LONGITUDINAL PANEL STUDY IN SINDH

Using Performance Monitoring for Action (PMA) Framework

PHASE-II, 2024




Government of Pakistan
M/o National Health Services, Regulations & Coordination
National Institute of Population Studies, Training & Research (NIPST&R)

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National Institute of Population Studies, Training & Research
Islamabad

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LIST OF ACRONYMS

ANC	Antenatal Care
BHU	Basic Health Unit
CCI	Council of Common Interest
cLMIS	contraceptive Logistics Management Information System
CMWs	Community Midwives
CPR	Contraceptive Prevalence Rate
DHIS	District Health Information System
DoH	Department of Health
DPM	Data Processing Manager
EAs	Enumeration Areas
EC	Emergency Contraception
FP	Family Planning
FWC	Family Welfare Centre
GoP	Government of Pakistan
GoS	Government of Sindh
IUCDs	Intra Uterine Contraceptive Devices
LHWs	Lady Health Workers
LHVs	Lady Health Visitors
mCPR	modern Contraceptive Prevalence Rate
MDG	Millenium Development Goal
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal, And Child Health
MSU	Mobile Service Unit
NGO	Non -Governmental Organization
NIPST&R	National Institute for Population Studies, Training & Research
OE	Office Editor
PBS	Pakistan Bureau of Statistics
PMA	Performance Monitoring for Action
PNC	Postnatal Care
PWD	Population Welfare Department
PDHS	Pakistan Demographic and Health Survey
RH	Reproductive Health
RHC	Rural Health Center
RTIs	Regional Training Institutes
SBA	Skilled Birth Attendant
SDPs	Service Delivery Points
SDGs	Sustainable Development Goals
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund

PREFACE

The commitment by the Government of Sindh is to raise CPR to 57 percent by 2030 as part of Pakistan's commitments under ICPD25+ and FP-2030 forums to lower fertility to 2.1 births and to enhance contraceptive prevalence rate to 60 percent by 2030. To achieve these targets, collective efforts are needed by all stakeholders to evolve new strategies that address emerging needs and enhance efficiency in implementation at the grassroots. Timely assessment of progress and performance of family planning services is essential to see the direction and momentum of the progress for any corrective actions.

A prompt assessment of the progress and effectiveness of family planning services is essential to evaluate the trajectory and pace of developments, enabling the implementation of any required actions.

The initiation of the Longitudinal Panel Study by the National Institute of Population Studies, Training and Research (NIPST&R), Islamabad is the first of its kind to capture the state and dynamics of important family planning indicators. Phase I of the survey was conducted in 2023 to establish a baseline on key family planning indicators encompassing not only the demand-side of the services through women (age 15-49), but also the supply-side information of nearest service delivery points, and quality of service through client exit interviews. The second phase was conducted in 2024, and the results are presented to assist Programme Managers in implementing necessary actions to meet the gaps that emerge in meeting the provincial family planning commitments.

The Institute is keenly looking forward to three key stakeholders owning the results and using these for remedial actions: the Population Welfare Department, the Health Department, and Sindh-based civil society organizations.

The institute commends the tireless work and significant contributions of Ms. Rabia Zafar, Director, for her dedication and technical proficiency throughout the project. Her perspectives and dedication remain an exceptional benefit to the institute.

The Institute acknowledges the financial support by UNFPA to undertake Phase-II of this study. NIPST&R recognizes the technical support provided by the Pakistan Bureau of Statistics (PBS) in sampling and weights establishment. The Institute highly acknowledges the support and guidance extended by the members of the Technical Advisory Committee, which included experts from the Departments of Population Welfare and Health.

(Samina A. Hasan)
Executive Director

ACKNOWLEDGEMENTS

Performance Monitoring for Action (PMA) Framework is the result of dedicated efforts of individuals and organizations. The survey was implemented by the National Institute of Population Studies, Training and Research (NIPST&R) and conducted under the aegis of the Ministry of National Health Services, Regulations and Coordination.

We are optimistic that the findings of this study will be utilized by the public, particularly by policy-makers, planners, researchers, development partners, and Non-Governmental Organizations (NGOs), to create and oversee policies, programs, and strategies aimed at developing targeted services for family planning. This will emphasize affordable, quality services accessible to the underserved communities and significantly contribute to tackling the problem of population growth in the country.

I would like to express my gratitude and acknowledgment for the unwavering dedication, passion, and commitment demonstrated by Mrs. Samina A. Hasan, the Executive Director of NIPST&R. Her motivation empowered the core team to put forth their best efforts and successfully finalize the survey within the designated timeline. I am thankful for her professional leadership.

NIPST&R is highly obliged and appreciates the guidance, and technical support of Tauseef Ahmed Ph.D., Technical Advisor throughout the project activities from study design to report writing. Additionally, the dedication and hard work of Mr. Ali Raza, Data Processing Manager (DPM), is highly appreciated.

Ms. Rizwana Timsal, Fellow is highly appreciated for imparting training to field staff and field monitoring to ensure the data quality. Dr. Muhammad Mohsin Latif Kiani, Researcher, and Syed Talha Ali, Research Associate are acknowledged for their assistance in preparation of tabulation plan for report writing.

Mr. Muhammad Arif, Accounts Officer and Mr. Asif Amin Khan, PS to ED/Staff Officer are acknowledged for their commendable services in administration and financial management. Mr. Mr. Qamer Ur Rasool, Data Entry Operators are highly acknowledged for facilitation in data entry, error checking and maintaining data files. Mr. Mustafa Ali Khan, Office Coordinator, efficiently managed teams' coordination, and the Office Editors are appreciated for their editing and validation to maintain the quality of data.

(Rabia Zafar)
Director

EXECUTIVE SUMMARY

Government of Sindh made several commitments as part of national endeavour to address the rising population growth rate by strengthening family planning activities among key stakeholders. The Government evolved necessary policies and strategies to create an enabling environment, strengthen institutions, and improve the coverage and access of the services to enhance family planning performance and progress. Additionally, the Government of Sindh has emphasized the need to move forward with functional integration and prioritize strategies to increase access and coverage to address the growing number of new users, while also enhancing resources to overcome regional inequities.

To support the measurement of progress on the commitments, the National Institute of Population Studies, Training & Research (NIPST&R), Islamabad established a Longitudinal Panel Study using Performance Monitoring for Action (PMA) framework. This framework provides an annual stream of information on critical family planning and maternal health indicators using representative household sample across the province. This approach has an advantage over the Pakistan Demographic Health Surveys (PDHS), which are typically conducted every five years to show impact. The PMA framework provides process-level field evidence needed to bring programme improvements, addressing policy commitments to enhancing access to services, improving service quality, and strengthening the enabling environment.

The Phase-2 of Longitudinal Panel Survey in Sindh (2024), using the Performance Monitoring for Action (PMA) Framework, collects provincial-level data from 64 clusters selected from 8 districts across the province. The survey involves a representative sample of 2,450 households, interviewing 2,612 currently married women aged 15 to 49 years within these households, and assessing 279 selected health facilities serving the visited communities. Additionally, the survey includes interviews with currently married women and gathers data from Department of Health and Population Welfare Department (PWD) facilities, as well as private facilities providing family planning services in the selected clusters. Information was also collected from 2,668 clients/patients exiting various selected health facilities located within five kilometers of the selected clusters.

Key Findings:

Currently Married Women on Family Planning and Maternal Health:

- The contraceptive prevalence rate (CPR) among currently married women in Sindh recorded at 41.8 percent in 2024 which was 41.4 percent in 2023.
- The modern contraceptive use rate shows no change at 33.5 percent in 2023 and 2024. The percent women using traditional methods are 8 percent in both surveys.
- The source of modern contraception is predominantly PWD facilities, serving 41 percent of women.

- Public sector is attributed by 60.8 percent as the source of modern FP methods of which 19.8 percent is attributed to health outlets. Previous survey (2023) reported 18.4 percent attributed to health facilities.
- Three contraceptive methods are reported as currently popular among women including: tubaligation (11.1%), condoms (8.9%) and injectables (5.7%). These methods maintain their popularity as were in 2023. Use of traditional methods in much higher among urban women (almost 15 percent women) while almost all rural women depend on modern methods.
- Analysis of first and current method use of contraceptive shows 9 percent dropped out (in general) while close to 8 percent women dropped out of modern method use.
- Fertility related reasons are dominant reason to discontinue use of contraception in both urban and rural areas. Rural women reflect relatively higher percent discontinuing due to method specific reasons than urban counterpart.
- Analysis of contraceptive prevalence by programme interventions reveals that LHWs visit to women's households marginally effect mCPR positively (36 % mCPR among women for LHWs visit as against 31% mCPR for women not visited by LHW).
- Survey reveals LHWs attend more of younger women than older women to encourage them use contraception for birth spacing.
- Analysis of contraceptive use among women who visited health facility and asked for FP counseling reveals actionable results. Use of modern contraceptive rate is noted to be 42 percent for women who sought FP counseling from a health facility workers and 30 percent for those who did not. This is a remarkable finding to strengthen functional integration.
- Analysis of contraceptive use (first and current methods) reveals three methods show decline – condoms decline 11.7% to 8.9%, injectables declined from 8.8 percent to 5.7 percent, and oral pills from 5.2 percent to 2.9 percent. Tubal ligation is the only method that shows increase from 8.6 percent to 11.1 percent. Implants is reported by a very small percent of women as their first method (2.7%), followed by IUCDs (1.8%).
- Almost five percent women reported experiencing unintended pregnancy over their lifetime. Close to 60 percent unintended pregnancies occur to women between ages 25 and 34. This raises serious concerns about addressing the unmet need for contraception.
- Unmet need for contraception estimates show a slight decline from 27 percent (2023) to 22.3 percent (2024). Interestingly, six point fall over two surveys in unmet need for spacing (from 20 percent to 14 percent) and one percent increase in unmet need for limiting (7 to 8 percent) reflects women desire to limit births.
- A bit higher unmet need for contraception among rural women reflects issues of access and need of proper counseling to educated rural women.
- Birth spacing appears to be the key intent behind current use of contraception while birth limiting is practiced by relatively lower proportion of users.

- Survey reveals that three key maternal health indicators reflect good progress over two surveys: percentage women reporting receiving ANC services increased from 80 to 94 percent; skilled birth attendance (74 to 86 percent) and facility based delivery (from 77 to 86 percent).
- Urban women are more likely to talk to facility staff about FP (35.8%) relative to rural women (28.8%) in their postnatal care visit to the facility.

Family Planning and MCH Service Delivery Points

- Four modern methods (condoms, oral pills, injectables and IUCDs) are universally available at facilities of Heath, PWD and private sector closely followed by implants and emergency contraceptive pills available in fairly large percent of facilities. On the other hand, tubal ligation and vasectomy services are available at only limited number of Health and private facilities.
- A large of number facilities both public and private have trained staff and are prepared with supplies of IUCD and implants (insertion and removal). Fewer PWD facilities are prepared to offer implants to serve to clients. Overall, comparing two surveys Sindh reflects a slight improvement in the coverage/provision of implants from 56% to 60 percent of all facilities.
- Stocks of key contraceptives at facility level varied across entities: majority of PWD facilities show improved stocks availability (except Implants); as compared to 2023 survey results, Health Dept. facilities show adequate stocks of oral pills, IUCDs and injectables, while implants are reported stock-out in more health facilities and average stock out days of more than three months (96 days). Furthermore, fewer private sector facilities show several contraceptives (condoms, pills, injectables, and emergency pills) stock outs for over years.
- Three quarters of private health facilities provide injectables (which was 53% in 2023), with an average cost of Rs 318, which was Rs 260 in 2023 survey. Availability of implants have seen an increase over the two surveys (from 20 percent facilities to 37 percent facilities) and with relatively lower cost than previous year. IUCD is available at around two thirds of facilities with bit higher cost than previous year.
- A review of three month record prior to survey shows that 77,815 family planning clients were served by 279 public and private facilities. Fourteen percent of these clients are served by private sector facilities. Moreover, 47 percent of all FP clients are registered and served by Dept of Health facilities over the three months period which is a positive aspect of enhancing access and availability of contraception to women.
- Almost all facilities including public and private are providing counselling after delivery.
- Facility registers reveal a total of 78 thousand MCH visits recorded over the three months in the 279 facilities. In addition, 406 thousand visits were made for general ailment health issues during these months. These visits reflect tremendous potential for FP counseling and PNC patients for post-pregnancy FP. Currently facilities do not maintain any record on integration of services.

- The client exit survey reveals that though injectables remains at top of the prescribed list (37%), oral pills and condoms are also prescribed/ suggested to a high percent of clients (28% and 19%). IUCDs and Implants are prescribed at distant fourth position.

BACKGROUND OF THE SURVEY 1

Pakistan's commitment of achieving a CPR of 55 percent was therefore contextualized to the four provinces, with each determining a contribution, and as a result, Sindh committed to attain a CPR of 45 percent by 2020 as part of its contribution towards the overall national target. Sindh, in line with national commitment towards Sustainable Development Goals and FP2030 has resolved to achieve higher level of contraceptive prevalence through increased investment to enhance coverage and availability of FP, increase number of users and enhance resources to address regional inequities. Sindh pledged to achieve CPR 47 percent and 57 percent by 2025 & 2030 by lowering unmet need for contraception by two-thirds by 2030 and raising the total users. Under FP2030 Commitments, government expressed the need of moving forward with functional integration and prioritizing strategies to enhance access and coverage to address growing number of new users besides enhancing resources to overcome regional inequities. Fulfilling these commitments require a comprehensive and detailed plans that translates Population Policies into people centered programs for spread of information, and services that are easily accessible to the people within their communities, especially to rural poor and dwellers of urban slums in an environment of trust and care. The Sindh Population Policy 2015 postured family planning as an important intervention to save lives and protect the wellbeing of mothers and children and envisioned to increase Contraceptive Prevalence Rate (CPR) from 29.5 percent in 2012-13 to 45 percent by 2020 and to raise modern CPR from 25.5 percent in 2012-13 to 39 percent by 2020. The Population Policy also envisioned to raise contraceptive prevalence rate to 55 percent by 2032. Family planning services and activities by Population Welfare Programme and other stakeholders have contributed to increase modern CPR to 30.9 percent in 2017-18. The use of modern methods of family planning has increased to 24.4 percent in 2017-18. During the same time period, traditional method use increased from 3 percent in 1990-91 to 6.5 percent in 2017-18. Accordingly, access to FP information, commodities, and services was highlighted as a basic right for every woman and individual in the community to enable them to exploit their full potential. The public sector (Population Welfare and Department of Health) has a large network of facilities in Sindh that provide FP services. These facilities provided contraceptives to 40 percent of users, whereas 54 percent users accessed contraceptives through private sector outlets.

1.1 Introduction to Performance Monitoring for Action Framework

Performance monitoring is a function that is performed by planners and implementers at different levels of organization including assessment of outcomes, process and efficiency of activities, including quality and knowledge valuation. The current status of family planning in Sindh seeks attention of performance monitoring to help managers evolve strategies for programme improvements. Though the public sector spearheads family planning activities but the scope of performance monitoring is much wider today due to active role of private sector in dispensing FP across the province. For effective family planning decision making, this exercise provides information on outcome indicators (based on user's perspective), facility service data, and client satisfaction information.

The PMA framework is multifaceted as it gathers information at household level; from women in households to assess use of contraceptives; family planning service delivery points serving local women; and women clients exiting facilities after receiving services. The framework allows tracking of users both as a cross-section and as a panel over time to see their behavioural and attitudinal changes, and willingness to use contraception and access facilities, preparedness and availability and choices at facilities, measures taken to address missed opportunities, and to maintain stocks of all needed commodities, and finally assess quality of service using responses of women exiting health facilities. Furthermore, PMA results have an edge over the routine service statistics because of its roots in the beneficiaries and greater reliability towards decision making to address emerging needs besides eliminating exaggerated services statistics by linking field data with users' responses. The uniqueness of PMA is frequent availability of data to see progress and steer programme activities. The second Phase of this PMA exercise in Sindh undertaken during 2024 provides a good database to track trend of several key reproductive health indicators. The exercise is a bit different from Pakistan Demographic Health Survey due to its research design and sample selection process, thus results are not comparable.

The framework provides a unique design that links users to FP service delivery points nearest to their community. The survey provides information about women's access to contraceptive methods in both public and private facilities and how that affects their method choice options. Quality of services has remained central to contraceptive uptake and sustaining CPR. This exercise tries to assess quality of services from users and service provider's perspective but also assesses knowledge about FP among service providers across sectors to relate it to service delivery standards. The survey framework focuses on current users (…their most recent visit), discontinued users for reasons, and women with unmet need, identify access and quality barriers, service accessibility, and service quality and integration (where provided).

The slow increase in contraceptive use over a decade against the expectation of rise in CPR is serious challenge as it counters the plans and strategies set for lowering fertility. The slow progression persists in the presence of commitment to enhance CPR and to lower fertility. The presence of unmet need for contraception, unintended pregnancies, high missed opportunities for family planning etc. consistently point towards the need to improve the situation by regular review programme activities. Prior studies of family planning programmes note four areas as critical for achievement of FP goals that are set under FP2030 Commitments: Access, Equity, Quality and Choice, contraceptive security, and coverage. These areas have challenges and need regular critical assessments to help understand the ways to ensure best practices are implemented.

The existing challenges vary from low uptake of family planning, poor quality of services and counselling, stock outs of contraceptives, weak communication of service providers with clients, low knowledge of effective methods reflecting poor choice, poor availability of contraceptives in remote facilities and areas, and large unserved areas.

Ownership of the government of the exercise results is vital to bring necessary improvements and to align with the FP/RH goals. The support by UNFPA to address this critical research gap lays the basis of long-term improvements in the FP enabling environment in Sindh.

1.2 Objectives of the Study

The aim of the Panel Study is to produce reliable estimates for family planning and reproductive health on a regular basis. The following are the objectives:

1. To generate reliable point estimates of key indicators that provides evidence to family planning Programme managers in Sindh for improvements and track programme performance
2. To analyze contraceptive dynamics and cause factors to identify areas needing attention for remedial initiatives
3. To monitor core indicators over time as a guide and advise on performance monitoring and improve systems to meet FP2030 Commitments including enhancing access and quality services
4. To assess feedback on:
    - Policy Commitments on strategies to lower unmet need for contraception, improve service quality and ensure easy access to family planning services and facilities
    - Service integration at facility level for enabling environment to boost FP and MCH services to address missed opportunities and enhancing modern CPR

1.3 Survey Methodology

Sample Design and Size

The Panel Study focused exercise to collect province level data using a representative sample of households and women in selected clusters. The design involves (i) interviewing a sample of currently married females aged 15 to 49 years in selected households; and (ii) identifying a sample of facilities that provide family planning services including public sector (Health and Population Welfare facilities), and outlets of private sector serving the selected communities/clusters. The currently married female respondents are asked questions about their use and experiences of family planning, reproduction, and fertility preferences.

1.4 Sample Selection

Target Clusters / Areas and Households

This Phase-2 of the Sindh Panel Study 2024 household selection used a two-stage cluster design. Sixty-four (64) enumeration areas (EA) were drawn from the Pakistan Maternal Mortality Survey (PMMS) 2019 master sampling frame, of which 34 clusters from rural and 30 clusters from urban areas. Following the general sampling rule laid down by PMA2020, 42 households from urban and 35 from rural are selected. The survey aimed for sample size of 2,450 households. Data collection of Phase 2 was conducted in September and October 2024.

In this Phase-2, five (5) health service delivery points (SDPs) were visited that lie within 5 kilometers from each selected EA. These SDPs were obtained from the community that served FP-RH to the selected EAs at all three levels. The SDP sample design is linked to the household survey design, the SDP sample size is determined by two factors: the number of EAs selected for the population-based survey, and the family planning service system in Sindh. The public sector system included facilities of Dept of Health (that include District Hospital, Rural Health Centres,

Basic Health Units, and MCH Centres), and of Population Welfare Department (Reproductive Health Service Centres and Family Welfare Centres). Three public sector facilities were selected from available with 5 kilometres from the EA. Two non-public SDPs were selected which are run by non-government organizations (NGOs), private formal health facilities, such as hospitals and clinics, and non-formal health facilities, such as pharmacies and drug shops. The survey aimed for sample of 279 SDPs. Data gathering of SDPs focused on type of FP services, stocks, skills of service providers, quality of service aspects, and knowledge of service providers regarding FP. The SDP survey monitors service availability and quality, understand attributes for the availability and readiness, and explore the association of these SDP results with individual behaviors in the cluster, by linking data from both the SDP and household surveys.

Ten (10) client exit interviews are included for each SDP to cover ample information from users who visited SDPs for family planning and MCH services. The client exit surveys provides data to understand service provision (i.e., the process dimension of quality) and perceived quality among FP and RH service users.

Survey follows three-stage sample selection design:

(i) Random selection of districts from each division of Sindh covering all ecological zones.

(ii) Random selection of 64 enumeration areas (clusters) from all districts (see table 1.1 below); and random selection of households 42 from urban and 35 from rural clusters. The exercise produces province level estimates of key indicators.

Table 1.1: Sample Selection

Division	District	PSU Selected			No of Household		
		Rural	Urban	Total	Rural	Urban	Total
Thatta	Badin	6	2	8	210	84	294
Hyderabad	Dadu	6	2	8	210	84	294
Karachi	Karachi Central	-	9	9	-	378	378
	Karachi East	-	8	8	-	336	336
Sukkar	Khairpur	7	3	10	245	126	371
Larkana	Shikarpur	5	2	7	175	84	259
Mirpur Khas	Umerkot	5	2	7	175	84	259
Shaheed Benazirabad	Sanghar	5	2	7	175	84	259
Total		**34**	**30**	**64**	**1,190**	**1,260**	**2,450**

The survey includes a sample size that allows to calculate province level estimates for all indicators, including computing the modern contraceptive prevalence rate (mCPR) with a margin of error of ±5 percentage points. Sample weights were estimated by the Pakistan Bureau of Statistics (PBS), based on non-response at the cluster, household, and individual level and were applied to the women dataset for analysis.

The Sindh Panel Study 2024 focused on 64 enumeration areas (EAs), with 30 clusters from urban areas and 34 from rural areas. The study selected 2,450 households, of which 2,443 were successfully interviewed. A total of 2,715 eligible women participated in the interviews.

Table 1.2: Household Coverage

Household Coverage	**Phase II**
Number of households contacted	**2,443**
Number of currently married eligible women interviewed	**2,715**
Number of Facilities visited for interview	**279**
Number of client exit interviews held	**2,790**

In this phase, 580 households (24%) were replaced for various reasons including: Not found/ migrated – 17.5% or No eligible women in household – 3.4%, or Refused – 1.9%, and Others – 0.9%. A total of 1862 households were same which were interviewed in the previous survey.

On average, 1.1 women were interviewed per selected household. This report summarizes cross-sectional data collected from selected households of EAs, service delivery points that were reached out in this Phase of the survey, summarizing readiness to provide FP services and reproductive health services, and clients exiting facilities reflecting their experiences and satisfaction regarding services.

HOUSEHOLD CHARACTERISTICS AND BACKGROUND OF RESPONDENTS 2

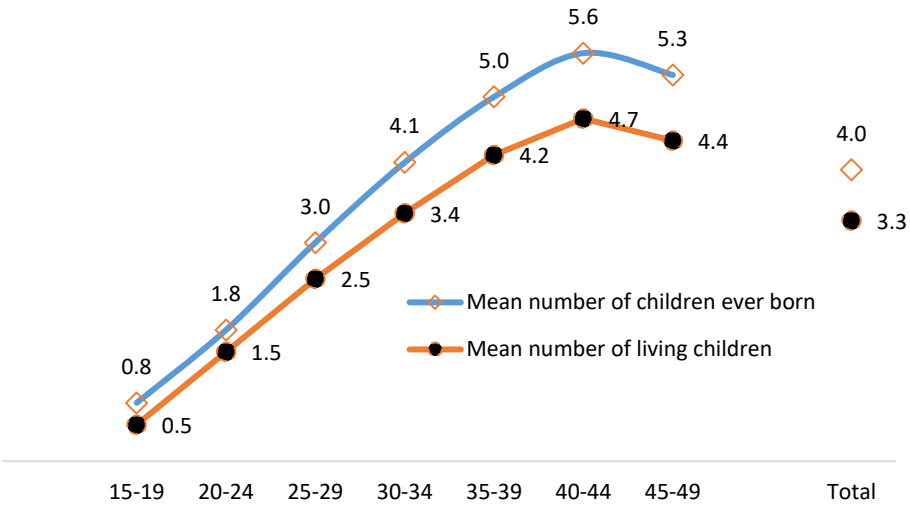
2.1 Profile of the Woman Respondents

The percent distribution of currently married women by age groups reflects a fair distribution of women interviewed in Sindh. Survey reflects Sindh population as youthful at household level - half of population is under age 18, while 62 percent are under age 25. Sixty-seven percent of households in rural Sindh sample fall in the two lowest wealth quintiles while 73 percent of urban household fall in upper two wealth quintiles.

There has been a modest rise in female-headed households. Female headed households were 4.5 percent in 2023 and increased to 5.2 percent in 2024. More than half (53%) women fall in urban sample. A very large proportion of women (58%) have not attended schooling while 28 percent respondents have completed Secondary or higher schooling.

Survey asked women regarding the number of children they have ever given birth to and number of children currently living (Figure 2.1). Age and number of births are closely associated variables, as age increases, mean numbers will rise. Women aged 15-19 have lowest percentage, with 0.8 percent children ever born and 0.5 percent living children, while those aged 40-44 exhibit the highest numbers, with 5.6 percent children ever born and 4.7 percent living children. Notably, there's a slight decline in the mean number of children ever born between the 45-49 age group, as well as the mean number of living children. The difference between the two indicators (ever born and living children) reflects loss of children to women.

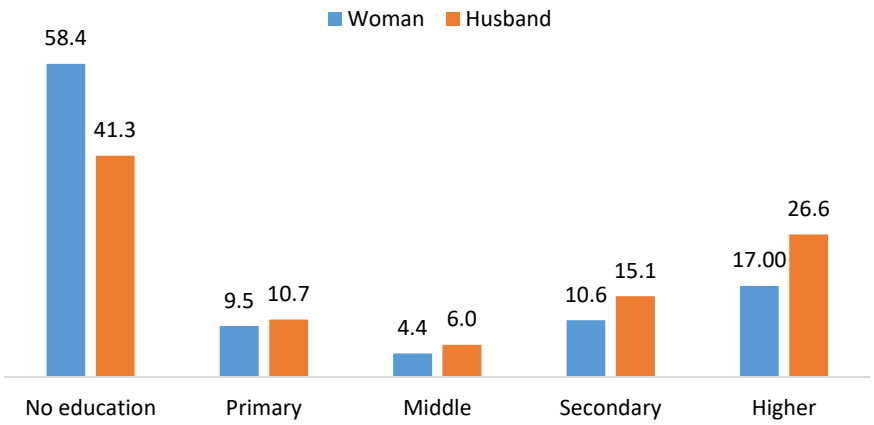
Figure 2.1 : Percent distribution of women by mean number of children ever born and living



Inequity in educational attainment exists among husbands and wives in Sindh. Figure 2.2 shows that educational attainment among women is lower than their husbands at each level of educational attainment. While 58% women had no education only 41% of their husband had no education. On

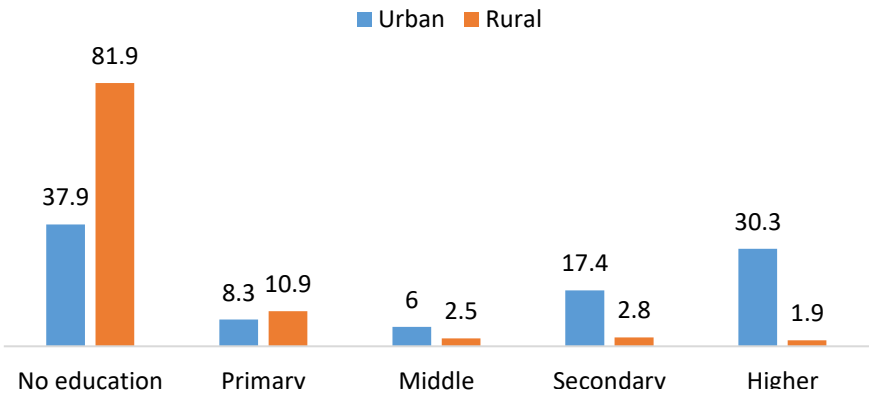
the other hand, extreme 17% of women have higher education whereas, almost 27% of the husbands have attained higher education.

Figure 2.2: Percent distribution of educational attainment of women and husband



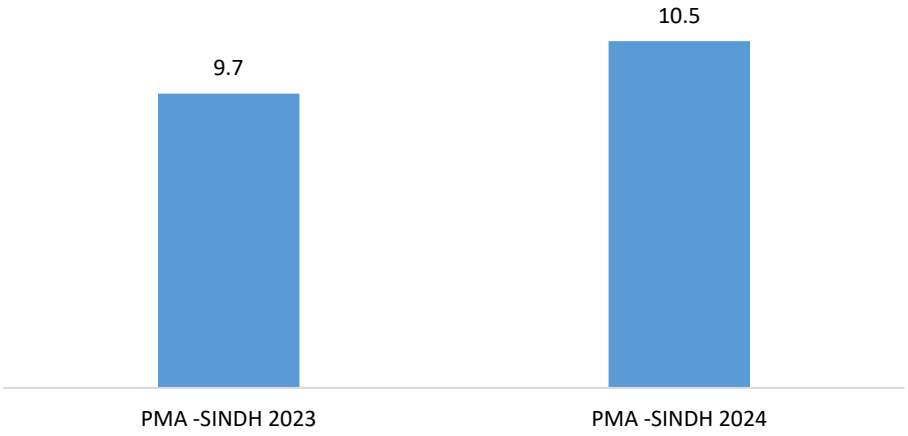
Women's educational attainment shows significant variation depending on their place of residence (Figure 2.3). In urban areas, more than a third of women (37.9%) have no formal education, while nearly a third (30.3%) have achieved higher education. In contrast, a majority of rural women (81.9%) lack formal education, with about 11 percent having completed primary education. This disparity in educational attainment has persisted over years and needs urgent attention and investment.

Figure 2.3: Percent distribution of currently married women by attainment of education



The percent of women who are currently pregnant increased slightly from 9.7% in 2023 to 10.5 % in 2024.

Figure 2.4: Trend of percent of women who are currently pregnant

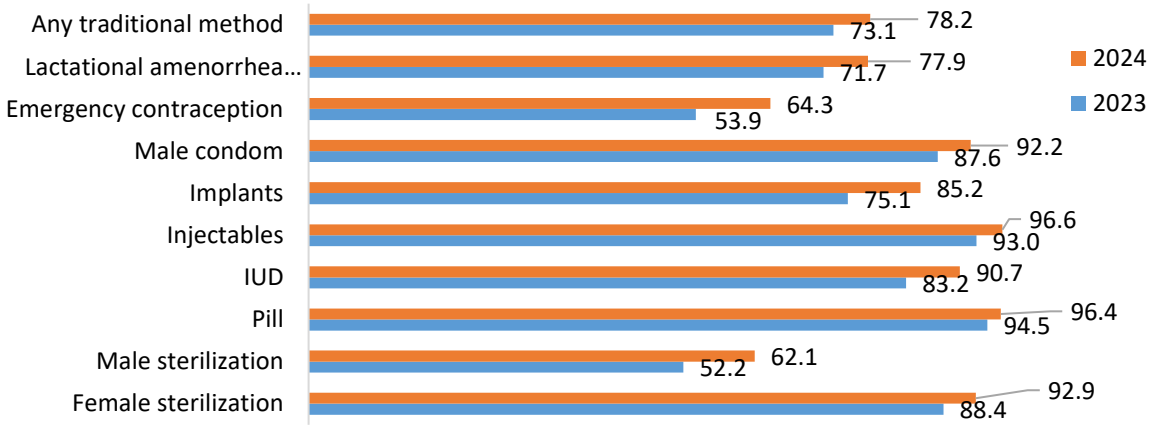


WOMEN'S KNOWLEDGE AND CONTRACEPTIVE USE 3

3.1 Knowledge of Family Planning Methods

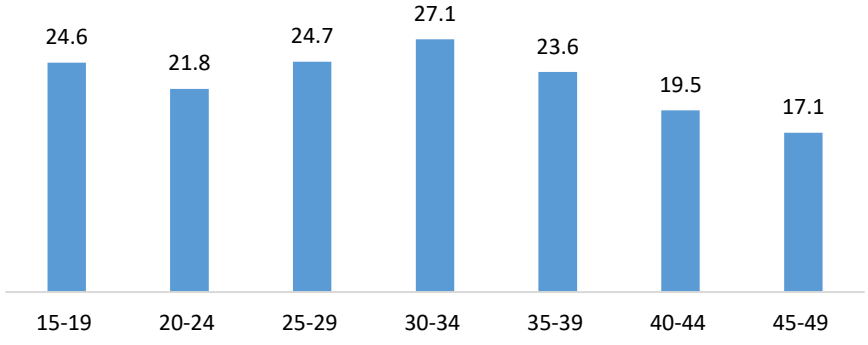
Surveys are keenly interested to learn the knowledge of various contraceptives among women and heard about it. Currently married women were also asked about their knowledge of different methods. Overall, almost all women reported hearing about one or more methods in 2024 survey (99%) (Figure 3.1). Moreover, results for 2024 survey show increase in percent women reporting knowledge of all methods. Seven points increase is noted among women for implants and IUCD, which reflects an outcome of field efforts (Figure 3.1). Emergency pills though not a contraceptive method, is known to almost two-thirds of all women (64%). The awareness for male sterilization too has jumped to 62 percent.

Figure 3.1: Trend of percentage of respondents who have heard of contraceptive methods



An important indicator of family planning relates to woman's knowledge of family planning concept and methods prior to woman's marriage. Knowledge of contraceptive methods before marriage peaks among women aged 30-34 (27.1%) and is low among older women ages between ages 40 to 49 years (Fig. 3.2). The finding shows that an increasing percent of women in their younger years have necessary knowledge regarding contraceptives before marriage as compared to women age beyond 35 years.

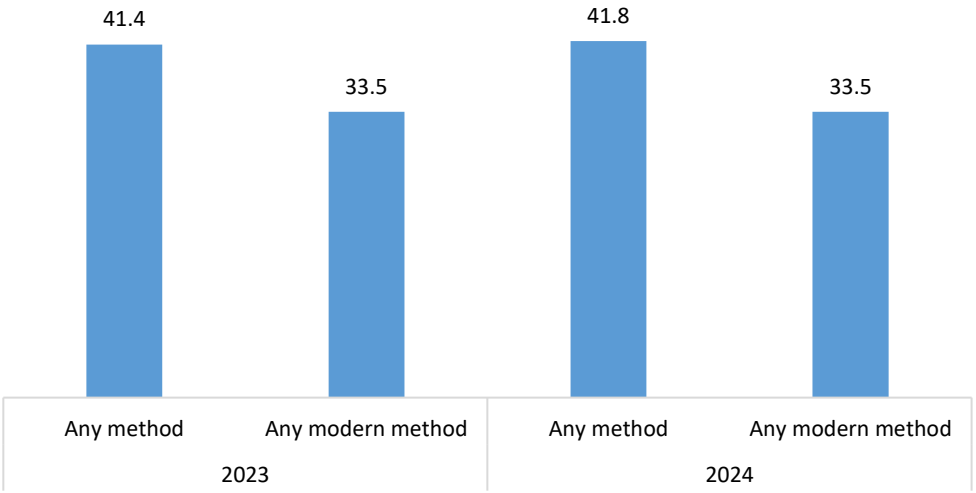
Figure 3.2 Percent of women who heard of any method before marriage by age groups



3.2 Family Planning Practices and Contraceptive Prevalence

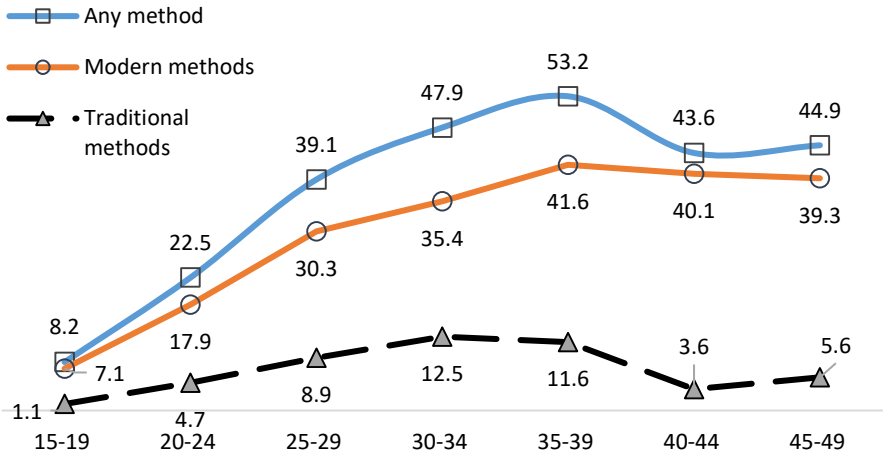
The PMA Sindh 2024 findings reveal that the Contraceptive Prevalence Rate (CPR) among currently married women is 41.8 percent, while the use of modern contraceptive method rate (mCPR) is 33.5 percent. There is hardly any change in the overall CPR in 2023 and 2024, while the same is reflected of modern methods for the two surveys (Figure 3.3). This underscores the need for effective interventions to increase the scope of family planning programme and use of modern contraceptive methods.

Figure 3.3: Trend of contraceptive use among married women (15-49)



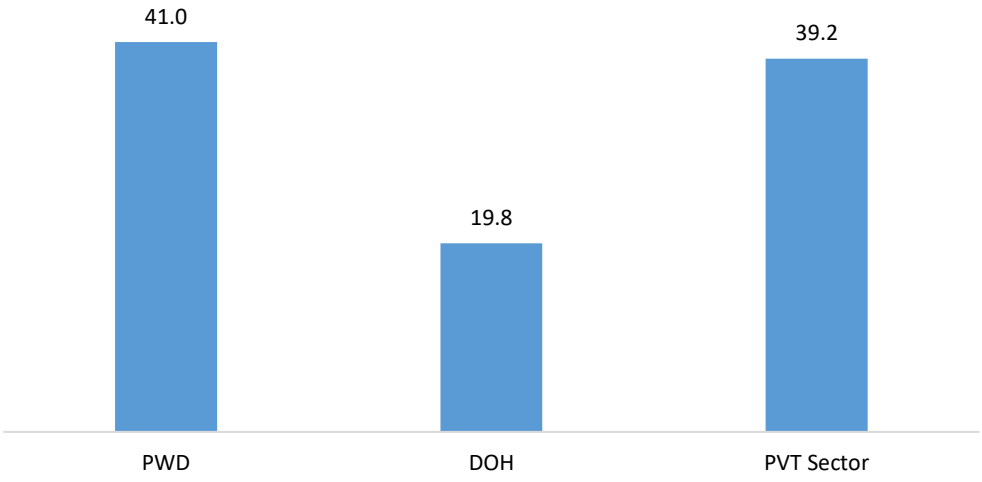
The percent distribution of women using any method increases as the age of the women increases, however, it declines for women of older age groups i.e. 40 to 49 years old. The use of modern methods shows a similar pattern whereby the percentage of women using modern methods increases as the age of women increases. The use of modern methods rises steadily from 18 percent for ages 20-24 to 42 percent for women in ages 35-39. It then gradually drops to 39 percent by ages 45-49. The use of traditional methods though remains low but rises from 5 percent (age group 20-24) to the highest-level 12.5 percent by ages 30-34 (Figure 3.4) and then declining to 6 percent. These changes reflect a need for innovative interventions to encourage women to adopt modern methods during their most fertile ages.

Figure 3.4: Percent distribution of currently married women who are using any method



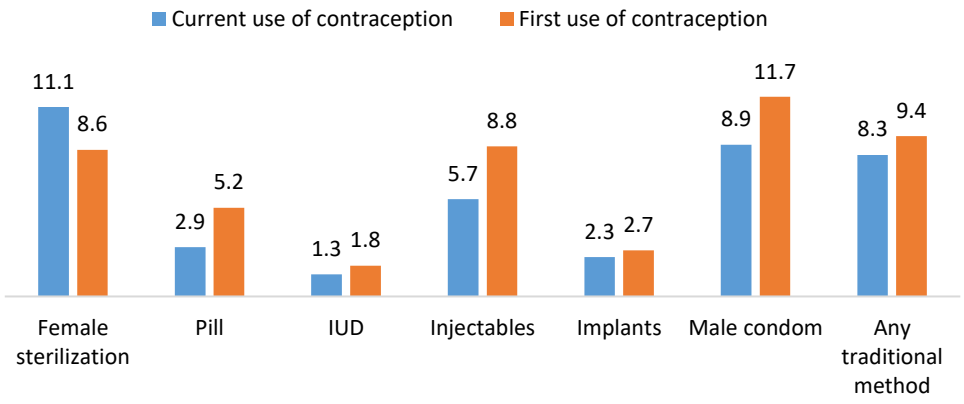
An interesting aspect of the survey is the enquiry of the source of acquiring the family planning services. Survey reveals that the PWD facilities are the most commonly utilized source of services for women, accounting for 41% of women accessing the services followed closely by private sector facilities (39%) (Figure 3.5). On the other hand, the facilities of Department of Health (DOH) which was expected to take a much larger and active role, emerged to be least popular source for family planning (FP) services among women, with only 20 % of women receiving FP services through these health facilities.

Figure 3.5: Percent women received modern contraceptives by source



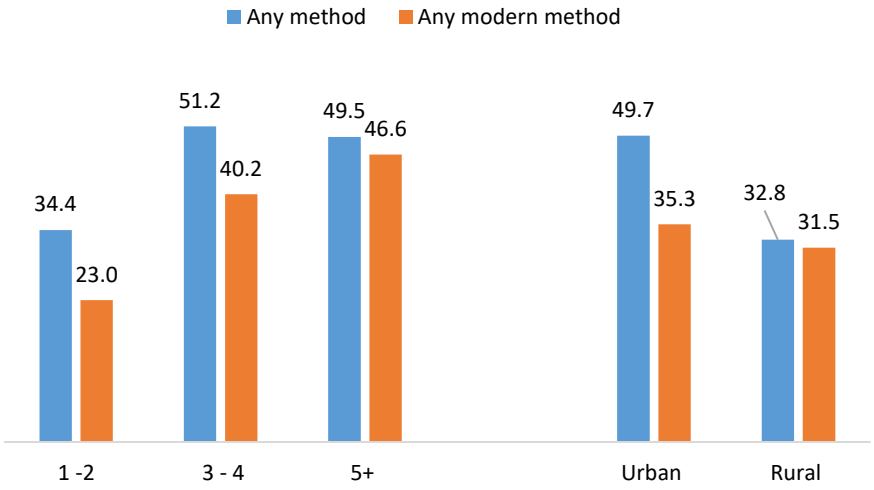
Respondents were asked regarding which family planning method they started to use first and their current in use. The survey reveals that male condoms were the most popular first method of contraception, followed by traditional methods (9.4%), injectables (8.8%), oral pills (5%) and implants (2.7%) – Figure 3.6. Review of current methods show that female sterilization is the most popular method (11.1%) followed by male condoms and traditional methods (8.9 and 8.3%). The large percent of women currently using traditional methods indicates the need for effective interventions incentivizing women and men to use of modern methods.

Figure 3.6: Contraceptive change status of current and first use of contraceptive methods



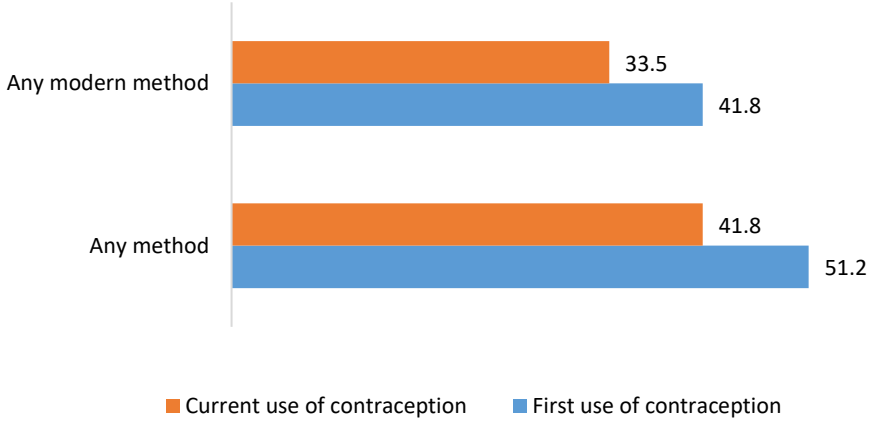
Examining contraceptive use by place of residence and number of living children are two critical areas of differential. Interesting to note that there is hardly any difference by urban and rural women for their use of modern methods - urban (35%) and rural (32%) (Figure 3.7) but significant difference is noted for use of any method reflecting much higher use of traditional methods by urban women in Sindh, where access to contraceptive services is easier than rural areas. In terms of number of living children, the percent women using contraception rises significantly high for women who have three or more children than women who have one to two children. The use of modern methods continues to rise especially among women with more than five children (47%). The low use of modern methods by low parity women needs attention and focus of future campaigns.

Figure 3.7: Contraceptive use by number of living children and place of residence



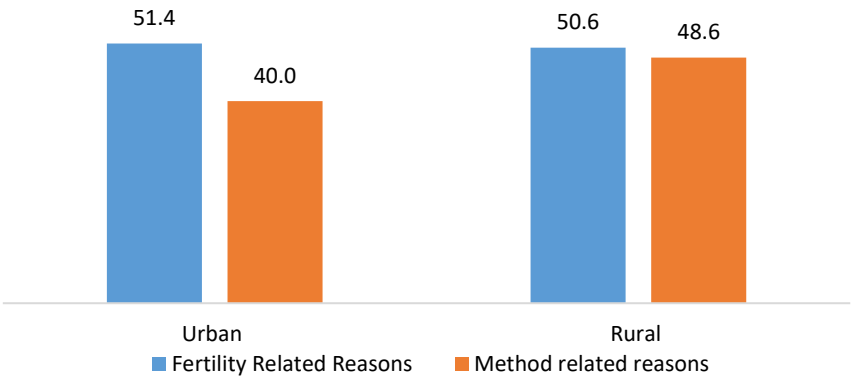
Discontinuation of contraceptive use is a serious issue in Pakistan. Discontinuation of contraception leads to not only rise in unmet need but also adds risk to unintended pregnancy, which in many cases face induced abortion. The survey reveals that more than half of all women (51%) used a family planning method (ever since they first started using). Survey reveals that almost 10 percent of women started to use traditional methods as their first method. A large portion (42 percent) of women started family planning by using a modern method but this percentage of women drops to 33.5 percent for current use of any modern method (Figure 3.8). The discontinuation of modern methods is a serious issue that surely need programmatic attention.

Figure 3.8: Comparing first and current use of contraceptive methods



Discontinuation of contraceptive methods by women who need protection against unintended pregnancies and desire to space or limit births is a serious issue. Survey enquired from women the reasons of their discontinuation which are lumped to evolve two broad categories – method specific reasons and fertility related reasons. Both the urban and rural women reflect quite high percent in favour of fertility related reasons to discontinue implying high demand for additional children. However, when it comes to method related discontinuation rural women were more likely to discontinue (48.6%) as compared to urban women (40%) (Figure 3.9). Lack of necessary information regarding side effects, fear of side effects and how to manage side effects are major reasons for method specific reasons for discontinuation.

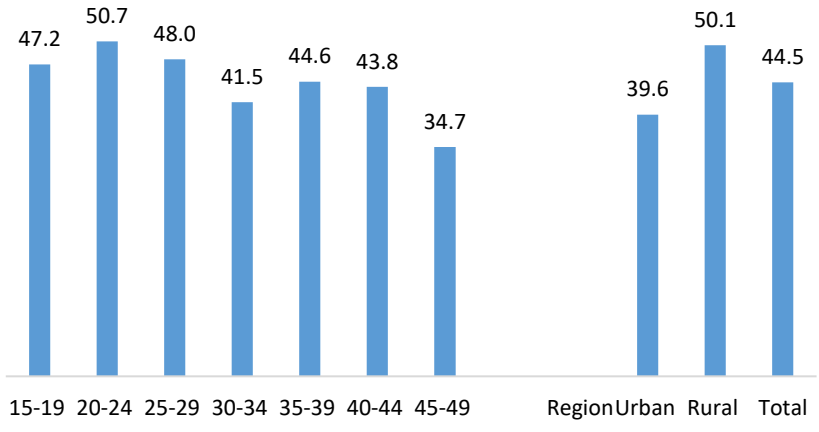
Figure 3.9: Percentage of women who reported reasons for discontinuing contraception



3.3 Assessing Performance of Community Based Workers and Facility Based Staff

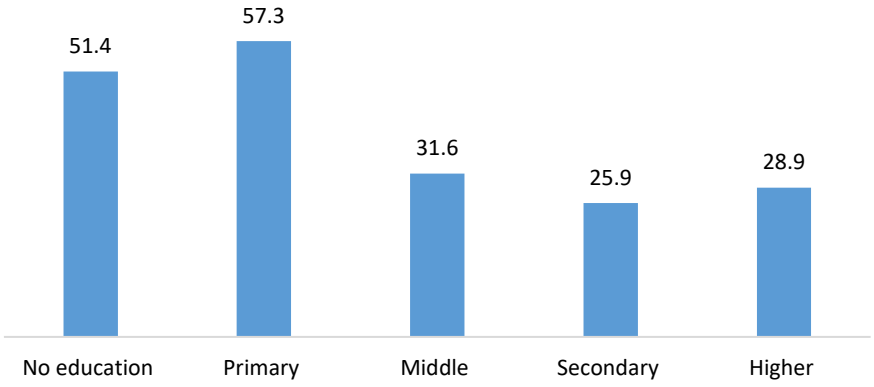
Close interaction and counselling of community workers is well recorded for enhanced and continuous use of contraception especially among rural women. LHWs are grassroots community-based workers are reported by women who have contracted them to inform about primary healthcare including FP. Women were asked regarding visit by Lady Health Worker to provide information and services for family planning and maternal health. Surveys results show that currently married women between the ages of 20 and 29 years reported most frequent visits by LHWs (Figure 3.10). The percentage of LHW visits declines for ages 30 and above implying older women are less frequently visited by LHWs. This is understandable considering the LHWs attend younger women to encourage them use contraception for birth spacing. Older women also need the same of attention to ensure they continue use contraception to limit births as they age. LHWs programme has a rural focus which is reflected by much higher percentage of rural women reporting visit by LHWs than their urban counterparts.

Figure 3.10: Percent distribution of women who were visited by LHW by woman's age and place of residence



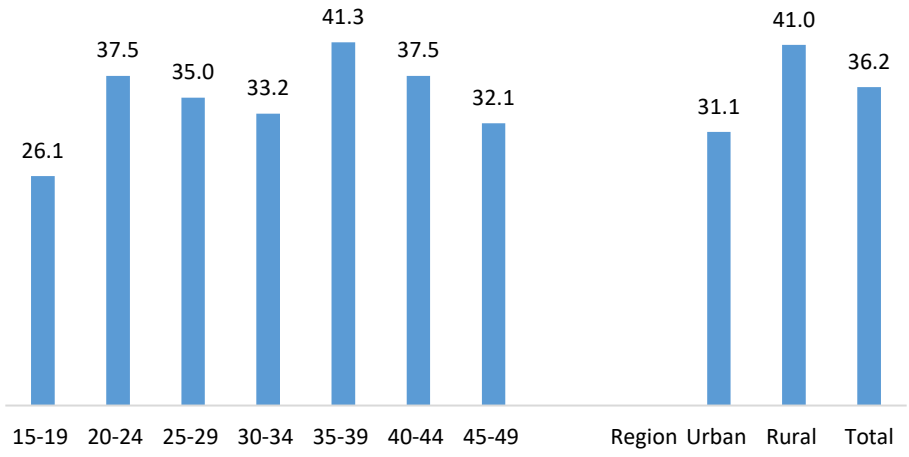
The survey reveals that women who were most frequently visited by LHWs were either uneducated (51.4%) or had received low education i.e. primary level education (57.3%). Women with secondary and higher education were least likely to be visited by LHWs (Fig. 3.11). One of the reasons for such pattern may be that women with higher educational attainment have other sources of seeking counselling regarding FP. Survey results in terms of mCPR reveals that women visited by LHWs have a little higher (36 percent) relative to women who didn't report visit of LHWs (31 percent in 2024). This is a serious flaw to be noted by the programme managers.

Figure 3.11: Percentage distribution of women who visit by LHW by woman's educational attainment



An important source of seeking information regarding FP is health facilities. Survey asked women respondents who visited a health facility whether the staff talked to them regarding FP. Survey reveals that women aged 35 to 39 years, reported the highest percentage (41.3) of visiting a health facility and staff talked about the FP (Figure 3.12). Women aged 20 to 24 years and 40 to 44 years reported the second highest percentage (37.5%) of staff talked to about FP. Least percentage of FP counselling (26.1%) is reported by women in the youngest age group i.e. 15 to 19 years.

Figure 3.12: Percentage of women who visited health facility in last 12 months and staff spoke about FP method

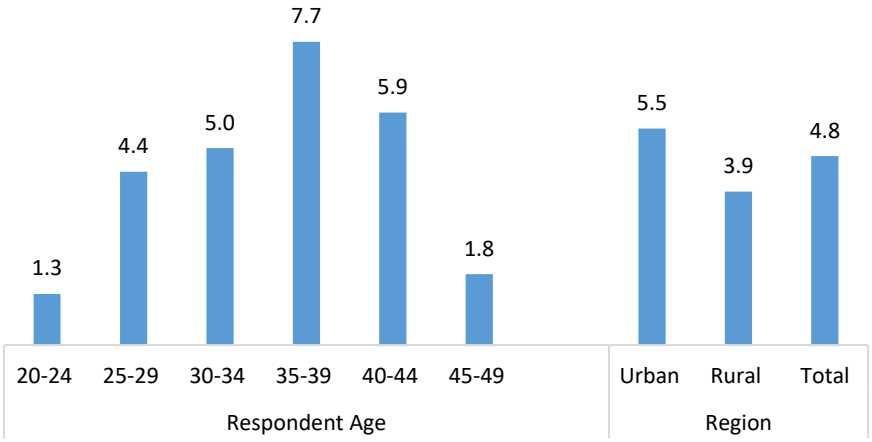


Rural women reported higher percentage of counselling by health staff about FP while visiting health facilities (41%) as compared to urban women (31%). Analysis of contraceptive use among women who visited health facility and asked for FP counseling reveals actionable results. Use of modern contraceptive rate is noted to be 42 percent for women who sought FP

counseling from a health facility workers and 30 percent for those who did not. This is a remarkable finding to strengthen functional integration.

Survey also enquired from women whether they experienced any unintended pregnancy. Less than five percent women acknowledged the same (Figure 3.13). Almost five percent women (4.8%) reported experiencing unintended pregnancy over their lifetime. The highest percent of unintended pregnancies (7.7%) were reported by women aged 35 to 39 years, followed by women aged 40-44 years (5.9%). The low percent of women reporting unintended pregnancies (1.3%) were reported by women aged less than 24 years and those above 44. Close to 60 percent unintended pregnancies occur to women between ages 25 and 34. This raises serious concerns about addressing the unmet need for contraception. Urban women report higher percentage of unintended pregnancies (5.5%) as compared to rural women (3.9%).

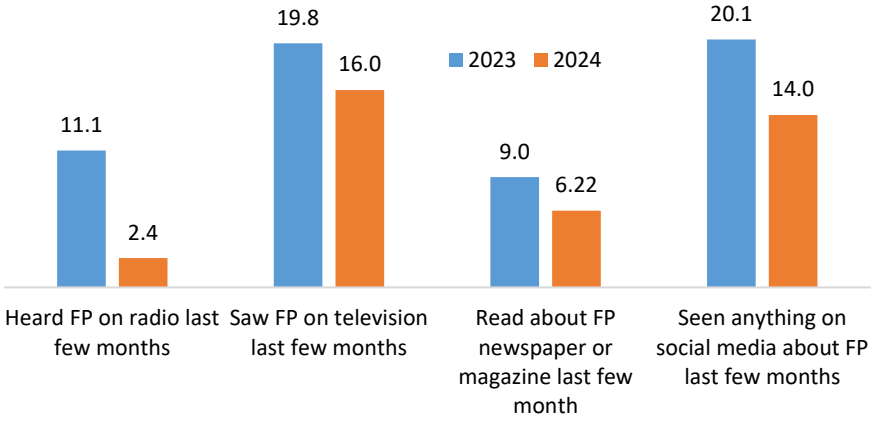
Figure 3.13: Percentage of women who experienced an unintended pregnancy by age of women



3.4 Communication Regarding Family Planning

Women were asked whether they heard about family planning in the previous few months on one or more media. Overall results reveal a downward trend in all sources of information regarding family planning. Television remains the main source of information regarding family planning declined from 20 percent to 16 percent women affirmed (Figure 3.14). Social media too was reported by 20 percent women in 2023 which has declined to 14 percent in 2024. Radio and print media including newspaper are now not as popular as these used to be over the past. These are important changes to be noted by Programme managers responsible for communication.

Figure 3.14: Percent of women who reported about their source of FP information

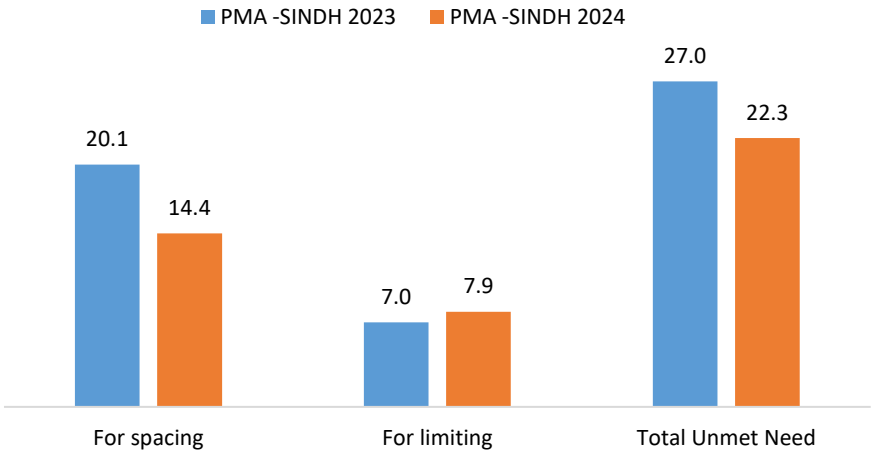


3.5 Purpose of Use and Unmet Need for Family Planning

Birth spacing has been a key strategy in Sindh to lower overall fertility rates. This aspect is assessed by asking women regarding the purpose of contraceptive use and also estimating unmet need for family planning. The unmet need which reflects fecund women desiring to space or limit births but not using any family planning method to achieve their desired objective. Secondly, women who are currently pregnant, but their pregnancy is considered mistimed or unwanted. Thirdly, women who experiencing postpartum amenorrhea, whose most recent birth within the last two years was deemed mistimed or unwanted/unintended.

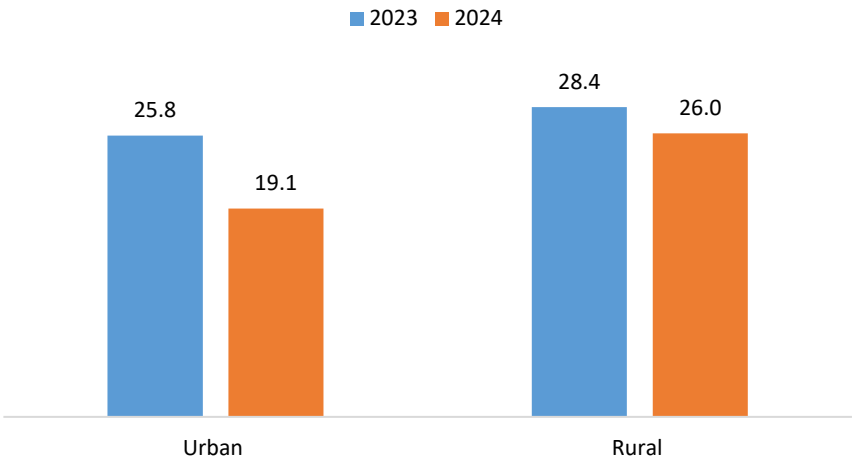
The unmet need for contraception according to PMA 2024 survey shows 22 percent of married women fall in the classification (Figure 3.15). PMA Sindh survey 2024 reveals a substantial proportion unmet need for spacing (14 percent), and a smaller proportion (only 8 percent) for limiting (Figure 3.15). Such patterns are expected – meaning with increased awareness and knowledge, women openly express their desire to space births learning the benefits of birth spacing. When compared with previous year's results six points decline in unmet need for birth spacing and one point increase in unmet need for birth limiting resulting in overall decline of 5 point. Better and improved

Figure 3.15: Trend of percentage of women with unmet need for family planning



access to family planning services are critical element related to decline in overall unmet need for family planning.

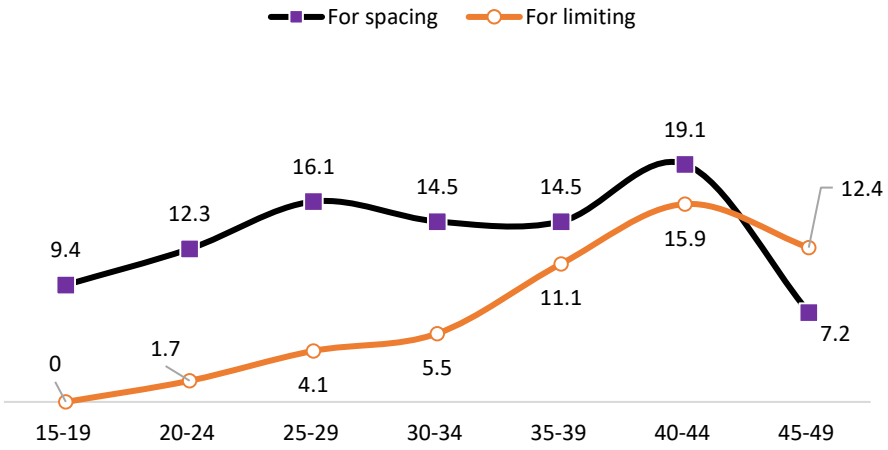
Figure 3.16: Trend of percentage of women with unmet need for family planning by place of residence



Trend analysis of unmet need for family planning reflects decline in both urban and rural areas in 2024 relative to 2023 results (Fig 3.16) but more in urban (6%) than in rural areas (2%). A bit higher unmet need for contraception among rural women reflects issues of access and need of proper counseling to educated rural women.

The survey reveals women in Sindh are eager to space births right from young ages (15-19 to 40-44) rising from 9 percent to 19 percent over these age groups (Figure 3.17). Unmet need for limiting births though low rapidly rises after age 30 and reaches almost 16 percent. Women's desire to space their births reflects a broader intention to use contraception, which may not always be accessible.

Figure 3.17: Percentage of women with unmet need for family planning by age of women

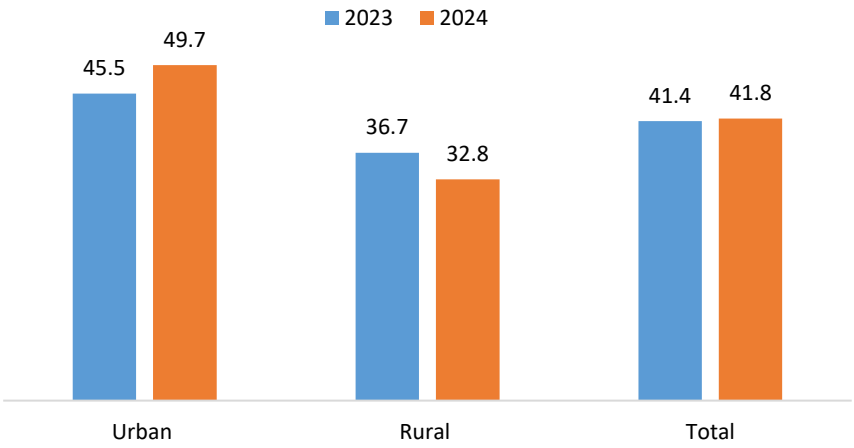


3.6 Contraceptive use for Spacing and Limiting Birth

According to the PMA Sindh 2023 and 2024 survey results, contraceptive use though remained unchanged over the two years but varied between urban and rural areas. Use of contraception reached almost 50 percent among urban women while slightly declined among rural women (33%)

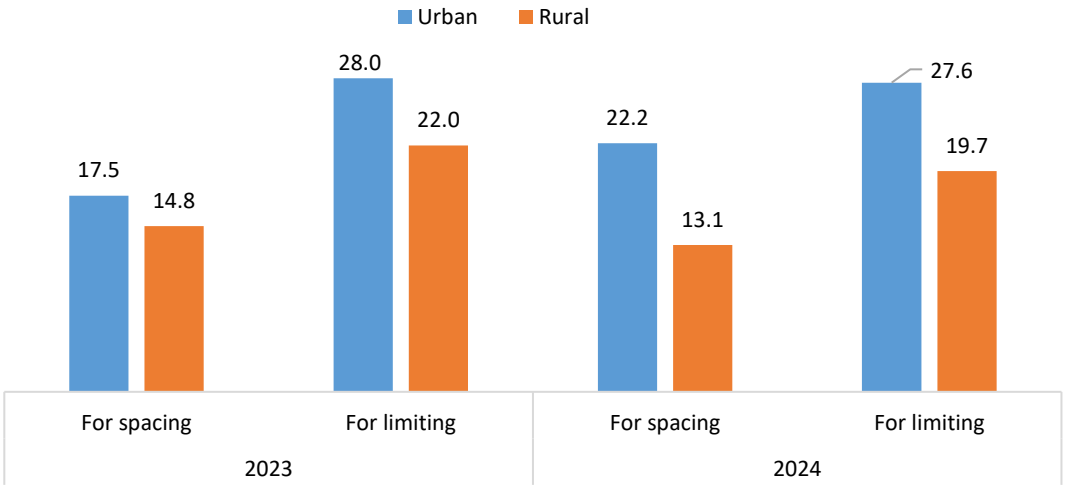
(Figure 3.18). It is interesting to note that improved access in urban areas may have led to enhance women use of contraception and on the contrary lower percentage use among rural women.

Figure 3.18: Trend of percentage of women using family planning by place of resdience



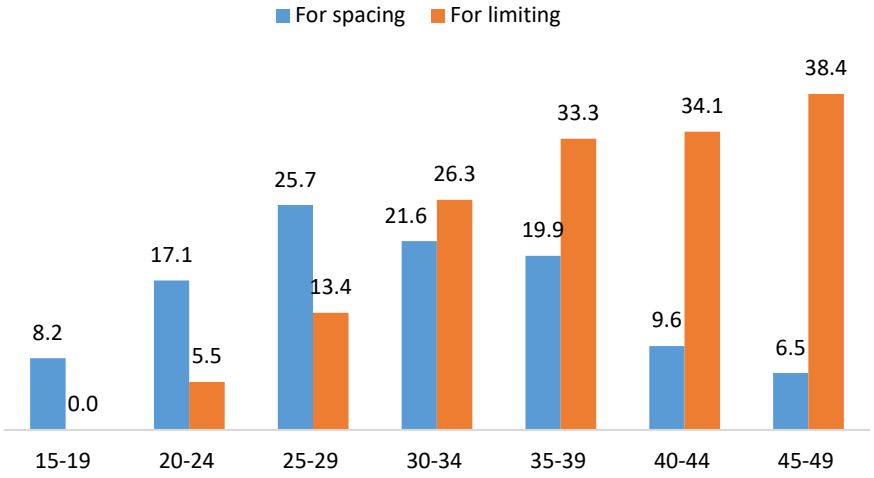
Trend of Use of family planning reflected by both surveys presents an increase of almost 5 percent among urban women for birth spacing and a simultaneous decline about 2 percent for limiting birth among rural women (Fig 3.19). The shift towards birth spacing is a positive behavioural sign among urban women who desire to space pregnancies using contraceptives.

Fig 3.19: Trend of percentage of use of family planning for spacing or limiting births



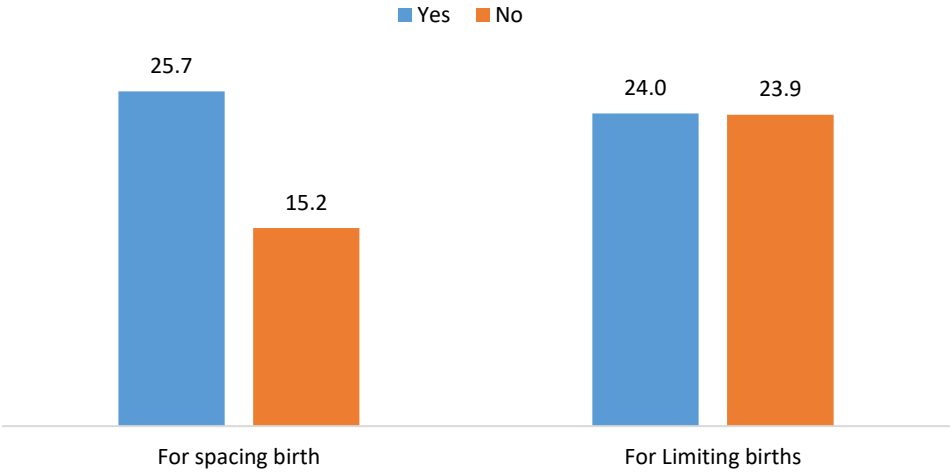
Based on responses from women respondents an assessment is made to see the purpose of use of family planning. The aim is to see whether women use contraception for birth spacing or limiting. Results show quite clearly that younger women age less than 30 use family planning for birth spacing while women above age 30 prefer using contraception for birth limiting rising from 26 percent (age 30-34) to 38 percent (age 45-49) – Figure 3.20. The percentage of women with met need for limiting births increases with the age. However, met need for birth spacing rapidly declines for women in ages beyond 39 years.

Figure 3.20: Percentage of women with met need for spacing or limiting births by age groups



The counselling and encouraging use of birth spacing and limiting methods by facility staff is an important determinant of effective use of contraception. Survey asked women whether they were counseled regarding contraception by health facility staff. Analysis reveals that women use of contraception is significantly higher (25.7 percent) for birth spacing when facility staff talked about contraception (Figure 3.21) relative to those women who were not talked about FP by health staff (15.2%). This is in contrast to women using contraception for birth limiting where health staff talked or not the use rate shows hardly any difference (24 percent).

Figure 3.21: Percentage of women use of contraception for spacing or limiting births when examined by facility staff speak about FP method



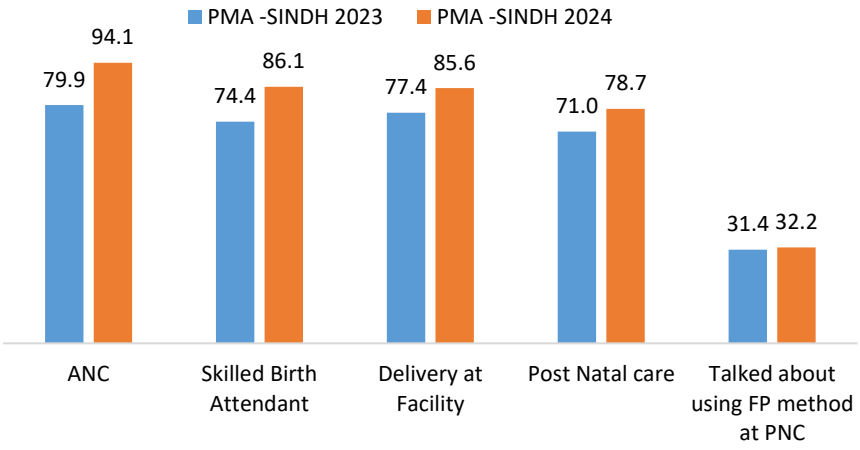
3.7 Maternal Health Indicators

Healthcare services during pregnancy, childbirth, and the postpartum period are crucial for ensuring the survival and well-being of both mother and infant. In April 2005, Pakistan introduced a comprehensive National Maternal, Neonatal, and Child Health (MNCH) Strategic Framework, followed by the launch of the National MNCH Programme in 2007 to accelerate progress toward achieving MDG 4 and 5. This framework outlines the vision and guidelines for developing MNCH

interventions. Key focus areas include promoting institutional deliveries, skilled birth attendance, and expanding primary healthcare services through Community Midwives (CMWs) and Lady Health Workers (LHWs), especially in rural areas via home visits. CMWs provide skilled birth attendance and antenatal care (ANC) at the community level, while LHWs directly contribute to improving maternal and child health by promoting personal hygiene, increasing contraceptive use, administering antenatal care, providing iron and folic acid supplements during pregnancy, monitoring child growth, and offering vaccination counseling for mothers and children.

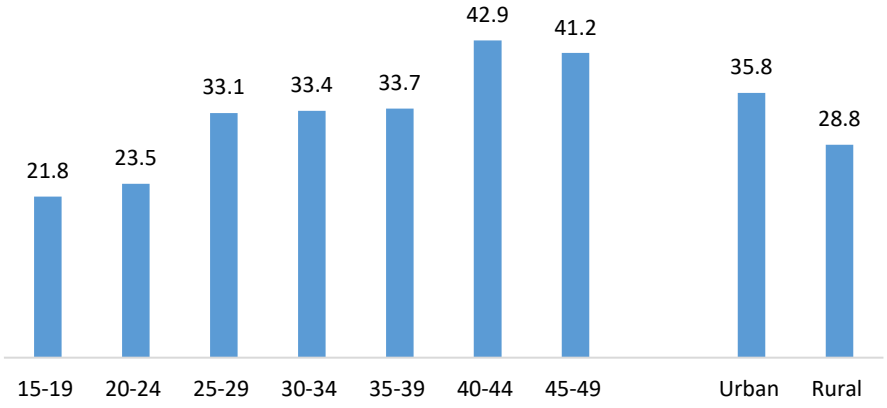
Several maternal health indicators are measured in the PMA 2024 to observe any improvement over time. Women were asked about ANC, skilled birth attendance, place of delivery and post natal checkup. These indicators are compared over time (comparing 2023 and 2024 results). The most significant improvement is observed for ante natal care (ANC), where 79.9 percentage women were reported receiving ANC services in 2023, which increased to 94.1 percent in 2024 (Figure 3.22). Improvement is also noted for skilled birth attendance, facility based delivery, and post natal care but estimated changes are not significant. One of the key indicators that can bring real change in family planning is the FP counseling by facility staff at PNC. Comparison over two surveys reveal hardly any change in percent women receiving counseling by facility staff re FP at the post-natal care (PNC) stage.

Figure 3.22: Trend of percent women reporting maternal health indicators



Respondents were asked about the healthcare provider's talk about FP during PNC and analyzed for age of respondent and place of residence. Results show a huge differential between younger women (age less than 25) and older women (age 40 and above). Almost 20 percentage points between these age groups identify issue that need attention (Figure 3.23). Younger women need more attention and advice regarding contraceptives to help them space births and address their reproductive needs. Urban women are more likely to talk to facility staff about FP (35.8%) relative to rural women (28.8%). This differential also identified areas of programmatic intervention so that rural women get same attention and advice as their urban counterparts.

Figure 3.23: Percent women who recieving information or healthcare provider talk about FP during PNC visit for the last birth by age and residence



MENTAL HEALTH 4

Mental health is a critical aspect of overall well-being, and its importance cannot be overstated, especially for married women in Sindh, where cultural, social, and economic factors often aggravate mental health challenges. Mental health is integral to physical health, emotional stability, and social functioning. Poor mental health can lead to chronic physical conditions, reduced productivity, and impaired relationships. Mental health problems can lead to social isolation, stigma, and discrimination, further worsening the individual's condition. Poor maternal mental health can negatively impact children's development, leading to long-term consequences for future generations.

Married women in Sindh often face societal expectations related to marriage, childbearing, and household responsibilities, which can lead to stress, anxiety, and depression. Many women in Sindh have limited decision-making power, which can contribute to feelings of helplessness and low self-esteem. High rates of domestic violence in the region can lead to trauma, anxiety, and depression among married women. Issues like unintended pregnancies, lack of access to family planning, and postpartum depression can significantly impact mental health. Stigma surrounding mental health prevents many women from seeking help, while limited access to mental health services further compounds the problem.

To assess symptoms of anxiety, the Mental Health Module includes the Generalized Anxiety Disorder 7 scale (GAD-7), a series of seven items designed to measure the main feature of anxiety: persistent and impairing worry. The GAD-7 captures characteristics of three other common anxiety disorders: panic disorder, social anxiety disorder, and posttraumatic stress disorder. Anxiety is a feeling of worry, nervousness, or unease about something with an uncertain outcome. It becomes a mental health disorder when it is excessive, persistent, and interferes with daily functioning. Furthermore, to assess symptoms of depression, the module includes nine items from the Patient Health Questionnaire, or PHQ-9. Stress is often inferred from symptoms like trouble relaxing, feeling nervous, or worrying too much. The questions in the PHQ-9 are based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for diagnosis of depression. Both scales focus on symptoms experienced in the 2 weeks preceding the survey. Severity of symptoms for both tools is depicted using a Likert scale in which scores of 0, 1, 2, and 3 are assigned to the response categories "not at all" (never), "several days" (rarely), "more than half the days" (often), and "nearly every day" (always), respectively. A total score is generated by adding together the scores of individual items. One of the key elements in implementing the Mental Health Module was the effort to use a set of translated questionnaires for the GAD-7 and PHQ-9 in the local languages.

The distribution of responses to each individual item in the GAD-7[1] is given in Table 4.1: (a) feeling nervous, anxious, or on edge; (b) not being able to stop or control worrying; (c) worrying too much about different things; (d) trouble relaxing; (e) being so restless that it is hard to sit still;

[1] GAD-7 scores range from a minimum of 0 to a maximum of 21. Higher scores are associated with more severe symptoms of anxiety.

(f) becoming easily annoyed or irritable; and (g) feeling afraid as if something awful might happen.

Prevalence of anxiety symptoms: A significant proportion of women reported experiencing anxiety symptoms often or always: (i) "Worrying too much about different things" (38.0% rarely, and 20.1% often/ always); (ii) "Feeling nervous, anxious, or on edge" (47.8% rarely, and 12.1% often/ always); and (iii) "Not being able to stop or control worrying" (33.5 rarely and 10.2 often/always). These findings suggest that anxiety is a notable mental health concern among women in this population.

Protective factors: The relatively low prevalence of symptoms like "Being so restless that it is hard to sit still" and "Feeling afraid as if something awful might happen" suggests that some women may have coping mechanisms or social support systems in place. In conservative or patriarchal settings, women may face stressors such as limited autonomy, domestic responsibilities, or gender-based violence, contributing to anxiety. Furthermore, limited access to mental health care may prevent women from seeking help.

Table 4.1 Symptoms of anxiety

Percent distributions of women by frequency of symptoms of anxiety in the 2 weeks preceding the survey, according to specific symptoms included in the Generalized Anxiety Disorder 7 (GAD-7) scale

Symptom of anxiety	Never	Rarely	Often	Always	Refuse	Don't Know	Total	Number of women
Feeling nervous, anxious or on edge	40.1	47.8	9.7	2.4	0.0	0.0	100.0	2,699
Not being able to stop or control worrying	55.9	33.5	9.0	1.2	0.2	0.1	100.0	2,699
Worrying too much about different things	41.9	38.0	17.2	2.9	0.1	0.0	100.0	2,699
Trouble relaxing	60.5	29.3	7.2	2.8	0.1	0.1	100.0	2,699
Being so restless that it is hard to sit still	73.7	21.6	3.4	1.1	0.2	0.0	100.0	2,699
Becoming easily annoyed or irritable	59.4	30.9	7.7	1.8	0.2	0.0	100.0	2,699
Feeling afraid as if something awful might happen	73.5	20.3	4.5	1.2	0.4	0.0	100.0	2,699

4.1 Severity of Symptoms of Anxiety

The percent distribution of women aged 15–49 by their Generalized Anxiety Disorder 7 (GAD-7) scores presented in Table 4.2, gives a measure the severity of anxiety symptoms and it shows the percentage of women with symptoms of anxiety (GAD-7 score ≥6) across various background characteristics.

General observation regarding Anxiety Severity which is reflected by the percentage with Symptoms of Anxiety (GAD-7 ≥6) shows that 29.5% of women interviewed in Sindh have symptoms of anxiety. Women with GAD-7 score distribution of 15–21 (severe anxiety) are 1.1 percent. Less than a third of all women have symptoms of anxiety (GAD-7 ≥6), indicating a moderate level of mental health burden. The survey data reveals that anxiety is an important mental health concern among women in Sindh.

Table 4.2 Severity of symptoms of anxiety

Percent distribution of women by their Generalized Anxiety Disorder 7 (GAD-7) score and percentage with symptoms of anxiety, according to background characteristics

Background characteristic	GAD-7 Score 0-5	6-14	15-21	Total	Percentage with symptoms of anxiety[5]	Number of women
Respondent Age						
15-19	78.8	21.2	0.0	100.0	21.2	75
20-24	76.7	22.5	0.8	100.0	23.3	355
25-29	70.5	27.0	2.5	100.0	29.5	538
30-34	71.2	27.3	1.5	100.0	28.8	556
35-39	71.6	27.4	1.1	100.0	28.4	525
40-44	64.3	35.7	0.0	100.0	35.7	413
45-49	65.4	34.6	0.0	100.0	34.6	238
Number of living children						
0	80.8	19.2	0.0	100.0	19.2	185
1-2	76.7	22.8	0.6	100.0	23.3	869
3-4	70.9	27.2	1.9	100.0	29.1	950
5+	59.5	39.4	1.1	100.0	40.5	695
Region						
Urban	76.0	22.9	1.0	100.0	24.0	1,441
Rural	64.2	34.6	1.2	100.0	35.8	1,258
Respondent's Education						
No education	65.2	33.5	1.3	100.0	34.8	1,577
Primary[1]	62.7	33.5	3.7	100.0	37.3	257
Middle[2]	82.7	17.3	0.0	100.0	17.3	119
Secondary[3]	75.4	24.6	0.0	100.0	24.6	286
Higher[4]	87.0	13.0	0.0	100.0	13.0	460
Employment status						
Currently employed	67.1	31.3	1.6	100.0	32.9	503
Not currently employed	71.3	27.7	1.0	100.0	28.7	2,197
Any spousal violence (physical or sexual or emotional) in last 12 months						
Yes	45.6	52.2	2.2	100.0	54.4	550
No	77.5	21.5	1.0	100.0	22.5	1,722
Privacy not obtained/Women not selected	74.5	25.3	0.2	100.0	25.5	427
Any spousal violence (physical or sexual or emotional) ever						
Yes	48.9	48.9	2.3	100.0	51.1	673
No	78.5	20.6	0.9	100.0	21.5	1,599
Privacy not obtained/Women not selected	74.5	25.3	0.2	100.0	25.5	427
Wealth Index						
Lowest	62.1	35.5	2.4	100.0	37.9	512
Second	65.9	33.2	0.8	100.0	34.1	507
Middle	58.9	40.0	1.1	100.0	41.1	523
Fourth	77.4	21.1	1.5	100.0	22.6	560
Highest	85.3	14.7	0.0	100.0	14.7	598
Total	**70.5**	**28.4**	**1.1**	**100.0**	**29.5**	**2,699**

[1] Primary refers to classes 1-5
[2] Middle refers to classes 6-8
[3] Secondary refers to classes 9-10
[4] Higher refers to class 11 and above
[5] Respondents with a GAD-7 score of 6 or higher

4.2 Patterns by Background Characteristics

Age-specific pattern: Percentage of women with symptoms of anxiety the highest prevalence is in the 40–34 age group (35.7%) and the lowest prevalence was in the 15–19 age group (21.2%).

Anxiety severity increases with age (21.2% of 15-19-year-olds vs. 35.7% of 40-44-year-olds show symptoms). Older women (40–44) have higher percentages of mild to moderate anxiety (GAD-7 6–14) while younger women (15-24) have higher percentages of minimal anxiety (GAD-7 0–5). Older women (e.g., 40 +) are more likely to experience anxiety, possibly due to increased responsibilities (e.g., childcare, financial stress).

Number of living children: Women with high parity (5+) have the highest prevalence of anxiety symptoms (39.4%) as against low parity women (with 1–2 children) who have the lowest prevalence of anxiety symptoms (22.8%). Women with 5+ children have the highest prevalence of anxiety, likely due to the physical, emotional, and financial strain of raising a large family.

Education level: Women with no education or primary level have the highest prevalence of anxiety symptoms (33.5%) it basically reflects the protective role of education in mental health.

Employment status: Currently employed women have higher prevalence of anxiety symptoms (31.1%) relative to unemployed women (27.7%). Employed women had higher anxiety rates, possibly due to workplace stress or the dual burden of work and household responsibilities.

Anxiety and spousal violence (Last 12 months): Women who experienced any form of spousal violence in the last 12 months have significantly higher anxiety symptoms (54.4%) compared to those who did not (22.5%). The proportion of women with moderate (GAD-7: 6-14) or severe anxiety (GAD-7: 15-21) is much higher among those who faced violence (52.2% + 2.2% = 54.4%) than those who did not (21.5% + 1.0%). The results suggest a strong association between spousal violence and anxiety symptoms, reinforcing the mental health burden of husband's violence.

Anxiety and spousal violence (Ever experienced): The pattern is similar when considering lifetime exposure to violence. Women who ever experienced spousal violence report anxiety symptoms at a higher rate (50.2%) compared to those who never experienced it (21.5%). The severity of symptoms remains notably higher among those who faced violence, with nearly 55% falling in the moderate anxiety category. The results suggest that even past exposure to violence has long-term mental health consequences.

4.3 Severity of Symptoms of Depression

The elements covered in the Patient Health Questionnaire (PHQ-9)2 include: (a) little interest or pleasure in doing things; (b) feeling down, depressed, or hopeless; (c) trouble falling asleep or staying asleep or sleeping too much; (d) feeling tired or having little energy; (e) poor appetite or overeating; (f) feeling bad about yourself or that you are a failure or have let yourself or your family down; (g) trouble concentrating on things such as reading the newspaper or watching television; (h) moving or speaking so slowly that other people could have noticed or the opposite (being so fidgety or restless that you have been moving around a lot more than usual); and (i) thoughts that you would be better off dead or of hurting yourself in some way. The PHQ-9 is a reliable and valid measure of depression severity. The PHQ-9 is a widely used tool to assess

[2] PHQ-9 scores range from a minimum of 0 to a maximum of 27. Higher scores are associated with more severe symptoms of depression. A PHQ-9 score of 0–4 is considered minimal symptoms or no symptoms, while a score of 5–9 is considered mild, 10–14 is considered moderate, 15–19 is considered moderately severe, and 20–27 is considered severe.

depression severity, and the symptoms listed in Table 4.3 are key indicators of depressive disorders. Detailed distribution of each element of PHQ-9 can be seen in Table 4.3.

Overall Prevalence of Depression Symptoms: Three elements are noted as most common symptoms. (i) “Feeling tired or having little energy" (21.9% often, 6.2% always); (ii) "Feeling down, depressed, or hopeless" (12.7% often, 2.1% always); and (iii) "Trouble falling asleep, staying asleep, or sleeping too much" (12.2% often, 2.4% always).

High Prevalence of Depression Symptoms: A significant proportion of women reported experiencing depression symptoms often or always: "Feeling tired or having little energy" (28.1% combined often/always); and "Feeling down, depressed, or hopeless" (14.8% combined often/always); and "Trouble sleeping" (14.6% combined often/always). These findings suggest that depression is a notable mental health concern among women in Sindh (Table 4.3).

Following key symptoms are noted based on results: (i) Fatigue and Low Energy is the most commonly reported symptom, indicating that many women may be experiencing physical and emotional exhaustion; (ii) Sleep Disturbances implies trouble sleeping is a significant issue, which can aggravate other depression symptoms; and (iii) Low Self-Esteem and Suicidal Thoughts are less common, these symptoms are critical to address due to their severe implications.

4.4 Patterns by Background Characteristics

Overall depression prevalence: One in four women (10.2%) in Sindh shows symptoms of depression (PHQ-9 score ≥10), while 8.5% experience moderate depression, 1.5% have moderately severe depression, and 0.2% suffer from severe depression. These results indicate that depression is an issue among women in Sindh, likely exacerbated by social, economic, and gender-based challenges.

Table 4.3 Severity of symptoms of depression

Percent distribution of women age 15-49 by their Patient Health Questionnaire (PHQ-9) score and percentage with symptoms of depression, according to background characteristics, Sindh Longitudinal Panel Study, 2024

	PHQ-9 Score							
Background characteristic	0-4	5-9	10-14	15-19	20-27	Total	Percentage with symptoms of depression[5]	Number of women
Respondent Age								
15-19	67.0	25.7	7.3	0.0	0.0	100.0	7.3	75
20-24	59.0	33.0	7.8	0.2	0.0	100.0	8.0	355
25-29	58.7	29.6	9.1	1.7	0.9	100.0	11.7	538
30-34	60.2	29.1	8.8	1.8	0.1	100.0	10.6	556
35-39	55.5	35.4	7.1	2.0	0.0	100.0	9.1	525
40-44	52.2	35.4	10.1	2.1	0.2	100.0	12.4	413
45-49	51.8	39.4	8.4	0.4	0.0	100.0	8.8	238
Number of living children								
0	62.1	24.6	12.3	1.1	0.0	100.0	13.4	185
1-2	65.8	27.3	6.2	0.8	0.0	100.0	7.0	869
3-4	58.4	31.3	8.7	1.4	0.2	100.0	10.3	950
5+	43.1	43.6	10.2	2.6	0.5	100.0	13.3	695
Region								
Urban	65.8	26.4	6.5	1.3	0.0	100.0	7.8	1,441
Rural	47.1	40.0	10.8	1.7	0.5	100.0	13.0	1,258
Respondent's Education								
No education	49.2	39.0	9.6	1.8	0.4	100.0	11.8	1,577
Primary[1]	53.6	29.4	13.5	3.5	0.0	100.0	17.0	257
Middle[2]	72.6	22.2	4.7	0.4	0.0	100.0	5.1	119
Secondary[3]	64.8	25.5	9.3	0.5	0.0	100.0	9.7	286
Higher[4]	77.1	20.3	2.4	0.2	0.0	100.0	2.6	460
Employment status								
Currently employed	54.1	31.7	10.1	3.4	0.7	100.0	14.2	503
Not currently employed	57.8	32.9	8.1	1.0	0.1	100.0	9.3	2,197
Any spousal violence (physical or sexual or emotional) in last 12 months								
Yes	30.5	47.3	19.2	2.7	0.4	100.0	22.2	550
No	64.5	29.1	4.9	1.3	0.2	100.0	6.4	1,722
Privacy not obtained/Women not selected	61.5	28.6	9.5	0.5	0.0	100.0	10.0	427
Any spousal violence (physical or sexual or emotional) ever								
Yes	34.1	45.3	18.1	2.2	0.3	100.0	20.6	673
No	65.6	28.5	4.2	1.4	0.2	100.0	5.9	1,599
Privacy not obtained/Women not selected	61.5	28.6	9.5	0.5	0.0	100.0	10.0	427
Wealth Index								
Lowest	46.2	40.1	9.7	3.0	1.0	100.0	13.7	512
Second	49.8	38.2	9.2	2.7	0.1	100.0	12.0	507
Middle	45.5	36.9	15.9	1.7	0.0	100.0	17.6	523
Fourth	64.4	29.3	6.2	0.1	0.0	100.0	6.3	560
Highest	75.8	21.4	2.7	0.1	0.0	100.0	2.8	598
Total	**57.1**	**32.7**	**8.5**	**1.5**	**0.2**	**100.0**	**10.2**	**2,699**

[1] Respondents with a GAD-7 score of 6 or higher [2] Respondents with a PHQ-9 score of 10 or higher

Age-specific pattern: The percentage with Symptoms of Depression show that the highest prevalence is in the age group 40–44 (12.4%) and the lowest prevalence is in the 15–19 age group

(7.3%) possibly due to fewer responsibilities or stronger family support. Prevalence fluctuate across age groups with bit higher for ages 24-39.

Number of living children: With respect to this background indicator, analysis shows that women with no child and those with 5+ children have the highest prevalence of depression symptoms (13.4%) while women with 1–2 children have the lowest prevalence of depression symptoms (7.0%). Women with 5+ children have the highest prevalence of depression, likely due to the physical, emotional, and financial strain of raising a large family.

Education level: Analysis of data from Sindh shows that women with primary education have the highest prevalence of depression symptoms (17.0%) while women with middle, secondary, or higher education had lower prevalence rates (5.1, 9.7 and 2.6%). Women with no education also have the high depression rates, highlighting the protective role of education in mental health.

Spousal violence and depression: Women who experienced spousal violence in the last 12 months have significantly higher rates of depression (22.2%) compared to those who did not (6.4%). A quarter of all of abused women (19.2 percent) have moderate depression (PHQ-9: 10-14), while 2.7% have moderately severe depression (15-19), and 0.4% experience severe depression (20-27). Interesting to note, women with no recent experience of spousal violence report much lower levels of depression, with only 4.9% in the moderate category and 1.3% in the moderately severe category.

Lifetime experience of spousal violence and depression: Around two in five women (20.6%) who have ever experienced spousal violence show symptoms of depression, compared to only 5.9% of women who have never faced violence. Furthermore, 18.1% of survivors have moderate depression (PHQ-9: 10-14), while 2.2% have moderately severe depression (15-19), and 0.3% suffer from severe depression (20-27). The results confirm that even past experiences of spousal violence contribute to long-term mental health struggles.

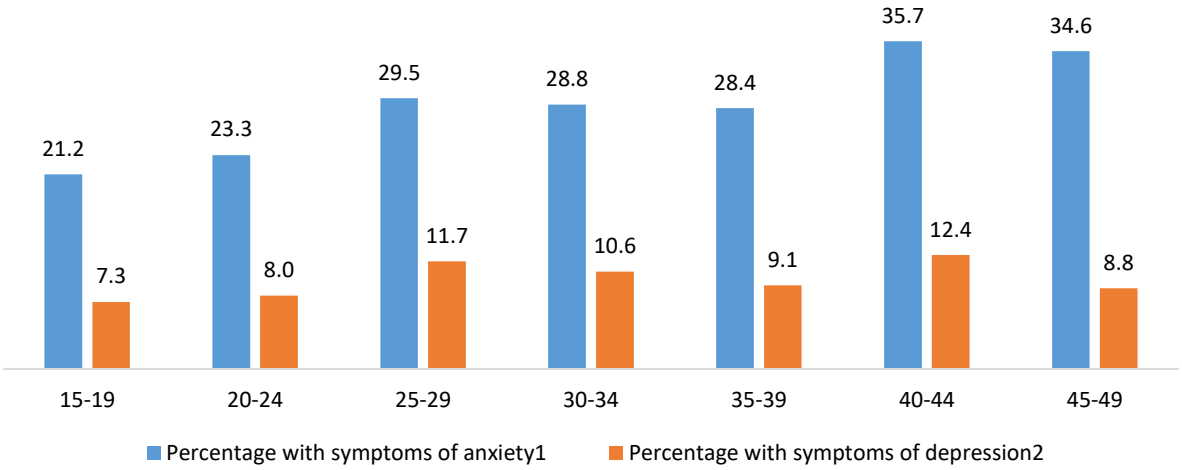
The analysis reveals that depression is an important mental health concern among married women in Sindh, particularly among older women, those with many children, and those with no education.

4.5 High Prevalence of Anxiety and Depression:

- Anxiety: More than third of women (35%) reported symptoms of anxiety, with the highest prevalence in the 40–49 age groups (Figure 4.1).
- Depression: Around 12 percent of women reported symptoms of depression in age groups 25 to 44 in a fluctuating manner.

Lower prevalence of anxiety and depression is reflected among younger women (15–24) while higher prevalence of anxiety and depression among older women (30–44). Younger women may benefit from stronger family support systems while some women may develop coping mechanisms over time, explaining the slight decline in depression prevalence in the 45–49 age group.

Figure 4.1: Percentages of women with symptoms of anxiety and depression by age



4.6 Treatment for Symptoms of Anxiety and Depression

Regardless of their scores on the GAD-7 or PHQ-9, all respondents were asked (a) if a health care provider had ever told them that they had anxiety or depression, (b) if they had taken medicine in the 2 weeks before the survey that was prescribed by a health care provider for anxiety or depression, or (c) if they had received counseling for their mental health condition in the 2 weeks before the survey.

Close to 4.6 percent of women age 15–49 were ever told by a health care provider that they had anxiety, while 5.4% of women were ever told by a health care provider that they had depression (Table 4.4). Close to 5.7 percent of women reported taking medicine prescribed by a health care provider for depression or anxiety in the past 2 weeks. The results indicate significant gaps in diagnosis and treatment.

Table 4.4 Treatment for symptoms of anxiety or depression

Percentage of women age 15?49 who have ever been told by a health care provider that they have anxiety or depression, percentage who took medicine prescribed by a health care provider for anxiety or depression in the 2 weeks preceding the survey, according, to background characteristics, Sindh Longitudinal Panel Study, 2024

Background characteristic	Ever told had anxiety	Ever told had depression	Ever told had anxiety or depression	Ever told had anxiety and depression	Took medicine prescribed by a health care provider for anxiety or depression in past 2 weeks	Number of women
Respondent Age						
15-19	2.2	1.1	3.3	0.0	3.7	75
20-24	4.0	2.2	4.8	1.4	4.8	355
25-29	3.8	4.7	5.7	2.9	4.6	538
30-34	5.1	5.9	7.1	3.9	5.8	556
35-39	4.3	6.2	8.0	2.5	5.0	525
40-44	5.5	6.4	8.2	3.6	7.1	413
45-49	5.6	8.0	9.8	3.8	9.2	238
Number of living children						
0	7.7	10.4	13.2	4.9	8.9	185
1-2	3.5	3.7	5.0	2.2	4.8	869
3-4	4.2	4.3	5.8	2.7	4.4	950
5+	5.5	7.7	9.6	3.6	7.9	695
Region						
Urban	4.2	6.8	7.7	3.3	4.3	1,441
Rural	4.9	3.8	6.2	2.5	7.3	1,258
Respondent's Education						
No education	5.2	5.2	7.0	3.4	6.1	1,577
Primary[1]	6.5	6.1	8.7	3.9	6.4	257
Middle[2]	2.2	3.4	4.3	1.4	8.1	119
Secondary[3]	3.6	6.6	7.2	2.9	4.8	286
Higher[4]	2.6	5.2	6.7	1.1	4.1	460
Employment status						
Currently employed	5.1	6.2	7.6	3.7	6.6	503
Not currently employed	4.4	5.2	6.9	2.7	5.5	2,197
GAD-7 Score						
0-5	1.8	1.9	2.9	0.9	2.7	1,903
6+	11.2	13.6	16.9	7.8	13.0	796
PHQ-9 Score						
0-9	3.1	3.4	4.7	1.8	4.6	2,424
10+	17.4	22.9	27.7	12.6	16.1	276
Any spousal violence (physical or sexual or emotional) in last 12 months						
Yes	8.9	9.7	13.3	5.3	10.0	550
No	3.5	4.3	5.4	2.5	4.6	1,722
Privacy not obtained/Women not selected	3.1	4.1	5.4	1.8	4.8	427
Any spousal violence (physical or sexual or emotional) ever						
Yes	8.7	9.8	13.2	5.3	9.4	673
No	3.2	3.9	4.9	2.2	4.5	1,599
Privacy not obtained/Women not selected	3.1	4.1	5.4	1.8	4.8	427
Wealth Index						
Lowest	4.6	5.3	6.2	3.7	5.7	512
Second	4.2	3.7	6.0	1.8	6.2	507
Middle	6.6	6.5	9.7	3.5	7.3	523
Fourth	5.8	7.2	8.1	4.8	6.5	560
Highest	1.9	4.2	5.1	1.0	3.2	598
Total	**4.6**	**5.4**	**7.0**	**2.9**	**5.7**	**2,699**

[1] Primary refers to classes 1-5 [2] Middle refers to classes 6-8 [3] Secondary refers to classes 9-10 [4] Higher refers to class 11 and above

4.7 Patterns by Background Characteristics

Number of living children: Women with no or 5+ children are more likely to take prescribed medicine (8.9 and 7.9%) compared to those with fewer children.

Education level: Women with middle education women reported more likely to take prescribed medicine (8.1%) compared to those with higher education (4.1%), possibly due to greater reliance on healthcare providers.

Employment status and mental health treatment: Employed women are little bit more likely to be diagnosed with anxiety (5.1%) compared to unemployed women (4.4%). However, depression rates are similar across employment status (6.2 and 5.2%). Medication usage is also close between employed and unemployed women (6.6 and 5.5%).

Severity of symptoms of anxiety (GAD-7 Score): Women with higher anxiety scores (6+) were more likely to be told they had anxiety (11.2%) and to take prescribed medicine (13.0%). Regarding severity of Depression, (PHQ-9 Score), women with higher depression scores (10+) were more likely to be told they had depression (22.9%) and to take prescribed medicine (16.1%). Women with higher anxiety or depression scores are more likely to be diagnosed and treated, indicating that severe symptoms may drive healthcare utilization.

- Women with symptoms of anxiety (GAD-7 score 6+) or depression (PHQ-9 score 10+) are far more likely to be diagnosed with mental health conditions.
- 16.6% of those with anxiety symptoms were told they had anxiety or depression, while 7.8% of those with depression symptoms were told they had anxiety or depression. However, even among symptomatic women, a significant proportion remains undiagnosed.
- Medication usage is lower than diagnosis rates. Only 13.0% of women with anxiety symptoms and 16.1% of women with depression symptoms took prescribed medication in the past two weeks. This suggests treatment gaps, potential barriers to accessing medication, or discontinuation of treatment.

Spousal violence and mental health treatment: Women who have experienced spousal violence (physical, sexual, or emotional) are nearly twice as likely to be diagnosed with anxiety and depression. More than one in ten IPV survivors (13.2%) were told they had anxiety or depression, compared to around 5% of those with non-experiences. However, around 10 % of abused women took medication, despite 13% having been diagnosed.

4.8 Care Seeking for Symptoms of Anxiety and Depression

Respondents who said that they had experienced any symptoms of anxiety or depression during the 2 weeks before the survey, regardless of frequency (i.e., respondents with a score of 1 or higher on either the GAD-7 or PHQ-9), were asked if they had ever sought help and the type of provider from whom they sought help.

Close to 28 percent of women who experienced any symptoms of anxiety or depression in the 2 weeks preceding the survey sought help (Table 4.5). Among those who sought help, almost 38 percent of women sought help from a health care provider while 62% sought help from other sources (e.g., traditional healers, religious leaders, family members). The results indicate existence of barriers to accessing mental health care.

Table 4.5 Care seeking and providers

Among women with any symptoms of anxiety or depression in the 2 weeks preceding the survey, percentage who have ever sought help, and among those who sought help, type of provider from whom the help was sought, according to, background characteristics, Sindh Longitudinal Panel Study, 2024

	Among women with any symptoms of anxiety or depression in the 2 weeks preceding the survey[5]		Among those who sought help by type of provider		
Background characteristic	Ever sought help	Number of women	Health care provider	Other[6]	Number of women
Respondent Age					
15-19	14.2	53	21.8	78.2	7
20-24	22.2	267	35.8	64.2	59
25-29	17.0	437	37.6	62.4	74
30-34	19.4	442	38.5	61.5	86
35-39	23.3	420	34.7	65.3	98
40-44	18.1	345	38.9	61.1	62
45-49	24.9	200	44.6	55.4	50
Number of living children					
0	32.1	135	55.6	44.4	43
1-2	18.1	649	33.9	66.1	118
3-4	19.7	785	31.9	68.1	154
5+	20.5	594	41.9	58.1	122
Region					
Urban	19.6	1,092	38.4	61.6	214
Rural	20.8	1,072	36.8	63.2	223
Respondent's Education					
No education	17.6	1,328	37.8	62.2	234
Primary[1]	30.7	195	42.5	57.5	60
Middle[2]	16.9	76	55.0	45.0	13
Secondary[3]	25.5	219	33.0	67.0	56
Higher[4]	21.6	345	33.5	66.5	74
Employment status					
Currently employed	17.4	406	38.1	61.9	71
Not currently employed	20.9	1,757	37.5	62.5	366
GAD-7 Score					
0-5	15.2	1,367	28.1	71.9	207
6+	28.9	796	46.2	53.8	230
PHQ-9 Score					
0-9	17.4	1,888	30.5	69.5	328
10+	39.6	276	58.9	41.1	109
Any spousal violence (physical or sexual or emotional) in last 12 months					
Yes	22.5	525	51.9	48.1	118
No	17.8	1,304	34.7	65.3	232
Privacy not obtained/Women not selected	26.1	334	25.8	74.2	87
Any spousal violence (physical or sexual or emotional) ever					
Yes	22.4	633	51.2	48.8	142
No	17.4	1,197	33.2	66.8	208
Privacy not obtained/Women not selected	26.1	334	25.8	74.2	87
Wealth Index					
Lowest	18.4	437	22.5	77.5	80
Second	23.5	418	35.4	64.6	98
Middle	20.7	445	53.2	46.8	92
Fourth	15.9	398	65.4	34.6	63
Highest	22.2	465	20.4	79.6	103
Total	**20.2**	**2,163**	**37.6**	**62.4**	**437**

[1] Primary refers to classes 1-5 [2] Middle refers to classes 6-8 [3] Secondary refers to classes 9-10 [4] Higher refers to class 11 and above

[5] Includes respondents who said that they experienced any symptom of anxiety or depression during the 2 weeks before the survey, regardless of frequency (i.e., respondents with a score of 1 or higher on either the GAD-7 or PHQ-9)

[5] It includes social service organization, social worker, community health worker/fieldworker, religious leader, current/former spouse/partner, other family member, friend, neighbor, and Other

4.9 Patterns by Background Characteristics

Age-specific trends: The highest percentage of women who ever seek help are in the 45–49 age group (25.0%) while the lowest percentage are in the 15–19 age group (14%). Women (age 20–44) are uniformly likely to use healthcare providers, possibly due to better access to education or healthcare services while older women (e.g., 45–49) are more likely to seek help, possibly due to greater awareness of mental health issues or accumulated stressors.

Number of living children: Women with no children are more likely to seek help (32%) compared to those with children.

Education level: Women with primary level education are more likely to seek help (30.7%), while those with middle education were least likely (17%). Women with middle education were more likely to seek help from healthcare providers (55%) compared to those with higher education (34%). Women with middle education were more likely to seek help, possibly due to greater awareness and resources compared to those with other education groups.

Employment status and help-seeking behavior: Employed women are more likely to seek help (36.4%) than unemployed women (26.8%) but are less likely to seek help from a healthcare provider (24.2%). Instead, 75.8% of employed women rely on informal sources of support.

Help-seeking by anxiety and depression scores: Women with higher anxiety or depression symptoms are much more likely to seek help than those with minimal symptoms. Only 15% of women with mild anxiety sought help, compared to 29% of those with moderate to severe anxiety. Similarly, help-seeking jumps from 17.4% (minimal depression) to 39.6% (moderate to severe depression).

Among those who sought help, only a third consulted a healthcare provider. More than half of women with severe depression (59%) sought help from a healthcare provider, while the rest relied on non-medical sources (family, religious leaders, social workers, etc.). For women with high anxiety, close to half (46%) women sought formal systems support and consulted a healthcare provider.

Impact of spousal violence on help-seeking: Women who have experienced spousal violence (physical, sexual, or emotional) are significantly more likely to seek help from healthcare provider. Less than a quarter of all women who experienced spousal violence in the last 12 months (23%) sought help, compared to only 17.8% of those who had not. However, only 52% of those who experienced spousal violence sought help consulted a healthcare provider, meaning others still rely on informal support systems.

Women who experienced spousal violence seek help more frequently, many rely on non-medical sources such as family, religious leaders, or community support. This highlights the need for better integration of mental health services within GBV response programs to ensure that survivors receive professional psychological care.

DOMESTIC VIOLENCE 5

Gender-based violence, particularly against women, is acknowledged worldwide as a violation of basic human rights. The United Nations defines gender-based violence as any act of violence that results in physical, sexual, or psychological harm or suffering to women, girls, men, and boys, as well as threats of such acts, coercion, or the arbitrary deprivation of liberty. There is substantial research that has determined the serious health burden and demographic consequences of domestic violence (United Nations 2006)[3]. This chapter focuses on spousal violence, a widely prevalent form of gender based domestic violence.

The Sindh Assembly passed the Domestic Violence (Prevention and Protection) Bill in 2013, aiming to protect women, children, and other vulnerable individuals from gender-based physical and psychological abuse within domestic relationships. Despite its progressive framework, the law faced implementation challenges, including procedural ambiguities and delays in establishing necessary mechanisms such as protection officers and commissions. Recognizing these issues, the Sindh government launched a comprehensive roadmap in December 2024 to strengthen the Act's enforcement. This initiative includes establishing one-stop protection centers, with the first model center set to operate in Hyderabad, and emphasizes collaboration among government bodies, civil society, and international partners to combat gender-based violence effectively. While these steps indicate progress, ongoing efforts are essential to ensure the law's full and effective implementation, addressing the persistent challenges in protecting vulnerable individuals from domestic violence in Sindh.

To better understand the prevalence of domestic violence in Sindh, the PMA Sindh 2024 successfully interviewed 2,272 women using a specially designed domestic violence module. Such data-driven insights are critical in shaping policies, improving protection mechanisms, and addressing gaps in the enforcement of the Domestic Violence Act.

5.1 Measurement of Violence

In the 2024 PMA Sindh, information was obtained from currently-married women on their experience of violence committed by their current husbands. More specifically, violence committed by the current husband was measured by asking all women if their husbands ever did the following to them:

Spousal physical violence: push you, shake you, or throw something at you; slap you; twist your arm or pull your hair; punch you with his fist or with something that could hurt you; kick you, drag you, or beat you up; try to choke you or burn you on purpose; or threaten or attack you with a knife, gun, or any other weapon.

***Spousal sexual violence*:** physically force you to have sexual intercourse with him even when you did not want to, physically force you to perform any other sexual acts you did not want to, or 'force you with threats or in any other way to perform sexual acts you did not want to'.

***Spousal emotional violence*:** say or do something to humiliate you in front of others, threaten to hurt or harm you or someone close to you, or insult you or make you feel bad about yourself.

In addition, information was obtained about physical violence committed by anyone during

[3] United Nations. 2006. *Secretary-General's In-depth Study on All Forms of Violence against Women*. New York, USA: United Nations.

pregnancy. Also, information was gathered on experiences of physical violence committed by women on their husbands when they were not hurting; kicking, dragging, or beating them up.

5.2 Ethical Considerations in the PMA 2024

Recognizing the challenges in collecting data on violence, the interviewers in the survey were given special training. The training focused on how to ask sensitive questions, ensure privacy, and build rapport between interviewer and respondent. Rapport with the interviewer, confidentiality, and privacy are all keys to building respondents' confidence so that they can safely share their experiences with the interviewer. Also, placement of the violence questions at the end of the questionnaire provided time for the interviewer to develop a certain degree of intimacy that should have further encouraged respondents to share their experiences of violence, if any. In addition, the following protections were built into the survey in keeping with the World Health Organization's ethical and safety recommendations for research on domestic violence (WHO, 2001)[4]:

1. Only one woman per household was administered the questions on violence to maintain confidentiality. In the selected household one female respondent was randomly selected to be administered the questions on domestic violence. The random selection of one woman was done through a simple selection procedure based on the Kish grid, which was built into the Household Questionnaire (Kish, 1965)[5].

2. As a means of obtaining additional consent beyond the initial consent provided at the start of the interview, the respondent was informed that the questions could be sensitive and was reassured regarding the confidentiality of her responses.

3. The violence module was implemented only if privacy could be obtained. The interviewers were instructed to skip the module, thank the respondent, and end the interview if they could not maintain privacy.

5.3 Spousal Physical Violence

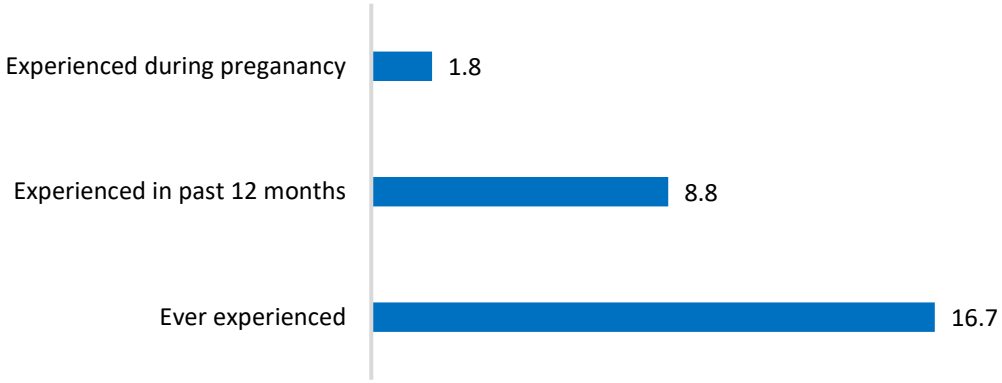
This section presents data on the experience of physical violence among currently married women of reproductive age. The percentage of women who have experienced any spousal physical violence during their lifetime and in the 12 months preceding the survey is discussed by background characteristics of women i.e. age, number of living children, place of residence, women's and husband's education, employment and wealth status.

Spousal physical violence is experienced by 16.7 percent of women during their lifetime and by 8.8 percent women in the twelve months preceding the survey (Figure 5.1).

[4] World Health Organization (WHO). 2001. *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women*. Geneva, Switzerland: Department of Gender and Women's Health, Family and Community Health, WHO.

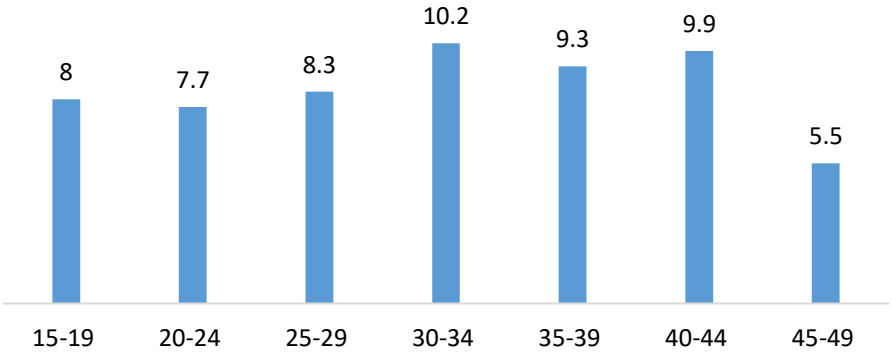
[5] Kish, L. 1965. *Survey sampling.* New York: John Wiley and Sons Inc.

Figure 5.1: Experience of spousal physical violence



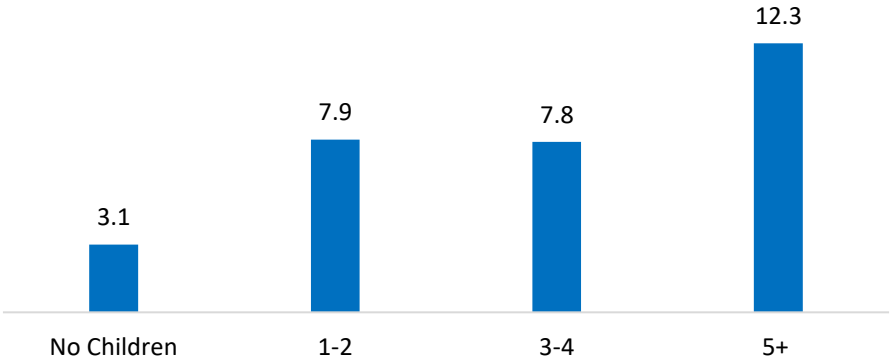
Women aged 30-34 years most frequently (10.2%) report the experience of spousal physical violence in the 12 months preceding the survey. Women in the middle to older age groups are more likely to become a victim of spousal physical violence, with the exception of the oldest age group (45-49 years)-Figure 5.2.

Figure 5.2: Percent of women have experienced spousal physical violence by age



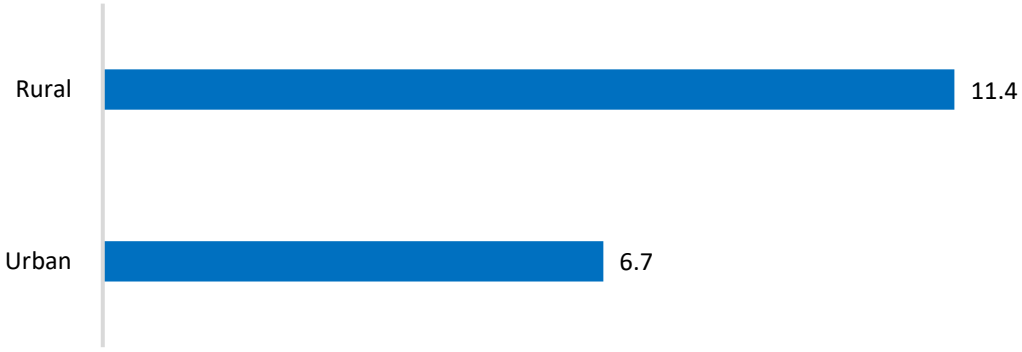
Women with no children report the lowest rates of spousal physical violence (in the 12 months preceding the survey) while women with five or more children have the highest incidence indicating a trend whereby the experience of spousal physical violence increases with the increase in number of living children-Figure 5.3.

Figure 5.3: Percent of women experiencing physical violence by number of living children



Urban women report lower rates of spousal physical violence than rural women, with 6.7 percent of urban women experiencing physical violence compared to 11.4 percent of rural women in the 12 months preceding the survey- Figure 5.4.

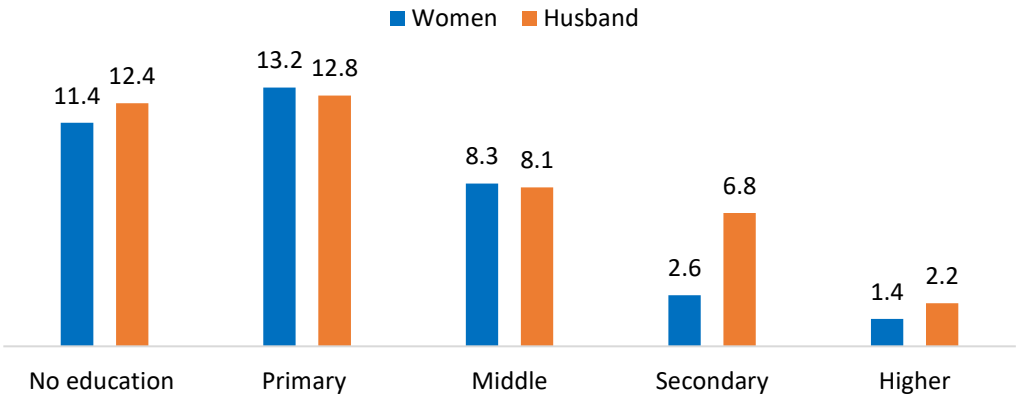
Figure 5.4: Percent of women experiencing physical violence by place of residence



Spousal physical violence decreases with the increase in educational attainment of women and their husbands as women with low levels of education report the highest percentage (13.2%) of experiencing violence, while those with higher education report the lowest percentage (1.4%)- Figure 5.5.

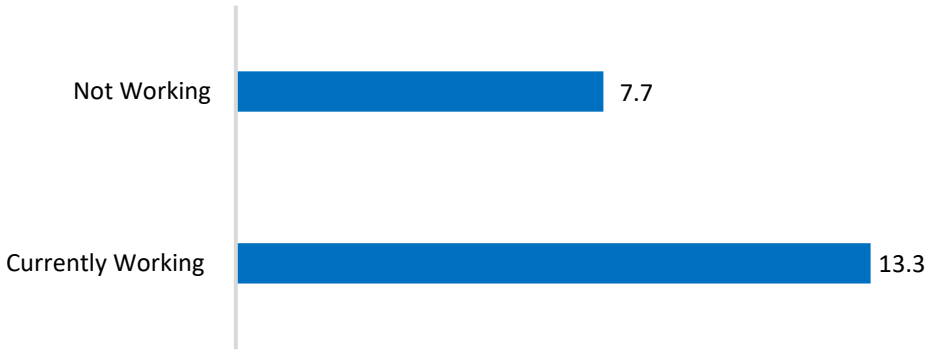
Husband's education level also influences the prevalence of physical violence. Women whose husbands have no education or little education (i.e. only primary level education) report the highest incidence of violence (in the 12 months preceding the survey). Whereas, women whose husbands have higher education report the lowest level of violence-Figure 5.5.

Figure 5.5: Percent of women experiencing physical violence by education



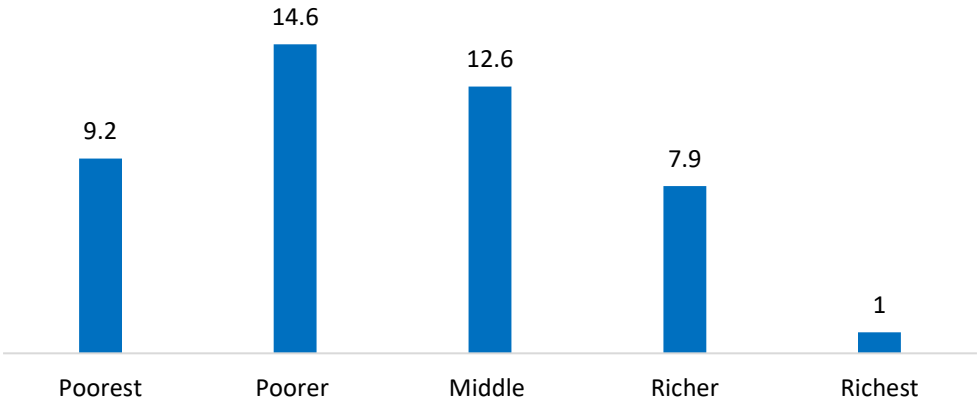
Employment status also plays a role in the experience of spousal physical violence. Employed women (13.3%) have more commonly experienced physical violence compared to unemployed women (7.7%)-Figure 5.6.

Fugure 5.6: Percent of women experiencing physical violence by employment status



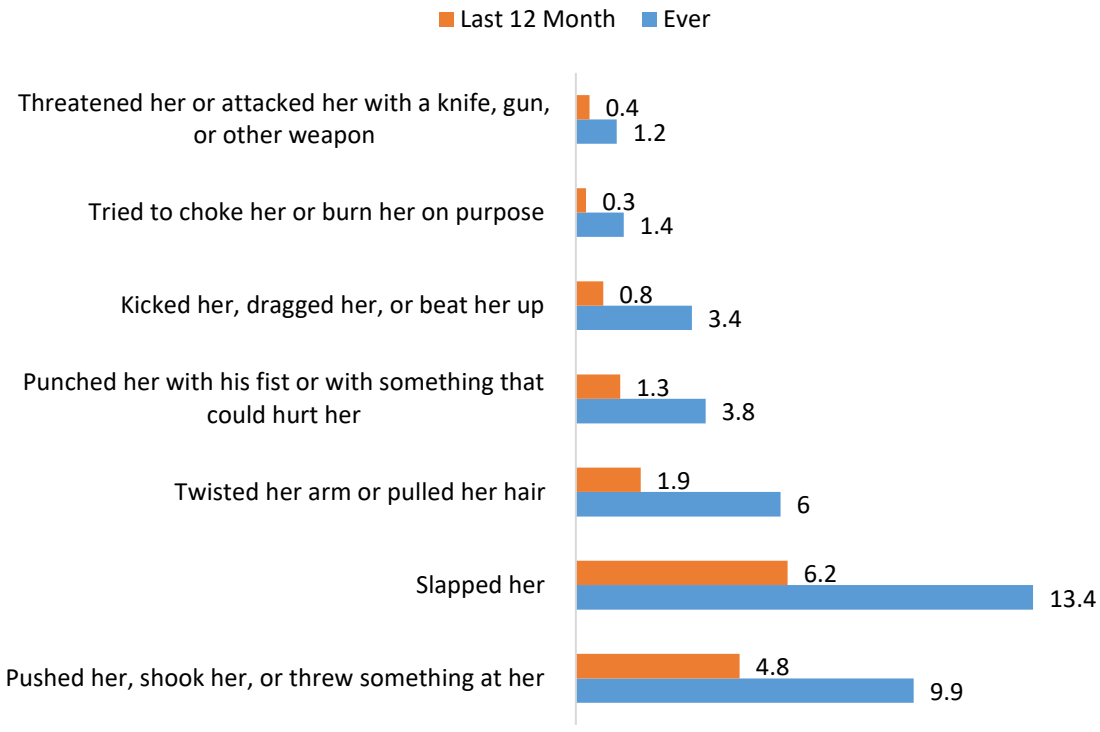
Wealth status is a significant factor influencing the experience of physical violence. Women in the second wealth quintile report the highest prevalence of physical violence (14.6%), followed by those in the middle quintile (12.6%)-Figure 5.7. In contrast, women in the highest wealth quintile report the lowest prevalence, at only 1%.

Figure 5.7: Percent of women experiencing physical violence by wealth



Women were also asked about the various forms of physical violence that they had ever experienced during their lifetime. Slapping was the most common form of violence (13.4%) followed by being pushed, shook or thrown something at (9.9%) and twisting arm and pulling hair (6%). Threatening or attacking with a knife or a gun and trying to choke or burn on purpose were the least reported forms of violence (Figure 5.8).

Figure 5.8: Percent of women experiencing various forms of physical violence

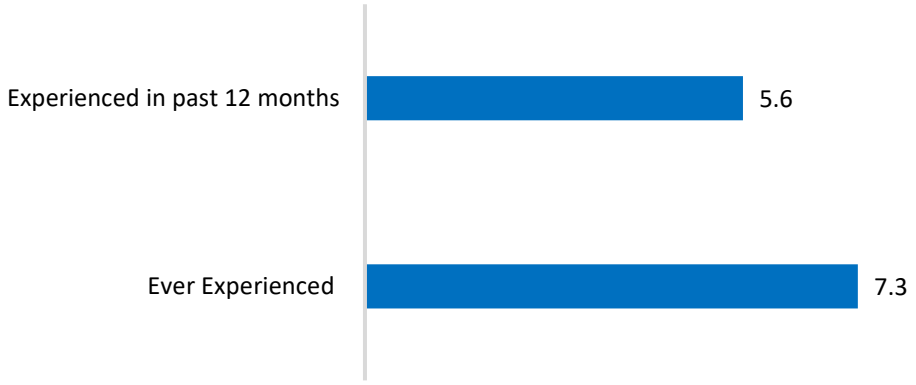


5.4 Spousal Sexual Violence

Women were asked about their experience of spousal sexual violence; the findings of the survey are reported by background characteristics of women in this section. Overall, 7.3 percent of women respondents said that they had experienced sexual spousal violence during their lifetime and, 5.6

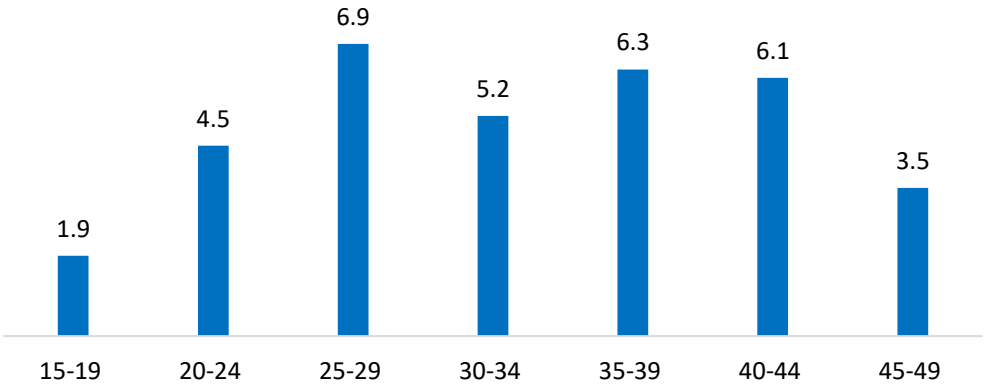
percent reported the experience of sexual spousal violence in the 12 months preceding the survey-Figure 5.9.

Figure 5.9: Lifetime experience of spousal sexual violence



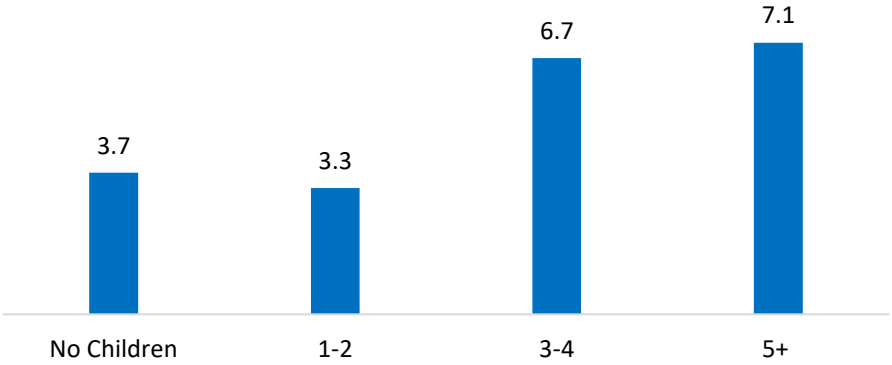
Women in the 25-29 years age group report the highest percentage of spousal sexual violence (6.9%), followed by women aged 35-39 years (6.3%) and women aged 40-44 years (6.1%). Married women in their teens (i.e. 15-19 years old) report the least percentage of spousal sexual violence (1.9%)-Figure 5.10.

Figure 5.10: Percent of women experiencing sexual violence by age



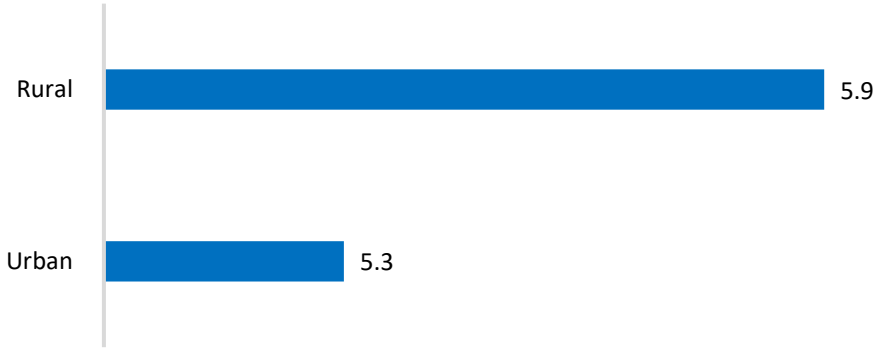
Prevalence of spousal sexual violence exhibits a pattern similar to that of spousal physical violence. Women with no children report significantly lower rates of spousal sexual violence (in the 12 months preceding the survey). In comparison, the prevalence of spousal sexual violence is highest among those with five or more children-Figure 5.11. These findings show a trend where the experience of spousal sexual violence increases with number of living children.

Figure 5.11: Percent of women experiencing sexual violence by number of living children



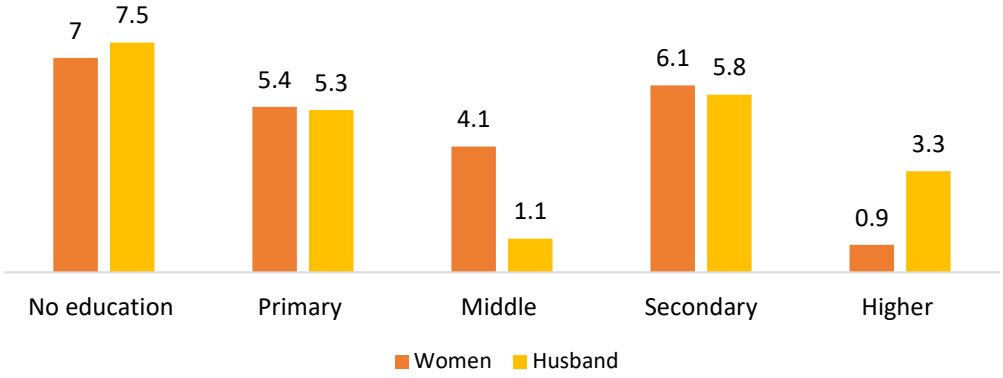
Even though urban women report a lower percentage (5.3%) of spousal sexual violence than rural women (5.9%), there was no significant difference in the percentage of women who reported experiencing spousal sexual violence by place of residence-Figure 5.12.

Figure 5.12: Percent of women experiencing sexual violence by place of residence



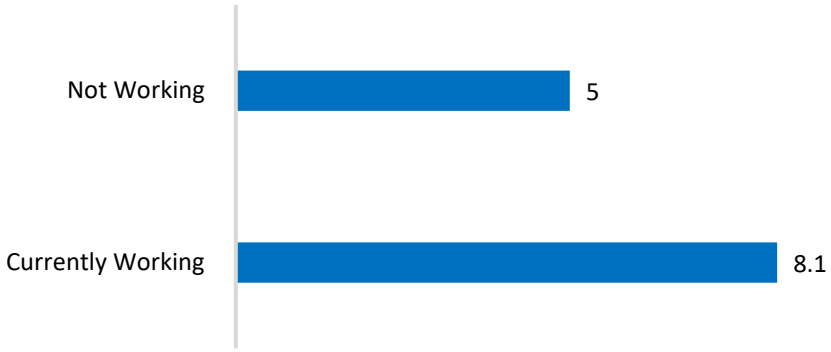
Spousal sexual violence trends to decrease with the increase in educational attainment of women, -Figure 5.13. Husband's education level also influences the prevalence of spousal sexual violence. Women whose husbands have no education report the highest incidence (7.5%). Women whose husbands have higher education report the lowest levels of spousal sexual violence (Figure 5.13).

Figure 5.13: Percent of women experiencing sexual violenceby women & husband education



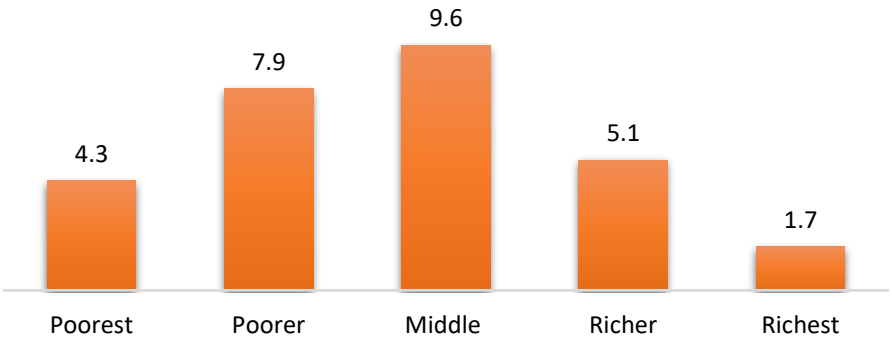
Women who are currently employed report higher percentage of the experience of spousal sexual violence (8.1%) than those who are unemployed (5%)-Figure 5.14.

Figure 5.14: Percent of women experiencing sexual violence by employment status



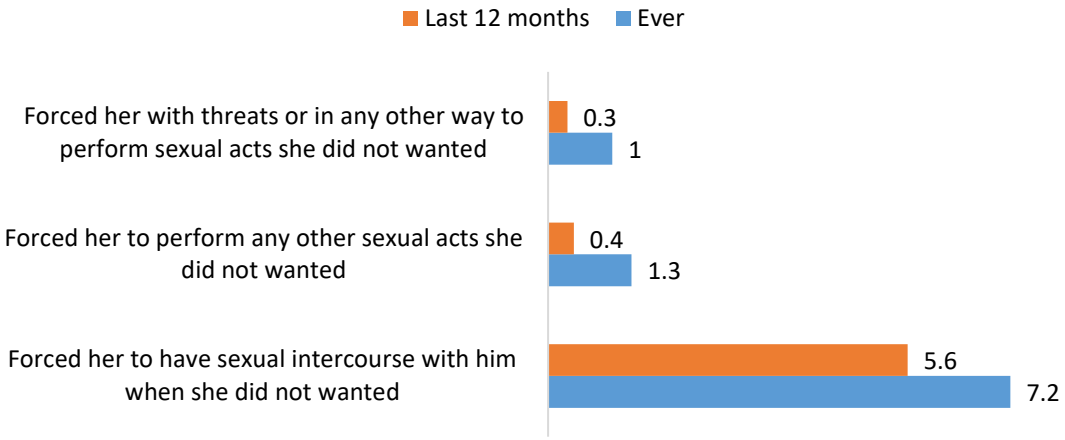
Women in the middle wealth quintile report the highest percentage (9.6%) of spousal sexual violence. Women in lowest and highest wealth quintile i.e. lower and upper-class women report lower incidence of spousal sexual violence than those in the middle-income groups- Figure 5.15.

Figure 5.15: Percent of women experiencing sexual violence by wealth quintiles



The most common form of spousal sexual violence ever experienced by women is 'physically forced her to have sexual intercourse with him when she did not want to' (7.2%) followed by 'physically forced her to perform any other sexual acts she did not want to'-Figure 5.16. The least common form of spousal sexual violence is 'forced her with threats or in any other way to perform sexual acts she did not want to' i.e. (only 1%).

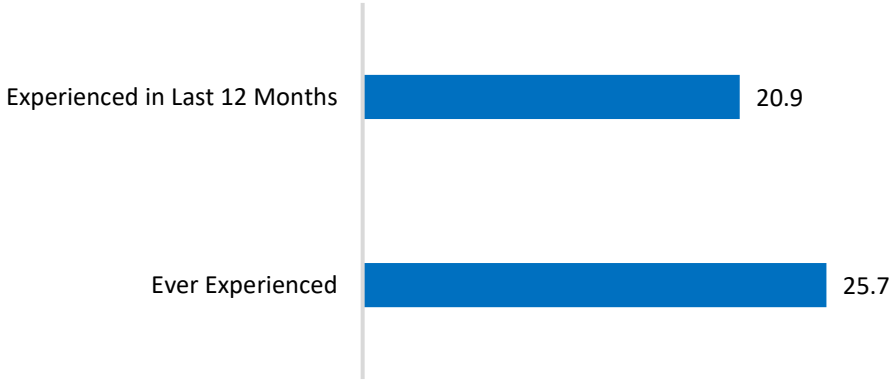
Figure 5.16: Percent of women experiencing various forms of sexual violence



5.5 Emotional Spousal Violence

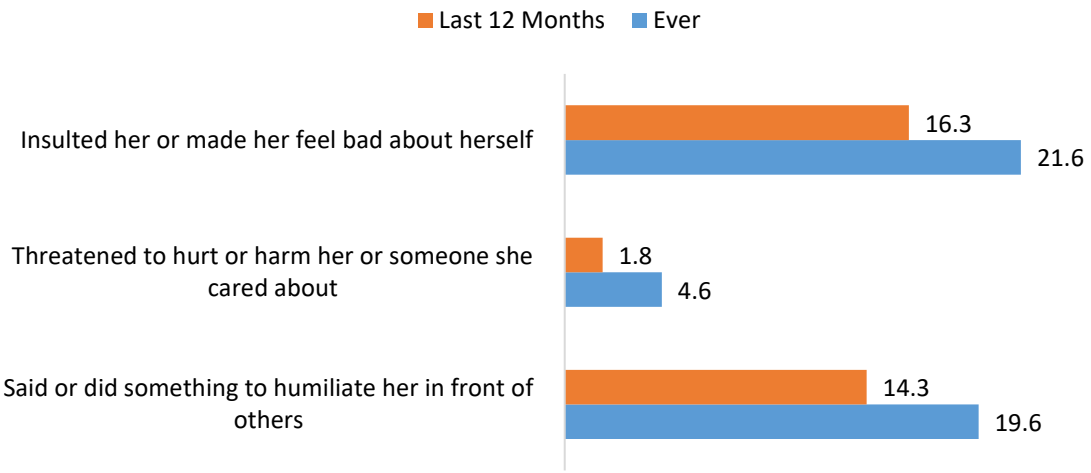
This section presents data on the experience of spousal emotional violence among currently married women of reproductive age. One-fourth of the women have experienced spousal emotional violence during their lifetime, while nearly one-fifth (20.9%) report experiencing spousal emotional violence in the past 12 months-Figure 5.17.

Figure 5.17: Experience of spousal emotional violence



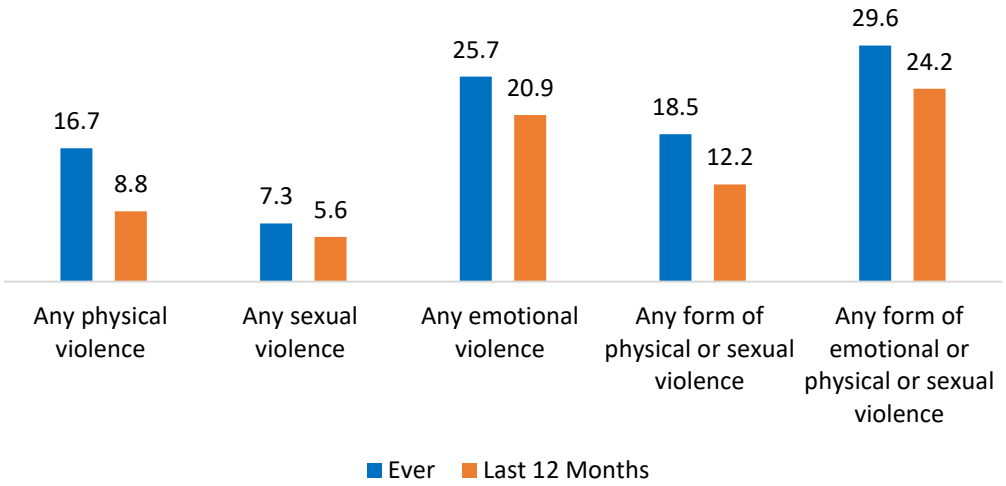
In the 12 months preceding the survey, 16.3% stated that their husbands insulted them or made them feel bad about themselves and, 14.3% of women report being humiliated in front of others by their husbands during the same period-Figure 5.18. Additionally, 1.8% of women report that their husbands threatened to harm someone they care about.

Figure 5.18: Percent of women experiencing various forms of emotional violence



Emotional violence was the most common form of spousal violence, where 25.7% of all participants report experiencing it and 20.9% report experience of emotional violence in the 12 months-Figure 5.19. Physical violence is reported by 16.7% women. Sexual violence is least common form of violence at only 7.3%. Furthermore, 29.6% report that they experienced some kind of physical, sexual, or emotional violence and only 18.5% report experience of either physical violence.

Figure 5.19: Percent of women experiencing any form of spousal violence



SERVICE DELIVERY POINTS SURVEY AND PREPAREDNESS FOR FP SERVICES 6

Under the FP2030 commitments achieving 'universal access to safe and quality reproductive health care and family planning services with increased and widely accessible method choices' is endorsed by government of Sindh. In this regard, strengthening of Population Departments' coordination with Department of Health to expand FP services including post-pregnancy family planning services to minimize missed opportunities; and approval of Task Shifting and Task Sharing strategies and competency-based training of paramedics and doctors in implant insertion and systematic procurement and introduction of implants and Sayana Press over the last 7-8 years has been significant steps forward. Strong ownership of Department of Health is recognized as means for universal access.

6.1 Structure of Family Planning Availability system

Family planning is provided both by the public and private sectors across province of Sindh. Outlets of PWD including Reproductive Health Service Centres (hospital based facilities) and Family Welfare Centers (facilities located at community level serving FP and basic MCH services), and facilities of Health Dept. including tertiary care hospitals, secondary healthcare and primary health care unit (District hospitals, RHCs, BHUs, and MCH Centres) are authorized to provide family planning services and commodities to clients who visit and seek these services from the facilities. Lady Health Workers (community based health workers) are essential part of primary healthcare system provide FP counseling and services as part of MCH package served to women and children of the communities they are assigned, mostly in rural areas. Private sector and NGOs outlets also provide family planning services within their health facilities. Private sector encompasses private clinics, hospitals, maternity homes and MCH facilities and drug stores spread mostly in urban areas. Population Welfare has a limited dedicated infrastructure while Dept. of Health has a wider infrastructure across Sindh where family planning services are provided. Public sector dispenses FP commodities free of cost or a nominal charges while private sector charges for commodities and services depending on commodities purchased. Private sector also charges service fee for the commodities. The analysis in this section would maintain distinction of the three entities to see their contribution and delivery of FP services.

A total of 279 public and private facilities were visited in the survey by the enumerators in 48 clusters across Sindh. These facilities were identified by the women respondents where they normally visit to obtain services for their family health and family planning needs. The aim of maintaining same facilities over all phase of survey was to see if any substantive changes have been made in the facilities especially in improving availability and quality of service that leads to 'choice'.

A comprehensive insight into the distribution of service delivery points, categorized into public and private facilities shows that public facilities constitute the majority, comprising 66 percent of the total service delivery points surveyed. Among these, the most covered are Family Welfare Centers, constituting 23 percent of all public facilities, followed by Rural Health Centres and Basic Health Units (22%) and MCH Centres and Public Dispensaries (12%) - Table 6.1. On the other

hand, private facilities accounted for 34 percent of the total service delivery points. Notable categories within private facilities included Maternity Homes (8%), Big and small Hospitals (9%), and doctors' Clinics (6%).

Table 6.1: Percent distribution of service delivery points

	Percent		Percent
Public Facility	**66**	**Private Facility**	**34**
District Head Quarter/Civil Hospital	1	Big hospital (4+ beds)	8
Tehsil Head Quarter	3	Small Hospital (less than 4 beds)	3
Rural Health Centre	8	Doctors Clinic (male/female)	6
Basic Health Unit	14	LHV Clinic	1
Public Dispensary	7	Midwife Clinic	2
Maternal and Child Health Care Center	5	Maternity Home	8
Family Welfare Centre	23	Private Dispensary	1
LHW Health Clinic /Health House	6	Other	4
Number of Facilities 279			

Available staff at the facility who serves family planning was the key respondent for the questionnaire. Table 4.2 shows the key staff who responded and facilitated the survey in public and private sector facilities. Respondents are asked questions about the general infrastructure, services available, resources, and systems at the facility including staff pattern, basic amenities, management information systems, performance monitoring by tracking records. A quick glance of respondents' show that almost all PWD facilities staff are FWWs or FWAs, while more than a quarter of Health facility staff are nurse/midwife (Table 6.2). Nearly two-thirds of private sector facility respondents are doctors/gynecologists.

Table 6.2: Percent distribution of respondents of FP service delivery points Questionnaire

Designation of respondent	**DOH**	**PWD**	**Private Facility**
Qualified Gynecologist	2	0	22
Qualified Specialist	3	0	16
Doctor	13	0	22
Nurse/Midwife	29	2	16
LHV/FHT	11	0	7
FWW/FWC	15	83	3
FWA	3	5	2
Other	24	11	11
Gender of respondent			
Male	10	0	3
Female	90	100	97

Among Dept of Health (118), Population Welfare (66), and Private facilities (92) family Planning services/ products are offered by all of them. Almost two-thirds of all Dept of Health facilities (66 percent) offer services for 6 days a week while 32 percent offer these services throughout the week (Table 6.3). On the other hand, three quarters (83%) of Population Welfare facilities provide services 6 days a week and a handful offer throughout the week. Amongst the Private Facilities more than half (52%) offer throughout the week and more than a third (41%) for six days a week.

Table 6.3: Percent distribution of family planning service availability

Characteristic	DOH	PWD	Public Facility	Private Facility
Offering family planning services/products				
Yes	99	100	99	98
Number of Facilities	119	66	185	94
Days in a week are family planning services offered	**DOH**	**PWD**	**Public Facility**	**Private Facility**
<=5	2	14	6	5
6	66	83	72	41
7	32	3	22	52
Number of facilities that offer family planning services	**118**	**66**	**184**	**92**

6.2 Availability of Family Planning Services

All facilities visited in Sindh were asked regarding availability of contraceptives. Four contraceptive methods are universally available in all facilities: condoms, injectables, oral pills, implants, and emergency contraceptive pills (Table 6.4). Availability of condoms was a problem during 2023 which has been taken care and all facilities report availability. Provision of tubal ligation and vasectomy remains limited to a few facilities across the province. Female sterilization is available in 32% private facilities much more than public sector facilities. Emergency contraceptive pills, though not recognized as a contraceptive method, is essentially available at large number of facilities of PWD and DoH and reasonable proportion of private facilities. Availability of implants appears to have gone down across all facilities esp public sector facilities. IUDs are available in large proportion of facilities. The overall availability appears to be good and reflects availability of various methods to enhance choice and accessibility.

Table 6.4: Percentage of family planning methods provided to Client

Characteristic	DOH	PWD	Private Facility
Female sterilization	13	0	32
Male sterilization	4	0	2
IUD	78	95	67
Injectables	93	100	88
Implants	67	73	43
Pills	98	100	86
condoms	97	100	62
Emergency contraception	84	98	56
Number of Facilities	**119**	**66**	**94**

Facility readiness to service family planning is an important area of enquiry and asked about a number of aspects. The results of the survey show that all public and private facilities are adequately ready with running water, equipment needed to service, examination table, visual and auditory privacy, examination table, and essential chemicals for disinfection and good quality service (Table 6.5). The survey data shows the percentage availability of various items necessary

for preparedness in examination rooms and adjacent areas across different types of health facilities. Overall, information below reflects a comprehensive overview of the availability of essential items in examination rooms and adjacent areas across different types of health facilities, highlighting variations in availability among different facilities.

Table 6.5: Percentage availability of separate room for examination and items in examination and adjacent room

Items necessary for Preparedness	DOH	PWD	Public Facilities	Private Facilities
Separate room examination	75	67	72	80
Running water (piped)	87	85	86	96
Other running water (bucket with tap or pour pitcher)	83	82	83	87
Available from other sources	80	77	79	83
Hand-washing soap	92	89	91	98
Hand drying towels	77	85	80	87
Waste basket with lid	89	89	89	86
Sharps container	87	98	91	90
Disposable latex gloves	92	98	95	98
Disinfectant	92	95	93	99
Disposable needles and syringes	97	91	95	97
Auditory privacy	92	86	90	96
Visual privacy	90	94	91	98
Examination table	89	98	92	94
Client educational materials on FP	91	97	93	88
Examination lamp on stand (Proper light arrangement)	92	97	94	98
Syringe cuter	83	79	82	88
Chlorine solution	87	95	90	87
Boiler/Sterilizer	79	94	84	79
Number of Facilities	**119**	**66**	**185**	**94**

6.3 Preparedness to Service IUDs and Implants

The survey focused on evaluating the readiness of facilities to provide key contraceptives, particularly Intrauterine Devices (IUDs) and Implants. Public and private facilities offering family planning services were visited for this purpose, aiming to assess staff training and service quality preparedness. Staff members were questioned regarding their training in IUD and Implant insertion and removal. The findings, as depicted in tables below, indicate that almost all facilities have trained personnel for IUD and Implant procedures. Overall it's evident that 78 percent of DOH facilities, 96 percent of PWD facilities, and 67 percent of private facilities reported prepared to serve IUCDs (Table 6.6).

IUD insertion emerges as a prominent contraceptive method offered by many health facilities, both public and private. Facilities offering IUD services were surveyed regarding the availability and functionality of various items required for the procedure. With the exception of autoclave availability and functionality in few PWD facilities (76%), all other necessary items were reported to be available and operational in a vast majority of facilities, indicating strong preparedness and adequate equipment for IUD services across different facility types. IUCD availability has improved over 2023 in facilities of Health and PWD.

Table 6.6: Percentage of family planning facilities have trained personnel and supplies to insert and remove IUDs

Facility has trained personnel able to insert or remove IUDs	DOH	PWD	Private Facility
Yes	98	98	100
No	2	2	0
Facility have the supplies needed to insert and/or remove IUDs:			
Sponge holding forceps	98	100	100
Vaginal speculum	98	100	100
Tenaculum	96	98	100
Uterine sound	97	98	95
Examination table/ couch	99	100	100
Examination lamp on stand	98	95	97
Adult weighing scale	97	92	95
Stethoscope	99	95	100
BP apparatus	99	95	100
Kidney tray	99	100	100
Scissors straight	98	98	98
Bowls	99	100	100
Pair of gloves	99	100	97
Disposable syringes 5cc, 3cc, 2cc	99	100	100
Sterilizer	90	84	92
Autoclave	88	76	87
Disinfection solution: (Dettol, Savlon, iodine)	97	98	95
Chlorine Solution	96	100	95
Container for chlorine solution	99	97	90
Number of facilities that provide IUDs	**93**	**63**	**63**

Facilities are also enquired concerning implant provision and their readiness with essential supplies and equipment for aseptic implant insertion/removal. The findings show that fair majority of visited facilities reported having necessary items for implant provision (Table 6.7). Upon reviewing it's evident that 67 percent of DOH facilities, 73 percent of PWD facilities, and 43 percent of private facilities reported prepared to serve implants. All required items were reported to be available and functional in a vast majority of facilities, demonstrating strong preparedness and adequate equipment for implant services across various facility types. In general, fewer PWD facilities are prepared to offer implants than claimed above to serve these to clients. Overall, Sindh reflects a slight improvement in the coverage/provision of implants from 56% to 60 percent of all surveyed facilities.

Table 6.7: Percentage distribution of family planning facilities have trained personnel and supplies to insert or remove the implants

Facility have trained personnel able to insert and remove implants	DOH	PWD	Private Facility
Yes	98	100	100
Facility has following supplies/items to insert or remove the implants			
Marking pen	96	90	98
Tape measure (Plastic ruler preferred)	86	81	93
Alcohol pads	94	79	98
5 ml syringe 2% lidocaine with Epi + 0.5 ml	91	88	93
8.4% Sodium Bicarbonate	90	67	93
18 g to draw up medication	81	65	95
25g 1-1/2 needle to attach syringe	85	75	98
Non-sterile 4 x 4's	85	69	95
A + D ointment	86	69	88
1 or 2 inch gauze roll for pressure	95	81	98
Tape	94	79	98
Bandage Scissors	96	94	98
Benzoin, Sterile-strips, Ethyl Chloride	93	79	100
Clean Gloves	98	100	98
Antiseptic	98	94	95
Sterile Gauze Pad or Cotton Wool	98	98	93
Local Anaesthetic	96	90	95
Sealed Implant Pack	98	94	98
Surgical Blade	95	85	98
Mosquito forceps (Straight or Curved)	90	77	98
Number of facilities that provides Implants method	**80**	**48**	**40**

6.4 Quality of Services

Effective communication between service providers and family planning (FP) clients plays a crucial role in ensuring continued use and satisfaction among clients. Counselling, as highlighted by previous research, is an essential aspect requiring persistence and comprehensiveness to encourage clients to adopt contraception for the long term. During the survey, facility staff were asked regarding FP counselling, specifically focusing on informing clients about the benefits and side effects of various methods. According to the facility staff, the benefits of all methods are communicated to clients, some are emphasized more than others as per the need of client. Disparities exist in terms of sharing the benefits with clients across different types of facilities. However, methods such as IUCD, Pills, Condoms, and ECP receive greater attention from the DOH and PWD facilities compared to private sector facilities. Table 6.8 reveals that DOH and PWD health facilities exhibit a significantly higher level of emphasis on communicating benefits relative to private sector facilities.

Staff across all types of facilities also provide necessary information on the side effects of various modern and traditional FP methods to clients. According to the survey results, DOH and PWD health facilities staff place a notably greater emphasis on communicating the side effects of FP methods compared to private sector facilities (Table 6.9).

Table 6.8: Percent distribution of service providers who give information on benefits of specific method

Characteristic	DOH	PWD	Private Facility
Female sterilization	78	89	80
Male sterilization	63	76	63
IUD	94	100	91
Injectables	99	100	96
Implant	89	95	89
Pills	99	100	97
Condoms	98	100	93
Emergency contraception	95	100	90
Standard days method	85	92	77
Lactational amenorrhea method	92	97	91
Rhythm method	93	95	91
Withdrawal	92	95	87
Number of Facilities	119	66	94

Table 6.9: Percent distribution of service providers who give information on side-effects of methods

Characteristic	DOH	PWD	Private Facilities
Female sterilization	79	92	80
Male sterilization	63	76	64
IUD	95	100	94
Injectables	98	100	96
Implant	89	97	90
Pills	98	100	96
Condoms	96	100	94
Emergency contraception	94	98	91
Standard days method	84	94	78
Lactational amenorrhea method	90	95	91
Rhythm method	92	98	91
Withdrawal	90	95	90
Number of Facilities	**119**	**66**	**94**

6.5 Charges made on FP Commodities and Services

A dedicated segment was incorporated in the survey to assess the pricing policies of different facilities. Service providers were requested to disclose their approach to charging for commodities. DOH and PWD facilities uniformly offer FP commodities and services either free of charge or at nominal rates. Conversely, private sector facilities indicated that a significant proportion levy charges for commodities and services to maintain their business operations. The percentage of facilities offering contraceptives for a fee and the average charges imposed on clients by private facilities for each contraceptive method is illustrated in Table 6.10.

- The survey indicates that among the visited facilities neither DOH nor PWDs offer both male and female sterilization services. In 2024, 27 percent private health facilities provide female sterilization services (tubal ligation), with an average cost of Rs 4,539 (up from Rs 3420 in

2023). Generally, a small proportion of private sector facilities offer tubal ligation and vasectomy, and the average charges differ.

- The survey findings indicate that only a few DOH and PWDs offer injectables on price, whereas 74 percent private health facilities provide injectables (up from 53% in 2023), averaging a cost of Rs 318, which was Rs 260 in 2023 survey.
- Among the long-acting contraceptives, implants provided by private facilities are the most costly item, priced at Rs. 1,253 which was above Rs 1400 in 2023 survey. Furthermore, a large proportion of private facilities (62%) make IUCD available and their charges are on average are Rs. 684 which were more than Rs. 800 per unit in 2023. IUCD is comparatively less expensive from private providers.
- The survey indicates oral pills, and condoms, made available by private sector are notably low priced than other commodities. Phase 2 survey reveals higher percent of private facilities charging for FP.

Table 6.10: Percentage of private facilities dispensing family planning methods on charge to clients

Methods	Private Facilities	
	2023	**2024**
Female sterilization	19	27
Average Charges (Rs)	3,420	4,539
Male sterilization	1	1
Average Charges (Rs)	9,000	7,000
IUD	41	62
Average Charges (Rs)	828	684
Injectables	53	74
Average Charges (Rs)	260	318
Implants	20	37
Average Charges (Rs)	1,404	1,253
Oral Pills	43	68
Average Charges (Rs)	155	115
Condom	35	47
Average Charges (Rs)	279	108
Emergency contraception	29	43
Average Charges (Rs)	169	117
Number of Facilities	**123**	94

6.6 Availability of Contraceptive Stocks

Availability of FP commodities is the backbone of FP delivery mechanism. All facilities visited during the survey were enquired about the stocks of each contraceptive method and the duration of stock outs where these were not available. The stocks register was used to record information of various key contraceptives at the facility. Table below (Table 6.11) captures percent of facilities that reported availability of specific commodity, percent facilities that experienced stock out which were asked for the period of stock outs of that commodity. As compared to 2023 survey report, Health Dept. facilities show adequate stocks of oral pills, IUCDs and injectables. Contrary to

previous year, implants are reported stock-out in more health facilities and average stock out days of more than three months (96 days). On the other hand, majority of PWD facilities show improved stocks availability (except Implants) (Table 6.11) and only a few facility reflect stock out. Few private sector facilities show several contraceptives (condoms, pills, injectables, and emergency pills) stock outs for over years. LARCs including IUCD and Implants are not available in few private facilities but lack of stocks in some facilities for several months need attention for improved availability to enhance accessibility and continuity of use.

Table 6.11: Percent facilities with stocks of contraceptives and others with stock outs by number of days stock-outs

Condoms	DOH		PWD		Private Facility	
	Available	Not Available	Available	Not Available	Available	Not Available
Percent of Facilities	90	8	89	11	56	5
Stock out days (average)		71		10		2274
Pills (Cycles)						
Percent of Facilities	97	1	89	11	79	7
Stock out days (average)		30		11		1599
IUD (units)						
Percent of Facilities	75	3	79	17	59	8
Stock out days (average)		21		109		191
Injection (Vials)						
Percent of Facilities	91	3	100	0	81	7
Stock out days (average)		13		-		1599
Implants						
Percent of Facilities	53	14	58	15	35	7
Stock out days (average)		96		59		291
Emergency Pills						
Percent of Facilities	71	13	88	11	50	6
Stock out days (average)		94		34		1873
Number of Facilities	**119**		**66**		**94**	

6.7 Human Resource Development for Family Planning

Proficient and skilled service providers are core to ensure quality of service delivery. Survey asked several questions regarding human development to staff dispensing family planning services in the facility. The idea is to assess their technical knowledge and how they use their knowledge in service delivery. Staff was asked about types of training in family planning received by them in the previous three years. Survey revealed that 67 percent of staff of DoH, 76 percent of PWD, and 53 percent staff of private sector facilities received training in the past three years (Table 6.12). Main training for PWD staff focused on FP technology, IUCD and implant insertion/removal (58-56%) followed by FP counselling and PPIUCD related training. However, the Health Department staff IUCD, FP counselling and contraceptive logistics related training distantly followed by implant were key training reported. Fewer staff received training in Minilap and infection prevention management, which needs to be enhanced to all staff.

Table 6.12: Percentage of staff reported type of training received

Type of training received on family planning/ contraceptive	DoH	PWD	Public Facility	Private Facility
Family planning (contraceptive technology)	49	56	52	64
IUCD insertion/removal	61	56	59	68
Contraceptive logistics management	51	48	50	52
Family planning counseling	56	54	55	74
Client Centered Family planning	49	40	45	46
Clients rights	38	40	38	46
Minilap/ Vasectomy	11	16	13	20
Implant insertion/ removal	44	58	49	50
PPIUCD insertion / removal	40	50	44	52
Infection prevention management	38	36	37	44
Number of respondent who attend training	**80**	**50**	**130**	**50**

6.8 Opinions Regarding Service Improvement

Provision and access to family planning services have been persistent issues over the years. All facility based service providers were asked what they felt was essential to help boost delivery of FP services. A wide variety of responses were noted across type of facilities and spelled out in the Table 6.13. More the half of DoH staff pointed additional staff needs followed by provision of transport for field visits and provide counseling to community level and community mobilisation. The PWD staff also noted need for additional staff and transport for field visit as important areas. For private sector staff provision of provision of free contraceptive (50%) and availability of contraceptive commodities (47%) are key areas (Table 6.13). These are good field level suggestions to enhance access and availability of family planning services at the grassroots.

Table 6.13: Percentage of requirements identified by staff to promote family planning

Requirements identified by staff	DoH	PWD	Public Facility	Private Facility
Training to provide and serve the methods	14	20	16	35
Training for management for side effects	24	30	26	34
Availability of contraceptives commodities	16	17	16	47
Provide counseling to community level	34	20	29	36
Clarify doubts about religious aspects	16	11	14	22
Provide contraceptive free of cost	14	15	15	50
Provide general medicines	25	32	28	36
More staff needed	53	56	54	35
Free camps	32	27	30	39
Ultrasound machine and delivery kit should be provided	33	12	25	22
Clients should be supported financially	19	27	22	21
Transport for field visits	39	50	43	18
Staff for community mobilization	35	39	37	16
Others	16	11	14	19
Number of Facilities	**119**	**66**	**185**	**94**

6.9 Suggestions Regarding Service Quality Improvement

Service providers were asked to identify key areas they deemed essential to discuss with potential family planning clients. Health, PWD, and private sector providers highlighted several crucial areas, including the advantages and disadvantages of various methods, instructions on how to use the method, clarification on how the method works to address any misinformation, the duration of use, and potential side effects (Table 6.14). However, there was a notable variance in prioritization

among Health staff regarding how the method works, management of side effects, and follow-up procedures. To ensure quality counseling, it is imperative that all these aspects are comprehensively covered and uniformly discussed with clients using standardized protocols. Encouragingly, there was a consensus among respondents across Health, PWD, and private sector providers on many aspects of counseling, indicating a degree of uniformity in practice.

Table 6.14: Percentage of areas of counselling given to clients

Suggestions for Improvement	DOH	PWD	Public Facility	Private Facility
Advantages and disadvantages of the method	88	91	89	90
How the method works	77	85	80	87
How to use the method	81	86	83	88
How often to use the method	79	82	80	89
Duration of use	76	86	80	86
Effectiveness level	80	80	80	84
Possible side effects	79	88	82	81
Management of side effects	55	71	61	57
Return for follow up	86	92	88	87
Refer, if method not available	66	71	68	64
Number of Facilities	**119**	**66**	**185**	**94**

6.10 Assessment of Service Provider's Technical Knowledge

To evaluate the technical knowledge of service providers, facility staff providing family planning were presented with eight specific questions covering various aspects of family planning, contraceptive technology, health conditions for contraception use, and technical issues related to different contraceptive methods. Multiple-choice responses were provided, aiming to seek the correct answer from respondents. The table below details the questions and the percentage of facility-based care providers who provided the correct answer (along with the correct answer).

Overall, PWD staff demonstrated better knowledge compared to staff from other entities, correctly responding to five questions with over 60 percent accuracy (Table 6.15). On the other hand, DOH, and private facility staff achieved a 60 percent accuracy rate in only two to three technical questions. For more specific inquiries concerning topics such as miscarriage, Norigest usage, oral pills, IUCD side effects, and emergency pills, the proportion of correct responses varied across staff entities, indicating the need for knowledge enhancement and refresher training among staff. The higher percentage of responses from Population Department staff suggests their enhanced understanding due to focused contraceptive training, while Health Department staff exhibit better pre-service training in maternal health issues, particularly related to miscarriage, postpartum care, and delivery. Questions with less than a 60 percent response rate warrant immediate attention and staff refresher training. Utilizing e-learning technology could be beneficial in addressing knowledge gaps among facility staff.

Table 6.15: Percentage of corrected responses to specific technical questions about contraceptive methods and family planning/ birth spacing

Responses to Technical Questions and Correct Answers	DOH	PWD	Public Facility	Private Facility
Period of spacing between birth of a baby and becoming pregnant again (At least 24 months)	60	53	57	48
How long should women wait after a miscarriage before becoming pregnant again (After 6 months)	50	68	57	64
Norigest injection to have continuous protection against pregnancy (8 weeks)	31	56	40	23
Indications when oral pills can be provided (Women aged over 35 years who smoke)	27	21	25	14
Who cannot have IUCD (Post abortion clients who have purulent discharge)	65	71	67	72
What is true about emergency contraception (EC Pills) (All of answers)	22	35	26	44
Side effects of IUCD (All of the above)	19	33	24	39
Replace IUCD after how long (After 12 Years)	39	48	43	34
Number of Facilities	**119**	**66**	**185**	**94**

6.11 Assessing Knowledge of FP Providers regarding Family Planning Methods and Services

FP service providers across all facilities were surveyed using 14 statements to assess their understanding of various aspects related to contraceptive methods and family planning/birth spacing. The table below (Table 6.16) illustrates the percentage of service delivery staff who provided correct responses to these statements. The questions covered a range of topics, including the decision-making process for providing contraceptive methods, handling of medical equipment, and guidelines for different contraceptive methods. Responses were categorized by the type of healthcare facility, including DoH, PWD, public facilities, and private facilities. Some questions were intentionally posed in a tricky format to gauge clarity of understanding among the staff, while others focused on recent advancements in infection prevention and other preventive measures. The aim was not only to evaluate their technical knowledge but also their perceptions based on their training and experience. Overall, the questions addressed quality-of-service aspects crucial for building confidence in contraception among clients.

Technical knowledge pertaining to disposable syringes, oral pills, IUCDs, and Depo-Provera appears to be lacking among several service providers based on the questions asked. The low percentage of correct responses across all sectors is concerning and highlights the urgent need for refresher training for all service providers. Enhancing competencies through refresher training for FP staff across all sectors is essential to improve the quality-of-service delivery.

Table 6.16: Percentage of service delivery staff understanding correctly to species about contraceptive methods and family planning/birth spacing

Questions (with Correct Responses)	DoH	PWD	Public Facility	Private Facility
The doctor should decide provision of contraceptive of method to a client as per his/her own best judgment (False)	82	83	82	78
It is important to discuss misconceptions and rumors about Family Planning methods with the client (True)	96	94	95	99
Always bend the needle of a disposable syringe after use to make sure it cannot be reused (False)	17	11	15	9
Decontamination of the needle and syringe must be done before destroying it in destruclip (False)	73	70	72	48
The strength of chlorine solution is 0.1% for effective decontamination (False)	62	74	66	46
If a client is on injection depo -provera, she comes one week later than the schedule time; she can be given a second injection (True)	88	79	85	82
Oral pills can be given to nulliparous women (True)	53	58	55	35
A woman who is breastfeeding a baby can take progestin-only pills after 6 weeks of delivery (True)	72	86	77	73
A progestin-only pills can be used for emergency contraception after unprotected sex (True)	51	50	51	56
A woman should stop using depo –provera (3 months injection) if she has no menstrual bleeding for a long time (amenorrhea) (False)	48	42	46	41
Sterilization should be offered only to woman who have had a certain number of children or who have reached a certain age (False)	40	39	40	24
A woman who has never had a baby can use an IUCD (True)	29	41	34	18
A woman with diabetes can be given/insert an IUCD (True)	61	55	59	51
Withdrawal method is highly effective and practical among teenagers (False)	41	38	40	46
Number of Facilities	**119**	**66**	**185**	**94**

6.12 Facility Level Performance Assessment

Survey examined and recorded two important pieces of information from facilities' based Client and Service Registers - the number of clients served and total commodities dispensed by various facilities from June to August 2024. The Table 6.17 gives an interesting distribution of clients for three months and facilities by Departments. Facilities register clients with the purpose of their visit and records commodities dispensed to them.

The three-month record of clients shows a mixed trend (some increase and others decline) in general clientele during June to August 2024 at Health and PWD facilities. Public sector clientele for IUDs reflects an increase and then a decline over three months but is much higher than private facilities. For injectables, the increasing trend of clientele over three months is noted but remains much higher than private facilities (Table 6.17). For injectables, clients visit for replenishment or first-time injection. Oral Pills is the only commodity where public and private facilities are equal and have good number of clienteles. Oral pills clients are provided with at least one cycle (for a month) but more than one is also feasible to minimize client's follow up visits. Trend of oral pills shows fluctuating rise over three months. Similarly, the trend for condoms clientele for public facilities as noted in Table 6.17 and it almost following similar patterns across all types of facilities. Male

sterilization has limited facilities and services so we notice few cases in each month for private facilities only. Private facilities have low condoms dispensation as these represent sales. Implant clients show a gradual decline from public sector facilities over three months. Emergency Contraceptive (EC) Pills are the lowest item dispensed also to fewer clients.

It is interesting to note that number of clients and number of commodities served by public sector for IUCDs, implants, and injectables are very well aligned (quite similar) reflecting accuracy in recording of commodity dispensation. Oral pills and condoms are two commodities that are dispensed more than one per client for longer term usage.

Closer analysis of Table 6.17 reveals total number of IUCD clients and number of IUCD dispensed are consistent over three months for each type of facility. Injectables clients do also match with the number of injectable dispensed. What catches eyes is the difference between PWD and DoH facilities number of clients and number of commodities dispensed oral pills, and condoms. Pills dispensation is almost 1.5 times the number of clients registered by the DoH and PWD facilities. Condoms are normally dispensed 5-6 items per client on their visit. Pills and condoms are provided free of charge but number of items given to clients does not show any uniformity across Depts.

A quick review of three-month record shows that 77,815 family planning clients were served by 279 public and private facilities. Fourteen percent of these clients are served by private sector facilities. It is interesting to note that more than 47 percent of all FP clients are registered and served by Dept of Health facilities over the three months period. The proactive pursuit of FP agenda by Health facilities is a positive aspect of enhancing access and availability of contraception to women.

Table 6.17: Percent distribution of total number of family planning clients according to type of facility

June-24	Total FP Clients				July-24	Total FP Clients				Aug-24	Total FP Clients			
Contraceptive Method	DOH	PWD	Public Facility	Private Facility		DOH	PWD	Public Facility	Private Facility		DOH	PWD	Public Facility	Private Facility
Female sterilization	236	0	236	35		239	0	239	44		191	0	191	47
Male sterilization	0	0	0	80		0	0	0	35		0	0	0	96
IUD	649	232	881	427		795	270	1,065	444		753	237	990	543
Injectables	3543	2721	6264	759		3,774	2,625	6,399	772		4,198	2,556	6,754	931
Implant	497	278	775	73		382	251	633	77		343	174	517	78
Pills	3471	2916	6387	750		3,632	4,010	7,642	862		3,437	3,125	6,562	1,011
Condoms	3089	3472	6561	924		3,524	3,103	6,627	1,210		3,160	3,018	6,178	1,455
Emergency contraception	353	341	694	112		326	345	671	139		273	295	568	122
Number of Facilities	**119**	**66**	**185**	**94**		**119**	**66**	**185**	**94**		**119**	**66**	**185**	**94**

Jun-24	Total Products/Services dispensed				July -24	Total Products/Services dispensed				Aug -24	Total Products/Services dispensed			
Contraceptive Method	DOH	PWD	Public Facility	Private Facility		DOH	PWD	Public Facility	Private Facility		DOH	PWD	Public Facility	Private Facility
Female sterilization	201	0	201	30		196	0	196	43		150	0	150	45
Male sterilization	0	0	0	80		0	0	0	35		0	0	0	96
IUD	639	232	871	418		735	270	1,005	439		756	237	993	539
Injectables	3,461	2,721	6,182	736		3,616	2,612	6,228	756		3,996	2,570	6,566	896
Implant	447	278	725	72		395	251	646	75		290	174	464	87
Pills	4,553	4,391	8,944	1,614		4,815	5,438	10,253	1,419		4,566	4,335	8,901	1,741
Condoms	17,763	16,252	34,015	4,515		19,183	19,998	39,181	6,001		15,936	17,706	33,642	6,346
Emergency contraception	304	371	675	153		281	486	767	145		238	293	531	124
Number of Facilities	**119**	**66**	**185**	**94**		**119**	**66**	**185**	**94**		**119**	**66**	**185**	**94**

6.13 Integration of Family Planning with Maternal Health Services

An important area of interest to enhance access to family planning is integration of FP in maternal health services especially by Department of Health and private sector facilities. The facility survey enquired this in particular from all outlets as to what extent this is being practiced. The reason behind that is to assess the scope that FP services could be enhanced by women coming for their maternal health needs.

Percentage of facilities that offer maternal health services besides FP services categorized by the Department of Health (DOH), Population Welfare Dept. (PWD), and private facilities are presented in Table 6.18. For instance, under the "Antenatal care service" characteristic, 83% of DOH facilities, 86% of PWD facilities, and 94% of private facilities provided antenatal care services. Similarly, "delivery service," is provided by 64% of DOH facilities, 12% of PWD facilities, and 79% of private facilities offered delivery services. Fewer of PWD facilities offer safe delivery services. All facilities also claimed to provide FP counseling and services at each of these maternal health stages. Overall, the table provides insights into the availability of various healthcare services beyond family planning across different types of health facilities.

Table 6.18: Percentage of health facilities which provided services other than family planning

Characteristic	DOH	PWD	Private Facility
Antenatal care service	83	86	94
Delivery service	64	12	79
Postnatal care service	80	89	91
Post-abortion/Miscarriage service	66	68	85
General Ailment service	99	94	96
Number of Facilities	**119**	**66**	**94**

A large proportion of DoH and Population Welfare facilities acknowledged providing needed counseling to women visiting facilities for ANC/PNC and post-abortion care. The areas of counseling include healthy timings and spacing of pregnancies, exclusive breastfeeding, long-acting methods, and where to obtain their choice method. Detail is provided in the Table 6.19 and 6.20.

Table 6.19: Percentage of health facilities which discussed the services with women after delivery or during first postnatal visit

Matters discussed with Women on Postnatal Visit	DOH	PWD	Private Facility
Return to fertility Healthy timing and spacing of pregnancies services	99	98	100
Immediate and exclusive breastfeeding services	98	98	94
Family planning methods available while breastfeeding services	98	98	94
Lactational Amenorrhea Method and to use transition to other methods services	92	97	93
Long-acting method options-LAM services	88	97	97
Woman offered a method of family planning during the postnatal visit	88	90	96
Number of facilities which provide ANC/ delivery care/ postnatal care	**101**	**59**	**89**

The survey revealed that most of the public facilities and private facilities discussed the services with women after delivery or during their first postnatal visit and during the post abortion visits (Table 6.20).

Table 6.20: Percentage of health facilities which discussed the services with women during post-abortion visits

Areas discussed with post-abortion patients	DOH	PWD	Private Facility
Post-abortion/ Miscarriage maternal health	95	93	99
Return to fertility Healthy timing and spacing of pregnancies	100	100	99
Long-acting method options-LAM	99	100	95
FP methods for birth spacing	99	100	98
Women offered a method of family planning during the post-abortion visit	91	93	81
Given information on where they can obtain contraception elsewhere	95	100	96
Number of facilities which provide post abortion/ miscarriage services	**79**	**45**	**80**

Facilities were asked to share their MCH services records and patients attendance for the three months prior to the survey (June to August 2024). The idea was to assess the functional integration of FP with various MCH services. Registers reveal a total of 78 thousand MCH visits recorded over the three months in the 279 facilities (Table 6.21). In addition, 406 thousand visits were made for general ailment health issues during these months. Twenty Seven percent of all maternal health visits are recorded by private facilities for ante-natal care, 16 percent for delivery and 9 percent for post-natal care. All these visits reflect tremendous potential for FP counseling and PNC patients for post-pregnancy FP. Of the total maternal health visits, 20 percent are recorded by private sector facilities. Of the total general ailment visits, 10 percent are recorded by private sector facilities. Private sector therefore plays an important role in health sector and their involvement in integrating family planning in MCH is critical and essential to move forward in the sector. Currently facilities do not maintain any record on integration of services.

Table 6.21: Average number of patient record in the month, according to type of facility

June-24	Average Number of Patients				Jul-24	Average Number of Patients				Aug-24	Average Number of Patients			
Health Services	DoH	PWD	Public Facility	Private Facility		DoH	PWD	Public Facility	Private Facility		DoH	PWD	Public Facility	Private Facility
Antenatal Care	166	53	127	139		196	55	147	142		161	55	125	154
Delivery	46	49	46	21		80	53	78	23		51	68	52	25
Postnatal Care	150	11	99	29		89	10	60	26		179	11	118	24
General Ailment	876	142	633	235		1,091	169	785	257		1,116	153	797	261
Number of Facilities	119	66	**185**	**94**		119	66	**185**	**94**		**119**	**66**	**185**	**94**

Total number of patients recorded in the month according to type of facility

June-24	Total Number of Patient Visits				Jul-24	Total Number of Patient Visits				Aug-24	Total Number of Patient Visits			
	DoH	PWD	Public Facility	Private Facility		DoH	PWD	Public Facility	Private Facility		DoH	PWD	Public Facility	Private Facility
Antenatal Care	15,615	2,660	18,275	6,649		18,465	2,766	21,231	6,799		15,179	2,766	17,945	7,413
Delivery	3,317	294	3,611	827		5,787	318	6,105	902		3,675	407	4,082	964
Postnatal Care	13,538	555	14,093	1,332		8,032	505	8,537	1,205		16,126	583	16,709	1,121
General Ailment	97,251	7,794	105,045	11,993		121,072	9,288	130,360	13,105		123,912	8,399	132,311	13,323
Number of Facilities	**119**	**66**	**185**	**94**		**119**	**66**	**185**	**94**		**119**	**66**	**185**	**94**

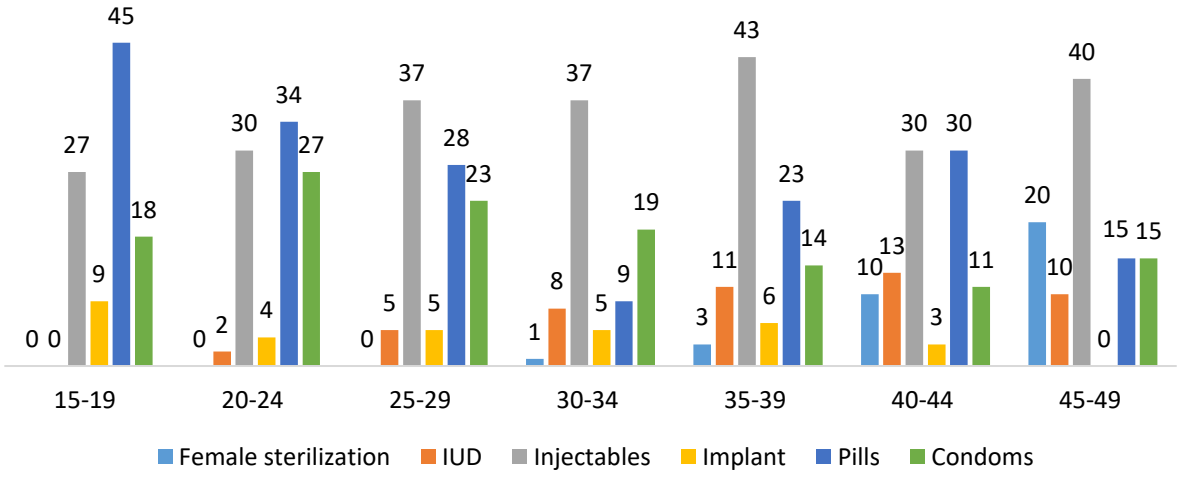
USER'S VOICE: CLIENT EXIT INTERVIEWS AND SERVICE SATISFACTION 7

Interviewing women exiting health facilities adds to the uniqueness of the survey to learn directly from them their experience of service quality and what they received. This segment is the only section where respondents are not the same as were in the household/woman section and Facility interviews. The survey focuses on family planning, the tool also seeks information from them regarding family planning services and experiences of counselling, and affordability. Ten exit interviews were performed with the women in each facility to seek their feedback and level of satisfaction for FP/MCH services received/ provided at the facility to them. A total of **2,789** women clients were interviewed, of whom 49 percent from urban facilities. Overall almost 54 percent were family planning clients (1492 cases), 13 percent came for ANC and 28 percent visited for general health issues.

7.1 Method Prescribed or given on the Visit

The exiting family planning clients were asked about the method prescribed or given to them. The Survey reveals that though injectables remains at top the list (37%), while oral Pills and condoms are also prescribed/ suggested to a high percent of clients (28% and 19%) (Table 7.1). There is no major difference between urban and rural exiting client's responses regarding method suggested to them. However, the most prescribed method at to young women are oral pill and condoms (54%). Interestingly, the older clients (age 40 plus) are prescribed tubal ligation, IUCD and injectables. Implants too are emerging as a common method prescribed to younger women (age less than 35 years).

Figure 7.1: Percent distribution of family planning methods prescribed to exiting clients



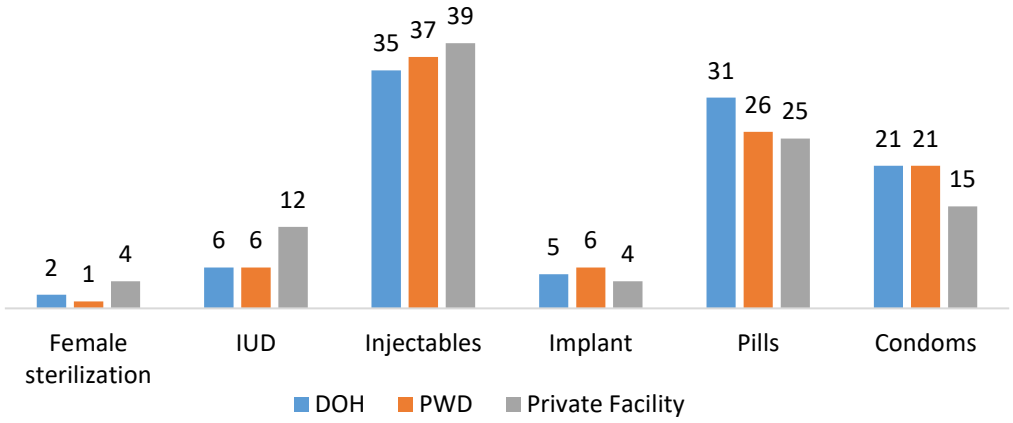
Percent distribution of prescribed methods by place of residence also interesting to note. Injectables are prescribed relatively higher to urban women while oral pills and condoms bit more to rural women exiting facilities (Table 7.1).

Table 7.1: Percent distribution of family planning method prescribed or given by place of residence

Residence	Female sterilization	IUD	Injectables	Implant	Pills	Condoms	Cases
Urban	3	8	40	6	25	18	**731**
Rural	2	7	34	4	31	20	**751**

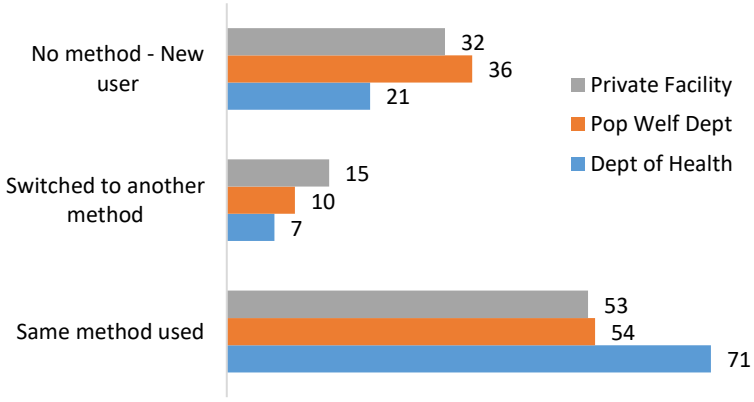
Moreover, more than a third of all injectables (35+ %) are prescribed public facility and maximum (39 percent) by private facilities (Figure 7.2). Little less than one-third of clients are prescribed pills (31%) by DoH facilities and a quarter of private sector facilities clients are prescribed oral pills. Overall situation is similar to what was recorded in previous year.

Figure 7.2: Percent distribution of family planning methods prescribed or given to clients by source of service



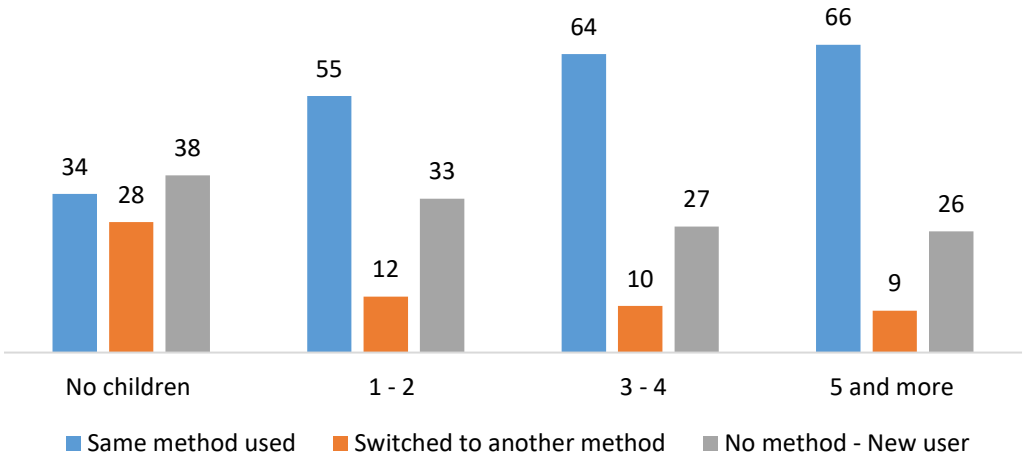
The survey reveals that a large percent of clients are using the same method and highest percent 71% is reported for DoH exit clients and 53 percent women given the same method by the private sector facilities. A small percent of clients switch methods (between 7 to 15%) by various entities. Most interesting group is the new users who are first time user almost a third (32%) reaching out to private facilities and only 21 percent reached out to DoH facilities. Need for accurate counseling is felt at this point esp when a large segment of clients visit private sector where counseling for family planning is rather weak.

Figure 7.3: Percent distribution of family planning methods prescribed or given by providers by whether clients were using the same or different methods



The clients exiting the facilities are about the kind of method they received from the facility. Analysis of percent distribution of type of FP method prescribed to user by women's parity size is shown in Figure 7.4. Clients reflect using the same method persistently with rise in the number of children. A small percent of clients (12% & 9 %) switch to another method across all parity size. While more than a quarter of clients are new users who are prescribed a method irrespective of parity size.

Figure 7.4: Percent distribution of family planning method prescribed or given to client by parity



7.2 Charges Paid by Clients for Contraceptive Methods and Services

Accessing family planning (FP) services may face obstacles, including affordability concerns. Clients exiting facilities were surveyed about the costs incurred for contraceptive methods and services received. For each contraceptive method, the Table 7.2 shows the percentage of facilities that charge for the service and the average charges in Rupees (Rs) for both the method (actual contraceptive) and service (administration or consultation fees). Survey reveals that public sector clients typically reported no charges, while private sector clients displayed varying charges for different contraceptive methods, indicating a price differential. Additionally, private sector clients bear extra service charges, potentially increasing the overall cost of contraceptives. Despite these factors, women continue to utilize private sector services due to affordability. Comparison of results of two surveys (2023 and 2024) reveals few positive elements: increase in percent of private facilities providing various methods and services; lower commodity prices charged in 2024 over 2023 for Depo-provera, implants, and oral pills; and a bit higher commodity prices for IUCD, and condoms. A decline of service charges for tubal ligation, IUCD, implants and oral pills reflect lower costs to clients in 2024. Condoms though a popular method reflects an overall increase in cost to clients from an average of Rs 306 to Rs 500 over two years. In general, two family planning methods (tubal ligation and implant) show a decline in cost to clients while there is no overall change in costs of IUCD, injectables, and implants.

Several noteworthy observations arise from the survey findings. Firstly, not all private sector facilities charge for the commodities as a fair percent do provide free items and services. Secondly, overall prices of commodities and service are bit lower in 2024 relative to previous year charges

reported by clients. Thirdly, private sector needs to reflect on costs (commodities and service charges) to ensure women in need must get it and when they need it.

Table 7.2: Average charges for method by type of facilities

Contraceptive Methods		Private Facilities	
		2024	2023
Tubal ligation - Service Charges	Percent Facilities Charged	53	14
	Average Charges (Rs)	3,611	3,893
IUD - Method Price	Percent Facilities Charged	73	57
	Average Charges (Rs)	786	590
IUD - Service Charges	Percent Facilities Charged	70	38
	Average Charges (Rs)	312	550
Depo-Provera injection - Method Price	Percent Facilities Charged	65	47
	Average Charges (Rs)	279	307
Depo-Provera injection - Service Charges	Percent Facilities Charged	57	37
	Average Charges (Rs)	224	191
Implant - Method Price -	Percent Facilities Charged	41	25
	Average Charges (Rs)	843	2,175
Implant - Service Charges	Percent Facilities Charged	47	8
	Average Charges (Rs)	1,633	1,913
Pills - Method Price	Percent Facilities Charged	52	30
	Average Charges (Rs)	119	360
Pills - Service Charges	Percent Facilities Charged	18	13
	Average Charges (Rs)	286	401
Condoms - Method Price	Percent Facilities Charged	20	24
	Average Charges (Rs)	171	123
Condoms - Service Charges	Percent Facilities Charged	86	10
	Average Charges (Rs)	331	183

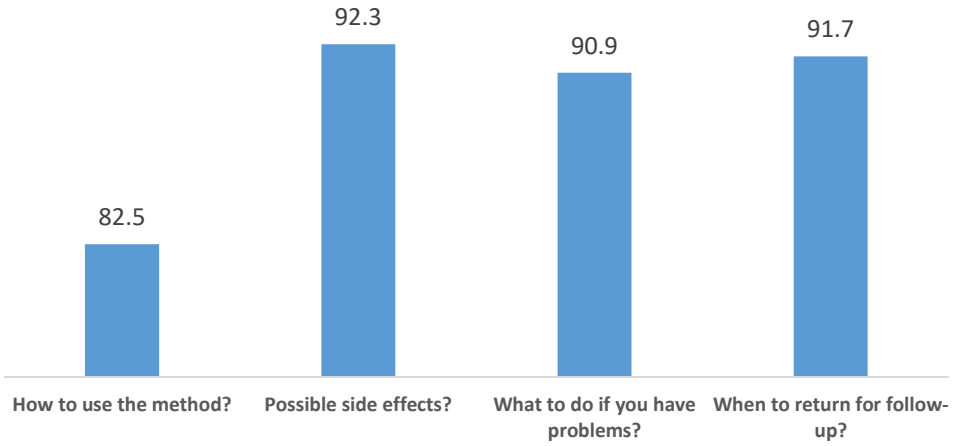
7.3 Quality of Service – Family Planning

Effective counselling is essential to ensure good understanding among women regarding contraceptive choice and selection of right method to address women's birth spacing needs. Several questions were posed to women exiting facilities to assess the comprehensiveness of counselling. The areas included: Whether they were explained how to use the method; Possible side effects of various methods; What to do if you have problems; When to return for follow-up; Contraceptive methods other than the method you were given or prescribed; Family planning method preference; and she could switch to a different method in the future.

Upon analyzing clients' feedback across different departments (Health, Population Welfare, or Private Sector), it becomes apparent that a higher percentage of women exiting all health facilities are informed about all four aspects of family planning focused quality of services. The survey, which addressed various aspects separately, revealed that slightly lower percentage of the women eighty three percent (83%) were explained how to use the contraceptive method, while ninety two percent (92%) were informed about the side effects of the contraceptives (Figure 7.5). Similarly, ninety one percent (91%) of the women were explained that what to do in case of problems.

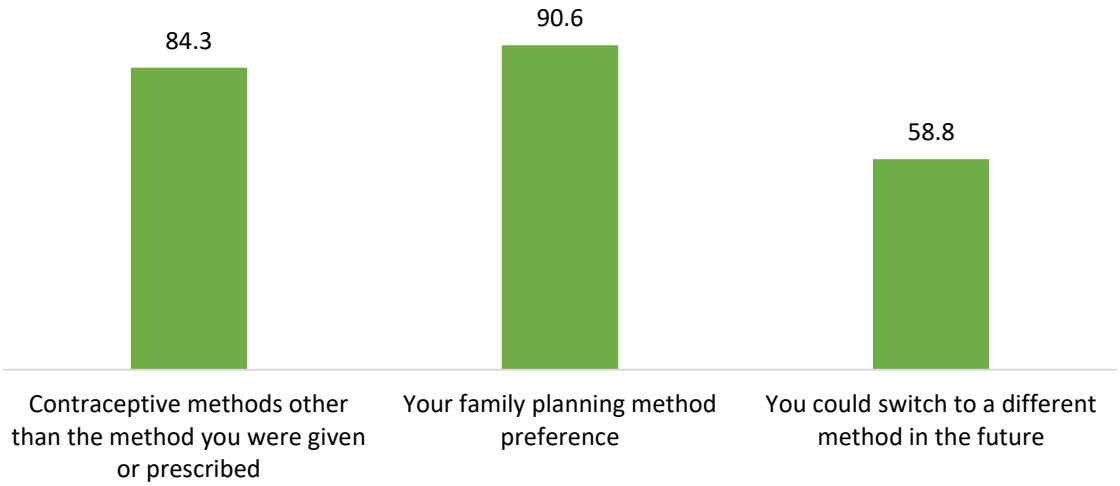
However, ninety two percent (92%) of the women were informed about when to return for follow up.

Figure 7.5: Percent FP clients who were advised on four aspects of FP (N 636)



Additionally, three additional inquiries were directed towards the Family Planning (FP) clients regarding the quality of FP services. The survey results indicate that 84 percent of the women were briefed about contraceptive methods other than the one provided to them. Furthermore, 91 percent of FP method users were inquired about their method preferences, while slightly fewer, 59 percent were informed about the option to switch to another FP method (Figure 7.6). Switching methods appears to be discussed lowest with clients by all service providers.

Figure 7.6: Percent FP clients advised by facility staff about three issues (N 663)



7.4 Counselling aspects of Family Planning

All aspects of family planning counselling provided by different types of facilities categorized as Department of Health (DOH), Population Welfare Dept. (PWD), and private facility, and across urban and rural areas is presented in Table 7.3. In general, almost all exiting clients reported to have been briefed on

these areas by the staff of three types of facilities. One area - switching methods is discussed lowest with clients by all service providers esp the PWD staff (Table 7.3).

Table 7.3: Percent FP Client advised by facility staff about different aspects of FP counselling

Areas of Counselling	DOH	PWD	Private Facilities	Urban	Rural
Explain how to use the method	81	80	86	78	87
Possible side effects	87	95	96	90	94
What to do if you have problems	86	94	93	89	92
When to return for follow-up	89	95	92	92	91
Contraceptive methods other than the method you were given or prescribed	83	82	87	79	89
Family planning method preference	86	94	92	92	90
You could switch to a different method in the future	61	48	67	60	58
Number of clients, prescribed or given family planning methods	**223**	**201**	**212**	**311**	**325**

7.5 Maternal Health and Integration of Services - Quality of Counselling Services

Integration of family planning with MCH services is an important area covered in the survey. Women were asked whether counseling was done or not on important matters during ANC visit. Four important areas of counseling were covered in the survey: early initiation of breastfeeding; exclusive breastfeeding; maintaining a balanced diet during pregnancy; and birth spacing.

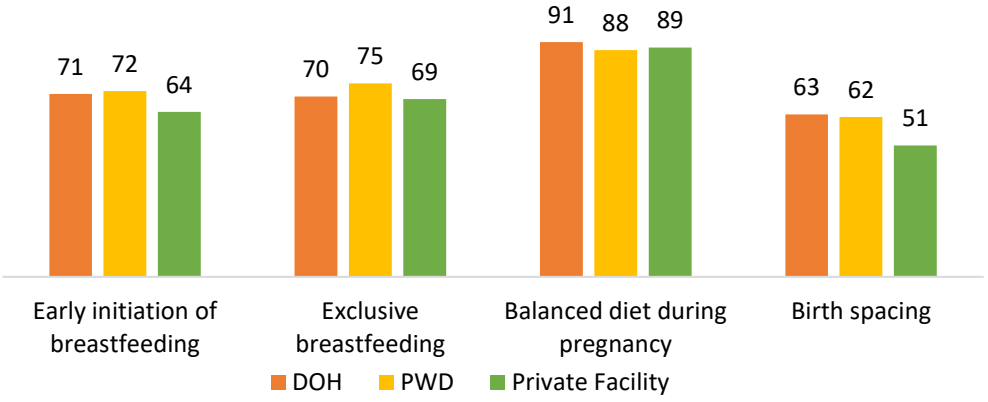
Client's responses by place of residence reflect higher percent of urban facilities provide counseling on three aspects than rural facilities (early initiation of breastfeeding, exclusive breastfeeding and Balanced diet during pregnancy) (Table 7.4).

Table 7.4: Percentage of women who reported counseling during ANC visit on specific matters by residence

Residence	Early initiation of breastfeeding	Exclusive breastfeeding	Balanced diet during pregnancy	Birth spacing	No of Cases
Urban	81	81	91	60	223
Rural	57	62	88	54	169

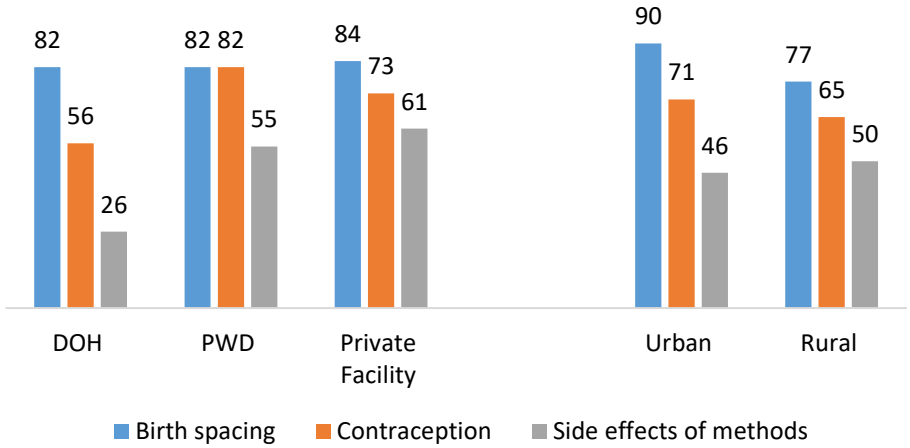
Moreover, women were asked four aspects of the quality of counseling services during antenatal care. Results indicate that 70% or more of women received counseling on early initiation of breastfeeding, exclusive breastfeeding and birth spacing from DOH facilities, followed by private facilities and least from PWDs staff (Figure 7.7). Survey reveals overall clients visiting DOH facilities get more opportunity of counseling than those who visit PWD facilities or even private facilities.

Figure 7.7: Percent distribution of responses on four aspects of quality of services of ANC by source



Another crucial aspect of integration of services relates to counselling provided to women during postnatal care by healthcare providers. To assess integration status among visiting mothers across various health facilities in both urban and rural settings, three questions were posed regarding the quality of counseling services on birth spacing, contraception, and the side effects of family planning (FP) methods. Survey results indicate that the majority of women were informed about birth spacing and its benefits. Birth spacing-focused counseling services were slightly higher among women visiting private facilities, at (84%), followed by for those visiting DOH and PWD facilities (82%). In terms of contraception-focused quality of services, PWD facilities led followed by private facilities (82% vs 73%) and DOH facilities with relatively low attention (56%) (Figure 7.8). Side effects of FP methods was reported highest by women visiting private facilities (61%), followed by PWD (55%) and quite low by women visiting DOH facilities with only 26 percent (Figure 7.8). DoH facilities need to gear up their facility staff to be better prepared and respond to quality-of-service issue and convey the same to clients.

Figure 7.8: Percent distribution of quality of services of postnatal care by facility and place of residence



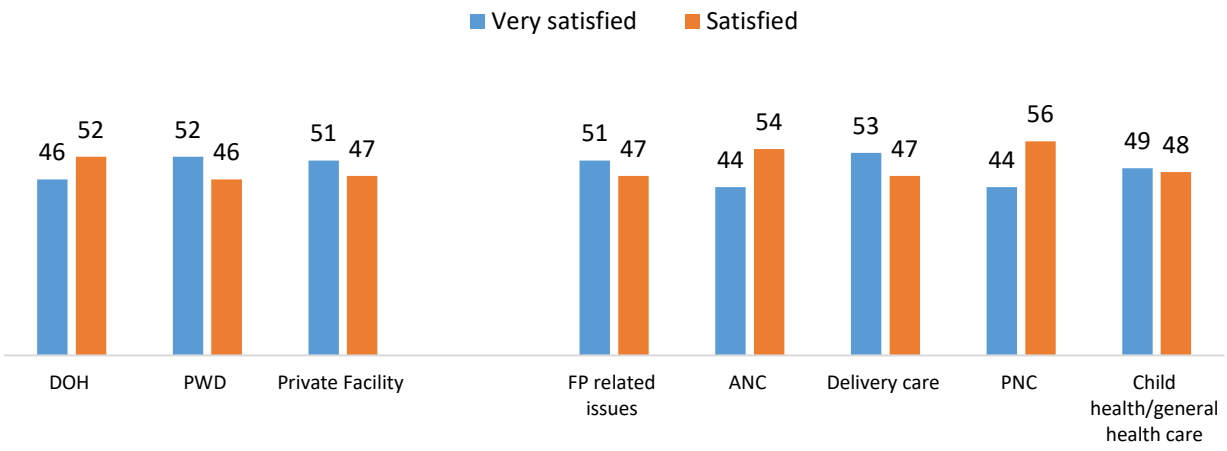
Examining responses across urban and rural facilities, results reveal no major difference across both setting except urban facilities are reported better counselling on birth spacing.

7.6 Client Satisfaction

Women exiting various facilities were asked regarding their satisfaction with the services they received from the facilities. Results reveal that 46 percent of women were very satisfied with the services provided by PWD facilities, followed by 51% with private facilities. Conversely, only 46% of women expressed satisfaction with services provided by DOH facilities (Figure 7.9).

Furthermore, when analyzed on specific services received, the highest percentage (53%) of delivery care clients expressed being 'very satisfied,' followed closely by those Family Planning (FP) services (51%), and Antenatal Care (ANC) services (44%). Overall results reflect clients are satisfied with the services received at these facilities.

Figure 7.9: Percent distribution of clients satisfaction of services



CONCLUSIONS AND RECOMMENDATIONS 8

8.1 Main Conclusions

1. The PMA framework-based exercise is efficient in terms of cost and time, and a tool for program decision makers with provincial level representative estimates of actionable results.
2. The exercise provides valuable information on several indicators and its use to reform and improve programme components is critical to capture desired progress.
3. Two messages are evident from the exercise: (i) changes in CPR in Sindh are currently driven by modern methods which needs acknowledgement of programme efforts; and (ii) Public sector has played an active role as a source to access and provide modern contraceptives. Private sector has a complementary role in the last few years to support access to modern methods.
4. The contraceptive method mix reflects a tilt towards use of modern methods. Female sterilization, condoms and injectables are the most popular methods while traditional methods are being adopted in increasing proportions by urban women. The use of injectables and implants has increased in recent years, reflecting the concerted effort made to promote choice of methods, as well as availability in facilities.
5. The adoption of modern methods especially among rural women reflects effectiveness of FP counseling provided to new users or first time users. Continuity of these efforts to maintain increased proportion of users is deemed necessary to encourage to use modern methods.
6. Rural women are estimated to have higher unmet need for contraception (26%) relative to urban women (19%) reflecting issues of access and need for counseling women to practice contraception.
7. Survey reveals more rural women (50%) have had interaction with LHWs than urban women (40%) and a good reason to believe LHWs played effective counseling to promote modern methods among rural women.
8. Women's interaction with health staff and discussion regarding FP is noted to give boost to percent women using contraception for birth spacing. Eighty percent of rural women reported visit to health facility for personal health issues or child health matters as against 67 percent urban women. Forty one percent rural women reported facility staff talking to them regarding family planning as against only 31 percent urban women.
9. ANC provides women the opportunity to learn more about contraception and improve their reproductive behaviours. Survey reveals that 94 percent of women received ANC from a skilled person (98 percent in urban areas).
10. Use of modern FP method is significantly higher among women who had interaction with health facility staff (42 percent against 30 percent). Women who reported ANC visits have modern CPR 37 percent against 18 percent of those who didn't had ANC visit.
11. Overall around 5 percent women reported experiencing unintended pregnancy over their lifetime. Urban women have higher unintended pregnancies (5.5 percent women relative to 3.9 percent rural women) that could be related to increased use of traditional methods. Almost 60

percent unintended pregnancies occur to women when they were between ages 25 and 34 is a serious concern reflecting urgent need to meet contraception needs.

12. Sindh reflects an improvement in the coverage/provision of implants from 56% to 60 percent of all surveyed facilities - 67 percent of DOH facilities, 73 percent of PWD facilities, and 43 percent of private facilities reported prepared to serve implants. This scale up has enabled clients with enhanced 'choice' of methods. Stock-outs are noted in handful of facilities and method availability promotes conditions that ultimately encourage the use of modern methods and likely lead to increased contraceptive continuation.
13. Overall prices of commodities and service charged by private facilities are bit lower in 2024 relative to previous year charges reported by clients.
14. The number of clients and number of commodities served by public sector for IUCDs, implants, and injectables are very well aligned (quite similar) reflecting accuracy in recording of commodity dispensation.
15. The proactive pursuit of FP agenda by Health facilities is a positive aspect of enhancing access and availability of contraception to women.
16. All DoH outlets/facilities integrate FP counseling and services at all maternal health stages. This integration needs thorough review at all facilities in the light of results of client exit interviews. All gaps in FP counselling to women during ANC, PNC and general ailment visits needs to be addressed effectively to encourage women use modern methods.
17. Technical knowledge of contraceptives and family planning is critical for effective counseling and FP services. PWD service providers have relatively better technical knowledge than staff at Health Department and private sector. Low proportion of providers across all sectors giving correct responses to a few critical questions is upsetting indicating urgent need for refresher training to all service providers. In particular, refresher training for DoH staff in various aspects of contraceptive methods (IUCD, and Norigest), contraceptive technology and counseling is needed. E-Learning technology may employed to reach out facility staff in remote areas to address staff's knowledge gaps.

8.2 Key Recommendations

1. To accelerate programme performance and timely achieve the policy objectives, all stakeholders must fully and urgently implement FP2030 commitments and CCI Recommendations. Regular meetings of the Sindh Provincial Population Task Force be called and strengthen provincial accountability fora and to coordinate among partners. Continuation of such surveys like PMA- Sindh and timely availability of reliable data will be important instrument to enable decision makers to track progress and make informed decisions.
2. Enhancing access, coverage, quality of service and contraceptive security are critical to fulfill FP2030 prime commitments. Making family planning counselling and services universally available at all public sector health facilities and private sector health facilities by 2025, especially where deliveries and PNC services are available is important. Promote post-pregnancy family planning services. Strong support and ownership by Department of Health is fully recognized as means for universal access.
3. For accelerated family planning programme social mobilization and community level counseling are essential. Adequate preparation is critical to overhaul demand creation and communication strategy and components. All community-based service providers (LHWs and

CMWs) and facility-based care providers (FWWs and LHVs) should give greater attention to counseling and must receive refresher training to focus on newly-wed, younger couples, low parity women and promote IUDs and implants. Furthermore, male mobilizers posted in rural communities must proactively pursue social mobilization role to educate men to make informed choices for birth spacing and use of long acting reversible methods. Myths and misinformation among men needs to be addressed.

4. Inequity in access remains a management barrier across the province. Proactively reaching out the vulnerable, poorest of the poor and marginalized population through its infrastructure should be a key priority of the public sector. Link family planning activities with Social Safety Net Programme (such as providing vouchers to poor women) and introduce innovative schemes for adoption of FP service and institutionalized birth delivery. Use of mobile service unit and local health facilities with trained staff must be engaged to reach out the poor communities for better access to services. Home delivery services of contraceptives must be tested and scaled up by the private sector entities.
5. The Heath Dept. has made credible progress in training facility staff in insertion and removal of implants. Survey reveals that several staff is actually trained in implant insertion. Supplies need to be coordinated to ensure smooth availability of services. Top priority be given to fully equip remaining health facilities in rural communities with trained staff in implant insertion with due provision of implants supplies to address unmet need and unintended pregnancies.
6. Boosting integration of family planning counseling and services: With a very large base of women visiting health facilities for their health needs (ante natal care, delivery and post-natal care) complete plan of action for functional integration of FP in all health protocols needs to be developed to ensure family planning services are delivered at ANC, delivery or postnatal stages including counseling regarding birth spacing and contraception services.
7. Proper implementation of Life Skills Education and Planned Parenthood programmes should be carried forward to boost not only demand but better understanding of contraceptive methods.
8. In order to achieve programme objectives and accelerate the FP Programme, competent and motivated human resource is of crucial importance. E-Learning technology developed and successfully tested in recent years has become very convenient to use. This technical advancement must be brought under use to meet the human development needs across all sectors especially for those working in remote facilities.
9. Stock-outs of contraceptives at private facilities is a serious concern. Contraceptive stock outs are a barrier to choice, easy access and a cause of unintended pregnancies. Long-term Joint assessment and procurement plan for all stakeholders is highly recommended to overcome the supply related problem. A dynamic logistics system must be in place to minimize chances of clients returning without a method and face increased risk of unintended pregnancies. The procurement plans for the upcoming years should specifically include the acquisition of implants. Additionally, ensuring long-term financing is crucial to guarantee contraceptive security.

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