USAID
FROM THE AMERICAN PEOPLE

فلاح
FALAH
FAMILY ADVANCEMENT FOR LIFE & HEALTH

Baseline Household Survey

Swabi
District

May 2010

Population Council

Family Advancement for Life and Health

(FALAH)

Swabi

Baseline Household Survey
May 2010

Dr. Yasir Bin Nisar
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 came together 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 directed and implemented under the guidance and encouragement of Dr. Arshad Mahmood, Director Research, 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, Mr. Muhammad Ashraf and Ms. Saman Naz. 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. Yasir Bin Nisar prepared the first draft of the Swabi report. Mr. Muhammad Jamil Arshad reviewed the report. Mr. Muhammad Ashraf tabulated the data and figures for the report.

In the final stages Ms. Pamela Ledbetter edited the report and Ms. Saman Naz worked diligently to incorporate the various suggestions. Mr. 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 Swabi 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 Swabi, one of the 26 project districts.

The survey was conducted between March and May of 2008 in a probability sample of 520 households in 40 clusters in Swabi. It included interviews with 491 currently married women aged 15-49 ("married women of reproductive age", or MWRA), along with 200 married men, of whom 180 were married to women included in the sample. As a separate activity, a mapping study[1] was also carried out in Swabi. The FALAH project is primarily focused on birth spacing and family planning.

Household and Respondent Characteristics

Swabi is a relatively well developed primarily rural district in Pakistan; it ranked 30th of 91 districts on the overall Human Development Index, according to UNDP's Pakistan National Human Development Report, 2003. 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 Swabi household survey

Variable	Value
Percentage of household population in rural areas	85.9
Percentage of households with electricity	96.9
Percentage of households with indoor water supply	88.6
Percentage of households with flush toilet	59.6
Percentage of households with a television	53.6
Percentage of literate female respondents	28.9
Percentage of respondents with literate husbands	65.8
Total fertility rate	3.1

Swabi is a fairly thinly populated district with a well-developed road system. Electrification is essentially complete (97 percent of sample households), and ownership of appliances requiring electricity, such as , refrigerators, washing machines, etc., was not very common

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

in Swabi district. A considerable majority of the households had some indoor water supply, and almost all had either a flush toilet or a latrine. According to the MDG report, Swabi is 35th nationally in sanitation ranking. On the other hand, female literacy was relatively low, 29 percent of females were literate. Forty-one percent of the respondents said they watched TV, 17 percent listened to radio, and 5 percent read newspapers or magazines. Overall, 45 percent of the women had access to some sort of media, whereas 35 percent had ever been exposed to any FP messages through these mediums.

Fertility

There is evidence that fertility was declining in Swabi. The crude birth rate was 25 births per thousand population, and the total fertility rate was 3.1 children per woman. Fertility was higher for illiterate women and wives of illiterate men, and in households with a lower standard of living. However, there was almost no urban-rural difference in fertility. Many births were spaced too closely for optimum health; for example, nearly 65 percent of closed birth intervals were less than 36 months. Nearly 10 percent of all current pregnancies in the sample were among women who already had two living children under five years of age.

Maternal and Neonatal Care

The household survey obtained data on selected key indicators of maternal and neonatal health from 277 sampled women who had delivered a child during the previous four years (see Table B). Of these women, 67 percent had visited a health provider at least once for antenatal care; 55 percent had at least two tetanus toxoid immunizations; 47 percent were delivered by a skilled birth attendant; and 38 percent were delivered in a public or private health facility. On the other hand, only 41 percent had at least one postnatal check-up. Exclusive breastfeeding was reportedly widespread, 80 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 Swabi baseline survey

Indicator	Value
Percentage of mothers with at least one antenatal care visit	67.1
Percentage of mothers who received at least two tetanus shots	55.1
Percentage of most recent deliveries conducted by a skilled birth attendant	47.1
Percentage of most recent deliveries carried out in a facility	37.6
Percentage of MWRA not wanting more children	59.2
Percentage of MWRA wanting to delay next birth for at least two years	22.0
Percentage of MWRA with knowledge of at least one contraceptive method	100.0
Contraceptive prevalence rate	36.3
Percentage of MWRA who were past users of contraception	21.2
Percentage of MWRA with unmet need for family planning	33.6
Percentage of MWRA with unmet need for spacing	9.8
Percentage of MWRA with unmet need for limiting	23.8
Total demand for family planning (CPR + unmet need)	69.9

Preference for Children

The median "ideal" family size, according to the respondents, was 4 children, which is a common finding for Pakistan. Regarding desire for more children in the future, 18 percent said they wanted another child soon (within two years), 22 percent said they wanted another child, but only after two years, and 59 percent said they did not want more children. The proportion wanting more children soon decreased rapidly with the number of living children, while the proportion not wanting more increased; the proportion wanting more children later was highest for women with one child. Nearly, 62 percent of women said their husband wanted the same number of children that they did, while 30 percent said their husband wanted more than they did.

Contraceptive Knowledge and Use

All currently married women knew of at least one contraceptive method. The contraceptive prevalence rate (the percentage of MWRA currently using some method of contraception) was 36 percent, which was higher than the average for Khyber Pakhtunkhwa or for Pakistan. The most commonly modern methods in use were condoms (14 percent),

injectables (5 percent) and female sterilization (4 percent). Past users comprised 21 percent of MWRA; pills, injectables, condoms and IUD were all common past methods. Seventy-eight percent of current users did not want more children, while 22 percent wanted more, but at a later time. Most users reported obtaining their supplies and services from LHWs or their husband obtained the supplies (especially condoms and pills).

Experience with Contraceptive Methods

Stated reasons for respondents' choices of their current or past method varied by method, but commonly cited reasons included suitability for respondent and husband, low side effects, convenience of use, low cost and easy availability. Costs were generally low, only 9 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; only 14 percent reported requiring more than 30 minutes to reach their service. Information provided at acceptance of method was not sufficient regarding side effects, contraindications, and advantages of method. Clients generally reported being reasonably treated by providers, but were not always examined properly, and respondents often did not feel the providers were capable of dealing with side effects. A variety of side effects was reported by current and past users.

Reasons for Non-use

Asked hypothetically about hindrances a couple might face if they wanted to avoid or delay pregnancy, women typically mentioned husband's disapproval, family planning being against religion, problem of managing side effects and fear of side effects. Less frequently mentioned were distance/cost, method failure, or that people might find out their contraceptive use. Past users were most likely to discontinue use because they wanted more children, or because of side effects; their reasons for current non-use were infrequent sex/husband away, breastfeeding/lactational amenorrhea and currently pregnant. Fear of side effects was also frequently mentioned. Never users were most likely to say they were not using for reasons relating to childbearing, but infrequent sex/husband away, husband's opposition and fear of side effects were also common reasons. Ninety-three percent of never users approved of spacing, whereas 94 percent approved for limiting births. Knowledge of contraceptive sources was lower among never users. A majority of female current and past users (more than 96 percent) said they could discuss family planning easily with their husbands, but 57 percent of never users said they could do so. About 52

percent of women expressed their intent to use contraception in the future. The information obtained in this study indicates that a substantial number of women in Swabi were ready to use birth spacing and family planning.

Unmet Need for Family Planning

A woman is said to be in "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, 34 percent of the women in this sample were in unmet need, 24 percent for limiting and 10 percent for spacing. This proportion is typical for Pakistan. Unmet need for limiting is higher in rural areas, among illiterate women, and among women with lower standard of living; but unmet need for spacing is higher among literate women. Women in unmet need tend to be characterized by poor communication with their husbands and/or disagreement on whether to have more children, fear of side effects, and lack of knowledge of family planning sources.

Reproductive Preferences and Behavior of Men

The findings reveal that all men knew at least one modern contraceptive method. Male sterilization was one of the least known contraceptive methods among men in Swabi. More than 53 percent of the men did not want more children in the future and 32 percent wanted to delay the next pregnancy. Fifty-six percent of the male respondents reported that they or their wives were currently using any family planning method and 39 percent were using modern contraceptive method. Among the current users, 77 percent were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, 38 percent reported that they were not intending to use any FP method in future. The fear of side effects was one of the main reasons for not using any FP method. Of those who did intend to use contraceptives in the future, relatively small proportions reported that they intended to use male methods. 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 and limiting needs.

Conclusion

In district Swabi, the knowledge and approval of family planning was high, and contraceptive prevalence, at 36 percent, was higher than that of Pakistan. Nevertheless, there is much need for improvement; unmet need for family planning remains high at 34 percent. Among the important reasons that should be addressed in an improved program are fear of side effects, husbands' attitudes, religion, inter-spousal communication, and knowledge of contraceptives sources. 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 with 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, Lasbela, Quetta, Kech and Zhob;
- **Khyber Pakhtunkhwa:** Charsadda, Mansehra, Mardan and Swabi;
- **Punjab:** Bahawalpur, Dera Ghazi Khan, Jhelum, Khanewal, Multan and Rajanpur;
- **Sindh:** Dadu, Ghotki, Jacobabad, Karachi (townships of Godap, Liyari, Orangi), Larkana, Sanghar, Shikarpur, Sukkur, and Thatta.

The aims of the FALAH project are:

a) To increase 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 is working 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, a maternal and neonatal health project, especially in the PAIMAN districts, and with other projects as appropriate. In Swabi, district-level activities are being coordinated by Save the Children (US), with Greenstar providing information and service through social marketing and other partners supporting specific activities as needed.

Swabi District

Swabi is primarily a rural district of the Khyber Pakhtunkhwa Province. The overall population of the district was estimated to be 1.3 million in 2008, with a population density of around 83 persons per square kilometer. Geographically, the district is covered by Buner on the north, Haripur on the east, Attock (Punjab) on the south and on the west by Nowshera and Mardan districts. The education profile of the district shows a disparity among male and female educational institutes at all levels, particularly in the polytechnic and vocational fields.

According to the UNDP Pakistan National Human Development Report 2003,[2] Swabi stood 30th among 91 districts in Pakistan, and 21st among 24 districts of Khyber Pakhtunkhwa (UNDP, 2003). In the 2006 Planning Commission's Millennium Development Goals report (Planning Commission of Pakistan, 2006), Swabi was an average district on both national and provincial levels on measures of education, literacy, water supply, and sanitation (Planning Commission of Pakistan, 2006; Government of Pakistan, 2006).

[2] The districts of Pakistan were ranked according to a Human Development Index in 2003. Districts were ranked based on literacy rates, enrolment ratios, immunization ratios, infant survival ratios, real GDP per capita, educational attainment index, health index and income index.

The Swabi Baseline Household Survey

In Swabi (as in each of the 26 FALAH focus districts), Population Council implemented a baseline sample household survey to learn about knowledge, attitude, and practice 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 health and reproductive health services, including maternal health, neonatal and child health, and child spacing/family planning. This baseline survey will be compared with an endline survey toward the end of the project to assess progress.

Objectives

The objectives of the Swabi 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, attitude and practice of married couples of Swabi 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 that 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 practice 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 with the number of villages selected in rural areas are presented in Table 1.1. A total of 40 blocks/villages were selected, with 13 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 , which 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 13 households was 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 a rural sample. Villages in rural areas have been treated as primary sampling units (PSU). 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 13 households was selected from each sample enumeration village by the systematic random technique.

Selection of Respondents

Within each household, all married women aged 15-49 (MWRA) were interviewed. In addition, husbands of MWRA who were available were also interviewed to a maximum of 5 per block; if fewer than 5 husbands could be interviewed from the 13 sampled households; additional interviews were sought from neighboring households.

Table 1.1 presents the planned and enumerated number of households and eligible women of reproductive age in Swabi.

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

Result	Rural	Urban	Total
Number of blocks/villages	34	6	40
Households contacted	527	120	647
Households interviewed	442	78	520
Eligible women identified	485	79	564
Eligible women interviewed	425	66	491
Total women's interviews	**425**	**66**	**491**

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 that 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 survey were currently married women and their husbands, female interviewers were hired to interview female respondents and male interviewers were used for male respondents. The required number of interviewers was 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 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 criteria 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 the questionnaires. Each team leader completed on-the-spot checks and preliminary editing of questionnaires during the enumeration period. Team supervisors were provided with editing instructions emphasizing the importance of completing each questionnaire, correctly identifying each eligible respondent, and the completeness of household composition. Each team leader engaged in preliminary editing of completed questionnaires during the enumeration period. On receipt of the questionnaires at the Islamabad office, a special team of experienced staff edited the completed questionnaires. After the completion of the editing and coding process, the questionnaires were dispatched to a data entry center. The data were then analyzed using SPSS for Windows.

Fieldwork

Fieldwork for Swabi district was carried out between March and May 2008.

Chapter 2

Household Characteristics

Geographic Distribution

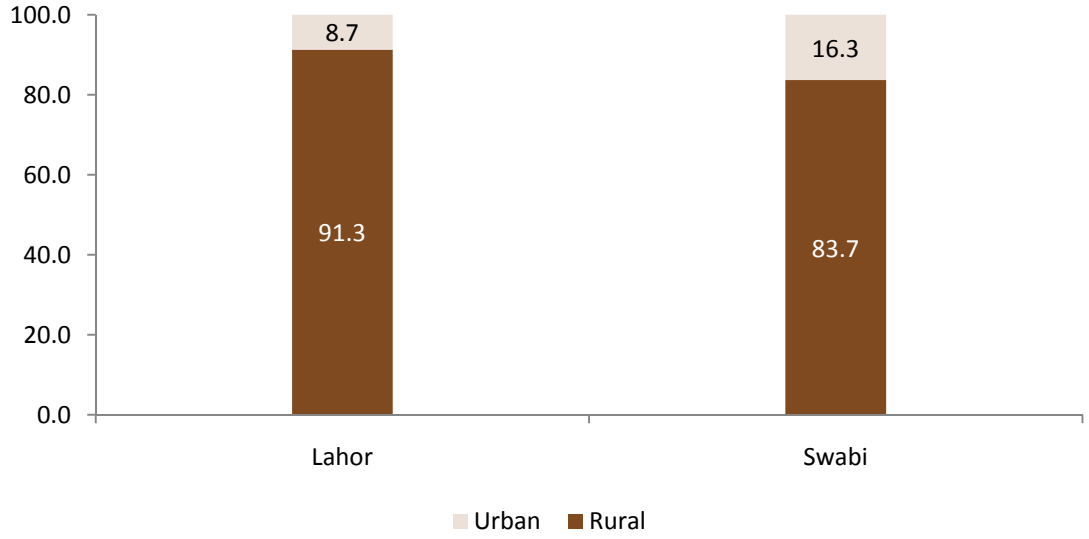
Swabi district is comprised of Lahor and Swabi tehsils both of which are primarily rural. Table 2.1 and Figure 2.1 show the population distribution of sample households according to residence (urban and rural) and by tehsil, with comparisons to the population distribution of the 1998 National Population and Housing Census.

Table 2.1: Distribution of the population in sample households by residence and tehsil

	Rural			Urban			Total	
Tehsil	N	%	1998 Census %	N	%	1998 Census %	N	%
Lahor	1034	91.3	90.9	99	8.7	9.1	1133	100.0
Swabi	2346	83.7	79.0	457	16.3	21.0	2803	100.0
Total	**3380**	**85.9**	**82.5**	**556**	**14.1**	**17.5**	**3936**	**100.0**

As Table 2.1 shows, the distribution of the population of the 520 households in the sample by urban-rural residence and tehsil closely followed the distribution recorded for the whole district in the 1998 Population Census (Population Census Organization, 2000); in Lahor tehsil the same proportion was sampled. Swabi district was almost 86 percent rural and 14 percent urban. About 29 percent of the sample population lived in Lahor tehsil, while 71 percent resided in Swabi tehsil.

Figure 2.1: Distribution of population in sample households by residence and tehsil



Data show that the mother tongue of 96 percent of the sample households was Pashto, reflecting the dominant ethnic group in the district.

Age-Sex Distribution

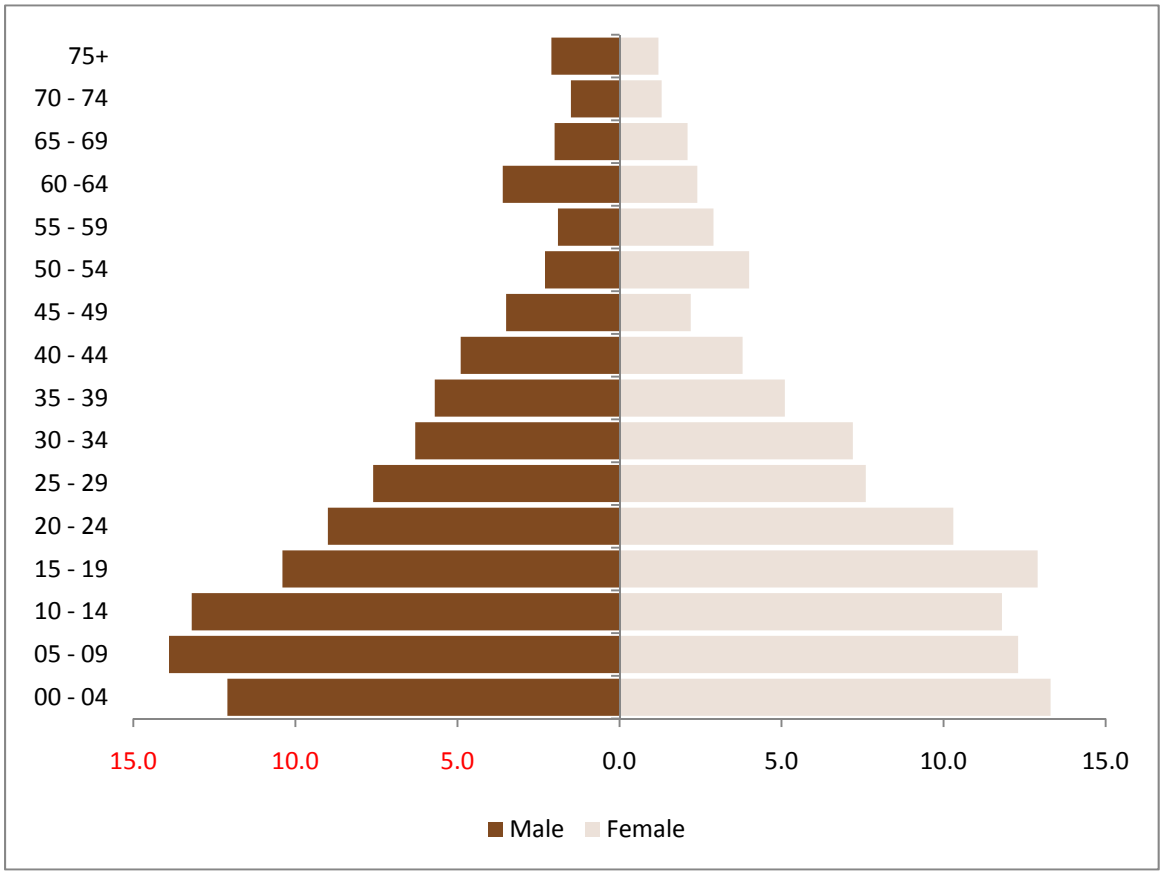
Table 2.2 shows the population distribution of the sampled households by age and sex. Figure 2.2 shows the same information in the form of an age-sex pyramid.

The population was typical of a society with high fertility, with the median age of 19 years. As is the case in many places in Pakistan, there were somewhat more males than females at older ages (75+).

Table 2.2: Distribution of sample household population by age and sex

	Sex of household member					
	Male		Female		Total	
Age group	N	%	N	%	N	%
00 - 04	234	12.1	265	13.3	499	12.7
05 - 09	267	13.9	245	12.3	512	13.0
10 - 14	255	13.2	236	11.8	491	12.5
15 - 19	200	10.4	258	12.9	458	11.7
20 - 24	174	9.0	205	10.3	379	9.7
25 - 29	147	7.6	152	7.6	299	7.6
30 - 34	121	6.3	144	7.2	265	6.8
35 - 39	109	5.7	101	5.1	210	5.4
40 - 44	94	4.9	76	3.8	170	4.3
45 - 49	68	3.5	44	2.2	112	2.9
50 - 54	44	2.3	79	4.0	123	3.1
55 - 59	37	1.9	58	2.9	95	2.4
60 -64	69	3.6	47	2.4	116	3.0
65 - 69	39	2.0	41	2.1	80	2.0
70 - 74	28	1.5	25	1.3	53	1.4
75+	40	2.1	23	1.2	63	1.6
Total	**1926**	**100.0**	**1999**	**100.0**	**3925**	**100.0**

Figure 2.2: Percentage of sample household population by sex and age group



Of the total population of the sampled households, 25 percent consisted of females 15-49 years of age, and 12.7 percent consisted of children under 5 years old. These groups comprise the population of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

Marital Status

In Swabi (as in Pakistan generally), two trends can be identified: first, in general women married at an early age and, second, that women married men who were much older than they were. Singulate mean age at marriage for men and women was 28 and 22 years respectively. Therefore, as Table 2.3 shows, a higher proportion of women at younger ages were married than men. At older ages, women were more often widowed than men; this

might be due to the fact that the husbands were much older and probably reached their life expectancy.

Table 2.3: Percentage distribution of household population by marital status, sex and age

	Married		Widow/divorced/ separated		Never married	
Age group	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
15 - 19	20.2	2.5	0.0	0.0	79.8	97.5
20 - 24	53.2	13.2	1.0	0.0	45.9	86.8
25 - 29	69.3	51.0	0.7	0.0	30.0	49.0
30 - 34	85.4	76.9	1.4	0.0	13.2	23.1
35 - 39	82.2	93.6	6.9	0.9	10.9	5.5
40 - 44	80.3	92.6	5.3	1.1	14.5	6.4
45 - 49	63.6	95.6	13.6	4.4	22.7	0.0
50 - 54	82.3	97.7	10.1	2.3	7.6	0.0
55 - 59	65.5	94.6	27.6	2.7	6.9	2.7
60 - 64	53.2	95.7	40.4	4.3	6.4	0.0
65 - 69	51.2	84.6	36.6	15.4	12.2	0.0
70 – 74	32.0	85.7	60.0	14.3	8.0	0.0
75+	30.4	70.0	65.2	27.5	4.3	2.5
All ages 15+	**57.9**	**58.0**	**8.8**	**2.6**	**33.3**	**39.3**
N	724	679	110	31	417	460

Household Characteristics and Wealth Indicators

Several household characteristics were assessed that reflect the wealth and well-being of its inhabitants. Some of these may have a direct bearing on health; for example, a clean indoor water supply and flush toilets are important for hygiene, and 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 – for example, by indicating ability to buy sufficient food for good nutrition or pay for quality health care.

Physical Characteristics of Households

Table 2.4 shows selected physical characteristics of the sample households. A considerable number of households (89 percent) had an indoor water supply. It is important to note that there was less difference between urban and rural indoor water supply. Nearly 39 percent of the households had motorized/hand pump inside on a self-help basis and only 27 percent of the inside water supply was provided by the government, particularly in urban areas (see also Figure 2.3). Sixty percent had some type of flush toilet (Figure 2.4). Huge differentials may be seen between rural (56 percent) and urban (83 percent) availability of flush toilets. Figure 2.4 shows that 40 percent of the households had a latrine, and only 1 percent had no toilet at all.

While most households used firewood (79 percent) for cooking, particularly in rural areas, about 17 percent used gas, usually Sui gas in urban areas. Almost all households had electricity in urban areas (99 percent) and 96 percent in rural areas. Thirty-five percent of the houses were roofed with wood/bamboo and mud, 65 percent had earth or mud floors, and 76 percent of the walls were made of burnt bricks or cement blocks.

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

Characteristic	Rural	Urban	Total
Source of drinking water			
Govt. supply (tap water inside)	25.1	35.9	26.7
Govt. supply (communal)	2.0	2.6	2.1
Motorized/Hand pump (inside)	39.1	37.2	38.8
Motorized/Hand pump (outside)	3.2	3.8	3.3
Well (inside)	24.2	16.7	23.1
Well (outside)	5.0	3.8	4.8
River/Canal/Stream	1.4	0.0	1.2
Sanitation facility			
Flush connected to septic tank	53.2	76.9	56.7
Flush connected to open drain	2.3	6.4	2.9
Raised latrine	43.9	16.7	39.8
Pit latrine/ In fields	0.7	0.0	0.6
Main type of fuel used for cooking			
Fire wood	84.4	50.0	79.2
Kerosene oil	0.2	0.0	0.2
Gas cylinder	6.1	16.7	7.7
Natural gas (Sui gas)	5.4	28.2	8.8
Dry dung	3.8	5.1	4.0
Electrical connection			
Yes	96.2	98.7	96.5
No	3.8	1.3	3.5
Main material of the roof			
Concrete	41.0	52.6	42.7
Guarder and T-iron	20.4	32.1	22.1
Wood/Bamboo and mud	38.7	15.4	35.2
Main material of the floor			
Earth/Sand/Mud	65.6	61.5	65.0
Cement	29.2	29.5	29.2
Others	5.2	9.0	5.8
Main material of the walls			
Burnt bricks/Blocks	74.2	87.2	76.2
Mud bricks/Mud	25.8	12.8	23.8
N	**442**	**78**	**520**

Figure 2.3: Water supply for households

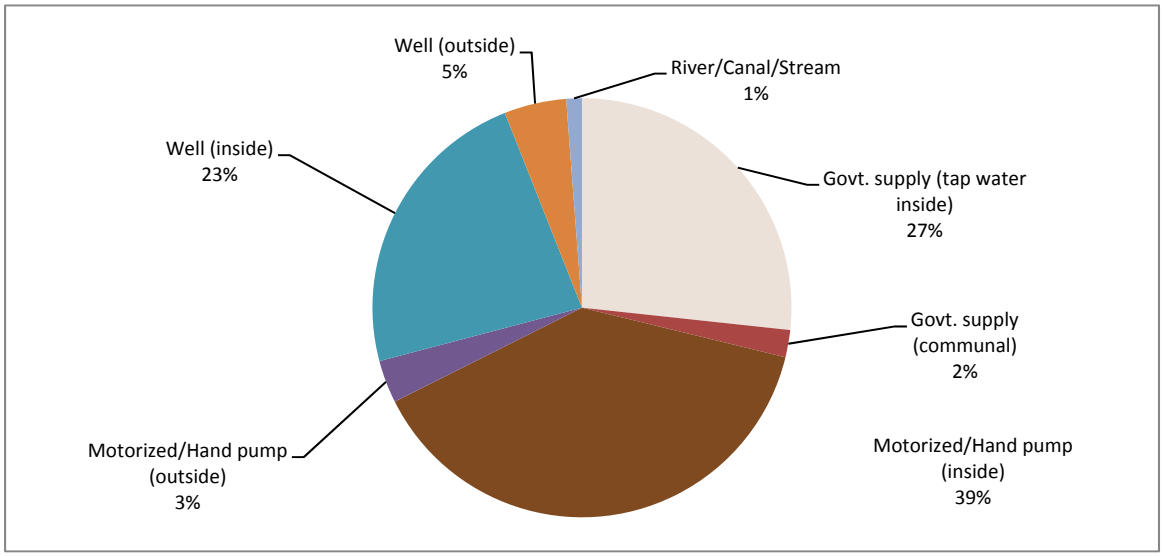
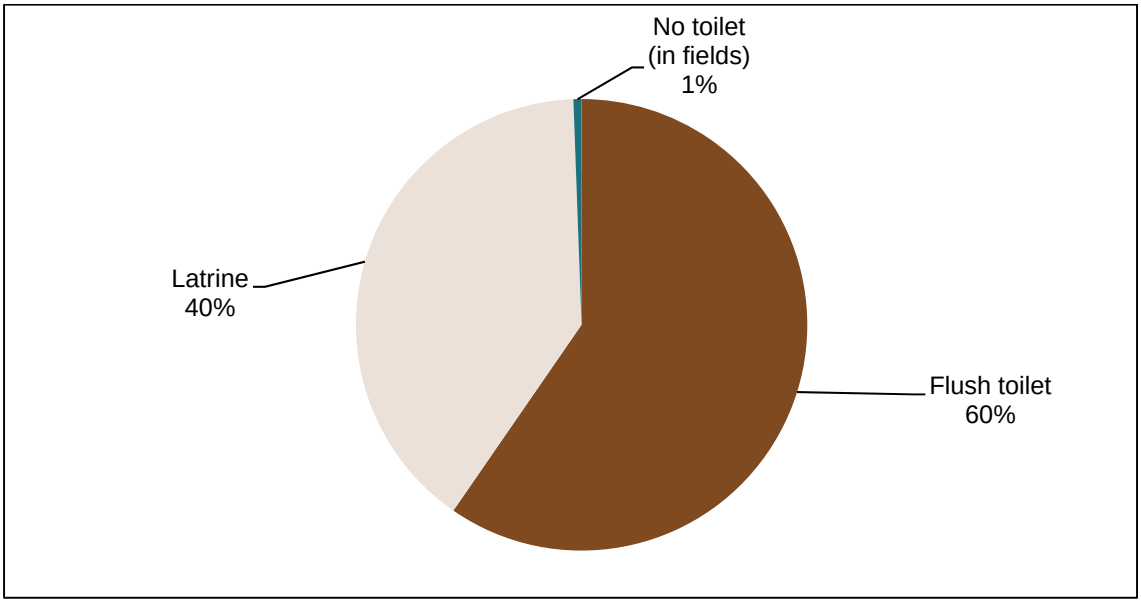


Figure 2.4: Toilet facilities for Swabi households



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 – along with

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, to reach health facilities, and telephones 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 characterized Pakistan in recent years, although comparable past data for Swabi are not available to us. Several items requiring electricity were available in households, such as television (54 percent overall); nearly half of the rural households had access to TV. This could be of particular interest to communications specialists. The recent expansion of information technology in Pakistan was reflected by ownership of mobile phones by three-fifths (59 percent) of all households (56 percent rural; 80 percent urban), and ownership of a computer by about 7 percent of the households. Motorized transport, however, remained fairly uncommon, suggesting difficulties in arranging transport in health emergencies.

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

Household item	Rural	Urban	Total
Wall clock	90.0	100.0	91.5
Chairs	60.2	75.6	62.5
Bed	62.7	84.6	66.0
Sofa	31.2	53.8	34.6
Sewing machine	57.5	71.8	59.6
Camera	7.5	9.0	7.7
Radio/Tape recorder	43.4	61.5	46.2
Television	49.5	75.6	53.5
Refrigerator	39.6	66.7	43.7
Land line telephone	14.5	25.6	16.2
Mobile phone	55.4	79.5	59.0
Room cooler/ Air conditioner	14.7	38.5	18.3
Washing machine	32.8	69.2	38.3
Bicycle	22.9	39.7	25.4
Motor cycle	5.4	12.8	6.5
Jeep/Car	1.4	1.3	1.3
Computer	6.3	7.7	6.5
No. of observations	**429**	**91**	**520**

Standard of Living Index

It is useful to use the data above to get an overall index of the economic well-being of a household, both for a general estimate of economic development for 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 6. For rural households the median index was 5 and for urban households it was 7.

About 86 percent of all households fell in the range from 3 to 8. This index will be used later in this report to examine differences in reproductive health knowledge and behavior.

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

Standard of living index	Rural		Urban		Total	
	N	%	N	%	N	%
1	2	0.5	0	0.0	2	0.4
2	12	2.7	0	0.0	12	2.3
3	71	16.1	4	5.1	75	14.4
4	82	18.6	5	6.4	87	16.7
5	71	16.1	10	12.8	81	15.6
6	55	12.4	11	14.1	66	12.7
7	56	12.7	21	26.9	77	14.8
8	47	10.6	15	19.2	62	11.9
9	33	7.5	6	7.7	39	7.5
10	8	1.8	5	6.4	13	2.5
11	4	0.9	1	1.3	5	1.0
12	1	0.2	0	0.0	1	0.2
Total	**442**	**100.0**	**78**	**100.0**	**520**	**100.0**
Median	5	na	7	na	6	na

na = not applicable.

Chapter 3

Respondent Characteristics

The primary source of data from the Household Survey is the interviews conducted with 491 currently married women of reproductive age. 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. Since many younger women were yet to be married, the numbers at age 15-19 years were relatively small; at older ages the numbers declined, because significant numbers of women were widowed after 40. Nearly half of the sample respondents were less than age 30. In urban areas, 39 percent of the women were less than age 30 and 50 percent of the women in rural areas were less than age 30.

Table 3.1: Age distribution of female respondents by residence

	Rural		Urban		Total	
Age group	**N**	**%**	**N**	**%**	**N**	**%**
15 - 19	43	10.1	3	4.5	46	9.4
20 – 24	85	20.9	14	21.2	99	20.2
25 – 29	81	19.1	9	13.6	90	18.3
30 – 34	88	20.7	15	22.7	103	21.0
35 – 39	67	15.8	12	18.2	79	16.1
40 – 44	44	10.4	9	13.6	53	10.8
45 – 49	17	4.0	4	6.1	21	4.3
Total	**425**	**100.0**	**66**	**100.0**	**491**	**100.0**

Education and Literacy

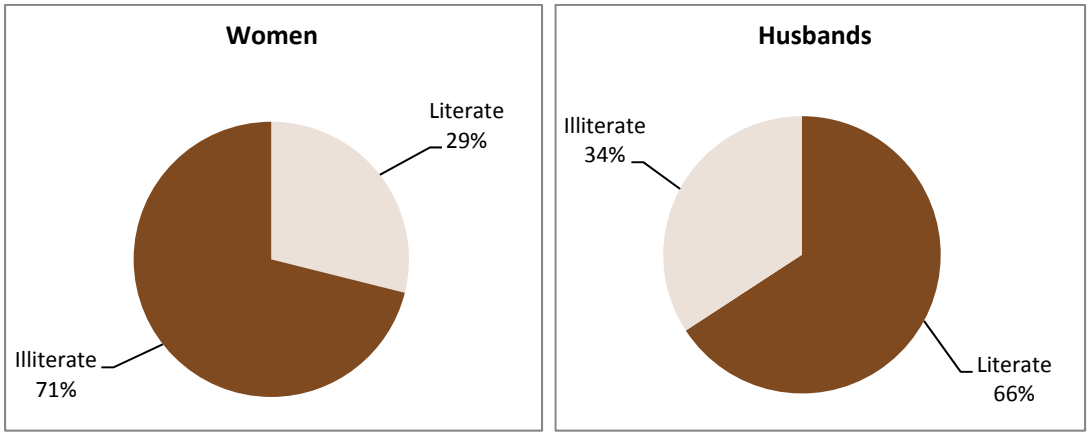
Levels of schooling completed and literacy rates for the respondents and their husbands are given in Table 3.2; literacy rates are also shown in Figure 3.1. The literacy rate of 29 percent for females was very low compared to the literacy rate for husbands, which was 66 percent. Literacy of female respondents was higher than reported in PSLMS 2004-05 for Khyber Pakhtunkhwa province as a whole (22 percent), and lower than for Pakistan (36 percent) (Government of Pakistan, 2005; Government of Pakistan, 2006). Similarly, only about 31 percent of female respondents reported having ever attended school. For men as well, literacy (at 66 percent) was lower than the PSLMS found for Khyber Pakhtunkhwa in 2004-05 (68 percent), although these rates were higher than the national average (63 percent) (Government of Pakistan, 2005). Table 3.2 also shows that younger women (15-24 years) were significantly more literate than older women (25-34 years or 35-49 years of age).

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

	Age group			Residence		
Variable	**15 - 24**	**25 – 34**	**35 - 49**	**Rural**	**Urban**	**Total**
Respondent(women)						
Proportion literate	53.1	23.3	12.4	27.8	34.8	28.7
Education level						
No education	40.7	74.6	87.6	69.9	60.6	68.6
Up to primary	21.4	8.3	5.2	11.8	7.6	11.2
Up to secondary	32.4	13.5	4.6	15.1	24.2	16.3
Above secondary	5.5	3.6	2.6	3.3	7.6	3.9
N	**145**	**193**	**153**	**425**	**66**	**491**
Respondent's husband						
Proportion literate	81.4	63.2	53.6	65.4	66.7	65.6
Education level						
No education	17.2	35.8	45.8	33.4	33.3	33.4
Up to primary	2.1	3.6	5.2	4.0	1.5	3.7
Up to secondary	57.2	45.1	34.0	44.7	48.5	45.2
Above secondary	22.8	15.0	15.0	17.4	16.7	17.3
Don’t know	0.7	0.5	0.0	0.5	0.0	0.4
N	**145**	**193**	**153**	**425**	**66**	**491**

For both men and women respondents, literacy rates were higher in urban areas. The difference, however, was relatively minor. Literacy levels for women were lower in Swabi than in Pakistan as a whole.

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. Men in general are expected to work for pay; the question is, doing what? Interestingly, in Swabi district only 21 women (4 percent) were reported to be working for cash (other than household chores). Their occupations are shown in Figure 3.2. This shows that a majority of the women did embroidery/stitching followed by government service.

Figure 3.2: Type of work of women working for pay (n=21)

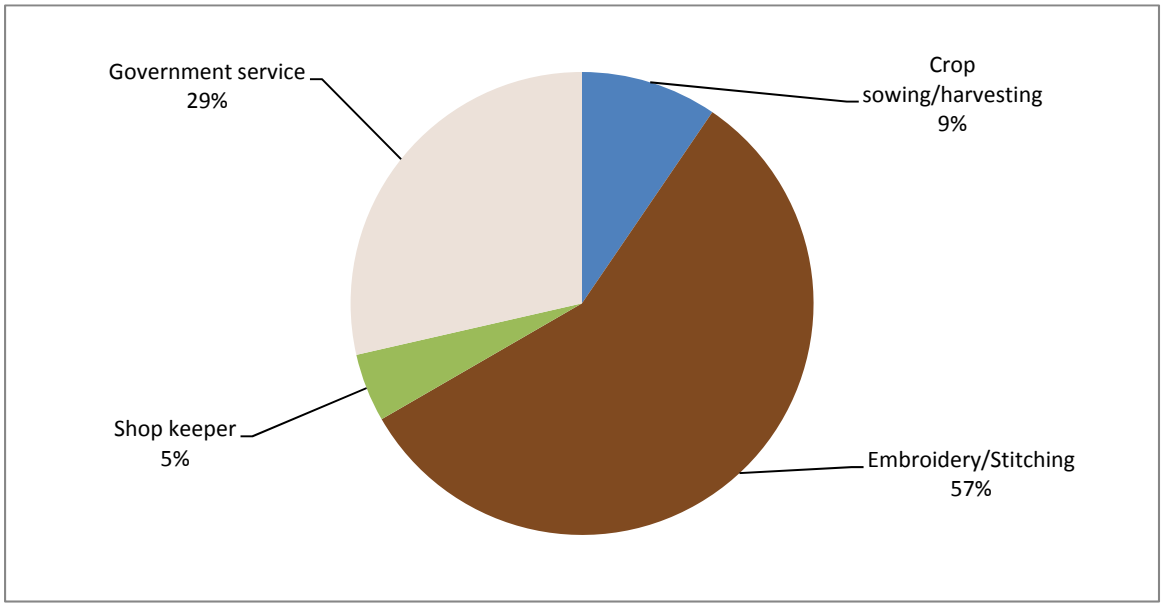


Table 3.3: Percentage distribution of occupational categories of respondents' husbands by residence

Occupation/economic activity	Rural	Urban	Total
Agriculture/Livestock/Poultry	17.9	15.2	17.5
Petty trader	10.4	15.2	11.0
Labor (Daily wages)	26.1	24.2	25.9
Government service	15.8	19.7	16.3
Private service	8.0	3.0	7.3
Own business	2.4	3.0	2.4
Abroad	11.3	10.6	11.2
Unemployed	7.8	9.1	7.9
Others	0.5	0.0	0.4
N	**425**	**66**	**491**

The largest group of husbands in both rural and urban areas worked as hired laborers for daily wages (Table 3.3). Slightly less than one-fifths of the husbands of the women were working in agriculture/livestock/poultry. Overall, 45 percent of rural husbands were either in agriculture or worked as day laborers, which was mostly agricultural labor. Only 16

percent of the men were in government service. Trading was more common in the towns, employing one in six urban men. About 11 percent of the husbands of respondents were living abroad and 8 percent were unemployed.

Female Mobility

Women respondents were asked about their ability to go to places outside their homes, and what degree of permission was required to do so. Only a few women reported being able to go to any of the places named without permission; on the other hand, a large majority of women reported not being able to go to the market (85 percent) at all. For health centers, a majority said they could go with someone (63 percent) or with permission (16 percent).

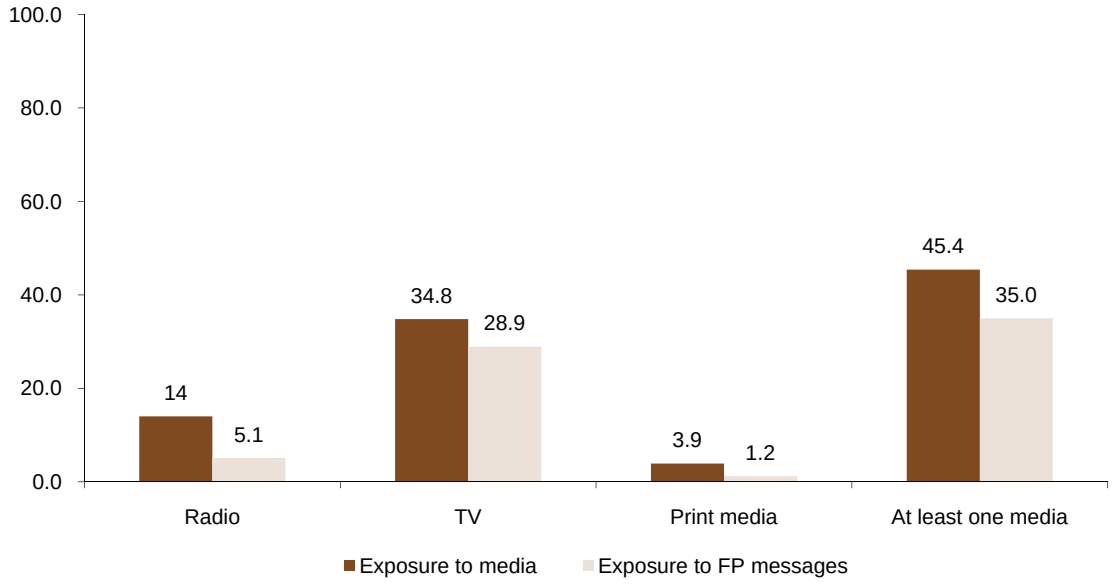
Table 3.4: Women's reports regarding mobility outside the home, by degree of permission and destination

Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Can't go/ doesn't go	%	N
Market	0.0	9.6	5.3	85.1	100.0	491
Health center	8.8	16.3	63.3	11.6	100.0	491
Relatives/friends	6.5	39.3	54.2	0.0	100.0	491
Out of village/town	1.8	20.6	74.9	2.6	100.0	491

Mass Media Access and Exposure to Family Planning 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. Table 2.5 showed that 54 percent of households owned a television, while 46 percent owned a radio. Figure 3.3 shows the proportions of women who reported that they watch TV, listen to the radio, or read newspapers/ magazines. Television was the most commonly accessed medium (35 percent), followed by radio (14 percent), and only 4 percent accessed print materials. This is fairly typical of the situation in much of Pakistan.

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 about their exposure to family planning messages. This pattern was much the same as for exposure to media. More women said that they had heard about family planning messages on television (29 percent) than radio (5 percent) and only 1 percent of women reported reading messages from print materials. Overall, more than a third of the women reported exposure to family planning messages through any one 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 fertility, such as the number of children ever born and living children, was collected from the currently married women interviewed. This information was used to obtain the level of cumulative fertility.

Other information collected in this baseline survey included the date of birth for all live births, and whether those children were still alive at the time of the survey. If a mother was unable to remember the date of birth, she was asked how long ago her live birth was. From these responses, births that occurred during the last three years were ascertained. The number of births obtained through this procedure was then used to analyze current fertility. For a family planning program, it is essential to be informed 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 percent 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)

	Children ever born						
Age group	0	1-2	3-4	5 or more	%	Mean CEB	N
15-19	56.5	43.5	0.0	0.0	100.0	0.5	46
20-24	26.3	48.5	23.2	2.0	100.0	1.6	99
25-29	2.2	32.2	50.0	15.6	100.0	3.2	90
30-34	5.8	6.8	29.1	58.3	100.0	4.9	103
35-39	3.8	5.1	16.5	74.7	100.0	5.7	79
40-44	3.8	3.8	17.0	75.5	100.0	6.1	53
45-49	0.0	0.0	4.8	95.2	100.0	7.0	21
Total	**13.2**	**22.4**	**24.6**	**39.7**	**100.0**	**3.9**	**491**

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

	Number of living children						
Age group	0	1-2	3-4	5 or more	%	Mean LC	N
15-19	58.7	41.3	0.0	0.0	100.0	0.5	46
20-24	26.3	53.5	20.2	0.0	100.0	1.5	99
25-29	3.3	33.3	55.6	7.8	100.0	2.9	90
30-34	5.8	8.7	34.0	51.5	100.0	4.5	103
35-39	3.8	6.3	27.8	62.0	100.0	5.0	79
40-44	3.8	5.7	20.8	69.8	100.0	5.4	53
45-49	0.0	0.0	28.6	71.4	100.0	6.0	21
Total	**13.6**	**24.2**	**29.3**	**32.8**	**100.0**	**3.5**	**491**

The table shows that early childbearing was common in Swabi. 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, as would be expected in data of good quality. Table 4.3 shows the mean number of sons and daughters. The mean number of children ever born increased from 0.5 in age group 15-19 years to 7.0 in age group 45-49. Among women aged 15-49 in Swabi, the mean number of children ever born was 3.9 for currently married women. The mean number of children ever born increased steadily with age, reaching a high of 7 children among women aged 45-49 years. On average, these women

also had 6 living children. Each woman of age group 45-49 had lost one child on average during her reproductive life.

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

	Mean number of children						
	Ever born			Surviving			
Age group	Boys	Girls	Total	Boys	Girls	Total	N
15-19	0.3	0.3	0.5	0.2	0.2	0.5	46
20-24	0.7	0.8	1.6	0.7	0.8	1.5	99
25-29	1.6	1.6	3.2	1.4	1.5	2.9	90
30-34	2.5	2.4	4.9	2.3	2.2	4.5	103
35-39	3.1	2.6	5.7	2.6	2.4	5.0	79
40-44	2.9	3.1	6.1	2.6	2.8	5.4	53
45-49	3.3	3.7	7.0	3.0	2.9	6.0	21
Total	**1.9**	**1.9**	**3.9**	**1.7**	**1.7**	**3.5**	**491**

Table 4.1 also shows that about 43 percent of married women who were 15-19 years of age had already given birth to at least one child. Women aged 45-49 had virtually completed childbearing. Among currently married women in this age group, 5 percent had reached the end of childbearing with fewer than five children ever born, and 95 percent had five or more children ever born. The data show that all women aged 45-49 had at least one live birth in their reproductive period, suggesting no primary infertility (i.e., the proportion of couples who are unable to have any children) in this sample in Swabi.

Differentials in Children Ever Born and Surviving

Tables 4.4 and 4.5 show that differences in mean number of children by literacy, age and educational level of currently married women were pronounced. On average, literate women produced 2.3 fewer children than illiterate women. As expected, fertility also declined with the level of education. Those who had “up to primary” education had an average of 2.5 children ever born as compared to 4.6 children ever born to women who had no schooling. Those who had “up to secondary” education had 1.9 children ever born.

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

Characteristic	Mean number of CEB	Mean number of LC	Proportion dead	N
Literacy of mother				
Literate	2.2	2.0	0.0707	141
Illiterate	4.5	4.0	0.1117	350
Schooling of mother				
No education	4.6	4.1	0.1124	337
Up to primary	2.5	2.2	0.0889	55
Up to secondary	1.9	1.8	0.0710	80
Above secondary	2.5	2.5	0.0208	19
Residence				
Rural	3.9	3.5	0.1077	425
Urban	3.8	3.5	0.0876	66
Literacy of husband				
Literate	3.3	3.0	0.0924	322
Illiterate	5.0	4.4	0.1207	169
Schooling of husband				
No education	5.0	4.4	0.1212	164
Up to primary	5.1	4.4	0.1209	18
Up to secondary	3.3	3.0	0.0938	222
Above secondary	2.9	2.7	0.0732	85
Don't know	8.0	6.5	0.1875	2
Standard of living index				
Low	5.3	4.6	0.1157	74
Medium low	3.9	3.4	0.1215	168
Medium high	3.5	3.1	0.1020	133
High	3.4	3.2	0.0709	116
Occupation/economic activity of husband				
Agriculture/livestock/poultry	4.3	3.8	0.1260	86
Petty trader	3.8	3.5	0.0878	54
Labor (daily wages)	4.2	3.8	0.1134	127
Government service	3.3	3.1	0.0752	80
Private service	3.4	2.8	0.1721	36
Own business	2.7	2.7	0.0000	12
Working abroad	3.1	2.9	0.0872	55
Unemployed	4.4	3.9	0.1000	39
Total	**3.9**	**3.5**	**0.1050**	**491**

Differentials were also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 3.3 children ever born, while women with illiterate husbands had 5. The differentials relating to the background characteristics of husbands were somewhat smaller than those relating to the background characteristics of the currently married women themselves. Women with illiterate husbands had the highest number of children ever born (5 children) compared to the women who themselves were illiterate (4.5 children). Similarly, women with unemployed husbands had the highest number of children ever born (4.4 children). Women whose husbands had their own business had the lowest number of children ever born (2.7 children).

Table 4.5 further explains the relationship between age of mother and literacy with the 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 (2.2) compared to mothers who were illiterate (4.5). Similarly, the survival of children with literate mothers was far better than for those born to 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. As shown in Table 4.5, 73 percent of the literate women were below the age of 30 years as compared to 37 percent of the illiterate women. It is not only that, overall, literate women had fewer children, but on average 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	25	17.7	0.8	0.7	21	6.0
20 – 24	1.5	1.4	52	36.9	1.6	1.5	47	13.4
25 – 29	2.7	2.5	27	19.1	3.4	3.1	63	18.0
30 – 34	3.7	3.7	18	12.8	5.1	4.6	85	24.3
35 – 39	3.8	3.4	10	7.1	6.0	5.3	69	19.7
40 – 44	5.2	4.3	6	4.3	6.2	5.5	47	13.4
45 – 49	4.7	4.7	3	2.1	7.4	6.2	18	5.1
Total	**2.2**	**2.0**	**141**	**100.0**	**4.5**	**4.0**	**350**	**100.0**

Current Fertility

Crude Birth Rate

The crude birth rate (CBR), though a crude measure of fertility, is the most widely 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 provides an estimate of 25 births per thousand population (Table 4.6).

Age-specific Fertility Rates and Total Fertility Rate

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 until age 25-29, then decline with increasing age. A TFR of 3.1 for the period of 2004-2007 was obtained from the set of ASFRs calculated from the data presented in Table 4.6; in comparison, TFRs of 4.3 for Khyber Pakhtunkhwa and 4.1 for Pakistan as a whole were 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 rates (ASFRs)
15 – 19	258	20	25.8
20 – 24	205	86	139.8
25 – 29	152	88	193.0
30 – 34	144	64	148.1
35 – 39	101	25	82.5
40 – 44	76	8	35.1
45 – 49	44	0	0.0
Total	**980**	**291**	**na**
TFR: 3.1			
CBR: 24.7			

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 shows a significant number of women with the burden of caring for several young children. Among those who already had two living children under 5 years of age, 10 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 that point.

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

Number of children < 5 years	Currently pregnant		Currently not pregnant		Total
	N	%	N	%	N
0	22	11.5	169	88.5	191
1	27	16.6	136	83.4	163
2	11	10.3	96	89.7	107
3	0	0.0	29	100.0	29
4	0	0.0	1	100.0	1
N	**60**	**12.2**	**431**	**87.8**	**491**

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 their 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

Characteristic	Less than 18 months	18 - 23 months	24 - 35 months	36 - 47 months	48 or more months	Total	N
Age group							
15 – 19	33.3	33.3	33.3	0.0	0.0	100.0	3
20 – 24	19.6	23.2	41.1	12.5	3.6	100.0	56
25 – 29	18.8	15.0	35.0	16.3	15.0	100.0	80
30 – 34	13.0	14.1	30.4	17.4	25.0	100.0	92
35 – 39	9.4	3.1	40.6	12.5	34.4	100.0	32
40 – 44	7.7	7.7	23.1	7.7	53.8	100.0	13
45 – 49	0.0	0.0	0.0	0.0	0.0	0.0	0
Number of live births							
2	11.9	28.6	28.6	16.7	14.3	100.0	42
3	16.1	12.5	44.6	12.5	14.3	100.0	56
4	18.5	20.4	31.5	16.7	13.0	100.0	54
5	22.9	2.9	34.3	14.3	25.7	100.0	35
6+	12.4	11.4	33.7	14.6	28.1	100.0	89
Education level							
No education	14.8	13.3	33.2	15.3	23.5	100.0	196
Up to primary	19.4	19.4	41.9	9.7	9.7	100.0	31
Up to secondary	16.2	18.9	40.5	16.2	8.1	100.0	37
Above secondary	20.0	10.0	30.0	20.0	20.0	100.0	10
Standard of living index							
Low	10.8	9.2	41.5	18.5	20.0	100.0	65
Medium low	19.6	15.0	35.5	15.9	14.0	100.0	107
Medium high	16.9	23.7	22.0	10.2	27.1	100.0	59
High	11.1	11.1	40.0	13.3	24.4	100.0	45
Total	**15.6**	**14.9**	**34.8**	**14.9**	**19.9**	**100.0**	**276**

A short interval has traditionally been viewed as a risk factor for poor pregnancy outcomes, particularly neonatal mortality in developing countries (Cleland and Sathar, 1984). It has been observed in several studies that the death risks of an index child whose birth closes a short birth interval are higher than those experienced by an index child whose birth closes a longer birth interval (Mahmood, 2002). It has been observed 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 almost 16 percent of children were born with a birth interval of less than 18 months. Almost 65 percent were born with a birth interval of less than 36 months, while 35 percent were born after three years or more. The differentials by mother's age, educational level and standard of living index are also shown. Younger and lower-parity women – particularly women 15-19 and of parity 3 – were substantially more likely to have short birth intervals.

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 277 women out of the 491 women interviewed had born a child during the past four years, and so were asked these questions.

Antenatal Care

Antenatal check-ups allow for skilled health personnel to advise expecting mothers as to how to best take care of themselves and their unborn baby during pregnancy, to prepare them for childbirth and care of 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 many women, understanding childbirth as a natural experience and perhaps not finding health providers nearby, have not gone to skilled providers for antenatal care. However, in recent years these proportions have been increasing in Pakistan (NIPS/PDHS, 2008). Table 5.1 and Figure 5.1 show the number of antenatal care (ANC) visits for the last birth of women who had delivered during the last four years. About 67 percent of the sample respondents had received at least one ANC visit during the last pregnancy. This was significantly higher than the level obtained for Swabi in the 2004-05 PSLM Survey (39 percent), the level for Khyber Pakhtunkhwa in the PDHS (51 percent) or the level obtained nationally in the PDHS (61 percent) (Government of Pakistan, 2006; NIPS/PDHS, 2008). Fifty-three percent had at least three such visits and 42 percent had four or more visits. The percentage of at least one ANC visit was 25 percent higher for urban mothers than for rural ones.

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

	Rural		Urban		Total	
Number of ANC visits	**N**	**%**	**N**	**%**	**N**	**%**
No visit	87	36.0	4	11.4	91	32.9
1-2 visits	32	13.2	3	8.6	35	12.6
3 visits	27	11.2	6	17.1	33	11.9
4 or more visits	94	38.9	21	60	115	41.5
Don't remember	2	0.8	1	2.9	3	1.1
Total	**242**	**100.0**	**35**	**100.0**	**277**	**100.0**

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

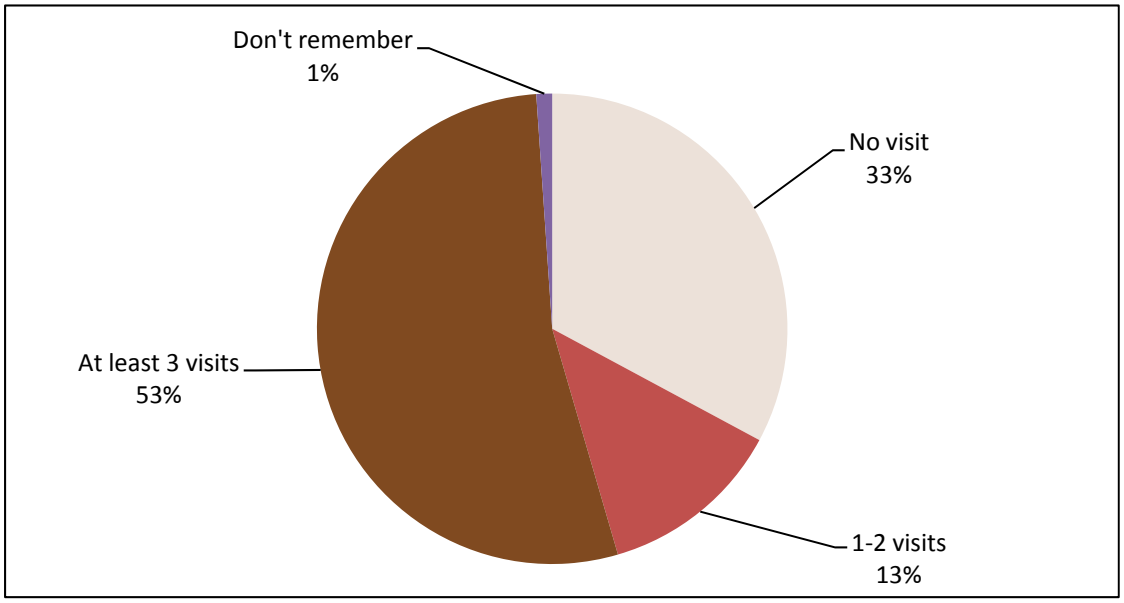


Figure 5.2 shows that many of these visits were in response to some problem, rather than for a routine checkup. Thirty-eight percent of the first antenatal visits were for curative purposes.

Figure 5.2: Distribution of MWRA by reason for first antenatal visit during last pregnancy

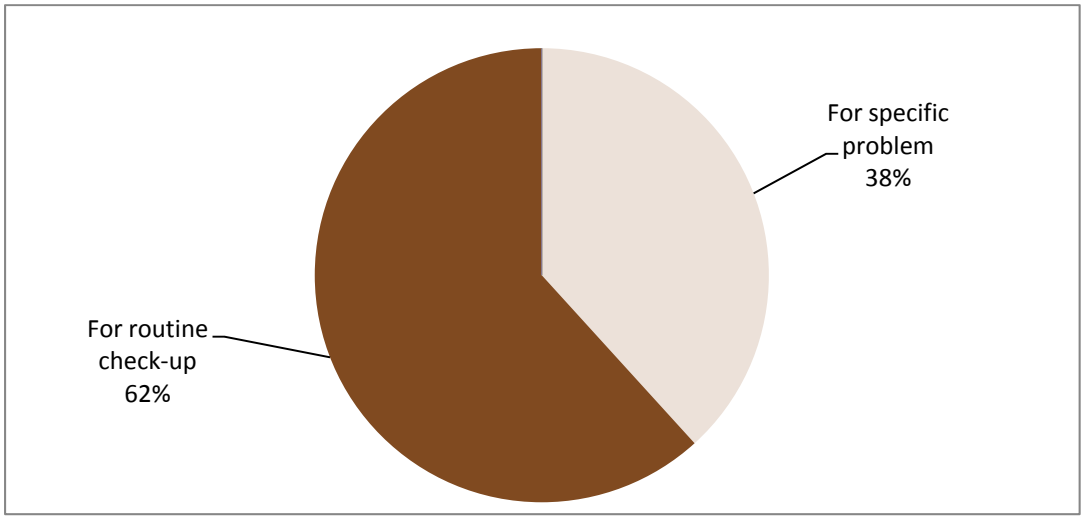


Figure 5.3 shows that more than half of the time (56 percent), the first visit took place within the first three months of gestation, and 14 percent of the first visits occurred during the third trimester.

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

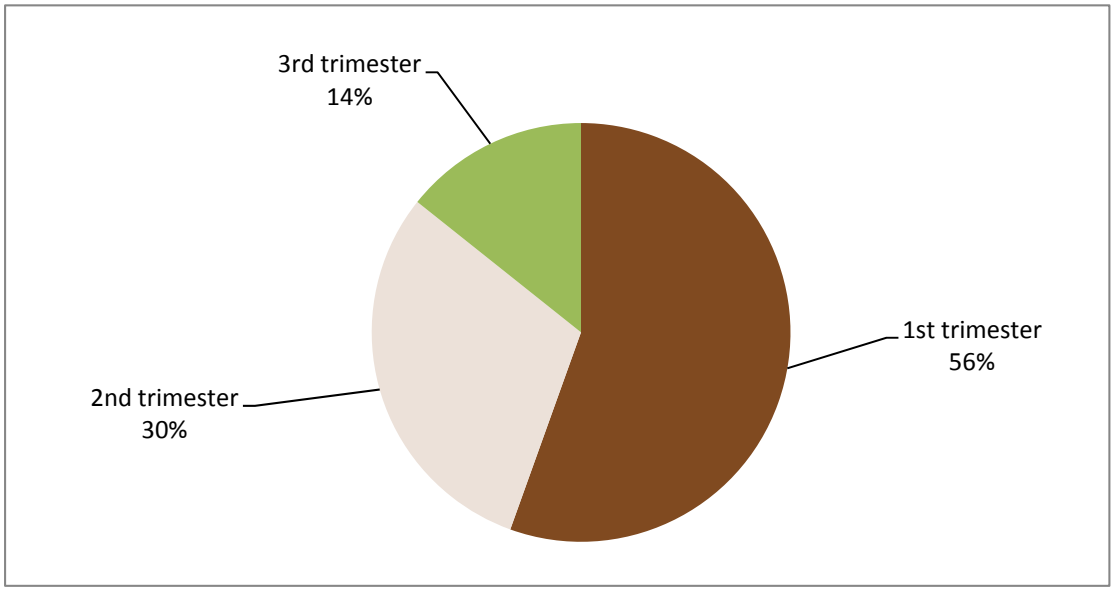


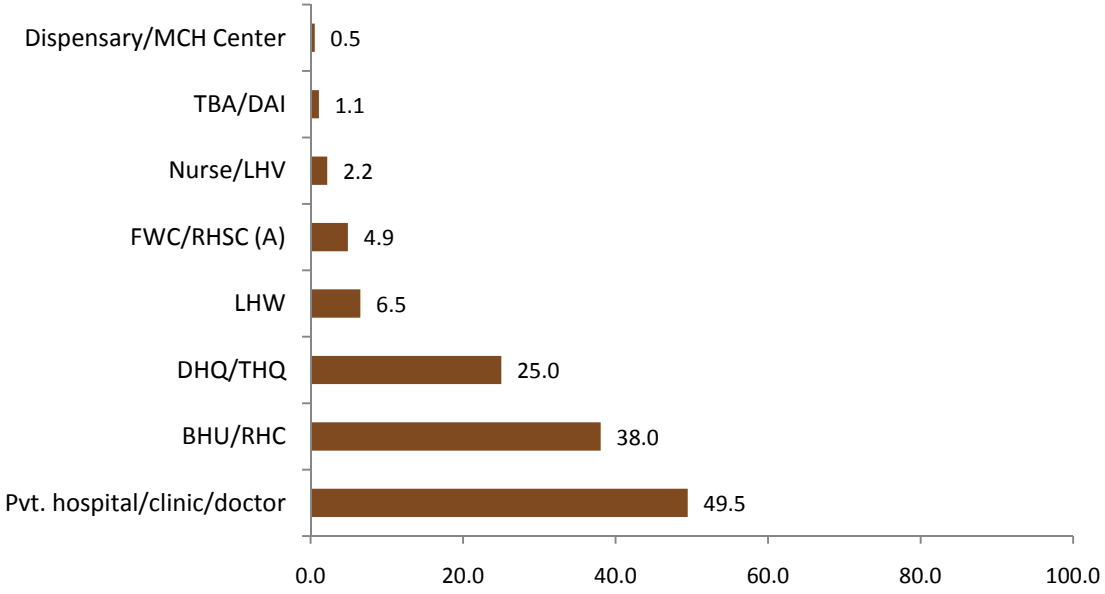
Table 5.2 shows the locations where respondents made one or more antenatal visits. Most antenatal visits took place in private sector facilities. The most common providers of antenatal care were private hospitals/clinics/doctors (50 percent). Thirty-eight percent of the antenatal check-ups were done at BHUs and RHCs, followed by DHQ/THQ hospitals (25 percent); other providers were less common.

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

Facility/service provider	Rural	Urban	Total
Pvt. hospital/clinic/doctor	46.4	64.5	49.5
BHU/RHC	39.9	29.0	38.0
DHQ/THQ	24.2	29.0	25.0
LHW	3.9	19.4	6.5
FWC/RHSC (A)	5.2	3.2	4.9
Nurse/LHV	2.0	3.2	2.2
TBA/DAI	1.3	0.0	1.1
Dispensary/MCH Center	0.7	0.0	0.5
N	**153**	**31**	**184**

multiple responses were allowed.

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



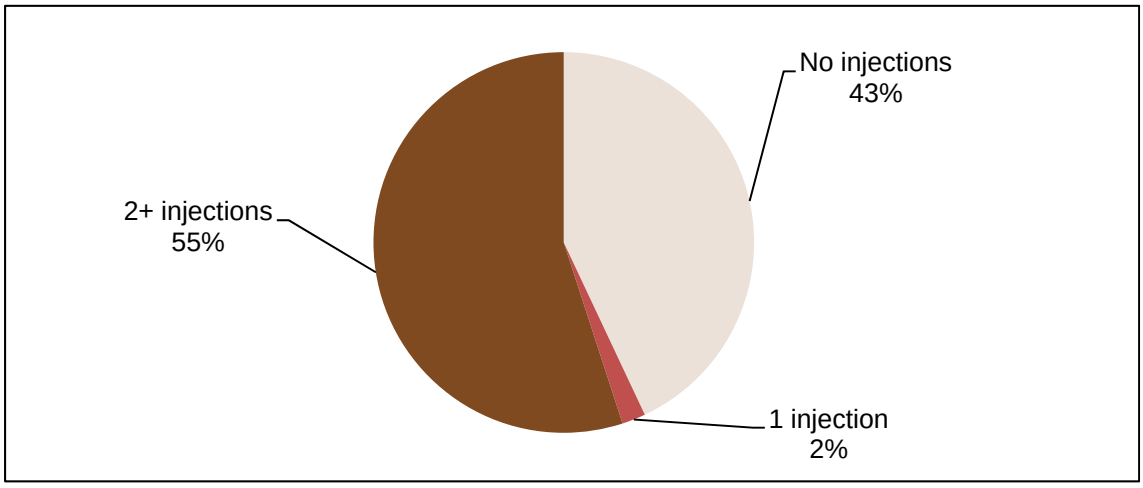
Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn or the 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, and five doses are sufficient for lifetime protection. According to the PSLMS 2004-05, 52 percent of mothers in Swabi had received at least one TT shot; according to the PDHS 2006-07, 43 percent in Khyber Pakhtunkhwa and 53 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 5.3 shows that 57 percent of mothers had received at least one shot during their last pregnancy and 55 percent had received two or more shots. The immunization rate was higher in urban areas. While tetanus immunization appeared to be increasing in Swabi, a substantial proportion of mothers (43 percent) remained unprotected.

Table 5.3: Tetanus immunization at last delivery

	Rural		Urban		Total	
Number of injections	**N**	**%**	**N**	**%**	**N**	**%**
No TT injections	110	46.0	7	20.0	117	42.7
One TT injection	3	1.3	2	5.7	5	1.8
2+ TT injections	126	52.7	26	74.3	152	55.5
Total	**239**	**100.0**	**35**	**100.0**	**274**	**100.0**

Figure 5.5: Tetanus immunization at last delivery



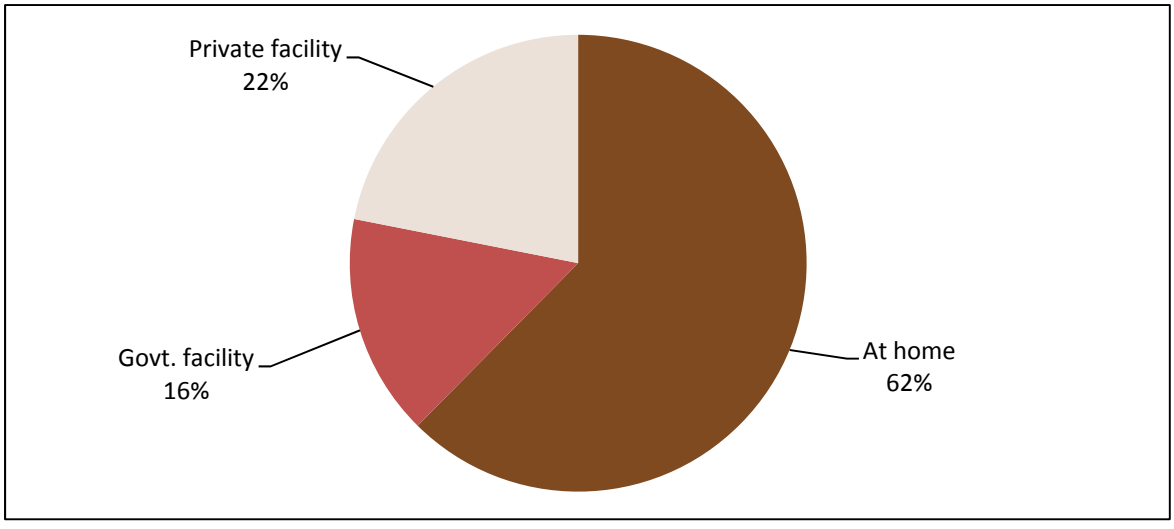
Location and Attendance at Delivery

One of 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. These proportions have been historically low in Pakistan, contributing substantially to high maternal mortality, but they have been rising in recent years. In Swabi, according to the 2004-05 PSLMS, 19 percent of the deliveries took place in institutions, compared with PDHS 2006-07 figures of 30 percent for Khyber Pakhtunkhwa and 34 percent nationally (Government of Pakistan, 2006; NIPS/PDHS, 2008). In the present survey, 38 percent of the most recent deliveries were in a health facility, a substantially higher number (Table 5.5 and Figure 5.6). A substantial number of deliveries took place in private hospitals/clinics (22 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	153	63.8	19	54.3	172	62.5
BHU/RHC	13	5.4	0	0.0	13	4.7
DHQ/THQ hospital	27	11.3	3	8.6	30	10.9
Pvt. hospital/clinic	47	19.6	13	37.1	60	21.8
Total	**240**	**100.0**	**35**	**100.0**	**275**	**100.0**

Figure 5.6: Distribution of mothers by location of last delivery

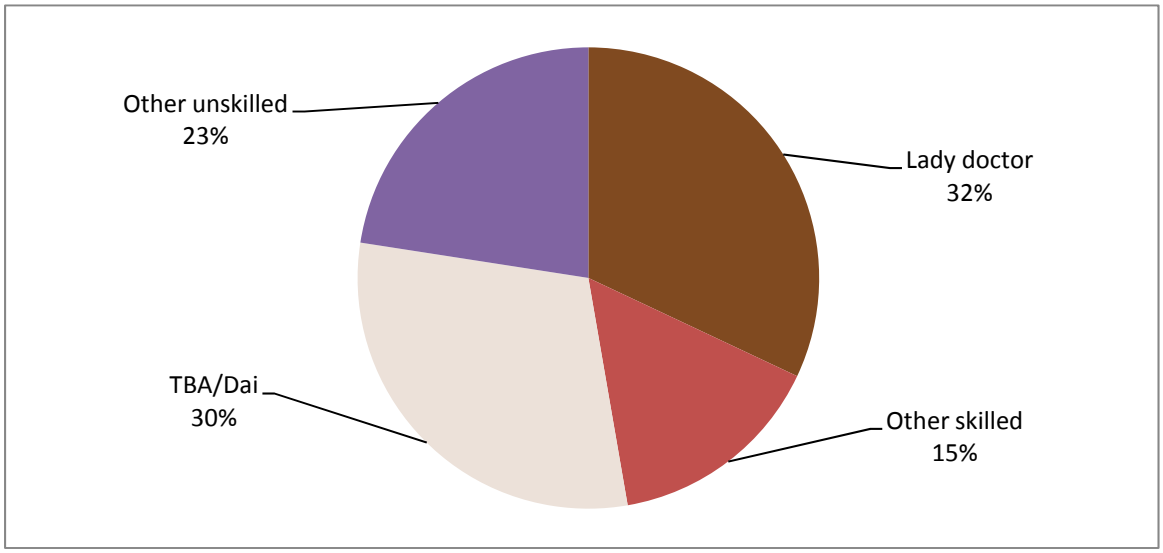


Likewise, the proportion of births delivered by skilled birth attendants was higher than expected from previous data. In this survey, 47 percent of the reported deliveries in the previous 4 years were delivered by a skilled birth attendant. This was much higher in urban areas (Table 5.5 and Figure 5.7). In the PSLMS 2004-05 for Swabi, only 24 percent of births were delivered by a skilled attendant; in the PDHS 2006-07, the corresponding figures were 38 percent for Khyber Pakhtunkhwa and 39 percent for Pakistan as a whole (Government of Pakistan, 2006; NIPS/PDHS, 2008). Most of the births attended by a skilled birth attendant in this household survey were reportedly attended by a lady doctor. The term "doctor," however may mean a paramedic, such as a Lady Health Visitor, in such interviews. About 30 percent of births were delivered by *dais* (traditional birth attendants), while another 21 percent, mostly in rural areas, the deliveries were carried out by a relative or neighbor who was not a dai.

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

	Rural		Urban		Total	
Birth attendant and skill level	**N**	**%**	**N**	**%**	**N**	**%**
No one	3	1.3	1	2.9	4	1.5
TBA/Dai	75	31.3	8	22.9	83	30.2
LHW	1	0.4	0	0.0	1	0.4
Midwife	1	0.4	0	0.0	1	0.4
Nurse/LHV	30	12.5	11	31.4	41	14.9
Lady doctor	75	31.3	13	37.1	88	32.0
Female relative/Friend/Neighbor (Not Dai)	55	22.9	2	5.7	57	20.7
Total	**240**	**100.0**	**35**	**100.0**	**275**	**100.0**
Skilled birth attendant	106	44.2	24	68.6	130	47.3
Unskilled birth attendant	134	55.8	11	31.4	145	52.7

Figure 5.7: Distribution of mothers by attendant at last delivery



Postpartum Care

For both the health of the mother and the health of the newborn, a newly delivered mother and baby should receive follow-up for at least 6 weeks after delivery; MoH guidelines recommend at least one postpartum visit after discharge during the first 42 days after delivery. However, this is a major weakness of maternal and neonatal care in Pakistan; women who deliver at home rarely go for any postnatal check-up, and women who deliver in facilities will usually be seen while they are in the facility, but not after that. Swabi is no exception. Only 41 percent of respondents reported receiving postnatal care within 40 days after delivery. In 92 percent of these cases, the first visit took place within 24 hours and just 8 percent had a check-up after 24 hours after the delivery of her child. Unsurprisingly, only 5 percent of the women who delivered at home reported one or more postnatal visits; whereas all the women who delivered in facilities reported receiving postnatal check-ups.

In any case, 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 and its role in the next birth interval, or on how and when to take steps to end childbearing (WHO, 2006).

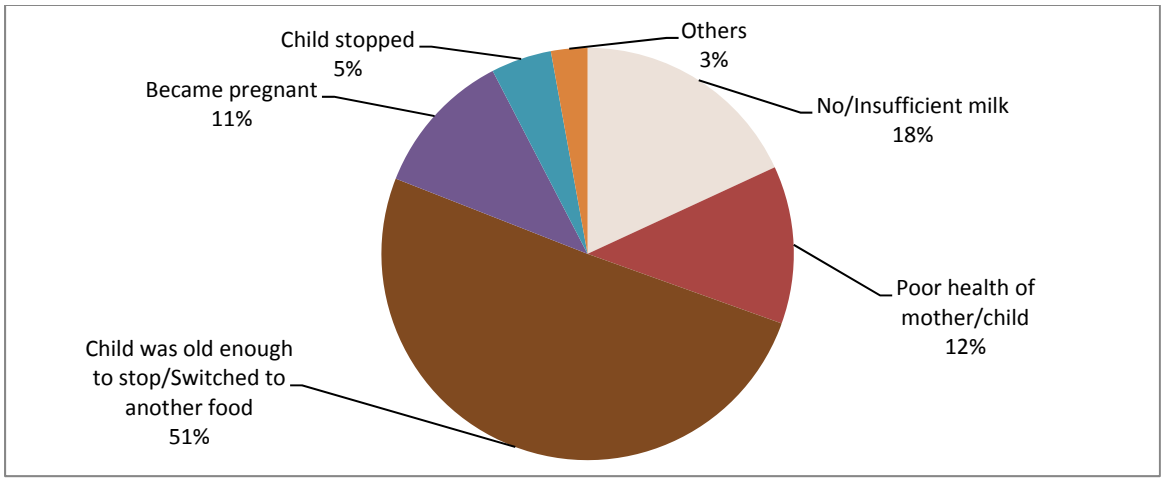
Table 5.6: Distribution of mothers by status of postnatal check-up and place of delivery

Place of delivery	Postnatal check-up within 24 hours		Postnatal check-up after 24 hours		Did not have postnatal check-up		Total	
	N	%	N	%	N	%	N	%
Institution	103	100.0	0	0.0	0	0.0	103	100.0
Non-institution	0	0.0	9	5.2	163	94.8	172	100.0
Total	**103**	**37.5**	**9**	**3.3**	**163**	**59.3**	**275**	**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 aspect, 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 9 of 265 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 22 months. Four main reasons were given for discontinuing breastfeeding: child was old enough to stop (51 percent); no or insufficient milk (18 percent); poor health of mother or child (12 percent) and mother became pregnant (11 percent).

Figure 5.8: Distribution of mothers by reason for discontinuing breastfeeding (n=105)



Chapter 6

Preference for Children

In order to meet the family planning needs of couples, it is essential to understand how they feel about the number and timing of children they want. In general, couples' views on this typically evolve over the course of their reproductive years; in the beginning, they want their first children quickly, while toward 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 learn what couples truly feel 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 exactly the number of children to have in your whole life, how many would that be?" Table 6.1 shows the responses.

The median "ideal" number, in the sense indicated above, was four children; 70 percent of the respondents wanted four or fewer, however, substantial numbers cited more than four (28 percent) and 2 percent of the women also gave a non-numeric response to this question, such as up to God. These proportions vary according to residence.

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

	Rural		Urban		Total	
Number of children	**N**	**%**	**N**	**%**	**N**	**%**
1	0	0.0	1	1.5	1	0.2
2	51	12.1	5	7.6	56	11.5
3	93	22.1	7	10.6	100	20.5
4	155	36.8	29	43.9	184	37.8
5	61	14.5	10	15.2	71	14.6
6+	53	12.6	14	21.2	67	13.7
Up to God	8	1.8	0	0.0	8	1.6
Total	**421**	**100.0**	**66**	**100.0**	**487**	**100.0**

Desire for More Children

Levels of Desire for More Children

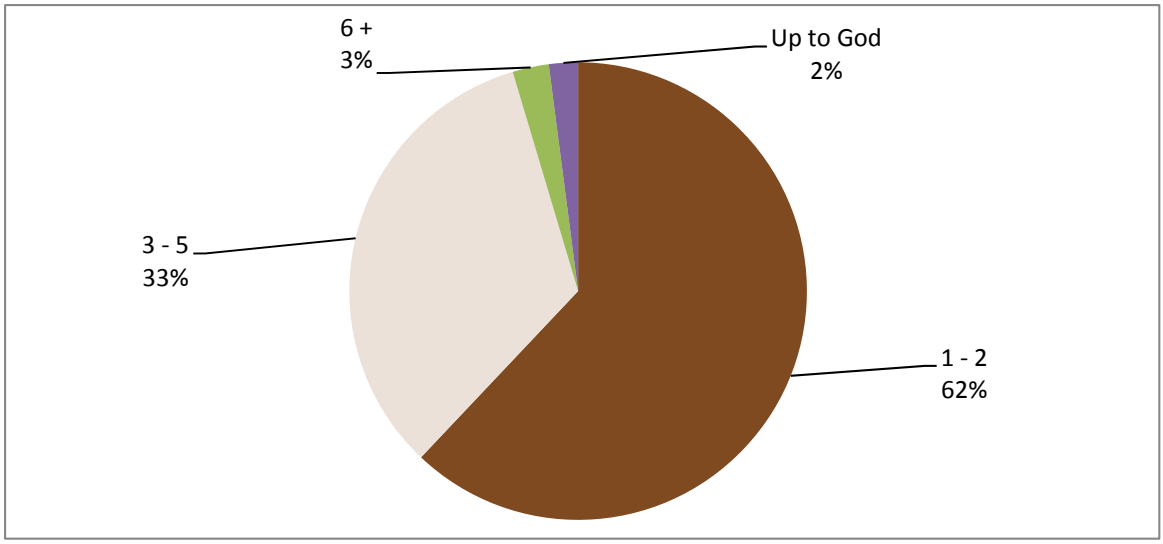
A more immediate measure of fertility preference is whether a couple wants more children; if so, do they want the next one now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already has. Table 6.2 shows that whether women wanted more children soon, later (after 2 years or more) or not at all was based on the number of living children they already had. More than half of the women who had 3 or more children did not want more children. Of those who wanted more children, the proportion wanting more children soon declined sharply after the first birth. Even most mothers with a single living child would like to wait before having a second child. Among those who had two living children, and wanted another child, a third of them wanted to have it later. Most women with four or more living children did not want to have more; for those with five or more, the proportion wanting to stop was over 94 percent. This table indicates clearly the high 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	Don't know/unsure	%	N
0	68.7	29.9	1.5	0.0	100.0	67
1	20.7	63.8	15.5	0.0	100.0	58
2	34.4	32.8	32.8	0.0	100.0	61
3	10.9	28.1	59.4	1.6	100.0	64
4	3.8	11.3	85.0	0.0	100.0	80
5	0.0	5.6	94.4	0.0	100.0	54
6+	0.9	1.9	96.3	0.9	100.0	107
Total	**18.3**	**22.2**	**59.1**	**0.4**	**100.0**	**491**
N	**90**	**109**	**290**	**2**	**491**	**491**

For those women who wanted more children, we also asked how many more. More than three-fifths of all the women who wanted more children, and who had an opinion, wanted one or two more. Three percent said they wanted 6 or more children, while 2 percent of the women said it was up to God (Figure 6.1). It would be useful to explore what such respondents mean, i.e., whether this is a religious statement, an indication that she has not thought about it, or a polite way of telling the interviewer that she did not want to give a specific answer (Figure 6.1).

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



Socioeconomic Correlates of Desire for Children

A woman's stated desire for children was analyzed in relation to four possible socioeconomic determinants: standard of living index (SLI) and respondent's age, literacy, and residence (Table 6.3). The relationship between SLI and desire for more children was weak and inconsistent. Age of the women was strongly associated with the desire for more children. Literate women were more likely to want the next child at a later time (40 percent) compared to illiterate women (14 percent). On the other hand, illiterate women were more likely to not want to have more children (68 percent) compared to literate women (39 percent). Rural residents were more likely to want more children soon compared to urban 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	Don't know/Unsure	%	N
Standard of living index						
Low	9.5	12.2	75.7	2.7	100.0	74
Medium low	23.2	23.2	53.6	0.0	100.0	168
Medium high	20.3	23.3	56.4	0.0	100.0	133
High	14.7	25.9	59.5	0.0	100.0	116
Age group						
<25	38.6	47.6	13.8	0.0	100.0	145
25 or more	9.8	11.6	78.0	0.6	100.0	346
Literacy of respondent						
Literate	20.6	41.1	37.6	0.7	100.0	141
Illiterate	17.4	14.6	67.7	0.3	100.0	350
Residence						
Rural	18.8	21.2	59.5	0.5	100.0	425
Urban	15.2	28.8	56.1	0.0	100.0	66
Total	**18.3**	**22.2**	**59.1**	**0.4**	**100.0**	**491**
N	**90**	**109**	**290**	**2**	**491**	**491**

Son Preference

In Pakistan, there is known to be a substantial preference for sons over daughters. In particular, the belief that a family is incomplete without sons is stronger than the corresponding belief for daughters. In this survey, respondents were asked how many daughters they would have before they stopped trying for a son, and vice versa. Son preference came out most strongly in the proportions saying that there would be no limit: 81 percent of women said there would be no limit to the number of daughters before having a son, while 47 percent said there was no limit to sons before having a daughter. For those women who gave a number, the number of daughters before having a son was significantly lower than the number of sons before having a daughter. In both cases the median was three children.

Table 6.4: Son and daughter preferences by the respondents

	Number of daughters for the desire of a son		Number of sons for the desire of a daughter	
Response	**N**	**%**	**N**	**%**
Up to God	3	0.6	3	0.6
No limit	399	81.3	229	46.6
Other non-numeric responses	3	0.6	6	1.2
Numeric responses	86	17.5	253	51.5
Total	**489**	**100.0**	**489**	**100.0**
Median*	3	na	3	na

*Of the numeric responses.
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 it does not matter much to them. We asked respondents whether they would be pleased, worried, accepting, or indifferent if they became pregnant. Results are shown in Table 6.5 and Table 6.6. (This question excludes those 160 of the total 491 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 become pregnant in near future

Reaction if pregnant	Desire for next child		Total	
	Later	Never	%	N
Pleased	19.2	3.8	7.5	24
Worried	43.6	74.2	66.7	212
Accept it	37.2	21.7	25.5	81
Doesn't matter	0.0	0.4	0.3	1
Total	**100.0**	**100.0**	**100.0**	**318**
N	**78**	**240**	**318**	**318**

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

Reaction if pregnant	Desire for next child		Total	
	Later	Never	%	N
Own health	59.2	79.0	79.0	249
Health of youngest child	64.5	63.5	63.5	200
Caring of children	55.3	68.9	68.9	217
Schooling of children	39.5	66.0	66.0	208
Family economic situation	48.7	67.8	67.8	213
Others	0.0	0.3	0.3	1
N	**76**	**238**	**314**	**314**

Respondents could give more than one response.

Among those who did not want more children at all nearly three-quarters of the women (74 percent), said that they would be worried if they became pregnant. However, more than one-fifth (22 percent) of the women who did not want more children reported that they would accept the new pregnancy. Among those women who wanted to delay their next child for at least two years, 44 percent reported that they would be worried if they got pregnant right now, whereas about 36 percent of these spacers would accept it or would even be pleased (20 percent) if they got pregnant now. This shows a weak motivation for spacing.

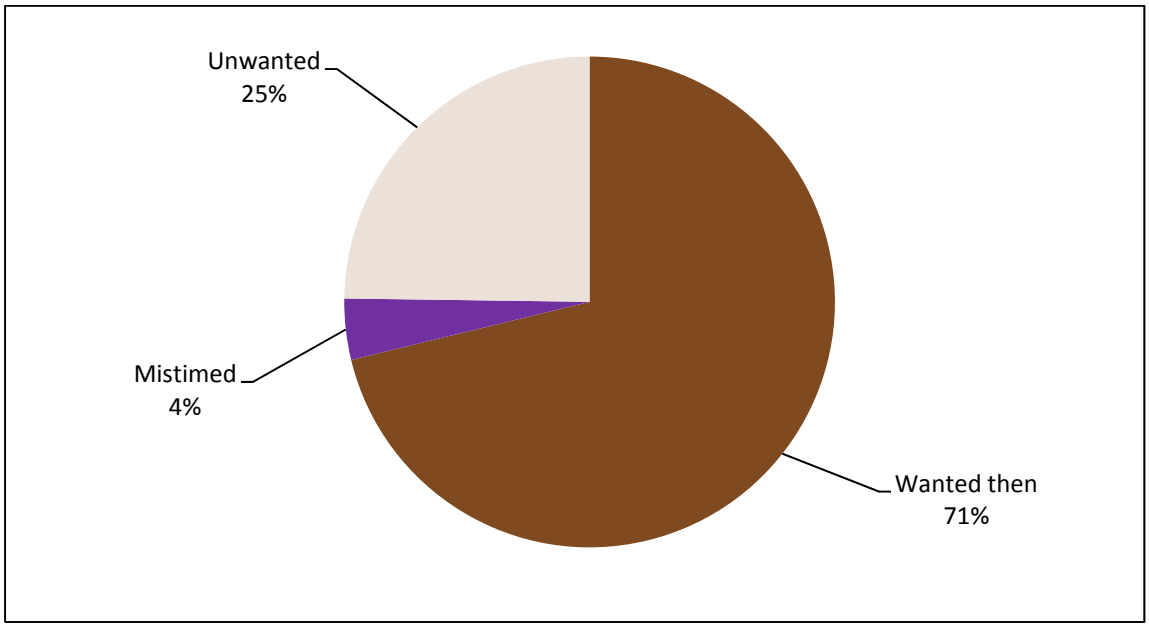
Further, women who expressed a desire to not have more children or to delay their next child were asked what problems they would face if they became pregnant. Table 6.6 shows their responses. The problems most commonly faced by those who did not want more

children at all were their own health (85 percent) and the schooling of children (75 percent). Health of the youngest child (65 percent), own health (59 percent), and caring for the children (55 percent) were commonly cited by those who wanted to delay the next child.

Attitude toward Last Pregnancy

Another important dimension of fertility preference relates to whether the last pregnancy was wanted at the time, or 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 (25 percent) or mistimed (4 percent).

Figure 6.2: Distribution of MWRA by attitude towards their last pregnancy



Women's Perception of Fertility Preference of Husbands

Women were asked whether they thought their husbands wanted the same number of children as they did, more, or fewer. In Table 6.7, their responses are tabulated according to their ideal family size. About 7 percent of the women did not know their husband's preference, while another 62 percent thought their husbands wanted the same number of children as they did. However, more than 30 percent thought their husbands wanted more than they did. A negligible number (1 percent) thought that their husbands wanted fewer children. These proportions do not vary systematically according to the wife's ideal family size.

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

Ideal family size	Perception of husband's desire for m ore children				Total	
	Same number	More children	Fewer children	Don't know	%	N
1-2 children	56.1	33.3	3.5	7.0	100.0	57
3-4 children	65.8	27.1	0.7	6.3	100.0	284
5+ children	58.0	34.8	0.7	6.5	100.0	138
Up to God	12.5	37.5	0	50.0	100.0	8
Total	**61.6**	**30.2**	**1.0**	**7.2**	**100.0**	**487**
N	300	147	5	35	100.0	487

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 that method, if she had ever used it, and 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 of contraceptive methods.

Knowledge

For many years, at least 95 percent of married women of reproductive age in Pakistan have known at least one method of contraception. Table 7.1 shows that this holds true for Swabi; all women knew of at least one method. A majority of the respondents knew the most commonly used program methods – female sterilization, pills, injections, IUD and condoms. These methods and withdrawal were known to higher proportions in Swabi than in the national PDHS, 2006-07. Conversely, more women in the PDHS knew the less common methods, i.e., rhythm ("safe period"), male sterilization, Norplant, and emergency contraceptive pills (NIPS/PDHS, 2008). Data show that there was not much difference in knowledge between rural and urban women.

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

Method	Rural	Urban	Total
Female sterilization	93.9	98.5	94.5
Male sterilization	20.0	28.8	21.2
Pill	99.8	100.0	99.8
IUD	92.7	98.5	93.5
Injectables	99.3	100.0	99.4
Norplant	6.1	10.6	6.7
Condom	90.1	97.0	91.0
Rhythm	10.6	4.5	9.8
Withdrawal	85.4	81.8	84.9
Emergency pills	4.5	3.0	4.3
At least one method	100.0	100.0	100.0
At least one modern method	100.0	100.0	100.0
At least one traditional method	85.4	83.3	85.1
N	**425**	**66**	**491**

Use of Contraceptive Methods

Levels of Ever Use and Current Use

For the purpose of analyzing use of contraception in a population, currently married women of reproductive age (typically taken to be 15-49 years) are generally 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" are 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, 57 percent reported having used some method of contraception during their married lives (Table 7.2). This was higher for urban women (62 percent) as compared to rural women (57 percent). It was substantially higher than the proportions 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	21.9	27.3	22.6	111	2.8	3.0	2.9	14	19.1	24.2	19.8	97
IUD	12.2	15.2	12.6	62	3.1	0.0	2.7	13	9.2	15.2	10.0	49
Injectables	24.0	27.3	24.4	120	5.4	1.5	4.9	24	18.6	25.8	19.6	96
Condom	24.0	27.3	24.4	120	13.2	16.7	13.6	67	10.8	10.6	10.8	53
Rhythm	0.0	0.0	0.0	0	0.0	0.0	0.0	0	0.0	0.0	0.0	0
Withdrawal	14.4	24.2	15.7	77	6.8	18.2	8.4	41	7.5	6.1	7.3	36
Female sterilization	3.3	4.5	3.5	17	3.3	4.6	3.5	17	0.0	0.0	0.0	0
Others	0.9	1.5	1.0	5	0.2	1.5	0.4	2	0.7	0.0	0.6	3
Any method	56.7	62.1	57.4	282	34.8	45.5	36.3	178	21.9	16.7	21.2	104
Modern method	51.3	56.1	51.9	255	27.8	25.8	27.5	135	23.5	30.3	24.4	120
Traditional method	15.1	25.8	16.5	81	7.1	19.7	8.8	43	8.0	6.1	7.7	38
Emergency pills	0.5	0.0	0.4	2	na	na	na	na	0.5	0.0	0.4	2
N	**425**	**66**	**491**	**491**	**395**	**53**	**448**	**448**	**425**	**66**	**491**	**491**

na=not applicable.

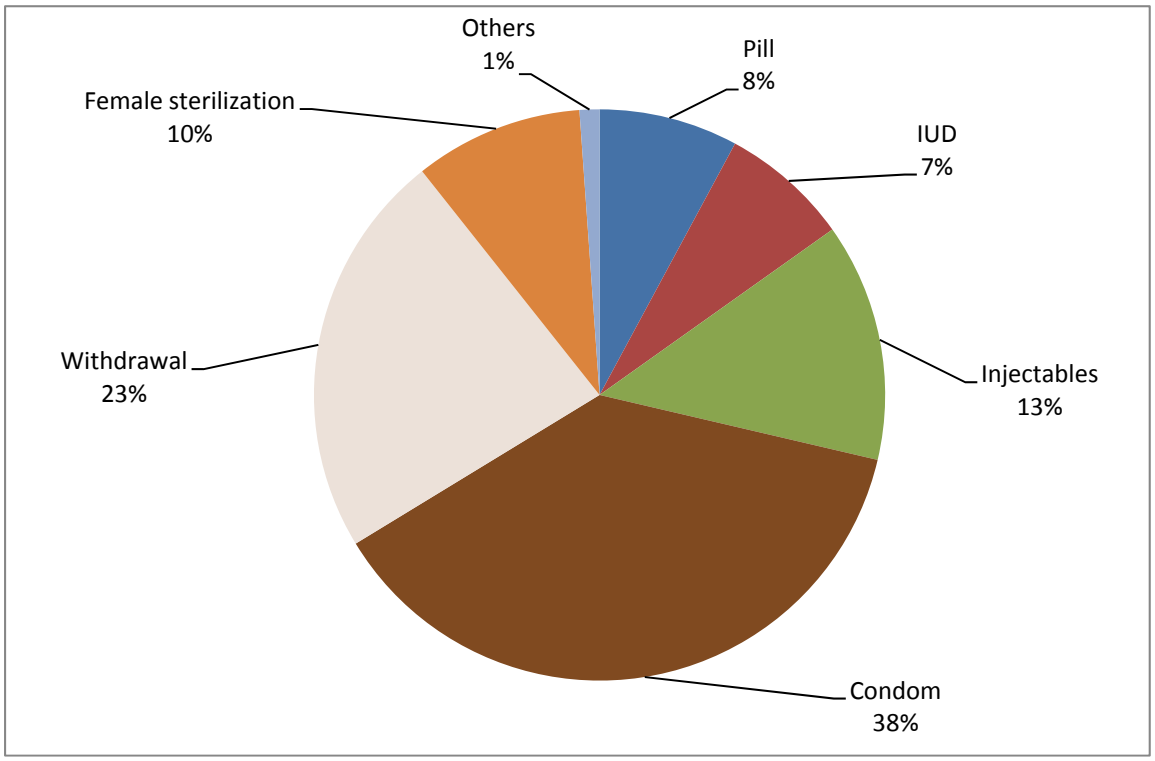
The proportion of currently married women of reproductive age who were currently using some form of contraception, commonly known as the contraceptive prevalence rate (CPR), is one of the central indicators of the status of family planning programs. It shows the degree to which couples are actively involved 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).

Current use of family planning in Swabi, compared with Pakistan in general, was high (see Table 7.2). A total of 36 percent of all married women in the sample were currently using some method of contraception (CPR), compared with 29.6 percent for Pakistan in the 2006-07 PDHS, and 24.9 percent for Khyber Pakhtunkhwa as a whole (NIPS/PDHS, 2008). In urban Swabi, the CPR was 46 percent, compared with 35 percent in rural Swabi.

The methods most commonly being used were condoms, withdrawal, injectables and female sterilization. Table 7.2 reflects that current use of injectables, at 4.9 percent, was slightly high by national standards. Conversely, the current use of female sterilization, at 3.5 percent, was lower than found in national data. Overall, 27.5 percent of married women were using modern methods, 8.8 percent were using traditional methods (withdrawal and

rhythm), which were also lower than national standards, and 0.4 percent were using "other" methods. Figure 7.1 shows the proportion of current users by method mix.

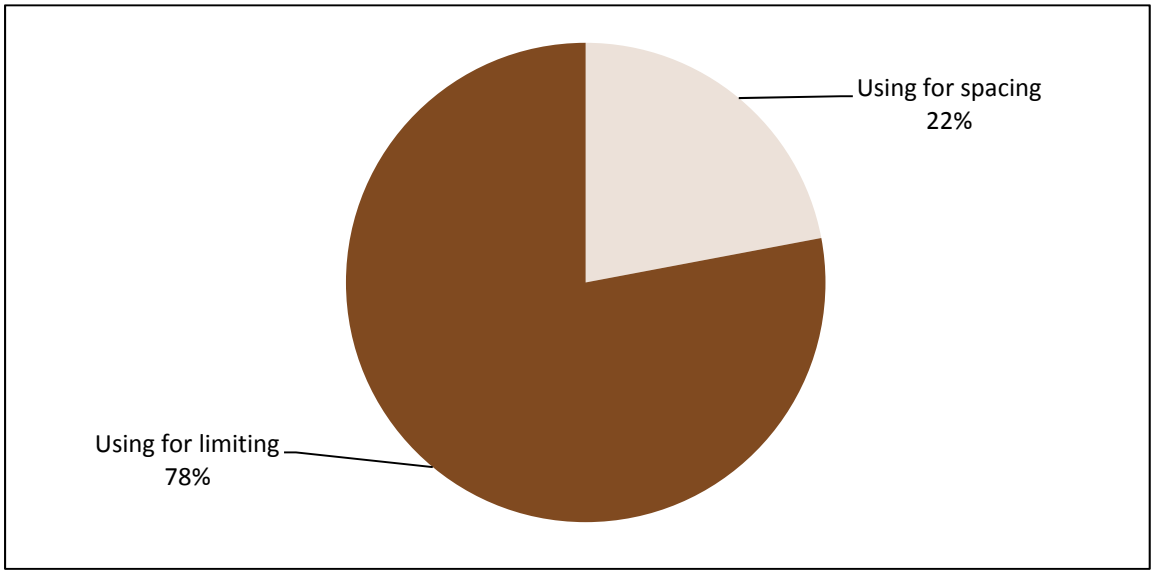
Figure 7.1: Distribution of current users by method mix



Current Use and Desire for Children

For current users of contraception, it is important to determine how many are using methods for spacing purpose, and how many are using to stop having children altogether. Figure 7.2 shows this by current method. Overall, 78 percent of current use was for limiting purposes, compared with 22 percent for spacing.

Figure 7.2: Current use and desire for children



Correlates of Contraceptive Use

Figure 7.3 and 7.4 show the relationship between contraceptive prevalence and the women's ages and the number of living children. The shape of the graph for age is similar to that seen in other Pakistani and international studies, with low prevalence among younger and older women, and higher prevalence in between. The CPR of 56 percent was highest for women aged 35 to 39 years.

Figure 7.3: Contraceptive prevalence by age

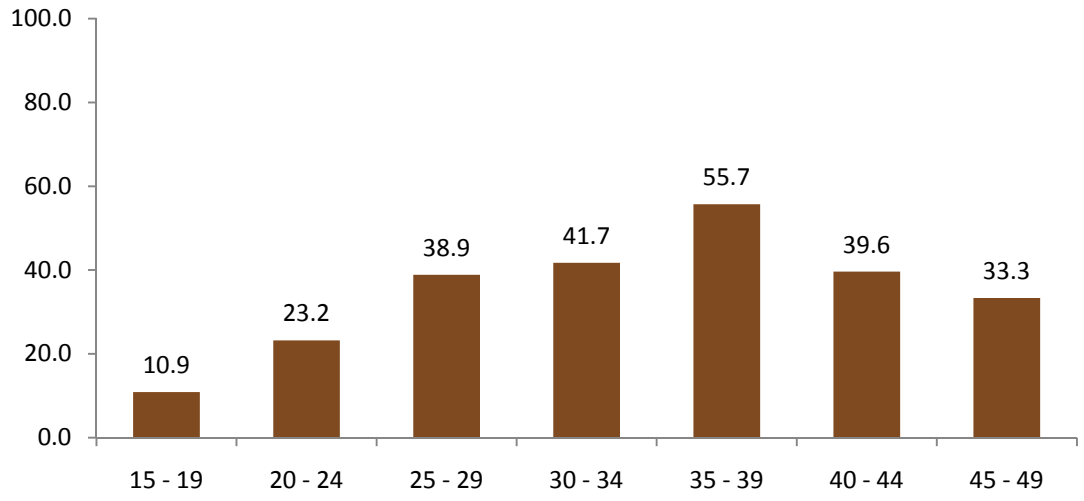
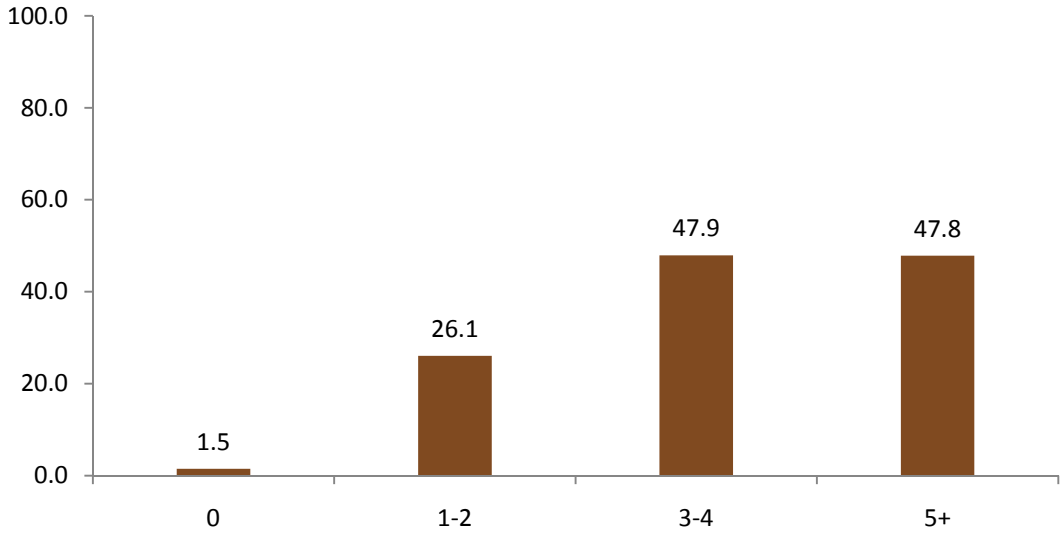


Figure 7.4 indicates the contraceptive prevalence by number of living children. Those having more children had a higher contraceptive prevalence rate. A maximum CPR of 48 percent was recorded for women having 3 or more children.

Figure 7.4: Current contraceptive use by number of living children



In Pakistan as well as internationally, contraceptive use is associated with higher socioeconomic status and urban residence. This is not true in Swabi, as shown in Table 7.3. Respondents in households with the highest SLI had slightly lower contraceptive prevalence (33 percent) than those with the lowest SLI (37 percent); however, women from households with low SLI (43 percent) were more likely to be never users compared to highest SLI (36 percent). Similarly, not much difference was observed with reference to respondents' literacy for current use and never use. Ownership of television was also not associated with current use. However, past users were much more likely to live in rural areas, while current users were more likely to live in urban areas. The reasons for this association deserve more detailed analysis.

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	36.5	20.3	43.2	74	100.0
Medium low	34.5	16.7	48.8	168	100.0
Medium high	41.4	18.8	39.8	133	100.0
High	32.8	31.0	36.2	116	100.0
Ownership of television					
Yes	36.0	22.8	41.2	272	100.0
No	36.5	19.2	44.3	219	100.0
Literacy of respondent					
Yes	36.5	20.3	44.2	138	100.0
No	36.3	22.1	41.6	339	100.0
Residence					
Rural	34.8	21.9	43.3	425	100.0
Urban	45.5	16.7	37.9	66	100.0
Total	**36.3**	**21.2**	**42.6**	**491**	**100.0**

Source of Method

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

From this table, it is clear that the source depends on the method. Pills and condoms were mostly obtained from the Lady Health Worker or by the husband; IUDs were inserted in government and private health facilities; and injectables were mostly obtained from the BHU/RHC/MCH or the LHWs. Female sterilization was nearly always carried out at the DHQ hospital and to a lesser extent at private hospitals.

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

	FP method ever used					Total	
Facility/service provider	Pill	IUD	Injectables	Condom	Female sterilization	%	N
Govt. hospital (DHQ/THQ)	5.3	20.8	6.8	0.0	82.4	10.9	25
BHU/RHC/MCH	5.3	41.7	23.7	0.0	0.0	11.4	26
FWC	2.6	8.3	6.8	0.0	0.0	3.1	7
LHW/TBA/dai/referral	39.5	0.0	18.7	37.4	0.0	26.2	60
Pvt. Doctor	0.0	12.5	11.9	0.0	0.0	4.4	10
Pvt. hospital/clinic	5.3	16.7	5.1	0.0	17.6	5.2	12
Dispenser/compounder	7.9	0.0	13.6	0.0	0.0	4.8	11
Pharmacy/chemists/grocery shop	13.2	0.0	6.8	1.1	0.0	4.4	10
Husband brings method	21.1	0.0	6.8	61.5	0.0	29.7	68
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**229**
N	38	24	59	91	17	229	229

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 method is right for everyone. In looking carefully at the experience of those who have used contraceptive methods, both currently 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 the 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.

Overall, the reasons for current and past users were similar, so the data has been combined. Among the most common reasons for choosing a method were suitability for respondent and husband, , no or few side effects, convenience of use, low cost and easy availability. For female sterilization, IUD and injectable users, suitability of use for a long period 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 90 percent of both current and past pill users cited lack of side effects as a reason for choosing the pill, even though this method 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

	Contraceptive method						
Reason	**Pill**	**IUD**	**Injectables**	**Condom**	**Withdrawal**	**Female sterilization**	**N**
Easily available	100.0	100.0	100.0	97.8	0.0	76.5	224
Low cost	100.0	96.0	98.3	97.8	0.0	88.2	224
Convenient to use	100.0	92.0	96.6	100.0	61.2	82.4	253
Suitable for respondent/husband	97.4	100.0	100.0	100.0	100.0	100.0	278
No/fewer side effects	89.5	84.0	81.4	98.9	100.0	76.5	255
Can be used for long period	60.5	96.0	86.4	49.5	53.1	88.2	184
No other method available	0.0	0.0	1.7	4.4	2.0	0.0	6
Method always available	55.3	52.0	54.2	48.4	0.0	23.5	115
Provider advised	42.1	60.0	50.8	33.0	100.0	70.6	103
Others	0.0	0.0	0.0	0.0	0.0	5.9	1
N	**38**	**25**	**59**	**91**	**49**	**17**	**279**

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. Side effects were by far the main issue: 83 percent cited fear of side effects, and 39 percent reported their own experience of side effects. Husband's disapproval (of modern methods) was cited by only 12 percent of the users (Table 8.2).

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

Reason	**Percentage**
Fear of side effects	82.9
Husband disapproves	12.2
Experienced side effects	39.0
Costs too much	2.4
Others	7.0
N	**41**

Respondents could give more than one reason.

Cost, Distance and Time to Reach a Facility

Costs to users of contraceptive methods vary widely in Pakistan according to method, whether public or private sector, and the distance from the home to the facility. Table 8.3 and Figure 8.1 show the reported costs the last time the women obtained the method. About 40 percent of clients were not charged for their contraceptives, including nearly all female sterilization users (who are, in fact, typically reimbursed for expenses involved). For nearly a quarter, notably condom users, the husband obtained the method, so a majority of the women did not know the cost. About 28 percent of respondents paid, but not more than 50 rupees. IUD users often paid more than 50 rupees for their method; but for IUDs, in particular, this was a one-time cost, so the monthly cost may be quite low.

Table 8.3: Distribution of costs of current specific contraceptive method

	Cost (in rupees)					Total	
Method	**No payment**	**1-20**	**21-50**	**51+**	**Don't know**	**%**	**N**
Pill	57.1	35.7	7.1	0.0	0.0	100.0	14
IUD	7.7	15.4	15.4	46.2	154	100.0	13
Injectables	16.7	20.8	20.8	16.7	12.5	100.0	24
Condom	37.3	22.4	22.4	0.0	40.3	100.0	67
Female sterilization	100.0	0.0	0.0	0.0	0.0	100.0	17
Total	**40.1**	**19.7**	**8.0**	**8.8**	**23.4**	**100.0**	**137**

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

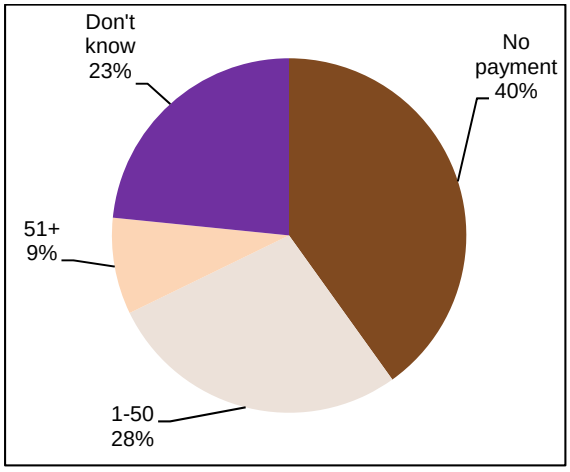
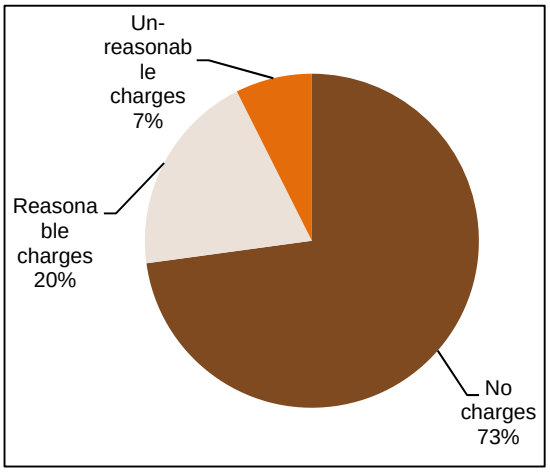


Figure 8.1B: Attitude towards service charges for current method other than contraceptive



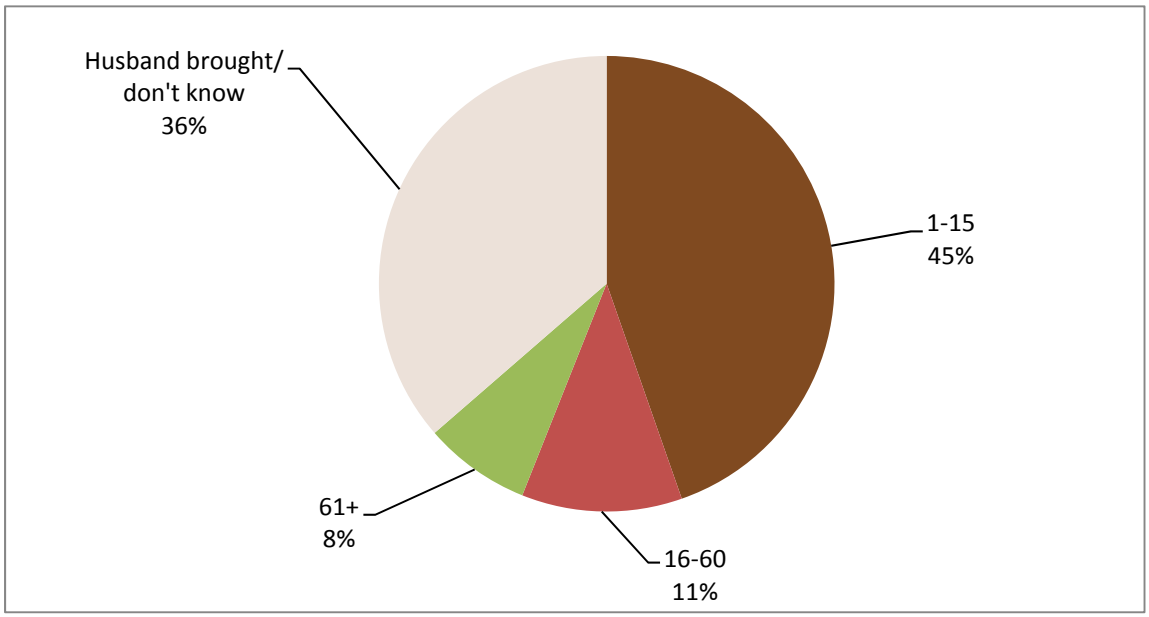
Current users were also asked whether their facility charged them for services, other than the method itself. Of the 130 users who were asked this question, 73 percent said that they were not charged, 20 percent were charged a reasonable amount, and 7 percent reported that they were charged an unreasonable amount (Figure 8.1B).

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 method. Nearly half of the users did not need more than 15 minutes to obtain their method. This included getting the method from LHWs who often brought injectables, pills, and condoms to the doorstep. For 11 percent of users it took up to one hour. For 8 percent of users, particularly female sterilization and IUD users, 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. More than one-third of the users did not know how long it took as their husbands brought the contraceptives, mostly condoms and pills.

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

	Time (in minutes)					Total	
Method	**1-15**	**16-30**	**31-60**	**61-180**	**Don't know/ husband brought**	**%**	**N**
Pill	78.6	0.0	0.0	0.0	21.4	100.0	14
IUD	61.5	15.4	7.7	7.7	7.7	100.0	13
Injectables	75.0	8.3	12.5	0.0	4.2	100.0	24
Condom	31.7	1.6	0.0	0.0	66.7	100.0	63
Female sterilization	6.4	12.5	25.0	56.3	0.0	100.0	16
Others	50.0	0.0	0.0	0.0	50.0	100.0	2
Total	**44.7**	**5.3**	**6.1**	**7.6**	**36.4**	**100.0**	**132**

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



Treatment by Provider

Information Provided

Current and past users were asked what information the service provider gave them from a list of important topics that was read out to them (Table 8.5). The accuracy of clients' responses may be questioned due to problems of recall or understanding. However, it appears that the information provided was seriously inadequate. The most common topics respondents said they were told about were effectiveness/ duration, how to use a method, how the method works, possibility of switching, and other methods you could use. Some were told about side effects or what to do about them. A few were told about advantages and contraindications. Condom users were given less information in general than users of clinical methods. There is a need to emphasize to providers that they provide comprehensible information on the method selected by the clients, especially hormonal contraceptives.

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

	Family planning method					
Information provided at acceptance	**Pill**	**IUD**	**Injectable**	**Condom**	**Female sterilization**	**N**
How the method works	44.7	64.0	45.8	12.1	58.8	81
How to use the method	57.9	52.0	55.9	19.8	11.8	88
Contraindications	34.2	36.0	25.4	9.9	23.5	50
Effectiveness	47.4	88.0	78.0	15.4	70.6	112
Advantages	18.4	32.0	18.6	5.5	11.8	33
Possible side effects	28.9	40.0	35.6	11.0	17.6	55
What to do if experienced side effects	18.4	36.0	25.4	4.4	11.8	37
Possibility of switching	39.5	68.0	44.1	17.6	29.4	79
About other methods of FP you could use	28.9	52.0	28.8	17.6	11.8	59
N	**38**	**25**	**59**	**91**	**17**	**230**

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. As Table 8.5 shows, responses were mainly positive, but with exceptions. Nearly half of the respondents said that the provider could not deal with the side effects. Twenty-seven percent of the respondents said that the provider demanded charges for services, and 5 percent said that the attitude of service providers was not cooperative. However, 35 percent said that the provider did not examine properly.

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

Aspect of treatment	Percentage
Staff attitude cooperative	95.3
Provider available	89.8
Attend/examine properly	64.9
Doesn't demand charges for services	72.8
Can deal with side effects	49.3

Side Effects

Current users were asked if they had experienced, or were experiencing, any side effects from their current method; past users were asked if side effects were among the reasons for their discontinuation of a method. If so, a list of possible side effects was read out to them, and they were asked if they had experienced them; multiple responses were allowed. Twenty-five current users and 38 past users (22 percent of all current and past users) responded positively. Side effects were most commonly reported by the users of female sterilization, injectables, IUD and pills (53, 44, 40 and 32 percent respectively), and they were least commonly reported by condom users (7 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

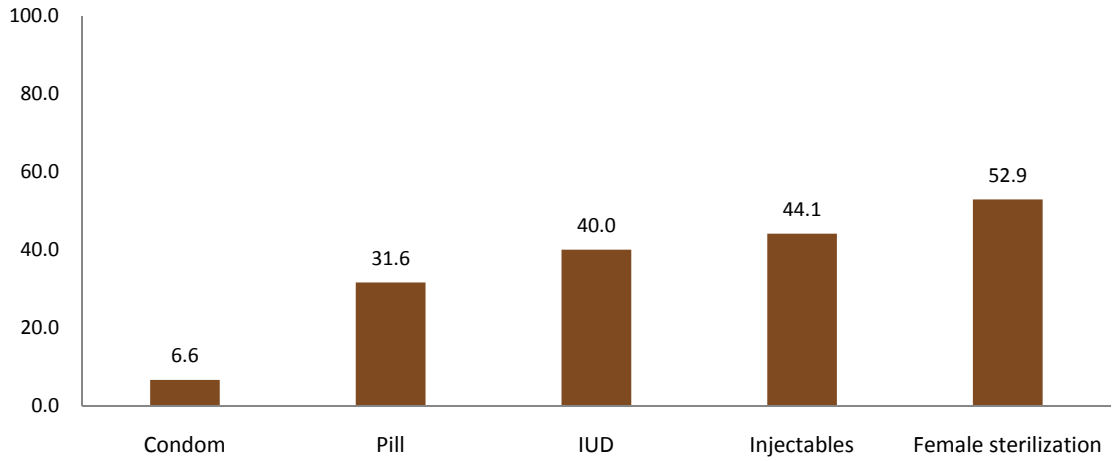
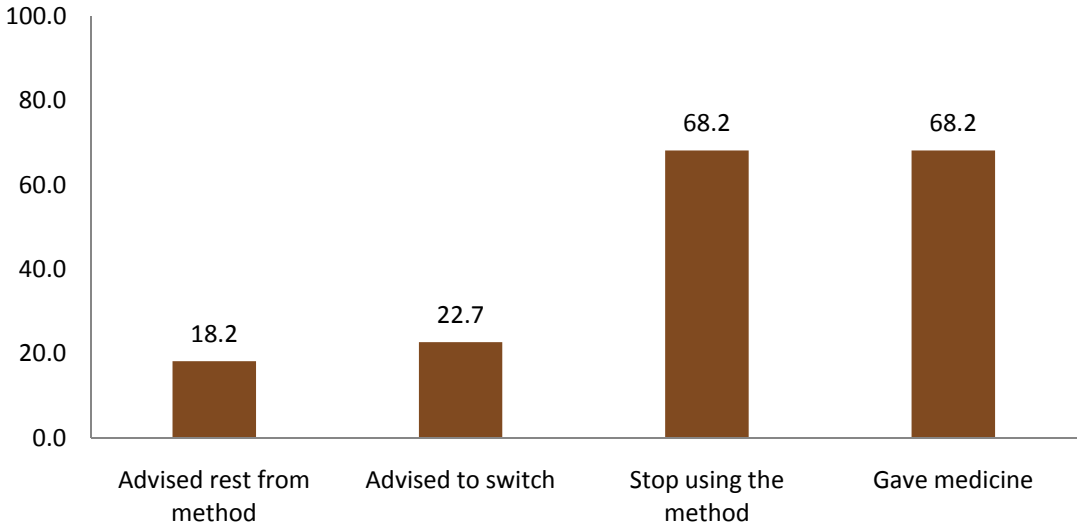


Figure 8.4: Distribution of provider responses upon consultation for side effects among past users



Of the 38 past users who reported experiencing side effects, 22 (58 percent) said they had consulted someone for managing these side effects; in 20 of these 22 cases, this was said to be a doctor. These were asked if the provider had taken any measure out of the list of possible responses (Figure 8.4). None of the users was advised to continue the method, 68 percent were asked to stop using the method, 23 percent were advised to switch methods, 18 percent were advised to take rest from the method and 68 percent were given medication.

Chapter 9

Reasons for Non-use

There are many reasons why a couple may not be using birth spacing at any given time. The wife may already be pregnant, the couple may want another child soon, or the wife may already have passed menopause, or believe herself to be sterile. Other reasons, however, may result in a couple that wants to avoid having children, but may not be using any contraception that could help them to do so. There are many such reasons: for example, lack of knowledge of methods or places to obtain them, fear of side effects of methods they know of, opposition of husband or family, and concern that birth spacing may be against Islam, or somehow wrong, and so on. To understand how to best meet the needs of such people, it is important to understand the reasons why couples are not using birth spacing in relation to the situation they are currently in.

Hindrances to Use

One way to understand common types of hindrances to contraceptive use is to ask respondents about their understanding of the concerns of people in general, with the view that people may feel less need to conceal their real concerns than when they are discussing 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 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

	Use of family planning					
	Current users		Past users		Never users	
Hindrance	**N**	**%**	**N**	**%**	**N**	**%**
Husband's disapproval	178	100.0	104	100.0	207	99.5
Other people may find out about contraceptive use	134	75.3	75	72.8	154	74.0
Distance and travel costs to FP outlet	144	80.9	80	76.9	158	76.0
Probability of getting pregnant while using	157	88.2	89	85.6	152	73.1
Fear of side effects	174	97.8	102	98.1	190	91.3
Problem of managing side effects	174	97.8	102	98.1	193	92.8
FP is against religion	177	99.4	103	99.0	206	99.0
N	**178**	**na**	**104**	**na**	**208**	**na**

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

Some hindrances that couples might face were almost universally acknowledged. Possible husband's disapproval was mentioned by nearly all respondents, while 99 percent acknowledged religious concerns. Ninety-eight percent of both current and past users mentioned the problem of managing side effects as well as fear of side effects. For three other possibilities, however, a substantial proportion of women respondents also thought them to be a hindrance: other people might find out about their use; the distance and cost of going to an FP outlet; and the possibility of getting pregnant while using a method.

Past Users

Reasons for Discontinuing Contraceptive Use

Table 9.2 shows past users by reason for discontinuing their last contraceptive method. (More than one reason was permitted). The most commonly given reasons were desire for another child, side effects experienced, infrequent sex/husband away, husband's advice, rest from the method and method failure. Method failure results from using methods that have high failure rates. Clinical methods do have associated side effects, but as we have seen

from Table 8.5, 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

Reason	Percentage
Wanted another child	37.9
Fear of side effects	11.7
Side effects experienced	36.5
Method failure	11.7
Lack of access/unavailability	1.0
Method inconvenient to use	1.0
Rest from method/ provider's advice	21.4
Missed the dose	2.9
Infrequent sex/husband away	29.1
Husband's advice	18.4
In-laws oppose	1.9
Menopause	3.9
N	**103**

Respondents could give more than one reason.

Reasons for Current Non-use

It is important to know the reasons why couples who had used contraception in the past were not currently using any method. Past users were read out a list of possible reasons for their not currently using contraception, with more than one reason possible (Table 9.3). The most common reason was infrequent sex. Other reasons related to childbearing, e.g., breastfeeding/amenorrheic, currently pregnant. However, significant percentage cited fear of side effects as a reason for non-use.

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

Reason	Percentage
Fear of side effects	17.5
Want another child	6.8
Currently pregnant	23.3
Rest from method/provider's advice	4.9
Infrequent sex/husband away	35.0
Breastfeeding/lactational amenorrhea	28.2
Menopause	4.9
Just not using/too lazy	1.0
Others	7.9
N	**101**

Respondents could give more than one reason.

Never Users of Contraceptives

Reasons for Non-use

The 209 women in the sample who reported never use of contraceptives were asked about various possible reasons for not using, with each reason read out separately (Table 9.4). The most important reason was desire for more children, with a concern about their ability to conceive sometimes being an additional factor. Infrequent sex/husband away and husband and in-laws opposition were also significant reasons, as well as currently breastfeeding (17 percent). Very few reported lack of access/unavailability of supply, while religious objection was reported by only 3 percent of the women.

Table 9.4: Percentage distribution of never users by reason for never use

Reason	Percentage
Husband opposes	23.9
In-laws oppose	10.0
Fear of side effects	21.5
Lack of access/unavailability	2.4
Cost not affordable	0.5
Shy to consult about family planning	2.9
Method inconvenient to use	1.4
Infrequent sex/husband away	26.8
Difficult/unable to conceive	18.7
Breastfeeding/lactational amenorrhea	17.3
Wanted (more) children	79.9
Against religion	3.4
Natural spacing	1.9
Others	1.9
N	**209**

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 it in principle but not using a method for some other reason. Table 9.5 shows this for never using women. Disapproval for spacing was slightly higher than that for limiting. About 7 percent of women disapproved of spacing and 6 percent of limiting. The implications of this for whether a couple does or does not use birth spacing or limiting may be profound, and require further investigation.

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

	Attitude towards spacing		Attitude towards limiting	
Attitude	**N**	**%**	**N**	**%**
Approve	192	92.8	194	93.7
Disapprove	15	7.2	13	6.3
Total	**207**	**100.0**	**207**	**100.0**

Knowledge of Contraceptive Users, Methods and Facilities

Of the 209 female never users in the sample, 71 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy. Nearly 67 percent of the respondents knew relatives who had ever used some method, 45 percent knew friends/neighbors and 11 percent knew non-relatives who had ever used a method.

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

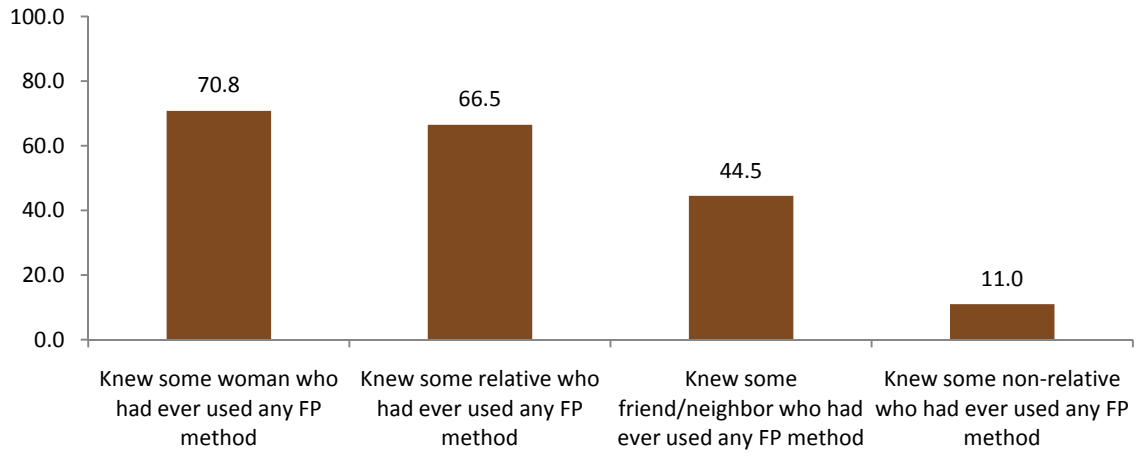


Table 9.6: Percentage distribution of never users by knowledge of contraceptive methods

Method	Percentage
Female sterilization	90.9
Male sterilization	15.3
Pill	100.0
IUD	90.0
Injectables	99.0
Norplant	4.3
Condom	87.1
Rhythm	7.2
Withdrawal	77.5
Emergency pills	0.5
Others	0.0
Know at least one FP method	100.0
N	**209**

Respondents could give more than one response.

All the never users knew of at least one method. For each method, (with the exception of knowledge of pills) a somewhat lesser percent of never users knew that method than the general distribution (Table 7.1); and most never users knew a variety of methods. However, their knowledge of where to get services and supplies was less satisfactory (Table 9.7).

Of 209 never users, 93 (45 percent) did not know 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 department outlets – BHU/RHC/MCH centers, the District/Tehsil Headquarters hospitals and the Lady Health Workers. A substantial number of respondents knew the Family Welfare Centers of the Ministry of Population Welfare and private facilities, including Greenstar clinics, pharmacies/chemists. Very few were aware of other sources, including mobile service unit camps.

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

Source	Percentage
Knowledge of at least one service provider	55.3
DHQ/THQ hospital	35.1
BHU/RHC/MCH center	42.8
Family welfare center	21.2
Mobile service unit camp	7.2
Lady Health Worker	26.0
Greenstar clinic	14.9
Private hospital/clinic/doctor	26.0
Dispenser/compounder	14.9
Pharmacy/chemists	13.9
Homeopath/hakim	4.8
TBA/dai	4.8
Grocery shop (not pharmacy/chemist)	5.8
N	**208**

Respondents could give more than one source.

As shown in Figure 9.2, most walked to where they could obtain their method. Of the 111 respondents who indicated the time needed to go to the nearest facility, 70 percent cited 15 minutes time or less, 23 percent mentioned 16 to 30 minutes, and 7 percent gave a time-frame of more than 30 minutes, while the maximum time was one hour (Figure 9.3).

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

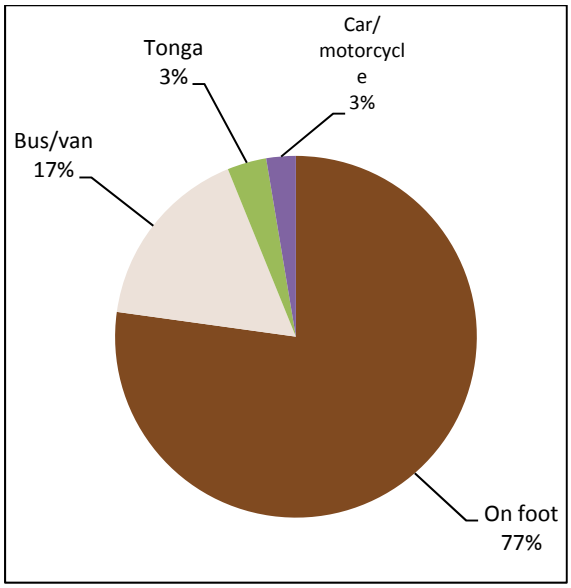
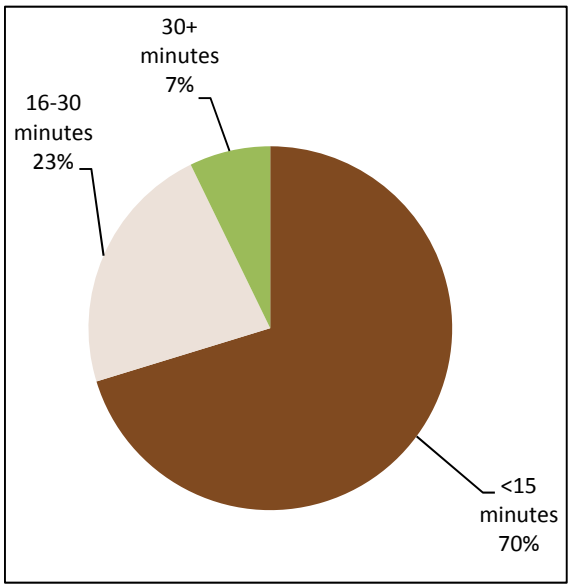


Figure 9.3: Time taken to go to the nearest facility/provider



Intent to Use Contraceptives

When never users were asked about whether they intended to use a method in the future, nearly 52 percent of the respondents said that they did intend to use family planning (Table 9.8). Most of the low parity women who had not yet used a method (82 percent of those with no children and 63 percent of those with 1-2 children) expressed their intent to use in the future, compared with women with 3 or more children (17 percent of those with 3-4 children and 25 percent of those with 5 or more children).

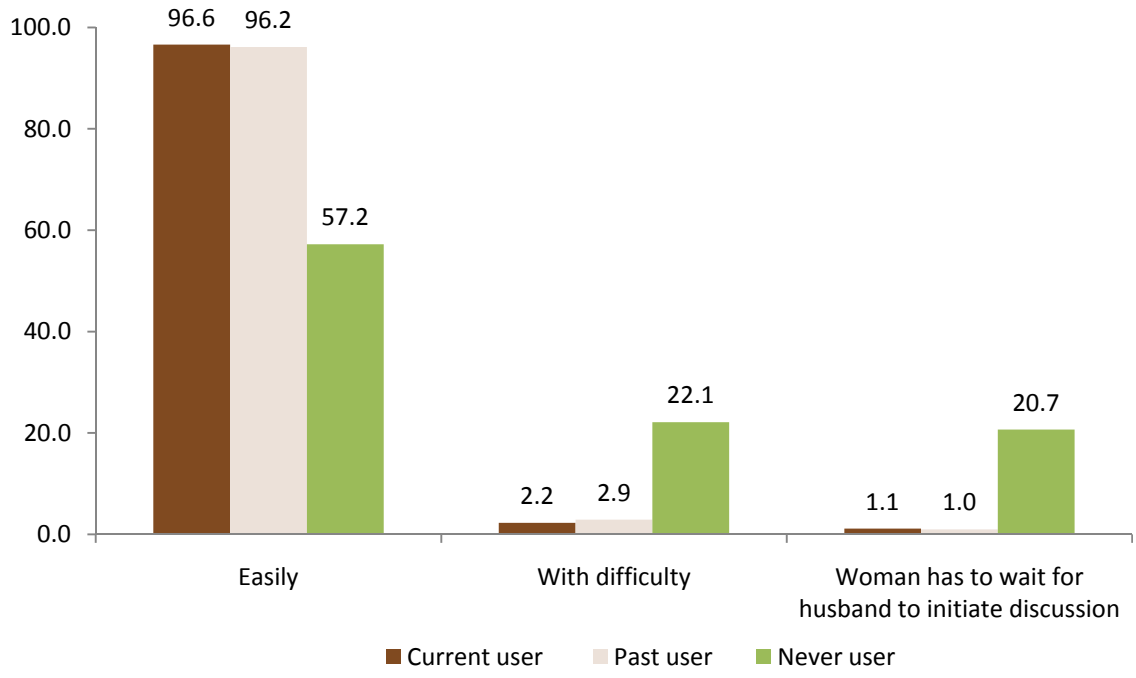
Table 9.8: Distribution of never users by intent to use a method in the future and number of living children

	Intention to use any FP method in future				Total	
Number of living children	**Yes**	**No**	**Unsure/ uncertain**	**Can't get pregnant**	**%**	**N**
0	81.8	7.6	10.6	0.0	100.0	66
1-2	63.3	28.3	8.3	0.0	100.0	60
3-4	17.0	68.1	12.8	2.1	100.0	47
5 or more	25.0	72.2	2.8	0.0	100.0	36
Total	**52.2**	**38.3**	**9.1**	**0.5**	**100.0**	**209**
N	109	80	19	1	100.0	209

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Women were also asked whether they could approach their husbands to discuss family planning easily, with difficulty, or if they had to wait for their husbands to initiate the discussion. Most women said they could do so easily (Figure 9.4). However, this varied by use status. About 97 percent of the current users and 96 percent of the past users said they could approach their husbands easily, and very few said they had to wait for their husband to initiate the discussion. But for never users, only 57 percent reported being able to approach their husbands easily, 22 percent reported that they could only do so with difficulty, and another 21 percent said they had to wait for him to begin the conversation. This did not vary systematically by number of living children.

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 long 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 (if pregnant) or last (if amenorrheic) pregnancy was said to be unwanted or mistimed. Women who want to delay their next pregnancy are said to be in unmet need of spacing; those who do not want more children at all are said to be in unmet need of 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 appear to be in need of some support to avoid unwanted pregnancy.

Levels and Correlates

Table 10.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Swabi. Of the total 491 women, 165 (34 percent) were judged to be in unmet need. This proportion was slightly lower than is typically found using the same definition in Pakistan. The lower proportion may be a reflection of the relatively higher contraceptive prevalence; higher levels of use may mean that more of the total demand for family planning is being met. This is supported by the relatively low levels of unmet need for women with 5 or more children, where contraceptive prevalence was particularly high (see Chapter 7).

Of the 34 percent women who had unmet need, 10 percent was for spacing, while 24 percent was for limiting. Unmet need for spacing was concentrated among women with one

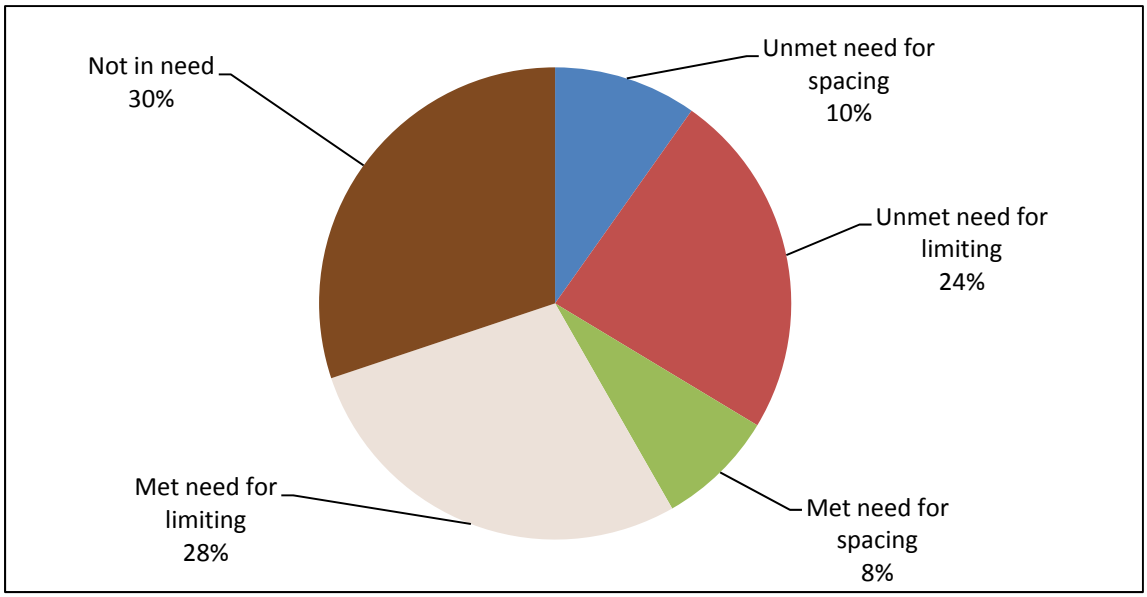
to two children: 28 of the 48 cases were in this category. Unmet need for limiting, unsurprisingly, was highest among women with five or more living children.

Table 10.1: Distribution of women with unmet need for spacing and limiting by background characteristics

Characteristic	Unmet need			Met need			Total demand	Not in need	Total	N
	For spacing	For limiting	Total	For spacing	For limiting	Total				
Age group										
15 - 24	20.0	4.8	24.8	14.5	4.8	19.3	44.1	55.9	100.0	145
25 - 34	9.3	27.5	36.8	8.8	31.6	40.4	77.2	22.8	100.0	193
35 - 49	0.7	37.3	37.9	1.3	45.8	47.1	85.0	15.0	100.0	153
Type of community										
Rural	8.9	25.2	34.1	8.0	26.8	34.8	68.9	31.1	100.0	425
Urban	15.2	15.2	30.3	9.1	36.4	45.5	75.8	24.2	100.0	66
Literacy of respondent										
Literate	15.2	13.0	28.3	17.4	18.1	35.5	63.8	36.2	100.0	138
Illiterate	7.4	28.9	36.3	4.4	31.9	36.3	72.6	27.4	100.0	339
Education of respondent										
No education	7.2	29.2	36.4	3.9	32.5	36.4	72.9	27.1	100.0	332
Up to primary	16.4	14.5	30.9	12.7	20.0	32.7	63.6	36.4	100.0	55
Up to secondary	16.3	7.5	23.8	17.5	15.0	32.5	56.3	43.8	100.0	80
Above secondary	10.5	26.3	36.8	26.3	21.1	47.4	84.2	15.8	100.0	19
Number of Children										
0	1.5	1.5	3.1	1.5	0.0	1.5	4.6	95.4	100.0	65
1-2	25.5	7.3	32.7	20.9	4.5	25.5	58.2	41.8	100.0	110
3-4	11.6	24.8	36.4	10.7	34.7	45.5	81.8	18.2	100.0	121
5+	2.6	40.0	42.6	1.5	46.7	48.2	90.8	9.2	100.0	195
Ownership of TV										
Yes	10.3	21.0	31.3	10.3	25.7	36.0	67.3	32.7	100.0	272
No	9.1	27.4	36.5	5.5	31.1	36.5	73.1	26.9	100.0	219
Standard of living index										
Low	10.8	37.8	48.6	4.1	32.4	36.5	85.1	14.9	100.0	74
Medium low	11.9	21.4	33.3	7.1	27.4	34.5	67.9	32.1	100.0	168
Medium high	6.8	16.5	23.3	9.8	31.6	41.4	64.7	35.3	100.0	133
High	9.5	26.7	36.2	10.3	22.4	32.8	69.0	31.0	100.0	116
Total	**9.8**	**23.8**	**33.6**	**8.1**	**28.1**	**36.3**	**69.9**	**30.1**	**100.0**	**491**

Correlations between unmet need and various socioeconomic indicators varied by whether the unmet need was for spacing or for limiting (Table 10.1).

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 70 percent of all married women of reproductive age. As the table shows, total demand did rise rapidly, and fairly consistently, by number of children. Even at 1-2 children, demand was quite substantial (58 percent), and it increased to over 90 percent for those with 5 or more living children.

Strength of Preference

It is of interest to look at the responses of women in unmet need (those not currently pregnant) according to their reaction if they became pregnant in the near future (Table 10.2). About 35 percent of the women with unmet need for spacing said they would accept it if they became pregnant again. Fifty percent of the women would be worried, and only 15 percent would be pleased. Of those with unmet need for limiting, 73 percent said they

would be worried if they became pregnant. It is perhaps not unreasonable for women to be more concerned about the consequences of an unwanted pregnancy than about the consequences of a wanted pregnancy coming too soon. However, the responses of women who wanted to delay their next child for 2 or more years and those who wanted to stop childbearing were encouraging.

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	7	15.2	5	4.7
Worried	23	50.0	78	72.9
Accept it	16	34.8	24	22.4
Total	**46**	**100.0**	**107**	**100.0**

Reasons for Non-use

Women with unmet need were asked (whether they were never users or past users) why they were not using some method of contraception; the results are shown in Table 10.3. Some of these reasons represented barriers as perceived by the women. The most important of these were fear of side effects, opposition by 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 wanted more children, infrequent sex/husband away, difficult/unable to conceive and currently pregnant. Some of these women may have more need than they realize. For example, women who were 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 limiting	Total unmet need
Fear of side effects	22.9	30.2	28.0
Husband opposes	20.8	22.4	22.0
In-laws oppose	14.6	6.0	8.5
Rest from method/provider's advice	2.1	2.6	2.4
Shy to consult about FP	6.3	0.9	2.4
Against religion	4.2	2.6	3.0
Lack of access/unavailability	4.2	1.7	2.4
Cost not affordable	0.0	0.9	0.6
Method inconvenient to use	0.0	0.9	0.6
Infrequent sex/husband away	25.0	39.7	35.4
Natural spacing	0.0	3.4	2.4
Difficult/unable to conceive	10.4	6.9	7.9
Want (more) children	66.7	35.3	44.5
Currently pregnant	4.2	5.2	4.9
Breastfeeding/lactational amenorrhea	0.0	2.6	1.8
Others	4.2	8.6	7.3
N	**48**	**116**	**164**

Respondents could give more than one reason.

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprised 48 (9.8 percent) of MWRA. As shown in the Table 10.4, they were characterized by:

- **Living Children:** Most (58 percent) had 1 or 2 living children.
- **Family Planning Use:** More never users (75 percent) than past users (25 percent).
- **Strength of Preference:** Moderate (50 percent "worried" if they became pregnant earlier than they wanted compared to those who were pleased (15 percent) or accept (35 percent) the unwanted pregnancy).
- **Intent to Use FP method in Future:** Moderate (about 62 percent intended to use a FP method in future).
- **Approval of FP:** High (85 percent approved of using a FP method for spacing purpose).
- **FP Communication with Husband:** Moderate (only 48 percent had communicated with husbands on FP in the past one year; while 29 percent said approaching the husband was "not easy").
- **Obstacles to FP Use:** Fear of side effects (23 percent); husband and in-laws opposition (21 percent and 15 percent respectively) (Table 10.3).

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

Characteristic	Unmet need for spacing		Unmet need for limiting	
	N	%	N	%
Number of living children				
0	1	2.1	1	0.9
1-2	28	58.3	9	7.7
3-4	14	29.2	41	35.0
5 or more	5	10.4	66	56.4
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	12	25.0	53	45.3
Never user	36	75.0	64	54.7
Reaction if become pregnant in near future				
Pleased	7	15.2	5	4.7
Worried	23	50.0	78	72.9
Accept it	16	34.8	24	22.4
Intention to use a FP method in future				
Yes	29	61.7	44	38.9
No	14	29.8	62	54.9
Unsure/uncertain	4	8.5	7	6.2
Approval of FP				
Approve	40	85.1	113	96.6
Disapprove	7	14.9	4	3.4
FP communication with husband in past one year				
Never	25	52.1	71	60.7
Once or twice	15	31.3	19	16.2
More often	8	16.7	27	23.1
Approach the topic of FP with husband				
Easily	34	70.8	83	70.9
Not easily	14	29.2	34	29.1
Total	**48**	**100.0**	**117**	**100.0**

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprised 117 (23.8 percent) of MWRA. As shown in the Table 10.4, they were characterized by:

- **Living Children:** A strongly positive association with number of living children; 56 percent had 5+ living children.
- **Family Planning Use:** More never users (55 percent) than past users (45 percent).
- **Strength of Preference:** High (73 percent would be "worried" if they became pregnant compared to those who were pleased (5 percent) or accept (22 percent) the unwanted pregnancy).
- **Intent to Use FP method in Future:** Low (about 39 percent intended to use an FP method in future.
- **Approval of FP:** High (97 percent approved of FP for limiting purpose).
- **FP Communication with Husband:** Limited (only 39 percent had communication with husband on FP in the past year; while 29 percent said approaching the husband was "not easy").
- **Obstacles to Use FP method:** Fear of side effects (30 percent); husbands and in-laws opposition (22 percent and 6 percent respectively) (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 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 contraception (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 as many husbands as possible who were available when the household interviews were undertaken. Knowing that some number of husbands might be at their places of work during the timing of the interviews, the plan was to then make up for any of the husbands who were unavailable, by interviewing other married men available in the selected communities in order to come as close as possible to meeting the objective of interviewing 200 husbands/men in each FALAH district. In Swabi, the field team was able to interview 180 men who were husbands of the married women of reproductive age who had been interviewed for the survey plus 20 married men living in selected areas who were not husbands of the female respondents. In this chapter, the results for the respondents' husbands and the other married men who were interviewed (N = 200) are always grouped together, whether the reference is to "men," "male respondents," "married men," or "husbands."

A 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 contraception. Earlier studies suggest that the husband's approval of and discussion about family planning are important predictors of a woman's contraceptive use and fertility desire (Bongaarts and Bruce, 1995; Mahmood and Ringheim, 1997).

This baseline survey investigates social and demographic differentials, and 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 men was to investigate their perspective on the issues of fertility and family planning.

Background Characteristics

Table 11.1 shows the background characteristics of the men interviewed in the survey. It shows that less than one percent of the men were under 25 years of age and 22 percent were 50 years of age and above.

As shown in Table 11.1, the men were substantially better educated than the sampled currently married women of reproductive age. Twenty-eight percent of the men had not been to school, compared to 68 percent of the currently married women (Table 3.2). It also shows that 65 percent of the men had more than primary education, whereas 20 percent of the currently married women had attained that level of education (Table 3.2). More than 76 percent of the urban men had received some schooling compared to 72 percent of the rural men.

The occupations of men are also presented in Table 11.1. The highest proportion (37 percent) of men were working in agriculture-related activities and 20 percent were working as daily laborers. More than twenty percent were running their own business.

Table 11.1: Background characteristics of male respondents by residence

Characteristic	Rural	Urban	Total
Age group			
20-24	0.6	0.0	0.5
25-29	4.7	6.7	5.0
30-34	13.5	10.0	13.0
35-39	18.2	10.0	17.0
40-44	17.1	13.3	16.5
45-49	18.8	33.3	21.0
50-54	15.9	20.0	16.5
55+	5.9	3.3	5.5
Education			
Proportion literate	67.1	73.3	68.0
No education	28.2	23.3	27.5
Up to primary	5.9	16.7	7.5
Up to secondary	50.0	43.4	49.0
Above secondary	15.9	16.7	16.0
Economic activity /occupation			
Agriculture/livestock/poultry	38.8	26.7	37.0
Petty trader	3.5	6.7	4.0
Labor	20.0	16.7	19.5
Govt. service	15.3	13.3	15.0
Pvt. Service	9.4	10.0	9.5
Own business	21.8	13.3	20.5
Working abroad	1.2	3.3	1.5
Unemployed	4.1	13.3	5.5
Others	1.2	3.3	1.5
N	**170**	**30**	**200**

Contraceptive Knowledge and Use

All of the interviewed men in Swabi knew of at least one modern method of contraception. As presented in Table 11.2, knowledge of modern methods was highest for pills (98 percent) followed by condoms (97 percent), injections (94 percent) and female sterilization (87 percent). The least known modern methods were Norplant (3 percent), male

sterilization (18 percent), and IUD (52 percent). Knowledge of at least one traditional method was prevalent among only 62 percent of the men. All currently married women of reproductive age interviewed in Swabi also 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. Fifty-seven percent of the MWRA reported having used some method of contraception during their married lives (Table 7.2); of the male respondents, 69 percent reported ever using some method of contraception in their married lives. For the men, among modern methods, condoms were the most popular method ever used (35 percent), followed by the pill (26 percent) and injectables (25 percent). Condom was used more in rural areas. Although, 3 percent of the men living in urban areas reported ever use of IUDs, surprisingly, none of them reported current use of IUDs by their wives.

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	86.4	93.3	87.4	3.5	13.3	5.0	3.5	13.3	5.0
Male sterilization	18.5	16.7	18.2	0.0	3.3	0.5	0.0	3.3	0.5
Pill	97.0	100.0	97.5	25.9	30.0	26.5	4.7	10.0	5.5
IUD	56.5	30.0	52.4	7.1	3.3	6.5	1.2	0.0	1.0
Injectables	92.9	96.7	93.5	22.9	33.3	24.5	10.0	6.7	9.5
Norplant	3.0	0.0	2.5	0.0	0.0	0.0	0.0	0.0	0.0
Condom	96.5	100.0	97.0	35.3	33.3	35.0	19.4	20.0	19.5
Rhythm	30.4	23.3	29.3	10.0	13.3	10.5	7.6	6.7	7.5
Withdrawal	52.1	60.0	53.3	19.4	23.3	20.0	10.6	20.0	12.0
Others	0.6	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0
At least one FP method	100.0	100.0	100.0	67.1	76.7	68.5	52.4	76.7	56.0
At least one modern FP method	100.0	100.0	100.0	56.5	56.7	56.5	37.1	50.0	39.0
At least one traditional FP method	61.8	60.0	61.5	26.5	30.0	27.0	17.1	26.7	18.5
Emergency pills	16.6	20.0	17.1	0.0	0.0	0.0	na	na	na
N	**170**	**30**	**200**	**170**	**30**	**200**	**170**	**30**	**200**

na = not applicable.

As mentioned in table 7.2, a total of 36 percent of all MWRA in the sample were currently using some method of contraception, while for the male respondents this figure was higher at 56 percent. The most common current modern method reported by male respondents was condom (20 percent), followed by injectables (10 percent). The use of traditional methods was also substantial; more than 18 percent of the current users were relying on such methods. 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. Although 17 percent of the respondents knew about the emergency contraceptive pill, none of the men reported ever using it.

Table 11.3: Percentage of male respondents reporting ever use or current use of a contraceptive method, by selected background characteristics

Characteristic	Ever used at least one FP method	Currently using any FP method	N
Residence			
Rural	67.1	52.4	170
Urban	76.7	76.7	30
Education level			
No education	65.5	47.3	55
Below secondary	69.8	62.3	53
Secondary and above	69.6	57.6	92
Number of living children			
None	12.5	6.3	16
1-2	58.1	39.5	43
3-4	75.0	70.0	60
5+	80.2	64.2	81
Future desire for children			
Soon	20.0	15.0	20
Later	57.1	41.3	63
Never	83.2	72.0	107
Don't know/unsure	80.0	60.0	10
Total	**68.5**	**56.0**	**200**

Table 11.3 shows ever use and current use of modern contraception among respondents by background characteristics. A higher proportion of urban men were currently using a family planning method compared to rural men. More than 69 percent of the respondents who had some education reported ever use of any contraceptive method, compared to 65 percent with no education. The current use of family planning also showed almost the same pattern by education of men.

Table 11.3 also shows a positive relationship between the number of living children and ever use as well as current use. Of those who had 5 or more children, 80 percent reported ever use of family planning methods compared to 75 percent who had 3-4 children and 58 percent who had 1-2 children.

Table 11.3 also shows contraceptive ever use and current use by the future desire for children. Highest ever use was found among the male respondents who said they did not want any more children: 83 percent of those respondents who did not want more children

had ever used any contraceptive method, and 72 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 contraceptive methods, 24 percent reported that they obtained it from the "pharmacy/ chemist" and 22 percent obtained from "Grocery shop/general store. Government hospitals (DHQ/THQ) were the source for only 10 percent of the users. BHU/RHC/MCH Center and LHWs were reported by 10 percent and 11 percent, respectively. Seven percent of the male respondents said that their wives brought the method.

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

Source	Percentage
Government hospital (DHQ/THQ)	9.9
BHU/RHC/MCH center	9.9
FWC	1.0
LHW	10.9
Pvt. Doctor	1.0
Pvt. hospital/clinic	4.0
Dispenser/compounder	7.9
NGO hospital	1.0
Pharmacy, chemist	23.8
Homeopath/hakim	1.0
TBA/dai	1.0
Grocery shop/general store	21.8
Wife brings method	6.9
Total	**100.0**
N	101

Approval of Family Planning

Respondents were asked about their approval of birth spacing and use of any form of contraception for spacing purpose. A husband's opposition may prevent his wife from using contraception, even when she wants to delay or stop childbearing (Casterline, Perez, and Biddlecom, 1997). In Swabi, 98 percent of the men approved of spacing between children and 93 percent also approved the use of any form of contraception for this purpose (Table

11.5). Eight percent disapproved of using any form of contraception to space between children.

Table 11.5: Distribution of male respondents' by attitude towards spacing and use of contraceptives for spacing by residence

Variable	Rural	Urban	Total
Spacing between children			
Approve	97.6	96.7	97.5
Disapprove	2.4	3.3	2.5
Total	**100.0**	**100.0**	**100.0**
N	170	30	200
Using family planning methods for spacing			
Approve	92.9	90.0	92.5
Disapprove	7.1	10.0	7.5
Total	**100.0**	**100.0**	**100.0**
N	170	30	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 77 percent of the current users were very satisfied with their current method; only 3 percent reported that they were not satisfied with their current method. More than 20 percent of the current users 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 continue using a family planning method.

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

Level of satisfaction	Rural	Urban	Total
Very satisfied	77.8	73.3	76.9
Somewhat satisfied	20.6	20.0	20.5
Not satisfied at all	1.6	6.7	2.6
Total	**100.0**	**100.0**	**100.0**
N	63	15	78

Table 11.7: Distribution of male past contraceptive users by the reason for discontinuing last method

Reason	Percentage
Cost not affordable	4.0
Experienced side effects	16.0
Fear of side effects	20.0
Want another child	44.0
Method failure	32.0
Method inconvenient to use	8.0
Health concern	12.0
Service provider's advice	4.0
Infrequent sex/respondent away	16.0
Wife opposes	4.0
N	**25**

Respondents could give more than one reason

The reasons why male respondents stopped using their last method 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, 16 percent of male past users stopped using their method because of side effects the couple experienced with their method. Thirty-two percent of the past users stopped using a contraceptive due to method failure. This contraceptive failure may be due to the fact that a significant proportion of users was relying on natural methods. There were also a few cases where the wife opposed the use of a contraceptive method.

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Husbands were asked if during the last 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. Ninety percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, Figure 11.2 shows that 40 percent of the men

reported that their wives had never approached them during the last year about this issue. Thirty-seven percent of the men reported that their wives had talked often about this subject during the last year, while 23 percent reported they had talked once or twice.

Figure 11.1: Men's reports of ease of approach by their wives to discuss FP

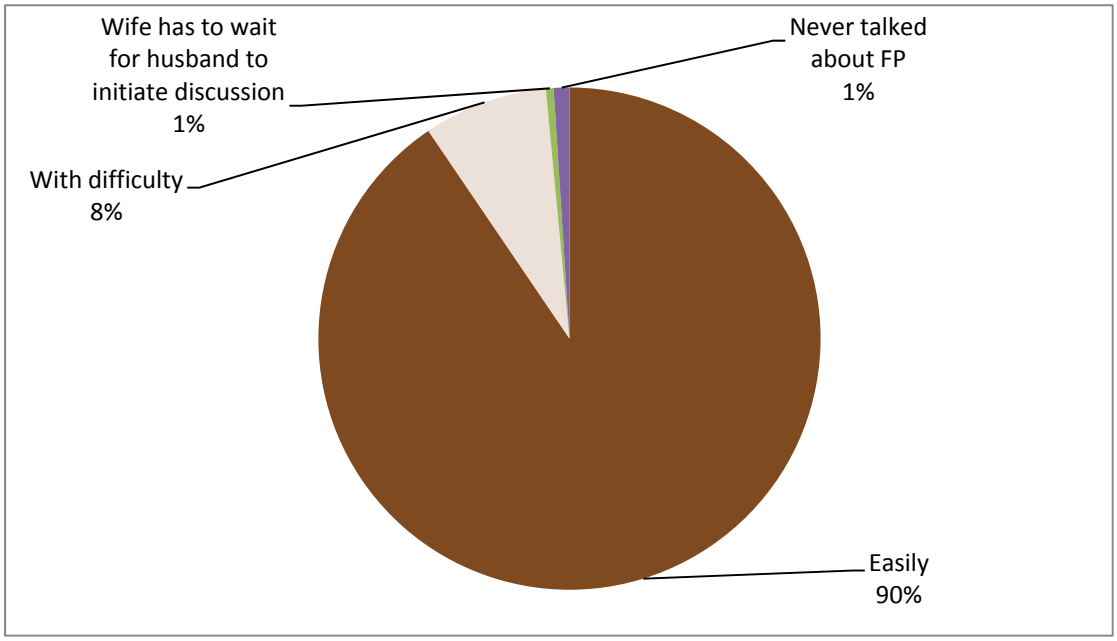
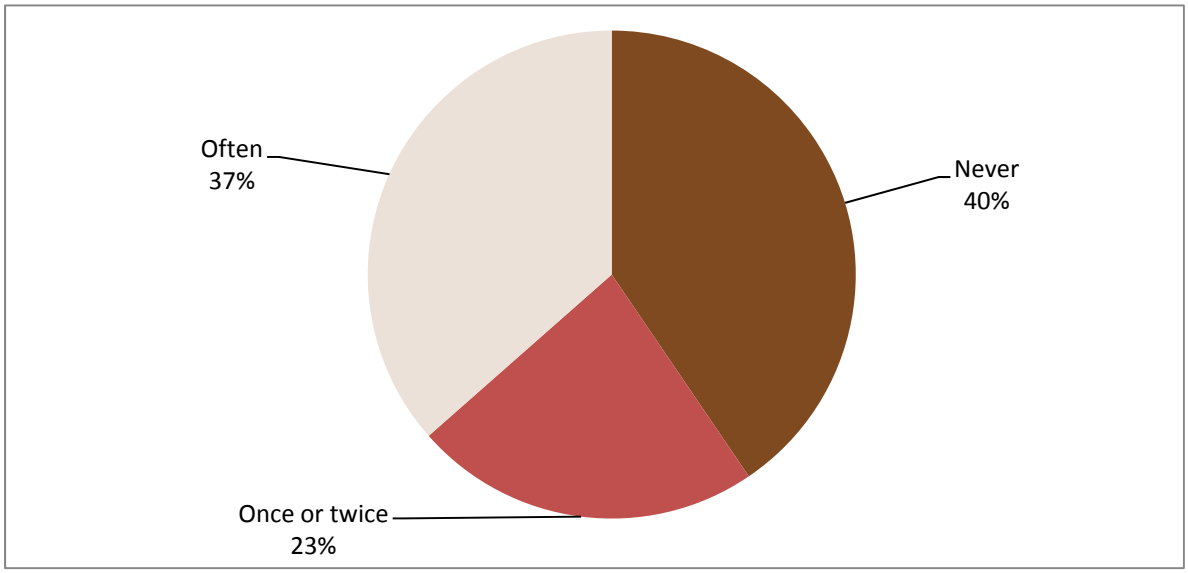


Figure 11.2: Men's reports of frequency of discussion on FP with wife in last year



Potential Users

Men who were non-users of contraception were asked about their intended future use of contraception and their method preferences. Table 11.8 shows that 40 percent intended to use contraception in the future, while 38 percent did not intend to do so. Twenty-two percent of the respondents were uncertain about their future use of contraception.

Table 11.8: Distribution of male never users by intent to use contraceptive methods in future

Intent	Percentage
Will use	39.7
Will not use	38.1
Unsure/Uncertain	22.2
Total	**100.0**
N	63

As shown in Table 11.9, the major reason husbands said they did not intend to use was that their wives were unable to conceive (50 percent). Their desire for more children was cited by 71 percent of the husbands, while for 25 percent, fear of side effects was the reason for not using a contraceptive method.

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

Reason	Percentage
Wife opposes	16.7
In laws/parents appose	4.2
Fear of side effects	25.0
Lack of access/unavailability	4.2
Cost too much	8.3
Shy to go to FP clinic	29.2
Infrequent sex/respondent away	16.7
Difficult/unable to conceive	50.0
Breast feeding/ lactational amenorrhea	25.0
Respondent/wife infertile	25.0
Want more children	70.8
N	**24**

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 relatively a small proportion wanted to use male methods. Injectables and pills were the main contraceptive methods proposed to be used in the future.

Table 11.10: Distribution of male never users who intend to use specific contraceptive methods in the future

Method	Percentage
Female sterilization	8.0
Pills	20.0
IUD	8.0
Injectable	20.0
Condom	16.0
Rhythm	4.0
Withdrawal	4.0
Not decided	4.0
Total	**100.0**
N	25

Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 11.11 shows that 10 percent of the respondents wanted another child soon (within two years). Another 32 percent wanted to delay their next child for more than two years. The largest proportion of respondents (54 percent) did not want any more children at all.

The desire to stop having children was positively associated with the number of living children. Thirty-five percent of the respondents who had 3 children did not want more children. More than 82 percent who had 5 or more children did not want more children.

Table 11.11: Distribution of male respondents by desired timing for next child and number of living children

Number of living children	Desire for next child				Total	
	Soon	Later	Never	Don't know/ unsure	%	N
0	68.8	25.0	6.3	0.0	100.0	16
1	10.5	73.7	5.3	10.5	100.0	19
2	20.8	66.7	8.3	4.2	100.0	24
3	3.8	61.5	34.6	0.0	100.0	26
4	2.9	11.8	79.4	5.9	100.0	34
5+	0.0	11.1	82.7	6.2	100.0	81
Total	**10.0**	**31.5**	**53.5**	**5.0**	**100.0**	**200**

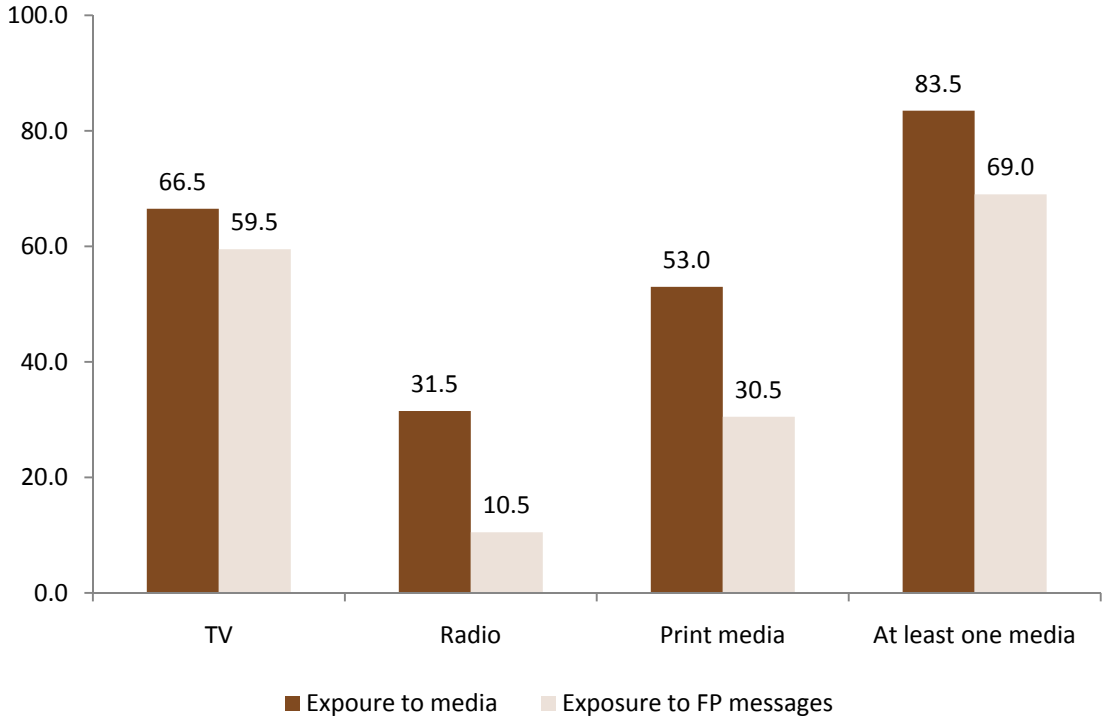
Mass Media Access and Exposure to FP Messages

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 67 percent of the male respondents in Swabi watched TV and 53 percent 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. Sixty percent of the men had seen FP messages on television. Ten percent of

the men reported that they had ever listened to a family planning message on the radio. Overall, 69 percent of the male respondents and 35 percent of the MWRA (Figure 3.3) had seen a family planning message on at least one medium.

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



References

Adair, L., B. Popkin and D. Guilkey. 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 S. Bergstrom. 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., Z. Sathar and M. ul Haque. 2001. *Obstacles to Contraceptive Use in Pakistan: A Study in Punjab*. Studies in Family Planning 32(2): 95-110.

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

Garner, P., T. Smith, M. Baea, D. Lai and P. Heywood. 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 Swabi.* Islamabad: Statistics Division Government of Pakistan.

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

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

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

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

United Nations. 2006. *Millennium Development Goals Report 2006*. New York: United Nations Department of Economic and Social Affairs.

Westoff C. F. and A. Bankole A. 1999. *Mass Media and Reproductive Behavior in Pakistan, India, and Bangladesh*. Demographic and Health Surveys Analytic Reports No.10. Calverton, Maryland: Macro International Inc.

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