FPwatch RESEARCH BRIEF

India 2016 FPwatch Survey: Findings from a contraceptive commodity and service assessment among public and private sector outlets in Uttar Pradesh and Bihar states
Contents

Background ............................................................................................................................................. 5

FPwatch at a glance ................................................................................................................................. 6

Methods .................................................................................................................................................. 8

Sample ................................................................................................................................................... 10

Market composition ............................................................................................................................... 12

Availability of a diversity of methods ..................................................................................................... 15

Contraceptive commodity availability ................................................................................................. 18

Stock-outs .............................................................................................................................................. 24

Contraceptive market share .................................................................................................................. 26

Readiness to provide contraceptive services ......................................................................................... 31

Modern contraceptive market prices ..................................................................................................... 35

Summary .................................................................................................................................................. 37

Acknowledgements ............................................................................................................................... 42
Background

India aims to provide family planning services to 48 million additional women to fulfill their FP2020 commitment through an expanded contraceptive method mix. India also pledged to sustain the current coverage of over 100 million contraceptive users through 2020.

FAMILY PLANNING ENVIRONMENT IN INDIA

At the current growth rate of 16-18 million people per year, India is projected to be the most populous country in the world by 2030. Despite having one of the ten fastest growing economies in the world, India struggles with providing adequate access to the family planning (FP) and reproductive health services required to match population growth. The modern contraceptive prevalence rate (mCPR) has increased from 43% (DLHS-1) in 1999 to 48% (NFHS-3/DLHS-3) in 2006/8, but remains low compared to national goals. Of contraceptive users, most married women rely on female sterilization (72%), followed by male condoms (13%), oral contraceptives (9%) and/or intrauterine devices (IUDs; 4%). Unmet need for family remains high, particularly among married women. According to DLHS-3, the estimate of total unmet need for FP was 21% at the national level. For both mCPR and unmet need, there are significant disparities by geography and socioeconomic characteristics.

The mCPR is considerably lower than the national average of 58% in the states of Uttar Pradesh (UP) (29%) and Bihar (29%). Unmet need is also higher than the national average in UP (32.6%) and Bihar (35.9%). The large unmet need for FP, along with the significant regional and socioeconomic disparities, are areas requiring unprecedented focus in these states which together, account for 25% of the national population.

SECTOR ROLES IN CONTRACEPTIVE PROVISION

India’s public health program, the National Rural Health Mission (NHM) is the largest in the world and focuses on provision of a “basket of contraceptive choices” for Indian men and women. These choices include condoms, oral contraceptives, emergency contraceptive pills, IUDs, male/female sterilizations and, recently added, contraceptive injectables. Commodities and services are distributed through tiered health centres and short-acting methods can be provided directly to households through Accredited Social Health Activists (ASHAs) working from public sub-centres. Within the public sector, most contraceptive methods can be provided free of charge or with nominal fees. The public sector has maintained its role as the immediate source of commodities and supplies for most contraceptive users in India. Over 70% of Indian women reported receiving their contraceptive methods through the public sector. However, this is largely a result of women getting sterilizations through the public sector. Nearly one-third of contraceptive users reported receiving their contraceptive method from the private sector, which are the primary source of short-acting methods. However, in both Bihar and UP, over 45% of contraceptive users report the private sector as the source for contraceptive methods.

KEY STRATEGIES TO DATE

Since implementation of a national family planning program over 60 years ago, India has taken many important steps to achieve family planning progress. Most recently in 2012, India committed to the London Summit on Family Planning’s FP2020 Initiative goals. India pledged to reach an additional 48 million women with access to family planning by 2020 while sustaining the coverage of 100 million women currently using contraceptives in India. The former part of their goal represents 40% of the global FP2020 goal to reach 120 million women. In addition, the pledge includes a commitment to greater equity and quality, with a new focus on more and better training of health workers as well as an emphasis on shifting from limiting to spacing contraceptive methods and an expansion of method choice.

KEY INTERVENTIONS

India has implemented several initiatives to address its high unmet need for family planning and to improve contraceptive access, including:

- Free provision of family planning services and supplies to 200 million couples and 234 million adolescents
- Health system and infrastructure strengthening
- Mobilization of domestic resources
- Implementation of the National Urban Health Mission with a focus on the poor
- Increased provision of post-partum IUD services
- Community-level contraceptive distribution
- Increased collaboration with private sector partners through a social franchising scheme

References on this page:
FPwatch at a glance

WHAT IS FPWATCH?

FPwatch is a multi-country research project implemented by Population Services International (PSI) with funding from the Bill and Melinda Gates Foundation (BMGF) and the Three Millennium Development Goal (3MDG) Fund. Standardized tools and approaches are employed to provide comparable data across countries and over time. FPwatch is a response to the Family Planning 2020 (FP2020) goal to enable 120 million additional women and girls to have informed choice and access to family planning information and a range of modern contraceptive methods.\(^5\) Launched in 2015, FPwatch is designed to provide timely, relevant and high-quality FP market information. Research methods implemented include outlet surveys and interviews with national FP experts.

GOAL

The FPwatch project aims to inform and monitor national and global policy, strategy and funding decisions for improving informed choice and access to FP information and a range of modern contraceptive methods.

RELEVANCE

FPwatch is an expansion of PSI’s ACTwatch research initiative\(^7\) and is designed to deliver high-quality evidence on modern contraceptive availability, price and relative market share and contraceptive service availability and readiness through outlet surveys in the proposed countries. FPwatch market evidence will complement other FP research and monitoring that is heavily reliant on population-based studies and modeling. The data gathered and analyzed through FPwatch will provide the FP community with relevant evidence to support the strategic decision making necessary for reaching women and girls in need of FP information, services and contraceptives.

The 2016 baseline FPwatch India survey complements concurrent data collection focused on tracking FP2020 progress, including surveys conducted by the Performance Monitoring and Accountability 2020 (PMA2020) project in India.\(^8\) The 2016 India FPwatch survey supplements and builds upon these surveys by conducting a full contraceptive commodity audit and service provider questionnaire with information on contraceptive commodity and service availability, price, volume and service readiness for all public and private outlets.

FPwatch market monitoring in India in 2016 was implemented in the context of national strategies designed to improve access to and choice of modern contraceptive methods.

OUTLET SURVEYS

Outlet surveys are the core component of the FPwatch project. The outlet survey was conducted by PSI-DC/India with support from the Uttar Pradesh and Bihar Ministries of Health (MoH) with research support from TNS India. The outlet survey was designed to monitor and provide estimates for key FP market indicators at the regional level and for two of India’s largest states: UP and Bihar. Estimates also compare metro, urban and rural locations.

This summary report presents cross-sectional data from the 2016 outlet survey.

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What questions are answered by the outlet survey?

What types of outlets in the public and private sectors are carrying modern contraceptive methods?

What proportion of public and private sector outlets are stocking selected modern contraceptive commodities and providing a range of methods?

What is the relative market share for each contraceptive method and for each outlet type?

What is the consumer price of modern contraceptive methods among private sector outlets?

What proportion of public and private sector outlets are providing selected modern contraceptive services, and what is the readiness of selected outlet types for performing contraceptive services?
Methods

FPwatch implements standardized methods and questionnaires that allow for comparisons within and between countries. Together, a full census of all outlets providing contraceptive methods, a full audit of all available contraceptive commodities and a provider interview on contraceptive services give a complete picture of the FP commodity and services market.

HOW IS THE SAMPLING CONDUCTED?
For each of the two states, three strata were constructed: metro, urban and rural strata based on India census designations. Two-stage sampling was conducted for urban and rural strata selecting first districts, then urban wards or rural villages (clusters) employing probability-proportional-to-size (PPS) sampling. One-stage sampling was conducted for metro strata selecting wards using PPS. A representative sample of outlets providing contraceptive methods directly to consumers was selected.

WHAT TYPES OF OUTLETS ARE SAMPLED?
The main types of outlets sampled included higher level public health facilities including hospitals, health centres and sub-centres (with affiliated auxiliary nurse midwives -ANMs and ASHAs), Anganwadi workers (AWWs), not-for-profit facilities, private for-profit health facilities, registered and unregistered pharmacies/chemists, AYUSH providers, rural medical practitioners (RMPs) and general retailers. Regulations for provision of contraceptive commodities and services are shown to the right.

HOW ARE THE OUTLETS IDENTIFIED?
The FPwatch survey included all outlets in selected localities with the potential to sell modern contraceptive commodities or offering contraceptive services. As many of these outlets are unregistered, mobile or recently opened, official listings of these outlets and their locations were not available. A census approach was therefore implemented, supported by local informants, maps and lists of registered outlets where available.

WHAT IS AN OUTLET CENSUS?
This involves a team of data collectors moving systematically through a defined area to identify all outlets that have the potential to sell or distribute contraceptive methods.

WHAT HAPPENS AFTER AN OUTLET IS IDENTIFIED?
The outlet is screened for availability of modern contraceptive methods or services. Outlets were eligible for the full survey if they had modern contraceptive commodities including oral contraceptives, emergency contraceptive pills, contraceptive injectables, implants or IUDs in stock at the time of survey or in the previous three months, or offer contraceptive services including contraceptive injections, implant or IUD insertions, or male or female sterilizations. Some information on brands, prices and distribution of condoms was collected from all outlets screened if condoms were available. Other commodities including vaginal foaming tablets, diaphragms, and birth control rings were audited if found in outlets surveyed. Permission to conduct the interview was obtained from the main provider.

India FP Guidelines (2005)¹⁰
Public facilities consist of public hospitals and health centres, sub-centres and AWWs. According to National FP Guidelines, public hospitals and comprehensive health centres (higher public health facilities) can provide all contraceptives and services if credentialed/trained staff available. Sub-centres can stock and provide services for all methods, with trained staff for services and ASHAs can distribute short-acting methods (except injectables which are only available in sub-centres as of late 2016 and being rolled out gradually). AWWs can stock all short-acting methods, but are not allowed to perform injection, IUD or sterilization services. Private medical facilities consist of private health facilities and pharmacies. Private health facilities consist of private hospitals, clinics and private doctors or health workers providing health commodities and services. Private hospitals can stock all contraceptive commodities and provide all contraceptive services if credentialed/trained staff are available. Pharmacies can stock all short-acting contraceptive commodities but are not allowed to provide any contraceptive services without trained/credentialed staff. Private other facilities include AYUSH providers, rural medical practitioners and general retailers. These outlet types can stock short-acting methods, but typically do not provide associated services unless trained. Provision of contraceptive injectables was recently allowed throughout India and implants are not currently available.

HOW IS INFORMATION ON CONTRACEPTIVE COMMODITIES AND SERVICES CAPTURED?
Full contraceptive audits were conducted among outlets with eligible contraceptive commodities in stock. Information was recorded for each unique contraceptive identified in the outlet. Among outlets offering eligible contraceptive services, providers were interviewed to give information for each type of service. Data was collected on tablet computers using a Computer Assisted Personal Interviewing (CAPI) software developed by TNS.

WHAT INFORMATION IS RECORDED ON THE AUDITS AND PROVIDER INTERVIEWS?
An audit sheet is completed for each unique modern contraceptive commodity in stock. The audit sheet captures product information from the product package including the brand name, manufacturer, country of manufacturer and formulation/strength (if applicable). The audit sheet also captures information from the provider including the amount sold in the last one month, retail price and stock-outs in the previous three months. The provider interview captures the number of services performed, price, provider credentials and the availability of a minimum set of essential equipment.

Comprehensive product information and provider reports on amount distributed and retail price allow for calculating estimates of contraceptive method availability, price and relative market share. Comprehensive service and provider information allows for calculating estimates of readiness for contraceptive services.

¹ Metro designates a population of 1,000,000 and above.
HOW MANY OUTLETS WERE INCLUDED IN THE SAMPLE AND SCREENED?

More than 20,000 outlets across 678 clusters were enumerated (i.e. identified as outlets with potential to sell or provide modern contraceptive commodities and services). Among the over 19,000 that were screened (11,333 in Uttar Pradesh and 8,439 in Bihar), over one-fifth provided information on condoms and 21 percent met at least one of the three eligibility criteria in that they had at least one brand of modern contraceptive commodity including oral contraceptives, emergency contraceptive pills, contraceptive injectables, implants and/or IUDs, in stock in the previous three months, or provided contraceptive services. Less than 2 percent of eligible outlets refused or were otherwise unavailable for interview.

1 in 5

Number of outlets screened that met eligibility for full interview

Key:

1: Modern contraceptive commodities (includes oral contraceptives, emergency contraceptives, contraceptive injectables or IUDs) in stock on day of visit
2: Modern contraceptive commodities reportedly in stock during the previous three months but not on the day of the visit
3: Contraceptive services (including contraceptive injections, IUD insertions, male sterilizations or female sterilizations) available but no modern contraceptive commodities in stock (commodities purchased elsewhere and brought for service)

* Outlets enumerated: Identified as outlets with potential to sell or distribute modern contraceptive commodities (male condoms, female condoms, oral contraceptives, emergency contraceptives, contraceptive injectables, IUDs) and/or provide contraceptive services (injections, IUDs, male/female sterilizations) during the census

† Outlets screened: Administered questions to assess current or recent (previous three months) availability of modern contraceptive commodities or services

‡ Outlets interviewed: A partial or complete interview was conducted with an outlet representative (health facility provider or staff)
A Outlets enumerated 11,851

B Outlets screened 11,333

C Outlets that met screening criteria
2,563
1 = 2,325
2 = 72
3 = 166

D Outlets interviewed 2,516
1 = 2,283
2 = 70
3 = 163

Uttar Pradesh Sample by District

<table>
<thead>
<tr>
<th>Strata</th>
<th># Selected clusters (wards/villages)</th>
<th># Outlets Enumerated</th>
<th># Outlets that Met Screening Criteria</th>
</tr>
</thead>
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<td>1,963</td>
<td>770</td>
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<tr>
<td>Bihar Urban</td>
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<td>3,548</td>
<td>640</td>
</tr>
<tr>
<td>Bihar Rural</td>
<td>120</td>
<td>3,141</td>
<td>718</td>
</tr>
<tr>
<td>Total</td>
<td>678</td>
<td>20,512</td>
<td>4,150</td>
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</tbody>
</table>
Market composition

WHAT IS CONTRACEPTIVE MARKET COMPOSITION?

Contraceptive market composition illustrates the distribution of all outlets that were found to have at least one modern contraceptive commodity in stock on the day of survey or in the past three months or provide at least one contraceptive service. The pie charts below illustrate the distribution of these outlet types according to the public and private sector and by each outlet category for UP and Bihar States. Outlets only providing male condoms and no other modern method were not considered in market composition graphs.

WHAT TYPES OF OUTLETs DID THE SURVEY TEAM COME ACROSS IN UP AND BIHAR?

Over 20,000 outlets were enumerated, or identified as having the potential to sell or distribute modern contraceptive commodities and/or provide contraceptive services during the census. The private sector, and mostly general retailers, accounted for over half of outlets in both UP and Bihar. In the public sector, there was a higher proportion of sub-centres/ANM/ASHAs and AWWs among the outlets enumerated in UP compared with Bihar. These outlets were screened but most were not eligible for the full survey.

WHAT IS THE 2016 MODERN CONTRACEPTIVE MARKET COMPOSITION AMONG ELIGIBLE OUTLETs?

In UP, the private sector accounted for 18 percent of outlets stocking at least one modern contraceptive commodity (excluding outlets with condoms only). The majority of market composition in the private sector was accounted for by pharmacies/chemists (15 percent). The public sector accounted for 82 percent of market composition in UP with 56 percent from sub-centres/ANM/ASHAs, 1 percent from higher public health facilities and health centres and 26 percent from AWWs.

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**Figures and Charts:**

- **Enumerated outlets, 2016**
  - **Uttar Pradesh N = 11,851**
  - **Bihar N = 8,661**

- **Contraceptive market composition of eligible outlets**, by outlet type, 2016
  - **Uttar Pradesh N = 2,358**
  - **Bihar N = 1,237**

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18% of modern contraceptive market composition accounted for by the private sector in 2016 in UP

35% of modern contraceptive market composition accounted for by the private sector in 2016 in Bihar

*Higher public health facilities include: government/municipal hospitals, government dispensaries, UHC/UHP/UFWCs, CHC/FRU/rural hospitals, and PHCs.

**This chart only includes outlets with modern contraceptive commodities above the level of condoms.
In Bihar, the private sector accounted for 35 percent of the market composition. Compared to UP, there was greater diversity, with 24 percent of the total market composition from pharmacies and 4 percent from private facilities. In addition, in Bihar, 6 percent of the total market composition was accounted for by rural medical practitioners and a further 1 percent each from general retailers and AYUSH providers. The public sector contribution of market composition in Bihar was predominantly from public facilities at 65 percent of total market composition, with two percent from higher public health facilities and health centres and one percent from AWWs.

**HOW DOES CONTRACEPTIVE MARKET COMPOSITION DIFFER AMONG GEOGRAPHIC ZONES?**

It is important to consider the contraceptive market composition according to geographic differences. For example, the public sector market composition ranged from less than three percent in metro UP and Bihar to three and 11 percent in urban UP and Bihar, respectively, to 93 and 72 percent in rural UP and Bihar, respectively. Most public sector outlets were sub-centres or affiliated ANMs and ASHAs, which accounted for about two-thirds of the contraceptive market composition in rural UP and Bihar. AWWs were only an appreciable proportion of the market composition in rural UP, accounting for slightly less than one-third of that contraceptive market. Looking at the private sector contribution to the market composition, which was approximately 90 percent or greater in metro and urban strata in both states, the predominant private outlet contributing to contraceptive market composition was pharmacies/chemists. There was a slightly higher share of private health facilities in metro UP compared to metro Bihar. General retailers accounted for a slightly higher share of the market composition in urban UP and rural medical practitioners for a slightly higher share of the market in rural Bihar compared to other strata.

*Higher public health facilities include: government/municipal hospitals, government dispensaries, UHC/UFP/UFCs, CHC/FRU/rural hospitals, and PHCs.*

**These charts only include outlets with modern contraceptive methods above the level of condoms.**
WHAT IS THE AVAILABILITY OF SELECTED RANGES OF CONTRACEPTIVE METHODS AMONG ELIGIBLE OUTLETS?

Access to and choice of contraceptive method are integral components of the FP2020 Initiative and of India’s national FP2020 commitments. This section reports on the availability of any modern contraceptive method, three or more methods, three or more methods with at least one long-acting reversible contraceptive (LARC) or permanent method (LARC/PM) and five or more methods. Graphs are shown on this and the following page. Availability indicators are given among outlets screened.

In UP’s public sector, about 40 percent of sub-centres/ANM/ASHAs screened had three or more modern methods available. While almost two-thirds of AWWs screened stocked at least one modern contraceptive method, very few stocked three or more methods. Very few lower level public sector outlets in UP stocked five or more methods. In the private sector of UP, one-quarter or less of facilities, AYUSH providers, rural medical practitioners and general retailers screened stocked at least one modern method. Less than five percent of private facilities stocked three or more methods. Nearly all pharmacies/chemists, however, stocked at least one method and over half stocked three or more methods but rarely with a LARC/PM method.

In Bihar’s public sector (graph on next page), approximately 40 percent of sub-centres/ANM/ASHAs screened had three or more methods, but few had a LARC/PM or five or more methods. Few AWWs in Bihar stocked modern methods. In the private sector of Bihar, one-third of private facilities and rural medical practitioners screened stocked at least one method while less than five percent of each provided three or more methods. About 85 percent of pharmacies/chemists screened stocked at least one method and 40 percent stocked three or more methods but rarely with a LARC/PM method. AYUSH providers (15 percent) and general retailers (< five percent) did not commonly stock modern contraceptives.

ARE THERE DIFFERENCES IN AVAILABILITY OF SELECTED RANGES OF METHODS AMONG METRO, URBAN AND RURAL AREAS?

There were few notable differences comparing method diversity in metro, urban and rural areas of UP (graph on next page). Public outlets in urban and rural areas tended to have higher proportions of outlets with three or more methods compared to metro UP. In addition, public outlets in metro and urban UP tended to have higher proportions with five or more methods available compared to public outlets in rural areas.

There were bigger differences in Bihar (graph on next page) where public sector outlets in metro areas did not commonly carry modern methods and public outlets in rural areas tended to have higher proportions with any method or three or more methods compared to those in urban areas. In the private sector in Bihar, private medical outlets tended to have slightly higher proportions with any method or three or more methods in metro and urban Bihar compared to rural Bihar.

### Availability of a diversity of methods

![Graph showing availability of contraceptives by outlet type in Uttar Pradesh](image)

*In Uttar Pradesh Sub-Centres and ASHA are equipped to provide family planning services. ANM are not.*
AVAILABILITY OF A DIVERSITY OF MODERN CONTRACEPTIVE METHODS, BY OUTLET TYPE: BIHAR

AVAILABILITY OF A DIVERSITY OF MODERN CONTRACEPTIVE METHODS, BY SECTOR: UTTAR PRADESH METRO/URBAN/RURAL

Note: Sub centres are found in rural areas and managed by ANM workers, ASHA can be found across strata. Categories with a small sample size (n<30) are not shown.
WHAT IS THE AVAILABILITY OF SELECTED MODERN CONTRACEPTIVE METHODS AMONG SCREENED OUTLETS?

**Uttar Pradesh**

In the public sector of UP (graphs on page 19), over 90 percent of sub-centres/ANM/ASHAs and almost one-third of AWWs screened stocked male condoms. In the private sector, over 90 percent of pharmacies screened stocked male condoms but less than 20 percent of all other private outlet types screened stocked male condoms on the day of the survey. Other methods such as female condoms, Cyclebeads and vaginal pessaries were not commonly stocked, though about 10 percent of pharmacies/chemists screened stocked vaginal pessaries.

At least one brand of oral contraceptives was in stock in over 80 percent of sub-centres/ANM/ASHAs and by about two-thirds of AWWs. At least one brand of emergency contraceptive pills was found in over 40 percent of sub-centres/ANM/ASHAs and was carried by less than five percent of AWWs screened. Contraceptive injectables (all depot medroxyprogesterone acetate; DMPA) were rarely found in public sector outlets. In the private sector, oral contraceptives were in stock in over 80 percent of pharmacies but only about 15 percent of private facilities. About five percent of AYUSH providers and rural medical practitioners and less than one percent of general retailers screened stocked oral contraceptives. Nearly all oral contraceptives were combined oral contraceptives (COCs), with very low proportions stocking progestin-only pills (POPs) and centchroman pills found only in appreciable numbers in pharmacies (over 40 percent of those screened). Emergency contraceptives were commonly stocked by pharmacies/chemists (over 60 percent) and were found in about nine percent of private facilities screened, but rarely in other private sector outlets types. Contraceptive injectables were found in a handful of pharmacies/chemists and private facilities.

IUDs (all Copper-T) were stocked in less than five percent of sub-centres/ANM/ASHAs – as to be expected at the community level. Only about one percent of private facilities and only a handful of pharmacies/chemists stocked IUDs.

HOW DOES AVAILABILITY OF SELECTED MODERN CONTRACEPTIVES DIFFER AMONG SCREENED OUTLETS DIFFER AMONG GEOGRAPHIC STRATA?

**Uttar Pradesh**

Availability of selected modern contraceptive methods among metro, urban and rural strata in UP is shown on page 20. There was similar availability of male condoms across strata. Female condoms, Cyclebeads and vaginal pessaries were not common across all strata and sectors.

Public sector outlets in rural UP were considerably more likely to have oral contraceptives in stock and slightly more likely to have emergency contraceptives in stock compared to metro and urban UP. Availability of emergency contraceptives in public sector metro outlets was very low compared to urban and rural UP. Similar availability was seen in the private medical sectors across strata for oral contraceptives, emergency contraceptive pills and contraceptive injections. However, urban and rural private medical outlets were more likely to have centchroman pills available compared to metro UP. Similarly, low availability for all contraceptive methods (except condoms) was seen in the non-traditional private sector (AYUSH providers, rural medical practitioners and general retailers).

Although small proportions of outlets stocked IUDs, about twice the proportion of lower level public sector outlets in urban areas (13 percent) stocked IUDs compared to metro areas (six percent) and an even higher proportion of urban public sector outlets stocked IUDs compared with rural public outlets (two percent). IUD availability was low across all strata for private sector outlets.
Availability of IUDs was low across outlets screened in UP. Just one percent of private facilities and less than one percent pharmacies/chemists screened had an IUD in stock on the day of the survey. The lower level public outlets, since mostly composed of ANM, ASHA and AWWs, also had negligible availability of IUDs (not shown).

Note: Categories with a small sample size (n<30) are not shown.
Note: Sub centres are found in rural areas and managed by ANM workers, ASHA can be found across strata. Categories with a small sample size (n<30) are not shown.
WHAT IS THE AVAILABILITY OF SELECTED MODERN CONTRACEPTIVE METHODS AMONG SCREENED OUTLETS?

Bihar

In the public sector of Bihar (graphs on page 22), about 60 percent of sub-centres/ANM/ASHAs screened stocked male condoms. AWWs were not found to be commonly stocking any modern contraceptives in Bihar. In the private sector, about two-thirds of pharmacies/chemists and one-quarter of private facilities screened stocked male condoms. In Bihar, rural medical practitioners were found to be commonly stocking male condoms (about one-quarter of those screened). Less than 10 percent of AYUSH Providers and about three percent of general retailers screened stocked male condoms on the day of the survey. Other methods such as female condoms, Cyclebeads and vaginal pessaries were not commonly stocked, though a small percentage of pharmacies screened stocked vaginal pessaries.

At least one brand of oral contraceptives was in stock in almost 60 percent of sub-centres/ANM/ASHAs, and at least one brand of emergency contraceptive pills was found in over 40 percent of sub-centres/ANM/ASHAs. Only a handful of AWWs screened in Bihar stocked oral contraceptives. Contraceptive injectables (all depot medroxyprogesterone acetate; DMPA) were not found in any public sector outlets among those screened. In the private sector, oral contraceptives were in stock among slightly more than half of pharmacies/chemists and in less than 10 percent of private facilities screened. Nearly 20 percent of rural medical practitioners stocked oral contraceptives, while about nine percent of AYUSH providers stocked oral contraceptives. Nearly all oral contraceptives were combined oral contraceptives (COCs), with very low proportions of gastroin- only pills (POPs) and centchroman pills found only in appreciable numbers in pharmacies (13 percent of those screened). Emergency contraceptives were commonly stocked by pharmacies/chemists (about 45 percent) and were found in about 15 percent of private facilities, and among about four percent of AYUSH providers and rural medical practitioners screened. Contraceptive injectables were commonly stocked by pharmacies/chemists (about 45 percent) and were found in about 15 percent of private facilities, and among about four percent of AYUSH providers and rural medical practitioners screened. Contraceptive injectables were found among about 15 percent of pharmacies/chemists, less than five percent of private facilities and rural medical practitioners and a handful of AYUSH providers screened.

IUDs (all Copper-T) were stocked in three-quarters of higher public health facilities and slightly more than 10 percent of sub-centres/ANM/ASHAs. IUDs were rarely in stock in all private sector outlet types in Bihar.

HOW DOES AVAILABILITY OF SELECTED MODERN CONTRACEPTIVES DIFFER AMONG SCREENED OUTLETS DIFFER AMONG GEOGRAPHIC STRATA?

Bihar

Availability of selected modern contraceptive methods among metro, urban and rural strata in UP is shown on page 23. Male condoms were found in significantly higher proportions of public outlets in rural areas (35 percent) compared to urban areas (22 percent) and, especially, metro areas (six percent). Female condoms, Cycle beads and vaginal pessaries were uncommon across all strata and sectors, although about eight percent of metro private medical outlets had vaginal pessaries in stock.

Public sector outlets in rural Bihar were considerably more likely to have male condoms, oral contraceptives and emergency contraceptives in stock compared to metro and urban Bihar. In the private medical sector, similar availability was seen across strata for oral contraceptives but a higher proportion of outlets in metro Bihar had emergency contraceptive pills (49 percent) and contraceptive injectables (16 percent) compared to urban areas (42 and 11 percent, respectively) and compared to rural areas (30 and nine percent, respectively). Similar availability was seen in the private medical sectors across strata for contraceptive injections. Low availability for all contraceptive methods was seen in the non-traditional private sector (AYUSH providers, rural medical practitioners and general retailers).

Although small proportions of outlets stocked IUDs, higher proportions of public sector outlets in rural areas (seven percent) stocked IUDs compared to urban areas (two percent), while very few metro public outlets stocked IUDs. Availability was low across all strata for private sector outlets, with five percent or less of outlets stocking IUDs.
Seventy-four percent of higher public health facilities and 10 percent of sub-centres/ANM/ASHAs screened had at least one brand of IUD in stock on the day of the survey.

Only one percent or less of private facilities and pharmacies/chemists screened had an IUD in stock on the day of the survey.

Note: Categories with a small sample size (n<30) are not shown.
BIHAR METRO/URBAN/RURAL

AVAILABILITY OF SHORT-ACTING, NON-HORMONAL METHODS, BY SECTOR – BIHAR METRO/URBAN/RURAL

Note: Subcentres are found in rural areas and managed by ANM workers, ASHA can be found across strata. Categories with a small sample size (n<30) are not shown.

Note: Public total is primarily composed of lower level outlets such as AWW and SC/ANM/ASHA. These results are based on this large denominator of community-level workers.
**What Are Stock-Outs?**

The graphs below present data for point-in-time stock-outs or the percentage of outlets stocked out on the day of the survey of all brands of a method, among outlets reportedly stocking at least one brand of the method in the previous three months.

**What Contraceptive Methods Are Out of Stock Among Outlets Typically Stocking the Method?**

In UP’s public sector, stock outs among those reportedly stocking a selected method in the previous three months was relatively low across methods. Eight percent of sub-centres/ANM/ASHAs and 11 percent of AWWs were stocked out of emergency contraceptive pills. About seven percent of sub-centres/ANM/ASHAs reportedly providing IUDs in the previous three months were stocked out all brands on the day of the survey. Stock outs were slightly higher in private sector outlets in UP. Notably, about 10 percent of private facilities were stocked out of oral contraceptives and/or contraceptive injectables and 20 percent were stocked out of emergency contraceptive pills and/or IUDs. While stock outs were lower among pharmacies/chemists for oral contraceptives and emergency contraceptive pills (about two percent), stock outs of injectables (17 percent) and IUDs (19 percent) were high. Few of the non-traditional private outlet types were reportedly stocking these modern contraceptives in the previous three months, but among those that were, stock outs ranged from about 10 – 20 percent, especially for oral contraceptives and emergency contraceptive pills (not shown). There were few notable differences in stock outs by geographic strata (not shown).

In Bihar’s public sector, high stock outs were reported among sub-centres/ANM/ASHAs for oral contraceptives (20 percent) and emergency contraceptives (22 percent). AWWs did not typically stock modern contraceptives. In the private sector, about one in five private facilities reportedly carrying the method were stocked out of oral contraceptives, injectables and IUDs and seven percent were stocked out of emergency contraceptive pills. Stock outs were relatively high among pharmacies/chemists with about one in five stocked out of emergency contraceptive pills and injectables, one-quarter stocked out of IUDs and 13 percent of oral contraceptives. Short-acting methods were often stocked by rural medical practitioners in Bihar and stock outs were common with more than half of these practitioners stocked out of oral contraceptives, emergency contraceptive pills and contraceptive injectables. Among strata, stock outs in the public sector tended to be highest in rural areas and the private sector, and highest in urban areas.

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**Note:** Categories with a small sample size (n<30) are not shown.
Contraceptive market share

Role of the private sector

WHAT IS CONTRACEPTIVE MARKET SHARE?

Market share of modern contraceptive methods, or the relative distribution for all modern contraceptive commodities directly to the individual consumer, is estimated using information about reported distribution of each commodity sold during the one-month period preceding the survey. Market share is reported in couple years of protection (CYP). CYP is the estimated protection provided by contraceptive methods during a one-year period. Volume distributed for each method type is converted to CYP by a conversion factor specific to each method. The graphs on this page and page 28 show private contraceptive market share as a proportion of the total CYP by outlet and method types for UP and Bihar, respectively. The first graphs on pages 27 and 29 compare this for geographic strata for UP and Bihar, respectively. The second graphs on page 27 and 29 present private sector market share as a proportion of the total CYP within outlet types by method for UP and Bihar, respectively.

67% Pharmacy/chemist contribution to total private contraceptive market share in CYP in UP

17% Percent of private sector CYP, across outlets, accounted for by LARC/PMs in UP

The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor. For example, 1 sterilization service equals:
- 139.5 Oral contraceptives
- 37.2 Injectables
- ~2.0 IUDs

UNPACKING THE PRIVATE SECTOR* CONTRACEPTIVE MARKET SHARE

Uttar Pradesh

The private medical sub-sector (private health facilities and pharmacists/chemists) accounted for most of the total private sector market share in UP (89 percent). The private medical sub-sector market share was primarily accounted for by pharmacists/chemists (67 percent), with the remaining coming from private health facilities (22 percent). Condoms, primarily distributed by pharmacies/chemists, were responsible for almost one-third of the total private sector market share. Oral contraceptives, also primarily from pharmacies/chemists accounted for over one-quarter of total private market share. Female sterilizations in private health facilities comprised about 13 percent of the total private sector market share. The private other sub-sector (AYUSH providers, RMPs, and general retailers) contributed to

* Public sector market share is not shown. Sterilization services are concentrated into a few higher-level facilities; due to our small sample of these outlet types, the results would have been skewed, and shown an inaccurate portrayal of the total market.

Female sterilization accounts for 15% of UP’s total private contraceptive market share (12% public, 3% private).

IUDs account for 12% of UP’s total private contraceptive market share (11% public, 1% private). IUDs accounts for 4% of metro area, 5% of urban area and 16% of rural area total CYP.
about 10 percent of total private sector market share, with male condoms from general retailers accounting for almost this entire contribution. When comparing strata in UP, method profiles were generally similar with the exception of sterilizations, which were present in metro and urban UP but not in rural UP. In addition, there was a higher proportion of market share attributable to the private other sector in rural areas compared with metro and urban areas.

Within private facilities market share came largely from female sterilization (57 percent) and IUDs (13 percent), but primarily from short-acting methods among the more numerous pharmacies/chemists. Method profiles were similar among strata, with the exception of sterilizations, which were present in metro and urban UP but not in rural UP.

Similarly to UP, the private medical sub-sector comprised 89 percent of the total private sector market share. Private health facilities and pharmacists/chemists made up roughly equal proportions of the private medical sub-sector market share. Female sterilizations from private health facilities accounted for over a third of total private sector market share. Pharmacists/chemists were comprised of mostly short-acting methods. Male condoms distributed/sold by pharmacists/chemists accounted for one-fifth of total private sector market share and thirteen percent of total private market share was accounted for by oral contraceptives distributed/sold by pharmacies/chemists. Emergency contraceptives, injectables, and IUDs comprised the remaining market share among pharmacies/chemists. The private other sub-sector made up roughly 11 percent of the total private sector market share, with most accounted for by RMPs and general retailers. Together, male condoms from these two outlet types contributed six percent of the total private sector market share. When comparing strata, method profiles were similar in Bihar, with the exception of rural Bihar which had lower levels of female sterilization compared to metro and urban areas.

Within private facilities market share was largely from female sterilization, while market share was from short-acting methods in the more numerous pharmacies. Comparing strata, while method profiles were similar, female sterilizations were less common in rural areas.

**Bihar**

![Private market share as a percentage of total volume of CYP by contraceptive type, outlet type and sub-sector – Bihar](image)

89%  
Private medical contribution to total private contraceptive market share in CYP in Bihar  

5%  
Percent of private CYP, across outlets, accounted for by LARCs (IUDs) in Bihar
Female sterilization accounts for 37% of Bihar’s total private contraceptive market share. IUDs account for <5% of Bihar’s total private contraceptive market share. IUDs account for 10% of metro area, 7% of urban area and 0% of rural area total CYP.

Note: Sub centres are found in rural areas and managed by ANM workers, ASHA can be found across strata.
Readiness to provide contraceptive services

This section addresses the public and private sector readiness to offer provider-dependent contraceptive services according to India’s National FP Guidelines under the National Health Mission. It addresses availability and service readiness to provide contraceptive services.

WHERE ARE PROVIDER-DEPENDENT CONTRACEPTIVE SERVICES OFFERED?

These graphs show the percentage of outlets with selected provider-dependent procedures available among all screened outlets of the outlet type.

Uttar Pradesh

In the public sector, about 20 percent of sub-centres/ANM/ASHA screened offered contraceptive injection and IUD insertion services. Services were not commonly offered in the private sector, except for contraceptive injections (almost 20 percent) in private health facilities. Few variations in service availability between metro, urban and rural areas were observed in UP (graph not shown), except that urban public outlets were slightly more likely to offer IUD insertions.

Bihar

Among public sector outlets, less than 15 percent of sub-centres/ANM/ASHAs offered contraceptive injections or IUD insertion services. In the private sector, about one-quarter of private health facilities offered contraceptive injections and 5 percent offered IUD insertions. While two-fifths of rural medical practitioners screened had injection services available, few pharmacies/chemists or AYUSH providers screened offered the service. In Bihar, there were few considerable differences in availability of services comparing metro, urban and rural areas (graph not shown). It was slightly more common for public and private outlets to offer all services in rural areas compared to metro and urban areas.

Note: Categories with a small sample size (n<30) are not shown.
ARE OUTLETS MEETING QUALITY STANDARDS TO DELIVER PROVIDER-DEPENDENT CONTRACEPTIVE SERVICES?

In the service readiness graphs on the following page, overall service readiness is given for contraceptive injection and IUD insertion among outlets reportedly offering the selected service. Readiness to provide contraceptive services is a composite indicator combining: 1. Availability of the contraceptive on-site on the day of the survey; 2. Availability of a provider with the legal credentials to perform the procedure, on current staff; and 3. Availability of a sentinel set of equipment needed for the service.*

Uttar Pradesh

For injection services, fewer than 2 percent of sub-centres met service readiness criteria. However, this was primarily due to outlets not yet stocking an injectable contraceptive. Nearly all sub-centres had staff with ANM credentials and the equipment necessary to provide injection services, indicating the potential of this outlet for expansion of injection services. About one-fifth of private health facilities reportedly offering contraceptive injection services were found to meet service readiness requirements. Again, this was predominantly due to low availability of the commodity and nearly all private facilities had necessary equipment and three-quarters had necessary training.

Service readiness for IUD insertion services was also relatively low among those reportedly offering the service, again, primarily due to not stocking an IUD. Approximately 11 percent of sub-centres providing IUD services met service readiness conditions. While most of these outlets had the necessary equipment available (98 percent) and provider credentials (nearly all) in place, just 12 percent of sub-centres had the IUD commodity available on the day of the survey. Looking at the private sector, less than one-third of private for-profit health facilities reportedly offering IUD insertion services were found to be service ready on the day of the survey. This failure to meet service readiness requirements was almost entirely attributable to commodity availability on the day of the survey.

Bihar

For contraceptive injection services in Bihar, three-quarters of sub-centres had credentialed staff and 90 percent of sub-centres had key equipment available. Less than 10 percent of private health facilities reportedly offering injection services were considered service ready, with less than 20 percent stocking the commodity, 57 percent having trained/credentialed staff and 82 percent having equipment. In Bihar, pharmacies/chemists and rural medical practitioners often had availability of contraceptive injection services with about 10 percent of outlets classified as service ready for each. Pharmacies/chemists often lacked the commodity and credentials and rural medical practitioners were frequently credentialed but lacked the commodity.

Over one-third of sub-centres were service ready for IUD insertion services, and over half of sub-centres reportedly offering the service stocked IUDs and nearly three-quarters had key equipment available. In private health facilities, about 13 percent of outlets were service ready for IUD insertion services with about 16 percent stocking the commodity, nearly all with credentialed staff and key equipment.

* Full service readiness is defined as having available: 1. The commodity (not applicable for male/female sterilization); 2. A provider with credentials meeting the India National Family Planning Guidelines (http://nrhm.gov.in/nhm/nrhm/guidelines/nrhm-guidelines/family-planning-guidelines.html) to perform the service; and 3. A minimum set of sentinel equipment (http://www.cpc.unc.edu/measure/prh/m_indicators/specific/long-acting-permanent-methods/percent-of-facilities-with-appropriate) for providing the service.

Readiness to provide contraceptive services is a composite indicator combining:

1. Availability of contraceptive on-site (not applicable to sterilizations);
2. Availability of credentialed providers; and
3. A sentinel, minimum set of equipment needed for the service.

If an outlet meets all 3 conditions, it is classified as service-ready.
Percent of all public and private facilities, respectively, in UP reportedly offering IUD insertion services meeting service readiness requirements

Percent of all public and private facilities, respectively, in Bihar reportedly offering IUD insertion services meeting service readiness requirements
Modern contraceptive market prices

Within the private sector

WHAT IS THE COST PER CYP IN USD, FOR CONTRACEPTIVE METHODS IN THE PRIVATE MEDICAL SECTOR?

Prices for contraceptive methods were standardized across methods by converting into price per CYP. The following graphs report median USD price and price per CYP with interquartile ranges for all brands of a method in private sector outlets. In the public sector, most contraceptive commodities and services are distributed for free or at nominal cost. The prices listed are those incurred by the end-user and do not necessarily reflect any subsidy that may be provided. Prices for commodities with a service component may reflect cost of the service as well.

Uttar Pradesh

Comparing short-acting methods, the median price per CYP in private outlets for the three largest market share contributors in UP was: $5.97 per CYP for male condoms, $5.59 per CYP for oral contraceptives and $2.87 per CYP for female sterilization. The median price per CYP for IUDs was most cost-effective among common methods at $1.62 per CYP. For other notable methods, the price for emergency contraceptive pills per CYP was high at $23.86 and the price for the newly introduced injectable contraceptives was $8.95 per CYP. There was little variation in prices of major methods by private sector outlet types. Prices for the most common methods tended to be lower in rural areas compared to metro and urban areas (geographic strata not shown).

Bihar

Comparing short-acting methods, the median price per CYP in private outlets for the three largest market share contributors in UP was: $1.95 per CYP for female sterilization, $1.29 per CYP for IUDs, $11.93 per CYP for male condoms and $5.59 per CYP for oral contraceptives. Similar to UP, median price per CYP for IUDs was most cost-effective among common methods for IUDs in Bihar. For other notable methods, the price for emergency contraceptive pills per CYP was high at $23.86 and the price for the newly introduced injectable contraceptives was $5.97 per CYP. There was little variation in prices of major methods by private sector outlet types, except short-acting methods tended to be lowest in private non-traditional outlets. Prices for the most common methods tended to be moderately lower in rural areas compared to metro and urban areas (not shown).

Note: Categories with a small sample size (n<5) are not shown.

* For those outlets selling both the commodity and providing the service, prices were often not distinguished into separate prices for both the commodity and service and, instead the combination was reported. In these cases, the combined price was used.

† Price conversion was done from Indian Rupee (INR) to USD based on the average rate of exchange from June 9th to September 10th, 2016 of 67.0478 INR per 1 USD.
Summary

While India is making strides toward reaching its ambitious FP2020 goals to sustain the country's 100 million contraceptive users and to reach an additional 48 million women with modern contraceptive methods, FPwatch findings on the family planning markets in the two large states of Uttar Pradesh and Bihar suggest that there is potential to expedite progress toward FP2020 commitments, providing increased access and choice to women in India.

This 2016 study in UP and Bihar, conducted among 4,083 public and private outlets with modern contraceptives and/or services within fully-censused wards and villages, provides market data for the contraceptive-supply environment in UP and Bihar. The data are relevant for monitoring and informing India’s FP2020 commitments and as part of a market development approach. India is one of the principal protagonists in FP2020 and its success in achieving national commitments is critical to meeting FP2020 global commitments. India alone accounts for 40 percent of the global commitment of reaching 120 million new contraceptive users. In addition, the states of UP and Bihar account for 40 percent of India’s population and 40 percent of the nation’s unmet need for family planning.

The FPwatch survey also aims to better understand health markets and consumer needs to improve market performance with a vision toward universal health coverage. FP2020 targets require an understanding of the current market for modern contraceptive methods. This includes the need for market information on distribution volume of each method, types of methods available at country and service delivery levels, choice within those methods as well as price points for consumers. Market information on the size and scale of the market is critical to guide investment decisions and provide information symmetry across all market players. FPwatch was designed to provide high-quality and timely information to understand and shape markets at country and regional levels.

What is the scope and scale of public and private sectors in modern contraceptive commodity provision in Uttar Pradesh and Bihar?

Of the 2,358 outlets with modern contraceptive commodities (excluding condoms-only outlets) in UP and the 1,237 in Bihar, private sector outlets in the contraceptive market comprise 18 percent of all outlets with at least one modern method available in UP and 35 percent in Bihar, with private pharmacies/chemists being the most numerous type of private facility stocking modern contraceptives.

Given India’s commitments to tapping private sector provision of contraceptive methods, strengthening public-private partnerships and instituting social franchising to meet the contraceptive needs and choices of Indian women, the FPwatch findings on the private sector contributions contribute a rigorous
baseline understanding to strengthen and build upon these efforts. They also reinforce the need to creatively reach rural populations where there is high reliance on the public sector to meet the contraceptive needs of rural women and men.

**What are the successes and challenges in the states of Uttar Pradesh and Bihar for expanding the “basket of choices” for women and men for family planning?**

As part of their FP2020 commitments, India has committed to expanding the basket of contraceptive choices, which is an integral component of the FP2020 initiative. FPwatch indicators can be used to assess progress in meeting this objective.

In UP, 41 percent of sub-centres/ANM/ASHAs had three or more modern methods of contraception available, and this outlet type accounted for almost 60 percent of contraceptive market composition. In the private sector, 57 percent of pharmacies/chemists stocked three or more modern contraceptives and this outlet type accounted for 15 percent of market composition. However, this basket of choices did not often include a LARC. Other outlet types, including private facilities, did not often stock three or more methods, but most that did included a LARC or permanent method. There was little variation between metro, urban and rural areas in availability of three or more methods and/or availability of a LARC or permanent method.

In Bihar, about 40 percent of sub-centres/ANM/ASHAs had three or more modern methods of contraception available and this outlet type accounted for over 60 percent of contraceptive market composition. In the private sector, 39 percent of pharmacies/chemists stocked three or more modern contraceptives and this outlet type accounted for nearly one-quarter of market composition. However, similar to Uttar Pradesh, this basket of choices did not often include a LARC. Other outlet types, including private facilities, did not often stock three or more methods. There was little variation between metro, urban and rural areas in availability of three or more methods and/or availability of a LARC or permanent method.

In UP, AWWs were also active in providing modern contraceptive methods, accounting for one-quarter of the market composition. Over two-thirds of AWWs screened stocked at least one short-acting method, with one-third stocking male condoms and nearly two-thirds stocking oral contraceptives. AWWs were also more likely to be stocking modern methods in metro and rural areas of UP, compared with urban areas.

In addition, in Bihar, while AWWs did not commonly stock any contraceptive methods, AYUSH providers, rural medical practitioners, and general retailers contributed a small role in providing modern contraception. Rural medical practitioners accounted for 6 percent of the contraceptive market composition (excluding those outlets that provide male condoms only), with about one-third of those screened stocking at least one method of short-acting commodity, an appreciable portion stocking oral contraceptives and about 5 percent stocking emergency contraceptive pills and/or injectable contraceptives. About 13 percent of AYUSH providers screened and 3 percent of the highly numerous general retailers screened also stocked at least one short-acting method, with appreciable numbers of AYUSH providers stocking short-acting methods other than male condoms, including oral contraceptives.

India has also recently allowed provision of contraceptive injectables (DMPA) throughout the
country. In UP, trace amounts of injectables were found in the public sector, while about 3 percent of private facilities and providers and 5 percent of pharmacies/chemists were found to be stocking injectables. Stock outs of injectables in private sector outlets were low, with just over 15 percent of those reportedly having injectables in stock in the previous three months being stocked out of injectables at the time of the survey. As well, prices for injectables in the private sector were high in comparison to other common short-acting methods with a median of $8.95 per CYP. Contraceptive injectables were also more commonly available in outlets in urban UP compared to rural UP.

In Bihar, no contraceptive injectables were found in the public sector. Availability of injectables was higher in Bihar’s private sector compared to UP with 5 percent of private facilities and providers and 12 percent of pharmacies/chemists screened stocking injectables. An additional 5 percent of rural medical practitioners and 2 percent of AYUSH providers screened were found to be stocking contraceptive injectables. Stock outs of injectables were also high in Bihar, with 20 percent of private facilities, 23 percent of pharmacies/chemists and over half of rural medical practitioners that reportedly stocked injectables in the previous three months found to be stocked out on the day of the survey. In Bihar, the median price for contraceptive injectables was more comparable to other common short-acting methods at a median cost of $1.29 per CYP.

What are the successes and challenges in task-sharing and community-based provision of contraceptives?

In 2012, India began scaling up community-based provision of contracept through ASHAs in addition to their community education and demand generation activities. Sub-centres and the ASHAs attached to them demonstrate the ability to provide a range of modern contraceptives at the community level as seen in our availability indicators.

What are the successes and challenges in providing provider-dependent procedures associated with modern contraceptives?

The FPwatch project assessed both availability of provider-dependent services—contraceptive injection, IUD insertion and male and female sterilization—as well service readiness for providing these services. In India, the recent emphasis on IUD scale up and introduction of contraceptive injectables highlights the importance of availability and quality of these services.
In UP, female sterilization was reportedly available in only a small number of outlets outside of higher level facilities, including 3 percent of private facilities. Nevertheless, this method accounted for the majority of CYP volume within higher level facilities. Female sterilizations were more commonly available as a proportion of screened outlets in metro and urban areas and accounted for a larger market share in those areas compared to rural UP. Among outlets reportedly offering female sterilization, service readiness was high among higher-level public health facilities and private health facilities. Among outlets offering female sterilization, 54 percent offered mini-laparotomy and 72 percent offered laparoscopic tubal ligation.

For contraceptive injection and IUD insertion services in UP, about 17 percent of sub-centres/ANM/ASHAs screened offered these services. Despite having been rolled out only recently, in the private sector, 18 percent of private facilities offered contraceptive injections. An additional 2 percent of pharmacies/chemists, 6 percent of AYUSH providers and 5 percent of rural medical practitioners screened reported availability of contraceptive injection services. Only private facilities (3 percent of screened) offered IUD insertion services in the private sector. Service readiness was very low for these methods, primarily due to lack of the availability of the physical commodity at the outlet. However, the physical commodity might have been purchased outside and injected or inserted at the outlet. Taking this into consideration, most higher-level public health facilities, sub-centres and private facilities had credentialed staff and equipment for contraceptive injections, whereas only half of pharmacists/chemists had credentialed providers available. Similarly, most outlets that offered IUD insertion procedures had credentialed staff and key equipment. However, 20 percent of sub-centres reported a lack of availability of at least one piece of key equipment for IUD insertions.

In Bihar, female sterilization was reportedly only in 6 percent of private facilities. Among outlets reportedly offering female sterilization, service readiness was high among higher-level public health facilities and private health facilities. Among outlets that offered female sterilization, 52 percent offered mini-laparotomy and 82 percent offered laparoscopic tubal ligation.

For contraceptive injection and IUD insertion services in Bihar, 6 percent and 11 percent of sub-centres/ANM/ASHAs screened offer contraceptive injections and/or IUD insertions, respectively, indicating readiness of these facilities for a full roll out of contraceptive injection services. In the private sector, 26 percent of private facilities offered contraceptive injections. An additional 8 percent of pharmacies/chemists and 42 percent of rural medical practitioners screened reported availability of contraceptive injection services. Only private facilities (6 percent of those screened) offered IUD insertion services in the private sector. In contrast to UP, relatively high proportions of private facilities suggested a lack of availability of credentialed staff and/or the commodity for both contraceptive injections and IUD insertions.
Assessing progress toward FP2020 goals and national India policies

The contraceptive market findings in both UP and Bihar demonstrate a mixed market with contributions from the public and private sectors. There are challenges in increasing the basket of methods available to women in these states, especially in ensuring that a sufficient number of accessible outlets meet standards such as having three or more methods available or having an IUD available. There were some notable disparities in availability of methods and method mixes when comparing metro, urban and rural areas as well as comparing UP and Bihar states. However, there appear to be some successes in introducing new methods such as contraceptive injectables, scaling up cost-effective methods such as IUDs and increasing community-based distribution of modern contraceptives through ASHAs. Finally, relatively few outlets offer provider-dependent procedures, especially in the private sector. Among those that do, many lack an on-site commodity, trained or credentialed staff and/or key pieces of equipment for the procedure, especially in Bihar. However, service readiness for female sterilizations, the most commonly used method in India was generally good. Overall, the FPwatch survey in UP and Bihar provides key data to inform and supplement FP market monitoring and highlight key action points toward the India FP2020 goals to reach an additional 48 million women with modern methods by 2020.
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The project will inform FP market strategies and priorities for national Ministries of Health and their partners. Additional resources are available on the website (www.fpwatch.info).

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