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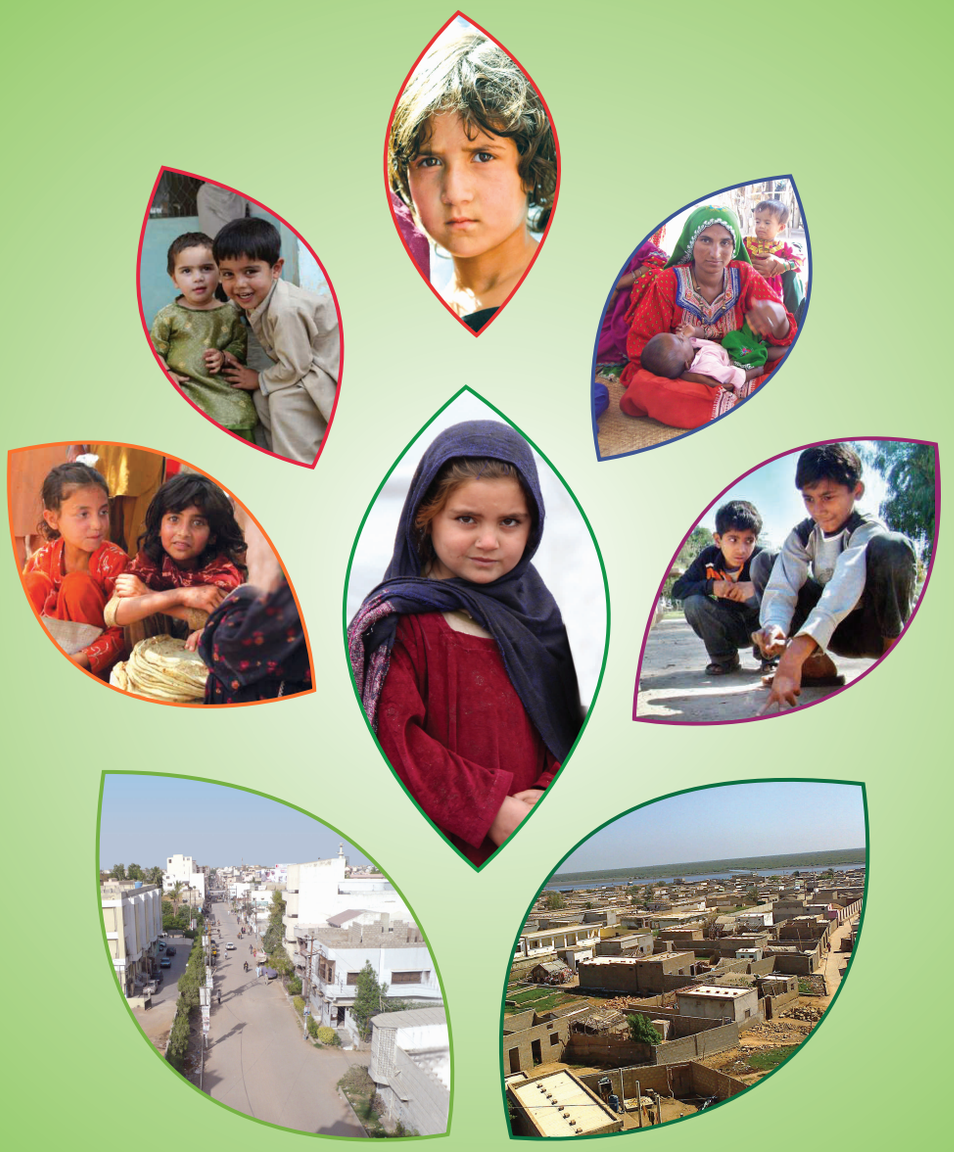
صحت اپنانا... سکھی گھرانہ



SUKH INITIATIVE BASELINE ASSESSMENT

Department of Community Health Sciences, Aga Khan University, Karachi

April 2015

Sponsored by:

Aman Health Care Services, Karachi

This report summarizes the findings from the baseline data that were collected as part of Sukh Initiative MLE effort during 2014-2015. The Baseline Assessment of Sukh Initiative was carried out under the sponsorship of Aman Health Care Services, a project of Aman Foundation, Karachi, Pakistan. Department of Community Health Sciences, Aga Khan University, in the capacity of MLE Partner carried out the baseline assessment.

The Sukh Initiative is a joint undertaking of multiple partners, spearheaded by Program Management Unit of Aman Health Care Services.

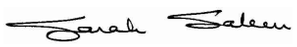
The baseline assessment was conducted at ten Sukh stations located in four towns of Karachi i.e. Korangi, Landhi, Bin Qasim and Malir. The findings from the baseline data represent the selected populations.

The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the donor organization, Aman Health Care Services.

ACKNOWLEDGEMENTS

We would like to express our sincere gratitude to the sponsor, Aman Health Care Services, Program Management Unit and Aman Community Health Program, whose continuous support and invaluable feedback materialized this endeavor.

We are truly thankful to the participants of the study; without their contribution, we would not have accomplished our goals. We take this opportunity to deeply acknowledge the services of all those who directly or indirectly contributed in our Baseline Evaluation.



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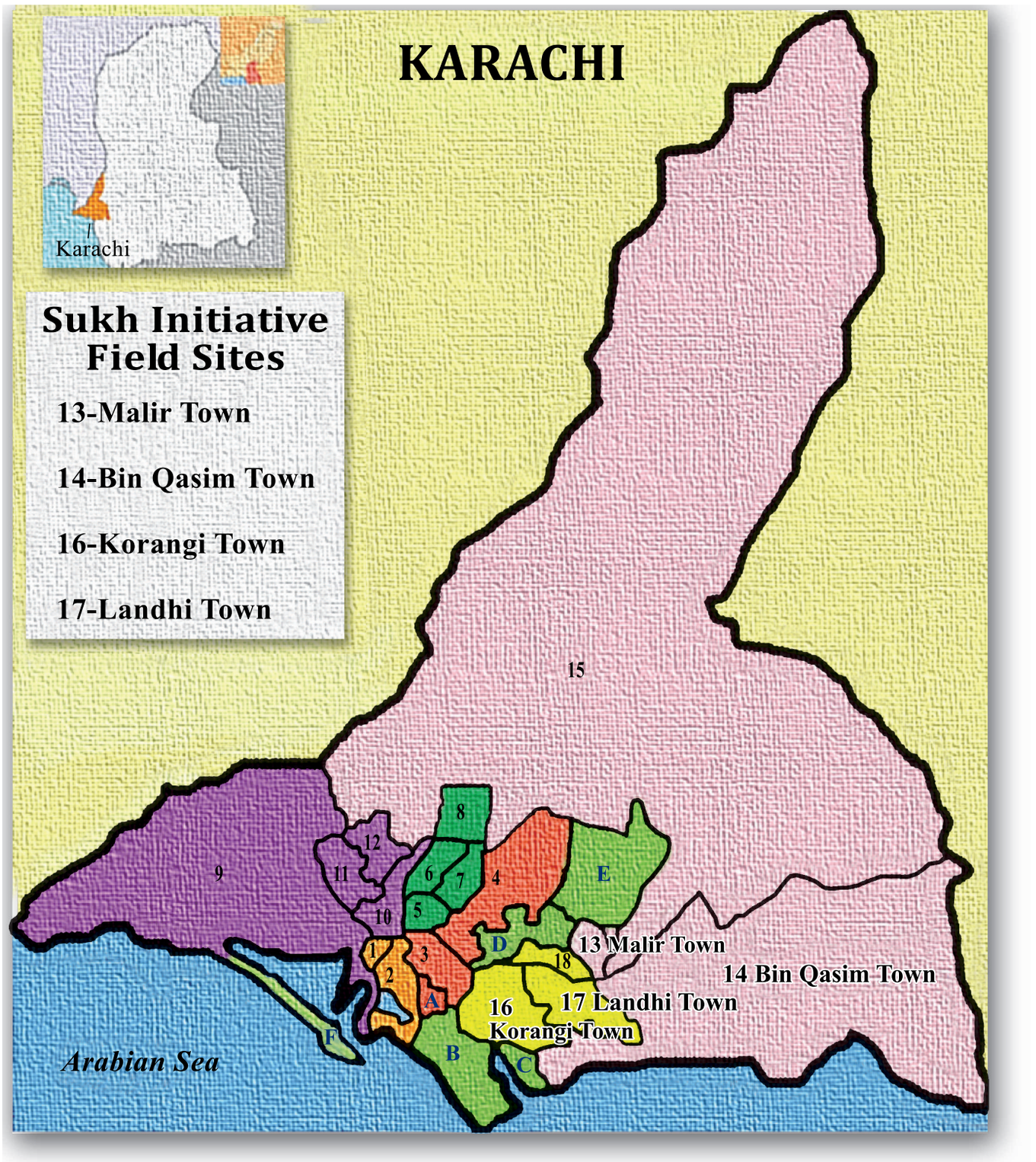
LIST OF ABBREVIATIONS

ACHP	Aman Community Health Program
AKU	Aga Khan University
ATH	Aman Tele-Health
BF	Breast Feeding
BHU	Basic Health Unit
CDC	Centre for Disease Control
CHWs	Community Health Workers
Co-PI	Co-Principal Investigator
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development
FALAH	Family Advancement for Life and Health
FDGs	Focus Group Discussions
FLE	Family Life Education
FP	Family Planning
FWW	Family Welfare Worker
HTSP	Healthy Timing and Spacing of Pregnancy
ID Card	Identity Card
IDIs	In-Depth Interviews
IQR	Interquartile Range
IUD	Intrauterine Device
JHPIEGO	[not an acronym] (formerly Johns Hopkins Program for International Education in Gynecology and Obstetrics
KIs	Key Informant Interviews
LAM	Lactational Amenorrhea
LHV	Lady Health Visitor
LHW	Lady Health Workers
MCPR	Modern Contraceptive Prevalence Rate
MDGs	Millennium Development Goals
MNCH	Maternal Neonatal and Child Health
MWRA	Married Women of Reproductive Age
OCP	Oral Contraceptive Pills
PAC	Post Abortion Care
PAFP	Post Abortion Family Planning
PCO	Public Call Office
PDHS	Pakistan Demographic and Health Survey
PMU	Program Management Unit
PI	Principal Investigator
PPFP	Postpartum Family Planning
RCC	Reinforced Cement Concrete
RH	Reproductive Health
RHC	Rural Health Centre
RHS-A	Reproductive Health Service A center
SD	Standard Deviation
SDM	Standard Days Method
SMS	Short Message Service
SBA	Skilled Birth Attendant
TBAs	Traditional Birth Attendants
UC	Union Council
UK	United Kingdom
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization


KARACHI
Karachi
Sukh Initiative Field Sites
13-Malir Town
14-Bin Qasim Town
16-Korangi Town
17-Landhi Town
15
8
12
9
11
6
7
4
E
10
5
D
1
3
18
13 Malir Town
14 Bin Qasim Town
2
A
16
17 Landhi Town
Korangi Town
F
B
C
Arabian Sea

EXECUTIVE SUMMARY

The Sukh Initiative emerged out of commitments made at the London Summit held in July 2012. It is a partnership between three private Foundations, Aman Foundation, the Bill & Melinda Gates Foundation and the David and Lucile Packard Foundation. Sukh Initiative is a five-year program (2013-2018), with goal of increasing the use of modern contraceptives by 15 percentage points amongst one million underserved population of Karachi, Pakistan. Sukh Initiative is committed to provide FP related quality information, counseling, supplies, referrals and services to women of reproductive age residing in underserved areas.

This report summarizes findings from the baseline household survey and qualitative assessment conducted at ten Sukh stations located in four towns of Karachi, i.e Korangi, Landhi, Bin Qasim and Malir. Overall, the baseline data collection has two main goals:

- Establish a baseline for the evaluation of the effects of the Sukh Initiative strategies for midline and endline assessment
- Provide benchmarks for target setting, decision making and course correction against which progress can be measured and success assesed

i. Quantitative Assessment - Household Survey

The household survey was conducted from November 21st 2014 to January 2nd 2015. Data were analyzed on 5,140 married women.

The survey questions on FP were adopted from PDHS 2012-13. These included questions on FP knowledge, ever use, current use, unmet need, reasons for non-use and side effects etc. In addition, questions were asked on acceptability of use of Tele-Health Services and Family Life Education at Sukh sites. This report present results on the selected indicators.

Findings of Household Survey

Women in our sample were young and educated

The median age of the sampled women was 30 years (IQR 25-35year). The majority of the women were in the age group of 20-34 years (67.4%). About 64% women had formal education whereas 36% women had never attended a school.

Teen-age marriages and pregnancies exist

Approximately 4% of MWRA in our sample were in the age group of 15-19 years. Of these, 20% were pregnant at the time of interview and 53.3% had already given a birth.

Almost a quarter of sampled women mentioned their current pregnancy as unplanned

Twelve percent of women were pregnant at the time of interview; of these 23% reported current pregnancy as unplanned. These women are at a potential risk of seeking unsafe abortion.

Knowledge of modern contraceptive methods is high but use of modern methods is low

Knowledge about any method of family planning was universal (98.2%). Ninety-seven percent women were aware of any modern method of contraception. Among modern methods, most commonly mentioned names were injectables (90.2%), pill (85.6%), condom (84.2%), IUD (78.3%), implant (65%) or LAM (62.5%). The mean number of methods known by a woman was 7.7± 2.5.

Sixty-nine percent of women reported ever using any contraceptive method with 59% ever using a modern method of contraception. Approximately 42% women were current users of any method of family planning and 32.1% were using a modern method of contraception. Commonly used methods were condom (14.4%), female sterilization (6.4%) injectables (4.6%) and pill (2.3%). Approximately 10% of women were using traditional methods. Of these, withdrawal was the most common (9%) method.

Mostly young, uneducated women with low parity discontinue use of contraceptive method

The wide gap in proportion of ever users (69.2%) and current users (42.3%) suggests high discontinuation rate for contraceptive use (27 percentage points). Approximately 46% of all women who started family planning but discontinued later, were in the age group of 20-29 years, having one to two children (57.4%) with primary level education or no schooling (60%).

Use of contraception in non-pregnant women with a child under one year of age is very low

Only 7.5% of women in our sample who were not pregnant at the time of the interview and had a child below one year of age, were currently using any method of contraception.

Use of long-term modern contraceptive is low in women with high parity

Among current users, women with one to two children were mostly using condom (60%), injectables (14%), pill (6.5%) or IUD (5%). By third child, the preference for method reduced for condom (49%), remained same for injectables (14.9%) but increased for female sterilization (14.9%). No change was observed for the use of pill (6.3%) and IUD (6.9%). After the third child, preference for female sterilization more than doubled (34.4%), condom use further reduced (36.4%), injectables and pill use remained almost same (15.1% and 8.5% respectively). Women did not mention use of implant and IUD.

Current contraceptive use is low in certain ethnic and minority groups

The highest use of modern contraceptive method was observed in Urdu speaking (36.7%) women and lowest in Balochi (5.1%) and Hindko (6.8%) speaking women. Punjabi, Sindhi and Pushto speaking had more or less same rates of use (15.5%, 11.1% and 11.9% respectively).

Non-users of family planning methods is a special group with special needs

Approximately 56% of women were not using any method of contraception at the time of interview. These women were mostly uneducated or have primary level of education and had low parity of one to two children. Of these, 22% wanted a male child. The common reasons mentioned for non-use of contraception were ongoing breast-feeding, want more children, being pregnant and infrequent sex, etc.

Current users get services from Public Health Facilities

Fifty-seven percent of current contraceptive users in our sample received their contraceptives from various government facilities, which included government hospitals (52.9%), dispensary and MNCH centers (22.9%), LHW (10.4%), RHC/BHU (4.8%), family welfare centers (3.6%), male mobilizers (3.2%), LHV (1.7%) and camps (0.2%).

Youth

For the youth component of the Sukh Initiative, the baseline survey included questions on acceptability for FLE messages, awareness about occurrence of any training/event related to youth in their area, and their perceptions on important youth issues.

Receiving formal education, unemployment and addiction to recreational drugs are important youth issues

The women who had heard of or had attended a meeting related to youth issues (n=353) identified education (53.7%), unemployment (55.2%), and addiction to recreational drugs (19.9%) as important youth issues. A small percentage of women were concerned about youth getting involved with criminal groups (3.9%).

Women less favored FLE messages related to young age at marriage and use of FP by teen- agers

For FLE messages, about 53% responses were in favor of formal education and 25.3% to understand the right age at marriage. The responses were less in favor of avoiding young age at marriage (18.4%), importance of antenatal care (16.5%), dangers of early marriage (18.4%) and use of FP to avoid teen-age pregnancy (9.3%). Nearly every respondent (94%) perceived that such messages would be beneficial to their youth.

Tele-Health Services have strong potential for providing information on FP, FLE and MCH

One of the strategies to increase demand for contraceptive methods in Sukh Initiative is to provide information through Tele-Health Services. Aman Tele-Health (ATH) is the implementation partner for this strategy. Only 6.1% of women were aware of ATH services. About 84% of women said they would be comfortable using a telephone booth if placed by ATH in their areas to access information on RH and FP. About 18% of women mentioned that they had already shared their cell number with the ACHP team and are willing to access hotline (80.7%) provided by ATH for any health related information they require.

Qualitative Assessment - FGDs and KIs

Sixty FGDs were conducted at community level from selected areas with married men and women, girls and boys of 16-18 years and parents of youth. In each FGD, 8-10 persons participated. These FGDs were conducted using semi structured FGD guidelines.

Seventeen Key Informant interviews were conducted with stakeholders at program and community level. The key informants were Town Technical Officers of the Dept. of Health and Population Welfare, administrator and healthcare providers of hospital/facility, head of local NGOs, pharmacist of the pharmacy/drug store, religious leader/Imam of a mosque.

ii. Findings from Qualitative Assessment

Family Planning

Knowledge of modern contraceptive methods is high but use of modern contraceptive methods is low

FGD Participants and Key Informants unanimously informed that universal awareness about the FP program exists but this adequate knowledge of contraceptive methods is not translated into practice. People consider contraceptive use a personal matter and feel shy to get advice about contraceptive methods.

FP is considered as 'women's issue' but men are decision makers

Men in nearly all the FGDs, healthcare administrators and community leaders, mentioned that the main focus of FP programs is on women and therefore men are less informed. Women on the other hand, explained this as men's disinterest in family planning.

Information on family planning in both men and women is primarily on several traditional as well as modern contraceptive methods. Traditional method most commonly known to them was withdrawal. The modern contraceptive methods known were condom, pill, injectables, implant, IUD and tubal ligation. Information on vasectomy was not available to any participant. Both FGD participants and key informants quoted TV and internet as the most often accessed means for information on family planning. Women also said that doctors and LHWs are amongst the key information provider of family planning.

Though men are decision makers but are neglected by FP programs

The majority of men and key informants revealed that most of the FP centers are providing services for women only and there is need to involve men in family planning programs. Healthcare providers also informed that comprehensive FP, PPFP, PAC and PAFP services are not actively offered to men and women of these areas.

Changing social values support FP use

Several women pointed out females being educated, support from married woman's mother and changing social values as facilitative factors for family planning. Unfortunately, religious beliefs, traditional norms, fear of side effects and resistance from in-laws were persistently the inhibiting factors in family planning. Both FGD participants and Key Informants highlighted this barrier in adoption of family planning.

Available FP facilities are inadequate

Women and healthcare providers informed that condom, pill and injectables are available from clinics, general and medical stores and from LHWs of the area. IUD and implant services are not available at health facilities within the area. Women further informed that travelling to other areas for FP services is socially, geographically and economically difficult.

Youth

The youth feels insecure

The youth generally lack safety and security and have inadequate education, health and sports facilities. Some of the major issues girls face includes harassment, acquaintance with boys and restrictions on pursuing education. Boys tend to be aggressive which leads to conflicts with parents, friends and girls. Increasingly addictive behavior patterns and involvement in crimes such as thefts, mobile snatching and rape, was found amongst boys.

Youth do not share their problems with parents

The youth share their problems with friends and very infrequently with their parents; and if so, mostly with mothers. They get information from their friends, T.V, and the internet and are extensively involved with the use of mobile phones. The youth need information on pubertal changes, including but not limited to menses and physical developments, and sexual health, pubertal acne, communication skills, career opportunities, information on contraception in light of religion, stress on the significance of good company and the harmful effects of addictions, healthy habits and lifestyles.

Decision making power is not with the youth

The youth can only make decisions about education, employment or minor day-to-day issues like the type of clothes they would wear and what food to eat. All the major decisions especially those related to marriage are taken by parents, mostly fathers.

Awareness on FLE and Tele- Health Services is limited

The parents and the youth residing in the study areas do not have knowledge about Family Life Education (FLE) and use of Tele-Health Services. Participants expressed that FLE for the youth would be acceptable and the venues for such trainings could be homes or health and educational institutions. Topics suggested for FLE are communication skills, career counseling, pubertal issues, physical and sexual health and rights, minor problems such as acne and religious information. It was further pointed out that Tele-Health Services would be acceptable for men primarily. For health related text messages, Urdu or Roman English scripts would be preferable.

INTRODUCTION

Pakistan is the seventh most populous country of the world, contributing 2.5 percent to the globe's population (1). The current annual growth rate for Pakistan is 1.49 percent, and urbanization is occurring at a rapid annual rate of 3 percent; nearly 35 percent of population lives in urban areas and it is expected that by 2025, this will increase to 50 percent (2). Of all the major cities of Pakistan, Karachi is the fastest growing city with 80 percent increase in its population between years 2000 and 2010. The estimated population of Karachi is 18.5 million as of July 1, 2014 (3,4).

Karachi is administratively divided into four districts with eighteen towns (5). About 40 percent of Karachi's underserved population lives in squatter settlements which are characterized by poverty, lack of basic amenities such as appropriate sewage system, clean water, and health facilities.

The resources available for housing, transport, education and health are not sufficient to cope with the ever-increasing demand of burgeoning population of the city (2). The people most affected are those who live in the poverty-stricken urban slums. Because of poverty, lack of movement space and environmental pollution, the dwellers of these areas are at greater risk of morbidity and mortality; women and children being most vulnerable (3,6).

The disparity in the availability of health services and health indicators amongst the urban rich and poor is well documented in PDHS 2012-13 (6). The women in the richest quintiles of wealth are more likely to receive antenatal, natal and postnatal services as compared to women in poorest quintiles. Similarly, the use of contraceptives is higher in rich and better-educated women as compared to women in lowest quintiles of wealth (6).

Research has demonstrated that global increase in the contraceptive use has reduced MMR by 26 percent in the past ten years worldwide, and that addressing the current unmet need for family planning could prevent an additional 30 percent of maternal death (7). Evidence from Matlab, Bangladesh, suggests that long-term investment in an integrated family planning and maternal and child health (FPMCH) program contributed to improved economic security for families, households, and communities through larger incomes, greater accumulation of wealth, and higher levels of education (8). The evidence indicates that family planning and maternal-child health services helped reduce poverty too (7). Studies have shown that use of family planning methods influence every aspect and phase of women's health, life and their lifestyle. In the short-term, its use decreases obstetric complications through decreasing number of pregnancies; which, in effect, prevents nutritional depletion by avoiding too many, frequent and closely spaced pregnancies, and in the long-term reduces the MMR and brings social and economic benefits to women and hence nations (8-11). Based on this evidence, in 2012, global leaders re-emphasized the provision of contraceptives to additional 120 million women of poor countries (12).

Realizing and believing these facts, family planning has been included as one of the key interventions within the Sukh Initiative; a joint health project of Aman, the Bill & Melinda Gates and the David and Lucile Packard Foundations. Aman Health Care Services, Aman Foundation, is the main implementer of Sukh Initiative. Sukh Initiative was launched in late 2013 in selected areas of four towns of Karachi, namely; Korangi, Landhi, Malir and Bin Qasim.

The overall aim of the project is to increase the use of modern contraceptives among married couples and to build capacity of the youth as future responsible adult. A combination of approaches and strategies will be used to address supply and demand issues of FP use. These include house-to-house visits by CHWs for family planning counseling, referral and replenishment of supplies, Family Life Education for the youth, Tele-Health Services and enhancement of quality of services of Family Planning and

Maternal Neonatal and Child Health facilities existing at the program sites. The project is being managed and supervised by its own Program Management Unit. PMU has identified organizations having knowledge and experience in each of the prioritized approaches and strategies. These selected organizations were taken on board for the implementation of the prioritized components. The Department of Community Health Sciences, Aga Khan University has been selected as a measurement partner to inform program, measure progress and assess performance and impact.

Summary of Sukh Evaluation Design

To fulfill the measurement role, assessment activities have been planned at three different points in time: before the initiation of the program i.e. Baseline, in the middle of the program i.e. Midline, and at the conclusion of the program i.e. Endline. The assessment activities will use quantitative and qualitative methods. The quantitative method is primarily a survey of three different randomly selected sample of married women of reproductive age in three different timings corresponding to baseline, midline and endline surveys; whereas the qualitative methods include: Focus Group Discussions and Key Informant Interviews carried out at baseline and at endline assessment. In addition, Quick Investigation of Quality for public and private facilities providing FP care will be carried out at the baseline and at the end of the project.

METHODOLOGY

The baseline data collection has two main goals:

- Establish a baseline for the evaluation of the effects of the Sukh Initiative strategies for midline and endline assessment
- Provide benchmarks for target setting, decision making and course correction against which progress can be measured and success assesed

1. Household Survey Design

A cross sectional survey was conducted on randomly selected households. To achieve our sample size we used a multi stage sampling design. The lists of households were made available for all the Sukh stations through ACHP. From each household list, for each station, sequentially numbered blocks of 200-250 households were formed. The number of blocks varied from a minimum of 33 in station 10 to a maximum of 76 in Station 2. Since, we planned to interview 50 women from each block; the value of estimated sample size for each station was divided by 50 to achieve number of blocks to be included in the survey. The households in each randomly selected block were then approached using systematic sampling technique, i.e. approaching every '5th' house after selecting one house randomly. In a household where more than one eligible woman was found, one woman was selected randomly for the interview. In case of refusals, according to a predetermined strategy, interviewers were instructed to approach the next house, walking in the same direction. The total sample was distributed among stations proportionate to their population size.

A total of 5,340 married women in the reproductive age group of 15-49 years were interviewed, however data were analyzed for responses of 5,140 questionnaires. Survey data collection was completed in 38 days, commencing from November 21, 2014 and ending on January 2, 2015.

The fundamental themes for household survey included:

- Socio-demographics: age, marital status, literacy, ethnicity, wealth
- Pregnancy and antenatal care: practice during last pregnancy, delivery care provider
- Family Planning: knowledge, attitude and practices of married women regarding family planning, source of information regarding FP methods
- Access to media: radio, television, and print media, frequency of use
- Acceptability of parents for family life education for youth
- Acceptability and utilization of Tele-Health Services by community women for receiving FP and FLE messages

2. Qualitative Design

For qualitative assessment, focus group discussions and key informant interviews were conducted. Sixty FGDs were conducted with married men and women, girls and boys aged 16-18 years and parents of youth from the communities. In each of the FGDs, 8-10 persons participated. These FGDs were conducted using semi structured FGD guidelines.

Seventeen key-informant interviews were conducted with stakeholders at both the program and community level. The key informants included Town Technical Officers of the Departments of Health and Population Welfare, the administrator and healthcare providers of the most frequently utilized hospital/facility, head of the local NGOs, pharmacist of the pharmacy/drug store, religious leader and Imam of the mosque.

3. Training of Interviewers

For the quantitative survey, fifty-two female interviewers were hired and trained. These interviewers were Karachi University students with Masters in Sociology. A three-day training of the team members was carried out before the start of the survey.

For qualitative component, a team of four field staff was hired and trained in October 2014. Formal three-day training was conducted. This was both knowledge and skilled-based training. The knowledge part focused primarily on what a FP program is, FP methods, barriers and motivators of FP use, the purpose and aim of Sukh, its objectives and significance of information gathering, methodologies of assembling the baseline report, including quantitative and qualitative methods, elements of good team work and precautions required in the current safety situation. The skills imparted included communication skills both interpersonal and in a group, conduction of FGDs, note taking and observations.

A male research coordinator, with rich experience of working with challenging communities and conducting surveys, led the teams. Each team had its supervisor who supervised fieldwork and watched over the team for safety. This was done considering the law and order situation in Karachi and for cultural reasons.

4. Field Supervision and Monitoring

At the field level, data quality assurance was the responsibility of the field supervisors. For quantitative survey, the field supervisors on daily basis reviewed questionnaires at the field site to identify incomplete/missing information. Subsequently at the department, the data editors comprehensively reviewed the questionnaires for completeness and corrected coding etc. The PI reviewed any errors identified in the edited data forms and approved relevant and logical corrections.

For qualitative component rigorous and meticulous monitoring was done to ensure:

- Conduction of FDGs and KIs by stations and towns respectively
- Purposeful and appropriate selection of participants meeting the eligibility requirements
- Neutral venue selection that was conducive for the discussions/interviews
- Correct use of developed guidelines for FGDs and KIs
- Adherence to standards and protocols for FGDs and KIs
- Satisfactory description of notes and observations
- Comprehensive transcriptions and translations

5. Study Sample

Our estimated sample size was 3800 MWRA which was estimated keeping the expected change of 5% (change of 15 percentage points would have resulted in smaller sample size) in the use of modern methods of contraception at the endline survey. The contraceptive use (any method) in urban Sindh, Pakistan was 42.7% as reported in PDHS 2012-13 (6). Therefore, the estimated value of 42.7% was taken for the baseline sample of our study. Further, assuming 2.5% as bound on the error, 95% confidence level of significance and design effect of 2.247 (PDHS 2012 -13), the minimum sample size estimated for baseline survey turned out to be approximately 3,755 currently married women in the reproductive age group (rounded off to at least 3,800). Considering the sensitivity attached with the family planning use, and assuming a high refusal rate from some of the Sukh areas, we increased our estimated sample size by additional 30% to 5000. The sample was distributed among stations proportionate to their population size (6).

For qualitative component, as per the standards of qualitative research, FGDs and KI interviews were continued until saturation in information was reached. Purposive sampling based on snowballing was used for selection of participants to ensure comprehensive and meaningful data.

6. Data Collection

The ACHP team introduced survey teams to the community and community leaders. The field coordinators helped survey teams in assembling the FGD participants and identifying the blocks of the households selected for the quantitative survey.

All the interviews were conducted in the national language Urdu as it is the language most understood and spoken despite presence of various ethnicities at Sukh sites. Ethical approval was obtained from the Ethics Review Committee of Aga Khan University, Karachi. Women were requested for written informed consent after explaining the purpose of the survey. For illiterate women, thumbprint was taken on the form. Utmost care was taken to conduct the interviews in privacy.

FINDINGS FROM THE HOUSEHOLD SURVEY

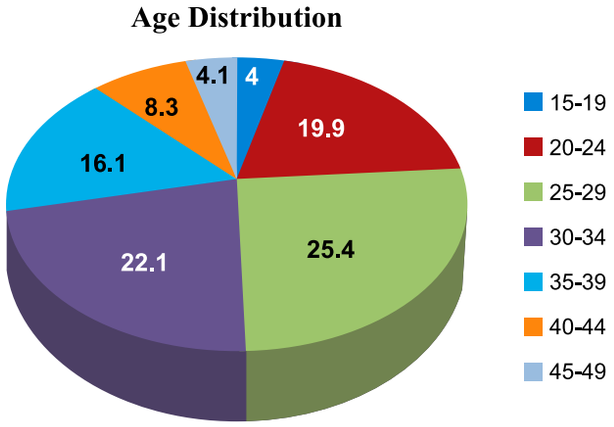
1. Characteristics of Respondents

The demographic and socioeconomic characteristics of the sampled population provide important information about the target population such as the age structure, socioeconomic status, ethnicity, parity and wealth quintiles. The basic characteristics also enable us to examine the variations of key indicators according to age groups, education status, ethnicity, parity and wealth quintiles.

Women in our sample were mostly young and educated

The median age of the women interviewed was 30 years (IQR 25-35year). The majority of the women (67.4%) were in the age group of 20-34 years. About 64% of women had formal education whereas 36% women had never attended a school. Among those who had formal education, 22% acquired primary education, 15% attended middle school and more than a quarter of respondents (27.5%) received secondary or higher education (Figure 1-3).

Figure 1



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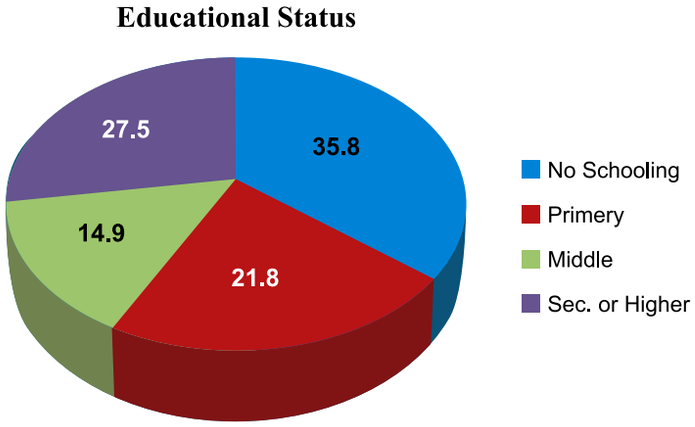

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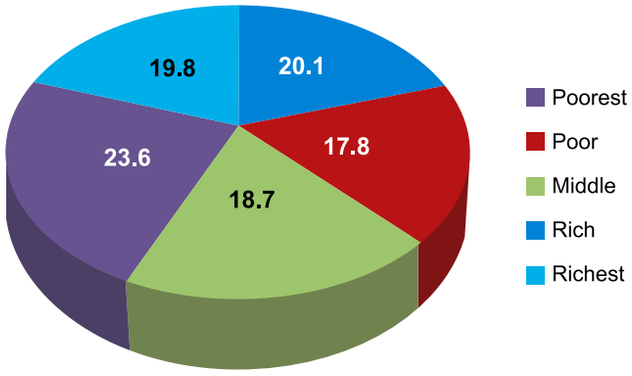


Wealth quintiles for Sukh population indicate that 37.9% of population is poor out of which 20.1% are the poorest. Interpretation of wealth quintiles at Sukh sites should be done with caution as these sites are situated in low-income areas and assessment of wealth quintiles is artificially dividing already poor population into a distribution, which may not be the true reflection of actual socio-economic status.

The educational status of women varied between the towns, age groups, and wealth quintiles

Illiteracy was highest in Bin Qasim town and lowest in Malir town. (Figure 4) Women in the age group of 25-29 years had the highest percentage who completed secondary and above (32.3%). (Figure 5)

Figure 4

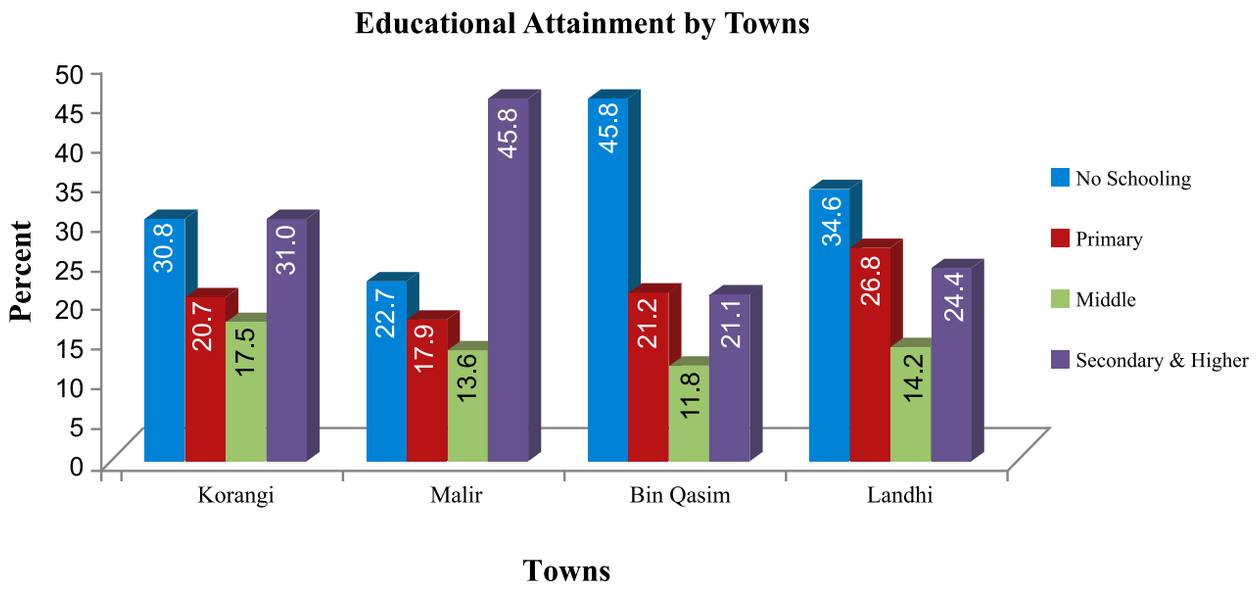
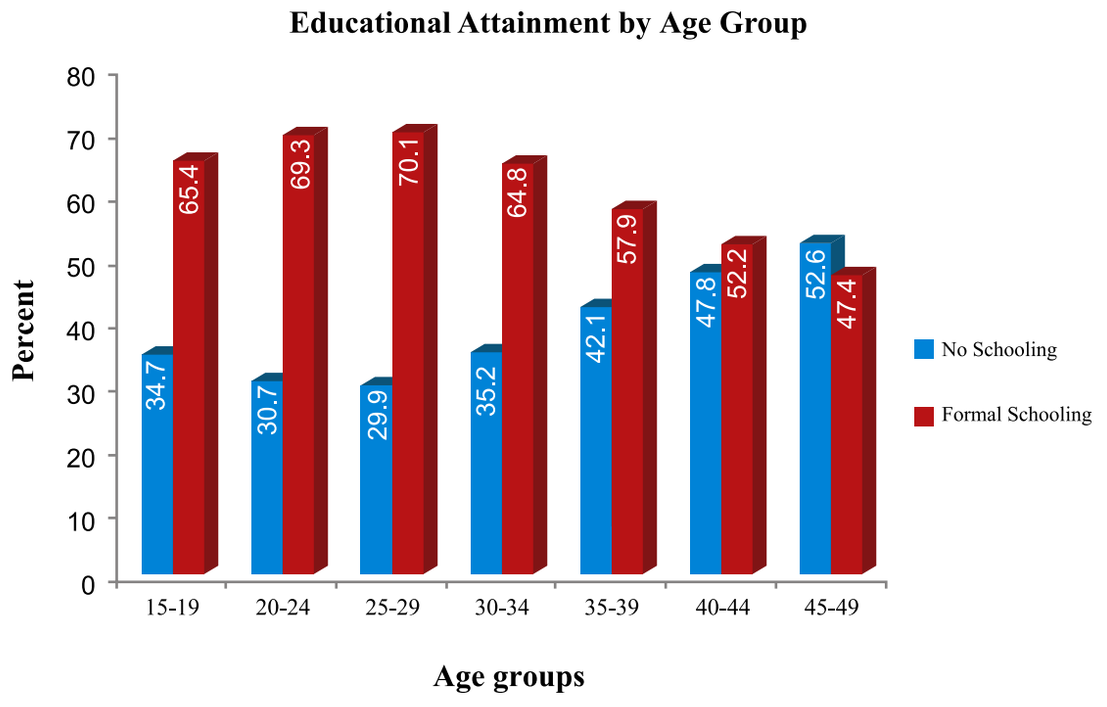


Figure 5



The sampled women largely belonged to Urdu speaking (33.3%), Punjabi (14.3%), Sindhi (12.7%), and Pushto (12.2%) speaking groups. (Figure 6) However, ethnically dominant groups varied amongst towns. In Bin Qasim town, dominant ethnic group was Sindhi speaking (28.5%), followed by equal proportion of Urdu and Punjabi speaking women (18.1% each). In Korangi town commonly spoken languages were Urdu (54.2%) and Punjabi (12.4). In Landhi town commonly spoken languages were Pushto (28.3%) Balochi (23.6%) and Hindko (17.5%). In Malir town, most commonly spoken language was Urdu (43.6%) and Sindhi (14.3%) (Figure 7).

Figure 6

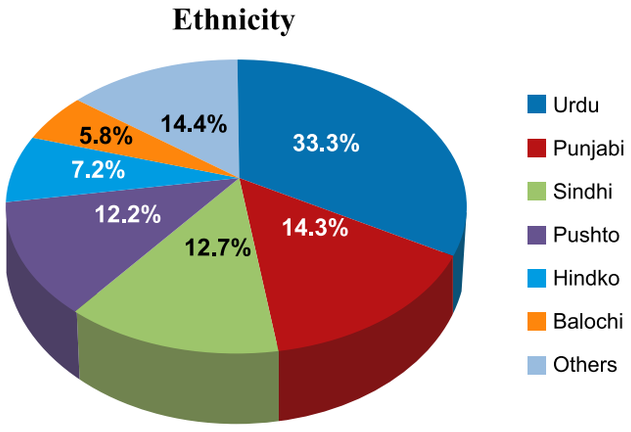
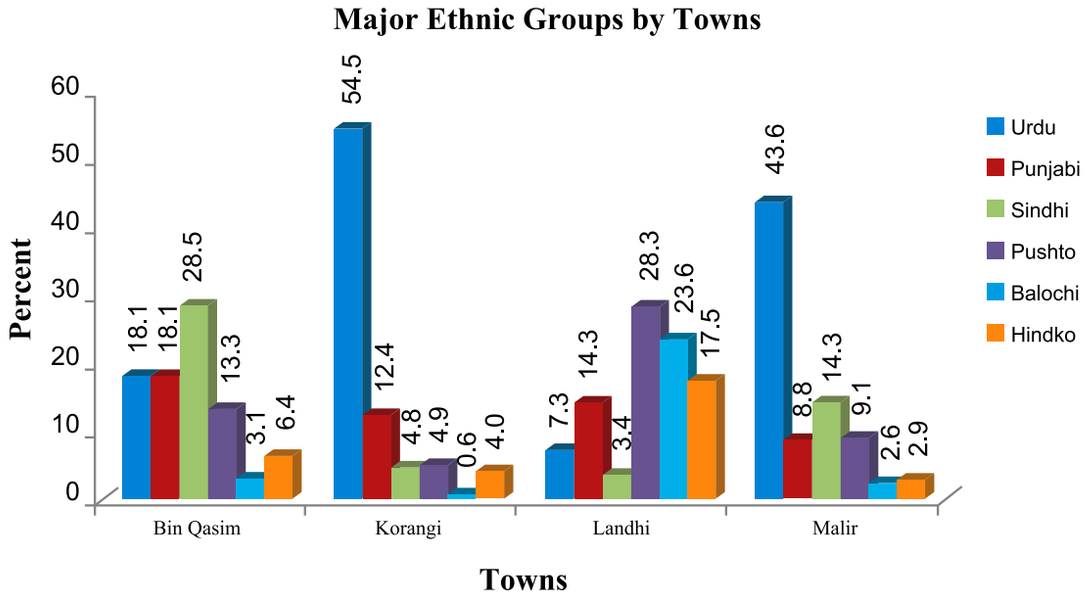


Figure 7



Teen-age marriages and pregnancies exist

The reported median age at first marriage was 18 years; however, 48.1% got married when they were in the age bracket of 15-19 years. The median duration of marriage was 10 years. About 93% of the sampled women had given birth at least once. The median age at first birth was 20 years; however, 41% of women gave first birth between the ages of 16-19 years. Approximately 4% of MWRA in our sample were in the age group of 15-19 years. Of these, 20% were pregnant at the time of interview, and 53.3% had already given a birth.

Twenty-three percent of women reported current pregnancy as unplanned

Median number of children alive at the time of survey was three and 24% of women had five or more living children. About 12% of women were pregnant at the time of interview. Of these, 23% reported this pregnancy as unplanned or unwanted.

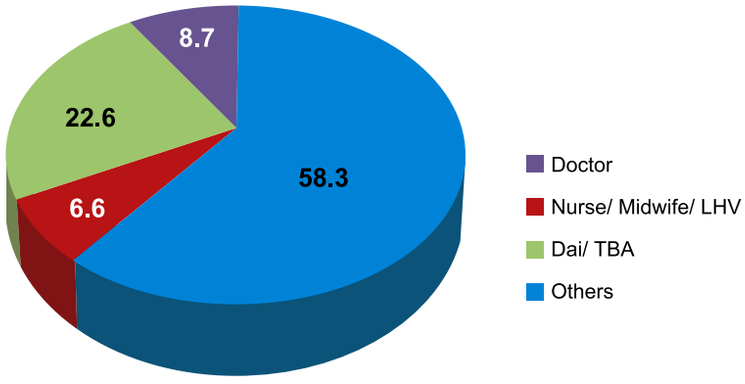
Most of these women were uneducated (35.2%) or had primary education (26.8%). They belonged to Urdu (35.2%), Sindhi (19%), and Bengali (7%) speaking groups. Nearly 42% were in the lowest quintiles of wealth (poorest 25.6% and poor 16.3%). They were in the age group of 25-29 years (36.6%) with at least two living children (25%).

Forty percent of sampled women did not receive antenatal care during last pregnancy

Nearly, 60% of women had four or more antenatal visits during their last pregnancy. Rest of the women either had no visits (5.4%) or had less than optimal number of antenatal visits during pregnancy. Thirty-three percent of women mentioned that they could name the facility from where they sought ANC. Of these, 68.0% utilized services from private sector and 25.5% from public sector. Unskilled provider conducted nearly 31% of last deliveries. (Figure 8)

Figure 8

Healthcare Providers who assisted in last delivery



2. Family Planning

Modern contraceptive methods are defined as female sterilization, male sterilization, pill, IUD, injectables, implant, condom, LAM and emergency contraception (but included emergency contraception in others category). Traditional methods included standard days methods, rhythm and withdrawal.

Knowledge of modern contraceptive methods is high but use is low

Knowledge about any contraceptive method was universal (98.2%). About 97.5% of women were aware of any modern method of contraception. Among modern methods, most commonly mentioned names were injectables (90.2%), pill (85.6%), condom (84.2%), IUD (78.3%), implant (65.0%) and LAM (62.5%). Commonly mentioned traditional methods were withdrawal (77%), rhythm (57.2%) and SDM (16.8%). The mean number of methods known by a woman was 7.7± 2.5. (Figure 9)

Figure 9

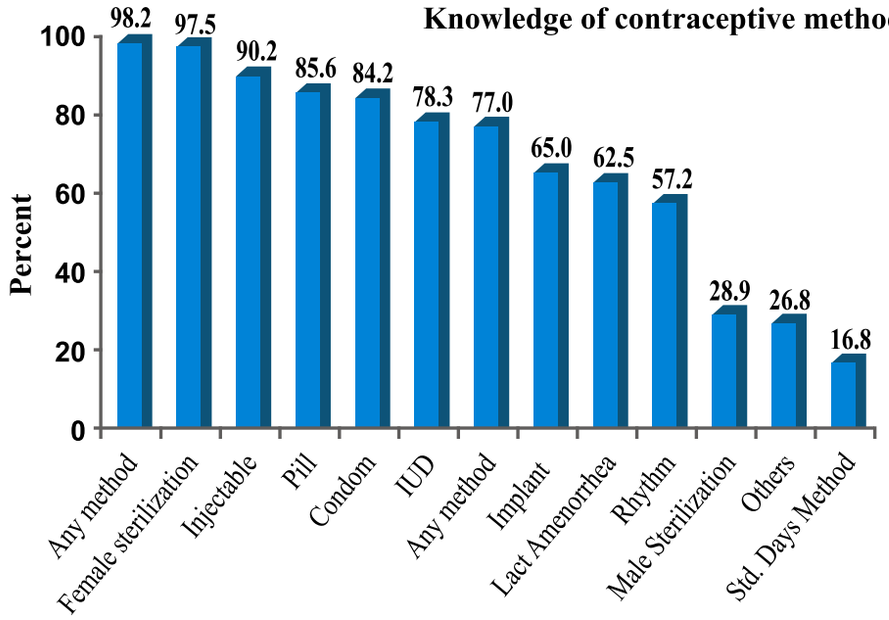


Figure 10

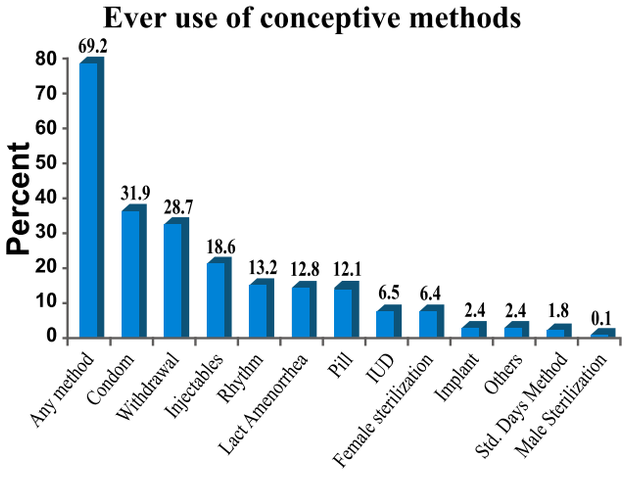
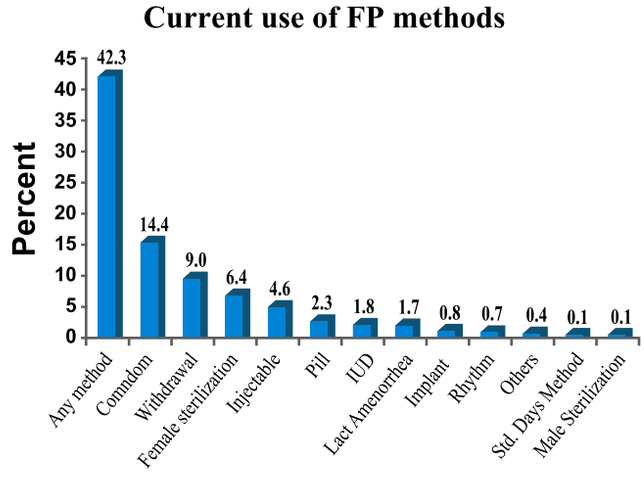


Figure 11



About 69% of women reported ever using any contraceptive method with 58.9% ever using a modern method of contraception. Ever use of traditional methods was 35%. Most commonly ever-used methods were condom (31.9%), injectables (18.6%), pill (12.1%) and withdrawal (28.7%). (Figure 10)

Approximately 42% of women were currently using any method of contraceptive and 32.1% were using any modern method of contraception. Among those who mentioned using any modern method of contraception, 14.4% were using condom, female sterilization (6.4%) injectables (4.6%) and pill (2.3%). Traditional methods were used by 9.8% of women. Of these, withdrawal was the most commonly (9%) used method. (Figure 11)

PDHS 2012-13 for Sindh urban shows use of any current method as 42.7%, any modern method as 32.6% and any traditional methods as 10.2%. Most commonly used modern methods were condom (15.9%), female sterilization (9.8%), injectables (2.9%) and pill (2.1%). The commonly used traditional method was withdrawal (9.8%). The use of female sterilization was higher and use of injectables was lower for PDHS 2012-13, Sindh urban population, as compared to Sukh population.

Wealth and education in our sample have no role for modern contraceptive use

Highest use of modern methods of contraception was observed in women with no education (34.7%) and with secondary and higher level of education (28.3%). The use of modern methods was high for women between the age group of 25-34 years but declined from the age of 35 years and onwards. Similarly, the use of contraceptives was lowest in women with no children or with one child but increased with increasing number of children. (Figer 12-14)

Figure 12

Current modern contraceptive use by education

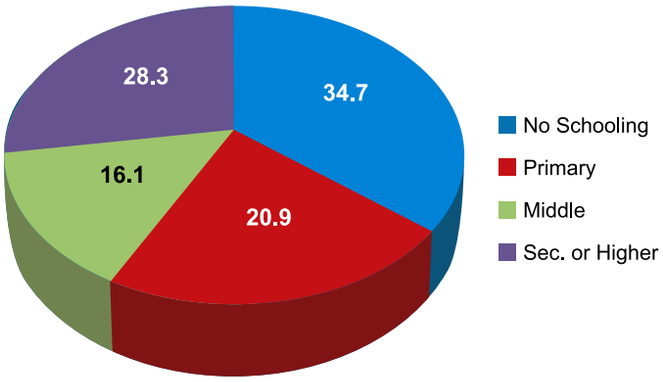
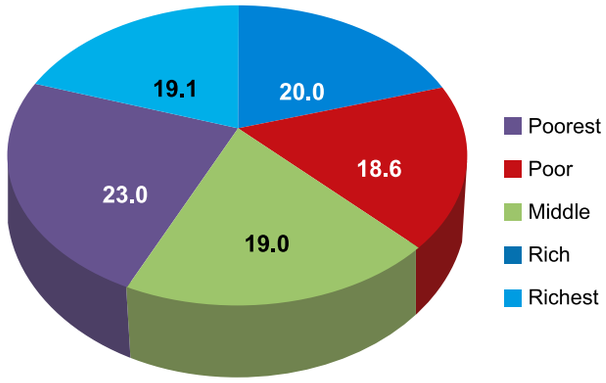


Figure 13

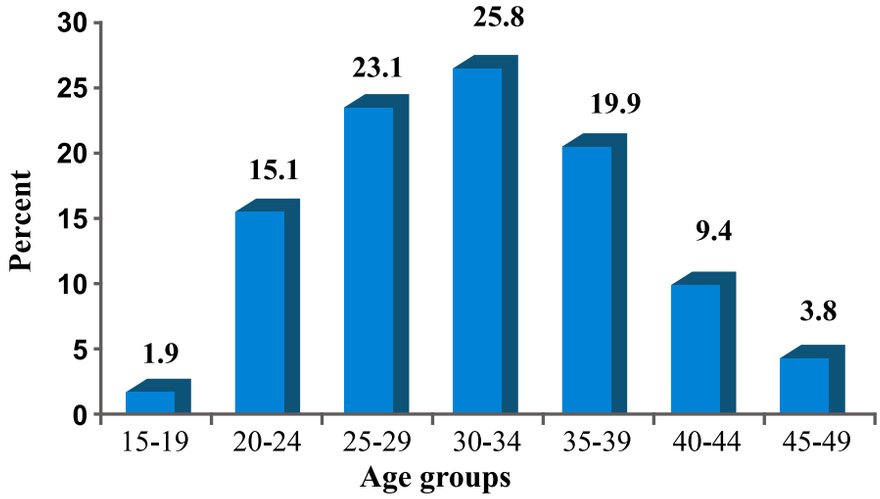
Current modern contraceptive use by wealth quintiles



Focus of counseling on modern contraceptive methods should be for women from 15-29 years (youth)

Figure 14

Current modern contraceptive use by age groups

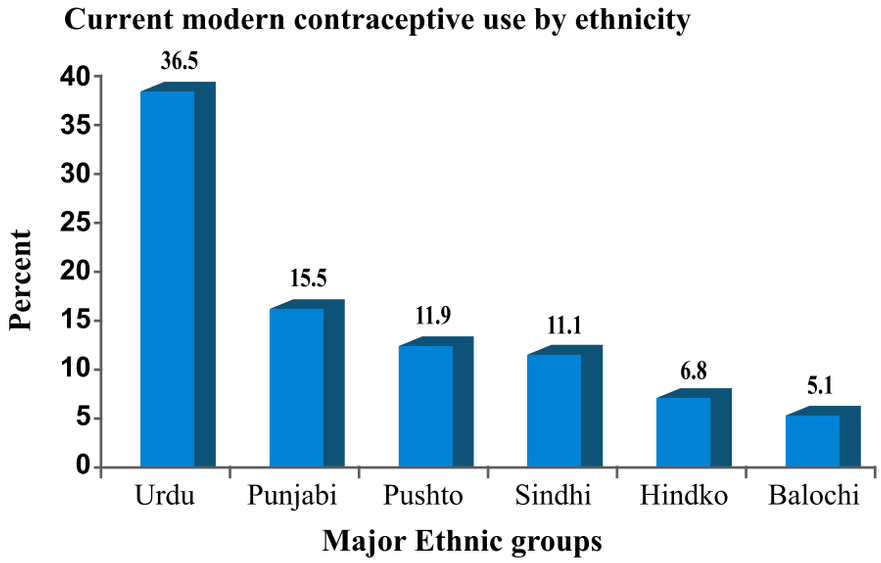


Current modern contraceptive method use is low in certain ethnic and minority groups

The highest use of modern contraceptive method was observed in Urdu speaking (36.7%) women and lowest in Balochi (5.1%) and Hindko (6.8%) speaking women. Punjabi, Sindhi and Pushto speaking had more or less same rates of use (15.5%, 11.1% and 11.9% respectively). Certain minority groups residing at Sukh catchment populations such as Bengalis and Burmese should also be counseled about family planning use.

Women belonging to Sindhi, Balochi, Hindko speaking groups should be the focus of motivational and counseling activities. (Figure 15)

Figure 15



Use of contraception in non-pregnant women with a child under one year of age is very low

Only 7.5% of women in our sample who were not pregnant and had child below one year of age were currently using any method of contraception. Post-partum family planning services and referral for such services should be made available to women in the post-partum period. Tracking of FP use in such women should be maintained through routine service data maintained by CHWs.

Use of long-term modern contraceptive is low in women with high parity

Among current users, women with one to two children were mostly using condoms (60%), injectables (14%), pill (6.5%) and IUD (5%). By third child, the preference for method reduced for condom (49%), remained same for injectables (14.9%) but increased for female sterilization (14.9%). No change was observed for use of pill (6.3%) and IUD (6.9%). After third child, the preference for female sterilization more than doubled (34.4%), condom use further reduced (36.4%), injectables and pill use remained almost same (15.1% and 8.5% respectively). Women did not mention use of implant and IUD. Women in older age group of 30 years and above should be counseled for more effective long-term methods of family planning.

Mostly young, uneducated women with low parity discontinue use of contraceptive method

The wide gap in proportion of ever users (69.2%) and current users (42.3%) suggests high discontinuation rate for contraceptive use (27 percentage points). Approximately 46% of all women who started family planning but discontinued later were in the age group of 20-29 years. More than 60% of discontinued users had no schooling or had primary level education. Approximately 57% of all discontinued users had parity between one to three children.

Provision of adequate pre and post procedure counseling and regular follow-up of family planning clients can help in reducing the discontinuation rate. Sukh MIS should guide the program for continuation of contraceptive method use.

Less than a quarter of current users were given information on the side effects of a method

Only 21% of current users were informed about the side effects of the method and 19% to contact a person in case of a side effect. Fourteen percent of current users mentioned experiencing a side effect. Most common side effects were headache (19.8%), excessive bleeding (18.6%), irregular menses or no menses (17.6%) and nausea and dizziness (9.7%).

Among 305 women who experienced side effects, nearly 58% consulted a health care provider for treatment. Government Hospital/RHS was approached by 40.6% of women and private doctor by 27.7% of women.

Among those women who did not seek any health care provider (n=108), 21.6% considered treatment as not necessary, 25.3% thought treatment as costly, 12% had time constraints for getting treatment and 7% had no one to accompany them to a health care facility. (Table 1)

Table 1. Knowledge and Experiences of side effect among current FP users n=2174

Characteristics	n	%
Informed about side effect	458	21.1
Informed about person to contact in case of side effects	408	18.7
Ever experienced side effects	305	14.0
Side effects (n=305)		
Headache	60	19.8
Excessive bleeding	57	18.6
Irregular menses/no menses	54	17.6
Nausea/dizziness	30	9.7
Backache	22	7.2)
Depression	20	6.6
Spotting	13	4.3
Weight gain	14	4.4
Infection	9	3.0
Body pain	6	2.0
Itching	8	2.5
Pain in uterus	8	2.6
Weakness	5	1.7
Others	13	4.1

Non-users of family planning methods is a special group with special needs

Approximately 56% of women were not using any method of contraception at the time of interview. These women were mostly uneducated or have primary level of education and had low parity of one to two children. Of these, 22% wanted a male child. However, the reasons given by these women for non-use of contraceptives failed to show any specific direction. The common reasons mentioned for non-use of contraception were ongoing breast-feeding (10.4%); want more children (14.4%), being pregnant, and infrequent sex, etc. These women should be considered as a special group with special needs, for example breast-feeding women can be counseled about exclusive breast-feeding, back up support of condoms or for use of hormonal methods after 3 to 4 months of breast-feeding or if BF is not exclusively done. Similarly, women who want more children or who are currently pregnant could be counseled about HTSP and PPFP. These women can be referred to FP counselors.

Most of the current users of FP received their contraceptives from government facilities

Most of the women (57%) received their contraceptives from various government facilities which included government hospitals (52.9%), dispensary and MNCH centers (22.9%), LHW (10.4%), RHC/BHU (4.8%), family welfare centers (3.6%), male mobilizers (3.2%), LHV (1.7%) and camps (0.2%). In private sector, they received contraceptives through doctors (29.7%), friends and relatives (25.5%), pharmacy and chemists (24.3%), ACHP's CHWs (9.5%), shops (5.7%) homeopath clinics (3.9%) and TBAs (1.0%). (Figure 16)

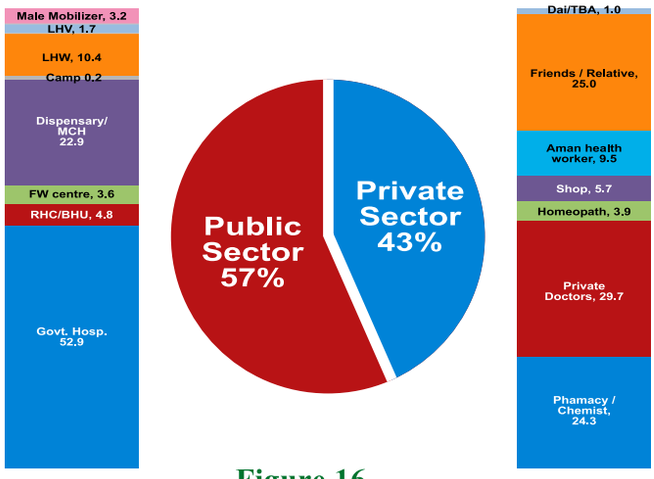


Figure 16

Need and Demand for Family Planning is High

Overall at Sukh sites, 33.3% percent of married women had unmet need for family planning. Unmet need for spacing was 16.2% and 17.1% for limiting. The total demand for family planning (which is defined as the sum of unmet need and current CPR) was 75.6%. The total demand satisfied, which is assessed as total contraceptive use, divided by the sum of unmet need and total contraceptive use (any method) was only 56%. Total demand satisfied by modern methods is 42.5%. Approximately, 41% of non-users showed intention to use contraception in future (Table 2).

Table 2 - Need and Demand for Family Planning Services

Characteristics	Total (%)
Unmet need for FP	1712 (33.3)
Unmet need for spacing	832 (16.2)
Unmet need for limiting	880 (17.1)
Intention to use FP by non-users	1214 (41.0)

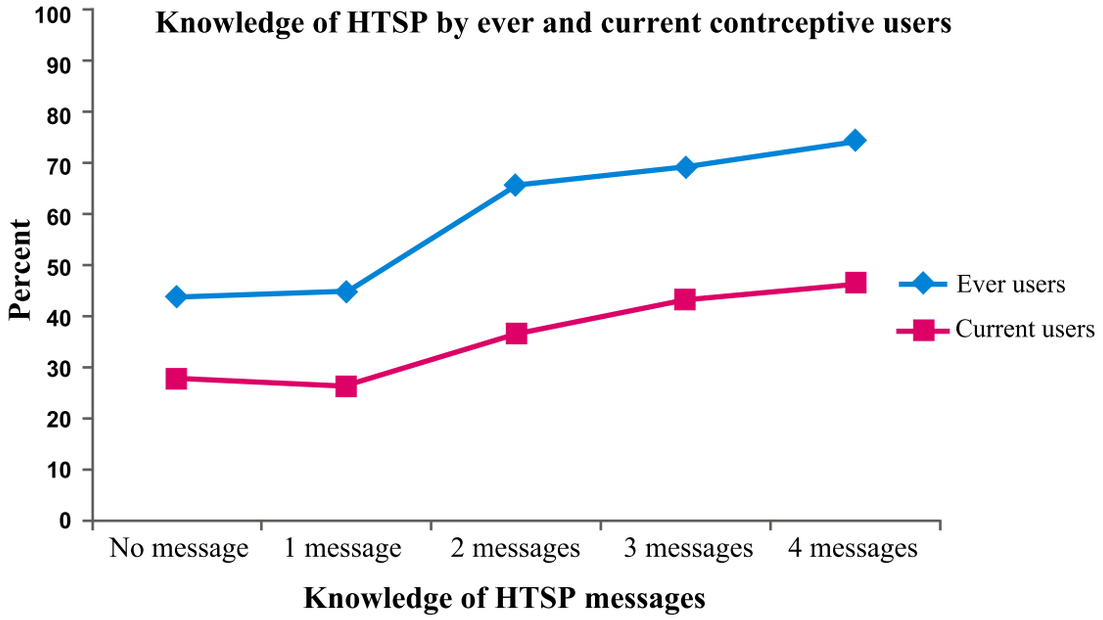
Ever and current use of contraceptive method was linearly associated with the knowledge of number of HTSP messages.

Questions were asked about the perceptions of women on duration of spacing after a live birth or an abortion, ideal age at first birth and the age limit for becoming pregnant. Majority of women (91.5%) mentioned that most suitable age at first marriage should be 18 years or more; ninety-four percent mentioned that there should be a gap of 24 months after a live birth and a gap of 6 months after a miscarriage (70.2%) before planning next conception. Approximately 57% mentioned that women should not bear children after 35 years of age. (Table 3).

Table 3 – Healthy Timing and Spacing of Pregnancy (HTSP) n = 5140

Variables	n (%)
Age for first pregnancy should not be less than 18 years	4705 (91.5)
Age for limiting pregnancy after 35 years	2917 (56.7)
Spacing pregnancy at least 24 months after live birth	4836 (94.1)
Spacing pregnancy at least 6 month after abortion	3609 (70.2)

Figure 17



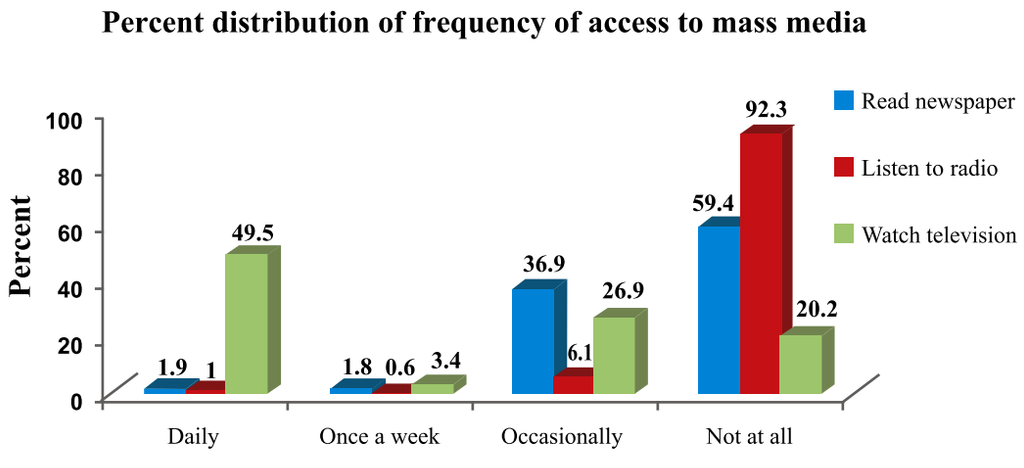
It was observed that the ever and current use of contraceptive methods was linearly associated with number of messages known to women. Among women with no knowledge or having the knowledge of any one of the HTSP messages, the use of FP was more or less same; however, the ever and current use of contraceptive methods increased linearly with knowledge of two or more messages. (Figure 17) The most commonly known messages were related to age at marriage and having a gap of 24 months after a live birth before planning next conception.

Source of Information about MCH and FP

Television is the main source of information for women (mass media)

Exposure to media was considered adequate if women watched television, listened to radio or read newspaper, at least once in a week. Respondents were asked on possession of radio, television, availability of newspapers and mobile telephones; and how frequently they access these sources of information. About 50% of women watched television daily exposure to newspaper and radio was very low. (Figure 18)

Figure 18



The use of media except television is low. Therefore, it may be important to use other approaches to access household. For instance, use of mobile phones as 87.5% of household owned a mobile phone and nearly 45.6% of women reported having a mobile phone that they use for themselves.

Nearly 23% of women mentioned a health worker visiting their home during last 6 months prior to the survey. Of these, 35.5% mentioned visits made by LHW, and 24.4% by Sukh CHWs. Topics frequently discussed were related to mother and child health (31.6%), family planning (27.0%), and child immunization (21.5%). (Figures 19-20)

Figure 19

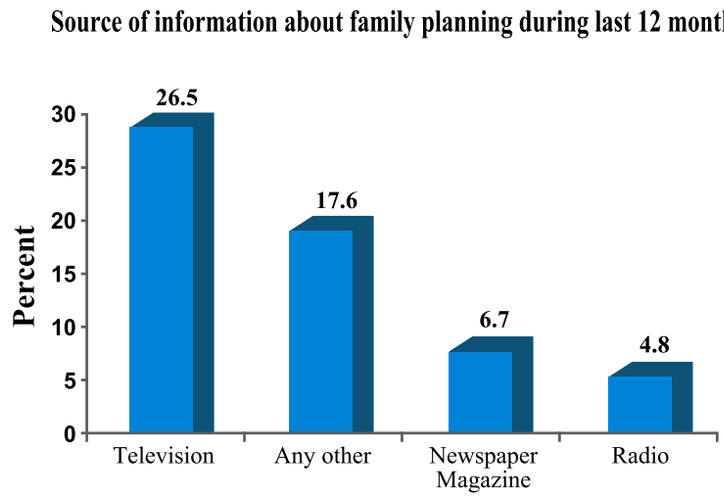
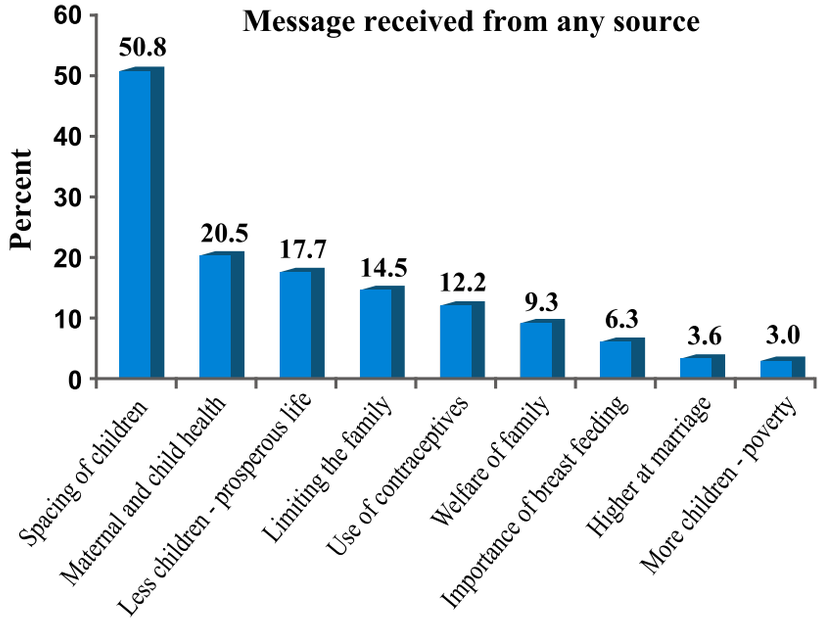


Figure 20



3. Youth Issues

In Sukh Initiative, the youth is defined as boys and girls in the age group of 12-24 years. Aahung is the implementation partner addressing youth issues at Sukh stations by providing Family Life Education. For the age group of 12-16 years, FLE will be provided through formal schools and for youth in the age group of 16-24 years and who are not enrolled in formal schools, FLE sessions will be conducted through group meetings in the communities. Sessions on youth issues with parents are also planned.

The baseline survey included questions on acceptability of parents for FLE messages, awareness about occurrence of any training/event related to youth in their area, their perceived important youth issues, and their acceptability of messages to youth proposed by Aahung to prepare youth for responsible adult life.

Women consider receiving formal education, unemployment and addiction to recreational drugs as important youth issues

About 7% of women had heard about any discussions/trainings being held in the area related to the youth issues. Of these, only 14.3% had attended a meeting. (Figure 21) The women who had heard of or attended a meeting (n=353) identified education (53.7%), unemployment (55.2%), and addiction to recreational drugs (19.9%), as important youth issues. A small percentage of women were concerned about youth getting involved with criminal groups (3.9%). (Figure 22)

Figure 21

Awareness about any meeting/discussion related to youth issues

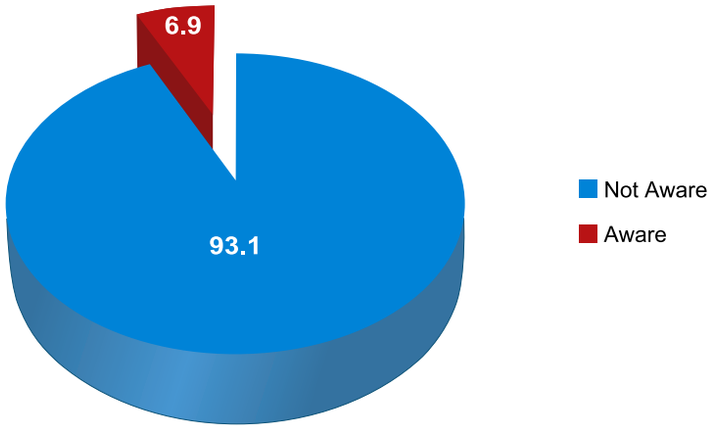
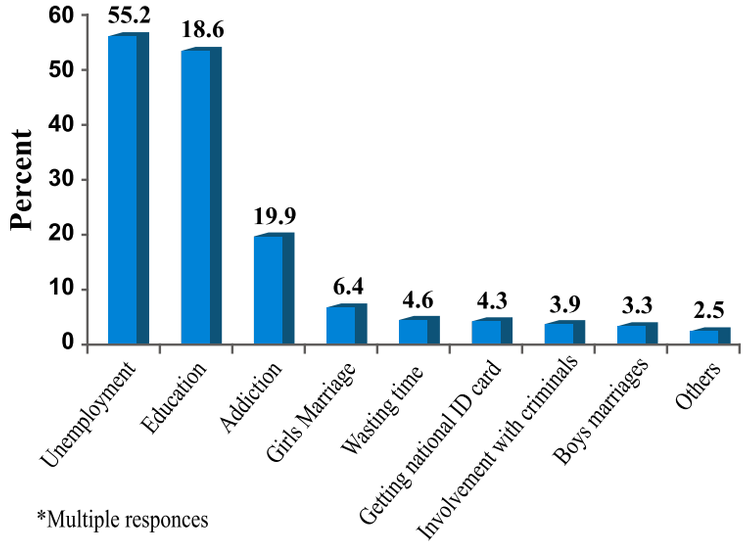


Figure 22

Perceptions about important youth issues*



*Multiple responces

Perceptions about FLE

The messages included in the questionnaire were related to what Aahung proposed to include in its group meetings with youth as a strategy to progress them as responsible adults when they initiate their own family life. The purpose was to assess the acceptability of these messages by the women.

Women hardly knew the importance of having a national ID card by youth

About 62% of the responses were in favor of importance of religious education, 52.8% were for the importance of formal education, and 25.3% to understand the right age at marriage. The importance of having a national ID card by youth was hardly known to any woman. Nearly every respondent (93.8%) perceived that such messages would be beneficial to their youth.

FLE message related to young age at marriage and use of FP by teen-agers were less favored by women

The women were not aware of information which could be imparted to youth to prepare them as responsible adults when they start their own family life. The responses were less in favor of avoiding young age at marriage (25.3%), importance of antenatal care (16.5%), dangers of early marriage (18.4%) and use of FP to avoid teen-age pregnancy (9.3%).

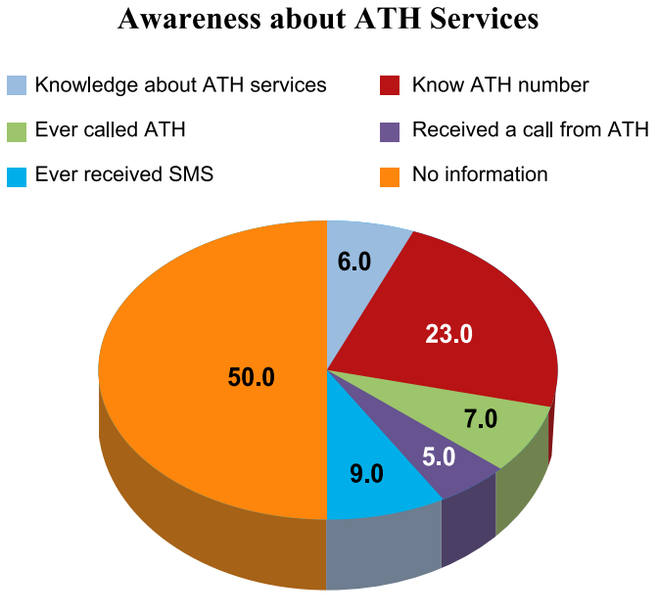
4. Tele-Health Services

One of the strategies to increase demand for contraceptive methods is to provide information through Tele-Health Services. Aman Tele-Health (ATH) is the implementation partner for this strategy. Baseline survey provides information on the acceptability of ATH services for FP, PPFA, PAFP, PAC and FLE by the community women.

Awareness about ATH is low

In additions to questions on acceptability of services related to reproductive health issues, women were asked questions on the awareness of ATH services in general, and their experience for utilization of these services. Only 6.1% women were aware of ATH services. Among those who had some awareness, 23% knew the telephone number of ATH, 7.5% had ever called at this number and 5.3% had received a call from ATH. 8.6% women received SMS messages. These SMS messages were mostly related to maternal and child health (43.1%) or to any medical problem (34.3%). (Figure 23)

Figure 23



A small percentage of women have personal mobile phone

Only 45.6% women owned personal mobile phones. In case of non-availability of personal telephones, 32.4% mentioned that they use Public Call Office (PCO), 21.5% use neighbor's phone or borrow a mobile phone (21.2%).

Tele-Health Services have strong potential for providing information on FP, PPFP, PAFP, PAC, FLE and MCH

About 84% of women said they would be comfortable using a telephone booth placed in their areas by ATH to access information on reproductive health and family planning. About 18% of women mentioned that they have already shared their cell number with the ACHP team and are willing to access hotline (80.7%) provided by ATH for any health related information they need.

Regarding text messages related to maternal and child health, family planning and youth issues, more than 75% of women said that their husbands will have no objection in receiving these messages.

Less percentage of women perceived that their husbands would support text messages sent to their youth's phone number

Women were further explored about their perceptions regarding acceptability of messages sent to husband's, respondent's, her son's or daughter's cell phone. About 67% of women mentioned that their husbands would not have any objection to receiving messages; however, this percentage declined to 58.9% for receiving messages on women's phone, 22.5% to son's phone and only 18% to daughter's phone.

When asked whether husband would share the messages received on his cell number with his wife or children about 64% of women mentioned that husband would share the message with wife, a negligible number of women mentioned that a husband would share messages with son (0.6%) or daughter (0.6%).

5. Conclusion and Discussion

The results from our baseline survey suggest that there is a large gap in the family planning related demand, supply and provision of quality services. In spite of universal knowledge about contraceptive methods, contraceptive prevalence rate for modern methods was low and women were generally using less effective methods such as condom and withdrawal method. Moreover, when compared to ever users a far less percentage of modern methods use was observed among current users. It seems that on supply side adequate method mix is not available which is making continuous use of a method difficult, resulting in large dropouts. In addition there is a possibility of a gap in the provision of quality services including proper counseling, management of side effects, management of stock outs and availability of trained staff in the facilities all adding to low use of modern contraceptive methods. The solution levers for Sukh Initiative aim to address many of these gaps especially through door-to-door services, Tele-Health Services and enhancing availability and quality of FP services.

The focus of family planning services should be on raising awareness and providing adequate counseling to young married women in their teens and or to women with low parity with lesser duration of marriage i.e. immediately after marriage to 5 years of marriage. It is suggested that HTSP messages be broadly disseminated to young women and to women and men in general to increase the support for young women for spacing first birth and delaying pregnancy until the age of 18 years. For these women, the emphasis of the family planning messages could be on the use of efficient modern contraceptive methods. However, women should be provided with information on all methods to help them make informed choices.

Women who reported unplanned pregnancy were young, uneducated with two living children and poor. Provision of equitable FP services should be ensured for such women. Some mechanism for identifying high-risk groups and provision of safety nets for these women could be considered. Moreover, women belonging to certain ethnic and minority groups can be considered as high-risk groups requiring extra vigilance in care.

Women in older group i.e. 30 years and above with three or more children were either opting for tubal ligation or were using condom. These women should be counseled for and provided with more effective long-term methods of family planning.

The reasons for non-use of contraceptives do not show any pattern. The common reasons for non-use were on-going breast-feeding, wanting more children and being pregnant. These women are the potential candidates for spacing and belong to a special group with special needs; for example breast-feeding women can be counseled about exclusive breast-feeding, back up support of condom or for use of appropriate hormonal methods in case of breast-feeding, which is not exclusive. Similarly, for the newly married, and/or young women who want more children could be counseled about HTSP. These women and their husbands can be referred to FP counselors.

Encouraging inter-spousal communication and couple counseling would be helpful in increasing the rate of contraceptive use. For women who have had a recent delivery or miscarriage can be referred for PPFP, PAFP or PAC.

One of the reasons for high unmet need of family planning at Sukh stations could be due to high dropouts because of side effects of modern methods or due to fears related to the side effects. Proper information on side effects, counseling about seeing a health care provider when coming across a side effect and appropriate referrals to trained health care providers can help in decreasing this aspect of unmet need of family planning. Emphasis of counseling should be on continuity in the use of a method. ACHP MIS should guide the program for tracking and continuation of contraceptive method use.

Every registered non-pregnant woman who has a young infant should be counseled about the spacing and referral services, which Sukh Initiative already has in place.

The health care provider's trainings on FP, PPFP, PAC and PAFP should be assured and women and men in general should be provided with information on FP, PPFP, PAC and PAFP. Messages on family planning should also address adverse consequences of seeking an unsafe abortion. Tele-Health Services should be a rich resource for increasing awareness about PAFP and PPFP.

A behavior change communication strategy is required to make youth and parents cognizant of the issues related to preparing youth as a responsible future adult. Very specific messages designed separately for parents and youth will be helpful. Dissemination of information regarding availability of ATH helpline can facilitate both parents and youth to access information they need. Although mobile phones are available in abundance in the community, its maximum and wide range use for raising health awareness is yet to be understood.

Availability of Aman Tele-Health Services in the communities will provide means where men, women, and youth can have access to information in confidentiality and in privacy. Tele-Health Services can become a powerful source of information for women, men and youth. Provision of telephone booths especially to access information on FP, RH, PPFP, PAC, and PAFP would be helpful for women and youth who do not have access to telephone. These can be used in privacy and at their own convenience.

Women with formal education can mentor those who had no exposure to any sort of education and can help uneducated women in understanding the messages and information provided by the CHWs of ACHP. CHWs should be guided to build good rapport with this local resource of educated women.

FINDINGS FROM QUALITATIVE ASSESSMENT

1. Family Planning

This section presents perceptions, knowledge, behaviors, practices and attitudes of community members and key resource persons' with regard to family planning. The community members who participated in FGDs to discuss family planning were married men and women. The findings are described under following themes:

- Awareness about a FP program, knowledge of contraceptive methods and their side-effects and sources of information
- Factors facilitating and inhibiting FP use and contextual dynamics that modify the behaviors and practices related to contraceptive use
- Benefits and risks of FP use to individuals, families and communities
- Availability and access to Family Planning /Post-Partum Family Planning (PPFP)/Post-Abortion Family Planning (PAFP)/Post-Abortion Care (PAC) services
- Factors that may influence Sukh FP program

Awareness and Knowledge about FP Program and Methods and Sources of Information

Participants of most of the stations showed willingness to discuss family planning. Reluctance to discuss FP was observed at stations 3 (Umar Marvi Goth), 5 (Etihad Colony) and 10 (Ghazi Town). Participants of both FGDs and Key Informants interviews said that people are generally aware of FP programs. It is not a foreign topic for the community, even if the practice is low. Men in nearly all the FGDs, healthcare administrators and community leaders mentioned that the main focus of FP programs is on women and therefore men are less informed. Women on the other hand, explained this as men's disinterest in family planning.

Men consider family planning as wives' issue and therefore, do not want to know about it and tell their wives to enquire on and use FP methods.

Women from station-5 (Etihad Colony)

Information on family planning in both men and women is primarily on several traditional as well as modern contraceptive methods. Traditional method most commonly known to them was withdrawal. The modern FP methods known were condom, pill, injecables, implant, IUD and tubal ligation. Information on vasectomy was not available to any participant. Both FGD participants and key informants quoted TV and internet as the most often accessed means for information on family planning. Women also said that doctors and LHWs are amongst the key information provider of family planning.

Contraceptive Use, Type of FP Methods Used and Reasons for Selection of a FP method

FGD Participants and Key Informants unanimously informed that universal awareness about the FP program exists but this adequate knowledge of FP methods is not translated into practice; people consider FP use a personal matter and feel shy to get advice about FP methods (men from station-1, Shah Latif Town and women from station 8, Future Colony.) A sentiment expressed was that the Pakistani nation has an attitude not to plan anything including family planning.

There is no planning in our lives neither for marriage nor for children.

Man from station 8 (Future Colony)

Men expressed that to achieve spacing of 2-3 years between births, traditional methods are preferred including withdrawal and breastfeeding; some couples also use condoms. Women from station 8 (Future Colony) reported that Islam also advises abstinence to plan families but no one practices it these days. Only few women use modern contraceptives such as pill, injectables and IUD; male participants from station-8 (Future Colony) reported termination of pregnancy as a contraceptive method for spacing or limiting family size. Women from nearly all the FGDs informed that preference is given to a family planning method that has minimum side effects and is easily available.

Men do not allow contraceptives, but give permission for abortion to get rid of the baby when wife becomes pregnant.

Man from station 8 (Future Colony)

Factors Facilitating and Inhibiting FP Use and Contextual Dynamics that Modify the Behaviors and Practices Related to Contraceptive Use

Several women pointed out females being educated, support from married woman's mother and changing social values as facilitative factors for family planning. Unfortunately, religious beliefs, traditional norms, fear of side effects and resistance from in-laws were persistently the inhibiting factors in family planning. Both FGD participants and Key Informants highlighted this barrier in adoption of family planning.

Prohibition of practicing family planning in Islam is a well-established belief in the community under study and was most strongly found in men. Men say that children are God's gift and God has promised to feed them. On the other hand, women said that too many children is now becoming a social barrier as large families are not invited in social events and are not preferred by landlords for renting houses.

Conception is God's decision and there should be NO interference in this.

Men from station-4 (Bhittai Colony)

Men reported that religious leaders preach against family planning and advise them to have more children in order to increase the number of muslims in this world; hence, more people will be available to participate in *jihad.* It came up that religious leaders have also conveyed to the community how Government, influenced by foreign nations, is curtailing conception just to eliminate muslims. This, they say is being achieved through polio vaccine and family planning supplies from foreign countries to make users impotent. Healthcare providers, health administrators and the community leaders strongly supported this concept of religious interpretation by spiritual leaders as one of the major barriers in contraceptive use.

God has promised to provide food to every new soul that comes to this world. Men from Stations 2 (Dabla Para) & 9 (Mansehra Colony)

Women from Stations-3 (Umer Marvi Goth) & 6 (Korangi No. 5)

Religious teachers approached in madrassas were hesitant to talk about family planning. They say Islam allows planning of family but to be practiced according to resources and contraceptive methods recommended by Islam are breastfeeding, abstinence and withdrawal. Nonetheless, they did admit to having inadequate knowledge on family planning methods and Islam's actual disposition for the use of these methods. They added that religious scholars could comment better from the standpoint of Islam on contraception.

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Additional probing revealed how traditional norms such as encouraging early first pregnancy after marriage and a required family size of at least four to six children with a minimum of two boys, discourages family planning in couples. Slave to such norms, women are ready to become pregnant. The other opinion amongst women was their preference for big families, which gets very convenient later in life, when elder children become the helping hands for raising their younger offsprings. Other than norms, experiences, directly or heard, for instance, side effects of family planning method use is one major reason for non-use. Surprising finding was that doctors sometime play a key role in discouraging women from using contraceptives by inculcating fear in them when giving information on side effects.

My eldest daughter takes care of all sibilings while I enjoy my life.

Women from station-3 (Umer Marvi Goth)

A general expression in women was that although both husband and wife discuss the use of family planning methods, still it's the husband who gets to take the final decision. Furthermore, resistance in FP use comes most from in-laws especially mother-in-law and husband. To emphasize their point they disclosed how a husband would beat a wife who asks him to get a family planning method for her.

Without husband's permision nothing can be done.

Women from station-7 (Umer Marvi Goth)

Perceived Benefits and Risks of FP Use on Individuals, Families and Communities

An understanding of the benefits of family planning in most of the FGD participants' was how it's helpful in deciding number and timing of pregnancy whereby decreasing work load of women, leaving them with time for themselves and their children. It reduces expenses, lessens financial worries, and increases availability of more resources for education, training of children and food. All these add up to improved nutrition and health of mother and child.

Women and a few men reiterated that the main risk in family planning use was their side effects. Women to back this statement quoted a few myths such as use of condom can cause menorrhagia, body edema, vision loss and vertigo, IUD can become rusty, and contraception can result in infertility. Other spelled out barriers were accessibility, affordability and distance. Women mentioned that clinics are too far away, cost of transportation, consultation, and medicines is too high and beyond their reach.

Side effects of FP methods include irregularity of menses, heavy menses, ulcers, obesity, hypertension, swelling, bloating, infection, tubal pregnancy and infertility.

Women & Men

Availability and Access to FP/PPFP/PAFP/PAC Supplies/Services

All the FGD participants and Key Informants could not differentiate among FP/PPFP/PAFP/PAC services and considered all these services related to family planning. The only exception was healthcare providers and administrators who knew these services and the differences among them. Healthcare providers and administrators informed that in general family planning services are provided by clinics run by Non-Governmental Organizations (NGOs). The scope and extent of FP services at most of these clinics do not completely meet the standards and criteria of FP / PPFP / PAFP / PAC.

With regard to FP supplies, the majority of women as well as the healthcare providers informed that condom, pill and injectables could be obtained from clinics, general and medical stores, and from LHWs of the area. IUD and implant services are not available at health facilities within the area. Women further informed that travelling to other areas for FP services is socially, geographically and economically difficult.

Husband has to do two jobs and do not have time for the family if they have more children.

Women from station 5 (Etihad Colony)

The majority of men and key informants revealed that most of the FP centers are providing services for women only and there is need to involve men in family planning programs. Healthcare providers also informed that comprehensive FP, PPFP, PAC and PAFP services are not actively offered to men and women of these areas.

Factors that may Influence FP Program

Participants of all the FGDs and Key Informants revealed that the involvement of the community's resourceful personnel is vital for the initiation of any program and more so for the family planning program. Those mentioned included, men, community/ religious/ political/ social leaders, teachers/ scholars and healthcare providers. Participants of some stations identified influential person from their area who could be involved to make the FP program successful for example, Nazim for station-5 (Etihad Colony), religious leaders for stations-1 (Shah Latif Town) and 10 (Ghazi Town), and political leaders for station-4 (Bhittai Colony). Participants of all the FGDs and key informants appreciated the idea of Community Health Workers providing door-to-door services in their residential areas and informed that they will be well accepted if they are selected from the communities they will be serving. They also suggested strategies to make the program successful such as use of dramas and musical programs through TV or live theatre, to inform about correct interpretation of religion related to family planning use, to eliminate fears and eradicate misconceptions and myths about contraceptives, sensitization and motivation of men and development of messages that link FP use to men's earning capacity and their pivotal role in equal and shared active participation.

"We have to go to Naik Mohammad Goth and transportation is very expensive and can cost as much as Rs. 1000/visit."

Women from station 2 (Dabla Para) Women & Men

Conclusions

Based on the findings of the FGDs and KIs, following key conclusions can be drawn:

1. Awareness about the country's family planning program is universal and men and women generally know most of the contraceptives including condom, pill, injectables, implant and IUD. Vasectomy was not known.
2. Limited FP use was reported, as traditional values encourage minimum family size of 4-6 children with at least two sons.
3. To space children, condom, withdrawal method and breast-feeding are preferred; termination of pregnancy is also used to space or limit births.
4. Women and men are well familiar with the benefits and risks of contraceptives. Side effects are considered the biggest hindrance for use. Misconceptions and myths about contraceptives still prevail.
5. Education of a married woman, support extended by a married woman's mother and changing social values facilitate; while religious misinterpretations, fear of side effects, resistance from in-laws, and traditional norms inhibit FP use.
6. Health facilities existing in the areas are dispensing FP supplies including condom, pills and injectables; however, counseling, availability of full choice and range of contraceptive services are inadequate.
7. FP is considered a 'Women's Issue'; men take no notice of FP programs and healthcare providers pay little to no attention to men. Yet, the decision regarding contraceptive use is always taken by husband.
8. Abstention from FP leads to a large family size that negatively influence health and nutrition of mother and children and increases economic burden of father.
9. The key stakeholders for the family planning program are men, community representatives like religious leaders, politicians, social workers, teachers and healthcare providers.
10. Media especially T.V is the most frequent source of accessing information including FP.

Recommendations

From these conclusions, following recommendations can be made:

1. To improve scope and quality of FP / PPFP / PAFP / PAC services; health facilities existing in the area need to be strengthened in terms of trained and skilled health human resource, equipment and supplies.
2. Referral mechanism needs to be established that links clinics with hospitals for prompt and effective management of any experienced side effects of contraceptives.
3. Extensive knowledge dissemination campaigns are required to sensitize and motivate men, and to create awareness regarding the effectiveness and efficacy of modern especially long-term contraceptives and the dangers of abortion. Also to correct religious beliefs, eliminate fears and eradicate misconceptions and myths about contraceptives.
4. Media especially T.V should be utilized as a channel to disseminate information. FP messages should be incorporated into drama, theatre and music programs. Context specific, evidence-based and value laden messages linking FP to men's increased economic burden of large families and shared responsibility in informed decision making and FP program participation needs to be developed to sensitize and motivate men who are the main decision makers for FP use.
5. Key stakeholders of the family planning program including community representatives like religious leaders, politicians, social workers, teachers and healthcare providers should be actively involved.
6. Female education needs to be emphasized and enhanced.

2. Youth

This section presents the perceptions, knowledge, behaviors, practices and attitudes of community members with regard to the Youth. The community members who participated in FGD to discuss youth issues were boys and girls aged 16-18 years and mothers and fathers of the youth. The findings are described under following themes:

- Definition/Characterization of 'Youth'
- Activities of youth
- Youth issues and entertainment- family, social and health
- Age for marriage
- Persons with whom youth share their issues and the reasons
- Youth decision making
- Youth information needs and information mechanism and channels available and accessed

Defining/Characterizing 'Youth'

All participants described youth period generally commencing around 12-14 years of age for girls and 15-18 years of age for boys. Other indications of the beginning of youth period were describes as physical changes around puberty such as start of menstruation and breast changes in girls and appearance of moustache and beard and change of voice in boys. These physical changes also determine their physiological, psychological, social and sexual activities and needs. According to some youth, growing up was also associated with responsibilities undertaken by them. Others described change of dress code in girls where they are expected to cover themselves with a veil, and a change in their attitude as signs that she is now growing up. Some youths summed up growing up for girls and boys as an equally opposite experience where boys gain their freedom to go out while girls get confined at homes.

Activities of Youth

There was a widespread opinion that once a girl enter her pubertal years, she was generally known to discontinue her studies and take up household chores. Girls and mothers reported that a few girls in their area are factory workers or housemaids.

Boys on the other hand, during this period either continue with studies and or take up minor jobs to contribute financially at home. Boys of the fishermen community also go and work as fishermen either helping out their fathers or as someone's employee to earn some money.

Youth Issues and Entertainments- Family, Social and Health

Both parents and youth stated that youth lack security and have inadequate education and health facilities. A reiterated need was sports opportunities and playgrounds, which was reflective of their unfulfilled recreational outlets. Unavailability of these basic necessitates affect their physical and social development. Continuous struggle for the fulfillment of basic needs hinder and delay educational achievements and hence better employment opportunities. The recreational activities and issues during this period nonetheless are remarkably different for boys and girls.

Entertainment and activities available to young girls are merely dressing-up nicely, self- grooming, visiting relatives, shopping and watching TV. In fact, TV in some cases is the only gateway to the outer world. Major concerns surrounding them are restrictions for educational pursue, relationship obstructions with boys and a probability of facing sexual and social harassment in the name of honor.

Boys on the other hand are known to exhibit aggression, resulting into relationship conflicts, injuries because of conflicts and road traffic accidents, criminal activities such as drug selling, thefts, mobile snatching, and rape. Indulgence in substance abuse is also prevalent in the form of smoking tobacco, chewing varieties of beetle nuts such as *pan, mava, gutka,* alcohol and drugs.

These activities may just be an outlet to their suppressed feeling and unfulfilled desires harboring on their belief that education and alcohol is a solution to all problems. Proper education they cannot get and alcohol, which is accessible.

Main entertainment activities in boys are sports, socialization with friends either at hotels or in streets, killing time on cell phones and also hooting at girls for some- both a confession by a few boys and a strong perception of a small number of girls and mothers. A common activity of young girls and by boys is excessive use of cell phone, which is looked upon by most parents as misuse of mobile phones.

Age for Marriage

The appropriate age of marriage for girls and boys is reported to be somewhere around 20-25 years. Yet, it was pointed out that parents want to marry-off their girls as early as possible to fulfill their responsibility on a daughter and fearing any mishap regarding illicit relationships. Girls conversely stated that before the age of 20 years they do not feel themselves to be mature enough to handle relationship with in-laws and adequately manage matrimonial responsibilities. Mothers also admitted that early marriage leads to maternal complications and exert economic burden on young married boys.

Girls sometimes become the victim of violence up to being killed occasionally because of friendship with boys.

Girls from Station-1 (Shah Latif Town)

Persons with Whom Youth Share their Issues and their Reasons

Parents as well as the youth identified that youth mostly share their problems with friends and very rarely with their parents. Youth felt that asking questions or raising concerns is considered disobedience in families. They expressed that because of a large family size parents are working hard to run and maintain the household. For earning salaries, fathers are working long hours, most of them doing two jobs, while mothers are always occupied by household chores. Due to an excessively hectic workload, both parents do not have the time to spend with their children. Fathers, especially, are in foul moods most of the time and are not willing to listen to the issues their teenaged and young adult children have been facing. Mothers are usually more welcoming and therefore accessed more often. As a result of sharing and seeking guidance from friends, especially for physical and sexual concerns, these youth are often involved in misguided practices and sometimes become victims of physical violence by elders in the society. Furthermore, some youth became victims of sexual abuse by elders.

Youth do not share their problems with their parents because of shyness and fear of disobedience.

Boys from station-6 (Area I Korangi No. 5)

Youth's Decision Making

Parents and children unanimously informed that the youth can only decide about their education, employment or minor day-to-day issues like clothes and food. Parents specifically father, take major decisions especially those related to marriage. Parents felt that the youth do not have the capacity and maturity to make integral decisions.

Youth Information Needs and Information Channels

Both parents and youth pointed out that youth are in dire need of information. Main focus ought to be given on pubertal physical and sexual health, minor ailments such as pimples and menses, communication skills, career opportunities, correct Islamic interpretation on contraception and in general, significance of good company, harmful effects of addictions, healthy habits and life style. Currently, internet is the most frequently accessed information channel for both boys and girls. Boys also get information from friends and girls from TV.

Conclusions

Based on the findings of the FGDs, following key conclusions can be drawn:

1. Girls around 12 and boys around 15 years are undergoing physical and hormonal changes that determine their physiological, psychological, social and sexual needs and activities and hence influence their lifestyle.
2. Although the majority of the youth are studying, many also enter into gainful employment mostly in the informal sector.
3. Youth in general lack safety and security and have inadequate provision of education, health and sports facilities in addition to limited availability of daily necessities like water, electricity and cooking gas.
4. Major issues that girls face appear to be harassment, acquaintanceship with boys and restrictions on pursuing education.
5. Boys are generally found to be aggressive which leads to conflicts in relationships with their parents, friends and girls; increasingly becoming addicted to smoking, *pan, mava, gutka*, alcohol and drugs; and involvement in crimes such as thefts, mobile snatching and rape.
6. The youth share their problems with friends and very infrequently with parents, and if so, often with their mothers.
7. Youth can only make decisions about education, employment or minor day-to-day issues like the type of clothes to wear and what food to eat. All the major decisions especially those related to marriage are taken by parents specifically the father.
8. The youth obtain information from sources like friends, T.V and the internet and are extensively involved with the use of mobile phones.
9. The youth needs information on pubertal physical changes and sexual health, minor ailments such as acne and pubertal changes such as menses, communication skills, career opportunities, correct religious information with regard to contraception, significance of keeping good company and the harmful effects of addictions, healthy habits and lifestyles.

Recommendations

From these conclusions, following recommendations can be made:

1. For provision of timely, age specific, appropriate and relevant information to youth, they should be contacted at an early age; girls at 12 and boys at 15 years of age.
2. Youth friendly spaces need to be created at institutions such as, formal and informal schools, workplaces and health facilities to provide opportunities to the youth to get support whenever required.
3. Educational sessions need to be arranged for the youth on pubertal physical changes and sexual health, minor ailments such as acne and pubertal changes like menses, communication skills, career opportunities, correct religious information with regard to contraception, significance of keeping good company, harmful effects of addictions, healthy habits and lifestyles.
4. Quality formal education is a dire need of the day, for both younger children and the youth.

5. Parents need to be informed about the significance of frequent two-way communication with the youth to develop healthy relationships with them. This will help in the development of a conducive environment for the youth to share their problems with parents.
6. Parents need to be informed about the significance of education and the risks of early marriage of girls.
7. New educational and sports facilities should be developed for the youth so that they can be prevented from unhealthy and deleterious behaviors such as aggression, relationship conflicts, addictions, crimes and female harassment.
7. Peers, media- including TV and the internet- and mobile text messages can be used as channels to provide information to the youth.

3. Family Life Education (FLE)

This chapter presents the perceptions, knowledge, behaviors, practices and attitudes of community members with regard to Family Life Education (FLE). The community members who participated in FGDs to discuss FLE were boys and girls aged 16-24 years and parents of these youth. The findings are described under the following themes:

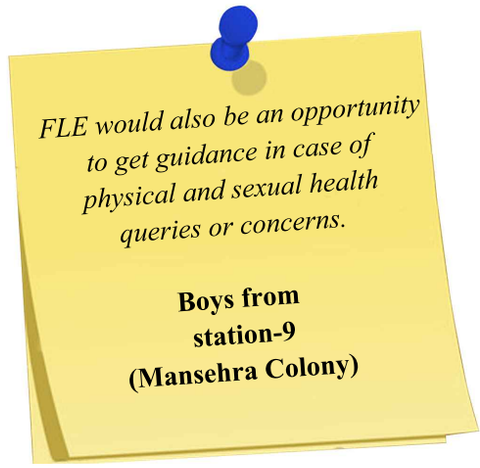
- Awareness and knowledge about FLE
- Acceptability of FLE in these areas and enabling/disabling factors for FLE

Awareness and Knowledge about FLE

Almost all of the parents and youth had never heard about Family Life Education.

Acceptability and Enabling/Disabling Factors for FLE

The majority of parents and youth expressed that FLE will be acceptable in all these areas, however girls from station-1 (Shah Latif Town), 2 (Dabla Para Rehri Goth) and 10 (Ghazi Town) felt that parents may not give permission to them to attend FLE sessions in their area. It was suggested that FLE sessions should be conducted at home or institutions. The institutions could be educational centers such as schools, tuition centers, libraries, sports clubs or health facilities for instance hospitals. The facilitators of these FLE sessions could be either school/*madrassa* teachers or healthcare providers. The topics suggested for FLE were communication skills, career counseling, pubertal issues, physical and sexual health and rights, minor ailments such as acne and religious information.



Boys felt that conduction of FLE sessions alone would create youth friendly spaces. However, mothers from station-1 (Shah Latif Town) were concerned that FLE sessions on sexual and reproductive issues might imbue indulgence amongst girls towards sexual practices.

Conclusions

Based on the findings of the FGDs, following key conclusions can be drawn:

1. Little or no knowledge exist about Family Life Education in these areas.
2. FLE is acceptable in all these areas, however provision of FLE to girls may be challenging in stations-1 (Shah Latif Town), 2 (Dabla Para Rehri Goth) and 10 (Ghazi Town).
3. The venue suggested for FLE sessions conduction include homes, educational institutions such as schools, tuition centers, libraries, sports clubs and hospitals.
4. Topics suggested for FLE are communication skills, career counseling, topics tackling pubertal issues, physical mental and sexual health and rights, minor ailments such as acne and religious information.

Recommendations

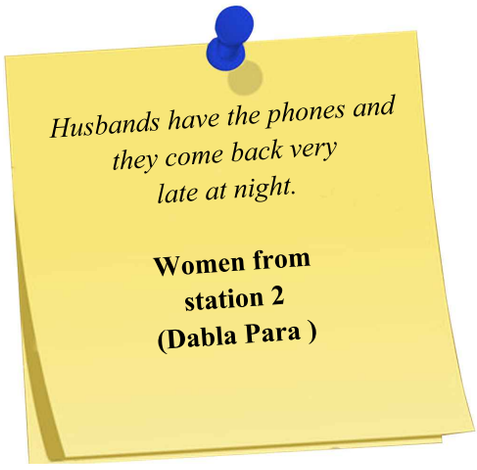
From these conclusions, following recommendations can be made:

1. FLE is highly recommended in these areas, however station-1 (Shah Latif Town), 2 (Dabla Para Rehri Goth) and 10 (Ghazi Town) need to be prepared carefully and sensibly before launching FLE at these areas.
2. FLE can be conducted at home, by CHWs and by teachers, and by healthcare providers at educational institutions such as schools, tuition centers or libraries, sports clubs and hospitals.
3. FLE should be conducted on communication skills, career counseling, pubertal issues, physical and sexual health and rights, minor ailments such as acne and religious information.

4. Tele-Health

This section presents the perceptions, knowledge, behaviors, practices and attitudes of community members with regard to Tele-health. The community members who participated in FGD to discuss Tele-Health were boys and girls of 16-18 years and parents of these youth. The findings are described under following themes:

← Awareness and knowledge about Tele-Health
← Acceptability of Tele-Health in these areas and enabling/disabling factors for Tele-Health



Awareness and Knowledge about Tele-Health

Most of the parents and youth had never heard about Tele-Health, however, few men knew about Aman Emergency Tele-Health Service.

Acceptability and Enabling/Disabling Factors for Tele-Health

The majority of parents and youth expressed that Tele-Health would be acceptable in all these areas for men, women and boys. For girls however, Tele-Health would not be very effective as most of them do not possess cell phones and those who do may have difficulty in getting permission to receive calls and messages. All men, boys, and most of the women had mobile phones and expressed willingness to share their phone numbers. However, few women and most of the girls did not have mobile phones. It was further suggested that textual messages should be either in Urdu or in Roman English script.

Conclusions

Based on the findings of the FGDs, following key conclusions can be drawn:

1. Little or no knowledge exists about Tele-Health Services in these areas.
2. Tele-Health Services as a strategy is acceptable in all these areas for men, women and boys but would demonstrate limited effectiveness for girls.
3. Urdu and Roman English are the preferred script for textual messages by community members.

Recommendations

From these conclusions, following recommendations can be made:

1. Tele-health Services are highly recommended in these areas.
2. Tele-Health Services would be effective for men, women and boys, however may be challenging in terms of reaching out to girls.
3. Text messages should be in Urdu or Roman English.

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