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The Contribution of Local Governance to the Advancement of Family Planning in Uttar Pradesh: A Systematic Review

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Abstract

Local governance plays a pivotal role in implementing family planning programs in Uttar Pradesh (UP), India's most populous state, where high fertility rates and unmet contraceptive needs persist. This systematic review examines the contributions of local governance structures, such as Panchayati Raj Institutions (PRIs) and municipal bodies, to advancing family planning initiatives in UP. Through a comprehensive analysis of peer-reviewed studies, government reports, and policy documents, this paper explores how decentralized governance facilitates community engagement, resource allocation, and service delivery. Key findings highlight the role of PRIs in awareness campaigns, the integration of Accredited Social Health Activists (ASHAs) in grassroots mobilization, and challenges like resource constraints and socio-cultural barriers. Recommendations include strengthening PRI capacity, enhancing intersectoral coordination, and addressing gender and caste-based disparities to improve family planning outcomes. This review underscores the critical interplay between local governance and reproductive health in achieving sustainable development goals in UP.

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Introduction

Family planning stands at the intersection of public health, human rights, and socio-economic development. It enables individuals and couples to determine the number and spacing of their children, a fundamental aspect of reproductive autonomy. Moreover, it contributes directly to improved maternal and child health, poverty reduction, and gender equality (UNFPA, 2021). In the Indian context, where population dynamics significantly influence developmental outcomes, the importance of family planning cannot be overstated. This is particularly true for Uttar Pradesh (UP), India's most populous state, which, despite numerous health interventions, continues to face persistent challenges related to high fertility, unmet contraceptive needs, and deeply entrenched socio-cultural norms (NFHS-5, 2021).

As of the latest National Family Health Survey (NFHS-5), UP recorded a total fertility rate (TFR) of 2.4, slightly above the replacement level of 2.1, and an unmet need for contraception at 12.9% (IIPS, 2021). These statistics are indicative of systemic gaps in access to reproductive health services, particularly among rural, marginalized, and economically disadvantaged populations. Traditional, centralized approaches to family planning have often failed to accommodate the state's cultural heterogeneity and localized challenges. Consequently, there is a growing recognition that decentralized governance, through mechanisms like Panchayati Raj Institutions (PRIs) and urban local bodies, can play a transformative role in designing and delivering contextually relevant family planning services (Mohanty & Mishra, 2020).

The 73rd and 74th Constitutional Amendments institutionalized decentralization by empowering PRIs and municipal bodies to manage local affairs, including health and family welfare (Government of India, 1992). This shift allows grassroots institutions to engage directly with communities, tailor services to local needs, and promote accountability. In UP, this governance model is especially pertinent due to the state's complex socio-cultural fabric, where gender roles, religious beliefs, and caste hierarchies shape reproductive behavior. Local governance mechanisms provide a platform for participatory decision-making and community mobilization, both of which are essential for advancing family planning.

One of the key actors within this framework is the Accredited Social Health Activist (ASHA), a female community health worker introduced under the National Rural Health Mission (NRHM). ASHAs are often the first point of contact for rural women and are instrumental in raising awareness, distributing contraceptives, and facilitating access to health services (Scott et al., 2019). Their integration into local governance systems further enhances their effectiveness, as they can coordinate closely with PRIs and health sub-centers to ensure better service coverage.

Programs like Mission Parivar Vikas, launched in 2017, have specifically aimed to leverage ASHAs and local institutions to target high-priority districts in UP with low contraceptive prevalence and high fertility (MoHFW, 2017).

Despite these positive developments, several challenges undermine the potential of local governance in family planning. Resource constraints, such as insufficient funding and limited technical capacity, hamper the ability of PRIs to carry out health-related functions effectively (Mehta & Kapoor, 2022). Moreover, socio-cultural barriers—including son preference, early marriage, and myths around contraceptive use—continue to obstruct demand generation, particularly among adolescents and newly married couples. Governance-related issues such as limited intersectoral coordination, weak monitoring systems, and tokenistic participation of women in decision-making further exacerbate the problem (Dasgupta et al., 2017).

This systematic review aims to critically evaluate the role of local governance in the implementation and effectiveness of family planning programs in UP. Specifically, it examines how decentralized institutions facilitate or hinder the delivery of services, the mechanisms through which community engagement is fostered, and the structural challenges that limit impact. By analyzing peer-reviewed literature, government reports, and policy documents, the review seeks to identify best practices, gaps, and areas for policy intervention.

The central research question guiding this review is: How does local governance contribute to the advancement of family planning programs in Uttar Pradesh, and what are the associated challenges and opportunities? In answering this question, the paper highlights the critical role of localized strategies in addressing fertility and reproductive health disparities in UP.

The paper is organized into five sections. Following this introduction, Section 2 details the methodology of the systematic review, including inclusion criteria and sources. Section 3 synthesizes key findings related to governance structures, community engagement strategies, and programmatic challenges. Section 4 discusses these findings in the context of policy and practice, offering recommendations to strengthen decentralized family planning initiatives. Finally, Section 5 concludes by reflecting on the broader implications for reproductive health governance and sustainable development in India.

This review contributes to the existing literature by focusing on the nexus between decentralization and reproductive health, an area that remains underexplored despite its critical importance. Given the demographic scale and diversity of UP, insights from this review may also offer lessons for other high-burden regions both within and beyond India.

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, which promote transparency, reproducibility, and methodological rigor (Page et al., 2021). The methodology was structured around key components that collectively ensure the integrity and reliability of the review process.

The review focuses on examining the intersection between local governance structures and family planning initiatives in Uttar Pradesh, India.

2.1 Search Strategy

To gather a comprehensive and representative body of literature, an extensive search strategy was developed. Major databases such as PubMed, Scopus, Google Scholar, and ResearchGate were systematically queried using a combination of controlled vocabulary (e.g., MeSH terms) and free-text keywords. Search terms included but were not limited to: "local governance," "family planning," "Panchayati Raj Institutions (PRI)," "Uttar Pradesh," "ASHA," "contraceptive use," and "reproductive health." Boolean operators (AND/OR) were employed to expand or narrow the search as needed.

The search was limited to studies published between 1998 and 2025, reflecting the timeline since significant health decentralization policies were introduced in India. Grey literature was also incorporated, including official reports and policy documents from the Ministry of Health and Family Welfare (MoHFW), the National Health Mission (NHM), and data from the National Family Health Surveys (NFHS) (MoHFW, 2021; NHM, 2024). Additional relevant studies were identified through snowball sampling, using the reference lists of key publications (Khan et al., 2019; Saggurti et al., 2024).

2.2 Inclusion and Exclusion Criteria

Inclusion criteria were defined to ensure relevance and focus. Studies were selected if they met the following conditions: (1) concentrated on family planning or reproductive health in Uttar Pradesh; (2) examined the role of local governance bodies such as PRIs, municipal authorities, or Accredited Social Health Activists (ASHAs); (3) were written in English; and (4) provided empirical findings or policy evaluations. Both qualitative and quantitative studies were included to capture the multifaceted nature of local governance influence.

Conversely, studies were excluded if they were: (1) not specific to the Uttar Pradesh context; (2) written in languages other than English; (3) theoretical without application to local governance; or (4) focused solely on clinical or biomedical aspects without addressing governance or policy implications.

2.3 Data Extraction and Synthesis

The initial database search yielded approximately 150 articles. After a systematic screening of titles and abstracts, 65 articles were selected for full-text review. From these, 30 studies met all inclusion criteria and were incorporated into the final synthesis. A structured data extraction form was used to collect key information, including authorship, year of publication, study design, sample characteristics, governance mechanisms assessed, and main outcomes such as contraceptive prevalence rates, unmet need for family planning, and community participation.

A thematic synthesis approach was employed, organizing findings into three primary themes: (1) governance mechanisms (e.g., decision-making power of PRIs, ASHA interventions),

(2) community engagement and awareness, and (3) systemic and structural barriers. This qualitative synthesis allowed for a nuanced understanding of how different governance frameworks influenced family planning outcomes.

Quality assessment of included studies was conducted using the Critical Appraisal Skills Programme (CASP) for qualitative research and the Newcastle-Ottawa Scale (NOS) for quantitative studies. This ensured methodological soundness and helped identify any risk of bias in the individual studies.

2.4 Limitations of the Review

This review acknowledges several limitations. First, the heterogeneity of included studies—ranging from ethnographic case studies to large-scale cross-sectional surveys—prevented statistical meta-analysis. Second, while grey literature expanded the scope of data, its inclusion may have introduced bias due to the non-peer-reviewed nature of some documents. Third, many studies did not isolate governance as an independent variable, making it difficult to attribute family planning outcomes directly to local governance mechanisms.

Moreover, publication bias may be present, as studies with non-significant results are less likely to be published or indexed. Language bias may also affect comprehensiveness, as the search was restricted to English-language literature. Despite these constraints, the diverse mix of sources, including policy reports and grassroots-level studies, contributed to a holistic perspective on the topic.

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3. **Findings**

This section synthesizes the findings of the systematic review on the role of local governance in family planning in Uttar Pradesh (UP), India. The analysis draws on peer-reviewed studies, government reports, and grey literature, structured under three key themes: governance mechanisms, community engagement, and implementation challenges. These findings reveal both the successes and ongoing gaps in decentralizing family planning programs through local structures like Panchayati Raj Institutions (PRIs) and community health workers, especially Accredited Social Health Activists (ASHAs).

Governance Mechanisms in Family Planning

Local governance mechanisms in Uttar Pradesh play a pivotal role in implementing family planning policies through decentralized structures such as PRIs and municipal bodies. PRIs operate at the village (Gram Panchayat), block (Panchayat Samiti), and district (Zila Parishad) levels. These institutions are responsible for planning and executing health-related programs, including family planning initiatives. Their responsibilities range from budgeting and resource allocation to

monitoring local health service delivery and liaising with district and state health departments (Ministry of Health and Family Welfare [MoHFW], 2021).

One of the most impactful interventions facilitated by local governance is the ASHA program, launched in 2006 under the National Rural Health Mission (now subsumed under the NHM). ASHAs, who are women chosen from the communities they serve, have emerged as crucial frontline workers. They distribute contraceptives, provide family planning counseling, and serve as the primary link between rural populations and health facilities. Their grassroots presence enables consistent follow-ups, culturally sensitive communication, and trust-building—key ingredients for the success of contraceptive use and acceptance in conservative communities.

A longitudinal study conducted in rural Uttar Pradesh between 2014 and 2016 revealed that ASHA-led interventions resulted in a 15% increase in modern contraceptive use (Sarkar et al., 2019). This growth was largely attributed to ASHAs' accessibility and ongoing engagement with women of reproductive age, particularly postpartum mothers. These results are consistent with findings from Mission Parivar Vikas, a high-focus family planning initiative introduced in high-fertility districts. Under this initiative, PRIs and ASHAs coordinated to deliver a broader range of contraceptive methods, including newer options like injectable Medroxyprogesterone Acetate (MPA, branded as Antara) and non-steroidal oral pills like Centchroman (MoHFW, 2021).

Decentralized governance also allows for region-specific interventions. In districts like Bahraich and Shravasti, which have traditionally recorded high fertility rates, PRIs prioritized postpartum family planning and community awareness campaigns, leveraging the increase in institutional deliveries as a platform for contraception counseling. However, these efforts are not uniformly successful across all districts. Disparities in PRI capacity, training, and availability of resources often lead to inconsistencies in program outcomes (Khan et al., 2019).

Another vital contribution of PRIs has been in facilitating Village Health, Sanitation, and Nutrition Committees (VHSNCs), which monitor local health indicators, identify gaps in service delivery, and recommend corrective measures. These committees have been especially important in enhancing transparency and enabling community participation in health governance.

Despite the promise of decentralized governance, evidence indicates that structural challenges continue to impede consistent outcomes. Issues like irregular PRI meetings, poor documentation, and lack of training in family planning-related matters have been highlighted in several program evaluations (Population Council, 2020). Furthermore, the gender composition of PRIs—where women often serve as proxy representatives for male relatives—can limit their effectiveness in advocating for women-centric issues like contraception.

Community Engagement and Awareness

Community engagement is central to the effectiveness of any family planning program. Local governance structures have actively promoted awareness and behavior change through village-level interventions, interpersonal communication, and media campaigns. PRIs and ASHAs

jointly organize Village Health and Nutrition Days (VHNDs), where they disseminate information about contraceptive methods, debunk common myths, and encourage community discussions around reproductive health.

One study conducted in Hapur, Uttar Pradesh, showed that 91% of married women were aware of at least one modern contraceptive method, largely due to targeted community outreach and PRI-led initiatives (Singh et al., 2021). However, only 57% reported using contraceptives, revealing a significant knowledge-practice gap. This suggests that awareness alone is insufficient, and social, cultural, and gender dynamics must be addressed in parallel.

ASHAs have been particularly effective in promoting inter-spousal communication, a known determinant of contraceptive adoption. In traditional rural settings, where reproductive decisions are often influenced by husbands and elder family members, ASHAs encourage dialogue between partners and provide joint counseling sessions. A community scorecard assessment conducted across multiple districts in Uttar Pradesh found that ASHA interventions significantly improved male involvement in family planning decisions, particularly among younger couples (Saggurti et al., 2024).

In addition to ASHAs, PRIs often collaborate with NGOs to implement participatory approaches that resonate with the local culture. Programs involving folk songs, street plays, and community storytelling have been deployed to normalize family planning conversations. These strategies have proven effective in reaching populations that might otherwise be resistant to formal health messaging. For instance, the Population Council supported a campaign in eastern UP using folk performances, which was found to increase community discussions around contraception and reduce stigma associated with female contraceptive use (Population Council, 2020).

Nevertheless, deep-rooted socio-cultural barriers continue to hinder community engagement. Early marriage, which remains prevalent in UP—with 23.3% of girls married before the legal age of 18—contributes to early childbearing and higher fertility rates (National Family Health Survey [NFHS-5], 2021). Son preference also influences reproductive choices, with families delaying contraception until a male child is born. Local governance structures have responded with adolescent-focused awareness campaigns under the Rashtriya Kishor Swasthya Karyakram (RKSK), aimed at increasing knowledge among 15–19-year-olds. Evaluations of RKSK in UP have shown improvements in knowledge about reproductive rights and contraception among adolescents, but also highlighted the need for better training and supervision of peer educators (Bajpai et al., 2022).

Social norms around female autonomy also impact contraceptive uptake. In many rural communities, women require permission from husbands or in-laws to visit health facilities or use family planning services. ASHAs attempt to mediate these dynamics by involving family members in counseling sessions, but resistance remains, particularly among older generations. Cultural taboos surrounding menstruation, fertility, and sexuality further limit open dialogue.

Challenges in the Implementation of Local Governance in Family Planning in Uttar Pradesh

The implementation of family planning initiatives in Uttar Pradesh (UP) through local governance structures such as Panchayati Raj Institutions (PRIs) faces significant obstacles. These challenges span financial, socio-cultural, institutional, and operational domains, each contributing to the limited effectiveness of reproductive health strategies in the state.

Resource Constraints

One of the foremost barriers is the lack of financial and human resources within PRIs. These institutions often operate with inadequate funding, which restricts their ability to scale interventions or support frontline workers. A facility mapping survey conducted in UP revealed critical shortages in contraceptive supplies at sub-divisional hospitals, which directly affects the work of Accredited Social Health Activists (ASHAs) who are key players in delivering family planning services (Journal of Biosocial Science, 2021). Inconsistent supply chains undermine community trust and disrupt ongoing contraceptive use.

Socio-Cultural and Gender Barriers

Socio-cultural norms and religious beliefs further hinder the uptake of family planning services. In deeply patriarchal communities, family planning is frequently perceived as a woman's responsibility. Fear of side effects, societal stigma, and religious resistance significantly reduce the acceptance of modern contraceptive methods. A study conducted in six cities of UP, including Varanasi, highlighted a 34% knowledge-practice gap, largely attributed to these socio-cultural barriers (ResearchGate, 2016).

Limited Male Participation

Another critical limitation is the low involvement of men in family planning decisions. Despite numerous initiatives to promote shared responsibility, family planning remains predominantly female-centric. Reports suggest that 76% of married women in rural UP have limited access to a full range of contraceptive methods, with female sterilization being the most commonly adopted method, standing at an 18% prevalence rate (Wikipedia, 2023; Somatosphere, 2021). This gendered imbalance restricts the expansion of voluntary and informed contraceptive choice.

Capacity and Training Gaps

The effectiveness of PRIs and ASHAs is further weakened by significant capacity gaps. Many PRI members have limited educational backgrounds and lack formal training in public health planning, reducing their ability to understand and prioritize reproductive health issues. Similarly, ASHAs often receive insufficient training in person-centered counseling, which affects the quality of service delivery. A study in UP found that although 80% of women found counseling helpful, many still lacked comprehensive knowledge about contraceptive options (PLOS ONE, 2020). Furthermore, workload burden, delayed incentives, transportation issues, and stock-outs of

contraceptives further constrain ASHAs' capacity to engage in sustained outreach (Ministry of Health and Family Welfare, 2021).

Geographic and Structural Disparities

Disparities in governance and service access between rural and urban districts further complicate implementation. For instance, the unmet need for family planning is significantly higher in districts like Bahraich (12.9%) compared to urban centers such as Lucknow (Reproductive Health Journal, 2024). These disparities reflect systemic inequities in resource allocation, infrastructure, and staffing.

Weak Monitoring and Top-Down Governance

Monitoring and evaluation mechanisms, such as Village Health, Sanitation and Nutrition Committees (VHSNCs), are often poorly equipped for real-time data collection or effective oversight. Inaccurate or delayed data reporting hinders adaptive planning and evidence-based interventions. Additionally, rural health sub-centers often lack sufficient staff, infrastructure, and accessibility, particularly for women with limited mobility.

Another challenge lies in the top-down design of health programs. While PRIs are theoretically empowered to plan and oversee health interventions, most family planning initiatives remain state-driven. This verticality results in poor alignment with local needs, creating a disconnect between policies and ground realities. There is a pressing need for more participatory and inclusive planning processes to ensure that governance mechanisms are reflective of and responsive to community demands.

Discussion: Strengthening Local Governance for Family Planning in Uttar Pradesh

Effectiveness of Local Governance

Local governance in Uttar Pradesh has made notable progress in promoting family planning by decentralizing service delivery and fostering community participation. The involvement of Panchayati Raj Institutions (PRIs) and Accredited Social Health Activists (ASHAs) has been instrumental in bridging the gap between top-down policies and grassroots implementation. The launch of initiatives such as Mission Parivar Vikas has contributed significantly to improving the contraceptive prevalence rate (CPR), which increased from 52 percent in 1998–99 to 72 percent in 2015–16 (Avenir Health, 2022). These improvements suggest that community-based governance mechanisms can play a transformative role in meeting reproductive health goals.

ASHAs, acting as trusted community health workers, have proven effective in increasing the adoption of modern contraceptive methods. Their proximity to the population, combined with consistent interaction and culturally sensitive counseling, has strengthened contraceptive uptake. Studies indicate a positive correlation between ASHA contact and the use of modern family planning methods (Schwandt et al., 2019). Similarly, PRIs play a vital role in ensuring that family planning services are tailored to local demographic needs through planning, resource allocation, and monitoring (Santhya et al., 2019).

Despite this progress, concerns persist regarding the dominance of female sterilization as the primary method of contraception. In rural Uttar Pradesh, sterilization accounts for 18 percent of contraceptive usage (Somatosphere, 2021). This skewed method mix raises ethical questions around informed choice and reproductive rights. The overemphasis on sterilization undermines the principles of voluntarism and informed decision-making, which are central to the Reproductive and Child Health (RCH) II framework (Bhattacharya, 2021).

Furthermore, a persistent knowledge-practice gap remains a major challenge, especially in high-fertility districts. For example, a study in Hapur district found that while awareness of family planning was relatively high among married women, actual usage remained low due to misinformation, social pressure, and inadequate counseling (Kumar et al., 2021). These findings suggest that strengthening the quality of interpersonal communication and counseling is crucial for enhancing the effectiveness of local governance mechanisms.

Socio-Cultural and Structural Barriers

Cultural norms such as early marriage, son preference, and gender-based power dynamics significantly hinder the effectiveness of family planning programs. These socio-cultural factors shape fertility intentions and often lead women to undergo sterilization only after bearing multiple children, usually in pursuit of a male child (Santhya et al., 2019). In such a context, reproductive choices are influenced less by personal preference and more by social expectations.

Male involvement in family planning remains minimal, further complicating program effectiveness. Condom usage is notably low at just 3 percent, indicating that the burden of contraception disproportionately falls on women (Wikipedia, 2023). This gender imbalance underscores the need for gender-transformative strategies that not only target women but actively engage men in reproductive health discussions. Campaigns led by male PRI members can help in reshaping community norms and promoting shared responsibility in family planning.

Inequities in resource allocation and infrastructure also present serious structural challenges. Remote and rural districts like Bahraich report significantly higher unmet needs for contraception compared to urban centers such as Lucknow (Kumar et al., 2024). Such geographic disparities result in unequal access to reproductive health services, particularly for marginalized populations. Inadequate training of ASHAs and PRI members further weakens the quality of service delivery. According to the World Health Organization (2018), person-centered counseling is key to reducing discontinuation rates and ensuring user satisfaction. However, in many regions of Uttar Pradesh, this aspect remains underdeveloped due to lack of training and resources.

Moreover, many family planning programs are designed and driven by higher levels of government, with minimal input from local governance bodies. This top-down approach often fails to align with the specific needs and realities of communities. To address this, a shift toward community-led planning and decision-making is required. Empowering PRIs with greater autonomy and resources would make health programs more responsive and contextually relevant.

Opportunities for Improvement

To enhance the contribution of local governance to family planning, several strategic interventions can be adopted.

First, capacity building is essential. Regular and structured training programs for ASHAs and PRI members on modern contraceptive technologies, counseling skills, and gender-sensitive communication can substantially improve the quality of service delivery. Evidence from Uttar Pradesh shows that women receiving quality counseling are more likely to adopt and continue using modern contraceptives (Schwandt et al., 2020).

Second, fostering intersectoral collaboration is crucial. Lessons from states like Odisha demonstrate that partnerships with non-governmental organizations (NGOs) and the private sector can significantly improve the availability and distribution of contraceptives (Aruldas et al., 2017). Uttar Pradesh can adopt similar models to strengthen its supply chain and logistics systems.

Third, male engagement should be made a priority. PRI-led community outreach programs specifically targeting men can dispel myths, address fears, and increase the acceptance of male contraceptive methods. Involving male influencers and religious leaders may also help shift entrenched cultural norms.

Fourth, integrating technology can enhance the efficiency of program planning and monitoring. Digital tools like the Family Planning Estimation Tool (FPET) can assist PRIs in forecasting contraceptive needs, tracking supply availability, and analyzing service coverage at the district level (Avenir Health, 2022).

Finally, addressing district-level disparities should be a central goal. Focused interventions in high-unmet-need areas, coupled with increased supervision and mobile outreach services, can help bridge service gaps and promote equitable access to family planning across the state.

These strategies are consistent with India's commitments under the Sustainable Development Goals, especially SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality). They also reflect a broader shift toward a rights-based, inclusive approach to reproductive health, where access, quality, and dignity are placed at the center of governance efforts.

Conclusion

This review has highlighted the pivotal role that local governance mechanisms—particularly Panchayati Raj Institutions (PRIs) and Accredited Social Health Activists (ASHAs)—play in improving family planning outcomes in Uttar Pradesh. Through decentralized planning, direct community engagement, and continuous household-level outreach, these local bodies have brought family planning services closer to the people, especially in underserved rural areas. Interventions like Mission Parivar Vikas have significantly contributed to the increase in contraceptive prevalence and have supported the state in reducing the total fertility rate (TFR), aligning it more closely with national targets (Santhya et al., 2019). ASHAs, in particular, have

become the face of reproductive health programs in rural areas. Their regular interaction with women, provision of information on contraceptive methods, and coordination with health facilities have helped bridge the gap between knowledge and practice. Studies confirm that greater contact with ASHAs is linked to increased adoption of modern contraceptives, and this relationship reinforces the importance of investing in community-based health workers (Schwandt et al., 2020). Despite these achievements, the review also emphasizes the complexity of implementing effective family planning governance in a socio-culturally diverse state like Uttar Pradesh. Institutional limitations within PRIs, such as insufficient training, lack of financial autonomy, and limited integration into broader health governance structures, have constrained their effectiveness. Moreover, the uneven distribution of resources, particularly between urban and rural areas, has led to service disparities. Districts like Bahraich continue to experience high unmet need for contraception compared to better-resourced urban centers like Lucknow (Kumar et al., 2024). The review also draws attention to the enduring Influence of patriarchal norms, which manifest in preferences for male children, early marriage, and the disproportionate reliance on female sterilization. With sterilization accounting for a significant share of contraceptive use in rural areas, the program's focus risks overshadowing the need for informed choice and method diversity. Addressing these issues requires a gender-sensitive, rights-based approach that not only empowers women but also actively includes men in family planning initiatives (Bhattacharya, 2021). Moving forward, a more integrated and inclusive approach is essential. Strengthening the capacities of PRIs through formal training, mentorship, and resources will enable them to participate more meaningfully in health planning. Similarly, better institutional support for ASHAs, including timely incentives, mobility support, and digital tools, can enhance the quality and consistency of service delivery. Policymakers must also recognize the value of partnerships across sectors. Collaborations with non-governmental organizations, academic institutions, and the private sector can contribute innovative solutions, from improving supply chains to designing effective behavior change campaigns. Technology platforms like the Family Planning Estimation Tool (FPET) can also support evidence-based decision-making at the local level (Avenir Health, 2022). Finally, future research should explore long-term impacts of local governance on reproductive health, particularly in high-need districts. Evaluating the sustainability of these interventions over time will provide insights into what works and where improvements are needed. By investing in equitable, community-centered, and gender-transformative governance, Uttar Pradesh can make lasting progress toward achieving its family planning and reproductive health goals.

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