USAID
FROM THE AMERICAN PEOPLE

FALAH
FAMILY ADVANCEMENT FOR LIFE & HEALTH

Baseline Household Survey

Rajanpur

District

May 2010

Population Council

Family Advancement for Life and Health

(FALAH)

Rajanpur

Baseline Household Survey

May 2010

Dr. Munir Afridi

Muhammad Ashraf

Population Council

Population Council

The Population Council, an international, non-profit, non-governmental organization established in 1952, seeks to improve the well-being and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources.

The Council analyzes population issues and trends; conducts research in the reproductive sciences; develops new contraceptives; works with public and private agencies to improve the quality and outreach of family planning and reproductive health services; helps governments design and implement effective population policies; communicates the results of research in the population field to diverse audiences; and helps strengthen professional resources in developing countries through collaborative research and programs, technical exchange, awards, and fellowships.

For inquiries, please contact:
Population Council
7, Street 62, F-6/3, Islamabad, Pakistan
Tel: 92 51 8445566
Fax: 92 51 2821401
Email: pcpak@popcouncil.org
Web: http://www.popcouncil.org
http://www.falah.org.pk

Layout and Design: Ali Ammad

Published: May 2010

Disclaimer

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

Table of Contents

List of Tables

List of Figures

Acknowledgements

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

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

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

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

We are grateful to Mr. Peter C. Miller and Dr. Arshad Mahmood for developing the main template for the report. Dr. Munir Afridi prepared the first draft of the Rajanpur report. Mr. Muhammad Jamil Arshad and Dr. Yasir Bin Nisar reviewed the report. Mr. Irfan Masood and Mr. Muhammad Ashraf tabulated the data and figures for the report. Ali Ammad developed the report layout and design. We thank these colleagues for their immense contributions.

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

Glossary of Terms

ANC	Antenatal Care
ASFRs	Age-specific Fertility Rates
BHU	Basic Health Unit
CBR	Crude Birth Rate
CEB	Children Ever Born
CPR	Contraceptive Prevalence Rate
DHQ	District Headquarter
EC	Emergency Contraception
ECP	Emergency Contraceptive Pill
EmOC	Emergency Obstetric Care
FALAH	Family Advancement for Life and Health
FP	Family Planning
HANDS	Health and Nutrition Development Society
IUD	Intra Uterine Device
LAM	Lactational Amenorrhea Method
LHW	Lady Health Worker
MCH	Maternal and Child Health
MNH	Maternal and Neonatal Health
MoH	Ministry of Health
MoPW	Ministry of Population Welfare
MSU	Mobile Service Unit
MWRA	Married Women of Reproductive Age
NGO	Non Governmental Organization
NIPS	National Institute of Population Studies
PAIMAN	Pakistan Initiative for Mothers and Newborns
PC	Population Council

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

Executive Summary

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

The survey was conducted between October and December 2009 using a probability sample of 586 households in 40 clusters in Rajanpur. It included interviews with 609 currently married women aged 15-49 ("married women of reproductive age", or MWRA), along with 200 married men, of whom 176 were married to women included in the sample. As a separate activity, a mapping study[1] was also carried out in Rajanpur during the period between November 2009 and January 2010. The FALAH project is primarily focused on birth spacing and family planning.

Household and Respondent Characteristics

Rajanpur is primarily an underdeveloped, rural district of Punjab. The characteristics of our sample are generally similar to those found in other surveys; some key indicators are presented in Table A.

Table A: Selected key district characteristics from Rajanpur household survey

Indicator	Value
Percentage of household population in rural areas	86.6
Percentage of households with electricity	72.7
Percentage of households with indoor water supply	86.2
Percentage of households with flush toilet	44.2
Percentage of households with television	40.6
Percentage of literate female respondents	19.7
Percentage of respondents with literate husbands	51.6
Total fertility rate	**4.6**

Electricity was available to 73 percent of the population, and ownership of appliances requiring electricity, such as a televisions, refrigerators, washing machines, etc., was not common in Rajanpur district. A majority of the households had indoor water supply and

[1] Mapping Survey of Health and Reproductive Health Services.

considerable number had flush toilets. The literacy was relatively low in Rajanpur. Only 20 percent of the female respondents and 52 percent of their husbands were literate. When asked about their exposure to media, 32 percent women said they watched TV, 8 percent listened to the radio, and only 4 percent read newspapers or magazines. Overall, only 20 percent of the women reported that they had exposure to FP messages through these mediums.

Fertility

There is evidence that fertility has been declining in Rajanpur. The crude birth rate was 28 per thousand of the population, and the total fertility rate was 4.6 children per woman. Fertility was higher for illiterate women and for the wives of illiterate men. Many births were spaced too closely for optimum health; for example, more than 68 percent of closed birth intervals were less than 36 months. Eighteen percent of the women in the sample who already had 2 children under five years of age were currently pregnant.

Maternal and Neonatal Care

The household survey obtained data on selected key indicators of maternal and neonatal health from a sample of 402 women who had delivered a child during the previous four years. Of these women, 52 percent had visited a health provider at least once for antenatal care, 53 percent had at least two tetanus toxoid immunizations, only 20 percent of the deliveries were handled by a skilled birth attendant and 19 percent were delivered in a public or private health facility. Seven percent of the women who had non-institutional deliveries had received at least one postnatal check-up. Exclusive breastfeeding was widely reportedly; 68 percent of the mothers reported breastfeeding their last child for at least 4 months without supplementation.

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

Indicator	Value
Percentage of mothers with at least one antenatal care visit	51.7
Percentage of mothers with at least two tetanus shots	52.5
Percentage of most recent deliveries conducted by a skilled birth attendant	19.7
Percentage of most recent deliveries in a facility	18.7
Percentage of MWRA not wanting more children	51.2
Percentage of MWRA wanting to delay next birth at least for two years	24.0
Percentage of MWRA who know of at least one contraceptive method	99.0
Contraceptive prevalence rate	20.4
Percentage of MWRA who are past users of contraceptives	14.8
Percentage of MWRA with unmet need for family planning	40.2
Percentage of MWRA with unmet need for birth spacing	14.9
Percentage of MWRA with unmet need for limiting births	25.3
Total demand for family planning (CPR + unmet need)	**60.6**

Preference for Children

The median "ideal" family size, according to the women respondents, was 5 children. Regarding desire for having more children in the future, 25 percent said they wanted another child soon (within two years), 24 percent said they wanted another child, but only after two years, and 51 percent said they did not want more children. The proportion of women wanting more children soon decreased rapidly with the number of living children, while the proportion of women who did not want more children increased. The proportion wanting more children later was highest among women with one or two children. Sixty-six percent of the women said their husbands wanted the same number of children that they did, while 21 percent said their husband wanted more children than they did.

Contraceptive Knowledge and Use

Nearly all currently married women knew of at least one contraceptive method. The contraceptive prevalence rate (the percentage of MWRA currently using any method of contraception) was 20 percent, which is substantially lower than the average for Punjab (33 percent) or for Pakistan (30 percent). Withdrawal was noted as the most popular method of family planning among current users (6.7percent). After withdrawal, the methods most commonly in current use were female sterilization (4.1 percent) and condom (2.8 percent).

Past users comprised 14.8 percent of MWRA; injections, pills, withdrawal and condoms were all common methods for past users. Eighty-three percent of the current users did not want more children, while 17 percent wanted more, but at a later time. Most users reported obtaining their supplies and services from private hospital/clinic and Government department sources, or their husband obtained the supplies (for condoms, pills and injections).

Experience with Contraceptive Methods

Stated reasons for the respondents' choice of their current or past method varied by method, but commonly cited reasons included suitability for the respondent and her husband, easy availability, low cost, convenience of use, no or fewer side effects and (for female sterilization, IUD and injectable users) ability to use for a long period. Costs were generally low (only 27 percent paid more than Rs.50 the last time they obtained their method) and did not appear to be a major obstacle to contraceptive use. Similarly, travel time was usually not excessive; 29 percent reported requiring more than 30 minutes reaching their service. Information given by the service providers at acceptance of contraceptive method often did not include information on side effects or method choice. On the other hand, clients generally reported being examined properly at a health facility. However, a considerable number of respondents often felt that providers were incapable of dealing with side effects. A variety of side effects was reported by users and past users, and it did not appear that these were effectively dealt with by providers.

Reasons for Non-use

Asked hypothetically about obstacles a couple might face if they wanted to avoid or delay pregnancy, women typically mentioned husband's disapproval, side effects of contraceptives and their management. Less frequently mentioned were: distance/cost, method failure or that people might find out contraceptive use. Past users were most likely to discontinue use because they experienced side effects, wanted more children and rest from method. Their reasons for current non-use were most often related to childbearing, but rest from method and side effects were also frequently mentioned. Never-users were most likely to say they were not using for reasons related to childbearing, but fear of side effects and husband's opposition were also common reasons. Twenty-seven percent of the women interviewed disapproved of birth spacing, while 13 percent disapproved of limiting births. A majority of female current and past users said they could discuss family planning easily with their husbands, but 56 percent of never-users said they could do so. Knowledge

of contraceptive methods and source of supply among never users was quite good. Over one-third of the never-using women expressed the intent to use contraceptives in the future. This indicates that a substantial number of women in Rajanpur were willing to practice birth spacing and family planning.

Unmet Need for Family Planning

A woman is considered to have an "unmet need" for family planning if she says she does not want more children, or wants them later, and is at risk of conceiving, but is not using any method of contraception. By this definition, 40.2 percent of the women in this sample were in the unmet-need category, 25.3 percent for limiting and 14.9 percent for spacing. Unmet need for limiting was higher among illiterate women and among rural women; while unmet need for spacing was also higher among illiterate women. Women in the unmet need category typically tended to have less communication with their husbands and not to have more children, feared side effects of contraceptive methods, and lacked knowledge of family planning sources.

Reproductive Preferences and Behavior of Men

The findings reveal that 56 percent of men knew at least one modern contraceptive method. Norplant was one of the least known contraceptive methods among men in Rajanpur. Twenty-eight percent of the men did not want more children in the future while 19 percent wanted to delay the next pregnancy. Twenty-seven percent of the male respondents reported that they or their wives were currently using a family planning method, and 18 percent were using modern contraceptive methods. Among the current users, more than 88 percent were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, only 16 percent reported that they were not intending to use any FP method in future. The fear of side effects was one of the prominent reasons for not using any FP method. Of those who did intend to use contraceptives in the future, very few reported the use of male methods (8 percent condom). It would be important to include specific interventions aimed at influencing men's attitude towards their role and responsibility in the overall health of the family and in birth-spacing needs.

Conclusion

Knowledge and approval of family planning were high. Contraceptive prevalence(20 percent) was lower than for Pakistan as a whole. There is much need for improvement; unmet need for family planning remained high at 40.2 percent. Among the important reasons that should be addressed in an improved program are husbands' attitudes, inter-spousal communication and fear of side effects. Also, the concept of birth spacing needs to be stressed to lengthen birth intervals, which are often too short.

Chapter 1

Introduction

Background

The FALAH Project

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

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

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

The aims of the FALAH project are:

a) To increase the demand for and practice of birth spacing;

b) To increase access to and quality of family planning services in the public sector;

c) To increase the coverage and quality of family planning services in the private sector;

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

At the district level, FALAH works to integrate communication and services through a "whole district" approach involving all available resources in the public and private sectors. FALAH is being implemented by a team of seven partner organizations: Population Council (as lead agency), Jhpiego, Greenstar Social Marketing, Save the Children (US), Mercy Corps, Health and Nutrition Development Society (HANDS), and the Rural Support Programmes Network (RSPN). FALAH is also coordinating its activities with the PAIMAN maternal and neonatal health project, especially in the PAIMAN districts, and with other projects as appropriate. In Rajanpur, district-level activities are being coordinated by Save the Children (US), with Greenstar providing information and services through social marketing and other partners supporting specific activities as needed.

Rajanpur District

District Rajanpur is mainly a rural district of Punjab. The overall population of the district was 1.104 million in 1998, with a population density of 90 persons per square kilometer. Geographically, Rajanpur is bounded on the north by DG Khan; on its east are Muzaffargurh and Rahimyar Khan and on south lies district Jacobabad while on the west are the districts of Dera Bugti and Barkan of Balochistan province. Currently, it is comprised of three tehsils: Jampur, Rajanpur and Rojhan. Ethnically, the district is inhabited by following main land owning tribes: Gorchani, Mazari, Tummons, Darishak, Gopang, Pathan and Mughals (Population Census Organization, 2000).

Rajanpur is situated on the main Indus highway which passes through Peshawar up to Karachi. All of the three tehsils are interlinked with metalled roads. There is a well-developed railway network in Rajanpur district.

In the Planning Commission's Millennium Development Goals report, 2006, Rajanpur stood 65th on literacy; 62nd on immunization; 38th on water supply; and 71th on sanitation in national rankings.

The Rajanpur Baseline Household Survey

In Rajanpur (as in each of the all FALAH focus districts), the Population Council implemented a baseline sample household survey to learn about knowledge, attitudes, and

practices regarding fertility, reproductive health, and child spacing/family planning. This represents one of two major studies to establish baseline indicators for the FALAH project. The other is a mapping exercise to compile complete, digitized maps of all facilities providing reproductive health services, including maternal health, neonatal and child health, and child spacing/family planning. This baseline survey will be compared with an end line survey towards the end of the project to assess progress.

Objectives

The objectives of the Rajanpur Baseline Household Survey are:

- To obtain baseline measurements for those FALAH indicators that can best be measured through such surveys;
- To obtain detailed information on the knowledge, attitudes and practices of married couples of Rajanpur district regarding reproductive health, so as to meet their needs more effectively;
- More specifically, to obtain information needed to improve reproductive health services and to design appropriate social mobilization activities.

Methodology

Study Population

FALAH is primarily a district-level project which intends to improve the health of women and children of the district over a five-year period. The baseline household survey covers married women of reproductive age (15-49 years old) and their husbands living in the community. The objective is to understand and measure general knowledge, attitude and practices of these married couples regarding family planning.

Sample Design and Size

The systematic stratified sample technique was used to select a representative sample of the district. The universe consisted of all urban and rural households of the district. The number of blocks selected in urban areas and the number of villages selected in rural areas are presented in Table 1.1. A total of 40 blocks/villages were selected, with 15 households selected per block/village. The selection procedure is described below.

Urban Sample

The required number of enumeration blocks was selected with probability proportional to size (number of circles) by adopting a multistage stratified sampling design. The "enumeration circles," i.e., the smallest units available in the 1998 Population District Census Reports as demarcated by the Population Census Organization, were selected. The maps of these circles were obtained from the Population Census Organization and were already divided into blocks of approximately 250-300 households depending upon the number of households in each circle. Following this, one block was randomly selected from each circle. The household listing of each block was then carried out by the enumeration teams before selecting the sampled households. A fixed number of 15 households were drawn from each sample enumeration block by using systematic random sampling.

Rural Sample

The 1998 Population Census list of villages was used as the sampling frame for the selection of the rural sample. Villages in rural areas have been treated as primary sampling units (PSUs). Sample PSUs were selected with probability proportional to size (number of households). Households within the sample PSUs were considered secondary sampling units. The household listing of each village was then prepared by the enumeration teams before selecting the sampled households. A fixed number of 15 households was selected from each sample enumeration village using the systematic random technique.

Selection of Respondents

Within each household, all women aged 15-49 were interviewed. In addition, husbands of MWRA who were present were also interviewed to a maximum of 5 per block.

The degree of success of the study in achieving the goals of the sampling procedure is shown in Table 1.1.

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

Results	Rural	Urban	Total
Sample blocks/villages	34	6	40
Households interviewed	496	90	586
Eligible women identified	630	85	715
Eligible women not interviewed	100	6	106
Eligible women interviewed	530	79	609
Total completed women's interviews	**530**	**79**	**609**

Questionnaire Design

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

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

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

Hiring of Interviewers and Supervisors

Since the respondents in the baseline were currently married women and their husbands, female interviewers were hired to interview female respondents and male interviewers were hired for male respondents. The interviewers were hired locally by advertising through local newspapers. A logistics supervisor and a data quality supervisor were also hired for each team.

Training of Interviewers and Supervisors

In order to ensure that the training provided for interviewers was of high quality, and that interviewers understood the definitions and concepts underlying the language of the questions, a two-week training of the Rajanpur team was conducted by the Population Council in Islamabad. During the training, interviewers conducted 2-3 field interviews in order to prepare for the actual interview process.

Training regarding the importance of the criterion for the selection of primary sampling units, mapping and listing procedures, sample selection, field operation procedures, and selection of particular households and respondents was also provided by specialists.

Quality Assurance

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

Data Entry and Edit Procedures

Data processing was initiated in the field with the checking of questionnaires. Each team leader completed on-the-spot checks and preliminary editing of questionnaires during the enumeration period. Editing instructions were provided to the team supervisors, which emphasized the importance of completing each questionnaire, correctly identifying each eligible respondent, and the completeness of household composition.

Fieldwork

Fieldwork for Rajanpur district was carried out between October and December 2009.

Chapter 2

Household Characteristics

Geographic Distribution

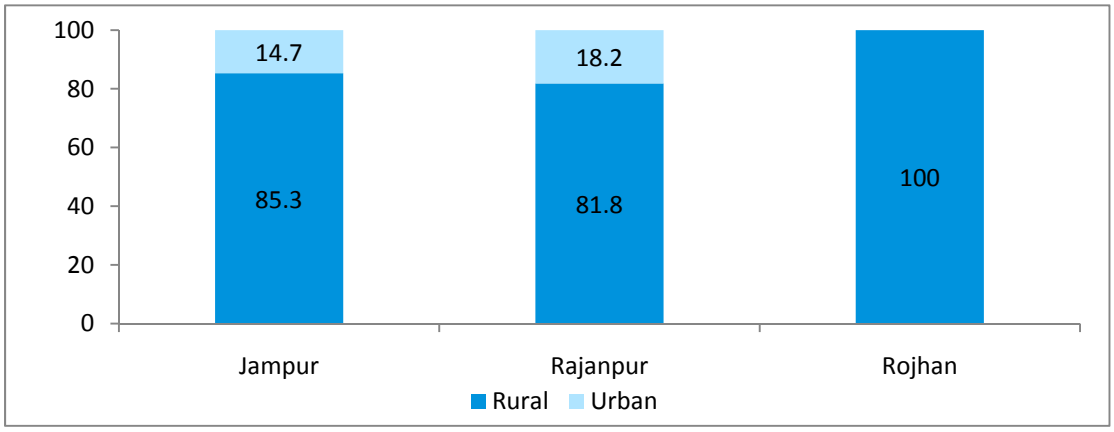
The district of Rajanpur is comprised of three Tehsils: Jampur, Rojhan and Rajanpur. Of these, one tehsil - Rojhan – has no urban population while the remaining two tehsils have around 13 percent urban population. Table 2.1 shows the population distribution of sample households by residence and tehsils (rural and urban).

Table 2.1: Percentage distribution of the population of sample households by residence and tehsil

	Rural			Urban			Total	
Tehsil	N	%	1998 Census %	N	%	1998 Census %	N	%
Jampur	1904	85.3	86.0	329	14.7	14.0	2233	100.0
Rajanpur	1532	81.8	79.5	341	18.2	20.5	1873	100.0
Rojhan	906	100	94.7	0	0.0	5.3	906	100.0
Total	**4342**	**86.6**	**85.5**	**670**	**13.4**	**14.5**	**5012**	**100.0**

Table 2.1 shows the population distribution of the 586 households in the sample by urban – rural residence and tehsil. Tehsil Rajanpur was about 82 percent rural and 18 percent urban. This closely follows the distribution recorded for the whole district in the 1998 Population Census (Population Census Organization, 2000). About 45 percent of the sample population lived in Jampur tehsil, while 37 percent and 18 percent lived in Rajanpur tehsil and Rojhan tehsil respectively.

Figure 2.1: Rural-urban population distribution of sample households



Age-Sex Distribution

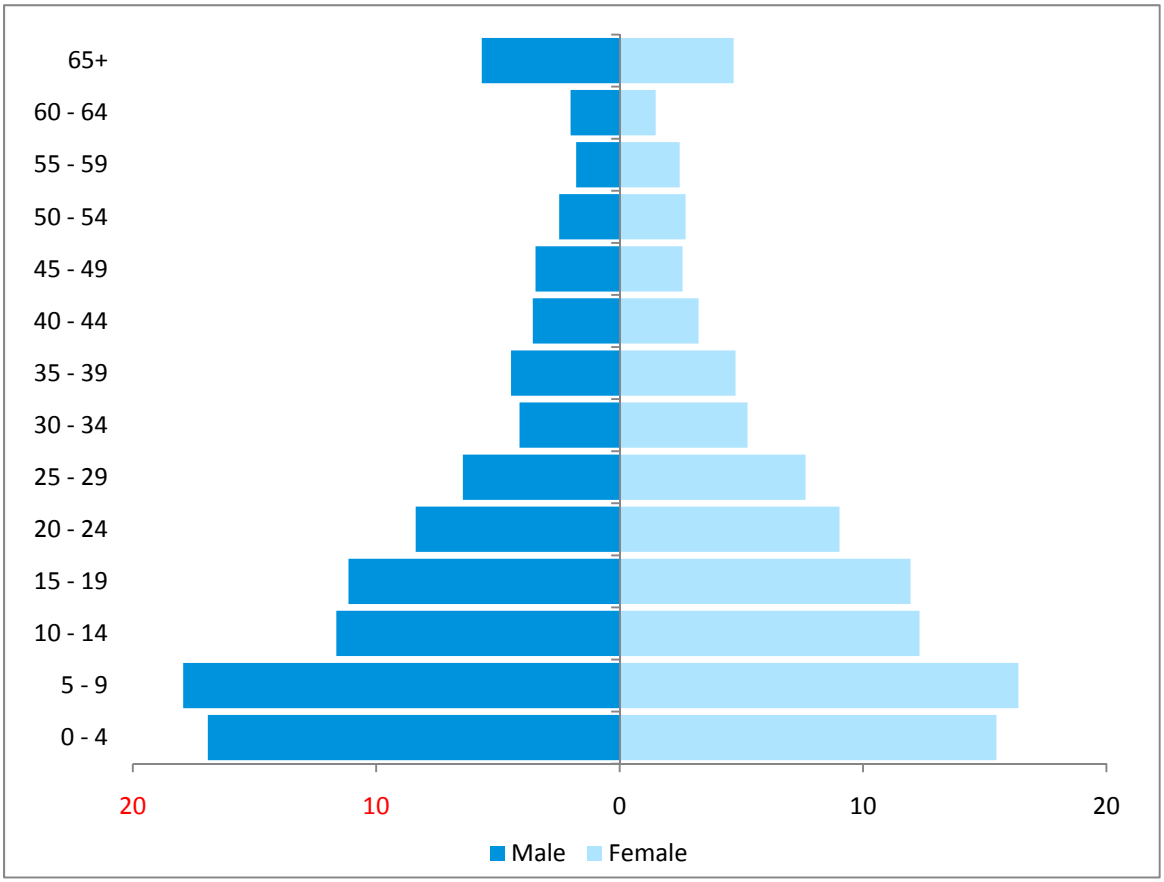
Table 2.2 shows the population distribution of the sampled households by age and sex.

Table 2.2: Percentage distribution of sample household population by age and sex

	Sex of household member		
Age group	**Male**	**Female**	**Total**
0 - 4	16.9	15.5	16.2
9-May	17.9	16.4	17.2
14-Oct	11.6	12.3	12.0
15 - 19	11.1	12.0	11.5
20 - 24	8.4	9.0	8.7
25 - 29	6.4	7.6	7.0
30 - 34	4.1	5.3	4.7
35 - 39	4.5	4.8	4.6
40 - 44	3.6	3.2	3.4
45 - 49	3.5	2.6	3.0
50 - 54	2.5	2.7	2.6
55 - 59	1.8	2.5	2.1
60 - 64	2.0	1.5	1.8
65+	5.5	4.6	5.2
N	**2577**	**2435**	**5012**

The population was typical of a society with past high fertility trends and sharply declining percentages by age; the median age was 16 years. The age-sex ratio of the age groups from 10 to 39 and 50-59 suggests there were less males than females while in all of the other age groups males were dominant. This may be due to the fact that males in these age groups are usually working and may migrate to other places in search of employment.

Figure 2.2: Age Sex distribution



Of the total population of the sampled households, 22 percent consisted of females 15-49 years of age, and 16 percent consisted of children under 5 years old. These individuals comprised the population of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

Table 2.3: Percentage distribution of males and females by marital status and age

	Married		Widow/Divorced/Separated		Never married	
Age group	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
15 - 19	3.5	21.0	0	0.3	96.5	78.7
20 - 24	34.7	57.3	1.4	1.4	63.9	41.4
25 - 29	71.1	83.3	1.8	2.7	27.1	14.0
30 - 34	88.7	96.1	1.9	1.6	9.4	2.3
35 - 39	97.4	97.4	0.9	1.7	1.7	0.9
40 - 44	98.9	98.7	0.0	1.3	1.1	0.0
45 - 49	94.4	88.9	5.6	9.5	0.0	1.6
50 - 54	98.4	84.8	1.6	13.6	0.0	1.5
55 - 59	89.1	83.3	10.9	16.7	0.0	0.0
60 - 64	92.3	77.8	7.7	22.2	0.0	0.0
65 - 69	90.9	76.9	9.1	23.1	0.0	0.0
70 - 74	88.9	51.7	11.1	48.3	0.0	0.0
75 - 79	88.9	65.0	11.1	35.0	0.0	0.0
80 - 84	89.5	23.1	10.5	76.9	0.0	0.0
85+	72.7	15.4	27.3	84.6	0.0	0.0
All ages 15+	**62.7**	**66.9**	**3.0**	**7.2**	**34.3**	**25.9**

Marital Status

In Rajanpur (as in Pakistan generally) women tend to marry men older than themselves. Therefore, as Table 2.3 shows, a higher proportion of younger women were married than men of the same age. It is interesting to note that in the 45 and above age group, all men and 55 and above age group, all women were married. Twenty-one percent of the women were married between the ages of 15 to 19. The estimated singulate mean age at marriage (SMAM) for women was 22 years and 25 years for men.

Household Characteristics and Wealth Indicators

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

Table 2.4: Distribution of households with selected physical characteristics, by residence

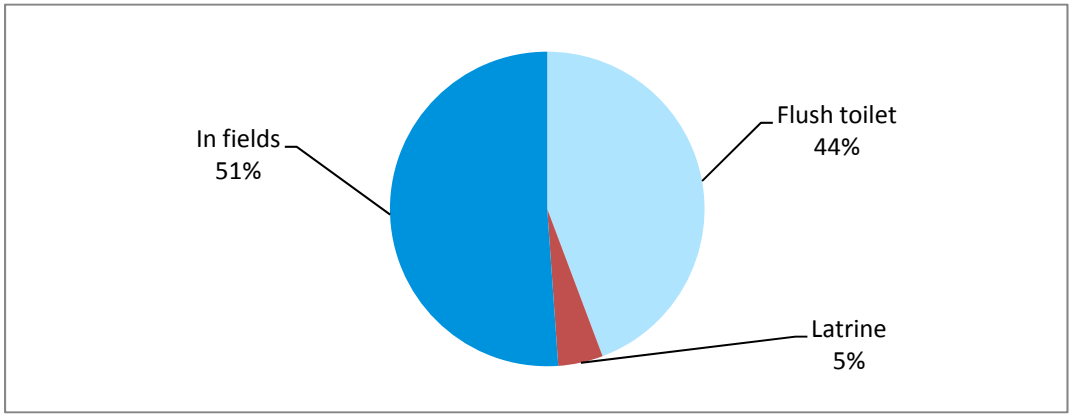
Characteristic	Rural	Urban	Total
Main source of drinking water			
Govt. supply (tap water inside)	4.2	1.1	3.8
Govt. supply (communal)	3.6	0.0	3.1
Motorized/Hand pump (inside)	79.4	98.9	82.4
Motorized/Hand pump (outside)	6.7	0.0	5.6
Well	1.8	0.0	1.6
River/Canal/Stream	3.6	0.0	3.1
Pooled/Pond water	0.6	0.0	0.5
Sanitation facility			
Flush connected to septic tank	18.3	45.6	22.5
Flush connected to open drain	16.3	51.1	21.7
Raised latrine	1.2	0.0	1.0
Pit latrine	3.8	2.2	3.6
In fields	60.3	0.0	51.0
Main type of fuel used for cooking			
Fire wood	91.7	75.6	89.2
Gas cylinder	1.0	22.2	4.3
Dry dung	7.3	2.2	6.5
Electrical connection			
Yes	67.9	98.9	72.7
No	32.1	1.1	27.3
Main material of roof			
Concrete	0.4	4.4	1.0
Guarder and T-iron	38.3	78.9	44.5
Wood/Bamboo and mud	61.3	16.7	54.4
Main material of floor			
Earth/Sand/Mud	75.2	6.7	64.7
Chips	0.6	14.4	2.7
Ceramic tiles	0.2	1.1	0.3
Marble	0.4	2.2	0.7
Cement	14.5	48.9	19.8
Bricks	9.1	26.7	11.8
Main material of walls			
Burnt bricks/Blocks	33.3	97.8	43.2
Mud bricks/Mud	66.1	2.2	56.3
Others	0.6	0	0.5
Total	**100**	**100**	**100**
N	496	90	586

Physical Characteristics of Households

Table 2.4 shows selected physical characteristics of the sampled households. More than four- fifth of sampled households had an indoor motorized/hand pump water supply .More than half of the sample households used fields as sanitation facility particularly in rural areas. Some type of flush toilet connected to septic tank or open drain was used by forty-four percent of households mainly in urban areas. It is important to note that there was more government indoor water supply for rural areas than urban areas.

While most households in Rajanpur district used firewood for cooking, particularly in rural areas (92 percent), only 4 percent of the total household in the district and 22 percent in urban areas used gas cylinder. Nearly all households, in urban areas, had electricity while electricity was available to only two third of rural households. The roofs of most houses were made with wood/bamboo and mud (54 percent), and had earth/sand/mud floors (65 percent), while 56 percent houses had walls made of mud/mud bricks.. These indicators show that Rajanpur district is a less developed area.

Figure 2.3: Toilet facilities for Rajanpur households



Ownership of Household Assets

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

facilities, and telephones are important to summon help when needed. Others are suggestive of more general well-being.

The distribution of these items appears to show the expansion of consumer purchasing power that has occurred in Pakistan in recent years. Several items requiring electricity were available in a limited proportion of households, even in urban areas. More than two fifth of all households had television sets. The recent expansion in information technology in Pakistan was reflected in the ownership of mobile phones by more than two-third (69 percent) of all households, and ownership of a computer by about 5 percent of all households. However, motorized transport (four wheels) remained fairly uncommon, suggesting difficulties in arranging for transport in health emergencies.

Table 2.5: Percentage of households owning selected items, by residence

Household item	Rural	Urban	Total
Wall clock	49.2	95.6	56.3
Chairs	17.5	57.8	23.7
Bed	25.0	78.9	33.3
Sofa	10.9	42.2	15.7
Sewing machine	38.3	83.3	45.2
Camera	5.0	14.4	6.5
Radio/Tape recorder	28.2	33.3	29.0
Television	32.3	86.7	40.6
Refrigerator	13.9	60.0	21.0
Land line telephone	3.4	12.2	4.8
Mobile phone	65.5	85.6	68.6
Room cooler/ Air conditioner	8.3	42.2	13.5
Washing machine	19.4	85.6	29.5
Bicycle	29.4	36.7	30.5
Motor cycle	33.9	44.4	35.5
Jeep/Car	1.2	8.9	2.4
Tractor	9.9	2.2	8.7
Computer	1.8	20.0	4.6
N	**496**	**90**	**586**

Standard of Living Index

The data presented below can be used to develop an overall index of the economic well-being of a household, both for a general estimation of the economic development of an area, and for use in investigating the relationship between household wealth and reproductive health behavior. One such index is the standard of living index (SLI), developed for international comparisons with data from the Demographic and Health Surveys (Rutstein, S.O., and K. Johnson, 2004). This index gives each household a score of 0-1 or 0-2 on each of the following: source of drinking water; toilet facilities; material of floor; availability of electricity; ownership of a radio; ownership of a TV; ownership of a refrigerator; and means of transportation. For the whole household, the value of the index can range from 0 to 12. Table 2.6 gives the distribution of the SLI for the sample households according to urban and rural residence. The median index for all households was 4; for rural households it was 3, and for urban households it was 7. About 92 percent of all households fell in the range from 0 to 8. This index will be used later in this report to examine differences in reproductive health knowledge and behavior.

Table 2.6: Percent distribution of sample households by residence and standard of living index

Standard of living index	Rural		Urban		Total	
	N	%	N	%	N	%
0	10	2.0	0	0	10	1.7
1	79	15.9	0	0	79	13.5
2	99	20.0	0	0	99	16.9
3	67	13.5	1	1.1	68	11.6
4	67	13.5	3	3.3	70	11.9
5	51	10.3	5	5.6	56	9.6
6	46	9.3	18	20.0	64	10.9
7	27	5.4	20	22.2	47	8.0
8	20	4.0	24	26.7	44	7.5
9	24	4.8	11	12.2	35	6.0
10	6	1.2	7	7.8	13	2.2
11	0	0	1	1.1	1	0.2
Total	**496**	**100**	**90**	**100**	**586**	**100**
Median	3	na	7	na	4	na

na= not applicable.

Chapter 3

Respondent Characteristics

The primary sources of data from the Household Survey are the interviews conducted with 609 currently married women of reproductive age (MWRA). The background characteristics of these respondents are described in this chapter.

Age

Table 3.1 shows the age distribution of the female respondents for rural and urban areas. Most of the women (22 percent) were in the age group of 25-29, as by that time most women were married. About 48 percent of the sample respondents were under age 30; urban-rural differences were visible.

Table 3.1: Age distribution of female respondents by residence

	Rural		Urban		Total	
Age group	**N**	**%**	**N**	**%**	**N**	**%**
15 - 19	50	9.4	0	0	50	8.2
20 - 24	95	17.9	15	19.0	110	18.1
25 - 29	110	20.8	23	29.1	133	21.8
30 - 34	90	17.0	13	16.5	103	16.9
35 - 39	90	17.0	10	12.7	100	16.4
40 - 44	55	10.4	11	13.9	66	10.8
45 - 49	40	7.5	7	8.9	47	7.7
Total	**530**	**100**	**79**	**100**	**609**	**100**

Education and Literacy

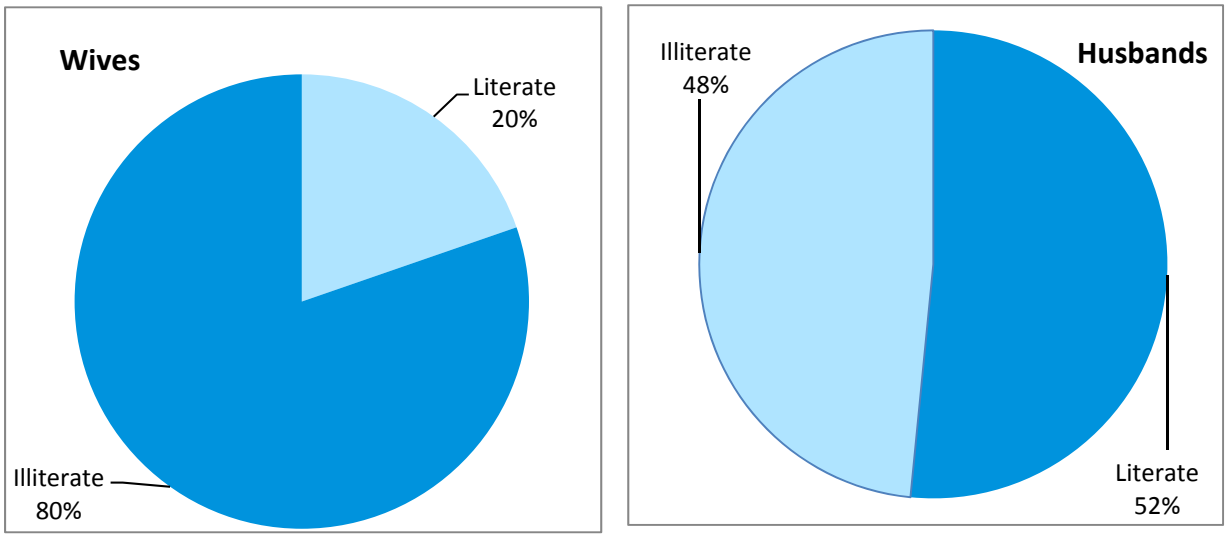
Levels of schooling completed and literacy rates for the respondents and their husbands are given in Table 3.2 and illustrated in figure 3.1. Literacy rates in Rajanpur were low. The literacy rate for females respondents was 20 percent, compared with 40 percent for Punjab as a whole and 36 percent for Pakistan as a whole (Government of Pakistan 2005 and 2006). Similarly, only about 10 percent of the female respondents reported being educated up to primary levels and only three percent above secondary levels. For the husbands of the women as well, literacy (at 52 percent) was lower than the Punjab (63 percent) as well as national average (63 percent) (Government of Pakistan 2005). The data also indicates that younger age women 15-24 years and 25-34 years were significantly more literate than older women 35-49 years old.

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

	Age of respondent			Residence		
Variable	**15 - 24**	**25 - 34**	**35 - 49**	**Rural**	**Urban**	**Total**
Respondent (women)						
Proportion literate	22.5	24.2	12.7	14.3	55.7	19.7
Education level						
No education	75	76.3	87.8	85.3	44.3	80.0
Up to primary	16.9	8.9	5.2	8.9	15.2	9.7
Up to Secondary	5.6	10.6	4.7	4.7	24.1	7.2
Above secondary	2.5	4.2	2.3	1.1	16.5	3.1
N	**160**	**236**	**213**	**530**	**79**	**609**
Respondent's husband						
Proportion literate	54.4	56.8	43.7	47.5	78.5	51.6
Education level						
No education	50.6	44.5	57.7	55.1	21.5	50.7
Up to primary	15.6	15.3	14.1	14.7	16.5	14.9
Up to Secondary	26.9	27.5	19.2	22.3	39.2	24.5
Above secondary	5.6	12.3	8.0	7.2	21.5	9.0
Don't know	1.3	0.4	0.9	0.8	1.3	0.8
N	**160**	**236**	**213**	**530**	**79**	**609**

The urban-rural gap was significantly high for women both in literacy and education levels. A significant gap was also noted in husband's literacy and education between urban and rural locations.

Figure 3.1: Literacy status of women and their husbands



Occupation and Work Status

For men, occupation is both an economic and social classification; some occupations usually indicate higher income levels than others, while at the same time may represent social status and life-style. In general, men are expected to work for pay. For women, the situation is somewhat different: many women do not work for pay. If they do, this may be because they have to, perhaps indicating serious economic distress, or because they choose to, whether for additional income, self-fulfillment, or other reasons. In any case, women's time spent working for pay is likely to compete, at least to some degree, with time spent on household management and child care. Therefore it is worthwhile to examine men and women's work separately.

Very few number of women i.e. 17 percent of female respondents reported working for cash. While about 83 percent of women were associated with crop sowing and harvesting.

Figure 3.2: Type of work of respondents working for pay (n=25)

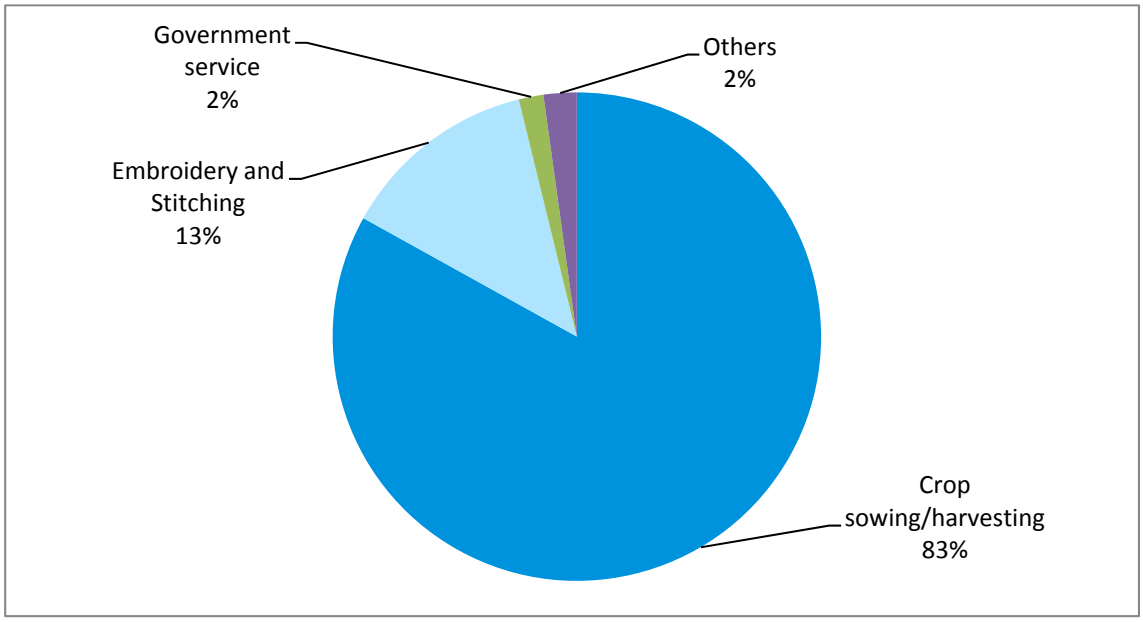


Table 3.3: Distribution of occupational categories of respondents' husbands by residence

Occupation	Rural	Urban	Total
Agriculture/Livestock/Poultry	46.4	5.1	41.1
Petty trader	6.2	21.5	8.2
Labor (Daily wages)	22.6	30.4	23.6
Government service	5.7	8.9	6.1
Private service	3.4	12.7	4.6
Own business	4.9	16.5	6.4
Abroad	1.7	1.3	1.6
Unemployed	8.3	3.8	7.7
Skilled worker	0.2	0.0	0.2
Others	0.6	0.0	0.5
Total	**100**	**100**	**100**
N	530	79	609

Slightly over two-fifth of the husbands were engaged in agriculture/livestock/poultry sector (Table 3.3). Twenty-four percent of women interviewed stated that labor (daily

wages) is the occupation of their husbands. More than one fifth of urban husbands were petty traders. Only 6 percent of husbands were government servants. The unemployment rate of husbands should also be noted at 8 percent. Rural unemployment was recorded double as compared to urban. This indicates that a fair number of people required employment.

Female Mobility

Female respondents were asked about the permission required for them to go to places outside their homes (Table 3.4). The mobility out of village/town and visiting health centre/doctor were the only places where a substantial number of women (88 percent and 76 percent respectively) said they could go with someone; 15 percent could go to health centre with permission. With the exception of visiting relatives and friends, only a few women reported being able to go to any of the places named without permission. To visit relatives/friends, about 16 percent of the respondents were able to go without permission, and another 25 percent were able to do so with permission. On the other hand, 26 percent of the women reported not being able to go at all to the market. For each of the named destinations, a substantial number said they were able to go with permission or with someone.

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

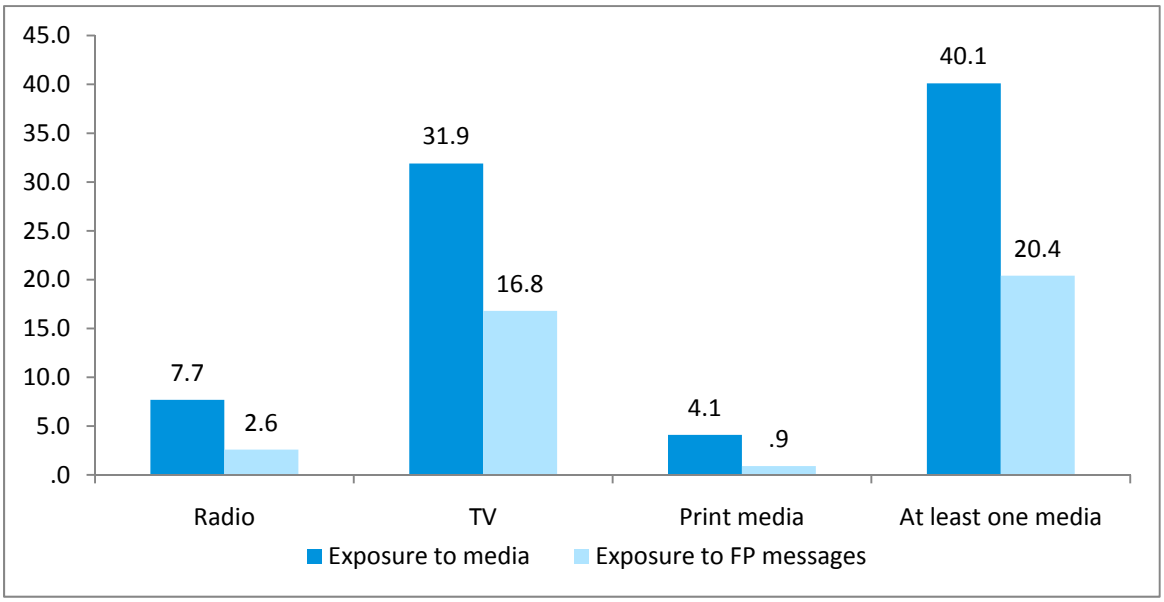
	Degree of permission				Total	
Destination	Without permission	With permission	With someone	Can't go/ Doesn't go	%	N
Market	13.6	16.3	43.8	26.3	100	609
Health center	7.9	14.6	76.4	1.1	100	609
Relatives/friends	16.3	25.0	58.6	0.2	100	609
Out of village/ town	1.8	4.8	87.5	5.9	100	609

Mass Media Access and Exposure to FP Messages

For the development of communication activities, it is important to know which forms of mass media are available, and to what extent they were used by various segments of the population. Table 2.5 showed that 41 percent of the households owned a television, while 29 percent owned a radio/tape recorder. Figure 3.3 shows the proportion of females who

reported that they watch TV, listen to the radio, or read newspapers or magazines. Television was the most commonly used medium (32 percent), while the radio and print media were used less (8 percent and 4 percent respectively).

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



Furthermore, women who reported access to any sort of media were asked if they had ever seen, heard, or read any message pertaining to methods of family planning through these mediums. Less than one-fifth (17 percent) of the respondents had seen FP messages on the television. Only 3 percent of the women said they had heard family planning messages on radio, whereas 1 percent of the women reported that they had ever read about a family planning message in print media. Overall, one-fifth of the women reported exposure to FP messages through any of these mediums.

Chapter 4

Fertility

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

Other information collected in this baseline survey included the date of birth of all live births, and whether that child was still alive at the time of the survey. In case the mother did not remember the date of birth, she was asked how long ago her live birth was. Births that occurred during the last three years were ascertained from these responses. The number of births obtained through this procedure was then used to analyze current fertility. For a family planning program, it is essential to know about fertility levels to understand couples' responses to family planning.

Cumulative Fertility

Children Ever Born and Living

The number of children a woman has ever borne reflects fertility in the past; it therefore provides a somewhat different picture of fertility levels, trends, and differentials than do period measures of fertility, such as the CBR and the TFR. Table 4.1 shows the percentage distribution of all currently married women by the number of children ever born (CEB). The table shows these distributions by the age of the woman at the time of the survey.

Table 4.1: Distribution of MWRA by age of mother and number of children ever born (CEB)

Age group	None %	1-2 %	3-4 %	5 or more %	Total %	Total N	Mean CEB
15 - 19	60	38	2	0	100	50	0.5
20 - 24	20.9	57.3	19.1	2.7	100	110	1.7
25 - 29	7.5	18.0	45.1	29.3	100	133	3.6
30 - 34	1.9	7.8	30.1	60.2	100	103	5.0
35 - 39	3.0	4.0	15.0	78.0	100	100	6.2
40 - 44	3.0	1.5	7.6	87.9	100	66	7.7
45 - 49	2.1	0.0	12.8	85.1	100	47	8.2
Total	**11.7**	**19.5**	**22.8**	**46.0**	**100**	**609**	**4.5**

Table 4.2: Distribution of MWRA by age of mother and number of living children (LC)

Age group	0 %	1-2 %	3-4 %	5 or more %	Total %	Total N	Mean
15 - 19	60	40	0	0	100	50	0.5
20 - 24	23.6	61.8	13.6	0.9	100	110	1.5
25 - 29	7.5	25.6	47.4	19.5	100	133	3.1
30 - 34	1.9	12.6	36.9	48.5	100	103	4.4
35 - 39	3.0	7.0	18.0	72.0	100	100	5.5
40 - 44	3.0	6.1	19.7	71.2	100	66	6.2
45 - 49	2.1	2.1	17.0	78.7	100	47	6.7
Total	**12.2**	**24.1**	**25.5**	**38.3**	**100**	**609**	**3.8**

The table shows that early childbearing was fairly common in Rajanpur. The table, as expected, shows that the mean number of children ever born (Table 4.1) and living children (Table 4.2) increased with the age of the mother. Table 4.3 shows the mean number of ever born children and surviving sons and daughters. Among currently married women aged 15-49 years in Rajanpur, the mean number of children ever born was 4.5. The mean number of children ever born increased steadily with age, reaching as high as 8.2 children for women aged 45-49 years. On average, these women also had 6.7 living children. Each woman of the age group 40-49 years had lost more than one child on average, during her reproductive life (Table 4.3).

Table 4.3: Mean number of children ever born and children surviving, by sex of child and age of mother

	Ever born			Surviving			
	Boys	Girls	Total	Boys	Girls	Total	
Age group	%	%	%	%	%	%	N
15 – 19	0.2	0.3	0.5	0.2	0.3	0.5	50
20 – 24	1.0	0.7	1.7	0.9	0.6	1.5	110
25 – 29	1.8	1.8	3.6	1.6	1.6	3.1	133
30 – 34	2.7	2.4	5.0	2.3	2.1	4.4	103
35 – 39	3.1	3.1	6.2	2.8	2.8	5.5	100
40 – 44	4.0	3.7	7.7	3.3	2.9	6.2	66
45 – 49	4.3	3.9	8.2	3.5	3.2	6.7	47
Total	**2.3**	**2.1**	**4.5**	**2.0**	**1.8**	**3.8**	**609**

Table 4.1 also shows that 38 percent of married women 15-19 years of age had already given birth to at least one child and two percent of women in the same age group had minimum three children. Women aged 45-49 years had virtually completed childbearing. Among currently married women in this age group, 13 percent had reached the end of childbearing with fewer than five children ever born, while 85 percent had five or more than five children ever born. Data show that 98 percent of women aged 45-49 years had at least one live birth in their reproductive period, while 2 percent were nulliparous. The sex ratio of children ever born was 109 males per 100 females, whereas the sex ratio of living children was 111 males per 100 females (from Table 4.3).

Differentials in Children Ever Born and Surviving

Table 4.4 shows that differences in the mean number of children by literacy and by educational level of currently married women were pronounced. On average, literate women had 1.5 fewer children than illiterate women. As expected, fertility also declined with the level of education. Those who had "up to primary" education had on average 3.6 children ever born compared to 4.8 born to those who had no schooling. Those who had up to secondary education had 3.5 and above secondary had 2.1 children ever born.

Table 4.4: Mean number of children ever born, living and dead, by background characteristics

Characteristic	Children ever born	Total living children	Proportion dead	N
Literacy of mother				
Literate	3.3	3.1	0.085	120
Illiterate	4.8	4.0	0.158	489
Schooling of mother				
No education	4.8	4.0	0.157	487
Up to primary	3.6	3.2	0.116	59
Up to Secondary	3.5	3.3	0.077	44
Above secondary	2.1	2.0	0.026	19
Residence				
Rural	4.5	3.8	0.158	530
Urban	4.3	4.0	0.074	79
Literacy of husband				
Literate	4.0	3.6	0.118	314
Illiterate	4.9	4.1	0.173	295
Schooling of husband				
No education	4.9	4.1	0.162	309
Up to primary	4.5	3.6	0.192	91
Up to Secondary	3.9	3.5	0.102	149
Above secondary	3.7	3.3	0.085	55
Don't know	4.2	4.0	0.048	5
Standard of Living Index				
Low	4.5	3.8	0.165	266
Medium low	4.6	3.9	0.161	134
Medium high	3.9	3.4	0.126	116
High	4.8	4.3	0.105	93
Economic activity/ occupation				
Agriculture/Livestock/Poultry	4.8	4.1	0.156	250
Petty trader	4.2	3.9	0.072	50
Labor (daily wages)	4.0	3.3	0.172	144
Government service	5.2	4.5	0.125	37
Private service	4.0	3.1	0.230	28
Own business	3.8	3.4	0.107	39
Abroad	3.1	2.8	0.097	10
Unemployed	5.3	4.7	0.124	47
Skilled worker	3.0	3.0	0.000	1
Others	1.3	1.3	0.000	3
Total	**4.5**	**3.8**	**0.147**	**609**

Differentials were also observed on the basis of literacy and economic activity of husbands (Table 4.4). Those who had literate husbands had 4 children ever born compared to 4.9 for those who had illiterate husbands. Similarly, women with unemployed husbands had the highest number of children ever born (5.3 children).

A comparison of mean numbers of children ever born and surviving children showed that survival of children increased with literacy and educational levels of mothers. The survival of children was also higher if husbands were literate.

Table 4.5 further explains the relationship between age of mothers and literacy with mean number of children ever born and their survival. It is evident that the mean number of children ever born to literate mothers was lower (3.3 children) compared with that of mothers who were illiterate (4.8 children). Similarly, the survival of children with literate mothers was far better than that of illiterate mothers. The mean number of children ever-born to younger literate mothers was lower and their survival was better than children born to mothers in older age groups. Literate mothers were younger than illiterate mothers. In the below 35 age group, 77 percent were literate, as compared to 62 percent who were illiterate. It is not only that, overall, literate women had fewer children, but younger literate women also had fewer children ever born compared to illiterate women.

Table 4.5: Mean number of children ever born and living by age and literacy of mother

	Literate				Illiterate			
Age group	Mean number of CEB	Mean number of LC	N	%	Mean number of CEB	Mean number of LC	N	%
15 – 19	0.3	0.3	7	5.8	0.5	0.5	43	8.8
20 – 24	1.2	1.2	29	24.2	1.9	1.6	81	16.6
25 – 29	2.6	2.3	28	23.3	3.9	3.3	105	21.5
30 – 34	4.3	3.8	29	24.2	5.3	4.6	74	15.1
35 – 39	5.1	4.9	16	13.3	6.4	5.6	84	17.2
40 – 44	7.6	6.9	8	6.7	7.8	6.1	58	11.9
45 – 49	8.0	7.3	3	2.5	8.2	6.6	44	9.0
Total	**3.3**	**3.1**	**120**	**100**	**4.8**	**4.0**	**489**	**100**

Current Fertility

Crude Birth Rate

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

Age-specific Fertility Rates and Total Fertility Rate

The total fertility rate (TFR) is a more refined fertility measure than CBR. Age-specific fertility rates (ASFRs) and TFR are based on births to currently married women and the number of women living in the sample households. One of the limitations of measuring ASFRs is the low number of births in the sample during the last three years. The findings show a pattern of ASFRs common in developing countries; rates rise rapidly till age 25-29, then decline with increasing age. A TFR of 4.6 for the period 2006-2009 was obtained from the set of ASFRs calculated from the data presented in Table 4.6; this is higher than the figure of 4.1 for Pakistan as a whole reported in the PDHS (NIPS/PDHS, 2008).

Table 4.6: Number of women in sample households and number of births during the last three years before the survey, by age of women, and ASFRs, TFR and CBR

Age group	Women	Births	Age specific fertility rate (ASFR)
15 – 19	291	22	25.2
20 – 24	220	100	151.5
25 – 29	186	124	222.2
30 – 34	128	75	195.3
35 – 39	116	62	178.2
40 – 44	79	26	109.7
45 – 49	63	9	47.6
Total	**1083**	**418**	**na**
TFR: 4.6			
CBR: 27.8			

na =not applicable.

Mothers with Children Under Five Years

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

Table 4.7: Distribution of mothers by pregnancy status and number of children under 5 years

	Currently pregnant		Currently not pregnant		Total	
Number of children < 5 years	%	N	%	N	%	N
0	15.8	30	84.2	160	100.0	190
1	17.9	34	82.1	156	100.0	190
2	17.7	33	82.3	153	100.0	186
3	14.3	6	85.7	36	100.0	42
4	0.0	0	100.0	1	100.0	1
N	**16.9**	**103**	**83.1**	**506**	**100.0**	**609**

Table 4.7 shows a significant number of women with the burden of caring for several young children. Among those women who already had had three living children under 5 years of age, 14 percent were currently pregnant. Moreover, among women who had two living children under five years of age, 18 percent were currently pregnant. For such mothers, it is particularly important for their health and that of their children to ensure that birth spacing is part of their married life at this point.

Preceding Birth Interval

Women with short birth intervals are at higher risk for delivering premature, low-birth-weight or small-for-gestational age infants (Fuentes-Affelick and Hessol, 2000; Miller et al., 1995; Zhu et al., 1999). The length of the preceding birth interval is very important for the health of both mothers and babies. Table 4.8 shows the length of last closed birth interval

for women with two or more births by background characteristics of mothers at the time of the survey.

Table 4.8: Distribution of women with preceding birth intervals (birth to birth) by background characteristics

Age group	Up to 17 months	18 - 23 months	24 - 35 months	36 - 47 months	48 and above	Total	N
15 – 19	33.3	0.0	66.7	0.0	0.0	100.0	3
20 – 24	20.0	20.0	40.0	18.5	1.5	100.0	65
25 – 29	14.5	31.2	29.7	18.8	5.8	100.0	138
30 – 34	19.6	18.6	28.4	18.6	14.7	100.0	102
35 – 39	8.9	12.7	36.7	16.5	25.3	100.0	79
40 – 44	6.5	12.9	35.5	25.8	19.4	100.0	31
45 – 49	20.0	6.7	13.3	26.7	33.3	100.0	15
Birth order							
2	16.7	22.9	37.5	20.8	2.1	100.0	48
3	18.2	19.7	27.3	21.2	13.6	100.0	66
4	12.7	24.1	30.4	21.5	11.4	100.0	79
5	18.8	17.2	32.8	15.6	15.6	100.0	64
6+	13.6	20.5	33.5	17.6	14.8	100.0	176
Education level							
No education	14.1	21.2	31.6	21.2	11.9	100.0	354
Up to primary	28.2	23.1	35.9	5.1	7.7	100.0	39
Up to Secondary	13.3	20.0	33.3	13.3	20.0	100.0	30
Above secondary	10.0	0.0	40.0	10.0	40.0	100.0	10
Standard of Living Index							
Low	15.0	20.5	34.0	23.5	7.0	100.0	200
Medium low	17.8	25.7	27.7	13.9	14.9	100.0	101
Medium high	12.0	14.7	32.0	22.7	18.7	100.0	75
High	15.8	21.1	35.1	7.0	21.1	100.0	57
Total	**15.2**	**20.8**	**32.3**	**18.9**	**12.7**	**100.0**	**433**

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

closes a short birth interval is higher than those experienced by an index child whose birth closes a longer birth interval (Mahmood, 2002). It has also been found that children born within the preceding interval of 18 months experienced higher mortality risks during infancy than those born in an interval of two to three years (Cleland and Sathar, 1984).

Table 4.8 shows that 15 percent of the children were born with less than 18 months of the birth interval. Sixty-eight percent were born with a birth interval of less than 36 months, while 32 percent were born after three years or more. The differentials by mother's age, educational level and standard of living index are also shown.

Chapter 5

Maternal and Neonatal Care

Birth spacing is an integral part of maternal and neonatal care. Adequate spacing of births improves the health of mothers and babies; at the same time, the survival of mothers and babies allows for longer birth intervals. In this survey, a small battery of questions was asked regarding the most recent child born during the past four years, reflecting some of the essential indicators of maternal and neonatal care. A total of 402 women out of the 609 total women interviewed had borne a child during the past four years, and therefore qualified for these questions.

Antenatal Care

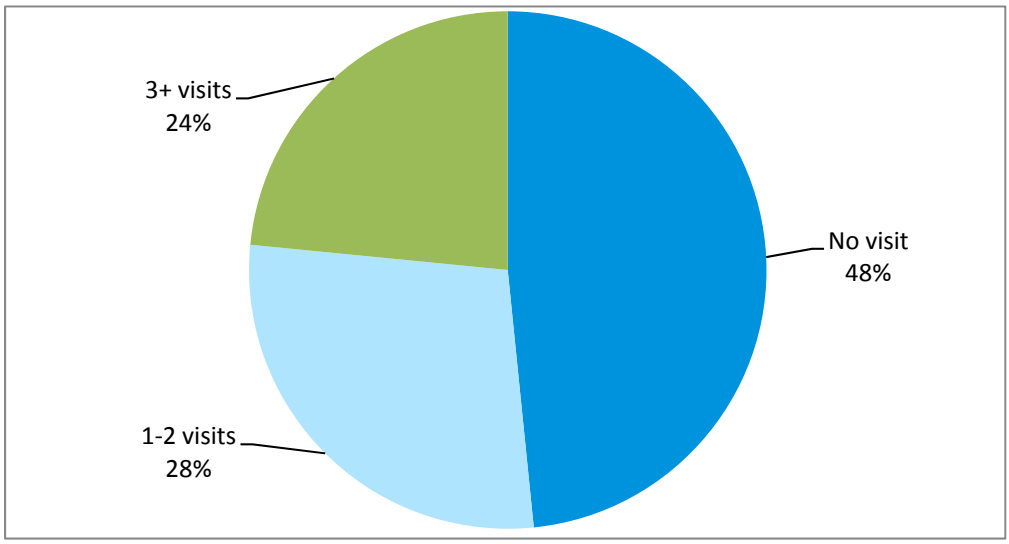
Antenatal check-ups allow for skilled health personnel to advise expectant mothers how to best take care of themselves and their unborn baby during the pregnancy, to prepare them for childbirth and caring for the newborn, and to identify possible problems during pregnancy and delivery. The Ministry of Health recommends at least three antenatal visits during pregnancy, preferably four. Traditionally however many women have viewed childbirth as a natural experience and perhaps did not find health providers nearby and have not gone to skilled providers for antenatal care. In recent years, those proportions have been increasing in Pakistan (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 5.1 and Figure 5.1 show the numbers of ANC visits for the last birth of women who had delivered babies during the previous four years. Almost 52 percent of the sample respondents had received at least one antenatal care visit during the last pregnancy; the percentage was higher for urban mothers (75 percent) than for rural ones (49 percent). This shows that more awareness about antenatal care exists in urban areas of Rajanpur. Overall 52 percent figure is lower than the level obtained for Punjab in the PDHS (61 percent) or the level obtained nationally in the PDHS (also 61 percent) (Government of

Pakistan, 2006; NIPS/PDHS, 2008). Twenty four percent of the women had at least three such visits, and 14 percent had four or more visits.

Table 5.1: Distribution of ANC check-ups during last pregnancy by residence

Number of ANC visits	Rural		Urban		Total	
	N	%	N	%	N	%
No visit	182	51.4	12	25.0	194	48.3
1-2 visits	99	28.0	14	29.2	113	28.1
3 visits	31	8.8	7	14.6	38	9.5
4+ visits	41	11.6	15	31.3	56	13.9
Don't remember	1	0.3	0	0.0	1	0.2
Total	**354**	**100**	**48**	**100**	**402**	**100**

Figure 5.1: Distribution of MWRA by number of antenatal visits during last pregnancy



Data also show that many of these visits were in response to problems during pregnancy rather than for some routine check-up. About 56 percent of the first antenatal visits were for some problem during pregnancy while 44 percent of first visits were for routine check-up (Figure 5.2).

Figure 5.2: Percentage of women according to the reason for the first antenatal visit during last pregnancy

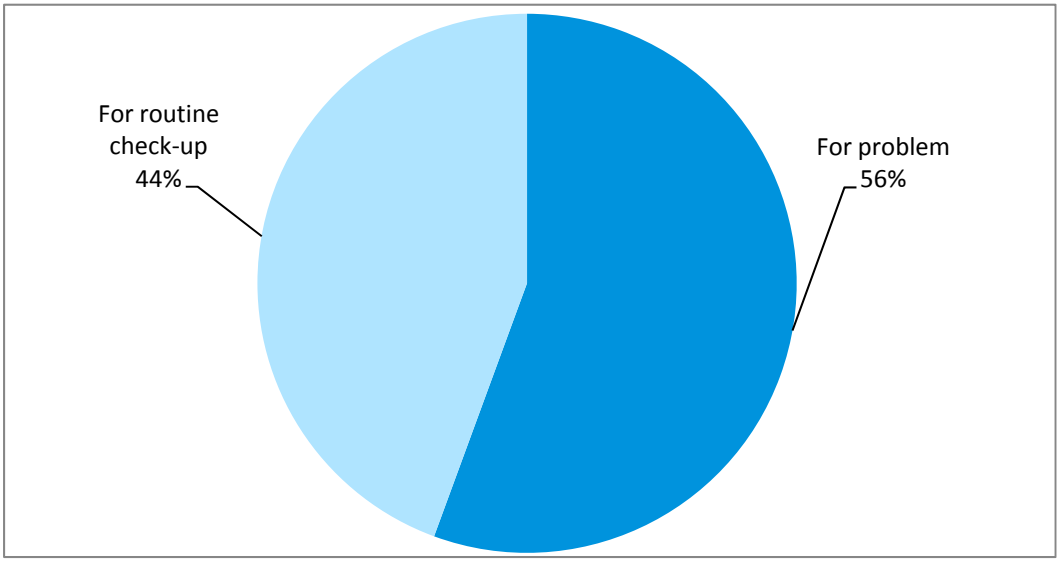


Figure 5.3 shows uniformity in first ante-natal visits during the period of gestation. One third of the women in each trimester had ante-natal visits

Figure 5.3: Distribution of MWRA by gestational age of first antenatal visit during last pregnancy

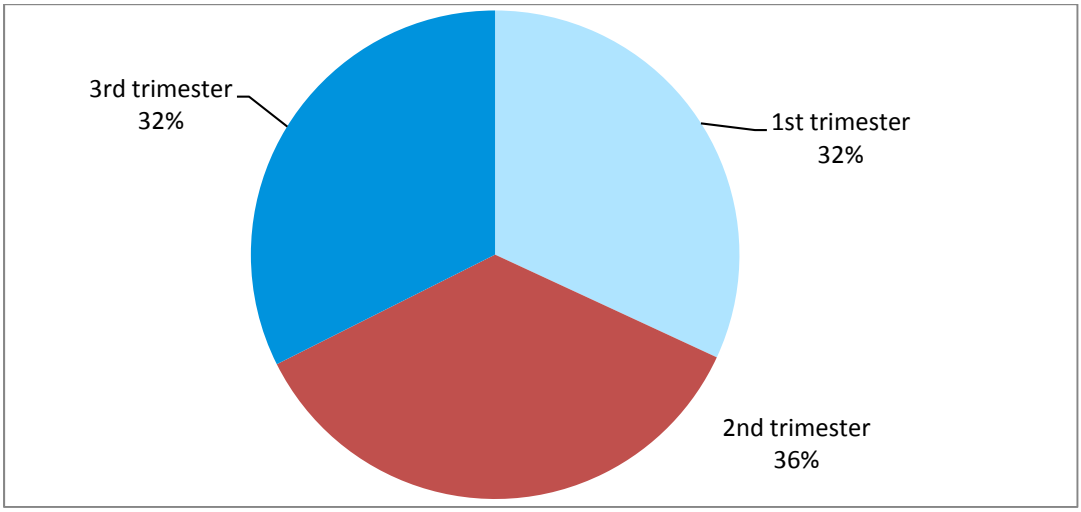
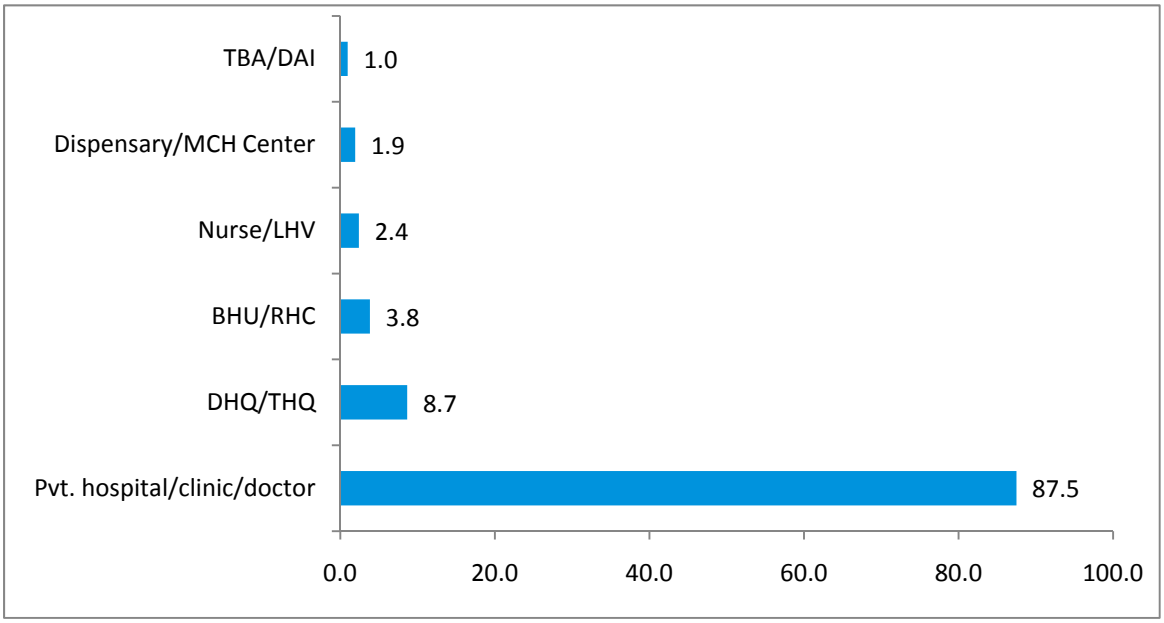


Table 5.2: Facilities/service providers mentioned for one or more antenatal visits by residence

Facilities/service providers	Rural	Urban	Total
Dispensary/MCH Center	2.3	0	1.9
BHU/RHC	4.7	0	3.8
DHQ/THQ	5.8	22.2	8.7
Pvt. hospital/clinic/doctor	88.4	83.3	87.5
TBA/DAI	1.2	0	1.0
Nurse/LHV	2.9	0	2.4
N	**172**	**36**	**208**

Table 5.2 and Figure 5.4 show the locations where respondents made one or more antenatal visits. Most antenatal visits took place in private sector facilities. The most common providers of antenatal care were private hospitals and clinics (88 percent), followed by DHQ/THQ hospitals (9 percent), and BHUs and RHCs (4 percent).

Figure 5.4: Location where respondents made one or more antenatal visits



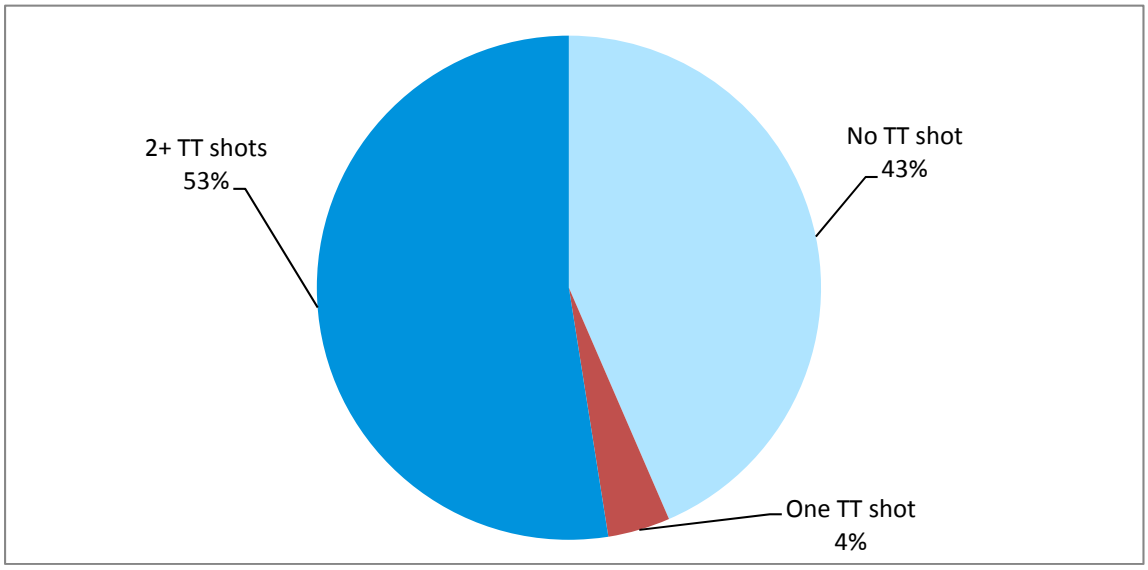
Tetanus Immunization

Tetanus Toxoid immunization is important to avoid tetanus in the newborn or mother. Two doses in a pregnancy are sufficient to prevent tetanus. However, if the woman was immunized during her previous pregnancy, only one dose may be needed. Five doses are sufficient for lifetime protection. According to the PSLMS 2004-05, 57 percent of the mothers in Rajanpur had received at least one shot. According to the PDHS 2006-07, 59 percent in Punjab and 53 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 5.3 and figure 5.5 show that 57 percent of the mothers in Rajanpur had received at least one shot during their last pregnancy, and 53 percent had received two or more shots. The immunization rate for 2+ shots was much higher in urban than in rural areas.

Table 5.3: Distribution of mothers according to residence, by status of tetanus Toxoid injections during last pregnancy

	Rural		Urban		Total	
Number of injections	**N**	**%**	**N**	**%**	**N**	**%**
No TT shot	169	47.7	6	12.5	175	43.5
One TT shot	15	4.2	1	2.1	16	4.0
2+ TT shots	170	48.0	41	85.4	211	52.5
Total	**354**	**100**	**48**	**100**	**402**	**100**

Figure 5.5: Tetanus immunization during last pregnancy



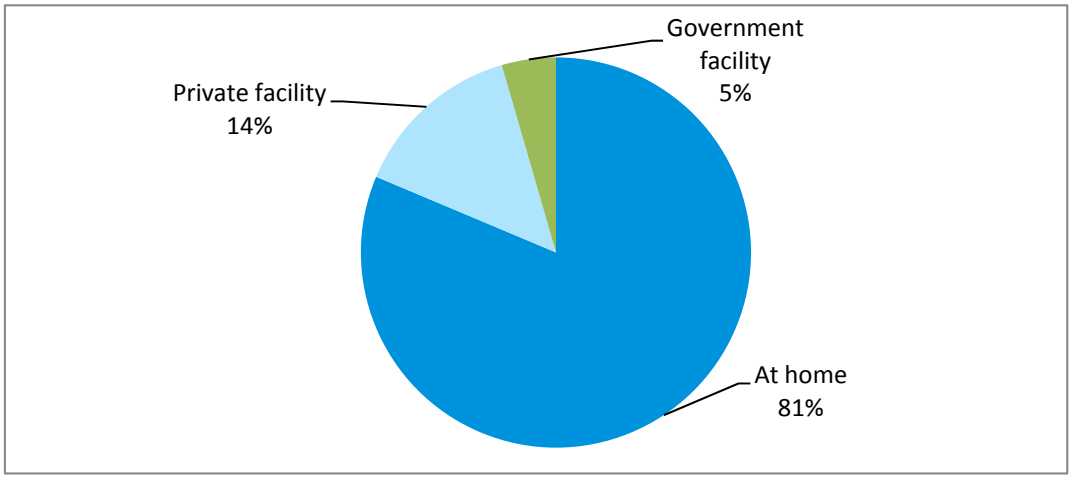
Location and Attendance at Delivery

Among the most important ways to reduce maternal mortality is to increase the proportion of mothers delivering in a health facility with the support of a trained birth attendant. Although these proportions have been historically low in Pakistan and have contributed substantially to high maternal mortality, they have been rising in recent years. In Rajanpur, according to the 2004-05 PSLMS, 7 percent of the deliveries took place in institutions, compared with PDHS 2006-07 figures of 33 percent for Punjab and 34 percent nationally (Government of Pakistan, 2006; NIPS/PDHS, 2008). In the present survey, a significant number of deliveries (81 percent) did take place at home placing the mothers at high risk of mortality. Nearly one- fifth of the most recent deliveries (19 percent) were in a health facility (Table 5.4; Figure 5.6). Deliveries at health facilities were higher in urban areas (46 percent) than rural ones (15 percent).

Table 5.4: Distribution of mothers by place of last delivery and residence

	Rural		Urban		Total	
Place of delivery	**N**	**%**	**N**	**%**	**N**	**%**
At home	301	85.0	26	54.2	327	81.3
Dispensary/MCH	0	0.0	1	2.1	1	0.2
BHU/RHC	2	0.6	0	0.0	2	0.5
DHQ/THQ	9	2.5	6	12.5	15	3.7
Pvt. hospital/clinic	42	11.9	15	31.3	57	14.2
Total	354	100	48	100	402	100

Figure 5.6: Distribution of mothers by location of last delivery

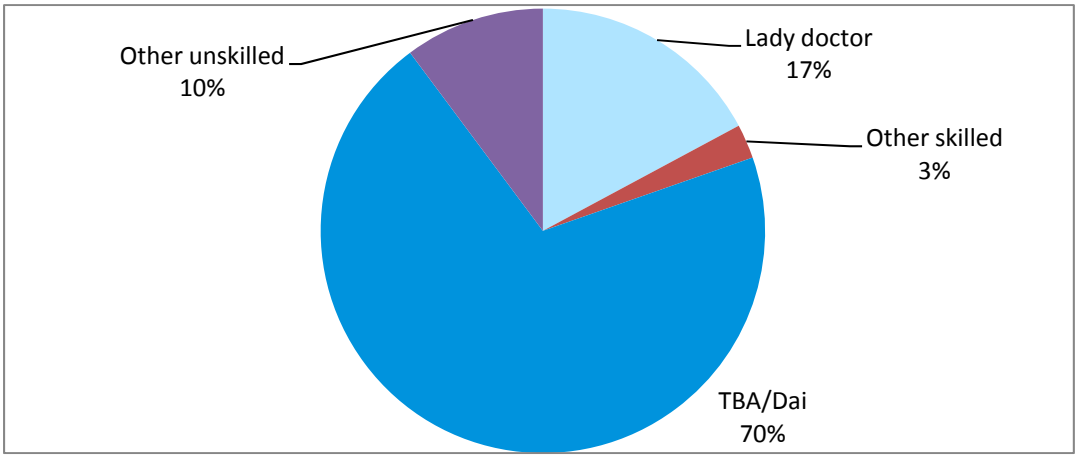


Moreover, in this survey, 20 percent of reported deliveries in the previous four years were delivered by a skilled birth attendant, 42 percent in urban areas versus 17 percent in rural areas (Table 5.5). In the PSLMS 2004-05 for Rajanpur, only 9 percent of births were delivered by a skilled attendant; in the PDHS 2006-07, the corresponding figures were 38 percent for Punjab and 39 percent for Pakistan as a whole (Government of Pakistan, 2006; NIPS/PDHS, 2008). Most of the births attended by a skilled attendant in this household survey were reportedly attended by a lady doctor. The term "doctor," however, may in such interviews mean a paramedic, such as a Lady Health Visitor. About 70 percent of the births were delivered by dais (traditional birth attendants), while one-tenth of deliveries (10 percent) were delivered by a relative or neighbor who was not a *Dai* (Figure 5.7).

Table 5.5: Distribution of mothers by attendant at last delivery and residence

	Rural		Urban		Total	
Birth attendant and skill level	**N**	**%**	**N**	**%**	**N**	**%**
TBA/Dai	255	72.0	27	56.3	282	70.1
Nurse/LHV	9	2.5	1	2.1	10	2.5
Lady doctor	50	14.1	19	39.6	69	17.2
Female relative/Friend/Neighbor (not a dai)	40	11.3	1	2.1	41	10.2
Total	**354**	**100**	**48**	**100**	**402**	**100**
Skilled birth attendant	59	16.7	20	41.7	79	19.7
Unskilled birth attendant	295	83.3	28	58.3	323	80.3

Figure 5.7: Distribution of mothers by attendant at last delivery



Postpartum Care

For both the health of the mother as well as the health of the newborn, a newly delivered baby and mother should receive follow-up check-ups for at least six weeks after delivery. The Ministry of Health guidelines recommend at least one postnatal visit during the first 42 days after delivery. However this is a major weakness of maternal and newborn health care in Pakistan. Women who deliver at home rarely go for any postnatal check-ups. Rajanpur is no exception (Table 5.6). Only two percent of the respondents who had a non-institutional delivery reported having postpartum care within 24 hours of delivery, whereas those who delivered at a facility were assumed to have received postnatal care within 24 hours of the delivery.

With regard to family planning, the absence of postpartum visits represents a missed opportunity to talk to the mother about birth spacing. Much international evidence supports the value of the postpartum period as a critical time for the mother to focus on family planning, its role in the next birth interval, and how and when to take steps to end childbearing (WHO, 2006).

Table 5.6: Distribution of mothers by status of postnatal check-up and place of delivery

	Postnatal check-up With in 24 hours		Postnatal check-up after 24 hours		Didn't have postnatal checkup		Total	
Place of delivery	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Institutional delivery	74	100.0	0	0.0	0	0.0	74	100.0
Non-institutional delivery	5	1.5	19	5.8	304	92.7	328	100.0
Total	**79**	**19.7**	**19**	**4.7**	**304**	**75.6**	**402**	**100.0**

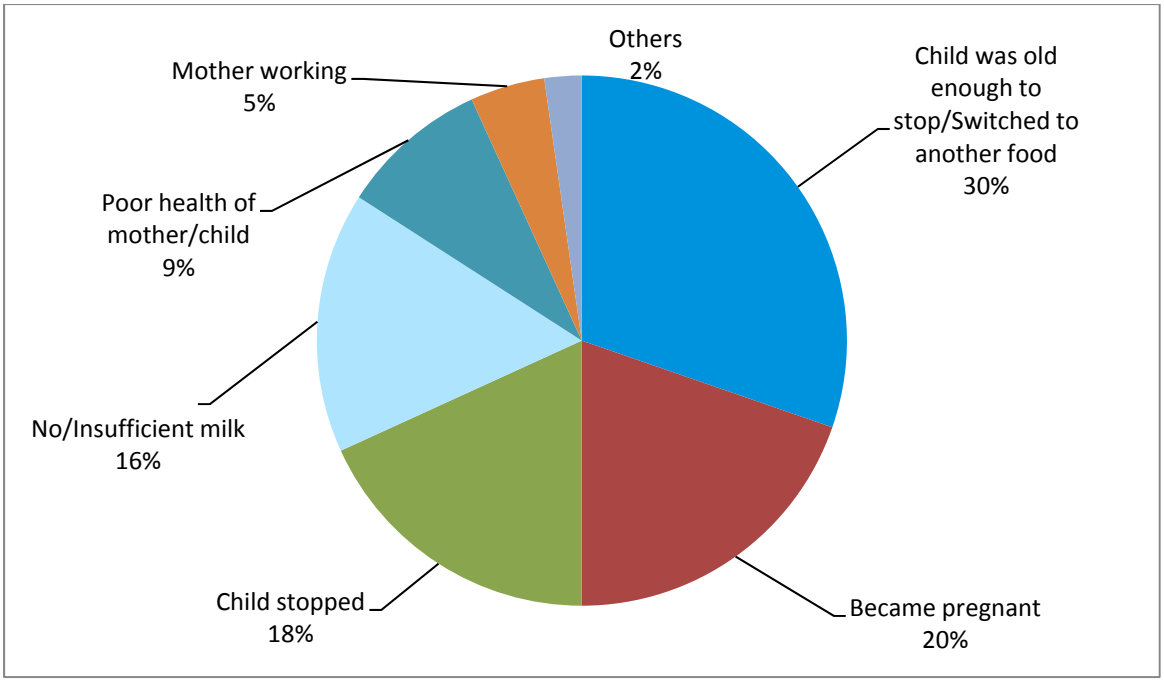
Breastfeeding

Breastfeeding is a critical component of newborn and infant health. In addition, it is a primary determinant of the length of postpartum amenorrhea. In this manner, breastfeeding can be deliberately used to delay pregnancy, either through a formal procedure, such as “lactational amenorrhea method” (LAM), or more informally through the assumption that breastfeeding protects against pregnancy. Virtually all Pakistani women breastfeed their children to some extent. In our sample, only 8 of 384 respondents reported

not having breastfed their last child at all. Breastfeeding is normally done for a substantial period of time; the median length of breastfeeding for the last baby (not currently being breastfed) was 20 months, and the most common length was 24 months. Six main reasons were given for discontinuing breastfeeding - the child was old enough (30 percent); mother became pregnant (20 percent); Child stopped (18 percent); No/ insufficient milk production (16 percent); poor health of the mother/child (9 percent) and mother working (5 percent)(Figure 5.8).

An important problem related to breastfeeding in Pakistan is the early initiation of supplementary food. About 26 percent of the women who had their last child in the past four years reported discontinuing exclusive breastfeeding prior to the fourth month. Most women went up to six months (58 percent). This shows that a majority of women were not protected from becoming pregnant while they were breastfeeding.

Figure 5.8: Distribution of mothers by reason for discontinuing breastfeeding (n=132)



Chapter 6

Preference for Children

To understand how to meet couples' family planning needs, it is essential to understand how they feel about the number and timing of the children they want. In general, couples' views on this subject typically evolve over the course of their reproductive years: in the beginning, they want their first children quickly; towards the end of their reproductive lives, they are quite sure they want to stop. At some point in the middle, they may go through a period of ambivalence, where their views are uncertain and conflicted. Husbands and wives may or may not agree on these matters, and may or may not communicate well. Often it is difficult to get at the full "truth" of couples' feelings on these issues, because they themselves may not be certain. However, we asked questions and recorded responses, and investigated in as much depth as possible.

Ideal Number of Children

One way of investigating fertility preference is to ask respondents, regardless of current fertility status, how many children they would ideally want. The exact wording, asked of female respondents, is (English translation): "If you could choose the exact number of children to have in your whole life, how many would that be?" Table 6.1 shows the responses.

The median "ideal" number, as indicated in the table below, was five children. About 49 percent of the respondents wanted four or less children, with 50 percent citing five or more. In fact, only 4 percent said they wanted two or fewer children. More than half of the rural women (52 percent) interviewed wanted five or more children, whereas 30 percent of the urban women also had the same desire. About one percent of women also gave a non-numeric response to the question, such as "up to God" that's too only in rural areas.

Table 6.1: Distribution of MWRA with ideal number of children for their family by residence

	Rural		Urban		Total	
Number of children	**N**	**%**	**N**	**%**	**N**	**%**
1	3	0.6	0	0	3	0.5
2	20	3.8	4	5.1	24	3.9
3	47	8.9	10	12.7	57	9.4
4	176	33.2	41	51.9	217	35.6
5	96	18.1	12	15.2	108	17.7
6	108	20.4	5	6.3	113	18.6
7 or more	73	13.8	7	8.9	80	13.1
Up to God	5	0.9	0	0.0	5	0.8
Don't know	2	0.4	0	0.0	2	0.3
Total	**530**	**100**	**79**	**100**	**609**	**100**

Desire for More Children

Levels of Desire for More Children

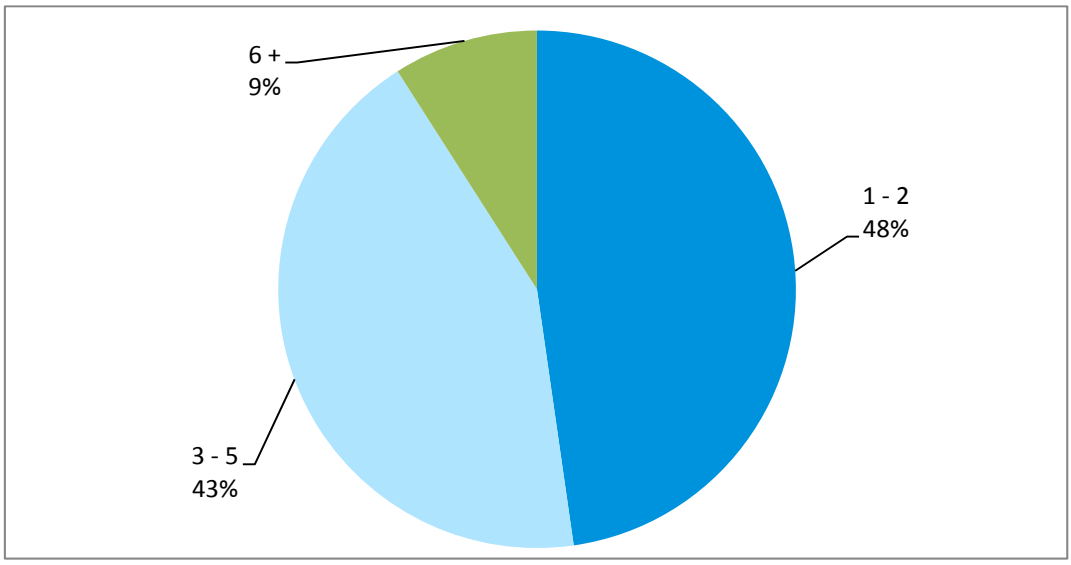
A more immediate measure of fertility preference is whether a couple wants more children; if so, do they want the next child now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already has. Table 6.2 shows that whether respondents wanted more children soon, later (after 2 years or more) or not at all, this was by the number of living children they already had. The proportion wanting more children soon declined sharply after the first birth. A quarter of the respondents sampled wanted their next child soon, whereas, slightly more than half of the women did not want more children. About one-quarter of the women (24 percent) wanted children later. For all those with one to three living children, most of those who wanted an additional child wanted to have it later, rather than right away. On the other hand, more than two third (68 percent) of the women with four living children did not want to have more children. For those with six or more children, 94 percent did not want to have more children. The pattern of desired fertility reported by women seems somewhat lower than their reported ideal number of children. The table below indicates clearly the level of interest in both spacing and limiting births.

Table 6.2: Distribution of MWRA by desire for next child and current number of living children

Number of living children	Desire for next child			Total	
	Soon	Later	Never	N	%
0	67.6	32.4	0	74	100
1	42.9	51.4	5.7	70	100
2	41.6	46.8	11.7	77	100
3	22.9	37.1	40.0	70	100
4	14.1	17.6	68.2	85	100
5	5.3	8.0	86.7	75	100
6 or more	4.4	1.9	93.7	158	100
Total	**24.8**	**24.0**	**51.2**	**609**	**100**
N	151	146	312	609	100

Women who wanted more children were asked to state how many more children they wanted. As shown in Figure 6.1, slightly less than half (48 percent) of all respondents who wanted more children said they wanted one or two more. More than two-fifth of respondents (43 percent) wanted 3-5 more children.

Figure 6.1: Distribution of women by desire for more children in future



Socioeconomic Correlates of Desire for Children

A woman's stated desire was analyzed in relation to three possible socioeconomic determinants: standard of living index (SLI), age, respondent's literacy and residence (Table 6.3). The relationship between SLI and desire for more children was weak and inconsistent. Literate women were more likely to want the next child at a later time (33 percent) compared to the illiterate women (22 percent). On the other hand illiterate women were more likely not to have more children (52 percent) compared to the literate women (47 percent). Like SLI, desire was not different for urban and rural dwellers.

Table 6.3: Distribution of MWRA by reported desire for more children and background characteristics

	Desire for next child			Total	
Characteristic	**Soon**	**Later**	**Never**	**N**	**%**
Standard of Living Index					
Low	30.5	20.3	49.2	266	100.0
Medium low	23.9	28.4	47.8	134	100.0
Medium high	23.3	23.3	53.4	116	100.0
High	11.8	29.0	59.1	93	100.0
Age group					
< 25	42.5	50.0	7.5	160	100.0
25 or more	18.5	14.7	66.8	449	100.0
Literacy of respondent					
Literate	20	33.3	46.7	120	100.0
Illiterate	26.0	21.7	52.4	489	100.0
Residence					
Rural	25.8	23.4	50.8	530	100.0
Urban	17.7	27.8	54.4	79	100.0
Total	**24.8**	**24.0**	**51.2**	**609**	**100.0**

Son Preference

In Pakistan, there is usually a preference for sons over daughters. The belief that a family is incomplete without sons is stronger than the corresponding belief for daughters. In this questionnaire, respondents were asked how many daughters they would have before stopping if they did not have a son, and correspondingly for sons if they did not have a daughter. Table 6.4 shows that only 7 percent said there was no limit to the number of sons before a daughter, while 15 percent of the women said there would be no limit in the number of daughters before having a son. For those women who gave a number, the median numbers of daughters before having a son was 4 and the median number of sons before having a daughter was 3.

Table 6.4: Son and daughter preferences by the respondents

	Number of daughters for desire of son		Number of sons for desire of daughters	
Responses	**N**	**%**	**N**	**%**
Up to God	10	1.6	26	4.3
No limit	94	15.4	44	7.2
Other non-numeric responses	3	0.5	3	0.5
Numeric responses	502	82.4	536	88.0
Total	**609**	**100.0**	**609**	**100.0**
Median*	**4**	**na**	**3**	**na**

*Of the numeric response. na=not applicable.

Strength of Preference

The strength of preferences asked in such surveys can be questioned. The need for birth spacing can be presumed to be greater if a couple is strongly motivated not to have more children, or to delay the next pregnancy than if this does not matter much to them. We asked women if they became pregnant soon, whether they would be pleased, worried, accept it, or if it did not matter. Results are shown in Table 6.5 and Table 6.6. (This question excludes those 293 of the total 609 women who wanted a next child soon, were currently pregnant, had been sterilized, had gone through menopause or had a hysterectomy.)

Table 6.5: Distribution of MWRA who did not want more children soon by reaction if they become pregnant in near future

	Desire for next child		Total	
Reaction if pregnant	**Later**	**Never**	**%**	**N**
Pleased			10.1	32
Worried	35.9	65.7	56.0	177
Accept it	29.1	26.3	27.2	86
Doesn't matter	2.9	5.6	4.7	15
Will abort	1.0	0.5	0.6	2
Others	0.0	1.9	1.3	4
N	**103**	**213**	**na**	**316**

na=not applicable.

Table 6.6: Distribution of MWRA who do not want more children soon by problem faced if they became pregnant

	Desire for next child		Total	
Reaction if pregnant	**Later**	**Never**	**%**	**N**
Own health	60.2	81.2	74.4	235
Health of youngest child	63.1	51.6	55.4	175
Caring of children	65.0	75.6	72.2	228
Schooling of children	28.2	54.0	45.6	144
Family economic situation	60.2	81.2	74.4	235
Against religion	0	0.5	0.3	1
Will feel shy because other kids are grown	0	1.9	1.3	4
N	**103**	**213**	**na**	**316**

Respondents could give more than one response, na=not applicable.

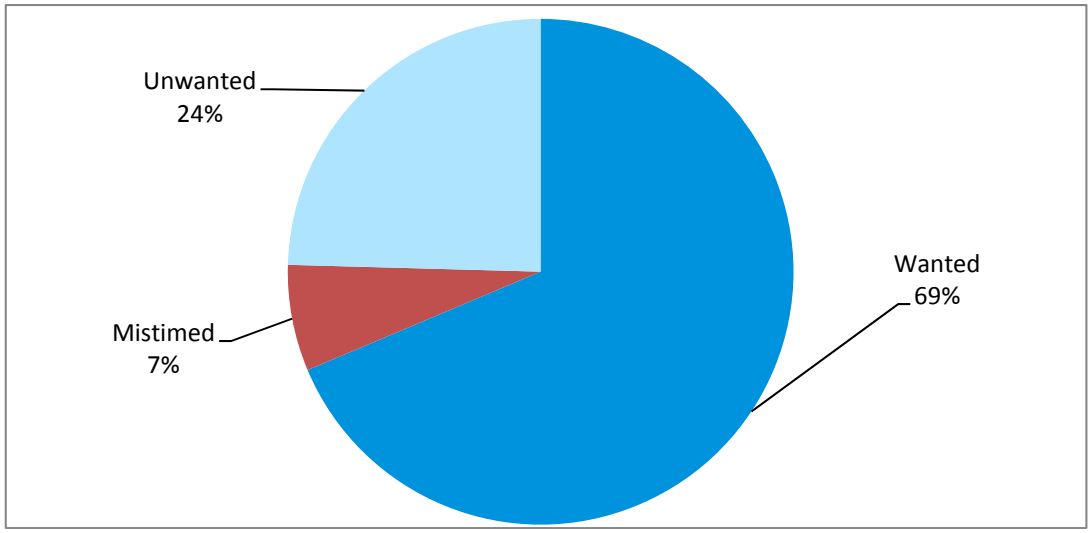
Among those who did not want more children at all, two third (66 percent) said that they would be worried if they became pregnant. Twenty-six percent reported that they would accept the new pregnancy. Among those women who wanted to delay their next pregnancy for more than 2 years, more than one-third (36 percent) said that they would be worried. About 29 percent of them said they would accept the pregnancy, which shows weak motivation for spacing and limiting. However, the high proportion of those saying they would be worried if they became pregnant supports their earlier statement that they wanted to delay or stop childbearing.

Further, women who expressed a desire to not have more children, or to delay the next child, were asked what problems they would face if they became pregnant soon. Table 6.6 shows their responses. The problems most commonly faced were regarding their own health and family economic situation while around two percent of respondents said that they will feel shy in the presence of their grown-up children if they become pregnant. Health (their own and that of their youngest child) and caring for children were commonly cited, along with the schooling of their children. This indicates that women's own health is now becoming a priority for them, which is consistent with the objectives of FALAH.

Attitudes towards Last Pregnancy

Another important dimension of fertility preference relates to whether the last pregnancy was wanted at the time, was mistimed (i.e., wanted later), or was not wanted at all. Pregnancies that are unwanted cause hardship in many ways, and represent a failure to realize a couple's right to have the number of children they want, at the time they are wanted. This can be somewhat difficult to determine precisely in surveys. Sometimes parents report that an unwanted pregnancy was actually wanted, but it is less common to report that a child was wanted when in fact it was not. In this survey, women were far more likely to report that their last pregnancy was unwanted (24 percent) or mistimed (7 percent) (Figure 6.2.)

Figure 6.2: Distribution of MWRA by their attitudes toward their last pregnancy



Women's Perception of Fertility Preferences of Husbands

Women were asked whether they thought their husbands wanted the same number of children as they did, or whether they wanted more/fewer children. In Table 6.7, their responses are tabulated according to their ideal family size. About 9 percent did not know their husband's preference, while another 66 percent thought their husbands wanted the same number as they did. However, about 21 percent thought their husbands wanted more children than they did, while only about five percent thought their husbands wanted fewer children. This shows that almost two-thirds (66 percent) of the women felt that their desire and their husband's desire were the same.

Table 6.7: Distribution of MWRA according to perception of husband's desire for more children, by woman's ideal family size

	Perceived husband's desire for more children				Total	
Ideal family size of a woman	Same number	More children	Fewer children	Don't know	%	N
1 - 2 children	66.7	29.6	3.7	0.0	100	27
3 - 4 children	64.6	20.8	6.2	8.4	100	274
5 + children	68.4	19.6	3.3	8.6	100	301
Up to God	0.0	20.0	0.0	80.0	100	5
Don't know	50.0	0.0	0.0	50.0	100	2
Total	**66.0**	**20.5**	**4.6**	**8.9**	**100**	**609**
N	402	125	28	54	na	609

na=not applicable.

Chapter 7

Contraceptive Knowledge and Use

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

Knowledge

For many years, at least 95 percent of the married women of reproductive age in Pakistan have known of at least one method of contraception. Table 7.1 shows that this holds true for Rajanpur as well; nearly all women interviewed (99 percent) knew at least one method. The knowledge of a great majority of the female respondents regarding pills, injections, female sterilization, IUD and condoms was excellent. The highest knowledge was of pills (98.2 percent). These aforementioned methods along with withdrawal were known to a higher proportion of respondents in Rajanpur than in the National PDHS 2006-07. Conversely, more women in the PDHS knew the less common methods, i.e., rhythm ("safe period") and Norplant (NIPS/PDHS, 2008). Data shows that there was some visible difference in knowledge between rural and urban women in condom, norplant and male sterilization. The vast knowledge of various program methods among women may also be the result of activities of LHW program in the district.

Table 7.1: Distribution of MWRA by knowledge (prompted) contraceptive methods, by method and residence

Method	Rural	Urban	Total
Female sterilization	94.2	98.7	94.7
Male sterilization	58.9	93.7	63.4
Pill	97.9	100.0	98.2
IUD	89.8	98.7	91.0
Injectables	96.6	100.0	97.0
Norplant	22.5	67.1	28.2
Condom	71.9	100.0	75.5
Rhythm	27.4	65.8	32.3
Withdrawal	68.1	96.2	71.8
Other FP methods	4.3	2.5	4.1
Emergency Pills	10.9	62.0	17.6
Any FP method	98.9	100.0	99.0
Any modern FP method	98.9	100.0	99.0
Any traditional FP method	74.9	97.5	77.8
N	**530**	**79**	**609**

Use of Contraceptive Methods

Levels of Ever Use and Current Use

For the purpose of analyzing use of contraceptives in a population, currently married women of reproductive age (typically taken to be 15-49) have been divided into "ever users," i.e., women who have used some form of contraception at some point, and "never users," who have not. The ever users were further divided into current users and past users. These categories are in standard use in Pakistan and internationally.

Of all the married women interviewed in our sample, 35 percent reported having used some method of contraception during their married lives (Table 7.2). This percentage was substantially lower for rural women (31 percent) than for urban women (62 percent). It was also substantially lower than the proportion obtained in the PDHS 2006-07 for Pakistan (48.7 percent) (NIPS/PDHS, 2008).

Table 7.2: Percentage distribution of MWRA by contraceptive use status and residence

	Ever users				Current users				Past users			
Method	**Rural**	**Urban**	**Total**	**N**	**Rural**	**Urban**	**Total**	**N**	**Rural**	**Urban**	**Total**	**N**
Pill	7.9	13.9	8.7	53	1.3	1.3	1.3	8	6.6	12.7	7.4	45
IUD	6.6	16.5	7.9	48	1.7	8.9	2.6	16	4.9	7.6	5.3	32
Injectable	9.8	15.2	10.5	64	2.5	1.3	2.3	14	7.4	13.9	8.2	50
Nor plant	0.0	0.0	0.0	0	0.0	0.0	0.0	0	0.0	0.0	0.0	0
Condom	4.3	25.3	7.1	43	1.7	10.1	2.8	17	2.6	15.2	4.3	26
Rhythm method	1.3	5.1	1.8	11	0.2	0.0	0.2	1	1.1	5.1	1.6	10
Withdrawal	10.2	26.6	12.3	75	5.5	15.2	6.7	41	4.7	11.4	5.6	34
Female sterilization	4.2	3.8	4.1	25	4.2	3.8	4.1	25	0.0	0.0	0.0	0
Male sterilization	0.4	0.0	0.3	2	0.4	0.0	0.3	2	0.0	0.0	0.0	0
Any FP method	31.1	62.0	35.1	214	17.4	40.5	20.4	124	13.8	21.5	14.8	90
Any modern FP method	27.4	53.2	30.7	187	11.7	25.3	13.5	82	15.7	27.8	17.2	105
Any traditional FP method	10.4	27.8	12.6	77	5.7	15.2	6.9	42	4.7	11.4	5.6	34
N	**530**	**79**	**609**	**609**	**530**	**79**	**609**	**609**	**530**	**79**	**609**	**609**
Emergency pills	0.2	0.0	0.2	1	na	na	na	0	na	na	na	0

na= not applicable.

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

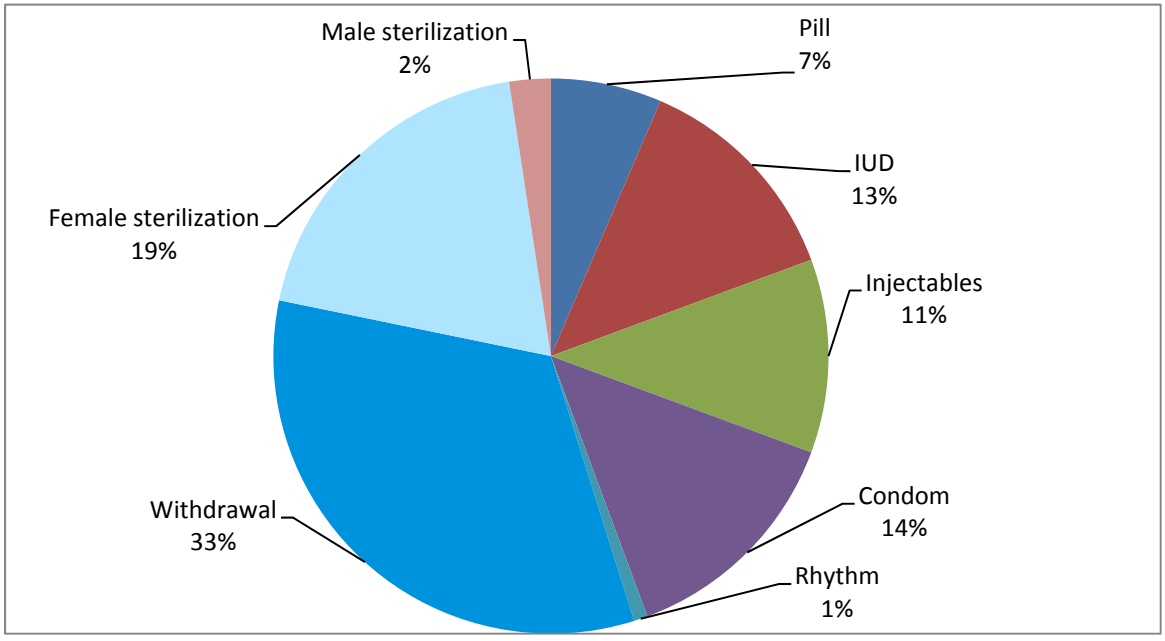
In an analysis of data for ever use of any modern method, injectables (11 percent), Pills (9 percent), IUD (8 percent) and condoms (7 percent) were the most used methods. The ever

use of any traditional method was 13 percent by the respondents as compared to 31 percent who ever used any modern method. Condoms and the withdrawal method were more commonly used in urban areas as compared to rural areas. For other modern methods, a similar pattern was observed in both urban and rural areas with the exception of female and male sterilization. None of the respondents reported ever use of norplant.

A total of 20 percent of all married women in the sample area of Rajanpur were currently using some method of contraception (the "contraceptive prevalence rate", or CPR), compared with 30 percent for Pakistan in the 2006-07 PDHS, and 32 percent for Punjab as a whole (NIPS/PDHS, 2008). In urban Rajanpur the CPR was 41 percent, compared with 17 percent in rural Rajanpur.

The current method most commonly being used was withdrawal followed by female sterilization (Table 7.2). The use of condoms at 2.8 percent was substantially lower than in national data (6.8 percent in the PDHS 2006-07). Overall, 14 percent of married women were using modern methods, 7 percent were using traditional methods (withdrawal and rhythm). Figure 7.1 shows the distribution of the women who were using some contraceptive method by method mix.

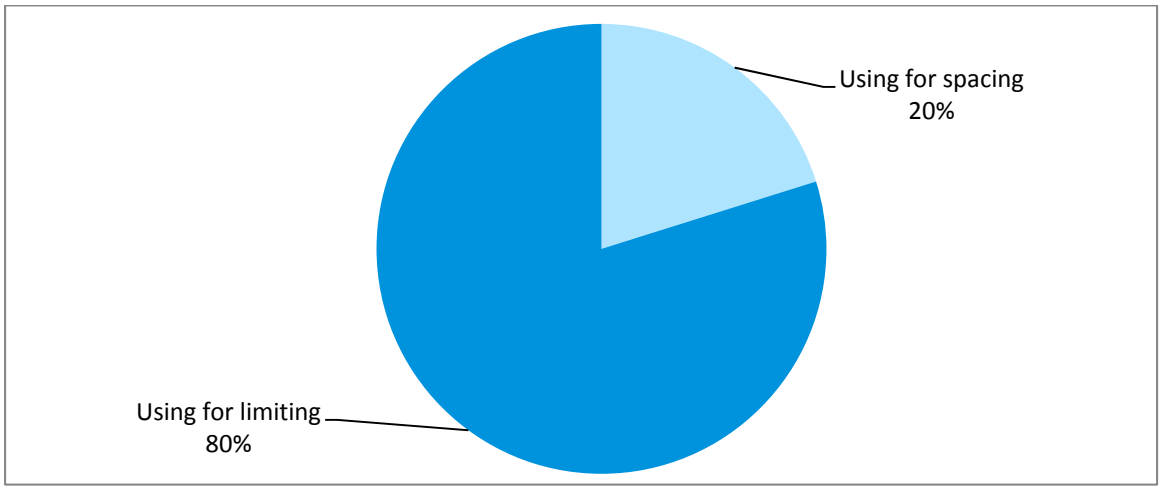
Figure 7.1: Distribution of current users by method mix



Current Use and Desire for Children

For current users of contraception, it is important to determine how many were using contraceptive methods for spacing purposes, and how many wanted to stop having children altogether. Overall, 80 percent of current use was for limiting purposes, compared to 20 percent for spacing (Figure 7.2).

Figure 7.2: Current use and desire for children



Correlates of Contraceptive Use

Figures 7.3 show the relationship between contraceptive prevalence and the woman's age. The shape of the graph for age reflects the low prevalence among younger women and higher prevalence for women aged 30 years or more. The CPR for the age group 15-19 years was zero. Between ages 40 and 44, prevalence was 38 percent.

Figure 7.4 indicates the contraceptive prevalence by number of living children; those having three or more children had a higher contraceptive prevalence rate. A maximum CPR of 32.6 percent was recorded for women having five or more living children.

Figure 7.3: Contraceptive prevalence by woman's age

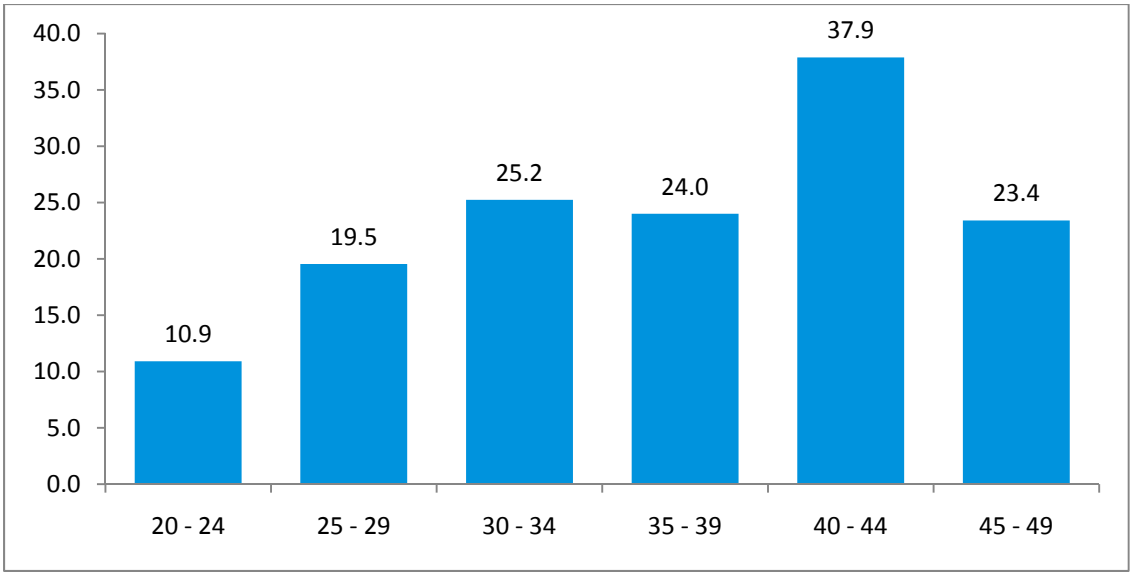
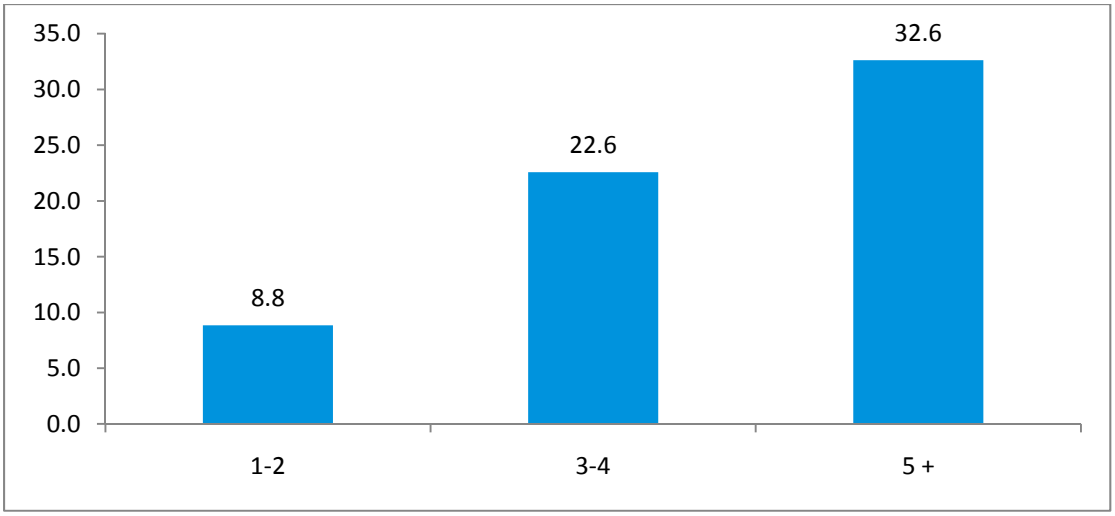


Figure 7.4: Current contraceptive use by number of living children



As shown in Table 7.3, contraceptive use is associated with higher socioeconomic status and urban residence. Respondents in households with the highest SLI had substantially higher contraceptive prevalence (36.6 percent) than those with the lowest SLI. Conversely, women from households with low SLI were more likely to be never users. Similarly, respondents' literacy was associated with higher current use and lower never use. Owning a television was found to be positively associated with current use. However, there were more never users in rural areas, while more current users resided in urban areas.

Table 7.3: Distribution of women by contraceptive use status and selected characteristics

Characteristic	Contraceptive use status			Total	
	Current user	Past user	Never user	N	%
Standard of Living Index					
Low	14.3	8.3	77.4	266	100.0
Medium low	18.7	15.7	65.7	134	100.0
Medium high	23.3	23.3	53.4	116	100.0
High	36.6	21.5	41.9	93	100.0
Ownership of TV					
Yes	27.8	20.6	51.6	252	100.0
No	15.1	10.6	74.2	357	100.0
Literacy of respondent					
Literate	30.8	24.2	45.0	120	100.0
Illiterate	17.8	12.5	69.7	489	100.0
Residence					
Rural	17.4	13.8	68.9	530	100.0
Urban	40.5	21.5	38.0	79	100.0
Total	**20.4**	**14.8**	**64.9**	**609**	**100.0**

Source of Method

With many types of outlets available to obtain various contraceptives, it is important to know which ones are being used, and for which methods. Table 7.4 shows the place at which current and past users (combined, i.e., ever users) last time obtained their contraceptive method.

From this table, it is clear that the source depends on the method. Pills and condoms were mostly obtained from Lady Health Workers, or by the husband; IUDs were inserted by private hospitals/clinics followed by Government Hospitals (DHQ/THQ), private doctors, BHU/RHC/MCH Centers, family welfare centers; injectables were obtained from private hospitals/clinics/private doctors followed by BHU/RHC/MCH Centers or from the LHWs. Female sterilization was usually conducted at DHQ hospital and private hospitals. The role of LHWs has emerged as being very important for dispensing simpler methods like pills, injectables and condoms, which shows their usefulness for provision of FP services at people's homes.

Table 7.4: Distribution of ever users of specific contraceptive method by most recent source of supply

Source of method	Pill	IUD	Injectable	Condom	Female sterilization	Male sterilization	Total
Govt. hospital (DHQ/THQ)	3.1	21.4	0.0	0.0	54.2	66.7	14.6
BHU/RHC/MCH Centre	12.5	10.7	12.9	0.0	0.0	0.0	7.3
FWC	0.0	3.6	0.0	0.0	0.0	0.0	0.7
MSU	0.0	0.0	0.0	0.0	20.8	0.0	3.3
LHW	31.3	0.0	6.5	21.2	0.0	0.0	12.6
Pvt. Doctor	6.3	14.3	19.4	0.0	0.0	0.0	7.9
Pvt. hospital/clinic	6.3	46.4	29.0	0.0	25.0	33.3	20.5
Dispenser/Compounder	0.0	0.0	3.2	0.0	0.0	0.0	0.7
NGO hospital	0.0	3.6	0.0	0.0	0.0	0.0	0.7
Pharmacy, chemists	0.0	0.0	0.0	3.0	0.0	0.0	0.7
TBA/Dai	3.1	0.0	0.0	0.0	0.0	0.0	0.7
Grocery shop/general store	9.4	0.0	3.2	6.1	0.0	0.0	4.0
Husband brings method/Don't know	28.1	0.0	25.8	69.7	0.0	0.0	26.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
N	**32**	**28**	**31**	**33**	**24**	**3**	**151**

Chapter 8

Experience with Contraceptive Methods

An important part of the success of a birth spacing program is to ensure that users are able to choose the method that is right for them, and to provide appropriate support for that method. All methods have their strengths and weaknesses, and no one method is right for everyone. In looking carefully at the experience of those who have used contraceptive methods both now and in the past, we can gain insights into the problems users face, and how to solve them. We asked a series of questions regarding the experience of current and past users. For past users who had used more than one method, we asked about their most recent method.

Reasons for Method Choice

In this survey, current and past users were asked the reasons they chose a particular method. The list of possible reasons was read out to them and the results are shown in Table 8.1. Among the most common reasons for choosing a method were suitability for respondent and husband, easy availability, low cost, convenience of use, no or fewer side effects, and effectiveness over a long period of time. For condom, male & female sterilization, IUD and Injectable users and pills suitability of use for respondents and their husbands was often cited. Cited less frequently were no other method available, provider advice and method always available. Clients tend to make decisions according to the known attributes of the various methods, but not always. For example, about 50 and 52 percent of ever users of IUD and injectables respectively cited lack of side effects as a reason for choosing the pill, even though it is in fact associated with a number of common side effects.

Table 8.1: Distribution of ever users of specific contraceptive method by reason for choosing that method

Reason for choosing	Pills	IUD	Injectables	Condom	Female sterilization	Male sterilization	Total
Easily available	93.8	57.1	83.9	93.9	29.2	33.3	73.5
Low cost	78.1	35.7	58.1	93.9	41.7	33.3	62.9
Convenient to use	71.9	50.0	71.0	93.9	16.7	0.0	62.3
Suitable for respondent and/or husband	78.1	78.6	77.4	100.0	83.3	100.0	84.1
No/fewer side effects	37.5	50.0	51.6	100.0	58.3	33.3	59.6
Can be used for long period	28.1	92.9	54.8	36.4	87.5	100.0	58.3
No other method available	28.1	10.7	9.7	6.1	8.3	0.0	12.6
Method always available	56.3	28.6	22.6	72.7	8.3	0.0	39.1
Provider advised	37.5	53.6	48.4	18.2	50.0	66.7	41.1
Others	3.1	7.1	0.0	0.0	8.3	66.7	4.6
N	**32**	**28**	**31**	**33**	**24**	**3**	**151**

Respondents could give more than one reason.

To look more specifically at why some users preferred traditional methods to modern ones, 41 current traditional method users were asked why they were not using modern methods (table 8.2). Side effects were by far the main issue; 76 percent of these women cited fear of side effects, and 34 percent reported their own experience of side effects. Cost of contraceptive as reasons for not using modern contraceptives was indicated by 39 percent of respondents. Husband's disapproval of the modern methods, method not available, lack of knowledge of method and its source were cited by very few women.

Table 8.2: Percentage distribution of MWRA using traditional methods by reasons for not using modern contraceptive methods

Reasons	Rural	Urban	Total
Fear of side effects	76.7	75.0	76.2
Husband's disapprove	6.7	8.3	7.1
Experienced side effects	34.5	33.3	34.1
Method not available	10.3	0.0	7.3
Cost too much	37.9	41.7	39.0
Doesn't know about modern methods	3.4	0.0	2.4
Doesn't know about source of method	3.4	0.0	2.4
N	**29**	**12**	**41**

Respondents could give more than one reason.

Cost, Distance and Time to Reach a Facility

Costs to users for contraceptive methods vary widely in Pakistan. Table 8.3 and figure 8.1A show the reported costs for contraceptives that were incurred the last time the women obtained the method. More than two-fifth of the respondents (44 percent) were not charged for their contraceptives; this included female sterilization users (who are, in fact, typically reimbursed for expenses involved). With regard to condom users, it was reported by great number in table 7.4 that the respondent's husband was the one who obtained the method; therefore 65 percent wives did not know the cost. About 12 percent of the respondents surveyed paid less than 50 rupees, while 27 percent were paying more than 50 rupees. IUD and Injectable users often paid more than 50 rupees for their method. For IUD users being one time activity, monthly cost may be quite low.

Table 8.3: Distribution of costs of current specific contraceptive method

	Cost in rupees					Total	
Contraceptive method	**Nil**	**1-20**	**21-50**	**51+**	**Don't know**	**%**	**N**
Pill	62.5	12.5	12.5	0.0	12.5	100	8
IUD	6.3	6.3	6.3	75.0	6.3	100	16
Injectables	14.3	0.0	14.3	71.4	0.0	100	14
Condom	11.8	23.5	0.0	0.0	64.7	100	17
Female sterilization	100.0	0.0	0.0	0.0	0.0	100	24
Others	66.7	0.0	0.0	0.0	33.3	100	3
Total	**43.9**	**7.3**	**4.9**	**26.8**	**17.1**	**100**	**82**

Current users were also asked whether their facility charged them for services rendered, other than the method itself. Figure 8.1B indicates that of the 82 users who were asked this question, 49 percent said they were not charged, 21 percent said that they were charged a reasonable amount, and only 30 percent said they were charged an unreasonable amount.

Figure 8.1A: Cost in Rupees of contraceptive supply for current method

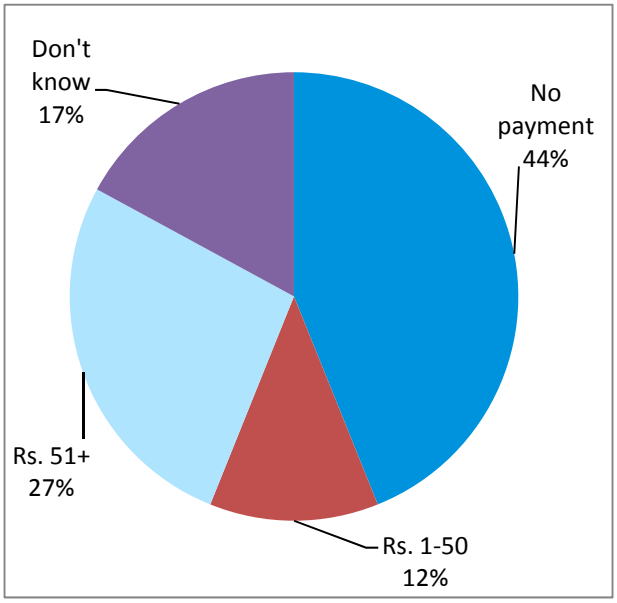
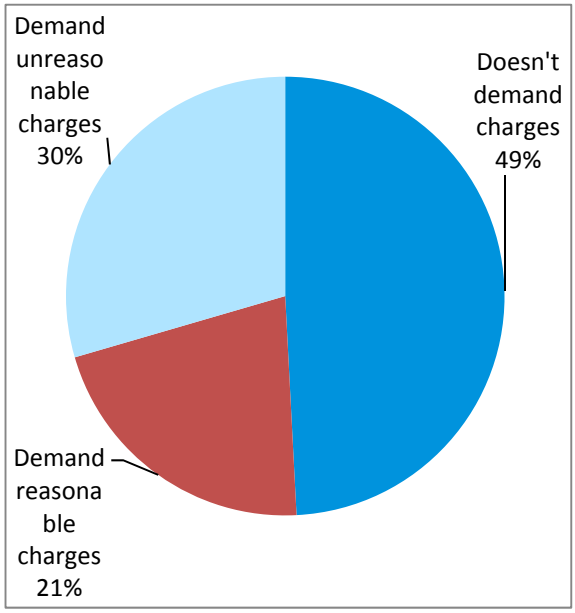


Figure 8.1B: Attitude towards service charges for current method other than contraceptive

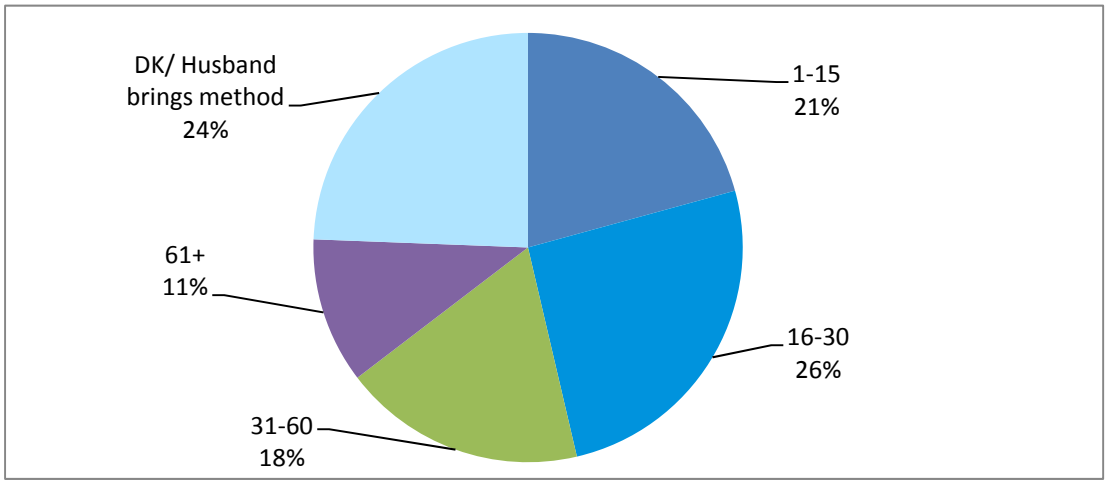


The time usually needed for current users to obtain a specific method is shown in Table 8.4, while Figure 8.2 shows the overall travel time in minutes to acquire the contraceptive methods. About 21 percent of users did not need more than 15 minutes to obtain their method; this included LHWs, who often brought pills, condoms and injectables to the doorstep. For a quarter of the women sampled it took up to 30 minutes. More than 24 percent of the women were unaware of the time required to obtain their method as their husbands were responsible for procuring the contraceptive. For a few users, particularly those who chose female sterilization, it took more than an hour to reach the service delivery point; but in these cases, there was usually no need to visit the facility frequently.

Table 8.4: Distribution of current contraceptive users by time to reach specific contraceptive service

Methods	Time (in minutes)				Don't know /husband brings method	Total	
	1-15	16-30	31-60	61+		%	N
Pill	37.5	25.0	12.5	0.0	25.0	100	8
IUD	37.5	31.3	25.0	6.3	0.0	100	16
Injectables	21.4	42.9	14.3	7.1	14.3	100	14
Condom	11.8	5.9	0.0	0.0	82.4	100	17
Female sterilization	12.5	20.8	29.2	29.2	8.3	100	24
others	0.0	66.7	33.3	0.0	0.0	100	3
Total	**20.7**	**25.6**	**18.3**	**11.0**	**24.4**	**100**	**82**

Figure 8.2: Travel time (in minutes) for contraceptive supplies



Treatment by Provider

Information Provided

Current and past users were asked, from a list of important topics that were read out to them, what information the service provider might have given to them regarding contraceptive methods (Table 8.5). The accuracy of clients' responses may be questioned due to problems of recall or understanding. The most common topics which respondents said they were told about were effectiveness/advantage of the method as well as

advantages and possible side effects. Some were told about how the method works and how to use the method and management of side effects. A few were told about the possibility of switching methods or other methods they could use. Condom users were given less information in general than users of clinical methods, perhaps because these were often obtained by husbands. There is a need to emphasize that providers should give comprehensible information on method selection to the clients, especially for hormonal contraceptives.

Table 8.5: Distribution of ever users of contraceptives by information provided at acceptance for specific method

Information provided at acceptance	Pill	IUD	Injectables	Condom	Female sterilization	Male sterilization	Total
How the method works	46.9	39.3	35.5	3.0	62.5	33.3	35.8
How to use the method	71.9	25.0	25.8	15.2	20.8	0.0	31.8
Contraindications	6.3	39.3	22.6	6.1	29.2	0.0	19.2
Effectiveness	56.3	100.0	61.3	12.1	95.8	33.3	61.6
Advantages	28.1	60.7	29.0	15.2	83.3	33.3	40.4
Possible side effects	34.4	67.9	29.0	3.0	62.5	33.3	37.1
What to do if experienced side effects	37.5	46.4	29.0	0.0	33.3	33.3	28.5
Possibility of switching	25.0	50.0	19.4	3.0	4.2	0.0	19.9
Other methods of FP you could use	12.5	32.1	16.1	6.1	16.7	0.0	15.9
N	**32**	**28**	**31**	**33**	**24**	**3**	**151**

Respondents could give more than one response.

Treatment at Facility

Current users were asked about various aspects of their treatment when they last visited a provider for family planning services. As table 8.6 shows, responses were mainly positive, but with exceptions. Eighty-three percent of the respondents were satisfied with the attitude of the staff and 60 percent said that provider was able to deal with side effects. However, more than half of respondents (52 percent) stated that the provider charged them for services rendered while 5 percent said they were not examined properly.

Table 8.6: Percent current users responding positively on treatment at last visit, by aspect of treatment

Aspect of treatment	Percent
Staff attitude cooperative	82.5
Provider available	96.6
Attend/examine properly	95.2
Doesn't demand charges	48.4
Can deal with side effects	59.7

Side Effects

Current users were asked if they had experienced, or were experiencing, any side effects from their current method, while past users were asked if side effects were among their reasons for discontinuing method use. If so, a list of possible side effects was read out to them, and they were asked if they had experienced any of them; multiple responses were allowed. As shown in Figure 8.3, 45 ever users (21 percent of all current and past users) responded positively. Side effects were most commonly reported by Pills and Injectables users (47 percent and 45 percent, respectively), and they were least commonly reported by Condom users (3 percent). Those who reported side effects, when asked to respond to a list of possibilities, tended to report a variety of side effects, including many not associated with the method, regardless of the method used.

Figure 8.3: Percent ever users who experienced side effects by method used

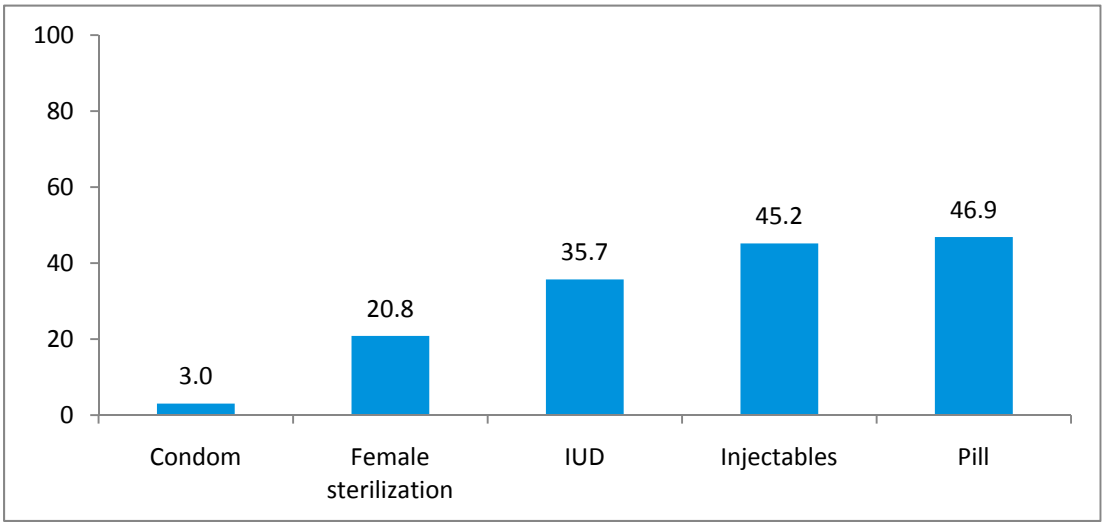
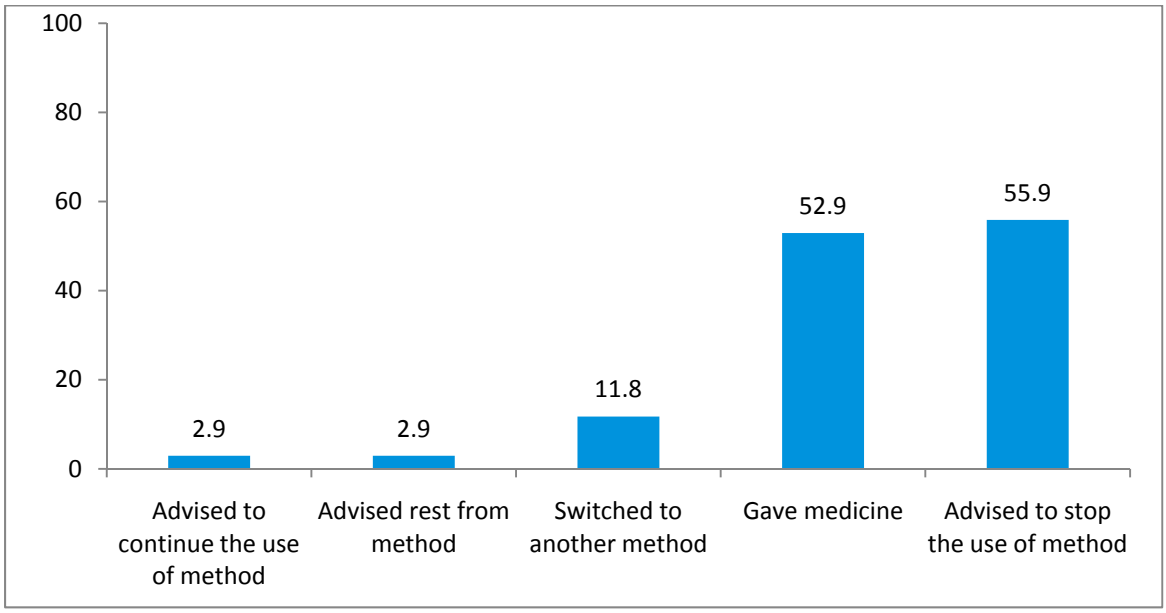


Figure 8.4: Distribution of provider responses upon consultation for side effects among past users (N=34)



Of the 34 past users who reported experiencing side effects, 25 said they had consulted someone for the management of these side effects; in 20 of these 25 cases, a doctor was reportedly visited. These respondents were asked if the provider responded in a manner included in a list read out to them. Fifty-six percent were advised to stop, and 53 percent were advised to take medicines. Twelve percent were advised to switch over the method while 3 percent each were advised to continue using the method, and to take rest from the method (Figure 8.4).

Chapter 9

Reasons for Non-use

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

Hindrances to Use

One way to understand the various types of hindrances to contraceptive use is to ask respondents about the concerns of people in general. This way, people may be more open in discussing their views without feeling a need to conceal concerns specific to their own situation. All respondents were asked, “If a couple wants to avoid or space a birth, which of the following hindrances might they face?” Each item on the list was read out to the respondent. Table 9.1 shows the responses of the female respondents, according to whether they were current users, past users, or never users.

Table 9.1: Distribution of opinions of MWRA regarding hindrances faced by couples wanting to avoid or space a birth, by family planning use status

	Current user		Past user		Never user	
Hindrances	**N**	**%**	**N**	**%**	**N**	**%**
Husband's disapproval	117	94.4	88	97.8	383	97.0
Other people may find out about contraceptive use	76	61.3	57	63.3	259	65.6
Distance and travel costs to FP outlet	85	68.5	63	70.0	294	74.4
Probability of getting pregnant while using	100	80.6	72	80.0	284	72.1
Fear of side effects	117	94.4	86	95.6	374	94.9
Problem of managing side effects	112	90.3	84	93.3	362	91.9
FP is against religion	103	83.1	71	78.9	342	86.6
Total	**124**	**na**	**90**	**na**	**395**	**na**

na= not applicable; respondents could give more than one response.

Some hindrances that couples might face were almost universally acknowledged. Nearly all respondents mentioned husband's disapproval, while a great number acknowledged fear of side effects, the problems of managing side effects, as well as religious concerns. Reasons such as "other people might find out about their use" and "the distance and costs of going to a FP outlet" were rated less important. However, the possibility of getting pregnant while using a method also carried considerable weight.

Past Users

Reasons for Discontinuing Contraceptive Use

Past users were asked about their reasons for choosing to discontinue their last contraceptive method. Several reasons were given; the most commonly cited ones were side effects, desire for another child, rest from the method, method failure, husband's advice and infrequent sex (Table 9.2). Method failure results from using methods that have high failure rates. Clinical methods do have associated side effects; but as we have seen, providers rarely try to counsel users through the temporary experience of common, non-dangerous side effects.

Table 9.2: Distribution of past contraceptive users by reason for discontinuing last method

Reasons	Percentage
Wanted another child	33.3
Fear of side effects	10.0
Side effects experienced	36.7
Method failure	22.2
Lack of access/unavailability	5.6
Cost not affordable	5.6
Method inconvenient to use	1.1
Rest from method	23.3
Missed the dose	1.1
Provider's advice	12.2
Infrequent sex/Husband away	14.4
Husband's advice	16.7
In laws oppose	2.2
Menopause	2.2
N	**90**

Respondents could give more than one reason.

Reasons for Current Non-use

It is important to know the reasons for non-use of those couples who have used contraceptives in the past, but are not current users. Past users were read out a list of possible reasons for their decision to discontinue method use, with more than one reason being cited (Table 9.3). The most common reasons were related to childbearing, e.g., currently pregnant, infrequent sex, breastfeeding/ amenorrheic or wanting another child. However, a significant percentage cited fear of side effects for current non-use. Rest from the method was another reason for non-use. As shown in Table 3.3, two percent of the husbands of female respondents were abroad.

Table 9.3: Distribution of past users by reason for current non-use

Reasons	Percentage
Fear of side effects	22.2
Want another child	18.9
Currently pregnant	32.2
Rest from method	22.2
Provider's advice	14.4
Infrequent sex/husband away	12.2
Breast feeding/Lactational amenorrhea	26.7
Menopause/hysterectomy	4.4
Just not using/too lazy	5.6
Others	5.6
N	**90**

Respondents could give more than one reason.

Never Users

Reasons for Non-use

The 395 women in the sample who reported never use were asked about various possible reasons for not using, with each reason read out separately. The most important reason given was desire for more children by 79 percent of the women. Another important reason for never use was breast feeding /lactational amenorrhea (43 percent); the fear of side effect and opposition of husband were reported by 38 percent and 31 percent respectively (Table 9.4).

A limited number of women (16 percent) reported lack of access/unavailability of supply. Cost and religious objections carried less weight, each of which is often cited in literature as a barrier to family planning use. Religious opposition was reported only by 5 percent of the women.

Table 9.4: Distribution of never users by reason for never use

Reasons	Percentage
Husband opposes	30.9
In laws oppose	20.5
Fear of side effects	38.2
Lack of access/Unavailability	16.5
Cost not affordable	18.7
Shy to consult about family planning	23.5
Method inconvenient to use	3.0
Infrequent sex/Husband away	7.1
Difficult/Unable to conceive	13.4
Breast feeding/ Lactational amenorrhea	43.1
Respondent/Husband infertile	1.8
Wanted (more) children	78.9
Against religion	4.8
Natural spacing	1.0
Didn't know of any FP method	1.5
Others	1.3
N	**395**

Respondents could give more than one reason.

Attitude towards Birth Spacing and Limiting

It is important to see the extent to which never users disapproved of family planning in principle, as opposed to accepting in principle, but were not using contraceptives for some other reasons. Table 9.5 shows this for never using respondents. More than a quarter of the women (27 percent) disapproved of spacing, while for limiting it was 13 percent. More women approved of limiting family size than spacing.

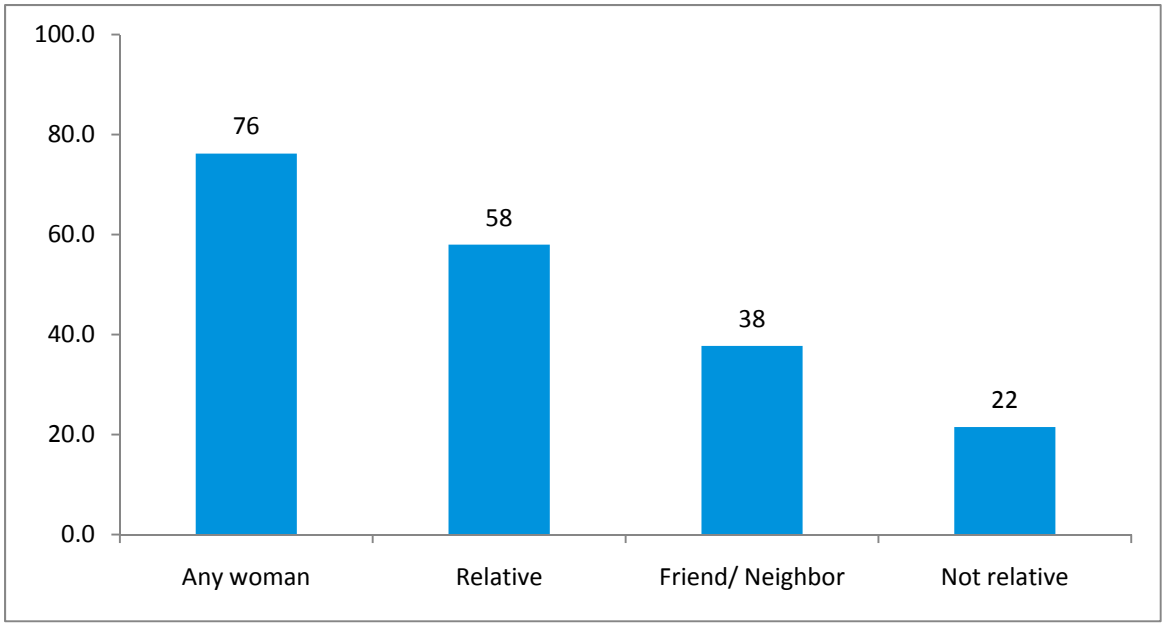
Table 9.5: Distribution of never users by attitude towards spacing and limiting birth

	Attitude towards spacing		Attitude towards limiting	
Attitude	**N**	**%**	**N**	**%**
Approve	284	71.9	337	85.3
Disapprove	108	27.3	51	12.9
Don't know	0	0.0	2	0.5
Others	3	0.8	5	1.3
Total	**395**	**100**	**395**	**100**

Knowledge of Contraceptive Users, Methods and Facilities

Of the 395 female never users in the sample, more than three-fourth reported knowing some woman who had ever used a method to delay or avoid pregnancy. Fifty-eight percent of the respondents had a relative who had used some method, and 38 percent of the respondents knew a friend or neighbor who had been a user. Nearly a quarter of never-using women knew someone other than relative who had ever used a FP method to delay or avoid pregnancy (Figure 9.1).

Figure 9.1: Percent of never users who knew some woman who had ever used any FP method



Almost all never-using women knew at least one method. Most never-users knew a variety of methods as shown in Table 9.6.

Table 9.6: Distribution of never users by knowledge of contraceptive methods

FP method	Percentage
Pill	97.5
IUD	88.6
Injectables	96.2
Nor plant	21.5
Condom	69.6
Rhythm	25.1
Withdrawal	65.3
Female sterilization	92.9
Male sterilization	55.7
Emergency Pills	13.2
Other FP method	4.3
Any FP method	98.5
Any modern FP method	98.5
Any traditional FP method	72.7
N	**395**

Respondents could give more than one response.

Of the 395 never users, one-third of women did not know of a place to obtain a method. For those who did know, the places they were aware of are shown in Table 9.7. The sources best known were health outlets – the District/Tehsil Headquarters hospitals, BHUs/RHCs/MCH centers, and private hospital/clinic/doctor. Almost one- fifth of Lady Health Workers were mentioned as sources of supply (19 percent). Substantial numbers knew of the pharmacy/chemists as a source of supply. Very limited number of women was aware of other sources, including family welfare centers and Greenstar clinics.

Table 9.7: Knowledge of sources of contraception of never users, by source of supply

Source	Percentage
Knowledge of at least one service provider	66.8
DHQ/THQ Hospitals	42.5
BHU/RHC/MCH Center	21.8
Family Welfare center	2.8
Mobile service unit camp	5.6
Lady Health Worker	18.7
Greenstar clinic	0.8
Private hospital/ Clinic/ Doctor	48.6
Dispenser/ Compounder	2.8
Pharmacy/ Chemists	21.0
Homeopathic/ Hakim	2.8
TBA/ Dai	3.8
Grocery shop (not pharmacy/ chemist)	10.1
N	**395**

Respondents could give more than one response.

As shown in Figure 9.2, most users would go to the nearest facility by bus or van, and sometimes on foot. Of the 261 respondents who indicated the time needed to go to the nearest facility, one-third of the women indicated that it took them 15 minutes or less, slightly more than a quarter quoted 16 to 30 minutes, and 38 percent reported taking 30 minutes or more to reach the nearest facility (Figure 9.3). It appears that time required to obtain the contraceptive did not have a significant impact on never users.

Figure 9.2: Mode of transportation to the nearest facility/provider

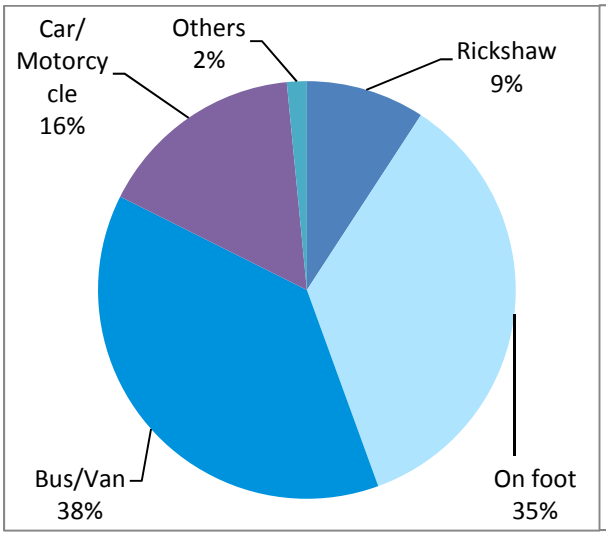
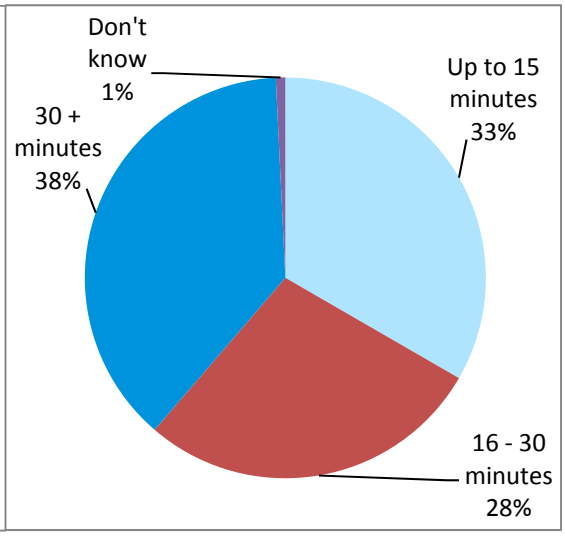


Figure 9.3: Time taken to go to the nearest facility/provider



Intent to Use

Never users were asked if they intended to use contraceptives in the future. Table 9.8 shows that nearly two-fifth (39 percent) showed willingness to adopt a method, while 30 percent refused to do so. Almost an equal number of women (27 percent) was unsure. Five percent stated that they were unable to conceive. This indicates that much work needs to be done to bring the non-acceptors of FP into the flow of acceptance.

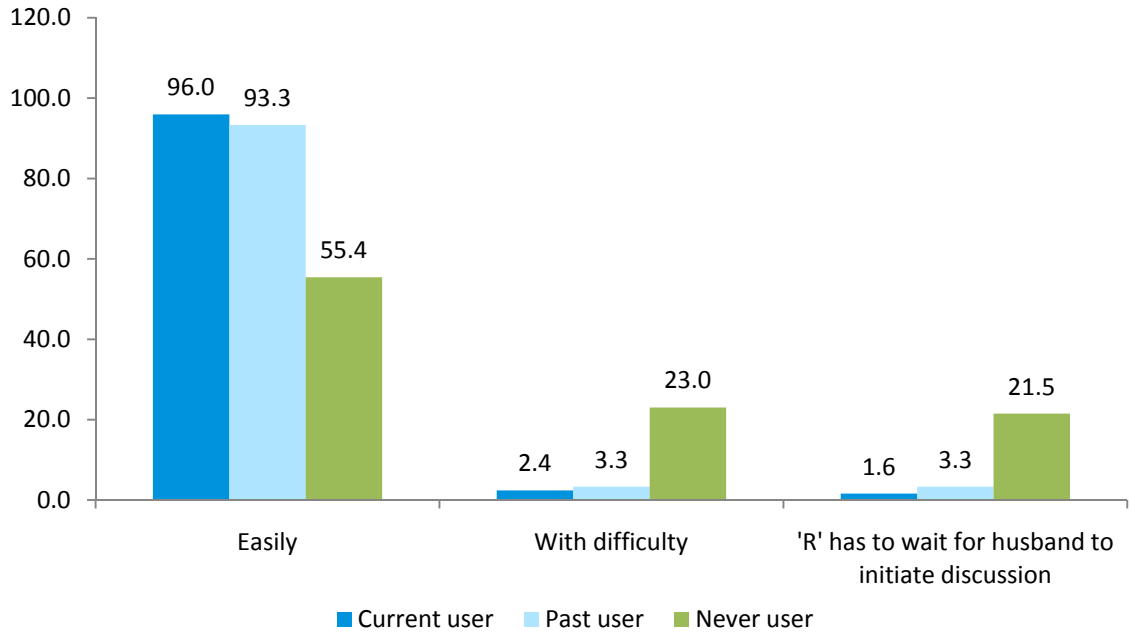
Table 9.8: Distribution of never users by intent to use a method in future and number of living children

Number of living children	Intention to use FP method in future				Total	
	Yes	No	Unsure/ Uncertain	Can't get pregnant	%	N
0	35.1	21.6	41.9	1.4	100	74
1-2	44.0	24.8	30.3	0.9	100	109
3-4	41.0	30.0	25.0	4.0	100	100
5 or more	34.8	39.3	15.2	10.7	100	112
Total	**39.0**	**29.6**	**26.8**	**4.6**	**100**	**395**

Inter spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on family planning. Women were asked about the level of ease with which they could approach their husbands to discuss family planning. Most women said they could do so easily (Figure 9.4). However, this varied by use status. Ninety-six percent of current users, and 93 percent of past users, said they could approach their husbands easily, and very few said they had to wait for their husband to initiate the discussion. For never users, 55 percent reported being able to approach their husbands easily, with less than a quarter of never users reporting that they could only do so with difficulty, and another one-fifth of women saying they had to wait for him to begin the conversation.

Figure 9.4: Women's reports regarding ease of approach to husband to discuss family planning



Chapter 10

Unmet Need

"Unmet need" for family planning is a term used to help focus attention in a family planning program on those who need it. Conceptually, unmet need refers to women who say they do not want more children, or want them later, and are at risk of conceiving, but are not currently using contraceptives. Women currently pregnant or who are experiencing postpartum amenorrhea are said (in this formulation) to be in unmet need if their current or last (if amenorrheic) pregnancy was said to be unwanted or mistimed. Women who want to delay their next pregnancy are said to have an unmet need of spacing; those who do not want more children at all are said to have an unmet need for limiting. Women in unmet need in this sense are those for whom there is an inconsistency between what they say they want and what they are doing; these women would appear to be in need of some support to avoid unwanted pregnancies.

Levels and Correlates

Table 10.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Rajanpur. Of the 609 women, 245 (40 percent) were considered to be in the unmet need category. This proportion is higher than what is typically found using the same definition in Pakistan, where unmet need tends to be around one-third of MWRA. The higher proportion of unmet need may be a reflection of the relatively low contraceptive prevalence; low levels of use may mean that some of the total demand for family planning was being met. This is supported by the relatively high levels of unmet need for women with 5 or more children, where contraceptive prevalence was particularly low.

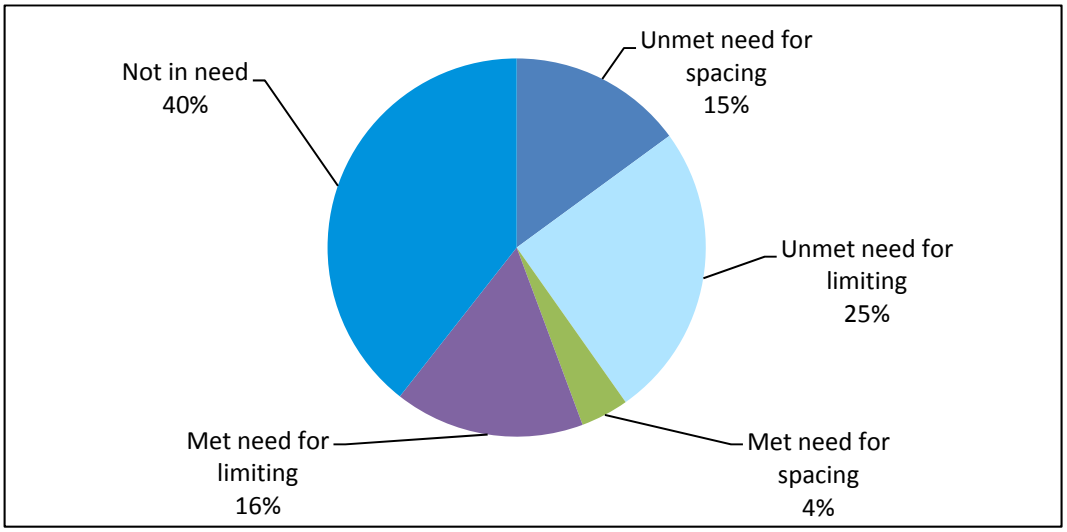
Table 10.1: Need and demand for FP among MWRA by background characteristics

Characteristic	Unmet need			Met need			Total demand	Not in need	Total	
	For spacing	For limiting	Total	For spacing	For limiting	Total			%	N
Age of respondent										
15 - 24	28.1	1.9	30.0	5.6	1.9	7.5	37.5	62.5	100	160
25 - 34	17.4	28.0	45.3	6.4	15.7	22.0	67.4	32.6	100	236
35 - 49	2.3	39.9	42.3	0.5	27.7	28.2	70.4	29.6	100	213
Type of community										
Rural	15.1	26.6	41.7	3.4	14.0	17.4	59.1	40.9	100	530
Urban	13.9	16.5	30.4	8.9	31.6	40.5	70.9	29.1	100	79
Literacy of respondent										
Literate	13.3	16.7	30.0	7.5	23.3	30.8	60.8	39.2	100	120
Illiterate	15.3	27.4	42.7	3.3	14.5	17.8	60.5	39.5	100	489
Education of respondent										
No education	15.4	27.7	43.1	3.1	14.2	17.2	60.4	39.6	100	487
Up to primary	13.6	20.3	33.9	5.1	16.9	22.0	55.9	44.1	100	59
Up to Secondary	11.4	15.9	27.3	11.4	27.3	38.6	65.9	34.1	100	44
Above secondary	15.8	0.0	15.8	10.5	42.1	52.6	68.4	31.6	100	19
Children ever born										
None	2.8	0.0	2.8	0.0	0.0	0.0	2.8	97.2	100	71
1 – 2	35.3	3.4	38.7	5.9	0.8	6.7	45.4	54.6	100	119
3 – 4	23.0	17.3	40.3	7.9	13.7	21.6	61.9	38.1	100	139
5 or more	5.4	45.0	50.4	2.5	28.2	30.7	81.1	18.9	100	280
Ownership of TV										
Yes	14.7	24.2	38.9	4.8	23.0	27.8	66.7	33.3	100	252
No	15.1	26.1	41.2	3.6	11.5	15.1	56.3	43.7	100	357
Standard of Living Index										
Low	14.3	25.6	39.8	3.0	11.3	14.3	54.1	45.9	100	266
Medium low	15.7	26.9	42.5	4.5	14.2	18.7	61.2	38.8	100	134
Medium high	14.7	24.1	38.8	3.4	19.8	23.3	62.1	37.9	100	116
High	16.1	23.7	39.8	7.5	29.0	36.6	76.3	23.7	100	93
Total	**14.9**	**25.3**	**40.2**	**4.1**	**16.3**	**20.4**	**60.6**	**39.4**	**100**	**609**

Of the 40 percent women who had unmet need, 15 percent was for spacing, while 25 percent was for limiting. Unmet need for spacing was concentrated among women with 1-2 children; 42 of the 46 cases were in this category. As could be expected, unmet need for limiting was highest among women with 5 or more children.

The correlations between unmet need and various socioeconomic indicators varied by whether the unmet need was for spacing or for limiting (Table 10.1). Unmet need for limiting was strongly associated with illiteracy and rural residence. Unmet need for spacing, on the other hand, was strongest for women age 15-24 years and with having more than secondary education, while associations with high SLI and television ownership were weak. It is possible that educated women having more than secondary education were more aware of the need to space their births, but were inhibited from doing so for various reasons. Once they reached their desired family size, educated women may be more able to use family planning than their uneducated counterparts. However, conclusions can be tentative, given the small sample sizes involved. Figure 10.1 shows the need and demand for family planning of the sampled women.

Figure 10.1: Need and demand for family planning



Total Demand

The sum of current use ("met need") and unmet need is often called "total demand" for family planning. It would normally be expected to rise with the number of living children a couple has. Table 10.1 shows total demand by number of children. Overall, total demand was 61 percent for all married women of reproductive age. As the table shows, total demand rose rapidly with the number of children going up to 5 or more. Even at one or two children, demand was reasonable high (45 percent), and it increased up to 81 percent for those with five or more children. The high proportion of total demand that is in unmet need at earlier reproductive stages is an important problem that needs to be addressed.

Strength of Preference

It is of interest to look at the responses of women in the unmet need category (those not currently pregnant) according to what their reaction would be if they became pregnant in the near future (Table 10.2). Slightly less than one-third of the women with unmet need for spacing said they would be worried if they became pregnant again; 37 percent would be pleased and 26 percent would accept it. Of those with unmet need for limiting, around two-third said they would be worried if they became pregnant. None of the women would be pleased. However, around 30 percent said they would accept it. It is important to note that the women who have decided to limit their family have started to understand the consequences of an unwanted pregnancy. For that reason, they would be less pleased about an unwanted pregnancy. For those who would accept an unwanted pregnancy, they appeared to believe that such things occur according to the will of God.

Table 10.2: Distribution of non-pregnant women with unmet need for spacing and limiting, by strength of desire to avoid pregnancy

Reaction if become pregnant in near future	Unmet need for spacing		Unmet need for limiting	
	N	%	N	%
Pleased	30	37.0	0	0.0
Worried	26	32.1	79	59.8
Accept it	21	25.9	39	29.5
Doesn't matter	3	3.7	12	9.1
Will abort	1	1.2	1	0.8
Others	0	0.0	1	0.8
Total	**81**	**100**	**132**	**100**

Reasons for Non-use

Past and never users were asked why they were not using some method of contraception; for those later classified as having unmet need, the results are shown in Table 10.3. Some of these reasons represent barriers as perceived by the women; the most important of these were fear of side effects and the opposition of husbands and in-laws. On the other hand, many women with defined unmet need gave reasons that did not reflect perceived need, at least at present. Such reasons included infrequent sex/husband away, natural spacing, difficulty in conceiving, wanted more children, currently pregnant, and currently breastfeeding. Some of these women may have more need than they realize; for example,

women using "natural spacing" or breastfeeding may in fact be at substantial risk of pregnancy. Women currently pregnant or amenorrheic may be in need of contraception in the near future.

Table 10.3: Women with unmet need for spacing and limiting by stated reasons for non-use of contraception

Reason	Unmet need for spacing	Unmet need for spacing	Total unmet need
Fear of side effects	41.8	44.8	43.7
Husband opposes	31.9	27.3	29.0
In laws oppose	22.0	10.4	14.7
Rest from method	2.2	4.5	3.7
Shy to consult about FP	23.1	24.0	23.7
Provider's advice	0.0	5.2	3.3
Against religion	2.2	5.2	4.1
Lack of access/Unavailability	13.2	12.3	12.7
Cost not affordable	16.5	16.9	16.7
Don't know any FP method	1.1	0.6	0.8
Just not using/too lazy	0.0	3.2	2.0
Method inconvenient to use	5.5	1.9	3.3
Infrequent sex/Husband away	5.5	14.3	11.0
Natural spacing	1.1	1.9	1.6
Difficult/Unable to conceive	11.0	2.6	5.7
Want (more) children	82.4	34.4	52.2
Currently pregnant	4.4	6.5	5.7
Breast feeding/Lactational amenorrhea	5.5	3.2	4.1
Others	1.1	4.5	3.3
Total	**91**	**154**	**245**

Respondents could give more than one reason.

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprised 91 (15 percent) of MWRA. As shown in Table 10.4, they were characterized by:

- **Living Children:** Most (52 percent) had 1 or 2 living children.
- **Family Planning Use:** More never users (91 percent) than past users (9 percent).
- **Strength of Preference:** Low (only 32 percent "worried" if they became pregnant earlier than they wanted compared to those who were pleased (37 percent) or accept (26 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** High (about 54 percent intended to use a FP method in future).
- **Approval of FP:** High (79 percent approved of using a FP method for spacing purpose).
- **FP Communication with Husband:** Moderate (54 percent had communicated with husbands on FP in the past one year; while 22 percent said approaching the husband was difficult).
- **Obstacles to FP Use:** Fear of side effects (42 percent); husband and in-laws opposition (32 percent and 22 percent respectively) and shy to consult about FP(23 percent)(Table10.3).

Table 10.4: Percent distribution of MWRA in unmet need for spacing and limiting by selected characteristics

Characteristics	Unmet need for spacing		Unmet need for limiting	
	N	%	N	%
Number of living children				
0	2	2.2	0	0.0
1-2	47	51.6	4	2.6
3-4	33	36.3	42	27.3
5 or more	9	9.9	108	70.1
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	8	8.8	40	26.0
Never user	83	91.2	114	74.0
Reaction if become pregnant in near future				
Pleased	30	37.0	0	0.0
Worried	26	32.1	79	59.0
Accept it	21	25.9	39	29.1
Doesn't matter	3	3.7	12	9.0
Menopausal/Hysterectomy/Sterilized	0	0.0	0	0.0
Will abort	1	1.2	1	0.7
Others	0	0.0	3	2.2
Intention to use a method in future				
Yes	49	53.8	75	48.7
No	18	19.8	51	33.1
Unsure/Uncertain	24	26.4	27	17.5
Can't get pregnant	0	0.0	1	0.6
Approval of FP				
Approve	72	79.1	126	81.8
Disapprove	18	19.8	28	18.2
Others	1	1.1	0	0.0
FP communication with husband in past one year				
Never	42	46.2	63	40.9
Once or twice	29	31.9	36	23.4
More often	20	22.0	55	35.7
Approach the topic of FP with husband				
Easily	55	60.4	113	73.4
With difficulty	20	22.0	26	16.9
Respondent has to wait for husband to initiate discussion	16	17.6	15	9.7
Total	**91**	**100.0**	**154**	**100.0**

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 154 (25 percent) of MWRA. As shown in Table 10.4, they were characterized by:

- **Living Children:** A strongly positive association with number of living children; 70 percent had 5+ living children.
- **Family Planning Use:** More never users (74 percent) than past users (26 percent).
- **Strength of Preference:** High (59 percent would be "worried" if they became pregnant compared to those who were pleased (0 percent) or accept (29 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** Moderate (about 49 percent intended to use a FP method in future.
- **Approval of FP:** High (82 percent approved of FP for limiting purpose).
- **FP Communication with Husband:** Moderate (59 percent had communication with husband on FP in the past year; while 17 percent said approaching the husband was difficult).
- **Obstacles to FP Use:** Fear of side effects (45 percent); husbands and in-laws opposition (27 percent and 10 percent respectively) and shy to consult about FP (24 percent) (Table 10.3).

Chapter 11

Reproductive Preferences and Behavior of Men

It is often the case that in matters relating to family planning the focus has too often been more on women, despite the fact that husbands are equal partners in the reproductive process and often have greater responsibility for decision-making in the family. In addition, women often mention their husbands as a constraint to the use of contraceptives (NIPS/PDHS, 2008; Population Council, 1995). The objectives of interviewing husbands/men in the FALAH baseline survey were to explore their perspectives on birth spacing/family planning and to use the information obtained to design the communication strategy for the FALAH project. Overall, the planned sample size was 200 husbands in each district. The intention was to interview the husbands of the same women who were interviewed at household level. In Rajanpur, the field team was able to interview 176 men who were husbands of the married women of reproductive age interviewed for the survey plus 24 married men living in the selected areas who were not husbands of the female respondents. In this chapter, the results for the respondents' husbands and other married men who were interviewed (N = 200)are always grouped together, whether the reference is to "men", "male respondents" "married men " or "husbands."

Husband's approval of family planning is a powerful factor in explaining contraceptive use (Tawiah, 1997). In families, fertility decisions occur within specific social contexts and according to prevailing social norms that restrict individual decisions on fertility and behaviors related to spacing of births, stopping childbearing, and using contraceptives. Earlier studies suggest that the husband's approval of and discussion about family planning were important predictors of a woman's contraceptive use and fertility desire (Bongaarts and Bruce, 1995; Mahmood and Ringheim, 1997).

The survey investigates social and demographic differentials, knowledge, ever-use and current use of family planning methods. It also explores how approval and discussion of

birth spacing/family planning influence the use of contraceptive methods. Traditionally, the measurement of contraceptive use has been based on women's self-reports of current use. The rationale for interviewing husbands was to investigate their perspective on the issues of fertility and family planning.

Background Characteristics

Table 11.1 shows the background characteristics of the husbands interviewed in the survey. It shows that about 15 percent of the men were under 25 years of age and 9 percent were 50 years of age and above.

As shown in Table 11.1, men were substantially better educated than the sampled currently married women of reproductive age. Less than 47 percent of the men had not been to school, compared to 80 percent of the currently married women (Table 3.2). It also shows that 36 percent of the husband had more than primary education, whereas 10 percent of the currently married women had attained that level of education (Table 3.2). A higher proportion of urban husbands had received some schooling compared to their rural counterparts. Sixty-eight percent of the urban husbands had received some schooling compared to 51 percent of the rural husbands.

The occupations of husbands are also presented in Table 11.1. The highest proportion of men (58 percent) was working in agriculture-related activities, 18 percent were running their own businesses, and 8 percent were working as daily wage labors.

Table 11.1: Background characteristics of husbands by residence

Characteristic	Rural	Urban	Total
Age			
15-19	0.0	3.6	0.5
20-24	16.3	7.1	15.0
25-29	18.6	3.6	16.5
30-34	15.7	14.3	15.5
35-39	20.9	21.4	21.0
40-44	12.8	10.7	12.5
45-49	10.5	7.1	10.0
50-54	1.7	25.0	5.0
55+	3.5	7.1	4.0
Education			
Proportion literate	50.0	64.3	52.0
No education	48.8	32.1	46.5
Up to primary	19.8	7.1	18.0
Up to Secondary	26.7	42.9	29.0
Above secondary	4.7	17.9	6.5
Occupation			
Agriculture/Livestock/Poultry	65.7	7.1	57.5
Petty trader	2.9	0.0	2.5
Labor	6.4	17.9	8.0
Govt. service	3.5	14.3	5.0
Pvt. Service	3.5	21.4	6.0
Own business	14.5	35.7	17.5
Unemployed	3.5	3.6	3.5
N	**172**	**28**	**200**

Contraceptive Knowledge and Use

The knowledge and use of contraceptives by husbands was found very limited in Rajanpur. All of the interviewed men, more than half (56 percent) knew of at least one method of contraception. As presented in Table 11.2, the highest level of knowledge recorded for modern methods was for pills (29 percent), followed by injections (27 percent), condom (21 percent) and female sterilization (17 percent). The least known methods were Norplant (1 percent), male sterilization (4 percent), and IUD (10 percent). Knowledge of at least one traditional method was prevalent among only 19 percent of the husbands. Contrary to husband's knowledge, almost all currently married women of reproductive age interviewed in Rajanpur knew at least one contraceptive method (Table 7.1).

The pattern of ever use and current use of contraception reported by husbands is also shown in Table 11.2. Thirty-five percent of the MWRA reported having used some method

of contraception during their married lives (Table 7.2); of the male respondents, 39 percent reported ever using some method of contraception in their married lives. For the husbands, among modern methods, injectable was the most popular method ever used (12 percent), followed by condom and pills (9 percent each), IUD (6 percent) and female sterilization (4 percent). The ever use of condom and norplant was found more in rural areas while the use of all other modern methods (pill, injectables and IUD) was higher in urban areas.

As mentioned in table 7.2, a total of 20 percent of all MWRA in the sample were currently using some method of contraception, while for the male respondents this figure was higher at 27 percent. The most common current modern method reported by male respondents was condom (5 percent), followed closely by female sterilization and injectables (4 percent each). The use of traditional methods was recorded among 9 percent of the current users. Since traditional methods are far less reliable than modern methods, an important goal of the FALAH project may be to shift users of traditional methods to more effective modern methods. The knowledge and use of emergency contraceptive among the husbands was also reported minimal.

Table 11.2: Distribution of male respondents by contraceptive knowledge, use status and residence

	Knowledge			Ever use			Current use		
Method	**Rural**	**Urban**	**Total**	**Rural**	**Urban**	**Total**	**Rural**	**Urban**	**Total**
Female sterilization	15.7	25.0	17.0	2.9	7.1	3.5	3.5	7.1	4.0
Male sterilization	2.3	14.3	4.0	0.6	7.1	1.5	0.6	3.6	1.0
Pill	29.7	25.0	29.0	7.6	14.3	8.5	2.9	0.0	2.5
IUD	10.5	10.7	10.5	4.7	10.7	5.5	1.7	3.6	2.0
Injectables	26.2	28.6	26.5	11.0	17.9	12.0	4.1	3.6	4.0
Norplant	0.6	3.6	1.0	0.6	0.0	0.5	0.0	0.0	0.0
Condom	20.3	25.0	21.0	8.7	7.1	8.5	5.2	3.6	5.0
Rhythm	3.5	14.3	5.0	2.9	7.1	3.5	1.2	3.6	1.5
Withdrawal	14.5	21.4	15.5	9.9	14.3	10.5	6.4	14.3	7.5
Others	1.2	0.0	1.0	0.6	0.0	0.5	0.0	0.0	0.0
At least one FP method	55.2	60.7	56.0	36.0	53.6	38.5	24.4	39.3	26.5
At least one modern FP method	47.1	50.0	47.5	27.9	42.9	30.0	16.9	21.4	17.5
At least one traditional FP method	17.4	25.0	18.5	12.8	17.9	13.5	7.6	17.9	9.0
Emergency pills	0.6	0.0	0.5	0.0	0.0	0.0	na	na	na
N	**172**	**28**	**200**	**172**	**28**	**200**	**172**	**28**	**200**

na= not applicable.

Table 11.3 shows ever use and current use of modern contraceptives among respondents by background characteristics. A higher proportion of rural men were currently using a family planning method compared to urban men. There was a positive relationship between education level and contraceptive use. Slightly over 59 percent of the respondents who had secondary and above education reported ever use of any contraceptive method, compared to 25 percent and 28 percent who had below secondary and no education respectively. The current use of family planning also showed the same pattern by education of men.

Table 11.3: Distribution of male respondents who have ever used or were currently using a contraceptive method, by selected background characteristics

Characteristic	Ever used at least one FP method	Currently using any FP method	N
Residence			
Rural	31.2	21.1	171
Urban	7.5	5.5	28
Education level			
No education	28.3	21.7	92
Below secondary	25.0	19.4	36
Secondary and above	59.2	36.6	71
Number of living children			
None	0.0	0.0	19
1-2	34.1	15.9	44
3-4	40.4	32.7	52
5+	48.8	34.5	84
Future desire for children			
Soon	25.5	14.5	55
Later	27.8	19.4	36
Never	57.1	44.6	56
Don't know/unsure	40.4	25	52
Total	**38.7**	**26.6**	**199**

Table 11.3 also shows a positive relationship between the number of living children and ever use as well as reported current use. Of those who had 5 or more children, almost 35 percent reported currently using family planning methods compared to 33 percent who had 3-4 children and 16 percent who had 1-2 children. The same pattern was observed in ever use of contraceptives by number of living children.

Table 11.3 also shows contraceptive ever use and current use by the future desire for children. Highest ever use (57 percent) was found among the male respondents who said they did not want any more children. Almost 28 percent of those respondents who wanted to delay the next pregnancy had ever used any contraceptive method, and about 19 percent were currently using a form of contraception.

Source of Contraceptive Methods

As shown in Table 11.4, among those who reported the last source for obtaining their contraceptive method, 30 percent in urban and 36 percent in rural areas reported that they obtained it from the "pharmacy, chemist, grocery or general store." Other more common sources for contraceptives in rural areas were private doctors & hospitals, BHU/RHC/MCH Centre as well as LHWs. Eleven percent of the rural respondents and 10 percent of urban respondents said that their wives brought the method.

Table 11.4: Distribution of ever users by the last reported source of contraceptive supply

Source	Rural	Urban	Total
Govt. hospital (DHQ/THQ)	8.9	30.0	12.7
BHU/RHC/MCH Centre	6.7	0.0	5.5
LHW	6.7	10.0	7.3
Greenstar clinic	2.2	0.0	1.8
Pvt. Doctor	15.6	0.0	12.7
Pvt. hospital/clinic	8.9	20.0	10.9
NGO hospital	2.2	0.0	1.8
Pharmacy, chemist	6.7	0.0	5.5
Grocery shop/general store	28.9	30.0	29.1
Wife brought the method	11.1	10.0	10.9
Others	2.2	0.0	1.8
Total	**100**	**100**	**100**
N	45	10	55

Approval of Family Planning

Respondents were asked about their approval of birth spacing and use of any form of contraception for spacing purpose. Husband's opposition may prevent his wife from using contraceptives, even when she wants to delay or stop childbearing (Casterline, Perez, and Biddlecom, 1997). In Rajanpur, 87 percent male respondents approved of spacing between children; and almost same proportion (86 percent) approved the use of any form of contraception for spacing between children (Table 11.5). Fourteen percent disapproved of using any form of contraception to space between children. There was a difference recorded among urban and rural residents on this issue where all urban respondents (100 percent) approved spacing and use of means for spacing.

Table 11.5: Distribution of respondents by the approval status of spacing and use of contraceptives for spacing and residence

Variable	Rural	Urban	Total
Spacing between children			
Approve	84.9	100.0	87.0
Disapprove	14.5	0.0	12.5
Other	0.6	0.0	0.5
Total	**100.0**	**100.0**	**100.0**
N	172	28	200
Using family planning methods for spacing			
Approve	83.1	100.0	85.5
Disapprove	16.3	0.0	14.0
Other	0.6	0.0	0.5
Total	**100.0**	**100.0**	**100.0**
N	172	28	200

Satisfaction Level of Current Users

Satisfaction of the user with his/her contraceptive method is an important factor in whether or not he/she continues with the method. Male contraceptive users were asked to report how satisfied they were with their present contraceptive method. Table 11.6 shows 97 percent of the current users were very satisfied with the current method; only three percent reported that they were not satisfied with their current method. While none of the urban current users reported dissatisfaction with their method, 86 percent of the rural and 100 percent of the urban users were very satisfied with their methods. Ten percent of the rural users were reported being somewhat satisfied with their current method. These users

would seem to be in need of more information on their current method as well as on other available methods so that they could continue using a family planning method.

Table 11.6: Level of satisfaction of male respondents with their current method by residence

Level of satisfaction	Rural	Urban	Total
Very satisfied	86.2	100.0	88.6
Somewhat satisfied	10.3	0.0	8.6
Not satisfied at all	3.4	0.0	2.9
Total	**100**	**100**	**100**
N	29	6	35

Table 11.7: Distribution of past contraceptive users by reason for discontinuing last method and residence

Reason	Rural	Urban	Total
Lack of access/unavailability	5.0	0.0	4.2
Cost not affordable	0.0	0.0	0.0
Experienced side effects	40.0	25.0	37.5
Fear of side effects	25.0	0.0	20.8
Want another child	70.0	50.0	66.7
Method failure	10.0	0.0	8.3
Method inconvenient to use	10.0	0.0	8.3
Rest from method	20.0	0.0	16.7
Health concern	45.0	25.0	41.7
Service provider's advice	10.0	0.0	8.3
Infrequent sex/respondent away	0.0	0.0	0.0
Wife opposes	0.0	0.0	0.0
In-laws/parents oppose	5.0	0.0	4.2
N	**20**	**4**	**24**

Respondents could give more than one reason.

The reasons for stopping use of their last method among husbands are presented in Table 11.7. The table shows that wanting another child was the main reason for stopping the use of a family planning method. However, about 42 percent of male past users stopped using their method because of health concern and 38 percent due to side effects they experienced with their method. Almost 21 percent of the past users stopped using a contraceptive due to fear of side effects. There were also a few cases where the in-laws/parents opposed the use of a contraceptive method, in rural areas.

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. When husbands were asked if during the last one year their wives could approach them to discuss family planning easily, with difficulty, or if they had to wait for their husbands to initiate the discussion, the responses are shown in Figure 11.1. Fifty-eight percent of the husbands reported that their wives could talk to them about family planning and fertility-related issues easily. However, 38 percent of the husbands reported that their wives had never approached them during the last one year on this issue. Almost 62 percent of the men reported that their wives had talked once or twice about this subject during the last year (Figure 11.2).

Figure 11.1: Husbands reports regarding ease of approach by their wives to discuss FP

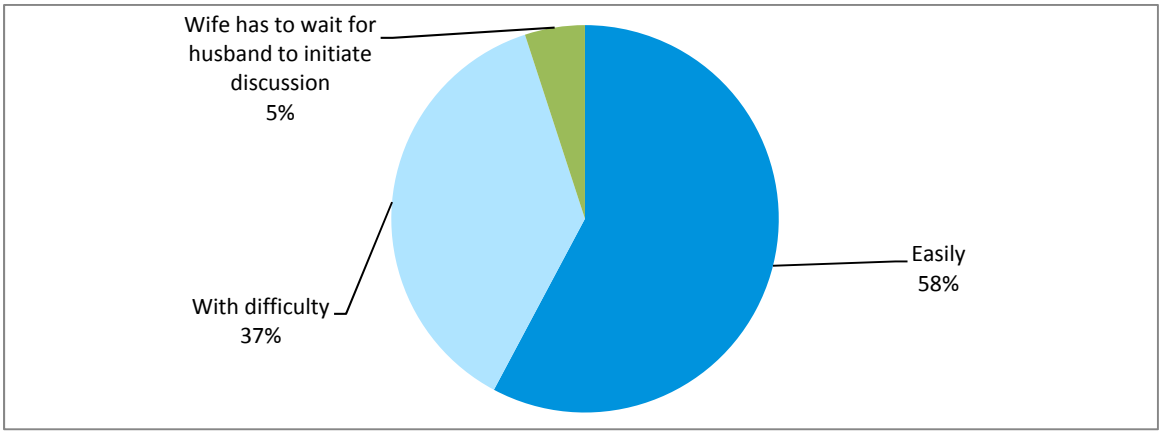
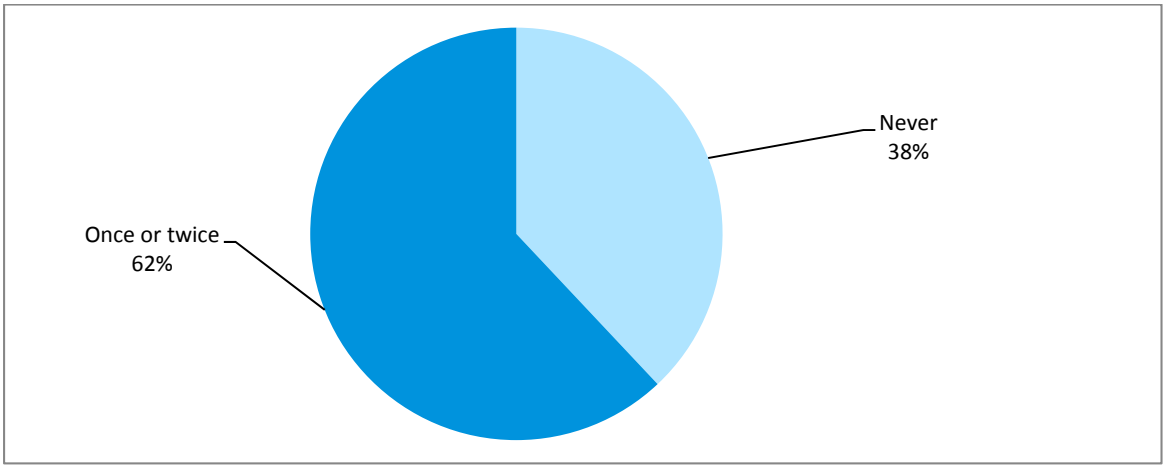


Figure 11.2: Frequency of discussion on FP with wife in last year



Potential Users

Husbands who had never used any contraceptive method were asked about their intended future use of contraceptives and their method preferences. Table 11.8 shows that only 11 percent intended to use contraceptives in the future; a large majority (74 percent) of husbands were uncertain about their future use of contraceptives and 16 percent did not intend to use contraceptives in the future.

Table 11.8: Distribution of non-users by intent to use contraceptive methods in future by residence

Intent	Rural	Urban	Total
Will use	10.1	15.4	10.7
Will not use	17.4	0.0	15.6
Unsure/uncertain	72.5	84.6	73.8
Total	**100**	**100**	**100**
N	109	13	122

As shown in Table 11.9, there was no husband in urban area that was a never user and will not use FP method in future; therefore the analysis has been made for rural husbands taken as total. The major reason husbands said they did not intend to use was their desire for more children (74percent). Slightly over one third (36 percent) reported that due to fear of side effects they don't use contraceptives. About 32 percent each reported the reasons being opposed by in-laws and breast feeding of babies. Slightly more than a quarter reported that wives oppose contraceptive use. Eleven percent of husbands said that their wives were unable to conceive. For 21 percent, non-availability of contraceptives was the main reason, while 11 percent were shy about visiting family planning clinics.

Table 11.9: Distribution of never users according to reasons for not intending to use contraceptive methods in future by residence

Reason	Total
Wife opposes	26.3
In-laws/parents oppose	31.6
Fear of side effects	36.8
Lack of access/unavailability	21.1
Costs too much	5.3
Shy to go to FP clinic	10.5
Inconvenient to use	21.1
Difficult/unable to conceive	26.3
Breastfeeding/lactational amenorrhea	31.6
Respondent/wife infertile	10.5
Want more children	73.7
N	**19**

Respondents could give more than one reason.

Table 11.10 shows the distribution of the male respondents who intended to use a specific contraceptive method in the future. It is observed that a small proportion (8 percent) wanted to use male methods. The urban husbands indicated the use of female sterilization and Injectables while none has mentioned the use of condom.

Table 11.10: Distribution of never users by intention of future use of a specific contraceptive method

Method	Rural	Urban	Total
Female sterilization	18.2	50.0	23.1
Pills	36.4	0.0	30.8
IUD	9.1	0.0	7.7
Injectable	27.3	50.0	30.8
Condom	9.1	0.0	7.7
Total	**100**	**100**	**100**
N	11	2	13

Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 11.11 shows that 28 percent of the respondents wanted another child soon

(within two years). Another 19 percent wanted to delay their next child for more than two years. The largest proportion of respondents (28 percent) did not want any more children at all while slightly more than a quarter of husbands were not sure about the desire for next child.

This desire for having another child soon was inversely associated with the number of living children. Fifty-three percent of the respondents who had no child wanted their child soon, while 44 percent who had two children and 38 percent who had three children wanted their next child soon.

Table 11.11: Distribution of male respondents by desire of next child and number of living children

	Desire of next child					
Number of living children	Soon	Later	Never	Don't know /unsure	Total	N
0	52.6	47.4	0.0	0.0	100	19
1	72.7	18.2	0.0	9.1	100	22
2	43.5	17.4	4.3	34.8	100	23
3	37.5	20.8	8.3	33.3	100	24
4	14.3	21.4	35.7	28.6	100	28
5	3.8	15.4	53.8	26.9	100	26
6+	8.6	8.6	50.0	32.8	100	58
Total	**27.5**	**18.5**	**28.0**	**26.0**	**100**	**200**

The desire to stop having children was positively associated with the number of living children. Thirty-six percent of the respondents who had 4 children did not want any more children. Around 54 percent who had 5 children did not want any more children.

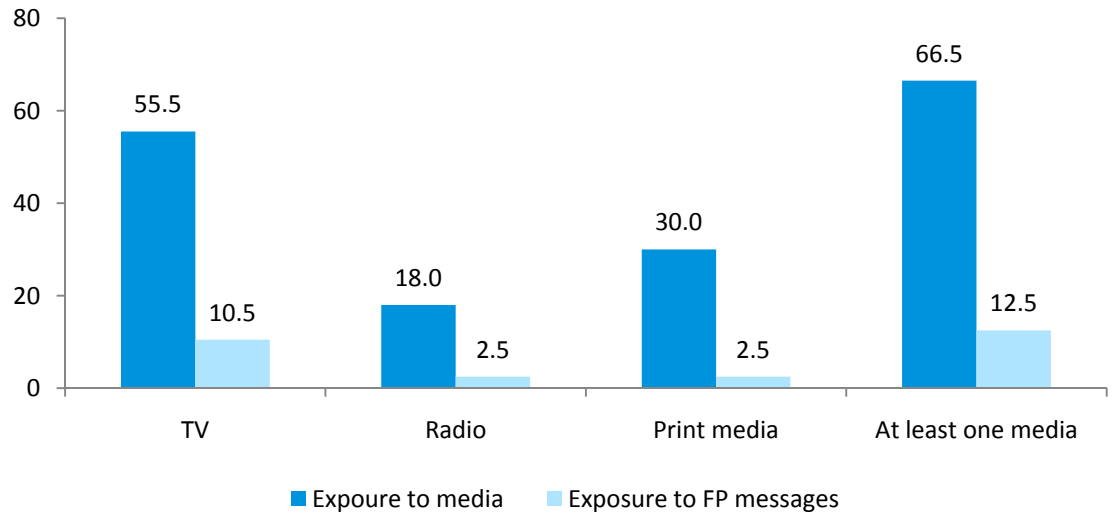
The percentage of respondents who did not want more children was almost equal to those who reported current use of contraception (27 percent of husbands). If those who wanted to postpone having another child are combined with those who did not want any more, the sum would constitute about half of all husbands. This suggests that there is a substantial need for family planning, but motivational programs and service delivery were not keeping pace with the need.

Mass Media Access and Exposure to FP Messages

For the development of communication activities, it is important to know which forms of mass media are available and to what extent they are used by various segments of the population. Figure 11.3 shows the proportion of men who reported that they watched TV, listened to the radio, or read newspapers or magazines. TV and print media were the most commonly accessed mediums as 56 percent of the male respondents in Rajanpur watched TV and 30 percent of them reported access to print media.

Furthermore, respondents who reported access to any sort of media were asked if they had ever seen, heard, or read any message pertaining to methods of family planning through these mediums. Eleven percent of the husbands had seen FP messages on the television. Overall, 13 percent of the male respondents had seen a family planning message on at least one medium. Less than 3 percent of the men reported that they had ever listened to a family planning message on the radio.

Figure 11.3: Distribution of male respondents according to exposure to media and FP messages, by type of media



References

Adair,L., Popkin, B., and Guilkey, D. 1994. *The duration of breastfeeding: How is it affected by biological, socioeconomic, health sector, and food industry factors?* Demography 30(1): 63.

Bohiler, E. and Bergstrom, S. 1995. *Subsequent pregnancy affects morbidity of previous child.* Journal of Biosocial Science 27(4): 431-442. Oct. 1995.

Bongaarts, J., and J. Bruce. 1995. *The Causes of Unmet Need for Contraception and the Social Content of Services.* Studies in Family Planning 26(2): 57-75.

Caldwell, J.C. 1976. *Toward a Restatement of Demographic Transition Theory*. Population and Development Review 2(3-4): 321-366.

Casterline, J.B., A.E. Perez, and A.E. Biddlecom. 1997. *Factors Underlying Unmet Need in the Philippines.* Studies in Family Planning 28(3): 173-191.

Casterline J. B., *et al* 2001. Obstacles to Contraceptive Use in Pakistan: A Study in Punjab. *Studies in Family Planning.* 32(2): 95-110.

Cleland and Sathar. 1984. *The Effect of Birth Spacing on Childhood Mortality in Pakistan*. Population Studies, Vol. 38, No. 3 (Nov., 1984), pp. 401-418.

Fuentes-Affelick, E. and Hessol, N.A. 2000. *Interpregnancy interval and the risk of premature infants.* Obstetrics and Gynecology 95(3): 383-390. Mar. 2000.

Garner, P., Smith, T., Baea, M., Lai, D., and Heywood, P. 1994. *Maternal nutritional depletion in a rural area of Papua New Guinea*. Tropical and Geographical Medicine 46(3): 169-171. 1994.

Government of Pakistan. 2005. *Pakistan Social and Living Standards Measurement Survey 2004-05: National/Provincial.* Islamabad: Federal Bureau of Statistics.

Government of Pakistan. 2006. *Pakistan Social and Living Standards Measurement Survey 2004-05: Provincial/District.* Islamabad: Federal Bureau of Statistics.

Mahmood, Arshad. 2002. *Determinants of Neonatal and Post-Neonatal Mortality in Pakistan*. The Pakistan Development Review, Vol. 41, No. 4, Part (Winter 2002), pp.723-744.

Mahmood, N. and K. Ringheim. 1997. *Knowledge, Approval and Communication about Family Planning as Correlates of Desired Fertility among Spouses in Pakistan*. International Family Planning Perspectives 23(3): 122-129, 145.

Miller, J.E. 1994. *Birth order, Interpregnancy Interval and Birth Outcomes among Filipino Infants*. Journal of Biosocial Science 26(2): 243-259. Apr. 1994.

NIPS (National Institute of Population Studies). 2001. *Pakistan Reproductive Health and Family Planning Survey 2000-01.* Islamabad.

NIPS (National Institute of Population Studies). 2007. *Status of Women, Reproductive Health and Family Planning Survey: Main Report.* Islamabad.

NIPS/ DHS (National Institute of Population Studies and MEASURE DHS, Macro International). 2007. *Pakistan Demographic and Health Survey 2006-07: Preliminary Report.* Calverton, Maryland: Macro International Inc.

Planning Commission of Pakistan. 2006. *Pakistan Millennium Development Goals Report 2006.* Islamabad: Center for Research on Poverty and Income Distribution.

Population Census Organization. 2000. *District Census Report of Rajanpur.* Islamabad: Statistics Division Government of Pakistan.

Population Council. 1997. *The Gap between Reproductive Intentions and Behavior: A Study of Punjab Men and Women.* Islamabad: The Population Council.

Population Council. 2006. Women's Health in Pakistan 2005. Islamabad. Unpublished.

Population Council. 2007. *Diversification of Family Planning Activities in Pakistan (DFPAP): Performance Monitoring Plan.* Islamabad: The Population Council. Unpublished.

Population Council. 2008. *Communication, Advocacy and Mobilization (CAM) Strategy for the FALAH Project: A Draft Strategy.* Islamabad: The Population Council. Unpublished.

Rutstein, S.O., and K. Johnson. 2004. *The DHS Wealth Index*. DHS Comparative Report No. 6. Calverton, Maryland, USA: ORC Macro.

Tawiah, E.O. 1997. *Factors Affecting Contraceptive Use in Ghana*. Journal of Biosocial Science 29(2): 141-149.

UNDP (United Nations Development Program). 2003. *Pakistan National Human Development Report 2003.* Karachi.

UNFPA/PC (United Nations Population Fund and Population Council). 2007. *Report of the Seminar on Unpacking Unmet Need for Family Planning in Pakistan.* Islamabad: The Population Council.

Westoff C. F. and Bankole A. 1999. *Mass Media and Reproductive Behavior in Pakistan, India, and Bangladesh*. Demographic and Health Surveys Analytic ReportsNo.10. Calverton, Maryland: Macro International Inc.

WHO. 2006. *Policy Brief on Birth Spacing- Report from a World Health Organization Technical Consultation*. WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safe.

Zhu, B.P., Rolfs, R.T., Nangle, B.E., and Horan, J.M. 1999. *Effect of the Interval between Pregnancies on Perinatal Outcomes*. New England Journal of Medicine 340(8): 589-594. Feb 25, 1999.