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FALAH
FAMILY ADVANCEMENT FOR LIFE & HEALTH

Baseline Household Survey

Khanewal District

May 2010

Population Council

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Family Advancement for Life and Health

(FALAH)

Khanewal

Baseline Household Survey
May, 2010

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Population Council

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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.

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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 Contraception Pill
EmOC	Emergency Obstetric Care
FALAH	Family Advancement for Life and Health
FP	Family Planning
HANDS	Health and Nutrition Development Society
IEC	Information Education Communication
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 Khanewal, one of the project districts. The survey was conducted from September to November 2009 in a probability sample of 582 households in 40 clusters in Khanewal. It included interviews with 571 currently married women 15-49 years ("married women of reproductive age" or MWRA), along with 199 married men, of whom 188 were married to women included in the sample. As a separate activity, a mapping study[1] was also carried out in Khanewal during the period between May and August, 2009. Selected data from that study are included in this report, although a separate report is also available. The FALAH project is primarily focused on birth spacing and family planning.

Household and Respondent Characteristics

Khanewal, a district in Punjab, is primarily a rural district. According to the Pakistan National Human Development Report 2003, Khanewal stood 34th among 91 districts of Pakistan on the Human Development Index. The characteristics of our sample are generally similar to those found in other surveys; some key indicators are given in Table A.

Table A: Selected key district characteristics from Khanewal household survey

Variable	Value
Percentage of households in rural areas	83.0
Percentage of households with electricity	94.0
Percentage of households with indoor water supply	92.3
Percentage of households with flush toilet	69.1
Percentage of households with television	47.1
Percentage of literate female respondents	39.9
Percentage of respondents with literate husbands	72.9
Total fertility rate	3.8

Electrification is complete in 94 percent of the sample households, and ownership of appliances that require electricity was as: televisions (47percent), refrigerators and washing machines (32 percent for each). Majority of the households (92 percent) had some

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

indoor water supply, and 69 percent of the households had a flush toilet. However, 27 percent of the households use fields as they do not have any toilet facility. A good number of women were working for wages.(43 percent) Female literacy was relatively low: 40 percent of the females were literate. However, 73 percent of their husbands were literate. Thirty-seven percent of the respondents said they watched TV, 18 percent listened to the radio and 11 percent read newspapers or magazines. Most women who heard of any FP message heard it on television.

Service Availability

There was a wide range of health and reproductive health facilities in Khanewal district. Of the 4568 facilities in the district, 1792 were public while 2776 were in the private sector. These health facilities included health houses of Lady Health Workers and were widely scattered around the district, so the simple services such as antenatal check-ups, iron tablets for anemia, and non-clinical contraceptive methods were readily available in both public and private sectors. However, access to services requiring specialized care was difficult. For example, there were 76 facilities –5 public, 71 private – which were able to offer Caesarean section deliveries. There were 40 facilities which were able to provide female sterilization and 11 facilities for male sterilization.

Fertility

The crude birth rate was 29 per thousand population, and the total fertility rate was 3.8 children per woman. Fertility was higher for illiterate women and wives of illiterate men and in households with a lower standard of living. This was also observed higher in rural areas. Many births were spaced too closely. For example, 71 percent of birth intervals were less than 36 months. Among those who already had two living children under 5 years of age, 12 percent were currently pregnant.

Maternal and Neonatal Care

The household survey obtained data on selected key indicators of maternal and neonatal health from 303 sampled women who had delivered a child during the previous four years. Of these women, 74 percent had visited a health provider at least once for antenatal care; 60 percent had two or more tetanus toxoid immunizations; 43 percent were delivered by a skilled birth attendant; and 42 percent were delivered in a public or private health facility. On the other hand, 44 percent had at least one postnatal check-up, which has negative

implications for family planning as well as for maternal and neonatal health. 52 percent reported to be currently breastfeeding their last child; 15 percent of mothers reported breastfeeding their last child for at least 6 months without supplementation.

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

Indicator	Value
Percentage of mothers with at least one antenatal care visit	73.9
Percentage of mothers with at least two tetanus shots	60.1
Percentage of most recent deliveries conducted by a skilled birth attendant	42.9
Percentage of most recent deliveries in a facility	41.6
Percentage of MWRA not wanting more children	53.6
Percentage of MWRA wanting to delay next birth for at least two years	22.2
Percentage of MWRA knowing at least one contraceptive method	100.0
Contraceptive prevalence rate	34.0
Percentage of MWRA who are past users of contraception	24.7
Percentage of MWRA with unmet need for family planning	27.0
Percentage of MWRA with unmet need for spacing	10.3
Percentage of MWRA with unmet need for limiting	16.6
Total demand for family planning (CPR + unmet need)	60.9

Preference for Children

The median "ideal" family size according to the women respondents was 4 children. Regarding desire for more children in the future, 24 percent said they wanted another child soon (within two years), 22 percent said they wanted another child, but only after two years, and 54 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 two children. About 59 percent of the women respondents said their husband wanted the same number of children that they did, while 11 percent said their husband wanted more children 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 34 percent. The most commonly modern methods in use were: condom (7.7 percent), IUD (3.2 percent) and female sterilization (10.7 percent). Past users comprised 24.7 percent

of MWRA; condom, pills, IUD, injectables, withdrawal, and rhythm were all common past methods. Seventy-six percent of the current users did not want more children, while 24 percent wanted more, but at a later time. Most users reported obtaining their supplies and services from government facilities or their husbands obtained the supplies.

Experience with Contraceptive Methods

Stated reasons for a respondent's choice of her current or past method varied by method but commonly cited reasons included: suitability for respondent and husband, convenience of use and easy availability. Costs were generally low (only 11 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; Eighteen percent needed more than 30 minutes to reach their service. As regards provision of information at the time of acceptance of a method, a few were provided information on side effects. Clients generally reported being reasonably treated by providers, but 38 percent respondents viewed that providers were unable to deal with side effects. A variety of side effects was reported by users and past users; 48 percent were treated with medicine.

Reasons for Non-use

More than 92 percent of all users mentioned husband's possible disapproval while a great majority acknowledged fear of side effects, and the problems of managing side effects. Past users were most likely to discontinue use because they wanted more children; experience of side effects was also cited as an important reason; their reasons for current non-use were most often: rest from method, infrequent sex/husband away, breastfeeding/lactational amenorrhea, desire of another child and currently pregnant. Never users were most likely to say they were not using contraceptives for the desire of more children but women were more likely to cite fear of side effects, husband and in-laws' opposition, breastfeeding/ lactational amenorrhea and infrequent sex/husband away as significant reasons for not using contraceptives. Knowledge of at least one service provider was 46 percent among never users. A large majority of female current and past users said they could discuss family planning easily with their husbands, but 75 percent of the never users said they could do so. Twenty-five percent of the never users expressed their intent not to use contraceptives in the future, while 36 percent said they would do so. However,30 percent were unsure who might be future prospectus users.

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 the risk of conceiving but is not using any method of contraception. By this definition, 27 percent of the women in this sample were in unmet need, 16.6 percent for limiting and 10.3 percent for spacing. Unmet need for limiting was higher in urban areas, among illiterate women, and among women with lower standards of living. However, unmet need for spacing was higher among literate women and those with high standard of living.

Reproductive Preferences and Behavior of Men

The findings reveal that 86 percent of the men knew at least one modern contraceptive method. Least known contraceptive method among men was male sterilization (0.5 percent . More than 50 percent of the men did not want more children in the future and 25 percent wanted to delay the next pregnancy. Forty-four percent of the male respondents reported that they or their wives were currently using any family planning methods, and 25 percent were using modern contraceptive methods. Among the current users, 82 percent were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, 19 percent reported that they were not intending to use any FP method in the future. The main reason for not intending to sue any method was fear of side effects (80 percent).Of those who did intend to use contraceptives in the future, condom was the most preferred method. 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

The district of Khanewal is characterized by a variety of public and private reproductive health facilities. Knowledge and approval of family planning were high, and contraceptive prevalence stands at 34 percent. Therefore, there is much need for improvement; unmet need for family planning remains at 27 percent. Among the important reasons that should be addressed in an improved program are husbands' attitude, inter-spousal communication, fear of side effects, and knowledge of various contraceptive methods and their 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 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 inthe public and private sectors. FALAH is being implemented by a team of seven partner organizations: Population Council (as lead agency), Jhpiego, Greenstar Social Marketing, Save the Children (US), Mercy Corps, Health and Nutrition Development Society (HANDS), and the Rural Support Programmes Network (RSPN). FALAH is also coordinating its activities with the PAIMAN maternal and neonatal health project, especially in the PAIMAN districts, and with other projects as appropriate. In Khanewal, district level activities are being coordinated by Save the Children, US and RSPN with Greenstar providing information and service through social marketing and other partners supporting specific activities as needed.

Khanewal District

Geographically, Sahiwal and Vehari districts are on the eastern side of Khanewal, Jhang and Toba Tek Singh on its north, Multan and Muzaffarabad on its west and Lodhran and Multan districts on its south.

According to the 1998 census, the total number of lifetime in-migrants in Khanewal district were 8.2 percent of population of the district. Of total district migrants 64.2 percent came from other districts of Punjab, 2.4 percent were from Sindh , Khyber Pakhtunkhwa and Balochistan, while 33.4 percent were Pakistanis who repatriated from other countries.

According to the UNDP Pakistan National Human Development Report 2003,[2] Khanewal stood 34 th among 91 districts in Pakistan; within Punjab it stood 19 th of 26 districts (UNDP, 2003). In the Planning Commission's Millennium Development Goals Report 2006, district-level data (based on the Pakistan Social and Living Standards Measurement Survey 2004-05) were shown for various measures of education, gender equity, infant mortality, and environmental sustainability. In these comparisons, Khanewal stood 31st on literacy, 31st

[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.

on immunization, 20th on water supply and 68th on sanitation nationally (Planning Commission, Government of Pakistan, 2006).

The Khanewal Baseline Household Survey

In Khanewal (as in other FALAH project districts), Population Council conducted a baseline sampled household survey to learn about knowledge, attitude, and practices regarding fertility, reproductive health and child spacing/family planning. This represents one of two major studies to establish baseline indicators for the FALAH project. The other is a mapping exercise to compile complete, digitized maps of all facilities providing reproductive health services, including maternal health, neonatal and child health, and birth spacing/family planning. These baseline survey results will be compared with an endline survey toward the end of the project to assess progress.

Objectives

The objectives of the Khanewal Baseline Household Survey are:

- To obtain baseline measurements for those FALAH indicators that can best be measured through such surveys;
- To obtain detailed information on the knowledge, attitudes and practices of married couples of Khanewal 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, attitudes and practices of these married couples regarding family planning.

Sample Design and Size

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

Urban Sample

The required numbers of enumeration blocks were 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 then selected. The maps of these circles, obtained from the Population Census Organization, were already divided into blocks of approximately 250-300 households depending upon the number of households in each circle. One block was then randomly selected from each circle. The household listing of each randomly chosen block was carried out by the enumeration teams before selecting the sampled households. A fixed number of 15households was drawn from each sample enumeration block using systematic random sampling.

Rural Sample

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

Selection of Respondents

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

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

Table 1.1: Results of household and eligible women interview

Results	Rural	Urban	Total
Sample blocks/villages	33	7	40
Households interviewed	479	103	582
Eligible women identified	544	104	648
Eligible women not interviewed	67	9	76
Eligible women interviewed	477	95	572
Incomplete interviews	0	1	1
Total completed women's interviews	**477**	**94**	**571**

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 observations 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 of the Khanewal team was conducted by the Population Council in Islamabad. During the training, interviewers conducted 2-3 field interviews in order to prepare for the actual interview process.

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

Quality Assurance

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

Data Entry and Edit Procedures

Data processing was initiated in the field with the checking of 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 was 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 Khanewal district was carried out from 29th September to 17th November 2009.

Chapter 2

Household Characteristics

Geographic Distribution

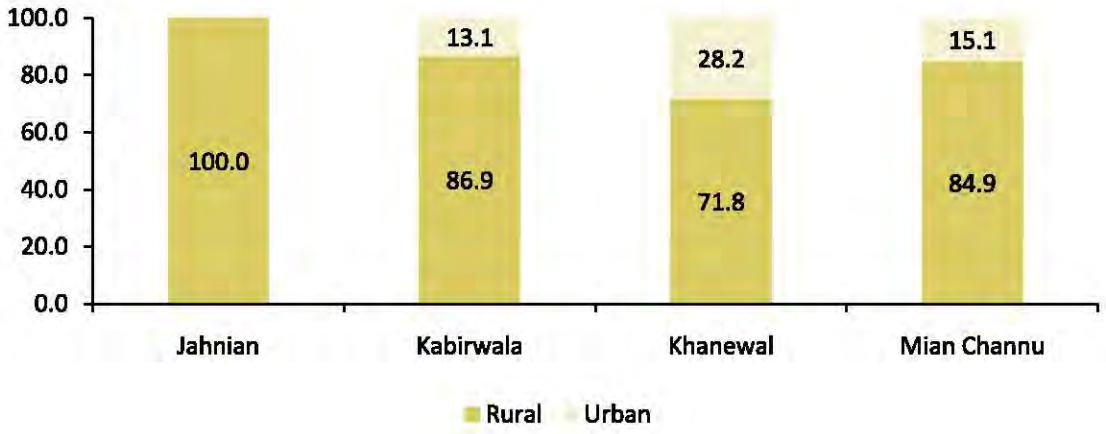
Khanewal district is divided into four tehsils: Jahanian,Kabirwala,Khanewal and Mian Channu .Jahanian is completely rural tehsil. Table 2.1 and Figure 2.1 show the distribution of the population of sample households according to residence (urban and rural) and by tehsils with comparisons to the distribution of the 1998 National Population and Housing Census.

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

	Rural			Urban			Total	
Tehsil	N	%	1998 Census %	N	%	1998 Census %	N	%
Jahanian	360	100.0	90.0	0	0.0	10.0	360	100.0
Kabirwala	1210	86.9	85.0	182	13.1	15.0	1392	100.0
Khanewal	878	71.8	72.1	345	28.2	27.9	1223	100.0
Mian Channu	983	84.9	85.6	175	15.1	14.4	1158	100.0
Total	**3431**	**83.0**	**82.4**	**702**	**17.0**	**17.6**	**4133**	**100.0**

Table 2.1 shows the distribution of the population of the 582 households in the sample by urban-rural residence and tehsils. Eighty-three percent of the sample population of Khanewal district lived in rural areas. Thirty- four percent of the sample population resided in Kabirwala tehsil, followed by 29 percent in Khanewal, 28 percent in Mian Channu and 9 percent in Jahanian.

Figure 2.1: Rural-urban distribution of population in sample households by residence and tehsil



Age-Sex Distribution

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

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

	Sex of household member		
Age group	**Male**	**Female**	**Total**
00 – 04	14.8	14.6	14.7
05 – 09	13	12.7	12.8
10 – 14	13	10.7	11.9
15 – 19	11.1	11.5	11.3
20 – 24	7.9	11.5	9.7
25 – 29	7.1	8.8	8.0
30 – 34	4.9	5.8	5.3
35 – 39	6	4.9	5.4
40 – 44	3.9	4.5	4.2
45 – 49	3.6	3.5	3.6
50 – 54	3.5	1.9	2.7
55 – 59	1.9	2.6	2.3
60 – 64	2.7	2	2.3
65 – 69	2.1	1.7	1.9
70 – 74	2.1	1.6	1.8
75 +	2.6	1.6	2.0
N	**2069**	**2964**	**4133**

The population is typical of a society with high fertility marking 15 percent children under 5 years. The median age was 19 years. Males are more from 0-14 years age group suggesting better care for male children.

Of the total population of the sample households, 25.2 percent consisted of females 15-49 years of age. These women 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 Khanewal (as in Pakistan generally), women tend to marry men older than themselves. Therefore, as Table 2.3 shows higher proportions of females at younger ages were married than males. The singulate mean age at marriage for females was 18 years. From the table, it may be observed that only a few males were married in the age group of 15-19 as compared to females. This indicates a later age-at-marriage for men and, at the same, time it also shows that an early age-at-marriage for women was common.

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

	Married		Widowed/divorced/ separated		Never married	
Age group	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
15-19	5.7	16.4	0.4	0.4	93.9	83.2
20-24	22.6	47.7	0.0	0.4	77.4	51.9
25-29	61.9	83.5	0.0	2.7	38.1	13.7
30-34	85.1	89.1	2.0	5.0	12.9	5.9
35-39	88.7	93.1	2.4	5.0	8.9	2.0
40-44	91.3	89.1	2.5	9.8	6.3	1.1
45-49	96.0	84.9	4.0	12.3	0.0	2.7
50-54	91.7	87.5	8.3	12.5	0.0	0.0
55-59	89.7	87.0	5.1	13.0	5.1	0.0
60-64	89.3	68.3	8.9	31.7	1.8	0.0
65-69	93.0	72.2	7.0	27.8	0.0	0.0
70-74	83.7	39.4	14.0	60.6	2.3	0.0
75+	66.0	36.4	32.1	63.6	1.9	0.0
All ages	**60.7**	**63.3**	**4.1**	**8.8**	**35.2**	**28.0**

Household Characteristics and Wealth Indicators

Several household characteristics were assessed that reflected the wealth and well-being of household 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 people learn 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 the 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. Majority of households (92.3 percent) had an indoor water supply, although in 2 percent of the households this consisted of an inside Govt. supply. Sixty-nine percent of the households had flush toilets. However, the number was very low for pit latrines. A considerable number of households (27 percent) were using fields as toilets. As a whole, a large majority of households used firewood for cooking (73 percent) but the majority of these were rural households (86 percent) while on the other hand 86 percent urban households were using natural gas. Almost all households in urban areas (98 percent) enjoyed electricity while this was available to 93 percent rural households. Most houses were roofed with Guarder or T-iron sheets (78 percent) while 65 percent of the walls were made of burnt bricks or blocks.

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

Characteristic	Rural	Urban	Total
Main source of drinking water			
Govt. supply (tap water inside)	0.6	8.7	2.1
Govt. supply (communal)	0.4	6.8	1.5
Motorized/Hand pump (inside)	92.1	81.6	90.2
Motorized/Hand pump (outside)	6.1	1.0	5.2
Others	0.8	1.9	1.0
Sanitation facility			
Flush to sewerage	1.3	8.7	2.6
Flush connected to septic tank	56.8	42.7	54.3
Flush connected to open drain	5.4	43.7	12.2
Pit latrine	3.8	1.9	3.4
In fields	31.9	1.9	26.6
Others	0.8	1.0	0.9
Main type of fuel used for cooking			
Fire wood	85.6	11.7	72.5
Gas cylinder	2.3	1.0	2.1
Natural gas (Sui gas)	7.9	86.4	21.8
Dry dung	3.8	0.0	3.1
Others	0.4	1.0	0.5
Electrical connection			
Yes	93.1	98.1	94.0
No	6.9	1.9	6.0
Main material of roof			
Concrete	1.7	17.5	4.5
Guarder and T-iron	77.7	77.7	77.7
Wood/Bamboo and mud	19.6	2.9	16.7
Others	1.0	1.9	1.2
Main material of floor			
Earth/Sand/Mud	62.0	16.5	54.0
Chips	2.1	16.5	4.6
Marble	0.8	2.9	1.2
Cement	20.9	40.8	24.4
Bricks	13.2	20.4	14.4
Others	1.0	2.9	1.4
Main material of walls			
Burnt bricks/Blocks	58.5	93.2	64.6
Mud bricks/Mud	41.1	5.8	34.9
Others	0.4	1.0	0.5
N	**479**	**103**	**582**

Figure 2.2: Distribution of water supply for Khanewal households

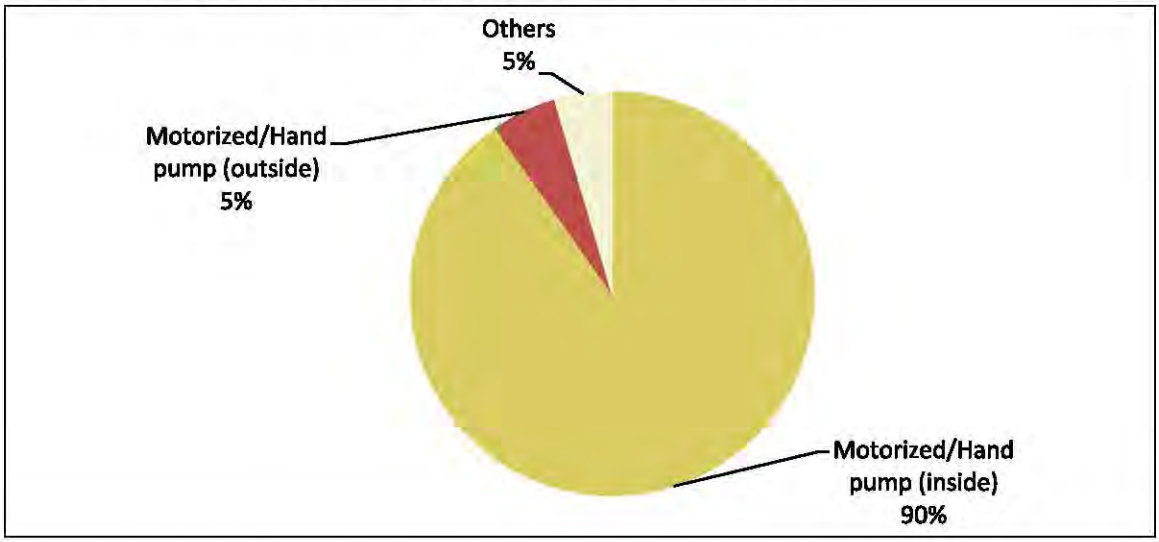
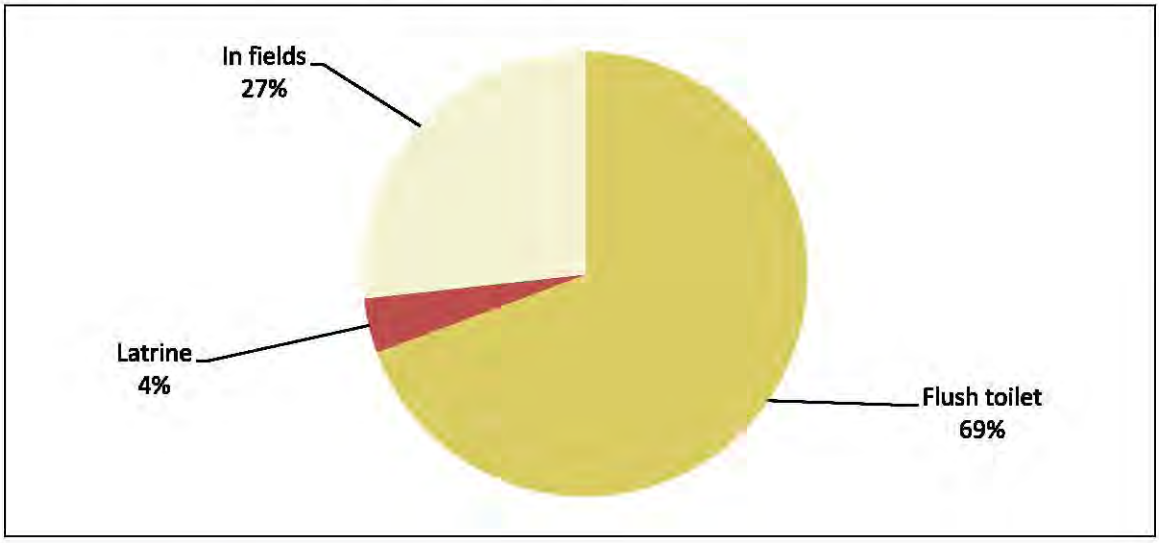


Figure 2.3: Toilet facilities for Khanewal households



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. These 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, vehicles to

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

Several items requiring electricity were available in a substantial proportion of households, even in rural areas. Forty-seven percent of all households had television sets and 33 percent had a radio/tape recorder, a figure of particular interest to communication specialists. The recent expansion of information technology in Pakistan is reflected by the ownership of mobile phones by 78 percent of all households. Motorized transport (four wheels), however, remained fairly uncommon suggesting difficulties in arranging for transport in health emergencies.

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

Household item	Rural	Urban	Total
Wall clock	75.2	86.4	77.1
Chairs	62.4	62.1	62.4
Bed	53.2	79.6	57.9
Sofa	20.7	43.7	24.7
Sewing machine	62.4	73.8	64.4
Camera	9.2	14.6	10.1
Radio/Tape recorder	33.6	32.0	33.3
Television	41.8	71.8	47.1
Refrigerator	28.6	47.6	32.0
Land line telephone	2.1	10.7	3.6
Mobile phone	76.6	81.6	77.5
Room cooler/ Air conditioner	7.3	29.1	11.2
Washing machine	24.8	65.0	32.0
Bicycle	67.2	54.4	64.9
Motor cycle	25.7	18.4	24.4
Jeep/Car	2.3	1.0	2.1
Tractor	7.3	0.0	6.0
Computer	2.3	11.7	4.0
No. of observations	**479**	**103**	**582**

Standard of Living Index

It is useful to use the above data 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), which was developed for international comparisons with data from the Demographic and Health Surveys. 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 5 while for rural and urban households it was 5 and 7 respectively. About 76 percent of all households fell in the range of 3 to 8. This index will be used later in this report to examine differences in knowledge and behavior regarding reproductive health.

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	17	3.5	0	0.0	17	2.9
2	59	12.3	0	0.0	59	10.1
3	65	13.6	5	4.9	70	12.0
4	66	13.8	5	4.9	71	12.2
5	81	16.9	12	11.7	93	16.0
6	62	12.9	22	21.4	84	14.4
7	47	9.8	24	23.3	71	12.2
8	39	8.1	16	15.5	55	9.5
9	37	7.7	14	13.6	51	8.8
10	6	1.3	4	3.9	10	1.7
11	0	0.0	1	1.0	1	0.2
Total	**479**	**100.0**	**103**	**100.0**	**582**	**100.0**
Median	**5**	**na**	**7**	**na**	**5**	**na**

na=not applicable

Chapter 3

Respondent Characteristics

The primary source of data from the Household Survey is the interviews conducted with 571 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 of the younger women were not married as yet, the numbers at age 15-19 were relatively small. At older ages the numbers declined which may be attributed to the possibility of being widowed after the age of 40. Forty three percent of the sample women were under age 30.

Table 3.1: Age distribution of female respondents by residence

	Rural		Urban		Total	
Age group	**N**	**%**	**N**	**%**	**N**	**%**
15 – 19	20	4.2	5	5.3	25	4.4
20 – 24	84	17.6	7	7.4	91	15.9
25 – 29	105	22.0	24	25.5	129	22.6
30 – 34	86	18.0	17	18.1	103	18.0
35 – 39	71	14.9	19	20.2	90	15.8
40 – 44	59	12.4	16	17.0	75	13.1
45 – 49	52	10.9	6	6.4	58	10.2
Total	**477**	**100.0**	**94**	**100.0**	**571**	**100.0**

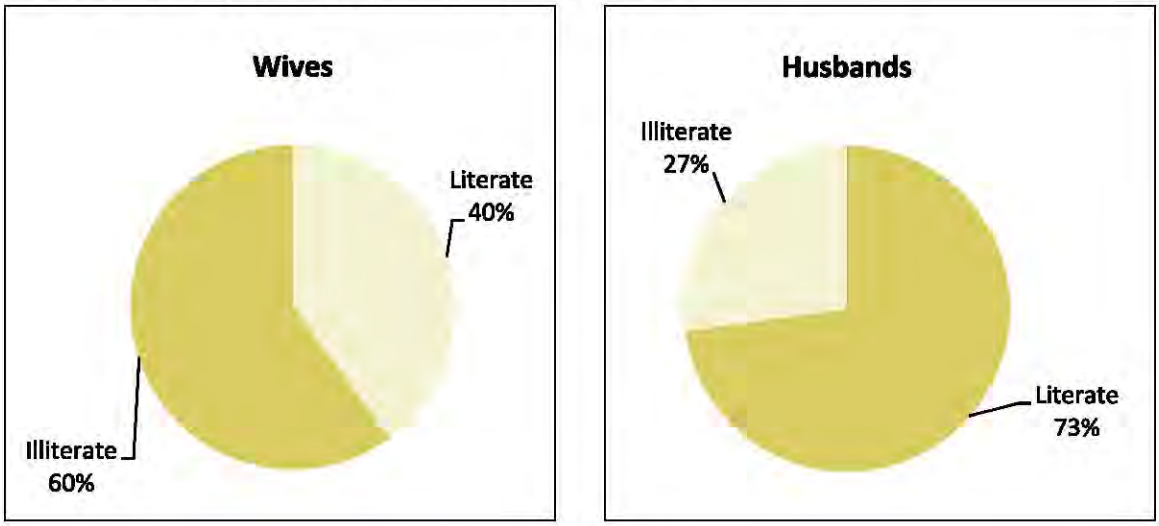
Education and Literacy

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 female literacy was 40 percent while husbands' literacy was marked as 73 percent. Similarly, about 42 percent of female respondents report having ever attended school while this percentage for husbands was 75. A higher proportion of urban women were literate when c ompared to rural women. For women respondents, education levels as expected were also higher in urban areas. Table 3.2 also shows that younger women aged 15-24 years and 25-34 years were significantly more literate than older women aged 35-49 years.

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	50.9	47.0	26.9	33.8	71.3	39.9
Education level						
No education	44.8	48.7	75.3	63.5	31.9	58.3
Up to primary	27.6	22.8	11.7	18.9	22.3	19.4
Up to Secondary	23.3	19.4	9.9	13.0	34.0	16.5
Above secondary	4.3	9.1	3.1	4.6	11.7	5.8
N	**116**	**232**	**223**	**477**	**94**	**571**
Respondent's husband						
Proportion literate	75.0	79.3	65.0	71.3	80.9	72.9
Education level						
No education	19.8	19.0	34.5	26.8	17.0	25.2
Up to primary	25.0	15.9	18.4	19.9	12.8	18.7
Up to Secondary	46.6	46.6	36.3	42.1	44.7	42.6
Above secondary	6.0	17.7	9.4	10.3	21.3	12.1
Don't know	2.6	0.9	1.3	0.8	4.3	1.4
N	**116**	**232**	**223**	**477**	**94**	**571**

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. Women's work, whether for necessary income or for career fulfillment, is likely to compete, at least to some degree, with time spent on household management and child care. Therefore, it is worthwhile to examine men and women's work separately. A good number of female respondents i.e 248 out of 571 (43 percent) reported working for wages; their occupations are shown in Figure 3.2.

Figure 3.2: Type of work of women working for pay (N=248)

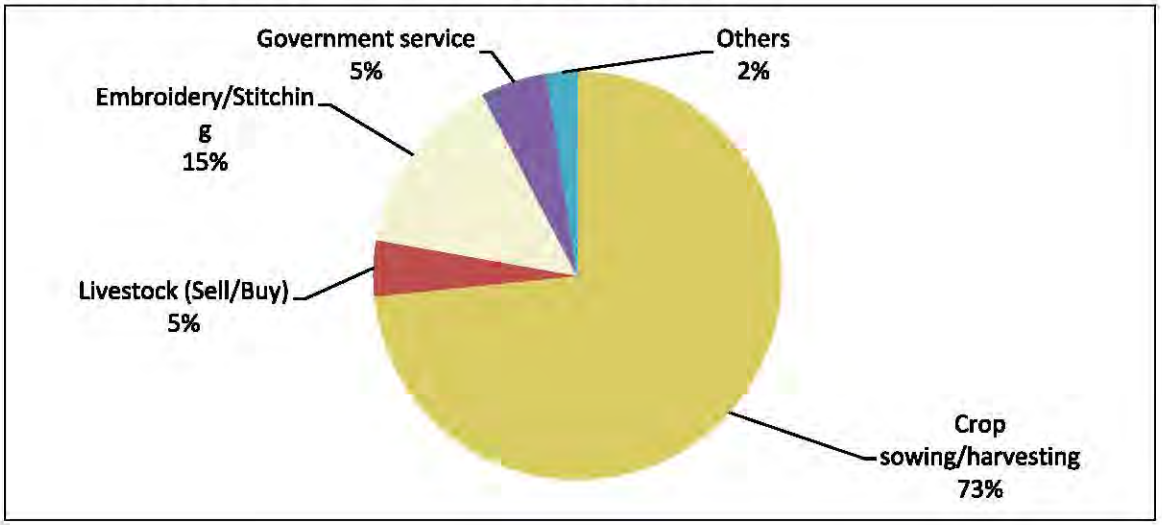


Table 3.3: Distribution of occupational categories of respondents' husbands by residence

Economic activity/occupation	Rural	Urban	Total
Agriculture/Livestock/Poultry	38.2	3.2	32.4
Petty trader	9.4	22.3	11.6
Labor (Daily wages)	14.0	9.6	13.3
Government service	9.9	10.6	10.0
Private service	8.6	14.9	9.6
Own business	5.2	19.1	7.5
Abroad	1.3	2.1	1.4
Unemployed	4.6	3.2	4.4
Skilled worker	5.9	11.7	6.8
Others	2.9	3.2	3.0
N	**477**	**94**	**571**

Table 3.3 shows that majority of the husbands of the women (32 percent) worked in agriculture/livestock/poultry. The 2nd largest occupation was labor (daily wages) which had engaged 13 percent of the husbands. About 10 percent were in government service. Four percent of the husbands of the respondents 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 (Table 3.4). Only a few women reported being able to go to any of the places named without permission. On the other hand it is interesting to know that only 4 percent of the women reported not being able to go at all to the market. However, this number is very low for health center, and near to two-third could go there with someone. For each of the named destinations, a good number said they could go with someone.

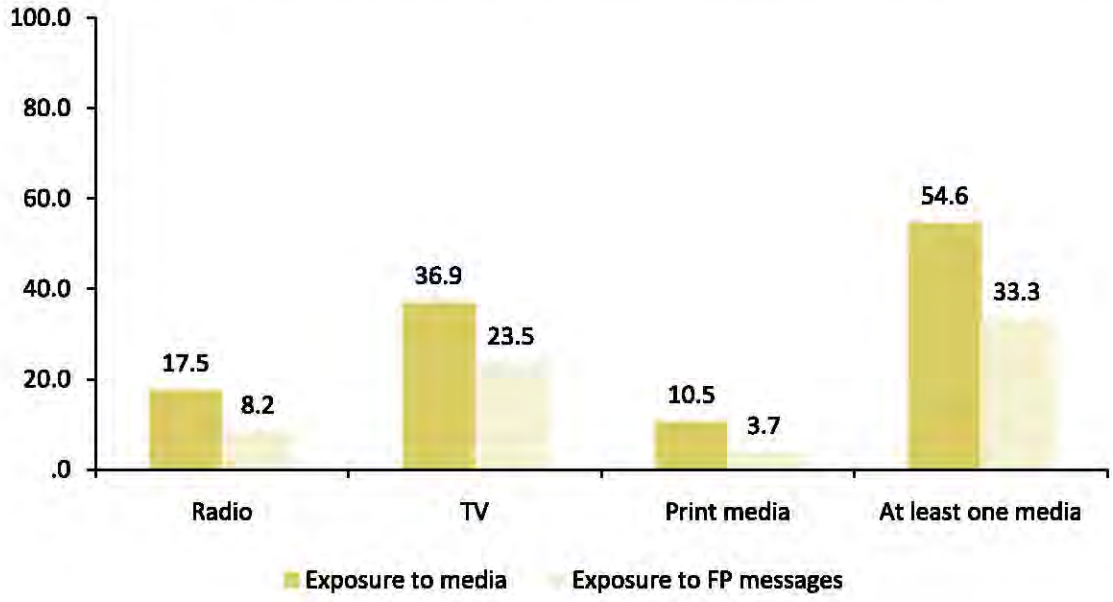
Table 3.4: Women's reports regarding mobility outside the home by degree of permission and destination

Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Can't go/ Doesn't go	%	N
Market	18.0	23.6	54.5	3.9	100.0	571
Health center	14.9	21.0	63.4	0.7	100.0	571
Relatives/friends	16.3	29.6	53.2	0.9	100.0	571
Out of village/ town	7.0	19.1	71.5	2.5	100.0	571

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 shows that 47 percent of households owned a television, while 33 percent owned a radio/tape recorder. Figure 3.3 shows the proportion of women who reported that they watched TV, listened to the radio, or read newspapers or magazines. Television was the most commonly used medium (37 percent), while radio and print media were less common (18 percent and 11 percent respectively).

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



Furthermore, women who reported access to any sort of media were asked if they had ever seen/ heard or read any message about methods of family planning through these mediums. Most women said that they had seen family planning messages on the television (24 percent), 8 percent had heard them on radio and only 4 percent of the women reported reading messages from print materials.

Chapter 4

Service Availability

Health status and practices in a district can only be understood in the context of the health facilities and trained personnel available to the population of that district. As a companion activity to the Khanewal Household Survey, the FALAH project undertook a mapping of health and reproductive health services study in the FALAH districts. The fieldwork in Khanewal was carried out from May to August, 2009. In this survey, all public and private facilities and providers for reproductive health, including family planning as well as maternal health, were identified and visited. Exact locations of these facilities were determined by using the global positioning system (GPS) device and the characteristics and activities of the facility and its staff were examined. The full results of this study are presented in a separate report titled "Mapping Survey of Health and Reproductive Health Services Khanewal district". In this section, some basic results are provided to give a rough context in which the knowledge, attitudes and behavior of the women of the household survey sample can be understood.

These results represent a range of maternal and reproductive health services being provided in Khanewal. The following tables summarize those findings, and are illustrated by maps indicating the location of various types of providers and facilities.

District Data

There are a total of 4568 health facilities in Khanewal district, of which 1792 are public and 2776 are from the private sector (75 – Greenstar Social Marketing; 2701 from other private facilities). Some facilities provide only limited care, such as the LHW's health house in the public sector, and dispensaries and traditional practitioners in the private sector.

Reproductive Health Facilities

The distribution of reproductive health facilities in the public and private sectors per union council is shown in maps 4.1 to 4.3. Map 4.1 shows the distribution of government static facilities by union council population density. Map 4.2 shows the availability of LHWs. Of total, 71 union councils have 10 to 20 LHWs, 9 union councils have less than 10 LHWs, while 20 union councils have more than 20 LHWs. On average there are 16 LHWs per union council. Map 4.3 shows the distribution of private facilities in the district. The gross density of reproductive health facilities, that is the number of facilities per union council, is shown in map 4.4. The variation is considerable; there are 70 union councils with more than 40 reproductive health facilities. Reproductive health services are available district wide, with an average of 48 facilities per union council.

Family Planning Facilities:

Overall, family planning services are available in half of the facilities in Khanewal district. The availability of clinical methods except injectables and IUD is almost non-existent. Injectables are available in less than half of the facilities in the district. Though, IUD is generally less available, most of the public static facilities are providing this service. Moreover, Norplant is available at only two public facilities and female and male sterilization services are also poorly available. In contrast, non clinical methods particularly condoms and pills are available at about half of the facilities; ECP (Emergency Contraceptive Pills) is the only least available non-clinical method. Overall, there are 84 MWRA per facility in terms of family planning services. There are 172 MWRA per facility for pills and 167 MWRA for condom, which reflects the contribution of LHWs.

Table 4.1: Number and proportion of facilities providing specified family planning services in Khanewal district, by sector and MWRA per facility

	Sector										
	Government		LHWs		Private GSM		Private others		Total		MWRA per facility
Service	N	%	N	%	N	%	N	%	N	%	
Injectables	149	84.7	1320	81.7	60	80.0	348	12.9	1877	41.1	204
IUD/Copper T	142	80.7	na	na	53	70.7	102	3.8	297	6.5	1288
Norplant	2	1.1	na	na	0	0.0	0	0.0	2	0.0	191231
Female sterilization	10	5.7	na	na	12	16.0	18	0.7	40	0.9	9562
Male sterilization	4	2.3	na	na	1	1.3	6	0.2	11	0.2	34769
Condom	148	84.1	1611	99.7	61	81.3	471	17.4	2291	50.2	167
Pills	148	84.1	1610	99.6	63	84.0	399	14.8	2220	48.6	172
ECP	5	2.8	0	0.0	18	24.0	16	0.6	39	0.9	9807
Any FP method	150	85.2	1611	99.7	66	88.0		19.9	2365	51.8	162
Any clinical method	149	84.7	1320	81.7	65	86.7	371	13.7	1905	41.7	201
Any non-clinical method	148	84.1	1611	99.7	64	85.3	493	18.3	2316	50.7	165
Total facilities	**176**	**100.0**	**1616**	**100.0**	**75**	**100.0**	**2701**	**100.0**	**4568**	**100.0**	**84**

Note: Multiple responses possible.
Clinical method include; injectables, IUDs, Norplant, female sterilization and male sterilization
na= not applicable

The geographic distribution of these services is as important as the number. Maps 4.5 to 4.7 show the availability of female sterilization, IUDs, and injectables, as illustrations. Female sterilization is available in 18 union councils from both public and private sectors. Availability of IUDs is more widespread 95 union councils are providing this service. Injectables are readily available in the district.

Maternal Health Facilities:

Provision of maternal health care services is a prerequisite of reproductive health care. Facilities available in Khanewal district to provide maternal health care are shown in Table 4.2. Anemia treatment is the most frequently available service in both public and private facilities. Service availability regarding antenatal check-ups and tetanus protection is higher in the public sector as compared to the private sector. Normal delivery services are available in 297 facilities and Caesarean Section services are available in 76 facilities; with the services provided predominantly in the private sector.

Table 4.2: Number and proportion of facilities providing specified maternal health care services in Khanewal district, by sector and MWRA per facility

	Sector										
	Government		LHWs		Private GSM		Private others		Total		MWRA per facility
Service	N	%	N	%	N	%	N	%	N	%	
Antenatal check-up	166	94.3	1606	99.4	58	77.3	290	10.7	2120	46.4	180
Anemia treatment	163	92.6	1615	99.9	71	94.7	1960	72.6	3809	83.4	100
TT injection	116	65.9	1598	98.9	37	49.3	107	4.0	1858	40.7	206
Normal delivery	97	55.1	na	na	57	76.0	143	5.5	297	6.5	1288
Caesarean section	5	2.8	na	na	22	29.3	49	1.8	76	1.7	5032
Total facilities	**176**	**100.0**	**1616**	**100.0**	**75**	**100.0**	**2701**	**100.0**	**4568**	**100.0**	**84**

Note: Multiple responses possible.
na= not applicable

Along with the number of facilities, their geographic distribution is of critical importance. Maps 4.8 and 4.9 show essential and comprehensive EmOC services in Khanewal district. There are 5 union councils with no basic obstetric facilities. Map 4.9 shows that comprehensive EmOC services which are available in 28 facilities of 20 union councils of the district, both in public and private sectors.

Service Providers:

The number of providers of different cadres is shown in table 4.3. There are a total of 483 MBBS doctors active in Khanewal district among those 401 are male and 82 are female MBBS doctors. The number of female paramedics (including LHVs and Nurses) is considerably higher comparative to male paramedics. A large number of paramedics in general and female paramedics in particular are employed by the private sector.

The number of married women of reproductive age per service provider is shown in Table 4.3. Overall, there are 792 MWRA per MBBS physician; however, since most women prefer female providers for their reproductive health needs, there are 4664 MWRA per female MBBS physician. For female paramedics the situation is somewhat better and there are 785 MWRA per female paramedic. Though a considerable number of nurses and LHVs are available to cater women's health needs, the cadres of medical assistants and medical/ health technicians are almost non-existent. Map 4.10 shows the availability of MBBS doctors by gender in each union council. Male doctors are not available in 12 union councils, while in 78 union councils there is no female MBBS doctor.

Table 4.3: Number of reproductive health care providers in Khanewal district, by sector and category, and MWRA per service provider

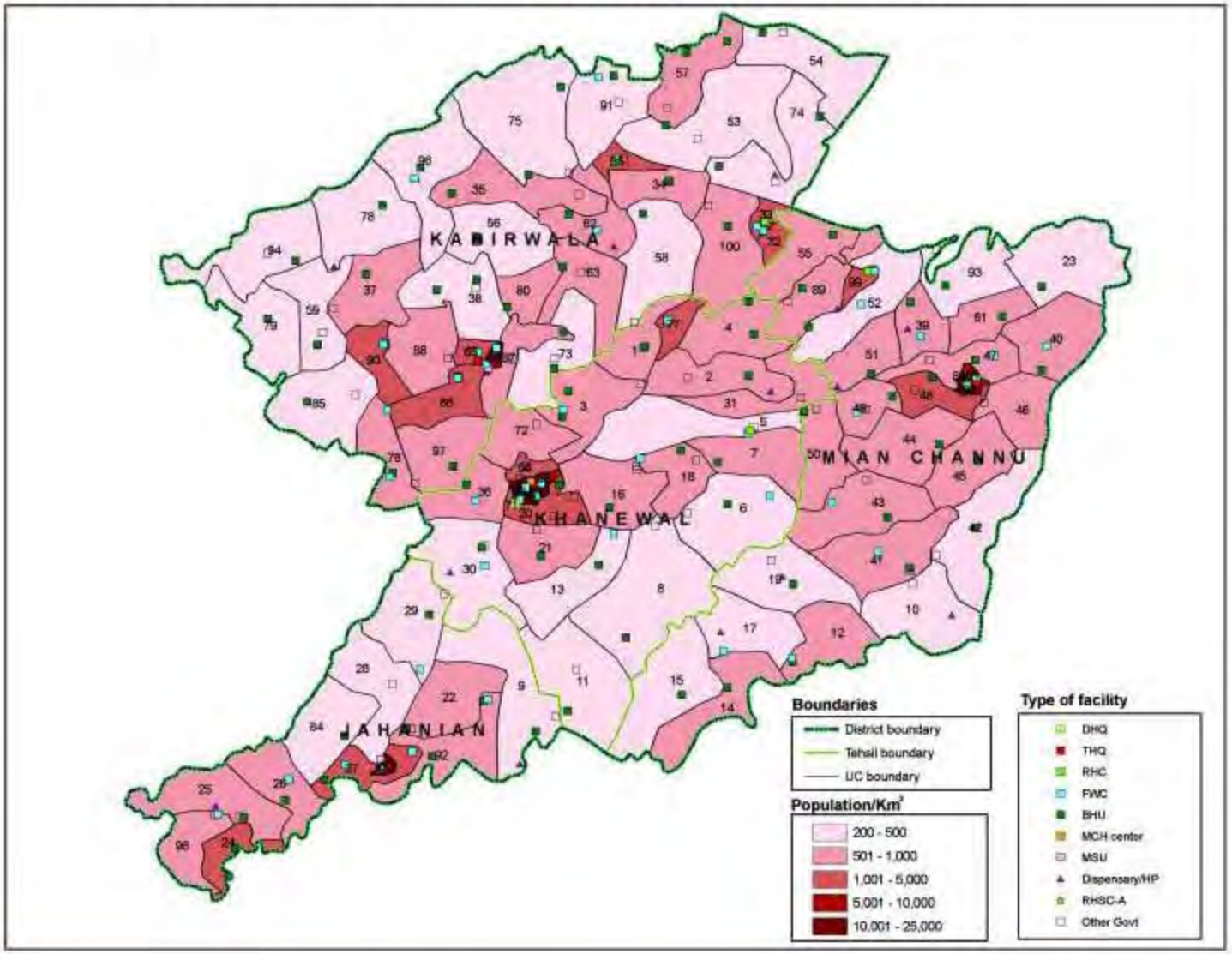
Provider	Sector								MWRA per provider
	Government		Private GSM		Private others		Total		
	N	%	N	%	N	%	N	%	
Doctors (MBBS)									
Male	124	82.1	28	58.3	249	87.7	401	8.3	954
Female	27	17.9	20	41.7	35	12.3	82	17.0	4664
Total	**151**	**100.0**	**48**	**100.0**	**284**	**100.0**	**483**	**100.0**	**792**
Female paramedics									
Medical assistant	0	0.0	0	0.0	3	1.4	3	0.6	127487
Nurse	74	39.4	45	54.9	117	53.9	236	48.5	1621
Medical/ health technician	5	2.7	1	1.2	4	1.8	10	2.1	38246
Lady health visitor	109	58.0	36	43.9	93	42.9	238	48.9	1607
Total	**188**	**100.0**	**82**	**100.0**	**217**	**100.0**	**487**	**100.0**	**785**
Male paramedics	**52**	**100.0**	**14**	**100.0**	**119**	**100.0**	**185**	**100.0**	**2067**

MWRA; married women of reproductive age

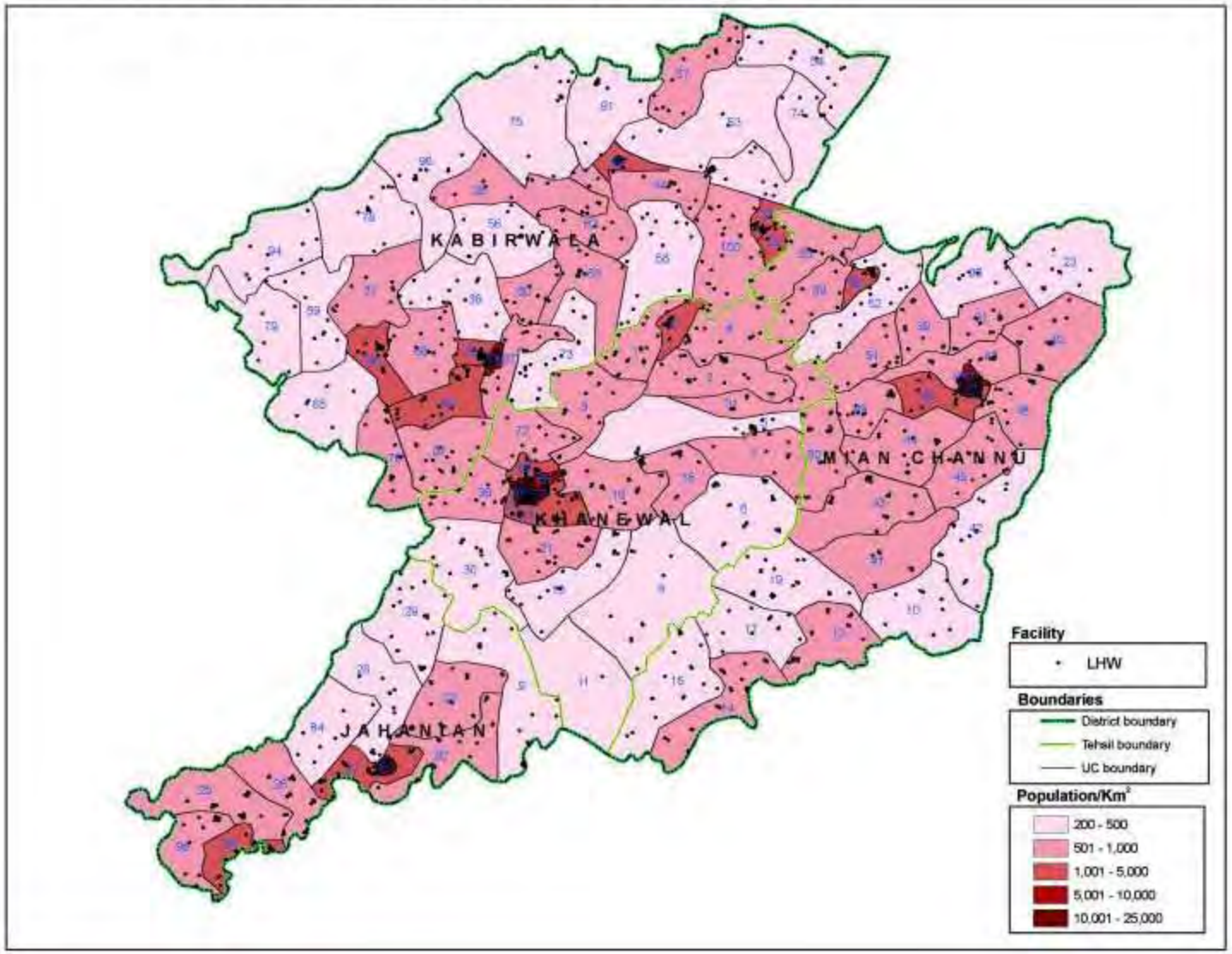
List of Union Councils

1	004/A.H (Abdul Hakim)	26	139/10-R	51	Chak No 7/8 AR	76	Mahni Sial
2	007/9-R	27	140/10-R	52	Chogatta Punjuana	77	Makhdoom Pur Pahoran
3	012/A-H	28	149/10-R	53	Dadoana	78	Mamdal
4	014/8-R	29	157/10-R	54	Dharkhana	79	Mankot
5	019/9-R	30	171/10-R	55	Ghaus Pur	80	Mari Sahu
6	030/10-R	31	4/8-AR	56	Hashmat Merali	81	Mian Channu-I
7	036/10-R	32	Abdul Hakim-I	57	Haveli Koranga	82	Mian Channu-II
8	043/10-R	33	Abdul Hakim-II	58	Hussain Abad-I	83	Mian Channu-III
9	055/10-R	34	Bagar Sargana	59	Ibrahimpur	84	Mian Pur
10	057/15-L	35	Baqarpur	60	Jahanian	85	Mongan Wala
11	058/10-R	36	Bhiru Wal	61	Jarahi	86	Mula Pur
12	061-A/15-L	37	Chak Hyderabad	62	Jasso Kanwen	87	Nabi Pur
13	070/10-R	38	Chak Naurang Shah	63	Jodhpur	88	Narhal
14	072/073/15-L	39	Chak No 014/8-AR	64	Kabirwala-I	89	Nuri Suhang
15	074/15-L	40	Chak No 044/15-L	65	Kabirwala-II	90	Okanwala
16	076/10-R	41	Chak No 092/15-L	66	Khanewal-I	91	Qatalpur
17	078/15-L	42	Chak No 093/15-L	67	Khanewal-II	92	Rahim Shah
18	080/10-R	43	Chak No 100/15-L	68	Khanewal-III	93	Rotla
19	084/15-L	44	Chak No 115/15-L	69	Khanewal-IV	94	Salar Wahan Nau
20	088/10-R	45	Chak No 124/15-L	70	Khanewal-V	95	Sarai Sidhu
21	092/10-R	46	Chak No 126/15-L	71	Khanewal-VI	96	Sardar Pur
22	106/10-R	47	Chak No 129/15-L	72	Khanewal Kohna	97	Sham Kot
23	123/7-ER	48	Chak No 131/15-L	73	Kot Bahadar	98	Thatta Sadiq Abad
24	127/10-R	49	Chak No 134/16-L	74	Kot Islam	99	Tulamba
25	136/10-R	50	Chak No 137/16-L	75	Kund Sargana	100	Umeed Garh

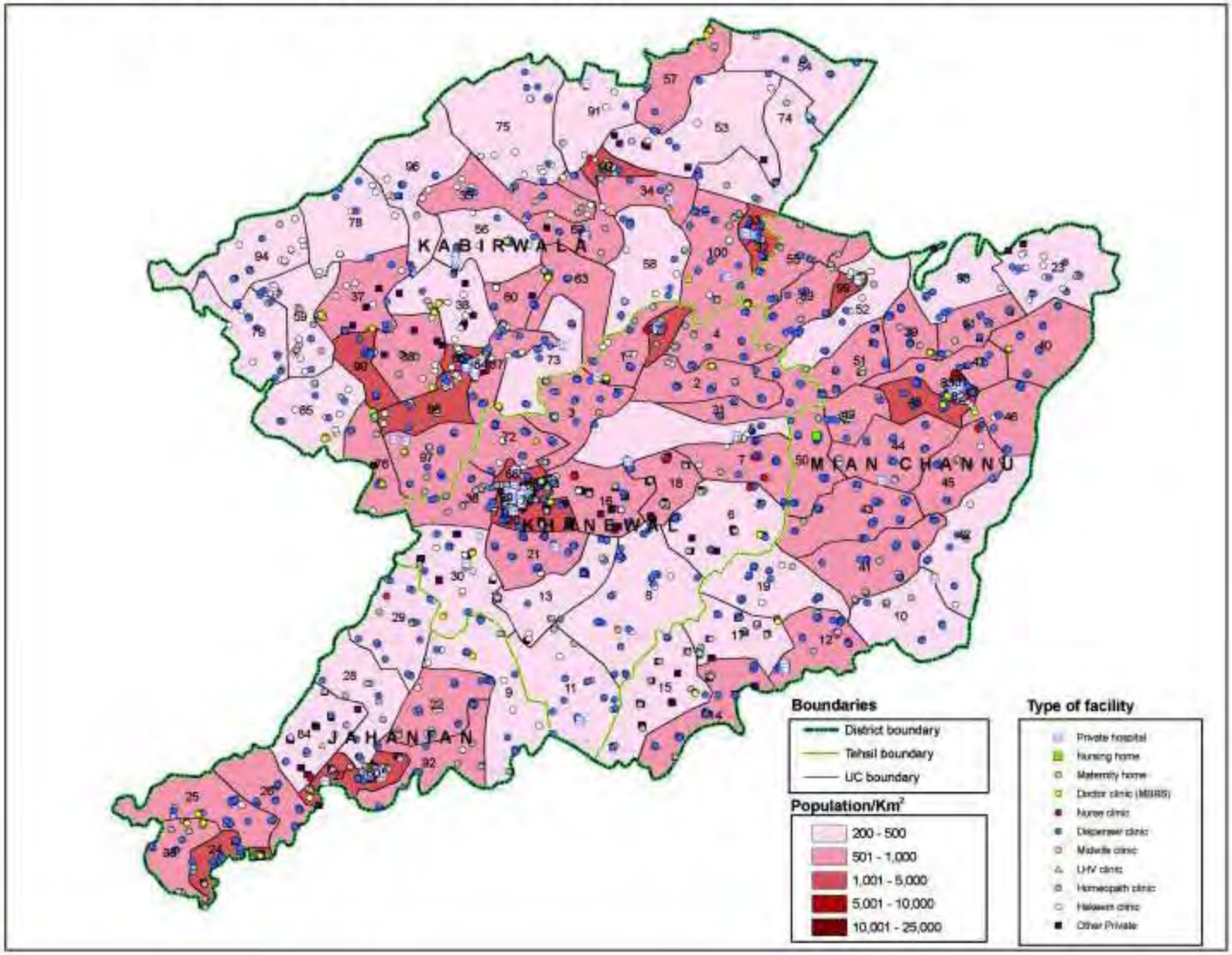
Map 4.1: Location of government facilities in Khanewal district, by population density of union council



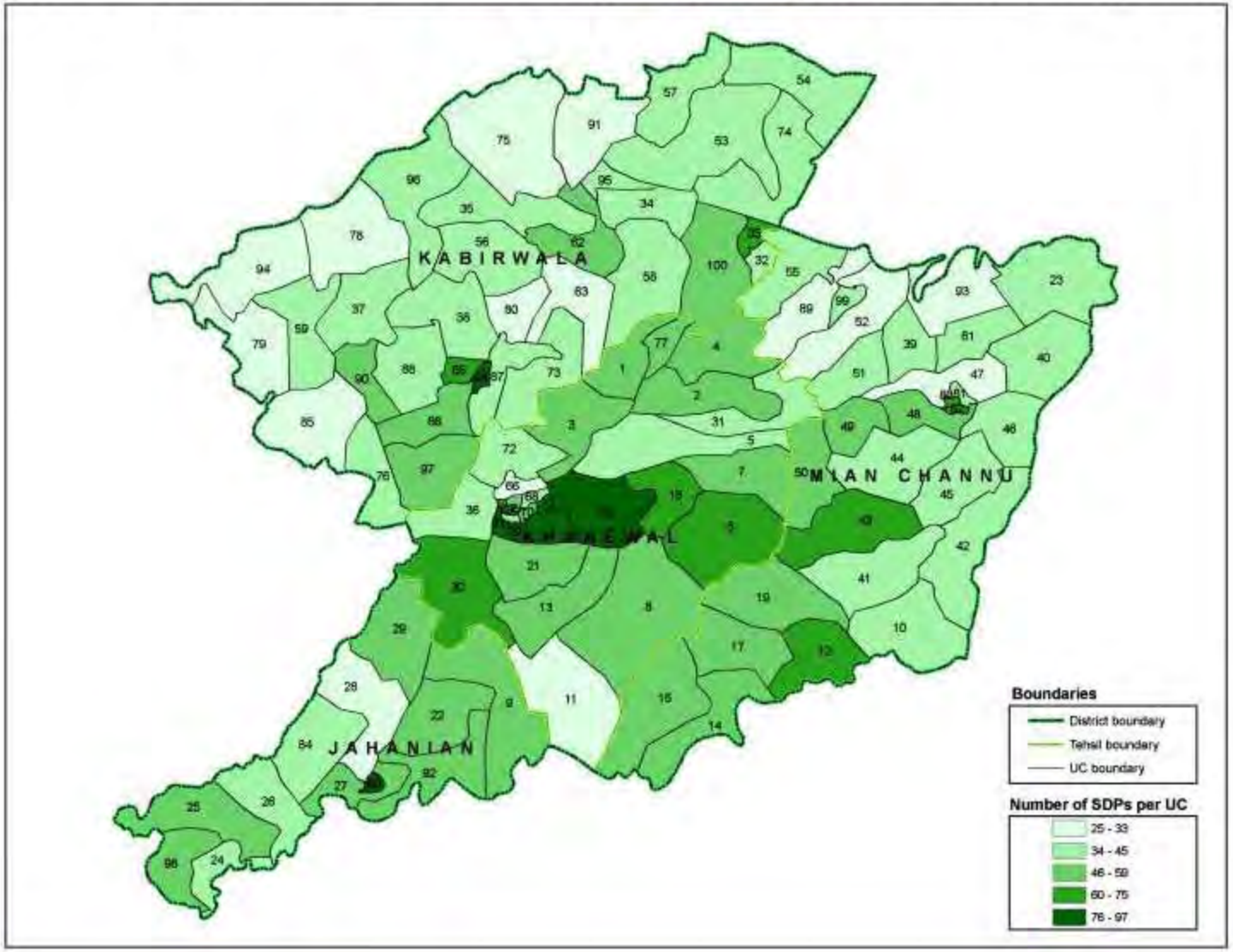
Map 4.2: Location of LHWs in Khanewal district, by population density of union council



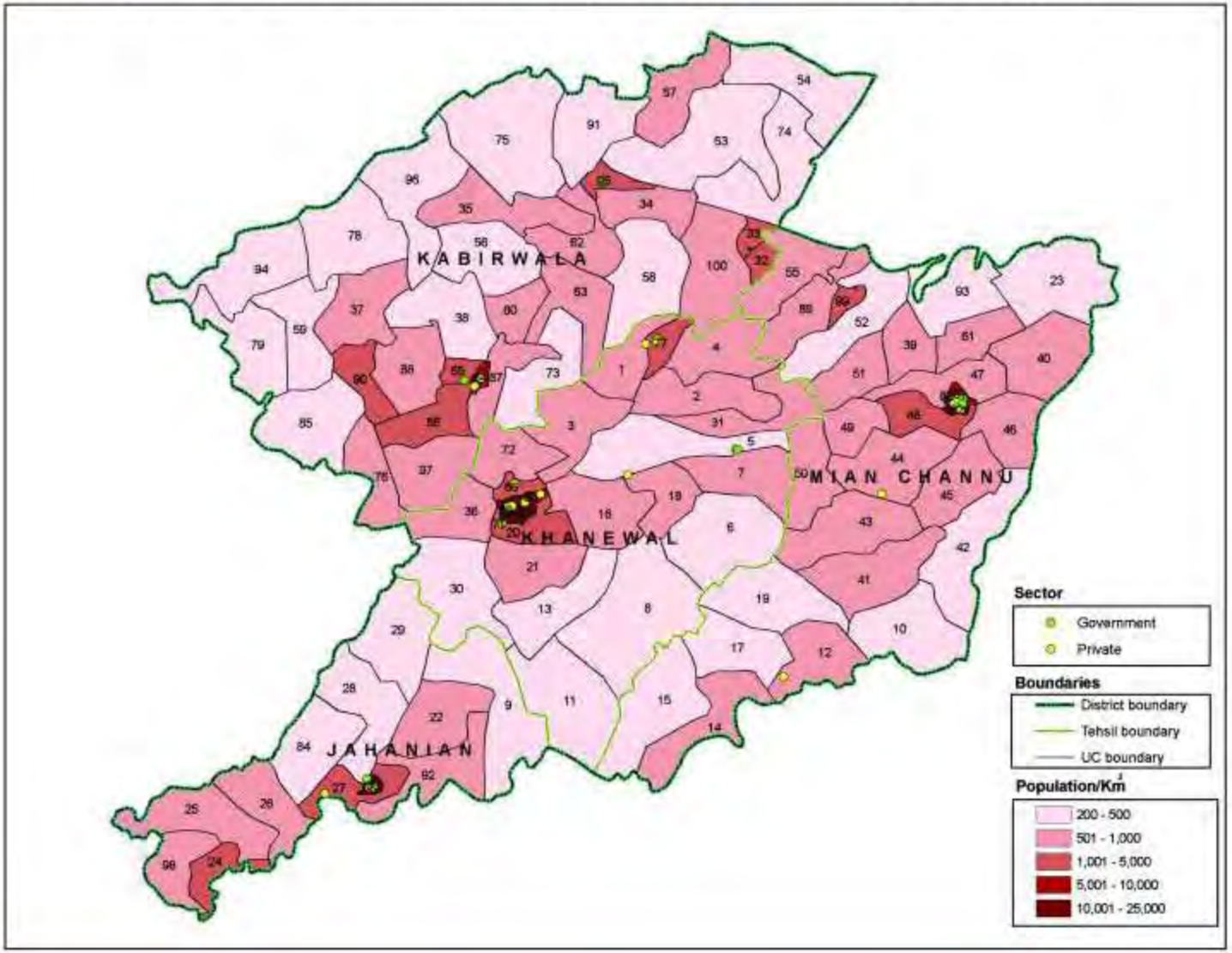
Map 4.3: Location of private facilities in Khanewal district, by population density of union council



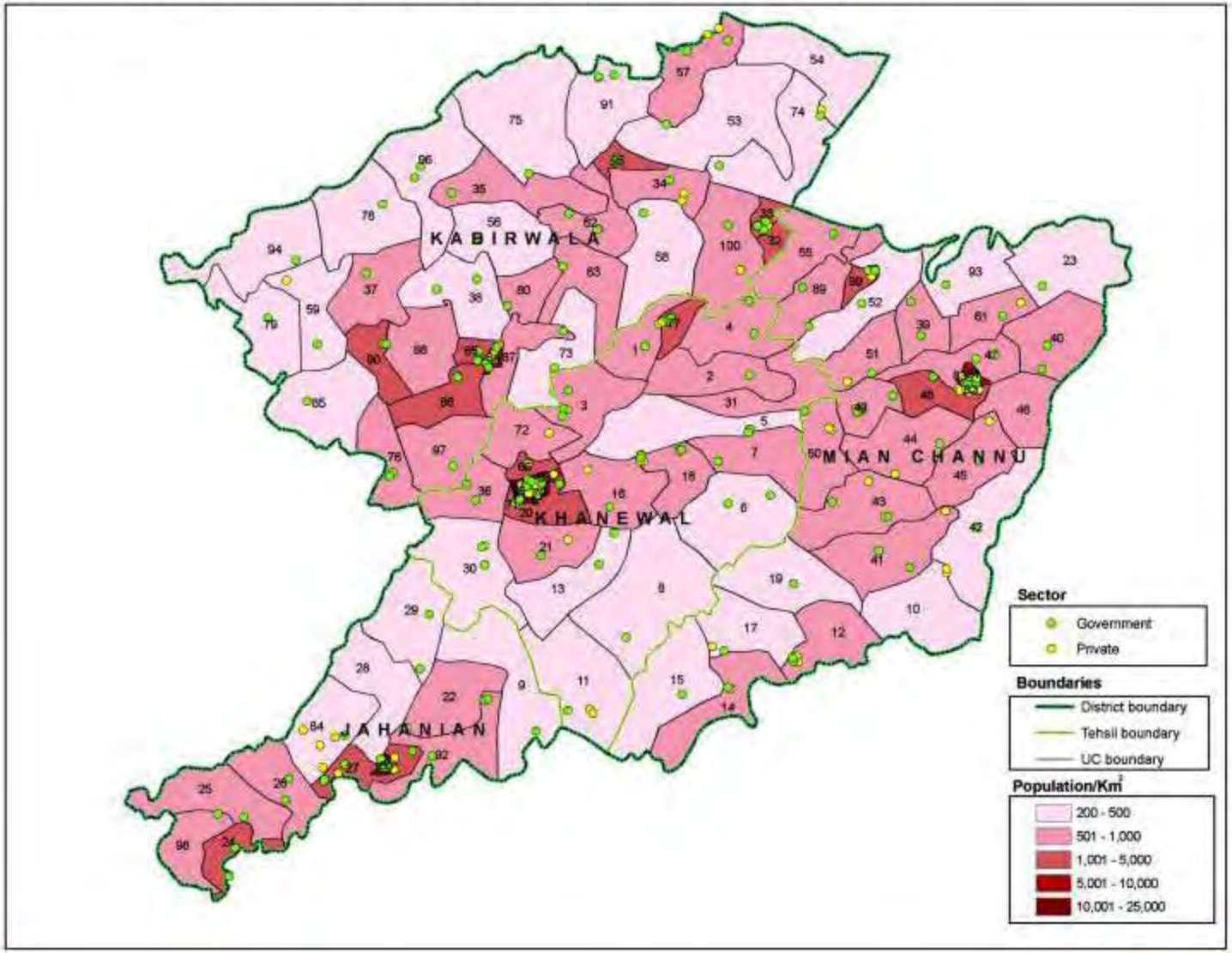
Map 4.4: Total number of reproductive health service delivery points (public and private) in Khanewal district, by union council



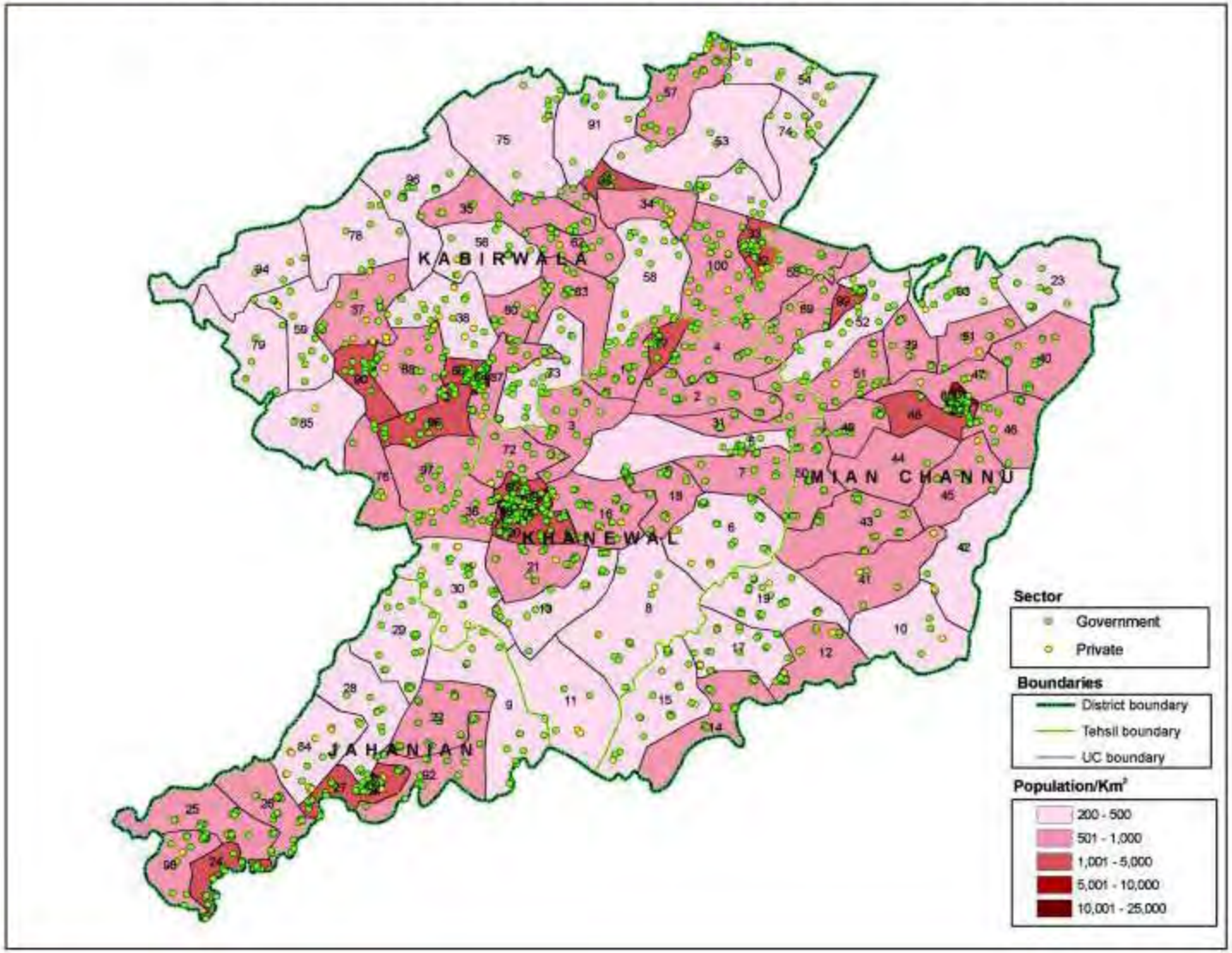
Map 4.5: Location of female sterilization facilities in Khanewal district, by population density of union council



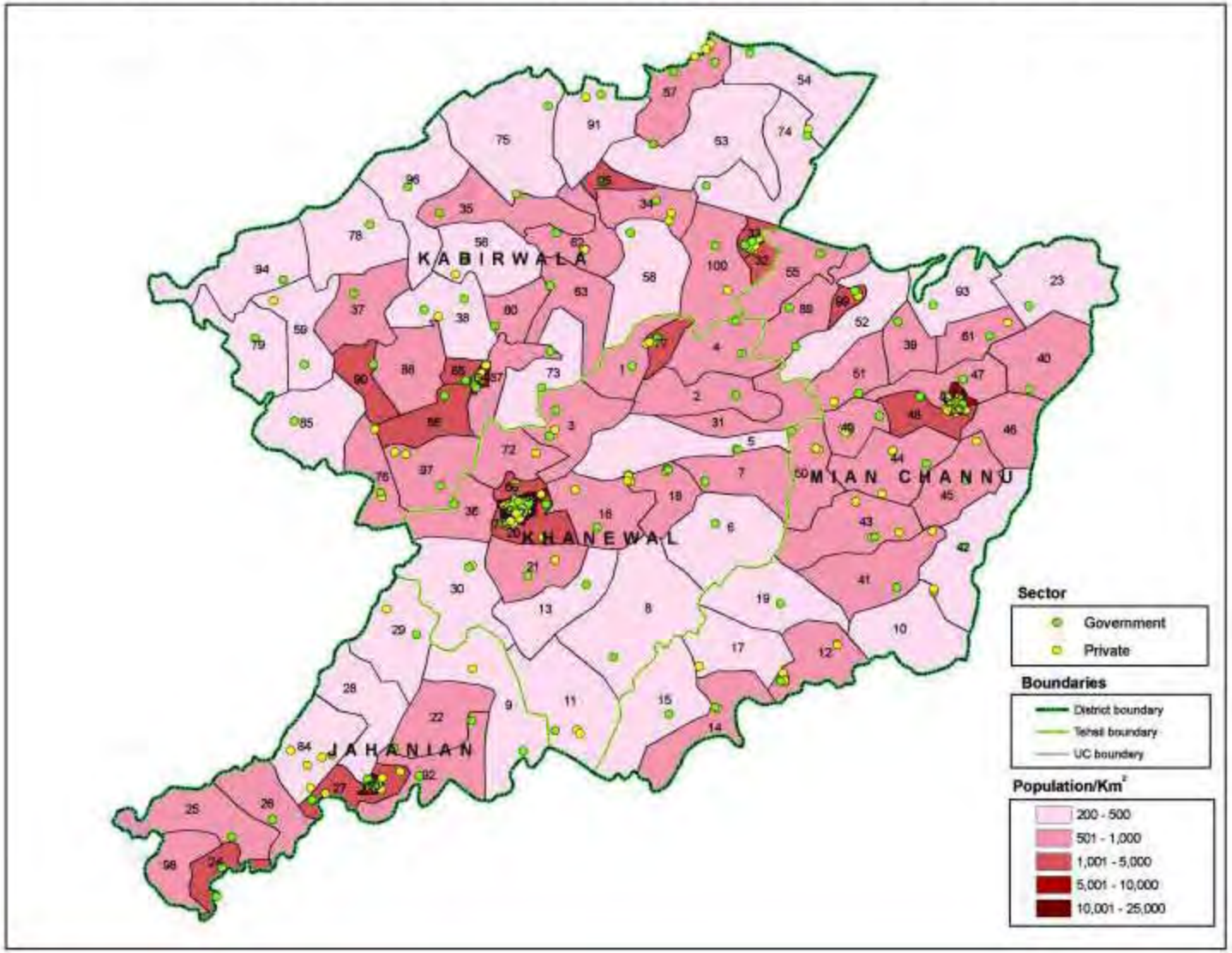
Map 4.6: Location of IUD facilities in Khanewal district, by population density of union council



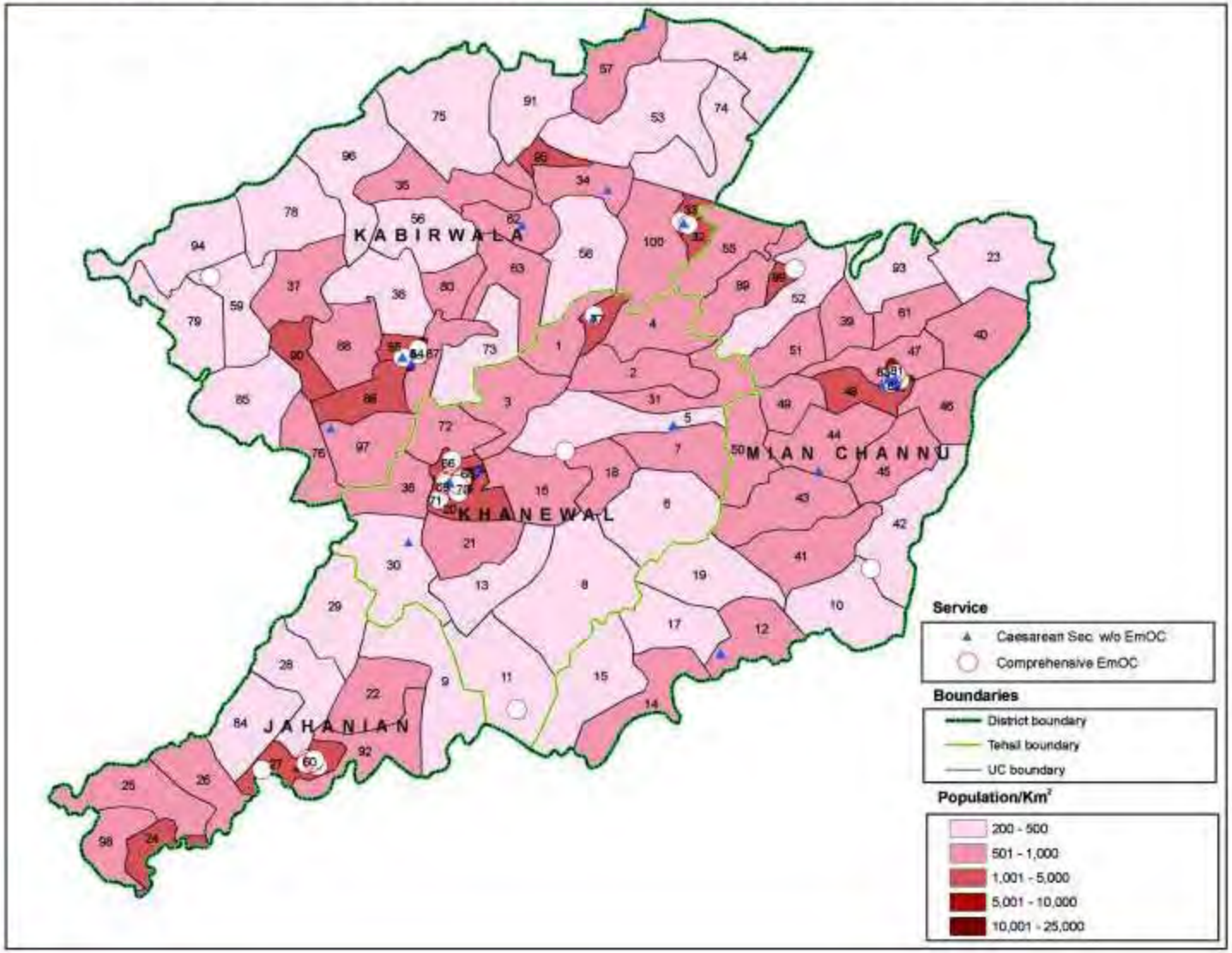
Map 4.7: Location of injectables contraceptive services in Khanewal district, by population density of union council



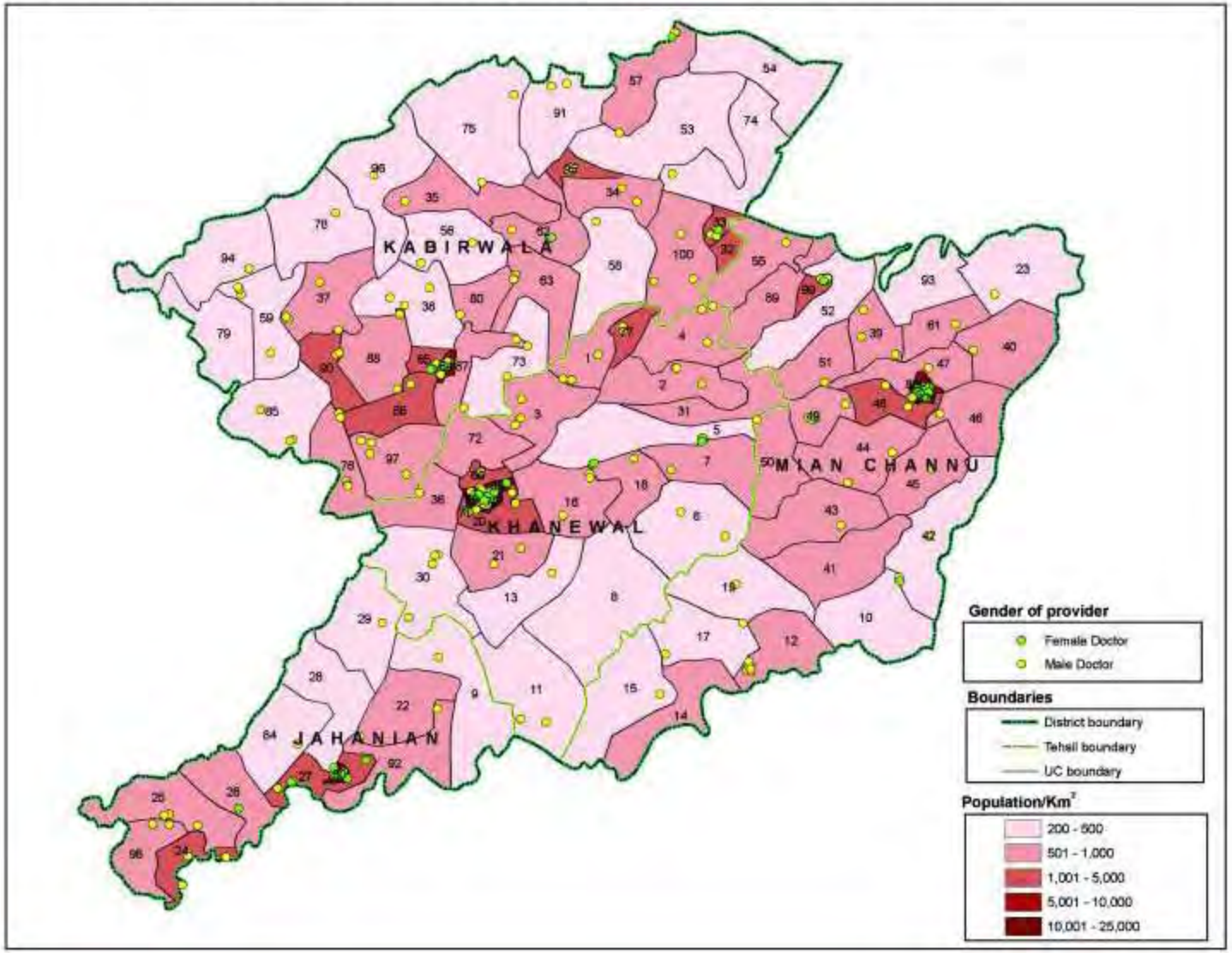
Map 4.8: Location of essential obstetric services in Khanewal district, by population density of union council



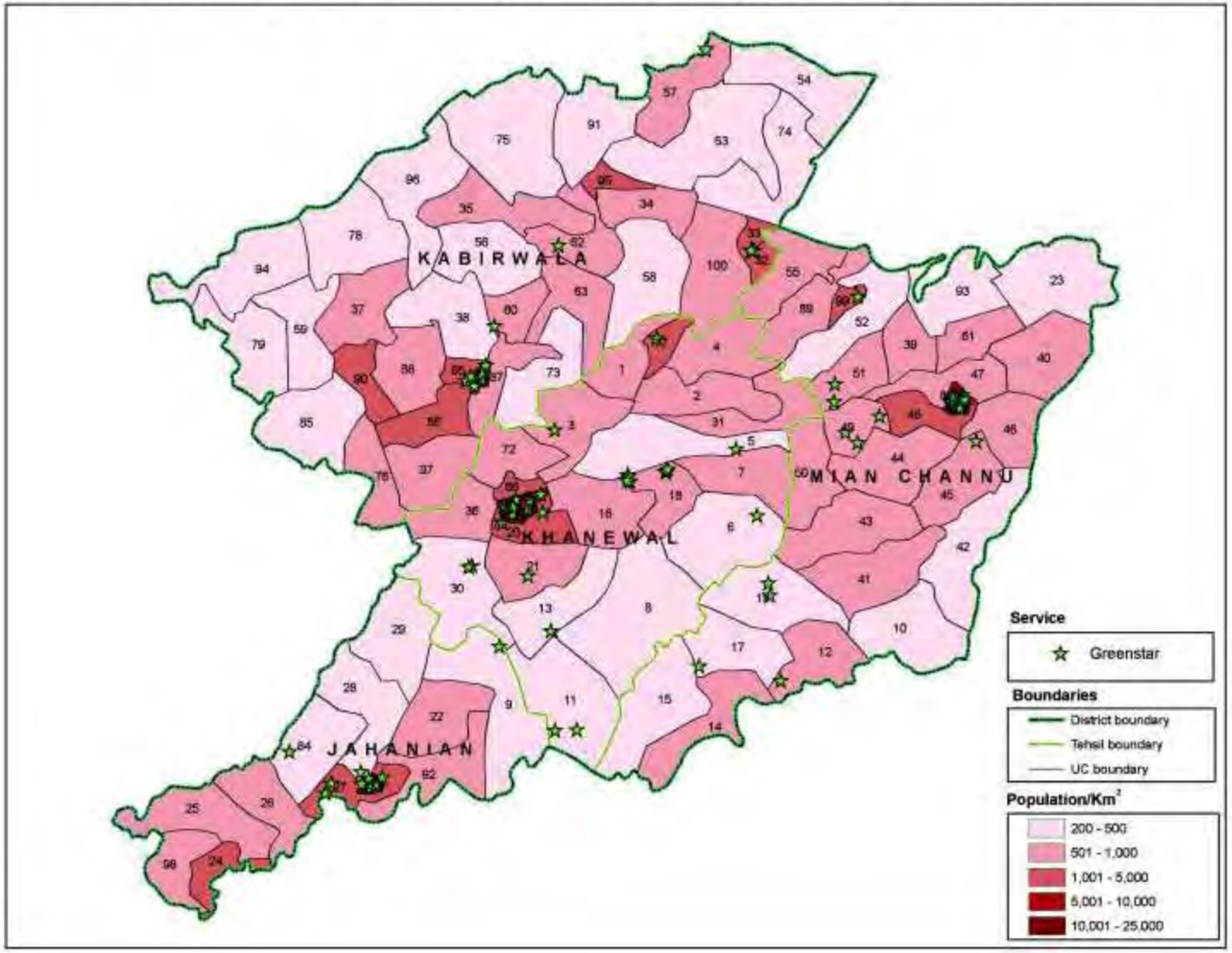
Map4.9: Location of emergency obstetric care facilities in Khanewal district, by population density of union council



Map 4.10: Location of doctors in Khanewal district, by gender and population density of union council



Map 4.11: Location of Greenstar Social Marketing SDPs in Khanewal district, by population density of union council



Chapter 5

Fertility

The main objective of this baseline survey was to seek information on the level of knowledge and acceptance of using 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. 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 last live birth was. From these responses, births that occurred during the last three years were ascertained. The numbers of births obtained through this procedure were then used to analyze current fertility. For a family planning program, it is essential to be informed about fertility levels to better 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 provides a somewhat different picture of fertility levels, trends and differentials than do period measures of fertility, such as CBR and TFR. Table 5.1 shows the percent distribution of all currently married women by the number of children ever born (CEB). The table shows this distribution by the age of the woman at the time of the survey.

Table 5.1: 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	68.0	32.0	0.0	0.0	100	0.4	25
20-24	27.5	48.4	19.8	4.4	100	1.6	91
25-29	9.3	36.4	38.0	16.3	100	2.9	129
30-34	7.8	14.6	33.0	44.7	100	4.2	103
35-39	0.0	14.4	25.6	60.0	100	5.2	90
40-44	4.0	6.7	16.0	73.3	100	6.3	75
45-49	5.2	3.4	6.9	84.5	100	6.9	58
Total	**11.9**	**23.5**	**24.5**	**40.1**	**100**	**4.0**	**571**

Table 5.2: 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	68.0	32.0	0.0	0.0	100	0.4	25
20-24	29.7	50.5	18.7	1.1	100	1.4	91
25-29	9.3	40.3	41.9	8.5	100	2.5	129
30-34	7.8	15.5	47.6	29.1	100	3.6	103
35-39	0.0	15.6	36.7	47.8	100	4.6	90
40-44	5.3	5.3	24.0	65.3	100	5.4	75
45-49	5.2	6.9	13.8	74.1	100	5.7	58
Total	**12.4**	**25.2**	**31.3**	**31.0**	**100**	**3.5**	**571**

Early childbearing was fairly common in Khanewal. Data shows that the mean number of children ever born (Table 5.1) and living children (Table 5.2) increased with the age of the mother, as would be expected in data of good quality. Table 5.3 shows the mean number of sons and daughters. Among currently married women aged 15-49 the mean number of children ever born was 4. The mean number of children ever born increased steadily with

age, from 0.4 in the age group 15-19 years to 6.9 in the age group of 45-49. On average, women aged 45-49 years had 5.7 living children; each woman in this age group had lost 1.2 children during her reproductive life.

Table 5.3: 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	0.2	0.2	0.4	0.2	0.2	0.4	25
20-24	0.8	0.7	1.6	0.7	0.7	1.4	91
25-29	1.4	1.4	2.9	1.3	1.3	2.5	129
30-34	2.0	2.2	4.2	1.7	1.9	3.6	103
35-39	2.7	2.4	5.2	2.5	2.1	4.6	90
40-44	3.1	3.1	6.3	2.6	2.7	5.4	75
45-49	3.8	3.1	6.9	3.0	2.6	5.7	58
Total	**2.0**	**2.0**	**4.0**	**1.8**	**1.7**	**3.5**	**571**

Table 5.1 also shows that 32 percent of married women 15-19 years of age had already given birth to at least one child. Among currently married women in the 45-49 age group, 10 percent had reached the end of childbearing with1-4 children while 5 percent had none. On the other hand 85 percent had five or more children ever born. The sex ratio at birth was 98.2 males per 100 females, which is consistent with international data. The sex ratio of living children was 100.

Differentials in Children Ever Born and Surviving

Table 5.4 shows that differences in mean numbers of children by literacy and educational level of currently married women were pronounced. On average, literate women bore 2.2 fewer children than illiterate women. Also, fertility declined with the level of education. Those who had "up to primary" education had, on average, 3.2 children ever born as compared to 4.9 born to women who had no schooling. Those who had "up to secondary" education had 2.3 children ever born, and those educated in college had 2.2.

Table 5.4: 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 respondent				
Literate	2.7	2.5	0.0785	228
Illiterate	4.9	4.1	0.1559	343
Schooling of respondent				
No education	4.9	4.2	0.1553	333
Up to primary	3.2	2.9	0.0855	111
Up to Secondary	2.3	2.1	0.0909	94
Above secondary	2.2	2.1	0.0411	33
Residence				
Rural	4.1	3.5	0.1376	477
Urban	3.7	3.2	0.1188	94
Literacy of respondent's husband				
Literate	3.5	3.1	0.1186	416
Illiterate	5.3	4.4	0.1640	155
Schooling of husband				
No education	5.4	4.5	0.1686	144
Up to primary	4.0	3.5	0.1343	107
Up to Secondary	3.5	3.1	0.1115	243
Above secondary	2.9	2.6	0.1010	69
Don't know	3.4	2.9	0.1481	8
Standard of living index				
Low	5.1	4.2	0.1689	130
Medium low	4.2	3.6	0.1525	148
Medium high	3.8	3.3	0.1216	155
High	3.1	2.9	0.0748	138
Husband's occupation				
Agriculture/Livestock/Poultry	4.4	3.8	0.1228	185
Petty trader	3.7	3.2	0.1322	66
Labor (Daily wages)	4.7	3.9	0.1573	76
Government service	4.0	3.4	0.1528	57
Private service	3.0	2.7	0.1257	55
Own business	3.0	2.6	0.1102	43
Abroad	3.4	3.1	0.0741	8
Unemployed	5.3	4.5	0.1504	25
Skilled worker	3.8	3.2	0.1486	39
Others	3.4	2.9	0.1404	17
Total	**4.0**	**3.5**	**0.1348**	**571**

Differentials were also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 3.5 children ever born as compared to 5.3 for those who had illiterate husbands. Women with illiterate husbands had the highest number of children ever born (5.3 children) compared to the women who themselves were illiterate (4.9 children). Similarly, women with unemployed husbands had the highest number of children ever born (5.3 children) .Women with husbands who had their own business or in private service had the lowest number of children ever born (3 children for each).

Table 5.5 further explains the relationship of age of mothers and literacy with mean number of children ever born and their survival. It is evident that the mean number of children ever born to literate mothers was lower (2.7 children) compared to those mothers who were illiterate (4.9 children). Similarly, the survival of children with literate mothers was better than those born to illiterate mothers. In the below 30 age group, 57 percent were literate as compared to 34 percent who were illiterate.

Table 5.5: 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	0.2	0.2	15	6.6	0.7	0.7	10	2.9
20 - 24	1.4	1.2	44	19.3	1.8	1.6	47	13.7
25 - 29	2.4	2.2	71	31.1	3.5	2.9	58	16.9
30 - 34	2.7	2.6	38	16.7	5.0	4.2	65	19.0
35 - 39	4.1	3.9	30	13.2	5.7	5.0	60	17.5
40 - 44	5.2	4.5	23	10.1	6.8	5.7	52	15.2
45 - 49	6.7	5.9	7	3.1	7.0	5.6	51	14.9
Total	**2.7**	**2.5**	**228**	**100.0**	**4.9**	**4.1**	**343**	**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 29 births per thousand population (Table 5.6).

Age-specific Fertility Rates and Total Fertility Rate

The total fertility rate (TFR) is a more refined measure of fertility 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 rose rapidly till age 25-29 then declined with increasing age. A TFR of 3.8 obtained from the set of ASFRs calculated from the data presented in Table 5.6, can be compared with 3.9 for Punjab and 4.1 for Pakistan as a whole reported in the PDHS (NIPS/DHS, 2008).

Table 5.6: Number of women in sample households and number of births during the last three years before the survey, by age of women, and ASFRs, TFR and CBR

Age group	Women	births	Age specific fertility rate (ASFR)
15 – 19	238	10	14.0
20 – 24	237	83	116.7
25 – 29	182	147	269.2
30 – 34	119	62	173.7
35 – 39	101	42	138.6
40 – 44	92	7	25.4
45 – 49	73	3	13.7
Total	**1042**	**354**	**na**
TFR: 3.8			
CBR: 28.6			

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 5.7 shows a significant number of women with the burden of caring for several young children. Further, among those who already had two living children less than 5 years of age, 12 percent were pregnant. For such mothers, it is particularly important for their health and that of their children to ensure that birth spacing is a part of their married life at this point.

Table 5.7: 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	10.4	26	89.6	223	100.0	249
1	16.1	25	83.9	130	100.0	155
2	12.1	16	87.9	116	100.0	132
3	6.3	2	93.8	30	100.0	32
4	0.0	0	100.0	3	100.0	3
Total	**12.1**	**69**	**87.9**	**502**	**100.0**	**571**

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 5.8 shows the length of the last closed birth interval for women with two or more births by background characteristics of mothers at the time of the survey.

Table 5.8: Distribution of women with preceding birth intervals (birth to birth) by background characteristics

characteristics	Less than 18 months	18 - 23 months	24 - 35 months	36 - 47 months	48 and above months	Total	N
Age							
15 – 19	100.0	0.0	0.0	0.0	0.0	100.0	2
20 – 24	32.1	26.4	30.2	5.7	5.7	100.0	53
25 – 29	21.2	19.5	39.8	11.0	8.5	100.0	118
30 – 34	20.3	17.6	23.0	17.6	21.6	100.0	74
35 – 39	6.1	24.5	22.4	16.3	30.6	100.0	49
40 – 44	7.1	7.1	21.4	28.6	35.7	100.0	14
45 – 49	0.0	0.0	50.0	0.0	50.0	100.0	4
Number of live births							
2	28.1	21.1	29.8	15.8	5.3	100.0	57
3	21.4	20.2	39.3	7.1	11.9	100.0	84
4	15.5	22.4	27.6	12.1	22.4	100.0	58
5	26.3	21.1	15.8	15.8	21.1	100.0	38
6+	13.0	16.9	31.2	16.9	22.1	100.0	77
Education level							
No education	17.0	22.7	26.1	14.2	19.9	100.0	176
Up to primary	22.9	12.9	40.0	10.0	14.3	100.0	70
Up to Secondary	27.7	17.0	31.9	14.9	8.5	100.0	47
Above secondary	19.0	28.6	33.3	9.5	9.5	100.0	21
Standard of living index							
Low	18.2	18.2	31.2	10.4	22.1	100.0	77
Medium low	23.2	23.2	23.2	15.9	14.6	100.0	82
Medium high	22.1	18.2	32.5	11.7	15.6	100.0	77
High	16.7	20.5	35.9	14.1	12.8	100.0	78
Total	**20.1**	**20.1**	**30.6**	**13.1**	**16.2**	**100.0**	**314**

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 found that children born within the preceding interval of 18 months experienced higher mortality risks during infancy than those born in an interval of two to three years (Cleland and Sathar, 1984).

Table 5.8 shows that 20 percent of children were born with a birth interval of less than 18 months. Almost 71 percent were born with a birth interval of less than 36 months, while 29 percent were born after three years or more. The differentials by mother's age, educational level and standard of living index are also shown.

Chapter 6

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 303 women out of 571 women interviewed had borne a child during the past four years, and these women were asked additional questions about maternal and neonatal care.

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 both 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, but in recent years those proportions have been increasing in Pakistan. Table 6.1 and Figure 6.1 show the number of ANC visits for the last birth of women who had delivered during the previous four years. About 74 percent of the sample respondents had received at least one antenatal care visit during the last pregnancy. Thirty-nine percent had at least three such visits and 27 percent had four or more ANC visits.

Table 6.1: Distribution of ANC check-ups during last pregnancy by residence

	Rural		Urban		Total	
Number of visits	**N**	**%**	**N**	**%**	**N**	**%**
No visit	74	28.5	5	11.6	79	26.1
1-2 visits	93	35.8	11	25.6	104	34.3
3 visits	30	11.5	8	18.6	38	12.5
4+ visits	62	23.8	19	44.2	81	26.7
Don't remember	1	0.4	0	0.0	1	0.3
Total	**260**	**100.0**	**43**	**100.0**	**303**	**100.0**

Figure 6.1: Distribution of MWRA by number of antenatal visits during last pregnancy

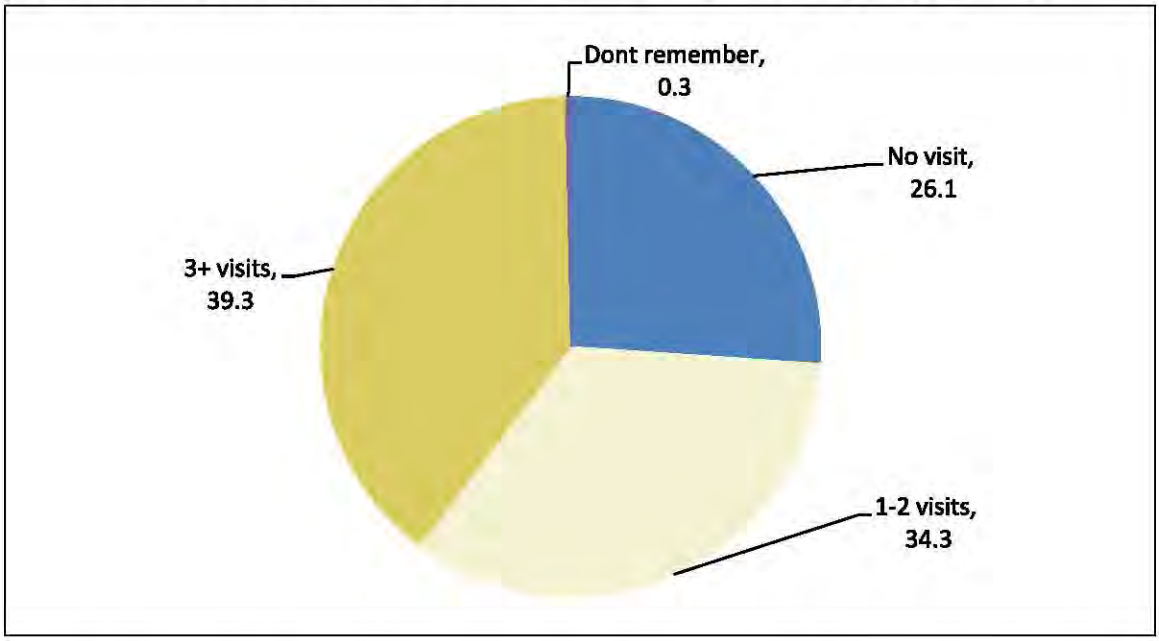


Figure 6.2 shows that many of these visits were in response to a routine check-up rather than for some problem,. Forty-eight percent of the first antenatal visits were for curative purpose.

Figure 6.2: Distribution of MWRA by reason of first antenatal visit during last pregnancy

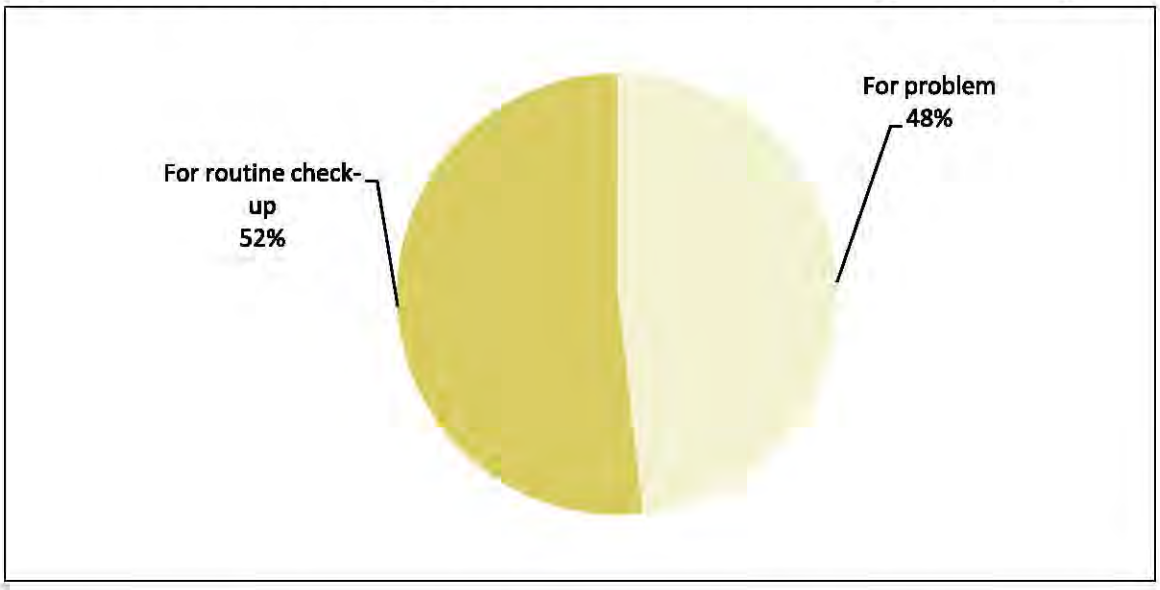


Figure 6.3 shows that 35 percent of the first visits took place within the first three months of gestation, and 29 percent of the first visits occurred during the third trimester.

Figure 6.3: Distribution of MWRA by gestational age at first antenatal visit during last pregnancy

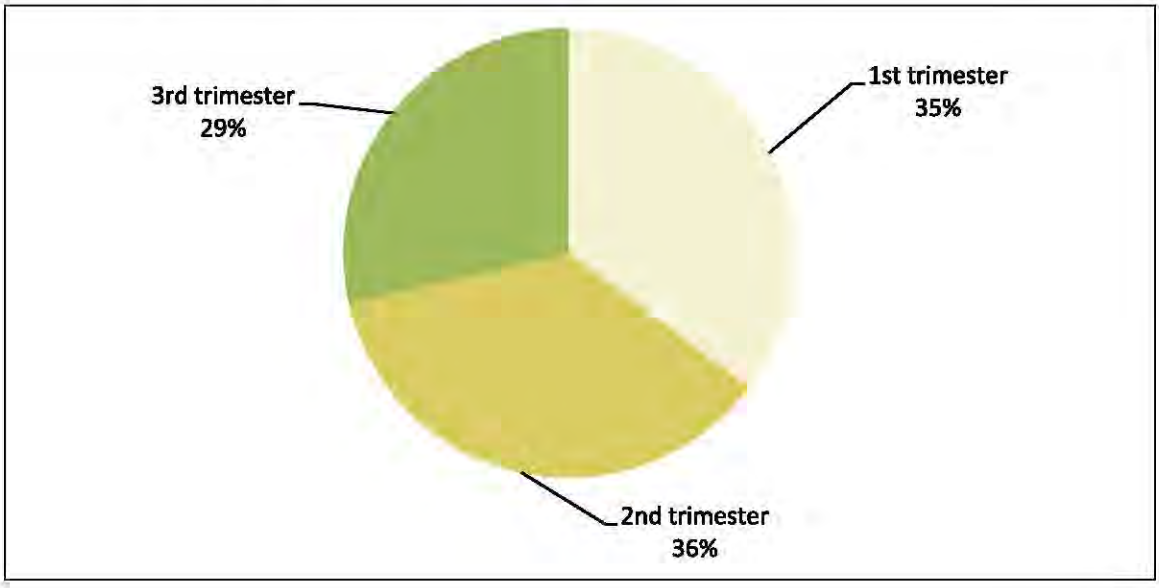
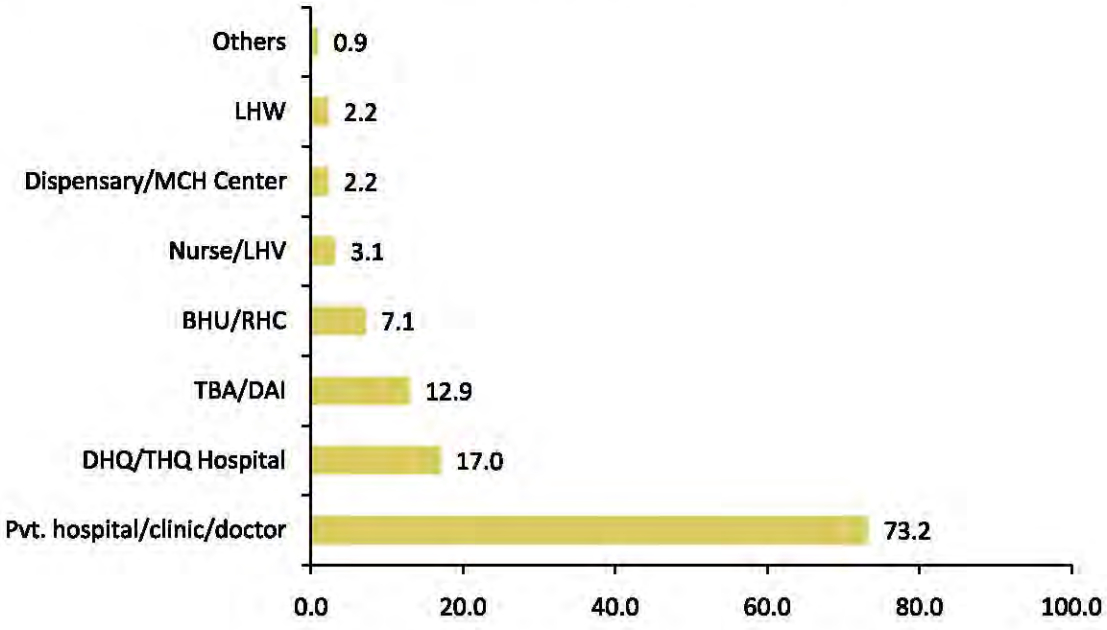


Table 6.2 shows the locations where respondents made one or more antenatal visits. Most antenatal visits took place in private-sector facilities followed by DHQ/THQ hospitals and TBA/Dais; other providers were less common.

Table 6.2: Facilities/service providers mentioned for one or more antenatal visits by residence

Facility/provider	Rural	Urban	Total
Dispensary/MCH Center	2.7	0.0	2.2
BHU/RHC	8.6	0.0	7.1
DHQ/THQ Hospital	15.6	23.7	17.0
Pvt. hospital/clinic/doctor	73.1	73.7	73.2
LHW	2.7	0.0	2.2
TBA/DAI	12.4	15.8	12.9
Nurse/LHV	2.2	7.9	3.1
Others	1.1	0.0	0.9
N	**186**	**38**	**224**

Figure 6.4: Locations where respondents made one or more antenatal visits



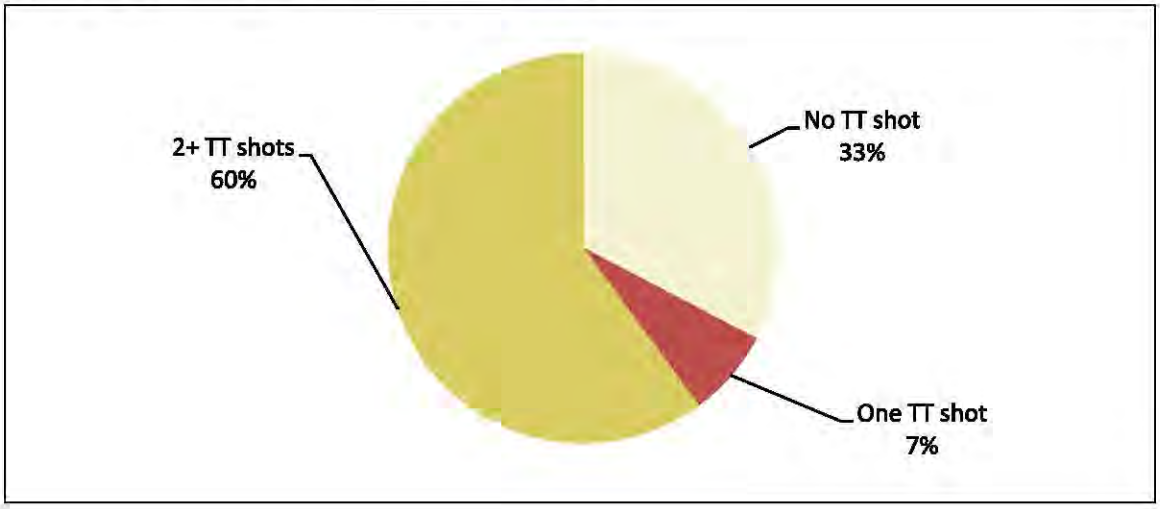
Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn and mother. Two doses in a pregnancy are sufficient to prevent tetanus; however, if the woman was immunized during her previous pregnancy only one dose may be needed. Five doses are sufficient for lifetime protection. According to PSLMS 2004-05, 46 percent of mothers in Khanewal had received at least one shot; according to the PDHS 2006-07, 59 percent in Punjab and 53 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 6.3 and Figure 6.5 show that 67 percent of the mothers had received at least one shot during their last pregnancy, and 60 percent had received two or more shots. The immunization rate was higher in urban areas than in rural areas. However, overall one-third women were at stake as they had no tetanus immunization, thus remained unprotected.

Table 6.3: Tetanus immunization at last delivery

Number of injections	Rural		Urban		Total	
	N	%	N	%	N	%
No TT shot	91	35.0	8	18.6	99	32.7
One TT shot	20	7.7	2	4.7	22	7.3
2+ TT shots	149	57.3	33	76.7	182	60.1
Total	**260**	**100.0**	**43**	**100.0**	**303**	**100.0**

Figure 6.5: 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. Although these proportions have been rising in recent years, they have been historically low in Pakistan and have contributed substantially to high maternal mortality. According to the 2004-05 PSLMS, in Khanewal 23 percent of deliveries took place in institutions, compared with PDHS 2006-07 figures of 33.4 percent for Punjab and 34 percent nationally (Government of Pakistan, 2006; NIPS/PDHS, 2008). In the present survey, 42 percent of the most recent deliveries were in a health facility (Table 6.4 and Figure 6.6). Of these, most of the deliveries took place in private hospitals. The table indicates that a large number of deliveries are still taking place in homes, particularly in rural areas, which increases the risk of maternal mortality.

Table 6.4: Distribution of mothers by place of last delivery and residence

	Rural		Urban		Total	
Place of delivery	**N**	**%**	**N**	**%**	**N**	**%**
At home	157	60.4	20	46.5	177	58.4
BHU/RHC	2	0.8	0	0.0	2	0.7
DHQ/THQ Hospital	11	4.2	3	7.0	14	4.6
Pvt. hospital/clinic	74	28.5	20	46.5	94	31.0
FWC/RHSC(A)/others	16	6.2	0	0.0	16	5.3
Total	**260**	**100.0**	**43**	**100.0**	**303**	**100.0**

Figure 6.6: Distribution of mothers by location of last delivery

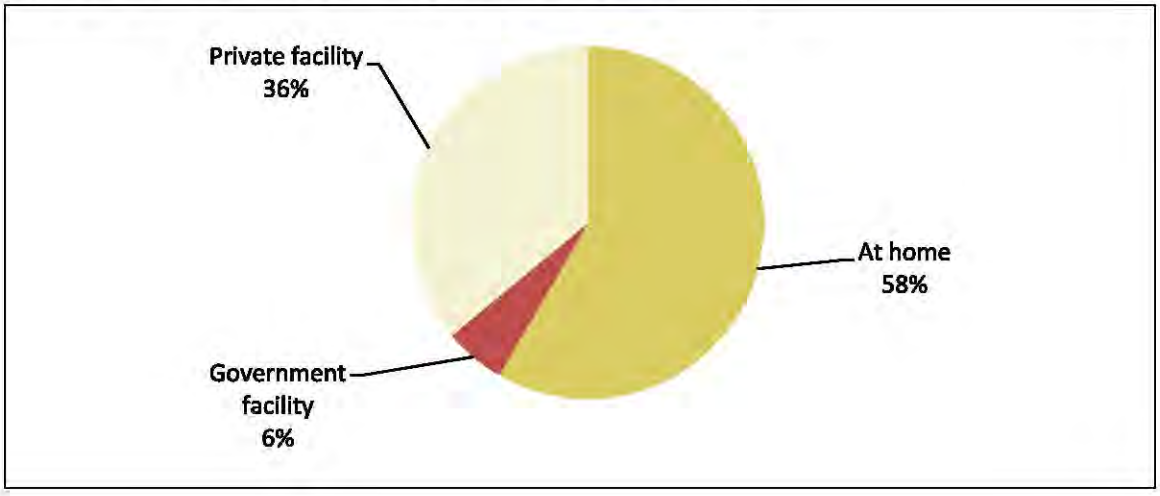
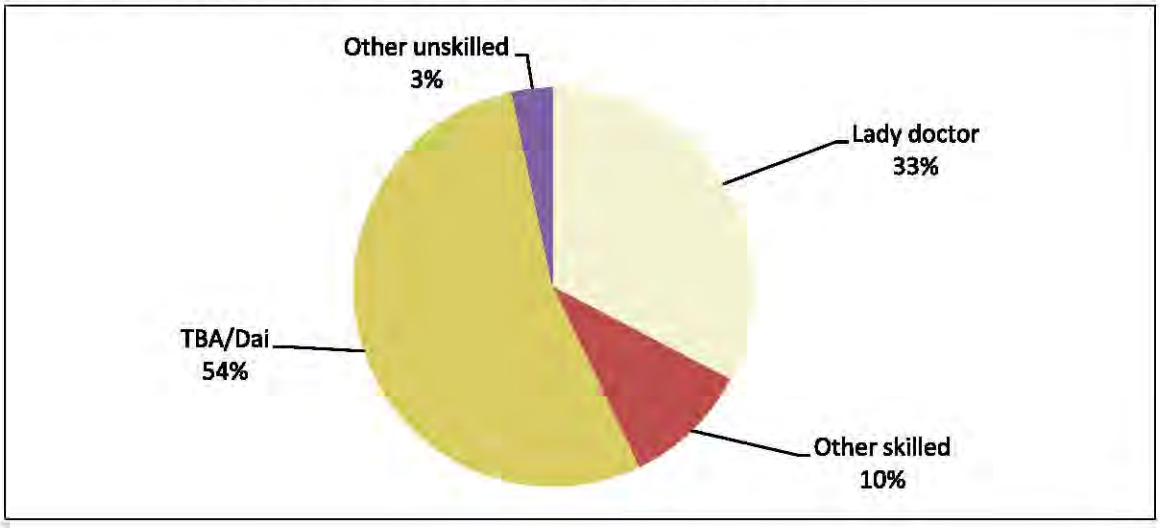


Table 6.5 and Figure 6.7 indicate that in this survey, 43 percent of the reported deliveries in the previous 4 years were assisted by a skilled birth attendant. This was significantly higher in urban areas. In the PSLMS 2004-05 for Khanewal , only 27 percent of the births were delivered by a skilled attendant; in the PDHS 2006-07, the corresponding figure was 37.7 percent for Punjab and 39 percent for Pakistan as a whole (NIPS/PDHS, 2008). A number of births attended by a skilled attendant in this household survey were reportedly attended by a lady doctor. (The term "doctor" however, may, in such interviews, mean a paramedic, such as a Lady Health Visitor.) About 54 percent of births were delivered by Dai /TBA (traditional birth attendants), while 33 percent were delivered by a lady doctor.

Table 6.5: Distribution of mothers by attendant at last delivery and residence

Birth attendant and skill level	Rural		Urban		Total	
	N	%	N	%	N	%
TBA/Dai	144	55.4	19	44.2	163	53.8
LHW	1	0.4	0	0.0	1	0.3
Nurse/LHV	30	11.5	1	2.3	31	10.2
Lady doctor	76	29.2	23	53.5	99	32.7
Female relative/Friend/Neighbor (not dai)	8	3.1	0	0.0	8	2.6
Others	1	0.4	0	0.0	1	0.3
Total	**260**	**100.0**	**43**	**100.0**	**303**	**100.0**
Skilled birth attendant	106	40.8	24	55.8	130	42.9
Unskilled birth attendant	154	59.2	19	44.2	173	57.1

Figure 6.7: Distribution of mothers by attendant at last delivery



Postpartum Care

For the health of mothers and newborns, a newly delivered mother and baby should be followed up for at least about 6 weeks after delivery. MoH guidelines recommend at least one postpartum visit after discharge during the first 42 days after delivery. This, however, is a major weakness of maternal and newborn health care in Pakistan: women who deliver at home rarely go for any postnatal check-up, and women who deliver in facilities are usually seen while they are in the facility, but not after. This is also the case in Khanewal. Almost 44 percent of respondents reported receiving postnatal care within 40 days after delivery (Table 6.6) compared with 43 percent nationally and 40 percent in Punjab (NIPS/PDHS, 2008). However, 39 percent received this care within 24 hours. As expected, only 11 percent of the women who delivered at home reported that they had a postnatal check-up within or after 24 hours.

It is pertinent to mention that 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 critical for the mother to focus on family planning and the role it can play in postponing the next pregnancy or in ending childbearing.

Table 6.6: Distribution of mothers by status of postnatal check-up and place of delivery

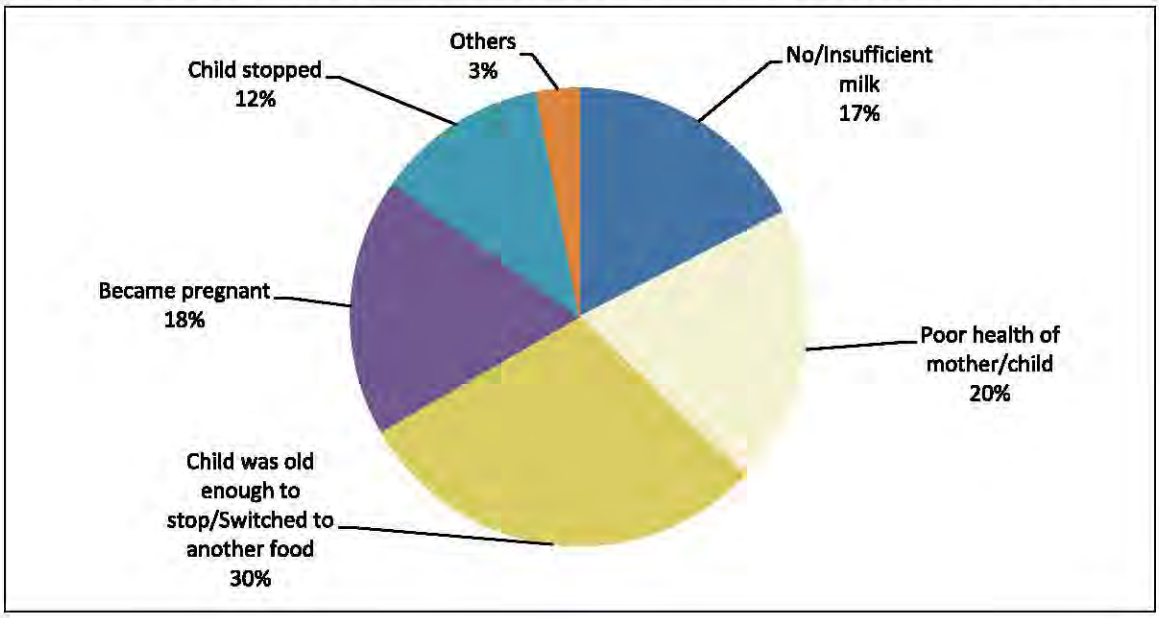
	Postnatal check-up within 24 hours		Postnatal check-up after 24 hours		Did not have postnatal check-up		Total	
Place of delivery	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Institutional delivery	111	100.0	0	0.0	0	0.0	111	100.0
Non institutional delivery	7	3.6	15	7.8	170	88.5	192	100.0
Total	**118**	**38.9**	**15**	**5.0**	**170**	**56.1**	**303**	**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. Breastfeeding can be used to deliberately 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 10 of 284 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 14 months. Five main reasons were given for discontinuing breastfeeding: child was old enough (30 percent); poor health of mother or child (20 percent); mother became pregnant (18 percent); no or insufficient milk (17 percent) and child stopped (12 percent).

Figure 6.8: Distribution of mothers by reasons for discontinuing breastfeeding (N=132)



Chapter 7

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. Couples' views 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 about these issues because they themselves may not be certain. We can, however, ask questions, record responses, and investigate 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 7.1 shows the responses.

The median "ideal" number, in the sense indicated above, was 4 children; 73 percent of the respondents wanted 4 or fewer children. However, only 10 percent said they wanted 2 children. These proportions varied according to residence; 4 percent urban women gave non–numeric answers while only 6 percent of the rural women responded in non-numeric answers to the ideal number of children they would like to have.

Table 7.1: Distribution of MWRA with ideal number of children for their family by residence

	Rural		Urban		Total	
Number of children	**N**	**%**	**N**	**%**	**N**	**%**
2	38	8.0	16	17.0	54	9.5
3	79	16.6	19	20.2	98	17.2
4	221	46.3	41	43.6	262	45.9
5	46	9.6	7	7.4	53	9.3
6	41	8.6	7	7.4	48	8.4
7+	25	5.2	0	0.0	25	4.4
Up to God	27	5.7	4	4.3	31	5.4
Total	**477**	**100.0**	**94**	**100.0**	**571**	**100.0**

Desire for More Children

Levels of Desire for More Children

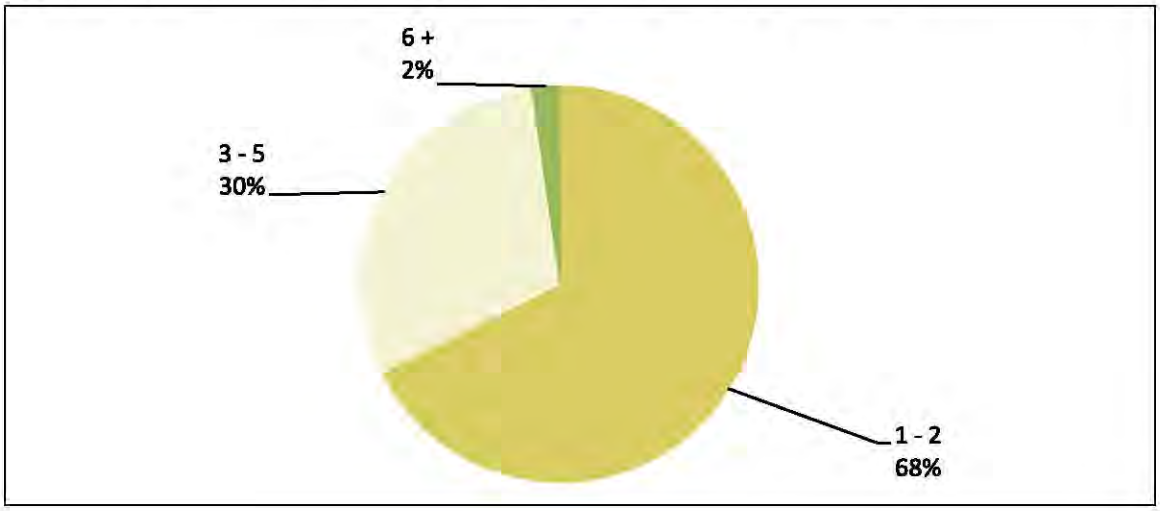
A more immediate measure of fertility preference is whether a couple wants to have more children; if so, do they want the next child now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already has. Table 7.2 shows that whether respondents 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. Fifty-four percent of the respondents did not want more children. About one quarter women (22 percent) wanted to delay their next child. Also, the proportion wanting more children sooner rather than later declined sharply after the first birth. Those who had two living children, most of the respondents who wanted an additional child wanted to have it later, rather than right away. On the other hand, most women with three or more living children did not want to have more children; for those with six or more, the proportion wanting to stop was 96 percent. This table clearly indicates the level of interest in both spacing or limiting births.

Table 7.2: Distribution of MWRA by desire for next child and current number of living children

	Desire for next child			Total	
Number of living children	**Soon**	**Later**	**Never**	**N**	**%**
0	67.6	32.4	0.0	71	100
1	51.6	40.6	7.8	64	100
2	31.3	48.8	20.0	80	100
3	13.8	25.5	60.6	94	100
4	11.8	10.6	77.6	85	100
5	8.9	8.9	82.1	56	100
6+	3.3	0.8	95.9	121	100
Total	**24.2**	**22.2**	**53.6**	**571**	**100**
N	138	127	306	571	100

For those women who wanted more children, we also asked how many more. Figure 7.1 indicates that more than two-third of the women who wanted more children, and who had an opinion, wanted one or two more children.

Figure 7.1: Distribution of women by desire for more children in the future



Socioeconomic Correlates of Desire for Children

A woman's stated desire was analyzed in relation to four possible socioeconomic determinants: standard of living index (SLI), respondent's age, literacy and residence (Table 7.3). The relationship between SLI and desire for more children was consistent. The age of the respondent was strongly associated with the desire to not have more children. Illiterate women were more likely to never want more children (62 percent) compared to the literate women (41 percent). Rural-urban residence had no remarkable difference.

Table 7.3: Distribution of MWRA by reported desire for more children and background characteristics

Characteristic	Desire for next child			Total	
	Soon	Later	Never	N	%
Standard of living index					
Low	25.4	13.1	61.5	130	100
Medium low	23.0	26.4	50.7	148	100
Medium high	24.5	18.7	56.8	155	100
High	23.9	30.4	45.7	138	100
Age group					
<25	40.5	45.7	13.8	116	100
25 or more	20.0	16.3	63.7	455	100
Literacy of respondent					
Literate	25.4	33.8	40.8	228	100
Illiterate	23.3	14.6	62.1	343	100
Residence					
Rural	24.3	22.4	53.2	477	100
Urban	23.4	21.3	55.3	94	100
Total	**24.2**	**22.2**	**53.6**	**571**	**100**
N	138	127	306	571	100

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 questionnaire, respondents were asked how many daughters they would have before stopping if they did not have a son, and correspondingly for sons if they did not have a daughter. For respondents , son preference

came out most strongly in the proportions saying that there would be no limit: 47 percent said there would be no limit to the number of daughters before having a son while 30 percent said there would be no limit to the number of sons before having a daughter. (Table7.4). For those women who gave a number, in both cases the median was 4 children.

Table 7.4: Son and daughter preferences by the respondents

	Number of daughters for desire of son		Number of sons for desire of daughters	
Response	**N**	**%**	**N**	**%**
Up to God	39	6.8	28	4.9
No limit	266	46.6	171	29.9
Numeric responses	262	45.9	367	64.3
Other non-numeric responses	4	0.7	5	0.9
Total	**571**	**100.0**	**571**	**100.0**
Median*	4	na	4	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 this does not matter much to them. We asked respondents whether, if they became pregnant soon, would they be pleased, worried, accept it, or it did not matter. Results are shown in Tables 7.5 and 7.6. (This question excludes 203 of the total 571 women who wanted a next child soon, were currently pregnant, had been sterilized, had gone through menopause or had a hysterectomy). Table 7.5 shows that among those who did not want more children at all, 65 percent said that they would be worried if they became pregnant. More than 27 percent reported that they would accept the new pregnancy, while none , among those who did not want more children, said they would be pleased. Among those women who wanted to delay their next pregnancy for more than 2 years, 35 percent would be worried while 4 percent would be pleased if they became pregnant, and 49 percent would accept the pregnancy. These responses show weak motivation for spacing. However, the high proportion of women who said they would be worried if they became pregnant supports their earlier statement that they wanted to delay or stop childbearing.

Table 7.5: Distribution of MWRA who did not want more children soon by reaction if become pregnant in near future

	Desire for next child		Total	
Reaction if pregnant	**Later**	**Never**	**%**	**N**
Pleased	3.7	0.0	1.1	3
Worried	34.6	65.4	56.3	153
Accept it	49.4	27.2	33.8	92
Doesn't matter	12.3	6.8	8.5	23
Other	0.0	0.5	0.4	1
Total	**100**	**100**	**100**	**272**
N	81	191	272	272

Further, women who expressed a desire not to have more children or to delay the next child were asked what problems they would face if they became pregnant soon. Table 7.6 shows their responses. If we observe the situation overall the problem most commonly faced was own health followed by family economic situation. This shows that health is emerging as a priority in planning a family.

Table 7.6: Distribution of MWRA who do not want more children soon by problem faced if they became pregnant

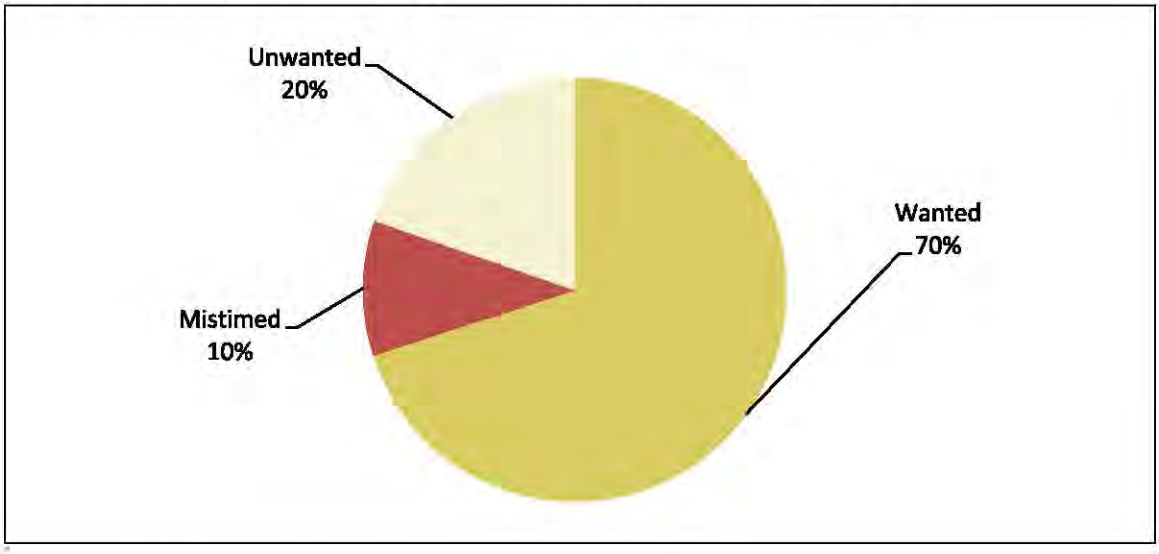
	Desire for next child		Total	
Reaction if pregnant	**Later**	**Never**	**%**	**N**
Own health	69.5	85.7	80.9	225
Health of youngest child	73.2	49.0	56.1	156
Caring of children	75.6	67.7	70.0	194
Schooling of children	53.7	67.7	63.5	176
Family economic situation	54.9	79.0	71.8	199
Will feel shy because other kids are grown	1.2	5.2	4.0	11
Other	0.0	1.0	0.7	2
N	**81**	**192**	**273**	**273**

Respondents could give more than one response

Attitude towards Last Pregnancy

Another important dimension of fertility preference relates to whether the last pregnancy was wanted at the time, was mistimed (i.e., wanted later) or was not wanted at all. Pregnancies that are unwanted cause hardship in many ways and represent a failure to realize a couple's right to have the number of children they want at the time they want them. 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, as shown in Figure 7.2, many women reported that their last pregnancy was unwanted (20 percent) or mistimed (10 percent).

Figure 7.2: Distribution of MWRA by attitudes toward their last pregnancy



Women's Perception of Husband's Fertility Preferences

Women were asked whether they thought their husbands wanted the same number of children as they did, more or fewer children. In Table 7.7, responses are tabulated according to the woman's ideal family size. About 26 percent did not know their husband's preference, while 59 percent thought their husbands wanted the same number of children as they did. However, 11 percent of the women thought their husbands wanted more children than they did, while only 4 percent thought their husbands wanted fewer children.

Table 7.7: Distribution of MWRA according to perception of husband's desire for more children by woman's ideal family size

Ideal family size of women	Perceived husband's desire for more children				Total	
	Same number	More children	Fewer children	Don't know	%	N
1-2 children	55.6	14.8	0.0	29.6	100	54
3-4 children	62.2	11.7	5.3	20.8	100	360
5+ children	62.7	9.5	2.4	25.4	100	126
Up to God	9.7	6.5	3.2	80.6	100	31
Total	**58.8**	**11.2**	**4.0**	**25.9**	**100**	**571**
N	336	64	23	148	571	571

Chapter 8

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 for contraceptive methods.

Knowledge

At least 95 percent of married women of reproductive age in Pakistan have known of at least one method of contraception for many years. Table 8.1 shows that this holds true for Khanewal as well where 100 percent of the respondents knew of at least one FP method. A majority of the female respondents knew of the most commonly used program methods – female sterilization, pills, IUD, injections and condoms. Male sterilization, norplant, and emergency pills were relatively less known. Natural methods were also less known. Variations in knowledge between rural and urban women are shown in Table 8.1.

Table 8.1: Distribution of MWRA by knowledge (prompted) of contraceptive methods, by method and residence

Method	Rural	Urban	Total
Female sterilization	98.7	97.9	98.6
Male sterilization	53.2	50.0	52.7
Pill	95.8	100.0	96.5
IUD	95.8	98.9	96.3
Injectables	96.2	94.7	96.0
Norplant	42.8	40.4	42.4
Condom	82.0	90.4	83.4
Rhythm	34.6	46.8	36.6
Withdrawal	67.3	77.7	69.0
Others FP method	9.0	8.5	8.9
Emergency Pills	14.5	18.1	15.1
Any FP method	100.0	100.0	100.0
Any modern FP method	100.0	100.0	100.0
Any traditional FP method	76.5	86.2	78.1
N	**477**	**94**	**571**

Use of Contraceptive Methods

Levels of Ever Use and Current Use

For the purpose of analyzing contraceptive use 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. 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, 59 percent reported having used some method of contraception during their married lives (Table 8.2). This percentage was higher in urban areas (68 percent) as compared to rural areas (57 percent). It was also higher than the proportion obtained in the PDHS 2006-07 for Pakistan as a whole (48.7 percent) (NIPS/PDHS, 2008).

Table 8.2: 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	13.2	10.6	12.8	73	1.0	1.1	1.1	6	12.2	9.6	11.7	67
IUD	13.4	22.3	14.9	85	3.4	2.1	3.2	18	10.1	20.2	11.7	67
Injectable	12.2	11.7	12.1	69	1.0	0.0	0.9	5	11.1	11.7	11.2	64
Nor plant	0.6	0.0	0.5	3	0.2	0.0	0.2	1	0.4	0.0	0.4	2
Condom	23.7	42.6	26.8	153	7.3	9.6	7.7	44	16.4	33.0	19.1	109
Rhythm method	16.8	16.0	16.6	95	3.1	2.1	3.0	17	13.6	13.8	13.7	78
Withdrawal	23.5	43.6	26.8	153	5.2	12.8	6.5	37	18.2	30.9	20.3	116
Female sterilization	10.5	11.7	10.7	61	10.5	11.7	10.7	61	0.0	0.0	0.0	0
Male sterilization	0.6	0.0	0.5	3	0.6	0.0	0.5	3	0.0	0.0	0.0	0
Other FP method	2.3	2.1	2.3	13	0.4	0.0	0.4	2	1.9	2.1	1.9	11
Any FP method	56.8	68.1	58.7	335	32.9	39.4	34.0	194	23.9	28.7	24.7	141
Any modern FP method	52.2	63.8	54.1	309	24.1	24.5	24.2	138	28.1	39.4	29.9	171
Any traditional FP method	33.8	50.0	36.4	208	8.8	14.9	9.8	56	24.9	35.1	26.6	152
N	477	94	571	571	477	94	571	571	477	94	571	571
Emergency pills	0.0	1.1	0.2	1	na	na	na	na	na	na	na	na

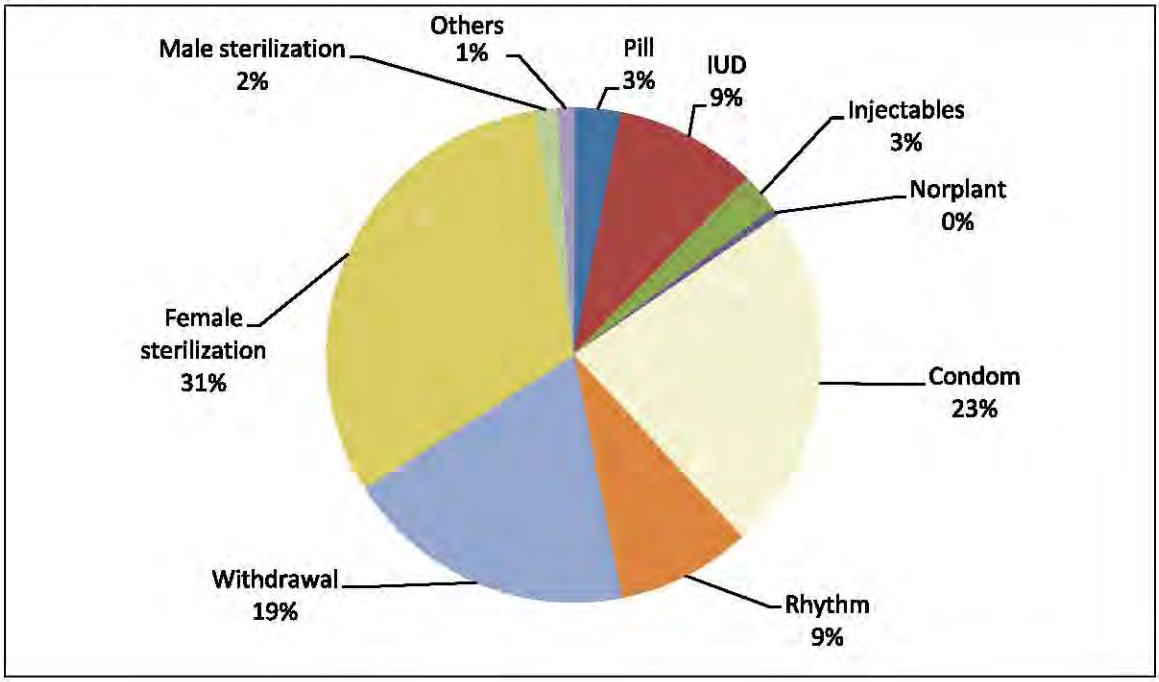
na=not applicable.

The proportion of currently married women of reproductive age who are currently using some form of contraception, commonly known as the contraceptive prevalence rate (CPR), is one of the central indicators of the status of family planning programs. It shows the degree to which couples are actively involved in spacing or limiting births, and the proportions by method (the method mix) indicate 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 been stable at about 30 percent (NIPS, 2001; NIPS, 2007; Population Council, 2006; NIPS/PDHS, 2008).

A total of 34 percent of all married women in the sample were currently using some method of contraception (contraceptive prevalence rate or CPR), compared with 29.6 percent for Pakistan in the 2006-07 PDHS, and 33 percent for Punjab as a whole (NIPS/PDHS, 2008). In this survey, the CPR was 39 percent in urban areas compared with 33 percent in rural areas.

The modern methods most commonly in use were condoms and IUD. (Table 8.2). Female sterilization was also a popular choice for those who did not want more children. Overall, 24 percent of married women were using modern methods; 10 percent were using traditional methods. Figure 8.1 shows the proportion of current users by method mix.

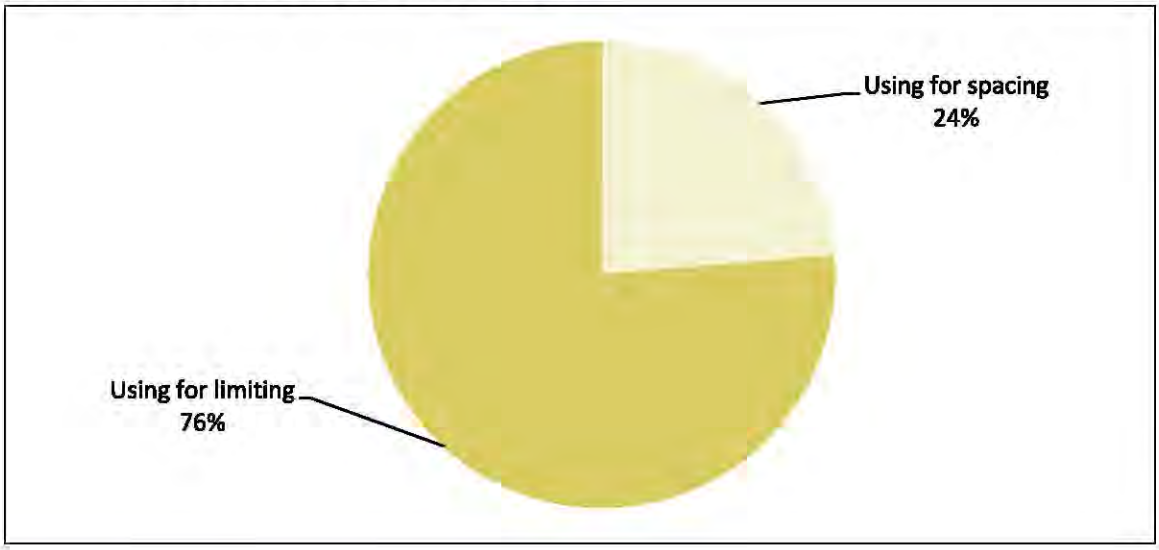
Figure 8.1: Distribution of current users by method mix



Current Use and Desire for Children

It is important to determine how many current users of contraception were using contraceptives for spacing purpose, and how many were using them to stop having children altogether. Figure 8.2 shows that overall 76 percent of current use was for limiting compared with 24 percent for the purpose of spacing births.

Figure 8.2: Current use and desire for children



Correlates of Contraceptive Use

Figures 8.3 and 8.4 show the relationship between contraceptive prevalence and the woman's age and number of living children. The shape of the graph for age shows increasing prevalence up to the age group of 35-39 years. The prevalence was highest in this age group. Figure 8.4 shows that prevalence for women with more than five children was higher.

Figure 8.3: Contraceptive prevalence rate by age

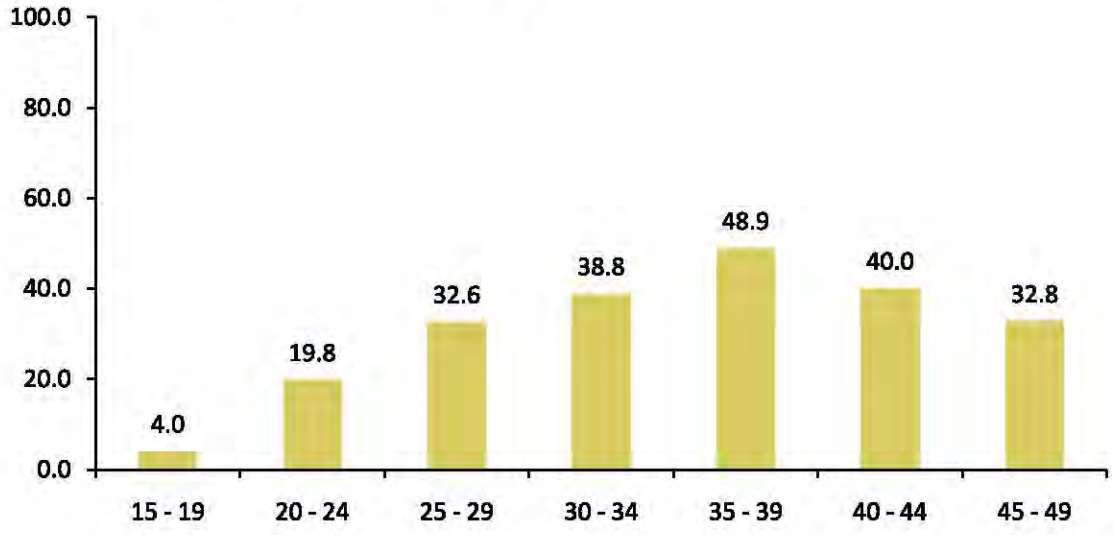
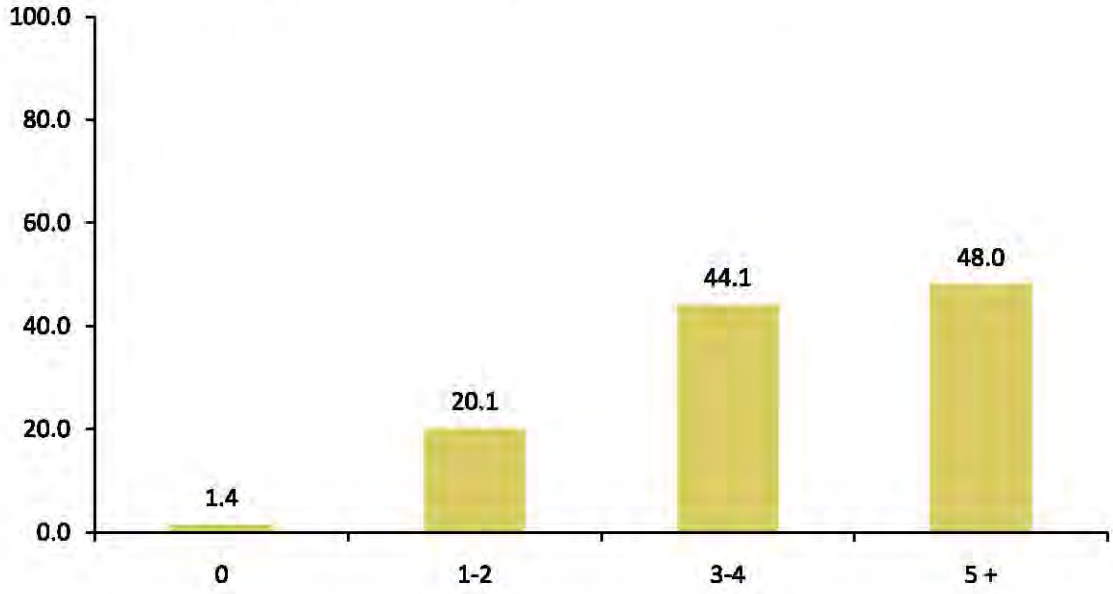


Figure 8.4: Contraceptive prevalence rate by number of living children



Contraceptive use is associated with higher socioeconomic status and urban residence, as shown in Table 8.3. Respondents in households with the highest SLI had higher contraceptive prevalence (37 percent) than those with the lowest SLI (35 percent); conversely, women from households with low SLI were substantially more likely to be never users. Similarly, respondents' literacy was associated with higher current use. Past use was also consistent with SLI. However, past and current users were more likely to live in urban areas, while more never users resided in rural areas.

Table 8.3: 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	34.6	20.0	45.4	130	100.0
Medium low	27.7	23.6	48.6	148	100.0
Medium high	36.8	24.5	38.7	155	100.0
High	37.0	30.4	32.6	138	100.0
Ownership of television					
Yes	36.6	28.3	35.1	279	100.0
No	31.5	21.2	47.3	292	100.0
Literacy of respondent					
Literate	36.4	21.9	41.7	228	100.0
Illiterate	32.4	26.5	41.1	343	100.0
Residence					
Rural	32.9	23.9	43.2	477	100.0
Urban	39.4	28.7	31.9	94	100.0
Total	**34.0**	**24.7**	**41.3**	**571**	**100.0**

Source of Method

With many types of outlets available to obtain various contraceptives, it is important to know which ones are being used and for which methods. Table 8.4 shows the place at which current and past users combined (i.e., ever users) obtained their contraceptive method the last time.

From this table, it is evident that the source depends on the method. Pills and condoms were mostly obtained from the Lady Health Worker or through the husband; IUDs were mostly inserted in government outlets. Injectables were obtained mostly also from LHWs.

Table 8.4: Distribution of ever users of specific contraceptive method by most recent source of supply

	FP method ever used							Total
Source	Pill	IUD	Injectables	Norplant	Condom	Female sterilization	Male sterilization	Percent
Govt. hospital (DHQ/THQ)	0.0	23.3	12.5	100.0	1.2	62.3	33.3	24.1
BHU/RHC/MCH Centre	5.6	13.3	6.3	0.0	1.2	4.9	0.0	4.7
FWC/ MSU	0.0	16.7	0.0	0.0	1.2	0.0	0.0	2.8
LHW/ TBA/ Dai/Rreferral	55.6	3.3	37.5	0.0	24.4	0.0	0.0	17.4
Other public facility	0.0	0.0	0.0	0.0	0.0	1.6	0.0	0.5
Greenstar clinic	0.0	0.0	0.0	0.0	0.0	1.6	0.0	0.5
Pvt. hospital/ clinic/doctor	0.0	33.3	25.0	0.0	0.0	29.5	0.0	15.1
Dispenser/Compounder	5.6	0.0	18.8	0.0	0.0	0.0	0.0	1.9
Pharmacy, chemists/ grocery shop	16.7	0.0	0.0	0.0	9.7	0.0	0.0	5.2
Husband brings method	16.7	0.0	0.0	0.0	57.3	0.0	66.7	24.5
Others	0.0	10.0	0.0	0.0	4.9	0.0	0.0	3.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
N	18	30	16	2	82	61	3	212

Chapter 9

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 appropriate for them and to provide sufficient information and support for that method. All methods have their strengths and weaknesses, and no method is deemed to be appropriate 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 why they chose a particular method. The list of possible reasons was read out to them; the results are shown in Table 9.1. Overall, the reasons for current and past users were similar, so the data were combined. Among the most common reasons for choosing a method were: suitability for respondent and husband, convenience of use and easy availability. For female sterilization and IUD users, suitability of use for a long period of time was often cited. Least cited reason was "No other method available ". Thismeans that clients had access to a variety of methods. They tended to make decisions according to the known attributes of the various methods, but not always. For example, about 75 percent of pill users cited lack of side effects, even though pills are in fact associated with a number of common side effects.

Table 9.1: Distribution of ever users of specific contraceptive method by reason for choosing that method

	Contraceptive method								
Reason	Pill	IUD	Injectables	Norplant	Condom	Withdrawal	Female sterilization	Others	N
Easily available	90.0	64.7	87.5	50.0	91.5	67.2	66.7	100.0	80
Low cost	65.0	32.4	37.5	50.0	68.3	57.4	33.3	0.0	55
Convenient to use	85.0	70.6	100.0	100.0	89.0	78.7	100.0	80.0	84
Suitable for respondent/ husband	85.0	79.4	50.0	100.0	91.5	93.4	100.0	100.0	87
No/fewer side effects	75.0	61.8	50.0	100.0	75.6	83.6	66.7	60.0	74
Can be used for long period	55.0	94.1	93.8	50.0	46.3	100.0	100.0	80.0	74
No other method available	20.0	2.9	12.5	0.0	6.1	0.0	0.0	0.0	5
Method always available	75.0	64.7	81.3	0.0	70.7	52.5	33.3	80.0	65
Provider advised	60.0	44.1	50.0	50.0	26.8	47.5	66.7	20.0	40
Other	0.0	2.9	0.0	0.0	1.2	11.5	0.0	0.0	4
N	**20**	**34**	**16**	**2**	**82**	**61**	**3**	**5**	**223**

Respondents could give more than one reason

To look more specifically at why some users preferred traditional methods to modern ones, 54 current traditional method users were asked why they were not using modern methods. Side effects were by far the main issue: 91 percent cited fear of side effects, and 37 percent reported their own experience of side effects. Husband's disapproval (of modern methods) was cited by 15 percent of the users.

Table 9.2: Distribution of MWRA using traditional methods by reasons for not using modern contraceptive methods

Reason	Percentage
Fear of side effects	90.7
Husband disapproves	14.8
Experienced side effects	37.0
Method not available	3.7
Costs too much	5.6
Doesn't know about modern methods	16.7
Doesn't know about source of method	13.0
N	**54**

Respondents could give more than one reason

Cost, Distance and Time to Reach a Facility

Costs of contraceptive methods for users vary widely in Pakistan according to method, whether public or private sector, and the distance from home to facility. Table 9.3 and Figure 9.1 show women's reported costs the last time they obtained a method. Sixty-four percent of users were not charged for their contraceptives, including a great majority of female sterilization users (who are, in fact, typically reimbursed for expenses involved). For another one-fifth of respondents (21 percent), notably condom users, the husband obtained the method, so the wife did not know the cost. Eleven percent paid more than Rs 50 and 4 percent paid less than Rs 50. IUD users often paid more than Rs 50 for their method. However, for IUD it is a one-time cost, so the monthly cost may be quite low.

Table 9.3: 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	83.3	0.0	16.7	0.0	0.0	100.0	6
IUD	11.1	5.6	0.0	77.8	5.6	100.0	18
Injectables	60.0	20.0	0.0	20.0	0.0	100.0	5
Norplant	100.0	0.0	0.0	0.0	0.0	100.0	1
Condom	31.8	6.8	0.0	0.0	61.4	100.0	44
Female sterilization	100.0	0.0	0.0	0.0	0.0	100.0	61
Male sterilization	66.7	0.0	0.0	0.0	33.3	100.0	3
Total	**63.8**	**3.6**	**0.7**	**10.9**	**21.0**	**100.0**	**138**

Figure 9.1A: Cost in rupees of contraceptive supply for current method

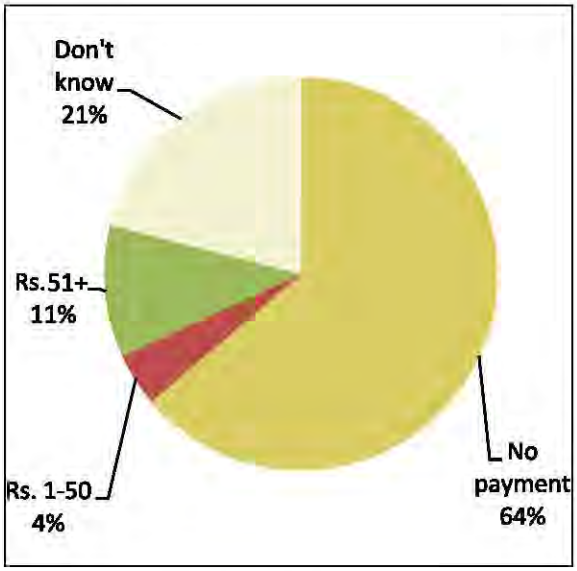
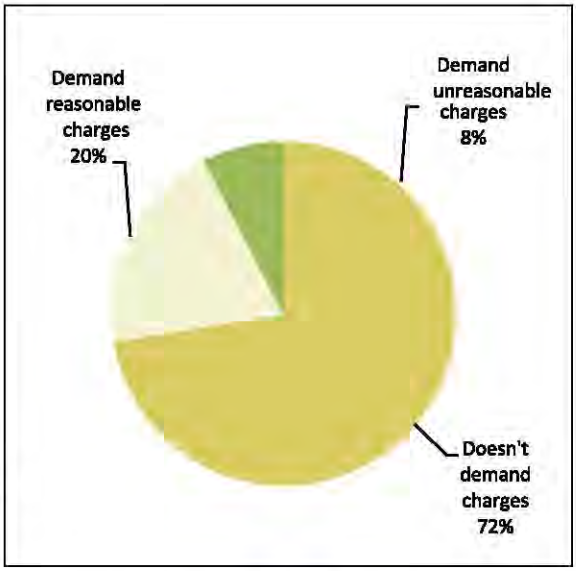


Figure 9.1B: Attitude towards service charges for current method other than contraceptive



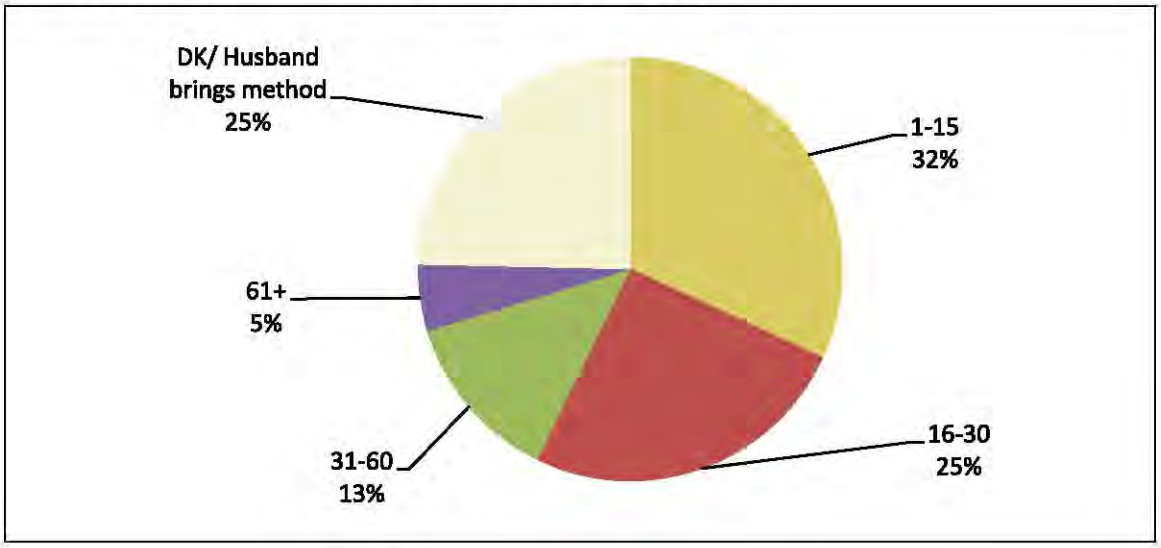
Current users were also asked whether their facility charged them for services, other than the method itself. Seventy-two percent said they were not charged, 20 percent said that they were charged a reasonable amount and only 8 percent were of the view that they were charged an unreasonable amount.

The time usually needed for current users to obtain a specific method is shown in Table 9.4; Figure 9.2 shows the overall travel time in minutes to acquire the contraceptive methods. About 32 percent of users needed no more than 15 minutes to obtain their method; this included contraceptives from LHWs, who often brought injectables, pills and condoms to the doorstep. Eighteen percent needed more than 30 minutes. For another about one quarter, their husband brought the supplies, so they did not know how long it took. For a few, particularly female sterilization and IUD users, it took more than an hour to reach the service place; usually in these cases there was no need to visit frequently. In case of norplant, it took more than 60 minutes but it is pertinent to mention here that there was only a single case.

Table 9.4: 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	66.7	16.7	16.7	0.0	0.0	100	6
IUD	44.4	38.9	5.6	5.6	5.6	100	18
Injectables	100.0	0.0	0.0	0.0	0.0	100	5
Norplant	0.0	0.0	0.0	100.0	0.0		1
Condom	31.8	4.5	2.3	0.0	61.4	100	44
Female sterilization	21.3	39.3	24.6	8.2	6.6	100	61
Male sterilization	0.0	33.3	0.0	0.0	66.7	100	3
Total	**31.9**	**25.4**	**13.0**	**5.1**	**24.6**	**100**	**138**

Figure 9.2: Travel time (in minutes) for contraceptive supplies



Treatment by Provider

Information Provided

Current and past users were asked what information was provided to them by service providers. For this purpose, a list of important topics was read out to them, and the results are shown in Table 9.5. The accuracy of client responses may be questioned, due to problems of recall or understanding; still, it appears that information provided was seriously deficient. The most common topic respondents said they were told about was effectiveness. Few were told about how to use the method, how the method works, advantages of the method, side effects and other methods available. On other topics, very less number of users were provided information. Norplant was the method regarding which different aspects were totally ignored. There is a need to emphasize to providers that they give comprehensible information on the method selected by the clients, especially hormonal contraceptives.

Table 9.5: Distribution of ever users of contraceptives by information provided at acceptance for method

	Family planning method							
Information provided at acceptance	Pill	IUD	Injectables	Norplant	Condom	Female sterilization	Male sterilization	N
How the method works	40.0	35.3	25.0	0.0	11.0	36.1	0.0	25
How to use method	65.0	38.2	37.5	50.0	15.9	27.9	0.0	29
Contraindications	15.0	11.8	12.5	0.0	2.4	26.2	0.0	12
Effectiveness/duration of effectiveness	55.0	82.4	100.0	100.0	13.4	83.6	0.0	55
Advantages compared to other method	30.0	29.4	31.3	100.0	8.5	37.7	0.0	24
Possible side effects	20.0	26.5	31.3	0.0	4.9	21.3	0.0	16
What to do if experienced side effects	20.0	41.2	25.0	50.0	2.4	31.1	0.0	20
Possibility of switching	20.0	41.2	12.5	50.0	3.7	13.1	0.0	15
About other method that you could use	40.0	20.6	25.0	0.0	15.9	16.4	0.0	19
N	**20**	**34**	**16**	**2**	**82**	**61**	**3**	**218**

Respondents could give more than one response

Treatment at Facility

Current users were asked about various aspects of their treatment on their last visit to the provider for family planning. As Table 9.6 shows, responses were mainly positive but with some exceptions. Thirty-eight percent of the respondents said that the provider was unable to deal with side effects.

Table 9.6: Percent current users responding positively on treatment at last visit, by aspect of treatment

Aspect of treatment	Percentage
Staff attitude cooperative	84.8
Provider available	96.2
Attend/examine properly	96.2
Doesn't demand charges	71.4
Can deal with side effects	61.9

Side Effects

Current users were asked if they had experienced, or were experiencing, any side effects from their current method, and 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. As shown in the Figure 9.3, side effects were most commonly reported by IUD users (64 percent) and were least commonly reported by condom users (1.2 percent).

Figure 9.3 Percent ever users who experienced side effects by method used

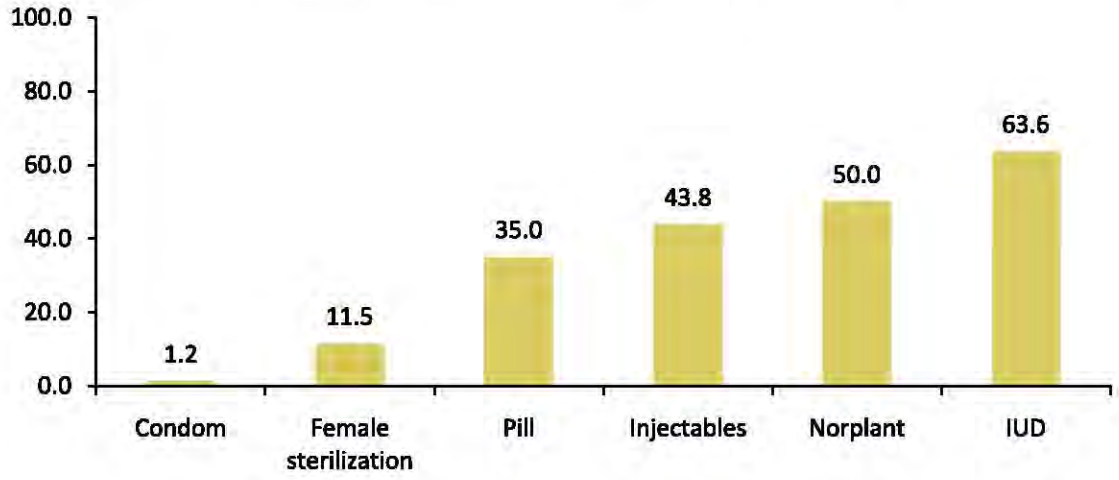
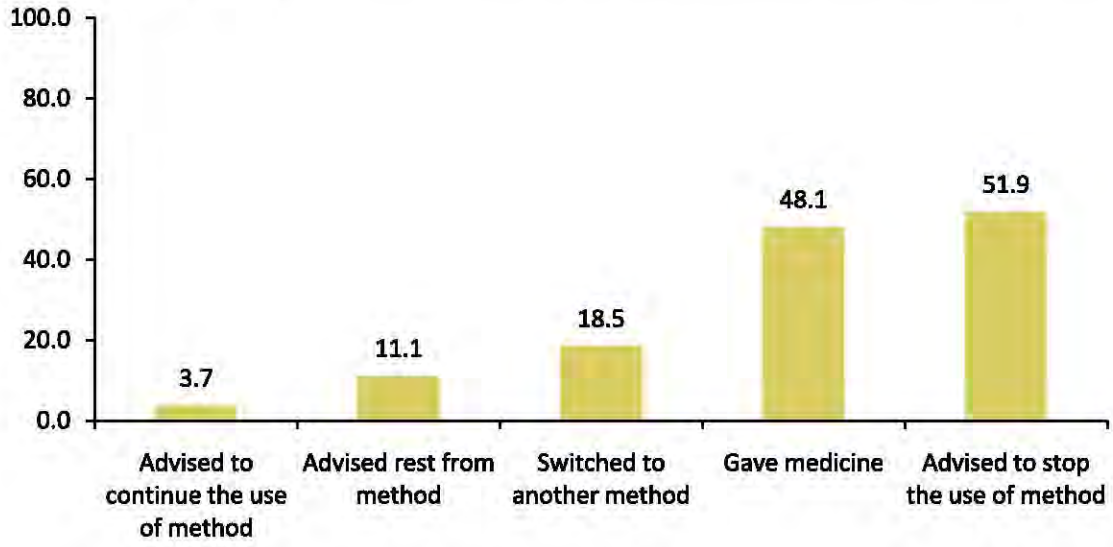


Figure 9.4: Distribution of provider responses upon consultation for side effects among past users (N=27)



These respondents were asked if the provider responded in a manner included in a list read out to them (Figure 9.4). Only 4 percent were advised to continue the use of the chosen method, 11 percent were advised to have rest from the method, 19 percent were asked to switch to another method and 52 percent were advised to stop,. However, the treatment was provided with medicine to 48 percent of the users.

Chapter 10

Reasons for Non-use

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

Hindrances to Use

One way to understand common 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 10.1 shows the responses of the female respondents, according to whether they were current users, past users or never users.

Table 10.1: 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 user		Past user		Never user	
Hindrance	N	%	N	%	N	%
Husband's disapproval	184	94.8	131	92.9	221	93.6
Other people may find out about contraceptive use	139	71.6	101	71.6	177	75.0
Distance and travel costs to FP outlet	131	67.5	88	62.4	133	56.4
Probability of getting pregnant while using	160	82.5	111	78.7	177	75.0
Fear of side effects	186	95.9	130	92.2	210	89.0
Problem of managing side effects	173	89.2	123	87.2	196	83.1
FP is against religion	164	84.5	127	90.1	202	85.6
Total	**194**	**na**	**141**	**na**	**236**	**na**

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

Some obstacles that couples might face were almost universally acknowledged. More than 92 percent all users mentioned husband's possible disapproval while a great majority acknowledged religious concerns, fear of side effects, and the problems of managing side effects. Other reasons were relatively less rated.

Past Users

Reasons for Discontinuing Contraceptive Use

Past users were asked about their reasons for discontinuing their last contraceptive method. The most commonly given reasons were rest from the method, infrequent sex, experience of side effects and method failure apart from desire for another child (Table 10.2). These reasons are appropriate in many cases, but not always. Clinical methods do have associated side effects; but as we have seen, providers rarely try to counsel users through the temporary experience of common, non-dangerous side effects.

Table 10.2: Distribution of past contraceptive users by reason for discontinuing last method

Reason	Percentage
Wanted another child	41.8
Fear of side effects	3.5
Side effects experienced	19.1
Method failure	17.7
Lack of access/unavailability	2.1
Cost not affordable	0.7
Method inconvenient to use	5.0
Rest from method	37.6
Missed the dose	1.4
Provider's advice	5.0
Infrequent sex/Husband away	24.1
Husband's advice	8.5
In laws oppose	0.7
Menopause	1.4
N	**141**

Respondents could give more than one response.

Reasons for Current Non-use

It is important to know the reasons for non-use of those couples who have used contraceptive methods in the past but are not currently using them. A list of possible reasons was read out to past users for their not currently using contraceptives, with more than one reason possible (Table 10.3). The most common reasons were: rest from method, infrequent sex/husband away, breastfeeding/lactational amenorrhea, desire of another child and currently pregnant.

Table 10.3: Distribution of past users by reason for current non-use

Reason	Percentage
Fear of side effects	10.7
Want another child	22.9
Currently pregnant	21.3
Rest from method	32.6
Provider's advice	5.7
Infrequent sex/husband away	32.1
Breast feeding/Lactational amenorrhea	28.6
Menopause/hysterectomy	6.4
Just not using/too lazy	3.5
Others	15.4
N	**141**

Respondents could give more than one response.

Never Users

Reasons for Non-use

The 236 women in the sample who reported never use were asked about various possible reasons for not using contraceptives, with each reason read out separately. As shown in Table 10.4, the most important reason was a desire for more children, and a concern about their ability to conceive as an additional factor. Women were more likely to cite fear of side effects, husband and in-laws' opposition, breastfeeding/lactational amenorrhea and infrequent sex/husband away as significant reasons for not using contraceptives. Other important reason cited was: shy to consult about family planning. A small number of women reported religious objection which is often taken in other literature as a barrier to family planning use.

Table 10.4: Distribution of never using wives by reason for never use

Reason	Percentage
Husband opposes	19.5
In laws oppose	14.4
Fear of side effects	34.6
Lack of access/Unavailability	3.8
Cost not affordable	4.2
Shy to consult about family planning	14.8
Method inconvenient to use	5.1
Infrequent sex/Husband away	16.7
Difficult/Unable to conceive	32.6
Breast feeding/Lactational amenorrhea	19.2
Respondent/Husband infertile	2.1
Wanted (more) children	78.6
Against religion	5.9
Natural spacing	1.7
Didn't know of any FP method	0.4
Others	3.0
N	**236**

Respondents could give more than one response.

Attitude towards Birth Spacing and Limiting

It is important to see the extent to which never users disapprove of family planning in principle, as opposed to accepting it in principle but not using contraceptives for some other reason. Table 10.5 shows this for never using respondents. About 20 percent of the women disapproved of limiting, while 17 percent disapproved of spacing. There seems to be more opposition to contraceptive use for limiting rather than for the purpose of spacing children.

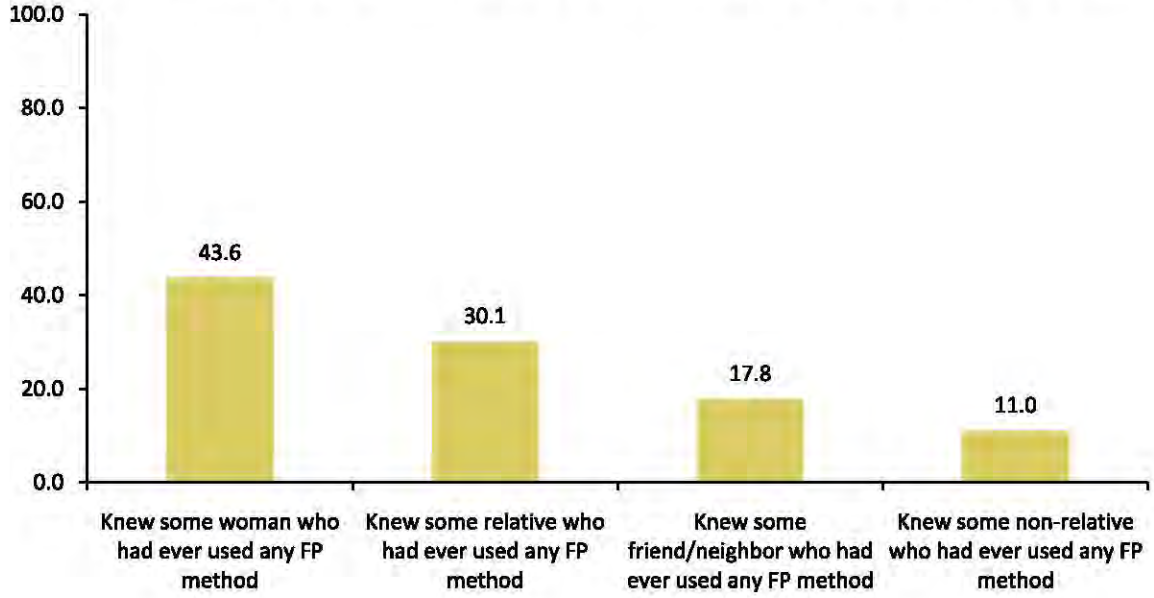
Table 10.5: Distribution of never users by attitude toward spacing and limiting birth

	Attitude towards spacing		Attitude towards limiting	
Attitude	**N**	**%**	**N**	**%**
Approve	196	83.1	186	78.8
Disapprove	40	16.9	48	20.3
Don't know	0	0.0	2	0.8
Total	**236**	**100.0**	**236**	**100.0**

Knowledge of Contraceptive Users, Methods and Facilities

Of the 236 female never users in the sample,44 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy. Thirty percent of the respondents had a relative who had used some method, and 18 percent knew of a friend or neighbor who had used contraceptives. Eleven percent of the never users knew someone (who was not relative) who had ever used an FP method to delay or avoid pregnancy.

Figure 10.1: Percent of never users who knew some woman who had ever used any FP method



Respondents who were never users had the same level of knowledge of at least one FP method (100 percent) as of general cited in Table 8.1(100 percent). For each method, a smaller percent of never users knew that method than the general distribution. Never users knew a variety of methods.

Table 10.6: Distribution of never users by knowledge of contraceptive methods

Method	Percentage
Pill	96.2
IUD	94.1
Injectables	93.2
Nor plant	26.7
Condom	69.5
Rhythm	21.6
Withdrawal	50.8
Female sterilization	97.5
Male sterilization	39.0
Emergency Pills	9.7
Other FP methods	6.8
At least one FP method	100.0
N	**236**

Respondents could give more than one response.

Of 236 never users, 54 percent did not know of a place to obtain a method. For those who did know, the places they were aware of are shown in Table 10.7. The sources best known were, Department of Health outlets – the District/Tehsil Headquarters hospitals and BHUs/RHCs/MCH centers, Lady Health Workers, private hospitals/clinics/doctor ,pharmacy/ chemists and, some knew of green star clinics , and Family Welfare Centers of the Ministry of Population Welfare. A few women were aware of other sources.

Table 10.7: Knowledge of sources of contraception of never users by source of supply

Source	Percentage
Knowledge of at least one service provider	46.2
DHQ/THQ Hospitals	32.6
BHU/RHC/MCH Centre	19.9
Family Welfare Center	7.2
Mobile Service Unit Camp	2.5
Lady Health worker	32.6
Greenstar clinic	9.3
Private hospital/ Clinic/ Doctor	22.5
Dispenser/ Compounder	7.6
Pharmacy/ Chemists	22.5
Homeopathic/ Hakim	6.4
TBA/ Dai	8.5
Grocery shop (not pharmacy/ chemist)	10.6
Others	0.4
N	**236**

Respondents could give more than one response.

When asked which of the facilities named was nearest, the respondents were most likely to name the Lady Health Worker, BHU/RHC/MCH Centre and DHQ/THQ Hospitals. Mostly they would go there on foot, sometimes by Rickshaw (Figure 10.2). Of the 106 respondents who indicated the time required to go to the nearest facility, 54 percent reported 15 minutes or less, 19 percent cited 16 to 30 minutes and 15 percent replied more than 30 minutes; the maximum was three hour (Figure 10.3).

Figure 10.2: Mode of transportation to the nearest facility/provider

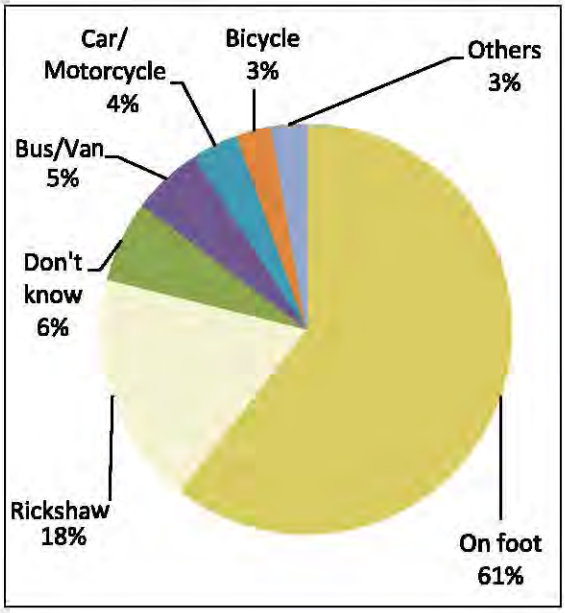
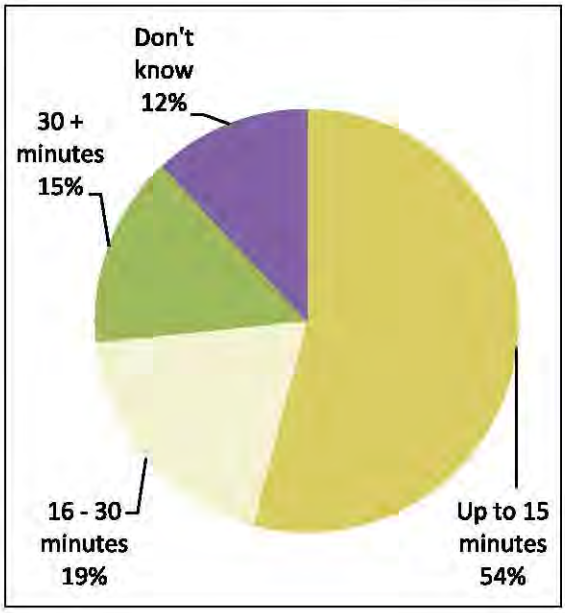


Figure 10.3: Time taken to go to the nearest facility/provider



Intent to Use

Never users were asked about whether they intended to use contraceptives in the future. Table 10.8 shows that 36 percent of female respondents said that they intended to use some method. Lower parity women who had not yet used a method (women with 2 or fewer children) expressed their more intent to use contraception in the future than women with 3 or more children. Twenty –five percent of the never user women said they did not intend to use contraceptives in the future and a number of women (30 percent) were unsure ; this is a grey area. An effective IEC strategy is required to encourage them to acceptance and use of family planning methods.

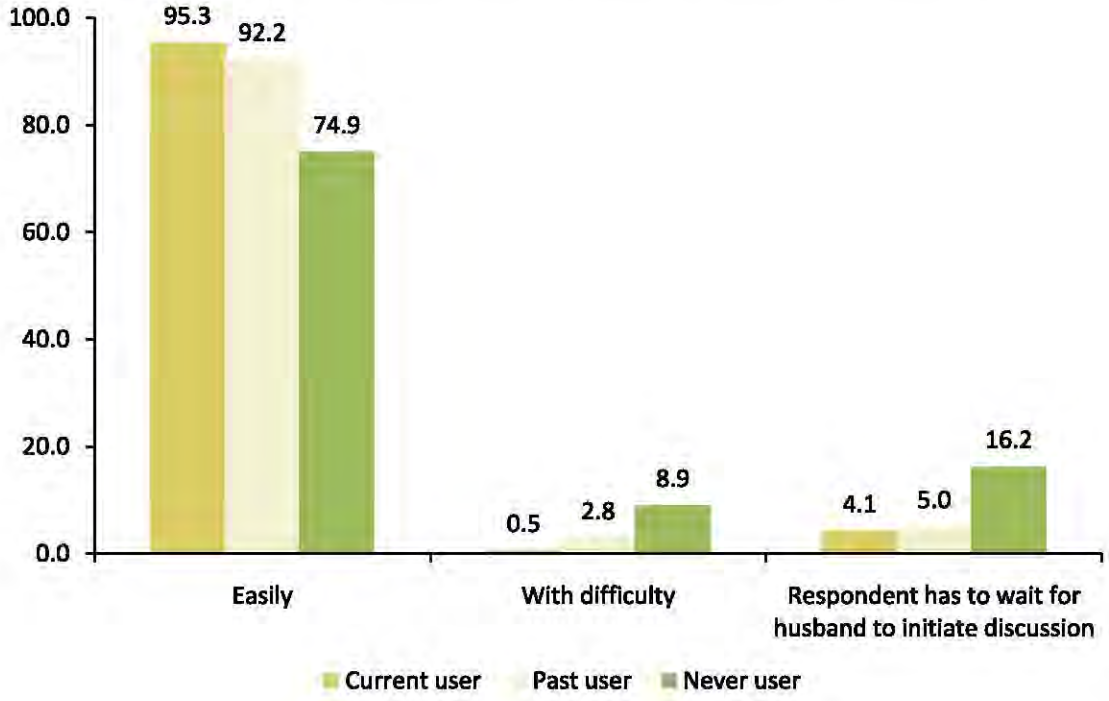
Table 10.8: Distribution of never users by intent to use a method in future and number of living children

Number of living children	Intention to use FP method in future				Total	
	Yes	No	Unsure/ Uncertain	Can't get pregnant	%	N
0	49.3	10.4	37.3	3.0	100.0	67
1-2	35.5	25.0	35.5	3.9	100.0	76
3-4	29.2	41.7	25.0	4.2	100.0	48
5 or more	26.7	26.7	15.6	31.1	100.0	45
Total	**36.4**	**24.6**	**30.1**	**8.9**	**100.0**	**236**
N	86	58	71	21	236	**236**

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 of those who responded said they could do so easily (Figure 10.4). However, this varied by use status. Ninety-five percent of the current users and 92 percent of the past users said they could approach their husbands easily; very few said they had to wait for their husband to initiate the discussion. However, for never users, 75 percent reported being able to approach their husbands easily,9 percent could only do so with difficulty and 16 percent said they had to wait for him to begin the conversation.

Figure 10.4: Women's report regarding ease of approach to husband to discuss family planning



Chapter 11

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 the 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 would appear to be in need of some support to avoid unwanted pregnancies.

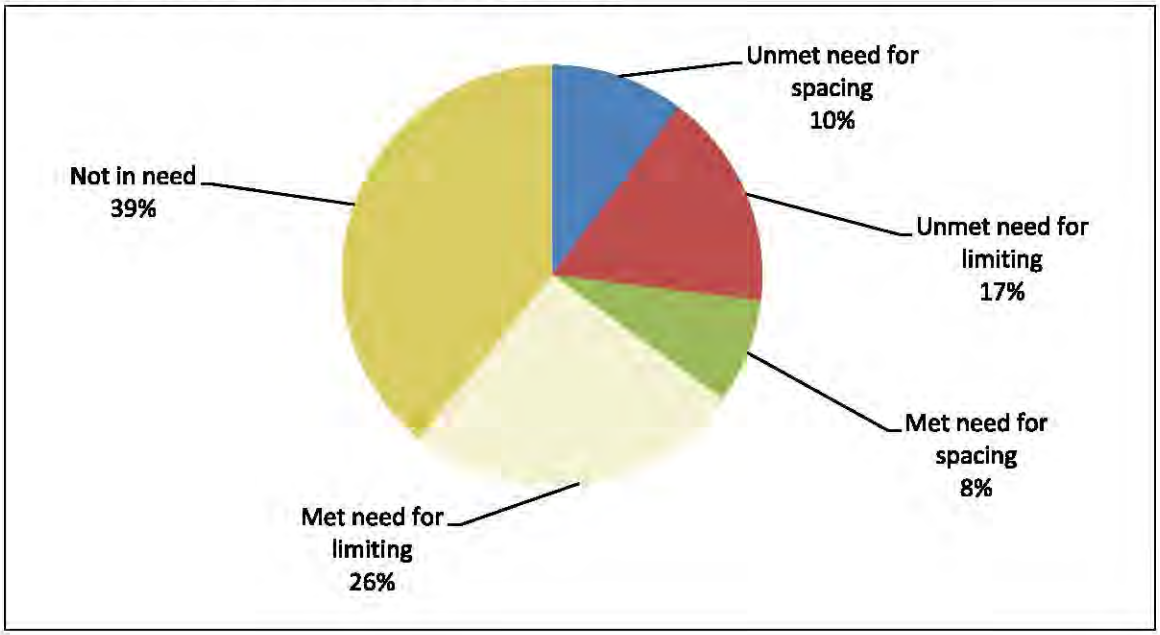
Levels and Correlates

Table 11.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Khanewal. Of the 571 women, 27 percent were judged to be in unmet need. This proportion is lower than is typically found in Pakistan, where unmeet need tends to be around 37 percent of MWRA. Of the 27 percent of the women who had unmet need, 10 percent were for spacing and 17 percent for limiting. Unmet need for spacing was concentrated among younger women and women with one or two children. Unmet need for limiting, unsurprisingly, was highest among women with five or more children, because at that stage couples do not want to have more children.

Table 11.1: Distribution of women with unmet need for spacing and limiting by background characteristics

Characteristic	Unmet need			Met need			Total demand	Not in need	Total	
	For spacing	For limiting	Total	For spacing	For limiting	Total			%	N
Age of respondent										
15 – 24	18.1	2.6	20.7	7.8	8.6	16.4	37.1	62.9	100.0	116
25 – 34	15.9	12.9	28.9	12.9	22.4	35.3	64.2	35.8	100.0	232
35 – 49	0.4	27.8	28.3	3.1	38.6	41.7	70.0	30.0	100.0	223
Residence										
Rural	10.9	16.6	27.5	7.8	25.2	32.9	60.4	39.6	100.0	477
Urban	7.4	17.0	24.5	9.6	29.8	39.4	63.8	36.2	100.0	94
Literacy of respondent										
Literate	16.7	10.1	26.8	11.8	24.6	36.4	63.2	36.8	100.0	228
Illiterate	6.1	21.0	27.1	5.5	26.8	32.4	59.5	40.5	100.0	343
Education of respondent										
No education	6.6	21.9	28.5	4.8	27.0	31.8	60.4	39.6	100.0	333
Up to primary	12.6	12.6	25.2	9.9	24.3	34.2	59.5	40.5	100.0	111
Up to Secondary	17.0	6.4	23.4	13.8	23.4	37.2	60.6	39.4	100.0	94
Above secondary	21.2	6.1	27.3	18.2	27.3	45.5	72.7	27.3	100.0	33
Children ever born										
None	0.0	0.0	0.0	1.5	0.0	1.5	1.5	98.5	100.0	68
1 – 2	26.1	5.2	31.3	16.4	3.0	19.4	50.7	49.3	100.0	134
3 – 4	12.1	18.6	30.7	12.1	32.9	45.0	75.7	24.3	100.0	140
5 or more	3.1	27.1	30.1	2.6	42.8	45.4	75.5	24.5	100.0	229
Ownership of TV										
Yes	12.2	15.1	27.2	8.6	28.0	36.6	63.8	36.2	100.0	279
No	8.6	18.2	26.7	7.5	24.0	31.5	58.2	41.8	100.0	292
Standard of living index										
Low	3.8	20.8	24.6	5.4	29.2	34.6	59.2	40.8	100.0	130
Medium low	13.5	20.3	33.8	7.4	20.3	27.7	61.5	38.5	100.0	148
Medium high	9.7	16.8	26.5	9.0	27.7	36.8	63.2	36.8	100.0	155
High	13.8	8.7	22.5	10.1	26.8	37.0	59.4	40.6	100.0	138
Total	**10.3**	**16.6**	**27.0**	**8.1**	**25.9**	**34.0**	**60.9**	**39.1**	**100.0**	**571**

Figure 11.1: 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 11.1 also shows total demand by background characteristics of the women. Overall, total demand was 61 percent of all married women of reproductive age. As the table shows, total demand did rise rapidly, and fairly consistently, by number of 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 11.2). Twenty-nine percent of the women with unmet need for spacing said they would be worried if they became pregnant again; 51percent said that they would accept it. Of those with unmet need for limiting, 57 percent said they would be worried if they got pregnant. Thirty-three percent would accept it. None of the women who had unmet need for limiting would be pleased if she got pregnant.

Table 11.2: 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	1	2.2	0	0.0
Worried	13	28.9	51	57.3
Accept it	23	51.1	29	32.6
Doesn't matter	8	17.8	8	9.0
Others	0	0.0	1	1.1
Total	**45**	**100.0**	**89**	**100.0**

Reasons for Non-use

Past and never users were asked why they were not using some method of contraception; the results are shown in Table 11.3. Some of these reasons represent barriers as perceived by the women; the most important of these were fear of side effects and opposition by husbands or in-laws. On the other hand, many women with defined unmet need stated reasons that did not reflect perceived need, at least at present. Such reasons included: wanted more children, infrequent sex/husband away, natural spacing, difficulty in conceiving, currently pregnant and currently breastfeeding. Some of these women may have had more need than they realized; for example, women using "natural spacing" or breastfeeding may in fact be at substantial risk of pregnancy. Women currently pregnant or amenorrheic may be in need of contraception in the near future.

Table 11.3: 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
Fear of side effects	25.4	34.7	31.2
Husband opposes	13.6	8.4	10.4
In laws oppose	16.9	1.1	7.1
Rest from method	20.3	13.7	16.2
Shy to consult about FP	6.8	10.5	9.1
Provider's advice	1.7	5.3	3.9
Against religion	3.4	2.1	2.6
Lack of access/Unavailability	0.0	4.2	2.6
Cost not affordable	0.0	5.3	3.2
Just not using/too lazy	1.7	2.1	1.9
Method inconvenient to use	1.7	5.3	3.9
Infrequent sex/Husband away	18.6	37.9	30.5
Natural spacing	0.0	4.2	2.6
Difficult/Unable to conceive	11.9	11.6	11.7
Want (more) children	49.2	26.3	35.1
Currently pregnant	15.3	5.3	9.1
Breastfeeding/Lactational amenorrhea	1.7	6.3	4.5
Others	16.9	5.3	9.7
Total	**59**	**95**	**154**

Respondents could give more than one reason

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprise 59 (10.3 percent) of MWRA. As shown in Table 11.4, they were characterized by:

Living Children: Most (61 percent) had 1 or 2 living children.

Family Planning Use: More never users (53 percent) than past users (48 percent).

Strength of Preference: Low (28 percent "worried" if they became pregnant earlier than they wanted compared to those who were pleased (2 percent) or would accept (50 percent) the unwanted pregnancy).

Intent to use FP method in Future: High (76 percent intended to use an FP method in future).

Approval of FP: High (90 percent approved of using an FP method for spacing purpose).

FP Communication with Husband: Moderate (48 percent had communicated with husbands on FP in the past one year; while only 3 percent said approaching the husband was "difficult").

Obstacles to FP method Use: Fear of side effects (25 percent); husband and in-laws opposition (14 percent and 17 percent respectively) (Table 11.3).

Table 11.4: Percent distribution of MWRA in unmet need for spacing and limiting by selected characteristics

	Unmet need for spacing		Unmet need for limiting	
Characteristics	**N**	**%**	**N**	**%**
Number of living children				
0	1	1.7	0	0.0
1-2	36	61.0	8	8.4
3-4	19	32.2	36	37.9
5 or more	3	5.1	51	53.7
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	28	47.5	49	51.6
Never user	31	52.5	46	48.4
Reaction if become pregnant in near future				
Pleased	1	2.2	0	0.0
Worried	13	28.3	51	57.3
Accept it	23	50.0	29	32.6
Doesn't matter	8	17.4	8	9.0
Menopausal/Hysterectomy/Sterilized	0	0.0	0	0.0
Others	1	2.2	1	1.1
Intention to use a method in future				
Yes	45	76.3	41	43.2
No	4	6.8	37	38.9
Unsure/Uncertain	10	16.9	16	16.8
Can't get pregnant	0	0.0	1	1.1
Approval of FP				
Approve	53	89.8	86	90.5
Disapprove	5	8.5	9	9.5
Others	1	1.7	0	0.0
FP communication with husband in past one year				
Never	31	52.5	57	60.0
Once or twice	13	22.0	11	11.6
More often	15	25.4	27	28.4
Approach the topic of FP with husband				
Easily	53	89.8	80	84.2
With difficulty	2	3.4	5	5.3
Respondent has to wait for husband to initiate discussion	4	6.8	10	10.5
Total	**59**	**na**	**95**	**na**

na=not applicable.

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 95 (16.6 percent) of MWRA. As shown in Table 11.4, they were characterized by:

Living Children: A strongly positive association with number of living children; 54 percent had 5+ living children.

Family Planning Use: Almost equal number of never users and past users (48 percent and 52 percent respectively)

Strength of Preference: Moderate (57 percent would be "worried" if they became pregnant compared to those who would accept (33 percent) the unwanted pregnancy.

Intent to use FP method in Future: Moderate (43 percent intended to use an FP method in future.

Approval of FP: High (91 percent approved of FP for limiting purpose).

FP Communication with Husband: Low (40 percent had communication with husband on FP in the past year; while 5 percent said approaching the husband was "difficult").

Obstacles to FP Method Use: Fear of side effects (35 percent); husbands opposition (8 percent) (Table 11.3).

Chapter 12

Reproductive Preferences and Behavior of Men

It is often the case that in matters relating to family planning the focus has too often been more on women, despite the fact that husbands are equal partners in the reproductive process and often have greater responsibility for decision-making in the family. In addition, women often mention their husbands as a constraint to the use of 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 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 Khanewal, the field team was able to interview 188 men who were husbands of the married women of reproductive age interviewed for the survey plus 11 married men living in selected areas but 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 = 199) 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 12.1 shows the background characteristics of the men interviewed in the survey. It shows that 8 percent of the men were under 25 years of age and 15 percent were 50 years of age and above.

As shown in Table 12.1, the men were much better educated than the sampled currently married women of reproductive age. Twenty-three percent of the men had not been to school, compared to 58 percent of the currently married women (Table 3.2). It also shows that 47 percent of the men had more than primary education, whereas 22 percent of the currently married women had attained that level of education (Table 3.2).

The occupations of men are also presented in Table 12.1.The highest proportion (41 percent) of men were engaged in agriculture/livestock/poultry , 24 percent were laborers while 20 percent were running their own business. Interestingly, unemployment was very low ,only 1 percent.

Table 12.1: Background characteristics of male respondents

Characteristic	Percentage
Age	
15-19	2.0
20-24	6.0
25-29	21.1
30-34	15.1
35-39	16.6
40-44	14.1
45-49	10.1
50-54	7.0
55+	8.0
Education	
Proportion literate	71.4
No education	23.1
Up to primary	29.6
Up to middle	24.6
Up to Secondary	14.6
Above secondary	8.0
Occupation	
Agriculture/Livestock/Poultry	41.2
Petty trader	2.0
Labor	24.1
Govt. service	6.0
Pvt. Service	5.0
Own business	19.6
Unemployed	1.0
Skilled worker	0.5
Others	0.5
N	**199**

Contraceptive Knowledge and Use

Eighty-six percent of the interviewed men (Table 12.2) while 100 percent of the currently married women of reproductive age interviewed in Khanewal knew of at least one method of contraception.

As presented in Table 12.2, knowledge of modern methods was highest for pills (74 percent), followed by condom (64 percent), injectables (60 percent) , female sterilization (30 percent), and IUD (17 percent). The least known methods were norplant and male sterilization (2 percent and 0.5 percent respectively). Knowledge of at least one traditional method was prevalent among 27 percent of the men. The pattern of ever use and current use of contraception reported by husbands is also shown in Table 12.2. Fifty-nine percent of the MWRA reported having used some method of contraception during their married lives (Table 8.2); of the male respondents, also 59 percent reported ever using some method of contraception in their married lives. For the men, among modern methods, condom was the most popular method ever used (23 percent), followed by female sterilization (13 percent), IUD (8 percent), pills (7 percent) and injectables (6 percent). Male sterilization method has never been used while norplant has least been used (1 percent).

Table 12.2: Distribution of male respondents by contraceptive knowledge and use status

Method	Knowledge	Ever use	Current use
Female sterilization	29.6	13.1	13.1
Male sterilization	0.5	0.0	0.0
Pill	74.4	7.0	0.5
IUD	16.6	7.5	2.0
Injectables	59.8	6.5	1.0
Norplant	2.0	1.0	0.5
Condom	64.3	22.6	8.5
Rhythm	23.6	31.7	18.6
Withdrawal	4.0	7.0	0.5
Others	3.5	1.5	0.5
At least one FP method	85.9	59.3	43.7
At least one modern FP method	85.9	40.2	24.6
At least one traditional FP method	27.1	34.2	19.1
Emergency Pills	0.5	0.0	na
N	**199**	**199**	**199**

na=not applicable.

As mentioned in Table 8.2, a total of 34 percent of all MWRA in the sample were currently using some contraceptive method, while for the male respondents this figure was 44 percent. The most common current modern method reported by male respondents was condom (9 percent).However, 13 percent male respondents reported female sterilization. The use of traditional methods was also reported by 19 percent of the current users. Since traditional methods are far less reliable than modern methods, an important goal of the FALAH project may be to shift users of traditional methods to more effective modern methods.

Table 12.3: Percent of respondents who have ever used, currently using a contraceptive method by selected back ground characteristics

characteristics	Ever used at least one FP method	Currently using any FP method	N
Education level			
No education	60.9	45.7	46
Below secondary	58.3	42.6	108
Secondary and above	60.0	44.4	45
Number of living children			
None	3.1	0.0	32
1-2	54.8	35.7	42
3-4	68.5	48.1	54
5+	80.3	64.8	71
Future desire for children			
Soon	36.0	20.0	25
Later	30.0	18.0	50
Never	83.0	63.0	100
Don't know	45.8	41.7	24
Total	**59.3**	**43.7**	**199**

Table 12.3 shows ever use and current use of modern contraception among respondents by background characteristics. As regards ever use of contraceptives, no big difference has been marked among secondary and above education and no education; on the other hand interestingly slightly higher ever use has been noted among non educators. The current use of family planning method also showed the same pattern by education of men.

Table 12.3 also shows contraceptive use by the number of living children and ever use as well as current use. Of those who had one or two children, 55 percent reported ever use of family planning methods, compared to 69 percent ever use by men who had 3-4 children.

Table 12.3 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 63 percent were currently using a form of contraception. Among those men who wanted to delay their next child for at least two years, 18 percent reported current use of any contraceptive method.

Source of Contraceptive Methods

As shown in Table 12.4, among those who reported the last source for obtaining contraceptive methods, 20 percent obtained it from Government hospitals (DHQ/THQ), 19 percent from private hospitals/clinincs,17 percent from "grocery shop/general store" and 16 percent obtained their last method from pharmacy/chemists. LHWs were also reported as source by 11 percent of the ever users.

Table 12.4: Distribution of male ever users by the last reported source of contraceptive supply

Source	Percentage
Govt. hospital (DHQ/THQ)	20.0
BHU/RHC/MCH Centre	4.3
FWC	5.7
LHW	11.4
Pvt. Doctor	2.9
Pvt. hospital/clinic	18.6
Pharmacy, chemist	15.7
Homeopath/Hakim	1.4
Grocery shop/general store	17.1
Wife brings method	1.4
Others	1.4
Total	**100.0**
N	**70**

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 et al., 1997). In Khanewal , 97 percent of men approved of spacing between children and also approved the use of any form of contraception for this purpose (Table 12.5). This means that spacing message is acceptable to men and for that they are ready to use the methods as well.

Table 12.5: Distribution of male respondents' attitudes toward spacing and use of contraceptives for spacing

Variable	Percentage
Spacing between children	
Approve	97.5
Disapprove	2.5
Total	**100.0**
N	**199**
Using FP methods for spacing	
Approve	97.0
Disapprove	3.0
Total	**100.0**
N	**199**

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 12.6 shows that 82 percent of the current users were very satisfied with their current method. Eighteen 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 12.6: Level of male respondents' satisfaction with their current method

Level of satisfaction	Percentage
Very satisfied	81.6
Somewhat satisfied	18.4
Total	**100**
N	**49**

Table 12.7: Percentage distribution of male past contraceptive users by reason for discontinuing last method

Reason	Percentage
Experienced side effects	22.7
Want another child	54.5
Method failure	9.1
Rest from method	40.9
Health concern	4.5
Service provider's advice	13.6
Infrequent sex/respondent away	9.1
Wife opposes	9.1
N	**22**

Respondents could give more than one response.

The reasons the male respondents stopped using their last method are presented in Table 12.7. The table shows that the most important reasons were: the desire of another child(55 percent) followed by rest from method(41 percent) and experience of side effects(23 percent). 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 12.1. Fifty-

seven percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, 48 percent of the men reported that their wives had never approached them during the last year on this issue. It is noted that 14 percent of the men reported that their wives had talked more often about this subject during the last year, while 38 percent reported they had talked once or twice.

Figure 12.1: Men's reports of ease of approach by their wives to discuss FP

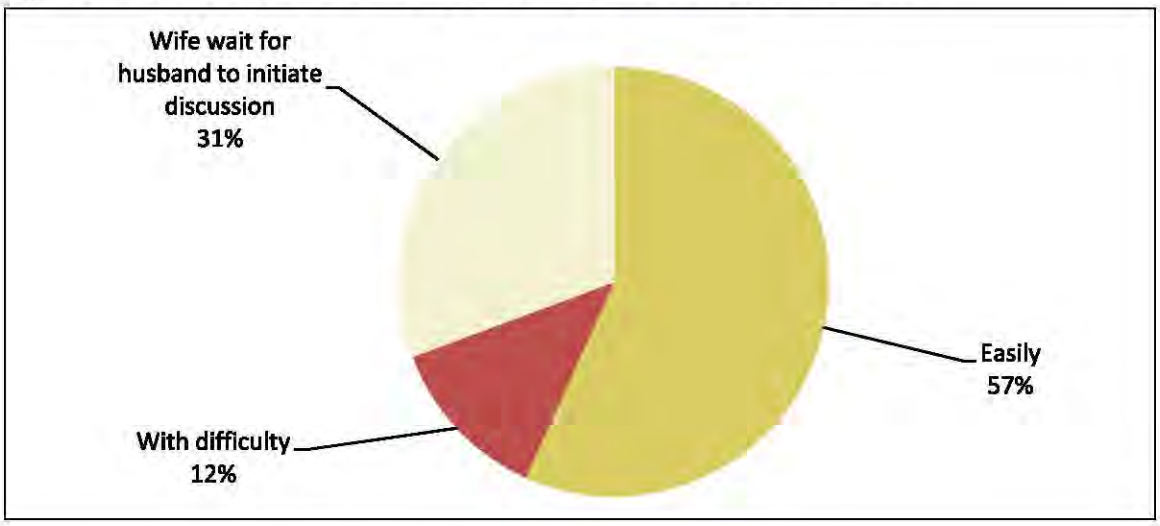
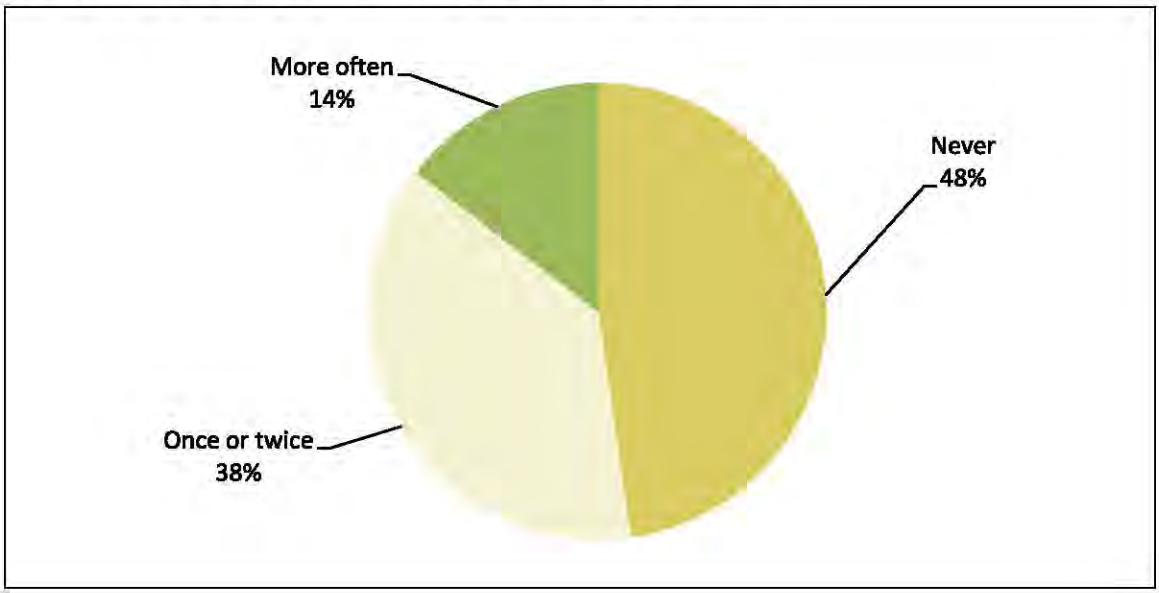


Figure 12.2: Frequency of discussion on FP with wife in last year



Potential Users

Men who were non-users of contraception were asked about their intended future use of contraception and their method preferences. Table 12.8 shows that 22 percent intended to use a contraceptive method in the future, while 19 percent did not intend to do so. Fifty – nine percent of the respondents were uncertain about their future use of contraception.

Table 12.8: Distribution of male never users by intent to use contraceptive methods in future

Intent	Percentage
Will use	22.2
Will not use	18.5
Unsure/Uncertain	59.3
Total	**100.0**
N	**81**

As shown in Table 12.9, the major reason husbands said they did not intend to use was fear of side effects (80percent). For 33 percent, shyness to go to FP clinic was the reason for not using a contraceptive method while their desire for more children was cited by 27 percent of the husbands. Lack of access and inconvenient to use was also cited by 27 percent.

Table 12.9: Distribution of male never users according to reasons for not intending to use contraceptive methods in future

Reason	Percentage
Wife opposes	13.3
In laws/parents oppose	6.7
Fear of side effects	80.0
Lack of access/unavailability	26.7
Cost too much	13.3
Shy to go to FP clinic	33.3
Inconvenient to use	26.7
Infrequent sex/respondent away	0.0
Difficult/unable to conceive	20.0
Breast feeding/ Lactational amenorrhea	13.3
Respondent/wife infertile	0.0
Want more children	26.7
N	**15**

Respondents could give more than one reason

Table 12.10 shows the distribution of the male respondents who intended to use a specific contraceptive method in the future. Condom was the most preferred method for future use followed by female sterilization and injectables.

Table 12.10: Distribution of male never users who intend to use specific contraceptive methods in the future

Method	Percentage
Female sterilization	22.2
IUD	5.6
Injectable	16.7
Condom	33.3
Rhythm	5.6
Not decided	16.7
Total	**100.0**
N	**18**

Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 12.11 shows that 13 percent of the male respondents wanted another child soon (within two years). Another 25 percent wanted to delay their next child for more than two years. The reasonable proportion of male respondents (50 percent) did not want any more children at all.

The desire to stop having children was positively associated with the number of living children. Fifty-six percent of the respondents who had 3 children did not want more children, whereas more than 92 percent who had 6 or more children did not want more children.

Table 12.11: Distribution of male respondents by desired timing for next child and number of living children

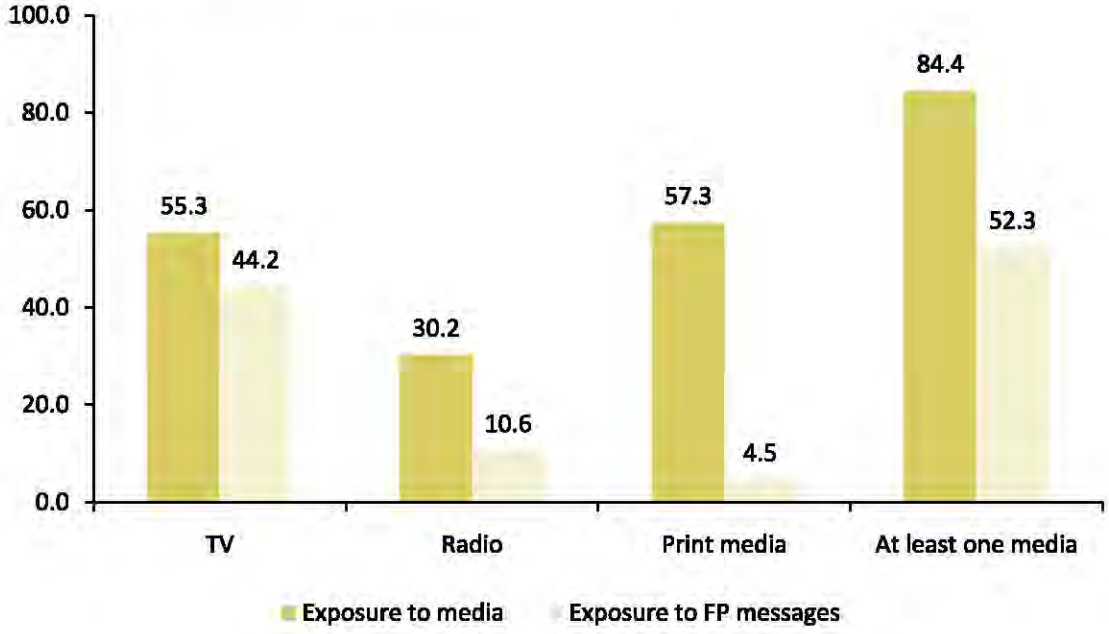
	Desire for next child				Total	
Number of living children	Soon	Later	Never	Don't know/unsure	%	N
0	37.5	62.5	0.0	0.0	100.0	32
1	35.0	60.0	5.0	0.0	100.0	20
2	9.1	40.9	22.7	27.3	100.0	22
3	11.1	16.7	55.6	16.7	100.0	36
4	0.0	11.1	66.7	22.2	100.0	18
5	0.0	0.0	72.2	27.8	100.0	18
6+	0.0	1.9	92.5	5.7	100.0	53
Total	**12.6**	**25.1**	**50.3**	**12.1**	**100.0**	**199**

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 12.3 shows the proportion of men who reported that they watched TV, listened to the radio or read newspapers or magazines. Print media and TV were the most commonly used mediums: 57 percent reported the use of print media while 55 percent of the male respondents in Khanewal watched TV.

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. Forty-four percent of the men had seen FP messages on television. About eleven percent of the men reported that they had ever listened to a family planning message on the radio. Overall, 52 percent of the male respondents and 33 percent of the MWRA had seen or heard a family planning message on at least one medium.

Figure 12.3: Distribution of male respondents according to exposure to media and FP messages, by type of media



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