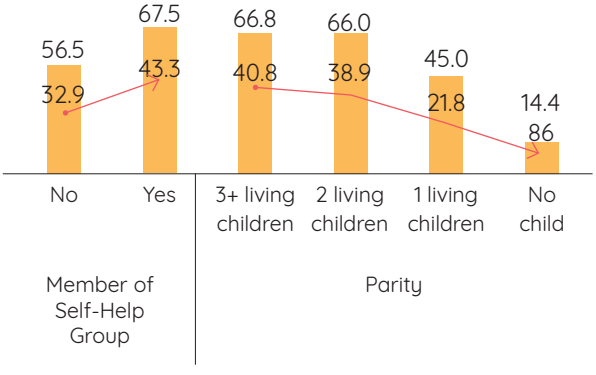


Figure 9b: CPR and mCPR among CMWRA by parity and SHG membership, 2020-21



CPR mCPR

While overall more than 42 percent of the women respondents were not using any method of family planning, nearly every two of three (62.5%) 15–24-year-olds, over 85 percent with no children, and more than half (55%) with one child were non-users. Among users, nearly a quarter (24%) used traditional methods, followed by female and male sterilization (17.5%) and condoms (12.5%). Of 15-29 years old women, nearly a quarter (23%) were using traditional methods and 6 percent had already undergone sterilization. As against this, among 30- to 49-year-old women, one-third (36%) were non-users, and about a quarter were using traditional methods (24%) or had undergone sterilization (25%). The use of new methods such as injectables (Antara) and centchroman (Chhaya) was overall very low (Table 8).

Table 8: Contraceptive method mix among CMWRA by selected background characteristics, 2020-21

Background characteristics	Contraceptive methods				
	Sterilization[1]	IUCD-Copper-T/ Loop	Injectables/ Antara	Pills (Daily)	Chhaya/ Centchroman (weekly)
Age					
15-24	2.2	1.0	0.4	0.4	0.1
25-29	10.0	2.1	0.8	1.0	0.1
30-34	18.7	2.2	0.5	1.3	0.4
35-39	26.5	1.1	0.4	0.8	0.6
40-49	29.4	0.5	0.1	0.5	0.1
15-29	6.1	1.5	0.6	0.7	0.1
30-49	25.4	1.2	0.3	0.8	0.3
Parity					
0	0.0	0.1	0.0	0.1	0.0
1	1.1	1.3	0.1	0.6	0.1
2-3	20.6	2.0	0.6	0.9	0.2
4+	26.2	0.8	0.5	0.9	0.4
Years of schooling					
No schooling	23.1	0.7	0.3	0.7	0.3
<5 years	23.6	0.8	0.3	0.7	0.2
5-10 years	16.1	1.8	0.6	0.7	0.2
10+ years	8.6	1.8	0.4	1.1	0.2
Religion					
Hindu	19.8	1.4	0.5	0.8	0.2
Non-Hindu	4.5	0.8	0.3	0.8	0.4
Missing	15.5	2.0	0.0	0.0	0.0
Caste/tribe					
SC/ST	20.8	0.9	0.3	0.7	0.1
OBC	15.9	1.5	0.4	0.8	0.4
Others	16.8	1.4	0.6	1.1	0.2
Do not know	20.2	0.0	0.0	0.0	0.0
Missing	15.5	2.0	0.0	0.0	0.0
Wealth quintile					
Lowest	20.7	0.8	0.3	0.4	0.2
Second	18.7	1.1	0.6	0.9	0.2
Middle	19.0	1.0	0.2	0.9	0.1
Fourth	16.2	1.6	0.6	0.9	0.2
Highest	13.3	2.2	0.4	0.8	0.5
Missing	15.5	2.0	0.0	0.0	0.0
Total	**17.5**	**1.3**	**0.4**	**0.8**	**0.2**

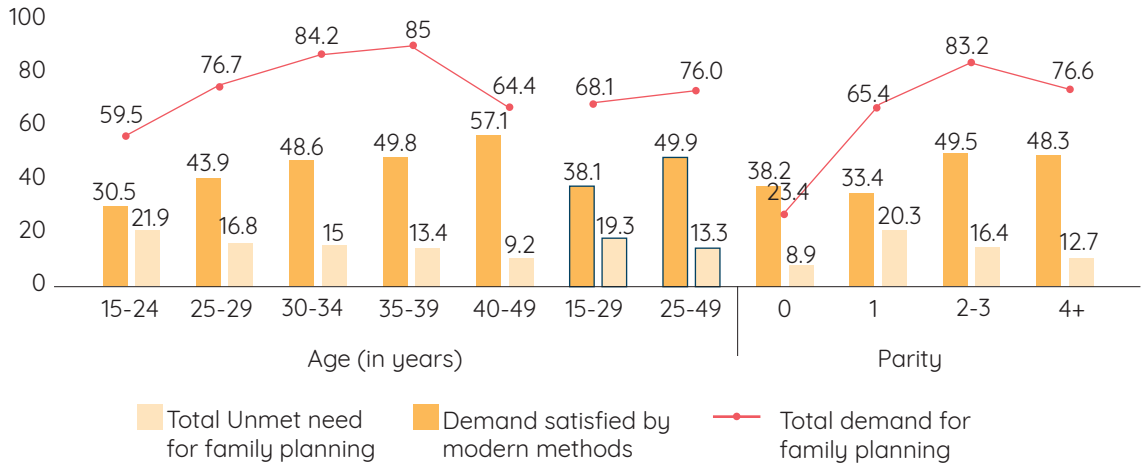
[1]includes male and female sterilization

Contraceptive methods						Not using
Emergency Contraceptive pill	Condom	Standard days method (SDM)	Lactational amenorrhoea method (LAM)	Any traditional method	Others modern method	
0.0	12.0	0.4	1.6	19.4	0.1	62.5
0.2	18.2	0.4	0.6	26.2	0.2	40.1
0.1	17.1	0.2	0.3	28.3	0.1	30.8
0.1	12.4	0.3	0.0	29.3	0.0	28.4
0.1	5.3	0.3	0.2	18.4	0.3	44.9
0.1	15.1	0.4	1.1	22.8	0.1	51.3
0.1	10.7	0.3	0.2	24.3	0.2	36.3
0.0	8.7	0.1	0.0	5.6	0.0	85.5
0.1	17.1	0.4	1.0	23.3	0.1	54.9
0.1	15.8	0.4	0.6	25.6	0.1	33.2
0.2	7.1	0.3	0.4	26.9	0.2	36.1
0.1	7.2	0.5	0.5	24.0	0.2	42.4
0.0	6.9	0.0	1.3	26.3	0.4	39.5
0.1	12.5	0.3	0.7	23.7	0.1	43.3
0.1	22.9	0.1	0.3	22.6	0.1	41.8
0.1	11.9	0.3	0.5	23.2	0.1	41.1
0.1	16.1	0.3	0.7	26.1	0.3	49.5
0.0	8.4	0.0	0.0	21.3	0.0	52.8
0.3	10.8	0.2	0.6	22.9	0.1	42.5
0.0	12.8	0.4	0.5	24.8	0.2	42.3
0.1	14.8	0.3	0.5	21.6	0.1	42.7
0.0	7.8	0.0	0.0	19.7	0.0	52.3
0.0	8.4	0.0	0.0	21.3	0.0	52.8
0.2	5.9	0.5	1.2	23.9	0.3	45.7
0.1	9.0	0.7	0.5	23.2	0.0	45.2
0.1	9.8	0.1	0.6	24.5	0.3	43.5
0.2	13.7	0.3	0.3	24.1	0.0	42.1
0.1	23.5	0.1	0.3	22.7	0.1	35.9
0.0	8.4	0.0	0.0	21.3	0.0	52.8
0.1	**12.5**	**0.3**	**0.5**	**23.7**	**0.1**	**42.4**

Demand for family planning, demand satisfied and unmet need for family planning

The overall share of women whose demand for family planning was satisfied by modern contraceptive methods was 47 percent, which is still far from the state's Vision 2030 target of 60 percent by 2024. As seen in Figure 10, the demand for FP was higher among women with higher age and parity, with the highest being among 35–39-year-old women (85%) and those with two to three children (83%). The total unmet need was higher among younger women and vice versa.

Figure 10: Demand for family planning, unmet need and demand satisfied by modern contraceptives among CMWRA by age and parity, 2020-21



Overall, the total unmet need for family planning among 15-49-year-old women was 15 percent, i.e. about 4 percent for spacing, and 11 percent for limiting. By background characteristics, the highest share of women expressing unmet needs for limiting births was from the lowest wealth quintile (14%) (Table 9).

Table 9: Demand for family planning, unmet need and demand satisfied by modern contraceptives among CMWRA by select socio-demographic characters, 2020-21

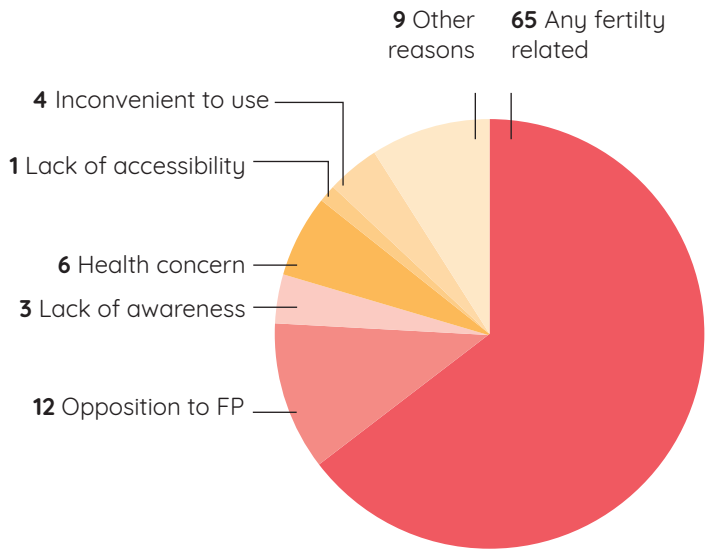
Background characteristics	Unmet need for family planning			Total demand for family planning	Demand satisfied by modern contraceptive methods
	For spacing	For limiting	Total		
Years of schooling					
No schooling	2.4	11.4	13.8	71.4	47.0
<5 years	4.5	8.8	13.3	73.7	46.3
5-10 years	5.3	11.2	16.5	73.3	45.1
10+ years	6.6	8.9	15.5	73.7	48.3
Religion					
Hindu	4.3	10.6	14.8	73.7	48.4
Non-Hindu	5.0	11.7	16.6	67.1	36.3
Caste/tribe					
SC/ST	5.0	11.3	16.3	73.8	47.0
OBC	4.5	10.4	14.9	72.6	45.4
Others	3.0	10.9	13.9	70.6	50.1

Background characteristics	Unmet need for family planning			Total demand for family planning	Demand satisfied by modern contraceptive methods
	For spacing	For limiting	Total		
Wealth quintile					
Lowest	4.6	14.3	18.9	73	41.2
Second	4.3	11.8	16.0	71.8	44.4
Middle	4.3	11.9	16.2	72.4	43.8
Fourth	5.5	9.6	15.1	73.1	46.4
Highest	3.1	6.6	9.7	73.7	55.8
Total	**4.4**	**10.7**	**15.1**	**72.6**	**46.7**

Total demand: Total demand is the sum of unmet need and met need (using any contraceptive method .ie., CPR+ unmet need).
Calculation : (CPR+ total unmet need) / (All CMW)
Demand satisfied by modern method: Women who are using any modern contraceptive method among those who had demand.
Calculation : mCPR/ Total Demand

As depicted in Figure 11, in the case of women who were not using any contraceptive method despite not wanting another child within the next two years, or any more children, fertility-related issues (infrequent sex, menopause, having hysterectomy, sub-fecund or infecund, etc.) emerged as the most common reasons (65%) as cited by respondents. This was followed by opposition to FP, arising out of the belief that childbearing was up to God or being fatalistic, opposition by the respondent, her husband, partner or in-laws, or religious prohibition. The age and division-wise findings on reasons for not using contraceptive methods show similar trends (Table A.7).

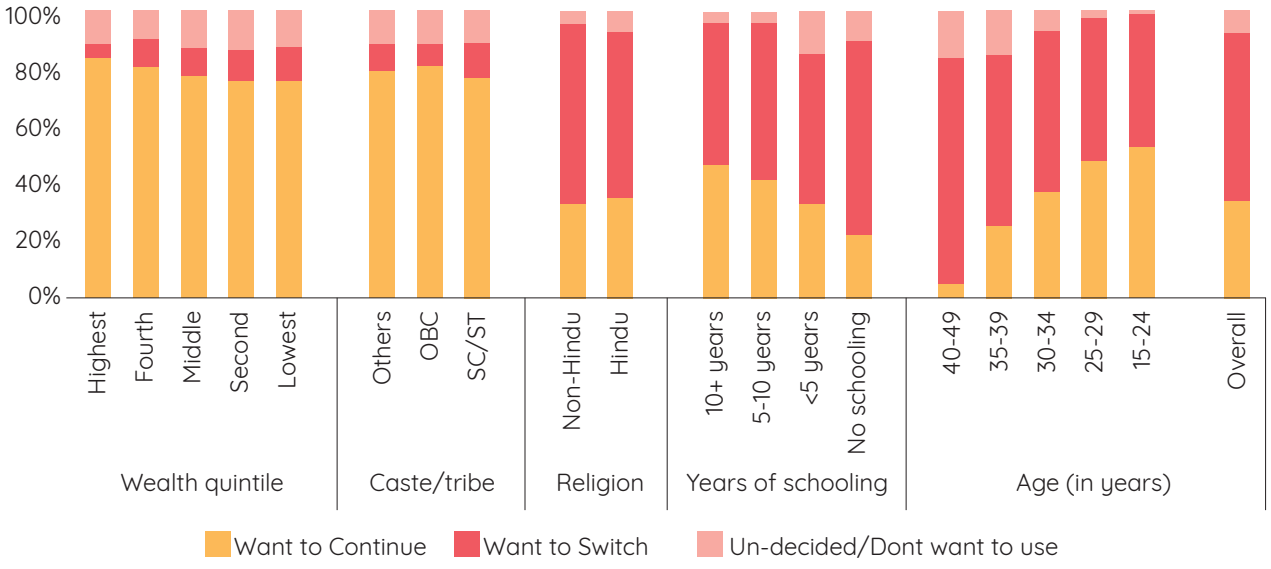
Figure 11: Reasons for non-use of contraceptive among CMWRA who want to space or limit children, 2020-21



2.3.3 Future preference for contraceptive use

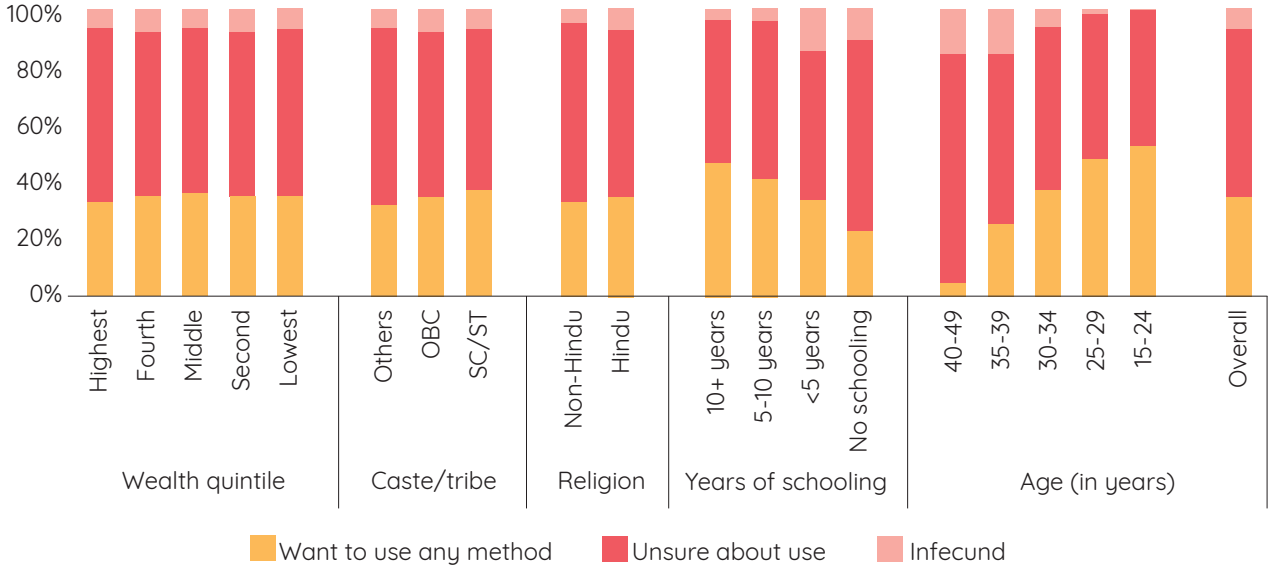
Most of the women respondents using modern methods (79%) wanted to continue using the current method. 14 percent wanted to switch to another method while 12 percent were undecided or did not want to continue using contraception (Figure 12).

Figure 12: Preference for future contraceptive use among CMWRA using modern methods by selected background characteristics, Uttar Pradesh, 2020-21



Among women not using any FP method, a third (34%) wanted to use any method in the future, while 59 percent were unsure about the use (Figure 13). A higher share of younger non-user women (15-24 years), those with higher education (Figure 13), or had lower birth order wanted to use any method of contraception (Table A.8).

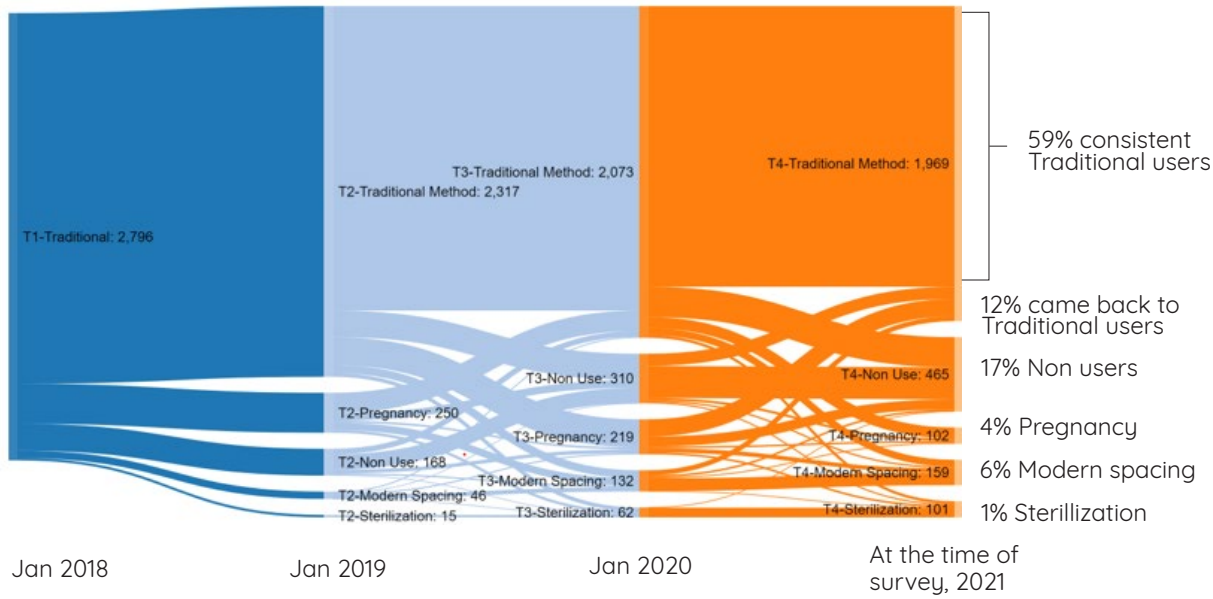
Figure 13: Preference for future contraceptive use among non-user CMWRA by selected background characteristics, Uttar Pradesh, 2020-21



2.3.4 Family planning discontinuation

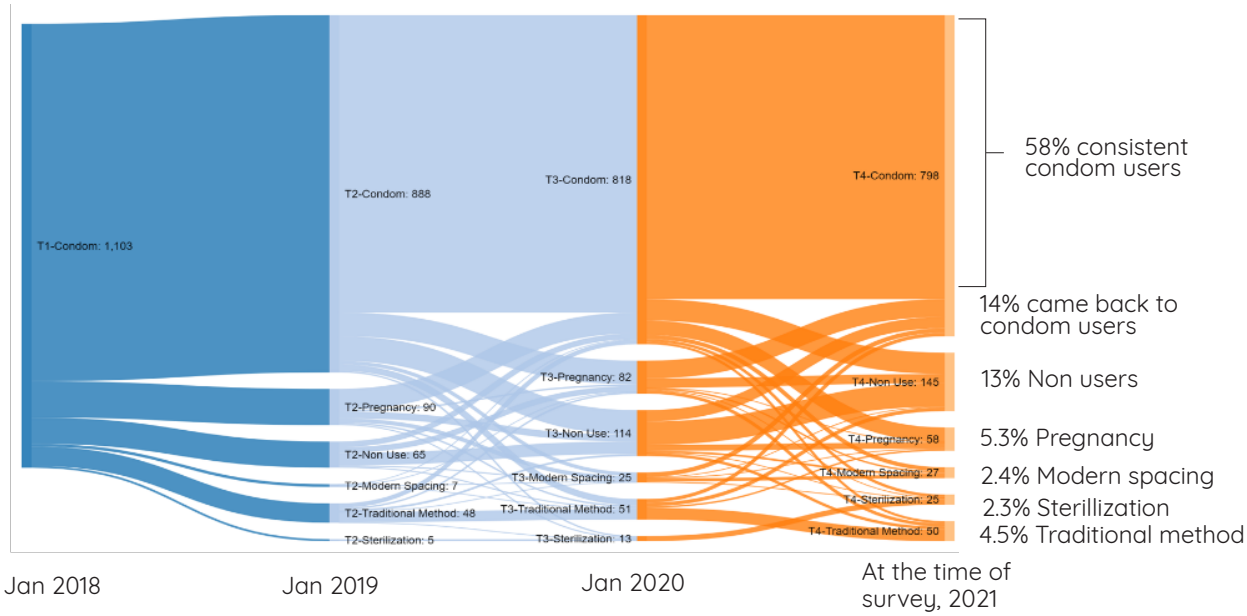
The community component of the IFPS included the contraceptive journey of the women respondents over three years from 2018 to 2021, captured retrospectively through calendar data. Figure 14, depicts the contraceptive journey of 2,908 traditional method users in 2018. Of these, by 2021 more than half (55%) consistently used traditional methods, while 13 percent of users came back to using traditional methods, after either stopped using contraception, were pregnant or had shifted to modern spacing methods in the interim. 18 percent had stopped using any method and 4 percent had undergone sterilization. Just 6 percent of the women using TM in 2018 had shifted to modern spacing methods.

Figure 14: Prospective contraceptive use journey among cohort of TM users in last 3 years, UP



Similarly, in the case of condom users, about 58 percent had been consistently using it for the last three years, while 14 percent came back as condom users. Almost 13 percent of women discontinued the method, while about 5 percent went for pregnancy (Figure 15).

Figure 15: Prospective contraceptive use journey among cohort of Condom users in last 3 years, UP



2.3.5 Contraceptive use, unwanted pregnancy and abortion

Almost 6 percent of the respondents were pregnant at the time of survey, while about 30 percent of current pregnancies were unwanted. Also, the majority of women with unwanted current pregnancies did not use any method, while about 23.6% used traditional methods (Figure 16.a). Further, among the women with unwanted current pregnancies who opted for abortions, the contraceptive use pattern showed the high risks involved with traditional methods (Figure 16.b).

Figure 16: Pre-pregnancy and pre-abortion contraceptive use among CMWRA with unwanted pregnancy

Figure 16.a: Pre-pregnancy contraceptive use among CMWRA with unwanted current pregnancy, 2020-21

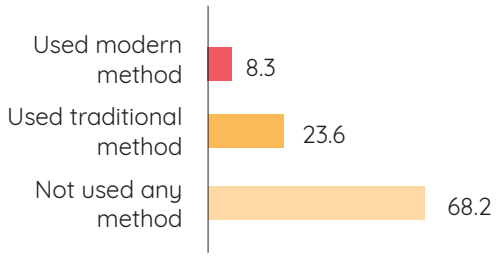
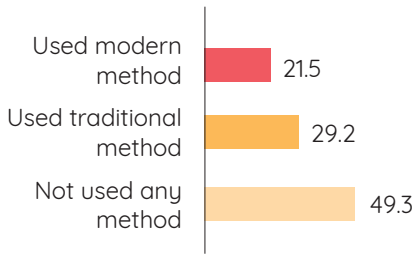


Figure 16.b: Pre-abortion contraceptive use among CMWRA with unwanted current pregnancy, 2020-21



2.4 Women respondents' experience of the quality of care in family planning

2.4.1 Quality of care

The study captured the respondents' experience of services related to information on methods, post-procedural care, especially on side effects, and follow-up care as depicted in Table 10. Among CMWRA who were using IUCDs, injectables (Antara), daily or centchroman (Chhaya), or had undergone sterilization, one-fourth (26%) were informed by a health worker about possible side effects or problems. An even lower share (18%) was told what to do if they experienced side effects. Overall, about one in five (21%) women using the above-mentioned methods were counselled by health workers on alternative methods they could use.

Further, the share receiving information on possible side effects and problems of methods was highest among women aged 40–49 years (35%), and lowest among women aged 15-24 years (17%). Further, a higher share of women with parity 0 or 1 (30%), those who were educated (29%), Hindus (27%), other castes (29%), and those from the highest wealth quantile reported receiving information on possible side-effects. A similar pattern of variations in the share who received counselling on what to do in the event of experiencing side effects and alternative methods was observed across background characteristics, except with respect to age. By age, the highest share to receive information on mitigating measures was among the 30–34 age-group (23%), while the share of those receiving information on alternative methods was highest among women in the 25–29 and 30–34 age-groups (22%).

Table 10: Percentage of CMWRA using contraceptive methods* informed about side effects, coping strategies and alternative methods by select background characteristics, 2020-21

Background characteristics	Informed by a health worker about the possible side effects or problems	Informed about what to do if they experienced side effects	Informed by a health worker of other methods that could be used	Method information index (MII)
Age (in years)				
15-24	16.7	8.5	19.8	0.8
25-29	28.8	20.4	21.5	5.6
30-34	30.9	23.2	21.7	5.5
35-39	17.9	11.9	17.4	5.6
40-49	34.9	20.8	15.6	0.0
25-49	**27.9**	**19.9**	**20.5**	**5.3**
Parity				
0-1	29.6	20.6	36.3	10.56
2-3	27	18.8	22.8	4.09
4+	25.2	17.5	14.3	4.92
Education				
Not educated	22.7	16.4	16.3	2.9
Educated	28.7	19.6	22.9	5.7
Religion				
Hindu	26.6	18.8	20.1	4.6
Non-Hindu	25.2	13.9	25.9	6.3
Caste/tribe				
SC/ST	26.1	17.9	16.0	2.8
OBC	26.0	18.0	21.5	5.9
Others	28.8	21.1	27.5	5.4
Wealth quintile				
Lowest	23.6	17.2	15.3	4.0
Second	24.1	17.4	15.7	3.4
Middle	27.0	20.8	18.6	4.2
Fourth	28.1	16.8	25.5	6.3
Highest	31.6	21.1	31.5	6.0
Total	26.4	18.4	20.5	4.7

*includes sterilization, IUCD, injectable(Antara) and Pills(daily/weekly)

2.5 Programme Exposure

2.5.1 Overview of family planning programme in MPV Districts

Under National Health Mission (NHM) flagship program for improved access to contraceptives and family planning services, the Government of Uttar Pradesh rolled out Mission Parivar Vikas (MPV) in 57 districts in 2017. The major activities initiated in the MPV districts are:

- Rollout of new contraceptives (injectables (Antara) and centchroman (Chhaya) in DH, CHC and PHC
- Orientation of FLWs and facility-based providers on injectables (Antara)
- Planning and roll out of the Family Planning Logistic Management Information System (FPLMIS)
- Implementation of innovative outreach programmes including *Saas Bahu Sammelans*[9], *Nayi Pahal Kits*[10], and *Saarthi Vans*[11].

2.5.2 Progress of family planning programme in MPV districts and exposure to CMWRA

The progress of MPV in the state is presented here based on the program MIS, HMIS data of the state government, and the IFPS. Initially, the MPV program focused on training FLWs and facility-based providers on the newer methods of contraception (i.e., injectables (Antara) and Chhaya) – especially about the frequencies, doses, and side effects – and making methods available at the health facilities. One of the objectives of the MPV district program was training the health cadre about the LMIS, and the program data shows that in 2017-2018 around 505 Medical Officers In-Charge (MOICs), 780 pharmacists, and 15,500 ANMs were trained on FPLMIS. A large number of ASHAs (1,15,803) have been oriented on the new methods of contraception and LMIS. The IFPS survey shows that 71 percent ANMs and 78 percent of ASHAs in MPV districts have received training on injectables (Antara) and Chhaya.

Two rounds of facility assessments conducted by the UP TSU during 2018 and 2020–21 show a substantial increase in the availability of the new contraceptives including in facilities from the MPV districts. For instance, the availability of injectables (Antara) stocks improved from 8 percent of CHC and above facilities in 2018 to 80 percent in 2020-2021. During the same period, the availability of centchroman (Chhaya) increased from 7 percent to 62 percent of the facilities. The findings from IFPS also corroborate the improved availability of FP methods at PHC and higher levels in MPV districts. On the day of the facility assessment, injectables (Antara) stocks were available at around 90 percent DHs, 80 percent CHCs, 75 percent Urban-PHCs (UPHCs), and 50 percent PHCs.

It was also encouraging to note that the majority (90%) of DH, CHC-First Referral Units (FRUs), and CHCs had at least one staff nurse trained in the administration of injectables (Antara), while 80 percent of UPHCs and 53 percent of PHCs had at least one staff nurse trained on the administration of injectables (Antara). Almost 90 percent of DHs and CHC-FRUs had at least one staff nurse trained in centchroman (Chhaya). Further, the HMIS data from 2017–2021 shows a manifold increase in the number of injectables (Antara) doses administered – from 16,800 in 2017, to 2,76,746 in 2021. The distribution of centchroman (Chhaya) has also increased from 1,90,000 strips to 8,90,000 strips in 2021; over a four-fold increase between 2017 and 2021. However, given the large number of CMWRA (2.97 crores) in the MPV districts, and the current numbers of injectables (Antara) doses administered and Chhaya strips distributed, demand generation activities further need to be intensified in these districts.

[9]Part of promotional schemes under the MPV, these mother-in-law and daughter-in-law meetings are aimed to facilitate improved communication among them through interactive games and exercises, to foster shifts in their attitudes and beliefs about reproductive and sexual health.
[10]The Nayi Pahal kit, is given to newly-wed couples by the ASHA and contains a marriage registration form, an information pamphlet on delaying the first birth, pregnancy test and family planning schemes, condoms, oral and emergency contraceptive pills, pregnancy testing kits, an information card with contact details of the nearest FLWs, and a grooming kit.
[11]A mobile campaign platform, this bus or van equipped with interactive communication devices, IEC material and family planning commodities, visits high fertility districts for a fortnight each in designated months of the year.

With respect to the distribution of *Nayi Pahal* kits to newly married women, approximately 10 Lakh kits were procured during 2017–2020, and 85 percent of them have been distributed by ASHAs over the last three years. The FLW assessment conducted by UP TSU revealed that around 90 percent of ASHAs were aware of the *Nayi Pahal* kit, and 54 percent reported that they had distributed the kits to recently-married women.

For the *Saas Bahu Sammelan*, almost 60 percent of the planned meetings have been conducted between 2017-2020. The *Saarthi Van* was initially operationalized in 19 districts in 2017, and its coverage was increased to all 57 MPV districts in 2018–2019. Due to COVID-19, in 2020–2021, the vans were operational only in 30 districts of the state. The FLW survey shows that less than one-fifth ASHAs and ANMs in the MPV districts were aware of the *Saarthi van*.

The IFPS found that in the MPV districts, the program coverage was fairly low, as around 8 percent of women married in the last two years had heard of the Nayi Pahal Kit, while only 10 percent aged 15–24 years had heard of the Saas-Bahu Sammelans. Additionally, only 7 percent of reproductive age women in the MPV districts have seen the Saarthi van. These data and survey findings show that while the government focused on training staff and making the new contraceptive methods available at all the facilities in the MPV districts, the low intensity of outreach with users, coupled with restricted contact activities due to COVID-19 restrictions, resulted to low program exposure among CMWRA.

2.5.3 Missed opportunities in service-delivery

FLWs – ASHAs, ANMs and Anganwadi Workers (AWWs) are the vital link for the government's family planning outreach and service-delivery in the community, especially for rural areas. The IFPS found that overall a little less than three-fourths (72%) of CMWRA in rural areas had ever interacted with FLWs, while two-thirds (67%) had an interaction in the last three years (Figure 17). Notably, less than one-third (32%) of the respondents reported interacting with FLWs on family planning in the last three years.

Figure 17: Percentage and nature of interaction of CMWRA in rural areas with FLWs in last 3 years, 2021

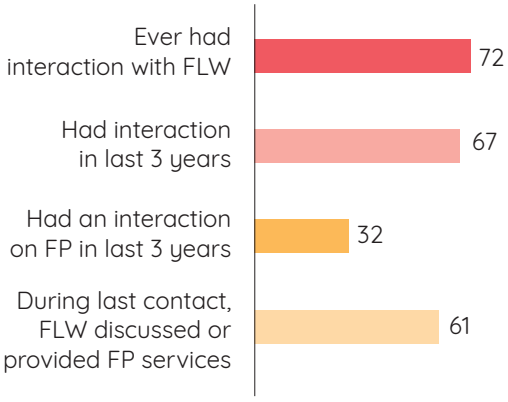
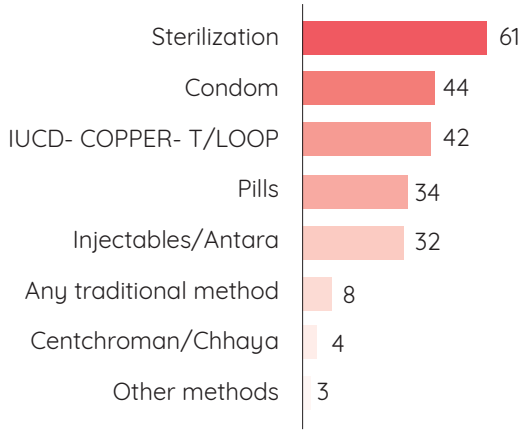


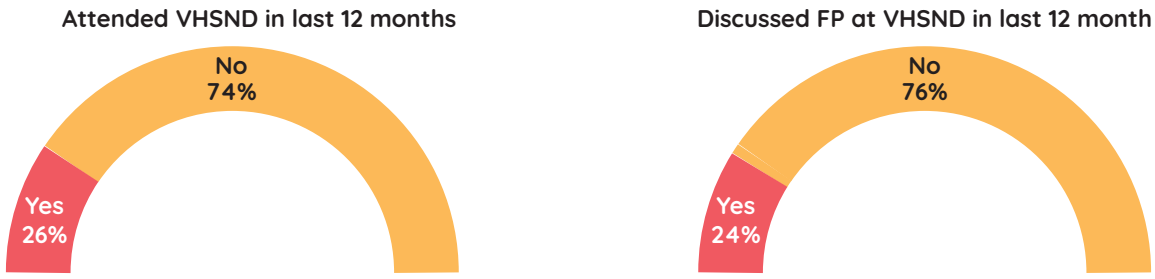
Figure 18: Percentage of CMWRA informed by FLW by type of method in last 3 years, 2021



With respect to receiving information on family planning methods from FLWs, the highest share of women (61%) reported being informed about sterilization (Figure 18), followed by condoms (44%) and IUCD (42%). A far less proportion was informed of new methods of spacing, such as injectables (32%) and the weekly centchroman (Chhaya) (4%).

VHSNDs conducted once every month are meant to improve access to maternal, newborn, and child health, and nutrition services at the village level. However, just over a quarter (26%) of women respondents reported attending a VHSND in the last one year (Figure 19). Those who got information on family planning at the VHSNDs were also low, with FLWs discussing FP with less than a quarter (24%) of those who attended VHSNDs in the last one year.

Figure 19: Percentage of CMWRA in rural areas who attended VHSNDs in last 12 months and discussed FP with FLWs, 2021



Frequency and nature of interaction women respondents had with FLWs

Table 11 presents the nature of interaction with FLWs reported by women respondents, by their socio-demographic characters. Women aged 25-29 years reported the highest ever interaction with FLWs (79%), however, it was highest among women aged 15-24 years (91%) so far as interaction in the last three years was concerned. The proportion of women who interacted with FLWs in the last three years decreased with the increasing age. Despite higher interaction with FLWs in the last three years among 15-24 years, the interaction on FP issues was the lowest among them (26%) as compared to the women aged 30–34-year-old who recorded the highest interaction on FP issues (41%). About 66 percent of women aged 25-29 years reported discussing or receiving FP services in their last contact with FLWs. No significant difference in the interaction on FP in the last three years was observed across educational levels, except that the women with 10 or more years of education had significantly higher interaction on FP matters during their last contact with an FLW (67%).

Almost 41 percent of women who were working had higher interaction with an FLW on FP issues in the last three years as against 31 percent of women who were not working. SHG membership was seen to be positively related with the women's level and nature of interaction with FLWs. More women who were members of SHGs reported interacting with FLWs and discussing family planning than those who were not. About 80 percent of SHG members had ever interacted with FLWs as against 71 percent of those who were not members, and 40 percent of members had interacted with family planning in the last three years as against 31 percent of non-members.

Table 11: Percentage and nature of interaction of currently married women 15–49 years old residing in rural areas with FLWs in last 3 years according to demographic and economic characteristics, Uttar Pradesh, 2021

Background characteristics	Ever had interaction with FLWs	Had any interaction with FLWs in last 3 years	Had any interaction on FP in last 3 years	During last contact, FLW discussed or provided FP services
Age				
15-24	67.6	90.8	25.9	57.4
25-29	79.0	78.1	33.9	65.9
30-34	76.4	61.2	41.3	64.0
35-39	72.5	50.6	34.7	62.6
40-49	64.8	47.4	29.4	50.3
15-29	73.0	84.2	29.7	62.0
Education				
No education	69.5	58.4	31.9	59.1
<5 years	73.4	64.1	38.2	60.2
5-10 years	73.1	71.2	31.6	58.9
10+ years	73.3	77.4	33.0	67.0

Background characteristics	Ever had interaction with FLWs	Had any interaction with FLWs in last 3 years	Had any interaction on FP in last 3 years	During last contact, FLW discussed or provided FP services
Working status				
Yes	79.1	58.5	39.1	57.4
No	69.8	68.6	30.8	61.8
Occupation				
Cultivator/ Agricultural labour	80.2	57	45.7	54.8
Non-agricultural labour	78	59.1	37.3	60.5
Self-employed	81.3	63.9	34.8	72.1
Salaried	70.4	66.5	39.7	50.2
Unpaid work	81.2	55.5	33.4	55.6
Not working	69.8	68.6	30.8	61.8
Cash earnings				
Yes	78.9	60.8	40.2	57.3
No	70.6	67.4	31.2	61.4
Wealth quintile				
Lowest	70.3	64.5	35.9	63.5
Second	72.2	66.6	32.6	56.6
Middle	72.7	66	31.8	58.7
Fourth	69.5	68.4	29.7	63
Highest	73.6	69.1	30.1	66.7
Women who are members of SHGs				
Yes	80.1	68.4	39.9	60.2
No	70.5	66.3	31.1	60.9
Total	**71.5**	**66.6**	**32.2**	**60.8**

The levels and nature of interaction with FLWs were similar across caste and tribe demarcations, with a marginally higher percentage of SC/ST women reporting interactions and receiving FP services from FLWs (Table A.9). However, the interactions of the women with FLWs were seen to be closely related to the duration of marriage, parity, the number of living children and achievement of the desired family size. Only 19 percent of women married for less than 3 years reported any interaction with FLWs on FP in the last three years as against 35 percent of those with 10 or more years of marriage. Further, a higher proportion of women with zero and low parity had interaction with FLWs, but the interaction on FP in the last three years was low among them (9% and 24% respectively). A larger proportion of women who achieved their desired family size reported any interaction on FP in the last three years (37%) as against those who wanted more children (24%). Based on current contraceptive use among women, 63 percent of current users reported any interaction with FLWs in the last three years, while only 38 percent reportedly interacted with FP. Among non-users, 72 percent reported any interaction with FLWs in the last three years, but just 25 percent interacted with them on family planning. In the case of future intention, the proportion of women reporting interaction on family planning with FLWs in the last three years was more among those who wanted to switch (48%), as compared to those who wanted to continue (37%) and those who were undecided or did not want to use any method in the future (28%) (Table A.9).

Information on family planning methods received by women respondents from frontline workers

The survey looked at variations in information on FP methods received by the CMWRA from FLWs in the last three years. With respect to demographic characteristics, the findings depicted that while about 48 percent of 15–29-year-old women received information on condoms, a high share of 52 percent of women in this age group received information on the permanent method of sterilization from FLWs (Table A.10).

The proportion of women informed about sterilization and centchroman (chhaya) increased with age, except for condoms and IUCDs. Almost 40 percent of women aged 15-24 years were informed about pills as against 31 percent of women aged 25–29 years. The proportion of women informed about injectables (Antara) was highest among 25–29-year-olds (35%) and lowest among 40–49-year-olds (26%). More women with higher levels of education were informed about IUCDs, injectables (Antara) and condoms, while the reverse was observed in the case of sterilization. The proportion of women receiving information on daily oral pills was similar across educational levels, though it was slightly higher among those with less than five years of education (38%). The proportion of women receiving information on sterilization was inversely proportional to their wealth levels, unlike other FP methods. A higher proportion of women who were SHG members of SHGs received information across most contraceptive methods, except IUCDs and centchroman, as against non-members (Table A.10).

The survey found different levels of information on family planning methods by marital status, parity, number of living children and desired family size of the women respondents. The highest proportion of women to receive information on condoms was among those who were married for less than three years (67%) and those who had not begun childbearing (61%) or had one child (60%). As against this, 32 percent of women married for less than three years received information on injectables (Antara) and 3 percent on centchroman. Women who reported having completed their desired family size had the highest share to receive information on sterilization (68%). Among those who wanted more children, the highest share received information on condoms (54%) (Table A.11).

Interactions of women respondents with frontline workers at Village Health and Nutrition Days (VHSNDs)

Table 12 shows the level and nature of the interaction of women respondents with frontline workers at VHSNDs by selected background characteristics. As per the study, women's attendance at the VHSNDs reduced with age. Almost 41 percent of women in the youngest age group of 15-24 years attended a VHSND in the last one year, while 11 percent in the oldest age-group of 40-49 years did so. Of those who attended VHSNDs, the highest proportion of women who reported discussing family planning in the last one year were in the 35-39 age-group. As against this, 22 percent of 15–24-year-olds reported discussing FP. Women's educational levels were found to be directly proportional to their attendance in a VHSND, with the highest being 33 percent among women who had 10 or more years of education and the lowest at 21 percent of those who had no education. However, the proportion who discussed FP at the VHSNDs remained similar across educational levels.

Additionally, the survey found that the proportion of women attending VHSNDs in the last one year was slightly higher among those who were not working (27%), while the share who discussed FP at the VHSND was marginally higher among those who were working (27%). Salaried women reported the highest share (28%) among women attending VHSNDs and those who discussed FP issues at the VHSND (46%). The proportion of women who reported attending VHSNDs in the last one year was inversely proportional to their wealth, with the lowest quantile having the highest share (28%), and the highest quantile the least (23%). Women who were members of SHGs reported a higher percentage of attending VHSNDs and discussing FP issues in the last one year, as against those who were not members (Table 12).

Table 12: Percentage of CMWRA residing in rural areas who had any interaction and discussed FP methods at VHSNDs in last 12 months, by selected background characteristics, 2021

Background characteristics	Any interaction at VHSND in last 12 months		Had discussions on FP at VHSND	Number of women had interaction at VHSND in last 12 months
	Yes	No		
Age				
15-24	40.8	59.2	22.1	948
25-29	37.0	63.0	27.6	743
30-34	23.3	76.7	24.0	396
35-39	14.2	85.8	31.7	196
40-49	11.4	88.6	17.7	263
Education				
No education	20.7	79.3	24.6	863
<5 years	23.8	76.2	27.0	79
5-10 years	28.7	71.3	23.0	991
10+ years	33.0	67.0	25.8	613
Working status				
Yes	21.4	78.6	26.7	428
No	26.7	73.3	24.0	2,118
Occupation				
Cultivator/Agricultural labour	19.4	80.6	29.6	123
Non-agricultural labour	19.6	80.4	27.1	113
Self employed	25.6	74.4	30.0	38
Salaried	27.7	72.3	46.1	47
Unpaid work	22.3	77.7	12.8	107
Not working	26.7	73.3	24.0	2,118
Cash earnings				
Yes	22.3	77.7	32.0	281
No	26.2	73.8	23.5	2,265
Wealth quintile				
Lowest	27.6	72.4	30.6	534
Second	25.7	74.3	22.8	622
Middle	26.7	73.3	21.2	651
Fourth	24.1	75.9	22.3	490
Highest	22.8	77.2	25.5	242
Women who are member of SHG				
Yes	27.6	72.4	29.9	317
No	25.5	74.5	23.6	2,229

By social characteristics, the highest proportion of women who attended VHSNDs in the last one year and discussed FP issues were from the SC/ST group (29% and 26% respectively). Parity wise, the lowest proportion of women with zero parity women attended VHSNDs (13%), while women with one parity had the highest attendance (41%). The proportion of women who discussed FP issues at the VHSND increased with the number of children (Table A.12). A lower percentage of women from those who had completed their desired family size attended VHSNDs as compared to women who wanted more children.

By current and future contraceptive use, there was a small difference between users and non-users. While a greater proportion of non-users attended VHSNDs in the last one year (29%), a higher proportion of current users discussed FP issues at the VHSND (27%). Further, the highest proportion of women who were using long-acting reversible methods (LARM) attended VHSNDs (34%) and discussed FP issues (46%). With respect to the future use of family planning methods, the highest proportion of women who discussed FP issues at the VHSND were those who wanted to switch methods (32%) (Table A.12).

Division-wise levels and quality of interaction of women respondents with frontline workers and at VHSNDs

Table A.13 shows the division-wise share of women interacting with FLWs and receiving information on FP. The proportion of women who had any interaction with family planning with FLWs in the last three years was the highest in Aligarh (46%), and lowest in the Saharanpur division (21%). The highest proportion of women from Basti and Meerut reported discussing FP in their last contact with FLWs (76% and 75% respectively), while the lowest proportion was from the Saharanpur division (36%). On the contrary, the highest proportion of women who reported discussing FP issues at the VHSND was in Saharanpur (89%) and the lowest in Aligarh and Kanpur Nagar (60%).

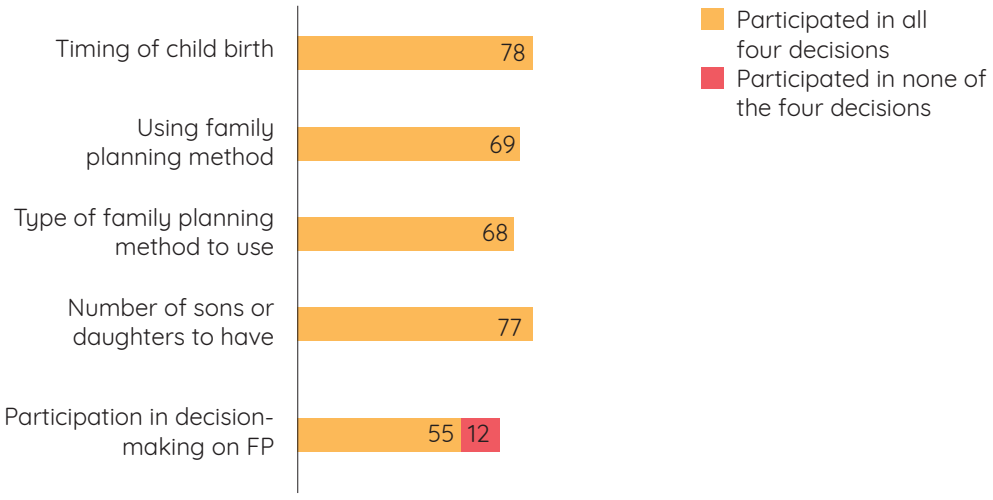
2.6 Women's status and its impact on family planning decisions

2.6.1 Women's status and family planning use

The IFPS also assessed women's ability to exercise choice in FP decisions related to the timing of childbirth, adopting family planning, the type of method to use and the desired sex ratio of the children (Figure 20). The extent to which women were able to take these decisions, either by themselves or along with their husbands, indicated their self-efficacy. The findings show that more than three-fourths of CMWRA made decisions alone or jointly with the husband on the timing of childbirth (78%) and the number of sons or daughters to have (77%). However, women's share in decision-making on the adoption of FP and the methods to use was lower (69% and 68% respectively), and just over half the women respondents (55%) reported participating in all four decisions.

Division wise, the share of women participating in decision-making on FP was highest in the Azamgarh division (66%) and lowest in Bareilly (34%). Almost 95 percent of women reported that they made decisions on current contraceptive use either by themselves or jointly with their husbands (Table A.14).

Figure 20: Role of CMWRA in decision-making on family planning, 2021



Women's roles in decision-making varied by their socio-demographic characteristics (Table A.15). Women who were older, or had higher education had more say in decision-making on FP. A higher proportion of women from non-Hindu or non-SC/ST backgrounds took decisions on FP individually or jointly with their husbands. By economic status, the highest proportion of women from the wealth quintile reported participating in all four decisions on FP (60%), while those from the lowest wealth quintile had the lowest share (50%).

The inter-couple age and educational difference had some bearing on women's decision-making ability. Among women who knew their husband's age, the highest proportion with decision-making powers was for those who were of the same age, while the lowest was among women who were 10 or more years younger than their husbands. A higher proportion of women with more or equal schooling as their husbands took FP decisions, while it was the lowest for women who neither attended school.

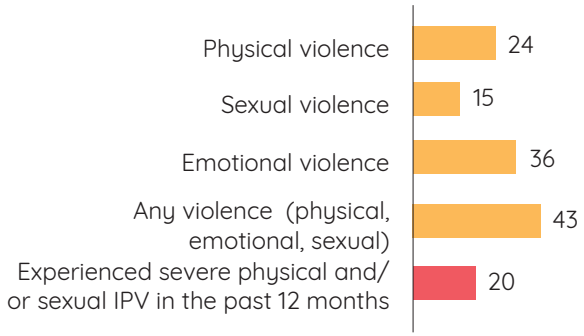
Under fertility characteristics, the lowest proportion of women with no child had decision-making powers. Women with egalitarian gender attitudes, i.e., those who either wanted an equal number of daughters and sons or children of either sex, had the highest participation in FP decisions. Women who had completed their desired family size had higher participation in all four decisions (58%) than those who wanted more children (51%).

Current contraceptive use had a clear relation with women's self-efficacy, which is also reflected in their decisions on family planning. The proportion of women who participated in FP decisions was highest among those who used LARM of contraception, with 77 percent reporting participation in all four decisions, followed by 63 percent among those who used modern short-acting methods. On the other hand, the lowest participation was among women who were not using any method, with only 46 percent saying they participated in all four decisions.

2.6.2 Intimate partner violence experienced by married women

Women's experience of marital violence has a deleterious effect on their self-efficacy and ability to make decisions, especially related to their fertility. The IFPS findings show a high prevalence of intimate partner violence (IPV) experienced by the women respondents. While 43 percent of CMWRA had experienced some form of violence in the year preceding the survey, 36 percent reported experiencing emotional violence, 24 percent physical violence, and 15 percent sexual violence (Figure 21). Moreover, one in five women (20%) reported experiencing severe physical and/or sexual violence by their husbands.

Figure 21: Percentage of CMWRA who have experienced intimate partner violence over 12 months preceding the survey, 2021



As seen in Table 13, division-wise the highest proportion who reported experiencing any form of IPV were among respondents from Meerut (56%), and the lowest were from Jhansi (27%). Of those who reported experiencing severe forms of violence, the highest proportion was from the Aligarh division (30%), while the lowest was from Saharanpur (7%).

Table 13: Division-wise percentage of CMWRA who have experienced intimate partner violence during the 12 months preceding the survey, 2021

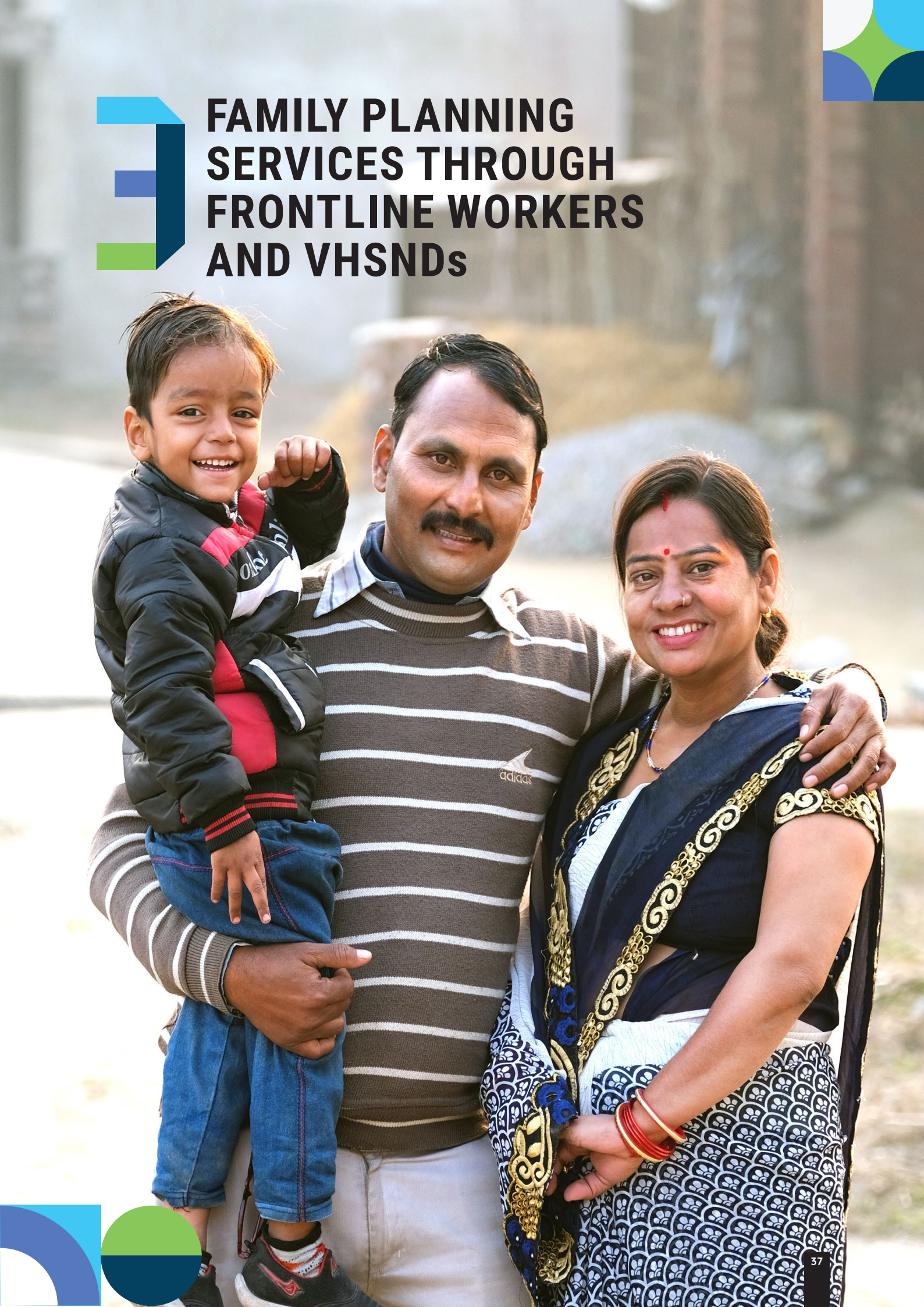
Divisions	Physical violence	Sexual violence	Emotional violence	Physical or sexual violence	Any violence (physical, emotional, sexual)	Experienced severe physical &/or sexual IPV in the past 12 months	Number of women
Agra	26.5	26.4	38.3	40.6	50.0	28.3	654
Aligarh	25.0	29.0	40.5	40.2	51.0	30.3	636
Ayodhya	18.3	8.0	31.5	21.1	34.4	13.5	425
Azamgarh	32.2	20.1	47.9	38.9	53.5	28.5	516
Bareilly	25.6	17.0	27.0	33.7	41.6	19.9	489
Basti	21.4	6.6	35.1	23.7	38.4	14.9	347
Chitrakoot	17.9	11.0	24.4	22.0	31.5	14.6	646
Gonda	29.1	6.7	34.1	30.5	41.0	17.4	291
Gorakhpur	34.0	17.3	45.4	39.5	52.2	25.3	554
Jhansi	16.1	8.3	20.2	18.6	27.1	11.1	627
Kanpur Nagar	15.0	6.9	24.0	18.8	29.8	11.6	471
Lucknow	25.4	9.2	36.0	28.3	42.6	17.4	468
Meerut	31.2	21.3	50.0	38.6	55.7	24.4	678
Mirzapur	26.2	22.5	43.2	37.5	51.5	27.3	630
Moradabad	17.2	6.7	24.0	19.6	29.6	10.1	573
Prayagraj	19.6	22.1	33.1	32.2	43.9	23.7	527
Saharanpur	13.2	4.5	23.6	15.8	28.8	7.3	681
Varanasi	27.3	18.9	43.6	35.5	49.7	24.4	613
Total	**24.3**	**14.8**	**35.6**	**30.6**	**42.9**	**19.9**	**9,826**

Table A.16 presents women respondents' experience of IPV by socio-demographic characteristics. About 47 percent of women aged 30-34 years reported experiencing IPV in the last one year preceding the survey. Similarly, the highest proportion of women to report experiencing severe forms of violence was also among the 30-34 years age-group (23%). However, the proportion of women experiencing IPV is further reduced for older women. Educational levels had an inverse relation with women's experience of IPV. The highest proportion of women with no education reported experiencing any form of IPV (48%) as well as severe forms of violence (22%). A similar trend was found in the case of the educational levels of the husbands. 50 percent of women whose husbands had no education reported experiencing any form of IPV, as against 34 percent among women whose husbands had 10 or more years of education.

With respect to social characteristics, a higher proportion of Hindu women and those belonging to SC/STs reported experiencing violence against non-Hindus and other caste groups. Economic stability and wealth status also had an impact on women's experience of IPV. Women who were working reported a higher experience of any form of violence as against those who were not working (48% versus 42%). By occupation, salaried women reported the lowest experience of any form of violence (32%), while non-agricultural labourers reported the highest (42%). Women from the lowest wealth quintile had the highest proportion reporting any form of violence and severe forms of violence (55% and 29% respectively).

IPV increased with the number of children. While 34 percent of women with no children experienced any form of violence, 48 percent with four or more children did so. With respect to contraceptive use, the highest proportion reporting any form of violence was among women using LARM (52%), while the lowest was among those who were not using any method (39%). Among non-users, infecund women had the highest share who reported experiencing domestic violence.

FAMILY PLANNING SERVICES THROUGH FRONTLINE WORKERS AND VHSNDs



3.1 Profile of frontline health workers (ASHAs, ANMs):

Frontline health workers (FLWs), including ASHAs and ANMs, are essential pillars of the public health system under the NHM. Their connection to the last mile, places them as a critical intermediary between the community and the healthcare system, especially for women's and children's health. Apart from providing health services, they also share information, dispel myths, and help in shaping positive attitudes of community members, especially with respect to reproductive, maternal, newborn and child health practices. Therefore, their background characteristics, trainings, working conditions, levels of awareness and perceptions related to family planning, have a bearing on the quality of services that they provide. As part of IFPS, a total of 419 ASHAs and 370 ANMs across the 18 administrative divisions of Uttar Pradesh were interviewed. Their demographic and socio-economic profiles are illustrated in Table 14 below.

The survey found that most FLWs were close to 40 years, with the mean age being 39 years for ASHAs and 40 years for ANMs. Most ASHAs had at least eight years of education and just 13 percent had studied beyond 12 years. The mean years of schooling of ASHAs were 10.5 years. A majority of the FLWs – 91 percent of the ASHAs and 86 percent of the ANMs were currently married. Almost 20 percent ANMs had the technical qualifications of Basic Health Workers. Most of the ASHAs (71%) and the major share of ANMs (44%) had 10 or more years of experience with 11.7 mean years of experience for ASHAs, and 12.6 mean years for ANMs. Almost 60 percent of the ANMs reported having permanent employment, while the remaining were employed as contractual workers. The majority (97%) of FLWs were Hindus, and the highest share belonged to Other Backward Castes (OBCs). However more than three-quarters (76%) of ASHAs belonged to a caste different from the predominant caste of people in the catchment area.

The husbands of the majority of ASHAs (42%) were cultivators or farmers, while about 15 percent were self-employed. Husbands of most of the ANMs (60%) were employed in other occupations. Further, the average monthly household income for ASHAs was about INR 17100 while that for ANMs was about INR 50300.

Table 14: Profile of FLWs by select background characteristics, 2020-21

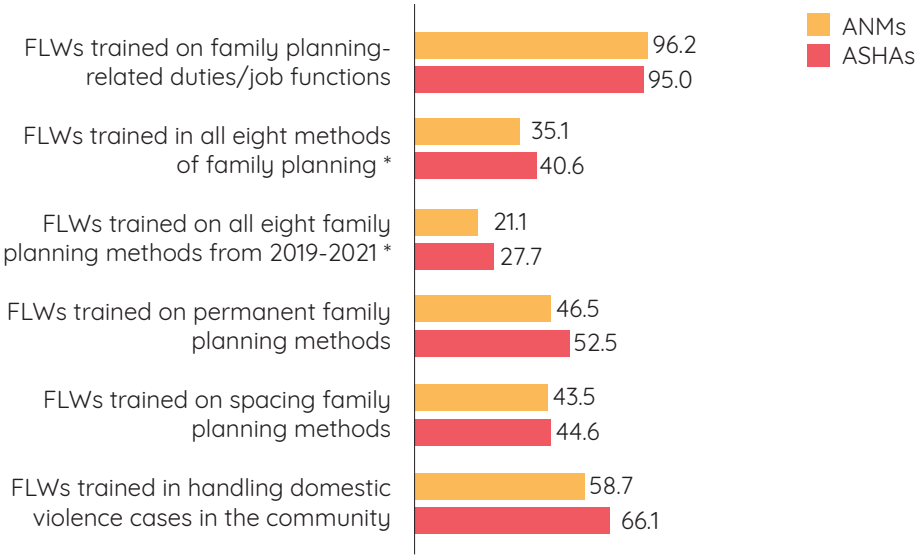
ASHA		ANM	
Age			
<30	9.3	<30	19.2
30-39	45.4	30-39	38.1
40-49	34.8	40-49	11.6
>=50	10.5	>=50	31.1
Mean age	38.8	**Mean age**	39.8
Median age	38.0	**Median age**	37.0
Education		**Current Technical qualification (%)**	
<=8	34.1	ANM	78.7
9-10	24.6	Basic Health Worker	20.3
11-12	27.9	Other	1.1
>12	13.4		
ASHAs with at least 8 years of education	99.1	**NA**	
Mean years of schooling	10.5		
Marital status			
Currently married	90.9	Currently married	86.2
Other*	9.1	Other#	13.8

ASHA		ANM	
Work experience (Years)			
<5	11.9	<5	21.1
5-9	17.2	5-9	34.6
>=10	70.9	>=10	44.3
Mean years of experience	11.7		12.6
		Type of job (percentage)	
NA		Permanent	59.7
		Contractual	40.3
Religion (percentage)			
Hindu	96.9	Hindu	97.3
Non-Hindu@	3.1	Non-Hindu@	2.7
Caste (percentage)			
SC/ST	28.4	SC/ST	28.7
OBC	48.0	OBC	37.6
General	23.5	General	33.8
Predominant religion at the catchment area %			
Religion similar to ASHAs	92.1	NA	
Predominant caste at the catchment area %			
Caste similar to ASHAs	23.9	NA	
Husband's occupation %			
Cultivator/ Farmer	41.5	Cultivator/ Farmer	18.7
Agricultural labour	19.6	Labour	1.9
Self-employed	15.0	Self-employed	19.7
Other	23.9	Other	59.7
Monthly HH income ('000 - percentage)			
<10	38.4	<10	1.4
10-19	31.7	10-19	14.3
>=20	29.8	>=20	84.3
Average monthly HH income (INR)	17,126		50,263.5

*Includes ASHAs who are separated, divorced and widowed
#Includes ANMs who are separated, widowed and never married
@Includes those who are Muslims or belong to another religion

Figure 22 shows the level of training received by FLWs on family planning and domestic violence. While the majority of ASHAs and ANMs (96%) reported that they had received training on family planning-related duties or job functions, just 41 percent ASHAs and 35 percent ANMs received training in all eight methods of family planning. A higher proportion of ASHAs had received training in permanent family planning methods (53%) as against those who received training in spacing methods (45%). With ANMs, the percentage who received training in reversible methods was nearly the same as those who received training in permanent methods (44% and 47% respectively). Further, almost 66 percent ASHAs and 59 percent ANMs reportedly received training for handling cases of domestic violence within the community.

Figure 22: Percentage of FLWs who received training on family planning and domestic violence, Uttar Pradesh, 2020-21



* Eight modern family planning methods: Female sterilization, Male sterilization, Copper-T (IUCD/PPIUCD/PAIUCD), injectables (Antara), Pills (Mala N), Centchroman (Chhaya), Emergency contraceptive pill, and Condoms

3.2 Knowledge and attitudes of FLWs towards family planning

3.2.1 Operational parameters

As community-level public health volunteers, ASHAs are responsible for assisting community members in accessing health services and disseminating information on entitlements as well as good health and hygiene practices (Table 15). They are also responsible for updating birth and death records in their catchment area and distributing essential medicines and contraceptives. In the survey, more than 60 percent of ASHAs reported their engagement in pregnancy care, while 52 percent reported distributing commodities such as IFA pills, ORS, contraceptives etc.

Table 15: Major activities related to pregnancy, birth and postpartum well-being carried out by ASHAs, Uttar Pradesh, 2020-21

Activities	Percent
Pregnancy care to women/ expectant mother	
Counsel women on delivery care	66.4
Arrange transportation for pregnant women	63.3
Birth preparedness and complication readiness (BPCR)	
Inform woman and family on birth preparedness	53.0
Inform woman and family on birth complication readiness	35.8
Informing about Cash incentive scheme for maternity benefit to women	
Inform pregnant woman about JSY scheme*	19.8
Informing pregnant women and lactating women on PMMVY#	11.0
Accompanying women's, children's, and adolescents' for health	
Accompany pregnant women requiring admission	58.5
Accompany children requiring treatment / admission	30.6
Accompany adolescent girls for check-ups	27.5

Activities	Percent
Providing information and services related to health	
Inform community about health services	49.6
Inform woman and family for Post-natal check-ups	49.4
Aware people of village about cleanliness and hygiene	36.5
Provide primary medical care and advice for minor ailments	17.4
Facilitate group meetings for adolescent girls	22.9
Inform about the births and deaths happened in village	28.9
Work with VHSNC@ to develop a village health action plan	22.2
Provide essentials like ORS, IFA pills, contraceptive pills, condoms etc	52.0

*Janani Suraksha Yojana (JSY) is a safe motherhood intervention under India's National Health Mission to reduce maternal and neonatal mortality. The scheme promotes institutional delivery among poor women through cash assistance and delivery and post-delivery care.
#Pradhan Mantri Matru Vandana Yojana (PMMVY) is a centrally-sponsored maternity benefits programme that provides a cash incentive of 5,000 rupees directly to pregnant women and lactating mothers for their first living child.
@Village Health, Sanitation and Nutrition Committees (VHSNCs) are formed at the village level with members of the Gram Panchayat, health workers, community members and the ASHA. Their task is to take collective actions for improving awareness of and access to health services, address local needs, and work for community-based planning and monitoring.

With respect to family planning activities, IFPS captured the extent to which ASHAs fulfilled their roles and responsibilities mandated under the NHM (Table 16). The highest proportion of ASHAs were engaged in routine administrative activities such as listing (60%) and identification of eligible couples (41%), and distribution of contraceptives such as OCPs, centchroman (Chhaya), ECPs and condoms (58%). 47 percent of the ASHAs also reported counselling women about contraceptive methods based on the number of children.

However, fewer ASHAs provided counselling on delaying marriage and childbirth, on the health and economic benefits of spacing of births, information on contraceptive methods and their side effects, and method continuation. Just one in five ASHAs (20%) reported providing information on available contraceptive methods and their side effects. About one in three (35%) said they counselled newly-married couples on delaying childbirth.

Similarly, the proportion of ASHAs who were engaged in follow-up activities such as assisting the ANM for follow-up of contraceptive users, accompanying women for family planning services or referring them to health facilities in case of any complication, and informing couples about incentives provided for sterilization, was also low. One in five (20%) ASHAs followed up on the adoption of family planning with eligible couples. Just over one in 10 ASHAs (11%) referred women with complications to health facilities.

Table 16: Major activities related to family planning carried out by ASHAs, Uttar Pradesh, 2020-21

Activities	Percent
Identification	
Develop a line list of eligible couples	59.7
Identify users having problems with contraceptive usage during home visit	34.6
Develop a list of potential FP users	40.6
Counselling	
Counsel women about appropriate methods based on marital status	32.9
Counsel women about the method based on the number of children	47.0
Counsel the women about side-effects of the methods	20.1
Counsel the women to continue with the method	32.7
Counsel families for the delay in age of marriage	37.5
Counsel newly married couples to delay in age of first childbearing	34.6
Counsel women based upon childbearing intentions (i.e, when and how many children)	28.6
Counsel women on health benefits of family planning	23.9
Counsel women on economic benefits of family planning	23.9
Others	
Follow-up of eligible couples	19.8
Provide information about the different type of contraception	20.1
Provide information on where, when and how to access	20.5
Provide contraceptive methods (OCP/ Chhaya/ ECP and Condoms)	58.2
Assist ANM in the follow-up of contraceptive users	14.1
Accompany woman for family planning services	26.3
Refer women to health facility in case of any complication	11.2
Inform about incentives on male & female sterlization	15.0

IFPS also assessed the confidence of FLWs in counselling couples and women on family planning methods. As seen in Table 17 below, just 9 percent ASHAs and 21 percent ANMs were confident of counselling on all of the nine methods (female and male sterilization, IUCDs, injectables (Antara), daily pills, weekly centchroman (Chhaya), Emergency Contraceptive Pills, condoms and Lactational Amenorrhea Method). About 22 percent ASHAs and 35 percent ANMs reported to be confident to counsel on both the permanent methods: female and male sterilization. Moreover, a larger proportion of ASHAs and ANMs (44% and 55% respectively) expressed confidence to counsel on all temporary contraceptive methods. Further, 60 percent of ASHAs and 73 percent of ANMs reported confidence to counsel on the new contraceptives – injectables (Antara) and centchroman (Chhaya).

Table 17: Percentage of FLWs who are completely confident to counsel eligible couples/women in the community about different family planning methods, Uttar Pradesh, 2020-21

Activities	ASHA	ANM
Permanent methods (FS & MS)	21.5	35.1
Permanent methods (FS / MS)	92.8	97.3
Temporary Methods (CT & Inj. & Mala & Chhaya & ECP & Condom)	44.4	54.9
Temporary Methods (CT & Inj. / Mala / Chhaya / ECP / Condom)	97.9	99.2
LARM (Copper-T & Injectables)	65.9	76.5
LARM (Copper-T / Injectables)	90.2	96.0
Condom	83.3	79.2
Other (Mala & Chhaya & ECP)	59.7	79.2
Other (Mala / Chhaya / ECP)	95.0	98.4
New contraceptives (Antara & Chhaya)	59.9	73.2
New contraceptives (Antara / Chhaya)	83.5	94.6
Other (Copper-T & Mala & ECP)	64.0	81.1
Other (Copper-T / Mala / ECP)	96.2	99.2
Confident on all the spacing methods (Copper-T & Injectables & Mala & Chhaya & ECP)	48.7	64.6
Confident on any of the spacing methods (Copper-T / Injectables / Mala / Chhaya / ECP)	96.7	99.2
Confident on all (Nine) of the above (incl. LAM)	9.3	21.1
Confident on any (Nine) of the above (incl. LAM)	98.6	99.5

Permanent methods: Female Sterilization (FS), Male Sterilization (MS)
Temporary methods: Copper-T (IUCD/PPIUCD/PAIUCD), Injectable contraceptive (Antara), Pills (Mala N), Centchroman (Chhaya), Emergency Contraceptive Pill, Male condom (Nirodh)
Lactational Amenorrhea Method (LAM)

3.2.2 Knowledge about family planning methods

Knowledge of each of the seven methods and Healthy Timing and Spacing of Pregnancy (HTSP)

An important metric for assessing the FLWs' ability to provide appropriate FP advice and services to women in the community is their knowledge of different FP methods and Healthy Timing and Spacing of Pregnancy (HTSP)[12].

The findings of IFPS (Table 18) show that more than two-third of ASHAs and ANMs had medium levels of knowledge about the seven modern contraceptive methods and HTSP. Method-wise, one out of five ASHAs had low knowledge of IUCD and weekly centchroman (Chhaya). Although, a higher proportion of ASHAs (24%) had high levels of knowledge of Emergency Contraceptive Pills (ECPs). The knowledge of injectables (Antara) was better among ASHAs, with 8 percent reporting low knowledge levels and 77 percent with medium knowledge levels.

[12]Healthy timing and spacing of pregnancy (HTSP) is an approach to family planning that helps women and families delay, space, or limit their pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children.

Among ANMs, more than one out of five had low knowledge of injectables (Antara) and ECPs (20% and 24% respectively). However, more than one-fourth ANMs also had high knowledge of injectables (Antara) (26%). About two-third of ANMs had medium levels of knowledge about male sterilization, IUCD/PPIUCD, daily pills, and centchroman (Chhaya). With respect to knowledge of HTSP, the majority of both ASHAs and ANMs reported medium knowledge (72% and 71% respectively), while only 10 percent of ASHAs and 15 percent of ANMs had high knowledge of HTSP.

Table 18: Knowledge levels of FLWs on healthy timing and spacing of pregnancy, and family planning methods, Uttar Pradesh, 2020-21

Family planning methods	ASHA (%)			ANM (%)		
	Low	Medium	High	Low	Medium	High
Permanent methods	13.4	72.1	14.6	17.6	67.6	14.9
Temporary methods	16	68.5	15.5	15.7	68.9	15.4
Long-acting reversible methods	14.6	70.9	14.6	18.1	64.6	17.3
Female sterilization	18.6	63	18.4	11.4	64.1	24.6
Male sterilization	17.7	73.3	9.1	10.3	74.3	15.4
Copper-T (IUCD/PPIUCD/PAIUCD)	20.3	68	11.7	17.3	74.1	8.7
Injectable contraceptive (Antara)	8.1	77.3	14.6	20.3	54.1	25.7
Mala-N contraceptive pills	19.1	59.7	21.2	13	75.1	11.9
Centchroman pills (Chhaya)	21.7	63.5	14.8	10.8	77.6	11.6
Emergency contraception pills (ECPs)	16.5	59.2	24.3	23.8	64.9	11.4
Healthy timing and spacing of pregnancy	18.4	71.6	10	14.3	70.5	15.1

A total of ten indicators were used to assess FLWs' awareness of HTSP, and knowledge of seven contraceptive methods (FS, MS, Copper-T, injectables (Antara), Mala, centchroman (Chhaya) , and ECP). With these 10 items, a composite score was calculated. Based on mean and standard deviation, three categories were determined: Low, Medium, and High

The findings on the proportion of ASHAs with low knowledge of FP methods and HTSP by background characteristics are shown in (Table A.17). Age-wise, more of younger ASHAs had low knowledge of FP methods, except in the case of modern spacing methods (daily and centchroman (Chhaya) and ECPs). For modern spacing methods, most ASHAs to score low on knowledge were 50 years or older (16%). Most ASHAs under 30 years had low knowledge of LARMs (IUCD and injectables) and HTSP (28%) in comparison to other age groups. With respect to the relation of FP knowledge with education, ASHAs with higher educational backgrounds had high knowledge of modern methods and HTSP. By caste groups, a higher proportion of ASHAs from Scheduled Castes or Scheduled Tribes (SC/ST – 19% and 17% respectively) had low knowledge of LARM and modern spacing methods as against those from the General category (7% and 9% respectively). Years of work experience were proportional to the FLW's knowledge about FP methods, as only 17 percent of ASHAs with 10 or more years of experience had low knowledge of HTSP as compared to 28 percent ASHAs with less than five years of experience. Region-wise, ASHAs from the Central region of Uttar Pradesh were found to have overall better levels of knowledge of family planning methods. Further, a higher proportion of ASHAs in the Bundelkhand region had low knowledge of LARMs (39%), modern spacing methods (29%) and HTSP (45%).

Myths and misconceptions related to family planning methods reported by frontline health workers

Frontline health workers have to deal with barriers to the adoption of FP methods arising out of commonly prevalent myths and misconceptions related to contraceptives. The community component of IFPS captured information from the FLWs about prevalent myths and misconceptions and based on a set of items, myths for each method were classified as low or high. Figure 23 shows that FLWs reported an overall higher prevalence of myths and misconceptions related to IUCDs and PPIUCD (49% of both ASHAs and ANMs). Further, almost 37 percent ASHAs and 45 percent ANMs reported high levels of myths and misconceptions regarding injectables (Antara).

Figure 23: Percentage of FLWs reporting high levels of myths and misconceptions related to contraceptive methods prevalent in communities, Uttar Pradesh, 2020-21

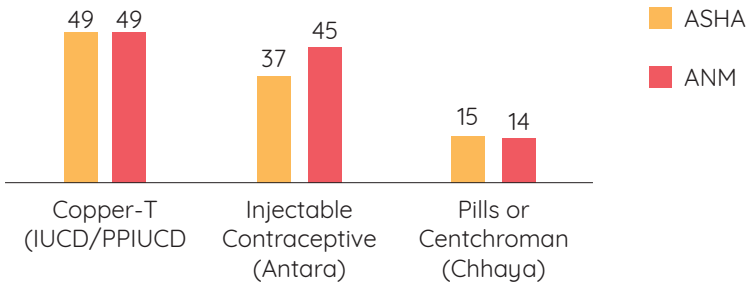
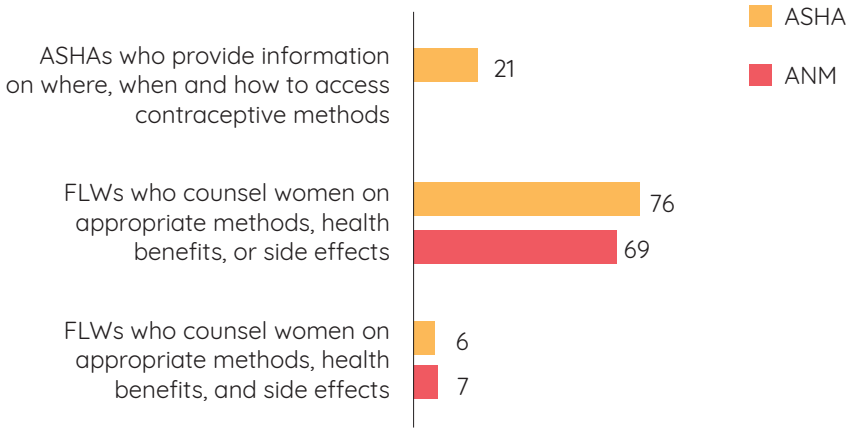


Table A.18 looks at the prevalence of myths and misconceptions reported by ASHAs, on their background characteristics. By age, the highest proportion of ASHAs aged 40-49 years reported a high prevalence of myths related to all three LARMs. ASHAs with higher education had lower reporting of myths and misconceptions regarding FP methods. Further, a higher proportion of ASHAs from the SC/ST category reported high levels of myths and misconceptions related to IUCDs and pills or centchroman. On the contrary, a higher proportion of ASHAs from the General category reported high levels of myths and misconceptions related to injectables (Antara). By years of experience, the ASHAs with 10 or more years of work experience reported the highest levels of myths and misconceptions for IUCDs. For injectables (Antara) and pills or centchroman (Chhaya), a higher proportion of ASHAs with less than five years of work experience reported a high prevalence of myths and misconceptions. Looking at regional variations, the highest proportion of ASHAs from the Central region reported high levels of myths and misconceptions related to all three contraceptive methods.

3.2.3 Attitudes and practices related to family planning services for newlywed and lower parity women

Appropriate and timely advice on FP options to couples and married women helps them in exercising choice. However, social norms related to fertility behaviours often influence the nature of information that FLWs share with community members. The findings of the community provider component of IFPS show that overall, just one in five ASHAs provided complete information related to FP (21%), including where, when and how to access contraceptives (Figure 24). Only 6 percent ASHAs and 7 percent ANMs provided complete counselling to women on appropriate contraceptive methods, their health benefits and side effects.

Figure 24: Percentage of FLWs performing activities related to family planning, Uttar Pradesh 2020-21



As seen in Figure 25 below, overall, a slightly higher proportion of ASHAs discussed temporary methods of contraception (53%) as compared to permanent methods (48%) with married women. Among ANMs, on the other hand, a higher proportion discussed permanent methods of contraception (68%) than temporary methods (32%). Figure 26 shows that while about two-thirds of ASHAs counselled women about appropriate FP methods based on their marital status or number of children (64%), very few ASHAs counselled women on all aspects, including benefits, side effects and access (2%).

Figure 25: Percentage of FLWs discussing family planning methods with married women, Uttar Pradesh, 2020-21

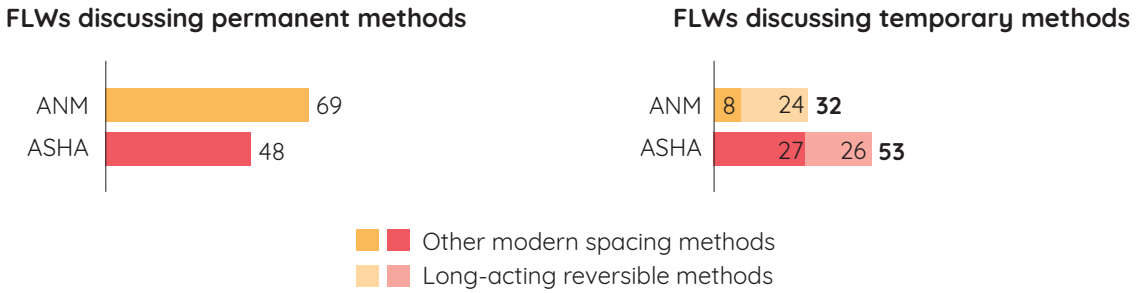
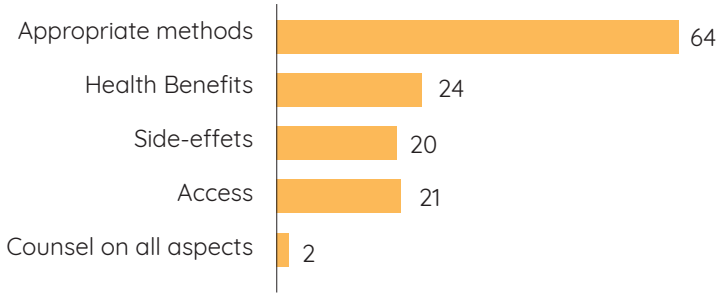


Figure 26: Percentage of ASHAS who counselled women on different FP methods by number of children



The survey looked at differences in the counselling offered by FLWs to women or couples based on their fertility preferences (Table 19). With newlyweds, 75 percent of ASHAs and 83 percent of ANMs discussed methods to delay the first birth, and 70 percent ASHAs and 75 percent ANMs told them of the benefits of FP. However, very few ASHAs (8%) and ANMs (12%) provided counselling on all aspects of FP to newlyweds, including available contraceptive methods, their benefits and side effects, and where they could be obtained. Among methods suggest to delay the birth of their first child, the highest proportion of FLWs recommended condoms (ASHAs – 90%, ANMs – 89%), followed by daily pills (ASHAs – 64%, ANMs – 68%). The least recommended were ECPs (ASHAs - 5%, ANMs – 12%), followed by injectables (Antara) (ASHAs – 18%, ANMs 25%).

Similarly, for married women or couples who wanted to space their children, more than two-thirds of FLWs discussed different reversible contraceptive methods (ASHAs - 64%, ANMs – 65%) and their benefits (ASHAs - 64%, ANMs – 68%), but a much lower proportion provided information on the side- effects and points of access to the methods. In this case, also, the condom was the most suggested method by both ASHAs and ANMs (70% and 78% respectively), followed by daily pills (67% and 76% respectively). After ECPs, the least recommended method for spacing was the LARM centchroman (Chhaya) (ASHAs – 48%, ANMs – 58%).

In their interaction with married women or couples who do not want to have any more children, the FLWs were found to follow a similar pattern. Hardly any FLWs provided complete information on the choice of methods, benefits and side-effects of each method and where to access them. Among the methods suggested, there was a significant skew towards female sterilization, as a majority of FLWs recommended female sterilization, while more than one-third FLWs recommended male sterilization and a little more than one-fourth of FLWs suggested condoms or daily pills.

Table 19: Percentage of FLWs who discuss different aspects of family planning methods with reproductive-age women of differing fertility-related aspirations, Uttar Pradesh, 2020-2021

	ASHA	ANM
Discussion on family planning with newlyweds		
Methods to delay the birth of the first child	75.4	83.0
Benefits of family planning	70.4	75.4
Side effects of family planning methods	26.7	32.4
Where to obtain contraceptive methods	49.6	42.2
Different methods of family planning, its benefits and side effects	23.9	28.4
Available methods, their benefits, side effects, and where they can be obtained	7.6	12.4
Delaying methods suggested		
Copper-T (IUCD/PPIUCD/PAIUCD)	16.7	19.5
Injectable contraceptive (Antara)	17.7	24.6
Pills (Mala N)	63.5	68.4
Centchroman (Chhaya)	32.7	42.7
Emergency contraceptive pill	5.0	11.9
Condoms	90.0	88.7
Discussion on family planning with women/couples who want to space their children		
Different reversible methods	63.5	65.1
Benefits	64.2	67.8
Side-effects	21.2	27.3
Access	26.3	34.1
Discuss all above	1.2	3.5
Spacing methods suggested:		
Copper-T (IUCD/PPIUCD/PAIUCD)	53.2	65.7
Injectable contraceptive (Antara)	51.8	60.0
Pills (Mala N)	67.1	76.0
Centchroman (Chhaya)	47.5	57.8
Emergency contraceptive pill	7.6	11.6
Condoms	69.7	77.8
Discussion on family planning with women/couples who don't want to have any more children		
Different methods	59.2	63.2
Benefits	59.0	64.9
Side-effects	20.8	22.7
Access	39.9	48.4
Discuss all above	1.2	5.1

	ASHA	ANM
Contraceptive methods suggested:		
Female sterilization	94.0	92.7
Male sterilization	35.1	38.1
Copper-T (IUCD/PPIUCD/PAIUCD)	54.7	58.4
Injectable contraceptive (Antara)	39.4	38.7
Pills (Mala N)	25.3	26.5
Centchroman (Chhaya)	12.2	17.6
Emergency contraceptive pill	4.3	4.6
Condoms	26.3	23.5

Table 20 shows the methods recommended by FLWs to married women based on their parity. For zero parity women, condoms were the most recommended method (86% ASHAs and 82% ANMs), followed by daily or centchroman (Chhaya) (52% ASHAs and 61% ANMs) by FLWs. Moreover, just 9 percent ASHAs and 13 percent ANMs recommended injectables (Antara). For women with low parity, an equal proportion of ASHAs (85%) recommended condoms and daily or centchroman (Chhaya), while 79 percent ANMs suggested condoms. About two-thirds of ASHAs (68%) and almost three-fourths (73%) of ANMs suggested IUCDs, while 59 percent ASHAs and 61 percent ANMs recommended injectables. IUCDs were the topmost method recommended by ASHAs (80%) for women with two children, while an equal share of ANMs recommended IUCDs and female sterilization (84%). Nearly an equal proportion of FLWs (64%) recommended injectables (Antara) and daily or centchroman (Chhaya) to women with two children. While discussing FP methods with women who had three or more children, nearly all FLWs recommended female sterilization, followed by IUCDs.

IFPS also looked at the determinants of method recommendations by FLWs based on the gender of children that women had. The top method recommended to women with one girl child remained condoms, followed by daily or centchroman (Chhaya), but a much lower proportion of FLWs recommended IUCDs (ASHAs – 48%, ANMs – 58%) and injectables (ASHAs – 43%, ANMs – 52%), as compared to the overall percentage for those with one child. Looking at the recommendations for women with two children, as compared to those with two girl children, condoms continued to be the topmost method suggested in the latter case (ASHAs – 78%, ANMs – 77%), followed by daily or centchroman (Chhaya) (ASHAs – 78%, ANMs – 82%). Sterilization was not recommended at all to women with two girl children. This reflects the social pressure on women to continue childbearing till they have sons and the resultant practice of the FLWs.

Table 20: Recommendations of FLWs on contraception for women of different parities, (percentage) Uttar Pradesh, 2020-21

Contraception recommendations to women of different parities	ASHA	ANM
Parity '0'		
Condoms	85.7	82.2
Mala-N Contraceptive Pills / Centchroman Pills (Chhaya)	52.3	60.5
Injectable contraceptive (Antara)	9.3	12.7
Parity '1'		
Condoms	85.0	78.7
Mala-N Contraceptive Pills / Centchroman Pills (Chhaya)	85.0	87.3
Copper-T (IUCD/PPIUCD/ PAIUCD)	67.8	72.7
Injectable contraceptive (Antara)	59.4	61.4
Parity '2'		
Copper-T (IUCD/PPIUCD/ PAIUCD)	80.0	84.3
Female Sterilization	78.8	84.3
Injectable contraceptive (Antara)	64.4	64.3
Mala-N Contraceptive Pills / Centchroman Pills (Chhaya)	64.0	64.9
Parity '3+'		
Female Sterilization	98.3	98.7
Copper-T (IUCD/PPIUCD/ PAIUCD)	54.7	59.5
Injectable contraceptive (Antara)	34.8	42.7
Mala-N Contraceptive Pills / Centchroman Pills (Chhaya)	30.8	37.0
With 1 girl child		
Condoms	83.1	78.9
Mala-N Contraceptive Pills / Centchroman Pills (Chhaya)	74.2	84.9
Copper-T (IUCD/PPIUCD/ PAIUCD)	48.0	57.6
Injectable contraceptive (Antara)	43.4	51.9
With 2 girl children		
Condoms	78.0	76.8
Mala-N Contraceptive Pills / Centchroman Pills (Chhaya)	77.6	82.2
Copper-T (IUCD/PPIUCD/ PAIUCD)	73.5	80.5
Injectable contraceptive (Antara)	60.6	67.0

3.3 Family planning service delivery through frontline health workers and community processes

The IFPS found almost universal knowledge among FLWs regarding community platforms such as Village Health Sanitation and Nutrition Days (VHSND), and a high level of knowledge of the AAA forum and monthly cluster meetings to discuss FP issues (Table 21). However, just one-third of ASHAs and one-fourth of ANMs reported knowledge of SHGs as the platform to discuss FP with women. 67 percent ASHAs and 59 percent ANMs knew about fixed day services for sterilization and IUCD procedures, but very few knew about the Saarthi family planning outreach vans (ASHAs – 17%, ANMs – 15%). Just one in 10 ASHAs and one in 20 ANMs knew about all six community platforms to discuss FP issues with community members. With respect to the program innovations in the Mission Parivar Vikas (MPV) districts, a significant share knew about the Nayi Pahal or Shagun kits for newlyweds and the Saas Bahu Sammelans.

Table 21: Percentage of FLWs who reported knowledge of community platforms and program innovations to discuss family planning with clients, Uttar Pradesh, 2020-21

Contraception recommendations to women of different parities	ASHA	ANM
VHSND meetings	99.8	100.0
AAA (Triple A) forum meetings	95.0	94.1
Monthly cluster meeting	82.8	75.1
SHG	33.9	27.0
Saarthi Van	17.2	15.1
Fixed Day Services for sterilization and IUCD	67.1	58.9
Knowledge of all (6) above platforms	10.0	4.9
Know about Nayi Pahel/Shagun Kit*	87.1	80.0
Heard about the Saas Bahu Sammelan*	92.0	95.9

*Indicators considered only for MPV districts: ASHAs: N=326, ANMs: N=290

Likewise, ASHAs and ANMs reported that they universally participated in VHSND meetings. FLWs also reported high participation in the AAA forum and monthly cluster meetings. However, just 27 percent ASHAs and 16 percent ANMs participated in SHG meetings, and 23 percent ASHAs and 15 percent ANMs participated across all platforms (Figure 27). Table 22 shows the services provided by FLWs at the community platform meetings. The proportion of FLWs who reported discussing FP issues at their last community meeting was highest for VHSNDs and lowest for the AAA forums. Overall, a high proportion of FLWs reported providing FP services at their last VHSND (ASHAs – 86%, ANMs – 88%). Looking at a breakdown of services provided, 52 percent of ASHAs and 59 percent of ANMs reported providing counselling on the basket of FP choices. A slightly lower proportion reported distributing condoms and pills to beneficiaries. However, very few provided information on the importance of family planning in the ante-natal and postpartum period, where to obtain contraceptives, how to use them and their side-effects, precautions in the case of complications and switching from one method to the other (Table 22). Less than 1 percent ASHAs and 2 percent ANMs reported administering injectables (Antara). Hardly any ASHAs and ANMs reported providing all FP services including discussing the basket of contraceptive choices, informing clients on where to access them and side-effects, and providing consultation on complications.

Looking at specific contraceptive methods, more than two-thirds of FLWs reported providing condoms and daily pills to community members at VHSND meetings. 55 percent ASHAs and 64 percent ANMs said community members had received weekly centchroman (Chhaya). With respect to the use of program innovations, a very low proportion of FLWs informed community members of the location of Saarthi vans. In MPV districts, 55 percent ASHAs reported distributing Nayi Pahal or Shagun kits, and 61 percent reported that the kits were useful in communicating with newlyweds. 78 percent ASHAs and 79 percent ANMs reported participating in Saas Bahu Sammelans in their catchment area, and ASHAs reported mobilizing an average of five mothers-in-law – daughter-in-law pairs for the last Sammelan. On the other hand, just one-third (36%) ASHAs reported receiving incentives for mobilizing mother–in–law–daughter–in–law pairs, and for distributing family planning kits to newlywed couples (Table 22).

Figure 27: Percentage of FLWs who reported participating in community platforms, Uttar Pradesh, 2020-21

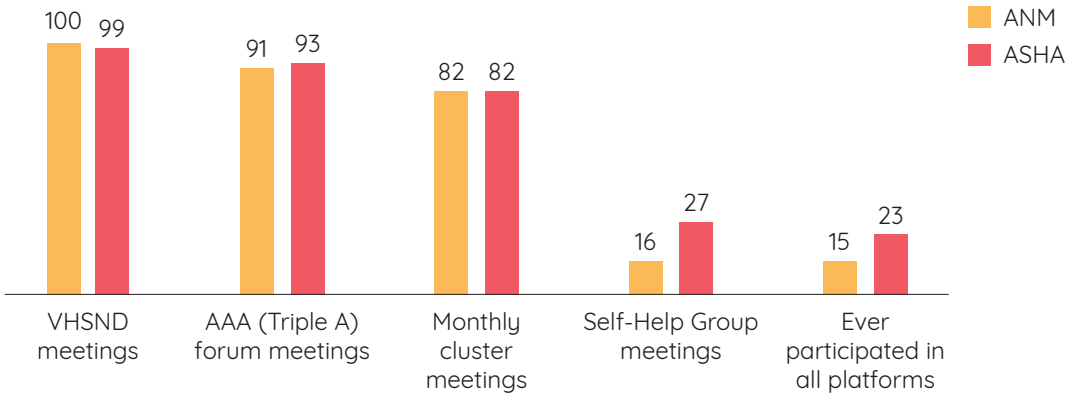


Table 22: Percentage of FLWs who reported supporting FP activities at community platforms, Uttar Pradesh, 2020-21

	ASHA	ANM
FLWs who reported family planning issues were discussed at their last community meeting		
VHSND meetings	87.1	94.1
AAA (Triple A) forum meetings	55.1	64.6
Monthly cluster meeting	56.8	66.8
FLWs who reported FP services were provided during the last VHSND		
Family planning-related services were provided in their last VHSND meeting	86.4	88.4
Counselled on the basket of choice of FP	51.6	58.9
Distributed Condoms & pills to beneficiaries	47	50.8
Discussed importance of FP in the ANC period and postpartum	39.4	42.7
Informed on the place of receiving methods of contraception	37.7	43.2
Discussed how to use contraceptives	29.6	37
Explained method specific side-effects	16.7	16.5
Informed about switching over from one method to another	16.2	19.2
Discussed what to do in case of complication	12.2	16.8
Administered Injectable contraceptive	0.7	2.2
Discussed basket of choices, informed on access, side-effects, or consultation on complications	69.2	75.7
Discussed basket of choices, informed on access, side-effects, and consultation on complications	0.5	2.2
FLWs reported different FP methods received by the community at VHSND meetings		
Centchroman (Chhaya)	55.1	63.5
Mala N	66.1	69.5
Condoms	66.4	68.7
Use of community platforms and FP program innovations by FLWs		
Informed community members about the location of the Saarthi van in their catchment area	11.2	9.2
AHSAs who distributed Nayi Pahel/Shagun Kits to newlyweds in the past 12 months*	54.9	NA
ASHAs who reported that the NPK was helpful when communicating with newlywed women in the past 12 months*	61.4	NA
ASHAs who received incentives for distributing Nayi Pahel/ Shagun Kits*	35.6	NA
FLWs who have participated in the Saas Bahu Sammelan in their catchment area*	77.6	79.3

	ASHA	ANM
Average number of mother-in-law and daughter-in-law pairs mobilized by ASHAs for the last Saas Bahu Sammelan*	5	NA
ASHAs who received incentives for mobilizing participants for Saas Bahu Sammelan*	35.6	NA

*Indicators considered only for MPV districts: ASHAs: N=326, ANMs: N=290

3.4 Working conditions and performance drivers for frontline health workers

3.4.1 Working conditions of frontline health workers

IFPS looked at the volume of clients the FLWs serve and their proximity to the community, in the catchment areas. The figures below show the populations covered by them and their proximity to the catchment areas. Most of the ASHAs (88%) lived within the catchment area, while only 17 percent of ANMs lived at the sub-centre where they worked (Figure 28).

Figure 28: Percentage of FLWs by their place of residence with respect to the catchment area

Almost 42 percent ASHAs served catchment areas of up to 1,000 population, while almost half (49%) served catchment areas of 1,001 to 1,500 people (Figure 29). Nearly two-thirds (62%) of ANMs served catchment areas of the size of 5,001 to 10,000 people. Almost 42 percent of ANMs covered five to nine revenue villages, and the mean number of villages they covered was 7.6 (Figure 30).

Figure 29: Percentage of FLWs by the population size of the catchment area they served, Uttar Pradesh, 2020-21

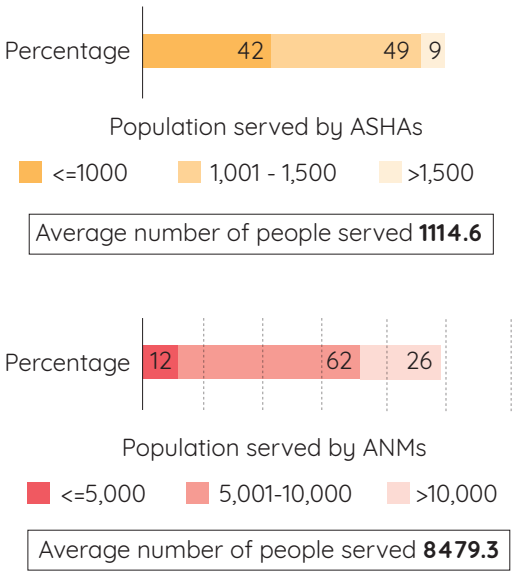


Figure 30: Percentage of ANMs by the number of revenue villages

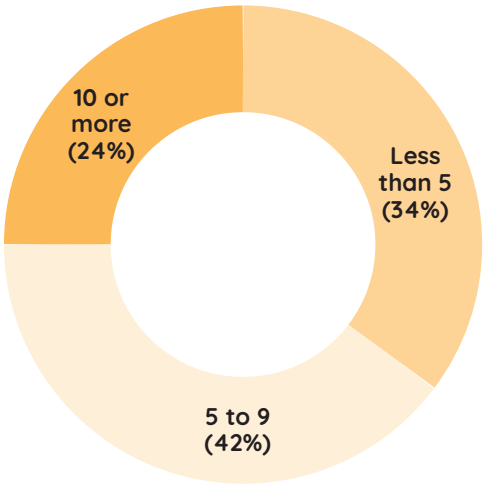


Table 23 shows the workload and conditions under which frontline health workers carry out their designated duties, as reported by them. With respect to the workload, ASHAs reported interacting with an average of 43.9 eligible women in the last three months, and ANMs reported interacting with an average of 50.1 eligible women over the same period. Further, ASHAs reported almost 17 household visits per week while ANMs also reported undertaking 12.5 home visits on an average. Due to their heavy workload and social barriers to FP practices, the ability of FLWs to perform their tasks adequately is reliant to an extent on the support they receive from their families and supervisors. Almost three- fourths (72%) ASHAs and two-thirds of ANMs (67%) reported receiving support from their husband or family members in their routine work. The majority of ANMs (92%) reported receiving supportive supervision by their supervisor in the last 30 days, as compared to ASHAs (64%). Almost 60 percent ANMs said they had permanent jobs, while the remaining were on contractual employment.

Table 23: Percentage/average number of FLWs by their workload and working conditions, Uttar Pradesh, 2020-21

	ASHA	ANM
Workload reported by FLWs		
Average number of eligible women interacted by ASHAs in the last three months	43.9	501.3
Average number of working days a week	5.5	6.2
Average number of working hours a day	4.9	7.0
Average number of households visited in a week	17.1	12.5
Work environment – percentage of FLWs who received support / experienced violence or threats		
Support from husband or family members in their routine work	72.3	66.5
Supportive supervision visits from the supervisor in the last 30 days	63.5	92.4
Experienced violence or threats from clients/community/doctor/other health professionals in the last 1 year	4.1	6
Type of job of ANMs		
Permanent	-	59.7
Contractual	-	40.3

The survey asked FLWs about specific difficulties they faced while carrying out their duties. Table 24 shows the percentage of FLWs by the perceived difficulties they reported. Lack of community support (ASHAs – 33%, ANMs – 36%), followed by lack of supplies and drugs (ASHAs – 30%, ANMs – 22%), was reported by the highest share of FLWs.

Table 24: Percentage of FLWs by perceived difficulties reported by them, Uttar Pradesh, 2020-21

Perceived difficulties	ASHA	ANM
Lack of supplies and drugs	30.1	22.2
Lack of training or knowledge	18.6	11.9
Delayed payments	14.9	8.1
Lack of equipment	7.4	11.4
Lack of physical security	6.2	6.8
Lack of motivation	3.8	2.7
Lack of feedback on performance	3.6	3.5
Lack of communication with health facility	2.2	1.1
Lack of coordination with health facility	1.4	1.4
Reported at least one difficulty from those mentioned above	44.9	40.8
Lack of community support	32.5	36
Lack of supervision	6.2	4.3

Table 25 shows specifically the percentage of FLWs who reported being supervised, and receiving job-aids and training. Nearly all (96%) ANMs reported having a supervisor. A relatively lower proportion of ANMs (32%) and ASHAs (14%) reported receiving job aids or IEC materials for their routine FP work. Training of FLWs is critical for them to be able to adequately serve the reproductive health needs of community members. The need for ongoing training is especially important with the introduction of new methods of contraception (injectables (Antara) and non-hormonal contraceptive pills) into the FP programme. However, a deep dive into specific aspects of training received by FLWs found inadequate levels as reported by them. Only 41 percent ASHAs and 35 percent ANMs reported of being trained in all eight methods of family planning. Those who received training on permanent methods were higher than those who received training on temporary methods, especially for ASHAs. A relatively higher proportion reported being trained in handling domestic violence cases in the community (ASHAs – 66%, ANMs – 59%).

Table 25: Percentage of FLWs by those who reported receiving supervision, jobs aids and training, Uttar Pradesh, 2020-21

	ASHA	ANM
Percentage of FLWs who received supervision and job aids		
ANMs who have a supervisor or someone who monitors their work	NA	96.2
FLWs who ever received any job aids or IEC material to use in their routine family planning work	14.1	32.4
FLWs using job aids/IEC materials in their routine family planning work#	12.2	31.1
Percentage of FLWs who received training		
Trained in all eight methods of family planning*	40.6	35.1
Trained on permanent family planning methods	52.5	46.5
Trained on temporary family planning methods	44.6	43.5
Trained on all eight family planning methods from 2019-2021*	27.7	21.1
Trained in handling domestic violence cases in the community	66.1	58.7

ASHAs: N=59, ANMs: N=120
*Female sterilization, Male sterilization, Copper-T (IUCD/PPIUCD/PAIUCD), injectables (Antara), Pills (Mala N), Centchroman (Chhaya), Emergency Contraceptive Pill, Condoms

Table 26 summarizes the contraceptive methods that FLWs preferred to discuss with women and those for which they reported experiencing pressures from the community while promoting. The highest proportion of FLWs reported female sterilization as the preferred method to discuss with married women (ASHAs – 47%, ANMs – 67%). Among reversible methods, IUCDs were the most preferred, followed by condoms for ASHAs and injectables (Antara) for ANMs. Just 4 percent ASHAs and 2 percent ANMs said they preferred to discuss centchroman (Chhaya) as a method of family planning. The lowest preference was for ECPs, followed by male sterilization. A majority of FLWs (ASHAs – 87%, ANMs – 85%) said there was no pressure from the community for promoting a specific method, indicating that demand for FP methods was low. Among the methods that FLWs did report experiencing pressure on to promote, female sterilization was cited by the most (7%). This was followed by injectables (Antara) cited by 4 percent of ANMs, and male sterilization cited by 3 percent ASHAs.

Table 26: Percentage FLWs by preferred family planning methods discussed with women, and community pressure experienced while promoting them, Uttar Pradesh, 2020-21

Methods	Preferred methods to discuss		Experienced community pressure while promoting	
	ASHA	ANM	ASHA	ANM
Female sterilization	46.5	67.3	6.7	7.3
Copper-T (IUCD/PPIUCD/PAIUCD)	17.9	17.3	0.2	0.3
Condoms	17.4	1.6	0.5	0.0
Injectables (Antara)	7.9	6.2	2.2	4.1
Pills (Mala N)	5.3	5.1	0.5	0.0
Centchroman (Chhaya)	3.6	1.6	0.0	0.3
Male sterilization	1.0	0.8	2.9	3.0
Emergency contraceptive pill	0.2	0.0	0.0	0.0
Other	0.2	0.0	-	-
No pressure to promote any method	-	-	87.1	85.1

3.4.2 Knowledge, motivation and performance of frontline health workers

Financial incentives to service providers are meant to encourage them to advance FP practices among community members. Knowledge of these incentives is the first step towards fulfilling the objective of having greater engagement by FLWs in the program. Table 27 shows the awareness among FLWs regarding financial incentives provided to ASHAs for various FP activities. Overall, 42 percent ASHAs and 12 percent ANMs were aware of incentives to ASHAs for all FP work or activities. Method-wise, the highest proportion of FLWs (ASHAs - 90%, ANMs – 84%) were aware of incentives to ASHAs for promoting limiting methods. Almost 73 percent ASHAs and 62 percent ANMs were aware of incentives to ASHAs for promoting LARM. A high proportion of ASHAs were aware of incentives for counselling couples on their fertility and FP practices – encouraging newlyweds to delay childbearing by two years, counselling couples with one child to have at least three years' spacing between children, and convincing couples to adopt a permanent method after two children. More than half of ASHAs (59%) had knowledge of incentives to them for promoting PAIUCD.

While knowledge of financial incentives was fairly high among FLWs, the share of ASHAs who received incentives for various activities was low (Table 28). Only 15 percent ASHAs received incentives for promoting limiting methods, while just 6 percent received them for spacing methods. Only 9 percent ASHAs reported receiving incentives for promoting LARMs. Method-wise, the highest share of ASHAs to receive incentives was for promoting PPIUCDs (21%). Almost 18 percent ASHAs had received per dose incentives for the administration of injectables (Antara).

Table 27: Percentage of FLWs who had knowledge of FP incentives, Uttar Pradesh, 2020-21

Knowledge of incentive for family planning activities	ASHA	ANM
FLWs who know of incentive to ASHAs for encouraging newly married couples to delay their first child by two years using a spacing method	81.9	72.7
FLWs who know of incentive to ASHAs for counselling and encouraging eligible couples to space their first and second child by 3 years using a spacing method	81.6	72.2
FLWs who know of incentive to ASHAs for counselling and ensuring eligible couples opt for a permanent method (FS/MS*) after the birth of two children	85.0	80.5
FLWs who are aware of incentive to ASHAs for female sterilization	85.4	79.7
FLWs who are aware of incentive to ASHAs for male sterilization	65.6	62.2
FLWs who are aware of incentive to ASHAs for PPS*	68.5	60.8
FLWs who are aware of incentive to ASHAs for PPIUCD*	79.5	70.3
FLWs who are aware of incentive to ASHAs for PAIUCD*	59.2	48.4
FLWs who are aware of incentive to ASHAs for per dose administration of injectables (Antara)	75.4	69.5
ANMs who are aware of incentive to ASHAs for distributing Nayi Pahal Kit to newly-married couples	NA	27.3
ANMs who are aware of the incentive to ASHAs for mobilizing mother-in-law – daughter-in-law pairs for Saas Bahu Sammelan	NA	32.7
FLWs who are aware of incentives to ASHAs for all family planning activities	42.0	11.6
FLWs who are aware of incentive to ASHAs for spacing methods	74.5	67.0
FLWs who are aware of incentive to ASHAs for limiting methods	89.7	83.5
FLWs who are aware of incentive to ASHAs for Long-acting reversible methods (LARM)*	72.8	62.2

*FS - Female Sterilization | MS - Male Sterilization | IUCD - Intra-Uterine Contraceptive Device | PPIUCD - Postpartum Intrauterine Contraceptive Devices | PAIUCD – Post-Abortion Intrauterine Contraceptive Devices | PPS - Postpartum Sterilization | ECP - Emergency Contraceptive Pill | LARM - Long-Acting Reversible Method (includes IUCD and Antara)

Table 28: Percentage of ASHAs who received incentives for FP activities, Uttar Pradesh, 2020-21

Receipt of incentives by ASHAs for family planning activities	
ASHAs who received incentives for encouraging newlyweds to delay having their first child for two years after marriage using a spacing method	13.8
ASHAs who received incentives for counselling and ensuring eligible couples space their children by three years using a spacing method	12.2
ASHAs who received incentives for counselling and ensuring eligible couples to opt for permanent methods (male/female sterilization) after two children were born	12.7
ASHAs who received incentives for female sterilizations	13.8
ASHAs who received incentives for male sterilizations	1.0
ASHAs who received incentives for PPS	3.6
ASHAs who received incentives for PPIUCD	21.0
ASHAs who received incentives for PAIUCD	1.2
ASHAs who received incentives for per dose administration of injectables (Antara)	17.9
ASHAs who received incentives for all family planning activities	0.0
ASHAs who received incentives for spacing methods	5.7
ASHAs who received incentives for limiting methods	15.0
ASHAs who received incentives for Long-Acting Reversible Methods (LARM)*	8.6

*LARM - Long-Acting Reversible Method (includes IUCD and Antara)

The IFPS findings on ANMs who had correct knowledge of financial incentives for ASHAs with respect to family planning activities are shown in Table 29. Overall, the percentages of ANMs with correct knowledge were lower than that of ASHAs. With respect to family planning methods, 55 percent had correct knowledge of incentives for promoting spacing methods, 45 percent on incentives for promoting limiting methods, and 37 percent on incentives for LARMs. A very low share of ANMs were aware of ASHA's incentives for distributing Nayi Pahal FP kits to newly-married couples (19%), and mobilizing mother–in–law–daughter–in–law pairs for Saas Bahu Sammelans (12%).

Table 29: Percentage of ANMs who had correct knowledge of FP incentives, Uttar Pradesh, 2020-21

Correct knowledge of incentives for FP activities	
Has correct knowledge of incentives to encourage newlywed couples to delay their first child for two years after marriage	55.1
Has correct knowledge of incentives to counsel and ensure eligible couples space their first and second child by 3 years using a spacing method	51.6
Has correct knowledge of incentives to encourage and ensure eligible couples opt for a permanent method (FS/MS) after the birth of two children	36.0
Has correct knowledge of incentives related to female sterilization	47.0
Has correct knowledge of incentives related to male sterilization	19.5
Has correct knowledge of incentives related to PPS*	8.1
Has correct knowledge of incentives related to PPIUCD*	52.7
Has correct knowledge of incentives related to PAIUCD*	39.5
Has correct knowledge of incentives related to per dose administration of injectables (Antara)	48.7
Has correct knowledge of incentives related to distributing Nayi Pahal Kit to newly-married couples	18.7
Has correct knowledge of incentives for mobilizing mother-in-law – daughter-in-law pairs in Saas Bahu Sammelans	11.9
Has correct knowledge of incentives related to all family planning activities	0.5
Has correct knowledge of incentives related to spacing methods	55.1
Has correct knowledge of incentives related to limiting methods	44.9
Has correct knowledge of incentives related to Long-acting reversible methods (LARM)	37.0

*FS - Female Sterilization | MS - Male Sterilization | IUCD - Intra-Uterine Contraceptive Device | PPIUCD - Postpartum Intrauterine Contraceptive Devices | PAIUCD – Post-Abortion Intrauterine Contraceptive Devices | PPS - Postpartum Sterilization | ECP - Emergency Contraceptive Pill | LARM - Long-Acting Reversible Method (includes IUCD and Antara)

The rationale for providing financial incentives to service providers is to boost motivation and thereby improve their service-delivery performance. In the IFPS, a mean motivation score was calculated based on 19 questions that ASHAs were asked. The questions ranged from the value they placed on the work, motivating factors such as a job or financial security, status in the community, enjoying the work and self-worth. The performance score was calculated based on services availed in the last calendar month by eligible women. The family planning activity-wise findings on knowledge of incentives, the mean motivation score and the mean performance score are shown in Table 30. While a high percentage of ASHAs had knowledge of the activity-wise incentives, and in most cases a matching high mean motivation score, the mean performance score was lower than for those who did not have knowledge of incentives and had a lower mean motivation score. The exceptions were male sterilization, PPS, PPIUCD and PAIUCD, where the mean motivation score was lower among ASHAs who had knowledge of incentives for promoting the specific methods, as compared to those who did not have knowledge. In the first four (male sterilization, PPS and PPIUCD), the performance score was also lower for those who had knowledge of incentives, but had lower motivation scores. In the case of PAIUCD, while the mean motivation score was lower among

those who were familiar with the incentives to promote the method, the mean performance score was higher among those who had knowledge, than those who did not.

In other words, there was no directly established link between the knowledge of incentives, motivation and service-delivery performance by the ASHAs. The survey also compared the relationship between receipt of incentives and the mean motivation and performance scores (Table A.19). By method groups, only with respect to limiting methods the mean motivation and performance scores were higher for ASHAs who had received incentives, as against those who had not. For both spacing methods and LARMs, the mean motivation and performance scores were lower for ASHAs who had received incentives.

Table 30: Percentage ASHAs who are familiar with incentives to motivate couples for different FP methods, and their corresponding mean motivation and mean performance scores, Uttar Pradesh, 2020-21

Activities carrying incentives to counsel eligible couples/women	Knowledge (%)	Mean Motivation Score	Mean Performance Score
Delaying method (first child for two years after marriage)			
No	18.1	1.72	2.00
Yes	81.9	2.00	1.71
Spacing method (for spacing of 3 years between their first and second child)			
No	18.4	1.73	1.79
Yes	81.6	2.00	1.76
Limiting method (to opt permanent method for MS/FS after the birth of two children)			
No	15.0	1.73	2.24
Yes	85.0	1.99	1.68
Female Sterilization			
No	14.6	1.87	2.13
Yes	85.4	1.97	1.70
Male Sterilization			
No	34.4	1.99	1.92
Yes	65.6	1.93	1.68
PPS			
No	31.5	2.02	1.70
Yes	68.5	1.92	1.79
PPIUCD			
No	20.5	1.99	1.82
Yes	79.5	1.94	1.75
PAIUCD			
No	40.8	2.02	1.70
Yes	59.2	1.90	1.81
Limiting methods			
No	10.3	1.77	2.22
Yes	89.7	1.97	1.71
Spacing methods			
No	25.5	1.77	1.92
Yes	74.5	2.02	1.71
LARM			
No	27.2	1.92	1.91
Yes	72.8	1.96	1.71

3.4.3 Relationship of performance with motivation and self-efficacy of FLWs

The work motivation scale was derived from mean motivation scores, which were categorized according to their mean and standard deviation to form low, medium, and high categories. Similarly, a self-efficacy scale was derived from a mean score based on 10 questions related to the FLW's confidence in problem-solving and dealing with challenging situations at work. Overall, more than half of both for ASHAs and ANMs (57% and 58% respectively – Table 31), had medium levels of self-efficacy and motivation. Region-wise, the highest share of ASHAs and ANMs from the western region had high self-efficacy levels (28% and 41% respectively). On the other hand, the highest proportion of FLWs with high levels of motivation were from the Purvanchal region (23%). The lowest proportion of ASHAs and ANMs with high levels of self-efficacy were from the Bundelkhand region (22% and 26% respectively). The lowest proportion of ASHAs and ANMs with high motivation levels was from the central region (4% and 3% respectively).

Table 31: Region-wise percentage of FLWs with different levels of self-efficacy and motivation, Uttar Pradesh, 2020-21

Self-efficacy level	ASHA					ANM				
	Bundel-khand	Central	West	Purv-anchal	Total	Bundel-khand	Central	West	Purv-anchal	Total
Low	17.7	45.8	4.7	18.8	17.4	14.9	15.8	1.7	9.5	8.4
Medium	60.8	31.3	67.2	55.2	56.8	59.6	50.0	57.8	59.2	57.8
High	21.6	22.9	28.1	26.0	25.8	25.5	34.2	40.5	31.4	33.8
Motivation level										
Low	15.7	35.4	3.9	29.2	20.5	8.5	36.8	9.5	46.8	29.2
Medium	68.6	60.4	86.7	47.9	63.7	76.6	60.5	81.0	30.8	55.4
High	15.7	4.2	9.4	22.9	15.8	14.9	2.6	9.5	22.5	15.4

Composite score for self-efficacy and motivation was obtained based on 10 and 19 items respectively. After that, they were categorized according to their mean and standard deviation to form low, medium, and high categories.

Comparing the self-efficacy and motivation levels with the mean performance score of FLWs (Table 32), the survey found that among ASHAs the mean performance scores were the highest for those who had low self-efficacy (1.91) and low motivation (2.23). With respect to ANMs, those with medium levels of self-efficacy had the highest mean performance score (0.40), while those with high motivation levels had the highest mean performance score (0.42). Therefore, a positive relation between self-efficacy, motivation levels and performance could not be established from the survey findings.

Table 32: FLWs' motivational and self-efficacy levels by their mean performance scores, Uttar Pradesh, 2020-21

	ASHA		ANM	
Self-efficacy level	Percentage	Mean Performance Score	Percentage	Mean Performance Score
Level of Self-efficacy				
Low	17.4	1.91	8.4	0.38
Medium	56.8	1.73	57.8	0.40
High	25.8	1.75	33.8	0.39
Level of Motivation				
Low	20.5	2.23	29.2	0.41
Medium	63.7	1.69	55.4	0.38
High	15.8	1.46	15.4	0.42

3.4.4 Logistical constraints of frontline health workers with respect to family planning commodity supplies

Table 33 shows the current availability of contraceptive methods with frontline health workers by regions of Uttar Pradesh. There was wide variation in available stocks of contraceptive methods, and an overall low proportion of ASHAs and ANMs reported current availability of all the following contraceptive methods – condoms, Mala-N, centchroman (Chhaya), ECPs and injectables (Antara) (20% and 13% respectively). Among methods, the highest percentage of ANMs reported current stocks for condoms (81%), and the lowest stock for injectables (Antara) (18%). With ASHAs, the highest proportion reported current stocks for condoms (72%), followed by Mala-N (59%), ECPs (41.5%) and lastly centchroman (Chhaya) (33%). This shows that current stocks of contraceptives with FLWs continued to be skewed towards condoms, daily pills and ECPs, as against the new long-acting reversible methods.

Table 33: Region-wise percentage of FLWs with currently available contraceptive methods, Uttar Pradesh, 2020-21

Contraceptive type	ASHA					ANM				
	Bundel-khand	Central	West	Purv-anchal	Total	Bundel-khand	Central	West	Purv-anchal	Total
Condoms	84.3	56.3	73.4	70.8	71.6	85.1	84.2	80.2	79.3	80.8
Mala N	64.7	52.1	57.8	59.4	58.7	80.9	73.7	79.3	79.9	79.2
Centchroman (Chhaya)	33.3	31.3	28.9	35.4	32.7	53.2	47.4	58.6	62.7	58.7
Emergency contraceptive pill	45.1	35.4	50.8	35.9	41.5	78.7	81.6	75.9	78.1	77.8
Injectable contraceptive (Antara)	NA	NA	NA	NA	NA	21.3	10.5	18.1	18.3	17.8
Any of the above contraceptives	90.2	77.1	81.3	77.1	80	87.2	92.1	87.9	91.1	89.7
All of the above contraceptives	21.6	14.6	19.5	21.4	20.1	14.9	5.3	12.9	13.6	12.7

Stock-outs of any of the above-mentioned contraceptive methods lasting more than 15 days were significantly high as mentioned by 61 percent ASHAs and 62 percent ANMs (Table 34). As much as 20 percent of ASHAs reported stock-outs lasting more than 15 days for all the contraceptive methods, while 10 percent of ANMs reported so. Region-wise, the highest percentage of FLWs to report stock-outs for all the methods was from the Purvanchal region (26% and 12% respectively). The reporting percentage of ASHAs from the Western region (11%) and ANMs from the Bundelkhand region (6%) reported stock-outs for all the methods were the lowest. Method-wise, among ASHAs the highest percentage reporting stock-outs of more than 15 days was for centchroman (Chhaya) (53%), while the lowest was for condoms (28%). Among ANMs, the highest proportion reporting stock-outs of more than 15 days was for injectables (Antara) (54%) followed by centchroman (Chhaya) (33%), ECP (20.3%), Mala-N (16.8%) and the lowest was for condoms (16%). Here again, a significantly high proportion of FLWs reported stock-outs of the new long-acting reversible methods.

Table 34: Region-wise percentage of FLWs with stock-outs for different contraceptive methods lasting more than 15 days in the last three months, Uttar Pradesh, 2020-21

Contraceptive type	ASHA					ANM				
	Bundel-khand	Central	West	Purv-anchal	Total	Bundel-khand	Central	West	Purv-anchal	Total
Condoms	23.5	37.5	20.3	30.7	27.5	6.4	6.4	17.2	16.6	16
Mala N	37.3	37.5	25.8	36.5	33.4	10.6	10.6	17.2	16.6	16.8
Centchroman (Chhaya)	51	56.3	49.2	55.2	53	29.8	29.8	32.8	34.3	33.2
Emergency contraceptive pill	43.1	54.2	30.5	51.6	44.4	12.8	12.8	19.8	24.3	20.3
Injectable contraceptive (Antara)	NA	NA	NA	NA	NA	51.1	51.1	43.1	65.7	53.8
Any of the above contraceptives	62.8	68.8	54.7	63	61.1	51.1	51.1	56	71.6	61.6
All of the above contraceptives	15.7	25	10.9	25.5	19.8	6.4	6.4	8.6	11.8	10

3.5 Functioning of community-level service delivery

3.5.1 VHSND readiness

The community survey section of the IFPS showed a low share of married women who attended the Village Health, Sanitation and Nutrition Days (VHSNDs). The survey looked at the readiness of service delivery at the VHSNDs, as well as practices by FLWs in terms of FP services. A total of 193 VHSND sites were surveyed under IFPS. Table 35 shows the availability of service providers and facilities at VHSND sites on the day of the survey observer's visit. The study found that ANMs were present at all VHSND sites, and ASHAs at most of them. Two-thirds of VHSNDs had Anganwadi workers present, and about a quarter of the sites had ASHA Sanginis and Anganwadi helpers. Very few sites were observed to be attended by Panchayat members, and less than 5 percent had UP TSU representatives present. With respect to facilities at the VHSND sites, a higher share had infrastructural facilities, as compared to hygiene and IEC materials related to FP. Nearly all the sites had a separate sitting place for ANMs, 80 percent had sitting arrangements for beneficiaries, and more than half had functional toilets. However, less than half (44%) of VHSND sites had IEC materials related to FP.

Table 35: Percentage of VHSND sites with availability of service providers and UP TSU representatives, and readiness for FP activities on the surveyors' visit date, Uttar Pradesh, 2020-21

ASA VHSND attendee present		Availability of facilities	
ANM	100	Family planning related IEC materials	43.5
ASHA	96.9	Drinking water	75.7
Anganwadi worker	63.7	Functional toilet	54.4
ASHA Sangini	22.3	Soap for hand washing	34.7
Anganwadi helper	25.4	Sitting arrangements for beneficiaries	79.3
PRI member / Others	7.3	Separate place for sitting for ANM	96.9
UP-TSU representative	4.7	All above are available	13

Observations related to hygiene and waste disposal practices by ANMs recorded at the VHSND sites are shown in Tables 36 and 37. Nearly 66 percent of ANMs used hand sanitisers during sessions with clients. With respect to the disposal of PPE waste such as used personal protection kits, masks, gloves, etc. after VHSND sessions, three-fourths of the ANMs (76%) took them away with other logistics, while 18 percent did not use the kits. About two to three percent of the ANMs disposed of the used kits by either burying or throwing them near the session site, or throwing them in water.

Table 36: Observed handwashing practices among percentage of ANMs at VHSND sessions, Uttar Pradesh, 2020-21

Handwashing practice	Before the session	Anytime during session	After vaccinating or physically examining every beneficiary
Only with plain water	13.5	1	50.3
With soap	8.8	1.6	--
Used hand-sanitizer	43	66.3	--
Used both soap & sanitiser	3.6	3.6	0.5
Did not do anything	26.4	27.5	49.2
Could not be observed	4.7	--	--

Table 37: Observed disposal of used PPE kits (personal protection kits, masks, gloves, etc.) by percentage of ANMs after VHSND sessions, Uttar Pradesh, 2020-21

Waste disposal practice	
Buried near the session site	1.6
Thrown near the session site	3.1
Thrown in the water near the session site	2.1
Taken away with other logistics	75.7
Not used at all	17.6

The VHSND observations focusing on FP activities found that at less than half of the sites (46%), women received counselling from FLWs on method use, at 18 percent sites, women were counselled on side-effects and in only 8 percent on managing complications (Table 38). The share of VHSNDs where women received counselling on different aspects of family planning for at least two or three methods was much lower. At just 9 percent of sites, women were counselled on atleast 3 methods, 4 percent on their side-effects and only 2 percent on managing the complications. Method-wise, in 33 percent of VHSNDs women were counselled for daily pills while in only 6 percent of sites, they were counselled for ECPs. Within the methods, counselling on side-effects and complication management was very low. With respect to new contraceptive methods, 24 percent VHSNDs provided counselling on use of centchroman (Chhaya) and 9 percent on injectables (Antara). In 8 percent VHSNDs, women were counselled on side-effects and in 5 percent on managing complications for centchroman (Chhaya).

Table 38: Percentage of VHSNDs where women were counselled on different aspects of family planning, by contraceptive methods, Uttar Pradesh, 2020-21

Family planning methods	Counselled on how to use method	Counselled on side effects	Counselled on complication management
Condoms	14	5.2	2.6
OCP- Mala N	32.6	9.8	3.6
OCP- Centchroman (Chhaya)	24.4	7.8	4.7
ECP	5.7	2.1	0.5
Injectables (Antara)	9.3	7.3	3.1
Any method	46.1	18.1	8.3
At least 2 methods	26.9	8.3	3.6
At least 3 methods	8.8	4.2	2.1

Table 39 presents the findings of IFPS observers on the availability and distribution of FP methods to eligible women at the VHSND sites. While 92 percent of VHSND sites had at least one method available, just 5 percent had all five methods – condoms, daily pills (Mala- N), centchroman (Chhaya), ECPs and injectables (Antara) – available. Distribution of contraceptive methods at the VHSND sites was found to be much lower than the available stocks. Looking at the availability of specific methods, the majority of VHSNDs had condoms available (85%), however only 49 percent of sites distributed them.

Table 39: Percentage of VHSNDs with the availability of contraceptives and distribution to eligible women, by contraceptive methods, Uttar Pradesh, 2020-21

Percentage of VHSNDs with method availability		Percentage of VHSNDs where FP methods were distributed to eligible women	
Condoms	84.5	Condoms	48.7
OCP- Mala N	80.8	OCP- Mala N	27.5
OCP- Chhaya	59.1	OCP- Centchroman (Chhaya)	15.0
ECP	75.7	ECP	2.6
Injectable (Antara)	8.8	Injectable (Antara)	4.7
Any method	92.2	Any method	53.9
At least 3 methods	73.6	At least 2 methods	45.6
All 5 methods	5.2	At least 3 methods	36.3

Table 40 shows the survey observer's feedback on the discussions related to FP that FLWs had with clients at the VHSNDs. They reflect on the FLWs' reluctance to counsel newly married clients on family planning, and the relatively lower emphasis on new methods of contraception. Regarding FP behaviours, nearly 60 percent reported discussions on the importance of FP, while only 18 percent reported discussions by FLWs on delaying the first pregnancy for two years after marriage.

With respect to contraceptive methods, while 61 percent reported FLWs discussing any method, 58 percent said temporary methods were discussed, and 36 percent said permanent methods were discussed. Among temporary methods, 41 percent FLWs were reported to discuss the new methods (injectables (Antara) and centchroman (Chhaya)), while 32 percent FLWs were reported to discuss LARM (injectables (Antara) and IUCDs). More than half of FLWs were reported to discuss other temporary methods (55%).

Table 40: Percentage of FLWs who discussed FP methods at the VHSND with all or some clients, as per the survey observer's feedback, Uttar Pradesh, 2020-21

Topics discussed	
Importance of family planning	59.6
Delay first pregnancy for 2 years after marriage	17.6
Spacing between births	54.4
Limiting family size	36.3
Postpartum family planning	36.8
Female Sterilization	35.2
Male Sterilization	4.2
IUCD/PPIUCD/PAIUCD insertion	25.9
Oral Contraceptive Pill- Mala N	43.5
Centchroman (Chhaya)	32.1
Emergency Contraceptive Pill	9.3
Injectables (Antara)	20.2
Condom	45.1
Any method	61.1
Any permanent methods	35.8
Any temporary methods	58
New methods	40.9
Long-acting reversible contraceptive methods	32.1
Other methods	55.4
Any 2 temporary methods	50.8
Any 3 temporary methods	36.3

The VHSND offers an excellent opportunity for FP counselling with women who come for antenatal or postpartum care and for immunization and growth monitoring of their newborns and infants. The observations on ANMs discussing FP issues with women who came for ANC or postpartum care is shown in Table 41. Discussions with pregnant women were low, with nothing observed to have been discussed at 41 percent of the VHSND meetings. Among issues discussed, the highest share observed was on types of FP methods (41%), and the lowest was on the importance of having a three-year interval before the next pregnancy (7%). Pregnant women's intention to have more children was discussed at just one-fifth of the meetings (21%), and one-third discussed a return to fertility and the importance of using contraception after childbirth (37%).

Discussions by ANMs on family planning issues were higher for women who came to VHSND meetings for postpartum care. The highest share discussed types of FP methods (77%), while the lowest share had discussions on the client's FP preferences (28%). ANMs at 41 percent of the meetings were observed to have discussed return to fertility in case of partial breastfeeding and at 48 percent of the meetings on return to fertility in case of no breastfeeding. While the discussion on a three-year birth interval and risk of pregnancy was discussed with a significant share of women who came for postpartum care, there were still high percentages of women who were not counselled and presented a missed opportunity in adopting birth spacing as they returned to fertility.

Table 41: Percentage of VHSND meetings where FP issues were observed to have been discussed by ANMs with women coming for ANC check-ups and postpartum care, Uttar Pradesh, 2020-21

Issues informed/discussed with women arriving for Antenatal care (ANC) check-ups		Issues informed/discussed with women arriving for postpartum care	
Importance of 3 years' birth interval before next pregnancy	6.9	Importance of 3 years' birth interval before next pregnancy	59.1
Intention to have more children	20.7	Types of FP Methods	77.3
Types of FP Methods	41.4	Place of availability of FP methods	56.8
Place of availability of FP methods	33.6	Client's FP preferences	28.4
Discussions about switching methods	11.2	Helped woman in selecting suitable method after delivery	43.2
Discussion on side-effects	11.2	Importance of using FP after the childbirth	52.3
Lactational Amenorrhea Method (LAM)	25	Lactational Amenorrhea Method (LAM)	43.2
Importance of using FP after childbirth	37.1	Return to fertility in case of partial breastfeeding	40.9
Return to fertility	37.1	Return to fertility in case of no breastfeeding	47.7
Nothing was discussed	41.4	Nothing was discussed	--
Less than 4 topics were discussed	28.5	Less than 4 topics were discussed	25
4 or more topics discussed	30.2	4 or more topics discussed	75

In the case of women coming to the VHSND meetings for their child's immunization or growth monitoring, discussion on FP issues by ANMs was observed to be low. While at 48 percent of the meetings, nothing was discussed with women coming for immunization, this was the case for as much as 71 percent of the women arriving for their children's growth monitoring (Table 42). Various types of FP methods were discussed by ANMs in the highest share of meetings with women coming for their child's immunizations or growth monitoring (44% and 38% respectively). The risk of pregnancy in normal menstruating women was discussed by ANMs with women coming for their child's immunizations or growth monitoring in the lowest share of meetings (7% and 4% respectively). The observer responses in the survey indicate that while focusing on other maternal and child health care activities, FLWs missed opportunities to counsel and motivate eligible women to adopt FP methods.

Table 42: Percentage of VHSND meetings where FP issues were observed to have been discussed by ANMs with women coming for child's immunization or growth monitoring, Uttar Pradesh, 2020-21

Issues informed/discussed with women arriving for child's immunization care		Issues informed/discussed with women arriving for child's growth monitoring	
Reproductive goals of woman	21.3	Reproductive goals of woman	17.7
Type of FP methods	44.2	Type of FP methods	38.1
Place of availability of FP methods	34	Place of availability of FP methods	30.1
Client's FP preferences	17.6	Client's FP preferences	16.8
Helped woman in selecting suitable method after delivery	26.6	Helped woman in selecting suitable method after delivery	18.6
Importance of using FP after childbirth	29.3	Importance of using FP after childbirth	26.6
Lactational Amenorrhea Method (LAM)	11.7	Lactational Amenorrhea Method (LAM)	13.3
Risk of pregnancy after childbirth	16.5	Risk of pregnancy after childbirth	15.9
Risk of pregnancy in normal menstruating woman	6.9	Risk of pregnancy in normal menstruating woman	4.4
Nothing was discussed	48.4	Nothing was discussed	71.3
Less than 4 topics were discussed	26.1	Less than 4 topics were discussed	12.2
4 or more topics discussed	25.5	4 or more topics discussed	16.5

4 SERVICE PROVIDERS AND QUALITY OF SERVICES AT HEALTH FACILITIES

4.1 Status of health providers

Trained clinical providers and adequately equipped health facilities are key to the provision of adequate and quality family planning services. This chapter provides a snapshot of service providers, their training on family planning and the availability of equipment and amenities at the health facilities in the state.

4.1.1 Profile Of Doctors And Staff Nurses

Clinical providers like doctors and nurses are essential pillars of the public health system. Doctors are responsible for providing clinical family planning services like sterilization, insertion/removal of IUCDs, administering injectables (Antara) etc., along with counselling the beneficiaries. Under IFPS-2021, a total of 476 doctors and 451 staff nurses across the public health facilities in 18 administrative divisions of Uttar Pradesh were interviewed on their socio-demographic profile, awareness and attitude related to family planning etc. Information on their background characteristics, work experience in FP, and the type of facilities they work in are illustrated in Table 43 below.

The survey found that most of the health providers were above 35 years, with the mean age being 41 years for doctors and 36 years for staff nurses. Almost 28 percent of doctors and 26 percent of staff nurses had less than five years of experience. The doctors and nurses had 11.2 and 8.7 mean years of experience in family planning respectively.

Table 43: Distribution of sampled doctors and staff nurses by selected characteristics, Uttar Pradesh, IFPS 2020–21

Background Characteristics	Doctors	Background Characteristics	Staff-Nurses
Age		**Age**	
<35 years	24.4	<30 years	22.4
35-44 years	45.4	30-39 years	47
45-54 years	20	40-49 years	19.7
>=55 years	10.3	>=50 years	10.9
Mean age	40.9	Mean age	36.2
Median age	40	Median age	34
Sex		**Sex**	
Male	45.2	Male	1.6
Female	54.8	Female	98.5
Highest educational qualification			
MS/MD in Gynaecology and Obstetrics	5	GNM	93.1
Diploma in Gynaecology and Obstetrics (DGO)	10.1	B.Sc/M.Sc Nursing and ANM	4.2
Bachelor of Medicine and Bachelor of Surgery (MBBS)	63.5	Other	2.7
M.S./ M.D. in Other speciality	1.7		
Others: BHMS/ BAMS/ BUMS/ Others	19.7		
Work experience in family planning			
<5 years	27.9	<5 years	25.7
5-9 years	26.5	5-9 years	44.4
10-14 years	25.6	10-14 years	16.2
>=15 years	20	>=15 years	13.8

Background Characteristics	Doctors	Background Characteristics	Staff-Nurses
Location		**Location**	
Urban	22.9	Urban	24.8
Rural	77.1	Rural	75.2
Type of facility		**Type of facility**	
District Hospitals: DCH/DMH/DWH	15.6	District Hospitals: DCH/DMH/DWH	16.4
First Referral Units: FRUs	26.1	First Referral Units: FRUs	26.8
Community Health Center: CHC/ UCHC	24.4	Community Health Center: CHC/ UCHC	25.5
Primary Health Center: PHC/UPHC	32.4	Primary Health Center: PHC/UPHC	29.7
Others: Unspecified	1.7	Others: Unspecified	1.6
Total number of providers	**476**	**Total number of providers**	**451**

Figure 31 and 32 shows the level of training on family planning methods and counselling received by facility-based health providers. Less than a percent of doctors had received training in all family planning methods, with 3 and 17 percent of doctors trained in permanent and modern reversible family planning methods respectively. 31 percent of doctors had received training in family planning counselling. 25 and 39 percent of staff nurses had received training in modern reversible methods and family planning counselling respectively.

More doctors from urban health facilities had received training in family planning methods and counselling as compared to the doctors from rural health facilities (Table A.20). On the contrary, more staff nurses from rural health facilities had received training in family planning methods as compared to their counterparts from urban health facilities (Table A.21).

Figure 31: Percentage of doctors and staff nurses who ever received training on various family planning methods, Uttar Pradesh, 2020-21

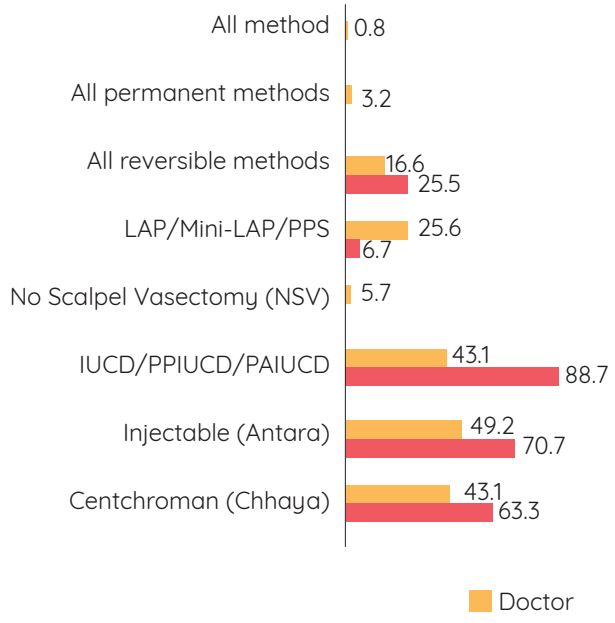


Figure 32: Percentage of doctors and staff nurses who ever received training on family planning counselling, Uttar Pradesh, 2020-21

All reversible methods include IUCD/PPIUCD/PAIUCD, injectables (Antara), Centchroman (Chhaya), OCPs, ECPs and Condoms.

4.1.2 Knowledge of doctors and nurses on different types of methods (pre- & post- procedures)

One of the important aspects for assessing the providers' ability to provide appropriate family planning services to the women was through questions on their knowledge of family planning methods. The IFPS assessed the knowledge of doctors and staff nurses on different permanent and reversible modern methods. Their knowledge has been assessed on the type of information collected (demographic, menstrual history, obstetric history, medical history, contraceptive usage etc.) from new clients who visit the facility for availing family planning services, pre and post-procedural information provided to clients for modern methods (female sterilization (LAP/Mini-LAP/PPS), male sterilization (NSV), IUCD/PPIUCD/PAIUCD and injectables (Antara)).

Table 44: Knowledge levels of facility-based provider on pre and post procedures of different family planning methods, Uttar Pradesh, 2020-2021

Family Planning Methods	Doctor		Staff Nurses	
	Low (%)	High (%)	Low (%)	High (%)
Pre LAP/Mini-LAP/PPS	55.7	44.3	63.4	36.6
Post LAP/Mini-LAP/PPS	40.3	59.7	49.7	50.3
Pre NSV	45.4	54.6	52.8	47.2
Post NSV	41.2	58.8	47.7	52.3
Pre IUCD	53.4	46.6	49.4	50.6
Post IUCD	48.1	51.9	44.8	55.2
Pre Injectable	58.0	42.0	60.5	39.5
Post Injectable	61.1	38.9	59.0	41.0

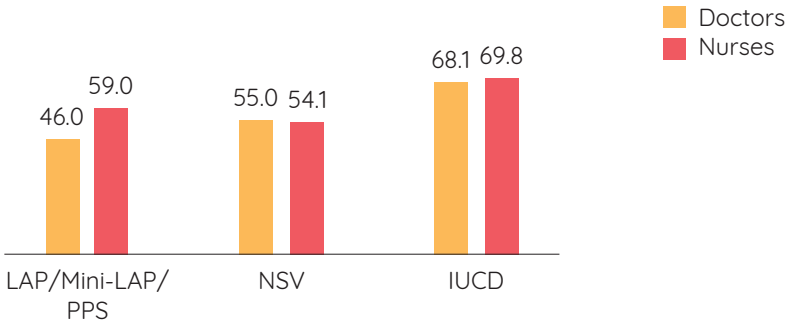
The findings in Table 44 show that most of the doctors have low knowledge of the pre-procedures of the methods. 56 percent and 45 percent of the doctors had low knowledge of pre-procedures of female and male sterilization respectively. The level of knowledge of both pre and post procedures of injectables (Antara) was poor among doctors.

Among staff nurses, 63 percent and 50 percent scored low on knowledge of pre-procedures and post-procedures for female sterilization. 45 percent of staff nurses scored low on knowledge for post-procedures of IUCD. An equal share of staff nurses (60%) scored low on knowledge of pre and post procedures of injectables (Antara). Such a low level of procedural knowledge of providers impacts the quality of services and counselling given to the clients.

More than two-thirds of the male doctors scored low on knowledge of procedures of injectable (Antara). More than half of the doctors from rural health facilities had scored low on the pre-procedures of the methods (Table A.22).

The study also assessed the information given to clients by providers regarding the health problems or complications that might occur due to various methods like female sterilization, male sterilization and IUCD. 46 percent of doctors and 59 percent of staff nurses scored low on informing clients regarding complications from female sterilization. Almost equal number of doctors and staff nurses scored low for male sterilization (55 percent doctors and 54 percent staff nurses) and IUCD (68 percent doctors and 70 percent staff nurses) (Figure 33).

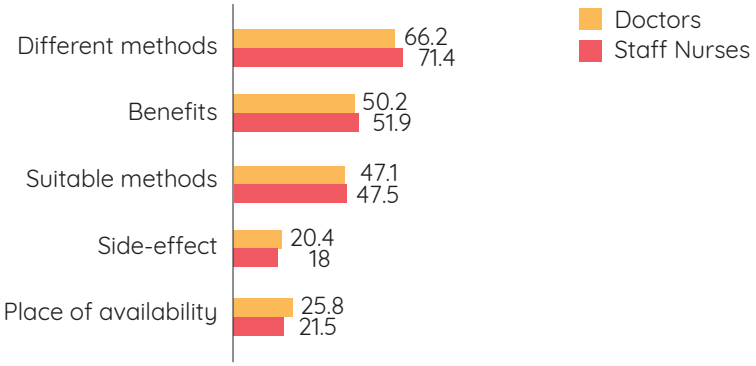
Figure 33: Percentage of doctors and staff nurses who scored low13 on informing clients regarding complications associated with various family planning methods, Uttar Pradesh, 2020-21



4.1.3 Attitude of doctors and nurses for different types of methods

The survey assessed the attitude of providers related to counselling married women or couples who do not want to have any more children. Figure 34 shows that most of the health providers discuss about different methods and their benefits but do not discuss side effects (20% by doctors and 18% by staff nurses) and accessibility of methods (26% by doctors and 21% by staff nurses) which are crucial factors for continuing a method by women. These findings suggest that providers need to be better prepared to understand the needs of the clients.

Figure 34: Percentage of doctors and staff nurses who discuss different aspects of family planning with women who wanted to limit their family, Uttar Pradesh, 2020-21



4.1.4 Profiling of counsellors

Family Planning Counsellors are well-trained non-clinical providers stationed in public health facilities. They are responsible for providing clients with knowledge about identifying the right time for pregnancy, advantages of using family planning methods post-delivery, knowledge about available FP methods, their advantages, use and side effects. Their role is also to help pregnant mothers choose suitable FP methods during ANC and PNC, and follow up with mothers who had consented to use the postpartum family planning method post-delivery. Counsellors ensure that all the information of clients remains confidential.

The survey interviewed all 223 Family Planning counsellors positioned in public health facilities across the state. The survey found that 61 percent of FP counsellors were in the 30-39 age group, while their mean age was approximately 37 years (range: 36.5-38.1 years). The majority (97%) were female, postgraduates (65%) and had experience (87%) of 6 or more years in family planning (Table 45).

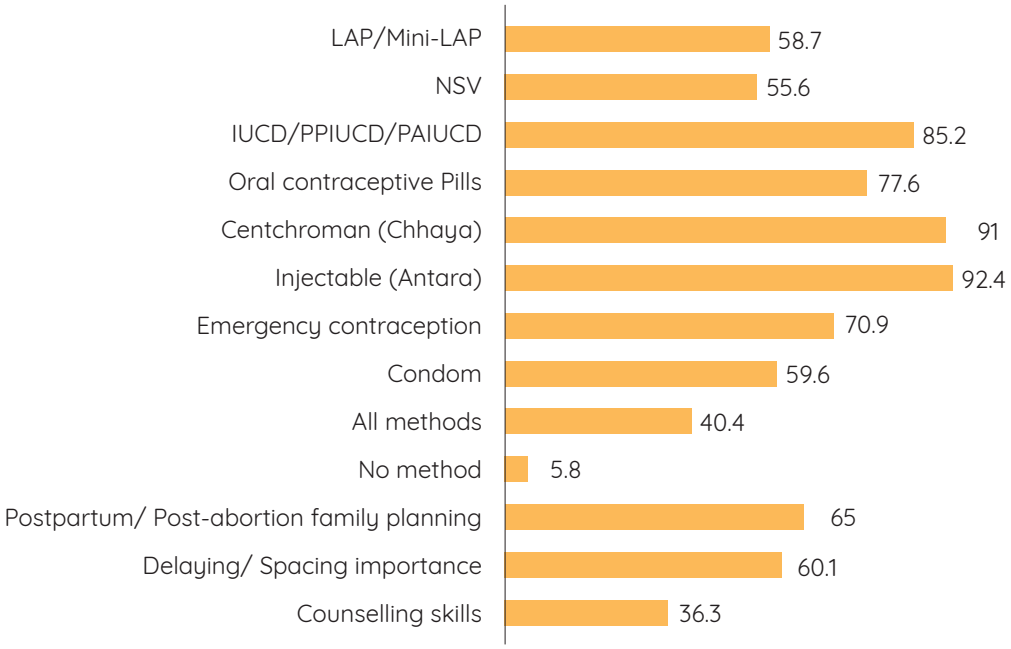
[13]In the case of complications associated with various methods, the level of information provided to clients by service providers is determined by using the mean score: a score below the mean is considered low, while a score above the mean is considered high. Following are the number of items that are considered to explain the complications associated with each family planning procedure: 8 items for LAP/Mini-LAP/PPS (0/2.5- low, 2.6/8.0-high), 6 items for NSV (0/1.4- low, 1.5/6.0-high), 6 items for IUCD/PPIUCD/PAIUCD (0/2.1- low, 2.2/6.0-high)

40 percent of the counsellors have received training for all the family planning methods while approximately 6 percent have not received any training in the last 5 years. The highest training has been received on injectables (Antara) (92%) and the lowest on male sterilization (56 %) (Figure 35).

Table 45: Distribution of sampled counsellors by selected characteristics, Uttar Pradesh, IFPS 2020-21

	Characteristics	%
Age (in years)	<30	6.7
	30-34	28.7
	35-39	32.3
	40-44	19.7
	>=45	12.6
Sex	Male	2.7
	Female	97.3
Highest education	Postgraduate	65.5
	Graduate & Others	34.5
Work experience in FP	<=5 years	13
	6-9 years	78.5
	>=10 years	8.5
Location	Urban	26
	Rural	74
Type of facility	District Hospitals	24.7
	First Referral Units	64.6
	Others	10.8

Figure 35: Percentage of family planning counsellors who received training on various family planning methods and concepts in the last five years, Uttar Pradesh, 2020-21



4.1.5 Knowledge of counsellors about different family planning methods, pre- and post-procedures

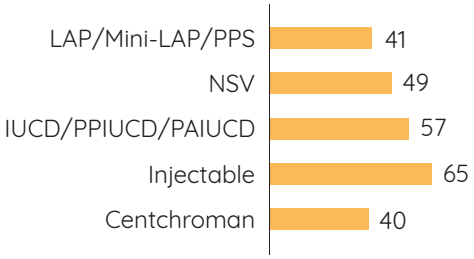
The survey assessed the knowledge of FP counsellors on different modern methods. Their knowledge has been assessed on eligibility criteria, benefits, health problems, complications, follow-up duration, and pre-post procedures for modern methods (female sterilization (LAP/Mini-LAP/PPS), male sterilization (NSV), IUCD/PPIUCD/PAIUCD, injectables (Antara) and centchroman (Chhaya).

Figure 36 shows that 41 percent and 49 percent of the counsellors had low knowledge of female and male sterilization respectively. Surprisingly, more than half (57%) of the counsellors had low knowledge of IUCDs. Considering the knowledge of new modern spacing contraceptives, a larger share (65%) of counsellors had low knowledge of injectables (Antara) while 40 percent of counsellors had low knowledge of centchroman (Chhaya).

Age-wise, more young counsellors had low knowledge of IUCD and injectables (Antara), while those above 40 years had low knowledge of male sterilization and centchroman (Chhaya). Concerning the relation of FP knowledge with education, counsellors with the highest qualification as postgraduates had low knowledge (67%) of injectables (Antara), for other methods their counterparts had a high share. Findings show that counsellors with less experience have low levels of knowledge of all methods, however, there is not much difference among less or more experienced counsellors regarding knowledge of injectables (Antara). A higher share of counsellors stationed in rural health facilities had low knowledge of all methods except IUCD (Table A.23).

Overall, the method on which counsellors scored low knowledge of pre-procedure were permanent methods (female and male sterilization) (61% each), followed by centchroman (Chhaya) (60%) (Table A.24). Almost 61 percent of counsellors scored low on knowledge of post-procedure of injectables (Antara) and 55 percent of counsellors scored low for female sterilization (Table A.25).

Figure 36: Percentage of FP counsellors with low level of knowledge of various family planning methods



4.1.6 Attitude of counsellors on counselling women with different reproductive needs

The most crucial role of counsellors is to counsel the clients based on their needs to help them choose suitable family planning methods. The survey looked at the differences in the counselling offered by FP Counsellors to women or couples based on their fertility preferences (Table 46). Findings show that the counsellors do not discuss side effects and accessibility of methods with the clients which are crucial aspects in the counselling.

The findings show that a very small proportion of counsellors (1.4%) provide complete counselling[14] to women/couples who want to delay their first child. With newlywed women/couples, 78 percent of counsellors discussed the concept and benefits of delaying the first birth after marriage, 77 percent discussed methods to delay the first birth, and 62 percent of counsellors told them about the benefits of family planning

[13]Complete counselling has been defined here as providing knowledge of delaying first child/birth spacing/limiting, different methods, their benefits, side-effects, and accessibility.

methods. However, less than one-fourth provided information on accessing contraceptives and their side effects. Among methods suggested to delay the birth of their first child, the most suggested method was centchroman (Chhaya) (81%) and the least suggested was IUCD (33%).

For married women or couples who wanted to space their children, 65 percent of counsellors discussed the concept and benefits of spacing, 68 percent discussed methods to maintain space, and 78 percent of counsellors told them about the benefits of family planning methods. A much lower percentage of counsellors provided information on accessing contraceptives and their side effects. The most suggested methods were IUCD (88%) and injectables (Antara) (87%), and the least suggested method was Condom (46%). Only 4 percent of the counsellors provide complete counselling to women/couples who want to maintain space between children.

In their interaction with married women or couples who do not want to have any more children, the counsellors were found to follow a similar pattern. 72 percent of counsellors discussed the concept and benefits of limiting births, 73 percent discussed methods for limiting, and 63 percent of counsellors told them about the benefits of family planning methods. Around 5 percent of counsellors provide complete counselling to them. Among the methods suggested, there was a significant skew towards female sterilization, recommended by 97 percent of the counsellors. Contraceptive pills and condoms were among the lowest recommended methods by the counsellors.

For women who recently delivered or had an abortion, less than 2 percent of counsellors provide complete counselling to them. 86 percent discussed the concept of birth spacing and limiting, 72 percent discussed different family planning methods and 57 percent discussed the benefits of family planning methods. Among the methods suggested, IUCD has been recommended the most (82%) by the counsellors.

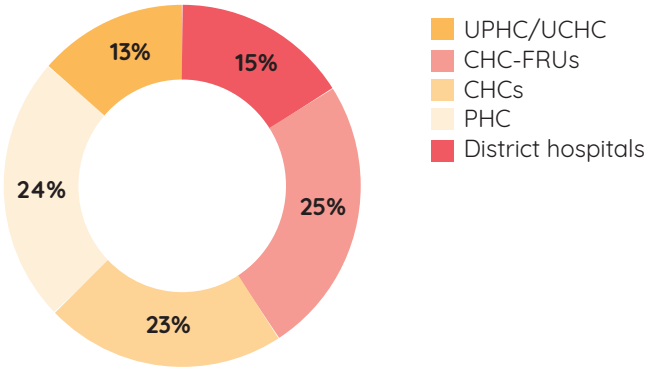
Table 46: Counsellors who discuss different aspects of family planning methods with reproductive-age women of different aspirations related to pregnancy and childbirth, Uttar Pradesh, IFPS 2020-2021

Discuss	Women/couples who want to (%)			
	delay their first child	maintain space between children	no more children	recently delivered or had an abortion
Concept and benefits of				
Delaying first child	78.0	--	--	--
Birth spacing or limiting	--	--	--	86.1
Birth spacing	--	64.6	--	--
Limiting	--	--	72.2	--
Different methods	77.1	68.2	73.5	71.8
Benefits	61.9	78.0	63.2	57.4
Side-effects	22.0	25.1	20.6	21.5
Accessibility of methods	23.3	24.7	22.4	26.5
Discuss all above	1.4	3.6	4.9	1.8
Suggested methods:				
Female sterilization	-	0.9	96.9	1.4
Male Sterilization	-	0.5	82.5	0.5
IUCD/ PPIUCD	33.2	88.3	56.5	82.1
OCP	44.0	50.7	11.7	37.2
Centchroman (Chhaya)	80.7	76.7	17.5	70.0
Injectable (Antara)	50.2	86.6	27.4	66.8
ECP	6.7	9.0	3.6	4.5
Condom	77.1	45.7	16.1	44.0
Total (N)	**223**			

4.2 Highlights of family planning service delivery through health facilities

A total of 496 public health facilities across 18 administrative divisions were assessed for availability and quality of family planning services, availability of infrastructure, job aids/IEC material and service delivery. The distribution of health facilities by their type is shown in Figure 37.

Figure 37: Percentage distribution of public health facilities by their type, Uttar Pradesh,2020-21



Majorly, the facilities were in rural areas. All the district hospitals (DH) and CHCs, 98 percent of CHC-FRUs, 78 percent of PHCs and 91 percent of UPHC/UCHCs had a laboratory. 99 percent of district hospitals, 86 percent of CHC-FRUs, and 81 percent of CHCs had a functional operation theatre. A small proportion of PHCs (23%) and UPHC/UCHCs (5%) had a functional operation theatre. The majority of high-level facilities had a labour room. 71 percent of district hospitals and 30 percent of CHC-FRUs had counselling corners, and only a small proportion of UHPC/UCHCs had a counselling corner (Table 47).

Table 47: Basic characteristics of the selected health facilities, Uttar Pradesh, IFPS 2020–21

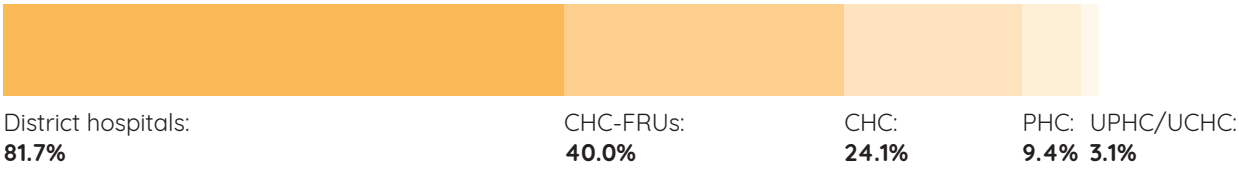
Discuss	DH	CHC-FRU	CHC	PHC	UPHC/UCHC	Total
Location						
Urban	43.8	14.4	12.9	3.4	72.3	23.4
Rural	56.2	85.6	87.1	96.6	27.7	76.6
Region						
Bundelkhand	12.3	10.4	10.3	16.2	6.2	11.5
Central	15.1	13.6	5.2	9.4	7.7	10.1
West	31.5	16.8	53.4	30.8	49.2	35.1
Purvanchal	41.1	59.2	31	43.6	36.9	43.3
Availability of infrastructure						
Laboratory	100	98.4	100	77.8	90.8	93.1
Functional Operation	98.6	86.4	81	23.1	4.6	61.3
Theatre						
Pre-operative room	83.6	51.2	53.4	6.8	3.1	39.7
Labour room	94.5	96.8	100	79.5	55.4	87.7
Counselling corner	71.2	29.6	30.2	11.1	4.6	28.2
Total	**73**	**125**	**116**	**117**	**65**	**496**

4.3 Facility readiness for providing clinical methods

4.3.1 Mini-Lap

Overall, 30 percent of the facilities are providing Mini-LAP services, out of them 82 percent of district hospitals, 40 percent of CHC-FRUs, 24 percent of CHCs, 9 percent of PHCs and 3 percent of UPHC/UCHCs provide Mini-LAP services in the state (Figure 38).

Figure 38: Percentage of public health facilities providing Mini-LAP services, Uttar Pradesh,2020-21



Most of the district hospitals were providing Mini-LAP services regularly. In CHC-FRU, CHCs, PHCs and UPHC/UCHCs, Mini-Lap service is provided mainly through Fixed Day Services (FDS) or Fixed Day Outreach Services (FDOS). Data suggests that low-level facilities lacked basic infrastructure like toilets, hand washing areas, office area etc. Functional operation theatre was available in only 82 percent of district hospitals, 38 percent of CHC-FRUs and 24 percent of CHCs where mini-LAP services were provided. The Government of India (GoI) guidelines for Mini-LAP mandate urine analysis for sugar and albumin, and blood tests for haemoglobin, however around 30 percent of the facilities reported conducting these. Around 80 percent of district hospitals and 38 percent of CHC-FRUs were conducting urine and haemoglobin test before the Mini-LAP procedure. Very few PHCs and UPHC/UCHCs conducted the lab tests before the Mini-LAP procedure. For performing the Mini-LAP procedure 56 percent of district hospitals, 11 percent of each CHC-FRUs and CHCs, 3.4 percent of PHCs and only 1.5 percent of UPHC/UCHCs had all the eleven essential equipment[15]. 4 percent of CHC-FRUs had none of the essential equipment. Only 20 percent of the facilities had a trained doctor for Mini-LAP. About half of the district hospitals, 19 percent and 21 percent of CHC-FRUs and CHCs had trained doctors for Mini-LAP. A very few PHCs and UPHC/UCHC reported the availability of trained doctors for Mini-LAP. Overall, 23 percent of the facilities had at least 1 kit of Mini-LAP available at the time of the survey. More than two-thirds of the district hospitals and one-fourth of the CHC-FRUs reported having kits of Mini-LAP. A high percentage of low-level facilities had no complete kits of Mini-LAP (Table 48).

Table 48: Availability of essential infrastructure, laboratory test, equipment, and HR for Mini-LAP services by type of health facilities, Uttar Pradesh, 2020-21

Requirements of Mini-LAP	DH	CHC-FRU	CHC	PHC	UPHC/UCHC	Total
Mini-Lap service provided through						
Regular	77.5	4.8	6.0	0.0	1.5	14.0
Fixed Day Service (FDS)	1.4	20.0	4.3	2.6	1.5	6.9
Clinical Outread Team (COT)	0.0	4.8	0.9	0.9	0.0	1.6
Fixed Day Outreach Service (FDOS)	1.4	14.4	12.9	6.8	0.0	8.5
Infrastructure Requried						
Waiting area with seating arrangements	81.7	40.0	24.1	9.4	3.1	30.2
Separate FP counselling corner	66.2	10.4	9.5	2.6	0.0	15.0

[15]Essential equipment for mini-LAP includes: instrument boiler, scalpel, scalpel blade size 15, Allis forceps, medium artery forceps curved, needle holder, straight scissors, babcock clamp (medium size), small Langen beck (right angle abdominal), O' chromic catgut and Small round bodied curved needle

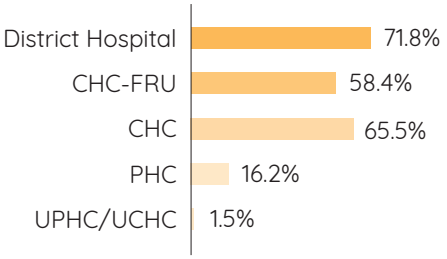
Requirements of Mini-LAP	DH	CHC-FRU	CHC	PHC	UPHC/ UCHC	Total
Pre-operative room for washing, changing clothes, and pre-medication	69.0	20.0	16.4	3.4	1.5	19.8
Functional operation theatre (OT)	81.7	38.4	24.1	8.5	3.1	29.6
Recovery room	77.5	21.6	12.9	5.1	1.5	21.1
Office area for keeping records	80.3	40.0	21.6	7.7	3.1	28.9
Hand washing area tap near OT for scrubbing	81.7	37.6	22.4	7.7	3.1	28.7
Toilets with running water	81.7	37.6	21.6	7.7	3.1	28.5
Electricity supply with power backup (Generator/Invertor)	81.7	37.6	23.3	8.5	3.1	29.1
Emergency light	76.1	24.0	19.0	6.0	3.1	23.3
Laboratory Test Required						
Urine examinations	80.3	38.4	23.3	9.4	3.1	29.4
HB test	80.3	38.4	22.4	8.5	3.1	28.9
Essential equiment available and functional						
Instrument boiler	73.2	32.0	20.7	6.8	3.1	25.5
Scalpel	78.9	34.4	18.1	6.8	3.1	26.3
Scalpel blade size 15	76.1	32.0	18.1	6.8	3.1	25.3
Allis forceps	81.7	31.2	19.0	5.1	3.1	25.7
Medium artery forceps curved	80.3	32.0	18.1	6.8	3.1	25.9
Needle Holder	80.3	32.8	19.0	6.8	3.1	26.3
Straight scissors	80.3	35.2	19.0	6.8	3.1	26.9
Babcock clamp (Medium size)	77.5	19.2	16.4	4.3	3.1	21.3
Small Langen beck (Right angle abdominal)	74.6	20.0	14.7	4.3	3.1	20.6
O' chromic catgut	77.5	29.6	16.4	5.1	1.5	23.9
Small round bodied curved needle	77.5	28.0	18.1	6.8	3.1	24.5
Availability of all 11 essential equipment	56.3	11.2	11.2	3.4	1.5	14.6
Availability of none of the essential equipment	0.0	4.0	1.7	2.6	0.0	2.0
Availability of trained doctor for LAP	50.7	19.2	21.5	7.7	6.2	19.8
Availability of complete kits of Mini-LAP	76.1	25.6	15.5	6.0	3.1	22.9
Total	**71**	**125**	**116**	**117**	**65**	**494**

DH = District Women Hospital and District Combined Hospital

4.3.2 LAP

Overall, 44 percent of the public health facilities are providing LAP services, out of them 72 percent of district hospitals, 58 percent of CHC-FRUs, 66 percent of CHCs, 16 percent of PHCs and less than 2 percent of UPHC/UCHCs provide LAP services in the state (Figure 39).

Figure 39: Percentage of public health facilities providing LAP services, Uttar Pradesh,2020-21



About half of the district hospitals were providing LAP services on a regular basis. In CHC-FRU, CHCs and PHCs, LAP service is provided majorly through Fixed Day Outreach Services (FDOS). UPHC/UCHC provided LAP services on a regular basis. The data suggest that low-level facilities lacked basic infrastructure like toilets, hand washing area, power supply, office area etc. Functional operation theatre was available in only 72 percent of district hospitals, 58 percent of CHC-FRUs and 64 percent of CHCs where LAP services were provided. 58 percent of district hospitals, 22 percent each of CHC-FRU and CHC providing LAP services had a separate FP counselling corner. Around 72 percent of district hospitals, 60 percent of CHCs and 53 percent of CHC-FRUs providing LAP services were conducting urine examinations before the LAP procedure. Very few PHCs and UPHC/UCHCs conducted the lab tests before the LAP procedure. 43 percent of all facilities conducted haemoglobin tests before the LAP procedure. For performing LAP procedures 48 percent of district hospitals, 16 percent of each CHC-FRUs and CHCs, 2 percent of PHCs and only 1.5 percent of UPHC/UCHCs reported having all the twelve essential equipment[16].

10 percent of CHC-FRUs and 7 percent of CHCs had none of the essential equipment for the LAP procedure. Only 11 percent of the facilities had a trained doctor for LAP. A little more than one-third of the district hospitals (37%), one-tenth of CHC-FRUs and 8 percent of CHCs reported having trained doctors for LAP. Only 3 percent of PHCs and UPHC/UCHC reported the availability of trained doctors for LAP. Overall, 27 percent of the facilities had at least 1 complete kit of LAP available at the time of the survey. Around 69 percent of the district hospitals, 32 percent of the CHC-FRUs and 36 percent of the CHCs reported having at least 1 complete kit of LAP. Only a handful of PHCs reported the availability of LAP kits (Table 49).

[16]Essential equipment for LAP includes: operating laparoscope or laparocator, light source for laparoscope, fibre-optic scale, trocar with cannula, Pneumoperitoneum insufflation apparatus, Falope ring loader, Falope ring, dissecting forceps-toothed, scalpel with #11 blade, glutaraldehyde, glutaraldehyde container with cover, SS tray (to rinse laparoscope)

Table 49: Availability of essential infrastructure, laboratory test, equipment, and HR for LAP services by type of health facilities, Uttar Pradesh, 2020-21

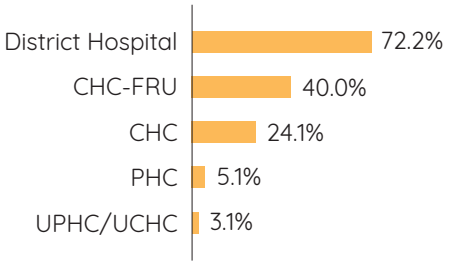
Requirements of Mini-LAP	DH	CHC-FRU	CHC	PHC	UPHC/ UCHC	Total
LAP service provided through:						
Regular	50.7	6.4	6.0	0.9	1.5	10.7
FDS	14.1	22.4	6.0	1.7	0.0	9.5
COT	0.0	12.0	8.6	3.4	0.0	5.9
FDOS	8.5	28.0	48.3	10.3	0.0	22.1
Infrastructure Requried						
Waiting area with seating arrangements	71.8	58.4	63.8	16.2	1.5	44.1
Separate FP counselling corner	57.7	21.6	21.6	5.1	0.0	20.0
Pre-operative room for washing, changing clothes, and pre-medication	62.0	35.2	44.8	3.4	0.0	29.1
Sterilization room near OT for autoclaving & cleaning equipment	70.4	51.2	56.9	8.5	1.5	38.7
Functional operation theatre (OT)	71.8	57.6	63.8	12.8	1.5	43.1
Recovery room	69.0	32.8	47.4	5.1	0.0	30.6
Office area for keeping records	71.8	56.0	54.3	13.7	1.5	40.7
Hand washing area tap near OT for scrubbing	70.4	56.0	59.5	12.0	1.5	41.3
Toilets with running water	71.8	54.4	60.3	15.4	1.5	42.1
Electricity supply with power backup (Generator/Invertor)	71.8	55.2	61.2	12.0	1.5	41.7
Emergency light	64.8	36.8	49.1	10.3	1.5	32.8
Laboratory Test Required:						
Urine examinations	71.8	52.8	59.5	15.4	1.5	41.5
HB test	70.4	57.6	61.2	16.2	1.5	43.1
Essential equiment available and functional						
Operating laparoscope or laparocator	70.4	32.8	37.1	5.1	1.5	28.5
Glutaraldehyde	57.7	33.6	32.8	4.3	1.5	25.7
Light source for Laparoscope	70.4	42.4	50.9	6.8	1.5	34.6
Fibre-optic cable	67.6	30.4	41.4	6.0	1.5	28.7
Trocar with cannula	69.0	36.0	39.7	6.0	1.5	30.0
Pneumoperitoneum insufflation apparatus	60.6	28.0	32.8	2.6	1.5	24.3
Falope ring loader	70.4	33.6	39.7	4.3	1.5	29.1
Falope ring	70.4	33.6	37.1	6.8	1.5	29.1
Dissecting forceps, toothed	69.0	35.2	37.9	6.0	1.5	29.4
Scalpel with # 11 blade	69.0	38.4	37.1	7.7	1.5	30.4
Glutaraldehyde container with cover	66.2	36.8	44.8	5.1	1.5	30.8
SS tray (to rinse laparoscope)	70.4	36.0	44.8	9.4	1.5	32.2
Availability of all 12 essential equipment/item	47.9	16.0	16.4	1.7	1.5	15.4
Availability of none of the essential equipment	0.0	9.6	6.9	6.0	0.0	5.5
Availability of trained doctor for LAP	36.6	10.4	7.7	2.6	3.1	10.7
Availability of complete kits of LAP	69.0	32.0	36.2	3.4	1.5	27.5
Total	**71**	**125**	**116**	**117**	**65**	**494**

DH = District Women Hospital and District Combined Hospital

4.3.3 NSV

It is interesting to see that only 20 percent of the public health facilities are providing Non-Scalpel Vasectomy (NSV) services, out of them 72 percent of district hospitals[17], 40 percent of CHC-FRUs, 24 percent of CHCs, 5 percent of PHCs and only 3 percent of UPHC/UCHCs provide NSV services in the state (Figure 40).

Figure 40: Percentage of public health facilities providing NSV services, Uttar Pradesh, 2020-21



Around 44 percent of the district hospitals were providing NSV services on a regular basis. 28 percent of the district hospitals and 22 percent of the CHC-FRUs were providing NSV service through Fixed Day Services (FDS). NSV at 15 percent of the CHCs and 5 percent of the PHCs were conducted through Fixed Day Outreach Services (FDOS). Only 28 percent of the district hospitals, 14 percent of CHC-FRUs and only 9 percent of the CHCs had a separate FP counselling corner. No UPHC/UCHC had a separate FP counselling corner. Functional operation theatre was available in only 72 percent of district hospitals, 39 percent of CHC-FRUs and 23 percent of CHCs where NSV services were provided. CHCs, PHCs and UPHC/UCHCs lacked basic infrastructure like toilets, hand washing areas, power supply, office area etc.Around 72 percent of district hospitals, 37 percent of CHC-FRUs and 22 percent of CHCs providing NSV services were conducting urine examinations before the NSV procedure. As per the GoI mandate, semen examination is necessary before performing the NSV procedure. Overall, only 4 percent of the facilities reported performing this test. About 50 percent of district hospitals and only 5 percent of the CHC-FRUs reported performing semen examination. Less than a percent of PHCs were found performing semen examination before the NSV procedure. For performing NSV procedures 61 percent of district hospitals, 14 percent of CHC-FRUS, 7 percent of CHCs, 1 percent of PHCS and 3.1 Percent of UPHC/UCHCs reported having all the five essential functional equipment[18]. 4 Percent of CHC-FRUS and 2 percent of UPHC/CHCs had none of the essential equipment for the NSV procedure. Only 10 percent of the facilities had a trained doctor for NSV. About 40 percent of the district hospitals, and 13 percent each of CHC-FRUs and CHCs reported having trained doctors for NSV. Only 3 percent of PHCs and 6 percent UPHC/UCHC reported the availability of trained doctors for NSV. Overall, 14 percent of the facilities had at least 1 complete kit of NSV available at the time of the survey. Around 72 percent of the district hospitals, 23 percent of the CHC-FRUs and 13 percent of the CHCs reported having at least 1 complete kit of NSV. Less than a percent of PHCS reported the availability of NSV kits (Table 50).

[17]Male sterilization is provided in District Male Hospital and District Combined Hospital
[18]Essential equipment for NSV includes: instrument boiler, Metzenbaum scissors, extra cutaneous vas fixation ring forceps, vas dissecting forceps and non-absorbable suture (2-0 silk)

Table 50: Availability of essential infrastructure, laboratory test, equipment, and HR for non-scalpel vasectomy (NSV) services by type of health facilities, Uttar Pradesh, 2020-21

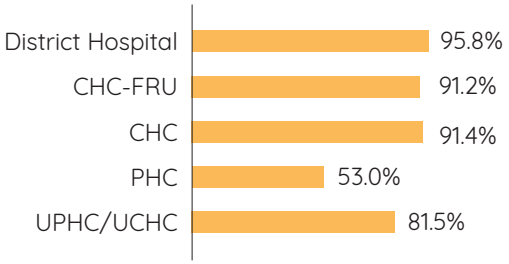
Requirements of Mini-LAP	DH	CHC-FRU	CHC	PHC	UPHC/ UCHC	Total
NSV service provided through:						
Regular	44.4	8.0	4.3	0.0	3.1	5.7
FDS	27.8	21.6	4.3	0.0	0.0	8.4
COT	0.0	3.2	1.7	0.0	0.0	1.4
FDOS	5.6	13.6	15.5	5.2	0.0	9.5
Infrastructure Requried						
Waiting area with seating arrangements	72.2	40.0	23.3	5.1	3.1	22.2
Separate FP counselling corner	27.8	14.4	8.6	0.9	0.0	7.7
Pre-operative room for washing, changing clothes, and pre-medication	55.6	24.0	18.1	0.9	3.1	14.5
Sterilization room near OT for autoclaving & cleaning equipment	72.2	36.0	22.4	2.6	3.1	20.2
Functional operation theatre (OT)	72.2	39.2	23.3	4.3	3.1	21.8
Recovery room	72.2	21.6	19.8	1.7	1.5	15.0
Office area for keeping records	72.2	39.2	22.4	5.1	3.1	21.8
Hand washing area tap near OT for scrubbing	72.2	39.2	21.6	4.3	3.1	21.3
Toilets with running water	72.2	38.4	23.3	5.1	3.1	21.8
Electricity supply with power backup (Generator/Invertor)	72.2	38.4	23.3	4.3	3.1	21.5
Emergency light	66.7	23.2	20.7	3.4	3.1	16.1
Laboratory Test Required:						
Urine examinations	72.2	36.8	22.4	5.1	3.1	21.1
Semen examination	50.0	4.8	2.6	0.9	0.0	4.3
Essential equiment for NSV - available and functional						
Instrument boiler	72.2	29.6	21.6	2.6	3.1	18.1
Metzenbaum scissors	66.7	22.4	10.3	1.7	3.1	12.7
Extra cutaneous vas fixation ring forceps	61.1	20.8	10.3	1.7	3.1	12.0
Vas dissecting forceps	72.2	24.8	10.3	1.7	3.1	13.6
Non-absorbable suture (2-0 silk)	72.2	25.6	12.9	1.7	3.1	14.5
Availability of all 5 essential equipment/item	61.1	13.6	6.9	0.9	3.1	8.8
Availability of none of the essential equipment	0.0	4.0	0.9	1.7	0.0	1.8
Availability of trained doctor for NSV	38.9	12.8	12.9	2.6	6.2	10.2
Availability of complete kits of NSV	72.2	23.2	12.9	0.9	3.1	13.8
Total	**18**	**125**	**116**	**117**	**65**	**441**

DH = District Women Hospital and District Combined Hospital

4.3.4 IUCD

Overall, 82 percent of the public health facilities are providing IUCD insertion services. Out of them 96 percent of the district hospitals, 91 percent each of CHC-FRUs and CHCs, 53 percent of PHCs and 81 percent of UPHC/UCHCs provide IUCD insertion services in the state (Figure 41).

Figure 41: Percentage of public health facilities providing IUCD services, Uttar Pradesh, 2020-21



For performing ICUD insertion, 70 percent of district hospitals, 27 percent of CHC-FRUs, 53 percent of CHCs, 14 percent of PHCs and 34 percent of UPHC/UCHCs reported having all the nine essential functional equipment[19]. 15 percent each of CHC-FRUs & CHCs and around 49 percent of PHCs had none of the essential equipment for IUCD procedure. About 41 percent of the facilities had a trained doctor for IUCD. About 86 percent of the district hospitals, 43 percent of CHC-FRUs, and 47 percent of CHCs reported having trained doctors for IUCD. Only 12 percent of PHCs and 29 percent UPHC/UCHC reported the availability of trained doctors for IUCD. Overall, 57 percent of the facilities had at least 1 complete kit of IUCD available at the time of the survey. 89 percent of the district hospitals, 50 percent of the CHC-FRUs and 70 percent of the CHCs reported having at least 1 complete kit of IUCD. UPHC/UCHCs reported good availability of IUCD kits but availability in PHCs was poor (Table 51).

Table 51: Availability of essential functional equipment, HR and kits for IUCD insertion by type of health facilities, Uttar Pradesh, 2020-21

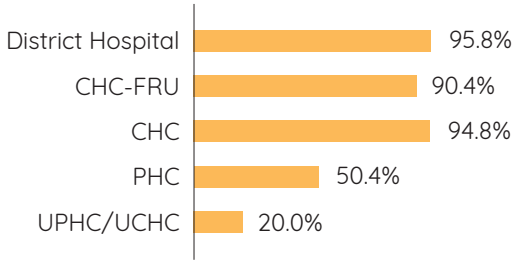
Requirements of Mini-LAP	DH	CHC-FRU	CHC	PHC	UPHC/ UCHC	Total
Essential equiment for IUCD - available and functional						
Kidney tray	85.9	76.8	76.7	37.6	76.9	68.8
Sim's or Cusco's vaginal speculum-large, medium, small	93.0	63.2	72.4	41.0	72.3	65.6
Anterior vaginal wall retractor (If Sim's speculum is used)	93.0	60.0	69.0	38.5	66.2	62.6
Sponge holding forceps	93.0	74.4	80.2	47.9	80.0	72.9
Vulsellum forceps curved/tenaculum	91.5	72.0	77.6	42.7	70.8	69.0
Uterine sound	94.4	65.6	74.1	43.6	73.8	67.6
Mayo scissors	80.3	51.2	62.1	30.8	61.5	54.5
Long artery straight forceps (for IUCD removal)	90.1	56.8	69.0	39.3	64.6	61.3
Artery forceps medium	90.1	68.8	72.4	41.0	75.4	67.0
Availability of all 9 essential equipment	70.4	27.2	52.6	13.7	33.8	37.0
Availability of none of the essential equipment	4.2	15.2	15.5	48.7	18.5	22.1
Availability of trained doctors for IUCD	85.9	43.2	46.6	12.0	29.2	40.7
Availability of complete kits of IUCD	88.7	50.4	69.9	29.1	61.5	56.9
Total	**71**	**125**	**116**	**117**	**65**	**494**

[19]Essential equipment for IUCD includes: Kidney tray, Sim's or Cusco's vaginal speculum, anterior vaginal wall retractor (if Sim's speculum is used), sponge holding forceps, Vulsellum forceps curved/tenaculum, uterine sound, mayo scissors, long artery straight forceps (for IUCD removal), artery forceps medium

4.3.5 PPIUCD

Overall, 73 percent of the public health facilities are providing PPIUCD insertion services. Out of them 96 percent of the district hospitals, 90 percent of CHC-FRUs, 95 percent of CHCs, 50 percent of PHCs and 20 percent of UPHC/UCHCs provide PPIUCD insertion services in the state (Figure 42).

Figure 42: Percentage of public health facilities providing PPIUCD services, Uttar Pradesh,2020-21



For performing PPICUD insertion, 91 percent of district hospitals, 83 percent of CHC-FRUs, 87 percent of CHCs, 47 percent of PHCs and 15 percent of UPHC/UCHCs reported having all three essential functional equipment[20]. 51 percent of PHCs and 83 percent of UPHC/UCHCs had none of the essential equipment for the PPIUCD procedure.

About 40 percent of the facilities had a trained doctor for PPIUCD. About 90 percent of the district hospitals, 45 percent of CHC-FRUs, and 44 percent of CHCs reported having trained doctors for PPIUCD. Only 14 percent of PHCs and 17 percent UPHC/UCHC reported the availability of trained doctors for PPIUCD. Overall, 66 percent of the facilities had at least 1 complete kit of PPIUCD available at the time of the survey. 96 percent of the district hospitals, 80 percent of the CHC-FRUs and 84 percent of the CHCs reported having at least 1 complete kit of PPIUCD. PHC had a fair availability of PPIUCD kits but availability in UPHC/UCHCs was poor. (Table 52)

Table 52: Availability of essential functional equipment, HR and kits for PPIUCD insertion by type of health facilities, Uttar Pradesh, 2020-21

Requirements of Mini-LAP	DH	CHC-FRU	CHC	PHC	UPHC/ UCHC	Total
Essential equiment for PPIUCD - available and functional						
Sponge holder	94.4	85.6	88.8	49.1	16.9	69.8
Sim's speculum	91.5	85.6	88.8	49.1	16.9	69.4
Stainless steel tray with cover (12"*8"*2")	94.4	88.0	92.2	47.4	15.4	70.6
Availability of all 3 essential equipment	91.5	83.2	87.1	46.6	15.4	67.6
Availability of none of the essential equipment	5.6	11.2	7.8	50.9	83.1	28.3
Availability of trained doc for PPIUCD	90.1	44.8	44.0	14.5	16.9	40.1
Availability of complete kits of PPIUCD						
No kit available	0.0	20.0	15.5	56.9	86.2	34.0
1-4	87.3	80.0	82.8	44.0	13.8	64.4
>4	8.5	0.0	1.7	0.0	0.0	1.6
Total	**71**	**125**	**116**	**117**	**65**	**494**

[20]Essential equipment for PPIUCD includes: Sponge holder, Sim's speculum, stainless tray with cover (12"*8*2")

4.4 Quality of services at the health facilities

4.4.1 Availability of trained HR

Table 53 shows the availability of at least one trained provider per facility for different family planning methods. For permanent methods, the availability of trained doctors has been checked, while for spacing methods, the availability of doctors, staff nurses and ANMs have been checked.

Table 53: Availability of at least one trained HR per facility for different family planning methods/ procedures, Uttar Pradesh, IFPS 2020–21

Method	DH	CHC-FRU	CHC	PHC	UPHC/UCHC	Total
Permanent methods	**58.9**	**29.6**	**29.3**	**11.1**	**12.3**	**27.2**
LAP	37.0	10.4	7.8	2.6	3.1	10.9
Mini-LAP	50.7	19.2	21.6	7.7	6.2	20.0
NSV	17.8	12.8	12.9	2.6	6.2	10.3
Spacing methods	**93.2**	**97.6**	**98.3**	**65.0**	**89.2**	**88.3**
IUCD	91.8	93.6	93.1	53.0	81.5	82.1
PPIUCD	93.2	95.2	93.1	57.3	58.5	80.7
Antara	90.4	93.6	96.6	63.3	76.9	84.5
Chhaya	86.3	88.0	82.8	52.1	69.2	75.6
Total (N)	**73**	**125**	**116**	**117**	**65**	**496**

The availability of trained providers for permanent methods is high in district hospitals (59%), followed by CHC and CHC-FRUs (30% each). More than half (51%) of the District hospitals in the state have trained providers for Mini-LAP, 37 percent have for LAP and 18 percent for NSV. All the facilities reported high availability of trained providers for spacing methods (ranging from 89% to 98%) except PHCs (65%). 52 percent of the PHCs had trained providers for centchroman (Chhaya), and an almost equal number of providers for IUCD were available.

It is surprising to see that only 18 and 23 percent of facilities have the required number of doctors and staff nurses respectively as per the IPHS norms, 2022 (Table 54). This shows the lack of availability of required human resources in the public health facilities of the state. High-level facilities lack staff nurses while low-level facilities lack the required doctors. 58 percent of district hospitals had the required number of doctors and only 3 percent of district hospitals had required staff nurses. For UPHC/UCHC , 5 percent of the facilities had the required number of doctors and 71 percent of facilities had the required number of staff nurses.

Table 54: Availability of required HR as per the IPHS 2022 norms for different facility type, Uttar Pradesh, IFPS 2020–21

Method	% having required number of doctors	% having required number of nurses	Number of facilities (N)
DH	57.8	3.1	**64**
CHC-FRU	25.5	3.6	**110**
CHC	12.4	8.3	**97**
PHC	1.7	38.5	**117**
UPHC/UCHC	4.6	70.8	**65**
Total	**18.1**	**23.2**	**453**

4.4.2 Availability of IEC material

IEC material helps the provider in counselling the clients. The table shows the availability of IEC materials in the counselling corner of the facility on different permanent and reversible modern methods, postpartum and post-abortion family planning and birth spacing. Data suggests that high-level facilities like district hospitals and CHC-FRUs are fairly well equipped with the IEC material for family planning methods, but the same is not true with low-level facilities like PHC. The survey found that 23 percent of the facilities had no IEC material in their FP counselling corner, PHCs at high with 44 percent and district hospitals at low with 12 percent. Facilities lacked the availability of IEC material on male sterilization, postpartum and post-abortion family planning (Table 55).

Table 55: Availability of IEC materials at the family planning counselling corner by type of facility, Uttar Pradesh, IFPS, 2020–21

IEC Material	DH	CHC-FRU	CHC	PHC	UPHC/ UCHC	Total
Female sterilization	79.5	73.6	47.4	30.8	33.8	53.0
Male sterilization	63.0	62.4	37.9	28.2	32.3	44.8
IUCD	83.6	79.2	56.9	42.7	58.5	63.3
Condom	84.9	77.6	50.0	45.3	56.9	61.9
Post-abortion family planning	72.6	43.2	27.6	12.8	21.5	33.9
Postpartum family planning	76.7	59.2	28.4	25.6	21.5	41.7
MPA (Antara)	86.3	80.8	73.3	48.7	72.3	71.2
Centchroman	86.3	79.2	73.3	49.6	76.9	71.6
Mala-N	84.9	75.2	54.3	45.3	60.0	62.7
None of the above are available	12.3	15.2	19.8	43.6	21.5	23.4
At least four of the above are available	86.3	80.8	56.9	42.7	56.9	63.9
All of the above are available	56.2	36.0	18.1	12.0	12.3	26.0
Ensuring Spacing of Birth Scheme	67.1	47.2	25.9	16.2	23.1	34.7
Total (N)	**73**	**125**	**116**	**117**	**65**	**496**

4.4.3 Availability of quality improvement team

Overall, 68 percent of the facilities reported having a quality assurance committee and quality improvement plan for their facilities. Most of the high level facilities (96%of district hospitals, 84% CHCs and 78% CHC-FRUs) reported having a quality assurance committee and quality improvement plan for their facilities. It was found that the family planning component was available in the quality improvement plan developed by the facilities (Table 56).

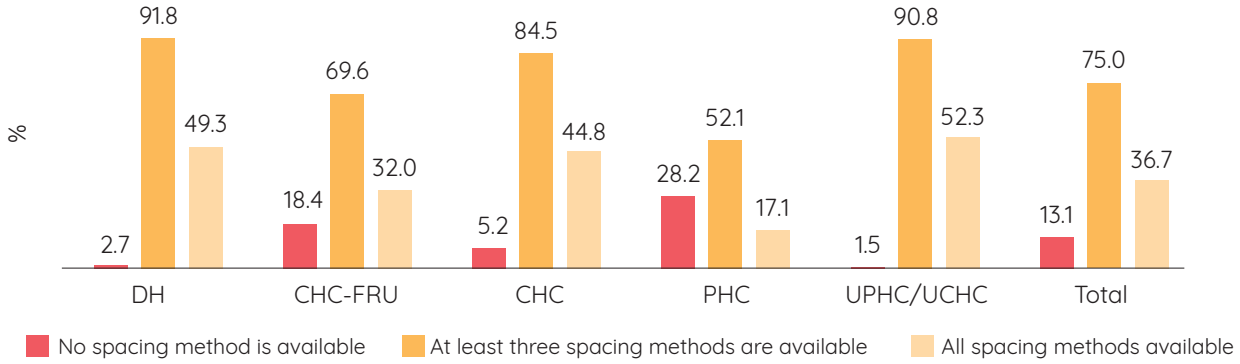
Table 56: Components of quality assurance committee by type of facility, Uttar Pradesh, IFPS 2020–21

Presence of:	DH	CHC-FRU	CHC	PHC	UPHC/UCHC	Total
Quality Assurance Committee	95.9	78.4	84.5	34.2	52.3	**68.5**
Quality Improvement Plan	95.9	78.4	84.5	34.2	52.3	**68.5**
FP component in Quality Improvement Plan	91.8	76.0	80.2	33.3	52.3	**66.1**
Total	**73**	**125**	**116**	**117**	**65**	**496**

4.4.4 Method stock out

Figure 43 shows the current availability of modern spacing contraceptives in the public health facilities across the state. 13 percent of facilities did not have any spacing method available on the day of assessment, among them 28 percent of PHC and 18 percent of CHC-FRU had no spacing method available. 37 percent of facilities had all the spacing methods available on the day of assessment. Nearly half of the district hospitals, as well as UPHC/UCHC, 32 percent of CHC-FRU and 45 percent of CHC, had all the spacing methods available.

Figure 43: Availability of modern spacing methods by type of facility



Facilities reported a very good availability of IUCDs, injectables (Antara) and Condoms. Only 58 percent of facilities reported the availability of centchroman (Chhaya). Almost an equal percent (~73 percent) of district hospitals and UPHC/UCHC reported the availability of centchroman (Chhaya) with them, and only 38 percent of PHCs had centchroman (Chhaya) available with them. PHCs reported less availability of all the methods. UPHC/UCHC had a good stock of ECPs and OCPs than other facilities (Table 57). 46 percent and 38 percent of facilities in Bundelkhand and Purvanchal regions respectively reported a stock-out of centchroman (Chhaya) which lasted for more than a month. Stock-out of IUCDs were reported most in the Bundelkhand region (Table A.26)

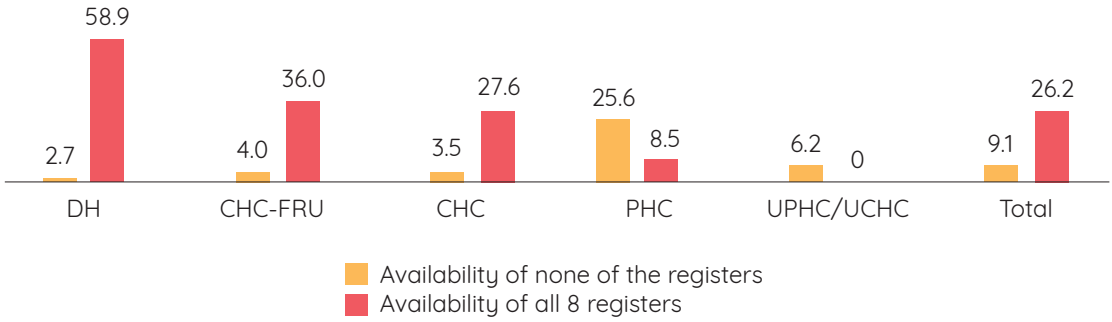
Table 57: Availability of different modern spacing methods by type of facility

Spacing Method	DH	CHC-FRU	CHC	PHC	UPHC/UCHC	Total
IUCD	91.8	70.4	83.6	39.3	80.0	70.6
MPA (Antara)	89.0	65.6	84.5	47.0	75.4	70.4
OCP-Chhaya	72.6	51.2	65.5	38.5	73.8	57.7
ECP	79.5	64.8	75.0	47.9	86.2	68.1
OCP	75.3	59.2	75.0	49.6	90.8	67.1
Condom	87.7	66.4	80.2	59.8	86.2	73.8
Total	**73**	**125**	**116**	**117**	**65**	**496**

4.4.5 Record maintenance

Overall, 68 percent of the facilities reported having a quality assurance committee and quality improvement The survey assessed the availability of registers – male or female sterilization, IUCD insertion and follow-up, PPIUCD insertion and follow-up, centchroman (Chhaya) /OCP register, MPA register, Counselling register, Contraceptive stock and maternal death register in the facility. Out of all the surveyed facilities, 26 percent of facilities reported having all the above mentioned registers. 59 percent of district hospitals, 36 percent of CHC-FRUs, and 28 percent of CHCs reported having all the registers at their facilities. None of the surveyed UPHC/UCHCs reported having all the listed registers (Figure 44).

Figure 44: Availability of different contraceptive and stock registers by type of facility

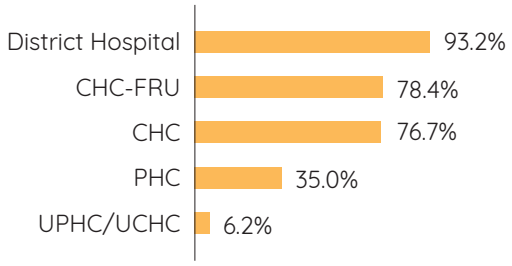


It was seen that registers related to family planning services were fairly available at District hospitals, CHC-FRUs and CHCs. The counselling register was available only in less than half of the CHCs. Maternal Death Register was found in very few UPHC/UCHCs and some PHCs (Table A.27)

4.4.6 Waste management

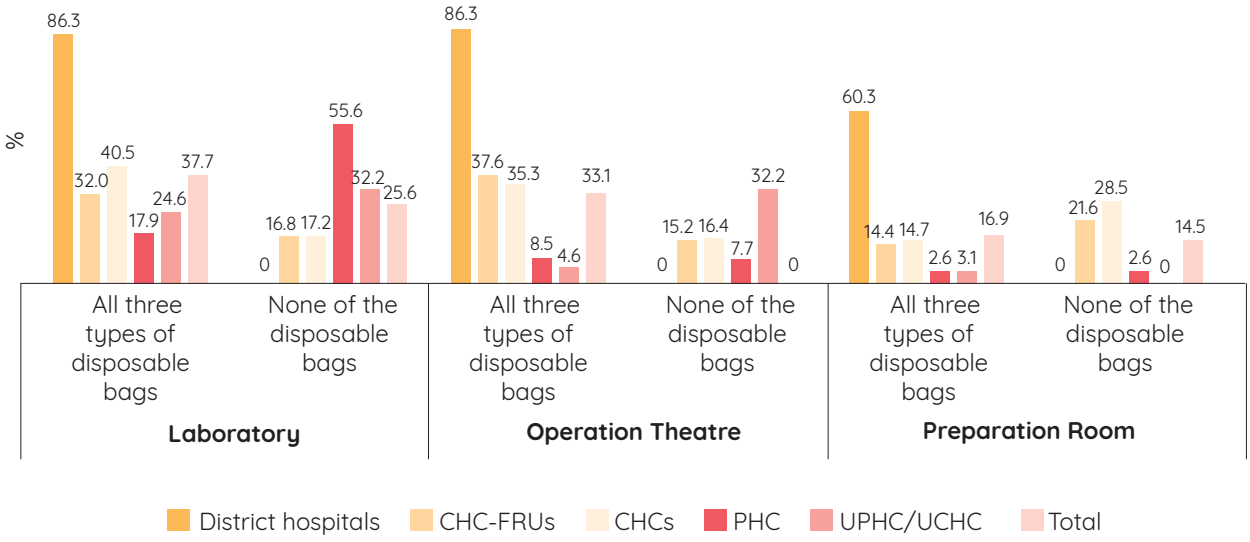
Within healthcare facilities, different work areas generate different types of biomedical waste. Biomedical waste needs to be segregated into different categories to enable proper treatment and disposal in accordance with the Bio-Medical Waste Management Rules. The IFPS has recorded the availability of different disposal bags in the health facility. Out of 496 facilities, 60 percent of facilities reported having a bio-medical waste collection room. 93 percent of the District hospitals, 78 percent of the CHC-FRUs and 77 percent of the CHCs reported having a bio-medical waste collection room in their facilities. Only 35 percent of the PHCs and 6 percent of the UPHC/UCHCs reported having a bio-medical waste collection room (Figure 45).

Figure 45: Percentage of facilities with bio-medical waste collection room



38 percent of facilities reported having all three types of disposable bags in their laboratories, 33 percent of facilities reported having all three types of disposable bags in their operation theatre and only 17 percent of facilities reported having all three types of disposable bags in their preparation room. A large proportion (85%) of district hospitals reported using different colour-coded bags in laboratory and operation theatres to segregate the bio-medical waste. 32 percent of CHC-FRUs and 41 percent of CHCs reported using any of the colour-coded bags in laboratories. More than half of the PHCs reported not using any of the colour-coded bags in laboratories (Figure 46).

Figure 46: Items available for waste disposal at different locations by type of facility



5 LINKAGES BETWEEN METHOD UPTAKE, PROVIDER'S AVAILABILITY AND FACILITY PREPAREDNESS

The utilization of FP services, especially method specific use depends on a number of factors such as women's knowledge of different methods available, their access to the services or facilities, provider's availability, and facility preparedness for the provision of the said method. Additionally, ASHA's and ANM's knowledge and training on family planning may have a linkage with contraceptive use among women in that geography.

5.1 Method-specific use and availability

5.1.1 STERILIZATION

The prevalence of sterilization was at 17.5 percent in the state and it varied widely across the state. Divisions such as Jhansi (36.9%), Mirzapur (36.4%) and Varanasi (32.4%) had the highest prevalence of sterilization with more than one-third of FP users opting for these limiting methods. While on the other hand, divisions such as Gonda (4.1%), Basti (7.9%) and Kanpur Nagar (9.0%) had less than one-tenth of FP users going for sterilization. The variations in the prevalence of a method across the geography can potentially be linked to various factors such as the availability of trained providers at the facility and readiness of the facilities for the provision of that service along with the demand for that method (Table 58).

As depicted in Table 58, the Jhansi division which showed a high prevalence of sterilization also had higher availability of trained providers at facilities (50%), and a lower unmet need for limiting (6.1%) than the state average, depicting fair availability and access to sterilization services in the division. However, the facility readiness for sterilization services as defined by the availability and functionality of essential instruments for sterilization, infection prevention materials and availability of trained providers was very low in the same division (10.7%). The same was the case in Mirzapur. In these divisions, improving the facility readiness can help sustain the high prevalence, and improve the quality of services for limiting methods.

Varanasi division also depicted a high prevalence of sterilization, but the availability of trained providers was only at 36 percent of facilities. Moreover, only 3 percent of facilities had the functional essential instruments, infection prevention materials and trained providers to provide sterilization services, depicting a big gap in the quality of services being provided at the facilities.

Gonda and Basti divisions showed the lowest prevalence of sterilization, and the highest unmet need for limiting within the state, highlighting the high demand but low utilization of sterilization in these divisions. Additionally, the facility readiness for sterilization services was poor in both these divisions. Further, about 18 percent of facilities in Gonda and 33 percent of facilities in Basti had providers trained on sterilization. Given the high demand and poor availability of services and providers, improving the availability of trained providers and facility readiness may help in improving the utilization of sterilization services in these divisions.

The divisions like Aligarh and Saharanpur have a low prevalence of sterilization and a low level of facility readiness for the provision of these services. Further, the low level of unmet need for limiting reflects lower demand for sterilization in these divisions. However, ASHAs in these divisions have a fair knowledge of sterilization. Moreover, in these divisions, the reliance is more on traditional methods and modern spacing methods, that too on condoms, which are majorly provided by the private sector.

Table 58: Division-wise prevalence of sterilization, availability of trained provider in facility, facility readiness and unmet need for limiting

Divisions	Sterilization (%)	Facilities with availability of trained provider (%)	Facility readiness[21](%)	Unmet need for limiting (%)
Agra	19.9	25.8	9.7	7
Aligarh	9.3	16.7	4.2	6.7
Ayodhya	12.7	47.8	21.7	9.9
Azamgarh	19.8	23.1	7.7	10.5
Bareilly	10.7	36	8	14.4
Basti	7.9	33.3	9.5	16.3
Chitrakoot	29	37.9	6.9	8.1
Gonda	4.1	17.7	11.8	16.1
Gorakhpur	26.9	32.3	12.9	10.9
Jhansi	36.9	50	10.7	6.1
Kanpur Nagar	9	50	4.6	12.7
Lucknow	12.7	35.7	14.3	14.7
Meerut	14.9	47.4	10.5	6.7
Mirzapur	36.4	51.7	13.8	8.9
Moradabad	12.1	37	11.1	10.2
Prayagraj	24.1	45.5	15.2	10.8
Saharanpur	10.7	27.6	6.9	7.1
Varanasi	32.4	36.4	3	9
Uttar Pradesh	**17.5**	**36.8**	**10.1**	**10.7**

5.1.2 Traditional methods

As mentioned in Chapter 2, the findings from IFPS showed that the use of TM is high in the state irrespective of the women's socio-demographic characteristics however, the geographic variations across the divisions persisted. Table 59 shows that while Ayodhya, Aligarh and Basti divisions reported 30-34 percent TM use, even the divisions reporting the lowest TM use within the state (Jhansi and Lucknow) had almost 17 percent of women relying on TM. The data further suggested that high TM use could not be attributed to the non-availability of modern methods or lack of trained providers and FLWs, as across all divisions, 50 percent or more facilities had availability of three or more spacing methods and trained FLWs on modern spacing methods. More than two-thirds of the facilities across the divisions have availability of at least 3 modern spacing methods, except Azamgarh and Bareilly. Divisions with high availability of modern spacing methods at the facility also reported high traditional method users (more than the state prevalence of 23.7%). The majority of the divisions have more than one-thirds of ASHAs trained in modern spacing methods, except Bareilly and Agra where only 9-10 percent of the ASHAs have ever received training in these methods. The above analysis shows that the use of TM is not usually determined by the unavailability of the method rather it is governed largely by women's preferences, choice of first method use and ease/confidence in using the method as described in the earlier sections of the report.

[21]Facility readiness has been defined as availability of sterilization, trained providers, availability & functionality of essential instruments for sterilization, and availability of infection prevention materials in the facility.

Table 59: Division-wise prevalence of traditional method use, availability of modern spacing methods[22] in the facility and ASHAs trained in modern spacing methods

Divisions	Traditional Method (%)	Facilities with at least 3 modern spacing methods (%)	ASHAs trained on modern spacing methods (%)
Agra	26.2	87.1	10.0
Aligarh	32.3	83.3	33.3
Ayodhya	34.1	73.9	58.3
Azamgarh	23.9	50.0	71.4
Bareilly	24.3	52.0	9.1
Basti	30.0	81.0	33.3
Chitrakoot	21.7	69.0	42.3
Gonda	26.1	72.2	46.7
Gorakhpur	21.0	68.8	59.3
Jhansi	17.2	82.1	44.0
Kanpur Nagar	20.6	86.4	36.8
Lucknow	17.6	64.3	27.6
Meerut	27.5	94.7	38.9
Mirzapur	19.1	75.9	67.7
Moradabad	22.2	77.8	20.8
Prayagraj	21.1	69.7	59.1
Saharanpur	26.0	75.9	47.8
Varanasi	21.8	78.8	70.4
Uttar Pradesh	**23.7**	**75.0**	**44.6**

5.1.3 Modern spacing methods

The use of modern spacing methods (IUCD, injectables (Antara), OCPs, ECPs and condoms) was found to be much lower than the limiting methods and traditional methods of family planning. Table 60 showed varied use of modern spacing methods across divisions in the state, with the highest use in the Saharanpur division (26.7%) and the lowest use in the Mirzapur division (6.8%). The availability of modern spacing methods and trained human resources for them in the facilities across divisions was quite high, hinting that the availability of methods is not an issue.

In the divisions of Gonda, Basti and Mirzapur, the usage of modern spacing methods was very less despite the high unmet need for spacing. Moreover, three or more spacing methods were available across all divisions in at least 50 percent of the facilities (Table 59) and a majority of facilities across divisions had at least one trained provider on modern spacing methods (Table 60). In the case of the usage of spacing methods, a major contribution was from condoms, which are primarily sourced from the private sector. As per IFPS, only 3.7 percent of users reported getting it from ASHA/VHSND or public health facilities, while the rest depended on pharmacies/medical shops. Thus, the high availability of spacing methods may not necessarily translate into the utilization of these methods.

[22]Modern spacing method includes – IUCD, injectables, Pills, Chhaya, Emergency Contraceptive Pills and Condoms

Table 60: Division-wise prevalence of modern spacing methods, availability of method and trained HR in the facilities, and unmet need for spacing, Uttar Pradesh

Divisions	Modern spacing methods (%)	Facilities with the availability of at least 1 trained HR on modern spacing methods (%)	Unmet need for spacing (%)
Agra	19.2	90.3	4.5
Aligarh	22.4	79.2	4.8
Ayodhya	10.6	91.3	4.2
Azamgarh	9.5	96.2	4.5
Bareilly	17.9	96.0	4.9
Basti	9.9	95.2	6.1
Chitrakoot	11.0	86.2	4.3
Gonda	7.1	88.9	5.9
Gorakhpur	8.2	90.6	3.8
Jhansi	15.8	78.6	2.5
Kanpur Nagar	20.9	90.9	2.7
Lucknow	17.2	82.1	4.3
Meerut	25.8	97.4	2.6
Mirzapur	6.8	82.8	6.5
Moradabad	19.5	85.2	4.9
Prayagraj	12.5	90.9	4.6
Saharanpur	26.7	86.2	3.6
Varanasi	10.2	81.8	5.5
Uttar Pradesh	**15.4**	**88.3**	**4.4**

5.2 Individual, community and facility level factors determining modern method use

To capture the effect of different factors on the use of family planning methods (limiting and spacing), a linked analysis was conducted comprising women's socio-demographic characters, their participation in decision making on FP, their awareness about methods and their sources, and their engagement with FLWs or facility based service providers. In addition, ASHA's characteristics such as population covered, training, self-efficacy, motivation, knowledge of incentives etc. were also considered. Table 61 shows that women's working status significantly affects the use of both limiting (Male and female sterilization) and modern spacing methods. The use of limiting methods was higher among working women (31%), while spacing methods were more prevalent among non-working women (21.3%). Further, women's decision-making also matters in the uptake of FP services. Women who participated in all four decisions on FP[23] used more limiting methods than those who did not participate (22.7% vs. 14.7%). The use of spacing methods doubled among women who know at least three platforms for obtaining the methods (25%). Interaction with FLWs/ facility-based providers positively affects the uptake of limiting methods among women. Training of ASHAs and their knowledge about incentives was also significantly associated with the uptake of limiting methods. Limiting methods use was higher among the areas where ASHA was trained (22.5%) and knew about their incentives (23.1%). Additionally, in communities where ASHA faced difficulties while performing their job function, women had lower use of both limiting (20.1%) and spacing methods (16.2%). The uptake of services was always higher if the facility was ready in terms of availability of services, trained staff, and instruments related to services, to provide the services. The use of limiting methods was significantly higher where the facility readiness score was high compared to those facilities where readiness was low (23.3% vs. 18%) (Table 61).

[23]Decisions on timing of childbirth, using family planning method, type of family planning method to use, and number of sons or daughters.

Table 61: Use of limiting and spacing methods by women's and ASHA's characteristics

Background characteristics	Limiting methods (%)	p-value	Spacing methods (%)	p-value
Age (in years)		<0.0001		<0.0001
15-29	7.3		23.7	
30+	29.1		18.3	
Education		<0.0001		<0.0001
No education	27.3		14.1	
upto 5std	22.3		15.2	
6-9std	17.7		22.3	
10-12std	12.2		23.8	
>12std	8.4		38.2	
Parity		<0.0001		<0.0001
Zero	0		13	
1	0.9		25.2	
2-3parity	22.4		24.2	
4+	30.7		14.7	
Caste		<0.0001		<0.0001
SC/ST	23.6		17.3	
OBC	17.9		21.3	
Others	18.6		24.1	
Religion		<0.0001		<0.0001
Hindu	22.3		19.9	
Non-Hindu	5.8		24.6	
Wealth index		<0.0001		<0.0001
Poorest	24.2		12.1	
Poorer	22.3		16.1	
Middle	21.1		17.1	
Richer	18.7		21	
Richest	13.8		34.1	
Working		<0.0001		<0.0001
No	17.3		21.5	
Yes	31		16.6	
Participated in all four decisions on FP		<0.0001		0.323
No	14.7		21.3	
Yes	22.7		20.2	
Correct knowledge of at least three methods		<0.0001		<0.0001
No	20.2		16.7	
Yes	18.4		29.9	
Awareness about at least three source of FP methods		0.425		<0.0001
No	18.7		12.2	
Yes	20.2		24.9	

Background characteristics	Limiting methods (%)	p-value	Spacing methods (%)	p-value
Interaction with FLWs/ Facility based providers		<0.0001		0.005
No	10.4		21.9	
Yes	23.4		20.1	
ASHA's characteristics Population covered		0.005		0.011
≤1000	21		18.8	
1000-1500	21.1		16.4	
>1500	22.2		15.3	
Work experience		<0.0001		0.041
Upto 10 years	19.5		18.3	
≥11 years	21.8		16.8	
Self-efficacy		0.772		0.273
Low	18.9		16.5	
Medium	21.7		16.7	
High	21.4		18.8	
Multi-dimensional work and motivation index		0.261		0.615
Low	19.5		16.7	
Medium	21.4		16.8	
High	21.6		18.1	
Training		<0.0001		0.164
No	16.2		17.7	
Yes	22.5		16.1	
Incentive's knowledge		0.001		0.258
No	20		17.5	
Yes	23.1		16.8	
Perceived difficulty		0.002		<0.0001
No	24.6		20.8	
Yes	20.1		16.2	
Facility level factors Facility readiness		<0.0001		0.719
Low	18		20.3	
Medium	17.4		21.1	
High	23.3		20.5	

The likelihood of limiting method use was about 4 times higher among 30+ years age group women (AOR: 3.95; CI: 3.32 – 4.69) whereas the odds of spacing method use was less likely among the same age group women (AOR: 0.68; CI: 0.60 – 0.78) compared to women aged 15-29 years. The likelihood of limiting method use decreased with the increase in the educational level of the women however, the odds of spacing method use increased with the same. The odds of limiting method use were significantly more likely among women who participated in all four decisions on FP (AOR: 1.40; CI: 1.20 – 1.62). Moreover, women who interacted with FLWs/facility-based providers had higher odds of limiting methods use (AOR: 2.52; CI: 2.07 – 3.05). The likelihood of limiting method use was significantly higher among the communities where ASHAs were trained in all FP methods (AOR: 1.76; CI: 1.29 – 2.42). Similarly, in the areas where ASHA knew about their incentives, had a higher likelihood of limiting methods used than their counterparts (AOR: 1.25; CI: 0.97 – 1.62). Additionally, if ASHA faced difficulties while performing their job

function, had lower odds of spacing methods use compared to those who did not face difficulties in their ASHA areas (AOR: 0.79; CI: 0.64 – 0.97). With reference to communities with low facility readiness, the likelihood of limiting method use was higher among the communities where facility readiness was high (OR: 1.53; CI: 1.20 – 1.95). However, this result was not significant after adjusting the effect of other socio-economic and demographic characteristics (Table 62).

The intra-class correlation coefficient (ICC) for the null model (or empty model), which had no individual, community or facility level variables was 22 percent and 16 percent for limiting and spacing, respectively. It examines the random variable and intercept. According to ICC implied by the estimated, intercept component variance, 22 percent and 16 percent of the variance in the limiting and spacing methods used, respectively could be attributed to community-level factors. After including individual and community-level variables in the final model, the ICC values decreased to 10 percent for spacing methods and for limiting method use, ICC remain the same (22%) (Table 62).

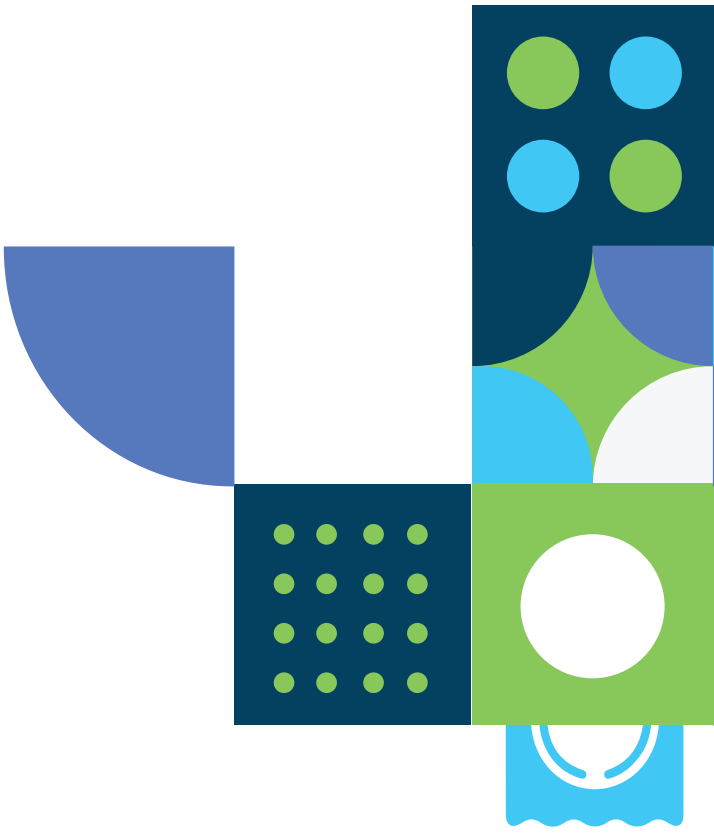


Table 62: Results from the linked analysis for limiting and spacing methods, Uttar Pradesh, IFPS 2020-21

	Limiting methods			
Background characteristics	**Individual**	**Community**	**Facility**	**Individual + Community**
Age (in years)				
15-29				
30+	4.17***(3.58 -4.86)			3.94***(3.31 -4.68)
Education				
No education				
Up to 5std	0.92(0.77 -1.11)			0.93(0.76 -1.14)
6-9std	0.59***(0.49 -0.71)			0.57***(0.46 -0.7)
10-12std	0.40***(0.33 -0.5)			0.37***(0.29 -0.48)
>12std	0.20***(0.15 -0.27)			0.23***(0.17 -0.33)
Parity				
Zero				
1				
`2-3 (reference for limiting)				
4+	1.32***(1.15 -1.52)			1.29***(1.1 -1.5)
Caste				
SC/ST	0.86(0.7 -1.05)			0.86(0.68 -1.09)
OBC	0.82**(0.68 -0.98)			0.83*(0.66 -1.03)
Others				
Religion				
Hindu				
Non-Hindu	0.17***(0.12 -0.22)			0.16***(0.11 -0.23)
Wealth index				
Poorest				
Poorer	0.94(0.78 -1.13)			0.99(0.81 -1.21)
Middle	1.05(0.86 -1.27)			1.07(0.87 -1.32)
Richer	1.12(0.91 -1.38)			1.16(0.92 -1.46)
Richest	1.02(0.79 -1.3)			0.98(0.72 -1.32)
Working				
No				
Yes	1.32***(1.14 -1.52)			1.37***(1.17 -1.62)
Participated in all four decisions on FP				
No				
Yes	1.37***(1.2 -1.56)			1.4***(1.2 -1.62)
Correct knowledge of at least three methods				
No				
Yes	0.91(0.79 -1.06)			0.91*(0.77 -1.08)
Awareness about at least three source of FP methods				
No				
Yes	1.02(0.88 -1.18)			1.0(0.85 -1.17)

	Spacing methods				
Individual + Community + Facility	Individual	Community	Facility	Individual + Community	Individual + Community + Facility
3.95***(3.32 -4.69)	0.68***(0.6 -0.78)			0.67***(0.57 -0.79)	0.67***(0.57 -0.79)
0.93(0.76 -1.14)	1.09(0.89 -1.32)			1.06(0.85 -1.33)	1.06(0.84 -1.33)
0.57***(0.47 -0.7)	1.52***(1.27 -1.8)			1.57***(1.27 -1.93)	1.56***(1.27 -1.92)
0.37***(0.29 -0.48)	1.67***(1.39 -2.01)			1.78***(1.43 -2.22)	1.78***(1.42 -2.22)
0.23***(0.17 -0.33)	2.9***(2.37 -3.56)			2.71***(2.09 -3.51)	2.7***(2.08 -3.51)
	2.43***(1.87 -3.17)			2.38***(1.69 -3.35)	2.38***(1.7 -3.35)
	2.83***(2.2 -3.65)			2.58***(1.86 -3.56)	2.58***(1.86 -3.56)
1.28***(1.1 -1.5)	2.61***(1.96 -3.48)			2.56***(1.78 -3.68)	2.56***(1.78 -3.67)
0.86(0.68 -1.09)	1.02(0.85 -1.23)			1.05(0.84 -1.32)	1.05(0.84 -1.33)
0.82*(0.66 -1.03)	1.08(0.92 -1.26)			1.15(0.94 -1.41)	1.15(0.94 -1.41)
0.16***(0.11 -0.23)	1.41***(1.17 -1.68)			1.26*(0.99 -1.6)	1.25*(0.99 -1.59)
0.99(0.81 -1.21)	1.27**(1.02 -1.58)			1.12(0.89 -1.42)	1.12(0.89 -1.42)
1.08(0.88 -1.32)	1.31**(1.05 -1.62)			1.18(0.94 -1.49)	1.18(0.94 -1.49)
1.16(0.92 -1.46)	1.36***(1.09 -1.7)			1.23*(0.96 -1.56)	1.23*(0.96 -1.56)
0.98(0.73 -1.33)	1.93***(1.52 -2.44)			1.57***(1.19 -2.08)	1.57***(1.19 -2.08)
1.37***(1.16 -1.61)	0.87*(0.75 -1.02)			0.75***(0.61 -0.91)	0.75***(0.61 -0.91)
1.40***(1.2 -1.62)	0.93(0.83 -1.05)			0.94(0.82 -1.09)	0.94(0.82 -1.09)
0.91(0.77 -1.08)	1.50***(1.32 -1.7)			1.43***(1.22 -1.67)	1.43***(1.22 -1.67)
1.00(0.85 -1.17)	1.52***(1.31 -1.76)			1.45***(1.22 -1.72)	1.45***(1.23 -1.72)

	Limiting methods			
Background characteristics	**Individual**	**Community**	**Facility**	**Individual + Community**
Interaction with FLWs/ Facility based providers				
No				
Yes	2.45***(2.08 -2.88)			2.52***(2.07 -3.05)
ASHA's characteristics Population covered				
≤1000				
1000-1500		0.92(0.72 -1.16)		0.92(0.71 -1.19)
>1500		1.12(0.76 -1.64)		1.19(0.78 -1.81)
Work experience				
Upto 10 years				
≥11 years		1.31**(1.02 -1.69)		1.22(0.93 -1.6)
Self-efficacy				
Low				
Medium		1.36*(0.98 -1.88)		1.59**(1.12 -2.26)
High		1.32(0.88 -1.98)		1.55*(1 -2.4)
Multi-dimensional work and motivation index				
Low				
Medium		1.36*(0.97 -1.92)		1.48**(1.02 -2.14)
High		1.25(0.87 -1.81)		1.31(0.88 -1.94)
Training				
No				
Yes		1.95***(1.45 -2.61)		1.81***(1.31 -2.48)
Incentive's knowledge				
No				
Yes		1.31**(1.03 -1.66)		1.25*(0.97 -1.62)
Perceived difficulty				
No				
Yes		0.79*(0.61 -1.01)		0.82(0.62 -1.08)
Facility level factors Facility readiness				
Low				
Medium			0.99(0.77 -1.26)	
High			1.53***(1.2 -1.95)	
Ramdom effects parameters				
Variance	0.92	0.82	0.88	0.93
ICC	0.22	0.2	0.21	0.22

	Spacing methods				
Individual + Community + Facility	Individual	Community	Facility	Individual + Community	Individual + Community + Facility
2.52***(2.07 -3.06)	0.82***(0.71 -0.94)			0.92(0.77 -1.11)	0.92(0.76 -1.1)
0.92(0.72 -1.19)		0.88(0.72 -1.07)		0.91(0.75 -1.11)	0.92(0.75 -1.11)
1.20(0.79 -1.82)		0.78(0.55 -1.09)		0.85(0.61 -1.2)	0.84(0.6 -1.19)
1.19(0.91 -1.56)		0.94(0.76 -1.16)		0.91(0.73 -1.12)	0.90(0.73 -1.11)
1.54**(1.09 -2.18)		1.0(0.76 -1.3)		0.89(0.68 -1.16)	0.88(0.68 -1.15)
1.50*(0.97 -2.32)		1.06(0.76 -1.49)		0.98(0.7 -1.37)	0.97(0.69 -1.35)
1.50**(1.04 -2.17)		0.89(0.68 -1.18)		0.91(0.69 -1.2)	0.91(0.69 -1.21)
1.31(0.89 -1.94)		0.97(0.72 -1.31)		0.99(0.74 -1.34)	1.0(0.74 -1.35)
1.76***(1.29 -2.42)		0.90(0.74 -1.09)		0.84*(0.69 -1.01)	0.83*(0.68 -1)
1.26*(0.97 -1.63)		0.92(0.75 -1.12)		0.90(0.74 -1.1)	0.91(0.75 -1.11)
0.83(0.63 -1.09)		0.74***(0.61 -0.91)		0.79**(0.64 -0.97)	0.79**(0.64 -0.97)
0.89(0.66 -1.2)			1.04(0.84 -1.29)		1.12(0.89 -1.4)
1.29(0.95 -1.74)			1.01(0.82 -1.26)		1.08(0.85 -1.37)
0.9	0.41	0.4	0.63	0.36	0.36
0.22	0.11	0.11	0.16	0.1	0.1

Interaction results

Knowledge about contraceptive methods among services providers and frontline workers plays a crucial role in the increase of acceptance of methods in their areas. The result shows that knowledge about limiting methods among ANM and ASHAs does not affect the uptake of limiting methods in their areas. The use of limiting methods in their areas was almost similar irrespective of their knowledge of the methods. However, ANM and ASHAs' knowledge about spacing methods increased the uptake of spacing methods use.

Table 63: Percentage of ASHAs and ANMs with knowledge about contraceptive methods and method use in their catchment area, Uttar Pradesh, 2020-2021

Knowledge about limiting methods	Limiting method use
Both have low knowledge	20.3
ANM High but Asha Low	20.9
ANM Low but ASHA High	22.2
Both have high knowledge	21.1
Knowledge about spacing methods	**Spacing method use**
Both have low knowledge	14.9
ANM High but Asha Low	19.3
ANM Low but ASHA High	18.4
Both have high knowledge	17.3
Knowledge about healthy timing and spacing of pregnancy	**Spacing method use**
Both have low knowledge	18.3
ANM High but Asha Low	16.4
ANM Low but ASHA High	14.9
Both have high knowledge	16.4

The use of spacing methods was more in the areas where ANM has high knowledge about spacing methods than ASHA. After adjusting the effects of other background characteristics, the likelihood of limiting methods use was higher in the areas where either ANM or ASHA had high knowledge about limiting methods, though the results were not significant. Further, the likelihood of spacing method use was found to be higher in the areas where ANM had high knowledge about the spacing methods compared to those areas where both ANM and ASHA has low knowledge about the spacing methods (Table 63).

6 RECOMMENDED PATHWAYS TO MEET FAMILY PLANNING GOALS OF UP POPULATION POLICY

The Government of Uttar Pradesh (GoUP) unveiled a UP Population Policy 2021-30 in July 2021 with the objective of bringing down the fertility rate and stabilizing the population. The goal is to bring the fertility rate to replacement level (2.1 per thousand populations by 2026 and to 1.92 by 2030). GoUP has also set the goal of achieving 75 percent demand satisfied by modern methods.

As per the IFPS 2021, the current modern contraceptive prevalence rate (mCPR) in UP stands at 34 percent and total unmet need at 15 percent. The total demand satisfied with modern methods is at 47 percent (Table 64). According to the NFHS-5 (2019-21) data, the mCPR is at 45 percent, the total unmet need at 13 percent, and demand satisfied by modern methods at 59 percent.

To achieve the goal of 75 percent demand satisfied by modern methods, the state will have to strive to:

- reduce the unmet need to at least half
- increase the mCPR to 60 percent
- bring down traditional methods use by at least 3%-4%

Table 64: Current and expected level of FP outcomes

Indicators	Current level		As per UP Population Policy goals	Expected level to achieve UP Population Policy goals
	As per IFPS	As per NFHS-5 (2019-21)		
mCPR	34%	45%	52%	60%
Traditional methods	24%	18%	-	14%
Total unmet need	15%	13%	-	6%
Total demand	73%	75%	-	80%
Demand satisfied by modern methods	47%	59%	75%	75%

6.1 Pathways to reduce unmet need and improve modern contraceptive prevalence

IFPS 2021 data shows that the unmet need for spacing is high among young couples aged 15-24 years (14.4%), and zero (7.2%) and low parity (14.9%) couples, while unmet need for limiting is high among older couples aged 25-49 years (11.5%) and high parity (2+ parity) couples (13.4%). It is even higher in the postpartum period (Figure 10 and 11).

The majority of women with unmet need reside in rural areas (83%). 50 percent of women with unmet need belong to the poorest wealth quintile and have <5 years of schooling. Also, unmet need is found to be highest among women in first year after delivery (24% in the postpartum period) which is double than the overall unmet need. NFHS-5 data also shows that currently there are 51 lakh women in UP with an unmet need for FP of which 32 lakh women have limiting need and 19 lakhs have unmet need for spacing.

There has been a geographical variability in the unmet need in the state. Six divisions viz. Lucknow, Gorakhpur, Bareilly, Gonda, Moradabad and Varanasi contribute to about 50 percent of the overall unmet need of the state (Table 58 & 60).

While use of sterilization has remained constant (17%), the use of condoms has increased from 10.8 percent (NFHS-4) to 12.5 percent (IFPS, 2021). More than 80 percent of condoms are still sourced from the private sector. Other modern methods, including oral contraceptive pills, injectable contraceptives and IUCDs have seen a marginal increase between NFHS-4 and IFPS, 2021. Geographical patterns in method preference are

also observed. Southern divisions have a stronger preference towards sterilizations, while divisions in Tarai region lean towards traditional methods. Western parts of the state depict a predominance of condom users and traditional users.

In terms of knowledge of women on FP methods, the IFPS 2021 shows that a higher share of women knows about condoms, IUCDs, daily oral contraceptive pills, and injectable contraceptives (Antara). However, the knowledge of emergency pills and weekly oral contraceptive pills (Chhaya) is comparatively low.

In considering future intentions around FP, 8 out of 10 users have expressed a desire to continue with their chosen method. Among the non-users, 34 percent have indicated an interest in using any method in future, with nearly 21 percent planning to adopt a contraceptive in the next 12 months. There is a positive trend seen among couples in meeting their reproductive choices as overall demand satisfied for FP methods has increased from 72 percent to 80 percent from NFHS-4 to IFPS, 2021.

Given that contraceptive preferences vary based on parity, the strategies to achieve desired outcomes should similarly be tailored to individual choices. Accordingly, the approaches outlined below encompass community, facility, and system-level interventions to cater to the FP preferences of women of all parity levels.

6.1.1 Women with Parity 0

The IFPS data shows that though younger and low parity women are early initiators of contraceptives compared to older women, the mean period of initiation of contraceptives from cohabitation to first use is still 1.2 years. Given that the majority of times, the first FP method ends up being the current method in use, it becomes crucial to leverage this opportunity and encourage more zero-parity women to adopt modern methods as their first choice of contraception. Also, reaching to zero-parity women soon after the marriage would be helpful in reducing the gap between cohabitation and first contraceptive use.

Messaging on contraceptives for young people is critical for them to make a decision in favour of using the contraceptive. Yet, younger women frequently face mobility constraints. Among them, 83 percent women aged 15-19 years and 69 percent women aged 20-24 years are allowed to leave the home only when accompanied. Evidence from IFPS further show that among younger women, those who have contact with FLWs or are SHG members, have a higher contraceptive use as against those with no contact with FLWs or SHGs. They also have access at household level where they can reach young women. Therefore, the presence of community level workers and leaders could be leveraged to impart correct and life stage appropriate information to younger and zero parity women/couples. Engagement of elected representatives like village Pradhans on creating discussion within community on core health issues, including FP can be an effective strategy as well.

However, findings from IFPS show that only 34.6 percent ASHAs meet newlyweds to advice on delaying first child while only 7.6 percent ASHAs provide overall counselling to newlyweds on various FP methods, their benefits and side effects, and place of access. Thus, reaching to the newlyweds through multiple channels becomes important to impart them with information on modern methods, which helps them make informed decisions that they are likely to continue with in future. Hence, using the innovative methods like D2C (Direct to Client) can be tested to reach this unreached segment with multiple set of information and messages in a more effective way through different mediums like WhatsApp, Chatbot, IVRS and text messages. The contents could also include images, texts and audio-visuals.

Enhancing the home delivery of contraceptives (HDC) can ensure that young women/couples have a range of modern methods readily accessible, enhancing their ability to choose based on their needs and

preferences. Another important strategy is to ensure the availability of FP commodities with ASHAs through FPLMIS for the uninterrupted distribution of contraceptives.

Distribution of '*Shagun* Kits' to newlyweds by ASHAs, is one such intervention that can provide the avenue to initiate the conversation on FP between newlyweds and ASHAs. However, only providing the kit is not enough. Initiating the conversation on contraceptives by ASHAs, follow-ups and creating touch points by FLWs with the newlywed couples will help them choose a contraceptive that suits their need. ASHAs could also connect newly-weds and 0 parity women to Chhaya integrated VHSNDs (CiVHSNDs) for counselling, access to contraceptives so that they are introduced to the platform and can also connect with ANMs as well. Effective availability of information and services to this group of women through multiple touch points will be crucial for them building an understanding and subsequently adopting a contraceptive method till the time they choose to have children.

Data also shows that condoms are the preferred method among newly-weds and zero parity couples. Since the private sector is the preferred source, improving supply side availability of condoms in the public sector can further catalyze the uptake of condoms.

To facilitate meaningful conversations with women, FLWs must be equipped with skills to discuss FP options with newlyweds and 0 parity women. The training packages for the FLWs will need to be tailor-made to specifically understand the need of the 0 parity couples and have specific conversations that align with their needs. Existing cluster meetings platform can be leveraged to capacitate the ASHAs to be better able to comprehend and cater to the unique preferences and choices of young women regarding FP.

6.1.2 Women with Parity 1

Findings from IFPS show that the unmet need is highest (20%) in the post-partum period, and it is highest for spacing among women with parity 1 (14.9%). This presents a great opportunity to counsel women post-partum on the importance of contraceptives and enable them to make an informed decision to space between pregnancies.

Strengthening postpartum family planning (PPFP) at all delivery points will help address the high unmet need during the immediate postpartum period and encourage women to adopt contraceptives. Low level of knowledge among providers has significant impact on the appropriate provisioning of services and counselling given to the clients. The IFPS results reveal that less than 1 percent of doctors, and none of the staff nurses ever received training across all methods. However, more than 40 percent of them were trained on IUCDs, injectables, weekly oral contraceptive pill –Chhaya. For better service provisioning, all above block facilities should have between 2-3 providers well trained in offering the entire basket of contraceptive services especially during post-partum period. Additionally, to ensure that no one is left behind, it will be important to ensure service availability in hard-to-reach areas as well as hard-to-reach population in those areas.

Effective counselling empowers women to choose the most appropriate contraceptive method according to their life stage. Ideally, counsellors should guide clients based on individual needs, assisting them in selecting appropriate FP methods. Yet, the data indicates that only a handful (3.6%) provide comprehensive counselling. Many overlook discussing potential side effects and method accessibility, which are fundamental components of FP counselling. Building the capacity of RMNCAH and other counsellors in the health system can expand the coverage and quality of counselling in facilities.

Offering counselling services across all facilities for parity 1 women would be crucial to support them in making well-informed contraceptive decisions tailored to their unique needs and that best align with their preferences and circumstances. This would ensure both initiation and sustained use of methods.

Augmenting this with external resources like a helpline could further ensure that women can privately access information on contraceptives at their convenience as well as addressing any questions or concerns they may have during their contraceptive journey. Further, while most of the health providers discussed about different methods and their benefits, they rarely discussed side effects (20% doctors and 18% staff nurses) and accessibility of methods (26% doctors and 21% staff nurses) which are crucial for a client to continue with any method. Since women with parity 1 would largely be using reversible contraceptive methods with high discontinuation rates, this support would go a long way in helping them seek information from time to time as their bodies adjust to the changes from the reversible methods.

Women with parity 1 exhibit greater independence in visiting health facilities alone (33.3%) compared to women with no children (0 parity) at 21.4 percent. Maximizing on this, enhancing the availability of basket of FP services at facilities closer to the community (PHCs and SCs) could help improve uptake of spacing methods from these facilities. Data also shows that availability of three or more spacing methods has a positive effect on uptake.

Front line workers provide a critical link between their communities and the health system. Intention to use contraceptives among younger women are higher (39% vs 29%) if there has been contact with FLWs in last 12 months. However, less than half of front line workers (47%) were engaged in counselling women on contraceptives. FLWs can help increase use of contraception, particularly where unmet need is high, access is low, and geographic or social barriers to use of services exist. They are particularly important to reducing inequities in access to services by bringing information, services, and supplies to women and men in the communities where they live and work rather than requiring them to visit health facilities, which may be distant or otherwise inaccessible.

At the community level, strengthening CiVHSNDs for interactions on FP with women arriving for antenatal and postnatal checkups, and immunization of their child can help minimize the missed opportunities for conversations on FP. CiVHSNDs should also be strengthened to improve availability of information and family planning services for women in the inter-conception stages. Provisioning the first dose of injectable contraceptives at CiVHSND level will also help in greater adoption of the method. FLWs can also initiate a conversation on postpartum family planning during home based newborn care (HBNC) visits. Training of ASHAs/ANMs on effective interaction with parity 1 women with spacing needs would be the turning point at the CiVHSND level.

The results show that over two-thirds of ASHAs and ANMs had mid-level knowledge about all modern contraceptive methods and healthy timing and spacing of pregnancies. The effect of this is also reflective in the discussions on FP they have with couples. Overall, one-fifth ASHAs provided complete information related to FP (21%), including where, when and how to access contraceptives. While the counselling on appropriate FP methods based on their marital status or number of children was frequently done, only 6-7 percent ASHAs and ANMs provided complete counselling to women on appropriate contraceptive methods, their health benefits and side effects. Proper training of FLWs is therefore critical to effectively address FP needs of the community including the need for correct and precise information. Also frequency of trainings would be important for re-iterating the importance of FP and understanding of counselling for parity 1 women. Integrated packages for training would be most helpful for ASHAs to counsel parity 1 women.

The use of abortifacients is also extensive among this cohort, with more than 80 percent of the demand for MMA drugs being met by private pharmacies (IFPS). One strategy can be to engage private pharmacies for information along with abortifacients so that post abortion family planning (PAFP) can be strengthened. Private sector providers could be significantly engaged to offer various FP services. Public health facilities can also be strengthened for provisioning of MMA so that women have access to services especially women who may find it difficult to procure these services at a cost, and the services will be given by a trained service provider.

6.1.3 Women with Parity 2+

Among all women with unmet need, need for limiting is almost double the need for spacing. Data suggests that nearly half of the women with unmet need for limiting have a preference for sterilization. This translates to ~15 lakh women in UP today. Therefore, considering the current annual uptake of sterilization services (~3 lakhs) plus taking into account the backlog of unmet need, the state needs to plan for provisioning ~8 lakh sterilizations every year over the next three years if the unmet need has to be reduced to half (Table 63). To cater to additional sterilization services, the state would have to focus on few key strategies. Since most of the sterilizations happen at fixed-day services (FDS), strengthening mobilization and pre-registration of clients for effective planning and implementation of FDS is imperative.

The uptake of sterilization services is higher at CHCs as compared to DH. To further improve the uptake of sterilization, it is critical to make the services available on a regular and consistent basis at all CHCs. This would require a trained provider posted at the CHCs so that services are available in routine mode. Effective availability of sterilization services all year round at all facilities above block level will result in increased uptake of the services. Till such time that all CHCs have a full time provider posted, services through FDS can be strengthened by organizing more FDS days at the facilities (at least two FDS per week per CHC). Quarterly FDS calendar can be shared with FLWs to pre inform them about availability of assured services on pre-defined days especially at such facilities.

The seasonality trend in sterilization service provisioning also need to be addressed. More than 80 percent of sterilizations are done in the second half of the year. Providers play a very critical role in the availability of services across the year, and the same holds true for FP services as well. As regards to provisioning of sterilization services, there is a mindset that has been developed among providers that it is a winter month procedure. Sessions with providers will need to be planned to break this mindset. Tracking availability of supplies and medicines required for sterilization services through FPLMIS and DVDMS, and assessment of facility readiness on half yearly basis for offering sterilization services at CHCs and DHs can further help in improving the service quality and further meet the demand within stipulated time.

Broadening the base of providers for sterilization services is critical to the facility offering services on a regular and consistent basis. Each CHC should have a team of two trained providers, while each DH should have a team of four. In total, the system requires 2,266 providers trained in providing sterilization services: 1,886 at CHCs and 380 at DHs. With the current count standing at 526 providers, the state should strategize to train incoming specialists, including Gynecologists and Surgeons, in sterilization techniques.

In terms of practice, the survey found that mCPR increased by 2 percent points since NFHS-4 (2015), with a majority of the divisions showing an increase in mCPR except for Saharanpur, Moradabad, Meerut, Bareilly and Aligarh, which registered a decline.

Findings show that overall, 30 percent of the facilities provided sterilization services through minilap technique, and while district hospitals provided minilap services on a regular basis, other facilities provided minilap through FDS or Fixed Day Outreach Services (FDOS). About 44 percent of the public health facilities comprising of District hospitals and CHCs (FRUs and non-FRUs) provided sterilization services through laparoscopic technique. Most of the facilities across all levels did not have all the twelve essential equipment for performing laparoscopic sterilization procedure. In case of NSV services, only one out of five public health facilities are providing them. Here also, except for DHs (61%), very few facilities had all five essential functional equipment available at the time of the study for NSV. Overall, only 37 percent facilities across the state had providers trained in sterilization, while only 10 percent facilities were ready in terms of availability of all functional equipment, infection prevention material and trained HR to provide sterilization services in state.

Overall, 96 percent of the DHs, 91 percent each of CHCs, 53 percent of PHCs and 81 percent of UPHC/UCHCs were providing IUCD services. The availability of all nine essential functional equipment was better in DHs (70%), followed by CHCs (53%), while it was low in other facilities. 70 percent facilities were also providing PPIUCD, with majority of DH, CHC with all functional equipment available. About 37 percent facilities had all the spacing methods available at the time of the study.

The prevalence of sterilization in the state has remained constant over several years. Data from IFPS 2021 shows that there is a large number of women whose method of choice is sterilization as they have achieved their desired family size. Therefore, to meet the high unmet need of sterilization services, the state will have to significantly ramp up the capacity of public health facilities to provide sterilization services in a routine mode so that assured services are available when and where couples need them. This would also mean that every facility upto CHCs has a performing provider posted at the facility. Also focus on creating effective availability of services that women can access through the year as per their convenience.

6.2 Pathways to curb the traditional methods use

The survey indicates a notable rise in the use of traditional methods across the state, increasing from 13.8 percent (NFHS-4) to 23.9 percent (IFPS). Among these users, about 55 percent have consistently used the method during the last three years with 13 percent users returning to use TM. However, only 40 percent couples who chose traditional methods as their first contraceptive method want to continue.

It was found that only half of the TM users had correct knowledge of the method and ovulation cycle, with most citing peers as their primary source of information. It is interesting to note that about 70 percent of traditional method users have never used any modern method, and a mere 6 percent switched to a modern method in the last three years. No-side effects, easy to use, and no-cost incurred were the most commonly reported reasons for continuing the method. It is important to note that traditional method users reported higher instances of unintended pregnancies and abortions compared to modern method users. A significant 80 percent of medical abortions were conducted outside health care facilities, relying on abortifacients procured from private pharmacies.

Moreover, use of traditional method as the initial method of contraception was also found to be high among high parity (parity 2+) women with majority of women's intention to continue using the method in future. Program can reach out to these women with modern method choices, by leveraging FLWs in rural areas. Technological solutions and platforms could also be explored for reaching information to women/ couples on family planning to help them make informed decisions.

6.3 Conclusion

The choices made by women/couples in favour of a particular contraceptive method depend on them having unbiased information including benefits and risks of adoption and non-adoption of family planning and different types of contraceptive options. Strengthening availability, acceptability, and access to quality information, counseling and services to women and couples of different age groups hold the key to the state achieving the FP goals. The choices made by women and couples will depend on them having complete information, through multiple sources and at regular periodicity on the various contraceptive options. Additionally, having complete availability of and access to all methods will also affect their choices. Once information, availability and access are addressed, the women/ couples will be able to make a choice as per their needs and preferences, in the time period that suits them the best.

Access to modern contraceptives is crucial to women's empowerment as it increases their decision-making power and autonomy, individually and within the household, enables them to plan for their life goals including around employment more efficiently and leads to an improved balance in their life and at times also allowing confidentiality from partner and other family members. It places the decisions around her own life in her own hands. And therefore empowering women to choose modern contraceptives has the potential to reduce gender inequality and raise women's agency and subsequently enhancing autonomy enabling true choice constituting informed choice, full choice and free choice.

Also once a contraceptive choice is made, it is not necessary that it stays appropriate for the entire reproductive life span as needs may undergo change. We do see women/ couples moving between contraceptive choices for a variety of reasons such as having the desired number of children, workload, change in relationships etc. Hence, access to basket of contraceptive choices provides the required options to safely switch between methods and make choices that suit her life stage the best at that point in time. Thus, contraceptives have the power to empower and transform the lives of those who use them. Therefore, there is a need to reimagine the FP program from the reproductive rights and health perspective and focus on aspects of quality, access, equity and autonomy which would empower women to make free choices that are deliberate and help them achieve their full potential.

ANNEXURES

Table A.1: Age-group wise distribution of currently married women of reproductive age (CMWRA) by age at first marriage, median age at first marriage, cohabitation and sex, Uttar Pradesh, 2020-21

Current age (in years)	Percentage first married by exact age					Number of women	Median age at first marriage	Median age at first cohabitation	Median age at first sex
	15	18	20	21	25				
15-19	8.1	na	na	na	na	407	a	a	a
20-24	3.8	23.8	62.8	na	na	2,149	a	a	a
25-29	6.7	26	56.6	69.8	93.8	2,508	19.0	19.0	19.0
30-34	11.6	41.3	69.4	80.2	94.8	2,145	18.0	18.0	18.0
35-39	15.9	49.1	76.8	85.5	95.3	1,875	18.0	18.0	18.0
40-44	18.6	52.2	78.3	87.4	97	1,576	17.0	18.0	18.0
45-49	23.9	55.6	78.4	88.5	97.6	1,540	17.0	18.0	18.0
20-29	5.4	25	59.4	na	na	4,657	19.0	19.0	19.0
20-49	12.4	39.5	69	na	na	11,793	18.0	18.0	18.0
25-49	14.3	42.9	70.4	81	95.5	9,644	18.0	18.0	18.0

na = Not applicable due to censoring
a = Omitted because less than 50 percent of the women or men were married or began living with their spouse before reaching the beginning of the age group

Table A.2: Division wise Total Fertility Rate by IFPS,2021 and NFHS-4

Divisions	IFPS (2021)	NFHS-4 (2015)
Agra	2.3	2.8
Aligarh	2.7	3.0
Ayodhya	1.9	2.6
Azamgarh	2.3	2.6
Bareilly	2.2	3.1
Basti	2.5	3.2
Chitrakoot	2.5	2.7
Gonda	2.9	3.7
Gorakhpur	2.1	2.6
Jhansi	2.0	2.1
Kanpur Nagar	2.1	2.3
Lucknow	2.4	2.7
Meerut	2.2	2.5
Mirzapur	2.5	2.9
Moradabad	2.1	2.9
Prayagraj	2.2	2.5
Saharanpur	2.3	2.9
Varanasi	2.2	2.6

Table A.3: Percent distribution of non-first order birth among CMWRA by birth interval since preceding birth, by select background characteristics, 2020-21

Background characteristics	Months since preceding birth							Number of non-first order women
	7-17	18-23	24-35	36-47	48-59	60+	Missing	
Age (in years)								
15-24	19.0	24.8	31.3	12.1	4.5	1.4	6.8	828
25-29	13.4	13.9	28.7	15.8	9.8	7.9	10.6	1,801
15-29	15.1	17.3	29.5	14.7	8.2	5.9	9.4	2,629
30-39	10.0	13.3	22.7	15.7	9.3	14.8	14.2	3,634
40-49	7.1	11.3	21.8	14.3	7.7	14.8	22.9	2,957
Education								
Not educated	9.8	13.2	23.5	13.9	7.6	10.7	21.3	4,429
Educated	11.2	14.3	25.0	15.9	9.3	13.8	10.4	4,791
Religion								
Hindu	10.9	14.1	24.7	15.4	8.8	12.5	13.5	7,845
Non-Hindu	8.2	12.1	21.7	12.4	6.2	11.7	27.7	1,348
Caste/tribe								
SC/ST	10.3	13.9	24.8	16.8	8.7	10.4	15.1	2,788
OBC	10.5	13.8	24.4	14.7	8.2	12.4	16.1	4,883
Others	10.8	13.6	23.1	12.7	8.9	15.9	15.0	1,512
Wealth quintile								
Lowest	11.3	15.6	26.7	14.8	7.5	10.5	13.6	1,608
Second	11.5	12.9	23.7	15.8	7.6	12.8	15.6	1,869
Middle	10.0	14.7	26.5	14.5	9.3	9.2	15.7	1,981
Fourth	10.4	14.8	23.0	15.1	8.2	12.4	16.0	1,944
Highest	9.4	10.7	21.4	14.6	9.5	17.2	17.3	1,791
Total	**10.5**	**13.8**	**24.3**	**15.0**	**8.4**	**12.3**	**15.7**	**9,220**

Table A.4: Percentage of CMWRA with myths and misconceptions about contraceptive methods by type of methods, according to selected background characteristics, 2020-21

Background characteristics	Myths and misconceptions about								Number of non-first order women
	Female sterilization	Male sterilization	IUCD/ PPIUCD	Injectable/ Antara	Pills	Chhaya/ Centchroman	ECP	Condom	
Age (in years)									
15-24	31.7	8.6	31.9	10.7	5.8	0.6	1.5	9.5	2,556
25-29	43.1	11.9	48.0	15.3	9.0	1.9	3.6	13.6	2,508
30-34	42.0	14.3	52.4	16.4	9.7	1.8	3.6	13.7	2,145
35-39	47.7	16.3	53.6	14.3	11.0	3.1	3.3	12.8	1,875
40-49	49.7	18.1	52.1	12.5	9.6	1.5	2.1	11.6	3,116
15-29	37.4	10.3	39.9	13.0	7.4	1.3	2.5	11.6	5,064
25-49	45.9	15.3	51.4	14.5	9.8	2.0	3.1	12.8	9,644
Education									
Not educated	43.5	14.3	43.8	11.2	7.4	1.1	0.9	10.5	5,005
Educated	42.6	13.6	49.9	15.4	10.0	2.2	4.0	13.3	7,195
Religion									
Hindu	45.1	14.7	48.5	14.2	9.0	1.7	2.8	12.2	10,369
Non-Hindu	31.2	9.6	40.6	11.1	8.5	1.8	2.6	11.6	1,790
Caste/tribe									
SC/ST	43.0	12.2	44.4	13.5	7.9	1.4	1.7	11.4	3,665
OBC	43.4	14.5	46.6	13.2	8.6	1.6	2.5	12.1	6,438
Others	42.0	15.1	54.9	15.7	11.7	2.5	5.3	13.5	2,041
Wealth quintile									
Lowest	44.1	13.1	41.6	11.6	6.5	0.7	1.2	10.9	2,028
Second	44.6	15.0	45.1	12.4	7.6	0.8	0.9	11.1	2,457
Middle	40.4	12.9	43.4	12.6	7.4	1.5	1.4	11.2	2,622
Fourth	43.2	14.7	51.0	14.3	10.1	1.8	2.5	12.4	2,609
Highest	42.9	14.0	54.6	17.2	12.7	3.5	7.6	14.9	2,443
Total	**43.0**	**13.9**	**47.4**	**13.7**	**8.9**	**1.7**	**2.7**	**12.1**	**12,200**

Table A.5: Percentage of CMWRA who were exposed to family planning messages on mass media platforms in the past 12 months by divisions, Uttar Pradesh, 2021

Division	Radio	Television	Newspaper /Magazine /Pamphlets	Internet/ Social Media	Posters/ Banners	Wall paintings/ Hoardings	Exposed to any mass media (Electronic/ Print)	None of these media sources	Number of women
Agra	1.4	27.8	5.2	7.0	6.8	8.2	31.6	68.4	811
Aligarh	3.5	25.7	8.4	10.1	13.1	15.7	32.2	67.8	772
Ayodhya	4.7	18.2	9.8	9.6	15.9	14.6	28.2	71.8	533
Azamgarh	2.5	20.2	6.6	11.0	9.5	10.2	28.2	71.8	686
Bareilly	5.4	23.6	7.4	9.3	13.6	15.1	35.1	64.9	603
Basti	4.7	19.0	7.7	12.7	15.3	13.4	30.6	69.4	438
Chitrakoot	1.4	11.9	2.8	5.4	5.0	5.6	18.5	81.5	799
Gonda	2.4	12.9	5.8	7.4	15.8	16.4	26.8	73.2	376
Gorakhpur	2.0	25.3	7.7	10.7	23.2	23.0	40.5	59.5	694
Jhansi	2.0	23.8	8.6	9.8	10.4	11.0	28.6	71.4	788
Kanpur Nagar	3.7	30.7	11.8	16.2	20.7	22.3	42.3	57.7	562
Lucknow	4.6	22.6	11.8	10.4	19.6	19.7	36.1	63.9	551
Meerut	2.1	39.6	14.8	15.8	17.2	10.7	42.4	57.6	801
Mirzapur	2.7	19.4	3.8	8.8	6.4	7.2	26.1	73.9	791
Moradabad	1.8	28.5	10.2	13.3	14.9	13.4	33.9	66.1	716
Prayagraj	2.3	21.2	5.0	9.4	7.7	9.6	30.1	69.9	657
Saharanpur	2.1	37.2	12.5	11.8	14.4	8.2	40.9	59.1	802
Varanasi	2.2	35.2	12.6	15.6	16.7	18.6	44.1	55.9	820

Table A.6: Percentage of CMWRA with current use of any contraceptive and any modern contraceptive by selected background characteristics, Uttar Pradesh, 2020-21

Background characteristics	Current use of any contraceptive method (CPR)	Current use of any modern contraceptive method (mCPR)
Age (in years)		
15-24	37.5	18.1
25-29	59.9	33.7
30-34	69.2	40.9
35-39	71.6	42.3
40-49	55.1	36.7
15-29	48.7	25.9
Parity		
0	14.5	8.9
1	45.1	21.8
2-3	66.8	41.2
4+	63.9	37.1
Years of schooling		
No schooling	57.6	33.6
<5 years	60.5	34.1
5-10 years	56.7	33.1
10+ years	58.2	35.6
Religion		
Hindu	58.9	35.7
Non-Hindu	50.5	24.3
Caste/tribe		
SC/ST	57.5	34.7
OBC	57.7	33.0
Others	57.3	35.7
Wealth quintile		
Lowest	54.3	30.4
Second	54.8	31.6
Middle	56.5	32.0
Fourth	57.9	33.8
Highest	64.1	41.4
Total	**57.6**	**33.9**

Table A.7: Percentage of CMWRA not using any contraceptive method by reasons, among those who do not want another child within 24 months or any more children by age, Uttar Pradesh, 2020-21

Background characteristics	Any fertility related[1]	Opposition[2]	Lack of awareness[3]	Health concern[4]	Lack of accessibility[5]	Inconvenient to use[6]	Other reasons	Number of women not using any method
Age (in years)								
15-24	73.5	11.0	5.3	4.4	2.3	0.9	7.0	442
25-29	71.1	9.9	3.3	6.0	1.0	5.1	6.1	401
30-34	59.3	10.9	2.6	10.7	0.9	6.2	11.6	288
35-39	50.7	16.6	5.0	9.0	0.5	6.5	12.6	255
40-49	70.7	10.7	1.4	5.0	0.9	4.2	8.9	604
15-29	72.4	10.5	4.4	5.1	1.7	2.8	6.6	843
25-49	65.1	11.6	2.7	7.1	0.9	5.2	9.4	1,548
Divisions								
Agra	74.4	5.1	0.0	7.4	0.0	4.2	5.6	102
Aligarh	78.4	6.7	1.0	4.3	1.0	1.8	10.0	109
Ayodhya	66.1	17.9	2.1	6.7	0.0	4.9	10.4	91
Azamgarh	82.7	5.5	2.7	7.6	1.6	3.1	4.0	127
Bareilly	49.9	10.5	4.7	3.9	2.8	4.1	15.4	137
Basti	83.9	7.9	0.0	9.4	1.8	2.9	9.1	99
Chitrakoot	75.9	5.1	4.2	3.2	0.0	2.4	11.5	116
Gonda	71.0	18.6	2.5	3.1	2.4	0.9	3.4	111
Gorakhpur	86.7	6.4	4.8	4.0	1.4	1.6	6.8	134
Jhansi	66.6	7.6	0.4	5.9	1.3	4.9	14.7	84
Kanpur Nagar	49.6	7.4	7.4	11.9	0.0	9.7	14.0	104
Lucknow	48.0	14.5	4.1	8.2	2.1	5.9	12.4	131
Meerut	56.1	17.8	1.0	7.3	0.0	7.7	17.1	79
Mirzapur	87.3	9.7	2.0	7.0	0.0	1.6	7.0	121
Moradabad	50.2	21.8	5.1	9.0	0.6	7.0	6.1	121
Prayagraj	90.0	3.8	1.8	0.5	0.9	2.5	4.7	107
Saharanpur	60.0	17.5	3.6	7.1	0.9	5.8	1.8	100
Varanasi	84.4	6.9	1.4	9.5	0.0	3.5	3.8	117
Total	**66.9**	**11.5**	**3.2**	**6.5**	**1.2**	**4.3**	**8.9**	**1,990**

Note
[1]Includes infrequent sex, menopausal, hysterectomy, sub-fecund/infecund, not menstruated since last birth, currently breastfeeding and abstinence.
[2]Includes up to God/fatalistic, respondent opposed, husband/partner opposed, In-laws opposed, and religious prohibition.
[3]Includes knows no method, knows no source.
[4]Includes fear of side effects and heath concerns.
[5]Includes lack of access/too far, costs too much, preffered method not available, and no method available.
[6]Includes interferes with body's processes and incpnvenience to use.

Table A.8: Intention to use contraception among CMWRA current modern method users and non-users by selected background characteristics, 2020-21

	Intention to continue use among women using any modern contraceptive method			Number of women using any modern spacing method	Intention to begin use among women not using any contraceptive method			Number of women not using any method
	Want to continue (%)	Want to switch (%)	Undecided/ Don't want to use (%)		Want to use any method (%)	Unsure about use (%)	Infecund (%)	
Women who are members of SHGs								
Yes	76.3	13.4	10.2	434	27.1	56.1	16.8	406
No	79.1	8.9	11.9	4,462	34.2	59.4	6.4	4,523
Women informed on family planning by FLWs in past three years								
Yes	72.0	18.6	9.4	860	51.7	44.2	4.1	537
No	80.3	7.5	12.3	4,036	31.5	61.0	7.5	4,392
Women who had interaction with facility-based providers on family planning in past three years								
Yes	71.8	17.5	10.8	640	57.1	40.4	2.4	439
No	80.0	8.0	11.9	4,256	31.4	61.1	7.6	4,490
Women who had seen about FP on television in the last 12 months								
Yes	78.3	9.7	12.0	1,510	39.2	55.4	5.4	1,053
No	79.2	9.1	11.7	3,386	32.2	60.2	7.6	3,876
Birth order								
<2	80.9	5.3	13.8	178	41.6	58.3	0.1	1,021
2-3	77.9	10.3	11.9	3,260	38.0	55.9	6.1	2,620
4-6	79.7	8.1	12.2	1,265	20.6	64.3	15.0	1,032
7+	88.9	4.9	6.3	193	13.5	74.8	11.7	256
Number of living children								
None	80.1	6.2	13.7	190	40.9	58.8	0.3	1,098
1	81.0	7.5	11.6	829	40.9	57.8	1.3	1,013
2	77.5	10.5	11.9	1,604	38.6	53.9	7.4	1,021
3+	79.0	9.4	11.6	2,273	22.9	63.0	14.1	1,797

Table A.9: Percentage and nature of interaction of CMWRA from rural areas with FLWs in last 3 years by social and reproductive health characteristics, 2020-21

Background characteristics	Ever had interaction with FLWs	Number of women	Had any interaction with FLWs in last 3 years	Number of women who ever interacted with FLW	Had any interaction on family planning in last 3 years	Number of women who ever interacted with FLW in last 3 years	During last contact, FLW discussed or provided FP services
Religion							
Hindu	72.7	8,575	66.2	6,398	33.0	4,235	60.6
Non-Hindu	63.1	1,100	70.0	717	26.3	511	64.3
Caste/tribe							
SC/ST	73.7	3,128	68.2	2,369	34.6	1,636	61.8
OBC	70.5	5,066	66.9	3,662	30.9	2,439	60.6
Others	70.4	1,469	62.4	1,075	31.4	668	59.7
Marital duration							
<3 years	52.8	1,143	93.1	621	19.2	586	58.5
3-4 years	76.8	750	91.9	585	26.9	546	60.4
5-9 years	80.8	1,704	83.3	1,420	34.7	1,187	60.2
10+ years	71.8	6,107	54.7	4,510	35.2	2,439	61.5
Parity							
0	31.4	932	88.2	303	8.5	274	62.9
1	77.7	1,300	81.8	1,040	23.2	863	57.8
2-3	78.3	4,184	66.6	3,346	34.1	2,237	62.2
4+	72.0	3,288	57.5	2,447	39.2	1,384	59.9
Number of living children							
No child	34.3	1,014	86.5	363	8.9	320	61.1
1	77.8	1,429	81.7	1,145	23.6	946	56.3
2	78.2	2,404	68.5	1,918	34.0	1,320	60.9
3+	74.2	4,857	59.0	3,710	38.2	2,172	62.0
Completed desired family size							
Yes	75.8	6,668	61.7	5,162	37.0	3,170	62.2
No	63.6	2,782	80.1	1,824	23.8	1,494	56.4
Currently using contraceptive							
Yes	76.2	5,681	62.8	4,417	37.8	2,764	62.4
No	65.5	4,023	72.2	2,719	25.1	1,994	57.8
Contraceptive users							
Any method	76.2	5,681	62.8	4,417	37.8	2,764	62.4
Limiting method	81.8	1,992	47.1	1,642	39.2	762	46.6
Modern spacing method	74.3	1,322	76.2	997	41.8	774	65.6
Contraceptive use							
Long-acting reversible	82.1	154	71.3	126	56.0	93	55.3
Permanent	81.8	1,992	47.1	1,642	39.2	762	46.6
Modern, short-acting	73.2	1,168	76.9	871	39.8	681	67.6
Traditional methods	73.0	2,367	68.4	1,778	34.4	1,228	70.5
Not using any method	65.5	4,023	72.2	2,719	25.1	1,994	57.8

Background characteristics	Ever had interaction with FLWs	Number of women	Had any interaction with FLWs in last 3 years	Number of women who ever interacted with FLW	Had any interaction on family planning in last 3 years	Number of women who ever interacted with FLW in last 3 years	During last contact, FLW discussed or provided FP services
Intention to use mong current contraceptive users (any modern spacing/traditional methods)							
Want to continue	70.7	2,826	69.2	2,048	36.6	1,430	66.7
Want to switch	87.9	424	84.9	375	47.9	325	72.7
Undecided/ Don't want to use	77.9	439	69.5	352	28.1	247	71.8
Intention to use method among non-users							
Want to use any method	69.9	1,485	81.9	1,069	30.0	888	61.2
Unsure about use	61.8	2,247	68.5	1,424	21.9	995	54.5
Infecund	73.7	291	51.4	226	15.9	111	48.6
Currently pregnant							
Yes	75.6	643	92.6	504	19.8	474	51.0
No	71.2	9,061	64.6	6,632	33.6	4,284	61.5
Non-numeric responses	52.0	254	65.0	150	9.7	94	58.1
Years since sterilization							
<2	80.3	1,401	89.8	1,153	41.5	1,035	68.9
2-3	81.9	520	73.9	432	44.0	329	60.5

Table A.10: Percentage of CMWRA from rural areas informed about family planning methods by FLWs in last 3 years, by demographic and economic characteristics, 2020-21

Background characteristics	Sterilization	IUCD - COPPER-T/ LOOP	Injectables (Antara)	Pills	Centchroman (Chhaya)	Condom	Any traditional method	Other methods	Number of women who were informed on FP methods by FLW in last 3 years
Age									
15-24	44.0	45.1	34.0	39.6	3.9	54.8	8.6	2.5	362
25-29	58.0	44.2	34.5	31.2	2.1	41.7	8.6	2.5	427
30-34	66.2	40.7	32.0	33.6	4.9	45.0	6.2	2.7	333
35-39	75.6	38.4	32.6	31.5	5.8	40.8	7.2	3.2	196
40-49	74.7	34.6	26.0	35.2	6.2	34.8	10.4	1.4	205
15-29	51.6	44.6	34.2	35.0	2.9	47.7	8.6	2.5	789
Education									
No education	71.7	35.2	27.9	34.2	4.6	38.9	7.7	1.2	551
<5 years	69.1	36.5	20.5	37.7	6.4	47.8	8.5	1.1	65
5-10 years	59.4	43.6	34.9	34.0	3.2	45.9	8.6	3.2	559
10+ years	45.2	49.5	37.7	34.2	4.7	50.4	8.2	3.5	348
Working status									
Yes	73.0	32.8	27.6	32.7	5.6	38.7	9.7	1.6	331
No	58.0	43.9	33.6	34.7	3.8	45.9	7.7	2.7	1,192
Occupation									
Cultivator/ Agricultural labor	81.9	38.5	27.4	27.0	3.5	36.9	7.8	2.0	127
Non-agricultural labor	73.0	21.5	21.4	23.7	6.8	32.2	3.4	0.0	90
Self-employed	44.8	30.0	43.8	51.8	4.0	53.6	5.6	0.0	24
Salaried	69.8	52.6	43.4	45.2	22.8	59.3	12.7	9.5	29
Unpaid work	69.1	27.4	21.5	40.4	1.3	34.5	21.4	0.0	61
Not working	58.0	43.9	33.6	34.7	3.8	45.9	7.7	2.7	1,192
Cash earnings									
Yes	73.2	34.5	29.4	31.5	7.0	41.8	7.4	2.4	227
No	59.2	42.7	32.9	34.7	3.7	44.8	8.3	2.5	1,296
Wealth quintile									
Lowest	71.4	37.1	26.5	32.8	5.1	40.0	7.5	1.5	340
Second	65.6	40.7	30.2	33.0	3.8	39.3	7.8	2.0	373
Middle	60.1	44.1	38.0	35.7	3.5	45.4	10.5	3.9	357
Fourth	52.4	40.3	30.8	33.5	3.4	50.6	7.9	2.7	288
Highest	45.6	50.1	40.9	38.7	6.2	52.1	5.4	1.7	160
Women who are members of SHGs									
Yes	75.7	36.0	31.4	41.9	3.3	48.2	8.0	3.5	238
No	58.5	42.5	32.5	32.9	4.4	43.7	8.2	2.3	1,285

Table A.11: Percentage of CMWRA from rural areas informed about family planning methods by FLWs in last 3 years, according to social and reproductive health characteristics, Uttar Pradesh, 2021

Background characteristics	Sterilization	IUCD - COPPER-T/ LOOP	Injectables (Antara)	Pills	Centchroman (Chhaya)	Condom	Any traditional method	Other methods	Number of women who were informed on FP methods by FLW in last 3 years
Religion									
Hindu	62.8	40.6	31.4	33.2	4.1	43.0	8.4	2.4	1,383
Non-Hindu	43.7	51.5	43.2	45.5	5.0	57.9	6.1	3.0	135
Caste/tribe									
SC/ST	66.4	39.4	30.8	34.4	3.5	42.0	7.9	2.0	563
OBC	59.0	39.7	33.3	35.8	4.5	46.1	8.5	2.8	749
Others	54.1	54.4	33.9	28.6	5.0	44.4	7.7	2.6	205
Marital duration									
<3 years	26.8	42.4	32.1	40.5	3.1	67.4	6.7	4.0	114
3-4 years	34.4	45.5	34.3	34.1	2.0	43.2	9.5	0.8	147
5-9 years	52.7	46.3	35.8	32.7	2.6	48.0	10.3	2.8	404
10+ years	73.7	38.5	30.5	34.2	5.4	40.1	7.1	2.4	858
Parity									
0	26.8	39.4	37.9	28.8	3.5	60.8	9.1	3.9	24
1	26.0	39.9	29.9	42.5	2.0	60.4	9.5	2.0	191
2-3	60.2	44.5	35.6	33.1	4.1	44.9	8.5	2.7	767
4+	76.5	38.1	28.5	33.2	5.2	37.3	7.1	2.2	541
Number of living children									
No child	28.6	34.3	36.8	37.7	5.2	68.1	7.4	7.3	30
1	25.3	41.4	31.8	37.9	2.1	55.5	11.0	2.0	215
2	55.8	46.5	36.6	32.7	3.6	47.4	8.7	2.4	450
3+	74.6	39.1	30.1	34.0	5.1	39.0	7.1	2.5	828
Completed desired family size									
Yes	68.3	41.7	31.9	34.5	4.5	41.9	7.6	2.6	1,171
No	37.2	41.5	34.9	34.1	3.3	53.6	9.6	2.1	343
Non-numeric responses	78.1	18.3	0.0	13.1	0.0	13.1	24.4	0.0	9
Currently using contraceptive									
Yes	64.6	41.6	32.2	33.4	4.1	43.2	7.0	3.0	1,037
No	54.6	41.3	32.7	35.9	4.4	46.6	10.4	1.4	486
Contraceptive users									
User of any method	64.6	41.6	32.2	33.4	4.1	43.2	7.0	3.0	1,037
User of limiting	91.7	32.0	22.0	26.9	4.4	28.6	5.5	4.4	285
User of modern spacing	48.9	47.2	34.9	34.4	4.3	58.8	5.6	3.7	326
Contraceptive use									
Long-acting reversible	35.6	71.7	45.9	34.1	3.8	44.3	4.9	0.0	51
Permanent	91.7	32.0	22.0	26.9	4.4	28.6	5.5	4.4	285
Modern, short-acting	51.5	42.3	32.7	34.5	4.4	61.6	5.8	4.4	275

Background characteristics	Sterilization	IUCD - COPPER-T/ LOOP	Injectables (Antara)	Pills	Centchroman (Chhaya)	Condom	Any traditional method	Other methods	Number of women who were informed on FP methods by FLW in last 3 years
Traditional	58.6	43.7	36.9	37.1	3.7	41.0	9.0	1.5	426
Not using any method	54.6	41.3	32.7	35.9	4.4	46.6	10.4	1.4	486
Intention to use among current contraceptive users (any modern spacing/traditional methods)									
Want to Continue	50.8	47.4	37.8	37.0	3.9	52.0	7.2	2.5	529
Want to Switch	69.5	37.8	35.0	28.8	3.0	39.2	6.5	2.5	156
Undecided/Don't want to use	49.6	44.6	24.7	42.4	6.0	43.9	12.2	2.2	67
Intention to use method among non-users									
Want to use any method	52.9	42.1	32.8	34.9	4.1	44.9	11.4	1.8	264
Unsure about use	55.1	39.5	31.9	35.5	3.5	45.3	9.8	1.2	204
Infecund	72.6	52.6	41.2	52.7	20.8	86.5	4.3	0.0	18
Currently pregnant									
Yes	51.2	42.6	33.7	21.6	0.6	45.7	10.4	2.2	97
No	61.8	41.4	32.3	35.1	4.4	44.3	8.0	2.5	1,426
Years since sterilization									
<2	57.4	43.6	33.8	32.6	4.1	43.7	7.3	2.2	438
2-3	71.9	48.2	26.9	29.0	4.7	41.0	4.8	4.2	140

Table A.12: Percentage of CMWRA residing in rural areas who had any interaction and discussed FP methods at VHSNDs in last 12 months, by selected background characteristics, 2020-21

Background characteristics	Any interaction at VHSND in last 12 months		Had discussions on FP at VHSND	Number of women who had interaction at VHSND in last 12 months
	IUCD - COPPER-T/ LOOP	IUCD - COPPER-T/ LOOP		
Religion				
Hindu	25.9	74.1	24.6	2,252
Non-Hindu	24.3	75.7	21.9	287
Caste/tribe				
SC/ST	29.0	71.0	25.9	940
OBC	24.8	75.2	24.0	1,272
Others	22.6	77.4	21.4	325
Marital duration				
<3 years	34.1	65.9	20.6	412
3-4 years	46.3	53.7	22.4	368
5-9 years	41.9	58.1	24.6	729
10+ years	17.4	82.6	26.2	1,037
Parity				
0	13.3	86.7	12.8	137
1	40.9	59.1	23.3	561
2-3	28.1	71.9	24.7	1,182
4+	20.4	79.6	26.8	666
Number of living children				
No child	14.5	85.5	12.3	163
1	41.2	58.8	23.4	621
2	28.1	71.9	25.4	678
3+	22.5	77.5	25.9	1,084
Completed desired family size				
Yes	23.7	76.3	26.5	1,568
No	31.4	68.6	21.6	929
Non-numeric responses	15.9	84.1	4.1	49
Currently using contraceptive				
Yes	23.5	76.5	26.5	1,324
No	28.7	71.3	22.1	1,222
Contraceptive users				
User of any method	23.5	76.5	26.5	1,324
User of limiting	15.0	85.0	15.1	284
User of modern spacing	29.4	70.6	34.8	401
Contraceptive use				
Long-acting reversible	34.4	65.6	46.4	51
Permanent	15.0	85.0	15.1	284
Modern, short-acting	28.7	71.3	32.9	350
Traditional	26.6	73.4	26.3	639
Not using any method	28.7	71.3	22.1	1,222

Background characteristics	Any interaction at VHSND in last 12 months		Had discussions on FP at VHSND	Number of women who had interaction at VHSND in last 12 months
	IUCD - COPPER-T/ LOOP	IUCD - COPPER-T/ LOOP		
Intention to use among current contraceptive users (any modern spacing/traditional methods)				
Want to continue	24.1	75.9	30.1	693
Want to switch	48.2	51.8	31.9	208
Undecided/Don't want to use	31.4	68.6	23.2	139
Intention to use method among non-users				
Want to use any method	38.6	61.4	24.7	608
Unsure about use	24.0	76.0	20.1	572
Infecund	16.5	83.5	14.8	42
Currently pregnant				
Yes	54.7	45.3	20.0	377
No	23.7	76.3	25.1	2,169
Years since sterilization				
<2	45.3	54.7	27.9	645
2-3	23.3	76.7	35.4	125

Table A.13: Percentage of CMWRA from rural areas who interacted with FLWs or at VHSND and had discussion on FP in last 12 months, by divisions, 2020-21

Divisions	Interaction with FLW	Any interaction in last 3 years	Any interaction on family planning in last 3 years	Last interaction on Family Planning			
					Sterilization	IUCD- COPPER- T/ LOOP	Injectables/ Antara
Agra	84.2	74.6	30.3	53.1	62.5	48.9	40.3
Aligarh	83.4	74.9	45.8	57.6	66.0	55.1	44.2
Ayodhya	64.8	71.8	27.6	56.8	49.7	51.3	23.6
Azamgarh	84.5	62.3	33.0	73.4	80.3	36.6	43.6
Bareilly	65.6	67.9	26.0	51.3	60.3	37.6	25.4
Basti	63.7	73.3	27.1	76.2	63.1	35.6	57
Chitrakoot	70.7	59.1	37.2	68.4	65.0	33.8	24.5
Gonda	51.8	80.7	27.1	53.9	64.1	59.9	47.9
Gorakhpur	77.2	66.8	35.9	67.7	65.2	25.7	22.4
Jhansi	66.2	54.9	29.4	63.7	71.7	22.9	15.7
Kanpur Nagar	70.7	60.2	41.7	59.2	46.0	35.6	20.9
Lucknow	56.5	57.8	30.6	54.3	50.3	40.6	40.4
Meerut	76.1	70.8	35.7	75.2	38.4	54.5	33.3
Mirzapur	91.6	68.3	27.5	47.7	76.6	37.5	31.0
Moradabad	51.9	60.8	23.3	55.0	35.0	38.2	21.6
Prayagraj	88.9	60.1	41.3	59.2	72.3	41.8	23.4
Saharanpur	58.1	68.7	20.5	36.2	26.9	24.8	27.7
Varanasi	90.0	68.7	29.3	66.3	71.4	43.3	39.0
Total	**71.5**	**66.6**	**32.2**	**60.8**	**61.2**	**41.5**	**32.4**

Type of method informed by FLW in in last 3 years					Any interaction at VHSND in last 12 months Yes	Had discussion on FP at VHSND
Pills	Chhaya/ Centchroman	Condom	Any traditional methods	Other methods		
37.2	3.9	46.5	3.7	5.7	30.2	75.4
35.9	4.7	56.1	4.8	5.6	30	59.9
37.7	7.6	48.8	14.4	1.1	23.8	68.2
29.7	0.9	40	5.9	2.1	26.4	69
35.7	0	44.6	5	1.8	29.5	81.6
43.7	1.8	53.1	8	0	25.6	72.5
17.2	2.4	32.4	3.7	1	25.4	72.3
53.3	12.4	50.4	14.3	1.4	26.1	68.7
39.8	5.5	40.5	17.5	0	28.2	65.7
15.7	0	39	9.4	7	16.6	76
13.7	1.5	49.8	7.5	1.5	25.8	60.3
40.8	2.5	56.5	10.6	3.9	18.2	64.5
33.6	4.1	52.1	2.7	1.6	26.3	67.3
26.5	1.9	19.6	3.5	3.9	32.7	77.5
42.2	2.5	46.4	9.7	5.1	20.5	84
20.4	3.2	30.8	1.5	2.4	29.8	74.6
45.4	9	55.1	16	1.5	23	88.6
41.9	6.8	41.7	7.3	2.1	28.2	67.2
34.3	**4.2**	**44.4**	**8.1**	**2.5**	**25.8**	**24.4**

Table A.14: Role of CMWRA in decision making on family planning, 2020-21

Divisions	Timing of child birth	Family planning method to use	Type of family planning method to use	Number of sons or daughters to have	Participate in all four decisions	Participate in none of the four decisions	Decision macking on current contraceptive use by self or jointly	Number of current users
Agra	76.7	67.7	65.5	77.2	55.0	12.7	97.0	553
Aligarh	79.0	71.1	68.1	80.9	58.5	11.6	96.0	490
Ayodhya	77.4	70.5	69.8	74.7	56.6	12.4	92.6	380
Azamgarh	84.2	76.6	75.5	85.2	65.8	9.6	97.9	368
Bareilly	68.3	52.0	51.5	60.5	33.9	18.3	88.9	318
Basti	83.9	75.5	76.1	85.3	64.3	7.8	97.0	215
Chitrakoot	81.0	70.2	68.9	80.2	62.1	13.9	93.9	510
Gonda	81.3	67.7	67.4	77.2	55.1	11.4	96.1	148
Gorakhpur	77.5	72.6	72.3	77.5	57.4	10.8	95.1	388
Jhansi	77.2	77.4	75.3	77.5	63.4	11.0	92.6	547
Kanpur Nagar	80.2	68.4	65.2	75.4	52.7	12.0	88.5	298
Lucknow	76.2	65.6	67.8	76.2	49.8	9.2	91.4	274
Meerut	78.7	65.8	64.1	76.6	51.4	10.7	97.3	544
Mirzapur	75.9	74.8	72.1	76.9	61.2	13.5	96.0	504
Moradabad	76.7	65.2	62.4	71.7	47.6	12.7	95.0	412
Prayagraj	81.2	69.9	70.6	82.2	63.8	12.4	95.7	378
Saharanpur	81.8	70.7	69.1	77.0	56.0	10.3	94.7	507
Varanasi	82.2	73.5	73.1	79.8	61.6	9.3	97.2	529
Total	**78.4**	**68.7**	**67.8**	**76.7**	**55.0**	**11.6**	**94.5**	**7,271**

Table A.15: Decision making by CMWRA on family planning by themselves or jointly with their husband, by background characteristics, 2020-21

Divisions	Timing of child birth	Family planning method to use	Type of family planning method to use	Number of sons or daughters to have	Participate in all four decisions	Participate in none of the four decisions	Number of women	Decision making on current contraceptive use by self or jointly	Number of current users
Age									
15-24	76.4	62.8	60.1	75.6	48.5	12.0	2,556	9-4.4	993
25-29	82.3	73.0	73.1	80.3	60.4	8.9	2,508	94.7	1,522
30-34	81.3	71.9	71.6	78.0	58.7	9.9	2,145	94.2	1,539
35-39	78.2	70.9	71.3	78.4	57.1	11.1	1,875	94.2	1,398
40-49	75.0	66.7	65.1	72.7	52.1	14.8	3,116	94.8	1,819
15-29	79.4	67.9	66.6	78.0	54.5	10.5	5,064	94.6	2,515
Spousal age difference									
Wife is older	79.6	66.3	68.5	78.2	53.2	10.5	247	95.5	153
Both same age	83.1	70.9	69.0	77.2	58.4	8.6	491	91.5	262
Wife is 1-4 years younger	78.7	69.3	68.3	77.2	55.2	11.0	7,319	94.5	4,420
Wife is 5-9 years younger	77.9	68.5	67.4	76.0	55.6	12.8	3,416	94.8	2,027
Wife is 10+ years younger	71.3	61.4	62.3	70.6	46.0	15.8	573	94.3	325
Do not know husband age	82.4	73.3	72.9	83.2	58.9	6.6	154	95.3	84
Education									
No education	73.0	63.8	62.6	72.3	49.2	15.8	5,005	94.1	3,036
<5 years	69.1	64.9	65.5	66.9	49.0	16.1	369	94.6	234
5-10 years	80.5	68.6	68.3	77.3	55.3	10.2	4,111	94.6	2,392
10+ years	86.5	78.5	76.9	85.0	65.9	5.4	2,715	94.9	1,609
Husband education									
No education	71.8	59.9	60.7	70.0	45.6	16.6	2,181	92.5	1,246
<5 years	80.7	68.4	67.3	78.5	54.2	10.2	221	94.1	125
5-10 years	77.3	67.9	67.0	75.2	54.2	12.4	5,920	95.1	3,547
10+ years	84.2	75.5	73.6	82.9	62.1	7.2	3,806	94.7	2,314
Do not know	71.4	67.8	57.0	72.8	54.8	18.3	72	94.2	39
Spousal schooling difference									
Husband has more schooling	78.4	69.4	68.0	77.0	55.2	11.5	6,755	95.1	4,168
Wife has more schooling	83.5	73.5	72.3	81.4	60.7	8.2	2,028	94.1	1,089
Both have equal schooling	83.0	71.9	72.2	79.6	60.2	8.1	1,603	95.5	964
Neither attended school	69.0	58.1	58.7	67.8	43.4	18.4	1,742	91.8	1,011
Do not know	71.4	67.8	57.0	72.8	54.8	18.3	72	94.2	39

Divisions	Timing of child birth	Family planning method to use	Type of family planning method to use	Number of sons or daughters to have	Participate in all four decisions	Participate in none of the four decisions	Number of women	Decision making on current contraceptive use by self or jointly	Number of current users
Marital duration									
<3 years	76.4	59.8	57.3	75.4	46.2	12.3	1,422	95.0	439
3-4 years	81.0	71.6	68.9	79.9	58.8	9.0	953	93.5	431
5-9 years	81.8	71.2	70.2	79.6	58.0	9.3	2,157	93.9	1,293
10+ years	77.5	69.3	69.0	75.7	55.3	12.4	7,668	94.7	5,108
Working status									
Yes	73.3	67.7	66.3	72.0	52.8	15.8	2,401	95.0	1,596
No	79.5	69.0	68.2	77.7	55.5	10.7	9,799	94.4	5,675
Occupation									
Cultivator/ Agricultural labour	68.9	60.6	59.4	67.3	45.2	20.8	692	96.0	463
Non-agricultural labour	73.4	67.9	68.0	73.9	55.2	15.3	674	95.0	474
Self employed	79.6	73.4	69.3	75.3	56.8	12.1	263	94.4	167
Salaried	84.8	79.9	79.3	88.0	69.3	5.4	289	94.5	204
Unpaid work	67.1	65.0	62.2	62.4	45.4	19.2	483	94.4	288
Not working	79.5	69.0	68.2	77.7	55.5	10.7	9,799	94.4	5,675
Religion									
Hindu	78.9	70.3	69.3	77.9	56.6	11.0	10,369	94.7	6,316
Non-Hindu	75.4	60.6	60.1	70.2	46.6	14.9	1,790	93.5	934
Caste/tribe									
SC/ST	76.0	66.8	66.5	75.5	53.0	13.0	3,665	94.5	2,160
OBC	78.8	68.8	67.5	77.0	54.5	11.1	6,438	94.2	3,857
Others	81.3	72.4	71.8	78.0	60.5	10.6	2,041	95.4	1,225
Parity									
0	73.4	51.7	50.3	70.6	40.8	16.1	1,200	93.2	179
1	82.5	70.0	69.2	81.5	57.9	8.1	1,723	93.4	790
2-3	82.4	74.0	73.1	80.3	60.6	8.8	5,406	94.6	3,719
4+	72.5	66.1	65.4	71.3	50.3	15.6	3,871	94.7	2,583
Fertility preference									
Want more sons than daughters	75.9	67.9	66.6	75.4	52.4	12.4	3,067	94.4	1,917
Want more daughters than sons	72.5	60.5	67.0	69.6	49.8	15.2	138	94.2	83
Want equal	80.0	70.6	69.8	78.4	57.6	10.6	6,503	94.8	3,947
Either sex	82.9	74.0	72.5	80.2	61.9	9.6	1,481	93.7	817
Do not know	42.6	49.1	35.0	52.6	26.7	26.2	18	100.0	12
Non-numeric responses	68.6	51.0	50.2	62.3	35.0	19.4	598	92.9	314
Missing	74.9	57.5	58.3	71.5	43.3	13.7	395	95.6	181

Divisions	Timing of child birth	Family planning method to use	Type of family planning method to use	Number of sons or daughters to have	Participate in all four decisions	Participate in none of the four decisions	Number of women	Decision making on current contraceptive use by self or jointly	Number of current users
Current Contraceptive use									
Long-acting reversible	89.7	88.5	89.1	88.4	76.5	2.8	209	95.1	209
Permanent	76.9	74.9	74.0	76.8	60.2	13.0	2,375	94.2	2,375
Modern, short-acting	84.1	79.9	77.6	81.4	63.0	6.3	1,766	93.6	1,766
Traditional	82.1	73.3	72.3	80.0	60.1	8.4	2,921	95.2	2,921
Not using any method	74.5	59.0	58.6	72.6	46.4	15.0	4,929	94.8	3,808
Among current users (any modern spacing/traditional users)									
Want to Continue	84.4	77.3	76.0	81.7	62.7	6.4	3,808	95.0	493
Want to Switch	79.5	76.9	76.2	81.3	64.2	9.8	493	92.8	595
Un-decided/ Dont want to use	77.6	69.9	67.2	74.9	54.7	12.3	595		
Intension to use method among non-users									
Want to use any method	80.6	68.6	68.5	80.8	56.9	10.0	1,731	na	na
Unsure about use	71.8	53.4	53.0	68.6	40.5	17.1	2,840	na	na
Infecund	68.3	59.9	58.5	67.2	45.3	20.6	358	na	na
Number of living children									
No child	73.0	51.5	50.4	70.5	40.6	16.1	1,290	92.9	192
1	81.9	70.0	69.1	81.6	57.7	8.6	1,882	93.2	869
2	83.4	75.6	74.3	81.6	62.6	8.1	3,166	94.1	2,145
3+	75.7	68.5	67.8	73.8	53.2	13.4	5,862	95.1	4,065
Completed the desired family size									
Yes	79.2	71.9	71.2	77.4	57.7	11.0	8,354	95.0	5,858
No	77.8	63.7	62.4	76.6	51.3	11.8	3,519	92.3	1,296
Non-numeric responses	65.8	47.0	45.6	62.0	31.9	21.8	327	93.2	117
Wealth index									
Lowest	73.2	63.5	61.9	72.6	49.6	15.0	2,028	94.9	1,185
Second	74.5	66.1	66.3	74.8	52.5	13.8	2,457	93.6	1,400
Middle	80.1	68.8	68.5	7 8.2	55.4	10.8	2,622	93.3	1,521
Fourth	80.7	71.6	71.3	77.8	57.3	9.8	2,609	95.1	1,556
Highest	82.3	72.9	70.4	79.2	59.6	9.4	2,443	95.5	1,588
Total	**78.4**	**68.7**	**67.8**	**76.7**	**55.0**	**11.6**	**12,200**	**94.5**	**7,271**

Table A.16: Percentage CMWRA who have experienced intimate partner violence (IPV) in the past 12 months, by background characteristics, 2020-21

Background characteristics	Physical violence	Sexual violence	Emotional violence	Physical or sexual violence	Any violence (physical, emotional, sexual)	Experienced severe physical and/ or sexual IPV in the past 12 months	Number of women who had interaction at VHND in last 12 months
Age							
15-24	23.9	17.3	31.7	31.7	41.0	21.4	1,761
25-29	25.3	16.4	36.4	32.5	44.3	21.3	2,012
15-29	24.7	16.8	34.2	32.1	42.7	21.3	3,773
30-34	28.3	17.7	39.4	35.5	46.9	23.0	1,853
35-39	24.9	13.7	34.8	30.5	42.3	19.0	1,682
40-49	20.4	10.4	35.5	24.7	40.6	15.9	2,518
Spousal age difference							
Wife is older	22.2	13.7	31.1	28.0	39.0	16.2	210
Wife is same age	18.5	10.8	30.1	25.4	36.2	16.9	371
Wife is 1-4 years younger	24.6	15.5	35.7	31.2	43.2	20.0	5,842
Wife is 5-9 years younger	24.6	13.7	36.6	30.1	43.5	19.5	2,779
Wife is 10+ years younger	26.4	15.4	36.2	32.5	43.8	23.9	505
Do not know husband age	21.8	18.1	34.0	30.2	41.4	20.8	119
Education							
No education	28.7	15.5	40.7	34.3	47.8	22.1	4,181
<5 years	28.2	15.7	39.5	33.7	46.9	21.9	303
5-10 years	25.7	16.0	35.1	32.6	43.6	21.2	3,280
10+ years	13.2	11.4	25.9	20.1	31.9	13.2	2,062
Husband education							
No education	30.9	16.4	42.4	36.7	50.2	24.0	1,813
<5 years	30.5	20.5	42.1	39.5	50.1	25.1	192
5-10 years	26.2	16.0	37.6	32.7	45.1	21.2	4,844
10+ years	16.6	11.3	27.7	22.8	34.3	14.7	2,917
Do not know	24.3	17.5	34.7	26.1	38.7	20.0	60
Marital duration							
<3 years	15.3	14.8	23.3	23.7	31.7	16.5	925
3-4 years	22.3	16.1	35.4	28.9	42.6	20.5	709
5-9 years	25.2	17.0	34.6	33.1	43.4	21.0	1,686
10+ years	25.6	14.1	37.7	31.2	44.4	20.0	6,506
Working status							
Yes	30.5	18.1	40.6	36.4	48.3	25.8	2,023
No	22.9	14.0	34.5	29.3	41.7	18.5	7,803
Occupation							
Cultivator/Agricultural labour	31.5	19.6	44.0	39.0	52.0	28.9	573
Non-agricultural labour	38.4	19.5	46.1	42.4	53.6	29.7	584
Self employed	24.9	22.2	39.5	35.5	47.9	25.1	228
Salaried	16.2	9.8	26.3	21.1	32.4	14.1	252
Unpaid work	32.6	17.6	39.6	36.2	48.2	25.3	386
Not working	22.9	14.0	34.5	29.3	41.7	18.5	7,803

Background characteristics	Physical violence	Sexual violence	Emotional violence	Physical or sexual violence	Any violence (physical, emotional, sexual)	Experienced severe physical and/ or sexual IPV in the past 12 months	Number of women who had interaction at VHND in last 12 months
Religion							
Hindu	24.7	15.3	35.8	31.2	43.3	20.6	8,320
Non-Hindu	22.1	12.1	34.0	27.4	40.2	15.8	1,468
Caste/tribe							
SC/ST	29.5	18.9	41.7	36.6	49.3	25.2	3,030
OBC	23.8	14.2	35.3	30.0	42.3	18.8	5,123
Others	16.1	9.3	25.6	21.5	32.8	13.5	1,621
Household own agricultural land							
Yes	22.8	13.2	33.3	28.6	40.5	18.2	4,947
No	25.8	16.4	37.9	32.6	45.3	21.6	4,879
Parity							
0	18.2	13.4	26.0	25.4	33.5	17.4	796
1	17.9	13.8	29.9	24.8	37.3	17.9	1,292
2-3	24.5	14.2	36.1	30.5	42.9	18.8	4,425
4+	28.3	16.3	39.7	34.5	47.6	22.8	3,313
Fertility preference							
Want more sons than daughters	30.6	17.3	41.6	37.2	50.0	23.4	2,541
Want more daughters than sons	19.9	11.5	37.9	26.2	42.7	16.1	120
Want equal	23.9	15.3	35.2	30.6	42.7	20.5	5,238
Either sex	17.0	9.5	26.0	21.1	31.9	12.9	1,136
Do not know	5.8	24.7	29.9	24.7	29.9	24.7	12
Non-numeric responses	16.7	9.1	33.5	21.2	37.8	11.9	486
Missing	19.0	13.4	29.4	25.0	34.6	18.6	293
Contraceptive use							
Long-acting reversible	32.6	21.2	41.5	41.4	52.4	27.1	169
Permanent	26.6	15.6	38.2	32.6	45.6	20.9	1,990
Modern, short-acting	22.2	16.9	32.3	29.7	40.8	18.8	1,455
Traditional	28.2	18.3	39.5	36.0	47.5	24.2	2,416
Not using any method	21.4	11.3	33.1	26.4	39.3	16.9	3,796
Among current users (any modern spacing/traditional users)							
Want to Continue	24.4	16.4	34.6	31.8	43.2	20.6	3,150
Want to Switch	39.8	31.7	48.6	51.3	58.2	37.9	406
Un-decided/Don't want to use	27.9	17.3	43.9	34.6	49.0	21.7	484
Intension to use method among non-users							
Want to use any method	21.7	14.1	33.5	28.2	39.4	18.2	1,282
Unsure about use	20.8	9.5	32.7	25.0	38.9	15.7	2,223
Infecund	24.4	13.8	35.2	29.9	42.3	20.8	291
Currently pregnant							
Yes	23.3	14.1	33.4	30.6	43.6	19.7	543
No	24.4	14.8	35.7	30.6	42.9	19.9	9,283

Background characteristics	Physical violence	Sexual violence	Emotional violence	Physical or sexual violence	Any violence (physical, emotional, sexual)	Experienced severe physical and/ or sexual IPV in the past 12 months	Number of women who had interaction at VHND in last 12 months
Number of living children							
No child	18.8	13.8	26.5	25.8	34.2	17.9	872
1	18.2	13.4	30.4	24.8	37.6	17.5	1,422
2	24.3	14.2	36.4	30.7	43.1	18.8	2,564
3+	27.2	15.7	38.5	33.2	46.0	21.5	4,968
Completed the desired family size							
Yes	25.2	15.3	37.1	31.5	44.2	20.4	6,959
No	22.8	14.6	33.0	29.7	40.9	19.7	2,617
Non-numeric responses	16.4	5.3	23.9	17.1	29.8	8.5	250
Wealth index							
Lowest	36.7	19.3	46.5	43.1	55.3	28.9	1,817
Second	28.0	15.8	38.7	33.4	45.8	21.5	2,049
Middle	22.5	14.2	33.6	28.5	40.9	18.6	2,057
Fourth	19.3	13.6	29.5	27.1	37.3	17.4	1,985
Highest	15.1	11.1	30.0	21.1	35.3	12.9	1,880
Total	**24.3**	**14.8**	**35.6**	**30.6**	**42.9**	**19.9**	**9,826**

Table A.17: Percentage of ASHAs with low level of knowledge on the healthy timing and spacing of pregnancy and FP methods, UP, IFPS 2020-21

Background characteristics	Healthy timing and spacing of pregnancy (%)	Female sterilization [a] (%)	Male sterilization [b] (%)	Copper-T (IUCD/ PPIUCD/ PAIUCD) [c] (%)	Injectable contra-ceptive (Antara) [d] (%)	Mala-N contra-ceptive pills [e] (%)	Centchro-man pills (Chhaya) [f] (%)	Emergency contracep-tion pills [g] (%	Permanent methods [a],[b] (%)	Long-acting reversible methods [c],[d] (%)	Modern spacing methods [e],[f],[g] (%	N
Age												
<30 years	28.2	33.3	41.0	35.9	7.7	25.6	35.9	23.1	33.3	25.6	15.4	39
30-39 years	18.4	14.2	12.1	18.9	5.8	18.9	18.4	14.2	9.5	15.3	11.6	190
40-49 years	15.8	19.9	16.4	18.5	11.0	18.5	24.7	19.2	12.3	11.6	15.1	146
>=50 years	18.2	20.5	25.0	18.2	9.1	15.9	13.6	11.4	15.9	11.4	15.9	44
Marital status												
Currently married	18.9	18.6	17.8	20.5	7.3	19.2	21.5	16.0	13.4	14.2	13.9	381
Other	13.2	18.4	15.8	18.4	15.8	18.4	23.7	21.1	13.2	18.4	10.5	38
Reading skills												
Unable to read /partial ability to read	19.0	22.4	28.4	22.4	12.1	22.4	27.6	20.7	21.6	16.4	17.2	116
Able to read	18.2	17.2	13.5	19.5	6.6	17.8	19.5	14.9	10.2	13.9	12.2	303
Education												
<=8 std	21.0	19.6	21.7	24.5	11.9	27.3	25.9	16.8	16.1	18.2	17.5	143
9-10 std	23.3	25.2	19.4	19.4	6.8	16.5	22.3	17.5	15.5	14.6	14.6	103
11-12 std	15.4	16.2	15.4	17.9	4.3	14.5	18.8	18.8	12.8	12.0	12.0	117
>12 std	8.9	8.9	8.9	16.1	8.9	12.5	16.1	8.9	3.6	10.7	5.4	56
Religion												
Hindu	18.5	18.5	17.2	20.9	8.4	18.7	21.7	16.7	13.3	15.0	13.8	406
Non-Hindu	15.4	23.1	30.8	0.0	0.0	30.8	23.1	7.7	15.4	0.0	7.7	13
Caste												
SC/ST	16.0	15.1	16.0	21.0	10.1	24.4	24.4	16.8	12.6	19.3	16.8	119
OBC	19.4	19.9	19.9	22.9	8.0	17.4	20.9	18.9	13.9	15.4	13.9	201
General	19.2	20.2	15.2	14.1	6.1	16.2	20.2	11.1	13.1	7.1	9.1	99
Work experience												
<5 years	28.0	34.0	26.0	40.0	6.0	26.0	24.0	18.0	28.0	28.0	14.0	50
5-9 years	18.8	17.4	26.1	15.9	7.2	14.5	27.5	23.2	14.5	13.0	13.0	69
>=10 years	16.7	16.3	14.3	18.0	8.7	19.0	20.0	14.7	10.7	12.7	13.7	300
Household income												
Rs <10,000	16.3	20.0	18.8	18.1	6.3	11.9	18.8	16.9	17.5	12.5	9.4	160
Rs 10,000-19,999	21.1	18.8	20.3	21.8	10.5	18.8	23.3	18.8	12.8	18.0	13.5	133
Rs >=20,000	18.3	16.7	13.5	21.4	7.9	28.6	23.8	13.5	8.7	13.5	19.0	126
Region												
Bundelkhand	45.1	39.2	19.6	45.1	19.6	33.3	45.1	33.3	19.6	39.2	29.4	51
Central	14.6	14.6	22.9	10.4	8.3	6.3	4.2	14.6	12.5	4.2	4.2	48
West	18.0	22.7	28.9	14.8	3.1	20.3	21.1	14.1	21.9	9.4	12.5	128
Purvanchal	12.5	11.5	8.3	19.8	8.3	17.7	20.3	14.1	6.3	14.1	12.5	192
Total	**18.4**	**18.6**	**17.7**	**20.3**	**8.1**	**19.1**	**21.7**	**16.5**	**13.4**	**14.6**	**13.6**	**419**

Note: IFPS- Integrated Family Planning Survey| FLWs- Frontline Workers| ASHA- Accredited Social Health Activist| % - Unweighted percent | N - Unweighted numbers | CI- Confidence Interval 1 Includes ASHAs who are separated, divorced and widowed; 2 Includes ASHAs who are Muslim or belong to another religion

Table A.18: Percentage of ASHAs expressing low/high levels of myths/misconceptions prevalent in their communities regarding various contraceptive methods, Uttar Pradesh, IFPS 2020-21

Background characteristics	Copper-T (IUCD/PPIUCD) (%)		Injectable contraceptive (Antara) (%)		Pills or Centchroman (Chhaya) (%)		N
	Low	High	Low	High	Low	High	
Age							
<30 years	69.2	30.8	69.2	30.8	92.3	7.7	39
30-39 years	50.5	49.5	64.7	35.3	84.2	15.8	190
40-49 years	46.6	53.4	58.2	41.8	83.6	16.4	146
>=50 years	54.5	45.5	63.6	36.4	90.9	9.1	44
Marital status							
Currently married	51.4	48.6	63.5	36.5	85.3	14.7	381
Other	50.0	50.0	55.3	44.7	86.8	13.2	38
Reading skills							
Unable to read/partial ability to read	50.0	50.0	61.2	38.8	87.1	12.9	116
Able to read	51.8	48.2	63.4	36.6	84.8	15.2	303
Education							
<=8 std	49.0	51.0	60.8	39.2	88.8	11.2	143
9-10 std	49.5	50.5	68.0	32.0	80.6	19.4	103
11-12 std	55.6	44.4	57.3	42.7	83.8	16.2	117
>12 std	51.8	48.2	69.6	30.4	89.3	10.7	56
Religion							
Hindu	51.0	49.0	63.3	36.7	86.0	14.0	406
Non-Hindu	61.5	38.5	46.2	53.8	69.2	30.8	13
Caste							
SC/ST	43.7	56.3	59.7	40.3	79.0	21.0	119
OBC	54.7	45.3	66.7	33.3	88.1	11.9	201
General	53.5	46.5	58.6	41.4	87.9	12.1	99
Work experience							
<5 years	52.0	48.0	60.0	40.0	82.0	18.0	50
5-9 years	58.0	42.0	62.3	37.7	84.1	15.9	69
>=10 years	49.7	50.3	63.3	36.7	86.3	13.7	300
Household income							
Rs <10,000	55.6	44.4	61.3	38.8	80.0	20.0	160
Rs 10,000-19,999	48.9	51.1	65.4	34.6	85.0	15.0	133
Rs >=20,000	48.4	51.6	61.9	38.1	92.9	7.1	126
Region							
Bundelkhand	66.7	33.3	82.4	17.6	92.2	7.8	51
Central	22.9	77.1	54.2	45.8	72.9	27.1	48
West	58.6	41.4	55.5	44.5	87.5	12.5	128
Purvanchal	49.5	50.5	64.6	35.4	85.4	14.6	192
Total	51.3	48.7	62.8	37.2	85.4	14.6	419

Note
IFPS- Integrated Family Planning Survey| FLWs- Frontline Workers| ASHA- Accredited Social Health Activist| % - Unweighted percent | N - Unweighted numbers | CI- Confidence Interval
1 Includes ASHAs who are separated, divorced and widowed; 2 Includes ASHAs who are Muslim or belong to another religion

Table A.19: Percentage of ASHAs with varying levels of motivation and self-efficacy by background characteristics, Uttar Pradesh, IFPS 2020-21

Background characteristics	Self-efficacy Level			Motivation Level			N
	Low	Medium	High	Low	Medium	High	
Age							
<30 years	20.5	56.4	23.1	17.9	66.7	15.4	39
30-39 years	16.3	56.3	27.4	21.6	61.6	16.8	190
40-49 years	17.1	61.0	21.9	19.9	65.1	15.1	146
>=50 years	20.5	45.5	34.1	20.5	65.9	13.6	44
Marital status							
Currently married	17.3	56.7	26.0	20.7	63.5	15.7	381
Other	18.4	57.9	23.7	18.4	65.8	15.8	38
Reading skills							
Unable to read/partial ability to read	19.8	56.0	24.1	17.2	68.1	14.7	116
Able to read	16.5	57.1	26.4	21.8	62.0	16.2	303
Education							
<=8 std	15.4	57.3	27.3	16.1	69.2	14.7	143
9-10 std	20.4	58.3	21.4	24.3	60.2	15.5	103
11-12 std	17.9	53.0	29.1	24.8	60.7	14.5	117
>12 std	16.1	60.7	23.2	16.1	62.5	21.4	56
Religion							
Hindu	18.0	55.9	26.1	20.7	63.1	16.3	406
Non-Hindu	0.0	84.6	15.4	15.4	84.6	0.0	13
Caste							
SC/ST	14.3	63.9	21.8	24.4	59.7	16.0	119
OBC	19.9	52.2	27.9	16.9	66.2	16.9	201
General	16.2	57.6	26.3	23.2	63.6	13.1	99
Work experience							
<5 years	16.0	54.0	30.0	32.0	50.0	18.0	50
5-9 years	13.0	60.9	26.1	11.6	72.5	15.9	69
>=10 years	18.7	56.3	25.0	20.7	64.0	15.3	300
Household income							
Rs <10,000	12.5	62.5	25.0	30.0	53.1	16.9	160
Rs 10,000-19,999	17.3	53.4	29.3	18.8	63.9	17.3	133
Rs >=20,000	23.8	53.2	23.0	10.3	77.0	12.7	126
Region							
Bundelkhand	17.6	60.8	21.6	15.7	68.6	15.7	51
Central	45.8	31.3	22.9	35.4	60.4	4.2	48
West	4.7	67.2	28.1	3.9	86.7	9.4	128
Purvanchal	18.8	55.2	26.0	29.2	47.9	22.9	192
Total	17.4	56.8	25.8	20.5	63.7	15.8	419

Note
IFPS- Integrated Family Planning Survey| FLWs- Frontline Workers| ASHA- Accredited Social Health Activist| % - Unweighted percent | N - Unweighted numbers | CI- Confidence Interval.
1 Includes ASHAs who are separated, divorced and widowed; 2 Includes ASHAs who are Muslim or belong to another religion

Table A.20: Training of doctors on family planning methods based on selected background characteristics, Uttar Pradesh, 2020-21

Background characteristics	LAP/ Mini-LAP/ PPS (%)	No Scalpel Vasectomy (NSV) (%)	IUCD/ PPIUCD/ PAIUCD (%)	Injectable (Antara) (%)	Centchroman (Chhaya) (%)	Family planning counselling (%)	N
Sex							
Male	16.7	11.2	17.2	34.9	28.8	21.4	215
Female	33.0	1.1	64.4	60.9	54.8	38.7	261
Age							
<35 years	18.1	3.4	30.2	38.8	33.6	24.1	116
35-44 years	19.4	3.7	40.3	49.5	43.5	31.5	216
45-54 years	35.8	10.5	52.6	54.7	47.4	35.8	95
>=55 years	51.0	10.2	67.3	61.2	55.1	34.7	49
Highest educational qualification							
MS/MD & DGO	66.3	12.5	65.0	55.0	53.8	38.8	80
MBBS	22.5	5.6	35.8	45.7	38.7	28.1	302
Others: BHMS/BAMS/BUMS/Others	1.1	0.0	47.9	55.3	47.9	33.0	94
Work experience in family planning							
<5 years	18.0	3.0	18.0	31.6	24.1	18.8	133
5-9 years	31.7	4.8	50.8	50.8	46.0	31.7	126
>=10 years	26.7	7.8	53.9	59.0	53.0	37.8	217
Location							
Urban	34.9	7.3	57.8	57.8	53.2	32.1	109
Rural	22.9	5.2	38.7	46.6	40.1	30.5	367
Type of facility							
District Hospitals: DCH/DMH/DWH	64.9	9.5	74.3	60.8	59.5	43.2	74
First Referral Units: FRUs	24.2	7.3	42.7	49.2	41.9	31.5	124
Community Health Center: CHC/UCHC	23.3	4.3	41.4	44.8	41.4	29.3	116
Primary Health Center: PHC/UPHC	10.4	3.9	27.9	46.1	36.4	24.7	154
Others: Unspecified	12.5	0.0	75.0	62.5	62.5	50.0	8
Region							
Bundelkhand	25.0	9.6	34.6	46.2	38.5	26.9	52
Central	32.1	3.8	54.7	50.9	37.7	30.2	53
West	24.4	3.0	50.6	59.8	54.9	29.9	164
Purvanchal	25.1	7.2	36.2	41.1	36.2	32.9	207
Total	**25.6**	**5.7**	**43.1**	**49.2**	**43.1**	**30.9**	**476**

Table A.21: Training of nurses on family planning methods based on selected background characteristics, Uttar Pradesh, 2020-21

Background characteristics	LAP/Mini-LAP/PPS (%)	IUCD/ PPIUCD/ PAIUCD (%)	Injectable (Antara) (%)	Centchroman (Chhaya) (%)	Family planning counselling (%)	N
Sex						
Male	0.0	0.0	28.6	28.6	14.3	7
Female	6.8	90.1	71.4	63.7	39.4	444
Age						
<30 years	3.0	75.2	70.3	62.4	41.6	101
30-39 years	4.2	93.4	71.7	63.7	35.8	212
40-49 years	4.5	92.1	69.7	64.0	37.1	89
>=50 years	28.6	89.8	69.4	61.2	51.0	49
Highest educational qualification						
General Nursing and Midwifery (GNM)	6.9	90.2	71.9	64.0	39.3	420
Others: B.Sc/M.Sc Nursing, ANM, Other	3.2	67.7	54.8	51.6	35.5	31
Work experience in family planning						
<5 years	0.9	75.9	63.8	56.9	40.5	116
5-9 years	5.5	95.0	77.5	68.0	37.0	200
>=10 years	13.3	90.4	66.7	61.5	40.7	135
Location						
Urban	8.9	87.5	61.6	56.3	33.0	112
Rural	5.9	89.1	73.7	65.5	41.0	339
Type of facility						
District Hospitals: DCH/DMH/DWH	12.2	90.5	70.3	64.9	43.2	74
First Referral Units: FRUs	7.4	90.9	74.4	66.9	39.7	121
Community Health Center: CHC/UCHC	8.7	93.9	71.3	59.1	38.3	115
Primary Health Center: PHC/UPHC	0.7	81.3	67.2	62.7	37.3	134
Others: Unspecified	14.3	85.7	71.4	57.1	28.6	7
Region						
Bundelkhand	9.8	84.3	60.8	51.0	31.4	51
Central	17.8	93.3	64.4	51.1	48.9	45
West	5.1	88.5	71.8	67.9	35.9	156
Purvanchal	4.5	88.9	73.9	65.3	41.2	199
Total	**6.7**	**88.7**	**70.7**	**63.2**	**39.0**	**451**

Table A.22: Pre and post-procedure knowledge of doctors on family planning methods by selected characteristics, Uttar Pradesh, IFPS 2020-2021

Divisions	Lap/Mini-LAP/ PPS		NSV		IUCD/PPIUCD/ PAIUCD		Injectables		N
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	
Sex of respondent									
Male	58.6	48.8	34.9	33.5	59.1	65.1	67.0	73.0	215
Female	53.3	33.3	54.0	47.5	48.7	34.1	50.6	51.3	261
Age									
<35 years	53.4	39.7	43.1	38.8	55.2	42.2	56.0	58.6	116
35-44 years	60.2	43.1	47.2	42.1	57.9	51.4	60.6	64.4	216
45-54 years	58.9	43.2	43.2	38.9	49.5	54.7	60.0	62.1	95
>=55 years	34.7	24.5	46.9	46.9	36.7	34.7	46.9	51.0	49
Highest educational qualification									
MS/MD & DGO	35.0	20.0	30.0	31.3	40.0	27.5	46.3	40.0	80
MBBS	56.0	43.7	43.7	39.1	56.3	51.3	59.3	65.2	302
Others: BHMS/ BAMS/ BUMS	72.3	46.8	63.8	56.4	55.3	55.3	63.8	66.0	94
Work experience in family planning									
<5 years	57.1	45.9	44.4	42.1	57.9	50.4	62.4	60.9	133
5-9 years	55.6	33.3	46.8	37.3	50.8	43.7	49.2	57.9	126
>=10 years	54.8	41.0	45.2	42.9	52.1	49.3	60.4	63.1	217
Location									
Urban	48.6	27.5	36.7	38.5	45.0	36.7	46.8	50.5	109
Rural	57.8	44.1	48.0	42.0	55.9	51.5	61.3	64.3	367
Type of facility									
District Hospitals: DCH/DMH/DWH	40.5	27.0	39.2	37.8	41.9	28.4	52.7	44.6	74
First Referral Units: FRUs	54.8	41.1	50.0	47.6	58.1	50.0	58.1	62.1	124
Community Health Center: CHC/UCHC	54.3	37.9	47.4	42.2	46.6	46.6	54.3	62.1	116
Primary Health Center: PHC/UPHC	62.3	46.1	41.6	35.7	58.4	56.5	61.7	66.9	154
Others	100.0	75.0	75.0	62.5	87.5	62.5	87.5	75.0	8
Region									
Bundelkhand	69.2	44.2	55.8	44.2	63.5	53.8	71.2	75.0	52
Central	79.2	56.6	71.7	71.7	71.7	62.3	73.6	73.6	53
West	45.1	32.3	36.6	29.9	40.2	40.9	48.2	56.1	164
Purvanchal	54.6	41.5	43.0	41.5	56.5	48.8	58.5	58.5	207
Total	**55.7**	**40.3**	**45.4**	**41.2**	**53.4**	**48.1**	**58.0**	**61.1**	**476**

Table A.23: Percentage of counsellors with low knowledge of various family planning methods based on selected characteristics, Uttar Pradesh, IFPS 2020-21

Background characteristics	LAP/Mini-LAP/PPS (%)	NSV (%)	IUCD/ PPIUCD/ PAIUCD (%)	Injectable (Antara) (%)	Centchroman (Chhaya) (%)	N
Age						
<35 years	38.0	46.8	63.3	68.4	34.2	79
35-39 years	44.4	44.4	45.8	62.5	38.9	72
>=40 years	40.3	55.6	61.1	62.5	48.6	72
Sex						
Male	33.3	33.3	33.3	83.3	50.0	6
Female	41.0	49.3	57.6	64.1	40.1	217
Highest educational qualification						
Postgraduate	36.3	47.3	50.7	67.1	37.7	146
Graduate & Others	49.4	51.9	68.8	59.7	45.5	77
Work experience in family planning						
<=5 years	37.9	55.2	65.5	55.2	34.5	29
6-9 years	43.4	51.4	56.6	67.4	42.3	175
>=10 years	21.1	15.8	47.4	52.6	31.6	19
Location						
Urban	39.7	41.4	60.3	62.1	39.7	58
Rural	41.2	51.5	55.8	65.5	40.6	165
Type of facility						
District Hospitals	38.2	45.5	49.1	58.2	32.7	55
First Referral Units	45.1	54.2	56.9	66.7	45.1	144
Others	20.8	25.0	75.0	66.7	29.2	24
Total	**40.8**	**48.9**	**57.0**	**64.6**	**40.4**	**223**

Table A.24: Counsellors providing clients a lower level of pre-procedure information on family planning methods based on selected characteristics, Uttar Pradesh, IFPS 2020-2021

Background characteristics	LAP/Mini-LAP/PPS (%)	NSV (%)	IUCD/ PPIUCD/ PAIUCD (%)	Injectable (Antara) (%)	Centchroman (Chhaya) (%)	N
Age						
<35 years	65.8	64.6	62.0	55.7	58.2	79
35-39 years	54.2	59.7	54.2	51.4	59.7	72
>=40 years	63.9	59.7	61.1	51.4	62.5	72
Sex						
Male	33.3	33.3	66.7	33.3	50.0	6
Female	62.2	62.2	59.0	53.5	60.4	217
Highest educational qualification						
Postgraduate	58.2	58.9	58.9	50.7	58.2	146
Graduate & Others	67.5	66.2	59.7	57.1	63.6	77
Work experience in family planning						
<=7 years	73.6	65.3	63.9	58.3	69.4	72
>7 years	55.6	59.6	57.0	50.3	55.6	151
Work experience in family planning						
<=5 years	65.5	69.0	55.2	62.1	62.1	29
6-9 years	62.9	62.3	61.7	54.3	61.7	175
>=10 years	42.1	42.1	42.1	26.3	42.1	19
Location						
Urban	51.7	48.3	55.2	46.6	53.4	58
Rural	64.8	66.1	60.6	55.2	62.4	165
Type of facility						
District Hospitals	49.1	54.5	50.9	43.6	50.9	55
First Referral Units	66.7	63.9	61.8	58.3	66.0	144
Others	58.3	62.5	62.5	41.7	45.8	24
Region						
Bundelkhand	80.0	85.0	80.0	60.0	75.0	20
Central	76.9	69.2	65.4	59.6	65.4	52
West	34.4	48.4	35.9	32.8	43.8	64
Purvanchal	67.8	60.9	67.8	62.1	65.5	87
Total	**61.4**	**61.4**	**59.2**	**52.9**	**60.1**	**223**

Table A.25: Counsellors providing clients a lower level of post-procedure information on family planning methods based on selected characteristics, Uttar Pradesh, IFPS 2020-2021

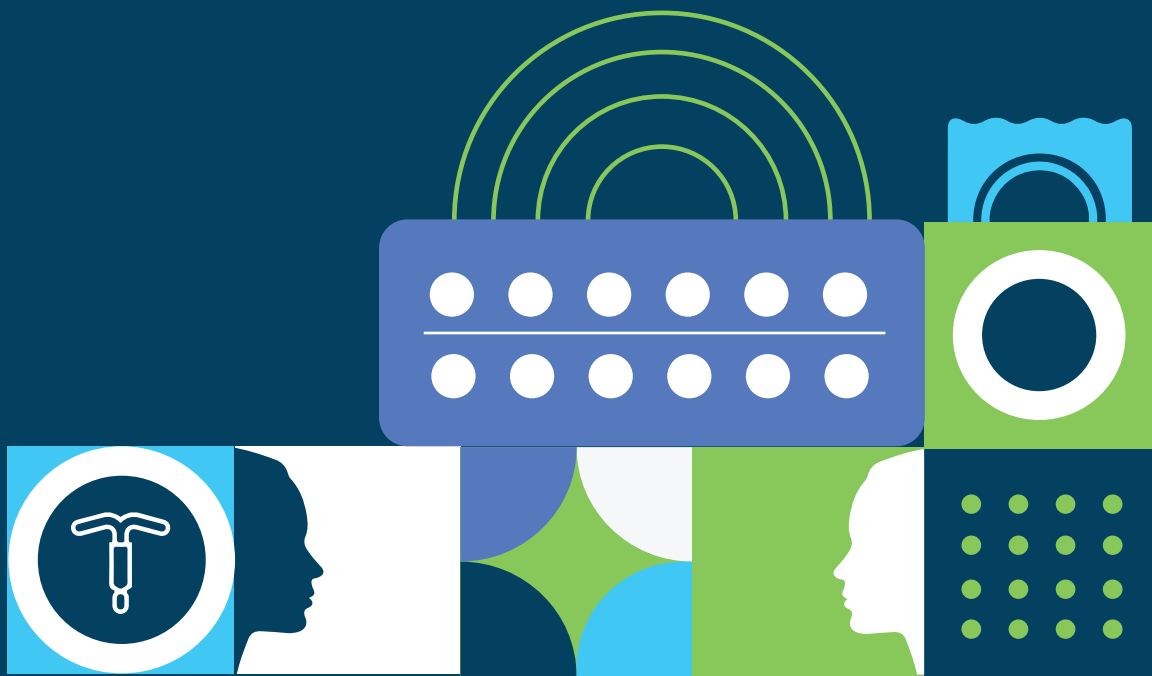
Background characteristics	LAP/Mini-LAP/PPS	Injectables	N
Age			
<35 years	57.0	63.3	79
35-39 years	50.0	59.7	72
>=40 years	58.3	61.1	72
Sex			
Male	50.0	66.7	6
Female	55.3	61.3	217
Highest educational qualification			
Postgraduate	52.1	58.9	146
Graduate & Others	61.0	66.2	77
Work experience in family planning			
<=7 years	66.7	68.1	72
>7 years	49.7	58.3	151
Work experience in family planning			
<=5 years	58.6	62.1	29
6-9 years	54.9	62.3	175
>=10 years	52.6	52.6	19
Location			
Urban	48.3	62.1	58
Rural	57.6	61.2	165
Type of facility			
District Hospitals	52.7	58.2	55
First Referral Units	59.0	61.8	144
Others	37.5	66.7	24
Total	**55.2**	**61.4**	**223**

Table A.26: Stock-outs of contraceptive methods in facilities lasting more than a month across different regions, Uttar Pradesh, IFPS 2020–21

Contraceptive methods	Bundelkhand	Central	West	Purvanchal	Total
Condom (free)	21.1	22.0	15.5	27.5	22.0
OCP (free)	22.8	20.0	24.1	29.3	25.8
Antara	22.8	20.0	17.8	26.1	22.2
Chhaya (free)	45.6	24.0	27.6	38.1	33.9
ECP (free)	9.1	9.9	33.3	47.7	26.6
IUCD	38.6	22.0	36.2	35.8	34.9
Number of facilities	**57**	**50**	**174**	**215**	**496**

Table A.27: Types of registers available by facility type, Uttar Pradesh, IFPS 2020–21

Register type	DH	CHC-FRU	CHC	PHC	UPHC/UCHC	Total
Sterilization registers (male or female)	91.8	86.4	76.7	27.4	6.2	60.5
IUCD insertion / IUCD follow-up combined register	87.7	84.8	84.5	42.7	75.4	74.0
PPIUCD insertion and PPIUCD follow-up register	91.8	88.8	87.1	43.6	21.5	69.4
Chhaya/OCP Register	83.6	86.4	78.4	50.4	53.8	71.4
MPA register	89.0	84.8	84.5	53.0	81.5	77.4
Counselling Register	75.3	59.2	49.1	25.6	36.9	48.4
Contraceptive stock register	89.0	85.6	75.0	57.3	67.7	74.6
Maternal Death Register (MDR)	76.7	60.0	52.6	23.9	7.7	45.4
Total	**100**	**100**	**100**	**100**	**100**	**100**



India Health Action Trust
S&S Elite, 2nd Floor
No. 197, 10th Cross, CBI Road, Ganganagar
Bengaluru – 560032
Karnataka, India
Phone: +91 80 2340 9698
Email: contactus@ihat.in
Website: www.ihat.in

Uttar Pradesh Technical Support Unit
India Health Action Trust 404, 4th Floor
Ratan Square No. 20-A Vidhan Sabha Marg
Lucknow-226001
Uttar Pradesh, India
Phone: +91-522-4922350 / 4931777