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Baseline Household Survey

Thatta District

April 2009



Family Advancement for Life and Health (FALAH)

Thatta

Baseline Household Survey

April 2009



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For inquiries, please contact:

Population Council

7, Street 62, F-6/3, Islamabad, Pakistan

Tel: 92 51 2277439

Fax: 92 51 2821401

Email: pcpak@popcouncil.org

Web: <http://www.popcouncil.org>

<http://www.falah.org.pk>

Layout and Design: Ali Ammad

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Table of Contents

Acknowledgements	xiii
Glossary of Terms	xv
Executive Summary	xvii
Chapter 1	1
Introduction.....	1
Background.....	1
The FALAH Project.....	1
Thatta District.....	2
The Thatta Baseline Household Survey	3
Objectives.....	3
Methodology	3
Chapter 2	7
Household Characteristics.....	7
Geographic Distribution	7
Geographic Distribution	7
Age-Sex Distribution	8
Marital Status	9
Household Characteristics and Wealth Indicators	10
Physical Characteristics of Households	11
Ownership of Household Assets	13
Standard of Living Index.....	14
Chapter 3	15
Respondent Characteristics.....	15
Age.....	15
Education and Literacy	16
Occupation and Work Status.....	17
Female Mobility.....	19
Mass Media Access and Exposure to FP Messages	20
Chapter 4	21
Service Availability.....	21
Thatta District Data	21

Reproductive Health Facilities.....	22
Family Planning Facilities.....	22
Maternal Health Facilities.....	23
Service Providers	24
Chapter 5	39
Fertility.....	39
Cumulative Fertility	39
Children Ever Born and Living	39
Differentials in Children Ever Born and Surviving	41
Current Fertility	43
Crude Birth Rate	43
Age-specific Fertility Rates and Total Fertility Rate	44
Mothers with Children Under Five Years	44
Preceding Birth Interval.....	45
Chapter 6	49
Maternal and Neonatal Care	49
Antenatal Care.....	49
Tetanus Immunization.....	53
Location and Attendance at Delivery	54
Postpartum Care.....	56
Breastfeeding	57
Chapter 7	59
Preference for Children	59
Ideal Number of Children	59
Desire for More Children.....	60
Levels of Desire for More Children.....	60
Socioeconomic Correlates of Desire for Children	62
Son Preference	63
Strength of Preference	63
Attitude toward Last Pregnancy.....	65
Women’s Perception of Fertility Preference of Husbands.....	65
Chapter 8	67
Contraceptive Knowledge and Use	67

Knowledge	67
Use of Contraceptive Methods	68
Levels of Ever Use and Current Use	68
Current Use and Desire for Children	70
Correlates of Contraceptive Use	71
Source of Method	73
Chapter 9	75
Experience with Contraceptive Methods	75
Reasons for Method Choice	75
Cost, Distance and Time to Reach a Facility	77
Treatment by Provider	79
Information Provided	79
Treatment at Facility	80
Side Effects	81
Chapter 10	83
Reasons for Non-use	83
Hindrances to Use	83
Past Users	84
Reasons for Discontinuing Contraceptive Use	84
Reasons for Current Non-use	85
Never Users	86
Reasons for Non-use	86
Attitude towards Birth Spacing and Limiting	87
Knowledge of Contraceptive Users, Methods and Facilities	88
Intent to Use	91
Inter-spousal Communication	91
Chapter 11	93
Unmet Need	93
Levels and Correlates	93
Total Demand	95
Strength of Preference	96
Reasons for non-use	96
Unmet Need for Spacing: Profile	98

Unmet Need for Limiting: Profile	100
Chapter 12	101
Reproductive Preferences and Behavior of Men	101
Background Characteristics	102
Knowledge and Use of Contraception.....	103
Source of Contraceptive Methods.....	106
Approval of Family Planning.....	106
Satisfaction Level of Current Users	107
Inter-spousal Communication	108
Potential Users	109
Fertility Desire	110
Mass Media Access and Exposure to FP Messages	111
References	113

List of Tables

Table 1.1: Results of households and eligible women (MWRA) interviews.....	5
Table 2.1: Percentage distribution of the population of the sample households by residence and taluka.....	7
Table 2.2: Percentage distribution of sample household population by age and sex	8
Table 2.3: Percentage distribution of males and females by marital status and age	10
Table 2.4: Distribution of households with selected physical characteristics by residence	12
Table 2.5: Percentage of households owning selected items by residence.....	13
Table 2.6: Percent distribution of sample households by residence and standard of living index.....	14
Table 3.1: Age distribution of female respondents by residence	15
Table 3.2: Percentage distribution of MWRA and husbands by educational achievement, literacy status, age and residence	16
Table 3.3: Distribution of occupational categories of respondents' husbands by residence	18
Table 3.4: Women's reports regarding mobility outside the home by degree of permission and destination	19
Table 4.1: Number and proportion of facilities providing specified family planning services in Thatta district, by sector and MWRA per facility	23
Table 4.2: Number and proportion of facilities providing specified maternal health care services in Thatta district, by sector and MWRA per facility	24
Table 4.3: Number of reproductive health care providers in Thatta district, by sector and category, and MWRA per service provider	25
Table 5.1: Distribution of MWRA by age of mother and number of children ever born (CEB).....	40
Table 5.2: Distribution of MWRA by age of mother and number of living children (LC)	40
Table 5.3: Mean number of children ever born and children surviving, by sex of child and age of mother	41
Table 5.4: Mean number of children ever born, living and dead by background characteristics..	42
Table 5.5: Mean number of children ever born and living by age and literacy of mother	43
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)	44
Table 5.7: Distribution of mothers by pregnancy status and number of children under 5 years..	45
Table 5.8: Distribution of women with preceding birth intervals (birth to birth) by background characteristics	46

Table 6.1: Distribution of ANC check-ups during last pregnancy by residence.....	50
Table 6.2: Facilities/service providers mentioned for one or more antenatal visits by residence	52
Table 6.3: Distribution of mothers according to residence, by status of tetanus toxoid injections during last pregnancy	53
Table 6.4: Distribution of mothers by place of last delivery and residence.....	54
Table 6.5: Distribution of mothers by attendant at last delivery and residence	55
Table 6.6: Distribution of mothers by status of postnatal check-up and place of delivery	56
Table 7.1: Distribution of MWRA with ideal number of children for their family by residence	60
Table 7.2: Distribution of MWRA by desire for next child and current number of living children.....	61
Table 7.3: Distribution of MWRA by reported desire for more children and background characteristics	62
Table 7.4: Son and daughter preferences by the responses.....	63
Table 7.5: Distribution of MWRA who did not want more children soon by reaction if they become pregnant in near future	64
Table 7.6: Distribution of MWRA who did not want more children soon by problem faced if they became pregnant	64
Table 7.7: Distribution of MWRA according to perception of husband's desire for more children, by woman's ideal family size.....	66
Table 8.1: Distribution of MWRA by knowledge (prompted) of contraceptive methods, by method and residence	68
Table 8.2: Percentage distribution of MWRA by contraceptive use status and residence.....	69
Table 8.3: Distribution of women by contraceptive use status and selected characteristics.....	72
Table 8.4: Distribution of ever users of specific contraceptive method by most recent source of supply	73
Table 9.1: Distribution of ever users of specific contraceptive methods by reason for choosing that method	76
Table 9.2: Distribution of MWRA using traditional methods by reasons for not using modern contraceptive methods	76
Table 9.3: Distribution of costs for specific current contraceptive methods.....	77
Table 9.4: Distribution of current contraceptive users by time to reach specific contraceptive service	79
Table 9.5: Distribution of ever users of contraceptives by information provided at acceptance for specific method	80
Table 9.6: Percent current users responding positively on treatment at last visit, by aspect of treatment	81

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	84
Table 10.2: Distribution of past contraceptive users by reason for discontinuing last method	85
Table 10.3: Distribution of past users by reason for current non-use	86
Table 10.4: Distribution of never user women by reason for never use	87
Table 10.5: Distribution of never users by attitude towards spacing and limiting birth	88
Table 10.6: Distribution of never users by knowledge of contraceptive methods	89
Table 10.7: Knowledge of sources of contraception of never users by source of supply.....	90
Table 10.8: Distribution of never users by intent to use a method in future and number of living children.....	91
Table 11.1: Need and demand for FP among MWRA by background characteristics	94
Table 11.2: Distribution of non-pregnant women with unmet need for spacing and limiting, by strength of desire to avoid pregnancy	96
Table 11.3: Women with unmet need for spacing and limiting by stated reasons for non-use of contraception	97
Table 11.4: Percent distribution of MWRA in unmet need for spacing and limiting by selected characteristics	99
Table 12.1: Background characteristics of male respondents, by residence	103
Table 12.2: Distribution of male respondents by contraceptive knowledge, use status and residence.....	104
Table 12.3: Percentage of male respondents reporting ever use or current use of a contraceptive method, by selected background characteristics.....	105
Table 12.4: Distribution of male ever users by the last reported source of contraceptive supply.....	106
Table 12.5: Distribution of male respondents' attitudes toward spacing and use of contraceptives for spacing.....	107
Table 12.6: Level of male respondents' satisfaction with their current method.....	107
Table 12.7: Distribution of male never users by intent to use contraceptive methods in future	109
Table 12.8: Distribution of male never users according to reasons for not intending to use contraceptive methods in future	109
Table 12.9: Distribution of male never users who intend to use specific contraceptive methods in the future.....	110
Table 12.10: Distribution of male respondents by desired timing for next child and number of living children	111

List of Figures

Figure 2.1: Percentage of sample household population by sex and age group	9
Figure 2.2: Toilet facilities for Thatta households	11
Figure 3.1: Literacy status of women and their husbands	17
Figure 3.2: Type of work of women working for pay (n=271)	18
Figure 3.3: Distribution of respondents according to exposure to media and FP messages by type of media	20
Map 4.1: Location of government facilities in Thatta district, by population density of union council	27
Map 4.2: Location of LHWs in Thatta district, by population density of union council	28
Map 4.3: Location of private facilities in Thatta district, by population density of union council	29
Map 4.4: Total number of reproductive health service delivery points (public and private) in Thatta district, by union council	30
Map 4.5: Location of female sterilization facilities in Thatta district, by population density of union council	31
Map 4.6: Location of IUD facilities in Thatta district, by population density of union council	32
Map 4.7: Location of injectables contraceptive services in Thatta district, by population density of union council	33
Map 4.8: Location of essential obstetric services in Thatta district, by population density of union council	34
Map 4.9: Location of emergency obstetric care facilities in Thatta district, by population density of union council	35
Map 4.10: Location of doctors in Thatta district, by gender and population density of union council	36
Map 4.11: Location of Greenstar Social Marketing SDPs in Thatta district, by population density of union council	37
Figure 6.1: Distribution of MWRA by number of antenatal visits during last pregnancy	50
Figure 6.2: Distribution of MWRA by reason for the first antenatal visit during last pregnancy	51
Figure 6.3: Distribution of women by gestational age at first antenatal visit during last pregnancy	51
Figure 6.4: Facilities visited for antenatal care	52
Figure 6.5: Tetanus immunization at last delivery	53

Figure 6.6: Location of delivery of last baby	54
Figure 6.7: Attendant at last delivery	55
Figure 6.8: Reasons for discontinuing breastfeeding (n=123)	57
Figure 7.1: Women’s desire for more children	61
Figure 7.2: Attitudes of women toward their last pregnancy	65
Figure 8.1: Proportion of current users by method mix.....	70
Figure 8.2: Current use and desire for children	71
Figure 8.3: Contraceptive prevalence by woman’s age	71
Figure 8.4: Contraceptive prevalence by number of living children	72
Figure 9.1A: Cost in rupees of contraceptive supply for current method.....	78
Figure 9.1B: Attitude toward service charges for current method other than contraceptive.....	78
Figure 9.2: Travel time (in minutes) for contraceptive supplies	79
Figure 9.3: Ever users who experienced side effects by method used	81
Figure 9.4: Percentage distribution of provider responses upon consultation for side effects among past users	82
Figure 10.1: Percent of never users who knew some woman who had ever used any FP method.....	88
Figure 10.2: Mode of transportation to the nearest facility/provider	90
Figure 10.3: Time taken to the nearest facility/provider	90
Figure 10.4: Women’s reports regarding ease of approach to husband to discuss family planning	92
Figure 11.1: Need and demand for family planning.....	95
Figure 12.1: Male responses of ease of approach by wives to discuss FP	108
Figure 12.2: Frequency of discussion on FP with wife in last year	108
Figure 12.3: Distribution of male respondents according to exposure to media and FP messages, by type of media.....	112

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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
PSLMS	Pakistan Social and Living Standard Measurement Survey
PSU	Primary Sampling Unit
Pvt.	Private
RH	Reproductive Health
RHC	Rural Health Center
RHSC(A)	Reproductive Health Services Center- A
RSPN	Rural Support Programmes Network
SMAM	Singulate Mean Age at Marriage
TBA/<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 Thatta, one of the 20 project districts.

The survey was conducted between February and April of 2008 in a probability sample of 520 households in 40 clusters in Thatta. It included interviews with 666 currently married women aged 15-49 (“married women of reproductive age”, or MWRA), along with 200 married men, of whom 192 were married to women included in the sample. In addition, as a separate activity a mapping study¹ was also carried out during the period between March and April 2008 in Thatta. Selected data from that study are also 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

Thatta is a predominately rural district in Sindh. According to the UNDP National Human Development Report 2003, it ranked 64th 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 Thatta household survey

Variable	Value
Percentage of households in rural areas	91.4
Percentage of households with electricity	48.2
Percentage of households with indoor water supply	31.7
Percentage of households with flush toilet	13.7
Percentage of households with television	24.4
Percentage of female respondents literate	7.7
Percentage of respondents' husbands literate	38.4
Number of MBBS physicians per 1000 MWRA	3.0
Total fertility rate	4.9

¹ Mapping Survey of Health and Reproductive Health Services.

Although Thatta is the capital of southern Sindh, it is low on most of the development indicators compared to other districts in Sindh. More than half of the sampled households did not have electricity, hence ownership of appliances requiring electricity, such as televisions, refrigerators, washing machines, etc., was less common in the rural parts of the district. Twenty percent of the respondents said that they watched TV, 29 percent listened to the radio, and 3 percent read newspapers or magazines. About 32 percent of the households had some indoor water supply, 44 percent had either a flush toilet or a latrine, whereas 56 percent had no toilet. According to the Planning Commission's Millennium Development Goals Report 2006, Thatta ranked 61st nationally on sanitation. On the other hand, literacy was relatively low. Only 8 percent of the females and 38 percent of their husbands were literate, which was lower than average for Sindh Province and substantially lower than national averages. Forty-two percent of MWRA had access to at least one form of media, including 29 percent of the women who listened to the radio, 20 percent of the women who watched TV, and 3 percent who read newspapers or magazines. Eighteen percent of MWRA reported having heard at least one FP message through any of these mediums.

Service Availability

There were a substantial number of health facilities in Thatta district with a total of 976 facilities, of which 618 were public and 358 were in the private sector. These were widely scattered around the district, so the simple services, such as antenatal check-ups, iron tablets for anemia, and non-clinical contraceptive methods, were readily available in both the public and private sector. However, access to services requiring specialized care was more difficult. For example, there were only 8 facilities – 2 public, 6 private – that were able to offer Caesarean section deliveries. There were 6 facilities able to provide female sterilization, but many of these could only provide the service occasionally when an external sterilization team visited. Though services were available throughout the district, there were some areas where access was relatively difficult.

Fertility

Although there is evidence that fertility has been declining in Thatta, it is still high. The crude birth rate was 31.3 per thousand population and the total fertility rate was 4.9 children per woman. Both of these rates were higher than the national rates for Pakistan. Fertility was higher for illiterate women and wives of illiterate men and in urban areas.

Many births were spaced too closely for optimum health; for example, 71 percent of closed birth intervals were less than 36 months. Among those women in the sample who already had two living children less than 5 years of age, 18 percent were currently pregnant.

Maternal and Neonatal Care

The household survey obtained data on selected key indicators of maternal and neonatal health from 462 sampled women who had delivered a child during the previous four years (see Table B). Of these women, 73 percent had visited a health provider at least once for antenatal care and 37 percent had at least two tetanus toxoid immunizations. Of the births, 42 percent were delivered by a skilled birth attendant and 42 percent were delivered in a public or private health facility. These statistics were all higher than national averages. On the other hand, 52 percent had at least one postnatal check-up (including 100 percent of those delivering in facilities).

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

Indicator	Value
Percentage of mothers with at least one antenatal care visit	72.9
Percentage of mothers who received at least two tetanus shots	36.9
Percentage of most recent deliveries conducted by a skilled birth attendant	42.2
Percentage of most recent deliveries carried out in a facility	41.7
Percentage of MWRA wanting no more children	44.6
Percentage of MWRA wanting to delay next birth for at least two years	18.9
Percentage of MWRA with knowledge of at least one contraceptive method	99.8
Contraceptive prevalence rate	20.9
Percentage of MWRA who were past users of contraception	9.2
Percentage of MWRA with unmet need for family planning	33.8
Percentage of MWRA with unmet need for spacing	10.8
Percentage of MWRA with unmet need for limiting	23.0
Total demand for family planning (CPR + unmet need)	54.7

Preference for Children

The median “ideal” family size, according to the women respondents, was 4 children, which is a common finding for Pakistan. Regarding desire for more children in the future, 37 percent said they wanted another child soon (within two years), 19 percent said they wanted another child, but only after two years, and 45 percent of the women 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 of women wanting more children later was highest for women with one or two children. About half of women respondents said their husband wanted the same number of children that they did, while 35 percent said their husband wanted more children than them.

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 some method of contraception) was 21 percent, which was lower than the average for Sindh or for Pakistan. The most common methods being used were female sterilization (10.4 percent), injectables (3.3 percent), pills (2.6 percent), condoms (2.3 percent) and IUDs (0.5 percent). Past users comprised 9.2 percent of MWRA; injectables and pills were common methods used in the past. Seventy-four percent of the current users were using contraceptives for limiting while the other 26 percent were using them for spacing births. Most users reported obtaining their supplies and services from government department sources, or their husband obtained the supplies (for condoms and pills).

Experience with Contraceptive Methods

Stated reasons for a respondent’s choice of her current or past method varied by method, but commonly cited reasons included convenience of use, few side effects, easy availability, suitability for respondent and her husband, and (for IUD users and female sterilization) ability to use for a long period. Costs were generally low (31 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 excessive; about 54 percent reported requiring more than 30 minutes to reach their service. Information provided when obtaining contraceptives often did not include information on side effects or method choice.

Clients generally reported being reasonably treated by providers, and were often examined properly (96 percent). However, 25 percent felt that providers were not capable of dealing with side effects. A variety of side effects were reported by users and past users, and it did not appear that these were effectively dealt with by providers.

Reasons for Non-use

Asked hypothetically about obstacles a couple might face if they wanted to avoid or delay a pregnancy, most of the respondents mentioned husband's disapproval, fear of side effects, problem of managing side effects and FP against religion. Past users were most likely to discontinue use because of side effects, or they wanted more children, method failure, fear of side effects, provider's and husband's advice. Their reasons for current non-use were most often related to current or anticipated childbearing, but fear of side effects and infrequent sex/husband away were also frequently mentioned. Never users were most likely to say they were not using for the desire of children and fear of side effects. Knowledge of contraceptive methods was noticeably low among never users. Thirty-seven percent of never users expressed the intent to use contraception in the future. A large majority of female current and past users said they could discuss family planning easily with their husbands; however, 47 percent of never users said they could do so. This indicates that a substantial number of women in Thatta were willing to practice birth spacing and family planning.

Unmet Need for Family Planning

A woman is said to have an "unmet need" for family planning if she says she does not want more children, or wants them later, and is at risk of conceiving, but is not using any method of contraception. By this definition, 33.8 percent of the women in this sample were in unmet need: 23 percent for limiting and 10.8 percent for spacing. This proportion is fairly typical for Pakistan, but high by international standards. Unmet need for spacing was higher in rural areas and among literate women; but unmet need for limiting was higher among illiterate women. Women in unmet need tended to be characterized by poor communication with their husbands and/or disagreement on 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 almost all men knew at least one modern contraceptive method. Male sterilization was one of the least known contraceptive methods among men in Thatta. Fifty-two percent of the men either did not want more children in the future or wanted to delay the next pregnancy. Twenty-three percent of the male respondents reported that they or their wives were currently using a family planning method, and 17 percent were using modern contraceptive methods. Among the current users, 62 percent were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, 47 percent reported that they were not intending to use any FP method in the future. A fear of side effects was one of the main reasons never users gave 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 condoms. It would be important to include specific interventions aimed at influencing men's attitude towards their role and responsibility in the overall health of the family and in birth-spacing and limiting needs.

Conclusion

Thatta district is characterized by a relatively less developed infrastructure, an average standard of living, a variety of public and private reproductive health facilities, and relatively moderate maternal and neonatal health care. In this setting, knowledge and approval of family planning were high, and contraceptive prevalence at 21 percent, was moderate for a rural district in Pakistan. Nevertheless, there is much need for improvement; unmet need for family planning remains high at 34 percent. Among the important reasons that should be addressed in an improved program are husbands' attitude, inter-spousal communication, fear of side effects, and knowledge of different 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, and Swabi;
- **Punjab:** Dera Ghazi Khan and Jhelum;
- **Sindh:** Dadu, Ghotki, Larkana, Sanghar, Sukkur, and Thatta.

The aims of the FALAH project are:

- a) To increase demand for and practice of birth spacing;
- b) To increase access to and quality of family planning services in the public sector;
- c) To increase the coverage and quality of family planning services in the private sector;

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

At the district level, FALAH 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 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 Thatta, district-level activities are being coordinated by Health and Nutrition Development Society (HANDS) with Greenstar providing information and service through social marketing and other partners supporting specific activities as needed.

Thatta District

Thatta district is bound by Dadu district on the north, by Hyderabad and Badin districts and India on the east, on the South by Rann of Kutch area and the Arabian Sea and by Karachi division on the west. The overall population of the district is estimated to be 1.395 million in 2008, with a population density of around 80 persons per square kilometer.

The district has a good number of educational and health Institutions (Population Census Organization, 1999). According to Pakistan National Human Development Report 2003,² Thatta stood 64th among the 91 districts of Pakistan on the Human Development Index (UNDP, 2003).

In the Millennium Development Goals report of the Planning Commission 2006, district level data based on the Pakistan Social and Living Standards Measurement Survey, 2004-05 were shown for various measures of education, gender equity, infant mortality and environmental sustainability. In these comparisons, Thatta ranked below average on all measures (Planning Commission of Pakistan, 2006).

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.

The Thatta Baseline Household Survey

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

Objectives

The objectives of the Thatta 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 Thatta district regarding reproductive health, so as to meet their needs more effectively;
- More specifically, to obtain information needed to improve reproductive health services and to design appropriate social mobilization activities.

Methodology

Study Population

FALAH is primarily a district-level project 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 the general knowledge, attitude and practices of these married couples regarding family planning.

Sample Design and Size

The systematic stratified random sample technique was used to select a representative sample of the district. The universe consisted of all urban and rural households of the district. The number of blocks selected in urban areas and the number of villages selected in

rural areas are presented in Table 1.1. A total of 40 blocks/villages were selected, with 13 households selected per block/village. The selection procedure is described below.

Urban Sample

The required number of enumeration blocks was selected with probability proportional to size (number of circles) by adopting a multistage stratified sampling design. The "enumeration circles," i.e., the smallest units available in the 1998 Population District Census Reports as demarcated by the Population Census Organization, were selected. The maps of these circles were obtained from the Population Census Organization which 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 block was then carried out by the enumeration teams before selecting the sample households. A fixed number of 13 households were drawn from each sample enumeration block by using systematic random sampling.

Rural Sample

The 1998 Population Census list of villages was used as the sampling frame for the selection of 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 sample 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 Thatta.

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

Result	Rural	Urban	Total
Number of blocks/villages	36	4	40
Planned households	468	52	520
Households contacted	512	61	573
Households replaced	44	9	53
(Households locked)	44	9	53
Eligible women identified	607	59	666
Total women's interviews	607	59	666

Questionnaire Design

Two questionnaires, one for women and one for men, were developed for this survey. The questionnaires contained sufficient information to estimate all FALAH indicators to be collected by the household survey as well as additional information of interest to the project.

The questionnaires were pre-tested in urban and rural areas of Islamabad/Rawalpindi. The main objective of the pre-testing was to examine the suitability and effectiveness of questions in eliciting adequate responses. Pre-testing was also carried out to find out if the interviewers or respondents would face any linguistic 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 Thatta team was conducted by the Population Council in Islamabad. 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 members were also available to provide on-the-spot guidance to interviewers in the event that any part of the questionnaire was unclear to them. This ensured the completeness and accuracy of each questionnaire.

Data Entry and Edit Procedures

Data processing was initiated in the field with the checking of the questionnaires. Each team leader completed on-the-spot checks and preliminary editing of questionnaires during the enumeration period. Team supervisors were provided with editing instructions 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 Thatta district was carried out between February 26 and April 7, 2008.

Chapter 2

Household Characteristics

Geographic Distribution

Thatta is primarily a rural district, with about 89 percent of the population living in rural areas. It is comprised of nine talukas/tehsils. Although Sujawal taluka was slightly more urbanized as compared to the other talukas, only 18 percent of its Sujawal's population was urban. Table 2.1 shows the distribution of the population of sample households according to residence (urban and rural) and by taluka, with comparisons to the distribution of the 1998 National Population and Housing Census

Geographic Distribution

As Table 2.1 shows the distribution of the population of the 520 households in the sample by urban-rural residence and taluka differs from the distribution recorded for the whole district in the 1998 Census. The urban proportion of the population was 4 percent lower when compared to the distribution of the Population Census Organization (Population Census Organization, 2000).

Table 2.1: Percentage distribution of the population of the sample households by residence and taluka

Taluka	Rural			Urban			Total	
	N	%	Census %	N	%	Census %	N	%
Ghorabari	551	100.0	100.0	0	0.0	0.0	551	100.0
Jati	449	100.0	93.7	0	0.0	6.3	449	100.0
Keti Bunder	124	100.0	90.2	0	0.0	9.8	124	100.0
Kharo Chan	111	100.0	100.0	0	0.0	0.0	111	100.0
Mirpur Bathoro	634	86.3	89.1	101	13.7	10.9	735	100.0
Mirpur Sakro	767	87.1	88.1	114	12.9	11.9	881	100.0
Shah Bunder	378	100.0	86.7	0	0.0	13.3	378	100.0
Sujawal	507	84.4	81.7	94	15.6	18.3	601	100.0
Thatta	1048	89.5	85.2	123	10.5	14.8	1171	100.0
Total	4569	91.4	88.8	432	8.6	11.2	5001	100.0

The mother-tongue of 96 percent of the sampled households was Sindhi, reflecting the dominant ethnic group in the district.

Age-Sex Distribution

Table 2.2 shows the population distribution of the sampled households by age and sex; Figure 2.1 shows the same information in the form of an age-sex pyramid.

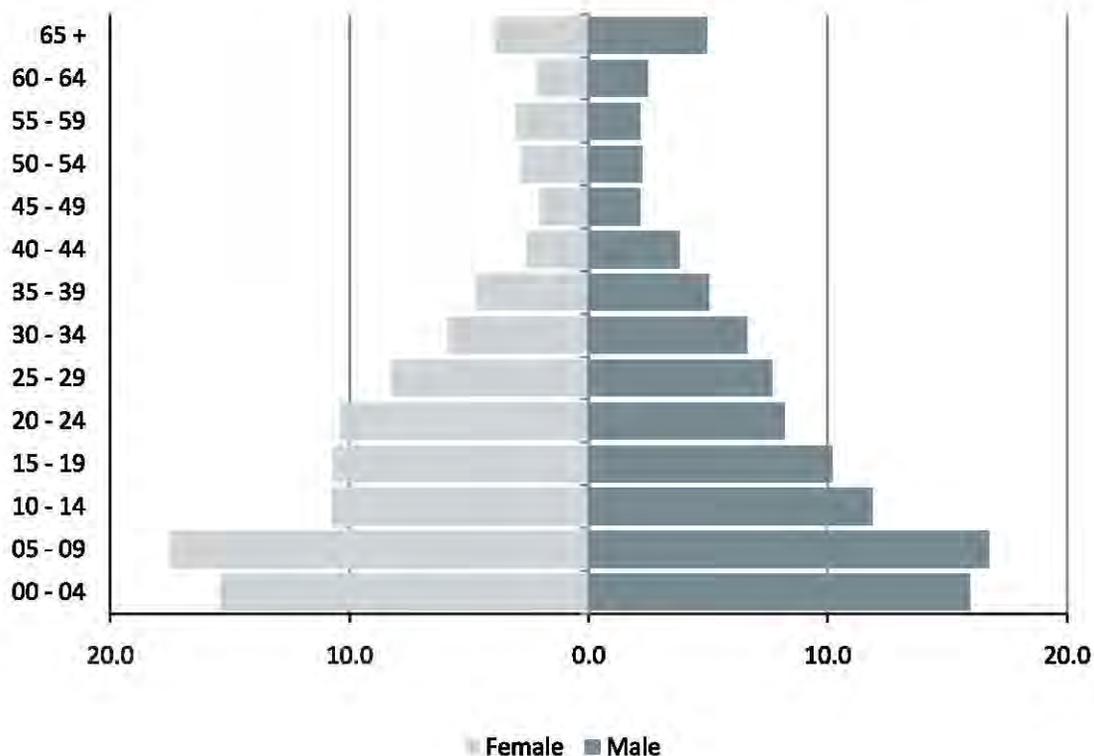
Table 2.2: Percentage distribution of sample household population by age and sex

Age group	Sex of household member					
	Male		Female		Total	
	N	%	N	%	N	%
00 - 04	416	15.9	367	15.4	783	15.7
05 - 09	437	16.7	415	17.4	852	17.1
10 - 14	310	11.9	256	10.8	566	11.3
15 - 19	266	10.2	254	10.7	520	10.4
20 - 24	214	8.2	247	10.4	461	9.2
25 - 29	200	7.7	196	8.2	396	7.9
30 - 34	173	6.6	141	5.9	314	6.3
35 - 39	131	5.0	111	4.7	242	4.9
40 - 44	99	3.8	62	2.6	161	3.2
45 - 49	56	2.1	48	2.0	104	2.1
50 - 54	58	2.2	66	2.8	124	2.5
55 - 59	56	2.1	72	3.0	128	2.6
60 - 64	65	2.5	51	2.1	116	2.3
65 - 69	37	1.4	41	1.7	78	1.6
70 - 74	36	1.4	19	0.8	55	1.1
75+	56	2.1	33	1.4	89	1.8
Total	2610	100.0	2379	100.0	4989	100.0

The population is typical of a society with high fertility, where a sharp decline in population after the age group of 5-9 years as can be seen in the age-sex pyramid (Figure 2.1). Fifty-five percent of the population was under 19 years of age. The number of children in age group 0-4 years was slightly lower than the next age group (5-9 years), which suggests a recent

decline in birth rates. The sex ratio of the sample population was 110 males per 100 females.

Figure 2.1: Percentage of sample household population by sex and age group



Of the total population of the sampled households, 21 percent (1059 women of the 4989 total sampled population) consisted of females 15-49 years of age, and 16 percent consisted of children under 5 years old. These groups comprise the population of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

Marital Status

Table 2.3 shows a higher proportion of women at younger ages were married than men of the same age, whereas more elderly women were never married. The singulate mean age at marriage for women was 17 years old. About 21 percent of the women in the age group 40-49 years were either widowed or divorced. Overall, among the female population, 8.3 percent fell in this category, whereas males were less likely to be widowed or divorced as compared to females in the 520 sample households interviewed.

Table 2.3: Percentage distribution of males and females by marital status and age

Age group	Married		Widow/divorced/separated		Never married	
	Male	Female	Male	Female	Male	Female
15 – 19	7.2	24.2	0.0	0.4	92.8	75.4
20 – 24	41.3	72.1	1.4	2.0	57.3	25.9
25 – 29	62.3	88.8	0.5	0.0	37.2	11.2
30 – 34	82.0	86.5	1.7	6.4	16.3	7.1
35 – 39	90.1	88.3	3.1	7.2	6.9	4.5
40 – 44	89.9	88.7	6.1	6.5	4.0	4.8
45 – 49	89.3	85.4	7.1	14.6	3.6	0.0
50 – 54	86.2	89.4	12.1	7.6	1.7	3.0
55 – 59	85.7	84.7	10.7	15.3	3.6	0.0
60 – 64	96.9	60.0	3.1	34.0	0.0	6.0
65 – 69	83.3	53.7	13.9	43.9	2.8	2.4
70 – 74	94.4	63.2	5.6	31.6	0.0	5.3
75+	78.6	42.9	21.4	42.9	0.0	14.3
All ages 15+	62.2	69.0	3.9	8.3	33.9	22.7
N	897	923	56	111	489	304

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 a household may correlate with good health – for example, by indicating ability to buy sufficient food for good nutrition or pay for quality health care.

Physical Characteristics of Households

Table 2.4 shows selected physical characteristics of the sample households. Only about one-third (32 percent) of the households had an indoor water supply; of these, only 5 percent had tap water and another 26 percent had a motorized pump or a hand pump inside. Forty-eight percent of the households had motorized pumps/hand pumps outside. About 14 percent of the households in Thatta had some type of flush toilet, whereas, 56 percent of the households did not have any type of toilet and 30 percent had raised or pit latrines (Figure 2.2).

The majority of the households, i.e. 94 percent, used firewood for cooking. Only 4 percent of the sampled households in Thatta district were using gas for cooking purposes, whereas a negligible number of households in the rural areas (0.2 percent) were using gas compared to 35 percent in urban areas. Ninety-six percent of the households in urban areas had electricity, whereas 57 percent of rural households still did not have electrical facilities. Almost 73 percent of the houses were roofed with wood/bamboo and mud, 71 percent had floors made of earth/sand or mud, and about 56 percent of the houses had walls made of wood or bamboo.

Figure 2.2: Toilet facilities for Thatta households

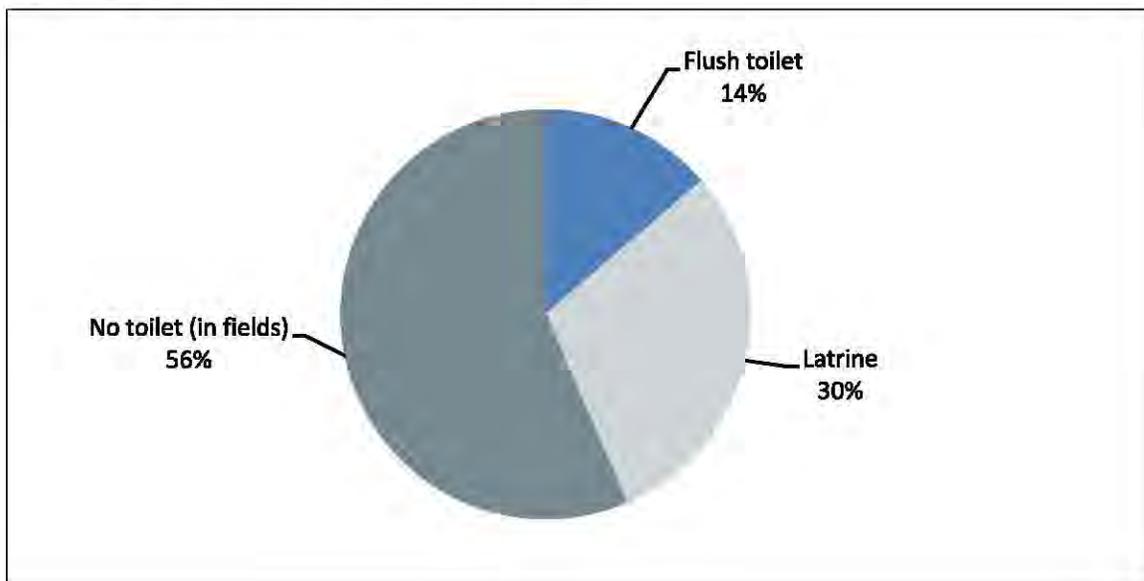


Table 2.4: Distribution of households with selected physical characteristics by residence

Characteristic	Rural	Urban	Total
Main source of drinking water			
Govt. supply (tap water inside)	2.4	26.9	4.8
Govt. supply (communal)	0.9	3.8	1.2
Motorized/hand pump (inside)	26.9	17.3	25.9
Motorized/hand pump (outside)	49.2	34.6	47.8
Well (inside)	1.1	0.0	1.0
Well (outside)	9.9	9.6	9.9
Tube-well	0.6	0.0	0.6
River/canal/stream/pooled/pond water	8.2	1.9	7.5
Others	0.9	5.8	1.4
Sanitation facility			
Flush to sewerage	0.4	25.0	2.9
Flush connected to septic tank	3.0	5.8	3.3
Flush connected to open drain	4.3	36.5	7.5
Raised latrine	24.3	21.2	24.0
Pit latrine	5.8	5.8	5.8
No toilet (in fields)	62.2	5.8	56.5
Main type of fuel used for cooking			
Firewood	97.8	60.8	94.2
Natural gas (sui gas)	0.2	35.3	3.7
Others	1.9	3.9	2.2
Electrical connection			
Yes	42.8	96.2	48.2
No	57.2	3.8	51.8
Main material of the roof			
Concrete	6.9	9.8	7.2
Iron sheet	1.1	0.0	1.0
Guarder and T-iron	16.8	43.1	19.4
Wood/bamboo and mud	75.3	47.1	72.5
Main material of the floor			
Earth/sand/mud	76.0	26.9	71.1
Cement	23.3	67.3	27.7
Others	0.6	5.7	1.2
Main material of the walls			
Burnt bricks/blocks	26.3	69.2	30.6
Mud bricks/mud	13.6	5.8	12.8
Wood/bamboo	59.9	25.0	56.4
Stones	0.2	0.0	0.2
N	468	52	520

Ownership of Household Assets

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

Table 2.5: Percentage of households owning selected items by residence

Household item	Rural	Urban	Total
Wall clock	40.0	80.8	44.0
Chairs	10.5	50.0	14.4
Bed	26.5	57.7	29.6
Sofa	3.8	30.8	6.5
Sewing machine	26.3	50.0	28.7
Camera	4.9	15.4	6.0
Radio/tape recorder	45.9	48.1	46.2
Television	18.6	76.9	24.4
Refrigerator	4.3	34.6	7.3
Land line telephone	2.8	21.6	4.6
Mobile phone	33.5	65.4	36.7
Room cooler/ air conditioner	1.1	1.9	1.2
Washing machine	4.3	40.4	7.9
Cycle	9.0	5.8	8.7
Motorcycle	17.0	19.2	17.2
Jeep/car	2.4	7.7	2.9
Tractor	3.0	0.0	2.7
Computer	0.6	11.5	1.7
Number of observations	468	52	520

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 Thatta was not available to us. Several items requiring electricity were available in a substantial number of urban households; in rural areas 46 percent of all households had a radio or tape recorder. Twenty-four percent of all households had television sets and 7 percent of all households had refrigerators. A figure of particular interest to communications specialists is the recent expansion of information technology in Pakistan which is reflected by the ownership of mobile telephones. Thirty-seven percent of all households had mobile phones (urban - rural differential was high for mobile phone use)

and about 2 percent of all households owned a computer. Motorized transport was low suggesting difficulties in arranging for transport in health emergencies.

Standard of Living Index

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

The median index for all households in rural areas was 3 and for urban households it was 6. About 89 percent of all households fell in the range from 0 to 6 and about half of the rural households fell in the range from 0 to 2 indicating higher poverty in the area. Overall, only 11 percent of the households fell in the range 7 - 10. This index will be used later in this report to examine differences in knowledge and behavior regarding reproductive health.

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

Standard of living index	Rural		Urban		Total	
	N	%	N	%	N	%
0	10	2.1	0	0.0	10	1.9
1	117	25.0	0	0.0	117	22.5
2	106	22.6	3	5.8	109	21.0
3	92	19.7	3	5.8	95	18.3
4	50	10.7	6	11.5	56	10.8
5	33	7.1	6	11.5	39	7.5
6	27	5.8	9	17.3	36	6.9
7	20	4.3	6	11.5	26	5.0
8	7	1.5	7	13.5	14	2.7
9	6	1.3	8	15.4	14	2.7
10	0	0.0	4	7.7	4	0.8
Total	468	100.0	52	100.0	520	100.0
Median	3	na	6	na	3	na

na=not applicable.

Chapter 3

Respondent Characteristics

The primary sources of data from the Household Survey are the interviews conducted with 666 currently married women of reproductive age. The background characteristics of these respondents are described in this chapter.

Age

Table 3.1 shows the age distribution of the female respondents for rural and urban areas. Since many of the younger women were unmarried, the numbers at age less than 19 were relatively small; at older ages, the numbers declined as reflected in the overall shape of the age pyramid. More than half (56 percent) of the sample female respondents were under the age of 30. Urban-rural differences were significant as 48 percent of the urban female respondents were below 30 years, while 57 percent of the rural female respondents fell in this age bracket.

Table 3.1: Age distribution of female respondents by residence

Age group	Rural		Urban		Total	
	N	%	N	%	N	%
< 19	55	9.1	7	11.9	62	9.3
20 - 24	137	22.6	13	22.0	150	22.5
25 - 29	156	25.7	8	13.6	164	24.6
30 - 34	98	16.1	8	13.6	106	15.9
35 - 39	87	14.3	8	13.6	95	14.3
40 - 44	44	7.2	7	11.9	51	7.7
45 - 49	30	4.9	8	13.6	38	5.7
Total	607	100.0	59	100.0	666	100.0

Education and Literacy

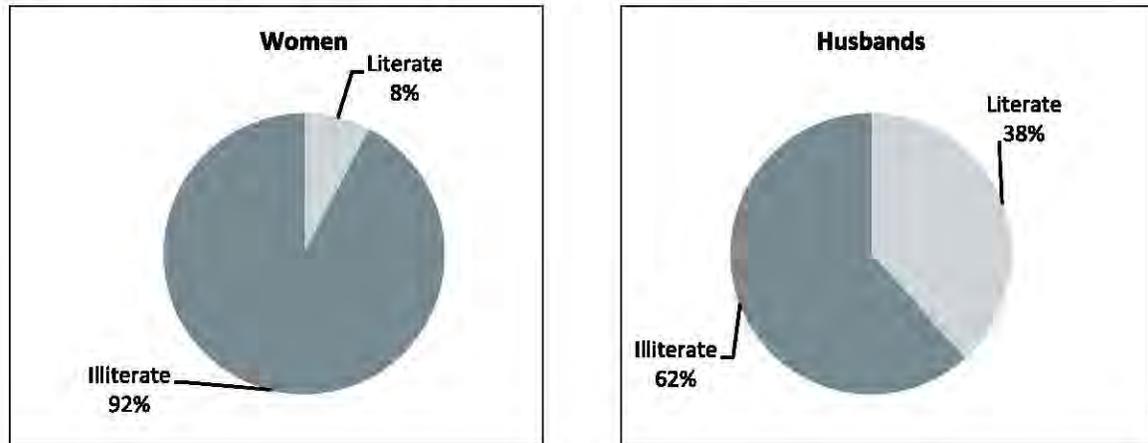
Levels of schooling completed and literacy rates for the respondents and their husbands are given in Table 3.2. Literacy rates are also shown in Figure 3.1. Rates in Thatta were lower than the rates for Sindh province. The literacy rate for female respondents was only about 8 percent, which was also low for females 15 and over in the 2004-05 PSLMS, compared with 38 percent in Sindh as a whole and 36 percent (at that time) for Pakistan as a whole (Government of Pakistan, 2005; Government of Pakistan, 2006). Similarly, only about 8 percent of female respondents reported being educated up to primary level, 3 percent up to secondary level, and just about 1 percent to above secondary level. For the husbands, as well, literacy (at 38 percent) was lower than the PSLMS found for Sindh in 2004-05 (68 percent), and the national average (63 percent) (Government of Pakistan, 2005). Table 3.2 also shows that younger women 15-24 years and 25-34 years were more literate than older women 35-49 years old.

Table 3.2: Percentage 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	8.6	9.7	3.8	5.7	28.8	7.7
Education level						
No education	88.2	85.5	93.5	90.7	66.1	88.6
Up to primary	8.5	9.7	4.3	6.9	16.9	7.8
Up to secondary	3.3	3.3	1.1	1.8	11.9	2.7
Above secondary	0.0	1.5	1.1	0.5	5.1	0.9
N	211	269	184	605	59	664
Respondent's husbands						
Proportion literate	35.6	45.1	31.8	36.6	56.1	38.4
Education level						
No education	60.6	53.1	64.8	60.4	42.4	58.8
Up to primary	15.8	15.4	20.7	17.6	10.2	17.0
Up to secondary	16.3	18.1	5.6	13.2	22.0	14.0
Above secondary	7.4	13.5	8.9	8.7	25.4	10.3
N	203	260	179	584	59	643

For both women and their husbands, literacy and education levels were higher in urban areas. The urban-rural gap was significantly high for women both in literacy and education levels.

Figure 3.1: Literacy status of women and their husbands



Occupation and Work Status

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

A substantial number, i.e., 41 percent (272 of 666 women) of the women respondents, reported working for money. Forty-six percent of women were engaged in embroidery/stitching, and about 42 percent were earning money through crop sowing and harvesting. Their occupation distribution is shown in Figure 3.2.

Figure 3.2: Type of work of women working for pay (n=271)

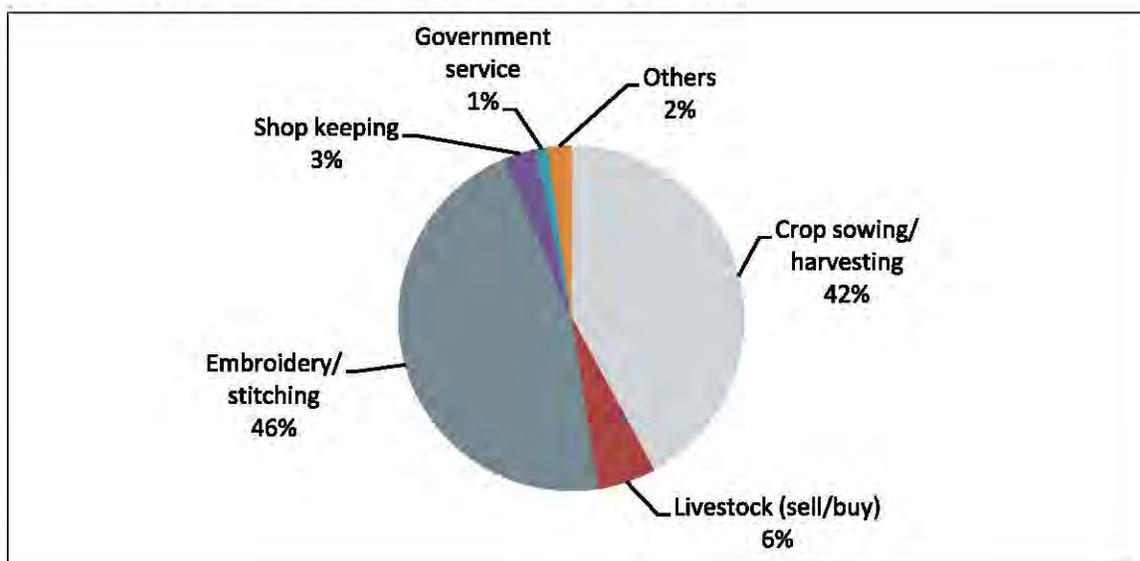


Table 3.3: Distribution of occupational categories of respondents' husbands by residence

Economic activity /occupation	Rural	Urban	Total
Agriculture/livestock/poultry	39.9	6.8	36.9
Petty trader	3.8	15.3	4.8
Labor (daily wages)	26.7	37.3	27.6
Government service	9.4	13.6	9.8
Private service	7.9	1.7	7.4
Own business	4.1	16.9	5.3
Working abroad	0.3	0.0	0.3
Unemployed	7.4	6.8	7.4
Others	0.5	1.7	0.6
Total	100.0	100.0	100.0

Table 3.3 shows the occupation distribution of the respondents' husbands. A total of 37 percent were engaged in agriculture/livestock/poultry related occupations. Overall, about 67 percent of rural husbands were either in agriculture or worked as daily-wage laborers. Thirty-seven percent of the urban husbands were working as daily-wage laborers. About 14 percent of the husbands were employed in government service in urban areas, which was the fourth largest employer in urban areas in the district. About 17 percent of urban husbands were doing their own business, whereas for rural husbands the number was about 4 percent. Unemployment in both urban and rural areas was almost the same, and overall 7 percent of the husbands were unemployed.

Female Mobility

Women respondents were asked about their ability to go to places outside their homes, and what degree of permission was required (Table 3.4). The health center was the only place where a substantial number of women (67 percent) said they could go with someone. Only a few women reported being able to go to any of the places named without permission. About 8 percent of the respondents could go without permission to their relatives/friends and another 32 percent needed permission to do so. Thirty-eight percent of the women reported not being able to go at all to the market. For each of the named destinations, a majority said they could go with someone or they could go with permission.

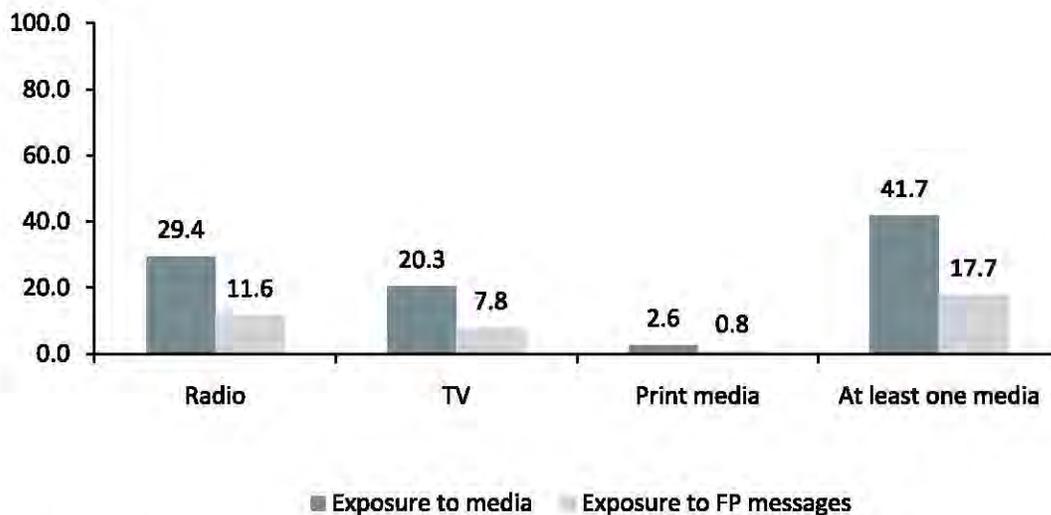
Table 3.4: Women's reports regarding mobility outside the home by degree of permission and destination

Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Can't go/ doesn't go	%	N
Market	2.4	19.8	39.5	38.3	100.0	666
Health center	2.4	28.8	67.4	1.4	100.0	666
Relatives/friends	8.3	32.3	58.9	0.6	100.0	666
Out of village/town	2.7	30.5	64.9	1.8	100.0	666

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. Table 2.5 shows that 46 percent of households owned a radio, while 24 percent owned a television. Figure 3.3 shows the proportions of respondents who reported that they watched TV, listened to the radio, or read newspapers or magazines. Radio was the most commonly accessed medium, as 29 percent of the women reported listening to the radio, while 20 percent of the respondents watched television and only 3 percent of the respondents had access to print materials.

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



Furthermore, the women who reported having access to any sort of media were asked if they had ever seen, heard, or read any message about family planning methods through these mediums. According to Figure 3.3, 12 percent of the women said that they had heard family planning messages on the radio. About 8 percent of the women had seen FP messages on the television. Less than one percent of the respondents said that they had ever read a family planning message in a newspaper or magazine. Overall, nearly 42 percent of the women had access to some sort of media, and 18 percent of the women had ever been exposed to a FP message through any of these mediums.

Chapter 4

Service Availability

Health status and practices in a district can be better understood in the context of the health facilities and trained personnel available to the population of that district. To supplement the Thatta Household Survey, the FALAH project undertook a mapping of health and reproductive health services study in the FALAH districts. The fieldwork in the district was carried out from March to April 2008. In this survey, all public and private facilities and providers for reproductive health, including family planning as well as maternal health, were identified and visited. Exact locations of these facilities were determined by a global positioning system (GPS) device. The characteristics and activities of the facilities and their staff were acquired. The results in whole of the study are being issued in a separate report titled "Mapping Survey of Health and Reproductive Health Services - Thatta district." In this section, some relevant key results are added to offer an overview of the context in which the knowledge, attitude and behavior of the men and women of the household survey sample can be better assessed.

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

Thatta District Data

There are a total of 976 health facilities in Thatta, of which 618 are from the public sector and 358 are from the private sector (97 - Greenstar Social Marketing; 261 - other private facilities). Some facilities provide only limited care, such as a LHW's health house in the public sector, and dispensaries and traditional practitioners in the private sector.

Reproductive Health Facilities

The distribution of reproductive health facilities in the public and private sectors per union council is shown in Maps 4.1 to 4.3. Map 4.1 shows the distribution of government static facilities by union council population density. There is only one union council without a government static facility. Map 4.2 shows the availability of LHWs; 7 union councils have more than 20 LHWs, while 10 union councils have no lady health workers in the area. On average, there are about 9 LHWs per union council. Map 4.3 shows the distribution of private facilities in the district; 16 union councils have no private facility.

The gross density of reproductive health facilities, that is the number of facilities per union council, is shown in Map 4.4. The variation is considerable: 6 union councils have more than 40 reproductive health facilities, while 26 others have fewer than 10 facilities. On the whole however, there do not appear to be any large geographic areas for which some reproductive health services are not available. Nearly all union councils in Thatta district are well served, with an average of 18 facilities per union council

Family Planning Facilities

By and large, family planning services are available at a large number of facilities from both the public and private sectors. Clinical methods are available in 61 percent of the facilities. Injectables, mostly provided by the LHWs, are the most frequently available method in the district, and this service is why public facilities are ahead of private ones in the provision of clinical methods. The availability of IUDs is found to be higher in the private sector. Female and male sterilization services are available in both sectors. Norplant is not available at all in the district. For non-clinical methods, almost all public facilities are providing some non-clinical methods; again, it is LHWs who provide the majority of the non-clinical methods, particularly condoms and pills. To the extent that emergency contraceptive pills are available at all, they are mostly available at private facilities.

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

Service	Sector								Total		MWRA per facility
	Government		LHWs		Private GSM		Private others				
	N	%	N	%	N	%	N	%	N	%	
Injectables	76	57.1	430	88.7	50	51.5	29	11.1	585	59.9	289
IUD/Copper T	33	24.8	na	na	37	38.1	16	6.1	86	8.8	1967
Norplant	0	0.0	na	na	0	0.0	0	0.0	0	0.0	na
Female sterilization	4	3.0	na	na	2	2.1	0	0.0	6	0.6	28194
Male sterilization	1	0.8	na	na	2	2.1	0	0.0	3	0.3	56388
Condom	89	66.9	475	97.9	49	50.5	36	13.8	649	66.5	261
Pills	89	66.9	485	100.0	49	50.5	31	11.9	654	67.0	259
ECP	3	2.3	0	0.0	22	22.7	7	2.7	32	3.3	5286
Any FP method	89	66.9	485	100.0	71	73.2	53	20.3	698	71.5	242
Any clinical method	76	57.1	430	88.7	54	55.7	34	13.0	594	60.9	285
Any non-clinical method	89	66.9	485	100.0	64	66.0	42	16.1	680	69.7	249
Total facilities	133	100.0	485	100.0	97	100.0	261	100.0	976	100.0	173

Multiple responses are possible.

na= not applicable.

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

The geographic distribution of these services is as important as the number. Maps 4.5 to 4.7 illustrate the availability of female sterilization, IUDs and injectables. Female sterilization is available in only 4 union councils. IUDs, provided by public and private sectors, are available in 23 union councils. Availability of injectables is widespread: government facilities are providing injectables in 50 union councils, while the private sector provides this service in 19 union councils.

Maternal Health Facilities

The ability to provide maternal health care services is a basic foundation of reproductive health care. Maternal health care facilities are shown in Table 4.2. A large number of the service delivery points, from both the public and private sectors, provide antenatal care services. Anemia treatment is the most frequently available service. Routine antenatal check-ups are available in one-third of all facilities in the district. Service availability regarding tetanus protection is higher in the public sector. Normal delivery services are more readily available from the private sector than from the public sector. Of the 8 Caesarean section services in the district 6 are provided by the private sector.

Table 4.2: Number and proportion of facilities providing specified maternal health care services in Thatta district, 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	86	64.7	404	83.3	67	69.1	114	43.7	671	68.8	252
Anemia treatment	114	85.7	485	100.0	81	83.5	220	84.3	900	92.2	188
TT injection	58	43.6	450	92.8	8	8.2	8	3.1	524	53.7	323
Normal delivery	27	20.3	na	na	56	57.7	31	11.9	114	11.7	1484
Caesarean section	2	1.5	na	na	4	4.1	2	0.8	8	0.8	21145
Total facilities	133	100.0	485	100.0	97	100.0	261	100.0	976	100.0	173

Multiple responses are possible.

na= not applicable.

Along with the sheer numbers, the geographic distribution of health facilities is of critical importance. Maps 4.7 and 4.8 show essential and comprehensive EmOC services, respectively. There are 21 union councils in Thatta without any essential obstetric care facility. Comprehensive EmOC services are available in 3 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 married women of reproductive age are shown in Table 4.3. There are a total of 501 MBBS doctors in the district; of these, three-quarters are males. There are more MBBS doctors in the private sector than in the public sector. Among the 166 female paramedics, LHVs are a majority, followed by nurses. There are substantially more female paramedics than their male counterparts. The total number of paramedics in the district is equally divided between the private and public sectors.

The number of married women of reproductive age per provider is a good indicator of the status of health in the district. In Thatta, there are 338 married women of reproductive age

per MBBS doctor. Since a majority of women prefer female service providers, this number increases to about 2014 MWRA per female MBBS doctor. Map 4.9 shows the availability of MBBS doctors by gender in each union council. Male doctors are not available in 10 union councils; there are no female MBBS doctors in 37 union councils. As for paramedics, there are 1019 MWRA per female paramedic. Female medical assistants and medical health technicians are rarely available in the district. There are 56388 married women per medical assistant and 24166 per medical technician; this shows a serious deficiency of these cadres.

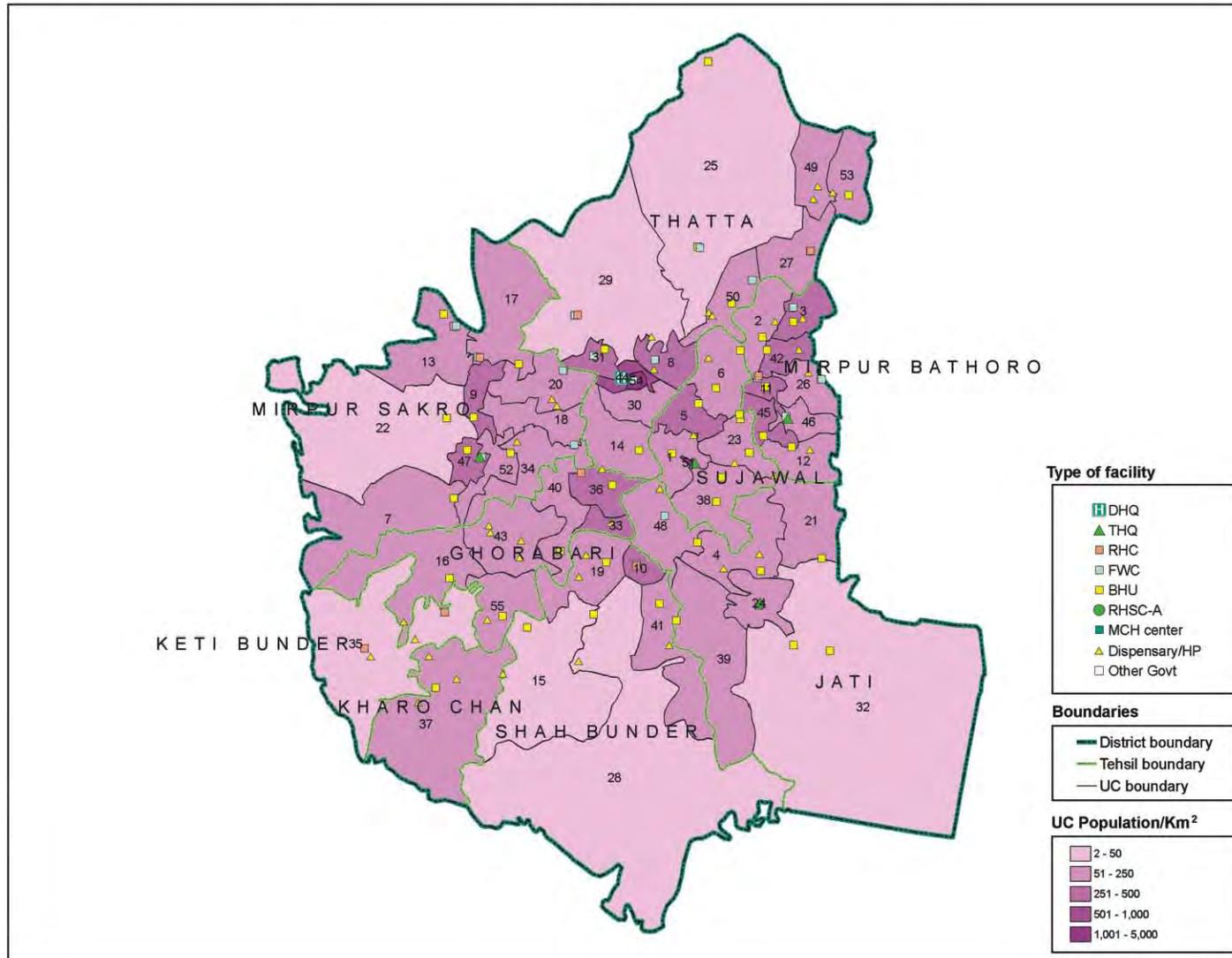
Table 4.3: Number of reproductive health care providers in Thatta district, by sector and category, and MWRA per service provider

Provider	Sector						Total		MWRA per provider
	Government		Private GSM		Private others		N	%	
	N	%	N	%	N	%	N	%	
Doctors (MBBS)									
Male	161	83.9	66	66.7	190	90.5	417	83.2	406
Female	31	16.1	33	33.3	20	9.5	84	16.8	2014
Total	192	100.0	99	100.0	210	100.0	501	100.0	338
Female paramedics									
Medical assistant	0	0.0	0	0.0	3	0.0	3	1.8	56388
Nurse	27	34.2	15	28.8	10	28.6	52	31.3	3253
Medical/ health technician	4	5.1	3	5.8	0	0.0	7	4.2	24166
Lady health visitor	48	60.8	34	65.4	22	62.9	104	62.7	1627
Total	79	100.0	52	100.0	35	100.0	166	100.0	1019
Male paramedics	30	100.0	6	100.0	20	100.0	56	33.7	3021

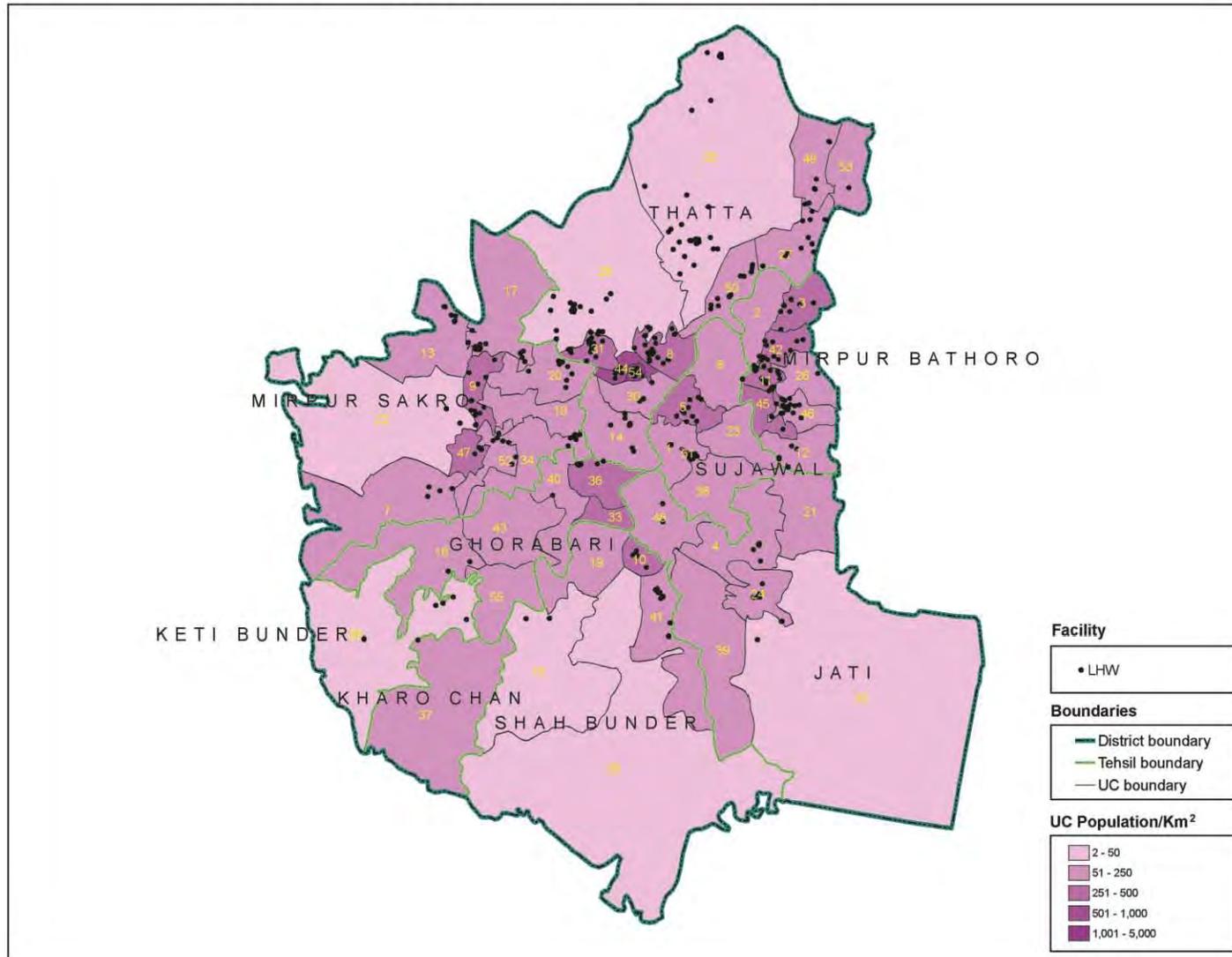
List of Union Councils

1	Ali Bahar	20	Gujjo	39	Kothi
2	Bachal Gugo	21	Gul Mohammad Baran	40	Kotri Allah Rakhio
3	Bano	22	Haji Ghirano	41	Ladiun
4	Begna	23	Jar	42	Liakpur
5	Belo	24	Jati	43	Mahar
6	Bijora	25	Jhampir	44	Makli
7	Buhara	26	Jhoke Sharif	45	Mehar Shah
8	Chato Chand	27	Jhurruck	46	Mirpur Bathoro
9	Choubandi	28	Jongo Jalbani	47	Mirpur Sakro
10	Chuhar Jamali	29	Jungshahi	48	Mureed Khoso
11	Darro	30	Kalan Kot	49	Ongar
12	Darya Khan Suho	31	Kalri	50	Sonda
13	Dhabeji	32	Kar Malik	51	Sujawal
14	Domani	33	Kar Shah	52	Sukhpur
15	Doulat Pur	34	Karam Pur	53	Tando Hafiz Shah
16	Gahro	35	Keti Bundar	54	Thatta
17	Gharo	36	Khan	55	Udassi
18	Ghulamullah	37	Kharo Chan		
19	Goongani	38	Kinjhar		

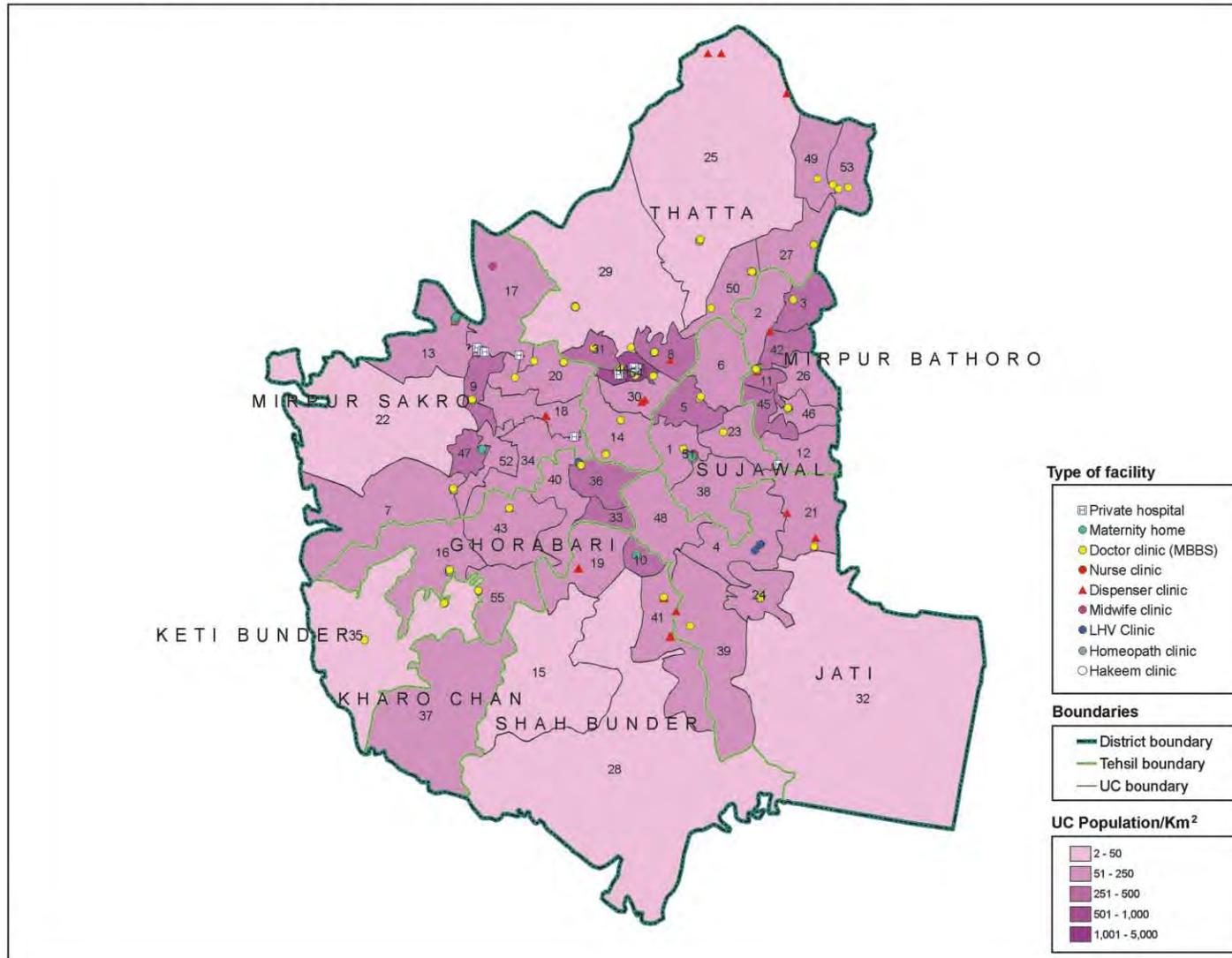
Map 4.1: Location of government facilities in Thatta district, by population density of union council



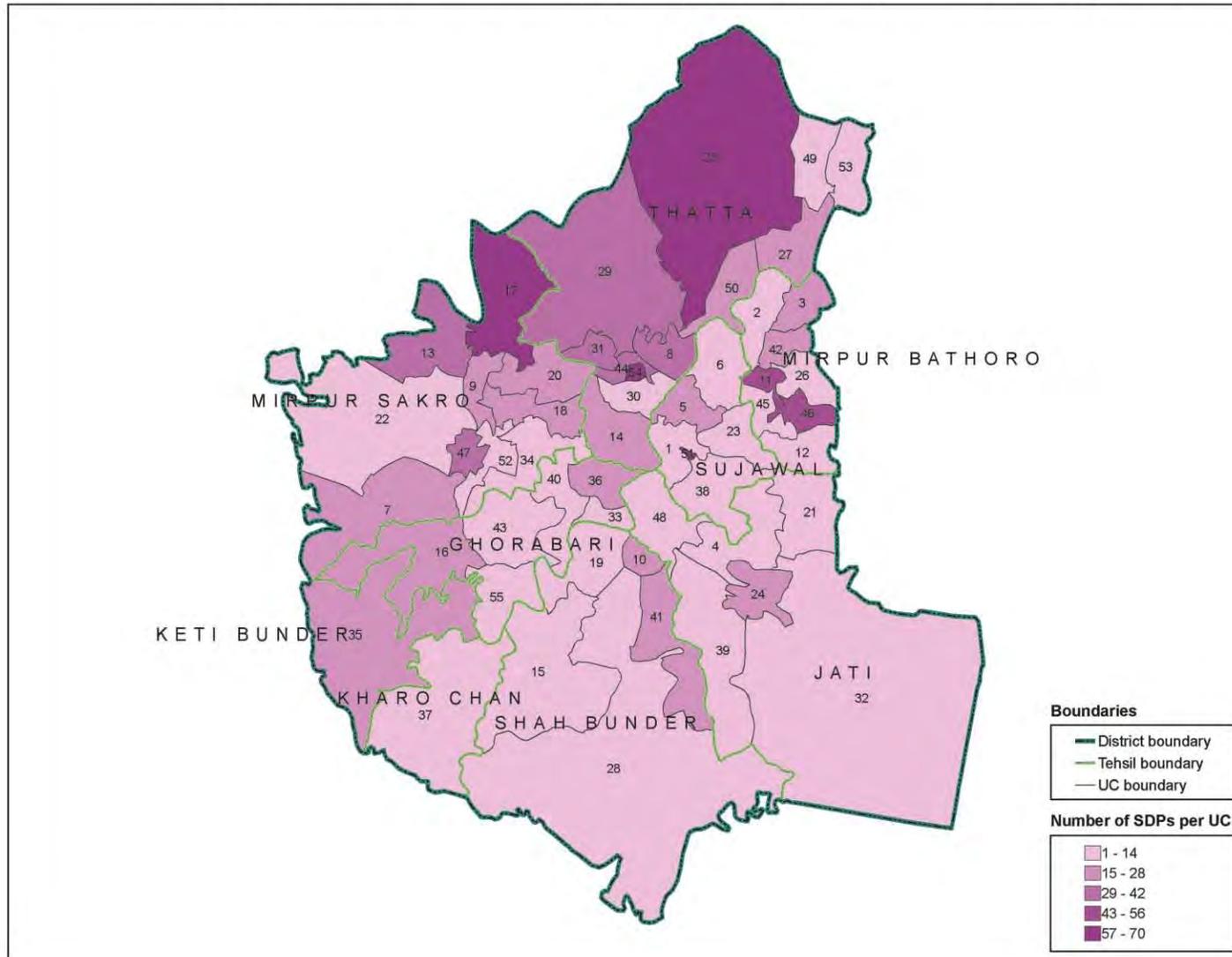
Map 4.2: Location of LHWs in Thatta district, by population density of union council



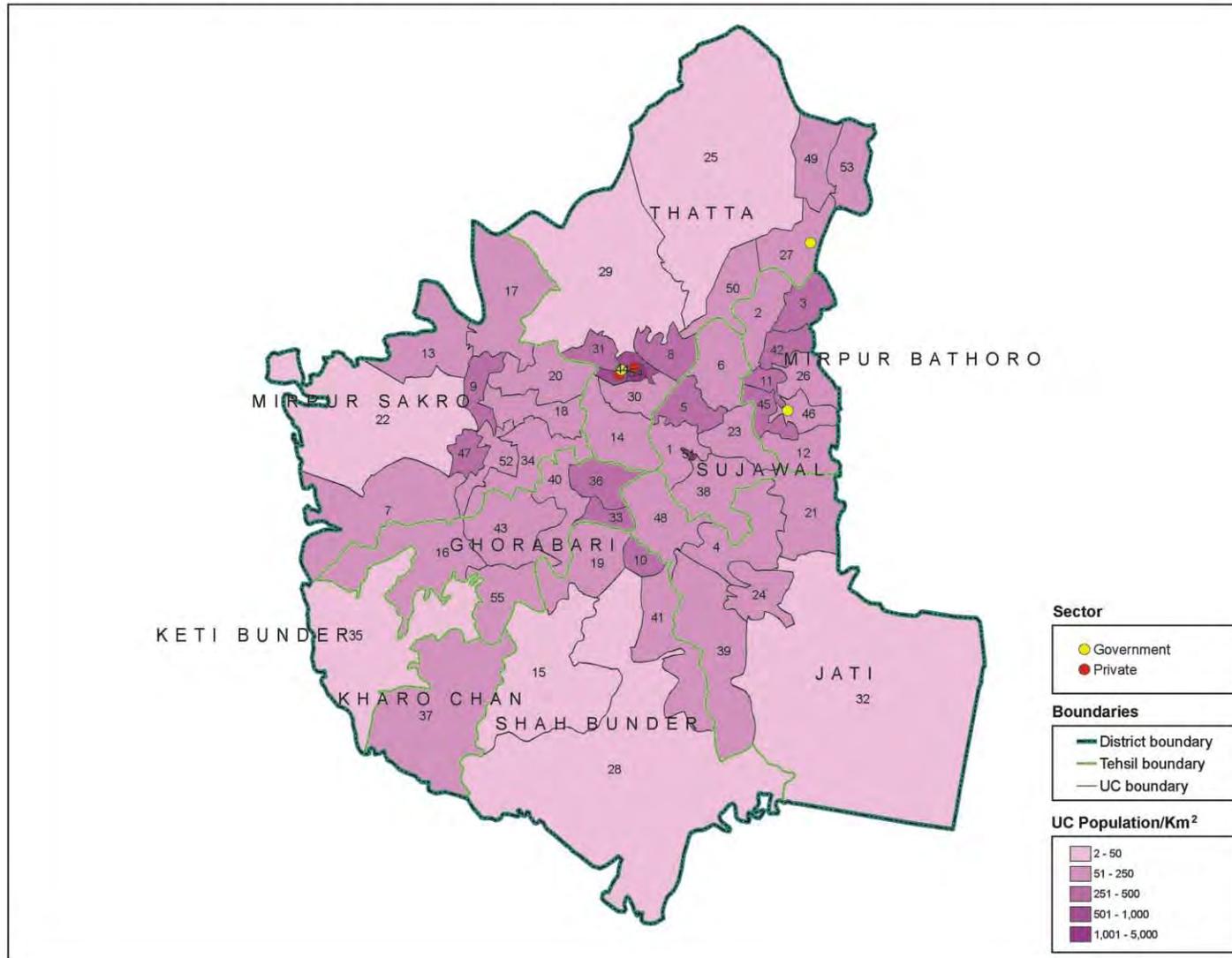
Map 4.3: Location of private facilities in Thatta district, by population density of union council



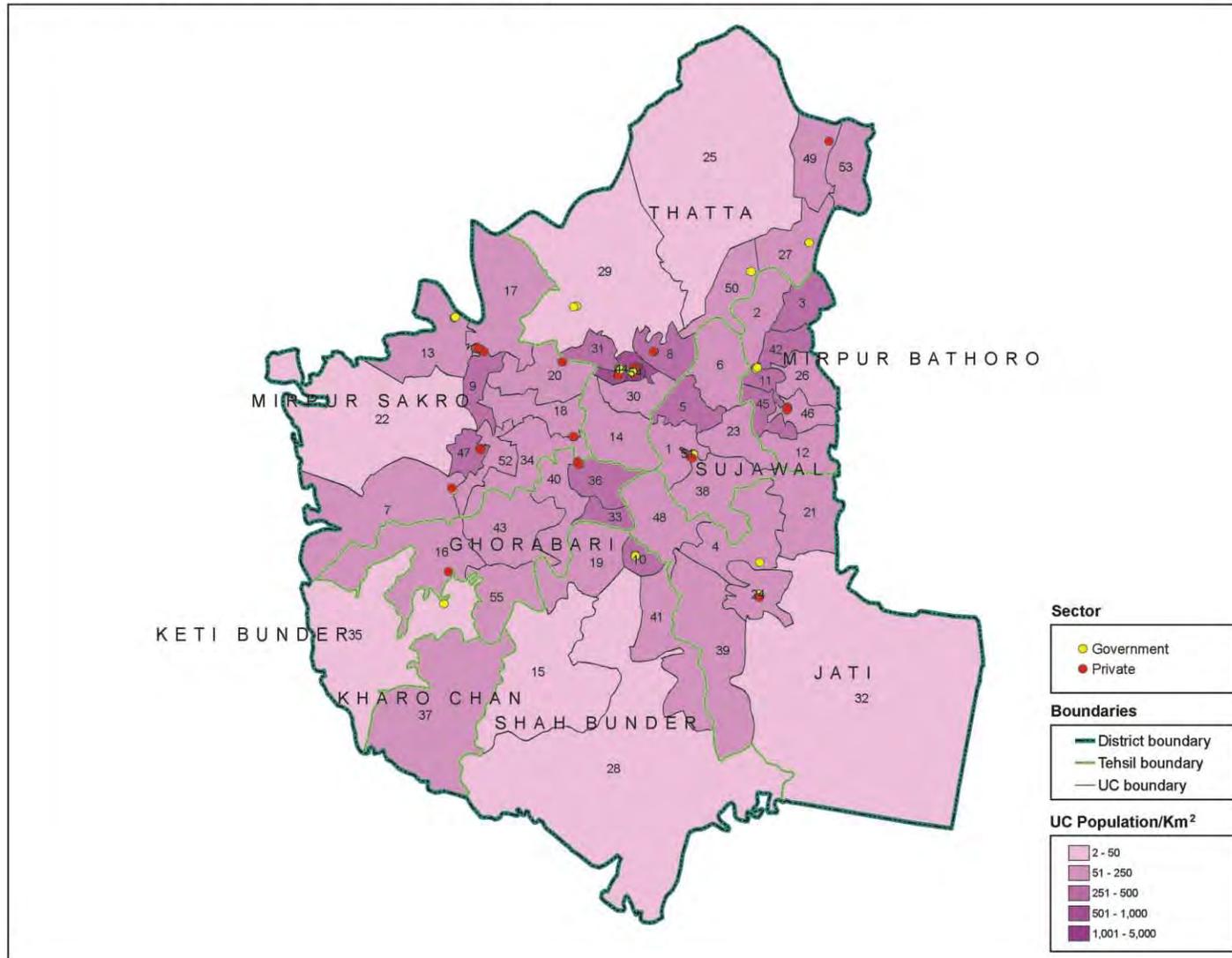
Map 4.4: Total number of reproductive health service delivery points (public and private) in Thatta district, by union council



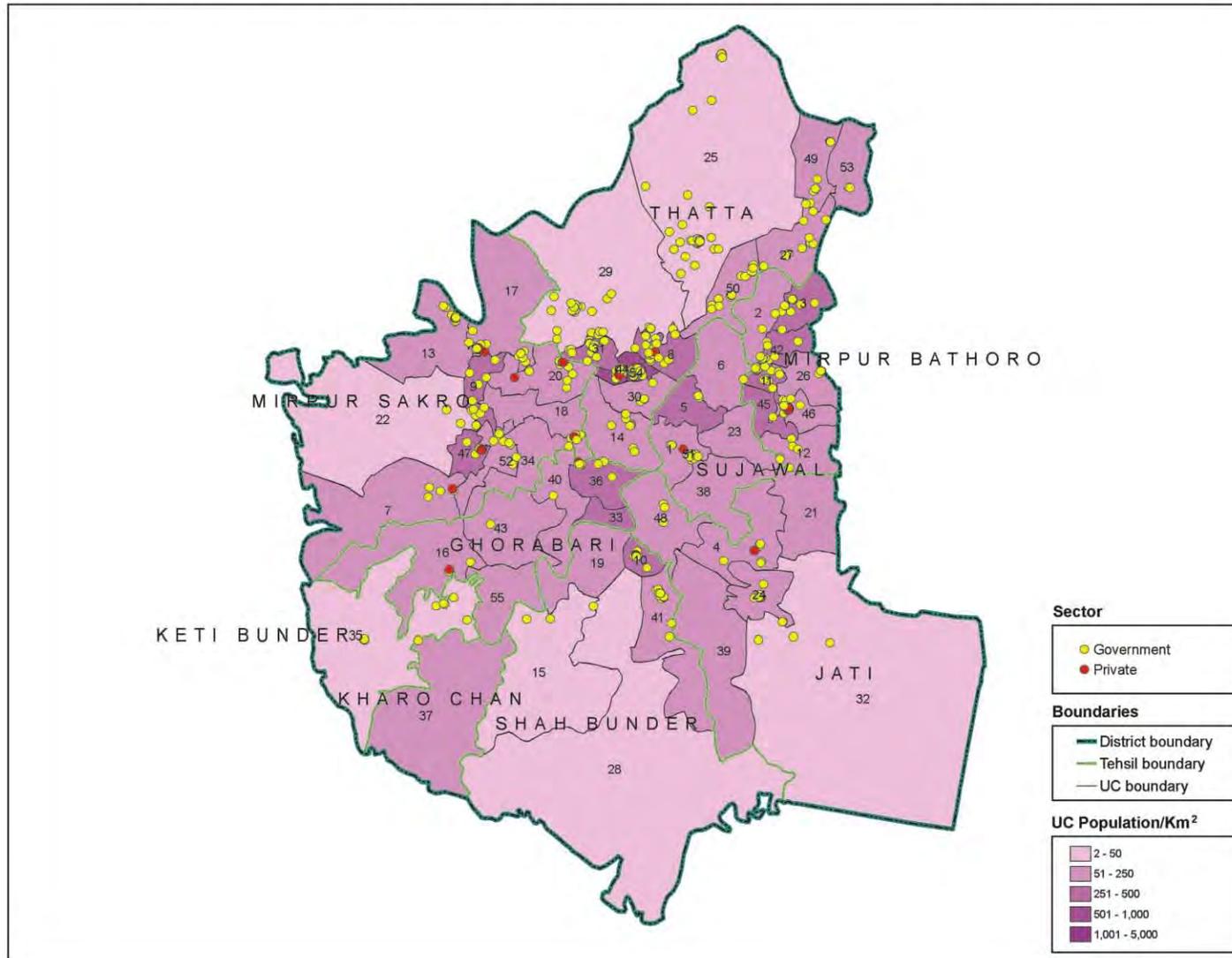
Map 4.5: Location of female sterilization facilities in Thatta district, by population density of union council



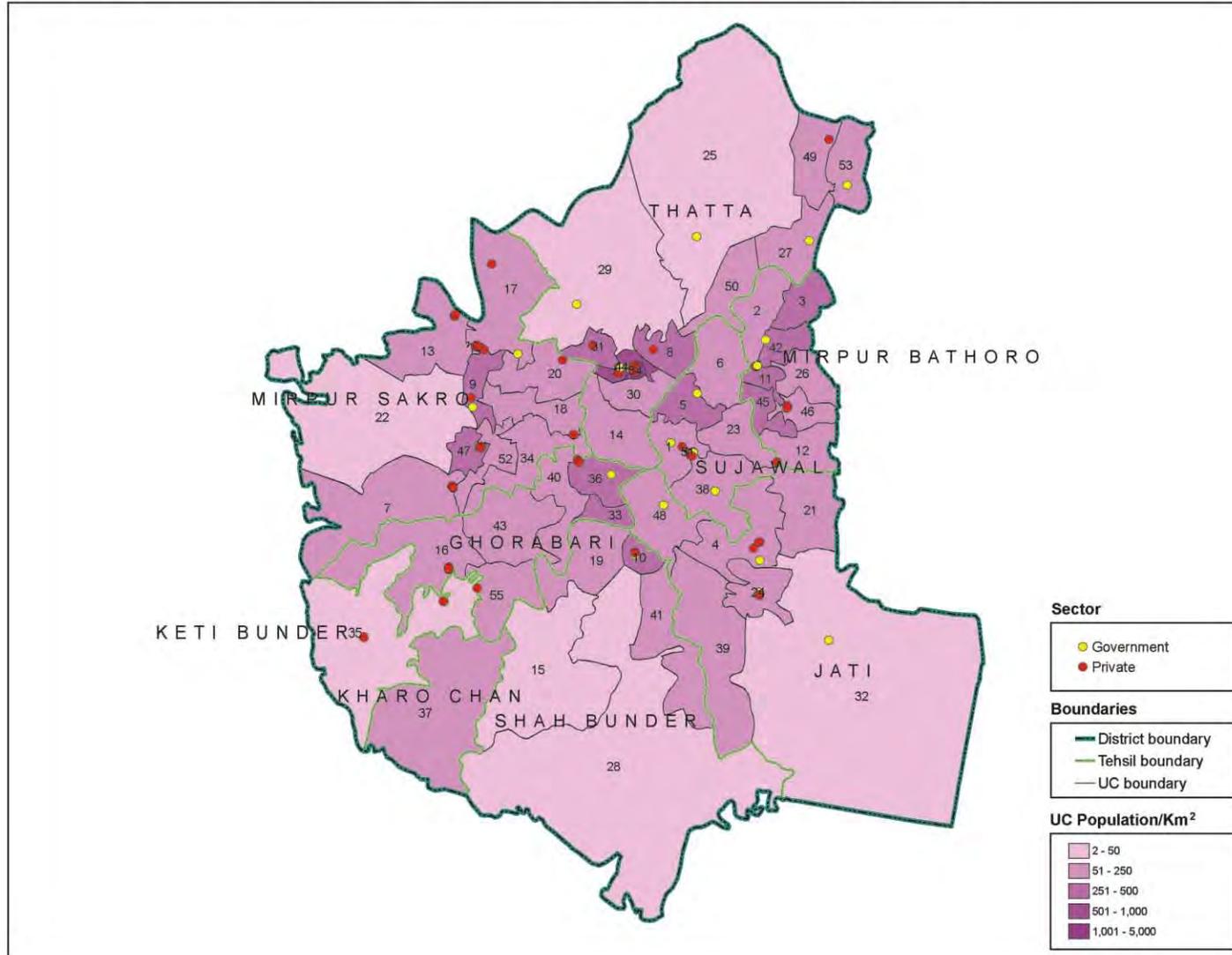
Map 4.6: Location of IUD facilities in Thatta district, by population density of union council



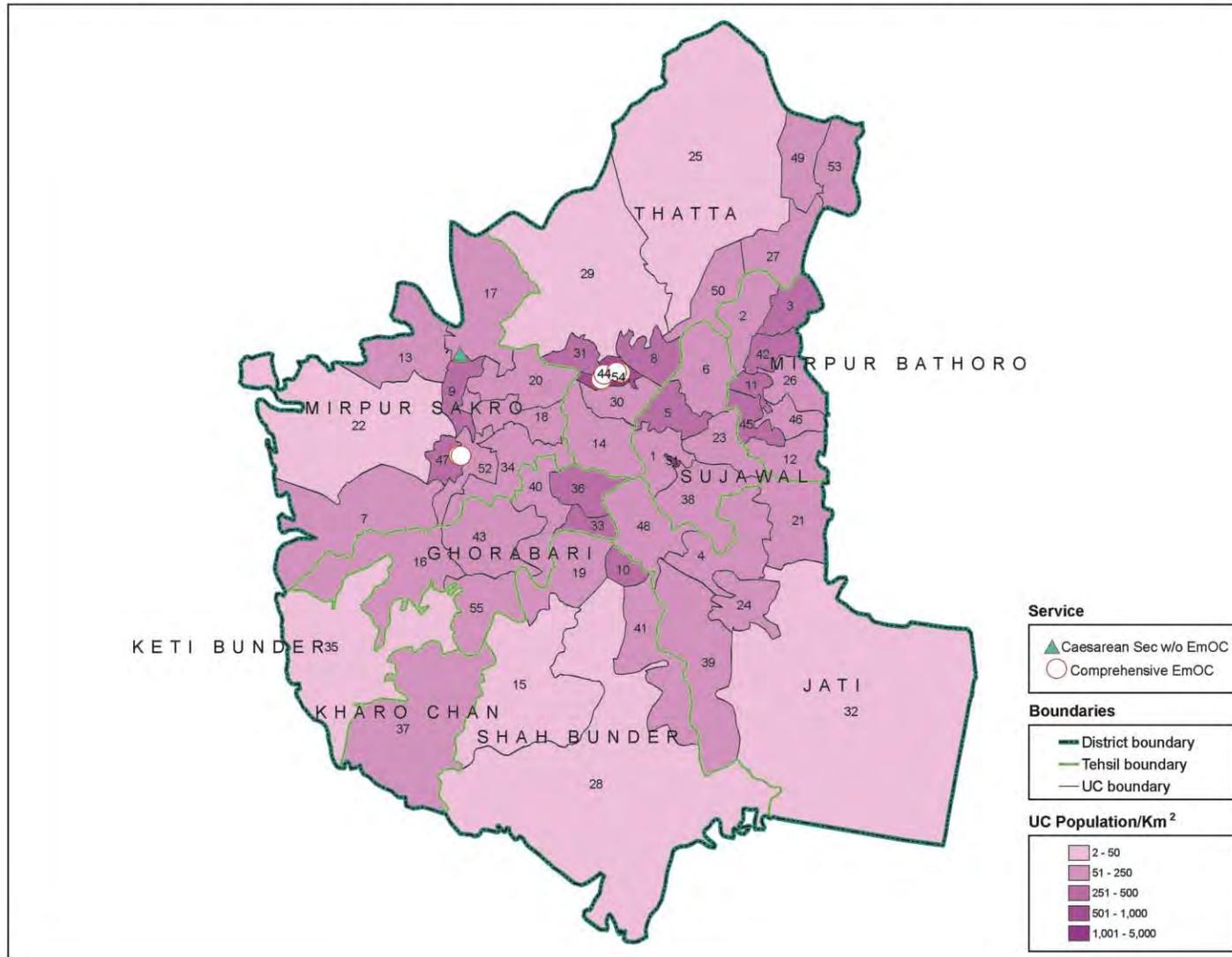
Map 4.7: Location of injectables contraceptive services in Thatta district, by population density of union council



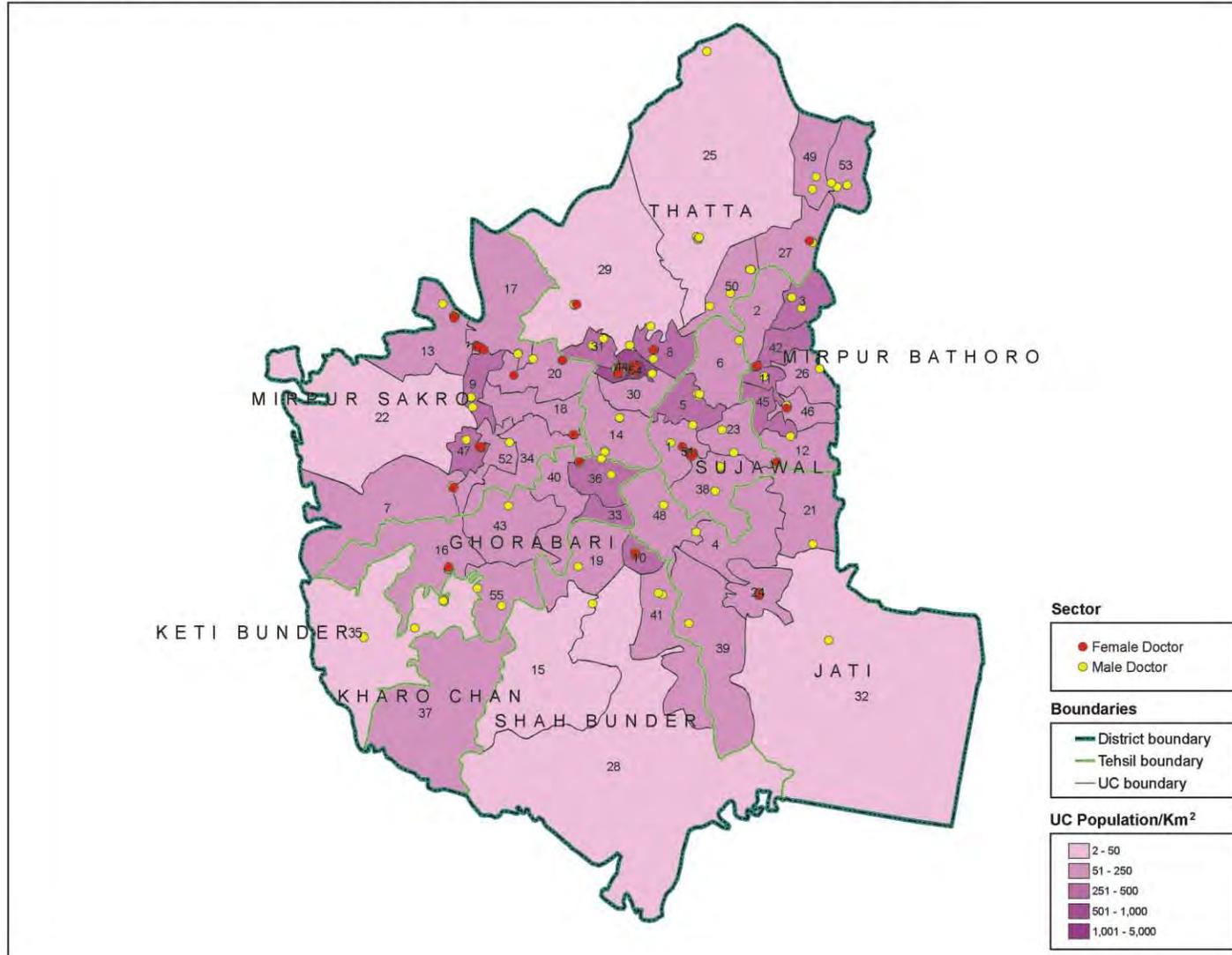
Map 4.8: Location of essential obstetric services in Thatta district, by population density of union council



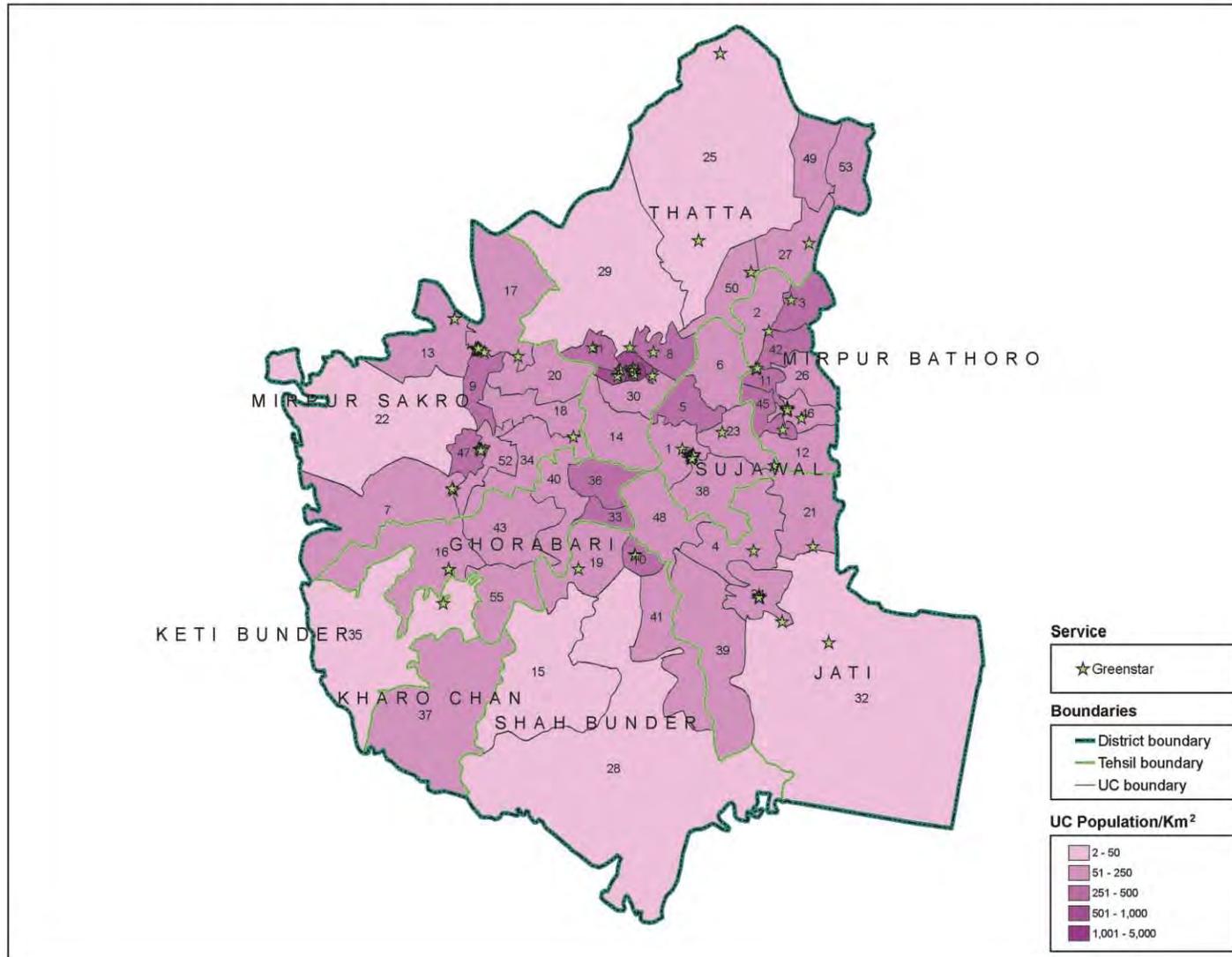
Map 4.9: Location of emergency obstetric care facilities in Thatta district, by population density of union council



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



Map 4.11: Location of Greenstar Social Marketing SDPs in Thatta 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. However, some information on the number of children ever born and living children was also 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 the live births and whether that child was still alive at the time of the survey. In case the mother did not remember the date of birth, she was asked how long ago her live birth was. Births that occurred during the last three years were ascertained from these responses. The number of births obtained through this procedure was used to analyze current fertility. For a family planning program, it is essential to know about fertility trends 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	N
	0	1-2	3-4	5 or more			
15-19	59.7	40.3	0.0	0.0	100.0	0.5	62
20-24	20.7	50.7	22.0	6.7	100.0	1.8	150
25-29	9.8	27.4	33.5	29.3	100.0	3.4	164
30-34	1.9	13.2	27.4	57.5	100.0	5.0	106
35-39	1.1	16.8	15.8	66.3	100.0	5.8	95
40-44	3.9	3.9	15.7	76.5	100.0	7.1	51
45-49	2.6	7.9	13.2	76.3	100.0	7.6	38
Total	13.5	27.2	21.8	37.5	100.0	3.9	666

Table 5.1 shows that early childbearing was fairly common in Thatta. Tables 5.1 and 5.2 show that the mean number of children ever born and living children increased with the age of the mother, as would be expected in data of good quality. Table 5.1 also shows that 40 percent of the married women who were 15-19 years of age had already given birth to at least one child. Since women 45-49 years old have usually completed childbearing, of the currently married women in this age group, 24 percent had reached the end of childbearing with fewer than 5 children ever born, and 76 percent had 5 or more children ever born. Data show that 97 percent women aged 45-49 years had at least one live birth in their reproductive period, whereas about 3 percent were nulliparous.

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	59.7	40.3	0.0	0.0	100.0	0.4	62
20-24	24.0	50.7	22.7	2.7	100.0	1.6	150
25-29	11.0	34.1	34.8	20.1	100.0	2.9	164
30-34	2.8	18.9	30.2	48.1	100.0	4.3	106
35-39	1.1	17.9	20.0	61.1	100.0	5.1	95
40-44	3.9	9.8	17.6	68.6	100.0	6.0	51
45-49	2.6	15.8	15.8	65.8	100.0	6.3	38
Total	14.7	30.8	23.6	30.9	100.0	3.3	666

Table 5.3 shows the mean number of ever born and living sons and daughters. Among women aged 15-49 in Thatta, the mean number of children ever born was 3.9 for currently married women. The mean number of children ever born increased steadily with age, reaching as high as 7.6 children among women aged 45-49. On average, these women also had 6.3 living children. Each woman of age group 40-49 had lost one child on average in her reproductive life. The sex ratio of children ever born was 105 males per 100 females, whereas the sex ratio of children surviving was 106 (from Table 5.1 and 5.2).

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

Age group	Children ever born			Children surviving			N
	Boys	Girls	Total	Boys	Girls	Total	
15-19	0.2	0.3	0.5	0.2	0.3	0.4	62
20-24	1.0	0.8	1.8	1.0	0.7	1.6	150
25-29	1.6	1.8	3.4	1.4	1.5	2.9	164
30-34	2.6	2.4	5.0	2.2	2.1	4.3	106
35-39	3.2	2.6	5.8	2.8	2.2	5.1	95
40-44	3.7	3.4	7.1	3.2	2.8	6.0	51
45-49	3.6	4.0	7.6	3.0	3.3	6.3	38
Total	2.0	1.9	3.9	1.7	1.6	3.3	666

Differentials in Children Ever Born and Surviving

Table 5.4 shows that differences in mean numbers of children by literacy and educational level of currently married women were pronounced. On average, literate women had 1.2 fewer children than illiterate women. As expected, fertility also declined as the level of education increased. According to Table 5.4, those who had “up to primary” education had on average 3.3 children ever born compared to 4 born to those who had no schooling. Those who had “up to secondary” level of education had 2.6 children, and those with “above secondary” level of education had 2.7 children ever born.

Differentials were also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 3.6 children compared to 4 children ever born to those who had illiterate husbands. Similarly, women with husbands who worked in government services or agriculture/livestock had the highest number of children ever born.

A comparison of mean numbers of children ever born and surviving children showed that survival of children increased with literacy of mothers and fathers.

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 mother				
Literate	2.8	2.6	0.08	51
Illiterate	4.0	3.4	0.14	609
Schooling of mother				
No education	4.0	3.4	0.14	588
Up to primary	3.3	3.1	0.09	52
Up to secondary	2.6	2.3	0.11	18
Above secondary	2.7	2.7	0.00	6
Residence				
Rural	3.9	3.3	0.14	607
Urban	4.1	3.6	0.12	59
Literacy of husband				
Literate	3.6	3.2	0.12	239
Illiterate	4.0	3.5	0.15	384
Schooling of husband				
No education	4.0	3.5	0.14	378
Up to primary	4.3	3.6	0.17	109
Up to secondary	3.0	2.8	0.08	90
Above secondary	3.6	3.1	0.14	66
Standard of living index				
Low	3.9	3.3	0.15	405
Medium low	3.7	3.2	0.15	129
Medium high	4.0	3.5	0.11	86
High	3.9	3.6	0.08	46
Economic activity /occupation				
Agriculture/livestock/poultry	4.0	3.5	0.13	247
Petty trader	3.8	3.7	0.03	32
Labor (daily wages)	3.5	2.9	0.17	184
Government service	4.6	3.9	0.15	64
Private service	3.8	3.1	0.19	49
Own business	3.7	3.2	0.13	35
Unemployed	3.8	3.4	0.11	49
Others	3.7	3.7	0.00	6
Total	3.9	3.3	0.14	666

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 to that of mothers who were illiterate (4.0 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, 61 percent were literate, as compared to 56 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 CEB	Mean LC	N	%	Mean CEB	Mean LC	N	%
15 - 19	0.3	0.3	4	7.8	0.5	0.4	58	9.5
20 - 24	1.6	1.5	14	27.5	1.8	1.6	133	21.8
25 - 29	2.5	2.3	13	25.5	3.5	2.9	150	24.6
30 - 34	3.3	3.2	13	25.5	5.2	4.4	92	15.1
35 - 39	0.0	0.0	0	0.0	5.8	5.1	94	15.4
40 - 44	5.8	5.3	4	7.8	7.2	6.1	47	7.7
45 - 49	6.7	6.0	3	5.9	7.7	6.3	35	5.7
Total	2.8	2.6	51	100.0	4.0	3.4	609	100.0

Current Fertility

Crude Birth Rate

Although a crude measure of fertility, the crude birth rate (CBR) is the most commonly 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 of the sample households. The baseline survey provides an estimate of 31.3 births per thousand of the 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
15 – 19	254	26	34.1
20 – 24	247	133	179.5
25 – 29	196	142	241.5
30 – 34	141	80	189.1
35 – 39	111	62	186.2
40 – 44	62	15	80.6
45 – 49	48	11	76.4
Total	1059	469	na

TFR: 4.9

CBR: 31.3

na=not applicable.

Age-specific Fertility Rates and Total Fertility Rate

The total fertility rate (TFR) is a more refined fertility measure than the CBR. Age-specific fertility rates (ASFRs) and TFR were calculated based on births among currently married women and the number of women living in the sampled households. One of the limitations of measuring ASFRs was the low number of births in the sample during the last three years. The findings show a pattern of ASFRs common in developing countries; rates rose rapidly until age 25-29, and then declined with increasing age. A TFR of 4.9 for the period 2004-2007 was obtained from the set of ASFRs calculated from the data presented in Table 5.6, compared with 4.3 for Sindh and 4.1 for Pakistan as a whole found 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 two living children less than 5 years of age, 18 percent were currently pregnant. Moreover, among women who had 3 living children less than 5 years of age, 11 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.

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	27	13.0	181	87.0	208	100.0
1	46	21.3	170	78.7	216	100.0
2	32	18.3	143	81.7	175	100.0
3	7	11.3	55	88.7	62	100.0
4	2	40.0	3	60.0	5	100.0
Total	114	17.1	552	82.9	666	100.0

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 the last closed birth interval for women with two or more births by background characteristics of mothers at the time of the survey.

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

Characteristic	Less than 18 months	18 - 23 months	24 - 35 months	36 - 47 months	48 and more months	Total	N
Age of the mother							
15 - 19	0.0	100.0	0.0	0.0	0.0	100.0	2
20 - 24	30.6	13.3	38.8	11.2	6.1	100.0	98
25 - 29	20.5	11.6	45.9	13.0	8.9	100.0	146
30 - 34	15.1	7.5	38.7	23.7	15.1	100.0	93
35 - 39	19.0	11.9	31.0	22.6	15.5	100.0	84
40 - 44	8.3	4.2	45.8	20.8	20.8	100.0	24
45 - 49	21.4	14.3	21.4	35.7	7.1	100.0	14
Number of live births							
2	33.9	12.5	26.8	16.1	10.7	100.0	56
3	13.0	18.5	35.9	22.8	9.8	100.0	92
4	14.7	10.7	52.0	8.0	14.7	100.0	75
5	24.1	9.3	40.7	13.0	13.0	100.0	54
6+	21.7	8.2	39.1	20.7	10.3	100.0	184
Education level							
No education	20.3	10.3	40.1	17.8	11.5	100.0	399
Up to primary	21.7	19.6	37.0	15.2	6.5	100.0	46
Up to secondary	37.5	12.5	0.0	25.0	25.0	100.0	8
Above secondary	20.0	20.0	40.0	0.0	20.0	100.0	5
Standard of living index							
Low	22.1	10.7	40.0	15.5	11.7	100.0	290
Medium low	14.0	9.3	46.5	19.8	10.5	100.0	86
Medium high	26.8	14.3	25.0	23.2	10.7	100.0	56
High	13.8	17.2	37.9	20.7	10.3	100.0	29
Total	20.6	11.3	39.3	17.6	11.3	100.0	461

A short interval has traditionally been viewed as a risk factor for poor pregnancy outcomes, particularly neonatal mortality, in developing countries (Cleland and Sathar, 1984). It has been observed in several studies that the death risks of an index child whose birth closes a short birth interval are higher than those experienced by an index child whose birth closes a longer birth interval (Mahmood, 2002). It has also been found that children born within the preceding interval of 18 months experienced higher mortality risks during infancy than those born after an interval of two to three years (Cleland and Sathar, 1984).

Table 5.8 shows that almost 21 percent of children were born within 18 months of the last birth. About 71 percent were born with a birth interval of less than 36 months, while 29 percent were born after three years or more. Differentials by mother's age, parity, educational level and standard of living index are also shown.

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 both mothers and babies, and a baby's survival 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 462 women out of the 666 total women interviewed (69 percent) had borne a child during the past four years, and they were asked additional questions about maternal and neonatal care.

Antenatal Care

Antenatal check-ups allow for skilled health personnel to advise expectant mothers as to how to best take care of themselves and their unborn baby during pregnancy, to prepare them for childbirth and care of the newborn, and to identify possible problems during pregnancy and delivery. The Ministry of Health recommends at least three antenatal visits during pregnancy, preferably four. Traditionally, many women, understanding childbirth as a natural experience and perhaps not finding health providers nearby, have not gone to skilled providers for antenatal care. In recent years, however these proportions have been increasing in Pakistan (NIPS/PDHS, 2008). Table 6.1 and Figure 6.1 show the numbers of ANC visits for the last birth of women who had delivered during the last four years. About 73 percent of the respondents had obtained at least one antenatal care visit during the last pregnancy; the percentage was higher for urban mothers (91 percent) than for rural ones (72 percent). This was significantly higher than the level obtained for Thatta in the 2004-05 PSLM Survey (46 percent), and it is also higher than the level for Sindh (70 percent) or the level obtained nationally in the PDHS (61 percent) (Government of Pakistan, 2006; NIPS/PDHS, 2008). About 42 percent of the respondents had at least three such visits and 28 percent had four or more visits.

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

Number of visits	Rural		Urban		Total	
	N	%	N	%	N	%
No visit	122	28.4	3	9.1	125	27.1
1-2 visits	128	29.8	14	42.4	142	30.7
3 visits	60	14.0	6	18.2	66	14.3
4+ visits	117	27.4	10	30.3	127	27.5
Don't remember	2	0.5	0	0.0	2	0.4
Total	429	100.0	33	100.0	462	100.0

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

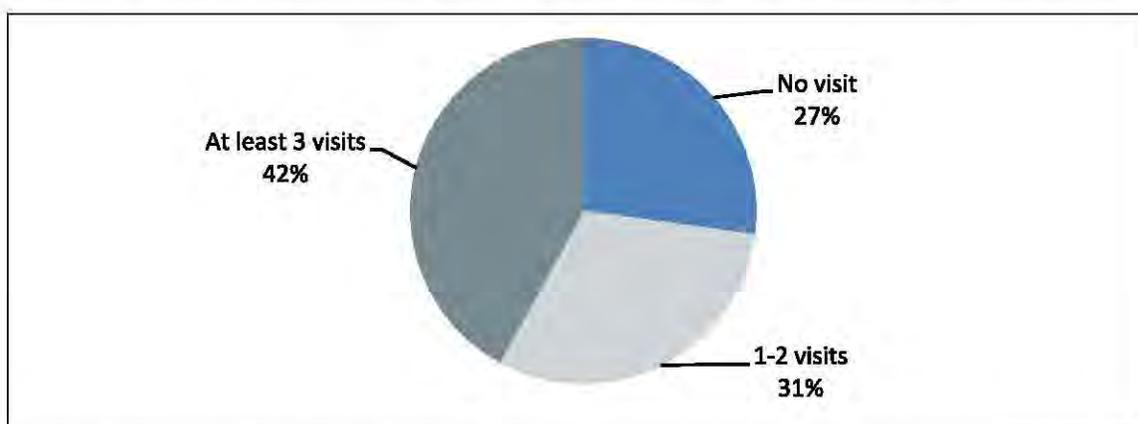
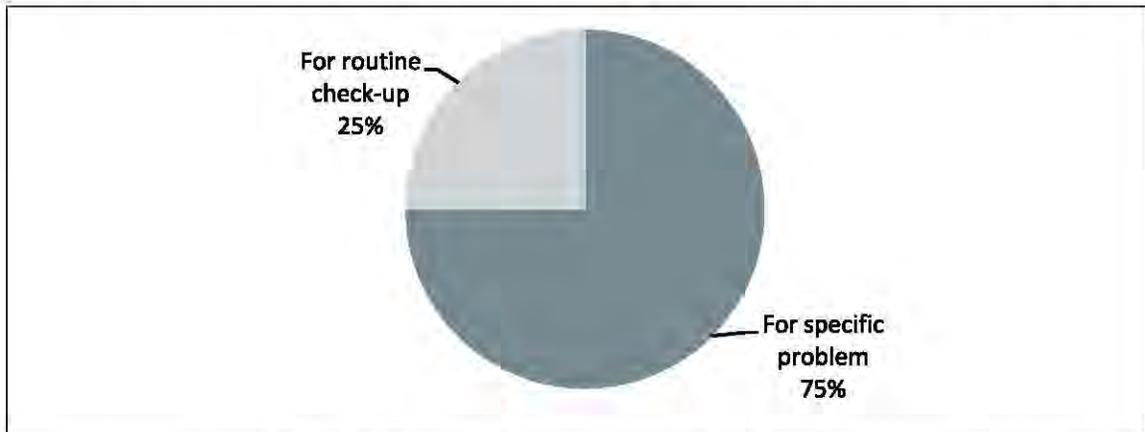


Figure 6.2 shows that many of these visits were in response to some problem, rather than for a routine check-up. Three-fourths of the first antenatal visits were for curative purposes.

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

About one-quarter of the first visits took place within the first three months of gestation, and about 42 percent of the first visits occurred during the third trimester (Figure 6.3).

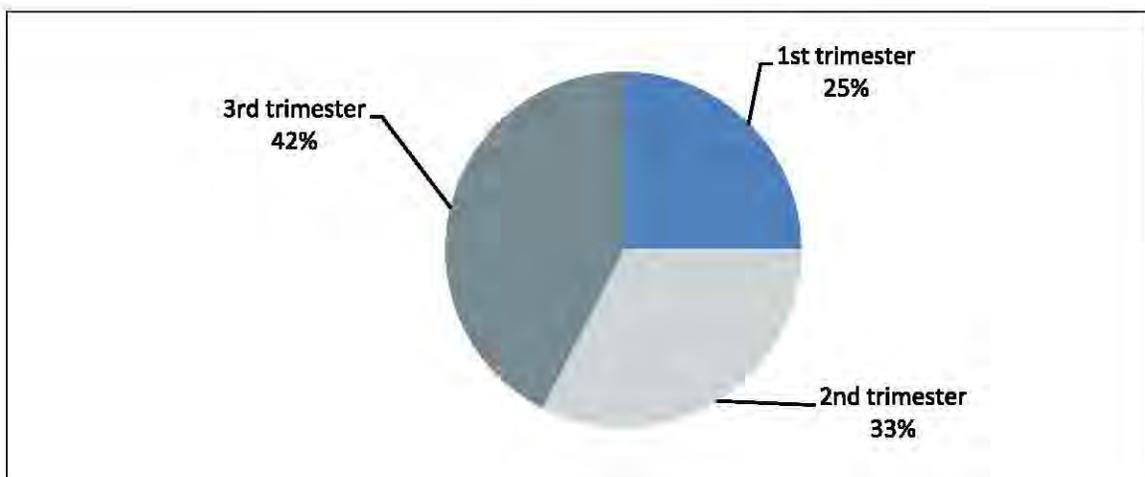
Figure 6.3: Distribution of women by gestational age at first antenatal visit during last pregnancy

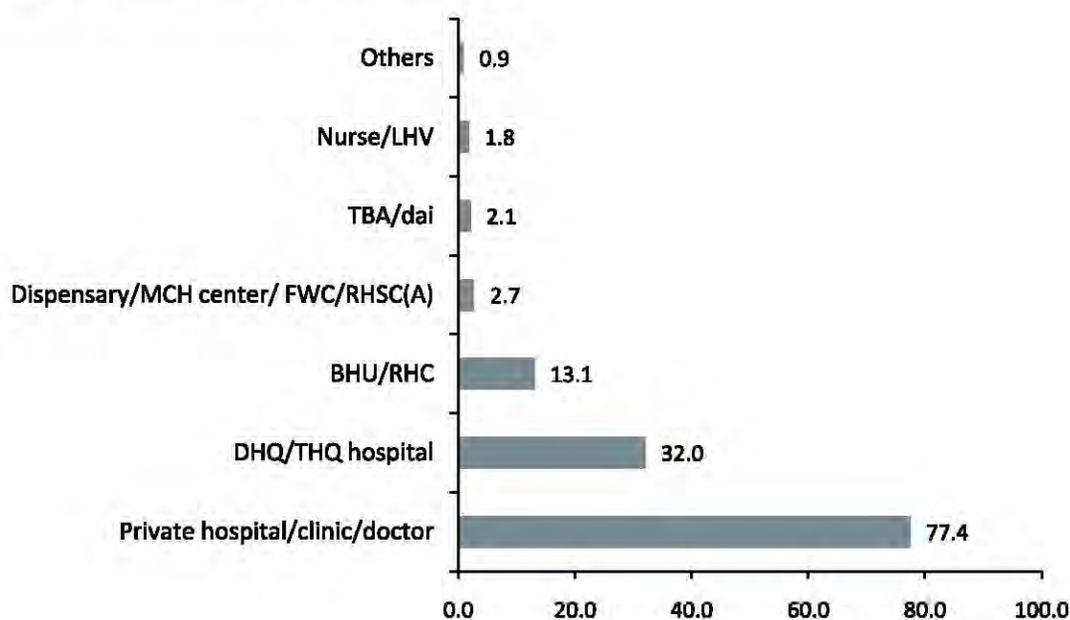
Table 6.2 and Figure 6.4 show the locations where respondents made one or more antenatal visits. Most antenatal visits took place in private sector facilities. The most common providers of antenatal care in the public sector were DHQ/THQ hospitals, followed by BHUs and RHCs; other providers were less common.

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

Facility/provider	Rural		Urban		Total	
	N	%	N	%	N	%
BHU/RHC	44	14.3	0	0.0	44	13.1
DHQ/THQ hospital	90	29.3	18	60.0	108	32.0
Private hospital/clinic/doctor	240	78.2	21	70.0	261	77.4
Dispensary/MCH center/ FWC/RHSC(A)	8	2.6	1	3.3	9	2.7
TBA/dai	7	2.3	0	0.0	7	2.1
Nurse/LHV	5	1.6	1	3.3	6	1.8
Others	3	1.0	0	0.0	3	0.9
Total	307	na	30	na	337	na

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

Figure 6.4: Facilities visited for antenatal care



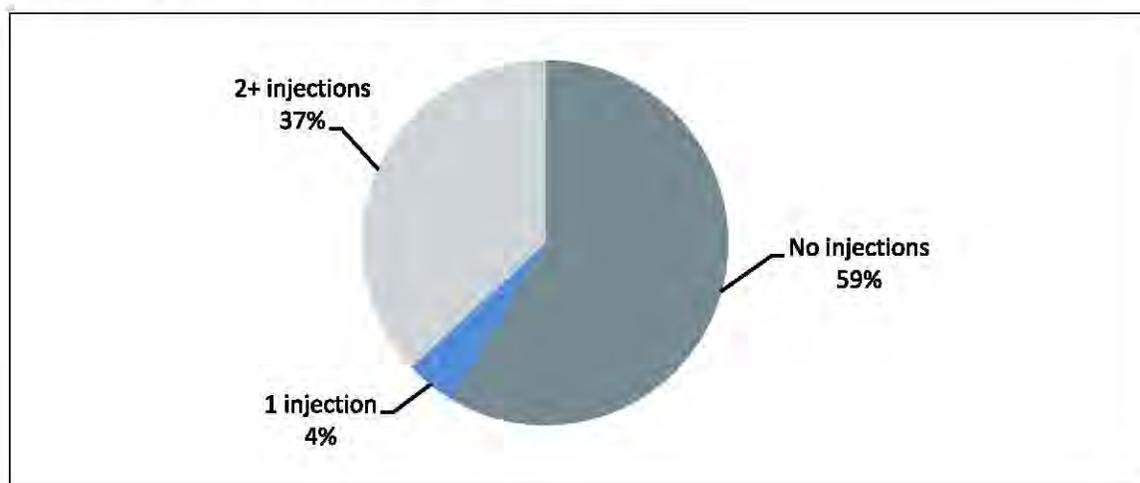
Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn or mother. Two doses in a pregnancy are sufficient to prevent tetanus. However, if a 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, 32 percent of the mothers in Thatta had received at least one TT shot. According to the PDHS 2006-07, 51 percent in Sindh and 53 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 6.3 and Figure 6.5 show that 5 percent of the mothers had received one shot during their last pregnancy, and 37 percent had received two or more shots. The immunization rate was higher in urban areas versus rural areas. Although tetanus immunization appeared to be increasing in Thatta, a substantial proportion of mothers remained 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	258	60.3	12	36.4	270	58.6
One TT shot	17	4.0	4	12.1	21	4.6
2+ TT shots	153	35.7	17	51.5	170	36.9
Total	428	100.0	33	100.0	461	100.0

Figure 6.5: Tetanus immunization at last delivery



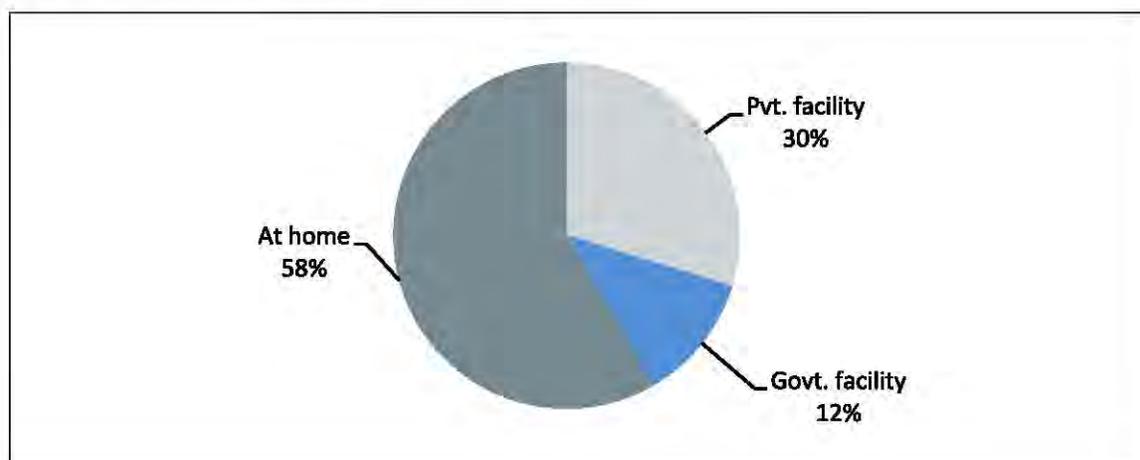
Location and Attendance at Delivery

Among the most important ways to reduce maternal mortality is to increase the proportion of mothers delivering in a health facility with the support of a trained birth attendant. Although these proportions have been historically low in Pakistan and contributed substantially to high maternal mortality, they have been rising in recent years. In Thatta, according to the 2004-05 PSLMS, 27 percent of deliveries took place in institutions, compared with PDHS 2006-07 figures of 42 percent for Sindh and 34 percent nationally (Government of Pakistan, 2006; NIPS/PDHS, 2008). In the present survey, 42 percent of the most recent deliveries were in a health facility (Table 6.4 and Figure 6.6). This percentage was higher in urban areas (61 percent) compared to rural areas (40 percent).

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

Place of last delivery	Rural		Urban		Total	
	N	%	N	%	N	%
At home	256	59.8	13	39.4	269	58.4
BHU/RHC	8	1.9	0	0.0	8	1.7
DHQ/THQ hospital	32	7.5	13	39.4	45	9.8
Pvt. hospital/clinic	127	29.7	7	21.2	134	29.1
Others	5	1.2	0	0.0	5	1.1
Total	428	100.0	33	100.0	461	100.0

Figure 6.6: Location of delivery of last baby

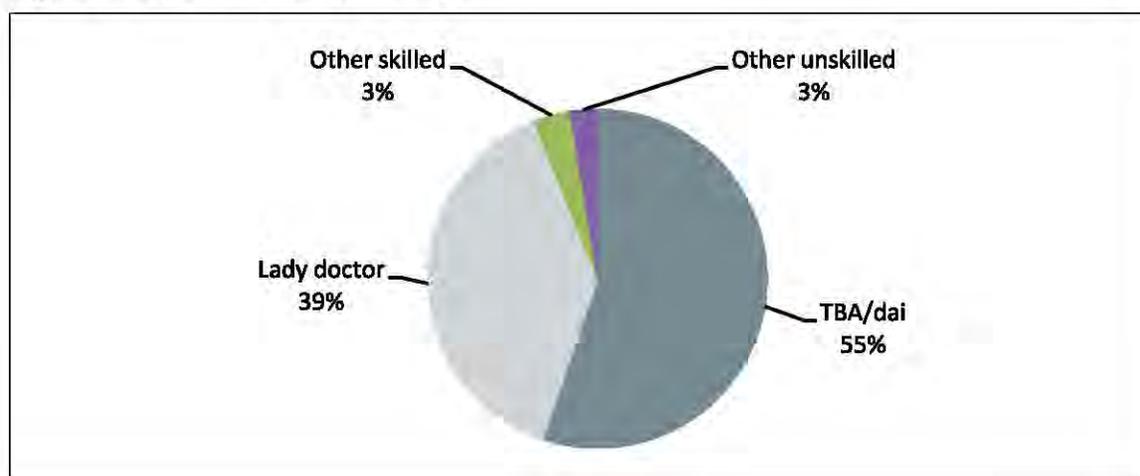


The proportions of births delivered by skilled attendants were higher than expected from previous data. In this survey, 42 percent of the reported deliveries in the previous 4 years were delivered by a skilled birth attendant, substantially higher in urban areas (Table 6.5 and Figure 6.7). In the PSLMS 2004-05 for Thatta, only 30 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. Fifty-five percent of the births were delivered by a *dai* (traditional birth attendant) or LHW, while in rural areas only 2 percent of the deliveries were conducted 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	%
TBA/dai/LHW	244	57.1	11	33.3	255	55.4
Nurse/LHV/midwife	15	3.5	1	3.0	16	3.5
Lady doctor	157	36.8	21	63.6	178	38.7
Female relative/friend/neighbor (not dai)	9	2.1	0	0.0	9	2.0
Others	2	0.5	0	0.0	2	0.4
Total	427	100.0	33	100.0	460	100.0
Skilled birth attendant	172	40.3	22	66.7	194	42.2
Unskilled birth attendant	255	59.7	11	33.3	266	57.8

Figure 6.7: Attendant at last delivery



Postpartum Care

For both the health of the mother and the health of the newborn, a newly delivered mother and baby should be followed up for at least 6 weeks after delivery; MoH guidelines recommend at least one postnatal visit after discharge during the first 42 days after delivery. However, this is a major weakness of MNH care in Pakistan. Women who deliver at home rarely go for any postnatal check-up, and women who deliver in facilities are usually seen while they are in the facility, but not after that. All those respondents who had institutional deliveries had a postpartum check-up within 24 hours. Of the mothers who had non-institutional deliveries, only 3 percent (9 out of 221) had a postnatal check-up within 24 hours, 15 percent (42) had a postnatal check up after 24 hours and 81 percent did not have a postnatal check-up at all (Table 6.6). These findings should be investigated. At face value, this represents very poor care at the facilities, although possibly some respondents did not know what a postnatal check-up was, and may have actually received such care without knowing it.

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 how it might assist in postponing the next pregnancy or in ending childbearing (WHO, 2006).

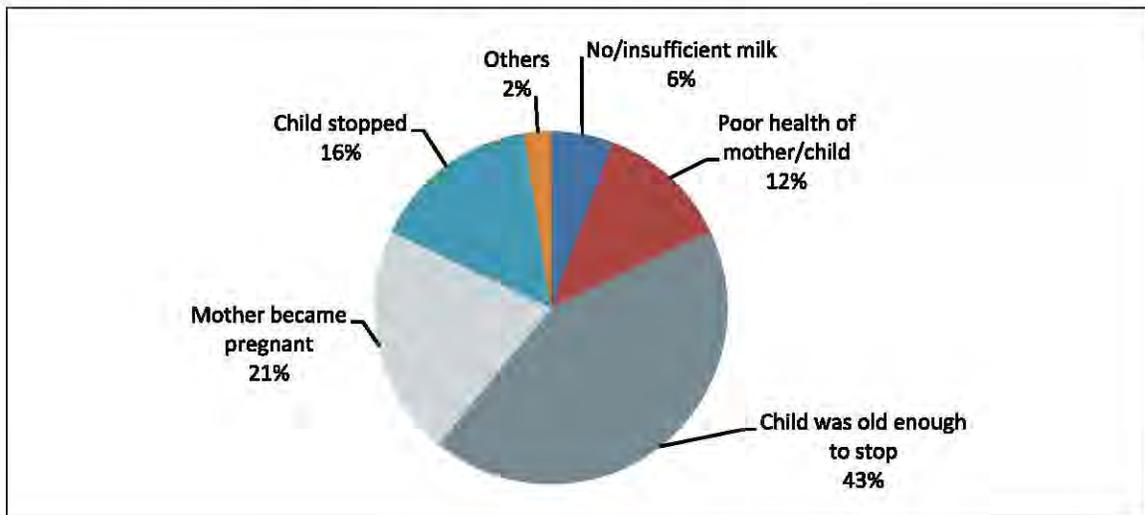
Table 6.6: Distribution of mothers by status of postnatal check-up and place of delivery

Place of delivery	PNC check-up within 24 hours		PNC check-up after 24 hours		Didn't have PNC check-up		Total	
	N	%	N	%	N	%	N	%
Institution	189	100.0	0	0.0	0	0.0	189	100.0
Non-institution	9	3.3	42	15.4	221	81.3	272	100.0
Total	198	43.0	42	9.1	221	47.9	461	100.0

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. Four main reasons were given for discontinuing breastfeeding: child was old enough (43 percent); mother became pregnant (21 percent); child stopped (16 percent); poor health of mother or child (12 percent) (Figure 6.8).

Figure 6.8: Reasons for discontinuing breastfeeding (n=123)



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

The median "ideal" number, in the sense indicated below, was four children; about 55 percent of the respondents wanted four or fewer children, with substantial numbers citing four. However, only 13 percent said they wanted three or fewer children. About 80 percent of the rural women wanted four or more children, whereas 69 percent of the urban women also had the same desire. Overall in Thatta, more than 8 percent of the women also gave non-numeric responses to this 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	3	0.5	0	0.0	3	0.5
2	45	7.7	4	6.9	49	7.6
3	23	3.9	7	12.1	30	4.7
4	247	42.1	25	43.1	272	42.2
5	67	11.4	3	5.2	70	10.9
6 +	153	26.1	12	20.7	165	25.6
Other non-numeric responses	9	1.5	2	3.4	11	1.7
Up to God	38	6.5	5	8.6	43	6.7
Do not know	2	0.3	0	0.0	2	0.3
Total	587	100.0	58	100.0	643	100.0
Median	4	na	4	na	4	na

na=not applicable.

Desire for More Children

Levels of Desire for More Children

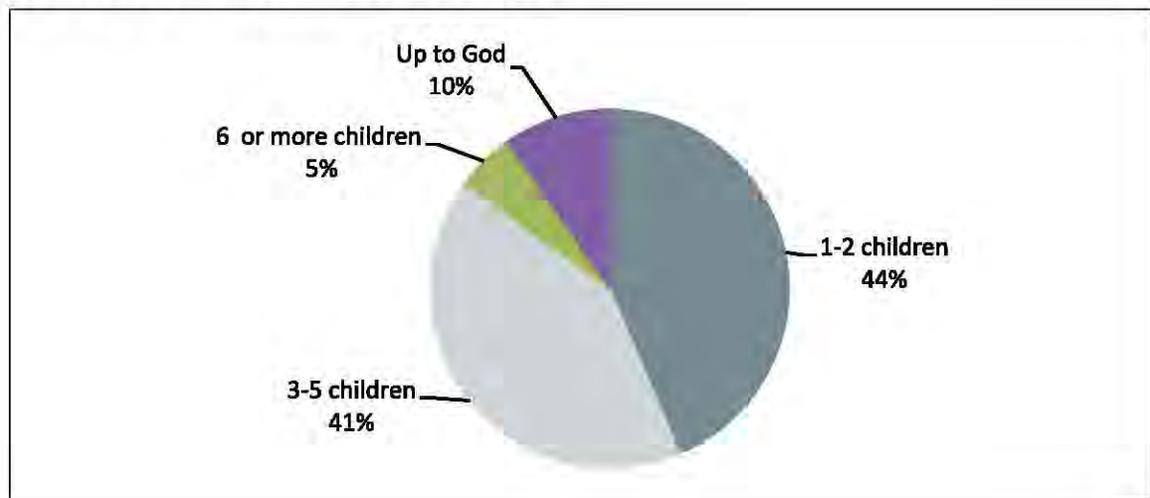
A more immediate measure of fertility preference is whether a couple wants more children; if so, do they want the next one now or later, and how many more do they want. The desire for future children is closely linked to the number of children a couple already has. Table 7.2 shows that whether respondents wanted more children soon, later (after 2 years or more) or not at all, this was based on the number of living children they already had. About 45 percent of the women did not want more children than they then had. The proportion of the women wanting more children soon, declined sharply after the first birth. About 37 percent of the women wanted more children soon and 19 percent of the women wanted more children later. A higher proportion of respondents who had 3 and more living children, did not want to have more 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	89.8	9.2	1.0	98	100.0
1	58.7	32.1	9.2	109	100.0
2	43.2	32.6	24.2	95	100.0
3	27.6	31.6	40.8	76	100.0
4	19.2	17.9	62.8	78	100.0
5	10.3	11.8	77.9	68	100.0
6+	4.3	2.9	92.8	138	100.0
Total	36.6	18.9	44.6	662	100.0
N	242	125	195	662	100.0

For those women who wanted more children, we also asked how many more they wanted. As shown in Figure 7.1, about 44 percent of all respondents who wanted to have more children wanted one or two children. Almost 10 percent of women said that it was up to God. It would be useful to explore what such respondents mean, i.e., whether this is a religious statement, an indication that the woman 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: Women’s desire for more children



Socioeconomic Correlates of Desire for Children

A woman's stated desire for more children was analyzed in relation to four possible socioeconomic determinants: standard of living index (SLI), respondent's age, literacy and residence. Table 7.3 shows that the relationship between SLI and desire for more children was weak and inconsistent. The age of the women was strongly associated with the desire for next child. Literate women were more likely to want the next child at a later time (29 percent) compared to the illiterate women (18 percent). On the other hand, illiterate women were more likely not to have more children (46 percent) compared to the literate women (31 percent). Rural residents were more likely to want more children soon compared to urban dwellers.

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

Characteristic	Desire for next child			Total	
	Soon	Later	Never	N	%
Standard of living index					
Low	37.9	16.7	45.4	401	100.0
Medium low	37.2	20.9	41.9	129	100.0
Medium high	32.6	24.4	43.0	86	100.0
High	30.4	21.7	47.8	46	100.0
Age of woman					
<25	56.7	31.9	11.4	210	100.0
25 or more	27.2	12.8	60.0	452	100.0
Literacy					
Literate	39.2	29.4	31.4	51	100.0
Illiterate	36.7	17.5	45.8	605	100.0
Residence					
Rural	37.5	19.1	43.4	603	100.0
Urban	27.1	16.9	55.9	59	100.0
Total	36.6	18.9	44.6	662	100.0

Son Preference

In Pakistan, there is usually a preference for sons over daughters. The belief that a family is incomplete without sons is stronger than the corresponding belief for daughters. In this questionnaire, respondents were asked how many daughters they would have before stopping if they did not have a son, and correspondingly for sons if they did not have a daughter. Son preference came out most strongly with a substantial number saying that there would be no limit: about 65 percent of women said there would be no limit to the number of daughters before having a son, while 55 percent said there was no limit to sons before having a daughter. For those women who gave a number, in both cases the median was 3 children (Table 7.4).

Table 7.4: Son and daughter preferences by the responses

Response	Number of daughters for the desire of a son		Number of sons for the desire of a daughter	
	N	%	N	%
Up to God	6	0.9	6	0.9
No limit	427	64.5	364	55.0
Other non-numeric responses	3	0.5	5	0.8
Numeric responses	226	34.1	287	43.4
Total	662	100.0	662	100.0
Median*	3	na	3	na

*Of the numeric response. na=not applicable.

Strength of Preference

The strength of preferences asked in such surveys can be questioned. The need for birth spacing can be presumed to be greater if a couple is strongly motivated not to have more children, or to delay the next pregnancy, than if this does not matter much to them. We asked respondents whether, if they became pregnant soon, would they be pleased, worried, accept it, or if it would not matter. Results are shown in Tables 7.5 and 7.6. (This question excludes those 411, of the total 666 women, who wanted the next child soon, were currently pregnant, were sterile, had gone through menopause or had a hysterectomy.)

Among those who did not want more children at all, more than three-fourths (78 percent) said that they would be worried if they became pregnant. More than 15 percent reported that they would accept the new pregnancy, while only 5 percent, said they would be

pleased. Among those women who wanted to delay their next pregnancy for more than 2 years, more than half would be worried, while a quarter said they would be pleased, which 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.

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 problems most commonly faced by those who did not want more children at all were the family's economic situation and their own health, while the least commonly faced issue was the schooling of children. Health of the youngest child and caring of children were commonly cited factors by those who wanted to delay the next child.

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

Reaction if pregnant	Desire for next child		Total	
	Later	Never	%	N
Pleased	25.0	4.6	11	28
Worried	51.3	77.7	69.4	177
Accept it	17.5	15.4	16.1	41
Doesn't matter	6.3	1.1	2.7	7
Other	0	1.1	0.8	2
Total	100.0	100.0	100.0	255
N	80	175	100.0	255

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

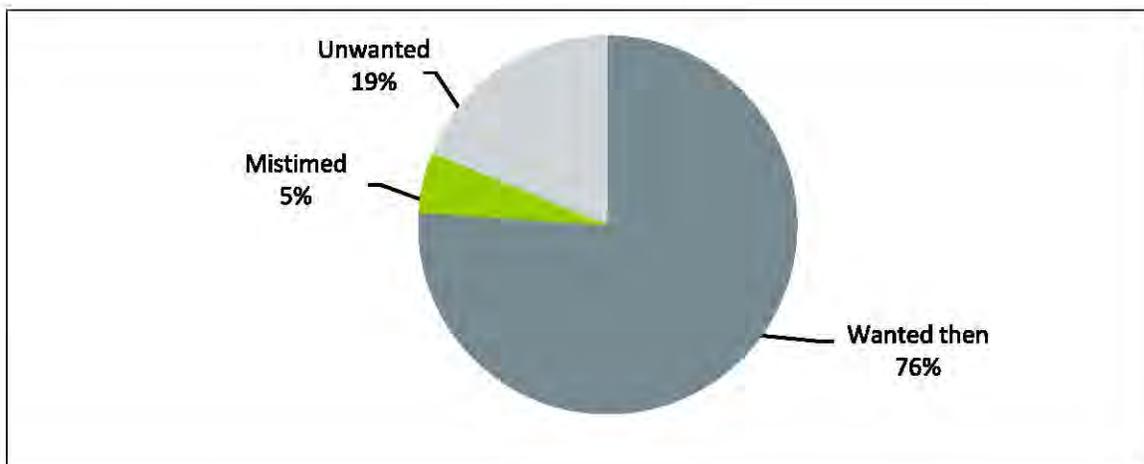
Problem faced if pregnant	Desire for next child		Total	
	Later	Never	%	N
Own health	72.5	90.9	85.1	217
Health of youngest child	81.3	81.1	81.2	207
Caring of children	76.3	84.6	82.0	209
Schooling of children	36.7	63.2	54.9	139
Family economic situation	71.3	93.1	86.3	220
Other	2.5	3.4	3.1	8
N	80	175	255	255

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

Attitude toward Last Pregnancy

Another important dimension of fertility preference relates to whether the last pregnancy was wanted at the time, was mistimed (i.e., wanted later), or was not wanted at all. Pregnancies that are unwanted cause hardship in many ways, and represent a failure to realize a couple's right to have the number of children they want, at the time they 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 more likely to report that their last pregnancy was wanted (76 percent), whereas it was reported to be an unwanted pregnancy by 19 percent of the women and mistimed by 5 percent (Figure 7.2).

Figure 7.2: Attitudes of women toward their last pregnancy



Women's Perception of Fertility Preference of Husbands

Women were asked whether they thought their husbands wanted the same number of children as they did. In Table 7.7, their responses are tabulated according to the woman's ideal family size. About 11 percent of the women did not know their husband's preference, while half of the respondents thought their husbands wanted the same number of children as they did. However, 35 percent thought their husbands wanted more children than they

did, while only 4 percent thought their husbands want fewer children. These proportions did not vary systematically according to the woman's ideal family size.

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

Ideal family size of women	Perceived husband's desire for more children				Total	
	Same number	More children	Fewer children	Don't know	%	N
1-2 child	42.3	48.1	0.0	9.6	100.0	52
3-4 children	59.6	30.1	1.7	8.6	100.0	302
5 or more children	48.5	34.9	6.0	10.6	100.0	235
Other non-numeric responses	0.0	36.4	9.1	54.5	100.0	11
Up to God	18.6	58.1	7.0	16.3	100.0	43
Do not know	0.0	50.0	0.0	50.0	100.0	2
Total	50.2	35.3	3.6	10.9	100.0	645
N	324	228	23	70	100.0	645

Chapter 8

Contraceptive Knowledge and Use

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

Knowledge

For many years, at least 95 percent of the 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 Thatta; virtually all women knew of at least one method. A majority of the respondents knew of the most commonly used program methods such as female sterilization (98 percent), injectables (97 percent), pills (95 percent), IUDs (79 percent), condoms (65 percent) and Norplant (45 percent). Except for condoms, modern contraceptive methods were known by a higher proportion of the women in Thatta than in the national PDHS 2006-07. Conversely, more women in the PDHS knew of the condom, rhythm ("safe period") and withdrawal methods (NIPS/PDHS, 2008). Data shows that urban women had better knowledge about contraceptives compared to rural respondents.

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

Method	Rural	Urban	Total
Female sterilization	97.7	100.0	97.9
Male sterilization	26.0	52.5	28.4
Pill	94.7	100.0	95.2
IUD	77.9	91.5	79.1
Injectables	96.5	98.3	96.7
Norplant	42.4	69.5	44.8
Condom	63.0	89.8	65.4
Rhythm	29.0	45.8	30.5
Withdrawal	46.7	62.1	48.0
Emergency pills	7.6	25.4	9.2
At least one method	99.8	100.0	99.8
At least one modern method	99.8	100.0	99.8
At least one traditional method	51.6	62.7	52.6
N	607	59	666

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 years old) 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 were further divided into current users and past users. These categories are in standard use in Pakistan and internationally.

Of all the married women interviewed in our sample, 30 percent reported having used some method of contraception during their married lives (Table 8.2). This was substantially lower for rural women (28 percent) compared to urban women (53 percent). It was also lower than the proportion obtained in the PDHS 2006-07 for Pakistan as a whole (48.7 percent) (NIPS/PDHS, 2008).

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

Method	Ever users				Current users				Past users			
	Rural	Urban	Total	N	Rural	Urban	Total	N	Rural	Urban	Total	N
Pill	7.7	11.9	8.1	54	2.5	3.4	2.6	17	4.8	8.5	5.1	34
IUD	1.0	1.7	1.1	7	0.5	0.0	0.5	3	0.3	1.7	0.5	3
Injectable	10.4	23.7	11.6	77	3.1	5.1	3.3	22	6.8	18.6	7.8	52
Norplant	0.3	0.0	0.3	2	0.2	0.0	0.2	1	0.2	0.0	0.2	1
Condom	3.3	11.9	4.1	27	1.8	6.8	2.3	15	1.2	5.1	1.5	10
Rhythm method	2.6	5.1	2.9	19	0.3	3.4	0.6	4	1.8	1.7	1.8	12
Withdrawal	4.1	6.8	4.4	29	1.3	0.0	1.2	8	2.3	6.8	2.7	18
Female sterilization	9.9	15.3	10.4	69	9.9	15.3	10.4	69	0.0	0.0	0.0	0
Other FP method	0.3	0.0	0.3	2	0.0	0.0	0.0	0	0.3	0.0	0.3	2
Any method	27.8	52.5	30.0	200	19.6	33.9	20.9	139	8.2	18.6	9.2	61
Any modern method	25.0	47.5	27.0	180	18.0	30.5	19.1	127	6.8	16.9	7.7	51
Any traditional FP method	5.3	10.2	5.7	38	1.6	3.4	1.8	12	3.0	6.8	3.3	22
N	607	59	666	666	607	59	666	666	607	59	666	666

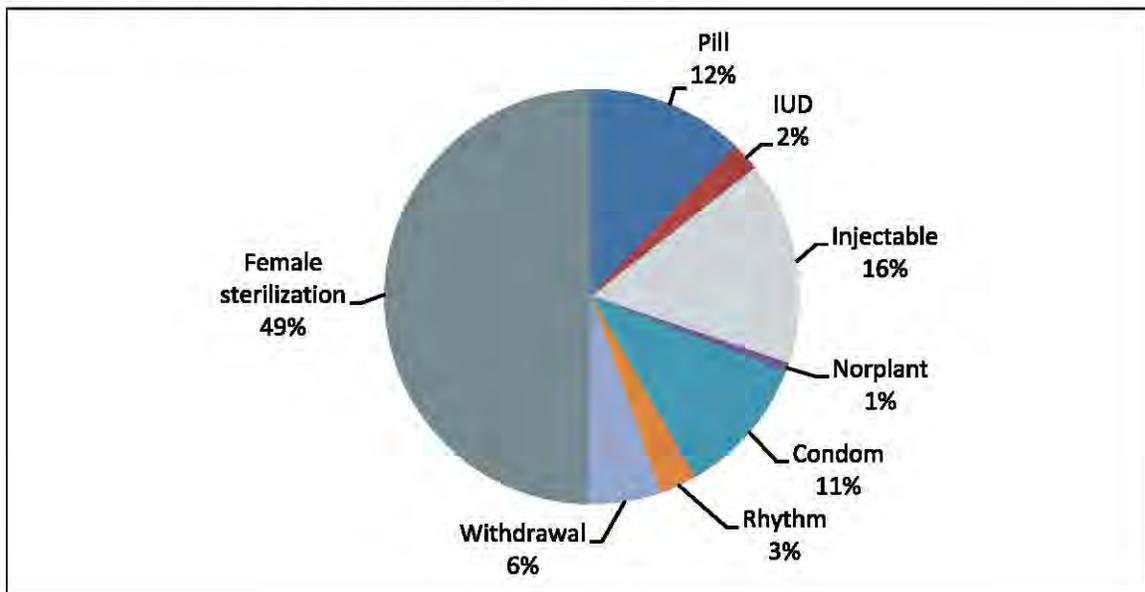
The proportion of currently married women of reproductive age who are currently using some form of contraception, commonly known as the contraceptive prevalence rate (CPR) is one of the central indicators of the status of family planning programs. It shows the degree to which couples are actively involved in spacing or limiting births, and the proportions by method (the method mix) indicates the means couples are using to do this. Historically, the program in Pakistan has been characterized 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). A total of 21 percent of all married women in the sample area of Thatta were currently using some contraceptive method, 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 Thatta, the CPR was 34 percent compared to 20 percent in rural Thatta.

An analysis of data for ever use of any modern method excluding female sterilization showed that injectables (12 percent), pills (8 percent), condom (4 percent) and IUD (1 percent) were the most used methods. Traditional methods such as rhythm and withdrawal were used by 6 percent as compared to 27 percent who used modern methods. Condoms were used in urban areas more than in rural areas. For other modern methods, similar

patterns were observed in both urban and rural areas. The use of traditional methods was also higher in urban areas than rural areas.

The current methods most commonly used were female sterilization, injectables, pills and condom. Table 8.2 reflects that female sterilization had been used by 10 percent of the women. Conversely, the use of IUDs at 0.5 percent was substantially lower than the figures in national data (2.3 percent IUD users) (NIPS/PDHS, 2008). Overall, 19 percent of married women were using modern methods, while 2 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.

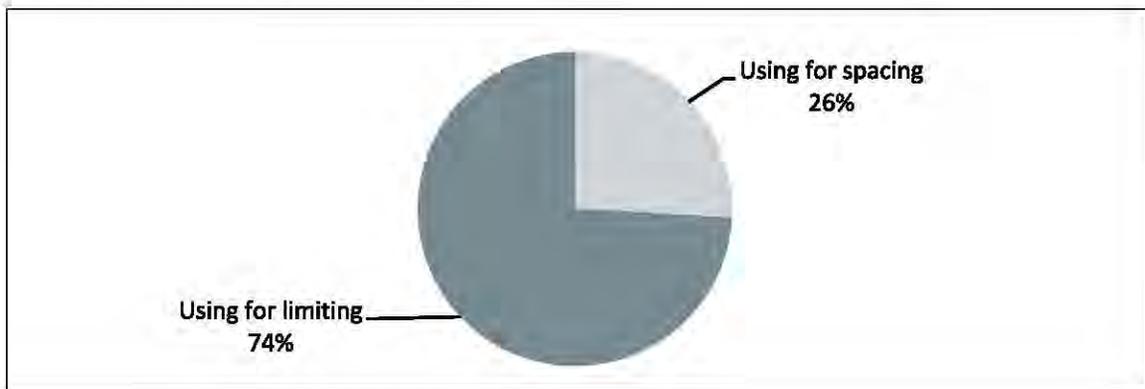
Figure 8.1: Proportion of current users by method mix



Current Use and Desire for Children

For current users of contraception, it is important to determine how many women were using family planning methods for spacing purposes, and how many wanted to stop having children altogether. Overall, 74 percent of current use was for limiting purposes, compared to 26 percent for spacing (Figure 8.2).

Figure 8.2: Current use and desire for children



Correlates of Contraceptive Use

Figures 8.3 and 8.4 show the relationship between contraceptive prevalence and the women’s age and number of living children. The shape of the graph for age is similar to that seen in other Pakistani and international studies, with low prevalence among both younger (15-29 years) and older women (45-49 years) and higher prevalence in between.

Prevalence by number of living children increased with the number of children. It was highest among the women with more than five children. This is consistent with a high proportion of current use to unmet need for these women (from Chapter 11) and low age-specific fertility rates among women at older ages (from Chapter 5).

Figure 8.3: Contraceptive prevalence by woman’s age

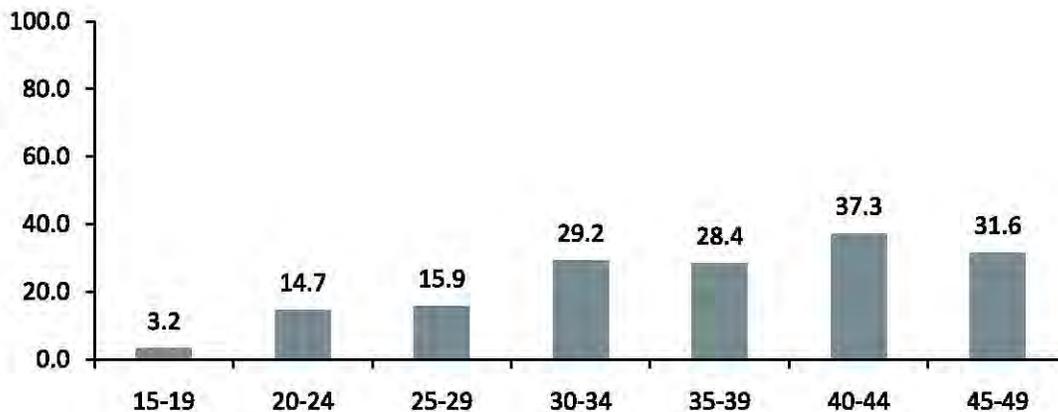
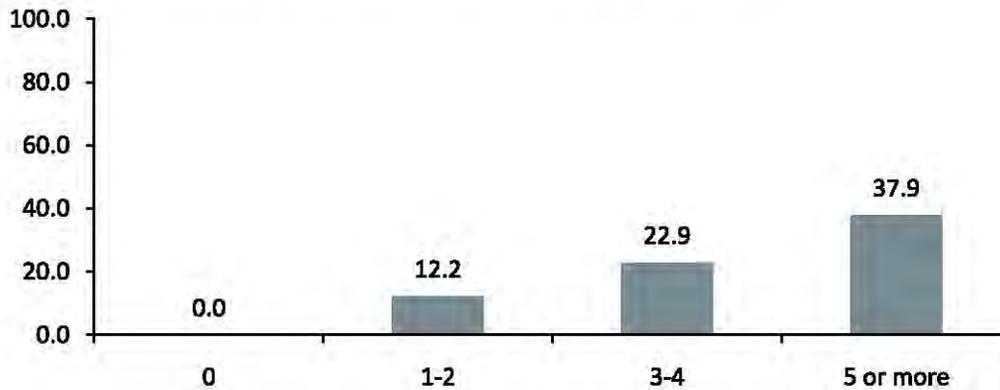


Figure 8.4: Contraceptive prevalence by number of living children



Contraceptive use is associated with higher socioeconomic status and urban residence, as shown in (Table 8.3). Respondents in households with the highest SLI had substantially higher contraceptive prevalence (59 percent) than those with the lowest SLI (13 percent). Conversely, women from households with low SLI were more likely to be never users. Similarly, respondents' literacy was associated with higher current use and lower never use.

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	13.1	7.4	79.5	405	100.0
Medium low	24.8	10.9	64.3	129	100.0
Medium high	31.4	15.1	53.5	86	100.0
High	58.7	8.7	32.6	46	100.0
Ownership of television					
Yes	39.3	11.3	49.4	168	100.0
No	14.7	8.4	76.9	498	100.0
Literacy of respondent					
Literate	33.3	13.7	52.9	51	100.0
Illiterate	19.9	8.7	71.4	609	100.0
Residence					
Rural	19.6	8.2	72.2	607	100.0
Urban	33.9	18.6	47.5	59	100.0
Total	20.9	9.2	70.0	666	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 that current and past users combined (i.e., ever users) last time obtained their contraceptive method.

From this table, it is clear that the source depended on the method. Pills and condoms were usually obtained from pharmacy/chemists the Lady Health Worker, or by the husband; IUDs were inserted at private facilities; and injectables were obtained from the DHQ/THQ hospitals, BHUs/RHCs/MCH centers or private clinics or (recently) from the LHWs. Female sterilization was carried out at government hospitals (DHQ/THQ) and private hospitals. These statements hold true for both current and past users.

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

Source	Pill	IUD	Injectables	Norplant	Condom	Female sterilization	N
Govt. hospital (DHQ/THQ)	3.8	0.0	23.2	100.0	5.6	82.4	72
BHU/RHC/MCH center	3.8	0.0	17.9	0.0	0.0	1.5	12
FWC	0.0	0.0	3.6	0.0	0.0	0.0	2
LHW	15.4	0.0	3.6	0.0	11.1	0.0	8
Pvt. doctor	11.5	33.3	21.4	0.0	0.0	2.9	18
Pvt. hospital/clinic	0.0	66.7	12.5	0.0	0.0	13.2	18
Dispenser/compounder	0.0	0.0	5.4	0.0	0.0	0.0	3
Pharmacy/chemists	38.5	0.0	12.5	0.0	16.7	0.0	20
Husband brings method	26.9	0.0	0.0	0.0	66.7	0.0	19
Total	100.0	100.0	100.0	100.0	100.0	100.0	172

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 method is right for everyone. Upon examining the experience of those who have used contraceptive methods, both currently and in the past, we can gain insights into the problems users face and how to solve them. We asked a series of questions regarding the experience of current and past users. For past users who had used more than one method, we asked about their most recent method.

Reasons for Method Choice

In the survey, current and past users were asked the reasons they chose a particular method. A list of possible reasons was read out to them and the results are shown in Table 9.1. The table shows the reasons for choosing each method of contraception. 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, no or few side effects, easy availability, suitability for respondent and husband, low cost, and provider advised. For IUD and female sterilization users, suitability of use for a long period was often cited. Cited less frequently were no other method available and method always available. Clients tended to make decisions according to the known attributes of the various methods, but not always. For example, about 74 percent of pill users cited lack of side effects, even though pills are 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	
Easily available	96.3	100.0	87.5	94.4	0.0	34.8	119
Low cost	85.2	33.3	53.6	83.3	0.0	62.3	112
Convenient to use	85.2	100.0	82.1	94.4	75.0	55.1	139
Suitable for woman/husband	51.9	100.0	35.7	100.0	100.0	68.1	118
No/fewer side effects	74.1	66.7	53.6	88.9	43.8	65.2	120
Can be used for long period	18.5	100.0	48.2	27.8	6.3	87.0	101
No other method available	11.1	0.0	14.3	5.6	0.0	2.9	14
Method always available	51.9	33.3	25.0	50.0	0.0	10.1	45
Provider advised	63.0	100.0	67.9	44.4	6.3	72.5	117
Others	7.4	0.0	8.9	16.7	12.5	15.9	23
N	27	3	56	18	16	69	189

Respondents could give more than one reason.

To look more specifically at why some users preferred traditional methods to modern ones, 12 current traditional method users were asked whether they were not using modern methods for a number of possible reasons. Side effects were by far the main issue: 92 percent of the current traditional method users reported their own experience of side effects. Husband's disapproval (of the modern methods) was cited by 75 percent of the users, with other reasons; method not available, cost not affordable and lack of knowledge cited by 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	91.7
Husband disapproves	75.0
Experienced side effects	91.7
Method not available	16.7
Cost too much	27.3
Doesn't know about modern methods or their source	33.3
N	12

Respondents could give more than one reason.

Cost, Distance and Time to Reach a Facility

Costs to users of contraceptive methods vary widely in Pakistan, according to the method, whether it is available in the public or private sector, and the distance from the home to the facility. Table 9.3 and Figure 9.1A show reported costs for current users the last time they obtained the method. Forty-seven percent of the clients were not charged for their contraceptives, including all female sterilization users (who are, in fact, typically reimbursed for expenses involved) and 18 percent of pills users who were also not charged. About 31 percent of the respondents paid more than 50 rupees. IUD and injectable users often paid more than 50 rupees for their method. On average the paid amount for an IUD was Rs. 400 and for injectables it was Rs. 80. The IUD, in particular, entails a one-time cost, so the monthly cost may be quite low.

Table 9.3 Distribution of costs for specific current contraceptive methods

Method	Cost of contraceptive (in rupees)				Total	
	No payment	1-20	21-50	51+	%	N
Pill	17.6	64.7	0.0	17.6	100.0	17
IUD	0.0	0.0	0.0	100.0	100.0	3
Injectables	9.1	31.8	9.1	50.0	100.0	22
Condom	13.3	46.7	6.7	33.3	100.0	15
Female sterilization	75.4	0.0	0.0	24.6	100.0	69
Total	47.2	19.7	2.4	30.7	100.0	126

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

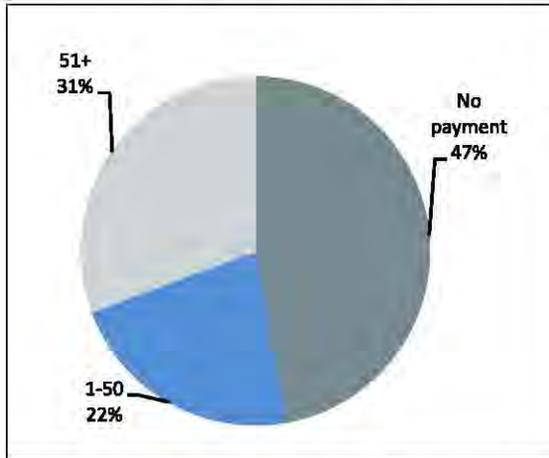
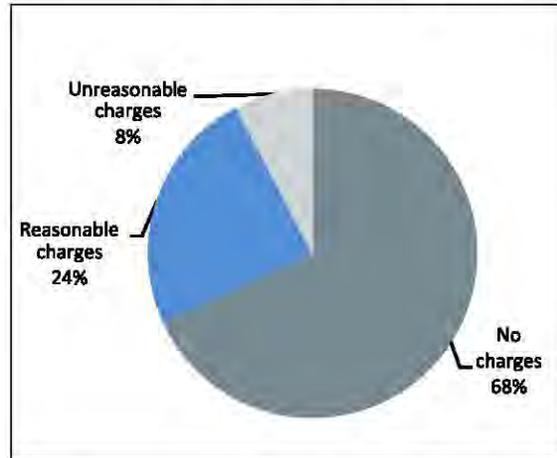


Figure 9.1B: Attitude toward service charges for current method other than contraceptive

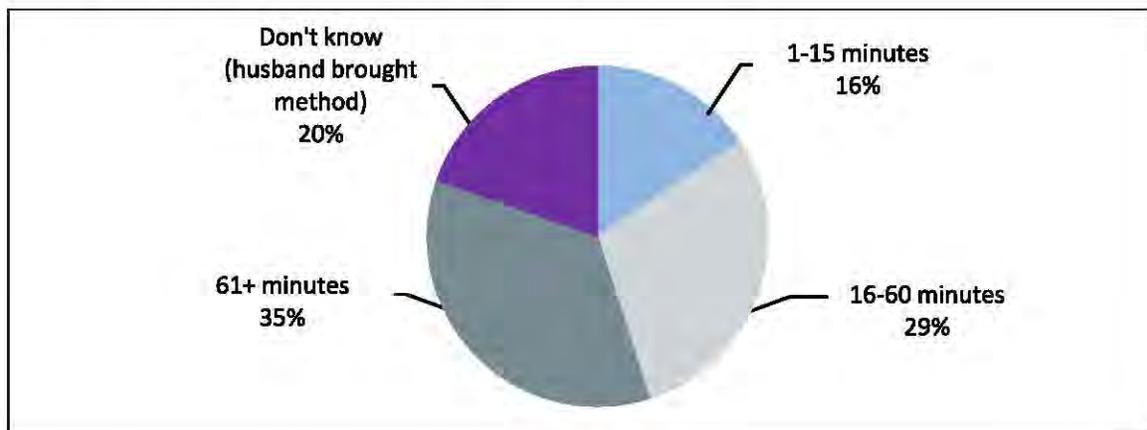


Current users were also asked whether their facility charged them for services, other than the method itself. Sixty-eight percent denied any demand, another 24 percent reported that the cost for service was reasonable, whereas 8 percent were not satisfied with the service charges (Figure 9.1B).

The time usually required 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 method. About 16 percent of users needed no more than 15 minutes to obtain their method; this included those obtained from LHWs, who often brought injectables, pills, and condoms to the doorstep. For another 11 percent it took up to 30 minutes to obtain their contraceptive, for 19 percent it took between 30 to 60 minutes, and for 20 percent their husband brought the supply, so they did not know how long it took. For slightly more than one-third of the women (35 percent), particularly female sterilization, Norplant and IUD users, it took more than an hour to reach the service facility, but in these cases, there was usually no need to visit frequently.

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

Method	Time (in minutes)					Total	
	1-15	16-30	31-60	61-180	Don't know (husband brought method)	%	N
Pill	29.4	0.0	23.5	5.9	41.2	100.0	17
IUD	0.0	0.0	0.0	33.3	66.7	100.0	3
Injectables	33.3	14.3	38.1	14.3	0.0	100.0	21
Norplant	0.0	0.0	0.0	100.0	0.0	100.0	1
Condom	26.7	13.3	0.0	0.0	60.0	100.0	15
Female sterilization	4.6	12.3	16.9	56.9	9.2	100.0	65
Total	15.6	10.7	18.9	35.2	19.7	100.0	122

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

Treatment by Provider

Information Provided

Current and past users were asked, what information the service provider might have given them. For this purpose, a list of important topics was read out to them (Table 9.5). The accuracy of client responses may be questioned due to problems of recall or understanding. The most common topics respondents said they were told about were effectiveness/duration, how to use the method and how it works. Some were told about the

possibility of switching, or about other methods they could use. A few were told about side effects or what to do about them, or about contraindications. 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 to providers that they give comprehensible information on the method selected by the clients, especially hormonal contraceptives.

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

Information provided at acceptance	Family planning methods						Total	
	Pill	IUD	Injectables	Norplant	Condom	Female sterilization	%	N
How the method works	40.7	100.0	71.4	100.0	22.2	76.8	64.4	112
How to use the method	66.7	100.0	60.7	100.0	27.8	49.3	54.6	95
Contraindications	40.7	66.7	23.2	0.0	0.0	42.0	31.6	55
Effectiveness	59.3	100.0	89.3	100.0	11.1	87.0	75.9	132
Advantages	22.2	100.0	35.7	100.0	5.6	52.2	38.5	67
Possible side effects	25.9	100.0	32.1	100.0	5.6	42.0	33.9	59
What to do if experienced side effects	25.9	100.0	32.1	100.0	11.1	44.9	35.6	62
Possibility of switching	11.1	33.3	26.8	100.0	5.6	5.8	14.4	25
About other methods of FP you could use	29.6	100.0	25.0	100.0	11.1	10.1	20.1	35
N	27	3	56	1	18	69	174	174

Respondents could give more than one response.

Treatment at Facility

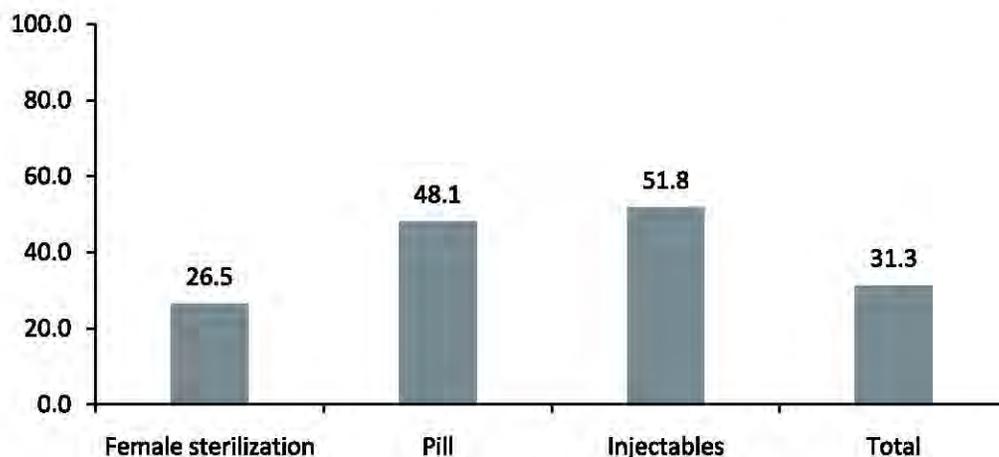
Current users were asked about various aspects of their treatment when they last time visited a provider for family planning. As Table 9.6 shows, responses were mainly positive, but with some exceptions. Ninety-two percent of the respondents were satisfied with the attitude of the staff. Three percent of the respondents said that the provider was not available when they went; another 4 percent said they were not examined properly. Seventy-five percent said that the provider could deal with side effects. Sixty-six percent of the respondents reported that they were not charged for the services provided.

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

Aspect of treatment	Percentage
Staffs attitude cooperative	92.1
Provider available	96.8
Attend/examine properly	95.8
Doesn't demand charges for services	66.0
Can deal with side effects	74.7

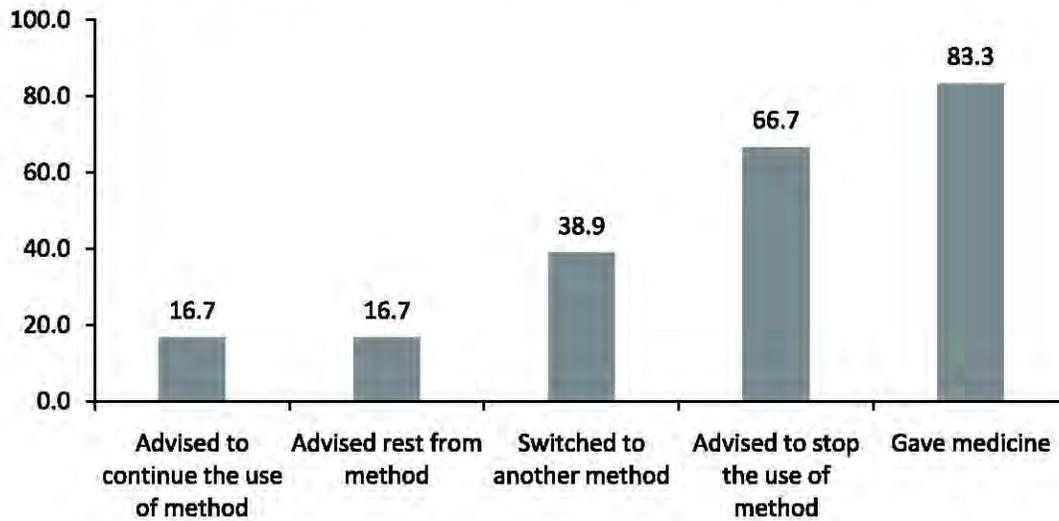
Side Effects

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. If so, a list of possible side effects was read out to them, and they were asked if they had experienced them; multiple responses were allowed. Sixty-nine percent of the ever users did not experience any side effects. The most commonly reported side effects were associated with injectables, pill and female sterilization users (52 percent, 48 percent and 27 percent respectively), and no side effect was reported by condom, IUD and Norplant users (Figure 9.3). Those who reported side effects when asked to respond to a list of possibilities, tended to report a variety of side effects, including many not associated with the method, regardless of the method used.

Figure 9.3: Ever users who experienced side effects by method used

Of the 36 past users who reported experiencing side effects, 18 said they had consulted someone for the management of these side effects, of these 15 had consulted doctor. These respondents were asked if the provider had suggested any advice out of a list of possible responses. Seventeen percent were advised to continue using, another 17 percent to rest from the method, 39 percent to switch to another method, 67 percent to stop, and 83 percent were given medication (Figure 9.4).

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



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

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

Hindrancel	Use of family planning					
	Current user		Past user		Never user	
	N	%	N	%	N	%
Husband's disapproval	122	88.4	50	82.0	431	92.7
Other people may find out about contraceptive use	95	68.8	37	60.7	341	73.3
Distance and travel costs to FP outlet	110	79.7	48	78.7	358	77.0
Probability of getting pregnant while using contraceptives	95	68.8	43	70.5	308	66.2
Fear of side effects	122	88.4	54	88.5	403	86.7
Problem of managing side effects	114	82.6	49	81.7	387	83.2
FP is against religion	121	87.7	51	83.6	429	92.7
N	138	na	61	na	463	na

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

Some hindrances that couples might face were almost universally acknowledged. Most of the never using respondents mentioned husband's possible disapproval and acknowledged religious concerns (93 percent) while 87 percent reported fear of side effects and 83 percent cited the problems of managing side effects. For three other possibilities substantial proportions of women respondents thought they might be a hindrance: other people might find out about their contraceptive use; the distance and costs of going to a FP outlet; and the possibility of getting pregnant while using contraception. In general current non-users (never users and past users) were slightly less likely to agree with each of the proposed obstacles than current users.

Past Users

Reasons for Discontinuing Contraceptive Use

Past users were asked about their reasons for discontinuing their last contraceptive method. The most commonly given reasons were experience of side effects, desire for another child, method failure and fear of side effects (Table 10.2). Method failure results

from using methods that have high failure rates. Clinical methods do have associated side effects, but, as we have seen, providers rarely tried to counsel users through the temporary experience of common, non-dangerous side effects.

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

Reason	Percentage
Wanted another child	30.5
Fear of side effects	17.0
Side effects experienced	61.1
Method failure	18.3
Lack of access/unavailability	5.5
Cost not affordable	9.6
Method inconvenient to use	7.1
Provider's advice/rest from method	10.3
Infrequent sex/husband away	10.0
Husband's advice	10.2
In-laws oppose	6.8
Menopause	5.0
N	60

Respondents could give more than one reason.

Reasons for Current Non-use

It is important to know the reasons for non-use of those couples who have used contraception in the past but are not currently using. Past users were read out a list of possible reasons for not currently using contraception, with more than one reason possible. The results are shown by status of desire for more children. The most common reasons overall related to childbearing, e.g., currently pregnant, breastfeeding/amenorrheic, and wanting another child. However, significant percentage cited fear of side effects, provider's advice and infrequent sex as reasons for non-use (Table 10.3).

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

Reason	Percentage
Fear of side effects	44.1
Want another child	16.9
Currently pregnant	33.9
Provider's advice/rest from method	11.9
Infrequent sex/husband away	20.3
Breastfeeding/lactational amenorrhea	23.7
Menopause	5.1
Just not using/too lazy	8.5
Others	5.0
N	60

Respondents could give more than one reason.

Never Users

Reasons for Non-use

The 466 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 that they wanted more children (62 percent). These issues dominated for childless couples and declined rapidly with increasing number of children. Other reasons given frequently were fear of side effects, husband or in-laws opposition, lack of access/unavailability and cost not affordable (Table 10.4).

Table 10.4: Distribution of never user women by reason for never use

Reason	Percentage
Husband opposes	42.6
In-laws oppose	31.2
Fear of side effects	49.8
Lack of access/unavailability	24.1
Cost not affordable	25.2
Shy to consult about family planning	18.4
Method inconvenient to use	14.1
Infrequent sex/husband away	8.5
Difficult/unable to conceive	16.5
Breastfeeding/lactational amenorrhea	16.5
Wanted (more) children	62.2
Against religion	2.2
Natural spacing	0.4
Others	9.1
N	460

Respondents could give more than one reason.

Attitude towards Birth Spacing and Limiting

It is important to see the extent to which never users disapproved of family planning in principle, as opposed to accepting it in principle but not using a method for some other reasons. Table 10.5 shows this for never using respondents. The majority approved of limiting as well as spacing of births. In fact slightly over three-quarters (76 percent) of the women were in favor of limiting. About 39 percent of women disapproved of spacing and 24 percent of limiting. The implications of this, for whether a couple does or does not use birth spacing or limiting may be profound, and require further investigation.

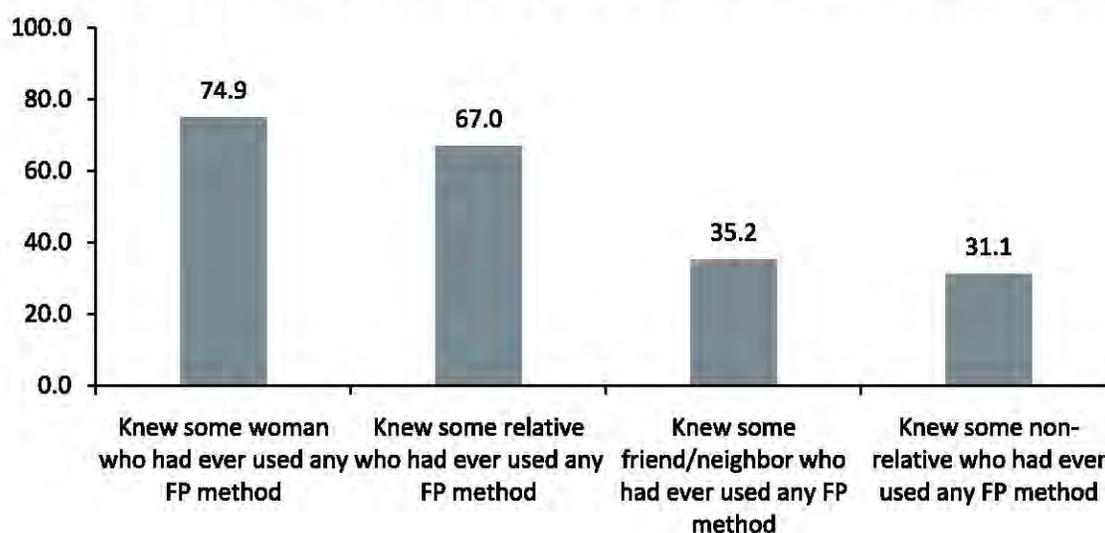
Table 10.5: Distribution of never users by attitude towards spacing and limiting birth

Attitude	Attitude towards spacing		Attitude towards limiting	
	N	%	N	%
Approve	284	61.2	354	76.3
Disapprove	180	38.8	110	23.7
Total	464	100.0	464	100.0

Knowledge of Contraceptive Users, Methods and Facilities

Of the 466 female never users in the sample, 75 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy. Sixty-seven percent of the respondents had a relative who had used some method, and 35 percent knew of a friend or neighbor who had used any FP method.

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. However, surprisingly almost all never using women knew of at least one method (Table 10.6). A majority of the never users knew of female sterilization (97 percent), followed by injectables (96 percent) and pills (94 percent). However, their knowledge about where to obtain services and supplies was less satisfactory with 197 of the 466 never users (42 percent) not knowing a place to obtain a method.

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

Method	Percentage
Female sterilization	97.4
Male sterilization	22.3
Pill	93.8
IUD	72.5
Injectables	95.5
Norplant	38.8
Condom	56.3
Rhythm	23.6
Withdrawal	40.6
Emergency pills	5.6
Others	5.4
Know at least one FP method	99.8
N	466

Respondents could give more than one response.

For those who did know a place to obtain a method, the places they were aware of are shown in Table 10.7. The sources best known were government health outlets – the District/Tehsil headquarters hospitals, BHUs/RHCs/MCH centers, and the Lady Health Workers. Almost 30 percent knew of private hospitals/doctors. A substantial number knew a combination of pharmacies, chemists and grocery shops (34 percent). Very few were aware of other sources, including Greenstar clinics.

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

Source	Percentage
Knowledge of at least one service provider	57.7
DHQ/THQ hospital	43.3
BHU/RHC/MCH center	22.1
FWC	3.2
Mobile service unit camp	0.9
Lady Health Worker	13.9
Greenstar clinic	2.1
Private hospital/clinic/doctor	29.6
Dispenser/compounder	2.8
Pharmacy/chemist/grocery shop	34.3
Homeopath/hakim	1.1
TBA/dai	1.9
Others	0.2
N	466

Respondents could give more than one response.

When asked which of the facilities named was nearest, the respondents were again most likely to name DHQ/THQ hospitals, LHW and BHU/RHC/MCH centers in that order. About half of the respondents reported they would go there by bus/van. Respondents were asked about the time required to go to the nearest facility. Twenty-five percent gave a time frame of 15 minutes or less, 39 percent said it took 16 to 30 minutes, and 36 percent gave a time of more than 30 minutes (Figures 10.2 and 10.3).

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

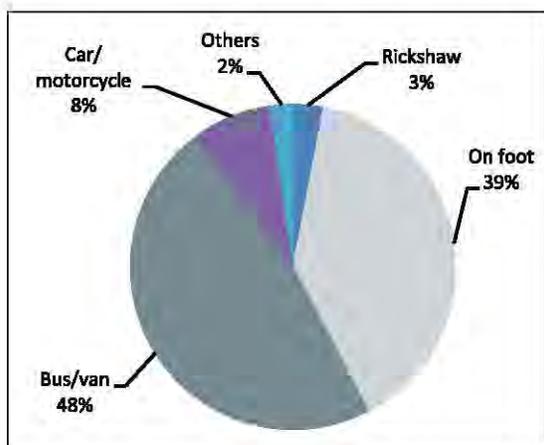
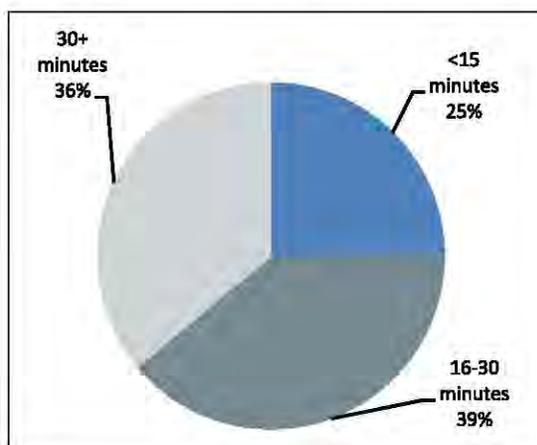


Figure 10.3: Time taken to the nearest facility/provider



Intent to Use

When never users were asked about whether they intended to use contraceptives in the future, 37 percent of the respondents (i.e., 171 out of 466 who believed they could get pregnant) said that they intended to use (Table 10.8). Women who had 3 to 4 living children and not yet used a method were more likely expressed their willingness to use in the future. Overall, 42 percent of the women did not want to use a contraceptive and 19 percent were not sure about their future intention to use a method.

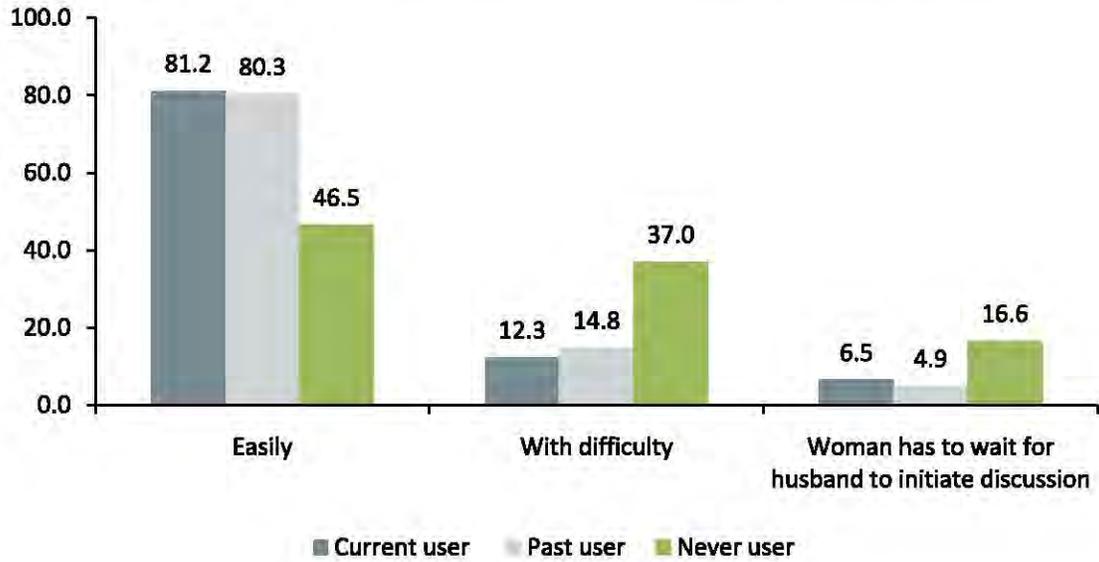
Table 10.8: Distribution of never users by intent to use a method in future and number of living children

Number of living children	Intention to use a method in future				Total	
	Yes	No	Unsure/ uncertain	Can't get pregnant	%	N
0	28.6	30.6	33.7	7.1	100.0	98
1-2	34.7	44.3	20.4	0.6	100.0	167
3-4	44.7	42.7	9.7	2.9	100.0	103
5 or more	39.8	48.0	11.2	1.0	100.0	98
Total	36.7	41.8	18.9	2.6	100.0	466
N	171	195	88	12	100.0	466

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Women were asked whether they could approach their husbands to discuss family planning easily, with difficulty, or if they had to wait for their husbands to initiate the discussion. Most women – 57 percent of those responding – said they could discuss family planning easily with their spouse (Figure 10.4). However, this varied by use status. Eighty-one percent of current users, and about the same proportion 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, 47 percent reported being able to approach their husbands easily. Among past users, 15 percent reported that they could only do so with difficulty, but only about 5 percent said they had to wait for their husband to begin the conversation.

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



Chapter 11

Unmet Need

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

Levels and Correlates

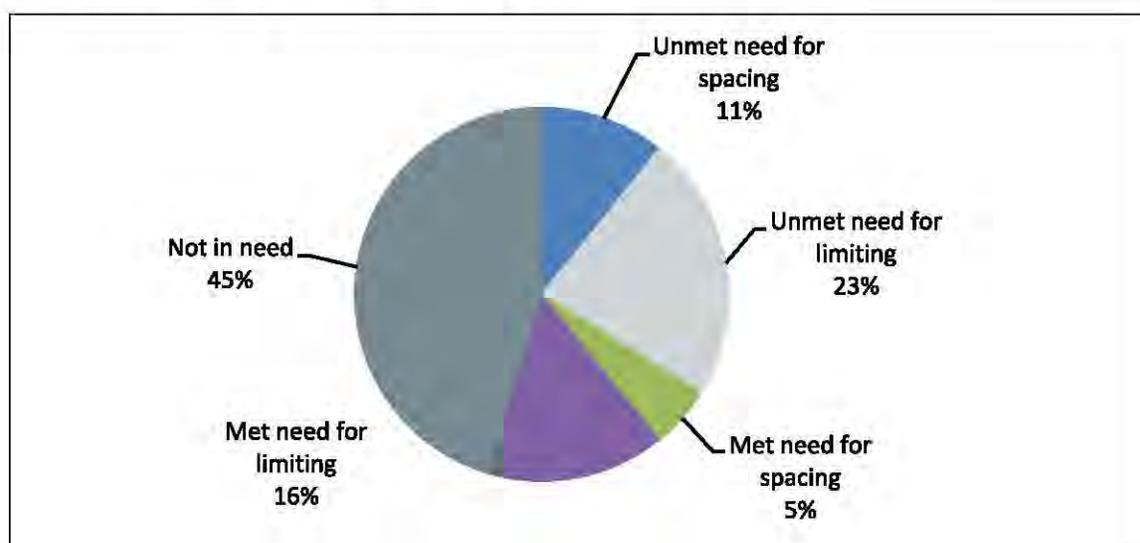
Table 11.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Thatta. Of the total 666 women, 225 (34 percent) were judged to be in unmet need. This proportion was slightly lower than is typically found using the same definition in Pakistan, where unmet need tends to be around 37 percent of MWRA. Of the total unmet need in Thatta, 11 percent was for spacing and 23 percent for limiting. Unmet need for spacing was relatively high among women with one to two living children. Unmet need for limiting, unsurprisingly, was highest among women with five or more living children, because at that stage couples did not want to have more children.

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

Characteristic	Unmet need			Met need			Total demand	Not in need	Total	N
	For spacing	For limiting	Total	For spacing	For limiting	Total				
Age of respondent										
15 - 24	20.8	5.7	26.4	9.0	2.4	11.3	37.7	62.3	100.0	212
25 - 34	8.9	27.0	35.9	5.6	15.6	21.1	57.0	43.0	100.0	270
35 - 49	2.2	37.0	39.1	1.1	30.4	31.5	70.7	29.3	100.0	184
Residence										
Rural	11.2	22.9	34.1	4.9	14.7	19.6	53.7	46.3	100.0	607
Urban	6.8	23.7	30.5	10.2	23.7	33.9	64.4	35.6	100.0	59
Literacy										
Literate	17.6	11.8	29.4	15.7	17.6	33.3	62.7	37.3	100.0	51
Illiterate	10.3	23.8	34.2	4.4	15.4	19.9	54.0	46.0	100.0	609
Education level										
No education	10.2	24.1	34.4	4.1	15.5	19.6	53.9	46.1	100.0	588
Up to primary	17.3	17.3	34.6	11.5	15.4	26.9	61.5	38.5	100.0	52
Up to secondary	11.1	0.0	11.1	33.3	11.1	44.4	55.6	44.4	100.0	18
Above secondary	16.7	16.7	33.3	0.0	33.3	33.3	66.7	33.3	100.0	6
Children ever born										
None	5.6	2.2	7.8	0.0	0.0	0.0	7.8	92.2	100.0	90
1 - 2	17.7	7.7	25.4	11.0	0.6	11.6	37.0	63.0	100.0	181
3 - 4	13.8	24.8	38.6	8.3	13.1	21.4	60.0	40.0	100.0	145
5 or more	6.0	40.4	46.4	1.6	33.2	34.8	81.2	18.8	100.0	250
Ownership of TV										
Yes	7.1	15.5	22.6	12.5	26.8	39.3	61.9	38.1	100.0	168
No	12.0	25.5	37.6	3.0	11.6	14.7	52.2	47.8	100.0	498
Standard of living index										
Low	10.9	26.9	37.8	1.7	11.4	13.1	50.9	49.1	100.0	405
Medium low	12.4	17.1	29.5	8.5	16.3	24.8	54.3	45.7	100.0	129
Medium high	12.8	22.1	34.9	9.3	22.1	31.4	66.3	33.7	100.0	86
High	2.2	6.5	8.7	21.7	37.0	58.7	67.4	32.6	100.0	46
Total	10.8	23.0	33.8	5.4	15.5	20.9	54.7	45.3	100.0	666

Of the 34 percent women who had unmet need, 11 percent was for spacing, while 23 percent was for limiting. The correlations between unmet need and various socioeconomic indicators varied by whether the unmet need was for spacing or for limiting. Unmet need for spacing was moderately associated with the first three categories of SLI, ranging from 11 percent to 13 percent, and was also associated with rural residence and literacy. 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 reach their desired family size, educated women may be more able to use family planning than uneducated women. However, conclusions should be tentative, given the small sample sizes involved. Unmet need for limiting and spacing was high among households that did not own a television. Unmet need for limiting was strongly associated with respondents whose age was above 24 years, while it was high for spacing among women in the age group 15-24 years. Figure 11.1 shows the need and demand for family planning of the sampled women.

Figure 11.1: Need and demand for family planning



Total Demand

The sum of current use (“met need”) and unmet need is often called “total demand” for family planning. It would normally be expected to rise with the number of living children a couple has. Table 11.1 shows the total demand by the number of living children. Overall, total demand was 55 percent of all married women of reproductive age. As the table shows,

total demand rose rapidly, and fairly consistently by the number of children ever born. Even at 1-2 children, demand was quite substantial (37 percent), and it increased to 81 percent for those with five or more children.

Strength of Preference

It is of interest to look at the responses of women in unmet need (those not currently pregnant) according to their reaction if they became pregnant in the near future (Table 11.2). Forty-five percent of the women with unmet need for spacing said they would be worried if they became pregnant again; 27 percent would be pleased and 23 percent would accept it. Of those with unmet need for limiting, 79 percent said they would be worried if they became pregnant. It is perhaps not unreasonable for women to be more concerned about the consequences of an unwanted pregnancy, than about the consequences of a wanted pregnancy coming too soon.

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	17	27.4	3	2.2
Worried	28	45.2	107	79.3
Accept it	14	22.6	22	16.3
Doesn't matter	3	4.8	1	0.7
Others	0	0.0	2	1.5
Total	62	100.0	135	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 represented barriers as perceived by the women, the most important of these being fear of side effects and opposition of husband and of in-laws. On the other hand, many women with defined unmet need gave reasons that did not reflect perceived need, at least at present. Such reasons included wanted more children, currently pregnant and currently

breastfeeding, infrequent sex/husband away, natural spacing and difficulty in conceiving. Some women may have more need than they realize; for example, women using “natural spacing” or breastfeeding may in fact be at substantial risk of pregnancy. Women currently pregnant or amenorrheic may be in need of contraception in the near future.

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

Reason	Unmet need for spacing	Unmet need for limiting	Total unmet need
Fear of side effects	47.1	66.9	60.6
Husband opposes	28.6	37.7	34.8
In-laws oppose	28.6	28.5	28.5
Shy to consult about FP	18.6	17.2	17.6
Provider's advice	0.0	2.0	1.4
Against religion	4.3	2.0	2.7
Lack of access/unavailability	20.0	31.1	27.6
Cost not affordable	12.9	32.5	26.2
Just not using/too lazy	1.4	2.6	2.3
Method inconvenient to use	8.6	13.9	12.2
Infrequent sex/husband away	11.4	7.3	8.6
Natural spacing	0.0	0.7	0.5
Difficult/unable to conceive	7.1	6.0	6.3
Want (more) children	72.9	4.6	26.2
Currently pregnant	2.9	5.3	4.5
Breastfeeding/lactational amenorrhea	8.6	13.9	12.2
Others	10.0	11.3	10.9
N	70	151	221

Respondents could give more than one reason.

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprised 72 (11 percent) of MWRA. As shown in Table 11.4, they were characterized by:

- **Living Children:** Most (47 percent) had 1 or 2 living children.
- **Family Planning Use:** More never users (88 percent) than past users (12 percent).
- **Strength of Preference:** Moderate (45 percent “worried” if they became pregnant earlier than they wanted compared to those who were pleased (27 percent) or accept (23 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** Moderate (about 43 percent intended to use a FP method in future).
- **Approval of FP:** High (62 percent approved of using a FP method for spacing purpose).
- **FP Communication with Husband:** Limited (only 36 percent had communicated with husbands on FP in the past one year; while 38 percent said approaching the husband was “not easy”).
- **Obstacles to FP Use:** Fear of side effects (47 percent); husband and in-laws opposition (29 percent each) (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	5	6.9	2	1.3
1-2	34	47.2	20	13.1
3-4	25	34.7	43	28.1
5 or more	8	11.1	88	57.5
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	9	12.5	29	19.0
Never user	63	87.5	124	81.0
Reaction if become pregnant in near future				
Pleased	17	27.4	3	2.2
Worried	28	45.2	107	79.3
Accept it	14	22.6	22	16.3
Doesn't matter	3	4.8	1	0.7
Others	0	0.0	2	1.5
Intention to use a method in future				
Yes	31	43.1	67	45.3
No	30	41.7	63	42.6
Unsure/uncertain	11	15.3	17	11.5
Can't get pregnant			1	0.7
Approval of FP				
Approve	44	62.0	127	83.0
Disapprove	27	38.0	26	17.0
FP communication with husband in past one year				
Never	46	63.9	77	50.3
Once or twice	23	31.9	58	37.9
More often	3	4.2	18	11.8
Approach the topic of FP with husband				
Easily	45	62.5	90	58.8
Not easily	27	37.5	63	41.2
Total	72	na	153	na

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprised 153 (23 percent) of MWRA. As shown in Table 11.4, they were characterized by:

- **Living Children:** A strongly positive association with number of living children; 58 percent had 5+ living children.
- **Family Planning Use:** More never users (81 percent) than past users (19 percent).
- **Strength of Preference:** High (79 percent would be “worried” if they became pregnant compared to those who were pleased (2 percent) or accept (16 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** Moderate (about 45 percent intended to use a FP method in future).
- **Approval of FP:** High (83 percent approved of FP for limiting purposes).
- **FP Communication with Husband:** Moderate (50 percent had communication with husband on FP in the past year; while 41 percent said approaching the husband was “not easy”).
- **Obstacles to FP Use:** Fear of side effects (67 percent); husbands and in-laws opposition (38 percent and 29 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 Thatta, the field team was able to interview 192 men who were husbands of the married women of reproductive age who had been interviewed for the survey, plus 6 married men living in the selected areas who were not husbands of the female respondents. In this chapter, the results for the respondents' husbands and the other married men who were interviewed (N = 198) 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 13 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. More than 38 percent of the men had not been to school, compared to more than 89 percent of the currently married women (Table 3.2). It also shows that 25 percent of the men had more than primary education, whereas 4 percent of the currently married women had attained that level of education (Table 3.2). Seventy-five percent of the urban men had received some schooling compared to 60 percent of the rural men.

The occupations of men are also presented in Table 12.1. The highest proportion (56 percent) were working as daily wage laborers, 36 percent were working in agriculture-related activities and 11 percent were running their own businesses.

Table 12.1: Background characteristics of male respondents, by residence

Characteristic	Rural	Urban	Total
Age			
20-24	1.7	0.0	1.5
25-29	10.7	5.0	10.1
30-34	17.4	20.0	17.7
35-39	18.5	15.0	18.2
40-44	24.7	20.0	24.2
45-49	12.4	15.0	12.6
50-54	9.0	0.0	8.1
55+	3.4	15.0	4.5
Education			
Proportion literate	45.5	60.0	47.0
No education	39.9	25.0	38.4
Up to primary	38.8	15.0	36.4
Up to secondary	14.0	30.0	15.7
Above secondary	7.3	30.0	9.6
Economic activity/occupation			
Agriculture/livestock/poultry	39.3	10.0	36.4
Labor (daily wages)	57.9	40.0	56.1
Govt. service	6.2	5.0	6.1
Pvt. service	7.3	10.0	7.6
Own business	9.0	25.0	10.6
Unemployed	2.8	5.0	3.0
Others	0.6	5.0	1.0
N	178	20	198

Knowledge and Use of Contraception

Almost all (99 percent) men in Thatta knew of at least one method of contraception, and nearly every woman knew at least one method. As presented in Table 12.2, knowledge of modern methods among men was highest for female sterilization (92 percent), followed by injectables (89 percent), pills (87 percent), and condoms (63 percent). The least known methods were Norplant (25 percent), male sterilization (29 percent), and IUD (44 percent). Knowledge of at least one traditional method was prevalent among 57 percent of the men.

The pattern of ever use and current use of contraception reported by husbands is also shown in Table 12.2. Of all the MWRA respondents interviewed in our sample, 30 percent reported having used some method of contraception during their married lives (Table 8.2); men reported ever use of 33 percent. For men, female sterilization was the most common method ever used (10 percent), followed by pills (9 percent), injectables (8 percent) and condoms (6 percent).

The current use of any family planning reported by male respondents (23 percent) was, slightly higher than the current use reported by female respondents (21 percent) in Thatta. The most common current method reported by male respondents was female sterilization (10 percent). The use of traditional methods was substantial: more than 7 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 33 percent of the respondents knew about the emergency contraceptive pill, only 1 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	92.1	90.0	91.9	9.0	20.0	10.1	9.0	20.0	10.1
Male sterilization	28.2	35.0	28.9	0.0	0.0	0.0	0.0	0.0	0.0
Pill	86.0	95.0	86.9	8.4	10.0	8.6	1.1	5.0	1.5
IUD	41.6	70.0	44.4	0.6	5.0	1.0	0.0	0.0	0.0
Injectables	88.2	100.0	89.4	9.0	0.0	8.1	2.8	0.0	2.5
Norplant	24.2	30.0	24.7	0.6	0.0	0.5	0.0	0.0	0.0
Condom	60.7	85.0	63.1	4.5	20.0	6.1	1.1	15.0	2.5
Rhythm	34.5	45.0	35.5	5.1	10.0	5.6	3.4	5.0	3.5
Withdrawal	43.5	40.0	43.1	7.3	10.0	7.6	3.4	0.0	3.0
Others	3.4	0.0	3.0	1.1	0.0	1.0	1.1	0.0	1.0
At least one FP method	98.9	100.0	99.0	30.9	55.0	33.3	20.8	45.0	23.2
At least one modern FP method	98.3	100.0	98.5	23.0	50.0	25.8	14.0	40.0	16.7
At least one traditional FP method	55.6	65.0	56.6	12.9	20.0	13.6	7.3	5.0	7.1
Emergency pills	34.3	20.0	32.8	0.6	0.0	0.5	na	na	na
N	178	20	198	178	20	198	178	20	198

na=not applicable.

Table 12.3 shows ever use and current use of modern contraception among male respondents by background characteristics. There was a positive relationship between education level and contraceptive use. More than 41 percent of the respondents who had secondary and above education, reported current use of any contraceptive method. This was considerably higher than the 23 percent and 16 percent reported for those who had below secondary and no education, respectively.

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	30.9	20.8	178
Urban	55.0	45.0	20
Education level			
No education	28.9	15.8	76
Below secondary	28.4	22.7	88
Secondary and above	55.9	41.2	34
Number of living children			
None	14.3	4.8	21
1-2	23.7	13.6	59
3-4	26.7	22.2	45
5+	50.7	37.0	73
Future desire for children			
Soon	13.7	3.9	51
Later	16.7	12.5	24
Never	51.9	41.8	79
Don't know/unsure	31.8	18.2	44
Total	59.5	45.0	200

Table 12.3 also shows a positive relationship between the number of living children and reported ever use as well as reported current use. Of those who had 5 or more children, almost 37 percent were currently using family planning methods compared to 22 percent who had 3-4 children and 14 percent who had 1-2 children. The same pattern was observed in ever 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. Among the male respondents who said they did not want any more children, almost 42 percent were currently using a method. Only 17 percent of those respondents

who wanted to delay the next pregnancy had ever used any contraceptive method, and 13 percent were currently using a method.

Source of Contraceptive Methods

As shown in Table 12.4, of those who reported the last source for obtaining contraceptive methods, 39 percent reported that they obtained their last method from the government hospital (DHQ/THQ), and 27 percent reported getting it from the pharmacy/chemist. LHWs were reported as a source of contraceptives by only 2 percent of ever users in Thatta.

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

Source	Percentage
Govt. hospital (DHQ/THQ)	38.8
BHU/RHC/MCH center	4.1
FWC	2.0
MSU	2.0
LHW	2.0
Other public	4.1
Pvt. doctor	6.1
Pvt. hospital/clinic	6.1
Pharmacy/chemist	26.5
Wife brought method	4.1
Others	4.1
Total	100.0
N	49

Approval of Family Planning

Respondents were asked about their approval of birth spacing and use of any form of contraception for spacing purpose. 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 Thatta, 72 percent of all male respondents approved of spacing between children, and 70 percent approved of using any form of contraception for spacing (Table 12.5). Twenty-nine percent of the men disapproved of using any form of contraception to space between children.

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

Variable	Percentage
Spacing between children	
Approve	72.2
Disapprove	25.8
Others	2.0
Total	100.0
N	198
Using family planning methods for spacing	
Approve	69.7
Disapprove	28.8
Others	1.5
Total	100.0
N	198

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 62 percent of the current users were very satisfied with their current method, and 32 percent were somewhat satisfied; only 6 percent reported that they were not satisfied with their current method. Those who were only somewhat satisfied or who were not satisfied with their method 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

Level of satisfaction	Percentage
Very satisfied	61.8
Somewhat satisfied	32.4
Not satisfied	5.9
Total	100.0
N	34

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. When 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-one percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, more than 64 percent of the men reported that their wives had never approached them during the last year on this issue (Figure 12.2). Twenty percent of the men reported that their wives had talked often about this subject during the last year, and 16 percent reported they had talked once or twice.

Figure 12.1: Male responses of ease of approach by wives to discuss FP

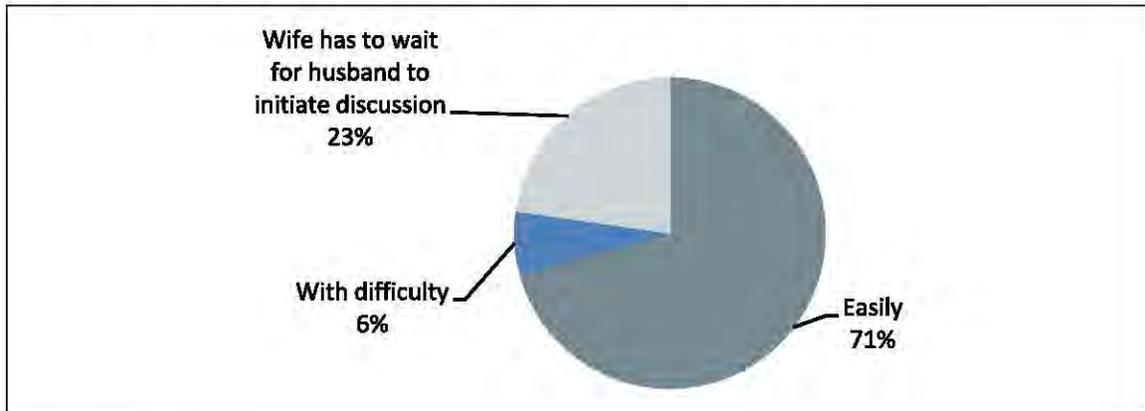
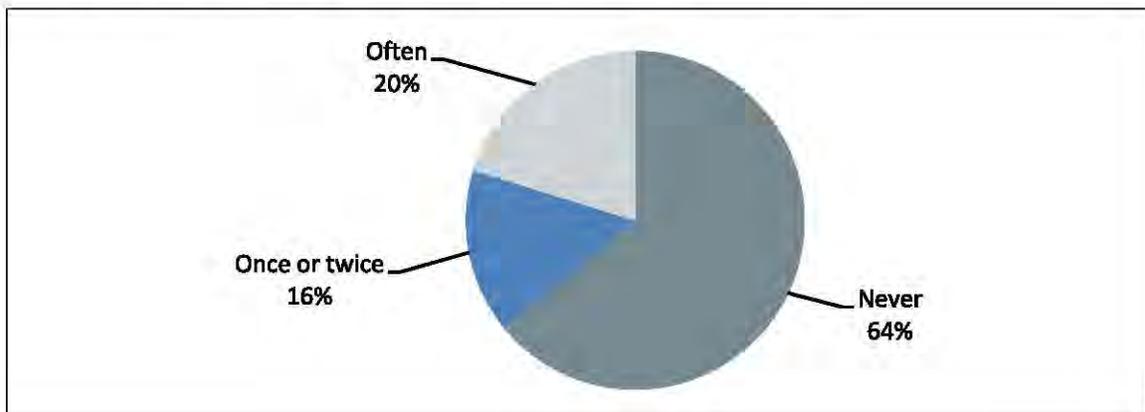


Figure 12.2: Frequency of discussion on FP with wife in last year



Potential Users

Men who were non-users of contraception were asked about their intended future use of contraception and their method preferences. Table 12.7 shows that 30 percent intended to use contraception in the future, 47 percent did not intend to use contraception in the future whereas 24 percent were unsure about their future use of contraception. Twenty-four percent of the respondents were uncertain about their future use of contraception.

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

Intent	Percentage
Will use	29.5
Will not use	47.0
Unsure/uncertain	23.5
Total	100.0
N	132

As shown in Table 12.8, the major reason husbands said they did not intend to use a method in the future was their desire for more children (52 percent). Others said they did not need contraception since their wives were unable to conceive (32 percent) or because they had infrequent sex (3 percent). For 18 percent, fear of side effects was the main reason, while 11 percent were shy about visiting family planning clinics.

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

Reason	Percentage
Wife opposes	9.7
In-laws/parents oppose	8.1
Fear of side effects	17.7
Lack of access/unavailability	12.9
Cost too much	14.5
Shy to go to FP clinic	11.3
Inconvenient to use	9.7
Infrequent sex/respondent away	3.2
Difficult/unable to conceive	32.3
Breastfeeding/lactational amenorrhea	6.5
Respondent/wife infertile	1.6
Want more children	51.6
N	62

Respondents could give more than one reason.

Table 12.9 shows the distribution of the male respondents who intended to use a specific contraceptive method in the future. It is observed that a small proportion (10 percent) wanted to use condoms.

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

Method	Percentage
Female sterilization	35.9
Pills	20.5
Injectable	30.8
Condom	10.3
Rhythm	2.6
Total	100.0
N	39

Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 12.10 shows that 26 percent of the respondents wanted another child soon (within two years). Another 12 percent wanted to delay their next child for more than two years. The largest proportion of respondents (40 percent) did not want any more children at all.

The desire for having another child soon was inversely associated with the number of living children. Sixty-seven percent of the respondents who had no child wanted a child soon, while 47 percent who had 1 child and 44 percent who had 2 children wanted their next child soon.

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

Number of living children	Desire for next child				Total	
	Soon	Later	Never	Don't know/unsure	%	N
0	66.7	19.0	9.5	4.8	100.0	21
1	46.9	28.1	6.3	18.8	100.0	32
2	44.4	14.8	11.1	29.6	100.0	27
3	21.7	13.0	30.4	34.8	100.0	23
4	13.6	9.1	45.5	31.8	100.0	22
5	0.0	4.5	63.6	31.8	100.0	22
6+	3.9	2.0	80.4	13.7	100.0	51
Total	25.8	12.1	39.9	22.2	100.0	198

The desire to stop having children was positively associated with the number of living children. Eleven percent of the respondents who had 2 children did not want any more children, while 80 percent who had 6 or more children did not want more.

The 40 percent of respondents who did not want more children was much larger than the 23 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 more than half of the interviewed men. This suggests that there is a substantial need for family planning, but that motivational programs and service delivery are not keeping pace with this need.

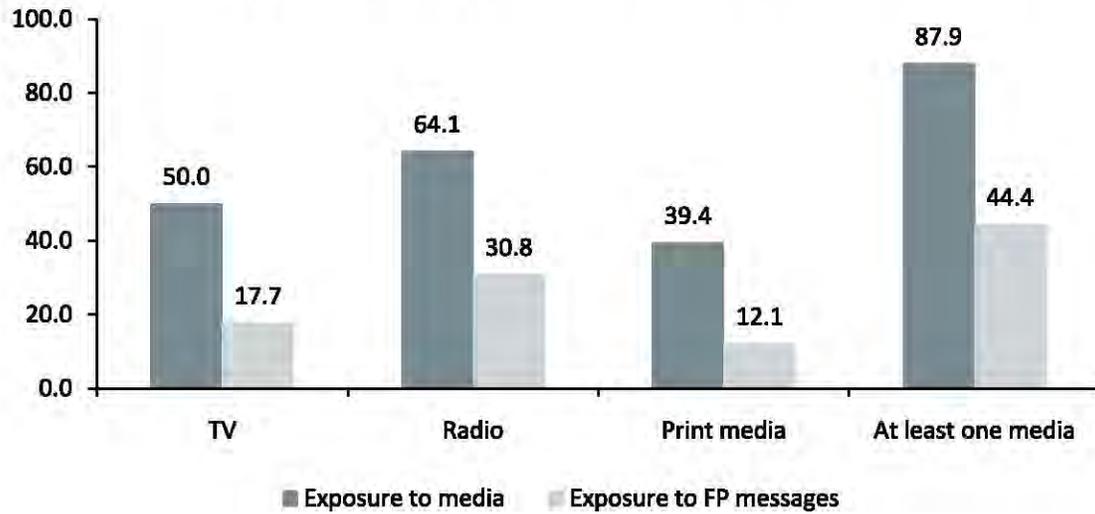
Mass Media Access and Exposure to FP Messages

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

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. Only 18 percent of the men had seen FP messages on the television and 31 percent had ever listened to a family planning message on the radio. Overall, 44 percent of

the male respondents and 18 percent of the MWRA had seen or listened to a family planning message through at least one medium.

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



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