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WHEN ONE SIZE DOESN'T FIT ALL: SEGMENTING THE FAMILY PLANNING MARKET IN AZERBAIJAN

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ACRONYMS

ACQUIRE	Access, Quality and Use in Reproductive Health
AzDHS	Azerbaijan Demographic Health Survey
BCC	Behavior Change Communication
CDC	Center for Disease Control and Prevention
CHAID	Chi-Squared Automatic Interaction Detection
DHS	Demographic and Health Survey
FP	Family Planning
FMP	*Feldsher*-Midwife Point
IPC	Interpersonal Communication Campaign
IUCD	Intrauterine Contraceptive Device
LCA	Latent Class Analysis
LAPM	Long-acting and Permanent Methods
MOH	Ministry of Health
MoE	Ministry of Education
NGO	Non-governmental Organization
OB-GYN	Obstetrician/Gynecologist
PBC	Process of Behavior Change
PHC	Primary Health Care
PHRC	Public Health and Reform Center of the Ministry of Health
PSP-*One*	Private Sector Partnerships-*One* Project (USAID-funded; 2005-2009)
RDA	Rural Doctor Ambulatories
RH	Rural Hospitals
RH/FP	Reproductive Health and Family Planning
RHS	Reproductive Health Survey
SSC	State Statistical Committee
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WC	Women's Consultations

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EXECUTIVE SUMMARY

BACKGROUND

Unlike many other Former Soviet Union countries, Azerbaijan experienced virtually no increase in modern contraceptive use since the late 1990s and continues to have one of the highest abortion rates in the region. Nevertheless, data from the most recent Demographic and Health Survey for Azerbaijan (AzDHS) (State Statistical Committee and Macro International, 2006) indicate that there is substantial latent demand for modern family planning (FP). These findings suggest an opportunity to expand the market for high quality and affordable modern contraceptives in Azerbaijan. Therefore, the United States Agency for International Development (USAID) in Azerbaijan funded Private Sector Partnerships-*One* (PSP-*One*) to conduct a client-centered market segmentation study to identify the needs and preferences[1] of different groups of potential modern FP users[2] so that program interventions can be tailored accordingly.

STUDY OBJECTIVES

The main purpose of this study is to develop unique segments of the population based on socio-demographic, economic and psychographic factors for the purpose of tailoring FP messages for each segment. Specific objectives are as follows: 1) Using a quantitative model, to systematically create like segments of FP non-users[3]; 2) determine the relative size of these different segments; 3) offer suggestions on how to prioritize the different segments according to a variety of considerations, including health impact priorities and the amount of effort and resources needed to effectively promote FP use; 4) develop recommendations, through a participatory process with in-country stakeholders, on the ways that program managers can effectively meet the FP needs of the segments through a targeted strategy; 5) gain a better understanding of provider attitudes and beliefs regarding FP; and recommend ways to meet the FP needs of different segments taking into account provider realities.

METHODOLOGY

We employed both quantitative and qualitative methodologies to achieve a comprehensive and rich understanding of FP issues from the client and provider perspectives. Using findings from a previous qualitative study of potential FP clients, we conducted a quantitative household survey of 1000 men and 1000 women of reproductive age to form the basis of identifying unique segments. We also conducted interviews with health providers to better understand their views and practices with regard to FP. All research activities were approved by the Ministry of Health (MOH) as well as by the Abt Associates Institutional Review Board, and all respondents gave informed consent to participate.

[1] We use "needs" here to mean a person's desire or need to use FP methods; we use "preferences" to mean a person's decision to prioritize or choose one method option over another for any personal reason.

[2] As per the DHS definition of CPR, "users" of modern contraceptives are the number of women currently using any method of contraception (http://www.measuredhs.com/help/Datasets/Current_Use_of_Contraceptive_Methods.htm). We use "potential users" to mean a possible or likely user of FP methods.

[3] As per the DHS definition of CPR, "non-users" of modern contraceptives are the number of women currently not using any method of contraception (http://www.measuredhs.com/help/Datasets/Current_Use_of_Contraceptive_Methods.htm).

QUANTITATIVE KEY FINDINGS

The market segmentation analysis produced six unique women's segments and four men's segments. We developed profiles for each of the segments by comparing results on several dimensions: general health attitudes; fertility and FP behaviors, awareness, attitudes, values and beliefs; and media and lifestyle characteristics. Descriptions of non-user segments of women and men follow.

Women's non-user segments:

- **Rural Conservatives** (32.4% of female non-users) are the poorest segment. They tend to hold traditional views about religion and its role in making FP decisions. Unlike other segments, Rural Conservatives believe that abortion is an FP method. They believe that using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion and that it is less expensive to get an abortion when needed, as opposed to paying regularly for an FP method. Overall, Rural Conservatives are distrustful of sources for FP advice other than their immediate family, doctors, midwives, older persons, and those who have already used FP.

- **Aware Ambivalents** (37.0%) believe a woman should pursue her career before having children. They understand the financial and health benefits of FP and have high awareness of the most common modern methods used in Azerbaijan. They recognize the psychological impact an abortion has on a woman and feel it is important for a health provider to counsel a woman whohas just had an abortion on FP methods. Although this segment is not the poorest, they worry about the cost of medical care and medication. The Aware Ambivalent has great trust in her partner/husband and typically consults him to make joint decisions on everything from how to spend household resources to healthcare and FP.

- **Prudent Urbanites** (8.8%) are wealthy and frequent radio listeners with high awareness of commonly used FP methods. Overall they are FP-positive. At the same time, they strongly reject the idea that an abortion is easier to obtain than an FP method. Prudent Urbanites also feel that an abortion causes psychological harm to a woman and that providers should discuss FP with a woman who has just had an abortion. Although this segment may be open to FP, they want to make sure the method is safe and that it does not interfere with their sexual pleasure or that of their partner. They trust their partner and feel that it is important to make joint decisions in daily life and on reproductive health matters.

- **Coming-of-Age Traditionalists** (15.1%) include young women who are unsure about their intention to use FP. Even though they have confidence that their healthcare provider can answer their questions about FP, they are embarrassed to ask. They believe their religion frowns upon pregnancy outside of marriage and they do not think one should worry about FP until after the first child. While Coming-of-Age Traditionalists trust their immediate family and their partner for FP-related advice, there are many sources they do not trust, including: friends, extended family, religious leaders, midwives, health station workers, pharmacists, pharmacy employees other than pharmacists, government and agency staff, and product advertisements.

- **Young Uncertain Urbanites** (3.6%) are single and college-educated. Due to a lack of experience, they are not yet sure whether FP methods might interfere with sexual pleasure and if this would be important to their partner. Young Uncertain Urbanites have limited knowledge about abortion. For example, they do not know if it is less expensive to get an abortion compared with using FP regularly.

They are also unsure whether using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion. The Young Uncertain Urbanite typically only trusts her mother, doctor, and nurses for FP advice, and distrusts many sources.

- **High-tech Progressives** (3.2%) are younger, wealthy, higher educated and tech-savvy. They frequently use the Internet and own mobile phones. Unlike other segments, High-tech Progressives do not believe it is important for an FP method to be in accordance with their religious beliefs. They also think learning about FP before becoming sexually active is important. Compared with other segments, this segment does not trust others for FP advice. Although they have higher awareness of FP methods compared with other younger segments, they are still unsure about the effects of abortion.

Men's non-user segments:

- **Inexperienced Progressives** (18% of male non-users) are young and single and have never had sex. They may be FP-positive: they consider it wise to learn about FP before becoming sexually active. They are more likely to believe that a woman should pursue her career before having children and that FP has health benefits for the woman. Inexperienced Progressives advocate for employees providing access to FP information and products in the workplace. In terms of FP needs, they believe non-interference with the woman's sexual pleasure is important, but seem indifferent to the man's sexual pleasure. Safety for the woman's health, effectiveness in preventing pregnancy, and convenient availability are important to them. While they trust their immediate family, they do not trust many others for FP advice.

- **Reluctant Rurals** (49.7%) constitute the poorest segment. Overall this segment holds traditional views. They believe that couples should listen to religious leaders about FP. Reluctant Rurals cannot afford to purchase medications when they are sick. They stress affordability and non-interference with the man's sexual pleasure when considering FP methods. Unlike other segments, Reluctant Rurals believe that hormonal contraceptives are more harmful to a woman than having an occasional abortion. This segment trusts their wife/partner, immediate family, doctors, nurses, and midwives for FP advice; they do not readily trust extended family and friends or other sources.

- **Educated Conventionalists** (16.6%) are mostly urban and higher educated. Like Reluctant Rurals, they hold more traditional views about religion, and they believe it is against their religion to use FP methods. On the other hand, they believe that using FP will decrease the financial burden on a family. They prefer traditional methods to treat illnesses. Although they are likely to have used some kind of FP method, they believe withdrawal is the best method for them. When deciding to use a method, they stress approval from people who are important to them, in addition to the method's safety to the woman's health, effectiveness at preventing sexually transmitted infections (STIs), ease of use, affordability, and non-interference with the man's sexual pleasure. Educated Conventionalists have great trust in their wife or partner and their doctors for FP advice.

- **Urban Individualists** (15.8%) are higher-educated urbanites. Like Inexperienced Progressives, this segment may be more open to FP, as they believe that a woman should pursue her career before having children and that FP has health benefits for the woman. They are also more likely to believe that FP may decrease a family's financial burden. In regard to abortion, Urban Individualists believe it is easier and less expensive to obtain an abortion than to use an FP method. They prefer to use

traditional methods to treat illness and, like Educated Conventionalists, they believe withdrawal is the best method of FP. When evaluating an FP method, accordance with personal or religious beliefs is important to them, in addition to the method's safety for the woman's health and its effectiveness at preventing pregnancy and STIs. Unlike other segments, however, they are less trusting of their immediate family for FP advice.

QUALITATIVE KEY FINDINGS

The qualitative findings reflect the major themes that emerged from the health provider interviews. These themes include the providers' description of their patients, general health and FP services provided, views regarding sex education and FP, and recommendations on educating the public.

Providers felt that they were the best source of FP services/information and sex education and that they have a crucial role in driving demand for FP services in Azerbaijan. Providers also considered that the government, in the form of the MOH and Ministry of Education (MoE), has an essential role in educating and serving the population with regard to FP. Pharmacies and pharmaceutical companies were not described as trusted sources of FP services/information, and many providers had little or no interaction with them.

More than half of the respondents indicated that access to FP was difficult, due to financial difficulties in many communities and insufficient supply of certain methods. However, some providers responded that FP services were accessible and easily affordable.

Many respondents suggested that the best way to educate and spread awareness of FP in Azerbaijan was to launch a mass media campaign with the assistance of the MOH and other government ministries.

In general, the majority of providers said they encouraged their patients to seek modern methods of FP. They noted the obvious disadvantages of traditional methods, and cited the lack of financial resources as a reason people continue to use traditional methods. A majority of respondents also indicated that their patients have a positive attitude and preference for modern FP methods over traditional methods. Most respondents indicated that they offer intrauterine contraceptive devices (IUCDs) to their patients. Many stated that they provide condoms and pills as well. Across the board, most respondents said that they do not offer injectables.

With regard to abortion, most respondents said that it was unfortunate, but abortion is very commonly used in Azerbaijan. They mentioned social and economic reasons for abortion. Some respondents said that abortion is not actually a method of FP, but people in Azerbaijan think of it as such. Additionally, almost every respondent mentioned the negative impact of abortion on a woman's health. More than half of respondents indicated that they provide pre- and post-abortion counseling on FP methods as part of their job.

In general, providers feel there is an overwhelming lack of knowledge amongst their patient base regarding FP. Some reported that knowledge is basic or nonexistent. A few mentioned however that it has increased since the recent past, but didn't suggest an explanation.

When asked if they would like to offer any suggestions or advice that could help assess the status of FP services in Azerbaijan, the majority of providers recommended an increased effort at basic public

education on FP and sex education, with the help of the MOH and MoE, and with the support of local district health authorities. More specifically, recommendations and advice generally fell into these categories:

- New training for healthcare professionals/providers on newer methods
- Government supply (or subsidy) of FP services to health facilities
- Education of youth and young families
- More educational literature, materials, and outreach for patients regarding FP
- Mass media campaign led by government

NEXT STEPS

Stakeholders in Azerbaijan should prioritize the unique non-user segments according to stakeholders' public health and communication objectives and identify which segments warrant further research. We recommend doing qualitative research with each segment to further understand segment barriers to using FP and how to overcome them. This research should confirm the most appropriate messages and the communication channels that will resonate with each segment. In addition, research can be done with health providers to determine the specific messages and materials that will appeal to them. The results of this qualitative research can inform the development of a detailed communication implementation plan at the national and the segment level. The plan should outline specific communication activities tailored to primary and secondary target audiences and should summarize the specific messages, materials and channels to be used. All messages and materials should be pretested with each target audience before dissemination. As a last step, we recommend that local stakeholders be tasked to carry out the communication implementation plan. A monitoring and evaluation system should be in place to identify obstacles and provide regular feedback to improve upon the communication strategy at each step of the national and segment-level BCC (behavior change communication) campaigns.

I. BACKGROUND

1.1 INTRODUCTION

Private Sector Partnerships-*One* (PSP-*One*) is a worldwide project that provides technical leadership to facilitate private sector provision of high-quality reproductive health and family planning (RH/FP) products and services. Funded from 2004-2009 by the United States Agency for International Development (USAID), PSP-*One* is led by Abt Associates Inc., a US-based research and consulting firm. USAID/Azerbaijan funded PSP-*One* to conduct a client-centered market segmentation research study in Azerbaijan, to understand how RH/FP needs and preferences differ among various non-user groups. This is a key step to developing effective program interventions that can catalyze demand for RH/FP products and services.

Unlike many other Former Soviet Union countries, Azerbaijan experienced virtually no increase in modern contraceptive use during the late 1990s, and it continues to have one of the highest abortion rates in the region. Data from the most recent Azerbaijan Demographic and Health Survey (AzDHS) (State Statistical Committee and Macro International, 2006) indicate that there is substantial latent demand for modern FP in the country. Overall, 23 percent of currently married women have an unmet need, primarily for limiting; rural areas have slightly higher unmet need (24 percent) than urban areas (22 percent) (AzDHS, 2006).

Moreover, 38 percent of women of reproductive age have had at least one abortion (AzDHS, 2006)[4], and over half of these women reported not using any method before pregnancy. In the Azerbaijan Reproductive Health Survey (Center for Disease Control, 2001), about half of the women surveyed believed that abortion poses a "high" risk to women's health; in another survey, 83 percent of the women said that abortion negatively affects health and that they would like to avoid it (Bradley et al., 2007).

Equally challenging to the modern contraceptive movement are reports of provider bias towards abortion as a method of contraception. Although abortion is regarded by providers as harmful to a woman's health, they continue to provide abortion services on a regular basis. According to a baseline study conducted by the USAID-funded Access, Quality and Use in Reproductive Health (ACQUIRE) project, a quarter of providers interviewed, mainly midwives and feldshers, mentioned abortion as a means of pregnancy prevention; when asked about the methods they knew, several traditional methods were mentioned more often than some of the modern methods (Bradley and Mursagulova, 2006). Additionally, according to a 2006 contraceptive security assessment conducted by the DELIVER and PSP-*One* projects (in conjunction with United Nations Population Fund (UNFPA) Azerbaijan), it is claimed to be more financially beneficial for providers to offer abortions than to provide FP services (Abt Associates and JSI/DELIVER, 2006).

Taken together, these findings suggest an opportunity to expand the market for modern contraception in Azerbaijan. Understanding how FP needs and preferences differ among various non-user groups is

[4] Also see Sedgh, G., Henshaw, S. K., Singh, S., Bankole, A., and Drescher, J. 2007. Legal abortion worldwide: Incidence and recent trends. *Perspectives on Sexual and Reproductive Health,* 33(3):106-116.

key to developing effective program interventions that can catalyze this latent demand into use. Client-Centered Market Segmentation Research is a tool to identify the needs and preferences of different groups of potential modern FP users so that program interventions can be tailored accordingly. The tool draws on classic market segmentation approaches used by major commercial companies—such as Proctor and Gamble, Levi Strauss, and Ford Motor Company—to increase product sales and grow market share. The research develops a multi-dimensional profile of different prospective client groups by gathering qualitative and quantitative information on a broad array of behavioral, attitudinal, demographic, geographic, socioeconomic, lifestyle, and psychographic characteristics. FP program implementers can then use the information to position their communications messages and FP service offerings to meet the FP needs, lifestyles, preferences, and purchasing power of different groups.

A key feature of the Client-Centered Market Segmentation Research tool is that it distinguishes those groups that are most likely to be responsive to FP interventions from those that are not. As a result, it can help channel limited resources towards groups where the impact on FP use is likely to be greatest. Interventions to reach these groups may be national in scope or smaller in scale, depending on the size of the segment, the cost of the intervention, and the likely impact on modern method use.

In order to gain further insight on how this tool could be applied in Azerbaijan, PSP-*One*, in February 2009, began data collection for a quantitative analysis, surveying men and women between the ages of 18-49. Following the completion of the quantitative data collection process, upon USAID/Azerbaijan's request, a small scale qualitative research study surveying healthcare providers was conducted in April and May 2009, to assess and further understand the anecdotal reports of provider bias mentioned above.

1.2 STUDY OBJECTIVES

The main purpose of this study is to identify unique segments of the population based on socio-demographic, economic, and psychographic factors, for the purpose of tailoring FP messages to specific audiences. Specific objectives to reach this purpose are as follows:

1) Using a quantitative model, systematically create like segments of FP non-users.

2) Determine the relative size of these non-user market segments (for both women and men).

3) Offer suggestions for prioritizing the different market segments according to a variety of considerations, including health impact priorities and the amount of effort and resources needed to effectively promote FP use.

4) Develop recommendations, through a participatory process with in country stakeholders, for targeted strategies to enable program managers—particularly those involved in behavior change communication—to meet the FP needs of the different women and men's non-user segments.

5) Gain a better understanding of provider attitudes and beliefs regarding FP and recommend ways to meet the needs of different segments taking into account provider realities.

1.3 THE RH AND FP CONTEXT IN AZERBAIJAN

In recent years, FP and reproductive health initiatives have begun to make an impact in Azerbaijan. Much of this can be attributed to efforts of the USAID-funded ACQUIRE project[5] which, in 2004, embarked on a mission to improve access, quality, use, and sustainability of reproductive health and FP services. The ACQUIRE project used a multi-faceted approach towards increasing access to and awareness of RH/FP products and services by tapping into various media channels, partnering with pharmaceutical companies and private sector pharmacies, and conducting trainings for providers, pharmacists, and peer educators.

One of the project's most notable successes was a national media campaign launched in conjunction with the Azerbaijani MOH and two international pharmaceutical companies: "Pregnancy Planning, Choose the Right Time!" (also known as the Pomegranate Campaign). Launched in September 2007, the campaign focused on promoting modern contraceptives as the most safe and reliable method of FP. The campaign included a series of five television advertisements, as well as billboards, educational materials, and branding commercial contraceptive products with the campaign's Pomegranate logo and slogan. The campaign's television advertisements were aired from October 2007 through February 2009 and were estimated to have been viewed by 75 percent of all women in Azerbaijan between the ages of 25 and 40. Additionally, the project brought trainings, promotional materials, and an increased variety of methods of contraception to more than 40 pharmacies in project areas. Azerbaijan has also benefited from UNFPA's work[6] with increasing reproductive health knowledge among Azerbaijani youth. One such effort is the UNFPA's Youth Peer Education Network, a web-based peer networking site that brings together youth from Azerbaijan and other countries across the region to discuss and share information regarding reproductive health issues.

Although these interventions have had some success, it has been challenging to change the overall social norms within Azerbaijan. These social norms serve to limit the increase in contraceptive use. The current study provides an in-depth examination of individual segments of non-users, essential to developing tailored communication strategies to increase contraceptive use and reduce reliance on abortion.

[5] For more information on the ACQUIRE Project's campaign in Azerbaijan, see http://www.acquireproject.org/index.php?id=314

[6] For more information on UNFPA's Youth Peer Education Network activities, see http://www.comminit.com/en/node/134770

2. METHODOLOGY

This section summarizes the data collection and analysis methods used to conduct the market segmentation study. We employed both quantitative and qualitative approaches to achieve a comprehensive and rich understanding of FP issues from the client and provider perspectives. Using findings from a previous qualitative study of potential FP clients, we conducted a quantitative household survey of men and women of reproductive age to develop the basis for identifying unique segments. We also conducted a qualitative study of health providers to better understand their views and practices with regard to FP. The methods for each study are presented below. All research activities were approved by the MOH as well as the Abt Associates Institutional Review Board, and all respondents gave informed consent to participate.

2.1 QUANTITATIVE STUDY OF WOMEN AND MEN OF REPRODUCTIVE AGE

2.1.1 SAMPLING DESIGN

The objective of the design was to select a representative probability sample of households containing women or men between 18 to 49 years, and then to select randomly one woman or man between the ages of 18 and 49 from the selected household. In this section, we describe the sampling design adopted for the selection of households and individual participants in those households.

There are 11 economic regions in Azerbaijan. The Kalbajar–Lachin region and the Yukhari Garabakh region were excluded from the survey as they are occupied by Armenia. They represent about 10% of the total population, according to a 2005 projection. The third region excluded was the Autonomous Republic of Nakhichevan, which represents 4.5% of the total population, also according to a 2005 projection. The target population for this survey is men and women between 18 and 49 years in 8 of the 11 regions.

A four-stage stratified sampling design was adopted for the selection of women and men between 18 to 49 years. Each region was considered a stratum. At the first stage, a sample of rayons (or districts) was selected in each region with probability proportional to size (PPS), where size was defined as the population of women between 20 to 49 years in the rayon. A few background notes: The number of women was used as the size measure because the initial objective had been to survey only households that contain women between 18 to 49 years, and to include a sample of men from households in which women were surveyed. The problems in interviewing men and women from the same household led to a change of strategy, using a separate sample of households for the selection of men within the original rayons. Proportional probability was tied to the number of women between 20 and 49 (instead of between 18 and 49 years) in order to conform to the age categories of the last census.

The size of the sample was determined based on operational, time, and cost considerations. It was decided to select a sample of 1,000 women and 1,000 men between the ages of 18 and 49, from 11 rayons (at the first stage). Baku city was selected with certainty. The remaining sample of 10 rayons was

first allocated to each region in proportion to the total number of women between 20 and 49 years.

The allocation of rayons is shown in Table 1, along with the population of women in each region surveyed. If n_{ri} is the number of rayons allocated to region i then n_{ri} is given by

$$n_{ri} = 10 \frac{x_i}{x}$$

where x_i is the number of women between 20 and 49 in the region and x is the total number of women between 20 and 49 years in all the regions.

TABLE 1: DISTRIBUTION OF THE SAMPLE OF RAYONS BY REGION

Region	Population of Women (20 to 49)	Number of Rayons in the Population	Number of Rayons in the Sample
Baku City	470,028	1	1
Absheron	97,127	3	1
Genje-Gazakh	258,950	11	2
Sheki-Zagatala	127,226	6	1
Lenkeran	176,773	6	1
Guba-Khachmaz	105,453	5	1
Aran	397,724	18	3
Mountainous Shirvan	58,265	4	1
Total	**1,691,548**	**54**	**11**

The number of rayons (as shown in the last column of Table 1) was selected from each region with probability proportional to the number of women between 20 and 49 in each rayon, using systematic sampling.

The required sample of 2,000 persons (1,000 women and 1,000 men) was first allocated to selected rayons in proportion to the total number of persons from 20 to 49 in selected rayons. Table 2 shows the selected rayons, probability of selection of the selected rayon or rayons, and the number of persons required to be selected from each rayon. The probability of selection of a rayon within a region is

$$\pi_{ij} = n_{ri} \frac{x_{ij}}{x_i}$$

where π_{ij} is the probability of selecting rayon j in region i, x_{ij} is the population of persons between 20 to 49 in the rayon j in region i and x_i is the population in region i.

TABLE 2: SELECTED RAYONS AND THE DISTRIBUTION OF THE SAMPLE

Selected Rayons	Probability of Selection	Number of Women	Number of Men
Baku city	1.0000	558	558
Sumqayit city	0.7572	87	87
Genje city	0.5763	88	88
Gazakh rayon	0.1449	22	22
Sheki rayon	0.3033	46	46
Masally rayon	0.2425	50	50
Khachmaz rayon	0.3388	42	42
Mingechevir city	0.1865	29	29
Bilesuvar rayon	0/1336	21	21
Sabirabad rayon	0.2441	38	38
Ismayilly rayon	0.2891	20	20
Total		**1,001**	**1,001**

For the selection of households, urban and rural areas within each rayon were identified. The required sample of persons in the rayon was allocated to the urban and rural areas roughly in proportion to the population in the two areas. Roughly equal sized clusters of households, known as "sample points," were created within each area. Two simple random samples of clusters, or sample points, were selected within each area (rural and urban)—one for selecting households for interviews with women and the other for selecting households in which men were interviewed. This was to ensure that men and women are interviewed in different neighborhoods. The number of sample points to be selected for each gender was based on the condition that a maximum of 10 interviews be conducted in urban sample points and a maximum of 22 interviews be conducted in rural areas.

In each selected cluster, a systematic sample of households was screened to identify women or men between the ages of 18 and 49. One person was selected at random from the list of men or women in the household, using the last birthday sampling procedure. Table 3 gives the final distribution of the sample of men and women by urban and rural areas in selected rayons.

TABLE 3. DISTRIBUTION OF THE SAMPLE BY GENDER, URBAN AND RURAL

Location	Total # of interviews	Females		Males		# of sample points (for each gender)	
		Urban	Rural	Urban	Rural	Urban	Rural
Baku city	1116	558	0	558	0	57	0
Sumqayit city	174	87	0	87	0	9	0
Genje city	176	88	0	88	0	9	0
Gazakh rayon	44	0	22	0	22	0	1
Sheki rayon	92	12	34	12	34	2	2
Masally rayon	100	10	40	10	40	1	2
Khachmaz rayon	84	14	28	14	28	2	2
Mingechevir city	58	29	0	29	0	3	0
Bilesuvar rayon	42	8	13	8	13	1	1
Sabirabad rayon	76	16	22	16	22	2	1
Ismayilly rayon	40	6	14	6	14	1	1
Total	**2002**	**828**	**173**	**828**	**173**	**87**	**10**

2.1.2 SURVEY INSTRUMENT DEVELOPMENT

The survey instrument was designed to collect information on household and participant socio-demographic characteristics and mass media exposure, as well as a wide array of information on FP knowledge, attitudes, and experience with FP. As a special feature, the survey instrument also contains a number of questions on general health-related attitudes, attitudes toward marriage, sexuality, and family and life planning decisions, as well as about influencers of FP decisions.

The instrument contains eight sections:

- Section 1: Household and participants' socio-economic and demographic information
- Section 2: Mass media exposure: participants' communication and media habits
- Section 3: General health-related attitudes
- Section 4: Sexual activity and abortion experience
- Section 5: Fertility preferences
- Section 6: Knowledge, attitudes, and experience with FP methods
- Section 7: Role of influences in FP decisions
- Section 8: Attitudes toward marriage, sexuality, family and life planning decisions
- Section 9: Decision-making in the household

Generally, the questionnaire design followed the DHS methodology, except for sections 3, 7, and 8, which are not included in the DHS core questionnaire. The instrument was developed in English and translated into Azerbaijani for administration.

2.1.3 INTERVIEWER TRAINING

The training of the data collectors and supervisors was structured to ensure they understood the purpose of the study, were familiar with the content of the questionnaire, and had the requisite skills to successfully administer the surveys. Five training sessions (four in Baku and one in Ganja) were conducted by the project coordinator. Training sessions covered the following:

- Explanation of the research objective
- A section-by-section review of the survey tool
- Explanation of household and respondent selection procedures
- Conducting trial interviews to ensure the staff's suitability

All participants in the training sessions participated in pilot interviews. Afterward, the completed questionnaires were reviewed and discussed within the group, with special attention paid to typical mistakes or other difficulties. Regional supervisors were also given instruction in how to handle non-standard situations and responses.

2.1.4 INSTRUMENT PRETEST

The survey was implemented in the field by SIAR Research and Consulting, a local research firm. A pre-test of the instrument was conducted in urban Baku and its rural-like surroundings, to identify potential problems that might arise during fieldwork as well as to assess possible problems of the questionnaire, indications of inadequacy or irrelevance to the culture and views of respondents, and its suitability in terms of ease of language, flow, and length. To get more precise results, the pilot interviews were conducted with individuals of varying demographic parameters, such as gender, age, education, and location.

After completing pilot interviews, all problems with question comprehension, wording, operation, or interpretation of the questionnaire were outlined and discussed. Any necessary changes were made to the questionnaire.

One major problem identified in the pilot test was that many women sampled were reluctant to participate in the survey if their husband or partners were also interviewed. The survey team accordingly changed the sample strategy, from sampling women and their husbands/partners to sampling women and men in separate households. The instrument design was also adapted, to include one questionnaire for women and one for men.

2.1.5 SURVEY IMPLEMENTATION

Interviewers obtained informed consent prior to conducting any interviews. Respondents were assured that participation was voluntary and that they had the right to refuse questions or to withdraw from the interview. Interviewers carefully explained the confidentiality of data collected.

In the survey implementation, if the first visit to the household failed to locate the respondent, the household was visited a second or third time (at least 24 hours after the previous visit). If a household refused to respond, or if three visits failed to locate the respondent, the household was recorded as non-response, with the precise reason for non-response recorded. Households were only replaced if it was clear that they had permanently moved away from the area (and therefore should not have been part of the sampling frame). As a replacement, the interviewer simply selected the adjacent household.

Prior to implementation, the MOH approved the study. Starting February 20, 2009, the field work took about 40 days for all the interviews for both women and men.

2.1.6 QUALITY ASSURANCE

To assure survey quality, two major types of quality control were applied. One was quality monitoring by external consultants: two independent external consultants provided supervision and oversaw the entire data collection process.

The other quality control was conducted internally by the SIAR quality control group throughout the process of field interviews and data entry. During the field work, as interviews were being conducted (under the thorough control of supervisors), the quality control group was responsible for the overall survey validation, using a multi-step validation procedure:

- On-time-on-place control by the supervisors provided quality control during the fieldwork. The supervisors checked interviewers' adherence to the instructions on HH (household) and respondent selection.
- All the completed interviews were checked by the quality control staff.
- Approximately 20% of the interviews (mainly in urban areas) were checked by phone contacts with respondents
- 20 percent of the interviews were checked through direct contacts with respondents.

During the data entry, double data entry was used. The data from 320 randomly selected questionnaires (16% of the total number of questionnaires) was entered repeatedly. By crosschecking two data files, only three data entry errors were identified—within the permissible level of error (5%).

2.1.7 DATA WEIGHTING

For producing population-based estimates of totals, percentages, means and ratios, and for all statistical analyses, each respondent was assigned a sampling weight. This weight combines the base weight (based on the probability of selecting the respondent) with adjustments for non-response at various stages of sampling.

The base weight for this survey was constructed in accordance with the sampling design adopted for the selection of the sample. The design for selection was a four-stage design (as described in the section on sample design); the sampling weights were therefore determined at each stage, for each region. For each region, the product of the four weights—based on probabilities of selection at each stage—gave the

overall base weight. The first stage sampling weight was computed as the probability of selection of the rayon (which was known). Table 4 shows the sampling weights assigned to rayons selected in the sample.

TABLE 4. SAMPLING WEIGHT FOR RAYONS IN THE SAMPLE

Selected Rayons	Probability of Selection	Sampling Weight
Baku city	1.0000	1.0000
Sumqayit city	0.7572	1.3207
Genje city	0.5763	1.7352
Gazakh rayon	0.1449	6.9013
Sheki rayon	0.3033	3.2975
Masally rayon	0.2425	4.1241
Khachmaz rayon	0.3388	2.9512
Mingechevir city	0.1865	5.3619
Bilesuvar rayon	0.1336	7.4850
Sabirabad rayon	0.2441	4.0967
Ismayilly rayon	0.2891	3.4590

For determining the second stage weights, we need to know the number of clusters or "sampling points" created in the urban and rural areas of selected rayons. From this population, a sample of clusters (or sampling points) was selected. To compute the weights assigned to these selected sampling points, we need information on both the population and the sample number (of sampling points). The number of sampling points selected was available, as shown in the sampling design section of the report. But we lacked information on the total number of sampling points in the population, so the second stage weights could not be calculated.

For calculating the third stage weights, we need to know the number of households in each of the selected sampling points. Lacking this information, it was not possible to calculate the third stage weight. In the last stage of sampling, one person was selected from each eligible household. The number of eligible members in each household (men or women) was known, and a person weight was calculated based on the number of eligible members in the household. The product of the rayon weight and the person weight was used to obtain the weighted number of completes (completed surveys) for women and men. This obviously is an underestimate: it does not take into account the number of households in the population for constructing weights. To adjust for this underestimation, the ratio of the known population of women to the weighted number of completes was computed, and each weight was multiplied by this ratio to get an overall person weight.

These weights were raked in each region using the population control totals for women and men, for three age groups, and for urban and rural groups. The control totals for each region are given in Table 5.

TABLE 5. ESTIMATED POPULATION (18-49) BY GENDER, AGE AND URBAN/RURAL/ REGION

Region	Women	Men	18-24	25-34	35-49	Urban	Rural
Baku City	470,028	444,728	211,340	289,061	414,355	914,756	0
Absheron	97,127	93,717	46,864	62,047	81,932	187,561	3,283
Genje-Gazakh	258,950	246,971	125,952	172,317	207,653	231,454	274,468
Sheki-Zagatala	127,726	121,908	58,555	86,698	103,881	61,957	181,177
Lenkeran	176,773	170,058	98,289	124,117	124,425	79,539	267,292
Guba-Khachmaz	105,453	99,869	49,911	71,231	84,180	63,770	141,552
Aran	397,724	382,492	193,497	274,581	312,138	290,679	489,537
Mountainous Shirvan	58,265	55,427	29,560	39,795	44,338	31,193	82,499
Total	**1,691,548**	**1,615,170**	**813,968**	**1,119,847**	**1,373,902**	**1,860,910**	**1,445,808**

The raked weights were assigned to each respondent. The sum of the weights over all respondents agrees with the totals in the different categories of each margin in each region. For example, the sum of the weights assigned to women respondents in Baku equals the total number of women shown for Baku in Table 5. Similarly, the sum of the weights of respondents in different categories of other variables equals the total in those categories.

2.1.8 DATA QUALITY ASSESSMENT

Estimates from a sample survey based on a probability sample have two measures of quality. The first is the sampling error, which arises from obtaining data from a non-representative sample and not from the entire population. The second type of error is the non-sampling error. This error results from participants' incorrect response or non-response, data collection and processing errors, and coverage errors. Non-sampling errors introduce bias in the estimates. In our survey, every effort was made to keep the non-sampling errors to a minimum.

For example, the response rate to the survey was 74%, which is considered high, and therefore the non-response error is likely to be negligible. We checked the data for completeness and consistency. No demographic variables have an incomplete rate higher than 1%, and none of the behavioral and attitudinal variables have an incomplete rate higher than 5%. Respondents' responses on the variables of interest was consistent.

Because a probability sample was selected and appropriate sampling weights were used to get the estimates, we consider the estimates of population parameters of interest to be unbiased.

The estimates are based on a sample of 1,000 men and 1,000 women. If we were selecting simple random samples of men and women, the margin of error of the estimates of population percentages would be no greater than plus or minus 3 percentage points at the 95% confidence level. However, since we first selected rayons (or districts) within each region, then households within the rayons, and then individuals from selected households, there is a design effect. The design effect is the ratio of the variance,

under the sampling method used, to the variance calculated under the assumption of simple random sampling (Alecxih et al., 1998). With cluster sampling, there is less new information added at each sampling stage than if simple random sampling were used. This results in a loss of design effectiveness. In our case, if we assume a design effect of 1.5, the effective sample size of men and women would be n=667. With these sample sizes, we can estimate population percentages at the national level with a margin of error that is no greater than plus or minus 3.8 percentage points at the 95% confidence level.

Therefore, we expect the estimates at the national level to have reasonable precision. The estimates at sub-national levels will depend on the sample size. With a sample of 384 in some smaller areas, the margin of error would be no greater than plus or minus 5 percentage points. We have not computed the actual standard errors of the various estimates but, as indicated, the estimates have a reasonable precision at the national level.

2.1.9 SEGMENTATION ANALYSIS

The segmentation analysis was conducted for respondents not currently using modern FP methods. Separate analyses were done for female and male respondents.

HYBRID METHODOLOGY

A hybrid method combining Latent Class Analysis (LCA) and Chi-Squared Automatic Interaction Detection (CHAID) was used to identify the unique segments based on a combination of demographic, behavioral and attitudinal variables.

The CHAID analysis is an effective technique for obtaining meaningful segments which are tied to particular demographic or economic characteristics, so are identifiable and useful for targeted intervention. However, the limitation of CHAID is that segments are defined based on a single criteria variable (also called dependent variable). But in reality, individuals' FP decisions are driven by not only demographic and economic characteristics, but also by their attitudes, values, and beliefs. So the segmentation is desired to be predictive of multiple criteria; in other words, the dependent variables are a series of attitudinal variables.

Latent class analysis is useful in identifying segments that underlie multiple response variables, by grouping together individuals who share similar attitudes, values, and beliefs. However, by definition the resulting latent classes are latent and unobservable, and so not actionable like segments from CHAID.

The hybrid methodology combines the strength of both approaches. It produces actionable segments that are predictive of multiple criterion variables. The procedure involves two steps. First, LCA is performed on M attitudinal variables to obtain K-latent classes, presenting as a K-category class variable. Secondly, a CHAID algorithm is conducted with this K-category variable as the dependent variable. The resulting segments, derived from selected demographics that are predictive of the class variable, should also be predictive of the M attitudinal variables. The resulting segments of the hybrid method are, on the one hand, as distinct as possible in terms of attitudinal, values, and belief variables; on the other hand, they are all tied to particular socio-demographic variables, which are detectable within the population.

While the first step might be also completed using traditional clustering methods (for example, *K*-mean clustering), LAC offers several advantages over the *K*-mean:

- It is a probability-based approach, classifying individuals into clusters using model-based posterior membership probabilities estimated by maximum likelihood methods.
- It determines the number of clusters by providing various diagnostic measures.
- It allows variables of mixed types: variables can be continuous, categorical (nominal or ordinal), count data, or a combination of above.
- It does not need to standardize the variables.

LATENT CLASS ANALYSIS

The first step of the analysis was latent cluster analysis based on a series of attitudes, values, and belief variables. The latent class modeling generates a nominal K-category latent variable, X, to explain the association between observed variables.

The LC model can be defined as (Magidson, 2005):

$$P(Y=j)=\sum_{k=1}^{K}P(X=k,Y=j)=\sum_{k=1}^{K}P(X=k)P(Y=j\mid X=k)=\sum_{k=1}^{K}P(X=k)\prod_{m=1}^{M}P(Y_m=j_m\mid X=k)$$

Where Y and j refer to a full set of response vector and a full set of response categories; X is the latent category; X=1,2,3,…K, Y_m refers to one of M nominal observed variables; $P(X=k)$ denotes the probability of being in latent category k, k=1,2,…K; and $P(Y_m=j_m \mid X=k)$ denotes the conditional probability of obtaining the j_m th response to item Y_m , from members of class k, j_m =1,2,….

Latent-Gold software was used to implement LCA. Variables initially inserted into the model were all the attitudinal variables collected, including variables of general health related attitudes (Q301*), variables of attitudes toward FP attributes (Q603*), variables of influencers of FP decision (Q701* & Q703*), variables of attitudes toward marriage and sexuality (Q801), variables of attitudes toward FP and abortion (Q802*), and variables of opinions on who should be responsible for FP decisions (Q705, Q706, Q707). A variable selection was also conducted because removing unnecessary variables could improve the model performance in classification and improve interpretability of the model (Nema et al., 2008). The criterion used for variable selection was to keep the variable if the R2 is larger than 15%, which means 15% of variable variances are explained by the model. In other words, variables significantly contributed to the segmenting. Eventually, for the women's sample, almost all variables of attitudes toward FP attributes (Q603*), and variables of attitudes toward FP and abortion (Q802*) were maintained in the model, which means these variables have greater contribution to the segmentation. For men, besides these two groups of variables, variables on influencers of FP decision (Q703*) also showed important contribution to the segmentation.

Latent Gold provides multiple diagnostic criteria to choose the optimal model, such as BIC, AIC, goodness of fit test, et al. BIC is used most often. The smaller the value is, the better the model fits the data. However, other parameters should be considered too, such as degree of freedom, number of parameters, and the size of the resulting cluster. In this analysis, a nominal variable with six categories

was generated for women; a nominal variable with four categories was produced for men. A new dataset containing the class-specific predicted probabilities for each category, as well as posterior membership probabilities for each observation, was yielded for the next step of analysis – CHAID analysis.

CHAID ANALYSIS

SI-CHAID software was used to conduct the CHAID analysis. The analysis used the multi-category class variable as the dependent variable, and demographic and behavioral variables as the predictors. Chi-Squared goodness of fit test was used to identify significant predictors. The sample was divided repeatedly in terms of the significant predictors, until no remaining predictors were significant. The analysis yielded a set of segments that differ with respect to their average posterior membership probabilities for each category of the nominal variable developed from LCA. These segments significantly differ with respect to the dependent variable, and accordingly differ in terms of the multiple attitudinal variables.

The analysis resulted in six segments for women and four segments for men, in a "tree" structure shown in Figures 1 and 2.

FIGURE 1. SEGMENT TREE, WOMEN NOT CURRENTLY USING CONTRACEPTION

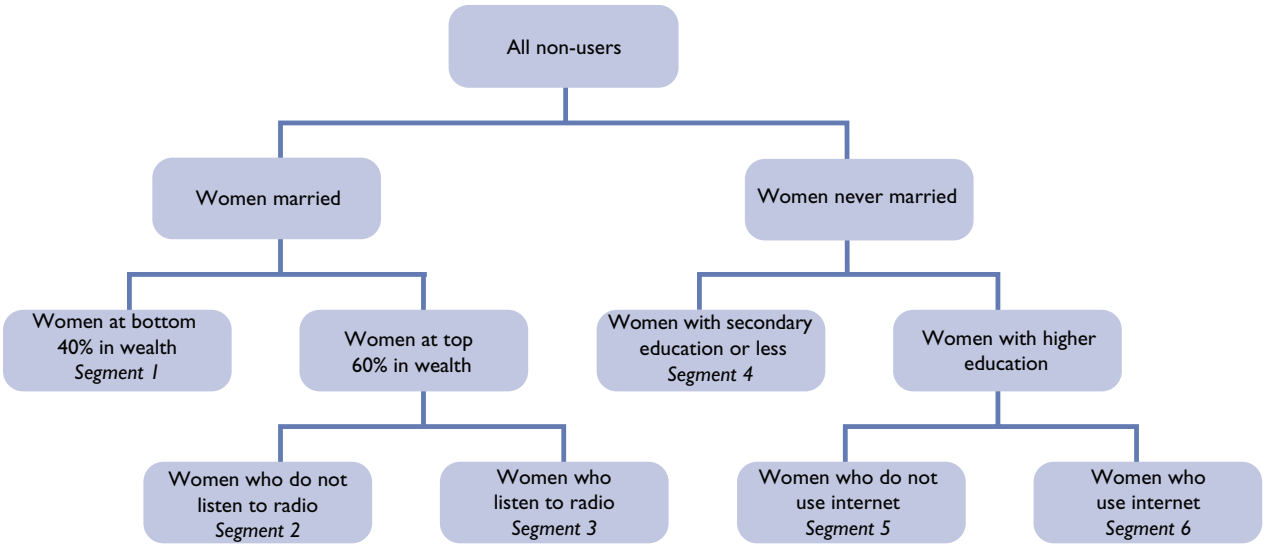
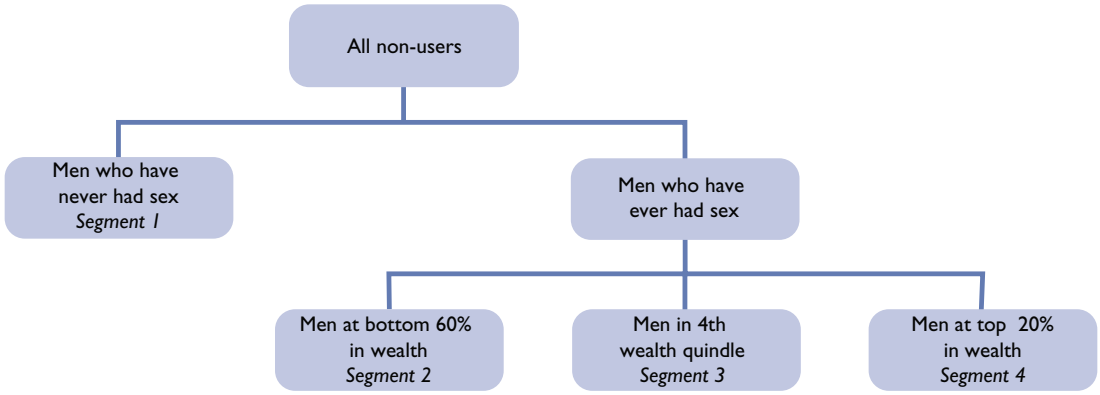


FIGURE 2. SEGMENT TREE, MEN NOT CURRENTLY USING CONTRACEPTION



2.2 QUALITATIVE STUDY OF FAMILY PLANNING PROVIDERS

In April and May of 2009, PSP-*One* conducted a qualitative research study with healthcare providers that provide FP services. As providers can influence FP decisions, gaining their perspective on the topic can contribute to a greater understanding of a wide array of issues and concerns surrounding FP in Azerbaijan. The sections that follow describe the sampling strategy, instrument development, field work, and analysis.

2.2.1 SAMPLING STRATEGY AND SAMPLING FRAME

Respondents were from the city of Baku as well as the rural areas of Salyan and Khachmaz. Forty-five interviews with healthcare providers were conducted in all—22 urban and 23 rural. Based on the existing healthcare delivery system, three types of providers were included in the study:

(i) 32 obstetricians/gynecologists (OB-GYNs), who are the only providers of FP services in the urban areas and a referral point for patients living in villages

(ii) 10 midwives, who are the first point of contact with regard to FP services for patients in villages

(iii) 3 Primary Healthcare (PHC) physicians, who are also involved in the provision of some FP services, especially in areas where OB-GYN doctors and midwives are not available.

The providers interviewed worked at one of four types of facilities, described as follows:

- **Women's Consultations (WC)** are the only type of facilities providing the whole range of FP services in urban areas. (The population of district centers are also served by WC). The study covered all 10 WCs based in Baku as well as the WC in the two rural districts (two in Khachmaz and one in Salyan). WC are staffed by OB-GYNs and midwives. However, only the OB-GYNs were interviewed in these facilities, because they are the main providers of FP services in WC facilities.

- **Rural Hospitals (RH)** are small hospitals which usually have 20-50 beds shared among the internal medicine, pediatric, and maternity departments. RH also have an outpatient department. Ideally the RH is staffed with PHC doctors, OB-GYNs, midwives, and nurses. Five rural hospitals were included in the research. Depending on the availability of staff, the interviewers spoke with the main FP provider at the facility. OB-GYNs were interviewed in two RHs, a PHC doctor in one RH, and two midwives in two RH.
- **Rural Doctor Ambulatories (RDA)** are the main type of rural facility providing primary care services. They are commonly staffed with PHC doctors, midwives, and nurses. Midwives are generally responsible for providing counseling and referral services related to FP. Where a midwife was not available at these facilities, a PHC doctor was interviewed instead.
- ***Feldsher*-Midwife Point (FMP)** is the smallest type of healthcare facility and is staffed by a midwife and a feldsher (equivalent of a physician assistant). In such facilities, the midwife is the main provider of basic FP services. In all, 5 FMPs were included in the study. Table 6 gives a breakdown of the number of interviews by facility type and geographic area.

TABLE 6. THE NUMBER OF INTERVIEWS

Type of Health facility	Number of urban interviews	Number of rural interviews
Women's Consultation	22	8
Rural Hospital	0	5
Rural Doctor Ambulatory	0	5
Feldsher-Midwife Point	0	5
Total	**22**	**23**

2.2.2 INSTRUMENT DEVELOPMENT

PSP-*One* developed two interview guides, one for OB-GYNs and another for primary care physicians and midwives, taking into account the differing levels of provider involvement in provision of FP services. The interview guide for OB-GYNs consisted of 40 questions (1 hour), while the other guide included 27 questions (45 minutes). Both study instruments were reviewed by Azerbaijani consultants and members of staff within the Public Health and Reform Center of the Ministry of Health to ensure cultural sensitivity.

2.2.3 FIELD WORK

Three interviewers (one female and two male) were recruited and trained on the study methodology and instruments. The pretest was conducted in the clinic of the Public Health and Reform Center of the Ministry of Health (PHRC) in Baku. No changes to the interview guide were indicated by the results of the pilot. In total, three interviewers spent 21 days to conduct the field work. All interviews were audiotaped with the consent of the respondent.

Baku

The interviews with providers in Baku were conducted from April 20 –27, 2009. The PHRC sent official letters to the head of each individual facility requesting assistance in implementing the FP survey. These

letters provided general survey-related information and asked the head of each facility to nominate several OB-GYN doctors to be interviewed. 22 OB-GYNs were selected by the heads of 10 WCs. Table 7 gives a summary of the providers surveyed in Baku.

TABLE 7. SURVEY SUMMARY FOR BAKU

Location	Date	Health Facility	Location of Health Facility	Interview serial number	Position
BAKU	20/04/2009	WC #2	Baku	1	Ob-gyn
	20/04/2009		Baku	2	Ob-gyn
	20/04/2009	WC #6	Baku	3	Ob-gyn
	20/04/2009		Baku	4	Ob-gyn
	21/04/2009	WC #1	Baku	5	Ob-gyn
	21/04/2009		Baku	6	Ob-gyn
	22/04/2009	WC #3	Baku	7	Ob-gyn
	22/04/2009		Baku	8	Ob-gyn
	22/04/2009		Baku	9	Ob-gyn
	23/04/2009	WC #10	Baku	10	Ob-gyn
	23/04/2009		Baku	11	Ob-gyn
	23/04/2009		Baku	12	Ob-gyn
	23/04/2009	WC #8	Baku	13	Ob-gyn
	21/04/2009		Baku	14	Ob-gyn
	27/04/2009	WC #5	Baku	15	Ob-gyn
	24/04/2009	WC #9	Baku	16	Ob-gyn
	27/04/2009		Baku	17	Ob-gyn
	24/04/2009	WC #7	Baku	18	Ob-gyn
	24/04/2009		Baku	19	Ob-gyn
	27/04/2009		Baku	20	Ob-gyn
	25/04/2009	WC #4	Baku	21	Ob-gyn
	25/04/2009		Baku	22	Ob-gyn

Khachmaz

All interviews in Khachmaz were conducted from April 20-23, 2009. Prior to launching the field work, the PHRC sent a letter to the district health authorities in Khachmaz. PSP-*One*'s consultant met with the Khachmaz District head doctor, prior to study implementation, to provide information on the study and to select appropriate health facilities. The head doctor nominated 11 providers with various backgrounds, including OB-GYNs, midwives, and PHC physicians involved in provision of FP services. To ensure better representativeness, interviewees were selected from different types of health facilities. The district's head doctor suggested interviews with providers from two WCs (there are two WCs in Khachmaz town and Khudat town in Khachmaz district), two RHs (Yenikend and Gusarchay), three RDAs (Yerguj, Hajibey and Kohna Khachmaz), and two FMPs (Garadag-Budug and Garadagli). The head doctor also assisted in identifying interview dates and notifying each health facility to ensure availability of interviewees. Table 8 gives a summary of the survey process in Khachmaz district.

TABLE 8. SURVEY SUMMARY FOR KHACHMAZ

Location	Date	Health Facility	Location of Health Facility	Interview serial number	Position
KHACHMAZ	20/04/2009	RDA	Yerguj	1	Midwife
	20/04/2009	RDA	Hajibey	2	Midwife
	22/04/2009	WC	Khachmaz	3	Ob-gyn
	21/04/2009	WC	Khachmaz	4	Ob-gyn
	21/04/2009	WC	Khachmaz	5	Ob-gyn
	21/04/2009	RH	Yenikend	6	Ob-gyn
	23/04/2009	WC	Khudat	7	Ob-gyn
	21/04/2009	RH	Gusarchay	8	Midwife
	22/04/2009	RDA	Kohna Khachmaz	9	PHC physician
	22/04/2009	FMP	Garadag-Buduq	10	Midwife
	22/04/2009	FMP	Garadagli	11	Midwife

Salyan

All interviews in Salyan were conducted during April 22–May 1, 2009. The preparation work for provider interviews in Salyan district resembled the process in Khachmaz. The district health authorities received an official letter from PHRC informing them about the study. PSP-*One*'s consultant visited Salyan district prior to starting the field work to meet with the district head doctor. The head doctor nominated 12 providers from different types of health facilities. The head doctor suggested interviews with providers from the WC, three RHs (Yenikend, Parcha Khalaj, and Sarvan), two RDAs (Garabagli and Garagashli) and three FMPs (Jangan, Dayikend, and Seyidsadigli). Table 9 provides a detailed summary of the providers interviewed in Salyan.

TABLE 9. SURVEY SUMMARY FOR SALYAN

Location	Date	Health Facility	Location of Health Facility	Interview serial number	Position
KHACHMAZ	20/04/2009	RDA	Yerguj	1	Midwife
	20/04/2009	RDA	Hajibey	2	Midwife
	22/04/2009	WC	Khachmaz	3	Ob-gyn
	21/04/2009	WC	Khachmaz	4	Ob-gyn
	21/04/2009	WC	Khachmaz	5	Ob-gyn
	21/04/2009	RH	Yenikend	6	Ob-gyn
	23/04/2009	WC	Khudat	7	Ob-gyn
	21/04/2009	RH	Gusarchay	8	Midwife
	22/04/2009	RDA	Kohna Khachmaz	9	PHC physician
	22/04/2009	FMP	Garadag-Buduq	10	Midwife
	22/04/2009	FMP	Garadagli	11	Midwife

2.2.4 TRANSCRIPTION

The transcription process started soon after field work and continued into May 2009. Three consultants were hired to transcribe the audiotaped interviews. In addition, three translators were recruited to translate the transcripts from Azeri to English. All translation was completed in May 2009.

2.2.5 ANALYSIS

PSP-*One* used NVIVO 8, a qualitative data analysis software package produced by QSR International, to analyze these data. Transcripts were imported into NVIVO 8 and coded for emergent themes. The coding process allowed analysts to determine emerging trends reported by various providers in Azerbaijan from urban and rural areas. The coding structure reflects well-defined themes, presented below as results of the study. The analysts working on this study discussed coding and themes to ensure that researcher bias did not influence conclusions.

2.3 STUDY STRENGTHS AND LIMITATIONS

The study has several notable strengths. It applies a multi-stage sampling design to obtain a nationally representative sample that covers Baku City and 10 other economically diverse regions. The extensive information collected on participants' demographic characteristics, FP knowledge, lifestyles, and values, as well as on their attitude toward marriage and sexuality, allowed us to create segments of non-users with unique characteristics.

However, it is also important to understand the potential limitations of the study. Because the data rely on self-reported information (the most common way to collect data), the findings may be affected by participants' responding in ways that they think are the most socially acceptable, often referred to as the "social desirability bias." Thus, there is potential for social desirability bias in this study as well.

Additionally, the final sample for Absheron region excludes women because of the region's very small population size (n=3283). This may have under-represented the region in the findings. However, we believe that by applying appropriate data weighting and raking adjustments, the final estimates for the population are representative at the national level.

Furthermore, while we have a satisfying response rate (74%), we could not interview some of the eligible respondents for various reasons, including repeated absence from the home or refusal to participate. As we do not have information about those individuals, we were unable to identify and control for characteristics of the individuals who dropped out of the survey that might differ from those who remained in the survey. This may have introduced "selection bias" into the study; that is, the study may have included more people with characteristics that make them more likely to consent to interviews or give certain responses. Although we tried to lower the non-response rate through several means, including re-visiting households, non-response is a common problem for this type of survey.

Finally, although this study answers many questions regarding segment-specific needs and preferences related to FP, it does not fully capture which messages and materials might appeal to each segment. Additional research is recommended to address this gap, as discussed in Section 6.

3. QUANTITATIVE FINDINGS: MEN AND WOMEN OF REPRODUCTIVE AGE

3.1 OVERVIEW OF FAMILY PLANNING IN AZERBAIJAN

As described in Section 1, the Demographic and Health Survey (DHS) reports a low rate of modern method use and a high rate of traditional method use (AzDHS 2006). This section summarizes our key findings on FP. Tables and detailed description of results can be found in Annex A.

About one-third of married women and 41 percent of married men are currently using a contraceptive method, with greater usage of modern methods (19 percent of women and 30 percent of men) over traditional methods (12 percent of women and 11 percent of men). IUCD is the method most commonly reported by both men and women, followed by the pill among women and the male condom among men. Contraceptive use rises with age (peaking at 30-34 years) as well as with education level. There is only a slight difference in modern contraception use between urban and rural married women.

Intention to use a method in the future is an important indicator of the change in FP demand. This study shows that about 17 percent of married women and 26 percent of married men, who are not currently using a contraceptive, intend to use it in the future. However, up to 60 percent of women and 47 percent of men do not intend to use FP in the future. A large proportion of adults in the youngest age group are uncertain whether they will use a contraceptive method.

Among those who intend to use a method, the majority prefers the IUCD (37 percent of women and 40 percent of men). For those who do not intend to use FP, fertility related reasons were the most common reasons given by women (29 percent of married women). Among married men, opposition to using contraceptives was the most common reason given (19 percent of married men).

Unmet need for FP is determined by the fertility goals of potential FP users and their actual FP practice. Currently married fecund women who are not using contraception and who want to have no more children (or want to wait at least two years before having another child) are considered to have an unmet need for FP. Overall, 61 percent of currently married Azerbaijan women aged 18-49 years have an unmet need for FP, mainly for limiting: 50 percent for birth limiting and 11 percent for birth spacing.

3.2 INTRODUCTION OF FAMILY PLANNING SEGMENTS

The analysis identified FP segments of men and women non-users, with unique profiles for each segment. To develop the profiles, we compared segments along several dimensions: general health attitudes; fertility and FP behaviors, awareness and attitudes regarding FP; and media and lifestyle characteristics. All segments are non-users of FP.

As a first step, we developed specific criteria for comparison across all segments, to standardize segment profile descriptions. We report an attribute as part of a segment profile only if its percentage is above 50% and at least 10% above the lowest percentage for all segments. In general, we reported each attribute for only the top two segments (after applying the 50%, 10% rule). For some attributes, where the percentage difference between the second and third highest segments was minimal, we reported the attribute for the top three segments. For example, the profiles for segments 3, 4, and 5 include the attribute "single/not married." For these three segments, 100% of respondents were "single/not married," whereas the percentage for all other segments was 0%. Thus, the attribute "single/not married" is unique to segments 3, 4 and 5 and is reported in their profile.

Because market segmentation is a comparative science, there are many instances where the information reported is not the same across all segments. For example, we may report attributes relating to FP awareness for one segment but not for another. This does not mean that the second segment has no awareness of FP methods; it means that other segments are more aware of those methods (by the 50%, 10% rule). In other cases, we did not report an important attribute in the segment profiles because it did meet the 50%, 10% rule. For example, across all segments, there was a strong belief that the number of children a couple has should be left up to God. Because this belief was not unique to any segment (or group of segments), we could not report it.

We did make exceptions to the 50%, 10% rule in some cases, to provide a full picture of each profile. For example, for each group we included demographic and some fertility information (for example, number of children), even if it did not completely meet the 50%, 10% rule. Because the behavior change communication aspect is so important, we also reported the overall media channels for each segment, as long as it was above 50% for that segment (suspending the 10% rule if necessary). In addition, for some attitudinal questions that asked respondents to indicate level of agreement or disagreement, we combined the categories of "strongly agree" and "agree" (or "strongly disagree" and "disagree"). In these cases, however, we still used the 50%, 10% rule for these combined categories.

3.3 MULTI-DIMENSIONAL MARKET SEGMENTS (WOMEN)

The six women non-user segments are as follows:

Segment 1: Rural Conservatives

Segment 2: Aware Ambivalents

Segment 3: Prudent Urbanites

Segment 4: Coming-of-Age Traditionalists

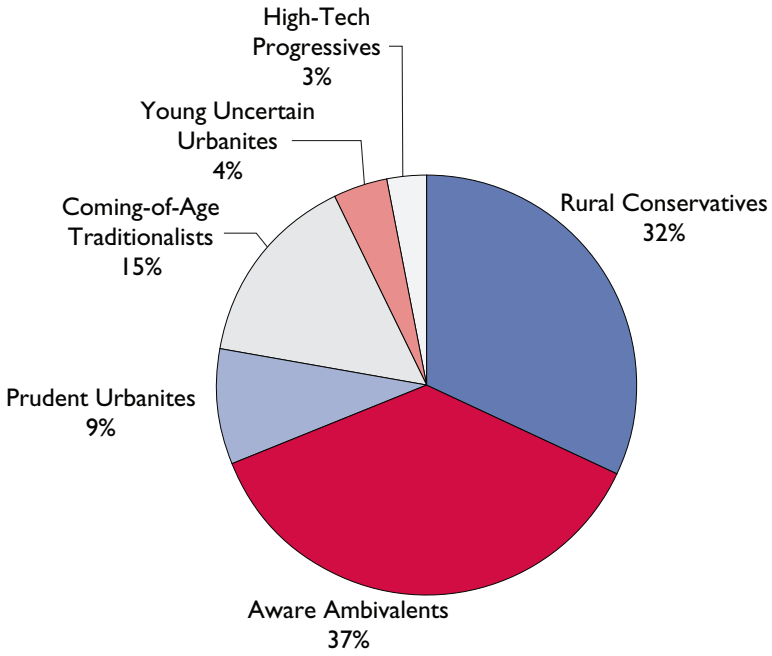
Segment 5: Young Uncertain Urbanites

Segment 6: High-tech Progressives

The segment names were developed to reflect key characteristics of each group. For example, Rural Conservatives is the segment who live in rural areas and are religious, factors that influence their FP decision making process.

Figure 3 shows the distribution of the segments as percentages of the population of women non-users. Rural Conservatives comprise about 32%; the older group of Aware Ambivalents make up 37%; and Prudent Urbanites are about 9% of non-users. The younger segments make up a smaller percentage of non-users: Coming-of-Age Traditionalists comprise about 15%, Young Uncertain Urbanites 4%, and High-tech Progressives only 3%.

FIGURE 3. MARKET SHARE OF WOMEN'S FAMILY PLANNING SEGMENTS



3.4 SEGMENTATION PROFILES: WOMEN

Below we present a brief description of the distinguishing features of each of the six market segments, as well as a bulleted profile.

Segment 1: Rural Conservatives[7] (32.4%)

The poorest segment, Rural Conservatives hold the strongest beliefs regarding FP: we were able to identify more unique attitudinal attributes for them than for any other segment. They tend to hold traditional views about religion and its role in making FP decisions, as they believe couples should listen to religious leaders about FP. Not only do Rural Conservatives believe their religion frowns upon pregnancy outside of marriage, but they feel it is against their religion to use FP and any method should be in accordance with their religious beliefs.

[7] Segment 1 contains 85.5% rural and 14.5% urban individuals. Initially, these were separate segments but were combined in the final analysis due to the small sample size of the urban group (n=18) and the methodological difficulty of creating a profile for a small group. Combining the segments, however, created some inconsistencies in attitudes about FP and fertility for this segment. We found that certain beliefs strongly reflected the urban group; thus, we decided to exclude those attitudes from the bullet points below. Please refer to Annexes A and B for a full listing of the women's attitudes.

Overall, they do not seem open to FP, believing that married couples should have their first child within one year of marriage and should not worry about FP until this child is born. They also equate happiness in marriage with the number of children conceived. Unlike other segments, Rural Conservatives believe that abortion is an FP method. They believe that using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion and that it is less expensive to get an abortion when needed, as opposed to paying regularly for an FP method. At the same time, Rural Conservatives still believe it is important for a healthcare provider to discuss FP methods with a woman who has just received an abortion.

While their awareness of the withdrawal method and IUCDs is high, Rural Conservatives have low awareness of the male condom. They believe their health care provider can answer their FP related questions, but they tend to be embarrassed to ask. Rural Conservatives are distrustful of sources for FP advice other than their immediate family, doctors, midwives, older persons, and those who have already used FP.

Demographics

- Mostly rural
- Least wealthy (within bottom two quintiles)
- Mixed age groups, although mostly older
- High school educated

General health attitudes

- Believe that midwives provide good quality medical services

Fertility and FP behaviors

- Mostly married
- Mostly 1-2 children/Some 3 or more children
- Have been/are currently sexually active
- Median age at first intercourse: 20 years
- Mostly do not want more children
- Half have not had an abortion/Many have had 1-4 abortions/Some have had 5 or more
- Have unmet need for birth limiting

Fertility and FP awareness

- Highest awareness of the withdrawal method
- High awareness of the IUCD
- Low awareness of the male condom

Fertility and FP attitudes

- Believe it is important that an FP method is in accordance with their personal/religious beliefs
- Believe it is against their religion to use FP methods
- Believe couples should listen to religious leaders regarding FP
- Believe their religion frowns upon pregnancy outside of marriage
- Believe it is considered shameful if a woman gets pregnant when she is not married
- Believe it is normal for women to get married at an earlier age than men
- Believe that today's television encourages premarital sex
- Believe the more children a married couple has, the happier their relationship will be
- Believe a married couple should have their first child within one year after marriage
- Believe there is no need to worry about FP until the first child
- Believe men do not want to use an FP method because it interferes with sexual pleasure
- Believe a woman should consult her partner when deciding to use FP
- Believe that if they decide to use an FP method, their husband will support their decision
- Believe a woman should consult her mother-in-law before deciding to use FP
- Believe if they decide to use FP, their mother-in-law will support their decision
- Believe needing a prescription for oral contraceptives is a barrier to using the method
- Feel confident that their healthcare provider can answer any questions about FP
- Believe it is difficult to insert an IUCD because only doctors can insert it
- Feel embarrassed to ask for FP methods at a pharmacy

Attitudes about abortion

- Believe abortion is a method of FP
- Believe using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion
- Believe it is less expensive to get an abortion when needed, as opposed to paying regularly for an FP method
- Believe the decision to have an abortion should be made jointly by a woman and her partner

Trusted sources of FP advice

- Trust husband/partner, mother, father, sister, brother, mother-in-law, doctors, midwives, an older person, and someone who already uses FP

- Do not trust extended family, friends, pharmacy employees other than pharmacists, the school system and educators, news reports on television, government agencies or workers, product advertisements, internet websites, and articles in newspapers
- Employers and co-workers are an irrelevant source for FP advice

Media and lifestyle characteristics

- Watch television more than any other segment
- Are more likely to watch television in the evening
- Watch entertainment/music/dance, serials, ANS TV, and ATV on television
- Unlikely to listen to the radio
- Do not use the internet
- Least likely segment to own a mobile phone

Household decision making: does not distinguish this segment

Segment 2: Aware Ambivalents (37.0%)

Aware Ambivalents believe that a married couple should have a child within one year of marriage and that FP should not be considered until after the first child; nevertheless, this segment feels that a woman should pursue her career before having children. However, they do not intend to use FP in the future. Aware Ambivalents do understand the financial and health benefits of FP and have high awareness of the most common modern methods used in Azerbaijan (oral contraceptives, male condom, and IUCD). From experience, Aware Ambivalents recognize the psychological impact an abortion has on a woman and feel it is important for a health provider to counsel a woman who has just had an abortion on FP methods. Although this segment is not the poorest, they worry about the cost of medical care and medication. This segment has great trust in their partner/husband and typically consults them to make joint decisions on everything from how to spend household resources to healthcare and FP. Aware Ambivalents tend to trust midwives and nurses to provide them with FP information and advice, while they do not trust product advertisements.

Demographics

- Mostly urban
- Mid-level wealth to wealthiest
- Mostly aged 35-49/Some aged 25-34
- Mostly high school educated/Some technicum or college educated

General health attitudes:

- Cost of private medical services prevents them from seeking care when they need it
- Cannot afford to purchase all the drugs they need when they are sick
- Believe their health care provider always spends enough time taking care of them when they visit

Fertility and FP behaviors

- Mostly married
- Mostly have 1-2 children/Some 3 or more children
- Have been/are currently sexually active
- Mostly do not want more children
- Most likely to have 5 or more abortions of any segment, although half have never had one and many have had between 1-4
- Have unmet need for birth limiting
- Do not intend to use FP in the future

Fertility and FP awareness:

- High awareness of IUCD, male condom, oral contraceptives (pill), and withdrawal

Fertility and FP attitudes

- Believe a woman should pursue her career before having children
- Believe a married couple should have their first child within one year after marriage
- Believe there is no need to worry about FP until after the first child
- Believe FP is beneficial to the health of a woman
- Believe FP decreases the financial burden on a family

Attitudes about abortion

- Believe receiving an abortion can cause psychological harm to a woman
- Believe it is important for a healthcare provider to discuss FP methods with a woman who has just received an abortion

Trusted sources of FP advice

- Trust husband/partner, nurses, and midwives
- Do not trust product advertisements

Media and lifestyle characteristics

- Watch television
- Mostly watch television in the evening, but are more likely to watch in the afternoon than any other segment
- Mostly watch television every day
- Watch news and Lider TV
- Do not listen to the radio
- Unlikely to use the internet
- Almost half own a mobile phone
- Household decision making:
- Make joint decisions (husband/wife) about how husband/partner's earnings will be used
- Make joint decisions about healthcare of the woman/wife
- Make joint decisions about making major household purchases

Segment 3: Prudent Urbanites (8.8%)

Prudent Urbanites are relatively wealthy and frequent radio listeners, with high awareness of FP methods such as the IUCD, male condom, oral contraceptives, and withdrawal. They are FP-positive, as they are more likely to believe a woman should pursue her career before having children, that FP has health benefits for the woman, and that it is wise to learn about FP before becoming sexually active. Prudent Urbanites feel that it is shameful if a woman gets pregnant before marriage and worries that television encourages premarital sex. Prudent Urbanites strongly do not believe that an abortion is easier to obtain than an FP method. They also feel that an abortion causes psychological harm to a woman and that providers should discuss FP with a woman who has just had an abortion. Although this segment may be open to FP, they want to make sure the method is safe and that it does not interfere with their sexual pleasure or that of their partner. They trust their partner and feel that it is important to make joint decisions in daily life and on reproductive health matters.

Demographics

- Exclusively urban
- Mostly wealthy
- Mostly aged 35-49, some aged 25-34
- Mixed educational level (half high school educated, half technicum or higher educated)

General health attitudes:

- Believe their healthcare provider always explains things about their health in a way they can understand

Fertility and FP behaviors

- Mostly married
- Most likely to have 1-2 children of any segment
- Have been/are currently sexually active
- Mostly do not want more children
- Mixed regarding number of abortions; more than half have had 1 or more

Fertility and FP awareness:

- Highest awareness of IUCD and male condom
- High awareness of oral contraceptives (pill) and withdrawal
- Fertility and FP attitudes
- Believe a woman should pursue her career before having children
- Believe FP is beneficial to the health of the woman
- Believe it is wise to learn about FP before becoming sexually active
- Believe it is normal for women to get married at an earlier age than men
- Believe that today's television encourages premarital sex
- Believe it is considered shameful if a woman gets pregnant when she is not married
- Believe a woman should consult her partner when deciding to use FP
- Believe that if she decides to use an FP method, her husband will support her decision
- Feel confident that their healthcare provider can answer any questions about FP
- Believe it is difficult to get an IUCD because only doctors can insert it
- Believe safety (associated health risk to the woman) is important
- Believe that non-interference with a man's or woman's sexual pleasure is important in an FP method

Attitudes about abortion

- Do not believe it is easier to get an abortion than to get an FP method
- Believe abortion poses significant health risks for women
- Believe receiving an abortion can cause psychological harm to women
- Believe it's important for a healthcare provider to discuss FP methods with a woman who has just received an abortion
- Believe the decision to have an abortion should be made jointly by a woman and her partner

Trusted sources of FP advice

- Trust husband/partner, doctors, nurses, midwives, and someone who already uses FP
- Do not trust friends, religious leaders, news reports on television, government agencies or workers, internet websites

Media and lifestyle characteristics

- Watch television
- Most watch television in the evening/some in the afternoon
- Watch television every day
- Watch movies, AZTV and Khazar TV
- Listen to the radio
- Mostly listen to the radio in the afternoon/some in the morning
- Listen to music and Azad Azerbaijan 106.3 on the radio
- Unlikely to use the Internet
- Mostly own a mobile phone

Household decision making:

- Makes joint decisions (husband/wife) about how husband/partner's earnings are used
- Makes joint decisions about healthcare of the woman/wife
- Makes joint decisions about major household purchases
- Makes joint decisions about daily household purchases

Segment 4: Coming-of-Age Traditionalists (15.1%)

Coming-of-age Traditionalists include young women who are unsure about their intention to use FP. Even though they have confidence that their healthcare provider can answer their questions about FP, they are embarrassed to ask. Coming-of-Age Traditionalists believe their religion frowns upon pregnancy outside of marriage and do not think one should worry about FP until after the first child. While Coming-of-Age Traditionalists trust their immediate family and their partner for FP related advice, there are a lot of sources they do not trust, including friends, extended family, religious leaders, midwives, health station workers, pharmacists, pharmacy employees other than pharmacists, government agencies or workers, and product advertisements. At this point in their lives, someone else makes decisions on household matters and they worry that they cannot afford to purchase the medications they need when sick.

Demographics

- Mixed rural and urban (although higher percentage rural)
- Mixed income (although mostly middle income)
- Mostly aged 18-24, a few aged 25-34
- High school educated

General health attitudes:

- Cannot afford to purchase all the drugs they need when they are sick

Fertility and FP behaviors

- Exclusively single/not married
- No children
- Have never had sex/not sexually active
- Mostly want children, but are unsure when
- Have never had an abortion
- Mostly are unsure about intention of future use

Fertility and FP awareness: does not distinguish this segment

Fertility and FP attitudes

- Believe their religion frowns upon pregnancy outside of marriage
- Believe there is no need to worry about FP until the first child
- Believe a woman should consult her partner when deciding to use FP
- Believe a woman should consult her mother-in-law when deciding to use FP
- Feel embarrassed to ask their healthcare provider questions about FP
- Feels confident their healthcare provider can answer any questions about FP

Trusted sources of FP advice

- Trust mother, sister, brother, an older person and someone who already uses FP
- Do not trust friends or extended family, religious leaders, midwives, health station workers, pharmacists, pharmacy employees other than pharmacists, government agencies or workers, or product advertisements
- Employers and co-workers are an irrelevant source for FP advice

Media and lifestyle characteristics

- Watch television
- Watch television in the evening
- Watch movies and serials, ANS TV, ATV, AZTV, ITV (public television) and Lider TV
- Unlikely to listen to the radio
- Unlikely to use the Internet
- Unlikely to own a mobile phone

Household decision making

- Someone else decides how the money they earn will be used
- Someone else decides how their husband/partner's earnings will be used
- Someone else usually makes decisions about healthcare of the woman/wife
- Someone else usually makes decisions about making major household purchases
- Someone else usually makes decisions about daily household purchases

Segment 5: Young Uncertain Urbanites (3.6%)

Young Uncertain Urbanites are single and college educated young women who may be open to FP. In terms of contraceptive needs, they stress effectiveness, ease of use, convenience and safety for the woman. Due to a lack of experience, they are not yet sure whether FP methods might interfere with sexual pleasure and if this would be important to their partner. Young Uncertain Urbanites have limited knowledge about abortion. For example, they do not know if it is less expensive to get an abortion compared with using FP regularly. They are also unsure whether using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion. Young Uncertain Urbanites typically only trust their mother, doctors, and nurses for FP advice, and are distrustful of many sources, like their counterparts Coming-of-Age Traditionalists. Although they do trust doctors, they tend to believe it is difficult to find one that is qualified and prefer not to seek care until they have a serious health problem.

Demographics

- Exclusively urban
- Mid-level wealth to wealthiest
- Mostly 18-24, some 25-34
- College/technicum educated

General health attitudes:

- Believe people have to wait until they have a serious health problem before seeking care
- Believe it is difficult to find a qualified doctor

Fertility and FP behaviors

- Exclusively single/unmarried
- No children
- Have never had sex/not sexually active
- Have never had an abortion
- Unsure about intention of future use

Fertility and FP awareness:

- High awareness of the male condom

Fertility and FP attitudes

- Strongly believe safety (associated health risk to the woman) is important in an FP method
- Believe effectiveness at preventing pregnancy is important in an FP method
- Believe convenience to get/purchase a method is important
- Believe ease of use of a method is important
- Believe non-interference of a method with a woman's sexual pleasure is important
- Believe a method's effectiveness at preventing STIs is important
- Do not know if men do not want to use FP methods because it might interfere with their sexual pleasure

Attitudes about abortion

- Do not know if it is less expensive to get an abortion when needed, as opposed to paying regularly for FP
- Do not know if using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion

Trusted sources of FP advice

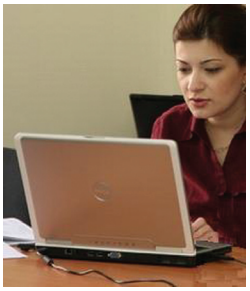
- Trust mother, doctors, and nurses

Media and lifestyle characteristics

- Watch television
- Watch television in the evening

- Watch television every day
- Watch news, ANS TV, ATV, Lider TV and Khazar TV
- Some listen to the radio
- Listen to Azad Azerbaijan 106.0 FM and Azad Azerbaijan 106.3 FM on the radio
- Do not use the Internet
- Mostly own a mobile phone

Household decision making: does not distinguish this segment



Segment 6: High-tech Progressives (3.2%)

High-tech Progressives are younger, wealthy, and highly educated. This group is tech savvy: they frequently use the Internet and own mobile phones. Unlike other segments, High-tech Progressives do not believe it is important for an FP method to be in accordance with their religious beliefs. They also think learning about FP before becoming sexually active is important. Like their counterparts in segment 5, this segment has strong opinions regarding what they want in an FP method including effectiveness, ease of use, convenience, and safety for the woman. Compared with other segments, this segment does not trust others for FP advice. They specifically distrust the school system or educators. High-tech Progressives believe their healthcare provider is attentive and explains healthcare related issues well, but they are concerned about the time they have to wait at a facility before they are seen. Typically, High-tech Progressives do not go to a healthcare provider unless they have a serious problem.

Although they have higher awareness of FP methods compared with other younger segments, they are still unsure about the effects of abortion. For example, they do not know if it is less expensive to get an abortion when needed, as opposed to paying regularly for FP, and they are unsure whether using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion.

Demographics

- Mostly urban
- Wealthiest and second wealthiest quintiles
- Mostly aged 18-24
- Exclusively single/not married
- Mostly college educated/some technicum

General health attitudes:

- Believe people have to wait until they have a serious health problem before seeking care
- Say they have to wait at a medical facility before seeing a health professional

- Believe their health care provider always spends enough time taking care of them when they visit
- Believe their healthcare provider always explains things about their health in a way they can understand

Fertility and FP behaviors

- Exclusively single/unmarried
- No children
- Have never had sex/not sexually active
- Have never had an abortion
- Unsure about intention of future use

Fertility and FP awareness:

- High awareness of the male condom and oral contraceptives (pill)

Fertility and FP attitudes

- Believe it is wise to learn about FP before becoming sexually active
- Believe it is normal for a woman to get married at an earlier age than men
- Believe a woman should consult her partner when deciding to use FP
- Do not believe it is important for an FP method to be in accordance with their personal/religious beliefs
- Do not know if men do not want to use FP methods because it might interfere with their sexual pleasure
- Do not know if employers should provide access to FP information and products in the workplace
- Do not know if needing to get a prescription for oral contraceptives is a barrier to using the method
- Believe that if a woman decides to use FP, the mother-in-law will support her decision
- Believe a method's safety (associated health risk to the woman), effectiveness in preventing pregnancy, convenience to get/purchase, and effectiveness in preventing STIs are important

Attitudes about abortion

- Do not know if it is less expensive to get an abortion when needed, as opposed to paying regularly for FP
- Do not know if using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion

Trusted sources of FP advice

- Do not trust the school system or educators

Media and lifestyle characteristics

- Watch television
- Watch television in the evening
- Watch movies, news, business/news magazine and entertainment/music/dance and Turkish TV channels on television
- Mostly listen to the radio
- Mostly listen to the radio in the afternoon
- Listen to music, Azad Azerbaijan 106.0 FM and Azad Azerbaijan 106.3 FM on the radio
- Use the Internet
- Mostly have internet at home/Some go to an internet café
- Use the internet daily or at least once a week
- Mostly own a mobile phone

Household decision making: does not distinguish this segment

3.5 MULTI-DIMENSIONAL MARKET SEGMENTS (MEN)

The four non-user men's segments are as follows:

Segment 1: Inexperienced Progressives

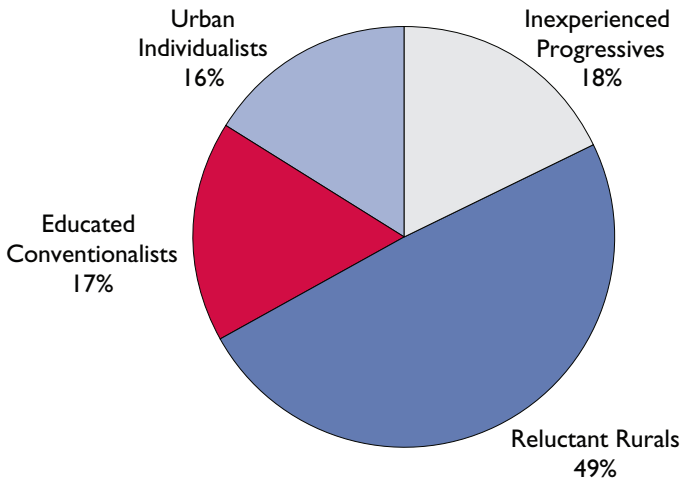
Segment 2: Reluctant Rurals

Segment 3: Educated Conventionalists

Segment 4: Urban Individualists

Figure 4 shows the distribution of the segments as a percentage of the population of male non-users. Reluctant Rurals constitute 49% of non-users; their younger counterparts, the Inexperienced Progressives, comprise about 18%. The Educated Conventionalists and the Urban Individualists follow closely behind, comprising 17% and 16% of non-users.

FIGURE 4. MARKET SHARE OF MEN'S FAMILY PLANNING SEGMENTS



3.6 SEGMENTATION PROFILES: MEN

Segment 1: Inexperienced Progressives (18%)

Inexperienced Progressives are young, single men who have never had sex. Inexperienced Progressives appear to be FP-positive as they consider it wise to learn about FP before becoming sexually active. They are more likely to believe that a woman should pursue her career before having children and that FP has health benefits for the woman. They believe that decisions on everything from income to daily household purchases should ideally be made with one's partner. Inexperienced Progressives advocate for employers' providing access to FP information and products in the workplace.

Although this segment is confident that they receive good quality care from their health care provider, they are embarrassed to ask them questions about FP. They are also embarrassed to ask for FP methods at the pharmacy, although when sick, they prefer to go directly to the pharmacy. The cost of drugs, however, is usually a barrier, and they tend to wait until they have a serious health problem before seeking care. In terms of FP needs, they believe non-interference with the woman's sexual pleasure is important, but seem indifferent to the man's sexual pleasure. Safety for the woman's health, effectiveness at preventing pregnancy, and convenience to get/purchase a method are important; however, perhaps due to a lack of experience, they are undecided about a method's ease of use, affordability, and effectiveness at preventing STIs. While they trust their immediate family, they do not trust many others for FP advice.

Demographics

- Mixed urban and rural
- Mixed income
- Mostly aged 18-24/some aged 25-34

- Mostly single/not married
- Secondary educated

General health attitudes

- Believe doctors and midwives provide good quality health care service
- Believe their health care provider always spends enough time taking care of them when they visit
- Believe people often wait until they have a serious health problem before seeking care
- Cost of private medical services prevents them from seeking care
- Cannot afford to purchase all the drugs they need when they are sick
- Usually go straight to the pharmacy to get the necessary drugs when sick

Fertility and FP behaviors

- Mostly single
- Have never had sex/not sexually active

Fertility and FP awareness: does not distinguish this segment

Fertility and FP attitudes

- Believe a woman should pursue her career before having children
- Believe FP is beneficial to the health of a woman
- Believe a woman should stop childbearing by the age of 35 to ensure healthy children
- Believe it is wise to learn about FP before becoming sexually active
- Believe employers should provide access to FP information and products in the workplace
- Believe that if the wife/partner decides to use an FP method, they will support her decision
- Believe that both husband and wife should make joint decisions about FP and that the woman should consult her partner about using FP
- Believe that if the wife/partner decides to use an FP method, the mother-in-law will support her decision
- Believe today's TV encourages premarital sex
- Believe it is normal for women to get married at an earlier age than men
- Feel embarrassed to ask for FP methods at the pharmacy and to ask the health care provider questions about FP
- Believe safety (associated health risk to the woman), effectiveness at preventing pregnancy, and convenience to get/purchase a method are important when deciding to use an FP method

- Believe interference of a method with a woman's sexual pleasure is important, but interference with a man's sexual pleasure is neither important nor unimportant

Attitudes about abortion

- Do not believe it is less expensive to get an abortion than to get an FP method

Trusted sources of FP advice

- Trust friends, mother, father, and brother
- Do not trust religious leaders, midwives, pharmacists, pharmacy employees other than pharmacists, and government agencies/workers

Media and lifestyle characteristics

- Watch television
- Watch crime programs, movies, show business news/magazine programs
- Watch ANS, ATV, AZTV, ITV (public), Lider TV, and Space TV
- Unlikely to listen to the radio or use the Internet
- Mostly own mobile phones

Household decision making:

- Make joint decisions (husband/wife) about the husband's/partner's earnings
- Make joint decisions (husband/wife) about wife's/partner's earnings
- Make joint decisions (husband/wife) about husband's/partner's health care
- Make joint decisions about major household purchases
- Make joint decisions about daily household purchases

Segment 2: Reluctant Rurals (49.7%)

Reluctant Rurals constitute the poorest segment. Although they advocate for employers to provide FP information and products in the workplace, overall this segment holds conservative views. They believe that couples should listen to religious leaders about FP. Reluctant Rurals feel married couples should have their first child within one year after marriage and should not worry about FP until after this child is born. Even though they are confident that their health care provider can answer any questions about FP, they are embarrassed to ask. They are also embarrassed to obtain FP methods from the pharmacist. Reluctant Rurals cannot afford to purchase the drugs they need when they are sick. They stress affordability and non-interference with the man's sexual pleasure when considering FP methods.

While they believe that men do not want to use an FP method because it would interfere with their sexual pleasure, they would support their wife/partner if she decides to use a method. Unlike other segments, Reluctant Rurals believe that hormonal contraceptives are more harmful to a woman than

having an occasional abortion. Reluctant Rurals trust their wife/partner, immediate family, doctors, nurses, and midwives for FP advice, but do not readily trust extended family and friends or other sources.

Demographics

- Mostly rural
- Poorest to mid-level wealth
- Mostly aged 25-34/some aged 35-49
- Mostly married/in union/some single
- Completed secondary education

General health attitudes

- Cannot afford to purchase all the drugs they need when they are sick
- Usually have to wait before seeing a health professional at a medical facility

Fertility and FP behaviors

- Mostly no children/some 1-2 children
- Have been/are currently sexually active

Fertility and FP awareness

- Higher awareness of IUCD and oral contraceptives (pill)

Fertility and FP attitudes

- Believe that the more children a married couple has, the happier the marriage will be
- Believe a married couple should have their first child within one year after marriage
- Believe there is no need to worry about FP until the first child
- Believe a woman should consult her partner when deciding to use FP and will support the wife/partner if she decides to use a method
- Believe men do not want to use an FP method because it might interfere with their sexual pleasure
- Believe employers should provide access to FP information and products in the workplace
- Believe a woman should consult her mother-in-law when deciding to use FP
- Believe the mother-in-law will support her decision if she decides to use an FP method
- Believe couples should listen to religious leaders regarding FP
- Believe it is against their religion to use FP methods
- Believe today's TV encourages premarital sex
- Believe sex education in school encourages premarital sex

- Believe having to get a prescription for oral contraceptives is a barrier to using that method
- Believe that affordability and interference with the man's sexual pleasure is important when deciding to use FP methods
- Feel embarrassed to ask for FP methods at the pharmacy
- Feel embarrassed to ask their health care provider questions about FP
- Feel confident that their health care provider can answer any questions they have about FP

Attitudes about abortion

- Believe using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion
- Believe it is less expensive to get an abortion when needed, as opposed to paying regularly for an FP method

Trusted sources of FP advice

- Trust wife/partner, mother, father, sister, brother, doctors, nurses, midwives, and an older person
- Do not trust friends, extended family, health station workers, school system/educators, news report on TV, product advertisements, or pharmacy employees other than pharmacists

Media and lifestyle characteristics

- Watch television
- Watch crime programs, movies, and news
- Watch ANS, ATV, AZTV, ITV (public), Lider TV, and Space TV
- Unlikely to listen to the radio or use the Internet
- Most or all own mobile phones

Household decision making

- Does not distinguish this segment

Segment 3: Educated Conventionalists (16.6%)

Educated Conventionalists are mostly urban and higher educated. Like Reluctant Rurals, they hold more traditional views about religion, as they believe that it is against their religion to use FP methods. On the other hand, they believe using FP will decrease the financial burden on a family. This segment is most likely to have used some kind of FP method, but believe withdrawal is the best method for them. When deciding to use a method, they stress approval from people who are important to them, in addition to the method's safety to the woman's health, effectiveness at preventing STIs, ease of use, affordability, and non-interference with the man's sexual pleasure. Educated Conventionalists have great trust in their wife or partner and doctors for FP advice. They trust midwives, health station workers and those who use FP, but do not trust coworkers or articles in magazines or newspapers. Finally, this segment feels that people have to travel far to see a health care provider and that it is difficult to find a qualified doctor. They prefer traditional methods to treat illness.

Demographics

- Mostly urban
- Wealthy to wealthiest
- Mixed age groups but mostly 25 and older
- Mostly married/some single
- Secondary and higher educated

General attitudes

- Believe cost of private medical services prevents them from seeking care
- Believe people have to travel a long way to see a health care provider
- Believe people often wait until they have a serious health problem before seeking care
- Believe it is difficult to find a qualified doctor
- Usually have to wait before seeing a health professional at a medical facility
- Prefer to use traditional methods to treat illness

Fertility and FP behaviors

- Mostly no children/some 1-2 children
- Have been/are currently sexually active
- Most have used some FP method

Fertility and FP awareness

- Higher awareness of IUCD and withdrawal method
- Most believe withdrawal is the best FP method for them

Fertility and FP attitudes

- Believe FP decreases the financial burden on a family
- Believe it is wise to learn about FP before becoming sexually active
- Believe a married couple should have their first child within one year after marriage
- Believe there is no need to worry about FP until the first child
- Believe the more children a married couple has, the happier the marriage will be
- Believe it is considered shameful if a woman gets pregnant when she is not married
- Believe their religion frowns upon pregnancy outside of marriage
- Believe it is against their religion to use FP methods
- Believe sex education in school encourages premarital sex
- Believe important factors are: an FP method's safety (associated health risk to the woman), affordability, non-interference with the man's sexual pleasure, ease of use, effectiveness at preventing STIs, and approval from people who are important to them

Attitudes about abortion

- Believe it is easier to obtain an abortion than to get an FP method

Trusted sources of FP advice

- Trust wife/partner, doctors, health station workers, midwives, and someone who already uses FP
- Do not trust coworkers or articles in magazines or newspapers

Media and lifestyle characteristics

- Watch TV
- Watch comedy and sport magazines/sport competitions

Household decision making

- Respondent usually makes decisions about how his earnings will be used

Segment 4: Urban Individualists (15.8%)

Urban Individualists are higher educated urbanites. Like Inexperienced Progressives, this segment may be more open to FP, as they believe that a woman should pursue her career before having children and that FP has health benefits for the woman. They are also more likely to believe that FP may decrease a family's financial burden. In regard to abortion, Urban Individualists believe it is easier and less expensive to obtain an abortion than to use an FP method. They prefer to use traditional methods to treat illness and, like Educated Conventionalists, they believe withdrawal is the best method. When evaluating an FP method, accordance with personal or religious beliefs is important

to them, in addition to the method's safety for the woman's health and effectiveness at preventing pregnancy and STIs.

Overall, Urban Individualists believe that their health care provider is attentive. Unlike other segments, however, they are less trusting of their immediate family for FP advice. Additionally, they are distrustful of many other people and the media for FP advice. While almost half of this group uses the Internet and uses it almost every day, they strongly distrust it as a source of FP information.

Demographics

- Exclusively urban
- Wealthy to wealthiest
- Mixed age groups but mostly 25 and older
- Mostly married/some single
- Secondary and higher educated

General attitudes

- Believe their health care provider always spends enough time taking care of them
- Believe their health care provider always explains things about their health in a way they can understand and always listens to them if they have questions about their health
- Believe midwives provide good quality medical service
- Believe cost of private medical services prevents them from seeking care
- Believe people often wait until they have a serious health problem before seeking care
- Believe people have to travel a long way to see a health care provider
- Prefer to use traditional methods to treat illness

Fertility and FP behaviors

- Mostly no children/some have 1-2 children
- Have been/are currently sexually active
- Wife/partner never had an abortion

Fertility and FP awareness

- Higher awareness of pill and withdrawal method
- Mostly believe withdrawal is the best method for them

Fertility and FP attitudes

- Believe a woman should pursue her career before having children
- Believe it is wise to learn about FP before becoming sexually active

- Believe FP is beneficial to the health of a woman
- Believe FP decreases the financial burden on a family
- Believe a woman should consult her partner when deciding to use FP
- Believe it is normal for women to get married at an earlier age than men
- Believe women should stop childbearing by the age of 35 to ensure the birth of healthy children
- Believe an FP method's safety (associated health risk to the woman), effectiveness at preventing pregnancy and STIs, and accordance with personal/religious beliefs are important

Attitudes about abortion

- Believe it is easier to obtain an abortion than to get an FP method
- Believe it is less expensive to get an abortion when needed, as opposed to paying regularly for an FP method

Trusted sources of FP advice

- Do not trust friends and extended family
- Strongly do not trust religious leaders, nurses, midwives, health station workers, pharmacists, pharmacy employees other than the pharmacist, an older person, employers, school system/ educators, government agencies/workers, news report on TV, product advertisements, Internet websites, articles in magazines or newspapers, or someone who already uses FP

Media and lifestyle characteristics

- Watch TV
- Watch news and sport magazines/sport competitions
- Almost half use the internet, access it at home and at work, and use it every day or at least once a week

Household decision making

- Respondent usually makes decisions about how his earnings will be used

4. QUALITATIVE FINDINGS: FAMILY PLANNING PROVIDERS

The qualitative findings below reflect the major themes that emerged from the provider interviews. These themes include the providers' description of their patients, general health and FP services provided, views regarding sex education and FP, and recommendations on reaching out to the public.

4.1 RESPONDENT BACKGROUND

Most respondents said they were currently married or had been widowed; a small number of respondents said they were single. Of those who were married, a majority indicated that their spouse was also employed. Most respondents said they had two or three children; a small number of respondents had one child or no children.

All providers had formal medical training of some kind. For example many physicians were educated at the Medical Institute in Baku, while midwives received special training at nursing schools throughout the country. The number of years that each health professional had been in practice varied from 3 years to 51 years. A majority of physicians had practiced at least 19 years. A majority of respondents indicated they had received in-service training in FP outside of their degree program.

4.2 DESCRIPTION OF PATIENTS SERVED

Most OB-GYNs indicated that their patients were primarily women of reproductive age, while midwives tended to report serving a broader clientele of all ages. However, some providers varied from this general trend. Most providers said that a majority of their patients were female. Some mentioned that they serve a few men, but not on a frequent basis.

These were some typical comments from providers:

I rarely see male patients, only 3-5 a month. They come only if they need to have some procedure prescribed by a physician, such as injections. Majority of my patients are female (Midwife/PHC, Salyan).

Male patients come with women if the reason of their visit is sexually transmitted infection. They represent around 2% of all cases (OB-GYN, Baku).

Because I am the only doctor in this village I see all kinds of patients – from newborns to elderly (Midwife/PHC, Khachmaz).

All women of reproductive age living in this area come to see me. Recently teenagers started to come to see me too (OB-GYN, Baku).

Most providers practicing in rural areas reported that their patients were from the surrounding rural villages. Providers practicing in Baku mentioned that most of their

patients were from the urban areas. However, some providers in both rural and urban areas said they had a mixture of rural and urban patients, particularly because of the influx of migration into Baku from the rural areas.

In the words of respondents:

I am an area OB-GYN and I cover an area where only urban population lives. I have rare instances of rural persons applying (OB-GYN, Baku).

All patients live in the villages served by our facility. Majority of my patients are women living in Sarvan village. (Midwife/PHC, Salyan).

Mainly urban women but due to migration rural people moved to city, and so among my patients there are many rural people too. I have mixture of patients both rural and urban (OB-GYN, Baku).

Many providers mentioned that they mostly serve the low-income or poor population, although several also stated that they served the middle class. Some mentioned that they serve a mix of patients from all economic classes. Very few providers served the upper class.

Typical responses included:

Mainly patients from poor families. My patients very often ask me to prescribe those medicines that are cheaper (Midwife/PHC, Salyan).

Mainly patients from middle class families. They derive their income from agricultural activities (Midwife/PHC, Salyan).

The economic status of my patients varies. I have patients from all classes (Midwife/PHC, Khachmaz).

Most respondents reported a mix in terms of patient education level. Many stated that a majority of their patients had received no more than a high school education, but were quick to mention that other patients may have graduated from college. A few respondents also stated that some of their patients may not have received more than an elementary school education.

In the words of two interviewees:

The education level of my patients used to be higher, but now I meet patients who have only primary (elementary) education (OB-GYN, Baku).

Majority of patients are high school educated. I also have many patients with college education (Midwife/PHC, Khachmaz).

When asked about the type of work that their patients typically do, a majority of respondents mentioned that several of their patients, if not most, were housewives. Many providers stated that their patients had a variety of professions in addition to being housewives, including teachers, nurses, agricultural workers, and those involved in the oil industry. Some providers mentioned that many patients are unemployed.

Here is what three providers said about their patients:

My patients do different work but majority are housewives and unemployed (Midwife/PHC, Salyan).

Housewives represent the greatest part.There are employed women too, many of them are teachers (OB-GYN, Baku).

Majority of patients are involved in agriculture such as cropping, cattle breeding. Many work at own plot of land. Teachers and other professionals also apply (OB-GYN, Khachmaz).

Providers mentioned a variety of health problems related to gynecology that their patients seek care for, such as: infertility, uterine bleeding, pelvic inflammatory diseases; pregnancy related problems; cervical erosions, sexually transmitted infections. Many health providers also mentioned that patients come to them for FP advice and ante-natal care. A few respondents, particularly midwives and PHCs stated that patients see them for general conditions such as cardio-vascular disease, acute respiratory infections, anemia, worms, and chronic diseases.

Below are a few comments from providers regarding the reasons for which patients sought care:

My patients most often come for gynecological disease such as ovarian cysts, fibromyoms, pelvic inflammatory diseases, infertility, pregnancy problems and FP related issues and etc. (OB-GYN, Salyan).

Pelvic inflammatory diseases are the most common conditions. In recent years I have observed increase in number of infertility cases. Of course, I see a lot of pregnancy related conditions (OB-GYN, Baku).

They commonly come because of pregnancy related conditions, common colds, anemia, elevated blood pressure, vaccination and other (Midwife/PHC, Khachmaz).

Many respondents indicated that they see between 10-15 or 15-20 patients per month. However, a few providers said they saw more than 20 or less than 10 patients each month.

Two OB-GYN s in Baku and Khachmaz said the following:

Each month 10-15 patients come for counseling on FP, however we regularly have conversations with pregnant women (OB-GYN, Baku).

6-7 patients a week/ 25-30 patients a month. Number of patients went down because they educate themselves on FP methods without coming to health provider (OB-GYN, Khachmaz).

4.3 PROVIDERS' PERSONAL VIEWS REGARDING SEX EDUCATION

Many respondents felt that everyone should receive sex education. Some respondents indicated that they thought women should be the first priority for education efforts so as to empower them, and because they will communicate their knowledge to men. Others stated that men should be the first priority, because they are more at risk. Some respondents also emphasized the importance of teaching youth, since they do not have as much awareness.

A few respondents mentioned that targeting low income and rural individuals is particularly important. These were typical of comments heard from providers regarding sex education:

All population needs sex education unmarried and married. If we educate women they can share the information with men (OB-GYN, Baku).

Men need more because they migrate for jobs more often and are at more risk (Midwife/PHC, Salyan).

Young people married and unmarried need sex education (OB-GYN, Baku).

When asked who should be responsible for providing sex education in the community, most respondents said that parents should be responsible. However, a few disagreed stating that in Azerbaijan, there is not an open forum for discussion, and parents themselves are uneducated.

In the words of respondents:

They should be the first responsible party. Parents are responsible for children's education (OB-GYN, Baku).

No. Parents rarely touch these problems because they are not trained to provide such education. I think they can be involved in this if they receive necessary training on communication of such messages (OB-GYN, Baku).

Most respondents stated that schools should also be responsible to teach youth sex education. However, a few respondents did not agree because they believed that schools are not ready to educate at this time. Others said the school does not hold primary responsibility, even though they should be involved.

Typical comments heard from providers included:

For teenagers school should be responsible. If education starts from school the knowledge of population will increase (OB-GYN, Baku).

It may be good but I envision certain problems related to people's mentality (OB-GYN, Khachmaz).

Almost all respondents believed that healthcare professionals should play a main role in providing sex education because of their knowledge and experience. Only a couple of respondents did not agree.

Here is what they had to say:

Health providers have more knowledge in this area and should be responsible for sex education of the population (OB-GYN, Baku).

They should play the main role in educating the population.They should disseminate sex education knowledge and encourage parents to influence their children and protect them from faulty behavior (OB-GYN, Baku).

Health care workers should be responsible for providing sex education in our community (Midwife/PHC, Khachmaz).

Most respondents indicated that religious leaders do not or should not play a role in sex education. Some respondents said that they did not know if it would be possible for

religious leaders to take responsibility for sex education. A few respondents went as far as to say that they do not trust religious leaders to educate the public in this way.

Two providers explained their views in this way:

Religious leaders in our community are poorly educated in this issue. I do not see a role for them (Midwife/PHC, Salyan).

I do not consider provision of sex education by religious leaders will have results. I am not sure about responsibility of religious leaders (OB-GYN, Khachmaz).

Responses regarding the responsibility of social organizations and activists were mixed. Some respondents felt that social organizations could play a role in educating the public, and others indicated that if possible these organizations should be involved. A few respondents said they did not know.

Here is what two OB-GYNs had to say about the involvement of social organizations:

Social organizations can be responsible too, if they are proficient in this work (OB-GYN, Baku).

Social organizations can be supportive too but not primarily responsible (OB-GYN, Khachmaz).

I do not think [social organizations and activists] should be involved in this (Midwife/PHC, Khachmaz).

A majority of respondents said that government agencies should play a role in sex education, particularly the Ministry of Health and Ministry of Youth. Many of the participants based in Baku discussed the possibility of government agencies leading a mass media campaign to educate the public. A small number of respondents did not feel the government should play a role.

In the words of three providers:

Yes, the Ministry of Health and the Ministry of Youth can organize educational campaigns through radio and television (OB-GYN, Baku).

The relevant government agencies should organize or support education campaign through mass media and printed materials (OB-GYN, Baku).

They should be interested. I think health authorities, local executive offices and municipalities should provide support (Midwife/PHC, Khachmaz).

4.4 PROVIDERS' PERSONAL VIEWS REGARDING FAMILY PLANNING

Almost all respondents mentioned the great need for FP in Azerbaijan. Most respondents said this need was a result of economic factors and mentioned the high rate of abortion in their communities.

The following are some typical comments heard from providers:

The need for family planning is great in Azerbaijan. The population has poor knowledge of health related issues. This results in high abortion rate. The need in effective family planning services is high in our village. Many women perform abortions sometimes using traditional methods (Midwife/PHC, Salyan).

It is necessary to educate population. Our women do not observe 2-3 years interval between pregnancies. They give birth consistently by demands of the family members. It is important to explain them it's harmful to their health and health of their children. Family planning is necessary for healthy generation (OB-GYN, Baku).

The economic situation of population in the country is quite hard. Many couples cannot afford to have more than one or two children. The needs in family planning are very great. Due to financial situation fertility fell and women have more abortions (OB-GYN, Baku).

Many respondents stated that everyone needs FP, including married and unmarried men and women from differing economic backgrounds. Some respondents emphasized the importance of prioritizing poor women for FP.

Two respondents explained their views in the following way:

Everyone regardless of gender and age needs family planning services (OB-GYN, Salyan).

All families in reproductive age need family planning. I think family planning is very important for young families to start family life with planning future (OB-GYN, Baku).

More than half of respondents indicated that access to FP was difficult due to financial difficulties in many communities and insufficient supply of certain methods. However, several study respondents disagreed, and felt that access to FP is not a problem in Azerbaijan and that it is easily affordable.

Here are some typical comments heard from providers regarding access to FP:

Access is good, there are no problems. We have good provision of contraceptives. I think the main issue is that some women are not compliant enough, some are not informed well enough (OB-GYN, Baku).

In the area where I provide services everyone has access to family planning services (OB-GYN, Khachmaz).

No, some pills are very expensive and not everybody can afford to buy them. The situation could be improved if more contraceptives are distributed free of charge. We try to cover needs, each women after abortion receives supply of contraceptives (condoms) (OB-GYN, Baku).

In terms of financial access probably not everyone can afford family planning services. But in terms of physical access to healthcare services, everyone has this (OB-GYN, Salyan).

Some respondents suggested ways to improve access to FP, including more health education, promoting awareness through materials and mass media, and an adequate supply of contraceptive methods. Many of these respondents suggested that FP should be free of charge to the public.

Regardless of their position, all health providers need to educate patients about FP to improve their awareness. In addition, all health facilities should be provided with FP supply so patients have access to it (Midwife/PHC, Khachmaz).

Increase in the supply of free contraceptives (both the range and quantity) is needed to improve the access of population to family planning services (OB-GYN, Baku).

There is a need for health education in mass media (OB-GYN, Salyan).

Almost all respondents said that healthcare providers have a large role to play in increasing demand for FP services. Many respondents indicated that it was part of their job description to do this, and they felt that providers could be doing more to promote FP. Most respondents also mentioned that healthcare providers have more influence over patients than their family members or others in the community, because of the great respect people have for their advice.

Healthcare workers need to conduct educational campaigns among population to increase the awareness about FP and generate more demand. As a health provider there are more chances that population will listen me because they trust and respect me in regards of health issues (Midwife/PHC, Khachmaz).

I think health care providers can increase the demand for FP services by strengthening their efforts in health education. I think I have more influence in this area in comparison to others. People know me well and feel more comfortable talking to me on these issues. As a health care worker I can provide better advice and more qualified information about FP (Midwife/PHC, Khachmaz).

Yes, of course, health providers play a great role in increasing contraception demand. Health provider's role is to explain to population the harmful impact of abortion on health of women. Education will help to increase the role of contraception in family life. Health providers have considerable influence on families and my influence is quite significant too (OB-GYN, Baku).

Health providers can educate and raise awareness of the population and so increase demand for FP. As a midwife I am always in communication with the population, and they accept me as health provider. I have more knowledge on FP than any ordinary person (Midwife/PHC, Salyan).

When asked which FP sources they most respect, a majority of respondents stated that they trust other healthcare providers the most, particularly OB-GYNs or specialty physicians.

I respect specialists in gynecology. We provide our patients with correct information, because this topic is related to our specialty (OB-GYN, Baku)

I respect most the doctors (OB-GYN s) who work at the District FP Center, I also respect the information provided by other doctors (Midwife/PHC, Khachmaz).

Many respondents also indicated their trust in information on FP provided by governmental agencies, particularly the Ministry of Health. However a few respondents said that they did not trust the government or were not sure of what role it could play.

Yes, especially [I trust] the Ministry of Health and its Scientific-Research Institute of Obstetrics and Gynecology (OB-GYN, Baku).

I trust official information from government agencies (OB-GYN, Khachmaz)

I don't trust all information provided by government agencies (OB-GYN, Baku).

Respondents had mixed views regarding social organizations and activists. While some believed that organizations or activists could play a role, many were not sure due to lack of familiarity with them. A few indicated that there is no role for them.

There are NGOs [non-governmental organizations] that specialize in this field. They can also be a good source of information (OB-GYN, Baku).

I do not know. I have difficulty in saying anything about social organizations because I do not have experience with working with them in this area (OB-GYN, Khachmaz).

Most respondents said that they do not trust pharmacists to provide FP information. Similarly, respondents felt that pharmaceutical company representatives are not trustworthy due to their commercial interests and lack of a medical background. Respondents also indicated distrust in religious leaders to provide FP information.

The information provided by pharmacies is not complete because the majority of pharmacy personnel are not healthcare workers. That is why their information cannot be trusted. If information is given by a certified pharmacist then it is ok (Midwife/PHC, Salyan).

Generally not [trustworthy]. Just one example. One pregnant woman from our community applied to the pharmacy for medication for abortion. I do not know what she was given but she developed severe bleeding after that and ended up in the hospital where she had an abortion. Many pharmacy workers do not have relevant background. So, I respect pharmacies as a source of information only if they are staffed by certified pharmacists (Midwife/PHC, Salyan).

I do not think we can fully trust the representatives of pharmaceutical companies. The companies may promote their products which may not be of good quality because they have clear commercial interest (OB-GYN, Baku).

Because religious leaders do not have medical background, they are not considered as a source of information in this area (OB-GYN, Khachmaz).

When asked about their personal preference for modern versus traditional FP methods, most respondents said they preferred modern methods. A few respondents said they had no preference and thought both modern and traditional methods should be used depending on the patient. Only one respondent indicated preference for traditional methods.

Everybody has his/her own preferred method. I prefer modern methods. Traditional methods are less effective and harmful for body. Withdrawal has bad impact on health of women and men. Calendar method drives the woman in stress, because it is very difficult to calculate safe and unsafe days and woman always afraid to get pregnant. Modern methods are easier to use and safer (OB-GYN, Baku).

The traditional methods require attention and strict compliance from patients. Because of that they are often difficult to follow which leads to high failure rate. But modern methods are more precise. Methods like IUCD are very suitable to women with little compliance (OB-GYN, Baku).

I prefer modern methods because they are more effective. Also, some treat from certain diseases, while other protect from STIs (OB-GYN, Khachmaz).

I value both types of methods. Depending on patient's need I may prefer one type over another but in general I do not see a big difference between traditional and modern methods (Midwife/PHC, Salyan).

4.5 FAMILY PLANNING SERVICES PROVIDED

Many respondents said that patients and community members were made aware that their practice provides FP services through one-on-one patient education when they visit, as well as brochures and posters in the waiting room. A few respondents said that patients learn of their services from their friends and neighbors.

In our healthcare system woman consultation centers provide all services related to woman's health. So all women know where they should apply for family planning. In addition to that, other health providers such as doctors working in maternities, adult and pediatric policlinics may refer such women to us. We also have posters and leaflets and patients receive information in our office (OB-GYN, Baku).

[They learn of our services] through brochures and posters in the waiting area. They may also hear about our practice from other patients (OB-GYN, Khachmaz).

Nearly half of respondents stated that the Ministry of Health influences the decisions about FP at their practice. Many of these respondents said that the Ministry of Health provides contraceptive supplies and issues clinical guidelines related to FP. Some respondents mentioned that other physicians and healthcare providers also influence decision making at their practice. Many respondents mentioned that their practice is not influenced by religious leaders.

There are many factors. We provide those services which we learned during family planning training organized by the Ministry of Health. The ministry also provides our practice with contraceptives (OB-GYN, Baku).

The Ministry of Health and Family Planning Center both influence the decisions on family planning (OB-GYN, Salyan).

Other doctors also have a role through advice and experience sharing (OB-GYN, Khachmaz).

Religious leaders do not influence my decision on which specific family planning services and products I provide.

Almost all respondents said that their patients use FP to prevent pregnancy because they do not want more children. Many respondents mentioned that in Azerbaijan it is typical for women to want no more than two to three children. Some respondents also mentioned that their patients use FP so that they do not have to get an abortion.

Views typical of most respondents were:

There are many women who do not want more children. Nowadays majority of urban families want to have maximum 2 children, while 20-30 years ago the families with 3-4 children were prevalent. Other women want to space their pregnancies. Patients would like to have healthy child and prefer to plan their family (OB-GYN, Baku).

Patients are interested in protection against unwanted pregnancies. They do not want to have more than 2-3 children. They also do not want to have abortions.

A majority of respondents indicated that their patients have a positive attitude towards FP. Most respondents said that their patients prefer modern methods to traditional methods. However, some respondents mentioned that traditional methods are still used by some of their patients.

Patients have positive attitude towards family planning modern methods because modern methods provide better protection from pregnancy and are more reliable. The use of traditional methods very often results in unwanted pregnancy and abortion (OB-GYN, Baku).

In recent years patients have given a preference to modern methods. The main reason for that is that modern methods are more effective (OB-GYN, Baku).

Women prefer modern family planning but some use traditional methods. In rural areas when one woman sees positive results from modern methods she tells other woman and they demand contraceptives too (Midwife, Salyan).

Overall, respondents based in rural areas mentioned that patient knowledge on FP is very poor. Respondents in Baku also said that patient knowledge is not up to the desired level, but that some patients were generally aware of FP. According to many respondents, this lack of knowledge leads to misconceptions about certain methods, particularly IUCDs and pills.

The following are common sentiments among many providers:

I think women living in urban areas are more or less aware of modern family planning methods. I would not say that the knowledge of my patients about family planning is at the desired level but it has certainly improved in comparison with what was observed 10 years ago. Misconceptions always exist. They mainly result from negative experience of some women in whom the modern family planning methods failed for some reasons such as severe side-effects, lack of compliance or incorrect choice of the method (OB-GYN, Baku).

Patient knowledge is poor. Those who do not have knowledge may have misconceptions such as that the some modern contraceptives have negative impact on health (Midwife, Khachmaz).

Misconceptions do exist. They are mainly related to side-effects of contraceptives. However, they are often exaggerated. We try to provide the relevant information to all patients using family planning so they know what kinds of adverse reactions they can expect. Also, we always tell them that complications of abortion are much more serious (OB-GYN, Baku).

When asked if the provider or the patient typically initiates conversations about FP, many respondents said that it varied based on the situation. Some providers mentioned that their current patients initiate conversations about FP much more than in years past. Others said that they still initiate most conversations, particularly with women who have just given birth. A small number of respondents said that they do not discuss FP with their patients.

In their words:

They usually initiate conversation by saying that they have several children (2-4) or due to family circumstances they do not want to become pregnant. Sometimes they ask directly about FP and talk openly (Midwife, Khachmaz).

In many cases I initiate the conversation about family planning; I ask the question during examination or right after examination (OB-GYN, Salyan).

Usually I start the conversation. However, in recent years more and more patients start such conversations. They usually say directly that they need protection from unwanted pregnancy. Moreover, sometimes they directly ask for particular method especially IUCD insertion (OB-GYN, Baku).

Of those respondents who discussed FP with their patients, the most frequently mentioned topics include pregnancy prevention, FP methods (primarily modern), the danger and harm of abortion, and general women's health issues.

These are a few comments that were typical of how the providers described their counseling practices on FP:

These conversations involve talking about importance of family planning for woman's health, modern family planning methods and choices, how to prevent pregnancy and practice effective and safe family planning, newborn and pregnant women care, and etc. (OB-GYN, Salyan).

I ask how they protect themselves when they do not want to get pregnant. The conversations also involve talking about importance of family planning to family health and wellbeing. I also ask about past medical history, family situation including number of children, when the last child was born, when they plan next pregnancy, if any. After that I talk about various family planning methods. I suggest the method which I think is best for her. Finally we come to certain conclusion on the contraception method considering woman's attitude and spousal consent (OB-GYN, Baku).

We also talk about sex of the children because very often couple want a child of certain sex. We also talk about danger of abortion. Then I talk about FP methods and answer their questions about different methods (Midwife, Khachmaz).

When asked about the advantages of traditional methods of FP, a majority of respondents said that they are inexpensive and easy for clients to use with fewer side effects than some modern methods. The main disadvantage of traditional methods mentioned was that they are not effective in preventing pregnancy. Some respondents highlighted the disadvantage of withdrawal, as a method that frustrates men and causes them to lose libido.

Typical explanations included:

The advantages are that these methods are natural and easy. They do not require additional expenses (OB-GYN, Baku).

The disadvantage is that they do not provide 100% protection and patients have to be very careful with some of the methods to achieve protection from unwanted pregnancy (Midwife, Khachmaz).

Withdrawal is a very bad method because it does not allow for enjoying sexual intercourse as it keeps them under pressure; a calendar method is not reliable and we tell this to our patients. I do not see any advantages of traditional methods (OB-GYN, Baku).

Almost all respondents stated that they encourage their patients to use modern FP methods over traditional methods because they are more reliable. Some mentioned the protection that certain modern methods provide against sexually transmitted infections.

In the words of respondents:

Yes, I encourage them, because modern FP methods very effective, protection period is long, some have curative characteristics, some protect from STIs (OB-GYN, Salyan).

Yes, I encourage my patients to use modern FP methods instead of traditional ones because they are more reliable. I witnessed that many women who used traditional methods got pregnant (OB-GYN, Baku).

4.5.1 SPECIFIC FP METHODS

Most respondents indicated that they offer the IUCD to their patients. Many stated that they provide pills and condoms to their patients. Across the board, most respondents said that they do not offer injectables. All respondents indicated that they do not offer implants, and one mentioned that they are not available in Azerbaijan. Abortion/mini abortions (manual vacuum suction performed before 6 weeks gestation) services were offered by many OB-GYNs in Baku.

Very few respondents said that they offer spermicide, sterilization, and emergency contraception, and of those that did many of them explained that they do not offer these methods often or were not in favor of them.

When asked about the advantages of pills, most respondents said that they were reliable in preventing pregnancy. Many respondents also mentioned that pills cure certain diseases or gynecological conditions. When asked about the disadvantages, many respondents mentioned that patients find it difficult to comply with taking pills daily, there are contraindications and numerous side effects.

Here are two comments that were typical of providers in Baku and Khachmaz:

[Pills] provide good protection against pregnancy, at the same time treat certain diseases (OB-GYN, Khachmaz).

Contraindicated in different pathology conditions, daily intake creates inconvenience; women forget to take pills (OB-GYN, Baku).

A majority of respondents stated that condoms are advantageous because they are reliable and protect against both unwanted pregnancy and sexually transmitted infections. Many respondents explained that there are also disadvantages to condoms including a decrease in sexual pleasure which leads to spousal disapproval. Several respondents also said that the condom could rupture if it is not put on correctly.

They explained their views in this way:

[Condoms] protect from both unwanted pregnancy and STIs (Midwife, Salyan).

[Condoms] could be ruptured or slide off. Some men do not agree to use them because they reduce sexual pleasure (OB-GYN, Baku).

Most respondents mentioned that the IUCD was advantageous because it provides cost effective, long-term reliable protection from unwanted pregnancy in a way that does not inconvenience their patients or inhibit them sexually. Many respondents said the

disadvantages include irritation and bleeding caused by the IUCD for some patients and contraindications for those with pelvic infections.

These were typical of comments heard from respondents:

Once inserted [IUCDs] provide long time protection against pregnancy (OB-GYN, Salyan).

[IUCDs] have many side effects, bleeding, and risk of intrauterine infections (OB-GYN, Baku).

Some patients mentioned that injectables are advantageous because they are convenient and easy for patients to use, as well as long lasting. More than half of respondents expressed concern over the long term side effects and hormonal imbalances to the menstrual cycle that is caused by injectables.

Typical comments were:

[Injectables] Protect for a long period, and very quickly applied (OB-GYN, Salyan).

It is impossible to stop its influence once injection is made. The have side-effects due to hormonal nature (OB-GYN, Baku).

Some respondents mentioned that spermicide was easy for patients to use, particularly for those with irregular or infrequent sexual activity. These respondents also mentioned disadvantages of the method, including lack of effectiveness, potential to cause irritation or rashes, and inconvenience of using it during the sexual act.

In their words:

Convenient to use for women with non regular sexual activity (OB-GYN, Baku).

[Spermacide causes] local irritation, it has a high failure rate (PHC, Salyan).

Some respondents mentioned the disadvantages of emergency contraception, including hormonal imbalance or side effects, and that it can not be used frequently by patients. Most respondents from the rural areas and some from Baku did not respond to the question or said that they did not know because they do not have much information on the method. Some respondents from Baku mentioned that emergency contraceptive was not their preferred method, but that they would recommend it in case of an emergency, particularly in the case of casual sexual relations. A few of these respondents made the point that although it is not an ideal method, it is better than if a woman gets an abortion.

Providers expressed the following sentiments about emergency contraceptives:

I am against using this method widely. But it is often the last choice and is better than abortion (OB-GYN, Baku).

[Emergency contraceptives] can't be used often (OB-GYN, Baku).

I know that it is hormonal method but I have little information about it (OB-GYN, Khachmaz).

Some respondents mentioned that sterilization is advantageous because it is 100% effective. Many respondents mentioned that although effective, sterilization is irreversible, which is a disadvantage.

Typical comments included:

Has life-long effect. The only method that provides 100% protection (OB-GYN, Khachmaz).

Irreversible process, can't get pregnant after this method (OB-GYN, Salyan).

A majority of respondents either said they did not know or did not respond regarding the advantages of implants, because of the lack of availability in Azerbaijan. A few respondents mentioned that they are long lasting. Similarly, very few respondents mentioned disadvantages. Of those that did, they said that implants are hormonal and could cause side effects.

When asked which factors they consider when deciding whether pills are the right method for a patient, most OB-GYNs in all locations mentioned that they take patient age, medical history, spousal consent, financial situation and attitudes and beliefs about pills into account. Most OB-GYNs stated that they do not believe a patient's religious background is relevant to the decision to recommend pills. Some respondents said that the patient's future reproductive intentions and number of sexual partners influenced their decision making. A few respondents said that the marital status of the patient was important.

When asked about which factors they consider when recommending condoms to patients, almost all OB-GYNs explained that they take the medical history, number of sexual partners, number of sexual partners and patient attitudes and beliefs into account. Several of these respondents said that a patient's religious beliefs should be taken into account. OB-GYN attitudes were mixed regarding finances as a factor. Many respondents said that finances are an important consideration, while others said that condoms are given free or at little expense so a patient's financial situation is not important. Most OB-GYNs did not mention patient age, marital status and number of children as factors that influenced them. A few OB-GYNs said that future reproductive intentions of a patient were important.

When asked the same question about the IUCD, almost all OB-GYNs said they find patient age, medical history, spousal consent, and attitudes and beliefs important factors. A majority of OB-GYNs said that future reproductive intentions of their patients are also important. Many OB-GYNs mentioned patient religious belief and number of sexual partners as important factors. Some OB-GYNs also stated that the number of children, marital status and financial situation are patient factors that they would consider when deciding whether to recommend the IUCD. Of these respondents, many explained that although IUCDs are generally inexpensive, those with a higher income can buy more expensive IUCDs. Additionally, most of these respondents mentioned that married women who have had children before are best suited for the IUCD, rather than unmarried women or married women who have not yet had children.

4.5.2 ABORTION AND FP ATTITUDES

Very few respondents gave an answer when asked about the advantages of abortions. A small number said that it can terminate unwanted pregnancy for medical reasons, but they were quick to say that they do not recommend it as an FP method. Many respondents mentioned the many complications from abortion as a disadvantage.

When asked about the role of abortion as a method of birth control in Azerbaijan, most respondents said that it was unfortunate, but abortion is very commonly used, although it is harmful. These respondents mentioned social and economic reasons for abortion. Some respondents said that abortion is not actually a method of FP, but people in Azerbaijan think of it as such.

Below are some explanations that were typical of the views expressed by most respondents:

As I told you already abortions are common in Azerbaijan for various reasons including lack of awareness about modern family planning methods or lack of compliance when using them. I do not have exact abortion rate, but in my estimates almost every woman has at least one abortion during her reproductive life. Abortion has negative impact on health. Women apply for abortion as a measure of last resort. The reasons are: not wanting more children, family situation and poor economic situation (OB-GYN, Baku).

Unfortunately it is very common here. It is very bad to use abortion as a method of birth control. Patients have to resort to abortion because they do not want more children for reasons. such as family situation and economic status which make them unable to grow up more children. The reason for abortions is that they do not practice family planning methods (OB-GYN, Salyan).

Abortions are common in Azerbaijan. Patients seek abortion because they do not practice family planning for various reasons such as unawareness, financial issues, lack of compliance in the use of contraceptive methods and other. It is very bad to use abortion as a method of birth control. It is harmful. When patients do not use family planning methods they get pregnant and then have to make abortions (OB-GYN, Khachmaz).

Almost every respondent mentioned the negative impact of abortion on a woman's health.

Here is how they explained their views:

Abortion has very bad effect on woman's health. Several years ago a women died from complication of abortion in the neighboring village. It often causes bleeding (Midwife, Salyan).

Abortion has very bad impact on woman's health. Abortions made to select the sex of children are particular dangerous because they are made in the late stages of pregnancy. Abortion can be fatal, it is often complicated by bleeding and infections (OB-GYN, Baku).

Abortion is a very bad thing. It may have bad consequences such as infection, bleeding, and uterine weakness. But artificial abortion conducted by health provider is better than abortion done using some traditional means (Midwife, Khachmaz).

More than half of respondents indicated that they provide pre- or post-abortion counseling on FP methods because it is part of their job and also so that patients choose FP methods over abortion in the future.

Typical comments were:

Yes, I provide counseling on FP methods before and after abortion. The main purpose is to provide information about the danger of abortion to woman's health and FP methods to prevent unwanted pregnancies (OB-GYN, Khachmaz).

Yes, it is part of our job. This counseling is important for spacing the child birth that is important for woman's and child's health. For women who do not want more children this counseling helps to select an appropriate family planning method (OB-GYN, Baku).

Yes, I provide counseling on family planning methods before or after abortions. I provide the information on modern family planning methods in order that women use them and prevent unwanted pregnancy and abortions later (OB-GYN, Salyan).

4.5.3 PATIENT AND PROVIDER CONCERNS

When asked about the concerns they hear from their patients with respect to FP (in general and about specific methods), most respondents gave specifics regarding certain methods rather than mention general concerns. Many respondents mentioned patient concerns regarding side effects of IUCD insertion and pills. A few mentioned problems patients have with condoms because of the decrease in sexual pleasure.

Providers explained their patients' concerns in the following ways:

Most concerns we hear are regarding pills. Women don't like to take pills. They often forget to take them on time and have a lot of side effects such as vomiting, headache, menstrual cycle disorders. Some patients after IUCD insertion develop profuse menstrual discharge and have to pull out IUCD (OB-GYN, Baku).

As for the specific concerns, I had patients who developed uterine bleeding from IUCD. In few cases I have met patients who developed polimenorrhea from Combined Oral Contraception (pills). With condoms women often complain of lack of spousal consent (OB-GYN, Baku).

Yes, I heard such concerns. There were episodes of headache, nausea and elevated blood pressure after the use of pills. Few women complained of abnormal bleeding after insertion of IUCD (Midwife, Khachamaz).

When respondents were asked if their personal beliefs regarding FP influence their likelihood to recommend a particular method, most explained that it did not because much depends on patient preference. A few respondents said that if they trust a particular method they will recommend it more often.

Typical comments included:

It does not influence. I am not imposing my preferences upon my patients. I always try to find the best method for each patient considering her age, medical history, personal preferences and other factors (OB-GYN, Baku).

My personal beliefs do not affect the prescription of family planning methods to the patients (OB-GYN, Salyan).

When asked about their preference for a particular method almost half of all respondents said that they prefer the IUCD. A few respondents mentioned preference for condoms and pills.

In the words of providers:

I prescribe IUCD in most cases. It has many advantages such as high protection rate, few side-effects and long-lasting protection (OB-GYN, Salyan).

I prefer IUCD because this method is long lasting, cost effective and once inserted can be used for five years, no additional expenses, no any inconvenience, and they are highly effective which is very good from psychological side, the woman feels confident (OB-GYN, Baku).

When asked about which methods they would not recommend to patients, many respondents mentioned injectables because they have side effects and are often not available in Azerbaijan. Some respondents also said that implants and emergency contraception were not preferable for similar reasons. Some respondents also said that they would not recommend sterilization because it is irreversible or not available.

The following views were echoed by many providers:

I never recommend injections. I never used them, but I heard about very severe complications resulting from using injections (OB-GYN, Baku).

I don't offer sterilization and implants, because they are not available here. The same time I have no information about Emergency Contraception (OB-GYN, Khachmaz).

Many respondents claimed that they do not have problems with scarcity of equipment or that problems are infrequent. A small number of respondents said that there are certain methods that they do not have available.

In their words:

As for the supply, in our Women Consultation we have IUCD in sufficient quantity. Condoms and pills are widely available on the market. Potentially such situation may happen if a patient requests some particular type of IUCD or pills that are available neither in our facility nor on the local market. However, as I said we have not had such situation yet (OB-GYN, Salyan).

Very rare. We do not have problems with equipment but sometimes we have shortage of supplies. During last a couple of years, we did not experience supply problems (OB-GYN, Baku).

Such situations are rare. It was several times when the patients required Depo-Provera and it was not available, because it is not supplied at all (OB-GYN, Khachmaz).

More than half of respondents said that they prescribe another method if a particular method is not available. This seemed to be an acceptable solution to these respondents. Several respondents also indicated that they refer patients to other providers if a method they prefer is not available. Some respondents said that they refer patients to a nearby pharmacy if it is not available in their health facility (for methods such as condoms and pills).

These were some typical comments heard from the providers:

When they cannot afford and find certain contraceptives I prescribe them another method (OB-GYN, Khachmaz).

Yes, we face such a problem when we are out of FP devices. I provide them information on traditional methods in such cases (OB-GYN, Salyan).

No, we provide supply. For methods that we do not have supply for, we send patients to pharmacy. I do not remember a case when patients could not get supply from pharmacies (Baku, OB-GYN).

We do not have any FP supply for our patient in our health facility. We discuss with a patient the most suitable method for her/him. Then the patient purchases supplies which we prescribe. So, this how we operate. This happens to all patients. We know what is available on the market, so it is very rare that a patient cannot obtain the needed supply. We do not prescribe what is not available on the market (OB-GYN, Khachmaz).

When asked if they have patients who want to change the method they are using because they cannot get the necessary supply, many respondents explained that patients do change methods, but because they cannot afford to purchase the method rather than because it is not available.

This is what they had to say:

Yes, it happens but rarely. We try to prescribe the method that is affordable to our patients. Also, as I said, we know what is available on the market and prescribe contraceptives that our patients can easily get. Rarely certain pills can be temporarily out of stock in pharmacies but they usually address such issues quickly (OB-GYN, Salyan).

It never happened. I mainly prescribe one of the three methods – IUCD, pills or condoms. If they are not available in our clinic, they are widely available on the market. I do not remember any situation when my patients were not able to get family planning method I prescribed (OB-GYN, Baku).

Yes, it does happen. Sometimes the patients don't have funds or they cannot find them (OB-GYN, Khachmaz).

When asked what resources, training and support they would need to increase the use of effective FP methods, more than half of respondents mentioned that they would like more training and a constant supply of contraceptives, particularly free contraceptives. Many respondents explained that they would like help with patient education in the form of more materials and mass media education campaigns.

Below are some typical suggestions reiterated by most providers:

We need support in educating our patients. It can be through mass media campaign. We also need medical literature on new developments in family planning. The state should ensure free contraceptive supply especially for poor population (OB-GYN, Baku).

It would be not bad if our hospital is provided with condoms and pills. Also, training on FP is needed for health personnel working in rural areas. It would be beneficial for both health providers and population if there is an OB-GYN in rural hospitals (Midwife, Khachmaz).

It would be very good if we can receive different family planning supplies in sufficient quantity and new materials on family planning for patient education (OB-GYN, Salyan).

Many respondents said they do not have interactions with representatives from pharmaceutical companies. Some respondents explained that these representatives do come, but not frequently. Many respondents said that if pharmaceutical representatives provided them with contraceptives at a more affordable price it would improve the relationship.

Some respondents said that if these representatives could come more frequently and provide more information it would be helpful. While some said that their interaction with them is helpful or important, a few respondents said that they do not trust pharmaceutical representatives.

These were some typical views expressed by providers:

They do not come regularly. I do not have often interaction with [pharmaceutical companies] (OB-GYN, Baku).

If they provide constant supply of quality contraceptives at affordable prices we can establish communication (OB-GYN, Khachmaz).

It will be good [if pharmaceutical representatives could] provide us with new information on modern family planning methods (OB-GYN, Baku).

4.5.4 TREATMENT SCENARIOS

Respondents were given different scenarios of patient types and asked to discuss how they would treat each of these patients. The first patient type was a twenty-year-old newly married woman.

Many respondents said they would first take the patient's medical history and ask about her reproductive intentions. Several respondents said that they would recommend a twenty-year-old married woman get pregnant right away. Only if the woman expressed objections to getting pregnant right after marriage, would these respondents go over FP methods with her and help her to choose a method.

Some respondents said they would prefer to give this type of patient condoms or pills, but others mentioned they preferred the IUCD or traditional methods. A few respondents indicated that they would also counsel this type of patient on abortion and birth spacing.

The following are some typical responses heard from providers:

After detailed examination and history collection I would recommend her to get pregnant and not to use any contraceptives. After the first two children I would recommend her to use IUCD. If she does not want to have children I would recommend her IUCD right away (OB-GYN, Salyan).

First I would ask when and how many children she is planning to have. Then I would examine her and explain why abortion is bad for women. For the young newly married woman I would recommend to get pregnant. I would also talk about importance of healthy life styles and eating for her and her child's health. I would talk about intervals between pregnancies that are important for woman's health to get fully restored and prepared for next pregnancy, if a couple wants more than one child. If she does not want to have a child now I would inform her about all family planning methods available. I personally would recommend her to use pills in such case (OB-GYN, Baku).

I would recommend her to get pregnant and not to use any contraceptives. After the first child I would recommend her to space her pregnancies if she wants more children. I would provide her thorough information on FP methods and help her to select the best one that meets her needs (OB-GYN, Khachmaz).

When asked about a scenario with a woman in her mid-to-late twenties or thirties who already had three children, almost half of respondents said that they would recommend the IUCD as a method for this woman.

These respondents said that once a woman has had three children in Azerbaijan, she typically does not want to have any more children and requires a long term method. Some respondents however, said that

they would recommend condoms or pills to this type of woman since she would still be quite young. In the words of providers:

Three children are good for our society, if she wants to stop childbearing I understand her. I will talk to her about harm of abortion and recommend using contraception with high protection. After examination I recommend pills, because she is young and healthy. I will ask her to come for periodic follow-ups. If appropriate we can offer IUCD as well (OB-GYN, Baku).

If she is healthy and does not want more children I would recommend IUCD (OB-GYN, Salyan).

It is most likely that the family with three children would not like to have more children. Nevertheless, I would ask her about her future reproductive plans, inform her on abortion harm and after detail examination I would recommend IUCDs. This is a long lasting method and she can use it for 5-10 years. She will need to come for periodic follow ups after IUCD insertion (OB-GYN, Baku).

Many respondents mentioned that with a new patient, they would take more time to understand a complete medical history and provide counseling on the advantages and disadvantages of different FP methods. Some respondents said they would feel more open and comfortable to speak their mind with an existing patient compared with a new patient. A few respondents indicated a particular method they would recommend for that patient, if she is healthy.

Typical comments were:

I think it is necessary to pay more attention to new patient and give more information about contraceptives, their advantages and disadvantages (OB-GYN, Baku).

I will need to find out her family situation – how many children she has, her plans for having more children. Depending on these factors we may decide on an appropriate method for her. If she is healthy I would recommend IUCD (OB-GYN, Khachmaz).

4.6 PROVIDER ADVICE

When asked to provide further guidance as to how to better reach Azerbaijanis who could benefit from FP, most respondents mentioned education of the public through media campaigns and community based education efforts as an essential element. Once again, these providers emphasized the need for access to more training and educational materials, so that they could better provide education to their patients.

Some respondents reiterated the need for a constant supply of free contraceptives. A few respondents mentioned the particular need to educate men and youth. The following suggestions were echoed by many respondents:

It would be good if the issues of women's health are discussed using mass media, including television. Much more people can be reached with family planning messages on television because not everybody can come to visit doctor. Television should start promoting contraception methods (OB-GYN, Baku).

High schools need to educate teenagers in FP. Also, civil registration offices may have a room dedicated to provision of counseling on FP for newly married couples (PHC, Khachmaz).

I would advocate that education should start in school, especially for girls (Midwife, Salyan).

5. TARGETING BEHAVIOR CHANGE COMMUNICATION TO SPECIFIC MARKET SEGMENTS

5.1 DESCRIPTION OF THE TARGET AUDIENCES

The sections that follow provide overall and specific recommendations for targeted BCC efforts to specific audences. The first step is to identify these key audiences.

5.1.1 PRIMARY TARGET AUDIENCE

As the main users of FP, women constitute the primary target audience for BCC. Other stakeholders strongly influence women in RH and FP decision making; nevertheless, given limited resources for BCC efforts, it is important to give priority to these potential beneficiaries. BCC efforts should help women understand the different methods of FP, the advantages and disadvantages of each, and the overall health and economic benefits of FP.

5.1.2 SECONDARY TARGET AUDIENCES

Although women of reproductive age are the primary audience, it is important to consider others who influence this group's RH and FP decision making. According to the quantitative and qualitative data from this study, providers and husbands (or other male family members) have the greatest influence over the primary audience. While these groups are important to target as key influencers, given limited resources, they should be considered secondary audiences.

- **Providers.** Health providers directly influence a patient's FP decision making. Ensuring that they are able to give their patients proper information, and that they understand the importance of all FP methods, will help to reduce provider bias. Improving provider-patient communication and counseling skills will, over the long run, assist in encouraging women to use FP in preference to abortion.
- **Men.** Husbands and other male family members often have substantial power and influence over a woman's FP decision making process. According to the quantitative data, men frequently have misconceptions and negative attitudes regarding FP and Long-acting and Permanent Methods (LAPMs). Therefore, marketing and communication efforts should target men as a secondary audience to improve knowledge and understanding of FP benefits, improve couple communication, and promote male support for wives or female family members.

5.2 INTEGRATING MARKET SEGMENTS WITHIN A BEHAVIOR COMMUNICATION FRAMEWORK

5.2.1 THE BEHAVIOR CHANGE COMMUNICATION FRAMEWORK

Each segment provides a wealth of information on a portion of the client base that can be translated into communication efforts and ultimately into results. We use the PBC framework, based on James Prochaska's *Stages of Change* model, to frame, analyze, and prioritize the non-user client-based segments (Glanz, Rimer, and Lewis, 2002).

This model has been widely used to implement BCC public health interventions. In addition to FP, it has been used for HIV/AIDS prevention, substance abuse, smoking cessation, obesity, and medication compliance interventions. Program implementers and other stakeholders can use this model to pinpoint where an individual is in his or her willingness to change behavior. According to the PBC model, an individual moves through six stages of behavior change, beginning with the Pre-knowledgeable Stage and ending with the Advocating Stage (Glanz, Rimer, and Lewis, 2002).

The six stages are as follows (O'Sullivan et al., 2003):

- Pre-knowledgeable – Is unaware of the problem or of their personal risk
- Knowledgeable – Is aware of the problem and knowledgeable about desired behaviors
- Approving – Is in favor of the desired behaviors
- Intending – Intends to personally take the desired actions
- Practicing – Practices the desired behaviors
- Advocating – Practices the desired behaviors and advocates them to others

This framework is based on the idea that different audiences are at different stages within the behavior change process, and must be treated differently in terms of communication messages and channels. For example, if an audience is at the Pre-knowledgeable stage, it is important to make them aware of the current or future problems they may face and to understand their personal risk so they can move to the Knowledgeable stage. In a low-resource environment, it is cost-effective to target specific segments of the population. For example, in the case of RH/FP, it is best to target those non-users who are more open, as it would require fewer resources to change their behavior to using FP methods.

We analyzed the women and men's segments individually to consider how each one could be targeted as a unique audience within a particular stage of the PBC framework. Tables 10 and 11 illustrate where each segment falls within the PBC stages of behavior change.

TABLE 10. WOMEN NON-USER SEGMENTS BY PBC STAGE

Segment Number	Segment Name	PBC Stage
1	Rural Conservatives	Knowledgeable
2	Aware Ambivalents	Approving
3	Prudent Urbanites	Knowledgable
4	Coming-of-Age Traditionalists	Pre-knowledgeable
5	Young Uncertain Urbanites	Pre-knowledgeable
6	High-tech Progressives	Approving

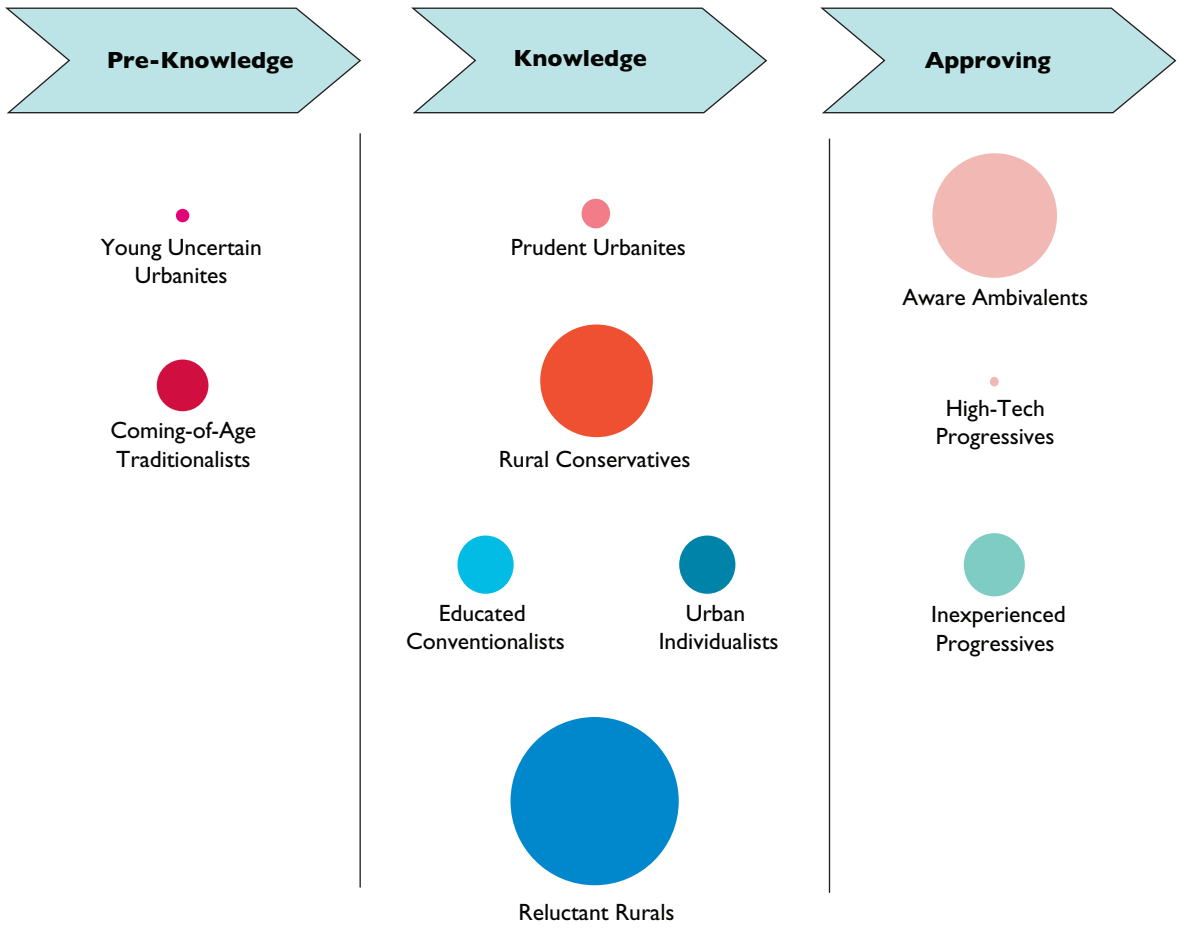
TABLE 11. MEN NON-USER SEGMENTS BY PBC STAGE

Segment Number	Segment Name	PBC Stage
1	Inexperienced Progressives	Approving
2	Reluctant Rurals	Knowledgeable
3	Educated Conventionalists	Knowledegable
4	Urban Individualists	Knowledgeable

Given that these are *non-user* segments, the Intending PBC stage is the highest stage before we would call them users of FP. However, none of these segments have reached the Intending stage, and are far from reaching the Practicing and Advocating stages. This is noteworthy, as it suggests a need to change overall societal norms and attitudes about FP. Therefore, the BCC approach will need to incorporate long-term strategies that work towards changing norms, as well as short-term strategies that target the specific non-user segments who are more open to FP.

A likely specific target is the women's segment Aware Ambivalents: they are at the Approving stage and may be more likely to use FP. Figure 5 illustrates the position of each segment on the PBC spectrum, as well as the relative size of each segment.

FIGURE 5. WOMEN AND MEN'S SEGMENTS BY PBC STAGE



Note: The size of each circle indicates the percentage of non-users represented by that segment.

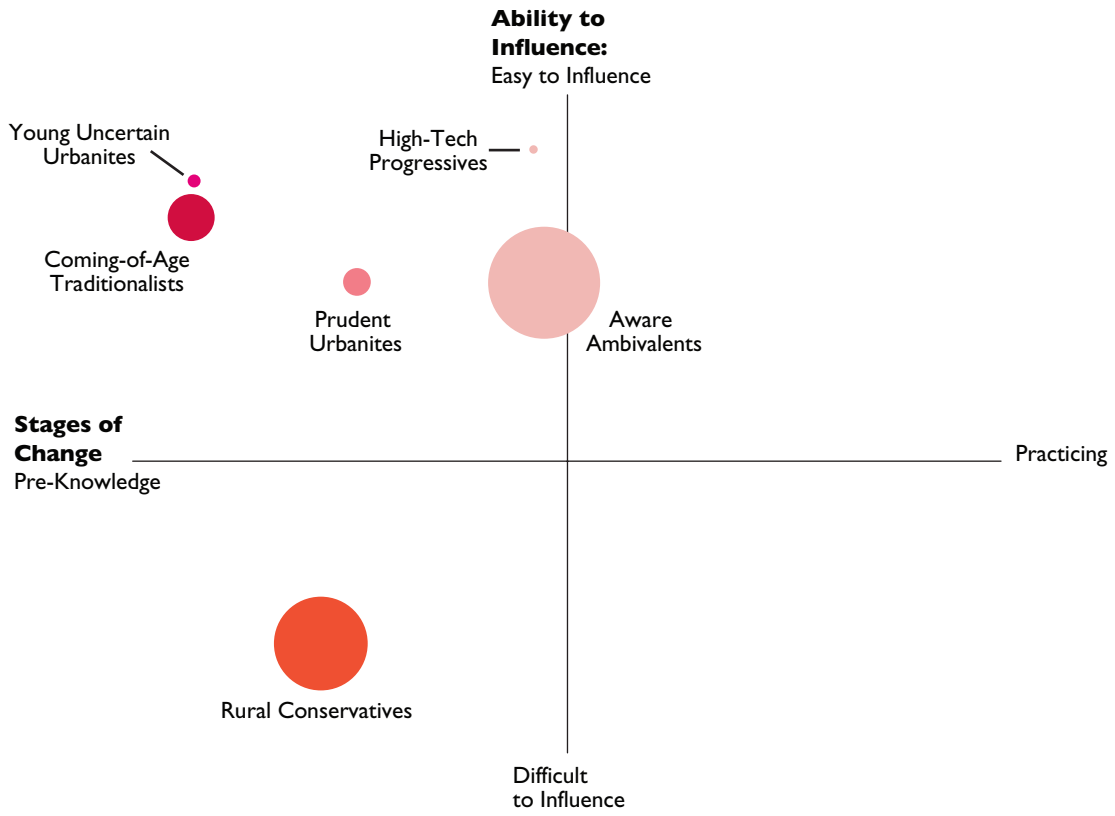
5.3 PRIORITIZING BCC EFFORTS FOR WOMEN'S SEGMENTS

Once we have identified the position of each segment on the PBC stage spectrum, we can group segments according to similarities in their characteristics, including PBC stage. These segment groups can then be prioritized, to target limited program resources.

To assist this prioritization process, we created an additional indicator for each of the women's segments, to capture "ability to influence": that is, how easy or difficult would it be to influence them? In determining the ability to influence, we subjectively analyzed each segment's sources of trusted information, the number and types of media channels used, and their overall openness to FP.

Figure 6 combines these two variables—the PBC stage of each (women's) segment, shown on the x-axis, and its susceptibility to influence, on the y-axis. The size of each segment, represented by a circle, is proportionate to its percentage of (women) non-users.

FIGURE 6. WOMEN'S SEGMENTS BY ABILITY TO INFLUENCE



Based on this analysis (and other factors discussed in the following sections), we recommend a three-tiered approach for initiating BCC efforts targeted to women's segments:

- The first tier, or priority group, is made up of Aware Ambivalents and Prudent Urbanites.
- The second tier comprises Coming-of-Age Traditionalists, Young Uncertain Urbanites and High-tech Progressives.
- The third tier consists of Rural Conservatives.

5.3.1 FIRST TIER: AWARE AMBIVALENTS AND PRUDENT URBANITES

Within the first tier, we recommend Segment 2, Aware Ambivalents as the highest priority. In a resource-limited environment, it makes sense to prioritize this segment, given that they comprise approximately 37% of all non-users and have reached the Approving stage on the PBC scale. Aware Ambivalents represent the "low-hanging fruit," compared with other segments.

Aware Ambivalents are considered to be at the Approving stage because of their openness to FP: they are not only aware of the most commonly used methods in Azerbaijan, but they understand the financial and health benefits of using FP. Aware Ambivalents nevertheless do not intend to use FP; and though they recognize the negative effects of abortion, they are more likely than any segment to have 4-5 abortions. But because of their general openness, with limited BCC efforts it is likely that they could shift to the Intending or even the Practicing stage.

The ultimate goal of a BCC campaign would be to move the Aware Ambivalents to the Advocating stage, as they are middle-aged mothers who may have a great deal of influence over the next generation. Many of those in the younger segments trust their mothers and mother-in-laws more than others for FP advice. To change social norms on a larger scale, it is essential for Aware Ambivalents to be invested in and advocating for FP with the younger generation. In addition to basic knowledge, therefore, messages for this group should ask them to talk with their daughters about FP. Understanding their ability to serve as a role model may moreover help motivate them to begin using FP themselves.

Although Prudent Urbanites are less open to FP, and represent a smaller portion of non-users at 8.8%, they have similar characteristics with Aware Ambivalents: they are similar in age range and are married with children. Like Aware Ambivalents, they also live primarily in urban settings and they make joint household and healthcare-related decisions with their partners.

A BCC campaign targeted to the more open Aware Ambivalents would also benefit Prudent Urbanites. Because both groups watch television often, a campaign for these segments should include television spots before and after the particular programming that each segment prefers: for example, Lider TV and the news for Aware Ambivalents. Since Prudent Urbanites listen to the radio more than any other segment, campaign messages should be adapted with radio spots to be placed on Azad Azerbaijan 106.3 and other music stations, which this segment listens to the most.

Both Aware Ambivalents and Prudent Urbanites trust nurses and midwives for FP advice. We therefore recommend an increased role for these providers in targeting this tier, by initiating an interpersonal communication campaign (IPC). Nurses and midwives can take part in imparting critical RH/FP information in a consistent way, using materials and job aids with similar messages to those presented on the television or radio.

5.3.2 SECOND TIER: COMING-OF-AGE TRADITIONALISTS, YOUNG UNCERTAIN URBANITES, AND HIGH-TECH PROGRESSIVES

We recommend grouping Coming-of-Age Traditionalists, Young Uncertain Urbanites and High-tech Progressives as the second priority tier. These segments are the youngest, with little experience. They are not sexually active, nor have they used FP. It is important to reach them because they are the future of Azerbaijan, and changing their behavior would help to change overall society norms for generations to come.

High-tech Progressives are at the Approving stage, and thus easier to influence to move along the PBC continuum to the Intending, Practicing, and Advocating stages. However, because this segment only makes up about 3% of non-users, we do not recommend targeting substantial resources to them. Instead, we recommend developing a young, hip educational campaign that would appeal to the less aware Coming-of-Age Traditionalists and Young Uncertain Urbanites. Once messages and materials are developed for these groups, a small amount of resources could suffice to adapt that campaign for High-tech Progressives.

Although Coming-of-Age Traditionalists are less open to FP than the other younger segments, they are more important as they comprise about 15% of non-users. Because they are young and impressionable, we believe that targeting BCC efforts to this group would be effective in the long run despite their association with more traditional values. Young Uncertain Urbanites (just 4% of non-users) are less

aware and have not yet formed an opinion. They don't know where to begin to ask questions about RH/FP. These two segments are at the Pre-knowledgeable stage on the PBC continuum: they need an increased basic awareness of modern methods, even more than other segments. These two segments could also benefit from messages that highlight the financial and health benefits of using FP. Reaching youth effectively is different from BCC efforts geared to older segments, because the approach must be interactive, hip, and dynamic.

Coming-of-Age Traditionalists and Young Uncertain Urbanites rely heavily on television to receive information, and there is certain programming they both watch: for example, ANS TV, ATV, and Lider TV. Television spots on these channels, using popular spokespersons, would most likely be effective. Coming-of-Age Traditionalists watch movies and serials, which may lend themselves to the discussion of RH/FP if they incorporate love stories; if possible, we recommend integrating FP messages into story lines of popular programs.

Young Uncertain Urbanites listen to the radio; if resources are available to develop radio spots, this would be beneficial. Both Young Uncertain Urbanites and High-tech Progressives tend to own mobile phones. We recommend a text-messaging campaign to reach these segments with interactive educational messages. Furthermore, since High-tech Progressives use the Internet more than any other segment, if resources permit we recommend reaching this segment through social networking sites. These sites provide an important forum for youth to receive information, chat, and ask questions.

5.3.3 THIRD TIER: RURAL CONSERVATIVES

We recommend Rural Conservatives as third priority because they are older and married, and have already made up their minds. Unlike their younger counterparts, they do have knowledge about FP, though often it is incorrect knowledge. Rural Conservatives are the segment that most relies on their religion and religious leaders for guidance regarding FP. Because of their conservative attitudes, it would be more difficult and more costly to move them along the PBC continuum, to the Approval or Intending stages, compared with other segments. However, because Rural Conservatives make up approximately 32% of all non-users, they should not be ignored. Notably, this is the poorest segment, residing in rural areas. Rural Conservatives may have the most need of any segment, due to their financial constraints.

We recommend conducting RH/FP educational sessions with Imams and other religious leaders. These religious leaders could then be involved in targeting Rural Conservatives, through sermons and weekly religious activities. After hearing information from spokespersons in the religious community whom they respect, this segment will be more likely to become open to FP. This will not be an easy undertaking; some religious leaders may not be willing to participate in educational trainings. Therefore, despite its large size and greater need, if resources are very limited and if religious leaders refuse to participate, it may not be worthwhile to target this segment.

Involving religious leaders can be a challenge, but once they are convinced this effort can contribute greatly to increasing people's knowledge about modern FP methods. Their participation in FP campaigns has proven successful in areas where religious leaders are highly regarded. For example, in the "Together for a Happy Family" campaign in Jordan, religious leaders increased knowledge about modern FP methods by participating in trainings, appearing on TV and radio spots, and writing newspaper articles in support of FP. Religious leaders clarified for the public that using modern FP methods was consistent

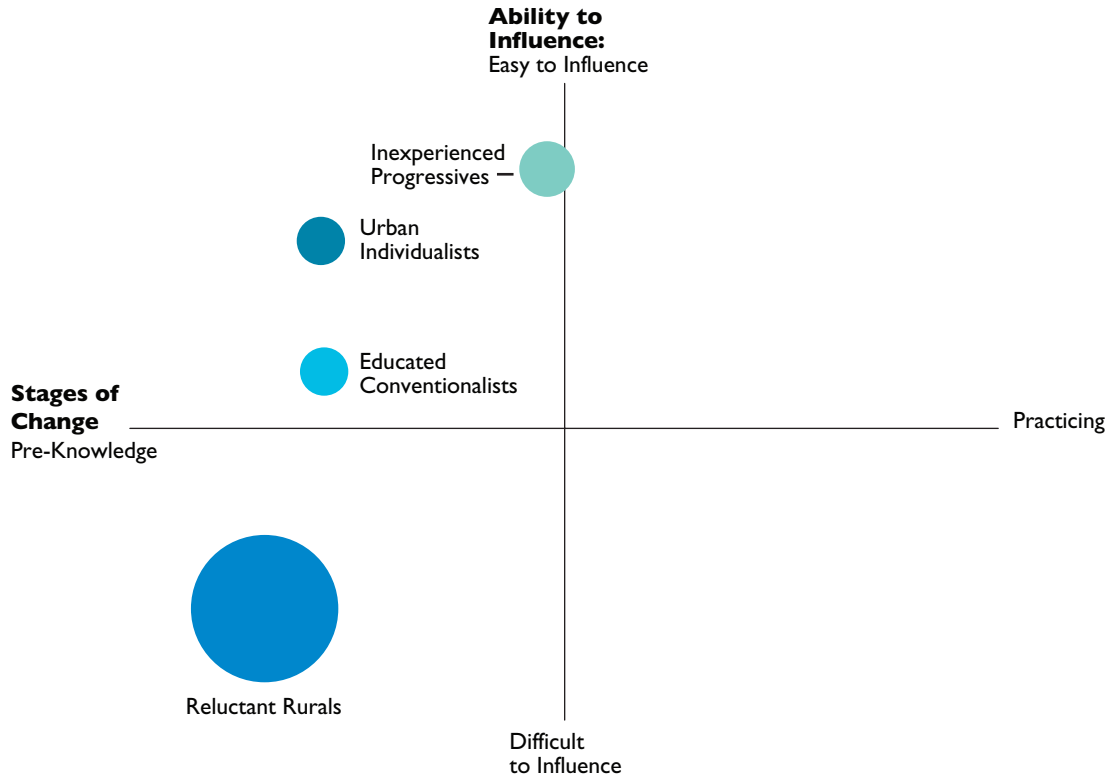
with Islam—an issue on which Jordanian men wanted to know more. A national follow-up survey after the launch of the campaign showed that a significantly higher proportion of men thought FP methods were safe, effective, and permitted in their religion, as compared to the baseline survey (Johns Hopkins University Center for Communication Programs, 2003). For instance, the percentage of men who said that the IUCD was "allowed by religion" increased from 30% in 1996 to 55% five years later (ibid.). A census of all religious leaders conducted in 2000 in Jordan revealed that 82% of male and 98% of female religious leaders believed that FP methods were consistent with Islamic laws (Underwood, 2000).

In Afghanistan, religious leaders (mullahs) had been hesitant to support modern FP methods because they thought the methods were unsafe; nevertheless, after learning that FP improves maternal and child health, the mullahs wanted to play an active role in informing their congregations about these methods. Similarly in Egypt, religious leaders who were at first disapproving of modern FP methods could cite scriptures in support of birth spacing, after learning more about the importance of FP for maternal and child health (Richey and Salem, 2008). In Bangladesh, imams worked with health workers to develop culturally sensitive leaflets on reproductive and FP topics, and they expressed interest in promoting FP in their sermons (Burket, 2006). In Iran, the support of the high court and top religious leaders for a national FP policy is credited with helping to boost the contraceptive prevalence rate from 37 percent in 1976 to 74 percent in 2006 (Roudi-Fahimi, 2002).

5.4 BCC EFFORTS FOR MEN'S SEGMENTS

The men's segments were less stratified in their beliefs and attitudes than the women's segments. As with the women's segments, we analyzed the men's segments according to the PBC stage along with their susceptibility to influence. Figure 7 presents this analysis.

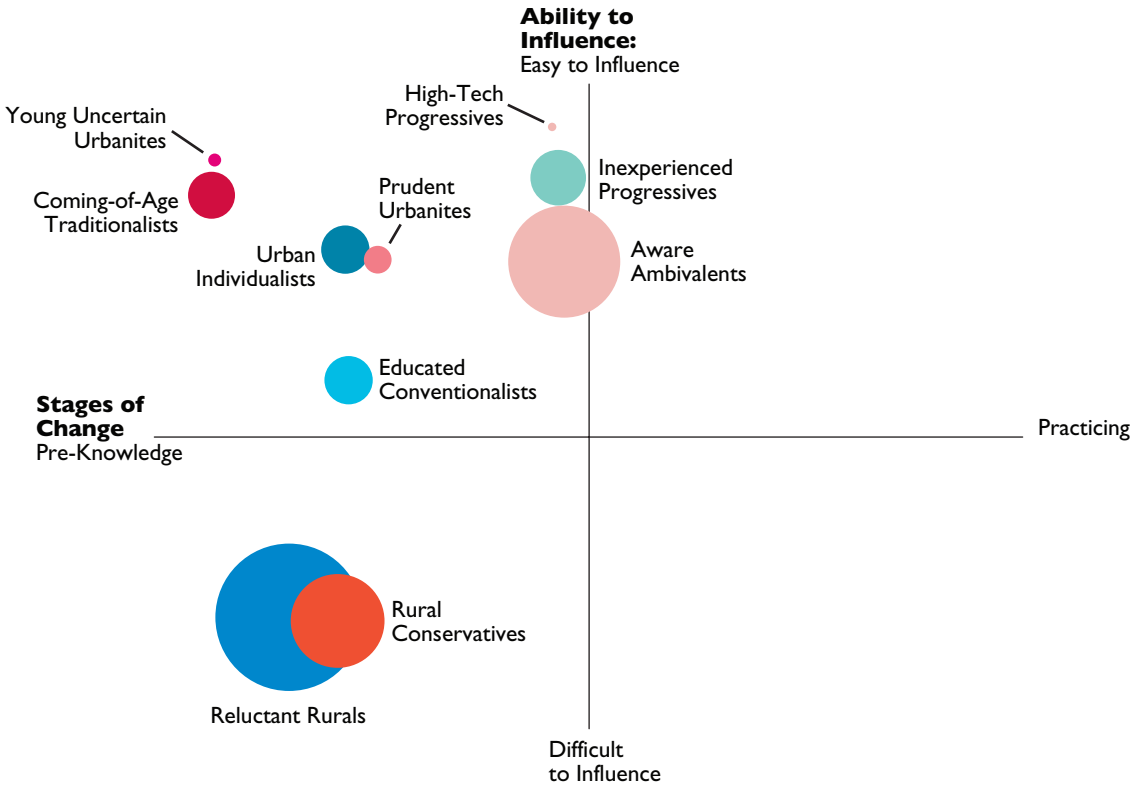
FIGURE 7. MEN'S SEGMENTS BY ABILITY TO INFLUENCE



As with the women's segments, we were able to group certain segments together for the purpose of targeting BCC interventions. We were also able to identify similarities in characteristics between some of the men's segments with those in certain women's segments. Because men are considered a secondary audience, in order to target them efficiently, we decided to pair each men's segment with one or more women's segments.

Figure 8 combines the charts of the men and women's segments, showing their position on both the PBC continuum and the susceptibility to influence dimension.

FIGURE 8. WOMEN'S AND MEN'S SEGMENTS BY ABILITY TO INFLUENCE



The chart suggests some groups of segments we can pair together. The sections that follow describe this strategic grouping of segments. We recommend creating sub-messaging for men in each group, based on the BCC messages and materials developed for women.

5.4.1 GROUP 1: INEXPERIENCED PROGRESSIVES (M), HIGH-TECH PROGRESSIVES (W), COMING-OF-AGE TRADITIONALISTS (W), AND YOUNG UNCERTAIN URBANITES (W)

Inexperienced Progressives comprise 18% of male non-users. They are open to FP, and we believe they would be fairly easy to move further along the PBC continuum with limited BCC efforts.

Inexperienced Progressives most resemble the women's segment High-tech Progressives: they are both young, open-minded, and at the Approving stage on the PBC continuum. Thus, these segments could be grouped together for targeted BCC efforts. We have recommended that High-tech Progressives be targeted along with two other women's segments—Coming-of-Age Traditionalists and Young Uncertain Urbanites. Therefore, we suggest developing a young, hip BCC campaign to suit the needs of all four segments. Messages for the younger women's segments, particularly the content adapted for High-tech Progressives, could apply to Inexperienced Progressives; sub-messaging could be developed to reach them.

The Inexperienced Progressives segment is open-minded towards women pursuing a career before having children, and they care about the health of the woman. We anticipate that they would not be offended at messaging geared toward both men and women. A campaign using text messages would work well for this segment, as most Inexperienced Progressives own a mobile phone. Television spots or integration of storylines into popular programming designed for other younger segments would also likely reach this segment.

5.4.2 GROUP 2: EDUCATED CONVENTIONALISTS (M), URBAN INDIVIDUALISTS (M), PRUDENT URBANITES (W) AND AWARE AMBIVALENTS (W)

Educated Conventionalists, 16.6% of male non-users, have characteristics similar to the women's segment Prudent Urbanites. They both are slightly less open to FP, due to religious reasons, but are quite knowledgeable, and they believe it is wise to learn about FP before becoming sexually active. Urban Individualists, like the women's segment Aware Ambivalents, tend to be older and more open to FP. We have grouped Prudent Urbanites with Aware Ambivalents for a targeted BCC strategy for the women's segments; therefore, we recommend adapting that BCC strategy with sub-messages for Educated Conventionalists and Urban Individualists. We believe we can reach these segments in the short term, and move many of them to the Intending and perhaps even Practicing stages on the PBC continuum.

5.4.3 GROUP 3: RELUCTANT RURALS AND RURAL CONSERVATIVES

Reluctant Rurals, who make up 49% of male non-users, have characteristics similar to the women's segment Rural Conservatives. Both segments are poor, live in rural areas, and make RH/FP decisions based on their religion and religious leaders. They are both less open to FP, as they have conservative values and attitudes. We recommend, resources permitting, expanding the campaign suggested for Rural Conservatives (involving religious leaders) to include Reluctant Rurals. Sub-messages would need to be developed that are appropriate for a male audience.

These segments represent a large percentage of women and men non-users, and due to their economic situation they may have the most need for FP. Reluctant Rurals and Rural Conservatives are therefore a high priority. However, these segments may be harder to reach due to their lack of openness to FP. It is important to recognize that a long-term strategy is needed for these segments, which may require a high level of resources.

5.5 NATIONAL-LEVEL BCC CAMPAIGN

The client-centered market segmentation approach would target unique subsets of the population. Nevertheless, the quantitative and qualitative data clearly show that there may be a need for a national strategy, in addition to the segment specific recommendations mentioned above. This is particularly relevant since no segment currently has moved beyond the Approving stage.

A national campaign developed for providers, integrated with an overall campaign for potential users of FP, would reinforce best practices and ensure that patients are getting correct and consistent messages. Providers interviewed in the qualitative study reported that they felt educating patients about FP is part of their job, and felt that they and their colleagues are the most trustworthy source of FP information. While these providers were generally knowledgeable about modern FP, they also frequently mentioned the need for more training and patient education materials from the MOH. Many also called for a mass media campaign to educate all Azerbaijanis on FP, as it would assist them in their own patient education efforts. We therefore believe most providers would be welcoming of a national strategy.

Additionally, we identified a clear need for provider education, as providers who understood the need for FP and the detrimental effects of abortion still offered abortions on a regular basis. Also, when asked how they would advise a newly-married 20 year old woman on FP, several providers indicated they would tell her to get pregnant right away, since she is young; they would only counsel her on FP methods if she told them that she did not yet want children. Providers need to be educated on the importance of counseling a woman of any age on FP methods, so she can make an informed choice.

Stakeholders may wish to add a hotline as part of a national strategy. Setting up such a national hotline, with separate call-in numbers for men and women, would alleviate a problem that affects many segments—embarrassment about asking questions about RH/FP. While the hotline would be accessible to those in all segments, we recommend creating segment-specific protocols for those staffing the line. We also recommend that the hotline be partially staffed with trained nurses and midwives, since most patients in Azerbaijan consider them a reliable source of FP advice.

6. NEXT STEPS

- We recommend prioritizing non-user segments based on local stakeholders' public health and communication objectives, and identifying segments that warrant further research.
- Next, we recommend conducting qualitative audience research with each segment identified in the previous step, to further understand segment barriers to FP and how to overcome them. This research should also identify appropriate communication channels and determine the types of messages and materials that might resonate with the audience.
- In addition to conducting research with the identified women and men's segments, we recommend audience research with providers to determine the specific messages and materials that are likely to encourage behavior change.
- Once the qualitative audience research has been conducted, the findings should be used to inform a detailed communication implementation plan both for the national level and for individual segments. This plan should outline the specific communication activities to be implemented with primary and secondary target audiences. The plan should also summarize the specific messages, materials and communication channels that will be used. All messages and materials should be pretested with each target audience before dissemination. The plan should also include training activities to be conducted with providers. A clear communication plan will not only make implementation of the promotional strategy more efficient, but it will also help to document project communication efforts.
- Local stakeholders can carry out the detailed communication implementation plan. A monitoring and evaluation system should be instituted to provide regular feedback and to determine the success of national and segment level BCC campaigns.

7. CONCLUSION

Azerbaijan has not seen an increase in modern contraceptive use since the late 1990s and continues to have one of the highest abortion rates in its region. Although many providers understand the negative effects of abortion, instead of advocating for their patients to use modern FP methods, they continue to provide abortions on a frequent basis.

PSP-*One* implemented a Client Centered Market Segmentation approach to help FP program managers better target their interventions to the unique FP needs of different population groups within Azerbaijan. Just as commercial companies use this tailored approach to meet consumer needs and boost product sales, the aim of this analysis is to help promote more tailored approaches to meet client FP needs and ultimately to move beyond the contraceptive plateau in the Azerbaijan. To supplement this market segmentation research, PSP-*One* conducted a qualitative study with healthcare providers to better understand their attitudes and beliefs regarding RH/FP.

A multi-dimensional segmentation, incorporating demographic, behavioral, and attitudinal characteristics, resulted in the identification of six women's and four men's unique segments of non-users. Incorporating a combination of characteristics that go well beyond the typical demographic and health survey allowed us to develop a comprehensive profile of each segment, bringing the segment to life (so to speak). The resulting profiles provide essential inputs for designing effective BCC strategies that take into account the life cycle, FP attitudes and needs, values, and lifestyles of women and men represented by the segment.

An important goal of the Client Centered Market Segmentation approach is to implement tailored interventions and messages that are designed to resonate with each target group, and ultimately to translate latent demand for FP into adoption of contraceptive methods. Additionally, there are also important non-targeted strategies that can be implemented at a national level. It is important for all non-user segments to obtain correct and consistent information regarding FP methods; a national level campaign to reinforce appropriate messages for all groups is appropriate. Finally, the qualitative research with providers clearly indicates that a national campaign developed specifically for providers, integrated with the campaign for potential users of FP, would be ideal.

It is hoped that the results of this segmentation analysis, together with the research with providers, will provide the necessary information for stakeholders to more effectively target FP interventions to meet the needs of different non-user groups in Azerbaijan.

ANNEX A. FAMILY PLANNING PRACTICES, PREFERENCES, AND UNMET NEED

In this section, we summarize the findings regarding FP practices: prior and current use of contraceptives; desire to use in the future; preferred methods for future use or reasons for future non-use; and unmet need for FP for both spacing births and limiting family size. We focus on married women and married men, between 18 and 49 years old.

A1. FAMILY PLANNING PRACTICES

A1.1 PRIOR USE OF CONTRACEPTION

The data (Table A1) show that about 49 percent of currently married women and 62 percent of married men have ever used a contraceptive method at some time in their lives. In women, 35 percent have used a modern method and 22 percent used a traditional method. More married men have tried a modern method (54 percent) than a traditional method (43 percent). The most common methods among women were the IUCD and withdrawal (17 percent for both methods). For men, the most common methods were male condom (46 percent), withdrawal (43 percent) and IUCD (19 percent).

TABLE A1. PERCENT OF CURRENTLY MARRIED WOMEN AND MEN AGED 18-49 WHO HAVE EVER USED ANY CONTRACEPTIVE METHOD

	Women	Men
Any method	***48.6%***	***62.3%***
Any modern method	***35.2%***	***53.7%***
Female sterilization	1.0%	0.0%
Pill	12.2%	3.1%
IUCD	17.3%	19.3%
Injectables	0.2%	0.0%
Male condom	7.8%	46.0%
Diaphragm/cap	0.4%	0.0%
Spermicides/foam/jelly	1.3%	0.9%
Lactational amenorrhea method (LAM)	1.2%	2.0%
Emergency contraception	0.8%	0.3%
Basal Body Temperature	0.9%	8.4%
Mucus, billings, ovulation	0.2%	0.8%
Standard days method	1.7%	14.0%
Any traditional method	***22.3%***	***43.4%***
Withdrawal	17.5%	42.3%
Calendar, rhythm, periodic abstinence	6.6%	4.6%

*Note: column percentages may not add up to 100%, as reporting multiple methods was allowed

A1.2 CURRENT USE OF CONTRACEPTION

Table A2 shows the current contraceptive practice of married women and men. About one-third of married women and 41 percent of married men are currently using a contraceptive method. Overall, modern methods are used more frequently than traditional methods by both women and men. About 19 percent of married women and 30 percent of married men are using a modern method, while 12 percent of women and 11 percent of men are using a traditional method. In both men and women the most frequently reported modern methods currently used is the IUCD, followed by the pill among women and the male condom among men.

TABLE A2. PERCENT OF CURRENTLY MARRIED WOMEN AND MEN AGED 18-49 WHO CURRENTLY USE CONTRACEPTION (BY METHOD)

	Women	Men
Any modern method	***18.9%***	***29.8%***
Female sterilization	0.4%	0.0%
Pill	5.0%	0.4%
IUCD	8.6%	15.7%
Implants	0.2%	0.0%
Male condom	3.2%	10.8%
Spermicides/foam/jelly	0.6%	0.0%
Lactational amenorrhea method (LAM)	0.5%	0.2%
Basal Body Temperature	0.0%	0.5%
Mucus, billings, ovulation	0.0%	0.1%
Standard days method	0.3%	2.0%
Any traditional method	***11.7%***	***11.2%***
Withdrawal	8.6%	10.1%
Calendar, rhythm, periodic abstinence	3.0%	1.1%
Not currently using any method	***69.5%***	***59.0%***
Total	***100%***	***100%***

A1.3 DIFFERENTIALS OF CONTRACEPTIVE USE BY BACKGROUND CHARACTERISTICS

Table A3 shows that, among currently married women, current contraceptive use increases with age, peaking at 44 percent among women aged 30-34 and falling to 18 percent among those aged 45-49. The use of modern contraceptives does not differ among married women in the age range between 18 and 29 years, but for women approaching age 35, the use of modern methods declines and the use of traditional methods increases. Both the modern method use and traditional method use were highest among women aged 30-34 (25 percent and 19 percent respectively). The lowest use of modern methods was reported by women aged 45-49, while the lowest traditional method use was reported by women aged 18-24. Among men, the highest use of contraception (modern and traditional) was among those aged 45-49: forty-one percent use a modern method and 19 percent use a traditional method.

The contraceptive prevalence rate for modern methods clearly rises with educational level, peaking with technicum-educated adults (28 percent for women and 39 percent for men). Women with higher education are more than twice as likely to use a modern method as women with secondary or less education (20 percent and 9 percent). The comparison by wealth quintiles does not reveal a clear trend. Overall, the use of modern methods does not differ by wealth quintiles, although it is slightly higher among women in the second least wealthy quintile (25 percent) and among men in the poorest

wealth quintile (34 percent). Rate of non-use is high across the wealth quintiles for both men and women, although it is slightly higher among men in the lower quintiles and among women in the second wealthiest quintile.

Area of residence does not make a difference in the use of modern methods for married women. However, married women are more likely to use traditional methods in rural than in urban areas. As married adults begin to have children, the use of both modern and traditional methods rises rapidly. The use of any contraception is almost zero for married adults who do not yet have children. Married women with 3 or more children are less likely to use modern methods and more likely to use traditional methods. On the other hand, men with 3 or more children are more likely to use modern methods than men with fewer children.

Table A3 also compares contraceptive use by employment status. On the whole, employment does not make a difference to the use of modern and traditional methods for married women. For married men, however, the use of both modern and traditional methods is lower for those who are currently unemployed.

TABLE A3. CONTRACEPTIVE USE AMONG CURRENTLY MARRIED WOMEN AND MEN AGED 18-49 BY BACKGROUND CHARACTERISTICS

	Women			Men		
	Modern method	Traditional method	Not currently using	Modern method	Traditional method	Not currently using
Age groups						
18-24	22.0%	3.9%	74.1%	20.1%	9.3%	70.6%
25-29	22.1%	13.2%	64.7%	17.2%	3.6%	79.2%
30-34	25.0%	18.5%	56.5%	30.0%	9.0%	61.0%
35-39	19.0%	11.8%	69.2%	27.7%	9.4%	62.9%
40-44	20.0%	15.2%	64.8%	38.7%	15.5%	45.8%
45-49	9.5%	8.3%	82.2%	41.0%	19.3%	39.7%
Education						
Basic secondary	8.9%	13.3%	77.8%	24.4%	3.4%	72.2%
Complete secondary	17.8%	12.9%	69.2%	25.9%	9.4%	64.7%
Technicum	28.4%	5.1%	66.5%	38.6%	23.3%	38.1%
Higher education	20.2%	10.7%	69.1%	35.2%	12.0%	52.8%
Wealth quintile						
Poorest	14.5%	14.4%	71.1%	34.0%	1.1%	64.9%
Second	25.2%	8.1%	66.7%	26.8%	8.6%	64.6%
Middle	21.4%	6.8%	71.8%	30.7%	14.2%	55.2%
Fourth	17.1%	5.2%	77.7%	31.7%	17.8%	50.6%
Richest	18.9%	15.1%	66.0%	25.7%	17.9%	56.4%
Residence						
Urban	18.2%	9.2%	72.6%	26.7%	16.5%	56.8%
Rural	19.7%	14.7%	65.6%	33.0%	5.7%	61.3%
Number of live children						
None	0.3%	0.0%	99.7%	8.3%	1.0%	90.7%
1 to 2	25.2%	12.1%	62.7%	28.9%	17.1%	54.0%
3 or more	11.6%	15.5%	73.0%	52.4%	7.5%	40.1%
Currently employed						
Yes	15.1%	10.1%	74.8%	32.1%	12.2%	55.6%
No	19.6%	12.0%	68.5%	25.9%	9.4%	64.7%
Total	**18.9%**	**11.7%**	**69.5%**	**29.8%**	**11.2%**	**59.0%**

A2. FUTURE USE OF CONTRACEPTION

A2.1 INTENTION TO USE CONTRACEPTION IN THE FUTURE

Table A4 shows that among married men and women who are not currently using any contraceptive methods, those ages 25-29 are most likely to use a method in the future (36 percent of women and 47 percent of men). Adults in the youngest age group are the most uncertain about their future intention to use (42 percent of women and 50 percent of men). Most married adults in the highest age group (45-49 years old) do not intend to use a method in the future (87 percent of women and 77 percent of men).

Most married current non-users who intend to use a method in the future have 1-2 children. Those who do not have any children are more likely to be unsure about their future use; those who do not intend to use any contraception already have 3 or more children.

TABLE A4. PERCENTAGE OF CURRENTLY MARRIED WOMEN AND MEN AGED 18-49 WHO ARE NOT USING A CONTRACEPTIVE METHOD BY INTENTION TO USE IN THE FUTURE, ACCORDING TO AGE AND NUMBER OF LIVING CHILDREN

	Women				Men			
	Intends to use	Unsure	Does not intend to use	Total	Intends to use	Unsure	Does not intend to use	Total
Age groups								
18-24	22.9%	42.4%	34.7%	100.0%	23.5%	50.3%	26.3%	100.0%
25-29	36.2%	22.4%	41.4%	100.0%	46.7%	16.5%	36.8%	100.0%
30-34	21.7%	40.1%	38.2%	100.0%	39.3%	33.0%	27.8%	100.0%
35-39	16.4%	34.0%	49.6%	100.0%	17.3%	28.6%	54.2%	100.0%
40-44	10.2%	10.4%	79.4%	100.0%	4.4%	25.6%	70.0%	100.0%
45-49	2.4%	10.7%	87.0%	100.0%	1.4%	21.4%	77.2%	100.0%
Number of live children								
None	15.5%	49.9%	34.6%	100.0%	27.8%	28.7%	43.5%	100.0%
1 to 2	21.4%	20.8%	57.8%	100.0%	30.0%	27.1%	43.0%	100.0%
3 or more	7.3%	16.2%	76.5%	100.0%	12.6%	20.9%	66.5%	100.0%
Total	**16.5%**	**24.0%**	**59.5%**	**100.0%**	**26.4%**	**26.6%**	**47.0%**	**100.0%**

A2.2. REASONS FOR NOT INTENDING TO USE

Table A5 shows percentage of married women and men ages 18-49 who are not using contraception and who do not intend to use in the future, showing the main reasons. The most common reasons women gave were fertility related reasons (29 percent of married women), including menopausal/hysterectomy status (16 percent), and low fertility/infertility (13 percent). Infrequent/no sex was the second most common reason women gave for non-intention to use (27 percent of married women), followed by method-related reasons (16 percent), which include fear of health risks (14 percent) and side effects (6 percent). Among married men, opposition to using contraceptives was the most common reason given for non-intention (19 percent of married men), including: the respondent's personal opposition (16 percent); religious prohibition (9 percent); spouse's opposition (8 percent); and respondent's belief that parenthood is predetermined by fate and not something to be manipulated (8 percent).

TABLE A5. REASONS FOR NOT INTENDING TO USE CONTRACEPTION IN THE FUTURE

Reasons for not intending to use	Women	Men
Wants as many children as possible	9.1%	21.8%
Infrequent sex/no sex	27.1%	0.0%
Unmarried	1.0%	1.1%
Fertility related reasons	29.0%	7.4%
Menopausal/had hysterectomy	16.4%	0.0%
Low fertility/infertility	13.0%	8.4%
Opposition to use	12.8%	19.0%
Respondent opposed	7.4%	15.9%
Spouse/partner opposed	7.9%	8.4%
Religious prohibition	0.3%	9.2%
Believes parenthood is predetermined by fate and one's course is unalterable/should not be manipulated	7.7%	7.9%
Lack of knowledge	5.1%	10.8%
Knows no method	4.1%	9.7%
Knows no source	2.9%	2.4%
Method-related reasons	15.6%	8.4%
Fear of health risks	13.9%	3.4%
Fear of side effects	6.2%	1.4%
Difficult to obtain/lack of access	0.4%	0.4%
Costs too much	0.0%	0.2%
Difficult to use	0.1%	0.0%
Interferes with body's natural processes	2.2%	1.4%
Interferes with woman's sexual pleasure	0.3%	2.9%
Interferes with woman's sexual pleasure	0.3%	4.2%

*Note: column percentages may not add up to 100, as multiple reasons are allowed

A2.3. PREFERRED METHODS FOR FUTURE USE

Table A6 presents the percentage of currently married women ages 18-49 who are not using a contraceptive method but who intend to use in the future, indicating preferred method. Among married women and men, the majority prefer to use the IUCD (37 percent among women and 40 percent among men). The second preferred method for women is the pill (15 percent), while men prefer the male condom (14 percent) and withdrawal (14 percent). Six percent of married women intend to use the withdrawal method and 5 percent intend to use the calendar method or periodic abstinence. About one in five men refused to give information about their preferred contraceptive method.

TABLE A6. PREFERRED METHOD OF CONTRACEPTION FOR FUTURE USE

	Women	Men
Preferred method for future use		
Pill	14.6%	1.9%
IUCD	36.5%	40.4%
Male condom	9.0%	14.1%
Spermicides/foam/jelly	0.5%	0.0%
Emergency contraception	1.4%	0.0%
Standard days method	0.9%	3.8%
Withdrawal	6.2%	14.3%
Calendar, rhythm, periodic abstinence	4.8%	0.4%
Natural method	0.5%	0.0%
Washing immediately after sex	2.0%	0.0%
By help of doctor	0.0%	1.3%
Others	0.5%	3.4%
Don't know	17.8%	0.0%
Refusal	5.5%	20.4%
Total	**100.0%**	**100.0%**

A3. UNMET NEED FOR FP

Currently married fecund women who either want no more children or want to wait at least two years before having another child, and who are not using contraception, are considered to have an unmet need for FP. Table A7 presents information for currently married women on unmet need for spacing births or limiting family size, according to background characteristics.

Overall, 61 percent of currently married women ages 18-49 have an unmet need for FP, mainly for limiting (with 50 percent for limiting and 11 percent for spacing). Unmet need for limiting is highest among married women aged 30-34 years (58 percent), women with basic secondary education (58 percent), or those who have 3 or more children (67 percent). In terms of wealth, women in the fourth quintile (that is, second wealthiest) have, surprisingly, the highest unmet need for limiting (58 percent). Slightly more urban women (52 percent) or currently employed women (52 percent) have high unmet need for limiting.

Unmet need for spacing is highest among the youngest women, ages 18-24 years (38 percent), followed by women ages 25-29 years old (13 percent), or those with basic secondary education (17 percent). The most and least wealthy women have the highest unmet need for spacing (13 percent and 12 percent) compared with women of other wealth quintiles. The majority of women with no children (55 percent) and the majority of unemployed women (12 percent vs. 7 percent) have unmet need for spacing.

TABLE A7. UNMET NEED FOR FP AMONG CURRENTLY MARRIED WOMEN

	Unmet need for limiting	Unmet need for spacing
Age groups		
18-24	26.5%	37.5%
25-29	42.0%	13.2%
30-34	44.2%	4.6%
35-39	58.0%	9.3%
40-44	48.6%	8.4%
45-49	70.7%	0.9%
Education		
Basic secondary	58.1%	16.6%
Complete secondary	50.4%	11.0%
Technicum	43.9%	13.3%
Higher education	48.9%	8.6%
Refusal	39.0%	0.0%
Wealth quintile		
Poorest	48.4%	12.4%
Second	46.6%	7.0%
Middle	51.9%	9.5%
Fourth	58.3%	8.8%
Richest	47.8%	13.4%
Urban	52.4%	8.8%
Rural	46.9%	14.5%
Number of live children		
None	33.4%	54.7%
1 to 2	45.1%	7.9%
3 or more	67.8%	1.7%
Currently employed		
Yes	51.9%	6.7%
No	49.6%	12.2%
Total	**49.9%**	**11.3%**

ANNEX B. SEGMENTATION PROFILES: WOMEN

TABLE A8. DEMOGRAPHIC CHARACTERISTICS OF WOMEN

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Mean Age	34.4	35.0	35.5	34.9	22.6	23.6
Median Age	35.5	35.5	35.0	34.5	20.0	22.0
Age Group						
18-24	16.7	9.8	8.8	63.1	55.4	78.8
25-34	34.6	29.4	30.0	21.0	32.3	13.2
35-49	48.7	60.8	61.2	15.9	12.3	8.0
Education Level						
Basic secondary	16.7	3.6	5.6	9.4	0.0	0.0
Complete secondary	76.9	56.4	45.1	90.6	0.0	0.0
Technicum	2.7	17.6	21.4	0.0	50.8	19.3
Higher	3.6	22.0	27.9	0.0	49.2	80.7
Marital Status						
Married/In union	91.2	90.6	91.3	0.0	0.0	0.0
Separated	6.8	5.3	4.0	0.0	0.0	0.0
Widowed	2.0	4.1	4.6	0.0	0.0	0.0
Single/not married	0.0	0.0	0.0	100.0	100.0	100.0
Wealth status						
Poorest	52.1	0.0	0.0	12.6	0.0	0.0
Second	47.9	0.0	0.0	37.5	0.0	0.0
Middle	0.0	38.3	19.8	22.7	29.1	3.3
Fourth	0.0	34.8	37.2	11.0	42.9	30.8
Richest	0.0	27.0	43.0	16.3	28.0	65.9
Location						
Rural	93.2	12.4	0.0	56.6	0.0	3.9
Urban	6.8	87.6	100.0	43.4	100.0	96.1

TABLE A9. WOMEN'S FERTILITY DESIRES AND FAMILY PLANNING

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Number of live children						
None	13.2	13.8	10.0	100.0	94.8	100.0
1 - 2	052.1	59.9	68.9	0.0	0.0	0.0
3 or more	34.7	26.4	21.1	0.0	5.2	0.0
Future fertility desire						
No more children desired	64.7	61.7	61.8	4.4	5.6	10.4
Wants child later (2 or more years)	5.4	4.4	8.4	9.9	6.4	21.3
Wants child sooner (<2 years)	17.5	7.7	7.6	19.3	8.0	12.7
Unsure if wants children	9.0	11.8	5.9	10.2	30.5	16.2
Wants children, unsure when	0.0	3.1	8.8	55.0	42.8	34.8
Cannot get pregnant	3.4	11.3	7.5	1.3	6.7	4.7
Ever had sex						
Yes	100.0	96.5	98.9	0.0	6.5	3.3
No	0.0	3.5	1.1	100.0	93.5	96.7
Ever use of FP method, by method[1]						
Modern method	21.8	21.6	17.5	0.0	0.0	1.6
Traditional method	24.4	20.2	16.2	0.0	0.0	1.6
Any method	40.1	34.4	27.9	0.0	0.0	1.6
Ever used FP method, by method[1]						
Pill	9.4	7.5	9.7	0.0	0.0	0.0
Calendar	8.5	4.5	4.8	0.0	0.0	0.0
Male condom	0.0	7.6	4.9	0.0	0.0	1.6
IUCD	9.8	8.9	5.6	0.0	0.0	0.0
Withdrawal	18.8	16.4	13.0	0.0	0.0	1.6
Number of abortions						
None	48.3	50.9	41.7	100.0	100.0	100.0
1 - 2	28.7	19.3	27.4	0.0	0.0	0.0
3 - 4	12.7	15.2	17.5	0.0	0.0	0.0
5 or more	10.4	14.7	13.4	0.0	0.0	0.0

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Mean number of abortions	1.6	2.3	1.9	0.0	0.0	0.0
Median number of abortions	1.0	1.0	1.0	0.0	0.0	0.0
Intention to use						
Yes	26.3	21.8	27.2	27.4	7.2	10.2
No	49.2	57.9	45.1	15.1	28.9	25.2
Unsure	24.5	20.4	27.8	57.6	63.9	64.6
Intention to use FP method						
Have used and will use in future	20.4	10.1	16.2	0.0	0.0	1.6
Have used and will not use in future	13.8	20.7	7.3	0.0	0.0	0.0
Have used and unsure if will use in future	6.0	3.6	4.4	0.0	0.0	0.0
Never used and will use in future	5.9	11.7	11.0	27.4	7.2	8.6
Never used and will not use in future	35.4	37.1	37.8	15.1	28.9	25.2
Never used and unsure if will use in future	18.6	16.7	23.4	57.6	63.9	64.6
Median age at first intercourse	20.0	21.0	21.0	0.0	26.0	18.0
Unmet need[2]						
Unmet need for birth spacing	16.5	10.9	17.4	N/A	N/A	N/A
Unmet need for birth limiting	57.1	67.5	52.9	N/A	N/A	N/A

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Awareness of FP methods, by method						
Diaphragm	0.0	3.6	4.1	0.8	0.9	5.4
Ring	0.9	3.3	8.8	0.9	0.0	6.3
Implants	5.6	11.0	8.4	6.8	14.5	7.8
Injectable	1.2	11.8	19.1	3.8	15.8	11.9
IUCD	82.5	82.3	86.1	51.3	65.2	47.3
Ligation	9.8	25.1	32.7	21.2	17.5	14.7
Emergency Contraceptives	1.4	8.1	8.6	2.4	0.6	6.3
Male condom	36.5	75.1	81.3	41.1	74.1	74.1
Pill	71.3	79.6	79.6	46.7	65.1	74.0
Spermicide	6.0	7.6	24.6	3.5	9.7	8.5
Vasectomy	1.8	16.0	8.0	15.1	11.1	10.7
Lactational Amenorrhea	0.0	10.6	10.0	1.1	5.2	4.7
BBT	2.2	6.7	14.7	4.5	1.3	3.1
Calendar	45.4	37.7	39.7	5.3	9.1	18.9
Mucus, Billings, fgfdiOvulation	0.0	2.5	7.3	1.2	0.0	3.1
Standard Days Method	13.6	16.8	15.2	2.2	10.9	7.2
Symptothermal	1.1	2.0	6.2	0.0	2.1	3.1
Withdrawal	66.6	64.6	64.3	26.2	30.0	23.0
Overall, which method do you think will be the best for you?[3]						
IUCD	19.4	26.2	13.6	N/A	N/A	N/A
Male Condom	0.0	9.8	5.7	N/A	N/A	N/A
Pills	10.6	4.1	13.8	N/A	N/A	N/A
Spermicide	0.0	0.0	1.9	N/A	N/A	N/A
Emergency Contraceptive	0.0	1.1	1.9	N/A	N/A	N/A
Calendar/Rhythm	23.3	8.6	9.8	N/A	N/A	N/A
Standard Days	0.0	1.1	0.0	N/A	N/A	N/A
Withdrawal	33.6	36.5	39.4	N/A	N/A	N/A
Natural	0.0	0.0	1.9	N/A	N/A	N/A
Washing immediately after sexual intercourse	0.0	0.6	0.0	N/A	N/A	N/A
Other	0.0	0.6	0.0	N/A	N/A	N/A
Don't know/NA	10.4	6.1	12.0	N/A	N/A	N/A
Refused to answer	2.8	3.5	0.0	N/A	N/A	N/A

[1] Ever use of FP method is limited to current non-users who report a history of sexual intercourse
[2] Unmet need only applies to married women
[3] Best FP method applies to married women who intend to use in the future

TABLE A10. WOMEN'S LIFESTYLES AND VALUES

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Attitudes towards health sector						
Midwives provide good quality medical service						
Strongly disagree	0.8	2.3	1.1	1.8	0.0	2.4
Disagree	22.3	18.3	29.2	19.1	2.1	3.2
Neither agree nor disagree	20.1	26.0	18.4	21.6	14.2	16.3
Agree	54.1	40.5	44.6	16.5	18.5	28.7
Strongly agree	0.7	6.0	4.8	3.9	10.2	1.6
Don't know	2.2	6.9	2.0	37.3	54.9	47.8
Cost of private medical services prevents me from seeking care when I need it						
Strongly disagree	0.0	0.0	0.0	0.3	0.6	0.0
Disagree	9.6	11.4	11.1	8.4	11.2	14.6
Neither agree nor disagree	31.5	25.4	33.7	32.7	19.6	33.2
Agree	46.7	46.4	49.5	44.9	38.1	44.1
Strongly agree	10.8	12.5	5.6	6.4	18.9	5.0
Don't know	1.4	4.3	0.0	7.2	11.7	3.2
When I go to medical facility, I usually have to wait before seeing a health professional						
Strongly disagree	5.0	1.2	1.1	0.0	0.0	2.4
Disagree	6.3	9.7	17.8	8.6	14.6	12.1
Neither agree nor disagree	47.5	34.4	29.8	37.8	24.6	20.8
Agree	36.0	48.1	47.8	41.6	45.4	56.2
Strongly agree	5.1	5.2	2.2	4.2	6.3	1.6
Don't know	0.0	1.3	1.3	7.9	9.2	7.0
Doctors provide good quality medical service						
Strongly disagree	1.5	2.1	3.2	1.0	8.2	5.6
Disagree	3.1	13.2	8.7	15.9	8.4	10.4
Neither agree nor disagree	44.9	34.3	39.8	31.9	28.8	39.9
Agree	40.6	42.6	43.8	46.6	35.0	37.8
Strongly agree	7.3	7.1	3.9	0.5	6.4	1.6
Don't know	2.6	0.8	0.6	4.0	13.2	4.8

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
When sick, I cannot afford to purchase all the drugs that I need						
Strongly disagree	0.0	0.2	0.0	0.3	2.2	0.0
Disagree	9.4	16.2	17.6	18.5	26.9	19.4
Neither agree nor disagree	48.9	28.9	33.7	23.9	17.6	29.3
Agree	35.2	42.7	45.4	46.2	42.0	42.6
Strongly agree	6.5	10.1	3.3	5.7	6.3	4.0
Don't know	0.0	1.9	0.0	5.5	4.9	4.8
People have to travel a long way to see a health care provider						
Strongly disagree	0.8	3.2	1.9	4.9	5.2	2.2
Disagree	14.1	28.0	33.5	18.9	37.7	37.4
Neither agree nor disagree	42.5	26.8	37.8	28.4	24.4	34.0
Agree	38.7	32.3	19.7	27.6	23.4	21.6
Strongly agree	3.5	5.6	2.4	4.0	1.9	0.0
Don't know	0.4	4.1	4.8	16.2	7.5	4.8
When sick, I prefer to use traditional methods to treat my illness						
Strongly disagree	4.7	3.1	3.0	3.5	2.2	6.3
Disagree	33.8	22.8	30.6	35.8	28.6	43.6
Neither agree nor disagree	38.2	32.7	21.9	25.0	32.8	22.0
Agree	18.9	35.1	40.8	25.2	31.5	21.3
Strongly agree	4.4	5.7	3.5	3.7	3.7	5.2
Don't know	0.0	0.8	0.3	6.9	1.4	1.6
My health care provider always spends enough time taking care of me when I visit						
Strongly disagree	1.4	0.6	3.2	0.9	0.0	3.9
Disagree	9.9	10.5	8.2	6.0	5.6	9.2
Neither agree nor disagree	41.5	33.0	38.6	45.8	42.7	24.8
Agree	41.7	48.1	46.2	38.4	39.4	52.6
Strongly agree	4.6	6.1	3.5	3.8	1.1	1.6
Don't know	1.1	1.7	0.3	5.2	11.2	8.0

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
When sick, I usually go straight to the pharmacy to get the drugs that I need						
Strongly disagree	2.7	0.1	0.8	0.3	0.6	0.0
Disagree	21.8	20.3	29.9	21.0	22.1	30.7
Neither agree nor disagree	35.2	33.9	26.9	24.6	39.2	33.2
Agree	38.3	39.4	37.4	45.3	32.3	30.6
Strongly agree	2.0	5.4	5.1	0.5	1.6	1.6
Don't know	0.0	0.9	0.0	8.3	4.2	4.0
People often wait until they have a serious health problem before seeking care						
Strongly disagree	1.7	0.4	1.1	2.8	0.0	1.6
Disagree	12.4	7.3	8.7	11.2	10.3	11.9
Neither agree nor disagree	33.4	23.0	19.3	38.0	13.5	10.4
Agree	33.0	46.1	43.0	20.9	42.1	32.1
Strongly agree	16.8	20.8	25.4	18.1	32.7	38.4
Don't know	2.7	2.5	2.6	9.1	1.4	5.6
My health care provider always explains things about my health in a way I can understand						
Strongly disagree	0.0	0.5	3.2	1.5	0.0	0.0
Disagree	5.2	7.1	3.2	1.9	7.5	3.2
Neither agree nor disagree	34.4	25.9	24.1	31.6	33.7	21.7
Agree	53.3	60.3	58.0	54.0	43.5	66.4
Strongly agree	7.1	4.6	10.8	5.6	5.0	4.0
Don't know	0.0	1.6	0.7	5.5	10.2	4.7
It is difficult to find a qualified doctor						
Strongly disagree	0.8	1.6	1.6	0.0	0.5	3.1
Disagree	7.1	17.9	12.4	20.5	19.9	19.9
Neither agree nor disagree	41.5	29.4	35.0	27.2	17.9	25.5
Agree	36.6	36.6	37.0	41.8	41.2	31.9
Strongly agree	13.7	12.7	14.0	7.7	16.9	16.5
Don't know	0.5	1.8	0.0	2.9	3.5	3.2

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
My health care provider always listens to me if I have a question about my health						
Strongly disagree	0.8	3.0	2.1	0.0	0.0	0.0
Disagree	3.8	7.5	4.2	3.0	16.4	0.0
Neither agree nor disagree	47.3	30.1	41.3	39.9	25.9	27.4
Agree	42.7	55.8	45.3	47.2	42.1	64.7
Strongly agree	1.9	2.6	5.4	4.4	3.2	3.2
Don't know	4.2	1.0	1.6	5.5	12.4	4.7
Importance of family planning method attributes						
Safety (associated health risk to the woman)						
Not at all important	N/A	N/A	N/A	N/A	N/A	N/A
Not very important	0.4	1.7	0.9	N/A	0.0	0.0
Neither important nor unimportant	1.4	12.9	4.4	N/A	0.0	0.0
Important	45.9	37.5	27.4	N/A	0.0	50.0
Very important	48.4	45.4	66.8	N/A	100.0	50.0
Don't know/NA	4.0	2.6	0.5	N/A	0.0	0.0
Effectiveness at preventing pregnancy						
Not at all important	0.4	0.2	0.0	N/A	0.0	0.0
Not very important	1.5	2.2	0.6	N/A	0.0	0.0
Neither important nor unimportant	9.8	11.1	4.1	N/A	0.0	0.0
Important	39.0	41.9	37.5	N/A	80.0	50.0
Very important	45.3	42.0	57.4	N/A	20.0	50.0
Don't know/NA	4.0	2.6	0.5	N/A	0.0	0.0
Affordability						
Not at all important	0.0	0.7	0.0	N/A	0.0	0.0
Not very important	3.4	4.9	8.0	N/A	80.0	50.0
Neither important nor unimportant	30.9	32.0	14.1	N/A	0.0	0.0
Important	43.6	42.5	38.3	N/A	0.0	50.0
Very important	17.7	17.1	35.8	N/A	20.0	0.0
Don't know/NA	4.4	2.9	3.8	N/A	0.0	0.0

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Convenience to get/purchase						
Not at all important	0.0	0.0	0.8	N/A	0.0	0.0
Not very important	3.0	7.2	4.4	N/A	0.0	0.0
Neither important nor unimportant	24.1	22.9	11.2	N/A	0.0	0.0
Important	55.4	46.5	59.0	N/A	100.0	100.0
Very important	13.6	19.8	21.1	N/A	0.0	0.0
Don't know/NA	4.0	3.6	3.6	N/A	0.0	0.0
Interference with the woman's sexual pleasure						
Not at all important	0.0	0.5	0.9	N/A	0.0	0.0
Not very important	10.8	5.3	3.0	N/A	0.0	0.0
Neither important nor unimportant	17.2	18.4	14.0	N/A	0.0	0.0
Important	49.8	42.7	50.4	N/A	80.0	50.0
Very important	12.2	28.0	26.8	N/A	20.0	50.0
Don't know/NA	10.0	5.2	4.9	N/A	0.0	0.0
Interference with the man's sexual pleasure						
Not at all important	0.0	0.5	0.3	N/A	0.0	0.0
Not very important	3.7	3.5	1.3	N/A	0.0	0.0
Neither important nor unimportant	18.3	18.0	11.4	N/A	80.0	50.0
Important	48.3	45.9	53.3	N/A	20.0	50.0
Very important	20.7	27.3	29.4	N/A	0.0	0.0
Don't know/NA	9.0	4.9	4.3	N/A	0.0	0.0
Ease of use						
Not at all important	0.0	0.2	0.3	N/A	0.0	0.0
Not very important	1.1	4.4	0.5	N/A	0.0	0.0
Neither important nor unimportant	9.8	19.9	9.3	N/A	0.0	50.0
Important	48.9	49.9	60.9	N/A	100.0	50.0
Very important	35.0	21.0	24.7	N/A	0.0	0.0
Don't know/NA	5.2	4.6	4.3	N/A	0.0	0.0

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Accordance with personal/religious beliefs						
Not at all important	0.0	2.3	0.5	N/A	0.0	0.0
Not very important	7.5	14.8	14.8	N/A	0.0	50.0
Neither important nor unimportant	15.9	20.6	16.3	N/A	100.0	0.0
Important	44.7	35.1	44.4	N/A	0.0	50.0
Very important	22.3	19.1	18.2	N/A	0.0	0.0
Don't know/NA	9.5	8.1	5.8	N/A	0.0	0.0
Effectiveness at preventing STIs						
Not at all important	0.4	0.0	0.2	N/A	0.0	0.0
Not very important	0.0	2.9	0.3	N/A	0.0	0.0
Neither important nor unimportant	4.6	11.7	9.5	N/A	0.0	0.0
Important	52.1	36.9	50.3	N/A	80.0	50.0
Very important	38.9	45.9	36.9	N/A	20.0	50.0
Don't know/NA	4.0	2.6	2.8	N/A	0.0	0.0
Approval from people who are important to me						
Not at all important	5.2	6.6	3.5	N/A	0.0	0.0
Not very important	12.6	19.4	7.9	N/A	20.0	50.0
Neither important nor unimportant	9.7	18.4	15.9	N/A	0.0	0.0
Important	42.3	32.4	43.1	N/A	80.0	50.0
Very important	24.9	17.1	19.1	N/A	0.0	0.0
Don't know/NA	5.3	6.1	10.6	N/A	0.0	0.0

TABLE A11. WOMEN'S COMMUNICATION PRACTICES

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Mass media habits						
Watch Television	100.0	99.2	98.3	98.8	99.7	99.2
Time of day TV is most watched						
Morning (06:00-12:00)	1.8	2.7	4.5	1.6	2.1	2.4
Afternoon (12.00 – 18:00)	3.4	20.4	15.1	9.7	6.7	5.5
Evening (18:00 – 00:00)	92.1	76.1	80.4	86.1	91.2	90.5
Night (00:00 – 06:00)	1.3	0.7	0.0	2.6	0.0	1.6
Don't know/NA	1.4	0.1	0.0	0.0	0.0	0.0
Frequency of watching TV						
Everyday	82.3	92.1	93.5	81.6	90.3	84.4
Not everyday	17.8	7.9	6.5	18.4	9.7	15.6
Type of television programming watched[1]						
Business/Business World	2.6	5.9	2.1	6.1	8.6	5.5
Cartoon	0.5	2.6	1.1	1.7	5.4	8.6
Children/						
Youth programs	4.5	4.7	6.2	6.6	14.1	25.7
Comedy	24.2	25.9	25.5	28.0	16.8	28.7
Crime programs	20.9	23.8	38.9	19.7	26.4	34.0
Cooking show	9.9	24.8	27.5	10.2	17.5	22.2
Cultural programs	1.6	11.8	20.5	3.2	12.1	19.9
Documentaries	5.4	14.1	7.6	10.3	13.4	14.4
Drama/Play	0.6	5.2	11.5	0.7	8.1	0.8
Educational programs	3.8	13.2	16.7	3.9	15.8	18.2
Economic programs	5.5	9.0	8.4	3.6	9.9	10.1
Entertainment Talk Shows	33.6	27.1	26.4	25.8	31.4	40.7
Entertainment/Music/ Dance	54.6	40.7	35.0	35.0	47.7	50.5
Game shows	12.9	15.3	14.9	15.6	13.4	9.3
Movies	59.5	55.9	69.8	67.5	65.2	69.0
News	52.0	64.1	53.9	29.0	59.3	69.3
Reality shows	9.8	20.2	17.3	21.9	22.8	32.6
Religious program	0.6	9.8	11.6	3.6	15.4	11.9
Serials	83.7	69.6	65.6	83.0	76.6	54.9

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Show business news/magazine programs	68.6	61.5	54.8	59.3	59.8	74.9
Social/Political Talk Shows	18.2	19.9	21.6	13.7	19.6	11.9
Sport Magazines/Sport Competitions	0.0	3.7	5.0	1.3	2.8	1.8
Talent shows	21.2	21.2	29.9	18.5	25.5	34.2
Women's shows (non-cooking)	15.4	30.3	35.9	15.7	32.7	45.3
Other	0.0	0.5	0.6	0.0	0.0	0.0
Type of TV channels watched						
None/Don't watch TV	0.0	0.8	1.7	1.2	0.3	0.8
ANS TV	90.5	81.1	79.9	89.3	88.2	75.4
ATV	94.1	87.0	87.5	93.9	92.3	89.1
AZTV	44.6	46.1	61.5	56.3	44.1	35.2
ITV (Public television)	64.9	67.1	61.2	71.6	60.4	65.3
Lider TV	62.9	57.8	68.3	72.9	71.0	60.7
Khazar TV	64.8	66.5	80.4	47.9	86.2	71.9
Space TV	49.6	61.0	64.8	52.8	61.5	70.5
Other Azerbaijani TV channels	11.7	10.9	5.7	8.2	14.5	10.6
Russian TV channels	0.5	5.7	11.3	5.8	16.0	26.0
Turkish TV channels	36.0	24.7	39.1	21.4	27.5	49.3
Other foreign TV channels	0.0	0.7	1.1	0.0	0.0	4.0
Listen to the radio	4.3	0.0	100.0	30.2	37.7	64.6
Time of day radio most often listened to						
Morning (06:00-12:00)	16.8	N/A	20.5	7.9	5.6	0.0
Afternoon (12.00 – 18:00)	77.8	N/A	58.7	52.6	62.9	73.2
Evening (18:00 – 00:00)	5.4	N/A	15.2	21.7	23.9	14.6
Night (00:00 – 06:00)	0.0	N/A	5.3	17.7	5.7	11.0
Don't know/NA	0.0	N/A	0.4	0.0	1.9	1.2
Frequency of listening to radio						
Everyday	0.0	N/A	17.3	13.3	15.1	12.2
4 - 6 days	9.3	N/A	14.1	16.6	17.0	42.8
2 - 3 days	80.2	N/A	52.3	58.8	63.1	40.3
Once a week	10.5	N/A	14.1	9.1	3.0	0.0
2 - 3 times a month	0.0	N/A	1.7	2.2	0.0	2.3
Don't know/NA	0.0	N/A	0.4	0.0	1.9	2.5

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Type of radio programming listened to[2]						
Religious programs	3.6	N/A	2.8	0.0	0.0	7.4
Drama/radio plays/radio novels	5.4	N/A	1.6	0.0	0.0	1.2
Entertainment talk shows	11.1	N/A	4.1	7.3	11.4	16.9
Entertainment programs	12.9	N/A	4.5	14.1	1.9	14.2
Economic programs	0.0	N/A	2.8	1.1	5.6	1.2
Crime programs	7.2	N/A	6.7	3.1	5.6	8.4
Educational programs	7.5	N/A	6.2	3.3	9.4	0.0
Cultural programs	0.0	N/A	1.6	1.7	12.5	0.0
Various topic discussions	15.6	N/A	20.7	16.1	18.8	32.5
Music	100.0	N/A	89.6	97.9	96.2	100.0
Game programs	27.9	N/A	7.2	5.0	0.0	4.7
Women's programs	14.7	N/A	11.0	5.3	7.6	7.0
Political programs	11.1	N/A	1.1	0.0	5.7	3.5
Social/political talk shows	26.1	N/A	2.8	0.0	0.0	7.2
News	29.7	N/A	10.6	6.4	16.9	12.9
Type of radio stations listened to						
None/Don't listen to radio	95.7	100.0	2.8	72.1	62.3	41.6
ANS ChM	29.7	N/A	22.0	29.2	39.5	25.0
Antenne FM	12.9	N/A	22.3	19.7	19.8	36.7
Azad Azerbaijan 106.0 FM	46.1	N/A	59.6	41.1	57.6	56.4
Azad Azerbaijan 106.3 FM	100.0	N/A	68.3	54.0	68.6	73.2
Burch FM	31.1	N/A	31.7	47.9	56.2	50.9
Ictimai Radio (Public radio)	14.2	N/A	12.6	18.5	14.9	17.3
Radio Lider	8.1	N/A	10.7	1.1	11.3	12.4
Radio Space	11.1	N/A	12.0	6.8	9.3	15.9
Khazar radio	24.0	N/A	22.1	25.4	26.1	23.0
Other Azerbaijani radio	1.1	N/A	1.2	0.0	5.6	0.0
Azadlig Radio station	0.0	N/A	0.8	0.0	0.0	0.0
Other foreign radio stations	0.0	N/A	0.9	0.0	0.0	1.2
Internet Use	0.0	5.5	12.3	10.0	0.0	100.0
Location of internet access[3]						
Home	N/A	72.8	77.8	53.9	N/A	60.2
Work	N/A	21.2	22.2	1.7	N/A	4.7
Internet Café	N/A	2.3	0.0	32.7	N/A	20.1
School	N/A	0.0	0.0	3.3	N/A	6.4
Cell phone	N/A	1.2	0.0	8.4	N/A	7.9

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Other home	N/A	0.0	0.0	0.0	N/A	0.8
Don't know/NA	N/A	2.5	0.0	0.0	N/A	0.0
Frequency of internet use	N/A					
Almost everyday	N/A	6.2	13.3	72.4	N/A	48.1
At least once a week	N/A	75.3	65.3	2.1	N/A	44.9
Less than once a week	N/A	16.1	21.5	3.3	N/A	7.1
Don't know/NA	N/A	2.5	0.0	3.3	N/A	0.0
Own a mobile phone	16.3	49.6	68.2	46.3	87.3	84.8
Trusted sources of family planning advice- family and friends						
Husband/partner						
Trust	86.6	81.3	81.4	2.9	16.7	11.1
Not trust	4.6	7.0	9.4	4.9	4.1	0.0
Irrelevant	8.8	8.1	9.2	87.1	73.6	81.8
Don't know/unsure	0.0	3.6	0.0	5.1	5.6	7.2
Friends						
Trust	24.0	30.4	25.0	27.4	22.4	28.2
Not trust	71.0	51.6	59.8	65.8	52.1	51.8
Irrelevant	0.4	8.3	8.2	2.0	10.2	1.4
Don't know/unsure	4.6	9.7	7.1	4.8	15.2	18.6
Mother						
Trust	86.6	63.7	68.4	88.9	82.8	75.5
Not trust	3.4	9.4	13.0	1.3	2.8	15.1
Irrelevant	9.9	20.3	14.1	6.3	2.1	1.6
Don't know/unsure	0.0	6.6	4.5	3.5	12.3	7.8
Father						
Trust	56.2	21.2	29.8	43.7	26.2	13.6
Not trust	24.5	29.6	24.1	14.8	30.9	36.8
Irrelevant	18.4	36.6	33.5	35.3	18.1	23.6
Don't know/unsure	0.9	12.6	12.5	6.2	24.8	26.0
Sister						
Trust	74.8	59.0	60.5	74.9	60.8	45.8
Not trust	15.0	12.5	14.5	3.7	6.9	17.6
Irrelevant	10.2	21.5	18.4	17.5	18.4	31.9
Don't know/unsure	0.0	7.1	6.7	3.9	13.9	4.7

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Brother						
Trust	67.3	22.8	43.2	55.7	11.4	8.5
Not trust	27.0	36.9	24.2	14.9	28.6	28.8
Irrelevant	5.2	26.6	20.2	22.6	39.3	36.3
Don't know/unsure	0.5	13.7	12.4	6.9	20.8	26.4
Daughter						
Trust	37.8	24.3	27.5	0.3	1.4	0.0
Not trust	23.4	27.3	24.1	5.4	10.5	3.4
Irrelevant	38.2	37.6	38.9	90.5	71.2	89.0
Don't know/unsure	0.5	10.8	9.5	3.9	17.0	7.7
Son						
Trust	41.4	14.3	23.0	0.0	0.0	0.0
Not trust	29.2	34.0	28.2	5.3	8.8	1.0
Irrelevant	25.4	38.5	35.9	90.8	74.3	91.4
Don't know/unsure	4.1	13.1	12.9	3.9	17.0	7.7
Mother-in-law						
Trust	58.6	40.8	28.8	0.3	1.6	1.0
Not trust	14.4	21.2	23.2	5.1	10.2	1.6
Irrelevant	26.1	28.4	33.1	90.7	74.5	89.6
Don't know/unsure	0.9	9.7	14.9	3.9	13.7	7.8
Extended family						
Trust	20.3	13.5	13.0	10.8	6.7	3.2
Not trust	76.1	56.0	62.4	73.6	60.4	61.9
Irrelevant	2.1	14.6	12.1	5.2	9.6	11.7
Don't know/unsure	1.5	15.9	12.5	10.4	23.3	23.2
Trust in less personal potential sources of family planning advice						
Religious leaders						
Trust	32.7	21.1	14.9	16.7	12.4	6.4
Not trust	57.9	52.9	63.7	68.8	50.3	48.9
Irrelevant	1.4	8.9	10.7	1.7	16.1	7.2
Don't know/unsure	8.0	17.1	10.7	12.8	21.2	37.6
Employers						
Trust	2.2	1.5	1.6	3.4	0.0	0.0
Not trust	27.2	34.0	35.3	20.4	45.6	29.7
Irrelevant	68.8	57.6	56.8	70.9	39.5	53.3
Don't know/unsure	1.8	6.9	6.2	5.3	14.9	17.0

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Coworkers						
Trust	2.3	5.7	12.5	1.1	16.3	3.7
Not trust	16.7	27.2	26.0	20.9	34.6	29.9
Irrelevant	79.6	61.5	57.6	72.4	34.9	56.2
Don't know/unsure	1.3	5.5	4.0	5.6	14.3	10.3
Doctors						
Trust	84.2	78.8	88.0	77.9	84.2	76.4
Not trust	14.9	8.6	6.3	16.8	6.9	1.6
Irrelevant	0.0	0.0	0.0	2.4	1.4	0.0
Don't know/unsure	0.9	12.6	5.7	2.9	7.5	22.0
Nurses						
Trust	54.5	55.3	60.4	45.8	55.9	49.5
Not trust	44.6	25.9	29.6	46.0	19.6	23.0
Irrelevant	0.0	3.9	0.8	0.0	6.0	0.0
Don't know/unsure	0.9	15.1	9.3	8.2	18.5	27.5
Midwives						
Trust	55.0	56.9	64.2	23.4	51.7	42.4
Not trust	42.5	24.3	26.4	64.2	17.6	23.2
Irrelevant	0.3	3.5	0.7	0.2	5.6	0.0
Don't know/unsure	2.3	15.3	8.7	12.3	25.1	34.4
Health station workers						
Trust	43.7	44.0	44.8	37.1	43.9	26.1
Not trust	46.7	31.8	42.8	52.3	37.8	44.2
Irrelevant	8.7	3.8	3.0	0.5	2.5	1.6
Don't know/unsure	0.9	20.4	9.4	10.2	15.9	28.1
Pharmacists						
Trust	46.4	44.0	44.8	37.1	43.9	26.1
Not trust	49.3	31.8	42.8	52.3	37.8	44.2
Irrelevant	0.0	3.8	3.0	0.5	2.5	1.6
Don't know/unsure	4.3	20.4	9.4	10.2	15.9	28.1
Pharmacy employees other than pharmacists						
Trust	12.1	25.8	18.4	13.3	13.6	21.2
Not trust	86.9	52.4	73.0	78.5	68.3	54.0
Irrelevant	0.0	6.1	3.6	0.8	5.0	0.0
Don't know/unsure	1.0	15.8	5.1	7.5	13.1	24.8

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
An older person						
Trust	72.3	46.2	42.3	50.9	28.2	29.2
Not trust	25.4	37.0	41.0	32.2	47.6	47.6
Irrelevant	1.5	4.6	7.7	0.5	9.1	4.0
Don't know/unsure	0.8	12.2	9.0	16.4	15.2	19.2
School system/educators						
Trust	15.3	13.6	12.9	24.5	6.1	6.8
Not trust	80.0	60.8	65.4	64.8	56.2	66.8
Irrelevant	4.6	13.9	11.1	3.1	18.5	6.4
Don't know/unsure	0.0	11.8	10.7	7.6	19.2	20.0
News report on TV						
Trust	24.9	19.3	17.6	23.4	5.9	17.9
Not trust	73.4	61.2	65.9	63.5	59.6	60.3
Irrelevant	0.3	5.6	3.7	1.2	7.9	4.0
Don't know/unsure	1.4	14.0	12.8	11.9	26.6	17.9
Government agencies/workers						
Trust	14.7	8.6	1.1	4.1	2.9	3.9
Not trust	78.5	66.5	75.8	80.8	63.8	68.2
Irrelevant	5.8	8.7	10.8	1.7	9.1	5.6
Don't know/unsure	1.0	16.3	12.3	13.5	24.2	22.3
Product advertisements						
Trust	12.7	4.1	6.7	7.3	0.0	4.8
Not trust	84.5	81.2	76.7	80.5	71.0	76.4
Irrelevant	2.3	3.9	6.7	2.5	5.9	4.0
Don't know/unsure	0.5	10.9	9.9	9.7	23.2	14.8
Internet websites						
Trust	1.2	3.9	5.8	3.0	2.9	10.5
Not trust	70.5	54.2	59.8	49.2	49.8	56.8
Irrelevant	28.3	26.6	24.2	31.6	22.1	4.0
Don't know/unsure	0.0	15.4	10.2	16.2	25.3	28.7
Articles in magazines or newspapers						
Trust	0.5	5.3	9.7	5.0	1.7	10.8
Not trust	83.3	58.5	57.8	58.2	60.4	59.6
Irrelevant	15.8	17.3	19.0	16.5	15.9	4.8
Don't know/unsure	0.4	19.0	13.5	20.4	22.0	24.8

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Someone who already uses FP						
Trust	52.6	47.6	51.7	31.6	37.2	44.8
Not trust	33.8	27.6	27.3	27.8	32.3	26.4
Irrelevant	8.0	11.8	11.0	11.8	14.7	3.1
Don't know/unsure	5.5	13.1	10.1	28.7	15.9	25.7
Who is most responsible for family planning decisions in a married couple						
Mainly the woman's decision	3.5	11.6	4.7	2.4	4.3	1.5
Mainly the husband's decision	11.5	6.6	11.6	15.1	4.2	3.2
Joint decision	77.8	78.7	79.0	73.9	73.7	78.2
Unsure	7.3	1.7	4.1	8.1	10.8	9.6
Refusal	0.0	1.4	0.6	0.5	7.0	7.6
Who is responsible for family planning decisions in a sexually active, unmarried couple in a committed relationship						
Mainly the woman's decision	25.1	20.7	20.5	15.5	9.8	9.4
Mainly the husband's decision	29.5	17.1	29.6	32.4	12.3	14.2
Joint decision	32.9	47.7	34.8	24.7	43.9	34.9
Unsure	12.2	10.1	9.0	25.2	24.9	29.2
Refusal	0.5	4.5	6.2	2.1	9.2	12.3
Who is responsible for family planning decisions in a sexually active, unmarried couple not in a committed relationship						
Mainly the woman's decision	29.1	20.1	18.1	25.2	13.8	9.5
Mainly the husband's decision	28.7	22.5	35.0	26.4	8.7	20.5
Joint decision	31.1	42.5	29.5	17.5	37.4	28.6
Unsure	10.6	9.8	10.7	28.3	30.9	29.2
Refusal	0.5	5.1	6.7	2.6	9.2	12.3
Attitudes toward marriage and sexuality						
It's normal for women to get married at an earlier age than men						
Strongly disagree	0.2	1.2	3.6	1.4	2.2	3.2
Disagree	2.2	8.5	9.8	7.3	9.3	2.9
Neither agree nor disagree	14.5	11.2	4.4	11.6	19.1	13.9

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Agree	54.0	49.4	59.1	48.1	44.3	58.7
Strongly agree	25.7	28.2	22.7	26.4	20.9	16.5
Don't know/NA	3.6	1.5	0.6	5.2	4.2	4.8
A woman should pursue her career before having children						
Strongly disagree	0.5	1.4	0.0	0.3	0.6	0.0
Disagree	6.7	8.2	11.5	8.3	12.6	7.9
Neither agree nor disagree	31.9	22.7	17.9	27.0	23.0	25.9
Agree	32.6	45.5	36.1	44.4	45.2	32.0
Strongly agree	23.6	19.7	32.8	15.0	13.4	24.7
Don't know/NA	4.6	2.5	1.7	5.1	5.3	9.6
Today's TV encourages premarital sex						
Strongly disagree	2.0	6.8	7.0	3.3	6.1	7.2
Disagree	18.4	17.0	13.2	23.9	12.8	26.1
Neither agree nor disagree	9.8	21.5	11.9	10.9	12.1	13.4
Agree	29.4	29.6	23.4	26.1	32.5	12.6
Strongly agree	31.4	16.7	33.2	25.2	17.8	18.1
Don't know/NA	9.0	8.4	11.4	10.7	18.7	22.6
Sex education in school encourages premarital sex						
Strongly disagree	4.0	9.4	8.2	7.5	5.1	5.6
Disagree	19.0	25.2	20.2	26.4	22.8	31.1
Neither agree nor disagree	11.5	12.0	12.9	10.4	16.8	9.8
Agree	13.5	27.5	13.1	12.8	13.8	13.3
Strongly agree	36.2	18.2	35.6	33.8	20.2	25.2
Don't know/NA	15.8	7.7	9.9	9.1	21.3	15.0
It is considered shameful if a woman gets pregnant when she is not married						
Strongly disagree	0.0	5.3	2.9	0.2	3.8	0.0
Disagree	1.2	4.6	4.4	7.9	10.2	1.6
Neither agree nor disagree	5.3	4.2	3.7	2.8	2.0	6.3
Agree	31.6	33.9	27.1	23.9	16.2	20.7
Strongly agree	59.4	51.4	61.9	63.9	61.7	66.4
Don't know/NA	2.6	0.7	0.0	1.2	6.0	5.0

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
My religion frowns upon pregnancy outside of marriage						
Strongly disagree	0.0	0.7	1.9	0.0	0.6	0.0
Disagree	0.0	1.6	1.1	5.7	5.6	5.6
Neither agree nor disagree	6.3	10.7	5.8	1.0	5.4	1.6
Agree	46.4	43.7	33.3	39.7	28.0	37.5
Strongly agree	44.2	42.6	56.3	51.5	56.9	51.2
Don't know/NA	3.1	0.6	1.7	2.1	3.6	4.0
The more children a married couple has, the happier their marital relationship will be						
Strongly disagree	4.7	4.1	4.3	3.3	2.6	10.3
Disagree	23.1	21.6	22.8	29.1	16.5	19.7
Neither agree nor disagree	14.7	23.4	22.3	29.8	25.3	14.7
Agree	43.0	29.5	26.7	18.5	17.3	19.0
Strongly agree	9.7	13.6	18.8	6.3	12.8	15.9
Don't know/NA	4.9	7.7	5.1	13.0	25.4	20.4
To ensure healthy children, women should stop childbearing by the age of 35						
Strongly disagree	2.7	2.9	7.2	0.1	5.3	0.0
Disagree	21.3	19.3	13.7	13.6	17.7	12.6
Neither agree nor disagree	28.1	21.8	31.6	31.6	17.1	12.6
Agree	34.4	27.9	25.8	24.6	26.8	20.2
Strongly agree	5.2	11.4	11.5	4.7	4.9	16.1
Don't know/NA	8.3	16.7	10.3	25.3	28.1	37.8
A married couple should have their first child within one year after marriage	.					
Strongly disagree	0.7	1.3	1.1	1.4	6.1	3.2
Disagree	3.9	7.1	5.6	8.6	5.0	11.8
Neither agree nor disagree	26.2	16.9	29.9	11.3	25.6	16.3
Agree	48.4	52.7	43.6	44.2	32.7	23.6
Strongly agree	15.5	15.1	14.0	10.6	11.3	25.6
Don't know/NA	5.2	6.9	5.9	23.8	19.4	19.6

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Attitudes toward family planning and abortion						
It is wise to learn about family planning before you become sexually active						
Strongly disagree	4.2	1.7	0.0	0.0	0.0	0.0
Disagree	3.5	7.2	4.7	1.8	0.7	0.0
Neither agree nor disagree	11.2	14.7	9.4	9.7	12.7	7.2
Agree	62.6	53.9	57.8	59.5	52.8	71.5
Strongly agree	13.8	22.0	27.0	23.2	22.9	16.5
Don't know/NA	4.7	0.5	1.1	5.8	11.0	4.8
Family planning is beneficial to the health of the woman						
Strongly disagree	0.0	2.7	0.0	4.4	0.0	0.0
Disagree	9.5	10.8	5.9	6.6	2.0	11.9
Neither agree nor disagree	17.8	12.8	17.1	6.9	28.0	15.2
Agree	40.6	50.1	42.7	48.0	45.0	45.9
Strongly agree	23.5	20.2	28.6	18.0	11.5	12.7
Don't know/NA	8.6	3.4	5.8	16.1	13.6	14.3
Family planning decreases the financial burden on a family						
Strongly disagree	0.0	0.2	0.0	0.1	0.0	0.0
Disagree	5.8	10.0	7.2	5.6	8.2	4.8
Neither agree nor disagree	18.3	21.3	21.6	21.5	26.2	31.8
Agree	44.0	45.1	38.8	33.6	31.5	35.8
Strongly agree	26.6	17.6	20.8	21.6	9.1	10.3
Don't know/NA	5.3	5.8	11.6	17.6	25.1	17.3
There is no need to worry about family planning until you have had your first child						
Strongly disagree	0.2	0.3	0.8	0.5	0.0	0.0
Disagree	0.7	5.4	2.3	3.0	5.1	5.6
Neither agree nor disagree	2.0	5.8	10.9	5.1	9.2	7.2
Agree	34.7	42.5	31.5	35.4	40.9	39.8
Strongly agree	61.3	44.8	52.1	54.6	38.6	34.9
Don't know/NA	1.2	1.3	2.4	1.4	6.3	12.6

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Couples should listen to religious leaders regarding family planning						
Strongly disagree	1.8	2.0	1.9	0.0	0.6	3.0
Disagree	12.7	14.3	19.8	12.5	10.3	14.2
Neither agree nor disagree	27.1	35.6	25.2	28.1	38.2	45.2
Agree	21.3	27.2	19.5	17.5	24.7	9.3
Strongly agree	34.1	12.2	17.0	24.7	9.2	11.9
Don't know/NA	3.1	8.7	16.6	17.3	17.1	16.4
A woman should consult her partner when deciding to use family planning						
Strongly disagree	0.5	0.0	1.1	1.3	1.4	1.6
Disagree	2.5	3.2	0.9	5.1	7.3	0.8
Neither agree nor disagree	5.2	9.4	5.4	1.9	9.0	3.2
Agree	44.7	43.7	37.9	44.6	44.2	54.3
Strongly agree	45.9	43.2	51.7	45.2	28.9	36.2
Don't know/NA	1.2	0.6	3.1	1.9	9.2	3.9
I feel embarrassed to ask my health care provider questions about family planning						
Strongly disagree	1.4	4.6	10.7	0.3	5.0	5.6
Disagree	14.7	36.5	43.3	10.8	16.1	17.1
Neither agree nor disagree	29.2	26.2	20.6	22.3	17.6	13.6
Agree	13.8	22.4	18.8	35.5	29.4	39.7
Strongly agree	35.8	8.3	4.9	21.5	14.1	8.5
Don't know/NA	5.2	2.0	1.7	9.5	17.8	15.6
Men do not want to use family planning methods because it might interfere with their sexual pleasure						
Strongly disagree	1.7	1.8	0.0	0.5	0.7	0.0
Disagree	2.3	7.6	12.9	2.3	0.0	4.8
Neither agree nor disagree	8.3	12.7	13.5	2.1	12.3	4.8
Agree	26.4	40.1	39.9	28.4	13.2	6.3
Strongly agree	45.3	19.6	23.5	20.1	5.0	11.9
Don't know/NA	16.0	18.2	10.2	46.7	68.8	72.2

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
I am confident that my health care provider can answer any questions that I have about family planning						
Strongly disagree	0.4	1.0	1.6	1.0	0.0	0.0
Disagree	0.1	3.3	3.0	0.8	4.9	5.3
Neither agree nor disagree	14.8	22.2	17.4	15.0	12.8	16.7
Agree	44.4	56.5	47.8	42.0	54.6	49.5
Strongly agree	34.1	13.4	27.0	32.2	6.6	8.8
Don't know/NA	5.5	3.7	3.3	9.0	21.2	19.7
The number of children you will have should be left up to God						
Strongly disagree	0.0	1.8	1.6	0.0	0.0	2.4
Disagree	1.5	3.4	3.0	5.7	2.0	1.6
Neither agree nor disagree	6.9	7.8	7.1	3.9	5.9	4.8
Agree	26.6	25.7	27.8	28.8	32.6	29.6
Strongly agree	63.7	59.3	59.9	58.5	55.2	56.0
Don't know/NA	1.2	2.1	0.6	3.1	4.3	5.6
If I decide to use a family planning method, my husband will support my decision						
Strongly disagree	1.2	4.9	0.0	0.0	3.6	0.8
Disagree	6.5	6.8	3.7	0.1	5.8	3.2
Neither agree nor disagree	8.0	12.6	11.9	2.6	5.3	3.9
Agree	39.5	39.3	37.9	24.3	10.8	11.8
Strongly agree	29.2	19.9	35.0	19.2	2.9	6.4
Don't know/NA	15.6	16.5	11.5	53.7	71.6	74.0
Employers should provide access to family planning information and products in the workplace						
Strongly disagree	2.0	5.2	4.8	0.1	0.6	0.8
Disagree	2.7	12.8	5.2	3.9	8.1	3.1
Neither agree nor disagree	20.9	16.7	18.2	15.4	18.6	9.3
Agree	33.4	24.2	25.0	29.0	15.2	11.1
Strongly agree	19.6	10.1	13.9	13.4	6.0	12.0
Don't know/NA	21.3	31.2	32.9	38.1	51.6	63.8

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
It is against my religion to use family planning methods						
Strongly disagree	1.4	3.3	3.2	0.9	0.0	3.2
Disagree	8.2	19.0	35.6	11.4	14.2	17.3
Neither agree nor disagree	29.7	24.8	20.9	18.2	23.0	33.0
Agree	30.5	27.4	16.5	29.2	18.2	13.3
Strongly agree	22.7	12.5	9.2	15.3	9.7	6.2
Don't know/NA	7.6	13.0	14.6	25.1	35.0	27.0
Having to get a prescription for oral contraceptives is a barrier to using that method						
Strongly disagree	0.0	1.4	1.2	0.0	0.7	0.0
Disagree	5.5	12.8	10.8	0.8	11.6	4.0
Neither agree nor disagree	21.8	14.7	15.3	9.1	9.1	10.7
Agree	29.1	27.1	19.4	16.8	9.1	18.3
Strongly agree	25.2	8.7	14.8	16.9	8.6	2.4
Don't know/NA	18.3	35.3	38.6	56.3	61.0	64.7
A woman should consult her mother-in-law when deciding to use family planning						
Strongly disagree	3.1	6.4	9.8	0.9	5.0	3.7
Disagree	13.7	12.9	17.8	11.7	8.3	9.5
Neither agree nor disagree	3.0	21.5	23.1	12.7	18.2	19.1
Agree	39.3	36.6	26.8	36.9	27.3	14.2
Strongly agree	33.7	11.1	11.5	18.4	0.9	4.8
Don't know/NA	7.3	11.6	11.1	19.4	40.2	48.8
It is difficult to get an IUCD because only doctors can insert it						
Strongly disagree	0.0	0.8	1.1	0.1	1.4	0.0
Disagree	2.7	5.1	0.0	0.0	3.1	2.4
Neither agree nor disagree	4.0	8.4	3.7	1.4	9.0	3.2
Agree	28.0	38.1	38.6	28.9	33.0	28.6
Strongly agree	45.2	33.0	53.4	25.4	23.6	33.6
Don't know/NA	20.2	14.5	3.3	44.2	30.0	32.3

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
If I decide to use a family planning method, my mother-in-law will support my decision						
Strongly disagree	1.1	3.8	0.6	0.5	5.2	0.0
Disagree	4.6	9.8	4.2	0.1	7.3	0.0
Neither agree nor disagree	6.3	16.1	21.9	2.1	9.3	6.2
Agree	32.9	27.5	26.3	16.9	9.4	4.0
Strongly agree	28.3	13.6	10.7	15.9	5.6	6.4
Don't know/NA	26.8	29.2	36.3	64.4	63.1	83.4
I feel embarrassed to ask for family planning methods at the pharmacy						
Strongly disagree	0.3	6.3	6.8	1.0	0.7	1.5
Disagree	13.9	22.8	31.8	3.6	11.0	16.4
Neither agree nor disagree	26.1	15.1	23.9	19.1	23.4	15.7
Agree	27.3	35.7	17.1	23.2	30.4	24.0
Strongly agree	23.3	13.6	16.8	25.8	6.7	16.8
Don't know/NA	9.1	6.4	3.6	27.3	27.8	25.7
It is easier to obtain an abortion than to get a family planning method						
Strongly disagree	17.8	8.3	17.4	1.7	3.6	2.4
Disagree	17.1	35.7	39.6	22.0	29.1	33.7
Neither agree nor disagree	4.6	9.8	3.2	7.4	9.6	7.0
Agree	16.4	22.7	11.6	0.8	3.8	7.9
Strongly agree	27.5	11.6	17.4	21.9	4.9	5.6
Don't know/NA	16.6	11.9	10.8	46.2	49.1	43.4
Abortion poses significant health risks for women						
Strongly disagree	1.0	0.8	0.6	0.0	0.0	0.8
Disagree	2.7	4.5	0.0	1.3	1.3	0.0
Neither agree nor disagree	4.8	10.6	2.8	6.2	3.3	5.6
Agree	22.3	37.4	45.0	39.7	41.6	42.8
Strongly agree	65.3	45.3	48.4	35.0	16.7	35.9
Don't know/NA	3.9	1.5	3.2	17.8	37.1	14.9

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Receiving an abortion can cause psychological harm to women						
Strongly disagree	0.3	0.8	0.6	0.1	0.0	0.8
Disagree	3.2	4.2	1.2	1.0	1.9	0.0
Neither agree nor disagree	9.0	10.7	3.7	4.3	8.4	7.1
Agree	15.7	40.0	38.0	32.6	39.5	44.3
Strongly agree	61.8	41.9	51.6	43.6	16.7	21.4
Don't know/NA	10.1	2.5	4.9	18.3	33.7	26.4
It's important for a health care provider to discuss FP methods with a woman who has just received an abortion						
Strongly disagree	0.0	0.5	0.0	0.0	0.0	0.0
Disagree	6.7	1.9	0.0	0.7	3.7	1.6
Neither agree nor disagree	7.8	12.8	14.7	11.7	8.8	3.2
Agree	29.5	53.8	40.9	35.1	40.5	36.5
Strongly agree	50.1	24.3	35.5	21.0	15.7	27.8
Don't know/NA	6.0	6.7	8.9	31.6	31.2	30.9
Using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion						
Strongly disagree	0.7	1.7	0.5	1.5	2.2	0.0
Disagree	6.7	9.9	8.8	3.0	4.8	0.0
Neither agree nor disagree	12.5	15.0	21.7	5.2	12.8	7.0
Agree	23.3	30.5	25.2	10.8	12.0	14.1
Strongly agree	26.3	11.0	14.9	15.9	2.8	0.8
Don't know/NA	30.5	32.0	28.8	63.5	65.4	78.1
It is less expensive to get an abortion when needed, as opposed to paying regularly for a family planning method						
Strongly disagree	0.0	3.3	4.9	2.6	2.4	0.0
Disagree	8.1	25.5	29.6	8.0	9.5	6.4
Neither agree nor disagree	21.9	14.1	14.8	5.3	13.3	3.1
Agree	26.1	22.2	21.3	1.9	8.0	11.2
Strongly agree	23.9	6.5	12.6	25.8	0.9	3.2
Don't know/NA	20.0	28.4	17.0	56.4	65.9	76.2

[1] Type of television programming watched was only reported for those who responded that they did watch television.

[2] Type of radio programming was only reported for those who responded that they did listen to the radio.

[3] Internet access locations were only reported for those who responded that they did use the Internet.

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
The decision to have an abortion should be made jointly by a woman and her partner						
Strongly disagree	0.0	0.1	1.1	0.0	1.4	0.8
Disagree	2.2	5.2	1.1	1.3	3.3	4.0
Neither agree nor disagree	4.6	10.3	2.7	0.6	8.2	6.9
Agree	56.0	43.7	46.6	39.5	39.0	33.7
Strongly agree	34.4	39.3	45.1	42.2	32.7	39.5
Don't know/NA	2.9	1.3	3.6	16.4	15.3	15.1
Abortion is a method of family planning						
Strongly disagree	7.7	10.5	22.9	3.8	11.6	7.2
Disagree	6.9	15.7	18.4	4.6	14.8	19.2
Neither agree nor disagree	6.7	22.5	8.8	9.4	11.2	10.2
Agree	46.9	27.7	28.1	21.2	11.4	21.7
Strongly agree	18.9	8.8	8.1	16.8	4.2	1.8
Don't know/NA	13.0	14.8	13.7	44.4	46.9	40.0

TABLE A12. WOMEN AND HOUSEHOLD DECISION-MAKING

	Rural Conservatives %	Aware Ambivalents %	Prudent Urbanites %	Coming-of-Age Traditionalists %	Young Uncertain Urbanites %	High-tech Progressives %
Household decision-making of married/in-union women						
Who usually decides how the money that you earn will be used?						
Respondent	6.6	14.5	18.4	0.0	N/A	N/A
Husband/partner	19.2	14.0	17.5	0.0	N/A	N/A
Jointly	36.7	47.3	48.4	0.0	N/A	N/A
I don't earn money	28.4	23.8	15.1	0.0	N/A	N/A
Someone else	7.7	0.0	0.6	100.0	N/A	N/A
Don't know/NA	1.5	0.5	0.0	0.0	N/A	N/A
Who usually decides how your husband's/partner's earning will be used						
Respondent	7.2	7.5	8.4	0.0	N/A	N/A
Husband/partner	36.7	26.8	30.7	0.0	N/A	N/A
Jointly	43.7	62.0	60.2	0.0	N/A	N/A
Husband/partner has	1.9	2.8	0.0	0.0	N/A	N/A
Someone else	9.0	0.4	0.6	100.0	N/A	N/A
Don't know/NA	1.5	0.5	0.0	0.0	N/A	N/A
Who usually makes decisions about health care for yourself?						
Respondent	9.8	15.3	15.2	0.0	N/A	N/A
Husband/partner	21.9	13.6	14.3	0.0	N/A	N/A
Jointly	63.3	70.1	68.6	0.0	N/A	N/A
Someone else	3.5	0.5	2.0	100.0	N/A	N/A
Don't know/NA	1.5	0.5	0.0	0.0	N/A	N/A
Who usually makes decisions about making major household purchases?						
Respondent	7.9	9.7	14.7	0.0	N/A	N/A
Husband/partner	34.4	24.8	11.6	0.0	N/A	N/A
Jointly	50.9	62.9	71.4	0.0	N/A	N/A
Someone else	5.4	2.1	2.4	100.0	N/A	N/A
Don't know/NA	1.5	0.5	0.0	0.0	N/A	N/A
Who usually makes decisions about making daily household purchases?						
Respondent	10.3	30.9	31.3	0.0	N/A	N/A
Husband/partner	35.1	22.0	14.5	0.0	N/A	N/A
Jointly	47.3	42.6	53.0	0.0	N/A	N/A
Someone else	5.8	3.8	1.2	100.0	N/A	N/A
Don't know/NA	1.5	0.7	0.0	0.0	N/A	N/A

ANNEX C. SEGMENTATION PROFILES: MEN

TABLE A13. MEN'S DEMOGRAPHIC CHARACTERISTICS

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Mean Age	23.5	33.6	31.7	30.8
Median Age	21.0	34.0	29.0	28.0
Age Group				
18-24	57.1	16.0	27.2	21.7
25-34	35.5	44.3	35.2	38.5
35-49	7.4	39.7	37.6	39.8
Education Level				
Basic secondary	4.4	3.6	4.9	0.6
Complete secondary	72.3	72.5	61.9	48.1
Technicum	10.2	9.9	7.1	4.8
Higher	12.8	11.9	25.6	46.5
Refused to answer	0.3	2.1	0.6	0.0
Marital Status				
Married/In union	7.8	85.2	68.5	72.0
Separated	0.0	0.1	0.5	0.4
Single/not married	92.2	14.7	30.9	27.6
Wealth status				
Poorest	20.0	34.0	0.0	0.0
Second	15.8	36.7	0.0	0.0
Middle	27.2	29.3	0.0	0.0
Fourth	13.2	0.0	100.0	0.0
Richest	23.8	0.0	0.0	100.0
Location				
Rural	41.6	70.7	1.0	0.0
Urban	58.4	29.3	99.0	100.0

TABLE A14. MEN'S FERTILITY DESIRES AND FAMILY PLANNING

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Number of live children				
None	99.4	41.9	45.1	42.8
1 - 2	0.6	43.4	41.2	49.9
3 or more	0.0	14.7	13.7	7.3
Future fertility desire				
No more children desired	13.6	36.2	36.5	32.2
Wants child later (2+ years)	21.3	7.4	12.8	22.3
Wants child sooner (<2 years)	8.5	26.5	16.8	11.8
Unsure if wants children	8.3	7.7	14.6	9.5
Wants children, unsure when	48.4	21.1	17.8	21.0
Cannot get pregnant	0.0	1.2	1.5	3.3
Ever had sex				
Yes	8.3	100.0	100.0	100.0
No	91.7	0.0	0.0	0.0
Ever use of FP method, by method[1]				
Modern method	0.5	31.7	32.8	42.0
Traditional method	0.0	27.3	43.7	46.4
Any method	0.5	39.9	55.3	63.5
Ever used FP method, by method[1]				
Pill	0.0	1.1	2.2	1.7
Calendar	0.0	3.1	3.5	3.5
Male condom	0.5	29.3	28.7	39.3
IUCD	0.0	4.2	5.5	4.4
Withdrawal	0.0	26.6	43.4	44.8
Number of abortions wife/partner had				
None	100.0	90.5	87.9	91.6
1 - 2	0.0	8.8	9.8	5.2
3 - 4	0.0	0.4	0.8	2.8
5 or more	0.0	0.3	1.6	0.4

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Mean number of abortions	0.0	0.7	0.9	0.8
Median number of abortions	0.0	0.0	0.0	0.0
Intention to use				
Yes	28.6	34.3	42.0	48.7
No	28.7	38.5	30.0	36.6
Unsure	42.8	27.3	28.0	14.7
Intention to use FP method				
Have used and will use in future	0.0	24.1	29.0	33.0
Have used and will not use in future	0.5	7.5	14.5	19.8
Have used and unsure if will use in future	0.0	8.3	11.9	10.7
Never used and will use in future	28.6	10.2	13.0	15.7
Never used and will not use in future	28.2	31.0	15.6	16.8
Never used and unsure if will use in future	42.8	19.0	16.1	4.0
Median age at first intercourse	N/A	20.0	18.0	18.0
Awareness of FP methods, by method				
Diaphragm	2.0	0.0	3.7	6.0
Ring	0.2	1.4	1.4	5.1
Implants	3.3	2.6	5.4	10.1
Injectable	3.4	1.0	7.3	12.5
IUCD	34.6	59.4	51.0	49.0
Ligation	27.9	9.6	17.1	20.0
Emergency Contraceptive	3.4	1.8	6.1	11.6
Male condom	90.0	93.1	96.8	97.6
Pill	55.4	75.2	57.5	67.6

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Spermicide	3.5	1.3	1.8	5.9
Vasectomy	25.0	5.1	7.6	15.6
Lactational Amenorrhea	1.1	2.8	4.8	4.3
BBT	3.4	13.8	8.3	8.7
Calendar	2.7	6.2	16.2	10.5
Mucus, Billings, Ovulation	2.2	1.5	2.1	2.9
Standard Days Method	3.0	19.1	9.0	7.0
Symptothermal	0.9	0.6	0.7	0.4
Withdrawal	74.6	80.4	86.8	84.5
Overall, which method do you think will be the best for you?[2]				
IUCD	9.4	38.5	3.8	4.0
Male Condom	35.8	6.3	17.6	22.2
Pills	15.1	1.6	5.0	3.6
Ring	0.6	0.0	0.0	0.0
Calendar/Rhythm	0.0	2.7	4.1	3.8
Standard Days	0.5	3.5	0.8	0.0
Withdrawal	24.0	23.0	51.9	57.6
By help of doctor	0.0	0.0	2.7	0.0
Other	5.1	1.8	0.0	5.0
Refused to answer	9.5	22.6	14.1	3.9

1 Ever use of FP method is limited to current non-users who report a history of sexual intercourse

2 Best FP method applies to married men who intend to use in the future

TABLE A15. MEN'S LIFESTYLES AND VALUES

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Attitudes towards health sector				
Midwives provide good quality medical service				
Strongly disagree	1.6	3.5	8.7	3.6
Disagree	12.7	30.0	20.7	14.2
Neither agree nor disagree	19.3	20.0	23.4	15.3
Agree	44.9	44.7	32.9	46.2
Strongly agree	21.6	1.8	14.3	20.7
Cost of private medical services prevents me from seeking care when I need it				
Strongly disagree	0.2	0.2	2.9	2.8
Disagree	10.9	4.5	15.0	17.0
Neither agree nor disagree	21.6	38.0	13.8	11.2
Agree	42.1	35.8	33.9	39.3
Strongly agree	25.3	21.5	34.5	29.7
When I go to medical facility, I usually have to wait before seeing a health professional				
Strongly disagree	3.5	1.8	5.8	4.8
Disagree	12.6	11.7	18.7	20.1
Neither agree nor disagree	30.9	26.4	18.9	24.6
Agree	46.9	45.8	48.3	43.7
Strongly agree	6.1	14.3	8.4	6.9
Doctors provide good quality medical service				
Strongly disagree	12.2	5.9	14.5	9.0
Disagree	13.6	14.2	19.6	15.5
Neither agree nor disagree	22.7	35.8	16.7	26.7
Agree	34.7	36.8	36.4	38.5
Strongly agree	16.9	7.4	12.9	10.3
When sick, I cannot afford to purchase all the drugs that I need				
Strongly disagree	0.6	0.7	4.3	2.5
Disagree	17.4	11.6	21.3	26.9
Neither agree nor disagree	25.8	35.0	29.4	23.5
Agree	43.5	42.6	36.6	38.4
Strongly agree	12.7	10.1	8.3	8.6

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
People have to travel a long way to see a health care provider				
Strongly disagree	12.3	6.0	18.0	24.9
Disagree	35.6	33.4	32.0	42.7
Neither agree nor disagree	23.6	25.2	18.9	15.8
Agree	19.1	22.5	27.5	11.9
Strongly agree	9.4	12.9	3.6	4.7
When sick, I prefer to use traditional methods to treat my illness				
Strongly disagree	5.7	4.0	8.6	5.7
Disagree	22.8	22.3	14.4	14.1
Neither agree nor disagree	34.4	38.8	23.3	14.7
Agree	22.7	25.3	30.6	37.2
Strongly agree	14.4	9.6	23.1	28.3
My health care provider always spends enough time taking care of me when I visit				
Strongly disagree	2.3	3.7	2.1	3.5
Disagree	7.3	10.2	12.3	9.9
Neither agree nor disagree	23.5	30.7	24.8	19.4
Agree	53.5	47.9	47.7	54.7
Strongly agree	13.4	7.5	13.1	12.5
When sick, I usually go straight to the pharmacy to get the drugs that I need				
Strongly disagree	2.7	0.1	3.4	3.9
Disagree	9.1	19.4	24.5	20.9
Neither agree nor disagree	27.7	40.3	19.6	24.9
Agree	51.1	29.2	42.6	38.1
Strongly agree	9.5	10.9	10.2	12.3
People often wait until they have a serious health problem before seeking care				
Strongly disagree	1.6	0.0	1.8	0.7
Disagree	5.9	3.6	5.5	3.9
Neither agree nor disagree	8.5	23.4	10.1	10.2
Agree	35.7	39.3	34.4	31.6
Strongly agree	48.4	33.7	48.2	53.7

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
My health care provider always explains things about my health in a way I can understand				
Strongly disagree	2.9	0.0	6.4	0.6
Disagree	3.7	3.9	7.4	5.0
either agree nor disagree	25.6	35.4	11.9	12.0
Agree	62.7	52.5	52.6	55.1
Strongly agree	5.1	8.2	21.7	27.3
It is difficult to find a qualified doctor				
Strongly disagree	6.6	9.5	10.2	14.5
Disagree	21.9	22.3	11.1	11.2
Neither agree nor disagree	22.2	21.2	14.2	16.4
Agree	23.8	26.6	38.6	33.7
Strongly agree	25.6	20.4	25.9	24.3
My health care provider always listens to me if I have a question about my health				
Strongly disagree	0.5	1.1	0.8	1.0
Disagree	6.9	4.2	7.0	6.8
Neither agree nor disagree	28.5	35.8	24.9	14.3
Agree	57.9	49.9	54.8	63.4
Strongly agree	6.3	9.2	12.6	14.6
Importance of family planning method attributes				
Safety (associated health risk to the woman)				
Not at all important	0.0	1.0	0.0	0.0
Not very important	0.0	3.8	0.7	1.1
Neither important nor unimportant	0.0	3.7	6.5	1.3
Important	56.5	44.5	33.0	39.6
Very important	43.4	47.0	59.9	58.1
Effectiveness at preventing pregnancy				
Not at all important	0.0	3.7	0.0	0.0
Not very important	0.0	4.0	6.5	1.4
Neither important nor unimportant	0.0	6.2	6.9	1.2
Important	56.5	42.2	44.9	60.4

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Very important	43.5	43.9	41.8	37.0
Affordability				
Not at all important	0.0	3.1	3.9	4.0
Not very important	0.0	2.9	5.8	7.9
Neither important nor unimportant	56.5	24.3	16.0	25.5
Important	0.0	35.1	55.8	44.9
Very important	43.5	34.6	18.4	21.3
Convenience to get/purchase				
Not at all important	0.0	1.8	1.1	2.0
Not very important	0.0	6.1	9.5	9.2
Neither important nor unimportant	0.0	16.3	16.1	21.6
Important	100.0	36.8	53.9	45.9
Very important	0.0	38.9	19.5	21.4
Interference with the woman's sexual pleasure				
Not at all important	0.0	9.4	9.3	1.7
Not very important	0.0	10.6	4.6	13.7
Neither important nor unimportant	0.0	13.2	17.7	23.6
Important	56.5	32.3	43.3	31.0
Very important	43.5	34.5	25.1	30.0
Interference with the man's sexual pleasure				
Not at all important	0.0	0.1	8.0	0.4
Not very important	0.0	2.8	3.3	9.9
Neither important nor unimportant	100.0	12.2	15.6	21.4
Important	0.0	37.0	37.4	33.4
Very important	0.0	47.9	35.8	34.9
Don't know/NA				
Ease of use				
Not at all important	0.0	0.1	0.7	0.0
Not very important	0.0	4.6	2.0	3.3
Neither important nor unimportant	56.5	19.4	13.3	17.9
Important	43.5	40.3	51.0	50.6
Very important	0.0	35.5	33.0	28.3

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Accordance with personal/religious beliefs				
Not at all important	0.0	0.2	1.6	1.4
Not very important	0.0	9.5	6.9	2.0
Neither important nor unimportant	56.5	22.3	20.0	20.1
Important	0.0	26.1	34.0	32.2
Very important	43.5	41.9	37.6	44.3
Effectiveness at preventing STIs				
Not at all important	0.0	0.9	0.0	0.2
Not very important	0.0	2.5	1.6	0.4
Neither important nor unimportant	43.5	6.1	2.6	3.3
Important	56.5	35.5	31.4	37.9
Very important	0.0	55.0	64.4	58.2
Approval from people who are important to me				
Not at all important	0.0	5.7	4.6	5.6
Not very important	0.0	23.1	11.0	10.0
Neither important nor unimportant	56.5	23.2	18.9	21.9
Important	43.5	24.8	47.2	36.3
Very important	0.0	23.3	18.3	26.1

TABLE A16. MEN'S COMMUNICATION PRACTICES

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Mass media habits				
Watch Television	96.5	99.9	97.0	99.0
Time of day TV is most watched				
Morning (06:00-12:00)	0.0	0.5	0.0	0.8
Afternoon (12.00 – 18:00)	3.4	4.7	7.3	2.7
Evening (18:00 – 00:00)	86.4	88.0	89.2	92.5
Night (00:00 – 06:00)	10.2	6.5	3.5	4.1
Don't know/NA	0.0	0.3	0.0	0.0
Frequency of watching TV				
Everyday	75.5	90.5	84.3	68.5
Not everyday	24.5	9.5	15.7	31.5
Type of television programming watched[1]				
Business/Business World	15.0	6.3	13.2	19.9
Cartoon	4.7	0.3	4.9	8.4
Children/Youth programs	9.1	1.3	4.2	8.7
Comedy	36.6	37.9	52.5	41.8
Crime programs	69.2	63.2	52.9	43.3
Cooking show	2.2	0.7	3.9	2.4
Cultural programs	19.9	4.9	13.6	20.5
Documentaries	41.2	14.4	33.8	39.2
Drama/Play	3.8	5.2	10.1	8.8
Educational programs	20.8	4.6	16.4	38.6
Economic programs	31.0	13.1	34.7	40.4
Entertainment Talk Shows	34.8	28.1	34.5	26.2
Entertainment/Music/ Dance	33.1	22.2	37.4	28.4
Game shows	17.2	12.0	21.4	20.0
Medicine related programs	0.6	0.0	0.0	0.4
Movies	85.2	85.9	81.0	74.5
News	67.4	87.8	76.7	88.5
Reality shows	18.9	11.0	22.3	26.5
Religious program	6.2	3.1	7.1	13.4
Serials	32.5	41.5	30.0	23.3
Show business news/magazine				
programs	52.4	42.3	26.8	25.7
Social/Political Talk Shows	23.2	14.8	17.7	15.4

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Sport Magazines/Sport Competitions	35.3	34.5	54.8	54.2
Talent shows	17.5	15.4	23.0	19.1
Women's shows (non-cooking)	0.8	0.0	1.2	1.9
Type of TV channels watched				
None/Don't watch TV	3.5	0.1	3.0	1.0
ANS TV	89.6	94.7	83.7	82.7
ATV	80.9	86.1	71.3	68.2
AZTV	56.3	69.7	45.5	26.4
AZTV Sport	0.5	0.7	0.2	1.0
ITV (Public television)	74.3	70.1	49.9	36.3
Lider TV	58.0	65.6	46.7	40.8
Khazar TV	44.3	73.5	66.9	55.4
Space TV	53.0	67.7	42.2	31.2
Other Azerbaijani TV channels	24.7	23.6	17.9	17.3
Russian TV channels	14.6	2.8	18.9	36.8
Turkish TV channels	19.4	22.2	28.6	46.1
BBC	0.2	0.1	1.4	1.5
CNN	0.2	0.0	1.1	1.5
Other foreign TV channels	0.2	0.3	1.2	3.1
Other	0.0	0.7	0.0	0.0
Don't know/NA	0.7	0.2	1.1	0.7
Listen to the radio	24.2	20.2	33.7	34.7
Time of day radio most often listened to				
Morning (06:00-12:00)	8.8	13.2	6.0	2.8
Afternoon (12.00 – 18:00)	63.7	73.2	47.9	65.0
Evening (18:00 – 00:00)	12.4	13.7	24.8	21.5
Night (00:00 – 06:00)	15.1	0.0	20.3	6.4
Don't know/NA	0.0	0.0	1.0	4.3
Frequency of listening to radio				
Everyday	40.0	20.4	50.2	31.3
4 - 6 days	14.1	17.4	17.2	22.3
2 - 3 days	36.6	41.8	24.1	35.6
Once a week	8.0	13.0	4.7	9.8
2 - 3 times a month	1.4	7.5	0.0	0.0
Don't know/NA	0.0	0.0	3.9	1.1
Type of radio programming listened to[2]				

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Religious programs	0.6	1.7	0.0	2.2
Entertainment talk shows	6.4	4.3	9.1	8.5
Entertainment programs	14.6	13.2	17.3	16.0
Economic programs	9.8	3.4	2.1	14.9
Crime programs	19.8	3.4	4.2	10.3
Educational programs	9.9	4.6	3.1	13.7
Cultural programs	1.9	4.3	2.0	9.3
Various topics discussions	18.1	4.5	8.0	23.6
Music	96.4	100.0	96.8	89.8
Game programs	9.2	1.1	0.0	0.0
Women's programs	0.0	0.0	0.0	2.1
Political programs	10.1	2.2	2.1	14.8
Social/political talk shows	0.0	3.4	0.0	0.0
News	39.1	18.7	38.3	44.9
Type of radio stations listened to				
None/Don't listen to radio	68.7	72.4	63.5	63.7
ANS ChM	66.8	34.7	56.9	82.9
Antenne FM	42.3	10.2	29.1	32.0
Azad Azerbaijan 106.0 FM	51.0	12.9	32.0	50.0
Azad Azerbaijan 106.3 FM	53.9	78.0	46.3	56.3
Burch FM	34.5	38.8	54.0	43.4
Ictimai Radio (Public radio)	24.1	6.8	20.0	33.4
Radio Lider	7.3	5.7	11.8	26.5
Radio Space	12.3	8.8	26.2	31.8
Khazar radio	28.3	73.0	26.8	41.8
Other Azerbaijani radio	8.9	2.6	16.8	4.9
BBC	0.6	0.0	0.0	1.1
Internet Use	27.5	8.9	24.4	48.9
Location of internet access[3]				
Home	28.3	22.2	31.4	60.5
Work	10.4	8.2	23.8	23.1
Internet Café	40.3	22.5	34.3	12.9
School	1.3	0.0	3.3	0.0
Cell phone	19.8	45.9	5.7	3.5
Don't know/NA	0.0	1.2	1.5	0.0
Frequency of internet use				
Almost everyday	39.9	65.0	39.8	51.0

[1] Type of television programming watched was only reported for those who responded that they did watch television.

[2] Type of radio programming was only reported for those who responded that they did listen to the radio.

[3] Internet access locations were only reported for those who responded that they did use the Internet.

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
At least once a week	45.7	18.4	49.6	29.9
Less than once a week	14.4	16.6	10.5	19.2
Own a mobile phone	84.9	84.9	98.5	95.8
Trusted sources of family planning advice- family and friends				
Wife/partner				
Trust	14.1	82.1	74.3	62.0
Not trust	3.3	4.9	4.9	15.6
Irrelevant	82.7	13.0	20.8	22.4
Friends				
Trust	55.1	33.0	46.5	40.1
Not trust	44.1	65.2	50.1	56.8
Irrelevant	0.7	1.8	3.3	3.1
Mother				
Trust	68.6	65.8	58.8	54.4
Not trust	15.8	10.9	12.8	30.8
Irrelevant	15.6	23.3	28.4	14.8
Father				
Trust	74.6	65.7	49.6	45.7
Not trust	13.6	9.6	12.5	31.1
Irrelevant	11.8	24.7	37.9	23.2
Sister				
Trust	36.7	51.6	45.6	28.8
Not trust	12.7	20.0	18.9	34.7
Irrelevant	50.6	28.4	35.5	36.6
Brother				
Trust	63.5	74.2	54.3	42.0
Not trust	17.1	14.2	17.4	38.9
Irrelevant	19.4	11.7	28.3	19.1
Daughter				
Trust	4.2	13.6	11.4	6.7
Not trust	4.6	18.4	12.2	28.6
Irrelevant	91.3	68.0	76.5	64.6
Son				
Trust	4.9	22.8	10.4	10.1
Not trust	3.8	20.1	15.2	31.0
Irrelevant	91.3	57.2	74.4	58.9

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Mother-in-law				
Trust	3.0	48.3	25.9	17.9
Not trust	5.2	13.9	17.7	38.3
Irrelevant	91.8	37.8	56.4	43.8
Extended family				
Trust	10.8	14.5	22.6	13.7
Not trust	77.0	79.1	62.7	79.3
Irrelevant	12.3	6.4	14.7	7.0
Trust in less personal potential sources of family planning advice				
Religious leaders				
Trust	30.7	45.9	35.5	21.0
Not trust	58.3	51.3	56.6	71.6
Irrelevant	11.0	2.7	8.0	7.4
Employers				
Trust	10.5	4.2	7.2	4.6
Not trust	23.6	46.8	63.1	77.2
Irrelevant	65.9	49.0	29.7	18.2
Coworkers				
Trust	17.2	10.8	13.6	11.8
Not trust	19.5	39.6	57.8	70.8
Irrelevant	63.4	49.6	28.6	17.4
Doctors				
Trust	62.6	77.5	71.0	56.0
Not trust	33.2	21.0	27.2	43.6
Irrelevant	4.2	1.5	1.9	0.4
Nurses				
Trust	49.5	62.2	52.3	30.5
Not trust	50.5	36.3	46.7	67.7
Irrelevant	0.0	1.5	1.0	1.9
Midwives				
Trust	26.0	54.0	51.8	37.1
Not trust	62.5	39.7	45.1	62.3
Irrelevant	11.5	6.3	3.1	0.7
Health station workers				
Trust	43.1	44.3	55.1	32.9
Not trust	50.8	53.9	41.6	65.4

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Irrelevant	6.1	1.8	3.3	1.7
Pharmacists				
Trust	40.1	42.1	43.0	24.5
Not trust	56.2	54.5	52.1	72.1
Irrelevant	3.8	3.4	4.9	3.4
Pharmacy employees other than pharmacists				
Trust	25.4	23.5	45.9	25.0
Not trust	71.8	75.0	51.7	70.7
Irrelevant	2.8	1.5	2.5	4.4
Don't know/unsure				
An older person				
Trust	61.2	67.2	61.2	38.8
Not trust	32.4	32.2	28.0	57.8
Irrelevant	6.4	0.6	10.9	3.4
Don't know/unsure				
School system/educators				
Trust	21.5	17.9	12.6	10.3
Not trust	59.0	63.7	58.9	62.2
Irrelevant	19.6	18.4	28.4	27.5
Don't know/unsure				
News report on TV				
Trust	30.7	25.3	25.1	27.5
Not trust	59.5	72.1	62.8	67.3
Irrelevant	9.8	2.6	12.1	5.2
Government agencies/workers				
Trust	9.6	17.6	12.8	10.2
Not trust	82.2	77.7	72.5	81.0
Irrelevant	8.1	4.8	14.7	8.9
Product advertisements				
Trust	13.7	3.5	5.9	4.8
Not trust	73.1	91.0	84.9	88.1
Irrelevant	13.3	5.6	9.2	7.2
Internet websites				
Trust	7.8	0.6	14.0	10.3
Not trust	57.9	62.1	65.8	81.2
Irrelevant	34.3	37.3	20.2	8.5
Articles in magazines or newspapers				

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Trust	11.7	6.4	8.9	22.6
Not trust	73.4	74.7	84.0	74.4
Irrelevant	14.9	18.9	7.1	3.0
Don't know/unsure				
Someone who already uses FP				
Trust	39.9	46.4	66.8	44.4
Not trust	43.6	38.6	28.5	50.1
Irrelevant	16.5	15.0	4.7	5.5
Who is most responsible for family planning decisions in a married couple				
Mainly the wife's decision	3.1	4.7	12.7	8.6
Mainly the husband's decision	9.9	11.0	17.3	29.3
Joint decision	87.0	84.4	70.0	62.1
Who is responsible for family planning decisions in a sexually active, unmarried couple in a committed relationship				
Mainly the wife's decision	27.0	24.0	19.0	17.1
Mainly the husband's decision	35.2	34.5	33.1	51.7
Joint decision	37.9	41.5	47.9	31.2
Who is responsible for family planning decisions in a sexually active, unmarried couple not in a committed relationship				
Mainly the wife's decision	32.1	45.4	25.2	24.4
Mainly the husband's decision	44.5	29.0	37.7	50.2
Joint decision	23.4	25.7	37.1	25.4
Attitudes toward marriage and sexuality				
It's normal for women to get married at an earlier age than men				
Strongly disagree	0.5	0.9	1.6	1.8
Disagree	4.6	2.0	5.6	4.5
Neither agree nor disagree	5.6	8.2	12.8	4.2
Agree	49.1	35.5	32.5	45.4
Strongly agree	40.2	53.4	47.5	44.2
A woman should pursue her career before having children				

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Strongly disagree	2.8	6.5	8.5	4.3
Disagree	13.7	28.6	13.0	17.5
Neither agree nor disagree	20.5	29.8	22.3	19.1
Agree	48.4	26.8	42.5	49.3
Strongly agree	14.7	8.3	13.8	9.7
Today's TV encourages premarital sex				
Strongly disagree	6.8	7.3	14.3	7.8
Disagree	20.3	16.5	22.1	27.1
Neither agree nor disagree	12.6	10.7	11.8	11.7
Agree	36.6	34.1	31.5	33.3
Strongly agree	23.7	31.5	20.2	20.2
Sex education in school encourages premarital sex				
Strongly disagree	15.5	8.3	29.7	18.7
Disagree	18.8	23.3	25.0	24.7
Neither agree nor disagree	25.4	14.5	10.7	13.5
Agree	23.9	33.3	16.9	27.1
Strongly agree	16.4	20.6	17.8	15.9
It is considered shameful if a woman gets pregnant when she is not married				
Strongly disagree	0.0	3.3	0.7	1.4
Disagree	7.7	7.7	4.4	3.8
Neither agree nor disagree	11.3	10.0	6.7	15.7
Agree	33.7	21.7	35.4	24.8
Strongly agree	47.4	57.4	52.8	54.3
My religion frowns upon pregnancy outside of marriage				
Strongly disagree	0.6	0.1	0.4	1.1
Disagree	6.2	7.3	4.4	3.7
Neither agree nor disagree	13.1	9.7	4.6	11.5
Agree	23.0	26.2	41.0	36.6
Strongly agree	57.0	56.8	49.7	47.1
The more children a married couple has, the happier their marital relationship will be				
Strongly disagree	3.6	4.5	6.4	6.8
Disagree	26.3	11.5	12.8	20.8
Neither agree nor disagree	22.2	17.1	14.6	15.5
Agree	34.2	49.4	38.1	35.3

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Strongly agree	13.8	17.5	28.1	21.6
To ensure healthy children, women should stop childbearing by the age of 35				
Strongly disagree	4.0	11.2	17.3	10.9
Disagree	7.2	40.4	19.1	14.4
Neither agree nor disagree	34.9	11.0	15.1	15.0
Agree	41.5	25.7	34.0	38.1
Strongly agree	12.4	11.8	14.5	21.5
A married couple should have their first child within one year after marriage				
Strongly disagree	3.2	4.8	2.7	4.7
Disagree	9.2	4.3	9.5	13.0
Neither agree nor disagree	30.7	18.0	15.9	22.4
Agree	37.9	40.9	47.4	42.5
Strongly agree	18.9	32.0	24.6	17.3
Attitudes toward family planning and abortion				
It is wise to learn about family planning before you become sexually active				
Strongly disagree	0.0	1.7	1.1	0.0
Disagree	1.8	2.0	1.1	1.4
Neither agree nor disagree	3.3	17.1	6.7	3.3
Agree	59.2	61.8	46.6	45.3
Strongly agree	35.7	17.4	44.5	50.0
Family planning is beneficial to the health of the woman				
Strongly disagree	0.0	0.3	0.0	0.0
Disagree	7.7	12.6	5.1	5.0
Neither agree nor disagree	7.2	12.8	11.3	6.0
Agree	64.6	56.5	55.8	59.0
Strongly agree	20.6	17.9	27.8	30.0
Family planning decreases the financial burden on a family				
Strongly disagree	1.0	0.5	3.1	3.6
Disagree	9.1	5.7	7.1	6.5
Neither agree nor disagree	23.0	28.6	16.6	16.6
Agree	56.3	45.5	50.9	46.8
Strongly agree	10.6	19.7	22.3	26.6

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
There is no need to worry about family planning until you have had your first child				
Strongly disagree	7.7	3.0	5.1	1.2
Disagree	21.7	11.7	10.0	22.1
Neither agree nor disagree	8.2	12.7	10.8	9.0
Agree	41.0	30.6	48.7	48.3
Strongly agree	21.4	42.0	25.4	19.4
Couples should listen to religious leaders regarding family planning				
Strongly disagree	2.6	2.8	15.7	15.5
Disagree	26.2	9.2	17.8	24.0
Neither agree nor disagree	25.1	35.1	21.2	16.1
Agree	26.2	32.8	33.8	34.1
Strongly agree	19.9	20.1	11.5	10.4
A woman should consult her partner when deciding to use family planning				
Strongly disagree	0.0	0.6	1.9	0.0
Disagree	4.8	0.1	3.0	2.4
Neither agree nor disagree	3.2	0.9	6.1	4.6
Agree	59.1	39.5	44.1	30.1
Strongly agree	32.9	58.9	44.9	63.0
I feel embarrassed to ask my health care provider questions about family planning				
Strongly disagree	3.0	10.8	16.8	19.8
Disagree	18.3	10.4	13.5	26.8
Neither agree nor disagree	15.2	21.9	21.4	19.9
Agree	48.8	35.3	27.0	23.8
Strongly agree	14.7	21.6	21.3	9.7
Men do not want to use family planning methods because it might interfere with their sexual pleasure				
Strongly disagree	4.8	3.7	14.2	16.3
Disagree	20.6	5.0	16.4	23.3
Neither agree nor disagree	9.9	20.8	10.3	14.2
Agree	48.0	41.7	37.2	29.5
Strongly agree	16.7	28.9	22.0	16.7
I am confident that my health care provider can answer any questions that I have about family planning				
Strongly disagree	1.6	0.4	1.7	3.9

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Disagree	15.5	8.1	8.8	1.6
Neither agree nor disagree	8.9	5.1	13.5	16.3
Agree	56.5	60.8	52.8	58.3
Strongly agree	17.5	25.6	23.3	19.9
The number of children you will have should be left up to God				
Strongly disagree	2.0	1.1	3.2	3.0
Disagree	2.4	1.9	5.3	6.9
Neither agree nor disagree	8.6	16.2	10.4	9.2
Agree	29.2	21.6	18.8	14.3
Strongly agree	57.9	59.2	62.4	66.8
If my wife/partner decides to use a family planning method, I will support her decision				
Strongly disagree	10.8	8.9	6.5	11.2
Disagree	4.6	11.2	19.2	10.8
Neither agree nor disagree	14.6	11.8	10.9	19.7
Agree	57.4	39.7	38.7	42.7
Strongly agree	12.6	28.4	24.7	15.7
Employers should provide access to family planning information and products in the workplace				
Strongly disagree	5.5	1.5	6.8	4.7
Disagree	6.6	2.7	7.4	9.9
Neither agree nor disagree	15.9	23.5	23.2	17.3
Agree	58.5	45.9	44.9	54.5
Strongly agree	13.5	26.5	17.8	13.7
It is against my religion to use family planning methods				
Strongly disagree	5.1	1.0	8.9	6.7
Disagree	24.4	13.5	16.1	16.3
Neither agree nor disagree	19.4	19.5	18.5	27.1
Agree	34.8	38.7	38.0	28.2
Strongly agree	16.3	27.3	18.6	21.7
Having to get a prescription for oral contraceptives is a barrier to using that method				
Strongly disagree	6.2	3.5	10.6	3.4
Disagree	31.7	6.7	18.7	23.5
Neither agree nor disagree	23.4	25.2	21.4	20.0
Agree	29.3	35.6	40.4	46.5

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Strongly agree	9.5	29.0	9.0	6.9
A woman should consult her mother-in-law when deciding to use family planning				
Strongly disagree	7.7	1.8	10.0	14.5
Disagree	18.7	9.6	16.2	33.7
Neither agree nor disagree	13.6	12.8	13.5	13.8
Agree	42.2	47.2	37.3	27.7
Strongly agree	17.8	28.8	23.0	10.3
If my wife/partner decides to use a family planning method, my mother-in-law will support her decision				
Strongly disagree	12.3	5.6	10.1	11.6
Disagree	19.5	22.8	18.0	25.0
Neither agree nor disagree	16.8	10.3	24.1	22.9
Agree	42.1	46.5	29.2	30.5
Strongly agree	9.4	14.8	18.5	10.0
I feel embarrassed to ask for family planning methods at the pharmacy				
Strongly disagree	10.8	10.3	18.0	14.3
Disagree	14.8	16.6	14.0	36.8
Neither agree nor disagree	9.6	11.8	20.1	17.2
Agree	49.7	39.7	32.4	22.6
Strongly agree	15.2	21.6	15.6	9.2
It is easier to obtain an abortion than to get a family planning method				
Strongly disagree	15.7	18.3	48.4	32.0
Disagree	46.2	29.1	23.6	41.9
Neither agree nor disagree	15.1	8.6	8.0	9.7
Agree	10.4	25.1	16.2	10.3
Strongly agree	12.7	19.0	3.9	6.2
Abortion poses significant health risks for women				
Strongly disagree	1.6	0.0	2.2	0.7
Disagree	2.7	1.5	1.0	5.8
Neither agree nor disagree	6.1	5.8	9.2	7.5
Agree	48.0	38.7	32.2	36.0
Strongly agree	41.6	54.1	55.4	50.0
Receiving an abortion can cause psychological harm to women				
Strongly disagree	1.0	0.0	0.8	1.8

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Disagree	3.9	1.9	1.9	0.8
Neither agree nor disagree	5.2	9.7	5.4	5.9
Agree	42.5	33.8	29.8	32.0
Strongly agree	47.5	54.6	62.2	59.6
It's important for a health care provider to discuss FP methods with a woman who has just received an abortion				
Strongly disagree	3.3	0.0	1.3	1.6
Disagree	1.8	3.2	7.0	4.5
Neither agree nor disagree	7.0	11.7	8.0	7.0
Agree	61.9	48.1	39.7	30.2
Strongly agree	26.1	37.1	44.1	56.7
Using hormonal contraception to prevent pregnancy is worse for a woman's health than having an occasional abortion				
Strongly disagree	11.4	3.9	18.4	5.5
Disagree	35.2	12.9	20.6	25.6
Neither agree nor disagree	24.3	21.2	31.8	28.1
Agree	8.5	38.4	23.4	31.2
Strongly agree	20.5	23.6	5.8	9.5
It is less expensive to get an abortion when needed, as opposed to paying regularly for a family planning method				
Strongly disagree	5.8	5.8	18.3	12.7
Disagree	48.7	28.7	31.8	41.7
Neither agree nor disagree	12.7	12.4	13.7	18.7
Agree	25.9	32.9	32.1	22.7
Strongly agree	7.0	20.2	4.1	4.1
The decision to have an abortion should be made jointly by a woman and her partner				
Strongly disagree	0.8	0.2	0.7	1.5
Disagree	1.3	0.2	3.3	4.4
Neither agree nor disagree	5.0	5.8	3.0	10.6
Agree	54.0	59.7	38.4	37.5
Strongly agree	39.0	34.1	54.7	46.1
Abortion is a method of family *planning*				
Strongly disagree	8.1	12.0	27.9	16.5
Disagree	37.7	27.3	15.5	16.0
Neither agree nor disagree	23.3	14.5	15.1	18.1
Agree	20.4	35.1	29.0	39.9
Strongly agree	10.4	11.2	12.5	9.5

TABLE A17. MEN AND HOUSEHOLD DECISION-MAKING

	Inexperienced Progressives %	Reluctant Rurals %	Educated Conventionalists %	Urban Individualists %
Household decision-making of married/in-union men				
Who usually decides how the money that you earn will be used?				
Respondent	19.9	43.5	53.2	69.7
Wife/partner	0.0	6.6	3.7	0.0
Jointly	80.1	35.7	39.5	24.0
I don't earn money	0.0	6.0	2.6	1.0
Someone else	0.0	8.2	1.0	0.8
Don't know/NA	0.0	0.0	0.0	4.4
Who usually decides how your wife's/ partner's earning will be used				
Respondent	0.0	6.6	14.0	14.3
Wife/partner	0.0	3.5	7.2	8.8
Jointly	71.4	20.7	21.9	17.0
Wife/partner has no earnings	28.6	69.2	55.7	54.4
Don't know/NA	0.0	0.0	1.2	5.5
Who usually makes decisions about health care for yourself?				
Respondent	6.1	14.2	28.7	11.0
Wife/partner	0.0	11.2	7.4	13.5
Jointly	93.9	70.0	63.4	67.6
Someone else	0.0	4.6	0.5	3.5
Don't know/NA	0.0	0.0	0.0	4.4
Who usually makes decisions about making major household purchases?				
Respondent	27.1	26.6	31.7	25.8
Wife/partner	0.0	4.5	5.4	6.1
Jointly	72.9	50.0	60.5	53.2
Someone else	0.0	18.9	2.5	10.6
Don't know/NA	0.0	0.0	0.0	4.4
Who usually makes decisions about making daily household purchases?				
Respondent	7.7	29.4	32.7	23.6
Wife/partner	19.7	20.4	14.5	21.9
Jointly	72.6	36.7	49.8	43.3
Someone else	0.0	13.5	3.0	6.8
Don't know/NA	0.0	0.0	0.0	4.4

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