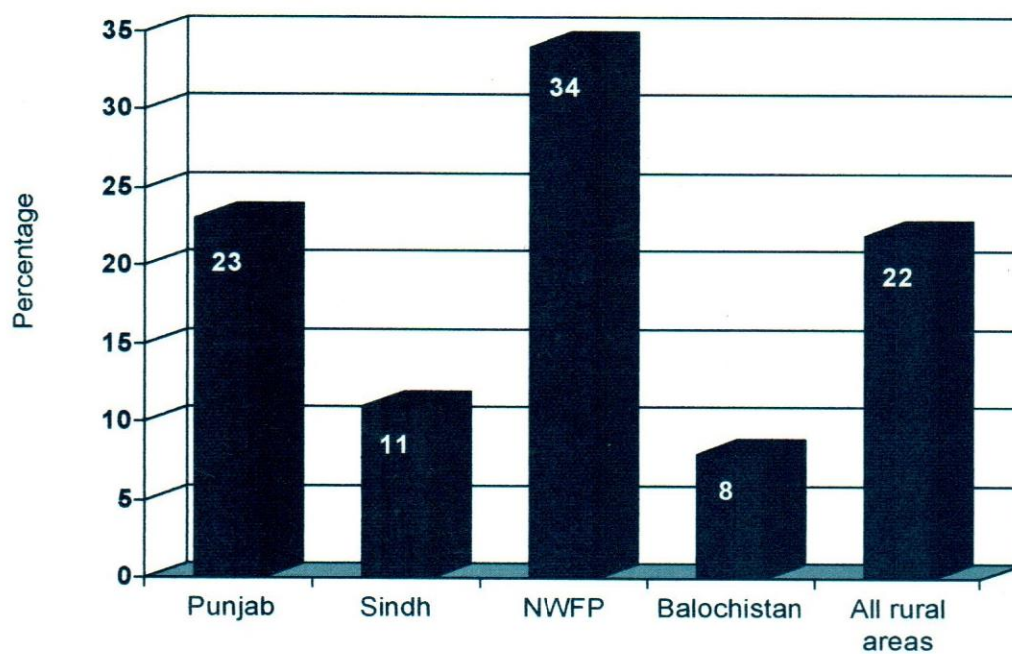


HEALTH AND FAMILY PLANNING ACCESSIBILITY SURVEY 1996 - 97

**PERCENTAGE OF WOMEN HAVING ACCESS TO
FWC IN RURAL AREAS**



National Institute of Population Studies
Islamabad, 2000

Handwritten signature

**HEALTH AND FAMILY PLANNING
ACCESSIBILITY SURVEY
1996-97**

**Mehboob Sultan
John Cleland**

**National Institute of Population Studies
Islamabad, 2000**

HEALTH AND FAMILY PLANNING
CAPABILITY SURVEY
1987

This survey was conducted by the Health and Family Planning Council of the Government of India, New Delhi, in 1987. The survey was conducted in 100 villages in the State of Karnataka.

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John Chelmsford

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Foreword

Health and Family Planning Accessibility Survey was undertaken concurrently and as part of the 1996-97 Pakistan Fertility and Family Planning Survey. The National Institute of Population Studies conducted both the surveys with technical assistance from the London School of Hygiene and Tropical Medicine. This is the first ever attempt to make an inventory of all health and family planning service outlets in all sampled geographical clusters of a nationally representative cross sectional fertility and family planning survey. The basic objective of this survey was to assess the precise nature of family planning services available to the women of reproductive age, closer to their residence. Besides static outlets, availability of family planning through registered medical practitioners and community workers like village based family planning workers of the Ministry of Population Welfare and lady health workers of the Ministry of Health was also examined. This is the first time that coverage of family planning services at national, urban, rural and provincial level are ascertained on scientific basis.

The survey was carried out in 295 clusters of the 1996-97 Pakistan Fertility and Family Planning Survey. A total of 407 static outlets of the health and family planning programme falling within a radius of one kilometre of urban clusters and five kilometres of rural clusters were visited. A structured questionnaire was used to illicit information on availability of family planning methods and health services, trained staff, stock position, shortage of supplies in the past, availability of equipment, and record keeping. Medical practitioners and community workers like VBFPWs and LHWs within the prescribed radius were also visited to ascertain the services offered by them.

Several organisations and individuals assisted NIPS for undertaking this part of the survey along with the main 'Pakistan Fertility and Family Planning Survey (PFFPS 1996-97)'. The NIPS staff of PFFPS specially Dr. Abdul Hakim, Project Director, Mr. Mansoor-ul-Hassan Bhatti, Principal Investigator, and Mr. Mehboob Sultan, Co-Principal Investigator deserve special commendation for successfully conducting the survey. We are also obliged to Professor John Cleland, London School of Hygiene and Tropical Medicine, for the technical assistance.

I believe that the survey has collected valuable information, which could be utilised for better management of the family planning programme. I am grateful to the Ministry of Population Welfare for their support. We are grateful to the UK Department for International Development for funding this project.

Ahmad Shamsul Huda
Executive Director

Foreword

This was Family Planning Association survey was conducted in 1975 and is part of the 1975-76 Family and Family Planning Survey. The National Family Planning Survey was conducted in 1975 and 1976 with technical assistance from the United States Agency for International Development. This is the first ever survey to study an aspect of all health and family planning services available to all people in a nationally representative cross-sectional family and family planning survey. The basic objective of the survey was to assess the present status of family planning services available to the women of reproductive age class in their residence. The data were used to assess the availability of family planning services in different regions, and to identify areas where the village-based family planning workers of the Ministry of Health and Family Planning are not working in the field. This is the first time that coverage of family planning services in national, regional, local and provincial level are examined on scientific basis.

The survey was carried out in 1975-76 in 1000 villages of the 1975-76 Family and Family Planning Survey. A total of 400 women of the reproductive age class and family planning programme were interviewed in each village. The survey was conducted in 1000 villages in the country. A national questionnaire was used to collect information on availability of family planning methods and health services, family size, and other socio-economic characteristics. The questionnaire was available in English, Hindi, and Urdu. The questionnaire was available in English, Hindi, and Urdu. The questionnaire was available in English, Hindi, and Urdu. The questionnaire was available in English, Hindi, and Urdu.

The survey was conducted and implemented under the leadership of the Director, National Family Planning Survey, Ministry of Health and Family Planning, Government of India. The survey was conducted in 1000 villages in the country. The survey was conducted in 1000 villages in the country. The survey was conducted in 1000 villages in the country. The survey was conducted in 1000 villages in the country.

I believe that the survey has collected valuable information which could be useful for the management of the family planning programme. I am grateful to the Ministry of Health and Family Planning for their support. We are grateful to the IUCD program for financial assistance for funding this project.

Secretary, Health
Ministry

Acknowledgements

The management of the Health and Family Planning Accessibility Survey 1996-97, was undertaken as part of the Pakistan Fertility and Family Planning Survey (PFFPS) 1996-97. The report of the PFFPS 1996-97 was published in 1998. The whole project team of the PFFPS 1996-97 in his / her own capacity, contributed for the execution of this project, in particular during the survey designing and data collection stage.

Mr. Mansoor-ul-Hassan Bhatti, Principal Investigator of the PFFFPS project, contributed in various ways during the data collection. Mr. Faateh-ud-Din Ahmad, Programmer NIPS undertook the responsibility for computerisation of data and tabulations for the report. Mr. Muhammad Ali, Research Fellow, Department of Epidemiology and Population Health, London School of Hygiene and Tropical Medicine prepared tabulations used in Chapter 4 of the report. Dr. Abdul Hakim, Director NIPS was the Project Director and provided guidance and support during the execution of the project and reviewed an earlier draft of the report. We are thankful to all of them for their contribution.

We would also like to thank for the support and persuasion of Mr. Ahmad Shamsul Huda, Executive Director, NIPS for finalisation of the report.

Mehboob Sultan
Prof. John Cleland

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EXECUTIVE SUMMARY

Health and Family Planning Accessibility (HFPA) Survey was conducted as part of the 1996-97 Pakistan Fertility and Family Survey (PFFPS). The principal objective of the survey was to examine the extent of coverage of family planning through health and family planning facilities. The survey was carried out in 295 geographical clusters of the PFFPS out of which 120 clusters were in urban and 175 in rural areas. Under the HFPA Survey, an inventory was made of all health and family planning facilities and staff within a radius of one kilometre in urban areas and five kilometres in rural areas. All facilities and including medical practitioners, Village Based Family Planning Workers and Lady Health Workers were visited to ascertain the precise nature of family planning services on offer. In order to obtain a complete picture, profile of the urban and rural clusters was also prepared which include availability of electricity, post office, bank, police station, pharmacy, general store, educational facilities, and income level of the community.

For analysis of the data, the HFPA survey information was linked to the women file of the 1996-97 Pakistan Fertility and Family Planning Survey. However, the analysis presented in this report is based on both the HFPA survey file and the restructured file.

Data presented in this report are based on the availability of health and family planning services to the population of the representative sample of women in Pakistan and not a representative sample of the health and family planning outlets. Therefore, findings of the survey cannot be generalised for the outlets as such.

Some of the main findings of the survey are summarised below:

- In all, 407 health and family planning static outlets were visited throughout Pakistan. All of them were providing general health care, while up to 72 percent were providing pre and postnatal care, 52 percent delivery services, and 44 percent regular immunisation services.
- In all 295 clusters, health facilities visited include 51 hospitals, 107 BHUs, 1 Urban Health Centre, 19 Rural Health Centre, 80 Dispensaries, and 24 MCH Centre. Out of

these 282 health facilities 109 or 38 percent were offering family planning services. Besides, these clusters had 19 NGO facilities of which 17 or 88 percent were offering family planning services. In addition to the health and NGO outlets, the sampled clusters had 105 family welfare centres, which were exclusively offering family planning services.

- Record keeping was proper in 48 percent of all the centres where family planning services were offered. In rest of the centres, the records were either partially maintained or altogether missing.
- At the national level, 18 percent women had no access to any kind of health or family planning services. In rural Sindh and Balochistan four-tenths women had no access to health / family planning services within a distance of five kilometres. One-third women had access to one facility, one-quarter had access to two facilities, one-fifth had access to three or more facilities within a distance of five kilometres in rural and one kilometre in urban areas.
- Thirty-two percent women in Pakistan had access to a family welfare centre at national level. However, in rural areas only one-fifth (21.7 percent) had access to family welfare centres within a radius of five kilometres.
- In rural Pakistan, highest access to family welfare centres was noted in NWFP (33.8 percent) followed by Punjab (22.5 percent), Sindh (10.7 percent) and Balochistan (7.6 percent).
- NGOs centres were accessible to 7.7 percent women at national level and three percent in rural areas.
- In rural Pakistan, general health care services were available to three-fourths women, pre/postnatal care and immunisation services to six-tenths women, delivery services to half of women and family planning services to four-tenths women within a distance of five kilometres.
- At the national level, half of the women had no access to any outlet offering family planning services within a distance of one kilometre in urban areas and five kilometres in rural areas. A quarter of the women (26.6 percent) had access to one, one-sixth (15.4 percent) to two and one-eighth (7.9 percent) to three or more centres offering family planning services.
- At the national level, 47 percent women had access to a private practitioner offering health services within one kilometre in urban and five kilometres in rural areas. However, only 27 percent women had access to a private practitioner offering family planning services. In rural areas, private practitioners offering family planning services were available to 22 percent women only.

- At the national level, 37 percent women had access to lady health workers of the health programme. About the same proportion of women in rural areas had access to lady health workers. The village based family planning workers were accessible to 39 percent women within a distance of five kilometres in rural areas.
- Analysis of impact of accessibility on the use of reversible modern methods in rural areas suggests that accessibility to static family planning services has no impact whereas access to private practitioners who offer family planning services has minor effect. The analysis detects that the existence of both VBFPWs and LHWs in five kilometres radius shows a significant association with the use of modern reversible methods in rural areas. The results show that women are 86 percent more likely to use a modern reversible method when both VBFPW and LHW are accessible in five kilometres.
- The analysis also show the extent to which women living within five kilometres of two, one and no community workers in rural areas were more likely to have received a household visit in the past twelve months. When one worker is available, women were twice as likely to have been visited and when two workers were available women were nine times more likely, compared with women having no worker available. This very strong link supports the above finding that LHWs and VBFPWs are starting to have an impact on use of modern reversible methods of contraception.

Population welfare programme thus needs to pay special attention to the component of community workers, which has the required potential to raise the level of contraception in the country. The speedy expansion of community workers schemes is expected to prove a more effective way of meeting the huge unmet demand for contraception in rural areas where 67 percent of the population reside. This will facilitate fertility decline in rather a shorter duration. The lady health workers are also noted to be actively promoting contraception and thus need to be taken along.

At the present time, the only way to obtain a copy of the report is to purchase it from the publisher. The report is available in both hard copy and electronic form. The electronic form is available in PDF format and can be viewed on a computer screen. The hard copy is available in a spiral-bound format and is suitable for use as a reference work.

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Chapter 1

BACKGROUND, OBJECTIVES AND METHODOLOGY

1.1 Historical background

The family planning programme in Pakistan has a long and chequered history. It has passed through various phases, each conspicuous for its approach, coverage and impact. It has been applauded, criticised and restructured at various times. It has been reshaped with each political change and has undergone numerous internal and external organisational reviews and evaluations. It has generally been found weak and lacking in the ability to mobilise favourable conditions for the adoption of small family norms. The programme has been characterised as less efficient than those in many other countries, such as South Korea and Indonesia. The family planning programme in Pakistan has not been able to accelerate contraceptive prevalence and make a major impact on fertility, in spite of continued increases in allocation of funds and renewed political commitment at various times.

The problem of rapid growth of population was recognised by the government of Pakistan in the wake of global awareness of the issue, which started in the 1950s. In Pakistan, the recognition of this problem resulted in allocation of one million rupees¹ in the First Five-Year Plan (1955-60) to the NGO sector for family planning activities (Pakistan, 1957). During this period the Family Planning Association of Pakistan, which was created in 1953, established clinics in selected cities and started providing family planning services. Thus the government adopted the philosophy of family planning by initially supporting limited contraceptive services through the NGO sector.

The second phase started with the introduction of a family planning scheme through the existing infrastructure of the health department. The scheme remained operative during 1960-65

¹ Currency equivalents: Prior to 1972 One Rupee=US\$ 0.21, up to February 1973 One Rupee = US\$ 0.09, after February 1973 One Rupee = 0.101. From January 1982 Rupee is floating against dollar and is linked to a basket of currencies (Pakistan, 1982).

and the government introduced family planning services into hospitals, dispensaries, and maternal and child health centres of the health department.

The third phase of the programme started with the adoption of a comprehensive and detailed scheme which separated the programme from the health sector and established its own infrastructure which was exclusively responsible for family planning. An intensified family planning programme was introduced as an administrative activity and was backed-up by a massive promotional campaign. At the grass roots level was a part-time 'dai' responsible for contraceptive information, supplies and referral for clinical methods. Part-time/contracted doctors carried out IUD insertions and sterilisations. Supply outlets, including stores, pharmacies, and public and private medical centres, were established. By the end of 1964 there were 2683 family planning outlets functioning in the country, of which 1094 were in East Pakistan-now Bangladesh (Pakistan, 1963). During this period the programme was able to build-up an efficient administrative structure to develop and implement policies that challenged traditional attitudes. It made the subject of family planning a matter of public discussion and generally frustrated any organised religious opposition (UN/WHO, 1969). However, contraceptive use remained low during this period (Population Planning Council, n.d.).

The fourth phase begun with the change in political leadership in 1969. Dais were replaced with male-female motivator teams for continuous motivation and procurement of contraceptives. An 'inundation' scheme was introduced, on the assumption that massive supply of contraceptives would create its own demand. This phase lasted till 1975 and, at that time the programme had around 28,000 outlets including commercial distribution points, clinics, health centres, doctors, and 15,000 male and female frontline motivators offering family planning services (Pakistan, 1975).

During the fifth phase, the programme remained in transition. A number of committees were set up to report on the reorganisation of the programme. The programme was federalised and placed under the Population Planning Division. Field operations, which were suspended in September 1977, were resumed in 1979. The programme remained at a low ebb during this period and no increase in the service delivery outlets took place.

During the sixth phase (1980-83) the programme was reactivated and structured around a multi-sectoral approach. The Population Welfare Programme continued with this approach during phase 7 and was strengthened with the involvement of the private sector, institutionalisation of NGOs, restoration of the IEC campaign and establishment of NIPS to provide regular research feedback on the programme implementation and achievements. By 1988, the programme had 1250 family welfare centres, 34 mobile service units, 8 extension-teams, 450 NGO outlets, and over 900 outlets of health and other line departments. In addition, 174 outlets of the target group institutions (such as the Armed Services, railways, postal services), more than 1,000 Hakeems and Homoeopaths, and 50,000 social marketing outlets were also offering selected contraceptive services (Population Welfare Division, 1988). The programme performance, however, remained low; the contraceptive prevalence rate, as assessed in the 1990-91 Pakistan Demographic and Health Survey, was only 12 percent (NIPS/IRD Macro International, 1992).

Policy-makers realised that the national Population Welfare Programme needed an innovative booster to increase its coverage especially in rural areas. Accordingly, the programme underwent consolidation, acceleration and experimentation with a community-based infrastructure for rural areas during the eighth phase (1988-98). Taking stock of the situation, programme managers estimated that the actual coverage of the programme was limited to around 20-25 percent of the population of the country. The coverage in rural areas was dismally low at five percent whereas slightly over half (54 percent) of the urban population had reasonable access to family planning services. Extension of services to rural areas through static outlets such as family welfare centres was considered to be too expensive as well as time-consuming. Instead, a village-based family planning worker approach, in line with the programme in Bangladesh, was thought to be potentially effective to reach the target population for family planning services in rural Pakistan.

A pilot study of the new Village-Based Family Planning Workers (VNFPW) programme was launched in 1561 villages in eight districts during the terminal year of the Seventh Plan (1993). In each selected village, an ever-married woman, residing in the community, between the age 18-50 and with high school qualification was appointed. She was trained in family planning,

MCH, treatment of minor ailments, first aid, motivation and counselling. Her main duties included following:

- Register all eligible couples (currently married aged 15-49).
- Visit 10-15 couples per working day.
- Motivate eligible women to use family planning methods.
- Keep a record of all family planning acceptors
- Provide conventional methods of family planning (oral pills, condoms and subsequent doses of injectables).
- Refer motivated clients of clinical methods to FWCs and RHS centres, and
- Provide treatment for minor ailments.

Each VBFPW received four months classroom training in a phased manner. After each phase she was required to practice the acquired skills in the field for a period of one month, and thus the total training was spread over a period of seven months. In addition, refresher courses were held for the workers.

The scheme was extended to other rural areas during the Eighth Five-Year Plan period (M/o Population Welfare, 1993). By the end of the plan period (1998) around 12000 VBFPWs were in place. In the Ninth Five-Year Plan (1998-2003) the number of workers will be increased to 30,000 by mid 2003 (M/o Population Welfare, 1998). The duration of training has also been increased to nine months to cover a wider spectrum of reproductive health.

Evaluation of the VBFPW scheme indicates that regular payment of salary, supervision and replenishment of supplies of contraceptives increases the impact of VBFPWs in the community (Population Council, 1995 and 1997).

A scheme similar to the VBFPW one, the Prime Minister's Programme for Family Planning and Primary Health Care, was launched in April 1994. The objective of this programme was to arrest the high population growth rate and improve health care indicators, which are amongst the lowest in the region. The programme focuses on creating a countrywide network of outreach health and family planning services, particularly in rural and under-privileged urban areas. During the first phase, the programme was implemented in 42 districts throughout the country involving more than 1000 Basic Health Units and Rural Health Centres. A special cadre of Lady Health Workers (LHWs) was created and trained in the following areas:

- Maternal care
- Nutrition and care of the newborn
- Family planning
- Control of diarrhoea
- Control of acute respiratory infections
- Immunization of children
- Education of the community in hygiene and sanitation
- Care of the sick, and
- Health Management Information System

The LHW is preferably to be a married woman between the age of 18-50 years, and at least qualified up to middle standard and a resident of the village or urban locality in which she works.

The Prime Minister's Programme is operating in 113 districts throughout the country and over 43,000 workers are deployed in the field to provide primary health and family planning services.

At the end of the Eighth Five-Year Plan (1993-98) family planning services were being offered through 1500 family welfare services, 131 mobile service units, 101 reproductive health services centres (based in big hospitals), 12000 VBFPWs, over 43,000 LHWs, 6369 outlets of Health Department, Local Government and Rural Development and Labour Departments (Social Security Institutions), over 21500 Registered Medical Practitioners, about 20000 Hakeems and Homoeopaths and 450 outlets of Target Group Institutions. In addition, family planning services are also offered through 140 family welfare centres of NGOs (funded by National Trust for Population Welfare), a number of NGO centres funded directly by donors, and about 38,000 commercial outlets of the Social Marketing component of the programme. These centres / service delivery points offer a range of modern family planning methods which include surgical contraception especially for female, IUDs, pills, injectables, condoms, and implants. The Population Welfare Programme aims to increase the coverage of services from an assumed current level of 70 percent population to the level of 100 percent by the end of Ninth Plan Period (M/o Population Welfare, 1998).

1.2 Background to the survey

Since the inception of the family planning programme in Pakistan, seven major surveys have so far been conducted to measure the knowledge, attitude and practice of contraception, fertility levels, trends and differentials, health status of mother and children, family size preferences and marriage patterns. The National Institute of Population Studies (NIPS) conducted two important surveys, which collected information on these aspects, in 1990-91 and 1996-97. The 1990-91 survey was conducted in co-ordination with Macro International as part of the Demographic and Health Surveys programme, whereas the 1996-97 survey was undertaken in collaboration with the London School of Hygiene & Tropical Medicine, London. Surveys prior to 1996-97 had focused primarily on women's demand for contraception and health services and had rarely looked into the availability of health and family planning services. It was probably assumed that family planning and health services were available to women and there was only a need to record their reaction to the use of these services. However, this premise was rejected when NIPS was planning the 1996-97 Pakistan Fertility and Family Planning Survey (PFFPS). It was considered useful to add a new dimension to the fertility and family planning survey by collecting information on the availability of health and family planning services to the respondents. Accordingly, a separate module was devised to collect this information. This report is based primarily on the data collected through the special module.

1.3 Objectives of the survey

The principal objectives of the survey were as follows:

1. To measure access of Pakistani families to different types of health and family planning facilities and staff;
2. To provide data for an analysis of the link between access to services and uptake of these services; and
3. To examine the influence of community characteristics on contraceptive use.

1.4 Methodology

The Health and Family Planning Accessibility survey was undertaken as part of the 1996-97 PFFPS. The PFFPS was based on a nationally representative sample of 8002 households drawn from 295 primary sampling units (PSUs) out of which 120 PSUs were from urban and 175 PSUs from rural Pakistan. The Federal Bureau of Statistics (FBS) drew the sample in mid-1996 using the 1981 census list of clusters in rural areas and a similar updated list for urban areas. A two-stage sample design was used, with area units at the first stage and households at the second. Full details of the sample may be found in Hakim et al (1998). In each rural PSU, or cluster, 31 households were selected and all resident ever-married women aged 15-49 years were interviewed. In urban clusters, the corresponding figure was 22 households.

The Health and Family Planning Accessibility survey is not based on a representative sample of outlets but is rather a study of outlets within a specified radius of the representative sample population of the PFFPS. Since the main purpose of the survey was to assess the access of the population to health and family planning services and measure their impact on women's reproduction and fertility regulation, a representative sample of the outlets would not have given the desired results.

The methodology adopted for the Health and Family Planning outlets survey was based on the following principles:

1. In urban areas, all health and family planning facilities falling within a radius of **one kilometre** from the centre of each sampled PSU were visited for assessing availability of health and family planning services to the respective population.
2. In rural areas, availability was measured by visiting health and family planning facilities falling within a radius of **five kilometres** from the centre of the PSU.
3. Health and family planning facilities include all public hospitals, urban health and rural health centres, basic health units, urban and rural dispensaries run by the federal or provincial governments, MCH centres, family welfare centres (FWCs) of the Population Welfare Programme, NGO's health and family planning facilities, private medical

practitioners, VBFPWs of the Population Welfare Programme and LHWs of the Health Programme.

1.5 Questionnaire and data collection

A simple questionnaire (Annex-1) was designed to collect information about the availability of health and family planning services within the guidelines prescribed above. The questionnaire included questions on distance to the facility from the centre of the PSU; usual mode of transport used from the PSU to the facility; time spent to reach the facility; availability of specified health services; availability of specified family planning services; availability of staff for health and family planning services; contraceptive stock at the facility and the replenishment procedure. Questions relating to private medical practitioners and VBFPWs/LHWs were simple and only related to the availability of family planning methods.

The PFFPS interviewing team consisted of one male supervisor, one female supervisor and three female interviewers. The responsibilities of the male supervisor of the PFFPS included visits to all health and family planning outlets and interviewing a responsible person at the facility. These supervisors were given two days training at Islamabad in filling out the health facility questionnaire. These supervisors were postgraduates and most of them had earlier experience in data collection and supervision (Annex-2).

In addition, supervisors were also required to fill in a prescribed format about general characteristics of each PSU such as the presence of schools, banks, post-offices and other modern facilities. The formats used for urban and rural PSUs were slightly different. The information collected through these formats (urban-rural profiles) has also been used in this report.

The completed questionnaires of the health and family planning outlets and urban-rural profiles were mailed back to NIPS together with the filled-in household and women's questionnaires of the PFFPS. These questionnaires were edited in the office and passed on to the computer section for data entry.

1.6 Restructuring of data file

The information collected through the health and family planning outlets survey questionnaire was entered as one record for each facility visited. If there was more than one facility in a cluster, each constituted a separate record. As such the original data file was facility-based rather than cluster-based. To facilitate the analysis, the data file was restructured in such a way that all facilities in the same cluster were strung together to form a single record. The restructured cluster-based file was then linked to the woman-file of the PFFPS using cluster number as the linking variable. However, the analysis presented in this report is based on both the facility-based file and the restructured linked file.

1.7 Data limitations

There are certain limitations of the data, which may be kept in mind while interpreting the results of the survey. These limitations are:

1. Data presented in the report are based on the availability of health and family planning services to a representative sample of women in Pakistan and not on a representative sample of health and family planning facilities. Therefore, findings of the survey cannot be generalised for the facilities as such.
2. Women in particular and residents of the clusters in general do not necessarily prefer to utilise the services of nearby facilities. People may like to go to a distant facility for various reasons (such as privacy or perceived service quality) rather than confine themselves to nearby facilities within a distance of one kilometre in urban and five kilometres in rural areas. It should also be acknowledged that the criteria of one and five kilometres are based on logistical considerations, rather than on empirical evidence of the distance that people are willing to travel.

3. In urban areas, the facilities visited were within a distance of one kilometre of the centre of clusters. However, mobility in urban areas is comparatively easy and the non-availability of a specific service within this radius may not be a serious problem for the urban population. The absence of a service within one kilometre does not mean that it is not available to the population. Accordingly, results for the rural sector are more easy to interpret than those for the urban sector.
4. Contraceptives such as condoms and pills are widely available through private sources like medical and general stores. Since information about availability of contraceptives from these sources was not gathered, access to such methods may be underestimated, especially for urban clusters where the majority of such retail outlets are located.
5. Data on availability of health and family planning services were obtained from the facilities within a radius of five kilometres in rural areas. However, for practical reasons, this rule was not followed in rural clusters that were located less than five kilometres from cities/towns. The radius in the direction of the city/town was thus confined to the rural limits. This factor may have led to an underestimation of access to services in such clusters.
6. The provision of health and family planning services through the VBFPWs and LHWs is limited to prescribed catchment areas. Hence their existence within the prescribed radius of the cluster does not necessarily mean that family planning and health services were available through these outreach workers to the population of the sample cluster.

Chapter 2

Facilities and Services Available at Static Outlets

2.1 Introduction

The mere presence of a nearby static health or family planning facility may be of little significance if it lacks basic physical attributes such as running water and electricity or provides only a limited range of services. This chapter presents results obtained from visits to static facilities. It describes the physical infrastructure of facilities, equipment available and services provided, with a particular focus on provision of family planning services.

A total of 407 static outlets were visited (Table 2.1). These comprise 114 family welfare centres, 100 basic health units, 61 hospitals and 60 dispensaries. Smaller numbers of other types of facility were also visited: 24 MCH centres, 15 rural health centres, 16 NGO centres and 1 urban health centre. About half of all facilities were in urban areas and nearly half (195) were in Punjab. Though, as mentioned earlier, this sample of static health and family planning facilities is not strictly representative of all static facilities in Pakistan, it is a sufficiently large cross-section to provide valuable information on the physical condition and services provided by static facilities.

The representativeness of the sample is improved by using the cluster-level weights of the PFFPS, which oversampled Baluchistan because of the relatively small population size of this province. The numbers and types of facility visited after application of weighting factors are shown in Table 2.2. Numbers have been rounded to the nearest integer. All results in this chapter are based on weighted data.

Table 2.1: Number and Type of Static Health and Family Planning Outlets Visited, (Unweighted)

Type of Outlets	Type of Area		Province				Total
	Urban	Rural	Punjab	Sindh	NWFP	Balochistan	
Hospital	50	11	22	21	11	7	61
Urban Health Centre	1	0	0	0	0	1	1
Basic Health Unit	2	98	45	21	26	8	100
Rural Health Centre	15	16	12	13	5	1	31
Dispensary	22	38	34	10	6	10	60
MCH Centre	19	5	18	1	4	1	24
Family Welfare Centre	76	38	59	23	23	9	114
NGO Centre	13	3	5	5	4	2	16
<i>Total</i>	<i>198</i>	<i>209</i>	<i>195</i>	<i>94</i>	<i>79</i>	<i>39</i>	<i>407</i>

Table 2.2: Number and Type of Static Health and Family Planning Outlets Visited, (Weighted)

Type of Outlets	Type of Area		Province				Total
	Urban	Rural	Punjab	Sindh	NWFP	Balochistan	
Hospital	36	15	32	12	5	1	51
Urban Health Centre	0		0	0	0	0	0
Basic Health Unit	1	106	82	10	14	2	107
Rural Health Centre	9	11	13	4	2	0	19
Dispensary	33	47	70	3	3	4	80
MCH Centre	19	6	21	2	1	0	24
Family Welfare Centre	63	42	76	19	9	1	105
NGO Centre	16	4	10	6	3	1	19
<i>Total</i>	<i>177</i>	<i>230</i>	<i>304</i>	<i>57</i>	<i>37</i>	<i>9</i>	<i>407</i>

2.2 Availability of facilities at the outlets

Table 2.3 shows availability of basic necessities such as running water, weighing scales, BP apparatus and other facilities such as operating theatre, blood bank and standby generator at the outlets. Though running water, electricity and BP apparatus are common, they are not available at all outlets. For instance only 66 percent of dispensaries and MCH centres had toilet facilities. Similarly, the availability of weighing scales for children is limited to only 63 percent of the outlets and weighing scale for adults is limited to 70 percent of outlets. The NGO outlets were slightly better off than the family welfare centres in terms of availability of running water, toilets, electricity, weighing scale for adults and BP apparatus. It may be noted that less than half of the hospitals visited had a blood bank and that few outlets, apart from hospitals and rural health centres, had a standby generator.

Table 2.3: Percentage of Outlets with Availability of Necessities

Type of Facility	Equipment and Other Necessities								
	Running Water	Electricity	Toilet	OP Theatre	Standby generator	Blood Bank	W. Scale for Child.	W. Scale for Adults	BP App.
Hospital	99.1	99.6	99.3	86.5	74.4	40.1	84.0	82.6	95.3
Basic Health Unit	84.1	80.4	95.2	2.8	2.7	1.9	62.7	52.8	91.4
Rural Health Centre	93.3	93.6	96.3	83.2	47.9	1.8	93.0	90.6	100.0
Dispensary	71.9	86.0	66.8	.8	19.7		34.1	51.6	93.2
MCH Centre	100.0	100.0	66.0	5.8	5.5	5.5	70.7	64.9	73.8
Family Welfare Centre	95.7	96.7	95.9		1.2	4.1	67.4	87.9	88.8
NGO Centre	97.0	100.0	100.0	12.1	12.1		66.7	91.0	100.0
Total	88.6	90.9	88.9	16.6	17.4	7.0	63.0	69.7	91.3

2.3 Type of services provided

Table 2.4 shows the percentage of outlets providing general health care, pre and post-natal care, delivery services and immunization for children. General health care, which is the basic requirement of the population, was available at all outlets. Delivery services could be accessed in half of the outlets at national level. However, pre and post-natal services were available in over seventy percent of outlets. The availability of immunization was reported in only forty-four percent of outlets. Key maternal and child health services were provided by about half of basic health units and by a little over one-third of dispensaries.

Table 2.4: Percentage of Outlets by Provision of Specific Health Services

Type of Facility	Type of Services				
	General Health Care	Prenatal Care	Delivery Services	Postnatal Care	Immunization
Hospital	100.0	79.4	76.2	77.6	67.5
Basic Health Unit	100.0	58.5	51.3	58.2	53.4
Rural Health Centre	100.0	92.4	89.3	92.4	89.1
Dispensary	100.0	37.2	17.3	38.3	43.7
MCH Centre	100.0	100.0	97.9	97.9	56.7
Family Welfare Centre	99.6	95.6	54.7	94.4	12.0
NGO Centre	100.0	83.2	25.0	79.9	51.4
Total	99.9	71.9	52.0	71.2	44.3

2.4 Provision of family planning services

Table 2.5 shows the percentages of outlets offering family planning services by type of outlet, urban-rural sector and province. At the national level, 61 percent of hospitals were offering family planning services and most of them were located in urban areas. Provision of family planning services was limited to 38 percent of basic health units, 76 percent of rural health centres, 9 percent of dispensaries and 69 percent of MCH centres. The majority of the NGO centres (88 percent) was offering family planning services at the time of survey and, not surprisingly, all family welfare centres were offering such services. Availability at the provincial level, and especially in the smaller provinces of Balochistan and NWFP, needs to be cautiously interpreted because of the small number of facilities visited in the survey. Nevertheless, it appears that basic health units in Sindh are more likely to offer family planning services than units in other provinces.

The fact, which needs to be emphasised, is the proportion of facilities not offering any family planning services. In Punjab, 45 percent of the hospitals, 65 percent of basic health units, 90 percent dispensaries, and one-fourth MCH centres were not offering any family planning methods. Similarly, in Sindh, one-fifth of hospitals, about one-fourth of basic health units, and one-third of rural health centres were not offering family planning methods. In NWFP, about half of the hospitals, two-thirds of basic health units, sixth-tenths of rural health centres and 45 percent of all facilities visited were not offering any family planning methods. In Balochistan, where the population is widely dispersed, two-thirds of the facilities visited were not offering family planning methods.

Table 2.5: Percentage of Static Outlets Offering Family Planning Services by Type of Outlet

Place/Region of Residence		Type of Outlets													
		Hospital		Basic Health Unit		Rural Health Centre		Dispensary		MCH Centre		Family Welfare Centre		NGO Centre	
		%	N	%	N	%	N	%	N	%	N	%	N	%	N
Punjab	Urban	35.6	22			88.4	6	22.9	30	68.1	16	100.0	43	83.5	7
	Rural	100.0	10	34.7	82	79.0	7	0.0	40	100.0	5	100.0	33	100.0	3
	Total	54.9	32	34.7	82	83.4	13	9.9	70	75.8	21	100.0	76	89.0	10
Sindh	Urban	84.4	10			83.2	2	0.0	1	0.0	2	100.0	17	84.7	6
	Rural	43.4	2	77.5	10	52.7	2	0.0	2			100.0	2		
	Total	79.0	12	77.5	10	70.3	4	0.0	3	0.0	2	100.0	19	84.7	6
NWFP	Urban	100.0	2	0.0	1.0	100.0	0	0.0	1	100.0	0	100.0	2	89.7	2
	Rural	21.9	3	34.2	13	33.7	2	0.0	2	100.0	1	100.0	7	100.0	1
	Total	52.2	5	31.8	14	39.0	2	0.0	3	100.0	1	100.0	9	91.8	3
Balochistan	Urban	76.6	1	0.0	0			0.0	0	0.0	0	100.0	1	100.0	1
	Rural	0		0.0	2	0	0	1.3	4		0	0	0		
	Total	76.6	1	0.0	2	0	0	1.3	4	0.0	0	100.0	1	100.0	1
Pakistan	Urban	54.6	36	0.0	1	87.1	8	21.2	33	60.0	19	100.0	63	85.5	15
	Rural	76.3	15	38.1	106	67.3	11	0.1	47	100.0	5	100.0	42	100.0	4
	Total	60.8	51	37.7	107	76.1	19	8.7	80	69.2	24	100.0	105	88.4	19

2.5 Supplies of contraceptives

Table 2.6 shows the percentage of outlets having an uninterrupted flow of various contraceptives during six months period prior to survey. Overall, the flow pills, IUD, injections and condom has remained uninterrupted quite appreciably in the six months period prior to survey. The position of availability of these contraceptives was better in Balochistan followed by NWFP. But at the facility level, it appears that quite substantial number of outlets both at national and provincial level, who were offering family planning services had experienced shortage of various contraceptive methods during the reference period. The flow of contraceptives was better at FWC and NGO centres level but health outlets especially MCH centres and dispensaries had experienced shortage of various contraceptives during the period under reference.

Table 2.6: Among Static Outlets that Provided Family Planning Services, the percentage that Experienced an Uninterrupted Flow of Supplies, by Type of Contraceptive

Region of Residence	Type of Contraceptive	Type of Outlets							All
		Hospital	Basic Health Unit	Rural Health Centre	Dispensary	MCH Centre	Family Welfare Centre	NGO Centre	
Punjab	Pills	61.0	94.6	47.0	71.3	29.8	88.1	100.0	77.9
	IUD	57.2	90.1	65.1	62.9	28.3	97.0	100.0	81.5
	Injection	82.8	85.7	89.0	62.9	42.8	87.0	52.7	79.3
	Condom	93.3	94.7	66.9	100.0	70.6	94.5	77.3	89.6
Sindh	Pills	92.4	48.3	77.7			75.4	100.0	77.5
	IUD	93.2	87.1	62.4			81.6	100.0	85.9
	Injection	86.6	83.0	100.0			89.5	100.0	89.7
	Condom	95.9	67.2	84.0			71.6	100.0	79.8
NWFP	Pills	90.1	100.0	100.0		62.6	100.0	100.0	97.2
	IUD	94.8	61.1	100.0		62.6	93.3	100.0	86.2
	Injection	66.6	84.2	84.0		62.6	89.3	100.0	85.2
	Condom	81.6	84.9	100.0		100.0	100.0	100.0	94.1
Balochistan	Pills	100.0		100.0	100.0		100.0	50.0	90.5
	IUD	100.0		100.0	100.0		100.0	100.0	100.0
	Injection	100.0		100.0	100.0		100.0	50.0	90.5
	Condom	100.0		100.0			100.0	50.0	88.9
Total	Pills	74.3	86.5	57.5	71.5	31.4	86.9	98.3	79.7
	IUD	72.8	86.3	67.2	63.2	29.9	93.9	100.0	83.0
	Injection	82.9	85.0	91.3	63.2	43.8	87.8	74.0	81.9
	Condom	93.2	88.4	71.7	99.3	72.0	90.9	86.6	88.1

2.6 Record keeping

Table 2.7 shows the status of record keeping at the outlets offering family planning services. Overall, less than half of the outlets (47.5 percent) were keeping proper records of family planning services; the rest had either not properly maintained their records or were not maintaining any record at all. Record keeping was found to be better at the NGO centres (86.3 percent) followed by FWCs (56.6 percent). Record keeping was more dismal at the dispensary and MCH Centre level.

Table 2.7: Percent of Static Outlets by Status of Record Keeping

Type of Outlets	Properly Maintained	Partially Maintained	Not Maintained	Not Available	Total	Number of Outlets
Hospital	32.8	35.2	27.0	5.1	100.0	31
Basic Health Unit	40.6	28.2	23.3	7.9	100.0	41
Rural Health Centre	31.3	47.6	17.7	3.4	100.0	15
Dispensary	29.2	8.4	62.5		100.0	7
MCH Centre	15.6	42.9	39.3	2.2	100.0	17
Family Welfare Centre	56.6	42.2	1.1	.1	100.0	105
NGO Centre	86.3	13.7			100.0	17
Total	47.5	36.1	14.0	2.5	100.0	233

Table 2. Effect of various factors on the yield of cotton (kg/ha)

Factor	Yield (kg/ha)	Standard Error	Significance
1. Irrigation			
a. Full	1250	15	
b. Half	1180	15	
c. No	1100	15	
2. Fertilizer			
a. 100 kg N	1300	15	
b. 200 kg N	1250	15	
c. 300 kg N	1200	15	
3. Variety			
a. A	1280	15	
b. B	1220	15	
c. C	1150	15	
4. Interaction			
a. Irrigation x Fertilizer			
i. Full x 100 kg N	1320	15	
ii. Full x 200 kg N	1280	15	
iii. Full x 300 kg N	1240	15	
iv. Half x 100 kg N	1250	15	
v. Half x 200 kg N	1200	15	
vi. Half x 300 kg N	1150	15	
vii. No x 100 kg N	1180	15	
viii. No x 200 kg N	1120	15	
ix. No x 300 kg N	1080	15	
b. Irrigation x Variety			
i. Full x A	1300	15	
ii. Full x B	1250	15	
iii. Full x C	1200	15	
iv. Half x A	1250	15	
v. Half x B	1200	15	
vi. Half x C	1150	15	
vii. No x A	1200	15	
viii. No x B	1150	15	
ix. No x C	1100	15	
c. Fertilizer x Variety			
i. 100 kg N x A	1350	15	
ii. 100 kg N x B	1300	15	
iii. 100 kg N x C	1250	15	
iv. 200 kg N x A	1300	15	
v. 200 kg N x B	1250	15	
vi. 200 kg N x C	1200	15	
vii. 300 kg N x A	1250	15	
viii. 300 kg N x B	1200	15	
ix. 300 kg N x C	1150	15	
5. Total	1200	15	

Chapter 3

Access to Health and Family Planning Services

In this chapter women's access to health and family planning services is examined. As already mentioned, the Health and Family Planning Accessibility Survey was undertaken as part of the PFFPS, in which 8362 ever-married women from 295 PSUs, or clusters, were interviewed. By linking the outlet survey data to women's data, on a cluster-by-cluster basis, access of women to services can be measured.

3.1 Availability of outlets

Table 3.1 shows the percent distribution of women according to the number of static outlets offering health and or family planning services within a radius of five kilometres in rural areas and one kilometre in urban areas. At the national level, about 18 percent of women had no access to a health and family planning facility within a radius of one kilometre in urban areas and five kilometres in rural areas. The situation in rural Sindh and Balochistan is more critical where four out of ten women have no access to health or family planning outlets within five kilometres (Figure 3.1).

Though in major urban and other urban areas, the availability of number of health and family planning outlets varies, the fact needs to be kept in mind that the restriction of one kilometre radius may at times over-or under-estimate availability. Women are more mobile in urban than in rural areas and availability of transport facilities in urban areas is another factor to be kept in mind while assessing availability of services within one kilometre radius.

Table 3.1: Percent Distribution of Ever-Married Women According to Number of Static facilities within One km in Urban and Five kms in Rural Areas

Region/Place of Residence		Number of Facilities					Total	Number of women
		0	1	2	3	4+		
Major Urban	Punjab	20.7	11.5	10.0	27.1	30.6	100.0	542
	Sindh	46.2	12.0	31.6	10.3		100.0	617
	NWFP		100.0				100.0	107
	Balochistan		47.8		52.2		100.0	16
	All	31.0	19.6	19.4	17.1	12.9	100.0	1282
Other Urban	Punjab	11.2	21.4	24.9	27.7	14.8	100.0	670
	Sindh	10.1	23.7	39.3	17.9	9.0	100.0	239
	NWFP	35.0	35.4	13.4	16.2		100.0	101
	Balochistan	38.8	9.4	43.2	8.6		100.0	46
	All	14.4	22.7	27.9	23.6	11.4	100.0	1056
Rural	Punjab	8.6	39.0	29.3	10.5	12.6	100.0	3370
	Sindh	39.2	42.5	13.1	5.1		100.0	893
	NWFP	7.3	46.3	38.3	7.1	1.0	100.0	928
	Balochistan	40.9	37.6	21.6			100.0	320
	All	15.2	40.7	27.7	8.4	7.9	100.0	5510
Pakistan		17.7	34.9	26.4	11.9	9.2	100.0	7848

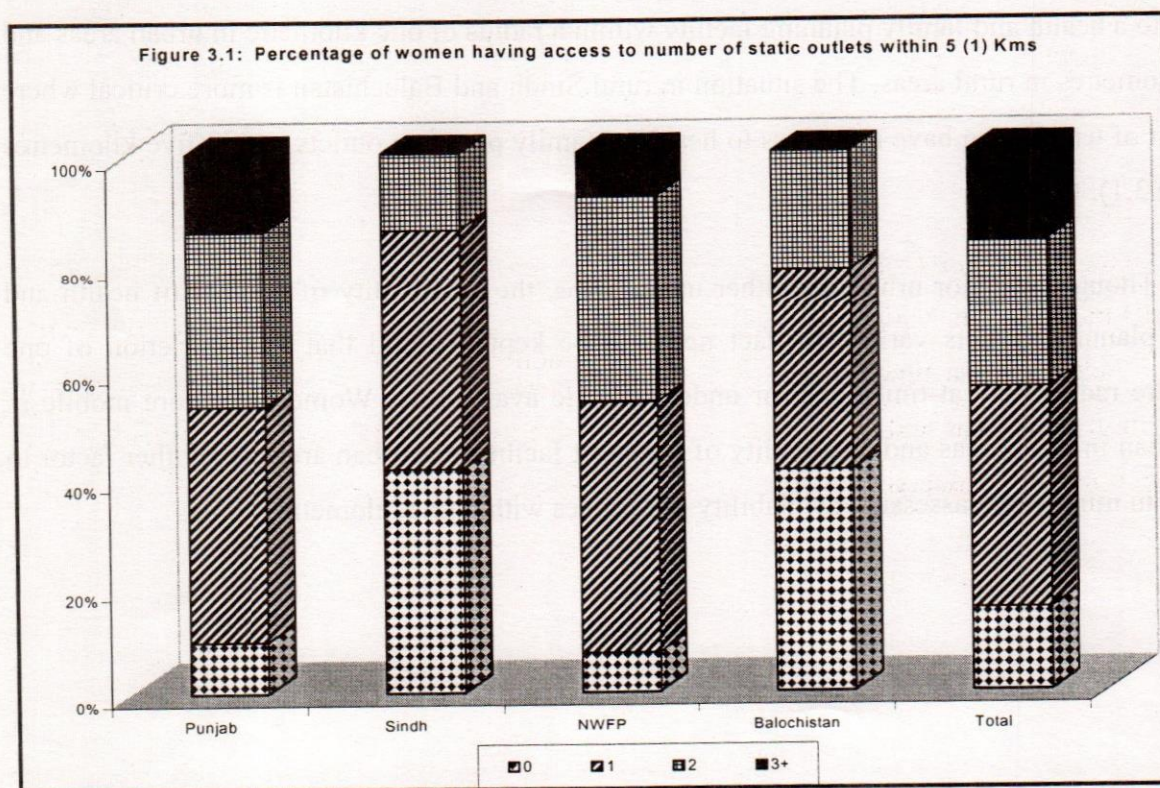


Table 3.2 shows access of women to specific type of static outlets offering health and or family planning services. The expected concentration of hospitals in urban areas and Basic Health Units (BHUs) in rural areas is found in this survey. In cities, about 20 percent have easy access to a hospital and this figure rises to 46 percent in the other urban sector. By comparison, only 9 percent of rural women live within five kilometres of a hospital, though this figure is higher for NWFP (15.5 percent). Over half (54 percent) of all rural women have access to a BHU, though again there are sharp provincial differences, with women in NWFP recording the best access and those in Balochistan the worst. Under 10 percent of rural women have access to a health centre and under 3 percent to an MCH centre.

Family Welfare Centres, which are run by the Population Welfare Programme, cater primarily for family planning services and are available to about 32 percent women at the national level. These centres are available to 46 percent women in the major urban sector, 66 percent in the other urban sector and 22 percent in rural areas. More women in urban areas of Punjab (74 percent) and Sindh (58 percent) had an access to these centres than in the other provinces. More rural women have access to Family Welfare Centres in NWFP (34 percent), compared with Punjab (23 percent) Sindh (11 percent), and Balochistan (8 percent). The contribution of NGO centres in terms of access is limited to about eight percent women at the national level, three percent in rural areas, ten percent in small towns and 26 percent in big cities.

Table 3.2: Percentage of Ever-Married having Access to Specified Types of Facilities

Place/Region of Residence	Type of Facilities							
	Hospitals	Health Centre	Basic Health Unit	MCH Centre	Dispensary	Family Welfare Centre	NGO Centre	
Major Urban	Punjab	35.3			27.9	66.2	65.8	23.9
	Sindh	8.8			10.3		36.1	21.1
	NWFP					38.6	3.4	58.0
	Balochistan		52.2					100.0
	All	19.1	.6		16.7	31.2	45.5	26.4
Other Urban	Punjab	48.5	21.8		35.9	15.4	74.4	5.0
	Sindh	43.5	28.5			11.2	58.3	24.1
	NWFP	40.6	5.0		11.2	5.0	41.4	7.6
	Balochistan	46.6		5.5	5.2	10.1	45.7	3.8
	All	46.5	20.8	.2	24.1	13.2	66.3	9.5
Rural	Punjab	8.9	10.5	56.4	3.8	36.1	22.5	4.3
	Sindh	6.9	8.5	40.3		14.9	10.7	
	NWFP	15.5	9.6	72.4	1.8	7.0	33.8	2.6
	Balochistan		4.2	19.9		38.7	7.6	
	All	9.2	9.7	54.4	2.6	27.9	21.7	3.0
Pakistan	15.8	9.7	38.2	7.8	26.5	31.6	7.7	

3.2 Availability of specific infrastructure and equipment

Table 3.3 shows the percentage of women having access to any static health or family planning outlets where running water, electricity, standby generator and toilet facilities were available. Surprisingly only 69 percent women had access to a static outlet where running water, electricity and toilet facilities were available. In rural areas, access to a good health infrastructure is much more prevalent in Punjab and NWFP than in the other two provinces.

Table 3.3: Percentage of Ever-Married women having Access to Facilities with Specified Infrastructure

Place/Region of Residence		Type of Facilities			
		Running Water	Toilet	Electricity	Standby Generator
Major Urban	Punjab	79.3	79.3	79.3	42.3
	Sindh	53.8	52.7	53.8	19.1
	NWFP	100.0	100.0	100.0	
	Balochistan	52.2	52.2	52.2	
	All	68.4	67.9	68.4	27.0
Other Urban	Punjab	85.9	85.9	83.8	47.4
	Sindh	82.5	84.7	86.7	63.3
	NWFP	65.0	65.0	65.0	29.0
	Balochistan	61.2	61.2	61.2	30.8
	All	82.0	82.5	81.7	48.5
Rural	Punjab	75.6	71.5	78.7	20.4
	Sindh	36.6	48.6	30.6	11.9
	NWFP	76.3	79.6	76.3	9.7
	Balochistan	15.9	30.1	23.1	
	All	66.0	66.8	67.3	16.1
Pakistan		68.5	69.1	69.4	22.2

Since the outlets located within one and five kilometres of the women were of varying nature, the type of equipment and facilities available also varied. For example, only 23 percent women had access to outlets with operating theatre facilities, 49 percent to maternal waiting room facilities, only 7 percent to blood bank facilities, 62 percent to an outlet with a weighing scale and 34 percent to Hemoglobinometer for diagnosis of anaemia. Surprisingly only 75 percent women had access to outlets with Blood Pressure Apparatus (Table 3.4). In rural areas, access to well-equipped outlets is much superior in Punjab and NWFP than elsewhere.

Table 3.4: Percentage of Ever-Married Women having Access to Specified Types of Equipment

Place / Region of Residence	Types of Equipment and Facilities						
	Operation Theatre	M. Waiting Room/Place	Blood Bank	Weighing Scale for Child	Blood pressure apparatus	H. for Diagnosis of Anaemia	
Major Urban	Punjab	24.3	52.7	24.3	73.7	79.3	51.1
	Sindh	19.1	12.3	7.7	47.0	53.8	19.1
	NWFP	0	100.0	0	100.0	100.0	0
	Balochistan	0	52.2	0	0	52.2	0
	All	19.4	37.2	14.0	62.1	68.4	30.8
Other Urban	Punjab	65.1	70.8	19.6	79.8	85.1	71.7
	Sindh	45.7	59.6	19.2	77.9	84.7	72.0
	NWFP	34.7	41.4	6.3	59.3	65.0	46.6
	Balochistan	51.8	51.9	13.9	55.7	61.2	30.8
	All	57.2	64.7	18.0	76.4	82.1	67.6
Rural	Punjab	18.8	59.6	5.1	64.4	81.2	27.9
	Sindh	7.7	24.9	2.2	35.3	58.7	25.0
	NWFP	24.3	44.0	1.8	77.6	79.6	35.4
	Balochistan	0.4	16.6	0	18.6	45.7	15.4
	All	16.8	48.8	3.8	59.3	75.2	28.0
Pakistan	22.7	49.1	7.3	62.0	75.0	33.8	

3.3 Availability of staff

The percentages of women having access to outlets with Specified trained staff available is shown in Table 3.5. The table also shows a comparison between sanctioned and in-post staff. Overall, 61 percent women had access to facilities with doctors, 64 percent with dispensers, 55 percent with paramedics, and 31 percent with family welfare assistants. Access to sanctioned health and family planning personnel as slightly higher than access to staff who were in-post at the time of the survey.

In rural areas, access to a static outlet with an available doctor is highest in NWFP (73 percent), fairly high in Punjab (67 percent) and Sindh (60 percent) but low in Balochistan (28 percent). Access to a female paramedical staff is less favourable than access to a doctor, particularly in Sindh where only 23 percent of women live within five kilometres of such staff. In this regard, women in NWFP record the best access, with 70 percent living within five kilometres. In all four provinces, access to a family welfare assistant is low, with figures ranging from 4 percent in Balochistan to 26 percent in Punjab.

Table 3.5: Percentage of Ever-Married Women with Access to Specified Type of Facility-based Staff

Place/Region of Residence	Sanctioned				In-Position				
	Doctor	Dispenser	Nurse/ FWW/LHV	FWA	Doctor	Dispenser	Nurse/ FWW/LHV	FWA	
Major Urban	Punjab	63.6	69.6	67.8	65.8	69.5	69.6	67.8	65.8
	Sindh	12.3	12.3	47.0	47.0	12.3	12.3	47.0	47.0
	NWFP	38.6	38.6	61.4	3.4	38.6	38.6	100.0	3.4
	Balochistan			52.2		52.2		52.2	
	All	36.0	38.5	57.0	50.7	39.2	38.5	60.3	50.7
Other Urban	Punjab	68.5	68.5	82.8	72.6	65.1	68.5	82.8	67.3
	Sindh	62.2	64.7	79.2	42.3	74.7	64.7	79.2	42.3
	NWFP	45.6	45.6	41.4	47.7	45.6	45.6	53.0	49.4
	Balochistan	51.8	57.3	61.2	46.0	51.8	57.3	51.1	46.0
	All	64.1	64.9	77.1	62.2	64.8	64.9	77.8	59.0
Rural	Punjab	74.5	82.8	68.0	27.5	67.3	81.7	52.8	26.4
	Sindh	58.7	54.4	26.1	8.5	60.4	42.6	22.9	8.5
	NWFP	79.6	60.7	74.6	33.8	73.0	60.7	69.7	19.6
	Balochistan	36.0	55.7	21.3	4.2	28.3	55.7	21.3	4.2
	All	70.5	72.9	59.6	24.1	64.9	70.3	49.0	21.1
Pakistan	64.0	66.2	61.6	33.6	60.7	64.4	54.7	31.0	

3.4 Access to specified services

The percentages of women who had access to specified types of health and family planning services are shown in Table 3.6. At the national level, slightly over two-thirds women had access to general health care services within the specified radius in urban and rural areas. Other facilities such as surgery were accessible to about one-fifth women; prenatal and postnatal care to six-tenths of women; birth delivery and family planning services to about half of the women; and child immunisation services to about 54 percent women. Accessibility to family planning services was higher in Punjab (68 percent) in major urban areas, in Sindh in other urban areas (85 percent) and in NWFP in rural areas (46 percent). In Balochistan, which is predominantly rural, only nine percent of women had access to family planning services. Figure 3.2 shows accessibility of health and family planning services to rural women in Pakistan.

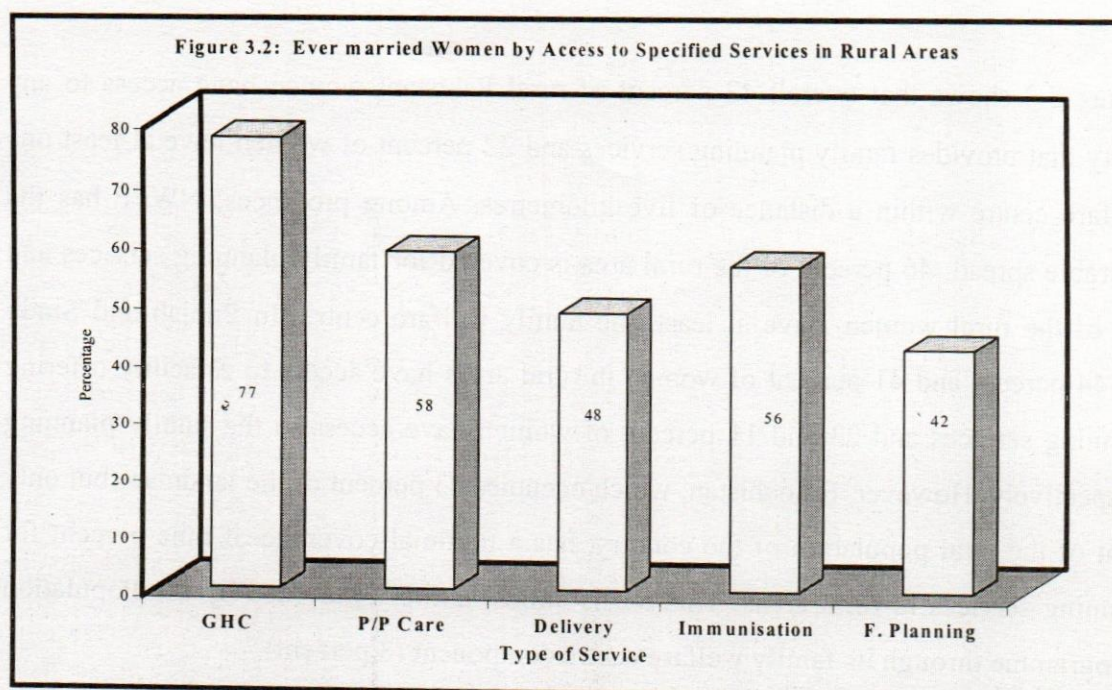


Table 3.6: Percentage of Ever-Married Women having Access to Specified Types of Services

Place/Region of Residence		Specified Types of Services						
		General Surgery H. Care	Prenatal Care	Delivery services	Postnatal care	Immunisation	F. Planning	
Major Urban	Punjab	79.3	24.3	67.8	46.8	67.8	61.4	67.8
	Sindh	53.8	19.1	48.1	12.3	48.1	24.2	53.8
	NWFP	100.0	0	26.5	0	3.4	0	61.4
	Balochistan	52.2	0	52.2	52.2	52.2	52.2	52.2
	All	68.4	19.4	54.6	26.3	52.7	38.2	60.3
Other Urban	Punjab	85.9	53.2	85.9	74.1	85.9	59.9	81.3
	Sindh	89.9	41.0	84.7	82.8	81.5	74.7	84.7
	NWFP	65.0	40.6	59.9	59.9	48.3	45.6	65.0
	Balochistan	61.2	30.7	55.7	55.7	55.7	57.3	45.7
	All	83.7	48.3	81.8	73.9	80.0	61.8	78.9
Rural	Punjab	82.8	12.8	64.9	55.0	64.9	63.5	44.1
	Sindh	60.4	7.7	53.6	29.9	49.4	30.5	41.1
	NWFP	79.6	24.3	44.4	47.1	44.4	60.2	45.6
	Balochistan	55.7	0	34.2	29.8	30.4	35.9	9.2
	All	77.1	13.2	57.8	48.1	56.9	56.0	41.8
Pakistan		76.6	18.9	60.5	48.0	59.3	53.9	49.8

Though only half of the women had any access to family planning services, fifteen percent of women had two sources and eight percent of women had three or more static sources of family planning services available to them. Similarly about 36 percent women had access to one or more static outlets with separate units for family planning services (Table 3.7).

Figure 3.3 shows that overall 42 percent of rural Pakistani women have access to any static facility that provides family planning services and 22 percent of women have at least one family welfare centre within a distance of five kilometres. Among provinces, NWFP has the most favourable spread; 46 percent of the rural area is covered for family planning services and 32 percent of the rural women have at least one family welfare centre. In Punjab and Sindh Provinces, 44 percent and 41 percent of women in rural areas have access to a facility offering family planning services and 23 and 11 percent of women have access to the family planning centres, respectively. However, Balochistan, which occupies 43 percent of the landmass but only five percent of the total population of the country, has a minimal coverage of nine percent for family planning services in rural areas. This too is almost entirely provided by the Population Welfare Programme through its family welfare centre component (8 percent).

Table 3.7: Percent Distribution of Ever-Married Women According to Number of Facilities that Provide FP within One km in Urban and Five kms in Rural Areas

Region/Place of Residence		All facilities with FP				Facilities with Separate Units for FP				Total Number of women	
		0	1	2	3+	0	1	2	3+		
Major Urban	Punjab	32.2	25.6	34.2	8.0	34.2	40.7	23.3	1.8	100.0	542
	Sindh	46.2	27.9	25.8	0	57.1	17.1	25.8	0	100.0	617
	NWFP	38.6	61.4	0	0	38.6	61.4	0	0	100.0	107
	Balochistan	47.8	0	0	52.2	47.8	0	52.2	0	100.0	16
	All	39.7	29.4	26.9	4.0	45.8	30.6	22.9	.7	100.0	1282
Other Urban	Punjab	18.7	29.1	21.6	30.5	24.0	46.5	22.6	7.0	100.0	670
	Sindh	15.3	52.3	32.4	0	47.3	49.2	3.5	0	100.0	239
	NWFP	35.0	43.0	10.8	11.2	47.0	48.0	5.0	0	100.0	101
	Balochistan	54.3	9.1	36.6	0	54.3	23.2	22.4	0	100.0	46
	All	21.1	34.8	23.7	20.4	32.8	46.2	16.6	4.4	100.0	1056
Rural	Punjab	55.9	20.2	15.0	8.9	71.0	22.6	2.2	4.2	100.0	3370
	Sindh	58.9	37.0	3.4	.7	91.5	8.5	0	0	100.0	893
	NWFP	54.4	32.2	8.3	5.0	66.2	32.1	1.8	0	100.0	928
	Balochistan	90.8	9.2	0	0	95.8	4.2	0	0	100.0	320
	All	58.2	24.3	11.1	6.4	74.9	20.9	1.6	2.6	100.0	5510
Pakistan		50.2	26.6	15.4	7.9	64.5	25.9	7.1	2.5	100.0	7848

Figure 3.3 Percentage of women having access to a static facility that provide family planning services in rural areas

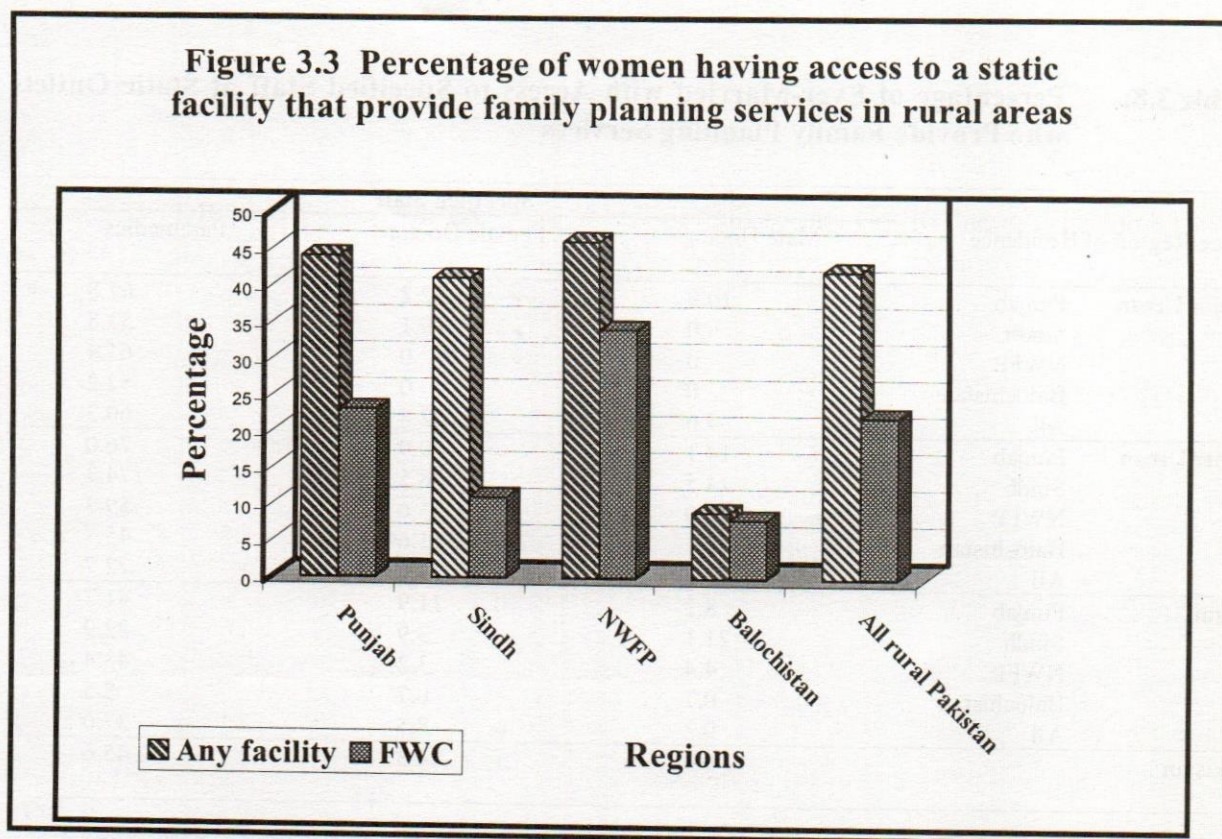


Table 3.8 summarises access in terms of type of family planning provider. For cultural reasons, access to a female rather than a male doctor is critically important. In rural areas, only 8.5 percent of women live within five kilometres of a female doctor who provides family planning services, compared with access of 23 percent in cities and 34.5 percent in other urban centres. In this regard, the situation in Punjab is much more favourable than elsewhere.

Family planning services are also provided by paramedical staff. In rural areas, over 40 percent of women in Punjab and NWFP live within five kilometres of such personnel, but only 23 percent in Sindh and 8.5 percent in Balochistan have similar access

Table 3.8: Percentage of Ever-Married with Access to Specified Staff at Static Outlets who Provide Family Planning Services

Place/Region of Residence		Specified Staff		
		Male Doctor	Female Doctor	Paramedics
Major Urban	Punjab	10.9	32.2	67.8
	Sindh	0	19.1	53.8
	NWFP	0	0	61.4
	Balochistan	0	0	52.2
	All	4.6	22.8	60.3
Other Urban	Punjab	14.1	30.9	76.0
	Sindh	14.5	48.5	74.3
	NWFP	0	35.6	59.3
	Balochistan	14.1	11.6	45.7
	All	12.9	34.5	72.7
Rural	Punjab	8.2	11.9	41.7
	Sindh	21.1	3.9	22.9
	NWFP	4.4	3.2	43.4
	Balochistan	0.7	0.7	8.5
	All	9.2	8.5	37.0
Pakistan		9.0	14.3	45.6

3.5 Access to contraceptive methods

If a contraceptive method was not available in an outlet at the time of the survey but was reported to be usually available and provided to clients, women were considered to have access to that method. Table 3.9 shows that, at the national level, about half of women had access to facilities usually offering pills (49 percent) and condoms (48 percent) within one kilometre in urban areas and five kilometres in rural areas. Similarly, IUD and injectables were accessible to 44 percent and 47 percent women respectively. However, accessibility to female sterilisation was limited to about ten percent women only. Accessibility of contraceptives through static outlets was higher in other urban than major urban and rural areas. Roughly three-fourths women had access to conventional and clinical contraceptives excluding sterilisation in other urban areas compared with six-tenths in major urban and four-tenths in rural areas.

Table 3.9: Percentage of Ever-Married Women Who have Access to Specified Contraceptive Methods

Place/Region of Residence		Access to Contraceptive Methods							
		Pills	IUD	Injection	Condom	Foam/ Jelly	F. Sterilisation	M. Sterilisation	Norplant
Major Urban	Punjab	67.8	67.8	67.8	67.8	0	3.4	3.4	0
	Sindh	53.8	53.8	53.8	53.8	0	19.1	5.7	5.7
	NWFP	61.4	61.4	61.4	61.4	0	0	0	0
	Balochistan	52.2	52.2	52.2	52.2	52.2	0	0	0
	All	60.3	60.3	60.3	60.3	0.6	10.6	4.2	2.8
Other Urban	Punjab	81.3	81.3	81.3	81.3	5.0	24.9	4.6	0
	Sindh	84.7	72.3	84.7	74.3	0	17.5	0	0
	NWFP	65.0	59.3	65.0	65.0	12.5	24.0	0	0
	Balochistan	45.7	45.7	45.7	45.7	0	8.6	0	0
	All	78.9	75.6	78.9	76.6	4.3	22.5	2.9	0
Rural	Punjab	44.1	40.5	41.5	42.5	2.3	11.1	1.3	0
	Sindh	39.4	15.4	26.8	36.1	9.3	0.4	0	0
	NWFP	42.3	40.4	45.6	42.9	0	1.8	0	0
	Balochistan	9.2	4.6	4.6	9.2	0	0	0	0
	All	41.0	34.3	37.6	39.6	2.9	7.1	.8	0
Pakistan		49.2	44.1	46.9	48.0	2.7	9.8	1.7	0.4

A comparison of Table 3.9 and Table 3.10 shows that access to contraceptive methods like IUD, Injection and Condom was typically uninterrupted during the six months period prior to the survey. However, the accessibility of pills was interrupted for about seven percent women during this period, at the aggregate level.

Table 3.10: Percentage of Ever-Married Women Who Have Access to Uninterrupted Supplies of Specified Contraceptive Methods

Place/Region of Residence		Uninterrupted Supplies of Contraceptives			
		Pills	IUD	Injection	Condom
Major Urban	Punjab	67.8	67.8	49.8	67.8
	Sindh	53.8	53.8	53.8	53.8
	NWFP	61.4	61.4	61.4	61.4
	Balochistan	52.2	52.2	52.2	52.2
	All	60.3	60.3	52.7	60.3
Other Urban	Punjab	69.8	78.9	81.3	79.6
	Sindh	72.2	62.9	69.7	63.6
	NWFP	59.3	59.3	65.0	65.0
	Balochistan	45.7	45.7	45.7	45.7
	All	68.3	75.3	75.5	75.2
Rural	Punjab	36.4	32.6	38.9	41.3
	Sindh	22.7	11.9	23.8	23.8
	NWFP	42.3	37.7	45.0	39.6
	Balochistan	9.2	4.6	4.6	8.5
	All	34.4	35.9	43.7	38.5
Pakistan		42.6	39.5	43.7	45.1

3.6 Access to Private Practitioners

The private medical sector is playing an important role in providing health and family planning services. Table 3.11 shows that slightly less than half of the women (47 percent) at national level had access to private practitioners for health services within one kilometre of their residence in urban areas and five kilometres in rural areas. Private practitioners are found to be more concentrated in major and other urban areas. In major urban areas, about half of the women and in other urban areas 70 percent of women had access to at least one private practitioner within a kilometre of their residence. In Balochistan, though half of the women had access to a private practitioner in urban areas, only 15 percent women had such access in the rural areas.

Figure 3.4 shows that only 42 percent women have access to any private practitioner within five kilometres in rural Pakistan. Access is over twice as high in Punjab and NWFP than in Sindh and Balochistan. The percentage of women having access to private practitioners providing family planning services is even further reduced to 22 percent in rural areas. Private practitioners are much more likely to offer family planning in Punjab than in other provinces, with the result that this type of access is much higher in Punjab than elsewhere. Only a small minority of practitioners in Sindh and Balochistan provide contraceptives, with the result that under 10 percent of women can access family planning through the private sector.

Table 3.11: Percent Distribution of Ever-Married Women According to Number of Private Practitioners within One km in Urban and Five kms in Rural Areas

Region/Place of Residence	Medical Practitioners					Total	Number of women
	0	1	2	3	4+		
Major Urban							
Punjab	20.7	5.6	0	8.6	65.1	100.0	542
Sindh	86.3	0	2.0	0	11.7	100.0	617
NWFP	0	0	23.1	34.9	42.0	100.0	107
Balochistan	47.8	0	52.2	0		100.0	16
All	50.9	2.4	3.5	6.5	36.7	100.0	1282
Other Urban							
Punjab	27.2	1.6	3.3	10.7	57.2	100.0	670
Sindh	26.3	16.4	1.8	12.3	43.3	100.0	239
NWFP	52.9	0	10.7	9.8	26.6	100.0	101
Balochistan	49.4	0	0	0	50.6	100.0	46
All	30.4	4.7	3.5	10.5	50.8	100.0	1056
Rural							
Punjab	51.9	8.1	8.3	12.1	19.5	100.0	3370
Sindh	80.9	3.4	10.5	0	5.1	100.0	893
NWFP	47.8	25.3	20.8	2.6	3.6	100.0	928
Balochistan	85.0	10.4	0	0	4.6	100.0	320
All	57.9	10.4	10.3	7.8	13.7	100.0	5510
Pakistan	53.0	8.3	8.3	8.0	22.4	100.0	7848

In major urban areas, 33 percent women had access to a private practitioner offering family planning services while half of the women had access to such practitioners in other urban areas.

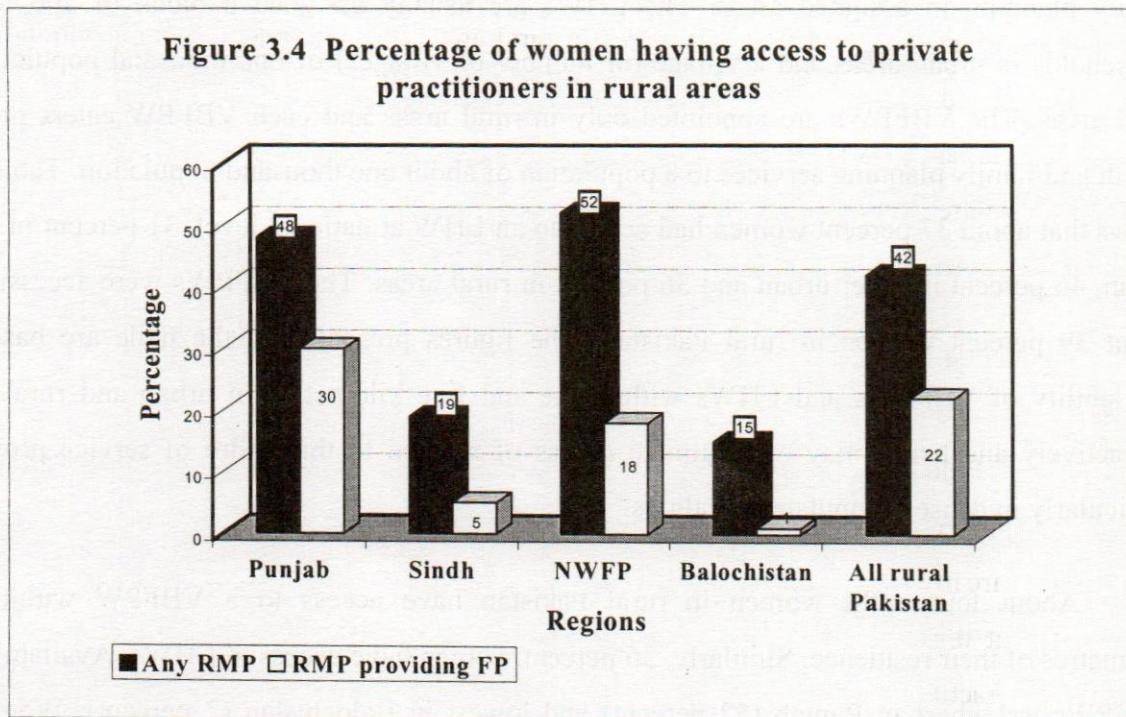


Table 3.12: Percent Distribution of Ever-Married Women According to Number of Private Practitioners within One km in Urban and Five kms in Rural Areas, Who Provide Family Planning Services

Region/Place of Residence		Medical Practitioners Providing FP					Total	Number of women
		0	1	2	3	4+		
Major Urban	Punjab	47.6	26.2	2.0	8.0	16.3	100.0	542
	Sindh	89.4	0	10.6	0	0	100.0	617
	NWFP	58.0	0	38.6	0	3.4	100.0	107
	Balochistan	47.8	52.2	0	0	0	100.0	16
	All	68.6	11.7	9.2	3.4	7.2	100.0	1282
Other Urban	Punjab	44.0	14.3	7.1	9.5	25.1	100.0	670
	Sindh	54.3	31.9	0	4.7	9.1	100.0	239
	NWFP	58.0	9.6	11.5	10.0	10.9	100.0	101
	Balochistan	63.4	11.1	0	3.8	21.7	100.0	46
	All	48.5	17.7	5.6	8.2	20.0	100.0	1056
Rural	Punjab	70.1	12.7	14.7	0.0	2.6	100.0	3370
	Sindh	94.7	4.6	0	.7	0	100.0	893
	NWFP	82.3	2.2	13.7	1.8	0	100.0	928
	Balochistan	99.3	0	0	0	.7	100.0	320
	All	77.8	8.8	11.3	.4	1.6	100.0	5510
Pakistan		72.4	10.5	10.2	1.9	5.0	100.0	7848

3.7 Accessibility to VBFPWs and LHWs

The accessibility of VBFPWs and LHWs to women in urban and rural areas is shown in Table 3.13. The VBFPWs and LHWs offer a range of primary health care services including family planning in assigned areas. The LHWs are usually assigned a block of 200 to 250 households in urban areas and a village (or number of villages) of one thousand population in rural areas. The VBFPWs are appointed only in rural areas and each VBFPW caters primary health and family planning services to a population of about one thousand population. Table 2.13 shows that about 37 percent women had access to an LHW at national level, 31 percent in major urban, 46 percent in other urban and 36 percent in rural areas. The VBFPWs were accessible to about 39 percent women in rural Pakistan. The figures presented in the table are based on availability of VBFPWs and LHWs within one and five kilometres in urban and rural areas respectively and hence may overestimate access of women to this cadre of service providers particularly in densely populated localities.

About four-tenths women in rural Pakistan have access to a VBFPW within five kilometres of their residence. Similarly, 36 percent women have access to LHWs. Availability of VBFPWs is highest in Punjab (52 percent) and lowest in Balochistan (2 percent). Women in Balochistan have very low access to both VBFPWs and LHWs in rural areas (Figure 3.5 and Figure 3.6). It may also be noted that access to LHWs in Sindh province is much greater than to VBFPWs.

Table 3.13: Percentage of Ever-Married Women having Access to Specified Type of Community Based Workers

Place/Region of Residence		Lady Health Worker	Village Based FP Worker
Major Urban	Punjab	50.5	0
	Sindh	3.1	0
	NWFP	100.0	0
	Balochistan	0.0	0
	All	31.2	0
Other Urban	Punjab	40.4	0
	Sindh	59.2	0
	NWFP	53.4	0
	Balochistan	38.2	0
	All	45.8	0
Rural	Punjab	38.5	51.9
	Sindh	33.4	12.7
	NWFP	39.5	29.4
	Balochistan	8.5	2.4
	All	36.1	38.9
Pakistan		36.6	

Figure 3.5: Percentage of women having access to outreach workers in rural areas

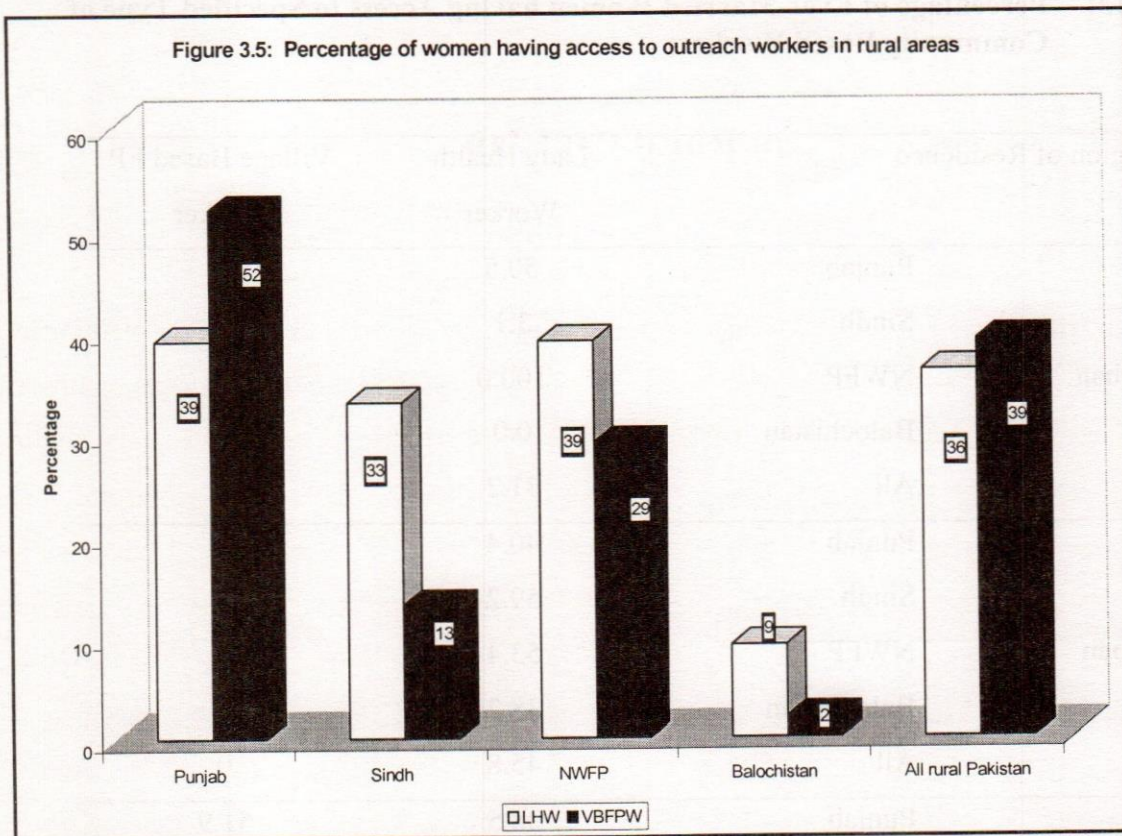
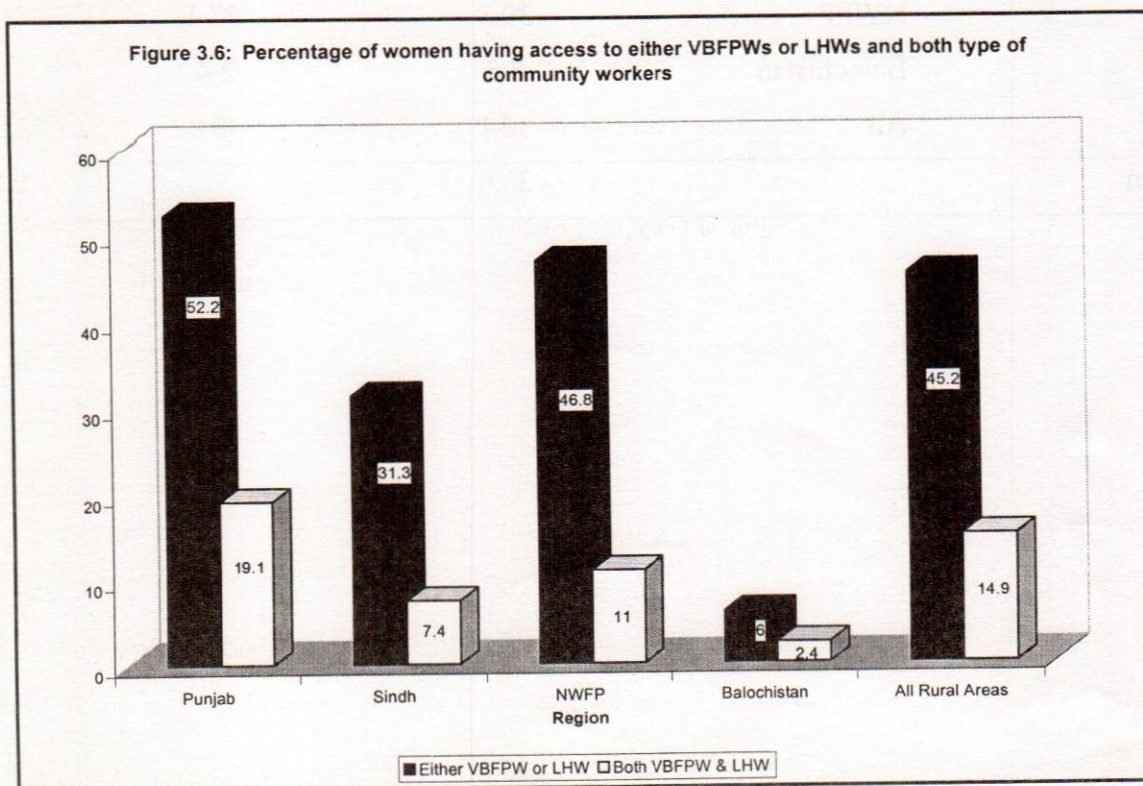


Figure 3.6: Percentage of women having access to either VBFPWs or LHWs and both type of community workers



Chapter 4

Impact of Accessibility on Contraceptive Use in Rural Pakistan

4.1 Background and Methods

The 1996-97 survey shows that around 24 percent women in Pakistan were using contraception (Hakim et al., 1998). The use rate is higher in major urban (40 percent) compared with small cities (32 percent) and rural areas (18.6 percent). Comparison with previous studies suggests an increasing trend in contraceptive use in recent times. Both in urban and rural areas contraceptive use has doubled in six years period (1991-97) at the national level. It has gone up from 19 to 32 percent in small cities and tripled (6 to 19 percent) in rural areas during the same period (NIPS, 1992 and Hakim et al., 1998). Use of modern contraceptive methods has increased from 9 percent in 1990-91 to 17 percent in 1996-97 at national level, from 19 percent to 27 percent in urban areas and from 6 percent to 13 percent in rural areas during the same period.

In this chapter the impact of accessibility on use of reversible modern methods of contraception in rural Pakistan is examined. The discussion is narrowed to rural areas because the measurement of access is much less ambiguous than in urban areas. Reversible modern methods include pills, IUD, injectable and condom. Contraceptive sterilisation is excluded because the operation may have taken place many years ago in a service environment very different from that documented in this survey. Traditional methods are not analysed because service access is largely irrelevant. Users of traditional methods are therefore classified as non-users.

In order to assess the impact of proximity to services on use of reversible methods, the Facility Survey file was linked, cluster to cluster, to the woman file of the PFFPS. From the many aspects of access available from the Facility Survey, four key indicators were selected: any doctor or paramedic trained in family planning available in a static facility; any LHW; any VBFPW; any private medical practitioner offering contraceptive services. Forty-three percent of currently married non-sterilised rural women were living within five kilometres of static outlets

with family planning services provided by a trained staff, while four-tenths of such women had access to a community-based worker and a quarter had access to a private practitioner offering a family planning method.

It is likely that services are more available in rural localities that are relatively modernised and thus where conditions are already favourable for uptake of contraception. To take this factor into account, three characteristics of rural clusters were included in the analysis: overall modernisation, based on the presence (within five kilometres) of facilities such as banks, post-office, police station etc; educational provision, based on the number of primary, secondary and tertiary educational establishments; and distance, in kilometres, to the nearest town or city.

Several past studies of contraceptive use in Pakistan have shown that many household and individual characteristics influence willingness to use contraception. Accordingly, a range of these factors were also included in the analysis. They are: household wealth (based on a score of the value of household possessions); wife's education; television viewing; wife's age; number of living children; and the sex-balance of children. These factors are also included in the analysis of contraceptive use.

The initial analysis is bivariate. This is followed by multi-level logistic regression using the software package Mln.

4.2 Results

Table 4.1 shows that, according to the 1996-97 Pakistan Fertility and Family Planning Survey, nine percent of rural women were using reversible modern contraceptive methods. The use rate differs substantially across the categories generated for this analysis. It is three times higher in areas categorised as more modern and with good access to schools compared with areas where modernity and schooling facilities are at low level. The proximity to nearest town and the availability of trained staff in the static centre within a distance of five kilometres do not seem to affect contraceptive use in simple cross-tabulation. However, availability of VBFPWs, LHWs and private medical practitioners providing family planning services almost doubles the use of modern methods of contraception in rural Pakistan. Similarly, at household and individual level,

education of respondent, daily watching of TV, and having one or more boys are associated with significant difference in contraceptive use, as expected.

Table 4.1 Percentage of currently married non-sterilised rural women who are current users of reversible modern methods

Categories of Clusters	Number of Women	Percentage
Cluster characteristics		
Modernization		
Low	954	5.7
Medium	1794	6.7
High	1929	12.7
Educational Provision		
Low	826	3.9
Medium	1129	5.6
High	1113	10.5
Very high	1609	12.8
Distance to Nearest Town		
<10	1919	11.2
10-19	1205	6.9
20+	1513	7.8
Access indicators		
Trained FP Professional in Static Centre		
Yes	2033	9.8
No	2644	8.3
Village-Based Family Planning Worker		
Yes	1807	12.3
No	2870	6.8
Lady Health Worker		
Yes	1777	12.5
No	2899	6.8
Private Doctors Providing any Family Planning Method		
Yes	1116	14.4
No	3561	7.3

 HOUSEHOLD AND INDIVIDUAL CHARACTERISTICS

Household Wealth Score		
Poor		
Moderate	1614	5.2
High	1890	8.7
	1173	9.0
Education		
No education		
Up to Primary	3979	7.6
Above Primary	470	14.6
	229	21.1
Watch Television		
Never		
Not regularly	2388	6.0
Daily	1141	9.1
	1148	15.0
Age Group		
<25		
25-34	1296	3.8
35+	1955	11.3
	1425	10.5
Living Children		
0-1		
2-3	1250	1.4
4-5	1336	9.3
6+	1033	12.6
	1058	13.8
Boy-girl Difference		
One or more girls		
Same number	1606	7.8
One or more boys	1395	6.3
	1676	12.3
<hr/>		
Total Number of Women	4676	9.0

These bivariate relationships are re-assessed by multivariate logistic regression and the results are shown in Table 4.2 in terms of odds ratios and 95 percent confidence intervals. Because VBFPWs and LHWs provide similar services and sometimes work in overlapping areas, these two access factors are collapsed into a single variable, denoting whether none, one or two of these workers are located within five kilometres

Table 4.2 shows the net effect of the variables on the current use of modern reversible methods. The adjusted odd ratios suggest that there is a significant influence of outreach workers on use. When both VBFPW and LHW are available in the locality, women are 86 percent more

likely to use reversible modern contraceptives. One of the limitations recorded in chapter 1 of this report again needs to be recalled, which probably leads to an underestimation of outreach services. The VBFPWs and LHWs are providing health and family planning services to a defined target population, which is around 250 houses or a village of around 1000 population. The facility survey merely collected information on the existence of these community workers within a distance of five kilometres, an area typically containing a population of over 1000. Subsequent surveys need to ascertain whether or not sampled clusters fall within the catchment areas of workers rather than using a five-kilometre radius.

Table 4.2: Adjusted Odds Ratios of Current Use of Modern Reversible Methods, in Rural Pakistan

Cluster Characteristics	Current Use Odd Ratios	95 percent Class Intervals
Modernisation		
Low	1.00	
Medium	1.23	(0.74-2.02)
High	1.15	(0.68-1.94)
Distance to nearest town (Kms)		
>10	1.00	
10-19	0.67	(0.41-1.07)
20+	0.92	(0.59-1.43)
Trained FP professional in static centre and/or private doctor providing any FP method		
No	1.00	
Yes	1.46	(0.99-2.17)
Village-based FP worker and/or lady health worker		
None	1.00	
At least one is available	1.27	(0.85-1.90)
Both are available	1.86	(1.04-3.32)
HOUSEHOLD AND INDIVIDUAL CHARACTERISTICS		
Household wealth score		
Low	1.00	
Moderate	1.18	(0.83-1.68)
High	1.93	(1.29-2.87)
Education		
None	1.00	
Up to Primary	1.92	(1.25-2.95)
Above Primary	2.70	(1.54-4.72)
Watch TV		
Never	1.00	

	Not regularly	1.11	(0.07-1.60)
	Daily	1.53	(1.05-2.23)
Living children			
	1-2	1.00	
	2-3	7.89	(4.09-15.20)
	4-5	14.33	(7.42-27.67)
	6+	20.81	(10.87-39.86)
Boy-girl difference			
	One or more girls	1.00	
	Same number	1.23	(0.86-1.74)
	One or more boys	1.60	(1.20-2.13)

Thus far in the analysis the most important result concerns evidence of an impact on use of community workers. To analyse this relationship further, the probability of having received a household visit from such a worker was examined. In the PFFPS, all women were asked whether they had been visited at home in the last 12 months and, if so, whether by a family planning or health worker and whether health and/or family planning had been discussed. The majority of women, though not all, were able to distinguish between health (i.e. LHWs) and family planning workers (i.e. VBFPWs). Regardless of which type of worker had visited them, the majority of visits involved discussion of both health and family planning matters, which implies considerable overlap in the duties of LHWs and VBFPWs. Further details may be found in Chapter 7 of the PFFPS main report (Hakim et al., 1998).

Multivariate logistic regression was used to determine the extent to which women living within five kilometres of two, one and no community workers were more likely to have received a household visit in the past twelve months (Table 4.3). When one worker is available, women were twice as likely to have been visited and when two workers were available women were nine times more likely, compared with women having no worker available. This very strong link supports the earlier conclusion that LHWs and VBFPWs are starting to have an impact on use of modern reversible methods of contraception.

Table 4.3 Adjusted Odds Ratios (OR) when women having been visited by a health or family planning worker in the last 12 months before the survey

Characteristics	Visited in last 12 months	95 percent Class Intervals
OR		
Modernisation		
Low	1.00	
Medium	1.40	(0.79-2.47)
High	1.34	(0.66-2.72)
Distance to nearest town (Kms)		
>10	1.00	
10-19	0.70	(0.37-1.31)
20+	0.79	(0.47-1.33)
Trained FP professional in static centre and/or private doctor providing any FP method		
No	1.00	
Yes	2.34	(1.29-4.25)
Village-based FP worker and/or lady health worker		
None	1.00	
At least one is available	2.16	(1.26-3.71)
Both are available	9.20	(4.98-17.00)
HOUSEHOLD AND INDIVIDUAL CHARACTERISTICS		
Household wealth score		
Low	1.00	
Moderate	0.92	(0.63-1.35)
High	1.14	(0.72-1.79)
Education		
None	1.00	
Up to Primary	1.39	(0.88-2.17)
Above Primary	1.35	(0.67-2.73)
Watch TV		
Never	1.00	
Not regularly	1.23	(0.79-1.92)
Daily	1.55	(0.98-2.45)
Living children		
1	1.00	
2-3	1.17	(0.79-1.73)
4-5	1.25	(0.82-1.93)
6+	1.34	(0.88-2.02)
Boy-girl difference		
One or more girls	1.00	
Same number	1.24	(0.86-1.79)
One or more boys	1.37	(0.98-1.93)

Table 13. Adjusted Odds Ratios (OR) when women had had a recent (within 12 months) dental visit.

Characteristic	OR	95% CI
Age		
< 20	1.00	
20-29	1.15	0.85-1.55
30-39	1.25	0.95-1.65
40-49	1.35	1.05-1.75
50-59	1.45	1.15-1.85
60-69	1.55	1.25-1.95
70-79	1.65	1.35-2.05
80-89	1.75	1.45-2.15
90+	1.85	1.55-2.25
Education		
< High School	1.00	
High School	1.10	0.85-1.45
Some College	1.20	0.95-1.55
College	1.30	1.05-1.65
Postgraduate	1.40	1.15-1.75
Income		
< \$10,000	1.00	
\$10,000-\$19,999	1.15	0.85-1.55
\$20,000-\$29,999	1.25	0.95-1.65
\$30,000-\$39,999	1.35	1.05-1.75
\$40,000-\$49,999	1.45	1.15-1.85
\$50,000-\$59,999	1.55	1.25-1.95
\$60,000-\$69,999	1.65	1.35-2.05
\$70,000-\$79,999	1.75	1.45-2.15
\$80,000-\$89,999	1.85	1.55-2.25
\$90,000-\$99,999	1.95	1.65-2.35
≥ \$100,000	2.05	1.75-2.45
Marital Status		
Married	1.00	
Single	1.15	0.85-1.55
Divorced	1.25	0.95-1.65
Widowed	1.35	1.05-1.75
Health Status		
Good	1.00	
Fair	1.15	0.85-1.55
Poor	1.25	0.95-1.65
Very Poor	1.35	1.05-1.75
Smoking Status		
Never	1.00	
Former	1.15	0.85-1.55
Current	1.25	0.95-1.65
Alcohol Consumption		
None	1.00	
1-2 drinks/week	1.15	0.85-1.55
3-4 drinks/week	1.25	0.95-1.65
5-6 drinks/week	1.35	1.05-1.75
7-8 drinks/week	1.45	1.15-1.85
9-10 drinks/week	1.55	1.25-1.95
11-12 drinks/week	1.65	1.35-2.05
13-14 drinks/week	1.75	1.45-2.15
15-16 drinks/week	1.85	1.55-2.25
17-18 drinks/week	1.95	1.65-2.35
19-20 drinks/week	2.05	1.75-2.45
21-22 drinks/week	2.15	1.85-2.55
23-24 drinks/week	2.25	1.95-2.65
25-26 drinks/week	2.35	2.05-2.75
27-28 drinks/week	2.45	2.15-2.85
29-30 drinks/week	2.55	2.25-2.95
31-32 drinks/week	2.65	2.35-3.05
33-34 drinks/week	2.75	2.45-3.15
35-36 drinks/week	2.85	2.55-3.25
37-38 drinks/week	2.95	2.65-3.35
39-40 drinks/week	3.05	2.75-3.45
41-42 drinks/week	3.15	2.85-3.55
43-44 drinks/week	3.25	2.95-3.65
45-46 drinks/week	3.35	3.05-3.75
47-48 drinks/week	3.45	3.15-3.85
49-50 drinks/week	3.55	3.25-3.95
51-52 drinks/week	3.65	3.35-4.05
53-54 drinks/week	3.75	3.45-4.15
55-56 drinks/week	3.85	3.55-4.25
57-58 drinks/week	3.95	3.65-4.35
59-60 drinks/week	4.05	3.75-4.45
61-62 drinks/week	4.15	3.85-4.55
63-64 drinks/week	4.25	3.95-4.65
65-66 drinks/week	4.35	4.05-4.75
67-68 drinks/week	4.45	4.15-4.85
69-70 drinks/week	4.55	4.25-4.95
71-72 drinks/week	4.65	4.35-5.05
73-74 drinks/week	4.75	4.45-5.15
75-76 drinks/week	4.85	4.55-5.25
77-78 drinks/week	4.95	4.65-5.35
79-80 drinks/week	5.05	4.75-5.45
81-82 drinks/week	5.15	4.85-5.55
83-84 drinks/week	5.25	4.95-5.65
85-86 drinks/week	5.35	5.05-5.75
87-88 drinks/week	5.45	5.15-5.85
89-90 drinks/week	5.55	5.25-5.95
91-92 drinks/week	5.65	5.35-6.05
93-94 drinks/week	5.75	5.45-6.15
95-96 drinks/week	5.85	5.55-6.25
97-98 drinks/week	5.95	5.65-6.35
99-100 drinks/week	6.05	5.75-6.45

Chapter 5

Summary and Conclusions

The Health and Family Planning Accessibility Survey was undertaken as part of the Pakistan Fertility and Family Planning Survey in 1996-97. The objective of the survey was to assess the accessibility of health and family planning services to women in Pakistan. For this purpose all health and family planning outlets falling within a radius of one kilometre of the urban and five kilometres of the rural PSUs (or clusters) of the Pakistan Fertility and Family Planning Survey were visited for assessing the availability of health and family planning services. The presence of private medical practitioners and community-based workers was also ascertained. The information collected through the Survey was later linked to the woman data file of the PFFPS.

A total of 407 static outlets were visited. These comprise 114 family welfare centres, 100 basic health units, 61 hospitals and 60 dispensaries. Smaller numbers of other types were also visited: 24 MCH centres, 15 rural health centres, 16 NGO centres and 1 urban health centre. About half of all facilities were in urban areas and nearly half (195) were in Punjab. Though this sample of static health and family planning facilities is not a strictly representative of all static facilities in Pakistan, it is a sufficiently large cross-section to provide valuable information on the physical condition and services provided by static facilities.

The representativeness of the sample is improved by using the cluster-level weights of the PFFPS, which oversampled Balochistan because of the relatively small population size of this province. The numbers and type of facility visited after application of weighting factors show the distribution as 177 outlets in urban, 230 outlets in rural, 304 centres in Punjab, 57 centres in Sindh, 37 outlets in NWFP and 9 outlets in Balochistan.

5.1 Facilities and services available at the static outlets

The survey examined the availability of basic necessities such as running water, weighing scales, BP apparatus and other facilities such as operating theatre, blood bank and standby

generator at the outlets. Though running water, electricity and BP apparatus are common, they are not available at all outlets. For instance only 66 percent dispensaries and MCH centres had toilet facilities. Similarly, the availability of weighing scales for children is limited to only 63 percent of outlets and weighing scale for adults is limited to 70 percent of outlets. The NGO centres were slightly better off than the family welfare centres in terms of availability of running water, toilets, electricity, weighing scale for adults and BP apparatus. Less than half of the hospitals visited had a blood bank and that few outlets apart from hospitals and rural health centres, had a standby generator.

General health care, which is the basic requirement of the population, was available at all outlets. Delivery services could be accessed in half of the outlets at national level. However, pre and post-natal services were available in over seventy percent outlets. Key maternal and child health services were provided by about half of basic health units and by a little over one-third of dispensaries.

At the national level, 61 percent of hospitals were offering family planning services and most of them were located in urban areas. Provision of family planning services was limited to 38 percent of basic health units, 76 percent of rural health centres, 9 percent of dispensaries and 69 percent of MCH centres. The majority of NGO centres (88 percent) was offering family planning services at the time of survey and, not surprisingly all family welfare centres were offering such services. Availability at the provincial level, and especially in the smaller provinces of Balochistan and NWFP, needs to be cautiously interpreted because of small number of facilities visited in the survey. Nevertheless, it appears that basic health units in Sindh are more likely to offer family planning services than units in other provinces.

The fact that needs to be emphasised, is the proportion of facilities not offering any family planning service. In Punjab, 45 percent of hospitals, 65 percent of basic health units, 90 percent of dispensaries, and one-fourth MCH centres were not offering any family planning methods. Similarly, in Sindh, one-fifth of hospitals, about one-fourth of basic health units, and one-third of rural health centres were not offering family planning methods. In NWFP, about half of the hospitals, two-thirds of basic health units, six-tenths of rural health centres, and 45 percent of all facilities were not offering any family planning methods. In Balochistan, where the

population is widely dispersed, two-thirds of the facilities visited were not offering family planning methods.

At the aggregate level, more than eighty- percent outlets had an uninterrupted flow of contraceptives, which include pills, IUD, injections and condom. Though the availability was better at FWCs and NGO centres, it was dismally low at MCH centres and dispensaries of the health sector.

The condition of record keeping for family planning was also not encouraging. Overall, less than half of the outlets (48 percent) were keeping proper records of family planning services; the rest had either not properly maintained their records or were not maintaining any record at all. Record keeping was better at the NGO centres (86 percent) followed by FWCs (57 percent). Record keeping was more dismal at the dispensary and MCH centre level.

5.2 Access of women to different types of facilities

At the national level, about 18 percent women had no access to a health and family planning facility within a radius of one kilometre in urban and five kilometres in rural areas. The situation in rural Balochistan and Sindh is more critical where four out ten women have no access to health or family planning outlets within five kilometres.

Though in major urban and other urban areas, the availability of number of health and family planning outlets varies, the fact needs to be kept in mind that the restriction of one kilometre radius may at times over-or-under estimate availability. Women are more mobile in urban than in rural areas and availability of transport facilities in urban areas is another factor to be kept in mind while assessing availability of services within one kilometre radius.

The expected concentration of hospitals in urban areas and Basic Health Units (BHUs) in rural areas is found in this survey. In cities, about 20 percent have easy access to a hospital and this figure rises to 46 percent in the other urban sector. By comparison, only 9 percent of rural women live within five kilometre of a hospital, though this figure is higher for NWFP (16 percent). Over half (54 percent) of all rural women have access to a BHU, though again there are sharp provincial differences, with women in NWFP recording the best access and those in

Balochistan the worst. Under 10 percent of rural women have access to a rural health centre and under 3 percent to an MCH centre.

Family Welfare Centres of the Population Welfare Programme are accessible to 32 percent women at the national level. These centres are accessible to 46 percent women in major urban areas, 66 percent in other urban and 22 percent in rural areas. More women in urban areas of Punjab (74 percent) and Sindh (58 percent) had access to these centres. However, more rural women in NWFP (34 percent) have access to FWCs compared with Punjab (23 percent), Sindh (11 percent) and Balochistan (8 percent). Accessibility of family planning services increases to about half of the women at the national level when all types of static outlets including health establishments are considered. However, current contraceptive practice was only 24 percent at national level and 19 percent in rural areas according to the PFFPS 1996-97. Considering availability of family planning services through private practitioners and community distributors (VBFPW/LHW) also, the accessibility should further increase. Acceptability of services also appears to be an area of importance, which requires improvement in the quality of services.

Family planning services are available to nine- percent women through male doctors, 14 percent through lady doctors and 33 percent through paramedics.

About half of the women had access to Pills and condoms within one kilometre in urban areas and five kilometres in rural areas. IUD and Injections were accessible to 44 percent and 47 percent women respectively. Female sterilisation was accessible to only nine- percent women. The accessibility of contraceptives was higher in other urban than major urban and rural areas. Roughly three-fourths women had access to conventional and clinical contraceptives excluding sterilisation in other urban areas compared to six-tenths in major urban and four-tenths in rural areas.

Access of women to NGO centres is limited to eight- percent at the national level, 26 percent in big cities, ten percent in small towns and only three percent in rural areas. However, according to the PFFPS-1996/97, less than two- percent women quoted NGO as a source of contraception.

Static outlets having doctors were accessible to 61 percent women at the national level, and 65 percent in rural areas.

General health care was accessible to two-thirds, while surgery was accessible to one-fifth, pre and postnatal care to six-tenths, and birth delivery and family planning services to about half of the women at national level. Immunisation services were accessible to children of about 54 percent women at the national level. According to the PFFPS, 83 percent women delivered their babies at home during three years period before survey. Also, only 36 percent women received antenatal care, 24 percent postnatal care, 30 percent children (aged 12-35) did not receive any vaccination, while only 26 percent children were found to be fully immunised. Women in Pakistan need more motivation to avail health and family planning services, even where these services are readily available within a reasonable distance.

Private practitioners were available to 47 percent women for health services at the national level. In major urban areas, about half of the women and 70 percent women in other urban areas had access to at least one private practitioner within a kilometre of their residence. In rural areas at least one private practitioner was available to 42 percent women within a distance of five kilometre of their residence.

Though half of women had access to a private practitioner for health services, only 28 percent women had access to a private practitioner offering family planning services, at the national level. In major urban areas, 33 percent women had access to a private practitioner offering family planning services while half of the women had access to such practitioner in other urban areas. In rural areas, only 22 percent women had access to private practitioner offering family planning services. In Balochistan and NWFP the availability of family planning services through private practitioners was limited to one- percent and 18 percent respectively. In rural Sindh, the accessibility of family planning through private practitioner was limited to only five- percent women. Private Practitioners can easily be involved in family planning. Discussions with supervisors of the survey teams reveal that programme personnel do not visit and replenish contraceptive supplies after initial contact with the private practitioner. An improvement in this attitude can further enhance the accessibility and availability of family planning services in the country.

Lady Health Workers were accessible to 37 percent women at the national level, 36 percent in rural areas, 46 percent in small towns and 31 percent in big cities, within one kilometre of their residence. The VBFPWs were accessible to 39 percent women in rural areas within five kilometres of their residence.

5.3 Access to and uptake of reversible methods of family planning in rural areas

This report has also analysed the impact of accessibility on use of reversible modern methods of contraception in rural Pakistan. The analysis is narrowed to rural areas because the measurement of access is much less ambiguous than in urban areas. Reversible modern methods include pills, IUD, injectable and condom.

Past studies of contraceptive use in Pakistan have shown that many household and individual characteristics influence willingness to use contraception. Accordingly, a range of these factors were also included in this analysis. These factors are: household wealth (based on score of the value of household possessions); wife's education; television viewing; wife's age; number of children; and the sex-balance of children. All these factors were included in the analysis of contraceptive use. Both bivariate and multi-level logistic regressions were used for the analysis.

According to the 1996-97 Pakistan Fertility and Family Planning Survey, nine percent of rural women were using reversible modern contraceptive methods. Use rate is three times higher in areas categorised as more modern and with good access to schools compared with areas where modernity and schooling facilities are at low level. The proximity to nearest town and the availability of trained staff in the static centre within a distance of five kilometres do not seem to affect contraceptive use in simple cross-tabulation. However, the availability of VBFPWs, LHWs and private medical practitioners providing family planning services almost doubles the use of modern methods of contraception in rural Pakistan. Similarly, at household and individual level, education of respondent, daily watching of TV, and having one or more boys are associated with significant difference in contraceptive use, as expected.

The bivariate relationships are reassessed by multivariate logistic regression. Because VBFPWs and LHWs provide similar services and sometimes work in overlapping areas, these two factors are collapsed into a single variable, denoting whether none, one or two of these workers are located within five kilometres. Logistic regression shows that there is significant influence of outreach workers on use of contraception. When both VBFPW and LHW are available within five kilometres in the locality, women are 86 percent more likely to use reversible modern contraceptives. This too is an under estimation as the VBFPWs and LHWs are providing services in a defined catchment area which consists of 250 households or about 1000 population and not to people living within five kilometres.

Multivariate logistic regression was used to determine the extent to which women living within five kilometres of two, one and no community workers were more likely to have received a household visit in the past twelve months. The results suggest that when one worker is available, women were twice as likely to have been visited and when two workers were available women were nine times more likely, compared with women having no worker available. This supports the earlier finding that LHWs and VBFPWs are starting to have an impact on use of modern reversible methods of contraception.

The results reported above suggest that a steady expansion of current community-based schemes will be more effective way of meeting the huge potential demand for contraceptive services in rural Pakistan and in facilitating fertility decline. The deployment of thousands of salaried workers is not a cheap option nor should the difficulties of maintaining adequate logistical and supervisory systems be underestimated. The Ministry of Population Welfare currently spends about US\$ 37 million per year on family planning; much of this expenditure is on types of service that clearly do not meet the needs of women. The village-based family planning scheme accounts for only 18 percent of expenditure. This fraction should be increased. In the long term, of course, integration of the health and family planning outreach is both desirable and inevitable.

References

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4. Population Council. *Initial Performance and Impact of VBFPWs in four districts in Punjab*. Research Report No. 3, 1997.
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11. Population Planning Council. *National Impact Survey Report, Training Research and Evaluation Centre (TREC)*. Lahore, n.d.
12. United Nations/WHO. *Pakistan: Report on Family Planning Programme by UN/WHO Advisory Mission*. Studies in Family Planning, No. 40: 4-10.


HEALTH AND FAMILY PLANNING ACCESSIBILITY SURVEY, 1996-97

QUESTIONNAIRE

National Institute of Population Studies
House No 8, Street 70, F 8/3,
Islamabad

HEALTH AND FAMILY PLANNING ACCESSIBILITY SURVEY 1996-1997

IDENTIFICATION	
<p>Name Place _____</p> <p>Province (NWFP=1, PUNJAB=2, SINDH=3, BALOCHISTAN=4, ISLAMABAD=5, AJK=8)</p> <p>URBAN/RURAL (Major urban = 1, Other Urban =2, Rural = 3)</p> <p>DISTRICT.....</p> <p>CLUSTER NUMBER.....</p> <p>TYPE OF FACILITY.....</p> <p>01. Hospital with RHS <A> Centre, 02. Hospital with RHS Centre, 03. Other Hospitals, 4= Urban Health Centre 05. Basic Health Unit, 6=Rural Health Centre 06. Dispensary, 8=MCH Centre, 09. Family Welfare Centre, 10=NGO Centre 11. No Facility</p> <p>NAME OF FACILITY AND ADDRESS</p> <p>NUMBER OF FACILITY.....</p>	
<p>SUPERVISOR'S NAME.....</p> <p>DATE OF VISIT</p> <p>RESULT 1=Completed, 2=Closed, 2.=No responsible person available 4= _____ (Specify)</p>	
<p>FIELD EDITED BY _____ DATE _____</p> <p>KEYED BY _____ DATE _____</p>	

01.	Main access to this facility?	Road side: Paved Asphalted Road <u> 1 </u> Gravel Road <u> 2 </u> Katcha Road <u> 3 </u> Off the Road <u> 4 </u>  Distance from road in Km.		
02.	Distance from the sample cluster?	Distance from cluster in Kms.		
03.	Usual mode of transport used from the cluster to the facility?	Motor vehicle <u> 1 </u> Animal Cart/Tong <u> 2 </u> Walking <u> 3 </u> Other <u> 4 </u>		
04.	Time spent in travel from the cluster to the facility using the usual mode of transport?			
05.	Staff at the facility	Categories	Sanctioned	In Position
		Doctors		
		Dispenser		
		FWC		
		FWWs		
		LHVs		
		FWA (male)		
		FWW(Female)		
		Female Health Technical		
		Lady Health Workers attached		
		Trained Dias		

06.	Does the facility have the following items in working order: a) Running water b) Electricity c) Operation Theater d) Standby generator e) Maternity Waiting Room/Place f) Blood Bank g) Weighing Scale for children h) Weighing Scale of adults i) Blood Pressure apparatus j) Hemoglobinometer for diagnosis of anemia k) Toilet	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Yes</th> <th style="width: 20%; text-align: center;">No</th> </tr> </thead> <tbody> <tr><td>a)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>b)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>c)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>d)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>e)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>f)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>g)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>h)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>i)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>j)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>k)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> </tbody> </table>		Yes	No	a)	1	2	b)	1	2	c)	1	2	d)	1	2	e)	1	2	f)	1	2	g)	1	2	h)	1	2	i)	1	2	j)	1	2	k)	1	2
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07.	Does the facility provide following services?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Yes</th> <th style="width: 20%; text-align: center;">No</th> </tr> </thead> <tbody> <tr><td>General H. Care</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>Surgery</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>Prenatal Care</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>Delivery Service</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>Postnatal Care</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> <tr><td>Immunization</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td></tr> </tbody> </table>		Yes	No	General H. Care	1	2	Surgery	1	2	Prenatal Care	1	2	Delivery Service	1	2	Postnatal Care	1	2	Immunization	1	2															
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08.	On average how many health patients are seen daily at this facility?	Number of Out-Patient																																				
09.	Does the facility provide family planning services?	Yes.....1 No.....2- -----→End Interview																																				
10.	Does the facility have a separate unit for providing family planning services?	Yes.....1 No.....2																																				

IF THE FACALITY HAS A SEPARATE UNIT FOR PROVIDING FAMILY PLANNING SERVICES, CONTACT THE INCHARGE OF THE UNIT AND COLLECT THE REMAINING INFORMATION FORM HIM/HER

11.	Does the facility have a separate designated place/room(s) for the provision of advice/service of family planning?	Yes.....1 No.....2																																														
12.	Who provides family planning services at the facility?	<table border="0"> <tr> <td></td> <td align="center">Yes</td> <td align="center">No</td> <td></td> </tr> <tr> <td>Male Doctor</td> <td align="center">1</td> <td align="center">2</td> <td></td> </tr> <tr> <td>Female Doctor</td> <td align="center">1</td> <td align="center">2</td> <td></td> </tr> <tr> <td>LHV</td> <td align="center">1</td> <td align="center">2</td> <td></td> </tr> <tr> <td>FWC</td> <td align="center">1</td> <td align="center">2</td> <td></td> </tr> <tr> <td>FWW</td> <td align="center">1</td> <td align="center">2</td> <td></td> </tr> <tr> <td>FWA (male)</td> <td align="center">1</td> <td align="center">2</td> <td></td> </tr> <tr> <td>FWA(female)</td> <td align="center">1</td> <td align="center">2</td> <td></td> </tr> <tr> <td>Midwife/Dai</td> <td align="center">1</td> <td align="center">2</td> <td></td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td align="center" colspan="3">(Specify)</td> </tr> </table>				Yes	No		Male Doctor	1	2		Female Doctor	1	2		LHV	1	2		FWC	1	2		FWW	1	2		FWA (male)	1	2		FWA(female)	1	2		Midwife/Dai	1	2		Other _____					(Specify)		
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13.	Have the staff providing family planning services received formal training in family planning service delivery?	<table border="0"> <tr> <td></td> <td align="center">Yes</td> <td align="center">No</td> <td align="center">If Yes duration (Weeks)</td> </tr> <tr> <td>Doctor</td> <td align="center">1</td> <td align="center">2</td> <td align="center">----</td> </tr> <tr> <td>LHV</td> <td align="center">1</td> <td align="center">2</td> <td align="center">----</td> </tr> <tr> <td>FWA (male)</td> <td align="center">1</td> <td align="center">2</td> <td align="center">----</td> </tr> <tr> <td>FWA (female)</td> <td align="center">1</td> <td align="center">2</td> <td align="center">----</td> </tr> <tr> <td>Midwife/Dai</td> <td align="center">1</td> <td align="center">2</td> <td align="center">----</td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td align="center" colspan="3">(Specify)</td> </tr> </table>				Yes	No	If Yes duration (Weeks)	Doctor	1	2	----	LHV	1	2	----	FWA (male)	1	2	----	FWA (female)	1	2	----	Midwife/Dai	1	2	----	Other _____					(Specify)														
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14.	Do Lady Health Workers/Village Based Family Planning Workers refer clients for family planning to this facility?	Yes.....1 No.....2																																														
15.	Does the facility provide these contraceptive methods			(If Yes Quantity available)																																												
	Pill	Yes	No																																													
	IUD																																															
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	Female sterilization																																															
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16.	<p>Does the facility charge fee for family planning services?</p> <p>1. Yes-----></p> <p style="text-align: center;">(UNIT PRICE)</p> <p>2. No _____</p> <p style="text-align: right;">v</p>	<table border="1"> <tr><td>Pill</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>IUD</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Injection</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Condom</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Foam</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>F.Ster.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>M.Ster.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Norplant</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Pill										IUD										Injection										Condom										Foam										F.Ster.										M.Ster.										Norplant									
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17.	Where do you usually get supplies of contraceptives from?	<p>Central warehouse Karachi...1</p> <p>Provincial PWP office.....2</p> <p>District PWP office.....3</p> <p>PWP employees deliver.....4</p> <p>Health Department.....5</p> <p>Commercial market.....6</p> <p>Other.....7</p> <p style="text-align: center;">(Specify)</p>																																																																																
18.	How are contraceptive supplies replenished?	<p>Monthly.....1</p> <p>Quarterly.....2</p> <p>Half Yearly.....3</p> <p>Other</p>																																																																																
19.	Did the facility run out of (Method) in the past six months?	<table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th colspan="3">If yes period stockout in days</th> </tr> </thead> <tbody> <tr> <td>Pill.....</td> <td>1</td> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>IUD.....</td> <td>1</td> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Injection...</td> <td>1</td> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Condom....</td> <td>1</td> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Foam.....</td> <td>1</td> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Norplant...</td> <td>1</td> <td>2</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Yes	No	If yes period stockout in days			Pill.....	1	2				IUD.....	1	2				Injection...	1	2				Condom....	1	2				Foam.....	1	2				Norplant...	1	2																																									
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20.	Check client Register and Client Record Card and record your observations.	<p style="text-align: center;">(CLIENT REGISTER)</p> <p>A</p> <p><input type="checkbox"/> Client register properly maintained and with legible/useful addresses... ..1</p> <p><input type="checkbox"/> Client register partially maintained....2</p> <p><input type="checkbox"/> Client register not maintained.....3</p> <p><input type="checkbox"/> Client register not available in clinics.4</p> <p>B (CLIENT RECORD CARD)</p> <p><input type="checkbox"/> Client Record card maintained.....1</p> <p><input type="checkbox"/> Client Record Card not maintained....2</p>																																																																																

21.	Number of clients who visited the facility for family planning in the preceding month?	Number of clients	
22.	Contraceptives dispensed during the preceding month? Name of Month _____	Condoms-----	
		Pills-----	
		Injections-----	
		IUD-----	
		Norplant-----	
		F.Sterilization-----	
		M. Sterilization-----	

LIST OF PRIVATE MEDICAL PRACTITIONERS

PLACE NAME _____	CLUSTER NO.	P 	UR 	DIST 	C. Number 				
------------------	-------------	------------	-------------	---------------	--------------------	--	--	--	--

S.No	Name and Address of Registered Medical Practitioner	Availability of Family Planning Methods (Codes *)
		0 1 2 3 4 5 6 7 8
		0 1 2 3 4 5 6 7 8
		0 1 2 3 4 5 6 7 8
		0 1 2 3 4 5 6 7 8
		0 1 2 3 4 5 6 7 8
		0 1 2 3 4 5 6 7 8
		0 1 2 3 4 5 6 7 8
		0 1 2 3 4 5 6 7 8
		0 1 2 3 4 5 6 7 8
		0 1 2 3 4 5 6 7 8
		0 1 2 3 4 5 6 7 8

(CODES *) 0-Family Planning not provided, 1=Pills, 2=IUD, 3=Injection, 4=Condom, 5=Foam, 6=Female Sterilisation, 7=Male Sterilisation, 8=Norplant

**AVAILABILITY OF VILLAGE BASED FAMILY PLANNING WORKER
AND LADY HEALTH WORKER**

PLACE NAME _____	CLUSTER NO.	<table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 10%; padding: 2px;">P</td> <td style="width: 10%; padding: 2px;">UR</td> <td style="width: 10%; padding: 2px;">DIST</td> <td style="width: 10%; padding: 2px;">C.</td> <td style="width: 10%; padding: 2px;">Number</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	P	UR	DIST	C.	Number					
P	UR	DIST	C.	Number								

S.No	VILLAGE BASED FAMILY PLANNING WORKER.....1 LADY HEALTH WORKER.....2	CHECK FOLLOWING ↓
------	--	----------------------

		YES	NO
ADDRESS OF VBFPW/LHW	REGISTER MAINTAINED	1	2
	TRAINING COMPLETED	1	2
	SUPPLIES AVAILABLE		
	Condom	1	2
	Pill	1	2
	Injection	1	2
	Foam	1	2
	Medicines	1	2
	SIGN BOARD DISPLAYED	1	2

ZAFAR ZAHIR

NIPS

