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Baseline Household Survey

Sukkur District

May 2010



Family Advancement for Life and Health (FALAH)

Sukkur

Baseline Household Survey

May 2010

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Layout and Design: Ali Ammad

Published: May 2010

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"This study/report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the Population Council, Islamabad and do not necessarily reflect the views of USAID or the United States Government."

Table of Contents

Acknowledgements	xiii
Glossary of Terms	xv
Executive Summary	xvii
Chapter 1	1
Introduction.....	1
Background.....	1
The FALAH Project.....	1
Sukkur District	2
The Sukkur Baseline Household Survey	3
Objectives.....	3
Methodology	3
Chapter 2	7
Household Characteristics.....	7
Geographic Distribution	7
Age-Sex Distribution	8
Marital Status	10
Household Characteristics and Wealth Indicators	11
Physical Characteristics of Households	11
Ownership of Household Assets	13
Chapter 3	17
Respondent Characteristics.....	17
Age.....	17
Education and Literacy	18
Occupation and Work Status.....	19
Female Mobility.....	20
Mass Media Access and Exposure to Family Planning Messages	21
Chapter 4	23
Service Availability.....	23
Sukkur District Data	23
Reproductive Health Facilities.....	24

Family Planning Facilities.....	24
Maternal Health Facilities.....	25
Service Providers	26
Chapter 5	41
Fertility	41
Cumulative Fertility	41
Children Ever Born and Living	41
Differentials in Children Ever Born and Surviving	43
Current Fertility	46
Crude Birth Rate	46
Age-specific Fertility Rates and Total Fertility Rate	46
Mothers with Children Under Five Years	47
Preceding Birth Interval.....	47
Chapter 6	51
Maternal and Neonatal Care	51
Antenatal Care.....	51
Tetanus Immunization.....	55
Location and Attendance at Delivery	56
Postpartum Care.....	58
Breastfeeding	58
Chapter 7	61
Preference for Children	61
Ideal Number of Children	61
Desire for More Children.....	62
Levels of Desire for More Children.....	62
Socioeconomic Correlates of Desire for Children	64
Son Preference	65
Strength of Preference	65
Attitude towards Last Pregnancy	67
Women’s Perception of Husband’s Fertility Preferences	68
Chapter 8	69
Contraceptive Knowledge and Use	69

Knowledge	69
Use of Contraceptive Methods	70
Levels of Ever Use and Current Use	70
Current Use and Desire for Children	72
Correlates of Contraceptive Use	73
Source of Method	75
Chapter 9	77
Experience with Contraceptive Methods	77
Reasons for Method Choice	77
Cost, Distance and Time to Reach a Facility	78
Treatment by Provider	81
Information Provided	81
Treatment at Facility	82
Side Effects	83
Chapter 10	85
Reasons for Non-use	85
Hindrances to Use	85
Past Users	86
Reasons for Discontinuing Contraceptive Use	86
Reasons for Current Non-use	87
Never Users	88
Reasons for Non-use	88
Attitude towards Birth Spacing and Limiting	89
Knowledge of Contraceptive Users, Methods and Facilities	90
Intent to Use	92
Inter-spousal Communication	93
Chapter 11	95
Unmet Need	95
Levels and Correlates	95
Total Demand	97
Strength of Preference	97
Unmet Need for Spacing: Profile	100

Unmet Need for Limiting: Profile	102
Chapter 12	103
Reproductive Preferences and Behavior of Men	103
Background Characteristics	104
Contraceptive Knowledge and Use	105
Source of Contraceptive Methods.....	108
Approval of Family Planning.....	109
Satisfaction Level of Current Users	109
Inter-spousal Communication	111
Potential Users	112
Fertility Desire	113
Mass Media Access and Exposure to FP Messages	114
References	117

List of Tables

Table 1.1: Results of households and eligible women(MWRA) interviews.....	5
Table 2.1: Percentage distribution of population in sample households by residence and talukas, and comparison with 1998 census data	7
Table 2.2: Distribution of sampled population by age and sex.....	8
Table 2.3: Distribution of household population by marital status ,sex and age	10
Table 2.4: Distribution of households with selected physical characteristics by residence	12
Table 2.5: Percent of sample households owning selected items by residence Standard of Living Index.....	14
Table 2.6: Percent distribution of sample households by residence and standard of living index	15
Table 3.1: Age distribution of female respondents by residence	17
Table 3.2: Distribution of MWRA and husbands by educational achievement and literacy status, age and residence	18
Table 3.3: Distribution of occupational categories of respondents' husbands by residence	20
Table 3.4: Women’s reports regarding mobility outside the home, by degree of permission, and destination.....	21
Table 4.1: Number and proportion of facilities providing specified family planning services in Sukkur district, by sector and MWRA per facility.....	25
Table 4.2: Number and proportion of facilities providing specified maternal health care services in Sukkur district, by sector and MWRA per facility	26
Table 4.3: Number of reproductive health care providers in Sukkur district, by sector and category, and MWRA per service provider	27
Table 5.1: Distribution of MWRA by age of mother and number of children ever born (CEB).....	42
Table 5.2: Distribution of MWRA by age of mother and number of living children	42
Table 5.3: Mean number of children ever born and children surviving by sex of child and age of mother	43
Table 5.4: Mean number of children ever born, living and dead by background characteristics..	44
Table 5.5: Mean number of children ever born and living by age and literacy of mother	45
Table 5.6: Number of women in sample households and number of births during last three years before survey by age of women, and ASFRS, TFR and CBR	46
Table 5.7: Distribution of mothers by pregnancy status and number of children under 5 years..	47
Table 5.8: Distribution of women with preceding birth intervals (birth to birth) by background characteristics.....	48
Table 6.1: Distribution of ANC check-ups during last pregnancy by residence.....	52

Table 6.2: Facilities/service providers mentioned for one or more antenatal visits by residence	54
Table 6.3: Tetanus immunization at last delivery	55
Table 6.4: Distribution of mothers by place of last delivery and residence.....	56
Table 6.5: Distribution of mothers by attendant at last delivery and residence	57
Table 6.6: Distribution of mothers by status of postnatal check-up and place of delivery.....	58
Table 7.1: Distribution of MWRA with ideal I number of children for their family by residence ..	62
Table 7.2: Distribution of MWRA by desire for next child and current number of living children.....	63
Table 7.3: Distribution of MWRA by reported desire for more children and background characteristics.....	64
Table 7.4: Son and daughter preference by respondents.....	65
Table 7.5: Distribution of MWRA who did not want more children soon, by reaction if they become pregnant in near future	66
Table 7.6: Distribution of MWRA who did not want more children soon, by problems faced if they became pregnant	66
Table 7.7: Distribution of MWRA according to perception of husband's desire for more children, by woman's ideal family size	68
Table 8.1: Distribution of MWRA by knowledge (prompted) of contraceptive methods, by method and residence.....	70
Table 8.2: Percentage distribution of married women of reproductive age by contraceptive use status and residence	71
Table 8.3: Distribution of women by contraceptive use status and selected characteristics.....	74
Table 8.4: Distribution of ever users of specific contraceptive method by most recent source of supply	75
Table 9.1: Distribution of ever users of specific contraceptive method by reason for choosing that method.....	78
Table 9.2: Distribution of MWRA using traditional methods by reason for not using modern contraceptive methods	78
Table 9.3: Distribution of costs of current specific contraceptive method.....	79
Table 9.4: Distribution of current contraceptive users by time to reach specific contraceptive service.....	80
Table 9.5: Distribution of ever users of contraceptives by information provided at acceptance for method	82
Table 9.6: Percent of current users responding positively on treatment at last visit by aspect of treatment	82
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	86

Table 10.2: Distribution of past contraceptive users by reason for discontinuing last method	87
Table 10.3: Distribution of past users by reason for current non-use	88
Table 10.4: Distribution of never users by reason for never use	89
Table 10.5: Distribution of never users by attitude towards spacing and limiting birth	89
Table 10.6: Distribution of never using females by knowledge of contraceptive methods	90
Table 10.7: Knowledge of sources of contraception of never users by source of supply.....	91
Table 10.8: Distribution of never users by intent to use a method in future and number of living children	92
Table 11.1: Distribution of women with unmet need for spacing and limiting by background characteristics.....	96
Table 11.2: Distribution of non-pregnant women with unmet need for spacing and limiting, by strength of desire to avoid pregnancy.....	98
Table 11.3: Women with unmet need for spacing and limiting by stated reasons for non-use of contraception	99
Table 11.4: Percent distribution of MWRA in unmet need for spacing and limiting by selected characteristics.....	101
Table 12.1: Background characteristics of male respondents by residence	105
Table 12.2: Distribution of male respondents by contraceptive knowledge, use status and residence	106
Table 12.3: Percent of male respondents reporting ever use or current use of a contraceptive method, by selected background characteristics.....	107
Table 12.4: Distribution of male ever users by the last reported source of contraceptive supply and residence.....	108
Table 12.5: Distribution of male respondents' attitude towards spacing and use of contraceptives for spacing by residence	109
Table 12.6: Level of male respondents' satisfaction with their current method by residence ...	110
Table 12.7: Percentage distribution of past contraceptive users by reason for discontinuing last method by residence	110
Table 12.8: Distribution of male never users by intent to use contraceptive methods in future by residence.....	112
Table 12.9: Distribution of male never users respondents according to reasons for not intending to use contraceptive methods in future by residence	112
Table 12.10: Distribution of male never users who intend to use specific contraceptive methods in future by residence	113
Table 12.11: Distribution of male respondents by desired timing for next child and number of living children	113

List of Figures

Figure 2.1: Rural- urban distribution of population in sample households	8
Figure 2.2: Age sex distribution.....	9
Figure 2.3: Toilet facilities for Sukkur households	13
Figure 3.1: Literacy status of women and their husbands	19
Figure 3.2: Type of work of women working for pay (n=216).....	19
Figure 3.3: Distribution of MWRA according to exposure to media and FP messages, by type of media	21
Map 4.1: Location of government facilities in Sukkur district, by population density of union council.....	29
Map 4.2: Location of LHWs in Sukkur district, by population density of union council.....	30
Map 4.3: Location of private facilities in Sukkur district, by population density of union council.....	31
Map 4.4: Total number of reproductive health service delivery points (public and private), in Sukkur district, by union council.....	32
Map 4.5: Location of female sterilization facilities in Sukkur district, by population density of union council.....	33
Map 4.6: Location of IUD facilities in Sukkur district, by population density of union council.....	34
Map 4.7: Location of injectables contraceptive services in Sukkur district, by population density of union council.....	35
Map 4.8: Location of essential obstetric services in Sukkur district, by population density of union council.....	36
Map 4.9: Location of emergency obstetric care facilities in Sukkur district, by population density of union council.....	37
Map 4.10: Location of doctors in Sukkur district, by gender and population density of union council.....	38
Map 4.11: Location of Greenstar Social Marketing SDPs in Sukkur district, by population density of union council.....	39
Figure 6.1: Distribution of MWRA by number of antenatal visits during last pregnancy	52
Figure 6.2: Distribution of MWRA by reason of first antenatal visit during last pregnancy	53
Figure 6.3: Percentage of MWRA by gestational age at first antenatal visit during last pregnancy	53
Figure 6.4: Location where respondents made one or more antenatal visits	54
Figure 6.5: Tetanus immunization at last delivery	55

Figure 6.6: Distribution of mothers by location of last delivery.....	56
Figure 6.7: Distribution of mothers by attendant at last delivery.....	57
Figure 6.8: Distribution of mothers by reasons for discontinuing breastfeeding (n=131).....	59
Figure 7.1: Distribution of women by desire for more children in future.....	63
Figure 7.2: Distribution of MWRA by attitude towards their last pregnancy	67
Figure 8.1: Distribution of current users by method mix.....	72
Figure 8.2: Current use and desire for children	73
Figure 8.3: Contraceptive prevalence by woman’s age	73
Figure 8.4: Current contraceptive use by number of living children.....	74
Figure 9.1A: Cost in rupees of contraceptive supply for current mmmmmethodmethod in rupees.....	79
Figure 9.1B: Attitude towards service charges for current method other than contraceptive	79
Figure 9.2: Travel time (in minutes) for contraceptive supplies	81
Figure 9.3: Percent ever users who experienced side effects by method used.....	83
Figure 9.4: Distribution of provider responses upon consultation for side effects among past users	83
Figure 10.1: Percent of never user women who knew some woman who had ever used any FP method	90
Figure 10.2: Mode of transportation to the nearest facility/provider	92
Figure 10.3: Time taken to go to the nearest facility/provider	92
Figure 10.4: Women’s report regarding ease of approach to husband to discuss family planning.....	93
Figure 11.1: Need and demand for family planning.....	97
Figure 12.1: Men’s reports of ease of approach by their wives to discuss FP	111
Figure 12.2: Men’s reports of frequency of discussion on FP with wife in last year.....	111
Figure 12.3: Distribution of male respondents according to exposure to media and FP messages, by type of media	114

Acknowledgements

The FALAH project is a five year project funded by USAID to improve the survival and health of women and children in Pakistan and the well-being of families, communities and the country through increased demand and utilization of births spacing and quality family planning services. Population Council is leading a consortium of national and international NGOs to support family planning activities in both the public and private sector in Pakistan. The consortium members include Greenstar Social Marketing, Health and Nutrition Development Society (HANDS), Jhpiego, Mercy Corps, Rural Support Programmes Network (RSPN) and Save the Children US. The partners bring together a blend of technical expertise combined with a rich experience of working within Pakistan and internationally.

As with any major project, it is important to have a baseline study in order to assess the progress of the project in meeting the set goals and objectives over a 5-year period. The report is a collaborative effort involving partners, Population Council staff and district officials/workers who joined their hands to make this endeavor possible.

The Population Council was primarily responsible for designing the baseline study and managing the collection of data, its analysis and for producing the reports for the project districts. We are grateful to Chief of Party of the FALAH project who strongly encouraged and facilitated the baseline survey process. Dr. Zeba Sathar, Country Director Population Council Islamabad provided invaluable input and was instrumental in the quality of the report produced.

The baseline surveys were designed and implemented under the guidance and encouragement of Dr. Arshad Mahmood, Director Monitoring and Evaluation. Several staff of the Population Council contributed substantially at various stages of producing this report and we would like to thank them individually. At the level of the training of the field staff and monitoring the quality of the data collected, we would like to particularly acknowledge the efforts of Dr. Munir Afridi, Ms. Nayyer Farooq, Ms. Ashfa Hashmi and Mr. Muhammad Ashraf. Mr. Abdul Kashif dealt with all the financial matters during the survey process and Mr. Rahim Dad Malik was responsible for making the logistical arrangements for the survey. We thank Mr. Nadeem Akhtar and Mr. Imran Rashid who were involved at various stages of the survey.

We are grateful to Mr. Peter C. Miller and Dr. Arshad Mahmood for developing the main template for the report. Mr. Muhammad Jamil Arshad prepared the first draft of the Sukkur report and Dr. Yasir Bin Nisar reviewed the report. Mr. Irfan Masood prepared the tables and figures for the report.

In the final stages Ms. Pamela Ledbetter edited the reports and Ms. Saman Naz worked diligently to incorporate the various suggestions. Mr. Ali Ammad developed the report layout and design. We thank these colleagues for their immense contributions.

Finally, we must acknowledge the women and men of the households in the district Sukkur for sharing their lives and their information and giving life to the survey. We hope very much that our effort will be of use to provide the necessary information to improve the quality of peoples' lives and to provide better reproductive health and family planning services.

Glossary of Terms

ANC	Antenatal Care
ASFRs	Age-specific Fertility Rates
BHU	Basic Health Unit
CBR	Crude Birth Rate
CEB	Children Ever Born
CPR	Contraceptive Prevalence Rate
DHQ	District Headquarter
EC	Emergency Contraception
ECP	Emergency Contraception Pill
EmOC	Emergency Obstetric Care
FALAH	Family Advancement for Life and Health
FP	Family Planning
HANDS	Health and Nutrition Development Society
IEC	Information Education Communication
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
PAIMAN	Pakistan Initiative for Mothers and Newborns

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

Executive Summary

The Family Advancement for Life and Health (FALAH) project conducted a baseline household survey for Sukkur, one of the 26 project districts.

The survey was conducted between February and April of 2008 in a probability sample of 520 households in 40 clusters in Sukkur. It included interviews with 585 currently married women 15-49 years ("married women of reproductive age" or MWRA), along with 200 married men, of whom 184 were married to women included in the sample. As a separate activity, a mapping study¹ was also carried out in Sukkur during the period between January and March 2008. Selected data from that study are included in this report, although a separate report is also available. The FALAH project is primarily focused on birth spacing and family planning.

Household and Respondent Characteristics

Almost three-fifths of Sukkur district is rural. According to the Pakistan National Human Development Report 2003, Sukkur stood 47th among 91 districts of Pakistan on the Human Development Index. The characteristics of our sample are generally similar to those found in other surveys; some key indicators are given in Table A.

Table A: Selected key district characteristics from Sukkur household survey

Variable	Value
Percentage of households in rural areas	57.6
Percentage of households with electricity	95.2
Percentage of households with indoor water supply	86.2
Percentage of households with flush toilet	67.2
Percentage of households with television	65.8
Percentage of literate female respondents	32.4
Percentage of respondents with literate husbands	64.0
No. of MBBS physicians per 1000 MWRA	3.4
Total fertility rate	3.9

¹ Mapping Survey of Health and Reproductive Health Services.

Electrification is complete in 95 percent sample households, and ownership of appliances that require electricity, such as television, refrigerator, washing machine, etc., was common in Sukkur. A majority of the households had some indoor water supply, and 67 percent of the households had a flush toilet. However, still 18 percent households use fields for the purpose. Thirty-seven percent of the women were working for pay. On the other hand, female literacy was relatively low. Only 32 percent of the females were literate. However, 64 percent of their husbands were literate, which is encouraging. Sixty-five percent of the respondents said they watched TV, 32 percent listened to the radio and 12 percent read newspapers or magazines. Most women, who heard of any FP message, heard it on the television.

Service Availability

There was a wide range of health and reproductive health facilities in Sukkur district. Of the 1650 facilities in the district, 1006 were public while 644 were in the private sector. These health facilities included health houses of Lady Health Workers and were widely scattered around the district, so the simple services such as antenatal check-ups, iron tablets for anemia, and non-clinical contraceptive methods were readily available in both public and private sectors. However, access to services requiring specialized care was difficult. For example, there were only 25 facilities – 3 public, 22 private – which were able to offer Caesarean section deliveries. There were 33 facilities which were able to provide female sterilization, but many of these could only provide the service occasionally, when an external sterilization team was present. Though services were spread throughout the district, there were some areas where access was relatively difficult.

Fertility

The crude birth rate was 27 per thousand population, and the total fertility rate was 3.9 children per woman. Fertility was higher for illiterate women and wives of illiterate men. However, there was little urban-rural difference in fertility. Many births were spaced too closely for optimum health; for example, nearly 72 percent of closed birth intervals were less than 36 months. Among those who already had two living children under 5 years of age, 15 percent were currently pregnant.

Maternal and Neonatal Care

The household survey obtained data on selected key indicators of maternal and neonatal health from 367 sampled women who had delivered a child during the previous four years (see Table B). Of these women, 63 percent had visited a health provider at least once for antenatal care; 37 percent had at least two tetanus toxoid immunizations; 49 percent were delivered by a skilled birth attendant; and 53 percent were delivered in a public or private health facility. On the other hand, only 51 percent had at least one postnatal check-up, which has negative implications for family planning as well as for maternal and neonatal health. Exclusive breastfeeding was reportedly widespread; 57 percent of mothers reported breastfeeding their last child for at least 6 months without supplementation.

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

Indicator	Value
Percentage of mothers with at least one antenatal care visit	62.9
Percentage of mothers with at least two tetanus shots	37.4
Percentage of most recent deliveries conducted by a skilled birth attendant	49.3
Percentage of most recent deliveries in a facility	52.9
Percentage of MWRA not wanting more children	48.0
Percentage of MWRA wanting to delay next birth for at least two years	25.5
Percentage of MWRA knowing at least one contraceptive method	94.9
Contraceptive prevalence rate	30.9
Percentage of MWRA who are past users of contraception	14.5
Percentage of MWRA with unmet need for family planning	33.0
Percentage of MWRA with unmet need for spacing	13.5
Percentage of MWRA with unmet need for limiting	19.5
Total demand for family planning (CPR + unmet need)	63.9

Preference for Children

The median “ideal” family size according to the women respondents was 5 children. Regarding desire for more children in the future, 27 percent said they wanted another child soon (within two years), 26 percent said they wanted another child, but only after two years, and 48 percent said they did not want more children. The proportion wanting more children soon decreased rapidly with the number of living children, while the proportion

not wanting more increased. The proportion wanting more children later was highest for women with one or two children. About 71 percent of the women respondents said their husband wanted the same number of children that they did, while 19 percent said their husband wanted more children than they did.

Contraceptive Knowledge and Use

Ninety five percent 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 31 percent. The most commonly methods in use were the female sterilization (10 percent), condom (9 percent) and withdrawal (4 percent). Past users comprised 14.5 percent of MWRA; injectables, pills, withdrawal, and condoms were all common past methods. Seventy-seven percent of current users did not want more children, while 23 percent wanted more, but at a later time. Most users reported obtaining their supplies and services from private hospitals /clinics and Government hospitals or their husband obtained the supplies.

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, suitability for respondent and husband, convenience of use, low side effects, easy availability and low cost. Costs were generally low (only 25 percent paid more than Rs.50 the last time they obtained their method) and did not appear to be a major obstacle to contraceptive use. Similarly, travel time was usually not excessive; 16 percent reported requiring more than 30 minutes to reach their service point. Information provided at the time of acceptance of a method often did not include information on side effects. Clients generally reported being reasonably treated by providers, but 53 percent were being charged. A considerable variety of side effects was reported by current and past users; 78 percent were treated with medicine.

Reasons for Non-use

Nearly all users mentioned husband's possible disapproval, while a great number of all users acknowledged religious concerns, fear of side effects, and the problems of managing side effects. Past users were most likely to discontinue use because they wanted more children, or because of side effects; their reasons for current non-use were most often

related to current or anticipated childbearing, however, side effects were also frequently mentioned. Never users were most likely to say they were not using contraceptives for reasons relating to childbearing, but husband's opposition and fear of side effects were also common reasons. Knowledge of at least one service provider was low among never users. A large majority of female current and past users said they could discuss family planning easily with their husbands, but only 60 percent of never users said they could do so. Nearly half of never using women expressed their intent not to use contraceptives in the future while 35 percent said they would do so.

Unmet Need for Family Planning

A woman is said to be in "unmet need" for family planning if she says she does not want more children, or wants them later, and is at risk of conceiving, but is not using any method of contraception. By this definition, 33.0 percent of the women in this sample were in unmet need, 19.5 percent for limiting and 13.5 percent for spacing. This proportion was fairly typical for Pakistan, but high by international standards. Unmet need for limiting was higher in rural areas, among illiterate women, and among women with lower standards of living. However, unmet need for spacing was higher among illiterate women and with lower standards of living.

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 Sukkur. More than 42 percent of the men did not want more children in the future and 27 percent wanted to delay the next pregnancy. Thirty-nine percent of the male respondents reported that they or their wives were currently using any family planning methods, and 34 percent were using modern contraceptive methods. Among the current users, 94 percent were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, 38 percent reported that they were not intending to use any FP method in future. The fear of side effects was one of the main reasons for not using any FP method. Of those who did intend to use contraceptives in the future, female sterilization and condom were their preferred methods. 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

The district of Sukkur is characterized by a relatively well-developed infrastructure, a fairly high standard of living, a variety of public and private reproductive health facilities, and relatively good maternal and neonatal health care. In this setting, knowledge and approval of family planning were high, and contraceptive prevalence, at 31 percent, was more than that of Pakistan as a whole. Nevertheless, there is much need for improvement; unmet need for family planning remains high at 33 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 various contraceptive methods and their sources. Also, the concept of birth spacing needs to be stressed to lengthen birth intervals, which are often too short.

Chapter 1

Introduction

Background

The FALAH Project

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

The FALAH project will specifically focus on 26 districts. These are:

- **Balochistan:** Gwadar, Jaffarabad, Khuzdar, Lasbela, Quetta, Kech and Zhob;
- **Khyber Pakhtunkhwa:** Charsadda, Mansehra, Mardan and Swabi;
- **Punjab:** Bahawalpur, Dera Ghazi Khan, Jhelum, Khanewal, Multan and Rajanpur;
- **Sindh:** Dadu, Ghotki, Jacobabad, Karachi (townships of Orangi, Liyari and Godap), Larkana, Sanghar, Shikarpur, 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;

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

At the district level, FALAH works to integrate communication and services through a “whole district” approach involving all available resources in the public and private sectors. FALAH is being implemented by a team of seven partner organizations: Population Council (as the lead agency), Jhpiego, Greenstar Social Marketing, Save the Children (US), Mercy Corps, Health and Nutrition Development Society (HANDS), and the Rural Support Program 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 Sukkur, district-level activities are being coordinated by HANDS and RSPN with Greenstar providing information and services through social marketing and other partners supporting specific activities as needed.

Sukkur District

Sukkur is nearly half rural district of Sindh. The population of the district in 2008 is estimated 1118400, with a population density of 217 persons per square kilometer. Sukkur is bounded on the north by Ghotki and Shikarpur districts, on the south by Khairpur, on the east by Ghotki and Jaisalmer (India) and on the west by Shikarpur and Khairpur districts.

According to the 1998 census, 8.2 percent of the district population was lifetime immigrants. Of whom immigrants within the province (Sindh) were 27.7 percent while 45.1 percent were from Punjab, 7.4 from Khyber Pakhtunkhwa and 4.2 from Balochistan. Repatriated from other countries were 4.3 percent.

Sukkur stood 47th among 91 districts in Pakistan,² and within Sindh it stood 7th of 16 districts (UNDP, 2003). In the UNDP Millennium Development Goals report of 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, Sukkur ranked above average on most measures of literacy, water supply and sanitation (17th nationally out of 98 districts on

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.

sanitation), Sukkur stood 63rd on immunization ranking, (Planning Commission of Pakistan, 2006; Government of Pakistan, 2006).

The Sukkur Baseline Household Survey

In Sukkur (as in other FALAH project districts) Population Council conducted a baseline sampled household survey to learn about knowledge, attitude, 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 birth spacing/family planning. This baseline survey results will be compared with an end line survey toward the end of the project to assess progress.

Objectives

The objectives of the Sukkur 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 Sukkur 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 general knowledge, attitudes and practices of these married couples regarding family planning.

Sample Design and Size

The systematic stratified sample technique was used to select a representative sample of the district. The universe consisted of all urban and rural households of the district. 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 were 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 then 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 randomly chosen block was then carried out by the enumeration teams before selecting the sampled households. A fixed number of 13 households were drawn from each sample enumeration block using systematic random sampling.

Rural Sample

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

Selection of Respondents

Within each household, all married women of reproductive age (MWRA) 15-49 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 Sukkur.

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

Result	Rural	Urban	Total
Number of blocks/villages	20	20	40
Planned households	260	260	520
Households contacted	284	313	597
Households replaced	24	53	77
Households refused	4	27	31
Households locked	20	26	46
Eligible women identified	341	246	587
Eligible women refused	2	0	2
Total women's interviews	339	246	585

Questionnaire Design

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

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

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

Hiring of Interviewers and Supervisors

Since the respondents in the baseline survey were currently married women and their husbands, female interviewers were hired to interview female respondents and male interviewers were used for male respondents. The required number of interviewers was

hired locally by advertising through local newspapers. A logistics supervisor and a data quality supervisor was also hired for each team.

Training of Interviewers and Supervisors

In order to ensure that the training provided for interviewers was of high quality, and that interviewers understood the definitions and concepts underlying the language of the questions, a two-week training of the Sukkur 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 criterion for the selection of primary sampling units, mapping and listing procedures, sample selection, field operation procedures, and selection of particular households and respondents was also provided by specialists.

Quality Assurance

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

Data Entry and Edit Procedures

Data processing was initiated in the field with the checking of the questionnaires. Each team leader completed on-the-spot checks and preliminary editing of questionnaires during the enumeration period. Team supervisors were provided with editing instructions 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 Sukkur district was carried out between February 26 and April 16, 2008.

Chapter 2

Household Characteristics

Geographic Distribution

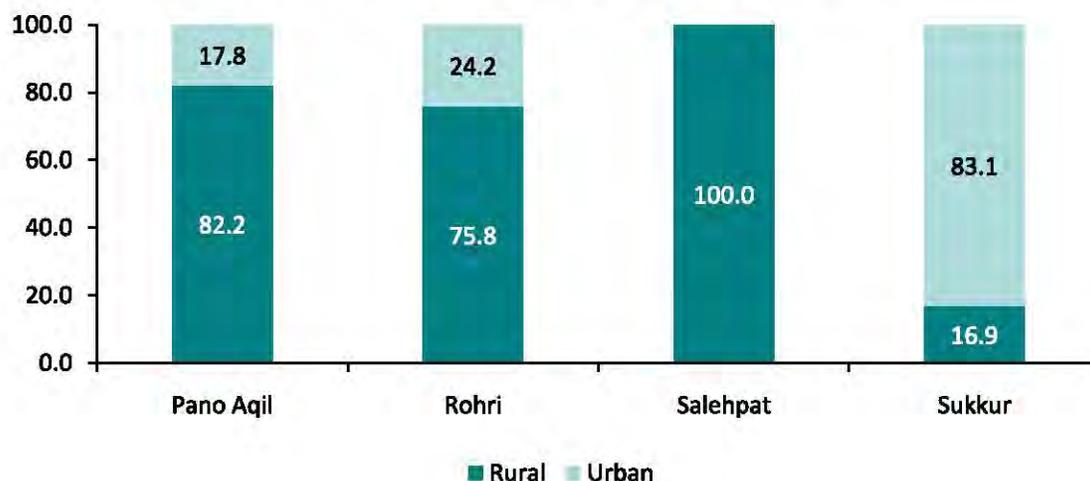
Sukkur district is divided into four talukas: Sukkur, Pano Aqil, Rohri and Salehpat. Except Sukkur, other talukas are primarily rural. Table 2.1 and Figure 2.1 show the distribution of the sample population according to residence (urban and rural) and by taluka, with comparisons to the distribution of the 1998 National Population and Housing Census.

Table 2.1: Percentage distribution of population in sample households by residence and talukas, and comparison with 1998 census data

Talukas	Rural			Urban			Total	
	N	%	1998 Census %	N	%	1998 Census %	N	%
Pano Aqil	1017	82.2	74.6	220	17.8	25.4	1237	100.0
Rohri	955	75.8	74.4	305	24.2	25.6	1260	100.0
Salehpat	457	100.0	100.0	0	0.0	0.0	457	100.0
Sukkur	303	16.9	8.5	1487	83.1	91.5	1790	100.0
Total	2732	57.6	49.1	2012	42.4	50.9	4744	100.0

As Table 2.1 shows the distribution of the population of the 520 households in the sample by urban-rural residence and talukas. Fifty-eight percent of sample population of Sukkur district fell in rural areas. Thirty eight percent of the sample population lived in Sukkur followed by 26 percent in Pano Aqil, 26 percent in Rohri and 10 percent in Salehpat.

Figure 2.1: Rural- urban distribution of population in sample households



Age-Sex Distribution

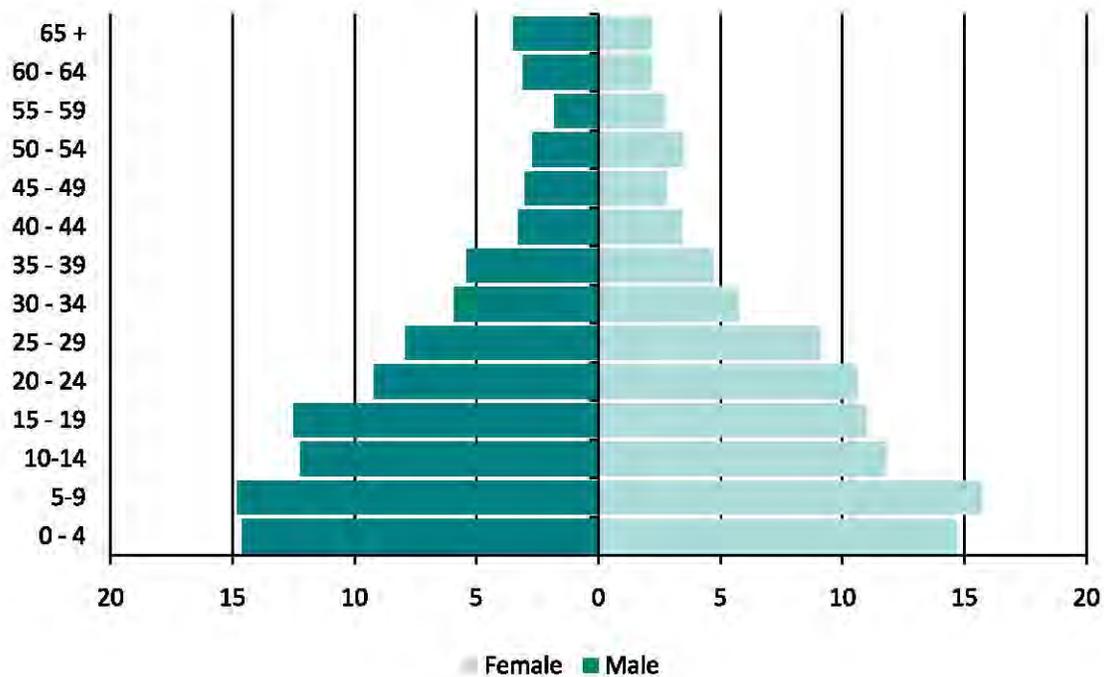
Table 2.2 shows the population of the sampled households by age and sex. Figure 2.2 shows the same information in the form of an age-sex pyramid.

Table 2.2: Distribution of sampled population by age and sex

Age group	Male		Female		Total	
	N	%	N	%	N	%
0 - 4	363	14.6	331	14.7	694	14.7
5 - 9	367	14.8	354	15.7	721	15.2
10 - 14	303	12.2	266	11.8	569	12.0
15 - 19	311	12.5	249	11.0	560	11.8
20 - 24	229	9.2	238	10.6	467	9.9
25 - 29	196	7.9	205	9.1	401	8.5
30 - 34	146	5.9	128	5.7	274	5.8
35 - 39	134	5.4	105	4.7	239	5.0
40 - 44	81	3.3	76	3.4	157	3.3
45 - 49	74	3.0	64	2.8	138	2.9
50 - 54	66	2.7	78	3.5	144	3.0
55 - 59	45	1.8	61	2.7	106	2.2
60 - 64	78	3.1	50	2.2	128	2.7
65 +	86	3.5	50	2.2	136	2.9
Total	2479	100.0	2255	100.0	4734	100.0

The population is typical of a society with past high fertility, with sharply declining percentages by age; the median age was 19 years old. It is important to note that there were more female children in the age group of 0-4 and 5-9 compared to male children. This shows the better survival rates of females. However, in the age group of 10-14 and 15-19 the number of male children was higher as compared to the women. The more number of males however, in the older age group of 60+ suggest more longevity of life of males than females.

Figure 2.2: Age sex distribution



Of the total population of the sampled households, 22.5 percent consisted of females 15-49 years of age, and 14.7 percent consisted of children under 5 years old. These women and children comprise the population of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

Marital Status

Table 2.3 shows, higher proportions of females at younger ages were married than males. The singulate mean age at marriage for females was 22.5 years. From the table it may be observed that a few males were married in the age group of 15-19 as compared to women. This indicates late marriages of men and at the same time this shows that early marriages of women are in practice in considerable number.

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

Age group	Married		Widow/divorced/ separated		Never married	
	Male	Female	Male	Female	Male	Female
15 - 19	3.2	20.3	0.3	0.0	96.5	79.7
20 - 24	29.3	57.6	0.4	0.8	70.3	41.5
25 - 29	61.7	80.5	2.0	2.9	36.2	16.6
30 - 34	79.5	85.9	1.4	4.7	19.2	9.4
35 - 39	87.3	90.5	3.0	7.6	9.7	1.9
40 - 44	97.5	85.5	0.0	10.5	2.5	3.9
45 - 49	100.0	87.5	0.0	12.5	0.0	0.0
50 - 54	90.9	80.8	4.5	17.9	4.5	1.3
55 - 59	86.7	77.0	13.3	23.0	0.0	0.0
60 - 64	87.2	60.0	10.3	40.0	2.6	0.0
65 - 69	80.6	28.6	19.4	66.7	0.0	4.8
70 - 74	87.9	56.3	12.1	43.8	0.0	0.0
75 - 79	85.7	33.3	14.3	66.7	0.0	0.0
80 +	86.7	0.0	13.3	100.0	0.0	0.0
All ages	57.0	64.1	2.9	9.2	40.1	26.7

Household Characteristics and Wealth Indicators

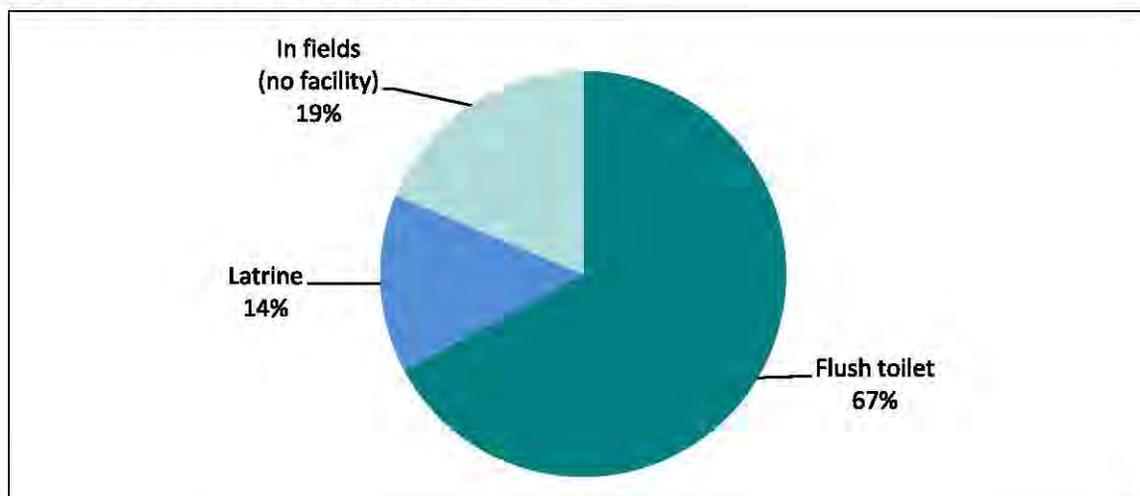
Several household characteristics were assessed that reflected the wealth and well-being of its inhabitants. Some of these may have a direct bearing on health; for example, a clean indoor water supply and flush toilets are important for hygiene, and access to radio and television can help learn about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

Physical Characteristics of Households

Table 2.4 shows selected physical characteristics of the sample households. A considerable majority of households (86.2 percent) had an indoor water supply, although (58 percent) of households this consisted of an inside motorized/hand pump (see also Figure 2.3). Sixty-seven percent of households had flush toilets. However, the number was very low for raised or pit latrines. While many households used firewood for cooking, particularly in rural areas almost the same proportion (49 percent) used natural gas, usually Sui gas. Ninety five percent of the households, even in rural areas, had electricity. Most houses were roofed with guarder or T-iron, while 66 percent of the walls were made of burnt bricks or cement blocks.

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)	7.7	49.6	28.7
Govt. supply (communal)	1.2	0.8	1.0
Motorized/hand pump (inside)	70.0	45.0	57.5
Motorized/hand pump (outside)	18.8	4.2	11.5
Others	2.4	0.4	1.4
Sanitation facility			
Flush to sewerage	1.2	10.0	5.6
Flush connected to septic tank	20.8	20.4	20.6
Flush connected to open drain	13.5	68.5	41.0
Raised latrine	16.9	0.8	8.8
Pit latrine	10.8	0.0	5.4
No facility (in fields)	36.2	0.4	18.3
Others	0.8	0.0	0.4
Type of fuel used for cooking			
Fire wood	82.7	11.2	47.1
Kerosene oil	0.0	0.8	0.4
Gas cylinder	0.8	0.4	0.6
Natural gas (sui gas)	11.5	86.0	48.6
Dry dung	5.0	1.6	3.3
Electricity connection			
Yes	90.8	99.6	95.2
No	9.2	0.4	4.8
Main material of the roof			
Concrete	0.4	23.5	11.9
Iron sheet	0.0	0.4	0.2
Guarder and T-iron	57.7	62.7	60.2
Wood/bamboo and mud	41.5	13.5	27.5
Others	0.4	0.0	0.2
Main material of the floor			
Earth/sand/mud	71.5	11.2	41.3
Chips	0.0	8.8	4.4
Ceramic tiles	0.4	7.7	4.0
Marble	0.0	6.9	3.5
Cement	25.8	56.9	41.3
Bricks	2.3	8.1	5.2
Others	0.0	0.4	0.2
Main material of the walls			
Burnt bricks/blocks	43.8	87.3	65.6
Mud bricks/mud	53.1	12.3	32.7
Wood/bamboo	3.1	0.4	1.7
N	260	260	520

Figure 2.3: Toilet facilities for Sukkur households

Ownership of Household Assets

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

Several items requiring electricity were available in a substantial proportion of households, even in rural areas. Sixty-six percent of all households had television sets and 52 percent had a radio/tape recorder, a figure of particular interest to communications specialists. The recent expansion of information technology in Pakistan is reflected by the ownership of mobile phones by nearly two-thirds of all households, and of a computer by about 13 percent of all households. Motorized transport (four wheels), however, remained fairly uncommon suggesting difficulties in arranging for transport in health emergencies.

Table 2.5: Percent of sample households owning selected items by residence Standard of Living Index

Household item	Rural	Urban	Total
Wall clock	52.7	94.2	73.5
Chairs	15.4	49.6	32.5
Bed	20.4	68.8	44.6s
Sofa	7.7	51.5	29.6
Sewing machine	40.0	76.2	58.1
Camera	8.1	23.5	15.8
Radio/tape recorder	46.9	56.2	51.5
Television	38.8	92.7	65.8
Refrigerator	20.4	66.5	43.5
Land line telephone	5.8	30.0	17.9
Mobile phone	49.8	76.5	63.2
Room cooler/ air conditioner	6.9	38.2	22.5
Washing machine	31.2	84.6	57.9
Bicycle	32.7	19.6	26.2
Motorcycle	21.2	31.2	26.2
Jeep/car	3.5	10.4	6.9
Tractor	7.7	3.1	5.4
Computer	3.1	22.3	12.7
N	260	260	520

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

households was 7 while for rural and urban households it was 5 and 8 respectively. About 65 percent of all households fell in the range from 3 to 8. 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	%
1	9	3.5	0	0.0	9	1.7
2	38	14.6	1	0.4	39	7.5
3	46	17.7	1	0.4	47	9.0
4	37	14.2	7	2.7	44	8.5
5	45	17.3	9	3.5	54	10.4
6	30	11.5	25	9.6	55	10.6
7	28	10.8	43	16.5	71	13.7
8	12	4.6	53	20.4	65	12.5
9	11	4.2	69	26.5	80	15.4
10	3	1.2	35	13.5	38	7.3
11	1	0.4	15	5.8	16	3.1
12	0	0.0	2	0.8	2	0.4
Total	260	100.0	260	100.0	520	100.0
Median	5	na	8	na	7	na

na = not applicable.

Chapter 3

Respondent Characteristics

The primary sources of data from the Household Survey are the interviews conducted with 585 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. As reflected in the age pyramid, since many of the younger women were not yet married, the numbers at age 15-19 were relatively small; at older ages the numbers declined, because significant numbers of women were widowed after the age of 40. About half the sample female respondents were under age 30; urban-rural differences may be seen from the table. Rural women are more married up to the age group of 25-29 which may be attributed to early marriages in rural areas. Thereafter less rural women were found married in the rest age groups which may be due to relatively more maternal mortality and the death of husbands.

Table 3.1: Age distribution of female respondents by residence

Age group	Rural		Urban		Total	
	N	%	N	%	N	%
15 - 19	38	11.2	6	2.4	44	7.5
20 - 24	76	22.4	30	12.2	106	18.1
25 - 29	88	26.0	52	21.1	140	23.9
30 - 34	55	16.2	43	17.5	98	16.8
35 - 39	38	11.2	51	20.7	89	15.2
40 - 44	20	5.9	37	15.0	57	9.7
45 - 49	24	7.1	27	11.0	51	8.7
Total	339	100.0	246	100.0	585	100.0

Education and Literacy

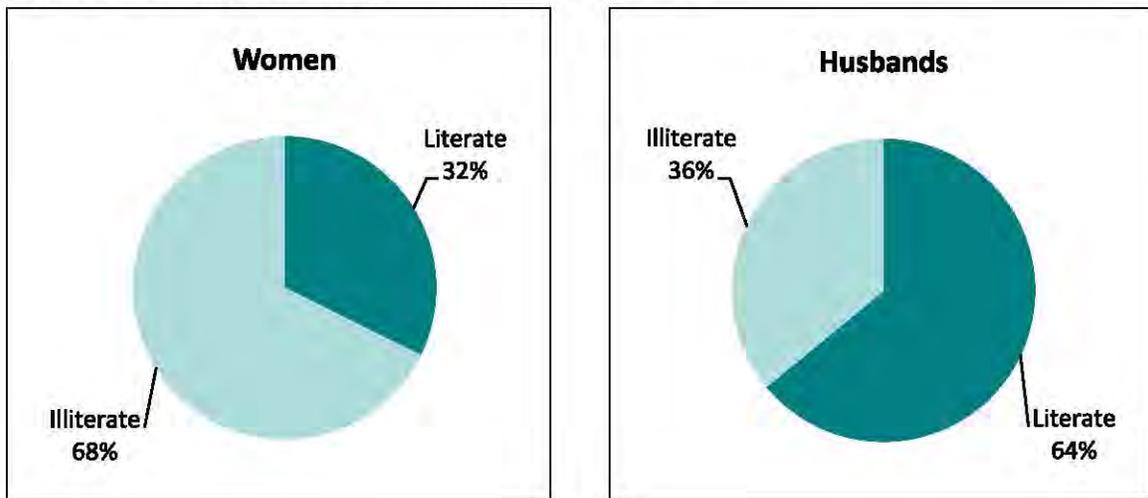
Levels of schooling completed and literacy rates for the respondents and their husbands are given in Table 3.2; literacy rates are also shown in Figure 3.1. The female literacy stands at 32 percent while husbands' literacy is marked as 64 percent. Similarly, about 36 percent of female respondents report having ever attended school while this percentage for husbands' was 66. Table 3.2 shows that younger women aged 15-24 years were less literate than older women 35-49 years old which indicates a converse trend of females education.

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

Variable	Age of respondent			Residence		
	15 - 24	25 - 34	35 - 49	Rural	Urban	Total
Respondent (women)						
Proportion literate	27.3	32.9	35.5	14.5	56.9	32.4
Education level						
No education	67.3	62.9	61.9	82.0	38.6	63.7
Up to primary	12.7	16.5	17.3	11.5	21.5	15.8
Up to secondary	12.7	11.8	13.2	5.9	21.5	12.5
Above secondary	7.3	8.9	7.6	0.6	18.3	8.0
N	150	237	197	338	246	584
Respondent's husband						
Proportion literate	66.2	66.8	59.0	57.8	72.6	64.0
Education level						
No education	32.0	31.3	38.1	40.6	24.4	33.7
Up to primary	28.0	20.5	18.5	28.0	13.4	21.8
Up to secondary	20.0	21.0	16.9	16.3	23.5	19.4
Above secondary	20.0	27.2	26.5	15.1	38.7	25.0
N	150	224	189	325	238	563

For women respondents, literacy and education levels were higher in urban areas. Literacy for women was substantially low in rural areas.

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. Only 216 of the 585 (37 percent) female respondents reported working for cash; their occupations are shown in Figure 3.2.

Figure 3.2: Type of work of women working for pay (n=216)

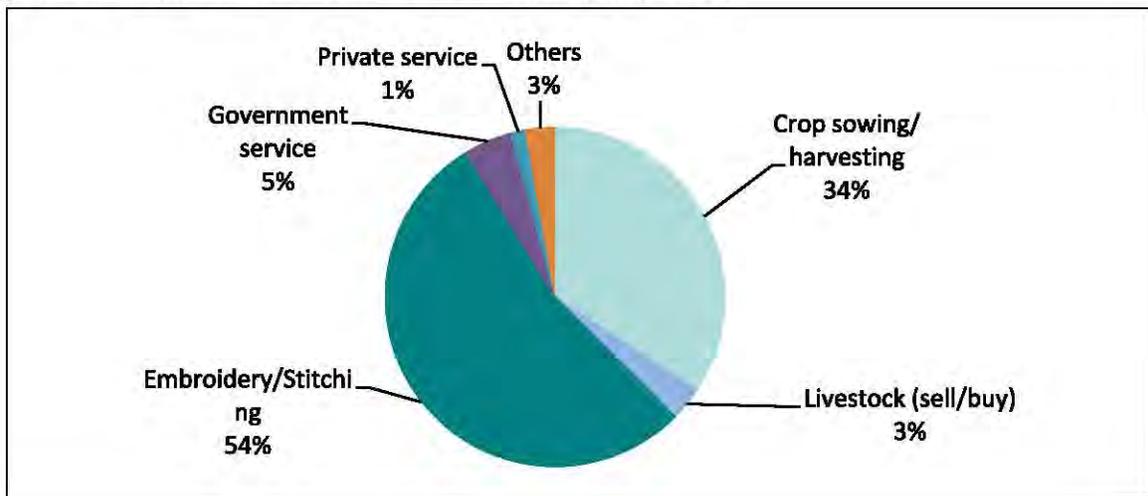


Table 3.3: Distribution of occupational categories of respondents' husbands by residence

Economic activity/occupation	Rural	Urban	Total
Agriculture/livestock/poultry	42.5	5.3	26.8
Petty trader	5.0	12.6	8.2
Labor (daily wages)	21.2	22.4	21.7
Government service	12.1	23.6	16.9
Private service	7.4	13.4	9.9
Own business	2.9	18.3	9.4
Unemployed	5.0	2.8	4.1
Others	3.8	1.6	2.9
Total	100.0	100.0	100.0
N	339	246	585

Table 3.3 shows that about one-fourth of men (27 percent) worked in agriculture/livestock/poultry in the sense that they worked on their own land or were regularly employed on someone else's land. The second largest occupation was labour (daily wages). About 17 percent were in Government service, the third largest employer in the district. About 4 percent of husbands of the respondents 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). Only a few women reported being able to go to any of the places named without permission. On the other hand, 23 percent of the women reported not being able to go at all to the market. However this number is reasonably low for health centre. For each of the named destinations, a majority said they could go with someone.

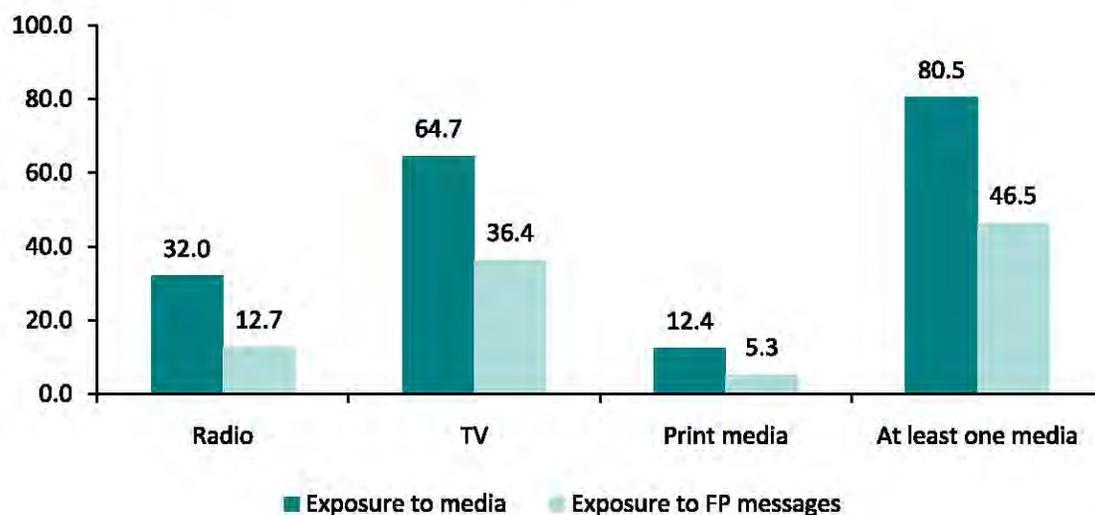
Table 3.4: Women’s reports regarding mobility outside the home, by degree of permission, and destination

Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Can't go/ Doesn't go	%	N
Market	4.4	13.0	60.0	22.6	100.0	585
Health center	7.4	11.3	75.2	6.2	100.0	585
Relatives/friends	10.1	17.3	67.0	5.6	100.0	585
Out of village/ town	1.5	8.0	83.5	7.0	100.0	585

Mass Media Access and Exposure to Family Planning Messages

For the development of communication activities, it is important to know which forms of mass media are available, and to what extent they are used by various segments of the population. Table 2.5 shows that 66 percent of households owned a television, while 52 percent owned a radio. Figure 3.3 shows the proportion of women who reported that they watch TV, listen to the radio, or read newspapers or magazines. Television was the most commonly used medium (65 percent) while radio and print media were less common (32 percent and 12 percent respectively).

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



Furthermore, women who reported access to any sort of media were asked if they had ever seen, heard, or read any message about the methods of family planning through these mediums. Most women said that they had heard about family planning messages on the television (36 percent), 13 percent had heard them on the radio and only 5 percent of the women reported reading messages from print materials.

Chapter 4

Service Availability

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

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

Sukkur District Data

There are total of 1650 health facilities in Sukkur district, of which 1006 are from the public sector and 644 from the private sector (135 - Greenstar Social Marketing; 509 - other private facilities). Some facilities provide only limited care, such as the LHW health houses and dispensaries in the public sector and traditional practitioners in the private sector.

Reproductive Health Facilities

The distribution of reproductive health facilities in the public and private sectors per union council are shown in Maps 4.1 to 4.3. Map 4.1 shows the distribution of government static facilities by union council population density. Similarly, Map 4.2 shows the availability of LHWs; the variation is considerable as 15 union councils have more than 20 LHWs, while 12 have fewer than 10 LHWs. Moreover, there are 3 union councils having no LHW in the area. On average, there are 18 LHWs per union council. Map 4.3 shows the distribution of private facilities in the district.

The gross density of reproductive health facilities in terms of the number of facilities per union council is shown in Map 4.4. Sukkur appeared to be a quite well-served district: there are 12 union councils having more than 40 service delivery points, and there is no union council with less than 10 service delivery points. On the whole, however, there do not appear to be large geographic areas for which no reproductive health services are available. On average, there are 34 reproductive health facilities per union council.

Family Planning Facilities

By and large, family planning services are available in a large number of facilities in Sukkur district. However, the availability of clinical methods, with the exception of injectables, is quite limited; IUDs are available at only 7 percent of all facilities, while female sterilization services are available at only 33 facilities (2 percent), 10 public sector facilities and 23 private. Male sterilization services are available only at 9 facilities, while Norplant is not available at all. In contrast, non-clinical methods, particularly condoms and pills, are available in a large number of public facilities, with LHWs being the main contributing factor. These methods are less available at private facilities. Emergency contraceptive pills are available at 96 facilities mainly from the private sector. Generally, the choice of permanent methods is limited in Sukkur district.

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

Service	Sector										MWRA per facility
	Government		LHWs		Private GSM		Private others		Total		
	N	%	N	%	N	%	N	%	N	%	
Injectables	82	68.9	782	88.2	73	54.1	79	15.5	1016	61.6	184
IUD/Copper T	46	38.7	na	na	47	34.8	14	2.8	107	6.5	1751
Norplant	0	0.0	na	na	0	0.0	0	0.0	0	0.0	na
Female sterilization	10	8.4	na	na	23	17.0	0	0.0	33	2.0	5676
Male sterilization	6	5.0	na	na	3	2.2	0	0.0	9	0.5	20813
Condom	83	69.7	880	99.2	61	45.2	60	11.8	1084	65.7	173
Pills	83	69.7	884	99.7	74	54.8	79	15.5	1120	67.9	167
ECP	14	11.8	2	0.2	58	43.0	22	4.3	96	5.8	1951
Any FP method	85	71.4	885	99.8	81	60.0	96	18.9	1147	69.5	163
Any clinical method	83	69.7	782	88.2	75	55.6	82	16.1	1022	61.9	183
Any non-clinical method	84	70.6	884	99.7	77	57.0	83	16.3	1128	68.4	166
Total facilities	119	100.0	887	100.0	135	100.0	509	100.0	1650	100.0	114

Note: Multiple responses possible.

Clinical method includes; injectables, IUDs, Norplant, female sterilization and male sterilization

na = not applicable

The geographic distribution of these services is as important as the number. Maps 4.5 to 4.7 show the availability of female sterilization, IUDs and injectables, as illustrations. Female sterilization is available in 17 union councils, while IUD services are available in 35 union councils. Availability of injectables is more widespread than other clinical methods, as it is available in all but one union council. Methods like pills and condoms (not shown in the map) are readily available throughout the district.

Maternal Health Facilities

The provision of maternal health care services is an essential component of reproductive health care. Maternal health care services are shown in Table 4.2. Anemia treatment is the most frequently available service, followed by antenatal check-up, in both public and private facilities. Service availability for tetanus protection is generally low, but it is higher in public facilities than in private facilities. Normal delivery services are available at less

than one-tenth of the facilities. Overall, one normal delivery facility is available for every 1398 married women of reproductive age. On the other hand, Caesarean section, an important element of comprehensive obstetric care services, is available in only 25 facilities, mainly from the private sector.

Table 4.2: Number and proportion of facilities providing specified maternal health care services in Sukkur 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	85	71.4	762	85.9	83	61.5	104	20.4	1034	62.7	181
Anemia treatment	101	84.9	779	87.8	105	77.8	288	56.6	1273	77.2	147
TT injection	63	52.9	662	74.6	48	35.6	49	9.6	822	49.8	228
Normal delivery	29	24.4	na	na	59	43.7	46	9.0	134	8.1	1398
Caesarean section	3	2.5	na	na	20	14.8	2	0.4	25	1.5	7493
Total facilities	119	100.0	887	100.0	135	100.0	509	100.0	1650	100.0	114

Note: Multiple responses possible. na= not applicable

Along with the sheer number of facilities, their geographic distribution is of critical importance. Map 4.8 shows the distribution of essential obstetric facilities in each union council of Sukkur district. There are 10 union councils with no obstetric care facilities, while there are 39 union councils that do have facilities providing these services. Map 4.9 shows that comprehensive emergency obstetric care (EmOC) services are available in 12 union councils.

Service Providers

The number of providers of different categories and number of women per provider are shown in Table 4.3. There are a total of 634 MBBS doctors; only about one-third of these are women. There are 297 female paramedics to serve the entire female population of the district; two-thirds of the female paramedics are nurses.

The number of married women per provider or facility is a good indicator of the status of health in the district. Table 4.3 shows that, overall, there is 1 MBBS doctor available to serve 295 married women of reproductive age. Since women usually prefer female service providers, especially for their reproductive health needs, this burden increases to 875 MWRA per female MBBS doctor, indicating a considerable dearth of female doctors. For female paramedics, there are about 631 MWRA per female paramedic. Map 4.10 shows the availability of MBBS doctors by gender in each union council. There are 5 union councils where male doctors are not available, while in 15 union councils there is no female MBBS doctor.

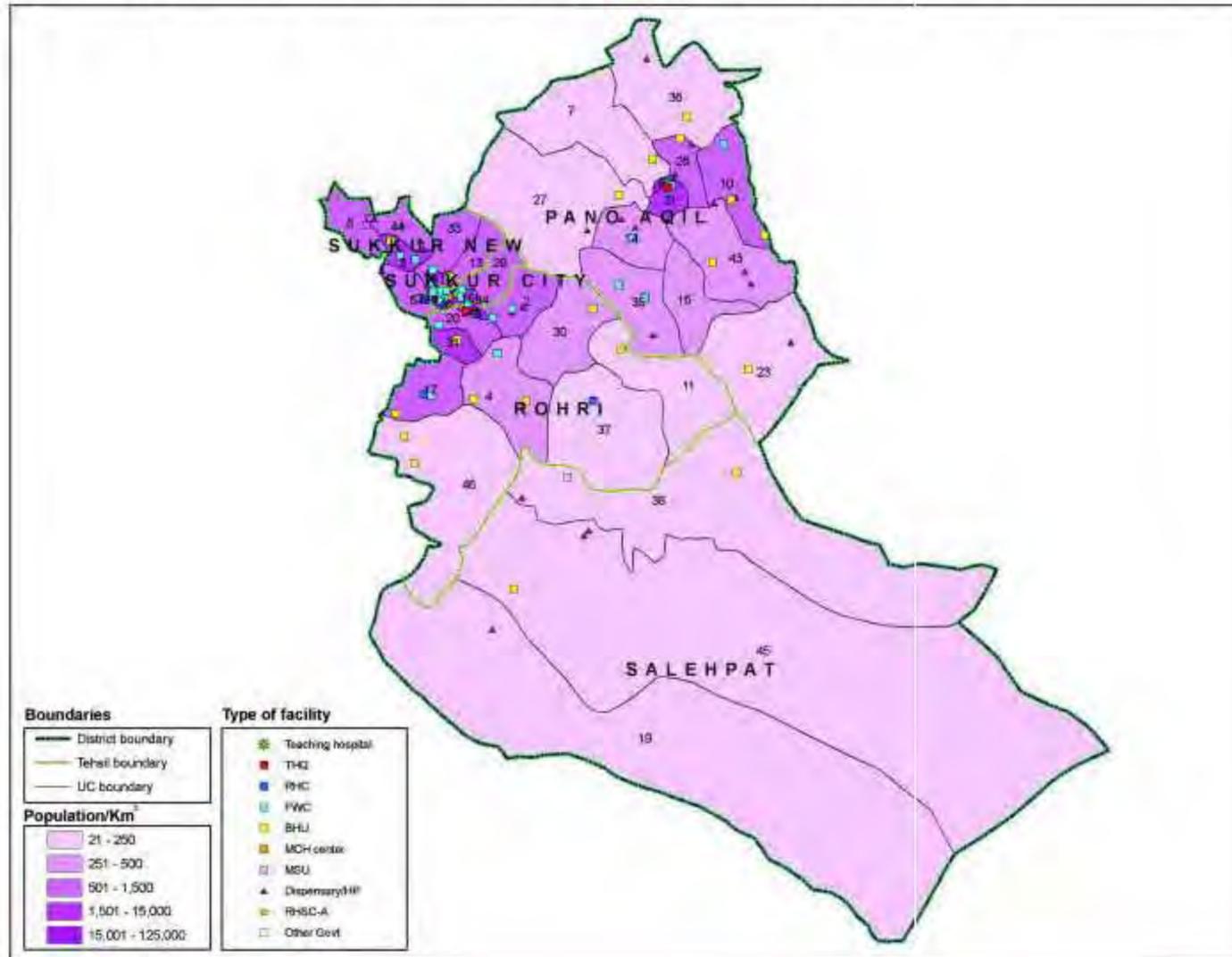
Table 4.3: Number of reproductive health care providers in Sukkur district, by sector and category, and MWRA per service provider

Provider	Sector								MWRA per provider
	Government		Private GSM		Private others		Total		
	N	%	N	%	N	%	N	%	
Doctors (MBBS)									
Male	124	59.9	145	57.8	151	85.8	420	66.2	446
Female	83	40.1	106	42.2	25	14.2	214	33.8	875
Total	207	100.0	251	100.0	176	100.0	634	100.0	295
Female paramedics									
Medical assistant	2	2.1	12	8.6	4	0.0	18	6.1	10407
Nurse	61	64.2	91	65.0	45	72.6	197	66.3	951
Medical/ health technician	3	3.2	3	2.1	0	0.0	6	2.0	31220
Lady health visitor	29	30.5	34	24.3	13	21.0	76	25.6	2465
Total	95	100.0	140	100.0	62	100.0	297	100.0	631
Male paramedics	68	100.0	75	100.0	32	100	175	100.0	1070

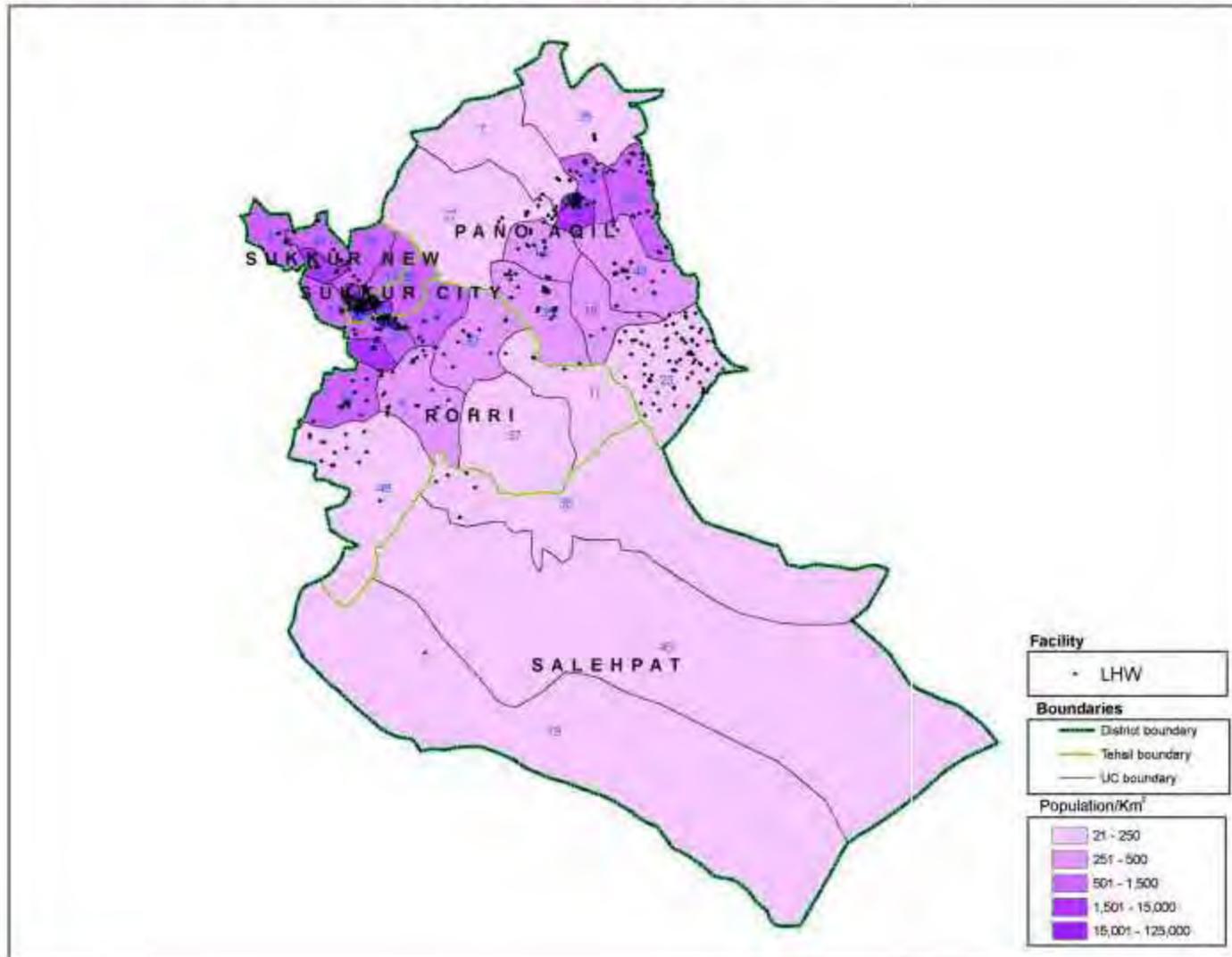
List of Union Councils

- | | |
|---------------------|----------------------|
| 1. Adam Shah | 24. New Goth |
| 2. Ali Wahan | 25. New Pind |
| 3. Arain | 26. Nindapur |
| 4. Arrore | 27. Nouraja |
| 5. Bachal Shah | 28. Old Sukkur |
| 6. Bagerji | 29. Pak Colony |
| 7. Baiji Sharif | 30. Panhwar |
| 8. Bedil Bekas | 31. Patni |
| 9. City Pano Aqil | 32. Pir Illahi Bux |
| 10. Dadlo | 33. Rahuja |
| 11. Dhandhi | 34. Rohri |
| 12. Gharreb Abad | 35. Saangi |
| 13. Gulshane-Iqbal | 36. Sadhooja |
| 14. Hingoro | 37. Sagarar |
| 15. Jia Shah | 38. Salehpat |
| 16. Junas | 39. Shaheed Ganj |
| 17. Kandhara | 40. Shaikh Shehn |
| 18. Kunbhar Para | 41. Shamsabad |
| 19. Laljuriyo | 42. Small Industries |
| 20. Loung Bhatti | 43. Sultanpur |
| 21. Mehran | 44. Tamachani |
| 22. Mir Masoom Shah | 45. Tarai |
| 23. Mubarakpur | 46. Trimoooh |

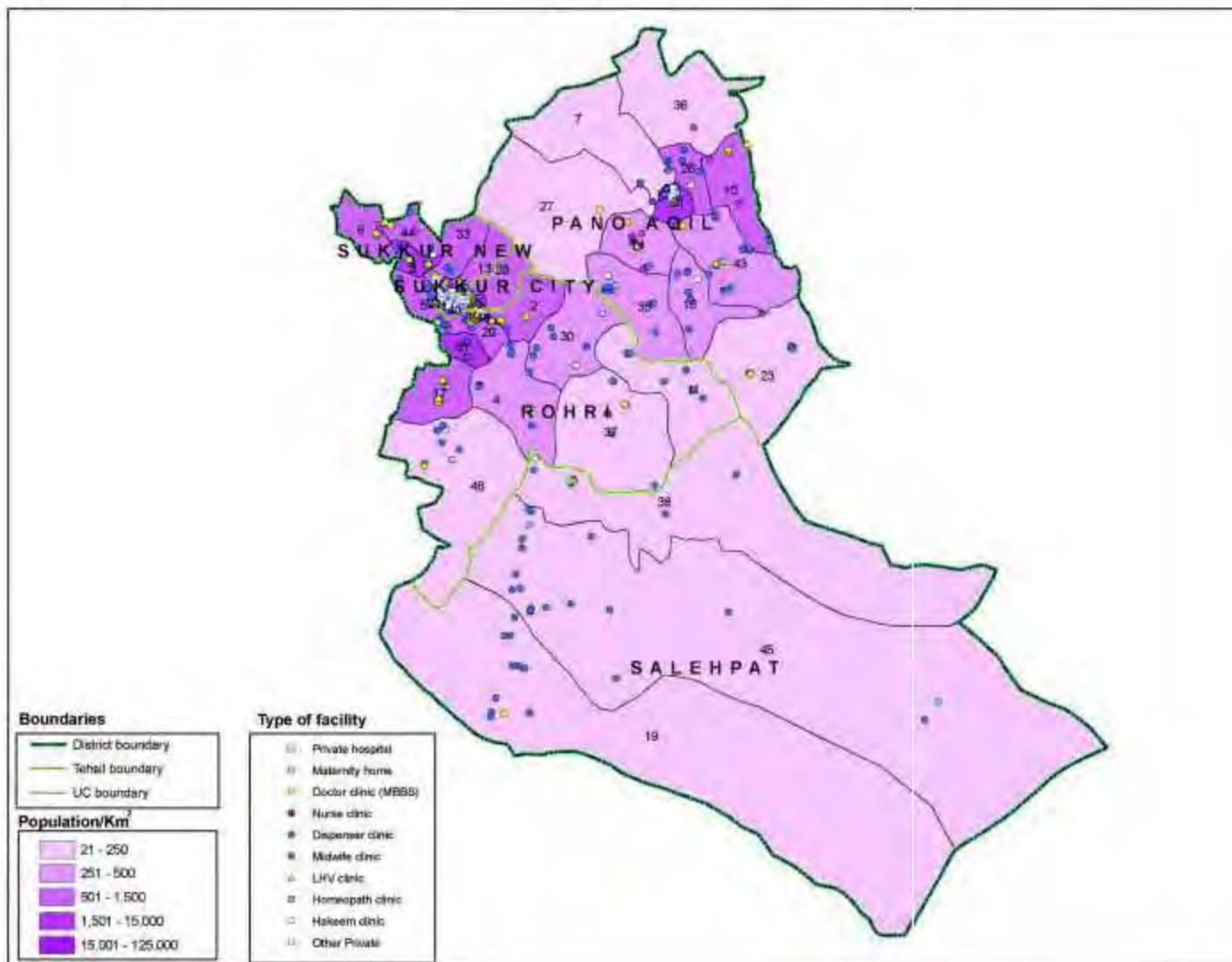
Map 4.1: Location of government facilities in Sukkur district, by population density of union council



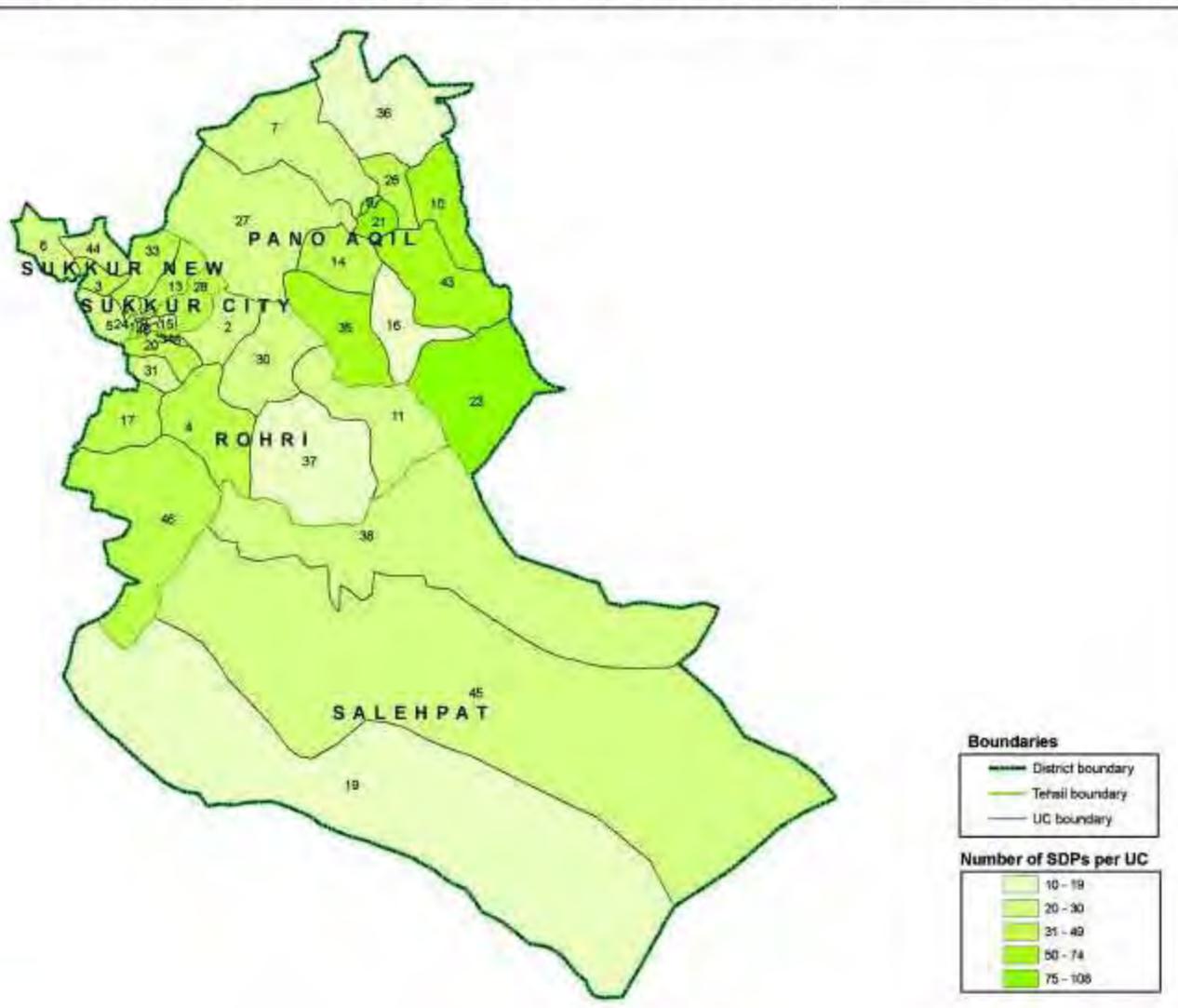
Map 4.2: Location of LHWs in Sukkur district, by population density of union council



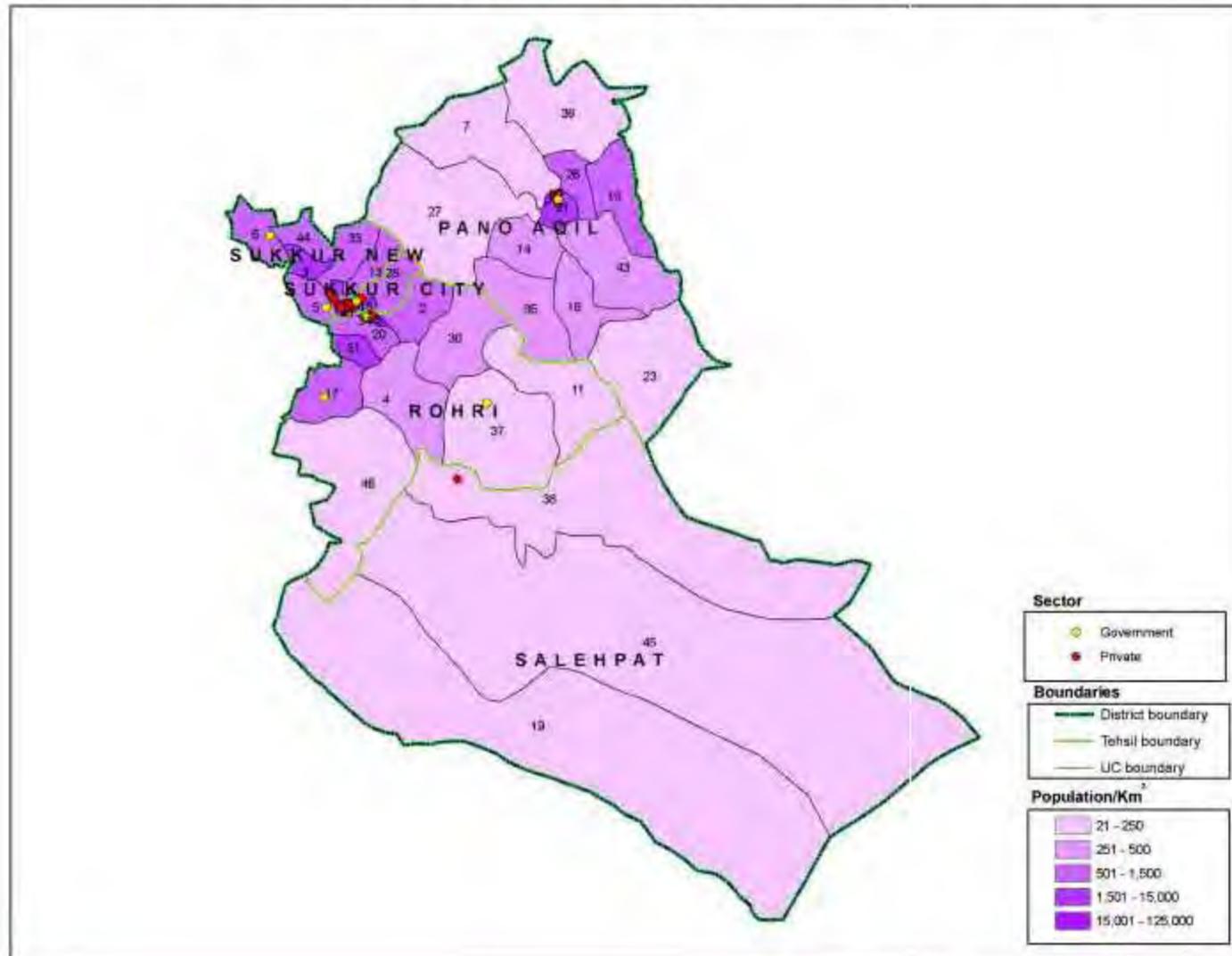
Map 4.3: Location of private facilities in Sukkur district, by population density of union council



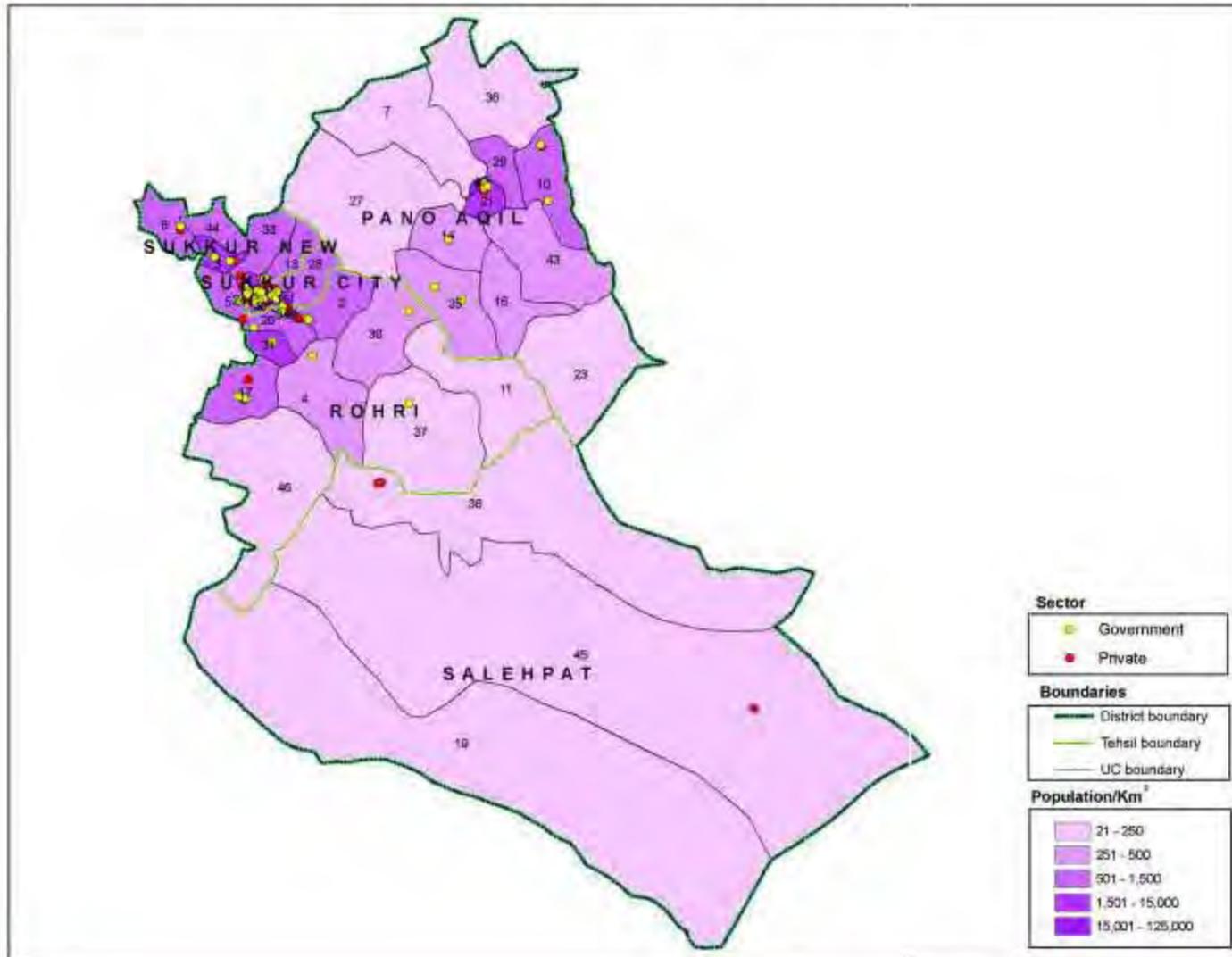
Map 4.4: Total number of reproductive health service delivery points (public and private), in Sukkur district, by union council



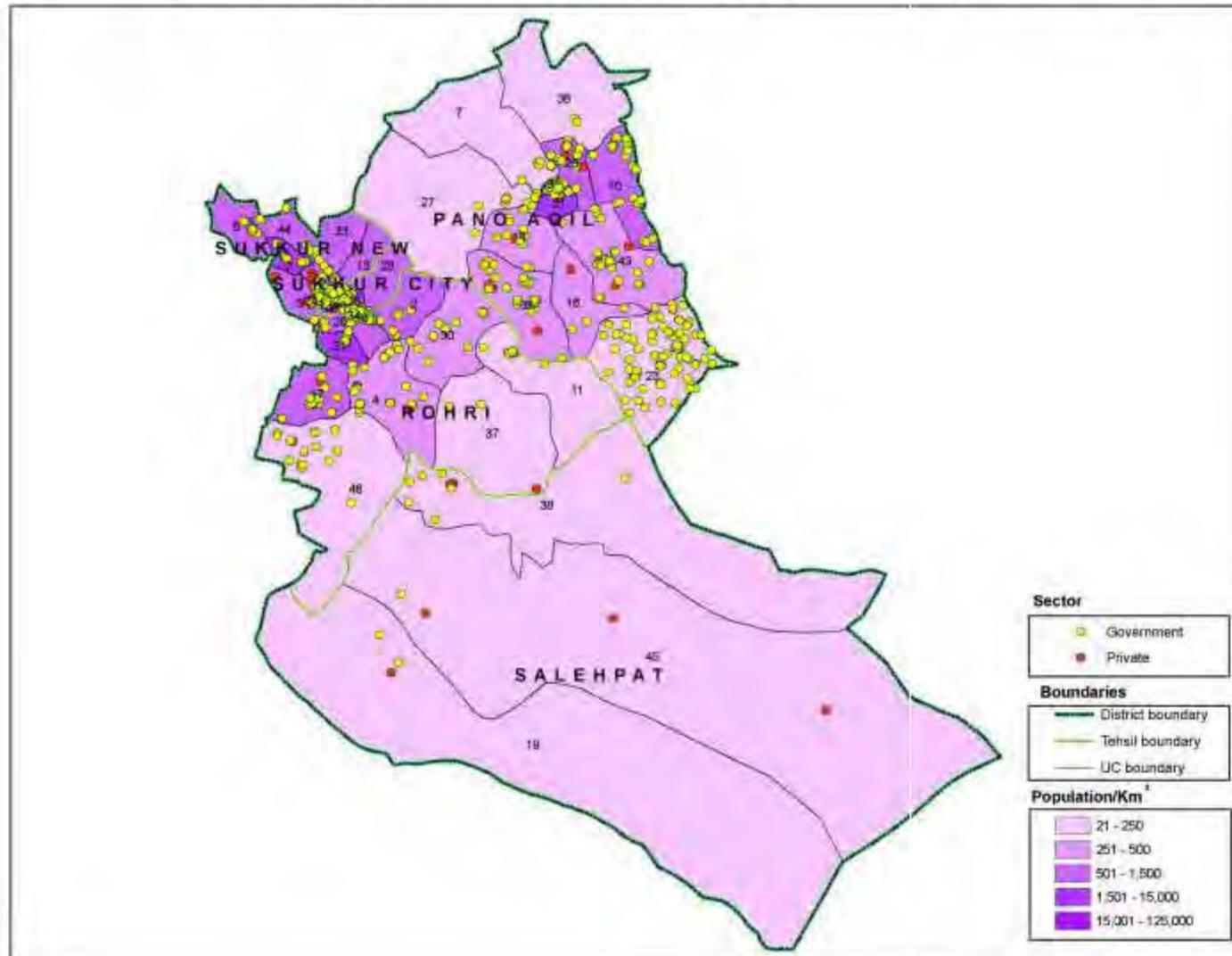
Map 4.5: Location of female sterilization facilities in Sukkur district, by population density of union council



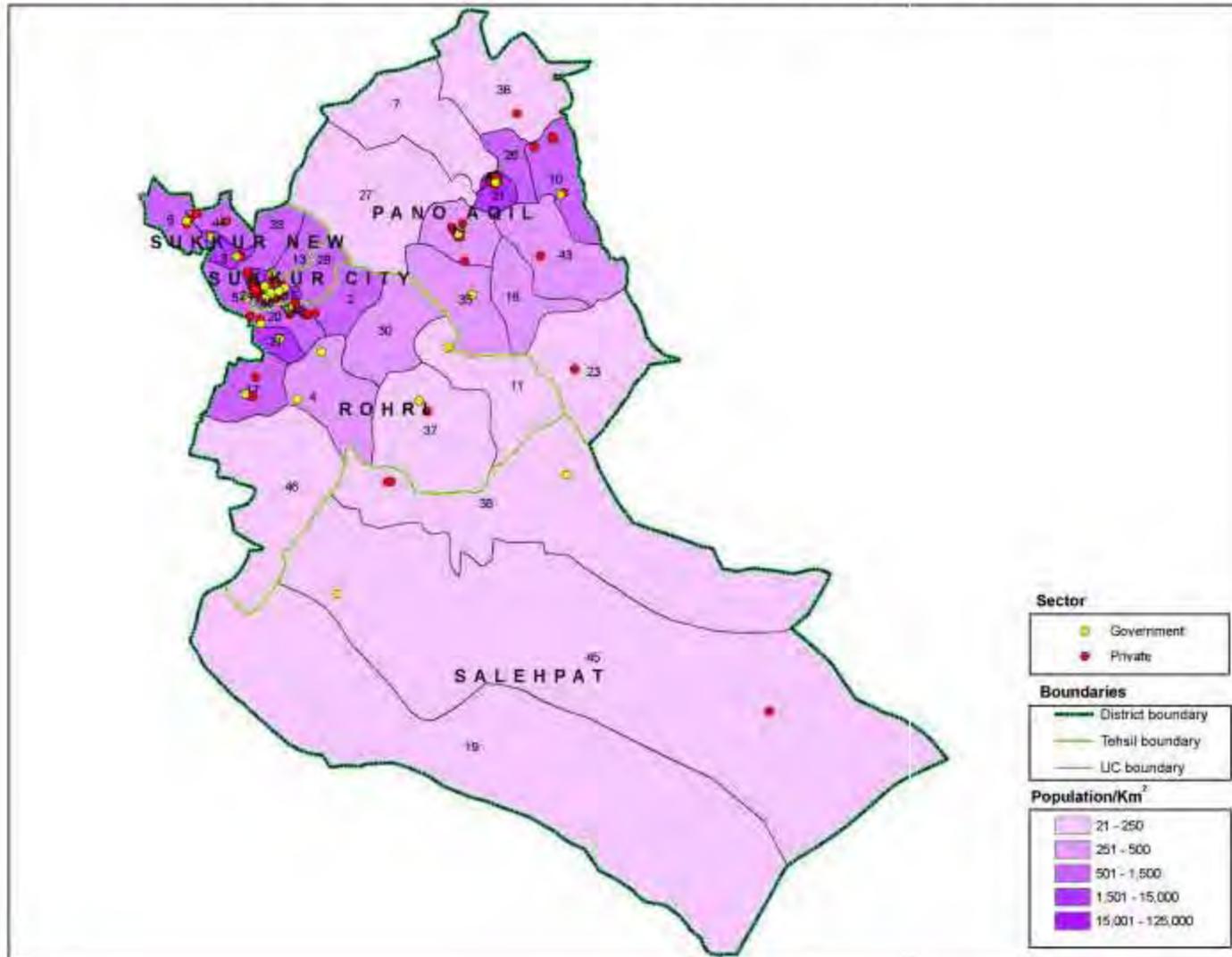
Map 4.6: Location of IUD facilities in Sukkur district, by population density of union council



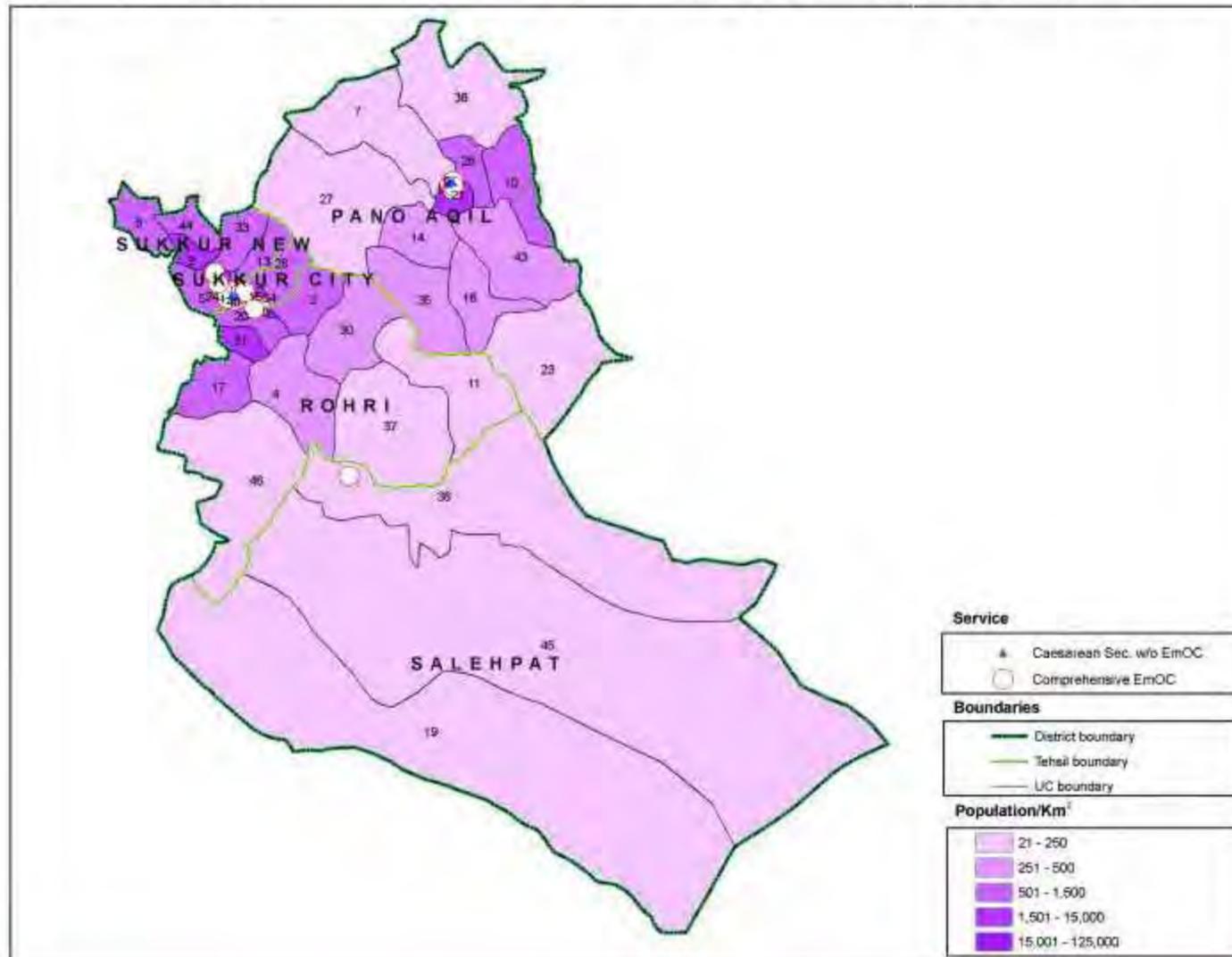
Map 4.7: Location of injectables contraceptive services in Sukkur district, by population density of union council



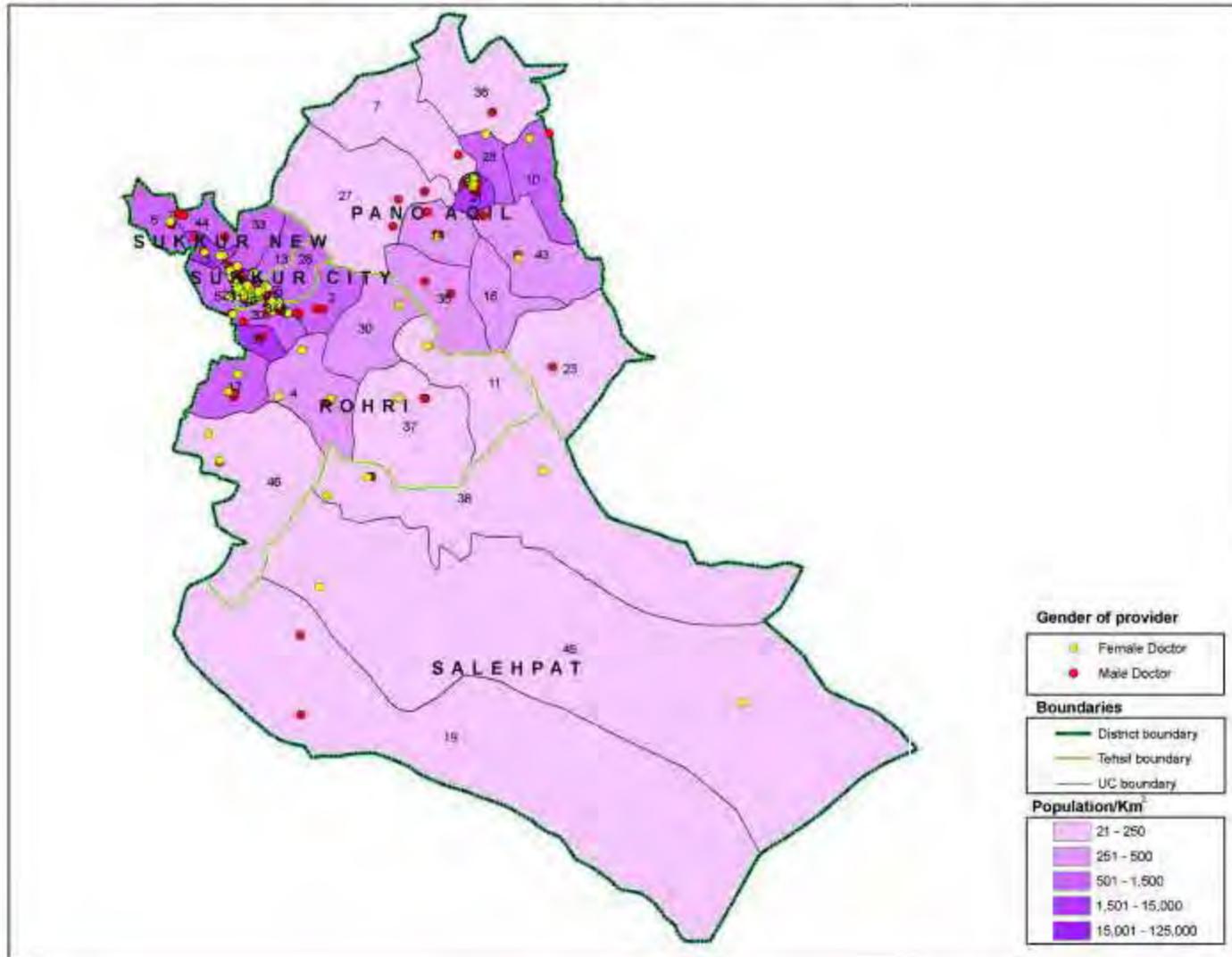
Map 4.8: Location of essential obstetric services in Sukkur district, by population density of union council



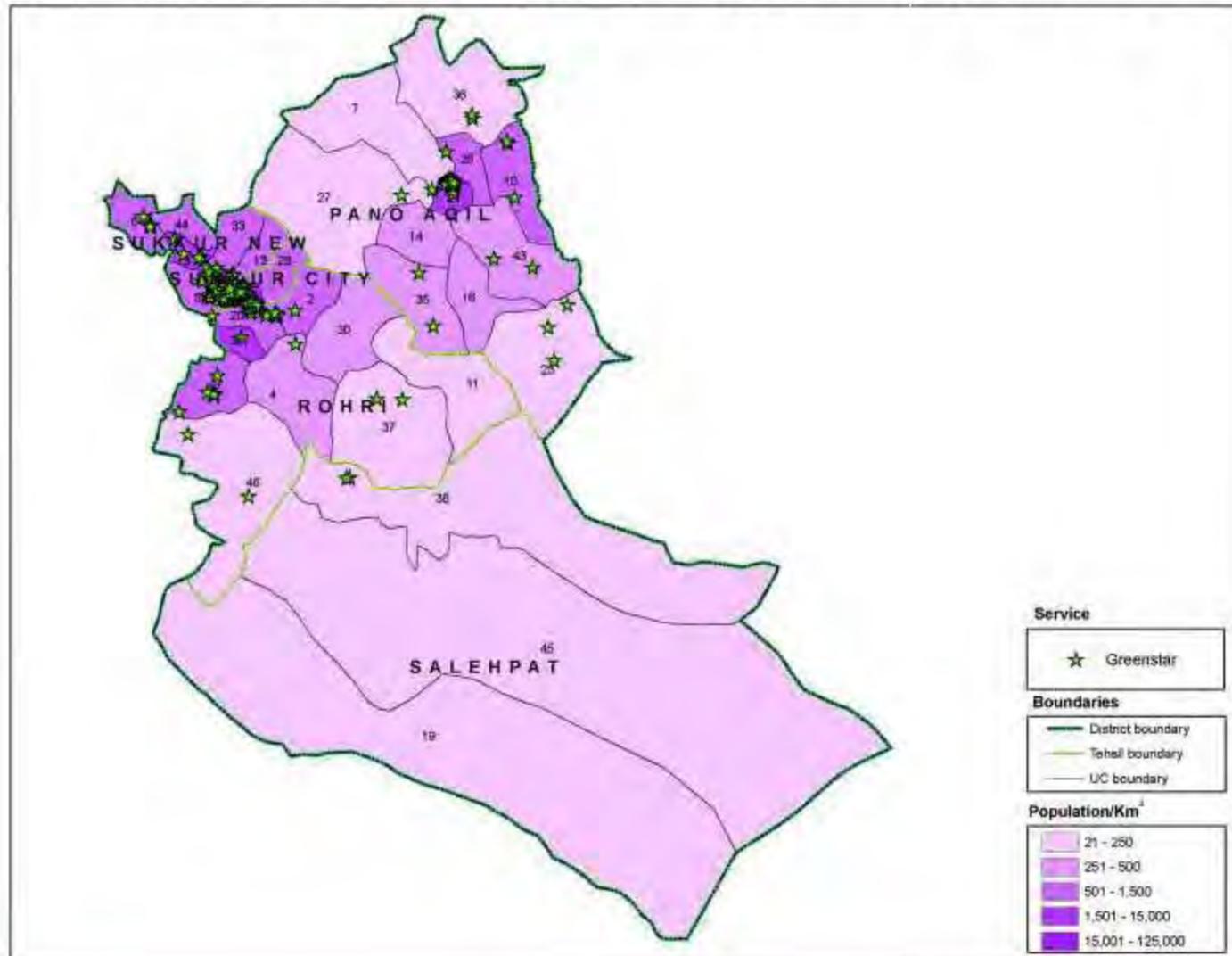
Map 4.9: Location of emergency obstetric care facilities in Sukkur district, by population density of union council



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



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



Chapter 5

Fertility

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

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

Cumulative Fertility

Children Ever Born and Living

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

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

Age group	Children ever born					Mean CEB	N
	0	1 - 2	3 - 4	5 or more	%		
15 - 19	38.6	61.4	0.0	0.0	100.0	0.8	44
20 - 24	17.9	50.0	25.5	6.6	100.0	2.0	106
25 - 29	8.6	27.9	39.3	24.3	100.0	3.2	140
30 - 34	5.1	12.2	23.5	59.2	100.0	5.0	98
35 - 39	1.1	7.9	20.2	70.8	100.0	6.0	89
40 - 44	5.3	7.0	14.0	73.7	100.0	6.7	57
45 - 49	2.0	3.9	7.8	86.3	100.0	8.3	51
Total	9.9	24.6	23.1	42.4	100.0	4.3	585

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

Age group	Number of living children					Mean CL	N
	0	1-2	3-4	5 or more	%		
15 - 19	38.6	61.4	0.0	0.0	100.0	0.8	44
20 - 24	18.9	53.8	24.5	2.8	100.0	1.8	106
25 - 29	8.6	37.9	36.4	17.1	100.0	2.8	140
30 - 34	6.1	12.2	33.7	48.0	100.0	4.4	98
35 - 39	1.1	12.4	23.6	62.9	100.0	5.2	89
40 - 44	5.3	8.8	17.5	68.4	100.0	5.8	57
45 - 49	2.0	7.8	15.7	74.5	100.0	6.8	51
Total	10.3	28.9	25.5	35.4	100.0	3.7	585

Early childbearing was fairly common in Sukkur. The table, as expected, shows that the mean number of children ever born (Table 5.1) and living children (Table 5.2) increased with the age of the mother, as would be expected in data of good quality. Table 5.3 shows the mean number of sons and daughters. Among currently married women aged 15-49 the mean number of children ever born was 4.3. The mean number of children ever born increased steadily with age, going from 0.8 in the age group 15-19 years to 8.3 in age group 45-49. On average, women aged 45-49 had 6.8 living children and each woman in this age group had lost 1.5 children during her reproductive life (Table 5.3).

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

Age group	Mean number of children						N
	Ever born			Surviving			
	Boys	Girls	Total	Boys	Girls	Total	
15 - 19	0.4	0.5	0.8	0.3	0.4	0.8	44
20 - 24	0.9	1.0	2.0	0.8	0.9	1.8	106
25 - 29	1.8	1.4	3.2	1.5	1.3	2.8	140
30 - 34	2.5	2.5	5.0	2.2	2.1	4.4	98
35 - 39	3.2	2.9	6.0	2.8	2.4	5.2	89
40 - 44	3.6	3.1	6.7	3.0	2.8	5.8	57
45 - 49	4.3	4.1	8.3	3.4	3.4	6.8	51
Total	2.2	2.1	4.3	1.9	1.8	3.7	585

Table 5.1 also shows that 61 percent of married women 15-19 years of age had already had a child. Among currently married women in the 45-49 age group, 12 percent had reached the end of childbearing with fewer than five children ever born and 86 percent had five or more than five children ever born. Data show that 2 percent of the women of age 45-49 had no live birth during their reproductive period, suggesting the existence of primary infertility (i.e., the proportion of couples who are unable to have any children) in this sample in Sukkur. The sex ratio at birth was 105 males per 100 females, which is consistent with the international data. The sex ratio of living children was 106.

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 are pronounced. On average, literate women bore 1.2 fewer children than illiterate women. Also, fertility declined with the level of education. Those who had “up to primary” education had, on average, 4.1 children ever born as compared to 4.8 born to women who had no schooling. Those who had “up to secondary” education had 3.2 children ever born and those educated in college had 2.3.

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

Characteristic	Mean number of CEB	Mean number of LC	Proportion dead	N
Literacy of respondent				
Literate	3.5	3.2	0.08	189
Illiterate	4.7	4.0	0.16	395
Schooling of respondent				
No education	4.8	4.1	0.16	372
Up to primary	4.1	3.8	0.09	92
Up to secondary	3.2	3.0	0.08	73
Above secondary	2.3	2.2	0.05	47
Residence				
Rural	4.3	3.7	0.14	339
Urban	4.4	3.8	0.13	246
Literacy of respondent's husband				
Literate	3.8	3.4	0.09	358
Illiterate	5.2	4.3	0.18	201
Schooling of husband				
No education	5.3	4.3	0.19	190
Up to primary	4.3	3.8	0.12	123
Up to secondary	3.6	3.3	0.09	109
Above secondary	3.5	3.3	0.07	141
Standard of living index				
Low	4.4	3.6	0.18	103
Medium low	4.5	3.7	0.17	117
Medium high	4.7	4.1	0.14	150
High	3.9	3.6	0.09	215
Husband's occupation				
Agriculture/livestock/poultry	4.1	3.5	0.14	157
Petty trader	4.7	4.3	0.08	48
Labor (daily wages)	4.5	3.6	0.19	127
Government service	4.4	4.1	0.07	99
Private service	4.1	3.5	0.13	58
Own business	4.0	3.7	0.08	55
Unemployed	5.2	4.1	0.20	24
Others	4.2	3.3	0.21	17
Total	4.3	3.7	0.14	585

Differentials were also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 3.8 children ever born as compared to 5.2 for those who had illiterate husbands. Women with illiterate husbands had the higher number of children ever born (5.2 children) compared to the women who themselves were illiterate (4.7 children). Similarly, women with unemployed husbands had the highest number of children ever born (5.2 children) . Women with husbands who had their own business had the lowest number of children ever born (4.0 children).

Table 5.5 further explains the relationship of age of mothers and literacy with mean number of children ever born and their survival. It is evident that the mean number of children ever born to literate mothers was lower (3.5 children) compared to those mothers who were illiterate (4.7 children). Similarly, the survival of children with literate mothers was far better than those born to illiterate mothers. Mean number of children ever-born to younger literate mothers was lower and their survival was better than children born to mothers in older age groups. In the below 30 age group, 47 percent were literate, as compared to 51 percent who were illiterate. It is not only that literate women had fewer children overall, but younger literate women also had fewer children ever born compared to illiterate women leaving 15-19 age group.

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

Age group	Literate				Illiterate			
	Mean number of CEB	Mean number of LC	N	%	Mean number of CEB	Mean number of LC	N	%
15 - 19	1.3	1.1	8	4.2	0.7	0.7	36	9.1
20 - 24	1.5	1.4	33	17.5	2.1	1.9	73	18.5
25 - 29	2.9	2.7	47	24.9	3.4	2.9	92	23.3
30 - 34	3.5	3.3	31	16.4	5.6	4.9	67	17.0
35 - 39	4.6	4.1	35	18.5	7.0	5.9	54	13.7
40 - 44	5.9	5.4	21	11.1	7.2	5.9	36	9.1
45 - 49	5.4	5.0	14	7.4	9.5	7.4	37	9.4
Total	3.5	3.2	189	100.0	4.7	4.0	395	100.0

Current Fertility

Crude Birth Rate

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

Age-specific Fertility Rates and Total Fertility Rate

The total fertility rate (TFR) is a more refined measure of fertility than CBR. Age-specific fertility rates (ASFRs) and TFRs are based on births to currently married women and the number of women living in the sample households. One of the limitations of measuring ASFRs is 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 till age 25-29, then declined with increasing age. A TFR of 3.9 for the period 2004-2007, obtained from the set of ASFRs calculated from the data presented in Table 5.6, can be compared with 4.3 for Sindh and 4.1 for Pakistan as a whole reported in the PDHS (NIPS/PDHS, 2008).

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

Age group	Women	Births	Age-specific fertility rate (ASFR)
15 - 19	249	32	42.8
20 - 24	238	99	138.7
25 - 29	205	138	224.4
30 - 34	128	64	166.7
35 - 39	105	38	120.6
40 - 44	76	16	70.2
45 - 49	64	5	26.0
Total	1065	392	na
TFR: 3.9			
CBR: 27.6			

na= not applicable.

Mothers with Children Under Five Years

If mothers have a child while breastfeeding an older child, they are often less able to produce breast milk for the older child (Adair et al., 1994). When children are weaned too soon, their growth suffers; they are more likely to suffer from diarrheal diseases (Bohiler et al., 1995). Milk diminution is more likely to occur as women have more children and are undernourished (Garner et al., 1994). In addition, when children are close in age, they compete for resources as well as for maternal care. The mother may also not be able to breastfeed the newborn properly, placing the newborn at higher risk for nutritional deficiency and infectious diseases contracted from older siblings.

Table 5.7 shows a significant number of women with the burden of caring for several young children. Moreover, among those who already had two living children less than 5 years of age, 15 percent were currently pregnant. For such mothers, it is particularly important for their health and that of their children to ensure that birth spacing is a part of their married life at this point.

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

Number of children <5 years	Currently pregnant		Currently not pregnant		Total	
	N	%	N	%	N	%
0	19	9.5	181	90.5	200	100.0
1	41	21.5	150	78.5	191	100.0
2	21	14.7	122	85.3	143	100.0
3	7	14.3	42	85.7	49	100.0
4	0	0.0	2	100.0	2	100.0
Total	88	15.0	497	85.0	585	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 Hessol, 2000; Miller et al., 1995; Zhu et al., 1999). The length of the preceding birth interval is very important for the health of both mothers and their 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 or more months	Total	N
Age group							
15 - 19	42.9	28.6	28.6	0.0	0.0	100.0	7
20 - 24	26.0	26.0	36.4	9.1	2.6	100.0	77
25 - 29	19.7	14.2	40.2	15.0	11.0	100.0	127
30 - 34	12.0	16.0	41.3	13.3	17.3	100.0	75
35 - 39	18.4	12.2	26.5	18.4	24.5	100.0	49
40 - 44	0.0	10.0	40.0	20.0	30.0	100.0	20
45 - 49	0.0	14.3	28.6	0.0	57.1	100.0	7
Birth order							
2	15.0	25.0	35.0	11.7	13.3	100.0	60
3	21.6	14.9	39.2	12.2	12.2	100.0	74
4	10.0	20.0	44.0	10.0	16.0	100.0	50
5	23.4	10.6	34.0	17.0	14.9	100.0	47
6+	19.1	15.3	35.9	15.3	14.5	100.0	131
Education							
No education	18.9	16.0	40.7	14.0	10.3	100.0	243
Up to primary	16.7	18.5	27.8	13.0	24.1	100.0	54
Up to secondary	17.1	12.2	41.5	12.2	17.1	100.0	41
Above secondary	13.6	31.8	18.2	13.6	22.7	100.0	22
Standard of living index							
Low	20.5	11.0	45.2	13.7	9.6	100.0	73
Medium low	17.4	20.9	37.2	11.6	12.8	100.0	86
Medium high	17.5	20.4	31.1	16.5	14.6	100.0	103
High	18.0	14.0	38.0	12.0	18.0	100.0	100
Total	18.2	16.9	37.3	13.5	14.1	100.0	362

A short interval has traditionally been viewed as a risk factor for poor pregnancy outcomes, particularly affecting neonatal mortality, in developing countries (Cleland and Sathar, 1984). It has been observed in several studies that the risk of death for an index child whose birth closes a short birth interval is 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 in an interval of two to three years (Cleland and Sathar, 1984).

Table 5.8 shows that 18 percent of children were born with less than 18 months of birth interval. Almost 72 percent were born with a birth interval of less than 36 months, while 28 percent were born after three years or more. The differentials by mother's age, educational level and standard of living index are also shown. Younger and lower-parity women – particularly women 20-24 and of parity 3 – were more likely to have short birth intervals.

Chapter 6

Maternal and Neonatal Care

Birth spacing is an integral part of maternal and neonatal care. Adequate spacing of births improves the health of mothers and babies; at the same time, the survival of mothers and babies allows for longer birth intervals. In this survey, a small battery of questions was asked regarding the most recent child born during the past four years, reflecting some of the essential indicators of maternal and neonatal care. A total of 367 women out of the 585 women interviewed had borne a child during the past four years, and these women were asked additional questions about maternal and neonatal care.

Antenatal Care

Antenatal check-ups allow for skilled health personnel to advise expecting 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 both 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, but in recent years those proportions have been increasing in Pakistan. Table 6.1 and Figure 6.1 show the number of ANC visits for the last birth of women who had delivered during the previous four years. About 63 percent of the sample respondents had received at least one antenatal care visit during the last pregnancy; the percentage was reasonably higher for urban mothers (75 percent) than for rural ones (57percent). This is significantly higher than the level obtained for Sukkur in the 2004-05 PSLM Survey (57percent). However, overall figure (63 percent) is lower than the level for Sindh in the PDHS (70 percent) but higher than the level obtained nationally in the PDHS (61 percent) (Government of Pakistan, 2006; NIPS/PDHS, 2008). Forty-four percent had at least three such visits and 37 percent had four or more visits. Urban residents were more likely to have had at least one check-up, and to have had more visits, than rural mothers.

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

Number of visits	Rural		Urban		Total	
	N	%	N	%	N	%
No visit	105	43.2	31	25.0	136	37.1
1-2 visits	53	21.8	13	10.5	66	18.0
3 visits	15	6.2	11	8.9	26	7.1
4+ visits	68	28.0	69	55.6	137	37.3
Don't remember	2	0.8	0	0.0	2	0.5
Total	243	100.0	124	100.0	367	100.0

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

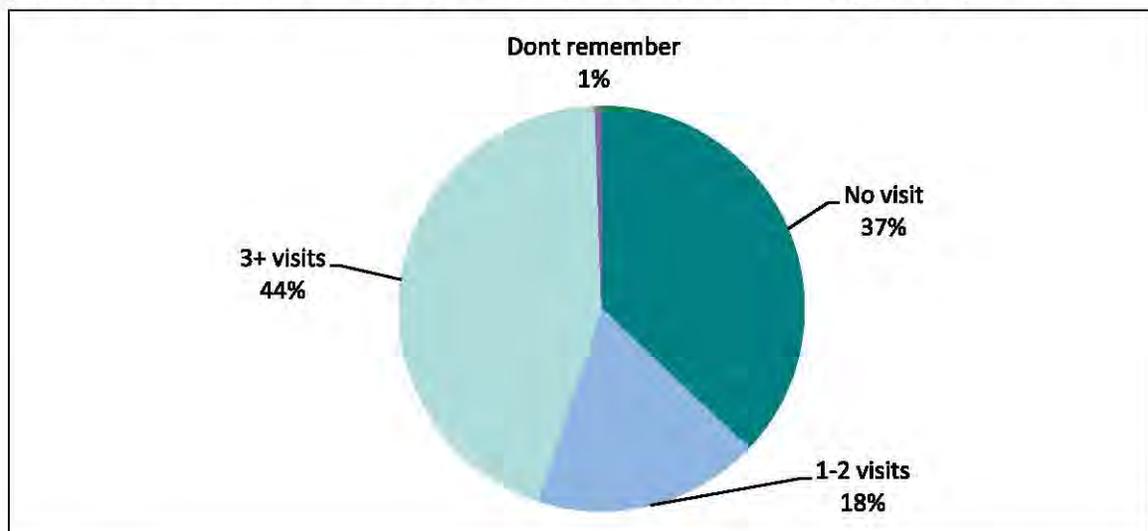


Figure 6.2 shows that many of these visits were in response to some problem, rather than for a routine check-up. Fifty-eight percent of the first antenatal visits were for curative purpose.

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

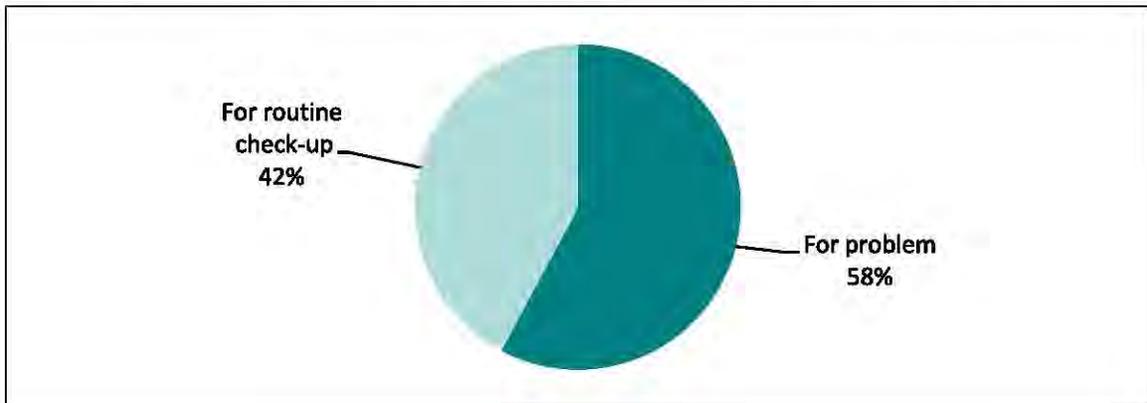


Figure 6.3 shows that 45 percent of the first visits took place within the first three months of gestation, and 23 percent of the first visits occurred during the third trimester.

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

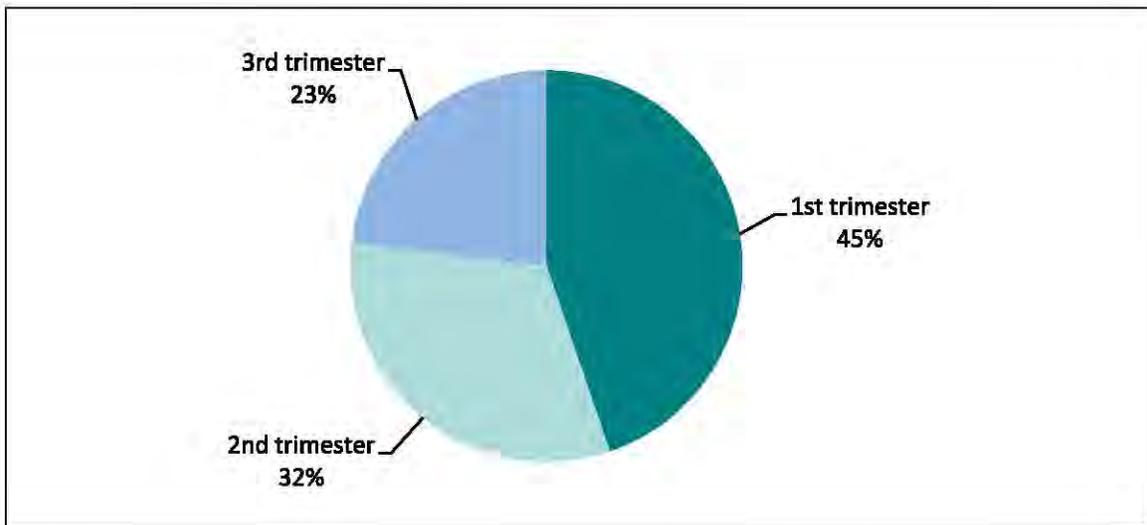
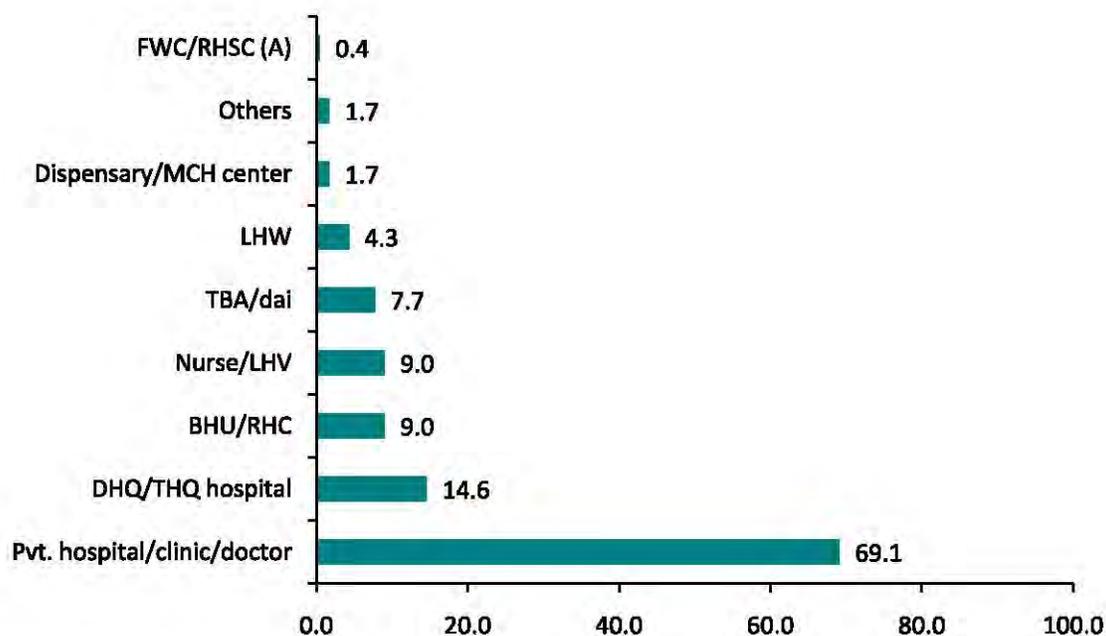


Table 6.2 shows the locations where respondents made one or more antenatal visits. Most antenatal visits took place in private sector facilities followed by DHQ/THQ hospitals; other providers were less common.

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

Facilities/service providers	Rural	Urban	Total
Dispensary/MCH Center	0.7	3.2	1.7
BHU/RHC	13.8	2.2	9.1
DHQ/THQ	15.2	14.0	14.7
Pvt. hospital/clinic/doctor	63.0	79.6	69.7
FWC/RHSC (A)	0.7	0.0	0.4
LHW	7.2	0.0	4.3
TBA/DAI	11.6	2.2	7.8
Nurse/LHV	10.9	6.5	9.1
Others	0.7	3.2	1.7
N	138	93	231

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



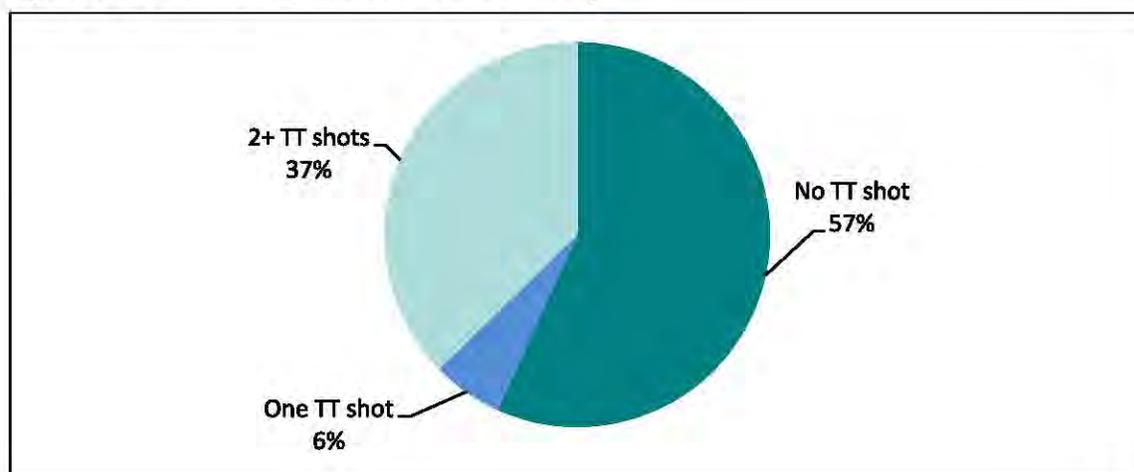
Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn or mother. Two doses in a pregnancy are sufficient to prevent tetanus; however, if the woman was immunized during her previous pregnancy only one dose may be needed. Five doses are sufficient for lifetime protection. According to PSLMS 2004-05, 54 percent of mothers in Sukkur had received at least one shot; according to the PDHS 2006-07, 51 percent in Sindh and 53 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 6.3 and Figure 6.5 show that 43 percent of the mothers had received at least one shot during their last pregnancy, and 37 percent had received two or more shots. Tetanus toxoid immunization for 2+shots was significantly higher in urban areas.

Table 6.3: Tetanus immunization at last delivery

Number of injections	Rural		Urban		Total	
	N	%	N	%	N	%
No TT shot	167	69.0	40	32.3	207	56.6
One TT shot	16	6.6	6	4.8	22	6.0
2+ TT shots	59	24.4	78	62.9	137	37.4
Total	242	100.0	124	100.0	366	100.0

Figure 6.5: Tetanus immunization at last delivery



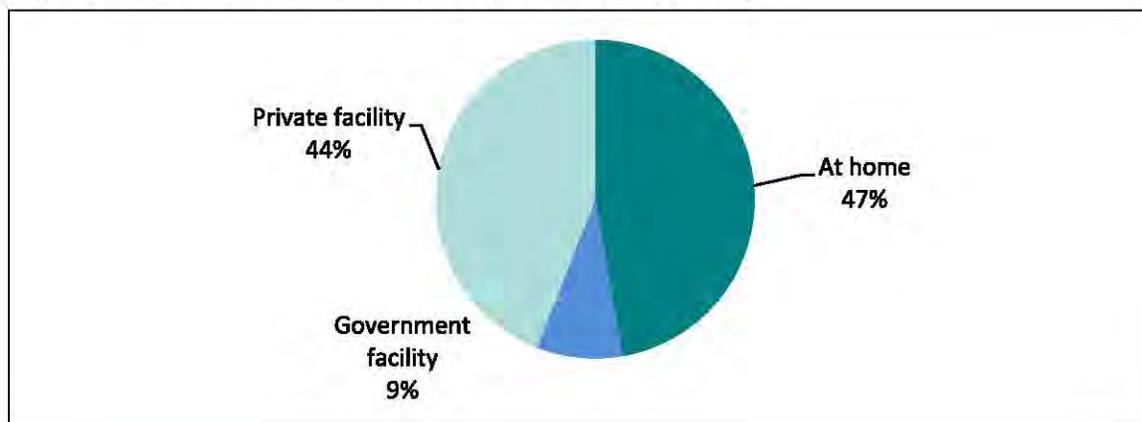
Location and Attendance at Delivery

One of the most important ways to reduce maternal mortality is to increase the proportion of mothers delivering in a health facility with the support of a trained birth attendant. Although these proportions have been rising in recent years, they have been historically low in Pakistan and have contributed substantially to high maternal mortality. According to the 2004-05 PSLMS, in Sukkur 40 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, 53 percent of the most recent deliveries were in a health facility (Table 6.4 and Figure 6.6). Most of the deliveries took place in private hospitals. The table indicates that a large number of deliveries are still taking place at home, particularly in rural areas which increases the risk of maternal mortality.

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

Place of delivery	Rural		Urban		Total	
	N	%	N	%	N	%
At home	148	60.9	25	20.2	173	47.1
Dispensary/MCH center	0	0.0	2	1.6	2	0.5
BHU/RHC	5	2.1	1	0.8	6	1.6
DHQ/THQ hospital	13	5.3	11	8.9	24	6.5
Pvt. hospital/clinic	64	26.3	81	65.3	145	39.5
Others	13	5.3	4	3.2	17	4.6
Total	243	100.0	124	100.0	367	100.0

Figure 6.6: Distribution of mothers by location of last delivery

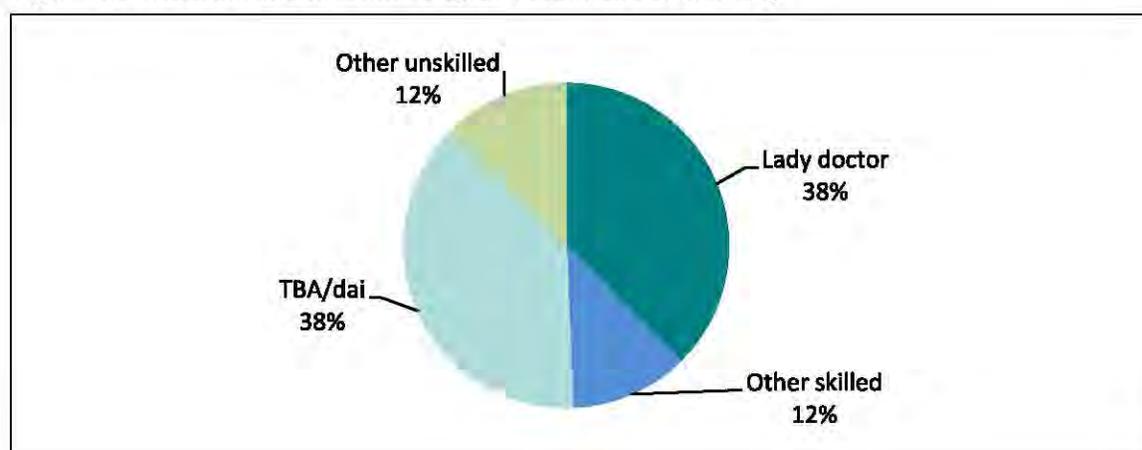


In this survey, 49 percent of the reported deliveries in the previous 4 years were delivered by a skilled birth attendant. This was substantially higher in urban areas (Table 6.5 and figure 6.7). In the PSLMS 2004-05 for Sukkur, only 40 percent of the births were delivered by a skilled attendant; in the PDHS 2006-07, the corresponding figures were 44 percent for Sindh and 39 percent for Pakistan as a whole (NIPS/PDHS, 2008). A number of births attended by a skilled attendant in this household survey were reportedly attended by a lady doctor. (The term “doctor” however, may, in such interviews, mean a paramedic, such as a Lady Health Visitor.) About 38 percent of births were delivered by dais (traditional birth attendants), while another 12 percent, mostly in rural areas, were delivered by a relative or neighbor who was not a *dai*.

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

Birth attendant and skill level	Rural		Urban		Total	
	N	%	N	%	N	%
TBA/dai	117	48.1	23	18.5	140	38.1
LHW	1	0.4	1	0.8	2	0.5
Midwife	4	1.6	1	0.8	5	1.4
Nurse/LHV	23	9.5	15	12.1	38	10.4
Lady doctor	56	23.0	82	66.1	138	37.6
Female relative/friend/ neighbor (not dai)	42	17.3	2	1.6	44	12.0
Total	243	100.0	124	100.0	367	100.0
Skilled birth attendant	83	34.2	98	79.0	181	49.3
Unskilled birth attendant	160	65.8	26	21.0	186	50.7

Figure 6.7: Distribution of mothers by attendant at last delivery



Postpartum Care

For the health of mothers and newborns, a newly delivered mother and baby should be followed up for at least about 6 weeks after delivery. MoH guidelines recommend at least one postpartum visit after discharge during the first 42 days after delivery. This, however, is a major weakness of maternal and newborn health care in Pakistan; women who deliver at home rarely go for any postnatal check-up, and women who deliver in facilities are usually seen while they are in the facility, but not after. This is also the case in Sukkur. Almost 51 percent of respondents reported receiving postnatal care within 40 days after delivery, (Table 6.6), compared with 43 percent nationally and 60 percent in Sindh (NIPS/PDHS, 2008). However, 49 percent received this care within 24 hours. As expected, only 5 percent of the women who delivered at home reported that they had a postnatal check up within or after 24 hours.

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 critical for the mother to focus on family planning and the role it can play in postponing the next pregnancy or in ending childbearing.

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

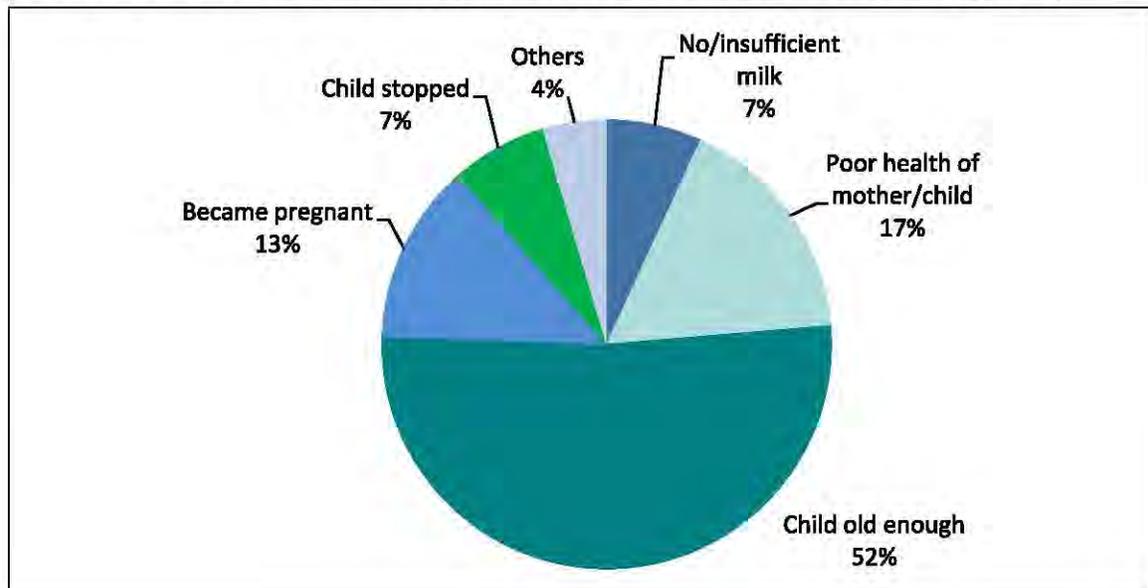
Place of delivery	Postnatal check-up within 24 hours		Postnatal check-up after 24 hours		Didn't have postnatal checkup		Total	
	N	%	N	%	N	%	N	%
Institution	177	100.0	0	0.0	0	0.0	177	100.0
Non institution	4	2.1	5	2.6	181	95.3	190	100.0
Total	181	49.3	5	1.4	181	49.3	367	100.0

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 used to deliberately 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; in our sample, only 4 of 355 respondents reported not having breastfed their last

child at all. Breastfeeding is normally done for a substantial period of time; the median length of breastfeeding for the last baby (not currently being breastfed) was 19 months. Five main reasons were given for discontinuing breastfeeding; child was old enough (52 percent); poor health of mother or child (17 percent); mother became pregnant (13 percent), no or insufficient milk (7 percent) and child stopped (7 percent).

Figure 6.8: Distribution of mothers by reasons for discontinuing breastfeeding (n=131)





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 typically evolve over the course of their reproductive years; in the beginning, they want their first children quickly, while toward the end of their reproductive lives, they are quite sure they want to stop. At some point in the middle, they may go through a period of ambivalence where their views are uncertain and conflicted. Husbands and wives may or may not agree on these matters, and may or may not communicate well. Often it is difficult to learn what couples truly feel 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 female respondents, is (English translation): "If you could choose exactly the number of children to have in your whole life, how many would that be?" Table 7.1 shows the responses.

The median "ideal" number, in the sense indicated above, was 5 children; 43 percent of the respondents wanted four or fewer children. However, only 8 percent said they wanted two or fewer children. These proportions varied according to residence; urban women's non-numeric responses were negligible while 3 percent of the rural women did report non-numeric answers to the ideal number of children they would like to have.

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

Number of children	Rural		Urban		Total	
	N	%	N	%	N	%
1	1	0.3	0	0.0	1	0.2
2	16	4.7	28	11.4	44	7.5
3	22	6.5	15	6.1	37	6.3
4	67	19.8	102	41.5	169	28.9
5	64	18.9	28	11.4	92	15.7
6	73	21.5	46	18.7	119	20.3
7+	85	25.1	24	9.8	109	18.6
Up to God	10	2.9	1	0.4	11	1.9
Others	1	0.3	2	0.8	3	0.5
Total	339	100.0	246	100.0	585	100.0

Desire for More Children

Levels of Desire for More Children

A more immediate measure of fertility preference is whether a couple wants to have more children; if so, do they want the next child now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already has. Table 7.2 shows that whether respondents wanted more children soon, later (after 2 years or more) or not at all was based on the number of living children they already had. Forty eight percent of the respondents did not want more children. A quarter (25 percent) wanted to delay their next child. The proportion not wanting more children may include more such women who have already completed their families. Also, the proportion wanting more children sooner rather than later, declined sharply after the first birth. Among those who had between one and three living children, most of the respondents who want an additional child wanted to have it later, rather than right away. On the other hand, most women with three or more living children did not want to have more children; for those with six or more, the proportion wanting to stop was over 90 percent. This table clearly indicates the high level of interest in both spacing and limiting births.

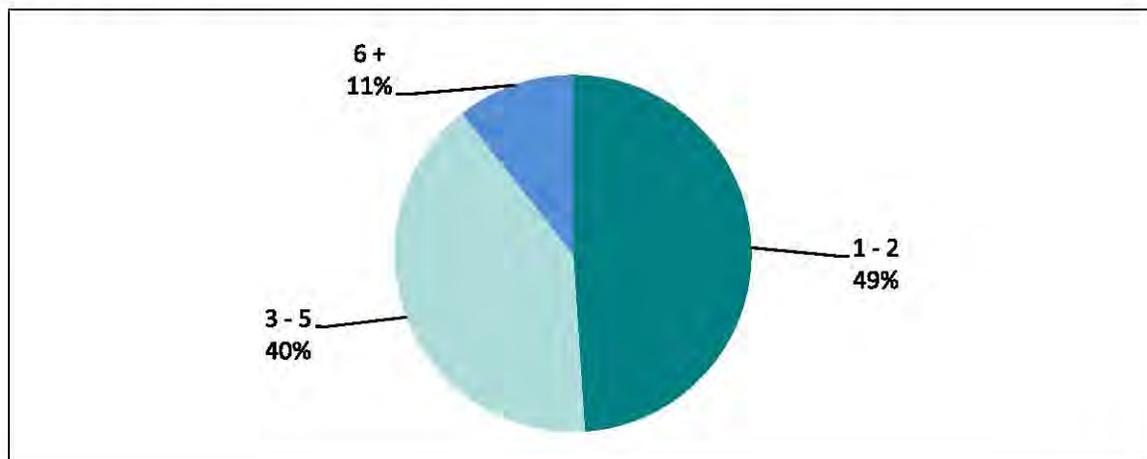
Table 7.2: Distribution of MWRA by desire for next child and current number of living children

Number of living children	Desire for next child			Total	
	Soon	Later	Never	N	%
0	78.3	21.7	0.0	60	100.0
1	47.4	48.7	3.9	76	100.0
2	22.6	50.5	26.9	93	100.0
3	31.6	32.9	35.5	76	100.0
4	20.5	15.1	64.4	73	100.0
5	5.7	22.6	71.7	53	100.0
6 +	5.8	2.6	91.6	154	100.0
Total	26.5	25.5	48.0	585	100.0
N	155	149	281	585	na

na = not applicable.

For those women who wanted more children, we also asked how many more. Figure 7.1 indicates that about half of the women who wanted more children, and who had an opinion, wanted one or two more children.

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



Socioeconomic Correlates of Desire for Children

A woman's stated desire was analyzed in relation to four possible socioeconomic determinants: standard of living index (SLI), respondent's age, literacy and residence (Table 7.3). The relationship between SLI and desire for more children was consistent. The age of the respondent was strongly associated with the desire to not have more children. Literate women were noticeably more likely to not want more children, less likely to want them soon, and much more likely to want more children later. 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	41.7	26.2	32.0	103	100.0
Medium low	35.9	22.2	41.9	117	100.0
Medium high	28.7	19.3	52.0	150	100.0
High	12.6	31.2	56.3	215	100.0
Age of woman					
< 25	42.0	49.3	8.7	150	100.0
25 or more	21.1	17.2	61.6	435	100.0
Literacy of respondent					
Literate	15.3	30.7	54.0	189	100.0
Illiterate	31.6	23.0	45.3	395	100.0
Residence					
Rural	34.8	26.0	39.2	339	100.0
Urban	15.0	24.8	60.2	246	100.0
Total	26.5	25.5	48.0	585	100.0

Son Preference

In Pakistan, there is known to be substantial preference for sons over daughters; in particular, the belief that a family is incomplete without sons is stronger than the corresponding belief for daughters. In this questionnaire, respondents were asked how many daughters they would have before stopping if they did not have a son, and correspondingly for sons if they did not have a daughter. Son preference came out most strongly in the proportions saying that there would be no limit: 30 percent for daughters before having a son, 23 percent for sons before having a daughter (Table 7.4). For those women who gave a number, the median number of daughters before having a son was 4 and the median number of sons before having a daughter was 5.

Table 7.4: Son and daughter preference by respondents

Preference	Number of daughters for desire of son		Number of sons for desire of daughters	
	N	%	N	%
Numeric responses	400	68.4	438	74.9
Other non-numeric responses	1	0.2	3	0.5
Up to God	6	1.0	11	1.9
No limit	178	30.4	133	22.7
Total	585	100.0	585	100.0
Median*	4	na	5	na

*Of the numeric responses.

na=not applicable.

Strength of Preference

The strength of preferences asked in such surveys can be questioned. The need for birth spacing can be presumed to be greater if a couple is strongly motivated not to have more children, or to delay the next pregnancy, than if this does not matter much to them. We asked respondents whether, if they became pregnant soon, would they be pleased, worried, accept it, or it did not matter. Results are shown in Tables 7.5 and 7.6. (This question excludes those 297 of the total 585 women who wanted a next child soon, were currently pregnant, had been sterilized, had gone through menopause or had a hysterectomy).

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	Future desire for children		Total	
	Later	Never	%	N
Pleased	33.7	7.1	16.7	48
Worried	47.1	59.8	55.2	159
Accept it	18.3	33.2	27.8	80
Doesn't matter	1.0	0.0	0.3	1
Total	100.0	100.0	100.0	288
N	104	184	288	288

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

Problems faced if pregnant	Future desire for children		Total	
	Later	Never	%	N
Own health	77.9	83.6	81.6	239
Health of youngest child	71.2	49.2	57.0	167
Caring of children	65.4	64.0	64.5	189
Schooling of children	36.5	59.3	51.2	150
Family economic situation	44.2	64.0	57.0	167
Others	0.0	1.1	0.7	2
N	104	184	288	288

Respondents could give more than one response.

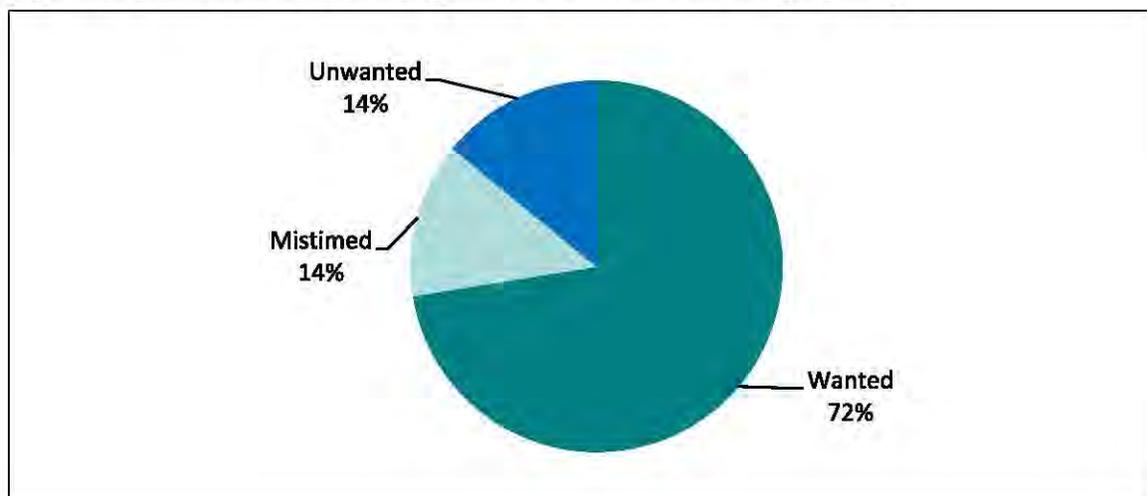
Table 7.5 shows that among those who did not want more children at all, 60 percent told they would be worried if they became pregnant. More than 33 percent reported that they would accept the new pregnancy, while only 7 percent, among those who did not want more children, said they would be pleased. Among those women who wanted to delay their next pregnancy for more than 2 years, 47 percent would be worried while 34 percent would be pleased if they became pregnant and 18 percent would accept the pregnancy. These responses show a weak motivation for spacing. However, the high proportion of women 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 want 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. If we observe the situation overall the problem most commonly faced was own health followed by caring for the children, health of youngest child and the family's economic situation. Health however is emerging as priority in planning a family.

Attitude towards 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 want them. This can be somewhat difficult to determine precisely in surveys. Sometimes parents report that an unwanted pregnancy was actually wanted, but it is less common to report that a child was wanted when in fact it was not. In this survey, as shown in Figure 7.2, many women reported that their last pregnancy was unwanted (14 percent) or mistimed (14 percent).

Figure 7.2: Distribution of MWRA by attitude towards their last pregnancy



Women’s Perception of Husband’s Fertility Preferences

Women were asked whether they thought their husbands wanted the same number of children as they did, more, or fewer children. In Table 7.7, their responses are tabulated according to the woman’s ideal family size. About 8 percent did not know their husband’s preference while 71 percent thought their husbands wanted the same number of children as they did. However, 19 percent of the women thought their husbands wanted more children than they did, while only 2 percent thought their husbands wanted fewer children. Though the majority of the women’s and their husbands’ thinking appears to be at the same wave, but at the same time 19 percent of women think that they have difference of opinion with their husbands who want more children. As in such society the real decision makers in general are males, they need to be focused.

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 children	62.2	28.9	0.0	8.9	100.0	45
3 - 4 children	71.8	21.4	2.9	3.9	100.0	206
5 + children	74.1	17.2	2.2	6.6	100.0	320
Others	0.0	25.0	0.0	75.0	100.0	4
Up to God	10.0	0.0	0.0	90.0	100.0	10
Total	70.8	19.3	2.2	7.7	100.0	585
N	414	113	13	45	100.0	585

Chapter 8

Contraceptive Knowledge and Use

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

Knowledge

At least 95 percent of married women of reproductive age in Pakistan have known of at least one method of contraception for many years. Table 8.1 shows that this holds true for Sukkur as well, where 95 percent women knew of at least one FP method. A majority of the female respondents knew of the most commonly used program methods – pills, injections, female sterilization, and IUDs. Condoms, Norplant, male sterilization, and emergency pills were relatively less known. Natural methods were also not known to the majority of the respondents. Variations in knowledge between rural and urban women may be seen in the table.

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

Method	Rural	Urban	Total
Female sterilization	82.0	96.7	88.2
Male sterilization	15.4	43.7	27.3
Pill	81.1	98.4	88.4
IUD	70.7	91.1	79.3
Injectables	80.7	97.1	87.6
Norplant	34.3	55.7	43.3
Condom	35.5	83.3	55.7
Rhythm	17.8	43.1	28.5
Withdrawal	18.0	63.4	37.2
Emergency pills	10.3	22.0	15.2
Other FP methods	4.5	4.9	4.7
At least one FP method	91.2	100.0	94.9
At least one modern FP method	90.9	100.0	94.7
At least one traditional FP method	27.7	69.1	45.1
N	339	246	585

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) are generally divided into “ever users,” i.e., women who have used some form of contraception at some point, and “never users,” who have not. The ever users are further divided into current users and past users. These categories are in standard use in Pakistan and internationally.

Of all the married women interviewed in our sample, 46 percent reported having used some method of contraception during their married lives (Table 8.2). This percentage was higher in urban areas (70 percent) as compared to rural areas (27 percent). It was lower than the

proportion obtained in the PDHS 2006-07 for Pakistan as a whole (48.7 percent) (NIPS/PDHS, 2008).

Table 8.2: Percentage distribution of married women of reproductive age 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	9.4	19.1	13.5	79	1.2	4.1	2.4	14	8.3	15	11.1	65
IUD	5.3	7.7	6.3	37	0.9	0.8	0.9	5	4.4	6.5	5.3	31
Injectables	11.2	19.5	14.7	86	2.1	2.8	2.4	14	9.1	15.9	12	70
Condom	4.7	33.7	16.9	99	2.4	18.3	9.1	53	2.1	14.2	7.2	42
Rhythm method	5.3	11.4	7.9	46	1.2	2.0	1.5	9	3.8	9.3	6.2	36
Withdrawal	3.8	24.4	12.5	73	0.6	9.3	4.3	25	2.9	15.0	8.0	47
Female sterilization	6.2	15.0	9.9	58	6.2	15.0	9.9	58	0.0	0.0	0.0	0
Other FP method	0.6	3.7	1.9	11	0.0	1.2	0.5	3	0.6	2.4	1.4	8
Any FP method	27.4	70.3	45.5	266	14.5	53.7	30.9	181	13	16.7	14.5	85
Any modern FP method	26.5	63.4	42.1	246	12.7	41.1	25.0	144	13.9	22.4	17.4	102
Any traditional FP method	8.0	33.3	18.6	109	1.8	12.6	6.3	37	6.2	20.7	12.3	72
N	339	246	585	585	339	246	585	585	339	246	585	585
Emergency pills	0.6	0.4	0.5	3	na	na	na	na	0.6	0.4	0.5	3

na=not applicable.

The proportion of currently married women of reproductive age who are currently using some form of contraception, commonly known as the contraceptive prevalence rate (CPR) is one of the central indicators of the status of family planning programs. It shows the degree to which couples are actively involved in spacing or limiting births, and the proportions by method (the method mix) indicates the means couples are using to do this. Historically, the Program in Pakistan has been characterized 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 been stable at about 30 percent (NIPS, 2001; NIPS, 2007; Population Council, 2006; NIPS/PDHS, 2008).

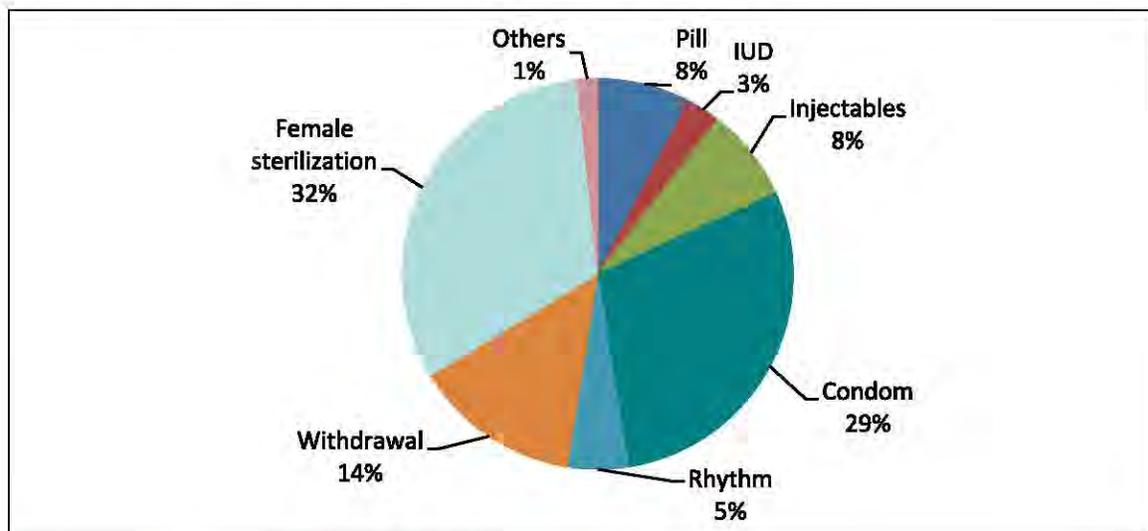
A total of 31 percent of all married women in the sample were currently using some method of contraception (contraceptive prevalence rate or CPR), compared with 29.6 percent for Pakistan in the 2006-07 PDHS, and 26.7 percent for Sindh as a whole (NIPS/PDHS, 2008). In

this survey in urban areas, the CPR was 53.7 percent, compared with 14.5 percent in rural areas.

The methods most commonly in use were condoms and withdrawal (Table 8.2). Female sterilization was also a popular choice for those who did not want more children. Overall, 25 percent of married women were using modern methods and 6 percent were using traditional methods. Figure 8.1 shows the proportion of current users by method mix.

If we compare ever use and the current use of individual methods, Table 8.2 shows that overall 79 women started using the pill as their FP method but 65 discontinued it, meaning that more than 82 percent of the pill users stopped using pills. Similarly, 84 percent and 81 percent, respectively, stopped using IUDs and injectables. The reasons for discontinuing these methods are given in Chapter 10.

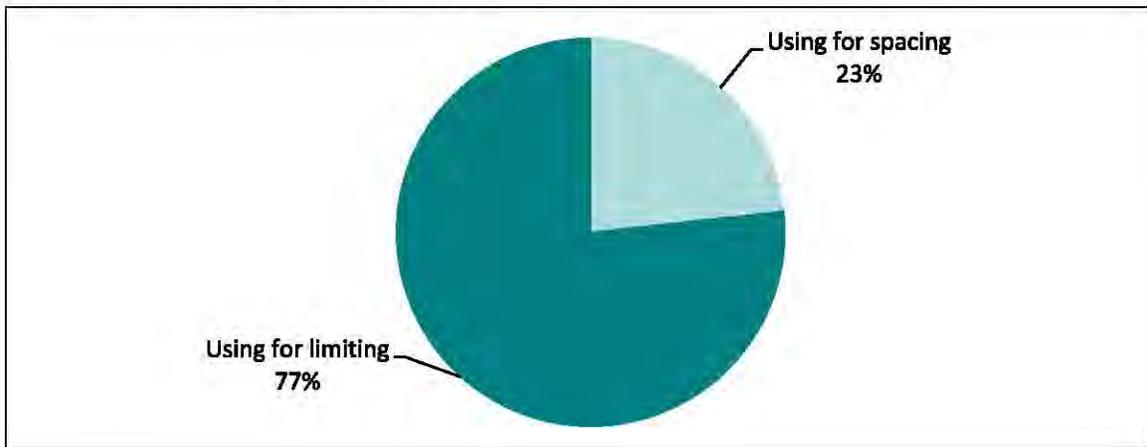
Figure 8.1: Distribution of current users by method mix



Current Use and Desire for Children

It is important to determine how many current users of contraception were using contraceptives for spacing purpose, and how many were using them to stop having children altogether. Figure 8.2 shows that overall 77 percent of current use was for limiting compared with 23 percent for the purpose of spacing births.

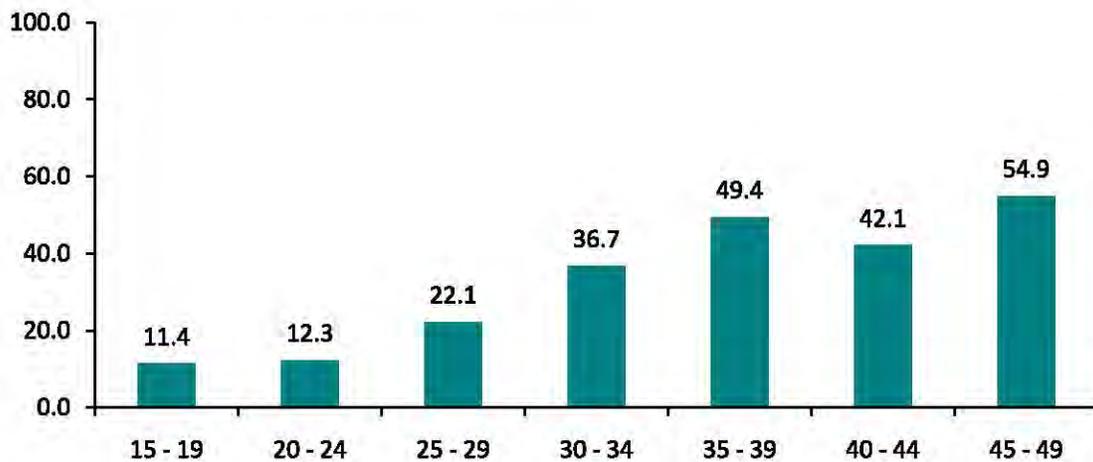
Figure 8.2: Current use and desire for children



Correlates of Contraceptive Use

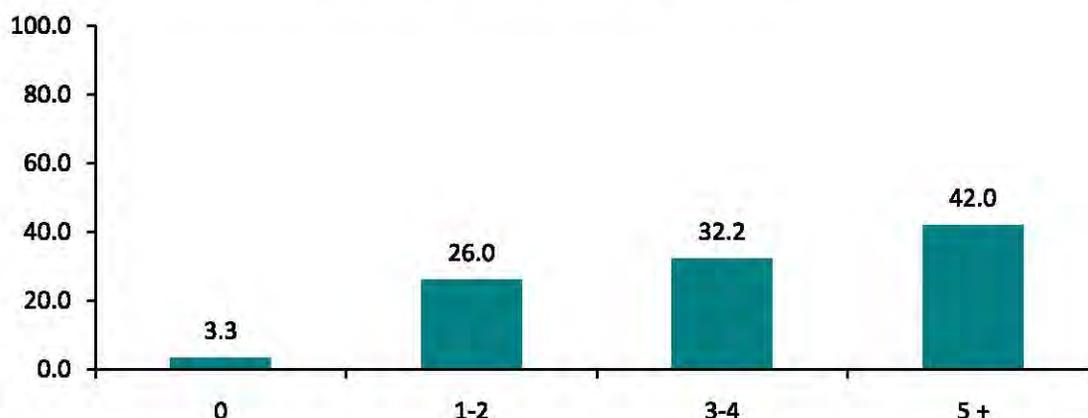
Figures 8.3 and 8.4 show the relationship between contraceptive prevalence and the woman's age and number of living children. The shape of the graph for age shows the increasing prevalence up to the age group of 35-39 years. The prevalence was highest among older women (35-39 years).

Figure 8.3: Contraceptive prevalence by woman's age



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

Figure 8.4: Current contraceptive use by number of living children



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 (52 percent) than those with the lowest SLI; conversely, women from households with low SLI were substantially more likely to be never users. Similarly, respondents' literacy was associated with higher current use and lower never use. Past use was also consistent with SLI and literacy. However, past and current users were much more likely to live in urban areas, while more never users resided in rural areas.

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	3.9	3.9	92.2	103	100.0
Medium low	16.2	9.4	74.4	117	100.0
Medium high	30.7	23.3	46.0	150	100.0
High	52.1	16.3	31.6	215	100.0
Ownership of TV					
Yes	42.3	17.8	39.9	366	100.0
No	11.9	9.1	79.0	219	100.0
Literacy of respondent					
Literate	50.3	18.5	31.2	189	100.0
Illiterate	21.5	12.7	65.8	395	100.0
Residence					
Rural	14.5	13.0	72.6	339	100.0
Urban	53.7	16.7	29.7	246	100.0
Total	30.9	14.5	54.5	585	100.0

Source of Method

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

From this table, it is evident that the source depends on the method. Pills and condoms were mostly obtained from the Lady Health Worker or by the husband; IUDs were mostly inserted in private hospitals or Government hospitals. It is important to note that not a single IUD was inserted in the Family Welfare Center. Injectables were obtained mostly from private hospitals or government 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	Family planning method					Total	
	Pill	IUD	Injectables	Condom	Female sterilization	%	N
Govt. hospital (DHQ/THQ)	2.9	30.8	19.4	0.0	42.1	17.5	36
BHU/RHC/MCH Centre	2.9	23.1	8.3	0.0	0.0	3.4	7
FWC	0.0	0.0	2.8	0.0	0.0	0.5	1
LHW	41.2	0.0	5.6	12.1	0.0	11.7	24
Pvt. Doctor	2.9	0.0	5.6	0.0	1.8	1.9	4
Pvt. hospital/clinic	2.9	30.8	41.7	0.0	50.9	23.8	49
NGO hospital	0.0	7.7	0.0	0.0	5.3	1.9	4
Pharmacy, chemists	29.4	0.0	5.6	1.5	0.0	6.3	13
TBA/Dai/ referral	0.0	7.7	0.0	0.0	0.0	0.5	1
Grocery shop/general store	0.0	0.0	2.8	1.5	0.0	1.0	2
Husband brings method/Don't know	14.7	0.0	8.3	84.8	0.0	31.1	64
Others	2.9	0.0	0.0	0.0	0.0	0.5	1
Total	100.0	100.0	100.0	100.0	100.0	100.0	206
N	34	13	36	66	57	206	206

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 appropriate for them, and to provide sufficient information and support for that method. All methods have their strengths and weaknesses, and no method is deemed to be appropriate for everyone. In looking carefully at the experience of those who have used contraceptive methods, both currently and in the past, we can gain insights into the problems users face and how to 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 why they chose a particular method. The list of possible reasons was read out to them and the results are shown in Table 9.1. Overall, the reasons for current and past users were similar, so the data were combined. Among the most common reasons for choosing a method were suitability for respondent and husband, convenience of use, no or few side effects, easy availability and low cost. For female sterilization and IUD users, suitability of use for a long period of time was often cited. Cited less frequently was no other method available. This means that clients had access to a variety of methods to choose from. They tended to make decisions according to the known attributes of the various methods, but not always. For example, about 82 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 method by reason for choosing that method

Reason	Contraceptive method					Total
	Pill	IUD	Injectables	Condom	Female sterilization	
Easily available	91.2	61.5	91.7	89.4	50.0	77.3
Low cost	79.4	69.2	69.4	86.4	55.2	72.5
Convenient to use	91.2	76.9	94.4	95.5	62.1	84.1
Suitable for R/husband	91.2	84.6	75.0	95.5	84.5	87.4
No/fewer side effects	82.4	76.9	61.1	92.4	75.9	79.7
Can be used for long period	20.6	92.3	83.3	34.8	94.8	61.4
No other method available	14.7	7.7	5.6	1.5	1.7	4.8
Method always available	47.1	23.1	44.4	47.0	17.2	36.7
Provider advised	38.2	61.5	50.0	3.0	75.9	41.1
Others	2.9	0.0	2.8	0.0	3.4	1.9
N	34	13	36	66	58	207

Respondents could give more than one reason

To look more specifically at why some users preferred traditional methods to modern ones, 35 current traditional method users were asked why they were not using modern methods. Side effects were by far the main issue: 86 percent cited fear of side effects, and 26 percent reported their own experience of side effects. Husband's disapproval (of modern methods) was cited by 14 percent of the users, with other reasons cited by a few women.

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

Reason for not using	%
Fear of side effects	85.7
Husband's disapprove	14.3
Experienced side effects	25.7
Cost too much	11.4
Doesn't know about modern methods	11.4
Doesn't know about source of method	8.6
N	35

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 method, whether public or private sector, and the distance from home to facility. Table 9.3 and Figure 9.1 show women's reported costs the last time they obtained a method. Nearly half of the clients (49.7 percent) were not charged for their contraceptives, including all female

sterilization users (who are, in fact, typically reimbursed for expenses involved). For another more than quarter (28 percent), notably condom users, the husband obtained the method, so the wife did not know the cost. Eight percent paid more than 50 rupees and 14 percent paid less than 50 rupees. IUD users often and injectable users sometimes, paid more than 50 rupees for their method. However, for IUD, in particular, it was a one-time cost, so the monthly cost may be quite low.

Table 9.3: Distribution of costs of current specific contraceptive method

Method	Cost in rupees					Total	
	No payment	1-20	21-50	51+	Don't know	%	N
Pill	50.0	21.4	7.1	21.4	0.0	100.0	14
IUD	20.0	0.0	20.0	60.0	0.0	100.0	5
Injectables	0.0	14.3	50.0	35.7	0.0	100.0	14
Condom	11.3	11.3	1.9	0.0	75.5	100.0	53
Female sterilization	100.0	0.0	0.0	0.0	0.0	100.0	58
Others	33.3	0.0	0.0	33.3	33.3	100.0	3
Total	49.7	7.5	6.8	8.2	27.9	100.0	147

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

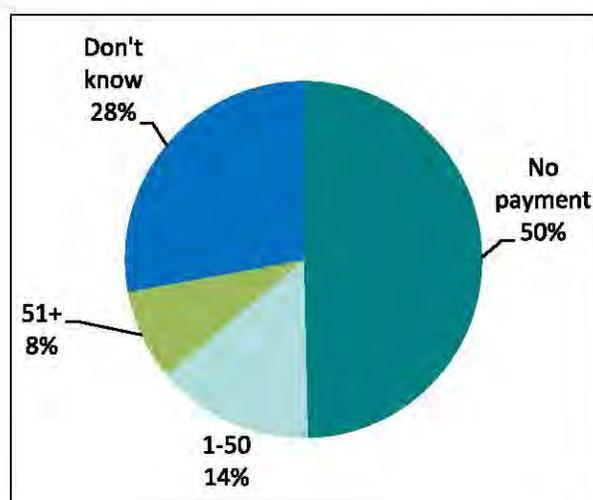
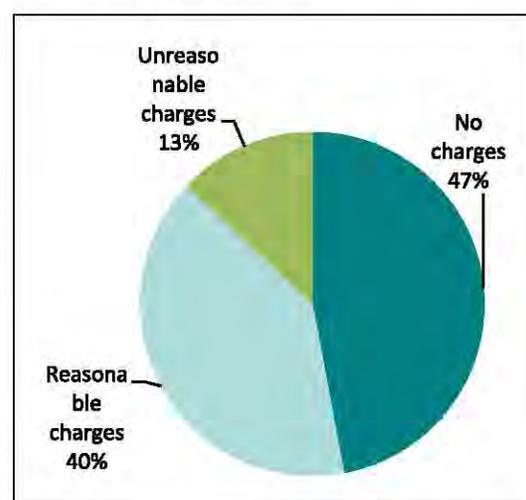


Figure 9.1B: Attitude towards service charges for current method other than contraceptive

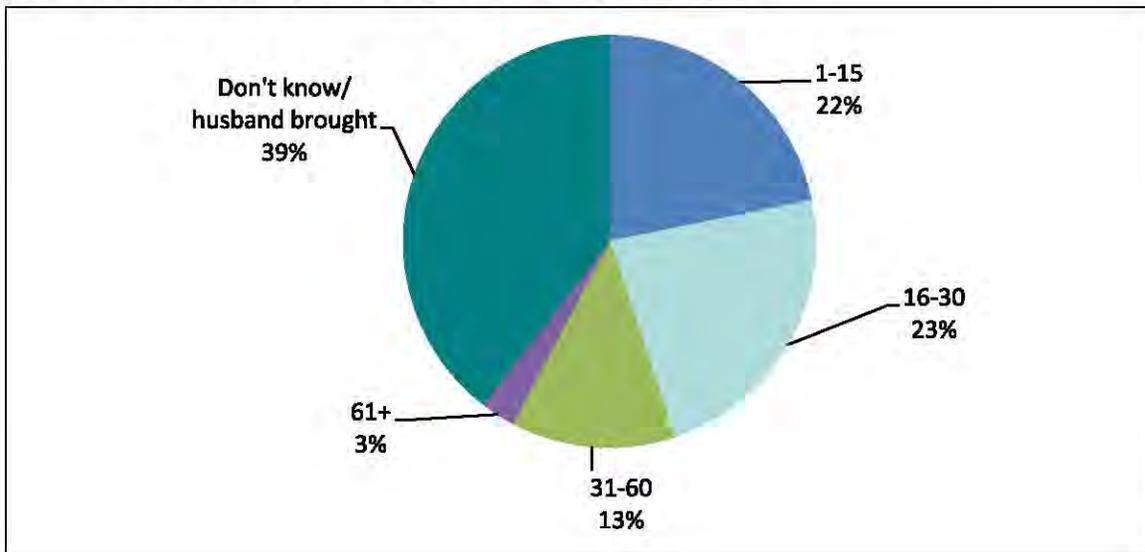


Current users were also asked whether their facility charged them for services, other than the method itself. Forty-seven percent said they were not charged, 40 percent said that they were charged a reasonable amount, and 13 percent were of the view that they were charged an unreasonable amount.

The time usually needed for current users to obtain a specific method is shown in Table 9.4; Figure 9.2 shows overall travel time in minutes to acquire the contraceptive methods. About 22 percent users needed no more than 15 minutes to obtain their method; this included methods from LHWs, who often brought injectables, pills, and condoms to the doorstep. Twenty-three percent needed less than 30 minutes. For a few, particularly female sterilization, it took more than an hour to reach the service place; but in this case, there was usually no need to visit frequently. However, 40 percent of the women did not know the time required to obtain a method, mostly as their husband brought the supply.

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

Methods	Time in minutes					Total	
	1 - 15	16 - 30	31 - 60	61 +	Don't know/ husband brought	%	N
Pill	35.7	14.3	7.1	0.0	42.9	100.0	14
IUD	60.0	40.0	0.0	0.0	0.0	100.0	5
Injectables	35.7	28.6	14.3	0.0	21.4	100.0	14
Condom	13.2	0.0	0.0	0.0	86.8	100.0	53
Female sterilization	20.7	44.8	25.9	6.9	1.7	100.0	58
Others	0.0	0.0	33.3	0.0	66.7	100.0	3
Total	21.8	23.1	12.9	2.7	39.5	100.0	147

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, and the results are shown in Table 9.5. The accuracy of clients' responses may be questioned, due to problems of recall or understanding; still, it appears that information provided is seriously deficient. The most common topics respondents said they were told about were effectiveness, how the method works, and how to use it. A few were told about the possibility of switching, or about other methods they could use. Overall the best information was provided on IUDs and the poor information was delivered on condoms. Condom users were given less information in general than users of clinical methods, perhaps because these were often obtained by husbands. Effectiveness was the only topic on which information was provided to more than 50 percent of the clients. 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 method

Information provided at acceptance	Family planning method					N
	Pill	IUD	Injectables	Condom	Female sterilization	
How the method works	58.8	92.3	52.8	7.6	74.1	99
How to use the method	76.5	69.2	58.3	15.2	62.1	102
Contraindications	38.2	61.5	36.1	4.5	69.0	77
Effectiveness	70.6	100.0	61.1	6.1	84.5	112
Advantages	44.1	76.9	41.7	6.1	69.0	84
Possible side effects	41.2	76.9	47.2	3.0	72.4	85
What to do if experienced side effects	35.3	69.2	41.7	1.5	65.5	75
Possibility of switching	26.5	23.1	33.3	1.5	13.8	33
About other methods of FP you could use	41.2	61.5	36.1	7.6	48.3	68
N	34	13	36	66	58	207

Respondents could give more than one reason

Treatment at Facility

Current users were asked about various aspects of their treatment on their last visit to the provider for family planning. As Table 9.6 shows, responses were mainly positive, but with some exceptions. Only 14 percent of the respondents said that the attitude of staff was uncooperative and 4 percent of the respondents said that the provider was not available on the visit. However, to be noted is that 47 percent reported to have not been charged. This indicates that rest (53percent) were being charged.

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

Aspect of treatment	Percentage
Staff attitude cooperative	85.6
Provider available	96.3
Attend/examine properly	95.1
Doesn't demand charges	47.1
Can deal with side effects	92.6

Side Effects

Current users were asked if they had experienced, or were experiencing, any side effects from their current method and past users were asked if side effects were among the reasons for their discontinuation of a method. 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. As shown in the Figure 9.3, side effects were most commonly reported by IUD and pills users (46 percent and 44 percent, respectively), and they were least commonly reported by condom users (5 percent).

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

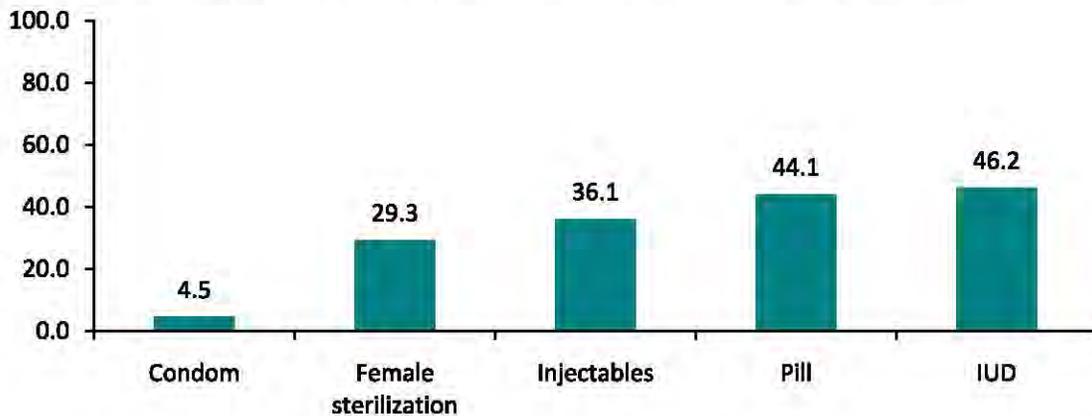
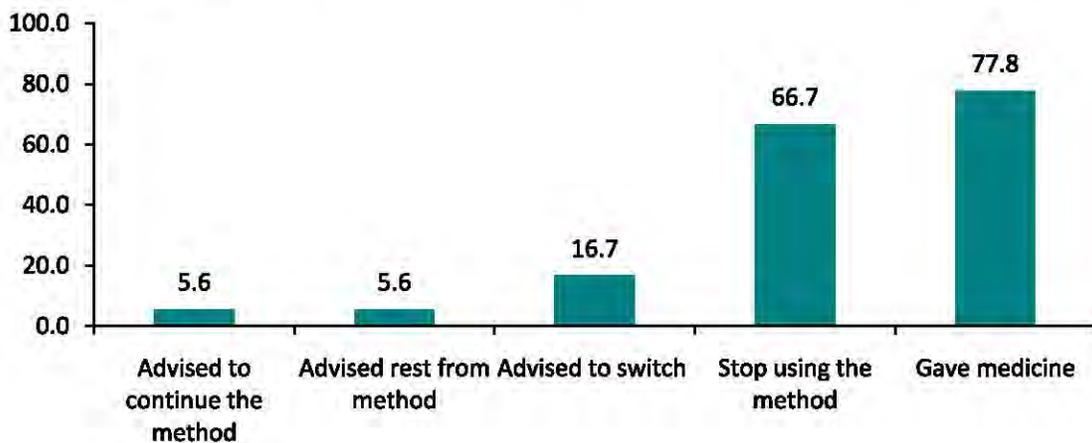


Figure 9.4: Distribution of provider responses upon consultation for side effects among past users



These respondents were asked if the provider responded in a manner included in a list read out to them (Figure 9.4). Only 6 percent were advised to continue the use of the chosen method, 67 percent were advised to stop, and 17 percent were advised to switch to another method. However, it is encouraging that treatment was provided with medicine to more than three-fourths of the users.

Chapter 10

Reasons for Non-use

There are many reasons why a couple may not be practicing birth spacing at any given time. The woman may already be pregnant, the couple may want another child soon, the woman may already have passed menopause, or believe herself to be sterile. Other reasons may prevent couples from using contraceptives even if they want to avoid having more children. Reasons may include: lack of knowledge of methods or inability to obtain them; fear of side effects; opposition of husband or family; and concern that birth spacing may be against Islam, or somehow wrong and so on. To understand how best to meet the needs of such people, it is important to understand the reasons why couples are not practicing birth spacing, in relation to the situation they are currently in.

Hindrances to Use

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

Some hindrances that might be faced by some couples were almost universally acknowledged. Nearly all users mentioned husband's possible disapproval, while a great number of all users acknowledged religious concerns, fear of side effects, and the problems of managing side effects. For three other possibilities, however, a substantial proportion of women respondents thought them least likely to be a hindrance: that other people might find out about their use; the distance and costs of going to an FP outlet; and the possibility of getting pregnant while using a contraceptive.

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

Hindrance	Current user		Past user		Never user	
	N	%	N	%	N	%
Husband's disapproval	175	96.7	80	94.1	305	95.6
Other people may find out about contraceptive use	79	43.6	31	36.5	162	50.8
Distance and travel costs to FP outlet	116	64.1	52	61.2	244	76.5
Probability of getting pregnant while using contraceptives	117	64.6	57	67.1	202	63.3
Fear of side effects	155	85.6	72	84.7	279	87.5
Problem of managing side effects	140	77.3	69	81.2	259	81.2
FP is against religion	147	81.2	67	78.8	285	89.3
N	181	na	85	na	319	na

na=not applicable, respondents could give more than one reason

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 desire for another child, experience of side effects, husband's advice, rest from the method, method failure and infrequent sex (Table 10.2). These reasons are appropriate in many cases, but not always. Clinical methods do have associated side effects; but as we have seen, providers rarely try to counsel users through the temporary experience of common, non-dangerous side effects.

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

Reason	Percentage
Wanted another child	49.4
Fear of side effects	7.1
Side effects experienced	29.4
Method failure	15.3
Lack of access/unavailability	1.2
Cost not affordable	2.4
Method inconvenient to use	4.7
Rest from method	18.8
Missed the dose	11.8
Provider's advice	7.1
Infrequent sex/Husband away	10.6
Husband's advice	18.8
In laws oppose	1.2
Menopause	1.2
N	85

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 contraceptive methods in the past but are not currently using them. A list of possible reasons was read out to past users for their not currently using contraceptives, with more than one reason possible (Table 10.3). The most common reasons were related to childbearing, e.g., currently pregnant, breastfeeding/ amenorrhœic, wanting another child. However, significant percentage cited fear of side effects.

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

Reason	Percentage
Fear of side effects	25.9
Want another child	23.5
Currently pregnant	32.9
Rest from method	17.6
Provider's advice	11.8
Infrequent sex/husband away	7.1
Breast feeding/ lactational amenorrhea	24.7
Menopause	3.5
Just not using/too lazy	3.5
Others	5.9
N	85

Respondents could give more than one reason

Never Users

Reasons for Non-use

The 319 women in the sample who reported never use were asked about various possible reasons for not using contraceptives, with each reason read out separately. As shown in Table 10.4, the most important reason was a desire for more children, and a concern about their ability to conceive was sometimes an additional factor. Women were more likely to cite husband and in-laws' opposition and fear of side effects as significant reasons for not using contraceptives. Other reason cited frequently included: currently breastfeeding. Very few reported lack of access, unavailability of supply, cost, or religious objections, each of which is often cited in other literature as a barrier to family planning use.

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

Reason	Percentage
Husband opposes	35.4
In-laws oppose	29.2
Fear of side effects	37.9
Lack of access/unavailability	14.1
Cost not affordable	16.3
Shy to consult about family planning	9.7
Method inconvenient to use	8.5
Infrequent sex/husband away	6.6
Difficult/Unable to conceive	13.5
Breast feeding/ lactational amenorrhea	24.8
Respondent/husband infertile	1.6
Wanted (more) children	64.6
Against religion	1.3
Natural spacing	2.2
Others	8.2
N	319

Respondents could give more than one reason

Attitude towards Birth Spacing and Limiting

It is important to see the extent to which never users disapprove of family planning in principle, as opposed to accepting it in principle but not using contraceptives for some other reason. Table 10.5 shows this for never using respondents. Forty-six percent of the women disapproved of limiting, while 34 percent disapproved of spacing. There seems to be more opposition to limiting rather than contraceptive use for the purpose of spacing children.

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

Attitude	Attitude towards spacing		Attitude towards limiting	
	N	%	N	%
Approve	210	65.8	170	53.3
Disapprove	108	33.9	147	46.1
Don't know	0	0.0	1	0.3
Others	1	0.3	1	0.3
Total	319	100.0	319	100.0

Knowledge of Contraceptive Users, Methods and Facilities

Of the 319 female never users in the sample, 71 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy. Fifty one percent of the respondents had a relative who had used some method, and 38 percent knew of a friend or neighbor who had used contraceptives. Thirty four percent of never users knew anyone (who was not relative) who had ever used a FP method to delay or avoid pregnancy.

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

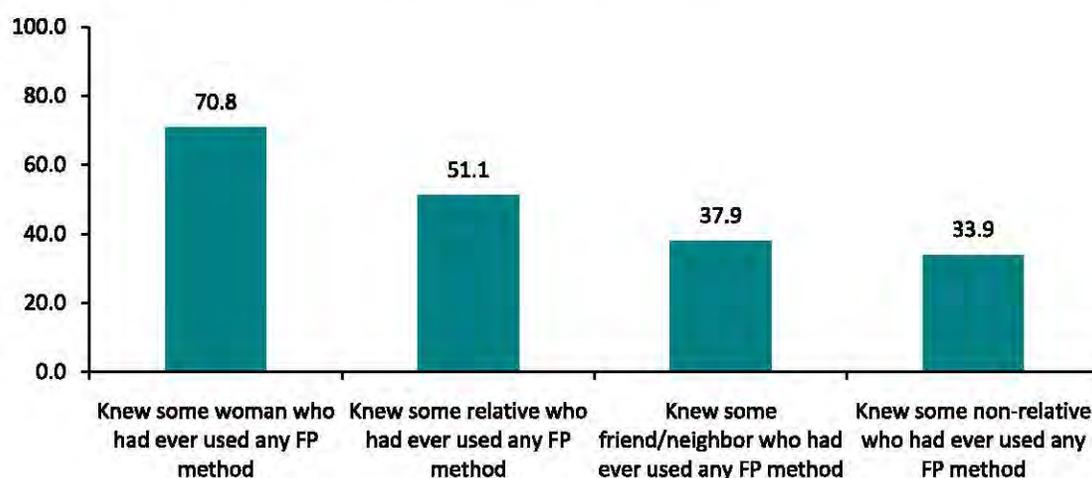


Table 10.6: Distribution of never using females by knowledge of contraceptive methods

FP method	Percentage
Female sterilization	80.3
Male sterilization	13.5
Pill	80.9
IUD	67.7
Injectables	79.7
Norplant	31.0
Condom	36.8
Rhythm	14.8
Withdrawal	17.0
Emergency Pills	7.2
Others	2.2
At least one FP method	90.6
N	319

Respondents could give more than one reason

As might be expected respondents who are never users have somewhat lower levels of knowledge of contraceptive methods than ever users but not by a great degree. Of all never user women, 91 percent knew at least one FP method compared to all ever users. For each method, a somewhat smaller percent of never users knew that method than the general distribution as shown in table 8.1; but most never users knew a variety of methods. However, these women's knowledge of where to get services and supplies was less satisfactory.

Of the 319 never users, 53 percent did not know of a place to obtain a method. For those who did know, the places they were aware of are shown in Table 10.7. The sources best known were Dispenser/Compounder, Department of Health outlets – the District/Tehsil Headquarters hospitals, BHUs/RHCs/MCH centers, and Lady Health Workers, pharmacy/chemists, and private hospitals/clinics/doctors. Some knew of the Family Welfare Centers of the Ministry of Population Welfare. A few women were aware of other sources, including Greenstar clinics.

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

Source	Percentage
Knowledge of at least one service provider	46.7
DHQ/THQ hospitals	32.3
BHU/RHC/MCH center	20.4
Family Welfare Center	14.4
Mobile service unit camp	1.3
Lady Health Worker	25.1
Greenstar clinic	10.3
Private hospital/ clinic/ doctor	22.9
Dispenser/ compounder	45.5
Pharmacy/ chemists	24.5
homeopathic/ hakim	1.6
TBA/ dai	8.5
Grocery shop (not pharmacy/ chemist)	4.7
Others	0.9
N	319

Respondents could give more than one reason

When asked which of the facilities named was nearest, the respondents were again most likely to name pharmacies/chemists, private clinics/hospitals, BHU/RHC/MCH centers and DHQ/THQ hospitals, in that order. Mostly they would go there on foot, sometimes by bus/van or tonga (Figure 10.2). Of the 130 respondents who indicated the time needed to go to the nearest facility, 44 percent reported 15 minutes or less, 28 percent cited 16 to 30

minutes, and 24 percent replied more than 30 minutes, the maximum being one hour (Figure 10.3).

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

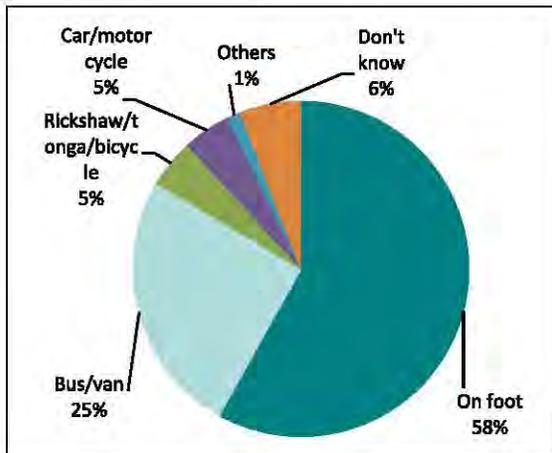
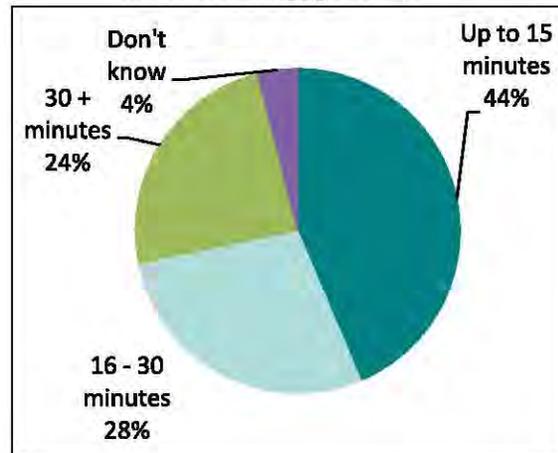


Figure 10.3: Time taken to go to the nearest facility/provider



Intent to Use

Never users were asked about whether they intended to use contraceptives in the future. Table 10.8 shows that 35 percent of female respondents (110 out of 319 who believed they could get pregnant) said that they intended to use some method. More younger women who had not yet used a method (women with 2 or fewer children) expressed their intent to use some method in the future compared with women with 3 or more children. Half of the never user women were in refusal which is a matter of concern and needs some effective IEC strategy.

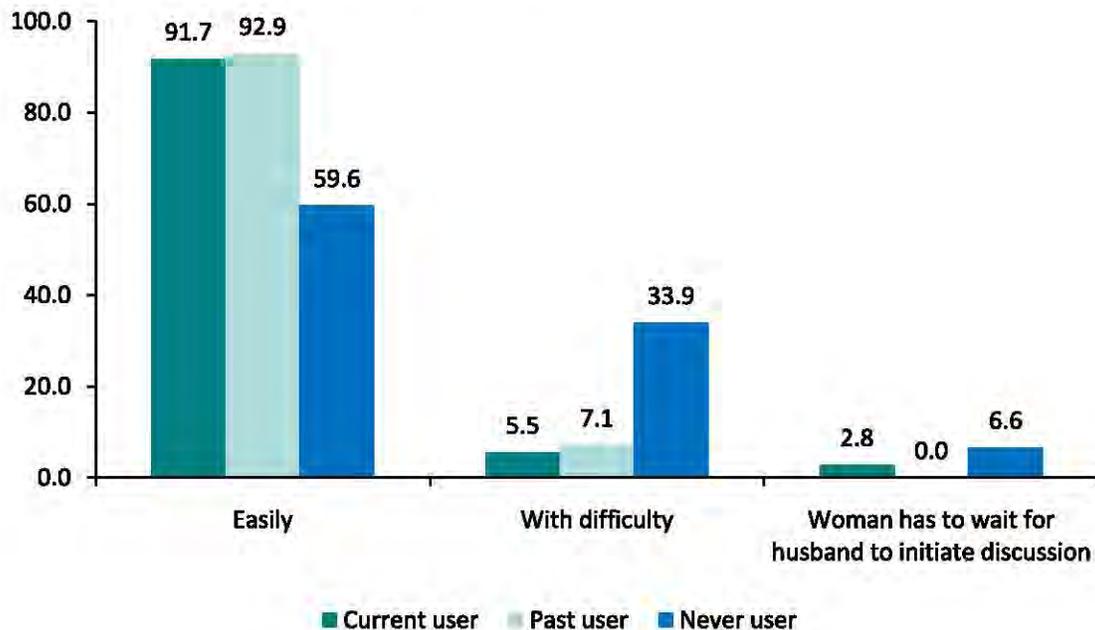
Table 10.8: Distribution of never users by intent to use a method in future and number of living children

Number of living children	Intention to use FP method in future				Total	
	Yes	No	Unsure/uncertain	Can't get pregnant	%	N
0	43.9	28.1	26.3	1.8	100.0	57
1-2	34.0	48.1	17.9	0.0	100.0	106
3-4	32.4	52.7	13.5	1.4	100.0	74
5 or more	30.5	63.4	4.9	1.2	100.0	82
Total	34.5	49.5	15.0	0.9	100.0	319

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Women were also 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 of those responding – said they could do so easily (Figure 10.4). However, this varied by use status. Ninety two percent of the current users, and 93 percent of the past users, said they could approach their husbands easily, and very few said they had to wait for their husband to initiate the discussion. However, for never users, 60 percent reported being able to approach their husbands easily, with 34 percent reporting that they could only do so with difficulty, and another 7 percent saying they had to wait for him to begin the conversation.

Figure 10.4: Women's report 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 Sukkur. Of the 585 women, 33 percent were judged to be in unmet need. This proportion is slightly lower than is typically found using the same definition in Pakistan, where unmet need tends to be around 37 percent of MWRA. The lower proportion may be a reflection of the relatively high contraceptive prevalence; higher levels of use may mean that more of the total demand for family planning is being met. This is supported by the relatively low levels of unmet need for women with 5 or more children, where contraceptive prevalence was particularly high.

Table 11.1: Distribution of women with unmet need for spacing and limiting by background characteristics

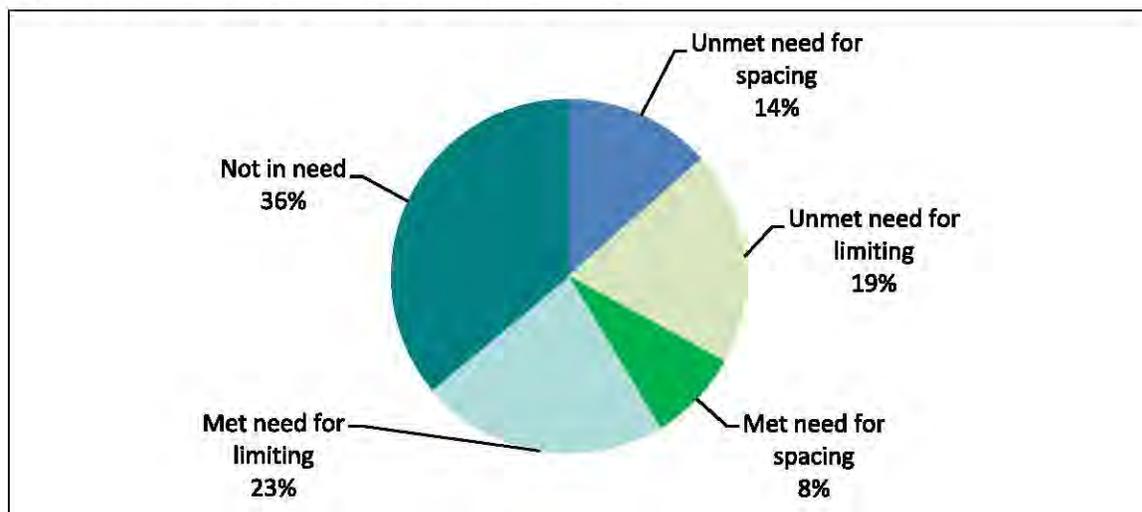
Characteristic	Unmet need			Met need			Total		%	N
	For spacing	For limiting	Total	For spacing	For limiting	Total met need	Total demand	Not in need		
Age of respondent										
15 - 24	28.7	6.0	34.7	11.3	0.7	12.0	46.7	53.3	100	150
25 - 34	13.0	20.6	33.6	12.2	16.0	28.2	61.8	38.2	100	238
35 - 49	2.5	28.4	31.0	1.5	47.2	48.7	79.7	20.3	100	197
Residence										
Rural	17.7	23.3	41.0	3.8	10.6	14.5	55.5	44.5	100	339
Urban	7.7	14.2	22.0	14.6	39.0	53.7	75.6	24.4	100	246
Literacy of respondent										
Literate	12.2	13.2	25.4	15.3	34.9	50.3	75.7	24.3	100	189
Illiterate	14.2	22.5	36.7	4.8	16.7	21.5	58.2	41.8	100	395
Education of respondent										
No education	14.2	23.1	37.4	4.3	16.7	21.0	58.3	41.7	100	372
Up to primary	14.1	16.3	30.4	6.5	34.8	41.3	71.7	28.3	100	92
Up to secondary	11.0	12.3	23.3	19.2	32.9	52.1	75.3	24.7	100	73
Above secondary	10.6	8.5	19.1	25.5	29.8	55.3	74.5	25.5	100	47
Children ever born										
None	5.2	0.0	5.2	3.4	0.0	3.4	8.6	91.4	100	58
1 - 2	25.0	3.5	28.5	19.4	6.3	25.7	54.2	45.8	100	144
3 - 4	18.5	20.7	39.3	10.4	21.5	31.9	71.1	28.9	100	135
5 or more	6.0	32.7	38.7	2.0	37.9	39.9	78.6	21.4	100	248
Ownership of TV										
Yes	11.7	17.5	29.2	11.7	30.6	42.3	71.6	28.4	100	366
No	16.4	22.8	39.3	2.7	9.1	11.9	51.1	48.9	100	219
Standard of living index										
Low	19.4	24.3	43.7	1.0	2.9	3.9	47.6	52.4	100	103
Medium low	13.7	23.1	36.8	2.6	13.7	16.2	53.0	47.0	100	117
Medium high	11.3	20.7	32.0	6.7	24.0	30.7	62.7	37.3	100	150
High	12.1	14.4	26.5	16.3	35.8	52.1	78.6	21.4	100	215
Total	13.5	19.5	33.0	8.4	22.6	30.9	63.9	36.1	100	585

Of the total unmet need, 13.5 percent was for spacing and 19.5 percent for limiting. Unmet need for spacing was concentrated among younger women and women with one or two children. Unmet need for limiting, unsurprisingly, was highest among women with three or more children, because at that stage couples begin to not want to have more children.

The correlations between unmet need and various socioeconomic indicators varied by whether the unmet need was for spacing or for limiting. Unmet need for limiting was

strongly associated with SLI, literacy and residence of the respondent. Unmet need for spacing, on the other hand, also had positive relationship with SLI and residence of the women. Figure 11.1 shows the need and demand for family planning of the sampled women.

Figure 11.1: Need and demand for family planning



Total Demand

The sum of current use (“met need”) and unmet need is often called “total demand” for family planning. It would normally be expected to rise with the number of living children a couple has. Table 11.1 also shows total demand by background characteristics of the women. Overall, total demand was 64 percent of all married women of reproductive age. As the table shows, total demand did rise rapidly, and fairly consistently, by number of 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 percent of the women with unmet need for spacing said they would be worried if they became pregnant again; and 41 percent said that they would be pleased. Of those with unmet need for limiting, 57 percent said they would be worried if they became pregnant. Thirty six percent would accept it. The number of those who would be pleased is small.

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	26	41.3	7	6.8
Worried	25	39.7	59	57.3
Accept it	12	19	37	35.9
Total	63	100	103	100

Reasons of Non-use

Past and never users were asked why they were not using some method of contraception; for those later classified as having unmet need, the results are shown in Table 11.3. Some of these reasons represent barriers as perceived by the women; the most important of these were fear of side effects and husbands' and in-laws' opposition. On the other hand, many women with defined unmet need stated reasons that did not reflect perceived need, at least at present. Such reasons included infrequent sex/husband away, natural spacing, difficulty in conceiving, wanted more children, currently pregnant, and currently breastfeeding. Some of these women may have had 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 amenorrhic 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	50.6	43.0	46.1
Husband opposes	20.3	28.1	24.9
In-laws oppose	19.0	19.3	19.2
Rest from method	2.5	7.0	5.2
Shy to consult about FP	11.4	10.5	10.9
Provider's advice	1.3	5.3	3.6
Against religion	0.0	0.9	0.5
Lack of access/unavailability	12.7	15.8	14.5
Cost not affordable	17.7	16.7	17.1
Just not using/too lazy	1.3	1.8	1.6
Method inconvenient to use	7.6	8.8	8.3
Infrequent sex/husband away	8.9	7.0	7.8
Natural spacing	2.5	0.9	1.6
Difficult/unable to conceive	1.3	2.6	2.1
Want (more) children	75.9	4.4	33.7
Currently pregnant	11.4	3.5	6.7
Breastfeeding/ lactational amenorrhea	7.6	8.8	8.3
Others	3.8	15.8	10.9
Total	79	114	193

Respondents could give more than one reason.

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprised 79 (13.5 percent) of MWRA. As shown in Table 11.4, they were characterized by:

Living Children: Most (52 percent) had 1 or 2 living children.

Family Planning Use: More never users (80 percent) than past users (20 percent).

Strength of Preference: Low (only 40 percent “worried” if they became pregnant earlier than they wanted compared to those who were pleased (41 percent) or accept (19 percent) the unwanted pregnancy).

Intent to Use FP in Future: Moderate (about 55 percent intended to use a FP method in future).

Approval of FP: High (81 percent approved of using a FP method for spacing purpose).

FP Communication with Husband: Limited (41 percent had communicated with husbands on FP in the past one year; while 24 percent said approaching the husband was “not easy”).

Obstacles to FP Use: Fear of side effects (51 percent); husband and in-laws opposition (20 percent and 19 percent respectively) and cost not affordable (18 percent) (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	3	3.8	0	0.0
1-2	41	51.9	9	7.9
3-4	23	29.1	30	26.3
5 or more	12	15.2	75	65.8
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	16	20.3	35	30.7
Never user	63	79.7	79	69.3
Reaction if become pregnant in near future				
Pleased	26	41.3	7	6.8
Worried	25	39.7	59	57.3
Accept it	12	19.0	37	35.9
Intention to use a method in future				
Yes	43	55.1	45	40.5
No	24	30.8	55	49.5
Unsure/uncertain	11	14.1	9	8.1
Can't get pregnant	0	0.0	2	1.8
Approval of FP				
Approve	63	80.8	80	70.2
Disapprove	15	19.2	34	29.8
FP communication with husband in past one year				
Never	47	59.5	56	49.1
Once or twice	27	34.2	45	39.5
More often	5	6.3	13	11.4
Approach the topic of FP with husband				
Easily	60	75.9	81	71.1
Not easily	19	24.1	33	28.9
Total	79	na	114	na

na=not applicable

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 114 (19.5 percent) of MWRA. As shown in Table 11.4, they were characterized by:

Living Children: A strongly positive association with number of living children; 66 percent had 5+ living children.

Family Planning Use: More never users (69 percent) than past users (31 percent).

Strength of Preference: Moderate (57 percent would be “worried” if they became pregnant compared to those who were pleased (7 percent) or accept (36 percent) the unwanted pregnancy).

Intent to Use FP in Future: Moderate (about 41 percent intended to use a FP method in future).

Approval of FP: High (70 percent approved of FP for limiting purpose).

FP Communication with Husband: Limited (51 percent had communication with husband on FP in the past year; while 29 percent said approaching the husband was “not easy”).

Obstacles to FP Use: Fear of side effects (43 percent); husbands and in-laws opposition (28 percent and 19 percent respectively), cost not affordable and lack of access/unavailability (17 percent and 16 percent respectively) (Table 11.3).

Chapter 12

Reproductive Preferences and Behavior of Men

It is often the case that in matters relating to family planning the focus has too often been more on women, despite the fact that husbands are equal partners in the reproductive process and often have greater responsibility for decision-making in the family. In addition, women often mention their husbands as a constraint to the use of contraception (NIPS/PDHS, 2008; Population Council, 1995). The objectives of interviewing husbands/men in the FALAH baseline survey were to explore their perspectives on birth spacing/family planning and to use the information obtained to design the communication strategy for the FALAH project. Overall, the planned sample size was 200 husbands in each district. 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 Sukkur, the field team was able to interview 184 men who were husbands of the married women of reproductive age who had been interviewed for the survey plus 16 married men living in selected areas who were not husbands of the female respondents. In this chapter, the results for the respondents' husbands and the other married men who were interviewed (N = 200) are always grouped together, whether the reference is to "men," "male respondents," "married men," or "husbands."

A husband's approval of family planning is a powerful factor in explaining contraceptive use (Tawiah, 1997). In families, fertility decisions occur within specific social contexts and according to prevailing social norms that restrict individual decisions on fertility and

behaviors related to spacing of births, stopping childbearing, and using contraception. Earlier studies suggest that the husband's approval of and discussion about family planning are important predictors of a woman's contraceptive use and fertility desire (Bongaarts and Bruce, 1995; Mahmood and Ringheim, 1997).

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

Background Characteristics

Table 12.1 shows the background characteristics of the men interviewed in the survey. It shows that one percent of the men were under 25 years of age and 14 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. Twenty-three percent of the men had not been to school, compared to 64 percent of the currently married women (Table 3.2). It also shows that 48 percent of the men had more than primary education, whereas 21 percent of the currently married women had attained that level of education (Table 3.2). Eighty-three percent of the urban men had received some schooling compared to 71 percent of the rural men.

The occupations of men are also presented in Table 12.1. The highest proportions (27 percent) of men were working in agriculture-related activities and 25 percent were working as daily laborers. Twenty percent were running their own business.

Table 12.1: Background characteristics of male respondents by residence

Characteristic	Rural	Urban	Total
Age			
20-24	1.0	1.0	1.0
25-29	13.0	3.0	8.0
30-34	18.0	8.0	13.0
35-39	18.0	20.0	19.0
40-44	16.0	18.0	17.0
45-49	22.0	24.0	23.0
50-54	7.0	14.0	10.5
55+	0.0	7.0	3.5
Education			
Proportion literate	61.0	77.0	69.0
No education	29.0	17.0	23.0
Up to primary	43.0	15.0	29.0
Up to Secondary	13.0	31.0	22.0
Above secondary	15.0	37.0	26.0
Occupation			
Agriculture/Livestock/Poultry	50.0	5.0	27.5
Labor	25.0	25.0	25.0
Govt. service	15.0	23.0	19.0
Pvt. Service	1.0	8.0	4.5
Own business	7.0	33.0	20.0
Unemployed	1.0	3.0	2.0
Others	1.0	3.0	2.0
N	100	100	200

Contraceptive Knowledge and Use

Almost all (99 percent) of the interviewed men in Sukkur knew of at least one modern method of contraception. As presented in Table 12.2, knowledge of modern methods was highest for female sterilization (94 percent) followed by pill (91 percent), injectables (90 percent) and condom (83 percent). The least known methods were Norplant (25 percent), and male sterilization (30 percent). Knowledge of at least one traditional method was prevalent among 69 percent of the men. Less than 95 percent of the currently married

women of reproductive age interviewed in Sukkur also knew at least one contraceptive method (Table 8.1).

The pattern of ever use and current use of contraception reported by husbands is also shown in Table 12.2. Forty-six percent of the MWRA reported having used some method of contraception during their married lives (Table 8.2); of the male respondents, 47 percent reported ever using some method of contraception in their married lives. For the men, among modern methods, condom was the most popular method ever used (29 percent), followed by female sterilization (15 percent) and pill (12 percent). Although, 6 percent of men areas reported ever use of IUDs, surprisingly, none of them reported current use of IUDs by their wives.

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	90.8	98.0	94.4	6.1	24.0	15.1	6.1	24.0	15.1
Male sterilization	22.4	37.0	29.8	0.0	0.0	0.0	0.0	0.0	0.0
Pill	82.8	99.0	90.9	6.1	17.0	11.6	0.0	1.0	0.5
IUD	57.7	84.8	71.4	5.1	7.0	6.0	0.0	0.0	0.0
Injectables	84.5	96.0	90.4	7.1	11.0	9.0	3.0	3.0	3.0
Norplant	21.4	28.0	24.7	1.0	1.0	1.0	0.0	0.0	0.0
Condom	70.4	96.0	83.3	11.1	46.0	28.6	8.1	26.0	17.1
Rhythm	26.3	67.7	47.0	7.1	12.0	9.5	2.0	1.0	1.5
Withdrawal	41.8	80.8	61.4	5.1	20.0	12.6	1.0	8.0	4.5
Others	4.1	1.0	2.6	1.0	0.0	0.5	1.0	0.0	0.5
At least one FP method	98.0	100.0	99.0	25.3	68.0	46.7	20.2	58.0	39.2
At least one modern FP method	98.0	100.0	99.0	22.2	62.0	42.2	17.2	51.0	34.2
At least one traditional FP method	52.5	85.0	68.8	10.1	24.0	17.1	3.0	9.0	6.0
Emergency Pills	20.4	41.4	31.0	1.0	3.0	2.0	na	na	na
N	99	100	199	99	100	199	99	100	199

na=not applicable

As mentioned in table 8.2, a total of 31 percent of all MWRA in the sample were currently using some method of contraception, while for the male respondents this figure was higher at 39 percent. The most common current modern method reported by male respondents was condom (17 percent), followed by female sterilization (15 percent). The use of

traditional methods was also reported by 6 percent of the current users. 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 31 percent of the respondents knew about the emergency contraceptive pill, only 2 percent of the men reported ever using it.

Table 12.3 shows ever use and current use of modern contraception among respondents by background characteristics. A higher proportion of urban men were currently using a family planning method compared to rural men. More than 62 percent of the respondents who had secondary and above education reported ever use of any contraceptive method, compared to 35 percent with no education. The current use of family planning also showed the same pattern by education of men.

Table 12.3: Percent 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
Type of community			
Rural	25.3	20.2	99
Urban	68.0	58.0	100
Education level			
No education	34.8	28.3	46
Below secondary	29.8	24.6	57
Secondary and above	62.5	53.1	96
Number of living children			
None	0.0	0.0	21
1-2	52.0	40.0	50
3-4	51.9	46.2	52
5+	52.6	44.7	76
Future desire for children			
Soon	13.2	3.8	53
Later	45.3	37.7	53
Never	69.4	63.5	85
Don't know/unsure	37.5	25.0	8
Total	46.7	39.2	199

Table 12.3 also shows no relationship between the number of living children and ever use as well as current use. Of those who had any child, 52 percent reported ever use of family planning methods compared to none of the men used any method who had no child.

Table 12.3 also shows contraceptive ever use and current use by the future desire for children. Highest ever use was found among the male respondents who said they did not want any more children: 69 percent of those respondents who wanted no more children had ever used any contraceptive method, and 64 percent were currently using a form of contraception. Among those men who wanted to delay their next child for at least two years, more than 37 percent reported current use of any contraceptive method.

Source of Contraceptive Methods

As shown in Table 12.4, among those who reported the last source for obtaining contraceptive methods, 32 percent obtained it from “Grocery shop/general store” and 18 percent obtained from private hospitals. Government hospitals were also reported by 19 percent of the ever users. Less than 4 percent of the male respondents said that their LHWs were the source of contraceptive method.

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

Source	Total
Govt. hospital (DHQ/THQ)	18.8
BHU/RHC/MCH Centre	1.3
LHW	3.8
Pvt. Doctor	2.5
Pvt. hospital/clinic	17.5
NGO hospital	1.3
Pharmacy, chemist	13.8
TBA/DAI	2.5
Grocery shop/general store	32.5
Others	6.3
Total	100.0
N	80

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 Sukkur, 86 percent of men approved of spacing between children and 85 percent also approved the use of any form of contraception for this purpose (Table 12.5). Fifteen percent of the men disapproved of using any form of contraception to space between children.

Table 12.5: Distribution of male respondents' attitude towards spacing and use of contraceptives for spacing

Variable	Total
Spacing between children	
Approve	86.0
Disapprove	13.5
Others	0.5
Total	100.0
N	200
Using family planning methods for spacing	
Approve	84.5
Disapprove	15.0
Others	0.5
Total	100.0
N	200

Satisfaction Level of Current Users

Satisfaction of the user with his/her contraceptive method is an important factor in whether or not they continue with the method. Male contraceptive users were asked to report how satisfied they were with their present contraceptive method. Table 12.6 shows 94 percent of the current users were very satisfied with their current method. Six percent of the current users, reported being somewhat satisfied with their current method. These users would seem to be in need of more information on their current method as well as on other available methods, so that they continue using a family planning method.

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

Level of satisfaction	Rural	Urban	Total
Very satisfied	88.2	96.0	94.0
Somewhat satisfied	11.8	4.0	6.0
Total	100.0	100.0	100.0
N	17	50	67

The reasons the male respondents stopped using their last method are presented in Table 12.7. The table shows that wanting another child was the main reason for stopping the use of a family planning method. However, 13 percent of male past users stopped using their method because of side effects the couple experienced with their method. More than 13 percent of the past users stopped using a contraceptive due to method failure. This contraceptive failure may be for those who were relying on natural methods. There were also a few cases where the wife opposed the use of a contraceptive method.

Table 12.7: Percentage distribution of past contraceptive users by reason for discontinuing last method by residence

Reason	Rural	Urban	Total
Cost not affordable	20.0	0.0	6.7
Experienced side effects	0.0	20.0	13.3
Fear of side effects	0.0	20.0	13.3
Want another child	80.0	60.0	66.7
Method failure	0.0	20.0	13.3
Method inconvenient to use	20.0	0.0	6.7
Rest from method	20.0	20.0	20.0
Health concern	0.0	30.0	20.0
Service provider's advice	20.0	10.0	13.3
Wife opposes	0.0	10.0	6.7
N	5	10	15

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Husbands were asked if during the last year their wives could approach them to discuss family planning easily, with difficulty, or if they had to wait for their husbands to initiate the discussion; the responses are shown in Figure 12.1. Ninety-one percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, 32 percent of the men reported that their wives had never approached them during the last year on this issue. Forty-one percent of the men reported that their wives had talked often about this subject during the last year, while 27 percent reported they had talked once or twice.

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

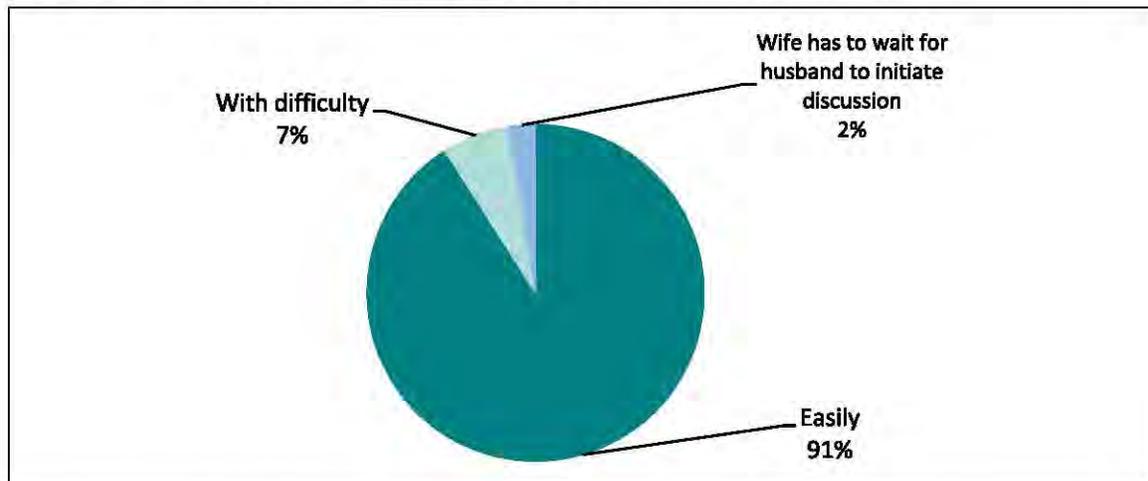
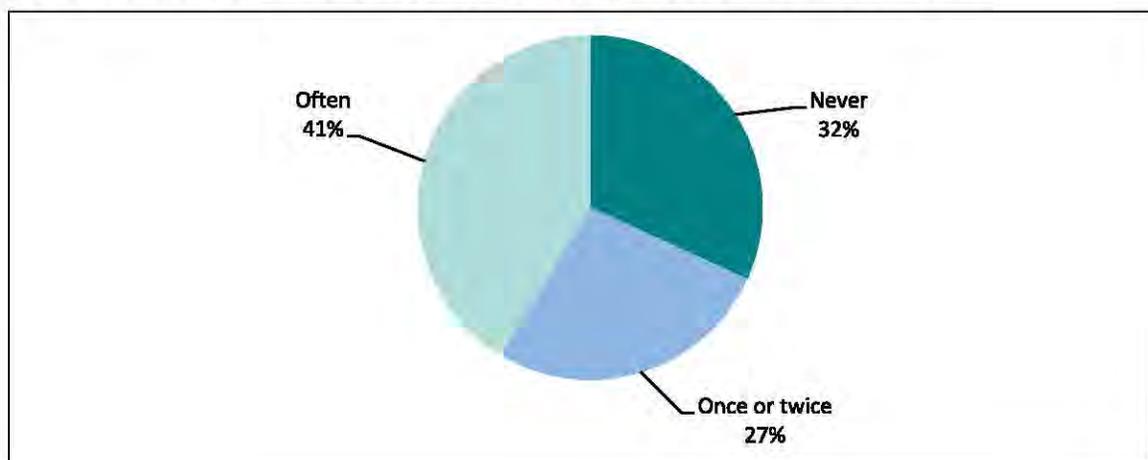


Figure 12.2: Men's reports of frequency of discussion on FP with wife in last year



Potential Users

Men who were non-users of contraception were asked about their intended future use of contraception and their method preferences. Table 12.8 shows that 42 percent intended to use contraception in the future, while 38 percent did not intend to do so. Twenty-one percent of the respondents were uncertain about their future use of contraception.

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

Intent	Rural	Urban	Total
Will use	43.2	37.5	41.5
Will not use	39.2	34.4	37.7
Unsure/Uncertain	17.6	28.1	20.8
Total	100.0	100.0	100.0
N	74	32	106

As shown in Table 12.9, the major reason husbands said they did not intend to use was that their wives were unable to conceive (38 percent). Their desire for more children was cited by 80 percent of the husbands, while for 18 percent, fear of side effects was the reason for not using a contraceptive method.

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

Reason	Rural	Urban	Total
In laws/parents oppose	3.4	0.0	2.5
Fear of side effects	20.7	9.1	17.5
Lack of access/unavailability	3.4	0.0	2.5
Cost too much	17.2	0.0	12.5
Shy to go to FP clinic	17.2	27.3	20.0
Inconvenient to use	3.4	0.0	2.5
Difficult/unable to conceive	31.0	54.5	37.5
Breastfeeding/ Lactational amenorrhea	24.1	18.2	22.5
Want more children	86.2	63.6	80.0
N	29	11	40

Table 12.10 shows the distribution of the male respondents who intended to use a specific contraceptive method in the future. Female sterilization was the most preferred method for future use followed by condom, injectables and pill.

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

Method	Rural	Urban	Total
Female sterilization	34.4	16.7	29.5
Pills	18.8	8.3	15.9
IUD	9.4	0.0	6.8
Injectable	21.9	8.3	18.2
Condom	9.4	58.3	22.7
Rhythm	3.1	0.0	2.3
Others	3.1	8.3	4.5
Total	100.0	100.0	100.0
N	32	12	44

Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 12.11 shows that more than 26 percent of the respondents wanted another child soon (within two years). Another 27 percent wanted to delay their next child for more than two years. The largest proportion of respondents (43 percent) did not want any more children at all.

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

Number of living children	Soon	Later	Never	Don't know /unsure	Total	N
0	71.4	28.6	0.0	0.0	100.0	21
1	45.5	50.0	0.0	4.5	100.0	22
2	28.6	39.3	17.9	14.3	100.0	28
3	30.8	30.8	34.6	3.8	100.0	26
4	11.1	33.3	55.6	0.0	100.0	27
5	15.8	10.5	68.4	5.3	100.0	19
6+	10.5	12.3	75.4	1.8	100.0	57
Total	26.5	27.0	42.5	4.0	100.0	200

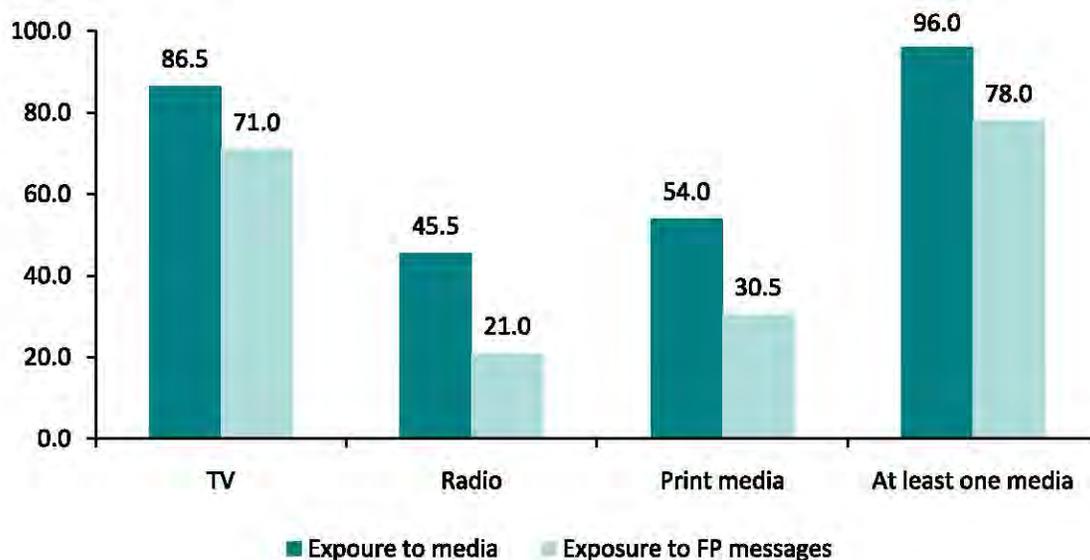
The desire to stop having children was positively associated with the number of living children. Eighteen percent of the respondents who had 2 children did not want more children whereas more than 75 percent who had 6 or more children did not want more children.

Mass Media Access and Exposure to FP Messages

For the development of communication activities, it is important to know which forms of mass media are available and to what extent they are used by various segments of the population. Figure 12.3 shows the proportion of men who reported that they watched TV, listened to the radio, or read newspapers or magazines. TV and print media were the most commonly accessed mediums as 87 percent of the male respondents in Sukkur watched TV and 54 percent of them reported access to print media.

Furthermore, respondents who reported access to any sort of media were asked if they had ever seen, heard, or read any message pertaining to methods of family planning through these mediums. Seventy-one percent of the men had seen FP messages on television. Overall, 78 percent of the male respondents and 47 percent of the MWRA had seen or heard a family planning message on at least one medium. Twenty-one percent of the men reported that they had ever listened to a family planning message on the radio.

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



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