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Baseline Household Survey

Jhelum District

April 2009



Family Advancement for Life and Health (FALAH)

Jhelum

Baseline Household Survey

April 2009



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For inquiries, please contact:

Population Council

7, Street 62, F-6/3, Islamabad, Pakistan

Tel: 92 51 2277439

Fax: 92 51 2821401

Email: pcpak@popcouncil.org

Web: <http://www.popcouncil.org>

<http://www.falah.org.pk>

Layout and Design: Ali Ammad

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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 Contraceptive Pill
EmOC	Emergency Obstetric Care
FALAH	Family Advancement for Life and Health
FP	Family Planning
HANDS	Health and Nutrition Development Society
IUD	Intra Uterine Device
LAM	Lactational Amenorrhea Method
LHW	Lady Health Worker
MCH	Maternal and Child Health
MNH	Maternal and Neonatal Health
MoH	Ministry of Health
MoPW	Ministry of Population Welfare
MSU	Mobile Service Unit
MWRA	Married Women of Reproductive Age
NGO	Non Governmental Organization
NIPS	National Institute of Population Studies
NWFP	Northwest Frontier Province
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 Fertillty Rate
THQ	Tehsil Headquarter
ToR	Term 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 Jhelum, one of the project districts.

The survey was conducted between February and April 2008 using a probability sample of 520 households in 40 clusters in Jhelum. It included interviews with 448 currently married women aged 15-49 (“married women of reproductive age”, or MWRA), along with 200 married men, of whom 133 were married to women included in the sample. In addition, as a separate activity, a mapping study¹ was also carried out during the period between September to December 2007 in Jhelum. Selected data from that study is 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

According to the UNDP Pakistan National Human Development Report 2003, Jhelum is the most developed district in Pakistan; it ranked 1st among 91 districts on the overall Human Development Index. The characteristics of our sample are generally similar to those found in other surveys; some key indicators are presented in Table A.

Table A: Selected key district characteristics from Jhelum household survey

Variable	Value
Percentage of household population in rural areas	72.0
Percentage of households with electricity	99.0
Percentage of households with indoor water supply	85.6
Percentage of households with flush toilet	72.2
Percentage of households with television	80.2
Percentage of literate female respondents	55.8
Percentage of respondents with literate husbands	83.0
No. of MBBS physicians per 1000 MWRA	1.9
Total fertility rate	2.9

Jhelum is a thinly populated district with a well-developed road system. Electrification was essentially complete (99 percent of sample households), and ownership of appliances requiring electricity, such as a televisions, refrigerators, washing machines, etc., was

¹ Mapping Survey of Health and Reproductive Health Services.

common in Jhelum district. A majority of the households had some indoor water supply and a flush toilet. The literacy and education levels among both males and females were quite satisfactory in district Jhelum. Fifty-six percent of the female respondents and 83 percent of their husbands were found to be literate. When asked about their exposure to media, 81 percent said they watched TV, 21 percent listened to the radio, and 14 percent read newspapers or magazines. Overall, 76 percent of the women reported that they had exposure to FP messages through these mediums.

Service Availability

There was a substantial presence of reproductive health facilities in Jhelum district. There were a total of 1,639 public and private health facilities, including 883 Health Houses of Lady Health Workers. These were widely scattered around the district, so that simple services such as antenatal check-ups, iron tablets for anemia, and non-clinical contraceptive methods are readily available in both public and private sectors. There were 36 facilities – a majority of them being private practices – able to offer Caesarean section deliveries. There were 37 facilities which were able to provide female sterilization services. While these facilities were spread throughout the district, in some areas they were more difficult to access than in others.

Fertility

There is evidence that fertility has been declining in Jhelum. The crude birth rate was 22 per thousand of the population, and the total fertility rate was 2.9 children per woman; both these rates were slightly lower than rates for Pakistan generally. Fertility was higher for illiterate women and for the wives of illiterate men. Many births were spaced too closely for optimum health; for example, nearly 54 percent of closed birth intervals were less than 36 months. Fifteen percent of the women in the sample who already had 2 children under five years of age were currently pregnant.

Maternal and Neonatal Care

The household survey obtained data on selected key indicators of maternal and neonatal health from a sample of 226 women who had delivered a child during the previous four years. Of these women, 88 percent had visited a health provider at least once for antenatal care, 77 percent had at least two tetanus toxoid immunizations, 67 percent of the deliveries were handled by a skilled birth attendant, and 65 percent were delivered in a public or private health facility. Nine percent of the women who had noninstitutional deliveries had

received at least one postnatal check-up. Exclusive breastfeeding was widely reported; 70 percent of the mothers reported breastfeeding their last child for at least 4 months without supplementation.

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

Indicator	Value
Percentage of mothers with at least one antenatal care visit	87.6
Percentage of mothers with at least two tetanus shots	76.5
Percentage of most recent deliveries conducted by a skilled birth attendant	67.3
Percentage of most recent deliveries in a facility	64.9
Percentage of MWRA not wanting more children	59.2
Percentage of MWRA wanting to delay next birth at least for two years	19.6
Percentage of MWRA who know of at least one contraceptive method	99.8
Contraceptive prevalence rate	37.5
Percentage of MWRA who are past users of contraceptives	21.4
Percentage of MWRA with unmet need for family planning	30.6
Percentage of MWRA with unmet need for birth spacing	10.5
Percentage of MWRA with unmet need for limiting births	20.1
Total demand for family planning (CPR + unmet need)	68.1

Preference for Children

The median “ideal” family size, according to the women respondents, was 4 children, which is a common finding for Pakistan. Regarding desire for having more children in the future, 21 percent said they wanted another child soon (within two years), 20 percent said they wanted another child, but only after two years, and 59 percent said they did not want more children. The proportion of women wanting more children soon decreased rapidly with the number of living children, while the proportion of women who did not want more children increased. The proportion wanting more children later was highest among women with one or two children. Sixty-four percent of the women said their husbands wanted the same number of children that they did, while 18 percent said their husband wanted more children than they did.

Contraceptive Knowledge and Use

Nearly all currently married women knew of at least one contraceptive method. The contraceptive prevalence rate (the percentage of MWRA currently using any method of contraception) was 37.5 percent, which is substantially higher than the average for Punjab (33 percent) or for Pakistan (30 percent). Female sterilization was noted as the most popular method of family planning among current users (11.8 percent). After sterilization, the methods most commonly in current use were condoms (11.2 percent) and withdrawal (7.1 percent). Past users comprised 21.4 percent of MWRA; condoms, pills, withdrawal and injections were all common methods for past users. Eighty-three percent of the current users did not want more children, while 17 percent wanted more, but at a later time. Most users reported obtaining their supplies and services from Government department sources, or their husband obtained the supplies (for condoms, pills and injections).

Experience with Contraceptive Methods

Stated reasons for the respondents' choice of their current or past method varied by method, but commonly cited reasons included suitability for the respondent and her husband, no or few side effects, convenience of use, easy availability, and (for female sterilization, IUD and injectable users) ability to use for a long period. Costs were generally low (only 9 percent paid more than Rs.50 the last time they obtained their method) and did not appear to be a major obstacle to contraceptive use. Similarly, travel time was usually not excessive; 20 percent reported requiring more than 30 minutes to reach their service. Information given by the service providers at acceptance of contraceptive method often did not include information on side effects or method choice. On the other hand, clients generally reported being examined properly at a health facility. However, a considerable number of respondents often felt that they were incapable of dealing with side effects. A variety of side effects was reported by users and past users, and it did not appear that these were effectively dealt with by providers.

Reasons for Non-use

Asked hypothetically about obstacles a couple might face if they wanted to avoid or delay pregnancy, women typically mentioned side effects of contraceptives and their management, husband's disapproval and method failure. Less frequently mentioned were distance/cost or that people might find out contraceptive use. Past users were most likely to discontinue use because they wanted more children, experienced side effects or became

pregnant. Their reasons for current non-use were most often related to childbearing, but infrequent sex/husband away and side effects were also frequently mentioned. Never-users were most likely to say they were not using for reasons related to childbearing, but husband's opposition and fear of side effects were also common reasons. About 13 percent of the women interviewed disapproved of birth spacing, while 15 percent disapproved of limiting births. A majority of female current and past users said they could discuss family planning easily with their husbands, but 72 percent of never-users said they could do so. Knowledge of contraceptive methods and source of supply among never users was quite good. Just over one-third of the never-using women expressed the intent to use contraceptives in the future. This indicates that a substantial number of women in Jhelum were willing to practice birth spacing and family planning.

Unmet Need for Family Planning

A woman is considered to have an "unmet need" for family planning if she says she does not want more children, or wants them later, and is at risk of conceiving, but is not using any method of contraception. By this definition, 30.6 percent of the women in this sample were in the unmet-need category, 20.1 percent for limiting and 10.5 percent for spacing. This proportion is fairly typical for Pakistan, but high by international standards. Unmet need for limiting was higher among illiterate women and among women with a lower standard of living; while unmet need for spacing was higher among literate women. Women in the unmet need category typically tended to have poor communication with their husbands and/or disagreed on whether or not to have more children, feared side effects of contraceptive methods, and lacked knowledge of family planning sources.

Reproductive Preferences and Behavior of Men

The findings reveal that all men knew at least one modern contraceptive method. Male sterilization was one of the least known contraceptive methods among men in Jhelum. Sixty percent of the men did not want more children in the future or wanted to delay the next pregnancy. Forty-five percent of the male respondents reported that they or their wives were currently using a family planning method, and more than 35 percent were using modern contraceptive methods. Among the current users, more than 85 percent were satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, 62 percent reported that they were not intending to use any FP method in future. The fear of side effects was one of the

pregnant. Their reasons for current non-use were most often related to childbearing, but infrequent sex/husband away and side effects were also frequently mentioned. Never-users were most likely to say they were not using for reasons related to childbearing, but husband's opposition and fear of side effects were also common reasons. About 13 percent of the women interviewed disapproved of birth spacing, while 15 percent disapproved of limiting births. A majority of female current and past users said they could discuss family planning easily with their husbands, but 72 percent of never-users said they could do so. Knowledge of contraceptive methods and source of supply among never users was quite good. Just over one-third of the never-using women expressed the intent to use contraceptives in the future. This indicates that a substantial number of women in Jhelum were willing to practice birth spacing and family planning.

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Chapter 1

Introduction

Background

The FALAH Project

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

The FALAH project will specifically focus on 20 districts. These are:

- **Balochistan:** Gwadar, Jaffarabad, Khuzdar, Lasbela, Turbat and Zhob;
- **Northwest Frontier Province:** Buner, Batagram, Charsadda, Mansehra, Mardan, Swabi;
- **Punjab:** Dera Ghazi Khan and Jhelum;
- **Sindh:** Dadu, Ghotki, Larkana, Sanghar, Sukkur, and Thatta.

The aims of the FALAH project are:

- a) To increase the demand for and practice of birth spacing;
- b) To increase access to and quality of family planning services in the public sector;
- c) To increase the coverage and quality of family planning services in the private sector;

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

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

Jhelum District

District Jhelum is mainly a rural district of Punjab. The overall population of the district was estimated to be 1.139 million in 2008, with a population density of 215 persons per square kilometer. Geographically, Rawalpindi lies on its north, Gujrat and Mirpur of Azad Jammu and Kashmir on the east, Mandi Bahauddin and Sargodha on the south and Chakwal and Khushab on the west. Currently, it is comprised of three tehsils: Jhelum, Pind Dadan Khan and Sohawa. Ethnically, the district is inhabited by three main land owning tribes: Gujars, Janjuas and Gakkhars (Population Census Organization, 2000).

Jhelum is situated on the Grand Trunk road which passes through Peshawar up to Karachi. All of the three tehsils are interlinked with metalled roads and there is a well-developed railway network.

Migration patterns are important to analyze the economic and social development of communities. According to the 1998 census, 7 percent of the district population consisted of lifetime in-migrants, 64.5 percent of whom came from other districts of Punjab, 12.9 percent from Sindh, NWFP and Baluchistan, 12.3 percent from Azad Kashmir and Northern areas, while the remaining 10.3 percent were Pakistanis who had repatriated from other countries. There was significant migration out of Pakistan for employment or other reasons. As seen in Table 3.3, 8.0 percent of the female respondents interviewed stated that their husbands were abroad.

According to the UNDP Pakistan National Human Development Report 2003,² Jhelum stood 1st among 91 districts in Pakistan. In the Planning Commission's Millennium Development Goals report, 2006, Jhelum stood 6th on literacy; 2nd on immunization; 46th on water supply; and 44th on sanitation in national rankings.

The Jhelum Baseline Household Survey

In Jhelum (as in each of the 20 FALAH focus districts), the Population Council implemented a baseline sample household survey to learn about knowledge, attitudes, and practices regarding fertility, reproductive health, and child spacing/family planning. This represents one of two major studies to establish baseline indicators for the FALAH project. The other is a mapping exercise to compile complete, digitized maps of all facilities providing reproductive health services, including maternal health, neonatal and child health, and child spacing/family planning. This baseline survey will be compared with an end line survey towards the end of the project to assess progress.

Objectives

The objectives of the Jhelum 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 Jhelum 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.

² In 2003, the districts of Pakistan were ranked according to a Human Development Index, taking into account the following factors: Literacy Rate; Enrolment Ratio; Immunization Ratio; Infant Survival Ratio; Real GDP per capita; Educational Attainment Index; Health Index; and Income Index.

Methodology

Study Population

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

Sample Design and Size

The systematic stratified sample technique was used to select a representative sample of the district. The universe consisted of all urban and rural households of the district. The number of blocks selected in urban areas and the number of villages selected in rural areas are presented in Table 1.1. A total of 40 blocks/villages were selected, with 13 households selected per block/village. The selection procedure is described below.

Urban Sample

The required number of enumeration blocks was selected with probability proportional to size (number of circles) by adopting a multistage stratified sampling design. The "enumeration circles," i.e., the smallest units available in the 1998 Population District Census Reports as demarcated by the Population Census Organization, were selected. The maps of these circles were obtained from the Population Census Organization and were already divided into blocks of approximately 250-300 households depending upon the number of households in each circle. Following this, one block was randomly selected from each circle. The household listing of each block was then carried out by the enumeration teams before selecting the sampled households. A fixed number of 13 households were drawn from each sample enumeration block by using systematic random sampling.

Rural Sample

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

before selecting the sampled households. A fixed number of 13 households was selected from each sample enumeration village using the systematic random technique.

Selection of Respondents

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

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

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

Result	Rural	Urban	Total
Number of blocks/villages	29	11	40
Planned households	377	143	520
Households contacted	434	173	607
Households replaced	57	30	87
(Households refused)	3	6	9
(Households locked)	54	24	78
Eligible women identified	336	113	449
(Eligible women refused)	1	0	1
Total women's interviews	335	113	448

Questionnaire Design

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

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

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

Hiring of Interviewers and Supervisors

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

Training of Interviewers and Supervisors

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

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

Quality Assurance

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

Data Entry and Edit Procedures

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

Fieldwork

Fieldwork for Jhelum district was carried out between February and April 2008.

Chapter 2

Household Characteristics

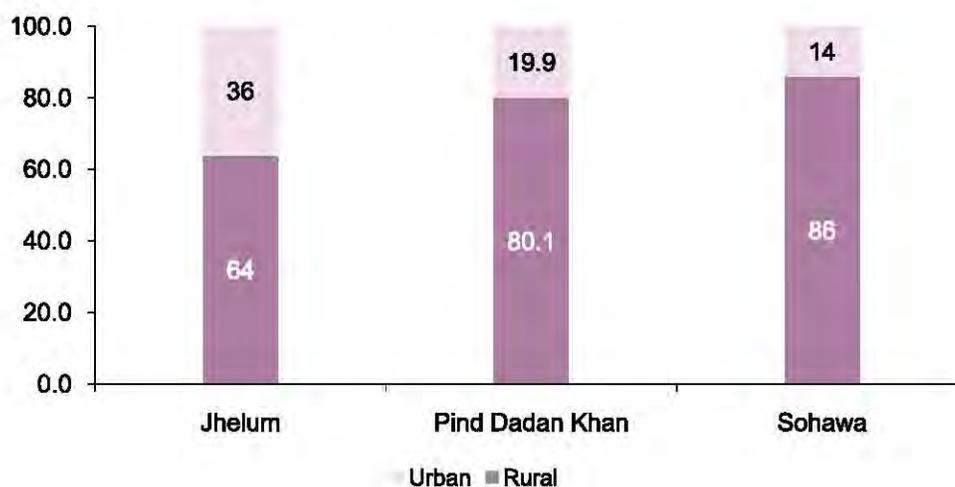
Geographic Distribution

The district of Jhelum is comprised of three Tehsils: Jhelum, Pind Dadan Khan and Sohawa. Of these, two tehsils - Pind Dadan Khan and Sohawa - are more rural than Jhelum. Table 2.1 shows the population distribution of sample households by residence and tehsils (rural and urban).

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

Tehsil	Rural			Urban			Total	
	N	%	Census %	N	%	Census %	N	%
Jhelum	1186	64.0	61.3	667	36.0	38.7	1853	100.0
Pind Dadan Khan	700	80.1	82.3	174	19.9	17.7	874	100.0
Sohawa	485	86.0	91.9	79	14.0	8.1	564	100.0
Total	2371	72.0	72.3	920	28.0	27.7	3291	100.0

Table 2.1 shows the population distribution of the 520 households in the sample by urban – rural residence and tehsil. Jhelum was about 72 percent rural and 28 percent urban. This closely follows the distribution recorded for the whole district in the 1998 Population Census (Population Census Organization, 2000). About 56 percent of the sample population lived in Jhelum tehsil, while 27 percent and 17 percent lived in Pind Dadan Khan tehsil and Sohawa tehsil respectively.

Figure 2.1: Rural-urban population distribution of sample Jhelum households


Age-Sex Distribution

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

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

Age group	Age-sex distribution		Total
	Male	Female	
00 - 04	12.2	10.5	11.3
05 - 09	12.1	10.1	11.2
10 - 14	12.2	11.1	11.6
15 - 19	12.7	10.9	11.9
20 - 24	9.7	11.6	10.6
25 - 29	8.4	8.9	8.6
30 - 34	4.7	6.2	5.4
35 - 39	4.6	5.2	4.9
40 - 44	4.5	5.8	5.1
45 - 49	3.8	5.6	4.7
50 - 54	2.7	2.9	2.8
55 - 59	2.5	3.2	2.8
60 - 64	3.7	3.1	3.4
65 +	6.2	5.1	5.6
N	1664	1626	3290

The population was typical of a society with past high fertility trends and sharply declining percentages by age; the median age was 21 years. The age-sex ratio of the age groups from 20 to 59 suggests there were more females than males while in all of the other age groups males were dominant. This may be due to the fact that males in this age group are usually working and may migrate to other places in search of employment (as shown in Table 3.3, 8.0 percent of the husbands of the eligible women in district Jhelum were earning their living abroad).

Of the total population of the sampled households, 27 percent consisted of females 15-49 years of age, and 11 percent consisted of children under 5 years old. These individuals comprised the population of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

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

Age group	Married		Widow/divorced/ separated		Never married	
	Male	Female	Male	Female	Male	Female
15 - 19	0.0	0.0	0.0	0.0	100.0	100.0
20 - 24	11.2	38.8	0.6	1.1	88.2	60.1
25 - 29	42.8	71.5	1.4	5.6	55.8	22.9
30 - 34	73.4	85.0	2.5	5.0	24.1	10.0
35 - 39	84.2	88.2	5.3	9.4	10.5	2.4
40 - 44	93.3	85.1	4.0	12.8	2.7	2.1
45 - 49	89.1	80.2	9.4	15.4	1.6	4.4
50 - 54	97.8	70.2	0.0	27.7	2.2	2.1
55 - 59	87.8	80.8	7.3	17.3	4.9	1.9
60 - 64	85.5	58.8	11.3	35.3	3.2	5.9
65 - 69	87.5	36.4	12.5	63.6	0.0	0.0
70 - 74	71.0	37.0	25.8	63.0	3.2	0.0
75 +	59.6	25.0	38.3	75.0	2.1	0.0
All ages 15+	50.2	55.8	5.4	13.0	44.4	31.2

Marital Status

In Jhelum (as in Pakistan generally) women tend to marry men older than themselves. Therefore, as Table 2.3 shows, a higher proportion of younger women were married than men of the same age. It is interesting to note that in the 15-19 age group, neither men nor women were married. Thirty-nine percent of the women were married between the ages of 20 to 24. It may be important to note that at age groups higher than 65 there was no woman who was never married. The estimated singulate mean age at marriage (SMAM) for women was 24 years.

Household Characteristics and Wealth Indicators

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

Physical Characteristics of Households

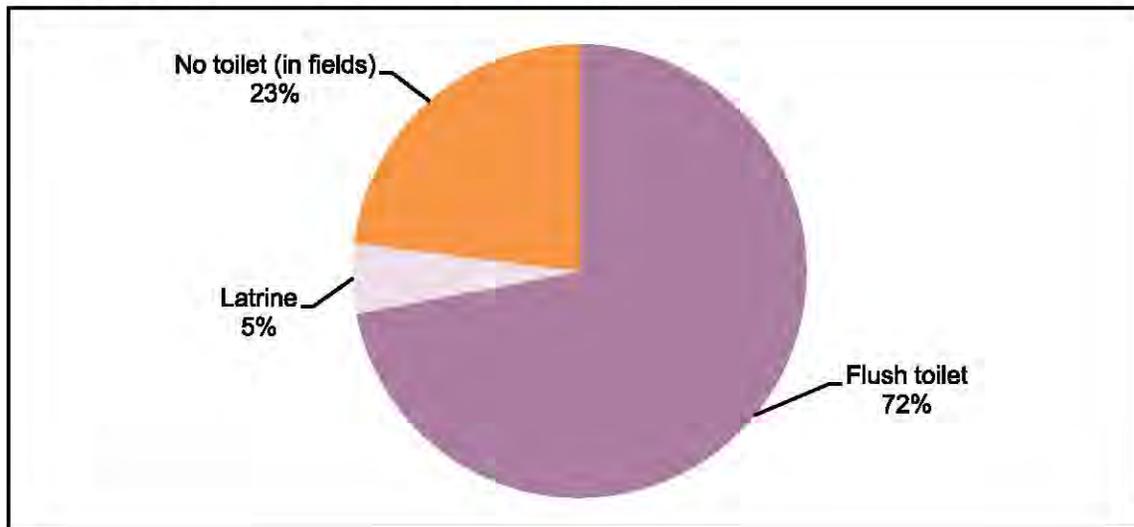
Table 2.4 shows selected physical characteristics of the sampled households. A considerable number of households had an indoor water supply and some type of flush toilet. It is important to note that there was a substantial difference between the source of indoor water for rural and urban areas. Nearly 32 percent of the rural households used fields as their toilets, compared with 1 percent of the urban households.

While most households in Jhelum district used firewood for cooking, particularly in rural areas (75 percent), a significant proportion used gas (74 percent) in urban areas. Nearly all households, even in rural areas, had electricity. The roofs of most houses were made with guarder/ T-iron and concrete (38 percent and 32 percent respectively), and had cemented floors (58 percent), while almost all the houses had walls made of burnt bricks/blocks (98 percent). These indicators show that Jhelum district is a well developed area.

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)	26.5	50.0	32.9
Govt. supply (communal)	3.5	4.9	3.9
Motorized/hand pump (inside)	49.5	29.6	44.0
Motorized/hand pump (outside)	6.1	3.5	5.4
Well	13.1	12	12.8
River/canal/stream	1.3	0.0	1.0
Sanitation facility			
Flush to sewerage	0.3	13.4	3.9
Flush connected to septic tank	59.7	81.7	65.8
Flush connected to open drain	2.9	1.4	2.5
Raised latrine	5.6	2.1	4.7
No toilet (in fields)	31.5	1.4	23.2
Main type of fuel used for cooking			
Firewood	74.5	18.9	59.2
Kerosene oil	0.5	7.0	2.3
Gas cylinder	17.0	37.1	22.5
Natural gas (sui gas)	2.7	37.1	12.1
Dung dry	5.3	0.0	3.8
Electrical connection			
Yes	98.9	99.3	99.0
No	1.1	0.7	1.0
Main material of the roof			
Concrete	21.8	58.0	31.7
Iron sheet	0.8	0.0	0.6
Guarder and T-iron	44.8	21.0	38.3
Wood/bamboo and mud	32.6	21.0	29.4
Main material of the floor			
Earth/sand/mud	14.1	1.4	10.6
Chips	10.3	17.5	12.3
Ceramic tiles	10.6	6.3	9.4
Marble	1.6	4.2	2.3
Cement	55.7	64.3	58.1
Bricks	7.7	6.3	7.3
Main material of the walls			
Burnt bricks/blocks	97.6	100.0	98.3
Mud bricks/mud	1.9	0.0	1.3
Stones	0.5	0.0	0.4
N	377	143	520

Figure 2.2: Toilet facilities for Jhelum households



Ownership of Household Assets

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

The distribution of these items appears to show the expansion of consumer purchasing power that has occurred in Pakistan in recent years. Several items requiring electricity were available in a substantial proportion of households, even in rural areas. A vast majority of all households had television sets, a figure of particular interest to communications specialists. The recent expansion in information technology in Pakistan was reflected in the ownership of mobile telephones by four-fifths (80 percent) of all households, and ownership of a computer by about five percent of all households. However, motorized transport remained fairly uncommon, suggesting difficulties in arranging for transport in health emergencies.

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

Household item	Rural	Urban	Total
Wall clock	93.9	95.1	94.2
Chairs	86.2	82.5	85.2
Bed	60.5	70.6	63.3
Sofa	42.6	55.3	46.0
Sewing machine	75.1	82.5	77.1
Camera	18.3	21.7	19.2
Radio/Tape recorder	49.1	39.2	46.3
Television	76.1	90.9	80.2
Refrigerator	60.2	72.7	63.7
Land line telephone	13.0	28.0	17.1
Mobile phone	77.2	88.1	80.2
Room cooler/ Air conditioner	19.4	36.4	24.1
Washing machine	52.0	79.0	59.4
Cycle	40.3	34.3	38.7
Motorcycle	16.2	21.0	17.5
Jeep/Car	4.2	7.7	5.2
Tractor	1.6	0.7	1.3
Computer	2.9	9.8	4.8
N	377	143	520

Standard of Living Index

The data presented below can be used to develop an overall index of the economic well-being of a household, both for a general estimation of the economic development of an area, and for use in investigating the relationship between household wealth and reproductive health behavior. One such index is the standard of living index (SLI), developed for international comparisons with data from the Demographic and Health Surveys (Rutstein, S.O., and K. Johnson, 2004). This index gives each household a score of 0-1 or 0-2 on each of the following: source of drinking water; toilet facilities; material of floor; availability of electricity; ownership of a radio; ownership of a TV; ownership of a refrigerator; and means

of transportation. For the whole household, the value of the index can range from 0 to 12. Table 2.6 gives the distribution of the SLI for the sample households according to urban and rural residence. The median index for all households was 7; for rural households it was 6, and for urban households it was 8. About 91 percent of all households fell in the range from 4 to 10. This index will be used later in this report to examine differences in reproductive health knowledge and behavior.

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

Standard of living index	Rural		Urban		Total	
	N	%	N	%	N	%
1	2	0.5	0	0.0	2	0.4
2	4	1.1	0	0.0	4	0.8
3	28	7.4	0	0.0	28	5.4
4	38	10.1	1	0.7	39	7.5
5	36	9.5	2	1.4	38	7.3
6	45	11.9	14	9.8	59	11.3
7	64	17.0	35	24.5	99	19.0
8	83	22.0	38	26.6	121	23.3
9	50	13.3	29	20.3	79	15.2
10	19	5.0	18	12.6	37	7.1
11	6	1.6	6	4.2	12	2.3
12	2	0.5	0	0.0	2	0.4
Total	377	100.0	143	100.0	520	100.0
Median	6	na	8	na	7	na

na=not applicable.

Chapter 3

Respondent Characteristics

The primary sources of data from the Household Survey are the interviews conducted with 448 currently married women of reproductive age (MWRA). The background characteristics of these respondents are described in this chapter.

Age

Table 3.1 shows the age distribution of the female respondents for rural and urban areas. Most of the women (21 percent) were in the age group of 25-29, as by that time most women were married. About half the sample respondents were under age 35; urban-rural differences were visible.

Table 3.1: Age distribution of female respondents by residence

Age group	Rural		Urban		Total	
	N	%	N	%	N	%
<19	0	0.0	1	0.9	1	0.2
20 - 24	49	14.6	12	10.6	61	13.6
25 - 29	75	22.4	18	15.9	93	20.8
30 - 34	55	16.4	24	21.2	79	17.6
35 - 39	46	13.7	24	21.2	70	15.6
40 - 44	61	18.2	16	14.2	77	17.2
45 - 49	49	14.6	18	15.9	67	15.0
Total	335	100.0	113	100.0	448	100.0

Education and Literacy

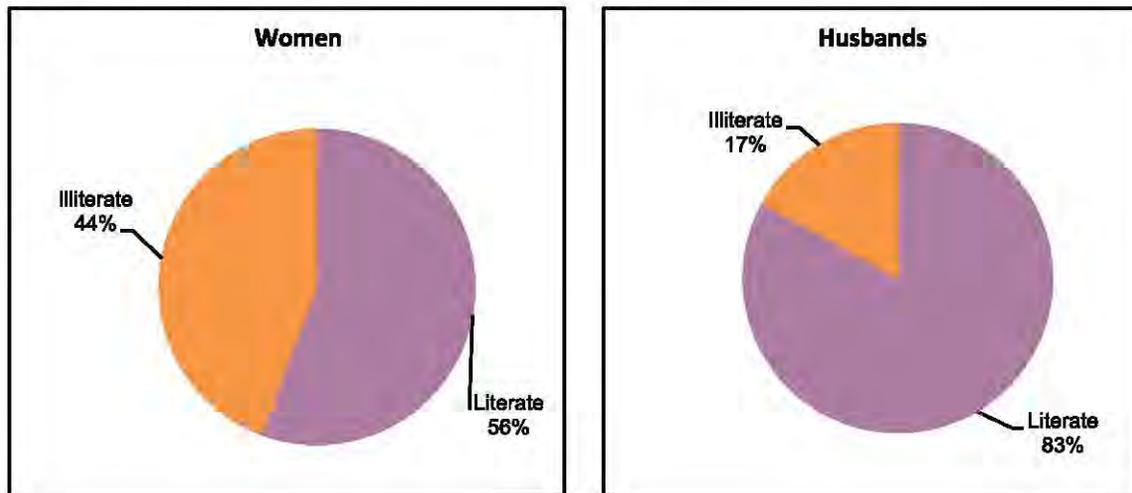
Levels of schooling completed and literacy rates for the respondents and their husbands are given in Table 3.2. Literacy rates for females and males were very encouraging (56 percent for females and 83 percent for males).

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

Variable	Age group			Residence		Total
	15 - 24	25 - 34	35 - 49	Rural	Urban	
Respondent (women)						
Proportion literate	80.6	71.5	36.0	53.1	63.7	55.8
Education level						
No education	16.1	23.3	58.4	42.1	30.1	39.1
Up to primary	38.7	28.5	24.3	29.6	23.0	27.9
Up to secondary	29.0	34.3	15.0	21.2	33.6	24.3
Above secondary	16.1	14.0	2.3	7.2	13.3	8.7
N	62	172	214	335	113	448
Respondent's husband						
Proportion literate	93.5	91.7	72.7	82.9	83.0	83.0
Education level						
No education	6.5	7.1	24.6	15.2	16.1	15.4
Up to primary	11.3	8.3	19.0	13.9	13.4	13.8
Up to secondary	71.0	66.3	46.9	60.6	49.1	57.7
Above secondary	11.3	18.3	9.5	10.3	21.4	13.1
N	62	169	211	330	112	442

Table 3.2 shows that both literacy and education levels were higher in urban areas. In fact, literacy of women was substantially higher in Jhelum than other areas of Pakistan.

Figure 3.1: Literacy status of women and their husbands



Occupation and Work Status

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

Only 25 of the female respondents reported working for money; their economic activity/occupations are shown in Figure 3.2.

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

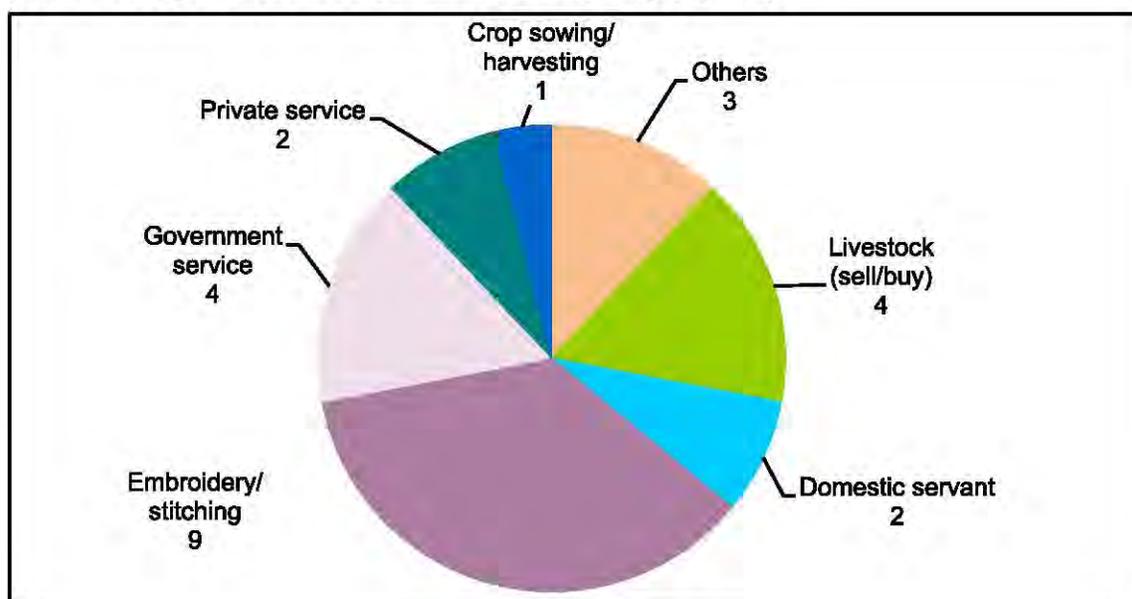


Table 3.3: Distribution of occupational categories of respondents' husbands by residence

Economic activity /occupation	Rural	Urban	Total
Agriculture/livestock/poultry	12.2	2.7	9.8
Petty trader	10.1	9.7	10.0
Labor (daily wages)	36.1	35.4	35.9
Government service	16.4	12.4	15.4
Private service	9.6	16.8	11.4
Own business	4.8	6.2	5.1
Working abroad	6.6	10.6	7.6
Unemployed	4.2	6.2	4.7
N	335	113	448
Total	100.0	100.0	100.0

The largest group of men in both rural and urban areas worked as hired daily wage laborers (36 percent). Twenty-seven percent of the women interviewed stated that Government and private service were their husband's occupation. Agriculture also played an important role, which is consistent with the socioeconomic development of the district. It can be assumed

that the population working abroad also made contributions through remittance payments from abroad, which would positively impact the socioeconomic development of the district. The unemployment rate of husbands should also be noted at 4.7 percent. This indicates that a fair number of people required employment.

Female Mobility

Women respondents were asked about their ability to go to places outside their homes. It is worthwhile to note that a number of women reported being able to go to any of the places named without having to seek permission. On the other hand, very few women reported not being able to go to any of the places mentioned. This number became lower when speaking about health centers where about half of the women were allowed to go, but had to be accompanied by someone. Overall, it is encouraging to note that a majority of women were not restricted from visiting health centers, and could go there when/if they needed to.

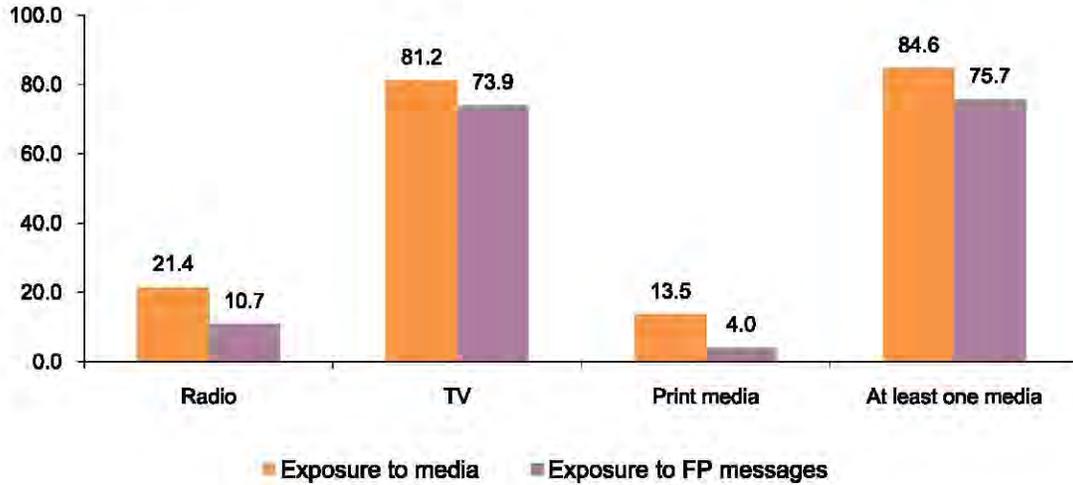
Table 3.4: Women's reports regarding mobility outside the home by degree of permission and destination

Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Can't go/ doesn't go	%	N
Market	29.5	24.1	43.8	2.6	100.0	448
Health center	22.5	25.0	52.2	0.2	100.0	448
Relatives/friends	30.1	26.3	43.3	0.2	100.0	448
Out of village/town	10.9	25.7	62.9	0.4	100.0	448

Mass Media Access and Exposure to FP Messages

For the development of communication activities, it is important to know which forms of mass media are available, and to what extent they were used by various segments of the population. Table 2.5 showed that more than 80 percent of the households owned a television, while 46 percent owned a radio. Figure 3.3 shows the proportion of females who reported that they watch TV, listen to the radio, or read newspapers or magazines. Television was the most commonly used medium (81 percent), while the radio and print media were used less (21 percent and 14 percent respectively).

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



Furthermore, women who reported access to any sort of media were asked if they had ever seen, heard, or read any message pertaining to methods of family planning through these mediums. Less than three-fourths (74 percent) of the respondents had seen FP messages on the television. Only 4 percent of the women reported that they had ever read about a family planning message in a newspaper or magazine. Overall, three-quarters of the women reported exposure to FP messages through any of these mediums.

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 Jhelum Household Survey, the FALAH project undertook a mapping of health and reproductive health services study in the FALAH districts. The fieldwork in the district was carried out from September to December 2007. In this survey, all facilities and providers for reproductive health, public and private, including family planning as well as maternal health, were identified and visited. Exact locations of these facilities were determined by using a 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 of Health and Reproductive Health Services- Jhelum district”. Some basic results are provided here to give a rough context to understand the knowledge, attitudes and behavior of the sampled men and women of the household survey.

These results represent a range of maternal and reproductive health services being provided in Jhelum. In this chapter the tables summarize these findings, and are illustrated by maps indicating the location of various types of providers and facilities.

District Data

There are a total of 1639 facilities in Jhelum, of which 933 are public and 706 are from the private sector (102 Greenstar Social Marketing; 604 other private organizations). Some facilities provide only limited care, such as the LHW health houses in the public sector and dispensaries and traditional practitioners in the private sector.

Reproductive Health Facilities

The distribution of reproductive health facilities per union council in the public and private sectors is shown in Maps 4.1 to 4.3. Map 4.1 shows the distribution of government static facilities by union council population. Similarly, Map 4.2 shows the availability of LHWs; the variation is considerable as 13 union councils have more than 20 while 44 have fewer than 10. Nearly all union councils in Jhelum district are well served: on average there are 14 LHWs per union council. Map 4.3 shows the distribution of private facilities in the district.

The gross density of reproductive health facilities in terms of the number of facilities per union council is shown in Map 4.4. The variation is considerable: 11 union councils have more than 40 reproductive health facilities, while only two have fewer than 10 facilities. On the whole, however, there do not appear to be large geographic areas for which no reproductive health services are available. Nearly all union councils in Jhelum district are well served with an average of 33 facilities per union council.

Family Planning Facilities

By and large, family planning services are available in over two-thirds of both public and private facilities. Clinical methods are available in only a number of facilities; public facilities are more developed than private ones, especially in the provision of injectables and IUDs. Female and male sterilization are not easily available, while Norplant is not available at all. On the contrary, a significant number of public facilities provide non-clinical methods; particularly condoms and oral pills, and LHWs are the major contributing factor. These methods are also available in one-fifth of the private facilities. Emergency contraceptive pills are hardly available.

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

Service	Sector										
	Government		LHWs		Private GSM		Private others		Total		MWRA per facility
	N	%	N	%	N	%	N	%	N	%	
Injectables	82	82.0	16	1.9	51	50.0	78	12.9	227	13.8	765
IUD/Copper T	73	73.0	na	na	43	42.2	56	9.3	172	10.5	1009
Norplant	0	0.0	na	na	0	0.0	0	0.0	0	0.0	na
Female sterilization	6	6.0	na	na	22	21.6	9	1.5	37	2.3	4691
Male sterilization	1	1.0	na	na	10	9.8	6	1.0	17	1.0	10209
Condom	88	88.0	831	99.8	42	41.2	93	15.4	1054	64.3	165
Pills	88	88.0	828	99.4	54	52.9	96	15.9	1066	65.0	163
ECP	4	4.0	0	0.0	28	27.5	23	3.8	55	3.4	3155
Any FP method	88	88.0	831	99.8	61	59.8	135	22.4	1115	68.0	156
Any clinical method	85	85.0	16	1.9	54	52.9	103	17.1	258	15.7	673
Any non-clinical method	88	88.0	831	99.8	57	55.9	107	17.7	1083	66.1	160
Total	100	100.0	833	100.0	102	100.0	604	100.0	1639	100.0	106

Multiple responses are possible.

na= not applicable.

Clinical method include; injectables, IUDs, Norplant, female sterilization and male sterilization.

Again, the geographic distribution of these services is as important as the number. Maps 4.5 to 4.7 illustrate the availability of female sterilization, IUDs, and injectables. The government is providing female sterilization services in 6 union councils while the private sector is providing these services in 13 union councils. Availability of IUDs is more widespread, in both the public and private sectors. Other methods, like pills and condoms (not shown), are readily available throughout the district.

Maternal Health Facilities

The provision of maternal health care services is an essential component of reproductive health care. Maternal health care facilities are shown in Table 4.2. A majority of the service delivery points provide antenatal care services both in the public and the private sector. Anemia treatment is the most frequently available service both in the public and private facilities. Service availability regarding routine antenatal check-ups and tetanus protection was higher in public facilities than in private facilities. More normal delivery services are also available in public facilities; overall, one facility is available for 847 women for a normal delivery. On the other hand, Caesarean sections are available in 36 facilities, which are mostly private although a few public hospitals also provide this service.

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

Service	Sector										MWRA per facility
	Government		LHWs		Private GSM		Private others		Total		
	N	%	N	%	N	%	N	%	N	%	
Antenatal check-up	87	87.0	408	49.0	48	47.1	116	19.2	659	40.2	263
Anemia treatment	97	97.0	825	99.0	83	81.4	555	91.9	1560	95.2	111
TT injection	60	60.0	10	1.2	57	55.9	102	16.9	229	14.0	758
Normal delivery	57	57.0	na	na	48	47.1	100	16.6	205	12.5	847
Caesarean section	4	4.0	na	na	21	20.6	11	1.8	36	2.2	4821
Total	100	100.0	833	100.0	102	100.0	604	100.0	1639	100.0	106

Multiple responses are possible.

na= not applicable.

Along with the sheer number of facilities, their geographic distribution is of critical importance. Map 4.8 and 4.9 show essential and comprehensive obstetric services respectively. There is only one union council in Jhelum with no essential obstetric care facility. Comprehensive emergency obstetric care services were available in 14 union councils, mostly in the private sector.

Service Providers

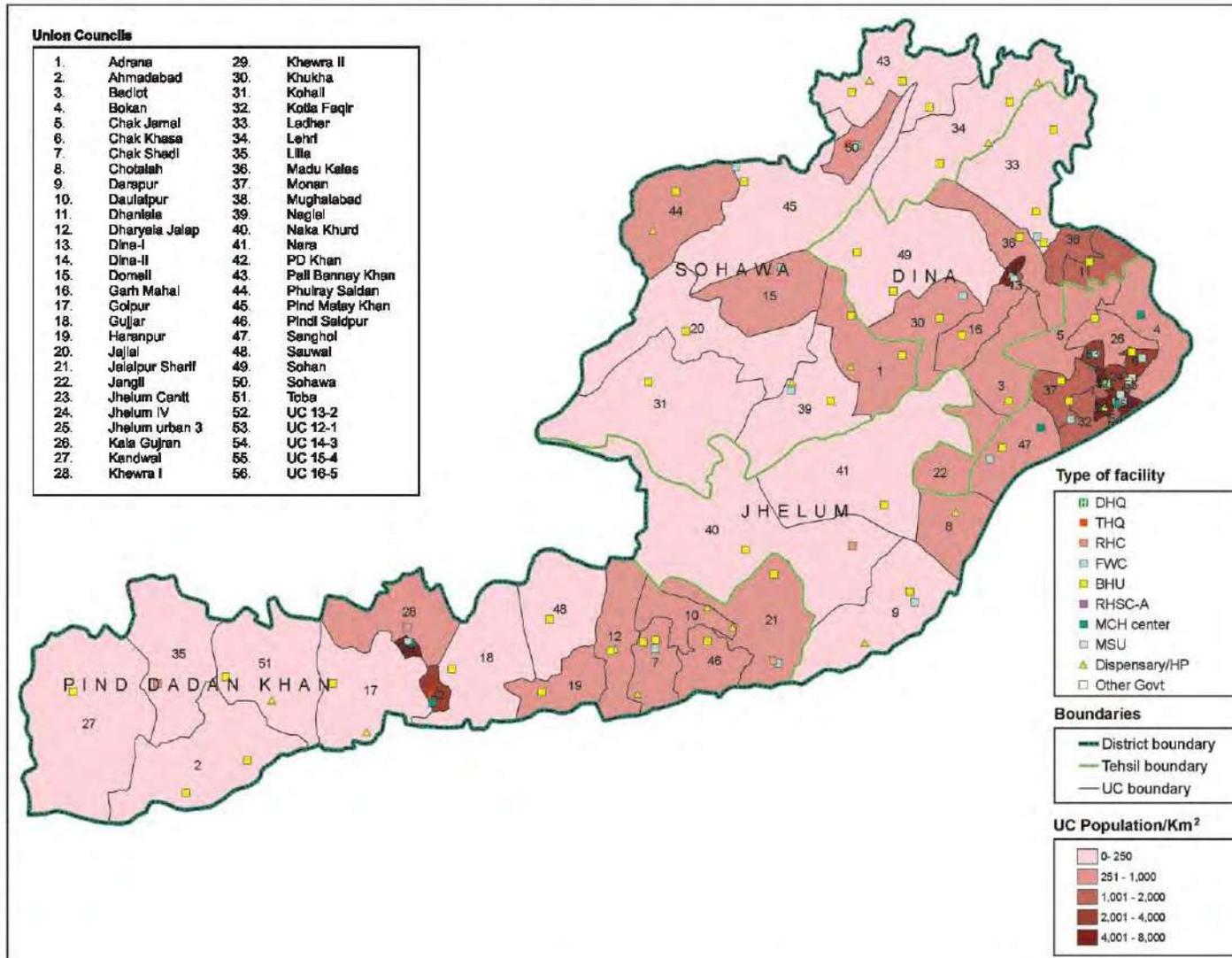
The number of providers of different categories and number of women per provider is shown in Table 4.3. There are a total of 338 MBBS doctors of whom about three-quarters are male. However, there are 429 female paramedics, including LHVs and nurses, the majority of whom are employed by the private sector.

The number of women per provider or facility may be a good indicator of the status of health in the district. In the whole district there is one MBBS doctor available for 513 married women of reproductive age. Since a majority of the women prefer female service providers, this number is as high as 2000 women per MBBS female doctor. Overall, there are 405 women per female paramedics; however, female medical assistants and medical/health technicians are rarely available. There are 24,793 married women per medical assistant and 10,209 women per medical/health technician, which shows a great dearth of female paramedics. Map 4.10 shows the availability of MBBS doctors by gender in each union council. Male doctors are not available in 10 union councils, while in 32 union councils there is no female MBBS doctor.

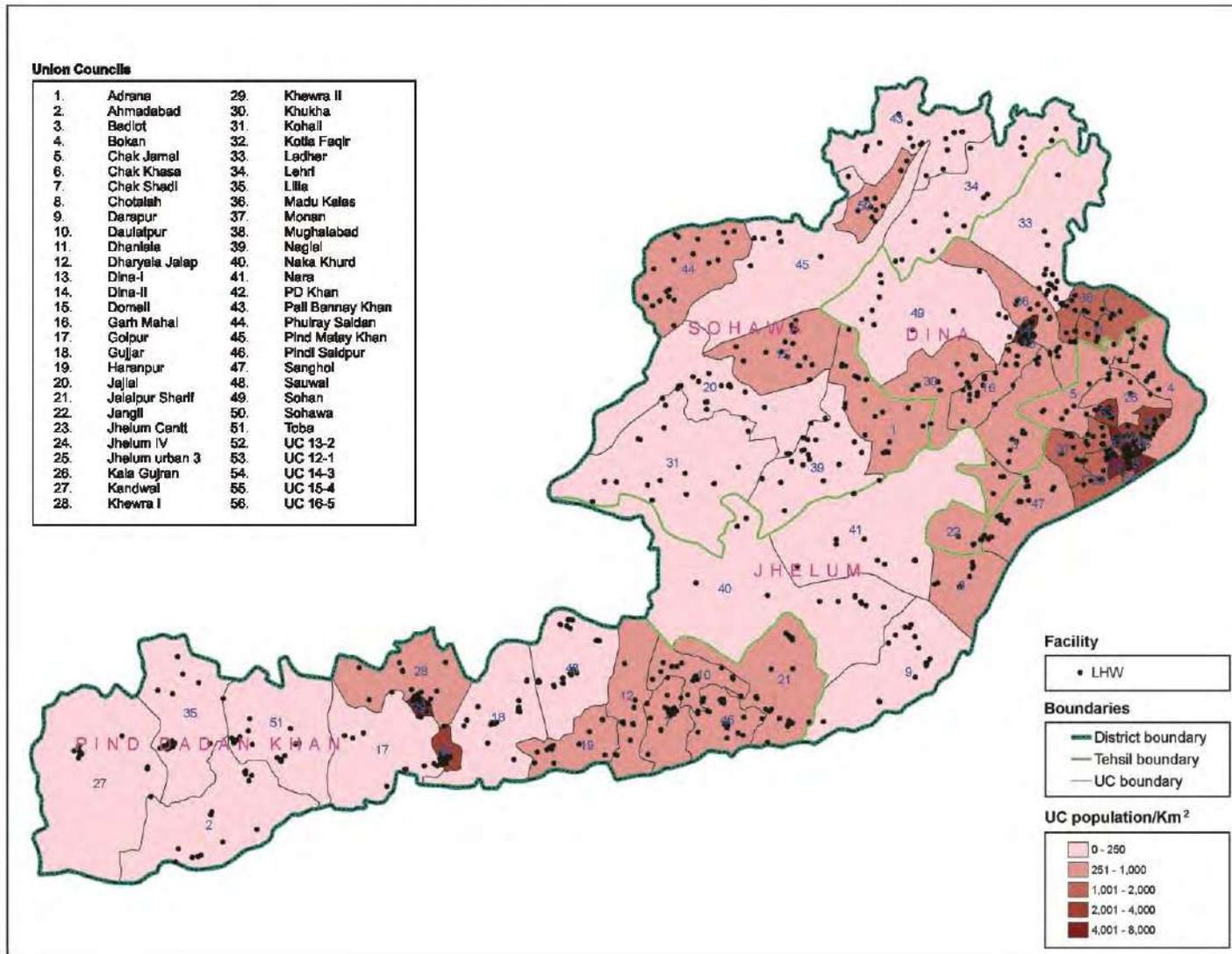
Table 4.3: Number of reproductive health care providers by sector and category and MWRA per service provider

Provider	Sector						Total		MWRA per provider
	Government		Private GSM		Private others		N	%	
	N	%	N	%	N	%	N	%	
Doctors (MBBS)									
Male	86	78.2	78	63.9	83	78.3	247	73.1	703
Female	24	21.8	44	36.1	23	21.7	91	26.9	1907
Total	110	100.0	122	100.0	106	100.0	338	100.0	513
Female paramedics									
Medical assistant	2	1.7	0	0.0	5	0.0	7	1.6	24793
Nurse	71	58.7	170	85.9	81	73.6	322	75.1	539
Medical/ health technician	4	3.3	10	5.1	3	2.7	17	4.0	10209
Lady health visitor	44	36.4	18	9.1	21	19.1	83	19.3	2091
Total	121	100.0	198	100.0	110	100.0	429	100.0	405
Male paramedics	44		25		35		104		1669

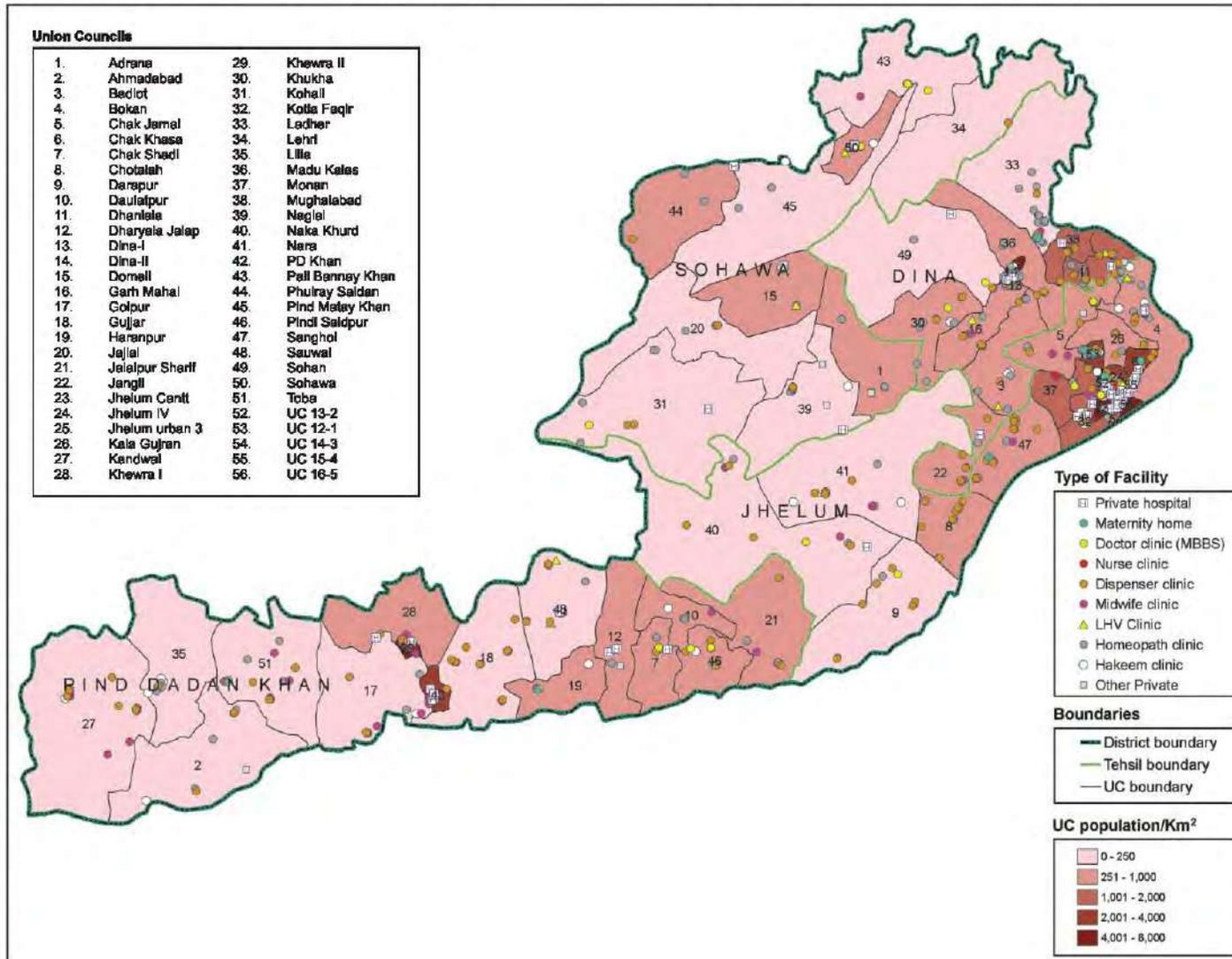
Map 4.1: Location of government facilities in Jhelum district, by population density of union council



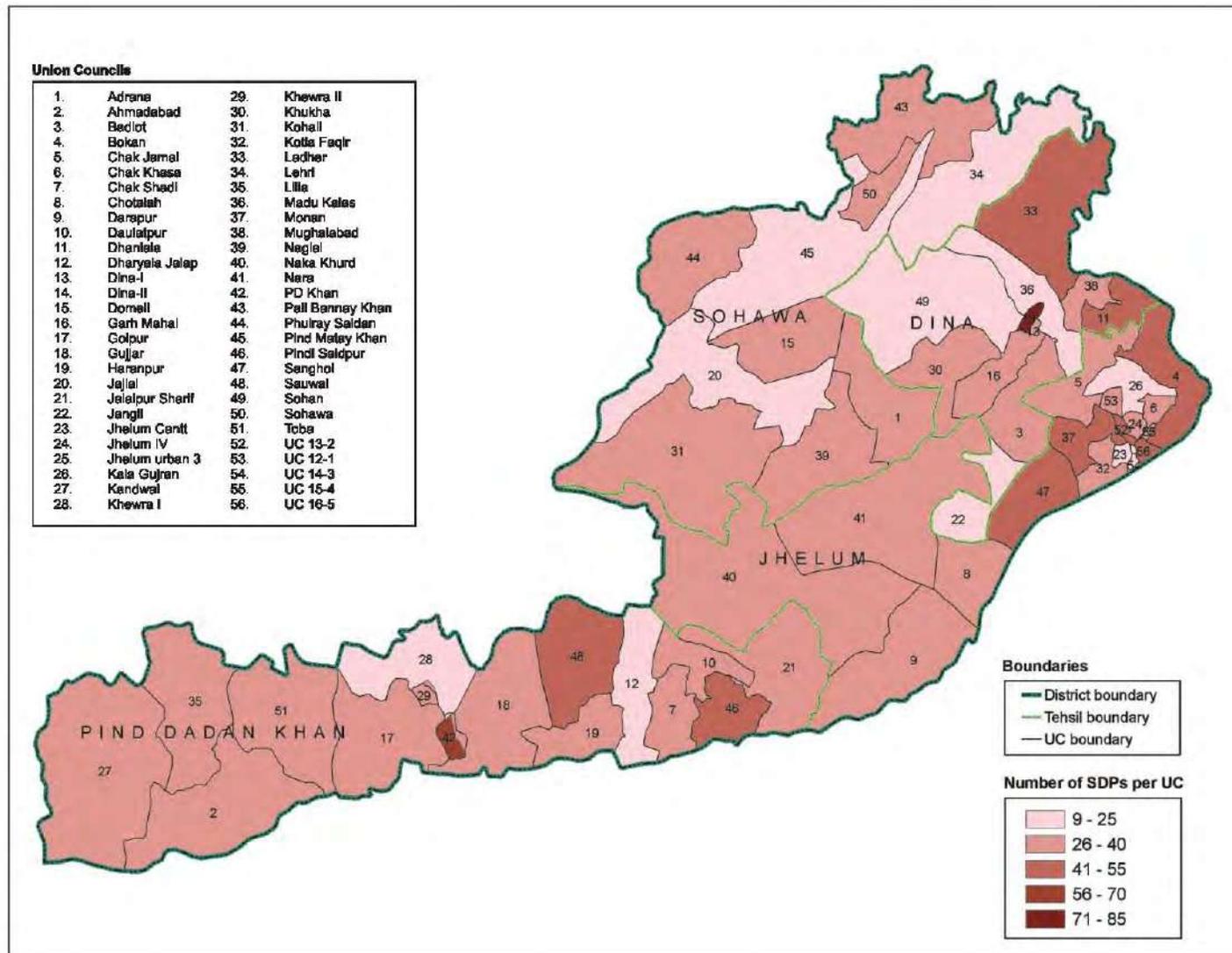
Map 4.2: Location of LHWs in Jhelum district, by population density of union council



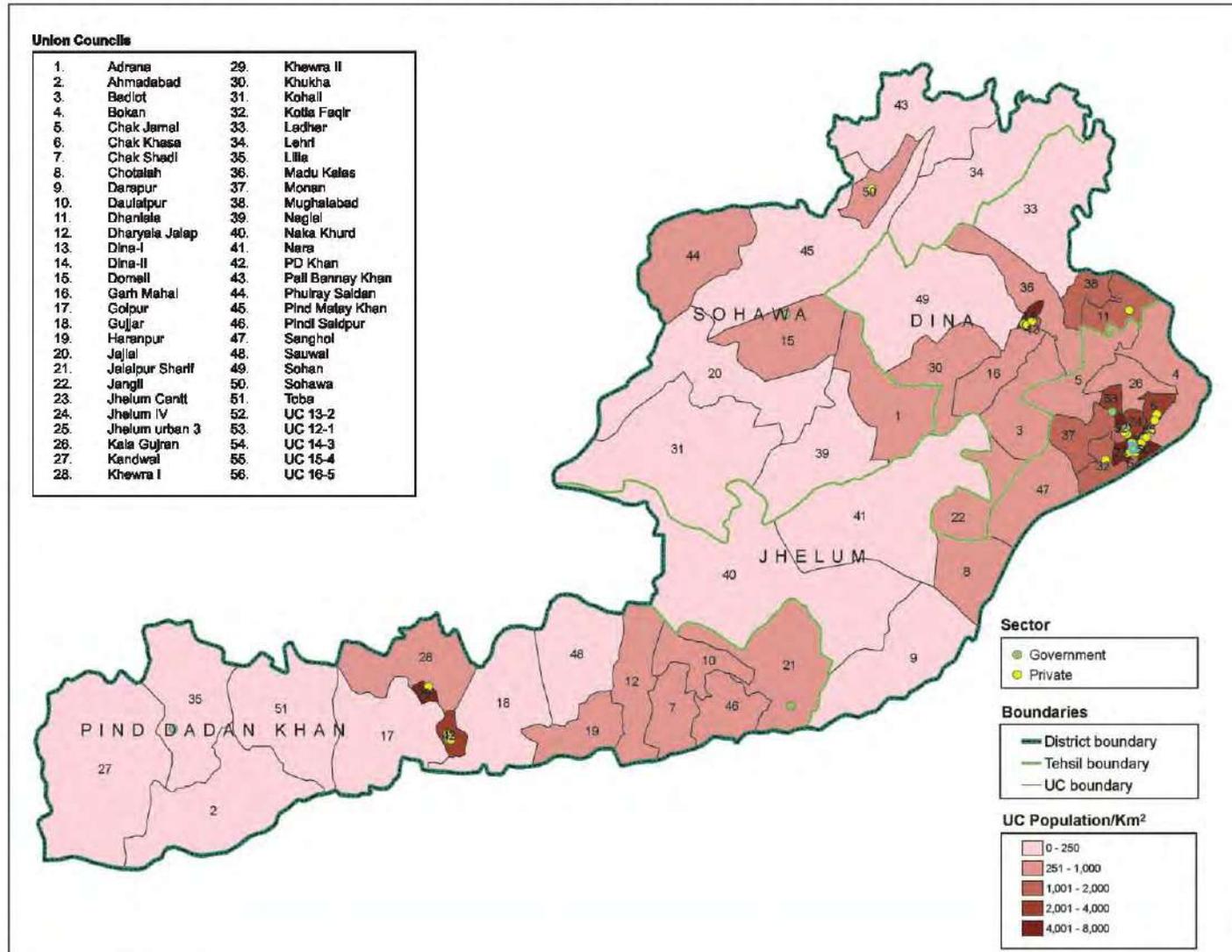
Map 4.3: Location of private facilities in Jhelum district, by population density of union council



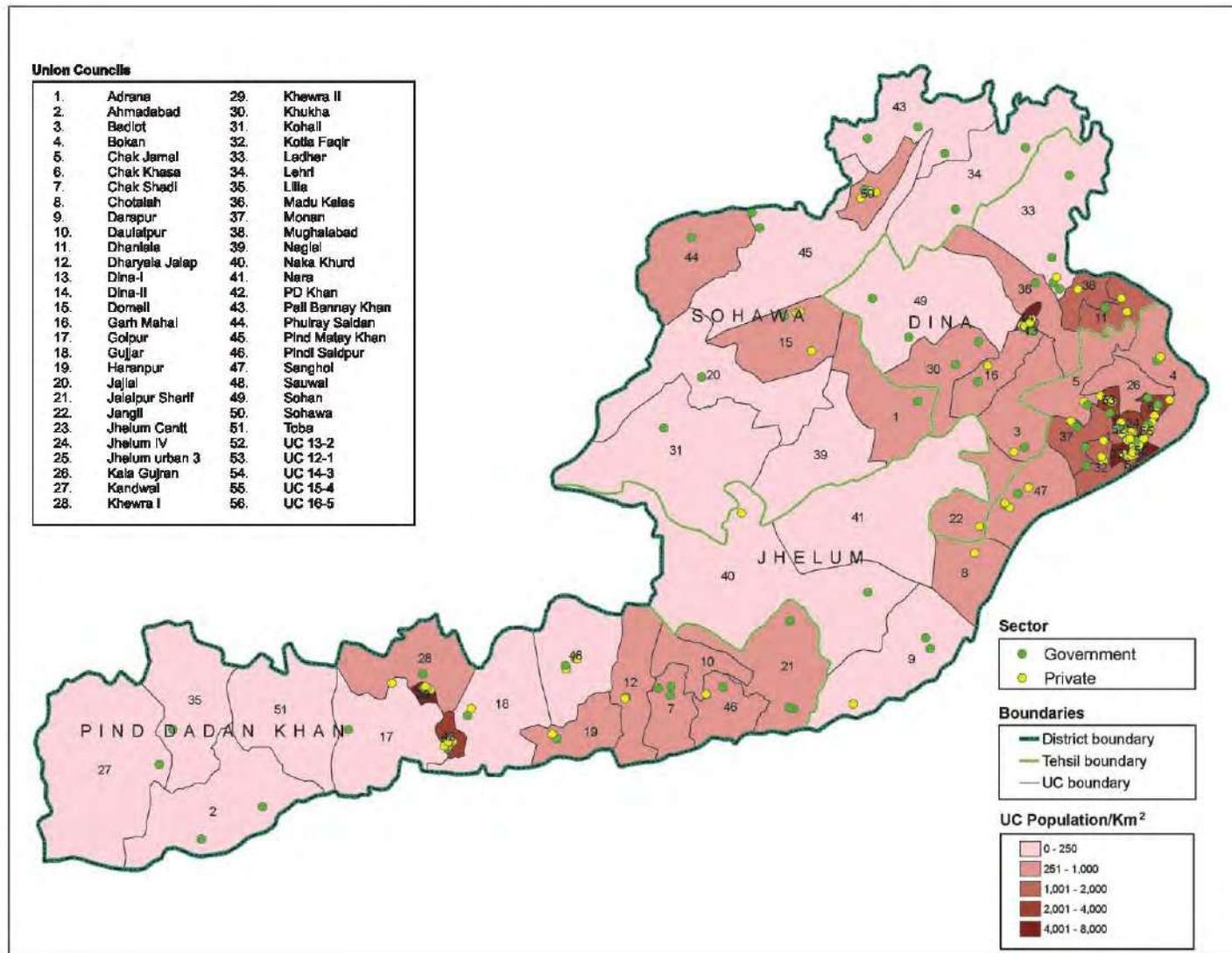
Map 4.4: Total number of reproductive health service delivery points (public and private), in Jhelum district, by union council



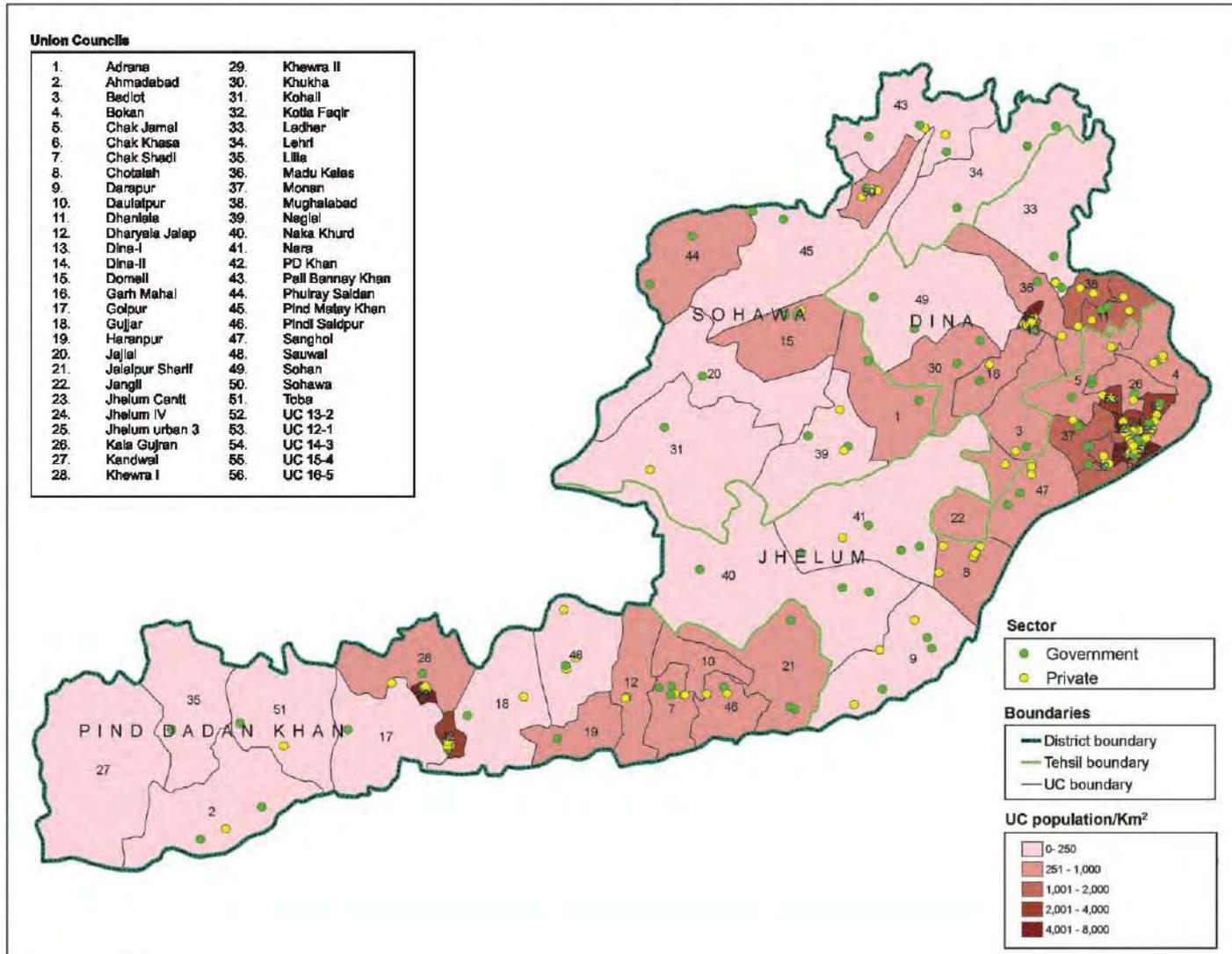
Map 4.5: Location of female sterilization facilities in Jhelum district, by population density of union council



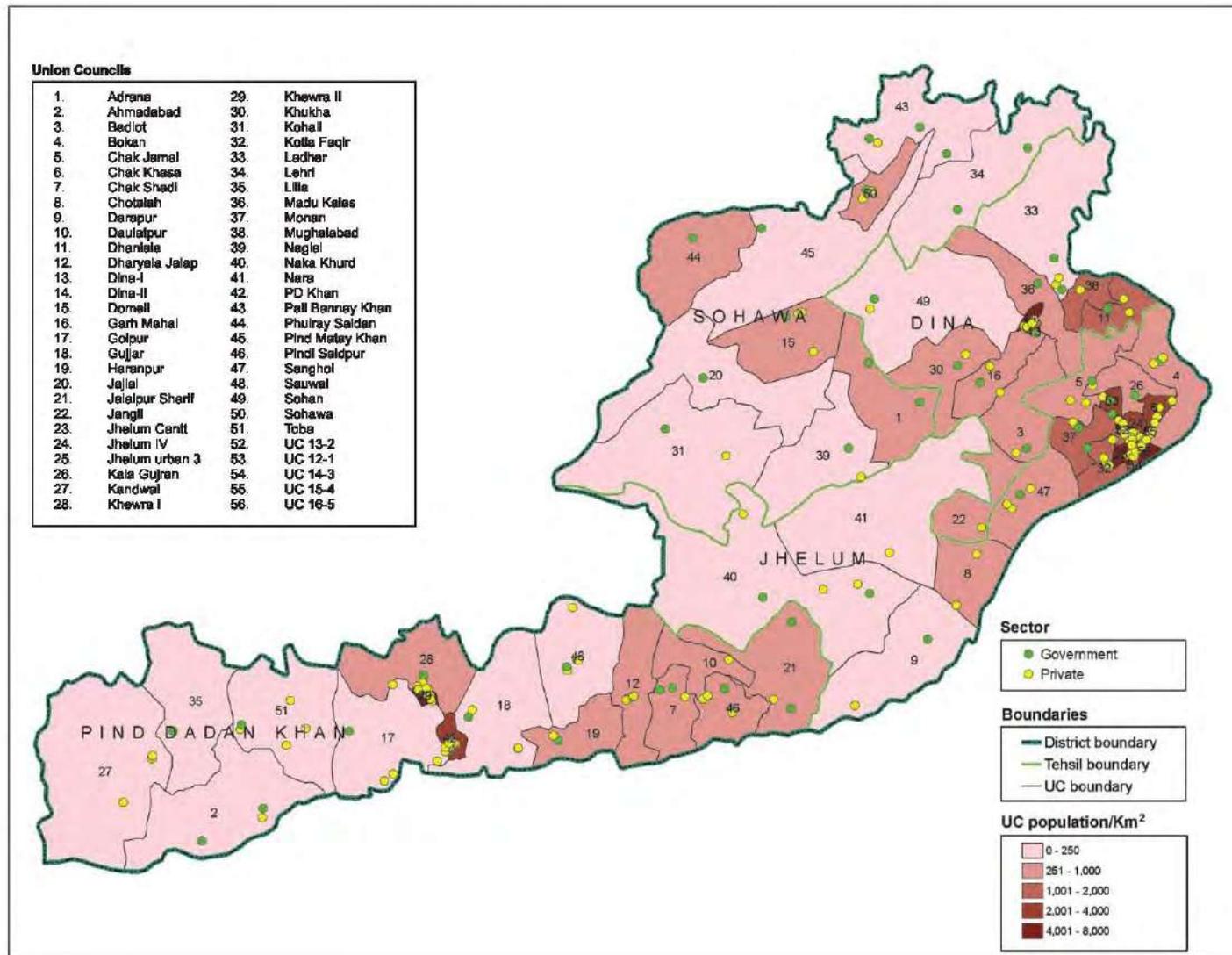
Map 4.6: Location of IUD facilities in Jhelum district, by population density of union council



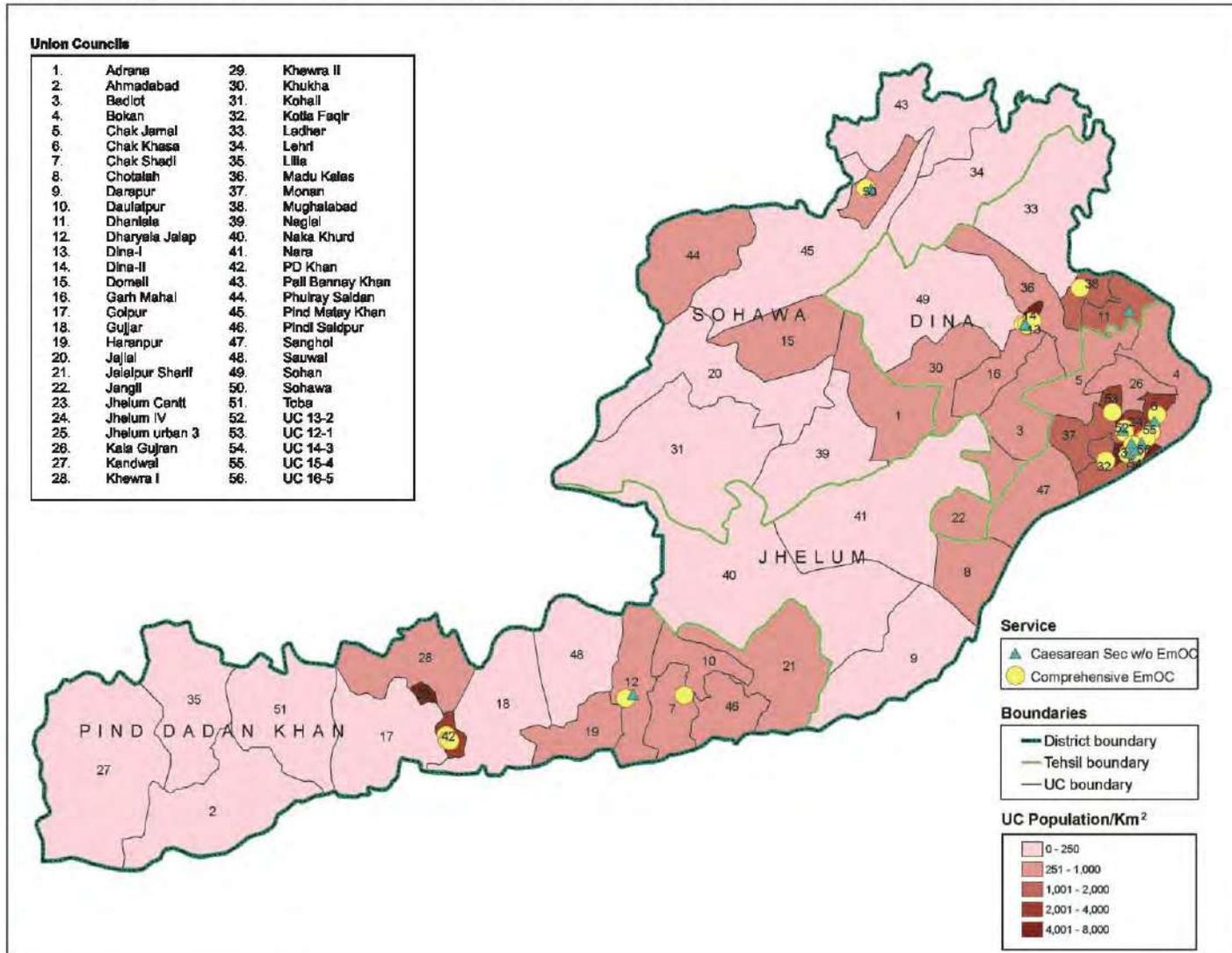
Map 4.7: Location of injectables contraceptive services in Jhelum district, by population density of union council



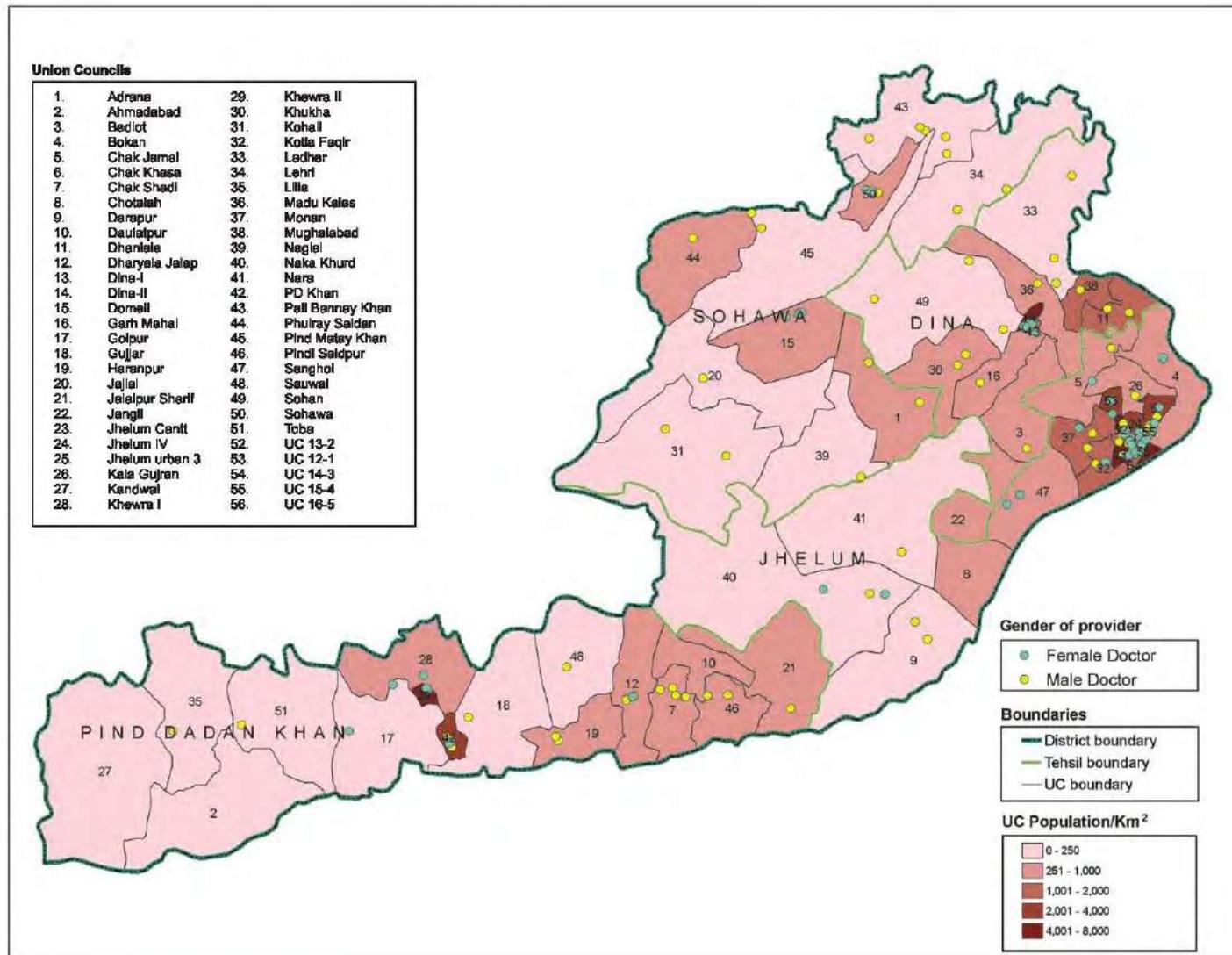
Map 4.8: Location of essential obstetric services in Jhelum district, by population density of union council



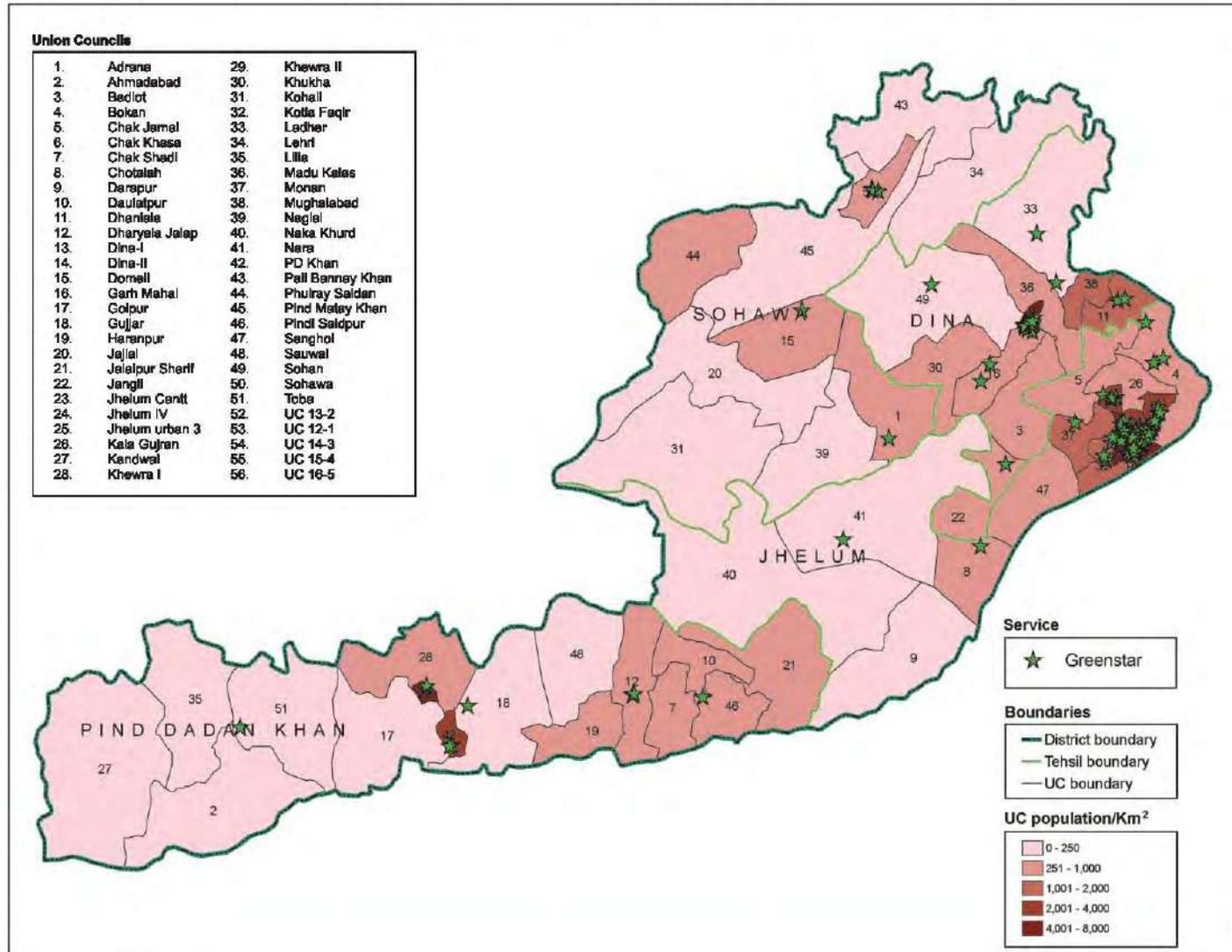
Map 4.9: Location of emergency obstetric care facilities in Jhelum district, by population density of union council



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



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



Chapter 5

Fertility

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

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

Cumulative Fertility

Children Ever Born and Living

The number of children a woman has ever borne reflects fertility in the past; it therefore provides a somewhat different picture of fertility levels, trends, and differentials than do period measures of fertility, such as the CBR and the TFR. Table 5.1 shows the percentage distribution of all currently married women by the number of children ever born (CEB). The table shows these distributions by the age of the woman at the time of the survey.

Table 5.1: Distribution of MWRA by age of mother and number of children ever born (CEB)

Age group	Children ever born				%	Mean CEB	N
	0	1-2	3-4	5 or more			
15-19	100.0	0.0	0.0	0.0	100.0	0.0	1
20-24	32.8	60.7	6.6	0.0	100.0	1.1	61
25-29	16.1	46.2	34.4	3.2	100.0	2.1	93
30-34	7.6	20.3	54.4	17.7	100.0	3.3	79
35-39	2.9	14.3	28.6	54.3	100.0	4.6	70
40-44	5.2	3.9	23.4	67.5	100.0	5.4	77
45-49	3.0	7.5	16.4	73.1	100.0	5.9	67
Total	11.2	25.4	28.6	34.8	100.0	3.7	448

This table indicates that there were no children in the age group of 15-19, which is compatible with the data in Table 2.3. However, the table shows that early childbearing was fairly common in Jhelum. The table 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 from data of good quality. Table 5.3 shows the mean number of sons and daughters with the same trend. Among currently married women aged 15-49 in Jhelum, the mean number of children ever born was 3.7. The mean number of children ever born increased steadily with age, reaching a high of 6 children per woman at age 45-49. On average, these women also had 5 living children, and each woman of this age group had lost one child, on average, during her reproductive life.

Table 5.1 also shows that childbearing among women in Jhelum began in the age group of 20-24. Women aged 45-49 had more or less completed their childbearing. Among currently married women in this age group, about 24 percent had reached the end of childbearing with fewer than five children ever born, and 73 percent had five or more children ever born. Data in Table 5.1 show that 3 percent of women aged 45-49 years had no live birth in their reproductive period, suggesting the existence of infertility in this sample in Jhelum.

Table 5.3 also shows a sex ratio of 106 males per 100 females, both for children ever born and living children, which is clearly indicative of good quality reporting of male and female births.

Table 5.2: Distribution of MWRA by age of mother and number of living children (LC)

Age group	Number of living children				%	Mean LC	N
	0	1-2	3-4	5 or more			
15-19	100.0	0.0	0.0	0.0	100.0	0.0	1
20-24	36.1	57.4	6.6	0.0	100.0	1.0	61
25-29	16.1	48.4	33.3	2.2	100.0	1.9	93
30-34	7.6	24.1	54.4	13.9	100.0	3.0	79
35-39	4.3	14.3	40.0	41.4	100.0	4.1	70
40-44	5.2	6.5	29.9	58.4	100.0	4.8	77
45-49	3.0	10.4	28.4	58.2	100.0	4.9	67
Total	11.8	27.0	33.0	28.1	100.0	3.3	448

Table 5.3: Mean number of children ever born and children surviving, by sex of child and age of mother

Age group	Mean number of children						N
	Ever born			Surviving			
	Boys	Girls	Total	Boys	Girls	Total	
15-19	0.0	0.0	0.0	0.0	0.0	0.0	1
20-24	0.5	0.5	1.1	0.5	0.5	1.0	61
25-29	1.1	0.9	2.1	1.1	0.9	1.9	93
30-34	1.7	1.6	3.3	1.6	1.5	3.0	79
35-39	2.5	2.1	4.6	2.2	1.9	4.1	70
40-44	2.9	2.5	5.4	2.6	2.2	4.8	77
45-49	2.9	3.0	5.9	2.3	2.6	4.9	67
Total	1.9	1.8	3.7	1.7	1.6	3.3	448

Differentials in Children Ever Born and Surviving

Tables 5.4 and 5.5 show that differences in the mean number of children by literacy and educational level of currently married women, were pronounced. On average, literate women had two less children than illiterate women. As expected, fertility also declined with the level of education. Those who had “up to primary” education had on average 3.1 children ever born, as compared to 5.0 born to those who had no schooling. Those who had “up to secondary” education had 2.9 children, and those educated in college had 1.7 children ever born.

Differentials were also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 3.4 children compared to 4.9 children ever born to those who had illiterate husbands. Differentials relating to the background characteristics of husbands were somewhat smaller than those relating to the background characteristics of the currently married women themselves. Women with illiterate husbands and who themselves were illiterate had almost the same number of children ever born. Women with husbands working in agriculture/livestock/poultry had the highest number of children ever born (4.3 children) in the occupation category. Women with husbands who were abroad or ran their own business had the lowest number of children ever born (2.8 and 2.9 children respectively).

A comparison of mean numbers of children ever born and surviving children shows that survival of children increased with the literacy and educational level of mothers. The survival of children was also better if the husband was literate.

Table 5.4: Mean number of children ever born, living and dead, by background characteristics

Characteristic	Mean number of children ever born	Mean number of living children	Proportion dead	N
Literacy of mother				
Literate	2.8	2.6	0.07	250
Illiterate	4.8	4.2	0.14	198
Schooling of mother				
No education	5.0	4.3	0.14	175
Up to primary	3.1	2.8	0.08	125
Up to secondary	2.9	2.8	0.06	109
Above secondary	1.7	1.6	0.06	39
Type of community				
Rural	3.6	3.3	0.10	335
Urban	3.8	3.3	0.13	113
Literacy of husband				
Literate	3.4	3.1	0.09	365
Illiterate	4.9	4.2	0.15	75
Schooling of husband				
No education	5.0	4.3	0.15	68
Up to primary	4.2	3.6	0.15	61
Up to secondary	3.4	3.1	0.08	255
Above secondary	2.9	2.6	0.10	58
Standard of living index				
Low	3.8	3.4	0.11	20
Medium low	3.7	3.3	0.12	63
Medium high	4.2	3.6	0.13	136
High	3.4	3.0	0.09	229
Economic activity/ occupation of husband				
Agriculture/livestock/poultry	4.3	3.8	0.12	44
Petty trader	3.3	3.1	0.06	45
Labor (daily wages)	3.8	3.4	0.10	161
Government service	4.1	3.7	0.10	69
Private service	3.5	3.0	0.14	50
Own business	2.9	2.7	0.07	23
Working abroad	2.8	2.5	0.11	34
Unemployed	3.5	2.8	0.21	21
Total	3.7	3.3	0.11	448

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 (2.8 children) compared to that of those mothers who were illiterate (4.8 children). Similarly, the survival of children with literate mothers was far better than those born to illiterate mothers. Mean number of children ever born to younger literate mothers was lower and their survival was better than children born to mothers in older age groups. Literate mothers were younger than illiterate mothers. In the below 30 age group, 70 percent were literate, as compared to 35 percent who were illiterate. It is not only that, overall, literate women had fewer children, but younger literate women also had fewer children ever born compared to illiterate women.

Table 5.5: Mean number of children ever born and living by age and literacy of mother

Age group	Literate				Illiterate			
	Mean number of CEB	Mean number of LC	N	%	Mean number of CEB	Mean number of LC	N	%
15 - 19	0.0	0.0	0	0.0	0.0	0.0	1	0.5
20 - 24	1.0	1.0	50	20.0	1.4	1.3	11	5.6
25 - 29	1.9	1.9	67	26.8	2.4	2.1	26	13.1
30 - 34	3.1	2.9	56	22.4	3.6	3.4	23	11.6
35 - 39	4.1	3.7	30	12.0	5.0	4.4	40	20.2
40 - 44	3.9	3.7	28	11.2	6.3	5.4	49	24.7
45 - 49	5.5	4.9	19	7.6	6.0	4.8	48	24.2
Total	2.8	2.6	250	100.0	4.8	4.2	198	100.0

Current Fertility

Crude Birth Rate

Although a crude measure of fertility, the crude birth rate (CBR) is the most commonly understood and used fertility measure. In this survey, it is calculated from the number of births that occurred during the last three years before the survey and the mid-period total

population in the sample households. The baseline survey provided an estimate of 22 births per thousand population.

Age-specific Fertility Rates and Total Fertility Rate

The total fertility rate (TFR) is a more refined fertility measure than CBR. Age-specific fertility rates (ASFRs) and TFR are based on births to currently married women and the number of women living in the sample households. One of the limitations of measuring ASFRs is the low number of births in the sample during the last three years. The findings show a pattern of ASFRs common in developing countries; rates rise rapidly until age 25-29, then decline with increasing age. A TFR of 2.9 for the period 2004-2007 was obtained from the set of ASFRs calculated from the data presented in Table 5.6; this is in line with the figure of 4.1 for Pakistan as a whole reported in the PDHS (NIPS/PDHS, 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 rates (ASFRs)
15 - 19	178	0	0.0
20 - 24	178	53	99.3
25 - 29	144	74	171.3
30 - 34	100	49	163.3
35 - 39	85	26	102.0
40 - 44	94	13	46.1
45 - 49	91	2	7.3
Total	870	217	na
TFR: 2.9			
CBR: 22			

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

Children < 5 years	Currently pregnant		Currently not pregnant		Total	
	%	N	%	N	%	N
0	7.3	16	92.7	204	100.0	220
1	12.1	17	87.9	124	100.0	141
2	15.1	11	84.9	62	100.0	73
3	21.4	3	78.6	11	100.0	14
Total	10.5	47	89.5	401	100.0	448

Table 5.7 shows a significant number of women with the burden of caring for several young children. Among those women who already had had three living children under 5 years of age, 21 percent were currently pregnant. Moreover, among women who had two living children under five years of age, 15 percent were currently pregnant. For such mothers, it is particularly important for their health and that of their children to ensure that birth spacing is part of their married life at this point.

Preceding Birth Interval

Women with short birth intervals are at higher risk for delivering premature, low-birth-weight or small-for-gestational age infants (Fuentes-Affelick and Hessol, 2000; Miller et al., 1995; Zhu et al., 1999). The length of the preceding birth interval is very important for the health of both mothers and babies. Table 5.8 shows the length of last closed birth interval for women with two or more births by background characteristics of mothers at the time of the survey.

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

Characteristic	Less than 18 months	18 - 23 months	24 - 35 months	36 - 47 months	48 months or more	Total	N
Age group							
15 - 19	0.0	0.0	0.0	0.0	0.0	0.0	0
20 - 24	33.3	19.0	33.3	14.3	0.0	100.0	21
25 - 29	9.2	16.9	26.2	24.6	23.1	100.0	65
30 - 34	14.9	13.4	23.9	16.4	31.3	100.0	67
35 - 39	4.9	14.6	31.7	9.8	39.0	100.0	41
40 - 44	0.0	14.3	14.3	14.3	57.1	100.0	14
45 - 49	33.3	0.0	33.3	33.3	0.0	100.0	3
Birth order							
2	20.8	17.0	17.0	17.0	28.3	100.0	53
3	10.2	8.2	32.7	18.4	30.6	100.0	49
4	10.4	20.8	22.9	27.1	18.8	100.0	48
5	10.3	10.3	41.4	6.9	31.0	100.0	29
6+	6.3	18.8	25.0	12.5	37.5	100.0	32
Education							
No education	6.7	15.0	28.3	18.3	31.7	100.0	60
Up to primary	9.7	16.7	27.8	19.4	26.4	100.0	72
Up to secondary	16.4	14.8	21.3	18.0	29.5	100.0	61
Above secondary	27.8	11.1	33.3	5.6	22.2	100.0	18
Standard of living index							
Low	16.7	33.3	16.7	8.3	25.0	100.0	12
Medium low	8.1	18.9	35.1	24.3	13.5	100.0	37
Medium high	15.0	13.3	23.3	25.0	23.3	100.0	60
High	11.8	12.7	26.5	11.8	37.3	100.0	102
Total	12.3	15.2	26.5	17.5	28.4	100.0	211

A short interval has traditionally been viewed as a risk factor for poor pregnancy outcomes, particularly affecting neonatal mortality in developing countries (Cleland and Sathar, 1984). It has been observed in several studies that the risk of death for an index child whose birth closes a short birth interval is higher than those experienced by an index child whose birth closes a longer birth interval (Mahmood, 2002). It has also been found that children born within the preceding interval of 18 months experienced higher mortality risks during infancy than those born in an interval of two to three years (Cleland and Sathar, 1984).

Table 5.8 shows that almost 12 percent of the children were born within 18 months of the birth interval. Almost 51 percent were born with a birth interval of less than 36 months, while 49 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 226 women out of the 448 total women interviewed had borne a child during the past four years, and therefore qualified for these questions.

Antenatal Care

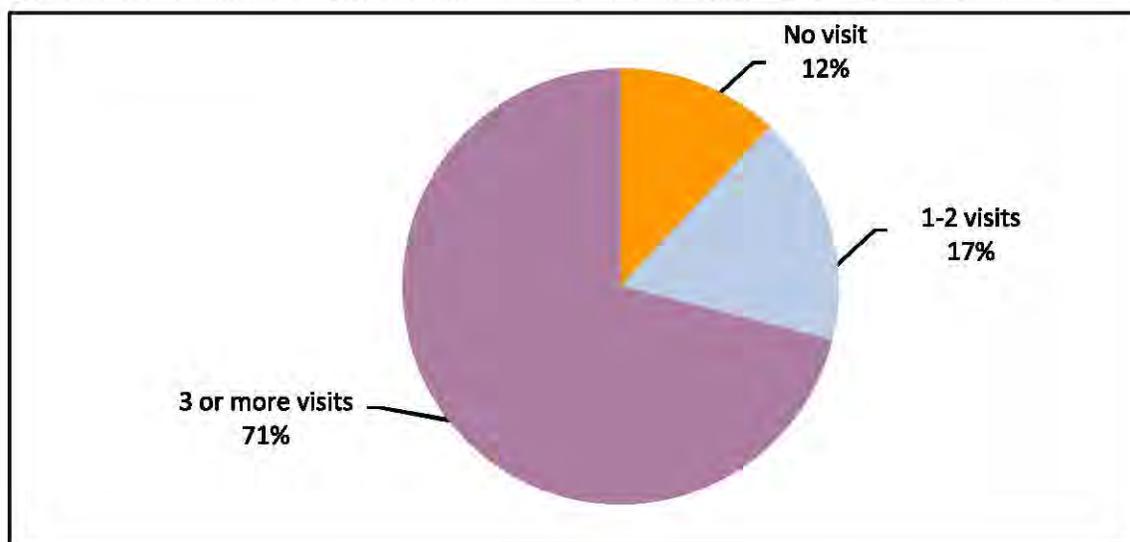
Antenatal check-ups allow for skilled health personnel to advise expectant mothers how to best take care of themselves and their unborn baby during the pregnancy, to prepare them for childbirth and caring for the newborn, and to identify possible problems during pregnancy and delivery. The Ministry of Health recommends at least three antenatal visits during pregnancy, preferably four. Traditionally however many women have viewed childbirth as a natural experience and perhaps did not find health providers nearby and have not gone to skilled providers for antenatal care. In recent years, those proportions have been increasing in Pakistan (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 6.1 and Figure 6.1 show the numbers of ANC visits for the last birth of women who had delivered babies during the previous four years. Almost 88 percent of the sample respondents had received at least one antenatal care visit during the last pregnancy; the percentage was higher for rural mothers (89 percent) than for urban ones (83 percent). This shows that more awareness about antenatal care exists in rural areas of Jhelum. This may also be attributed to the efforts of PAIMAN as Jhelum is also a project district of PAIMAN. The 88 percent figure is significantly higher than the level obtained for Jhelum in the 2004-05 PSLMS Survey (55 percent), the level for Punjab in the PDHS (61 percent) or

the level obtained nationally in the PDHS (also 61 percent) (Government of Pakistan, 2006; NIPS/PDHS, 2008). Seventy-one percent of the women had at least three such visits, and 60 percent had four or more visits.

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

Number of ANC visits	Rural		Urban		Total	
	N	%	N	%	N	%
No visit	20	11.2	8	17.4	28	12.4
1-2 visits	30	16.8	9	19.6	39	17.3
3 visits	21	11.7	3	6.5	24	10.7
4+ visits	108	60.3	26	56.6	134	59.6
Total	179	100.0	46	100.0	225	100.0

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



Data also show that many of these visits were in response to a routine check-up rather than for some problem. About 64 percent of the first antenatal visits were for routine check-ups (Figure 6.2).

Figure 6.2: Percentage of women according to the reason for the first antenatal visit during last pregnancy

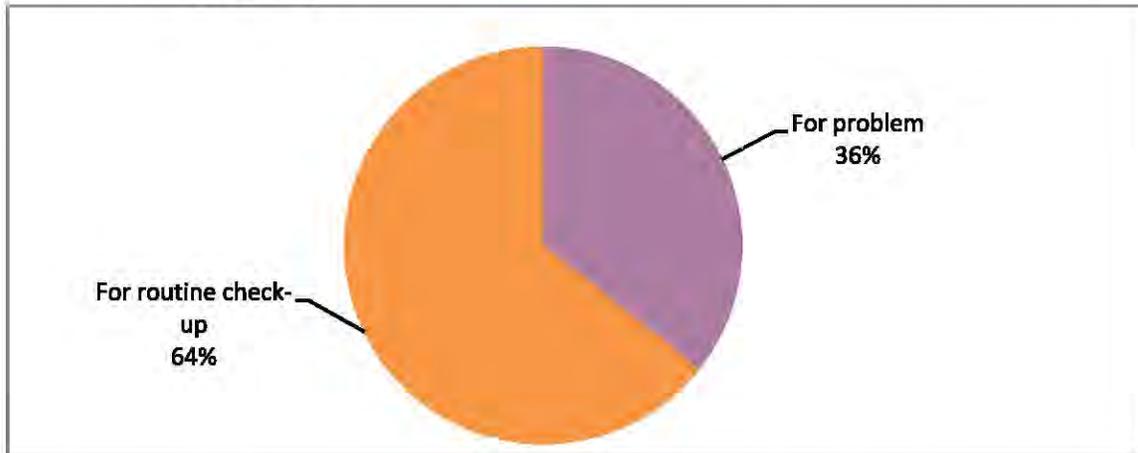


Figure 6.3 shows that more than two-thirds of the time (68 percent) the first visit took place within the first three months of gestation, and only 6 percent of first visits occurred during the third trimester.

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

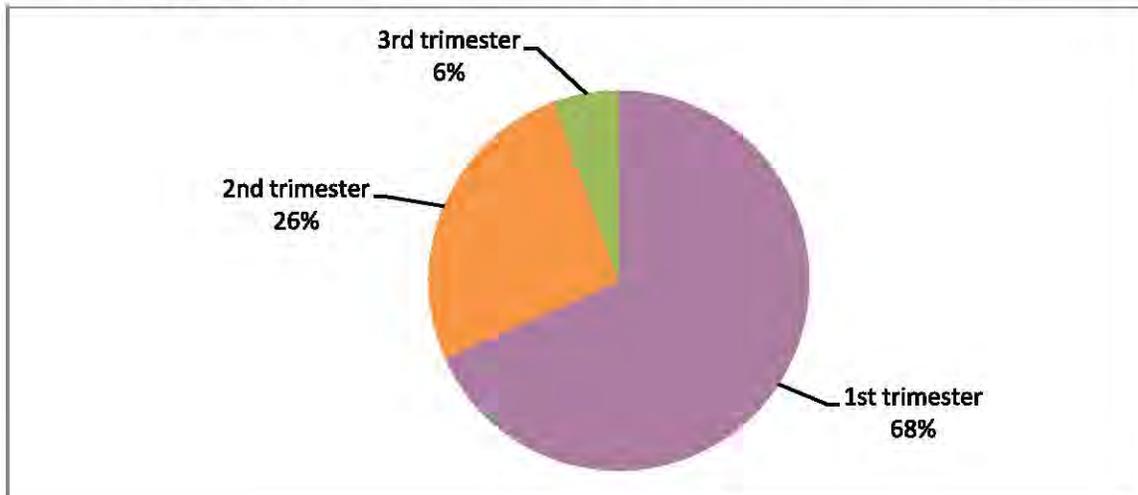


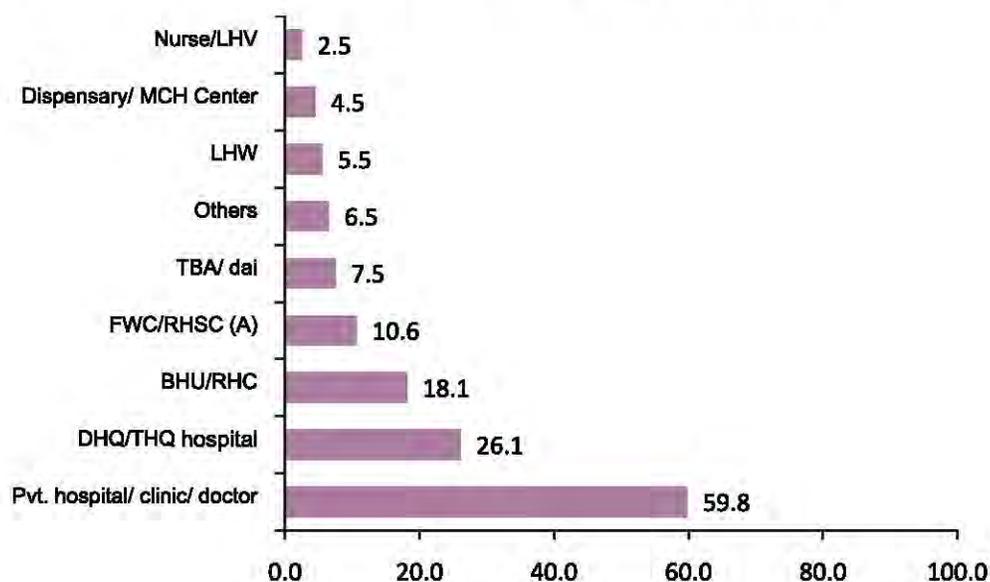
Table 6.2: Facilities/service providers mentioned for one or more antenatal visits by residence

Facilities/service providers	Rural		Urban		Total	
	N	%	N	%	N	%
Dispensary/MCH center	6	3.8	3	7.7	9	4.5
BHU/RHC	35	21.9	1	2.6	36	18.1
DHQ/THQ hospital	42	26.3	10	25.6	52	26.1
Pvt. hospital/clinic/doctor	91	56.9	28	71.8	119	59.8
FWC/RHSC (A)	14	8.8	7	17.9	21	10.6
LHW	11	6.9	0	0.0	11	5.5
TBA/Dai	13	8.1	2	5.1	15	7.5
Nurse/LHV	5	3.1	0	0.0	5	2.5
Others	12	7.5	1	2.6	13	6.5
Total	159	na	38	na	197	na

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

Table 6.2 and Figure 6.4 show the locations where respondents made one or more antenatal visits. Most antenatal visits took place in private sector facilities. The most common providers of antenatal care were private hospitals and clinics (60 percent), followed by DHQ/THQ hospitals (26 percent), and BHUs and RHCs (18 percent) which were the third most commonly visited facilities.

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



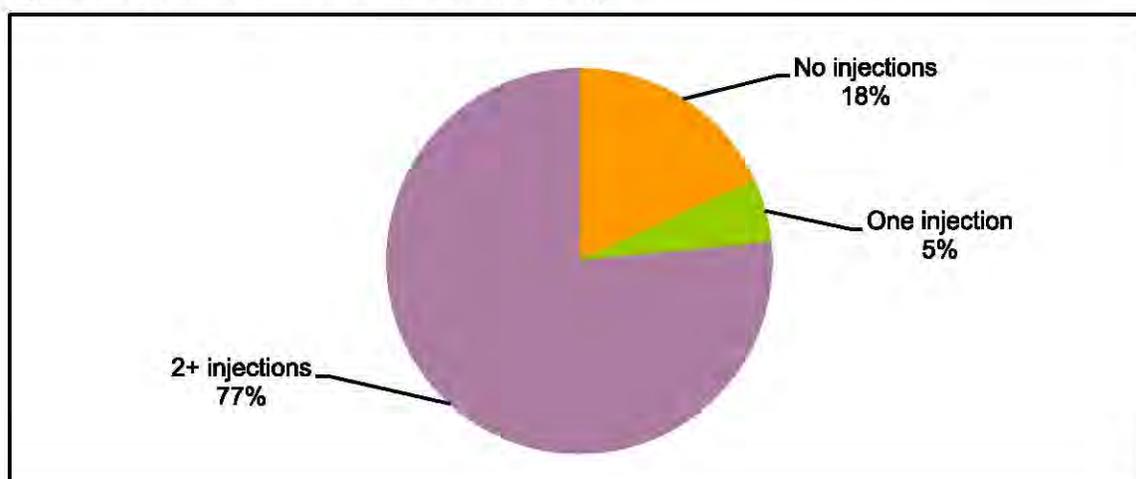
Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn or mother. Two doses in a pregnancy are sufficient to prevent tetanus. However, if the woman was immunized during her previous pregnancy, only one dose may be needed. Five doses are sufficient for lifetime protection. According to the PSLMS 2004-05, 77 percent of the mothers in Jhelum 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 shows that 82 percent of the mothers in Jhelum had received at least one shot during their last pregnancy, and 77 percent had received two or more shots. The immunization rate for 2+ shots was higher in rural than in urban areas.

Table 6.3: Distribution of mothers according to residence, by status of tetanus toxoid injections during last pregnancy

Number of injections	Rural		Urban		Total	
	N	%	N	%	N	%
No TT shot	33	18.4	8	17.0	41	18.1
One TT shot	7	3.9	5	10.6	12	5.3
2+ TT shots	139	77.7	34	72.3	173	76.5
Total	179	100.0	47	100.0	226	100.0

Figure 6.5: Tetanus immunization at last delivery



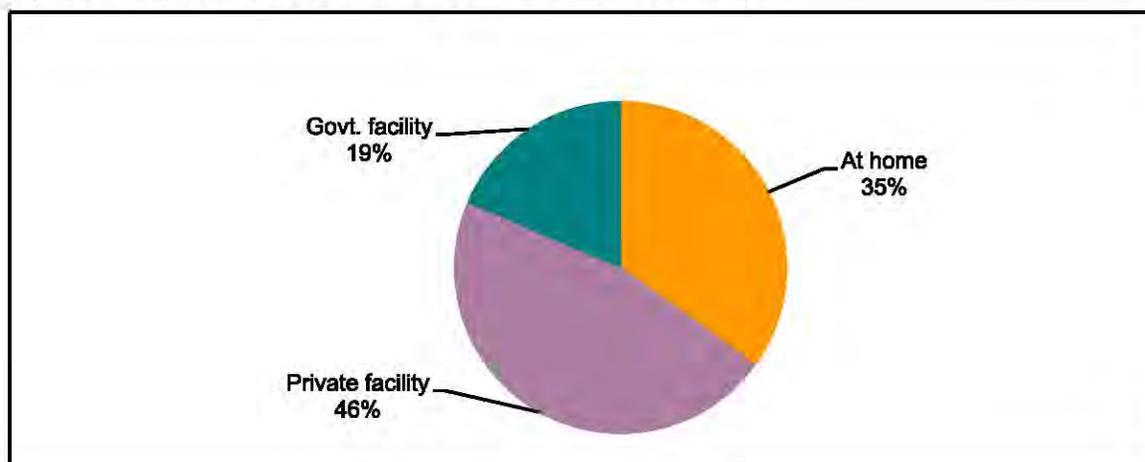
Location and Attendance at Delivery

Among the most important ways to reduce maternal mortality is to increase the proportion of mothers delivering in a health facility with the support of a trained birth attendant. Although these proportions have been historically low in Pakistan and have contributed substantially to high maternal mortality, they have been rising in recent years. In Jhelum, according to the 2004-05 PSLMS, 26 percent of the deliveries took place in institutions, compared with PDHS 2006-07 figures of 33 percent for Punjab and 34 percent nationally (Government of Pakistan, 2006; NIPS/PDHS, 2008). In the present survey, 65 percent of the most recent deliveries were in a health facility (Table 6.4; Figure 6.6). Deliveries at health facilities were higher in urban areas (72 percent) than rural ones (63 percent). A large number of deliveries (35 percent) did take place at home and put the mothers at high risk of mortality.

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

Place of last delivery	Rural		Urban		Total	
	N	%	N	%	N	%
At home	66	36.7	13	28.3	79	35.0
Dispensary/MCH/BHU/RHC	11	6.1	1	2.2	12	5.3
DHQ/THQ hospital	22	12.3	8	17.4	30	13.2
Pvt. hospital/clinic	74	41.1	23	50.0	97	42.9
Others	7	3.9	1	2.2	8	3.5
Total	180	100.0	46	100.0	226	100.0

Figure 6.6: Distribution of mothers by location of last delivery

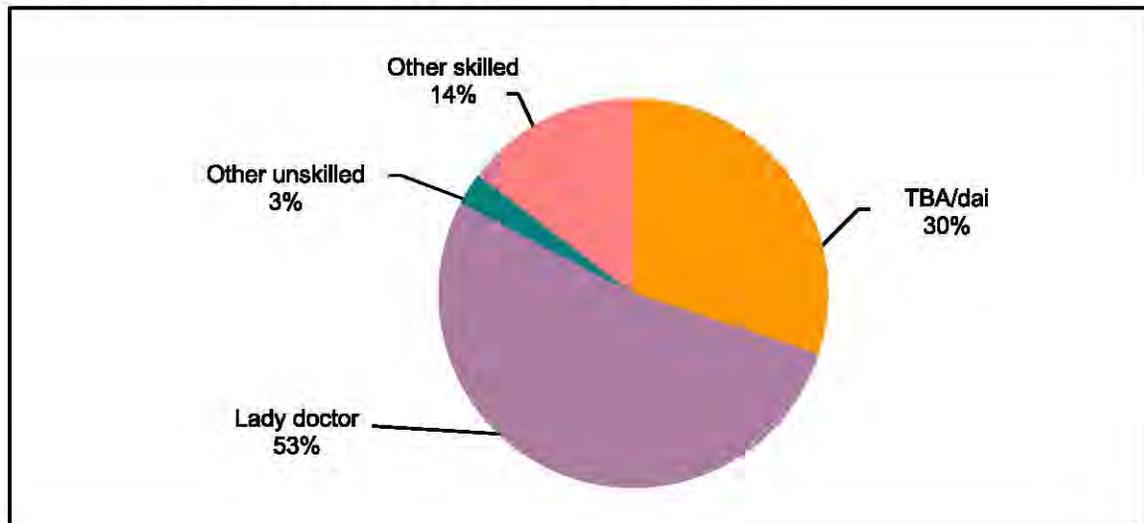


Moreover, in this survey, 67 percent of reported deliveries in the previous four years were delivered by a skilled birth attendant, 76 percent in urban areas versus 65 percent in rural areas (Table 6.5). In the PSLMS 2004-05 for Jhelum, only 35 percent of births were delivered by a skilled attendant; in the PDHS 2006-07, the corresponding figures were 38 percent for Punjab and 39 percent for Pakistan as a whole (Government of Pakistan, 2006; NIPS/PDHS, 2008). Most of the births attended by a skilled attendant in this household survey were reportedly attended by a lady doctor. The term “doctor,” however, may in such interviews mean a paramedic, such as a Lady Health Visitor. About 31 percent of the births were delivered by dais (traditional birth attendants) or LHWs, while a negligible number of women’s babies (1 percent) were delivered by a relative or neighbor who was not a *dai*. This shows that the trend of deliveries by relatives/neighbors has been diminishing in Jhelum.

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

Birth attendant and skill level	Rural		Urban		Total	
	N	%	N	%	N	%
LHW/TBA/dai	61	33.9	10	21.7	71	31.4
Nurse/LHV/ midwife	26	14.5	7	15.2	33	14.6
Lady doctor	91	50.6	28	60.9	119	52.7
Female relative/friend/ neighbor(not dai)	2	1.1	1	2.2	3	1.3
Total	180	100.0	46	100.0	226	100.0
Unskilled birth attendant	63	35.0	11	23.9	74	32.7
Skilled birth attendant	117	65.0	35	76.1	152	67.3

Figure 6.7: Distribution of mothers by attendant at last delivery



Postpartum Care

For both the health of the mother as well as the health of the newborn, a newly delivered baby and mother should receive follow-up check-ups for at least six weeks after delivery. The Ministry of Health guidelines recommend at least one postnatal visit during the first 42 days after delivery. However this is a major weakness of maternal and newborn health care in Pakistan. Women who deliver at home rarely go for any postnatal check-ups. Jhelum is no exception (Table 6.6). Only seven percent of the respondents who had a non-institutional delivery reported having postpartum care within 24 hours of delivery, whereas those who delivered at a facility were assumed to have received postnatal care within 24 hours of the delivery.

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

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

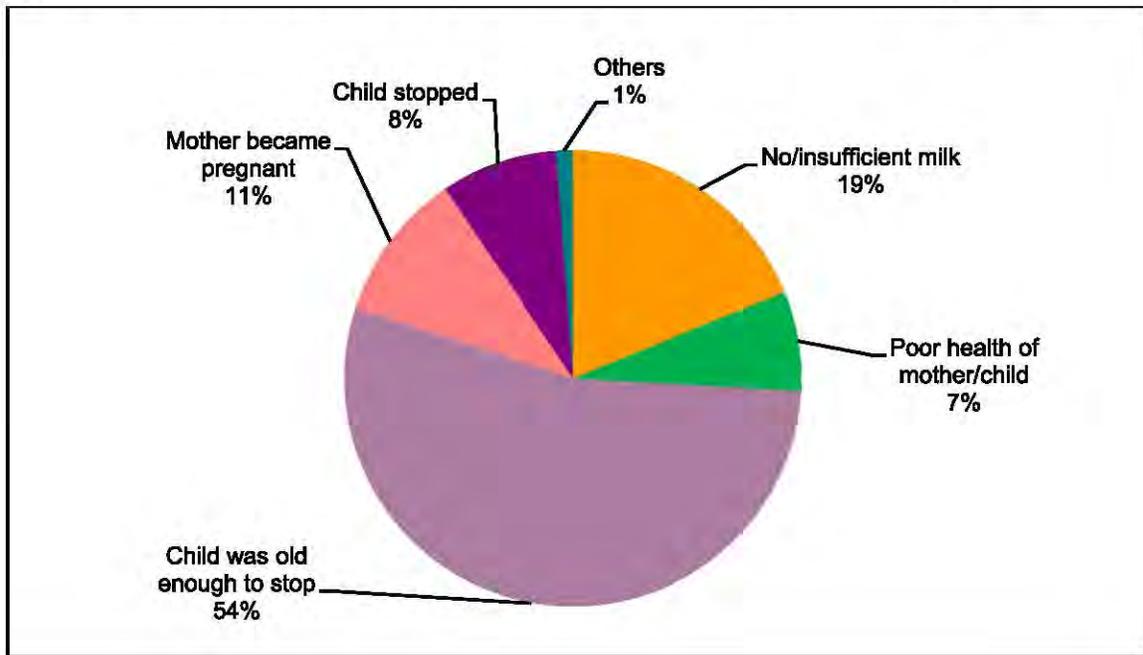
Place of delivery	Postnatal check-up within 24 hours		Postnatal check-up after 24 hours		Did not have postnatal check-up		Total	
	N	%	N	%	N	%	N	%
Institution	140	100.0	0	0.0	0	0.0	140	100.0
Non-institution	6	7.0	2	2.3	78	90.7	86	100.0
Total	146	64.6	2	0.9	78	34.5	226	100.0

Breastfeeding

Breastfeeding is a critical component of newborn and infant health. In addition, it is a primary determinant of the length of postpartum amenorrhea. In this manner, breastfeeding can be deliberately used to delay pregnancy, either through a formal procedure, such as “lactational amenorrhea method” (LAM), or more informally through the assumption that breastfeeding protects against pregnancy. Virtually all Pakistani women breastfeed their children to some extent. In our sample, only 15 of 217 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 24 months, and the most common length was also 24 months. Five main reasons were given for discontinuing breastfeeding - the child was old enough (54 percent); insufficient milk production (19 percent); mother became pregnant (11 percent); child stopped (8 percent) and poor health of the mother/child (7 percent) (Figure 6.8).

An important problem related to breastfeeding in Pakistan is the early initiation of supplementary food. Guidelines of the Ministry of Health recommend exclusive breastfeeding (no other food or drink, including water) until a child is four months old. About 13 percent of the women who had their last child in the past four years reported discontinuing exclusive breastfeeding prior to the fourth month. Most women went up to six months (31 percent). This shows that a majority of women were not protected from becoming pregnant while they were breastfeeding.

Figure 6.8: Distribution of mothers by reason for discontinuing breastfeeding (n=85)



Chapter 7

Preference for Children

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

Ideal Number of Children

The median "ideal" number, in the sense indicated above, was four children. A majority of the women (44 percent) stated the desire to have four children; 81 percent of the respondents wanted four children or less, while substantial numbers stated two or three children as the best number. These proportions did not vary substantially according to residence; urban women wanted about the same number of children as rural women. However, it is interesting to note that rural women in Jhelum were more likely to have three children than urban women. More than 10 percent of the women also gave non-numeric responses to this question, such as "up to God."

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

Number of children	Rural		Urban		Total	
	N	%	N	%	N	%
1	1	0.3	1	0.9	2	0.4
2	38	11.3	18	16.1	56	12.5
3	87	26.0	22	19.6	109	24.4
4	146	43.6	49	43.8	195	43.6
5	17	5.1	6	5.4	23	5.1
6+	14	4.2	3	2.7	17	3.8
Other non-numeric response	7	2.1	2	1.8	9	2.0
Up to God	25	7.5	11	9.8	36	8.1
Total	335	100.0	112	100.0	447	100.0

Desire for More Children

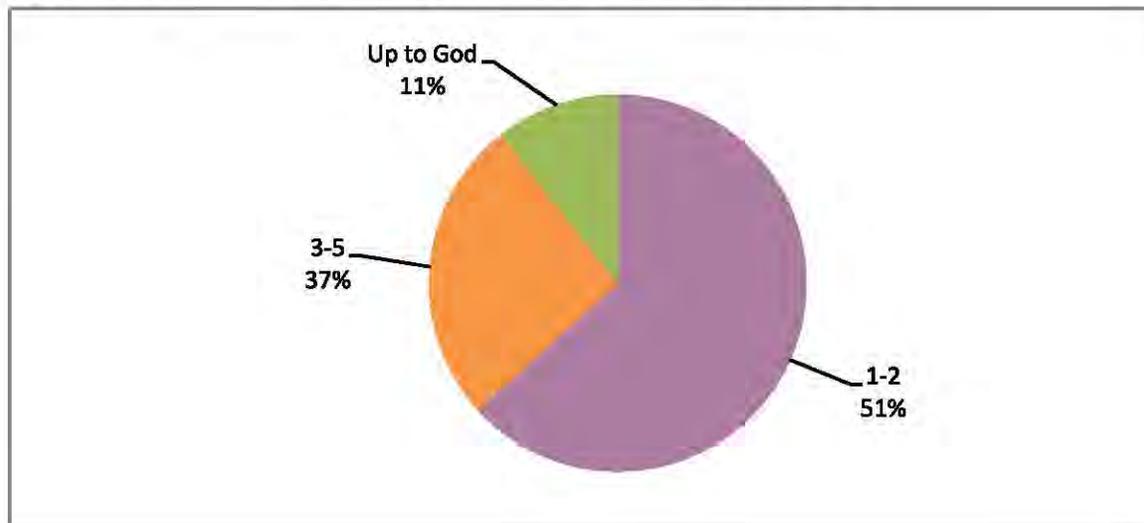
Levels of Desire for More Children

A more immediate measure of fertility preference is whether a couple wants more children; if so, do they want the next one now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already has. Table 7.2 shows that whether respondents wanted more children soon, later (after 2 years or more) or not at all, this was based on the number of living children they already had. Fifty-nine percent of the women did not want more children. Of those who wanted more children, the results were quite fascinating. Twenty-one percent of the women surveyed wanted children soon. The proportion wanting more children soon declined sharply after the first birth; most mothers with a single living child would like to wait before having a second. For all those with between one and three living children, most of those who wanted an additional child preferred to wait some time. Most of the women with three or more living children did not want to have more children. For those with four or more children, the proportion wanting to stop was over 90 percent. This table indicates clearly the high level of interest in both spacing and limiting births.

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

Number of living children	Desire for next child				Total
	Soon	Later	Never	Don't know/unsure	
0	83.0	17.0	0.0	0.0	53
1	38.8	51.0	10.2	0.0	49
2	19.4	45.8	33.3	1.4	72
3	14.6	22.0	62.2	1.2	82
4	3.0	3.0	93.9	0.0	66
5	2.0	2.0	96.0	0.0	50
6+	0.0	0.0	98.7	1.3	76
Total	20.5	19.6	59.2	0.7	448
N	92	88	265	3	448

For those women who wanted more children, we also asked how many more, the results of their responses are shown in Figure 7.1. About 11 percent said that this was up to God; this proportion tended to be higher for those with fewer children. It would be useful to explore what such respondents mean; whether this is a religious statement, an indication that the respondent has not thought about it, or a polite way of telling the interviewer that she did not want to give a specific answer.

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

Socioeconomic Correlates of Desire for Children

A woman's stated desire was analyzed in relation to three possible socioeconomic determinants: standard of living index (SLI), and respondent's literacy, age and residence (Table 7.3). The relationship between SLI and desire for more children was weak and inconsistent. Literate women were more likely to want the next child at a later time (53 percent) compared to the illiterate women (14 percent). On the other hand illiterate women were more likely not to have more children (73 percent) compared to the literate women (48 percent). Like SLI, desire was not different for urban and rural dwellers.

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

Characteristic	Desire for more children			Total	
	Soon	Later	Never	N	%
Standard of living index					
Low	20.0	15.0	60.0	20	100.0
Medium low	20.6	17.5	61.9	63	100.0
Medium high	21.3	17.6	60.3	136	100.0
High	20.1	21.8	57.6	229	100.0
Age of women					
<25	38.7	53.2	8.1	62	100.0
25 or more	17.8	14.4	67.9	383	100.0
Literacy of respondent					
Literate	23.6	27.6	48.0	250	100.0
Illiterate	16.8	9.6	73.1	197	100.0
Type of community					
Rural	20.3	20.0	58.8	335	100.0
Urban	21.2	18.6	60.2	113	100.0
Total	20.5	19.6	59.2	448	100.0

Son Preference

In Pakistan, there is usually a preference for sons over daughters. The belief that a family is incomplete without sons is stronger than the corresponding belief for daughters. In this questionnaire, respondents were asked how many daughters they would have before stopping if they did not have a son, and correspondingly for sons if they did not have a daughter. Only 8 percent said there was no limit to the number of sons before a daughter, while 14 percent of the women said there would be no limit in the number of daughters before having a son. For those women who gave a number, the number of daughters before having a son was slightly lower than the number of sons before having a daughter; in both cases the median was four children.

Table 7.4: Son and daughter preferences by the respondents

Response	Number of daughters for the desire of a son		Number of sons for the desire of a daughter	
	N	%	N	%
Numeric responses	299	67.3	318	71.9
Other non-numeric responses	4	0.9	6	1.4
Up to God	81	18.2	85	19.2
No limit	60	13.5	33	7.5
Total	444	100.0	442	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 did not matter much to them. We asked women if they became pregnant soon, whether they would be pleased, worried, accept it, or if it did not matter. Results are shown in Table 7.5 and Table 7.6. (This question excludes those 222 of the total 448 women who wanted a next child soon, were currently pregnant, had been sterilized, had gone through menopause or had a hysterectomy.)

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

Reaction if pregnant	Desire for next child			N
	Later	Never	Total	
Pleased	11.1	1.8	4.4	10
Worried	27.0	36.2	33.6	76
Accept it	60.3	58.9	59.3	134
Doesn't matter	1.6	1.8	1.8	4
Others	0.0	1.2	0.9	2
Total	100.0	100.0	100.0	226
N	63	163	226	226

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

Problem faced if pregnant	Desire for next child			N
	Later	Never	Total	
Own health	81.3	87.6	85.8	193
Health of youngest child	71.9	59.6	63.1	142
Caring of children	76.6	65.8	68.9	155
Schooling of children	43.8	64.0	58.2	131
Family economic situation	50.0	67.1	62.2	140
Others	4.7	2.5	3.1	7
N	64	161	225	225

Respondents could give more than one response.

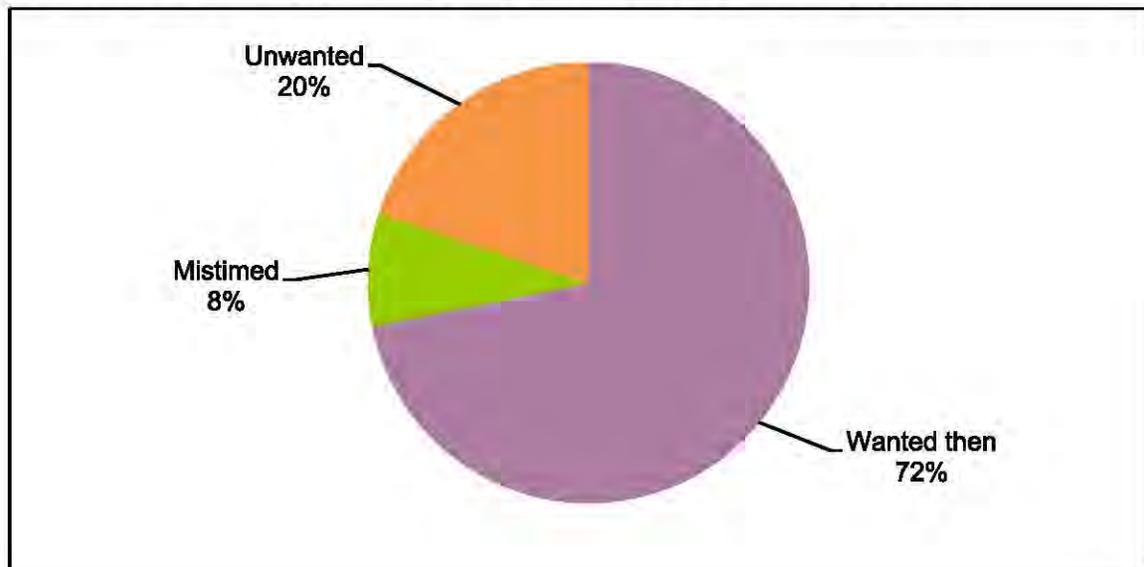
Among those who did not want more children at all, more than one-third (36 percent) said that they would be worried if they became pregnant. About 60 percent reported that they would accept the new pregnancy, while only 2 percent, among those who did not want more children, said they would be pleased. Among those women who wanted to delay their next pregnancy for more than 2 years, more than one-fourth said that they would be worried. Three-fifths of them said they would accept the pregnancy, which shows weak motivation for spacing and limiting. However, the high proportion of those saying they would be worried if they became pregnant supports their earlier statement that they wanted to delay or stop childbearing.

Further, women who expressed a desire to not have more children, or to delay the next child, were asked what problems they would face if they became pregnant soon. Table 7.6 shows their responses. The problem most commonly faced was regarding their own health, while the least commonly faced issue was the schooling of children. Health (their own and that of their youngest child) and caring for children were commonly cited, along with the family's economic situation. This indicates that women's own health is now becoming a priority for them, which is consistent with the objectives of FALAH.

Attitudes toward Last Pregnancy

Another important dimension of fertility preference relates to whether the last pregnancy was wanted at the time, was mistimed (i.e., wanted later), or was not wanted at all. Pregnancies that are unwanted cause hardship in many ways, and represent a failure to realize a couple's right to have the number of children they want, at the time they are wanted. This can be somewhat difficult to determine precisely in surveys. Sometimes parents report that an unwanted pregnancy was actually wanted, but it is less common to report that a child was wanted when in fact it was not. In this survey, women were far more likely to report that their last pregnancy was unwanted (20 percent) or mistimed (8 percent).

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



Women's Perception of Fertility Preferences of Husbands

Women were asked whether they thought their husbands wanted the same number of children as they did, or whether they wanted more/fewer children. In Table 7.7, their responses are tabulated according to their ideal family size. About 16 percent did not know their husband's preference, while another 64 percent thought their husbands wanted the same number as they did. However, about 18 percent thought their husbands wanted more children than they did, while only about three percent thought their husbands wanted fewer children. This shows that almost two-thirds (64 percent) of the women felt that their desire and their husband's desire were the same.

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	65.5	22.4	0.0	12.1	58	100.0
3-4	67.1	18.4	4.3	10.2	304	100.0
5+	60.0	25.0	0.0	15.0	40	100.0
Up to God	44.4	2.8	0.0	52.8	36	100.0
Other non-numeric response	22.2	0.0	0.0	77.8	9	100.0
Total	63.5	17.9	2.9	15.7	447	100.0
N	284	80	13	70	447	100.0

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 of it, if she had ever used it, or if she was using it currently. This approach is standard in such surveys in Pakistan and elsewhere. In addition, respondents were asked to report their most recent source for contraceptive methods.

Knowledge

For many years, at least 95 percent of the married women of reproductive age in Pakistan have known of at least one method of contraception. Table 8.1 shows that this holds true for Jhelum as well; nearly all women interviewed (99.8 percent) knew at least one method. The knowledge of a great majority of the female respondents regarding pills, female sterilization, injections, condoms, and IUDs was excellent. The highest knowledge was of pills. These aforementioned methods along with withdrawal were known to a higher proportion of respondents in Jhelum than in the national PDHS 2006-07. Conversely, more women in the PDHS knew the less common methods, i.e., rhythm (“safe period”) and Norplant (NIPS/PDHS, 2008). Data shows that there was not much difference in knowledge between rural and urban women. The vast knowledge of various program methods among women may also be the result of activities of PAIMAN in the district.

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

Method	Rural	Urban	Total
Female sterilization	97.0	99.1	97.5
Male sterilization	62.4	63.7	62.7
Pill	98.8	96.5	98.2
IUD	93.4	90.3	92.6
Injectables	96.1	93.8	95.5
Norplant	15.5	15.0	15.4
Condom	93.4	95.6	94.0
Rhythm	23.3	31.0	25.2
Withdrawal	71.3	77.9	73.0
Emergency pills	25.7	30.1	26.8
At least one method	99.7	100.0	99.8
At least one modern method	99.7	100.0	99.8
At least one traditional method	74.6	80.5	76.1
N	335	113	448

Use of Contraceptive Methods

Levels of Ever Use and Current Use

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

Of all the married women interviewed in our sample, 59 percent reported having used some method of contraception during their married lives (Table 8.2). This was slightly higher for urban ever users (64 percent) compared to rural ones (57 percent). It was substantially higher than the proportion obtained in the PDHS 2006-07 for Pakistan (48.7 percent) (NIPS/PDHS, 2008).

Table 8.2: Percentage distribution of MWRA by contraceptive use status and residence

Method	Ever user				Current user				Past user			
	Rural	Urban	Total	N	Rural	Urban	Total	N	Rural	Urban	Total	N
Pill	17.6	12.4	16.3	73	2.4	0.9	2.0	9	15.2	11.5	14.3	64
IUD	12.8	13.3	12.9	58	2.4	1.8	2.2	10	10.4	11.5	10.7	48
Injectables	17.6	13.3	16.5	74	3.0	2.7	2.9	13	14.6	10.6	13.6	61
Norplant	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Condom	30.1	35.4	31.5	141	9.9	15.0	11.2	50	20.3	20.4	20.3	91
Rhythm	0.6	0.9	0.7	3	0.3	0.0	0.2	1	0.3	0.9	0.4	2
Withdrawal	19.7	25.7	21.2	95	6.6	8.8	7.1	32	13.1	16.8	14.1	63
Female sterilization	11.6	12.4	11.8	53	11.6	12.4	11.8	53	0.0	0.0	0.0	0.0
Others	1.2	0.9	1.1	5	0.0	0.0	0.0	0.0	1.2	0.9	1.1	5
Any method	57.3	63.7	58.9	264	36.1	41.6	37.5	168	21.2	22.1	21.4	96
Modern method	53.7	51.3	53.1	238	29.3	32.7	30.1	135	18.8	15.9	18.1	81
Traditional method	20.0	26.5	21.7	97	6.9	8.8	7.4	33	7.2	8.8	7.6	34
N	335	113	448	448	335	113	448	448	335	113	448	448
Emergency pills	0.9	2.7	1.3	6	na	na	na	na	0.9	2.7	1.3	6

na= not applicable.

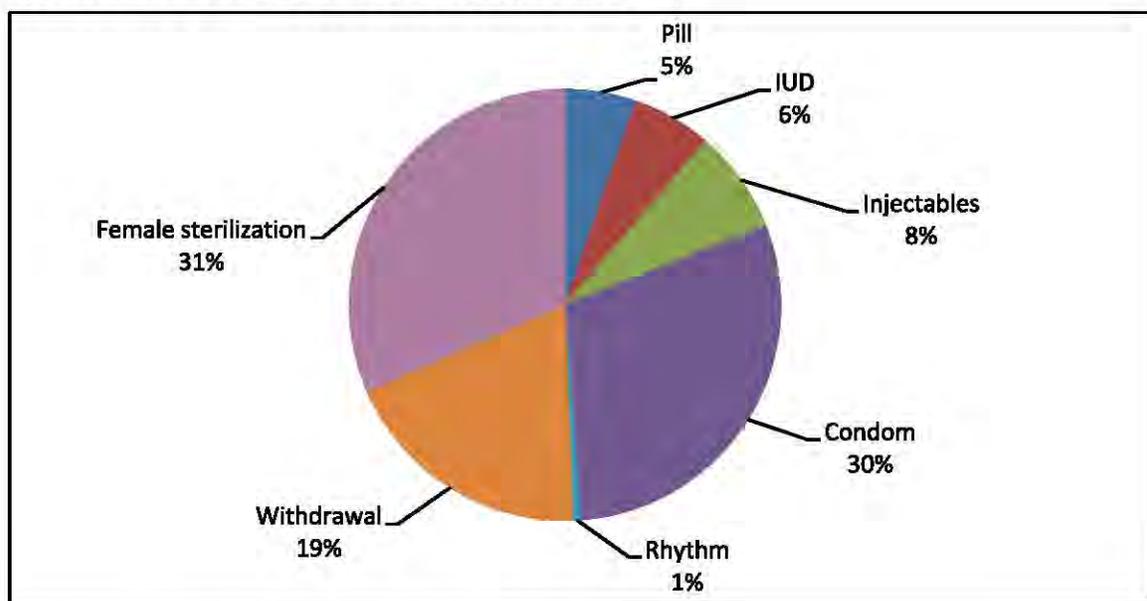
The proportion of currently married women of reproductive age who are currently using some form of contraception, commonly known as the contraceptive prevalence rate (CPR) is one of the central indicators of the status of family planning programs. It shows the degree to which couples are actively involved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

Family planning is extensively practiced in Jhelum (see Table 8.2). A total of 37.5 percent of all married women in the sample were currently using some method of contraception (the contraceptive prevalence rate - CPR), compared with 29.6 percent for Pakistan in the 2006-

07 PDHS, and 33.2 percent for Punjab as a whole (NIPS/PDHS, 2008). In urban Jhelum, the CPR was 42 percent, compared with 36 percent in rural Jhelum.

Figure 8.1 shows that female sterilization was the most popular method of family planning among current users (31 percent). After sterilization, the methods most commonly in use were condoms and withdrawal (30 percent and 19 percent respectively). The use of other methods was slightly low; pills (5 percent) and IUD (6 percent). Overall, 30 percent of the married women were using modern contraceptive methods, and 7 percent were using traditional methods (withdrawal and rhythm).

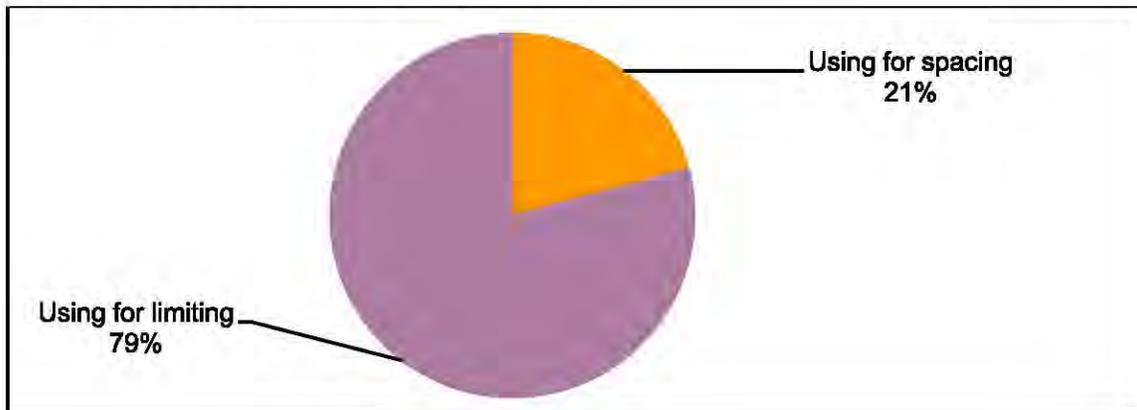
Figure 8.1: Distribution of current users by method mix



Current Use and Desire for Children

For current users of contraception, it is important to determine how many were using contraceptive methods for spacing purposes, and how many wanted to stop having children altogether. Overall, 79 percent of current use was for limiting purposes, compared to 21 percent for spacing (Figure 8.2).

Figure 8.2: Current use and desire for children



Correlates of Contraceptive Use

Figures 8.3 show the relationship between contraceptive prevalence and the woman’s age. The shape of the graph for age reflects the low prevalence among younger women and higher prevalence for women aged 30 years or more. The CPR for the age group 15-19 years was zero. Between ages 35 and 39, prevalence was over half of all the women in the age group.

Figure 8.4 indicates the contraceptive prevalence by number of living children; those having three or more children had a higher contraceptive prevalence rate. A maximum CPR of 50.7 percent was recorded for women having three to four living children.

Figure 8.3: Contraceptive prevalence by woman’s age

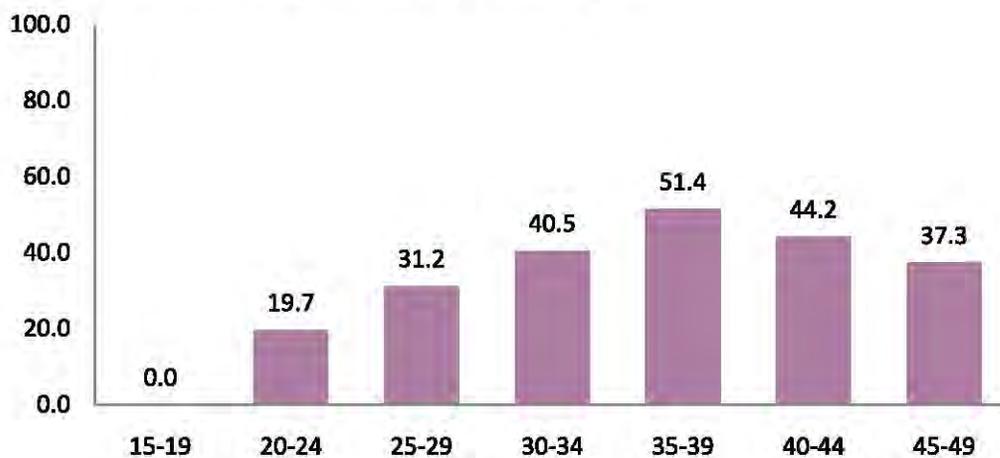
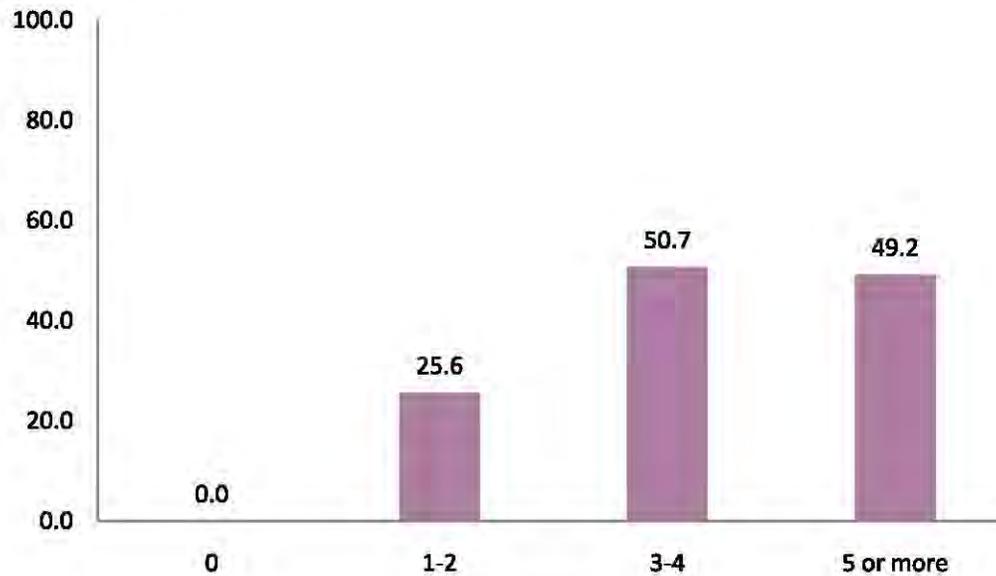


Figure 8.4: Current contraceptive use by number of living children



Contraceptive use is associated with higher socioeconomic status and urban residence. However, in Jhelum, as shown in Table 8.3, the results obtained were different. Respondents belonging to households with the highest SLI had higher contraceptive prevalence (36 percent) than those with the lowest SLI. However, respondents belonging to households with medium low SLI had the highest contraceptive prevalence rate (43 percent) followed by medium high SLI (39 percent); conversely, women from households with low SLI were substantially more likely to be never users.

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	25.0	15.0	60.0	20	100.0
Medium low	42.9	20.6	36.5	63	100.0
Medium high	39.0	18.4	42.6	136	100.0
High	36.2	24.0	39.7	229	100.0
Ownership of television					
Yes	38.8	21.4	39.8	374	100.0
No	31.1	21.6	47.3	74	100.0
Literacy of respondent					
Literate	36.8	23.6	39.6	250	100.0
Illiterate	38.4	18.7	42.9	198	100.0
Type of community					
Rural	36.1	21.2	42.7	335	100.0
Urban	41.6	22.1	36.3	113	100.0
Total	37.5	21.4	41.1	448	100.0

With regard to the literacy of respondents, current use of family planning methods was, surprisingly, marked slightly higher for illiterate respondents (38 percent) compared to literate respondents (37 percent). Owning a television was found to be positively associated with current use. However, there were more never users in rural areas, while more current users resided in urban areas.

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) last obtained their contraceptive method.

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

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

Source	FP method ever used					N
	Pill	IUD	Injectables	Condom	Female sterilization	
Govt. hospital (DHQ/THQ)/ RHS (A)	0.0	33.3	13.0	0.0	49.0	34
BHU/RHC/MCH	4.5	19.0	21.7	0.0	10.2	15
FWC	9.1	14.3	4.3	0.0	2.0	7
LHW	68.2	4.8	17.4	14.5	0.0	32
Other public	4.5	0.0	0.0	0.0	2.0	2
Pvt. hospital/clinic/doctor	0.0	19.0	26.1	0.0	34.6	28
Dispenser/compounder	4.5	0.0	0.0	0.0	0.0	1
Pharmacy/chemists/grocery shop	0.0	0.0	0.0	4.8	0.0	4
TBA/dai	0.0	9.5	4.3	0.0	0.0	3
Husband brings method	9.1	0.0	13.0	80.7	0.0	72
Total	100.0	100.0	100.0	100.0	100.0	198
N	22	21	23	83	49	198

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

Reasons for Method Choice

In this survey, current and past users were asked the reasons they chose a particular method. The list of possible reasons was read out to them and the results are shown in Table 9.1. Among the most common reasons for choosing a method were suitability for respondent and husband, no or few side effects, convenience of use, easy availability, and effectiveness over a long period of time. For female sterilization, IUD and injectable users, suitability of use for a long period was often cited. Cited less frequently were low cost, availability of method, provider advice and lack of available method choice. Clients tend to make decisions according to the known attributes of the various methods, but not always. For example, about 77 percent of ever pill users cited lack of side effects as a reason for choosing the pill, even though it is in fact associated with a number of common side effects.

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

Reason	Contraceptive method						N
	Pill	IUD	Injectables	Condom	Withdrawal	Female sterilization	
Easily available	86.4	63.6	65.4	63.9	3.8	35.8	124
Low cost	77.3	54.5	42.3	39.8	0.0	45.3	97
Convenient to use	72.7	68.2	88.5	84.3	56.6	30.2	170
Suitable for respondent/husband	86.4	77.3	76.9	92.8	92.5	71.7	220
No/fewer side effects	77.3	90.9	69.2	88.0	90.6	75.5	216
Can be used for long period	36.4	100.0	80.8	18.1	18.9	86.8	122
No other method available	0.0	4.5	0.0	0.0	0.0	0.0	1
Method always available	81.8	59.1	46.2	48.2	1.9	22.6	96
Provider advised	27.3	31.8	46.2	19.3	7.5	39.6	66
Others	4.5	4.5	7.7	7.2	9.4	15.1	23
N	22	22	26	83	53	53	259

Respondents could give more than one reason.

To look more specifically at why some users preferred traditional methods to modern ones, 33 current traditional method users were asked why they were not using modern methods. Side effects were by far the main issue: 88 percent cited fear of side effects, and 27 percent reported their own experience of side effects. Husband's disapproval (of modern methods) was cited by 24 percent users, with other reasons (method not available, cost, lack of knowledge) cited by a few or no respondents (Table 9.2).

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

Reasons	Percentage
Fear of side effects	87.9
Husband disapproves	24.2
Experienced side effects	27.3
Costs too much/ don't know about source of method	12.1
N	33

Respondents could give more than one reason.

Cost, Distance and Time to Reach a Facility

Costs to users for contraceptive methods vary widely in Pakistan. Table 9.3 shows the reported costs for contraceptives that were incurred the last time the women obtained the method. Nearly half of the respondents (54 percent) were not charged for their contraceptives; this included a great number of female sterilization users (who are, in fact, typically reimbursed for expenses involved). With regard to condom users, it was reported that the respondent's husband was the one who obtained the method; therefore the wife did not know the cost. About 13 percent of the respondents surveyed paid less than 50 rupees, while only 9 percent were paying more than 50 rupees. IUD and injectable users often paid more than 50 rupees for their method. For IUD users, monthly costs were usually very low.

Table 9.3: Distribution of costs of current specific contraceptive method

Method	Cost (in rupees)					Total	
	No payment	1-20	21-50	51+	Don't know	%	N
Pill	77.8	22.2	0.0	0.0	0.0	100.0	9
IUD	20.0	0.0	20.0	60.0	0.0	100.0	10
Injectables	15.4	0.0	23.1	46.2	15.4	100.0	13
Condom	18.0	16.0	4.0	0.0	62.0	100.0	50
Female sterilization	100.0	0.0	0.0	0.0	0.0	100.0	53
Total	54.1	7.4	5.2	8.9	24.4	100.0	135

Current users were also asked whether their facility charged them for services rendered, other than the method itself. Of the 88 users who were asked this question, 75 percent said they were not charged, 21 percent said that they were charged a reasonable amount, and only 4 percent said they were charged an unreasonable amount.

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

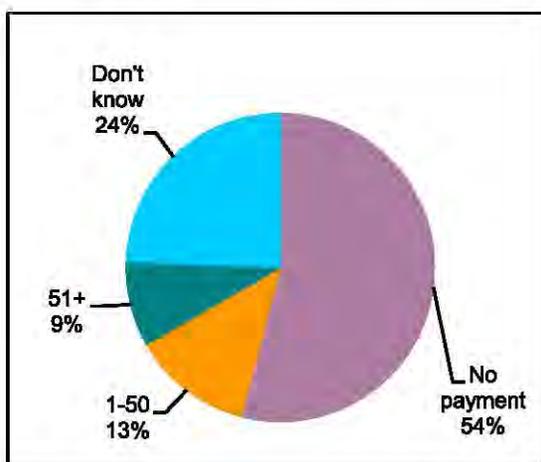
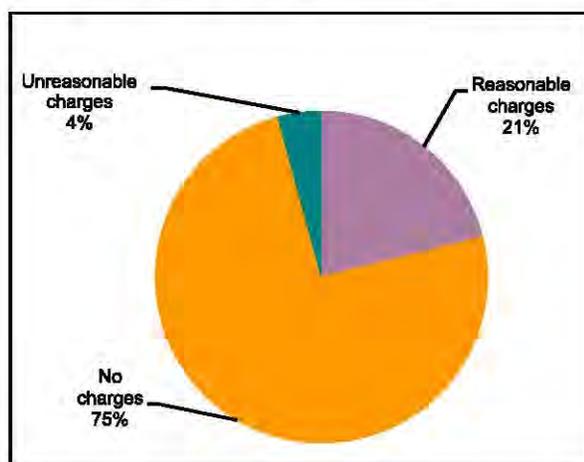


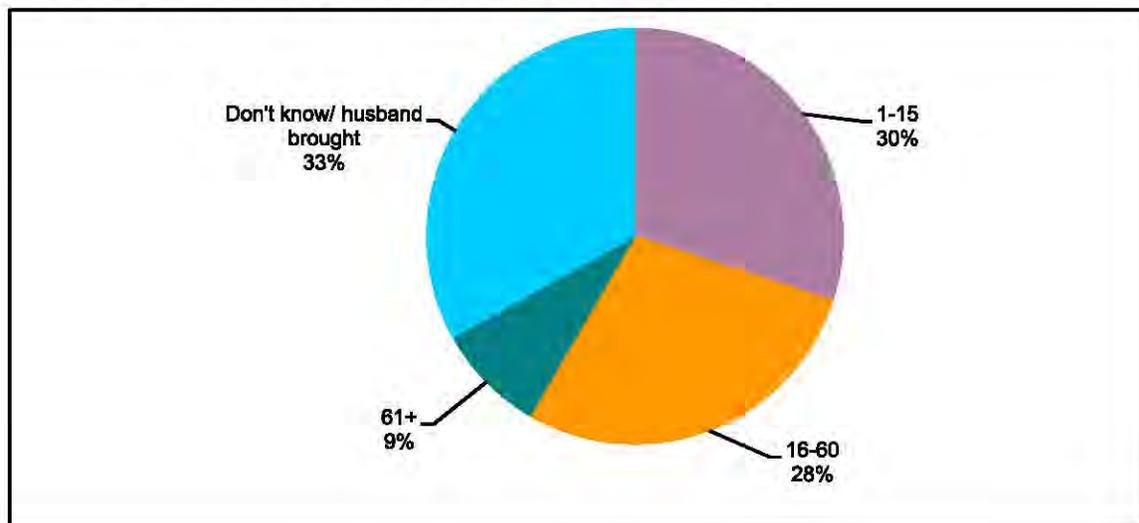
Figure 9.1B: Attitude toward service charges for current method other than contraceptive commodity cost



The time usually needed for current users to obtain a specific method is shown in Table 9.4, while Figure 9.2 shows the overall travel time required to acquire the contraceptive method. About a third of the users surveyed did not need more than 15 minutes to obtain their method; this included LHWs, who often brought injectables, pills, and condoms to the respondents' homes. For another third, the husband of the respondent obtained the supply, so they were unsure of how long it took to do so. For a few, particularly female sterilization and IUD users, it took more than an hour to reach a service facility; but in these cases, there was usually no need for visiting the facility frequently.

Table 9.4: Distribution of current contraceptive users by time to reach specific contraceptive service

Method	Time (in minutes)					Total	
	1-15	16-30	31-60	61-180	Don't know/ husband brought the method	%	N
Pills	100.0	0.0	0.0	0.0	0.0	100.0	9
IUD	50.0	20.0	20.0	10.0	0.0	100.0	10
Injectable	53.8	23.1	0.0	0.0	23.1	100.0	13
Condom	20.4	0.0	2.0	0.0	77.6	100.0	49
Female sterilization	16.3	34.7	24.5	20.4	4.1	100.0	49
Total	30.0	16.9	11.5	8.5	33.1	100.0	130

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

Treatment by Provider

Information Provided

Current and past users were asked, from a list of important topics that were read out to them, what information the service provider might have given to them regarding contraceptive methods (Table 9.5). The accuracy of clients' responses may be questioned due to problems of recall or understanding. However, it appears that the information provided is seriously deficient. The most common topic respondents said they were informed about was effectiveness. Some were told about side effects or what to do about them, or about the possibility of switching. A few were told about other methods available, how to use the method or the contraindications. Condom users were given less information in general than users of clinical methods, perhaps because condoms were often obtained by husbands. There is a need to emphasize to the providers that they provide 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 specific method

Information provided at acceptance	Family planning method					N
	Pill	IUD	Injectables	Condom	Female sterilization	
How the method works	18.2	9.1	11.5	1.2	3.8	12
How to use the method	63.6	22.7	11.5	4.8	0.0	26
Contraindications	4.5	13.6	23.1	3.6	20.8	24
Effectiveness/ duration of effectiveness	77.3	90.9	88.5	8.4	71.7	105
Advantages compared to other method	27.3	31.8	30.8	2.4	22.6	35
Possible side effects	36.4	63.6	38.5	3.6	37.7	55
What to do if experienced side effects	27.3	54.5	15.4	2.4	26.4	38
Possibility of switching	40.9	40.9	23.1	4.8	5.7	31
About other method that you could use	31.8	27.3	23.1	9.6	3.8	29
N	22	22	26	83	53	206

Respondents could give more than one response.

Treatment at Facility

Current users were asked about various aspects of their treatment when they last visited a provider for family planning services. As Table 9.6 shows, responses were mainly positive, but with exceptions. About one-fifth thought that facility staff was not cooperative, while almost all indicated that staff availability was not an issue. A small percent indicated that they were not attended to or examined properly. Nearly two-fifths (39 percent) of the respondents were of the opinion that the staff was not able to manage side effects.

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

Aspect of treatment	Percentage	No. of observations
Staff's attitude cooperative	81.4	70
Provider available	98.7	74
Attend/examine properly	90.5	76
Doesn't demand charges for services	77.5	69
Can deal with side effects	60.9	53

Side Effects

Current users were asked if they had experienced, or were experiencing, any side effects from their current method, while past users were asked if side effects were among their reasons for discontinuing method use. If so, a list of possible side effects was read out to them, and they were asked if they had experienced any of them; multiple responses were allowed. As shown in Figure 9.3, 64 ever users (24 percent of all current and past users) responded positively. Side effects were most commonly reported by injectable and IUD users (73 percent and 50 percent, respectively), and they were least commonly reported by condom users (5 percent). Those who reported side effects, when asked to respond to a list of possibilities, tended to report a variety of side effects, including many not associated with the method, regardless of the method used.

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

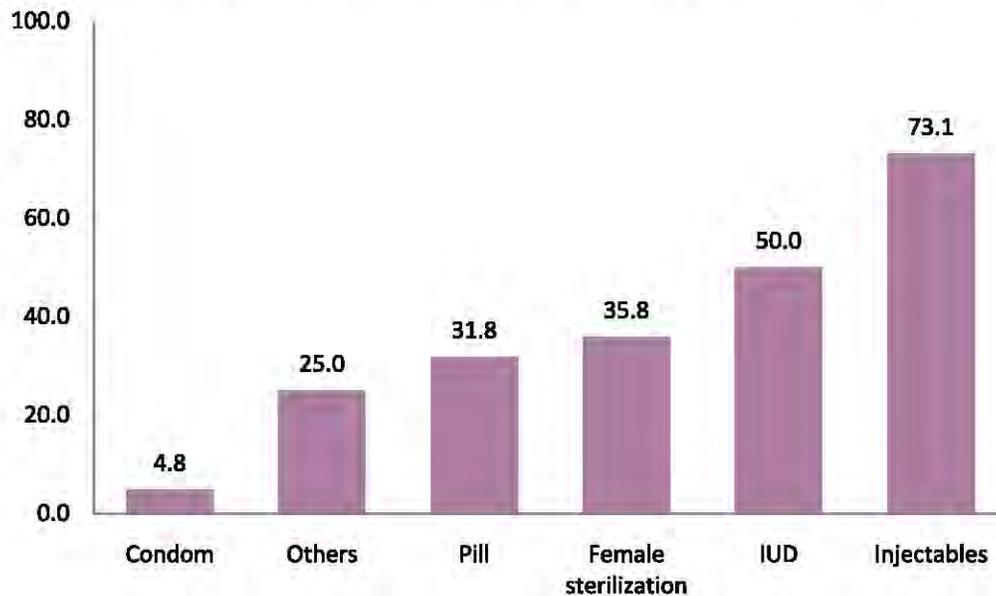
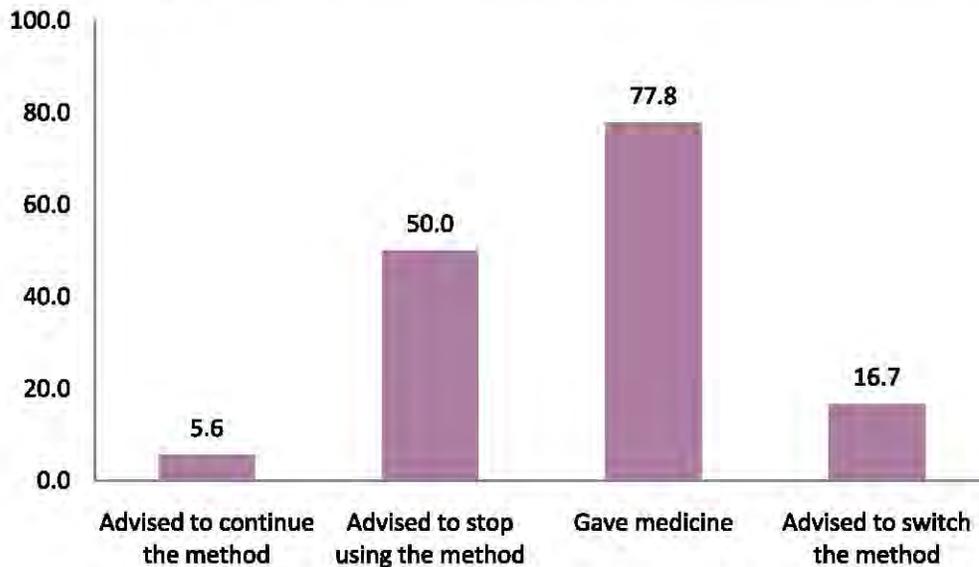


Figure 9.4: Distribution of provider responses upon consultation for side effects among past users



Of the 31 past users who reported experiencing side effects, 18 said they had consulted someone for the management of these side effects; in 12 of these 18 cases, a doctor was reportedly visited. These respondents were asked if the provider responded in a manner included in a list read out to them (Figure 9.4). Only 6 percent were advised to continue using the chosen method, 50 percent were advised to stop, and 17 percent were advised to switch to another method. Out of seventeen, fourteen (78 percent) were given medication (Figure 9.4).

Chapter 10

Reasons for Non-use

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

Hindrances to Use

One way to understand the various types of hindrances to contraceptive use is to ask respondents about the concerns of people in general. This way, people may be more open in discussing their views without feeling a need to conceal concerns specific to their own situation. All respondents were asked, "If a couple wants to avoid or space a birth, which of the following hindrances might they face?" Each item on the list was read out to the respondent. Table 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

Hindrance	Use of family planning					
	Current user		Past user		Never user	
	N	%	N	%	N	%
Husband's disapproval	163	97.0	92	95.8	175	95.1
Other people may find out about contraceptive use	84	50.0	45	46.9	88	47.8
Distance and travel costs to FP outlet	114	67.9	58	60.4	139	75.5
Probability of getting pregnant while using contraceptives	138	82.1	76	79.2	144	78.7
Fear of side effects	163	97.0	87	90.6	168	91.3
Problem of managing side effects	161	95.8	86	89.6	168	91.3
FP is against religion	142	84.5	79	82.3	163	88.6
N	168	na	96	na	184	na

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

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

Past Users

Reasons for Discontinuing Contraceptive Use

Past users were asked about their reasons for choosing to discontinue their last contraceptive method. Several reasons were given; the most commonly cited ones were side effects, desire for another child, infrequent sex, husband's advice and rest from the method/provider's advice (Table 10.2). Method failure results from using methods that have high failure rates. Clinical methods do have associated side effects; but as we have seen, providers rarely try to counsel users through the temporary experience of common, non-dangerous side effects.

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

Reason	Percentage
Want another child	30.5
Fear of side effects	9.5
Side effects experienced	32.3
Method failure	10.4
Lack of access/unavailability	1.1
Method inconvenient to use	3.1
Rest from method/provider's advice	15.6
Missed the dose	3.2
Infrequent sex/husband away	21.9
Husband's advice	14.6
In- laws oppose	2.1
Menopause	7.3
N	96

Respondents could give more than one reason.

Reasons for Current Non-use

It is important to know the reasons for non-use of those couples who have used contraceptives in the past, but are not current users. Past users were read a list of possible reasons for their decision to discontinue method use, with more than one reason being cited. The results are shown by status of desire for more children (Table 10.3). The most common reasons were related to childbearing, e.g., infrequent sex, currently pregnant, breastfeeding/ amenorrheic or wanting another child. However, a significant percentage cited fear of side effects for current non-use. Infrequent sex/husband away was rated higher than all other reasons for non-use. As shown in Table 3.5, eight percent of the husbands of female respondents were abroad.

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

Reason	Percentage
Fear of side effects	18.8
Want another child	14.6
Currently pregnant	25.0
Rest from method/provider's advice	15.6
Infrequent sex/husband away	35.4
Breastfeeding/lactational amenorrhea	17.7
Menopause	11.5
Just not using/too lazy	4.2
Others	9.4
N	96

Respondents could give more than one reason.

Never Users

Reasons for Non-use

The 184 women in the sample who reported never use were asked about various reasons for not using contraceptives, with each reason read out separately. Table 10.4 shows that the most important reason was desire for more children. This issue was most common for childless couples, and declined rapidly with increasing number of children. As the respondent's family size grew, other reasons came into play. For couples with five or more children, the strongest reason was fear of side effects. An important factor for respondents was their husband's opposition. The most mentioned reason for never use was the desire for children (51 percent), followed by fear of side effects (25 percent), opposition of husband and in-laws (25 percent), infrequent sex/husband away (23 percent) and difficulty/inability to conceive (21 percent).

A negligible number of women (0.5 percent) reported lack of access/unavailability of supply. Cost and religious objections carried less weight, each of which is often cited in literature as a barrier to family planning use. Religious opposition was reported only by 4 percent of the women.

Table 10.4: Distribution of never users by reason for never use

Reason	Percentage
Husband opposes	14.7
In-laws oppose	9.8
Fear of side effects	25.1
Lack of access/unavailability	0.5
Cost not affordable	2.2
Shy to consult about family planning	9.8
Method inconvenient to use	0.5
Infrequent sex/husband away	23.4
Difficult/unable to conceive	21.2
Breastfeeding/lactational amenorrhea	10.3
Respondent/husband infertile	0.5
Wanted (more) children	50.5
Against religion	4.3
Natural spacing	1.1
Others	13.0
N	184

Respondents could give more than one reason.

Attitude toward Birth Spacing and Limiting

It is important to see the extent to which never users disapproved of family planning in principle, as opposed to accepting in principle, but were not using contraceptives for some other reasons. Table 10.5 shows this for never using respondents. About 13 percent of the women disapproved of spacing, while for limiting it was 15 percent. Slightly more women approved of spacing than of limiting family size.

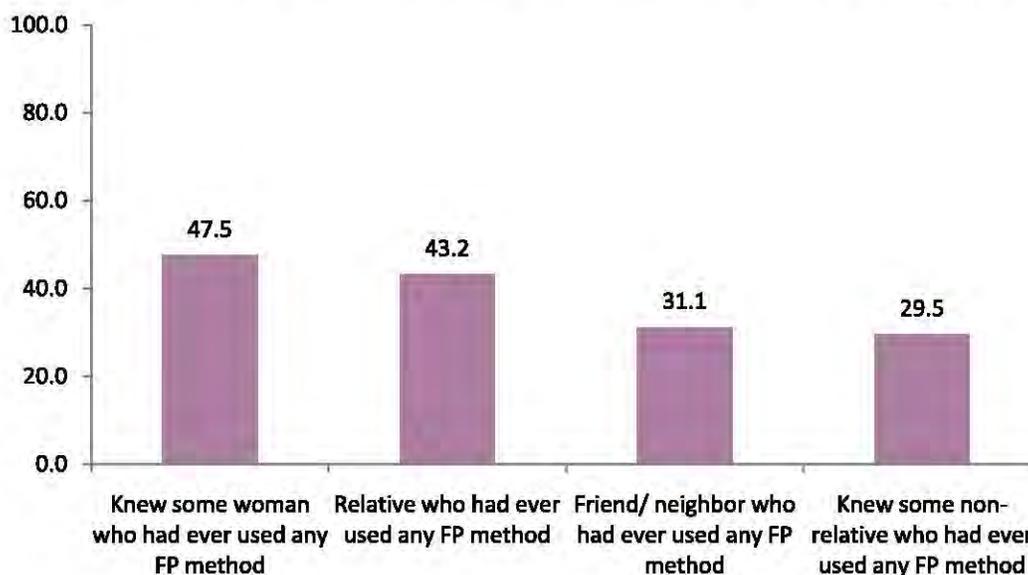
Table 10.5: Distribution of never users by attitude toward spacing and limiting birth

Attitude	Attitude toward spacing		Attitude toward limiting	
	N	%	N	%
Approve	159	86.9	153	83.6
Disapprove	24	13.1	27	14.8
Don't know	0	0.0	1	0.5
Others	0	0.0	2	1.1
Total	183	100.0	183	100.0

Knowledge of Contraceptive Users, Methods and Facilities

Of the 184 female never users in the sample, 48 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy. Forty-three percent of the respondents had a relative who had used some method, and 31 percent knew a friend or neighbor who had been a user. More than half of never-using women did not know anyone who had ever used a 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



Almost all never-using women knew at least one method. Most never-users knew a variety of methods as shown in Table 10.6.

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

Method	Percentage
Female sterilization	95.1
Male sterilization	52.7
Pill	96.2
IUD	88.0
Injectables	92.4
Norplant	8.7
Condom	88.0
Rhythm	25.5
Withdrawal	54.9
Emergency pills	16.8
Others	2.2
Know at least one FP method	99.5
N	184

Respondents could give more than one response.

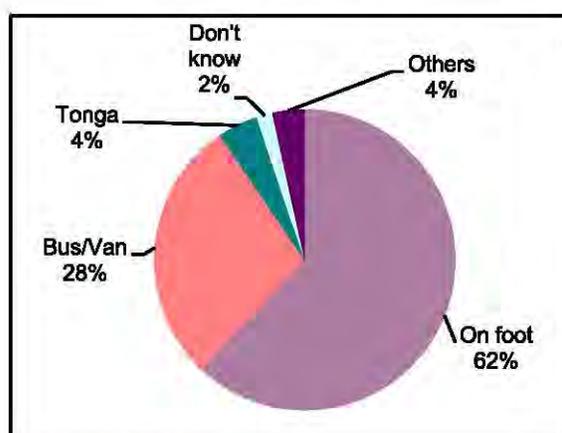
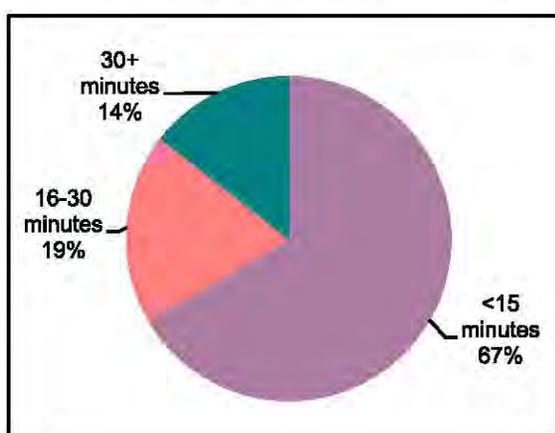
Of the 184 never users, 33 percent did not know of a place to obtain a method. For those who did know, the places they were aware of are shown in Table 10.7. The sources best known were health outlets – the District/Tehsil Headquarters hospitals, BHUs/RHCs/MCH centers, and private hospital/clinic/doctor. With regard to awareness, Lady Health Workers were rated as the most popular sources of supply (60 percent), which reinforces the popularity of the National Program for Family Planning and Primary Health Care/LHW Program. Substantial numbers knew of the Family Welfare Centers of the Ministry of Population Welfare and pharmacy/chemists as a source of supply. A few were aware of other sources, including Greenstar clinics.

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

Source	Percentage
Knowledge of at least one service provider	67.2
DHQ/THQ hospital	59.0
BHU/RHC/MCH center	42.6
Family Welfare Center	32.2
Mobile service unit camp	8.7
Lady Health Worker	59.6
Greenstar clinic	21.9
Private hospital/ clinic/ doctor	56.3
Dispenser/ compounder	19.1
Pharmacy/chemists/grocery shop	49.6
Homeopath/ hakim	9.8
TBA/ dai	14.8
Others	2.2
N	183

Respondents could give more than one response.

As shown in Figure 10.2, most users would go to the nearest facility on foot, and sometimes by bus or van. Of the 123 respondents who indicated the time needed to go to the nearest facility, 67 percent indicated that it took them 15 minutes or less, 19 percent quoted 16 to 30 minutes, and 14 percent reported taking 30 minutes or more to reach the nearest facility (Figure 10.3). We can infer that time required to obtain the contraceptive did not have a significant impact on never users.

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 if they intended to use contraceptives in the future. Table 10.8 shows that one-third (34 percent) showed willingness to adopt a method, while one-fourth refused to do so. Almost an equal number of women (26 percent) were unsure. Thirteen percent stated that they were unable to conceive. This indicates that much work needs to be done to bring the non-acceptors of FP into the flow of acceptance.

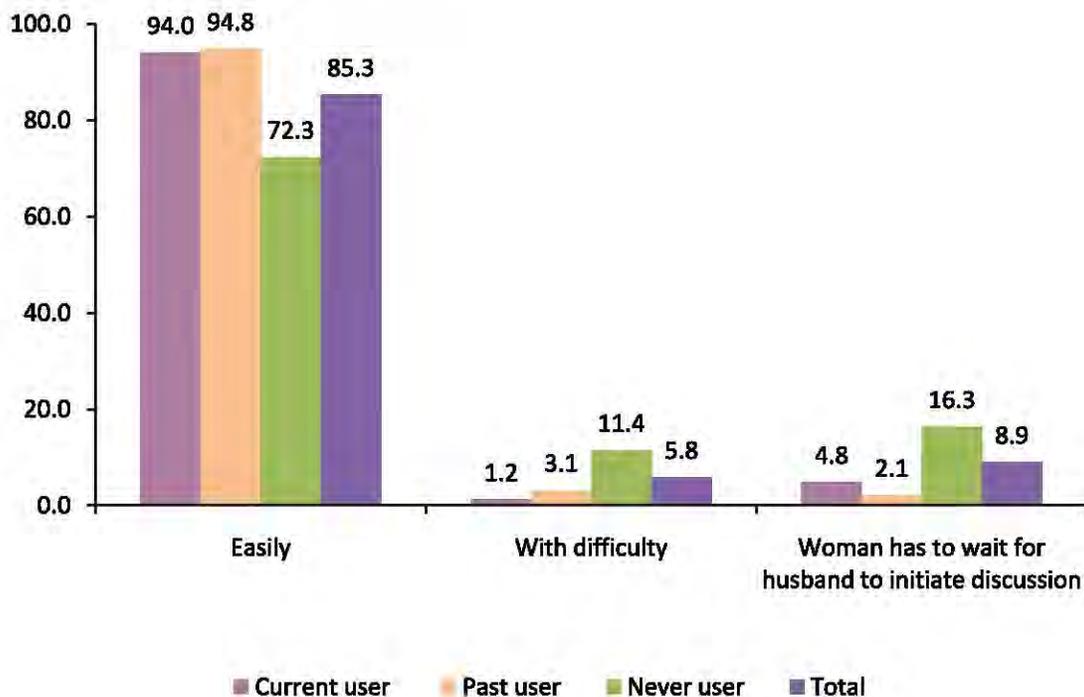
Table 10.8: Distribution of never users by intent to use a method in future and number of living children

Number of living children	Intent to use any FP method in future				Total	
	Yes	No	Unsure/uncertain	Can't get pregnant	%	N
0	55.8	1.9	38.5	3.8	100.0	52
1-2	32.3	30.6	25.8	11.3	100.0	62
3-4	26.3	34.2	26.3	13.2	100.0	38
5 or more	12.9	48.4	6.5	32.3	100.0	31
Total	34.4	26.2	26.2	13.1	100.0	183

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. Eighty-five percent of those responding said they could do so easily (Figure 10.4). However, this varied by use status. Ninety-four percent of current users, and 95 percent of past users, said they could approach their husbands easily, and very few said they had to wait for their husband to initiate the discussion. But for never users, 72 percent reported being able to approach their husbands easily, with about 11 percent reporting that they could only do so with difficulty, and 16 percent had to wait for their husbands to initiate the conversation.

Figure 10.4: Women’s reports regarding ease of approach to husband to discuss family planning



Chapter 11

Unmet Need

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

Levels and Correlates

Table 11.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Jhelum. Of the 448 women, 137 (31 percent) were considered to be in the unmet need category. This proportion is close to what is typically found using the same definition in Pakistan, where unmet need tends to be around one-third of MWRA. The lower proportion may be a reflection of the relatively high contraceptive prevalence; higher levels of use may mean that more of the total demand for family planning was being met. This is supported by the relatively low levels of unmet need for women with 6 or more children, where contraceptive prevalence was particularly high.

Table 11.1: Need and demand for FP among MWRA by background characteristics

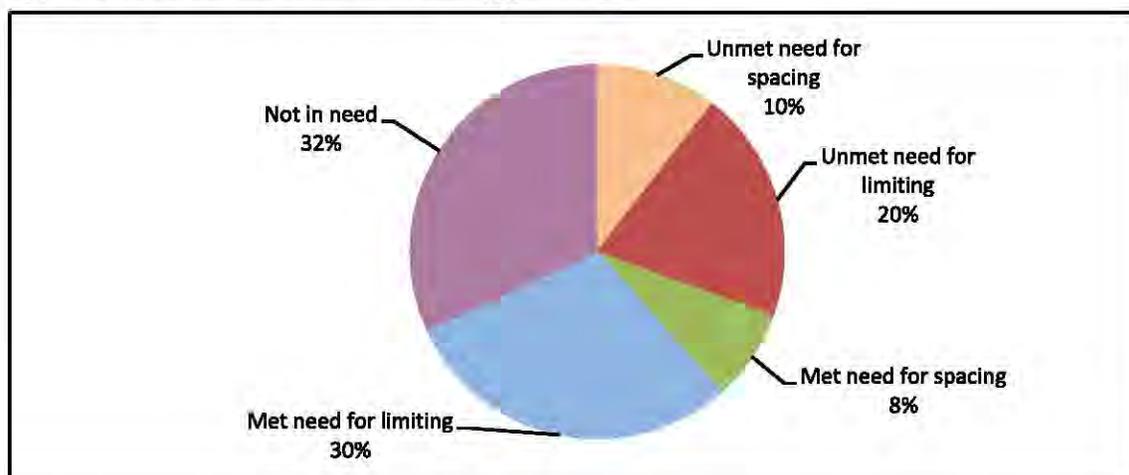
Characteristic	Unmet need			Met need			Total demand	Not in need	Total	N
	For spacing	For limiting	Total	For spacing	For limiting	Total				
Age of respondent										
15 - 24	24.2	1.6	25.8	16.1	3.2	19.4	45.2	54.8	100.0	62
25 - 34	17.4	15.1	32.6	13.4	22.1	35.5	68.0	32.0	100.0	172
35 - 49	0.9	29.4	30.4	0.9	43.5	44.4	74.8	25.2	100.0	214
Type of community										
Rural	11.6	20.3	31.9	8.1	28.1	36.1	68.1	31.9	100.0	335
Urban	7.1	19.5	26.5	7.1	34.5	41.6	68.1	31.9	100.0	113
Literacy of respondent										
Literate	14.4	15.6	30.0	11.2	25.6	36.8	66.8	33.2	100.0	250
Illiterate	5.6	25.8	31.3	3.5	34.8	38.4	69.7	30.3	100.0	198
Education of respondent										
No education	4.6	27.4	32.0	3.4	34.9	38.3	70.3	29.7	100.0	175
Up to primary	13.6	18.4	32.0	8.0	31.2	39.2	71.2	28.8	100.0	125
Up to secondary	13.8	11.9	25.7	12.8	26.6	39.4	65.1	34.9	100.0	109
Above secondary	17.9	15.4	33.3	12.8	10.3	23.1	56.4	43.6	100.0	39
Children ever born										
0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0	50
1-2	25.4	10.5	36.0	21.1	6.1	27.2	63.2	36.8	100.0	114
3-4	11.7	25.0	36.7	7.0	39.8	46.9	83.6	16.4	100.0	128
5+	1.9	29.5	31.4	1.3	48.1	49.4	80.8	19.2	100.0	156
Ownership of TV										
Yes	10.4	19.5	29.9	8.8	29.9	38.8	68.7	31.3	100.0	374
No	10.8	23.0	33.8	2.7	28.4	31.1	64.9	35.1	100.0	74
Standard of living Index										
Low	15.0	30.0	45.0	0.0	25.0	25.0	70.0	30.0	100.0	20
Medium low	7.9	19.0	27.0	9.5	33.3	42.9	69.8	30.2	100.0	63
Medium high	9.6	21.3	30.9	7.4	31.6	39.0	69.9	30.1	100.0	136
High	11.4	18.8	30.1	8.3	27.9	36.2	66.4	33.6	100.0	229
Total	10.5	20.1	30.6	7.8	29.7	37.5	68.1	31.9	100.0	448

Of the 31 percent women who had unmet need, 11 percent was for spacing, while 20 percent was for limiting. Unmet need for spacing was concentrated among women with 1-2 living children; 43 of the 47 cases were in this category. As could be expected, unmet need

for limiting was highest among women with three or more living children, because at that stage couples begin to not want to have more children.

The correlations between unmet need and various socioeconomic indicators varied by whether the unmet need was for spacing or for limiting (Table 11.1). Unmet need for limiting was strongly associated with low SLI, illiteracy and rural residence. Unmet need for spacing, on the other hand, was strongest for literate women, while associations with high SLI and television ownership were weak. It is possible that educated women were more aware of the need to space their births, but were inhibited from doing so for various reasons. Once they reached their desired family size, educated women may be more able to use family planning than their uneducated counterparts. However, conclusions can be tentative, given the small sample sizes involved. Figure 11.1 shows the need and demand for family planning of the sampled women.

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 shows total demand by number of living children. Overall, total demand was 68 percent for all married women of reproductive age. As the table shows, total demand rose rapidly with the number of living children going up to 4. Even at one or two children, demand was quite substantial (63 percent), and it increased up to 84 percent

for those with three or four living children. It is encouraging that the ratio of met need – i.e., current use – to unmet need was highest for couples with 5+ children.

Strength of Preference

It is of interest to look at the responses of women in the unmet need category (those not currently pregnant) according to what their reaction would be if they became pregnant in the near future (Table 11.2). Less than one-third of the women with unmet need for spacing said they would be worried if they became pregnant again; 14 percent would be pleased and the rest would accept it. Of those with unmet need for limiting, more than one-third said they would be worried if they became pregnant. A small number would be pleased. However, a majority said they would accept it. It is important to note that the women who have decided to limit their family have started to understand the consequences of an unwanted pregnancy. For that reason, they would be less pleased about an unwanted pregnancy. For those who would accept an unwanted pregnancy, they appeared to believe that such things occur according to the will of God.

Table 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	5	13.9	3	3.8
Worried	10	27.8	28	35.0
Accept it	20	55.6	44	55.0
Doesn't matter	1	2.8	3	3.8
Others	0	0.0	2	2.5
Total	36	100.0	80	100.0

Reasons for Non-use

Past and never users were asked why they were not using some method of contraception; for those later classified as having unmet need, the results are shown in Table 11.3. Some of these reasons represent barriers as perceived by the women; the most important of these were fear of side effects and the opposition of husbands and in-laws. On the other hand, many women with defined unmet need gave reasons that did not reflect perceived need, at

least at present. Such reasons included infrequent sex/husband away, natural spacing, difficulty in conceiving, wanted more children, currently pregnant, and currently breastfeeding. Some of these women may have more need than they realize; for example, women using “natural spacing” or breastfeeding may in fact be at substantial risk of pregnancy. Women currently pregnant or amenorrheic may be in need of contraception in the near future.

Table 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 unmet need
Fear of side effects	19.1	35.6	29.9
Husband opposes	10.6	7.8	8.8
In-laws oppose	6.4	6.7	6.6
Rest from method/provider's advice	10.6	7.8	8.8
Shy to consult about FP	2.1	12.2	8.8
Against religion	2.1	2.2	2.2
Cost not affordable	2.1	1.1	1.5
Just not using/too lazy	0.0	3.3	2.2
Method inconvenient to use	0.0	1.1	0.7
Infrequent sex/husband away	29.8	46.7	40.9
Natural spacing	0.0	2.2	1.5
Difficult/unable to conceive	6.4	12.2	10.2
Want (more) children	36.2	1.1	13.1
Currently pregnant	19.1	7.8	11.7
Breastfeeding/ lactational amenorrhea	0.0	1.1	0.7
Others	6.4	13.3	10.9
N	47	90	137

Respondents could give more than one reason.

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprised 47 (11 percent) of MWRA. As shown in Table 11.4, they were characterized by:

- **Living Children:** Most (62 percent) had 1 or 2 living children.
- **Family Planning Use:** More past users (53 percent) than never users (47 percent).
- **Strength of Preference:** Low (only 28 percent “worried” if they became pregnant earlier than they wanted compared to those who were pleased (14 percent) or accept (56 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** High (about 66 percent intended to use a FP method in future).
- **Approval of FP:** High (94 percent approved of using a FP method for spacing purposes).
- **FP Communication with Husband:** Limited (only 25 percent had communicated with husbands on FP in the past one year; while 11 percent said approaching the husband was “not easy”).
- **Obstacles to FP Use:** Fear of side effects (19 percent); husband and in-laws opposition (11 percent and 6 percent respectively) (Table11.3).

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

Characteristic	Unmet for spacing		Unmet for limiting	
	N	%	N	%
Number of living children				
0	1	2.1	0	0.0
1-2	29	61.7	15	16.7
3-4	15	31.9	35	38.9
5 or more	2	4.3	40	44.4
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	25	53.2	37	41.1
Never user	22	46.8	53	58.9
Reaction if become pregnant in near future				
Pleased	5	13.9	3	3.8
Worried	10	27.8	28	35.0
Accept it	20	55.6	44	55.0
Doesn't matter	1	2.8	3	3.8
Others	0	0.0	2	2.5
Intention to use a method in future				
Yes	31	66.0	35	40.2
No	9	19.1	32	36.8
Unsure/uncertain	7	14.9	14	16.1
Can't get pregnant	0	0.0	6	6.9
Approval of FP				
Approve	44	93.6	76	84.4
Disapprove	3	6.4	13	14.4
Don't know	0	0.0	1	1.1
FP communication with husband in past one year				
Never	35	74.5	68	75.6
Once or twice	8	17.0	18	20.0
More often	4	8.5	4	4.4
Approach the topic of FP with husband				
Easily	42	89.4	73	81.1
Not easily	5	10.6	17	18.9
Total	47	100.0	90	100.0

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 90 (20 percent) of MWRA. As shown in Table 11.4, they were characterized by:

- **Living Children:** A strongly positive association with number of living children; 44 percent had 5+ living children.
- **Family Planning Use:** More never users (59 percent) than past users (41 percent).
- **Strength of Preference:** Low (Only 35 percent would be “worried” if they became pregnant compared to those who were pleased (4 percent) or accept (55 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** Moderate (about 40 percent intended to use a FP method in future).
- **Approval of FP:** High (84 percent approved of FP for limiting purposes).
- **FP Communication with Husband:** Limited (only 24 percent had communication with husband on FP in the past year; while 19 percent said approaching the husband was “not easy”).
- **Obstacles to FP Use:** Fear of side effects (36 percent); husbands and in-laws opposition (8 percent and 7 percent respectively) (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 contraceptives (NIPS/PDHS, 2008; Population Council, 1995). The objectives of interviewing husbands/men in the FALAH baseline survey were to explore their perspectives on birth spacing/family planning and to use the information obtained to design the communication strategy for the FALAH project. Overall, the planned sample size was 200 husbands in each district to have a total of 4000 interviews with husbands/men in 20 FALAH districts. The intention was to interview as many husbands as possible who were available when the household interviews were undertaken. Knowing that some number of husbands might be at their places of work during the timing of the interviews, the plan was to then make up for any of the husbands who were unavailable, by interviewing other married men available in the selected communities to meet the objective of interviewing 200 husbands/men altogether. In Jhelum, the field team was able to interview 133 men who were husbands of the married women of reproductive age interviewed for the survey plus 67 married men living in the 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 = 200) will always be grouped together, whether the reference is to "men," "male respondents," "married men," or "husbands."

Husband's approval of family planning is a powerful factor in explaining contraceptive use (Tawiah, 1997). In families, fertility decisions occur within specific social contexts and according to prevailing social norms that restrict individual decisions on fertility and behaviors related to spacing of births, stopping childbearing, and using contraceptives.

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

The survey investigates social and demographic differentials, knowledge, ever use and current use of family planning methods. It also explores how approval and discussion of birth spacing/family planning influence the use of contraceptive methods. Traditionally, the measurement of contraceptive use has been based on women's self-reports of current use. The rationale for interviewing 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 less than 6 percent of the men were under 25 years of age and 22 percent were 50 years of age and above.

As shown in Table 12.1, men were substantially better educated than the sampled currently married women of reproductive age. Only 13 percent of the men had not been to school, compared to 39 percent of the currently married women (Table 3.2). It also shows that 69 percent of the men had more than primary education, whereas 33 percent of the currently married women had attained that level of education (Table 3.2). Contrary to expectations, a higher proportion of rural men had received some schooling compared to their urban counterparts. More than 89 percent of the rural men had received some schooling compared to 84 percent of the urban men.

The occupations of men are also presented in Table 12.1. The highest proportion of men (29 percent) was working as daily wage laborers, 25 percent were running their own businesses, and 20 percent were working in agriculture-related activities.

Table 12.1: Background characteristics of men by residence

Characteristic	Rural	Urban	Total
Age			
20-24	6.9	1.8	5.5
25-29	14.5	10.9	13.5
30-34	11.7	10.9	11.5
35-39	18.6	21.8	19.5
40-44	13.1	16.4	14.0
45-49	13.1	18.2	14.5
50-54	11.0	14.5	12.0
55+	11.0	5.5	9.5
Education			
Proportion literate	80.7	78.2	80.0
No education	11.0	16.4	12.5
Up to primary	20.0	14.5	18.5
Up to secondary	58.6	56.3	58.0
Above secondary	10.3	12.7	11.0
Economic activity/occupation			
Agriculture/livestock/poultry	24.8	7.3	20.0
Labor	26.2	34.5	28.5
Govt. service	11.7	7.3	10.5
Private service	9.0	12.7	10.0
Own business	20.7	36.4	25.0
Working abroad	3.4	0.0	2.5
Unemployed	4.8	0.0	3.5
Others	0.0	1.8	0.5
N	145	55	200

Contraceptive Knowledge and Use

Almost all men in Jhelum knew of at least one method of contraception. As presented in Table 12.2, knowledge of modern methods was highest for female sterilization (97 percent), followed by condoms (96 percent), pills (96 percent), and injections (91 percent). The least known methods were Norplant (16 percent), male sterilization (62 percent), and IUD (77 percent). Knowledge of traditional methods was prevalent among only 69 percent of the men. Nearly all women interviewed (99.8 percent) in Jhelum knew at least one method.

The pattern of ever use and current use of contraceptives reported by husbands is also shown in Table 12.2. Of all the MWRA respondents interviewed in our sample, just under 60 percent reported having used some method of contraception during their married lives

(Table 8.2). For the men, condom was the most popular method ever used (33 percent), followed by female sterilization (16 percent), injectables (11 percent) and pills (10 percent). The current use of female sterilization, injectables and IUD was more prevalent in rural areas, and the use of condoms and traditional methods was higher in urban areas. Although, more than 7 percent of men living in rural areas reported ever use of pills, surprisingly, none of them reported current use of pills by their wives.

As mentioned in Chapter 8, family planning was extensively practiced in Jhelum. A total of 37.5 percent of all married women in the sample were currently using some method of contraception. The current use reported by male respondents (45 percent) was, in fact, slightly higher than the current use reported by female respondents (37.5 percent) in Jhelum. The most common current method reported by male respondents was female sterilization (16 percent), followed closely by condoms (13 percent). The use of traditional methods was also substantial; less than one-fourth of current users were relying on such methods. Since traditional methods are far less reliable than modern methods, an important goal of the FALAH project may be to shift users of traditional methods to more effective modern methods. Although 23 percent of the respondents knew about the emergency contraceptive pill, only one-half a percent of the men reported ever using it.

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

Method	Knowledge			Ever use			Current use		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Female sterilization	95.2	100.0	96.5	17.2	12.7	16.0	17.2	12.7	16.0
Male sterilization	57.9	72.7	62.0	0.0	0.0	0.0	0.0	0.0	0.0
Pill	95.2	96.4	95.5	11.0	7.3	10.0	0.0	1.8	0.5
IUD	71.0	94.4	77.4	9.7	5.5	8.5	2.8	1.8	2.5
Injectables	88.3	96.4	90.5	11.0	9.1	10.5	4.1	1.8	3.5
Norplant	11.0	29.1	16.0	0.7	0.0	0.5	0.0	0.0	0.0
Condom	95.2	98.2	96.0	32.4	34.5	33.0	12.4	14.5	13.0
Rhythm	43.4	47.3	44.5	11.0	7.3	10.0	4.1	5.5	4.5
Withdrawal	49.7	63.6	53.5	13.1	10.9	12.5	4.8	5.5	5.0
Others	2.8	0.0	2.0	2.1	0.0	1.5	1.4	0.0	1.0
At least one FP method	100.0	100.0	100.0	60.0	58.2	59.5	45.5	43.6	45.0
At least one modern FP method	100.0	100.0	100.0	53.1	52.7	53.0	36.6	32.7	35.5
At least one traditional FP method	66.2	74.5	68.5	21.4	18.2	20.5	9.7	10.9	10.0
Emergency pills	15.2	43.6	23.0	0.7	0.0	0.5	na	na	na
N	145	55	200	145	55	200	145	55	200

na= not applicable.

Table 12.3 shows ever use and current use of modern contraceptives among respondents by background characteristics. A slightly higher proportion of rural men were currently using a family planning method compared to urban men. There was a positive relationship between education level and contraceptive use. More than 65 percent of the respondents who had secondary and above education reported ever use of any contraceptive method, compared to 58 percent and 44 percent who had below secondary and no education, respectively. The current use of family planning also showed the same pattern by education of men.

Table 12.3: Distribution of male respondents who have ever used or were currently using a contraceptive method, by selected background characteristics

Characteristic	Ever used at least one FP method	Currently using any FP method	N
Type of community			
Rural	60.0	45.5	145
Urban	58.2	43.6	55
Education level			
No education	44.0	36.0	25
Below secondary	58.1	44.2	86
Secondary and above	65.2	48.3	89
Number of living children			
None	8.3	0.0	24
1-2	60.0	34.5	55
3-4	66.1	52.5	59
5+	72.6	64.5	62
Future desire for children			
Soon	24.1	6.9	29
Later	52.8	33.3	36
Never	71.4	58.8	119
Don't know/unsure	50.0	37.5	16
Total	59.5	45.0	200

Table 12.3 also shows a positive relationship between the number of living children and ever use as well as reported current use. Of those who had 5 or more children, almost 65 percent reported currently using family planning methods compared to 53 percent who had 3-4 children and 35 percent who had 1-2 children. The same pattern was observed in ever use of contraceptives by number of living children, but the differentials were less pronounced.

Table 12.3 also shows contraceptive ever use and current use by the future desire for children. Highest ever use (71 percent) was found among the male respondents who said they did not want any more children. Almost 53 percent of those respondents who wanted to delay the next pregnancy had ever used any contraceptive method, and more than 33 percent were currently using a form of contraception.

Source of Contraceptive Methods

As shown in Table 12.4, among those who reported the last source for obtaining their contraceptive method, 48 percent in urban and 31 percent in rural areas reported that they obtained it from the “pharmacy, chemist, grocery or general store.” Other more common sources for contraceptives in rural areas were government/private hospitals, BHU/RHC/MCH as well as LHWs. Seven percent of the rural respondents said that their wives brought the method.

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

Source	Rural	Urban	Total
Govt. hospital (DHQ/THQ)	13.9	12.0	13.4
BHU/RHC/MCH	11.1	0.0	8.2
FWC	5.6	8.0	6.2
LHW	6.9	4.0	6.2
Other public	2.8	4.0	3.1
Pvt. doctor	1.4	4.0	2.1
Pvt. hospital/clinic	13.9	16.0	14.4
NGO hospital	1.4	0.0	1.0
Pharmacy, chemist, grocery/general store	30.5	48.0	35.1
Homeopath/hakim	1.4	0.0	1.0
TBA/DAI	1.4	0.0	1.0
Wife brought the method	6.9	4.0	6.2
Others	2.8	0.0	2.1
Total	100.0	100.0	100.0
N	72	25	97

Approval of Family Planning

Respondents were asked about their approval of birth spacing and use of any form of contraception for spacing purposes. Husband's opposition may prevent his wife from using contraceptives, even when she wants to delay or stop childbearing (Casterline, Perez, and Biddlecom, 1997). In Jhelum, almost all male respondents (99.5 percent) approved of spacing between children; however, a smaller proportion (86 percent) approved the use of any form of contraception for spacing between children (Table 12.5). Fourteen percent disapproved of using any form of contraception to space between children. There was no significant difference among urban and rural residents on this issue.

Table 12.5: Distribution of respondents by the approval status of spacing and use of contraceptives for spacing and residence

Variable	Rural	Urban	Total
Spacing between children			
Approve	99.3	100.0	99.5
Disapprove	0.7	0.0	0.5
Total	100.0	100.0	100.0
N	145	55	200
Using family planning methods for spacing			
Approve	86.1	85.5	85.9
Disapprove	13.2	14.5	13.6
Other	0.7	0.0	0.5
Total	100.0	100.0	100.0
N	145	55	200

Satisfaction Level of Current Users

Satisfaction of the user with his/her contraceptive method is an important factor in whether or not they continue with the method. Male contraceptive users were asked to report how satisfied they were with their present contraceptive method. Table 12.6 shows 86 percent of the current users were very satisfied with their current method; only 6 percent reported that they were not satisfied with their current method. While none of the urban current users reported dissatisfaction with their method, 89 percent of the rural and 78 percent of the urban users were satisfied with their methods. Twenty-two percent of the urban users and 4 percent of the rural 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 will continue using a family planning method.

Table 12.6: Level of satisfaction of male respondents with their current method by residence

Level of satisfaction	Rural	Urban	Total
Very satisfied	88.7	77.8	85.9
Somewhat satisfied	3.8	22.2	8.5
Not satisfied at all	7.5	0.0	5.6
Total	100.0	100.0	100.0
N	53	18	71

Table 12.7: Distribution of past contraceptive users by reason for discontinuing last method and residence

Reason	Rural	Urban	Total
Experienced side effects	23.8	12.5	20.7
Fear of side effects	19.0	12.5	17.2
Want another child	52.4	75.0	58.6
Method failure	9.5	0.0	6.9
Method inconvenient to use	9.5	0.0	6.9
Rest from method	33.3	37.5	34.5
Health concern	19.0	12.5	17.2
Infrequent sex/respondent away	14.3	25.0	17.2
Wife opposes	4.8	12.5	6.9
In-laws/parents oppose	0.0	12.5	3.4
N	21	8	29

Respondents could give more than one reason.

The reasons for stopping use of their last method among men are presented in Table 12.7. The table shows that wanting another child was the main reason for stopping the use of a family planning method. However, more than 21 percent of male past users stopped using their method because of side effects they experienced with their method. More than 17 percent of the past users stopped using a contraceptive due to fear of side effects. There were also a few cases where the wife and in-laws opposed the use of a contraceptive method, especially in urban areas.

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. When husbands were asked if during the last one year their wives could approach them to discuss family planning easily, with difficulty, or if they had to wait for their husbands to initiate the discussion, the responses are shown in Figure 12.1. Ninety-two percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, more than 34 percent of the men reported that their wives had never approached them during the last one-year on this issue. Almost 45 percent of the men reported that their wives had talked often and 21 percent reported they had talked once or twice about this subject during the last year.

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

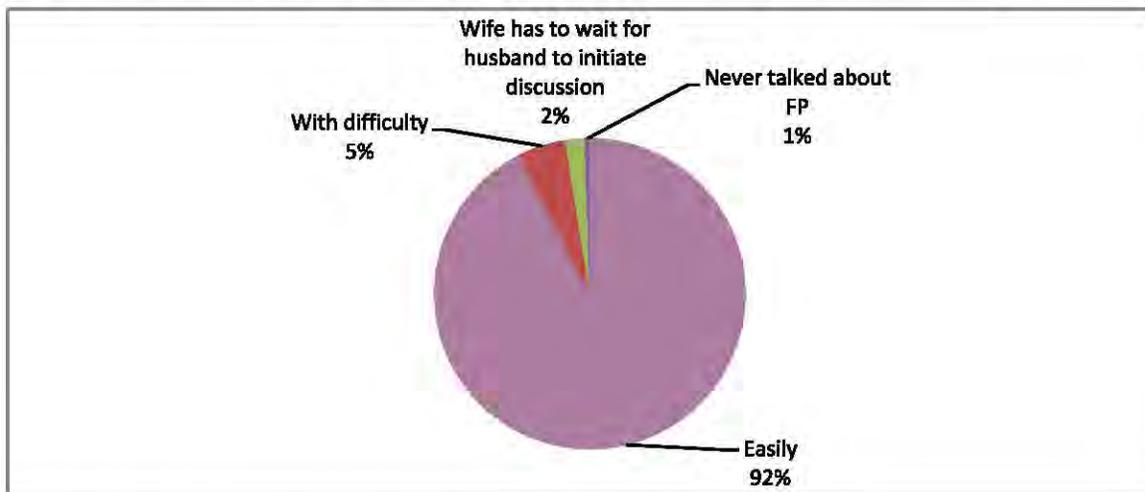
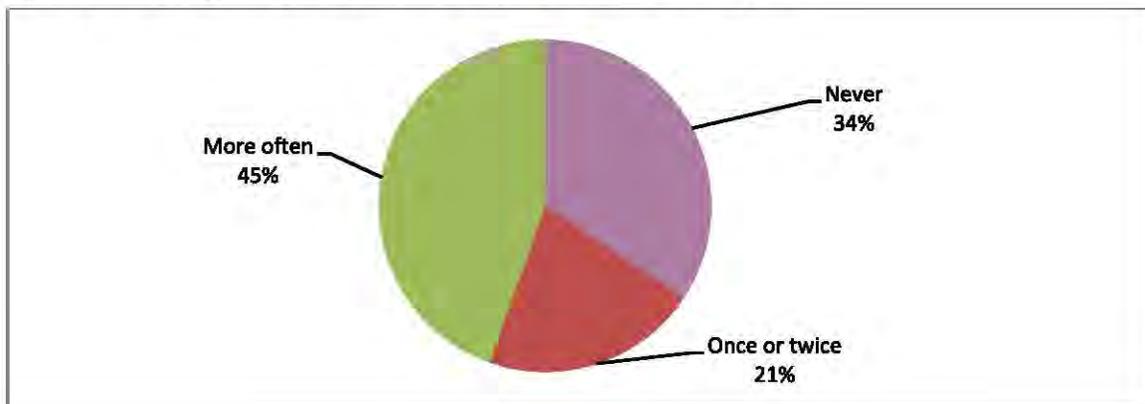


Figure 12.2: Frequency of discussion on FP with wife in last year



Potential Users

Men who had never used any contraceptive method were asked about their intended future use of contraceptives and their method preferences. Table 12.8 shows that 25 percent intended to use contraceptives in the future; a large majority (62 percent) of husbands did not intend to use contraceptives in the future. Fourteen percent of the respondents were uncertain about their future use of contraceptives.

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

Intent	Rural	Urban	Total
Will use	24.1	26.1	24.7
Will not use	67.2	47.8	61.7
Unsure/uncertain	8.6	26.1	13.6
Total	100.0	100.0	100.0
N	58	23	81

As shown in Table 12.9, the major reason husbands said they did not intend to use was their desire for more children (36 percent). The majority (34 percent) reported that they did not need contraception since their wives were unable to conceive and 42 percent reported that they had infrequent sex so they did not need contraception. For 26 percent, fear of side effects was the main reason, while 18 percent were shy about visiting family planning clinics.

Urban-rural differentials were observed among reasons for not intending to use contraceptive methods in the future. Although the numbers were small for examining urban-rural differentials, the differentials were obvious. There was no wife or in-law opposition to adopting family planning in urban areas. There was no lack of access to contraceptives or availability issues as well, nor was the cost of these contraceptive methods reported as an issue in urban areas of Jhelum. However, fear of side effects and shyness to go to family planning sources/outlets were higher in urban areas than in rural areas. The desire for more children was reported as the reason for not intending to use any contraceptive and was significantly higher among rural respondents (44 percent) compared to their urban counterparts (9 percent).

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

Reason	Rural	Urban	Total
Wife opposes	10.3	0.0	8.0
In-laws/parents oppose	7.7	0.0	6.0
Fear of side effects	23.1	36.4	26.0
Lack of access/unavailability	7.7	0.0	6.0
Costs too much	7.7	0.0	6.0
Shy to go to FP clinic	17.9	18.2	18.0
Inconvenient to use	5.1	0.0	4.0
Infrequent sex/respondent away	46.2	27.3	42.0
Difficult/unable to conceive	28.2	54.5	34.0
Breast feeding/lactational amenorrhea	12.8	0.0	10.0
Want more children	43.6	9.1	36.0
N	39	11	50

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. It is observed that a small proportion wanted to use male methods.

Table 12.10: Distribution of never users by intention of future use of a specific contraceptive method

Method	Rural	Urban	Total
Pills	14.3	33.3	20.0
Injectable	21.4	16.7	20.0
Condom	0.0	33.3	10.0
Withdrawal	7.1	0.0	5.0
Not decided	57.1	16.7	45.0
Total	100.0	100.0	100.0
N	14	6	20

Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 12.11 shows that 15 percent of the respondents wanted another child soon (within two years). Another 18 percent wanted to delay their next child for more than two

years. The largest proportion of respondents (60 percent) did not want any more children at all.

This desire for having another child soon was inversely associated with the number of living children. Seventy-one percent of the respondents who had no child wanted their child soon, while 29 percent who had one child and 13 percent who had 2 children wanted their next child soon.

Table 12.11: Distribution of male respondents by desire of next child and number of living children

Number of living children	Desire of next child				Total	N
	Soon	Later	Never	Don't know /unsure		
0	70.8	29.2	0.0	0.0	100.0	24
1	29.2	45.8	12.5	12.5	100.0	24
2	12.9	32.3	35.5	19.4	100.0	31
3	0.0	23.5	64.7	11.8	100.0	34
4	4.0	0.0	92.0	4.0	100.0	25
5	0.0	0.0	95.7	4.3	100.0	23
6+	0.0	0.0	97.4	2.6	100.0	39
Total	14.5	18.0	59.5	8.0	100.0	200

The desire to stop having children was positively associated with the number of living children. Thirty-six percent of the respondents who had 2 children did not want any more children. More than 90 percent who had more than 3 children did not want any more children.

The percentage of respondents who did not want more children was much larger than the 36 percent of husbands who reported current use of contraception. If those who wanted to postpone having another child are combined with those who did not want any more, the sum would constitute about three-fourths of all husbands. This suggests that there is a substantial need for family planning, but that motivational programs and service delivery were not keeping pace with the need.

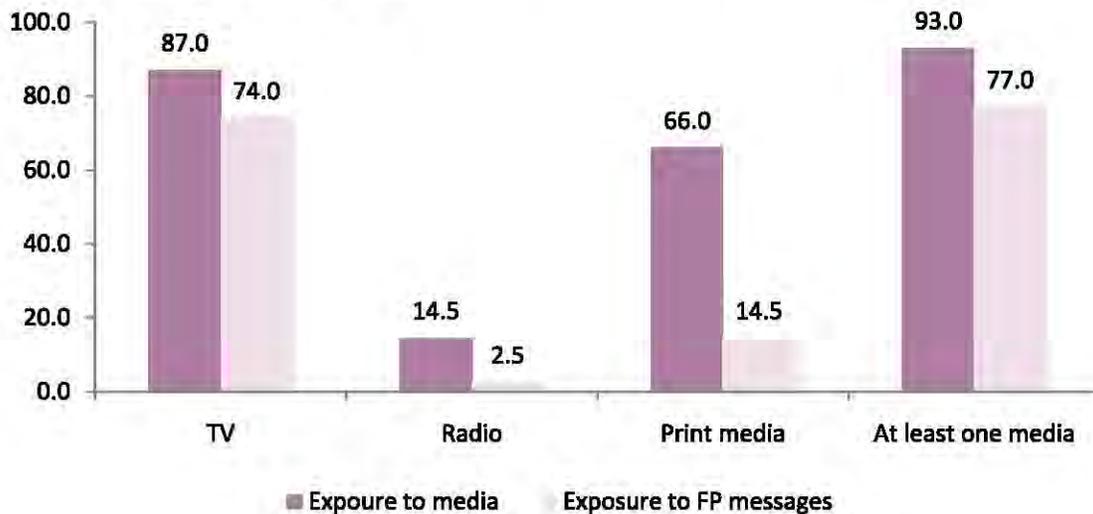
Mass Media Access and Exposure to FP Messages

For the development of communication activities, it is important to know which forms of mass media are available and to what extent they are used by various segments of the

population. Figure 12.3 shows the proportion of men who reported that they watched TV, listened to the radio, or read newspapers or magazines. TV and print media were the most commonly accessed mediums as 87 percent of the male respondents in Jhelum watched TV and 66 percent of them reported access to print media.

Furthermore, respondents who reported access to any sort of media were asked if they had ever seen, heard, or read any message pertaining to methods of family planning through these mediums. Seventy-four of the men had seen FP messages on the television. This percentage was the equivalent to the responses of women in Jhelum. Overall, 77 percent of the male respondents and 76 percent of the female respondents had seen a family planning message on at least one medium. Less than 3 percent of the men reported that they had ever listened to a family planning message on the radio.

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



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