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FALAH
FAMILY ADVANCEMENT FOR LIFE & HEALTH

Baseline Household Survey

Larkana District

April 2009

Population Council

Family Advancement for Life and Health

(FALAH)

Larkana

Baseline Household Survey

April 2009

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Glossary of Terms

ANC	Antenatal Care
ASFRs	Age-specific Fertility Rates
BHU	Basic Health Unit
CBR	Crude Birth Rate
CEB	Children Ever Born
CPR	Contraceptive Prevalence Rate
DHQ	District Headquarter
EC	Emergency Contraception
ECP	Emergency Contraception Pill
EmOC	Emergency Obstetric Care
FALAH	Family Advancement for Life and Health
FP	Family Planning
HANDS	Health and Nutrition Development Society
IUD	Intra Uterine Device
LAM	Lactational Amenorrhea Method
LHW	Lady Health Worker
MCH	Maternal and Child Health
MNH	Maternal and Neonatal Health
MoH	Ministry of Health
MoPW	Ministry of Population Welfare
MSU	Mobile Service Unit
MWRA	Married Women of Reproductive Age
NGO	Non Governmental Organization
NIPS	National Institute of Population Studies
NWFP	North-West Frontier Province
PAIMAN	Pakistan Initiative for Mothers and Newborns

PC	Population Council
PDHS	Pakistan Demographic and Health Survey
PNC	Postnatal Care
PSLMS	Pakistan Social and Living Standard Measurement Survey
PSU	Primary Sampling Unit
Pvt.	Private
RH	Reproductive Health
RHC	Rural Health Center
RHSC(A)	Reproductive Health Services Center- A
RSPN	Rural Support Programmes Network
SMAM	Singulate Mean Age at Marriage
TBA/*Dai*	Traditional Birth Attendant
TFR	Total Fertility Rate
THQ	Tehsil Headquarter
ToR	Terms of Reference
TT	Tetanus Toxoid
UC	Union Council
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

The Family Advancement for Life and Health (FALAH) project conducted a baseline household survey for Larkana, one of the 20 project districts.

The survey was conducted between March and May of 2008 in a probability sample of 520 households in 40 clusters in Larkana. It included interviews with 604 currently married women aged 15-49 years ("married women of reproductive age" or MWRA), along with 200 married men, of whom 178 were married to women included in the sample. As a separate activity, a mapping study[1] was also carried out in Larkana during the period between January and March 2008. Selected data from that study are included in this report, although a separate report is also available. The FALAH project is primarily focused on birth spacing and family planning.

Household and Respondent Characteristics

Larkana is a relatively developed rural district in Sindh. It ranked 67th of 91 districts on the overall Human Development Index, according to the National Human Development Report 2003 of UNDP. The characteristics of our sample are generally similar to those found in other surveys; some key indicators are presented in Table A.

Table A: Selected key district characteristics from Larkana household survey

Variable	Value
Percentage of households in rural areas	59.5
Percentage of households with electricity	98.8
Percentage of households with indoor water supply	97.7
Percentage of households with flush toilet	78.6
Percentage of households with television	66.5
Percentage of literate female respondents	22.8
Percentage of respondents with literate husbands	60.0
No. of MBBS physicians per 1000 MWRA	1.9
Total fertility rate	**3.9**

Larkana is a fairly densely populated district with a well-developed road system. Electrification is essentially complete (98.8 percent of the sampled households), and

[1] Mapping Survey of Health and Reproductive Health Services.

ownership of appliances requiring electricity, such as televisions (67 percent) and washing machines (50 percent), etc., was common in Larkana district. About 98 percent of the households had some indoor water supply, 86 percent had either a flush toilet or a latrine, and about 14 percent had no toilet. (According to the Millennium Development Goals report, Larkana was 17th nationally in sanitation ranking.) On the other hand, literacy was relatively low. Only 23 percent of the females and 60 percent of their husbands in Larkana were literate which was lower than the average for Sindh Province and substantially lower than national averages. About 78 percent of the women reported that they watched TV, 50 percent listened to the radio, and 9 percent read newspapers or magazines. Overall, 61 percent of the women reported that they had exposure to FP messages through these mediums.

Service Availability

There was a substantial density of reproductive health facilities in Larkana district with a total of 1467 public and private health facilities (including health houses of Lady Health Workers). These were widely scattered around the district, so the simple services such as antenatal check-ups, iron tablets for anemia, and non-clinical contraceptive methods were readily available in both public and private sectors. Services requiring specialized care were also available. For example, there were 21 facilities – 2 public, 19 private – able to offer Caesarean section deliveries. There were 12 facilities able to provide female sterilization, but many of these could only provide that service occasionally, when an external sterilization team was present. Reproductive health services are available in whole of the district, with an average of 34 facilities per union council.

Fertility

There is evidence that fertility has been declining in Larkana. The crude birth rate was 33 per thousand population, and the total fertility rate was 3.9 children per woman. Fertility was higher for illiterate women, among wives of illiterate men, and in households with lower standards of living. However, there was little urban-rural difference in fertility. Many births were spaced too closely for optimum health; for example, nearly 68 percent of closed birth intervals were less than 36 months. Among the women who already had two living children under five years of age, 21 percent were currently pregnant.

Maternal and Neonatal Care

The household survey obtained data on selected indictors of maternal and neonatal health from 347 sampled women who had delivered a child during the previous four years (see Table B). Of these women, 52 percent had visited a health provider at least once for antenatal care; 54 percent had at least two tetanus toxoid immunizations; 38 percent were delivered by a skilled birth attendant; and 38 percent were delivered in a health facility, public or private. These statistics are all higher than national averages, and higher than proportions previously obtained for Larkana. On the other hand, only 40 percent had at least one postnatal check-up. Exclusive breastfeeding was reportedly widespread; 79 percent of the mothers reported breastfeeding their last child for at least 4 months without supplementation.

Table B: Selected key MCH and family planning indicators from the Larkana baseline survey

Indicator	Value
Percentage of mothers with at least one antenatal care visit	52.0
Percentage of mothers with at least two tetanus shots	53.9
Percentage of most recent deliveries conducted by a skilled birth attendant	37.9
Percentage of most recent deliveries in a facility	37.5
Percentage of MWRA not wanting more children	45.8
Percentage of MWRA wanting to delay next birth for at least two years	24.2
Percentage of MWRA knowing at least one contraceptive method	99.3
Contraceptive prevalence rate	27.8
Percentage of MWRA who were past users of contraception	13.6
Percentage of MWRA with unmet need for family planning	33.8
Percentage of MWRA with unmet need for spacing	15.2
Percentage of MWRA with unmet need for limiting	18.5
Total demand for family planning (CPR + unmet need)	**61.6**

Preference for Children

The median "ideal" family size, according to the women respondents, was 5 children, which was higher than the finding of 4 children for Pakistan. Regarding desire for more children in the future, 30 percent said they wanted another child soon (within two years), 24 percent

said they wanted another child, but only after two years, and 46 percent said they did not want more children. The proportion wanting more children soon decreased rapidly with the number of living children, while the proportion not wanting more children increased. The proportion wanting more children later was highest for women with one or two children. More than three-fifths of the women said their husband wanted the same number of children that they did, while about a quarter said their husband wanted more children than they did.

Contraceptive Knowledge and Use

Nearly all currently married women knew of at least one contraceptive method. The contraceptive prevalence rate (the percentage of MWRA currently using some method of contraception) was 27.8 percent, this is close to the CPR obtained for Sindh and for Pakistan. The most common methods in use were female sterilization (13.7 percent), rhythm (4.1 percent), condom (2.8 percent) and withdrawal (2 percent). Past users comprised 13.6 percent of MWRA; injectables, pills, withdrawal, rhythm and condoms were all common past methods. Seventy-six percent of current users did not want more children, while 24 percent wanted more, but at a later time. Most users reported that they obtained their supplies and services from private hospitals/clinics/doctors, or their husband obtained the supplies (for condoms and pills).

Experience with Contraceptive Methods

Stated reasons for respondents' choices of their current or past methods varied by method, but commonly cited reasons included convenience of use, suitability for respondent and husband, easy availability, low side effects, and (for IUD users and female sterilization) ability to use for a long period. Costs were generally low (only 11 percent paid more than Rs.50 the last time they obtained their method) and did not appear to be a major obstacle to contraceptive use. Similarly, travel time was usually not excessive; 25 percent reported requiring more than 30 minutes to reach their service. Information provided at acceptance of FP method often did not include information on side effects or method choice. Clients generally reported being reasonably treated by providers, being examined properly, however respondents often did not feel that the providers were capable of dealing with side effects. A variety of side effects were reported by users and past users.

Reasons for Non-use

Asked hypothetically about hindrances a couple might face if they wanted to avoid or delay pregnancy, women typically mentioned religion, side effects and husband's disapproval. Less frequently mentioned were distance/cost, people might find out contraceptive use or method failure. Past users were most likely to discontinue use because of side effects or because they wanted more children. Their reasons for current non-use were most often related to current or anticipated childbearing, but side effects and infrequent sex/husband away were also frequently mentioned. Never users were most likely to say they were not using contraceptives for reasons related to childbearing, but fear of side effects were also common reasons. A large majority of current and past users said that they could discuss family planning easily with their husbands, but only 71 percent of never users said they could do so. Knowledge of contraceptive methods, and particularly of sources, was lower among never users than among current or past users. About 37 percent of never users expressed the intent to use contraception in the future. The information obtained in this study indicates that substantial number of women in Larkana were ready to practice birth spacing and family planning.

Unmet Need for Family Planning

A woman is said to be in "unmet need" for family planning if she says she does not want more children, or wants them later, and is at risk of conceiving, but is not using any method of contraception. By this definition, 33.8 percent of the women in this sample were in unmet need, 18.5 percent for limiting and 15.2 percent for spacing. This proportion was fairly typical for Pakistan, but high by international standards. Unmet need for limiting was higher in rural areas, among illiterate women, and among women with lower standards of living. On the other hand, unmet need for spacing was higher among literate women. Women in unmet need tended to be characterized by poor communication with their husbands, had a fear of side effects, and lacked knowledge about sources of family planning sources.

Reproductive Preferences and Behavior of Men

The findings reveal that almost all of the men interviewed in Larkana knew at of least one modern contraceptive method. Male sterilization was one of the least known contraceptive methods. Thirty percent of the men did not want more children and another 15 percent wanted to delay the next pregnancy. Twenty-five percent of the men reported that they or their wives were currently using a family planning method, and almost all were using

modern contraceptive methods. Among the current users, 86 percent were very satisfied with their current contraceptive methods.

Of those who were not using a contraceptive method, only 11 percent reported that they were intending to use any FP method in future. Wanting another child was one of the prominent reasons for not using any FP method. It would be important to include specific interventions aimed at influencing men's attitudes toward their role and responsibility in the overall health of the family and birth spacing and limiting needs.

Conclusion

Among rural districts in Pakistan, the district of Larkana is characterized by a relatively well-developed infrastructure, a fairly high standard of living, a variety of public and private reproductive health facilities, and relatively good maternal and neonatal health care. In this setting, knowledge and approval of family planning were high, and contraceptive prevalence, at 27.8 percent, was less than that of Pakistan as a whole. Nevertheless, there is much need for improvement; unmet need for family planning remains high at 34 percent. Among the important reasons that should be addressed in an improved program are husbands' attitude, inter-spousal communication, fear of side effects, and knowledge of contraceptive methods and their sources. Also, the concept of birth spacing needs to be stressed to lengthen birth intervals, which are often too short.

Chapter 1

Introduction

Background

The FALAH Project

The Family Advancement for Life and Health (FALAH) project is a 5-year project funded by the United States Agency for International Development (USAID) to support birth spacing and family planning in Pakistan. The FALAH Project works with the Government of Pakistan (particularly the Ministry of Population Welfare and the Ministry of Health) at Federal, Provincial, and District levels as well as the private sector, to improve birth spacing information and services.

The FALAH project will specifically focus on 20 districts. These are:

- **Balochistan**: Gwadar, Jaffarabad, Khuzdar, Lasbela, Turbat and Zhob;
- **North-West Frontier Province**: Buner, Batagram, Charsadda, Mansehra, Mardan and Swabi;
- **Punjab**: Dera Ghazi Khan and Jhelum;
- **Sindh**: Dadu, Ghotki, Larkana, Sanghar, Sukkur and Thatta.

The aims of the FALAH project are:

a) To increase demand for and practice of birth spacing;

b) To increase access to and quality of family planning services in the public sector;

c) To increase the coverage and quality of family planning services in the private sector;

d) To increase the coverage of social marketing of contraceptives, and provide support to the commercial sector for marketing contraceptives to strengthen contraceptive security.

At the district level, FALAH is working to integrate communication and services through a "whole district" approach involving all available resources inthe public and private sectors. FALAH is being implemented by a team of seven partner organizations: Population Council (as lead agency), Jhpiego, Greenstar Social Marketing, Save the Children (US), Mercy Corps, Health and Nutrition Development Society (HANDS), and the Rural Support Programmes Network (RSPN). FALAH is also coordinating its activities with the PAIMAN maternal and neonatal health project, especially in the PAIMAN districts, and with other projects as deemed appropriate. In Larkana, district-level activities are being coordinated by Mercy Corps, with Greenstar providing information and services through social marketing and other partners supporting specific activities as needed.

Larkana District

At present, Larkana district consists of 3 talukas (tehsils), Dokri, Larkana and Ratodero. The overall population of the district was estimated to be 2.64 million in 2008, with population density at around 355 persons per square kilometer. The river Indus flows from northeast to southwest towards the borders of the district.

The Bhuttas, a non-Balochi tribe, are dominant in Larkana taluka. Among other non-Balochi tribes, there are Abros, Chajras, Kalhoras, Bughies, Israns, Pluls Wagans, Junejo and Nichs. Among the Balochi tribes there are Rinds, Lasharis, Gopangs, Magsis and Mugheris. A large number of migrants from India also settled in the urban areas of the district. A majority of the population is Muslim, although a considerable number of Hindus also live in this district. The most common language is Sindhi (98 percent); other spoken languages are Balochi, Brahvi and Urdu. Urdu is understood by a majority of the population. The entire area of the district is irrigated by a network of barrage canals, mainly Rice Canal and Dadu Canal.

Larkana stood 67th among 91 districts in Pakistan,[2] and within Sindh it stood 13th of 16 districts (UNDP, 2003). In the UNDP Millennium Development Goals report of 2006, district-

[2] The districts of Pakistan were ranked according to a Human Development Index in 2003. Districts were ranked based on literacy rates, enrolment ratios, immunization ratios, infant survival ratios, real GDP per capita, educational attainment index, health index, and income index.

level data (based on the Pakistan Social and Living Standards Measurement Survey 2004-05) were shown for various measures of education, gender equity, infant mortality, and environmental sustainability. In these comparisons, Larkana ranked below average on most measures of education and literacy, above average on immunization and water supply, and high – 7th nationally out of 98 districts – on sanitation (Planning Commission of Pakistan, 2006; Government of Pakistan, 2006).

The Larkana Baseline Household Survey

In Larkana (as in each of the 20 FALAH focus districts) Population Council implemented a baseline sample household survey to learn about knowledge, attitudes, and practices regarding fertility, reproductive health, and child spacing/family planning. This survey represents one of two major studies to establish baseline indicators for the FALAH project. The other is a mapping exercise to compile complete, digitized maps of all facilities providing reproductive health services, including maternal health, neonatal and child health, and child spacing/family planning. This baseline survey will be compared with an endline survey towards the end of the project to assess progress.

Objectives

The objectives of the Larkana Baseline Household Survey are:

- To obtain baseline measurements for those FALAH indicators that can best be measured through such surveys;
- To obtain detailed information on the knowledge, attitudes andpractices of married couples of Larkana district regarding reproductive health, so as to meet their needs more effectively;
- More specifically, to obtain information needed to improve reproductive health services and to design appropriate social mobilization activities.

Methodology

Study Population

FALAH is primarily a district-level project that intends to improve the health of women and children of the district over a five-year period. The baseline household survey covers married women of reproductive age (15-49 years old) and their husbands living in the community. The objective is to understand and measure general knowledge, attitudes and practice of these married couples regarding family planning.

Sample Design and Size

The systematic stratified sample technique was used to select a representative sample of the district. The universe consisted of all urban and rural households of the district. The number of blocks selected in urban areas and the number of villages selected in rural areas are presented in Table 1.1. A total of 40 blocks/villages were selected, with 13 households selected per block/village. The selection procedure is described below.

Urban Sample

The required number of enumeration blocks was selected with probability proportional to size (number of circles) by adopting a multistage stratified sampling design. The "enumeration circles," i.e., the smallest units available in the 1998 Population District Census Reports as demarcated by the Population Census Organization, were selected. The maps of these circles were obtained from the Population Census Organization and were already divided into blocks of approximately 250-300 households depending upon the number of households in each circle. Following this, one block was randomly selected from each circle. The household listing of each block was then carried out by the enumeration teams before selecting the sample households. A fixed number of 13 households were drawn from each sample enumeration block by using systematic random sampling.

Rural Sample

The 1998 Population Census list of villages was used as the sampling frame for the selection of a rural sample. Villages in rural areas have been treated as primary sampling units (PSU). Sample PSUs were selected with probability proportional to size (number of households). Households within the sample PSUs were considered secondary sampling units. The household listing of each village was then prepared by the enumeration teams before selecting the sampled households. A fixed number of 13 households were selected from each sample enumeration village by the systematic random technique.

Selection of Respondents

Within each household, all married women aged 15-49 (MWRA) were interviewed. In addition, husbands of MWRA who were present were also interviewed to a maximum of 5 per block; if fewer than 5 husbands could be interviewed from the 13 sampled households, additional interviews were sought from neighboring households.

Table 1.1 presents the planned and enumerated number of households and eligible women of reproductive age in Larkana.

Table 1.1: Results of households and eligible women (MWRA) interviews

Result	Rural	Urban	Total
Number of blocks/villages	24	16	40
Planned households	312	208	520
Households contacted	361	237	598
Households replaced	49	29	78
(Households refused)	6	4	10
(Households locked)	43	25	68
Eligible women identified	369	246	615
(Eligible women refused)	4	7	11
Total women's interviews	**365**	**239**	**604**

Questionnaire Design

Two questionnaires, one for women and the other for men, were developed for this survey. The questionnaires contained sufficient information to make estimates of all FALAH indicators that the household survey aimed to collect as well as additional information of interest to the project.

The questionnaires were pre-tested in both urban and rural areas of Islamabad. The main objective of the pre-testing was to examine the suitability and effectiveness of questions in eliciting adequate responses, to check if the interviewers or respondents would face any language problems and to determine the approximate time required to complete one questionnaire.

In the pre-test, interviewers were advised to note down their experiences with regard to each question. After making all of the revisions on the basis of the pre-test, the questionnaires were finalized and translated into Urdu.

Hiring of Interviewers and Supervisors

Since the respondents in the baseline survey were currently married women and their husbands, female interviewers were hired to interview female respondents and male interviewers to interview male respondents. The required number of interviewers was hired locally by advertising through local newspapers. A logistics supervisor and a data quality supervisor were also hired for each team.

Training of Interviewers and Supervisors

In order to ensure that the training provided for interviewers was of high quality, and that interviewers understood the definitions and concepts underlying the language of the questions, a two-week training of the Larkana team was conducted by the Population Council in Quetta. During the training, interviewers conducted 2-3 field interviews in order to prepare for the actual interview process.

Training regarding the importance of the criteria for the selection of primary sampling units, mapping and listing procedures, sample selection, field operation procedures, and selection of particular households and respondents was also provided by specialists.

Quality Assurance

To ensure the quality of the data, Population Council staff monitored the fieldwork by accompanying the field teams. While supervising the fieldwork, Population Council supervisory staff members were also available to provide on-the-spot guidance to interviewers in the event that any part of the questionnaire was unclear to them. This ensured the completeness and accuracy of each questionnaire.

Data Entry and Edit Procedures

Data processing was initiated in the field with the checking of the questionnaires. Each team leader completed on-the-spot checks and preliminary editing of questionnaires during the enumeration period. Team supervisors were provided with editing instructions emphasized the importance of completing each questionnaire, correctly identifying each eligible respondent, and the completeness of household composition. Each team leader engaged in preliminary editing of completed questionnaires during the enumeration period. On receipt

of the questionnaires at the Islamabad office, a special team of experienced staff edited the completed questionnaires. After the completion of the editing and coding process, the questionnaires were dispatched to a data entry center. The data were then analyzed using SPSS for Windows.

Fieldwork

Fieldwork for Larkana district was carried out between March 13 and May 5, 2008.

Chapter 2

Household Characteristics

Geographic Distribution

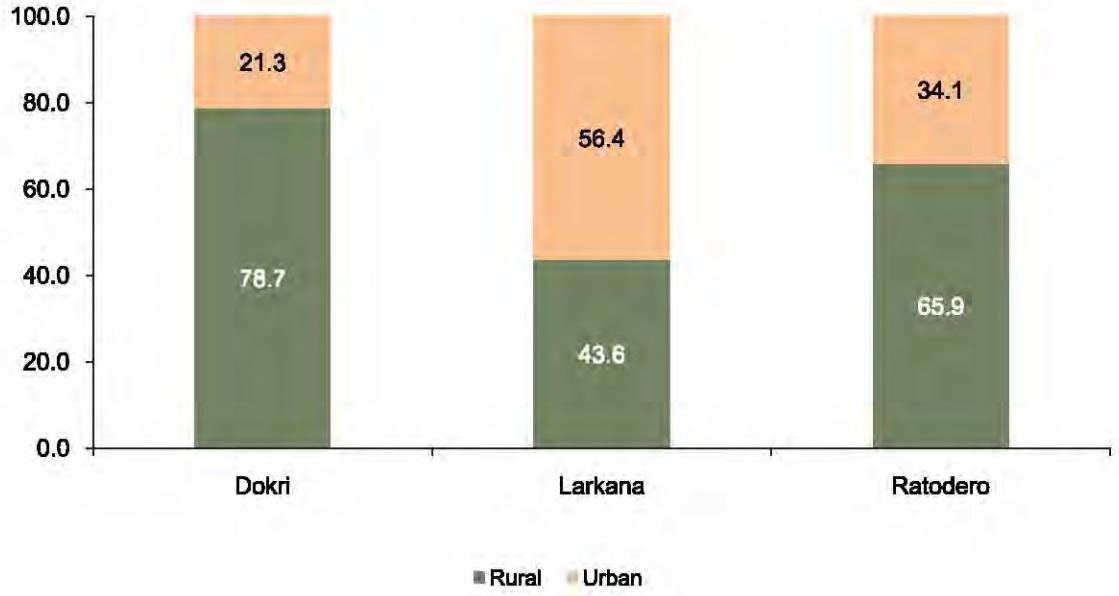
The district of Larkana is divided into three talukas/tehsils: Dokri, Larkana and Ratodero. Dokri and Ratodero are predominantly rural, whereas Larkana taluka is 56 percent urban. Table 2.1 and Figure 2.1 show the distribution of the population of sample households according to residence (urban and rural) and by taluka, with comparisons to the distribution of the population of 1998 National Population and Housing Census.

Table 2.1: Distribution of the population in sample households by residence and taluka

	Rural			Urban			Total	
Taluka	**N**	**%**	**Census %**	**N**	**%**	**Census %**	**N**	**%**
Dokri	1128	78.7	83.4	305	21.3	16.6	1433	100.0
Larkana	944	43.6	42.1	1220	56.4	57.9	2164	100.0
Ratodero	717	65.9	69.9	371	34.1	30.1	1088	100.0
Total	**2789**	**59.5**	**61.1**	**1896**	**40.5**	**38.9**	**4685**	**100.0**

Table 2.1 shows, the distribution of the population of the 520 households in the sample by urban-rural residence and taluka which closely follows the distribution recorded for the whole district in the 1998 Population Census (Population Census Organization, 2000). About 60 percent of the sampled population in Larkana District lived in rural areas.

Figure 2.1: Distribution of population in sample households by residence and taluka



Age-Sex Distribution

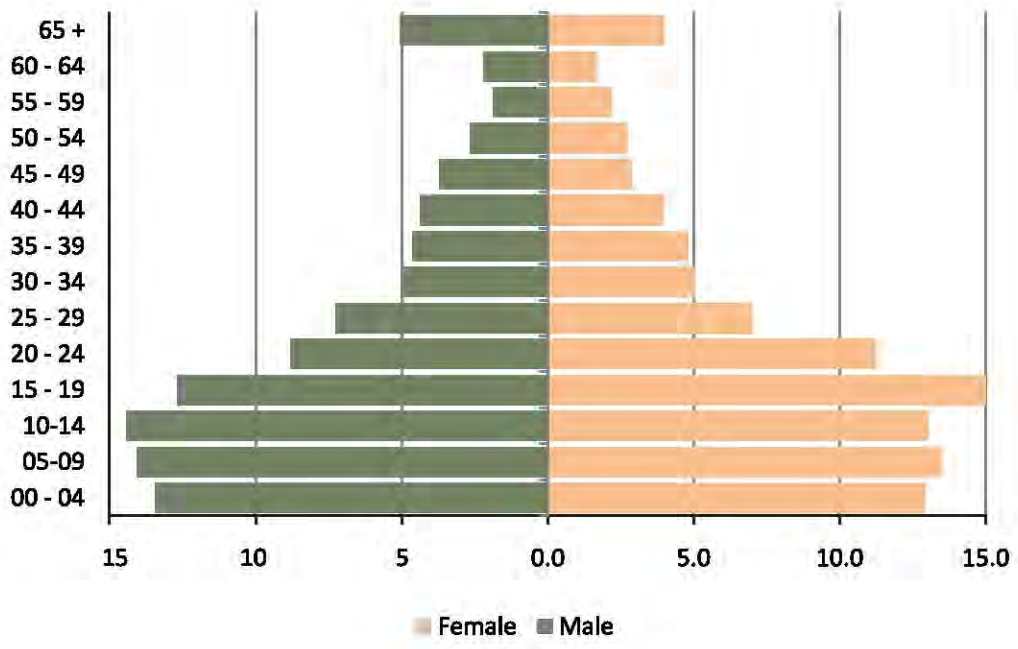
Table 2.2 shows the population distribution of the sample households by age and sex; Figure 2.2 shows the same information in the form of an age-sex pyramid.

The population is typical of a society characterized by high fertility with a median age of 18 years. As with many Pakistani populations, there were somewhat more males than females.

Table 2.2: Distribution of sample household population by age and sex

	Male		Female		Total	
Age group	**N**	**%**	**N**	**%**	**N**	**%**
00 - 04	319	13.4	298	12.9	617	13.2
05 - 09	334	14.1	311	13.5	645	13.8
10 - 14	343	14.4	301	13.0	644	13.8
15 - 19	301	12.7	347	15.0	648	13.8
20 - 24	209	8.8	260	11.3	469	10.0
25 - 29	172	7.2	162	7.0	334	7.1
30 - 34	117	4.9	116	5.0	233	5.0
35 - 39	110	4.6	111	4.8	221	4.7
40 - 44	104	4.4	91	3.9	195	4.2
45 - 49	88	3.7	66	2.9	154	3.3
50 - 54	63	2.7	63	2.7	126	2.7
55 - 59	44	1.9	50	2.2	94	2.0
60 -64	52	2.2	39	1.7	91	1.9
65 - 69	42	1.8	38	1.6	80	1.7
70 - 74	58	2.4	32	1.4	90	1.9
75+	20	0.8	22	1.0	42	0.9
Total	**2376**	**100.0**	**2307**	**100.0**	**4683**	**100.0**

Figure 2.2: Age-sex distribution of Larkana



Of the total population of the sampled households, 24.6 percent consisted of females 15-49 years of age, and 13.2 percent consisted of children under 5 years old. These groups comprised the population of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

Marital Status

Table 2.3 shows that a significant share of women was widowed/divorced/separated above the age of 50 years as compared to men. It also indicates remarriages of men after being widowed. The divorce/separation rate was quite low among males. The share of never married men was higher as compared to women; the differential was significant below age 30 years. The singulate mean age at marriage for women was 23 years.

Table 2.3: Distribution of household population by marital status, sex and age

	Marital status						
	Married		Widowed/ divorced/separated		Never married		
Age group	Male	Female	Male	Female	Male	Female	Total
15 - 19	4.0	17.1	0.0	0.0	96.0	82.9	100.0
20 - 24	17.3	48.5	0.0	0.0	82.7	51.5	100.0
25 - 29	57.6	82.7	1.7	0.0	40.7	17.3	100.0
30 - 34	87.2	90.5	0.9	4.3	12.0	5.2	100.0
35 - 39	91.8	96.4	0.9	1.8	7.3	1.8	100.0
40 - 44	95.2	90.1	3.8	4.4	1.0	5.5	100.0
45 - 49	93.2	93.9	6.8	6.1	0.0	0.0	100.0
50 - 54	95.2	77.8	4.8	20.6	0.0	1.6	100.0
55 - 59	90.9	68.0	9.1	32.0	0.0	0.0	100.0
60 - 64	88.5	69.2	9.6	30.8	1.9	0.0	100.0
65 - 69	88.1	68.4	11.9	31.6	0.0	0.0	100.0
70 - 74	77.6	40.6	20.7	56.3	1.7	3.1	100.0
75+	85.0	22.7	15.0	77.3	0.0	0.0	100.0
All ages 15+	**56.3**	**59.4**	**3.4**	**7.4**	**40.3**	**33.2**	**100.0**
N	776	829	47	103	556	463	100.0

Household Characteristics and Wealth Indicators

Several household characteristics were assessed that reflect the wealth and well-being of its inhabitants. Some of these may have direct bearing on health; for example, a clean indoor water supply and flush toilets are important for hygiene, and access to radio and television can help in learning about good health practices and health services. Others, that relate more to the general well-being of the household, may correlate with good health – for example, by indicating ability to buy sufficient food for good nutrition or pay for quality health care.

Physical Characteristics of Households

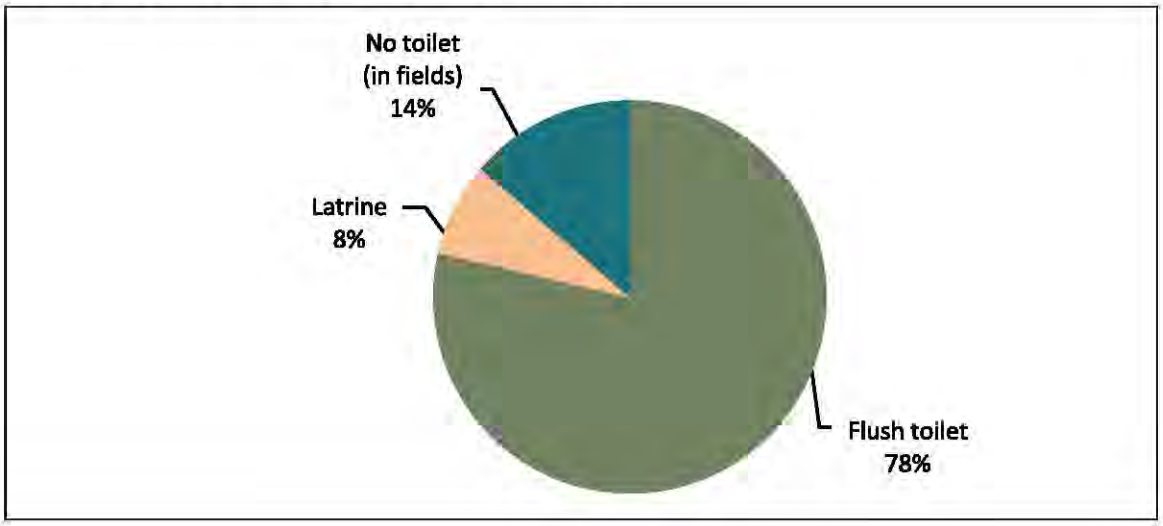
Table 2.4 shows selected physical characteristics of the sampled households. Nearly all households had an indoor water supply (98 percent) and only 1 percent had a hand pump outside (Table 2.4). More than three-fourths of the total households in Larkana had some type of flush toilet (Figure 2.3), about 8 percent had a raised or pit latrine; and about 14 percent had no toilet at all. This is consistent with the 2006 Millennium Development Report (based on PSLMS data), which found Larkana to have the seventh highest score for sanitation of any district in Pakistan (Planning Commission of Pakistan, 2006).

While 42 percent of the households used firewood for cooking, 34 percent used Sui gas (Table 2.4). Nearly all households, even in rural areas, had electricity. More than half of the houses (52 percent) were roofed with wood/bamboo and mud, and 62 percent had dirt floors. About 45 percent of the walls were of burnt bricks or cement blocks and 42 percent consisted of mud or mud bricks.

Table 2.4: Distribution of households with selected physical characteristics by residence

	Rural		Urban		Total	
Characteristic	**N**	**%**	**N**	**%**	**N**	**%**
Main source of drinking water						
Motorized/hand pump (inside)	305	97.8	203	97.6	508	97.7
Motorized/hand pump (outside)	3	1.0	4	1.9	7	1.3
Others	4	1.3	1	0.5	5	1.0
Sanitation facility						
Flush to sewerage	6	1.9	1	0.5	7	1.3
Flush connected to septic tank	98	31.5	93	44.7	191	36.8
Flush connected to open drain	103	33.1	107	51.4	210	40.5
Raised latrine	21	6.8	4	1.9	25	4.8
Pit latrine	15	4.8	0	0.0	15	2.9
No toilet (in fields)	68	21.9	3	1.4	71	13.7
Main type of fuel used for cooking						
Firewood	186	59.6	32	15.4	218	41.9
Kerosene oil	1	0.3	0	0.0	1	0.2
Gas cylinder	6	1.9	9	4.3	15	2.9
Natural gas (sui gas)	27	8.7	152	73.1	179	34.4
Dung dry	92	29.5	15	7.2	107	20.6
Electrical connection						
Yes	307	98.4	207	99.5	514	98.8
No	5	1.6	1	0.5	6	1.2
Material of the roof						
Concrete	2	0.6	4	1.9	6	1.2
Iron sheet	1	0.3	29	13.9	30	5.8
Guarder and T-iron	91	29.3	122	58.7	213	41.0
Wood/bamboo and mud	217	69.8	53	25.5	270	52.0
Material of the floor						
Earth/sand/mud	251	80.4	73	35.1	324	62.3
Chips	0	0.0	6	2.9	6	1.2
Ceramic tiles	0	0.0	2	1.0	2	0.4
Marble	0	0.0	9	4.3	9	1.7
Cement	42	13.5	98	47.1	140	26.9
Bricks	19	6.1	20	9.6	39	7.5
Material of the walls						
Burnt bricks/blocks	72	23.1	161	77.4	233	44.8
Mud bricks/mud	178	57.1	42	20.2	220	42.3
Wood/bamboo	50	16.0	4	1.9	54	10.4
Stones	12	3.8	1	0.5	13	2.5
Total	**312**	**100.0**	**208**	**100.0**	**520**	**100.0**

Figure 2.3: Toilet facilities for Larkana households



Ownership of Household Assets

Another indicator of household wealth can be the ownership of durable consumer goods, as shown in Table 2.5. These 18 items are suggestive of wealth in a variety of ways. They represent different types of need – e.g., transport, communications, comfort – along with different tastes and levels of expenditure. Some have specific relevance to the FALAH objectives; for example, electronic media can be used to access health messages, to reach health facilities, and telephones are important for summoning help when needed. Others are suggestive of more general well-being.

The distribution of these items appears to show the expansion in consumer purchasing power that has characterized Pakistan in recent years, although comparable past data for Larkana was not available to us. Several items requiring electricity were available in substantial proportions to households, even in rural areas. About two-thirds of all households had television sets, a figure of particular interest to communication specialists. The recent expansion of the information technology sector in Pakistan is reflected in the ownership of mobile telephones by 59 percent of all households (the urban-rural differential is high for mobile phone use) and ownership of a computer by about 6 percent of all households. However, motorized transport was low which suggests difficulties in arranging transport in health emergency situations.

Table 2.5: Percentage of households owning selected items by residence

Household item	Rural	Urban	Total
Wall clock	67.3	94.2	78.1
Chairs	10.6	45.2	24.4
Bed	12.8	38.5	23.1
Sofa	2.9	31.7	14.5
Sewing machine	39.1	75.5	53.7
Camera	8.0	23.1	14.0
Radio/tape recorder	47.4	57.2	51.3
Television	52.4	87.5	66.5
Refrigerator	17.6	53.4	31.9
Land line telephone	3.8	25.0	12.3
Mobile phone	43.9	82.7	59.4
Room cooler /air conditioner	1.6	23.2	10.2
Washing machine	32.4	77.4	50.4
Cycle	29.8	36.5	32.5
Motorcycle	9.6	31.3	18.3
Jeep /car	0.3	3.8	1.7
Tractor	3.8	2.9	3.5
Computer	0.6	14.9	6.3
N	**312**	**208**	**520**

Standard of Living Index

It is useful to use the data above to get an overall index of the economic well-being of a household, both for making a general estimate of economic development for an area, and for use in investigating the relationship between household wealth and reproductive health behavior. One such index is the standard of living index (SLI), developed for international comparisons with data from the Demographic and Health Surveys (Rutstein, S.O., and K. Johnson, 2004). This index gives each household a score of 0-1 or 0-2 on each of the following: source of drinking water; toilet facilities; material of floor; availability of electricity; ownership of a radio; ownership of a TV; ownership of a refrigerator; and means of transportation. For the whole household, the value of the index can range from 0 to 12. Table 2.6 gives the distribution of the SLI for the sample households according to urban and rural residence. The median index for all households was 6; for urban households, it was 7

and for rural households it was 5. More than half of all households fell in the range from 4 to 6. This index will be used later in this report to examine differences in reproductive health knowledge and behavior.

Table 2.6: Distribution of sample households by residence and standard of living index

Standard of living index	Rural		Urban		Total	
	N	%	N	%	N	%
1	1	0.3	0	0.0	1	0.2
2	25	8.0	0	0.0	25	4.8
3	37	11.9	4	1.9	41	7.9
4	59	18.9	9	4.3	68	13.1
5	71	22.8	30	14.4	101	19.4
6	73	23.4	34	16.3	107	20.6
7	26	8.3	43	20.7	69	13.3
8	15	4.8	50	24.0	65	12.5
9	5	1.6	26	12.5	31	6.0
10	0	0.0	12	3.0	12	2.3
Total	**312**	**100.0**	**208**	**100.0**	**520**	**100.0**
Median	5	na	7	na	6	na

na=not applicable.

Chapter 3

Respondent Characteristics

The primary sources of data from the Household Survey are the interviews conducted with 604 currently married women of reproductive age. The background characteristics of these respondents are described in this chapter.

Age

Table 3.1 shows the age distribution of the female respondents for rural and urban areas. Since many younger women were yet to be married, the numbers at age less than 19 years were relatively lower. At older ages, the numbers declined, as reflected in the overall shape of the age pyramid, because significant numbers of women were widowed after the age of 40. About 46 percent of the sample female respondents were under the age of 30; urban-rural differences were significant as about 49 percent of the female respondents from the rural sample were below the age of 30 years, while 40 percent of the urban female respondents fell in this age bracket.

Table 3.1: Age distribution of female respondents by residence

	Rural		Urban		Total	
Age group	**N**	**%**	**N**	**%**	**N**	**%**
<19	32	8.8	19	7.9	51	8.4
20 - 24	68	18.6	35	14.6	103	17.1
25 - 29	80	21.9	42	17.6	122	20.2
30 - 34	56	15.3	36	15.1	92	15.2
35 - 39	54	14.8	45	18.8	99	16.4
40 - 44	46	12.6	30	12.6	76	12.6
45 - 49	29	7.9	32	13.4	61	10.1
Total	**365**	**100.0**	**239**	**100.0**	**604**	**100.0**

Education and Literacy

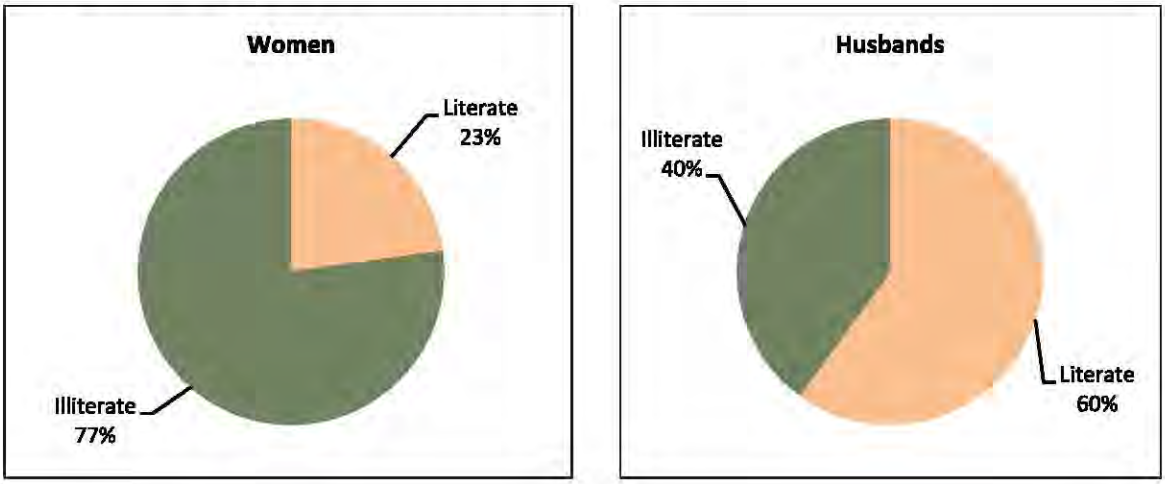
Levels of schooling completed and literacy rates for the respondents and their husbands are given in Table 3.2. Literacy rates are also shown in Figure 3.1. Rates were even lower than the rates for Sindh province as a whole. Literacy of female respondents at 22.8 percent was almost the same as for females 15 and over in the 2004-05 PSLMS, compared with 38 percent in Sindh as a whole and 36 percent (at that time) for Pakistan as a whole (Government of Pakistan, 2005; Government of Pakistan, 2006). Similarly, only about 7 percent of the female respondents reported having up to secondary level of education. Table 3.2 also shows that younger women, aged 15-24 were significantly more literate than older women between the ages of 25-34 as well as those who were 35-49 years old. For husbands of the respondents, literacy (at 60 percent) was lower than the PSLMS found for Sindh in 2004-05 (68 percent), although it was closer to the national average (63 percent) (Government of Pakistan, 2005).

Table 3.2: Distribution of MWRA and husbands by educational achievement and literacy status, age and residence

	Age group			Residence		
Variable	**15 - 24**	**25 - 34**	**35 - 49**	**Rural**	**Urban**	**Total**
Respondent (women)						
Proportion literate	33.6	26.5	12.4	15.6	33.8	22.8
Education level						
No education	60.5	67.3	82.0	78.3	60.8	71.3
Up to primary	25.0	19.0	12.9	16.4	20.7	18.1
Up to secondary	11.2	8.5	3.0	4.7	10.5	7.0
Above secondary	3.3	5.2	2.1	0.6	8.0	3.5
N	**152**	**211**	**233**	**359**	**237**	**596**
Respondent's husband						
Proportion literate	63.5	59.6	58.1	54.6	68.6	60.0
Education level						
No education	35.3	38.4	40.8	43.3	31.1	38.6
Up to primary	22.0	14.8	24.6	24.2	14.7	20.5
Up to secondary	20.0	22.7	9.6	15.7	18.7	16.9
Above secondary	22.7	24.1	25.0	16.9	35.6	24.1
N	**150**	**203**	**228**	**356**	**225**	**581**

For both women and their husbands, the urban–rural gap was significantly high for literacy and education levels. Women's literacy was substantially lower in Larkana as compared to the national average.

Figure 3.1: Literacy status of women and their husbands



Occupation and Work Status

For men, occupation is both an economic and social classification; some occupations usually indicate higher income levels than others, while at the same time may represent social status and life-style. Women's work, whether for necessary income or for career fulfillment, is likely to compete, at least to some degree, with time spent on household management and child care. Therefore, it is worthwhile to examine men and women's work separately.

A substantial number, 280 out of 604 (46 percent) of the women respondents reported working for money, and 75 percent were engaged in embroidery/ stitching. The second occupational category was agriculture and livestock where about18 percent of the working women were employed. The distribution of women's occupations is shown in Figure 3.2.

Figure 3.2: Type of work of women working for pay (n=280)

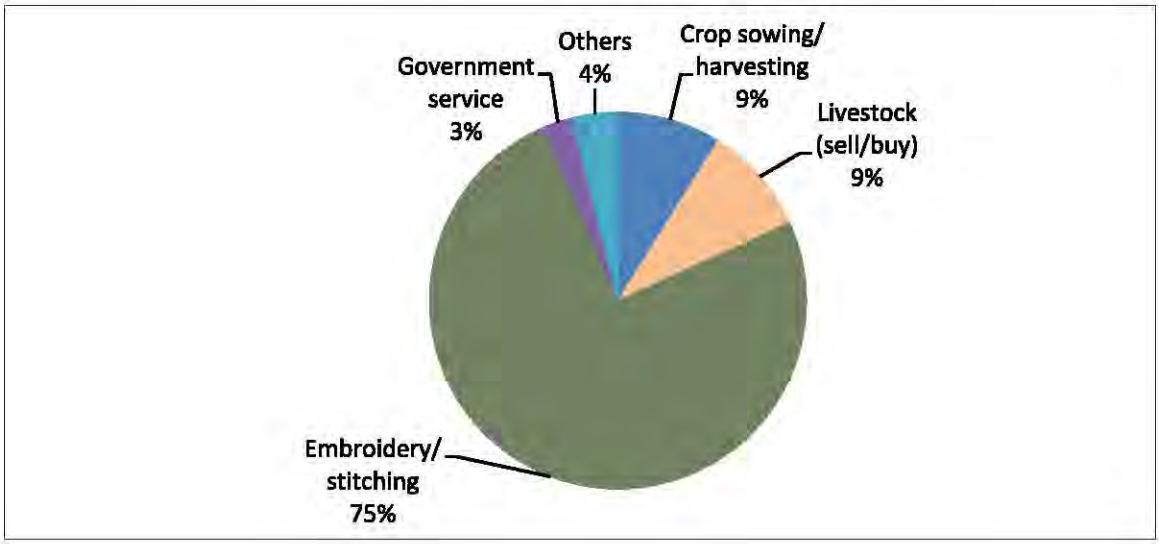


Table 3.3: Distribution of occupational categories of respondents' husbands by residence

Economic activity/ occupation	Rural	Urban	Total
Agriculture/livestock/poultry	37.8	9.6	26.7
Petty trader	10.7	18.8	13.9
Labor (daily wages)	30.1	24.3	27.8
Government service	11.8	25.1	17.1
Private service	3.3	7.1	4.8
Own business	1.9	4.6	3.0
Working abroad	1.9	2.1	2.0
Unemployed	4.7	7.5	5.8
Others	0.8	0.8	0.8
Don't know	0.8	0.0	0.5
N	**365**	**239**	**604**

More than a quarter of all husbands worked as hired laborers for daily wages (30 percent rural; 24 percent urban) (Table 3.3). About 68 percent of rural husbands were either employed in agriculture or worked as daily labor, which was mostly agricultural labor. About 17 percent of the men were in government service, which was the third largest employer in the district. In addition, about 6 percent of husbands were unemployed, and another 2 percent were living abroad.

Female Mobility

Women respondents were asked about their ability to go to places outside their homes, and about the degree of permission that was required to do so (Table 3.4). The health center was the only place where a substantial number of women (81 percent) said that they could go with someone. Only a few women reported being able to go to any of the places named without permission; visiting friends and relatives without permission (10 percent) was highest among the different destinations that they could go to. On the other hand, an insignificantly low number of women reported not being able to go at all to any of the places. However, 22 percent of these women reported that they could not go at all to the nearby market. For each of the named destinations, a majority said they could go with someone, and a minority said they could go with permission.

Table 3.4: Women's reports regarding mobility outside the home, by degree of permission, and destination

	Degree of permission				Total	
Destination	Without permission	With permission	With someone	Cannot go at all/ does not go	%	N
Market	3.0	20.4	55.1	21.5	100.0	640
Health center	2.8	16.2	80.6	0.4	100.0	640
Relatives/friends	10.3	34.6	53.6	1.5	100.0	640
Out of village/town	8.1	13.9	75.2	2.8	100.0	640

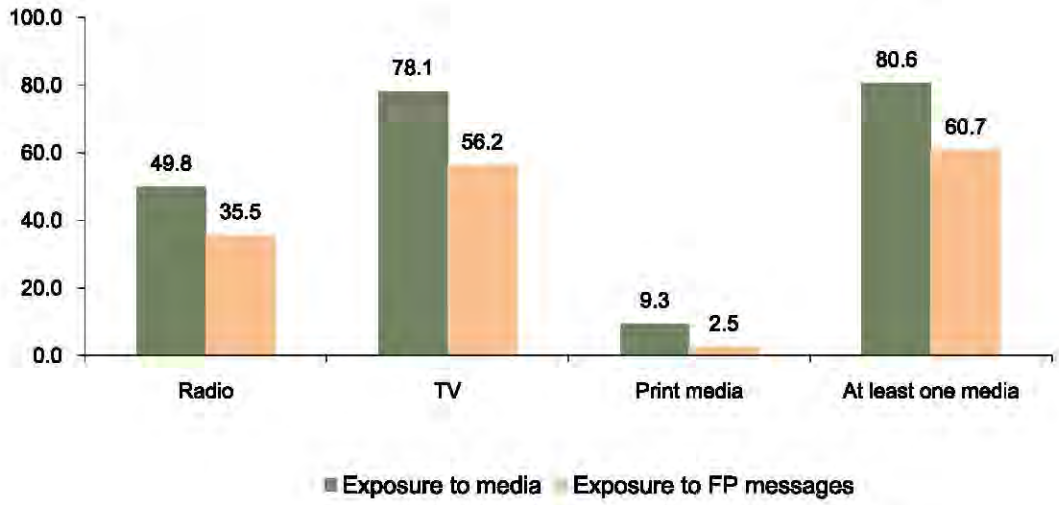
Exposure to Media and Family Planning Messages

For the development of communication activities, it is important to know which mass media forms are available, and to what extent they are used by various segments of the population. Table 2.5 showed that 66.5 percent of households owned a television, while 51 percent owned a radio. Figure 3.3 shows the proportion of respondents who reported that they

watch TV, listen to the radio, or read newspapers or magazines. Television was the most commonly accessed medium, while about half of respondents listened to the radio and less than ten percent read print media.

Furthermore, women who reported access to any sort of media were asked if they had ever seen, heard, or read any message about family planning methods through these mediums. Again, a majority of women said that they had heard about family planning messages on TV (56 percent), while more than a third (36 percent) of the respondents had heard family planning messages on the radio. As the readership of newspapers was very low among respondents, only 3 percent said that they had ever read about a family planning message in a newspaper or magazine (Figure 3.3).

Figure 3.3: Distribution of MWRA according to exposure to media and FP messages, by type of media



Chapter 4

Service Availability

Health status and practices in a district can be better understood in the context of health facilities and trained personnel available to the population of that district. As a companion activity to the Larkana Household Survey, the FALAH project undertook a mapping of health and reproductive health services study in the FALAH districts. The fieldwork in Larkana was carried out from January to March 2008. In this survey, all public and private facilities and providers for reproductive health, including family planning as well as maternal health, were identified and visited. Exact locations of these facilities were determined by using a global positioning system (GPS) device. The characteristics and activities of the facilities and their staff were also examined. The results in whole of the study are being issued in a separate report title "Mapping Survey of Health and Reproductive Health Services Larkana district". In this section, some basic results are provided to give a rough context in which the knowledge, attitudes and behavior of the women of the household survey sample can be understood.

These results represent a considerable range of maternal and reproductive health services being provided in Larkana. The following tables summarize those findings, and are illustrated by maps indicating the location of various types of providers and facilities.

Larkana District Data

There are a total of 1467 health facilities in Larkana, of which 893 are public and 574 are from the private (105 - Greenstar Social Marketing; 469 - others private facilities). Some facilities provide only limited care, such as the LHW's health house in the public sector and dispensaries and traditional practitioners in the private sector.

Reproductive Health Facilities

The distribution of reproductive health facilities in the public and private sectors per union council is shown in Maps 4.1 to 4.3. Map 4.1 shows the distribution of government static facilities by union council population density. There is no government static clinic in 2 union councils. Similarly, Map 4.2 shows the availability of LHWs; 8 union councils have more than 30 LHWs, while 12 have fewer than 10 LHWs. Notably, 2 union councils have no LHW. On average, there are about 18 LHWs per union council. Map 4.3 shows the distribution of private facilities in the district; only 1 union council is without any private facility.

The gross density of reproductive health facilities, that is the number of facilities per union council, is shown in Map 4.4. The variation is considerable: there are 17 union councils with more than 40 reproductive health facilities and 7 with less than 20 facilities. Reproductive health services are available in whole of the district, with an average of 34 facilities per union council.

Family Planning Facilities

Family planning services are available on a large number of facilities in the district. However, clinical methods are available in more than 50 percent of the facilities. Norplant and female and male sterilization are quite uncommon. In contrast, almost all public facilities are providing non-clinical methods. LHWs from the public sector and clinics from the private sectors were major providers of non-clinical methods, particularly condoms and oral pills. The public facilities are further ahead than private facilities in providing nearly all non-clinical methods. Emergency contraceptive pills were provided in 4 facilities in the public sector and 61 in the private sector.

Table 4.1: Number and proportion of facilities providing specified family planning services in Larkana district, by sector and MWRA per facility

	Sector										
	Government		LHWs		Private GSM		Private others		Total		MWRA per facility
Service	N	%	N	%	N	%	N	%	N	%	
Injectables	54	58.7	588	73.4	61	58.1	78	16.6	781	53.2	562
IUD/Copper T	26	28.3	na	na	47	44.8	30	6.4	103	7.0	4558
Norplant	0	0.0	na	na	0	0.0	0	0.0	0	0.0	0
Female sterilization	2	2.2	na	na	7	6.7	3	0.6	12	0.8	36547
Male sterilization	1	1.1	na	na	4	3.8	2	0.4	7	0.5	62652
Condom	58	63.0	801	100.0	54	51.4	104	22.2	1017	69.3	431
Pills	58	63.0	801	100.0	61	58.1	116	24.7	1036	70.6	423
ECP	4	4.3	0	0.0	39	37.1	22	4.7	65	4.4	6747
Any FP method	**59**	**64.1**	**801**	**100.0**	**73**	**69.5**	**140**	**29.9**	**1073**	**73.1**	**409**
Any clinical method	**54**	**58.7**	**588**	**73.4**	**66**	**62.9**	**84**	**17.9**	**792**	**54.0**	**554**
Any non-clinical method	**58**	**63.0**	**801**	**100.0**	**64**	**61.0**	**122**	**26.0**	**1045**	**71.2**	**420**
Total facilities	**92**	**100.0**	**801**	**100.0**	**105**	**100.0**	**469**	**100.0**	**1467**	**100.0**	**299**

Multiple responses are possible. na= not applicable.

Clinical method include; injectables, IUDs, Norplant, female sterilization and male sterilization.

The geographic distribution of these services is as important as the number of facilities. Maps 4.5 to 4.7 show the availability of female sterilization, IUDs, and injectables, as illustrations. Female sterilization is available in 6 union councils provided by both public and private sectors. Availability of IUDs is more widespread geographically, in both public and private sectors. Injectables are provided throughout the district.

Maternal Health Facilities

Provision of maternal health care services is a prerequisite of reproductive health care. Facilities available in Larkana to provide maternal health care are shown in Table 4.2. Service availability regarding antenatal check-ups, anemia treatment and tetanus protection is higher in the public sector than private. Provision of tetanus protection is particularly low in the private sector. Availability of normal delivery services are higher in the private sector than public. Caesarean section is provided only in 1 public and 21 private facilities. In terms

of number of women per facility, one Caesarean section facility is available to cater to more than 20,000 MWRA.

Table 4.2: Number and proportion of facilities providing specified maternal health care services in Larkana district, by sector and MWRA per facility

	Sector										
	Government		LHWs		Private GSM		Private others		Total		MWRA per facility
Service	N	%	N	%	N	%	N	%	N	%	
Antenatal check-up	65	70.7	751	93.8	76	72.4	92	19.6	984	67.1	446
Anemia treatment	83	90.2	801	100.0	101	96.2	331	70.6	1316	89.7	333
TT injection	35	38.0	665	83.0	11	10.5	9	1.9	720	49.1	609
Normal delivery	14	15.2	na	na	54	51.4	44	9.4	112	7.6	3916
Caesarean section	2	2.2	na	na	8	7.6	11	2.3	21	1.4	20884
Total facilities	**92**	**100.0**	**801**	**100.0**	**105**	**100.0**	**469**	**100.0**	**1467**	**100.0**	**299**

Multiple responses are possible. na= not applicable.

Along with the sheer number of facilities, their geographic distribution is of critical importance. Maps 4.8 and 4.9 show essential and comprehensive EmOC services in Larkana district. There are 16 union councils that have no basic obstetric facilities. Map 4.9 shows that comprehensive EmOC services are available in only 6 union councils provided by both public and private sectors.

Service Providers

The number of providers of different categories and number of women per provider are shown in Table 4.3. There are a total of 832 MBBS doctors; about three-quarters of these are males, and more than half are from the private sector. There are 236 female paramedics, including LHVs and nurses; the majority of these paramedics are employed by the public sector.

The number of women per provider or facility may be a good indicator of the status of health in the district. In the whole district, there is 1 MBBS doctor available for 527 married women of reproductive age. Since a majority of women prefer female service providers, this number is as high as 1882 women per female MBBS doctor. Overall, there are 1858 MWRA

per female paramedic. This ratio is very high for female medical assistants and medical/ health technicians, which shows a great dearth of these cadres. Map 4.10 shows the availability of MBBS doctors by gender in each union council. The map reveals that male MBBS doctors are not available in 6 union councils, while in 17 union councils there is no female MBBS doctor.

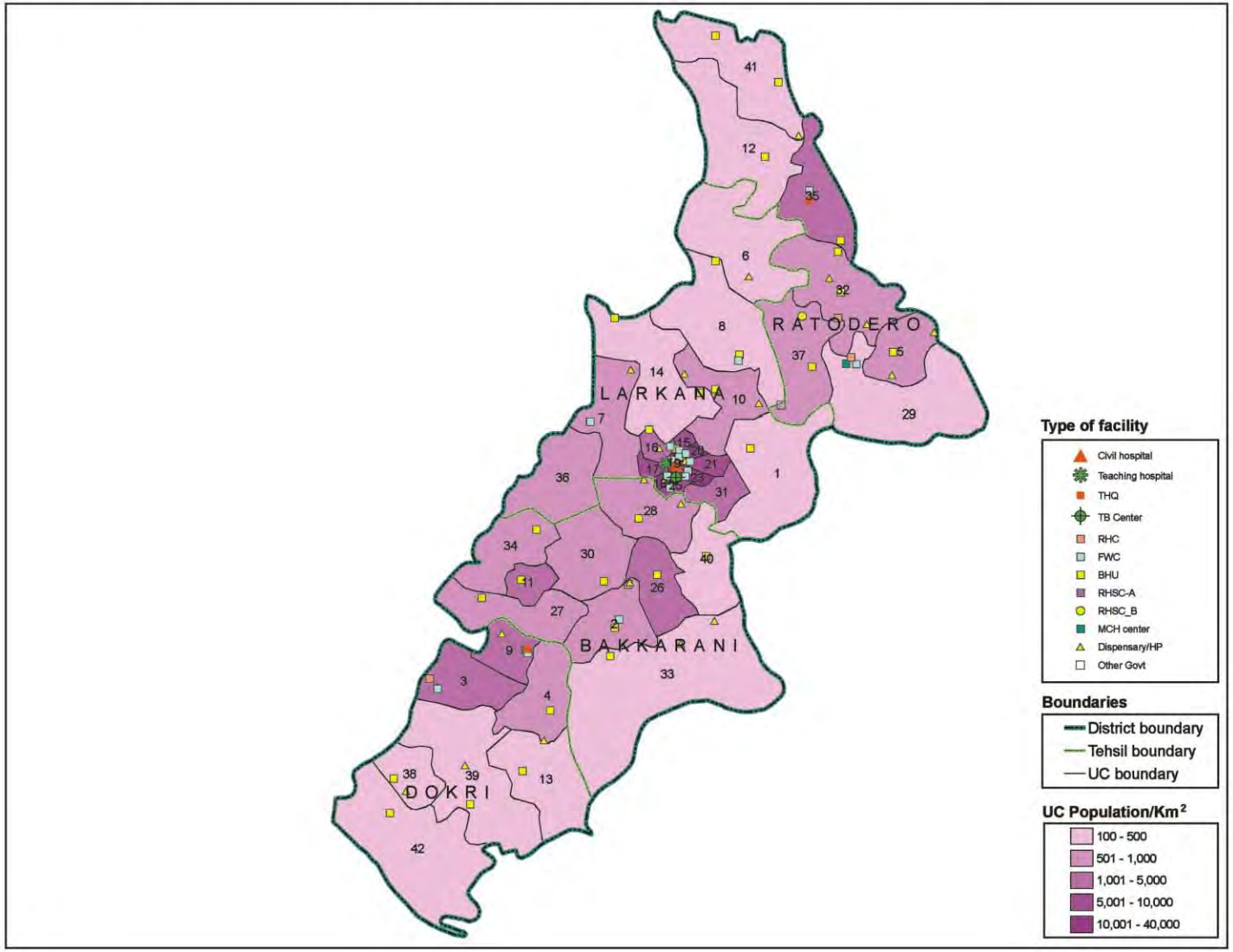
Table 4.3: Number of reproductive health care providers in Larkana district, by sector and category, and MWRA per service provider

	Sector								
	Government		Private GSM		Private others		Total		MWRA per
Provider	N	%	N	%	N	%	N	%	provider
Doctors (MBBS)									
Male	263	67.6	74	56.9	262	83.7	599	72.0	732
Female	126	32.4	56	43.1	51	16.3	233	28.0	1882
Total	**389**	**100.0**	**130**	**100.0**	**313**	**100.0**	**832**	**100.0**	**527**
Female paramedics									
Medical assistant	0	0.0	3	5.8	0	0.0	3	1.3	146188
Nurse	104	71.2	21	40.4	21	55.3	146	61.9	3004
Medical/ health technician	0	0.0	2	3.8	1	2.6	3	1.3	146188
Lady health visitor	42	28.8	26	50.0	16	42.1	84	35.6	5221
Total	**146**	**100.0**	**52**	**100.0**	**38**	**100.0**	**236**	**100.0**	**1858**
Male paramedics	**64**	**100.0**	**20**	**100.0**	**38**	**100.0**	**122**	**100.0**	**3595**

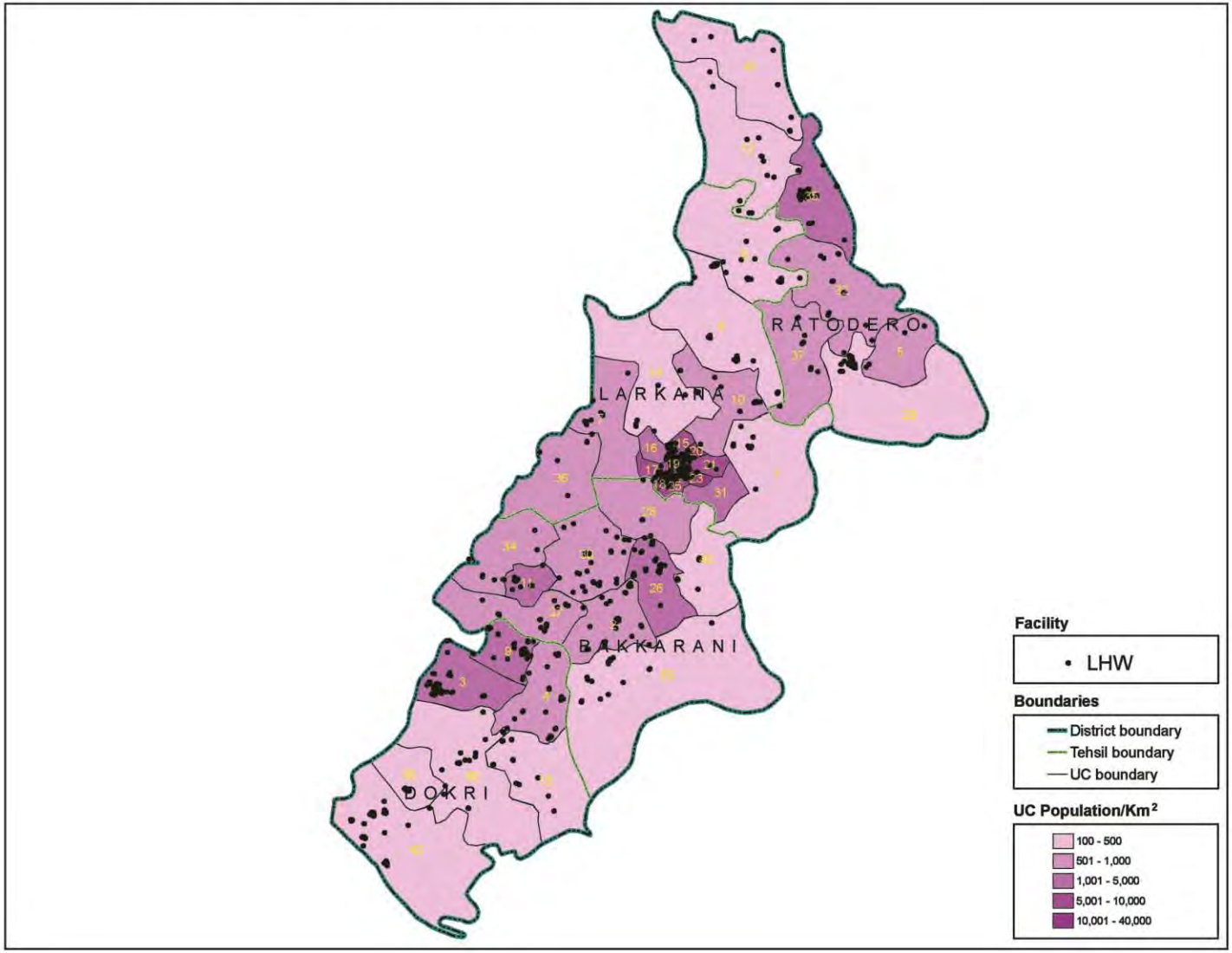
List of Union Councils

1	Akil	15	Larkana 01	29	Naudero
2	Arija	16	Larkana 02	30	Pathan
3	Badeh	17	Larkana 03	31	Phul
4	Bagi	18	Larkana 04	32	Pir Bakhsh Bhutto
5	Bahman	19	Larkana 05	33	Purano Abad
6	Banguldero	20	Larkana 06	34	Rashid Wagan
7	Beriochandio	21	Larkana 07	35	Ratodero
8	Dhamraha	22	Larkana 08	36	Ratokot
9	Dokri	23	Larkana 09	37	Saidu Dero
10	Fatehpur	24	Larkana 10	38	Sehar
11	Garello	25	Larkana 11	39	Tatri
12	Jumo Agham	26	Mad Bahu	40	Wada Mehar
13	Karani	27	Mehrabpur	41	Warisdino Machhi
14	Kothi	28	Naich	42	Yaru Lakhir

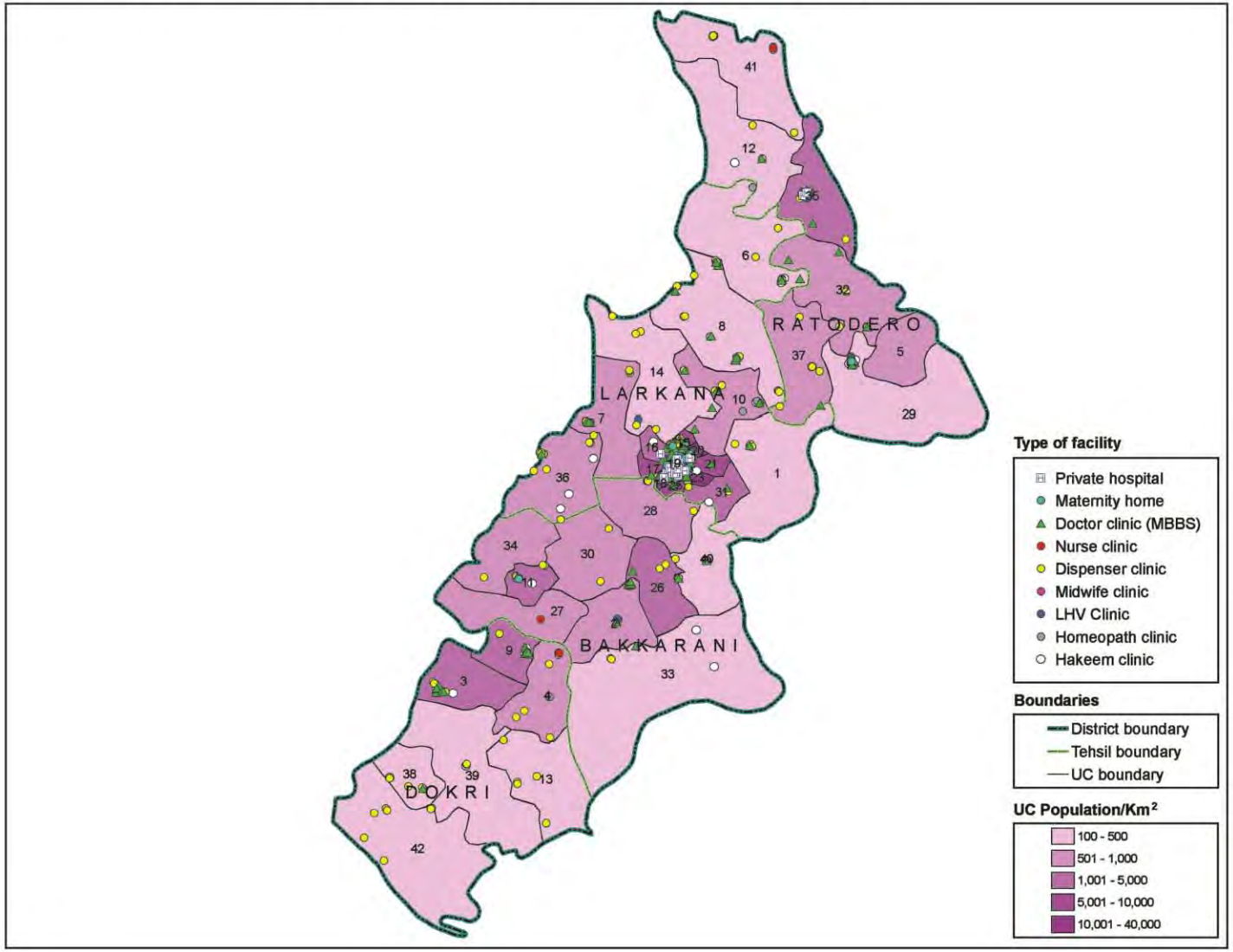
Map 4.1: Location of government facilities in Larkana district, by population density of union council



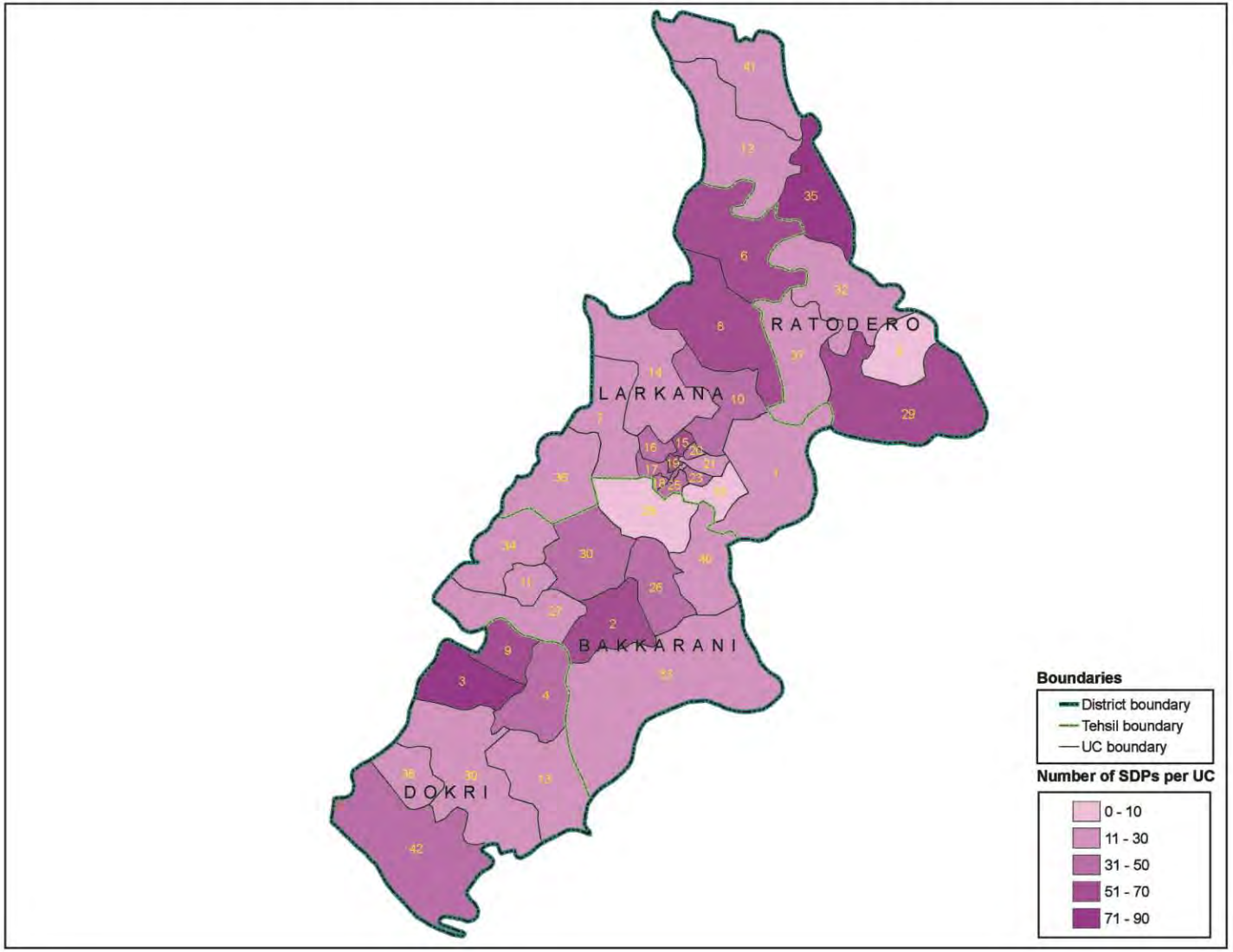
Map 4.2: Location of LHWs in Larkana district, by population density of union council



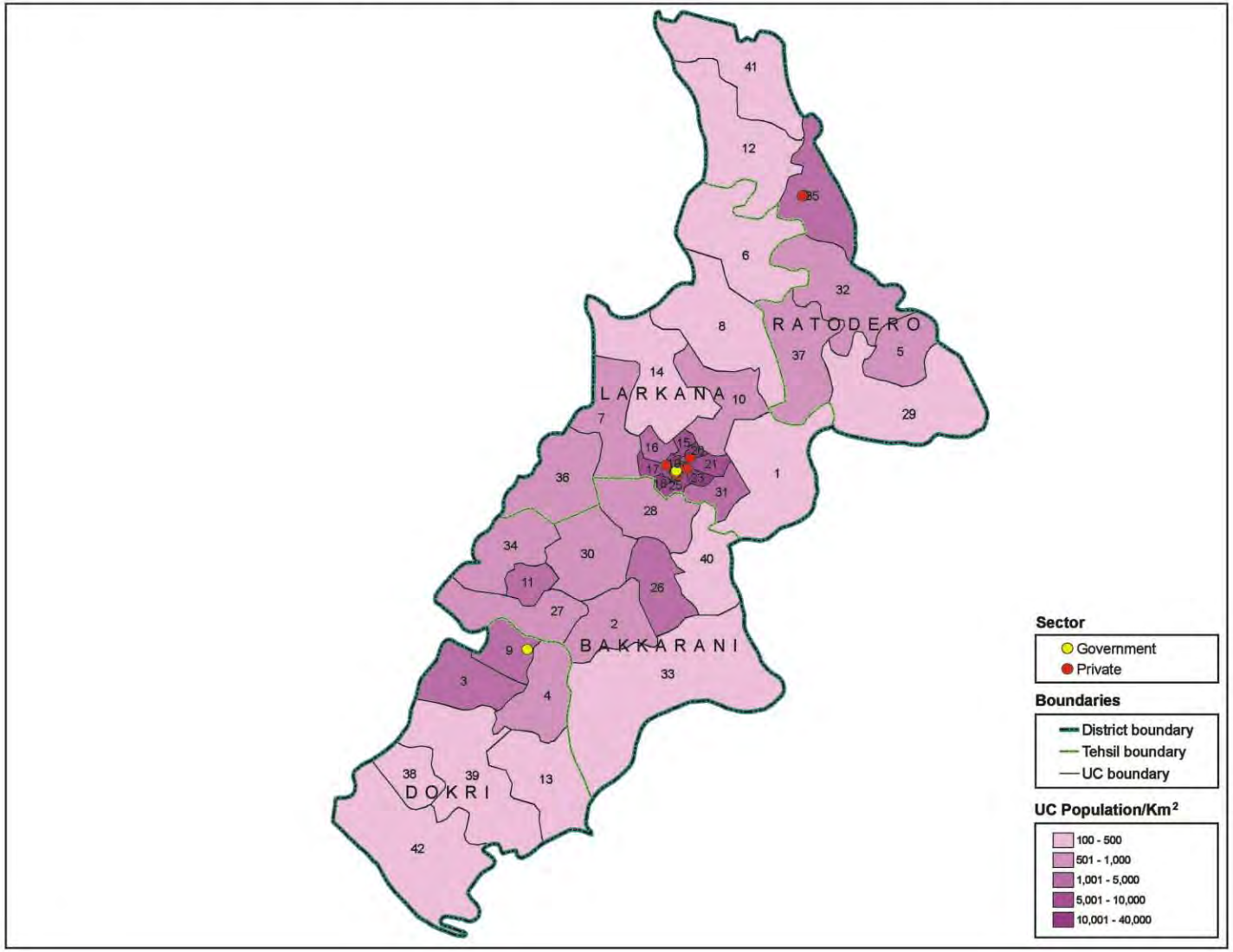
Map 4.3: Location of private facilities in Larkana district, by population density of union council



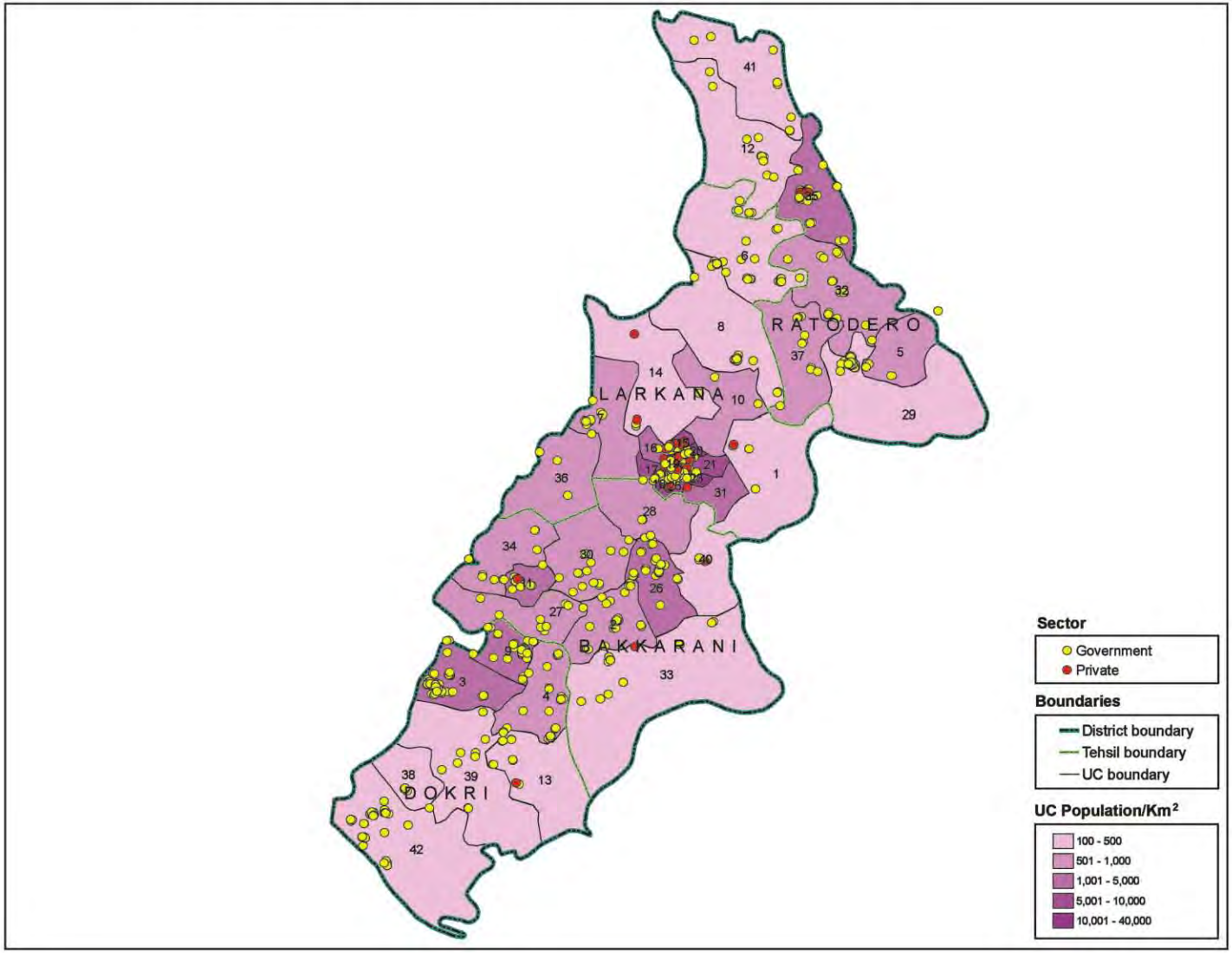
Map 4.4: Total number of reproductive health service delivery points (public and private) in Larkana district, by union council



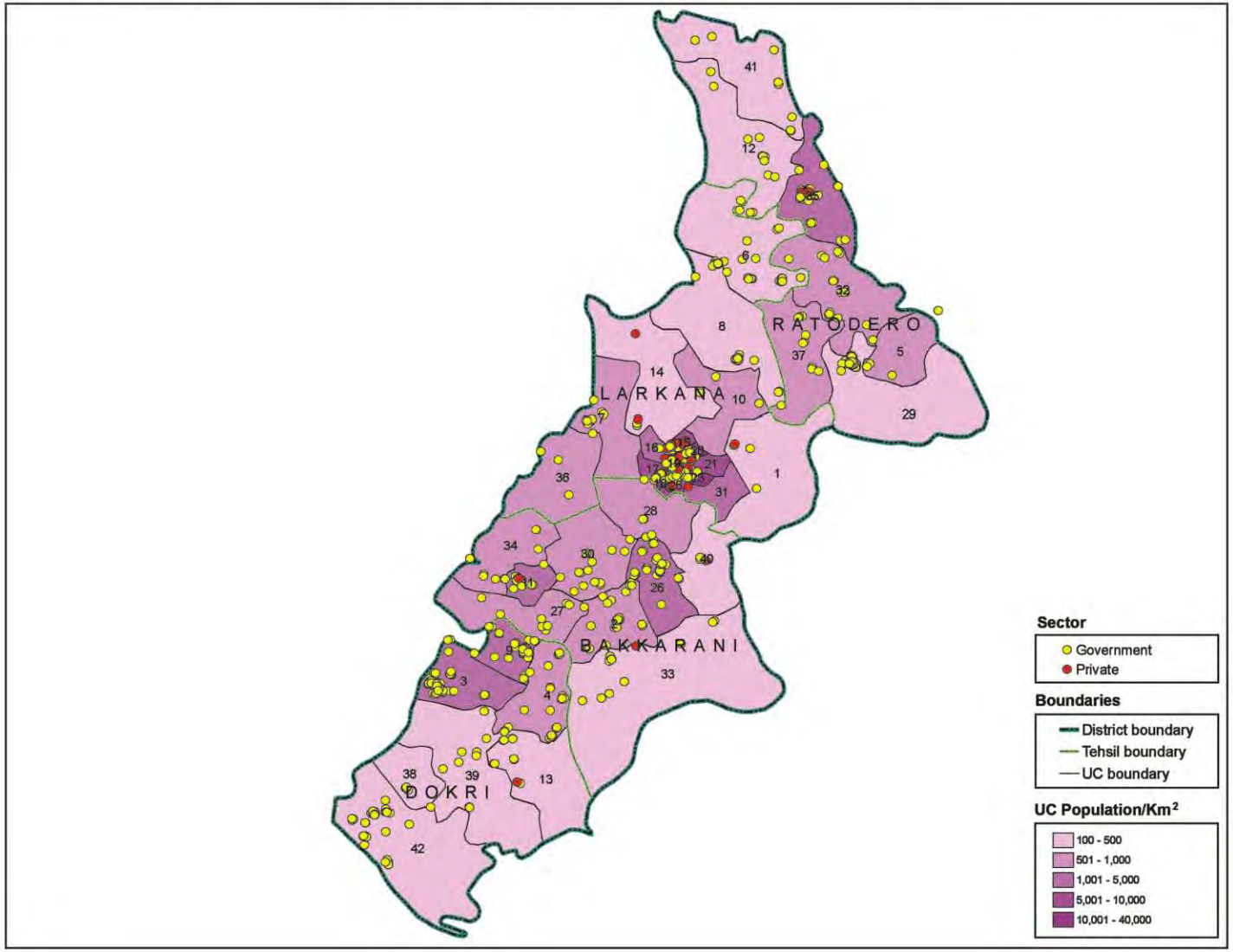
Map 4.5: Location of female sterilization facilities in Larkana district, by population density of union council



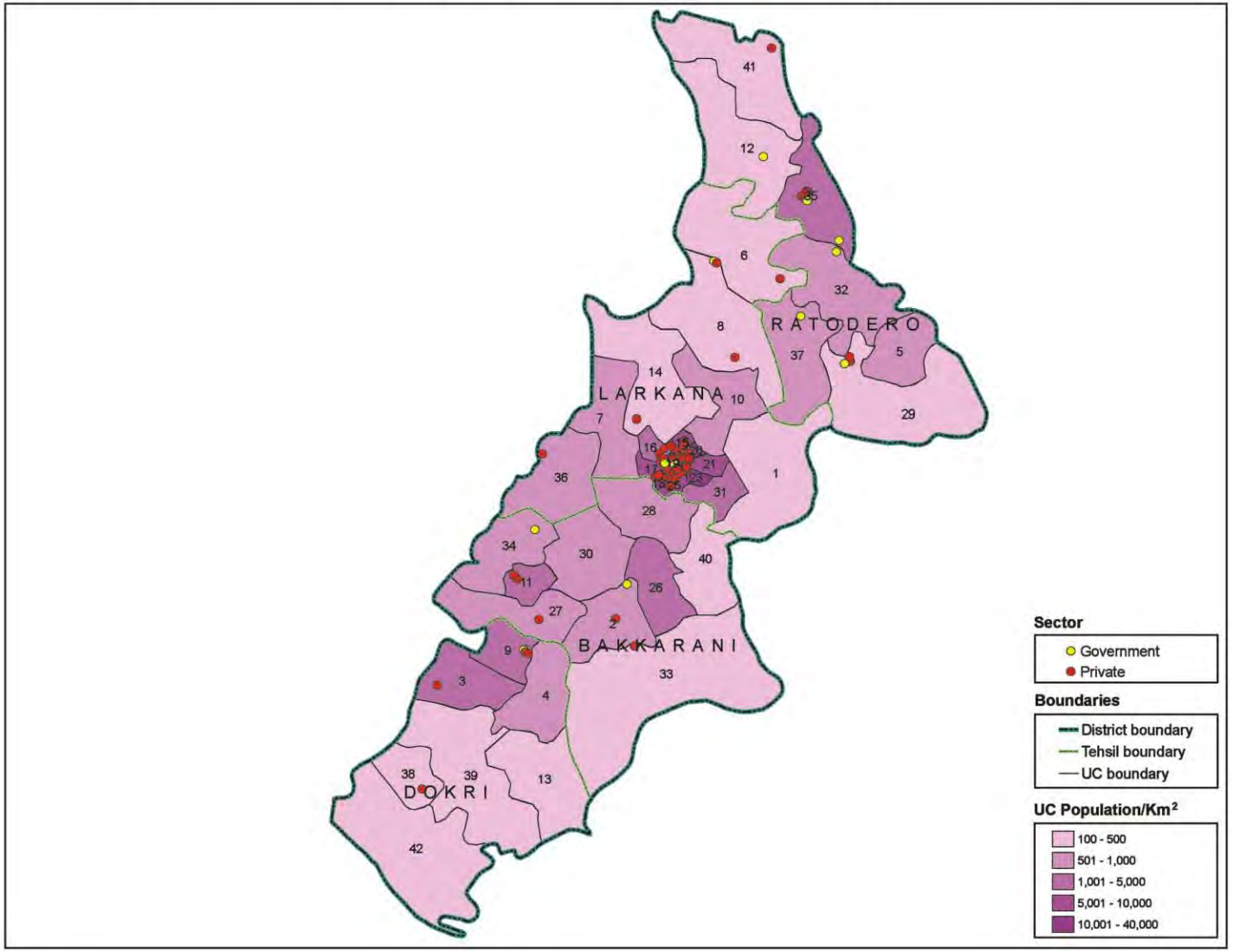
Map 4.6: Location of IUD facilities in Larkana district, by population density of union council



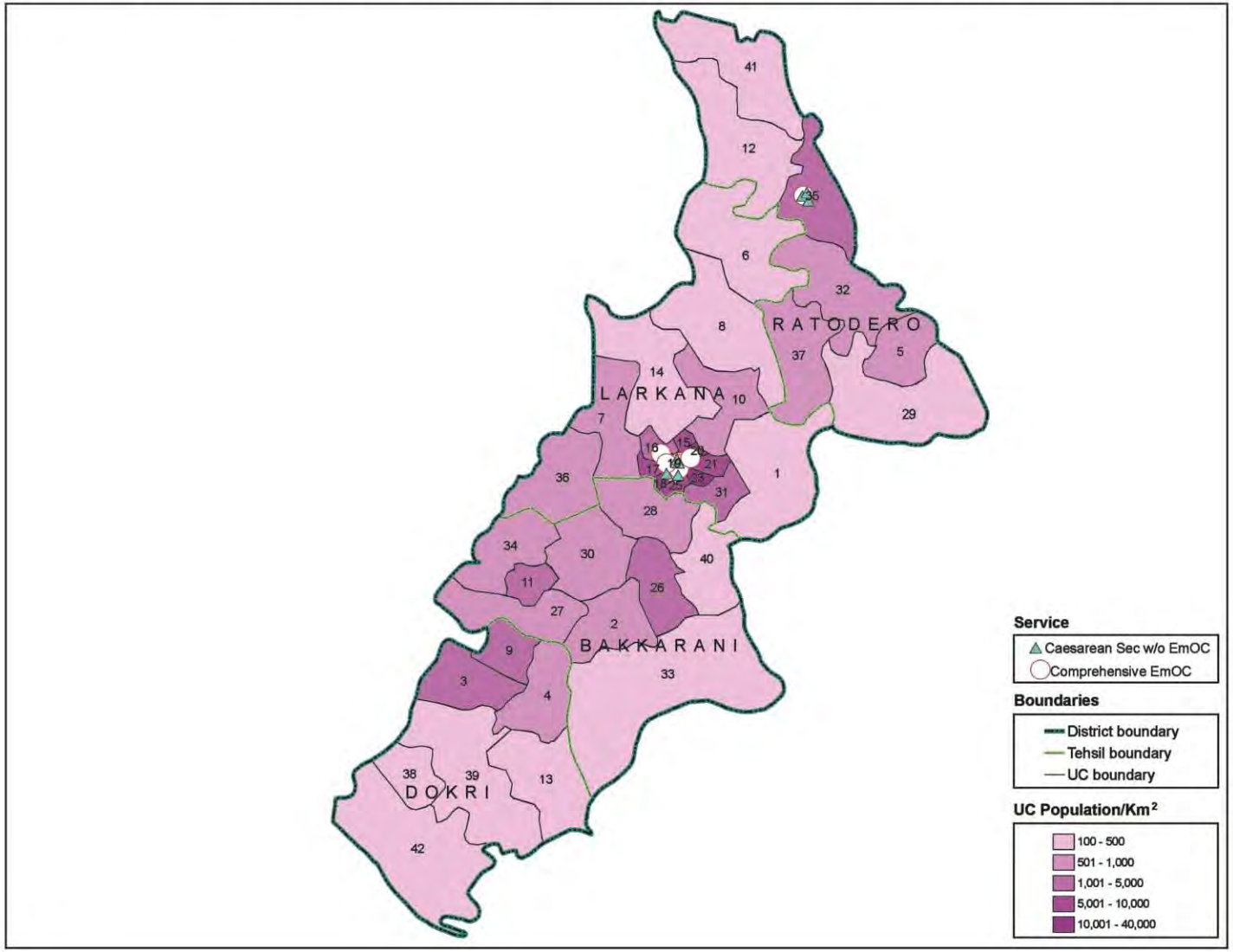
Map 4.7: Location of injectables contraceptive services in Larkana district, by population density of union council



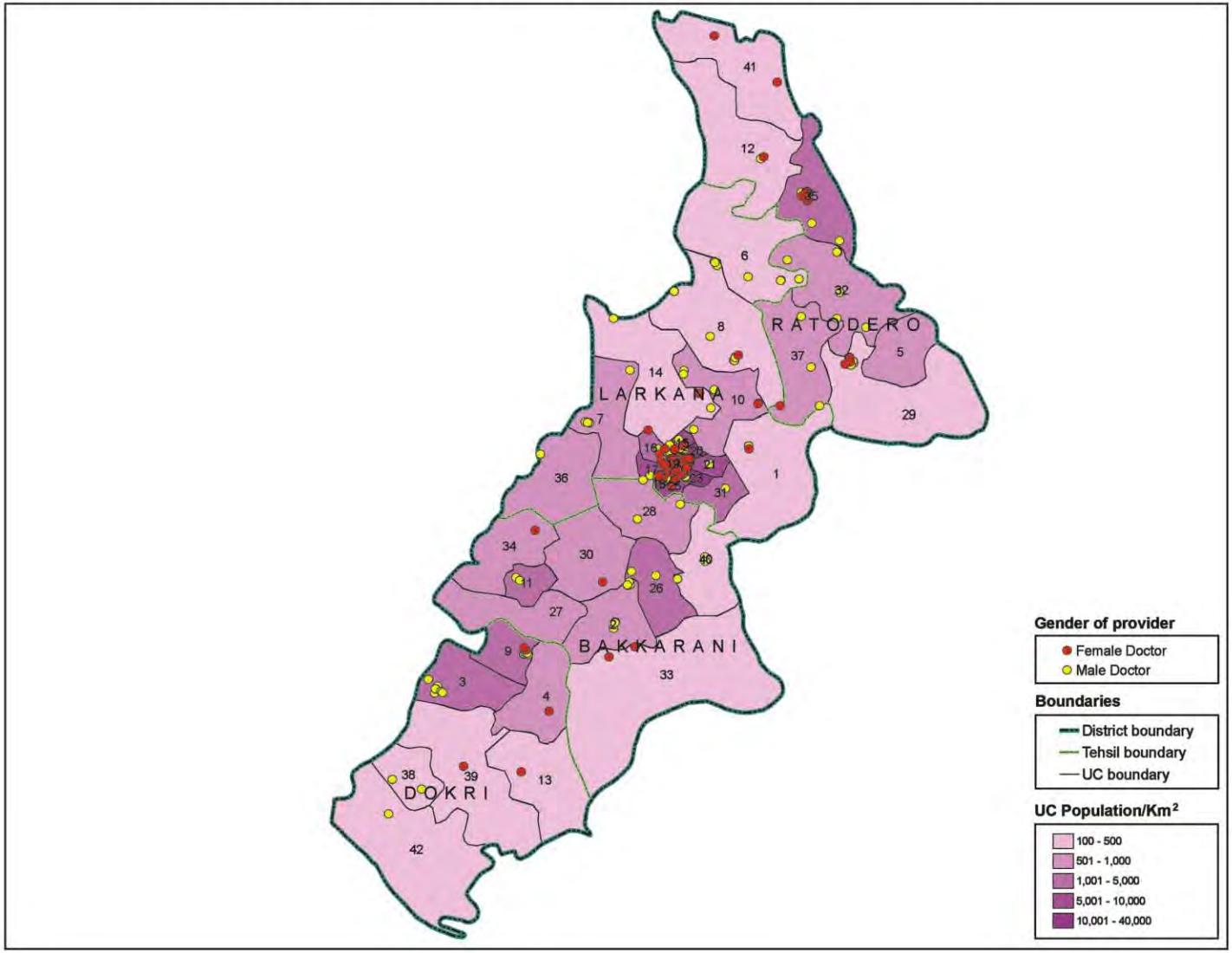
Map 4.8: Location of essential obstetric services in Larkana district, by population density of union council



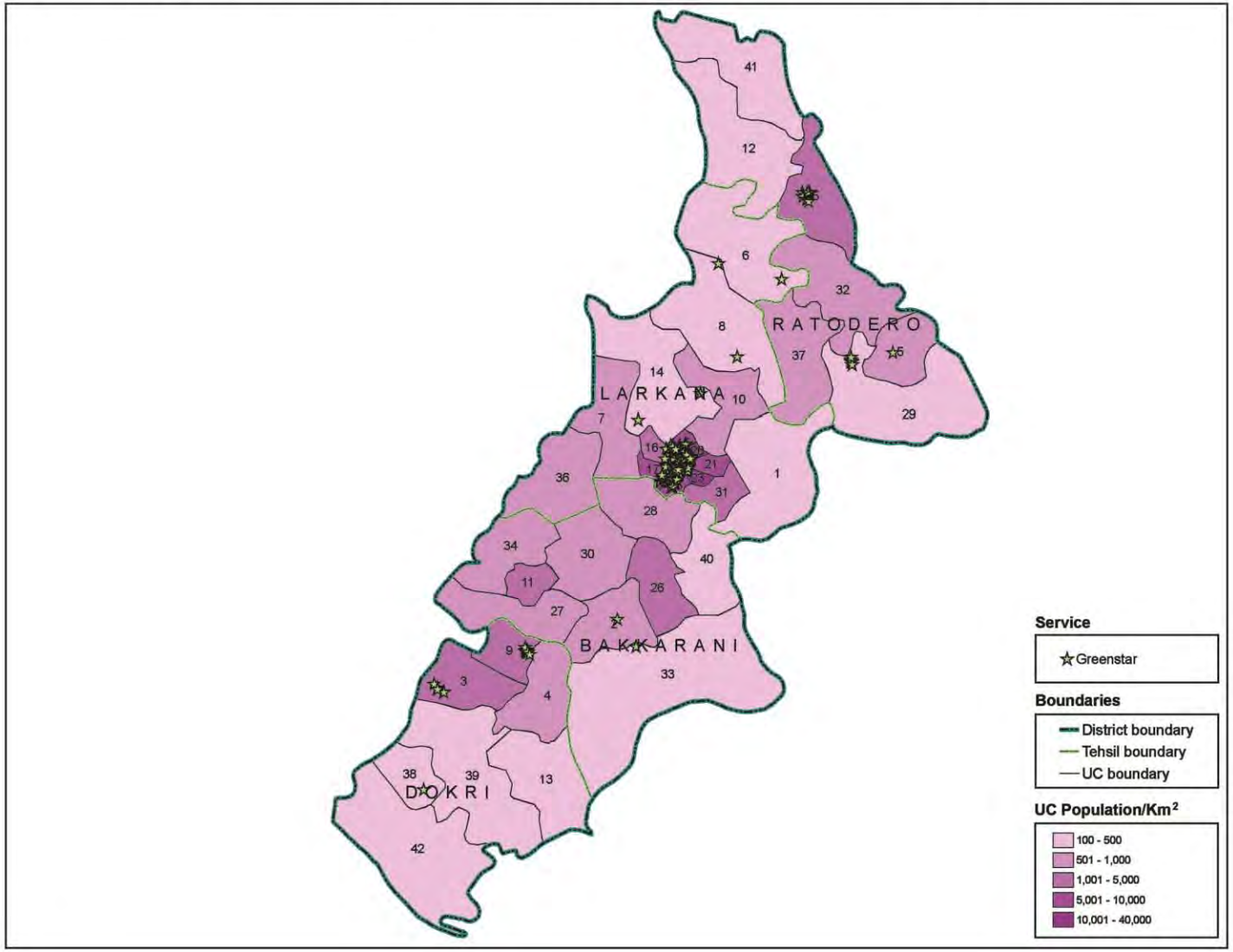
Map 4.9: Location of emergency obstetric care facilities in Larkana district, by population density of union council



Map 4.10: Location of doctors in Larkana district, by gender and population density of union council



Map 4.11: Location of Greenstar Social Marketing SDPs in Larkana district, by population density of union council



Chapter 5

Fertility

The main objective of this baseline survey was to monitor and evaluate progress on the level of knowledge and acceptance of birth spacing methods to improve maternal and child health. Some information on fertility, such as the number of children ever born and living children, was collected from the currently married women interviewed. This information was used to obtain the level of cumulative fertility.

Other information collected in this baseline survey included the date of birth for all live births, and whether those children were still alive at the time of the survey. If a mother was unable to remember the date of birth, she was asked how long ago her live birth was. From these responses, births that occurred during the last three years were ascertained. The number of births obtained through this procedure was then used to analyze current fertility. For a family planning program, it is essential to be informed about fertility levels to understand couples' responses to family planning.

Cumulative Fertility

Children Ever Born and Living

The number of children a woman has ever borne reflects fertility in the past; it therefore provides a somewhat different picture of fertility levels, trends, and differentials than do period measures of fertility, such as the CBR and the TFR. Table 5.1 shows the percent distribution of all currently married women by the number of children ever born (CEB). The table shows these distributions by the age of the woman at the time of the survey.

Table 5.1: Distribution of MWRA by age of mother and number of children ever born

	Children ever born						
Age group	0	1-2	3-4	5 or more	%	Mean CEB	N
15-19	52.0	48.0	0.0	0.0	100.0	0.6	50
20-24	17.5	64.1	14.6	3.9	100.0	1.7	103
25-29	11.5	31.1	32.0	25.4	100.0	3.1	122
30-34	5.4	9.7	24.7	60.2	100.0	5.2	93
35-39	7.1	4.0	14.1	74.7	100.0	6.3	99
40-44	5.3	1.3	3.9	89.5	100.0	7.1	76
45-49	4.9	6.6	9.8	78.7	100.0	7.1	61
Total	**12.7**	**24.2**	**16.6**	**46.5**	**100.0**	**4.4**	**604**

The table shows that early childbearing was fairly common in Larkana. As expected, the mean number of children ever born (Table 5.1) and living children (Table 5.2) increased with the age of the mother, as would be expected in data of good quality. Table 5.3 shows the mean number of both ever born and surviving sons and daughters. The mean number of children ever born increased from 0.6 in age group 15-19 years to 7.1 in the highest two age groups (40-44 and 45-49 years). Among women aged 15-49 in Larkana, the mean number of children ever born was 4.4 for currently married women. On average, women aged 40-49 had 6 living children; each woman of this age group had lost one child during her reproductive life.

Table 5.2: Distribution of MWRA by age of mother and number of living children

	Number of living children						
Age group	0	1-2	3-4	5 or more	%	Mean LC	N
15-19	58.0	42.0	0.0	0.0	100.0	0.5	50
20-24	17.5	66.0	15.5	1.0	100.0	1.6	103
25-29	13.9	34.4	33.6	18.0	100.0	2.7	122
30-34	6.5	16.1	30.1	47.3	100.0	4.3	93
35-39	7.1	5.1	16.2	71.7	100.0	5.5	99
40-44	5.3	6.6	9.2	78.9	100.0	6.1	76
45-49	6.6	6.6	16.4	70.5	100.0	6.2	61
Total	**14.1**	**26.5**	**19.5**	**39.9**	**100.0**	**3.8**	**604**

Table 5.1 also shows that 48 percent of married women 15-19 years of age had already given birth to at least one child. Women aged 45-49 had virtually completed childbearing. Among currently married women in this age group, 16.4 percent reached the end of

childbearing with fewer than five children ever born and 78.7 percent had five or more children ever born. Data show that 95 percent women of aged 45-49 had at least one live birth in their reproductive period and about 5 percent were nulliparous. The sex ratio of children ever born was 105 males per 100 females, whereas the sex ratio of living children was 100.

Table 5.3: Mean number of children ever born and children surviving, by sex of child and age of mother

	Ever born			Surviving			
Age group	**Boys**	**Girls**	**Total**	**Boys**	**Girls**	**Total**	**N**
15-19	0.3	0.3	0.6	0.3	0.2	0.5	50
20-24	0.9	0.7	1.7	0.8	0.7	1.6	103
25-29	1.6	1.5	3.1	1.4	1.3	2.7	122
30-34	2.6	2.6	5.2	2.2	2.1	4.3	93
35-39	3.2	3.1	6.3	2.7	2.8	5.5	99
40-44	3.5	3.6	7.1	2.9	3.2	6.1	76
45-49	4.0	3.2	7.1	3.5	2.7	6.2	61
Total	**2.3**	**2.2**	**4.5**	**1.9**	**1.9**	**3.8**	**604**

Differentials in Children Ever Born and Surviving

Table 5.4 shows that differences in mean numbers of children by literacy and educational level of currently married women were pronounced. On average, literate women had 2.2 fewer children than illiterate women. As expected, fertility also declined with the level of education. Those who had "up to primary" education had 3.6 children ever born on average as compared to 4.9 children to those women who had no schooling. Women who had "up to secondary" education had 2.5 children, and those educated in college had 1.9 children ever born.

Differentials were also observed on the basis of literacy and economic activity of husbands. Those women who had literate husbands had 4.2 children compared to 4.7 children ever born to those who had illiterate husbands. Similarly, women with husbands in private service had the highest number of children ever born (5.4 children), while women whose husbands were abroad had the lowest number of children ever born (2.9 children).

Table 5.4: Mean number of children ever born, living and dead by background characteristics

Characteristic	Mean number of CEB	Mean number of LC	Proportion dead	N
Literacy of respondent				
Literate	2.7	2.5	0.07	136
Illiterate	4.9	4.2	0.15	460
Schooling of mother				
No education	4.9	4.2	0.15	425
Up to primary	3.6	3.2	0.12	108
Up to secondary	2.5	2.3	0.08	42
Above secondary	1.9	1.8	0.03	21
Residence				
Rural	4.5	3.7	0.17	365
Urban	4.4	3.9	0.11	239
Literacy of respondent's husband				
Literate	4.2	3.7	0.13	347
Illiterate	4.7	3.9	0.17	231
Schooling of husband				
No education	4.7	3.9	0.17	224
Up to primary	5.0	4.2	0.17	119
Up to secondary	3.5	3.1	0.11	98
Above secondary	4.0	3.7	0.08	140
Standard of living index				
Low	4.7	3.8	0.20	67
Medium low	4.3	3.6	0.17	193
Medium high	4.6	4.0	0.14	207
High	4.1	3.8	0.08	137
Economic activity/ occupation of husband				
Agriculture/livestock/poultry	4.5	3.7	0.18	161
Petty trader	4.3	3.8	0.11	82
Labor (daily wages)	4.2	3.5	0.17	157
Government service	4.7	4.2	0.11	103
Private service	5.4	4.7	0.13	27
Own business	4.1	3.9	0.04	18
Working abroad	2.9	2.7	0.09	12
Unemployed	4.2	3.8	0.10	35
Others	4.5	4.5	0.00	4
Don't know	8.5	8.5	0.00	2
Total	**4.4**	**3.8**	**0.14**	**601**

A comparison of mean numbers of children ever born and surviving children showed that the survival of children increased with the literacy and educational level of mothers. The chances of survival of children were also better if the father was literate.

Table 5.5 further explains the relationship of age of mothers and literacy with mean number of children ever born and their survival. It is evident that the mean number of children ever born to literate mothers was lower (2.7 children) compared to those mothers who were illiterate (4.9 children). Similarly, the survival of children with literate mothers was far better than those born to illiterate mothers. Mean number of children ever-born to younger literate mothers was lower and their survival was better than children born to mothers in older age groups. Literate mothers were younger than illiterate mothers. In the below 30 age group, 66 percent were literate, as compared to 40 percent who were illiterate. It is not only that literate women had fewer children overall, but younger literate women also had fewer children ever born compared to illiterate women.

Table 5.5: Mean number of children ever born and living by age and literacy of mother

	Literate				Illiterate			
Age group	Mean number of CEB	Mean number of LC	N	%	Mean number of CEB	Mean number of LC	N	%
15-19	0.5	0.4	18	13.2	0.8	0.7	32	7.0
20-24	1.5	1.4	33	24.3	1.8	1.6	69	15.0
25-29	2.4	2.2	39	28.7	3.4	2.9	81	17.6
30-34	3.2	3	17	12.5	5.6	4.6	74	16.1
35-39	5.1	4.8	18	13.2	6.5	5.6	80	17.4
40-44	6.9	6.3	7	5.1	7.2	6.2	68	14.8
45-49	5.0	5.0	4	2.9	7.2	6.1	56	12.2
Total	**2.7**	**2.5**	**136**	**100.0**	**4.9**	**4.2**	**460**	**100.0**

Current Fertility

Crude Birth Rate

Although the crude birth rate (CBR) is a crude measure of fertility, it is the most commonly understood and used fertility measure. In this survey, it is calculated from the number of births which occurred during the last three years prior to the survey and the mid-period

total population in the sample households. The baseline survey provides an estimate of 33 births per thousand population (Table 5.6).

Age-specific Fertility Rates and Total Fertility Rate

The total fertility rate (TFR) is a more refined fertility measure than the CBR. Age-specific fertility rates (ASFRs) and the TFR were calculated based on births among currently married women and the number of women living in the sample households. One of the limitations of measuring ASFRs was the low number of births in the sample during the last three years. The findings show a pattern of ASFRs common in developing countries; rates rose rapidly until age 25-29 and then declined with increasing age. A TFR of 3.9 for the period 2004-2007 was obtained from the set of ASFRs calculated from the data presented in Table 5.6 and compared with 4.3 for Sindh and 4.1 for Pakistan as a whole found in the PDHS (NIPS/PDHS, 2008).

Table 5.6: Number of women in sample households and number of births during the last three years before the survey, by age of women, and ASFRs, TFR and CBR

Age group	Women	Births	Age-specific fertility rates (ASFRs)
15-19	307	223	21.6
20-24	260	95	121.8
25-29	162	100	205.8
30-34	116	62	178.2
35-39	111	47	141.1
40-44	91	21	76.9
45-49	66	6	27.8
Total	**1153**	**353**	**na**
TFR: 3.9			
CBR: 33			

na=not applicable.

Mothers with Children Under Five Years

If mothers have a child while breastfeeding an older child, they are often less able to produce breast milk for the older child (Adair et al., 1994). When children are weaned too soon, their growth suffers; they are more likely to suffer from diarrheal diseases (Bohiler et al., 1995). Milk diminution is more likely to occur as women have more children and are

undernourished (Garner et al., 1994). In addition, when children are close in age, they compete for resources as well as for maternal care. The mother may also not be able to breastfeed the newborn properly, placing the newborn at higher risk for nutritional deficiency and infectious diseases contracted from older siblings.

Table 5.7 shows a significant number of women with the burden of caring for several young children. Among those women who already had two living children under 5 years of age, 21 percent were currently pregnant. Moreover, among women who had 3 living children under 5 years of age, 14 percent were currently pregnant. For such mothers, it is particularly important for their health and that of their children to ensure that birth spacing is part of their married life at this point.

Table 5.7: Distribution of mothers by pregnancy status and number of children under 5 years

	Currently pregnant		Currently not pregnant		Total	
Children <5 years	**N**	**%**	**N**	**%**	**%**	**N**
0	24	9.7	224	90.3	100.0	248
1	39	20	156	80	100.0	195
2	28	21.2	104	78.8	100.0	132
3	4	13.8	25	86.2	100.0	29
N	**95**	**15.7**	**509**	**84.3**	**100.0**	**604**

Preceding Birth Interval

Women with short birth intervals are at higher risk for delivering premature, low-birth-weight or small-for-gestational-age infants (Fuentes-Affelick and Hessol, 2000; Miller et al., 1995; Zhu et al., 1999). The length of the preceding birth interval is very important for the health of both mothers and babies. Table 5.8 shows the length of the last closed birth interval for women with two or more births by background characteristics of mothers at the time of the survey.

A short interval has traditionally been viewed as a risk factor for poor pregnancy outcomes, particularly neonatal mortality in developing countries (Cleland and Sathar, 1984). It has been observed in several studies that the death risks of an index child whose birth closes a short birth interval are higher than those experienced by an index child whose birth closes a longer birth interval (Mahmood, 2002). Also, children born within the preceding interval of

18 months experienced higher mortality risks during infancy than those born in an interval of two to three years (Cleland and Sathar, 1984).

Table 5.8 shows that almost 17.3 percent of children were born within 18 months of the last birth. Almost 68 percent were born with a birth interval of less than 36 months, while 32 percent were born after three years or more. The differentials by mother's age, educational level and standard of living index are also shown. Younger women, particularly in the age group of 20-24 years were substantially more likely to have short birth intervals.

Table 5.8: Distribution of women with preceding birth intervals (birth to birth) by background characteristics

Characteristic	Less than 18 months	18 - 23 months	24 - 35 months	36 - 47 months	48 or more months	Total	N
Age group							
15 - 19	20.0	0.0	60.0	0.0	20.0	100.0	5
20 - 24	25.9	22.2	35.2	13.0	3.7	100.0	54
25 - 29	17.1	20.0	38.1	21.0	3.8	100.0	105
30 - 34	22.1	13.0	28.6	14.3	22.1	100.0	77
35 - 39	6.9	19.4	40.3	9.7	23.6	100.0	72
40 - 44	7.9	5.3	28.9	21.1	36.8	100.0	38
45 - 49	31.6	5.3	21.1	10.5	31.6	100.0	19
Number of live births							
2	18.9	15.1	41.5	17.0	7.5	100.0	53
3	21.3	17.0	31.9	14.9	14.9	100.0	47
4	24.5	18.4	30.6	18.4	8.2	100.0	49
5	18.2	18.2	36.4	15.9	11.4	100.0	44
6+	13.6	15.3	33.9	14.1	23.2	100.0	177
Education level							
No education	16.4	13.0	33.8	16.7	20.1	100.0	269
Up to primary	19.4	25.4	43.3	9.0	3.0	100.0	67
Up to secondary	16.7	16.7	29.2	20.8	16.7	100.0	24
Above secondary	50.0	25.0	25.0	0.0	0.0	100.0	4
Standard of living index							
Low	13.3	17.8	28.9	24.4	15.6	100.0	45
Medium low	14.7	13.8	35.8	18.3	17.4	100.0	109
Medium high	18.1	20.3	37.7	9.4	14.5	100.0	138
High	21.8	11.5	30.8	16.7	19.2	100.0	78
Total	**17.3**	**16.2**	**34.6**	**15.4**	**16.5**	**100.0**	**370**

Chapter 6

Maternal and Neonatal Care

Birth spacing is an integral part of maternal and neonatal care. Adequate spacing of births improves the health of mothers and babies. In this survey, a small battery of questions was asked regarding the most recent child born during the past four years; these questions reflect some of the essential indicators of maternal and neonatal care. A total of 347 women out of the 604 women interviewed, had borne a child during the past four years, and these women were asked questions about maternal and neonatal care.

Antenatal Care

Antenatal check-ups allow for skilled health personnel to advise expectant mothers as to how to best take care of themselves and their unborn baby during pregnancy, to prepare them for childbirth and care of the newborn, and to identify possible problems during pregnancy and delivery. The Ministry of Health recommends at least three antenatal visits during pregnancy, preferably four. Traditionally, many women, understanding childbirth as a natural experience and perhaps not finding health providers nearby, have not gone to skilled providers for antenatal care. In recent years, however, these proportions have been increasing in Pakistan (NIPS/PDHS, 2008). Table 6.1 and Figure 6.1 show the numbers of ANC visits for the last birth of women who had delivered during the previous four years. About 52 percent of the sample respondents had obtained at least one antenatal care visit during the last pregnancy. This was slightly higher than the level obtained for Larkana in the PSLM Survey 2004-05 (48 percent). It was, however, lower than the figures for the province of Sindh (70 percent) or the level obtained nationally in the PDHS (61 percent) (Government of Pakistan, 2006; NIPS/PDHS, 2008). Twenty-eight percent had at least three such visits and 21 percent had more than three visits. Urban residents were more likely to have at least one check-up (60 percent), and to have more visits, than rural mothers (47 percent had at least one check-up).

Table 6.1: Distribution of ANC check-up during last pregnancy by residence

Number of ANC visits	Rural		Urban		Total	
	N	%	N	%	N	%
No visit	116	53.5	52	40.0	168	48.4
1-2 visits	53	24.4	29	22.3	82	23.6
3 visits	17	7.8	8	6.2	25	7.2
4+ visits	31	14.3	41	31.6	72	20.7
Total	**217**	**100.0**	**130**	**100.0**	**347**	**100.0**

Figure 6.1: Percentage of MWRA by number of antenatal visits during last pregnancy

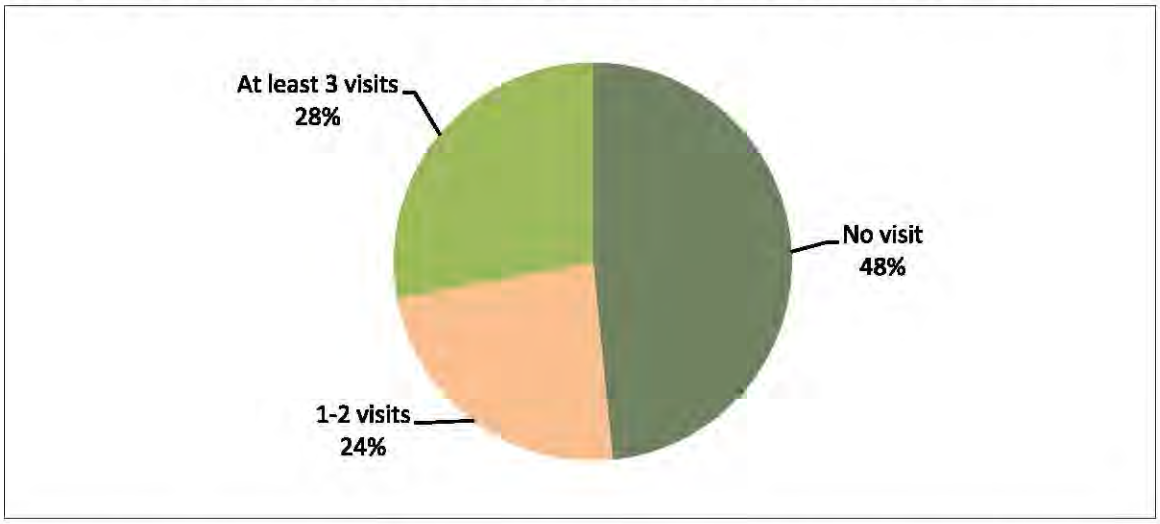


Figure 6.2 shows that many of these visits were in response to some problem, rather than for a routine check-up. More than two-thirds (68 percent) of the first antenatal visits were for curative purposes.

Figure 6.2: Percentage of MWRA by reason for first antenatal visit during last pregnancy

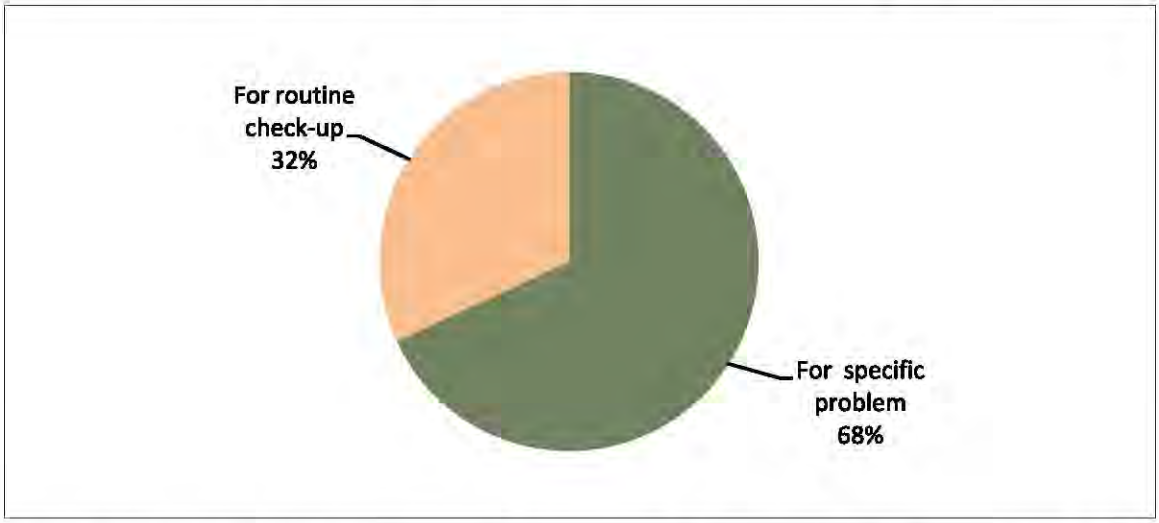


Figure 6.3 shows that for 36 percent of the women, the first visit took place within the first three months of gestation, and 35 percent of the women went for their first check-up during the third trimester of their pregnancy.

Figure 6.3: Percentage of MWRA by gestational age at first antenatal visit during last pregnancy

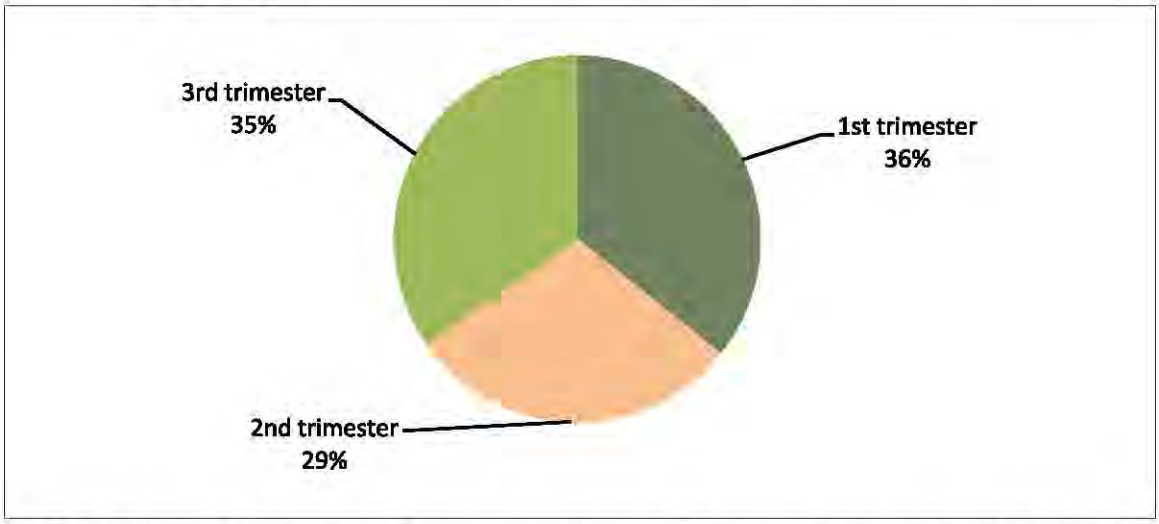


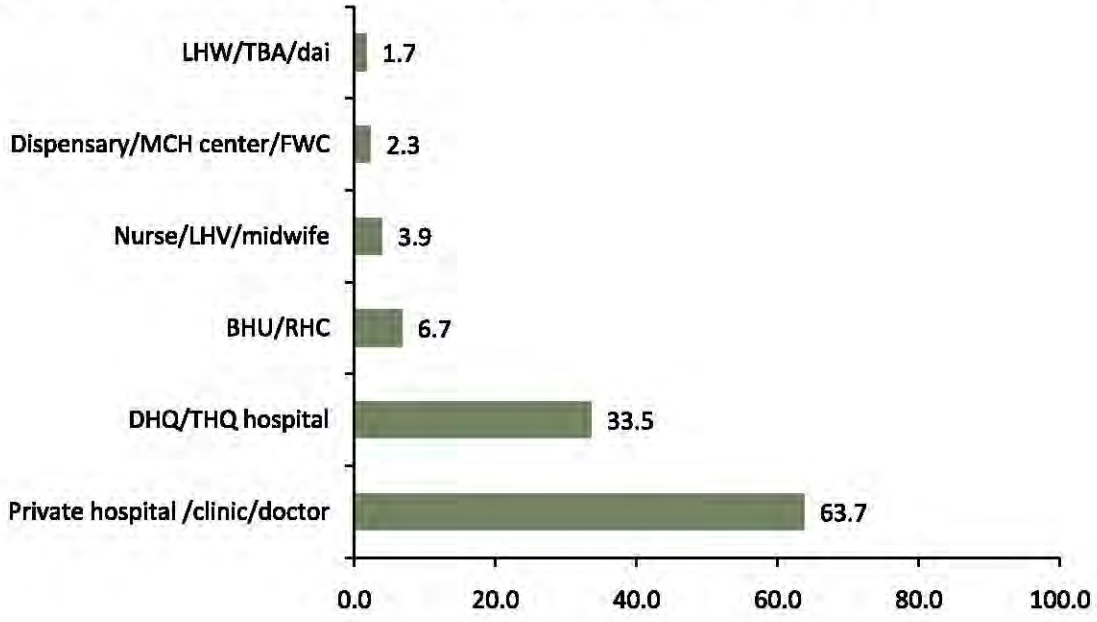
Table 6.2 shows the locations where respondents made one or more antenatal visits. Most antenatal visits took place in private sector facilities. The most common providers of antenatal care in the public sector were DHQ/THQ hospitals, followed by BHUs and RHCs; other providers were less common.

Table 6.2: Facilities/service providers mentioned for one or more antenatal visits by residence

	Rural		Urban		Total	
Facility/provider	**N**	**%**	**N**	**%**	**N**	**%**
BHU/RHC	8	7.9	4	5.1	12	6.7
DHQ/THQ hospital	42	41.6	18	23.1	60	33.5
Private hospital/clinic/doctor	57	57.4	56	71.8	114	63.7
Dispensary/MCH center/FWC	2	2.0	2	2.6	4	2.3
LHW/TBA/dai	2	2.0	1	1.3	3	1.7
Nurse/LHV/midwife	2	2.0	5	6.4	7	3.9
N	**101**	**na**	**78**	**na**	**179**	**na**

na = not applicable; respondents could name more than one provider.

Figure 6.4: Location where respondents made one or more antenatal visits



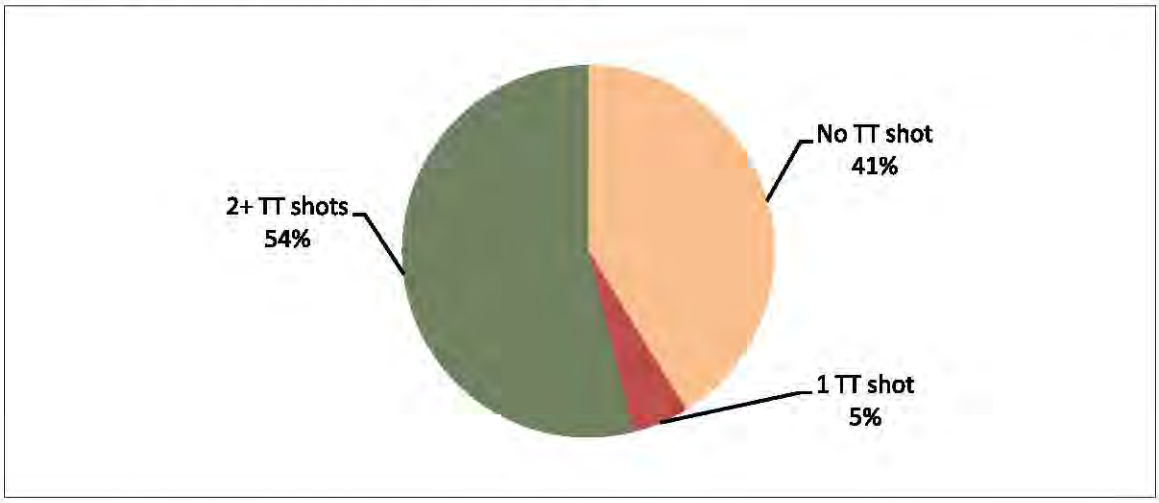
Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn or mother. Two doses in a pregnancy are sufficient to prevent tetanus. However, if the woman was immunized during her previous pregnancy only one dose may be needed. Five doses are considered sufficient for lifetime protection. According to PSLMS 2004-05, 54 percent of the mothers in Larkana had received at least one TT shot. According to the PDHS 2006-07, 51 percent in Sindh and 53 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Figure 6.5 and Table 6.3 show that 59 percent of mothers had received at least one shot during their last pregnancy, and 54 percent had received two TT shots. While tetanus immunization appears to be increasing in Larkana, a substantial proportion of mothers remain unprotected. It is interesting to note that a higher percentage (47.7 percent) of women in urban areas reported not having any TT shot as compared to women in rural areas (37.3 percent), whereas 57 percent of the women in rural areas had received 2 or more TT shots compared to 48 percent in urban areas.

Table 6.3: Distribution of mothers according to residence by status of tetanus toxoid injections during last pregnancy

Number of injections	Rural		Urban		Total	
	N	%	N	%	N	%
No TT shot	81	37.3	62	47.7	143	41.2
One TT shot	12	5.5	5	3.8	17	4.9
2+ TT shots	124	57.1	63	48.5	187	53.9
Total	**217**	**100.0**	**130**	**100.0**	**347**	**100.0**

Figure 6.5: Tetanus immunization at last delivery



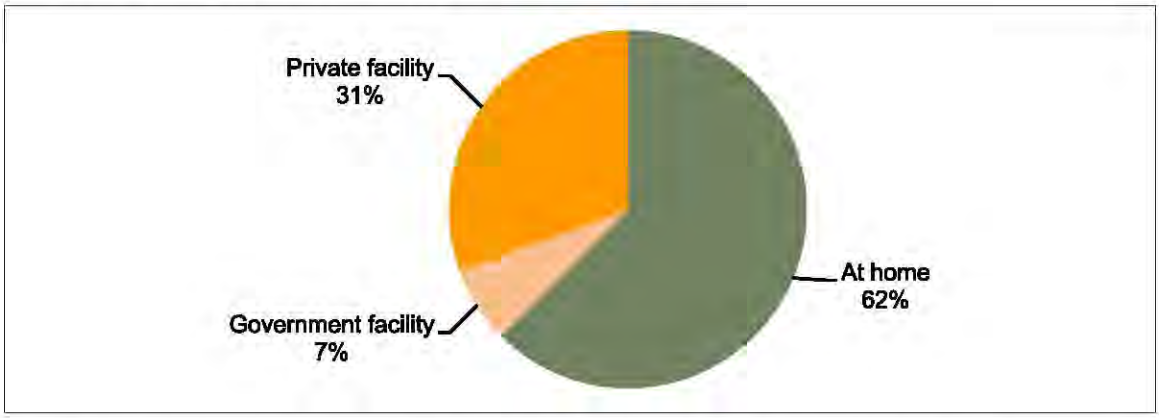
Location and Attendance at Delivery

Among the most important ways to reduce maternal mortality is to increase the proportion of mothers delivering in a health facility with the support of a trained birth attendant. Although these proportions have been historically low in Pakistan and contributed substantially to high maternal mortality, they have been rising in recent years. In Larkana, according to the 2004-05 PSLMS, 20 percent of deliveries took place in institutions, compared with PDHS 2006-07 figures of 42 percent for Sindh and 34 percent nationally (Government of Pakistan, 2006; NIPS/PDHS, 2008). In the present survey, 38 percent of the recent deliveries were carried out in some health facility (Table 6.4 and Figure 6.6). This percentage was higher in urban areas (42 percent) than in rural areas (35 percent).

Table 6.4: Distribution of mothers by place of last delivery and residence

	Rural		Urban		Total	
Place of last delivery	**N**	**%**	**N**	**%**	**N**	**%**
At home	141	65.0	76	58.5	217	62.5
BHU/RHC	3	1.4	3	2.3	6	1.7
DHQ/THQ hospital	10	4.6	8	6.2	18	5.2
Pvt. hospital/clinic	63	29.0	43	33.1	106	30.5
Total	**217**	**100.0**	**130**	**100.0**	**347**	**100.0**

Figure 6.6: Distribution of mothers by location of delivery

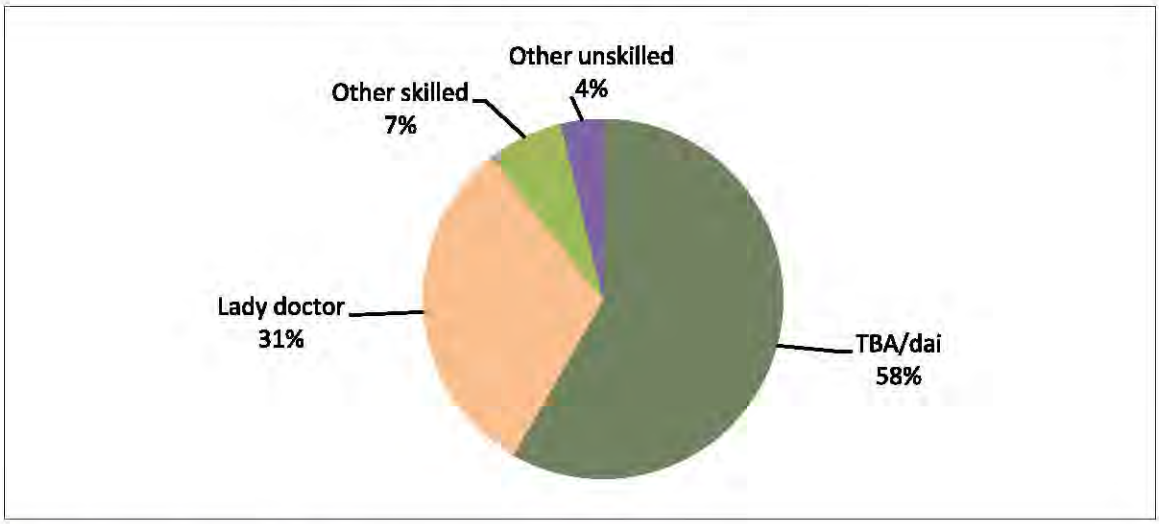


Likewise, the proportion of births delivered by skilled attendants was higher than expected from previous data. In this survey, 38 percent of reported deliveries in the previous 4 years were delivered by a skilled birth attendant, with higher proportions in urban areas (Table 6.5 and Figure 6.7). In the PSLMS 2004-05 for Larkana, only 20 percent of the births were delivered by a skilled attendant; in the PDHS 2006-07, the corresponding figures were 44 percent for Sindh and 39 percent for Pakistan as a whole (Government of Pakistan, 2006; NIPS/PDHS, 2008). Most of the births attended by a skilled attendant in this household survey were reportedly attended by a lady doctor. The term "doctor," however, may in such interviews mean a paramedic, such as a Lady Health Visitor. About 58 percent of the births were delivered by *dais* (traditional birth attendants), while only 2.3 percent, mostly in rural areas, the deliveries were carried out by a relative or neighbor who was not a dai.

Table 6.5: Distribution of mothers by attendent of last delivery and residence

	Rural		Urban		Total	
Birth attendant and skill level	**N**	**%**	**N**	**%**	**N**	**%**
TBA/dai	135	61.9	68	52.3	203	58.3
LHW	2	0.9	3	2.3	5	1.4
Nurse/LHV/midwife	13	6	11	8.4	24	6.9
Lady doctor	62	28.4	46	35.4	108	31
Female relative/friend/neighbor(not dai)	6	2.8	2	1.5	8	2.3
Total	**218**	**100.0**	**130**	**100.0**	**348**	**100.0**
Skilled birth attendant	75	34.4	57	43.8	132	37.9
Unskilled birth attendant	143	65.6	73	56.2	216	62.1

Figure 6.7: Distribution of mothers by attendant at last delivery



Postpartum Care

For both the health of the mother and the health of the newborn, a new mother and baby should be followed up for at least about 6 weeks after delivery. MoH guidelines recommend at least one postpartum visit after discharge during the first 42 days after delivery. However, this is a major weakness of maternal and newborn health care in Pakistan. Women who deliver at home rarely go for any postnatal check-up, and women who deliver in facilities are usually seen while they are in the facility, but not after that. In this survey, all of the respondents who had institutional deliveries had a postnatal check-up within 24 hours; among those who had non-institutional deliveries only 3 of 217 mothers (1.4 percent) had a postnatal check-up within 24 hours and 7 (3.2 percent) had one after 24 hours (Table 6.6).

Table 6.6: Distribution of mothers by status of postnatal check-up and place of delivery

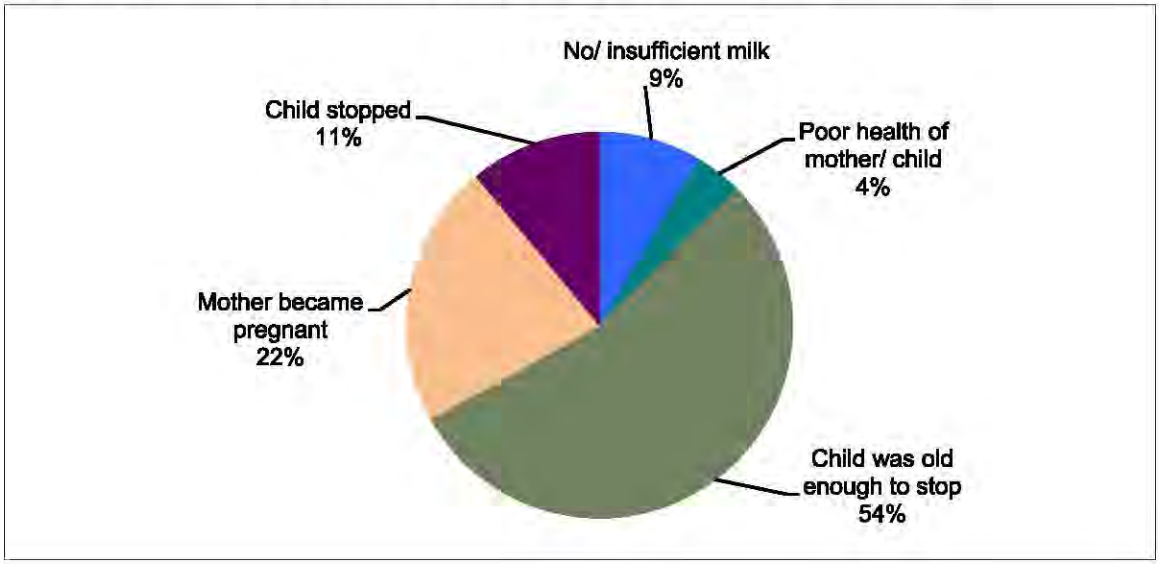
	Postnatal check-up within 24 hours		Postnatal check-up after 24 hours		Did not have a postnatal check-up		Total	
Place of delivery	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Institution	130	100.0	0	0.0	0	0.0	130	100.0
Non-institution	3	1.4	7	3.2	207	95.4	217	100.0
Total	**133**	**38.3**	**7**	**2.0**	**207**	**59.7**	**347**	**100.0**

With regard to family planning, the absence of postpartum visits represents a missed opportunity to talk to the mother about birth spacing. Much international evidence supports the value of the postpartum period as a critical time for the mother to focus on family planning, its role in the next birth interval, and how and when to take steps to end childbearing (WHO, 2006).

Breastfeeding

Breastfeeding is a critical component of newborn and infant health. In addition, it is a primary determinant of the length of postpartum amenorrhea. Breastfeeding can be deliberately used to delay pregnancy, either through a formal procedure such as "lactational amenorrhea method" (LAM), or more informally through the assumption that breastfeeding protects against pregnancy. Virtually all Pakistani women breastfeed their children to some extent. Breastfeeding is normally carried out for a substantial time; the median length of breastfeeding for the last baby (not currently being breastfed) was 18 months, and the most common length was 24 months. Exclusive breastfeeding was reportedly widespread. Seventy-nine percent of mothers reported breastfeeding their last child for at least 4 months without supplementation. As shown in Figure 6.8, four main reasons were given for discontinuing breastfeeding: the child was old enough (54 percent), mother became pregnant (22 percent), child stopped (11 percent), and no/insufficient milk (9 percent).

Figure 6.8: Distribution of mothers by reason for discontinuing breastfeeding



Chapter 7

Preference for Children

In order to meet the family planning needs of couples, it is essential to understand how they feel about the number and timing of children they want. Couples' views on this typically evolve over the course of their reproductive years; in the beginning, they want their first children quickly, while toward the end of their reproductive lives, they are quite sure they want to stop. At some point in the middle, they may go through a period of ambivalence where their views are uncertain and conflicted. Husbands and wives may or may not agree on these matters, and may or may not communicate well. Often it is difficult to learn what couples truly feel on these issues because they themselves may not be certain. We can however, ask questions, record responses, and investigate in as much depth as possible.

Ideal Number of Children

One way of investigating fertility preference is to ask respondents, regardless of current fertility status, how many children they would ideally want. The exact wording, asked of female respondents, was (English translation): "If you could choose exactly the number of children to have in your whole life, how many would that be?" Table 7.1 shows the responses.

The median "ideal" number, in the sense indicated above, was five children; 45 percent of the respondents wanted four or fewer children with substantial numbers citing 5 or more. However, only 7 percent said that they wanted two or fewer children. These proportions varied according to residence; 52 percent of urban women wanted 4 or less children, compared to 41 percent of the rural women who had the same desire. Overall, more than 2 percent of the women in Larkana also gave a non-numeric response to this question, such as up to God.

Table 7.1: Distribution of MWRA with ideal number of children for their family by residence

Ideal number of children	Rural		Urban		Total	
	N	%	N	%	N	%
1	1	0.3	1	0.4	2	0.3
2	24	6.6	19	7.9	43	7.1
3	16	4.4	22	9.2	38	6.3
4	109	29.9	83	34.7	192	31.8
5	62	17.0	33	13.8	95	15.8
6+	140	38.5	78	32.6	218	36.2
Other non-numeric response	8	2.2	2	0.8	10	1.7
Up to God	4	1.1	1	0.4	5	0.8
Total	**364**	**100.0**	**239**	**100.0**	**603**	**100.0**
Median	5	na	4	na	6	na

na = not applicable.

Desire for More Children

Levels of Desire for More Children

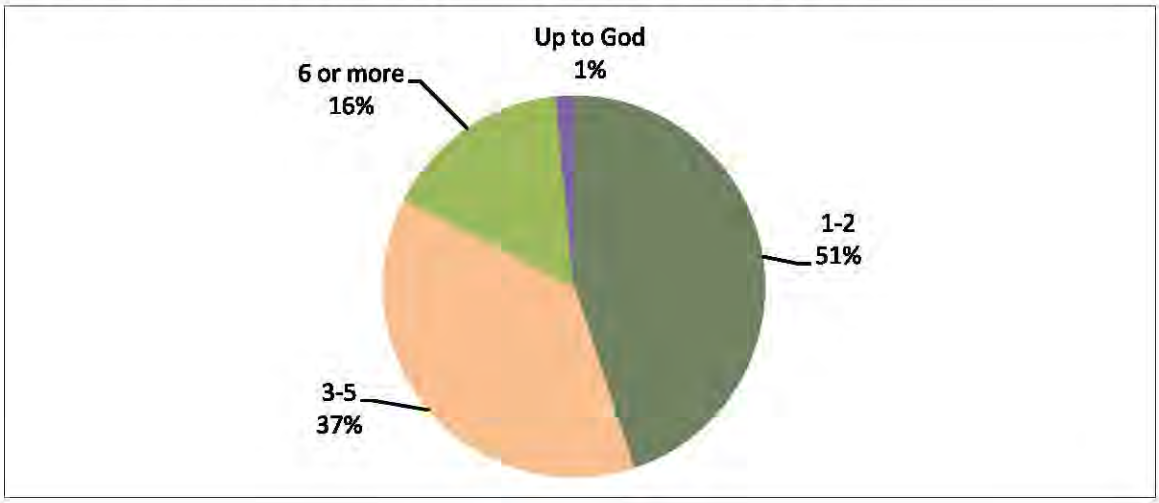
A more immediate measure of fertility preference is whether a couple wants to have more children; if so, do they want the next one now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already had. Table 7.2 shows that whether respondents want more children soon, later (after 2 years or more) or not at all, this was based on the number of living children they already had. About 46 percent of the women did not want more children than they now had, whereas slightly less than a quarter wanted to delay the next child. The proportion wanting more children soon declined sharply after the first birth. Among those who had two living children and wanted another child, half of them wanted to have the child later. The percentage of women wanting to have another child decreased as number of living children increased On the other hand, most women with three or more living children did not want to have more children. For those women who had five or more, the proportion wanting to stop was over 73 percent. This table indicates clearly the high level of interest in both spacing and limiting births.

Table 7.2: Distribution of MWRA by desire for next child and current number of living children

Number of living children	Future desire for children							
	Soon		Later		Never		Total	
	N	%	N	%	N	%	N	%
0	68	81.0	16	19.0	0	0.0	84	100.0
1	45	51.1	40	45.5	3	3.4	88	100.0
2	26	36.1	36	50.0	10	13.9	72	100.0
3	15	25.4	18	30.5	26	44.1	59	100.0
4	10	16.9	11	18.6	38	64.4	59	100.0
5	9	14.3	8	12.7	46	73.0	63	100.0
6+	8	4.5	17	9.6	153	86.0	178	100.0
Total	**181**	**30.0**	**146**	**24.2**	**276**	**45.8**	**603**	**100.0**

For those women who wanted more children, we also asked how many more. As depicted in Figure 7.1, more than half of the respondents who wanted more children, and who had an opinion, wanted one or two more. Sixteen percent said they wanted 6 or more children, and about 1 percent of the respondents said that having more children was in God's hands. It would be useful to explore what such respondents meant, i.e., whether this was a religious statement, an indication that the respondent had not thought about it or a polite way of telling the interviewer that she did not want to give a specific answer.

Figure 7.1: Distribution of women by desire for more children in future



Socioeconomic Correlates of Desire for Children

A woman's stated desire for children was analyzed in relation to four possible socioeconomic determinants: standard of living index (SLI) and respondent's literacy, age and residence (Table 7.3). Desire for more children was moderately associated with SLI. About 29 percent of the literate women compared to 51 percent of illiterate women did not want more children, whereas a third of the literate women wanted to delay their next birth compared to 22 percent of illiterate women. Rural residents were more likely to want more children than urban dwellers. Similarly, women's age was strongly associated with the desire for a next child.

Table 7.3: Distribution of MWRA by reported desire for more children and background characteristics

	Desire for next child			Total	
Characteristic	**Soon**	**Later**	**Never**	**N**	**%**
Standard of living index					
Low	35.8	25.4	38.8	67	100.0
Medium low	33.3	20.8	45.8	192	100.0
Medium high	28.0	24.6	47.3	207	100.0
High	25.5	27.7	46.7	137	100.0
Age group					
<25	46.8	47.4	5.8	154	100.0
25 or more	24.3	16.3	59.5	449	100.0
Literacy of respondents					
Literate	37.5	33.1	29.4	136	100.0
Illiterate	27.7	21.6	50.8	459	100.0
Residence					
Rural	32.1	25.0	42.9	364	100.0
Urban	26.8	23.0	50.2	239	100.0
Total	**30.0**	**24.2**	**45.8**	**603**	**100.0**
N	181	146	276	603	100.0

Son Preference

In Pakistan, there is usually a preference for sons over daughters. The belief that a family is incomplete without sons is stronger than the corresponding belief for daughters. In this questionnaire, respondents were asked how many daughters they would have before

stopping if they did not have a son, and correspondingly for sons if they did not have a daughter. Son preference came out most strongly in the proportions saying that there would be no limit: 34 percent for daughters before having a son, 25 percent for sons before having a daughter (Table7.4). For those women who gave a number, the number of daughters before having a son was only slightly higher than the number of sons before having a daughter. In both cases the median was five children.

Table 7.4: Son and daughter preferences by the respondents

	Number of daughters for the desire of a son		Number of sons for the desire of a daughter	
Response	**N**	**%**	**N**	**%**
No limit	204	33.8	152	25.2
Up to God	0	0.0	1	0.2
Other non-numeric response	0	0.0	1	0.2
Numeric response	400	66.2	450	74.5
Total	**604**	**100.0**	**604**	**100.0**
Median*	5	na	5	na

* Of the numeric responses. na=not applicable.

Strength of Preference

The strength of preferences asked in such surveys can be questioned. The need for birth spacing can be presumed to be greater if a couple is strongly motivated not to have more children, or to delay the next pregnancy, than if this does not matter much to them. We asked women whether, if they became pregnant soon, would they be pleased, worried, accept it, or it did not matter. Results are shown in Tables 7.5 and 7.6. (This question excludes those 358 of the total 604 women who wanted the next child soon, were currently pregnant, had been sterilized, had gone through menopause or had a hysterectomy.)

More than half the women (53 percent), especially if they did not want more children at all, said that they would be worried if they became pregnant. However, more than one-third of the women who did not want more children reported that they would accept the new pregnancy. Among those women who wanted to delay their next child for at least two years, only one-fifth (21 percent) reported that they would be worried if they got pregnant right now, whereas about three-quarters (73 percent) of these spacers would accept it or would even be pleased if they got pregnant now. This shows a weak motivation for spacing.

However, the high proportion of those women who said they would be worried if they became pregnant supports their earlier statement that they wanted to stop childbearing.

Table 7.5: Distribution of MWRA who did not want more children soon by reaction if they become pregnant in near future

	Future desire for children					
	Later		Never		Total	
Reaction if pregnant	**N**	**%**	**N**	**%**	**N**	**%**
Pleased	35	37.2	11	7.3	46	18.9
Worried	20	21.3	81	53.3	101	41.0
Accept it	34	36.2	57	38.0	91	37.3
Doesn't matter	5	5.3	2	1.3	7	2.9
Other	0	0.0	1	0.0	1	0.0
Total	**94**	**100.0**	**152**	**100.0**	**246**	**100.0**

Those who expressed a desire not to have more children, or to delay the next child, were asked what problems they would face if they became pregnant soon. Table 7.6 shows their responses. The problems most commonly faced by those who did not want more children at all were their own health and the family's economic situation, while the least commonly faced issue was the health of the youngest child. Healthcare (their own and that of their youngest child) and caring for children were commonly cited by those who wanted to delay the next child.

Table 7.6: Distribution of MWRA who did not want more children soon by problem faced if they became pregnant

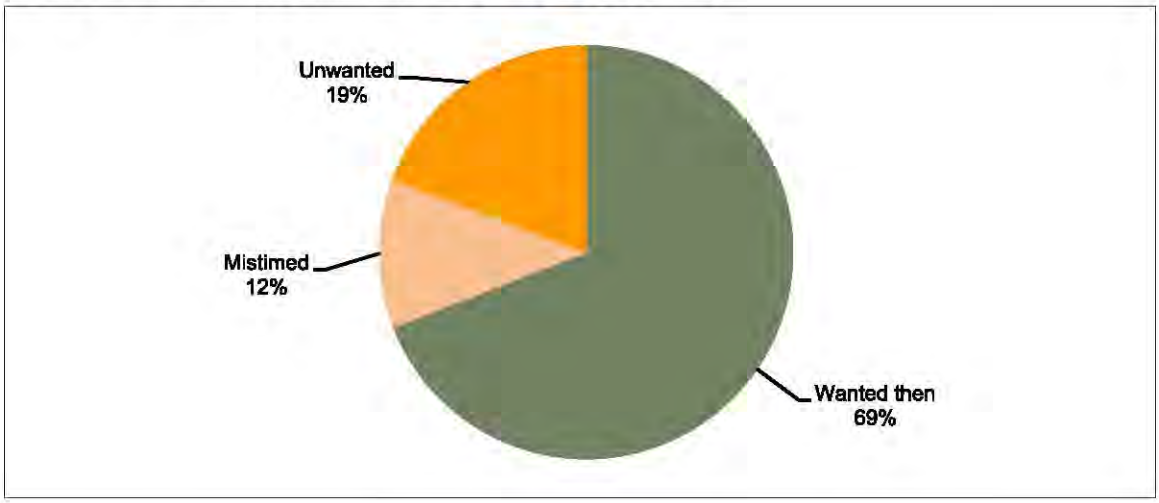
	Future desire for children					
	Later		Never		Total	
Problems faced if pregnant	**N**	**%**	**N**	**%**	**N**	**%**
Own health	39	41.5	110	72.7	149	60.7
Health of youngest child	53	56.4	60	40.0	113	46.3
Caring of children	36	38.3	89	58.7	125	50.8
Schooling of children	13	13.8	81	53.7	94	38.3
Family economic situation	24	25.5	108	71.3	132	53.7
Others	3	3.2	0	0.0	3	1.2
Total	**94**	**na**	**151**	**na**	**245**	**na**

na = not applicable; respondents could give more than one response.

Attitude toward Last Pregnancy

Another important dimension of fertility preference relates to whether the last pregnancy was wanted at the time, or was mistimed (i.e., wanted later), or was not wanted at all. Pregnancies that are unwanted cause hardship in many ways, and represent a failure to realize a couple's right to have the number of children they want, at the time they want them. This can be somewhat difficult to determine precisely in surveys. Sometimes parents report that an unwanted pregnancy was actually wanted, but it is less common to report that a child was wanted when in fact it was not. In this survey, as shown in Figure 7.2, many women reported that their last pregnancy was unwanted (19 percent) or mistimed (12 percent).

Figure 7.2: Attitudes of women toward their last pregnancy



Women's Perception of Fertility Preference of Husbands

Women were asked whether they thought their husbands wanted the same number of children as they did, or more, or fewer. In Table 7.7, their responses are tabulated according to the woman's ideal family size. About 10 percent did not know their husband's preference, while another 61 percent thought their husbands wanted the same number of children as they did. However, about one-fourth thought their husbands wanted more children than they did, while only about 4 percent thought their husbands wanted fewer children. These proportions did not vary systematically according to the woman's ideal family size.

Table 7.7: Distribution of MWRA according to perception of husband's desire for more children, by woman's ideal family size

Ideal family size of women	Perceived husbands desire for more children				Total	
	Same number	More children	Fewer children	Don't know	%	N
1-2	57.8	24.4	4.4	13.3	100.0	45
3-4	59.8	25.3	4.4	10.5	100.0	229
5 or more	64.9	24.3	2.9	8.0	100.0	313
Other non-numeric response	20.0	50.0	10.0	20.0	100.0	10
Up to God	20.0	40.0	20.0	20.0	100.0	5
Total	**61.3**	**25.2**	**3.8**	**9.6**	**100.0**	**602**
N	369	152	23	58	100.0	602

Chapter 8

Contraceptive Knowledge and Use

The FALAH baseline household survey obtained data on contraceptive knowledge and use by first asking what methods respondents knew, if any (spontaneous knowledge). Then, for each method not mentioned, that method was named by the interviewer and described, and the respondent was asked if she knew that method, if she had ever used it, and if she was using it currently. This approach is standard in such surveys in Pakistan and elsewhere. In addition, respondents were asked to report their most recent source of contraceptive methods.

Knowledge

For many years, at least 95 percent of married women of reproductive age in Pakistan have known of at least one method of contraception. Table 8.1 shows that this holds true for Larkana; virtually all women (99.3 percent) knew of at least one method. A majority of the female respondents knew of the most commonly used contraceptive methods: female sterilization (97.0 percent), pills (95.9 percent), injectables (95.5 percent), IUD (90.5 percent), Norplant (67.5 percent) and condoms (61.1 percent). These methods were known to higher proportions of women in Larkana than in the national PDHS 2006-07. Conversely, more women in the PDHS knew of the less common methods, male sterilization and emergency contraceptive pills (NIPS/PDHS 2008). Data show that the knowledge of contraceptives was slightly higher among urban women than their rural counterparts.

Table 8.1: Distribution of MWRA by knowledge (prompted) of contraceptive methods, by residence

Method	Rural	Urban	Total
Female sterilization	96.2	98.3	97.0
Male sterilization	21.4	32.6	25.8
Pill	94.5	97.9	95.9
IUD	87.4	95.4	90.5
Injectables	94.8	96.7	95.5
Norplant	63.8	73.2	67.5
Condom	54.2	71.5	61.1
Rhythm	36.1	41.4	38.2
Withdrawal	47.4	51.9	49.2
Emergency pills	11.0	16.5	13.2
At least one method	99.2	99.6	99.3
At least one modern method	99.2	99.6	99.3
At least one traditional method	61.6	66.5	63.6
N	**365**	**239**	**604**

Use of Contraceptive Methods

Levels of Ever Use and Current Use

For the purpose of analyzing use of contraception in a population, currently married women of reproductive age (typically taken to be 15-49 years) are generally divided into "ever users," i.e., women who have used some form of contraception at some point, and "never users," who have not. The ever users are further divided into current users and past users. These categories are in standard use in Pakistan and internationally.

Of all the married women interviewed in our sample, 41 percent reported having used some method of contraception during their married lives (Table 8.2). This percentage was lower than the proportion obtained in the PDHS 2006-07 for Pakistan as a whole (48.7 percent) (NIPS/PDHS, 2008).

Table 8.2: Percentage distribution of MWRA, by contraceptive use status and residence, according to method

	Ever users				Current users				Past users			
Method	Rural	Urban	Total	N	Rural	Urban	Total	N	Rural	Urban	Total	N
Pill	8.8	17.2	12.1	73	1.1	1.7	1.3	8	7.7	15.5	10.8	65
IUD	3.3	6.7	4.6	28	1.4	1.7	1.5	9	1.9	5.0	3.1	19
Injectables	10.4	17.6	13.2	80	1.6	2.1	1.8	11	8.8	15.5	11.4	69
Norplant	0.5	0.4	0.5	3	0.0	0.0	0.0	0	0.5	0.4	0.5	3
Condom	4.1	14.2	8.1	49	0.8	5.9	2.8	17	3.0	8.4	5.1	31
Rhythm	9.6	9.2	9.4	57	4.9	2.9	4.1	25	4.7	6.3	5.3	32
Withdrawal	6.8	8.8	7.6	46	2.2	1.7	2.0	12	4.7	7.1	5.6	34
Female sterilization	11.5	17.2	13.7	83	11.5	17.2	13.7	83	0.0	0.0	0.0	0
Others	2.2	5.9	3.6	22	0.3	0.8	0.5	3	1.9	5.0	3.1	19
Any method	36.4	49.0	41.4	250	23.8	33.9	27.8	168	12.6	15.1	13.6	82
Modern method	28.8	42.7	34.3	207	16.4	28.5	21.2	128	10.1	13.4	11.4	69
Traditional method	15.1	19.2	16.7	101	7.4	5.4	6.6	40	4.4	5.4	4.8	29
Emergency pills	0.3	0.0	0.2	1	na	na	na	na	0.3	0.0	0.2	1
N	365	239	604	604	365	239	604	604	365	239	604	604

na = not applicable.

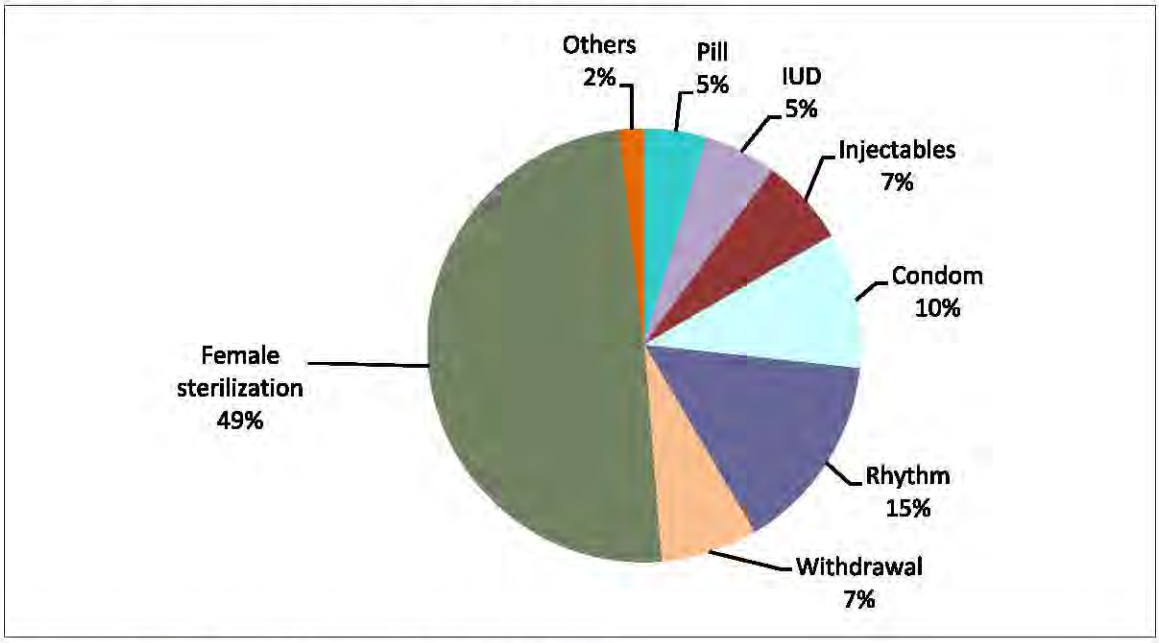
The proportion of currently married women of reproductive age who are currently using some form of contraception, commonly known as the contraceptive prevalence rate (CPR), is one of the central indicators of the status of family planning programs. It shows the degree to which couples are actively involved in spacing or limiting births, and the proportions by method (the method mix) indicates the means couples are using to do this. Historically, the program in Pakistan has been characterized bythe availability and use of a wide variety of methods, but at relatively low levels. For the last several years, the national CPR seems to have remained at about 30 percent (NIPS, 2001; NIPS, 2007; Population Council, 2006; NIPS/PDHS, 2008).

A total of 27.8 percent of currently married women of reproductive age in Larkana were currently using some method of contraception, compared with 29.6 percent for Pakistan in the 2006-07 PDHS, and 26.7 percent for Sindh as a whole (NIPS/PDHS, 2008). In urban Larkana, the CPR was 33.9 percent, compared with 23.8 percent in rural Larkana.

The current methods most commonly used were female sterilization, rhythm and condoms (Table 8.2). Female sterilization at 13.7 percent was unusually high by national standards (8.2 percent). Conversely, the use of condoms at 2.8 percent was substantially lower than figures in the national data (6.8 percent). Overall, 21 percent of married women were using modern methods, 6.6 percent were using traditional methods (withdrawal and rhythm), and 0.5 percent were using other methods. Figure 8.1 shows the distribution of the women who were using some contraceptive method by method mix.

In an analysis of data for ever use of any modern method excluding female sterilization, injectables (13 percent), pills (12 percent) and condoms (8 percent) were the most used methods. Among ever users, the traditional methods of rhythm and withdrawal were used by 17 percent compared to 34 percent who used modern methods. A similar pattern was observed in both urban and rural areas.

Figure 8.1: Distribution of current users by method mix

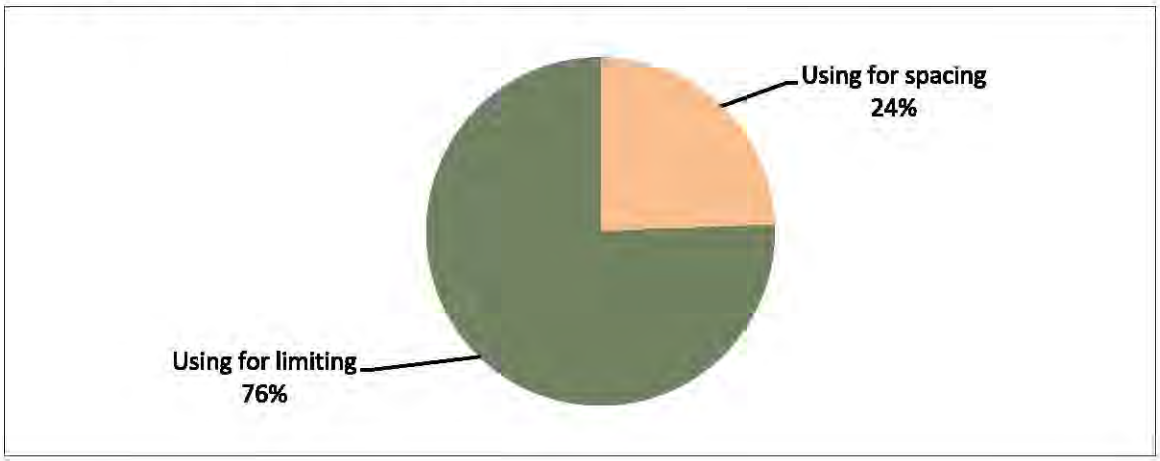


Current Use and Desire for Children

For current users of contraception, it is important to determine how many couples were using methods for spacing purposes, and how many were using to stop having children altogether. Overall, 76 percent of current use was for limiting purposes, compared with 24 percent for spacing (Figure 8.2). Among those who did not want more children, several

methods were used, while among those who wanted to delay their next child, withdrawal and IUDs were the most commonly used methods.

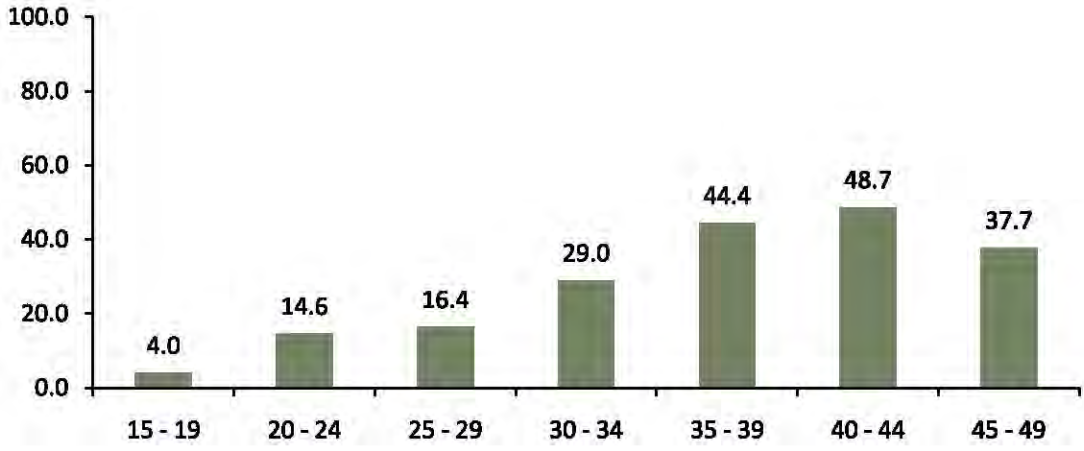
Figure 8.2: Current use and desire for children



Correlates of Contraceptive Use

Figures 8.3 and 8.4 show the relationship between contraceptive prevalence and the women's age and number of living children. The shape of the graph for age is similar to the trend seen in other Pakistani and international studies, with low prevalence among both younger and older women and higher prevalence in ages 35-44.

Figure 8.3: Contraceptive prevalence by woman's age



Prevalence by number of living children is somewhat more surprising in that prevalence for women with more than four children is higher than might be expected. However, this is consistent with a high proportion of current use to unmet need for these women (from Chapter 11) and low age-specific fertility rates among women at older ages (from Chapter 5).

Figure 8.4: Current contraceptive use by number of living children

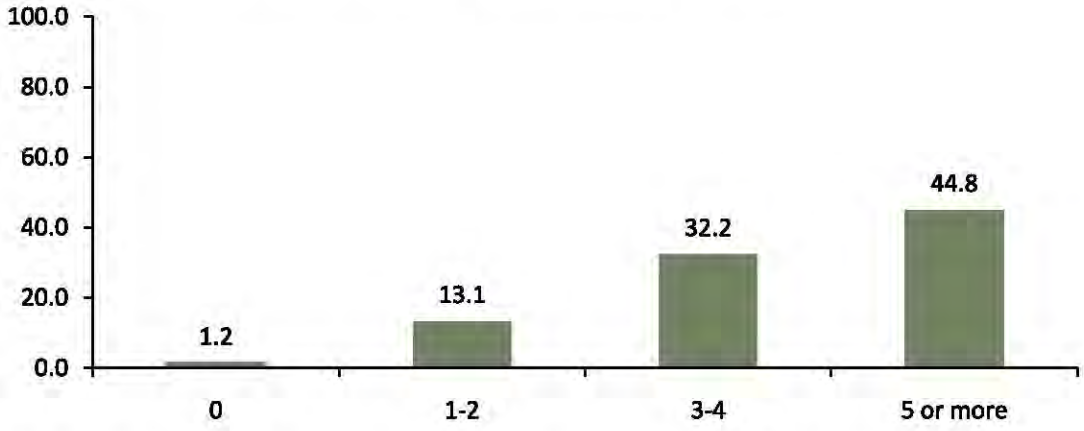


Table 8.3: Distribution of women by contraceptive use status and selected characteristics

	Contraceptive use status			Total	
Characteristic	**Current user**	**Past user**	**Never user**	**N**	**%**
Standard of living index					
Low	20.9	11.9	67.2	67	100.0
Medium low	25.4	14.0	60.6	193	100.0
Medium high	26.6	13.0	60.4	207	100.0
High	36.5	14.6	48.9	137	100.0
Ownership of TV					
Yes	29.8	13.1	57.1	413	100.0
No	23.6	14.7	61.8	191	100.0
Literacy of respondent					
Literate	30.1	16.2	53.7	136	100.0
Illiterate	27.0	12.8	60.2	460	100.0
Residence					
Rural	23.8	12.6	63.6	365	100.0
Urban	33.9	15.1	51.0	239	100.0
Total	**27.8**	**13.6**	**58.6**	**604**	**100.0**

Contraceptive use was associated with higher socioeconomic status and urban residence, as shown in (Table 8.4). Respondents in households with the highest SLI had substantially higher contraceptive prevalence (36.5 percent) than those with the lowest SLI (20.9 percent). Conversely, women from households with low SLI were more likely to be never users. Similarly, respondents' literacy was associated with higher current use and lower never use. Past use was not related to SLI. Ownership of television was only slightly associated with higher current use, whereas it was not related with past use. Current and past use of contraceptives was higher in urban areas versus rural areas.

Source of Method

With many types of outlets available to obtain various contraceptive methods, it is important to know which ones are being used, and for which methods. Table 8.4 shows, for current and past users combined – i.e., ever users – the source where they obtained their method the last time.

From this table, it is clear that the source depended on the method. Pills and condoms were mostly obtained from the Lady Health Worker, or by the husband. IUDs were mostly inserted either at private facilities or at DHQ/THQ hospitals. Injectables were mostly obtained at the DHQ/THQ, private doctors, private clinics or (recently) from the LHWs. Female sterilization was nearly always carried out at the DHQ/THQ hospital and private hospitals. These statements hold true for both current and past users.

Table 8.4: Distribution of ever users of specific contraceptive methods by most recent source of supply

	Contraceptive method					
Source	**Pill**	**IUD**	**Injectables**	**Condom**	**Female sterilization**	**N**
Govt. hospital (DHQ/THQ)	0.0	20.0	13.9	0.0	63.9	61
BHU/RHC/MCH center	0.0	6.7	5.6	0.0	9.6	11
LHW	34.5	0.0	13.9	11.1	0.0	18
Pvt. hospital/clinic/doctor	13.7	73.3	27.8	3.7	26.5	48
Dispenser /compounder	0.0	0.0	5.6	0.0	0.0	2
Pharmacy/chemists/grocery shop	31.0	0.0	16.6	0.0	0.0	15
Husband brings method	20.7	0.0	16.7	85.2	0.0	35
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**190**
N	29	15	36	27	83	190

Chapter 9

Experience with Contraceptive Methods

An important part of the success of a birth spacing program is to ensure that users are able to choose the method that is right for them, and to provide appropriate support for that method. All methods have their strengths and weaknesses, and no one method is right for everyone. In looking carefully at the experience of those who have used contraceptive methods, both currently and in the past, we can gain insights into the problems users face and how to best solve them. We asked a series of questions regarding the experience of current and past users; for past users who had used more than one method, we asked about their most recent method.

Reasons for Method Choice

In the survey, current and past users were asked the reasons they chose a particular method. A list of possible reasons was read out to them and the results are shown in Table 9.1. Overall, the reasons for current and past users were similar, so the data has been combined. Among the most common reasons for choosing a method were convenience of use, suitability for respondent and husband, easy availability, and no or few side effects. For female sterilization, IUD and injectable users, suitability of use for a long period was often cited. Cited less frequently were; provider's advice, no other method available and method always available. Clients tend to make decision according to the known attributes of the various methods, but not always. For example, about 53 percent of the injectable users cited lack of side effects, even though it is in fact associated with a number of common side effects.

Table 9.1: Distribution of ever users of specific contraceptive methods by reason for choosing that method

	Contraceptive method						
Reason	**Pill**	**IUD**	**Injectables**	**Condom**	**Withdrawal**	**Female sterilization**	**N**
Easily available	69.0	53.3	80.6	74.1	10.5	45.8	117
Low cost	51.7	13.3	50.0	55.6	5.3	39.8	84
Convenient to use	65.5	60.0	83.3	88.9	89.5	50.6	141
Suitable for respondent/husband	51.7	46.7	63.9	81.5	94.7	65.1	139
No/fewer side effects	24.1	46.7	52.8	70.4	84.2	57.8	116
Can be used for long period	17.2	73.3	77.8	44.4	26.3	62.7	113
No other method available	13.8	13.3	11.1	7.4	10.5	9.6	22
Method always available	37.9	13.3	47.2	59.3	10.5	30.1	73
Provider advised	51.7	33.3	55.6	14.8	10.5	30.1	71
Others	0.0	6.7	2.8	0.0	5.3	20.5	20
N	**29**	**15**	**36**	**27**	**19**	**83**	**209**

Respondents could give more than one reason.

To look more specifically at why some users prefer traditional methods to modern ones, 38 of the current traditional method users were asked why they were not using modern methods for a list of possible reasons (Table 9.2). Side effects were by far the main issue: 32 of the 38 cited fear of side effects (84 percent). Twenty-four women (63 percent) reported their own experience of side effects. Husband's disapproval (of modern methods) was cited by 40 percent of the users, with other reasons; method not available, cost not affordable and lack of knowledge cited by few.

Table 9.2: Distribution of MWRA using traditional methods by reason for not using modern contraceptive methods

Reason	Percentage
Fear of side effects	84.2
Husband disapproves	39.5
Experienced side effects	63.2
Method not available	15.8
Costs too much	13.2
Doesn't know about modern methods	7.9
Doesn't know about source of method	10.5
Others	2.6
N	**38**

Respondents could give more than one reason.

Cost, Distance and Time to Reach a Facility

Costs of contraceptive methods vary widely in Pakistan, according to the method, whether it is available in the public or private sector, and the distance from the home to the facility. Table 9.3 and Figure 9.1A show women's reported costs the last time they obtained their method. Seven in ten clients (70 percent) were not charged for their contraceptives, including all female sterilization users (who are, in fact, typically reimbursed for expenses involved) and a quarter of pills users. Another 11 percent of the respondents paid more than 50 rupees. Often both IUD users and injectable users paid more than 50 rupees for their method. For the IUD in particular, there is a one-time cost, so the monthly cost may be quite low.

Table 9.3: Distribution of cost of current specific contraceptive methods

	Cost (in rupees)					Total	
Method	**No payment**	**1-20**	**21-50**	**51+**	**Don't know**	**%**	**N**
Pill	25.0	50.0	0.0	0.0	25.0	100.0	8
IUD	0.0	0.0	11.1	88.9	0.0	100.0	9
Injectables	36.4	9.1	0.0	54.5	0.0	100.0	11
Condom	12.5	6.3	6.3	0.0	75.0	100.0	16
Female sterilization	100.0	0.0	0.0	0.0	0.0	100.0	83
Others	0.0	50.0	0.0	0.0	50.0	100.0	2
Total	**70.5**	**5.4**	**1.6**	**10.9**	**11.6**	**100.0**	**129**

Figure 9.1A: Cost of contraceptive supply for current method in rupees

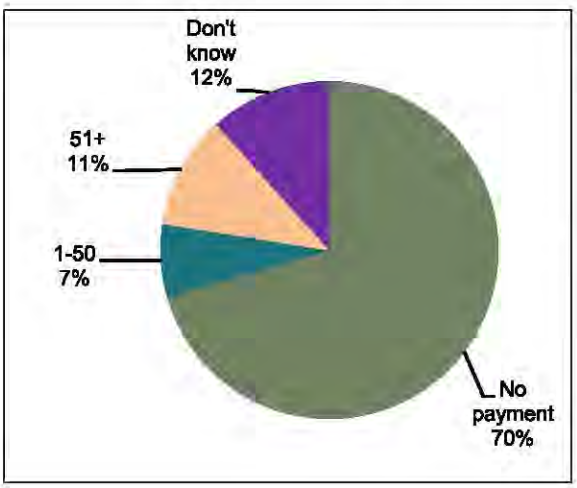
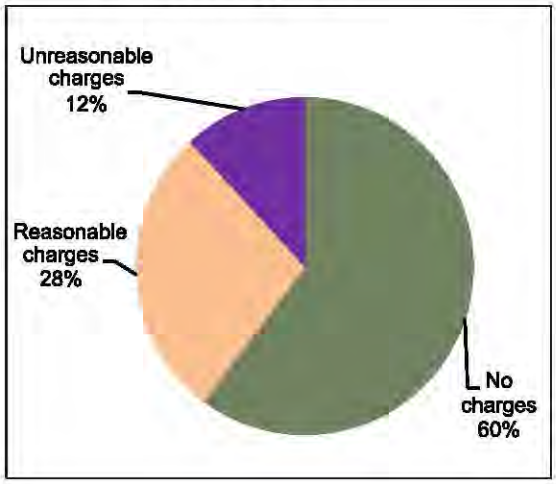


Figure 9.1B: Attitude toward service charges for current method other than contraceptive



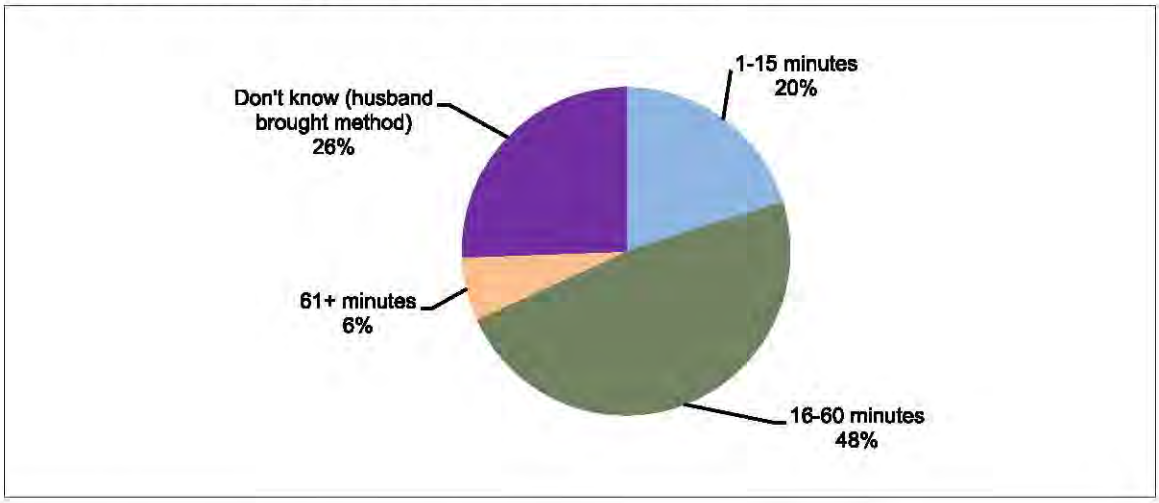
Current users were also asked whether their facility charged them for services, other than the method itself. Of the 93 users who were asked this question, 56 (60 percent) said they were not charged, 26 (28 percent) said that they were charged a reasonable amount, and 11 (12 percent) said they were charged an unreasonable amount (Figure 9.1B).

The time usually needed for current users to obtain a specific method is shown in Table 9.4, while Figure 9.2 shows the overall travel time in minutes to get the contraceptive method. About 20 percent of the users needed no more than 15 minutes to obtain their method. This included methods obtained from the LHWs, who often brought injectables, pills, and condoms to the doorstep. For another third it took up to 30 minutes and for a quarter their husband brought the supply, so they did not know how long it took. For a few female sterilization users, it took more than an hour to reach the service delivery; but in this case, there was usually no need to visit the facility frequently.

Table 9.4: Distribution of current contraceptive users by time to reach specific contraceptive service

	Time (in minutes)					Total	
Method	1-15	16-30	31-60	61-180	Don't know (husband brought method)	%	N
Pill	12.5	0.0	12.5	0.0	75.0	100.0	8
IUD	22.2	55.6	0.0	0.0	22.2	100.0	9
Injectables	27.3	45.5	0.0	0.0	27.3	100.0	11
Condom	6.3	0.0	0.0	0.0	93.8	100.0	16
Female sterilization	22.9	33.7	27.7	9.6	6.0	100.0	83
Others	0.0	0.0	0.0	0.0	100.0	100.0	2
Total	**20.2**	**29.5**	**18.6**	**6.2**	**25.6**	**100.0**	**129**

Figure 9.2: Travel time (in minutes) for contraceptive supplies



Treatment by Provider

Information Provided

Current and past users were asked, from a list of important topics that were read out to them, what information the service provider might have given them (Table 9.5). The accuracy of clients' responses may be questioned, due to problems of recall or understanding. However, it still appears that information provided is seriously deficient. The most common topics respondents said they were told about were

effectiveness/duration, how to use the method, the advantages and how it worked. Some were told about side effects or about contraindications. A few users were told about the possibility of switching, or about other methods they could use. Condom users were given less information in general than users of clinical methods, perhaps because these were often obtained by husbands. There is a need to emphasize that providers give comprehensible information on the method selected by the clients, especially hormonal contraceptives.

Table 9.5: Distribution of ever users of contraceptives by information provided at acceptance for specific methods

Information provided at acceptance	Method					
	Pill	IUD	Injectables	Condom	Female sterilization	N
How the method works	20.7	26.7	27.8	11.1	21.7	41
How to use the method	62.1	53.3	27.8	18.5	36.1	71
Contraindications	3.4	6.7	5.6	7.4	26.5	28
Effectiveness	37.9	73.3	50.0	14.8	38.6	76
Advantages	13.8	66.7	27.8	14.8	43.4	64
Possible side effects	17.2	26.7	13.9	0.0	18.1	29
What to do if experienced side effects	10.3	33.3	8.3	0.0	9.6	19
Possibility of switching	10.3	33.3	22.2	11.1	0.0	19
About other methods of FP you could use	10.3	26.7	13.9	14.8	9.6	24
N	**29**	**15**	**36**	**27**	**83**	**190**

Respondents could give more than one response.

Treatment at Facility

Current users were asked about various aspects of their treatment when they last visited a provider for family planning. As Table 9.6 shows, responses were mainly positive, but with some exceptions. Eighty-three percent of the respondents were satisfied with the attitude of the staff. Ninety-nine percent of the respondents said that the provider was available when they visited. However, 9 percent of the women said that they were not examined properly and 57 percent said the provider was unable to deal with side effects.

Table 9.6: Percent current users responding positively on treatment at last visit by aspect of treatment

Aspect of treatment	Percentage
Staff attitude cooperative	83.3
Provider available	99.0
Attend/examine properly	90.8
Doesn't demand charges for services	68.3
Can deal with side effects	42.6

Side Effects

Current users were asked if they had experienced, or were experiencing, any side effects from their current method. Past users were asked if side effects were among the reasons for their discontinuation. If so, a list of possible side effects was read out to them, and they were asked if they had experienced them; multiple responses were allowed. Three-fourth of the current users and half of the past users did not have any side effect. Among ever users, side effects were most commonly reported by injectable and pills users (58 percent and 55 percent, respectively), and they were least commonly reported by condom users (11 percent) (Figure 9.3). Those who reported side effects, when asked to respond to a list of possibilities, tended to report a variety of side effects, including many not associated with the method, regardless of the method used.

Figure 9.3: Percent ever users who experienced side effects by method used

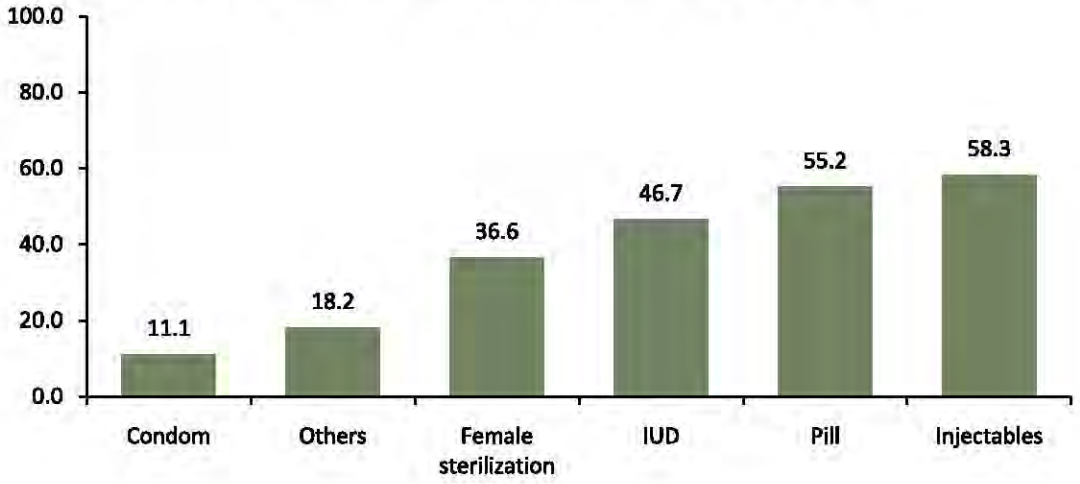
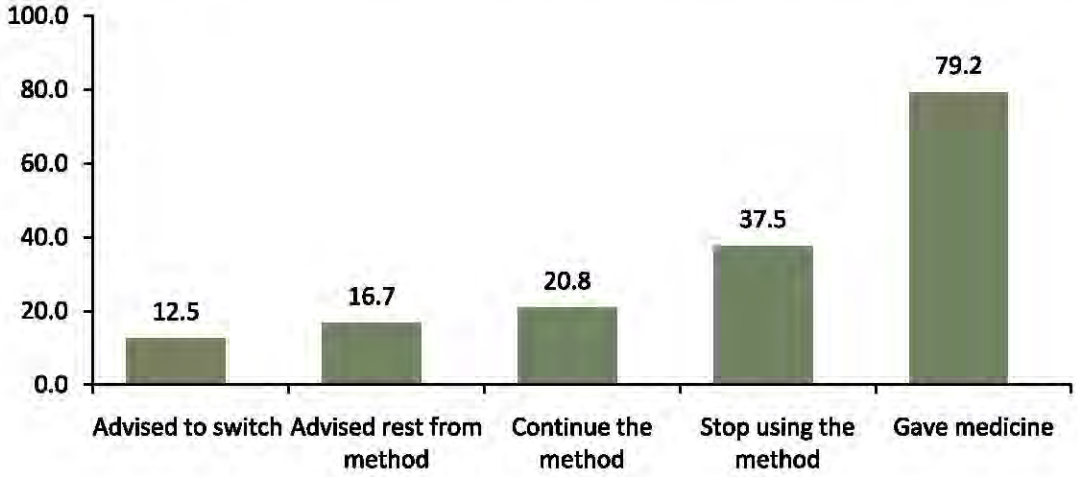


Figure 9.4: Distribution of provider responses upon consultation for side effects among past users



Of the 40 past users who reported experiencing side effects, 24 said they had consulted someone for the management of these side effects; in 23 of these cases, this was said to be a doctor. They were asked if the provider had taken any of a list of possible responses. Five out of 24 (21 percent) were advised to continue using; 4 (17 percent) were advised rest from the method; 9 (38 percent) were advised to stop, 3 (13 percent) were advised to switch to another method; and 19 (79 percent) were given medication (Figure 9.4).

Chapter 10

Reasons for Non-use

There are many reasons why a couple may not be using birth spacing at any given time. The wife may already be pregnant, the couple may want another child soon, the wife may already have passed menopause, or believe herself to be sterile. Other reasons may be a couple's desire to avoid having more children, but they may not be using means that could help them to do so. There are many reasons why this may happen: lack of knowledge of methods or places to obtain them, fear of the side effects of the methods they know of, opposition of husband or family, and concern that birth spacing may be against Islam, or somehow wrong, and so on. To understand how best to meet the needs of such people, it is important to understand the reasons why couples were not using birth spacing, in relation to the situation they are currently in.

Hindrances to Use

One way to understand how common various types of hindrances to contraceptive use is to ask respondents about their understanding of the concerns of people in general, with the view that people may feel less need to conceal their real concerns than when they are discussing their own situation. All respondents were asked, "If a couple wants to avoid or space a birth, which of the following hindrances might they face?" Each item on the list was read out to the respondent. Table 10.1 shows the responses of the female respondents, according to whether they are current, past or never users.

Table 10.1: Distribution of opinions of MWRA regarding hindrances faced by couples wanting to avoid or space a birth, by family planning use status

	Use of family planning					
	Current users		Past users		Never users	
Hindrance	**N**	**%**	**N**	**%**	**N**	**%**
Husband's disapproval	144	85.7	79	96.3	298	84.2
Other people may find out about contraceptive use	73	43.5	42	51.2	167	47.2
Distance and travel costs to FP outlet	78	46.4	39	47.6	157	44.4
Probability of getting pregnant while using	108	64.3	59	72.0	223	63.0
Fear of side effects	147	87.5	73	89.0	305	86.2
Problem of managing side effects	135	80.8	68	82.9	270	76.3
FP is against religion	154	91.7	73	89.0	334	94.4
N	**168**	**na**	**82**	**na**	**354**	**na**

na = not applicable; respondents could give more than one response.

Some hindrances that couples might face were almost universally acknowledged. Most of the respondents mentioned possible husband's disapproval, while another majority of never users acknowledged religious concerns followed by fear of side effects, and the problems of managing side effects. For three other possibilities, however, substantial proportions of the women respondents thought them less likely to be a hindrance: other people might find out about their use of contraceptives; the distance and costs of going to a FP outlet; and the possibility of getting pregnant while using contraception. None of the reasons was closely linked to use status, but in general ever users were slightly more likely to agree with each of the proposed obstacles than never users.

Past Users

Reasons for Discontinuing Contraceptive Use

Past users were asked about their reasons for discontinuing their last contraceptive method. Several reasons were given frequently; the most commonly given were experience of side effects, desire for another child, rest from method, provider's advice, fear of side effects, method failure, husband's advice and infrequent sex/husband away (Table 10.2). Method failure results from using methods that have high failure rates. Clinical methods do

have associated side effects, but as we have seen, providers rarely try to counsel users through the temporary experience of common, non-dangerous side effects.

Table 10.2: Distribution of past contraceptive users by reason for discontinuing last method

Reason	Percentage
Wanted another child	29.6
Fear of side effects	14.3
Side effects experienced	51.3
Method failure	11.3
Lack of access/unavailability	1.3
Method inconvenient to use	3.7
Rest from method/provider's advice	27.2
Missed the dose	3.8
Infrequent sex/husband away	6.2
Husband's advice	8.6
In-laws oppose	2.5
Menopause	2.5
N	**81**

Respondents could give more than one reason.

Reasons for Current Non-use

It is important to know the reasons for non-use of those couples who had used contraception in the past but were not currently using any method. Past users were read out a list of possible reasons for not currently using any method, with more than one reason possible. The results are shown in Table 10.3. The most common reasons overall related to childbearing: currently pregnant, breastfeeding/amenorrheic, and wanting another child. However, a significant proportion (31.3 percent) cited fear of side effects as a reason for non-use.

Table 10.3: Distribution of past users by reason for current non-use

Reason	Percentage
Fear of side effects	31.3
Want another child	15.0
Currently pregnant	32.5
Provider's advice/rest from method	8.8
Infrequent sex/husband away	8.9
Breastfeeding/lactational amenorrhea	19.0
Menopause	2.5
Just not using/too lazy	6.3
Others	10.1
N	**79**

Respondents could give more than one reason.

Never Users

Reasons for Non-use

The 354 women in the sample who reported never use were asked about various possible reasons for not using contraception, with each reason read out separately. As shown in Table 10.4, the most important reason was that they wanted more children (73 percent), with fear of side effects cited by 30 percent of the never users. Concern about their ability to conceive was sometimes an additional factor. Respondents also cited husband's and in-laws' opposition as significant reasons for not using contraceptives. Other reasons cited frequently included: husband away and currently breastfeeding. Very few reported unavailability of supply and cost, shyness to consult about family planning and method inconvenient to use.

Table 10.4: Distribution of never users by reason for never use

Reason	Percentage
Husband opposes	24.0
In-laws oppose	14.4
Fear of side effects	30.2
Lack of access/unavailability	5.6
Cost not affordable	3.4
Shy to consult about family planning	4.2
Method inconvenient to use	5.9
Infrequent sex/husband away	16.2
Difficult/unable to conceive	27.7
Breastfeeding/lactational amenorrhea	28.1
Respondent/husband infertile	4.8
Wanted (more) children	72.9
Against religion	0.6
Natural spacing	3.7
Others	7.9
N	**354**

Respondents could give more than one reason.

Attitude toward Birth Spacing and Limiting

It is important to see the extent to which never users disapprove of family planning in principle, as opposed to accepting in principle but not using for some other reasons. Table 10.5 shows that among never users only about 27 percent of the women disapproved of spacing and 24 percent of limiting. The implications of this for whether a couple does or does not use birth spacing or limiting, may be profound, and require further investigation.

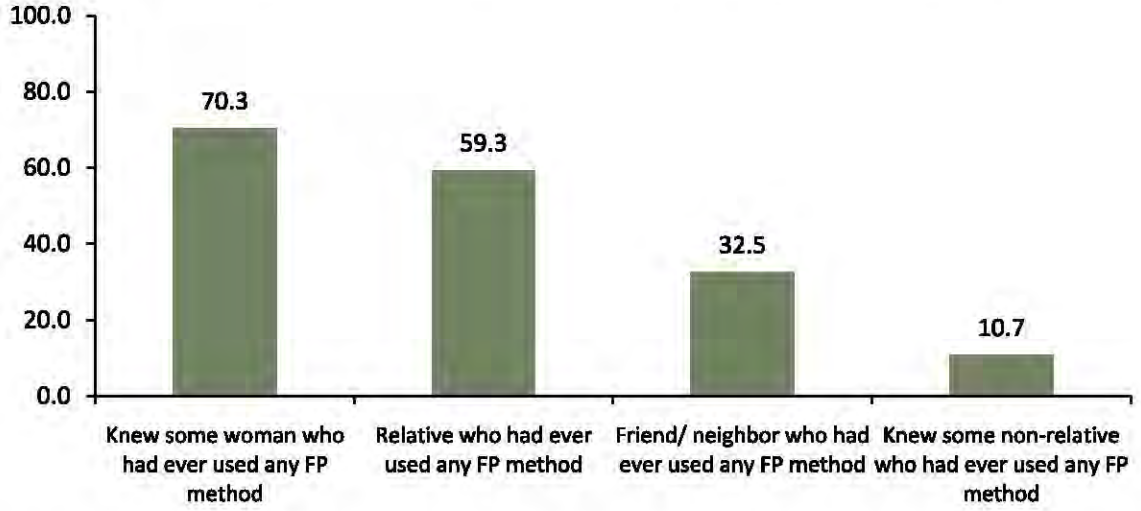
Table 10.5: Distribution of never users by attitude toward spacing and limiting birth

	Attitude toward spacing		Attitude toward limiting	
Attitude	**N**	**%**	**N**	**%**
Approve	258	72.9	269	76.2
Disapprove	95	26.8	84	23.8
Others	1	0.3	**0**	**0.0**
Total	**354**	**100.0**	**353**	**100.0**

Knowledge of Contraceptive Users, Methods and Facilities

Of the 354 female never users in the sample, 70 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy. Fifty-nine percent of the respondents had a relative who had used some method, and 33 percent knew of a friend or neighbor who had used any family planning method. Nearly 30 percent of the women did not know anyone who had ever used a FP method to delay or avoid pregnancy.

Figure 10.1: Percent of never users who knew some woman who had ever used any FP method



Never users had somewhat lower levels of knowledge of individual contraceptive methods than ever users, as might be expected, but surprisingly of all never using women, 99 percent knew of at least one method. For each method, a somewhat smaller percent of never users knew that method than the general distribution; but most never users knew a variety of methods. However, their knowledge of where to get services and supplies was less satisfactory.

Table 10.6: Distribution of never users by knowledge of contraceptive methods

Method	Percentage
Female sterilization	95.5
Male sterilization	20.9
Pill	94.1
IUD	89.2
Injectables	94.6
Norplant	63.8
Condom	54
Rhythm	27.6
Withdrawal	46.6
Emergency pills	11.4
Others	9.6
Know at least one FP method	98.9
N	**354**

Respondents could give more than one response.

Of the 354 never users, 126 (36 percent) did not know of a place to obtain a method. For those who did know, the places they were aware of are shown in Table 10.7. The sources best known were Department of Health outlets – the District/Tehsil Headquarters hospitals, BHUs/RHCs/MCH centers, and the Lady Health Workers. Less than 10 percent knew of the Family Welfare Centers of the Ministry of Population Welfare. Substantial numbers knew of private facilities, including pharmacies/chemists. A few were aware of other sources, including Greenstar clinics.

Table 10.7: Knowledge of sources of contraception of never users by source of supply

Source	Percentage
Knowledge of at least one service provider	64.0
DHQ/THQ hospital	52.6
BHU/RHC/MCH center	25.7
Family welfare center	9.1
Mobile service unit camp	16.0
Lady Health Worker	44.3
Greenstar clinic	13.1
Private hospital/clinic/doctor	43.4
Dispenser/compounder	4.0
Pharmacy/chemists/grocery shop	31.6
Homeopath/hakim	7.4
TBA/dai	18.0
Others	0.3
N	**354**

Respondents could give more than one response.

When asked which of the facilities named was nearest, the respondents were again most likely to name DHQ/THQ hospitals, LHW and BHU/RHC/MCH centers in that order. Mostly they would go there on foot, sometimes by bus/van or *tonga* (Figure 10.2). Of the 225 respondents who indicated the time needed to go to the nearest facility, 65 percent gave a time frame of 15 minutes or less, 26 percent reported a time of 16 to 30 minutes, and 9 percent thought it took more than 30 minutes, the maximum being two and a half hours (Figure 10.3).

Figure 10.2: Mode of transportation to the nearest facility/provider

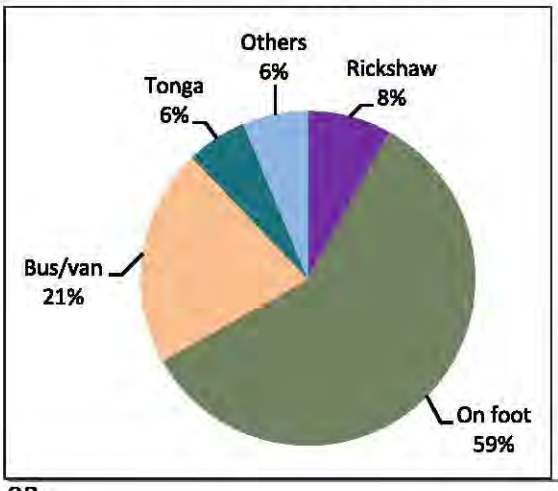
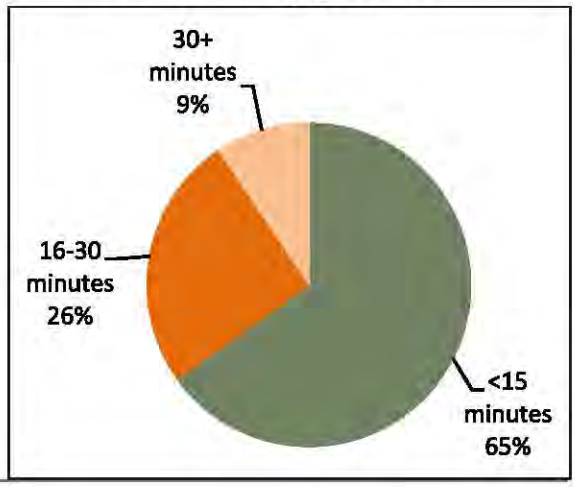


Figure 10.3: Time taken to go to the nearest facility/provider



Intent to Use

When never users were asked about whether they intended to use a contraceptive in the future, 37 percent of the respondents (130 out of 354) said that they intended to use, compared with 47 percent of the women who did not intend to use in the future (Table 10.8). Those women who had not yet used a method and had 4 or fewer children, expressed a higher intent to use contraception in the future than those women with 5 or more children. Of all the never users, 10 percent were unsure about their future use of contraceptives, while 6 percent reported that they would not get pregnant in future.

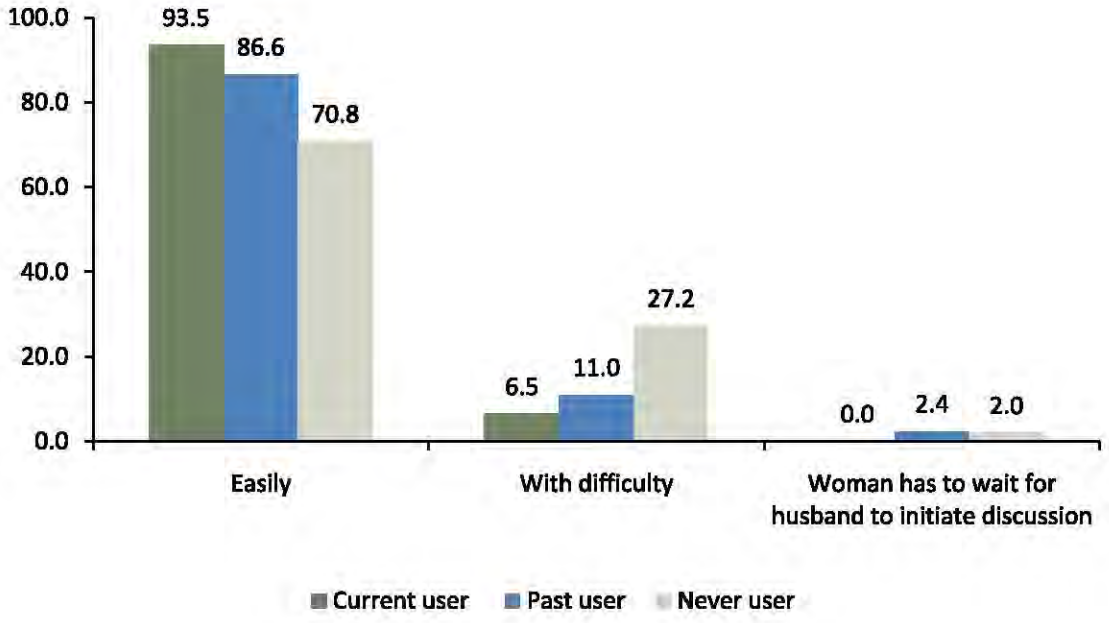
Table 10.8: Distribution of never users by intent to use a method in the future and number of living children

	Intent to use any FP method in future				Total	
Number of living children	Yes	No	Unsure/ uncertain	Can't get pregnant	%	N
0	38.1	36.9	11.9	13.1	100.0	84
1-2	43.2	44.8	11.2	0.8	100.0	125
3-4	37.3	49.2	10.2	3.4	100.0	59
5 or more	25.6	59.3	5.8	9.3	100.0	86
Total	**36.7**	**47.2**	**9.9**	**6.2**	**100.0**	**354**
N	130	167	35	22	100.0	354

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility and family planning. Women were asked whether they could approach their husbands to discuss family planning easily, with difficulty, or if they had to wait for their husbands to initiate the discussion. Most women said they could do so easily (Figure 10.4). However, this varied by use status. More than 93 percent of current users, and 87 percent of past users, said they could approach their husbands easily, and very few past users said they had to wait for their husband to initiate the discussion. For never users, 71 percent reported being able to approach their husbands easily, with slightly more than one-fourth (27 percent) reporting that they could only do so with difficulty, and 2 percent said they had to wait for him to begin the conversation.

Figure 10.4: Women's reports regarding ease of approach to husband to discuss family planning



Chapter 11

Unmet Need

"Unmet need" for family planning is a term long used to help focus attention in a family planning program on those who need it. Conceptually, unmet need refers to women who say they do not want more children, or want them later, and are at risk of conceiving, but are not currently using contraceptives. Women currently pregnant or who are experiencing postpartum amenorrhea are said (in this formulation) to be in unmet need if their current (if pregnant) or last (if amenorrheic) pregnancy was said to be unwanted or mistimed. Women who want to delay their next pregnancy are said to be in unmet need of spacing; those who do not want more children at all are said to be in unmet need of limiting. Women in unmet need in this sense are those for whom there is an inconsistency between what they say they want and what they are doing; these women would appear to be in need of some support to avoid unwanted pregnancies.

Levels and Correlates

Table 11.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Larkana. Of the 604 total women, 204 (33.8 percent) were judged to be in unmet need. This proportion is slightly lower than is typically found in Pakistan. The lower proportion may be a reflection of the relatively high contraceptive prevalence. Higher levels of use mean that more of the total demand for family planning is being met. This is supported by the relatively low levels of unmet need for women with 5 or more children, where contraceptive prevalence was particularly high (see Chapter 8).

Of the 34 percent women who had unmet need, 15 percent was for spacing, and 19 percent was for limiting births. Unmet need for spacing was relatively high among women with one to four living children. Unmet need for limiting, unsurprisingly, was highest among women

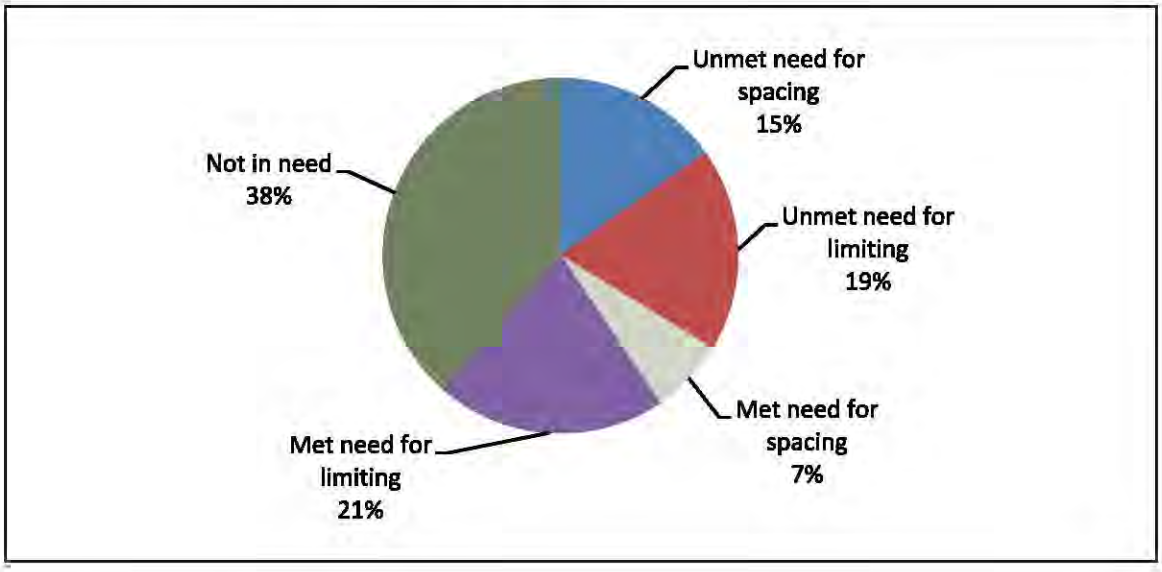
with five or more living children, because at that stage couples begin to not want to have more children.

Table 11.1: Need and demand for FP among MWRA by background characteristics

Characteristic	Unmet need			Met need			Total demand	Not in need	Total	N
	For spacing	For limiting	Total	For spacing	For limiting	Total				
Age group										
15 - 24	28.6	1.9	30.5	9.1	2.6	11.7	42.2	57.8	100.0	154
25 - 34	19.2	20.1	39.3	8.9	12.6	21.5	60.7	39.3	100.0	214
35 - 49	3.0	28.0	30.9	3.4	40.7	44.1	75.0	25.0	100.0	236
Residence										
Rural	14.8	20.0	34.8	7.4	16.4	23.8	58.6	41.4	100.0	365
Urban	15.9	16.3	32.2	5.9	28.0	33.9	66.1	33.9	100.0	239
Literacy of respondent										
Literate	19.1	7.4	26.5	13.2	16.9	30.1	56.6	43.4	100.0	136
Illiterate	14.1	22.2	36.3	4.8	22.2	27.0	63.3	36.7	100.0	460
Education of respondent										
No education	14.1	22.8	36.9	4.2	21.9	26.1	63.1	36.9	100.0	425
Up to primary	19.4	11.1	30.6	12.0	20.4	32.4	63.0	37.0	100.0	108
Up to secondary	19.0	7.1	26.2	9.5	16.7	26.2	52.4	47.6	100.0	42
Above secondary	9.5	0.0	9.5	23.8	14.3	38.1	47.6	52.4	100.0	21
Children ever born										
0	6.5	0.0	6.5	0.0	0.0	0.0	6.5	93.5	100.0	77
1-2	26.0	3.4	29.5	12.3	1.4	13.7	43.2	56.8	100.0	146
3-4	24.0	22.0	46.0	8.0	18.0	26.0	72.0	28.0	100.0	100
5+	8.9	30.2	39.1	5.3	38.1	43.4	82.6	17.4	100.0	281
Ownership of TV										
Yes	17.2	17.7	34.9	6.1	23.7	29.8	64.6	35.4	100.0	413
No	11.0	20.4	31.4	8.4	15.2	23.6	55.0	45.0	100.0	191
Standard of living index										
Low	14.9	19.4	34.3	9.0	11.9	20.9	55.2	44.8	100.0	67
Medium low	11.4	19.7	31.1	5.2	20.2	25.4	56.5	43.5	100.0	193
Medium high	18.4	21.3	39.6	6.8	19.8	26.6	66.2	33.8	100.0	207
High	16.1	12.4	28.5	8.0	28.5	36.5	65.0	35.0	100.0	137
Total	**15.2**	**18.5**	**33.8**	**6.8**	**21.0**	**27.8**	**61.6**	**38.4**	**100.0**	**604**

The correlations between unmet need and various socioeconomic indicators varied by whether the unmet need was for spacing or for limiting. Unmet need for limiting was associated with low SLI, with illiteracy, rural residence and households not owning a television. Unmet need for spacing, on the other hand, was strongest for literate women and for those owning a television, while associations with SLI and urban residence was weak. It is possible that educated women were more aware of the need to space their births, but they were inhibited from doing so for various reasons. Once they have reached their desired family size, educated women may be able to use family planning more than uneducated women. However, conclusions should be tentative, given the small sample sizes involved. Unmet need for limiting increased rapidly with the age of respondent, while unmet need for spacing was high among women in the age group 15-24 years. Figure 11.1 shows the need and demand for family planning of the sampled women.

Figure 11.1: Need and demand for family planning



Total Demand

The sum of current use ("met need") and unmet need is often called "total demand" for family planning. It would normally be expected to rise with the number of living children a couple has. Table 11.1 also shows total demand by background characteristics of the women. Overall, total demand was 62 percent of all married women of reproductive age. As the table shows, total demand did rise rapidly and fairly consistently by number of children ever born. Even at 1-2 children, demand was quite substantial (43 percent), and it increased to over 82 percent for those with five or more children.

Strength of Preference

It is of interest to look at the responses of women in unmet need (those not currently pregnant) according to their reaction if they became pregnant in the near future (Table 11.2). Only about 15 percent of the women with unmet need for spacing said they would be worried if they became pregnant again; 38 percent would accept it while 41 percent would be pleased. Of those with unmet need for limiting, 43 percent said they would be worried if they became pregnant. It is perhaps not unreasonable for women to be more concerned about the consequences of an unwanted pregnancy than about the consequences of a wanted pregnancy coming too soon. However, the responses of women who wanted to delay their next child for 2 years were not strong enough to adopt family planning.

Table 11.2: Distribution of non-pregnant women with unmet need for spacing and limiting, by strength of desire to avoid pregnancy

Reaction if become pregnant in near future	Unmet need for spacing		Unmet need for limiting	
	N	%	N	%
Pleased	28	41.2	7	6.9
Worried	10	14.7	44	43.1
Accept it	26	38.2	49	48.0
Doesn't matter	4	5.9	2	2.0
Total	**68**	**100.0**	**102**	**100.0**

Reasons of Non-use

Past and never users were asked why they were not using some method of contraception. For those later classified as having unmet need, the results are shown in Table 11.3. Some of these reasons represented barriers as perceived by the women; the most important of these were fear of side effects and opposition of husband and in-laws. On the other hand, many women with defined unmet need gave reasons that did not reflect perceived need, at least at present. Such reasons included wanted more children, currently pregnant and currently breastfeeding, infrequent sex/husband away, natural spacing and difficulty in conceiving. Such women may have more need than they realize; for example, women using "natural

spacing" or breastfeeding may in fact be at substantial risk of pregnancy. Women currently pregnant or amenorrheic may be in need of contraception in the near future.

Table 11.3: Women with unmet need for spacing and limiting by stated reasons for non-use of contraception

Reason	Unmet need for spacing	Unmet need for limiting	Total unmet need
Fear of side effects	34.8	45.9	40.9
Husband opposes	20.7	24.3	22.7
In-laws oppose	17.4	8.1	12.3
Shy to consult about FP	1.1	7.2	4.4
Provider's advice/rest from method	1.1	4.5	3.0
Against religion	1.1	0.0	0.5
Lack of access /unavailability	7.6	4.5	5.9
Cost not affordable	3.3	3.6	3.4
Just not using/too lazy	0.0	3.6	2.0
Method inconvenient to use	2.2	5.4	3.9
Infrequent sex/husband away	12.0	18.0	15.3
Natural spacing	3.3	6.3	4.9
Difficult/unable to conceive	6.5	8.1	7.4
Want (more) children	73.9	9.9	38.9
Currently pregnant	8.7	6.3	7.4
Breastfeeding/lactational amenorrhea	3.3	6.3	4.9
Others	9.8	10.8	10.3
N	**92**	**111**	**203**

Respondents could give more than one reason.

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprised 92 (15 percent) of MWRA. As shown in Table 11.4, they were characterized by:

- **Living Children:** Most (47 percent) had 1 or 2 living children.
- **Family Planning Use:** More never users (84 percent) than past users (16 percent).
- **Strength of Preference:** Low (only 15 percent "worried" if they became pregnant earlier than they wanted compared to those who were pleased (41 percent) or accept (38 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** Moderate (about 57 percent intended to use a FP method in future).
- **Approval of FP:** High (72 percent approved of using a FP method for spacing purposes).
- **FP Communication with Husband:** Limited (only 37 percent had communicated with husbands on FP in the past one year; while 23 percent said approaching the husband was "not easy").
- **Obstacles to FP Use:** Fear of side effects (35 percent); husband and in-laws opposition (21 percent and 17 percent respectively) (Table11.3).

Table 11.4: Percent distribution of MWRA in unmet need for spacing and limiting by selected characteristics

Characteristic	Unmet need for spacing		Unmet need for limiting	
	N	%	N	%
Number of living children				
0	5	5.4	0	0.0
1-2	43	46.7	5	4.5
3-4	25	27.2	28	25.0
5 or more	19	20.7	79	70.5
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	15	16.3	39	34.8
Never user	77	83.7	73	65.2
Reaction if become pregnant in near future				
Pleased	28	41.2	7	6.9
Worried	10	14.7	44	43.1
Accept it	26	38.2	49	48.0
Doesn't matter	4	5.9	2	2.0
Intention to use a method in future				
Yes	52	56.5	45	41.7
No	28	30.4	50	46.3
Unsure/uncertain	12	13.0	8	7.4
Can't get pregnant	0	0.0	5	4.6
Approval of FP				
Approve	66	71.7	100	89.3
Disapprove	25	27.2	12	10.7
Others	1	1.1	0	0.0
FP communication with husband in past one year				
Never	57	62.6	69	61.6
Once or twice	13	14.3	22	19.6
More often	21	23.1	21	18.8
Approach the topic of FP with husband				
Easily	70	76.9	87	77.7
Not easily	21	23.1	25	22.3
Total	**91**	**100.0**	**112**	**100.0**

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 112 (19 percent) of MWRA. As shown in Table 11.4, they were characterized by:

- **Living Children:** A strongly positive association with number of living children; 71 percent had 5+ living children.
- **Family Planning Use:** More never users (65 percent) than past users (35 percent).
- **Strength of Preference:** Moderate (Only 43 percent would be "worried" if they became pregnant compared to those who were pleased (7 percent) or accept (48 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** Moderate (about 42 percent intended to use a FP method in future.
- **Approval of FP:** High (89 percent approved of FP for limiting purposes).
- **FP Communication with Husband:** Limited (only 38 percent had communication with husband on FP in the past year; while 22 percent said approaching the husband was "not easy").
- **Obstacles to FP Use:** Fear of side effects (46 percent); husbands and in-laws opposition (24 percent and 8 percent respectively) (Table 11.3).

Chapter 12

Reproductive Preferences and Behavior of Men

It is often the case that in matters relating to family planning the focus has too often been more on women, despite the fact that husbands are equal partners in the reproductive process and often have greater responsibility for decision-making in the family. In addition, women often mention their husbands as a constraint to the use of contraception (NIPS/PDHS, 2008; Population Council, 1995). The objectives of interviewing husbands/men in the FALAH baseline survey were to explore their perspectives on birth spacing/family planning and to use the information obtained to design the communication strategy for the FALAH project. Overall, the planned sample size was 200 husbands in each district to have a total of 4000 interviews with husbands/men from the 20 FALAH districts. The intention was to interview as many husbands as possible who were available when the household interviews were undertaken. Knowing that some number of husbands might be at their places of work during the timing of the interviews, the plan was to then make up for any of the husbands who were unavailable by interviewing other married men available in the selected communities in order to come as close as possible to meeting the objective of interviewing 200 husbands/men in each FALAH district. In Larkana, the field team was able to interview 178 men who were husbands of the married women of reproductive age who had been interviewed for the survey plus 22 married men living in the selected areas who were not husbands of the female respondents. In this chapter, the results for the respondents' husbands and the other married men who were interviewed (N = 200) are always grouped together, whether the reference is to "men," "male respondents," "married men," or "husbands."

A husband's approval of family planning is a powerful factor in explaining contraceptive use (Tawiah, 1997). In families, fertility decisions occur within specific social contexts and according to prevailing social norms that restrict individual decisions on fertility and behaviors related to spacing of births, stopping childbearing, and using contraception. Earlier studies suggest that the husband's approval of and discussion about family planning are important predictors of a woman's contraceptive use and fertility desire (Bongaarts and Bruce, 1995; Mahmood and Ringheim, 1997).

This baseline survey investigates social and demographic differentials, and knowledge, ever use and current use of family planning methods. It also explores how approval and discussion of birth spacing/family planning influence the use of contraceptive methods. Traditionally, the measurement of contraceptive use has been based on women's self-reports of current use. The rationale for interviewing men was to investigate their perspective on the issues of fertility and family planning.

Background Characteristics

Table 12.1 shows the background characteristics of the men interviewed in the survey. It shows that only 1 percent of the men were under 25 years of age and 20 percent were 50 years of age and above.

The men were substantially better educated than the sampled currently married women. Thirty-one percent of the men had not been to school, compared to 71 percent of the currently married women (Table 3.2). Table 12.1 also shows that more than 24 percent of the men had higher than secondary education, whereas 3.5 percent of currently married women had attained that level of education. Findings show that more than 78 percent of urban men had received some schooling, compared to 63 percent of rural men.

The occupations of men are also presented in Table 12.1. The highest proportion of men (37 percent) was working as daily wage laborers, 27 percent were working in agriculture-related activities and 19 percent were running their own business.

Table 12.1: Background characteristics of male respondents, by residence

Variable	Rural	Urban	Total
Age			
20-24	1.6	0.0	1.0
25-29	6.6	5.0	5.9
30-34	17.2	16.3	16.8
35-39	18.0	13.8	16.3
40-44	23.8	13.8	19.8
45-49	15.6	25.0	19.3
50-54	16.4	23.8	19.3
55+	0.8	0.0	0.5
Education			
Proportion literate	59.8	75.0	65.8
No education	36.9	22.5	31.2
Up to primary	36.1	20.0	29.7
Up to secondary	9.8	23.8	15.3
Above secondary	17.2	33.8	23.8
Economic activity/occupation			
Agriculture/livestock/poultry	39.3	8.8	27.2
Petty trader	0.8	1.3	1.0
Labor (daily wages)	40.2	31.3	36.6
Govt. service	7.4	27.5	15.3
Pvt. service	2.5	3.8	3.0
Own business	16.4	23.8	19.3
Working abroad	0.8	0.0	0.5
Unemployed	3.3	5.0	4.0
Others	0.8	1.3	1.0
N	**120**	**80**	**200**

Contraceptive Knowledge and Use

Among the interviewed men in Larkana, more than 98 percent knew of at least one method of contraception; for the women, 99 percent knew of at least one method. As presented in Table 12.2, knowledge of modern methods was highest for female sterilization (92 percent), followed by pill (91 percent), injections (87 percent) and condom (82 percent). The least known methods were Norplant (9 percent), male sterilization (19 percent), and IUD (46 percent). At least one traditional method was known to only 29 percent of the men.

The pattern of ever use and current use of contraception reported by husbands is also shown in Table 12.2. Of the MWRA interviewed, 41 percent reported having used some method of contraception during their married lives (Table 8.2), while 29 percent of the men reported ever using any method. Among the men, female sterilization was the most ever-used method (16 percent), followed by condoms (6 percent), pills (5 percent) and injectables (4 percent).

Family planning was not extensively practiced in Larkana, as mentioned in Chapter 8. A total of 28 percent of the MWRA women in the sample were currently using some method of contraception (Table 8.2); the current use reported by male respondents was slightly lower at 25 percent. The most common currently used method reported by male respondents was female sterilization (16 percent), followed by condoms (4 percent) and pills (2 percent). The use of traditional methods was nominal: less than 1 percent of the current users were using withdrawal and none were using rhythm.

Although 26 percent of the respondents knew about the emergency contraceptive pill, none of the men reported ever using it.

Table 12.2: Distribution of male respondents by contraceptive knowledge, use status and residence

	Knowledge			Ever use			Current use		
Method	**Rural**	**Urban**	**Total**	**Rural**	**Urban**	**Total**	**Rural**	**Urban**	**Total**
Female sterilization	87.7	98.8	92.1	13.9	20.0	16.3	13.9	20.0	16.3
Male sterilization	15.6	24.1	18.9	0.0	0.0	0.0	0.0	0.0	0.0
Pill	86.7	97.5	91.0	4.9	6.3	5.4	1.6	2.5	2.0
IUD	40.0	55.1	46.0	0.0	2.5	1.0	0.0	1.3	0.5
Injectables	82.8	93.8	87.1	3.3	5.0	4.0	1.6	2.5	2.0
Norplant	5.0	13.8	8.5	0.0	1.3	0.5	0.0	0.0	0.0
Condom	73.0	95.0	81.7	3.3	11.3	6.4	0.8	8.8	4.0
Rhythm	14.9	30.0	20.9	0.0	0.0	0.0	0.0	0.0	0.0
Withdrawal	13.9	13.8	13.9	0.0	1.3	0.5	0.0	1.3	0.5
Others	1.6	1.3	1.5	0.0	0.0	0.0	0.0	0.0	0.0
At least one FP method	97.5	100.0	98.5	21.3	40.0	28.7	18.0	36.3	25.2
At least one modern FP method	97.5	100.0	98.5	21.3	40.0	28.7	18.0	35.0	24.8
At least one traditional FP method	22.1	38.8	28.7	0.0	1.3	0.5	0.0	1.3	0.5
Emergency pills	15.6	41.8	25.9	0.0	0.0	0.0	na	na	na
N	**120**	**79**	**200**	**120**	**80**	**200**	**120**	**80**	**200**

na = not applicable.

Table 12.3 shows ever use and current use of modern contraception among male respondents by background characteristics. There was a positive relationship between education level and contraceptive use. More than 46 percent of the respondents who had secondary and above education, reported ever use of any contraceptive method, compared to 21 percent and 18 percent who had below secondary and no education, respectively. The same pattern was found for current users by education.

Table 12.3 also shows a positive relationship between the number of living children and ever use. Of those men with 5 or more children, more than 36 percent reported ever use of family planning, compared to 33 percent who had 3-4 children and 16 percent who had 1-2 children.

Table 12.3: Percentage of male respondents reporting ever use or current use of a contraceptive method, by selected background characteristics

Characteristic	Ever used at least one FP method	Currently using any FP method	N
Residence			
Rural	21.3	18.0	120
Urban	40.0	36.3	80
Education level			
No education	17.5	15.9	63
Below secondary	21.4	18.6	70
Secondary and above	46.4	40.6	67
Number of living children			
None	0.0	0.0	10
1-2	16.3	12.2	49
3-4	33.3	33.3	42
5+	36.4	31.3	99
Future desire for children			
Soon	10.5	7.0	57
Later	16.1	16.1	31
Never	61.7	60.0	60
Don't know/unsure	18.5	11.1	52
Total	**28.7**	**25.2**	**200**

Table 12.3 also shows contraceptive ever use and current use by the future desire for children. Among men who reported they did not want any more children, 62 percent had

ever used any contraceptive method and 60 percent were currently practicing family planning. More than 16 percent of the men were currently using contraceptives for spacing purposes.

Source of Contraceptive Methods

As shown in Table 12.4, among those who reported the last source for obtaining their contraceptive method, 33 percent reported that they obtained it from government hospitals. In rural areas, 15 percent reported FWCs as their source of contraceptives, but no men in urban areas reported FWCs as their source. Thirty-two percent of the urban respondents said that their wives brought the method.

Table 12.4: Distribution of male ever users by the last reported source of contraceptive supply

Source	Rural	Urban	Total
Govt. hospital (DHQ/THQ)	34.6	32.3	33.3
FWC	15.4	0.0	7.0
LHW	11.5	3.2	7.0
Other public	3.8	0.0	1.8
Pvt. doctor	7.7	3.2	5.3
Pvt. hospital/clinic	11.5	16.1	14.0
Pharmacy/chemist	11.5	9.7	10.5
Wife brought method	3.8	32.3	19.3
Others	0.0	3.2	1.8
Total	**100.0**	**100.0**	**100.0**
N	26	31	57

Approval of Family Planning

Respondents were asked about their approval of birth spacing and use of any form of contraception for spacing purposes. A husband's opposition may prevent his wife from using contraception, even when she wants to delay or stop childbearing (Casterline, Perez, and Biddlecom, 1997). In Larkana, more than 58 percent of all the men approved of spacing between children, and nearly that many (56 percent) approved of using any form of contraception for spacing between children (Table 12.5). Disapproval of spacing was 41 percent, and disapproval of using contraceptives to space was 43 percent. A higher

proportion of urban men approved of spacing between children and of using contraceptives for spacing when compared to rural men.

Table 12.5: Distribution of male respondents' attitudes toward spacing and use of contraceptives for spacing, by residence

Variable	Rural	Urban	Total
Spacing between children			
Approve	53.3	66.3	58.4
Disapprove	45.9	32.5	40.6
Others	0.8	1.3	1.0
Total	**100.0**	**100.0**	**100.0**
N	122	80	202
Using family planning methods for spacing			
Approve	50.0	66.3	56.4
Disapprove	49.2	32.5	42.6
Others	0.8	1.3	1.0
Total	**100.0**	**100.0**	**100.0**
N	66	54	120

Satisfaction Level of Current Users

Satisfaction of a user with his/her contraceptive method is an important factor in whether or not they continue with the method. Contraceptive users were asked to report how satisfied they were with their present contraceptive method. Table 12.6 shows that 86 percent of the current users were very satisfied with their current methods. None of the current users reported dissatisfaction with their method. It is important to note that 18 percent of rural users and 11 percent of urban users reported being somewhat satisfied with their current method. This proportion of users needs more information on their current method as well as on other available methods so that they continue using a family planning method.

Table 12.6: Level of male respondents' satisfaction with their current method, by residence

Level of satisfaction	Rural	Urban	Total
Very satisfied	81.8	89.3	86.0
Somewhat satisfied	18.2	10.7	14.0
Total	**100.0**	**100.0**	**100.0**
N	22	28	50

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Husbands were asked if during the last year their wives could approach them to discuss family planning easily, with difficulty, or if they had to wait for their husbands to initiate the discussion; their responses are given in Figure 12.1. Forty-eight percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, Figure 12.2 shows that 55 percent of the men reported that their wives had never approached them during the last year on this issue. Seventeen percent of the men reported that their wives had talked often about this subject during the last year, and 28 percent had talked once or twice.

Figure 12.1: Men's reports of ease of approach by their wives to discuss FP

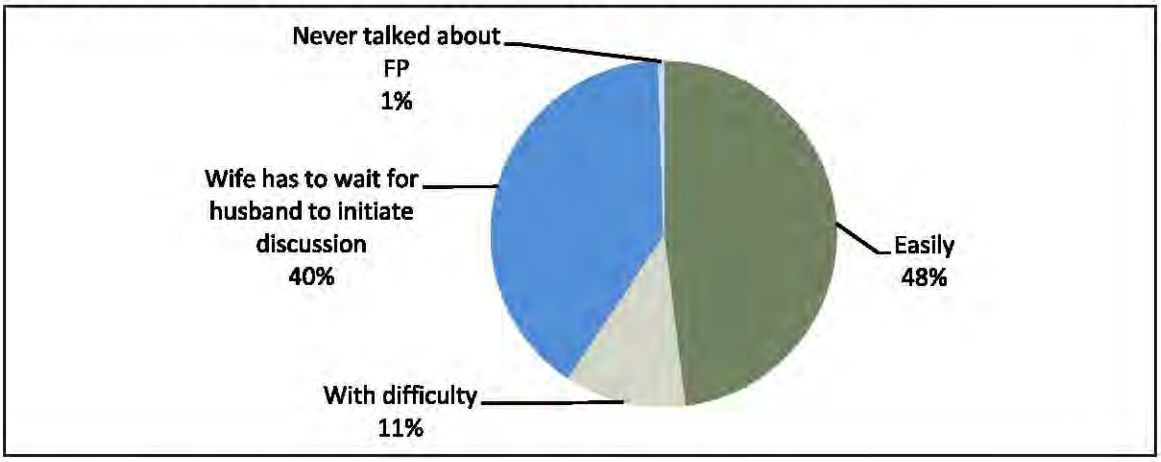
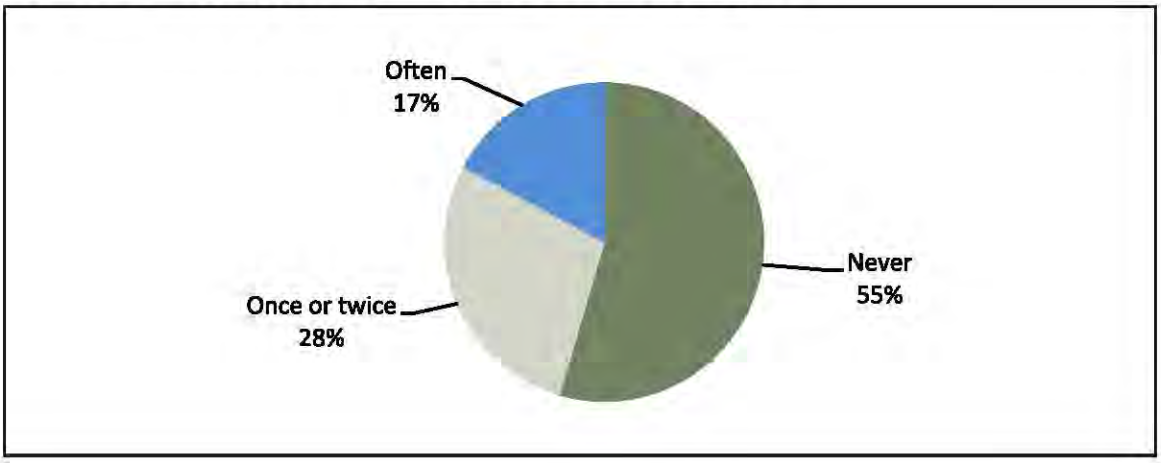


Figure 12.2: Frequency of discussion on FP with wife in last year



Potential Users

Men who had never used any contraceptive method were asked about their intended future use of contraception and their method preferences. Table 12.7 shows that only 11 percent of the men were intending to use any form of contraception in the future, while 41 percent were not intending to use contraception at any time in the future. Many (48 percent) were uncertain about their future use of contraception.

Table 12.7: Distribution of male never users by intent to use contraceptive methods in future, by residence

Intent	Rural	Urban	Total
Will use	9.4	14.6	11.1
Will not use	43.8	35.4	41.0
Unsure/uncertain	46.9	50.0	47.9
Total	**100.0**	**100.0**	**100.0**
N	96	48	144

Table 12.8 shows that the major reason men gave for why they did not intend to use a contraceptive method in the future was the desire for more children (73 percent). More than 27 percent reported that they did not need contraception since their wives were unable to conceive. For 10 percent, lack of access was the reas on, while 7 percent were shy about visiting family planning clinics.

Table 12.8: Distribution of male never users according to reasons for not intending to use contraceptive methods in future

Reason	Percentage
Wife opposes	3.4
In-laws/parents oppose	10.2
Fear of side effects	6.8
Lack of access/unavailability	10.2
Costs too much	1.7
Shy to go to FP clinic	6.8
Infrequent sex/respondent away	1.7
Difficult/unable to conceive	27.1
Breastfeeding/lactational amenorrhea	33.9
Want more children	72.9
N	**59**

Respondents could give more than one reason.

Table 12.9 shows the distribution of respondents who intended to use a specific contraceptive method in future. Female sterilization was the most preferred method (38 percent).

Table 12.9: Distribution of male never users who intend to use a specific contraceptive method in the future

Method	Percentage
Female sterilization	37.5
Pills	18.8
IUD	12.5
Condom	12.5
Not decided	18.8
Total	**100.0**
N	16

Fertility Desire

The respondents were asked about the number of their living children and their desire for more children. Table 12.10 shows that 28 percent of the respondents wanted another child soon (within two years). Another 15 percent wanted to delay their next child for more than two years, and 30 percent did not want any more children at all. More than one-quarter of the men were uncertain about their future desire for children.

Overall, the desire to have another child soon was inversely associated with the number of living children. Of the respondents who had no children, 92 percent wanted a child soon, compared to 62 percent who had one child, and 44 percent who had 2 children.

Table 12.10: Distribution of male respondents by desired timing for next child and number of living children

Number of living children	Desire for next child				Total	
	Soon	Later	Never	Don't know/ unsure	%	N
0	91.7	8.3	0.0	0.0	100.0	10
1	61.5	26.9	3.8	7.7	100.0	26
2	43.5	39.1	4.3	13.0	100.0	23
3	30.0	30.0	30.0	10.0	100.0	20
4	18.2	9.1	31.8	40.9	100.0	22
5+	10.0	6.1	45.5	38.4	100.0	99
Total	**28.2**	**15.3**	**29.7**	**26.7**	**100.0**	**200**

The desire to stop having children was positively associated with the number of living children. Of the respondents who had 5 or more children, 46 percent did not want any more children, and 32 percent of those with 4 children did not want more.

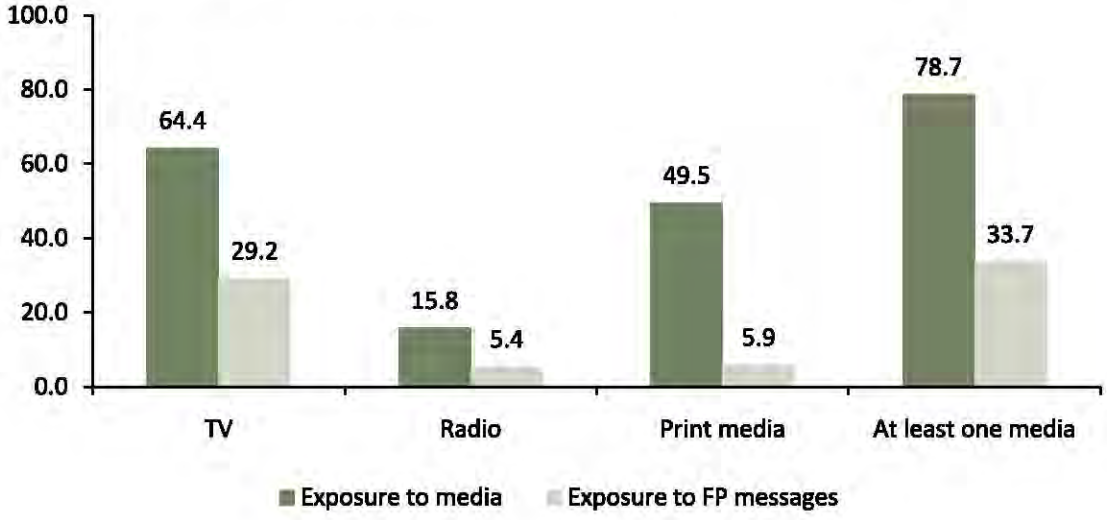
Overall in Larkana, only 25 percent of men reported current use of family planning methods. If those who wanted to postpone having another child are combined with those who did not want any more children, the sum would constitute about 45 percent of all men. This suggests that there is a substantial need for family planning, but that motivational programs and service delivery are not keeping pace with this need.

Mass Media Access and Exposure to FP Messages

For the development of communication activities, it is important to know which forms of mass media are available and to what extent they are used by various segments of the population. Figure 12.3 shows the proportion of men who reported that they watched TV, listened to the radio, or read newspapers or magazines. TV and print media were the most commonly accessed mediums, 64 percent of the men interviewed in Larkana watched TV, and 50 percent reported access to print media.

Furthermore, male respondents who reported access to any sort of media were asked if they had ever seen, heard, or read any message pertaining to methods of family planning through these mediums. Twenty-nine percent of the men had seen FP messages on the television; this was lower than the 56 percent of MWRA who said they had seen FP messages on television. Overall, 34 percent of the men and 61 percent of the women reported that they had seen any family planning message through at least one medium. Five percent of the men reported that they had ever listened to a family planning message on radio.

Figure 12.3: Distribution of male respondents according to exposure to media and FP messages, by type of media



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