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Baseline Household Survey

Sanghar District

April 2009



Family Advancement for Life and Health (FALAH)

Sanghar

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 Contraceptive 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
PSLM	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/<i>Dai</i>	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 Sanghar, one of the project districts.

The survey was conducted between May and July of 2008 in a probability sample of 520 households in 40 clusters in Sanghar. It included interviews with 630 currently married women aged 15-49 years (“married women of reproductive age” or MWRA), along with 200 married men, of whom 193 were married to women included in the sample. As a separate activity, a mapping study¹ was also carried out in Sanghar during the period between June and July 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

Sanghar is a relatively developed rural district in Pakistan. According to the UNDP National Human Development Report 2003, it ranked 56th of 91 districts on the overall Human Development Index. 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 Sanghar household Survey

Variable	Value
Percentage of rural household population	79.5
Percentage of households with electricity	83.3
Percentage of households with indoor water supply	69.0
Percentage of households with flush toilet	49.3
Percentage of households with television	46.5
Percentage of literate female respondents	20.0
Percentage of respondents with literate husbands	56.7
No. of MBBS physicians per 1000 MWRA	1.7
Total fertility rate	4.3

¹ Mapping Survey of Health and Reproductive Health Services.

Sanghar is a fairly densely populated district with a well-developed road system. Nearly 83 percent of the sampled households had access to electricity, and owned appliances requiring electricity – such as televisions, refrigerators, washing machines, etc. – were less common. Sixty-nine percent of the sampled households had some indoor water supply, and 73 percent either had a flush toilet or a latrine. About 27 percent had no toilet facility at all. According to the MDG report, Sanghar ranked 12th nationally on sanitation. On the other hand, literacy was relatively low. Only 20 percent of the female respondents and 57 percent of their husbands were literate, which was lower than the average literacy rate for Sindh and substantially lower than the national average. Sixty-one percent of MWRA had access to at least one form of media, including 49 percent of the women who watched TV, 28 percent who listened to the radio, and 4 percent who read newspapers or magazines. Forty-six percent of MWRA reported having heard at least one FP message through any of these mediums.

Service Availability

There was a wide range of health and reproductive health facilities in Sanghar district. Of the 1927 facilities in the district, 1105 were public while 822 were in the private sector. These health facilities included health houses of Lady Health Workers and were widely scattered around the district, so that 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. However, access to services requiring specialized care was difficult. For example, there were only 15 facilities – 4 public, 11 private – which were able to offer Caesarean section deliveries. There were 13 facilities which were able to provide female sterilization, but many of these could only provide the service occasionally, when an external sterilization team was present. Though services were spread throughout the district, there were some areas where access was relatively difficult.

Fertility

There is evidence that fertility has been declining in Sanghar. The crude birth rate was 27.6 per thousand population, and the total fertility rate was 4.3 children per woman. Fertility was higher for illiterate women and for the wives of illiterate men. However, there was little urban-rural difference in fertility levels. Many births were spaced too closely for optimum health; nearly 70 percent of the closed birth intervals were less than 36 months. Among

those women who already had three living children under 5 years of age, 13 percent were currently pregnant.

Maternal and Neonatal Care

The household survey obtained data on selected key indicators of maternal and neonatal health from 399 sampled women who had delivered a child during the previous four years (see Table B). Of these women, 58 percent had visited a health provider at least once for antenatal care; 35 percent had at least two tetanus toxoid immunizations; 43 percent had their deliveries conducted by a skilled birth attendant; and 43 percent had delivered in a health facility, public or private. On the other hand, 47 percent had at least one postnatal check-up (including all women who delivered in facilities). Exclusive breastfeeding was reportedly widespread; 89 percent of the mothers reported breastfeeding their last child for at least four months without supplementation.

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

Indicator	Value
Percentage of mothers with at least one antenatal care visit	58.4
Percentage of mothers with at least two tetanus shots	34.7
Percentage of most recent deliveries conducted by a skilled birth attendant	43.1
Percentage of most recent deliveries in a facility	43.0
Percentage of MWRA not wanting more children	41.5
Percentage of MWRA wanting to delay next birth for at least two years	33.9
Percentage of MWRA knowing at least one contraceptive method	100.0
Contraceptive prevalence rate	21.7
Percentage of MWRA who are past users of contraception	15.7
Percentage of MWRA with unmet need for family planning	32.5
Percentage of MWRA with unmet need for spacing	15.4
Percentage of MWRA with unmet need for limiting	17.1
Total demand for family planning (CPR + unmet need)	54.3

Preference for Children

The median “ideal” family size, according to female respondents, was five children, which was higher than the average finding for Pakistan. Regarding desire for more children in the future, 25 percent said they wanted another child soon (within two years), 34 percent said they wanted another child, but only after two years, and 42 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. About 63 percent of the female respondents said their husband wanted the same number of children that they did.

Contraceptive Knowledge and Use

All currently married women knew of at least one contraceptive method. The contraceptive prevalence rate (the percentage of MWRA currently using any method of contraception) was 21.7 percent. The most commonly used methods were female sterilization (6.7 percent), condoms (3.5 percent), IUDs (3 percent), and injectables (2.5 percent). Past users comprised 15.7 percent of MWRA; injectables, pills, condoms, and IUDs were all common methods used by past users. Sixty-eight percent of the current users did not want more children, while 32 percent wanted more, but at a later time. Most users reported obtaining their supplies and services from private hospitals/clinics, Government department sources or through their husbands (for condoms and pills).

Experience with Contraceptive Methods

Reasons for choosing a current or past method varied by method, but commonly cited reasons included convenience of use, suitability for respondent and husband, few side effects, easy availability, and (for IUD users and female sterilization) ability to use for a long period of time. Costs were generally low (25 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; thirty-eight percent reported requiring more than 30 minutes to reach their service. Information provided at acceptance of method often did not include information on side effects or method choice. Clients generally reported being reasonably treated by providers and often examined properly. Respondents

indicated that providers were capable of dealing with side effects caused by methods. A variety of side effects were reported by users and past users.

Reasons for Non-use

When asked about the obstacles a couple might face if they wanted to avoid or delay pregnancy, women typically mentioned side effects, husband's disapproval, and religion, while also mentioning distance/cost, method failure, or people finding out contraceptive use. Past users were most likely to discontinue use because they wanted more children or because of side effects. Their reasons for current non-use were most often related to current or anticipated childbearing, but side effects were also frequently mentioned. Never users were most likely to say they were not using for reasons related to childbearing, but fear of side effects and husband's opposition were also common reasons. Nearly half of the never users disapproved of spacing and/or limiting births. A large majority of current and past users said they could discuss family planning easily with their husbands, while 61 percent of never users made the same claim. Knowledge of contraceptive methods, and particularly of sources, was noticeably lower among never users than among current or past users. About a quarter of never users expressed the intent to use contraception in the future. This indicates that a substantial number of women in Sanghar were willing to practice birth spacing and family planning.

Unmet Need for Family Planning

A woman is said to have "unmet need" for family planning if she has a desire to limit or space her fertility, but is not using any method of contraception and is at risk of conceiving. By this definition, 32.5 percent of the women in this sample were considered to have unmet need for family planning; 17.1 percent for limiting and 15.4 percent for spacing. This proportion is 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 medium-to-low standards of living. However, unmet need for spacing was higher among literate women. Women with unmet need tended to be characterized by poor communication with their husbands, disagreement over whether to have more children, fear of side effects, and lack of knowledge of family planning sources.

Reproductive Preferences and Behavior of Men

The findings reveal that all men knew at least one modern contraceptive method. Male sterilization was one of the least known contraceptive methods among men in Sanghar. Sixty-four percent of the men did not want more children in the future or wanted to delay the next pregnancy. Thirty percent of the male respondents reported that they or their wives were currently using any family planning methods, and 18 percent were using modern contraceptive methods. Among the current users, more than 78 percent were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, 36 percent reported that they were not intending to use any FP method in future. The fear of side effects was one of the main reasons for not using any FP method. Of those who did intend to use contraceptives in the future, very few reported that they intended to use male methods. 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 in birth-spacing and limiting needs.

Conclusion

Among rural districts in Pakistan, Sanghar district 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 21.7 percent was moderate for a rural district in Pakistan. Nevertheless, there is much need for improvement; unmet need for family planning remained high at 32.5 percent. Among the important reasons that should be addressed in an improved program are the attitude of husbands, inter-spousal communication, fear of side effects, and knowledge of contraceptives 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 with 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, 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 works to integrate communication and services through a “whole district” approach involving all available resources in the public and private sectors. FALAH is being implemented by a team of seven partner organizations: Population Council (as the 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 appropriate. In Sanghar, district-level activities are being coordinated by Health and Nutrition Development Society (HANDS). Greenstar is providing information and services through social marketing and other partners are supporting specific activities as needed.

Sanghar District

Sanghar is predominantly a rural district in Sindh with more than three-fourths of its population living in rural areas. The overall estimated population of the district was 1,916,786 in 2008, with a population density of 179 people per square kilometer. Sanghar shares borders with Khairpur district to its north, Nawab Shah district to its north-west, Jaisalmir and Jodhpur (India) to its east, Mirpur Khas and Umer Kot districts to its south, and Hyderabad district to its south and southeast. Sanghar covers a total area of 10,728 square kilometers.

People living in the district belong to different castes and tribes, mainly Syed, Nizamaini, Mari, Keeria, Khaskheli, Shar, Lashari, Mehar, Jat, Rajan, Sama, Menghwar, Kohli and Bhell. The majority of the population is Muslim (79.2 percent). Hindus make up a large portion of the minority population in Sanghar (19.3 percent). Sindhi is the most commonly spoken language in the district, followed by Urdu, Punjabi, Balochi, Pushto and Saraki. Women in the district are also engaged in making *rillies* and local traditional embroidery. People in the district also work on making *ajraks*, *khurzins*, carpets, woolen *khathas* and *khes*, which are quite popular throughout the country.

The district has a number of educational and health institutions (Population Census Organization, 2000). According to the UNDP Pakistan National Human Development report 2003², Sanghar stood 56th among 91 districts of Pakistan on the Human Development Index.

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.

District-level data, based on the Pakistan Social and Living Standards Measurement Survey, 2004-05, were examined for various measures of education, gender equity, infant mortality and environmental sustainability. In these comparisons, Sanghar ranked below average on most measures of education, literacy and immunization, and above average on water supply availability. In fact, Sanghar ranked 12th nationally out of 98 districts on sanitation (Planning Commission of Pakistan, 2006).

The Sanghar Baseline Household Survey

In Sanghar (as in each of the 20 FALAH focus districts), the 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 represents one of the 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 toward the end of the project to assess progress.

Objectives

The objectives of the Sanghar 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 and practices of married couples of Sanghar 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 which 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, attitude and practice of these married couples regarding family planning.

Sample Design and Size

A representative sample of the district was selected using the systematic stratified random sample technique. 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 chosen 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. Next, one block was randomly selected from each circle. The household listing of each randomly chosen block was then carried out by the enumeration teams before selecting the sampled 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 the 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 using 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 Sanghar.

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

Result	Rural	Urban	Total
Number of blocks/villages	31	9	40
Planned households	403	117	520
Households contacted	433	141	574
Households replaced	30	24	54
(Households refused)	0	1	1
(Households locked)	30	23	53
Eligible women identified	507	124	631
(Eligible women refused)	0	1	1
Total women's interviews	507	123	630

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 were used for male respondents. The interviewers were 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 session of the Sanghar 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 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 was 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 emphasizing 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 Sanghar district was carried out between May 27 and July 13, 2008.

Chapter 2

Household Characteristics

Geographic Distribution

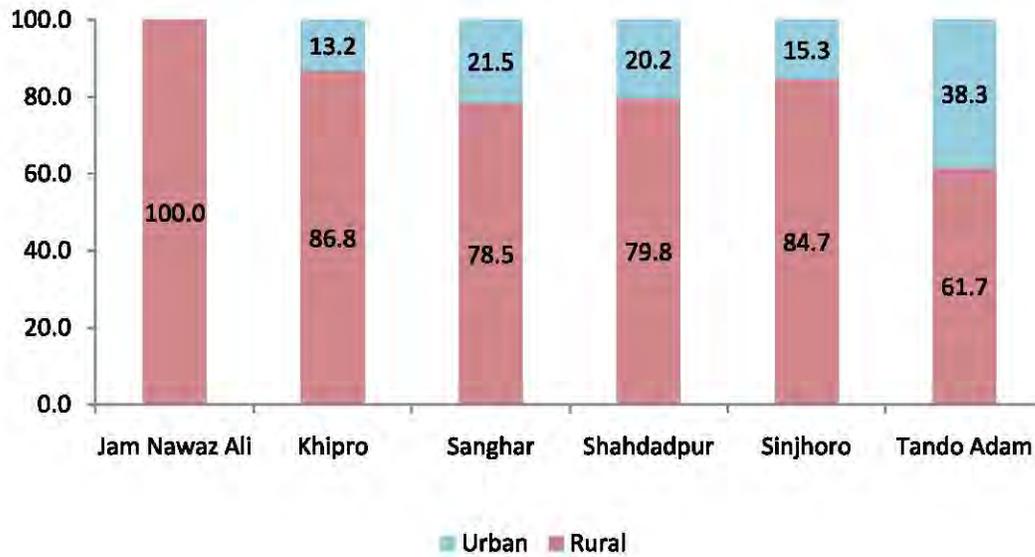
The district of Sanghar is comprised of six *talukas/tehsils* namely Jam Nawaz Ali, Khipro, Sanghar, Shahdadpur, Sinjhor and Tando Adam. These areas are predominantly rural – almost 80 percent of the sample population lives in rural areas. Table 2.1 and Figure 2.1 show the distribution of the population according to residence (urban and rural) and by taluka, with comparisons to the population distribution of the 1998 National Population and Housing Census.

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

Name of taluka	Rural			Urban			Total	
	N	%	Census %	N	%	Census %	N	%
Jam Nawaz Ali	240	100.0	85.8	0	0.0	14.2	240	100.0
Khipro	671	86.8	92.2	102	13.2	7.8	773	100.0
Sanghar	779	78.5	77.0	213	21.5	23.0	992	100.0
Shahdadpur	914	79.8	73.4	232	20.2	26.6	1146	100.0
Sinjhor	541	84.7	81.7	98	15.3	18.3	639	100.0
Tando Adam	457	61.7	54.5	284	38.3	45.5	741	100.0
Total	3602	79.5	77.2	929	20.5	22.8	4531	100.0

As 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, except for taluka Jam Nawaz Ali (Population Census Organization, 2000).

Figure 2.1: Rural - urban distribution of population in sample households by residence and taluka



The mother-tongue of half of the sample households was Sindhi, reflecting the dominant ethnic group in the district. Other languages spoken in Sanghar were Saraiki and Punjabi (9 percent and 7 percent respectively). About 47 percent of the sample population resided in Sanghar and Shahdadpur Talukas, whereas 100 percent of the sample population of Taluka Jam Nawaz Ali lived in rural areas. Taluka Tando Adam is comparatively urbanized, with 38 percent of its population residing in urban areas.

Age-Sex Distribution

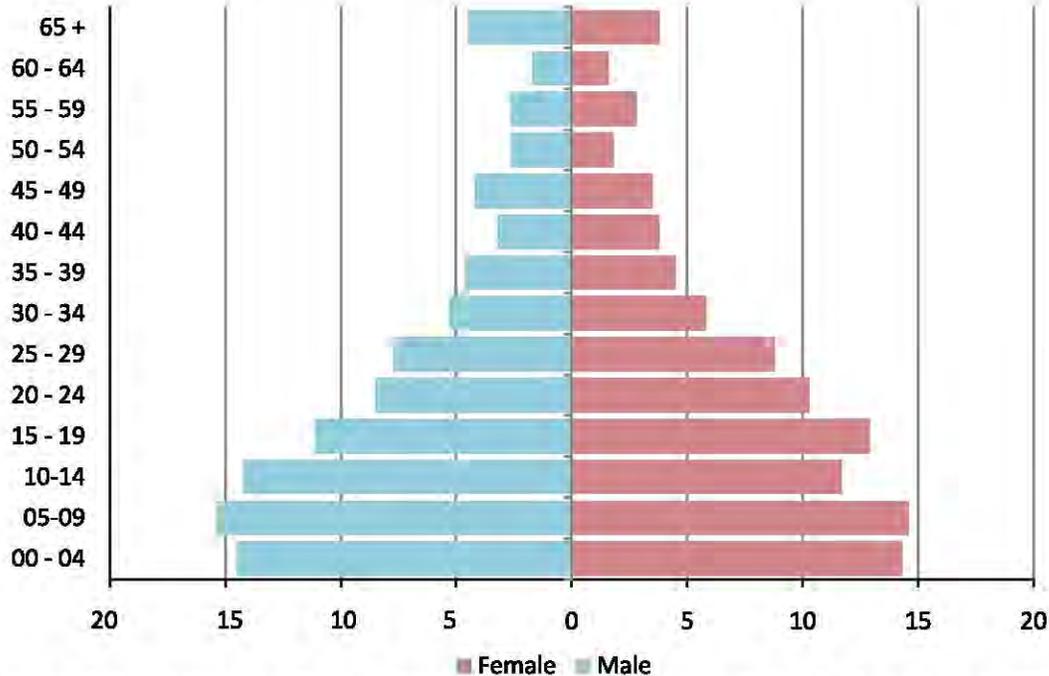
Table 2.2 shows the population distribution of the sampled households by age and sex; Figure 2.2 shows the same information in the form of an age-sex pyramid.

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

Age group	Sex of household member					
	Male		Female		Total	
	N	%	N	%	N	%
00 - 04	343	14.5	311	14.3	654	14.4
05 - 09	364	15.4	317	14.6	681	15.0
10 - 14	334	14.2	253	11.7	587	13.0
15 - 19	262	11.1	280	12.9	542	12.0
20 - 24	200	8.5	223	10.3	423	9.3
25 - 29	181	7.7	190	8.8	371	8.2
30 - 34	124	5.3	125	5.8	249	5.5
35 - 39	108	4.6	98	4.5	206	4.5
40 - 44	76	3.2	82	3.8	158	3.5
45 - 49	99	4.2	76	3.5	175	3.9
50 - 54	62	2.6	40	1.8	102	2.3
55 - 59	61	2.6	60	2.8	121	2.7
60 - 64	40	1.7	34	1.6	74	1.6
65 - 69	38	1.6	34	1.6	72	1.6
70 - 74	37	1.6	24	1.1	61	1.3
75+	30	1.3	24	1.1	54	1.2
Total	2359	100.0	2171	100.0	4530	100.0

The population is typical of a society with high fertility with 42 percent of the population being under 15 years of age. At older ages there were somewhat more males than females.

Figure 2.2: Age-sex distribution of Sanghar



Of the total population of the sampled households, 24 percent (1074 women of the total population of 4530) consisted of females who were 15-49 years of age, and 14.4 percent consisted of children under five years of age. These women and children comprise the population of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

Marital Status

The survey collected information on the marital status of all household members more than 15 years of age. The percentage of males in the 15 to 19 year old age group that had never married was higher (97 percent) than the percentage of never married females in the same age group (80 percent). The proportion of 15 to 19 year old females who were currently married stood at 20 percent, while only 3 percent of their male counterparts were currently married. The estimated singulate mean age at marriage (SMAM) for females was 22 years compared to 26 years for males. It is important to note that divorce rates were very low in the district of Sanghar.

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

Age group	Marital status of household members					
	Married		Widowed/divorced/ separated		Never married	
	Female	Male	Female	Male	Female	Male
15 - 19	20.4	3.1	0.0	0.0	79.6	96.9
20 - 24	59.5	27.6	0.9	2.0	39.6	70.4
25 - 29	82.6	62.2	1.6	2.2	15.8	35.6
30 - 34	86.4	87.1	7.2	2.4	6.4	10.5
35 - 39	93.9	91.7	5.1	0.0	1.0	8.3
40 - 44	89.0	93.4	7.3	1.3	3.7	5.3
45 - 49	90.8	91.9	7.9	5.1	1.3	3.0
50 - 54	77.5	95.2	22.5	4.8	0.0	0.0
55 - 59	76.7	86.9	21.7	9.8	1.7	3.3
60 - 64	73.5	82.5	26.5	10.0	0.0	7.5
65 - 69	50.0	91.9	50.0	8.1	0.0	0.0
70 - 74	41.7	78.4	58.3	21.6	0.0	0.0
75+	20.8	70.0	75.0	26.7	4.2	3.3
All ages 15+	44.3	38.5	8.6	3.7	49.7	59.1
N	822	773	111	49	356	494

Household Characteristics and Wealth Indicators

Several household characteristics that reflect the wealth and well-being of its inhabitants were assessed. Some of these may have a 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, 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 sample households. Six percent of the households had an indoor water supply through water taps, while 63 percent had motorized hand pumps inside. About half of the total households (49 percent) in Sanghar had some type of flush toilet (Figure 2.3), whereas 27 percent of the households did not have any type of toilet. This is consistent with the 2006 Millennium Development Report

(based on PSLMS data) which found Sanghar to have the 12th highest score for sanitation of all districts in Pakistan (Planning Commission of Pakistan, 2006).

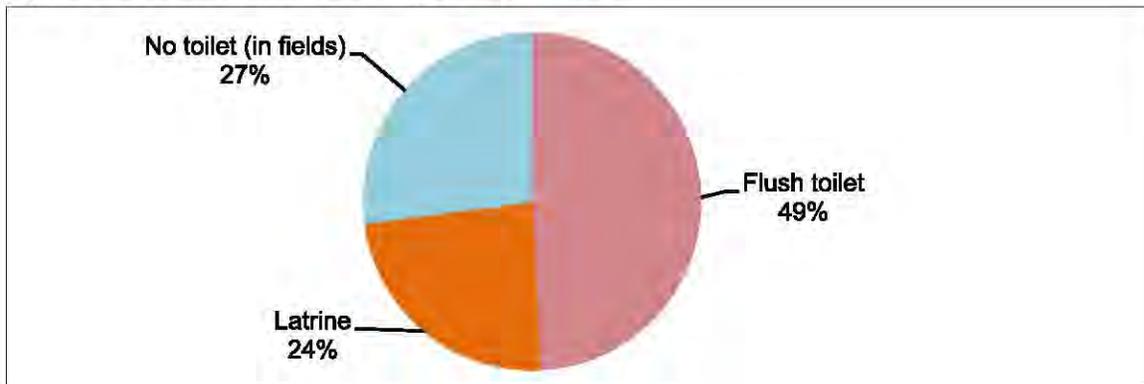
Table 2.4: Distribution of households with selected physical characteristics by residence

Characteristic	Rural		Urban		Total	
	N	%	N	%	N	%
Main source of drinking water						
Govt. supply (tap water inside)	1	0.2	32	27.4	33	6.3
Motorized/hand pump (inside)	248	61.5	78	66.7	326	62.7
Motorized/hand pump (outside)	122	30.3	5	4.3	127	24.4
River/canal/stream/pond water	30	7.4	0	0.0	30	5.8
Others	2	0.4	2	1.8	4	0.8
Sanitation facility						
Flush to sewerage	1	0.2	5	4.3	6	1.2
Flush connected to septic tank	89	22.1	16	13.7	105	20.2
Flush connected to open drain	52	12.9	93	79.5	145	27.9
Raised /pit latrine	122	30.3	1	0.9	123	23.6
No toilet (in fields)	139	34.5	2	1.7	141	27.1
Type of fuel used for cooking						
Firewood	375	93.3	29	25.2	404	78.1
Gas cylinder	2	0.5	0	0	2	0.4
Natural gas (sui gas)	18	4.5	86	74.8	104	20.1
Dung dry	7	1.7	0	0	7	1.4
Electricity connection						
Yes	317	78.7	116	99.1	433	83.3
No	86	21.3	1	0.9	87	16.7
Main material of the roof						
Concrete	4	1.0	20	17.1	24	4.6
Iron sheet	1	0.2	8	6.8	9	1.7
Guarder and T-iron	171	42.4	74	63.2	245	47.1
Wood/bamboo and mud	227	56.3	15	12.8	242	46.5
Main material of the floor						
Earth/sand/mud	276	68.7	23	19.7	299	57.6
Chips/marble/ceramic tiles	2	0.5	8	6.9	10	2.0
Cement	117	29.1	82	70.1	199	38.3
Bricks	7	1.7	4	3.4	11	2.1
Main material of the walls						
Burnt bricks/blocks	196	48.6	108	92.3	304	58.5
Mud bricks/mud	130	32.3	7	6.0	137	26.3
Wood/bamboo	77	19.1	2	1.7	79	15.2
Total	403	na	117	na	520	na

na=not applicable.

While 75 percent of the households in urban areas used natural gas, only 5 percent used this type of fuel for cooking in rural areas (Table 2.4). Almost all the households in urban areas had electricity, while 21 percent of the rural households still did not have any electric facilities. Nearly half of the household roofs were made of wood/bamboo and mud while the other half were made of guarder and T-irons. More than half of the walls were made of burnt brick or cement blocks.

Figure 2.3: Toilet facilities for Sanghar 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, and comfort – along with different levels of expenditure. Some have specific relevance to the FALAH objectives; for example, electronic media can be used to access health messages or to reach health facilities, and telephones to summon 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 Sanghar were not available to us. Several items requiring electricity were available in a substantial number of urban households; even in rural areas more than one-third of all households had a radio or tape recorder while 35 percent had television sets. The recent expansion in information technology in Pakistan is reflected by the ownership of mobile telephones by 60 percent of all households (urban-rural differentials were high for mobile

phone use) and a computer by about 3 percent of all households. Ownership of motorized transport, however, was low, suggesting difficulties in arranging for transport in health emergencies.

Table 2.5: Percentage of households owning selected items, by residence

Item	Rural	Urban	Total
Wall clock	48.4	87.2	57.1
Chairs	12.7	39.3	18.7
Bed	11.7	41.9	18.5
Sofa	10.0	30.8	14.6
Sewing machine	38.5	75.2	46.7
Camera	4.0	12.0	5.8
Radio/Tape recorder	35.7	34.2	35.4
Television	34.7	87.2	46.5
Refrigerator	17.6	42.7	23.3
Land line telephone	5.0	19.7	8.3
Mobile phone	54.3	77.8	59.6
Room cooler/ air conditioner	3.7	14.5	6.2
Washing machine	13.9	60.7	24.4
Cycle	17.9	20.5	18.5
Motorcycle	19.6	21.4	20.0
Jeep/car	5.2	3.4	4.8
Tractor	5.5	1.7	4.6
Computer	2.2	5.1	2.9
N	403	117	520

Standard of Living Index

The data presented below are useful in depicting an overall index of the economic well-being of a household, both for generally estimating economic development for an area, and for 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 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 depicts the distribution of the SLI for sample households according to urban and rural residence. The median index for all households in rural areas was 4, and it was 7 for urban areas. About 73 percent of all households fell in the range from 0 to 6. Forty-six percent of the rural households were in the range from 0 to 3, indicating higher poverty in the area, and 27 percent of all the households fell in the range 7-11. 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	%
0	6	1.5	0.0	0.0	6	1.2
1	37	9.2	0.0	0.0	37	7.1
2	75	18.6	2	1.7	77	14.8
3	66	16.4	1	0.9	67	12.9
4	63	15.6	3	2.6	66	12.7
5	41	10.2	13	11.1	54	10.4
6	41	10.2	29	24.8	70	13.5
7	25	6.2	24	20.5	49	9.4
8	27	6.7	22	18.8	49	9.4
9	20	5.0	15	12.8	35	6.7
10	2	0.5	7	6.0	9	1.7
11	0.0	0.0	1	0.9	1	0.2
Total	403	100.0	117	100.0	520	100.0
Median	4	na	7	na	5	na

na = not applicable.

Chapter 3

Respondent Characteristics

The primary sources of data from the Household Survey are the interviews conducted with 630 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 female respondents for rural and urban areas. Since many younger women were not married yet, the numbers at age less than 19 years were relatively small; at older ages, the numbers declined as reflected in the overall shape of the age pyramid. About half of the female respondents in the sample were under the age of 30. Urban-rural differences were significant, 51 percent of the rural female respondents were below the age of 30 years, compared to 42 percent for urban female respondents in the same age bracket.

Table 3.1: Age distribution of female respondents by residence

Age group	Rural		Urban		Total	
	N	%	N	%	N	%
<19	44	8.7	5	4.1	49	7.8
20 - 24	102	20.1	20	16.3	122	19.4
25 - 29	113	22.3	26	21.1	139	22.1
30 - 34	81	16.0	17	13.8	98	15.6
35 - 39	63	12.4	25	20.3	88	14.0
40 - 44	54	10.5	18	14.6	72	11.4
45 - 49	50	9.9	12	9.8	62	9.8
Total	507	100.0	123	100.0	630	100.0

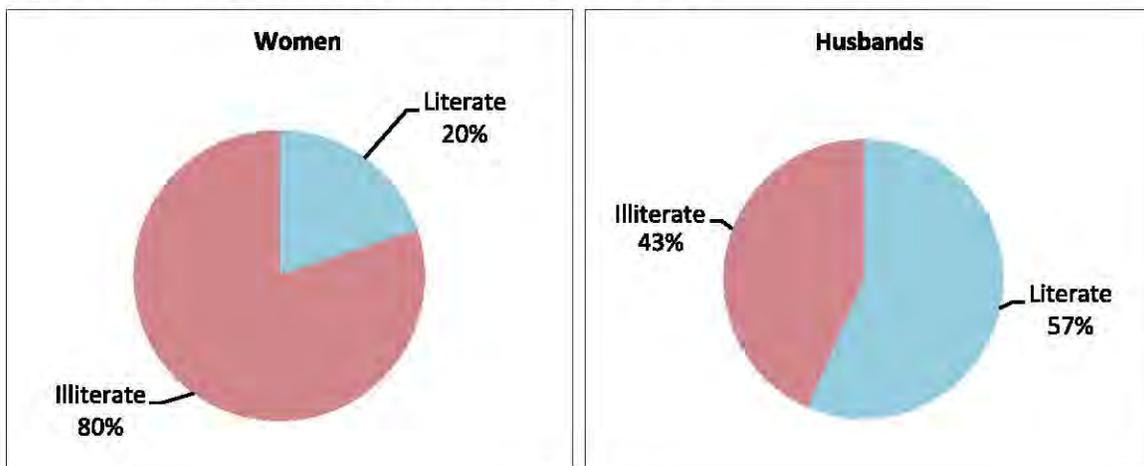
Education and Literacy

Levels of schooling completed and literacy rates for the respondents and their husbands are given in Table 3.2 and illustrated in Figure 3.1. Literacy rates in Sanghar were low. The literacy rate of female respondents was 20 percent, compared with 38 percent for 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 14 percent of the female respondents reported being educated up to primary levels and only 4 percent had above secondary level education. For the husbands of the women as well, literacy (at 57 percent) was lower than the rest of Sindh in 2004-05 (68 percent), as well as the national average (63 percent) (Government of Pakistan, 2005). Table 3.2 also shows that younger women aged 15-24 years and 25-34 years were significantly more literate than older women 35-49 years old.

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

Variable	Age group			Residence		Total
	15 - 24	25 - 34	35 - 49	Rural	Urban	
Respondent (women)						
Proportion literate	21.3	27.0	11.2	14.8	41.9	20.0
Education level						
No education	74.3	69.5	84.7	81.2	55.3	76.2
Up to primary	15.8	16.1	9.5	11.7	22.0	13.7
Up to secondary	8.2	6.8	3.6	4.7	11.4	6.0
Above secondary	1.8	7.6	2.3	2.4	11.4	4.1
N	172	236	221	506	123	629
Respondent's husband						
Proportion literate	56.5	63.9	49.2	53.2	71.0	56.7
Education level (husband)						
No education	43.6	38.1	50.0	46.7	31.9	43.8
Up to primary	16.7	12.4	21.3	18.9	7.8	16.7
Up to secondary	25.0	24.3	16.8	19.6	31.0	21.9
Above secondary	14.7	25.2	11.9	14.8	29.3	17.7
N	156	218	202	460	116	576

The urban–rural gap was significantly high for women both in literacy and education levels. Women's literacy was substantially lower in Sanghar 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 lifestyle. Women's work, whether for necessary income generation 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, i.e., 51 percent, of female respondents reported working for money. Half of these women were engaged in embroidery/stitching, while about 47 percent were employed in the agricultural industry.

Figure 3.2: Type of work of women working for pay (n=322)

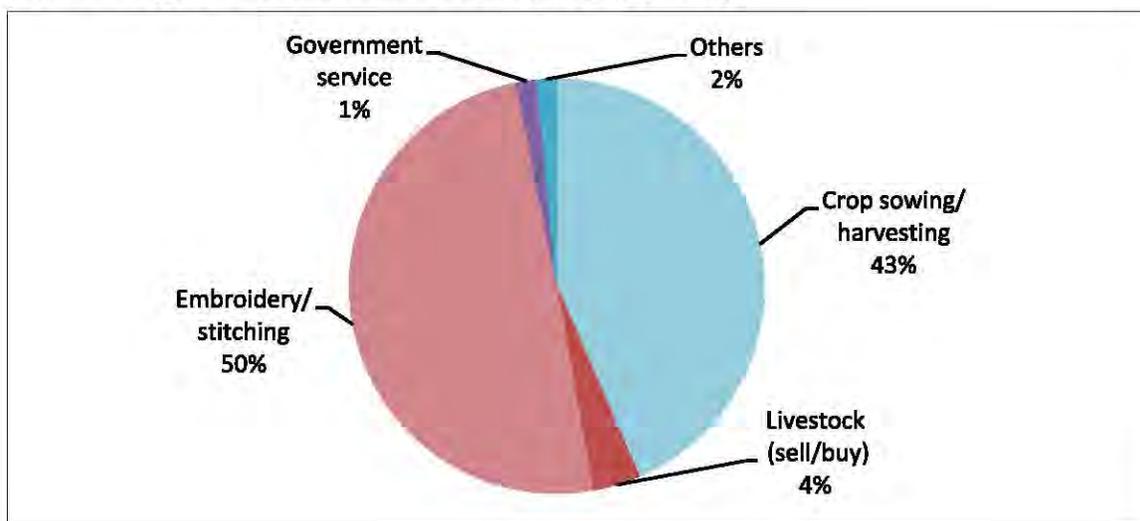


Table 3.3: Distribution of occupational categories of respondents' husbands by residence

Economic activity/occupation	Rural	Urban	Total
Agriculture/livestock/poultry	40.4	11.4	34.8
Petty trader	3.2	4.1	3.3
Labor (daily wages)	22.7	24.4	23.0
Government service	12.4	22.8	14.4
Private service	5.5	8.9	6.2
Own business	7.7	22.8	10.6
Working abroad	0.2	0.0	0.2
Unemployed	6.3	5.7	6.2
Others	1.6	0.0	1.3
N	507	123	630

Slightly over one-third of the husbands were engaged in the agriculture/ livestock/ poultry sector (Table 3.3). Two-fifths (40 percent) of the rural husbands worked in agriculture, either working their own land or regularly being employed by someone. Overall, about 63 percent of rural husbands were engaged in either agriculture or daily labor, 23 percent of

the urban husbands was employed in government service, which was the third largest employer in the district. Another 23 percent of the urban husbands were doing their own business, compared to 8 percent of the husbands in rural areas. Overall, about 6 percent of the husbands included in the sample were unemployed.

Female Mobility

Female respondents were asked about the permission required for them to go to places outside their homes (Table 3.4). The health centre/doctor was the only place where a substantial number of women (63 percent) said they could go with someone, 31 percent could go with permission. With the exception of visiting relatives and friends, only a few women reported being able to go to any of the places named without permission. To visit relatives/friends, about 28 percent of the respondents were able to go without permission, and another 45 percent were able to do so with permission. On the other hand, 36 percent of the women reported not being able to go at all to the market. For each of the named destinations, a substantial number said they were able to go with permission or with someone.

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

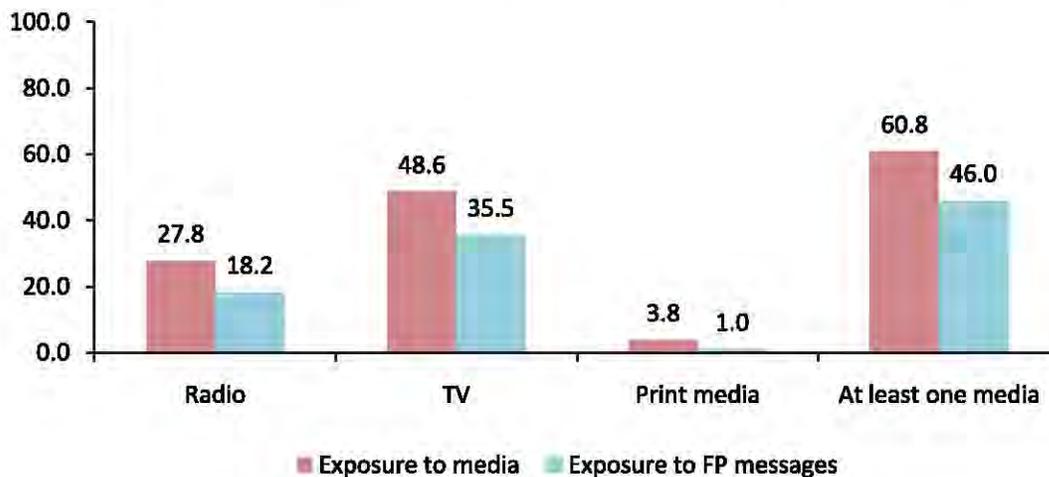
Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Can't go/ doesn't go	%	N
Market	2.1	27.9	34.3	35.8	100.0	630
Health center	2.1	30.8	63.2	4.0	100.0	630
Relatives/friends	27.5	44.6	27.6	0.4	100.0	630
Out of village/town	0.6	60.8	35.9	2.8	100.0	630

Mass Media Access and Exposure to Family Planning 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. Table 2.5 shows that 46.5 percent of households owned a television, while 35 percent owned a radio. Figure 3.3 shows the proportion of respondents who reported that they watched TV, listened to the radio, or read newspapers or magazines. Television was

the most commonly accessed medium (49 percent), while 28 percent of respondents also listened to the radio and only 4 percent of the respondents had access to print materials.

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



Furthermore, women who reported having access to any sort of media were asked if they had ever seen, heard, or read any message about the methods of family planning through these mediums. Eighteen percent of the women said that they had heard family planning messages on the radio. More than one-third of women had seen FP messages on the television. According to Figure 3.3, only one percent of the respondents said that they had ever read a family planning message in a newspaper. Overall, nearly three-fifths (61 percent) of the women had access to some sort of media, whereas less than half (46 percent) of the women had ever been exposed to any FP message through any of these mediums.

Chapter 4

Service Availability

Health status and practices in a district can only be understood in the context of the health facilities and trained personnel available to the population of that district. As a companion activity to the Sanghar Household Survey, the FALAH project undertook a mapping of health and reproductive health services study in the FALAH districts. The fieldwork in Sanghar was carried out from June to July 2008. In this survey, all facilities and providers for reproductive health, public and private, 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 and the characteristics and activities of the facility and its staff were examined. The full results of this study are presented in a separate report titled “Mapping of Health and Reproductive Health Services-Sanghar district”. Some basic results are provided to give an overview of the context in which the knowledge, attitudes and behavior of the men and women of the household survey sample can be understood.

These results represent a range of maternal and reproductive health services being provided in Charsadda. In this chapter the tables summarize these findings, and are illustrated by maps indicating the location of various types of providers and facilities

District Data

There are total of 1927 facilities in Sanghar, of which 1105 are public and 822 are from the private sector (117 from Greenstar Social Marketing; 705 other private organizations). Some facilities provide only limited care, such as the LHW health houses and dispensaries in the public sector and traditional practitioners in the private sector.

Reproductive Health Facilities

The distribution of reproductive health facilities per union council in the public and private sectors is shown in Maps 4.1 to 4.3. Map 4.1 shows the distribution of government static facilities by union council population density. Similarly, Map 4.2 shows the availability of LHWs; the variation is considerable as 20 union councils have more than 20 LHWs, while 11 have fewer than 10 LHWs. Nearly all union councils in Sanghar district are well served: on average there are 17 LHWs per union council. Map 4.3 shows the distribution of private facilities in the district.

The gross density of reproductive health facilities in terms of the number of facilities per union council is shown in Map 4.4. The variation is considerable: 10 union councils have more than 50 reproductive health facilities, while only one has fewer than 15 facilities. On the whole, however, there do not appear to be large geographic areas for which no reproductive health services are available. Nearly all union councils in Sanghar district are well served with an average of 36 facilities per union council.

Family Planning Facilities

By and large, family planning services are available in two-thirds of both public and private facilities. Clinical methods are available in half of the facilities in the district; public facilities are more likely to provide clinical methods than private ones, especially in the provision of injectables. A significant number of LHWs are providing injectables in addition to condoms and oral pills. Female and male sterilization are not easily available, while Norplant is not available at all. Family planning methods are available in less than one-fifth of private facilities. Emergency contraceptive pills are available on 40 private facilities.

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

Service	Sector										MWRA per facility
	Government		LHWs		Private GSM		Private others		Total		
	N	%	N	%	N	%	N	%	N	%	
Injectables	82	50.6	772	81.9	51	43.6	41	5.8	946	49.1	325
IUD/Copper T	49	30.2	na	na	41	35.0	23	3.3	113	5.9	2721
Norplant	0	0.0	na	na	0	0.0	0	0.0	0	0.0	na
Female sterilization	5	3.1	na	na	6	5.1	2	0.3	13	0.7	23654
Male sterilization	0	0.0	na	na	2	1.7	1	0.1	3	0.2	102501
Condom	84	51.9	935	99.2	27	23.1	24	3.4	1070	55.5	287
Pills	86	53.1	935	99.2	39	33.3	30	4.3	1090	56.6	282
ECP	8	4.9	0	0.0	25	21.4	7	1.0	40	2.1	7688
Any FP method	87	53.7	935	99.2	62	53.0	66	9.4	1150	59.7	267
Any clinical method	83	51.2	772	81.9	59	50.4	52	7.4	966	50.1	318
Any non-clinical method	86	53.1	935	99.2	41	35.0	34	4.8	1096	56.9	281
Total	162	100.0	943	100.0	117	100.0	705	100.0	1927	100.0	160

Multiple responses are possible.

na=not applicable.

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

Again, the geographic distribution of these services is as important as the number of facilities. Maps 4.5 to 4.7 illustrate the availability of female sterilization, IUDs, and Injectables. Female sterilization is available in 13 facilities of eight union councils. Availability of injectables is geographically more widespread, in both the public and private sectors. Pills and condoms (not shown) are readily available throughout the district.

Maternal Health Facilities

The provision of maternal health care services is an essential component of reproductive health care. Maternal health care facilities in Sanghar are shown in Table 4.2. A majority of

the service delivery points provided antenatal care services both in the public and the private sector. Anemia treatment is the most frequently available service both in the public and private facilities. Service availability for antenatal check-up, anemia treatment and tetanus protection is higher in the public sector. Normal deliveries are provided in both the private and public sectors. Provision of tetanus protection is particularly low in the private sector. Caesarean sections are provided in only four facilities in the public sector and eleven in the private sector.

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

Service	Sector										MWRA per facility
	Government		LHWs		Private GSM		Private others		Total		
	N	%	N	%	N	%	N	%	N	%	
Antenatal check-up	97	59.9	938	99.5	89	76.1	145	20.6	1269	65.9	242
Anemia treatment	147	90.7	942	99.9	111	94.9	511	72.5	1711	88.8	180
TT injection	57	35.2	912	96.7	4	3.4	5	0.7	978	50.8	314
Normal delivery	38	23.5	na	na	50	42.7	38	5.4	126	6.5	2441
Caesarean section	4	2.5	na	na	9	7.7	2	0.3	15	0.8	20500
Total	162	100.0	943	100.0	117	100.0	705	100.0	1927	100.0	160

Multiple responses are possible. na= not applicable.

Along with the sheer number of facilities, their geographic distribution is of critical importance. Map 4.8 shows the distribution of essential obstetric facilities in each union council of Sanghar district. There are 14 union councils that had no essential obstetric care facilities. Map 4.9 shows that comprehensive EmOC services are available in only six union councils and these services are provided by both the public and private sector.

Service Providers

The number of providers of different categories and number of women per provider is shown in Table 4.3. There are a total of 524 MBBS doctors of whom more than three-fourths

are male doctors. There are only 195 female paramedics, including LHVs and nurses, available to serve the female population of the entire district. The number of female paramedics is almost double than of male providers. The number of married women of reproductive age per service providers is also shown in Table 4.3. The number of women per provider or facility may be a good indicator of the status of health in the district. Overall, there are 587 MWRA per MBBS physician, but since most women prefer female providers, this number is increased to 3045 women per female MBBS doctor. This indicates a serious deficiency of female MBBS doctors. Similarly due to less availability of female paramedics the existing staff is overburdened. Map 4.10 shows the availability of MBBS doctors by gender in each union council. Male doctors are not available in four union councils while in 34 union councils there are no female MBBS doctors.

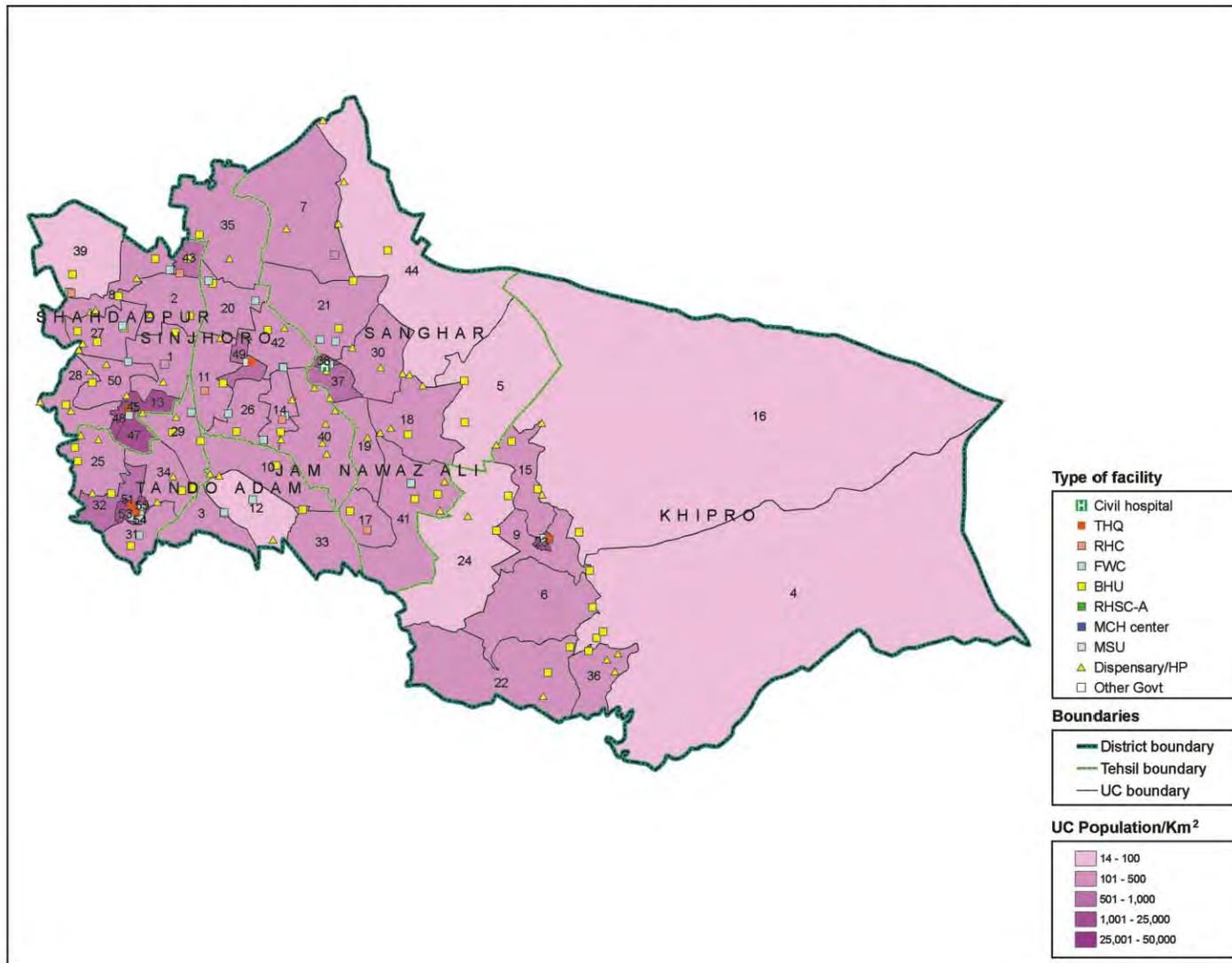
Table 4.3: Number of reproductive health care providers by sector and category and MWRA per service provider

Provider	Sector						Total		MWRA per provider
	Government		Private GSM		Private others		N	%	
	N	%	N	%	N	%			
Doctors (MBBS)									
Male	146	81.6	91	66.4	186	89.4	423	80.7	727
Female	33	18.4	46	33.6	22	10.6	101	19.3	3045
Total	179	100.0	137	100.0	208	100.0	524	100.0	587
Female paramedics									
Medical assistant	0	0.0	4	5.2	0	0.0	4	2.1	76876
Nurse	40	51.9	52	67.5	28	68.3	120	61.5	2563
Medical/health technician	11	14.3	0	0.0	0	0.0	11	5.6	27955
Lady health visitor	26	33.8	21	27.3	13	31.7	60	30.8	5125
Total	77	100.0	77	100.0	41	100.0	195	100.0	1577
Male paramedics	50	100.0	10	100.0	54	100.0	114	100.0	2697

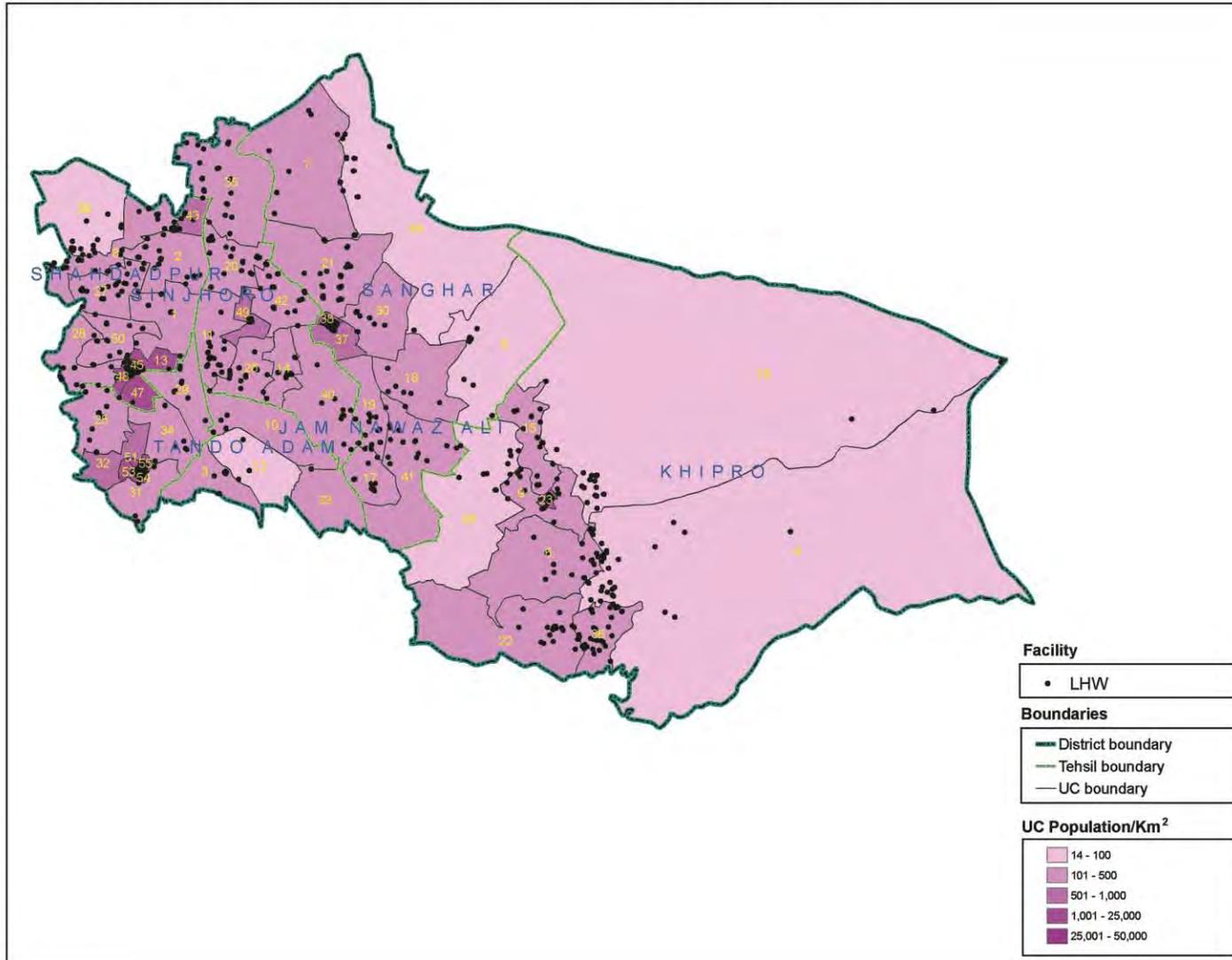
List of Union Councils

1	Asgharabad	16	Kamil Hingoro	31	Mir Hassan Mari	46	Shahdadpur-2
2	Barhoon	17	Kandiari	32	Mtho Khoso	47	Shahdadpur-3
3	Berani	18	Kanhar	33	Nauabad	48	Shahdadpur-4
4	Bilawal Hingorjo	19	Kehore	34	Peru Faqir Shoro	49	Sinjhero
5	Chotiaryoon	20	Khadro	35	Pritamabad	50	Soomar Faqir Hingoro
6	Dhilyar	21	Khadwari	36	Runjho	51	Tando Adam-1
7	Gujri	22	Khahi	37	Sanghar-1	52	Tando Adam -2
8	Gul Mohammad Laghari	23	Khipro	38	Sanghar-2	53	Tando Adam -3
9	Hathungo	24	Khori	39	Sarhari	54	Tando Adam -4
10	Hot Wassan	25	Khumb Darhoon	40	Sayyed Sibghatullah	55	Tando Adam -5
11	Jaffar Khan Leghari	26	Kurkali	41	Setharpir		
12	Jam Nawaz Ali	27	Lundo	42	Shah Mardan Abad		
13	Jatia	28	Maldasi	43	Shah Pur Chakar		
14	Jhol	29	Manik Thahim	44	Shah Sikandarabad		
15	Jinhar	30	Mian	45	Shahdadpur-1		

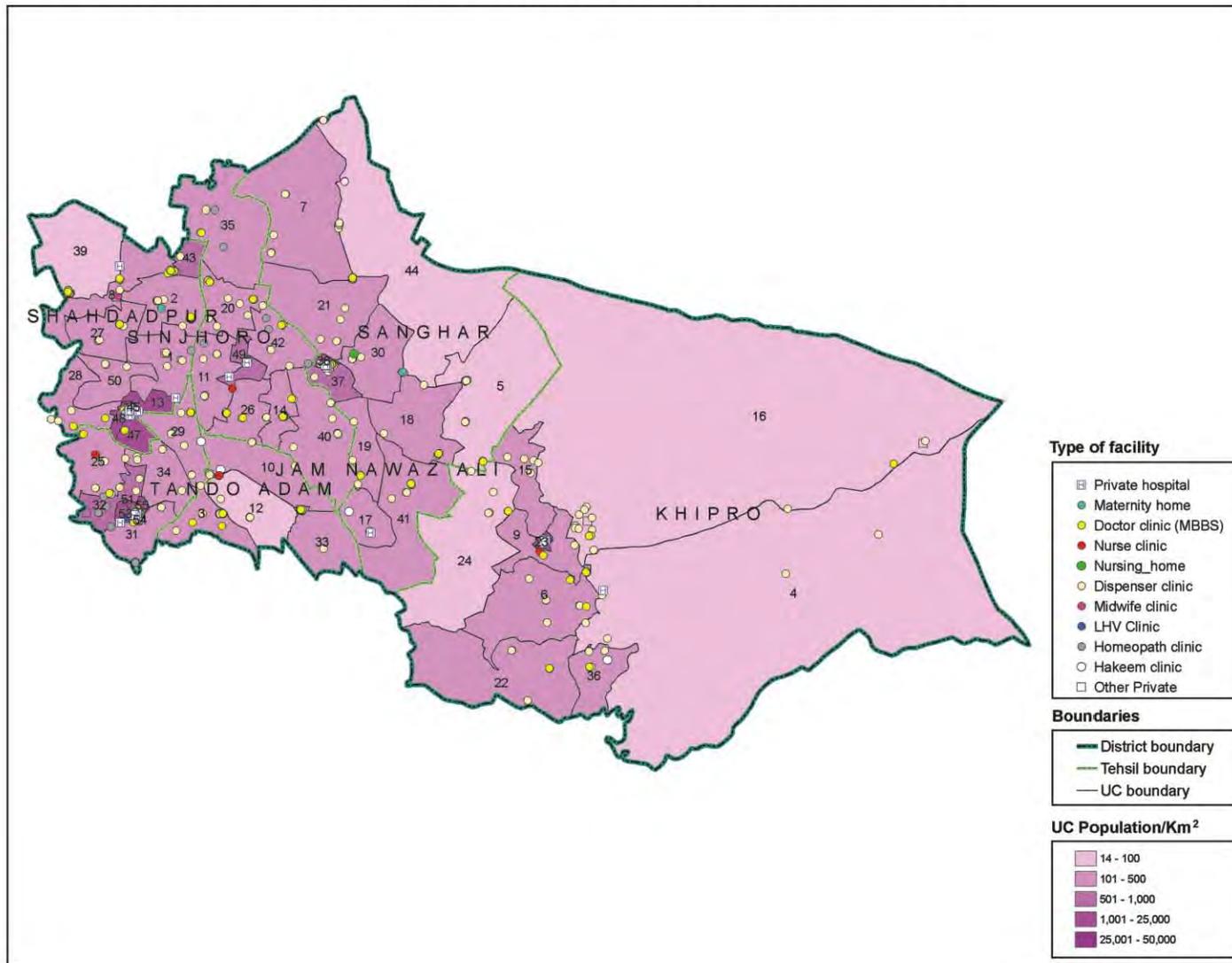
Map 4.1: Location of government facilities in Sanghar district, by population density of union council



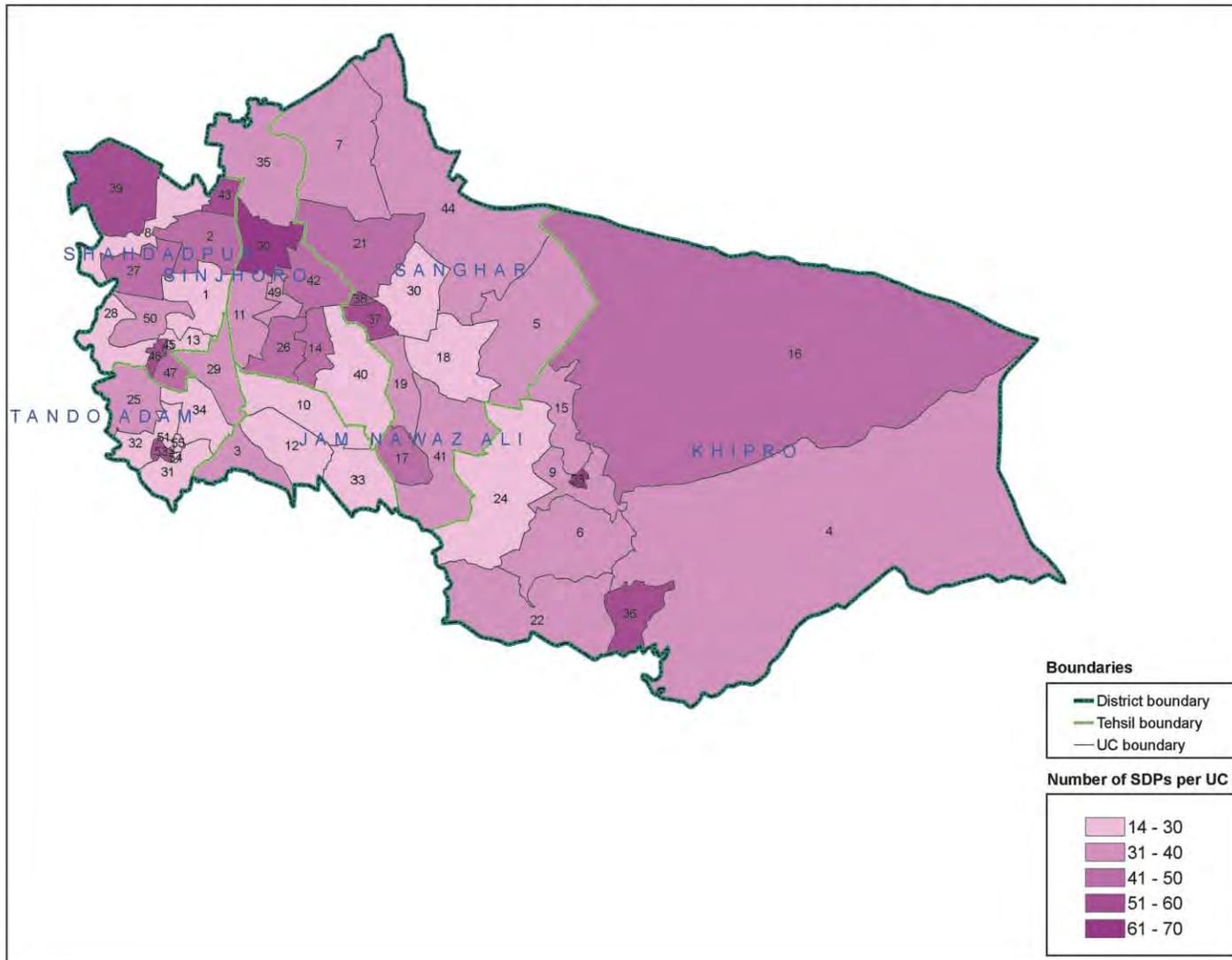
Map 4.2: Location of LHWs in Sanghar district, by population density of union council



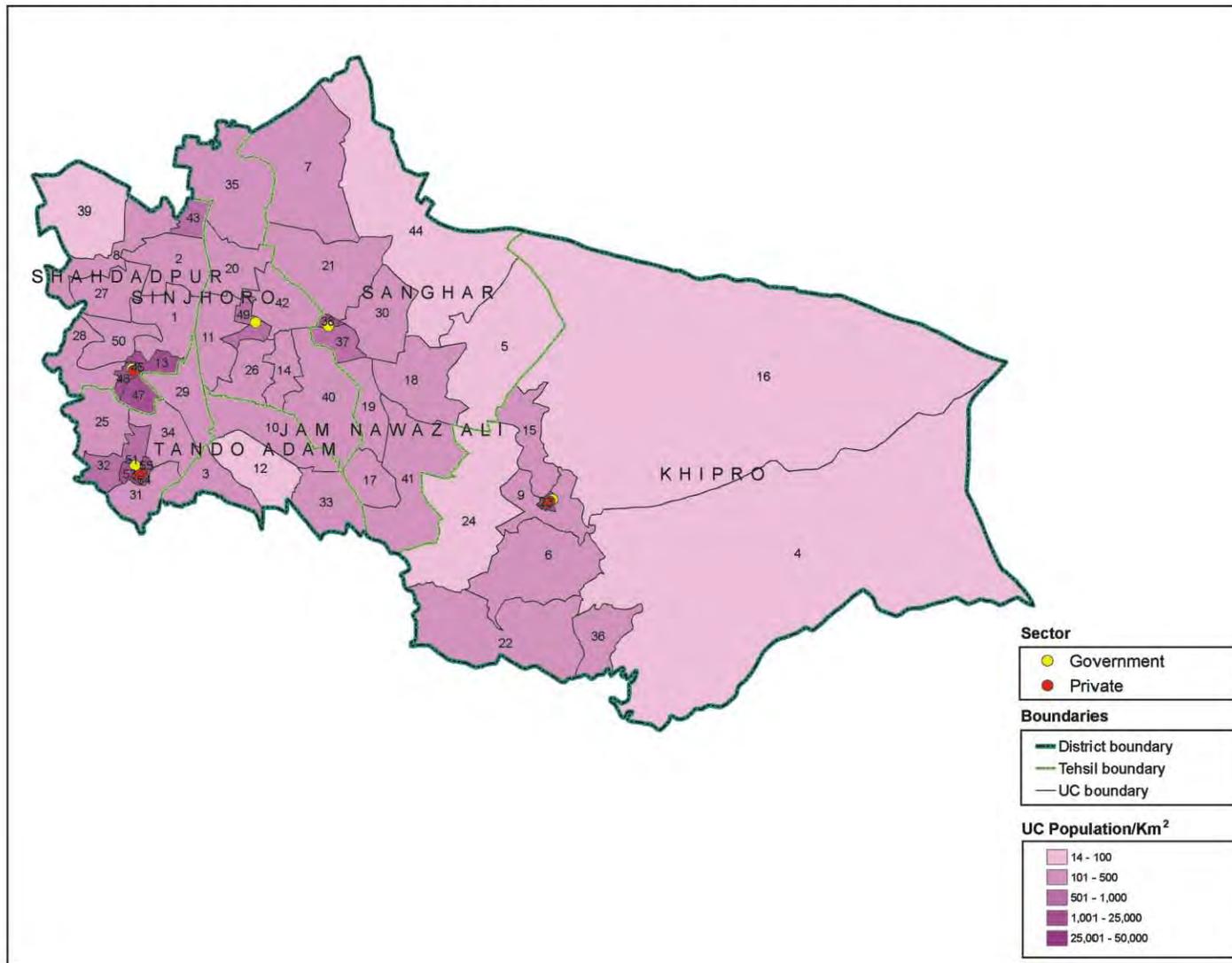
Map 4.3: Location of private facilities in Sanghar district, by population density of union council



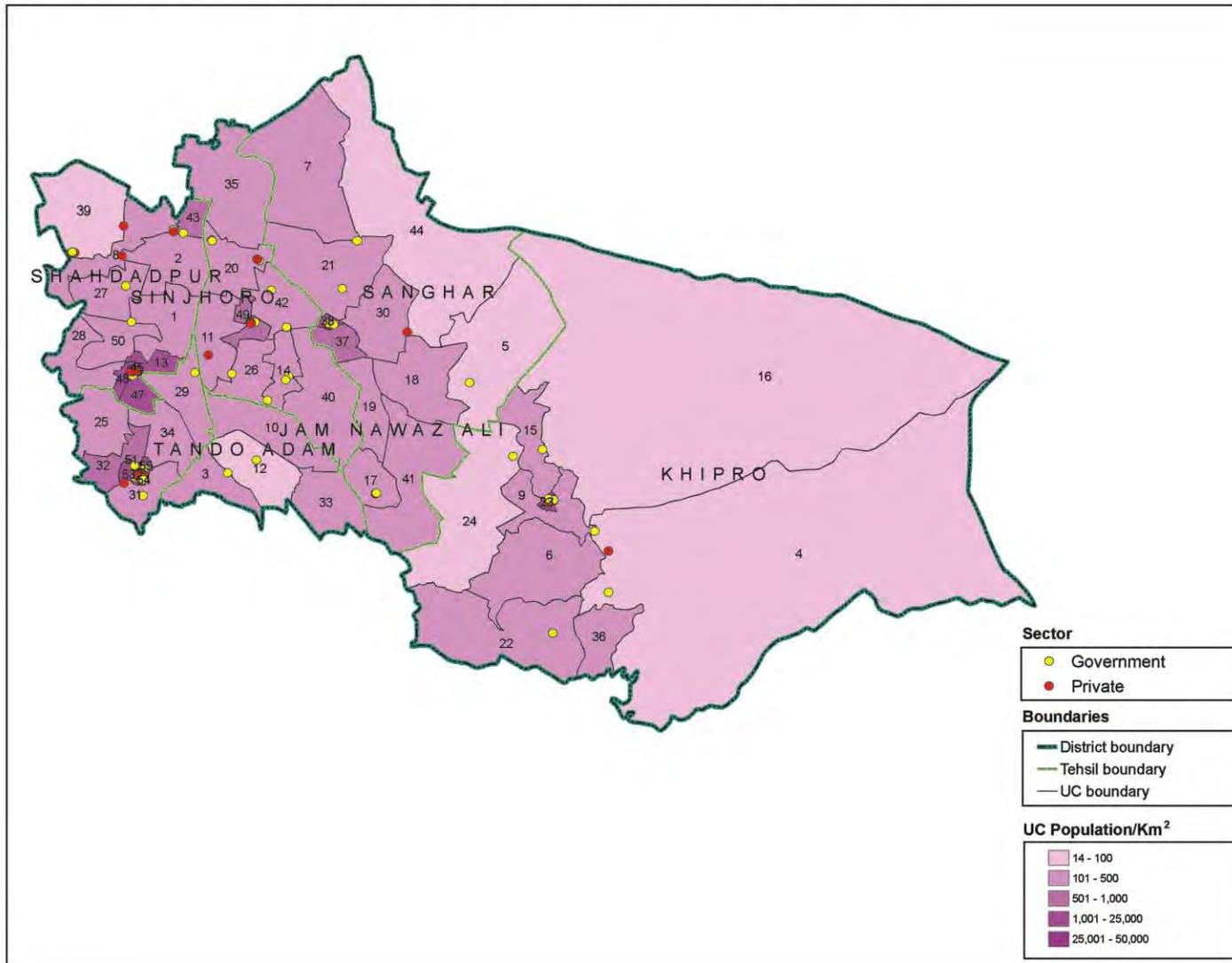
Map 4.4: Total number of reproductive health service delivery points (public and private), in Sanghar district, by union council



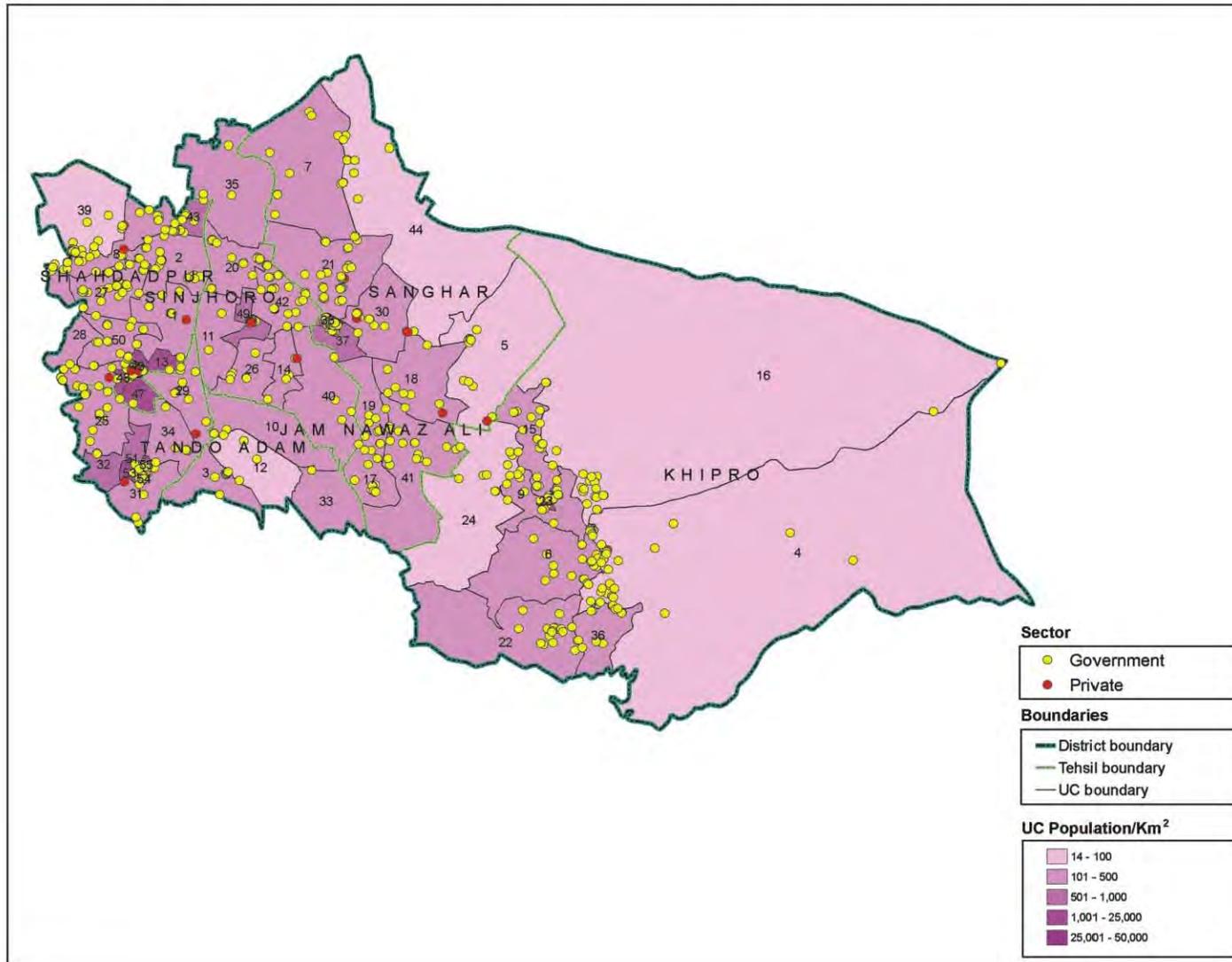
Map 4.5: Location of female sterilization facilities in Sanghar district, by population density of union council



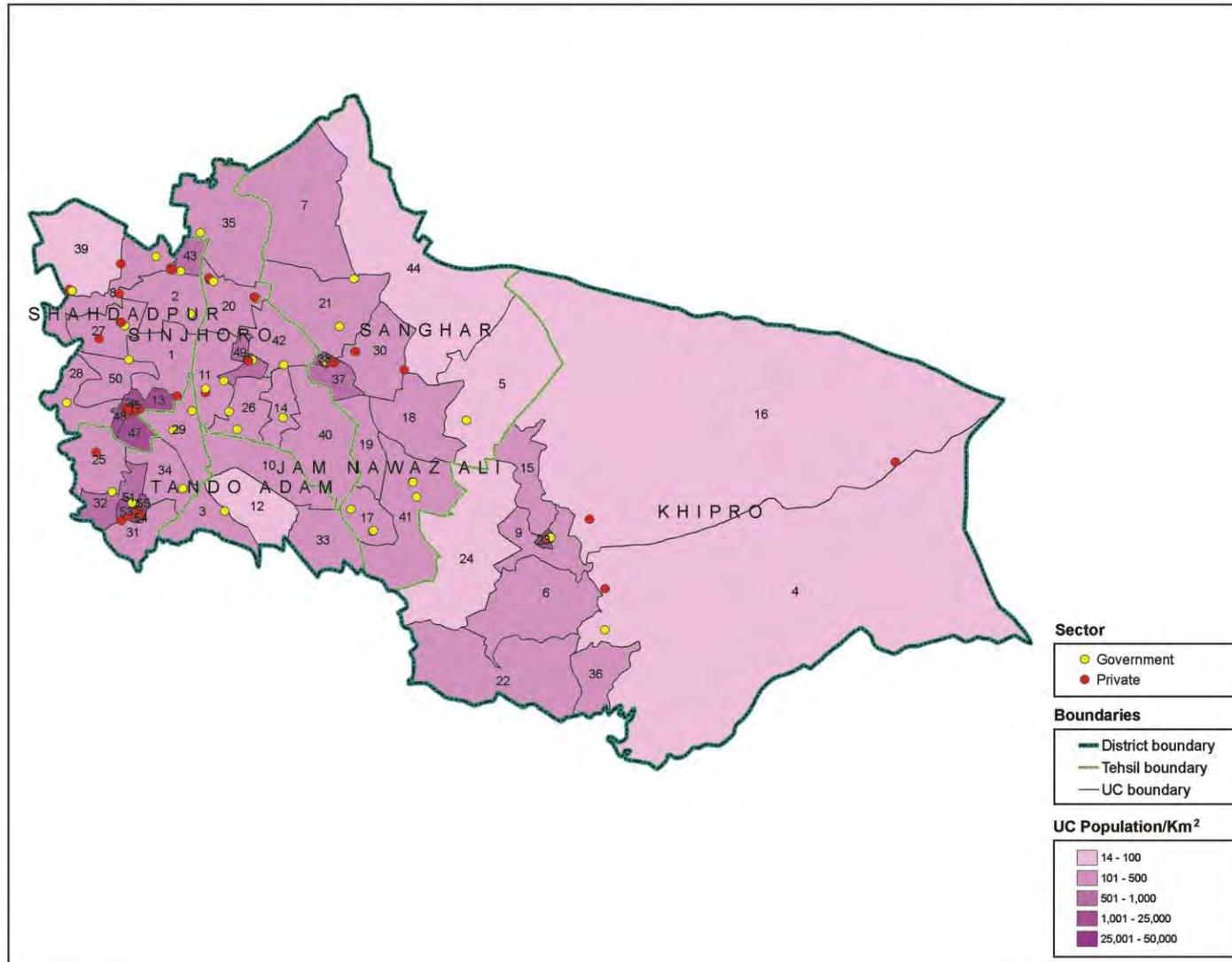
Map 4.6: Location of IUD facilities in Sanghar district, by population density of union council



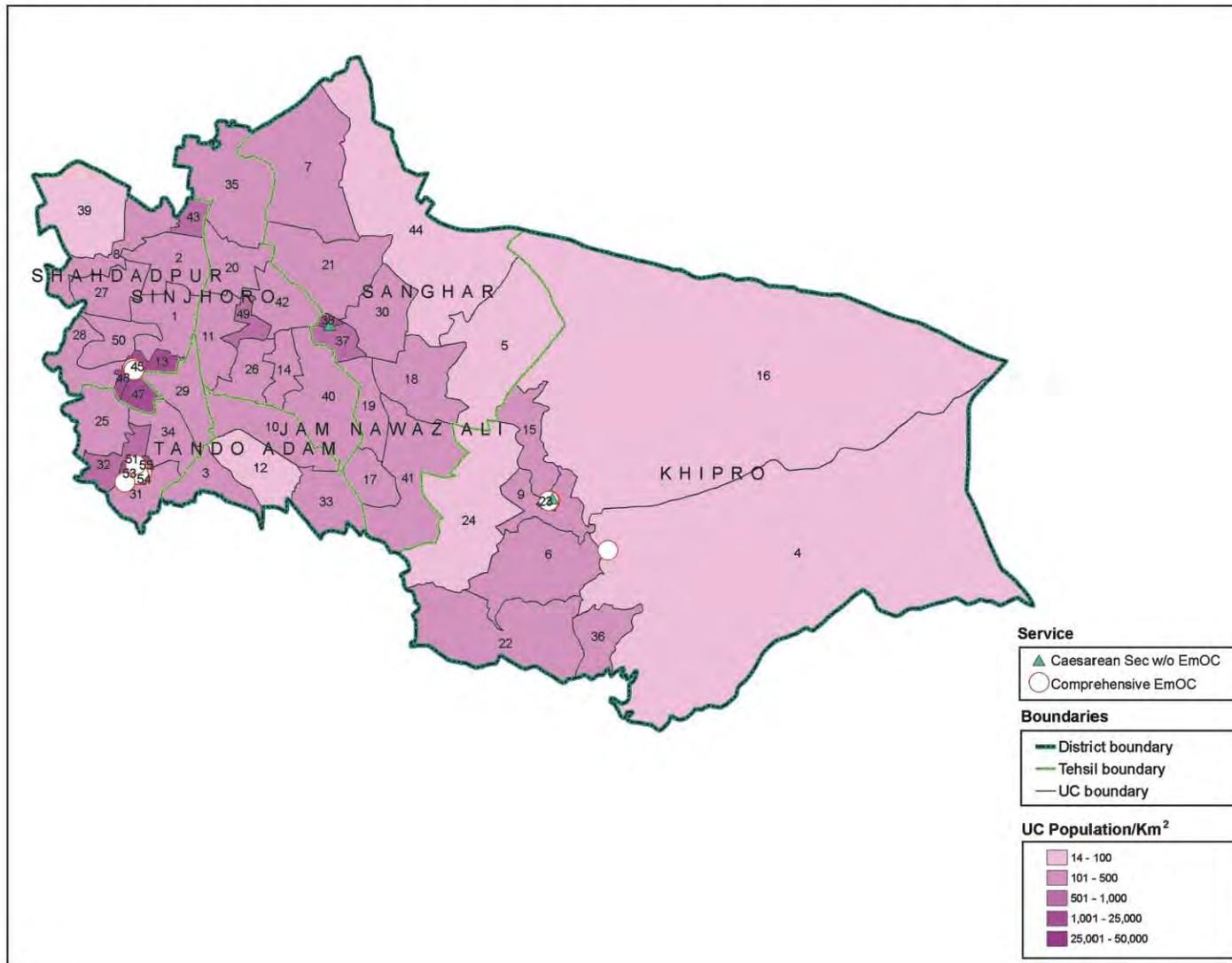
Map 4.7: Location of injectables contraceptive services in Sanghar district, by population density of union council



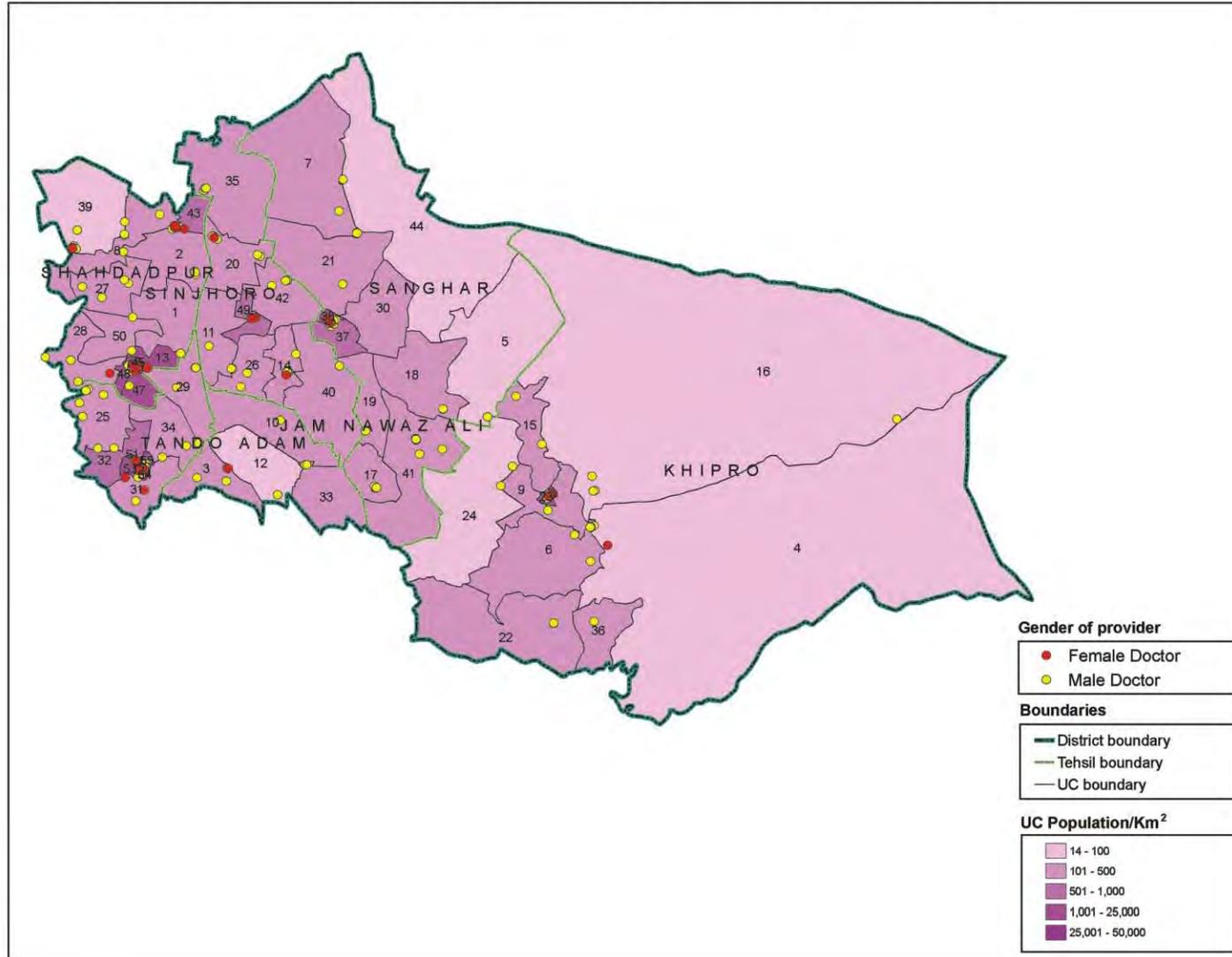
Map 4.8: Location of essential obstetric services in Sanghar district, by population density of union council



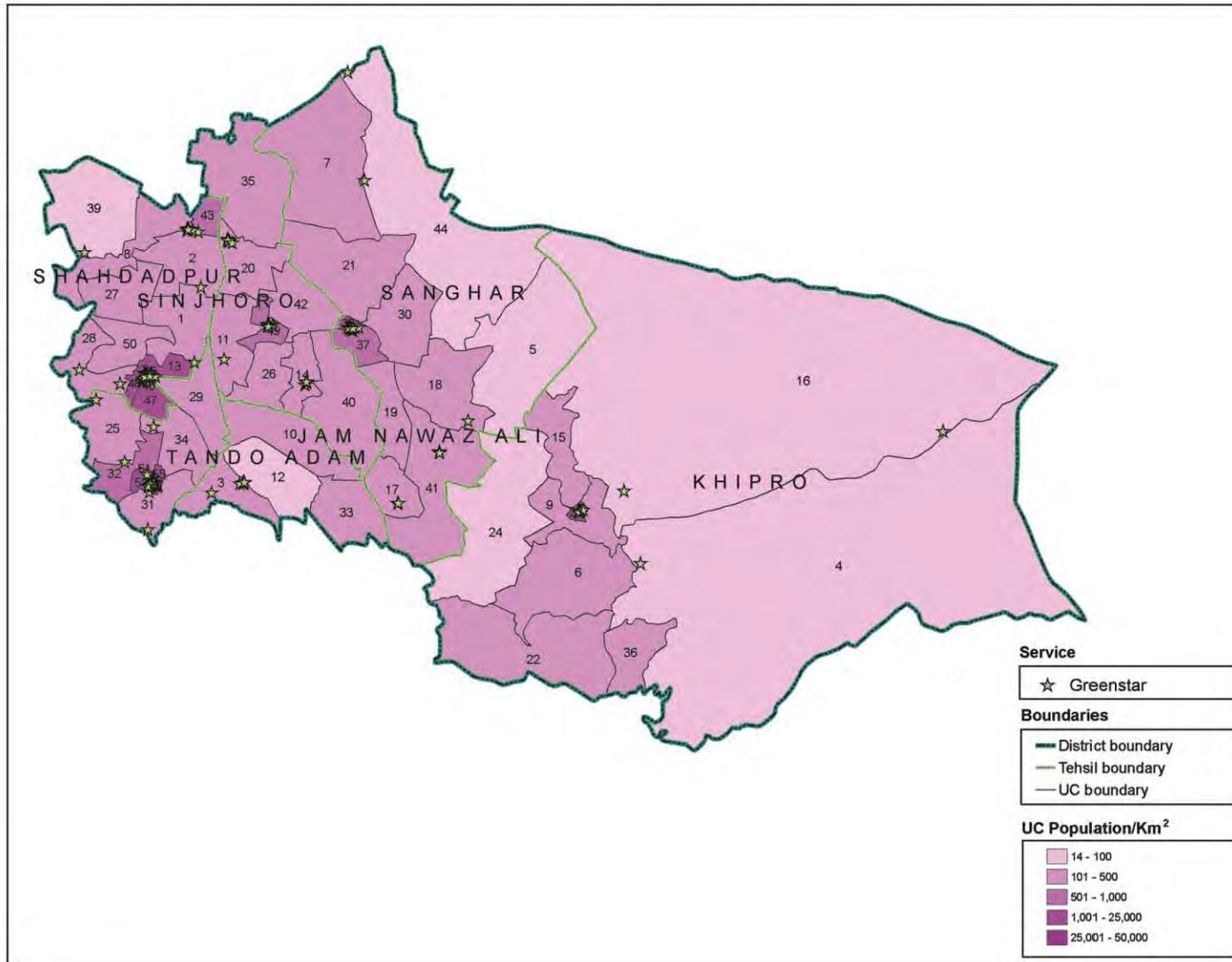
Map 4.9: Location of emergency obstetric care facilities in Sanghar district, by population density of union council



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



Map 4.11: Location of Greenstar Social Marketing SDPs in Sanghar 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 numbers of births obtained through this procedure were 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 (CEB)

Age group	Children ever born				%	Mean CEB	N
	0	1-2	3-4	5 or more			
15-19	69.4	30.6	0.0	0.0	100.0	0.3	49
20-24	23.0	55.7	15.6	5.7	100.0	1.6	122
25-29	5.0	33.1	39.6	22.3	100.0	3.2	139
30-34	5.1	13.3	32.7	49.0	100.0	4.6	98
35-39	0.0	6.8	22.7	70.5	100.0	6.1	88
40-44	0.0	6.9	12.5	80.6	100.0	7.2	72
45-49	1.6	8.1	12.9	77.4	100.0	7.6	62
Total	11.9	25.1	22.7	40.3	100.0	4.2	630

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

Age group	Number of living children				%	Mean LC	N
	0	1-2	3-4	5 or more			
15-19	73.5	26.5	0.0	0.0	100.0	0.3	49
20-24	27.9	55.7	14.8	1.6	100.0	1.3	122
25-29	5.8	38.1	43.9	12.2	100.0	2.7	139
30-34	6.1	19.4	35.7	38.8	100.0	4.1	98
35-39	0.0	9.1	29.5	61.4	100.0	5.3	88
40-44	1.4	8.3	16.7	73.6	100.0	6.1	72
45-49	1.6	9.7	14.5	74.2	100.0	6.2	62
Total	13.7	27.5	25.6	33.3	100.0	3.6	630

The table shows that early childbearing was fairly common in Sanghar. The table, as expected, shows that the mean number of children ever born (Table 5.1) and living children (Table 5.2) increased with the age of the mother. Table 5.3 shows the mean number of ever born children and surviving sons and daughters. Among currently married women aged 15-49 years in Sanghar, the mean number of children ever born was 4.2. The mean number of children ever born increased steadily with age, reaching as high as 7.6 children for women aged 45-49 years. On average, these women also had 6.2 living children. Each woman of the

age group 40-49 years had lost one child, on average, during her reproductive life (Table 5.3).

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

Age group	Mean number of children						N
	Ever born			Surviving			
	Boys	Girls	Total	Boys	Girls	Total	
15 - 19	0.2	0.1	0.3	0.2	0.1	0.3	49
20 - 24	0.9	0.7	1.6	0.7	0.6	1.3	122
25 - 29	1.8	1.4	3.2	1.5	1.2	2.7	139
30 - 34	2.5	2.1	4.6	2.2	1.9	4.1	98
35 - 39	3.2	2.9	6.1	2.8	2.5	5.3	88
40 - 44	3.7	3.5	7.2	3.2	3.0	6.1	72
45 - 49	4.0	3.6	7.6	3.3	2.9	6.2	62
Total	2.2	2.0	4.2	1.9	1.7	3.6	630

Table 5.1 also shows that 31 percent of married women 15-19 years of age had already given birth to at least one child. Women aged 45-49 years had virtually completed childbearing. Among currently married women in this age group, 23 percent had reached the end of childbearing with fewer than five children ever born, while 77 percent had five or more than five children ever born. Data show that 98 percent of women aged 45-49 years had at least one live birth in their reproductive period, while 1.6 percent were nulliparous. The sex ratio of children ever born was 110 males per 100 females, whereas the sex ratio of living children was 112 (from Table 5.3).

Differentials in Children Ever Born and Surviving

Table 5.4 shows that differences in the mean number of children by literacy and by educational level of currently married women were pronounced. On average, literate women had 1.7 fewer children than illiterate women. As expected, fertility also declined with the level of education. Those who had “up to primary” education had on average 3.3 children ever born compared to 4.5 born to those who had no schooling. Those who had up to secondary education and above, had 2.6 children ever born.

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	2.8	2.5	0.10	123
Illiterate	4.5	3.8	0.15	493
Schooling of mother				
No education	4.5	3.8	0.15	479
Up to primary	3.3	2.8	0.14	86
Up to secondary	2.6	2.4	0.07	38
Above secondary	2.6	2.5	0.03	26
Residence				
Rural	4.1	3.5	0.15	507
Urban	4.3	3.7	0.13	123
Literacy of respondent's husband				
Literate	3.8	3.3	0.13	308
Illiterate	4.7	3.9	0.17	235
Schooling of husband				
No education	4.7	3.9	0.17	252
Up to primary	5.0	4.3	0.15	96
Up to secondary	3.5	3.0	0.13	126
Above secondary	3.0	2.7	0.09	102
Standard of living index				
Low	4.0	3.4	0.16	215
Medium low	4.2	3.7	0.13	144
Medium high	4.4	3.7	0.16	147
High	4.1	3.7	0.11	124
Economic activity/occupation of husband				
Agriculture/livestock/poultry	4.6	3.9	0.15	219
Petty trader	4.5	3.7	0.19	21
Labor (daily wages)	3.5	3.0	0.14	145
Government service	4.6	4.0	0.13	91
Private service	3.4	2.9	0.12	39
Own business	4.3	3.7	0.13	67
Unemployed	4.4	3.6	0.18	39
Others	3.3	2.9	0.13	9
Total	4.2	3.6	0.14	630

Differentials were also observed on the basis of literacy and economic activity of husbands (Table 5.4). Those who had literate husbands had 3.8 children ever born compared to 4.7 for those who had illiterate husbands. Similarly, women with husbands in the occupational categories of agriculture/livestock and government services had the highest number of children ever born (4.6 children).

A comparison of mean numbers of children ever born and surviving children showed that survival of children increased with literacy and educational levels of mothers. The survival of children was also higher if husbands were literate.

Table 5.5 further explains the relationship between 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 (2.8 children) compared with that of mothers who were illiterate (4.5 children). Similarly, the survival of children with literate mothers was far better than with illiterate mothers. The 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, 64 percent were literate, as compared to 46 percent who were illiterate. It is not only that, overall, literate women had fewer children, 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

Age group	Literate				Illiterate			
	Mean number of CEB	Mean number of LC	N	%	Mean number of CEB	Mean number of LC	N	%
15 - 19	0.6	0.4	7	5.7	0.3	0.3	42	8.5
20 - 24	1.3	1.1	29	23.6	1.7	1.4	91	18.5
25 - 29	2.5	2.3	43	35.0	3.5	2.9	94	19.1
30 - 34	3.2	3.0	20	16.3	4.9	4.2	76	15.4
35 - 39	4.9	4.7	13	10.6	6.4	5.4	72	14.6
40 - 44	6.0	5.3	6	4.9	7.4	6.3	63	12.8
45 - 49	6.6	4.8	5	4.1	7.7	6.4	55	11.2
Total	2.8	2.5	123	100.0	4.5	3.8	493	100.0

Current Fertility

Crude Birth Rate

The Crude Birth Rate (CBR), though a crude measure of fertility, is the most widely understood and used fertility measure. In this survey, it is calculated from the number of births that occurred during the last three years before the survey and the mid-period total population in the sample households. The baseline survey provides an estimate of 28 births per thousand population (Table 5.6).

Table 5.6: Number of women and number of births during the last three years before the survey, by age of mother (includes ASFRs, TFR and CBR)

Age group	Women	Births	Age specific fertility rates (ASFRs)
15 - 19	280	13	15.5
20 - 24	223	85	127.1
25 - 29	190	124	217.5
30 - 34	125	73	194.7
35 - 39	98	46	156.5
40 - 44	82	29	117.9
45 - 49	76	5	21.9
Total	1074	375	na

TFR: 4.3

CBR: 27.6

na = not applicable.

Age-specific Fertility Rates and Total Fertility Rate

The total fertility rate (TFR) is a more refined measure of fertility than CBR. Age-specific fertility rates (ASFRs) and TFRs are based on births to 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 as age increased. A TFR of 4.3 for the period 2004-2007 was obtained from the set of ASFRs calculated from the data presented in Table 5.6. This is in line with the estimates of 4.3 for Sindh and 4.1 for Pakistan as a whole reported in the PDHS (NIPS/PDHS, 2008).

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 a 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 three living children under 5 years of age, 13 percent were currently pregnant. Moreover, among women who had two living children under five years of age, 16 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 a part of their married life at this point.

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

Children < 5 years	Currently pregnant		Currently not pregnant		Total	N
	N	%	N	%		
0	43	18.6	188	81.4	100.0	231
1	53	27.0	143	73.0	100.0	196
2	25	16.1	130	83.9	100.0	155
3	6	13.0	40	87.0	100.0	46
4	0	0.0	2	100.0	100.0	2
N	127	20.2	503	79.8	100.0	630

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 Hessel, 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 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 infant mortality, in developing countries (Cleland and Sathar, 1984), it has been found 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 with a preceding interval of two to three years (Cleland and Sathar, 1984).

Table 5.8 shows that almost 12 percent of children were born within an 18 month birth interval. Almost 70 percent were born with a birth interval of less than 36 months, while 30 percent were born after three years or more. The differentials by mother's age, birth order, educational level and standard of living index are also shown in Table 5.8.

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

Characteristic	Preceding birth interval					Total	N
	Less than 18 months	18 - 23 months	24 - 35 months	36 - 47 months	48 months or more		
Age group							
15 - 19	0.0	100.0	0.0	0.0	0.0	100.0	1
20 - 24	15.5	24.1	43.1	15.5	1.7	100.0	58
25 - 29	11.5	22.9	42.0	17.6	6.1	100.0	131
30 - 34	13.8	25.3	28.7	17.2	14.9	100.0	87
35 - 39	4.8	17.7	33.9	14.5	29.0	100.0	62
40 - 44	15.8	21.1	21.1	21.1	21.1	100.0	38
45 - 49	14.3	0.0	57.1	14.3	14.3	100.0	7
Birth order							
2	9.1	20.0	36.4	23.6	10.9	100.0	55
3	10.4	20.8	36.4	23.4	9.1	100.0	77
4	6.9	20.7	36.2	19.0	17.2	100.0	58
5	17.7	16.1	41.9	8.1	16.1	100.0	62
6+	13.6	28.0	32.6	13.6	12.1	100.0	132
Education							
No education	11.4	23.4	37.2	16.2	11.7	100.0	290
Up to primary	18.4	22.4	30.6	14.3	14.3	100.0	49
Up to secondary	12.0	16.0	36.0	24.0	12.0	100.0	25
Above secondary	5.6	11.1	27.8	27.8	27.8	100.0	18
Standard of living index							
Low	14.7	21.7	36.4	15.5	11.6	100.0	129
Medium low	10.8	20.4	39.8	14.0	15.1	100.0	93
Medium high	13.8	18.4	40.2	18.4	9.2	100.0	87
High	6.7	30.7	25.3	21.3	16.0	100.0	75
Total	12.0	22.4	35.9	16.9	12.8	100.0	384

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; at the same time, the survival of mothers and babies allows for longer birth intervals. In this survey, a small battery of questions was asked regarding the most recent child born during the past four years, reflecting some of the essential indicators of maternal and neonatal care. A total of 399 women (63 percent), out of the 630 total 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 their 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. However, in recent years these proportions have been increasing in Pakistan (NIPS/PDHS, 2008). Table 6.1 and Figure 6.1 show the number of ANC visits for the last birth of women who had delivered babies during the last four years. About 58 percent of the sample respondents had received at least one antenatal care visit during the last pregnancy; the percentage was higher for urban mothers (70 percent) than for rural ones (56 percent). This was significantly higher than the level obtained for Sanghar in the 2004-05 PSLM Survey (39 percent). However, this figure was quite low when compared to the averages obtained for Sindh (70 percent). More than 36 percent had at least three such visits and 25 percent had more than three visits.

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

Number of ANC visits	Rural		Urban		Total	
	N	%	N	%	N	%
No visit	142	44.4	24	30.4	166	41.6
1-2 visits	70	21.9	16	20.3	86	21.6
3 visits	36	11.3	10	12.7	46	11.5
4+ visits	71	22.2	29	36.7	100	25.0
Don't remember	1	0.3	0	0.0	1	0.3
Total	320	100.0	79	100.0	399	100.0

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

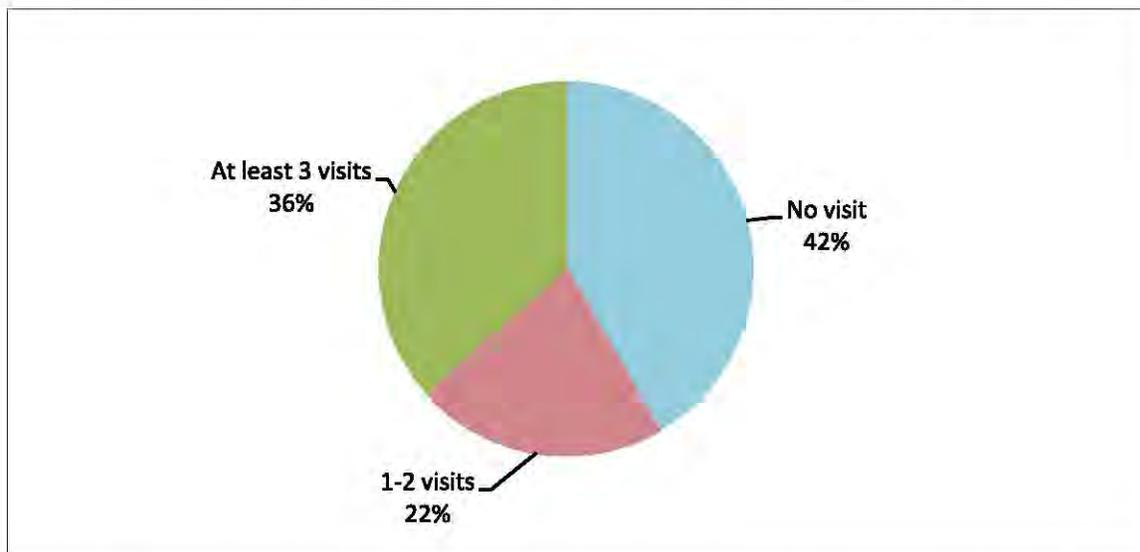
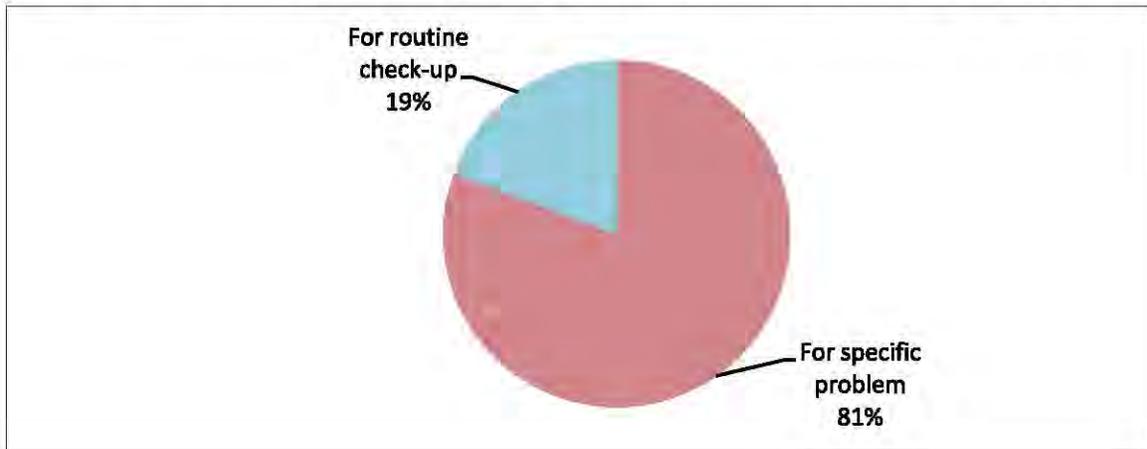


Figure 6.2 shows that in many cases these visits were made in response to some health problem rather than for a routine check-up. Eighty-one percent of the first antenatal visits were for curative purposes.

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



About two in five times, the first visit took place within the first three months of gestation, and about one in three times the first visit occurred during the third trimester (Figure 6.3).

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

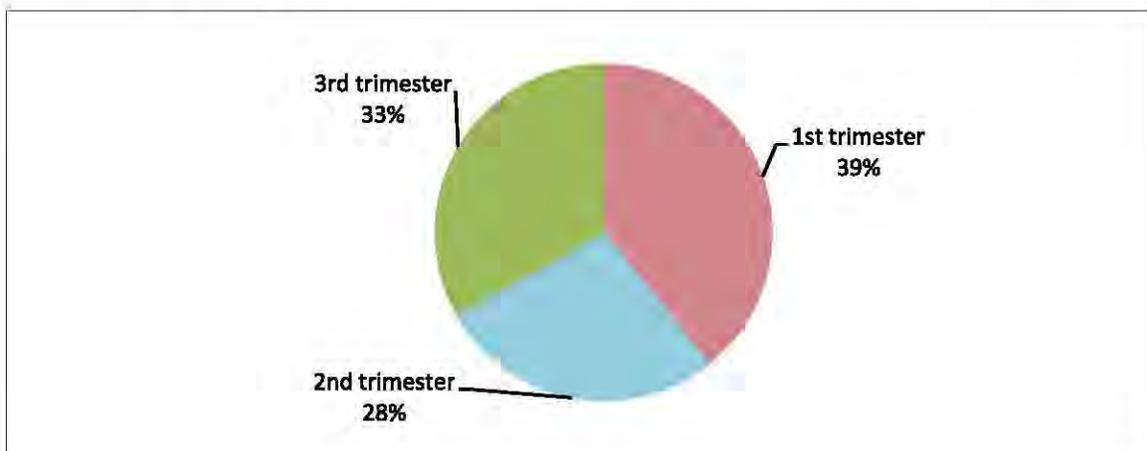


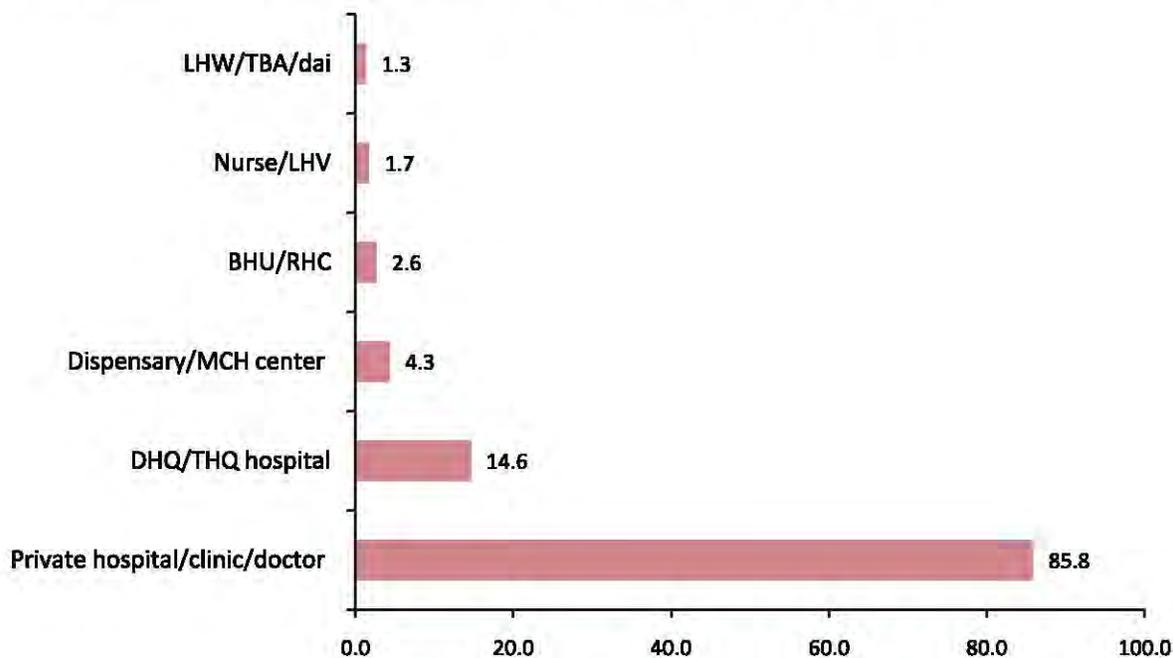
Table 6.2 presents the locations at which respondents obtained antenatal check-ups. Most antenatal visits took place in private sector facilities. The most common providers of antenatal care in the public sector were the DHQ/THQ hospitals, followed by MCH centers, BHUs and RHCs.

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

Facility/provider	Rural		Urban		Total	
	N	%	N	%	N	%
Dispensary/MCH center	8	4.5	2	3.6	10	4.3
BHU/RHC	6	3.4	0	0.0	6	2.6
DHQ/THQ hospital	24	13.5	10	18.2	34	14.6
Private hospital/clinic/doctor	154	86.5	46	83.6	200	85.8
LHW/TBA/dai	2	1.1	1	1.8	3	1.3
Nurse/LHV	1	0.6	3	5.5	4	1.7
Total	178	na	55	na	233	na

Respondents could give more than one response.

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



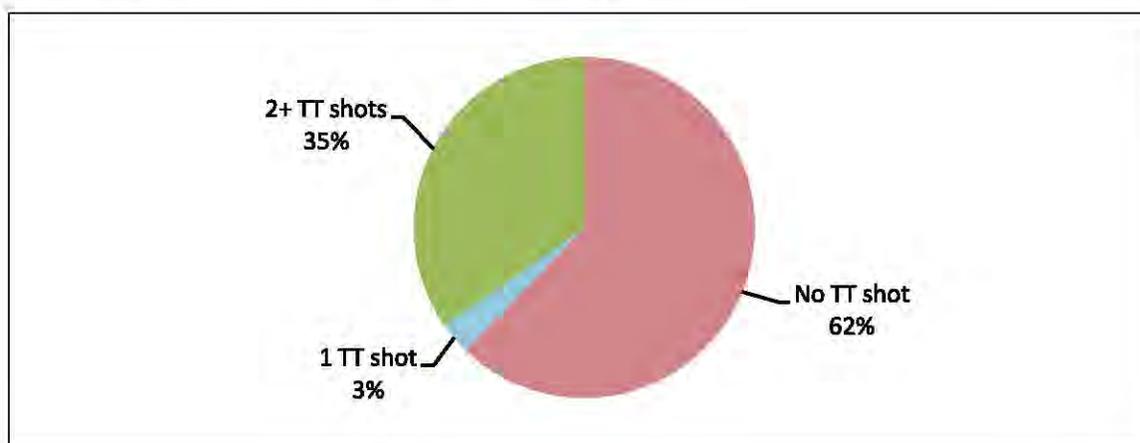
Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn or the 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 sufficient for lifetime protection. According to PSLMS 2004-05, 34 percent of the mothers in Sanghar had received at least one shot. According to the PDHS 2006-07, 51 percent in Sindh and 53 percent nationally were appropriately protected from tetanus (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 6.3 and Figure 6.5 show that 38 percent of mothers had received at least one shot during their last pregnancy, and 35 percent had received two shots or more. The immunization rate was higher in urban areas. While tetanus immunization appeared to be increasing in Sanghar, a substantial proportion of mothers remain unprotected.

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	212	66.5	36	45.6	248	62.3
One TT shot	9	2.8	3	3.8	12	3.0
2+ TT shots	98	30.7	40	50.6	138	34.7
Total	319	100.0	79	100.0	398	100.0

Figure 6.5: Tetanus immunization at last delivery



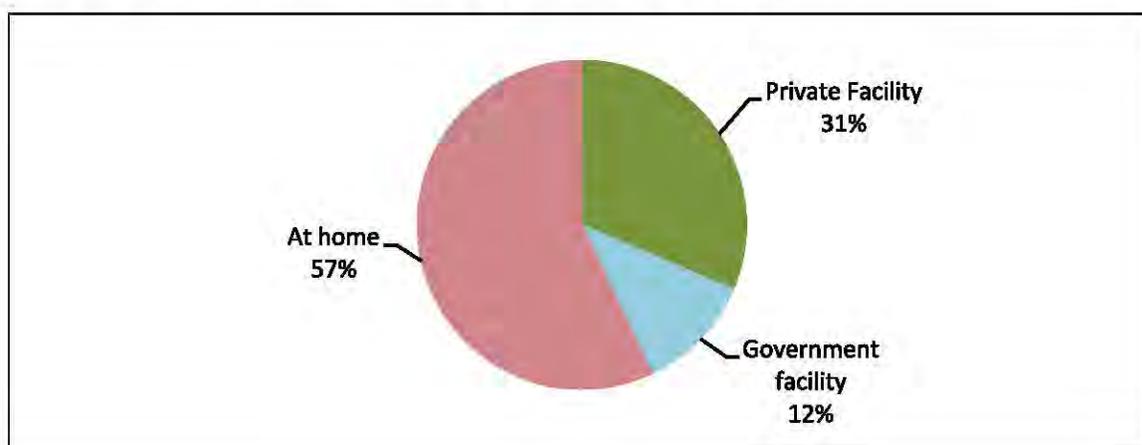
Location and Attendance at Delivery

One of 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. These proportions have been historically low in Pakistan, contributing substantially to high maternal mortality, but have been rising in recent years. In Sanghar, according to the 2004-05 PSLMS, 22 percent of the deliveries took place in institutions, compared to PDHS 2006-07 figures of 42 percent for Sindh and 34 percent nationally (Government of Pakistan, 2006; NIPS/PDHS, 2008). In the present survey, 43 percent of the most recent deliveries were carried out in a health facility (Table 6.4 and Figure 6.6). This percentage was higher in urban areas (54 percent) than rural areas (39 percent).

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

Place of delivery	Rural		Urban		Total	
	N	%	N	%	N	%
At home	191	59.9	36	45.6	227	57.0
BHU/RHC/MCH center/ dispensary	3	0.9	1	1.3	4	1.0
DHQ/THQ hospital	36	11.3	6	7.6	42	10.6
Pvt. hospital/clinic	86	27.0	36	45.6	122	30.7
Others	3	0.9	0	0.0	3	0.8
Total	319	100.0	79	100.0	398	100.0

Figure 6.6: Distribution of mothers by location of last delivery

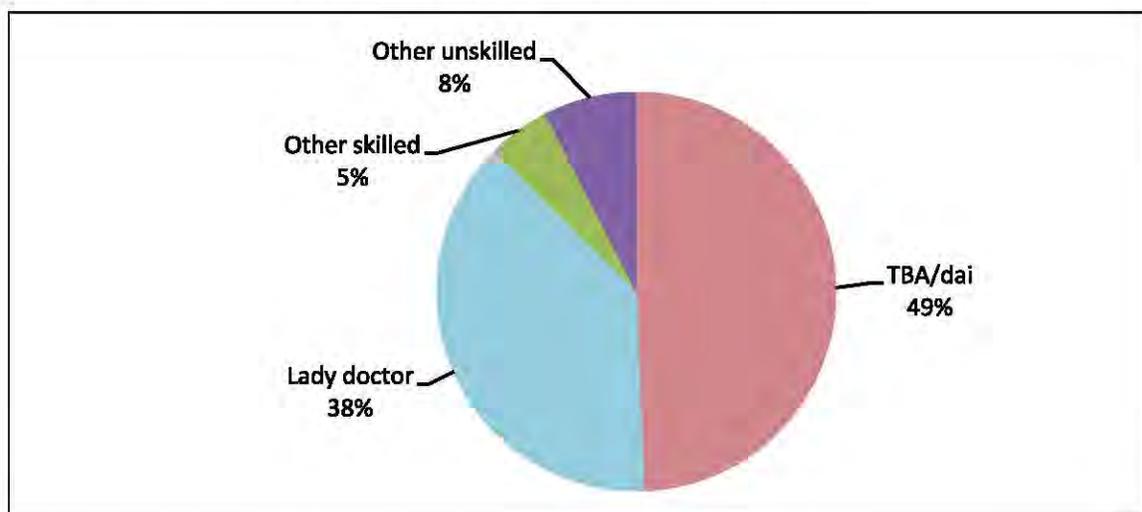


Likewise, the proportion of births delivered by skilled attendants was higher than expected from previous data. In this survey, 43 percent of reported deliveries in the previous four years were conducted by a skilled birth attendant; the figures were substantially higher in urban areas (Table 6.5). In the PSLMS 2004-05 for Sanghar, only 22 percent of 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 mean a paramedic, such as a Lady Health Visitor, in such interviews. About 50 percent of the births were delivered by *dais* (traditional birth attendants), while 7.3 percent, mostly in rural areas, were delivered by a relative or neighbor who was not a dai.

Table 6.5: Distribution of mothers by attendant at last delivery and residence

Birth attendant and skill level	Rural		Urban		Total	
	N	%	N	%	N	%
LHW/TBA/dai	170	53.1	28	35.4	198	49.7
Nurse/LHV/midwife	8	2.5	12	15.2	20	5.1
Lady doctor	116	36.3	36	45.6	152	38.1
Female relative/friend/neighbor (not dai)	26	8.1	3	3.8	29	7.3
Total	320	100.0	79	100.0	399	100.0
Skilled birth attendant	124	38.8	48	60.8	172	43.1
Unskilled birth attendant	196	61.3	31	39.2	227	56.9

Figure 6.7: Distribution of mothers by attendant at last delivery



Postpartum Care

For the health of both the mother and the newborn, a newly delivered mother and baby should receive postnatal care for at least six weeks following delivery. Ministry of Health guidelines recommend at least one postnatal visit after discharge during the first 42 days following delivery. However, this is a major weakness of MNH care in Pakistan. Women who deliver at home rarely go for a postnatal check-up, and women who deliver in facilities are usually checked while they are in the facility, but not after. All respondents who had institutional deliveries had received a postpartum check-up within 24 hours, whereas only 14 out of 230 mothers (6 percent) who had non-institutional deliveries, had received a postnatal check-up within 24 hours and just 5 (2.2 percent) had a check-up after 24 hours (Table 6.6).

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

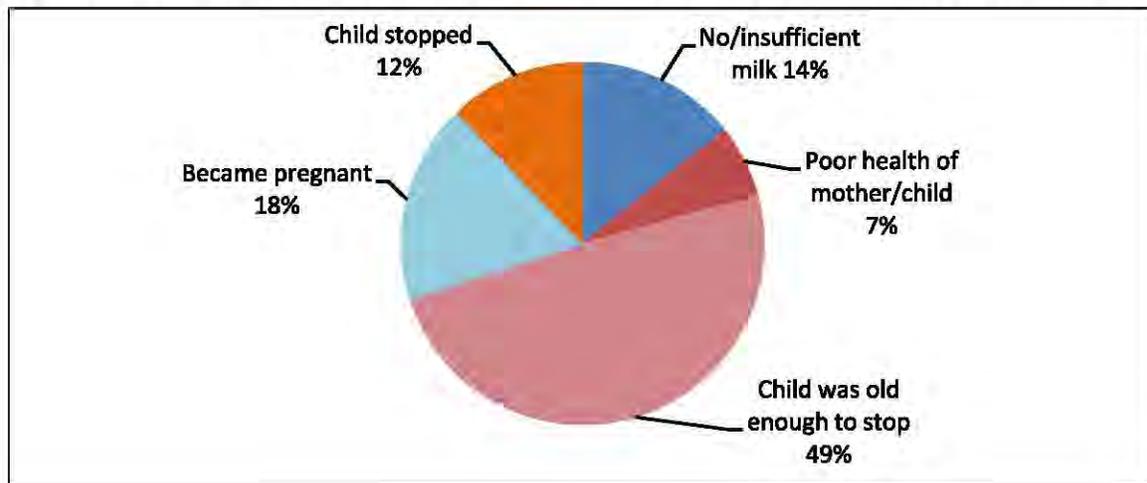
Place of delivery	Postnatal check-up within 24 hours		Postnatal check-up after 24 hours		Did not have PNC check-up		Total	
	N	%	N	%	N	%	N	%
Institution	168	100.0	0	0.0	0	0.0	168	100.0
Non institution	14	6.1	5	2.2	211	91.7	230	100.0
Total	182	45.7	5	1.3	211	53.0	398	100.0

In any case, 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 and its role in the next birth interval, or on 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. Among the respondents in Sanghar district, only one mother out of 376 did not breastfeed her last child at all. Exclusive breastfeeding was reported as being widespread. Eighty-nine percent of the mothers reported breastfeeding their last child for at least four months without supplementation. Five reasons were given for discontinuing breastfeeding: child was old enough (49 percent); no or insufficient milk (14 percent); mother became pregnant (18 percent); child stopped (12 percent) and poor health of mother or child (7 percent) (Figure 6.8).

Figure 6.8: Distribution of mothers by reason for discontinuing breastfeeding (n=140)



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, is (English translation): "If you could choose the exact number of children to have in your whole life, how many would that be?" Table 7.1 shows the responses.

The median "ideal" number, as indicated in the table below, was five children. About 46 percent of the respondents wanted four or less children, with 48 percent citing five or more. In fact, only 4 percent said they wanted two or fewer children. Slightly more than half of the rural women interviewed wanted five or more children, whereas 34 percent of the urban women also had the same desire. More than 6 percent of the women also gave a non-numeric response to the question, such as "up to God."

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

Number of children	Rural		Urban		Total	
	N	%	N	%	N	%
1	0	0.0	1	0.8	1	0.2
2	14	2.8	10	8.1	24	3.8
3	30	5.9	9	7.3	39	6.2
4	167	32.9	56	45.5	223	35.4
5	75	14.8	9	7.3	84	13.3
6+	185	36.5	33	26.8	218	34.6
Up to God	35	6.9	5	4.1	40	6.3
Don't know	1	0.2	0	0.0	1	0.2
Total	507	100.0	123	100.0	630	100.0

Desire for More Children

Levels of Desire for More Children

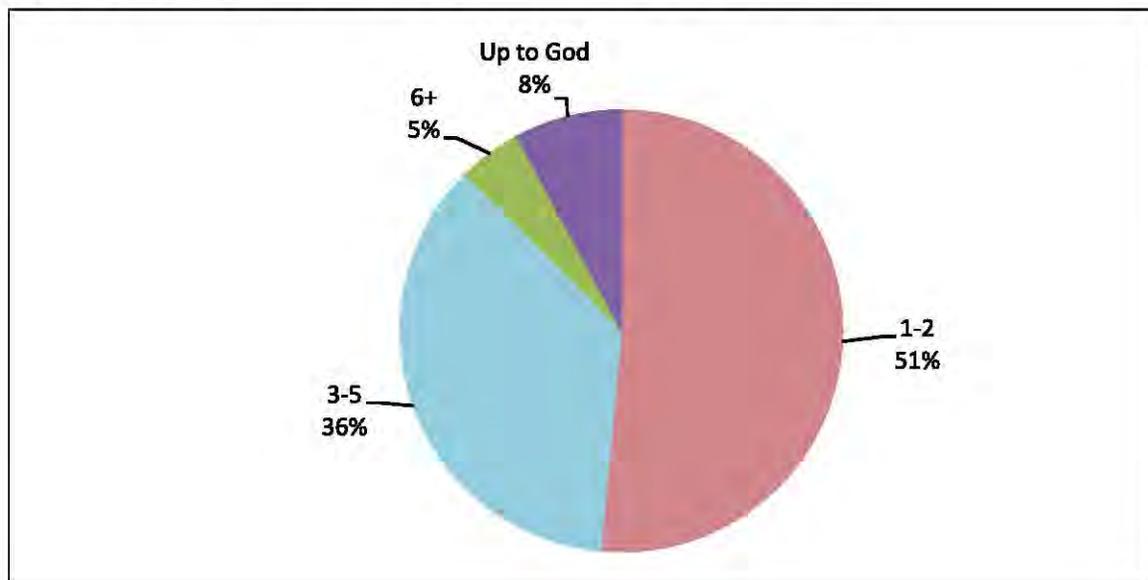
A more immediate measure of fertility preference is whether a couple wants more children; if so, do they want the next child now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already has. Table 7.2 shows that whether respondents wanted more children soon, later (after 2 years or more) or not at all, this was by the number of living children they already had. The proportion wanting more children soon declined sharply after the first birth. A quarter of the respondents sampled wanted their next child soon, whereas, about 42 percent did not want more children. About one-third of the women (34 percent) wanted children later. For all those with one to three living children, most of those who wanted an additional child wanted to have it later, rather than right away. On the other hand, 62 percent of the women with four living children did not want to have more children. For those with six or more children, 88 percent did not want to have more children. The pattern of desired fertility reported by women seems somewhat lower than their reported ideal number of children. The table below 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	Desire for next child			Total	
	Soon	Later	Never	N	%
0	66.3	33.7	0.0	86	100.0
1	39.3	58.3	2.4	84	100.0
2	28.4	56.8	14.8	88	100.0
3	25.0	45.5	29.5	88	100.0
4	11.0	27.4	61.6	73	100.0
5	9.8	18.0	72.1	61	100.0
6+	2.7	9.4	87.9	149	100.0
Total	24.6	33.9	41.5	629	100.0
N	155	213	261	629	100.0

Women who wanted more children were asked to state how many more children they wanted. As shown in Figure 7.1, slightly over half of all respondents who wanted more children said they wanted one or two more. About 8 percent of the women said that it was up to God. It would be useful to explore what this statement means, i.e., whether this is 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 age, literacy and residence (Table 7.3). Literate women were more likely to want the next child at a later time (52 percent) compared to the illiterate women (30 percent). On the other hand illiterate women were more likely not to have more children (44 percent) compared to the literate women (28 percent). Rural residents were substantially more likely to want more children sooner rather than later compared to urban dwellers.

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

Characteristic	Desire for more children			Total	
	Soon	Later	Never	N	%
Standard of living index					
Low	33.0	30.7	36.3	215	100.0
Medium low	22.2	36.8	41.0	144	100.0
Medium high	18.4	37.4	44.2	147	100.0
High	20.3	31.7	48.0	123	100.0
Age of women					
<25	39.5	54.7	5.8	172	100.0
25 or more	19.0	26.0	54.9	457	100.0
Literacy of respondent					
Literate	20.5	51.6	27.9	122	100.0
Illiterate	25.8	30.0	44.2	493	100.0
Residence					
Rural	26.3	33.8	39.9	506	100.0
Urban	17.9	34.1	48.0	123	100.0
Total	24.6	33.9	41.5	629	100.0

Son Preference

In Pakistan, there is known to be a substantial preference for sons over daughters; in particular, 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 they stopped trying for a son and correspondingly

how many sons would they be willing to have before they stopped trying for a daughter. About 70 percent of the women said there would be no limit to the number of daughters they were willing to have before having a son, while 60 percent said there was no limit to the number of sons they would have before having a daughter. For those women who gave a number, in both cases, the median was five children (Table 7.4).

Table 7.4: Son and daughter preferences by the respondents

Preference	Number of daughters for the desire of a son		Number of sons for the desire of a daughter	
	N	%	N	%
No limit	439	69.7	374	59.5
Other non-numeric responses	1	0.2	1	0.2
Numeric responses	190	30.2	254	40.4
Total	630	100.0	629	100.0
Median*	5	na	5	na

*Of the numeric responses. na = not applicable.

Strength of Preference

The strength of preferences 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 if they became pregnant soon, would they be pleased, worried, accept it, or be indifferent? Results are shown in Table 7.5 and Table 7.6. (This question excludes those 324 of the total 630 women who wanted the next child soon, were currently pregnant, sterilized, had gone through menopause or had a hysterectomy.)

Among those women who did not want more children at all, nearly three-fifths (59 percent) said that they would be worried if they became pregnant. Twenty-nine percent reported that they would accept the new pregnancy, while only 12 percent, among these women, said they would be pleased. Among those women who wanted to delay their next pregnancy for more than 2 years, 43 percent would be worried, while 57 percent said they would be pleased or accepting. This shows weak motivation for spacing. However, the high proportion of those who said they would be worried if they became pregnant, supports their earlier statement that they wanted to delay or stop childbearing.

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

Reaction if pregnant	Future desire for children		Total	
	Later	Never	%	N
Pleased	39.8	11.7	24.7	71
Worried	42.9	59.1	51.6	148
Accept it	17.3	29.2	23.7	68
Doesn't matter	0.0	0.0	0.0	0
Total	100.0	100.0	100.0	287
N	133	154	100.0	287

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

Problem faced if pregnant	Future desire for children		Total	
	Later	Never	%	N
Own health	69.9	90.3	80.8	232
Health of youngest child	72.9	80.5	77.0	221
Caring of children	71.4	82.5	77.4	222
Schooling of children	61.7	75.3	69.0	198
Family economic situation	58.6	76.6	68.3	196
N	133	154	287	287

Respondents could give more than one response.

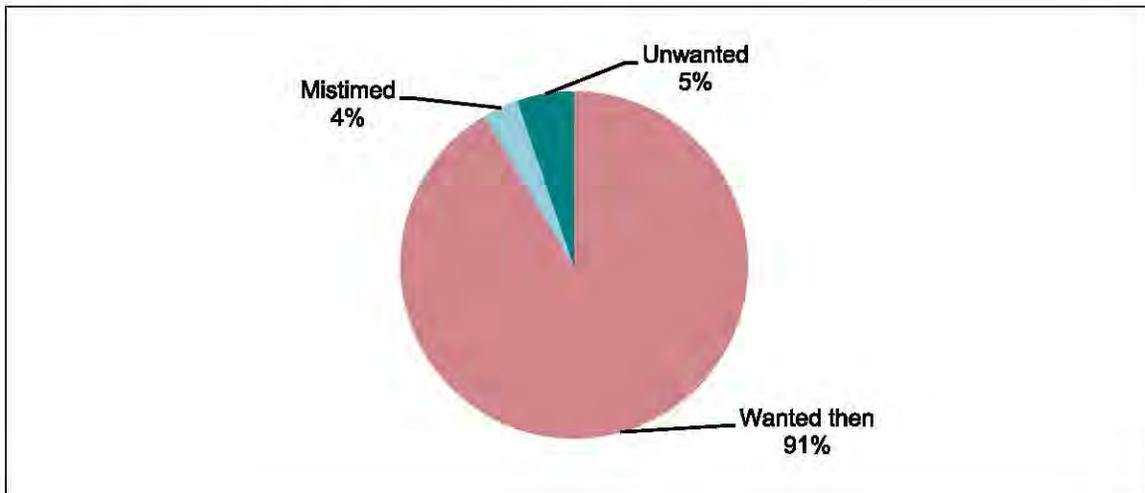
Further, women who expressed a desire to not have more children, or to delay the next child, were asked what problems they would face if they became pregnant soon. Table 7.6 shows their responses. The most commonly faced problems were regarding their own health and caring for the children, while the least commonly faced issue was the family's economic situation and schooling of children.

Attitudes toward Last Pregnancy

Another important dimension of fertility preference relates to whether the last pregnancy was wanted at the time, was mistimed (i.e., wanted later), or was not wanted at all. Pregnancies that are unwanted may 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 are wanted. 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, women were most likely to report that their last pregnancy was wanted (91 percent) for 5 percent women the last birth was unwanted, and 4 percent said it was mistimed (Figure 7.2).

Figure 7.2: Attitudes of the 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. In Table 7.7, the responses are tabulated according to their ideal family size. Nine percent of the MWRA in the sample did not know their husband's preference, while another 63 percent thought that their husbands wanted the same number of children as they did. However, 27 percent of the women thought their husbands wanted more children than they did, while only 5 of the 630 respondents thought their husbands wanted fewer children. These proportions did not vary systematically according to women'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 children	68.0	16.0	0.0	16.0	25	100.0
3-4 children	73.3	17.6	1.1	8.0	262	100.0
5 and more children	59.6	32.1	0.7	7.6	302	100.0
Up to God	17.5	57.5	0.0	25.0	40	100.0
Don't know	100.0	0.0	0.0	0.0	1	100.0
Total	63.0	27.0	0.8	9.2	630	100.0
N	397	170	5	58	630	100.0

Chapter 8

Contraceptive Knowledge and Use

The FALAH baseline household survey obtained data on contraceptive knowledge and use by first determining 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 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. Besides providing detailed data on use problems, this approach provides a useful check on accuracy of the information provided in the first set of questions.

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 Sanghar. Virtually all women knew of at least one method. A large majority of the female respondents knew of the most commonly used program methods: pills (99 percent), injectables (98.7 percent), female sterilization (98 percent), IUD (92 percent), condoms (59 percent) and Norplant (32 percent). According to this survey, pills, injectables, IUDs and female sterilization were known to a higher proportion of females in Sanghar than given in the national PDHS 2006-07. Conversely, more women in the PDHS knew of the less common methods, i.e., rhythm ("safe period"), male sterilization and emergency contraceptive pills (NIPS/PDHS, 2008).

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

Method	Rural	Urban	Total
Female sterilization	98.4	96.7	98.1
Male sterilization	20.3	31.7	22.5
Pill	99.0	100.0	99.2
IUD	90.5	96.7	91.7
Injectables	98.6	99.2	98.7
Norplant	30.6	37.4	31.9
Condom	53.8	81.3	59.2
Rhythm	11.1	27.9	14.3
Withdrawal	50.3	61.5	52.5
Emergency pills	4.0	9.8	5.1
At least one method	100.0	100.0	100.0
At least one modern method	100.0	100.0	100.0
At least one traditional method	56.0	70.7	58.9
N	507	123	630

Use of Contraceptive Methods

Levels of Ever Use and Current Use

For the purpose of analyzing contraceptive use in a population, currently married women of reproductive age (typically taken to be 15-49) 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.

The proportion of currently married women of reproductive age who are currently using some form of contraception, commonly known as the 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 by the 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).

Of all the married women interviewed in our sample, 38 percent reported having used some method of contraception during their married lives (Table 8.2). This percentage was substantially lower for rural women (32 percent) than for urban women (59 percent). It was also substantially lower than the proportion obtained in the PDHS 2006-07 for Pakistan (48.7 percent) (NIPS/PDHS, 2008).

Table 8.2: Percentage distribution of MWRA by contraceptive use status and residence

Method	Ever users				Current users				Past users			
	Rural	Urban	Total	N	Rural	Urban	Total	N	Rural	Urban	Total	N
Pill	8.1	20.3	10.5	66	1.2	4.1	1.7	11	6.9	16.3	8.7	55
IUD	7.9	20.3	10.3	65	2.4	5.7	3.0	19	5.5	14.6	7.3	46
Injectables	10.8	23.6	13.3	84	2.2	4.1	2.5	16	8.7	19.5	10.8	68
Condom	7.7	25.2	11.1	70	2.4	8.1	3.5	22	5.3	17.1	7.6	48
Rhythm	1.8	3.3	2.1	13	0.4	0.8	0.5	3	1.4	2.4	1.6	10
Withdrawal	6.1	18.7	8.6	54	2.6	6.5	3.3	21	3.6	12.2	5.2	33
Female sterilization	6.1	8.9	6.7	42	6.1	8.9	6.7	42	0.0	0.0	0.0	0
Male sterilization	0.4	0.0	0.3	2	0.4	0.0	0.3	2	0.0	0.0	0.0	0
Others	1.6	0.8	1.4	9	0.0	0.8	0.2	1	1.6	0.0	1.3	8
Any method	32.3	58.5	37.5	236	17.6	39.0	21.7	137	14.8	19.5	15.7	99
Modern method	29.2	54.5	34.1	215	14.6	30.9	17.8	112	14.6	23.6	16.3	103
Traditional method	8.3	21.1	10.8	68	3.0	8.1	4.0	25	5.3	13.0	6.8	43
Emergency pills	0.2	1.6	0.5	3	na	na	na	na	0.2	1.6	0.5	3
N	507	123	630	630	507	123	630	630	507	123	630	630

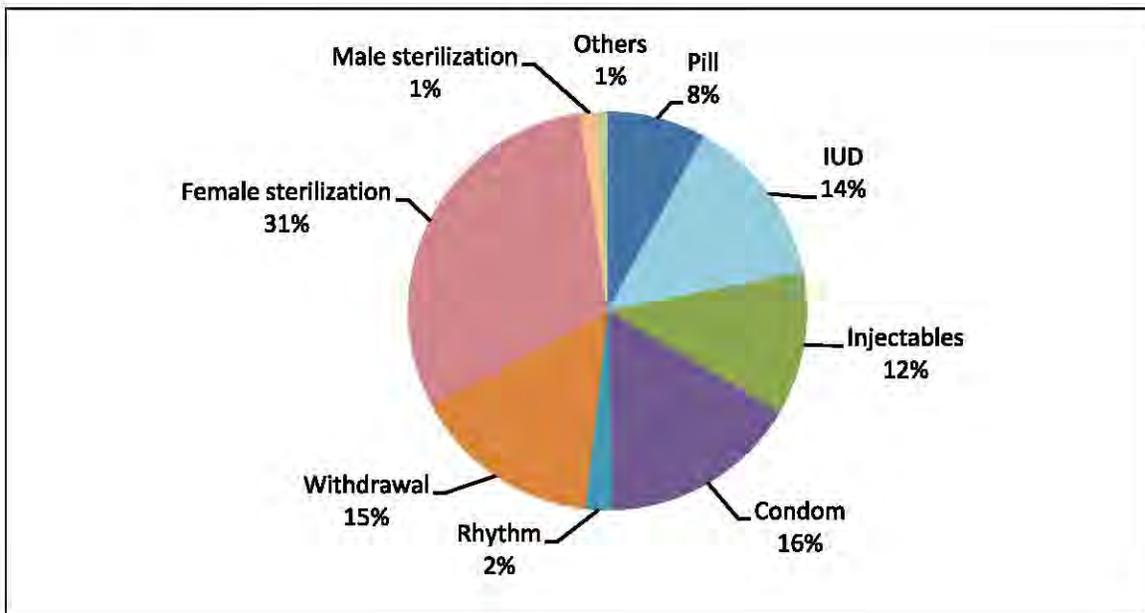
na = not applicable.

In an analysis of data for ever use of any modern method, injectables (13 percent), condoms (11 percent), pills (11 percent) and IUD (10 percent) were the most used methods. Traditional methods like rhythm and withdrawal were used by 10.8 percent of the respondents as compared to 34 percent who used modern methods. Condoms and the withdrawal method were more commonly used in urban areas as compared to rural areas. For other modern methods, a similar pattern was observed in both urban and rural areas.

A total of 22 percent of all married women in the sample area of Sanghar were currently using some method of contraception (the “contraceptive prevalence rate”, or CPR), 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 Sanghar, the CPR was 39 percent, compared with 17.6 percent in rural Sanghar.

The current methods most commonly used were female sterilization, condom, withdrawal and IUD (Table 8.2). The use of condoms at 3.5 percent was substantially lower than in national data (6.8 percent in the PDHS 2006-07). Overall, 17.8 percent of married women were using modern methods, 4 percent were using traditional methods (withdrawal and rhythm). Figure 8.1 shows the distribution of the women who were using some contraceptive method by method mix.

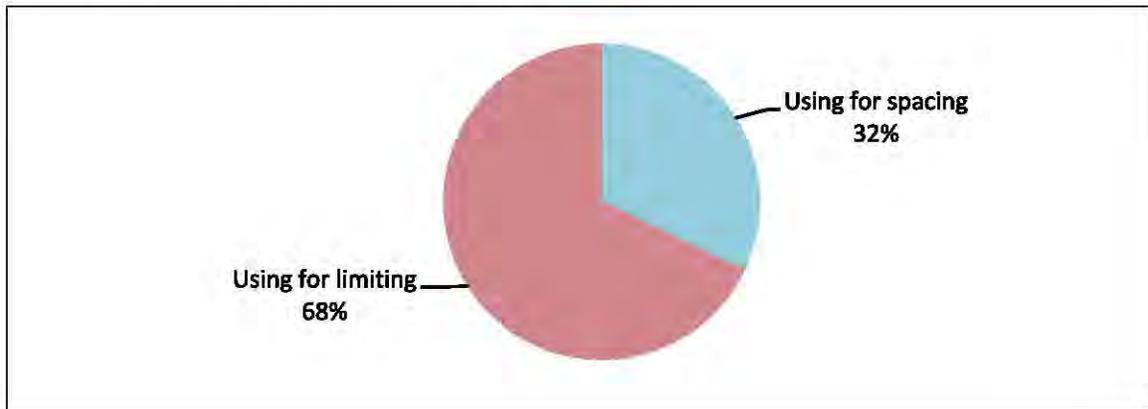
Figure 8.1: Distribution of current users by method mix



Current Use and Desire for Children

For current contraceptive users, it is important to determine how many were using methods for spacing purposes, and how many were using them to stop having children altogether. Overall, 68 percent of current use was for limiting purposes, compared with 32 percent for spacing.

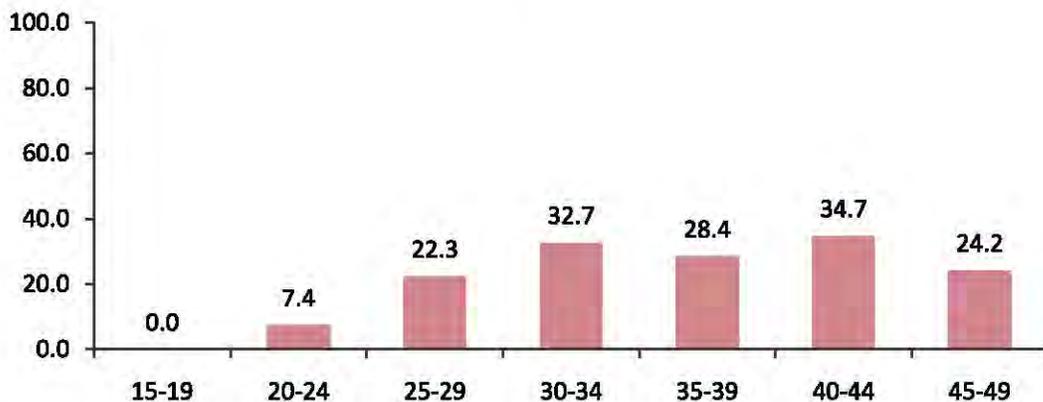
Figure 8.2: Current use and desire for children



Correlates of Contraceptive Use

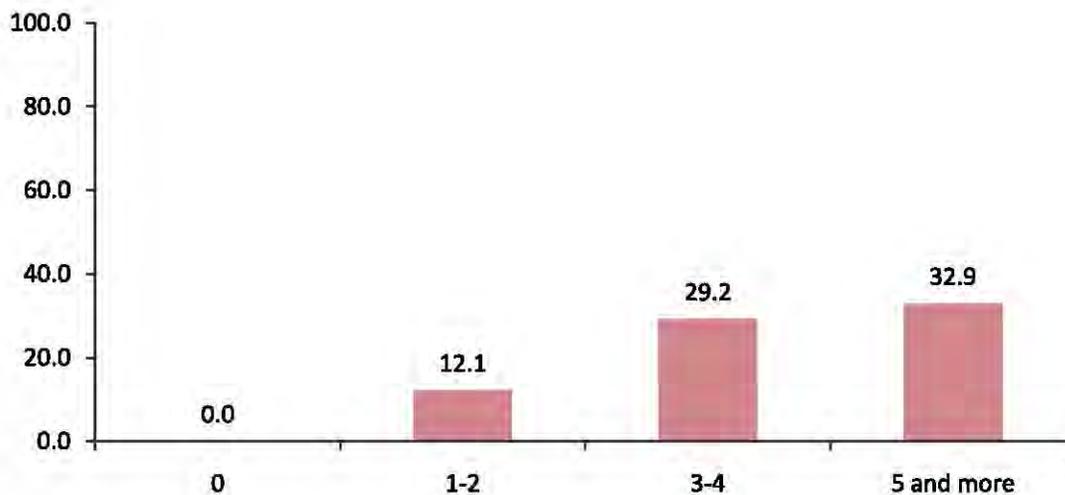
Figures 8.3 and 8.4 show the relationship between contraceptive prevalence and the women’s ages and number of living children. The shape of the graph for age is similar to that seen in other Pakistani and international studies, with low prevalence among both younger and older women (45–49 years) and higher prevalence in between ages.

Figure 8.3: Contraceptive prevalence by age



Contraceptive use increased rapidly with the increase in the number of living children. This is consistent with low age-specific fertility rates among women at older ages (from chapter 5). Figure 8.4 shows a rapid increase in contraceptive prevalence rate among the women who had 1-2 children compared to those women who had 3-4 children. The CPR was the highest at 33 percent among women who had 5 or more children.

Figure 8.4: Current contraceptive use by number of living children



As shown in Table 8.3, contraceptive use is associated with higher socioeconomic status and urban residence. Respondents in households with the highest SLI had substantially higher contraceptive prevalence (34.7 percent) than those with the lowest SLI. 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.

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

Characteristic	Contraceptive use status			Total	
	Current user	Past user	Never user	N	%
Standard of living index					
Low	11.6	8.4	80.0	215	100.0
Medium low	16.7	18.1	65.3	144	100.0
Medium high	30.6	15.6	53.7	147	100.0
High	34.7	25.8	39.5	124	100.0
Ownership of TV					
Yes	31.2	19.3	49.5	295	100.0
No	13.4	12.5	74.0	335	100.0
Literacy of respondent					
Literate	33.3	22.8	43.9	123	100.0
Illiterate	18.7	13.6	67.7	493	100.0
Residence					
Rural	17.6	14.8	67.7	507	100.0
Urban	39.0	19.5	41.5	123	100.0
Total	21.7	15.7	62.5	630	100.0

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 the place from which current and past users, combined, last time obtained their contraceptive method. From the table, it is clear that the source depended on the method. Pills and condoms were mostly obtained from Lady Health Workers, or by the husband. IUDs were inserted at private facilities or DHQ/THQ hospitals. Injectables were obtained from private hospitals and clinics or (recently) from LHWs. Female sterilization was carried out at DHQ/THQ hospitals and private hospitals.

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

Source	Family planning method						Total	
	Pill	IUD	Injectables	Condom	Female sterilization	Male sterilization	%	N
Government hospital (DHQ/THQ)	9.7	25.6	8.9	0.0	65.9	100.0	24.0	46
BHU/RHC/MCH center	0.0	2.6	2.2	0.0	0.0	0.0	1.0	2
FWC	3.2	5.1	2.2	0.0	0.0	0.0	2.1	4
LHW/TBA/dai	51.6	2.6	4.4	11.8	0.0	0.0	12.0	23
Pvt. doctor	6.5	7.7	17.8	0.0	0.0	0.0	6.8	13
Private hospital/clinic	3.2	53.8	33.3	0.0	34.1	0.0	26.5	51
Grocery shop/ pharmacy/ chemists	9.7	2.6	15.6	5.9	0.0	0.0	6.8	13
Husband brings method	9.7	0.0	11.1	76.5	0.0	0.0	17.7	34
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	192
N	31	39	45	34	41	2	100.0	192

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 experiences of those who have used contraceptive methods, both currently and in the past, we can gain insights into the problems users face and ways to solve them. We asked a series of questions regarding the experiences 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

Current and past users were asked if the reasons they chose a particular method included those from a list read out to them. 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, easily available, and no or few side effects. For female sterilization and IUD users, suitability of use for a long period was often cited. Cited less frequently were method availability, provider advice, and lack of other options. Clients tended to make decisions according to the known attributes of the various methods, but not always. For example, about 64 percent of pill users cited lack of side effects, even though the pill 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

Reason	Contraceptive method						N	
	Pill	IUD	Injectables	Condom	Withdrawal	Female sterilization		Male sterilization
Easily available	93.9	87.2	95.6	97.1	0.0	92.9	100.0	182
Low cost	97.0	51.3	60.0	97.1	0.0	69.0	100.0	143
Convenient to use	90.9	94.9	97.8	94.1	96.6	90.5	100.0	211
Suitable for respondent/husband	72.7	79.5	73.3	91.2	100.0	92.9	100.0	189
No/fewer side effects	63.6	51.3	57.8	88.2	89.7	81.0	100.0	159
Can be used for long period	15.2	92.3	44.4	29.4	27.6	100.0	100.0	123
No other method available	33.3	7.7	13.3	23.5	20.7	7.1	50.0	38
Method always available	54.5	61.5	75.6	67.6	10.3	33.3	50.0	117
Provider advised	42.4	71.8	64.4	11.8	6.9	52.4	100.0	101
Others	0.0	2.6	0.0	0.0	3.4	2.4	0.0	3
N	33	39	45	34	29	42	2	224

Respondents could give more than one reason.

To look more specifically at why some users preferred traditional methods to modern ones, 25 current traditional method users were asked why they were not using modern methods. Side effects were by far the main issue: 88 percent of these women cited fear of side effects, and 40 percent reported their own experience of side effects. Husband's disapproval of the modern methods was cited by 24 percent of the users, with other reasons (method not available, cost, lack of knowledge) were cited by very few women.

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

Reason	Percentage
Fear of side effects	88.0
Husband disapproves	24.0
Experienced side effects	40.0
Method not available	8.0
Costs too much	4.0
Doesn't know about modern methods	4.0
Others	4.0
N	25

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 method, whether it is obtained in the public or private sector, and the distance from home to facility. Table 9.3 and Figure 9.1A show the reported costs borne by current users at the time they last obtained their method. About half (47 percent) of the clients were not charged for their contraceptives, including all female and male sterilization users (who are, in fact, typically reimbursed for expenses involved) and 46 percent of pill users. Another quarter of the respondents paid more than 50 rupees. IUD and injectable users often paid more than 50 rupees for their method; but since IUD insertion is a one-time cost, related monthly expenses may be quite low.

Table 9.3: Distribution of costs of current specific contraceptive method

Method	Cost (in rupees)					Total	
	No payment	1-20	21-50	51+	Don't know	%	N
Pill	45.5	45.5	0.0	9.1	0.0	100.0	11
IUD	5.3	0.0	10.5	78.9	5.3	100.0	19
Injectables	0.0	6.3	6.3	68.8	18.8	100.0	16
Condom	9.5	9.5	4.8	4.8	71.4	100.0	21
Female sterilization	100.0	0.0	0.0	0.0	0.0	100.0	42
Male sterilization	100.0	0.0	0.0	0.0	0.0	100.0	2
Total	46.8	7.2	3.6	25.2	17.1	100.0	111

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

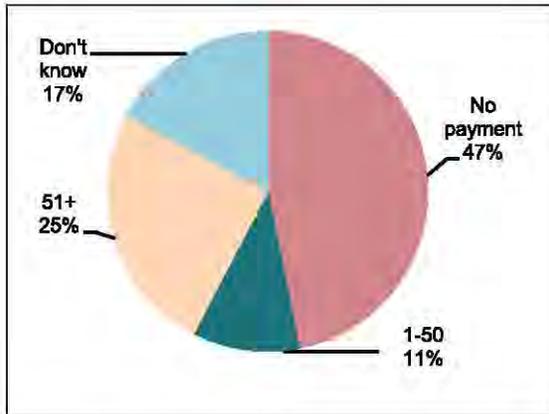
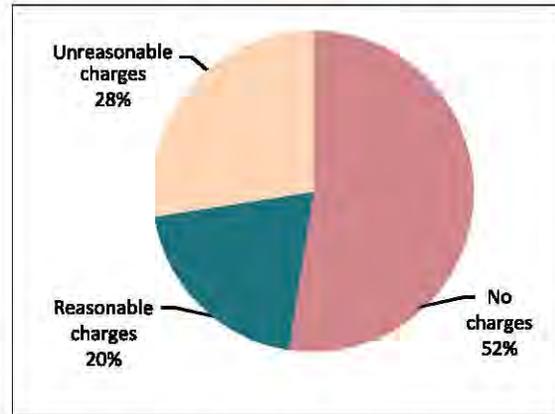


Figure 9.1B: Attitude toward service charges for current method other than contraceptive

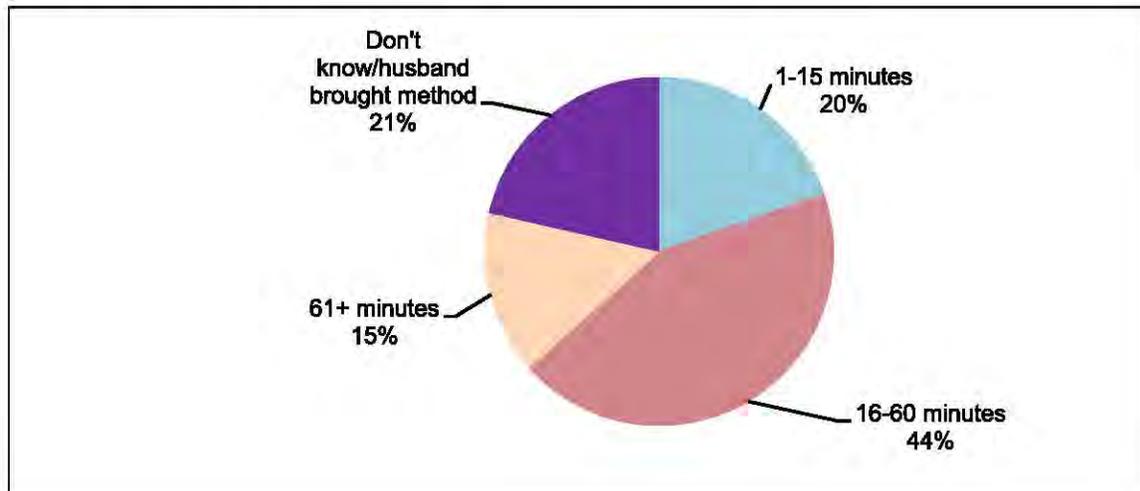


Current users were also asked whether their facility charged them for services provided. Fifty-two percent of the respondents said they were not charged for services, while another 28 percent reported that the cost for service was unreasonable. About one in five women reported that the service charges were reasonable (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 acquire the contraceptive methods. About 20 percent of users did not need more than 15 minutes to obtain their method; this included LHWs, who often brought pills, condoms and injectables to the doorstep. For a fifth of the women sampled it took up to 30 minutes. More than 21 percent of the women were unaware of the time required to obtain their method as their husbands were responsible for procuring the contraceptive. For a few users, particularly those who chose female sterilization and IUDs, it took more than an hour to reach the service delivery point; but in these cases, 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

Family planning method	Time (in minutes)					Total	
	1-15	16-30	31-60	61-180	Don't know /husband brought method	%	N
Pill	63.6	18.2	9.1	0.0	9.1	100.0	11
IUD	21.1	15.8	36.8	21.1	5.3	100.0	19
Injectables	25.0	18.8	37.5	6.3	12.5	100.0	16
Condom	9.1	0.0	0.0	0.0	90.9	100.0	22
Female sterilization	11.9	33.3	26.2	28.6	0.0	100.0	42
Male sterilization	0.0	50.0	50.0	0.0	0.0	100.0	2
Total	19.6	20.5	23.2	15.2	21.4	100.0	112

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

Treatment by Provider

Information Provided

Current and past users were asked to select the information provided to them by their service provider from a list read out to them by interviewers. The accuracy of clients' responses may be questioned, due to problems of recall or understanding. The most common topics which respondents said they were told about were effectiveness/duration of the method as well as the correct way to use the chosen method. Some were told about side effects and management of these side effects. Some also reported being told about the advantages of the method. A few were told about the possibility of switching methods or 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 should give comprehensible information on method selection to the clients, especially for hormonal contraceptives.

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

Information provided at acceptance	Family planning method						N
	Pill	IUD	Injectables	Condom	Female sterilization	Male sterilization	
How the method works	21.2	2.6	0.0	0.0	7.1	0.0	11
How to use the method	84.8	41.0	42.2	2.9	14.3	0.0	70
Contraindications	15.2	2.6	6.7	0.0	4.8	0.0	11
Effectiveness/ duration of effectiveness	57.6	76.9	62.2	2.9	45.2	0.0	97
Advantages	27.3	41.0	24.4	2.9	26.2	0.0	48
Possible side effects	27.3	56.4	26.7	0.0	28.6	0.0	55
What to do if experience side effects	27.3	64.1	28.9	0.0	28.6	0.0	59
Possibility of switching	24.2	20.5	11.1	2.9	0.0	0.0	22
About other methods of FP you could use	21.2	12.8	8.9	5.9	11.9	0.0	23
N	33	39	45	34	42	2	na

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

Treatment at Facility

Current users were asked about various aspects of their treatment when they last time visited a provider for family planning. As Table 9.6 shows, responses were mainly positive, with some exceptions. Ninety one percent of the respondents were satisfied with the attitude of the staff and almost all (98 percent) said that provider was able to deal with side effects. However, 48 percent stated that the provider charged them for services rendered while 15 percent said they were not examined properly.

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

Aspect of treatment	Percentage
Staffs attitude cooperative	91.0
Provider available	96.0
Attend/examine properly	85.1
Doesn't demand charges for services	51.9
Can deal with side effects	97.7

Side Effects

Current users were asked if they had experienced, or were experiencing, any side effects using their current method. Past users were asked if side effects were among the reasons for their discontinuation of a method. A list of possible side effects was read out to them, and they were asked to name the side effects they had experienced; multiple responses were allowed. Ninety-one percent of the current users and slightly above half (54 percent) of the past users did not have any side effects. As shown in Figure 9.3, the most commonly reported side effect by ever users were among those who used IUDs, injectables and pills (44 percent, 40 percent and 30 percent respectively), and only 6 percent of condom users reported having experienced side effects (Figure 9.3). When asked to respond to a list of possibilities, those who reported side effects, tended to have experienced a variety of side effects. This was regardless of the method used, and sometimes effects were reported which may not be associated with a specific method.

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

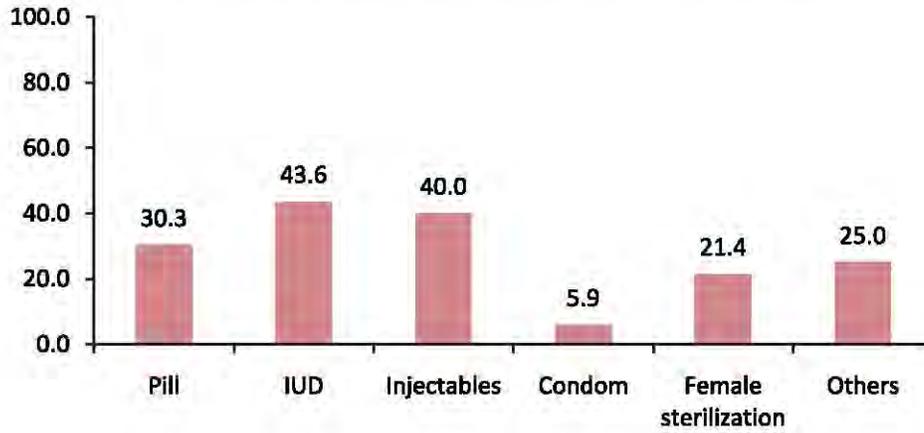
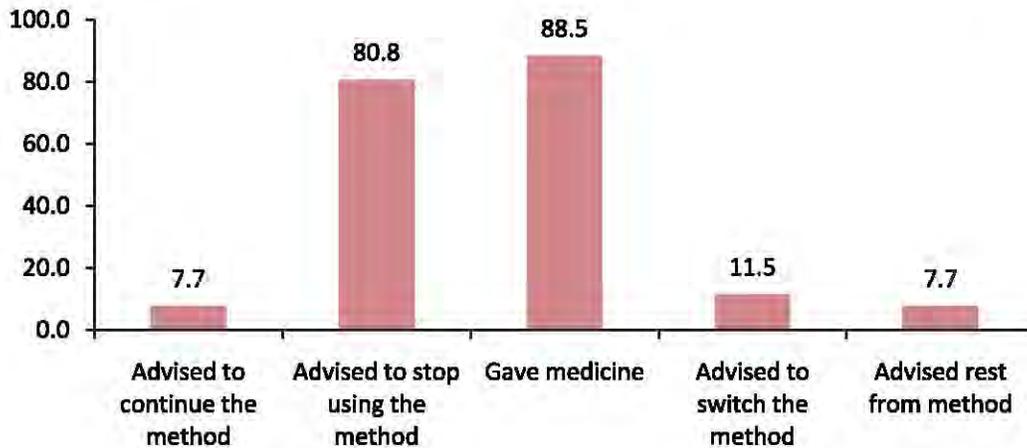


Figure 9.4: Distribution of provider responses upon consultation for side effects among past users



Of the 46 past users who reported experiencing side effects, 27 said they had consulted someone for managing these side effects. In 25 of these cases, this was said to be a doctor. These 27 respondents were asked if the provider had advised any of a list of possible responses. Eighty-one percent were advised to stop, and 12 percent were advised to switch to another method. Eighty-nine percent were given medication, 80 percent were advised to continue using the method, and 8 percent were told to rest from the method (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, or the wife may already have passed menopause, or believe herself to be sterile. Other reasons, however, may result in a couple that wants to avoid having children, but may not be using any contraception that could help them to do so. There are many such reasons: for example, lack of knowledge of methods or places to obtain them, fear of side effects of 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 to best meet the needs of such people, it is important to understand the reasons why couples are not using birth spacing in relation to the situation they are currently in.

Hindrances to Use

One way to understand common 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 compelled 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 given by female respondents, according to whether they were current users, past users, or never users.

Some obstacles that couples might face were almost universally acknowledged. Most of the respondents mentioned the possibility of husband's disapproval, religious concerns and a fear of side effects. Other possibilities that a substantial proportion of women respondents thought to be a hindrance were managing side effects, the reactions of other people regarding them using family planning methods, and distance and travel cost to a family

planning outlet. In general, never users were slightly more likely to agree with each of the proposed hindrances than current and past 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

Hindrance	Contraceptive use status					
	Current user		Past user		Never user	
	N	%	N	%	N	%
Husband's disapproval	132	96.4	94	94.9	383	97.5
Other people may find out about contraceptive use	85	62.0	66	66.7	289	73.5
Distance and travel costs to FP outlet	77	56.2	67	67.7	268	68.2
Probability of getting pregnant while using	76	55.5	63	63.6	255	65.1
Fear of side effects	125	91.2	87	87.9	384	97.7
Problem of managing side effects	86	62.8	74	74.7	314	79.9
FP is against religion	124	90.5	83	83.8	364	92.6
N	137	na	99	na	393	na

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

Past Users

Reasons for Discontinuing Contraceptive Use

Past users were asked about their reasons for discontinuing their last contraceptive method. The most common reasons given were desire for another child, side effects experienced, fear of side effects and husband's advice (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 in Table 9.4, 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 reasons for discontinuing last method

Reason	Percentage
Wanted another child	53.5
Fear of side effects	34.3
Side effects experienced	46.5
Method failure	8.1
Lack of access/unavailability	4.0
Cost not affordable	2.0
Method inconvenient to use	6.1
Rest from method	12.1
Missed the dose	5.1
Provider's advice	12.1
Infrequent sex/husband away	6.1
Husband's advice	23.2
In-laws oppose	1.0
N	99

Respondents could give more than one reason.

Reasons for Current Non-use

It is important to know whether couples who have used contraception in the past but are not currently using any method are acting in conformance with their expressed desires. Past users were read out a list of possible reasons for their non-use, with more than one reason possible (Table 10.3). The most common reasons overall were related to childbearing, e.g., wanting another child (32 percent) and currently pregnant (29 percent). However, a significantly higher percentage did cite fear of side effects (41 percent).

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

Reason	Percentage
Fear of side effects	41.4
Want another child	32.3
Currently pregnant	29.3
Rest from method/provider's advice	11.1
Infrequent sex/husband away	7.1
Breastfeeding/ lactational amenorrhea	11.1
Menopause	5.1
Just not using/too lazy	7.1
Others	13.7
N	95

Respondents could give more than one reason.

Never Users

Reasons for Non-use

The 393 women in the sample who reported never use were asked about various possible reasons for not using, with each reason read out separately. The most important reason given was desire for more children by 69 percent of the women. These issues were dominant among childless couples and declined rapidly with increasing number of children. Another important reason for never use was fear of side effects (45 percent); the opposition of husband and in-laws were reported by 42 percent and 25 percent respectively (Table 10.4).

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

Reason	Percentage
Husband opposes	41.7
In laws oppose	24.7
Fear of side effects	44.7
Lack of access/unavailability	11.9
Cost not affordable	9.9
Shy to consult about family planning	11.4
Method inconvenient to use	7.1
Infrequent sex/husband away	6.1
Difficult/unable to conceive	12.7
Breastfeeding/lactational amenorrhea	12.7
Wanted (more) children	69.3
Against religion	4.8
Natural spacing	16.5
Others	4.3
N	393

Respondents could give more than one reason.

Attitudes 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 it in principle but were not using a method for some other reasons. Table 10.5 shows this for never using respondents. When compared, the disapproval was slightly higher for spacing (47 percent) than for limiting (43 percent). The implications of this for whether a couple does or does not use birth spacing or limiting may be profound, and require further investigation.

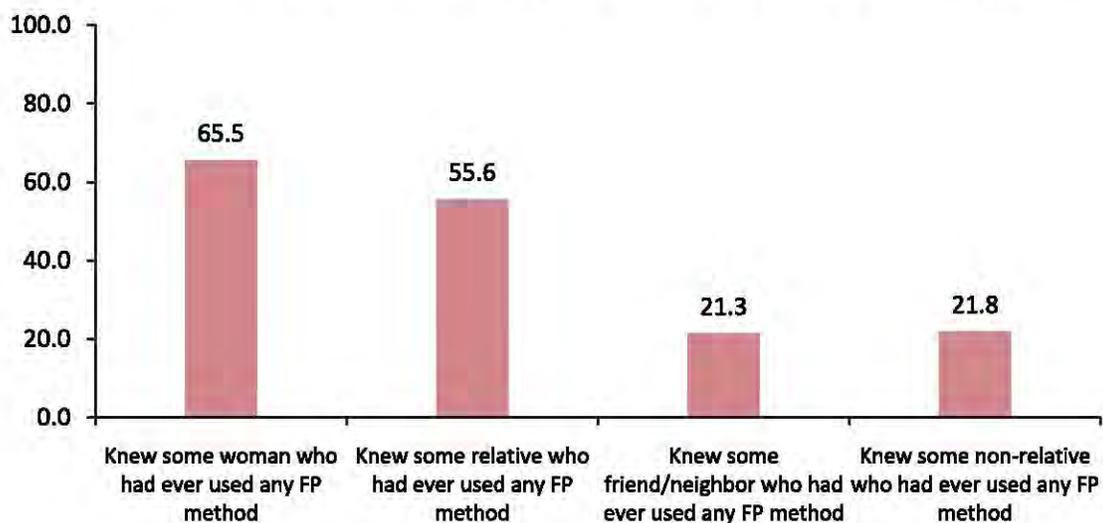
Table 10.5: Distribution of never users by attitude toward spacing and limiting birth

Attitude	Attitude toward spacing		Attitude toward limiting	
	N	%	N	%
Approve	210	53.3	223	56.6
Disapprove	184	46.7	171	43.4
Total	394	100.0	394	100.0

Knowledge of Contraceptive Users, Methods and Facilities

Of the 394 female never users in the sample, 66 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy. Fifty-six percent of the respondents had a relative who had used some method, and 21 percent knew of a friend or neighbor who had used a FP method. Nearly 35 percent of never using women did not know anyone who had ever used a contraceptive 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 contraceptive methods than ever users, as might be expected, but, surprisingly, all never using women knew of at least one method (Table 10.6). For each method, a somewhat smaller percent of never users knew that method than the overall knowledge as shown in Table 8.1, but most never users knew a

variety of methods. However, their knowledge of where to acquire the services and supplies was less satisfactory.

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

Method	Percentage
Female sterilization	97.5
Male sterilization	16.5
Pill	98.7
IUD	87.6
Injectables	98.2
Norplant	27.9
Condom	48.0
Rhythm	10.4
Withdrawal	44.7
Emergency pills	2.3
Others	7.1
Know at least one FP method	100.0
N	394

Respondents could give more than one response.

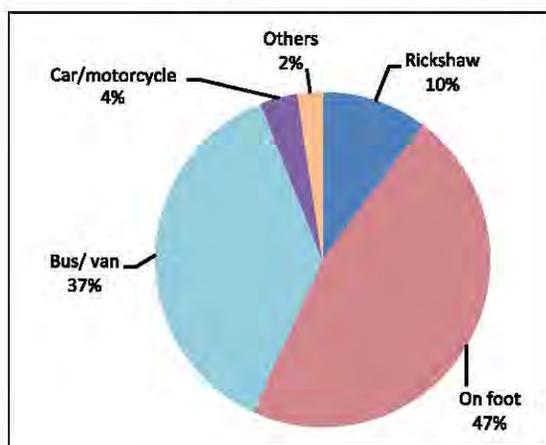
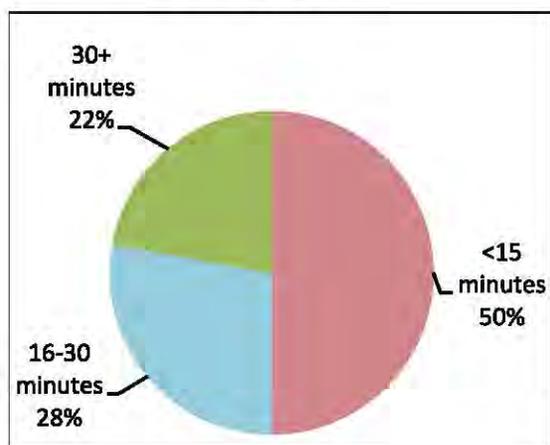
Of the 394 never users, 226 (57 percent) did not know of a place to obtain a method. For those who did know, the places they were aware of are shown in Table 10.7. The sources best known were department of health outlets – the District/Tehsil Headquarters hospitals, BHUs/RHCs/MCH centers, and Lady Health Workers. A substantial number knew of private hospitals/doctors including pharmacies/chemists. Few women 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	42.6
DHQ/THQ hospital	37.3
BHU/RHC/MCH center	10.7
Family welfare center	1.8
Mobile service unit camp	1.0
Lady health worker	21.1
Greenstar clinic	1.5
Private hospital/clinic/doctor	34.5
Dispenser/compounder	1.5
Pharmacy/chemists	25.6
Homeopath/hakim	1.5
TBA/ dai	1.8
Grocery shop (not pharmacy/ chemist)	1.5
N	394

Respondents could give more than one response.

When asked which of the facilities/sources named was nearest, the respondents were again most likely to name DHQ/THQ hospitals, LHWs and private hospitals/clinics in that order. Many said that they traveled there on foot, or sometimes by bus/van or rickshaw (Figure 10.2). Half of the respondents gave a travel time of 15 minutes or less, 28 percent gave a time frame of 16 to 30 minutes, and 22 percent gave a time frame of more than 30 minutes to acquire their desired contraceptive. The maximum travel time given was three hours (Figure 10.3). We can infer that the time required to obtain the contraceptive did not have a significant impact on never users.

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 whether they intended to use contraceptives in the future, a quarter of the female respondents (98 out of 394 who believed they could get pregnant) said that they intended to use (Table 10.8). Low parity women who had not yet used a method (women with 2 or fewer children) stated that they were unsure about FP use in the future compared to women with 3 or more living children.

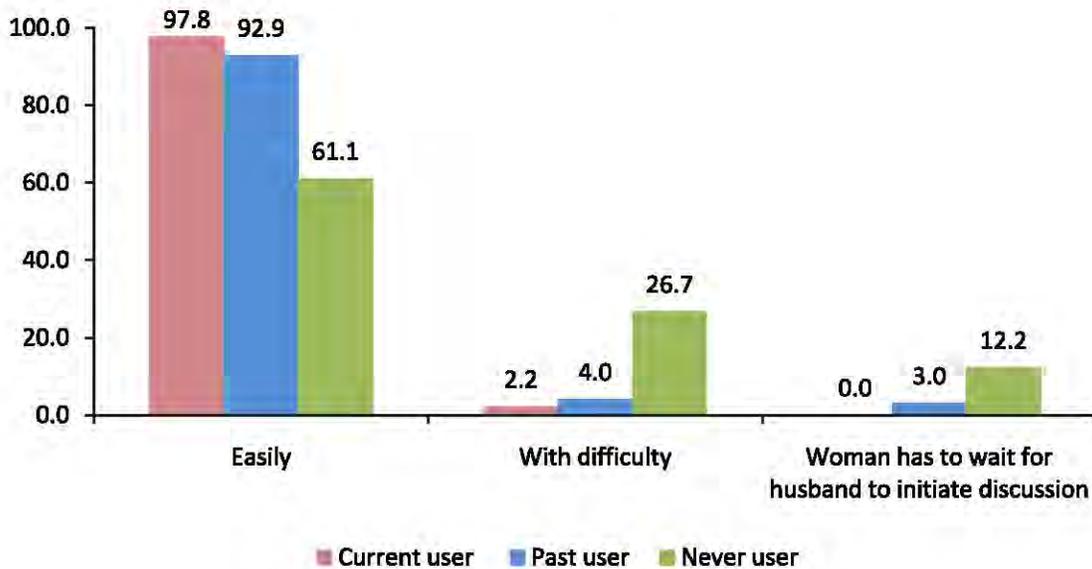
Table 10.8: Distribution of never users by intent to use a method in future and number of living children

Number of living children	Intent to use a method in future				Total	
	Yes	No	Unsure/uncertain	Can't get pregnant	N	%
0	25.0	35.7	39.3	0.0	84	100.0
1-2	25.2	41.7	32.3	0.8	127	100.0
3-4	19.8	51.2	26.7	2.3	86	100.0
5 or more	28.9	39.2	25.8	6.2	97	100.0
Total	24.9	41.9	31.0	2.3	394	100.0
N	98	165	122	9	394	100.0

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on family planning. Women were asked about the level of ease with which they could approach their husbands to discuss family planning. Most women said they could do so easily (Figure 10.4). However, this varied by use status. About 98 percent of current users, and 93 percent of past users, said they could approach their husbands easily, and very few said they had to wait for their husband to initiate the discussion. For never users, 61 percent reported being able to approach their husbands easily, with slightly more than a quarter of never users reporting that they could only do so with difficulty, and another 12 percent saying 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 as they are not currently using contraceptives. Women currently pregnant or who are experiencing postpartum amenorrhea are said (in this formulation) to have 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 have an 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 need some support to avoid an unwanted pregnancy.

Levels and Correlates

Table 11.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Sanghar. Of the 630 women, 205 (32.5 percent) were judged to be in unmet need. This proportion is typically found using the same definition in Pakistan. Of the 32 percent women who had unmet need, 15 percent was for spacing, while 17 percent was for limiting. Unmet need for spacing was relatively high among women with one or two living children; 70 of the 97 cases were in this category. Unmet need for limiting, unsurprisingly, was highest among women with five or more living children, because at that stage couples would probably want to limit births.

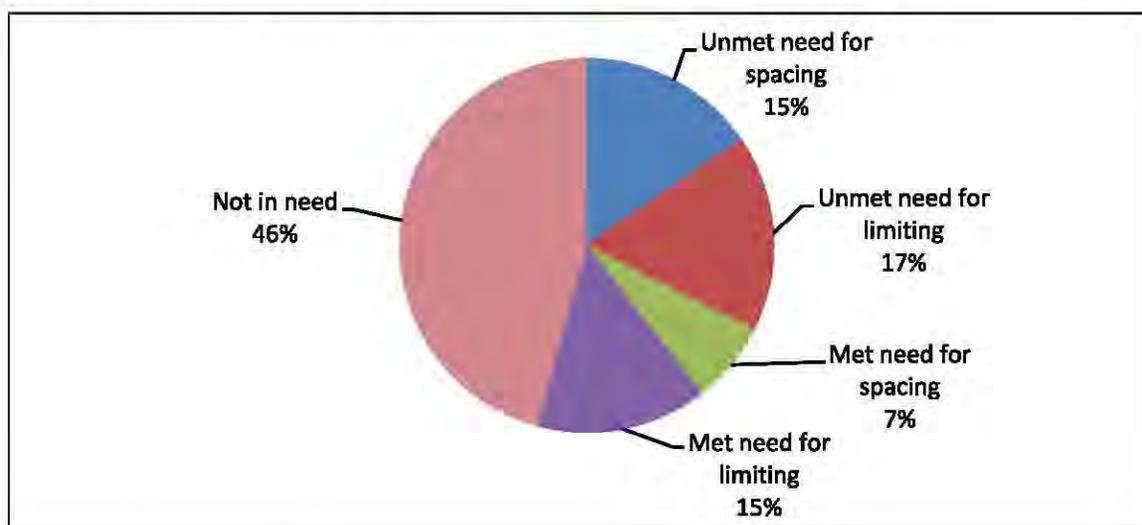
Table 11.1: Need and demand for FP among MWRA by background characteristics

Characteristic	Unmet need			Met need			Total demand	Not in need	Total	N
	For spacing	For limiting	Total	For spacing	For limiting	Total				
Age of respondent										
15 - 24	22.1	1.2	23.3	4.7	1.2	5.8	29.1	70.9	100.0	172
25 - 34	20.3	12.7	32.9	14.8	11.8	26.6	59.5	40.5	100.0	237
35 - 49	5.0	34.4	39.4	0.5	28.5	29.0	68.3	31.7	100.0	221
Residence										
Rural	16.6	17.4	33.9	4.9	12.6	17.6	51.5	48.5	100.0	507
Urban	10.6	16.3	26.8	15.4	23.6	39.0	65.9	34.1	100.0	123
Literacy of respondent										
Literate	17.9	7.3	25.2	17.1	16.3	33.3	58.5	41.5	100.0	123
Illiterate	15.2	19.1	34.3	4.5	14.2	18.7	52.9	47.1	100.0	493
Education of respondent										
No education	14.6	19.6	34.2	4.4	14.2	18.6	52.8	47.2	100.0	479
Up to primary	17.4	10.5	27.9	14.0	15.1	29.1	57.0	43.0	100.0	86
Up to secondary	23.7	5.3	28.9	13.2	10.5	23.7	52.6	47.4	100.0	38
Above secondary	11.5	11.5	23.1	23.1	30.8	53.8	76.9	23.1	100.0	26
Children ever born										
0	1.3	0.0	1.3	0.0	0.0	0.0	1.3	98.7	100.0	75
1-2	25.3	2.5	27.8	11.4	0.6	12.0	39.9	60.1	100.0	158
3-4	21.0	16.8	37.8	14.7	11.2	25.9	63.6	36.4	100.0	143
5+	10.2	31.5	41.7	2.0	29.9	31.9	73.6	26.4	100.0	254
Ownership of TV										
Yes	14.9	15.3	30.2	10.5	20.7	31.2	61.4	38.6	100.0	295
No	15.8	18.8	34.6	3.9	9.6	13.4	48.1	51.9	100.0	335
Standard of living index										
Low	15.8	18.1	34.0	3.3	8.4	11.6	45.6	54.4	100.0	215
Medium low	18.8	20.8	39.6	5.6	11.1	16.7	56.3	43.8	100.0	144
Medium high	11.6	14.3	25.9	10.9	19.7	30.6	56.5	43.5	100.0	147
High	15.3	14.5	29.8	10.5	24.2	34.7	64.5	35.5	100.0	124
Total	15.4	17.1	32.5	7.0	14.8	21.7	54.3	45.7	100.0	630

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, illiteracy, rural residence and with households not owning a

television. Unmet need for spacing, on the other hand, was strongest for literate women, while associations with SLI, ownership of television and urban residence were moderate. It is possible that educated women were more aware of the need to space their births, but were inhibited from doing so for various reasons. Once they have reached their desired family size, educated women may be more able to use family planning methods than their uneducated counterparts. However, conclusions should be tentative, given the small sample sizes involved. Unmet need for limiting was strongly associated with the age of respondent, as it was the lowest among women under 24 years of age. On the other hand, unmet need for spacing was high for women in the age group of 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 shows total demand by number of living children. Overall, total demand was 54 percent of all married women of reproductive age. As the table shows, total demand did rise rapidly, and fairly consistently, by number of living children ever born. Even at 1-2 children, demand was quite substantial (40 percent) and it increased to over 74 percent for those with five or more children. The high proportion of total demand that is in unmet need at earlier reproductive stages is an important problem that needs to be addressed.

Strength of Preference

It is of interest to look at the responses of women in unmet need (those not currently pregnant) according to their response if they became pregnant in the near future (Table 11.2). Forty percent of the women with unmet need for spacing said they would be worried if they became pregnant again, 42 percent would be pleased, and 18 percent would accept it. Of those with unmet need for limiting, 59 percent said they would be worried if they became pregnant and only 12 percent would be pleased. 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 space their next child and those who wanted to limit their family size were not strong.

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	38	42.2	12	11.9
Worried	36	40.0	60	59.4
Accept it	16	17.8	29	28.7
Total	90	100.0	101	100.0

Reasons for 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 represent barriers as perceived by the women. The most important of these were fear of side effects and opposition of husbands 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 for spacers included desire for more children and natural spacing. Some of these women may have more need than they realize; for example, women using “natural spacing” or breastfeeding may in fact be at a substantial risk of becoming pregnant. 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	51.5	57.4	54.6
Husband opposes	41.2	35.2	38.0
In-laws oppose	23.7	15.7	19.5
Rest from method	0.0	0.9	0.5
Shy to consult about FP	8.2	11.1	9.8
Provider's advice	1.0	0.9	1.0
Against religion	4.1	4.6	4.4
Lack of access/unavailability	8.2	15.7	12.2
Cost not affordable	7.2	13.0	10.2
Just not using/too lazy	1.0	3.7	2.4
Method inconvenient to use	5.2	4.6	4.9
Infrequent sex/husband away	8.2	10.2	9.3
Natural spacing	15.5	17.6	16.6
Difficult/unable to conceive	4.1	4.6	4.4
Want (more) children	84.5	2.8	41.5
Currently pregnant	3.1	0.0	1.5
Breastfeeding/lactational amenorrhea	5.2	6.5	5.9
Others	5.2	14.8	10.2
N	97	108	205

Respondents could give more than one reason.

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprised 97 (15 percent) of MWRA, as shown in Table 11.4. They were characterized by:

- **Living Children:** Most (46 percent) had 1 or 2 living children.
- **Family Planning Use:** More never users (87 percent) than past users (13 percent).
- **Strength of Preference:** Moderate (40 percent “worried” if they became pregnant earlier than they wanted compared to those who were pleased (42 percent) or accept (18 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** Low (about 33 percent intended to use a FP method in future).
- **Approval of FP:** Moderate (57 percent approved of using a FP method for spacing purposes).
- **FP Communication with Husband:** Limited (only 33 percent had communicated with husbands on FP in the past one year; while 28 percent said approaching the husband was “not easy”).
- **Obstacles to FP Use:** Fear of side effects (52 percent); husband and in-laws opposition (41 percent and 24 percent respectively) (Table 11.3).

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	1	1.0	0	0.0
1-2	45	46.4	6	5.6
3-4	33	34.0	25	23.1
5 or more	18	18.6	77	71.3
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	13	13.4	30	27.8
Never user	84	86.6	78	72.2
Reaction if become pregnant in near future				
Pleased	38	42.2	12	11.9
Worried	36	40.0	60	59.4
Accept it	16	17.8	29	28.7
Intention to use a method in future				
Yes	32	33.0	35	32.4
No	31	32.0	46	42.6
Unsure/uncertain	34	35.1	26	24.1
Can't get pregnant	0	0.0	1	0.9
Approval of FP				
Approve	55	56.7	73	67.6
Disapprove	42	43.3	35	32.4
FP communication with husband in past one year				
Never	65	67.0	69	63.9
Once or twice	30	30.9	39	36.1
More often	2	2.1	0	0.0
Approach the topic of FP with husband				
Easily	70	72.2	82	75.9
Not easily	27	27.8	26	24.1
Total	97	100.0	108	100.0

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 108 (17 percent) of MWRA, as shown in Table 11.4. They are 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 (72 percent) than past users (28 percent).
- **Strength of Preference:** Moderate (59 percent would be “worried” if they became pregnant compared to those who were pleased (12 percent) or accept (29 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** Low (about 32 percent intended to use a FP method in future).
- **Approval of FP:** High (68 percent approved of FP for limiting purposes).
- **FP Communication with Husband:** Limited (only 36 percent had communication with husband on FP in the past year; while 24 percent said approaching the husband was “not easy”).
- **Obstacles to FP Use:** Fear of side effects (57 percent); husbands and in-laws opposition (35 percent and 16 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 Sanghar, the field team was able to interview 193 men who were husbands of the married women of reproductive age who had been interviewed for the survey plus 7 married men living in 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 2 percent of the men were under 25 years of age and 21 percent were 50 years of age and above.

As shown in Table 12.1, the men were substantially better educated than the sampled currently married women of reproductive age. Forty percent of the men had not been to school, compared to 76 percent of the currently married women (Table 3.2). It also shows that 36 percent of the men had more than primary education, whereas 10 percent of the currently married women had attained that level of education (Table 3.2). More than 73 percent of the urban men had received some schooling compared to 56 percent of the rural men.

The occupations of men are also presented in Table 12.1. The highest proportion (47 percent) of men were working as daily laborers, and the same proportion were working in agriculture-related activities. Thirteen percent were running their own business.

Table 12.1: Background characteristics of male respondents, by residence

Characteristic	Rural	Urban	Total
Age			
20-24	2.6	0.0	2.0
25-29	11.0	2.2	9.0
30-34	18.1	11.1	16.5
35-39	16.8	17.8	17.0
40-44	15.5	24.4	17.5
45-49	10.3	20.0	12.5
50-54	14.2	11.1	13.5
55+	5.8	11.1	7.0
Education			
Proportion literate	48.4	66.7	52.5
No education	43.9	26.7	40.0
Up to primary	24.5	22.2	24.0
Up to secondary	16.8	31.1	20.0
Above secondary	14.8	20.0	16.0
Economic activity/ occupation			
Agriculture/livestock/poultry	56.1	13.3	46.5
Labor (daily wages)	51.0	31.1	46.5
Govt. service	9.0	13.3	10.0
Pvt. service	4.5	20.0	8.0
Own business	8.4	26.7	12.5
Unemployed	3.2	4.4	3.5
Others	0.6	0.0	0.5
N	155	45	200

Contraceptive Knowledge and Use

Almost all of the interviewed men (99 percent) in Sanghar knew of at least one method of contraception. As presented in Table 12.2, knowledge of modern methods was highest for female sterilization (90 percent), followed by injections (89 percent), pills (87 percent) and condoms (77 percent). The least known methods were Norplant (20 percent), male sterilization (34 percent), and IUD (65 percent). Knowledge of traditional methods was prevalent among only 67 percent of the men. All currently married women of reproductive age interviewed in Sanghar also knew at least one contraceptive method (Table 8.1).

The pattern of ever use and current use of contraception reported by husbands is also shown in Table 12.2. Thirty-eight percent of the MWRA reported having used some method of contraception during their married lives (Table 8.2); of the male respondents, 41 percent reported ever using some method of contraception in their married lives. For the men,

among modern methods, condom was the most popular method ever used (11 percent), followed by IUD (8 percent), pill (7 percent), and female sterilization (6 percent). The use of injectables and female sterilization was more prevalent in rural areas, and the use of condom, pill and IUD methods was higher in urban areas. Although, 4 percent of men living in urban areas reported ever use of injectables, surprisingly, none of them reported current use of injectables by their wives.

As mentioned in Chapter 8, a total of 22 percent of all MWRA in the sample were currently using some method of contraception, while for the male respondents this figure was higher at 30 percent. The most common current modern method reported by male respondents was female sterilization (6 percent), followed closely by the IUD (5 percent). The use of traditional methods was also substantial; more than 40 percent of the current users were relying on such methods. Since traditional methods are far less reliable than modern methods, an important goal of the FALAH project may be to shift users of traditional methods to more effective modern methods. Although 16 percent of the respondents knew about the emergency contraceptive pill, only one-half a percent of the men reported ever using it.

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

Method	Knowledge			Ever use			Current use		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Female sterilization	92.3	80.0	89.5	6.5	4.4	6.0	6.5	4.4	6.0
Male sterilization	34.8	31.1	34.0	0.6	0.0	0.5	0.6	0.0	0.5
Pill	84.5	93.3	86.5	4.5	15.6	7.0	0.6	2.2	1.0
IUD	63.0	73.3	65.3	5.8	13.3	7.5	3.9	8.9	5.0
Injectables	89.0	86.7	88.5	5.8	4.4	5.5	1.9	0.0	1.5
Norplant	19.4	20.0	19.5	0.0	0.0	0.0	0.0	0.0	0.0
Condom	72.9	91.1	77.0	8.4	20.0	11.0	3.9	6.7	4.5
Rhythm	46.5	48.9	47.0	9.7	13.3	10.5	7.1	11.1	8.0
Withdrawal	47.1	60.0	50.0	5.2	20.0	8.5	2.6	11.1	4.5
Others	3.2	2.3	3.0	0.6	0.0	0.5	0.6	0.0	0.5
At least one FP method	99.4	97.8	99.0	35.5	60.0	41.0	27.1	40.0	30.0
At least one modern FP method	99.4	97.8	99.0	25.8	40.0	29.0	17.4	20.0	18.0
At least one traditional FP method	64.5	73.3	66.5	14.8	31.1	18.5	10.3	20.0	12.5
Emergency pills	15.6	17.8	16.1	0.0	2.2	0.5	na	na	na
N	155	45	200	155	45	200	155	45	200

na=not applicable

Table 12.3 shows ever use and current use of modern contraception among respondents by background characteristics. A higher proportion of urban men were currently using a family planning method compared to rural men. More than 46 percent of the respondents who had secondary and above education reported ever use of any contraceptive method, compared to 47 percent and 33 percent who had below secondary and no education, respectively. The current use of family planning also showed the same pattern by education of men.

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	35.5	27.1	155
Urban	60.0	40.0	45
Education level			
No education	32.5	26.3	80
Below secondary	47.0	34.8	66
Secondary and above	46.3	29.6	54
Number of living children			
None	11.5	7.7	26
1-2	40.0	25.7	35
3-4	46.3	35.2	54
5+	47.6	35.7	84
Future desire for children			
Soon	22.2	16.7	36
Later	31.3	15.6	32
Never	53.7	43.2	95
Don't know/unsure	35.1	21.6	37
Total	41.0	30.0	200

Table 12.3 also shows a positive relationship between the number of living children and ever use as well as current use. Of those who had 5 or more children, almost 48 percent reported ever use of family planning methods compared to 46 percent who had 3-4 children and 40 percent who had 1-2 children. The same pattern was observed in current use of contraceptives by number of living children.

Table 12.3 also shows contraceptive ever use and current use by the future desire for children. Highest ever use was found among the male respondents who said they did not want any more children: 54 percent of those respondents who wanted no more children

had ever used any contraceptive method, and 43 percent were currently using a form of contraception.

Source of Contraceptive Methods

As shown in Table 12.4, among those who reported the last source for obtaining contraceptive methods, 33 percent knew that they obtained it from the “pharmacy/chemist/grocery/general store.” Government hospitals were reported by 25 percent of the ever users. Private doctor and LHWs were reported by 14 percent and 12 percent, respectively. Two percent of the male respondents said that their wives brought the method.

Table 12.4: Distribution of ever users of specific contraceptive method by most recent source of supply

Source	Percentage
Govt. hospital (DHQ/THQ)	25.0
BHU/RHC/MCH center	3.8
FWC	1.9
LHW	11.5
Other public	1.9
Pvt. doctor	13.5
Pvt. hospital/clinic	5.8
Pharmacy/chemist/grocery shop/general store	32.7
Wife brought method	1.9
Others	1.9
Total	100.0
N	52

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 Sanghar, 85 percent of men approved of spacing between children and also approved the use of any form of contraception for this purpose (Table 12.5). Fourteen percent disapproved of using any form of contraception to space between

children. A higher proportion of rural men approved of spacing between children than their urban counterparts.

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

Variable	Rural	Urban	Total
Spacing between children			
Approve	88.4	73.3	85.0
Disapprove	10.3	26.7	14.0
Others	1.3	0.0	1.0
Total	100.0	100.0	100.0
N	155	45	200
Using family planning methods for spacing			
Approve	88.4	71.1	85.0
Disapprove	11.0	28.9	14.5
Others	0.6	0.0	0.5
Total	100.0	100.0	100.0
N	155	45	200

Satisfaction Level of Current Users

Satisfaction of the user with his/her contraceptive method is an important factor in whether or not they continue with the method. Male contraceptive users were asked to report how satisfied they were with their present contraceptive method. Table 12.6 shows 78 percent of the current users were very satisfied with their current method; only 3 percent reported that they were not satisfied with their current method. Nineteen percent of the current users reported being somewhat satisfied with their current method. These users would seem to be in need of 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

Satisfaction	Percentage
Very satisfied	77.8
Somewhat satisfied	19.4
Not satisfied at all	2.8
Total	100.0
N	36

The reasons the male respondents stopped using their last method are presented in Table 12.7. The table shows that wanting another child was the main reason for stopping the use of a family planning method. However, 23 percent of male past users stopped using their method because of side effects the couple experienced with their method. Twenty-three percent of the past users stopped using a contraceptive due to method failure. This contraceptive failure may be due to the fact that significant proportion of users was relying on natural methods. There were also a few cases where the wife opposed the use of a contraceptive method.

Table 12.7: Distribution of male past contraceptive users by reason for discontinuing last method

Reason	Percentage
Cost not affordable	4.5
Experienced side effects	22.7
Fear of side effects	9.1
Want another child	45.5
Method failure	22.7
Method inconvenient to use	4.5
Rest from method	22.7
Health concern	27.3
Service provider's advice	9.1
Wife opposes	4.5
N	22

Respondents could give more than one reason.

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; the responses are shown in Figure 12.1. Seventy-seven percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, 53 percent of the men reported that their wives had never approached them during the last year on this issue. Thirteen percent of the men reported that their wives had talked often about this subject during the last year, while 34 percent reported they had talked once or twice.

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

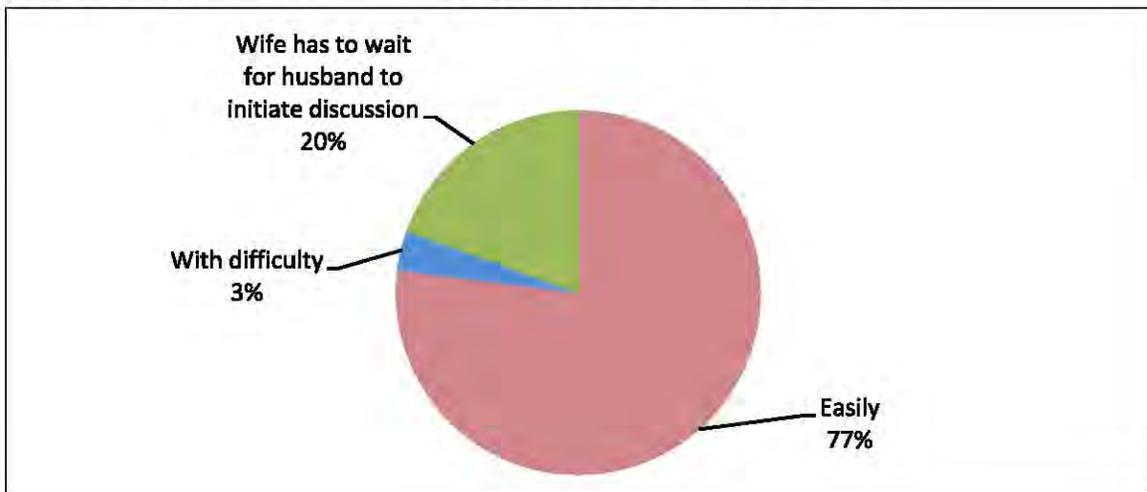
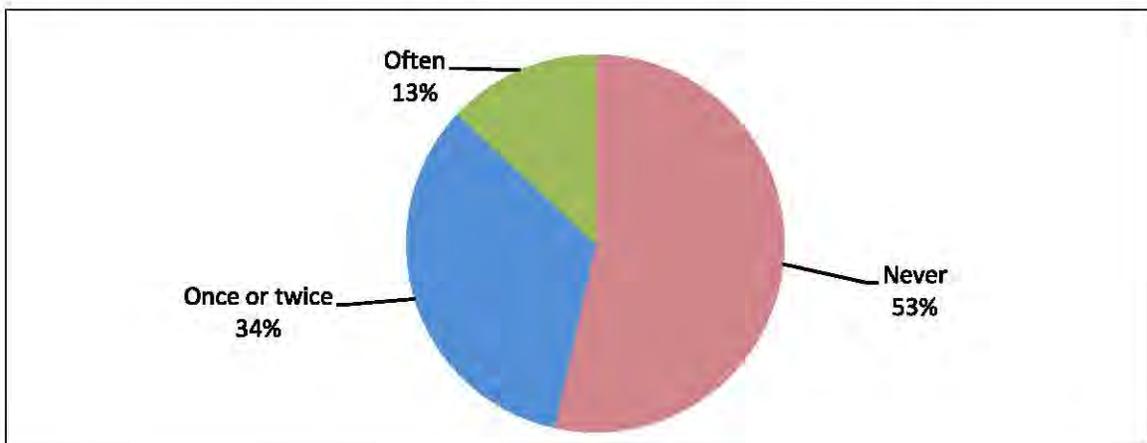


Figure 12.2: Men's reports of frequency of discussion on FP with wife in last year



Potential Users

Men who were non-users of contraception were asked about their intended future use of contraception and their method preferences. Table 12.8 shows that 35 percent intended to use contraception in the future, while 36 percent did not intend to do so. Twenty-nine percent of the respondents were uncertain about their future use of contraception.

Table 12.8: Percentage distribution of male never users by intent to use contraceptive methods in future, by residence

Intent	Rural	Urban	Total
Will use	36.0	27.8	34.7
Will not use	33.0	55.6	36.4
Unsure/uncertain	31.0	16.7	28.8
Total	100.0	100.0	100.0
N	100	18	118

As shown in Table 12.9, the major reason husbands said they did not intend to use was that their wives were unable to conceive (47 percent). Their desire for more children was cited by 44 percent of the husbands, while for 12 percent, fear of side effects was the main reason for not using a contraceptive method.

Table 12.9: Distribution of male never users according to reasons for not intending to use contraceptive methods in future

Reason	Percentage
Wife opposes	9.3
In-laws/parents oppose	4.7
Fear of side effects	11.6
Lack of access/unavailability	2.3
Infrequent sex/respondent away	2.3
Difficult/unable to conceive	46.5
Want more children	44.2
N	43

Respondents could give more than one reason.

Table 12.10 shows the distribution of the male respondents who intended to use a specific contraceptive method in the future. It is observed that a smaller proportion wanted to use male methods. Injectables and female sterilization were the main contraceptive methods proposed to be used in future.

Table 12.10: Distribution of male never users who intend to use specific contraceptive methods in the future

Method	Percentage
Female sterilization	26.8
Pills	14.6
IUD	2.4
Injectable	29.3
Condom	2.4
Rhythm	2.4
Withdrawal	2.4
Not decided	4.9
Others	14.6
N	41

Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 12.11 shows that 18 percent of the respondents wanted another child soon (within two years). Another 16 percent wanted to delay their next child for more than two years. The largest proportion of respondents (48 percent) did not want any more children at all.

Table 12.11: Distribution of male respondents by desired timing for next child, by number of living children

Number of living children	Desire for next child				Total	
	Soon	Later	Never	Don't know /unsure	%	N
0	57.7	34.6	0.0	7.7	100.0	26
1	20.0	53.3	6.7	20.0	100.0	15
2	35.0	20.0	25.0	20.0	100.0	20
3	10.3	17.2	31.0	41.4	100.0	29
4	16.0	4.0	68.0	12.0	100.0	25
5	4.5	4.5	68.2	22.7	100.0	22
6+	3.2	6.5	77.4	12.9	100.0	62
Total	17.6	16.1	47.7	18.6	100.0	199

The desire to stop having children was positively associated with the number of living children. Twenty-five percent of the respondents who had 2 children did not want more children. More than 77 percent who had 6 or more children did not want more children.

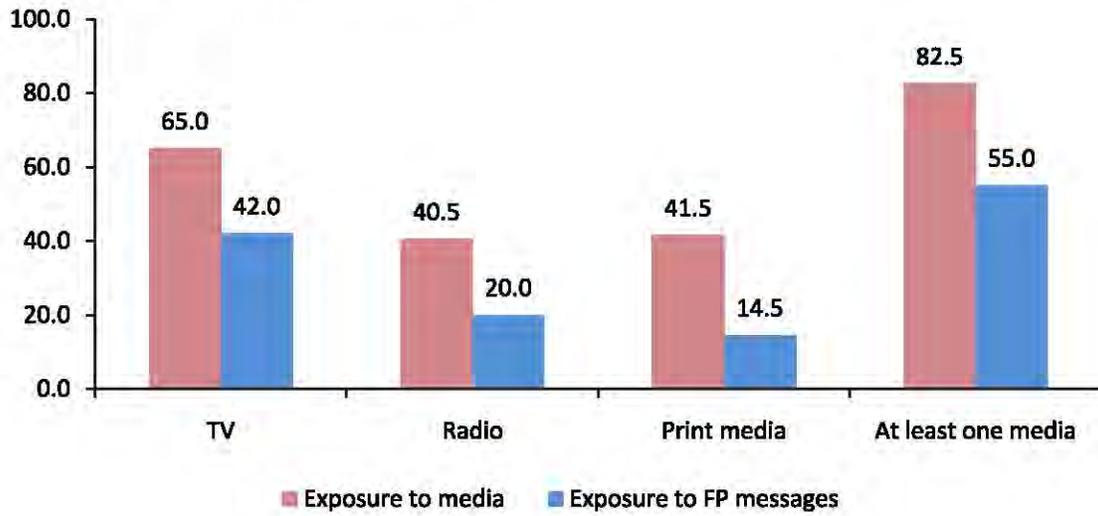
The percentage of respondents who did not want more children was much larger than the 30 percent of husbands who reported current use of contraception. If those who wanted to postpone having another child are combined with those who did not want any more, the sum would constitute about two-thirds of all husbands. This suggests that there is a substantial need for family planning, but 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 as 65 percent of the male respondents in Sanghar watched TV and 42 percent of them reported access to print media.

Furthermore, 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. Forty-two percent of the men had seen FP messages on television. Overall, 55 percent of the male respondents and 46 percent of the MWRA had seen a family planning message on at least one medium. Twenty percent of the men reported that they had ever listened to a family planning message on the radio.

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



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